World Vision

A matter of life or death

How 18 million children are relying on the G8 to keep its promises

a policy briefing and call to action

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A matter of life or death: How 18 million children are relying on the G8 to keep its promises

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contents

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There is a global epidemic that every year leaves millions dead, reaching across the borders of developing countries regardless of culture, language or sex. Despite efforts by the international community to stop it, the annual death count is so high that you can only make sense of the numbers by comparing them to country population figures.

This international killer is poor health. And in 2006, it claimed the lives of 9.7 million children under the age of five. The vast majority of these children died from preventable and treatable causes. Of the girls and boys who have survived this modern-day epidemic, 15 million to date have felt its effects through the loss of one or both parents to AIDS.

Worldwide, there are 136 countries with populations under 9.7 million. Imagine the news headlines if, on December 31, 2006, it was discovered that an epidemic had killed all the people of Senegal; or of Sweden; or of Hong Kong; or of Israel. Then imagine if, on December 31, 2007, the same thing happened again.

This number of deaths is almost too large to comprehend, but each death is that of a child, and the loss of a precious son or daughter. Whenever I travel to Africa I come face to face with this sad truth. Such tragedy is the stark reality for millions of parents and communities around the world – right now. Today in the developing world, more than 26,000 children under the age of five will die largely preventable deaths, and 1,400 women will die from complications related to pregnancy or childbirth.

Because half of these children die in sub-Saharan Africa, some might conclude that such outrageously high mortality figures are due mainly to tropical diseases such as dengue or yellow fever.

The reality, however, is that most children who die will do so from causes that would rarely, if ever, kill a child born in a country where there is access to adequate health care. Statistics tell us that 10,000 (37%) of the children who die today will do so from neo-natal causes. These include being born too early, or with congenital abnormalities, asphyxia or tetanus. Another 5,100 children (19%) will die from pneumonia, while 4,600 (17%) will die from diarrhea – an entirely preventable and treatable condition in any country with clean water and adequate health care.

While the latest figures show that the annual numbers of child deaths are gradually falling, it is painfully clear that Millennium Development Goal 4 will not be met. MDG4 aims to reduce the global under-five mortality rate from what is currently 9.7 million deaths per year to 4 million by 2015. At the current gradual rate of improvement in child mortality, an estimated 18 million more children will die between 2009 and 2015. Significant additional effort will be required if all countries, particularly those in southern Africa, are to meet MDG4 by 2015.

This is where the G8 leaders come in. Many people around the world have a share in the responsibility for achieving the eight MDGs, but the G8, as the world's wealthiest governments, can provide a massive boost to the effort to reach these global targets. By meeting its commitments, the G8 also acts as a powerful model for other donors and developing countries to do the same.

At the moment, non-governmental organisations such as World Vision are filling gaps in many areas of basic health service provision, something that ought to be the responsibility of national governments. If the G8 chooses not to address the gap in health systems funding, then funding of traditional health programmes that target specific diseases and conditions, and civil society gap-filling, will continue to be the major avenues by which reduction of child mortality is addressed.

And if the G8 chooses not to address the gap in health systems funding, the world will fail to meet MDG4 by 2015.

This is because, despite the rolling out of good health programmes by charities and other civil society organisations in developing countries, there is simply not enough money invested in these programmes to make a long-term difference on a national scale. What is more, such programmes are simply not sustainable. Ultimately a country's government must provide the resources for adequate health care, with the back-up of sufficient, long-term funding commitments for the poorest countries, where there is an absolute shortage of resources – commitments like those made by the G8 leaders.

The G8 itself has acknowledged that it has power to greatly improve the lives of the world's poorest people. Over the past decade it has made a range of funding promises that, if kept, would save millions of lives.

One example is the 2005 commitment to raise aid levels to US$130 billion by 2010. The promised rise of $50 billion could ensure adequate funding to provide comprehensive child and maternal health programmes, effective responses to TB and malaria, quality basic education for all children and universal prevention, treatment and care for people affected by HIV and AIDS.

This could save the lives of 6 million children and at least 2 million adults per year.*

However, well over two years after this commitment, there is still no timetable indicating when leaders will put their money on the table. And each year millions of men, women and children die unnecessarily while waiting for these promises to be fulfilled.

History has demonstrated that concrete action by the G8 does save lives. The last G8 summit in Japan, in 2000, laid the foundation of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Since its inception in 2002, the Fund has committed $7.6 billion to projects around the world – an effort that has saved over 1.8 million lives.

Eight years after the Okinawa G8 Summit, the Japanese Government, as the president of the G8, has announced it will put the issue of global health high on the agenda this year and said it aims to create a framework for action. Here is an historic opportunity for G8 leaders to seize the moment and save millions of lives.

What follows are World Vision's calls to the G8 leaders and their ministers of finance and development. They are not calls for more money. They are simply calls for the leaders of wealthy countries – countries where newborn babies are not at risk of dying from pneumonia or diarrhea – to hold themselves accountable for their commitments, and to be strategic with the commitments they have made.

We at World Vision pray that at this year's G8 Summit in Hokkaido, Japan, leaders will acknowledge that one of the most urgent crises facing the world is the epidemic of poor health – an epidemic that last year killed millions of innocent children, and which will kill many millions more in years to come unless world leaders act today to stop it.

Foreword footnotes

* Jones, Steketee, Black et al, "How many child deaths can we prevent this year?", The Lancet, 2003, 362; WHO, 2001, Report of the Commission on Macroeconomics and Health; Global Fund to Fight AIDS, Tuberculosis and Malaria, 2007, Resource Needs for the Global Fund 2008–10

part one

aid volume and effectiveness

At Gleneagles in 2005, the G8 announced that annual aid would increase by US$50 billion[i] from 2004 to 2010, to around $130 billion.[ii] This figure was presented by the G8 as a promise, for which the G8 received considerable praise. Of the $50 billion, around $35 billion was to come from G8 countries and the rest from non-G8 donors.

While $130 billion per year is still below the level of aid required to achieve the Millennium Development Goals, the additional $50 billion per year could ensure adequate funding to provide comprehensive child and maternal health programmes, effective responses to tuberculosis and malaria, quality basic education for all children and universal prevention, treatment and care for people affected by HIV and AIDS. This could save the lives of 6 million children and at least 2 million adults per year.[iii]

Total ODA has grown, but much of this has been debt relief – which donor nations have agreed should be additional to aid. When debt relief is deducted from ODA, there has been only a small increase in total aid from G8 countries in the three years since Gleneagles. It is now halfway towards the target date of 2010, yet G8 aid has increased by only 14% of the targeted amount. In addition to increasing aid volume, G8 countries will need to improve the effectiveness of their aid if they are to help achieve the Millennium Development Goals.

■ Call 1

That those G8 governments that have not yet done so publish a detailed timetable, with annual targets, that provides stepwise increases in aid towards their promised 2010 aid levels; and that all G8 donor countries work to reach the EU minimum target of 0.51% of GNI to aid by 2010.

■ Call 2

That the G8 ask other donor countries that have not yet done so to publish similar forward projections of their aid levels each year to 2010.

■ Call 3

That the G8 governments work actively to improve the effectiveness of their aid, by:

- refraining from attaching economic conditionalities to aid;
- delivering aid mainly in the form of real monetary transfers towards nationally owned development strategies, not artificially inflating aid through debt relief or technical assistance; and
- ensuring improved co-ordination and alignment around the priorities and plans of recipient countries.

part two

HIV and AIDS

Universal access

Worldwide, over 33 million people were living with HIV in 2007, including 2.5 million children.[iv] Despite the promises made, with less than two years until the target date for universal access, over 70% of people, including 85% of children, are not receiving the HIV treatment they urgently need. As a result, over 2 million people died of AIDS-related illnesses in 2007. Sub-Saharan Africa continues to be the region most affected by the AIDS pandemic, however a number of countries and vulnerable groups in the Asia-Pacific region are experiencing escalating rates of infection.

At the 2005 G8 Summit, world leaders committed to "develop and implement a package for HIV prevention, treatment, care and support, with the aim of as close as possible to universal access to treatment for all those who need it by 2010". In June 2006, all United Nations member states further promised "universal access to comprehensive prevention programmes, treatment, care and support by 2010". While funding for HIV and AIDS programmes reached around $5 billion in 2006, UNAIDS and the Global Fund estimate that around $17 billion will be needed by 2010.[v] Scaling up comprehensive HIV and AIDS services towards universal access is not only a moral imperative that will result in immense human and social benefits; it will have financial benefits too.

Prevention of mother-to-child transmission

Transmission of HIV from mother to child during pregnancy, childbirth and breastfeeding is the route by which 90% of all HIV-positive children are infected. Without access to services to prevent transmission, about 35% of infants born to HIV-positive mothers will acquire the virus during pregnancy, labour, delivery or breastfeeding.[vi] Providing a mother with a full range of PMTCT services, including anti-retrovirals (ARVs), can reduce the risk of transmission to less than 2%.[vii] But only some 11% of HIV-positive pregnant women in low- and middle-income countries who are in need of ARVs are receiving them. At their 2007 Summit in Heiligendamm, G8 leaders committed to "work towards the goal of providing universal coverage of PMTCT programmes by 2010", at an estimated cost of $1.5 billion.

Pediatric treatment

While rapid developments have been made over the last two years in the number of adults accessing anti-retroviral therapy, treatment for children has not kept pace. In 2006, children under 15 represented 13% of new HIV infections and 12% of all AIDS-related deaths. Without treatment, approximately half of all infected children will die before their second birthday,[viii] but only one in seven of the 780,000 children in need of ARV therapy are receiving it.

Treating children who have HIV is more complicated than treating adults and has, until recently, been more expensive. Many ARVs still do not exist in the easier-to-administer, child-adapted tablet formulation, and children continue to endure sub-standard care. Providing treatment to children can present major challenges, especially in resource-poor countries. At the 2007 Summit in Heiligendamm, G8 leaders committed to work "together with other donors towards meeting the needed resources for pediatric treatments in the context of universal access, at a cost of US$1.8 billion till 2010 …".[ix]

Support to orphans and vulnerable children

Worldwide, more than 15 million children under the age of 18 have lost one or both parents to AIDS, and this number is rising fast.[x] Nearly 80% of these orphans live in sub-Saharan Africa. Millions more children are highly vulnerable because their parents, relatives and other care-givers are living with or heavily affected by HIV or AIDS. The illness or loss of a parent begins a spiral of deprivation for the child.

UNAIDS estimates that prevention, treatment and care programmes for children affected by AIDS will require around 12% of total AIDS expenditure in the period 2008 to 2010.[xi] It is important that G8 leaders ensure financial resources and support for governments of all countries highly affected by HIV and AIDS to produce and implement National Plans of Action (NPAs) for the care and protection of orphans and vulnerable children.[xii] At the 2007 Summit in Heiligendamm, G8 leaders agreed: "As an important step to scaling up towards the goal of universal access to HIV/AIDS prevention, treatment, care and support in Africa, G8 members, in support of national HIV/AIDS programmes globally, individually and collectively over the next few years will aim … to prevent twenty-four million new infections, and to care for twenty-four million people, including ten million orphans and vulnerable children." [xiii]

■ Call 4

That the G8 governments provide a comprehensive plan (with annual funding pledges) to meet the G8 HIV and AIDS commitments to achieve universal access to prevention, treatment, care and support by 2010 for both children and adults.

■ Call 5

That the G8 support national governments to deliver comprehensive and integrated prevention of mother-to-child transmission (PMTCT) services, as outlined by the G8 leaders at the Heiligendamm Summit in 2007, by:

- supporting the production of national scale-up plans for PMTCT, using the WHO Scale-Up Planning Guide for the Prevention of MTCT and the "PMTCT-Plus" approach, which incorporates other members of the family;
- reinforcing country-level accountability mechanisms for national PMTCT goals and targets through the appointment of national management teams and the establishment of a functioning co-ordinating mechanism;
- providing a long-term, co-ordinated system of technical support to assist countries in developing comprehensive, well-targeted, evidence-based and scaled-up prevention programming; and
- working with other G8 countries to provide a comprehensive plan, and annual funding pledges, to meet the 2007 commitment to provide $1.5 billion to support PMTCT programmes.

■ Call 6

That the G8 ensure that affordable pediatric medicines, including generic combinations, are available, particularly for second-line treatments.

■ Call 7

That the G8 ensure that children are considered in national and international efforts to scale up access to treatment.

■ Call 8

That the G8 support pharmaceutical companies in developing simple and affordable diagnostic tests, increasing research and development for child-specific needs and producing pediatric fixed-dose combinations.

■ Call 9

That the G8 provide a comprehensive plan towards raising the US$1.8 billion needed for pediatric treatment in the context of universal access, as promised at the G8 summit in 2007.

■ Call 10

That the G8 make time-bound and measurable commitments to earmark 12% of HIV and AIDS expenditure specifically for all affected children and in particular for the more than 10 million orphans and vulnerable children in Africa, as promised at the G8 summit last year.

■ Call 11

That the G8 support governments of all highly affected countries to develop and implement national plans of action that protect orphans and vulnerable children and guarantee their human rights.

part three

health systems

Financial support for health system strengthening

This year some 9.7 million[xiv] children under the age of five will die largely preventable deaths; around 500,000 women[xv] will die from pregnancy-related complications; and over 6 million[xvi] older children and adults will die prematurely from AIDS, TB and other infectious diseases. Adequate community- and district-level health services could prevent the majority of these untimely deaths, however there is a critical shortage of funds to provide these services.

The estimated $13 billion aid to health in 2006 (around 13% of total ODA)[xvii] compares with a minimum estimate of $27 billion[xviii] and median estimates of around $50 billion required per year.[xix] Therefore, aid for health needs to at least double. Of total current health aid, around $5 billion to $6 billion supported basic health programmes (community and district health services, reproductive health care and infectious disease control, excluding HIV), and around $5 billion went to HIV and AIDS programmes.[xx] Between $15 billion and $25 billion in aid will be required annually to ensure adequate basic health services and staffing in 2010. Strong growth in funding for HIV and AIDS, TB and malaria programmes needs to continue, and accelerate, to bring these major infectious diseases under control. Growth in funding also must be complemented by much greater support for the strengthening of health systems at the community and district levels, to enable an effective and comprehensive response to all the major health problems facing poor people and to ensure the predictable and long-term funding that developing countries require to be able to train and employ new health staff.

Responding to the urgency of this issue, the Japanese prime minister recently said: "We must … formulate a framework for action to raise the overall level of the health care system, with the participation of all relevant stakeholders …".[xxi]

Supporting development and implementation of effective health plans in developing nations

At the same time as increasing financial support to developing countries' health systems, the G8 could play a key role in helping these countries to develop and implement effective health strategies that answer their specific local challenges. African and other developing countries have committed to increase health funding to at least 15% of budget expenditures, yet only a minority of countries have currently met this commitment. The G8 should also work with groups such as the International Health Partnership to help improve donor co-ordination and assist developing countries in creating and implementing effective, high-quality health plans that provide comprehensive and equitable services based on cost-effective, evidence-based interventions.

There are indications that some international financial institutions have imposed budget constraints on certain developing countries, which has prevented adequate funding of essential services.[xxii] The G8 could help to ensure that essential services are not jeopardised in this way.

■ Call 12

That by 2010 the G8 countries allocate at least 10% of their sector-allocable ODA to strengthening community- and district-level health systems[xxiii] in order to provide universal maternal and child health services and enable the scale-up of responses to HIV and other major infectious diseases. Alternatively, that each G8 donor country contribute its fair share[xxiv] of the minimum $15 billion per year aid required for basic health services by 2010.

■ Call 13

That the G8 countries also accelerate the increase in funding for HIV and AIDS, TB and malaria through the Global Fund and other mechanisms, where appropriate, in order to meet their commitments to universal HIV prevention, treatment, care and support by 2010 and their commitments to combating the other infectious diseases.

■ Call 14

That the G8 work with national governments through the International Health Partnership to assist them in developing comprehensive, adequately funded and workable health plans that focus on effective health systems, with particular focus on delivering an essential package of care through strengthened community and district health interventions.

■ Call 15

That the G8 work with the international financial institutions to ensure that fiscal conditions that hinder the provision of effective basic health services are not imposed on developing countries.

Executive Summary footnotes

i Gleneagles Communiqué, 2005, paragraph 28
ii In 2004 dollars
iii Jones, Steketee, Black et al, "How many child deaths can we prevent this year?", The Lancet, 2003, 362; World Health Organization, 2001; Report of the Commission on Macroeconomics and Health; and Global Fund to Fight AIDS, Tuberculosis and Malaria, 2007, Resource needs for the Global Fund 2008–10
iv UNAIDS, 2007, AIDS epidemic update, December 2007
v GFATM, 2007, Resource needs for the Global Fund 2008–2010
vi UNAIDS, 2005, AIDS epidemic update, December 2005
vii UNICEF, 2005, A call to action: Children, the missing face of AIDS
viii UNICEF, 2007, Children and AIDS: A stocktaking report
ix G8 Summit 2007 Heiligendamm, Growth and responsibility in Africa: Summit Declaration, 8 June 2007, paragraph 50
x Ibid.
xi UNAIDS, 2007 (September), Financial resources required to achieve universal access
xii Ibid.
xiii G8 Summit 2007 Heiligendamm, Growth and responsibility in Africa: Summit Declaration, 8 June 2007, paragraph 58
xiv UNICEF ChildInfo database, accessed 12 December 2007
xv Hill K, Thomas K et al, "Estimates of maternal mortality worldwide between 1990 and 2005", The Lancet, 2007, 370
xvi UNAIDS, 2007, AIDS epidemic update, December 2007 and WHO mortality database, accessed 12 December 2007
xvii OECD DAC CRS database, accessed 14 December 2007, and Kates J & Lief E, 2007, Donor funding for health in low- and middle-income countries, 2001–2005, Henry J. Kaiser Family Foundation and Center for Strategic and International Studies, extrapolated to 2006 and assuming the share of sector-allocated ODA going to health applies to total ODA
xviii WHO, 2001, Report of the Commission on Macroeconomics and Health; the $27bn figure includes aid for health research and greater support of UN agencies.
xix World Bank, 2006, Health financing revisited
xx Kates J, Izazola J & Lief E, 2007, Financing the response to AIDS in low- and middle-income countries: International assistance from the G8, European Commission and other donor governments, 2006 quotes $3.9 billion in disbursements but does not include the full value of payments to the Global Fund during 2006 by donor countries, as the authors are focusing on the distribution of funds.
xxi World Economic Forum, 26 January 2008
xxii Center for Global Development, 2007, Does the IMF constrain health spending in poor countries? Evidence and an agenda for action
xxiii That is, the sum of funding to OECD DAC sector 122 (basic health) and sector 130 (reproductive health) but excluding sub-sector 13040 (STD control including AIDS) should be at least 10% of sector-allocable ODA. Increasing use of general budget support (which cannot be sector-allocated) means that the share of sector-allocable aid, rather than total aid, is a better indicator of support for health systems and basic health care.
xxiv Fair share should be based on the donor country's share of total OECD donor country gross national income.

part one

aid volume and effectiveness

World Vision calls on the G8 governments to provide a detailed timetable, with annual targets, to meet the 2005 G8 commitment to increase total annual aid by $50 billion by 2010.

At Gleneagles in 2005, the G8 announced that annual aid would increase by US$50 billion[1] from 2004 to 2010, to around $130 billion.[2] This figure was based on the OECD's calculation of the impact of each nation's aid commitments to 2010,[3] but it was presented by the G8 as a promise and the G8 received considerable praise for this promise. Of the $50 billion, around $35 billion was to come from G8 countries and the rest from non-G8 donors, as follows:

Figure 1

Country shares for the $50 billion increase

Country	US$million at 2004 prices
Canada	1,049
France	5,637
Germany	7,975
Italy	6,800
Japan	3,000
United Kingdom	6,717
United States	4,295
Total from G8	35,473
Non-G8 donor countries	13,140
Total	**48,613**

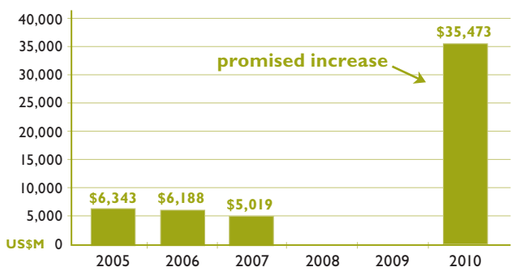
This promise to increase aid significantly is critical. While $130 billion per year is still below the level of aid required to achieve the Millennium Development Goals, and only around half of the target of 0.7% of gross national income, the additional $50 billion a year could ensure that adequate funding is available to provide comprehensive child and maternal health programmes, effective responses to tuberculosis and malaria, quality basic education for all children and universal prevention, treatment, care and support for people affected by HIV and AIDS. This could save the lives of 6 million children and at least 2 million adults per year.[4]

To achieve these breakthroughs, however, will require the increases in aid to be well-targeted, predictable and long-term, so that aid can be better planned and co-ordinated and so that developing country governments will have the confidence to train and recruit the millions of health staff and teachers necessary to improve health and education. While the problems in Africa need specific actions and focus by the G8 countries, the support that Africa requires should come from additional money and not money diverted from other poor regions.

Since 2004, total ODA has grown, but much of this has been debt relief – which donor nations have agreed should be additional to aid. Figure 2 shows that when debt relief is deducted from ODA, there has been only a small increase in total aid from G8 countries in the three years since Gleneagles. It is now halfway towards the target date of 2010, yet G8 aid has increased by only 14% of the targeted amount.

Figure 2

Additional annual aid to date after debt relief is deducted, compared with promised increase in 2010

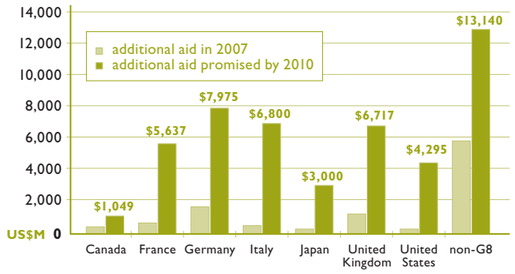


Source OECD DAC online database Table 1 and DAC 2010 projection of 14 Nov 2005, 2004 prices

The overall lack of growth in G8 aid hides individual differences between donor countries. Figure 3 plots the additional non-debt relief aid provided by each donor in 2007, the latest year for which data is available, and compares it with the additional annual aid promised by 2010. This shows that Canada, Germany and the United Kingdom have made some progress in reaching their targets by 2007, however the non-G8 donor countries have done much better. All the G8 donor countries will need to significantly increase their aid over the remaining years to 2010 if they are to meet their commitments.

Figure 3

Progress in providing additional aid: 2007 totals compared with 2010 promise



Source OECD DAC online database Table 1. Figures are in US$million (2004 prices) and indicate changes since 2004 in ODA with debt relief deducted.

Unfortunately, three of the G8 donor countries – Canada, Japan and the United States – are likely to still be providing relatively low levels of aid as a proportion of GNI in 2010, even if they reach the commitments they made in 2005. Using current trends, the OECD estimates the following ODA/GNI ratios for these countries in 2010:

Canada – 0.30%
Japan – 0.21%
United States – 0.17%

These levels compare with a minimum target of 0.51% for European Union donor countries in 2010 and a predicted average effort of 0.64% from the EU donors.[5] Each of these three countries – Canada, Japan and the United States – is likely to actually be giving less aid as a percentage of GNI in 2010 than it did in 2005.[6]

In addition to increasing aid volume, G8 countries will need to improve the effectiveness of their aid if they are to help achieve the Millennium Development Goals. As indicated in the Paris Declaration on Aid Effectiveness,[7] aid is often provided too inconsistently, with unrealistic conditions and a lack of co-ordination with other donors and with the receiving country's poverty reduction needs. G8 country leaders must work to ensure that aid is delivered effectively and efficiently to achieve development objectives and the realisation of rights by all people – particularly the most vulnerable, including children.

Recommendations

1. That those G8 governments that have not yet done so publish a detailed time-table, with annual targets, that provides stepwise increases in aid towards their promised 2010 aid levels; and that all G8 donor countries work to reach the EU minimum target of 0.51% of GNI to aid by 2010.
2. That the G8 ask other donor countries that have not yet done so to publish similar forward projections of their aid levels each year to 2010.
3. That the G8 governments work actively to improve the effectiveness of their aid, by:
   - refraining from attaching economic conditionalities to aid;
   - delivering aid mainly in the form of real monetary transfers towards nationally owned development strategies, not artificially inflating aid through debt relief or technical assistance; and
   - ensuring improved co-ordination and alignment around the priorities and plans of recipient countries.

part two

HIV and AIDS

World Vision calls on the G8 to provide a comprehensive plan (with annual funding pledges) to meet the G8 HIV and AIDS commitments to achieve universal access to prevention, treatment, care and support by 2010, including the specific commitments made by the G8 in 2007 to prevent mother-to-child transmission, to provide pediatric treatment and to assist orphans and vulnerable children.

Universal access

At the G8 Summit in 2005, the United Kingdom Government led world leaders in committing to "develop and implement a package for HIV prevention, treatment, care and support, with the aim of as close as possible to universal access to treatment for all those who need it by 2010". In June 2006, all United Nations member states further promised "universal access to comprehensive prevention programmes, treatment, care and support by 2010".

The need for urgent and decisive action is clear. Worldwide, over 33 million people were living with HIV in 2007, including 2.5 million children.[8] Despite the promises made, with less than two years to go until the G8-endorsed target date for universal access, over 70% of people, including 85% of children, are not receiving the HIV treatment they urgently need. As a result, over 2 million people died of AIDS-related illnesses in 2007.

Sub-Saharan Africa continues to be the region most affected by the AIDS pandemic, with AIDS remaining the leading cause of death. More than two out of three adults (68%) and nearly 90% of children infected with HIV live in this region, and more than three in four AIDS deaths (76%) in 2007 occurred here.[9] However it also should be noted that this year's G8 conference will be held in the Asia-Pacific region, where a number of countries are experiencing escalating rates of infection. In this region, particular attention needs to be paid to high-risk groups and people living in areas of weak governance or conflict.

While funding for HIV and AIDS programmes has grown significantly in recent years and reached around $5 billion in 2006, UNAIDS and the Global Fund estimate that HIV and AIDS aid requirements will be around $17 billion by 2010.[10]

Scaling up comprehensive HIV and AIDS services towards universal access is not only a moral imperative that will result in immense human and social benefits; it will have financial benefits too. Studies show that a fully-funded comprehensive response to HIV would prevent 28 million new infections up to 2015, half of all those projected to occur.[11] The previous UN Secretary General, Kofi Annan, stated that the Millennium Development Goals could not be achieved without success in dealing with HIV and AIDS. In many countries, HIV is not only by far the biggest burden on health and educational systems but also a major barrier to economic growth and life expectancy. Because of their wide and complex impacts, HIV and AIDS should also be seen as a cross-cutting issue in development and considered in all development activities.

Recommendation

4. That the G8 governments provide a comprehensive plan (with annual funding pledges) to meet the G8 HIV and AIDS commitments to achieve universal access to prevention, treatment, care and support by 2010 for both children and adults.

2008 G8 Policy Calls

Prevention of mother-to-child transmission

The transmission of HIV from mother to child during pregnancy, childbirth and breastfeeding drives the rapidly increasing number of HIV-positive children. Globally, 90% of all HIV-positive children are infected through mother-to-child transmission. Without access to services to prevent transmission, about 35% of infants born to HIV-positive mothers will acquire the virus during pregnancy, labour, delivery or breastfeeding.[12]

Yet this can be stopped. Providing a mother with a full range of PMTCT services, including anti-retrovirals (ARVs), can reduce the risk of transmission to less than 2%.[13] But it is estimated that just 11% of HIV-positive pregnant women in low- and middle-income countries who are in need of ARVs to prevent mother-to-child transmission of HIV are receiving them. This is a gross violation of the rights of both these women and their children.

A number of global commitments have been made to scale up PMTCT services. In May 2006, African heads of state issued the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa. They set clear goals for 2010, including that 80% of pregnant women have access to facilities to prevent mother-to-child transmission. And at their 2007 Summit in Heiligendamm, G8 leaders committed to "work towards the goal of providing universal coverage of PMTCT programmes by 2010", at an estimated cost of $1.5 billion.

Recommendation

5. That the G8 support national governments to deliver comprehensive and integrated prevention of mother-to-child transmission (PMTCT) services, as outlined by the G8 leaders at the Heiligendamm Summit in 2007, by:

   - supporting the production of national scale-up plans for PMTCT, using the WHO Scale-Up Planning Guide for the Prevention of MTCT and the "PMTCT-Plus" approach, which incorporates other members of the family;
   - reinforcing country-level accountability mechanisms for national PMTCT goals and targets through the appointment of national management teams and the establishment of a functioning co-ordinating mechanism;
   - providing a long-term, co-ordinated system of technical support to assist countries in developing comprehensive, well-targeted, evidence-based and scaled-up prevention programming; and
   - working with other G8 countries to provide a comprehensive plan, and annual funding pledges, to meet the 2007 commitment to provide $1.5 billion to support PMTCT programmes.

Pediatric treatment

Worldwide, 2.5 million children under the age of 15 are living with HIV or AIDS. While rapid developments have been made over the last two years in the number of adults accessing anti-retroviral therapy, treatment for children has not kept pace. In 2006, children under 15 represented 13% of new HIV infections and 12% of all AIDS-related deaths. However, during the same period children represented only 6% of all those accessing treatment.[14] Without treatment, approximately half of all infected children will die before their second birthday,[15] but only one in seven of the 780,000 children in need of ARV therapy are receiving it.

Treating children who have HIV is more complicated than treating adults and has, until recently, been more expensive. There are now a number of fixed-dose combinations for children, and the price of these first-line drugs has reduced dramatically with the aid of negotiating power from the Clinton Foundation and UNITAID. But many ARVs simply do not exist in the easier-to-administer, child-adapted tablet formulation, and children continue to endure sub-standard care. Second-line regimens for children are expensive and complex, and more research and development is urgently needed in this area.

Providing treatment to children essentially involves three stages: finding the child, testing the child and treating the child. Each of these stages can present major challenges, especially in resource-poor countries. In these countries, where health services are often weak and few facilities are available, most HIV-positive children are not even being identified, let alone tested or treated. Even after commencement of treatment, adherence to treatment is often challenging. Given the stigma surrounding HIV, parents and care-givers are often unwilling to make it publicly known that the child in their care is HIV-positive, leading to adherence problems. Community-based organisations like World Vision, with a large number of volunteers and home-based care providers, are critical in addressing these issues.

Another barrier that prevents children from accessing ARV treatment is the lack of specific child-focused training for health-care workers, especially in primary care settings. As pediatric treatment becomes more affordable and available, services for children with HIV must be decentralised from urban tertiary care centres to primary care facilities. Guidelines for the treatment of children with HIV were released by the World Health Organization in 2006; these must be regularly updated and disseminated widely to all health workers coming into contact with HIV-positive children.

At the 2007 Summit in Heiligendamm, G8 leaders committed to work "together with other donors towards meeting the needed resources for pediatric treatments in the context of universal access, at a cost of US$1.8 billion till 2010 …".[16]

Recommendations

6. That the G8 ensure that affordable pediatric medicines, including generic combinations, are available, particularly for second-line treatments.
7. That the G8 ensure that children are considered in national and international efforts to scale up access to treatment.
8. That the G8 support pharmaceutical companies in developing simple and affordable diagnostic tests, increasing research and development for child-specific needs and producing pediatric fixed-dose combinations.
9. That the G8 provide a comprehensive plan towards raising the US$1.8 billion needed for pediatric treatment in the context of universal access, as promised at the G8 summit in 2007.

Support to orphans and vulnerable children

Worldwide, more than 15 million children under the age of 18 have lost one or both parents to AIDS, and this number is rising fast.[17] Nearly 80% of these orphans live in sub-Saharan Africa, the region bearing the greatest burden. In some countries, orphans already account for upwards of 15% of all children, with between one-third and three-quarters of all orphaning in those countries due to AIDS. In addition to those children orphaned by the pandemic, millions more are made highly vulnerable because their parents, relatives and/or other care-givers are living with HIV or AIDS or are heavily affected by the pandemic.

Children orphaned or made vulnerable by AIDS experience a wide array of problems. The illness or loss of a parent begins a spiral of deprivation for the child. In addition to severe psycho-social distress, they may lack food, shelter, clothing and/or health care. They may be abandoned and left to grow up in state institutions and children's homes, in child-headed households or on the street. They may be forced to drop out of school or be required to care for younger siblings or chronically ill adults. They may face discrimination, abuse or exploitation. Deprived of parental guidance and protection, they may themselves become vulnerable to HIV infection.

UNAIDS estimates that prevention, treatment and care programmes for children affected by AIDS will require around 12% of total AIDS expenditure in the period 2008 to 2010.[18]

It is important that G8 leaders ensure the provision of financial resources and support for governments of all countries highly affected by HIV and AIDS to help with the production and implementation of National Plans of Action (NPAs) for the care and protection of orphans and vulnerable children. There are a number of countries with NPAs already in place but their success depends on their implementation. On average, in 2006, only 35% of total budgets of the NPAs for OVC had been pledged in the 14 sub-Saharan African countries for which data was available.[19]

At the 2007 Summit in Heiligendamm, G8 leaders agreed: "As an important step to scaling up towards the goal of universal access to HIV/AIDS prevention, treatment, care and support in Africa, G8 members, in support of national HIV/AIDS programmes globally, individually and collectively over the next few years will aim … to prevent twenty-four million new infections, and to care for twenty-four million people, including ten million orphans and vulnerable children". [20]

Recommendations

10. That the G8 make time-bound and measurable commitments to earmark 12% of HIV and AIDS expenditure specifically for all affected children and in particular for the more than 10 million orphans and vulnerable children in Africa, as promised at the G8 summit last year.
11. That the G8 support governments of all highly affected countries to develop and implement national plans of action that protect orphans and vulnerable children and guarantee their human rights.

part three

health systems

World Vision calls on the G8 to allocate at least 10% of ODA by 2010 to strengthening community- and district-level health services in order to provide predictable, long-term funding for the health systems that are required to achieve the Millennium Development Goals for maternal and child health and the scale-up of HIV and AIDS programmes.

> *"We will ensure our actions strengthen health systems at national and local levels and across all sectors, since this is vital for long-term improvements in overall health, and we will encourage donors to build health capacity".*
>
> Gleneagles Communiqué, 2005

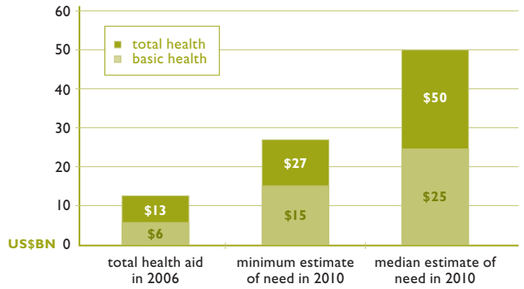
Financial support for health system strengthening

This year some 9.7 million[21] children under the age of five will die largely preventable deaths, around 500,000 women[22] will die from pregnancy-related complications and over 6 million[23] older children and adults will die prematurely from AIDS, TB and other infectious diseases.

Adequate community- and district-level health services could prevent the majority of these untimely deaths, however there is a critical shortage of funds to provide these services.

Figure 4

Aid for health will need to at least double



Source See footnotes 22 through 27

The best estimate of total current health aid is approximately $13 billion in 2006 or around 13% of total ODA.[24] Of this, approximately $5 billion to $6 billion, or 5%, of total ODA supported basic health programmes (community and district health services, reproductive health care and infectious disease control, excluding HIV) and around $5 billion went to HIV and AIDS programmes.[25]

This $13 billion current assistance compares with a minimum estimate for 2010 of $27 billion in total external assistance required[26] and median estimates of around $50 billion per year.[27] Therefore, aid for health needs to at least double. Indeed, it is likely that the higher estimates are more accurate, as UNAIDS and the Global Fund indicate that under realistic assumptions of developing country contributions, aid for HIV and AIDS, TB and malaria alone will need to reach at least $23 billion by 2010.[28]

Of these total health aid requirements, between $15 billion and $25 billion in aid will be required annually to ensure adequate basic health services in 2010. The higher amount largely reflects the need to recruit and train millions of new health staff and the likely need for increased salaries to attract and retain staff. In response to the weaknesses in health systems, the World Health Organization has recommended that 50% of health funding be allocated to the strengthening of health systems and that half of this amount be allocated to the recruitment, training and support of staff.[29]

No single comprehensive study covers the total cost of basic health services. However, in-depth costing studies have been carried out for each of the main components, and these provide detailed estimates of the cost of each sub-service. They are summarised in Figure 5.

Given some overlap (in staffing, equipment and facilities and some interventions) and synergies between the services (e.g., prevention programmes reducing treatment costs), it could be conservatively assumed that around 20% of estimated costs could be deducted from the above total. This indicates that at least $15 billion in aid for basic health services will be required in 2010.

Some of this $15 billion need could be covered by greater and more effective spending of domestic resources in developing countries, however most of the low-income countries have an absolute shortage of resources and

Figure 5

Main components of basic health funding requirements

	Main finding	Estimated minimum annual aid required in 2010 (US$)	Source of information and basis of aid estimate
Maternal and neo-natal health services	$5.3 bn per year additional funding required from all sources	$4.7 bn	Johns B et al, "Estimated global resources needed to attain universal coverage of maternal and newborn health services", Bulletin of the World Health Organization, April 2007, 85 (4). Our calculation assumes $1.7 bn currently provided in aid to this area and that two-thirds of the total funding requirements in low-income countries will be covered by aid in the short term (in line with UNICEF, World Bank and World Health Organization, 2007, A strategic framework for reaching the Millennium Development Goal on child survival in Africa).
Child health services	$5.6 bn per year additional funding required from all sources	$5.3 bn	Stenberg K et al, "A financial road map to scaling up essential child health interventions in 75 countries", Bulletin of the World Health Organization April 2007, 85 (4). We assume $2.3 bn currently provided in aid to this area and that two-thirds of the additional need will be covered by aid as above.
Family planning	$11 bn–$14 bn total per year required from all sources	$3.7 bn	UN Millennium Project, 2006, Final report of the Sexual and Reproductive Health Taskforce. We have conservatively used the minimum estimate and, in line with the International Conference on Population and Development, assumed one-third of total costs are required in aid.
Major infectious disease programmes, excluding HIV and AIDS	$8.3 bn total per year required for TB and malaria programmes	$5.5 bn	Global Fund to Fight AIDS, Tuberculosis and Malaria, Resource needs, February 2007. In line with UNAIDS estimates we assume aid will be required for two-thirds of costs in the short term.
Total		**$19.2 bn**	

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require greater financial support from donor countries to meet their essential health needs.[30] The estimates above are based on realistic assumptions of the amount that can be contributed by low-income countries in the short term.[31]

In recent years donor governments have increased aid for health, however much of this funding has gone to programmes focusing on AIDS and other specific diseases. This has resulted in significant improvements in responses to HIV and AIDS and other infectious diseases, however basic health services that deal with the major causes of maternal and child death as well as the most common health issues facing poor people have not maintained the same rates of improvement. There is a very significant shortage of trained staff, often very poor working conditions, a lack of infrastructure, equipment and essential medicines, and weak management.

In particular, this is preventing adequate and consistent levels of basic care, slowing reductions in maternal and child mortality and impeding expansion of services for people with HIV and AIDS. Without effective basic health systems at the community and district levels, Millennium Development Goals 4 and 5 and the provision of universal AIDS programmes will not be achieved.

The currently strong growth in funding for programmes to turn around HIV and AIDS, TB and malaria needs to continue, and accelerate, if these major infectious diseases are to be brought under control. Growth in funding also needs to be complemented by much greater support for the strengthening of health systems at the community and district levels to enable an effective and comprehensive response to all the major health problems facing poor people and a sustainable and effective foundation for health initiatives. A commitment to provide at least 10% of ODA to community and district health services (i.e., to the OECD DAC sector codes covering basic health) would double funding to this area, to around $13 billion per year by 2010, and would ensure a gradual increase in funds, and a further closing of the funding gap, as ODA continues to grow. It would also ensure the predictable and long-term funding that developing countries require in order to train and employ new health staff.

Responding to the urgency of this issue, the Japanese prime minister recently said: "We must … formulate a framework for action to raise the overall level of the health care system, with the participation of all relevant stakeholders …".[32]

A large body of research and on-the-ground experience indicates that the comprehensive provision of appropriate health services at the community and district levels will make a very big difference to the lives of poor people:

- saving the lives of around 6 million children each year;[33]
- reducing the number of maternal deaths by around 400,000 each year;[34] and
- allowing much more effective responses to the existing infectious diseases.

Recommendations

12. That by 2010 the G8 countries allocate at least 10% of their sector-allocable ODA to strengthening community- and district-level health systems[35] in order to provide universal maternal and child health services and enable the scale-up of responses to HIV and other major infectious diseases. Alternatively, that each G8 donor country contribute its fair share[36] of the minimum $15 billion per year aid required for basic health services by 2010.
13. That the G8 countries also accelerate the increase in funding for HIV and AIDS, TB and malaria through the Global Fund and other mechanisms, where appropriate, in order to meet their commitments to universal HIV prevention, treatment, care and support by 2010 and their commitments to combating the other infectious diseases.

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Supporting development and implementation of effective health plans in developing nations

At the same time as increasing financial support to developing countries' health systems, the G8 could play a key role in helping these countries to develop and implement effective health strategies that answer their specific local challenges.

Like the donor countries, many developing countries need to increase their budget support for essential health programmes. African and other developing countries have committed to increase health funding to at least 15% of budget expenditures, yet only a minority of countries have currently met this commitment. The G8 countries could play a more active role in encouraging developing countries to increase their health funding in line with increases in donor support.

The G8 should also work with groups such as the International Health Partnership to help improve donor co-ordination and assist developing countries in creating and implementing effective, high-quality health plans that provide comprehensive and equitable services based on cost-effective, evidence-based interventions.

There are indications that some international financial institutions have imposed budget constraints on certain developing countries, which has prevented adequate funding of essential services.[37] The G8 could help to ensure that essential services are not jeopardised in this way.

Recommendations

14. That the G8 work with national governments through the International Health Partnership to assist them in developing comprehensive, adequately funded and workable health plans that focus on effective health systems, with particular focus on delivering an essential package of care through strengthened community and district health interventions.
15. That the G8 work with the international financial institutions to ensure that fiscal conditions that hinder the provision of effective basic health services are not imposed on developing countries.

2008 G8 Policy Calls footnotes

1 Gleneagles Communiqué, 2005, paragraph 28

2 In 2004 dollars

3 Organization for Economic Co-operation and Development Development Assistance Committee, 2005, "Simulation of DAC members' net ODA volumes in 2006 and 2010", available at http://www.oecd.org/dataoecd/0/41/35842562.pdf

4 Jones, Steketee, Black et al, "How many child deaths can we prevent this year?", The Lancet, 2003, 362; World Health Organization, 2001; Report of the Commission on Macroeconomics and Health; and Global Fund to Fight AIDS, Tuberculosis and Malaria, 2007, Resource needs for the Global Fund 2008–10

5 OECD DAC, 2007, Final ODA flows in 2006

6 Ibid. The ODA/GNI levels in 2005 were: Canada 0.34%, Japan 0.28%, United States 0.23%.

7 The Paris Declaration is an international agreement to which over 100 ministers, heads of agencies and other senior officials in 2005 committed their countries and organisations. The Declaration commits donors to increase efforts in harmonisation, alignment and managing aid for results with a set of monitorable actions and indicators.

8 UNAIDS, 2007, AIDS epidemic update, December 2007

9 Ibid.

10 GFATM, 2007, Resource needs for the Global Fund 2008–2010

11 Stover, J et al, 2006, "The global impact of scaling up HIV/AIDS prevention programs in low- and middle-income countries", Science, vol. 311, no. 5766, pp. 1474–1476

12 UNAIDS, 2005, AIDS epidemic update, December 2005

13 UNICEF, 2005, A call to action: Children, the missing face of AIDS

14 WHO, 2006, Progress on global access to HIV antiretroviral therapy: A report on "3 by 5" and beyond

15 UNICEF, 2007, Children and AIDS: A stocktaking report

16 G8 Summit 2007 Heiligendamm, Growth and responsibility in Africa: Summit Declaration, 8 June 2007, paragraph 50

17 Ibid.

18 UNAIDS, 2007 (September), Financial resources required to achieve universal access

19 Ibid.

20 G8 Summit 2007 Heiligendamm, Growth and responsibility in Africa: Summit Declaration, 8 June 2007, paragraph 58

21 UNICEF ChildInfo database, accessed 12 December 2007

22 Hill K, Thomas K et al, "Estimates of maternal mortality worldwide between 1990 and 2005", The Lancet, 2007, 370

23 UNAIDS, 2007, AIDS epidemic update, December 2007 and WHO mortality database, accessed 12 December 2007

24 OECD DAC CRS database, accessed 14 December 2007, and Kates J & Lief E, 2007, Donor funding for health in low- and middle-income countries, 2001–2005, Henry J. Kaiser Family Foundation and Center for Strategic and International Studies, extrapolated to 2006 and assuming the share of sector-allocated ODA going to health applies to total ODA. The 2008 IMF/World Bank Global Monitoring Report estimates the total at $17 bn in 2006, however this is likely to reflect commitments rather than disbursements.

25 Kates J, Izazola J & Lief E, 2007, Financing the response to AIDS in low- and middle-income countries: International assistance from the G8, European Commission and other donor governments, 2006 quotes $3.9 billion in disbursements but does not include the full value of payments to the Global Fund during 2006 by donor countries, as the authors are focusing on the distribution of funds.

26 WHO, 2001, Report of the Commission on Macroeconomics and Health; the $27 bn figure includes aid for health research and greater support of UN agencies.

27 World Bank, 2006, Health financing revisited

28 GFATM, 2007, Resource needs for the Global Fund 2008–2010, p12

29 WHO, 2006, World Health Report

30 WHO, 2001, Report of the Commission on Macroeconomics and Health; World Bank, 2006, Health financing revisited

31 For example, UNAIDS and the Global Fund estimate that in the short term, approximately two-thirds of health support will need to come from aid, as do UNICEF, the World Bank and WHO in their recent strategic framework for reaching the Millennium Development Goal on child survival in Africa.

32 World Economic Forum, 26 January 2008

33 Jones, Steketee, Black et al, "How many child deaths can we prevent this year?", The Lancet, 2003, 362

34 Ensuring skilled attendance at all births, backed by emergency obstetric care, could achieve a reduction in maternal deaths of at least 75%. For example, Malaysia, Thailand and Sri Lanka have all achieved decreases in maternal mortality of more than 75%. See WHO, 2005, World Health Report, p66.

35 That is, the sum of funding to OECD DAC sector 122 (basic health) and sector 130 (reproductive health) but excluding sub-sector 13040 (STD control including AIDS) should be at least 10% of sector-allocable ODA. Increasing use of general budget support (which cannot be sector-allocated) means that the share of sector-allocable aid, rather than total aid, is a better indicator of support for health systems and basic health care.

36 Fair share should be based on the donor country's share of total OECD donor country Gross National Income.

37 Center for Global Development, 2007, Does the IMF constrain health spending in poor countries? Evidence and an agenda for action

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