



The Malaria-Donor Scorecard

Malaria Control and Bi-Lateral Donor Aid – an assessment of transparency and accountability among OECD Donor Agencies

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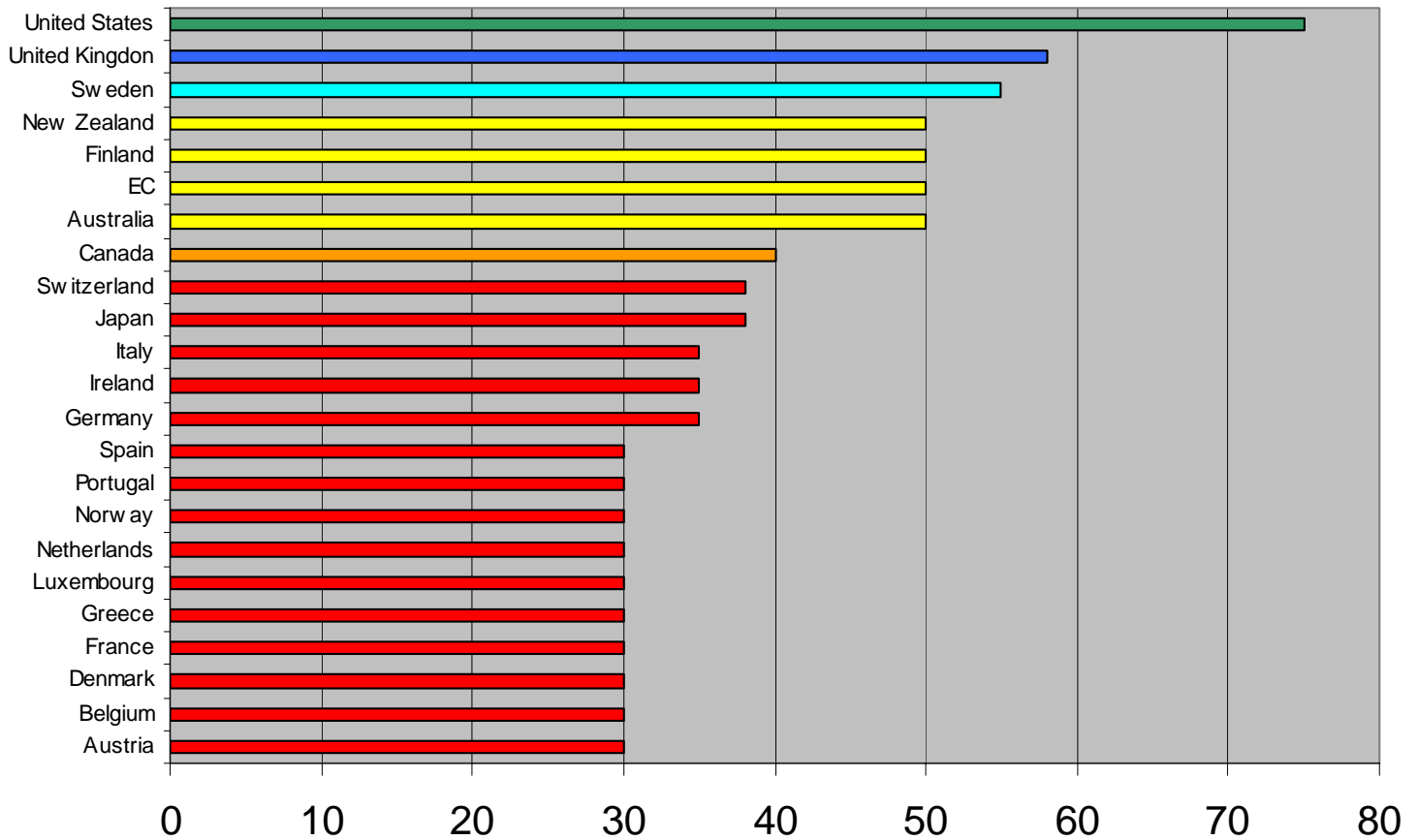
Executive Summary

Malaria claims over 1 million lives every year and in many countries, mainly in Africa, is a major public health problem. In recent years, thanks to advocacy efforts around the world, efforts to combat the disease are benefiting from increased political attention and funding. Several governments have pledged to fight malaria in order to achieve Goal 6 of the Millennium Development Goals (MDGs). Increased attention and funding for malaria control, however, should be accompanied by a greater willingness among donor agencies to explain how their interventions are in line with and support sound policies such as the World Health Organization's guidelines and strategies for malaria control. In addition, donor agencies should be in a position to explain how, where and when their taxpayers' funds are being used in malaria control. Perhaps most importantly, Africa Fighting Malaria (AFM) would expect that with the current increased attention for malaria control, donor agencies would be interested in understanding the outcomes of their efforts in terms of changes to malaria mortality and morbidity.

This malaria-donor scorecard is an initial attempt to gain a better understanding of what OECD donor agencies are doing for malaria control around the globe. With the notable exception of the US Agency for International Development (USAID) and the United Kingdom's Department for International Development (DFID) almost all OECD donor agencies fare badly. The majority of donor agencies (15 out of 23) declined to respond to our requests for information and did not even acknowledge receipt of repeated correspondence. Of the 8 donor agencies that did respond to our correspondence, only 5 provided us with an adequate amount of information about how their malaria control funds were being used with USAID providing the greatest detail. Only one agency, USAID, provided detailed information on monitoring and evaluation of its malaria control spending. Our analysis of donor agency websites reflects similar trends, with only USAID, DFID and the Swedish Aid Agency (SIDA) giving an adequate level of information on their malaria control activities.

Africa Fighting Malaria expects that the donor agencies featured in this report will respond proactively and assist us and other health advocacy groups to understand better how they are supporting malaria control programs. AFM also hopes that this report will focus the minds of those charged with malaria control among the various agencies to be open and transparent and to devote increased efforts into measuring and evaluating the effectiveness with which their taxpayer's money is spent in terms of malaria cases and deaths.

Overall OECD Malaria-Donor Scores



The Malaria-Donor Scorecard

Malaria Control and Bi-Lateral Donor Aid – an assessment of transparency and accountability among OECD Donor Agencies

Introduction

Malaria continues to be a major public health concern throughout the world and particularly in Africa. Approximately 90% of the world's malaria cases and deaths occur in Africa. A combination of severe poverty, poor health infrastructure and highly efficient malaria carrying mosquitoes contribute to this burden in Africa.¹ The disease, which is preventable and curable, claims over a million lives a year, predominantly among women and children², and has debilitating consequences for most others infected. As Nobel Laureate in Medicine T.H. Weller noted, "It has long been recognised that a malarious community is an impoverished community".³

The disease accounts for 40% of public health expenditure, 30-50% of inpatient admissions, and up to 50% of outpatient visits in areas with high malaria transmission.⁴ Furthermore, it is estimated that directly and indirectly, malaria costs Africa approximately \$12 billion per year,⁵ Yet it can be controlled effectively at a fraction of this cost, annually.

However, the majority of sub-Saharan African countries, which bear the brunt of the disease, are in no position to provide the necessary funding to control the disease. Indeed, many of these countries continue to be heavily reliant on donor country funding to sustain their malaria control programs. Although specific data relating to dependency on donor funding for malaria control programmes is difficult to establish, it is possible to get a generalised perspective of donor dependency for sub-Saharan African countries by looking at overall aid as a percentage of gross domestic product (GDP) and government expenditure.

According to the World Bank African Development Indicators (2006), Official Development Assistance (ODA) to sub-Saharan Africa was the equivalent of 4.5 percent of the region's GDP in 2004.⁶ This average masks some enormous variations in donor aid dependency. ODA makes up only 0.3% of South Africa's GDP while it forms 17.0% of GDP for Uganda, 22.6% of GDP for Ethiopia, 27.4% of GDP for the Democratic Republic of Congo, and 52.8% of GDP for Burundi. Exactly half (23) of the region's 46

¹ National Institute of Allergy and Infectious Diseases, 1997. Final report, International Conference on Malaria in Africa: challenges and opportunities for cooperation (January 6–9, 1997, Dakar, Senegal). Available at: <http://www.niaid.nih.gov/dmid/malaria/malafr/default.htm>. Accessed January 11, 2007.

² Malaria is Africa's leading cause of under-five mortality (20%) and constitutes 10% of the continent's overall disease burden (http://www.rbm.who.int/cmcc_upload/0/000/015/370/RBMInfosheet_3.htm).

³ Weller, T.H. (1958) 'Tropical Medicine,' in *Encyclopedia Britannica*, pp. 495-497.

⁴ "Malaria in Africa" Factsheet 3, Roll Back Malaria (http://www.rbm.who.int/cmcc_upload/0/000/015/370/RBMInfosheet_3.htm)

⁵ *Ibid.*

⁶ World Bank (2006) African Development Indicators 2006, Table 13.1 p 89. World Bank, Washington DC

countries (for which the World Bank has data) received in excess of 10% of GDP in ODA, and 11 countries received more than 20% in 2004.⁷

Perhaps of more relevance is the fact that 30 of the 45 sub-Saharan African countries for which the World Bank has data, report that ODA formed more than 30% of their central government expenditure in 2004⁸. Twenty-two Sub Saharan African countries report that ODA formed more than 50% of their government expenditure and for five countries ODA comprised more than 100% of government expenditure⁹.

Although many donor agencies provide significant budgetary support to many African countries, financial resources for malaria control is still in large part lacking. According to the Global Fund for AIDS, TB and Malaria (GFATM) in order to reach the Millennium Development Goals (MDGs)¹⁰ for malaria, \$3.1bn would be needed in 2008, \$3.4bn in 2009 and \$3.7bn in 2010. Given the inherent difficulties in measuring progress towards the MDGs and the lack of effort that donor agencies have put into measuring progress historically, these figures should be viewed with some scepticism. The failure of many donor agencies and multi-lateral funding organizations to live up to their promises to fund malaria and control the disease is arguably matched by a failure of many African countries to prioritise malaria control domestically and allocate sufficient domestic funds to disease control.^{11,12}

The US Malaria Policy Experience

In recent years financial resources and commitments from Western donor nations for the fight against malaria have increased. However, the act of giving by developed country agencies, although necessary to drive an on-going comprehensive malaria control program, is not sufficient in itself to control or even eradicate the disease.

First, increased funding for malaria control programs without an effort to ensure that donors support the full range of malaria control interventions may lead to a waste of resources. In addition, without an effort to measure the effective uses of interventions, in terms of malaria cases averted and lives saved, donor agencies will not be able to assess whether their policies are working and will be unable to adapt such policies based on

⁷ *ibid*

⁸ *ibid*

⁹ *Ibid*. These five countries are Burundi (132.6%) Democratic Republic of Congo (178.1%) Liberia (307.5%) Madagascar (112.9%) and Sierra Leone (128.4%)

¹⁰ The MDG for malaria is to “Halt and begin to reverse the incidence of malaria and other major diseases” by 2015. see <http://www.un.org/millenniumgoals/> Readers interested in the MDGs may wish to read Prof. Amir Attaran’s criticism of the measurement of the MDGs, Attaran A, An Immeasurable Crisis? A Criticism of the Millennium Development Goals and Why They Cannot Be Measured. *PLOS Medicine* Vol. 2(10) Oct 2005. <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1201695> and the subsequent response from John McArthur, Jeffrey Sachs & Guido Schmidt-Traub “Millennium Development Goals ‘not doomed to fail’” *SciDev.Net*. 13 September 2005, available at <http://www.scidev.net/opinions/index.cfm?fuseaction=readopinions&itemid=429&langauge=1>

¹¹ Narasimhan and Attaran, (2003) ‘Roll Back Malaria? The scarcity of international aid for malaria control’, *Malaria Journal* 2:8.

¹² Information on the level of domestic funding that African countries devote to malaria control or to healthcare in general is difficult to obtain. According to the WHO, only one country, Botswana, has complied with the Abuja target of devoting 15% of government expenditure to healthcare.

available evidence. Lastly, without an effort to explain how public funds for malaria control are spent and which agencies or contractors are charged with spending those funds, the scientific and advocacy community will be unable to assist, contribute and critique malaria control programs (aside from the fact that taxpayers should be able to know how their contributions are being used).

During 2005, the United States Congress began to enquire how the US Agency for International Development (USAID) conducted its malaria control program. This came after research by AFM director, Dr. Roger Bate, revealed a general opaqueness in the way in which USAID spent its malaria funds and limited efforts to measure the effectiveness of its programs in terms of changes to malaria morbidity and mortality.¹³ Perhaps as a direct result of this Congressional inquiry and oversight, the agency set about reforming its policies and increased its efforts to be both transparent and accountable. In June 2005, President Bush announced the formation of the President's Malaria Initiative (PMI), which would devote \$1.2bn to malaria control in 15 countries. With these increased funds available and more public interest in malaria, USAID and the PMI have made impressive progress in scaling up malaria control programs in the target countries in a more open and transparent manner.¹⁴

In addition to improving transparency and increasing efforts to measure progress in malaria control, USAID has aligned some of its policies with WHO policy recommendations. In January 2006, the newly appointed head of WHO's Global Malaria Program (GMP), Dr. Arata Kochi, released new malaria treatment guidelines, the first in 20 years. These guidelines call for Artemisinin-based Combination Therapy (ACT) as a first line treatment of uncomplicated malaria.¹⁵ In September 2006, Dr. Kochi released new policy guidelines on Indoor Residual Spraying (IRS). IRS as an intervention has been largely ignored by most donor agencies. For several decades, donors, along with the WHO, have either refused to support IRS programs or have actively discouraged their use. WHO is now attempting to redress that anti-IRS bias and is calling for IRS to be supported where appropriate. In line with WHO policy guidelines, USAID's policies support both IRS and the use of ACTs

Political interest in malaria control has increased within the major donor nations. One political party that is not even in power has made commitments to increase funding for malaria control should it be voted into office¹⁶. Africa Fighting Malaria believes that transparency in public spending is inherently important, however as resources for malaria control increase, it is especially important for donor agencies to be open and transparent with their plans for malaria funding as more is at stake. With increased transparency it will be possible for scientists, public health experts, activists and perhaps most

¹³ Bate R & B Schwab (2005) "The Blind Hydra USAID Policy Fails to Control Malaria" American Enterprise Institute, AEI Working Paper #108, 22 April 2005, Washington DC.

¹⁴ See "Moving Mountains. The Evolution of USAID's Malaria Control Program." AFM Working Paper, December 12, 2006, Available from: <http://www.fightingmalaria.org/research.aspx?id=14>

¹⁵ World Health Organization (2006) "Guidelines for the Treatment of Malaria" Geneva, Available from: <http://www.who.int/malaria/docs/TreatmentGuidelines2006.pdf>

¹⁶ For instance, George Osborne MP, UK Shadow Chancellor of the Exchequer pledged that "a future Conservative government will spend a minimum of £500 million – or \$1bn - a year tackling malaria in Sub-Saharan Africa." http://www.georgeosborne.co.uk/shadow_news.php?id=25

importantly, those suffering from malaria, to understand what is being planned and paid for and to contribute to improvements to those plans and programs.

Assessing Donor Agency and Anti-Malaria Programs

The OECD Development Assistance Committee

In order to assess and establish a benchmark on donor openness, transparency and accountability, AFM approached the Organisation for Economic Co-operation and Development (OECD) donor agencies for information on their support for malaria control. The OECD Development Assistance Committee (DAC) is made up of the 23 major bi-lateral agencies that represent most wealthy governments of the developed world. Collectively these countries provide the majority of donor funding for malaria control. These donor agencies either provide direct bilateral funding (country-to-country) or multilateral funding through agencies such as The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM).¹⁷ AFM initially attempted to utilise the official statistical database of the OECD, known as the Creditor Reporting System (CRS), which compiles all funding commitments and disbursements by the various donor country agencies. However, the reporting system does not explicitly account for malaria control programmes, but rather groups all health care funding together. As many donors provide funding for sector-wide approaches (SWAp) and for general health infrastructure it may be very difficult and impractical to determine a specific funding amount for malaria control. Providing broad SWAp funding is commendable; however many donor agencies continue to link their resources and support to MDGs and often pledge to achieve certain malaria-specific targets, such as the Roll Back Malaria target to halve the burden of malaria by 2010, that they cannot or will not measure.

Table 1 below gives OECD data on donor contributions for 2004, the latest year available. Given the lack of sufficiently disaggregated data, further research was necessary to understand the levels of funding destined for malaria control programmes in the CRS database. AFM focussed on the purpose code 12250, defined as “Infectious disease control: Immunisation; prevention and control of malaria; tuberculosis; diarrhoeal diseases; and vector borne diseases”¹⁸.

According to the latest available data provided by the OECD, the projects listed in this purpose code amounted to USD 544.3 million for the year 2004. Further information was gathered from an OECD representative on several other purpose codes that potentially capture malaria control funding (see Table 2 below).¹⁹

¹⁷ Private organisations and charities are increasingly providing significant amounts of funding for malaria control programmes. However, since the focus of this paper is to analyse the transparency of governmental donor agencies we do not consider donations given by private institutions.

¹⁸ OECD “The List of CRS Purpose Codes” available from:
<http://www.oecd.org/dataoecd/40/23/34384375.doc>

¹⁹ The letter sent to the OECD representative can be found in Annex 1.

Table 1: Aid to health 1996-2004 (Annual average commitments), constant 2004 prices

Donors	US\$ million		
	1996-1998	1999-2001	2002-2004
Australia	100	178	99
Austria	28	51	17
Belgium	66	92	124
Canada	45	87	214
Denmark	104	77	110
Finland	15	22	37
France	236	211	266
Germany	222	168	233
Greece	8	6	9
Ireland	15	33	96
Italy	33	55	84
Japan	402	327	423
Luxembourg	19	22	31
Netherlands	177	212	240
New Zealand	-	7	10
Norway	58	130	134
Portugal	12	11	10
Spain	159	140	114
Sweden	83	99	142
Switzerland	36	45	49
United Kingdom	309	647	691
United States	866	1,207	2,213
Total DAC	2,993	3,828	5,347

Source: OECD, CRS and DAC statistics (<http://www.oecd.org/dataoecd/0/31/37466488.xls>)

OECD's data is incomplete as several countries fail to report their spending on healthcare programs; therefore these data should be viewed with a certain amount of scepticism. For instance, the US Congressional Research Service confirms that US funding for TB and malaria control programs alone in 2004 was \$189.3m²⁰ yet the OECD reports that the US only spent \$7m under purpose code 12250. However, despite the efforts to isolate funding destined for malaria control programmes it was still not possible to derive definitive malaria control funding estimates using the CRS database.

²⁰ Salaam-Blyther, Taiji, "U.S. International HIV/AIDS, Tuberculosis and Malaria Spending: FY2004-FY2007. Congressional Research Service Report for Congress, December 28, 2006. Washington DC

²² It should be noted that these data pertain to commitments by the DAC countries and therefore potentially overstates that actual amounts disbursed.

Table 2: Source Codes Potentially Capturing Malaria Control Programmes: Bilateral aid commitments in current US dollars by DAC donors (2004)^{22,23}

Donor Country	Commitment (USD current – million)
Australia	11.2
Austria	Nd
Belgium	0.4
Canada	8.7
Denmark	0.5
Finland	Nd
France	Nd
Germany	0.8
Greece	0.1
Ireland	1.3
Italy	0.3
Japan	Nd
Luxembourg	Nd
Netherlands	0.6
New Zealand	Nd
Norway	0.7
Portugal	0.1
Spain	0.1
Sweden	Nd
Switzerland	2.4
United Kingdom	55.8
United States	7.0
Total	90.0

Source: OECD representative, CRS database.
Nd=No data

AFM therefore sent emails to the communication departments of OECD donor agencies as well as to the OECD itself to better understand their malaria control programs. The texts of the email that AFM sent along with the responses received are given in the Annexes below.

Based on the responses received AFM has attempted to score the various malaria programs. Given the important reforms made by USAID, AFM has scored the other OECD donors against this agency. USAID has gone further than any other agency to provide the public with details about its malaria control spending and to ensure that progress is measured in terms of changes to malaria death and disease. Although their efforts are far from perfect, AFM feels that the agency provides a useful and fair benchmark for grading other agencies.

²³ These data exclude any contributions made to The Global Fund to fight AIDS, TB and Malaria.

²⁵ The Global Fund, (2007) “Partners in Impact: Results Report” pg. 3

Direct Bi-Lateral Donor Questions

Each OECD donor agency was approached for detailed information on their support for malaria control programmes. Each agency was asked to provide information and data related to funds made available for malaria control programs. In addition to the general information requested, AFM asked the following specific questions:

1. In 2006, the World Health Organisation issued new malaria treatment guidelines that call for artemisinin-based combination therapies. In addition, WHO has called for an increase in the use of Indoor Residual Spraying (IRS) as a means of controlling malaria. Could you explain how your agency is responding to these new guidelines and how they will be assisting malarial countries to implement both interventions?
2. What is your agency's budget for malaria control programs?
3. Of that budget, what proportion is spent on malaria treatment (and of that, how much on the new artemisinin-based combination therapies) and what proportion is spent on malaria control (and of that, how much on indoor residual spraying and how much on insecticide treated nets)? What proportion of the budget is devoted to technical assistance and 'capacity-building'?
4. How does your country measure the effectiveness of the funds it devotes to malaria control (for instance, does your country measure changes in morbidity and mortality as a result of its anti-malaria spending)?

Responsiveness

AFM sent out three rounds of questionnaires on 26 October 2006, 14 November 2006 and 12 February 2007. Based on the time taken to respond to our initial request for information and the ability to answer each of the questions posed, a score was assigned to the DAC members' responses (see Table 3 below). Response time score was assigned according to the following criteria. If the country representative responded within the first month of the initial questionnaire, then the country received an 'A' for response time. Responses thereafter were reduced by one grade for each month after the initial questionnaire was sent. Countries that failed to respond after three rounds of questionnaires received an 'F'. Two-thirds of the DAC member countries failed to respond. Failure to respond could be the result of several factors, but based on the responses by the other DAC countries it not unreasonable to assume that many of the countries simply do not know how much of their donor funding is spent on malaria control projects. Furthermore non-responsive donors are also unlikely to measure the effectiveness of their contributions in reducing the rates of malaria mortality and morbidity.

Transparency

In addition to scoring the agencies in terms of response time, AFM has scored them according to transparency. As explained above, AFM used USAID as the benchmark for transparency, USAID. The President's Malaria Initiative (PMI) provides a significant amount of information on its malaria control program, including how and where funds are spent. Failure to respond to our repeated requests for information would automatically result in an F score for transparency.

Monitoring and Evaluation

Few donor agencies explain how they measure the effectiveness of their spending on malaria control. AFM therefore included a score for monitoring and evaluation (M&E) in our scorecard. USAID has begun to measure the effectiveness of its programs in terms of changes to malaria morbidity and mortality; however AFM obtained little information out of our requests from other donors on their (M&E) efforts.

Almost all donor agencies contribute to the Global Fund for HIV/AIDS, TB and Malaria (GFATM) which, as of 31 December 2006, signed grant agreements worth US\$5.3 billion for 410 grants in 132 countries. In just over three years, the GFATM has disbursed US\$3.24 billion to grant recipients. According to the GFATM their efforts to curb the deadly onslaught of the three major communicable diseases have resulted in 1.25 million lives being saved.²⁵ The GFATM states, "These are people who are walking in their communities, turning up to work, looking after families. They would no longer be there if it were not for the results of Fund supported programs".²⁶

Furthermore, the report suggests that this figure would rise by approximately 3,000 lives saved per day to an estimated 1.46 million lives saved by January 2007.²⁷ Yet despite these seemingly impressive results, the GFATM is still focuses on inputs when assessing impact.²⁸

The organization reports the following results for malaria projects, "The Global Fund reports that as of 1 December 2006 the organization has supported the delivery of over 18 million insecticide-treated bed nets (ITNs)...[and] 23 million malaria treatments delivered".²⁹ "The scaling up of ITNs and malaria services has been particularly important over the last year. In 2002, only five million ITNs were distributed globally, all sources combined. Two years ago, The Global Fund supported programs had added only 1.35 million ITNs. In the last year, as programs have matured, results have increased sharply to 18 million".^{30,31}

²⁶ The Global Fund, (2007) "Partners in Impact: Results Report" pg. 3

²⁷ The Global Fund, (2007) "Partners in Impact: Results Report" pg. 3

²⁸ If one looks at The Funds' malaria website the main page reports the number of ITN's and ACT's that they have helped to distribute. The Global Fund's malaria website is available at: <http://www.theglobalfund.org/en/about/malaria/default.asp>

²⁹ The Global Fund, (2007) "Partners in Impact: Results Report" pg. 3

³⁰ The Global Fund, (2007) "Partners in Impact: Results Report" pg. 14

The GFATM has attempted to capture the reduction in morbidity and mortality for a handful of its target countries. More specifically the GFATM reports reductions in malaria cases for Burundi, Eritrea, Tanzania and Zambia.³² For instance, GFATM reports from the small island of Zanzibar suggest that, “combined with efforts by the U.S. President’s Malaria Initiative...the approach has been successful. There were over 400,000 malaria cases in 2004 in Zanzibar; by 2006 it was under 60,000”.³³ In total the GFATM estimates that it has helped to save 110,000 lives with GFATM money. The GFATM notes that the morbidity and mortality will be examined and evaluated by partners and the GFATM five-year evaluation.

To date the GFATM rarely measures results based on reductions in malaria incidence. Indeed, if one analyses the Fund’s malaria report, nowhere does it measure the number of deaths averted or a reduction in the incidence of malaria in targeted countries as a result of the GFATM’s disbursements.³⁴ Any data presented on changes to disease incidence are likely to be based on estimates derived from commodities procured. In the GFATM’s defense, the organization is still in its infancy and the Fund argues that it is “too early to assess its impact”.^{35,36} Indeed, the average age of Fund supported programs is 23 months and thus difficult to establish the impact of these programs in terms of reductions in malaria mortality and morbidity rates. However, the Fund is not too new to ensure that its own funds are properly managed and that the commodities that it procures are delivered in a timely manner³⁷. An internal Global Fund report recently led to the board limiting access of senior executive staff to a private expense account, which should raised concerns about possible misuse of other accounts and funds.³⁸ The Global Fund has also been somewhat reluctant to make the decisions and reports of the technical review panels that assess applications available to the public.

Ultimately the GFATM measures the impact of its funding in accordance with the Millennium Development Goals (MDGs).⁴¹ The Fund notes that if the MDGs are to be

³¹ “These results are only the surface of the work carried out to scale up prevention, treatment and care in countries. They are the results of country partners, and the focus is not the Global Fund, which only provides the finance”.

³² The Global Fund, (2007) “Partners in Impact: Results Report” pg. 64, 65.

³³ The Global Fund, (2007) “Partners in Impact: Results Report” pg. 67

³⁴ The Global Funds malaria report is available at:

http://www.theglobalfund.org/en/files/about/replenishment/disease_report_malaria_en.pdf

³⁵ The Global Fund Disease Report pg. 42

³⁶ The Global Fund, (2007) “Partners in Impact: Results Report” pg. 10

³⁷ For instance, see Roger Bate “On The Trail of a Cure. Reality and Rhetoric on Treating Malaria” American Enterprise Institute, Washington DC, March 22, 2007. Available at

http://www.aei.org/publications/filter.all.pubID.25834/pub_detail.asp

³⁸ See John Donnelly, “Global Fund limits access to private expense account” Boston Globe, February 10, 2007. Available at

http://www.boston.com/news/nation/washington/articles/2007/02/10/global_fund_limits_access_to_private_expense_account/

⁴¹ Target 8 of the MDG: Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases.

achieved, “a one-third reduction in under five mortality by 2010 and a two-third reduction by 2015 are needed in malaria endemic areas. Correct ITN use results on average in 50 percent reduction of uncomplicated malaria episodes and 5.5 fewer deaths per 1,000 children per year in malaria-endemic regions of sub-Saharan Africa⁴². GFATM resources are also used to procure effective malaria drugs (ACT’s) that further reduce malaria-related deaths and to support IRS.”⁴³

The GFATM has some built in mechanisms to ensure that funds spent on disease control achieve the desired results and are spent appropriately.⁴⁴ The GFATM approves funding in principle for five years but initially commits money for the first two years only. The end of this first phase is a critical milestone in the performance-based funding model used by the GFATM since it determines whether the country will continue to receive additional funding in the second phase, which usually covers rounds three through five. Therefore to the extent that these donors support the GFATM, there will be some monitoring and evaluation, as well as a level of transparency. However, despite the monitoring and evaluation measures adopted by the GFATM to date, few DAC donor agencies appear to be aware of the impact their spending has on malaria morbidity and mortality.

Donor Websites

In addition to requesting information from the OECD and from the donor agencies themselves, AFM searched their websites and included this as an element in the scorecard. Scores were based on the amount of information and data provided to the general public, the ease of navigation and ability to find information and the degree to which the agencies explain what their activities are, how they are spending taxpayer’s money and what the outcomes of that spending are. Annex 4 to this report provides full details of our website research.

Results

After three separate attempts to obtain information from the twenty three DAC donor agencies only nine responded. USAID and the PMI obtained an A score for their quick response time and their willingness to discuss the malaria programs. New Zealand and Sweden were also awarded an A for its rapid response (within 2 weeks) to our initial request for information. The European Commission and United Kingdom responded relatively quickly (within 6 weeks) and were therefore both awarded a B.

USAID and the PMI provide the greatest amount of information on how taxpayer’s money for malaria control is spent. Much of this information is loaded on the www.fightingmalaria.gov website. AFM awarded USAID a B+ for the amount of information that they provide. A higher score would have been awarded to USAID if the contracts awarded to various USAID contractors did not have so much information

⁴² Gareth Jones et al. “How many child deaths can we prevent this year?” Lancet, Vol 362, Issue 9377, 5 July 2003, pp 65-71

⁴³ The Global Fund, (2007) “Partners in Impact: Results Report” pg. 77

⁴⁴ The Global Fund requires grant recipients to report results on a regular basis, and these reports are verified by independent consultants. This enables the Global Fund to ensure that funds are reaching those for whom they are intended and are being spent efficiently.

redacted. Aside from USAID, of the donor agencies contacted, the European Commission provided the most amount of information on their malaria spending. However, as can be seen from their response in Annex 1, the information is hardly comprehensive. The UK's Department for International Development (DfID) provided similar amounts of information and, along with the EC, was given a C for transparency.

Monitoring and Evaluation is an area where few donors perform well. AFM awarded USAID with a B+ for their greatly improved efforts to measure the impact of their PMI program in terms of changes to malaria morbidity and mortality. Given the specific goal of the PMI to halve number of malaria deaths over 5 years, USAID and its CDC partner have had to improve their monitoring and evaluation and in some cases have created M&E systems from scratch. Despite their significant improvement in M&E, AFM feels that there is still considerable scope for USAID to increase funding for M&E and to improve malaria surveillance systems.

Overall, USAID scores highest with a B+, followed by DFID with a C-. Most donors score very poorly due to a combination of failing to respond to our repeated requests for information and a seeming complete lack of interest in the outcomes of their anti-malaria spending. It is great concern to AFM that the OECD does not measure the effectiveness of DAC donor programmes.

Conclusion

Malaria continues to be a major public health problem in many developing countries and almost all sub-Saharan African countries. Political commitment to fund anti-malaria programs to control the disease has risen along side reforms to the WHO's Global Malaria Program. However, increased funding without more transparency as to how taxpayers' money will be spent and without any real commitment to improving monitoring and evaluation could undermine long term malaria control. Without sufficient transparency, scientists and other stakeholders will be unable to evaluate and contribute to malaria control plans. Without sufficient monitoring and evaluation, it will be difficult, if not impossible, to assess whether interventions are working and to adjust policies accordingly. Evidence-based decision making cannot occur without evidence. The WHO policy changes should be met with far greater efforts among the donor community on transparency and monitoring and evaluation.

AFM finds that most OECD donor agencies are dismissive of attempts to discover more about the way that they spend taxpayer's money. Perhaps most worrying is the lack of any attempt among most donors to reveal any method of measuring their performance. Many of the large donor agencies, despite their best intentions in wanting to control the disease, are simply not aware of where their money has been spent or if it has had a favourable impact in reducing malaria morbidity and mortality rates. This is confirmed by the fact that many of the DAC countries chose either to omit answers to our specific questions or simply stated that they were not aware of where and what their money has been spent on and if indeed it was helping to reduce the burden of malaria.

Of course, most of the donors fund the Global Fund to a greater or lesser extent. While AFM supports this funding route, recently the Global Fund has had a relatively poor record of funding malaria projects. In the latest Round 6 of Global Fund funding, less

than 30% of malaria projects were funded. There may be good reasons to deny funding for malaria projects. For instance, if the proposals are of a poor quality or if previous funding has not been utilised or if there are concerns about financial mismanagement. However, it is conceivable that good quality proposals are being rejected; without full access to the reports and decisions of the technical review panel, it will be difficult to make an assessment.

Without improved transparency and better monitoring of outcomes to show success or areas in need of improvement, AFM fears that the latest round of political focus on malaria will fade, along with much-needed funding. Unless donor agencies become far more explicit about how they spend their taxpayers' money in malaria control efforts, a unique opportunity truly to control malaria as a serious public health threat will be lost.

Reforms to the OECD system of collecting data on bilateral donor commitments to public health programs are urgent and necessary. We find that the information collected by the OECD on bilateral healthcare funding is out of date, incomplete and possibly inaccurate. Improving this system with better and more timely reporting of data from the donor agencies themselves would be an obvious step in the right direction and would improve transparency. This increase in transparency would help to target malaria control efforts where they are most needed and will help to improve evidence-based decision making.

Africa Fighting Malaria expects that the donor agencies featured in this report will respond in the future and assist us and other health advocacy groups to gain a better understanding of how they support malaria control programs. AFM also hopes that this will focus the minds of those charged with malaria control among the various agencies to be open and transparent and to allocate increased efforts into measuring and evaluating the effectiveness with which their taxpayer's money is spent in terms of malaria cases and deaths.

Table 3 – Malaria-Donor Score Card

Country	Response time	Transparency	Monitoring & Evaluation	Website	Total
Australia	D	C	F	D	D
Austria	E	F	F	N/A	F
Belgium	F	F	F	N/A	F
Canada	F	F	F	B-	E
Denmark	F	F	F	D	F
European Commission	B	C	D	F	D
Finland	D	C	D	D	D
France	F	F	F	F	F
Germany	F	F	F	D	F+
Greece	F	F	F	F	F
Ireland	F	F	F	D	F+
Italy	F	F	F	D	F+
Japan	F	F	F	C-	E-
Luxembourg	F	F	F	F	F
Netherlands	F	F	F	F	F
New Zealand	A	D	F	D-	D
Norway	F	F	F	F	F
OECD	A				
Portugal	F	F	F	F-	F
Spain	F	F	F	F	F
Sweden	A	D	F	C-	D+
Switzerland	F	F	F	C	E-
United Kingdom	B	C	F	C+	C-
United States	A	B+	B+	B+	B+

ANNEX 1: Letter to Development Assistance Committee (Dated 19 October 2006)

Dear Sir, Madam

Donor funded malaria control projects

As you may know, malaria continues to be a significant public health problem around the globe, especially in Africa. As a consequence, many donor agencies support malaria control programs, either by funding the Global Fund for AIDS, TB and Malaria or by funding bilateral malaria control programs. Africa Fighting Malaria (AFM) is a health advocacy group based in the US and South Africa. One of our activities is to monitor donor funded aid programs and assess their effectiveness at controlling malaria.

To this end we would be grateful if you could provide any information or data related specifically to donor funds for malaria control programs. We have conducted a search of both the DAC and CRS websites and although the sites are comprehensive and informative we failed to find any data specifically pertaining to malaria program funding.

If possible we would specifically like to provide answers to the following questions:

1. What are the DAC member countries budgets for malaria control programs?
2. Of those budgets, what proportion is spent on malaria treatment (and of that, how much on the new artemisinin-based combination therapies) and what proportion is spent on malaria control (and of that, how much on indoor residual spraying, and how much on insecticide treated nets)
3. How do the DAC member countries measure the effectiveness of the funds that they devote to malaria control (for instance, do the donors measure changes in morbidity and mortality as a result of their spending)?

We would be most grateful for any information and look forward to hearing from you in the near future. Should you be unable to provide this information, please could you advise us of the best person or organization to contact?

Yours faithfully
Jasson Urbach
Africa Fighting Malaria

Africa Fighting Malaria is incorporated as a 501(c)(3) organization in the United States and as a Section 22 not-for-profit company in South Africa

ANNEX 2: Individual DAC donor country letter (25 October 2006)

Dear Sir, Madam

Donor funded malaria control projects

As you may know, malaria continues to be a significant public health problem around the globe, especially in Africa. As a consequence, many donor countries support malaria control programs, either by funding large multilateral donor agencies such as the Global Fund for AIDS, TB and Malaria or through funding bilateral malaria control programs. Africa Fighting Malaria (AFM) is a health advocacy group based in the United States and South Africa. Given the ongoing burden of malaria, we are interested to know how donor agencies are responding and how they are utilising their malaria control budgets.

To this end we would be grateful if you could provide any information or data related specifically to funds destined for malaria control programs. If possible we would specifically like to provide answers to the following questions:

1. In 2006, the World Health Organisation issued new malaria treatment guidelines that call for artemisinin-based combination therapies. In addition, WHO has called for an increase in the use of Indoor Residual Spraying (IRS) as a means of controlling malaria. Could you explain how your agency is responding to these new guidelines and how they will be assisting malarial countries to implement both interventions.
2. What is your agency's budget for malaria control programs?
3. Of that budget, what proportion is spent on malaria treatment (and of that, how much on the new artemisinin-based combination therapies) and what proportion is spent on malaria control (and of that, how much on indoor residual spraying, and how much on insecticide treated nets)? What proportion of the budget is devoted to technical assistance and 'capacity-building'?
4. How does your country measure the effectiveness of the funds it devotes to malaria control (for instance, does your country measure changes in morbidity and mortality as a result of its anti-malaria spending)?

We would be most grateful for any information and look forward to hearing from you in the near future. Should you be unable to provide this information, please could you advise us of the best person or organization to contact?

Yours faithfully
Jasson Urbach
Africa Fighting Malaria

Africa Fighting Malaria is incorporated as a 501(c)(3) organization in the United States and as a Section 22 not-for-profit company in South Africa

ANNEX 3: Responses, in chronological order, to the letters sent via e-mail to the various DAC donor agencies.

USAID

Africa Fighting Malaria has been in contact with some of USAID's program staff in Washington DC and elsewhere and the President's Malaria Initiative (PMI) for several months prior to and during the compilation of this report. In researching the PMI and updating our information on the agency's work, we were provided with the information requested in the correspondence above timeously and in great detail. This is reflected in our report, Moving Mountains, The Evolution of USAID's Malaria Control Program. (available from <http://www.fightingmalaria.org/research.aspx?id=14>) and in other forthcoming publications.

New Zealand Aid (30 October 2006)

[New Zealand Aid] has provided around NZ\$ 3.5 million for GFATM since May 2003. Two community based health programmes in Indonesia (totalling around \$2.5 million) include malaria reduction in their project objectives and a project in Bougainville aimed at controlling leprosy, TB and malaria has received NZ\$267,047 (with total expected expenditure of \$655,000). Programme funding for the Public Health Programme of the Secretariat of the Pacific Community and for a sector wide health programme in Papua New Guinea also includes malaria control but expenditure specifically on this is not able to be extracted. NZAID's geographical focus is the Pacific. There is only a small programme in Africa. Priorities for this are basic education and HIV/AIDS prevention/response.

Sweden (13 November 2006)

Sweden is funding the Global Fund this year with 600 MSEK. Bilaterally we do not have any specific malaria programmes to my knowledge (apart from research programmes). The bilateral support is handled by the embassies so I do not have the full overview. Mostly we have sector programme support and then malaria support would be part of that.

European Commission (01 December 2006)

Response to question 1: Malaria treatment strategies in countries are decisions that must be taken by each country after careful weighing of potential impact, the investments needed, their resources and capacities and the comparison with other alternatives. The EC continues to provide assistance through the Global Fund to Fight AIDS, Tuberculosis and Malaria, country programs and research projects to support implementation of these strategies. In recent years, the EC has increased its development investment in confronting the three diseases by four-fold, reaching an annual average of €259 million in 2003-2006. This includes €475.5 million channelled through the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2001-2006, which has allocated 31% of its resources to malaria programmes based on demands by countries, and support to innovative initiatives to increase the coverage of essential malaria interventions, under the budget

line on poverty related diseases. In addition to the development assistance, the EC has been supporting research related to the three diseases under the 6th Framework Programme on Research and Technological Development. There was a 4-fold increase in funds from the 5th to the 6th Framework Programme, reaching more than €400 million annually targeting the three diseases in 2002-2006. The assistance towards communicable diseases in the financial perspective 2007 - 2013 is still being negotiated with the European Parliament.

Response to question 2: See above

Response to question 3: Given that we pursue a comprehensive approach towards the three diseases and we more and more operate through the Global Fund and country budget support, we are not able to provide this data.

Response to question 4: Effectiveness of our assistance is measured with respect to the MDG indicators.

United Kingdom (08 December 2006)

The UK looks to the World Health Organisation as the lead technical agency in health to help developing countries decide on the most appropriate strategies to control malaria and build capacity for procurement and distribution. The European Union, together with the United States and 149 other countries has signed the global Stockholm Convention on Persistent Organic Pollutants (POP). This agreement permits the use of DDT for disease control according to World Health Organisation (WHO) recommendations and guidelines. In this respect the European Commission (EC) recognises the right of all nations to set their own priorities for malaria control, including the use of DDT for indoor residual spraying as part of national malaria control strategies.

UK support to malaria control is provided through global partnerships, multilateral agencies, bilateral country programmes and research and development. Most of these channels support both treatment of malaria and reduction of incidence including through more widespread use of insecticide treated mosquito nets (ITNs). Increasingly DFID funds the broader health sector plans of developing country governments through sector wide programming and poverty reduction budget. Such sector programmes will build capacity in health services to diagnose and treat all major causes of illness. It is therefore difficult to attribute accurately all DFID's expenditure on malaria control projects.

The UK is a key donor to the Global Fund to fight AIDS, TB and Malaria (GFATM), and has pledged £359 million to the fund through to 2008, subject to performance. The UK also supports Roll Back Malaria (RBM) and UNITAID, the recently launched international drug purchase facility, and WHO. DFID has pledged £10 million over five years (2005-2010) to Medicines for Malaria Venture (MMV), which aims to discover, develop and deliver new affordable anti-malarial drugs. This is a joint commitment with the Wellcome Trust, who will match DFID's support. DFID will also give £6.5 million (2006-2009) to the Drugs for Neglected Diseases Initiative (DNDi), which includes funding for work on developing a more effective artemisinin combination drug for treatment for malaria.

Australia (09 February 2007)

Australia takes the fight against communicable diseases such as malaria very seriously. The Australian aid program continues to support the Global Fund to Fight AIDS, Tuberculosis and Malaria and has pledged \$75 million from 2004-2007. To date, the Global Fund has allocated approximately \$6.6 billion to combating malaria, HIV/AIDS and tuberculosis. Of which, 56 per cent of grants allocated to HIV/AIDS, 26 per cent to malaria and 14 per cent to tuberculosis.

Australia also contributes funding to the World Health Organization including the Roll Back Malaria program. Total funding for the health sector in 2005-06 is estimated to be \$280 million and the Australian Government will double this level of support by 2010.

Australia's aid is focused on the Asia-Pacific region, home to two-thirds of the world's poor and where Australia has a leading role and special responsibilities recognised by the international community. Australia's overall aid program to Africa in 2006-07 is estimated at over A\$82 million, an increase of \$5million from 2005-06.

Through the \$53 million Australian Partnerships with African Communities (APAC) program from 2004 to 2009 the Australian government funds Australian NGOs to work with partners in recipient countries to conduct community-based projects, addressing malaria, HIV/AIDS, food security and water and sanitation. Countries of focus include Kenya, Malawi, Mozambique, South Africa, Uganda and Zambia.

Australian NGOs receive funding, for programs in African countries, including malaria control, through the AusAID NGO Cooperation Program (ANCP).

Finland (14 February 2007)

As a member state we are aware of the new malaria guidelines of WHO and hope that they can be implemented effectively, particularly in countries disproportionately affected by malaria. For Finland, our support to malaria activities will increasingly happen through budget support and health sector support programmes to partner countries.

We do not have a specific malaria control budget line. Some of our interventions in the last year have, however, been allocated to malaria control activities. In Kenya our support to a malaria control programme implemented by Merlin organisation, is coming to an end this year. Last year some €400 000 was disbursed through the programme. Support for malaria control activities is also channelled through the Global Fund (€3 mill in 2006 & €2,5 mill in 2007). In addition our voluntary contribution to WHO will be un-earmarked, in support of MDG objectives, which do include malaria.

We do not have specific measurements of malaria morbidity and mortality in relation to our spending (with the exception of the Kenya programme), but do follow these indicators country-wise as relevant i.e. as part of MDG-follow up and as important information about health sector challenges and achievements in countries concerned.

Austria (07 March 2007)

In response to your questions I want to inform you that currently the Austrian Development Agency as a young organisation (founded in 2004) has no health program and is supporting only in a few cases health initiatives. Thus,

question 1): not applicable

question 2): nil

question 3): n.a.

question 4): n.a.

ANNEX 4 AID AGENCY WEBSITE SURVEY

This survey is being completed to get a general sense of what these agencies are doing in terms of malaria work and how much useful information is available via their website. The grades are based on the accessibility and quality of the information that the agency websites provide regarding malaria program activities, budgets and impacts.

AUSTRALIA

The Australian Agency for International Development (AusAID) manages the Australian government's federally funded overseas aid program. The agency's website (<http://www.ausaid.gov.au/default.cfm>) provides only very general information on the organization's work. Budget information is almost nonexistent and the little information that is provided is not at all detailed. AusAID indicates that it competitively contracts aid work (to Australian and international companies) and funds NGOs to deliver aid programs at the local level but further information on these contracts and funds is not provided on the website. It seems that no annual reports or budgets are published. AusAID's malaria work is summarized in one paragraph in the entire website, no further detail is provided. Regarding impacts, the website cites improvements in global indicators as signs of AusAID's success. The Australian Government established the Office of Development Effectiveness (ODE) in 2006 to monitor the quality and evaluate the impact of the Australian aid program and not many tangible results have come of it yet. While a framework for evaluations does exist, not many are available through the website.

WEBSITE GRADE	EXPLANATION
D	Some information is available but this is highly unsystematic and not very informative.

AUSTRIA

In response to the questions posed, the Austrian Development Agency (ADA) stated that it has no health program and is supporting only in a few cases health initiatives. The website (http://www.ada.gv.at/view.php3?r_id=3042&LNG=en&version=) indicates that in the frame of bilateral projects and programs in developing countries, the Austrian Development Cooperation also provides funding for developmental projects of Austrian NGOs, initiatives as well as private enterprises. Evaluation comes under the joint responsibility of ADA's Evaluation Unit and the department of the Austrian Development Cooperation in the Federal Ministry for European and International Affairs. ADA has a strategy of concentrating on a limited number of countries and areas. The website does confirm that health is not a priority sector at the moment. However, a list of the distribution of bilateral ADC funds (for ODA) by sector does list health for 5.3 million Euros in 2005. Documents related to ADA activities in Ethiopia also clearly show that ADA is and will be doing health (including malaria-related) work there. Overall, the website does provide some detail regarding activities and budget but concrete evaluations and reports are not readily available.

WEBSITE GRADE	EXPLANATION
N/A	The agency is relatively new (2004) so while <i>some</i> valuable information on activities and budgets is provided, it is not relevant to health at this time.

BELGIUM

Belgian Development Cooperation is the country's lead donor agency and their website (<http://www.dgdc.be>) is available in French, Dutch and English. Information is provided on their broad projects and some reports on their activities are available and can be easily found and downloaded. Much of their activities seem to centre on the Millennium Development Goals and malaria features as one of the MDGs. Aside from that however, there is scant information on what the agency is doing to support malaria control activities outside of providing funds to the Global Fund for AIDS, TB and Malaria. While the agency does conduct HIV/AIDS programs, it does not appear to have any specific malaria control activity and therefore AFM is unable to give the agency a score in this regard. AFM should note however that while the agency provides some broad data on the financial resources devoted to development aid, there does not appear to be any detail on the outcomes achieved with taxpayer's money.

WEBSITE GRADE	EXPLANATION
N/A	The agency does not appear to have support any specific activities related to malaria and therefore AFM is unable to grade its website in this regard.

CANADA

The Canadian International Development Agency (CIDA) is Canada's lead agency for development assistance (<http://www.acdi-cida.gc.ca/cidaweb/acdicida.nsf/En/Home>). CIDA's website provides a lot of information on the agency's activities and presents it in a very accessible manner (well classified and organized). A page is dedicated to each country to showcase CIDA's work there and provide links to further details. CIDA has a policy of proactive disclosure which entails the mandatory publication of contracts over \$10,000, grants and contribution awards by CIDA over \$25,000, travel and hospitality expenses for selected government officials and the disclosure of position reclassifications within the agency. The website provides all of this information. CIDA's Evaluation Division undertakes evaluations on behalf of the Agency, either as part of its annual Internal Audit and Evaluation Plan or on special request. These evaluations and internal audits are available on the website as well as results fact sheets. Annual reports and a bank of active and upcoming projects are also available. CIDA does seem to commit the common error of linking net distribution to net use and therefore 'estimating' the amount of lives saved. Still, it does at least provide numbers on its activities and results even if the level of detail is inadequate. CIDA contributes to the Canadian Red Cross and UNICEF to distribute free bed nets in Africa. CIDA also supports the Global Fund (recently increased commitment). CIDA has also contributed to the WHO to support

selected countries in their efforts to increase collaboration between traditional and modern medicine in national health systems. CIDA has also supported efforts to make home-grown antimalarial treatments that can be produced by the rural poor by contributing more than \$3.9 million to the World Agroforestry Centre.

WEBSITE GRADE	EXPLANATION
B-	A lot of useful and current information on activities, budgets and results is provided available and the proper mechanisms are in place for transparent results-based management. However, the data provided are not as informative as it should be and therefore only allows for a limited analysis of CIDA's work.

DENMARK

The administration of Danish development assistance is done through the Ministry of Foreign Affairs (<http://www.um.dk/en/>). This aid was decentralized in 2003 and capacity has been transferred from Copenhagen to the missions in program countries. Denmark's development assistance is focused on a selected number of developing countries that work with long-term national strategies for poverty reduction. The Evaluation Department is an independent, specialized department with sole responsibility for programming, designing and over-seeing evaluations of activities financed by Danida. All evaluations reports issued since 1995 and publicized on the website. Danida's latest annual report (2005) is supposed to also be provided but it is not accessible via the website. Furthermore, while informative and detailed information is provided regarding Denmark's contributions and distribution of funds by sector, it is very outdated (2001-2002). The website Danida DevForum (<http://www.danidadevforum.um.dk/en>) is supposed to provide more detail but many parts of the website don't function or are completely blank (like health program pages).

WEBSITE GRADE	EXPLANATION
D	Evaluations are provided on a systematic basis but for the most part the website does not seem to be maintained or updated frequently. Some detailed and informative information is provided but many sections are very outdated or even completely blank.

EUROPEAN COMMISSION

The joint development cooperation of the European Union is looked after by the European Community (EC) and its executive organ, the European Commission (http://ec.europa.eu/development/body/theme/index_en.htm). In April 2005 the European Commission adopted a European Program for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action. This document provides a Program for EU actions, both at country and global level. At country level, emphasis is put on capacity building. At global level, the EC will focus on affordable pharmaceutical products, strengthening regulatory capacity in developing countries and developing new tools and

interventions (such as vaccines and microbicides). The Commission is also one of the main donors to the Global Fund with an overall contribution of €22 million over the period 2002-2006. The European Commission measures progress on five key health indicators drawn from the Millennium Development Goals. This progress is monitored during the annual review of EC co-operation with all ACP countries but these are not very detailed. Overall, the website is very difficult to navigate and does not seem to target a member of the general public who is seeking more details on EC activities.

WEBSITE GRADE	EXPLANATION
F	This website is very hard to navigate and provides almost no useful information. This may be because of the nature of the organization itself. The website however does not seem to be made for public access at all.

FINLAND

Finland concentrates its development cooperation on fewer countries and sectors as well as larger cooperation entities in order to improve the effectiveness of cooperation (<http://formin.finland.fi/public/default.aspx?nodeid=15316&contentlan=2&culture=en-US>). In health, Finland directs the majority of appropriations to bilateral development cooperation work and is working to raise the share of countries that are Finland's long-term cooperation partners. Finland provides budget support (direct, non-earmarked support to the budget of the recipient country) in an effort to increase effectiveness. Finland's website has pages dedicated to countries with which it works to showcase what is being done there. Some useful information on current projects and budgets is available but detailed information is not provided. Finland seems to focus most of its health work on HIV/AIDS and there is not much information on malaria work at all. The website does provide some brief evaluations and reports as well as information on procurement policies and the contracts themselves. Overall though, it seems that impact is not consistently measured or reported on. The annual report does not provide very informative data either.

WEBSITE GRADE	EXPLANATION
D	Information is provided on Finland's development approaches, policies, activities and budgets but is quite superficial for the most part. The information provided on the site is not results-based at all.

FRANCE

The French Ministry of Foreign Affairs hosts the Directorate general for international co-operation and development (DGCID) website (<http://www.diplomatie.gouv.fr/en/>). The DGCID draws up French development policy and programs. The department of strategy, planning and evaluation prepares the major directions and ensures that the means are appropriately used and a co-ordination service draws up programs by country and by region. While the French language version seems to provide more detail, the English version has no reports, evaluations or informative data. While AFM naturally does not begrudge the publication of reports in French, more detail in English versions would assist the global public health community. Instead, there are some 'highlights' which

showcase some initiatives and numbers but none of this is informative or consistent. The French Development Agency (AFD) is the financial institution at the heart of France's development assistance policy (<http://www.afd.fr/jahia/Jahia/home/QuiSommesNous/lang/en>).

In 2004 the Inter-Ministerial Committee for International Cooperation and Development (ICICD) increased the responsibilities entrusted to AFD, which was mandated to finance all bilateral French programs in the area of health. In this area, many projects managed by the Ministry of Foreign Affairs, were transferred to the Agency in 2005. AFD's mission is to finance development and its website is much more useful. It includes annual reports and project databases with informative data. Project evaluations are carried out using a methodology in line with the recommendations of the OECD's Development Aid Committee (DAC) but these don't seem to be available on the website. Still, there is a lot of valuable information throughout the site on current activities. The problem is that this agency does not represent all French development work. While the French version of the DGCID website seems to be more informative, neither versions are well structured and therefore do not allow the user to find valuable information.

WEBSITE GRADE	EXPLANATION
F	Almost no useful information is easily accessible and there seems to be no centralized body which provides the public with details on France's aid. The websites do not seem to be made for the public at all.

GERMANY

The development policy of the Federal Republic of Germany is an independent area of German foreign policy. It is formulated by the Federal Ministry for Economic Cooperation and Development (BMZ <http://www.bmz.de/en/index.html>) and carried out by several implementing organizations like KfW development bank, DEG, GTZ, DED and InWent. The BMZ website is user-friendly and provides useful information on policies, priorities and activities. However, this information is not as detailed as it should be. The BMZ website also provides the summaries of evaluations (by an independent evaluation team) in English (full reports in German are available upon request). The BMZ seems to have a decentralized contracting structure (much like DFID). The BMZ commissions implementing organizations to execute projects. Their responsibilities include implementing financial cooperation and technical cooperation projects, preparing German experts and volunteers, providing occupational training and upgrading for specialists and executives from partner countries. This structure makes it difficult to track German aid's progress and results. According to the website, the division of roles between the evaluating units of the BMZ and the implementing organizations means that the BMZ's focus is on evaluating cross-cutting issues (topics, sectors, instruments). Project evaluations however are generally carried out by the implementing organizations "under their own responsibility". This structure dilutes transparency and accountability and makes it difficult to evaluate results. There is no detailed information on malaria initiatives on the BMZ website.

WEBSITE GRADE	EXPLANATION
D	The website is very accessible but the level of detail does not give the user much useful information. It seems that the responsibility of monitoring and evaluating is diluted among many organizations thus making results-based aid a challenge. No specific information on malaria-related work is provided.

GREECE

HELLENIC AID (YDAS), Greek's International Development Cooperation Department, is responsible for development programs, humanitarian aid, support of existing and newly founded NGOs, and educational and information activities promoting voluntary service (<http://www.mfa.gr/www.mfa.gr/en-US/>). It is an independent section of the Ministry of Foreign Affairs and does not have its own website. Once a year, YDAS invites expressions of interest from ministries, legal entities, NGOs, universities, etc., who wish to submit proposals for projects for consideration. Program implementation agencies are Ministries and NGOs. Ministries have the right to implement programs directly or through Public Sector Legal Entities which they control. Hellenic AID's website has absolutely no relevant or useful information. The sparse information that is provided is just about general policies and practices. This website is clearly not catered to a public looking for information on Greece's development work and it does not seem possible to get such information anywhere.

WEBSITE GRADE	EXPLANATION
F	This website is structured like a general brochure and makes no pretense of any level of transparency, monitoring or evaluation. There seems to be no way for the public to be informed regarding this organization's work.

IRELAND

Irish Aid is the Government of Ireland's program of assistance to developing countries (<http://www.irishaid.gov.ie/index.asp>). The Development Cooperation Directorate, a Division of the Department of Foreign Affairs, is responsible for administering the Irish Aid program. The website is very user-friendly and provides information on Irish Aid's work in different priority areas. However, the level of detail is not very informative. Approximately 20% of country program expenditure is directed to the health sector. The principal instrument used by Ireland to support health sector development at country level is the sector wide approach. The Annual Report is provided and gives some useful information on activities and budgets but is not detailed enough. The maintenance of an independent Evaluation and Audit function within Irish Aid is the responsibility of the Evaluation and Audit Unit (E&A Unit). Through the website the public has access to some evaluations and case studies but overall there is limited information on results and impact. There is no specific information on malaria.

WEBSITE GRADE	EXPLANATION
D	The website is very accessible but the level of detail does not give the user much useful information. No specific information on malaria-related work is provided. The information provided does not reflect enough of a results-based approach.

ITALY

The Italian Ministry of Foreign Affairs website (<http://www.esteri.it/eng/index.asp?>) does not have detailed information on specific malaria programs, as it only mentions that it donates to the GFATM. Italy donated \$200 million in 2001, \$100 million in 2002, \$100 million in 2003, and €180 million over 2004-2005 and €130 million over 2006-2007 to the Fund. It is the second-largest donor to GFATM, after the US and it is one of the seven donor countries to sit on the GFATM Board of Directors. The Assembly of Italian NGOs plays an important role in the Global Fund, as “One of its representatives is included in the government delegation at Board meetings, and in the run-up to each board meeting the DG for Development Cooperation organizes a meeting with the NGOs working in this sector and with all the bodies which have an interest in the Fund’s activities (the National Institute of Health, universities, etc.).” There is no breakdown of budget into ACT and ITN purchase, only a donation to the Global Fund. Italy does not procure resources; it gives money to procurement third-party organizations.

As far as all African initiatives go, the Directorate General for the Countries of Sub-Saharan Africa runs all aspects of Italian involvement and assistance in the region, and has five departments: West Africa, East Africa, Central Africa and the Great Lakes, Southern Africa and Regional Cooperation. Italy also supports the Doha Development Trust and the Integrated Framework for Least Developed Countries (in technical assistance). This information was updated on the website in 2004.

WEBSITE GRADE	EXPLANATION
D	Website lacks information on the impact of its funding. It does not procure resources, as it only provides a breakdown of contributions to the GFATM. No international development assistance budgetary information is found beyond GFATM contributions.

JAPAN

MOFA (http://www.mofa.go.jp/region/africa/ticad2/list98/health/1_2_60.html) outlines WHO’s 1999 Project for Malaria Control in Africa program for malaria assistance, citing \$18 million contribution to the effort by OTHER COUNTRIES (such as USAID), even though the Japanese MOFA did not contribute to this effort.⁴⁵ On December 16, 2003, MOFA donated \$50.3 million to GFATM, totalling \$85 million in Japanese aid to the Fund in 2003. Since 2002, Japan has pledged \$265 million to the GFATM.⁴⁶ The Global Fund is the main channel for the Japanese government’s malaria funding. However, it

⁴⁵ http://www.mofa.go.jp/region/africa/ticad2/list98/health/1_2_60.html

⁴⁶ http://www.mofa.go.jp/policy/health_c/aid0312.html

also invested in the Trust Fund for Human Security program. On January 27, 2003 The Japanese Government partnered with the UN to contribute \$997,052.15 towards the Trust Fund for Human Security program “Malaria Control with an Emphasis on Insecticide Treated Bed nets and Household Management of Malaria by Mothers” in Nigeria. The program will be implemented by UNICEF, hopefully reaching 625,000 individuals for ITN usage in the target Nigerian populations of Enugu, Ogun, Bauchi and the Federal Capital Territory Abuja. Beyond ITN procurement, UNICEF’s program will increase awareness of ITN use through the education of home management of malaria activities, increase the demand for ITN use and decrease mortality.⁴⁷ In an address by the Japanese Prime Minister Junichiro Koizumi announced two days ago that we would provide comprehensive assistance amounting to US \$5 billion over the next five years starting from this year.”⁴⁸ There was no breakdown of this funding available on the website.

JICA builds in-country capacity programs for handling disease control through training the local population and health sector, and malaria is listed as a target disease. It is implementing its own initiatives, including the West African Center for International Parasite Control from January 2004-2008.⁴⁹ This is a joint initiative between the governments of Ghana and Japan. The goal of the Center includes the implementation of human capacity in parasitic diseases by providing trainings, project support and information on disease control to member countries: Benin, Burkina Faso, Cameroon, Cote d’Ivoire, Ghana, Mali, Niger, Nigeria, Senegal, and Togo. The Japanese strategy for the WACIPC implementation of disease control emphasizes global partnership and community based initiatives.⁵⁰

When AFM searched for “malaria” a couple project evaluations came up. However, there is no central location for malaria initiatives, as the projects are scattered all over the website. When AFM searched for ITN, nothing came up. One example of these evaluations is the “Third Country Training Program on Communicable Disease Control,” a Japanese and Thai effort to train health personnel from other South East Asian countries. The course on malaria had 48 participants. According to the evaluation, the courses were very effective and the knowledge applied.⁵¹ JICA provides a list of projects undertaken from 1991-2001.⁵² The ODA by country⁵³ breaks down spending into technical and equipment spending, but not by sector (health, education, etc). The 2006 Fiscal Budget for JICA does not include a breakdown of sector programs or procurements.⁵⁴

WEBSITE	EXPLANATION
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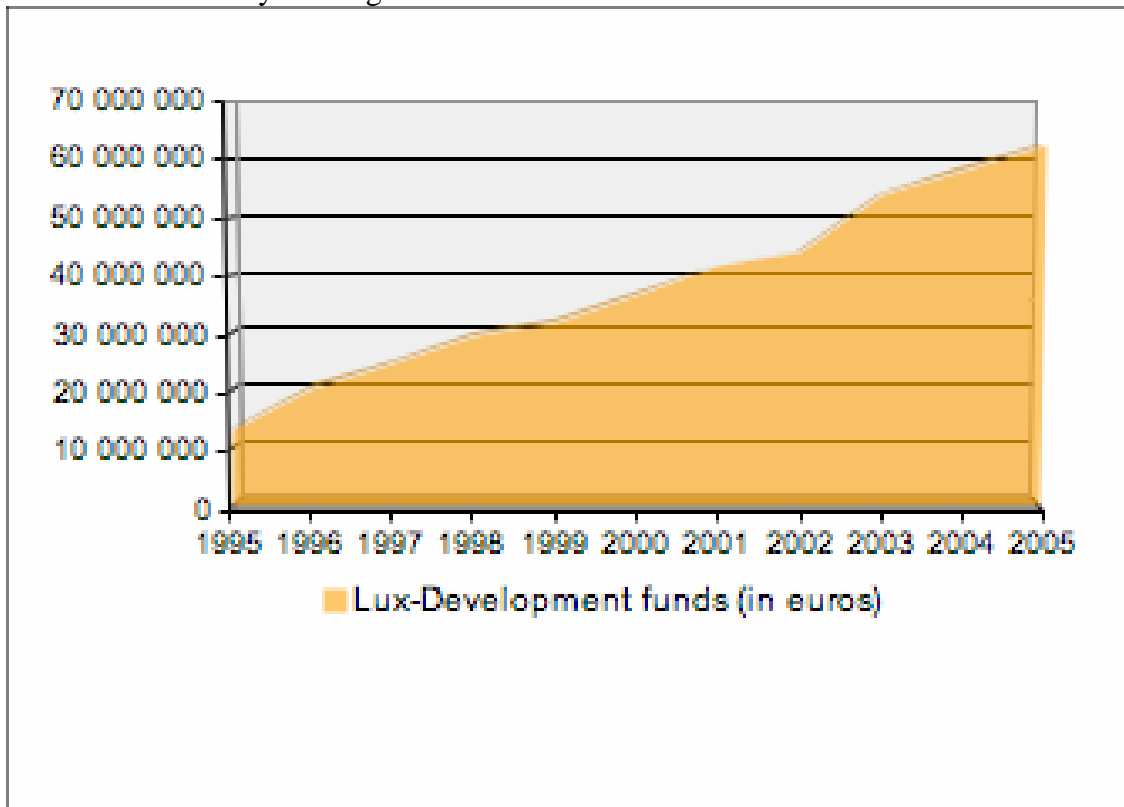
- ⁴⁷ <http://www.mofa.go.jp/announce/announce/2003/1/0127.html>
- ⁴⁸ http://www.mofa.go.jp/policy/health_c/gfatm/address0506.html
- ⁴⁹ <http://wacipac.org/index.htm>.
- ⁵⁰ <http://wacipac.org/JICA-Ohta.pdf>
- ⁵¹ http://www.jica.go.jp/english/evaluation/project/term/as/2003/tha_05.html
- ⁵² <http://www.jica.go.jp/english/resources/publications/annual/2001/main.html>.
- ⁵³ <http://www.jica.go.jp/english/resources/publications/annual/2006/pdf/124-133.pdf>
- ⁵⁴ <http://www.jica.go.jp/english/resources/publications/annual/2006/pdf/142.pdf>

GRADE	
C-	There was an abundance of information, hence the long paragraphs, but not necessarily the information AFM was looking for. GFATM funding by year was provided, as well as funding information of bilateral partnerships with the government of Ghana and the UN

LUXEMBOURG

The Luxembourg development agency, Lux-Development S.A. is actually a private company with shareholders including the Luxembourg government (99%) and Société Nationale des Crédits à l'Investissement (1%). According to the website the classification of the agency as a private entity gives it flexibility to deliver effective aid.⁵⁵ Lux-Development takes care of 90% of the bilateral aid contributed by the Luxembourg government and targets 10 countries identified by the Ministry of Foreign Affairs, Division of Cooperation and Humanitarian Affairs. Its aid has increased substantially due to the rising GNI of the country. Lux-Development is decentralized and employs 100 field officers that are currently working on about 120 projects. Although the contact information for the country programs is provided for each country, the website provides no information on individual projects, including malaria. The website employs rhetoric and broad goals, without any substantial information to back its claims.

This table is the only funding information available:⁵⁶



⁵⁵ <http://www.lux-development.lu/agence.lasso?lang=uk>

⁵⁶ <http://www.lux-development.lu/agence.lasso?lang=uk>

WEBSITE GRADE	EXPLANATION
F	Hardly any information available about anything; little or no spending information. No malaria information.

NETHERLANDS

The Dutch Ministry of Foreign Affairs website (<http://www.mfa.nl/en>) is not very comprehensive and outlines its focuses on poverty reduction, humanitarian aid, human and social development and human rights and more specifically, focuses on improvements in HIV/AIDS research, reproductive health, education and water purification, yet fails to provide examples of its projects. The budget for these efforts is outlined here, in hardly any detail and no breakdown:

Homogeneous Budget for International Cooperation 2005-2010 (x million euros)

	2005	2006	2007	2008	2009	2010
Expenditure	5,643.5	5,771.3	5,908.6	6,029.1	6,228.0	6,464.2
Revenue	109.2	96.6	97.0	101.3	101.3	101.3
Balance	5,534.3	5,674.6	5,811.6	5,927.9	6,126.7	6,362.9

The Dutch website (<http://www.minbuza.nl/en/developmentcooperation/Themes>) provides Public-Private Partnerships for research into and the development of medicines, vaccines and diagnostic aids in the domain of AIDS, tuberculosis and malaria', grant period 2006-2009.⁵⁷ The PDF that outlines the policy for awarding PPPs listed no current projects.⁵⁸ The majority of African disease funding from the Dutch government goes to HIV/AIDS before malaria efforts⁵⁹

The most comprehensive health information regarding bilateral assistance on the Dutch MFA is found here, outlining the Health Sector Development Program, updated January 31, 2007.⁶⁰ It does not provide numbers, lists small projects funded by in-country embassies, stating the following about malaria efforts: "In the past the Embassy has

⁵⁷ http://www.minbuza.nl/en/developmentcooperation/Grant_Programmes,Aids--TB-and-malaria-grant-scheme.html

⁵⁸ http://www.minbuza.nl/binaries/minbuza_development_cooperation/pdf/grant-scheme-product-development.pdf.

⁵⁹ http://www.minbuza.nl/en/developmentcooperation/Themes/HumanitarianAid.focus_on_africa.

⁶⁰ <http://www.mfa.nl/add/bilateral/health>.

contributed to many emergency situations in the health sector, such as for outbreaks of meningitis and malaria. In 2005 and 2006, the Embassy has again responded favourably to a consolidated emergency appeal for malaria outbreaks in several regions of the country. With this support UNICEF has procured an important amount of the drug Co-Artem for the MOH.”⁶¹ There is no budget breakdown available on the website regarding money spent on ACT or ITN coverage.

WEBSITE GRADE	EXPLANATION
F	Lack of budget breakdown into diseases by sector, public-private partnership funding information and monitoring information.

NEW ZEALAND

NZAID (<http://www.nzaid.govt.nz/what-we-do/health.html>) works through bilateral country-to-country support and donates to NGOs from New Zealand and in-country NGO programs. Its total budget is \$315 million. Multilateral aid organizations receive 20% or \$63 million of this budget. The largest recipients of NZAID funding are the World Bank (\$10 million annually) and ADB (\$12 million annually). NZAID also contributes to GFATM, ICRC, International Planned Parenthood Foundation (IPPF), UNAIDS, Save the Children NZ, UNICEF and UNFPA, and its website states that “spending is targeted at the public health priorities of immunization, malaria prevention, safe motherhood/family planning and HIV/AIDS.”⁶² NZAID just donated \$10.2 million through 2011 to Save the Children NZ and a \$2 million annual donation to Papua New Guinea’s National Department of Health, allocated by the Department for self-prioritized health concerns. Services provide include: “malaria prevention, the treatment of common illnesses and improved access to sexual and reproductive health services for women, including assistance during pregnancy, birth and the post-natal period.”⁶³ NZAID breaks down its aid given to recipient countries, but not by program (no malaria budget found).⁶⁴

WEBSITE GRADE	EXPLANATION
D-	Limited information available regarding malaria programs, but no information found regarding procurement, effectiveness of projects or follow-up with country programs and lack of budget breakdown into health sector within recipient countries.

⁶¹ <http://www.mfa.nl/add/bilateral/health>

⁶² <http://www.nzaid.govt.nz/what-we-do/health.html>

⁶³ *Ibid.*

⁶⁴ <http://www.nzaid.govt.nz/about/allocations.html>

NORWAY

The Norwegian Ministry of Foreign Affairs (<http://www.regjeringen.no/en/ministries/ud.html?id=833>) donates NOK 1.3 billion to GFATM. Norway is committed to TB and HIV/AIDS programs, but does not list malaria as a serious commitment.⁶⁵ Norway supports the Advanced Market Commitment, a vaccine-procurement organization for developing countries. It has pledged a NOK 350 million multi-year commitment. In 2007, Norway donated NOK 140 million through the raising of levies on air travel.⁶⁶ The press release regarding this donation pledged progress reports on the funding.⁶⁷ Norway also states it has made contributions to the World Bank and regional development banks, but fails to mention how much and to which sectors of the regional development banks it supports.⁶⁸

NORAD⁶⁹ is run by the MFA, and specializes in development assistance. In the Health sector, HIV/AIDS takes precedence over all other diseases and receives the majority of funding. When AFM searched for “malaria” on this website, all search results were in Norwegian. There was a press release regarding the Global Fund but it did not include any currency amounts. There was no information on malaria that AFM could find, which does not make sense because Norway is committed to the MDGs.

WEBSITE GRADE	EXPLANATION
F	No breakdown of which vaccines it has supported for procurement or allocation by disease, lack of clarification of World Bank donations.

ORGANISATION FOR ECONOMIC COOPERATION & DEVELOPMENT:

The OECD provides country program evaluations, health statistical data and research (such as the OECD Health Data 2006 database: <http://www.oecd.org/dataoecd/42/57/36945724.pdf>), and manages a budget fit to run the organization. Will not be scored due to incompatibility with country agencies, as it does not carry out separate OECD-specific malaria programs in non-member countries, rather it evaluates the activities of member-states.

PORTUGAL

This entire website is in Portuguese (<http://www.min-nestrangeiros.pt/mne/>). There is no option for translation available on the website, only through Google. However, the IPAD website (<http://www.ipad.mne.gov.pt/>) has a list of all of its funding programs in Africa

⁶⁵ <http://www.regjeringen.no/en/ministries/ud/About-the-Ministry/Minister-of-International-Development-Er/Speeches-and-articles/2007/The-Challenge-of-HIV-and-TB-co-infection.html?id=456341>

⁶⁶ <http://www.regjeringen.no/en/ministries/ud/Press-Contacts/News/2007/Norwegian-Government-to-provide-NOK-350-.html?id=450229>

⁶⁷ <http://www.innovativefinance-oslo.no/>

⁶⁸ <http://www.regjeringen.no/en/ministries/ud/Selected-topics/Development-cooperation/The-World-Bank-and-the-regional-development-banks.html?id=446986>

⁶⁹ http://www.norad.no/default.asp?V_ITEM_ID=1139&V_LANG_ID=0

(Angola, Cabo Verde, Guinea Bissau, Mozambique, Morocco and Sudan) including amount spent and sector. IPAD supports the UN World Food Program, WHO, UNICEF and the Portuguese organization ONGD OIKOS. None of these programs were malaria related. Its budget information was all in Portuguese as well, but there was an English document available that included all recipient aid organizations and NGOs.⁷⁰

WEBSITE GRADE	EXPLANATION
F	Lack of translation option, lack of malaria information

SPAIN

AECI (<http://www.aeci.es/>) has 36 technical cooperation offices, 12 cultural centers and 3 development centers situated in countries with agency programs. The priority areas are established in the Director’s Plan 2005-2008 document: The entire website is in Spanish and there is no option to translate it through the website itself, only through Google. On the International Cooperation link, there are six options. Most of these options list projects undertaken by multilateral aid organizations, such as WHO and UNDP. It is possible to search in the humanitarian action section by geographic zone and date. Some of the links do not work in the International Cooperation section. There is no “search” option to scan the site for malaria initiatives, and the only health initiatives AFM could find included infant mortality and HIV/AIDS information.

The 2006-2008 Executive Summary of the Plan of Action for Sub-Saharan Africa, or just “Plan Africa,” outlines eleven target countries: Mali, Equatorial Guinea, South Africa, Namibia, Angola, Mozambique, Nigeria, Mauritania, Senegal, Ethiopia, and Kenya. In this document, there is no plan of action in the health sector. It emphasizes African security, border control, economy and diplomatic relations.

WEBSITE GRADE	EXPLANATION
F	Lack of translation option; lack of health sector information; lack of spending information.

SWEDEN

Sida (http://www.sida.se/sida/jsp/sida.jsp?d=121&language=en_US) allocates 60% (SEK 14 billion in 2005) of Sweden's total contribution to international development cooperation (SEK 22.4 billion). Sida draws up cooperation strategies, which incorporates Swedish policy with country interests. The website claims that Sida’s development funding is overlooked by one agency that monitors and evaluates activities, but it does not specify what agency does this or the specific techniques it monitors and evaluates.⁷¹ Sida only procures goods to a “very limited extent” but procures consultancy services for

⁷⁰ http://www.ipad.mne.gov.pt/images/stories/APD/org_internacionais_2005.pdf

⁷¹ http://www.sida.se/?d=109&a=1845&language=en_US

follow-up, evaluation and internal development procedures on a regular basis, which is regulated by the LOU Swedish procurement act.⁷²

On March 12, 2007, Sida gave MSF's Kenya: Intervention Strategy for Malaria program SEK 2,000,000 for insecticide spraying, ITN distribution, training on diagnostics and treatment, and pre-positioning of malaria kits.⁷³ "Sweden has committed 600 million SEK for the period 2002-2004. 60% of the approved funds are to be used for HIV/AIDS interventions, 23% for Malaria and 17% for TB. 60% of the funds are designated for [Africa](#), 20% for [Asia](#) and 20% for [Latin America](#) and Eastern Europe. However, only USD 245 of the available funds has been disbursed so far."⁷⁴ In January 2007, Sida approved a SEK 437,000 commitment to International Aid Services Sweden to provide bednets, water purification tools/mechanisms and blankets to Kenya for its malaria and cholera epidemics.⁷⁵ Sida also pledged SEK 100 million to the DR Congo Humanitarian Action Plan to help eliminate the prevalence of preventable diseases and provide potable water to the region.⁷⁶ This article does not give a breakdown into what the HAP will actually be doing in the region or what steps the HAP will be taking. The breakdown of the Health sector into sub-sectors is as follows: Health Systems Development (176 MSEK), Health Services including Sexual and Reproductive Health and HIV/AIDS 657 MSEK, Public Health (44 MSEK), General within Health Care (364 MSEK).⁷⁷

WEBSITE GRADE	EXPLANATION
C-	Provided funding information, broken down by country and sector (only disease broken down further is HIV/AIDS) and fact sheets for each country "strategy" and country profiles. Website has "What does Sida do in ___?" pages for each sector and country program. Sida has limited information on specifics of tracking funding (such as prevalence of disease/number of Nets bought).

SWITZERLAND

The Swiss Agency for Development and Cooperation (<http://www.sdc.admin.ch/>) has individual websites, in addition to the main page, for all country programs. The agency has a number of malaria control projects partnering mainly with sub-Saharan African countries that are focused on net distribution and clinical research and drug distribution. With regards to its long term commitment to malaria control the agency is considering adding a malaria program or component in priority countries.

⁷²http://www.sida.se/sida/jsp/sida.jsp?d=148&a=940&language=en_US&searchWords=act%20procuremet

⁷³ http://www.sida.se/sida/jsp/sida.jsp?d=139&a=31148&language=en_US&searchWords=malaria

⁷⁴ http://www.sida.se/sida/jsp/sida.jsp?d=711&a=4885&language=en_US&searchWords=malaria

⁷⁵ http://www.sida.se/sida/jsp/sida.jsp?d=1236&a=28122&language=en_US&searchWords=monitoring%20malaria%20deaths

⁷⁶ http://www.sida.se/?d=1476&a=30593&language=en_US

⁷⁷ http://www.sida.se/sida/jsp/sida.jsp?d=715&language=en_US

WEBSITE GRADE	EXPLANATION
C	Switzerland is actively involved in clinical research and drug development for malaria control but does not provide any information regarding the impact of its investments nor does it provide detailed information about its expenditure on malaria control

UNITED KINGDOM

The UK Department for International Development (DFID) (<http://www.dfid.gov.uk>) does not procure goods and supplies directly; it contracts these services out to procurement agencies in order to remain transparent, efficient and responsible to taxpayers. The three procurement agencies it has been using since 2003 include: The Crown Agents, the International Procurement Agency and Charles Kendall and Partners.⁷⁸ DFID also has public-private partnership contracts with various organizations for its development activities, such as its 5 million GBP donation (over 5 years) to the Medicines for Malaria Venture for the development and disbursement of ACT and ITN treatments for malaria prevention and control and its £213,000 in 2003/04 and £286,000 in 2004/05 contribution to GlaxoSmithKline/WHO/University of Liverpool partnership to develop an ACT for drug resistant malaria.

A list of all DFID's current activities and contracts is available in the AiDA database sorted by month and year.⁷⁹ Its annual budget breaks down its funding by sector, but not by disease. DFID helped to fund (along with USAID and AusAID) WHO's Malaria Rapid Diagnosis Meeting Report from 20-23 January 2003, an informal consultation on field tests and quality assurance of malaria rapid diagnostic testing. DFID has conducted research on climate change and development in sub-Saharan Africa, which contributes to Rapid Diagnostic Testing efforts.

WEBSITE GRADE	EXPLANATION
C+	Better than most, but not as good as USAID. Still lacks a strong portfolio of epidemiological baseline data to monitor malaria deaths & changes in geographical contraction

UNITED STATES

The United States Agency for International Development (USAID) (<http://www.usaid.gov/>) has developed a site that is entirely dedicated to malaria control programs. The President's Malaria Initiative (<http://www.fightingmalaria.gov/>) is arguably the most comprehensive website and is therefore awarded with the highest mark. The website contains a great deal of information pertaining to budget expenditures. Budget expenditure data stipulates where funding has been spent on indoor residual

⁷⁸ <http://www.dfid.gov.uk/procurement/procurement.asp>

⁷⁹ <http://www.dfid.gov.uk/procurement/contractslet.asp>

spraying and/or commodities. The site suggests that impacts are measured by the tangible target of the number of lives saved as opposed to the majority of other websites that measured the impact of their spending through the number of nets distributed, houses sprayed with insecticides or treatments distributed. For this reason AFM has awarded the Presidents Malaria Website the highest score for transparency and their continued efforts to monitor and evaluate spending in order to ensure that targeted countries are achieving the ultimate objective – reducing the number of lives lost to a disease that is entirely preventable and curable.

WEBSITE GRADE	EXPLANATION
B+	The Presidents Malaria Initiative website tracks all of its spending on targeted countries and reports what the money has been used to procure. The PMI sets itself the target of reducing the number of deaths but fails to accurately record the reduction in prevalence rates.