BRIEFING PAPER

Contributing to Global Action: the European Union and the fight against Malaria

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This briefing paper was commissioned by the European Alliance Against Malaria. The report was written by Joyce Haarbrink, EEPA.

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List of acronyms

AAA	Accra Agenda for Action (on Aid Effectiveness)
ACP	African, Caribbean and Pacific
ACT	Artemisinin-based Combination Therapy
AECI(D)	Agencia Española de Cooperación Internacional (para Desarollo)
AMFm	Affordable Medicines Facility for Malaria
AMANET	African Malaria Network Trust
AMC	Advanced Market Commitments
BACKUP	Building Alliances, Creating Knowledge and Updating Partners, the initiative developed by GTZ (see below) on supporting development policies on health
CCM(s)	Country Coordinating Mechanism(s)
CRS	Creditor Reporting System, an OECD DAC's statistical system
CSP(s)	Country Strategy Paper(s)
DAC	Development Cooperation Directorate
DANIDA	Danish International Development Agency
DCI	Development Cooperation Instrument
DFID	Department for International Development
DGIS	Directoraat Generaal voor Internationale Samenwerking (Dutch Directorate for International Cooperation)
EC	European Commission
ECDTP	European and Developing Countries Clinical Trials Partnership
ECHO	European Community Humanitarian Office
EDF	European Development Fund
EMVI	European Malaria Vaccine Initiative
EU	European Union
GAERC	General Affairs and External Relations Council
GAVI	Global Alliance for Vaccines and Immunisation
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMAP	Global Malaria Action Plan
GNI	Gross National Income
GTZ	Gesellschäft für Technische Zusammenarbeit, the German Development Agency
FP	Framework Programme, for EU's research and development Programmes
IFFIm	International Finance Facility for Immunisation Company
IHP	International Health Partnership
IRS	Indoor Residual Spraying
IPT	Intermittent Preventive Treatment
LLINs	Long-Lasting Insecticidal Nets
LRRD	Linking Relief, Rehabilitation and Development
MDG(s)	Millennium Development Goals(s)
M&E	Monitoring and Evaluation
MIM	Multilateral Initiative on Malaria
MIMcom	Multilateral Initiative on Malaria, communication group
MMV	Medicines for Malaria Venture
MS(s)	Member State(s)
MR4	Malaria Research Reference Reagent Resource Centre
NGO(s)	Non-Governmental Organisation(s)
NMCP(s)	National Malaria Control Programmes(s)
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
OECD DAC	Organisation for Economic Cooperation and Development's Development Cooperation Directorate
OJ	Official Journal, the EU's official journal publishing adopted EU legislation and directives
OR	Operational Research
PfA	Programme for Action
RBM	Roll Back Malaria (Partnership)
RDT	Rapid Diagnostic Tests
R&D	Research and Development
SAREC	Department for Research Cooperation in SIDA
SIDA	Swedish International Development cooperation Agency
SUFI	Scaling up for Impact
TB	Tuberculosis
TDR	Special Programme for Research and Training in Tropical Diseases (WHO)
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UNITAID	The International Drug Purchase Facility financed with a.o. international air Ticket Tax
WB	World Bank
WHO	World Health Organisation

1. Introduction

Malaria is among the 5 most deadly diseases worldwide. Half the world's population, some 3 billion people, are at risk. In 2008, 109 countries were malaria endemic, 45 of which are to be found in Africa[1]. The disease proves to be not only devastating to human life, but also has a serious impact on economies and reinforces poverty, particularly in the poorest countries in the world. Today, malaria can be prevented, diagnosed and treated with a combination of available instruments as long as the necessary funding is in place. But the needs hugely exceed the response to malaria thus far.

In the past ten years malaria has risen on the global health agenda. New initiatives were taken and new commitments made at the global level to support health in general and the fight against malaria in particular. In April 2000 the Heads of State and Government of Africa adopted the Abuja Declaration and the Plan of Action on Malaria[2] aimed at halving malaria mortality in Africa by 2010, by strengthening health systems to ensure that by 2005 at least 60% of those suffering from malaria would have access to correct, affordable and appropriate treatment and at least 60% would benefit from appropriate protective measures, particularly vulnerable groups such as pregnant women and children under five. In September 2000 world leaders adopted the Millennium Declaration and the 8 Millennium Development Goals (MDGs), including MDG 6: Combating HIV/AIDS, Malaria and other diseases, with, as target 8, 'to have halted and begun to reverse the incidence of malaria by 2015'. This commitment was strengthened during the World Summit in 2005[3] when Heads of State and Governments committed to increase investments in health, guarantee substantial funding for the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and improve health systems in developing countries (art. 57). They also agreed to ensure the distribution of nets (including free distribution) and increased access to effective anti-malaria treatments (art. 34). In addition several international initiatives were developed to facilitate joint activities, such as the creation of the GFATM in 2002, the creation of the innovative funding mechanism UNITAID in 2007 and, as recently as April 2009, the launch of the Affordable Medicines Facility for Malaria (AMFm)[4] with an initial budget of $ 225 million for effective malaria drugs. Several countries have shown that malaria-related morbidity and mortality can be substantially reduced by relatively simple means such as long-lasting insecticidal nets (LLINs), indoor residual spraying (IRS) of internal walls and intermittent preventive treatment for pregnant women (IPTp) in high transmission settings. It is therefore important that these commitments and initiatives contribute to increased access to and dissemination of these interventions.

Funding for malaria control has hugely increased since 2004, reaching an estimated overall figure of US$ 1.5 billion in 2007[5]. International donors increased their contributions from US$ 250 million in 2004 to US$ 700 million in 2007[6], and this amount is expected to have increased to US$ 1.1 billion in 2008[7]. However, if target 8 of Millennium Development Goal 6. '*to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases*' is to be achieved, a major increase of funding of up to four times the present level is required, based on the assessment of intervention needs for global control, elimination and research and development up to 2025[8]. This will have to come partly from the malaria-endemic countries themselves, but international donors will have to contribute substantially in order to fill the large resource gaps.

1 See also *World Malaria Report 2008*. Geneva, World Health Organisation, 2008
2 See also http://www.rbm.who.int/docs/abuja_declaration_final.htm
3 See also the *Resolution adopted by the General Assembly on the 2005 World Summit Outcome*, adopted by the UN General Assembly on 24 October 2005. A/RES/60/1
4 See also http://www.theglobalfund.org/en/pressreleases/?pr=pr_090417
5 See also p. 13 in *The Global Malaria Action Plan. For a malaria-free world.* Published by the Roll Back Malaria Partnership. 2008
6 Ibid.
7 Ibid.
8 See also p.16 in *The Global Malaria Action Plan. For a malaria-free world.* Published by the Roll Back Malaria Partnership. 2008

Much, therefore, still needs to be done. Household surveys and data from national malaria control programmes (NMCPs) show that in 2006 the coverage of interventions in, for instance, African countries was far lower than the 80% target set by the World Health Assembly. The surveys showed that in 18 African countries only 34% of households owned an LLIN; only 23% of children and 27% of pregnant women slept under such a net; only 3% of children with a fever were treated with an Artemisinin-based Combination Therapy (ACT) and only 28% of pregnant women were given IPTp to prevent malaria infection[9].

In 1998 the World Health Organisation (WHO), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP) and the World Bank (WB) joined forces and launched the Roll Back Malaria (RBM) Partnership. Since then the Partnership has attracted many new members, including some European Union (EU) Member States[10]. Its vision is to have achieved the malaria-related MDG 6. In addition malaria should no longer be a major cause of mortality or a barrier to social and economic development and growth anywhere in the world[11]. In order to realise this vision and achieve the RBM's specific targets for 2010, the Partnership developed the *Global Malaria Action Plan For a malaria-free world* (GMAP)[12] in 2008. The GMAP is intended to provide a global framework for action aimed at achieving control of the disease, increased investment in research and development and ultimately the eradication of malaria, around which partners can coordinate their efforts. It presents a comprehensive overview of the global malaria landscape; it offers an evidence-based approach to deliver effective prevention and treatment to all people at risk and it provides an estimate of the annual funding needs for the achievement of the 2010 and 2015 targets for the fight against malaria (for more details see 4.1).

As the biggest donor of humanitarian and development aid, the EU, i.e. the European Commission (EC) and the Member States (MSs), is well-placed to play an important role in the fight against malaria and the achievement of the health MDGs, particularly of MDG 6 on combating HIV/AIDS, malaria and other diseases.

As some of the EU Member States have joined the RBM Partnership and as such have adopted the GMAP, the Action Plan could be a useful tool for the EU's contribution to the fight against malaria. However, the GMAP is not only a useful tool for donors. Partner countries in the South, parliamentarians, International Health Partnerships and initiatives and Non-governmental Organisations (NGOs) can also use GMAP as the framework for their work in fighting malaria. Partner countries can use the plan as a basis for their health policies, particularly in relation to malaria. As global players, International Health Partnerships and initiatives can have a strong impact in the fight against malaria. Even though many of these organisations focus on particular areas in the response to malaria,- ranging from health system strengthening, through research and support for malaria-specific policy development, to delivery of prevention and treatment drugs and instruments and funding/ fundraising for research and aid activities (see 4.3 below)-, the GMAP offers them a framework for close cooperation and alignment of their respective activities in order to collectively achieve the ultimate goal of the eradication of malaria.

RBM Targets for 2010:

- Protecting 80% of people at risk from malaria;
- Diagnosing and treating 80% of malaria patients with e.g. ACT within one day of their falling ill;
- Treating 80% of pregnant women with IPTp
- Reducing the malaria burden by 50% of the 2000 figures.

RBM Targets for 2015:

- Reducing malaria morbidity and mortality by 75% of the 2005 figures
- Achievement of the malaria-related MDGs across all affected countries
- Ensuring universal and equitable coverage.

Source: RBM Global Strategic Plan 2005-2015

9 See also *World Malaria Report 2008*. Geneva, World Health Organisation, 2008
10 Denmark (DANIDA), UK (DFID), The Netherlands (DGIS), Italy (Ministry of Foreign Affairs, Sweden (SIDA) and France.
11 See also the *Global Strategic Plan 2005-2015* on http://www.rollbackmalaria.org/forumV/docs/gsp_en.pdf
12 http://www.rollbackmalaria.org/gmap/

Some of the EU donor countries stress the importance of NGOs in developing and implementing their development cooperation policies on health. NGOs work closely with partners in the field, are often community-based and have a practical knowledge of the successes and failures of malaria-specific interventions at local and regional level. As such, NGOs therefore have an important role to play as watchdogs of national and international malaria-specific policies and activities. The GMAP can guide them in their monitoring activities.

This paper aims to analyse the GMAP and monitor the EU's performance in terms of policies and funding in relation to the fight against malaria, in line with GMAP objectives. On the basis of its findings the paper will come up with some recommendations for future activities targeted at increasing the support for the fight against malaria.

2. Scope and coverage

In many developing countries malaria is still a deadly disease, particularly in sub-Saharan Africa. Donors have realised this and have been supporting malaria-specific activities in the past. However, as development cooperation changes along with new visions of how it should be delivered, with a strong focus on country ownership and new aid modalities, support for the response to malaria changes as well. Donors see Budget Support as the most efficient form of development aid, whereby support can be given to certain sectors in line with government policies in the recipient countries. Support for health system strengthening is seen as beneficial for the whole health sector, including the response to malaria.

The objective of this paper is to look into these changes in EU policies for health, including the response to malaria, both at EU level, implemented by the EC, and at the level of the Member States in their bi-lateral aid. In addition donors are increasingly creating new international and global initiatives for health. How do these initiatives impact on national development aid for health and particularly on the response to malaria? This paper will therefore also include a discussion on these partnerships and their role in the fight against malaria. What is the impact of these initiatives on donor spending on health, particularly in the EU?

In order to use the most comprehensive figures on funding available the analysis will mainly focus on spending in 2007 based on the figures reported by the EU donors to the OECD DAC[13]. Moreover, 2007 was the first year that funding for malaria was reported upon separately in contrast to previous years where reports only mentioned combined spending on HIV and AIDS, Tuberculosis and Malaria.

Finally, the Roll Back Malaria Partnership has developed the *Global Malaria Action Plan For a malaria-free world* (GMAP), as a strategy framework for the response to malaria. This paper examines whether the activities of the EU donors are in line with this strategy framework.

13 Organisation for Economic Cooperation and Development (OECD) Development Cooperation Directorate (DAC)

Structure of the paper

The paper will consist of four major sections:

1 The introduction of the Global Malaria Action Plan (GMAP)

2 Analysis of policies and funding mechanisms for malaria of EC and EU Member States, subdivided into three parts:
- **Part 1** focuses on the policies developed in the EU, implemented by the EC, and in the EU Member States.
- **Part 2** focuses on the funding allocated by the EU through the EU budget and the EDF and by the EU Member States through bi-lateral aid and contributions to International Organisations (Multilateral Aid)
- **Part 3** focuses on the role of International Health Partnerships and initiatives as additional instruments for funding and aid delivery in relation to the fight against malaria.

3 An analysis of possible improvements towards achieving the objectives of the Global Malaria Action Plan both in performance and funding activities.

4 Conclusions and recommendations

3. Global Malaria Action Plan

Although at present effective tools exist to prevent and treat malaria in most settings, thereby substantially reducing the morbidity and mortality from malaria, prior to last year, a clear global strategy outlining the goals and activities had been missing. The Roll Back Malaria Partnership sought to address this by developing the Global Malaria Action Plan (GMAP). The Plan aims to maximise the impact of the malaria community's work by offering guidelines for the prioritisation of resources and promoting the alignment and effectiveness of the activities undertaken by the different stakeholders. It sees the cooperation between the endemic countries and the international (donor) community as the best way to make progress towards the achievement of the goals set out for 2010 of reducing the number of global malaria cases and deaths by 50% compared to 2000, and to 75% fewer cases and near zero deaths in 2015. It acknowledges that individual countries are best placed to know which actions are most appropriate to address the particular situation on malaria in their country, but that the international community can play a critical role by offering the country support and provide it with the necessary tools. The GMAP provides a global framework for action around which partners can coordinate their efforts. The ultimate target is to eradicate malaria worldwide by reducing the global incidence to zero through the progressive elimination of malaria in the individual countries.

In order to achieve the 2010 and 2015 targets the GMAP outlines a three-part global strategy (see also Fig. 1)[14]:

1 Control malaria to reduce the current burden which implies:
- Scaling-up for impact (SUFI) in order to reach universal coverage for all populations at risk with locally appropriate malaria control interventions, including strengthening health systems
- Sustaining control to prevent the resurgence of malaria. This requires strong political commitment at country level and continued investment in health system strengthening and universal coverage.

14 See also: *The Global Malaria Action Plan. For a malaria-free world* , Roll Back Malaria Partnership. 2008

2 Eliminate malaria over time country by country.

This requires not only new control tools in traditionally high-transmission areas, but also the promotion of cross-border initiatives, the use of strong surveillance and case detection instruments, significant and predictable financial and political commitments by the government and the prevention of 'elimination fatigue' by applying convincing communication and advocacy techniques.

3 Research new tools and approaches to support global control and elimination efforts, through three types of research:
- Research and development of new or improved anti-malaria interventions, e.g. drugs, vector control tools, diagnostics and vaccines,
- Research to inform policy decisions to define the type of interventions and programmes best suited for different contexts.
- Operational and implementation research needed to understand the use and effectiveness of interventions in the field and improve the delivery and quality of prevention and treatment interventions.

Fig. 1:
Three Core Components of the Strategy
Source: The Global Malaria Plan Action Plan

The GMAP[15] calculated that the estimated needs, based on the costs of prevention, treatment and programme strengthening in malaria-endemic countries - mainly in Asia and Africa - over the next years would be:
- ± US$ 5.3 billion in 2009
- ± US$ 6.2 billion in 2010
- An average of US$ 5.1 billion annually in the period 2011 – 2020
- An average of US$ 3.3 billion annually in the period 2021 – 2030
- An average of US$ 1.5 billion annually in the period 2031 – 2040
- In addition some US$ 750 – 900 million annually till 2018 should be spent on developing new malaria control tools such as vector control, drugs, vaccines and diagnostic technologies.

A closer look at the predicted annual global costs shows that certain elements of malaria prevention and elimination/eradication will need sustained financial support, while the support needed for others decreases. This will need to be taken into account when devising future advocacy campaigns.

15 See p. 16 of *The Global Malaria Action Plan. For a malaria-free world* , Roll Back Malaria Partnership. 2008

Table 1

Summary of annual global costs

Source: GMAP costing model

Cost (US$ millions)	2009	2010	2015	2020	2025
LLINs / ITNs	2,091	2,091	1,689	1,807	1,035
IRS	1,632	1,883	2,026	2,047	1,531
IPTp	6	8	9	9	10
Prevention cost	*3,728*	*3,982*	*3,724*	*3,864*	*2,576*
RDTs	679	975	368	109	43
ACTs	257	356	164	107	41
Chloroquine and primaquine	5	5	2	1	0
Severe case management	27	23	16	9	4
Case management cost	*968*	*1,359*	*550*	*226*	*87*
Community health workers	79	82	97	96	75
Training	104	96	91	93	58
M&E and Operational Research (OR)	207	242	245	251	298
Infrastructure/institutional strengthening	248	419	331	347	283
Programme Cost	*638*	*839*	*764*	*787*	*714*
Global control and elimination cost	*5,335*	*6,180*	*5,037*	*4,877*	*3,378*
Information needs	126	126	133	113	77
Diagnostics	13	13	13	13	13
Drugs	322	322	322	154	154
Vector control interventions	108	108	108	105	65
Vaccines	190	190	224	296	152
Research and Development cost	*759*	*759*	*800*	*681*	*460*
Total Cost	**6,094**	**6,939**	**5,837**	**5,559**	**3,838**

As can be seen in the above table, overall expenditure is expected to decrease over the years, which will allow for funding to be transferred to other health initiatives. Moreover, as the burden of malaria diminishes it also diminishes the cycle of poverty for the people hardest hit by the disease, which ultimately also has a positive impact on a country's economy. However, before this goal is achieved donor and partner countries will have to scale up their activities and ensure that coordination mechanisms are in place based on the GMAP guidelines. As the GMAP was only adopted in June 2008 it is difficult to assess impact. As we will see below certain donor policies and activities are already in line with some of the GMAP recommendations. Others still need to be implemented. But in order to ensure continued progress, it will be important to also analyse the challenges that can impede the implementation of the GMAP. The RBM Partnership therefore kick-started the Counting Malaria Out campaign on World Malaria Day, the 25th of April 2009[16]. The 2-year campaign will engage all the RBM partners in the North and the South in comprehensively tracking the global progress and impact made. It is to monitor and count the delivery of malaria commodities, the increases in financial resources and the development of new and improved tools and initiatives. Only by collecting and analysing these data at district, national, regional and global level can the malaria community ensure that it is still on the right track towards the ultimate goal of malaria eradication.

16 See also *World Malaria Day 2009: Countdown 2010* on http://www.rbm.who.int/worldmalariaday/countdown.html

The following chapters will be looking at how the EU moves forward in the fight against malaria. What policies are in place and how much funding has been allocated directly or indirectly to the achievement of the MDG 6 target on malaria? Are their policies and funding allocations in line with the guiding principles formulated in the Global Malaria Action Plan?

4. Analysis of policies and funding mechanisms for malaria of EC and EU Member States

4.1. EXISTING Policies and commitments to fight malaria in the EC and EU Member States

The EU Member States are the legislative authority, together with the European Parliament, on EU policies, which means that their views are integrated in the EU development policy instruments and programmes. In line with the Paris Declaration on Aid Effectiveness there is also a growing tendency to harmonise development activities and concentrate on those areas where Member States have the most expertise. The EC, as the EU institution with a global presence, is playing an important role delivering aid in so called 'aid orphan' countries. With the adoption of the Code of Conduct on the Division of Labour in Development Cooperation the role of the EC is also strengthened as coordinator of various development activities, i.e. as a multilateral partner.

In 2005 the EU adopted the *European Consensus on Development*, the framework for all development policies and activities developed and implemented by the European Commission and EU Member States. It states that the overarching objective of EU development cooperation is the eradication of poverty in the context of sustainable development, including the achievement of the MDGs[17]. It acknowledges that poverty relates to human capabilities such as consumption and food security, health, education, rights, the ability to be heard, human security especially for the poor, dignity and decent work. This means that it will be important to invest in people, particularly in relation to their health (art. 11). It points out that the developing countries have the primary responsibility for creating an enabling domestic environment for mobilising their own resources, including coherent and effective policies, but that the EU will assist them in accordance with the results of their regular dialogues. This will include support through General and Sector Budget Support, which will in some cases incorporate contributions to operating costs such as for health. The EC will be linking both Sector and Budget Support to MDG progress and identifies fair financing for health, strengthening health systems and addressing the human resource crisis of health workers as a specific area to promote better health outcomes (art. 94 and 95). As these commitments are in line with the GMAP the following chapters will analyse how the EC and the EU Member States implement these commitments through their policies and funding activities.

4.1.1. The EU

In 2003 the EU adopted the *Regulation on aid to fight poverty diseases (HIV/AIDS, tuberculosis and malaria) in developing countries*[18]. The EC committed itself to provide financial assistance and appropriate expertise to actors in development in order to improve access to health for all and to promote equitable economic growth (art. 2), particularly in relation to the three communicable diseases. It will do this with a particular focus on prevention, but without a bias to treatment and care. It aims to do this within the context of a strengthened comprehensive health system and in cooperation with global initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria.

17 OJ(206/C46/01)

18 Regulation (EC) no. 1568/2003

Although this Regulation was repealed in 2007 to be included in the Development Cooperation Instrument (see below) the policy commitments were retained in ensuing policy documents.

After presenting the EC Communication *A Coherent European Policy Framework for External Action to Confront HIV/AIDS, Malaria and Tuberculosis* in 2004, the EC adopted the *Communication from the Commission to the Council and the European Parliament – A European Programme for Action to confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007-2011)*[19] *(PfA)* in 2005, confirmed in the Council Conclusions of the General Affairs and External Relations Council (GAERC)[20] of 24 May 2005[21]. In the Policy Framework the EC had already indicated that it would increase its support to confronting the three diseases, including malaria, through innovative action, support for local production capacity for e.g. ACTs and other anti-malarials, LLINs, and strengthening research capacity in developing countries. It also stressed the importance of the Global Fund to fight AIDS, Tuberculosis and Malaria. The Programme for Action turns these commitments into more concrete proposals such as support to the targeted distribution of free LLINs, support to research provided through the EU's 7th Framework Programme for Research and Technological Development FP7 (see below), and the need to address not only the human resources for health crises, but also the strengthening of health systems in developing countries. In addition, the Programme for Action commits the EC to include preventive and curative measures against malaria as an integral part of the humanitarian response provided by the European Community Humanitarian Office (ECHO) and also include them in the Linking Relief, Rehabilitation and Development (LRRD) process. This is echoed in the *European Consensus on Humanitarian Aid*[22], adopted by all three European Institutions[23] in 2008, which states that humanitarian assistance policies, such as on health, need to ensure that they are adapted to the context and needs of people to ensure a maximum impact from the immediate emergency stage, through rehabilitation to development aid (art.42, 84 and 97).

As can be seen from the historical overview of the specific policies on the three diseases the EU has had over the years a strong commitment to fighting malaria as one of the three major diseases. When it adopted the Programme for Action (PfA) the Council invited the Commission and the EU Member States to report on the implementation of the Programme for Action in 2008 (art. 14). Since the implementation of the PfA only started in 2007, the Commission postponed the drafting of the report to the beginning of 2009. The report will focus mainly on the policy level and base itself on available data from both the EU Member States and the EC itself. At present the EC is conducting the assessment and has collected some preliminary findings.

Preliminary Findings of the report on the Implementation of the Programme for Action

As a result of the strong focus on partner country ownership and aid efficiency, there has been a clear move from earmarked project financing towards budget support financing modalities based on results management. By supporting a country's general budget the EC leaves it to the recipient country to decide on the ultimate destination of EC funding, although the financing agreements signed as a basis for general budget support lay down the general objectives to be achieved through the budget support allocated. Sector Budget Support, which allocates funding to specific sectors, such as health, is more focussed and the financing agreement for this type of budget support is more targeted to specific policy areas within the sector. However, in the case of the health sector it is seldom focussed on one specific disease such as malaria. This means that it becomes more difficult to monitor malaria-specific activities and funding. The use of general and sector budget support also diminishes the role civil society organisations formerly played through the implementation of projects.

In addition the implementation of the Paris Declaration and the EU Code of Conduct on Complementarity and the Division of Labour, have led the EC and the Member States to start concentrating on fewer sectors, based on their comparative strengths. While health is seen as an important sector, EU donors tend to concentrate their support on health system strengthening, i.e. a horizontal approach, instead of taking a disease-specific, i.e. vertical, approach. Although many Country Strategy Papers include support to health, and to malaria in malaria-endemic countries, it appears that there are few examples to be found of concerted efforts by EC delegations and EU Member States to come to a strategic coordinated policy dialogue on, for instance, the fight against malaria. This is also apparent in the fact that only 35% of the EC delegations took part in the Country Coordinating Mechanisms set up by the Global Fund to Fight AIDS, Tuberculosis and Malaria. This becomes even more relevant and worrying in the context of the response to malaria, considering that the EU collectively is an important donor to the Global Fund (see below). The move towards growing use of in-country budget support, and the increased funding for malaria through the Global Fund, also means that the existing technical expertise on fighting malaria at delegation level is rapidly diminishing. Likewise the progressive exclusion of Civil Society Organisations (CSOS) in the implementation of anti-malaria policies, impacts negatively on the in-country expertise and activities in relation to the fight against malaria. This may have a serious impact on the EU's capacity building activities in relation to individual country responses to malaria.

Research

Although at policy level the EU is moving away from disease-specific project-based support for the fight against malaria, focusing instead on the health sector in general by supporting health system strengthening as a horizontal approach thus benefitting all diseases prevalent in the developing world, it still invests strongly in disease-specific research and development through the 6th (2002-2006) and 7th European Framework Programmes (FP) for Research and Technological Development (2007-2013). Supported by funding from the 6th FP the European malaria research community organised itself into three large complementary networks each focussing on a given field of research. The three research areas are: a) fundamental research in the field of biology and pathology of the malaria parasite; b) research on malaria drugs; c) research on malaria vaccine development. In addition funding was made available for projects on vaccine delivery routes, on malaria projects that involved novel high-risk research approaches and support for clinical trials through the European and Developing Countries Clinical Trials Partnership (EDCTP). This strategy has been continued in the 7th FP.

Based on the above it can be concluded that the EC mainly concentrates its own (bi-lateral) activities on political dialogue with partner countries, general and sector budget support and funding for research in its support for the fight against malaria. However, it also contributes to multilateral initiatives by funding the Global Fund to Fight AIDS, Tuberculosis and Malaria. As a member of the board it can influence certain Global Fund policies and activities. A recent report by the European Court of Auditors[24] (discussed below), however, questions whether the EC takes advantage of this.

Multilateral cooperation

Besides contributing to the GFATM, the EC also supports WHO, the International Health Partnership (IHP) and various UN organisations such as UNFPA and UNICEF, which are involved in anti-malaria activities, particularly for pregnant women and children in malaria-endemic countries. In order to streamline and harmonise the EU's

19 COM(2005) 179 final

20 Which means that all the EU Member States support it as together they for the Council. The GAERC is the Council of Ministers of Foreign Affairs.

21 Council Doc. No. 9278/05

22 OJ 2008/C25/01

23 The three EU Institutions are the Council, the European Parliament and the European Commission.

24 See *EC Development Assistance to Health Services in Sub-Saharan Africa*. European Court of Auditors, Special Report No. 10/2008

contribution to development cooperation, the EC has proposed an *EU Code of Conduct on the Division of Labour in Development Policy*. Many developing country officials complain about the multitude of donors active in their countries. This means that recipient country government officials are spending most of their time developing plans and reporting on results to multiple donors. By promoting cooperation and developing joint activities and funding mechanisms the EC hopes to reduce the number of individual donors and improve aid effectiveness and sustainability. This will be even more important as the EU donors have all signed up to the Paris Declaration on Aid Effectiveness and its follow-up, adopted in September 2008, The *Accra Agenda for Action* on Aid Effectiveness. By joining forces at EU level through joint actions implemented by either the EC or the lead donor on activities related to the response to malaria in partner countries (see the *Code of Conduct on the Division of Labour*) or by allocating funding to international partnerships, the donors can ensure focussed, effective and coherent interventions in the response to malaria.

In 2007 the EU adopted the *EU Code of Conduct on the Division of Labour in Development Policy*[25]. The Code of Conduct is a voluntary commitment by EU Member States to work together in development cooperation. It was developed to reduce the number of donors in a particular recipient country and a particular sector by joining forces and to enhance the complementarity of EU Member States' development activities. It aims to ensure that each actor focuses its assistance on areas where it can add most value, given what others are doing, in order to achieve optimal use of human and financial resources. This complementarity can be implemented at in-country level, at cross-country level, across sectors such as health, but also take a disease-specific (i.e. vertical) approach. Complementarity can also be applied when using the various financing modalities and instruments such as for instance Budget Support, project support or technical assistance. It will be based on the comparative advantage of donors in specific countries. Based on its past experience in working on certain issues in a particular country the EU donor will be invited to take the lead in that particular sector or country and act with authority on behalf of one or more EU donors, i.e. the 'delegating' or 'silent' donor partner. In line with the Paris Declaration the primary leadership and ownership will remain with the recipient country. Although ultimately the Code of Conduct aims at achieving complementarity at all the levels mentioned above, for the time being, it will focus mainly on in-country, cross-country and cross-sector complementarity. This means that health might be a focal area for joint actions, but the vertical approach of the fight against malaria will not be addressed as a separate vertical issue.

Although many EU Member States are supportive of the concept of a Division of Labour, the implementation is still at an initial stage. In its report on *EC Development Assistance to Health Services in Sub-Saharan Africa,* the European Court of Auditors commented on the fact that the cooperation on health between the EC delegations and the EU donor countries in-country was still limited and not formalised[26].

The next chapter looks at the policies on health, and on malaria in particular, in some EU Member States and analyses their comparative strengths in supporting the response to malaria.

4.1.2. The EU Member States

In addition to contributing to the EU both in funding and policy development, EU Member States also implement bi-lateral policies on health. This chapter examines such policies, noting that levels of engagement in the fight against malaria differ considerably[27]. Most Member State policies are multiannual, covering the period 2007 to 2010 or further, depending on the State. In line with the European Consensus and the Paris Declaration on Aid Effectiveness, all EU Member States include dialogue with the partner countries as a crucial element of development cooperation.

Austria

Development Cooperation in Austria focuses mainly on water management and sanitation, energy, rural development, education, private-sector development and governance. Although it allocates funding to health (€ 5.30 million in 2005, € 6.37 million in 2006 and €4.47 million in 2007) this is mainly for contributions in the fight against HIV and AIDS[28].

Belgium

In its 2008 policy document *Het recht op gezondheid en gezondheidszorg*[29], Belgium outlines its priorities for development cooperation in relation to support for the health sector. In line with WHO it defines a health system as 'a set of activities aimed at promoting, restoring and maintaining good health' and interprets this in the broadest sense in that it includes health related activities in other sectors as well. In its policy document Belgium distinguishes two categories for support: the health sector and the health system. Acknowledging that the government, the private sector and NGOs have an important role to play in implementing health policies, the Belgian government believes that it is the national government that needs to ensure a sound health system. This means that it needs to guarantee equity in health care and universal access, to ensure the right to sound information, and to offer social security and promote prevention measures particularly in relation to infectious diseases such as malaria.

A key element of Belgium's development cooperation is therefore maintaining a close dialogue with the partner country government and ensuring the alignment of its development policy on health with the health policy of the recipient country. It proposes to offer its aid through either General Budget Support, Sector Budget Support, basket funding, programme or project support depending on the requirements of the partner country.

As part of the support for health systems it intends to focus on:

- Support for capacity building of human resources for health both in terms of quality as of quantity;
- The response to important infectious diseases with particular attention to neglected diseases. In malaria-endemic countries, prevention, early treatment and care will be receiving special attention;
- Support for the improvement of the quality, sustainability and use of health systems. This will be done through a comprehensive approach involving horizontal and vertical interventions, the use of public and private commodities, and include humanitarian (short term) and structural (long term) interventions;
- Support for increased research and availability of essential pharmaceutical products.

Belgium's development cooperation structure is complicated as development cooperation is not only offered at the central level, but both the Flemish and Walloon (French-speaking) regional governments contribute as well. However, the three donors tend to cooperate where possible and this is stressed by the federal government. International organisations such as the WHO and the GFATM also receive significant support as complementary (to bi-lateral aid) and coherence-promoting cooperation bodies.

25 COM(2007) 72 final
26 *EC Development Assistance to Health Services in Sub-Saharan Africa*. European Court of Auditors, Special Report No. 10/2008, art. 20
27 The countries are discussed in alphabetical order
28 See also p.20 in OEZA-Bericht 2007
29 *Beleidsnota. Het recht op gezondheid en gezondheidszorg*, opgesteld door D0.1 in samenwerking met WErkgroup Gezondheid en Platform Be-cause Health en goedgekeurd door Minister Charles Michel te Brussel op 24 November 2008

An indication of Belgium's increasing support to a horizontal approach at the expense of a vertical approach, such as the response to malaria, is the fact that although the financial contribution[30] to the health sector increased from € 52,436,479 in 2004, to € 69,971,682 in 2005 and € 77,263,119 in 2006, the contribution to malaria decreased from 0.91% in 2005 to 0.63% in 2006.

Denmark

Although Danish development cooperation includes health as an important focal area, it focuses its aid mainly on the response to HIV and AIDS and reproductive health. Capacity building of national health systems will therefore be a key item for future development activities on health[31]. Its support for malaria is mainly done by supporting GFATM, WHO, the Global Alliance for Vaccines and Immunisation (GAVI) and, at the regional level, for the African Malaria Network Trust (AMANET)[32]. In addition it supports research and development through support to the Danish Research Network in International Health (Enreca Health) which aims at enhancing research capacity in developing countries. Between 2008 and 2012, Denmark will earmark additional funding to medicine-related research of special relevance to poor countries.

It needs to be noted, however, that in spite of health being an important focal area for development cooperation, there has been a decrease. The total contribution to the health sector in 2006 was 550.87 million Danish Kroner (€ 73.89 million[33]), of which 274.01 million Kroner (€ 36.76 million) was allocated to health in general and 276.86 million Kroner (€ 37.14 million) to primary health. This decreased to 448.84 million Danish Kroner (€ 60.21 million) in 2007, 241.39 million Kroner (€ 32.38 million) being allocated to health in general and 207.45 million Kroner (€ 27.83 million) to primary health[34].

Finland

The Finnish Development Guidelines for the Health Sector[35] states that as Finland has considerable experience in the development of an equitable and functional health care system the main focal areas in Finnish development cooperation in the health sector of interest for the malaria community will be:

- Strengthening of health care systems and good governance in their administration,
- Primary health care, with the aim of providing quality services for everyone,
- Preventive health care and health education.

They identify the insufficient number of health care staff, which are often poorly trained, and the ineffective use of human resources in health as a huge problem. They also believe that the promotion of health care and social policies needs to be taken forward in actions related to other sectors. This means that they will focus their development aid on the whole sector instead of providing support for vertical issues such as the fight against malaria.

Development assistance for health is channelled multilaterally through the EU, UN organisations and WHO, while Finland also contributes to the GFATM. Bi-lateral aid is based on partner country poverty reduction strategies, preferably through budget support (both general and sector) and technical assistance. In addition Finland develops regional programmes especially in relation to programmes for control and treatment of communicable diseases. Research is also an important aspect of support for health, whereby the focus is mainly on building capacity for the health sector. For 2007 and 2008, Finland allocated €198.4 million and € 240.8 million respectively in country- and region-specific development cooperation and € 155 million and € 180.3 million for multilateral development cooperation[36]. Some 11-13% of Finland's budget for bi-lateral development cooperation is spent on health[37], but no exact figures are given.

France

In the past few years France has energetically revised its development cooperation system, not only by reforming its delivery structure, but also by significantly increasing its aid volume from 0.30% of GNI in 2000 to 0.42% in 2007 and 0.45% in 2008[38]. The health sector in French development cooperation has benefited strongly from this increase in aid funding, mostly through the multilateral channel.

The French strategy in support of the health sector has a strong multilateral focus with increasing contributions to GFATM, GAVI, UNITAID, UNICEF, WHO, and the World Bank (see French contributions below). Since the turn of the millenium, France has strongly supported the creation of the Global Fund and in May 2001, it made one of the first pledges to the Fund. It has continued to play an important role as a donor and as a political advocate on behalf of the Fund with European Heads of State and the European Commission. The 2004 Landau Report, commissioned by the French president Jacques Chirac,[39] focused on innovative financing mechanisms for international development in support of implementing the MDGs. As a consequence, France has been active in promoting innovative sources of financing for development, including the creation of public/private partnerships for health.

In addition France supports health systems at the national level by training human resources and investing in capacity building for research in health. As a means to develop sustainable funding for health and ensuring universal access to health France researches the possibility of developing national health insurance systems.

France uses three modalities to disburse development aid: Project funding, Multi-annual Programme funding and budget support. Although its contribution to health at the multilateral level is growing, it decreased at the bi-lateral level from € 48 million in 2007 to € 38 million in 2008[40].

The involvement of the French government in the fight against malaria through multilateral channels is balanced with bilateral support in the few countries where the health sector has been targeted as a priority (mothers' and infants' health and strengthening healthcare systems). The French Development Agency (Agence Française de Développement – AFD) provides funding for research and development as well as technical assistance. In 2006 for instance, it provided € 1.5 million to the Drugs for Neglected Diseases initiative for the development of two new drugs for malaria.

However, actual disbursements reported recently by the French Foreign Ministry to the European Alliance Against Malaria show that the contribution to the response to malaria in direct bi-lateral aid through the Agence Française

30 See also *Verslag voor het Parlement over de actie die België ondereneemt met het oog op de verwezenlijking van de Milllennium Ontwikkelingsdoelstellingen (MDG's)* published by FOD Buitenlandse Zaken, Buitenlandse Handel en Ontwikkelingssamenwerking, Directie-Generaal Ontwikkelingssamenwerking, 2007

31 See also *A World for All. The Government's Vision for New Priorities in Danish Development Assistnace 2008-2012.*

32 See also http://www.amanet-trust.org

33 The OECD exchange rate for 2007 were used for the conversion to Euro

34 See also *Sektorfordeling af bilateral bistand 2006 og 2007.* On http://www.um.dk/da/menu/Udviklingspolitik/OmUdviklingspolitik/FaktaOgTal/Bistandskronen/Sektorfordeling/

35 *Finnish Development Policy Guidelines for the Health Sector.* Published by the Development Policy Information Unit of the Ministry for Foreign Affairs of Finland. Helsinki. 2007

36 See also *Development cooperation appropriations by budget lines 2002-2008*. On http://formin.finland.fi/public/download.aspx?ID=32041&GUID={B0D8CE0D-CC2E-48F8-AA7D-A57140733223}

37 See p. 15 in *Finnish Development Policy Guidelines for the Health Sector.* Published by the Development Policy Information Unit of the Ministry for Foreign Affairs of Finland. Helsinki. 2007

38 See also p. 17 in *Mémorandum de la France sur ses politiques et programme en matière d'aide publique au développement*.published by the ministry for Foreign and European Affairs, the Ministry of Economy, Industry and Employment and the Ministry for Migration, Integration, National Identity and Development in Solidarity as a memorandum for the OECD DAC evaluation process. December 2007

39 See also http://www.cttcampaigns.info/documents/fr/landau_en/Landau1.pdf

40 See also p. 12 of the *Plan d'Affairs 2008* published by the Agence Française de Développement, June 2008

de Développement (AFD), decreased from € 1,500,000 in 2006 to € 0 in 2007. However, the same report indicates that multilateral contributions have increased from a total of € 56,348,741 in 2006 (and € 39,607,399 in 2005) to € 162,413,253 in 2007. The main beneficiaries of this increase are GFATM - from € 55,981,002 in 2006 (€ 39,333,938 in 2005) to € 130,286,805 in 2007 - and UNITAID which received € 31,572,500 in 2007, the year of its inception. In addition France demonstrates its commitment to research activities by increasing its funding for research from € 8,000,000 in 2005, through € 8,609,786 in 2006 to € 9,400,000 in 2007.

Germany

In its coalition agreement of 11 November 2005, the German Federal Government defined the fight against poverty as one of the priorities of Germany's engagement in Africa. In addition, it committed to achieving the targets of spending 0.51 percent of GNI by 2010 and 0.7 percent of GNI by 2015 on official development assistance (ODA).[41]

The white paper on development policy (*Weißbuch zur Entwicklungspolitik*) by the German Ministry for Economic Cooperation and Development (BMZ) of June 2008, states that health is a focus of German development policy. Within Germany's health development policy, horizontal programs play a vital role to improve health services through the establishment of health and social security systems. Malaria control measures are basic components of bilateral primary health care projects[42] and are thus integrated in Germany's development policy health interventions.

Germany's bilateral and multilateral health ODA spending has continuously increased in recent years: until 2007 the German Government had been allocating € 300 million for the fight against HIV/AIDS, malaria and tuberculosis. In 2007, this amount increased by € 100 million to a total of € 400 million. After the G8 Heiligendamm Summit in 2007, Germany pledged € 4 billion for health programs in developing countries for the period 2008-2015 (€ 500 million annually). As a result, German health ODA spending in 2008 reached € 500 million.[43]

In terms of multilateral health spending, Germany supports global malaria control efforts primarily via the Global Fund. During the Global Fund Replenishment Conference in September 2007 in Berlin, Germany committed € 600 million for the period 2008 to 2010. As of May 2009, the total contribution of Germany to the Global Fund since 2001 amounted to € 637.5 million,[44] of which approximately 25 per cent can be attributed to the fight against malaria. Germany also indirectly contributes to other multilateral malaria control efforts such as UNICEF, WHO and the World Bank. Until 2006, Germany also funded the Roll Back Malaria (RBM) Partnership.

In comparison to Germany's political and financial support to GFATM as well as Germany's support for two innovative financing mechanisms managed by the Fund: the Affordable Medicines Facility for malaria (AMFm) and the Debt2Health initiative, Germany's bilateral malaria-specific programs only accounted for € 3.6 million in the period from 2003 to 2007.[45]

In its bilateral aid policies on health Germany recognises that, in developing countries, health systems need to be supported and strengthened as there is a shortage in funding, weak health infrastructures and a lack of qualified staff, particularly in rural areas. Equity in access to health services is often non-existent with large differences in

41 http://www.bundesregierung.de/nn_22994/Content/DE/StatischeSeiten/Breg/koalitionsvertrag-9.html
42 Bundestag printing paper 16/7965 of 01 February 2008.
43 http://www.bmz.de/de/presse/pm/2007/juli/pm_20070704_82.html
44 See „pledges and contributions", http://www.theglobalfund.org/en/
45 Bundestag printing paper 16/7965 of 01 February 2008.

the quality of health systems between urban and rural areas. Germany's development cooperation in support of health is therefore focussing on the following[46]:

- Support to the development of a health policy strategy in line with the partner country's economic and social requirements;
- Support for the development of training schemes and proper employment conditions for health workers;
- Strengthening of management, representation and job-efficiency for staff in health systems;
- Promotion of the involvement of communities in health and social policy decision making;
- Support for the decentralisation of health structures to the regional and local level;
- Support for the development of a social security system.

To implement this policy GTZ, the German development agency, developed the BACKUP initiative. The acronym stands for Building Alliances, Creating Knowledge and Updating Partners.

When looking more in detail at actual spending on malaria as reported to the European Alliance Against Malaria, it can be seen that Germany's contributions to multilateral organisations has seen variations. While reported bi-lateral aid over the period 2005-2007 increased from € 955,000 in 2005, over € 1,038,460 in 2006, to € 1,384,970 in 2007, the overall contribution to multilaterals has fluctuated between € 21,731,112 in 2005, € 18,389,803 in 2006 and € 22,418,592 in 2007. Multilateral organisations such as GFATM - with a contribution of € 20,719,639 in 2005, € 17,556,850 in 2006 and € 17,556,850 in 2007-, UNICEF – € 11,920 in 2006 and € 372,245 in 2007- and the RBM - € 280,000 in 2005 and previous years, but € 0 in 2006 and 2007- will have been affected by these fluctuations.

Greece

Since 2000 Greece has slowly increased its bi-lateral development cooperation focussing on the achievement of the MDGs. It allocates some 0.17% of its Gross National Income to Official Development Assistance to be channelled through bi-lateral development aid activities, support to multilateral development initiatives or through activities initiated by NGOs.

In 2006 Greece spent 12.63% (€ 19.04 million) of total ODA (€ 142.28 million) on health. Of this contribution € 0.42 million went to research and training, € 18.34 million went to health system strengthening and € 0.09 million to infectious disease control[47]. In 2007 the percentage to health decreased to 11.03% with € 0.07 million spent on malaria.

Ireland

In its *White Paper on Irish Aid (2006)*[48] the Irish Government states that it is committed to developing programmes that address the root causes of illness and poor health among the poorest and most vulnerable people and to strengthening health systems. Research is another of Ireland's entry points for the fight against poverty-related diseases. In its bilateral support for development cooperation the Irish government will be moving away from project support towards Budget Support to ensure longer term, predictable funding in line with the recipient country's own national policies – including health. This can either be done through Area-Based Programmes in cooperation with regional authorities, through Sector-Wide Approaches leading to sector budget support or through general budget support. In its publication *Programme for Government 2007-2012 'A Blueprint for Ireland's*

46 See also Bundesministerium for wirtschaftliche Zusammenarbeithttp://bmz.de/de/themen/gesundheit/menschenrecht_gesundheid/Gesundheitssystemen
47 See also p. 121 in *Annual report of Greek bi-lateral and multilateral official development cooperation and assistance, year 2006* on http://www.hellenicaid.gr/appdata/documents/hellenic_eng_lq.pdf
48 http://www.irishaid.gov.ie/whitepaper/assets/White%20Paper%20English.pdf

Future'. Progress Report on Commitments[49], the Irish Foreign Ministry announced an increase in ODA for 2008 to a total of € 899 million. Of this it allocated € 100 million to the response to HIV and other communicable diseases, through amongst others GFATM and GAVI[50].

The Irish government sees cooperation with multilateral organisations, global health partnerships and regional institutions as important channels to support health in developing countries, though recent (late 2008 and 2009) and significant cuts in ODA are evidence of regression in general levels of support.

Italy

In the past Italy has not actively complied with its commitment on development cooperation. However, in the last few years a change had taken place. Development cooperation was recognised as a centre-piece of Italian foreign policy and Italy stepped up its development aid. Traditional health care would be one of Italian Cooperation's sector priorities, with a strong focus on the involvement of local communities. In addition Italy would include a strong global approach through the various global initiatives. As a first step it would fulfil its previous financial commitments to the GFATM and step up contributions in subsequent years with the intention of guaranteeing a functional and constant flow of funding[51]. Two other initiatives Italy supports are the Advanced Market Commitments for Vaccines (AMC) programme and the International Finance Facility for Immunisation Company (IFFIm).

In 2008 Italy continued its increased support for development aid, with health still as one of its priority areas. In answer to health needs, particularly in Africa, Italy commited to invest in training, materials, hospitals and doctors. Moreover, in its policy document on development cooperation for 2008[52] it focuses on the need to involve and increase its dialogue with civil society in its development activities by, for instance, including representatives of civil society in its delegation to the GFATM Board meeting. However, in relation to the response to malaria neither document discussed here refers to malaria-specific bi-lateral activities.

When looking at the actual spending by Italy on the response to malaria as reported in the Toyako report by the G8 Health Experts Group[53], it is clear that the response to malaria has decreased from € 2,130,000 in 2005, to € 40,000 in 2006 and € 0 in 2007. The contribution to the Global Fund rose from € 22,800,000 in 2005 to € 32,800,000 in 2006 and in 2007.

Luxembourg

Health is one of the priorities for both bi-lateral and multilateral development cooperation. In 2007 Luxembourg reported to have supported activities in its partner country on health system policies, policy making for health in development, addressing the human resource crisis for health, support for communicable diseases, training of doctors and health care technology management. In addition Luxembourg contributed funding to the Roll Back Malaria Partnership (€ 560,000), to the WHO Tropical Diseases Research Programme (TDR) and to the GFATM (see for amounts below). No malaria-specific activities were reported on[54].

49 *Published by the Irish Department of Foreign Affairs, September 2008. http://193.178.1.117/attached_files/Pdf%20files/ForeignEnglish.pdf*

50 Ibid. p. 17

51 See also *Forward Planning and Policy Paper on Development Cooperation activities in 2007* on http://www.cooperazioneallosviluppo.esteri.it/pdgcs/italiano/Pubblicazioni/pdf/RelazionePrevisionale2007-en.pdf

52 See *RElazione Previsionale e Programmatica sulle attiva' di Cooperazione allo Sviluppo nel'anno 2008* on http://www.cooperazioneallosviluppo.esteri.it/pdgcs/italiano/Pubblicazioni/pdf/RelazionePrevisionale2008-it.pdf

53 See also p.8 in the annex to the report on http://www.g8.utoronto.ca/summit/2008hokkaido/2008-healthexperts-annex.pdf

54 See also *Rapport Annual 2007. La Cooperation Luxembourgeoise au Dévellopement* on http://www.mae.lu/images/biblio/biblio-250-20_hsrvu_9528_5869_1622.pdf

The Netherlands

In 2007 the Dutch government presented the *Kabinetsagenda 2015*[55] setting out the Cabinet's policy intentions in relation to the achievement of the MDGs for the following four years. Although it recognises that the fight against malaria is stagnating, it prefers to focus its aid on improving health systems and ensuring a better harmonisation between horizontal and vertical approaches. Aid should preferably be demand-based instead of supply driven. It also intended to focus on easier access to and cheaper medicines, by ensuring better financing systems and global agreements within the framework of Trade Related Aspects of Intellectual Property Rights (TRIPs). However in 2008 it became clear that malaria would only be supported by the Netherlands through its contribution to the GFATM. The focal areas for health would be the response to HIV and AIDS and support for Sexual and Reproductive Health and Rights. However, as part of the activities for those two areas the Dutch government envisaged a sector approach aimed at health system strengthening and improving the situation of the shortage of health workers in developing countries.

It is interesting to note that in its budget overviews for the period 2005- 2006[56] it reports bi-lateral spending of € 71,851,000 for 2005 and € 87,642,000 in 2006 for support for HIV and AIDS, Malaria and TB and a contribution to the GFATM of € 46 million and € 45 million respectively, while in 2007 and 2008 the figures increase to € 89,643,000 and € 97,354,000 respectively, with a simultaneous increase to € 60 million in both years for the GFATM. This is to change in 2009 when the bi-lateral contribution for HIV and AIDS, malaria and TB will decrease to € 92,495,000, while the contribution to the GFATM increases to € 80 million[57].

Portugal

In its *Strategic Vision for Portuguese Development Cooperation*[58] (2006), the Portuguese Ministry for Foreign Affairs sets out its strategy for development cooperation for the next few years. Health is one of the focal areas for development aid. Support to primary health care and hygiene are seen as a guarantee that basic needs are addressed. In order to ensure equal access it also stresses the need to develop a comprehensive system for social protection in developing countries, which will cover the whole population. In its bi-lateral support it does not target malaria as such, but it contributes to the GFATM, thereby indirectly supporting the response to malaria. Of a total of some € 344 million spent in 2007 by the Portuguese Development Agency IPAD, € 7.87 million was spent on health, while € 2.06 million was allocated to the GFATM[59].

Spain

In November 2005 the Spanish Ministry of Foreign Affairs and Cooperation published its *Master Plan for Spanish Cooperation 2005-2008*[60]. The Master Plan acknowledges health as a fundamental human right and a key condition for a decent life. Spanish development cooperation therefore commits itself to help reinforce public healthcare systems, focussing particularly on primary care to ensure universal, equitable and sustainable access to health care. It will do this in close cooperation with other health cooperation donors, international organisations and the governments, particularly Ministries of Health in the recipient countries.

55 Cf. http://www.minbuza.nl/nl/actueel/brievenparlement,2007/06/Kamerbrief-inzake-kabinetsagenda-2015.html, seen on 2 April 2009

56 See *Tweede Kamer, vergaderjaar 2005-2006, 30 803, nrs. 1-2*

57 See also *Homogene Groep Internationale Samenwerking 2009 (HGIS-nota 2009), Tweede Kamer, vergaderjaar 2008-2009, 31 703, nrs. 1-2*

58 *A Strategic Vision for Portuguese Development Cooperation.* Published by the Instituto Português de Apoio ao Desenvolvimento, Ministério dos Negócios Estrangeiros, Lisbon, February 2006. ISBN 972-8975-05-8

59 See also http://www.ipad.mne.gov.pt/index.php?option=com_content&task=view&id=200&Itemid=220

60 *The Master Plan for Spanish Cooperation 2005-2008.* Published by the Ministry of Foreign Affairs and Cooperation, State Secretary of International Cooperation. Madrid, Spain. 2005

In relation to the response to malaria the following strategic lines and actions are important to note:

- Support for the institutional enhancement of public health systems with special attention to:
  - Reinforced support and technical assistance for planning and management in Health Ministries and public healthcare institutions;
  - Support for the decentralisation of health services to improve universal access to healthcare;
  - Reinforcement of the Systems for Management of Information and Epidemiological Vigilance;
  - Improvement of the capacity of national immunisation programmes;
  - Support to management and training of human resources for health;
  - Support for regional and sector health initiatives.
- Fighting prevalent and forgotten diseases by
  - Promoting prevention through education, information, communication and training of (non)health personnel;
  - Ensuring access to effective diagnoses and treatments;
  - Improving universal access to health systems, particularly in rural areas;
  - Supporting and promoting research on malaria, including the development of new tools and strategies for the prevention, diagnosis and treatment of communicable diseases;
  - Support world programmes and international organisations in their fight against malaria, particularly focussing on the prevention of malaria during pregnancy and healthcare for the infant population. In addition alliances in the private sector will be supported to ensure the sustainability of treatment and a sufficient supply of insecticide treated nets and of ACTs.

Although many Spanish ministries and the regional governments contribute to development cooperation, the Spanish Agency for development cooperation (AECI) managed an overall budget of € 745,349,767 for the year 2007, of which it disbursed € 658,662,475[61]. The spending on health in 2007 is reported as € 86,603,617 (a significant increase from the € 42,414,776 reported in 2006)[62].

Sweden

In its Policy Document *Global Challenges-Our Responsibility. Communication on Sweden's policy for Global Development*[63] the Swedish government states that HIV and AIDS, tuberculosis, malaria, diarrhoea and respiratory diseases still claim the largest number of lives in sub-Saharan Africa. This calls for carefully considered health promotion initiatives, including structural measures outside the health sector, such as education, sanitation and nutrition. The Swedish government has chosen to prioritise health promotion and preventive health programmes, sustainable healthcare systems and early warning systems for communicable diseases as part of its development policy on health. It points out that national governments have the primary responsibility for their health care systems, but need to be supported by the donor community. As main challenges for ensuring good health in sub-Saharan Africa Sweden identifies a lack of a sound basic health infrastructure, a shortage of health care personnel and of medicines and weak management systems. Based on its extensive expertise in the field of health system development, the Swedish government identified among others the following activities for its health interventions, which can impact the response to malaria:

- To ensure access by poor people to sustainable health systems and essential medicines. This means that it will support health system strengthening, inter alia through training of health care personnel and support capacity development, including on knowledge and innovation systems and the development and transfer of new technology;
- Promote, particularly at the EU and global level, the TRIPS Agreement and pursue the issue of access to essential medicines in negotiations on a global strategy and action plan for public health, innovation and intellectual property rights;
- Continue to support clinical testing of experimental vaccines against HIV and AIDS, malaria, tuberculosis, diarrhoea and respiratory diseases.
- Continue to press for an effective EU system for cooperation on issues relating to public health threats and seek to ensure that work in this area is such that it promotes cross-sector cooperation;
- Contribute to the strengthening of knowledge-based activities in the WHO;
- Strengthening preventive efforts to combat communicable diseases on the basis of the strategic action plan against communicable diseases.

Although Sweden has given project support as a useful way of promoting development cooperation, it intends to move more to budget support amongst others for contributions to health care. Budget support will enable recipient countries to implement their own strategies for poverty reduction in line with the Paris Declaration's requirement of increased ownership[64]. It can be supplemented by other forms of assistance such as project support though. In 2006 budget support accounted for just over 5% of total Swedish bilateral assistance, but this will be increased where the appropriate conditions, for instance on governance and accountability, exist. The Swedish government however acknowledges that this will make it more difficult to monitor expenditure, for instance on health care or the response to malaria.

In 2007 Sadev, the Swedish Institute for the Evaluation of Development Cooperation, calculated that Sweden allocated 419,131,473 Swedish Kroner (i.e. some € 45,307,301 in 2007 conversion rates) to health and 551,142,848 Swedish Kroner (i.e. some € 59,577,476 in 2007 conversion rates) to research[65].

Interviews with officials in Sweden working in the Ministry for Foreign Affairs and SIDA, the Swedish implementation agency, have indicated that Sweden is not actively supporting bi-lateral projects in relation to the fight against malaria. However, according to these sources, it invests in research by supporting the WHO Tropical Diseases Research (TDR) programme, contributing around € 2,327,000 in 2008, 20% of which is to be spent on malaria. Likewise it contributed some € 1,862,000 to the European and Developing countries Clinical Trials Programme (EDCTP). In addition SIDA supports the European Malaria Vaccine Initiative (EMVI) and the Multilateral Initiative on Malaria (MIM) (see below for exact figures).

The United Kingdom (UK)

Achieving the Health MDGs[66] is an important target of the UK's Department for International Development (DFID). In 2007 The UK adopted its health policy for development cooperation *Working together for better health,* setting out the strategy for DFID's support to the health sector in developing countries. By using its expertise in developing systems that deliver health services, its flexibility to create new approaches and its system of decentralisation to improve close cooperation with partner countries, DFID believes it can have an important impact on improving health in the developing world. It identifies three challenges to achieving good health: the high burden of disease; weak health systems and poorly coordinated international support. By focusing its aid on four priorities:

61 See also *Seguimento del PACI 2007*, the report on Spanish performance in relation to development cooperation in 2007, published by the Ministry for Foreign Affairs and Cooperation in 2008

62 Ibid.

63 Published by the Government Offices of Sweden, Ministry for Foreign Affairs. Stockholm, Sweden, 2008. ISBN 978-91-7496-382-2

64 See also http://www.sida.se/sida/jsp/sida.jsp?d=1357&a=25012&language=en_US

65 See also http://www.sadev.scb.se/sv/Dialog/varval.asp?ma=Data1998_2007_bilateralt_sv&ti=Svenskt+bilateralt+utvecklingssamarbete+f%F6rmedlat+genom+Sida&path=../Database/SADEV/bilateralt/&lang=2

66 MDG 4: Reduce Child Mortality; MDG 5: Improve Maternal Health; MDG 6: Combat HIV/AIDS, malaria and other diseases, with as special malaria related targets: **Target 8.** Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases and **the indicators**: 21. Prevalence and death rates associated with malaria, 22. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures.

- Delivering more resources for health;
- Expanding access to basic services;
- Improving the effectiveness of international funding for health;
- Demonstrating results and building evidence of what works.

DFID aims to improve the health situation for poor people. It will do so in close cooperation with national governments. Health system strengthening is therefore one of the areas DFID will be supporting by

- Ensuring equal access to health care by
  - promoting cost-effective interventions,
  - expanding the role of non-doctors in delivering basic surgery and treatment of common conditions,
  - Offer incentives to recruit and retain.
- Forging strong health systems by
  - Supporting viable policies,
  - Funding commitments,
  - Creating incentives for Research and Development,
  - Promoting knowledge transfer,
  - Offering training in specialities with high diseases burden, such as malaria.

In relation to the response to malaria the UK focuses on

- Expanding preventive treatment for pregnant women,
- Providing universal access to treated bed nets,
- Providing insecticide sprays for indoor use,
- Ensure the availability and use of cost effective drugs especially Artemisinin combination therapies.

In its bi-lateral development aid DFID uses not only general budget support, but also sector budget support for health and project and programme funding depending on governance related criteria adhered to within the partner country.

Prior to 2007 DFID supported, for instance, the GFATM, GAVI and UNITAID and while it recognizes that the cooperation between the various multi-lateral initiatives could be improved it committed itself to continue its support to these initiatives but at the same time promote a more coherent international approach through a better division of labour in line with national priorities of recipient countries.

Research and development (R&D) also play an important role in the UK's support for the health sector in the developing world. It focuses on three research priorities:

- Research to make health programmes more effective. For malaria this means research to help increase the impact of programmes that tackle malaria, e.g. insecticide treated nets, insecticide sprays for indoor use and more effective anti-malaria drugs;
- Research into improving health systems with a special focus on improving financial and human resources, improving the way health services are delivered and organised, managing political processes and knowledge on heath system strengthening and analysing global influences;
- Developing drugs and vaccines for priority diseases and getting them to poor people. It aims to promote through public/private partnerships, market research and research into barriers for the introduction of new technologies, including research on political and social issues that influence the creation of such barriers.

For the period 2007-2008 the UK had allocated some £ 50 million[67] of its overall research budget to health and £ 8 million[68] to research communication, synthesis and impact, both to be increased in the following years. In addition it expected to fund Global Health Partnerships with the overall amount of £ 24,201,000 for 2007 and £ 36,000,000 for 2008[69].

Data on actual expenditure on the response to malaria relayed by DFID to the European Alliance Against Malaria shows that both bilateral and multilateral aid have been somewhat volatile. Bi-lateral aid moved from £ 100,900,000 in 2005, through £ 110,200,000 in 2006 to £ 99,700,000 in 2007, while overall multilateral contributions to health and the response to malaria have moved from £ 32,300,000 in 2005, through £ 34,200,000 in 2006 to £ 21,000,000 in 2007. The contribution to the GFATM has increased from £ 17,700,000 in 2005 to £ 19,000,000 in 2007, while the Medicines for Malaria Venture received sustained funding to the amount of £ 2,000,000. In addition DFID increased its support to research from £ 8,500,000 in 2005, through £9,000,000 in 2006, to £ 10,000,000 in 2007, showing its strong commitments to the development of innovative ways to prevent and treat malaria.

The new EU Member States

Although many former Soviet Union States have a history of development assistance, it differed somewhat from the EU system of development cooperation. Since joining the EU, these states are redefining their development aid in line with the European Acquis and the European Consensus on Development Cooperation. However, their main geographical focus is on the near neighbourhood countries in Eastern and Southern Europe. Health is seldom a priority area, and will mainly be covered through their contributions to the EU budget and the EDF.

4.2 Existing Funding and Funding Mechanisms used by the EC and the EU Member States

This section looks at the different funding mechanisms the EU and the EU Member States have at their disposal to support health and particularly the response to malaria. It will also include data on actual EC and EU Member States' spending on health and malaria, where available. As the EU Member States contribute to the EU budget and the European Development Fund (the Financial Instrument for Development Aid for African, Caribbean and Pacific (ACP) countries), it will be important to focus on the European Commission's contribution to the response to malaria.

4.2.1. The EC

The European Commission has primarily two financial instruments for development cooperation at its disposal: the *Development Cooperation Instrument* (DCI) and the *European Development Fund* (EDF). The DCI is part of the Community budget, which means that the European Parliament can exert its full right of co-legislation and parliamentary scrutiny. The EDF is an intergovernmental financial instrument, directly funded by the EU Member States. The European Parliament does not have any legislative powers over the EDF, meaning that it cannot influence spending allocations; however it is annually requested to agree to the discharge of actual spending through the EDF. The EDF and the DCI cover different geographical regions: the EDF covers the African, Caribbean and Pacific (ACP) countries in line with the Cotonou agreement, while the DCI covers the countries in Asia and Latin America. In addition the DCI includes the thematic Programme for Human and Social Development,

67 See also p.36 in *Research Strategy 2008-2013* published by DFID, London, 2008
68 Ibid
69 See p. 247 in *Development: Making it happen. 2008 Annual Report*. Published by DFID, May 2008. http://www.dfid.gov.uk/pubs/files/departmental-report/2008/Cover-prelims.pdf

Investing in People, with the budget line *Good health for all*[70], and the Programme for support to Non-State Actors and local authorities, which covers the whole of the developing world.

While in the past the EC budget consisted of separate budget lines for geographic, thematic and specific policies and activities, based on the Financial Perspectives 2000-2006, the EU restructured its financial system when developing the financial framework for 2007–2013[71] in 2005. This resulted in serious reform of the EU financial instruments. For Development Cooperation the DCI was formed and allocated € 17 billion for the period 2007-2013. A separate Humanitarian Aid Instrument, funding emergency aid, including support for anti-malaria activities where needed, was put in place and allocated € 5.6 bn. The 10th EDF, which covers the period 2008-2013, was allocated € 22.7 bn.

EDF

The allocations and disbursement through the EDF are mainly based on the Country Strategy Papers (CSPs) developed in close cooperation with the recipient country. This means that support for anti-malaria policies and activities need to be included in the country's national action plans and the EC's indicative programmes which inform the CSPs. As mentioned above the EC uses General and Sector Budget Support as its favoured financial modality, aiming to achieve a rate of 50% of its aid delivery through Budget Support in the near future. It will therefore be extremely difficult to monitor EC funding for the response to malaria as a vertical sector. Funding for health in general through both the 9th and the 10th EDF has been and is low as fig. 2 shows:

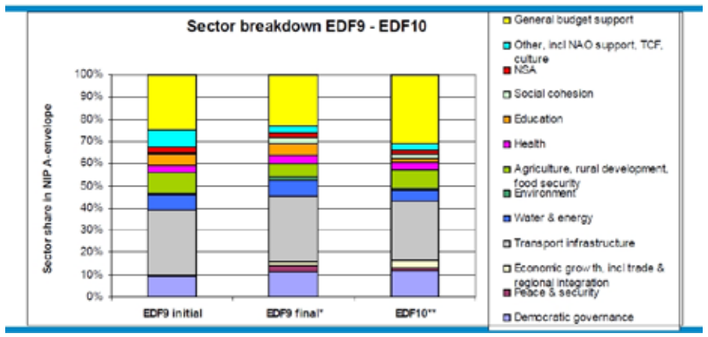


Fig. 2:
10th EDF programming results (7)

Source: EuropeAid lunch conference presentation Sept. 2008

This is also clearly shown in the allocation for health in 2008 through the EDF, where a total of € 322.9 million was allocated, which represents 3.3% of the overall budget for 2008. Although this still compares favourably to the ultimate allocation of 2.9% of the overall budget in the 9th EDF (for the period 2000–2006)[72], it is still far from the 20% allocation to basic health and education requested by the European Parliament.

Besides funding individual ACP partner countries the EDF also allocates funding to the Intra- ACP cooperation programme which is to jointly benefit the majority of ACP countries. For instance, in 2007 € 38 million of unspent funding from this programme was used for additional support for the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)[73].

70 EU Budget, Heading: 21 05 01 01
71 Financial Perspectives 2007-2013
72 DEV-C/1.7/06/2007
73 See also Art. 2.1.k in *Decision no. 1/2007 of the ACP-EC Council of Ministers,* Adopted May 2007. http://eur-lex.europa.eu/Notice.do?mode=dbl&lang=en&ihmlang=en&lng1=en,nl&lng2=bg,cs,da,de,el,en,es,et,fi,fr,hu,it,lt,lv,mt,nl,pl,pt,ro,sk,sl,sv,&val=451672:cs&page=

In 2008 the European Court of Auditors published a report on the *EC's Development Assistance to Health Services in Sub-Saharan Africa*[74]. It begins by commenting that EC funding for the health sector has not increased since 2000 in spite of its commitments to the MDGs and the health crisis, particularly in sub-Saharan Africa. The report only focuses on EDF performance in sub-Saharan Africa and also excludes the health interventions by the European Commission Humanitarian Office (ECHO). If the contribution to health through the Intra-ACP Cooperation Programme (over the period 2001 – 2007 it disbursed € 292.5 million to the health general budget lines and € 330 million to the Global Fund) is added to the funding for health through the geographical contributions of the EDF, the Commission spent € 770.6 or 5.5% of the 9th EDF budget on health.

The report also notes that in many EC delegations staff believe that there was too much disease-specific spending, mainly on the response to HIV and AIDS. Yet the Court of Auditors noticed that this did not result in increased support through the delegations for health system strengthening – one of the activities recommended by the GMAP as an important instrument in the fight against malaria-, partly due to the lack of health expertise in the respective delegations (only 4 delegations have full-time EC staff working on health). While General Budget Support is currently the preferred EC tool for development cooperation, EC delegations admit that it is not efficient in achieving the objective of improving health systems. While Sector Budget Support offers a much stronger focus on the sector, the Court found that it was mainly used in two countries that had health as a focal area. It therefore concludes that it is minimally used in sub-Saharan Africa. In malaria-endemic ACP countries this can mean that the EC does not contribute to the best of its capacity to the fight against malaria either through health system strengthening or malaria-specific actions.

DCI

In December 2006 the EC published the Regulation on the Development Cooperation Instrument in the *Official Journal of the European Union* [75] setting out the areas of cooperation to be financed under the Regulation. It clearly states that among others geographic programmes shall include actions addressing the essential needs of the population with prime attention to education and health. The actions for health should include[76]

- actions to address poverty diseases, in particular HIV/AIDS, tuberculosis and malaria,
- increase access to and provision of health services for lower income population groups and marginalised groups,
- strengthen health systems in order to prevent human resource crises in the health sector,
- enhance capacities particularly in areas such as public health and research and development.

As in case of the EDF the funding through the DCI is based on country and regional strategy plans. These are based on country ownership and usually limit themselves to two focal areas which receive the bulk of the funding either through budget support or project/programme funding. It depends therefore on the recipient country whether the issue of the fight against malaria will be addressed with EC financial support.

In addition the Regulation defines various Thematic Programmes which are not defined geographically as they are subsidiary to the geographic programmes and focus only on specific themes, such as health. They are to be implemented by or through intermediary organisations such as NGOs, International Organisations or multilateral mechanisms and they do not need the agreement of partner governments[77]. Human and Social Development is supported by the thematic programme *'Investing in People'.* It will cover all ODA countries, with a particular

74 European Court of Auditors Special report no. 10/2008
75 Regulation (EC) No 1905/2006 of the European Parliament and of the Council of 18 December 2006 establishing a financing instrument for development cooperation , OJ L 378/41 of 27 December 2006
76 Ibid Title II, Art. 5.2.b
77 Ibid. Title II, art 11

focus on those with the worst indicators in individual areas of human and social development. Investing in People includes a separate programme: Good health for all.[78] This programme aims to among others

- fight against poverty diseases targeting the major diseases such as malaria by
  - Increasing the affordability of key pharmaceuticals and diagnostics in accordance with the provisions of the TRIPS Agreement;
  - Encourage public and private investment in research and development for new treatments and new medicines;
  - Support global initiatives including the GFATM.
- Improve equitable access to health providers, commodities and health services by supporting among others:
  - Interventions to address the human resource crisis in health;
  - Health information systems with the ability to generate, measure and analyse disaggregated performance data to ensure better health and development outcomes and sustainability of delivery systems;
  - Fair mechanisms for financing equitable access to health care.

The *"Investing in People"* Strategy Paper for the thematic Programme 2007-2013[79] describes the proposed focus of the thematic programme for the period 2007-2013. In relation to health the main issues to be taken up are the human resource crisis in health care systems, improved access to prevention, care and support in relation to fighting the three major diseases, including malaria, and strengthening the EC's pivotal leadership, fund-mobilisation and monitoring role in the GFATM. The funding is to be disbursed through contributions to global partnerships, direct agreements, tenders and calls for proposals. In the period 2003-2006 the EC allocated € 108.8 million annually to health, 78% of which went to the three major diseases through contributions to the GFATM, the European and Developing Countries Clinical Trial Partnership (EDCTP) and calls for proposals. Although the thematic programme for 2007 – 2013 offers an increase of funding of nearly 30% resulting in a total of € 1.060 billion for the period, this includes funding for non-health related interventions such as education, vocational training, employment and culture. Although the health pillar will receive 55% of the funding within the thematic programme, it will still mean a reduction of 23% in annual funding for health compared to the period 2003-2006. What does this mean for the support for the response to malaria?

When analysing the Annual Action Programmes for the implementation of the *Good Health for All* pillar in *Investing in People* for 2007 and 2008, it is clear that the programme will not directly support malaria specific activities. For 2007 it allocates € 62 million to the GFATM through the signing of a tri-partite contribution agreement with the World Bank (WB). For 2008 the Annual Action Programme included support for strengthening health systems and services in response to the human resource crisis and support for the fight against the main communicable diseases (HIV/AIDS, TB and malaria) and neglected and emerging diseases. For the first action it set aside € 6 million for a project led by WHO on *Strengthening health workforce development and tackling the critical shortage of health workers*. This includes a mapping and analysis of human resources for heath and for developing global and regional coordination and response strategies. The second disbursement consists of a contribution to the GFATM of € 50 million in addition to contributions to the response to HIV and AIDS, GAVI and WHO. The multi-annual programme for 2007-2010 shows that Health System Strengthening will receive € 6 million in 2008, € 7 million in 2009 and € 8 million in 2010, while the GFATM received € 62 million in 2007, € 50 million in 2008 and can expect € 50 million in 2009 and 2010. How far the response to malaria will benefit from these contributions will depend on the Global Fund.

78 Ibid. Titel II, art. 12
79 *http://ec.europa.eu/development/icenter/repository/how_we_do_strategy_paper_en.pdf*

As referred to above the European Parliament has insisted (since 2000) that EU development aid should allocate 35% of its aid to ODA countries to social infrastructure and services. In addition a benchmark of 20% of the allocated assistance under country programmes needs to be dedicated to basic education and basic health. It is clear that so far this benchmark has not been achieved either for the EDF or the DCI. The EC committed itself to ensure that as of 2009 the benchmark of 20% is achieved through the DCI, but no guarantees have been given for the implementation of the EDF.

Research

An additional source of funding for the fight against malaria is the EU's Framework Programme for research and technological development, which invests in research on malaria. In 2006 the EU adopted the *7th Framework Programme (FP) of the European Community (EC) for Research and Technological Development*[80] with an overall budget of € 50,521 million for the period 2007-2013. The Programme consists of four specific programmes: Cooperation, Ideas, People and Capacities. The most important programme for the malaria community is the Cooperation Programme with a budget of € 32 billion, which includes the theme 'Health' with a budget of € 6,100 million. For International Cooperation the FP7 sets aside € 185 million to be used for international cooperation in all the Programmes of FP7. Based on bi-lateral cooperation agreements and multilateral dialogues between the EU and the partner countries the Programme will support cooperative activities targeting developing and emerging countries focussing on their particular needs in various fields including health, to be implemented in financial conditions adapted to their capacities.

On the theme of health the FP7 budget allocated for 2007 was € 670 million (€ 61 million paid), for 2008 € 695 million (€ 428 million paid) and for 2009 € 681 million is committed, with € 463 million expected to be paid. The difference between commitments and payments is based on the fact that some projects can be implemented over one year or over more years. One of the focal areas within the research on health is research on infectious diseases, including malaria. It is interesting to note that of the 32 projects accepted in 2008, 9 were focussing on malaria, ranging from research into mosquito strains (vectorial research), multi-drug resistance and infections during pregnancy. Some € 27 million was allocated for these projects[81].

4.2.2. The EU Member States

Besides allocating funding to the EU Budget the EU Member States also contribute bi-laterally to development cooperation. Below is an overview of what the Member States reported to the OECD DAC as their spending on overall development aid and to health and basic health in particular. Since 2007 the OECD DAC introduced a new purpose code in its Creditor Reporting System (CSR): 12262 on malaria control which collects donor data on prevention and control of malaria. The figures below on disbursements to malaria are based on the figures reported by the donors to the OECD DAC.

80 Council Doc. No 16887/06
81 See also http://cordis.europa.eu/fetch?CALLER=FP7_PROJ_EN&QZ_WEBSRCH=malaria+research. Seen on 26/3/2009

Table 2

Overview of EU Member States' bi-lateral Spending on Health, Basic health and malaria

Country	NET ODA in 2007 in USD and Euro million[82]	Percentage of GNI going to ODA in 2007[83]	Spending on Health in 2007 in % of ODA[84]	Spending on Basic Health in 2007 in %[85]	Disbursements to malaria in 2007 in USD and *Euro* million[86]	Disbursement to malaria in 2007 in % of ODA[87]
Austria	1,808 *1,319.84*	0.50	2.0	1.3	0.17259979 *0.12599785*	0.00010
Belgium	1,953 *1425.69*	0.43	7.6	4.5	2.5654798 *1.87280025*	0.00131
Bulgaria	N/A				N/A	
Cyprus	N/A					
Czech Republic	179	0.11				
Denmark	2,562 *1870.26*	0.81	5.2	0.4	N/A	
Estonia	N/A					
Finland	981 *716.13*	0.39	3.2	2.9	0.07597947 *0.05546501*	0.00003
France	9,884 *7215.32*	0.38	2.1	0.4	N/A	
Germany[88]	12,291 *8972.43*	0.37	2.6	1.6	0.0134155 *0.00979332*	0.000001
Greece	501 *365.73*	0.16	11.3	10.0	0.10020534 *0.0731499*	0.00020
Hungary	103	0.08				
Ireland	1,192 *870.16*	0.55	15.1	8.2	2.62687351 *1.91761766*	0.00220
Italy	3,971 *2,898.83*	0.19	6.3	2.6	N/A	
Latvia	N/A					
Lithuania	N/A					
Luxembourg	376 *274.48*	0.91	14.6	9.6	N/A	
Malta	N/A					
Netherlands	6,224 *4,543.52*	0.81	2.5	1.4	4.0361 *2.946353*	0.00065
Poland	363	0.09				
Portugal	471 *343.83*	0.22	3.9	0.6	N/A	
Romania	N/A					
Slovenia	N/A					
Slovakia	67	0.09				
Spain	5,140 *3,752.2*	0.37	5.3	4.4	2.32820124 *1,69958691*	0.00045
Sweden	4,339 *3,167.47*	0.93	6.1	3.8	N/A	
United Kingdom	9,849 *7,189.77*	0.36	8.1	4.3	34.5146761 *25.1957136*	0.00350
European Commission	11,774 *8,595.02*		0.8	3.0	1.09625161 *0.80026368*	
				Total for malaria	**47.52979352** **34.649656**	

4.3 International Financing Instruments and Partnerships

Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

In 2002 the GFATM was created with the help of the European Commission and EU Member States among others. From the outset the EC played an important role not only when the Global Fund was created, but also in helping it draft the various associated rules and implement its policies. In 2001 Romano Prodi, then President of the European Commission, announced a contribution of € 120 million from the EC budget to the incipient GFATM and since then, together with other EU Member States, the EC has continued its annual funding. At present the EC and the EU Member States provide some 62% of the resources of the Global Fund. As Vice-chair of the Board until 2007, the EC contributed to giving the GFATM its current prominent role as the main source of finance at the global level in the fight against malaria. Since its inception the Global Fund has financed programmes to fight AIDS, TB and malaria with approved funding of US$ 11.4 billion for more than 550 programmes in 136 countries. Globally it provides three quarters of the funding for malaria in the form of distributing 70 million nets to protect families from transmission of malaria and delivering 74 million malaria drug treatments.

The GFATM supports sustainable impact against malaria in three ways:

- Supporting country programmes with partners by leading with prevention and scaling up effective treatment
- Flexible financing of services and systems
- Performance-based funding for impact

In 2007 the GFATM Board decided that countries should also be given the opportunity to apply for funding specifically aimed at strengthening health systems and at responding more directly to gender inequities that impact access to health services. Round 8 will be implementing this request.

When looking at the GFATM spending on the three diseases in Rounds 5 (i.e. US$ 770 million) , 6 (US$ 846 million) and 7 (i.e. US$ 1,119 million) it transpires that in Round 5, US$ 202 million or 27% has been spent on malaria and US$ 38 million or 5% on health system strengthening, in Round 6 US$ 202 million or 24% was spent on malaria and 1% on health system strengthening, while in Round 7 US$ 471 million or 25% was spent on malaria and nothing on health system strengthening. In addition the GFATM will have spent US$ 1,568 million of US$ 2.703 billion on malaria in 2008. For 2008 itself the GFATM reported that it allocated US$ 10.3 billion i.e. signed 581 grants in 137 countries and disbursed US$ 7.2 billion[89]. By 2008 the GFATM had distributed 70 million insecticidal nets, an increase of 54% over one year. It has also supported the treatment of 74 million cases of malaria, with an increasing use of the artemisinin-based combination therapy. For the next two years it foresees the allocation of some US$ 1.6 billion in the form of malaria grants as a result of the largest-ever funding round (Round 8)[90]. It is clear that globally the GFATM is the biggest contributor of aid to the response against malaria.

82 *OECD DAC Statistical Annex of the 2009 Development Cooperation Report.* www.oecd.org/dac/stats/dac/dcrannex

83 Ibid.

84 Ibid, table 19

85 Ibid.

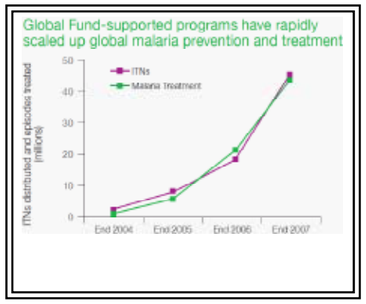
86 Figures are based on the DAC Purpose Code 12262 in the Creditor Reporting system of OECD Statistics extracted 2 April 2009 http://stats.oecd.org/WBOS/Index.aspx?DatasetCode=CRSNEW

87 Calculated by dividing the figure on malaria by the overall ODA.

88 There is some confusion on the figures for malaria for Germany. The figures in the table are the commitments as reported by the EU Member States to the OECD DAC. However, disbursements might be larger depending on previous disbursements or additionally committed funding. The figure for 2007 reported by the German Development Ministry in 2009 is in fact €1,759,215

89 See also http://www.theglobalfund.org/documents/publications/progressreports/ProgressReport2008_high_en.pdf

90 See also Scaling up for impact. Results report. Published by the Global Fund, March 2009



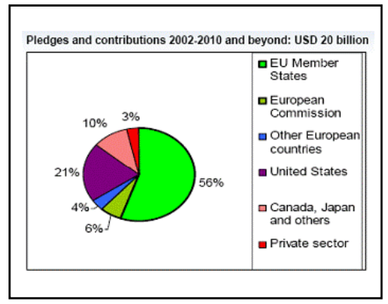


Fig. 4:

Overview of donor pledges to GFATM for the period 2002 – 2010 and beyond.

Table 3

EU Country Pledges for Contributions to the GFATM in US$ and Euro as reported by the GFATM[91].

Country	2006	2007	2008
Belgium	10,295,437 *8,206,915*	16,551,909 *12,093,454*	15,919,141 *10,867,600*
Denmark	23,905,471 *19,056,031*	25,905,777 *18,927,745*	29,397,930 *20,069,232*
Finland	3,636,300 *2,898,644*	3,321,000 *2,426,449*	3,934,250 *2,685,814*
France	292,665,213 *233,295,441*	424,417,829 *310,095,794*	402,731,500 *274,934,727*
Germany	88,114,680 *70,239,824*	116,680,260 *85,251,032*	312,202,200 *213,132,637*
Greece	-	484,260 *453,819*	1,320,800 *901,677*
Hungary	13,000 *10,363*	-	20,000 *13,653*
Ireland	20,416,900 *16,275,148*	27,016,700 *19,739,428*	37,246,688 *25,427,383*
Italy	180,375,000 *143,784,308*	180,375,000 *174,029,785*	186,890,600 *127,585,540*
Latvia	-	-	10,000 *6,827*
Luxembourg	2,571,000 *2,049,450*	3,107,700 *2,270,604*	3,899,250 *2,661,920*
Netherlands	76,768,478 *61,195,301*	82,698,000 *60,415,726*	114,192,000 *77,956,024*
Poland	10,000 *6,827*	-	100,000 *79,714*
Portugal	2,000,000 *1,594,282*	3,000,000 *2,191,914*	3,000,000 *2,191,914*
Romania	-	435,515 *318,204*	66,670 *45,514*
Slovenia	13,285 *10,590*	-	-
Spain	80,161,477 *63,900,000*	100,000,000 *73,063,000*	136,547,085 *93,217,281*
Sweden	82,312,947 *65,615,025*	60,095,251 *43,907,740*	104,797,958 *71,542,946*
UK	125,581,800 *100,106,402*	177,994,000 *130,049,180*	71,626,000 *48,897,280*
EC	117,153,200 *93,387,619*	151,363,270 *110,591,757*	132,760,000 *90,631,933*
Total	**1,105,994,188** ***881,632,170***	**2,273,446,471** ***1,045,825,631***	**1,556,752,072** ***1,062,849,652***

91 See also http://www.theglobalfund.org/en/pledges/

UNITAID

In September 2006 UNITAID was officially launched at the opening session of the UN General Assembly. The initiators, France, the UK, Brazil, Chile and Norway decided to create the organisation as an instrument to combat the high prices for drugs for the poverty related diseases and facilitate access to these drugs for the world's poorest people. From the outset France has been an important driving force, allocating, as the only EU Member State so far, the full amount of its international air ticket tax to UNITAID.

UNITAID's mission is to improve access to treatment, particularly against diseases such as HIV and AIDS, malaria and tuberculosis, by getting lower prices for quality medicines and diagnostics and speed up their availability and delivery in the field. Buying these drugs in bulk (pool procurement) allows them to negotiate lower prices and put pressure on the manufacturers to increase production and consequently lower their prices. In addition UNITAID supports the WHO Prequalification Programme aimed at speeding up the processing of pharmaceutical company applications for prequalification of potentially highly effective drugs such as ACTs, and supporting the testing and sampling of these drugs in the field, in collaboration with national regulatory authorities. By involving the participation of local laboratories the Programme also promotes the development of indigenous research capacity. UNITAID is hosted by WHO and works together with partners such as WHO, UNICEF, UNAIDS, the RBM Partnership, the Stop TB Partnership, GFATM, the Clinton Foundation and the Global Drug Facility, for the implementation of its objectives.

UNITAID directly collects its funds from countries which have introduced an air ticket tax on flights leaving their country. As an innovative financing mechanism the air ticket levy ensures sustained funding allowing UNITAID to ensure long-term commitments. However, so far only France has introduced the air ticket tax among EU Member States. In addition to the air ticket levy some donor countries, such as the UK and Spain allocate multi-year funding to UNITAID. In 2007 UNITAID received US$ 368,900,000, committed US$ 222,400,000 and disbursed US$ 141,800,000. Of this US$ 1,300,000 was spent on ACTs for Liberia and Burundi and US$ 15,600,000 for the scaling up of ACTs[92]. For the 2008 Budget US$ 388,900,000 was expected in revenue and US$ 223,800,000 in commitments. Of this US$ 14,800,000 was allocated to ACT Scale Up and US$ 100,000,000 for ACTs[93].

92 See also p. 45 of the *UNITAID Annual Report 2007*. Published by the WHO in 2008

93 See also pp 2&3 in *UNITAID 2008 Budget*, UNITAID Executive Board meeting, 6-7 December 2007, UNITAID/EB6/2007/10/1

Table 4

Contributions by EU Member States to UNITAID in US$ and Euro

Country	Contribution 2007	Contribution 2008
France	268,354,000 *196,069,630*	236,200,000 *160,000,000*
UK	26,490,000 *19,354,601*	44,200,000 *30,000,000*
Spain	20,435,000 *14,930,588*	22,100,000 *15,000,000*
Total 2007/2008	**315,279,000** ***230,354,819***	**302,500,000** ***205,000,000***

International Health Partnership

In 2007 a group of donors set up the International Health Partnership (IHP) in order to respond to the MDG challenges. Its aim is to accelerate action to scale-up coverage and use of health services, and deliver improved outcomes against the health-related MDGs and universal access commitments. Its key principles are:

- To increase aid effectiveness, improve policy, strategy and health systems performance by mobilising all actors in order to achieve the health-realted MDGs;
- Actions have to be country-focussed and country-led;
- The work will be based on the collaboration within the IHP and with other related partnerships and initiatives.

The aim is to develop 'country compacts', close-to-binding commitments by governments, national partners and international development agencies to sustained and predictable funding and increased harmonisation and alignment in support of costed, results-oriented national plans and strategies that tackle health system constraints. In this context the IHP favours sector-wide approaches. In addition it aims to generate and disseminate knowledge, guidance and tools in specific areas related to strengthening health systems and services. Enhancing coordination and efficiency and leveraging predictable and sustained aid delivery for health is a third objective of the IHP. Finally it aims to improve accountability and monitoring performance in countries. It intends to work not only at the country level, but also at the global and regional level by creating country health sector teams and regional and global cooperation mechanisms such as an Inter-agency Core Team and a Scaling-up Reference Group[94]. It envisages a budget of US$ 14 million for the period September 2007 – March 2009. Donors include the European Commission, Finland, France, Germany, Italy, Portugal, Sweden, the UK and the Netherlands.

Multilateral Initiative on Malaria

In 1997 the Multilateral Initiative on Malaria (MIM)[95] was established with the mission to strengthen and sustain, through collaborative research and training, the capacity of malaria-endemic countries in Africa to carry out research that is required to develop and improve tools for malaria control and to strengthen the research-control interphase. The MIM is an alliance of individuals, funding partners and four autonomous constituents: MIM/TDR (Tropical Disease Research), MIMCom (works on communication), MR4 (the Malaria Research Reference Reagent Resource Centre) and MIM Secretariat, coordinating the different MIM activities. Among its donors are France, Sweden, the EC and the UK.

94 *See Scaling up for Better Health. Work Plan for the International Health Partnership and related initiatives (IHP). For September 2007 to March 2009.* http://www.internationalhealthpartnership.net/ihp_plus_about_workplan.html

95 See also http://www.mimalaria.org/eng/abouttmim.asp

The MIM has four objectives:

- To develop sustainable malaria research capacity in Africa through international and Pan-African scientific partnerships as the development of human resources and institutional capacity in Africa is essential to enhance the ability of African countries to address their own health problems.
- To promote global communication and cooperation between organizations and individuals concerned with malaria to maximize the impact and avoid duplication of effort.
- To ensure research findings are applied to malaria treatment and control to translate practical problems into manageable research questions by stimulating and facilitating dialogue among scientists, public health professionals, policy makers, and industry.
- To raise international public awareness of the problem of malaria to raise the status of malaria on political agendas to mobilize resources and action.

The MIM/TDR is embedded in the UNICEF/UNDP/WB/WHO Special Programme for Research and Training in Tropical Diseases and as such manages the whole process for awarding research grants and evaluates and awards funds via a competitive peer-review process. The research priority areas funded through the MIM/TDR are:

- Chemotherapy and mechanisms of resistance to antimalarial drugs;
- Health system research to improve malaria control in Africa;
- Malaria vector control;
- Development of malaria control tools from products of indigenous plants;
- Evaluation of malaria control interventions, new strategies and policies;
- Malaria pathogenesis.

The European and Developing Countries Clinical Trials Partnership (EDCTP)

The EDCTP was created in 2003 as a European response to the global health crisis caused by the three main poverty related diseases HIV and AIDS, malaria and tuberculosis. The EDCTP's mission is to accelerate the development of new or improved drugs, vaccines and microbicides against the three diseases, with a focus on phase II and III clinical trials in sub-Saharan Africa. It aims to do this by supporting multicentre projects which combine clinical trials, capacity building and network in order to ensure that the developed capacity is utilised to successfully conduct the clinical trials in a sustainable way[96]. The basis of EDCTP's work is partnership between donors and sub-Saharan countries, working through Joint Programme Activities. At present the EDCTP is mainly financed through the EU's 6th Framework Programme for Research and Technological Development (FP6), but as of 2010 it will move to the EU's 7th Framework Programme (FP7). The following EU Member States are partners within the EDCTP: Austria, Belgium, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the UK. The EDCTP offers grants to Joint Programme Activities focussing mainly on clinical trials.

96 See also http://www.edctp.org

Table 5

Budget EDCTP

Funding	2006 in €	2007 in €	2008 in €
Value of Grants signed in €	14,680,000	21,921,000	23,392,000
Number of clinical trials approved	14	24	42
Capacity building activities in Africa	47	59	163
African countries involved in EDCTP activities	21	21	26
Annual EU Member States (including EU MS) co-funding (to be) spent on EDCTP activities in €	5,774,373	20,833,809	42,656,359
EC contribution	15,400,000	16,379,000	
EU Member States		17,436,000[97]	

As can be seen from the table above the support for the EDCTP has increased impressively over the past few years. By looking at the calls for proposals for the period 2006 -2007 an increase in spending on the response can be noted in that in 2006 the calls for proposals centred around the fight against HIV and AIDS[98], while 2007 included calls for malaria vaccines (with a budget of € 14 million), malaria treatment (with a budget of € 9 million) and malaria in pregnancy (with a budget of € 9 million)[99].

The European Malaria Vaccine Initiative (EMVI)[100]

Established in 1998 by the European Commission and some EU Member States the EMVI aims to provide a mechanism through which the development of experimental malaria vaccines can be accelerated within Europe and in developing countries. It focuses strongly on the standardization, harmonization and coordination of activities in relation to the development of vaccines. The EMVI works closely with the African Malaria Network Trust (AMANET). The Initiative also works closely with the EC through the FP7 and the EDCTP by joining in the implementation of funded projects. Its estimated budget for the period 2007 – 2010 is € 19 million. For 2008 the EU Member States supporting the EMVI were the Netherlands (DGIS), the EC, Denmark (DANIDA), Ireland (Irish Aid) and Sweden (SIDA/SAREC).

Table 6

Contribution EU to EMVI for 2008[101]

Countries	DGIS (Netherlands)	EC	DANIDA (Denmark)	Irish Aid (Ireland)	SIDA/SAREC (Sweden)	Total
Contributions in €	1,514,000	233,000	266,000	1,000,000	456,000	3,469,000

97 See p. 36 of EDCTP *Annual Report 2007*. Published by the EDCTP Secretariat. The Hague, The Netherlands, 2008
98 See p. 11 of ECDTP *Annual report 2006*. Published by the EDCTP Secretariat. The Hague, The Netherlands, 2007
99 See p. 12 of EDCTP *Annual Report 2007*. Published by the EDCTP Secretariat. The Hague, The Netherlands, 2008
100 See also http//www.emvi.org
101 See also p. 39 of the *EMVI Annual Report 2008*. http://www.emvi.org/files/Annual%20Reports/Annual%20Report%202008.pdf

WHO Tropical Diseases Research Programme

Established in 1975 as an independent global programme for scientific collaboration, the Special Programme for Research and Training in Tropical Diseases (TDR) has been an important actor in support for research in tropical diseases. At present it is hosted by the WHO. Its work is based on three key strategies[102]:

- Stewardship for research on infectious diseases as a facilitator and knowledge manager supporting needs assessments, priority setting, progress analysis and advocacy. In addition it will provide a platform for partners to discuss and harmonise activities;
- Empowerment of researchers and public health professionals from disease endemic countries, to provide support for training and research, and to build leadership at individual, institutional and national levels;
- Support research on neglected priority needs that are not adequately addressed by other partners. This strategy will focus on:
  - Innovation for product discovery and development,
  - Research on how interventions are used in real life settings,
  - Research to increase access to interventions.

The TDR is funded by International organisations such as the WB, Regional Development Banks, WHO, private donors, Research Institutes and donor countries, including EU Member States. In the period 1974 – 2001 the TDR had more contributors than in the period since 2002. These former donors included Cyprus and the former Czechoslovakia, Romania, and others such as Austria, France, Greece and Portugal. At present it is still funded by Belgium, Denmark, Finland (sporadically), Germany, Ireland, Italy, Luxembourg, the Netherlands, Spain, Sweden and the UK. (See table 7)

Table 7

EU donor country contribution to TDR in Euro[103]

Country	Belgium	Denmark	Finland	Germany	Ireland	Italy	Luxembourg	Netherlands	Spain	Sweden	UK	Total
2005	1,034,924	1,612,903	-	248,356	240,964	576,459	1,027,811	1,796,637	70,169	3,450,217	500,000	10,558,476
2006	1,005,019	1,712,328	-	474,498	257,069	-	1,036,730	1,226,230	-	3,125,000	3,678,261	12,515,135
2007	1,075,263	1,901,141	192,788	1,030,411	288,184	66,667	1,333,333	1,173,770	73,108	3,338,172	6,021,275	16,494,112

Medicines for Malaria Venture (MMV)

The MMV is a not-for-profit public-private partnership established in 1999. Its aim is to reduce the burden of malaria in disease-endemic countries by discovering, developing and facilitating the delivery of new, effective and affordable antimalarial drugs for the treatment and prevention of malaria[104]. In order to achieve its goal it brings together public, private and philanthropic partners from all over the world. By creating these public-private partnerships MMV ensures that those healthcare issues that are difficult to solve by the public or private sector on their own, are solved together. MMV's role is not only to bring partners together, but also to provide managerial

102 See also http://www.who.int/tdr/svc/about/strategy
103 See also http://www.who.int/tdr/svc/about/funding/financial-contributors
104 See also http://www.mmv.org

and logistical support for the research for and development and delivery of (affordable) new medicines. While in 2007 MMV mainly focussed on promoting access and delivery of ACTs, its business plan for 2008-2012 indicates that it will extend its programme to include more clinical studies and participate in post-licensure activities, such as resistance monitoring, pharmacovigilance and head-to-head comparisons. It will also invest in market research which looks into demand structures and analyses how mechanisms work which deliver ineffective non-ACT antimalarials to patients that do not have access to effective public sector drugs. In order to deliver on these objectives the MMV projects an increase of funding of US$ 75,700,000 in 2008 to US$ 169,300,000 in 2012. In 2007 the MMV received US$ 76,965,380, an increase of 250% compared to the income of US$ 30,618,703 in 2006 and US$ 44,770,355 in 2005.

Table 8
Budget MMV for the period 2006 – 2012 in US$ [105] and Euro

	2006	2007	2008	Needed for period 2008 - 2012
Research and Development	46,943,252 *37,420,391*	41,494,679 *30,317,590*	54,700,000 *37,342,323*	450,600,000 *307,613,355*
Access and Delivery	731,834 *583,375*	1,550,220 *1,132,650*	6,000,000 *4,096,050*	38,000,000 *25,941,650*
MMV Final Budget	51,473,776 *41,031,857*	47,946,314 *35,031,399*	75,700,000 *51,678,498*	596,500,000 *407,215,638*

MMV receives funding and support from Private Foundations, the Pharmaceutical sector, private companies, UN bodies and donor countries. The EU Member States of Ireland, Spain, the Netherlands and the UK are among the MMV contributors with the following amounts over the period 2006 – 2008:

Table 9
EU Member States' contributions to the MMV in US$ and Euro

Country	2006	2007	2008
Spain (AECID)	-	-	4,700,000 (pledged) *3,208,573*
Irish Aid	3,828,000 *2,939,357*	4,023,000 *3,051,456*	3,600,000 *2,457,630*
The Dutch Ministry for Foreign Affairs	572,980 *456,746* + 822,577 *655,710*	2,545,988 *1,860,196*	3,629,502 *2,477,771*
UK	5,425,100 *4,324,570*	3,885,500 *2,838,894*	2,004,000 *1,368,081*
Total	**10,648,657** ***8,376,383***	**10,454,488** ***7,750,546***	**13,933,502** ***9,512,055***

105 See also Ensuring Success: *MMV Business Plan (2008-2012)*, Final Draft Document for Board Approval, November 2008 on http://www.mmv.org/IMG/pdf/MMV_Business_Plan_2008-2012.pdf

Other international initiatives in the fight against malaria

Besides working as an important funder for HIV and AIDS, tuberculosis and malaria projects and programmes GFATM also initiates other innovative programmes and partnerships. In April 2007 the GFATM Board approved the Debt2Health[106] initiative. The initiative uses debt swaps to free up domestic resources that can then be invested in approved Global Fund programmes. The initiative is a partnership between creditors and GFATM grant recipient countries, with the participation of the GFATM (i.e. a trilateral arrangement). Germany is the first EU Member State to join this initiative with a commitment of US$ 290.2 million for the period 2008-2010. Although the first Debt2Health Agreement, signed between Germany, Indonesia and GFATM will mainly be used for HIV-services and public health interventions, it could open possibilities for funding for the response to malaria.

A second initiative sponsored by the GFATM is the Affordable Medicines Facility for Malaria (AMFm)[107] launched on 17th of April 2009. It is set up as an innovative financing mechanism to help increase access to affordable aretimisinin-based combination therapies (ACTs) for malaria through public, private and NGO sectors. The AMFm is hosted by the GFATM, with financial support from UNITAID and the UK (DFID). The members of the Roll Back Malaria Partnership offer technical support. The aim of the AMFm is to reduce the price of ACTs sold over the counter from US$ 6-10 per treatment to 20 – 50 cents by guaranteeing pharmaceutical companies increased and predictable demand and additional subsidies. Initially the programme will be implemented in 11 pilot countries in Africa, with an evaluation after two years to guide decisions on expanding the programme globally. The initial cost will be US$ 225 – 233 million for the two-year period, which will be shared between UNITAID and the UK. Other organisations and governments have already indicated their interest joining the initiative.

5. Possible improvements towards achieving the objectives of the Global Malaria Action Plan

This section will briefly recapitulate the objectives of the Global Malaria Action Plan (GMAP) in the context of the policies applied by the EC and the EU Member States.

The strategy of the GMAP proposes the following actions:

1 Actions to control malaria by:

- Scaling up for impact to achieve universal coverage focussing on locally appropriate malaria control interventions
- Invest in health system strengthening
- Ensure sustained control to prevent the resurgence of malaria in those areas where malaria incidence is decreasing

2 Eliminate malaria by actions in-country and at the regional level. This requires sustainable financial and political commitments both by recipient and donor countries

3 Investing in research at different levels:

- Develop new forms of interventions for the fight against malaria
- Ensure information on policy decisions and options
- Ensure the operationalisation and implementation of research results.

106 See also http://www.theglobalfund.org/en/innovativefinancing/debt2health/overview/?lang=en
107 See also http://www.theglobalfund.org/en/pressreleases/?pr=pr_090417

This strategy needs to be implemented in close cooperation between malaria endemic countries and the donor community.

As shown above the EC and the EU Member States are adhering in many cases to this strategy albeit not with the same dedication. The EC and EU Member States use three implementation tools in the fight against malaria. In bi-lateral cooperation they mainly use a sector-wide approach with a strong focus on health system strengthening and addressing the crisis in human resources for health. The preferred financing tool is more general and sector budget support, at the expense of project support. This can have a negative impact on the expertise in health, and malaria in particular, at the country level in EC delegations and Member State representations. However, these aid modalities are seen as contributing to a more sustainable and country-owned form of development aid also in relation to donor support for health. This is also in line with the GMAP requirement to cooperate closely with partner countries.

5.1 EU performance against GMAP

Action 1: Actions to control malaria

The tendency of the EC and the EU Member States actively supporting the health sector in developing countries is to prefer a sector-wide approach to a disease-specific one. This means that all EU donors have a strong focus on health system strengthening. A key area is the building of the government's capacity to set up and manage a sound health system, which will not only offer healthcare to citizens in urban areas, but also cater for the health needs of the rural population by decentralising healthcare systems. In addition the EC and EU Member States focus on addressing the shortage of health workers by supporting training and research into improving working conditions and identifying means to ensure that health workers are retained in the national health systems. Belgium and Sweden also recognise that support for health should not be limited to the sector, but that assistance in other sectors can have a beneficial impact on health.

The UK and Belgium have included support for malaria specific activities in their development cooperation, which is reflected in the funding allocated to malaria for 2007 (see table 2). Most of the EU Member States have delegated the scaling up of universal coverage to the International Health Partnerships by allocating funding to them.

Likewise ensuring sustained control to prevent the resurgence of malaria in areas where a certain level of control has been achieved is mainly delegated to the international partnerships and organisations.

Table 10

Policies for EU Member States in line with the GMAP

Policies	EC	Finland	The Netherlands	Germany	Belgium	Sweden	UK	Spain	Ireland	Portugal	Luxembourg	Italy	France	Denmark	Austria	Greece
Promotion of Universal coverage	x				x	x	x	x			x					
Promotion of Universal Access		x		x	x	x	x	x		x			x			
Health system strengthening	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x
Human Resources including training	x	x	x	x	x	x	x	x			x	x	x			
Sustained control/ prevention	x	x			x	x	x	x								
Support for local production	x															
Social policies/ social security		x		x	x					x			x			
Decentralisation/ Community				x				x	x			x				

Action 2: Eliminate malaria by actions in-country and at the regional level. This requires sustainable financial and political commitments both by recipient and donor countries

In line with the Paris Declaration Principle on Ownership, the EU donors believe that the recipient countries need to take the lead on their national health policies. Political dialogue is a crucial element in deciding on the support activities of the donor countries. Improving access to prevention, treatment and care is seen as crucial in the response to malaria; however, most EU Member States and the EC believe that disease-specific project support will not allow for a sustained effort to fight the disease. Supporting pooled efforts such as the Medicines for Malaria Venture and UNITAID are seen as more effective in the long run, not only to guarantee a sufficient amount of drugs, but also as a means to reduce the price of those drugs.

Table 11

Political and financial malaria specific commitments

Countries	EC	Finland	The Netherlands	Germany	Belgium	Sweden	UK	Spain	Ireland	Portugal	Luxembourg	Italy	France	Denmark	Austria	Greece
Dialogue with partner countries	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Financial bi-lateral commitments to malaria	x		x		x		x									

Action 3: Investing in research at different levels

Most the EU donor countries invest strongly in research and development, either through their own institutions such as the UK, Sweden and the EC, but also through for instance the WHO Tropical Diseases Research Programme. These programmes not only focus on research and development of new forms of malaria interventions, but also look into possible policy decisions, intervention options and social environment in the context of drug delivery. EU donors stress the need for information, communication and education in the response to malaria.

Table 12

Research and Development

Country	EC	Finland	The Netherlands	Germany	Belgium	Sweden	UK	Spain	Ireland	Portugal	Luxembourg	Italy	France	Denmark	Austria	Greece
Malaria specific	x				x	x	x		x					x		
Health policy				x			x	x			x					
Communication/ Information/ Building research capacity				x		x	x	x					x	x		

The role of International Partnerships

International Partnerships and organisations such as the GFATM, WHO, the IHP and others are playing an increasingly important role. Donor countries recognise this and as can be seen above most of the donor countries are increasing their contributions to these organisations, particularly the GFATM. However, the comment has been made that as more and more of these partnerships arise, the danger of fragmentation and duplication increases. It will therefore be important to ensure that these initiatives complement each other and coordinate activities in-country to achieve the best results. As EU donor countries are often represented on the boards of the different initiatives it will be important that they exert their influence to create a coherent environment for development cooperation activities in health.

Table 13

Support of EU Member States to International Partnerships and initiatives

Country	EC	Finland	The Netherlands	Germany	Belgium	Sweden	UK	Spain	Ireland	Portugal	Luxembourg	Italy	France	Denmark	Austria	Greece
GFTAM	x	x	x	x	x	x	x	x	x	x	x	x	x	x	N/A	x
IHP	x	x	x	x		x	x	x		x		x	x			
MIM	x					x	x						x			
EDCTP	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x
EMVI	x		x			x			x					x		
TDR		x	x	x	x	x	x	x	x		x	x		x		
MMV			x				x	x	x							
UNITAID							x	x					x			

At present the International Partnerships cover different aspects of the response to malaria. By ensuring that there is no overlap, duplication or completion these initiatives can contribute to the achievement of a coherent and comprehensive approach to the response to malaria in line with the guidelines of the GMAP. It is therefore useful to identify the different areas where the partnerships are active.

The GFATM, as the biggest player in this field, focuses strongly on the delivery of malaria prevention, treatment and care materials. So far it is dedicating some 26% of its funds to malaria, based on the project proposals of the Country Coordinating Mechanisms (CCMs). This means that the partner country can exert a strong influence on increasing malaria-specific interventions. In addition the GFATM supports other joint initiatives such as for instance the Debt2Health and the Affordable Medicines Facility for Malaria, together with national donors and multilateral organisations such as the WB and WHO.

Health system strengthening is promoted by the International Health Partnership, while the Multilateral Initiative on Malaria (MIM) focuses more on the promotion of the malaria research capacity in-country and offers information, education and implementation research at the global level. The MIM collaborates closely with the TDR and international UN organisations.

The WHO Tropical Diseases Research Programme (TDR) focuses strongly on research into tropical diseases, in collaboration with donor country national research initiatives and the EU Framework Programmes for Research and Development. The European Malaria Vaccine Initiative (EMVI) focuses on standardization, harmonization and coordination of vaccine development activities in an effort to speed up the development of experimental malaria vaccines. The European and Developing Countries Clinical Trials Partnership (EDCTP) is active in more or less the same field, but includes the development of drugs within its remit, focusing strongly on the process of clinical trials.

As a public private partnership the Medicines for Malaria Venture (MMV) is active in the field of medicine delivery, market access and cooperation activities, while the Affordable Medicines Facility for Malaria (AMFm) aims to increase access to affordable medicines outside the public health sector. UNITAID offers additional funding through innovative financing initiatives such as the air ticket tax and the Debt2Health initiative uses the innovative approach of using debt cancellation as a means of funding the health sector, and the response to infectious diseases in particular, by converting the debt relief funding to health sector contributions.

5.2 Eu Funding against GMAP[108]

When adding all bi-lateral donor contributions to the response to malaria the EU, i.e. the EC and the EU Member States, contributed US$ 47.52979352 million (€*34.649656* million*)*. This seems an impressive amount for one disease[109]. However, if compared to what Japan and the USA, both major donors in development cooperation, have contributed (in 2007 US$ 10.4 million (disbursed US$ 12.4 million) and US$ 244.3 million (disbursed US$ 27.2 million) respectively), it is clear that this can be improved upon.

If the total of pledges for contributions to the GFATM, as the biggest player in the response to malaria, by the EU donors, including some of the new EU Member States, for 2007 is calculated, the EU will have donated US$ 2,273,446,471 *(€ 1,045,825,631)*. Compared to the contributions of US$ 188,006,798 by Japan and US$ 679,445,592 by the US[110] it becomes clear that the EU donors demonstrate leadership in supporting a global partnership to ensure that malaria is combatted in a comprehensive and collaborative way.

When comparing the figures for the total contributions of the EU donors to the International Partnerships and initiatives for the years 2006-2008 there is a clear indication of an overall increase of funding (see also overview of contributions to indiviadual partnerships and initiatives above).

Table 14
Contributions of EU donors to International Partnerships over the priod 2006-2008 in Euro[111].

	GFTAM	IHP	EDCTP	EMVI	TDR	MMV	UNITAID
2006	881,632,170	946,000,000	15,400,000 (EC)	N/A	12,515,135	8,376,383	N/A
2007	1,045,825,631	N/A	33,815,000 (EC+MSs)	N/A	16,494,112	7,750,546	230,354,819
2008	1,062,849,652	N/A	N/A	3,469,000	N/A	9,512,055	205,000,000

However, analysis of the individual countries shows fluctuations in the respective national contributions to health, to the International Partnerships and to the response to malaria. The Netherlands for instance, increased its investment in health from some € 72 million in 2005 to € 97 million in 2008, but will only contribute € 93 million in 2009, while at the same time increasing the contribution to the GFATM from € 60 million in 2005 to € 80 million in 2009. While Spain nearly doubled its contribution to health over the period 2006 – 2007, France, Denmark, Austria and the EC had decreased their contributions to health by 2008.

When comparing the percentages spent on health with the percentages spent on malaria in particular (see table 2) one notices that the countries that have reported the largest percentages of ODA spent on health, do not spend a large percentage on malaria, except for the UK: Greece spent 11.3% of ODA on health, but only 0.0002% on malaria, Ireland spent 15.1% ODA on health, but only 0.0022% on malaria, Luxembourg spent 14.6% ODA on health, but reported no spending on malaria and the UK spent 8.1% ODA on health and 0.0035% on malaria.

Likewise the contributions to International Partnerships fluctuate. While most countries have gradually increased their contributions to the GFATM, France, Belgium, the UK and the EC have decreased their contributions in 2008. However, as the biggest actor on the three poverty-related diseases, the GFATM attracted additional support from the new EU Member States, Hungary, Latvia, Poland and Romania. For the TDR the Netherlands and France decreased their contributions, while the UK greatly increased its support, but at the same time decreased its support for the MMV. Likewise the Netherlands and Spain increased their support to the MMV.

It should be clear that the fluctuations discussed above will not contribute to ensuring sustained funding for health and for the fight against malaria in particular. If malaria is to be controlled in line with the objectives of the GMAP, there should not only be an increase in funding, but it needs to be retained over a longer period of time.

In March 2009 the OECD DAC published the preliminary figures for overall net ODA in 2008. It also calculated probable ODA figures for 2010 based on public announcements by member countries of the OECD DAC. Updated country specific figures are expected in June 2009[112]. Although this is not an indication of possible spending on the fight against malaria, the figures might give an indication as to the future trend in ODA for the EU Member States and the EC. The current financial crisis is hitting each EU donor country differently, but as ODA is usually allocated as a percentage of gross national income (GNI), the decrease in a donor country's national income will also have a serious impact on its allocation and disbursement of development aid both in bi-lateral and multilateral terms. This will also have an impact on a donor's spending for health and for the fight against malaria in particular.

Table 15
Preliminary findings of 2008 ODA for EU Member States and EC and simulated contributions for 2010[113]

Country	2007 ODA (US$ million - current)	2008 ODA (US$ million - current)	Percentage change 2007/2008	OECD DAC Simulation for 2010 (US$ million current)	Simulated growth in % compared to 2008
				At 2007 prices and exchange rates	
Austria	1,837	1,685	-15.1%	1,945	16%
Belgium	2,032	2,432	11.3%	3,361	41%
Denmark	2,666	2,863	-1.4%	2,623	-6%
EC	11,743	13,527	6.7%	N/A	N/A
Finland	981	1,139	6.7%	1,300	14%
France	11,498	12,386	0.0%	13,909	27%
Germany	13,687	15,891	8.5%	17,687	27%
Greece	501	693	26.9%	1,145	65%
Ireland	1,192	1,325	6.4%	1,307	-1%
Italy	4,290	4,680	-0.4%	10,866	145%

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108 The figures used in this chapter can be found in the earlier chapters in this paper.
109 See table 2
110 Figures are based on the DAC Purpose Code 12262 in the Creditor Reporting system of OECD Statistics extracted 2 April 2009 http://stats.oecd.org/WBOS/Index.aspx?DatasetCode=CRSNEW
111 Comparison between the various contributions is hazardous as exchange rates have not been used univocally between the different Partnerships and initiatives.
112 See also http://www.o7,282ecd.org/dataoecd/25/42/42472714.pdf
113 Ibid. It needs to be noted that not all figures are consistent with previous announcements.

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Country	2007 ODA (US$ million - current)	2008 ODA (US$ million - current)	Percentage change 2007/2008	OECD DAC Simulation for 2010 (US$ million current)	Simulated growth in % compared to 2008
				At 2007 prices and exchange rates	
Luxembourg	376	409	1.8%	395	-3%
Netherlands	6,620	7,282	2.6%	6,647	-5%
Portugal	477	621	20.8%	1,119	82%
Spain	5,442	7,354	24.1%	8,271	24%
Sweden	4,339	4,730	3.9%	4,625	-2%
UK	11,626	11,789	8.6%	14,243	25%

In addition the OECD DAC anounced that of the non-DAC members the Czech Republic had reported a decrease of -0.4% for 2008, Hungary of -7.4% and Poland of -9.0%, while the Slovak Republic had reported an increase of 14.4% of ODA. It is not clear how this has reflected on possible contributions to the health sector or to the response to malaria in particular.

5.3 Next Steps in line with GMAP

In relation to the policies, activities and funding by EU donors described in the previous chapters it is clear that the EU donors are concerned about the response to malaria. However, bi-lateral activities are not seen as the most efficient way to support this response. By concentrating their efforts on sector wide activities such as health system strengthening and addressing the critical shortage in human resources for health they believe they also contribute to the response to malaria. Support for research is also seen as an important contribution to the fight against malaria. However, they assign an important role to the governments of the recipient countries. This means that if the guidelines of the GMAP are to be followed the national governments will have to follow these as well. In the context of bi-lateral aid the UK plays a strong role by strongly supporting the response to malaria in-country and aims to play a leading role at the global level.

International Partnerships are seen by the EU donors as important tools in the response to malaria. Over the past three years, most EU donors have increased their contributions to the various partnerships and many have committed to continue to do so. So far France has taken the lead in ensuring large contributions to both the GFATM and UNITAID.

However, if one offsets the US$ 6,094 million needed in, for instance, 2009 against the US$ 47.52979352 million in bi-lateral aid and the US$ 2,273.447 billion as, for instance, the contribution to the GFTAM, it is clear that a lot more will need to be done.

The EU donors will need to make a stronger joint effort, by increasing their contributions to the International Partnerships. As new donors the new EU Member States can join in by offering increased malaria-specific funding. By joining the Boards of the International Partnerships, particularly those that also deal with other diseases the EU donors can promote a stronger focus on the response to malaria. Likewise they should increase their dialogues on malaria with their counterparts in the developing countries to ensure that they too increase their efforts to improve not only their health systems to ensure universal access to treatment and care, but also intensify prevention and information/communication and education efforts to increase the absorption capacity and ensure that for instance LLINs, IRS and IPTp not only reach everybody, but that everybody also knows how to use them and is aware of the need to use them. Only then can headway be made in the response to malaria.
As general and sectoral budget support are increasingly being seen as the preferred method for development cooperation, the EU donors and the partner countries will need to make sure that support for the response to malaria is integrated in the health policies in line with the GMAP guidelines. The WHO initiative, launched on World Malaria Day 2009, to promote the close monitoring by donors and partner countries of progress made in the response to malaria, will help to upgrade and adapt policies according to their effectiveness. NGOs can be of great importance in supporting these monitoring activities.

International Health Partnerships and initiatives have an important role to play, but they will need to align and harmonise their activities. In their report *Healthy Aid. Why Europe must deliver more aid, better spent to save the health Millennium Development Goals*[114], Action for Global Health, a network of European Health NGOs, commented on the profusion of new international health partnerships and initiatives and recommended that the EU and the Member States' policy makers should clarify and coordinate the many initiatives aimed at improving aid effectiveness (recommendation 4).

Likewise the EU, as a partnership at international level, should make sure that its interventions are coordinated and in line with the GMAP objectives. As the Code of Conduct for the Division of Labour is implemented, it should not become an excuse for many EU Member States to leave the support for health and for the fight against malaria to others such as the EC. This is in fact a tendency that has been pointed out by the latest report of Action for Global Health, where they state that donors have pulled out of the health sector in some countries, in some cases even against the will of the government[115].

At present the EC has foreseen the spending of € 7 million for health system strengthening and € 57 milion for confronting the main communicable diseases, including malaria for 2009 and € 8 million and € 62 million for the two headings in 2010, but this will only be a small increase towards the needs identified by the GMAP. In the 10th EDF framework the Intra-ACP Programme has allocated € 150 million for the period 2008-2010 and € 150 million for the period 2011-2013 to the GFATM, together with € 30 million to Public Health and € 40 million for Science and Research for the period 2008-2013, but here too it is not clear how much will support the fight against malaria[116].

The implementation of the GMAP will therefore require a coordinated effort of the EU donor countries, the EC, the partner countries and the International Health Partnerships and initiatives to come up with a comprehensive and coordinated strategy to ensure that each actor plays its role to ensure universal access to prevention, treatment and care in relation to the response to malaria.

114 Published by Action for Global Health, June 2008

115 See also p. 16 in *Health in Crisis. Why, in time of economic crisis, Europe must do more than ever to achieve the health Millennium Development Goals.* Report 3, published by Action for Global Health, March 2009

116 http://ec.europa.eu/development/icenter/repository/strategy_paper_intra_acp_edf10_en.pdf

6. Conclusions and Recommendations

Although malaria is one of the most dangerous diseases in the world, there is still insufficient support for the prevention, treatment and elimination of the disease. Major funding gaps persist and where originally development cooperation offered disease-specific support, the tendency now is to focus on health systems and health as a sector in general. Although this also contributes to more effective treatment and care of disease-stricken patients it does less for the prevention and elimination of the disease.

While it is clear that in the past financial support for health in general and for the fight against malaria in malaria-endemic countries has increased, there is still a serious funding gap. Although many donor countries are committing themselves to increases in spending on health, the current financial crisis might prove a serious threat to the honouring of these commitments. While donor countries might feel they are delivering on their targets for funding for health based on the percentages of ODA, the decrease of the donor's national income means a decrease in actual funds for health and the response to malaria. Donors need to take this into account by increasing their funding in real terms if the targets of the health related MDGs, particularly MDG 6 on halving and starting to reverse the incidence of malaria by 2015, are to be achieved by 2015.

As research and development produces new anti-malaria products, pricing and limited access in developing countries can diminish possible impacts. The use of LLINs, IRS and IPTp especially in rural areas needs to be promoted and facilitated. This means that not only should there be a sufficient stock of nets and insecticide and equipment for IRS, but the infrastructure needs to be improved in such a way that they also reach rural populations in remote areas.

The EU donors are investing funding in the various health partnerships and initiatives in order to ensure that the different areas for actions promoted by the GMAP are acted upon. It is therefore crucial that these partnerships cooperate closely if they are to achieve the ultimate goal of eradicating malaria. Sufficient funding is essential and donors not only need to commit themselves to increase their funding but also need to honour their commitments.

In the context of the EU Code of Conduct on the Division of Labour, the EC and the EU Member States need to ensure that all malaria-endemic countries are supported in their fight against malaria and that there are no aid-orphan countries in this context. When EU Member States pull out of the activities in relation to the fight against malaria, others need to ensure that there is no gap in support activities. In addition partner countries should be allowed the choice between general, sector, programme or project support given towards promoting and ultimately eradicating malaria. Only by using intervention mechanisms adapted to the situation in the recipient country can any progress be achieved.

The following recommendations for the EC and EU Member States will contribute to the ultimate achievement of GMAP objectives:

Funding

- Increase funding in real terms to ensure that financial needs, identified by GMAP, for the response to malaria are met.
- Commit to long term and predictable funding for health in the developing world. Contributions to the health sector, and to the response to malaria in particular, must be sustained. Fluctuations between bi-lateral and multilateral funding or in terms of allocations through both aid modalities must be avoided.
- Increase the use of Sector Budget Support to health care in the developing world and improve the balance with Direct Budget Support and sector-wide approaches.
- Introduce malaria-specific indicators in monitoring the implementation of health aid.

Focus

- Continue investment in health system strengthening but improve targeting of service delivery that benefits rural and isolated communities.
- Notwithstanding the need for continued support to health systems, increased support to ensure universal access to specific and proven prevention and treatment is urgently required.

Partnership

- Address malaria with focussed interventions. Partnerships with all stakeholders and sectors are critical. Aid must align with recipient country strategies.
- Coordinate International partnerships and initiatives to ensure coherence with GMAP and that sufficient funding is spent on the response to malaria.
- Improve EU support to community-based initiatives and national media and NGO coalitions against malaria, because Civil Society in the developing world has much to offer governments in the fight against malaria.

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