

# Trocaire

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## Health in a period of economic crisis:-who benefits?

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**Working for  
a just world.**

# The Outline:

Broad trends in terms of health and spending

Who benefits ? – experiences in the areas of:

- HIV
- Gender equality

People's own priority issues

Some issues for consideration

Working for a just world.

Keeping Commitments for HIV and AIDS:  
Access for All to Prevention, Treatment,  
Care and Support  
A Position Paper from the Catholic HIV and AIDS Network (CHAN)

MAY 2011

**The Asks**

1. **Maximize long-term funding commitments** for continuation of current AET programming, start-up of new programming where needed and for the infrastructure to meet the Universal Access targets.
2. **Provide comprehensive and integrated prevention, treatment, care and support** for adults and children living with or vulnerable to HIV infection, build, strengthen and sustain human resource capacity to carry out comprehensive programmes through training and mentorship of skilled staff and volunteers.
3. **Improve support for infected and affected**

The global community through mechanisms such as the Global Fund, PEPFAR, and UNFPA, has collectively contributed more than US\$ 520 billion to the response since 2002. Significant achievements have been achieved as a result of this investment – new HIV infections have decreased by 17 percent since 2001 and 5 million people living with HIV have been put on treatment – a 50-fold increase since 2001.

Despite these achievements, funding for HIV has seen a sharp decline in the recent past. In anticipation of the MDG Summit in October 2010, UN Secretary-General Ban Ki Moon noted that between 2011 and 2015 an estimated US \$28 billion to US \$30 billion yearly would be required to meet access targets. At the 2010 Hanoi summit, pledges of the US \$20 billion requested to support the Fund's programmes to cover the next three years. Since then countries have either scaled back or not pledged to HIV and AIDS entirely.

Irish-related partnership organizations throughout the world.

Dochas  
The Irish Association of Pharmaceutical Development Organizations

**AIDS IS NOT OVER:  
IRELAND'S RESPONSIBILITY  
TO HELP FINISH THE JOB**  
A Policy Paper of the Dochas HIV & AIDS Working Group

*Irish people being eliminated from treatment, 290,000 orphans and widows losing their food, education and assistance, and 20,000 babies born every year?*

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Continued to Support Global Response - Ireland at UNFPA

Working for a just world © 11. Ireland has 2011 health and social policy objectives. 10 October 2011.

**Integrating Gender Based Violence into the post-2015 development agenda**  
Irish Consortium on Gender Based Violence

DISCUSSION PAPER

The Millennium Development Goals (MDGs) have been the leading international development framework for more than a decade and the 2015 deadline for achieving them is fast approaching.

The debate on what should follow these MDGs is gaining momentum and various actors are engaged in a process of recovery and reimagining the MDGs and the 2015 agenda.

The Millennium Development Goals (MDGs)  
GOAL 1: Eradicate extreme poverty and hunger  
GOAL 2: Achieve universal primary education  
GOAL 3: Promote gender equality and empower women  
GOAL 4: Reduce child mortality  
GOAL 5: Improve maternal health  
GOAL 6: Combat HIV/AIDS, malaria and other diseases  
GOAL 7: Ensure environmental sustainability  
GOAL 8: Develop a global partnership for development

2015 agenda  
The Irish Consortium on Gender Based Violence has initiated a global consultation on follow the MDGs in 2015. The Irish Gender Based Violence is taking part in the writing a submission to the UN global consultation on Addressing Inequality and research report entitled *Assigning Gender to the post-2015 agenda*, which has been submitted to the UN Secretary-General. The Consortium is uniquely placed to bring a range of voices and experiences into the process. This research was based on in-depth interviews with a range of experts from different countries, regional staff of the Consortium, staff of policy units, from governments and academia, in addition to experience of Consortium members and a literature review.

See the proposed Sustainable Development Goals (SDGs) clearly that they have used terminology. See: Outcome Document of the High Level Review of the Millennium Development Goals, October 2011.

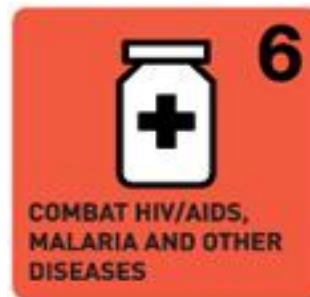
**My Rights Beyond 2015:  
Making the Post-2015 Framework  
Accountable to the World's Poor**  
September 2013

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YEARS

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# Millennium Development Goals

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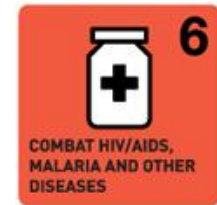
# The Gains:

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Number living in extreme poverty has been halved at a global level



Over 2 billion people gained access to improved sources of drinking water



Gains in the fight against malaria and tuberculosis

Proportion of slum dwellers in the developing world is declining



Hunger reduction target is within reach

A low debt burden and improved climate for trade



## And where we could do better:

- Nutrition
- Access to primary education
- Universal access to ART & prevention
- Access to sanitation
- Child survival
- Maternal health
- Environmental sustainability

**Inequality**

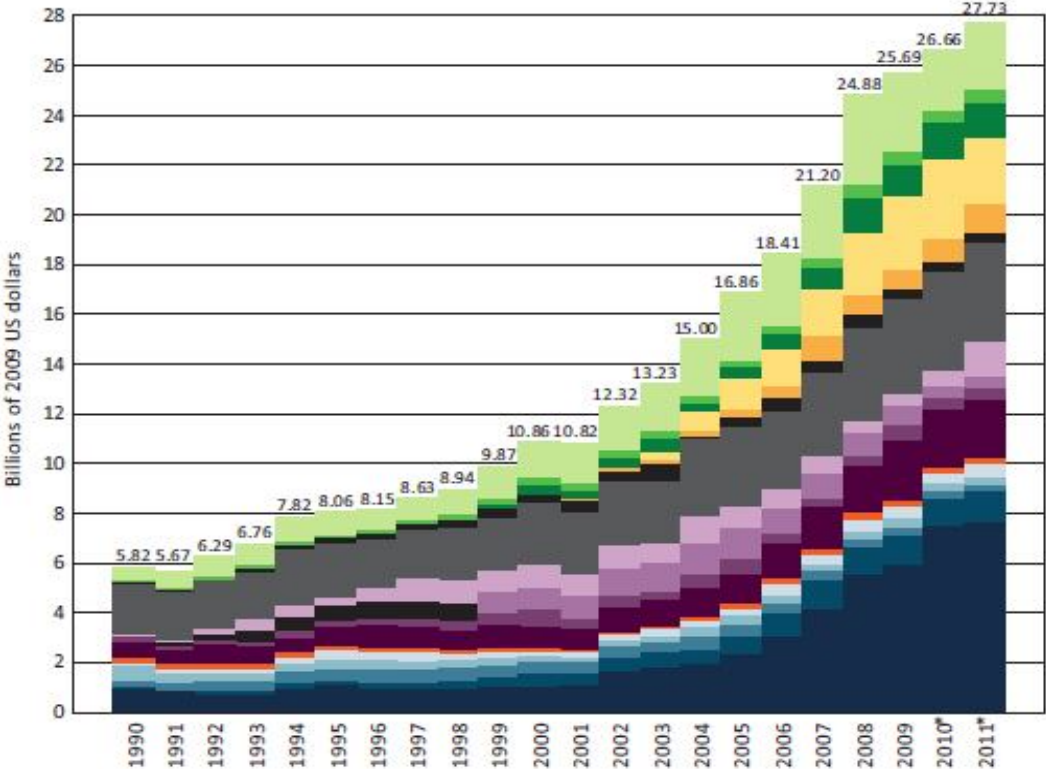


# Development Assistance for Health Trends

**FIGURE 2:**  
**DAH by channel of assistance, 1990-2011**

- NGOs
  - Other foundations
  - BMGF
  - GFATM
  - GAVI
  - European Commission
  - WHO, UNICEF, UNFPA, UNAIDS, PAHO
  - World Bank – IBRD
  - World Bank – IDA
  - Regional development banks
- Bilateral agencies:**
  - Other
  - Sweden
  - Germany
  - France
  - Japan
  - United Kingdom
  - United States

Source: IHME DAH Database 2011  
 \*2010 and 2011 are preliminary estimates based on information from the above organizations, including budgets, appropriations, and correspondence.



# What we need to be concerned about:

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- Total amount of financing available
- The volatility and uncertainty of aid
- Priority setting – who sets the priorities
- Co-ordination
- Accountability including downward accountability
- The rationale for aid

Source: Suerie Moon and Oluwatosin Omole, Development Assistance for Health: Critiques and Proposals for Change

# Case Study 1: HIV

## Keeping Commitments for HIV and AIDS: Access for All to Prevention, Treatment, Care and Support

A Position Paper from the Catholic HIV and AIDS Network (CHAN)

MAY 2011

### The Asks

1. Maintain long-term funding commitments for continuation of current ART programming, start-up of new programming where needed and for the infrastructure to meet the Universal Access targets.
2. Provide comprehensive and integrated prevention, treatment, care and support for adults and children living with or vulnerable to HIV infection; build, strengthen and sustain human resource capacity to carry out comprehensive programmes through training and retention of skilled staff and volunteers.
3. Improve support for infected and affected children through increased and sustained access to paediatric diagnostics (testing) and child friendly treatment for HIV and HIV/TB co-infection; prevention of vertical transmission; and continued support for orphans and vulnerable children.

### Background

The United Nations General Assembly Special Session (UNGASS) on HIV and AIDS in 2001 was a landmark event in the global response to HIV. The 2001 Declaration of Commitment on HIV/AIDS and subsequent 2006 Political Declaration on HIV/AIDS adopted by the UN General Assembly provide both a global framework for the response to the pandemic and a promise by governments to deliver on these commitments.

The Catholic HIV and AIDS Network (CHAN) is a network of Catholic Church-related partnership organizations from Europe, North America and Oceania that support HIV programmes throughout the world.

The global community, through mechanisms such as the Global Fund, PEPFAR, and UNITAID, has collectively contributed more than US \$32 billion to the response since 2002. Significant advancements have been achieved as a result of this investment – new HIV infections have decreased by 17 percent since 2001 and 5 million people living with HIV have been put on treatment – a 10-fold increase since 2003.<sup>1</sup>

Despite these advancements, funding for HIV has seen a sharp decline in the recent past. In anticipation of the MDG Summit in October 2010, UN Secretary-General Ban Ki Moon noted that between 2011 and 2015 an estimated US \$28 billion to US \$50 billion yearly would be required to reach universal access targets.<sup>2</sup> At the 2010 Global Fund Replenishment conference, pledges fell far short of the US \$20 billion requested to continue and expand the Fund's programmes in 145 countries over the next three years. Since then some donor countries have either scaled back or withdrawn their pledges to HIV and AIDS entirely.

Flat-lining budgets and funding cuts effectively rescind the commitments made at UNGASS in 2001 and 2006, lead to backtracking of progress made, and translate into millions of unnecessary deaths. It is estimated that proposed financial year 2012 cuts by the United States government<sup>3</sup> could result in 448,866 people being eliminated from anti-retroviral treatment; 299,294 orphans and vulnerable children losing their food, education and livelihood assistance; and 20,000 babies born with HIV each year.<sup>4</sup>





# AIDS by the numbers

# 40-fold

Increase in access to antiretroviral therapy since 2002.

More than 10% of people living with HIV in low- and middle-income countries are aged 50 years or above

# 35.3

million people living with HIV In the world.

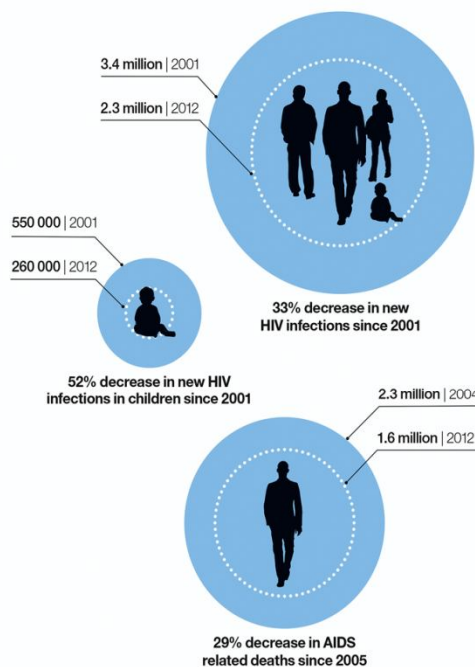
People accessing treatment

# 9 700 000

Every hour 50 young women are newly infected with HIV.



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Total number  
of people  
living with  
HIV in 2012



Every hour  
50 young  
women are  
newly infected  
with HIV



HIV treatment  
coverage for  
children was half  
of coverage for  
adults in 2012



Percentage of  
HIV-related  
funding from  
low and middle-  
income countries  
in 2012

**Figure 1. International HIV Assistance from Donor Governments: Commitments & Disbursements, 2002-2012**



# Lessons from HIV epidemic response:

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- ✓ Mobilise resources and invest in health
- ✓ Co-ordination and Partnership
- ✓ Include the voice of those affected by HIV and AIDS
- ✓ Evidence and data is important
- ✓ Using AIDS as an entry point to inclusive, human rights focused, people-centred, multi-disciplinary responses
  
- ✓ Stay the course

# Experience of Catholic Agencies

All experienced some degree of flat-lining/budget cuts

Staff and volunteer cutbacks evident

Issues with lack of adherence – drug shortages and transportation

Funding for wider care and support services declining

Move to government support but transition inadequate

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*“I keep hearing I need to do more with less; this is just not possible”*

*“Our integrated model of care includes home-based and palliative care, HIV prevention and psychosocial support”*

# Field Experience:

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Uganda – Nsambya Home Care Programme

75% funding cut



Staff Layoffs/Cuts to Supplies  
Embargo on enrolment of clients

*“Missed opportunities and early mortality”*

South Africa - St Mary's Outreach Centre



Temporary closure to OVC and HBC clients

Staff and volunteer cuts

Nutritional support and community food gardens

From 24 to 6 Treatment Sites

*“People are turned away once quotas are filled”*

*We risk going back to no-one dies alone*

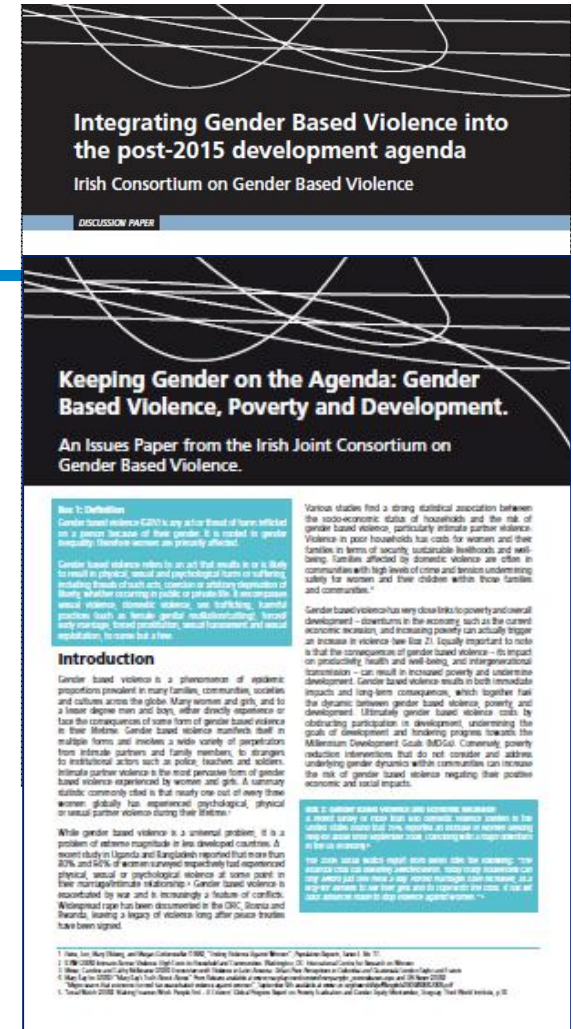
# Case Study 2: Gender

A recent World Bank Development Report found that **no fragile state will achieve any of the MDGs by 2015** and that violence is the main constraint to achieving the MDGs.

According to the OECD DAC definition, 47 states in the world are defined as fragile.

**Nata Duvvury : Economic Cost of GBV:**

*In Vietnam women's productivity in the home and wellbeing of children were affected. This amounted to 34 hours of household work and 8-10% of household income.*



Public policy can and should play an important role in offsetting these disadvantages as well as actively helping to transform institutional norms and practices which give rise to them Dr Naila Kabeer



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**Mind the Gap - Women's Vulnerability to the HIV Epidemic**

*"Thirty years into the HIV epidemic, physiological, sociocultural and structural factors, such as harmful gender norms, violence, poverty, legal inequalities and lack of education, continue to place women and girls at risk of HIV infections and influence their inability to access health care and services, thereby having an impact on their ability to mitigate the consequences of HIV and AIDS."*

UN Secretary-General, Ban Ki-Moon, regarding the 15<sup>th</sup> Commission on the Status of Women on women, the girl child and HIV and AIDS

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**Key Points**

To ensure an effective response to women's vulnerability to the HIV epidemic, decision makers must take action in four key areas of the response:

- Tackle the underlying social and cultural norms that drive gender inequality;
- Promote effective implementation of existing policies from national to local levels;
- Strengthen coherence between policies on HIV and gender equality;
- Include women living with HIV in decision making on HIV policy and response.

**Introduction**

Gender inequality and persistent power imbalances between men and women increase women's vulnerability to the HIV epidemic. Over thirty years into the epidemic, women and girls are still at a higher risk of HIV infection and shoulder a disproportionate burden of the impact of HIV.

Women represent 55% of people living with HIV globally and 59% of people living with HIV in sub-Saharan Africa.<sup>1</sup> The situation is particularly acute for young women in sub-Saharan Africa where they represent 72% of the 15-24 year olds living with HIV.<sup>2</sup> In some regions where women do not represent the majority of people living with HIV, there has been increases in the proportion of women living with HIV over the last ten years.<sup>3</sup>

The figures are indicative of the failure to prevent transmission to women and to address underlying social, cultural and economic factors that drive vulnerability to women and girls. We also know that care is overwhelmingly provided by women, they share a disproportionate burden of the effects of HIV on the household, often feel the effects of poverty, and most likely have received their schooling and nutritional food with the least nutritional value.

This vulnerability can further reinforce gender inequality. Less women's participation in decision making, limit women's access to education and economic empowerment and lead to new HIV infections and poor health outcomes for women, including death for women of reproductive age.<sup>4</sup>

**1. Tackle Underlying Social and Cultural Norms that Drive Gender Inequality**

International, national, and local responses have focused, for the most part, on technical interventions that are aimed at reducing women's vulnerability to the HIV epidemic. They do not adequately deal with the underlying social and cultural norms that create a power imbalance between men and women and in turn lead to increased vulnerability to HIV.

The United Nations General Assembly declarations on HIV in 2001,<sup>5</sup> 2006,<sup>6</sup> and 2011<sup>7</sup>, while recognizing the

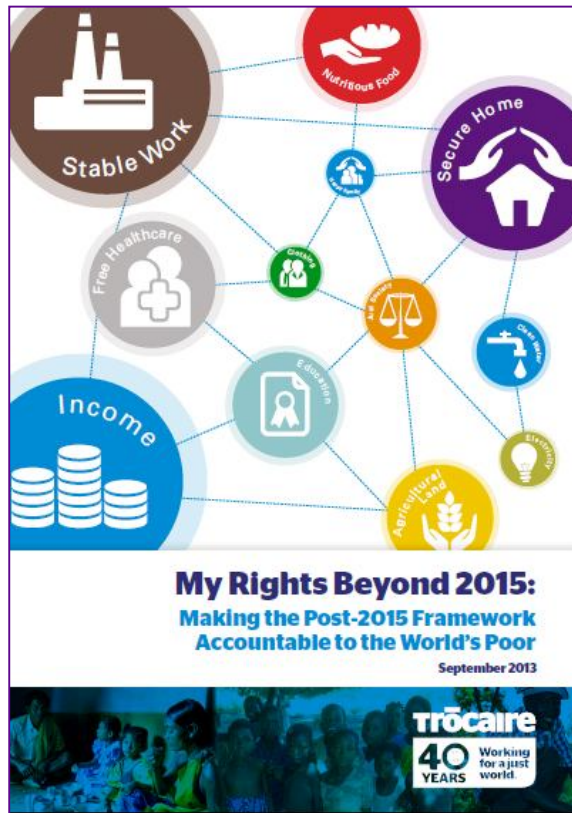
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It would be worse if I were a woman. They do not receive any benefits, and it is even worse if they haven't studied – Nicaragua male

All government, politicians and all departments are corrupt; no expectation from them, no one monitors them, and if someone does this he would be killed. Pakistan male

We do not have any health clinics. When we go to town, they humiliate and minimise us. We have no one to represent us. To be cared for at the clinic we need at least 500 gourdes – Haiti female focus group

# Final Thoughts:

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Address structural inequalities

Establish a human rights framework for goals

Explicitly address gender-based discrimination in responses

Develop accountability mechanisms with national regional and international layers

Balance the need for results and speed vs time for real social change and participation

Stay the course with what works

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Trócaire is the overseas development agency  
of the Catholic Church in Ireland.

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