

HEALTH

WHY IS HEALTH IMPORTANT?

The loss of life in Africa due to preventable and treatable diseases devastates families, communities and economies and is a major barrier to Africa's development. Africa is the only region of the world not on track to achieve a single one of the Millennium Development Goals (MDGs) for health.¹

While the situation is grim, there is hope. Interventions to fight HIV/AIDS and malaria have met with tremendous success where they have been implemented. Health care in Africa can be improved dramatically over the next few years if the world puts significant effort into attacking specific diseases and improving the continent's weak and failing health systems.

- **HIV/AIDS** There are almost 25 million people infected with HIV/AIDS in Africa, and 7,700 Africans are newly infected every day. 5,800 Africans die from HIV/AIDS daily.²
- **TUBERCULOSIS** TB mortality rates are twice as high in Africa as in any other region and Africa has the highest rate of TB per capita in the world.³
- **MALARIA** One child dies from malaria every 30 seconds in Africa and several hundred million Africans are infected each year, costing the continent an estimated \$12 billion in lost economic productivity annually.⁴
- **CHILD AND MATERNAL HEALTH** Each day, 700 women die of pregnancy-related causes in Africa, and in the poorest countries women have a 1 in 10 chance of dying in childbirth.⁵ The toll is even worse for newborns, with 3,100 newborns dying every day and 2,400 African babies stillborn each day. In addition, every day, another 9,600 African children who make it through their first month of life will die before their fifth birthday.⁶

- **POLIO** A concentrated effort to eradicate polio is succeeding: less than two decades ago, 1,000 children were paralysed by polio every day around the world, while during the whole of 2003 only 800 children were paralysed.⁷
- **HEALTH SYSTEMS** Africa faces a significant shortage of healthcare personnel and urgently requires an additional 1.5 million health workers, according to the World Health Organization.

While the attention and resources mobilised around HIV/AIDS and other infectious diseases has resulted in some progress in fighting specific diseases, these efforts have placed an additional burden on already strained and weak health systems by pulling scarce funding, supplies and human resources away from primary care and maternal and child health services. Africa needs concentrated investment in health capacity at all levels, in addition to specific disease interventions. This includes building the capacity to develop locally-owned strategies and the personnel to deliver quality prevention, treatment and support to hard-to-reach populations, as well as the supplies, technology and infrastructure necessary to deliver quality care.

The G8 have made a series of health-related commitments on HIV/AIDS, children orphaned as a result of infectious diseases, TB, malaria, child and maternal health care, polio and health systems. The first half of this chapter reviews those commitments, evaluates their ambition and reports on the progress being made to fulfil them. The second half of the chapter considers the financial needs required to meet G8 promises and evaluates individual donor progress.

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

At the St. Petersburg Summit, G8 leaders expanded their HIV/AIDS commitment:

'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.'

INTERPRETING THE COMMITMENT

UNAIDS defines 'universal access' as providing treatment to 80% of people in most urgent need. Urgent need is defined as a person who will die within 12 months if untreated. Universal access to prevention and care, as agreed at the St. Petersburg Summit, has not yet been defined with similar outreach targets. DATA has interpreted this commitment to mean that G8 members will contribute their equitable shares to finance these goals (based on share of DAC GNI). African countries are currently drafting costed plans for achieving these goals. Since these figures are not yet available, DATA has used UNAIDS global cost estimates for 2008⁸ and Global Fund cost estimates⁹ for 2009 and 2010 as the baseline for analysis.

HOW AMBITIOUS WAS THE G8 PROMISE?

The G8's commitment to work for an 'AIDS-free generation' is very ambitious given the scale of the HIV/AIDS challenge in Africa. Achieving this goal, however, will require equally ambitious financing commitments and comprehensive strategies, neither of which have been specified by individual donors. Furthermore, certain elements of the commitment that are most ambitious, such as providing care for all orphans and vulnerable children in need, have received limited follow-up by donors.

DELIVERING THE PROMISE

Donor financing for HIV/AIDS has scaled up considerably since 2001, when donors spent just \$1.6 billion globally. The two primary vehicles for this scale-up have been the Global Fund to Fight AIDS, Tuberculosis and Malaria and the US President's Emergency Plan for AIDS Relief (PEPFAR). Funding from the World Bank, UNAIDS and other bilateral programmes has also helped to meet some of the global needs. Through PEPFAR, the US has committed to spend \$15 billion to fight AIDS globally, targeting 15 focus countries around the world (12 of which are in Africa). To date, the US has allocated \$12.9 billion to this effort (this figure includes US financing for the Global Fund). In addition, the UK has committed to spend around \$3 billion (£1.6 billion) on HIV/AIDS between 2005/06 and 2007/08.

PROGRESS ON PREVENTION AND CARE?

Of the 4.3 million people worldwide who became newly infected with HIV during 2006, 2.8 million were in sub-Saharan Africa, bringing the number of people living with HIV/AIDS in Africa to 24.7 million.¹⁰ The number of newly-infected people in sub-Saharan Africa is higher than in the rest of the world combined, with young African women significantly more likely to become infected than young African men.¹¹ In addition to an increased risk of infection, women are also more likely to shoulder the burden of care for the sick and to care for orphans and vulnerable children.

According to the UNAIDS/WHO AIDS Epidemic Update from December 2006, 'Declines in national HIV prevalence are being observed in some sub-Saharan African countries, but such trends are currently neither strong nor widespread enough to diminish the epidemics' overall impact in this region.'¹² This means that while the epidemic can be described as stabilising in some areas, its impact continues to be felt in widespread mortality and shrinking economic growth and will impact Africa for some time, even with progress in decreasing infection rates.

Both the Global Fund and PEPFAR have made significant contributions to prevention and care. As of December 2006, the Global Fund had achieved the following HIV/AIDS results globally:

- Provided voluntary counselling and testing (VCT) to 9.4 million people;
- Provided basic care and support to 1.2 million orphans.

As of September 2006, PEPFAR had achieved the following results globally:

- Supported prevention of mother-to-child HIV transmission services for women during more than 6 million pregnancies;
- Supported care for more than two million orphans and vulnerable children;
- Supported care for more than 2.4 million people living with HIV/AIDS, including over 301,000 who received treatment and care for tuberculosis.

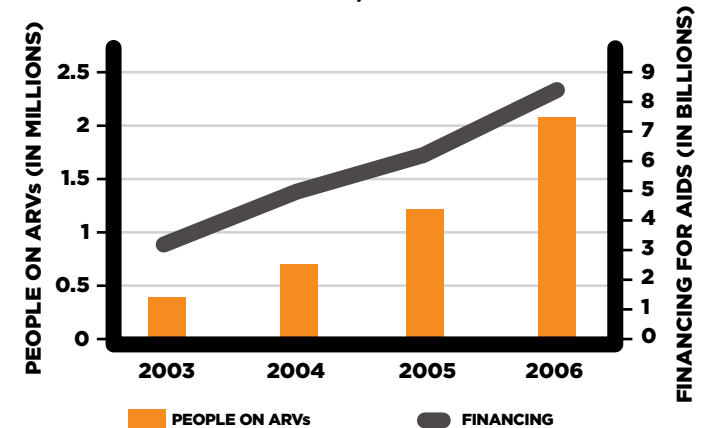
The G8 set itself the aim of creating the conditions for an 'AIDS-free generation in Africa.' Successful prevention will require each G8 country to commit to evidence-based prevention strategies. Treatment goals will not be achieved unless the rate of infection is slowed, and this will require a comprehensive approach, including a balance of behavioural interventions, harm-reduction efforts and the empowerment of marginalised groups. As is discussed in greater detail in the section on treatment below, shortfalls in treatment for pregnant women, in particular, are a serious stumbling block to efforts to achieve an AIDS-free generation in Africa. Successful prevention is also heavily dependent on African leadership and locally-owned strategies and messages. Although prevention

is not the primary focus of this report, successful strategies to stem the spread of AIDS are crucial to reversing the devastating impact of the epidemic.

PROGRESS ON HIV/AIDS TREATMENT

The total number of people in low and middle-income countries around the world receiving ARVs is currently 2 million. Access to treatment globally has increased significantly since 2003, when just 400,000 people were receiving treatment in low and middle-income countries. The Global Fund and PEPFAR have been the primary vehicles through which treatment access has been scaled-up, together providing ARVs to 1.27 million people around the world by the end of 2006. Significant increases in donor funding for HIV/AIDS since 2003 have made a real and direct difference to the number of lives saved. The following graph shows increases in global spending on HIV/AIDS together with increases in the number of people receiving ARVs worldwide.

GROWTH OF ACCESS TO ARVs COMPARED WITH GROWTH IN GLOBAL HIV/AIDS FINANCING

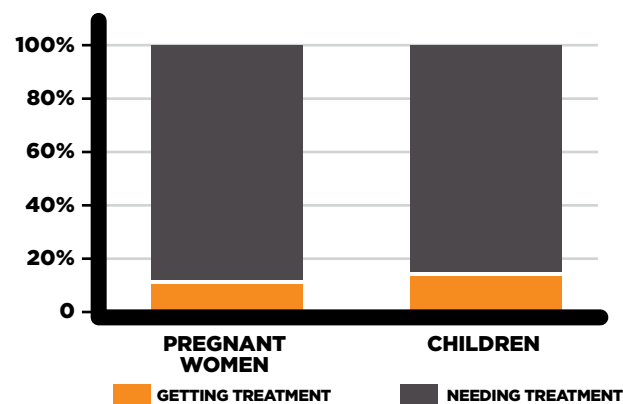


The total number of Africans receiving ARVs has increased dramatically from approximately 50,000 in 2002 to more than 1.3 million as of December 2006.¹³ This is an increase in access for those in need from 1% to 28% in just four years. While the scale-up has been significant, a total of 4.8 million people in Africa are in urgent need of treatment and more than 70% of them are not receiving it.

This treatment shortfall is particularly acute among HIV-positive children and women. Africa is home to more than

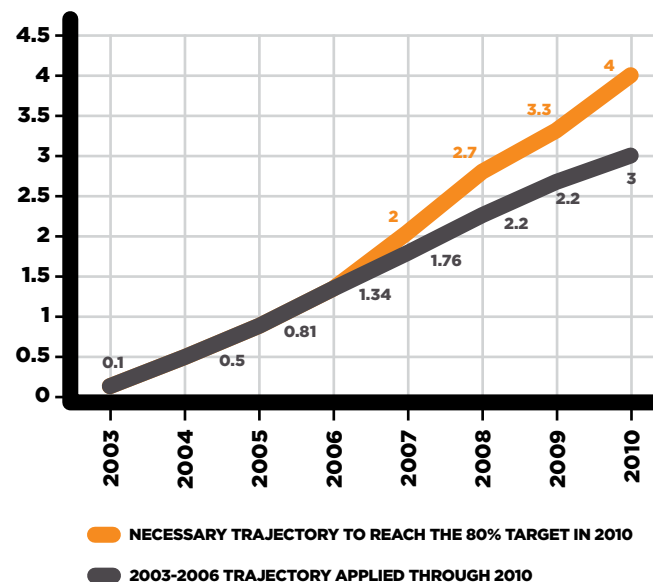
90% of the world's HIV-positive children and 85% of the world's HIV-positive pregnant women. But, as the graph below shows, just 11% of all HIV-positive pregnant women in Africa received ARV prophylaxis in 2006 and, while the number of African children receiving ARVs increased significantly in 2006, just 13% of all African children in need of ARVs are receiving them.¹⁴ These infections could be prevented if pregnant HIV-positive women had adequate access to diagnosis and treatment.

GAPS IN HIV/AIDS TREATMENT FOR CHILDREN AND PREGNANT WOMEN IN AFRICA



Putting people on treatment translates into lives saved: worldwide, it is estimated that between 250,000 and 350,000 deaths were averted as a result of increased access to treatment in 2005.¹⁵ The increase in Africa from 810,000 people on treatment in 2005 to 1.3 million on treatment in 2006 is further life-saving progress. However, there are a total of 4.8 million Africans in need of treatment, leaving a current gap of 3.5 million people. Last year we said that to be on track to hit 80% of those in need receiving treatment (UNAIDS' own definition of universal access), an additional 638,000 Africans needed to be receiving treatment each year. Because donors fell short of this target in 2006, the increase in treatment coverage now needs to be even faster, with an extra 665,000 Africans receiving treatment each year between now and 2010. The following graph shows the scale-up in treatment that will be needed to meet the most conservative estimate of the coverage needed to hit universal access for Africans in 2010, compared with the current trajectory.

GETTING TO 'NEAR UNIVERSAL' COVERAGE IN SSA (USING 5M AS LOW END ESTIMATE)



CARING FOR ORPHANS AND VULNERABLE CHILDREN

In addition to their commitments on HIV/AIDS, the G8 have also referenced the need to care for orphans and vulnerable children, although no firm financing commitments were made at the 2005 G8 Summit or in St. Petersburg. In total, there are an estimated 43 million orphans and vulnerable children in Africa, of whom approximately 12 million are AIDS orphans.¹⁶ Approximately 9% of all children under the age of 15 in Africa have lost at least one parent to HIV/AIDS and one in six households with children is caring for at least one orphan.¹⁷

Caring for orphans requires a series of key interventions, including health care, education, counselling, shelter and adult supervision. The global consensus is that, whenever possible, it is preferable to keep children within their communities to receive care than to place them in institutional care. The number of AIDS orphans in Africa will continue to increase as the epidemic continues to take its toll, making the importance of services and interventions for orphans and vulnerable children even more critical. The estimated cost to support children orphaned and made vulnerable by disease and

ACCESS TO ARVs

1.3m

Total number of Africans receiving ARVs in 2006. This is a dramatic increase from the 50,000 in 2002.

3.5m

Total number of Africans in need of treatment but not receiving ARVs in 2006.

11%

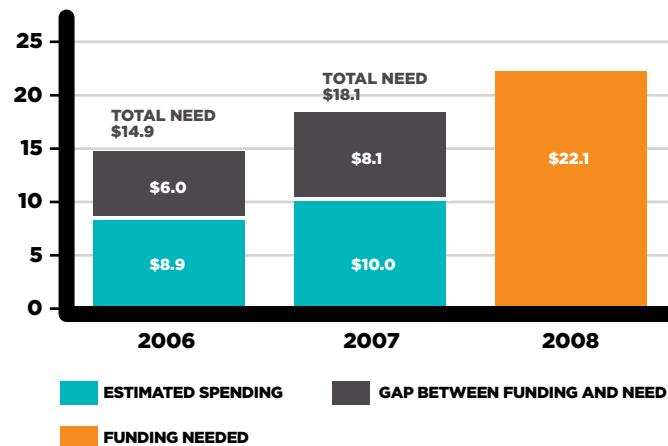
HIV positive pregnant women in Africa who received ARV prophylaxis to prevent mother-to-child transmission in 2006.

poverty in Africa, who are most in need of urgent support, is expected to increase from \$1.4 billion in 2006 to \$1.7 billion in 2010.¹⁸

FINANCING NEEDS

Global spending on HIV/AIDS increased considerably during the first half of this decade, from \$1.6 billion in 2001 to \$8.3 billion in 2005. However, donors are still not providing the funding needed to adequately battle HIV/AIDS. As shown in the graph below, a total of \$14.9 billion was needed from donors to fight AIDS globally in 2006, but just under \$9 billion was provided. For 2007, the need climbs to \$18.1 billion, with just \$10 billion expected to be available, leaving a significant gap. Donor spending has ramped up considerably through bilateral programmes, particularly PEPFAR, and through multilateral programmes, including the Global Fund. The Global Fund, however, continues to face financing shortfalls and inadequate levels of financing to allow for the significant growth needed.

**FINANCING NEEDS AND AVAILABILITY
IN THE FIGHT AGAINST GLOBAL HIV/AIDS**



TUBERCULOSIS (TB)

WHAT DID THE G8 PROMISE?

PARAGRAPH 18H: ‘...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.’

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. Two months before the 2005 G8 Summit in Gleneagles, the Stop TB Partnership published a ‘Blueprint to Intensify Action to Reach the TB MDGs in Africa,’ which offered more specific information on costings in Africa. The specific aims of the Stop TB Partnership in Africa are to reach 16.9 million people with directly observed therapy (DOTS) treatment and to enroll 2.7 million people on ARVs.¹⁹

HOW AMBITIOUS WAS THE G8 PROMISE?

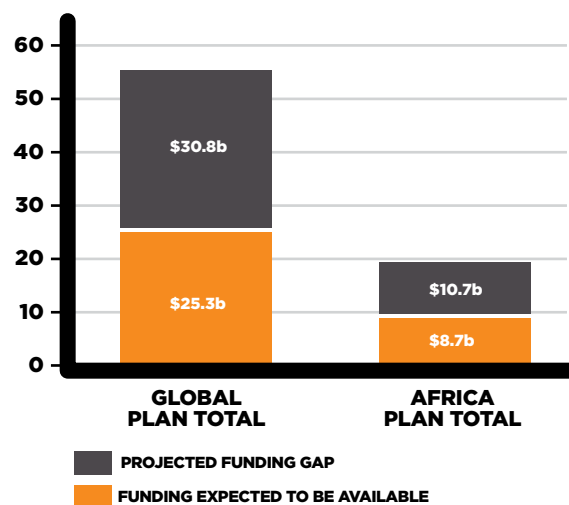
The G8 committed to support the Stop TB Partnership’s ambitious global strategy. Successful implementation of the strategy is expected to increase case detection to over 70% by 2010 and to over 80% by 2015. The treatment success rate should reach the target of 85% by 2010 and be sustained – if this occurs, it is predicted that the MDG target, to have halted and begun to reverse the incidence of TB by 2015, will 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 until later.

DELIVERING THE PROMISE

Progress is being made to control TB worldwide. Almost 60% of TB cases are now detected, and of those, the vast majority are cured. The incidence of TB is either stabilising or beginning to fall in most African countries but, in order to eradicate TB, a quantum increase in funding is necessary. As the following graph shows, a global total of \$56 billion will be needed to

fight TB from 2006–15. Currently \$25.3 billion of this is expected to be available, leaving a gap of \$30.8 billion.

STOPPING TB WORLDWIDE AND IN AFRICA: FUNDING AND UNMET NEEDS 2006-2015



Out of this global total, a cumulative total of \$19.4 billion will be needed to fight TB in Africa between 2006 and 2015, \$8.7 billion of which has been pledged, leaving a gap of \$10.7 billion. This means that there exists roughly a \$1 billion financing gap annually to 2015 to fight TB in Africa. If this funding gap is met, a total of 4.4 million lives in Africa will be saved between 2006 and 2015.

Unfortunately, the spread of the AIDS epidemic has also meant an expansion of the TB epidemic, and TB is a leading cause of death among people who are HIV-positive.

MDR-TB AND XDR-TB

Recently, a particularly lethal combination of extensively drug-resistant TB and HIV/AIDS, known as XDR-TB, has emerged. XDR-TB is essentially untreatable, as infected patients resist all first-line treatments and many of the available second-line drugs. Those infected with XDR-TB have an 85% mortality rate. One of the highest concentrations of XDR-TB is in KwaZulu Natal in South Africa, but XDR-TB poses a threat to human health and

security globally, with cases found so far in 35 countries, including all of the G8 countries.

Given the potential for XDR-TB to spread rapidly, it is imperative that donors allocate more resources to strengthen basic TB prevention and control and to address the role of weak and failing health systems, while also expanding efforts to find new diagnostics.

MALARIA

WHAT DID THE G8 PROMISE?

PARAGRAPH 18G: ‘By contributing to the additional \$1.5bn a year needed annually to help ensure access to anti-malaria insecticide-treated mosquito nets, adequate and sustainable supplies of Combination Therapies including Artemisin, 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.’

INTERPRETING THE COMMITMENT

The commitment to reach 85% of those in need with malaria prevention and treatment by 2015 will require scaled-up resources. The G8 specifically committed to provide an additional \$1.5 billion towards this effort, which DATA interprets to mean that they would scale up to reach this financing increase by 2010.

HOW AMBITIOUS WAS THE G8 PROMISE?

Since Gleneagles, new estimates for global financing and what is needed in Africa have become available, with needs for Africa ranging from \$1.9 billion to \$3.1 billion a year.²⁰ Despite varied global estimates, there is general agreement that the majority of global funding should be spent in Africa, and that the vast majority of funding will need to come from donor sources. The Global Fund estimates that global financing requirements for tackling malaria will increase to \$3.7 billion in 2010. The estimated need for Africa specifically averages \$3.1 billion a year to 2015, compared with a total funding level of \$500 million as of 2005.²¹

“ Targeted aid increases between 2003 and 2006 have translated directly into a leap in the percentage of people who are receiving life-saving antiretroviral treatment ”

PAYING FOR HEALTH

\$12bn

Cost of economic productivity lost in Africa each year as a result of Malaria infection.

TACKLING MALARIA

**\$3.1 BILLION**

Average annual amount estimated to be required to tackle malaria in Africa to 2010

**\$500 MILLION**

Total funding level in 2005

\$1.5bn

Pledged by the Bill and Melinda Gates Foundation since 1999 to GAVI to increase access to immunisation.

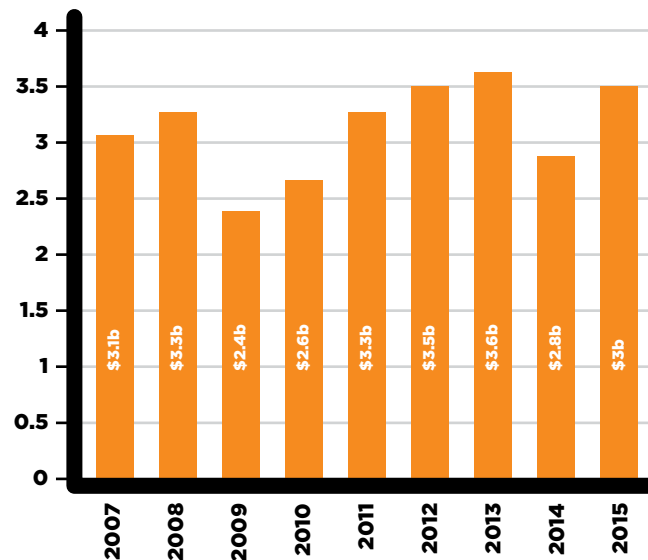
DELIVERING THE PROMISE

While funding for malaria has increased dramatically in the past five years, primarily through donor financing provided to the Global Fund, the US remains the only country to have made a specific financing commitment to meeting the G8 goal on malaria. The US has launched the President's Malaria Initiative (PMI) to scale up funding by \$1.2 billion over five years, aiming eventually to provide 33% of the \$1.5 billion financing gap identified in 2010. In 2006 and 2007, Congress appropriated the funds necessary to be on track to fulfil this commitment.

The UK has committed almost \$210 million over five years for research, bed nets and medicine, and Canada has committed \$18 million. Russia has announced plans to join forces with the World Bank in the fight against malaria in sub-Saharan Africa, and will support a World Bank-led malaria booster programme that aims to achieve tangible results by 2010.

Meanwhile, the Global Fund remains a key tool for mobilising additional resources. It currently finances two-thirds of all donor spending on malaria and has distributed 18 million bed nets and 23 million malaria treatments.

ESTIMATED FINANCING NEEDS TO FIGHT MALARIA IN AFRICA 2006-2015



As the previous graph shows, an average of \$3.1 billion will be needed to fight malaria between 2007-2015. Costs to fight the disease will rise in 2007 and 2008, due to the immediate funding required to purchase and distribute bed nets. After this frontloading of development assistance, costs will fall in 2009 and will then rise again in 2011 as bed nets are replaced and re-treated.

CHILD AND MATERNAL HEALTH

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...'

INTERPRETING THE COMMITMENT

The G8 pledged to support African partners' commitment to provide basic health to children and to reduce child and maternal mortality. DATA interprets this to mean increased investments for the treatment of infectious diseases, as well as basic health care and increased access to vaccinations.

HOW AMBITIOUS WAS THE G8 PROMISE?

At Gleneagles the G8 commitments on child and maternal health were welcome, but were not accompanied by specific financial pledges. In November 2006 the 'Opportunities for Africa's Newborns' report was published, detailing how maternal and child healthcare programmes in Africa can be strengthened to save 800,000 lives a year and reach 90% of Africa's mothers and newborn babies.

The WHO has determined that scaling up maternal and child health care to reach 95% coverage between 2006 and 2015 will require \$2.2 billion in 2006, increasing to \$7.8 billion in 2015. Currently, per capita maternal and child healthcare spending in Africa is \$0.58. The cost of reaching 90% of women in need with just basic services would be an additional \$1.39 per capita – or \$1 billion a year for sub-Saharan Africa.²²

It is important to note, however, that comprehensive improvements in maternal and child health care will require broader investments in health systems. Estimates for the cost of such improvements vary, with the Commission on Macroeconomics and Health estimating in 2002 that a basic package of primary health care in the developing world would cost about \$34 per capita per year.²³

DELIVERING THE PROMISE

Scaling up services for child and maternal health care requires the scaling-up of low-cost interventions, such as providing a skilled attendant at birth, promptly treating infections in newborns and educating mothers about hygiene, warmth and breastfeeding for infants. Scaling up access to simple vaccination packages can help prevent unnecessary infant deaths, and efforts to address the health risks that disproportionately affect the poorest communities can be addressed by incentivising research and development into treatments and vaccines. No data are available that break down G8 spending or broader efforts on these activities, although recent progress to address vaccines and Advanced Market Commitments (AMCs) should be noted and increased.

INNOVATIVE FINANCING FOR VACCINES

Each year, an estimated 28 million children miss out on basic vaccines, and two-thirds of these children are in Africa. Improving the delivery of existing vaccines and developing new vaccines for diseases that affect the developing world are critical components of improving health in Africa. At the 2005 G8 Summit, leaders agreed to support 'such mechanisms as Public Private Partnerships and Advance Purchase Commitments to encourage the development of vaccines, microbicides and drugs for AIDS, malaria, tuberculosis and other neglected diseases.'

In February 2007 five countries, with support from the Bill and Melinda Gates Foundation, made important progress on this promise by committing \$1.5 billion to launch the first AMC to help speed the development and availability of a new

vaccine. The new initiative will target pneumococcal disease (a major cause of pneumonia and meningitis that kills 1.6 million people every year) and is expected to save the lives of 5.4 million children by 2030. Italy provided \$635 million for this effort, followed by \$485 million from the UK and \$200 million from Canada. Norway and Russia provided additional support.

In addition, as noted in the development assistance chapter, donors have launched the International Financing Facility for Immunisation (IFFIm). Among G8 donors, to date the UK, France and Italy have made 20-year pledges to support IFFIm. Along with the \$750 million over 10 years from the Gates Foundation, IFFIm is generating \$4 billion for immunisation against a range of diseases, including polio, in the run-up to 2015.

POLIO

WHAT DID THE G8 PROMISE?

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 has measured 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 to a target of \$829 million – meets the need defined by the Global Polio Eradication Initiative (GPEI). However, these resources must be delivered urgently, as 2007 and 2008 are critical to the eventual global eradication of polio.

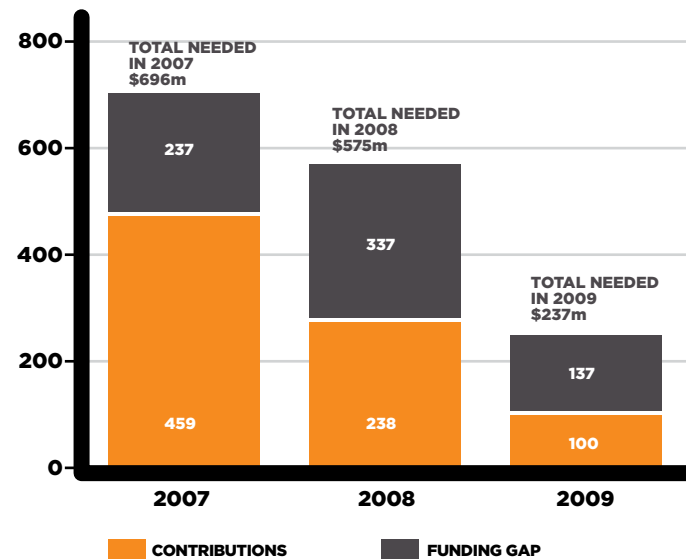
DELIVERING THE PROMISE

Progress in the fight against polio thus far has been a success story for Africa. In 2006, Egypt and Niger were removed from the list of polio-endemic countries. Of the four countries in

the world where the virus is still endemic, just one is in Africa (Nigeria).²⁴ The GPEI lists seven other African countries²⁵ with active transmission of polio as of January 2007. Across most of Africa, further preventative technical assistance will be needed over the next two years to ensure total defeat of the disease.

Funding requirements for polio for 2007–09 have been clearly laid out by the GPEI, and the funding gap has decreased slightly since the Gleneagles commitment to just \$711 million. As shown in the graph below, total estimated global needs will continue to decline from \$696 million in 2007 to \$575 million in 2008, and just \$237 million in 2009. As of January 2007, contributions from G8 countries accounted for 52% of the total financial investment to date in polio eradication, with the US, the UK and Japan being the largest donors.²⁶ As shown in the graph below, funding gaps of \$237 million in 2007, \$337 million in 2008 and \$137 million in 2009 remain to fight polio worldwide. Much of this unmet need will hit African efforts at eradication.

ENDING POLIO TRANSMISSION: MEETING THE \$711 MILLION GAP BETWEEN NEED AND FUNDING



An important new channel for the final push on polio funding is the \$145 million that will come from the Global Alliance for Vaccines and Immunisation (GAVI), which is financed by the International Finance Facility for Immunisation.

Over the past two decades the US has been the largest bilateral donor to polio eradication, providing more than \$1.3 billion. The UK is the second largest public sector donor to the GPEI, with total contributions of more than \$600 million, followed by Japan, with contributions of just over \$300 million. Canada and Germany are the next largest donors, and Germany has the largest current pledge for polio in 2008, with \$13 million. France and Italy, on the other hand, have made no pledges for the 2007–08 period.²⁷

HEALTH SYSTEMS

WHAT DID THE G8 PROMISE?

PARAGRAPH 18C: 'Investing in improved health systems in partnership with African governments, by helping Africa train and retain doctors, nurses and community health workers.'

INTERPRETING THE COMMITMENT

The G8 committed to invest in improved health systems, with specific reference to training and retaining doctors, nurses and community health workers. Because there were no financial commitments made against these goals and because estimates vary widely, DATA has measured the extent to which donors focus resources specifically on improvements to health systems and their individual efforts to address health worker shortages both by providing financing and by addressing their own policies.

HOW AMBITIOUS WAS THE G8 PROMISE?

The G8 commitment to health systems at Gleneagles, while welcome, was not demanding, in the sense that no specific financial pledges were made. Investment in health systems is often integrated into the costs of treating individual diseases, but financing the expansion of Africa's health workforce has been costed at \$2 billion, rising to \$7.7 billion by 2010.²⁸ In addition, health systems require investments in infrastructure, technology, supplies, drugs and transportation. Once these needs are taken into account, the total price tag for supporting Africa's health systems may rise to approximately \$18.7 billion.²⁹

DELIVERING THE PROMISE

The World Health Organization (WHO) has calculated that sub-Saharan Africa needs at least 2.2 trained health workers for every 1,000 people to achieve basic standards in health. Thirty-six countries in sub-Saharan Africa have serious shortages of health workers – specifically, a shortfall of 818,000 doctors, nurses and midwives and a need for an additional 700,000 other health workers.³⁰

Very little progress has been noted in addressing these widespread human capacity issues. In June, 2005, Japan announced the Health and Development Initiative, a five-year \$5 billion programme, which will include a focus on strengthening health systems. Since Gleneagles, Canada has pledged almost \$400 million between 2006 and 2016 to strengthen health systems, and France has committed to spend almost \$400 million in bilateral ODA in 2006/07 for the achievement of health-related MDGs and for the strengthening of health systems in developing countries. The overall lack of donor progress on strengthening health systems was noted at the AU Conference of Ministers of Health (CAMH) in April 2007.

THE TOLL OF BRAIN DRAIN

Africa has 75% of the world's disease burden and 14% of the world's population – yet its share of the world's health workforce is just 1.3%.³¹ Low salaries and poor working conditions in many African countries—combined with better paying opportunities in wealthier countries—lead many African health workers to move to wealthier countries where pay and conditions are better. In addition to boosting financing for health systems, G8 donors can help address Africa's health shortage without spending more money, by reducing the migration of health professionals from Africa. This can be done, in partnership with African governments, by providing incentives for professionals to stay and use their talents in African health systems.

The African Union has estimated that low-income countries lose \$500 million each year in lost investment in health care training.³²

- An examination of 25 African countries found that 40% or more of physicians born in those countries had migrated.³³
- Zambia's public sector has retained only 50 of the 600 physicians trained in the country's medical school between 1978 and 1999.³⁴
- About 50% of medical school graduates from Ghana emigrate within 4–5 years of completing their education, and 75% emigrate within 9–10 years.³⁵

Abysmal retention rates such as these must change, if Africa is to have any hope of strengthening health systems and turning the tide against devastating infectious diseases.

AFRICAN PROGRESS: HEALTH

At a 2001 AU Heads of State meeting in Abuja, African governments committed to take concrete steps to fight HIV/AIDS, TB, malaria and other infectious diseases, and pledged to raise spending on health to 15% of their national budgets.

While Botswana is so far the only country to have met the 15% budget target, progress is being made. One-third of African countries have allocated at least 10% of their national resources to health.³⁶ About 50% of African countries have declared HIV/AIDS to be an emergency, and in more than 20 countries the response to AIDS is now being led personally by heads of state or their deputies. Almost all countries have established national coordinating bodies for HIV/AIDS, TB and malaria.

Debt relief – and the resulting savings – have provided an opportunity for developing countries to make further investments in health. A World Bank analysis of 20 HIPC countries showed that 13 had significantly increased their share of total revenues directed toward activities to reduce poverty. Between 1998 and 2002 there was an average increase in health expenditures across all 20 countries as a share of national budgets, from 6.2% to 8.1%.³⁷

Innovative strategies employed by African governments for addressing public health challenges include the following:

- The Government of Swaziland, using its own resources as well as resources from the Global Fund, is providing ARVs free of charge to all citizens.
- Mauritius has achieved some of the best reproductive health indicators in Africa by providing family planning services, health promotion and public health education, while making a strong political commitment to tackling HIV/AIDS and investing in record-keeping and statistical analysis to gauge changes in health indicators.
- The governments of Mali and Mauritania have adopted community financing schemes to subsidise local communities in providing maternal healthcare services. In these plans, the cost is shared between community health associations, development partners and the government, with patients also making a small contribution.
- Focusing heavily on information, education and communication, and decentralised programmes that reach down to the village level, Uganda's government spurred a reduction in HIV/AIDS prevalence rates from over 15% in the 1990s to approximately 5% in 2001 – though studies are showing that rates have begun to rise once again. In South Africa, despite initial reluctance, the South African government is now involved in information campaigns and national treatment programmes.

WHAT DOES THE G8 NEED TO DO?

A comprehensive effort that addresses commitments on individual diseases, while also offering increased, predictable and long-term funding for health systems, is necessary. To maximise effectiveness, this must happen alongside efforts to ensure that domestic policies do not contribute to the poaching of African health professionals to work in developed economies. The table below shows the financing needs to fight HIV/AIDS and support orphans and children made vulnerable as a result of infectious diseases and poverty, and to fight TB, malaria and polio and provide maternal and child health care in Africa. It also shows the financing needed to ensure that there are enough trained health workers to fight these diseases and, more broadly, to strengthen health systems. Total financing requirements to meet all of these needs will increase from \$14.2 billion in 2006 to \$21.3 billion in 2010.

ESTIMATED COSTS TO TACKLE KEY DISEASES AND FUND HEALTH WORKERS IN AFRICA (US\$ BILLIONS)

DISEASE / SECTOR	2006	2007	2008	2009	2010
HIV/AIDS prevention and treatment ³⁸	4.1	5.1	6.2	6.4	6.4
Orphans and vulnerable children ³⁹ (as a result of poverty and infectious diseases)	1.4	1.5	1.6	1.6	1.7
TB ⁴⁰	2.1	2.1	1.9	1.9	1.9
Malaria ⁴¹	3.0	3.1	3.3	2.4	2.6
Maternal, newborn and child health care ⁴²	1.0	1.0	1.0	1.0	1.0
Polio ⁴³	0.6	0.7	0.6	0.2	
Health workers ⁴⁴	2.0	3.4	4.9	6.3	7.7
TOTAL	14.2	16.9	19.5	19.8	21.3

THE IMPORTANCE OF REPLENISHING THE GLOBAL FUND

A key component of the G8's commitment on infectious diseases is their promise to replenish the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Global Fund provides financing over the medium term, with initial two-year grants extendable by a further three years if they have been successful. The Global Fund estimates its needs to be a total of \$3 billion in 2007, rising to \$3.9 billion in 2008 and between \$6 billion and \$8 billion by 2010. As of March 2007, \$2.4 billion had been pledged to the Fund for 2007, of which \$357 million had been paid in or was in the process of being paid. The payment record for the Global Fund was excellent for the period 2001–05, when 99% of government pledges were paid in. However, for 2006, 16% of pledges remain unpaid.

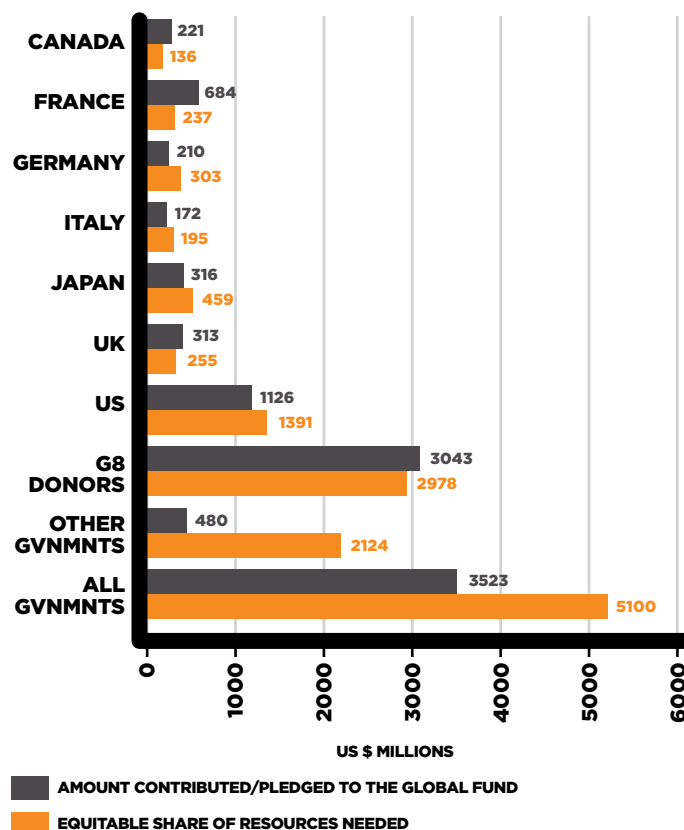
ARE THE G8 ON TRACK?

Because the DAC does not report on spending by donors in each of the specific sectors identified in this chapter, progress is measured against all health targets collectively. In total, development assistance for health in sub-Saharan Africa grew by 7% (from \$4.7 billion to \$5 billion) between 2004 and 2005, including estimated support to health systems through general budget support. However, this is only approximately one-third of the amount needed for priority diseases, health worker development and care of orphaned children.

Between 2000 and 2004, G8 donors tripled their funding for HIV/AIDS and infectious disease control, while funding for basic health, health infrastructure and basic nutrition all fell in real terms. Encouragingly, in 2005 these sectors showed an upturn. However, if G8 donors continue on their current funding path, in 2010 priority health needs will be under-resourced to the tune of around \$13 billion.

Donors made new pledges to the Fund for the 2006–07 period at a Replenishment Conference following Gleneagles. The following graph shows the contributions and pledges for 2006–07 from each G7 donor, compared with their equitable share (based on GNI).

CONTRIBUTIONS AND PLEDGES TO THE GLOBAL FUND IN 2006 AND 2007 COMPARED TO EQUITABLE SHARE OF RESOURCE NEEDS (BASED ON GLOBAL GDP)



A number of donors have made significant increases in their funding to the Global Fund for 2006–07 over previous levels. Significant increases by certain countries, particularly France, Canada and the UK, have meant that the US share has decreased from a peak of providing 33% of all Global Fund financing to current levels of around 30%.

- **CANADA** contributed \$432 million to the Global Fund during the 2001–05 period and already paid in its full pledge of \$222 million for 2006–07.
- **FRANCE** has paid in \$773 million to the Fund for 2001–06 and has pledged an additional \$400 million for 2007.

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- **GERMANY** has provided \$286 million over the 2001–06 period and pledged an additional \$123 million for 2007, which has already been paid in.
- **ITALY** paid in \$433 million from 2001–05 and has pledged \$173 million for 2007.
- **JAPAN** contributed \$477 million for 2001–06 and pledged \$186 million for 2007, which has already been paid in.
- **UK** contributed \$476 million for 2001–06 and has pledged \$197 million for 2007.
- **US** has contributed \$1.9 billion to the Fund to date and has pledged \$724 million for 2007.
- **RUSSIA** has contributed \$33 million to the Global Fund to date and is currently a net recipient of Global Fund financing. However, Russia recently announced that it will reimburse the Global Fund for grant financing it has received to date, totalling \$270 million over the next four years.

CONCLUSION

Since Gleneagles, G8 donors have increased funding in key areas, resulting in some real progress. On the whole, however, they are still falling short of adequately addressing the comprehensive challenge of health care in Africa.

Donor health spending in Africa increased by 7% from \$4.7 billion in 2004 to \$5 billion in 2005. This is just over one-third of the amount needed for priority diseases, health workers and care of orphans. While HIV/AIDS spending tripled between 2000 and 2004, funding for basic health fell over the same period. Success in increasing access to HIV/AIDS treatment, efforts on polio eradication and increases in funding for the Global Fund are all bright spots, but much remains to be done. Improving health in Africa requires significant investments, not only for specific diseases, but for strengthening broader health systems.

Because of the way health spending is tracked, it is difficult to comprehensively compare G8 donor progress on each of the key components of health outlined in this chapter. Therefore, we cannot create an overall on track/off track assessment section for health, as we have in other chapters of the DATA Report.

Several G8 countries, however, should be praised for their commitments and progress in specific areas, including the following.

- **HIV/AIDS:** Both the US and UK have made significant bilateral contributions to the fight against HIV/AIDS, and France has made significant pledges of support to UNITAID, along with the UK.
- **MALARIA:** The US has made a considerable commitment to scale up malaria funding bilaterally.
- **CHILD AND MATERNAL HEALTH:** Although there have not been significant increases in spending on maternal and child health, G8 support for efforts such as AMCs and the IFFIm should be noted. Recent progress has included contributions by Italy, the UK and Canada to the recently launched AMC for pneumococcal disease and contributions from the UK, France and Italy to the IFFIm.
- **POLIO:** Global success towards polio eradication has been notable, with the US, UK and Japan leading the way as the top three donors.
- **HEALTH SYSTEMS:** Both Canada and France have made new pledges for spending on health systems in the developing world.
- **THE GLOBAL FUND:** The US has been the Global Fund's largest donor to date. Recent increases from all G8 donors, particularly France, Canada and the UK, which are now exceeding their equitable share of Global Fund financing, have been notable.

