"Promoting Global Health"
L'Aquila G8 Health Experts' Report

1. In 2001, in Genoa, the G8 took up the bold challenge of "breaking the vicious cycle of poverty and disease". The 2001 G8 Presidency was also instrumental in translating the concept born in Okinawa into the Global Fund to fight AIDS, Tuberculosis and Malaria that is the success story we know today. The sustained leadership and commitment of the G8 to health in the last Summits together with partners support, have transformed the lives of millions of people in the developing world.

2. Where there have been substantial investments and good performances, impressive results have been achieved. This is especially evident in the dramatic increase in coverage notably: the scale up of HIV prevention and treatment programs; the significant reductions in child morbidity and mortality achieved through child immunization, micronutrients and other interventions- including a major reduction in measles mortality - and the rapid expansion of effective malaria interventions that has led to significant reductions in malaria cases; increased access to diagnosis and treatment of tuberculosis; and substantial progress towards the eradication of polio.
3. Despite these major advances, the job is far from done. Sustained political leadership and commitment are needed to maintain

momentum in global health, to safeguard investments made so far and further the achievements of international agreed goals and targets, including the MDGs, as well as the goals of: scaling up towards achieving universal access to HIV prevention, treatment, care and support by 2010; universal coverage of long-lasting insecticide treated nets; halting and beginning to reverse the incidence of the TB, and halving prevalence and death rates from 1990 base line; universal access to reproductive health services by 2015. Supporting actions are also required to address poverty and under nutrition, to reduce maternal, newborn and child mortality and for improving water supply, sanitation and hygiene. Women and children are among the most vulnerable groups and progress toward the MDGs related to maternal, newborn and child health remains too slow.

4. Preparation for the 2009 summit takes place at a time of global financial and economic crisis, which poses us not only challenges but opportunities to promote global health in a more effective and innovative way. Therefore protecting and possibly expanding health spending as well as delivering on existing commitments, using resources more efficiently and effectively, are key to maintain progress in the current unstable environment.

5. Recent G8 Summits, notably Saint Petersburg, Heiligendamm and Toyako have confirmed and implemented specific commitments to support global health, and to work towards the goal of providing at least a projected US$60 billion over 5 years to fight infectious diseases and strengthen health, as stated in the Toyako Leaders' Declaration. In respect to the Leaders' commitment to ensure accountability made in St. Petersburg and implemented in Toyako, the G8 Health Experts have developed the monitoring

report as attached, showing G8 implementation of past commitments.

6. We undertake to continue the work of monitoring progress on G8 health-related commitments and building on and processing the work of previous Presidencies, we have considered four themes as input to the 2009 Summit. These broad themes refer to the major challenges in global health and provide a structure to define priorities and focus within a broader agenda, to identify the main outcomes to be achieved, and potential G8 actions to be undertaken in support of developing countries.

7. The four themes are: (i) promoting a comprehensive and integrated approach to the achievement of the health-related Millennium Development Goals; (ii) strengthening health systems to advance the goal of universal access to health services; (iii) promoting health as an outcome of all policies, and (iv) increasing the quantity and quality of development aid in the context of existing G8 commitments and further advancing G8 accountability.

8. The four themes are closely linked. The first is primarily concerned with health outcomes; the second acknowledges the role of more equitable and better performing health systems, as a means of achieving those outcomes; the third recognizes that a multi-sectoral approach, can accelerate progress toward achieving MDGs and that better health is linked to other areas of G8 concern, such as poverty, gender equality, education, water supply and sanitation, food security, the environment and climate change; and the fourth concerns existing G8 commitments to increase the volume and improve the effectiveness of aid spending in health. More rapid progress in improving maternal newborn and child health should be an outcome of our efforts on all four themes.

Promoting a comprehensive and integrated approach to the achievement of the health-related Millennium Development Goals

Key issues

9. The challenge facing developing countries and their partners in the international community is to protect and expand the gains that have been achieved in combating HIV/AIDS, TB, malaria and NTDs; to complete the task of polio eradication; and to make more rapid progress towards the achievement of the MDGs concerned with maternal health and child mortality.

The health-related MDGs are mutually linked and interdependent. There is evidence that an integrated and comprehensive approach yields better health outcomes and is required to achieve the health-related MDGs. Progress could be accelerated, for example, by further enhancing integration of infectious disease with maternal and child health programs. Good examples of integration to build upon include provision of long-lasting insecticide-treated nets with antenatal and well-baby care services and integrated approach to address HIV and TB co-infection.

Priorities and focus

10. To reduce child mortality work has to be done toward: universal access to essential newborn care; increase uptake of the WHO integrated management of childhood illness strategy including immunization, breastfeeding and pneumonia care; incorporate measures to combat under-nutrition, diarrhoeal diseases and malaria. With regard to the implementation of maternal health care and services, an increased access to skilled birth attendants, emergency obstetric care, prevention and management of haemorrhage, family planning and sexual and reproductive health is essential. To that end, women human rights, their freedom of choice and the capacity to exercise those rights need to be ensured.

Improvement in maternal health and reduction of maternal mortality is important in its own rights and it has far- reaching benefits in improving the health of children, families and communities.
Building on progress achieved in fighting major diseases is essential to: scale-up efforts towards universal access to HIV/AIDS prevention, treatment, care and support, by 2010 and beyond, especially through accelerated efforts in HIV prevention, including access to sexual and reproductive care and services and interventions to prevent mother-to-child transmission, access to male and female condoms and comprehensive education programmes; strengthen basic TB control, and management of MDR/XDR TB; integrate HIV-TB care and increase availability of labs and diagnostics; scale-up coverage of a comprehensive approach to malaria prevention and treatment, and any other useful devices, including the use of long-lasting insecticide-treated bednets, indoor residual spraying with insecticides within the framework and regulations of the Stockholm Convention on Persistent Organic Pollutants (POPs), intermittent preventive treatment for pregnant women, and case management using artemesinin-based combination therapy; improve data-collection and management capacity and promote capacity development in countries and cross-border activities; continue polio eradication building on results so far achieved; focus on prevention efforts as a cost-effective approach to promote sustainable responses.

11. For all three MDGs it is crucial to: increase the awareness on the concept that health-related MDGs are complementary and synergic and cannot be achieved in isolation; promote the integration of interventions and services in national health strategies and plans; increase the attention paid to gender equality, community participation and empowerment; support country-led

health strategies and plans that incorporate MNCH together with HIV/AIDS, Tuberculosis and Malaria interventions; continue to work toward improving the link between HIV/AIDS activities and sexual and reproductive health and family planning programs and to improve access to affordable quality health care, including preventing mother-to-child transmission; target funding to the national priorities, based on the countries' health plans; follow and track progress through international agreed mechanisms (e.g. Countdown to 2015 on MDGs 4 and 5).

12. *Potential G8 actions:*

- support country-led approaches, as well as the development and implementation of robust national plans and budgets for achieving the health-related MDGs;
- foster the efforts by Global Health Partnerships, like the GAVI Alliance and GFATM, to deepen their support for country-led approaches in line with IHP+ principles;
- support country leadership and strengthen capacity with regard to HIV/AIDS, Malaria and Tuberculosis, especially in scaling up towards universal access to HIV/AIDS prevention, treatment care and support by 2010 and in accelerating HIV prevention and integrating services for HIV/TB;
- renewed support to countries in prioritizing the delivery of essential services to reduce maternal, neonatal and child deaths through strengthened policies and plans, and in recognizing the additional funds and effective financial management systems needed for their implementation;
- encourage countries to accelerate progress on reducing child mortality and improving maternal health, providing a basic package of health services, free wherever countries choose to provide this;

- strengthen the link of integrated and comprehensive maternal care, HIV prevention and family planning and increase support to the already identified effective intervention related to maternal newborn and child health (Countdown to 2015, The Partnership for MNCH);
- encourage the high level plenary meeting in September 2010 to pay adequate attention to securing commitment to accelerate progress on reduction of child mortality and maternal health;
- support efforts by Global Health Partnerships to ensure that their programs and activities promote equal and equitable access to health care and services for women and girls, men and boys.

Strengthening health system to advance the goal of universal access to health services

Key issues

13. In order to achieve health MDG outcomes and response to global health challenges, it is essential to develop and strengthen health systems so that health services, especially primary health care, can be provided on a sustainable and equitable basis. In working towards universal access to health services, a good starting point would be for countries to begin to implement as fully as possible the World Health Assembly resolutions on: "Sustainable health financing, universal coverage and social health insurance"; "Rapid scaling-up of the health workforce production"; "Strengthening health-information systems", "Working towards universal coverage of maternal, newborn and child health interventions", among others. Defining the move towards universal access to essential health services, including primary health care - as a political goal, related to fundamental rights, and unifying theme for health systems strengthening - would mark an important step forward in catalyzing a broader health agenda. The

intent to widen coverage sends a strong political signal on the part of governments to provide fair and equitable health services that meet people needs and expectations.

14. Universal access to health services implies more effective allocation of resources, and protects poor people from impoverishing expenditures. PHC is an inclusive approach to the organization of the health sector, fundamental to pursue universal access to health services. It calls for full community participation in managing own health and is consistent with G8 commitment to strengthen health systems and fight against infectious diseases. It is context-specific, contingent on resource availability, consistent with national plans and strategies; therefore it can be progressively realized .

Priorities and focus

15. The work carried out by the previous Japanese presidency has confirmed the importance of critical elements of health systems: human resources, information systems and health financing, including social health protection and more efficient spending. The international community should maintain a focus on these key elements in the face of financial crisis. Health information systems require investment in and the development of country capacity to collect and analyze data and evidence needed to inform health policy. In addressing human resources issues, it is essential to ensure policy coherence and support country-led plans to improve training, retention, deployment and performance. Sustainable and equitable health financing systems entail the removal of financial barriers and other obstacles to universal access to health services, especially for the most vulnerable. Health financing systems should rely on public budget allocations and methods of risk-pooling and prepayment of financial

contributions for health care, avoiding catastrophic health-care expenditure of individuals. In addressing health systems priorities further investment in health systems research, technical innovation and rapid technology transfer is required.

16. The international community affirms the need for continued commitment to primary health care, both politically and financially, including adequate coverage of recurrent costs of health systems. Countries and partners should move towards joint planning and monitoring frameworks where appropriate. To better deliver health care services and leave lasting improvements to health systems it is critical to maximise positive synergies between Global Health Initiatives and health systems.

17. *Potential G8 actions* :

- assist countries, also through the IHP+, Providing for Health and other initiatives, in identifying critical health systems investments required to reach MDGs outcomes, in scaling up their health system strengthening efforts as well as in building well-functioning information systems;
- support countries in greatest need to develop and adopt national plans on human resource development, retention and utilization including community and mid-level workers towards the WHO threshold of 2.3 health workers per 1000 people and in line with the 2008 Kampala Declaration and Agenda for Global Action launched by the Global Health Workforce Alliance;
- encourage G8 countries engagement to address both the push and pull factors related to the international migration of health workers;
- encourage the ongoing WHO process to finalize the Code of Practice on the International Recruitment of Health Personnel;

- support the efforts of global initiatives (e.g. Providing For Health) in assisting countries to remove obstacles to the equitable access to basic health services and to expand social health protection;
- encourage countries to develop sustainable and equitable health-financing systems paying attention to the most vulnerable, and where possible including pooled domestic finances, or methods for prepayment of financial contributions for health care;
- increase efforts to promote and develop countries' owned social health protection plans and strategies aiming to remove financial barriers to health care services;
- support partner countries improve their capacity on data-collection and building well-functioning information systems which enables them to formulate sound health policies;
- encourage the implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;
- encourage multilateral institutions to ensure alignment with national health strategies and processes and to increase funding and technical support for health systems strengthening with close coordination among them.

Promoting health as an outcome of all policies

Key issues

18. Health is one of the essential requirements to accomplish development. Almost 3 billion people live on less than two dollars per day. Moreover the current financial crisis follows hard on the heels of a food crisis which is estimated to have pushed over 100 million people back into poverty. Unemployment consequent to this economic downturn, with over 50 million people newly un-employed by the year end, now threatens to make this situation even worse. Poverty and inequality lead to poor health: lack of

access to economic resources, education, food, water and sanitation, accounts for almost one-third of the global burden of diseases. Yet countries world wide face growing burden of communicable diseases further aggravated by the increase of non-communicable diseases in developing countries. The rise of chronic diseases creates an enormous burden on health systems, and contributes to two other issues : high-cost long-term care, and a severe global shortage of health-care workers.

19. In this landscape more rapid progress on health outcomes cannot be achieved by health sector alone. Better health requires mutually reinforcing policy actions across many sectors that address the different determinants of health: poverty and social exclusion, food and nutrition, water and sanitation, environment, education, gender equality, employment, housing, justice, human rights. Public policies used to stimulate economic recovery can be geared to produce positive health effects such as ensuring universal access to primary health care, and seeking to protect lives and livelihoods through social protection. For instance health infrastructure, rural roads and communications and the removal of financial barriers to the access to health services are vital in increasing access to maternal care and reducing child mortality. Mitigating consequences of environmental threats such as climate change, natural disasters, unsustainable management of water resources, pollution and hazardous chemicals will have positive effects on health. For instance better management of the environment could prevent malaria related deaths linked to infections of the lower respiratory tract and deaths resulting from diarrheal diseases, three of the main causes of infant mortality in the world.

Priorities and focus

20. In order to break the vicious cycle among low economic development, poverty, poor environmental conditions, low literacy, gender inequality and ill-health, public policies should recognize that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being as well as contain an explicit concern for health and equity in all sectors. Relevant stakeholders should ensure effective planning, coordination and implementation of multi-sectoral plans for maternal and child health and HIV/AIDS. Gender equality and human rights as cross-cutting issues should be mainstreamed in all policies and programmes. Supportive legislation should improve legal and regulatory frameworks in countries. In addressing the high incidence of non communicable diseases it is essential to focus on prevention of the main risk factors such as harmful use of alcohol tobacco, physical inactivity, unhealthy diets, as well as harmful environmental conditions.

21. *Potential G8 actions* :

- encourage countries to ensure cross-sectoral coordination and integrated programs to achieve all MDGs;
- encourage international institutions and agencies to further coordinate with a view to ensuring progress across MDGs, maximising synergy effect;
- support integrated programs aiming at coordinating health, education, nutrition and water supply and sanitation, also by encouraging the implementation of the health-related actions pertaining the 2008 Education For All Oslo Declaration, (para 6);
- encourage work to assess and address the impact of climate change on human health and unsustainable management of water resources and health consequences of pollution and hazardous chemicals;

- encourage WHO and UNEP to assist countries in the implementation of the Libreville Ministerial Declaration on environment and health in Africa;
- encourage integrated interventions addressing the inadequacies of transport and building infrastructures that limit the access to health care;
- recognize the alarming increase in non-communicable diseases and promote the implementation of international health agreements, in particular the Framework Convention on Tobacco Control;
- promote the implementation of the International Health Regulations which foresee an inter-sectoral approach;
- encourage the integration of health strategies and plans in Poverty Reduction country-led policies;
- support programs that promote and protect human rights of women and girls and make knowledge about sexual and reproductive health widely accessible, especially in the context of prevention of sexual violence and sexually transmitted diseases, and actively work to implement the International Conference on Population and Development Programme of Action;
- work towards the elimination of stigma and discrimination, including travel restrictions on people living with HIV/AIDS.

Increasing the quantity and quality of development aid in the context of existing G8 commitments and further advancing G8 accountability

Key issues:

22. There is concern about health financing both from domestic and external resources. G8 efforts have contributed to the significant increase of ODA for health over the last 5 years and have

promoted better coordination of aid, through IHP+ and other initiatives. These efforts are beginning to yield results. The Global Fund represents today one of the main sources of finance for programs to fight AIDS, tuberculosis and malaria, with approved funding of US$ 15.6 billion for more than 500 programs in 140 countries providing a quarter of all international financing for AIDS globally, three-fifth for tuberculosis and for malaria. The International Financing Facility for Immunisation (IFFIm) has secured US$5.3bn in donor commitments. Six donors have also committed US$1.5bn to the pilot Advance Market Commitment (AMC) for a pneumococcal vaccine. Developing countries and other donors have also significantly increased their spending on health. Nevertheless, further improvement in health requires additional support, and funding sources should be diversified and expanded, by exploring new and innovative means of financing. For example, the High Level Task Force on Innovative International Financing for Health Systems (HLTF) has estimated the extent of the financing shortfall and is reviewing the potential of innovative sources of funding and the merits of different channels through which they can be transmitted to countries, with a view to maintain a strong link between resources and results, while increasing predictability.

Priorities and Focus:

23. It is important for donors and developing countries to deliver on existing financial commitments on health while considering new and innovative means of financing. G8 will continue to strongly contribute to the achievement of the health-related MDGs through bilateral and multilateral assistance. At the same time, the G8 will maintain its focus on decreasing fragmentation, increasing effectiveness and implementing the principles of the Rome, Paris and Accra Declarations in the health sector. Partner governments

should maintain commitments to providing domestic finance for health spending and effective use of limited resources and prepare, with support of WHO, the World Bank and the UN system, comprehensive robust, well-costed national health strategies and plans, involving civil society, community and non-governmental actors' in their implementation.

24. In order to unlock the full potential of aid delivery through cost-effective financing instruments, it is essential to: monitor the implementation of the Paris Declaration on Aid Effectiveness on the base of the Accra Action Plan, making the best use of existing mechanisms; share good practices of effective use of domestic resources and its equitable distributions; promote and increase supply and coordination of advice to countries in social health protection. In order to ensure that resources from all sources (including domestic and private sector flows) are used to maximise effectiveness it is crucial to monitor, at global and country level, the implementation of the holistic approach to financing for development agreed in the Monterrey Consensus and reaffirmed in the Doha Declaration. In this regard the HLTF will include specific recommendations in its final report be presented at the September 2009 UN General Assembly.

25. *Potential G8 actions*:

- reaffirm existing health commitments;
- explore and identify additional measures to increase efficiency and effectiveness of aid to the health sector, through inter alia better coordination and country-led division of labour;
- review options for new innovative financing mechanisms for health, including recommendations of the High Level Task Force on Innovative International Financing for Health Systems (HLTF)

as well as the Leading Group on innovative financing for development and other sources;

- following the launch of the pilot AMC, the G8 welcome the reconvention of the expert committee to learn lessons and may consider options for a successor vaccine AMC;
- continue investment in global public health and work to improve the predictability of funding in order to achieve the health-related MDGs and advance universal access to health services, including primary health care;
- support ongoing work by WHO, World Bank and other partners to analyze and monitor the impact of the financial crisis on health, and advise on mitigating actions to be taken at country and global level;
- further improve the accountability mechanism to monitor progress on meeting G8 commitments along the lines of the reporting formats developed by the Health Experts Group under the Italian Presidency.

G8 Accountability Exercise

Progress and challenges in Global Health

During the last decades, the international community has made significant progress towards the achievement of the health related Millennium Development Goals. MDG monitoring shows progress in reduction of under five child mortality in over 40 countries, including in at least 15 in Africa. However, there are other trends that must be taken into consideration. For instance, progress varies markedly among regions and countries, and in most countries it is still inadequate to reduce under-five child mortality by two thirds from its rate in 1990 by 2015 (MDG on child health). In sub-Saharan Africa, the under five mortality rate is still 174 of every 1,000 children while in South Asia it is 97 of 1,000[1]. Concerning maternal health, Sub-Saharan Africa has the highest maternal mortality rate at 920 maternal deaths per 100,000 live births, followed by South Asia, with a rate of 500. Sub-Saharan Africa and South Asia have also the highest neonatal mortality rates at 41 deaths per 1,000 live births[2]. Analyses show a need to expand coverage of essential maternal and child health interventions, including interventions to improve newborn health. Over 200 million women in the developing world have an unmet need for family planning, leading on an annual basis to 52 million unintended pregnancies, 22 million abortions, 1.4 million infant deaths and 142.000 pregnant-related deaths. The percentage of women with an unmet need are highest in the least developed countries and in Africa[3].

With regard to the goal of halting and beginning to reverse, the spread of

[1] Source: Countdown to 2015;
[2] Sources : WHO; UNICEF.
[3] Source: "Adding it up: the benefits of investing in sexual and reproductive health care" , the Alan Guttmacher Institute and UNFPA. Authors: *Susheela Singh Jacqueline E. Darroch Michael VlassoffJennifer Nadeau*

HIV, the scourge of malaria and other major diseases improved tools, know-how, and significant investments have led to progress. Figures show that the annual number of new HIV infections declined from 3.0 million in 2001 to 2.7 million in 2007 and that the overall number of deaths due to AIDS accounted for 2.0 million people in 2007, compared with an estimated 1.7 million in 2001[4]. Sub-Saharan Africa is the most affected by HIV, accounting for 67% of all people living with HIV and for 75% of AIDS deaths in 2007. Yet in several countries especially in sub-Saharan Africa, the share of HIV infection is increasing for women and children[5]. The number of people receiving anti-retroviral drugs in low and middle-income countries has increased tenfold in only six years, reaching almost 3 million people by the end of 2007. As of December 2007, an estimated 3 million people in low and middle-income countries were receiving anti-retroviral drugs, which represents 31% of those who need the medication and is a 45% increase of the 2006 Global Report[6].

The latest data suggest that the incidence rate of TB has been falling since 2004, although such decline is extremely slow at less than 1% per year. The global cure rate remains high, with 85% of diagnosed cases cured. Overall more than 37 million patients have been treated through DOTS programs since 1995. There are still some 37% of estimated cases of TB not reported or not detected at all. TB control is also aggravated by the HIV epidemic, with an estimated 1.4 million TB/HIV cases and half a million TB/HIV deaths in 2007, the vast majority in Africa. Very concerning, an estimated 500,000 cases of multidrug-resistant TB (MDR-TB) occur every year, with less than 5% detected and treated properly, and extensively drug-resistant TB (XDR-TB) has now been reported from 55 countries world-wide.

Half of the world's population- 3.3 billion people- are still at risk of malaria. There is clear evidence that reduction in morbidity and mortality from malaria has been significant: seven out of 45 countries in Sub-Saharan Africa and additional 22 countries worldwide reduced mortality due to malaria by 50 %, between 2000 and 2007[7]. Of the 247 million estimated cases of malaria in 2006, 86% were in the Africa region and over half of theses cases just in five countries (Nigeria, Democratic Republic of the Congo, Ethiopia, United

[4] Source: UNAIDS
[5] Source UNAIDS
[6] Source UNAIDS 2008 Global Report
[7] Source: WHO World Malaria Report 2008

Republic of Tanzania and Kenya).

While there has been some progress, the epidemics of HIV/AIDS, TB and Malaria are far from over, and will require continued vigilance and commitment.

G8 Accountability Exercise

Progress in Global Health, as above described, is a result of collective action involving manifold actors, and therefore difficult to attribute to any specific input of a subset of countries, such as the G8. However, G8 action can make a tremendous difference, and G8 countries are accountable against the commitments they have taken in the realm of Global Health. In this regard, with the Toyako Declaration, the G8 leaders agreed to establish a follow-up mechanism to monitor progress on meeting the G8 commitments (see paragraph 45 of the Leaders' Declaration) and tasked the G8 Health Experts' Group to develop such a mechanism for mutual accountability.

This year, the G8 Health Experts revised the *Toyako Framework for Action* and produced a new template of matrices with the aim of highlighting collective G8 performance in Global Health against agreed targets (e.g. 60 USD billion). In addition to disease-specific and sector-specific tables which assess progress against G8 commitments (Section C), a new cumulative Table to assess G8 contribution to Global Health was produced (Section A), resulting from the addition of new country tables (Section B), also including G8 contribution to the Polio Eradication Initiative. For purposes of transparency, Country Tables (Section B) are divided into two main sections: Aid to Health reported as ODA to DAC, and other specific inputs to Global Health for Developing Countries.

Moreover, specific tables were added in order to highlight collective and individual progress against achieving quantifiable outputs, namely in the fields of malaria and HIV-AIDS.

Improved Matrices Template

Section A: CUMULATIVE G8 EFFORT

A.1 - Global Health Investment

G8 Commitment:

- We will continue our efforts toward these goals (HIV/AIDS, malaria, TB, and health systems strengthening) to provide at least a projected US$60 billion over the coming years, and invite other donors to contribute as well. (Heiligendamm, 48)

- We reiterate our commitment to continue efforts, to work towards the goals of providing at least a projected US$60 billion over 5 years, to fight infectious diseases and strengthen health systems. (Hokkaido Toyako, 46)

A.1.1 - Aid to Health, reported as ODA to DAC - *sums individual B1.1 Tables*

US$, millions

Commitment	Japan	Canada	France	Germany	Italy	Russia	UK	US	EC
2007	842.20	634.08	1,302.58	741,6	638.71	102.18	1,609.31	6,625	692
2008	698.69	740.15	1,399.12	977,1	623.87	108.54	1,461.10	7,875	849

TOTAL G8	**26,379.23**
TOTAL G8 + EC	**27,920.23**

A.1.2 - Other specific inputs to Global Health - *sums individual B1.2 Tables*

US$, millions

Commitment	Japan	Canada	France	Germany	Italy	Russia	UK	US	EC
2007	16.03			12.5		15.78		7	
2008	18.60		39.8	10		43.78		57	

TOTAL G8	**220.49**
TOTAL G8 + EC	**220.49**

A. 1 - G8 Global Health Investment – TOTAL (*sums A.1.1 with A.1.2)*

US $, millions

Commitment	Japan	Canada	France	Germany	Italy	Russia	UK	US	EC
2007	858.23	634.08	1,302.58	754,1	638.71	117.95	1,609.31	6,632	692
2008	717.29	740.15	1,433.62	987,1	623.87	152.32	1,461.10	7,932	849

TOTAL G8	**26,599.72**
TOTAL G8 + EC	**28,140.72**

A - 2. Cumulative Tables on Specific G8 Commitments

(contributions already included in Table A.1 amounts)

Polio eradication

G8 Commitment:

- To maintain momentum towards the historical achievement of eradicating polio, we will meet our previous commitments to maintain or increase financial contributions to support the Global Polio Eradication Initiative, GPEI and encourage other public and private donors to do the same. (Hokkaido, Development and Africa, 46e)

A 2.1 Table on Polio eradication (from G8 Contributions to the Polio Eradication Initiative)

US$, millions current

Country	2006 contributions	2007 contributions	2008 contributions	2009 contributions
Canada*	42.46	9.07	32.56	13.91
France	12.55			
Italy*	5.85		12.62	2.11**
Germany	13.61	26.20	80.96	98*
Japan	14.09	20.32	21.49	*
Russia	3.0	3.0	9.0	5.0
UK	59.74	57.46	41.30	39.36
US	132.8	132.9	129.7	133
EC	30			
Total G8 Contributions	**1,182.06**			

CANADA * Figures for 2009 reflect spending to date as of June 15 2009. Up to a further $26 million CDN is planned for Canada's 2009- 2010 fiscal year, ending March 31, 2010

ITALY * The Italian contributions to the GPEI are included in the annual voluntary contributions to WHO. Contributions for 2009 are planned in millions euro.
**Italy has planned to commit 1,5 Mio € for the fight against Polio in 2009. Exchange rate: 1,4096 as of 2.7.2009 (OECD DAC exchange rate for 2009 not yet available)

JAPAN * The figure is not available as of 1st July 2009.

GERMANY * In January 2009, the German government pledged 100 Mio. € for the fight against Polio to be allocated in the upcoming five years. Out of the pledged 100 Mio. €, it is expected that 70 Mio. € will be committed in 2009. Exchange rate: 1,40 as of 25.6.2009 (OECD DAC exchange rate for 2009 not yet available)

EC Contribution to Polio eradication in 2008 is made through a specific support to Nigeria in the framework of the cooperation agreement between EC and this country. 20 M€ have been programmed for this activities for the year 2009 to 2010.

Malaria

G8 Commitment:

- As part of fulfilling our past commitments on malaria, we will continue to expand access to long-lasting insecticide treated nets (LLINs), with a view to providing 100 million nets through bilateral and multilateral assistance, in partnership with other stakeholders by the end of 2010. (Hokkaido Toyako, 46d)

A 2.2 - Table on long-lasting insecticide treated nets (LLINs)

Number of LLINs, millions

Country	2008 Multilateral	2008 Bilateral	2009 Multilateral	2009 Bilateral
Canada*	2.24		2.19	0.03
France	17.29*			
Italy	1.62*		2.07**	
Germany	2.0*	1.36**	4.6***.	n.a.
Japan	1.49*	1.38	**	**
Russia	0.51*		0,41**	
UK	2.75*	11.6		
US	6.56	7.28		11.05
EC				
Total G8 Contributions	**76.43**			

CANADA * As reported by fiscal years, i.e. April 1st 2008 to March 31st 2009 for 2008. Figures do not include nets that may be provided through CIDA's emergency assistance programs. 2008 multilateral figure includes data provided by the Global Fund. Estimate used for Global Fund portion of nets in 2009.

FRANCE * Consolidated figures calculated from data provided by Global Fund (3,081,505) and UNITAID (65% of 109 MU$D for LLINs) 1bednet : 5U$.

ITALY * The number of LLINs corresponds to the cumulative numbers of LLINs distributed at the end 2008 minus the cumulative number distributed at end 2007 and it refers to the cumulative Italian financial contributions 2001-2008 of 1,008,260,873 US$. Source: Global Fund
** estimation is based on Italian contribution to GFATM of 130 Mio. $ in 2009

GERMANY *See Italy's footnote; number of bednets in 2007: 1.916.569
** Estimations are based on contributions to special malaria/LLIN projects (Malawi, Ruanda), outputs achieved through larger bilateral programs - where malaria is a sub-component - are not included. Therefore, number of beneficiaries is actually much higher.
*** Estimation is based on German contribution to GFATM of 288 Mio. $ in 2009

JAPAN *The figure was calculated based on the cumulative data given by the Global Fund.
**The figures are not available as of 1st July 2009.

RUSSIA *Number of LLINs was calculated based on data provided by the GFATM and does not include number of LLINs procured through the Russian Federation contribution to the World Bank Malaria Booster Program. Under this program $1,5 mln. were allocated for LLINs in Zambia. **Figures for 2009 are estimated based on funding for GFATM.

UK *The figures for 2008 is for the financial year (April 2008 to March 2009). The multilateral figures are derived from data provided by the Global Fund (880,000) together with an attributed share of UNITAID bednet procurement (9.2% of 20 million nets).

EC is not funding any specific project to procure and/or distribute LLINs to developing countries, and is not aware of any method to count the number of LLINs which have been purchased by/and supplied to developing countries thanks to EC general or sectoral budget support, or to EC contribution to the GFATM.

Section B: G8 GLOBAL HEALTH INVESTMENT COUNTRY TABLES - ITALY

B.1 – Global Health Investment

B.1.1 – Aid to Health, reported as ODA to DAC (commitments[8])

US$, millions

	2007 (final)	2008 (provisional data*)
Aid to Health, General *(also includes technical assistance and sector budget support/basket funds)*[9]	53.80	81.25
Aid to Basic Health *(also includes technical assistance and sector budget support/basket funds)*[10]	37.99	38.30
Aid to Population Policies/Programs and Reproductive Health)[11]	14.52	7.67
Core contributions to International NGOs working in the Health Sector (ICRC and IFRC etc.) [12]		
Core contributions to Public-Private Partnerships working in the Health Sector (e.g. GAIN, IAVI, UNITAID, etc.) [13]	-	-
Core contributions to the multilateral agencies working in the Health Sector[14]		
- Global Fund	355.92	177.96[15]
- WHO (ODA part)	71.43	23.60
- GAVI Alliance	-	-
- UNAIDS	1.64	-
- UNFPA	8.58	2.88

[8] As defined by DAC ": "A firm obligation, expressed in writing and backed by the necessary funds, undertaken by an official donor to provide specified assistance to a recipient country or a multilateral organization".

[9] Identifiable and traceable through the DAC-CRS online database, codes from 12110 to 12191
[10] Identifiable and traceable through the DAC-CRS online database, codes from 12220 to 12281
[11] Identifiable and traceable through the DAC-CRS online database, codes from 13010 to 13081
[12] Identifiable and traceable through the DAC-CRS online database, codes from 21013 to 21055
[13] Identifiable and traceable through the DAC-CRS online database, codes from 30001 to 30100
[14] Identifiable and traceable through the DAC-CRS online database, code 47045
[15] Actually disbursed in 2007 but committed for 2008

Innovative Financing Mechanisms for Health (flows reported as ODA)		
- IFFIm	7.89	35.79
- AMCs	-	51.99
- Other		
*Other multilateral institutions (imputed percentage for health **)*		
- UN System (e.g. UNICEF, UNDP, UNHCR etc.)	11.97	1.67
- World Bank	2.18	56.29
- Regional Development Banks	0.07	17.98
- Other multilateral institutions		
- EC Budget	45.11	53.65
- European Development Fund (EDF)	26.21	71.99
General Budget Support, Bilateral (*imputed percentage for health*)	0.51	0.41
Health-related Debt conversion discount (e.g. Debt2Health)		
Other miscellaneous items	0.89	2.44
TOTAL AID TO HEALTH REPORTED AS ODA	**638.71**	**623.87**
TOTAL ODA commitments **(memo item)**	**4,239.91**	**4,822.22**

* Final data for 2008 will be provided in the second half of 2009 and the updated matrices published on the G8 Presidency website
** A common methodology of multilateral imputation for specific lines (UN System, MDBs, etc.) was identified, with the support of the DAC Secretariat.

B.1.2 – Other specific inputs to Global Health in Developing Countries

US$, millions

	2007	2008
Non-concessional lending and Other Official Flows to Health		
Research in health not reported as ODA		
UNITAID not reported as ODA (additional)		
Multilaterals not included in DAC Annex 2 - (imputed percentage health)		
Health-related Debt conversion (non-ODA part)		
IFFIm frontloading effect		
Other Technical Assistance not reported as ODA		
Other miscellaneous items		
TOTAL OTHER SPECIFIC INPUTS		

B.1.3 Narrative explanation by each G8 member *(max. 2 pages)*

Italy has identified according to its ODA Guidelines and plans 2009-11

(http://www.cooperazioneallosviluppo.esteri.it/pdgcs/italiano/LineeGuida/pdf/Linee_guida_ital.pdf) the following priority sectors: agriculture & food security; environment with a specific attention to water & sanitation; health; education; governance and private sector. Gender equality and empowerment of women should be mainstreamed in all sectors. Of the total budget, a 50% will be allocated to Sub-Saharan Africa and assistance to fragile states and post-conflict situations will benefit of special resource allocation additional to ODA.

Concerning the health sector, Italy will maintain its support to ongoing programmes related to the fight against major pandemics such as HIV/AIDS; Malaria; Tuberculosis; Polio and Neglected Tropical Disease and, possibly, will expand its investments on health system strengthening; health manpower development and maternal, newborn and child health.

Italy is investing on innovative financial mechanisms such as IFFIm and AMC that can increase service provisions through their frontloading effects. Italy has committed € 473,800,000 to IFFIm over 20 years and US$ 635 million to the Advanced Market Commitment (AMC), which has been launched on 12 June 2009.

The IFFim leverage has not been included in the template and accounts for $115.08 US millions in 2007 and $8.10 US millions in 2008.

Due to the disbursement to the GFATM of funds pledged for previous years, the total health investment in 2008 seems declining compared to 2007, while in real term there is an increase of around 10% compared to the previous year.

The Italian ODA strongly rely on the involvement and collaboration with civil society; NGOs; faith-based organization; Italian local Administrations.

In the search of better aid effectiveness and in line with donors harmonization agenda, Italy is committed and engaged in increasing the proportion of ODA allocations towards sector and general budget support.

Italian main contributions for disease control are made through the Global Fund. Concerning bilateral ODA, most of the funds are addressed to the health system strengthening at local/district or national level. Specific allocation for maternal, newborn and child health and manpower development and utilization are not easily traceable because part of wider initiatives. There is also a real difficulty in translating the allocations made with CRS codes into the table

Section C: DISEASE OR SECTOR-SPECIFIC COUNTRY TABLES - ITALY

Malaria

I. G8 Commitments:

- 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. (Heilingendamm, Africa Declaration, 55)

- As part of fulfilling our past commitments on malaria, we will continue to expand access to long-lasting insecticide treated nets, with a view to providing 100 million nets through bilateral and multilateral assistance, in partnership with other stakeholders by the end of 2010. (Hokkaido Toyako, 46d)

II. Inputs (*US $, millions*)

	2007	2008	2009
Bilateral (Project and Budget Support)	0.46	1.05	
Global Initiatives GF: 25%	88.98	44.49	
Multilateral (WB, UN, etc.)			
Research			

Footnotes and narrative to be provided by each G8 member (as needed)

The Global Fund funding reflects the malaria portion of the Italian Government contribution to the Global Fund, based on the 25 percent share of its cumulative total portfolio that the Global Fund reports that it commits to malaria. (Source 2008 GFATM Progress Report, p.30)
Italy contributes to the fight against malaria mainly through the GFATM but also through bilateral health projects and programs. In most cases these programs are not solely focused on malaria and are therefore not reported to DAC as malaria measures.

Tuberculosis

I. G8 Commitment:

- One-third of the world's population is exposed to the risk of contracting TB, which claims about two million lives each year. In certain regions, it affects more people today than it did twenty years ago. We reaffirm the commitment we made at the Genoa Summit in 2001 to halt the spread of this disease. We will also support the Global Plan to Stop TB, 2006-2015, which aims to cut TB deaths in half by the year 2015 compared to 1990 levels, saving some 14 million lives over ten years, and call upon all donors and stakeholders to contribute to its effective implementation. (St. Petersburg, Fight Against Infectious Disease, 21).

- We note with concern the rate of HIV/AIDS and tuberculosis co-infection and seek to promote unified coordination for activities in this regard. (St. Petersburg, Fight Against Infectious Disease, 22).

II. Inputs from G8 (to be completed by each G8 member)

	2006	2007	2008	2009 -
Bilateral (Project and Budget Support)		5.94	3.62	
Global Initiatives GF: 14 %		53.39	26.69	
Multilateral (WB, UN, etc.)				
Research				

Footnotes and narrative to be provided by each G8 member (as needed):

The Global Fund funding reflects the tuberculosis portion of the Italian Government contribution to the Global Fund, based on the 14 percent share of its cumulative total portfolio that the Global Fund reports that it commits to tuberculosis. (Source 2008 GFATM Progress Report, p.30)

Italy contributes to the fight against TB mainly through the GFATM but also through bilateral health projects and programs. These programs are not solely focused on TB and are therefore not reported to DAC as TB measures. The majority of bilateral TB projects and programs are part of wider programs such as HIV/AIDS programs, Primary Health Care programs, etc.

HIV/AIDS

I. G8 Commitment:

- As an important step to scaling up towards the goal of universal access to HIV/AIDS prevention, treatment, care and support in Africa, G8 members, in support of national HIV/AIDS programs globally, individually and collectively over the next few years will aim to employ existing and additional programs to support life-saving anti-retroviral treatment through bilateral and multilateral efforts for approximately five million people, to prevent twenty-four million new infections, and to care for twenty-four million people including ten million orphans and vulnerable children. (Heilingendamm, Africa Declaration, 58)

- The G8 will take concrete steps to work toward improving the link between HIV/AIDS activities and sexual and reproductive health and voluntary family planning programs, to improve access to health care, including preventing mother-to-child transmission, and to achieve the Millennium Development Goals by adopting a multisectoral approach and by fostering community involvement and participation. (Heilingendamm, Africa Declaration, 53)

II. Inputs from G8 (to be completed by each G8 member)

	2007	2008	2009 -
Bilateral (Project and Budget Support)	15.53	23.32	
Global Initiatives GF: 60%	213.55	106.78	
Multilateral (WB, UN, etc.)			
Research			

Footnotes and narrative to be provided by each G8 member (as needed):

The Global Fund funding reflects the HIV/AIDS portion of the Italian Government contribution to the Global Fund, based on the 60 percent share of its cumulative total portfolio that the Global Fund reports that it commits to HIV/AIDS. (Source 2008 GFATM Progress Report, p.30)

Italy contributes to universal access to HIV/AIDS prevention, treatment, care and support mainly through the GFATM but also through bilateral health projects and programs. These programs are mainly focused on Sub Saharan Africa and based on a comprehensive approach.

III. Outputs from G8 (to be completed by each G8 member)

G8 Country	**2008**	**2009**
Number of adults and children with advanced HIV infection receiving antiretroviral therapy	157,883*	
Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission	22,650*	

*According to the Italian contribution to the GFATM (as submitted by GFATM in June '09).

Health Systems Strengthening

I. G8 Commitment:

- We will ensure our actions to strengthen health systems at national and local level and across all sectors since this is vital for long-term improvements in overall health, as we will encourage donors to help build health capacity (Gleaneagles, 18/c)

- We emphasize the importance of comprehensive approaches to address the strengthening of health systems including social protection, the improvement of maternal, newborn and child health, the scaling up of programs to counter infectious diseases and access to essential medicines, vaccines and appropriate health-related products. […] We underline the need for partner countries to work toward sustainable and equitable financing of health systems (Hokkaido Toyako, 46)

(US $, millions)

	2007	2008	2009 -
Bilateral (Project and Budget Support)	98.74	101.15	

Narrative to be provided by each G8 member (as needed):

The Italian bilateral contribution to health systems focuses on the support of activities in the field of: human resources for health , capacity development, infrastructure, organization and structure of health systems and access to essential medicines.
Italy also supports health system strengthening through its contributions to multilateral organizations such as WHO, Global Fund to Fight AIDS, TB and Malaria, World Bank, UNICEF, UNAIDS, UNFPA .
Italy's Directorate General of Development Cooperation has recently supported the WHO led initiative on Maximizing Positive Synergies between Health Systems and Global Health Initiatives, whose research findings have been presented at the High Level Dialogue on Positive Synergies between health systems and global health initiatives, held in Venice on 22-23 June 2009.
Italy is also member of the International Health Partnership+ which aims at accelerating progress to the health related MDGs through better coordination and harmonization among the different partners with a view to strengthen country-owned health plans and strategies.

Health Workforce

I. G8 Commitment:

- The G8 members will work towards increasing health workforce coverage towards the WHO threshold of 2.3 health workers per 1000 people, initially in partnership with the African countries where we are currently engaged and that are experiencing a critical shortage of health workers. (Hokkaido Toyako, 46b)

II Inputs from G8 (to be completed by each G8 member)

	2007	2008 -	2009
Bilateral (Project and Budget Support)	7.57	19.54	

Footnotes and narrative to be provided by each G8 member (as needed):

Measures to support the increasing of the health workforce coverage are critical elements of strong health systems. The Italian bilateral contributions to promoting health workforce has increased over the last years, focusing particularly on medical education and training and health personnel development.

Maternal, Newborn and Child Health

I. G8 Commitment:

- We will scale up efforts to reduce the gaps, in the area of maternal and child health care and voluntary family planning, an estimated US$ 1,5 billion (Heiligendamm, 50)

Narrative to be provided by each G8 member

Italian contributions to maternal and child health are included in the contributions to health systems strengthening. Specific emphasis is put on the need to maintain and improve health infrastructure and the local health workforce.
The Italian Parliament has recently adopted a parliamentary resolution to save the lives of mothers and children in the countries with highest burden, by increasing Italian official development assistance (ODA) for maternal, newborn and child health. The resolution commits the Italian Government's support to reproductive health and maternal, newborn and child health as a priority for international cooperation, promoting exchange and training of health professionals.

Neglected Tropical Diseases

I. G8 Commitment:

- We must also increase our efforts in the fight against other preventable diseases, including pneumonia, diarrhea and neglected diseases such as Leishmaniasis, Chagas disease and Onchocerciasis, particularly by increasing the volume and quality of medical research on neglected diseases in developing countries. (St. Petersburg, Fight Against Infectious Disease, 31).

- To build on our commitments made on neglected tropical diseases at St Petersburg, we will work to support the control or elimination of diseases listed by the WHO through such measures as research, diagnostics and treatment, prevention, awareness-raising and enhancing access to safe water and sanitation. In this regard, by expanding health system coverage, alleviating poverty and social exclusion as well as promoting adequate integrated public health approaches, including through the mass administration of drugs, we will be able to reach at least 75% of the people affected by certain major neglected tropical diseases in the most affected countries in Africa, Asia, and Latin America, bearing in mind the WHO Plan. (Hokkaido, Development and Africa, 46f)

II. Inputs from G8 (to be completed by each G8 member)

	2006	2007	2008	2009
Bilateral (Project and Budget Support)				
Global Initiatives				
Multilateral (WB, UN, etc.)				
Research				

Footnotes and narrative to be provided by each G8 member (as needed):

Italian contributions to combat neglected tropical diseases are included in the contributions to health systems strengthening.

Section B: G8 GLOBAL HEALTH INVESTMENT COUNTRY TABLES -CANADA

B.1 – Global Health Investment

B.1.1 – Aid to Health, reported as ODA (FY Disbursements) [1] [8]

	Figures in $US millions	
	2007/2008 (final)	2008/2009 (preliminary) [7]
Bilateral [10]		
Aid to Health, General (also includes technical assistance and sector budget support/basket funds) [2]	37.15	50.47
Aid to Basic Health (also includes technical assistance and sector budget support/basket funds)[3]	123.80	160.16
Aid to Population Policies/Programs and Reproductive Health)[4]	62.11	50.58
Multilateral - Initiative Specific [11]	196.05	186.17
Core contributions to NGOs working in the Health Sector (e.g. MSF, HAI, IPPF etc.) [5]	6.27	6.45
Core contributions to Public-Private Partnerships working in the Health Sector (e.g. GAIN, IAVI, UNITAID, etc.)	9.82	14.90
Core contributions to the multilateral agencies working in the Health Sector		
- Global Fund	40.03	108.99
- WHO (ODA part 76%) [6]	10.34	10.51
- GAVI Alliance	0.00	0.00
- UNAIDS	0.00	5.02
- Other agencies working in the Health Sector [9]	35.90	21.68
Innovative Financing Mechanisms for Health (flows reported as ODA)		
- IFFIm		
- AMCs	0.00	0.00
- Other		
*Other multilateral institutions (imputed percentage for health **)*		
- UN System (e.g. UNICEF, UNDP, UNFPA, UNHCR etc.)	27.80	16.71
- World Bank [13]		
- Regional Development Banks and IFIs	20.19	24.36
- Other multilateral institutions	4.20	4.75
- EC Budget ***		
- European Development Fund (EDF) ***		
General Budget Support, Bilateral (*imputed percentage for health*****)		
Health-related Debt conversion discount (e.g. Debt2Health)		
Other miscellaneous items [12]	60.43	79.40
TOTAL AID TO HEALTH	**634.08**	**740.15**

[1] Figures are based on actual expenditures.
[2] Includes DAC CRS purpose codes from 12110 to 12191
[3] Includes DAC-CRS purpose codes from 12220 to 12281
[4] Includes DAC-CRS purpose codes from 13010 to 13081
[5] Includes ICCIDD, ICASO, IPPF, IHAA.
[6] Canada's assessed contribution to WHO is provided by the Department of Foreign Affairs. This is the only

amount from a government department other than the Canadian International Development Agency (CIDA) that is included in this matrix.
[7] 2008-2009 figures are preliminary. Final figures may differ following further quality assurance.
[8] Figures above include international assistance from the Canadian International Development Agency. Other Canadian Government Departments that provide international assistance are not included.
[9] Includes the Micronutrient Initiative.
[10] Includes amounts through CIDA's Geographic and Partnership Programs.
[11] Includes amounts through CIDA's Sectors and Global Partnership Branch, which respond to global initiatives such as the Global TB Drug Facility, or the Catalytic Initiative or funding a multilateral organization to provide micronutrients in a specific country or region.
[12] Includes bilateral amounts for DAC CRS purpose codes 14020, 14030, 14081, 16050, 16064, 52010, all of which CIDA counts as Improving Health.
[13] Canada's assessed contribution to IDA is provided by the Department of Finance, which is not included in this matrix.
** A common methodology of multilateral imputation for specific lines (UN System, MDBs, etc.) was identified, with the support of the DAC Secretariat.

B.1.2 – Other specific inputs to Global Health in Developing Countries

	2007	2008
Non-concessional lending and Other Official Flows to Health		
Research in health not reported as ODA		
UNITAID not reported as ODA (additional)		
Multilaterals not included in DAC Annex 2 - (imputed percentage health)		
Health-related Debt conversion (non-ODA part)		
IFFIm frontloading effect *[to be defined by IFFIm donors]*		
Other Technical Assistance not reported as ODA		
Other miscellaneous items		

B.1.3 Narrative explanation by each G8 member *(max. 2 pages)*

Canadian development efforts in the health sector are focused in four main areas: reducing child mortality (MDG4), improving maternal health (MDG5), combating infectious diseases, including HIV/AIDS (MDG6) and strengthening health systems. CIDA spends an average of 23% of all development assistance in the health sector, and spent approximately $785M on health, including water and sanitation and non-emergency food aid, in 2008-2009.

Major areas of investments include**:**

Health programming through our bilateral partnerships: Canada optimizes its bilateral, or country-to-country, delivery channel through an effective use of health sector-wide approaches (SWAps). Canada is actively engaged in the health sector in several of its twenty countries of focus, including Afghanistan, Bangladesh, Mali, Mozambique and Tanzania.

Regional initiatives: Canada's Africa Health Systems Initiative (AHSI), announced by Prime Minister Stephen Harper at the 2006 G8 Summit, is a 10 year (CAD $450 million) commitment to support African-led efforts to strengthen health systems and achieve concrete progress toward the Millennium Development Goals (MDGs) in Africa from 2006 through 2016.

A major component of the Africa Health Systems Initiative (AHSI) is the Catalytic Initiative to Save a Million Lives, a multi donor initiative launched by Canada's Prime Minister in 2007. Canada has contributed CAD $105 million over five years to the Initiative – co-funded and implemented by UNICEF, with funding focused on providing support to country health systems and scaling up the delivery of cost-effective, proven health services in order to accelerate progress towards MDG 4 & 5. This includes a particular focus on training community health workers and providing necessary logistical support and supplies to enable the delivery of basic health services.

Multilateral initiatives:
In the 2008 Budget the Government of Canada committed CAD $450 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria for the period from 2008 to 2010, bringing Canada's total commitment to $978.4M since the Fund's inception.

Canada is a leader in child immunization. We have provided approximately CAD $145 million through the Canadian International Immunization Initiative (CIII), which supports partners such as UNICEF, the World Health Organization and the Canadian Public Health Association; CAD $188 million to the GAVI Alliance for new and under-used vaccines, and a commitment of US $200 million for the Advance Market Commitment (AMC) for pneumococcal vaccines, to address the largest vaccine-preventable killer of children.

Canada has been a long-time supporter of the Global Polio Eradication Initiative and has disbursed more than CAD $282 million for polio eradication.

Section C: DISEASE OR SECTOR-SPECIFIC COUNTRY TABLES - CANADA

Malaria

III. G8 Commitments:

- 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. (Heiligendamm, Africa Declaration, 55)

- As part of fulfilling our past commitments on malaria, we will continue to expand access to long-lasting insecticide treated nets, with a view to providing 100 million nets through bilateral and multilateral assistance, in partnership with other stakeholders by the end of 2010. (Toyako, 46d)

IV. Inputs [16]

	Figures in $US millions		
	2007-2008	2008-2009 (preliminary)	2009-2010
Bilateral (Project and Budget Support)	0.19	0.75	
Global Initiatives	0.00	0.00	
Global Fund (25%):	10.01	27.25	
Other:	0.00	0.00	
Multilateral	13.40	37.32	
Research	0.00	0.00	
Total	**23.60**	**65.32**	

Canada

Canada remains committed to supporting prevention and treatment initiatives for malaria control primarily directed towards children and pregnant women, who are most vulnerable to the disease.

Canada works with a range of organizations in efforts to tackle this major killer of children in the developing world. Current programs support regional and multilateral initiatives to advance global malaria prevention and control efforts. In addition, CIDA is supporting broader health system programs that contribute to prevention and treatment of malaria. Since its inception, Canada has committed CAD $978.4 million to the Global Fund to Fight AIDS, TB and Malaria. Approximately 25% of Global Fund resources support malaria programming worldwide.

[16] All quoted Canadian figures (except for Polio) represent fiscal year amounts as opposed to calendar year amounts, and are based on disbursements and not commitments.

Canada has supported bednet distributions programs throughout Africa and was an early lead donor country in the provision of free-insecticide treated bednets.

Canada's catalytic role in the distribution of bednets has prompted exploration of new niche areas for cost-effective programs to further malaria control efforts, such as scaling up access to artemisinin-based combination therapies (ACTs) by the poor. To substantially decrease child death due to malaria, treatment needs to be available for the poor at the community level, where most child deaths occur. In the future, Canada will strive to play a major role in providing sick children with ACTs in their home communities.

Canada is providing CAD$60 million from 2008-2009 to 2010-2011 to increase access to treatment at the community level for malaria and pneumonia, two of the leading killers of children worldwide. It is conservatively estimated these programs will save over 135,000 lives.

Results achieved include:

- Since 2003, CIDA, through the Canadian Red Cross, World Vision, and UNICEF, has provided funding for the delivery of over 7.9 million insecticide-treated nets free-of-charge to pregnant women and children under 5 in Africa. Using conservative estimates, these nets will save over 121,000 lives.

- In 2008, through the Integrated Health Systems Strengthening component of the Catalytic Initiative, CIDA funding through UNICEF helped to supply 25,000 new doses of ACTs to treat malaria in Ghana.

- With support from Canada and other donors, the Global Fund to Fight AIDS, TB and Malaria had distributed 70 million insecticide-treated nets by December 2008.

Tuberculosis

I. G8 Commitment:

- One-third of the world's population is exposed to the risk of contracting TB, which claims about two million lives each year. In certain regions, it affects more people today than it did twenty years ago. We reaffirm the commitment we made at the Genoa Summit in 2001 to halt the spread of this disease. We will also support the Global Plan to Stop TB, 2006-2015, which aims to cut TB deaths in half by the year 2015 compared to 1990 levels, saving some 14 million lives over ten years, and call upon all donors and stakeholders to contribute to its effective implementation. (St. Petersburg, Fight Against Infectious Disease, 21).

- We note with concern the rate of HIV/AIDS and tuberculosis co-infection and seek to promote unified coordination for activities in this regard. (St. Petersburg, Fight Against Infectious Disease, 22).

II. Inputs from G8 (to be completed by each G8 member) [17]

	Figures in $US millions		
	2007-2008	2008-2009 (preliminary)	2009-2010
Bilateral (Project and Budget Support)	1.91	2.08	
Global Initiatives	0.00	0.00	
Global Fund (14%):	5.60	15.26	
Global TB Drug Facility:	11.17	7.25	
Multilateral (WB, UN, etc.)	1.01	18.97	
Research			
Total	**19.69**	**43.56**	

Footnotes and narrative to be provided by each G8 member (as needed):

Canada is a significant donor for tuberculosis control, focussing its efforts where they can have the highest impact – high-burden countries, people with limited access to services, and on interventions that have proven the most cost-effective.

[17] All quoted Canadian figures (except for Polio) represent fiscal year amounts as opposed to calendar year amounts, and are based on disbursements and not commitments.

Canada has contributed over CAD $360 million to TB control programs since 2000 with an average annual disbursement of approximately CAD $40 million.

The largest recipient is the Global TB Drug Facility of the Stop TB Partnership, with over CAD $110 million contributed to date. Canada was the founding donor to the Global TB Drug Facility and remains a strong supporter. In its first 6 years of operations, the Facility provided treatment to over 10 million TB sufferers, enabling greater expansion of TB control.

In addition, in Budget 2008, Canada pledged an additional CAD $450M over three years to the Global Fund to Fight Aids, Tuberculosis and Malaria, bringing Canada's total commitment to CAD $978.4M, of which approximately 14% have gone to TB control (as an average of Rounds 1 to 7).

The Government of Canada recently announced an additional CAD $127.4M towards innovative new TB control programs. The main component of the new funding is the TB Reach Facility, which is to be managed by the Stop Tuberculosis Partnership. The program will address urgent needs, gaps and bottlenecks in TB control through support to local initiatives in collaboration with National TB Control Programs. This program will provide opportunities for Stop Tuberculosis partners to implement new and innovative, or tried-and-tested solutions to improve and expand tuberculosis diagnosis, care, treatment and support in areas that are currently under-serviced.

Results achieved include:

- Since 2000, Canada has contributed to expanded access to TB treatment resulting in an additional 4 million TB sufferers being successfully treated, which is estimated to have averted over 500,000 deaths.

- Since the inception of the Stop TB Partnership, of which Canada was the founding chair, globally the number of people who received the WHO-approved "DOTS" treatment regimen has more than doubled.

- Canada is the founding donor of the Global TB Drug Facility (GDF), which provides drugs for over 10 million TB sufferers in over 60 countries.

- As of December 2008, programs supported through the Global Fund to Fight AIDS, Tuberculosis and Malaria provided DOTS treatment to 4.6 million people, representing an increase of 39% over mid-2007.

HIV/AIDS

I. G8 Commitment:

- As an important step to scaling up towards the goal of universal access to HIV/AIDS prevention, treatment, care and support in Africa, G8 members, in support of national HIV/AIDS programs globally, individually and collectively over the next few years will aim to employ existing and additional programs to support life-saving anti-retroviral treatment through bilateral and multilateral efforts for approximately five million people, to prevent twenty-four million new infections, and to care for twenty-four million people including ten million orphans and vulnerable children. (Heiligendamm, Africa Declaration, 58)

- The G8 will take concrete steps to work toward improving the link between HIV/AIDS activities and sexual and reproductive health and voluntary family planning programs, to improve access to health care, including preventing mother-to-child transmission, and to achieve the Millennium Development Goals by adopting a multisectoral approach and by fostering community involvement and participation. (Heiligendamm, Africa Declaration, 53)

II. Inputs from G8 (to be completed by each G8 member) [18]

	Figures in $US millions		
	2007-2008	2008-2009 (preliminary)	2009-2010
Bilateral (Project and Budget Support)	39.05	35.55	
Global Initiatives			
Global Fund (61%):	24.42	66.49	
Other:	0.80	7.87	
Multilateral (WB, UN, etc.)	41.94	21.67	
Research			
Total	**106.21**	**131.58**	

Footnotes and narrative to be provided by each G8 member (as needed):

Current Canadian programming takes a comprehensive and long term approach to HIV/AIDS that recognizes the importance of promoting and protecting human rights, with a particular emphasis on four key areas:

- advancing effective evidence-based HIV prevention, including linking HIV/AIDS with education and the development of new preventive technologies;
- promoting gender equality and women's empowerment to address the feminization of the

[18] All quoted Canadian figures (except for Polio) represent fiscal year amounts as opposed to calendar year amounts, and are based on disbursements and not commitments.

epidemic;

- strengthening health systems in developing countries to ensure equitable access to essential care, treatment and support for all those who need it; and
- promoting the rights and children and protecting and supporting those children infected and affected by HIV/AIDS.

The Canadian International Development Agency has provided over CAD $500 million over 2005-2006 to 2007-2008 to global efforts to tackle the HIV/AIDS epidemic. In addition, during the same period, Canadian contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria that were allocated to HIV/AIDS [19] totalled CAD $179 million.

At the XVII International AIDS Conference 2008 in Mexico, the Government of Canada announced CAD $45 million in new HIV/AIDS funding towards programs responding to HIV/AIDS in Africa. This funding includes support to civil society organisations, governments, regional organisations and the UN system to build capacity, implement programming and ensure harmonization of efforts to reduce HIV/AIDS incidence.

Results achieved include:

- Since 2002, Canadian support to the Southern African AIDS Trust (SAT) has helped SAT partners reach approximately 1.7 million children affected by HIV and AIDS. Moreover, more than 200,000 men and women received HIV/AIDS counseling and more than 180,000 people living with HIV/AIDS received home-based care.

- Canada has contributed significantly to Tanzania's National Voluntary Testing Campaign, which, as of June 2008, had provided testing and counseling for HIV/AIDS to over 4.8 million people (over 2.6 million were women and girls).

- Due in part to Canada's support to Tanzania's National Multisectoral Strategic Framework on HIV/AIDS, the percentage of sexually active women aged 15-49 who have used condoms during sex with non-regular partners has increased by 131% from 1999 to 2007 (amongst men the increase was 63%).

- Through Canada's funding to the Canada-South Africa Nurses HIV/AIDS Initiative, the Canadian Nurses Association, in partnership with the Democratic Nurses Organization of South Africa, has strengthened the capacity of South African nurses to address the enormous impact of HIV on South Africa's (SA) health system. Key results include:
    - 7,000 nurses increased the quality of care they provide, through access to hospital-based HIV information and support groups.
    - 700 nurses increased their HIV leadership skills through training and orientation to the SA National Strategic HIV Plan, the need to de-stigmatize HIV in the health sector and increased their understanding of the links between HIV and gender.

[19] Prorated at 61% as per the average allocation over Rounds 1 to 7.

- Through collaborative efforts to support the plans of the Mozambican Ministry of Health, Canada has helped strengthen local health systems and improve and increase access to health care services. As of January 2008, the number of:

    - HIV-positive people receiving antiretroviral treatment had risen by 454%, increasing to 88,211 from 15,900 in 2005; and 24,320 pregnant women are now receiving treatment to prevent mother-to-child transmission, compared to 8,244 in 2005;
    - health units providing preventative treatment for mother-to-child transmission of HIV had increased by 302%, rising to 386 from 96 in 2005; and
    - health units equipped to provide antiretroviral treatment had risen by 559%, increasing to 211 from 32 in 2005.

- Multilateral
    - Through its leading support to the World Health Organization's "3 by 5" initiative and subsequent Universal Access Plan, Canada has helped to facilitate the treatment of 3 million people with life-prolonging antiretroviral drugs as of 2007.
    - In addition, CIDA's support for the WHO's Universal Access Plan contributed to an increase in access of antiretroviral therapy for the prevention of mother to child transmission of HIV. The number of pregnant women living with HIV accessing this treatment in low and middle income countries rose from 23% in 2006 to 33% in 2007.

Prevention of Mother to Child Transmission:

Canada has been supporting efforts seeking to decrease the transmission of the virus from a mother to her child. The latest component of Canada's CAD $150 million support to the WHO's 3 by 5 Initiative and the Universal Access Plan places particular emphasis on the prevention of mother-to-child transmission of the virus in regions/areas with high HIV prevalence.

Canada also supports specific prevention of mother-to-child transmission programs through its bilateral programs. In Zimbabwe, the Canadian International Development Agency is supporting the ZVITAMBO Prevention of Mother-to-Child Transmission project in three key districts. As of September 2008, the results of the project included: 694 district nurses and other health workers were trained in comprehensive preventative HIV care; 85% of at-risk babies born in health centres received precautionary treatment in two of the districts; 2607 community leaders were informed about the importance of HIV prevention; and 44 health centres were upgraded to provide comprehensive preventative care to communities.

Research:

Canada works with partners to support the development of new HIV prevention tools. CIDA has provided CAD $30M in support to the International Partnership for Microbicides (IPM) and CAD $82M to the International AIDS Vaccine Alliance (IAVI) to facilitate the development of safe, effective and accessible HIV prevention technologies. Through support from CIDA, close to 30 clinical trials of preventative HIV vaccines and several microbicide trials have been initiated globally.

Canada is committed to coordinating its efforts for HIV/AIDS research with the global community, while recognizing the strong contribution Canadian researchers can make in this field. On February

20, 2007, Prime Minister Stephen Harper announced the creation of the Canadian HIV Vaccine Initiative (CHVI), a collaborative effort between the Government of Canada and the Bill & Melinda Gates Foundation to contribute to global efforts to develop a safe, effective, affordable and globally accessible HIV vaccine. Canada has committed up to CAD $111 million to the CHVI. In addition, Canada is supporting clinical trial capacity building in Africa by funding partnerships between Canadian and African researchers through the Global Health Research Initiative.

IV. Outputs from G8 (to be completed by each G8 member)

G8 Country	**2008**	**2009**
Number of adults and children with advanced HIV infection receiving antiretroviral therapy	25 347	
Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission	12 976	

Canada's funding helps partners to provide a broad range of support that enable the scale up of PMTCT, ART and other services. It is therefore difficult to attribute comprehensive numbers against Canadian funds. The figures in this table have been provided by the GFATM to the Italian Presidency in June 2009 and do not include results attributable to Canadian bilateral investments. 2009 figures were not available at that time.

Health Systems Strengthening

II. G8 Commitment:

- We will ensure our actions to strengthen health systems at national and local level and across all sectors since this is vital for long-term improvements in overall health, as we will encourage donors to help build health capacity (Gleneagles, 18/c)

- We emphasize the importance of comprehensive approaches to address the strengthening of health systems including social protection, the improvement of maternal, newborn and child health, the scaling up of programs to counter infectious diseases and access to essential medicines, vaccines and appropriate health-related products. […] We underline the need for partner countries to work toward sustainable and equitable financing of health systems (Toyako, 46)

Narrative to be provided by each G8 member (as needed):

Health systems strengthening is an important component of Canada's health programming. Through its bilateral programs, Canada supports a variety of health systems initiatives and programs on health sector reform and health systems strengthening in a number of developing partner countries in Latin America, Asia and Africa. Canada works with its partners to strengthen health systems in a responsive manner, so that efforts are geared to the expressed needs of these countries, adopting whenever possible a programs based approach and systems-wide approach.

In addition, there are a range of Canadian and international initiatives in which Canada is engaged to respond to health systems needs:

- In September 2007, Canada joined other countries in launching the International Health Partnership (IHP) which is working to improve co-ordination between international agencies, donors and developing countries to develop, implement, monitor and evaluate national heath plans in order to improve health services and strengthen health outcomes. Canada has signed the Mozambique and the Mali Country Compacts.

- Similarly, Canada supported the Action Plan that emerged from the First Global Forum on Health Human Resources, hosted by the Global Health Workforce Alliance in Kampala, Uganda (2-7 March, 2008) which identifies key actions for addressing the health human resource crisis in Africa.

- Canada's African Health Systems Initiative (AHSI), announced by Prime Minister Stephen Harper at the 2006 G8 Summit, is a 10 year (CAD $450 million) commitment to support African-led efforts to strengthen health systems and mobilize additional African health workers to expand the reach of basic health services to the most vulnerable. Under the AHSI,

Canada is supporting programming and partnerships with regional health organisations, countries, civil society and international partners to strengthen national-level health strategies and architecture, ensure appropriate human resources for health, strengthen front-line equitable health services delivery and build stronger health information management systems.

- A major component of AHSI is the Catalytic Initiative to Save a Million Lives, launched by Prime Minister Stephen Harper in 2007. This initiative in partnership with UNICEF, the Doris Duke Foundation, Norway, the Bill and Melinda Gates Foundation, USAID, and the Australian Government's Overseas Aid Program (AusAid), aims to reinforce country health system capacity to scale-up essential, proven, and affordable health services for women and children in order to achieve tangible improvements in their health. Canada's CAD $105 million support to this Initiative focuses on improving the cadre of community-based health workers trained to prevent and treat basic childhood and maternal illnesses. This also includes ensuring adequate supervision, incentives, and the basic equipment and supplies required to deliver health services to those who need them most.

- Similarly under AHSI, CIDA is working with African countries such as Mozambique, Mali, Zambia and Tanzania to support the implementation of their national health sector strategic plans that address critical national and cross-boundary health.

Canada also supports a wide range of international and Canadian NGOs, professional associations, universities and other civil society organizations engagement in health systems strengthening in developing countries.

Health Workforce[20]

I. G8 Commitment:

- The G8 members will work towards increasing health workforce coverage towards the WHO threshold of 2.3 health workers per 1000 people, initially in partnership with the African countries where we are currently engaged and that are experiencing a critical shortage of health workers. (Toyako, 46b)

II Inputs from G8 (to be completed by each G8 member)

	Figures in $US millions [1]		
	2007-2008	2008-2009 (preliminary)	2009-2010
Bilateral (Project and Budget Support)	15.20	21.11	
Global Initiatives	16.24	8.01	
Multilateral (WB, UN, etc.)	5.67	3.60	
Research			
Total	**37.11**	**32.71**	

Footnotes and narrative to be provided by each G8 member (as needed):

[1] Includes DAC CRS purpose code 12181, 12281, 13081

Canada is working with national ministries of health and other key partners to address the critical shortage of human resources for health, particularly in Africa.

Human resources for health has been identified as an important priority area within Canada's CAD $450 million ten year Africa Health Systems Initiative (2006-2016). For example, the Canada-led Catalytic Initiative to Save a Million Lives will train over 40,000 health workers and provide treatment for malaria, measles and malnutrition, which are expected to save 200,000 lives in Africa.

In order to help solve the health human resource crisis, Canada is providing CAD $5 million between 2006 and 2011 to WHO to support the activities of the Global Health Workforce Alliance (GHWA). Canada was until recently a board member of the Global Health Workforce Alliance.

Canada supports human resources for health development in Africa through a variety of mechanisms. In Mali, Mozambique, Tanzania and Zambia, Canada is contributing to the development and implementation of health sector and human resources for health strategic plans through program-

[20] Includes DAC CRS purpose code 12181, 12281, 13081

based support. In Zambia, for example, Canada, through the AHSI, is supporting the government in its implementation of its national Human Resources Strategy ($14.5M, 2009-2013), a fundamental and enabling component of its National Health Strategic Plan.

Canada also supports a number of human resources for health projects and programs at country level to strengthen the capacity of national Ministries of health, training institutions and health facilities involved in the recruitment, training, deployment and retention of front-line health workers.

Results achieved include:

In Honduras, the goal of the Community Health (REDES) project is to improve the health of vulnerable populations in communities in two of the most impoverished departments of Honduras—Santa Barbara and Copán—by improving maternal and child health, and expanding health service coverage. The project has already:

- Trained 210 community health volunteers—of which more than half are women—to monitor the growth and development of nearly 1,000 children. The volunteers participated in the national vaccination campaign where nearly 5,000 children were vaccinated.
- Trained 26 traditional birth attendants to identify signs of danger during pregnancy and childbirth to reduce maternal deaths during deliveries—which are often at home in remote rural areas.

Since 2006, Canada has helped to improve the knowledge and skills of medical and paramedical staff at the district level in Iraq on issues relating to primary health care programs, including maternal and child health.

- For instance, Canada funded 14 maternal and child health training courses in the Kirkuk governorate, which benefited 403 health staff (106 medical doctors and 297 health workers). In the Kurdistan Region, infant and young child feeding courses were also provided to 60 pediatricians and other physicians, 200 nurses/health workers and 120 community volunteers.
- Additionally, a series of workshops were also held in Baghdad and Basra where 180 participants acquired important infant and young child feeding skills.

In Zambia, Canadian support to the "Moyo wa Bana" Project helped improve the health of children under five years old, particularly in relation to the prevention of malaria, diarrhea and respiratory infections. Throughout the course of the project over 4,500 community health workers and traditional healers were trained in an integrated approach to preventing and managing the most common and deadly childhood illnesses.

By improving the skills and knowledge of caretakers in areas such as disease prevention and increasing access to health services through mobile health stations, Canada is helping to save the lives of children. Thanks to funding between 2001 and 2007, 275,000 urban children and 40,000 rural children received improved health care by utilizing a community-based approach. From 2002 to 2006:

- Diarrhea cases decreased from 41% to 25.6%;
- Malaria cases decreased from 46.8% to 29.5%; and

- Pneumonia cases decreased from 12% to 1.1%.

Maternal, Newborn and Child Health

I. G8 Commitment:

- We will scale up efforts to reduce the gaps, in the area of maternal and child health care and voluntary family planning, an estimated US $1.5 billion (Heiligendamm, 50)

Narrative to be provided by each G8 member

Canada and its partners have a strong and consistent history of support for programs designed to make real, measurable progress in improving the health of children and mothers in developing countries.

Canada supports a comprehensive approach to maternal, newborn and child health, including training of health workers, the provision of accessible sexual and reproductive health care and services, the prevention of mother-to-child transmission of HIV, support for exclusive breastfeeding, and the integrated management of pregnancy and childbirth. With a focus on strengthening health systems to support the delivery of proven services at the community level, Canada has also supported important work in the areas of immunization, micronutrient supplementation, HIV/AIDS, pneumonia and diarrheal treatment and malaria control.

Since 1998, Canada has been a significant donor for immunization programs, including CAD $145 million through the Canadian International Immunization Initiative (CIII) which supports partners such as UNICEF and the WHO; nearly CAD $282 million to the Global Polio Eradication Initiative; and CAD $188 million to GAVI for new and under-used vaccines. In addition, Canada has committed US $200 million for the Advance Market Commitment (AMC) for pneumococcal vaccines, addressing the largest vaccine-preventable killer of children.

Through the Micronutrient Initiative, Canada supports the iodization of salt due to its beneficial effects on fetal development. According to UNICEF, since 1992 over 7 million children have been born free of mental impairment due to salt iodization, largely because of the Canadian contribution. Canada also funds iron supplements to reduce maternal anemia, which in turn lowers the number of women dying in childbirth.

Canada is the world's leading provider of vitamin A for developing countries. UNICEF estimates that over 2 million deaths have been averted through vitamin A supplementation programs since 1998. Canada's contribution of vitamin A supplements has ensured a steady supply of vitamin A, allowing countries to plan for their delivery. This has dramatically increased global coverage with vitamin A supplementation.

Canada provided nearly CAD $15M in core funding to UNFPA in 2009, along with a CAD $2.5M commitment to the Reproductive Health Commodity Security Trust Fund.

In Haiti, Canada is providing CAD $8.2 million to UNFPA and UNICEF for the Support for the Fight Against Maternal Mortality project, which includes key components relating to technical assistance, family planning policies, emergency obstetrical care and support to distribution systems for medication.

Through the 10-year, CAD $450 million Africa Health Systems Initiative (AHSI, 2006-2016), Canada is working to improve equitable access to health services for all by supporting the implementation of national health sector strategic plans in Mali, Mozambique, Tanzania and Zambia. Under the Catalytic Initiative to Save a Million Lives, a component of the AHSI, Canada's contribution will train over 40,000 health workers and provide much-needed treatment for diseases such as malaria, measles and malnutrition, which is expected to save 200,000 lives in Africa.

Results achieved include:

- Canadian support to the UNICEF Immunization Program in Nigeria strengthened routine immunization in eight northern Nigerian states. Building on government-led polio eradication activities, this project supported vaccine planning, procurement, security and distribution, including improvements to the cold-chain system to ensure that vaccines are potent and effective. Community dialogue activities resulted in increased ownership and participation in polio campaigns by communities and opinion leaders, evidenced by a 50% reduction in never-reached (zero-dose) children in northern states since 2005.

- Since 2003, Canada has helped to strengthen reproductive health programs in the Kayes region of western Mali. As a result, the proportion of deliveries attended by skilled personnel rose from 24% in 2002 to 50% in 2007.

- Canada has been supporting programs aimed at improving the health of mothers and children in Bangladesh for well over thirty years. During that time indicators of child health have improved

significantly, moving Bangladesh from amongst the worst performing countries in its region to now being in the leading half. Through the procurement of nearly two million vials of polio vaccine, one million vials of tetanus vaccines, 35 million de-worming tablets and over 40 million types of different contraceptives, Canada's Bangladesh Health Commodities project has played an important role in improving some key indicators of maternal and child health. Canada has also provided funding to the International Centre for Diarrhoeal Disease Research in Bangladesh since 1978. This organization was instrumental in the development of the oral rehydration solution, which over the last two decades has saved the lives of 40 million children with diarrhea, and continues to save 3 million lives each year around the world. The centre's two hospitals and field clinic treat approximately 100,000 diarrhea/cholera patients annually, of whom 15 to 20% would likely die without treatment.

- A Canadian contribution of $125 million over five years to the World Food Programme is procuring, delivering, and distributing food products to school children in Africa, including Mali where the impact of school feeding programs is significant. In 2008, the program in Mali provided an estimated 120,000 children in 721 schools. Programs that offer nutritious meals in African schools can truly make a difference to the health and well-being of children, and can also provide an incentive to families to send their children to school. The World Food Programme is reporting that the number of children attending classes increased by 30 percent after the creation of canteens.

- CIDA's support to the Accelerated Child Survival and Development program led to a 20% reduction in child mortality in areas in which the full package of interventions was implemented. Canada is building upon the success of this approach through the recent commitment to scale-up child and maternal health interventions as part of the Catalytic Initiative to Save a Million Lives. The Catalytic Initiative is already producing results. In Mozambique, Canada's funding ensured the distribution of 400,000 long-lasting insecticide-treated bed nets to pregnant women and children in 2008 alone. In Ghana, Canada's funding will, among others things, facilitate much-needed education programs on exclusive breastfeeding to improve the health of newborns.

- Working with the International Rescue Committee and their local partners in Rwanda, Sierra Leone and Sudan, Canada has helped save over 5,000 lives. Since 2005, over 211,000 children under 5 years of age have been treated in their communities for pneumonia, diarrhea or malaria—three common causes of child mortality in developing countries. Through this CIDA-funded program, the International Rescue Committee has also worked with the respective governments to improve health care systems by ensuring the proper registration and supervision of patients.

Neglected Tropical Diseases

III. G8 Commitment:

- We must also increase our efforts in the fight against other preventable diseases, including pneumonia, diarrhea and neglected diseases such as Leishmaniasis, Chagas disease and Onchocerciasis, particularly by increasing the volume and quality of medical research on neglected diseases in developing countries. (St. Petersburg, Fight Against Infectious Disease, 31).

- To build on our commitments made on neglected tropical diseases at St Petersburg, we will work to support the control or elimination of diseases listed by the WHO through such measures as research, diagnostics and treatment, prevention, awareness-raising and enhancing access to safe water and sanitation. In this regard, by expanding health system coverage, alleviating poverty and social exclusion as well as promoting adequate integrated public health approaches, including through the mass administration of drugs, we will be able to reach at least 75% of the people affected by certain major neglected tropical diseases in the most affected countries in Africa, Asia, and Latin America, bearing in mind the WHO Plan. (Toyako, Development and Africa, 46f)

IV. Inputs from G8 (to be completed by each G8 member) [21] [22]

Canada
Figures are in CAD$.

	2006 (2006-07)	2007 (2007-08)	2008 (2008-09)	2009 (2009-10)[23]
Bilateral (Project and Budget Support)	1,288,375	1,615,172	697,817	
Global Initiatives **Guinea Worm Eradication Program (Carter Centre)**	1,000,000	999,451	1,000,000	

[21] This is an estimate as no sector coding exists to track Canada's spending on neglected tropical diseases. Figures were identified based on records pulled manually from the Canadian International Development Agency information system and may be an underestimation of actual spending.

[22] All quoted Canadian figures (except for Polio) represent fiscal year amounts as opposed to calendar year amounts; and based on disbursements and not commitments. Fiscal Year 2008-09 = CY 2008.

[23] Data to be compiled at end of fiscal year (March 2010).

Multilateral (WB, UN, etc.)				
African program for Onchocerciasis control (WB)	2,000,000		3,000,000	
PAHO prevention and control of priority Communicable diseases in South America	948,600	3,600,000	825,792	
Research **TDR**	1,400,000			

Footnotes and narrative to be provided by each G8 member (as needed):

While Canada recognizes the importance of tackling neglected tropical diseases and congratulates others for their efforts and engagement, these are not currently a top priority for Canada's health and development programming.

Canada has nonetheless traditionally supported some research in tropical diseases through WHO's special Programme for Research and Training in Tropical Diseases (approximately CAD $35 million since 1982) as well as some bilateral country programs.

Examples of Canada's programming towards neglected tropical diseases include:

Support to the Pan American Health Organization's Prevention and Control of Priority Communicable Diseases (CAD $7.3 million over 3 years) which addresses communicable diseases that cause the greatest burden of morbidity and mortality among children, youth and adults in South America, including Chagas disease.

In Africa, Canada has supported efforts to control river blindness since 1974. Canada recently renewed its support to the African Program for Onchocerciasis Control (CAD $15.5 million, 2008-2015) which develops and supports effective community-based programs to treat onchocerciasis in twenty countries where river blindness is endemic.

Canada has supported Guinea Worm Eradication efforts in Africa since 1994, including through the Guinea Worm Eradication Program with a recent CAD $6 million 6-year contribution to the Carter Center.

Bilaterally, Canada has supported the Government of Bolivia in developing its capacity to respond to Chagas disease and helped the Government of Honduras prepare a national plan to prevent and control Chagas disease, through a contribution of CAD $1.75M, the provision of insecticides and motor vehicles, and technical services such as information management, human resources training

and institution building.

The Canadian Global Health Research Initiative (GHRI) has funded projects in Brazil, Paraguay and Guatemala examining the impact of community involvement in tackling Chagas.

In addition, Canada supports projects in water supply and sanitation that have totaled approximately CAD $337 million between 2003-2004 and 2007-2008.

Section B: G8 GLOBAL HEALTH INVESTMENT COUNTRY TABLES – FRANCE

B.1 – Global Health Investment

B.1.1 – Aid to Health, reported as ODA to DAC (committments[24])

US$, millions

	2007 (final)	2008 (provisional data*)
Aid to Health, General *(also includes technical assistance and sector budget support/basket funds)*[25]	139	*
Aid to Basic Health *(also includes technical assistance and sector budget support/basket funds)*[26]		12,78
Aid to Population Policies/Programs and Reproductive Health)[27]	12	*
Core contributions to International NGOs working in the Health Sector (e.g. MSF, HAI, IPPF etc.) [28]	34,51	42,70
Core contributions to Public-Private Partnerships working in the Health Sector (e.g. GAIN, IAVI, UNITAID, etc.) [29]	219,02	230,78
Core contributions to the multilateral agencies working in the Health Sector[30]		
- Global Fund	410,67	432,71
- WHO (ODA part)	32,32	33,14
- GAVI Alliance		
- UNAIDS	2,94	3,17
- Other agencies working in the Health Sector	2,73	2,88
Innovative Financing Mechanisms for Health (flows reported as ODA)		
- IFFIm	26,28	57,37
- AMCs		
- Other		
*Other multilateral institutions (imputed percentage for health **)*		
- UN System (e.g. UNICEF, UNDP, UNFPA, UNHCR etc.)	16,42	14,04
- World Bank	57,79	55,86
- Regional Development Banks	10,86	12,96

[24] As defined by DAC ": "A firm obligation, expressed in writing and backed by the necessary funds, undertaken by an official donor to provide specified assistance to a recipient country or a multilateral organisation".].

[25] Identifiable and traceable through the DAC-CRS online database, codes from 12110 to 12191
[26] Identifiable and traceable through the DAC-CRS online database, codes from 12220 to 12281
[27] Identifiable and traceable through the DAC-CRS online database, codes from 13010 to 13081
[28] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)
[29] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)
[30] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)

- Other multilateral institutions		
- EC Budget		
- European Development Fund (EDF)	158,75	155,69
General Budget Support, Bilateral (*imputed percentage for health****)	181,71	187,99
Health-related Debt conversion discount (e.g. Debt2Health)	67,14	96,62
Other miscellaneous items		
TOTAL AID TO HEALTH REPORTED AS ODA		
TOTAL ODA (memo item)		

* Final data for 2008 will be provided in the second half of 2009 and the updated matrices published on the G8 Presidency website
** A common methodology of multilateral imputation for specific lines (UN System, MDBs, etc.) was identified, with the support of the DAC Secretariat.
*** A common methodology of bilateral and multilateral imputation for General Budget Support and other flows not included in DAC CRS was identified (health expenditure ratios by recipient countries)

B.1.2 – Other specific inputs to Global Health in Developing Countries

US$, millions

	2007	2008
Non-concessional lending and Other Official Flows to Health		
Research in health not reported as ODA		
UNITAID not reported as ODA (additional)		
Multilaterals not included in DAC Annex 2 - (imputed percentage health)		
Health-related Debt conversion (non-ODA part)		
IFFIm frontloading effect *[to be defined by IFFIm donors]*		
Other Technical Assistance not reported as ODA		
Other miscellaneous items		39,8

B.1.3 Narrative explanation by each G8 member *(max. 2 pages)*

Areas of intervention of French ODA for health as well as French priorities
-French ODA in the health sector has increased by four times since 2001, reaching in 2008 a total amount of **970 million euros**.
In 2008, 74% of the commitments in the health ODA are channeled through the multilateral sector : Global fund, GAVI IFFIM, UNITAID, WHO, UNAIDS and others.
Innovative funding mechanisms constitute an important part of these commitments : GAVI and UNITAID in particular.

With regards to the priorities of the health ODA, the fight against communicable diseases (MDG 6) represents the dominant sector from 2002 to 2008 with almost 75% of the commitments. Within MDG 6, 60% of the financing is dedicated to the fight against AIDS. Other sectors are epidemiological surveillance (support to the enforcement of the International health Regulations through the WHO Bureau de Lyon in particular) and the fight against neglected tropical diseases.
Another important priority is MDG 4, to which France contributes through GAVI's IFFIM.
France also places a strong focus on the strengthening of health systems, which are essential for achieving all the health MDGs, as well as on MDG 5 and target 17 of MDG8.

64% of French health contribution is dedicated to Africa.

The French strategy aims to significantly increase its interventions: i) in the field of the integrated management of childhood illness, including immunizations; ii) improving access to reproductive health care and services, iii) promotion and implementation of social health coverage iv) continuing our efforts towards the fight against AIDS and communicable diseases through the Global Fund and by strengthening research (vaccine against AIDS, malaria but also neglected diseases). To ensure that these interventions are fully effective and to consolidate long-term results, it is essential to contribute to the overall strengthening of health systems, notably by investing in human resources, infrastructure, management and financing.

Section C: DISEASE OR SECTOR-SPECIFIC COUNTRY TABLES- FRANCE

Malaria

V. G8 Commitments:

- 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. (Heilingendamm, Africa Declaration, 55)

- As part of fulfilling our past commitments on malaria, we will continue to expand access to long-lasting insecticide treated nets, with a view to providing 100 million nets through bilateral and multilateral assistance, in partnership with other stakeholders by the end of 2010. (Hokkaido Toyako, 46d)

VI. Inputs

	2007	2008	2009 -
Bilateral (Project and Budget Support)		1,44	
Global Initiatives **GF:** **Other : UNITAID**	138,20	146,47 70,0*	
Multilateral (WB, UN, etc.)		0,4	
Research	20,10	22,70	

Footnotes and narrative to be provided by each G8 member (as needed)

France participates in the fight against malaria through its contributions to the Global Fund, UNITAID and Roll Back Malaria.
It constitutes a priority for France among the various communicable diseases. Much progress has been achieved regarding this MDG, in Africa in particular, therefore we consider that maintaining the efforts is crucial in order to eradicate it.
*(65% of 109 US $ million) program of LLIN distribution through UNITAID's program started in 2008 (UNICEF and Roll-Back Malaria).

Tuberculosis

I. G8 Commitment:

- One-third of the world's population is exposed to the risk of contracting TB, which claims about two million lives each year. In certain regions, it affects more people today than it did twenty years ago. We reaffirm the commitment we made at the Genoa Summit in 2001 to halt the spread of this disease. We will also support the Global Plan to Stop TB, 2006-2015, which aims to cut TB deaths in half by the year 2015 compared to 1990 levels, saving some 14 million lives over ten years, and call upon all donors and stakeholders to contribute to its effective implementation. (St. Petersburg, Fight Against Infectious Disease, 21).

- We note with concern the rate of HIV/AIDS and tuberculosis co-infection and seek to promote unified coordination for activities in this regard. (St. Petersburg, Fight Against Infectious Disease, 22).

II. Inputs from G8 (to be completed by each G8 member)

	2006	2007	2008	2009 -
Bilateral (Project and Budget Support)		4,10	1,51	
Global Initiatives GF: Other:	56,68	125,22	132,28	
Multilateral (WB, UN, etc.)				
Research		21,68	25,27	

Footnotes and narrative to be provided by each G8 member (as needed):

HIV/AIDS

I. G8 Commitment:

- As an important step to scaling up towards the goal of universal access to HIV/AIDS prevention, treatment, care and support in Africa, G8 members, in support of national HIV/AIDS programs globally, individually and collectively over the next few years will aim to employ existing and additional programs to support life-saving anti-retroviral treatment through bilateral and multilateral efforts for approximately five million people, to prevent twenty-four million new infections, and to care for twenty-four million people including ten million orphans and vulnerable children. (Heilingendamm, Africa Declaration, 58)

- The G8 will take concrete steps to work toward improving the link between HIV/AIDS activities and sexual and reproductive health and voluntary family planning programs, to improve access to health care, including preventing mother-to-child transmission, and to achieve the Millennium Development Goals by adopting a multisectoral approach and by fostering community involvement and participation. (Heilingendamm, Africa Declaration, 53)

II. Inputs from G8 (to be completed by each G8 member)

	2007	2008	2009 -
Bilateral (Project and Budget Support)	26,69	22,42	
Global Initiatives GF: Other:	434,94	455,96	
Multilateral (WB, UN, etc.)			
Research	35,81	42,92	

Footnotes and narrative to be provided by each G8 member (as needed) :

Within MDG 6, 60% of France's financing is dedicated to the fight against HIV/AIDS.

France maintains an important contribution in this field, as we support the principle of universal access to treatment and prevention.

France participates in the fight against HIV/AIDS, not only through its contribution to the Global Fund, UNITAID, UNAIDS and WHO, but also through an important advocacy role in all international forta against discrimination and for prevention policies, particularly with vulnerable groups such as women, sexual minorities, migrants and drug users.

V. Outputs from G8 (to be completed by each G8 member)

G8 Country	**2008**	**2009**
Number of adults and children with advanced HIV infection receiving antiretroviral therapy	255,073	
Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission	38,000	

Estimation from figures provided by GFTAM. Numbers of treatments provided by UNITAID are not included here.

Health Systems Strengthening

III. G8 Commitment:

- We will ensure our actions to strengthen health systems at national and local level and across all sectors since this is vital for long-term improvements in overall health, as we will encourage donors to help build health capacity (Gleaneagles, 18/c)

- We emphasize the importance of comprehensive approaches to address the strengthening of health systems including social protection, the improvement of maternal, newborn and child health, the scaling up of programs to counter infectious diseases and access to essential medicines, vaccines and appropriate health-related products. […] We underline the need for partner countries to work toward sustainable and equitable financing of health systems (Hokkaido Toyako, 46)

Narrative to be provided by each G8 member (as needed):

France is convinced that it will not be possible to reach the MDGs without having viable and strong health systems. Therefore, the strengthening of health systems is one of France's priorities and represents a large part of our non targeted contributions (13%). This action involves two main areas: health human resources and promoting and establishing social health protection programs.

During the French presidency of European Union, France strongly committed to the promotion by the EU towards financing of health systems (social health protection and health workforce) to improve access to health care. France obtained the adoption of recommendations in the Conclusions of the Council of Europe urging Member States to take into account these priorities. Thus the Council underlined the need for the EU to establish a framework for concerted action to cover sickness and financing of health systems in developing countries.

At a multilateral scale, while ensuring the promotion of long-term financing of health care coverage, France actively participates to P4H (Providing for Health) and is engaging over **4 MU$D** to support this initiative and in addition to an expert technical assistance. France has also organized two international conferences in 2007 and 2008 in Paris which have contributed to build the momentum on social health protection worldwide.

In all the bilateral projects engaged through AFD (French Development Agency) this approach is systematically taken into account.

The following countries are concerned : Afghanistan, Burkina-Faso, Cambodia, Cameroon, Chad, Congo, DRC, Gabon, Haiti, Mauritania, Morocco, Mozambique, Senegal and Uganda.

GIP ESTHER is the major French operator in the field of technical support in the fight against HIV / AIDS in line with the multilateral engagement of France. The assessment of the work of ESTHER, in 2008, allowed the partners' countries to establish a solid foundation for the comprehensive care of patients, strengthening of health services and providing support to community-based associations ; in 18 countries (15 in Africa and 3 in Asia). These partnerships have involved 52 French hospitals, 60 hospital teams, on 167 different sites and contributed to the care of about 80 000 people.

Health Workforce

I. G8 Commitment:

- The G8 members will work towards increasing health workforce coverage towards the WHO threshold of 2.3 health workers per 1000 people, initially in partnership with the African countries where we are currently engaged and that are experiencing a critical shortage of health workers. (Hokkaido Toyako, 46b)

II Inputs from G8 (to be completed by each G8 member)

	2008	2009 -
Bilateral (Project and Budget Support)	122,60	
Global Initiatives	0,72	
Multilateral (WB, UN, etc.)		
Research		

Footnotes and narrative to be provided by each G8 member (as needed) :

Health work-force is also another crucial component of the strengthening of health systems. Regarding this issue, France advocates for planning policies not only in developing countries, but also in industrialized ones, in order to limit the brain drain in the poor countries which experience a health workers crisis.
France is an active partner of the Global Workforce Alliance and contributes with over 0,7 M US$ and has participated to the elaboration of the Kampala declaration.
Furthermore, France completely supports and collaborates to the elaboration by WHO of a code of practice for the recruitment of health personnel. Through the secondment of an expert, France also supports a program aiming at encouraging the staying of health personnel in rural areas in Africa.

In order to help increase health workforce, France ensures hosting and training of students from developing countries. The vast majority of these students return to their home countries.

Bilateral cooperation through ESTHER is currently twinning French University hospitals with hospitals from 18 developing countries This support consists in training medical actors, paramedical and voluntary partners to forge real bonds of cooperation and solidarity around the patient.

Maternal, Newborn and Child Health

I. G8 Commitment:

- We will scale up efforts to reduce the gaps, in the area of maternal and child health care and voluntary family planning, an estimated US$ 1,5 billion (Heiligendamm, 50)

Narrative to be provided by each G8 member

France is committed to continue and further promote an active participation in actions aiming to achieve the G8 goals with regard to family planning, maternal, newborn and child health, linking HIV/AIDS, SRHR (Sexual and Reproductive Health and Rights) and gender equality and the promotion of a gender sensitive approach.

Mother-to-child transmission is the major source of child HIV infections, and its prevention (PMTCT) is therefore essential. PMTCT is a capital issue of the prevention strategies for most countries. Through the French Agency for AIDS research (ANRS), over 350 women are currently followed in this program, and more than 100 children are being treated by ARV subsequently.

With regard to MDG 4, France actively participates in the fight to reduce infant mortality and has chosen to invest in immunization programs through its contribution to GAVI/IFFIm (1.3 billion euros over 20 years)
France's contribution to UNITAID (65%) has allowed the development of antiretroviral formulations for children and access to over 9.000 treatments.

With regard to MDG5, France has invested 80 M euros in this sector from 2003 to 2008. This contribution includes financing programs of multilateral organizations, such as UNFPA, WHO and UNICEF, mainly in the African region. France also provides technical assistance to these countries (in Niamey, Dakar, Addis-Ababa for instance) in order to assist them in designing and implementing their policies to fight maternal mortality.

Neglected Tropical Diseases

V. G8 Commitment:

- We must also increase our efforts in the fight against other preventable diseases, including pneumonia, diarrhea and neglected diseases such as Leishmaniasis, Chagas disease and Onchocerciasis, particularly by increasing the volume and quality of medical research on neglected diseases in developing countries. (St. Petersburg, Fight Against Infectious Disease, 31).

- To build on our commitments made on neglected tropical diseases at St Petersburg, we will work to support the control or elimination of diseases listed by the WHO through such measures as research, diagnostics and treatment, prevention, awareness-raising and enhancing access to safe water and sanitation. In this regard, by expanding health system coverage, alleviating poverty and social exclusion as well as promoting adequate integrated public health approaches, including through the mass administration of drugs, we will be able to reach at least 75% of the people affected by certain major neglected tropical diseases in the most affected countries in Africa, Asia, and Latin America, bearing in mind the WHO Plan. (Hokkaido, Development and Africa, 46f)

VI. Inputs from G8 (to be completed by each G8 member)

	2006	2007	2008	2009
Bilateral (Project and Budget Support)		8,21		
Global Initiatives			6,83	
Multilateral (WB, UN, etc.)				
Research	7,53	4,92	13,67	

Footnotes and narrative to be provided by each G8 member (as needed):

France's contribution is mainly channeled through WHO's programs, and consists in providing medicines to the countries in need, as well as technical expertise in this field.

France is funding a research project on drugs for neglected tropical diseases, through the initiative DNDI (Drug for Neglected Diseases Initiative) since 2007 with an engagement of over **8 million U$**. The diseases targeted by this project are trypanosomiasis and visceral leishmaniasis.

Concerning schistosomiasis, AFD is financing a project to support the *Office Régional de Mise en Valeur du fleuve Senega*l (OMVS), based in Dakar, covering Senegal, Mauritania, Guinea and Mali. As part of

this support, the AFD is funding a health component of **4,3 million U$** for the prevention and the fight against schistosomiasis. This component was launched in early 2008 for a duration of 4 years.

Section B: G8 GLOBAL HEALTH INVESTMENT COUNTRY TABLES-US

B.1 – Global Health Investment		
	2007	2008
	(final)	(provisional data*)
Aid to Health, General (also includes technical assistance and sector budget support/basket funds)[2]	34	77
Aid to Basic Health (also includes technical assistance and sector budget support/basket funds)[3]	1032	1001
Aid to Population Policies/Programs and Reproductive Health)[4]	4478	5607
Core contributions to International NGOs working in the Health Sector		
(e.g. MSF, HAI, IPPF etc.) [5]		
Core contributions to Public-Private Partnerships		
working in the Health Sector (e.g. GAIN, IAVI, UNITAID, etc.) [6]		
Core contributions to the multilateral agencies working in the Health Sector[7]		
- Global Fund	642	789
- WHO (ODA part)	71	71
- GAVI Alliance	69	72
- UNAIDS	36	30
- Other agencies working in the Health Sector		
Innovative Financing Mechanisms for Health (flows reported as ODA)		
- IFFIm		
- AMCs		
- Other		
*Other multilateral institutions (imputed percentage for health **)*		
- UN System (UNICEF, UNDP)	38	39
- World Bank – IDA	102	79
- Regional Development Banks (AfDF and ADB-SF)	11	12
- Other multilateral institutions (PAHO)	56	58
- EC Budget ***		
- European Development Fund (EDF) ***		
General Budget Support, Bilateral (*imputed percentage for health****)		
Health-related Debt conversion discount (e.g. Debt2Health)		

Other miscellaneous items	112	98
TOTAL AID TO HEALTH REPORTED AS ODA	6625	7875
TOTAL ODA (memo item)		

[1] As defined by DAC ": "A firm obligation, expressed in writing and backed by the necessary funds, undertaken by an official donor to provide specified assistance to a recipient country or a multilateral organization".].
[2] Identifiable and traceable through the DAC-CRS online database, codes from 12110 to 12191
[3] Identifiable and traceable through the DAC-CRS online database, codes from 12220 to 12281
[4] Identifiable and traceable through the DAC-CRS online database, codes from 13010 to 13081
[5] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)
[6] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)
[7] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)

* Final data for 2008 will be provided in the second half of 2009 and the updated matrices published on the G8 Presidency website
** A common methodology of multilateral imputation for specific lines (UN System, MDBs, etc.) was identified, with the support of the DAC Secretariat.
*** A common methodology of bilateral and multilateral imputation for General Budget Support and other flows not included in DAC CRS was identified (health expenditure ratios by recipient countries)

B.1.2 – Other specific inputs to Global Health in Developing Countries

US$, millions

	2007	2008
Non-concessional lending and Other Official Flows to Health	0	29
Research in health not reported as ODA		
UNITAID not reported as ODA (additional)		
Multilaterals not included in DAC Annex 2 - (imputed percentage health)		
Health-related Debt conversion (non-ODA part)		
IFFIm frontloading effect *[to be defined by IFFIm donors]*		
Other Technical Assistance not reported as ODA	7	28
Other miscellaneous items		

B.1.3 Narrative explanation by each G8 member *(max. 2 pages)*

President Obama believes that it is in keeping with America's values and our history of compassion to lead an effort to solve some of the most serious problems facing the world's poorest people. Already, American leadership, sparked in large part by President George W. Bush and a bipartisan majority in Congress, has helped to save millions of lives from HIV/AIDS, malaria, and tuberculosis. Yet, even with that monumental progress, 26,000 children around the world die every day from extreme poverty and preventable diseases.

In response, the President's 2010 Budget begins to focus attention on broader global health challenges, including child and maternal health, family planning, and neglected tropical diseases, with cost effective intervention. It also provides robust funding for HIV/AIDS. The initiative adopts a more integrated approach to fighting diseases, improving health, and strengthening health systems.

The U.S. global health investment is an important component of the national security "smart power" strategy, where the power of America's development tools -- especially proven, cost-effective health care initiatives -- can build the capacity of government institutions and reduce the risk of conflict before it gathers strength. In addition, the Administration's funding plan can leverage support from other nations and multilateral partners so that the world can come closer to achieving the health Millennium Development Goals. Discussions are underway with the G-8 partners on fulfilling all of the commitments. This comprehensive global health approach can yield significant returns by investing in efforts to:

- Prevent millions of new HIV infections;
- Reduce mortality of mothers and children under five, saving millions of lives;
- Avert millions of unintended pregnancies; and
- Eliminate some neglected tropical diseases.

To reach these goals, the Budget invests $63 billion cumulatively over six years (2009-2014) for global health programs. PEPFAR (the President's Emergency Plan for AIDS Relief) will constitute more than 70 percent of global health funding.

Moving forward, the Obama Administration will work with key stakeholders to deliver new congressionally mandated strategic plans for HIV/AIDS, tuberculosis, and malaria. These plans will be coordinated as part of the comprehensive global health strategy to identify specific initiatives, quantitative goals, and appropriate funding levels beginning in 2011.

Section C: DISEASE OR SECTOR-SPECIFIC COUNTRY TABLES - US

Malaria

VII. G8 Commitments:

- 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. (Heilingendamm, Africa Declaration, 55)

- As part of fulfilling our past commitments on malaria, we will continue to expand access to long-lasting insecticide treated nets, with a view to providing 100 million nets through bilateral and multilateral assistance, in partnership with other stakeholders by the end of 2010. (Hokkaido Toyako, 46d)

VIII. Inputs

	2007	2008[31]	2009
Bilateral[32] (Project and Budget Support)	233 m (PMI +non-PMI)	337 m (PMI+ non-PMI)	382 m (PMI + non-PMI)
Global Initiatives GF:[33] Other:	GF: 181 m	GF: 210 m	GF: 225 m
Multilateral[34] (WB, UN, etc.)	9,4 m	7,25 m	TBD
Research	142 m	177 m	179 m

Footnotes and narrative to be provided by each G8 member (as needed)

The U.S. Government supports the global fight against malaria through various programs.

To combat malaria in the most highly endemic countries in Africa, President Bush in 2005 established the President's Malaria Initiative (PMI), a five-year $1.2 billion initiative with the goal of reducing

[31] 2008 figures reflect actual obligations, and therefore differ slightly from the 2008 projections reported last year ($337 million versus $344 million projected).
[32] Includes bilateral funding channeled through USAID as well as some non-research funding channeled through the Centers for Disease Control and Prevention with in the U.S. Department of Health and Human Services.
[33] The Global Fund funding reflects the malaria portion of the U.S Government contribution to the Global Fund, based on the 25 percent share of its cumulative total portfolio that the Global Fund reports that it commits to malaria.
[34] Funding indicated is direct contributions to WHO for malaria. The U.S. Government also provides at total of $400 million to UNICEF, WHO, and the World Bank each year as part of its annual contribution, a proportion of which is used for malaria.

malaria-related deaths by 50 percent in 15 focus countries.[35] This Initiative has worked to expand coverage of four proven and highly effective malaria prevention and treatment measures to 85% of the most vulnerable populations – children under five years of age and pregnant women. This package of high-impact interventions includes insecticide-treated mosquito nets, indoor residual spraying with insecticides, intermittent preventive treatment for pregnant women, and artemisinin-based combination therapy. In its third year of operation, PMI reached millions of people with anti-malarial prevention and treatment measures. More than 7 million mosquito nets were procured and distributed. Indoor residual spraying covered 6 million houses and approximately 24 million residents. Nearly 16 million treatments with highly effective combination drugs were procured. In 2009, the U.S. Government doubled its support to malaria control efforts in Nigeria, Democratic Republic of Congo and South Sudan to about $32 million. Outside Africa, the U.S. Government supports malaria initiatives in the Amazon Basin of South America and the Mekong Region of Southeast Asia to strengthen national capacities and to help reduce the threat of anti-malarial drug resistance. We also support basic, programmatic, and operational research to develop new tools and approaches to fight malaria, including the development of candidate malaria vaccines and new malaria drugs. Finally, the U.S. Government supports malaria control through its annual contributions to the Global Fund and the Roll Back Malaria Partnership.

With the 2008 Lantos-Hyde Act and President Obama's commitments through the Global Health Initiative, funding for malaria will increase significantly between 2009 and 2014 and we would expect to expand our efforts in Nigeria and DRC, the two most highly malaria endemic countries in Africa, which together account for nearly 50% of the malaria cases on the continent, as well as into additional countries in Africa. In addition, the U.S. Government provides more than $180 million annually in funding for basic and applied research related to malaria, including development of candidate malaria vaccines and new antimalarial drugs, through the National Institutes of Health, Centers for Disease Control and Prevention, and Department of Defense.

[35] Angola, Benin, Ethiopia (Oromiya Region), Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Rwanda, Senegal, Tanzania, Uganda, and Zambia.

Tuberculosis

I. G8 Commitment:

- One-third of the world's population is exposed to the risk of contracting TB, which claims about two million lives each year. In certain regions, it affects more people today than it did twenty years ago. We reaffirm the commitment we made at the Genoa Summit in 2001 to halt the spread of this disease. We will also support the Global Plan to Stop TB, 2006-2015, which aims to cut TB deaths in half by the year 2015 compared to 1990 levels, saving some 14 million lives over ten years, and call upon all donors and stakeholders to contribute to its effective implementation. (St. Petersburg, Fight Against Infectious Disease, 21).

- We note with concern the rate of HIV/AIDS and tuberculosis co-infection and seek to promote unified coordination for activities in this regard. (St. Petersburg, Fight Against Infectious Disease, 22).

II. Inputs from G8 (to be completed by each G8 member -- this is last year's matrix with an additional column for 2009)

	2006	2007	2008[36]	2009 -
Bilateral[37] (Project and Budget Support)	75,5 m	72,4 m	139 m	168,6 m
Global Initiatives GF:[38] Other:	GF: 93 m	GF: 123 m	GF: 143 m	GF: 153 m
Multilateral[39] (WB, UN, etc.)	14,4 m (WHO)	14,4 m (WHO)	14,4 m (WHO)	TBD
Research	155 million	197,6 million	153,6 million	154,6 million

Footnotes and narrative to be provided by each G8 member (as needed):

In TB, the U.S. Government supports bilateral TB programs including TB/HIV co-infection efforts, works extensively with and through multi-lateral partners, particularly WHO, and supports early and late stage research. The U.S. Government also contributes to the Global Fund to Fight AIDS, TB and

[36] 2008 figures reflect actual obligations, and therefore differ slightly from the 2008 projections reported last year ($138 Bilateral plus $14.4 m multilateral ($152.4 m total) versus $152.1 m bilateral and multilateral projected).
[37] Does not include funding for TB/HIV provided through PEPFAR. TB/HIV funding is included in the HIV/AIDS matrix.
[38] Global Fund calculations reflected an average of 14% Global Fund grants for TB.
[39] Multilateral funding reflects direct contributions to WHO for specific activities. It does not include the general contributions made by the USG to the WHO and the World Bank, a portion of which supports TB.

Malaria and provides extensive technical support to countries in developing Global Fund programs and in implementing grants. U.S. Government agencies are active members of the Stop TB Partnership. USAID is the lead U.S. Government agency for international TB efforts, including bilateral support and work with multilateral partners. Under PEPFAR, the USG also supports extensive TB/HIV activities, as part of care and support for HIV/AIDS patients. The USG supports the international goal to reduce by 2015 fifty percent of the TB prevalence and deaths, and through USAID, focuses particularly on 20 high priority countries, supplemented by targeted activities in about 20 other countries. These efforts are focused on countries with: the highest number of cases and prevalence of TB, high HIV/TB co-infection rates, prevalence or potential for drug resistance (multi-drug resistant (MDR) or extensively drug resistant (XDR) TB), and lagging case detection and/or treatment success rates. USG goals and objectives are consistent with the targets and goals set by the international Stop TB Partnership's *Global Plan to Stop TB, 2006-2016*. At country level, USAID assistance supports implementation of national TB program plans and is fully consistent with the Stop TB Strategy, which builds on the Directly Observed Treatment Short Course (DOTS) approach and also includes support for TB/HIV, MDR-TB, health systems strengthening, active engagement of the private sector, support for patients, and targeted research.

HIV/AIDS

I. G8 Commitment:

- As an important step to scaling up towards the goal of universal access to HIV/AIDS prevention, treatment, care and support in Africa, G8 members, in support of national HIV/AIDS programs globally, individually and collectively over the next few years will aim to employ existing and additional programs to support life-saving anti-retroviral treatment through bilateral and multilateral efforts for approximately five million people, to prevent twenty-four million new infections, and to care for twenty-four million people including ten million orphans and vulnerable children. (Heilingendamm, Africa Declaration, 58)

- The G8 will take concrete steps to work toward improving the link between HIV/AIDS activities and sexual and reproductive health and voluntary family planning programs, to improve access to health care, including preventing mother-to-child transmission, and to achieve the Millennium Development Goals by adopting a multisectoral approach and by fostering community involvement and participation. (Heilingendamm, Africa Declaration, 53)

II. Inputs from G8 (to be completed by each G8 member)

	2007	2008	2009 -
Bilateral (Project and Budget Support)	3239 m	4506 m	4995[40]
Global Initiatives GF:[41] Other:	GF: 419 m	GF: 487 m	GF: 522 m
Multilateral (WB, UN, etc.)	UNAIDS- 30 m	UNAIDS- 35 m	UNAIDS: 40
Research	Research 362 m IAVI 29 m Microbicides– 40 m	Research 364 m IAVI 28 m Microbicides: 45	Research 426 m IAVI 28 m Microbicides: 45
Total			

Footnotes and narrative to be provided by each G8 member (as needed):

The Lantos-Hyde Act and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) before it represent the largest international health initiative in history dedicated to a specific disease. Through these initiatives, the U.S. Government has committed more than $25 billion to the response to global

[40] FY 2009 funding levels for research, IAVI and microbicides are planned and may be adjusted.
[41] The Global Fund funding reflects the HIV portion of the U.S Government contribution to the Global Fund, based on the 58 percent share of its cumulative total portfolio that the Global Fund reports that it commits to HIV.

AIDS. In the first five years of the program, the American people supported antiretroviral treatment for more than 2.1 million men, women, and children living with HIV/AIDS around the world; care for over 10.1 million people; and prevention of mother-to-child HIV transmission during nearly 16 million pregnancies. PEPFAR supported nearly 57 million HIV counseling and testing encounters.

PEPFAR has demonstrated unprecedented commitment to mobilizing leadership and building the capacity of local institutions to in the fight against AIDS. PEPFAR is working with host country governments to develop Partnership Frameworks – five-year joint strategic frameworks designed to fully align PEPFAR HIV/AIDS assistance with national strategies. By using HIV treatment as a platform, PEPFAR support has strengthened and extended health systems in many areas including human resources, infrastructure, informatics, commodities logistics, and laboratory services.

VI. Outputs from G8 (to be completed by each G8 member)

G8 Country	**2008**	**2009**
Number of adults and children with advanced HIV infection receiving antiretroviral therapy	2122800	
Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission	457300	

Health Systems Strengthening

IV. G8 Commitment:

- We will ensure our actions to strengthen health systems at national and local level and across all sectors since this is vital for long-term improvements in overall health, as we will encourage donors to help build health capacity (Gleaneagles, 18/c)

- We emphasize the importance of comprehensive approaches to address the strengthening of health systems including social protection, the improvement of maternal, newborn and child health, the scaling up of programs to counter infectious diseases and access to essential medicines, vaccines and appropriate health-related products. […] We underline the need for partner countries to work toward sustainable and equitable financing of health systems (Hokkaido Toyako, 46)

Narrative to be provided by each G8 member (as needed):

USG funding for health systems strengthening activities address all six components of the internationally-recognized World Health Organization health systems framework: service delivery, human resources for health, information, medicines and technologies, financing, and governance. This support includes funding for health worker education, training, and retention; laboratory support; national procurement and logistics systems; and surveillance system support.

Within these components, USG supports a variety of state-of-the-art health systems strengthening interventions. In country, USG works with other donors to develop and implement an evidence-based, tailored package of HSS interventions that complements and directly supports the country's national health plan and established basic package of health interventions. USG is currently developing monitoring and evaluation tools to track progress in these interventions as well as in their impact on health system performance.

USG Agencies collaborate on analyzing evidence on the relationships between health system strengthening interventions and health impact, developing monitoring and evaluation tools for tracking investments in health systems strengthening, and removing system bottlenecks to the achievement of the health MDGs. Furthermore, on May 5, 2009, President Obama announced his Global Health Initiative, stating "The initiative adopts a more integrated approach to fighting diseases, improving health, and strengthening health systems."

The activities described below are a few selected, illustrative examples of USG achievements in health systems strengthening.

Service delivery: USG works with host country governments to expand the use of modern health care quality improvement approaches widely used in the U.S. health care system. With USG support, twelve countries worldwide have developed twenty-five improvement and spread collaboratives.

Health workforce: USG supports human resources for health (HRH) planning through improved analysis and use of information. The integrated Human Resources Information System (iHRIS) was introduced in nine countries in response to country's needs to assess HRH problems and plan and evaluate interventions.

Health information: USG supports Demographic and Health Surveys (DHS) and AIDS Indicators Surveys (AIS) to provide the highest quality data to inform global and country efforts to improve health. Since 1985, 210 DHS have been conducted by 79 countries and seven countries with high HIV disease burdens have carried out AIS. USG also strengthened the capacity of five regional M&E training partners to serve as regional centers of reference in M&E and to conduct M&E training independently.

Medical products, vaccines, and technologies: USG helps countries to reduce inappropriate dispensing or misuse of drugs and anti-microbial resistance by improving counseling and treatment adherence at the facility level. USG-developed standard operating procedures and adherence assessment tools have been adopted for nationwide implementation in four countries. USG has been active in strengthening quality of medicines, especially through post-marketing surveillance and strengthening of national quality control labs. USG also promotes patient safety through pharmacovigilance and infection control by setting up Drug Therapeutic Committees or Therapeutics Information and Pharmacovigilance Centers to monitor safety and effectiveness of medicines.

Health financing: USG supports evidence-based, transparent policy-making by championing health expenditure tracking through the internationally-recognized National Health Accounts framework, which government stakeholders and civil society organizations in more than 100 countries are using today. USG supports expanding the learning agenda for performance-based financing for improving the efficient use of scarce financial resources in developing countries. In addition, USG works with countries in the process of developing health insurance, including community-based health insurance, to maximize associated potential benefits (e.g. achieving MDG targets) and to minimize potential risks (e.g. launching unsustainable benefits packages).

Leadership and governance: In addition, in several countries in Africa and Asia, USG enables health system leaders to systematically identify strengths and weaknesses through comprehensive country health system assessments and strategic priority setting. USG also supports leadership development through online leadership programs which 53 countries all over the world have participated in since 2002.

In 2009, the USG will allocate an estimated $1 billion for health system strengthening initiatives and activities from programs reported elsewhere in these matrices.

Health Workforce

I. G8 Commitment:

- The G8 members will work towards increasing health workforce coverage towards the WHO threshold of 2.3 health workers per 1000 people, initially in partnership with the African countries where we are currently engaged and that are experiencing a critical shortage of health workers. (Hokkaido Toyako, 46b)

II Inputs from G8 (to be completed by each G8 member)

	2008	2009 -
Bilateral (Project and Budget Support) (PEPFAR)	$734 m*	$519 m**
Other USG	$294m	$362m
Global Initiatives		
Multilateral (WB, UN, etc.)		
Research		
Total	**$1028 m**	**$881 m**

Footnotes and narrative to be provided by each G8 member (as needed):

*This figure reflects the total funding for health systems strengthening. PEPFAR was unable to break out specific HRH funding in FY 2008. These numbers are also contained within the USG budgets for HIV.
** This represents funding HRH alone for FY 2009 and is 14% of the total PEPFAR budget for FY 2009. These numbers are also contained within the USG budgets for HIV.

The Lantos-Hyde Act directs the U.S. Government, by 2013, to: train and support retention of 140,000 new health care professionals, paraprofessionals, and community health workers with an emphasis on the training and in-country deployment of critically needed doctors and nurses; and to strengthen capacities in developing countries to deliver primary health care with the objective of helping countries achieve staffing levels of at least 2.3 doctors, nurses and midwives per 1000 population. This

will require the USG to make increasing investments in pre-service education.

The focus of the strategy to achieve this goal will be on:

- Training and supporting retention of 140,000 new health care workers
- Focusing investments around key areas of intervention that will help achieve this target
- Promoting sustainability of all HRH efforts
- Coordinating HRH strategy and investments with other programs and development partners

Maternal, Newborn and Child Health

I. G8 Commitment:

- We will scale up efforts to reduce the gaps, in the area of maternal and child health care and voluntary family planning, an estimated US$ 1,5 billion (Heilingdamm, 50)

Narrative to be provided by each G8 member

USAID's funding for maternal and child health programs increased from $360 million to $450 million in 2008, and increased again to $495 million in 2009. With this additional funding, USAID has launched a strategic approach that focuses the majority of its maternal and child health resources in 30 priority countries that account for at least 50 percent of infant, child and maternal deaths worldwide. These countries are characterized by both high magnitude and severity of maternal deaths. Through this focused strategic approach, USAID aims to achieve and sustain the greatest possible reduction of maternal and child mortality and malnutrition with programs that:

- focus on maternal, newborn and child mortality as a clear goal;
- identify and scale up high-impact interventions most relevant to the country, using country–specific epidemiology as the basis for identifying priorities;
- specifically aim for impact at scale, while linking increased coverage of key intervention to measured change in inputs and outputs;
- strengthen health systems and human capacity to support and sustain improved maternal and child health outcomes;
- support the most effective approaches to deliver key interventions to families and communities that need them by identifying the best mix of system strengthening, demand creation, and community and public-private approaches;
- introduce approaches that link water and sanitation investments to improved women's and children's health; and
- complement other USG, donor, and host country resources.

Mother-to-child transmission remains the leading source of child HIV infections, and providing prevention of mother-to-child-transmission (PMTCT) remains an essential challenge. The United States supports host nations' efforts to provide PMTCT programs, including HIV counseling and testing for all women who attend antenatal clinics, and sharply increased its PMTCT resources in FY2008. PEPFAR has supported PMTCT interventions for women during nearly 16 million pregnancies to date, providing antiretroviral prophylaxis for over 1.2 million HIV-positive pregnancies, and preventing an estimated 237,600 infections of newborns. PMTCT is a key element of the prevention strategies of host nations, and PEPFAR has provided support for host nations' PMTCT interventions for women during approximately 16 million pregnancies. Of these, more than 1.2 million women were determined to be HIV-positive and received preventive ARVs, preventing an estimated 237600 infections of newborns.

In addition, the USG through the Centers for Disease Control provides more than $50 million for measles control and support for childhood vaccination programs; water, hygiene, and sanitation; and other activities.

Neglected Tropical Diseases

VII. G8 Commitment:

- We must also increase our efforts in the fight against other preventable diseases, including pneumonia, diarrhea and neglected diseases such as leishmaniasis, Chagas disease and onchocerciasis, particularly by increasing the volume and quality of medical research on neglected diseases in developing countries. (St. Petersburg, Fight Against Infectious Disease, 31).

- To build on our commitments made on neglected tropical diseases at St Petersburg, we will work to support the control or elimination of diseases listed by the WHO through such measures as research, diagnostics and treatment, prevention, awareness-raising and enhancing access to safe water and sanitation. In this regard, by expanding health system coverage, alleviating poverty and social exclusion as well as promoting adequate integrated public health approaches, including through the mass administration of drugs, we will be able to reach at least 75% of the people affected by certain major neglected tropical diseases in the most affected countries in Africa, Asia, and Latin America, bearing in mind the WHO Plan. (Hokkaido, Development and Africa, 46f)

VIII. Inputs from G8 (to be completed by each G8 member)

	2006	2007	2008	2009
Bilateral (Project and Budget Support)[42]	$17,8 m	$17,5 m	$17,5 m	$27,1 m
Global Initiatives				
Multilateral (WB, UN, etc.)				
Research	$37 m	$41,6 m	$38,6 m	TBD
Total	**54,8**	**59,1**	**56,2**	

[42] USAID's funding is for trachoma, lymphatic filiarisis, onchocerciasis, schistosomiasis, and soil-transmitted helminthes. USAID's Latin America Bureau also provides funding for Chagas disease, which is included in these figures.

Footnotes and narrative to be provided by each G8 member (as needed):

Note: USAID's funding for pneumonia and diarrheal diseases is included within the funding figures for
Maternal, Newborn, and Child Health, in the preceding table.

Section B: G8 GLOBAL HEALTH INVESTMENT COUNTRY TABLES - UK

B.1 – Global Health Investment

B.1.1 – Aid to Health, reported as ODA to DAC (committments[43])

US$, millions

	2007 (final)	2008 (provisional data*)
Aid to Health, General *(also includes technical assistance and sector budget support/basket funds)*[44]	281.55	291.6
Aid to Basic Health *(also includes technical assistance and sector budget support/basket funds)*[45]	313.73	303.6
Aid to Population Policies/Programs and Reproductive Health)[46]	419.43	464.2
Core contributions to International NGOs working in the Health Sector (e.g. MSF, HAI, IPPF etc.) [47]	45.84	55.6
Core contributions to Public-Private Partnerships working in the Health Sector (e.g. GAIN, IAVI, UNITAID, etc.) [48]	45.47	36.2
Core contributions to the multilateral agencies working in the Health Sector[49]		
- Global Fund	200.1	90.5
- WHO (ODA part)	7.7	16.7
- GAVI Alliance	48.6	0
- UNAIDS	38.0	0
- Other agencies working in the Health Sector		
Innovative Financing Mechanisms for Health (flows reported as ODA)		
- IFFIm	0	30.4
- AMCs	0.06	0

[43] As defined by DAC ": "A firm obligation, expressed in writing and backed by the necessary funds, undertaken by an official donor to provide specified assistance to a recipient country or a multilateral organisation".].

[44] Identifiable and traceable through the DAC-CRS online database, codes from 12110 to 12191
[45] Identifiable and traceable through the DAC-CRS online database, codes from 12220 to 12281
[46] Identifiable and traceable through the DAC-CRS online database, codes from 13010 to 13081
[47] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)
[48] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)
[49] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)

- Other		
*Other multilateral institutions (imputed percentage for health **)*		
- UN System (e.g. UNICEF, UNDP, UNFPA, UNHCR etc.)	61.2	52.6
- World Bank	61.4	58.8
- Regional Development Banks	3.4	5.4
- Other multilateral institutions		
- EC Budget	64.0	75.1
- European Development Fund (EDF)	(Total EC)	
General Budget Support, Bilateral (*imputed percentage for health****)	110.2	102.8
Health-related Debt conversion discount (e.g. Debt2Health)		
Other miscellaneous items		
TOTAL AID TO HEALTH REPORTED AS ODA	**1 609.31**	**1 461.10**
TOTAL ODA (memo item)		

* Final data for 2008 will be provided in the second half of 2009 and the updated matrices published on the G8 Presidency website
** A common methodology of multilateral imputation for specific lines (UN System, MDBs, etc.) was identified, with the support of the DAC Secretariat.
*** A common methodology of bilateral and multilateral imputation for General Budget Support and other flows not included in DAC CRS was identified (health expenditure ratios by recipient countries)

B.1.2 – Other specific inputs to Global Health in Developing Countries

US$, millions

	2007	2008
Non-concessional lending and Other Official Flows to Health		
Research in health not reported as ODA		
UNITAID not reported as ODA (additional)		
Multilaterals not included in DAC Annex 2 - (imputed percentage health)		
Health-related Debt conversion (non-ODA part)		
IFFIm frontloading effect *[to be defined by IFFIm donors]*		
Other Technical Assistance not reported as ODA		
Other miscellaneous items		

B.1.3 Narrative explanation by each G8 member *(max. 2 pages)*

The Bilateral aid for 2007 reported in the first 3 rows of table B1.1 is taken from DAC Table 5 and disbursements are reported as commitments. The imputed multilateral shares are based on DFID's own methodology for imputing multilateral shares. This uses data reported to the DAC on

multilateral commitments by sector. This may differ to the standard DAC methodology. All 2008 data is provisional and may change. Figures for 2008 Imputed multilateral shares are based on 2007 proportions applied to 2008 core contributions. Some elements of B.1.2 have not been completed because they are not relevant (e.g. all UK support for UNITAID is reported as ODA). Others have not been completed because additional technical work is required to identify the non-ODA elements of UK global health support. The UK is also currently assessing the technical issues around reporting an IFFIm 'frontloading effect'. IFFIm uses predictable long-term funding from the UK and other donors to create frontloading. It uses capital markets to leverage hugely more resources than would otherwise be available within constrained donors' budgets. Spending this money on immunisations now rather than later means we can achieve herd immunity effects and save more lives than if we spent the same amount of money over the longer-term without IFFIm. We estimate that $4bn spent in this way would immunise 500m children and save 10m lives. IFFIm has raised over $2bn to date; alongside donor disbursements to the IFFIm that amount to only some $300m. To date the UK's has contributed just over £38 million (£9m in 2007, £16.8m in 2008 and £12.5m so far in 2009) for IFFIm.

Section C: DISEASE OR SECTOR-SPECIFIC COUNTRY TABLES - UK

Malaria

IX. G8 Commitments:

- 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. (Heilingendamm, Africa Declaration, 55)

- As part of fulfilling our past commitments on malaria, we will continue to expand access to long-lasting insecticide treated nets, with a view to providing 100 million nets through bilateral and multilateral assistance, in partnership with other stakeholders by the end of 2010. (Hokkaido Toyako, 46d)

X. Inputs

	2007	2008 (provisional)	2009 -
Bilateral (Project and Budget Support)		$67.1m (2008/09)	
Global Initiatives GF: Other:			
Multilateral (WB, UN, etc.)	$41.6m		
Research			

Footnotes and narrative to be provided by each G8 member (as needed):

As in other areas, the UK contributes to malaria control through a combination of funding for bilateral, global, multilateral, and research budget lines. Support for health systems strengthening is also a key element of DFID's contribution to malaria control and commitments here amount to £6 billion up to 2015. Much of the specific contribution to malaria takes the form of long-lasting insecticide impregnated bednets (20 million of which the Prime Minister has pledged to provide by the end of 2010), and ACT treatments. DFID is providing £40 million of support to the Affordable Medicines for Malaria Facility (AMFm), an innovative funding mechanism housed in the Global Fund, which will make effective malaria drugs more available and affordable in public, private and NGO outlets. In terms of research, DFID has contributed over £16 million for new drug development to the Drugs for Neglected Diseases Initiative (DNDI) and the Medicines for Malaria Venture (MMV).

Through WHO, DFID supports the Special Programme for Research and Training on Tropical Diseases (TDR). DFID also supports consortia led by the London School of Hygiene and Tropical Medicine - £5 million (2005-2010) and the Nuffield Institute at Leeds University - £5 million (2006-2011). Both carry out research in communicable diseases including malaria.

DFID uses a system of input sector codes to allocate project expenditure to particular sectors. Our sector codes are in line with the DAC system of purpose codes. However, DFID projects can be allocated to up to eight input sector codes, with a percentage applied to each code. When we report to the DAC only one sector code is reported (i.e. the one with the highest percentage). The above figure for 2008/09 bilateral support is based on DFID's own methodology for allocating expenditure, which takes into account all input sector codes and proportions allocated to a project. Based on an ODA methodology the equivalent figure is $22.1 million (on a calendar year 2008 basis and using only the major input sector code). The 2007 multilateral figure is based on DFIDs own methodology for imputing multilateral shares. This uses data reported to the DAC on multilateral commitments by sector. This may differ to the standard DAC methodology.

Tuberculosis

I. G8 Commitment:

- One-third of the world's population is exposed to the risk of contracting TB, which claims about two million lives each year. In certain regions, it affects more people today than it did twenty years ago. We reaffirm the commitment we made at the Genoa Summit in 2001 to halt the spread of this disease. We will also support the Global Plan to Stop TB, 2006-2015, which aims to cut TB deaths in half by the year 2015 compared to 1990 levels, saving some 14 million lives over ten years, and call upon all donors and stakeholders to contribute to its effective implementation. (St. Petersburg, Fight Against Infectious Disease, 21).

- We note with concern the rate of HIV/AIDS and tuberculosis co-infection and seek to promote unified coordination for activities in this regard. (St. Petersburg, Fight Against Infectious Disease, 22).

II. Inputs from G8 (to be completed by each G8 member -- this is last year's matrix with an additional column for 2009)

	2006	2007	2008 (provisional)	2009 -
Bilateral (Project and Budget Support)			$23.2m (2008/09)	
Global Initiatives GF: Other:				
Multilateral (WB, UN, etc.)		$26.3m		
Research				

Footnotes and narrative to be provided by each G8 member (as needed):

DFID uses a system of input sector codes to allocate project expenditure to particular sectors. Our sector codes are in line with the DAC system of purpose codes. However, DFID projects can be allocated to up to eight input sector codes, with a percentage applied to each code. When we report to the DAC only one sector code is reported (i.e. the one with the highest percentage). The above figure for 2008/09 bilateral support is based on DFID's own methodology for allocating expenditure, which takes into account all input sector codes and proportions allocated to a project. Based on an ODA methodology the equivalent figure is $5.6 million (on a calendar year 2008 basis and using only the major input sector code). The 2007 multilateral figure is based on DFIDs own methodology for

imputing multilateral shares. This uses data reported to the DAC on multilateral commitments by sector. This may differ to the standard DAC methodology.

Through WHO, DFID supports the Special Programme for Research and Training on Tropical Diseases (TDR). DFID also supports consortia led by the London School of Hygiene and Tropical Medicine - £5 million (2005-2010) and the Nuffield Institute at Leeds University - £5 million (2006-2011). Both carry out research in communicable diseases including tuberculosis.

HIV/AIDS

I. G8 Commitment:

- As an important step to scaling up towards the goal of universal access to HIV/AIDS prevention, treatment, care and support in Africa, G8 members, in support of national HIV/AIDS programs globally, individually and collectively over the next few years will aim to employ existing and additional programs to support life-saving anti-retroviral treatment through bilateral and multilateral efforts for approximately five million people, to prevent twenty-four million new infections, and to care for twenty-four million people including ten million orphans and vulnerable children. (Heilingendamm, Africa Declaration, 58)

- The G8 will take concrete steps to work toward improving the link between HIV/AIDS activities and sexual and reproductive health and voluntary family planning programs, to improve access to health care, including preventing mother-to-child transmission, and to achieve the Millennium Development Goals by adopting a multisectoral approach and by fostering community involvement and participation. (Heilingendamm, Africa Declaration, 53)

II. Inputs from G8 (to be completed by each G8 member)

	2007	2008 (provisional)	2009 -
Bilateral (Project and Budget Support)	$824.24m (2007/08)	$917.7m (2008/09)	
Global Initiatives GF: Other:			
Multilateral (WB, UN, etc.)	$222.88m (2007/08) (*of which* $112.07m is GFATM)	$ 329.4m (2008/09) (*of which* $61.4m is GFATM)	
Research			

Footnotes and narrative to be provided by each G8 member (as needed):

The UK remains the second largest bilateral funder in the world of HIV prevention, treatment care and support, providing £1.5 billion between 05/06 and 07/08. In 2008, launching the up-dated AIDS strategy (Achieving Universal Access) UK Government committed £6 billion on strengthening health systems and services over seven years to 2015. The UK has also committed to spend £200 million on social protection over 3 years to support the most vulnerable households, including orphans and vulnerable children (OVC). The UK will also increase by at least 50% its funding for research and development of AIDS vaccines and microbicides over 2008-2013. This is in addition to our existing

commitment of £1 billion to the Global Fund to fight AIDS, tuberculosis and malaria, providing it with long term predictable funding until 2015.

DFID's approach to tackling HIV and AIDS is multi-sectoral and involves expenditure in a number of areas in addition to directly targeted initiatives. DFID put a system of Cross Cutting Objectives into place sometime ago. This enabled us to look at how effectively our projects and programmes were targeting particular policy areas. This system records whether a range of policy outcomes (including HIV and AIDS) are a "principal" (P) or "significant" (S) objective of the project.

DFID also provides a large amount of aid through budget support. In the case of sector budget support (SBS), where this is provided specifically to help target HIV and AIDS we have scored expenditure in exactly the same way as for other bilateral programmes.

In the case of general budget support (GBS) DFID estimates that 5% will be spent on HIV and AIDS. This figure is an average based on available information on government expenditure on HIV and AIDS in a number of relevant countries. A similar method is used to estimate the proportion of DFID's debt relief which can be attributed to HIV and AIDS expenditure although the amounts involved here are small.

The HIV-AIDS elements of multilateral expenditure and expenditure through partnership programme agreements (PPA) with civil society organisations are estimated using proportions of HIV-AIDS expenditure reported by each organisation and applying it to DFID's contribution to each organisation. There remains some degree of approximation and the methodology may vary across each organisation.

VII. Outputs from G8 (to be completed by each G8 member)

G8 Country	**2008**	**2009**
Number of adults and children with advanced HIV infection receiving antiretroviral therapy		
Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission		

Health Systems Strengthening

V. G8 Commitment:

- We will ensure our actions to strengthen health systems at national and local level and across all sectors since this is vital for long-term improvements in overall health, as we will encourage donors to help build health capacity (Gleaneagles, 18/c)

- We emphasize the importance of comprehensive approaches to address the strengthening of health systems including social protection, the improvement of maternal, newborn and child health, the scaling up of programs to counter infectious diseases and access to essential medicines, vaccines and appropriate health-related products. […] We underline the need for partner countries to work toward sustainable and equitable financing of health systems (Hokkaido Toyako, 46)

Narrative to be provided by each G8 member (as needed):

Over one-third of UK bilateral support to health in 2007/8 took the form of either direct support to health sector system development or funding national health systems through governments' health budgets. Through our bilateral funding programme and our engagement with the international system, including the International Health Partnership, we prioritise the following areas:

1. Increasing long-term predictable funds for recurrent costs.
We do this through long term partnership agreements with countries. We promote a balanced approach to health sector funding, depending on country context, and using a range of instruments from projects to general budget support. Our goal is to ensure maximum support for domestic health budgets - working with Ministries of Health and Finance to improve the effectiveness of both domestic and international resources.
2. Harnessing the resources of non-state actors to provide basic services.
Non-state actors provide substantial services in most developing countries, and out of pocket payment is a large proportion of health sector funding. We promote the integration of all health sectors into one overarching health plan. This leads to improved management, regulation and accountability within the non-state sector. We urge governments to engage more effectively with non-state actors, building on existing partnerships where they exist (eg CCMs).
3. Focusing on results.
We work with governments to make national plans more results focused, and more accountable to parliament for delivery of results. This encourages existing international funds to become more harmonised with these plans and promotes national ownership. The Global Fund and GAVI are both keen to support national health plans and get their priorities reflected in them. The World Bank is also working to improve the results focus of health funding.
4. Improving the international system.
On 5 September 2007 the UK supported the launch of the International Health Partnership (IHP+)

which aims to improve the effectiveness of international aid for health. Through improved coordination, support to HSS and greater results focus for national health plans, the signatories of the IHP have committed to use domestic and international resources for health more effectively and efficiently.

Health Workforce

I. G8 Commitment:

- The G8 members will work towards increasing health workforce coverage towards the WHO threshold of 2.3 health workers per 1000 people, initially in partnership with the African countries where we are currently engaged and that are experiencing a critical shortage of health workers. (Hokkaido Toyako, 46b)

II Inputs from G8 (to be completed by each G8 member)

	2008	2009 -
Bilateral (Project and Budget Support)		
Global Initiatives		
Multilateral (WB, UN, etc.)		
Research		

Footnotes and narrative to be provided by each G8 member (as needed):

- DFID supports African countries to build sustainable health systems to meet present and future health challenges. This includes the training and retention of an effective health workforce. Also, DFID works closely with the DoH to support and advocate for ethical recruitment policies of overseas health professionals in the UK and Europe. The UK is one of the only developed countries with a policy explicitly preventing the targeting of developing countries in the international recruitment of health care professionals. Countries covered by the code of conduct include all of sub-Saharan Africa countries and the Caribbean.
- Training is only one part of the response and international migration is only one reason for the shortage of health workers: inadequate salaries, the lack of career opportunities and poor working conditions contribute to the outflow as does the impact of AIDS. Within countries, recruitment, training and retention of health workers must be tackled within the context of broader health systems and the macro economic situation.. We need to give attention to HR planning and management, deployment to underserved areas, retention, productivity, continuing professional development. Political leadership in Africa is critical to ensuring domestic investment in health and health services including health workers.
- DFID uses a range of financing instruments and interventions from technical assistance to develop HRH plans (e.g. Nigeria, Somaliland and Kenya) to broader civil service reforms (e.g.

Tanzania), specific projects to train health workers and develop institutional capacity (e.g. Sierra Leone, Somaliland, Zimbabwe, Uganda) and ongoing policy dialogue within the health sector (e.g. Ghana, Uganda, Zambia, Mozambique). Our main earmarked country investment is the Malawi Emergency Human Resources Programme (EHRP) -£55 million over 6 years to support innovative recruitment training and retention strategies. This has already reduced vacancy rates and doubled the number of nurses in training. DFID Zambia is currently designing a £6m package of support to human resources in health for 2009-2012. This will include support to a Human Resource Information system linked to government's Payroll Management and Establishment Control system (PMEC); support to implementing the Ministry of Health's Community Health Workers Strategy and £970,000 to the Zambia UK Health Workforce Alliance which will be funded through Tropical Health and Education Trust (THET).

- DFID is continuing to engage at regional and global level though initiatives such as the Global Health Workforce Alliance, EU Programme for Action, engagement with WHO Geneva and at regional level with Africa regional office, and institutions such as the African Union (AU) and NEPAD.

Maternal, Newborn and Child Health

I. G8 Commitment:

- We will scale up efforts to reduce the gaps, in the area of maternal and child health care and voluntary family planning, an estimated US$ 1,5 billion (Heilingdamm, 50)

Narrative to be provided by each G8 member

DFID's approach to improving maternal health is through long-term broad support to health systems. We want to see faster progress towards maternal health goal and are working to improve maternal health by strengthening health systems to deliver better health services. In June 2008, the UK Government made a commitment to spend £6 billion on strengthening health systems and services over 7 years to 2015 (plus £1 billion to the Global Fund for AIDS, TB and Malaria (GFATM). A concentrated, sustained, long-term investment in health services and infrastructure is required. This includes having skilled birth attendants who have supplies and equipment, improving access to family planning services and action to address the issue of unsafe abortion. We also recognize the need for improved sexual and reproductive health and rights for women, as we know that ensuring access to reproductive health and family planning services could help to avert up to 35% of maternal deaths.

We supported current efforts to build a global Consenus, behind the message "every pregnancy wanted, every birth safe, every newborn healthy". This "consensus" is working for a healthcare continuum that extends across adolescence, pregnancy, childbirth and childhood. It also focuses on quality care during pregnancy and childbirth, including skilled attendance and emergency. Additional major maternal, newborn and child health investments include;

- £100 million - UN Population Fund (UNFPA) Global Programme for Reproductive Health Commodities Security (2008 -2013)

- £252 million over 2005 - 11 for Government of India's nationwide Reproductive and Child Health Programme;

- £90 million over 2006 - 2012 for a new National Maternal, Neonatal and Child Health Programme in Pakistan. This will expand maternal and newborn care and family planning services, and support the creation of a new cadre of community midwives, and the promotion of effective maternal and child health behaviour by families.

- Ethiopia 'Protecting Basic Services': block grants (planned £38.5m 2007-2011) commodities (£5m/yr 2007/8 through 2009/10).

- Kenya Essential Health Services project (£10.2m 2007/8-2010/11) and Social marketing of condoms (£16.4m 2007/8-2010/11);

- Sierra Leone. Support Reproductive & Child Health national plan (£11m over 2008/9-2010/11) to strengthen national systems to deliver sexual, reproductive and child health services and to improve access to water and sanitation.

- Nigeria. Commodities project (£23.3 million over 2007/8-2010/11) and Immunisation / MNCH (£17.1 million over 2007/8-2010/11).

Neglected Tropical Diseases

IX. G8 Commitment:

- We must also increase our efforts in the fight against other preventable diseases, including pneumonia, diarrhea and neglected diseases such as leishmaniasis, Chagas disease and onchocerciasis, particularly by increasing the volume and quality of medical research on neglected diseases in developing countries. (St. Petersburg, Fight Against Infectious Disease, 31).

- To build on our commitments made on neglected tropical diseases at St Petersburg, we will work to support the control or elimination of diseases listed by the WHO through such measures as research, diagnostics and treatment, prevention, awareness-raising and enhancing access to safe water and sanitation. In this regard, by expanding health system coverage, alleviating poverty and social exclusion as well as promoting adequate integrated public health approaches, including through the mass administration of drugs, we will be able to reach at least 75% of the people affected by certain major neglected tropical diseases in the most affected countries in Africa, Asia, and Latin America, bearing in mind the WHO Plan. (Hokkaido, Development and Africa, 46f)

X. Inputs from G8 (to be completed by each G8 member)

	2006	2007	2008	2009
Bilateral (Project and Budget Support)				
Global Initiatives	908.9k	920k	1.006m	904.6k
Multilateral (WB, UN, etc.)	919.9k	979.9k	1.007m	768.8k
Research	0	9.9m	4.0m	12.6m

Footnotes and narrative to be provided by each G8 member (as needed):

- The UK has supported NTD research and Lymphatic Filariasis and Onchocerciasis control for a number of years. Details in table above**. In 2008 the UK pledged a further £45m over 5 years starting in 2009 for which programming is in hand.**

- GAELF In 2000 the UK launched a public private partnership to support the Global Alliance and Global Programme to Eliminate Lymphatic Filariasis (GAELF/GPELF) with SmithKlineBeecham (now GlaxoSmithKline). Funding provided support for mass drug administration in a number of countries, operational research, monitoring and evaluation and the Secretariat of GAELF. In 2000 83 countries were endemic. By 2007 this figure had only fallen to 81. 48 countries had active programmes

with 546m people receiving treatment. There is increasing evidence of endemic country commitment to LF elimination. UK support is planned to extend to 2014 to all aspects of the Programme. Considerable funding gap remains.

- African Programme for Onchocerciasis Control (APOC) : Recent health impact assessments document significant reductions in disability and stigma within endemic countries (now 28) since the start of APOC in 1995. But 100 m people mainly in West Africa are still affected. The plan of action and budget 2008-2015 outlines additional measures to strengthen the delivery of ivermectin in post conflict countries, stronger coimplementation with other health interventions, streamlined gender issues and enhanced absorptive and implementation capacity at HQ and country levels, particularly through the integration of "oncho" control into national health systems.

Among the major policy challenges is how to ensure synergies between Neglected Tropical Diseases (NTD) programmes across Africa and prevent the build-up of separate disease interventions at local and community level.

The elimination of oncho in three West African countries (Senegal, Guinea and Mali), sets the stage to now achieve the same results in all remaining African countries with riverblindness including Nigeria and Kenya. These significant achievements provide clear evidence that the total elimination of oncho is possible with the right levels of funding and country commitment.

Research funding is awarded by UK fiscal rather than calendar years, hence the apparent peaks and troughs due to payment dates. Funding includes support to the Drugs for Neglected Diseases initiative (DNDi) and Tropical Disease Research (TDR) which both cover a range of different diseases.It is not possible to disaggregate amounts for each disease.

Section B: G8 GLOBAL HEALTH INVESTMENT COUNTRY TABLES - RUSSIA

B.1 – Global Health Investment

B.1.1 – Aid to Health (commitments[50])

US$, millions

	2007 (final)	2008 (provisional data*)
Aid to Health, General *(also includes technical assistance and sector budget support/basket funds)*[51]		1,636
Aid to Basic Health *(also includes technical assistance and sector budget support/basket funds)*[52]		
Aid to Population Policies/Programs and Reproductive Health)[53]		
Core contributions to International NGOs working in the Health Sector (e.g. MSF, HAI, IPPF etc.) [54]		
Core contributions to Public-Private Partnerships working in the Health Sector (e.g. GAIN, IAVI, UNITAID, etc.) [55]		
Core contributions to the multilateral agencies working in the Health Sector[56]		
- Global Fund	85,739	78,405
- WHO (ODA part)	8.0	14.573
- GAVI Alliance		

[50] As defined by DAC ": "A firm obligation, expressed in writing and backed by the necessary funds, undertaken by an official donor to provide specified assistance to a recipient country or a multilateral organisation".].

[51] Identifiable and traceable through the DAC-CRS online database, codes from 12110 to 12191
[52] Identifiable and traceable through the DAC-CRS online database, codes from 12220 to 12281
[53] Identifiable and traceable through the DAC-CRS online database, codes from 13010 to 13081
[54] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)
[55] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)
[56] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)

- UNAIDS	0,5	1,1
- Other agencies working in the Health Sector		
Innovative Financing Mechanisms for Health (flows reported as ODA)		
- IFFIm		
- AMCs		
- Other		
*Other multilateral institutions (imputed percentage for health **)*		
- UN System (e.g. UNICEF, UNDP, UNFPA, UNHCR etc.)	0,609	0.609
- World Bank	7,328	12.218
- Regional Development Banks		
- Other multilateral institutions		
- EC Budget		
- European Development Fund (EDF)		
General Budget Support, Bilateral (*imputed percentage for health*)		
Health-related Debt conversion discount (e.g. Debt2Health)		
Other miscellaneous items		
TOTAL AID TO HEALTH	**102.176**	**108.541**
TOTAL ODA (memo item)		

* Final data for 2008 will be provided in the second half of 2009 and the updated matrices published on the G8 Presidency website
** A common methodology of multilateral imputation for specific lines (UN System, MDBs, etc.) was identified, with the support of the DAC Secretariat.

B.1.2 – Other specific inputs to Global Health in Developing Countries

US$, millions

	2007	2008
Non-concessional lending and Other Official Flows to Health		
Research in health not reported as ODA	6,54	23,52
UNITAID not reported as ODA (additional)		
Multilaterals not included in DAC Annex 2 - (imputed percentage health)		
Health-related Debt conversion (non-ODA part)		
IFFIm frontloading effect *[to be defined by IFFIm donors]*		
Other Technical Assistance not reported as ODA		
Other miscellaneous items	9,237	20,258

B.1.3 Narrative explanation by each G8 member *(max. 2 pages)*

Although the Russian Federation is not a member of OECD DAC, it was agreed by Health Expert Group that the country tables for Russia will be fulfilled with maximum usage of the same methodology.

Since 2006 the Russian Federation is constantly increasing funding to health related international assistance programs. Overall Russian global health investment in 2000-2005 was estimated as $52,93 mln. In 2006 the figure was $29,85 mln., followed by more then four times increase in 2007 and 2008 with estimated figures respectively $117,95 mln. and $152,32 mln.

The President of the Russian Federation approved the Concept of Russia's Participation in International Development Assistance in June 2007. Health and fighting infectious diseases are among priorities of the Russian development assistance according to this Concept.

The Russian Federation supports multilateral and bilateral development programs in different areas of global health, such as HIV/AIDS, malaria, innovative financing for health, research, influenza pandemic preparedness, mitigating health consequences of natural and man-made disasters.

In 2006 the Russian Government pledged additional $217 millions to the Global Fund in 2007-2010 with overall figure $267 millions since 2001.

In 2007-2009 $20 millions were contributed to the World Bank Malaria Booster Program to support malaria programs in African countries.

In response to the threat of influenza pandemic the Russian Federation in 2006-2009 contributed $45,8 millions to a comprehensive program aimed on capacity building of health systems in CIS region, including procurement of laboratory equipment to CIS countries, training of health personnel, research of influenza viruses.

The Russian Federation leads efforts to fight HIV/AIDS in Eastern Europe and Central Asia, including assistance to CIS countries in the field of HIV-prevention and surveillance.

In 2006 and 2008 the Russian Federation organized biggest regional HIV/AIDS forum – Eastern Europe and Central Asia AIDS Conference (EECAAC). The Third EECAAC will be held in Moscow on the 28th-30th of October 2009. The Russian Government is a major donor of EECAAC

$38 millions set aside in 2008-2010 for HIV vaccine research and coordination of this work with CIS countries.

The Russian Government has committed to AMC $80 millions for the period 2010-2018, which is not included in the above table.

US$60 millions were set aside for the years 2007-2010 to strengthen existing networks aimed at mitigating health consequences of natural and man-made disasters, including through effective use of rapid response teams

The Russian Federation has funded the renovation and equipping the International Red Cross

Hospital in Ethiopia and Hospital in Tajikistan.

The Russian Federation is initiating collaboration on global health issues in the framework of different intergovernmental organizations, such as Shanghai Cooperation Organization, CIS, European Asian Organization of Economic Cooperation and others.

Section C: DISEASE OR SECTOR-SPECIFIC COUNTRY TABLES - RUSSIA

Malaria

XI. G8 Commitments:

- 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. (Heilingendamm, Africa Declaration, 55)

- As part of fulfilling our past commitments on malaria, we will continue to expand access to long-lasting insecticide treated nets, with a view to providing 100 million nets through bilateral and multilateral assistance, in partnership with other stakeholders by the end of 2010. (Hokkaido Toyako, 46d)

XII. Inputs

	2007	2008	2009 -
Bilateral (Project and Budget Support)			
Global Initiatives **GF:** **Other:**	$18,05 mln.*	$16,27 mln.*	$12,72 mln.*
Multilateral (WB, UN, etc.)	$5,0 mln.	$9,65 mln.	$5,35 mln.
Research			

Footnotes and narrative to be provided by each G8 member (as needed)

The Russian Federation contribution to the GFATM calculated as follows: 58% - HIV/AIDS, 24% - malaria and 18% - TB (as we did in Toyako).

Tuberculosis

I. G8 Commitment:

- One-third of the world's population is exposed to the risk of contracting TB, which claims about two million lives each year. In certain regions, it affects more people today than it did twenty years ago. We reaffirm the commitment we made at the Genoa Summit in 2001 to halt the spread of this disease. We will also support the Global Plan to Stop TB, 2006-2015, which aims to cut TB deaths in half by the year 2015 compared to 1990 levels, saving some 14 million lives over ten years, and call upon all donors and stakeholders to contribute to its effective implementation. (St. Petersburg, Fight Against Infectious Disease, 21).

- We note with concern the rate of HIV/AIDS and tuberculosis co-infection and seek to promote unified coordination for activities in this regard. (St. Petersburg, Fight Against Infectious Disease, 22).

II. Inputs from G8 (to be completed by each G8 member)

	2006	2007	2008	2009 -
Bilateral (Project and Budget Support)				
Global Initiatives GF: Other:	$1.8 mln*	$13.54 mln.*	$12.2 mln.*	$9.54 mln.*
Multilateral (WB, UN, etc.)				
Research				

Footnotes and narrative to be provided by each G8 member (as needed):
*The Russian Federation contribution to the GFATM calculated as follows: 58% - HIV/AIDS, 24% - malaria and 18% - TB.

HIV/AIDS

I. G8 Commitment:

- As an important step to scaling up towards the goal of universal access to HIV/AIDS prevention, treatment, care and support in Africa, G8 members, in support of national HIV/AIDS programs globally, individually and collectively over the next few years will aim to employ existing and additional programs to support life-saving anti-retroviral treatment through bilateral and multilateral efforts for approximately five million people, to prevent twenty-four million new infections, and to care for twenty-four million people including ten million orphans and vulnerable children. (Heilingendamm, Africa Declaration, 58)

- The G8 will take concrete steps to work toward improving the link between HIV/AIDS activities and sexual and reproductive health and voluntary family planning programs, to improve access to health care, including preventing mother-to-child transmission, and to achieve the Millennium Development Goals by adopting a multisectoral approach and by fostering community involvement and participation. (Heilingendamm, Africa Declaration, 53)

II. Inputs from G8 (to be completed by each G8 member)

	2007	2008	2009 -
Bilateral (Project and Budget Support)			
Global Initiatives GF: Other:	$43.62 mln.*	$39.32 mln.*	$30.75 mln.*
Multilateral (WB, UN, etc.)	$0.5 mln.	$1.1 mln.	$8,05 mln.
Research		**$14,478mln.**	**$17,92 mln.**

Footnotes and narrative to be provided by each G8 member (as needed):
*The Russian Federation contribution to the GFATM calculated as follows: 58% - HIV/AIDS, 24% - malaria and 18% - TB.

VIII. Outputs from G8 (to be completed by each G8 member)

G8 Country	2008	2009

Number of adults and children with advanced HIV infection receiving antiretroviral therapy	25395	20400
Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission	5006	4000

Comment: The figures were calculated based on the data provided by the GFATM to the Italian Presidency. Figures for the 2009 are estimated based on the projected funding for the GFATM.

Health Systems Strengthening

VI. G8 Commitment:

- We will ensure our actions to strengthen health systems at national and local level and across all sectors since this is vital for long-term improvements in overall health, as we will encourage donors to help build health capacity (Gleaneagles, 18/c)

- We emphasize the importance of comprehensive approaches to address the strengthening of health systems including social protection, the improvement of maternal, newborn and child health, the scaling up of programs to counter infectious diseases and access to essential medicines, vaccines and appropriate health-related products. […] We underline the need for partner countries to work toward sustainable and equitable financing of health systems (Hokkaido Toyako, 46)

Narrative to be provided by each G8 member (as needed):

Health Workforce

I. G8 Commitment:

- The G8 members will work towards increasing health workforce coverage towards the WHO threshold of 2.3 health workers per 1000 people, initially in partnership with the African countries where we are currently engaged and that are experiencing a critical shortage of health workers. (Hokkaido Toyako, 46b)

II Inputs from G8 (to be completed by each G8 member)

	2008	2009 -
Bilateral (Project and Budget Support)		
Global Initiatives		
Multilateral (WB, UN, etc.)		
Research		

Footnotes and narrative to be provided by each G8 member (as needed):

Maternal, Newborn and Child Health

I. G8 Commitment:

- We will scale up efforts to reduce the gaps, in the area of maternal and child health care and voluntary family planning, an estimated US$ 1,5 billion (Heiligendamm, 50)

Narrative to be provided by each G8 member

Neglected Tropical Diseases

XI. G8 Commitment:

- We must also increase our efforts in the fight against other preventable diseases, including pneumonia, diarrhea and neglected diseases such as Leishmaniasis, Chagas disease and Onchocerciasis, particularly by increasing the volume and quality of medical research on neglected diseases in developing countries. (St. Petersburg, Fight Against Infectious Disease, 31).

- To build on our commitments made on neglected tropical diseases at St Petersburg, we will work to support the control or elimination of diseases listed by the WHO through such measures as research, diagnostics and treatment, prevention, awareness-raising and enhancing access to safe water and sanitation. In this regard, by expanding health system coverage, alleviating poverty and social exclusion as well as promoting adequate integrated public health approaches, including through the mass administration of drugs, we will be able to reach at least 75% of the people affected by certain major neglected tropical diseases in the most affected countries in Africa, Asia, and Latin America, bearing in mind the WHO Plan. (Hokkaido, Development and Africa, 46f)

XII. Inputs from G8 (to be completed by each G8 member)

	2006	2007	2008	2009
Bilateral (Project and Budget Support)				
Global Initiatives				
Multilateral (WB, UN, etc.)				
Research				$4,2*

Footnotes and narrative to be provided by each G8 member (as needed):

*The Russian Government is considering for approval the program of Russian participation in the G8 initiative to fight NTDs. Program was developed for years 2009-2011 with overall funding up to $20 mln. The governmental decision are expected to be made soon. Therefore the data for 2009 are estimated based on mentioned program.

Section B: G8 GLOBAL HEALTH INVESTMENT COUNTRY TABLES –GERMANY

B.1 – Global Health Investment

B.1.1 – Aid to Health, reported as ODA to DAC (commitments[57])

US$, millions

	2007 (final)	2008 (provisional data*)
Aid to Health, General *(also includes technical assistance and sector budget support/basket funds)*[58]	96,50	110
Aid to Basic Health *(also includes technical assistance and sector budget support/basket funds)*[59]	154,08	170
Aid to Population Policies/Programs and Reproductive Health)[60]	129,50	135
Core contributions to International NGOs working in the Health Sector (e.g. MSF, HAI, IPPF etc.) [61] (*included in above mentioned figures)*	-	-
Core contributions to Public-Private Partnerships working in the Health Sector (e.g. GAIN, IAVI, UNITAID, etc.) [62]	-	-
Core contributions to the multilateral agencies working in the Health Sector[63]		
- GFATM	119,09	288
- WHO (ODA part)	28,5	31
- GAVI Alliance (*included in above mentioned figures, not double-counted)*	*5,95*	-
- UNAIDS	0,11	n.a.
- Other agencies working in the Health Sector		
Innovative Financing Mechanisms for Health (flows reported as ODA)		
- IFFIm	-	-
- AMCs	-	-
- Other	-	-
*Other multilateral institutions (imputed percentage for health **)*		
- UN System (e.g. UNICEF, UNDP, UNFPA, UNHCR etc.)	3,13	4
- World Bank	68,02	82
- Regional Development Banks	3,33	5

[57] As defined by DAC ": "A firm obligation, expressed in writing and backed by the necessary funds, undertaken by an official donor to provide specified assistance to a recipient country or a multilateral organisation".].

[58] Identifiable and traceable through the DAC-CRS online database, codes from 12110 to 12191
[59] Identifiable and traceable through the DAC-CRS online database, codes from 12220 to 12281
[60] Identifiable and traceable through the DAC-CRS online database, codes from 13010 to 13081
[61] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)
[62] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)
[63] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)

- Other multilateral institutions	-	-
- EC Budget	69,74	80
- European Development Fund (EDF)	48,83	56
General Budget Support, Bilateral (*imputed percentage for health*) *(Disbursements)*	8,06	5,89
Health-related Debt conversion discount (e.g. Debt2Health)	12,5	10
Other miscellaneous items	0,21	0,21
TOTAL AID TO HEALTH REPORTED AS ODA	741,6	977,1
TOTAL ODA (memo item)		

* Final data for 2008 will be provided in the second half of 2009 and the updated matrices published on the G8 Presidency website
** A common methodology of multilateral imputation for specific lines (UN System, MDBs, etc.) was identified, with the support of the DAC Secretariat.

B.1.2 – Other specific inputs to Global Health in Developing Countries

US$, millions

	2007	2008
Non-concessional lending and Other Official Flows to Health	n.a	
Research in health not reported as ODA	n.a	
UNITAID not reported as ODA (additional)	n.a.	
Multilaterals not included in DAC Annex 2 - (imputed percentage health)	n.a	
Health-related Debt conversion (non-ODA part)	12,5	10
IFFIm frontloading effect *[to be defined by IFFIm donors]*	n.a	
Other Technical Assistance not reported as ODA	n.a	
Other miscellaneous items	n.a	

B.1.3 Narrative explanation by each G8 member *(max. 2 pages)*

German development policy in the health sector aims to promote high-quality, equitably funded healthcare that is accessible to the entire population, that take a needs-driven approach to address the most serious health problems of the people, and that guarantees the rights of the poor and disadvantaged sections of the population to health. Healthcare which does not reach the poor and the disadvantaged, or which is not used by these groups, is not only at odds with human rights but is inefficient in macroeconomic terms. By reducing existing inequalities in access to health services and preventive measures, the health status of people living in developing countries can be improved overall.

The German government is endeavouring in particular to ensure improved access to health information and health services for women and girls. If they are to be effective, health information and health services must be aligned with the specific concerns of the target group in socio cultural terms. To ensure the sustainable success of activities, the German government encourages the health sector to network with other areas relevant for development, including education, nutrition and poverty reduction (multisectoral cooperation). Support is accorded in particular to projects and programmes which are based on participatory approaches and involve the target group in the planning, implementation and assessment of health measures. As well as national NGOs, self-help organisations and traditional care structures at local level should contribute to health planning. Increasingly, in recent years, the development-policy awareness of the private sector has increased along with the willingness to accept responsibility in this field. This is reflected in a number of public private partnership projects (PPPs).

German development policy in the health sector concentrates on horizontal programmes that are not dedicated to any one specific disease but which endeavour to improve healthcare across the board. Priority areas of support are:

- Health systems development
- Sexual and reproductive health and rights
- HIV/AIDS
- Establishing social health insurance schemes.

Section C: DISEASE OR SECTOR-SPECIFIC COUNTRY TABLES -GERMANY

Malaria

XIII. G8 Commitments:

- 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. (Heilingendamm, Africa Declaration, 55)

- As part of fulfilling our past commitments on malaria, we will continue to expand access to long-lasting insecticide treated nets, with a view to providing 100 million nets through bilateral and multilateral assistance, in partnership with other stakeholders by the end of 2010. (Hokkaido Toyako, 46d)

XIV. Inputs

	2007	2008	2009
Bilateral (Project and Budget Support)	see narrative below	see narrative below	see narrative below
Global Initiatives **GF:** **Other:**	GFATM: 29,75 Mio. $ (25% of 119 Mio.$)	GFATM: 72,0 Mio. $ (25% of 288 Mio.$)	GFATM: ca. 72,0 Mio. $ (25% of 288 Mio. $ - off. exchange rate not available, yet)
Multilateral (WB, UN, etc.)	n.a.	n.a.	n.a.
Research	n.a.	n.a.	n.a.

Footnotes and narrative to be provided by each G8 member (as needed)

Germany contributes to the fight against malaria mainly through the GFATM but also through bilateral health projects and programs. These programs are in most cases not solely focused on malaria and are therefore not reported to DAC as malaria measures.

Tuberculosis

I. G8 Commitment:

- One-third of the world's population is exposed to the risk of contracting TB, which claims about two million lives each year. In certain regions, it affects more people today than it did twenty years ago. We reaffirm the commitment we made at the Genoa Summit in 2001 to halt the spread of this disease. We will also support the Global Plan to Stop TB, 2006-2015, which aims to cut TB deaths in half by the year 2015 compared to 1990 levels, saving some 14 million lives over ten years, and call upon all donors and stakeholders to contribute to its effective implementation. (St. Petersburg, Fight Against Infectious Disease, 21).

- We note with concern the rate of HIV/AIDS and tuberculosis co-infection and seek to promote unified coordination for activities in this regard. (St. Petersburg, Fight Against Infectious Disease, 22).

II. Inputs from G8 (to be completed by each G8 member)

	2006	2007	2008	2009 -
Bilateral (Project and Budget Support)	see narrative below	see narrative below		
Global Initiatives GF: Other:	GFATM: 13.55 Mio. $ (15% of 90,37 Mio. $)	GFATM: 17,85 Mio. $ (15% of 119 Mio.$)	GFATM: 43,2 Mio $ (15% of 288 Mio. $)	GFATM: ca. 43,2 Mio $ (15% of 288 Mio. $ - off. exchange rate not available, yet)
Multilateral (WB, UN, etc.)	n.a.	n.a.	n.a.	n.a.
Research	n.a.	n.a.	n.a.	n.a.

Footnotes and narrative to be provided by each G8 member (as needed):

Germany contributes to the fight against TB mainly through the GFATM but also through bilateral health projects and programs, such as district health programs. These programs are not solely focused on TB and are therefore not reported to DAC as TB measures. Bilateral projects within the framework of financial cooperation are implemented in Kazakhstan, Uzbekistan, Tadzhikistan and Kirgizstan as well as in Armenia, Georgia and Azerbaijan. Within the past 10 years, Germany committed about 72 million USD for TB control in these countries. The majority of bilateral TB measures - within the framework of technical cooperation - are embedded in larger programs such as HIV/AIDS programs, Primary Health Care programs, national or district health programs etc.

HIV/AIDS

I. G8 Commitment:

- As an important step to scaling up towards the goal of universal access to HIV/AIDS prevention, treatment, care and support in Africa, G8 members, in support of national HIV/AIDS programs globally, individually and collectively over the next few years will aim to employ existing and additional programs to support life-saving anti-retroviral treatment through bilateral and multilateral efforts for approximately five million people, to prevent twenty-four million new infections, and to care for twenty-four million people including ten million orphans and vulnerable children. (Heilingendamm, Africa Declaration, 58)

- The G8 will take concrete steps to work toward improving the link between HIV/AIDS activities and sexual and reproductive health and voluntary family planning programs, to improve access to health care, including preventing mother-to-child transmission, and to achieve the Millennium Development Goals by adopting a multisectoral approach and by fostering community involvement and participation. (Heilingendamm, Africa Declaration, 53)

II. Inputs from G8 (to be completed by each G8 member)

	2007	2008	2009
Bilateral (Project and Budget Support)	117,87 Mio. $ (CRS)	n.a.	n.a.
Global Initiatives GFATM:	GFATM: 71,46 Mio. $ (60% of 119 Mio.)	GFATM: 172,8 Mio. $ (60% of 288 Mio.)	GFATM: ca. 172,8 Mio. $ (60% of 288 Mio. $ - off. exchange rate not available, yet)
Multilateral UNAIDS: World Bank/IDA: (WB, UN, etc.)	1,57 Mio. $ n.a.	2,52 Mio. $ n.a.	5,04 Mio. $ n.a.
Research	n.a.	n.a.	n.a.

Footnotes and narrative to be provided by each G8 member (as needed):

- The German government has greatly increased its commitments for the global fight against HIV/AIDS, malaria, tuberculosis and infectious tropical diseases and for the consequently necessary strengthening of health systems: Since 2002, the government has been providing average annual funding of more than 300 million Euro and further increased this amount to 400 million Euro in 2007.

IX. Outputs from G8 (to be completed by each G8 member)

G8 Country	**2008***	**2009**
Number of adults and children with advanced HIV infection receiving antiretroviral therapy	112.011	n.a.
Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission	18,789 plus 43.000 by bilateral programs	GFATM plus 43.000 by bilateral programs

**According to the German contribution to the GFATM (as submitted by GFATM in June '09).*

Health Systems Strengthening

VII. G8 Commitment:

- We will ensure our actions to strengthen health systems at national and local level and across all sectors since this is vital for long-term improvements in overall health, as we will encourage donors to help build health capacity (Gleaneagles, 18/c)

- We emphasize the importance of comprehensive approaches to address the strengthening of health systems including social protection, the improvement of maternal, newborn and child health, the scaling up of programs to counter infectious diseases and access to essential medicines, vaccines and appropriate health-related products. […] We underline the need for partner countries to work toward sustainable and equitable financing of health systems (Hokkaido Toyako, 46)

Narrative to be provided by each G8 member (as needed):

German bilateral aid for health is focused on health system strengthening based on a human rights approach. Currently health is a focus area of bilateral cooperation in 16 partner countries. Important fields of support are: organization and structure of health systems, capacity development for planning and management, infrastructure, sustainable and equitable financing (incl. social health protection), human resources for health as well as access to essential medicines.

In addition to bilateral programming Germany supports health system strengthening through its contributions to international organizations such as WHO, World Bank, UNICEF, UNAIDS, UNFPA , IPPF and within the specific context of the Global Fund to Fight AIDS, TB and Malaria.

Germany is a founding member and continuous supporter of the Providing for Health Initiative which aims at helping countries to expand social health protection. The Initiative became operational in 2008 (core group: France, Germany, Norway, WHO, ILO, World Bank).

Germany is an active member of the International Health Partnership+ formed between several developing countries, international health agencies and foundations, bilateral donors and other initiatives. IHP+ is aiming at accelerating progress to the health related MDGs through better coordination and harmonization among the different partners with a view to strengthen support to country-owned health sector strategies and their implementation. Participation of Germany in country level activities comprises Cambodia, Kenya, Nepal and Rwanda.

Health Workforce

I. G8 Commitment:

- The G8 members will work towards increasing health workforce coverage towards the WHO threshold of 2.3 health workers per 1000 people, initially in partnership with the African countries where we are currently engaged and that are experiencing a critical shortage of health workers. (Hokkaido Toyako, 46b)

II Inputs from G8 (to be completed by each G8 member)

	2008	2009 -
Bilateral (Project and Budget Support)	n.a.	n.a.
Global Initiatives	n.a	n.a.
Multilateral (WB, UN, etc.)	n.a	n.a.
Research	n.a.	n.a.

Footnotes and narrative to be provided by each G8 member (as needed):

Capacity development strategies are core elements of most supported activities in the health sector within the framework of German development aid. The German development agencies like GTZ, CIM, InWEnt or DED are strongly focusing on Capacity Development, TA aspects and knowledge transfer.

Measures to promote health workforce are seen as a key element of health system strengthening in general and form an integral part of health programs supported by German Development Cooperation. In Africa, health system strengthening including components related to health workforce is a focus area of bilateral cooperation with 7 countries[64]. Moreover, Germany offers professionals who were trained in Germany help with their reintegration upon return to their home country.

Germany strongly supported the implementation of the European Program of Action to address the Health workforce crisis and participated in the compilation of a report of the EU member states concerning their Health workforce related activities (2007/08).

[64] DR Congo, Guinea, Cameroon, Kenya, Malawi, Rwanda, Tanzania

Building on previous studies and evaluations Germany has undertaken in 2009 a study to explore further the scope and specific advantages of the different bilateral development instruments with regard to the promotion of human health work force.

In 2008/09 Germany started a dialogue with the Global Health Workforce Alliance with the aim to establish lines of cooperation.

Maternal, Newborn and Child Health

I. G8 Commitment:

- We will scale up efforts to reduce the gaps, in the area of maternal and child health care and voluntary family planning, an estimated US$ 1,5 billion (Heiligendamm, 50)

Narrative to be provided by each G8 member

Germany has undertaken to play an active part in achieving the goals agreed upon by the G 8 to step up the commitment to maternal and child health, family planning, preventing gender-based violence, linking HIV/AIDS, SRHR (Sexual and Reproductive Health and Rights) and gender equality. SRHR is a necessary prerequisite for achieving these goals. Therefore, German development cooperation works to promote SRHR through a human rights based and gender sensitive approach while also considering the complexity and causality of SRHR with other sectors through a multi sectoral approach.

In the area of maternal, newborn and child health and family planning, Germany promotes the following topics:

- For interventions in the area of sexual and reproductive health, young people are considered an important target group as they - in spite they are at special risk of contracting HIV or to face an early pregnancy - often visage restrictions in accessing information and services.

- Scaling up promotion and support of contraceptive choice, e.g. through social marketing interventions in more than 30 countries.

- Stepping up efforts to improve maternal health through promoting access to qualified family planning services, quality post-abortion care and counseling (if local laws allow), securing obstetric care by skilled midwives.

- In the response to AIDS not enough use has been made of the infrastructures already in place. German development cooperation works for linking sexual and reproductive health and rights with HIV/AIDS for improving synergies and work against fragmentation of services.

- Strengthening health systems and the promotion of social services is essential for all the above interventions and a prior area of Germany's development policy.

Since 1994, the Federal Ministry for Economic Cooperation and Development has allocated over 1

billion Euros for the implementation of the Cairo agenda. German development cooperation supports programs in health including in the area of SRHR and AIDS in about 15 countries. German development cooperation since 2001 supports prevention of mother-to-child transmission (PMTCT) and ensures provision of ART to HIV positive parents.

Neglected Tropical Diseases

XIII. G8 Commitment:

- We must also increase our efforts in the fight against other preventable diseases, including pneumonia, diarrhea and neglected diseases such as Leishmaniasis, Chagas disease and Onchocerciasis, particularly by increasing the volume and quality of medical research on neglected diseases in developing countries. (St. Petersburg, Fight Against Infectious Disease, 31).

- To build on our commitments made on neglected tropical diseases at St Petersburg, we will work to support the control or elimination of diseases listed by the WHO through such measures as research, diagnostics and treatment, prevention, awareness-raising and enhancing access to safe water and sanitation. In this regard, by expanding health system coverage, alleviating poverty and social exclusion as well as promoting adequate integrated public health approaches, including through the mass administration of drugs, we will be able to reach at least 75% of the people affected by certain major neglected tropical diseases in the most affected countries in Africa, Asia, and Latin America, bearing in mind the WHO Plan. (Hokkaido, Development and Africa, 46f)

XIV. Inputs from G8 (to be completed by each G8 member)

	2006	2007	2008	2009
Bilateral (Project and Budget Support)	see narrative below	see narrative below	see narrative below	
Global Initiatives	WHO-TDR: ca. 0,314 Mio. $	WHO-TDR: ca. 1,026 Mio. $	WHO-TDR: ca. 1,081 Mio. $	
Multilateral (WB, UN, etc.)				
Research			DNDI (Drugs for Neglected Disease Initiative): ca. 1,44 Mio. $	

Footnotes and narrative to be provided by each G8 member (as needed):

German contribution

The German Federal Ministry for Economic Cooperation and Development (BMZ) is supporting international institutions and initiatives against neglected tropical diseases in close coordination with

WHO (e.g. DNDI, the Drugs for Neglected Diseases Initiative). Germany has been contributing to multilateral aid mechanisms since over 30 years, in particular against onchocercosis. Since 1974, the German Government has been assisting the WHO Special Programme for Research and Training in Tropical Diseases (TDR). In total, 27,3 Mio Euro have been provided so far. Germany is also member of the TDR's Steering Committee.

In addition, the German Government supports the European and Developing Countries Clinical Trials Partnership (EDCTP) enabling European and African partner institutions to carry out clinical studies with the aim to develop drugs and vaccines against HIV/AIDS, Malaria, and Tuberculosis. The programme includes an investment of 600 Mio EUR (200 Mio. EUR from EU-Commission, 200 Mio. EUR from MS und 200 Mio EUR from other public and private sources. The German Government furthermore supports clinical studies through the European Clinical Research Infrastructures Network (ECRIN).

Tropical diseases are also addressed in the context of German bilateral aid in the health sector. There is evidence that integrated disease control as part of health systems strengthening approaches is highly effective, such as progress in filariasis control in Indonesia. In addition to integrated approaches, the German Government also supports targeted measures such as the provision of impregnated Mosquito nets in Malawi (1,5 Mio. EUR) und in Rwanda (1,3 Mio. EUR).

Section B: G8 GLOBAL HEALTH INVESTMENT COUNTRY TABLES – JAPAN

B.1 – Global Health Investment

B.1.1 – Aid to Health, reported as ODA to DAC (committments[65])

US$, millions

	2007 (final)	2008 (provisional data*)
Aid to Health, General *(also includes technical assistance and sector budget support/basket funds)*[66]	92.85	118.54
Aid to Basic Health *(also includes technical assistance and sector budget support/basket funds)*[67]	200.15	130.65
Aid to Population Policies/Programs and Reproductive Health)[68]	32.33	25.59
Core contributions to International NGOs working in the Health Sector (e.g. MSF, HAI, IPPF etc.) [69]	12.73	12.34
Core contributions to Public-Private Partnerships working in the Health Sector (e.g. GAIN, IAVI, UNITAID, etc.) [70]	-	-
Core contributions to the multilateral agencies working in the Health Sector[71]		
- Global Fund	183.84	194.43
- WHO (ODA part)	67.25	61.68

[65] As defined by DAC ": "A firm obligation, expressed in writing and backed by the necessary funds, undertaken by an official donor to provide specified assistance to a recipient country or a multilateral organisation".].

[66] Identifiable and traceable through the DAC-CRS online database, codes from 12110 to 12191
[67] Identifiable and traceable through the DAC-CRS online database, codes from 12220 to 12281
[68] Identifiable and traceable through the DAC-CRS online database, codes from 13010 to 13081
[69] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)
[70] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)
[71] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)

- GAVI Alliance	-	-
- UNAIDS	2.69	2.94
- Other agencies working in the Health Sector	-	-
Innovative Financing Mechanisms for Health (flows reported as ODA)		
- IFFIm	-	-
- AMCs	-	-
- Other	-	-
*Other multilateral institutions (imputed percentage for health **)*		
- UN System (e.g. UNICEF, UNDP, UNFPA, UNHCR etc.)[72]	109.14	122.61
- World Bank[72]	17.47	8.92
- Regional Development Banks[73]	5.71	0.40
- Other multilateral institutions[74]	58.55	20.59
- EC Budget ***	-	-
- European Development Fund (EDF) ***	-	-
General Budget Support, Bilateral (*imputed percentage for health*****)	-	-
Health-related Debt conversion discount (e.g. Debt2Health)	-	-
Other miscellaneous items[75]	59.49	[76]
TOTAL AID TO HEALTH REPORTED AS ODA	**842.20**	**698.69**
TOTAL ODA (memo item)		

* Final data for 2008 will be provided in the second half of 2009 and the updated matrices published on the G8 Presidency website
** A common methodology of multilateral imputation for specific lines (UN System, MDBs, etc.) was identified, with the support of the DAC Secretariat.

B.1.2 – Other specific inputs to Global Health in Developing Countries

US$, millions

	2007	2008
Non-concessional lending and Other Official Flows to Health	-	-

[72] The figures reflect funding provided through UNFPA, UNICEF, UNDP, FAO, UNESCO, WFP and UNHCR.
[72] The figures reflect funding provided through Policy and Human Resources Development Fund (PHRD) and Japan Social Development Fund (JSDF).
[73] The 2007 figure reflects funding provided through IDB special Oper Fund, JSF and JFPR, whereas 2008 figure reflects JSF only.
[74] The figures reflect funding provided through the UN Trust Fund for Human Security, OIE, and ICRC.
[75] The 2007 figure reflects aid to health as ODA.
[76] The figure is not available as of 25 June 2009.

Research in health not reported as ODA[77]	16.03	18.60
UNITAID not reported as ODA (additional)	-	-
Multilaterals not included in DAC Annex 2 - (imputed percentage health)	-	-
Health-related Debt conversion (non-ODA part)	-	-
IFFIm frontloading effect *[to be defined by IFFIm donors]*	-	-
Other Technical Assistance not reported as ODA	-	-
Other miscellaneous items	-	-

B.1.3 Narrative explanation by each G8 member *(max. 2 pages)*

1. Japan's basic policy on health

Japan's Official Development Assistance (ODA) has been implemented under the ODA Charter, which lays out the basic principles of Japan's aid policy. The Charter stipulates that the objectives of Japan's ODA are to contribute to the peace and development of the international community, and thereby to help ensure Japan's own security and prosperity. Building on the Charter, Japan has also put in place sector-specific policies. The current sectoral policy related to health is called the "Health and Development Initiative (HDI)," launched in 2005 to contribute to the achievement of health-related MDGs. The HDI encompasses not only health issues such as infectious diseases but also areas that reinforce the health sector such as basic education and water and sanitation. Japan's ODA in health is thus implemented both under the HDI as well as the ODA Charter.

The HDI acknowledges that the achievement of health MDGs is crucially important for making progress in all fronts of the MDGs as three out of the eight Goals are directly related to health, and proposes that Japan carry out the following activities to help achieve health-related MDGs in developing countries.

(1) Emphasizing a Human Security Perspective

Placing the focus on individuals, through provision of quality health services, Japan will support sustainable capacity development for individuals and local communities as a means of addressing their health problems.

(2) Cross-sectoral Approaches

In addition to directing support for efforts to address health-related issues, Japan will pursue a comprehensive approach, for example, by working to improve the health systems. Furthermore, Japan provides cross-sectoral support because progress in non-health sectors can often contribute to progress in the overall situation in the health sector.

(3) Collaboration and Coordination with International Development Partners

Japan will provide support with a view to enhancing South-South cooperation, in which developing countries share with their peers good practices—in this instance, practices they have

[77] The figures reflect funding provided through the Program of Founding Research Centers for Emerging and Reemerging Infectious Diseases organized by the Ministry of Education, Culture, Sports, Science and Technology. As of April 2008, the program has established a total of 12 overseas research centers in 8 countries (6 in Asia and 2 in Africa) with the participation of a total of 10 Japanese universities/institutions as partners. Research topics range from scientific studies to trainings and establishment of system to respond to emerging and reemerging diseases.

devised to tackle problems in the health sector. Collaborating with other donor agencies, Japan will continue to provide development assistance in a unified and consistent manner by sharing strategies and goals with them.

(4) Formulation of Assistance Programs in accordance with Local Needs of Developing Countries

Making certain that it first understands the priority needs of each developing country, Japan will formulate appropriate strategies and provide assistance effectively and efficiently. When developing countries have their own development programs relating to health, Japan will implement its assistance taking such programs fully into account.

(5) Strengthening Research Capacities in the Field and Implementation of Initiatives based on an understanding of the Local Context.

It is essential to fully understand each country's cultures and traditions as well as its social customs and practices in health care when providing assistance. Japan will make assistance available in a manner duly respectful of each country's practices and traditions.

Under the HDI, Japan pledged US$5 billion in assistance over the five years from FY 2005 to FY 2009. It provides health-related assistance throughout the world particularly in Asia and Africa, utilizing diverse assistance schemes, including bilateral aid and contributions to international organizations. Japan contributed approximately US$1.2 billion in FY 2005, US$1.9 billion in FY 2006 and US$1.4 billion in FY 2007. As of April 2009, its total contributions have considerably exceeded its initial pledge of US$5 billion.

2. Japan's Contribution on the Global Fund

Furthermore, in 2008 Japan announced an additional pledge of US$560 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), of which it disbursed US$194 million by March 2009. This puts the total amount of Japan's contribution disbursed to the GFATM at US$1.04 billion.

3. Japan's Contribution on Pandemic Influenza

Since the end of 2005, Japan has pledged and disbursed over US$300 million in response to pandemic influenza. Through its bilateral, regional and multilateral assistance, Japan supports developing countries for their pandemic preparedness and capacity development. Its contribution includes provision of 1.5 million courses of antiviral medicines for Asian countries, awareness raising campaigns through UNICEF and strengthening of the capacity of national laboratories in Viet-Nam.

Section C: DISEASE OR SECTOR-SPECIFIC COUNTRY TABLES – JAPAN

Malaria

XV. G8 Commitments:

- 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. (Heilingendamm, Africa Declaration, 55)

- As part of fulfilling our past commitments on malaria, we will continue to expand access to long-lasting insecticide treated nets, with a view to providing 100 million nets through bilateral and multilateral assistance, in partnership with other stakeholders by the end of 2010. (Hokkaido Toyako, 46d)

XVI. Inputs

US $, millions

	2007	2008	2009 -
Bilateral (Project and Budget Support)	24.73	16.93*	**
Global Initiatives GF: * Other:**	55.80	55.15	58.33
Multilateral (WB, UN, etc.)	4.87	**	**
Research	****	****	**

Footnotes and narrative to be provided by each G8 member (as needed)

*The figure reflects funding provided through grant aid assistance that has a component of malaria, but not technical cooperation and loan aid assistance as of 16 June 2009.

**The figures are not available as of 16 June 2009.

*** The proportional share for malaria: 30% (Source: Figure 13, pg 30, The Global Fund Results Report, 2008).

****Although the specific figure for research on malaria is not available, the Program of Founding Research Centers for Emerging and Reemerging Infectious Diseases includes malaria research (refer B.1.2).

Japan's basic strategy to fight malaria is to support interventions for prevention and education. Japan pledged to provide 10 million LLINs for African countries with serious malaria prevalence and fulfilled its commitment by the end of 2007. Japan will continue to work toward reducing prevalence and mortality rates in the partner countries through its contribution to GFATM and bilateral cooperation.

Amongst the assistance by JICA, Japan puts emphasis on the following approaches as essential ones that lead to the capacity building of the health workers and awareness raising of the affected communities: (1) Support to medical staff to obtain the ability of accurate diagnostic techniques and appropriate medication; and (2) Support to enhance activities at community level for participatory preventive actions.

Some of the good practices of the JICA's cooperation related to malaria are as follows:

- ✓ The Solomon Islands; necessary training and follow-up guidance to laboratory technicians and nurses were carried out so that appropriate diagnosis and care were provided. Data management and surveillance of health centers were also enhanced.
- ✓ Niger; preventive activities were promoted through community-based health committees. Various actions were taken, such as information dissemination on vector control, proper usage of preventive measures in the community. Together with the support of LLINs through grant aid, it is expected to bring greater impact in Niger.

The experience in the above countries will be utilized for the further malaria control cooperation which is planned to be extended to other affected countries mainly in Sub-Saharan Africa.

Tuberculosis

I. G8 Commitment:

- One-third of the world's population is exposed to the risk of contracting TB, which claims about two million lives each year. In certain regions, it affects more people today than it did twenty years ago. We reaffirm the commitment we made at the Genoa Summit in 2001 to halt the spread of this disease. We will also support the Global Plan to Stop TB, 2006-2015, which aims to cut TB deaths in half by the year 2015 compared to 1990 levels, saving some 14 million lives over ten years, and call upon all donors and stakeholders to contribute to its effective implementation. (St. Petersburg, Fight Against Infectious Disease, 21).

- We note with concern the rate of HIV/AIDS and tuberculosis co-infection and seek to promote unified coordination for activities in this regard. (St. Petersburg, Fight Against Infectious Disease, 22).

II. Inputs from G8 (to be completed by each G8 member)

US $, millions

	2006	2007	2008	2009 -
Bilateral (Project and Budget Support)	8.80	6.63	5.08*	**
Global Initiatives GF: * Other:**	20.82	29.76	29.42	31.11
Multilateral (WB, UN, etc.)	8.78	5.84	**	**
Research	-	****	****	**

Footnotes and narrative to be provided by each G8 member (as needed):

*The figure reflects funding provided through grant aid assistance that has a component of TB, but not technical cooperation and loan aid assistance as of 16 June 2009.

**The figures are not available as of 16 June 2009.

*** The proportional share for TB: 16% (Source: Figure 13, pg 30, The Global Fund Results Report, 2008).

****Although the specific figure for research on TB is not available, the Program of Founding Research Centers for Emerging and Reemerging Infectious Diseases includes TB research (refer B.1.2).

Japan has long been involved in the global fight against TB by contributing its rich knowledge and experience of its own fight against the serious epidemics in the post WWII era. Echoing the Global Plan to Stop TB 2006-2015, in July 2008, Stop TB Japan Action Plan was launched as a result of close

collaboration between the government and private sectors which has been established at national level. The Government of Japan will work closely with the international community mainly through its contribution to GFATM as well as its bilateral cooperation with partner countries.

For its bilateral assistance, the Government of Japan has been prioritizing the 22 high TB burden countries identified by WHO for its support through JICA. The importance of tackling MDR/XDR-TB and TB/HIV co-infection has also been taken into account in delivering assistance.

JICA has been extending its support to these countries to improve their TB control services particularly by expanding DOTS through institutional capacity building, system strengthening and human resource development.

Some of the good practices of the JICA's assistance related to TB are as follows,

- ✓ Indonesia; initiated a project to establish an EQA (external quality assurance) network for sputum examinations.
- ✓ Cambodia; support the national efforts to promote DOTS for last 10 years, the post civil war era of undertaking the nation's reconstruction and development.
- ✓ Afghanistan; help to develop capacity of the NTP (National TB Program) and conduct a training for TB officers and service providers for the last five years, hence contributing to expansion of the national TB control services. JICA will continue its support to the country for the next 5 years to achieve quality TB control services through the STOP TB strategy managed by NTP nationwide.
- ✓ Egypt and Nigeria respectively; support training programs to tackle the problems of TB/HIV co-infection, providing training opportunities for health professionals of African nations.

HIV/AIDS

I. G8 Commitment:

- As an important step to scaling up towards the goal of universal access to HIV/AIDS prevention, treatment, care and support in Africa, G8 members, in support of national HIV/AIDS programs globally, individually and collectively over the next few years will aim to employ existing and additional programs to support life-saving anti-retroviral treatment through bilateral and multilateral efforts for approximately five million people, to prevent twenty-four million new infections, and to care for twenty-four million people including ten million orphans and vulnerable children. (Heilingendamm, Africa Declaration, 58)

- The G8 will take concrete steps to work toward improving the link between HIV/AIDS activities and sexual and reproductive health and voluntary family planning programs, to improve access to health care, including preventing mother-to-child transmission, and to achieve the Millennium Development Goals by adopting a multisectoral approach and by fostering community involvement and participation. (Heilingendamm, Africa Declaration, 53)

II. Inputs from G8 (to be completed by each G8 member)

US $, millions

	2007	2008	2009 -
Bilateral (Project and Budget Support)	22.74	6.20*	**
Global Initiatives GF: * Other:**	100.44	99.28	104.99
Multilateral (WB, UN, etc.)	12.45	**	**
Research	****	****	**

Footnotes and narrative to be provided by each G8 member (as needed):

*The figure reflects funding provided through grant aid assistance that has a component of HIV/AIDS, but not technical cooperation and loan aid assistance as of 16 June 2009.

**The figures are not available as of 16 June 2009.

*** The proportional share for AIDS: 54% (Source: Figure 13, pg 30, The Global Fund Results Report, 2008).

****Although the specific figure for research on HIV/AIDS is not available, the Program of Founding Research Centers for Emerging and Reemerging Infectious Diseases includes HIV/AIDS research (refer B.1.2).

Japan is committed to contribute to the global effort to achieve the universal access for HIV/AIDS prevention, treatment and care program. Japan extends such contribution through its cooperation

with international organizations, including GFATM and NGOs as well as through its bilateral assistance to the national HIV/AIDS programs in partner countries. Japan puts the emphasis on comprehensive approach to be conducted along with maternal, newborn and child health and health systems strengthening, in order to strive for the fight against HIV/AIDS.

Prevention through promotion of CT (counseling and testing) services, and awareness raising and education have been focuses of Japan's bilateral assistance. For instance, JICA dispatches a good number of volunteers to conduct awareness raising activities and to provide preventive education including behavior change communication at community levels.

With regard to treatment of HIV/AIDS, Japan, through JICA, promotes mobile CT and ART (Anti-retrovirus treatment) services, especially for hard - to - reach populations. JICA is undertaking its programs particularly in the areas with high rates of the HIV infection such as Eastern and Southern Africa.

Some of the good practices of the JICA's cooperation related to HIV/AIDS are as follows:

- ✓ Kenya, Tanzania, and Zambia; support their national programs to develop M&E (monitoring and evaluation) tools, to organize a system of preventive education for youth, and to create models of mobile ART.
- ✓ Zambia; continue to help extend the mobile ART service model, in programmatic coordination with the funding support from the Global Fund.
- ✓ Namibia and several other countries in Southern African region; provide training in M&E.
- ✓ Botswana; assist district AIDS teams to develop their capacity.
- ✓ The Republic of South Africa; support the national endeavors to establish M&E system for home-based patient care.
- ✓ Zimbabwe; worked to develop human resources in line with the National Guideline for Prevention of Mother-to-Child Transmission, and made remarkable results.
- ✓ Ghana, Madagascar, and Senegal; work to help maintain the low infection rates at present. Main area of assistance in these countries is the strengthening of prevention measures such as prevention education for youth and improvement of CT guidelines.

Japan has been taking into consideration of providing HIV/AIDS prevention activities in large infrastructure construction projects. Since 2007, JICA programs its assistance of infrastructure development by HIV/AIDS prevention components for construction workers. This approach has been taken in some 20 large construction projects, mainly in Asia.

X. Outputs from G8 (to be completed by each G8 member)

G8 Country	**2008**	**2009**
Number of adults and children with advanced HIV infection receiving antiretroviral therapy	36,668†	*
Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission	19,426†	*

†The figures were calculated based on the cumulative data given by the Global Fund.

*The figures are not available as of 16 June 2009.

Health Systems Strengthening

VIII. G8 Commitment:

- We will ensure our actions to strengthen health systems at national and local level and across all sectors since this is vital for long-term improvements in overall health, as we will encourage donors to help build health capacity (Gleaneagles, 18/c)

- We emphasize the importance of comprehensive approaches to address the strengthening of health systems including social protection, the improvement of maternal, newborn and child health, the scaling up of programs to counter infectious diseases and access to essential medicines, vaccines and appropriate health-related products. […] We underline the need for partner countries to work toward sustainable and equitable financing of health systems (Hokkaido Toyako, 46)

Narrative to be provided by each G8 member (as needed):

Recognizing that sound health systems are the basis of all interventions toward achieving health related MDGs. Government of Japan places health systems strengthening as one of the main pillars of the Japan's health aid policy.

As a follow-up of G8 Hokkaido Toyako Summit, Japan will continue to contribute to stepping up the international efforts on health systems strengthening especially its workforce, finance and information components, taking into account "Global Action for Health System Strengthening – Policy Recommendation to the G8" which reflects the discussion of international opinion leaders in the field of health.

In implementing its bilateral assistances through JICA, Japan aims at sustainable and institutional capacity development of the health systems and focuses on following approaches;

(1) Efforts to directly strengthen health systems (e.g. capacity building of local administration, strengthening referral systems, enhancement of community health, human resources development, improvement of health information systems); and (2) Support for national programs or vertical programs such as infectious disease control and maternal and child health with the perspective of

health systems strengthening.

JICA's technical cooperation is often carried out in a synergistic manner with not only the Japan's grant aid and loan projects, but also other international health programs such as GFATM for expansion of outcomes and impacts.

-Service Delivery

- ✓ Concerning health infrastructure development and medical equipment procurement, JICA implement preparatory study for Japan's Grant Aid projects, for example, for Albania, the Philippines, Burundi, Zambia, Tonga, Uganda, Vietnam.
- ✓ Improvement of hospital management capacity and service quality by introducing 5S-TQM (Total Quality Management) in 15 African countries.
- ✓ Capacity development of hospital managers, health service providers by training programs in Japan and in the third countries.

-Human Resources

- ✓ Various projects of human resources development are under implementation in the areas such as initial education, continuous education, and training of health volunteers. In some countries JICA supported these simultaneously. Technical cooperation project for South Sudan started in 2009.

-Health Information

- ✓ Focuses on support for HMIS (facility-base routine information systems), for example, cooperation for Pakistan.
- ✓ Strengthen the capacity of practical use of information for evidence-based management, for example, projects being implemented in Tanzania, the Philippines.

-Medical Products, etc.

- ✓ The equipment procurement support (drug, vaccines, bed nets, etc.) expands their effects synergistically with technical cooperation projects.
- ✓ Technical cooperation for maintenance and management of medical equipment for Eritrea, Cambodia, Burundi, Uganda, Malawi.

-Financing

- ✓ Health Policy Advisors to the Ministry of Health advice on budget planning and implementation, for example in Afghanistan.
- ✓ Project facilitated Health Insurance enrollment, for example, in the Philippines.

-Leadership and Governance

- ✓ Health policy advisers to the Ministry of Health and Projects, urban health systems designing in Afghanistan, capacity development of local health administration in Tanzania, development of referral systems in Bolivia and Vietnam, etc.
- ✓ JICA projects promote the bottom-up approach which allows the on-site experiences and lessons to be reflected in the system and policy.

Health Workforce

I. G8 Commitment:

- The G8 members will work towards increasing health workforce coverage towards the WHO threshold of 2.3 health workers per 1000 people, initially in partnership with the African countries where we are currently engaged and that are experiencing a critical shortage of health workers. (Hokkaido Toyako, 46b)

II Inputs from G8 (to be completed by each G8 member)

US $, millions

	2008	2009 -
Bilateral (Project and Budget Support)	3.48*	**
Global Initiatives	-	-
Multilateral (WB, UN, etc.)	**	**
Research	***	**

Footnotes and narrative to be provided by each G8 member (as needed):

* The figure reflects funding provided through grant aid assistance that has a component of human resource development, but not technical cooperation and loan aid assistance as of 25 June 2009.

**The figures are not available as of 16 June 2009..

***Although the specific figure for research on health workforce is not available, the Program of Founding Research b Centers for Emerging and Reemerging Infectious Diseases includes component of human resource development (refer B.1.2).

Strengthening the health workforce is one of the key elements to improve health status of the population in developing countries and also to achieve health related MDGs. In fact, Japan pledged to train one hundred thousand people in Africa over the next five years as health workers at the fourth Tokyo International Conference on African Development (TICAD IV).

In this regard, Japan's assistance through JICA is based on following approaches, stated in the report of the G8 Health Experts Group last year: (1) To increase the number of skilled health workers; (2) To promote capacity-building for health workers in central/local health centers, and also to empower health workers (including volunteers) in the field; (3) To secure well-being and vitality of

health workers and to promote their retention; and (4) To promote assistance for strengthening planning for human resources development and equitable distribution of health workers.

Examples of cooperation related to health workforce are as follows, being categorized in correspondence with the above-mentioned approaches.

- (1) Increasing the number of skilled health workers
  - ✓ Assistance to pre-service education for human resources for health in Cambodia
  - ✓ Assistance to pre-service education for nurses in Central America
  - ✓ Assistance to pre-service education for nurses in Uzbekistan
  - ✓ Assistance to pre-service education for human resources for health in Mozambique
- (2) Promoting capacity-building for health workers in central/local health centers etc.
  - ✓ Strengthening of in-service training capacity for nurses and midwives in Paraguay
  - ✓ Strengthening of in-service training capacity for local nurses in Pacific Islands
  - ✓ Strengthening of in-service training capacity of hospitals in Vietnam

- (3) Securing well-being and vitality of health workers and promoting their retention
  - ✓ Strengthening of management of health infrastructure, especially medical equipment, in Cambodia
  - ✓ Strengthening of management of health infrastructure, especially medical equipment, in Eritrea

- (4) Promoting assistance for strengthening planning for human resources development etc.
  - ✓ Strengthening of training system for basic health staff in Myanmar
  - ✓ Development of human resources for health in Sudan
  - ✓ Strengthening of the administration for human resources for health in Bangladesh

- Cooperation using several approaches
  - ✓ Development of human resources for nurses and midwives in Laos (above (1) and (4))
  - ✓ Improvement of the quality of human resources for health in Vietnam (above (2) and (4))

Maternal, Newborn and Child Health

I. G8 Commitment:

- We will scale up efforts to reduce the gaps, in the area of maternal and child health care and voluntary family planning, an estimated US$ 1,5 billion (Heiligendamm, 50)

Narrative to be provided by each G8 member

Maternal, newborn and child health (MNCH) has been a focus of Japan's health aid policy with a view of contributing to MDGs 4 and 5. Japan places emphasis on the cooperation with international organizations such as UNICEF and UNFPA in this filed.

Bilateral assistances through JICA is based on the following approaches: (1) Continuum of Care: Improve continuum care of ante/post deliveries for women in pregnancy and MCH services (ex. EPI, nutrition, growth monitoring) for neonatal and infant care; (2) Collaboration between public health sector and community: Improve the quality of public health services and access to such services for local residents; (3) Delivery attended by Skilled Birth Attendant (SBA) at community level: Ensure the attendance at births by SBA and promote collaborative working environment among SBA, Traditional Birth Attendant (TBA) and other key stakeholders; and (4) School Health: Support health activities at school to improve nutrition and health status of school-aged children.

Examples of JICA's cooperation related to MNCH which were started recently are as follows.

✓ Enhancing capacity building of village midwives who implement health services at communities through pre-service and in-service training in North Sudan

✓ Promoting participatory community-based activities to reduce under-nutrition and to enhance the management role of health administration, capacity development of health workers in Ethiopia

✓ Scaling up the utilization of Maternal and Child Health Handbook as an effective tool to secure Continuum of care in Palestine.

✓ School health promotion activities through training for teachers in Egypt

Further efforts are made in the following countries for achieving quality health care for women and children: Afghanistan, Bangladesh, Benin, Bhutan, Bolivia, Cambodia, China, Ghana, Guatemala, Honduras, India, Indonesia, Kazakhstan, Lao People's Democratic Republic, Liberia, Madagascar, Malawi, Mongolia, Mozambique, Morocco, Myanmar, Nepal, Nicaragua, Pakistan, Philippines, Senegal, Syrian Arab Republic, Tajikistan, Uganda, Vietnam, Yemen, Zambia, including a regional project on EPI for 13 Pacific Islands, which are Cook Islands, Fiji Islands, Kiribati, Marshall Islands, Micronesia, Niue, Nauru, Palau, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.

Neglected Tropical Diseases

XV. G8 Commitment:

- We must also increase our efforts in the fight against other preventable diseases, including pneumonia, diarrhea and neglected diseases such as Leishmaniasis, Chagas disease and Onchocerciasis, particularly by increasing the volume and quality of medical research on neglected diseases in developing countries. (St. Petersburg, Fight Against Infectious Disease, 31).

- To build on our commitments made on neglected tropical diseases at St Petersburg, we will work to support the control or elimination of diseases listed by the WHO through such measures as research, diagnostics and treatment, prevention, awareness-raising and enhancing access to safe water and sanitation. In this regard, by expanding health system coverage, alleviating poverty and social exclusion as well as promoting adequate integrated public health approaches, including through the mass administration of drugs, we will be able to reach at least 75% of the people affected by certain major neglected tropical diseases in the most affected countries in Africa, Asia, and Latin America, bearing in mind the WHO Plan. (Hokkaido, Development and Africa, 46f)

XVI. Inputs from G8 (to be completed by each G8 member)

US $, millions

	2006	2007	2008	2009
Bilateral (Project and Budget Support)	8.33	4.03	1.58*	**
Global Initiatives	-	-	-	-
Multilateral (WB, UN, etc.)	0.15	0.00	**	**
Research	-	***	***	**

Footnotes and narrative to be provided by each G8 member (as needed):

*The figure reflects funding provided through grant aid assistance that has a component of NTD, but not technical cooperation and loan aid assistance as of 16 June 2009.

**The figures are not available as of 16 June 2009..

***Although the specific figure for research on NTD is not available, the Program of Founding Research Centers for Emerging and Reemerging Infectious Diseases includes NTD research (refer B.1.2).

Under the Japanese Government Initiative on International Parasite Control (Hashimoto

Initiative), triggered by G8 Birmingham Summit in 1998, JICA helped partner countries to establish the Centers for International Parasite Control in Asia, East Africa and West Africa. At these Centers and the neighboring countries, parasite control programs against schistosomiasis and soil transmitted helminthiasis have been steadily expanded.

As part of these programs, parasite control through school health activities has started to make results in Niger. School health and preventive education against NTDs have been widely extended by the Japanese volunteers, and they are also making results.

JICA's contribution was also accredited for interruption of new transmission of imported-vector-borne Chagas disease in Guatemala, which was certified by PAHO (Pan American Health Organization) in November 2008.

Similar efforts to tackle the disease have been made in Honduras, El Salvador, and Nicaragua. At the International Conference on the 4 Initiatives to combat Chagas disease in Central and South Americas in April 2008, JICA presented the results of its past efforts and its future plans, and obtained much appreciation from the national governments, relavant international organizations, donor organizations and research institutions.

In addition, we also support Pacific Programme to Eliminate Lymphatic Filariasis by means of providing drugs and consumables, and Ghana's efforts to combat Guinea Worms by providing assistance to secure safe drinking water in rural areas.

Section B: G8 GLOBAL HEALTH INVESTMENT COUNTRY TABLES – EC

B.1 – Global Health Investment

B.1.1 – Aid to Health, reported as ODA to DAC (committments[78])

US$, millions

	2007 (final)	2008 (provisional data*)
Aid to Health, General *(also includes technical assistance and sector budget support/basket funds)*[79]	113	156
Aid to Basic Health *(also includes technical assistance and sector budget support/basket funds)*[80]	352	244
Aid to Population Policies/Programs and Reproductive Health)[81]	90	147
Core contributions to International NGOs working in the Health Sector (e.g. MSF, HAI, IPPF etc.) [82]		
Core contributions to Public-Private Partnerships working in the Health Sector (e.g. GAIN, IAVI, UNITAID, etc.) [83]		
Core contributions to the multilateral agencies working in the Health Sector[84]		
- Global Fund	137	288
- WHO (ODA part)		
- GAVI Alliance		14
- UNAIDS		

[78] As defined by DAC ": "A firm obligation, expressed in writing and backed by the necessary funds, undertaken by an official donor to provide specified assistance to a recipient country or a multilateral organisation".].

[79] Identifiable and traceable through the DAC-CRS online database, codes from 12110 to 12191
[80] Identifiable and traceable through the DAC-CRS online database, codes from 12220 to 12281
[81] Identifiable and traceable through the DAC-CRS online database, codes from 13010 to 13081
[82] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)
[83] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)
[84] Identifiable and traceable through the DAC-CRS online database (DAC will provide exact reference)

- Other agencies working in the Health Sector		
Innovative Financing Mechanisms for Health (flows reported as ODA)		
- IFFIm		
- AMCs		
- Other		
Other multilateral institutions (imputed percentage for health **)		
- UN System (e.g. UNICEF, UNDP, UNFPA, UNHCR etc.)		
- World Bank		
- Regional Development Banks		
- Other multilateral institutions		
General Budget Support, Bilateral (*imputed percentage for health****)		
Health-related Debt conversion discount (e.g. Debt2Health)		
Other miscellaneous items		
TOTAL AID TO HEALTH REPORTED AS ODA	**692**	**849**
TOTAL ODA (memo item)	13630	17329

* Final data for 2008 will be provided in the second half of 2009 and the updated matrices published on the G8 Presidency website
** A common methodology of multilateral imputation for specific lines (UN System, MDBs, etc.) was identified, with the support of the DAC Secretariat.
*** A common methodology of bilateral and multilateral imputation for General Budget Support and other flows not included in DAC CRS was identified (health expenditure ratios by recipient countries)

B.1.2 – Other specific inputs to Global Health in Developing Countries

As discussed in the G8 Health expert Working group the European Commission will not report on non-ODA spending for health

B.1.3 Narrative explanation by each G8 member *(max. 2 pages)*

This table shows the EC direct contribution to supporting health in developing countries, as they are communicated to OECD DAC.

The European Commission, following Paris principles and commitments renewed in the Accra Agenda for action, is moving more and more away from project or ear marked financing towards general budget support modalities.

As there is not, until now, an internationally agreed and robust methodology to attribute to a given sector a proportion of the GBS, the EC is providing only the total amounts of its GBS to developing countries.

	2007	2008
EC General Budget support (MUS$)	955	3435

In addition it should be recognized that the EU agreed division of labor approach calls for Members states and the EC to focus on their respective areas of strength in their support to each country, in coordination and complementarity.

NB : on June12th, we are still waiting for data from DG Research on their commitment to Developing countries related health research in 2008 and 2009. (Programmed funding was in the order of 100 M€).

Section C: DISEASE OR SECTOR-SPECIFIC COUNTRY TABLES- EC

Malaria

I. G8 Commitments:

- 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. (Heilingendamm, Africa Declaration, 55)

- As part of fulfilling our past commitments on malaria, we will continue to expand access to long-lasting insecticide treated nets, with a view to providing 100 million nets through bilateral and multilateral assistance, in partnership with other stakeholders by the end of 2010. (Hokkaido Toyako, 46d)

Tuberculosis

I. G8 Commitment:

- One-third of the world's population is exposed to the risk of contracting TB, which claims about two million lives each year. In certain regions, it affects more people today than it did twenty years ago. We reaffirm the commitment we made at the Genoa Summit in 2001 to halt the spread of this disease. We will also support the Global Plan to Stop TB, 2006-2015, which aims to cut TB deaths in half by the year 2015 compared to 1990 levels, saving some 14 million lives over ten years, and call upon all donors and stakeholders to contribute to its effective implementation. (St. Petersburg, Fight Against Infectious Disease, 21).

- We note with concern the rate of HIV/AIDS and tuberculosis co-infection and seek to promote unified coordination for activities in this regard. (St. Petersburg, Fight Against Infectious Disease, 22).

HIV/AIDS

I. G8 Commitment:

- As an important step to scaling up towards the goal of universal access to HIV/AIDS prevention, treatment, care and support in Africa, G8 members, in support of national HIV/AIDS programs globally, individually and collectively over the next few years will aim to employ existing and additional programs to support life-saving anti-retroviral treatment through bilateral and multilateral efforts for approximately five million people, to prevent twenty-four million new infections, and to care for twenty-four million people including ten million orphans and vulnerable children. (Heilingendamm, Africa Declaration, 58)

- The G8 will take concrete steps to work toward improving the link between HIV/AIDS activities and sexual and reproductive health and voluntary family planning programs, to improve access to health care, including preventing mother-to-child transmission, and to achieve the Millennium Development Goals by adopting a multisectoral approach and by fostering community involvement and participation. (Heilingendamm, Africa Declaration, 53)

II. Inputs from G8 (to be completed by each G8 member) Million US dollars, for the 3 diseases

	2007	2008	2009 -
Bilateral (Project and Budget Support)	11	53	
Global Initiatives GF: Other:	137	288	
Multilateral (WB, UN, etc.)			
Research	137 (programmed)	144 (programmed)	

Specific financing related to HIV/AIDS, TB and malaria, from the European Commission is mainly channeled through the GFATM, which does not allow for ear marking to one specific disease. Data on

commitments for AIDS, TB and malaria research in 2008 are not available yet.

XI. Outputs from G8 (to be completed by each G8 member)

G8 Country	**2008**	**2009**
Number of adults and children with advanced HIV infection receiving antiretroviral therapy		
Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission		

Health Systems Strengthening

IX. G8 Commitment:

- We will ensure our actions to strengthen health systems at national and local level and across all sectors since this is vital for long-term improvements in overall health, as we will encourage donors to help build health capacity (Gleaneagles, 18/c)

- We emphasize the importance of comprehensive approaches to address the strengthening of health systems including social protection, the improvement of maternal, newborn and child health, the scaling up of programs to counter infectious diseases and access to essential medicines, vaccines and appropriate health-related products. […] We underline the need for partner countries to work toward sustainable and equitable financing of health systems (Hokkaido Toyako, 46)

Narrative explanation by each G8 member:

The European Commission main channel for strengthening health system is through its support to national budget, either general or sectoral. Except for some projects it is not in the spirit of our approach, and in the capacity of our system to identify and/or to attribute funding to specific blocks of the health systems (human resources, drugs procurement and distribution, health financing…).

This is why in the next tables EC mention only the financing directly attributed to these activities, run by IOs or international NGOs (WHO, UNIFEM, IPPF,..) at global or regional level.

Health Workforce

I. G8 Commitment:

- The G8 members will work towards increasing health workforce coverage towards the WHO threshold of 2.3 health workers per 1000 people, initially in partnership with the African countries where we are currently engaged and that are experiencing a critical shortage of health workers. (Hokkaido Toyako, 46b)

II Inputs from G8 (to be completed by each G8 member)

	2008	2009 -
Bilateral (Project and Budget Support)		**Programmed :** 6.5 million € (2009) + 8 million € (2010) – call for proposals: 'Engaging civil society organizations to support national health workforce policies, strategies, capacity building and skills transfer'
Global Initiatives		
Multilateral (WB, UN, etc.)	6 million € to WHO/GHWA – Health workforce observatory	
Research		

EXPLANATORY NOTE

1) COMPARABILITY WITH TOYAKO FRAMEWORK MATRICES: This year's matrices originate from a process of improvement of the transparency and user-friendliness of the existing templates annexed to the Toyako Framework for Action on Global Health (available at http://www.mofa.go.jp/policy/economy/summit/2008/doc/pdf/0708_09_02_en.pdf).

In addition to disease-specific and sector-specific tables which assess progress against G8 commitments (Section C), a cumulative Table to assess G8 contribution to Global Health was issued (Section A), resulting from the addition of separate country tables (Section B), which apply the same methodology and resulting therefore comparable.
For purposes of transparency, Country Tables in Section B are divided into two main sections: Aid to Health reported as ODA to DAC, and other specific inputs to Global Health.
Moreover, specific tables were added in order to highlight collective and individual progress against achieving quantifiable outputs, namely in the fields of malaria and HIV-AIDS.

Differences in the methodology applied may create problems of comparability, when comparing the 2009 matrices to last year's.
Other differences consist of the use of the US dollar as a common currency; the introduction of an agreed exchange rate; the use of current US dollars as opposed to 2006 base year; the identification of the nature of G8 "inputs" (commitments as defined by DAC).

Finally, while amounts in Tables B are reflected in cumulative Tables A, the group of Tables C (reflecting specific G8 commitments) cannot be compared with Tables B (being only a piece of a broader picture). Nor can they be summed up to achieve B as a total, as other flows (e.g. HSS) are not included.

2) CURRENCY: it was agreed to use as a common measure the US dollar

3) EXCHANGE RATE: the existing DAC rate which is issued in January every year

4) NOMINAL AMOUNTS: US DOLLARS: it was agreed to use current US dollars

5) NATURE OF FLOWS

> Past flows (including 2008) are equal to commitments as defined by DAC
> Future flows (from 2009 onwards) include pledges/binding commitments/appropriations

6) CALENDAR ISSUES: Countries that work on a fiscal year that does not match with the calendar year (Japan, US,) could use the same methodology they already use in proving

statistics to international organizations (OECD, IMF etc). As was done last year, Canada will report on a fiscal year basis (which is the basis for Canadian commitments). Fiscal Year 2008-09 = CY 2008.

7) Final data for 2008 will be provided in the second half of 2009 and the updated matrices published on the G8 Presidency website.