

// EUROPEAN ALLIANCE AGAINST **MALARIA**
Working for a malaria-free world



MALARIA AND THE G8

Leading or Lagging ?

July 2009



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List of acronyms

| | |
|----------|---|
| ACT | Artemisinin-based combination therapy |
| AMFm | Affordable Medicines Facility for malaria |
| BMGF | Bill and Melinda Gates Foundation |
| BMZ | German Federal Ministry for Economic Cooperation & Development |
| CAN | Canadian |
| CIDA | Canadian International Development Agency |
| DAC | Development Assistance Committee |
| DFID | Department for International Development , UK |
| DSW | German Foundation for World Population |
| EAAM | European Alliance Against Malaria |
| EC | European Commission |
| EDCTP | European and Developing Countries Clinical Trials Partnership |
| EU | European Union |
| EUR | Euro |
| FP | Framework Programme |
| FY | Fiscal Year |
| G8 | Group of Eight |
| GDP | Gross Domestic Product |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GMAP | Global Malaria Action Plan |
| GNI | Gross National Income |
| HIV/AIDS | Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome |
| HSS | Health Systems Strengthening |
| IDA | International Development Assistance |
| ITN | Insecticide Treated Net |
| IPTp | Intermittent Preventive Treatment in pregnancy |
| IRS | Indoor Residual Spraying |
| JASA | Japan AIDS and Society Association |
| JPY | Japanese Yen |
| LLIN(s) | Long lasting Insecticidal Net(s) |
| MDG(s) | Millennium Development Goal(s) |
| MFA | The Italian Ministry of Foreign Affairs |
| MMV | Medicines for Malaria Venture |
| MOFA | Ministry of Foreign Affairs, Japan |
| MRC | Medical Research Council |
| NGO | Non-Governmental Organisation |
| ODA | Official Development Assistance |
| OECD | Organization for Economic Co-operation and Development |
| PMI | President's Malaria Initiative |
| RBM | Roll Back Malaria |
| TB | Tuberculosis |
| TDR | UNICEF/UNDP/World Bank/WHO Special Programme for Research & Training in Tropical Diseases |
| TICAD | Tokyo International Conference on African Development |
| UN | United Nations |
| UNDP | UN Development Programme |
| UNICEF | UN Children's Fund |
| WB | World Bank |
| WHO | World Health Organization |
| WHO-AFRO | WHO-Africa Region |
| WHO-CDS | WHO- Communicable Diseases |
| WHO-GMP | WHO-Global Malaria Programme |

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1. Introduction

The Group of Eight (G8) is an informal but exclusive body, created in 1975, for governments of eight leading industrialized nations: Canada, France, Germany, Italy, Japan, Russia, the United Kingdom, and the United States. In addition, the European Union is represented within the G8, but cannot host or chair. The annual G8 leaders' summit is attended by the eight heads of government, and discusses a range of sometimes inter-related issues which include health, economic and social development, energy, environment and trade. The G8 summit sets the stage for what needs to be done in terms of policies and objectives and establishes an idea of how to do it, although compliance is voluntary.

Malaria remains one of the most deadly diseases, with 40% of the world's population at risk. In 2006, there were an estimated 247 million malaria cases, causing nearly a million deaths¹. Most of the deaths are amongst children under five who, together with pregnant women, are particularly vulnerable. South and Central America, South and East Asia, the Caribbean, Oceania, Central Asia and the Middle East are all affected by malaria, but Africa, where it is estimated that 90% of all malaria deaths occur, remains the hardest hit. Not only does the disease cause significant morbidity and mortality but the economic burden caused by malaria is estimated to cost Africa US\$ 12 billion in lost Gross Domestic Product (GDP). It is estimated to have slowed economic growth in Africa by 1.3% per year as a result of lost life and lower productivity². However, although a vaccine is not yet available, there are inexpensive and effective tools and methods available to combat malaria. The tools are Long-lasting Insecticidal Nets (LLINs) supported by Indoor Residual Spraying (IRS) and Intermittent Preventive Treatment in pregnancy (IPTp) for prevention of the disease and Artemisinin-based Combination Therapy (ACT) to treat it. The actual benefit achieved from these tools depends heavily on the capacity and systems to use them.

The fight against infectious diseases and the strengthening of health systems in developing countries have been long-standing priorities of the G8 countries. These issues have gained greater prominence and urgency since the adoption of the Millennium Development Goals (MDGs) in September 2000. MDG 6 is a commitment to combat HIV/AIDS, malaria, tuberculosis (TB), and other infectious diseases. This MDG aims to halt and begin to reverse the spread of the three diseases. Whilst significant progress has been achieved, much remains to be done. This report investigates the commitments and contributions of the G8 countries towards control of malaria, considering its massive adverse impact on humanity. Control is key to realising not only MDG 6 but four other MDGs especially MDG 4: Reduce child mortality and MDG 5: Improve Maternal health and also MDG 1: Eradicate extreme poverty and hunger and MDG 2: Achieve universal primary education.

In 1998 leaders of G8 nations, who met in Birmingham, UK, endorsed an international initiative to control malaria. The leaders agreed to improve mutual cooperation on infectious and parasitic diseases, and offered support for the new "Roll Back Malaria" movement to reduce levels of malaria-related mortality by 2010. UK Prime Minister Tony Blair was, however, the only leader to pledge new funding of US\$ 72 million for the initiative. The other G8 countries were not in favour of the inclusion of specific targets in the final joint G8 document and made no new commitment to fund the malaria initiative³. The Roll Back Malaria (RBM) Partnership (see Annex 1), is an international coalition with hundreds of partners. Specifically created by the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP) and the World Bank (WB) to provide a co-ordinated international approach to malaria control and to accelerate social and political action

¹ World Health Organisation, World Malaria Report 2008

² http://www.europeanallianceagainstmalaria.org/about_malaria/the_global_epidemic.html.

³ Lancet, 1998 May 23;351(9115):1561.

to stop the unnecessary spread of malaria, the Partnership's aim was to work towards achieving internationally agreed malaria control objectives with the goal to halve the burden of malaria by 2010⁴.

In the years after the creation of the RBM Partnership, the need for, and the clear feasibility of, greatly intensifying the control of malaria became more widely recognized. This led to a renewed global effort and commitment towards the control of malaria and other health problems, as demonstrated by the adoption of the MDGs by United Nations member states two years later. Furthermore, there has been a proliferation of initiatives and public-private partnerships dedicated to addressing key diseases in the developing world. For example, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was created in 2002, UNITAID, an international drug purchase facility, was launched in 2006, the United States President's Malaria Initiative (PMI) in 2005 and a call by the Bill and Melinda Gates Foundation (BMGF) in 2007 to eliminate country by country and eventually eradicate malaria worldwide was endorsed by Margaret Chan of the WHO. Signs of progress in scaling up malaria control have sparked further commitments and action including the development by the RBM Partnership of the *Global Malaria Action Plan: for a malaria-free world* (GMAP) in 2008⁵. The GMAP is intended to provide a global framework for action aimed at achieving control of the disease, increased investment in research and development and ultimately the eradication of malaria, around which partners can coordinate their efforts. The GMAP (page 16) calculated that the estimated needs, based on the costs of prevention, treatment and programme strengthening in malaria-endemic countries - mainly in Asia and Africa - over the next years would be:

- ± US\$ 5.3 billion in 2009
- ± US\$ 6.2 billion in 2010
- An average of US\$ 5.1 billion annually in the period 2011 – 2020
- An average of US\$ 3.3 billion annually in the period 2021 – 2030
- An average of US\$ 1.5 billion annually in the period 2031 – 2040
- In addition some US\$ 750 – 900 million annually until 2018 should be spent on developing new malaria control tools such as vector control, drugs, vaccines and diagnostic technologies.

Funding for malaria control has hugely increased since 2004, reaching an estimated overall figure of US\$ 1.5 billion in 2007 (GMAP, p. 13). Various international donors increased their contributions from US\$ 250 million in 2004 to US\$ 700 million in 2007, and this amount is estimated to have increased to US\$ 1.1 billion in 2008. However, if target 8 of MDG 6, 'to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases' is to be achieved, a major increase of funding of up to four times the present funding is required (GMAP, p. 16). In the current financial climate, where the G8 and other developed countries are facing economic crises, there is a risk that spending on international development will become a lower priority and an easy budget line to cut. Therefore now more than ever and in the coming years, it is imperative that recent momentum is not lost, and funding towards malaria control and the eventual goal of eradication continues. Already there is a shortfall between what is needed and committed as highlighted in GMAP. In order to fight malaria successfully and to strengthen health systems in general, funding should be multi-year, long-term, predictable and sustainable.

This report observes G8 country commitments to spending on malaria in the 10 year period (1998-2007) after the conception of the RBM Partnership at the Birmingham G8 summit. It looks at data on actual spending over the 10 years and the evidence of how this money was disbursed. Based on the findings recommendations have been made on how to improve effectiveness of contributions towards malaria control. It is important to note that by examining only G8 donors, the critical role in health of other actors (such as non-governmental

development organizations and developing world governments) is not being overlooked. Rather it is focusing to better understand this particular, highly influential group of actors because of their economic and political power. The report also briefly examines the European Union and World Bank funding towards malaria control as well as health systems strengthening, and notes that increased funding targeted towards budget and sector support, does indirectly contribute to fighting malaria.

2. Methods

This section describes the steps used to determine the amounts contributed by the G8 countries between 1998 and 2007, which is the first 10 years of the Roll Back Malaria Partnership.

- Data on G8 commitments towards malaria were obtained from communiqués and literature searches.
- In gathering information, funding streams were separated into bilateral, multilateral and research. The multilateral streams included were: GFATM, UNICEF, UNITAID, WHO and RBM. The Malaria Vaccine Initiative (MVI), and Medicines for Malaria Venture (MMV) were also examined. Bilateral funding figures were obtained directly from governments.
- Initial desk research on multilaterals was carried out through their websites and searching through their funding and disbursement pages as well as looking through their annual reviews. Where information was unclear or incomplete, questions were sent to contact addresses on these websites. Donor governments' websites were checked for information on pledges and disbursements as well as details of what bilateral projects were being funded. Donor websites searched included DFID, USAID and CIDA. Hard copy documents from organisations such as WHO, RBM and World Bank were also consulted for past figures.
- GFATM pools resources for AIDS, malaria and tuberculosis control. Its records indicate that the distribution of funding after 7 rounds for malaria is 25%⁶. Funding was divided accordingly for those grants made to the GFATM by donors considered in this study.
- UNICEF and WHO contributions are direct contributions for malaria only as these were easy to track. Indirect contributions are also spent on malaria and therefore it is noted that these figures are an underestimation of the total amount spent on malaria by countries that have contributed via these two streams.
- The authors realize that Research and Development Funding is not comprehensive but includes the MVI and MMV streams, as detailed above. Moreover, contributions to UNICEF/UNDP/World Bank/WHO Special Programme for Research & Training in Tropical Diseases (TDR) were examined, but the contributions are for all infectious diseases and no funds are earmarked for malaria. Therefore, the TDR figures were not included in the analysis. The authors note that the G-Finder report⁷ has performed a comprehensive search on R&D spending on neglected diseases including malaria for the year 2007. However, amounts were only given for the top 12 funders in the categories and so not all G8 country amounts to R&D are shown. Therefore these amounts were not included in the analysis.
- The G8 countries give significant amounts of funding to the World Bank but contributions are not earmarked for infectious disease or malaria. Therefore, contributions to the Bank, primarily through the World Bank Malaria Booster Programme, are examined as a separate section and not included in the country specific findings. To get a percentage of how much of the G8 money made up the International Development Assistance (IDA) World Bank funds, we divided the Total IDA money from the G8 countries

6 <http://www.theglobalfund.org/en/distributionfunding/?lang=en>

7 M. Moran et al., 2008. Neglected Disease Research & Development: How Much Are We Really Spending? The George Institute for International Health http://www.thegeorgeinstitute.org/shadomx/apps/fms/fmsdownload.cfm?file_uid=409D1EFD-BF15-8C94-E71C-288DE35DD0B2&siteName=iuh

4 <http://www.rollbackmalaria.org>

5 *The Global Malaria Action Plan. For a malaria-free world*, Roll Back Malaria Partnership. 2008 <http://www.rollbackmalaria.org/gmap/>

by the Total IDA money from all the countries and converted it into a percentage. We then calculated the overall percentage of how much of the IDA World Bank funds goes towards malaria control by dividing the total booster money for malaria by the total IDA (from all countries) and converted the number into a percentage. This percentage has been applied to total country IDA contributions to estimate the amount given to malaria for each country. The IDA contribution to malaria between 1998-2007 is included when discussing in the conclusions (section 7.1) the total amount contributed to malaria control.

- The European Union (EU) and its implementing arm, the European Commission (EC), provide significant amounts of ODA including for malaria. Four of the G8 countries are members of the EU (United Kingdom, France, Italy and Germany) but their donations through this body are not earmarked for malaria. Therefore, the EC contribution to malaria is examined separately. The EC contribution to malaria between 1998-2007 is included when discussing in the conclusions (section 7.1) the total amount contributed to malaria control.
- To examine country contributions versus commitments, the country's own currency was used except for Japan and Russia. For comparison between countries and to determine the total amount given during the 10 year period examined, total country contributions per year were converted into US \$ where the data were not initially analysed in this currency. Exchange rates for currency conversions were obtained for each of the years examined from the Organization for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) database⁸ which gives the historic exchange rate per year. DAC is an OECD sub-group that deals with issues related to co-operation with developing countries. For countries reporting in Fiscal Year (FY), the year which covers the most months was used when analyzing total country contributions (i.e. 2005/2006 contributions were allocated to 2005, where the 2005 element was more than six months).
- For UK bilateral figures, DFID presented us with a list of all its projects from which malaria only projects were disaggregated and tallied for each year (overall project totals being divided by the projects duration in years to gain an even spread).
- Once information on contributions was collected, the data was sent in the form of a table and a list of questions to European Alliance Against Malaria (EAAM) partners based in EU G8 nations (France, Germany, UK) and also to other established partners (civil society organizations) with whom EAAM has links in the remaining G8 countries (USA, Japan, Italy, Canada, Russia). These partners (see Annex 3) were responsible for liaising with their respective governments to verify the data, answer any questions and add any missing data. For Italy, Russia and USA the data were not verified, so the figures from the Annex of the Toyako Framework for Action on Global Health⁹ were used as the main source. The Toyako report is the recommendation from the G8 Health Experts Group to the G8 leaders in 2008. It outlines the current situation, the principles for action, and actions to be taken on health. To ensure accountability, the Toyako report also includes annexes that show G8 implementation of its past commitments. See Annex 2 of this report for G8 country contribution to malaria calculation tables.

3. G8 commitments towards health

At the G8 Heiligendamm Summit in June 2007, the G8 discussed 3 main topics, one of which was Growth and Responsibility in Africa¹⁰. The discussions focused on how the G8 countries could effectively contribute to the achievement of the MDGs in Africa. In the context of the G8 partnership with Africa one of the issues dealt with in greater detail was "Improving Health Systems and Fighting HIV/AIDS, TB, and Malaria". A core set of development principles was agreed based on the commitments made at the Gleneagles Summit in 2005 and jointly confirmed, in particular with regard to development financing. Debt relief, innovative finance initiatives as well as private sector engagements would contribute to fulfill these commitments.

Following the Heiligendamm Summit, for the first time a health report was issued¹¹ entitled "A Review of the Work of the G8 in the Field of Tackling the Three Pandemics HIV/AIDS, Tuberculosis and Malaria". Its aim was to provide transparency on the specific actions G8 nations were taking to deliver on the promises made over recent years. This review provided a very comprehensive overview of the commitments made as summarized below.

3.1 Key commitments towards tackling HIV/AIDS, TB and Malaria

The G8 has always been committed to the fight against infectious diseases and to supporting the hardest-hit countries. Highlighted below are commitments made towards the main three diseases during the G8 summits between 1998-2007.

Communiqués from Summits

1. At the Birmingham Summit in 1998, the G8 pledged to enhance mutual cooperation on infectious and parasitic diseases and support the World Health Organisation's efforts in those areas including the new initiative to 'Roll Back Malaria' to relieve the suffering experienced by hundreds of millions of people, and significantly reduce the death rate from malaria by 2010.
2. At the Okinawa Summit in 2000, fighting HIV/AIDS, tuberculosis and malaria was prominently on the agenda. At that time, the G8 countries committed to provide increased financial bilateral and multilateral aid, a commitment that also led to the creation of GFATM (see below for more detail) in 2001 at the time of the Genoa Summit. GFATM has to date leveraged pledges of more than US\$ 10 billion to support the implementation of global strategies to control and eventually eliminate the three diseases.
3. At the Kananaskis Summit in 2002, the G8 underlined the devastating consequences for Africa's development of diseases such as malaria, tuberculosis and HIV/AIDS and emphasized their ongoing commitments to combat these diseases.
4. At the Evian Summit in 2003, the G8 agreed a G8 Action Plan on Health aimed at enhancing close international cooperation on policies and methods in order to achieve the development goals set out in the Millennium Summit and at the World Summit on Sustainable Development. In the Action Plan, the G8 highlighted the

⁸ <http://www.oecd.org/dataoecd/37/22/37417595.xls>

⁹ Report of the G8 Health Experts Group. Toyako Framework for Action on Global Health. http://www.mofa.go.jp/POLICY/economy/summit/2008/doc/pdf/0708_09_en.pdf

¹⁰ Communiqué Heiligendamm 2007 http://www.g-8.de/Content/EN/Artikel/_g8-summit/2007-06-07-summit-documents.html

¹¹ A Review of the Work of the G8 in the Field of Tackling the Three Pandemics HIV/AIDS, Tuberculosis and Malaria. http://www.g-8.de/Content/EN/Artikel/_g8-summit/anlagen/2007-11-05-health-review,property=publicationFile.pdf

need to strengthen GFATM, the need to strengthen health systems and to improve access to health care in poor countries, including to drugs and treatments at affordable prices, as well as the need to encourage research on diseases that mostly affect developing countries, amongst other issues.

5. At the St. Petersburg Summit in 2006, the G8 adopted a separate statement on fighting infectious diseases in which they proposed key principles of a global strategy to tackle epidemics and highlighted their increasing efforts in addressing HIV/AIDS, tuberculosis and malaria. In addition as previously stated they committed to a regular review of their work in the field of tackling HIV/AIDS, tuberculosis and malaria.
6. At the Heiligendamm Summit in 2007, the G8 recognised the need for substantial resources to realise the MDG for fighting HIV/AIDS, malaria and tuberculosis on a sustainable basis. They committed to provide at least a projected US\$ 60 billion with a five year time frame (concrete timescale was not specified) to combat HIV/AIDS, malaria and tuberculosis and strengthen health systems, and invited other donors to contribute. As part of this commitment, the G8 pledged to work with other donors, to replenish GFATM and to provide long-term predictable funding based on ambitious, but realistic demand-driven targets. On malaria, the G8 committed to work individually and collectively over the next few years to enable the 30 highest malaria prevalence countries in Africa reach at least 85% coverage of the most vulnerable groups with effective prevention and treatment measures and achieve a 50% reduction in malaria related deaths in line with the goals of the RBM Partnership.

3.2 The Role of the Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)¹² is a unique global public/private partnership dedicated to attracting and disbursing additional resources to prevent and treat HIV/AIDS, tuberculosis and malaria. GFATM works in close collaboration with other bilateral and multilateral organizations to supplement existing efforts dealing with the three diseases.

Since its creation in 2002, GFATM has become the main source of funding for programmes to fight AIDS, tuberculosis and malaria, with approved funding of US\$ 15.6 billion for more than 572 programmes in 140 countries. It provides a quarter of all international financing for AIDS globally, two-thirds for tuberculosis (TB) and two-thirds of all international financing for malaria¹³.

GFATM financing is enabling countries to strengthen health systems by, for example, making improvements to infrastructure and providing training to those who deliver services. GFATM remains committed to working in partnership to scale up the fight against the diseases and to realize its vision – a world free of the burden of AIDS, TB and malaria.

The importance of GFATM is evident from the amounts donated to it by the G8 countries and its role has significantly increased with the support of the G8. Until 2007, the G8 contributed 87% of the total funds of US\$ 7.1 billion. The United States, at over US\$ 2 billion, is the largest contributor to the GFATM while the European Commission and the EU Member States collectively provide the majority of the funds¹⁴, as shown below:

¹² <http://www.theglobalfund.org/en/>

¹³ http://www.theglobalfund.org/en/pressreleases/?pr=pr_090424

¹⁴ EU + MS contributions to the GFATM = around 60% : (see: http://www.europeanallianceagainstmalaria.org/fileadmin/user_upload/pdf/Results_and_Innovation_in_Development_Cooperation_for_Health.pdf)

2002-2007 Total Contributions to GFATM:

- **United States** US\$ 2.69 billion
- **France** US\$ 1.2 billion
- **Italy** US\$ 821.4 million
- **European Commission** US\$ 790 million
- **Japan** US\$ 662.7 million
- **United Kingdom** US\$ 652 million
- **Canada** US\$ 431million
- **Germany** US\$ 403.1 million
- **Russia** US\$ 115.7 million

4. G8 commitments and mechanisms of support towards combating malaria

This section looks at malaria-specific commitments made by G8 countries. It also briefly examines the role of GFATM and other initiatives and mechanisms of support.

4.1 Key G8 Malaria Commitments¹⁵:

1. To collaborate with governments, private sector companies and non-governmental organizations in public-private partnerships to **expand malaria interventions and programmes** (St. Petersburg, 2006)
2. To work with African countries to scale up malaria control interventions, reduce the burden of the disease, and eventually defeat malaria on the continent and **meet the Abuja target of halving the burden of malaria by 2010** (St. Petersburg, 2006)
3. To support the development of **new, safe and effective drugs**, creation of a vaccine, and promotion of the **widest possible availability of prevention and treatment** to people in need (St. Petersburg, 2006)
4. To support activities of public and private entities to **save children** from the disease (St. Petersburg, 2006)
5. To contribute to the **additional US\$ 1.5 billion a year** needed annually to help ensure access to anti-malaria insecticide treated **mosquito nets**, adequate and sustainable supplies of **Combination Therapies**, including Artemisinin, preventive treatment for **pregnant women and babies** and **household residual spraying** and the **capacity** in African **health services** to effectively use them (Gleneagles, 2005).

4.2 GFATM and Malaria

The G8 contribute significantly to GFATM, which began disbursement for malaria control in 2003 and has been an important international funding source since then. After the disbursement of US\$ 200 million between 2003 and 2004, GFATM approved commitments for malaria control for 2005-2006 that total US\$ 881 million.

¹⁵ See p15 of A Review of the Work of the G8 in the Field of Tackling the Three Pandemics HIV/AIDS, Tuberculosis and Malaria

Currently, around 25% of GFATM resources are used to fund malaria programmes. GFATM is the largest financier of insecticide treated nets (ITNs) in the world and also the main financial engine globally behind the scale-up of ACTs. GFATM is helping to deliver 74 million artemisinin-based combination drug treatments and 70 million ITNs.

4.3 RBM Partnership

The G8 countries strongly support the RBM Partnership (see Annex 1) directly or through contributions to the WHO, UNICEF, UNDP and the World Bank.

4.4 Research and Development

In 2006, the G8 reaffirmed commitment to support the development of new, safe and effective drugs, the creation of a vaccine and the promotion of the widest possible availability of prevention and treatment to people in need. In December 2006 the WHO launched a new global strategy entitled "Malaria Vaccine Technology Roadmap"¹⁶ which aims for an effective malaria vaccine by 2025. The Roadmap also identifies the development and licensing of a first-generation malaria vaccine by 2015 as an interim target.

4.5 UNITAID

The international drug purchase facility UNITAID was formed in 2006, led by France along with the United Kingdom, Norway, Brazil and Chile. UNITAID uses the air ticket solidarity tax and/or long-term budget commitments to provide bulk purchasing of drugs for poor countries. As of 2007 UNITAID commitments to programs came to a total of US\$ 222.4 million of which \$ 38.4 million was for malaria ACTs and a further \$ 52.5 million was a contribution to GFATM¹⁷. By 2009 UNITAID reported that its efforts include the distribution of 17.6 million ACT treatments in 21 countries and the delivery, by early 2010, of 20 million ITNs to eight endemic countries¹⁸.

4.6 Other mechanisms for combating malaria

Private foundations, trust funds, partnerships, industry and other private donors in G8 countries are making a critical contribution toward combating malaria, both in financing and providing mosquito nets, drugs and other interventions, and in researching new drugs and vaccines. Faith-based and other community groups, including those in Africa and elsewhere, are helping to ensure that vital interventions reach those who need them.

16 Malaria Vaccine Roadmap 2006 http://www.malariavaccineroadmap.net/pdfs/Malaria_Vaccine_TRM_Final.pdf

17 See UNITAID 2007 Annual report P44 - <http://www.unitaid.eu/images/news/annualreporten2007.pdf>

18 http://www.dfid.gov.uk/Documents/pdf_misc/AMFm_pr.pdf

5. Country specific findings

Country specific findings are presented in alphabetical order. When reporting individual country commitments and contributions, the currency of the country was used. This format has been used in the G8 communiqués and also the Toyako report. For Russia and Japan, amounts were already given in US\$ so this currency was used. However, in order to compare between countries and also total G8 country contribution during 1998-2007, all amounts were converted to dollars.

For each country a table showing contributions per year and funding stream is found in Annex 2, and the figures below are based on these tables.

5.1 Canada

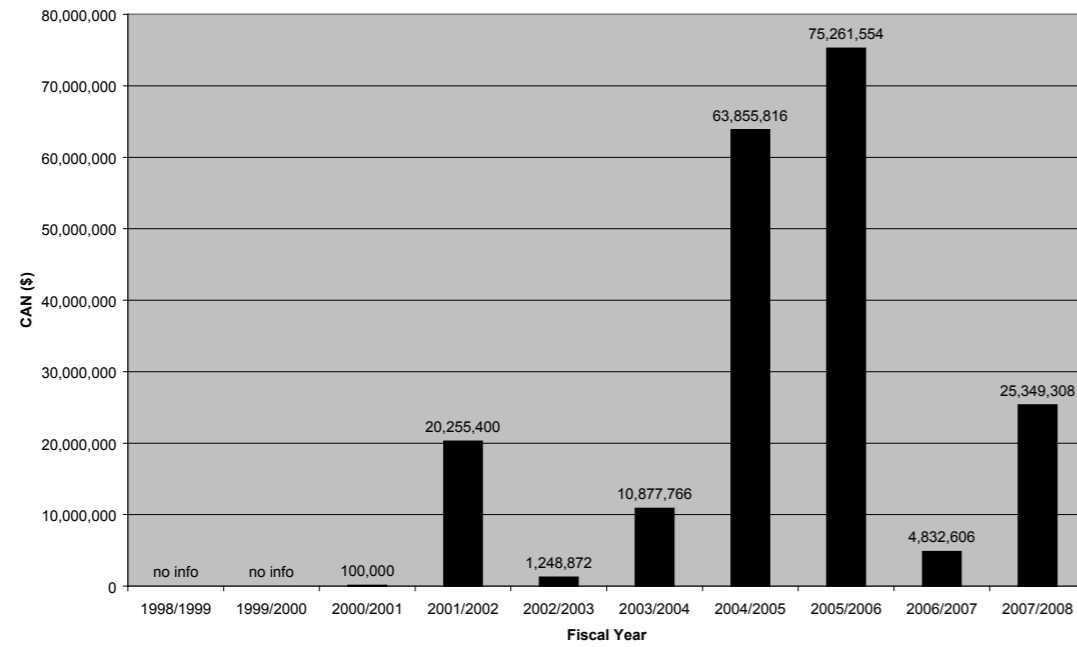
The document entitled "Review of the Work of the G8 in the Field of Tackling the Three Pandemics" states the contributions of Canada comprehensively. Since 2003, Canada has provided more than CAN\$ 35 million for the distribution of LLINs in Africa. Over a three-year period, it is estimated that close to 128,000 children's lives have been saved. Furthermore in 2005-06, Canada disbursed approximately CAN\$ 52 million to the Canadian Red Cross and GFATM. In 2006-07, Canada also disbursed approximately CAN\$ 42 million for malaria programming through UNICEF and GFATM and in 2007 an additional CAN\$ 20 million was committed to the Canadian Red Cross. Other anti-malaria projects include CAN\$ 10.5 million to the WHO's Regional Office for Africa (WHO-AFRO) to support selected countries to increase collaboration between traditional and modern medicine and to integrate the practice of traditional medicine into national health systems for the management of malaria and other priority diseases.

In 2007 the Canadian Government launched the *Catalytic Initiative to Save a Million Lives* (also known as the Catalytic Initiative). It brought together an international partnership with the goal of strengthening health systems to accelerate progress on the health-related Millennium Development Goals (MDGs). The Initiative aims to strengthen health systems by delivering life-saving health and nutritional services to disadvantaged children and pregnant women to dramatically reduce child and maternal mortality¹⁹.

Figures for the Canadian contribution to malaria control were obtained directly from the Canadian International Development Agency (CIDA) and all figures reflect current records of spending against figures taken from the OECD-DAC database, DAC Sector Code 12262 - Malaria Control. The figures are reported by FY as per Canadian requirements. The highest amount contributed by Canada was in FY 2005/2006 – a total of CAN \$ 75,261, 554 which then dropped significantly the following FY to just under CAN\$ 5 million (Figure 1). The total contributed over the 10 year period examined is CAN\$ 201.8 million.

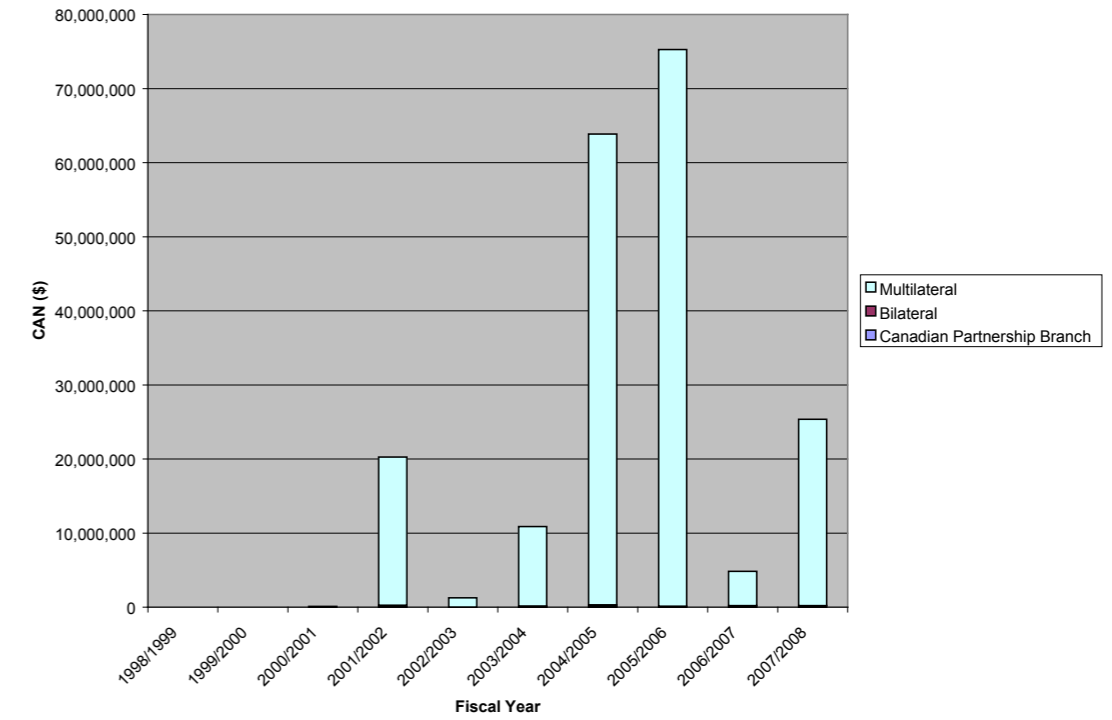
19 <http://www.acdi-cida.gc.ca/CIDAWEB/acdicida.nsf/En/NAD-1249841-JLG>

Figure 1. Total Canadian Contribution to Malaria Control from 1998-2007



As shown in Figure 2, there is an additional stream for malaria contributions called the Canadian Partnership Branch. It is the section of CIDA that partners with Canadian civil society and private sector organizations to promote capacity building of counterparts in developing countries²⁰. Similar to some other G8 countries, the majority of Canadian money is funnelled through multilateral channels (Figure 2); as little as 0.4% of contributions are bilateral compared with 99% of contributions being multilateral. The multilateral contribution includes CAN\$ 46 million for LLINs as part of three different projects through the Canadian Red Cross/International Federation of the Red Cross. These projects were disbursed from 02/03 - 08/09 FY. The 08/09 FY figures have not been included because they are outside the report timeframe. CIDA did not provide us with any figures spent for research on malaria and these were not available from the Toyako report.

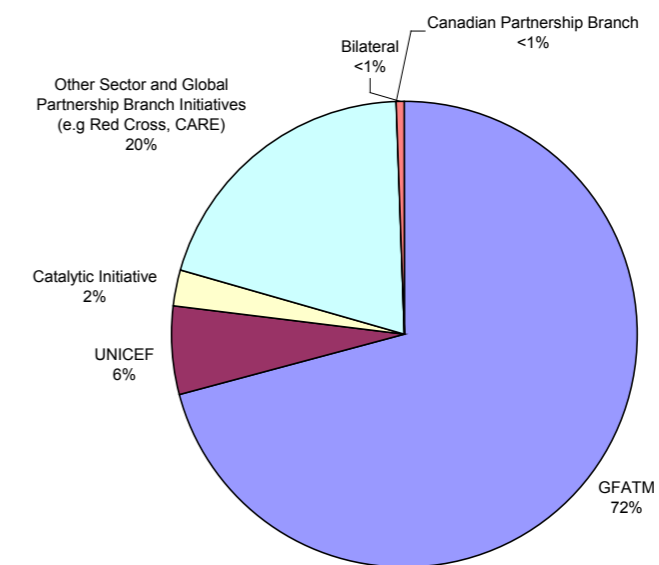
Figure 2. Bilateral, Multilateral and Canadian Partnership Branch Funding towards Malaria Control by Canada



*Bilateral and CPB proportions too small to be visible

Canada has provided CAN\$ 530 million to GFATM since its inception, with a total of CAN\$ 143 million for malaria and is the largest proportion of the Canadian contribution at 72% (Figure 3).

Figure 3. Distribution (%) of Canadian Contribution to Malaria Control (1998-2007)



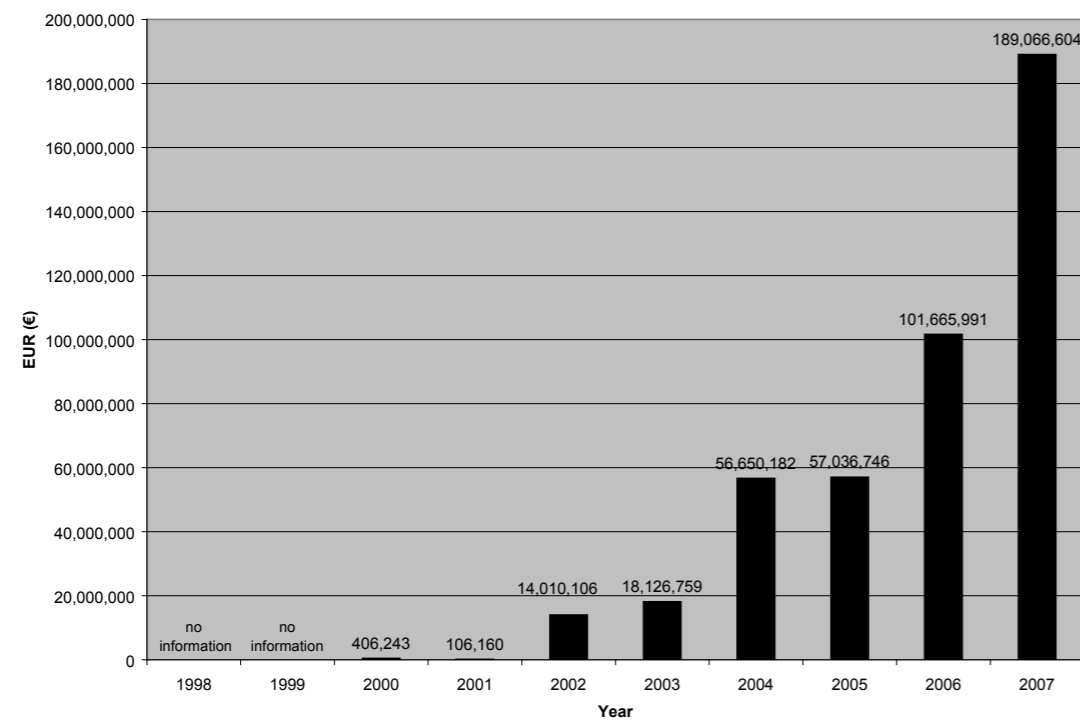
20 <http://www.acdi-cida.gc.ca/cidaweb/acdicida.nsf/En/NIC-54115825-LR9>

5.2 France

The contribution to malaria control from France is through Official Development Assistance (ODA), UNITAID (non-ODA) and malaria research (ODA and non-ODA). The lack of information in the late 1990s does not reflect minor involvement by the French government, but rather a problem of identification of malaria thematic lines in the aid budget.

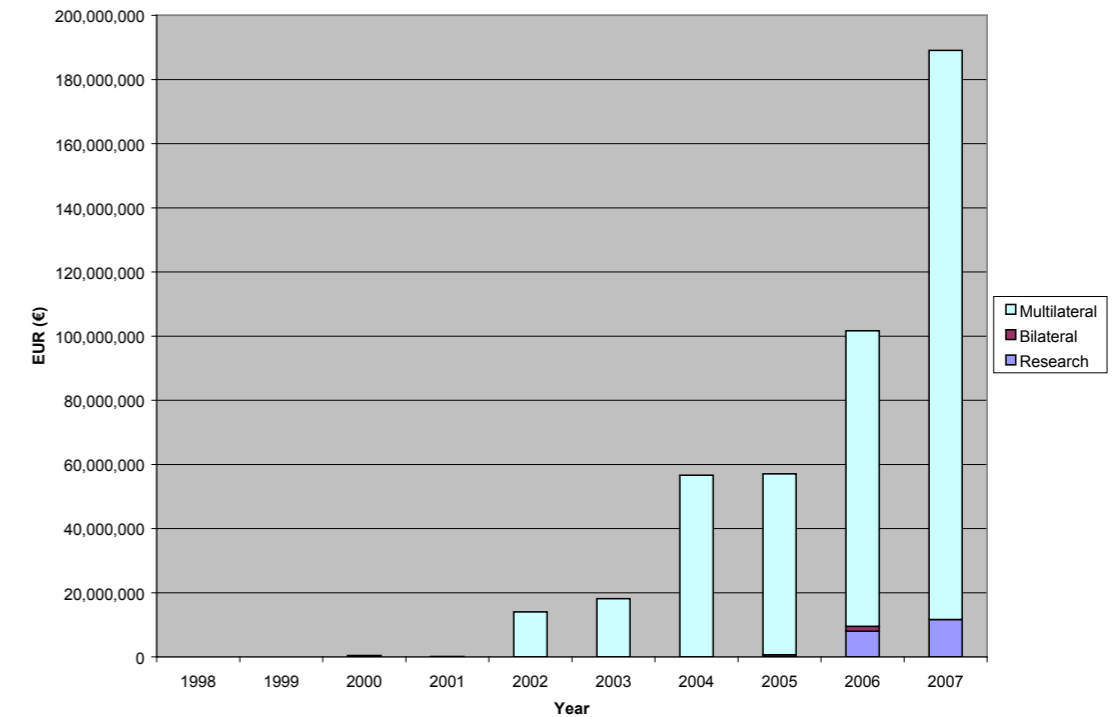
The French strategy in support of the health sector, including malaria, has a strong multilateral focus with increasing contributions not only to GFATM but also to the Global Alliance for Vaccines and Immunization (GAVI), UNITAID, UNICEF, WHO, the World Bank, and the European Union (through the European Development Fund). French contributions to global health have been significant since 2005 compared with 1998-2005 (Figure 4). France contributed € 680 million to GFATM and € 195 million to UNITAID between 2006 and 2007. It has also given € 114.3 million to United Nations bodies such as UNAIDS, WHO, UNFPA, UNICEF etc. The Ministry of Foreign Affairs gave € 2.15 million to malaria control in bilateral aid between 2005 and 2007, making the contribution 0.04% of total French bilateral ODA during those three years. Total estimated contribution to malaria over the 10 years examined was € 437 million.

Figure 4. Total French contribution to Malaria Control from 1998-2007



Research on malaria is also important with a total spend of € 19.65 million during 1998-2007. The French government identified an important specific budget line dedicated to research on HIV/AIDS and malaria in developing countries (VIHPAL) in 2000. This research programme financed by the Research Ministry became "PAL+" in 2001. However, PAL+ no longer exists and therefore it is difficult to track funding through this line dedicated to malaria research. The French government also supports research dedicated to malaria through funding distributed to the Pasteur Institute, the Development Research Institute (IRD), the National Institute for Medical Research (INSERM) and the National Centre for Scientific Research (CNRS). Budget lines to support research programmes dedicated to malaria are fragmented so that they are difficult to identify and hence figures presented in this report are an underestimate.

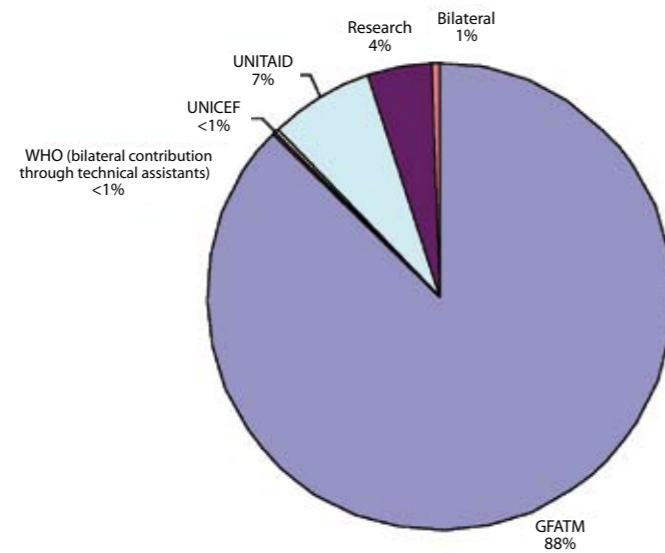
Figure 5. Bilateral, Multilateral and Research Funding towards Malaria Control by France



France supported the creation of GFATM, is its leading European contributor and the second largest contributor among G8 countries after the United States. The French contribution for the 2008 - 2010 period is up 33% in relation to the previous three year period (2005 to 2007). France currently provides over 10% of the GFATM total budget. A closer examination of the distribution of French contributions to malaria shows that 88% of its contributions are through GFATM (Figure 6). The total contribution from France to GFATM (for malaria only) is just over € 381.8 million.

Moreover, France has been active in promoting innovative sources of financing for development. It initiated the tax on air travel and the creation of UNITAID in 2006, as well as being one of the supporters of the International Financing Facility (IFF). With € 185 million (250 million US\$) dedicated to UNITAID, including € 31 million (US\$ 43 million) for malaria drugs, France is the principal donor backing UNITAID (table A2.2).

Figure 6. Distribution (%) of French Contribution to Malaria Control (1998-2007)



The priority given to the fight against communicable diseases, including malaria, has also been progressively integrated into a much wider framework of support for healthcare systems. This system involves the strengthening and structuring of national healthcare policies.

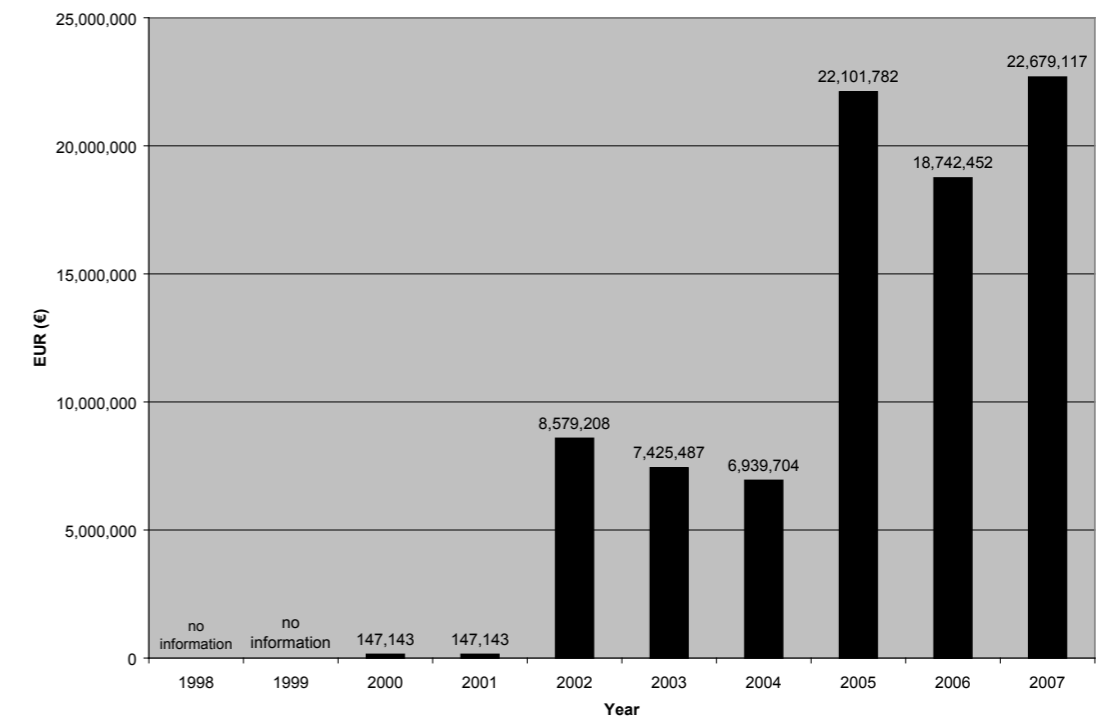
5.3 Germany

From 2003, Germany has committed € 300 million annually to combating HIV/AIDS, malaria and tuberculosis as well as to health system strengthening. In 2007 the German Government increased its contribution to € 400 million thus totalling € 1.6 billion in the 2003 to 2007 period. This figure includes bilateral commitments as well as contributions to multilateral institutions.

German contributions to GFATM for the period 2002–2007 were around € 323.5 million. In addition, German development cooperation designed a new mode of support with the BACKUP Initiative (Building Alliances, Creating Knowledge, Updating Partners) in the fight against HIV/AIDS, tuberculosis and malaria. It was launched in 2002 with the aim of providing technical support to facilitate better access to global funds available for tackling these diseases in recipient countries. It helps partner countries to develop the prerequisite capacities to apply for the resources available and to deploy them effectively once received²¹.

The overall trend shows that German spending on malaria has increased significantly between 1998 and 2007 (Figure 7). Total funding for malaria in 2007 was just over € 22.6 million compared with only € 147,143 in 2000. No information was available from the Federal Ministry for Economic Cooperation and Development (BMZ) for 1998 and the only contribution for 1999 was to WHO-Tropical Disease Research (TDR) where the money is not only for malaria but for all communicable diseases so was not included. The overall contribution estimated for malaria (1998-2007) is just over € 86.7 million.

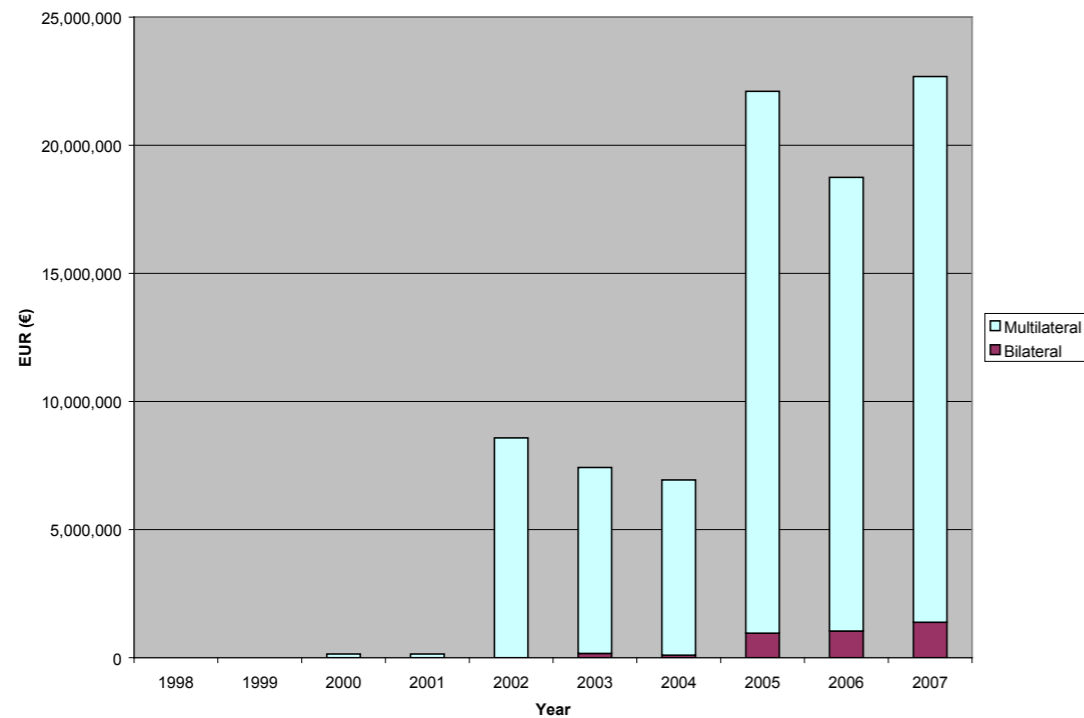
Figure 7. Total German contribution to Malaria Control from 1998-2007



Most of German money for malaria is through multilateral channels (see Figure 8) as only 3.81% of contributions have been bilateral over the years considered (although bilateral contributions have increased in the period 2005-2007). Generally, malaria control measures in Germany's bilateral development cooperation are an integral part of basic health service supporting schemes and therefore it is difficult to allocate specific amounts directly to malaria. The German Government does not support bilateral measures which include Dichlor-Diphenyl-Trichlorethan (DDT), giving preference to the Stockholm Convention's goal of reducing and ultimately eliminating the use of DDT. No information was available for funding towards research.

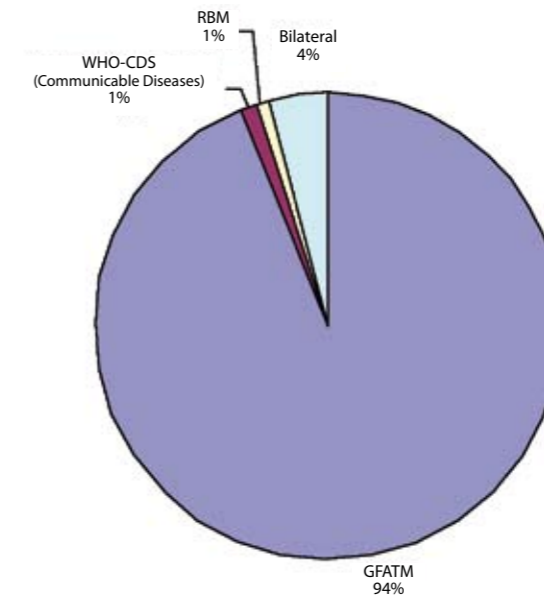
21 p 29-A Review of the Work of the G8 in the Field of Tackling the Three Pandemics HIV/AIDS, Tuberculosis and Malaria

Figure 8. Bilateral and Multilateral Funding towards Malaria Control by Germany from 1998-2007



The main increase in German malaria funding, as for several other G8 countries, is due to the large contribution given to GFATM (Figure 9). In 2007, € 21.3 million out of the € 22.6 million of funding for malaria were contributions to GFATM. The total German contribution to GFATM including the year 2008 rose to € 130 million for malaria (based on 25% allocation of GFATM funds for malaria). Besides its contribution to GFATM, Germany has supported the fight against malaria through the RBM Partnership as well as WHO's department for Communicable Diseases (WHO-CDS). The German Government has given a total of € 660,000 directly to RBM in the period 2003-2005. Additionally, Germany has supported RBM via trust funds which were provided for WHO-CDS. Of a total of € 3.1 million contributed during 2000-2006, approximately € 1.03 million was allocated to RBM and therefore only this amount was included in the calculations for Germany. It is possible that more money may have gone to malaria but no information on this was available. Therefore, the total contribution to RBM is € 1.59 million during 2000-2006.

Figure 9. Distribution (%) of German Contributions to Malaria Control (1998-2007)



In 2008 it was announced by the German Government that its spending for disease control (HIV/AIDS, malaria and tuberculosis) and health system strengthening will rise to € 4 billion until 2015 (€ 500 million per year) (BMZ). German spending for health ODA has increased significantly in the last few years. In 2006 German spending for health ODA was € 300 million, in 2007 it reached € 400 million and in 2008 € 500 million²². At the end of November 2008, the German Parliament approved the development budget for 2009 and as a result Germany is going to spend an additional € 800 million on ODA, which means an overall spend of € 9.8 billion. Most of these additional funds will go to BMZ. BMZ will accordingly see a budget increase by € 637 million to € 5.772 billion. This represents an increase of 12.4% for this department - the highest percent increase of all German Ministries. The increase in German ODA, especially in times of the global financial crisis shows the strong commitment of the German Government to fulfil its promises to reach the ODA targets of 0.51% by 2010 and 0.7% by 2015. Continuous demands from German civil society, including EAAM, to the German Government about fulfilling its ODA promises also contributed to this budgetary outcome.

5.4 Italy

Italy has disbursed € 114 million to fight the three diseases over the period 2000-2006 through bilateral channels. This amount includes special contributions to WHO Global Malaria Programme (WHO-GMP), Stop TB Department and the HIV/AIDS Department for Technical Assistance to African countries most affected by the pandemics. It has also contributed US\$ 821 million to GFATM since its establishment.

The total value of the Italian bilateral ODA on health, over the period 2000-2006, is above € 400 million²³. Italian ODA is concentrated in Africa and focused on issues of poverty, environment, health and education. Health ODA particularly looks at supporting health systems, and human resource development is provided to almost all African countries, mainly in collaboration with NGOs, faith based organizations and Italian local Administrations. Major investments are made most often in the form of sector budget support.

²² These figures were announced in a press release of BMZ on 4 July 2007: http://www.bmz.de/de/presse/pm/2007/juli/pm_20070704_82.html and reaffirmed in speech of Karin Kortmann, Parliamentary State Secretary BMZ, on 7 April 2008 at AfGH 2008 Conference in Berlin: http://www.karin-kortmann.de/downloads/reden/080407_Rede_Entwicklungspolitische_Gesundheitsinitiativen.pdf

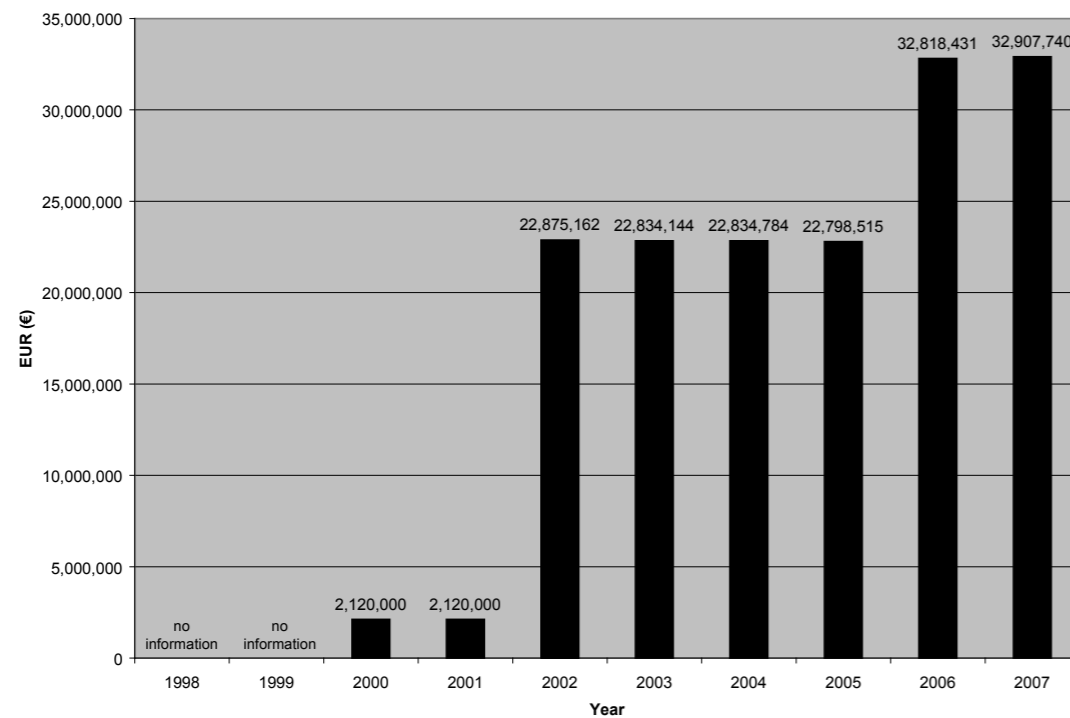
²³ A Review of the Work of the G8 in the Field of Tackling the Three Pandemics p29

Prior to the establishment of GFATM, most G8 countries did not earmark funds given for malaria projects and in most cases, the funds were classified under the broad umbrella of development assistance. In the case of Italy, the majority of the funds given through different streams (bilateral, multilateral, and NGO funding) were for HIV related activities²⁴.

The data researched was put to the Italian Ministry of Foreign Affairs by partners and the reply was that the only official data available is that presented in the Toyako report. Therefore, it was decided to use the figures from the Annex of the Toyako report for the purpose of this analysis as well as official figures from UNICEF (see Annex 2.4 for the calculation table).

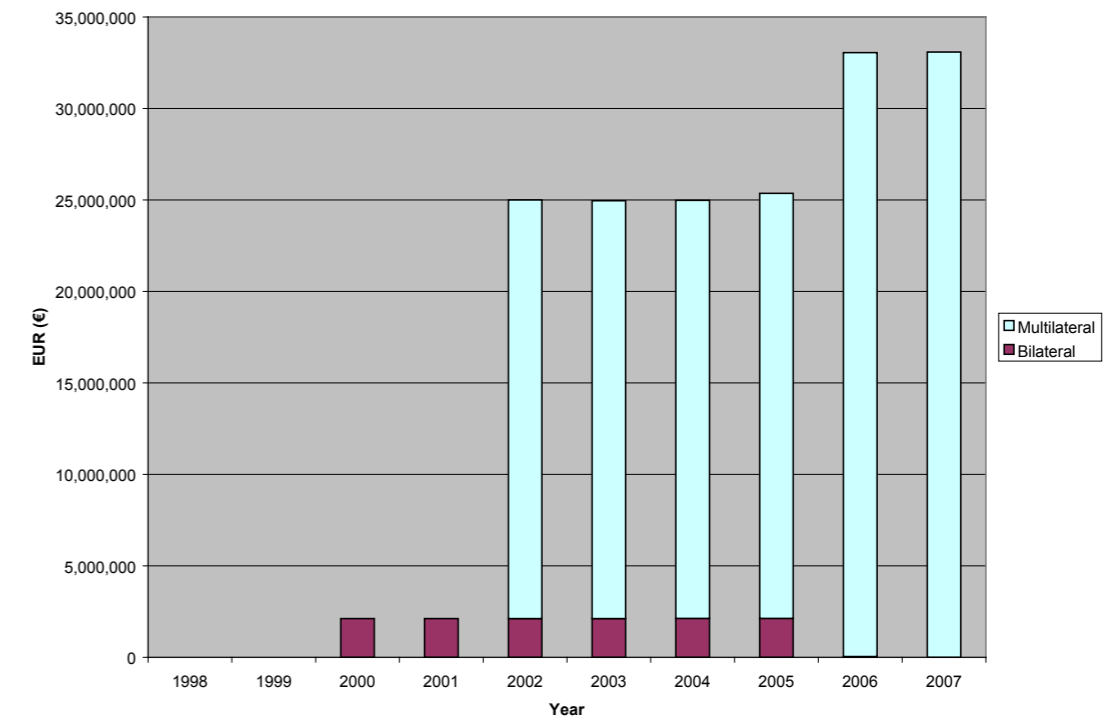
Overall the total Italian contribution of € 169.6 million to malaria control between 1998 and 2007 has increased (Figure 10).

Figure 10. Total Italian Contributions to Malaria Control from 1998-2007



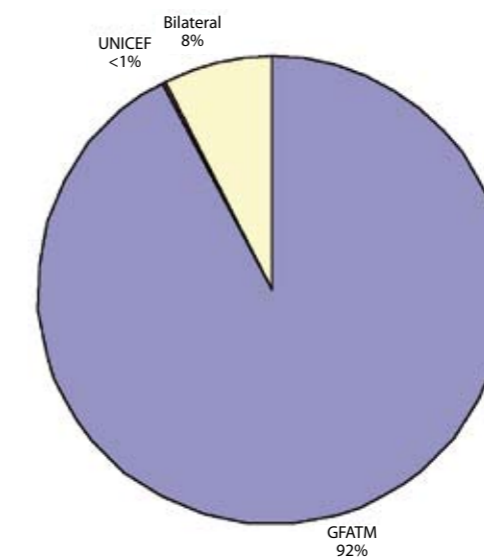
The majority of funding is through multilateral channels with no funding identified that can be specifically allocated to research towards malaria control (Figure 11).

Figure 11. Bilateral and Multilateral Funding towards Malaria Control by Italy from 1998-2007



The contribution to GFATM is 92% of Italy's total contribution towards malaria between 1998 and 2007 (Figure 12). Spending increased significantly from 2002 after the establishment of the GFATM.

Figure 12. Distribution (%) of Italian Contributions (1998-2007)



24 http://www.populationaction.org/Publications/Reports/Paying_their_Fair_Share/ITALY.shtml

5.5 Japan

In 2000, at the G8 Kyushu Okinawa Summit, Japan announced the 'Okinawa Infectious Diseases Initiative' (IDI) and proposed infectious diseases as a major agenda of the summit for the first time. Its aim was to enhance support to combat HIV/AIDS, tuberculosis, malaria, and other threats to health in developing nations with the target of providing US\$ 3 billion in 5 years from 2000 to 2004. The actual contribution by Japan based on this initiative exceeded the initial target and totalled up to US\$ 5.8 billion (Toyako Report).

Japan then launched the "Health and Development Initiative" in June 2005 aiming to provide comprehensive assistance amounting to US\$ 5 billion for five years (2005 to 2009) to combat infectious diseases, including HIV/AIDS, tuberculosis and malaria, and other threats to health such as high under-five mortality rates, high maternal mortality ratio and insufficient health systems among others, thereby achieving health-related MDGs. About US\$ 1.2 billion and US\$ 1.9 billion were disbursed during the fiscal years 2005 and 2006 respectively. Out of these, about US\$ 12 million (2005) and US\$ 14 million (2006) were allocated for malaria control (verified by Personnel communication from the Ministry of Foreign Affairs (MoFA) Japan).

In 2005, Japan also pledged to provide 10 million long lasting insecticidal nets (LLINs) for African countries with serious malaria prevalence by 2007 and by the end of fiscal year 2006 8 million nets had been distributed. The anti-malaria programmes included distribution of LLINs and training and awareness-raising were integrated as precautionary measures in some irrigation projects. The use of such nets is expected to prevent the deaths of up to 160,000 children in Africa. Japan supported with a yen-loan the technology transfer by a private company, Sumitomo Chemical, Co. Ltd. to a local company in Tanzania with the aim of reducing cost and increasing availability²⁵.

The Japanese data analysed below is from the MOFA, Japan. It shows that Japanese contributions for malaria have steadily risen since 1999 (Figure 13). Total funding for malaria has gone from US\$ 416,667 in 1999 to US\$ 71.2 million in 2007 and over the 10 years the total contribution has been US\$ 260.7 million. The figures above do not include Japanese bilateral and multilateral contributions which cannot be calculated in amounts of money (e.g. technical support) nor separated specifically for malaria and therefore it is likely that the amounts indicated are an underestimation of actual amounts spent. Additionally, Japan has given nearly \$ 123 million to the WHO over the years, by ad hoc contributions. However, this figure has not been included in the table because it is not clear how much has been allocated to malaria.

Figures not included in the calculations are Yen-loan projects which include a malarial response, which are:

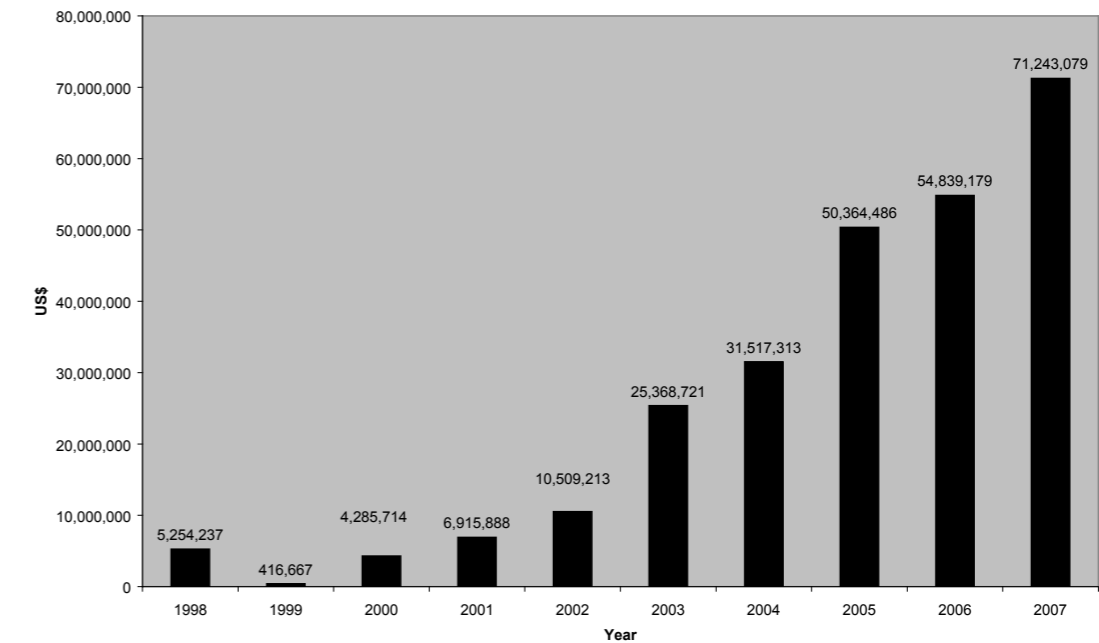
1) India: Rengali Irrigation Project (March 2004 / 6,342 mil JPY)

This project is to construct new irrigation facilities on the Brahmani River region in Orissa state, with the goal of raising farmers' incomes through increased agricultural production. Furthermore, as the project will be implemented in an area that is designated a "Malaria High Risk Area," the project will carry out the recommendations of a study conducted for taking measures to avoid any increase of malaria infection risks in the project area.

2) India: Rajasthan Minor Irrigation Improvement Project (March 2005 / 11,555 mil JPY)

This Project aims to increase agricultural production in a state that has extremely low rainfall compared with the rest of India by: rehabilitating the existing minor irrigation facilities dotted across Rajasthan; building water management systems; and conducting agricultural technology extension service. The project thereby pursues poverty reduction by increasing agricultural income. Furthermore, as irrigation water sources (reservoirs), which would become breeding grounds for malaria mosquitoes, will increase in the target areas of the project, in view of concerns over increased malaria infection, malaria reducing measures will be taken, thereby improving the overall standard-of-living of local residents.

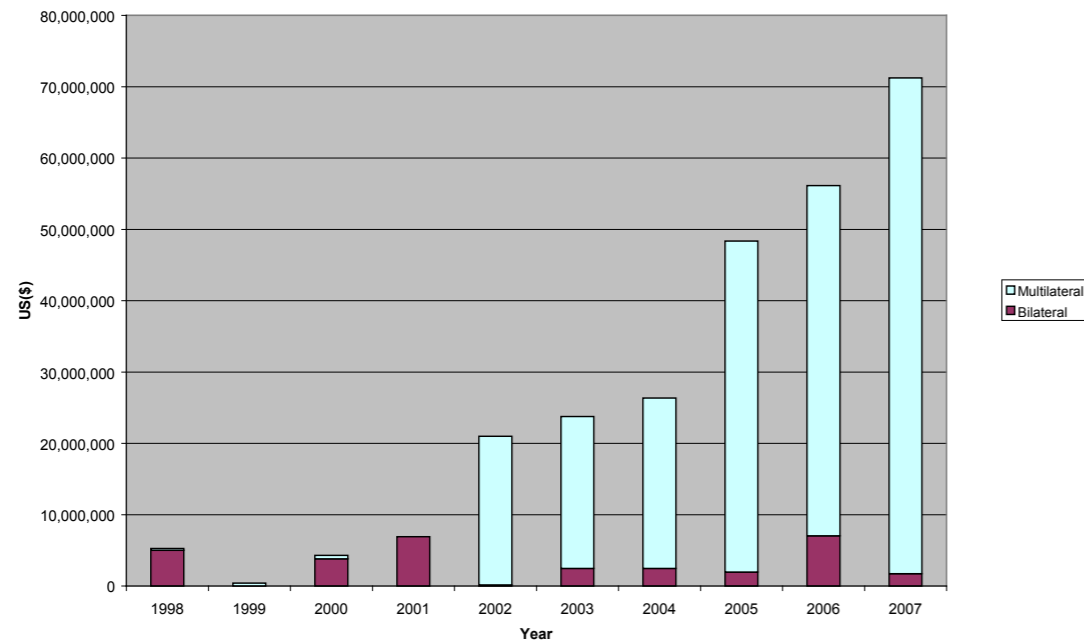
Figure 13. Total Japanese Contribution to Malaria from 1998-2007



The majority of Japanese funding for malaria is through multilateral channels (Figure 14) as only 9.5% of overall contributions are bilateral. The Bilateral programme is referred to as Grant Aid. The figures have been calculated by MoFA Japan and converted from yen to dollars. The yen to dollar rates are applied for convenience only. Actual disbursement rates vary depending on the disbursement period and agencies. Despite requests no figures on research spending on malaria were provided so it was documented according to the Toyako Report.

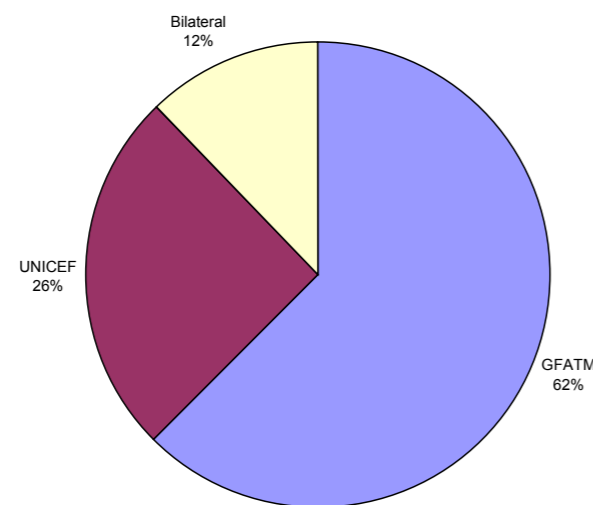
25 p17-A Review of the Work of the G8 in the Field of Tackling the Three Pandemics

Figure 14. Bilateral and Multilateral funding towards Malaria control by Japan



Between 2002 and 2007 Japan contributed US\$ 662 million to GFATM of which US \$ 162.6 million has been for malaria, making this contribution 62% of Japanese total contributions over the 10 years (Figure 15). A large proportion (26%) of contributions goes through UNICEF and in 2007 Japan was the 7th largest government donor to UNICEF²⁶. The figures obtained from MOFA Japan for UNICEF are from 1998 whereas UNICEF itself could only provide malaria specific funding information from 2002 under sector code 1044. This highlights the different ways that figures are tracked by countries themselves and multilaterals and the difficulties in getting information.

Figure 15. Distribution (%) of Japanese Contribution (1998-2007)



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In May 2008, on the occasion of the fourth Tokyo International Conference on African Development (TICAD IV) in Yokohama, Japan committed to doubling its ODA (without debt relief) to Africa by 2012. Under this commitment, Japan also pledged the following commitments for Africa: training 100,000 health workers, saving the lives of 400,000 children, improving maternal and reproductive health care and developing water facilities to provide safe drinking water to 6,500,000 people (Toyako Report).

5.6 Russia

Russian development assistance programmes in health include measures to combat the health workforce crisis as well as training and education. Currently the Russian Federation works in this area in African countries under the programme to support strategies to control malaria and in a framework of debt- relief initiative (Toyako Report).

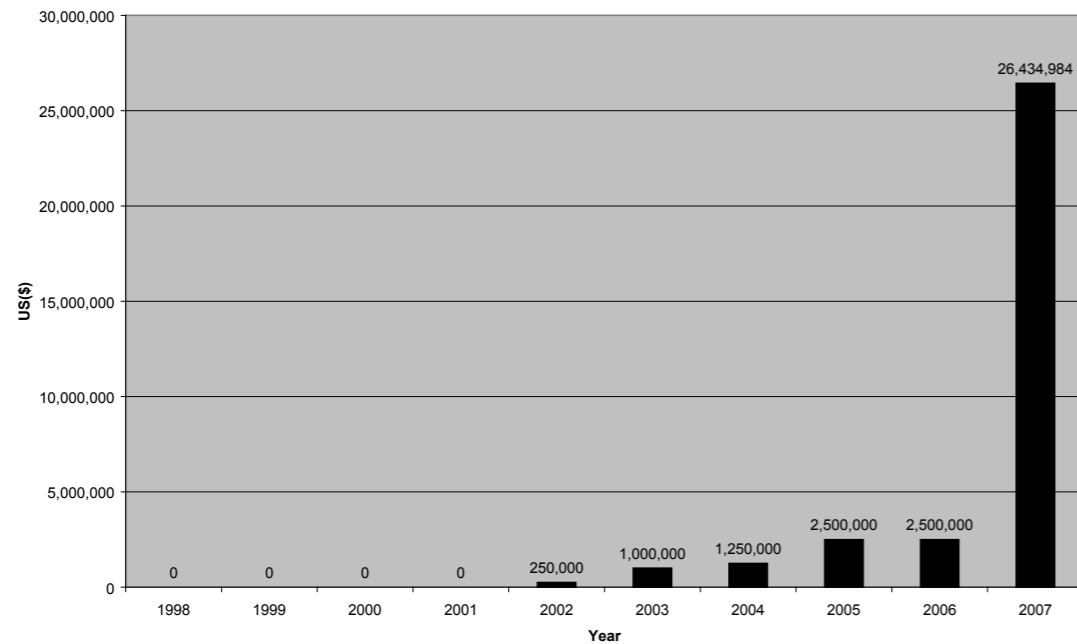
When verifying Russian data, the response received by partners upon enquiry to the Russian MOFA Unit dealing with International Organizations, was that such development assistance comes from different departments in the Government and thus it is very difficult to calculate the total development aid of Russian Federation. They referred to Russian Federal Service for Consumers' Protection and People's Wellbeing "Rospotrebnadzor" at www.rospotrebnadzor.ru but as the website is in Russian and it did not contain any information specific to malaria, this did not help with further clarification. As such, the figures obtained for Russia are from GFATM website and the Toyako Annex. In October 2006 the Russian Government took a decision to reimburse to the Global Fund US\$ 217 million, which was distributed to fund projects in the Russian Federation²⁷. In the absence of verification the analysis cannot comment on figures for total bilateral aid for infectious diseases or specific figures for malaria or funding for malaria research. The Toyako Report also did not show malaria specific figures in these two areas.

Russia's contribution increased significantly in 2007 (Figure 16). This is once again due to the contributions to GFATM and the World Bank (WB). Russia is the only country where WB funds have been added to the country specific contributions. In 2006, the Russian Government allocated US\$ 20 million to support the World Bank Booster Malaria Programme in Africa, and intends to expand its activities to contribute to fight against malaria in other regions, including Central Asia. The Russia-World Bank-WHO initiative includes: a US\$ 15 million trust fund under the World Bank Booster Programme for Malaria Control in Africa for Zambia and Mozambique which will co-finance projects in the two countries with the IDA, US\$ 4 million in support of training programmes and capacity building programmes for malaria control in Africa to be administered by the WHO Global Malaria Program, and US\$ 1 million for a staff development programme related to the initiative²⁸. Of the US\$ 20 million pledged, Russia has given US\$ 5 million in 2007 to the WB and only this amount has been included in the calculations.

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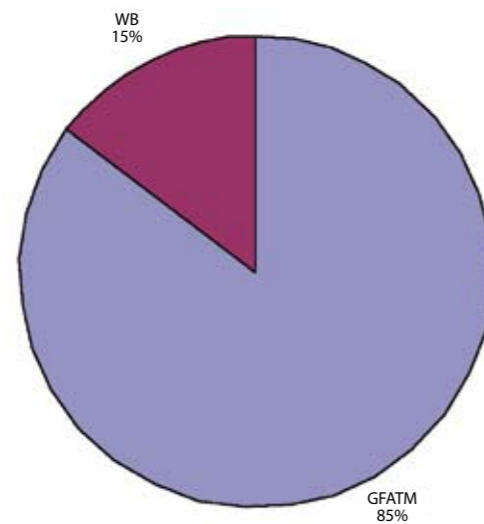
28 <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/0,,contentMDK:21519756~menuPK:258658~pagePK:2865106~piPK:2865128~theSitePK:258644,00.html>

Figure 16. Total Russian Contributions to Malaria Control from 1998-2007



As for several of the G8 countries the largest contribution from Russia is to GFATM and all funding is through multilateral channels. The Toyako Report did not have any figures for Russian bilateral and research contributions for malaria control.

Figure 17. Distribution (%) of Russian Contributions to Malaria Control (1998-2007)



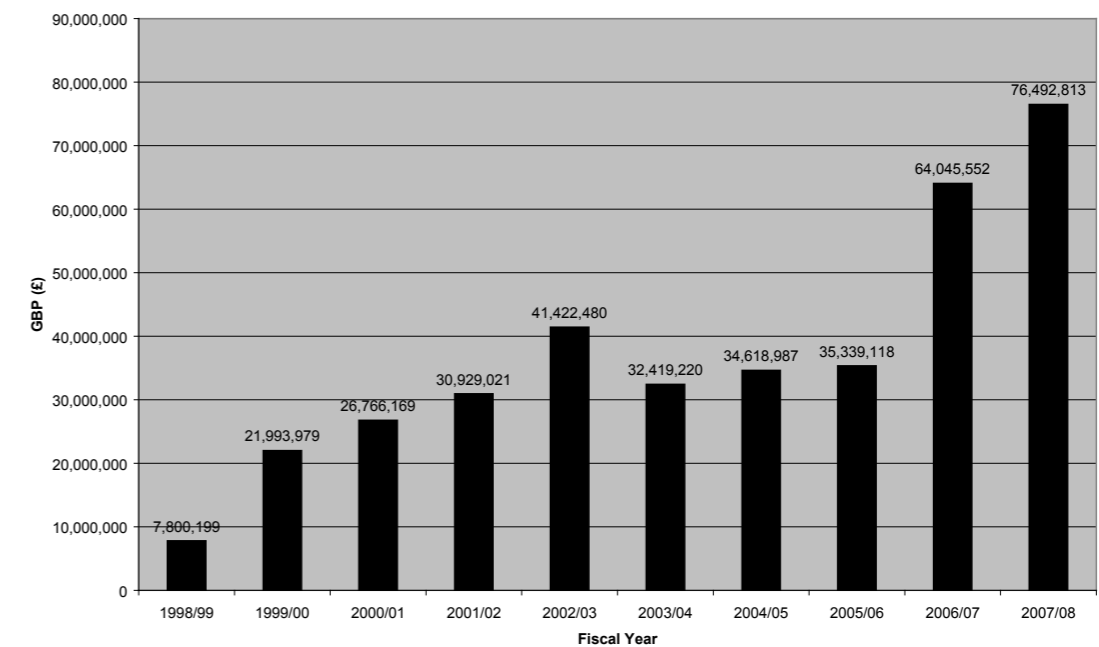
As the G8 country contributing the lowest amount to malaria, Russia should be encouraged to do more for malaria control.

5.7 United Kingdom

The United Kingdom supports countries to develop strong and sustainable health services to address all causes of illness including malaria. This allows countries to invest in training and for expansion of the number of health workers. The UK channels its support through a variety of different streams including through international organisations and partnerships and through its bilateral programmes, where the UK provides direct support to malaria control in several countries²⁹. This research found that the overall trend shows that UK funding for malaria control has increased significantly during the time period examined from £ 7.9 million in 1998/1999 to nearly £ 76.5 million in 2007/2008 (Figure 18). The overall contribution over the 10 years is £ 371.83 million. Due to its health systems strengthening approach, figures for bilateral funding from the Department for International Development (DFID) look small but this money only includes Bilateral Expenditure on malaria. For example this report has not included programmes such as “Scaling up Roll Back Malaria/Integrated Management of Childhood Illnesses” which is a £ 17.3 million contribution from September 2001 or the “Essential Health Package Bridging” in Malawi in 2002 which is nearly £ 5 million.

Contributions to WHO are malaria specific but it was not possible to find several of the figures for malaria and therefore it is an underestimated number. In general it was not easy to find malaria specific funding for the UK, as reflected in the Toyako Report which showed contributions for all HIV, TB and malaria together. Reporting will be made easier as DFID introduced a sector code in April 2008 which looks specifically at malaria. This should make UK contributions to malaria control easier to tabulate in the future.

Figure 18. Total UK contribution to Malaria control from 1998-2007

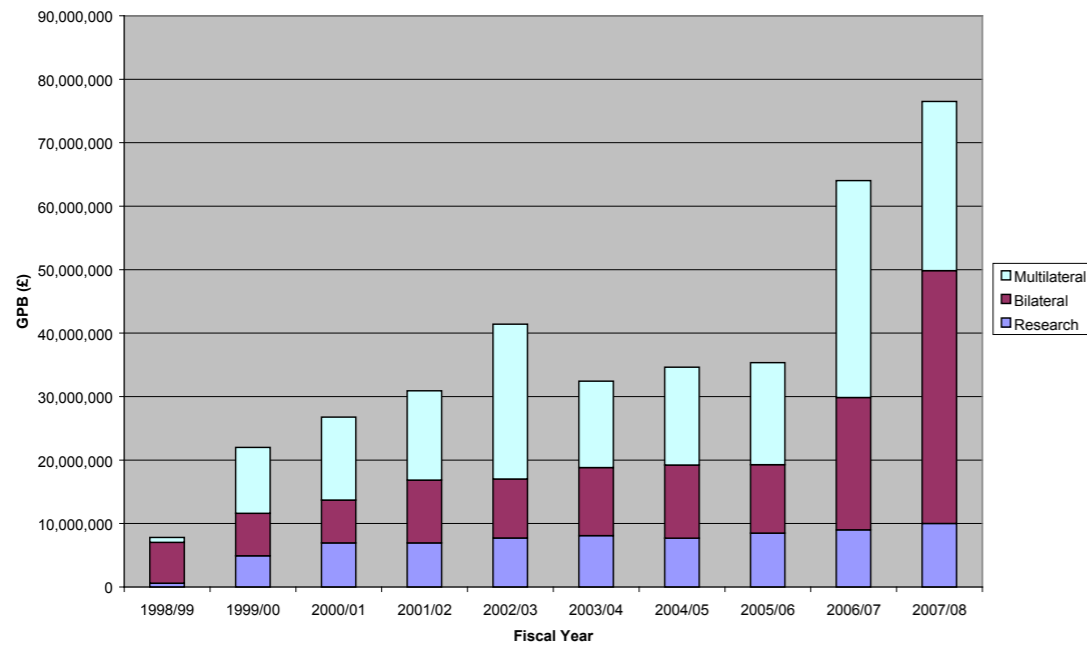


The majority of UK contributions are made bilaterally but the UK is one of the few G8 countries that spends significant amounts on malaria research (Figure 19); the total amount spent on malaria research over the 10 years is £ 70.4 million. UK data for research funding is not comprehensive as UK figures are directly from the UK Medical

²⁹ See p 17 A Review of the Work of the G8 in the Field of Tackling the Three Pandemics)

Research Council (MRC) and therefore some channels such as National Health Service are not included. The MRC commented that the 1998 figures for research funding for malaria were not easily available and that the 1999 figure does not include fellowships. In the graph below only contributions to research are specifically for malaria.

Figure 19. Bilateral, Multilateral and Research Funding towards Malaria Control by UK

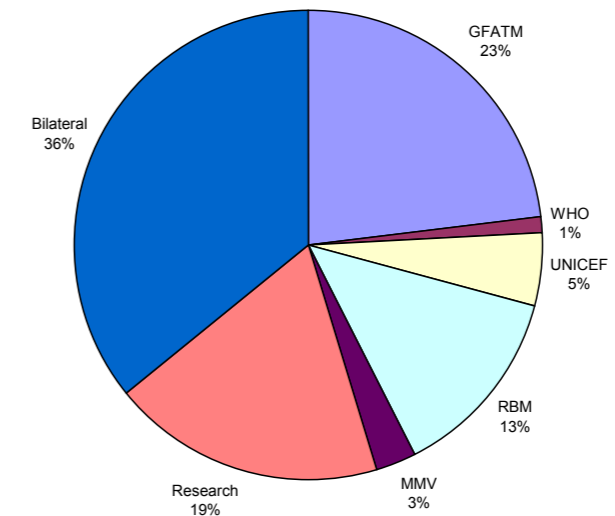


The UK has contributed £ 259 million to GFATM since it was established, of which £ 85.70 million has been contributed to malaria. The UK has also given the RBM Partnership, during its first 7 years, £ 49.45 million which is 13% of the UK's total contribution to malaria control over the years (Figure 20). The UK continues to support the RBM Partnership and its initiatives. Most recently it supported the Affordable Medicines Facility for malaria (AMFm) a global subsidy for ACTs to make the drugs widely available at an affordable price in both public and private outlets. The UK has pledged £ 40 million to date for this initiative³⁰. In 2007 the UK announced its long-term financial commitment to UNITAID, over a 20 year period starting at € 20 million (approx £ 15 million) in 2007 and, subject to the outcome of a joint assessment of its performance, to gradually rise to € 60 million (approx £ 40 million) by 2010³¹.

30 http://www.theglobalfund.org/documents/board/18/GF-B18-07_ReportAMFmAdHocCommittee.pdf

31 DFID press release - <http://www.dfid.gov.uk/Media-Room/Press-releases/2006/New-international-partnership-to-sink-prices-on-life-saving-medicines-for-poor-countries/>

Figure 20. Distribution (%) of UK Contributions (1998-2007)



The UK continues to contribute to malaria control beyond the timeframe of this report. For example in 2008, in Nigeria the UK committed £ 50 million to improve malaria control through providing LLINs, appropriate ACT treatment for children and IPTp.

5.8 USA

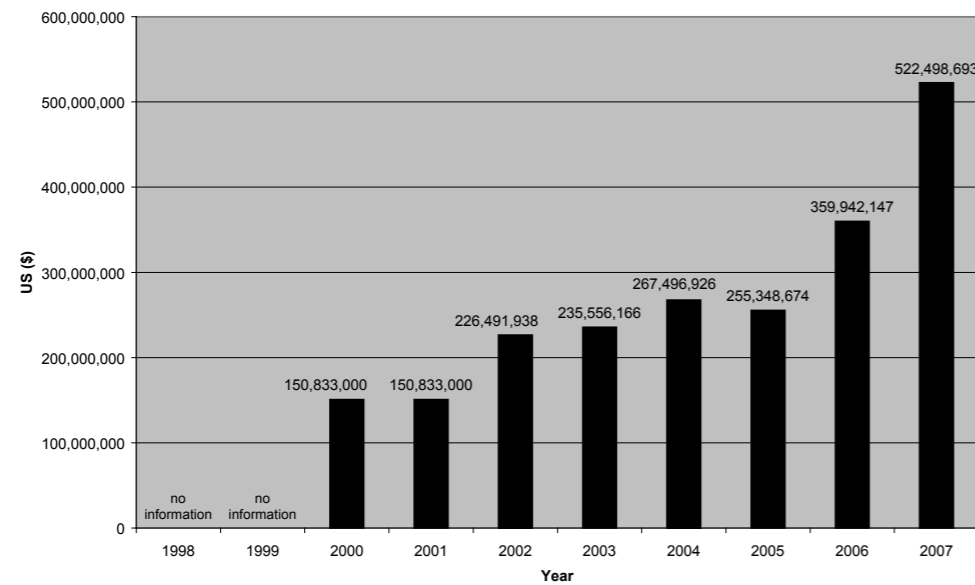
The United States supports the fight against malaria through significant bilateral and multilateral contributions, including GFATM. In 2006, the United States launched the President's Malaria Initiative (PMI), a five-year, US\$ 1.2 billion programme in fifteen of the hardest-hit countries in Africa. Through PMI, by the end of 2007, 30 million people are projected to benefit from LLINs, IRS to control mosquitoes, IPTp and treatment with ACT. PMI is led by the United States Agency for International Development (USAID) and implemented with the Department of Health and Human Services (HHS)/Centers for Disease Control and Prevention (CDC) and others. PMI works with host countries and in coordination with international partners, non-governmental organizations, faith-based and community groups, and the private sector³². Its funding has steadily increased from US\$ 30 million in fiscal year (FY) 2006 to US\$ 135 million in FY 2007, US\$ 300 million in FY 2008, and US\$ 300 million in FY 2009. PMI funding for FY 2010 is expected to reach US\$ 500 million³³.

The figures for USA have been confirmed for 2006 and 2007 but other years were not obtained directly from USAID and therefore have come from the following sources: the GFATM website, directly from UNICEF, MMV annual reports and the Toyako Annex. The USA is the biggest contributor to malaria control out of the G8 countries with total funding during 1999-2007 (Figure 21) of nearly US\$ 2.2 billion.

32 See p-17 The Review of the Work of the G8 in the Field of Tackling the Three Pandemics

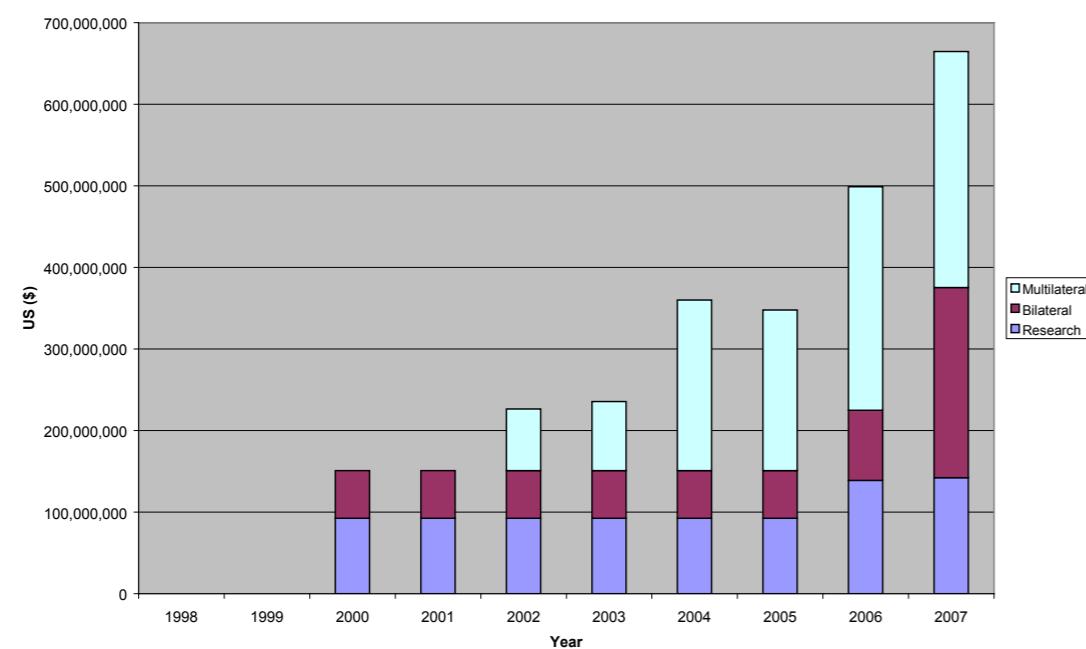
33 http://pmi.gov/resources/reports/pmi_fastfacts.pdf

Figure 21. Total USA Contribution to Malaria from 1998-2007



USA contributions to malaria are more evenly spread across funding streams compared to other G8 countries (Figure 22). The USA contribution to research is larger than any of the other G8 countries and the total over the 10 years examined is US\$ 836 million. For more than 40 years, the United States Government has been a major supporter of malaria vaccine research and development, with programmes supported by the Health and Human Services (the National Institutes of Health and CDC), the Department of Defence and USAID. It provides around US\$ 45 million each year for malaria vaccine development research³⁴.

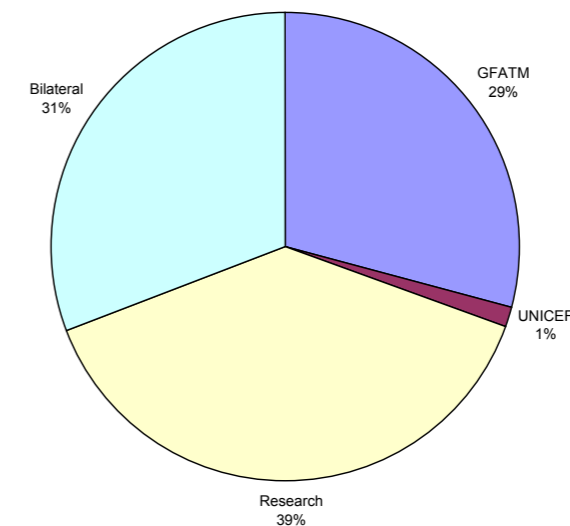
Figure 22. Bilateral, Multilateral and Research Funding towards Malaria Control by USA



34 See p-17 The Review of the Work of the G8 in the Field of Tackling the Three Pandemics

It is interesting to note that over the 10 years examined, the largest proportion of USA's contribution to malaria has been for malaria research (39%) (Figure 23). USA is also the largest contributor to GFATM in real terms but overall this is still only 29% of its contribution to malaria. Funding to malaria via GFATM is US\$ 634,903,622. USA is also a contributor to health systems strengthening and this is not included in the bilateral figures.

Figure 23. Distribution (%) of USA Contribution (1998-2007)



The USAID FY 2007 budget allocated US\$ 248 million for malaria assistance. This was increased in the Administration's FY 2008 request for USAID, with US\$ 388 million for malaria. The Health and Human Services FY 2007 budget also included US\$ 109 million for malaria work, with the same amount requested for FY 2008.

According to the G8 Summit Interim Compliance Report the USA has fully complied with its commitment to health systems and infectious diseases. Beyond the timeframe of this report it is interesting to note that in July 2008, US President George W. Bush enacted the Malaria Reauthorization Act (HR 5501), which pledged US\$ 5 billion to the President's Malaria Initiative (PMI). In its 2009 Annual Performance Plan, the US State Department requested close to US\$ 7 billion for health programming initiatives as part of its broader strategic objective of "investing in people." It was stated that these funds would be distributed to various global projects such as malaria and maternal and child health.

5.9 Total contribution of G8 countries

The contribution of the G8 countries per year is shown in Table 1 and Figures 24 and 25. To compare the countries and calculate total amounts, the figures were all exchanged into US\$. The G8 countries' contributions combined have steadily increased between 1998 and 2007. The USA is the largest donor contributing US\$ 2.18 billion followed by the UK which contributed US\$ 647.4 million. Russia is by far the lowest contributor giving only US\$ 33.9 million. Overall, the G8 countries have contributed almost US\$ 4 billion between 1998-2007.

It is important for readers to note that G8 countries' gross national income (GNI) have increased to varying degrees during the period examined. Consequently, increases in real terms do not reflect capacity to contribute more and may not be in line with income growth. The fact is that a serious deficit exists, and current contributions are not meeting it. While some non-G8 states are making great efforts to increase contributions to malaria control,

the responsibility to lead lies clearly with the wealthier nations and the G8 in particular. Developed nations first pledged to spend 0.7% of GNI on ODA in 1975. A renewed pledge was made for 2015. Table 2 shows how the G8 countries are performing with respect to this target. None of the countries is close to the target (the UK was the closest at 0.51% in 2006). Several countries, for example Denmark (0.85%), Luxembourg (0.83%), Netherlands (0.73%), Norway (0.87%) and Sweden (0.78%) (2004 percentages)³⁵, have met the target. The fact that G8 nations are being led rather than leading demonstrates a need for greater commitment.

35 http://www.unicef.ca/portal/Secure/Community/502/WCM/HELP/take_action/G8/Point7_EN.pdf

Table 1: Total country contributions per year in US\$

| Country | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | TOTAL (over 10 years) |
|------------|----------------|----------------|----------------|----------------|-------------|-------------|-------------|-------------|-------------|---------------|-----------------------|
| CANADA | no information | no information | 67,335 | 13,081,471 | 795,441 | 7,767,847 | 49,078,555 | 62,112,004 | 4,260,363 | 23,595,749 | 160,758,766 |
| FRANCE | no information | no information | 374,418 | 95,040 | 13,204,624 | 20,482,214 | 70,372,897 | 70,853,100 | 127,560,842 | 258,995,348 | 561,938,482 |
| GERMANY | no information | no information | 135,616 | 131,731 | 8,085,965 | 8,390,381 | 8,620,751 | 27,455,630 | 23,516,251 | 31,067,284 | 107,403,607 |
| ITALY | no information | no information | 1,953,917 | 1,897,941 | 21,560,002 | 25,801,293 | 28,366,191 | 28,321,136 | 41,177,455 | 45,079,096 | 194,157,031 |
| RUSSIA | no information | no information | no information | no information | 250,000 | 1,000,000 | 1,250,000 | 2,500,000 | 2,500,000 | 26,434,984 | 33,934,984 |
| JAPAN | 5,254,237 | 416,667 | 4,285,714 | 6,915,888 | 21,001,724 | 23,768,852 | 26,349,740 | 48,364,486 | 56,140,661 | 71,243,078 | 263,741,046 |
| UK | 12,923,840 | 35,583,956 | 40,519,748 | 44,547,748 | 62,145,315 | 52,948,456 | 63,434,110 | 64,240,910 | 117,864,673 | 153,062,734 | 647,271,492 |
| USA | no information | no information | 150,833,000 | 150,833,000 | 226,491,938 | 235,556,166 | 267,496,926 | 255,348,674 | 359,942,147 | 522,498,693 | 2,169,000,542 |
| TOTAL US\$ | 18,178,077 | 36,000,623 | 198,102,412 | 204,421,348 | 352,739,568 | 367,947,361 | 465,890,614 | 497,083,935 | 728,702,028 | 1,108,381,217 | 3,977,447,185 |

* All country amounts are underestimates as not all contributions towards malaria control could be verified or disaggregated from ODA (e.g. HSS, WB)

Figure 24. Total Contribution for Malaria Control over the 10 year period by G8 country

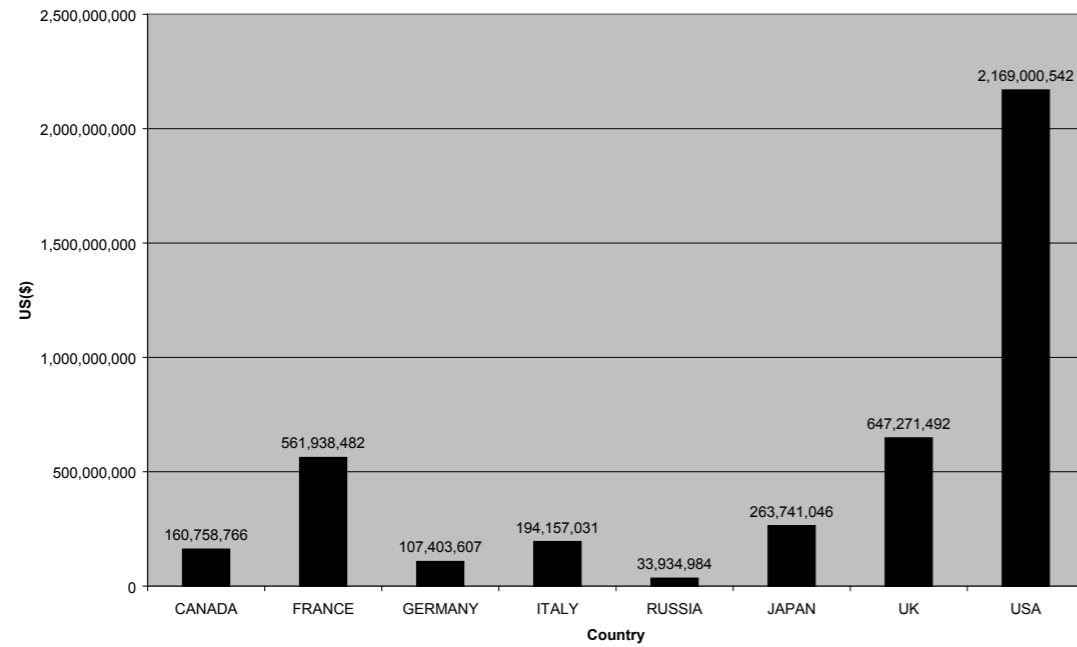


Figure 25. Combined Contribution by G8 countries towards Malaria Control by year

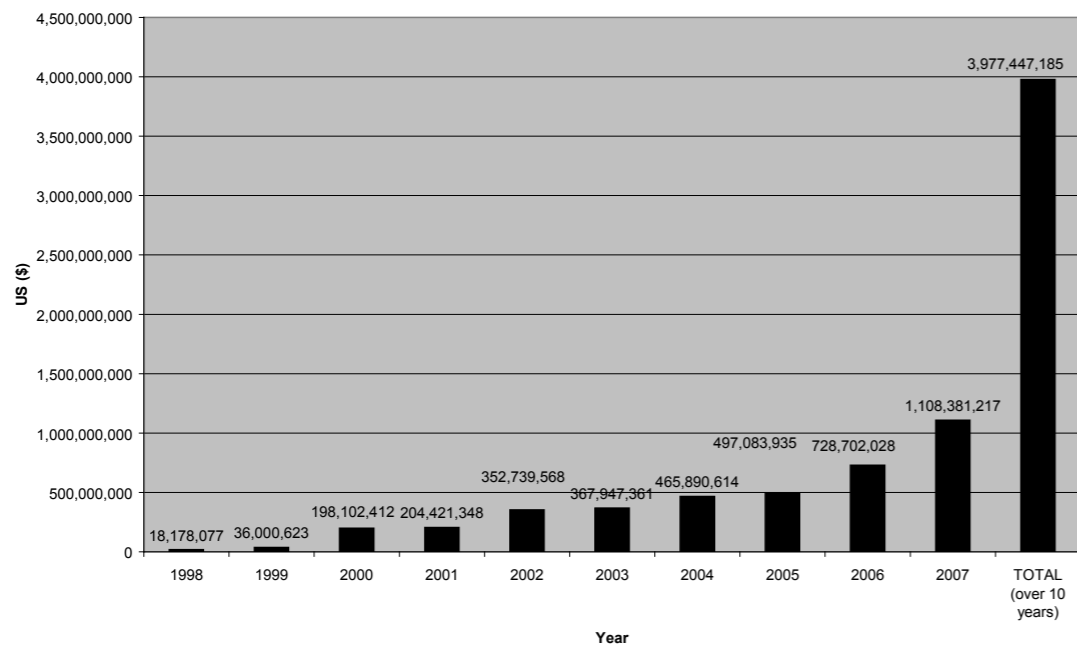


Table 2: Official Development Assistance (ODA) as % Gross National Income (GNI)

| | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Japan | 0.26% | 0.30% | 0.31% | 0.22% | 0.22% | 0.21% | 0.19% | 0.26% | 0.23% | 0.16% |
| Italy | 0.19% | 0.16% | 0.12% | 0.14% | 0.21% | 0.19% | 0.16% | 0.29% | 0.19% | 0.20% |
| UK | 0.29% | 0.24% | 0.30% | 0.31% | 0.33% | 0.37% | 0.39% | 0.47% | 0.51% | 0.40% |
| USA | 0.10% | 0.10% | 0.10% | 0.12% | 0.13% | 0.15% | 0.16% | 0.22% | 0.18% | 0.16% |
| France | 0.38% | 0.39% | 0.28% | 0.30% | 0.41% | 0.46% | 0.46% | 0.46% | 0.46% | 0.40% |
| Germany | 0.25% | 0.26% | 0.24% | 0.25% | 0.28% | 0.32% | 0.30% | 0.35% | 0.34% | 0.38% |
| Canada | 0.28% | 0.28% | 0.26% | 0.22% | 0.29% | 0.26% | 0.29% | 0.36% | 0.31% | 0.31% |

Source for GNI: World Development Indicators database, World Bank and where data not available it was taken from - http://www.nationmaster.com/graph/eco_gni_atl_met_cur_us-gni-atlas-method-current-us
 Source for ODA- Development/ Aggregate Aid Statistics/ ODA by Donor (then select country) <http://stats.oecd.org/WBOS/Index.aspx?DataSetCode=CSP2009> - ODA by Donor. Specific Line taken from - top line ODA. Other points to note- Flow type: Net disbursements, Amount type: US\$ millions

6. Contribution by the G8 countries to the World Bank, European Union and for Health Systems Strengthening

This section highlights the fact that there are other ways by which the G8 countries give significant amounts to malaria control, but it was not possible to disaggregate country specific funding for malaria. Two donors, World Bank and European Union (EU), and one approach, health systems strengthening, constitute 3 of the largest contributions in this respect.

6.1 World Bank

Countries' International Development Assistance (IDA) money to the World Bank (WB) is not earmarked, upon receipt, for any specific disease (neither by the donor countries nor the Bank itself). Therefore G8 country contributions cannot be tied to the money spent on malaria by the World Bank Booster Programme for Malaria Control, in terms of how much they give through these streams. Table 3 shows the amounts given by the G8 countries to WB IDA.

Table 3: Cumulative International Development Assistance Subscriptions to the World Bank

| All figures in US\$ | Cumulative IDA Subscriptions as of June 05 ^[2] | Fifteenth Replenishment (Dec 07) ^[1] | Overall contribution to WB per country |
|---------------------------------------|---|---|--|
| US | 28,691,780,000 | 3,974,140,579 | 32,665,920,579 |
| Japan | 26,500,190,000 | 3,261,119,246 | 29,761,309,246 |
| Germany | 14,212,810,000 | 2,299,070,263 | 16,511,880,263 |
| UK | 9,873,970,000 | 4,582,360,654 | 14,456,330,654 |
| France | 8,693,720,000 | 2,119,866,504 | 10,813,586,504 |
| Canada | 5,299,800,000 | 1,304,169,711 | 6,603,969,711 |
| Italy | 5,170,580,000 | 1,239,235,125 | 6,409,815,125 |
| Russia | 203,980,000 | 114,465,400 | 318,445,400 |
| Total IDA (from G8) | 98,646,830,000 | 18,894,427,482 | 117,541,257,482 |
| Total IDA (from all countries) | 124,353,080,000^[3] | 41,600,000,000^[4] | 165,953,080,000 |

[1] <http://www.iopcfund.org/SDR.htm> - Conversion of Special Drawing Rights (SDR)
 [2] <http://web.worldbank.org/WBSITE/EXTERNAL/EXTABOUTUS/IDA/0,,contentMDK:21205385~pagePK:51236175~piPK:437394~theSitePK:73154,00.html>
 [3] World Bank document - Cumulative IDA subscriptions 2005
 [4] World Bank Press release, Dec 14th 2007 "Record Funding for World's Poorest Countries" <http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:21587453~pagePK:34370~piPK:34424~theSitePK:4607,00.html>

The WB gives money to malaria through different projects and streams (see Table 4 below). In 1997 the Bank financed the Government of India's Enhanced Malaria Control Project (EMCP, 1997, US\$ 164 million). The project supported the government in transitioning from an earlier eradication strategy based solely on IRS towards a more current control strategy. The World Bank launched the Global Strategy and Booster Programme for Malaria Control as a renewed commitment to achieve the global Roll Back Malaria targets. This multi-year effort foresees a commitment of US\$ 500 million to US\$ 1 billion over five years. It was also translated into a specific plan for Bank support for malaria control efforts in Africa with the goal of cutting Africa's 850,000 malaria deaths in half by 2010 and in half again by 2015. This is in line with the targets set in 2000 by African leaders in the Abuja Declaration. The programme helps affected countries pay for preventive measures such as ITNs as well as medications to prevent and treat malaria.

Table 4: World Bank Contributions to Malaria Control

| | TOTAL |
|--|--------------------|
| Booster Programme for Malaria Control in Africa ^[1] | 626,000,000 |
| Enhanced Malaria Control Project - India ^[2] | 165,000,000 |
| Contributions to MMV (via Global Forum) ^[3] | 9,000,000 |
| TOTAL US\$ | 800,000,000 |
| G8 money as % of total IDA money | 71% |
| % of overall IDA money to malaria^[4] | 0.477% |

[1] Taken from World Bank Booster Programme for Malaria Control in Africa flyer - <http://siteresources.worldbank.org/EXTAFRBOOPRO/Resources/MalariaFlyer.pdf>
 [2] Taken from web page - Malaria Control Project in India- June 97 to Dec 2005 - <http://web.worldbank.org/external/projects/main?Projectid=P010511&theSitePK=40941&pagePK=64283627&menuPK=228424&piPK=73230>
 [3] MMV Annual Reviews 1999-2007 (from MMV website www.mmv.org)
 [4] Calculation does not include money to MMV as it is unclear whether the money is from IDA.

Given that the G8's contribution to the World Bank IDA is sizable (they contribute 71% of its funds) it is reasonable to assume that some, if not all, of the money that goes to malaria (which is less than 1% of all IDA) originated from some of the G8 donors. But as stated before, because each individual dollar is not marked on arrival it is impossible to say with complete certainty what funds have gone to which project and from which particular nation's contribution. The total WB contribution to malaria programmes from IDA is less than 0.5%.

Table 5: Country specific contribution to Malaria through the World Bank*

| All figures in US\$ | |
|---|----------------------|
| US | 155,699,088 |
| Japan | 141,854,527 |
| Germany | 78,702,349 |
| UK | 68,904,762 |
| France | 51,541,959 |
| Canada | 31,477,211 |
| Italy | 30,551,791 |
| Russia | 1,517,841 |
| Total approximate malaria money from G8 via World Bank | 560,249,527.6 |

* This figure was calculated by taking countries overall IDA contribution to World Bank (Table 3) against the percentage of 0.477% of overall IDA money that goes to malaria (Table 4)

6.2 EU and European Commission (EC)

The EU is not an official member of G8, but because of its role in the world's economy and trade, since 1977 it has participated in meetings and is represented by the country holding the EU Presidency, Commission and Council. The EU however does not take the G8 Presidency or host Summits. The Presidency of the Council of the European Union is only visible at G8 summits when the Presidency is held by a non-member of the G8, such as Sweden in July 2010.

The European Commission is a unique supranational organisation – not a sovereign Member State – hence the name G8 “Group of Eight” Nations, rather than G9. The European Commission is not a G8 member country but has all the privileges and obligations of membership except the right to host and chair a Summit. The Commission has all the responsibilities of membership, and what the President endorses at the Summit is also politically binding on it. The role of the European Commission is especially important when it comes to matters where it has exclusive competence (e.g. international trade and agricultural policy).

The EU is a significant contributor to malaria research and control. Like the WB, contributions from the EU member states are not earmarked for malaria. A recent European Alliance Against Malaria report on how the EC and EU member states' funding and policy are in line with GMAP demonstrates the various ways in which contributions are made towards malaria control from the EU³⁶.

By 2007, the European Commission (EC) had contributed US\$ 789 million to the GFATM. The EC announced an additional pledge for 2007 amounting to approximately US\$ 100 million, and proposed an additional € 300 million over the following three years, in conformity with its budget procedures.

The sixth Framework Programme for Research (FP6) is the European Community Framework Programme for Research, Technological Development and Demonstration. It is a collection of the actions at EU level to fund and promote research³⁷. During the period of implementation of FP6 (2002-2006), the European Commission has committed more than € 450 million in the fight against HIV/AIDS, tuberculosis and malaria. These funds were devoted to cover various basic/pre-clinical research projects for the three diseases as well as to clinical research (phase I-III) and research-oriented capacity building activities in Africa, by means of the European and Developing Countries Clinical Trials Partnership (EDCTP) pilot programme. Overall, the Commission has in the last four years allocated more than € 1.1 billion to assist partner countries confronting the three diseases through a wide array of financial instruments (with an average of € 280 million per year), which represents an almost four-fold increase from the annual average in the period 1994-2002³⁸.

EC contributions to malaria (see Annex A2.9) between 1998 and 2007 amount to € 219.5 million. This figure includes money to the GFATM, UNICEF and FP7. Overall EC ODA is almost € 73.5 billion³⁹.

The four G8 countries (Italy, France, Germany and UK) that are also EU member states have contributed € 51.8 billion, which amounts to 70% of overall EC ODA contributions. Therefore it is reasonable to assume that, as with the World Bank, most of the money that goes to malaria originated from some of the G8 donors. However, it is impossible to say with complete certainty the exact amounts contributed by the G8 countries due to the way finance is processed.

6.3 Health Systems Strengthening

Countries and multilateral organisations have recognised the importance of supporting the strengthening of public, private and community health systems where weaknesses and gaps in those systems constrain the achievement of improved outcomes in reducing the burden of malaria and other communicable diseases. Often, it is inadequate health systems that are one of the main obstacles to scaling-up interventions. Therefore, health systems strengthening (HSS) is becoming a more important part of ODA as time progresses, and increased amounts of contributions are being channelled under this stream. Funding for HSS can either be disease specific or cross-cutting across several diseases and health areas, but, due to the integrated nature of the funding it is not easy to determine the amounts specific for malaria. This report acknowledges that HSS is extremely important towards having an impact on malaria control and in achieving the 2010 and longer term goals.

Commitments made by the G8 countries include HSS efforts; several examples are noted below. At the 2006 G8 Summit in St. Petersburg, Canada announced CAN\$ 450 million (2006-2016) in new funding to support country-led efforts to strengthen health systems in Africa. Canada during FY2000 to 2007 spent over US\$ 1 billion on HSS. The USA has spent in FY2006 and FY2007 US\$ 7.5 million and US\$ 8.4 million respectively on HSS. This included service delivery, health workforce, information, medical products, vaccines, and technologies, financing and governance⁴⁰. Japan in 2005 and 2006 spent US\$ 265 million and US\$ 263 million respectively on HSS. DFID places a high priority on ensuring that the drugs, commodities and services that are needed to treat malaria are accessible through well functioning health systems. Since 1997, DFID has committed over £ 1.5 billion to strengthening health systems at country level so that better care and drugs can be delivered⁴¹.

7. Conclusions and Recommendations

This report has attempted to track G8 malaria-specific commitments between 1998 and 2007. As described below, this task proved complex due to varying levels of data availability, reporting and verification. The figures obtained are generally underestimates of what countries have actually contributed as some channels, through other sectors for example, have invariably been missed.

At its 2007 summit, the G8 referenced the MDGs, this time committing members to at least US\$ 60 billion to fight HIV/AIDS, malaria, and tuberculosis, and to improve health systems in developing countries in a five year time frame. The recent G8 Summit Interim Compliance Report⁴² has tried to score the progress of the countries towards honouring this and other commitments from 2007 onwards based on pledges, contributions and new

36 *Contributing to Global Action: The European Union and the fight against Malaria, June 2009*

37 The Sixth Framework Programme http://ec.europa.eu/research/fp6/pdf/fp6-in-brief_en.pdf

38 See p28-A Review of the Work of the G8 in the Field of Tackling the Three Pandemics

39 OECD.Stat database. Source – Development/ Aggregate Aid Statistics/ ODA by Donor (then select EC <http://stats.oecd.org/WBOS/Index.aspx?DataSetCode=CSP2009>). Specific figures taken from top line ODA. Other points to note- Flow type: Net disbursements, Amount type: US\$ millions

40 http://www.usaid.gov/our_work/global_health/home/Funding/funding_rd.html

41 DFID Malaria Factsheet <http://www2.dfid.gov.uk/mdg/malariafactsheet.asp>

42 p116-Health Systems and Infectious Disease Martell et al., 2008 Hokkaido-Toyako G8 Summit Interim Compliance Report by the G8 Research Group, Munk Centre of Toronto University. Available at <http://www.g8.utoronto.ca/evaluations/2008compliance-interim/2008-interim-all.pdf>

initiatives across the main three diseases and health systems strengthening. The scoring system used in the Interim Compliance report demonstrates both the continuing difficulty in holding G8 countries to their commitments and the arbitrary manner by which the scoring has been performed. For example, the present report shows that France is in the top three donors of the G8 countries (based on 1998-2007) but yet the Interim Compliance Report does not reflect this. Furthermore, the report demonstrates that not only are the majority of commitments and disbursements combined (i.e. for all main three diseases) but HSS and new initiatives such as taskforces and technical assistance are not easy to quantify and therefore underestimate the amounts given to malaria.

Considering these complications, this report has not attempted to either commend or criticise G8 states, but rather bases its conclusions on the data available and wider global health contributions. The report represents an historical record of commitments to malaria control, where evidence is available. Consequently, recommendations focus on ways and means by which we can better track malaria contributions in future and thereby encourage G8 countries to continue to increase their funding, to responsible levels, over the coming years.

7.1 Conclusions

- The estimated amount given to malaria from 1998-2007 is US\$ 3.98 billion. As not all malaria specific money from G8 nations can be tracked, their contributions are most likely underestimated. If WB and EC figures are combined (US\$ 1.1 billion) and are added to the US\$ 3.98 billion, the total malaria funding is bringing the total amount for these 10 years to approximately US \$ 5.08 billion. Notwithstanding the fact that this is an estimate, it can be clearly stated that there will be a huge funding gap to achieve the US \$ 11.5 billion required by the GMAP until the end of 2010.
- Malaria is certainly on the collective G8 agenda and in individual country ODA policies – though the latter to varying degrees. G8 contributions to malaria have increased over the past 10 years in real terms. However this needs to be put in the context of rising GNI and ODA over the same period.
- Interestingly, bilateral contributions were often the smallest proportion of money contributed to malaria control. This can perhaps be accounted for in the light of bilateral channels adjusting spending on their perception of priorities and moving towards controlling malaria through multilateral bodies.
- To achieve elimination and final eradication of malaria there is the need for increased investment in research and development of new tools and control methods with US\$ 750-900 million needed annually (GMAP). Research for this report found little data available on research spending, suggesting that it is not a priority for all G8 countries either as an element of the elimination strategy or as a budget line for tracking.
- The major difficulty in undertaking this research was the comprehensive tracking of funding specifically dedicated to malaria at national/bilateral levels. International level (multilateral) contributions were also difficult to track, with the exception of the GFATM. As most G8 governments do not report specifically on contributions to malaria, it is often integrated with other communicable diseases or other cross-cutting health issues (HSS, maternal health, communicable diseases). This makes disaggregation difficult. Moreover, it was difficult to identify contributions directly to multilateral agencies (e.g. WB) for malaria as they are not earmarked. In some instances e.g. UNICEF, WHO “direct” contributions to malaria can be identified but “indirect” contributions to malaria (often the larger amount) cannot be tracked. There is thus no clear and simple way of tracking expenditure on malaria. However, tracking methods for malaria have improved over time. As demonstrated by this report, with the exception of Japan, it was not possible to get malaria specific information for G8 countries in the late 1990’s.
- It is not easy to determine if countries are meeting their commitments. Countries are often broad or vague in their commitments, either making them for all three major diseases together, for health systems

strengthening, or sometimes for specific commodities such as LLINs and ACTs. Commitments are also made in areas like technical support which are not easy to quantify. Therefore, it is very difficult to hold countries to account as it is not possible to always determine what exactly they have committed in regard to malaria or their malaria-specific spending. Some nations, such as the UK, are seeking to correct this by adding malaria-specific funding streams to their reporting. In addition, both commitments and reporting are in several currencies. With exchange rates fluctuating widely even during short periods of time, it is very difficult to calculate actual contributions vs. commitments often made a few years ago.

- Countries have differing reporting systems so it is not easy to make comparisons. For example the UK until recently did not have an overall malaria specific reporting code whereas other G8 countries did.
- G8 countries give large amounts of money to the WB, EC, GFATM and other multilaterals but have limited control on how much is being spent on the three major diseases or how much will be allocated to malaria. While conditions should not be placed upon such grants, G8 nations should seek clarification on the destination of such funds so that their total spending on malaria can be tracked.
- GFATM has made a huge difference to international flows of money to malaria and continues to do so. For all countries except the USA and UK, contributions to malaria through the GFATM were the highest proportion of their contribution. The report found the GFATM to be the one of the most transparent of multilateral organizations researched and its impact in saving lives can be commended.
- UNICEF is a multilateral agency that spends a significant amount of money on malaria. However, tracking of its own spending on malaria is not easy. Although UNICEF did provide figures, they were not readily available and centralized and we received official figures only from 2002 onwards. Some countries appear to have their own methods of tracking malaria contributions through UNICEF but sometimes their figures and those of UNICEF were not the same (e.g. Japan was able to track its UNICEF contributions for malaria from 1998-2007 but UNICEF was only able to give us figures for Japan from 2002 onwards. Comparison of the figures for the latter years showed that the amounts were not the same). This report concludes that UNICEF should make its spending on malaria available for public scrutiny, as with other data in its annual reports or on its website.

7.2 Recommendations

This section makes recommendations on how to improve G8 contributions to malaria and also raises questions that need to be addressed.

- The financing gap for malaria is US\$ 11.5 billion from 2009 to the end of 2010 according to GMAP figures. Although we cannot define how much the G8 is expected to contribute altogether, as the most powerful and rich group of nations, it has a moral obligation to demonstrate leadership and best donor practice. Meeting and exceeding 0.7% targets of GNI for ODA must be a priority in this regard.
- G8 countries are part of a bigger partnership and it is through working with RBM and other key bodies that needs can be addressed through harmonized response programmes. If the goals of GMAP are to be met then a harmonized and more specific targeting of resources to malaria is required.
- G8 countries should make their information regarding malaria more transparent both in their tracking methods for their own bilateral contributions as well as those given through multilateral channels. As malaria is a named element of MDG 6, countries should have malaria-specific reporting categories and appropriate measurement indicators to demonstrate whether contributions are on track or not. G8 budgets should have clearly designated budget lines to track funding for malaria information, interventions and commodities.

- Bilateral decision makers need to see and understand what their peers are doing and how much they are spending. This report supports and recommends the Toyako Framework as a way to track and hold countries accountable to their commitments.
- To reach elimination and finally eradication, new tools for malaria control and treatment are required. G8 countries that are not prioritizing research should be encouraged to give more funding as well as undertaking better reporting on this issue. A new tracking method for investment in research towards malaria control is vital. This should be additional to meeting the implementation resource needs for sustaining malaria control towards elimination.
- While the US\$ 11.5 billion funding need for malaria control until end 2010 must be met, there is a clear role for civil society to play in determining where and how monies are effectively spent. More open dialogue on tracking (indicators, measurement procedures, reporting etc), innovative financing, malaria monitoring and needs assessments are required.

In March 2009, European NGOs gave recommendations on "A Comprehensive Approach to Health MDGs" during a Civil Society Hearing held by the G8 Health Experts Group. This report focused on MDG5- Improve Maternal Health and recommends, as above, better budget tracking for malaria. This report endorses and supports a further key recommendation made by European NGOs:

- Any health systems strengthening approach must include clearly identifiable financial coverage of malaria information, interventions and commodities, including efficient and sustainable supply chains for the procurement, delivery and distribution of malaria products such as mosquito nets and drugs.

Annex 1: Roll Back Malaria (RBM) Partnership

History ⁴³

Prior to RBM's launch, a series of unsuccessful initiatives to curb the growing burden of malaria contributed to a sense of scepticism and disillusionment among international health experts. During the 1980s and 90s, especially in Africa, malaria control programmes fell into disrepair or were abandoned entirely.

However during the 1990s, momentum towards a new attack on malaria, especially in Africa, gathered strength. A Malaria Control Strategy for Africa was first formulated in 1987, and adopted in Brazzaville in 1991. In 1992, the Ministerial Conference on Malaria in Amsterdam enunciated a Global Malaria Control Strategy, which was endorsed by The Economic and Social Council of the United Nations (UN) in 1994. The decade of the 1990s witnessed two major programmatic achievements. In mid-1996 WHO secured funding to accelerate the implementation of the Africa Regional Malaria Control Strategy in eight countries in Southern Africa. In 1997 the WHO Regional Office for Africa (WHO-AFRO) received \$ 9 million from the WHO Director-General's Special Fund for Accelerated Implementation of Malaria Control to support malaria control programmes in 21 countries. In 1998 WHO-AFRO received an additional \$ 9 million to support malaria control activities in 27 countries.

In 1997 a regional partnership initiative known as the African Initiative on Malaria Control (AIM) was launched by representatives of the World Bank, WHO, UNICEF and others (including DFID, Malaria Consortium and USAID). The goal was to intensify efforts to control malaria in the regions through long-term commitments by partners of up to 25 to 30 years. Together, AIM and the Accelerated Implementation of Malaria Control programme provided the foundation for the launch of Roll Back Malaria Partnership in October 1998.

Creation

The RBM Partnership is an international coalition with hundreds of partners. As stated above, the partnership was launched in October 1998, to provide a co-ordinated international approach to malaria control and to accelerate social and political action to stop the unnecessary spread of malaria. The intention of the founding partners of RBM – WHO, World Bank, UNICEF and the UNDP – was to mobilize a broad-based and comprehensive effort to tackle malaria by addressing the complexity of its roots. Many bilateral agencies also quickly pledged their support, and the RBM Partnership has since grown to include malaria endemic countries; bilateral and multilateral development partners; private sector; NGOs; community-based organizations; foundations; research and academic institutions. Roll Back Malaria was viewed to be different in important ways from other global partnerships. It was hoped that a 'loosely' constructed Partnership would avoid the risks inherent in a top-heavy management structure, and increase partners' flexibility to act.

Vision: By 2015 the malaria-related Millennium Development Goals (MDGs) are achieved. Malaria is no longer a major cause of mortality and no longer a barrier to social and economic development and growth anywhere in the world.

Mission: To work together to enable sustained delivery and use of the most effective prevention and treatment for those affected most by malaria by promoting increased investment in health systems and incorporation of malaria control into all relevant multisector activities.

⁴³ Final report of the external evaluation of RBM P6

Targets⁴⁴

Specific RBM targets were identified at the Abuja Summit of African heads of state and government leaders in Abuja, Nigeria, in April 2000. With the Abuja Declaration on Roll Back Malaria, representatives from 44 of the 50 malaria-affected countries in Africa committed themselves to halving malaria mortality by the year 2010. They also resolved to “initiate appropriate and sustainable action to strengthen the health systems to ensure that, by the year 2005:

- At least 60% of those suffering from malaria have prompt access to and are able to use correct, affordable and appropriate treatment within 24 hours of the onset of symptoms.
- At least 60% of those at risk of malaria, particularly pregnant women and children under five years of age, benefit from the most suitable combination of personal and community protective measures such as insecticide treated mosquito nets and other interventions which are accessible and affordable to prevent infection and suffering.
- At least 60% of all pregnant women who are at risk of malaria, especially those in their first pregnancy, have access to chemoprophylaxis or presumptive intermittent treatment.

The strength of partnership

Effective Partnerships - The RBM Partnership's strength lies in its ability to form effective partnerships both globally and nationally. Partners are working together to scale up malaria-control efforts at country level, coordinating their activities to avoid duplication and fragmentation and to ensure optimal use of resources.

Raising awareness - A key role of the RBM Partnership is to lead continuing advocacy campaigns to raise awareness of malaria at the global, regional, national and community levels, thus keeping malaria high on the development agenda, mobilizing resources for malaria control and for research into new and more effective tools (including a vaccine), and ensuring that vulnerable individuals are key participants in rolling back malaria.

RBM Structure:

- RBM Partner's Forum: an assembly of constituencies of all RBM partners which is the ultimate coordinating body of the partnership.
- RBM Partnership Board: this constitutes 20 voting members from various RBM constituencies. They provide strategic guidance, lobby for needed resources, and ensure increased support at country level.
- RBM Partnership Secretariat: the office that facilitates coordination of contribution from RBM partners fosters consensus on best practises in scaling up interventions recommended by WHO, leads global advocacy efforts, mobilises additional resources in the fight against malaria, strengthens communication between partners, and ensures partnership is broad and inclusive.
- Working Groups: these groups collate and disseminate information on complex issues regarding scale-up and advise the board accordingly. They are task orientated with specific goals, and identify and address any gaps in the partnership's ability to respond. Their membership is drawn from all levels of wider partnership.

Financing:

RBM's main sources of external financing include: Multilateral development banks (World Bank, African Development Bank, Asian Development Bank, Inter-American Development Bank), GFATM, Bilateral agencies, INGOs, Foundations, large multilateral corporations and wealthy individuals.

Successes and achievements to date:

- Commitment & Consensus: managed to unite global organisations under one banner with explicit shared aims. Since its conception, global desire and optimism in, and commitment to, the achieving of malaria-related MDGs and targets has greatly increased, highlighted by the UN's declaring 2001-2010 the Decade of Malaria.
- Ideals that have been reinforced by unified acceptance of GMAP. A document prepared with input from 30 endemic countries, 65 international institutions and over 250 specialists from a diverse range of spheres.
- Resource Mobilisation: between 1998 and 2002, a twofold increase in spending on malaria internationally (from \$ 67m/year to \$ 130m/year). According to World Malaria Report 2008, in 2006 more than \$ 688m was spent on malaria. It is estimated to be at \$ 1.1bn in 2008. It is impossible to know how much of this increase is down to RBM, but certainly the influence and effect it has had has been positive.
- Progress at the country level: Where prevention and treatment strategies were laid out on a large scale, malaria cases dropped by more than 50%.

All the above information was taken from the RBM website and the *Final report of the external evaluation of RBM*

⁴⁴ Final report of the external evaluation of RBM P7

Annex 2: Tables and Sources for Country Specific Data

Table A2.1-Canadian contributions to infectious disease control

| CAN\$ | 1998/ 1999 | 1999/ 2000 | 2000/ 2001 | 2001/ 2002 | 2002/ 2003 | 2003/ 2004 | 2004/ 2005 | 2005/ 2006 | 2006/ 2007 | 2007/ 2008 | TOTAL |
|--|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------|
| Exchange rate 1US\$=CAD | | | 1.485 | 1.548 | 1.570 | 1.400 | 1.301 | 1.212 | 1.134 | 1.074 | |
| GFATM ⁽¹⁾ | no information | no information | 0 | 20,000,000 | 0 | 6,309,500 | 43,291,312 | 62,625,000 | 0 | 10,750,000 | 142,975,812 |
| UNICEF ⁽²⁾ | no information | no information | 0 | 0 | 0 | 0 | 0 | 12,325,000 | 0 | 0 | 12,325,000 |
| Catalytic Initiative ⁽²⁾ | no information | no information | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4,939,646 | 4,939,646 |
| Other Sector and Global Partnership Branch Initiatives (e.g. Red Cross, CARE) ⁽²⁾ | no information | no information | 0 | 5,400 | 1,248,872 | 4,407,111 | 20,255,000 | 188,354 | 4,611,267 | 9,454,742 | 40,170,746 |
| Research | no information | no information | no information | no information | no information | no information | no information | no information | no information | no information | 0 |
| Canadian Partnership Branch ⁽²⁾ | 0 | 0 | 100,000 | 150,000 | 0 | 30,000 | 110,000 | 123,200 | 0 | 0 | 513,200 |
| Bilateral ⁽²⁾ | no information | no information | 0 | 100,000 | 0 | 131,155 | 199,504 | 0 | 221,339 | 204,920 | 856,918 |
| Total CAN\$ | no information | no information | 100,000 | 20,255,400 | 1,248,872 | 10,877,766 | 63,855,816 | 75,261,554 | 4,832,606 | 25,349,308 | 201,781,322 |
| Total multilateral | no information | no information | 0 | 20,005,400 | 1,248,872 | 10,716,611 | 63,546,312 | 75,138,354 | 4,611,267 | 25,144,388 | 200,411,204 |
| Total US\$ | no information | no information | 67,335 | 13,081,471 | 795,441 | 7,767,847 | 49,078,555 | 62,112,004 | 4,260,363 | 23,595,749 | 160,758,766 |

[1] Amounts obtained from CIDA Health Strategy Section. GFATM figure represents 25% of contributions to the Global Fund to Fight AIDS, TB and Malaria (as per the GFATM's reported allocations of funds in Rounds 1-7). Please also note that GFATM disbursements in 04/05 and 05/06 include pre-payments for commitments in subsequent years.

[2] Amounts obtained from CIDA Health Strategy Section. All figures reflect current records of spending against DAC Sector 12262 - Malaria Control. All figures are estimates and subject to change. CIDA does not track the specific use of our core or assessed funding to multilateral organisations such as UNICEF and WHO; that is, we do not require them to report on their activities specific to Canada's disbursements. For WHO, our assessed contributions go through the Dept. of Foreign Affairs and International Trade. As such, CIDA cannot verify this. The information provided in our malaria table for UNICEF is project-based funding.

Table A2.2-French contributions to malaria control

| EUR | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | TOTAL |
|--|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------|-------------|
| Exchange rate 1 US\$= EUR | | | 1.085 | 1.117 | 1.061 | 0.885 | 0.805 | 0.805 | 0.797 | 0.73 | |
| GFATM ⁽¹⁾ | | | | | 13,903,157 | 18,017,161 | 56,542,376 | 56,202,019 | 91,802,137 | 145,358,042 | 381,824,892 |
| WHO (bilateral contribution through technical assistants) ⁽²⁾ | no information | no information | no information | no information | no information | no information | no information | no information | no information | 300,000 | 300,000 |
| UNICEF ⁽³⁾ | no information | no information | 106,243 | 106,160 | 106,949 | 109,598 | 107,806 | 184,727 | 363,854 | 186,062 | 1,271,399 |
| UNITAID ⁽⁴⁾ | | | | | | | | | 0 | 31,572,500 | 31,572,500 |
| Research ⁽⁵⁾ | no information | no information | no information | no information | no information | no information | no information | no information | 8,000,000 | 11,650,000 | 19,650,000 |
| Bilateral ⁽⁶⁾ | no information | no information | 300,000 | 0 | 0 | 0 | 0 | 650,000 | 1,500,000 | 0 | 2,450,000 |
| Total EURO | no information | no information | 406,243 | 106,160 | 14,010,106 | 18,126,759 | 56,650,182 | 57,036,746 | 101,665,991 | 189,066,604 | 437,068,791 |
| Total multilateral | no information | no information | 106,243 | 106,160 | 14,010,106 | 18,126,759 | 56,650,182 | 56,386,746 | 92,165,991 | 177,416,604 | 414,968,791 |
| Total US\$ | no information | no information | 374,418 | 95,040 | 13,204,624 | 20,482,214 | 70,372,897 | 70,853,100 | 127,560,842 | 258,995,348 | 561,938,482 |

[1] The figures for all years are based on 25% of total contribution of France's overall contribution (given in US\$). 25% is per the GFATM's average reported allocations of funds for malaria in Rounds 1-7. <http://www.theglobalfund.org/documents/pledges&contributions.xls>

[2] The French Ministry of Foreign Affairs contributions to UNICEF, the majority is unrestricted in their use and other are restricted and are given for specific issues like malaria. French restricted contributions are identified here – without French Committee for UNICEF – but the share of malaria on overall UNICEF activities (and also French unrestricted contribution) is not included. The French Ministry of Foreign Affairs estimates that 36% of its contribution is dedicated to health issues and only 4% of this share to malaria. The last figure is probably underestimated. UNICEF - For info: French overall annual contribution to UNICEF taken from annual reports 1998 to 2007 (only government contributions - regular & other resources) available in comments. UNICEF: Within regular and voluntary government contributions to UNICEF the majority is unrestricted in their use and other are restricted and are given for specific issues like malaria. Restricted contributions are identified (see separate UNICEF Excel sheet "1044 - Malaria Control Activity code expenditures by Donor and Year") but the share of malaria on overall UNICEF activities (the most important contribution) is NOT included. UNICEF Source: UNICEF Malaria control Activity Code 1044 Expenditures by Donor and Year

[3] UNITAID Annual Report 2007: <https://www.unitaid.eu/images/governance/annualreport2007.pdf> (as for the Global Fund, results in commitments not in disbursements). UNICEF 2006-2007 commitments dedicated to malaria: 1,300,000 USD (ACT Liberia and Burundi) + 15,600,000 USD (ACT scale up) + 21,500,000 USD (ACT for GF Round 6 on an overall UNITAID contribution to the GF Round 6 of 52,500,000 USD). UNITAID Total commitment for 2006-2007 = 222,400,000 USD. 17.3 % dedicated to malaria for 2006-2007.

[4] 2006 amount from Annex of the Toyoko Report and 2007 amount Institut Pasteur + Institut de Recherche pour le Développement (IRD). <http://www.afd.fr/jahia/home/NoSProjets/Portailsante/pid/1562>

[5] Bilateral contribution through the Ministry of Foreign Affairs.

[6] Bilateral contribution through the Ministry of Foreign Affairs.

Table A2.3-German contributions to malaria control

| EUR | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | TOTAL |
|--|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|-------------|
| Exchange rate 1 US\$= EUR | | 0.939 | 1.085 | 1.117 | 1.061 | 0.885 | 0.805 | 0.805 | 0.797 | 0.73 | |
| GFATM ^[1] | | | | | 8,432,065 | 7,033,344 | 6,397,561 | 20,719,639 | 17,556,850 | 21,294,147 | 81,433,607 |
| WHO-CDS (Communicable Diseases) ^[2] | no information | no information | 147,143 | 147,143 | 147,143 | 147,143 | 147,143 | 147,143 | 147,142 | 0 | 1,030,000 |
| RBM ^[1] | no information | no information | no information | no information | no information | 80,000 | 300,000 | 280,000 | 0 | 0 | 660,000 |
| Research | no information | no information | no information | no information | no information | no information | no information | no information | no information | no information | |
| Bilateral ^[1] | no information | no information | no information | no information | no information | 165,000 | 95,000 | 955,000 | 1,038,460 | 1,384,970 | 3,638,430 |
| Total EURO | no information | no information | 147,143 | 147,143 | 8,579,208 | 7,425,487 | 6,939,704 | 22,101,782 | 18,742,452 | 22,679,117 | 86,762,037 |
| Total multilateral | no information | no information | 147,143 | 147,143 | 8,579,208 | 7,260,487 | 6,844,704 | 21,146,782 | 17,703,992 | 21,294,147 | 83,123,607 |
| Total US\$ | no information | no information | 135,616 | 131,731 | 8,085,965 | 8,390,381 | 8,620,751 | 27,455,630 | 23,516,251 | 31,067,284 | 107,403,607 |

[1] Source: Bundestag Drucksache 16/7965: The distribution of funds for malaria control represents approximately 25% of the GFATM's total spending.

[2] Source: Bundestag Drucksache 16/11477

Table A2.4-Italian contributions to malaria control

| EUR | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | TOTAL |
|---------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|-------------|
| Exchange rate 1 US\$= EUR | | 0.939 | 1.085 | 1.117 | 1.061 | 0.885 | 0.805 | 0.805 | 0.797 | 0.73 | |
| GFATM ^[1] | | | | | 22,800,000 | 22,800,000 | 22,800,000 | 22,800,000 | 32,800,000 | 32,800,000 | 156,800,000 |
| UNICEF ^[3] | no information | no information | no information | no information | 75,162 | 34,144 | 34,784 | -1,485 | 18,431 | 107,740 | 268,777 |
| Research ^[1] | no information | no information | no information | no information | no information | no information | no information | no information | no information | no information | |
| Bilateral ^[1] | no information | no information | 2,120,000 | 2,120,000 | 2,120,000 | 2,120,000 | 2,130,000 | 2,130,000 | 40,000 | 0 | 12,780,000 |
| Total Euro | no information | no information | 2,120,000 | 2,120,000 | 22,875,162 | 22,834,144 | 22,834,784 | 22,798,515 | 32,818,431 | 32,907,740 | 169,848,777 |
| Total multilateral | no information | no information | 0 | 0 | 22,875,162 | 22,834,144 | 22,834,784 | 22,798,515 | 32,818,431 | 32,907,740 | 157,068,777 |
| Total US\$ | no information | no information | 1,953,917 | 1,897,941 | 21,560,002 | 25,801,293 | 28,366,191 | 28,321,136 | 41,177,455 | 45,079,096 | 194,157,031 |

[1] Annex of the Toyoko Report p8: Figures for the years 2002-2005 the sum in report was divided by 4.

[2] WHO AFRO Reports (not yet in the Table)

[3] UNICEF Source: UNICEF Malaria control Activity Code 1044 Expenditures by Donor and Year

Table A2.5-Japanese contributions to malaria control

| US\$ | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | TOTAL |
|--------------------------------|-----------|---------|-----------|-----------|------------|------------|------------|------------|------------|------------|-------------|
| GFATM⁽¹⁾ | | | | | 20,100,084 | 19,998,361 | 21,531,558 | 25,000,000 | 32,537,057 | 46,501,700 | 165,668,760 |
| UNICEF⁽²⁾ | 254,237 | 416,667 | 476,190 | 0 | 737,705 | 1,311,475 | 2,363,636 | 21,401,869 | 16,576,577 | 23,017,241 | 66,555,597 |
| Research | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Bilateral⁽²⁾ | 5,000,000 | 0 | 3,809,524 | 6,915,888 | 163,934 | 2,459,016 | 2,454,545 | 1,962,617 | 7,027,027 | 1,724,138 | 31,516,690 |
| Total US\$ | 5,254,237 | 416,667 | 4,285,714 | 6,915,888 | 21,001,724 | 23,768,852 | 26,349,740 | 48,364,486 | 56,140,661 | 71,243,078 | 263,741,046 |
| Total multilateral | 254,237 | 416,667 | 476,190 | 0 | 20,837,789 | 21,309,836 | 23,895,194 | 46,401,869 | 49,113,634 | 69,518,941 | 248,292,167 |

[1] GFATM - Overall figure taken from Pledges and contributions document on GFATM website. 25% is per the GFATM's average reported allocations of funds for malaria in Rounds 1-7. <http://www.theglobalfund.org/documents/pledges&contributions.xls>

[2] Figures from the Ministry of Foreign Affairs of Japan (MOFA)

Table A2.6-Russian contributions to malaria control

| US\$ | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | TOTAL |
|-----------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|------------|
| GFATM⁽¹⁾ | | | | | 250,000 | 1,000,000 | 1,250,000 | 2,500,000 | 2,500,000 | 21,434,984 | 28,934,984 |
| Multilateral⁽²⁾ | No information | No information | No information | No information | No information | No information | No information | No information | No information | 5,000,000 | 5,000,000 |
| Basic research | No information | No information | No information | No information | No information | No information | No information | No information | No information | No information | |
| Bilateral | No information | No information | No information | No information | No information | No information | No information | No information | No information | No information | |
| Total US\$ | 0 | 0 | 0 | 0 | 250,000 | 1,000,000 | 1,250,000 | 2,500,000 | 2,500,000 | 26,434,984 | 33,934,984 |
| Total multilateral | 0 | 0 | 0 | 0 | 120,000 | 1,100,000 | 1,550,000 | 2,700,000 | 2,400,000 | 26,434,984 | 33,934,984 |

[1] GFATM - Overall figure taken from Pledges and contributions document on GFATM website. 25% is per the GFATM's average reported allocations of funds for malaria in Rounds 1-7. <http://www.theglobalfund.org/documents/pledges&contributions.xls>

[2] Toyoko Annex- Malaria Table (WB and UN etc.)

Table A2.7-UK contributions to malaria control

| GBP | 1998/99 | 1999/00 | 2000/01 | 2001/02 | 2002/03 | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 | TOTAL |
|------------------------------|----------------|----------------|----------------|----------------|------------|------------|------------|----------------|-------------|----------------|-------------|
| Exchange rate 1 USD=GBP | 0.604 | 0.618 | 0.661 | 0.694 | 0.667 | 0.612 | 0.546 | 0.550 | 0.543 | 0.500 | |
| GFATM ^[1,2&3] | | | | | 12,600,000 | 4,600,000 | 8,250,000 | 12,750,000 | 25,000,000 | 22,499,519 | 85,699,519 |
| WHO ^[4] | 266,313 | 1,078,813 | 1,078,813 | 1,078,813 | 812,500 | 0 | 0 | 0 | 0 | 0 | 4,315,250 |
| UNICEF ^[5] | no information | no information | no information | no information | 0 | 3,699,436 | 5,663,332 | 312,071 | 6,335,161 | 2,132,902 | 18,142,903 |
| RBM ^[6] | 500,000 | 9,300,000 | 12,000,000 | 12,000,000 | 10,000,000 | 4,300,000 | 500,000 | no information | 850,000 | no information | 49,450,000 |
| MMV ^[6] | | no information | no information | 1,000,000 | 1,000,000 | 1,000,000 | 1,000,000 | 3,000,000 | 2,000,000 | 2,000,000 | 11,000,000 |
| Research ^[7] | 595,000 | 4,925,000 | 6,945,567 | 6,958,067 | 7,712,500 | 8,100,000 | 7,700,000 | 8,500,000 | 9,000,000 | 10,000,000 | 70,436,134 |
| Bilateral ^[8] | 6,438,886 | 6,690,167 | 6,741,789 | 9,892,141 | 9,297,480 | 10,719,784 | 11,505,655 | 10,777,046 | 20,860,391 | 39,860,391 | 132,783,732 |
| Total GBP | 7,800,199 | 21,993,979 | 26,766,169 | 30,929,021 | 41,422,480 | 32,419,220 | 34,618,987 | 35,339,118 | 64,045,552 | 76,492,813 | 371,827,537 |
| Total multilateral | 766,313 | 10,378,813 | 13,078,813 | 14,078,813 | 24,412,500 | 13,599,436 | 15,413,332 | 16,062,071 | 34,185,161 | 26,632,421 | 168,607,672 |
| Total US\$ | 12,923,840 | 35,583,956 | 40,519,748 | 44,547,748 | 62,145,315 | 52,948,456 | 63,434,110 | 64,240,910 | 117,864,673 | 153,062,734 | 647,271,492 |

[1] - From DFID Inputted Share of Multilateral ODA on Health- Malaria Control (FY 2002/03 and 2003/04)

[2] - for FY 2004/05, 2005/06, 2006/07 - The figure for each FY is 25% of total contribution of DFID Inputted Share of Multilateral ODA on Health, 25% is per the GFATM's average reported allocations of funds for malaria in Rounds 1-7.

[3] - Overall figure taken from Pledges and contributions document on GFATM website and 25% taken as per [2]. <http://www.theglobalfund.org/documents/pledges&contributions.xls> Dollars converted to GBP as per OECD exchange rate

[4] - Figures disaggregated from DFID databases on communicable diseases according to money given to WHO which comprise of two projects 1) Southern Africa Sub-Regional Malaria Control (WHO) and 2) WHO Medicines for Malaria.

[5] - UNICEF Source: UNICEF Malaria control Activity Code 1044 Expenditures by Donor and Year

[6] - Correspondence from Joanne McFadden - DFID J-McFadden@dfid.gov.uk

[7] - Correspondence from MRC Senior Research Analyst - Corporate Head Office. It also includes several DFID research projects originally listed in bilateral including 1) Malaria Chemotherapy 2) Multilateral initiative on Malaria and 3) WP2 Malaria Research Work

[8] - Figures represent DFID malaria bilateral projects disaggregated from DFID databases on communicable diseases. Projects such as Integrated Management of Childhood Illness and DFID/MRC concordat include malaria components but as they also cover other diseases we have not included them and therefore the figure is an under estimate.

Table A2.8- USA contributions to malaria control

| US\$ | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | TOTAL |
|--------------------------|----------------|----------------|----------------|----------------|-------------|-------------|-------------|-------------|-------------|-------------|---------------|
| GFATM ^[1] | | | | | 75,000,000 | 80,681,250 | 114,720,320 | 103,502,813 | 128,247,276 | 132,751,963 | 634,903,622 |
| UNICEF ^[2] | no information | no information | no information | no information | 658,938 | 4,041,916 | 1,942,606 | 1,011,861 | 6,822,870 | 14,509,729 | 28,987,921 |
| Research ^[4] | no information | no information | 92,500,000 | 92,500,000 | 92,500,000 | 92,500,000 | 92,500,000 | 92,500,000 | 138,872,000 | 142,237,000 | 836,109,000 |
| Bilateral ^[5] | no information | no information | 58,333,000 | 58,333,000 | 58,333,000 | 58,333,000 | 58,334,000 | 58,334,000 | 86,000,000 | 233,000,000 | 669,000,000 |
| Total US\$ | 0 | 0 | 150,833,000 | 150,833,000 | 226,491,938 | 235,556,166 | 267,496,926 | 255,348,674 | 359,942,147 | 522,498,693 | 2,169,000,542 |
| Total multilateral | 0 | 0 | 0 | 0 | 75,658,938 | 84,723,166 | 209,162,926 | 197,014,674 | 273,942,147 | 289,498,693 | 1,500,000,542 |

[1] - The figures for all years are based on 25% of total contribution of USA. 25% is per the GFATM's average reported allocations of funds for malaria in Rounds 1-7. <http://www.theglobalfund.org/documents/pledges&contributions.xls>

[2] - UNICEF - government contribution includes direct malaria contribution and indirect funding which UNICEF has spent under activity code 1044. Therefore, there is some double counting (from bilateral direct contributions) but the exact amount from indirect contributions is not possible to obtain. 1044- includes SA-BPRM, USA-OFDA, USA-Washington, UNDP-USA

[3] - UNICEF Committee: UNICEF Malaria control Activity Code 1044 Expenditures by Donor and Year

[4] - Research-Toyako Annex- Malaria Table p24- Research includes funding through HHS (HHS/NIH and HHS/CDC), the Department of Defence, and USAID.

[5] - Bilateral-Toyako Annex- Malaria Table p24 Project and Budget Support (PMI and non PMI) includes non-research bilateral funding channelled through USAID as well as some non research funding channelled through the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) within the U.S. Department of Health and Human Services (HHS). Bilateral contributions include money towards WHO, RBM, MMV and direct funding for UNICEF

Table A2.8- EC contributions to malaria control

| EUR | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | TOTAL |
|--|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| Exchange rate 1 US\$= EUR | | 0.939 | 1.085 | 1.117 | 1.061 | 0.885 | 0.805 | 0.805 | 0.797 | 0.73 | |
| GFATM ⁽¹⁾ | | | | | 36,356,328 | 11,142,200 | 53,213,187 | 13,998,246 | 23,342,775 | 27,623,797 | 165,676,532 |
| UNICEF malaria ⁽²⁾ | No information | No information | No information | No information | 316,653 | 1,135,784 | 895,681 | 2,709,471 | No information | No information | 5,057,589 |
| FP6/FP7 ⁽³⁾ | No information | No information | No information | No information | 25,000,000 | 25,000,000 | 25,000,000 | 20,000,000 | 25,000,000 | 15,000,000 | 135,000,000 |
| TOTAL € | 0 | 0 | 0 | 0 | 61,672,981 | 37,277,984 | 79,108,868 | 36,707,717 | 48,342,775 | 42,623,797 | 305,734,122 |
| TOTAL US\$ | 0 | 0 | 0 | 0 | 58,127,221 | 42,122,016 | 98,271,885 | 45,599,648 | 60,655,929 | 58,388,763 | 363,165,462 |
| IHP ⁽⁵⁾ in EUR | No information | No information | No information | No information | No information | No information | No information | No information | 147,000,000 | No information | 147,000,000 |
| EC ODA (not malaria specific) ⁽⁶⁾ | No information | 4,635,514,350 | 5,329,791,250 | 6,658,760,930 | 5,780,465,930 | 6,348,299,700 | 7,006,373,850 | 7,558,917,800 | 8,165,424,400 | 8,492,987,900 | 59,976,536,110 |

[1] Global Fund Source: Pledges & Contributions - <http://www.theglobalfund.org/documents/pledges&contributions.xls>

[2] UNICEF Source: UNICEF Malaria control Activity Code Expenditures by Donor and Year (Money includes European Commission Humanitarian)

[3] Figure provided by EC: EU funds for malaria research under the previous 6th Framework Programme for Research and Development amounted to around € 25 million per year, a level of support likely to be maintained also under the present 7th Framework Programme 2007-2013.

[4] EAAM GMAP report: Table 4 "Bilateral Sources of ODA funds to IHP+ in US\$ million and Euro millions", Column - EC

[5] OECD. Stat database. Source - Development/ Aggregate Aid Statistics/ ODA by Donor (then select EC <http://stats.oecd.org/WBOS/Index.aspx?DataSetCode=CSP2009>). Specific figures taken from top line ODA. Other points to note- Flow type: Net disbursements, Amount type: US\$ millions

Annex 3: Partner Agencies used to verify country specific data

| Country | Intermediate agency | Verifying agency |
|---------|--|--|
| UK | Malaria Consortium | The Department for International Development (DFID) and the Medical Research Council (MRC) |
| Italy | Italian Partner in Action for Global Health - Centre of Health Education and Appropriate Health Technologies (CESTA) and Italian Association for Women & Development (AIDOS) | The Italian Ministry of Foreign Affairs (MFA) |
| France | Friends of the Global Fund Europe | The Ministry of Foreign Affairs |
| Germany | German Foundation for World Population (DSW) | The Federal Ministry for Economic Cooperation and Development (BMZ) |
| USA | VOICES | The United States Agency for International Development (USAID) |
| Canada | Results Canada | The Canadian International Development Agency (CIDA) |
| Russia | Jumana Qamruddin at World Bank | Russian MOFA Unit dealing with International Organizations |
| EU | Red Cross Office | The European Commission |
| Japan | Japan AIDS and Society Association (JASA)/ Africa Japan Forum | Ministry of Foreign Affairs of Japan (MOFA) |

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