

HEALTH

THE COMMITMENT

In 2005, G8 countries committed to helping African countries reach the health MDGs by reducing the burden of HIV/AIDS, malaria, tuberculosis and polio, and by improving access to

basic health care. At subsequent G8 Summits, including at the 2007 Heiligendamm Summit and the 2008 Hokkaido Summit, additional commitments were made that strengthen the disease-specific commitments and support health system strengthening, the training and retention of health workers and the control or elimination of neglected tropical diseases.

FIGURE 1

G7 AND DAC HEALTH ODA TO SUB-SAHARAN AFRICA, 2004-2007 (\$ MILLIONS, 2008 PRICES)

	2004	2005	2006	2007	2004-2007 INCREASE
CANADA	171.00	184.03	176.03	235.10	64.11
FRANCE	359.35	366.97	366.21	433.61	74.26
GERMANY	245.42	354.22	337.50	321.63	76.21
ITALY	194.12	248.93	206.02	254.57	60.45
JAPAN	242.82	296.23	298.61	348.20	105.38
UK	609.46	757.99	618.10	770.05	160.59
US	1,349.16	1,706.93	2,046.84	3,428.54	2,079.38
G7	3,171.33	3,915.30	4,049.31	5,791.70	2,620.37
NON-G7 DAC	1,498.39	2,160.03	2,084.15	2,402.23	903.84
DAC	4,669.72	6,075.33	6,133.45	8,193.93	3,524.21

THE TOLL OF HIV/AIDS IN AFRICA

22 million

Number of people living with HIV in Africa. 66% of people living with HIV/AIDS worldwide are in Africa.

1.5 million

Number of adult and child deaths due to HIV/AIDS in Africa in 2007. Worldwide, 2 million people died of AIDS in 2007.

THE TOLL OF MALARIA IN AFRICA

90% of all malaria deaths occur in sub-Saharan Africa, most among children under five.



39%

Of the 647 million people at risk of malaria in Africa, the portion covered by insecticide-treated bed nets has increased from 3% in 2001 to 39% in 2007.

MORE SPECIFICALLY, THE G8 PLEDGED TO:

- Pursue all necessary efforts to scale up towards the goal of universal access to comprehensive HIV/AIDS prevention programmes, treatment, care and support by 2010;
- Help to meet the needs identified by the Stop TB Partnership;
- Continue to expand access to long-lasting insecticide-treated nets (ITNs), with a view to providing 100 million nets by the end of 2010;
- Ensure that by 2015 all children have access to basic health care;
- Support the Polio Eradication Initiative for the post-eradication period in 2006-08 through continuing or increasing their own contributions;
- Reach at least 75% of the people affected by certain major neglected tropical diseases in the most affected countries;
- Work with other donors to replenish the Global Fund to Fight AIDS, TB and Malaria and provide long-term predictable funding based on ambitious, but realistic, demand-driven targets.
- Work towards increasing health workforce coverage towards the WHO minimum threshold of 2.3 health workers per 1,000 people, including the development of health workforce plans and establishing specific, country-led milestones as well as for enhanced monitoring and evaluation, especially for formulating effective health policies;

Though ONE commends the G8 for setting a five-year timeframe in Hokkaido to deliver the \$60 billion for infectious diseases and health systems that was originally committed to in 2007 at Heiligendamm, ONE has chosen not to monitor this commitment because it is less ambitious than previous commitments the G8 have made. Achieving the health outcomes to which they committed on HIV/AIDS, tuberculosis, malaria, polio and health systems will require more than \$60 billion in health spending over the next five years.

ONE has therefore interpreted the G8 health commitments to mean that each donor will provide its proportionate share¹ of funding to achieve each of the health commitments. Using that interpretation, ONE monitors progress on the outcomes committed to by the G8 and overall health ODA from each donor. The G8 commitments on health are very ambitious. If achieved, these commitments would significantly improve the health of Africans.

PROGRESS TOWARDS MEETING THE G8 HEALTH COMMITMENTS

Where concentrated investments have been made, results have been delivered. New HIV infections are declining and more people living with HIV are receiving care and treatment, rates of new cases of tuberculosis are declining, malaria mortality has been reduced in targeted countries and child mortality has declined.² Polio remains endemic in only one country in Africa and, with a recent influx of resources, could join smallpox on the list of eradicated diseases.³ However, as a region, Africa remains seriously off track to achieve the health MDGs, especially MDGs 4 and 5, which call for reducing the under-five death rate by two-thirds and the maternal death rate by three-quarters by 2015. Life expectancy remains stubbornly low and, more broadly, Africa's health indicators remain among the poorest in the world. Below is a summary of progress towards the health commitments made by the G8.

HIV/AIDS

SCALE UP TO UNIVERSAL ACCESS TO HIV/AIDS PREVENTION, CARE AND TREATMENT

By the end of 2008, nearly 4 million people globally were on anti-retroviral therapy (ART), up from 50,000 in 2002.⁴ Though exact figures are not yet available, extrapolating from past increases in Africa it is likely that nearly 3 million people are now on ARV therapy across the continent. If confirmed by WHO and UNAIDS in the coming months, this would represent a continuation of the enormous success of current global AIDS efforts, but would also mean that the world remains far from its 2010 goal of universal access.⁵ Worldwide, the number of children newly infected with HIV declined from 450,000 in 2000 to 370,000 in 2007 in part because of the expansion of prevention of mother-to-child transmission programmes.⁶ Also, fewer people are dying of HIV-related illness because of the expansion of care and treatment programmes.⁷

TUBERCULOSIS

DELIVER THE GLOBAL PLAN TO STOP TUBERCULOSIS

Detection rates in high-burden countries in Africa have increased significantly from 23% in 1995 to 42% in 2007, and many more people are receiving directly observed therapy – short-course (DOTS).⁸ DOTS coverage increased to 93% in high-burden African countries in 2007, up from 43% in 1995, and treatment success rates under DOTS improved from 59% in 1994 to 75% in 2006.⁹ However, TB cases have increased between two- and six-fold since 1990, and Africa accounts for nearly 80% of the world's total number of people living with HIV and TB.¹⁰ Multi-drug-resistant tuberculosis (MDR-TB) and extensively drug-resistant tuberculosis (XDR-TB) are increasingly important health concerns for Africa and more deadly in HIV-infected persons.¹¹ Only 3% of MDR-TB cases worldwide are being treated according to WHO standards.¹²

MALARIA

EXPAND ACCESS TO LONG-LASTING INSECTICIDE-TREATED NETS AND REACH VULNERABLE POPULATIONS WITH MALARIA PREVENTION AND TREATMENT

Substantial increases in funding for malaria since 2004 have facilitated expansions in interventions.¹³ The at-risk population in Africa covered by ITNs increased from 3% in 2001 to 39% in 2007¹⁴ and indoor insecticide spraying protected 25 million people in Africa between 2006 and 2007.¹⁵ The expansion of these interventions has led to declines in illness and mortality from malaria in Rwanda, Ethiopia, Zambia, Equatorial Guinea, Eritrea and Tanzania.¹⁶ Provision of artemisinin-based combination therapies (ACTs), the WHO-recommended treatment protocol for malaria in Africa, remains low: while 69 million doses of ACTs were distributed in Africa in 2006 (84% of the global total), only 3% of children on average of those who needed them were given ACTs.¹⁷

PROGRESS ON POLIO ERADICATION

946

Number of polio cases in Africa in 2008 out of 1,659 cases worldwide, concentrated in three countries (Nigeria, Pakistan and India). This is a reduction from an estimated 350,000 cases worldwide in 1998.

POLIO

SUPPORT THE GLOBAL POLIO ERADICATION INITIATIVE

In 1998, there were an estimated 350,000 cases of polio worldwide. In 2008, there were 1,659 polio cases worldwide, concentrated mainly in three countries (Nigeria, Pakistan and India), and 946 of these were in Africa.¹⁸ Eradication of this disease may be near, but the hardest work may be yet to come: reaching the remaining areas where polio is endemic poses financial, logistical and political challenges. Recent influxes of funding for polio eradication from the Bill and Melinda Gates Foundation, Rotary International, Germany and the United Kingdom could finally push polio onto the list of eradicated diseases.

REPLENISH THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

Since its inception, the Global Fund has distributed 70 million bed-nets, supported the detection and treatment of 4.6 million cases of tuberculosis and supported AIDS treatment for 2 million people globally through programmes in 137 countries.¹⁹ To continue to fully fund the demand from recipient countries and to produce these positive results, the Global Fund estimates that it will need \$13.5 billion between 2008 and 2010. As of April 2009, the Global Fund estimated that its pledges were \$4 billion short of meeting this need.²⁰

STRENGTHEN HEALTH SYSTEMS

In lieu of an internationally agreed upon method to measure progress on health systems development, ONE monitors progress in two areas that are primary beneficiaries of such investments – child and maternal health and progress towards increasing the number of trained health care workers in Africa.

CHILD HEALTH

Although child mortality rates in Africa declined from 186 per 1,000 live births to 148 per 1,000 live births between 1990 and 2007, a number of countries in the region are still registering increases in child mortality rates, and Africa still has the highest number of child deaths in the world (4.2 million in 2007).²¹

MATERNAL HEALTH

Maternal health in Africa remains poor, with a minimal decline in maternal mortality from 940 deaths per 100,000 live births in 1990 to 920 deaths per 100,000 live births in 2005.²² As gains in maternal health require that all components of a health system function, maternal mortality is a good marker for health system improvements. The link between maternal health and skilled health workers – a key component of a strong health system – is critical: Africa accounts for nearly 50% of all maternal deaths and ranks next to lowest of all world regions in skilled birth attendance.²³ Currently, only 40% of births in Eastern and Southern Africa are attended by skilled health workers.²⁴

HEALTH CARE WORKERS

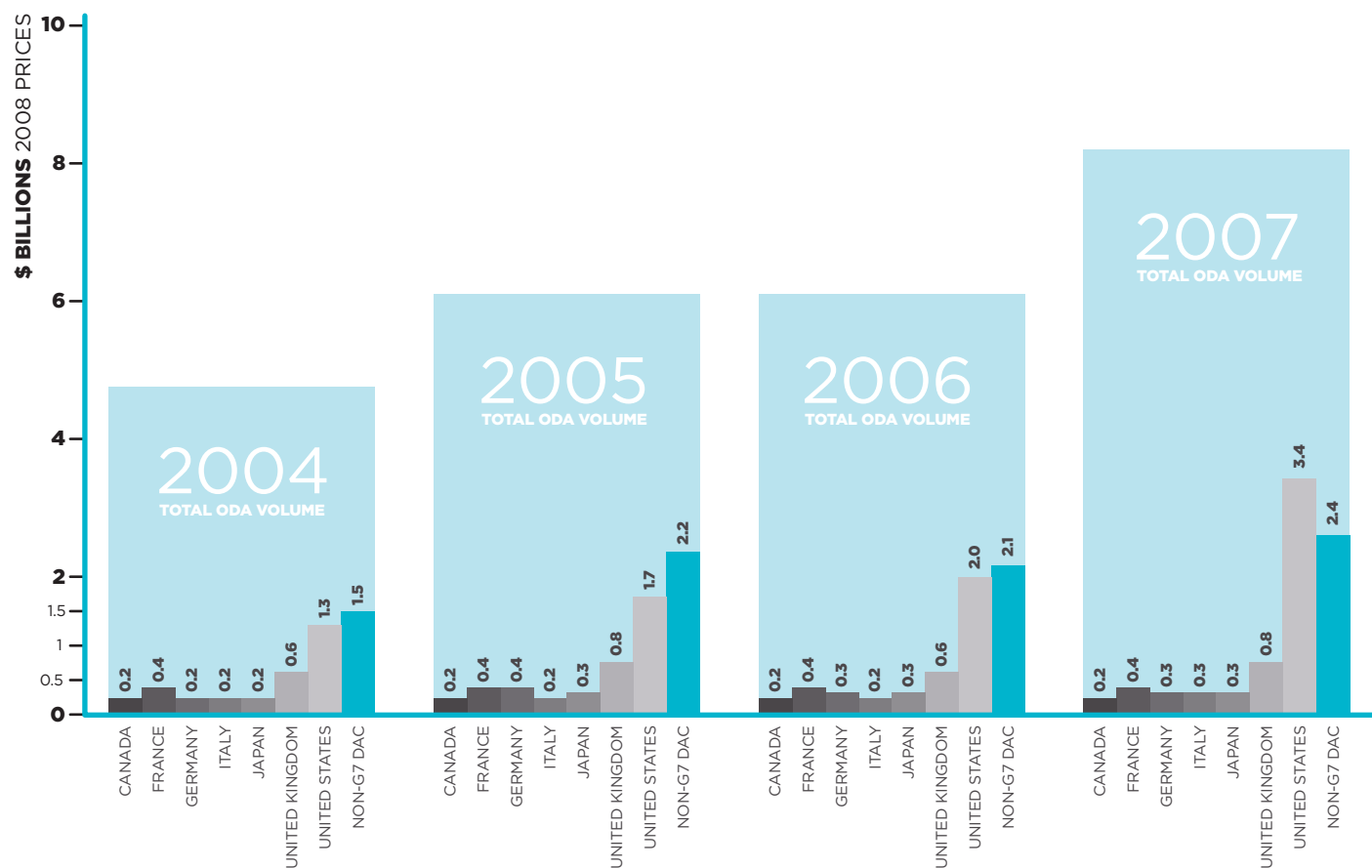
With 24% of the global disease burden and only 3% of the world's health workforce, African countries are ill equipped to address their health challenges.²⁵ Most countries in Africa have less than one health worker per 1,000 people, and only four countries in the region have more than the WHO-recommended 2.3 health workers per 1,000 people.²⁶

ODA FOR HEALTH

In 2007, the G7 directed \$5.8 billion in ODA for health to sub-Saharan Africa (see Figure 2), an increase of \$2.6 billion (83%) over 2004 levels. Including non-G8 DAC countries, ODA for health to Africa totalled \$8.2 billion in 2007.

FIGURE 2

G7 AND DAC BILATERAL AND MULTILATERAL HEALTH ODA TO AFRICA BY DONOR (2004-2007)



The United States is the largest donor of health ODA to Africa, having increased its commitments to health by \$2.1 billion (154%) between 2004 and 2007. ONE expects that this significant increase will continue in 2009 and 2010. In 2007, the US committed \$3.4 billion in health ODA, accounting for 59% of health ODA from all G8 countries. Among individual donors, the UK is the second largest donor for health: \$770.1 million was committed in 2007, and the UK increased

its health ODA to Africa by \$160.6 million (26%) between 2004 and 2007. Japan had the next most notable increase in absolute terms of health ODA to Africa between 2004 and 2007 (\$105.4 million), committing \$348.2 million in 2007. The other G8 countries (Canada, France, Germany and Italy) had marginal increases in health ODA in the three years from 2004, increasing their spending by \$64.1 million, \$74.3 million, \$76.2 and \$60.5 million respectively.

WHAT DO THE G8 NEED TO DO?



CONTINUE TO SCALE UP FUNDING TO FIGHT INFECTIOUS DISEASES IN AFRICA

The focus of ODA for health has been directed at fighting infectious diseases, as they account for 59% of the disease burden in Africa.²⁷ Of total G7 ODA for health, 74% was directed to fight infectious diseases in 2007 (see Figure 2). As described above, the G8 commitment to treatment for infectious diseases has already delivered positive results, but investments in this area need to increase rapidly to meet the 2010 targets of universal access to prevention, care and treatment for HIV/AIDS; to reach 85% of those in need of malaria prevention and treatment; to fully fund the Global Plan to Stop TB; to fully fund the Polio Eradication Initiative; and to reach the majority of those afflicted by neglected tropical diseases.

FULLY FUND THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

The Global Fund has proved a successful mechanism for making progress towards the goals of prevention, care and treatment for AIDS, TB and malaria. The G8 should fully fund the needs of the Global Fund through long-term, predictable financing. The total need for new grant proposals as well as renewing existing grants to cover 2009 and 2010 is projected at \$13.5 billion, but thus far only \$9.5 billion has been pledged, leaving a \$4 billion gap.

INCREASE ATTENTION TO AND FUNDING FOR OTHER KEY HEALTH ISSUES, TRAINING AND RETAINING HEALTH CARE WORKERS AND IMPROVING HEALTH INFRASTRUCTURE

While funding for fighting infectious diseases has increased rapidly, financing for health systems, basic health and reproductive health has remained nearly flat since 2004

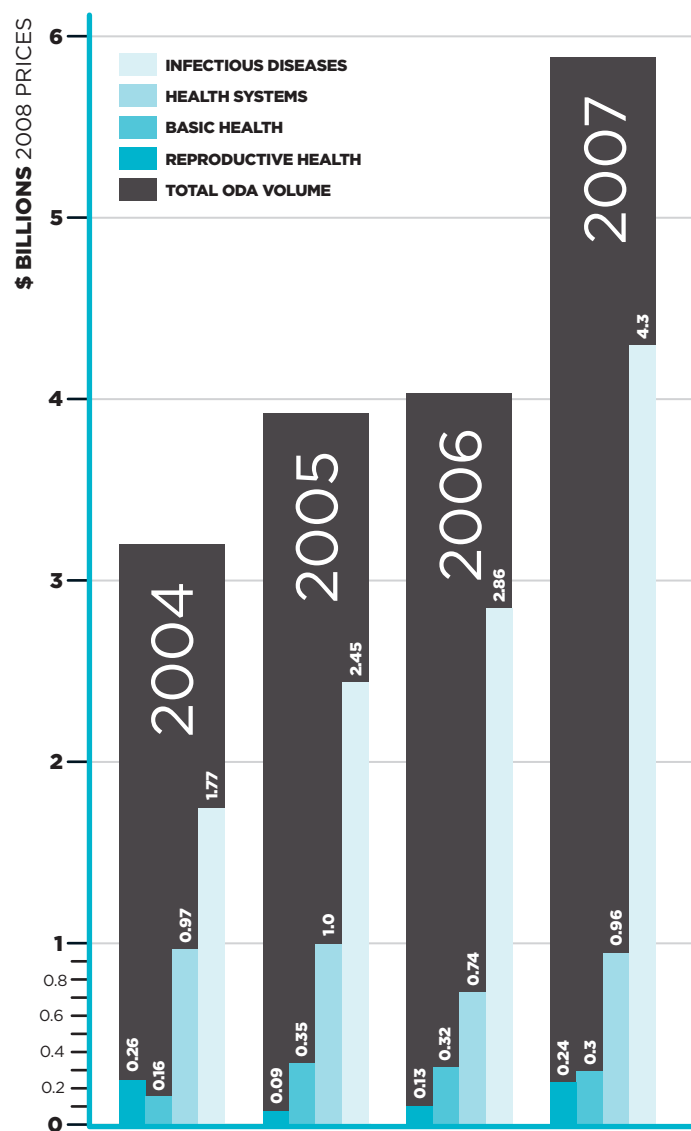
(see Figure 3). Growth in these areas is critical to improve people's health throughout their life and to maximise gains from investments in infectious diseases.

G7 funding for health systems fell by \$17.1 million between 2004 and 2007, whereas funding for infectious diseases increased by \$2.5 billion. As a share of health ODA, funding for infectious diseases increased from 55.9% to 74.2% between 2004 and 2007 (\$1.8 billion to \$4.3 billion), while funding for health systems as a share of health ODA declined from 30.7% to 16.5% during the same period. This was largely due to the funding allocation patterns of the United States, which directed 91% of its 2007 health commitments into infectious disease programmes. G8 financing for reproductive health also saw declines as a percentage of health ODA. While funding for basic health almost doubled between 2004 and 2007, its percentage of health ODA remained unchanged.

At the Japanese G8 Summit in Hokkaido, the G8 committed to a framework for health systems development but lacked clear direction on how they would implement it. As the G8 continue to increase funding to achieve the targets on AIDS, TB, malaria and polio, they should follow the Hokkaido health systems framework and begin to increase funding for sustainable health systems components, including the training and retention of healthcare workers, that will lead to long-term improvements in health outcomes. The system-wide gains already achieved through disease-specific funding can be leveraged to further strengthen health systems. In particular, child and maternal health, which have been under-funded relative to disease-specific programmes, could progress as beneficiaries of strengthened health systems delivering available, cost-effective and proven interventions. As the health workforce in African countries is strengthened, the cadres of health workers that are most influential for the health of mothers and children, including skilled birth attendants and community health workers, should be included in the measurement of progress, even if they are not formally included in the public sector health system.

FIGURE 3

G7 BILATERAL AND MULTILATERAL HEALTH ODA TO AFRICA BY SUB-CATEGORY (2004-2007)



SOURCE: STATISTICS FROM OECD DATABASE, PRODUCER SUPPORT ESTIMATE IN US BILLIONS, 2008 PRICES

CONCLUSION

Investments in health have made a difference, but with Africa significantly off-track to meet the health MDGs, additional investments in health by the G8 are critical going forward. Delivering on the G8 commitments on health would improve life expectancy and quality of life across the continent. Results-driven programmes like the Global Fund and the US President's Emergency Plan for AIDS Relief (PEPFAR) have demonstrated that this type of investment works. The emergence of innovative financing mechanisms for health, including the AMCs, IFFIm, UNITAID, (RED) and others are welcome and the G8 should adopt the findings of the Innovative Financing Task Force for Health that will be released at this year's G8 Summit in Italy.

Coupled with meeting the AIDS, TB, malaria and polio commitments, keeping the broader Hokkaido health systems commitments will help to ensure that Africans have access to sustainable and high-quality health care, and this ultimately will save lives. But, resources additional to the G8 ODA commitments and current national spending levels will be required to reach these goals and the health MDGs in Africa.

INFECTIOUS DISEASES
INCLUDES FUNDING FOR HIV/AIDS, TUBERCULOSIS, AND MALARIA PROGRAMMES AS WELL AS OTHER INFECTIOUS DISEASES

HEALTH SYSTEMS
INCLUDES HEALTH INFRASTRUCTURE, POLICY PLANNING, PERSONNEL DEVELOPMENT, MEDICAL SERVICES, HEALTH EDUCATION, AND AN IMPUTED CALCULATION OF GENERAL BUDGET SUPPORT

BASIC HEALTH
INCLUDES BASIC HEALTH CARE, NUTRITION, HEALTH INFRASTRUCTURE SPECIFIC TO BASIC HEALTH PROGRAMMES

REPRODUCTIVE HEALTH
INCLUDES STD PREVENTION AND FAMILY PLANNING