

HEALTH

Poor health in Africa comes not only in the form of headline-grabbing diseases such as HIV/AIDS, tuberculosis and malaria, but also as a lack of access to such basic commodities as immunisations or the presence of skilled health-care providers at childbirth. Not only does this multitude of challenges affect the quality of individual lives: it also has social and economic implications for the stability and productivity of communities and countries.

Since the G8 nations committed at Gleneagles in 2005 to support African countries' efforts to improve their health and the systems that support it, more than 1.2 million Africans have started treatment on lifesaving antiretroviral therapy (ART). Several African nations, including Kenya, Zambia and areas of Tanzania, have had success in fighting malaria, and polio remains endemic in only one African nation, Nigeria. The years since Gleneagles have shown the powerful impact on health that development assistance can have when it supports African efforts.

This chapter monitors the G8 members' progress towards meeting their Gleneagles commitments in five categories of health for which they offered measurable targets: health systems including maternal and child health, HIV/AIDS, tuberculosis, malaria and polio.

HEALTH SYSTEMS DEVELOPMENT

Health systems provide the platform upon which existing and emerging diseases can be prevented, diagnosed and treated. A functioning health system requires health-care workers, including doctors, nurses, community care workers and pharmacists. It requires supply chains for basic medical supplies, clinics, hospitals and transportation. Sub-Saharan Africa faces the most significant health-care worker shortage in the world: it has 24% of the global disease burden, but only 3% of the world's health workers.¹

The improvement of child health, and especially maternal and newborn health, is largely dependent on the upgrading of national health systems. Maternal mortality is often the result of not recognising that complications are serious enough to require medical attention and the result of delays in getting to an adequately equipped treatment centre and then starting treatment, because of a lack of medical personnel, equipment or drugs.

Child mortality is similarly linked to issues of scarce health worker resources, but is also due to the fact that very affordable vaccines, readily available in the developed world, are often a scarce commodity in developing nations. As a result, global child mortality numbers are high: 2 million children, 1.4 million of whom were under age five, died in 2002 from diseases that could have been prevented with vaccines that should be readily available.²

DATA has this year combined the G8 commitments on health systems and maternal and child health under one heading, to reflect the linkages between strengthening health systems and reducing morbidity and mortality among mothers and young children.

WHAT DID THE G8 PROMISE?

PARAGRAPH 17

‘We support our African partners’ commitment to ensure that by 2015 all children ... have access to basic health care (free wherever countries choose to provide this) to reduce mortality among those most at risk from dying from preventable causes, particularly women and children...’

PARAGRAPH 18C

‘We will work to achieve these aims by: Investing in improved health systems in partnership with African governments, by helping Africa train and retain doctors, nurses and community health workers.’

UPDATING THE COMMITMENT: HEILIGENDAMM

PARAGRAPH 62

‘...the G8 support the establishment by African countries of sustainable financing of health systems. Enhancing this process, the G8 welcome the ‘Providing for Health’ initiative as a means to work toward sustainable and equitable financing of health systems and improved access to quality health services, through linking national financing strategies with coordinated international support.’

PARAGRAPH 63

‘We will work with African states to address the different causes of this lack of human resource capacity within the health sector, including working conditions and salaries with the aim of recruiting, training, and retaining additional health workers.’

INTERPRETING THE COMMITMENT

The G8 pledged to support its African partners’ commitment to provide basic health care to children, to reduce child and maternal mortality and to help Africa train and retain health-care workers. DATA interprets this to mean increased investments for basic health care, increased access to vaccinations and assistance with health-care worker training, paired with policy conducive to building and maintaining

adequate health forces. Because no financial commitments were made against these goals and because estimates vary widely, DATA has measured the percentage of total health spending directed to health systems and has assessed contributions towards the Global Alliance for Vaccine and Immunizations (GAVI) because of its large contributions to the sector.

HOW AMBITIOUS WAS THE G8 PROMISE?

The G8 commitment to health systems and child and maternal health at Gleneagles, while welcome, was not ambitious because no specific targets or financial commitments were made. Investment in health systems is often integrated into the costs of treating individual diseases, but Africa's health systems needs are so vast that they require dedicated investments. Financing the expansion of Africa's health workforce alone has been estimated to cost \$4.9 billion in 2008, rising to \$7.7 billion per year by 2010.³ In 2006, 36 of the 57 countries facing shortages of health-care professionals were in sub-Saharan Africa. The region needs more than 800,000 health workers, an increase of 140%, just to meet the WHO recommendation for a minimum of 2.3 health workers per 1,000 people in every country.⁴ In addition, health systems require investments in infrastructure, technology, supplies, medicines and transportation. There are currently no comprehensive comparable estimates for all these health systems components across Africa.

The World Health Organization (WHO) has determined that scaling up maternal and child health care to reach 95% coverage between 2006 and 2015 would have required \$2.2 billion in 2006, increasing to \$7.8 billion in 2015. Because there is money in WHO's estimate for training health workers, it is likely that there is some overlap between this figure and that given at the beginning of this section for training health workers in Africa. From the information available, DATA is not able to determine how much overlap exists.

DELIVERING THE PROMISE

Funding for health systems as a percentage of total health sector spending has declined in the past three years, from more than 24.2% in 2004 to approximately 18.9% in 2007.⁵ Although funding in absolute terms has remained steady, increases for health systems have not kept pace with increases for infectious diseases.

In 2004, about 27 million children worldwide remained unvaccinated; 10 million of these children lived in sub-Saharan Africa.⁶ Today, including important vaccines for hepatitis B and Hib (haemophilus influenzae type B) and administration and delivery costs, a basic package of vaccinations costs \$20–\$40 per child.

GLOBAL ALLIANCE FOR VACCINES AND IMMUNIZATIONS (GAVI)

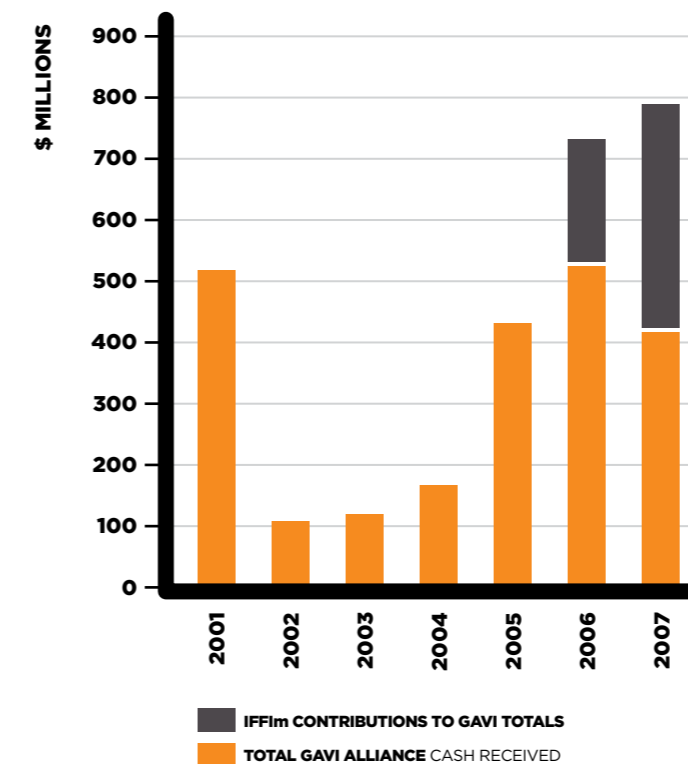
The GAVI Alliance is a public and private partnership that is dedicated to improving health systems and ultimately to improving child health. GAVI is both a fund raiser and a funder that supports national health plans for vaccine programmes and other child health organisations. Between 2001 and 2006, GAVI delivered a package of basic vaccinations to 25.6 million children, delivered hepatitis B vaccination to 123.7 million children and protected 136 million children with new or under-used vaccinations.⁷

Additionally, GAVI uses innovative financing schemes to incentivise the production of medical technology to benefit the world's poor people, including Advanced Market Commitments (AMCs) and the International Financing Facility for Immunisation (IFFIm). AMCs help to create commercially viable markets for producers of medical technologies by committing to a level of pricing for a vaccine before it is produced (AMCs are further discussed in the development assistance chapter). GAVI is a key facilitator of AMCs and is currently working with the World Bank and other major donors on a vaccine for strains of pneumococcal diseases.

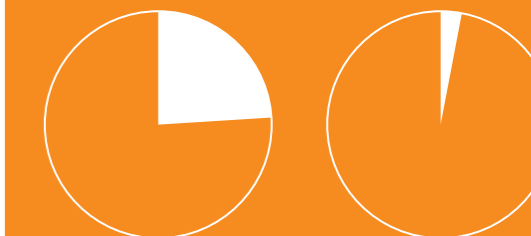
GAVI and major donors launched the IFFIm in 2005. This initiative seeks to secure legally binding 10 to 20-year pledges from donors and then uses these pledges of future aid to raise money on capital markets for immediate use, directing these resources to the GAVI Alliance. By the end of 2007, GAVI had received a total of \$3.192 billion in direct funding from governments and private sources, \$953 million of which was channelled through the IFFIm. In 2007, GAVI spent \$786 million.⁸ All of the G8 countries, except Japan and Russia, have contributed either to the IFFIm or directly to the GAVI Alliance.

The IFFIm anticipates that it will invest \$4 billion between 2006 and 2015 to help fund GAVI in its goal of protecting 500 million children against measles, tetanus and yellow fever, helping to reach the Millennium Development Goal of reducing child mortality by two-thirds by 2015.⁹ G8 countries have contributed 91.79% of total funding to the IFFIm over its lifetime and 23% of total funding to GAVI. The following chart shows contributions from the G8 to GAVI and the IFFIm since 2001. For 2006 and 2007, IFFIm contributions were added to GAVI contributions for the three G8 countries that contributed through the IFFIm: UK, France and Italy.¹⁰

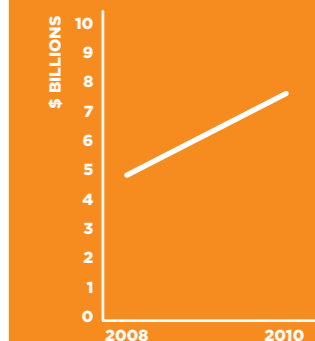
IFFIM'S MAJOR ROLE IN FUNDING THE GAVI ALLIANCE



AFRICA'S HEALTH WORKER SHORTAGE



Sub-Saharan Africa has 24% of the global disease burden, but only 3% of the world's health workers.



Financing the expansion of Africa's health workforce is estimated to cost \$4.9 billion in 2008, rising to \$7.7 billion per year by 2010.

CASH CONTRIBUTIONS TO GAVI AND IFFIM (\$ MILLIONS)

	2001	2002	2003	2004	2005	2006	2007	TOTAL
CANADA	0	1.9	4.8	6.0	130.9	5.2	0	148.8
FRANCE	0	0	0	6.0	0	94.6	64.0	164.6
GERMANY	0	0	0	0	0	5.3	6.0	11.3
ITALY	0	0	0	0	0	78.3	61.0	139.3
JAPAN	0	0	0	0	0	0	0	0
UK	0	15.1	5.6	18.5	6.6	357.9	308.6	712.3
US	48.1	53	58	59.6	64.5	69.3	69.3	421.8
G7 TOTAL	48.1	70	68.4	90.1	202	610.6	508.9	1,598.1
GAVI TOTAL FINANCING	518.1	107.9	117.0	164.2	429.7	740.7	785.7	2,863.3

INTERNATIONAL HEALTH PARTNERSHIP

Following up on the G8's support for the 'Providing for Health' Initiative, the International Health Partnership (IHP) was launched in September 2007, to 'improve the way that international agencies, donors and poor countries work together to develop and implement health plans, creating and improving health services for poor people and ultimately saving more lives'.¹¹ The UK, Germany, Canada, Italy and France were part of the founding group that signed the partnership's compact. By March 2008, eight developing countries had signed up with IHP, but firm results have not yet been reported, given the short timespan of these partnerships.

HIV/AIDS

More than two-thirds of people living with AIDS worldwide are in Africa – 22.5 million people.¹² In 2007, 1.6 million Africans died from AIDS.¹³ While 2.1 million Africans were on antiretroviral treatment (ART) by the end of 2007, a major increase from 2003, this still only represented 30% of those in need.¹⁴ Meeting the 2005 commitment to provide universal access to prevention, care and treatment by 2010 will require significantly intensified efforts.

WHAT DID THE G8 PROMISE?

PARAGRAPH 18D

'With the aim of an AIDS-free generation in Africa, significantly reducing HIV infections and working with WHO, UNAIDS and other international bodies to develop and implement a package for HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010. ... We will also work with them to ensure that all children left orphaned or vulnerable by AIDS or other pandemics are given proper support. ... We will work to meet the financing needs for HIV/AIDS, including through the replenishment this year of the Global Fund to fight AIDS, TB and Malaria; and actively working with local stakeholders to implement the '3 Ones' principles in all countries.'

UPDATING THE COMMITMENT: ST. PETERSBURG

'Building on the commitments we made at Gleneagles last year, the G8 and other international partners agreed a Political Declaration at the UN High-Level meeting on HIV/AIDS in June which commits to pursue all necessary efforts to scale up towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010; and to take measures to ensure that additional resources are made available to tackle AIDS, in view of the UNAIDS estimate that \$20–23 billion is needed annually by 2010. The Global Fund is an important instrument in the battle against HIV/AIDS.

We will work with other donors and stakeholders in the effort to secure a funding needed for the 2006–2007 replenishment period...'

UPDATING THE COMMITMENT: HEILIGENDAMM

At the Heiligendamm Summit, G8 leaders reaffirmed their HIV/AIDS commitment and added interim targets:

PARAGRAPH 48

'We will continue our efforts towards these goals to provide at least a projected \$60 billion over the coming years...' (these resources were not specifically for HIV/AIDS only)

PARAGRAPH 50

'We will contribute substantially with other donors to work towards the goal of providing universal coverage of PMTCT programs by 2010'

PARAGRAPH 50

'The G8 together with other donors will work towards meeting the needed resource for paediatric treatments in the context of universal access, at a cost of \$1.8 billion till 2010.'

PARAGRAPH 57

'The G8 reaffirm their commitment to scaling up towards 'universal access' to comprehensive HIV prevention, treatment and care by 2010...'

INTERPRETING THE COMMITMENT

With regards to HIV/AIDS, The DATA Report is primarily focused on the commitment to support universal access to prevention, care and treatment by 2010. DATA has interpreted this commitment to mean that G8 donors will contribute their proportionate shares to finance these goals based on their share of DAC GNI. This section also tracks progress in the expansion of access to prevention, care and treatment services, to the extent that information is available.

HOW AMBITIOUS WAS THE G8 PROMISE?

DATA considers the goal of universal access to prevention, care and treatment by 2010 to be an ambitious goal. When in 2005 the G8 committed to reach 'universal access' to prevention, care and treatment by 2010, global financing was approximately \$6 billion. In order to achieve universal access, UNAIDS estimates that the world's donor nations would need to contribute \$40.1 billion in 2010. DATA has chosen not to monitor the G8's Heiligendamm commitment to spend \$60 billion fighting HIV/AIDS because, as those resources are estimated to be directed to multiple health sectors in an unspecified period of time, DATA sees it as a less ambitious commitment than the 2005 commitment to universal access to care and treatment.

DELIVERING THE PROMISE

Despite recent progress that placed nearly 2.1 million people in Africa on ART by December 2007, still only 31% of Africans in need of ART are receiving it.¹⁵ It is worth noting that the percentage of those in need who have access to treatment in Africa is nearly the same as the average across all low- and middle-income countries. This represents enormous progress for the continent.

UNAIDS reports that global spending on HIV/AIDS rose to \$10 billion in 2007 but, on its current trajectory, will reach only \$15.4 billion in 2010.¹⁶ All G8 countries have contributed to the Global Fund to Fight AIDS, Tuberculosis and Malaria and to other multilateral agencies that have AIDS programmes. In addition, Germany and the US maintain significant bilateral AIDS programmes:

- The US's HIV/AIDS programme, the President's Emergency Plan for AIDS Relief (PEPFAR), provided \$4.1 billion in FY2007 to fight HIV/AIDS globally and another \$5.1 billion in FY2008.¹⁷ While an increasing amount has been dedicated to the Global Fund, PEPFAR primarily channels its efforts through bilateral assistance, with a focus

on 15 hard-hit countries, 12 of which are in Africa. When this report went to print, the US was still considering reauthorisation of PEPFAR for FY2009–13, but the programme was widely expected to be extended and expanded.

- Germany has committed to spend \$5.02 billion fighting HIV/AIDS between 2008 and 2015. It disbursed approximately \$150 million in 2006 and the same amount in 2007 for bilateral programmes. Germany's bilateral programmes for HIV/AIDS are active in more than 40 countries.

PREVENTION/CARE

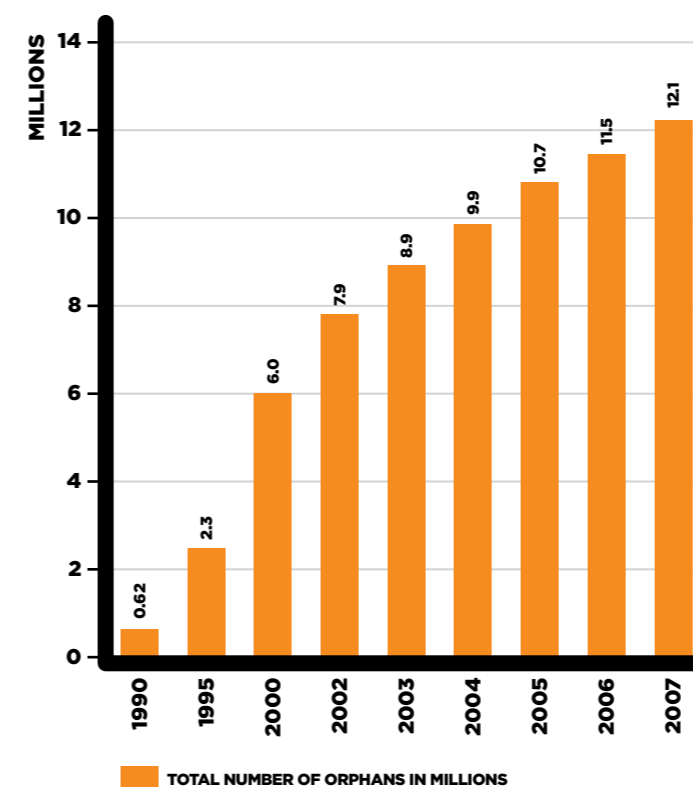
Of the 2.5 million people newly infected with HIV in 2007, 1.7 million were in sub-Saharan Africa, bringing the number of people there living with HIV/AIDS to 22.5 million.¹⁸ Revised UNAIDS estimates suggest that the trend of new HIV infections since the late 1990s may have been slowing and possibly declining slightly. Though the data used to derive new annual infections of HIV are rather uncertain, the estimate of 1.7 million Africans becoming newly infected in 2007 represents a decline from 2.2 million people in 2001.¹⁹ Within this overall trend, there are differences amongst countries and demographic groups. Some countries, such as Zimbabwe, Namibia, Kenya and Mali, show a declining or steadying prevalence rate overall. However, among young people in high-burden countries such as Zambia, South Africa and Mozambique, there is no evidence of a decrease in infection levels.²⁰

Realisation of the G8's aim for an 'AIDS-free generation in Africa' is possible only with significant investments in prevention and a heightened effort to find a vaccine. More than 85% of pregnant women infected with HIV live in sub-Saharan Africa. Recent reports show that by the end of 2007 in southern and eastern Africa, 31% of pregnant women received treatment to prevent mother-to-child-transmission (PMTCT) of HIV, up from only 11% in 2004. West and central Africa have shown much slower growth, with only 7% of HIV-positive pregnant women receiving treatment in 2006.²¹ Great disparity remains in access to PMTCT services: while

some sub-Saharan African countries have access for 54% of women, some provide access for only 1%. Increasing coverage of PMTCT programmes is particularly critical as mother-to-child transmission is the cause of infection for more than 90% of the estimated 420,000 children under the age of 15 who were newly infected in 2007.²²

AIDS not only affects children who carry the virus themselves, but also children whose care-givers are infected. In 2007, a total of 12.1 million African children were without one or both of their parents due to AIDS.²³ At the Gleneagles Summit, the G8 committed to 'work with [our partners in Africa] to ensure that all children left orphaned and vulnerable by AIDS and other pandemics are given proper support'.

CHILDREN UNDER 18 ORPHANED BY AIDS IN SUB-SAHARAN AFRICA (1990–2007)



SOURCE UNAIDS/WHO UNPUBLISHED ESTIMATES 2007

The Global Fund and the US's PEPFAR programme continue to make large contributions to prevention and care programmes, including care for orphans.

As of May 2007, the Global Fund had achieved the following results globally:

- Reached 9.4 million people with HIV counselling and testing;
- Provided 1.2 million orphans with basic care and support.²⁴

As of September 2007, PEPFAR had achieved the following results globally:

- Supported PMTCT services for women during more than 10 million pregnancies;
- Supported care for more than 6.6 million people, including 2.7 million orphans and vulnerable children;
- Supported over 33 million counselling and testing sessions for men, women and children.²⁵

HIV/AIDS IMPACT IN AFRICA

22.5 million

Amount of Africans living with AIDS.

More than two-thirds of people living with AIDS worldwide are in Africa. In 2007, 1.6 million Africans died from AIDS.

1.7 million

Of the 2.5 million people newly infected with HIV in 2007, 1.7 million live in sub-Saharan Africa.

TREATMENT

At the end of 2007, there were an estimated 2.1 million people on antiretroviral treatment in sub-Saharan Africa, out of 7 million on the continent who were in need – a coverage rate of about 30%.²⁶ This was a dramatic improvement from the 100,000 people (just 2% of those in need) who were on treatment in 2003,²⁷ but must dramatically increase in the next few years to reach the goal of universal access by 2010. UNAIDS now estimates that 13.7 million people will need to be on ART by 2010 to meet this target.

ESTIMATED NUMBER OF PEOPLE RECEIVING ART

	DECEMBER 2003 (% OF NEED)	DECEMBER 2005	DECEMBER 2006 (% OF NEED)	DECEMBER 2007 (% OF NEED)
SUB-SAHARAN AFRICA	100,000 (2%)	810,000	1,340,000 (28%)	2,120,000 (30%)
GLOBAL	400,000	1,330,000	2,015,000 (28%)	2,990,000 (30%)

BASED ON DATA FROM UNAIDS, 'TOWARDS UNIVERSAL ACCESS, SCALING UP PRIORITY HIV/AIDS INTERVENTIONS IN THE HEALTH SECTOR, PROGRESS REPORT'

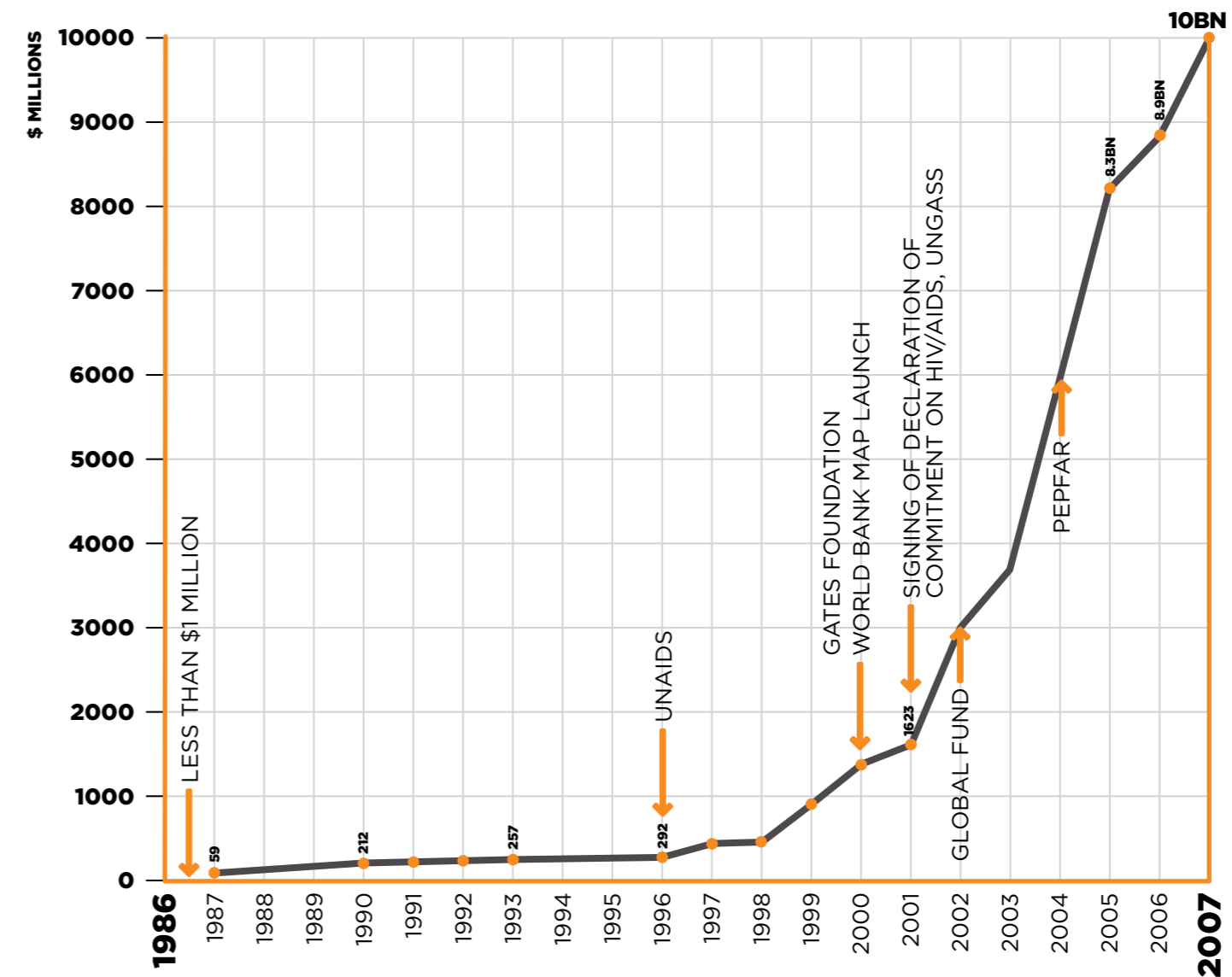
Particularly vulnerable and under-served groups such as children must receive special focus in the efforts to reach universal access to treatment. Almost 90% of children under 15 years of age living with HIV in 2007 were living in sub-Saharan Africa. By the end of 2006 (the latest point for which data were available), only 15% (115,000) of the 780,000 young people in need of treatment in sub-Saharan Africa were receiving it.²⁸

PEPFAR and the Global Fund have been the two largest donors supporting the initiation of antiretroviral therapy. As of December 2007, the Global Fund was supporting treatment for approximately 1.4 million people globally. As of September 2007, PEPFAR was supporting treatment for 1.445 million people globally. Removing the overlap between the two programmes, the Global Fund and PEPFAR are jointly supporting 1.992 million people.

FINANCING NEEDS

Donor funding has risen dramatically since 2001, when nations signed the Declaration of Commitment on HIV/AIDS at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS).

TOTAL ANNUAL RESOURCES AVAILABLE FOR AIDS (1986-2007)



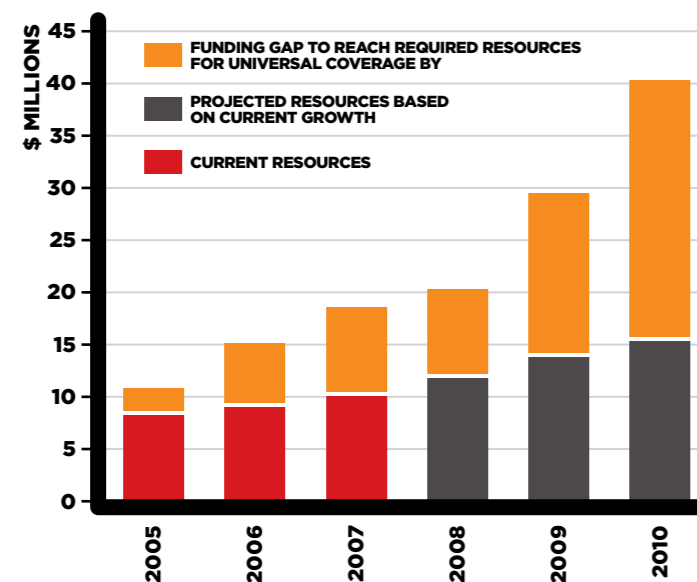
NOTES
1. 1986-2000 FIGURES ARE FOR INTERNATIONAL FUNDS ONLY
2. DOMESTIC FUNDS ARE INCLUDED FROM 2001 ONWARDS

1996-2005 DATA: EXTRACTED FROM 2006 REPORT ON GLOBAL AIDS EPIDEMIC (UNAIDS, 2006)

1986-1993 DATA: AIDS IN THE WORLD II. EDITED BY JONATHAN MANN AND DANIEL J. M. TARANTOLA (1996)

However, meeting the goal of universal access will require further scaling up. UNAIDS estimates that \$40.1 billion will be required in 2010 to achieve universal access – a quadrupling of 2007 spending levels. If donors were to provide 70% of the total \$40.1 billion required, or \$28.1 billion, the G7's proportionate share of this total based on their GNI would be 78.16%, or approximately \$21.9 billion.

RESOURCES REQUIRED FOR HIV/AIDS, COMPARED WITH CURRENT RESOURCES AND TRAJECTORY



UNAIDS REVISED EPIDEMIC FIGURES

Part of the UNAIDS mandate is to perform surveillance and to monitor the AIDS epidemic. UNAIDS issued its 2007 epidemiology report on 20 November 2007, providing an overview of the state of the pandemic. The report garnered press attention because of the significant changes it revealed in disease prevalence and incidence from the 2006 report.

Efforts to monitor the epidemic have long been complicated by the difficulties involved in obtaining accurate data in countries where HIV and AIDS are highly endemic. In 2007, UNAIDS and WHO undertook the most extensive review of HIV/AIDS estimation methodology since 2001. It showed that a number of countries, mostly in sub-Saharan Africa and Asia, have expanded and improved their HIV surveillance systems. In India alone, the number of sentinel surveillance sites increased from 155 in 1998 to more than 1,100 in 2006. Thirty countries in Africa have now conducted national representative population-based household surveys, improving the accuracy of UNAIDS' estimates.

Several improved assumptions were incorporated into the 2007 estimate:

- In countries which have not conducted a national population-based survey, HIV data from antenatal clinic attendees has been better adjusted for inherent flaws in the data, based on comparisons with countries that had both antenatal clinic data and population-based surveys.
- The average number of years that people living with HIV are estimated to survive without treatment has increased from nine to 11 years.

Approximately 70% of the difference in numbers between 2006 and 2007 was explained by reductions in prevalence in six countries: India (which alone accounted for approximately half of the revision) and a group of sub-Saharan African countries – Nigeria, Mozambique, Zimbabwe, Kenya and Angola. In Kenya and Zimbabwe, there was evidence that the decline was due to a reduction in the number of new infections, in part due to a reduction in risky behaviour. Changes relevant to estimating resource needs for achieving universal access to care and treatment by 2010 are incorporated into this year's DATA Report.

TUBERCULOSIS (TB)

Tuberculosis is a leading cause of death for people with HIV.²⁹ More than 2.5 million Africans are newly infected with tuberculosis each year, and more than 500,000 of those infected people die.³⁰ Without an aggressive scale-up of TB treatment programmes, the rise of drug-resistant TB could undermine the progress made on both TB and HIV.

WHAT DID THE G8 PROMISE?

PARAGRAPH 18H

‘We will work to achieve these aims by ... helping to meet the needs identified by the Stop TB Partnership. We also support the call for a high-level conference of Health Ministers for TB in 2006.’

UPDATING THE COMMITMENT: HEILIGENDAMM

PARAGRAPH 54

‘We are committed to working toward further integration of efforts against TB and HIV/AIDS and the integration of DOTS treatment and other comprehensive approaches necessary to control TB in our programmes and activities in order to alleviate the burden of the co-pandemic...’

INTERPRETING THE COMMITMENT

The G8 committed to help meet the needs identified by the Stop TB Partnership, detailed in its Global Plan to Stop TB 2006–2015, which aims to reverse the rise of the disease by 2015. For Africa, the specific aims of the Stop TB Partnership are to reach 16.9 million people with directly observed therapy (DOTS) treatment and to enroll 2.7 million people on antiretrovirals (overlapping with the Gleneagles commitment on universal access).³¹ DATA interprets the G8's commitment as providing their proportionate share of funding required for the Global Plan.

HOW AMBITIOUS WAS THE G8 PROMISE?

If fully implemented, the Global Plan would, during its ten-year lifespan, treat 50 million people for TB, including 1.2 million multi-drug resistant (MDR) cases and about 3 million patients co-infected with TB and HIV. In total, an estimated 14 million lives would be saved.³² Successful implementation of the Stop TB strategy is expected to increase case detection to more than 70% by 2010 and to cure at least 85% of those on treatment.³³ If the Stop TB strategy is fully funded, 85% of those in need would be on treatment by 2010, and it is predicted that the MDG target – to have halted and begun to reverse the incidence of TB by 2015 – would be met in Africa. However, achievement of the Partnership's other TB targets for 2015 – to halve the prevalence of TB and the death rate – will not be reached by 2015.

DELIVERING THE PROMISE

WHO estimated 9.2 million new and relapse TB cases in 2006; Africa accounted for 23% of these cases. Four of the ten countries with the highest number of TB cases were in Africa (Nigeria, South Africa, Ethiopia and Kenya), and the continent accounted for 79% of people worldwide who had TB and were co-infected with HIV.³⁴ The unprecedented growth of the tuberculosis epidemic in Africa is attributable to several factors, the most important being the HIV epidemic.

Directly observed therapy (DOTS) is a five-component strategy created in 1995 that combines political, logistical, diagnostic and treatment guidelines to fight TB. DOTS is a critical part of the Global Plan because those who get access to DOTS treatment have a high rate of treatment success; however, a case must be detected before treatment can begin.³⁵ Recent data show mixed results. In 2005, 89% of Africans lived in areas covered by DOTS, but in 2006 the case detection rate for Africa was only 47%.

STOPPING TB

2.5 million

Africans that are newly infected with tuberculosis each year. More than 500,000 of those infected people die.

If fully implemented, the Stop TB Global Plan would treat **50 million** people for TB, including 1.2 million multi-drug resistant (MDR) cases and about 3 million patients co-infected with TB and HIV. In total, an estimated **14 million lives would be saved.**

In order to fully implement the Global Plan and to reach these critical targets, it is estimated that \$56 billion will be needed from 2006 to 2015, including \$9 billion for research and development and \$47 billion for scaling up interventions.

Based on projections of trends in domestic and external financing, \$25 billion is likely to be available during this time, largely from TB-endemic countries themselves. This leaves a funding gap to be filled by external sources of \$31 billion, or an average of \$3.1 billion per year.

As shown in the following chart, the Global Plan called for \$3.1 billion to be spent in all regions of the world in 2007, but only \$1.984 billion was available.³⁶ It called for \$1.251 billion to be spent in Africa in 2007, but only \$436 million was available.

UNMET NEED FOR TB FUNDING (2007)

	STOP TB FUNDING NEEDED	STOP TB FUNDING AVAILABLE	UNMET NEED FOR 2007
AFRICA	\$1.251 billion	\$436 million	\$815 million
GLOBAL	\$3.1 billion	\$1.98 billion	\$1.12 billion

MDR AND XDR TUBERCULOSIS

Under-investment in tuberculosis control and poor management of anti-TB drugs led to approximately 490,000 cases of multi-drug-resistant tuberculosis (MDR-TB) in 2007. MDR-TB is much more costly and difficult to treat than drug-responsive TB. By October 2007, every continent and all G8 countries had also reported cases of extensively drug-resistant tuberculosis (XDR-TB). XDR-TB is multi-drug-resistant tuberculosis that is resistant to at least three of the six classes of second-line treatments. In response to this emerging health crisis, the WHO prepared a response plan for 2007 and 2008. Full implementation of the plan for these two years alone would save 134,000 lives affected by MDR-TB and XDR-TB. It would cost \$2.15 billion, in addition to what has been estimated for the Global Plan to Stop TB. When the plan was published, only \$165 million of this additional need had been mobilised.

MALARIA

Malaria causes more than one million deaths each year in Africa, most of them in pregnant women and children.³⁷ Recent successes in reducing mortality from malaria in Rwanda, Ethiopia and parts of Tanzania show that the disease can be prevented and treated using currently available and affordable interventions. Despite this progress, the magnitude of the malaria burden remains significant, and some new challenges are complicating the fight against the disease. Drug resistance is growing and malaria continues to cost Africa an estimated \$12 billion per year in lost GDP, even though it could be controlled for a fraction of that amount.³⁸

WHAT DID THE G8 PROMISE?

PARAGRAPH 18G

‘By contributing to the additional \$1.5 billion a year needed annually to help ensure access to anti-malaria insecticide-treated mosquito nets, adequate and sustainable supplies of Combination Therapies including Artemisinin, presumptive treatment for pregnant women and babies, household residual spraying and the capacity in African health services to effectively use them, we can reduce the burden of malaria as a major killer of children in sub-Saharan Africa.’

UPDATING THE COMMITMENT: HEILIGENDAMM

PARAGRAPH 55

‘As a priority, the G8 are committed to expand significantly their efforts to contributing to meet the Millennium Development Goal of having halted and begun to reverse the scourge of malaria. To this effect, we will work with African governments and donors to strengthen the effectiveness of their malaria control programmes in Africa along the three main intervention lines of artemisinin combination therapy, effective case management, effective, tailored vector control strategies and bednets.’

‘G8 members, in support of national malaria control programmes, using existing and additional funds, will individually and collectively over the next few years work to enable the 30 highest malaria prevalence countries in Africa (contributing to at least 80 percent of the global malaria deaths) reach at least 85 percent coverage of the most vulnerable groups with effective prevention and treatment measures and achieve a 50 percent reduction in malaria related deaths.’

INTERPRETING THE COMMITMENT

At the Heiligendamm Summit, the G8 strengthened their commitment to reverse the scourge of malaria on the continent of Africa. The commitment to reach 85% of those in need with malaria prevention and treatment in the next few years will require a rapid scale-up of malaria interventions. DATA has interpreted the ‘next few years’ to mean the years through to 2010. In the first two DATA Reports, DATA tracked G8 donors against their \$1.5 billion target. However, at Heiligendamm, donors emphasised their goal to target the 30 highest-prevalence countries in Africa in an effort to reach at least 85% of the most vulnerable groups with prevention and treatment. For the 2008 DATA Report we are instead measuring progress against the estimated costs needed to achieve this goal. Roll Back Malaria estimates the total cost to be \$2.2 billion per year, the G7 share of which is \$1.72 billion.³⁹

HOW AMBITIOUS WAS THE G8 PROMISE?

At Gleneagles, the G8 committed to reach 85% of those in need with \$1.5 billion in financing. Since that time, new estimates have been released that put resource needs in Africa at between \$1.9 billion and \$3.1 billion a year⁴⁰ and resource needs for the 30 most endemic countries at \$2.2 billion per year through to 2012. At Heiligendamm, the G8 reaffirmed that the goal was to reach 85% of those in need in the 30 most endemic regions, but did not reaffirm the financing they estimated to be needed to achieve that goal. If the commitment is adequately financed, reaching 85% of those in need is an ambitious goal and would have a substantial impact on improving the health of millions of people living in these 30 countries.

DELIVERING THE PROMISE

In Africa, malaria accounts for 40% of public health expenditure, 30%–50% of in-patient admissions and up to 50% of out-patient visits in areas with high rates of malaria transmission. Despite these daunting statistics, the past year has been filled with exciting progress on malaria. Successful bed net distribution campaigns have resulted in reductions in child mortality in high-burden countries. As of November 2007, the Global Fund alone had distributed more than 46 million bed nets to endemic countries⁴¹ and, as of January 2008, the US's President's Malaria Initiative had distributed 4.7 million nets as well as 6.2 million artemisinin-based combination therapy (ACT) treatments.⁴²

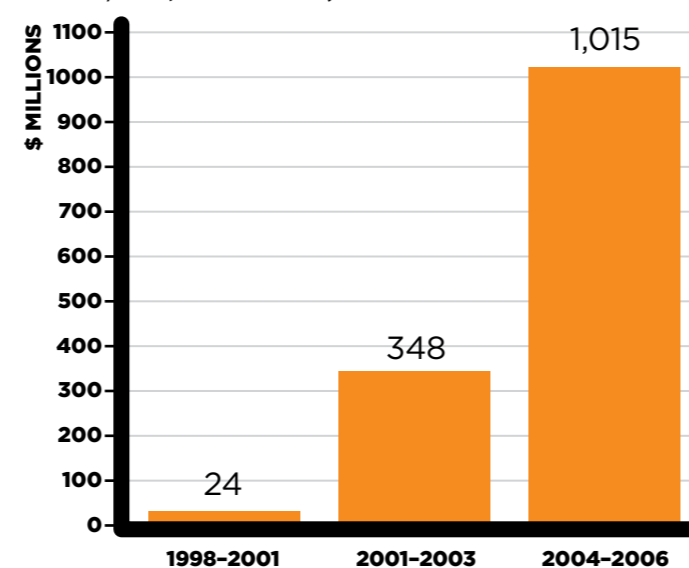
At a conference in Seattle in October 2007, Bill and Melinda Gates and Dr. Margaret Chan created a significant media storm when they called for the 'eradication' of malaria – a goal that has not been seriously considered since malaria eradication efforts ended in the 1970s. In April 2008, Prime Minister Gordon Brown announced that the UK would provide 20 million bed nets and challenged other governments and businesses to make similar commitments.

In January 2008, the Roll Back Malaria Partnership released a cost estimate specifically targeted to achieve

full coverage of prevention and treatment measures in the 30 hardest-hit malaria-endemic countries in Africa, closely mirroring the goal set by the G8 in Germany. The plan estimates that full coverage would require \$2.2 billion in external financing annually between 2007 and 2012. A rapid scale-up would prevent 672 million malaria cases and lead to an increase in annual GDP in Africa of more than \$20 billion in 2012.⁴³

All of the G8 countries have contributed to malaria programmes through the Global Fund, and the UK and the US also have substantial bilateral programmes. Globally, malaria funding has increased dramatically since 1998.

GROWTH IN GLOBAL SPENDING ON MALARIA
(GLOBAL FUND, WORLD BANK AND USAID/PMI, 1998–2006)



In order for the G8 to reach the goal of 85% coverage of people in the 30 most malaria-endemic African nations, the G8 would need to contribute their proportionate share of the total \$2.2 billion based on their share of total DAC GNI – which would be \$1.72 billion in each of the next five years. The DAC began reporting malaria-specific spending in its December 2006 data release; however, as this was the first year of reporting, the data are incomplete. The above graph does not provide a G8 donor specific break out for spending in 2006

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

The G8 has specifically recognised the importance of the Global Fund in fighting HIV/AIDS, tuberculosis and malaria.

WHAT DID THE G8 PROMISE AT GLENEAGLES?

PARAGRAPH 18D

'We will work to meet the financing needs for HIV/AIDS, including through the replenishment this year of the Global Fund to Fight AIDS, TB and Malaria.'

UPDATING THE COMMITMENT: HEILIGENDAMM

PARAGRAPH 49

'We recognise that the level of demand to the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) will increase substantially in the future as has been projected by the GFATM Board. In this regard, noting the conclusions of the April meeting of the GFATM Board, which estimated an additional demand approximately of \$6 billion by 2010 which might possibly reach \$8 billion, G8 members pledge to work with other donors to replenish the GFATM and to provide long-term predictable funding based on ambitious, but realistic demand-driven targets.'

The graph on the following page shows the support of G8 nations for the Global Fund in 2007, measured against their proportionate share of resources needed. A number of donors made significant increases in their funding to the Global Fund for 2007 and have made yet higher pledges for 2008 and beyond.⁴⁴ In total, the Global Fund has estimated its resource needs at approximately \$4 billion in 2008, of which \$2.9 billion has been pledged.

MALARIA'S HUMAN AND ECONOMIC TOLL

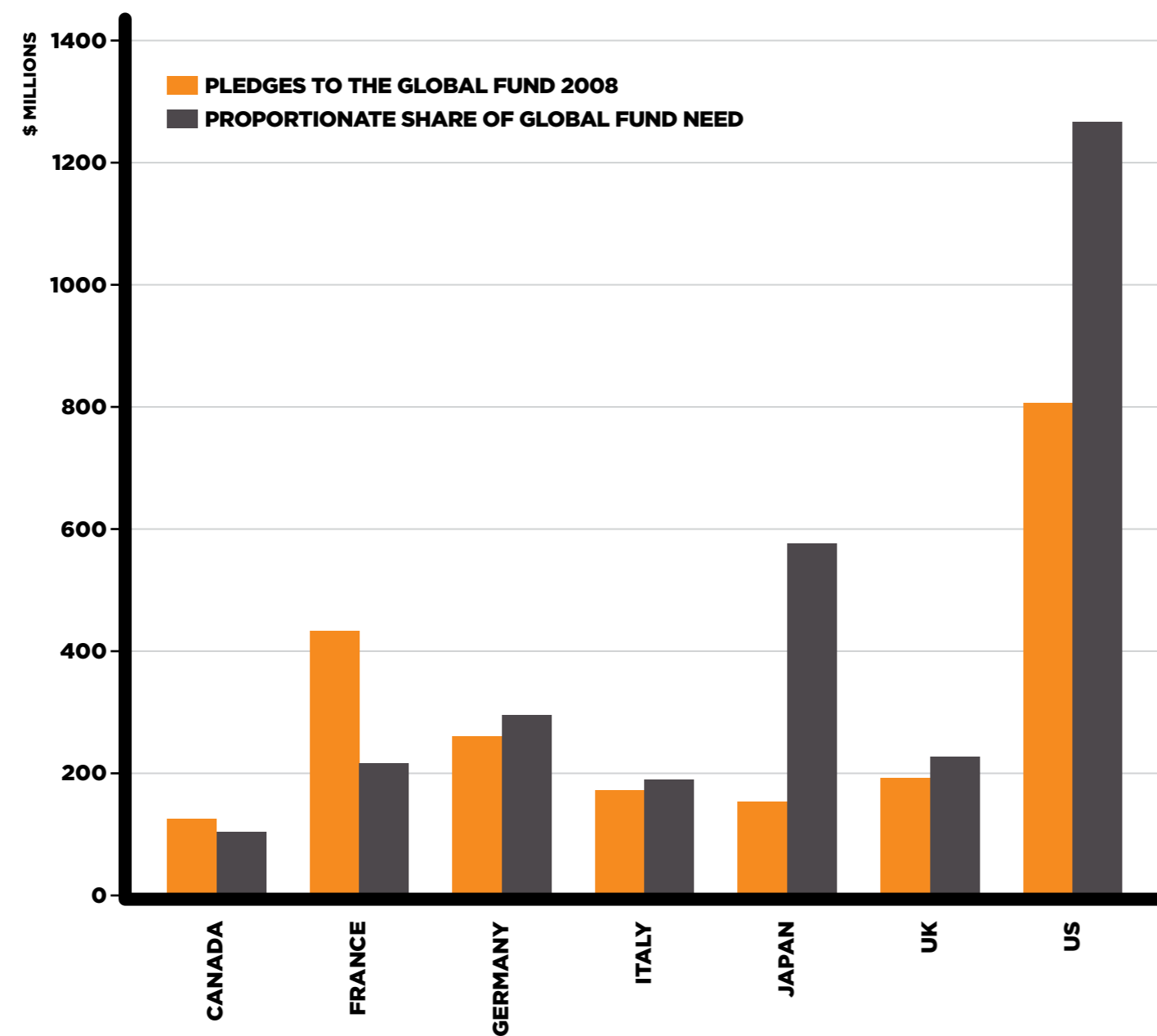
1 million

Deaths each year from Malaria in Africa.
Most of them in pregnant women and children.

\$12bn

Estimated cost per year to Africa in lost GDP due to Malaria. It could be controlled for a fraction of that amount.

GLOBAL FUND PLEDGES VS PROPORTIONATE SHARE OF RESOURCES PLEDGED, 2008

**UK**

The UK contributed \$202.5 million to the Global Fund in 2007 and has pledged \$219.6 million for 2008. At the 2007 replenishment conference in Berlin, it pledged a total of \$728.6 million for 2008–10.

CANADA

Canada contributed \$110.6 million to the Global Fund in 2007, and has committed CAD\$450 million for 2008–10, including a pledge in 2008 for \$147.4 million.

FRANCE

France contributed \$386.1 million to the Global Fund in 2007 and still has \$137 million in outstanding contributions for 2007. France has pledged \$469.5 million for 2008. At the 2007 replenishment conference in Berlin, it pledged a total of \$1.274 billion for 2008–10.

ITALY

Italy contributed \$180.4 million to the Global Fund in 2007 and has pledged \$186.9 million for 2008. At the 2007 replenishment conference in Berlin, it pledged a total of \$551.9 million for 2008–10, including a pledge for \$186.9 million in 2008.

Some countries are providing less than their proportionate share to the Global Fund:

GERMANY

Germany contributed \$116.7 million to the Global Fund in 2007 and has pledged \$314.4 million for 2008. At the 2007 replenishment conference, it pledged a total of \$849.1 million for 2008–10.

JAPAN

Japan contributed \$186 million to the Global Fund in 2007, and has pledged and already contributed \$183.8 million for 2008. In May 2008, Japan pledged an additional \$560 million to be paid in the 'coming years'.

US

The US contributed \$531 million to the Global Fund in 2007 and has \$192.9 million in outstanding contributions to deliver. It has pledged \$840.3 million for 2008.

Though DATA does not hold Russia (a net recipient of Global Fund financing) accountable for G8 commitments to the Fund, the country has contributed \$107.76 million to date. Additionally, Russia announced in 2007 that it will reimburse the Global Fund for grant financing it has received, totalling \$270 million, during the next four years.

NEARING A WIN ON POLIO

In 2007, there were only 1,307 cases of polio globally and only 375 in Africa.⁴⁵ With continued efforts, polio can join smallpox on the list of eradicated diseases.

POLIO

In 1998, there were an estimated 350,000 cases of polio worldwide. In 2007, there were only 1,307 cases globally and only 375 in Africa.⁴⁵ With continued efforts, polio can join smallpox on the list of eradicated diseases.

WHAT DID THE G8 PROMISE AT GLENEAGLES?

PARAGRAPH 18F

‘...supporting the Polio Eradication Initiative for the post-eradication period in 2006–08 through continuing or increasing our own contributions toward the \$829 million target and mobilising the support of others.’

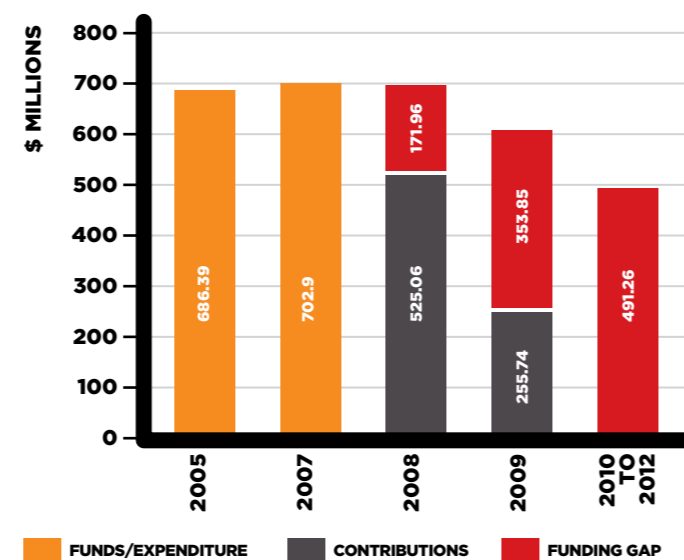
INTERPRETING THE COMMITMENT

DATA measures the resources mobilised against the specific \$829 million target identified in the Communiqué.

HOW AMBITIOUS WAS THE G8 PROMISE?

Ensuring that polio, like smallpox, becomes a disease of the past would represent a huge achievement. The G8 promise on polio – to support eradication by contributing \$829 million between 2006 and 2008 – meets the need defined by the Global Polio Eradication Initiative (GPEI) for that period. These resources must be delivered urgently, as 2007 and 2008 are critical to the eventual global eradication of the disease. In addition, truly eradicating polio will require commitments beyond 2008. As reflected in Figure 10, GPEI has re-evaluated the cost of achieving eradication and estimates a total financing gap of \$1.017 billion for 2008–10.

ENDING POLIO TRANSMISSION MEETING THE 2008–09 FUNDING GAP



DELIVERING THE PROMISE

The polio eradication programme has been successful across the globe. Only seven countries in Africa continue to report active transmission of the disease, with Nigeria being the only country where polio is still endemic.

Since the commitment was made in 2005, donors have begun to close the 2006–08 financing gap. According to GPEI, there remains a gap of \$171.96 million in 2008. As of January 2008, the G8 had contributed 48% of all funding to the polio eradication programme since it began in 1988, with the US, the UK and Japan being the largest donors.⁴⁶

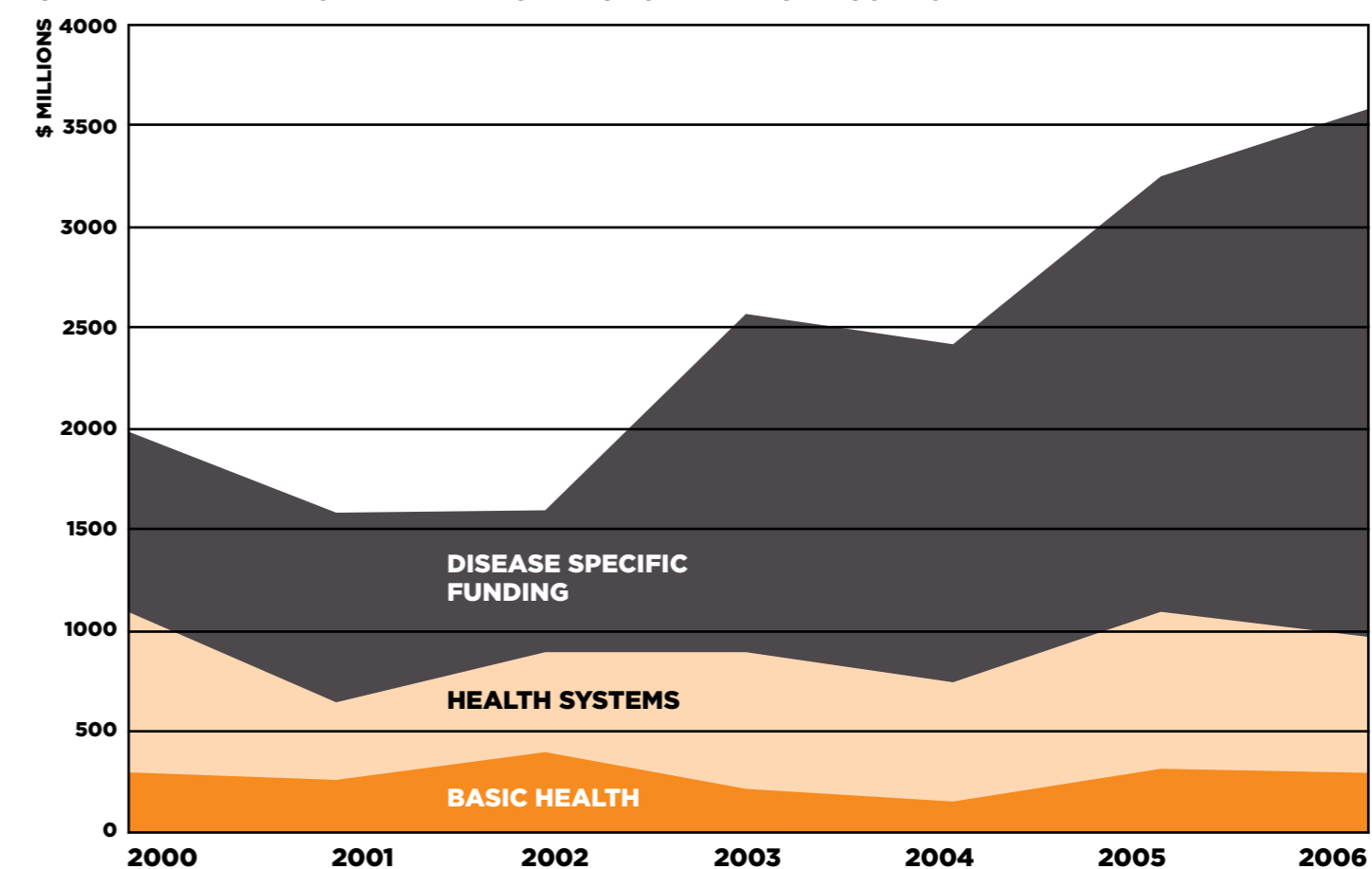
In 2007, the US was the largest G8 donor to GPEI, with a contribution of \$144.8 million. It was followed by the UK, with a contribution of \$44.6 million, and Japan, with a contribution of \$19.9 million.

MONITORING THE HEALTH COMMITMENTS: WHAT DO THE G8 NEED TO DO?

The health commitments recorded in this chapter reflect a comprehensive pledge in which all of the elements are critical. Progress to date has been most notable in fighting infectious disease, and the significant scale-up in these efforts is welcomed. Going forward, it will be critical to maintain momentum in fighting infectious diseases, while

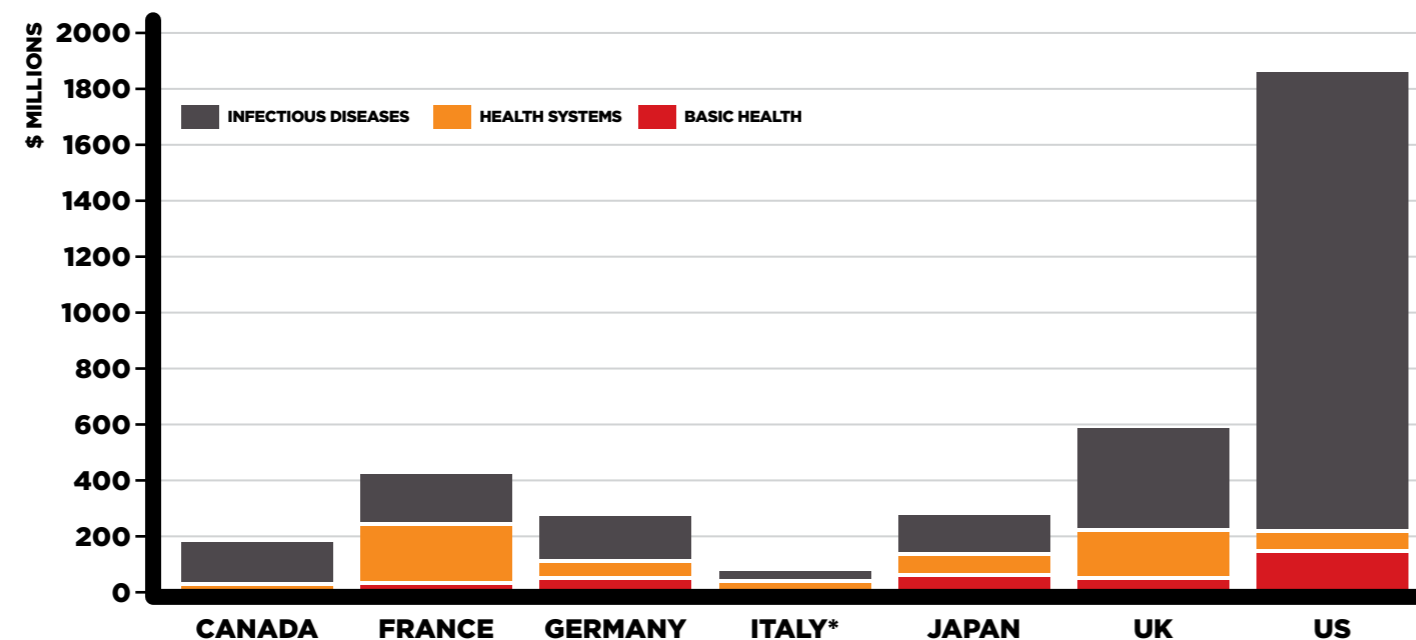
simultaneously scaling up broader efforts to invest in basic health and health systems. As shown in the graph below, funding for health has broadly continued to increase, but the actual amount available for basic health and health systems has remained relatively flat since 2004 and has declined as a proportion of total health spending. The graph below includes bilateral and multilateral health spending, as well as an estimate of general budget support that is directed towards health. Additionally, for the purposes of this analysis, DATA has assumed that multi-sector assistance was split equally between water, health and education, and added the health allocation to the health systems category.

G7 BILATERAL AND MULTILATERAL FUNDING TO HEALTH CATEGORIES



Further review of the health portfolios of each of the G7 shows that for each country, except France, disease-specific funding is the largest recipient of funding.⁴⁷

G7 BILATERAL AND MULTILATERAL FUNDING TO HEALTH SUB-SECTORS FOR 2006



*Italy's figures do not include bilateral spending in 2006 due to incomplete sectoral data.

FINANCING NEEDS FOR HEALTH SYSTEM DEVELOPMENT (\$ BILLION)

	2009	2010
HIV/AIDS ⁴⁸	28.7	40.1
TB ⁴⁹	1.9	1.9
MALARIA ⁵⁰	2.2	2.2
POLIO ⁵¹	0.6	N/A
HEALTH WORKERS ⁵²	6.3	7.7
TOTAL	40.7	51.9

ALL FIGURES ARE BASED ON CURRENT PRICES.

The G8 did not commit to a specific overall health ODA target, but the chart on the right shows the current financing estimates of funds needed to reach the various health goals to which they committed. Although there is not currently an estimate for developing health systems across Africa, DATA has included the cost estimates for increasing training, incentives to work in rural areas and compensation for health workers, since these will be major components (though certainly not the only components) of health systems development. Total financing requirements to meet all of these needs will increase from \$40.7 billion in 2009 to at least \$51.9 billion in 2010.

ARE THE G8 ON TRACK?

In total, G7 development assistance for health in sub-Saharan Africa grew from \$3.3 billion in 2005 to \$3.7 billion in 2006, a 9% increase. This total included bilateral and multilateral spending as well as an estimate of support to health systems through general budget support and multi-sector spending. Of the total, 73.1% was spent on infectious diseases and reproductive health, 18.7% on health systems and 8.14% on basic health programmes. Data on disease-specific expenditures were not available.

CANADA

Canada pledged and contributed \$110.6 million to the Global Fund in 2007, and has committed to contribute \$147.4 million in 2008. Canada has contributed \$148.7 million to GAVI and allocates approximately 8.5% of its health sector spending to health systems development, compared with a G7 average of 18.7%. Total health sector spending for sub-Saharan Africa in 2006 was \$192.3 million, an increase of 31.5% over 2005.

FRANCE

France is the second largest donor to the Global Fund by volume to date. In 2007 it pledged \$423.9 million to the Fund. Even though \$137 million remains outstanding for the year, the paid-in portion already represents a proportionate share of the 2007 total. France has pledged an additional \$469.5 million in 2008 (a pledge that, if fully paid, would also exceed its proportionate share). France has pledged a total of \$1.274 Billion for 2008–10. It has contributed \$164.9 million to GAVI and allocates approximately 54.7% of its health sector spending to health systems development, well above the G7 average of 18.7%. Total health sector spending for sub-Saharan Africa in 2006 was \$431.1 million, a 48.5% increase over 2005.

GERMANY

Germany pledged and contributed \$116.7 million to the Global Fund in 2007, but that amount was significantly below its proportionate share. Germany has pledged to contribute \$314.4 million for 2008, as well as a total of \$849.1 million for 2008–10. It has also distributed significant amounts of bilateral funding for HIV/AIDS, spending \$150 million in 2006 and 2007. In total, Germany has recently committed to spending \$5.02 billion between 2008 and 2015. It has contributed \$11.2 million to GAVI and allocates approximately 22.2% of its health sector spending to health systems development, compared with the G7 average of 18.7%. Total health sector spending for sub-Saharan Africa in 2006 was \$277 million, a 1.6% decrease from 2005.

ITALY

Italy pledged and contributed \$180.4 million to the Global Fund in 2007, just above its proportionate share. It has pledged and has already contributed \$186.9 million for 2008, as well as a total of \$551.9 million for 2008–10. Italy has contributed \$139.25 million to GAVI and allocates approximately 35.7% of its health sector spending to health systems development, compared with the G7 average of 18.7%. Total multilateral health sector spending for sub-Saharan Africa in 2006 was reported as only \$41.2 million at the time this report went to print, a 79% decrease from 2005. Italy did not report its bilateral commitments to the DAC on time for 2006, which affects total health spending and health systems spending figures in this chapter. Funding amounts for the Global Fund and other multilateral institutions are reported from those individual institutions.

JAPAN

Japan, the host country when the Global Fund was launched in 2000, pledged and contributed \$186 million to the Fund in 2007, significantly below its proportionate share. Japan has pledged and already contributed \$183.8 million for 2008, which also falls below its proportionate share. In May 2008, Japan pledged \$560 million to the Global Fund over the 'coming years'. It has not yet contributed to GAVI and allocates approximately 28.5% of its health sector spending to health systems development, compared with the G7 average of 18.7%. Total health sector spending for sub-Saharan Africa in 2006 was \$269.1 million, a 4.5% increase from 2005.

RUSSIA

Although DATA does not hold Russia (a net recipient of Global Fund financing) accountable for G8 commitments to the Fund, the country has contributed \$107.8 million to the Fund to date. However, Russia announced in 2007 that it will reimburse the Global Fund for grant financing it has received, totalling \$270 million over the next four years.

UK

The UK pledged and contributed \$202.5 million to the Global Fund in 2007, an amount equal to its proportionate share. It has pledged \$219.6 million for 2008, as well as a total of \$728.6 million for 2008–10. It has committed to spend around \$3 billion on HIV/AIDS between 2005/2006 and 2007/2008. The UK has contributed \$712.2 million to GAVI and allocates approximately 34.1% of its health sector spending to health systems development, compared with the G7 average of 18.7%. Total health sector spending for sub-Saharan Africa in 2006 was \$587.2 million, an 8.9% decrease from 2005.

US

The US pledged \$724 million in 2007 to the Global Fund, but still has \$192.9 million in outstanding pledges. Its contribution is below its proportionate share based on percentage of G7 GNI. The US has pledged \$840.3 million for 2008. Its AIDS programme (PEPFAR) and Malaria programme (PMI) will have contributed \$20 billion to the fight against HIV/AIDS, tuberculosis and malaria globally over five years by the end of 2008, although the amounts reported to DAC show that much of this money has yet to be disbursed. At the time this report went to press, the US was debating reauthorisation of PEPFAR for another five-year period. The US has contributed \$421.8 million to GAVI and allocates approximately 4.2% of its health sector spending to health systems development, compared with the G7 average of 18.7%. Total health sector disbursements to sub-Saharan Africa in 2006 were \$1.8 billion, a 22.8% increase from 2005.