



CONFERENCE REPORT

JOINING FORCES, SYNERGISING ACTION – SUSTAINABLE AND INNOVATIVE WAYS OF ENSURING LONG-TERM AVAILABILITY OF MALARIA PREVENTION AND TREATMENT MEASURES BY 2015

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

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Bernd Pastors

Managing Director of the German
medical aid organisation action
medeor e.V.

*“By joining forces and
synergising action the fight
against malaria can be won.”*

Dear readers,

In 2007, the Assembly of the World Health Organisation agreed that awareness of malaria as a global problem needs to be increased. It was concluded that April 25th 2008 will be commemorated as the first World Malaria Day in history. This was an important step in recognising that malaria has to be addressed as a global challenge.

In the forefront of the first World Malaria Day, the International Malaria Conference “Joining Forces, Synergising Action – Sustainable and Innovative Ways of Ensuring Long-Term Availability of Malaria Prevention and Treatment Measures by 2015” used this historic momentum, to set up recommendations in collaboration with stakeholders from governments, civil society organisations and the private sector from 26 countries in order to remind the European Union and the G8 of the urgent need to scale up efforts in order to prevent up to three million deaths due to malaria every year. By picking up the issue of how to achieve long-term availability of malaria prevention and treatment tools by 2015, the conference openly discussed sustainable and innovative ways towards accomplishing universal access to malaria diagnosis, prevention and treatment by 2015. In order to reach this target, we need accelerated action and effective partnerships of all stakeholders as well as the usage of all available tools.

It was an explicit aim of the meeting to call upon the European Union and the G8 to increase their efforts in order to reach the Millennium Development Goals by 2015. The final communiqué, as the outcome of the conference, has therefore been passed on to the German G8-Sherpa on the occasion of the Civil G8 Dialogue in Kyoto. In addition, the final communiqué was also forwarded to the German Federal Minister of Economic Cooperation and Development in order to ensure that malaria remains high on the political agenda of EU and G8. We acknowledge the efforts being made by international governments in terms of increased funding and political commitments as outlined in the Millennium Development

Goals (MDGs), the Abuja Declaration and the G8 Declarations of 2005, 2006 and 2007. But what is essential in this context is to ensure accountability of heads of state to their promises. The considerable attempts that have been made need to be continued and even upgraded.

There is urgency for action. According to a WHO baseline study, 38 to 45 billion US-Dollar from 2006 to 2015 or an amount of 3.8 to 4.5 billion US-Dollar annually are needed to achieve the MDGs. In order to meet the financial needs, the replenishment of international development funds as well as long-term, predictable and sustainable funding for malaria is vital. Regardless of the financial gap that has to be filled to combat malaria, we are facing several challenges that were highlighted at the conference. First, despite the fact that the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has contributed significantly to the amount of money being made available for malaria control as well as the fact that many of the G8 leaders have contributed substantially to the funds of the Global Fund, there is a need for technical assistance; there is a need for money to help countries to access those funds in order to make use of those funds effectively and to actually reach the communities, the women and children in need. Effective and long-term delivery will be equally important as community involvement in malaria control. In addition to that, much more emphasis has to be placed on research and development of new drugs and an effective vaccine. In this regard, public private partnerships are very important tools and have proved to be successful tools in the fight against other diseases. If we want to address the problem of malaria, we really have to join forces and to expand programmes. Only with joined forces and synergised action we will win the fight against this deadly disease.

Desmond Mtutu: “I support World Malaria Day. We can rid the world of the scourge of malaria. We have the means. We often lack the political will. Let us reverse this train and make our world malaria-free.”

In a nutshell, this tells us where we are, that we can do more and we should do more. But we can be hopeful. More effective prevention and treatment tools are being developed, people are working together and money is increasing. So it is a very positive time to look where we are today and where we have to go tomorrow.

I wish all readers an interesting lecture.



Miodrag Soric

Editor in Chief,
Deutsche Welle

“We are building a bridge from Europe to those regions where thousands of people suffer from malaria.”

The British Prime Minister pledges to donate 20 million mosquito nets as an effort to eradicate malaria, Brazil launches a cheap new malaria pill, Kenya needs 113 million US-Dollars to combat malaria. Similar headlines like these regularly appear on our computer screens when we access news agencies. But generally speaking, in the German media the malaria problem is rarely given a deep coverage and analysis. This is not the case at Deutsche Welle. Germany's broadcaster has constantly paid attention to this issue. For Deutsche Welle, diseases like malaria, tuberculosis and HIV/AIDS are issues of great importance because they affect people all over the world. The problems related to these diseases, are covered extensively by our radio and internet programmes in 30 languages as well as by Deutsche Welle TV, Germany's international television service. When we report about the diseases our audience is not only limited to the Europe continent. Of course, this issue is of fundamental importance in our programmes directed towards the African continent. Through our broadcasts in Kiswahili, Hausa, Amharic as well as in English, French and Portuguese, Deutsche Welle regularly reaches more than 30 million listeners in Africa.

We are building a bridge from Europe to those regions where thousands of people suffer from malaria and do not have mosquito nets or the necessary pharmaceuticals to treat it. Our aim is to provide a complete picture of the malaria problem: to report about both, the efforts that are made to fight malaria as well as the challenges and obstacles to do so. Creating this picture might also require focussing on the G8 summit where heads of state promised millions of dollars to fight the three diseases. Or it might include coverage of the different NGOs collecting money for mosquito nets and education campaigns. Or perhaps it might simple be an interview with one of those scientists searching for simple, cheap and effective treatment. With regard to this international conference on malaria prevention and treatment measures, you have definitely come to the right place and I am pleased to welcome you also on behalf of our Director General Mr Erik Bettermann to Deutsche Welle Broadcasting Centre here in Bonn. I hope during the next two days you will have a fruitful and stimulating conference and return home with useful ideas and positive impressions and of course I would like to take this opportunity to thank you for coming and I hope you enjoy your time here at Deutsche Welle.

MALARIA – MORE THAN AN INFECTIOUS TROPICAL DISEASE

It is more than 50 years ago, since the international community set itself the ambitious goal of conquering this disease. Yet no real break through has been achieved so far. On the contrary, even now at the beginning of 21st century, every year more than 1 million people die of malaria, between 350 and 500 million people are newly infected with malaria and countless people's lives and futures are permanently damaged by the after effects of malaria. Malaria accounts for one in five deaths among African children and has just become mankind's worst enemy among the infectious tropical diseases on our neighbouring continent. Infectious tropical disease that is the most common definition; a definition that has become standard in medical journals and is widely used in prophylaxis leaflets that travel agencies hand out to long distance travellers. From the development policy perspective there are undoubtedly other definitions one can think of. Definitions that are by no means less justified. Malaria is not just an infectious tropical disease that primarily affects the south. Malaria is also one of the biggest global obstacles to human development, a disease that has been neglected for decades, a disease that is also manmade to a certain extent and thus a disease that could be largely preventable by taking appropriate steps.

Malaria and development

Almost half of the global population lives in one of the approximately one hundred countries in the world where the buzzing of a mosquito can still be a harbinger of disease or death. Yet 90% of malaria cases occur in Africa. Children under the age of five are particularly affected, as well as pregnant women and their newborn infants. With its high number of incidents and deaths malaria is a serious development problem. Malaria causes poverty for individuals and for whole states. Every outbreak of the disease and every epidemic destroys development efforts for many years that had been a beacon of hope. The poorest countries in particular are struggling hard to cope with the economic costs of malaria. Malaria is putting a break on economic growth and some African countries

“It is in our hands to jointly solve the problems associated with the fight against malaria.”

might even see a halving of their gross national income in the long run. Uganda's Health ministry has tried to translate the burden that this disease places on the economy into concrete figures. In Uganda every bout of malaria causes treatment costs up to 4 Euros per person, as a consequence a family affected by malaria has to spend up to 25% of its income on treatment and prevention. Malaria mainly occurs during the rainy season at a time when every hand is needed for working in the fields. On average, every bout of malaria means seven working days lost. According to estimates, the field, crop of a family affected by malaria is nearly 40% of a healthy family's crop. In high prevalence areas up to 50% of absences due to sickness among workers in industry and on labour intensive cash crop plantation can be laid at the door of malaria. One consequence is that investors move to other cultivation areas. What is particular worrying is the fact that malaria affects school achievements and thus the future of 60% of children in high prevalence areas.

Challenges and opportunities

In 1998, the WHO launched its Roll Back Malaria Partnership initiative with the key aim to enhance better coordination of individual measures. Another objective of the initiative was to join forces with the private sector. Since 2000, fighting this pandemic has also been a focus of MDG 6 and of the Abuja Declaration signed by the African heads of state.

In 2002 the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was established to support and enhance these efforts. The G8 countries played a pivotal role in the fund's establishment. Up to 2006, the Global Fund spent some 700 million US-Dollars on malaria control. Currently, it is financing more than 60% of anti-malaria measures worldwide. German support concentrates primarily on this multilateral level. This means that my ministry acts mainly through the Global Fund. Until the end of 2007, the German government had pledged a total of 492 million Euros, about 25% of this amount is available for malaria control. At the replenishment conference last autumn in Berlin, donors increased their commitment to approximately 10 billion US-Dollars for the period of 2008 until 2010. The German government alone pledged funding of 600 million Euros. In addition, we are also supporting malaria control through bilateral measures within the framework of governmental and technical and financial cooperation. But we fight against an extremely tough enemy, an enemy that has been one of the most loyal companions of human evolution, an enemy that cannot be fought by mere expressions of will or by drawing up budget lines. On the contrary, there are various factors that contribute to the spread of this disease:

- Its extremely high adaptability leading to resistance to active agents
- Weak health systems in Sub-Saharan Africa in terms of structures and human resources



Hans-Dietrich Lehmann

General Director, German Federal Ministry of Economic Cooperation and Development (BMZ)

fully discontinue the use of DDT in the medium term under the Stockholm Convention. This has not yet been adopted as a clear and unambiguous approach regarding the issue of DDT usage. However, there is clear evidence that the extensive use of DDT causes environmental and health hazards. In addition, resistance formation is frequent. Therefore, DDT must not be regarded as a universal weapon but should only be used in the clear cut framework defined by international standards. In malaria control, there is no such thing as a silver bullet and despite increasing lobbying for DDT, we must not allow ourselves to be deceived. So far, no simple solutions have been discovered in the fight against malaria.

Conclusion

Malaria is transmitted in a complex interaction process between humans, parasites and mosquitoes, which means that the disease is always a result of individual living conditions. We need a mix of methods adapted to the specific contexts and particularly in Africa a strengthening of health systems. And another message is equally important, experiences with Immunochromatographic Tests (ICTs) and mosquito nets in particular have shown that malaria can be controlled. Malaria is a preventable disease; it is in our hands to jointly solve the problems associated with the fight against malaria. For this, we also need more funding and above all innovative financing instruments. If we implement promising solutions consistently, we can do what we have already managed to do in the fight against other diseases: control the disease effectively and protect human lives in all climate zones on this planet.

- High treatment costs: highly effective drugs cost between 0.50 to 3 US-Dollars per therapy and are not accessible for most people under the public health system

And there are clear signs that the disease will spread further as a result of climate change and that it might even return to Europe. In view of these complex challenges, we need to find answers that can actually deliver a viable solution. Above all, this means that the standards for malaria control and treatment have to be enforced. This applies to the poor and the rich, to urban and rural areas, to local inhabitants as well as migrants and refugees.

The key elements of malaria control are:

- The fight against the mosquitoes that carry the parasite regardless whether vulnerable people live in a village or in an urban slum area.
- Prevention of mosquito bites in particular by using Insecticide Treated Nets (ITNs) and regardless of whether it is about protecting a child living in a village or in a city.
- Prevention of infections by administering drugs, regardless of whether the patients can pay for these drugs out of their own pockets or not.
- Using drugs to treat those who are sick, regardless of whether they are in a village hospital or in a clinic in the capital.

A critical remark to DDT

Alongside many other countries and for good reasons, Germany has undertaken to



ACHIEVING UNIVERSAL ACCESS

Universal Access

Achieving universal access is one of the major challenges that the RBM Partnership faces today. Three major developments in the past few years have dramatically increased the Partnership's capacity to face this challenge. First, reliable protection and treatment tools have been developed and put to use in endemic areas. Second, partner consensus around strategies has strengthened, while the number of partners, especially from Europe, continues to grow. And last but not least, funding for malaria has increased significantly over the last years.

This conference is the first in a series of global activities to commemorate 25 April - traditionally Africa Malaria Day- as World Malaria Day. This year's commemoration of the first World Malaria Day is a recognition of the fact that malaria is a global health problem and not only an issue limited to endemic countries in Africa.

Roll Back Malaria

The Roll Back Malaria Partnership (RBM) is represented at this conference by many partners from the private sector, NGOs, and multilateral organisations. RBM stands for free exchange and every partner, including endemic countries, belongs to the RBM structure and is represented on the RBM Board. The Partnership has set ambitious



“We need to accelerate our efforts to fight malaria in the short term, sustain what we have achieved in the middle term, and push for eradication in the long term.”

Awa-Marie Coll-Seck

Executive Director of the Roll Back Malaria Partnership (RBM)

targets for itself – achieving 80% coverage and use of preventive and curative interventions by 2010. The Millennium Development Goals (MGDs) have set other important targets for malaria. By 2015 the Millennium Development Goal No 6 on malaria but also on other malaria-related MDG targets, such as child mortality, maternal mortality and education, have to be achieved. To achieve these goals we need to aim at providing universal access to effective malaria interventions.

Scaling up for impact works

The results that the scale-up of interventions at country level has yielded clearly demonstrate that malaria control is possible. A number of African countries such as Eritrea, Ethiopia, Kenya, Namibia, Swaziland, Tanzania, Zambia and Rwanda, as well as some Asian countries like Vietnam and Cambodia have obtained encouraging results in reducing malaria incidence and mortality. The key success factors behind these achievements in countries are:

- Strong commitment from national governments,
- Multiple interventions for prevention and treatment,
- Partnership (public, private, civil society)
- Harmonisation and alignment of partners supporting country strategy planning,
- Cross border initiatives (e.g. the Lubumbo project comprising Mozambique, South Africa and Swaziland),
- Increase in resources from USD 60 million (ten years ago) to 1.2 billion (today).

Although more financial support is available today, a big push is still needed to cover the existing funding gap. Many countries are far from reaching their targets, especially countries with large populations and high malaria incidence, e.g. Nigeria and the Democratic Republic of Congo. To help remedy delays in implementation on country level RBM partners call for an aggressive acceleration phase of 36 months to reach the 2010 targets. A dedicated team, the Malaria Implementation Support Team (MIST) was created within the Partnership's structures to assist countries in accelerating their efforts. The team provides countries with the technical assistance they need to implement their plans. RBM advocates for a frontloading strategy to make necessary funds available in a timely manner.

Challenges

The ongoing challenges for the Partnership include limited capacity and poor performance of health systems in endemic countries, and difficult access to the poorest people, such as remote populations, migrants and refugees. Other challenges relate to quality assurance of



commodities, pharmacovigilance, research and development and monitoring and evaluation. Further investment in research and development would ensure that the malaria community is prepared to respond to the risk of resistance to current drugs. New drugs, insecticides and vaccines are needed, as well as a reliable monitoring and evaluation system to track progress. Implementing the common strategy for malaria control has a cost. Although funding for the disease has increased, the Partnership still needs to bridge a gap of USD 2 billion to be able to implement its plan. Mobilising the necessary resources is key to the success of the global effort to tackle malaria. In addition, funding for monitoring and evaluation and for strengthening health systems is insufficient. Strong health systems are the basis of successful implementation and sustained control.

Solutions and Strategies

The RBM strategy for increasing access to malaria prevention and treatment in endemic countries includes:

- Free ITN/LLITN distribution campaigns (immunisation)
- Home based care
- Operational research for increased community use
- Affordable Medicines Facility – malaria (AMFm)
- Greater involvement of non-medical people
- Promote behaviour change



- Health worker extension programme
- Community health volunteers
- Engaging NGOs, faith-based organisations and women groups

Rendering effective anti-malarials affordable is another important challenge for the international community. If effective artemisinin-based combination therapies (ACTs) were available at the price of chloroquine in every community, much more people would be able to access effective treatment. Almost 2/3 of malaria patients buy drugs at privately owned pharmacies and shops. Therefore, the solutions that we identify for keeping effective drugs affordable need to encompass both the public and the private sectors.

Global vision

In addition to best practices and national strategies, we need a global vision, a global long-term strategy that guides planning and helps donors realise that investing in malaria pays off. The new Business Plan of the Roll Back Malaria Partnership is combining the 2010 targets with a visionary strategy and an action plan to enable the Partnership to push for malaria eradication in the long term. 2008 is a year of opportunity. As we commemorate the First World Malaria Day on April 25th and celebrate the recent country successes and the powerful momentum that our joint efforts have created, we call for global mobilization to accelerate action.

PROMOTING AN INTEGRATED APPROACH OF MALARIA CONTROL

Malaria in Mozambique

Malaria in Mozambique is responsible for 40% of all out-patient visits at health facilities, for 60% of all under five admissions to hospitals and for 30% of all hospital deaths. Malaria prevalence varies between 40% and 90% within the country.

The Malaria Control Strategies in Mozambique include three principal strategies:

- Health promotion, community mobilisation and advocacy
- Diagnosis, case management and supply of drugs
- Integrated vector control and personal protection

These principal strategies have to be combined with support of the system through programme management and system development, emergency response as well as surveillance, information and research.

Diagnosis and Case Management

At the country level, the first line drug remains AS+SP. However, changes to Coartem are in progress. For second and third treatments, Coartem and quinine are applied, respectively. The treatment is free of charge at public health facilities. Most cases of malaria in the country are diagnosed clinically by using microscopes, which are available in most of the health facilities; rapid test kits are not yet available throughout the country. Due to high turnover of staff, frequent trainings are needed and the diagnostic capacity of many health staff is still very limited. The health information system still needs improvement, since supervision of diagnosis and case management are difficult due to the size and the diversity of the country. Nevertheless, general guidelines for the Malaria Treatment Policy for communities were distributed to all provinces. In addition, and due to last recommendations of WHO, Intermittent Preventive Treatment (IPT) has been incorporated in antenatal care services since April 2006.

Integrated Vector Control

Although the discussion about DDT continues at the national and international level,

“We also need integration on the operational level.”

its application in several regions of Mozambique has been successfully conducted. Indoor Residual Spraying (IRS) activities will be expanded further and DDT will be applied throughout the country, except in areas where it is not recommended, i.e., urban brick houses. Since 2000, about 2,300,000 Insecticide Treated Nets (ITNs) and Long Lasting Insecticide Treated Nets (LLITNs) have been distributed through public health programmes free of charge. In general, the population coverage of treated nets is about 30%. The aim is to increase funding for LLITNs in order to be able to cover first priority populations in non-sprayed areas before the end of 2008. Overall malaria indicators are improving, especially in those provinces that already have combined programmes in place. However, there is still a lack of financing for research institutions to generate statistical data on the country as a whole.

Research Activities

All research activities follow the approach of integration at the operational level. Research is being conducted on descriptive epidemiology, monitoring of drug resistance, and with regard to economic factors. Research in these areas is carried out in cooperation with the most important research institutions in Mozambique as well as the National Malaria Control Programme. Another research activity focuses on Intermittent Preventive Treatment (IPT) through the Expanded Programme on Immunization (EPI) as part of an international consortium, wherein the Roll Back Malaria (RBM) Partnership is represented in the coordination committee. Research activities on a malaria vaccine are being conducted to high standards through a unique international partnership between the Manhica Health Research Centre (CISM) in Mozambique, the Hospital Clinic of the University of Barcelona, the Mozambique Ministry of Health, The PATH Malaria Vaccine Initiative and GlaxoSmithKline Biologicals. The study to test the vaccine candidate RTS,S/AS02* in African infants has served as the first proof of concept in this population, proving that the vaccine has a promising safety and tolerability profile and significantly reduces malaria parasite infection and clinical illness due to malaria. Additional phase II trials are underway and a carefully designed phase III trial should start by the end of 2008. The phase III trial is intended to confirm safety and efficacy against clinical malaria in a large sample size across different transmission settings. These trials are being implemented by an international public-private collaboration that includes research institutions and scientists from six other African countries, GlaxoSmithKline Biologicals, and the PATH Malaria Vaccine Initiative (MVI). If the trials are successful, RTS,S/AS02* candidate could potentially reduce the burden of malaria and save millions of lives in Africa.

Acknowledgement

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* GSK Proprietary Adjuvant System



Eusébio Macete

Manhica Health Research Centre (Centro de Investigação em Saúde da Manhica, CISM), Mozambique and Center for International Health at the Hospital Clinic of the University of Barcelona, Spain

MALARIA CONTROL – THE EXAMPLE OF KENYA

The burden of malaria in Kenya

Malaria is endemic in Kenya, though its endemicity varies from region to region. Malaria is a huge burden in Kenya because in the highly populated areas, such as the coastal region and the Lake Victoria region, malaria is endemic throughout the year. In Kenya, malaria accounts for 3 out of 10 outpatient department (OPD) attendances and for one out of five of all deaths. Malaria causes the death of about four Kenyan children every hour. Malaria kills more people than HIV/AIDS, while HIV exposes people to more severe or deadly episodes of malaria. In the country, 170 million working days are lost and the Kenyan GDP is reduced by 1% annually due to malaria. In addition, malaria contributes to poverty, since each Kenyan family spends up to US\$ 20 annually for the treatment of malaria.

Malaria control strategies in Kenya – huge efforts made

Kenya's National Malaria Control Strategy was launched in April 2001. Seven years later, impacts of the strategy are visible and lessons learned are discussed.

Kenya's National Malaria Control Strategy includes four main interventions and two cross cutting issues:

Areas of intervention:

- Provision of prompt and effective treatment for malaria (Artemisinin-Based Combination Therapies - ACTs)
- Management of malaria and anaemia in pregnancy
- Vector control
- Epidemic preparedness and response

Cross cutting issues:

- Information/education/communication and behaviour change
- Monitoring and evaluation

Achievements are made in the area of these interventions as well as with regard to case management, which is an essential basis for conducting all activities. Regarding the case management in Kenya, guidelines have been printed and distributed, national

“The strong partnership between civil society, government, donors, communities and the private sector is a perfect example of joining forces constituting a crucial element in the fight against malaria.”

Athuman Chiguzo

Vice Chairman of Kenya
NGOs Alliance Against Malaria



and provincial training of trainers (ToTs) as well as trainings of health workers have been conducted, rapid diagnostic tests have been procured and distributed and a survey has been conducted on post market surveillance. Antimalarial drug availability and use was increased to 98% in 2006, compared to 89% in 2002 by measuring the proportion of facilities offering first line drugs. In addition, the proportion of children receiving correct doses of first line treatment increased from 69% in 2002 to 92% in 2006. But the target of intervention management of malaria and anemia in pregnancy, to have 60% of the pregnant women sleeping under insecticide treated nets (ITNs) and to receive at least two doses of Intermittent Preventive Treatment (IPT), could not be achieved. However, the ITN use of pregnant women rose from 4.7% in 2002/3 to 36.5% in 2006 and IPT scaled up through antenatal care (ANC) from 4% to 24% during the same period of time.

As for vector control, the use of ITNs is very important and 13.5 million ITNs were distributed between 2002 and 2006. Poor people benefited from a free mass distribution of 3.4 million nets to children (<5) in 2006. Household ownership rose from 4.6% in 2003 to 50.2% in 2006 and the use of ITNs by children (<5) rose from 4.6% to 51.3% during the same time. The target of the intervention epidemic preparedness and response to cover 680,000 house units with Indoor Residual Spraying (IRS) activities was superseded as in 2007 already 860,000 house units were covered. But all these activities need to be complemented by increased knowledge and awareness raising activities; hence the use of ITNs is perceived as a major tool for malaria prevention among the population. The knowledge about mosquitoes transmitting malaria has also increased significantly due to awareness raising campaigns.

Lessons learned

The example of Kenya shows that several elements are necessary in order to implement a comprehensive malaria control programme. Mostly important is a high level of political commitment from the government. Technical assistance by WHO, which included the secondment of two staff members for providing technical assistance on a daily basis, as well as adequate funding from bilateral and multilateral donors also played an important role in implementing Kenya's Malaria Control Strategy. The strong partnership between civil society, government, donors, communities and the private sector is a perfect example of joining forces constituting a crucial element in the fight against malaria. In addition, through free distributions of LLITNs, high population coverage was reached and some inequalities in net use were eliminated.

The example of Kenya shows that malaria is preventable and treatable. The activities still need to be improved, but as we have the tools and the financial means, no one needs to die of malaria.

SUMMARY OF THE PANEL DISCUSSION

Controlling Malaria – Responsibilities of Governments, Civil Society and the Private Sector towards Achieving Universal Access

It is a common understanding that effective malaria control is possible and that it is time to join forces and synergise action in order to scale up efforts towards achieving universal access. In this context, defining responsibilities of governments, civil society and the private sector is crucial. How can partnerships between different actors be fruitful and really benefit the poor and most-affected by the disease? Bringing together representatives of each of the sectors from European and African countries is a first step to clarify expectations, capabilities and limits. Ms Susan Killick (Deutsche Welle) as moderator encouraged a lively discussion and exchange of perspectives.

Taking the example of Kenya, Mr Gerald Walterfang (Kenya NGOs Alliance Against Malaria), pointed out that a real partnership between the private sector, government, civil society and faith based organisations is key for the effective implementation of the National Malaria Strategy in Kenya. Moreover, Walterfang emphasised the necessity of involving all sectors in the implementation of the different malaria control tools and highlighted the participation of local communities as a part of the solution. He defines the civil society as “a bridge between what the private sector is trying to offer and what the government may have failed to offer” playing also an important role to maintain an effective check and balance system.

Silvio Gabriel (Novartis) emphasised the important role of the private sector in increasing access to prevention and treatment measures, pointing out the huge potential of private sector enterprises to increase production capacities on the one hand and selling their products at relatively low costs when following not-for-profit policies on the other hand. In order to increase access to life-saving medicines, Gabriel called the international donor community to support programmes which make high quality drugs available in the so-called non premium private market and ensure their affordability. Governmental and donor support for research & development of new drugs remains equally crucial according to Gabriel.

“We need equal partnerships of governments, private sector and civil society”

Heide Richter-Airijoki (GTZ) stated that it is the responsibility of donors to integrate malaria control in health sector programs. In this context she pointed out that strengthening local health systems is a precondition for achieving universal access and that donors should therefore support adequate qualification and payment of local health personnel as well as the adaption of distribution systems to local contexts. Moreover, Richter-Airijoki underlined the importance of best-practice exchange between all different actors within and between countries as well as scaled up investments in research and development.

Pascoal Mocumbi (EDCTP), stressed the importance of international partnerships in research and development. At the same time he referred to the need of more research activities by specialists of endemic countries in order to enhance the ownership of clinical trials and to include the knowledge of traditional medicine. “Civil society networks on malaria giving advice to local governments who lack malaria control experiences as well as cross-border activities are good examples for working partnerships. But to effectively align different partners, a national malaria control strategy is key”, so Mocumbi.

Dr. Karl Addicks, German Member of the Parliamentary Committee of Economic Cooperation and Development, called for more commitment from African as well as European governments. He asked donor countries to develop their strategies in a way to “create a kind of social security for developing countries” enabling them to implement long term strategies.

The panellists agreed that universal access can only be achieved if ACTs are available on community level and that ensuring access of people living in rural areas requires the public as well as the private sector and integration of communities. Equal partnerships of governments, the private sector and civil society are essential for successful malaria control including monitoring of programs being implemented. The willingness to work together and share information poses the first step to take over the responsibilities collectively.

By Britta Deutsch



Karl Addicks, Pascoal Mocumbi, Susan Killick, Silvio Gabriel, Heide Richter-Airijoki, Gerald Walterfang

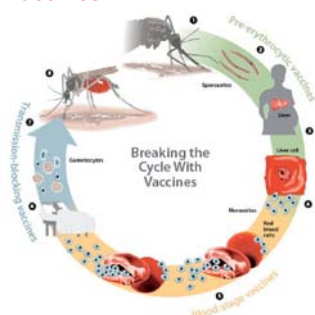
NEW TOOLS AND PARTNERSHIPS FOR RESEARCH AND DEVELOPMENT (R&D)

A broad range of tools for malaria control is available today. But in order to reach the goal of a malaria-free world, existing tools need to be improved so that problems like resistance can be appropriately dealt with. Moreover, malaria eradication requires sustained investment over time, including investments in research and development for new tools, and effective partnerships. Of equal importance is that these tools reach the people who need them. The development of an effective, accessible and affordable vaccine against malaria is a crucial step towards the goal of malaria eradication.

The PATH Malaria Vaccine Initiative (MVI), founded in 1999, is a Public Private Product Development Partnership (PPPDP) whose mission is to accelerate development of malaria vaccines and to ensure their availability and accessibility in the developing world. Funded by various public and private donors, MVI works with diverse partners, from academic institutions and private corporations to regulatory authorities and multi-lateral organizations, to achieve its mission. MVI seeks to foster collaboration among scientists and other researchers to achieve the goal adopted by the malaria vaccine community to develop a vaccine with at least 80% efficacy by 2025.

MVI can be described as a group of “malaria venture idealists”, who see the return on investment in terms of lives saved. In this regard, MVI particularly values its partnerships with clinical trial centres in Africa, given their critical role in establishing the safety and efficacy of malaria vaccine candidates.

Scientific approaches of malaria vaccines



“We are not talking about the present; we are preparing for the future, for the final straw to tackle malaria.”



Dr Christian Loucq

Director, PATH Malaria Vaccine Initiative (MVI), USA

Pre-erythrocytic vaccines

This type of vaccine targets the first stage of the parasite's lifecycle, as the sporozoite moves rapidly from the site of the bite into the liver and before it emerges from the liver. Thus far, it is these pre-erythrocytic vaccine candidates that have proven most successful.

Blood-stage vaccines

This type of vaccine targets the parasite in its merozoite stage, after it has emerged from the liver into the bloodstream. The challenge here is that the number of parasites is now much larger than in the previous stage.

Transmission-blocking vaccines

Transmission-blocking vaccines target gametocytes that enter the mosquito as it feeds on an infected human. Such vaccines would try to cut the transmission cycle or use the human immune system's machinery to act on the parasite's lifecycle in the mosquito itself.

MVI's Portfolio

In general, the development of a vaccine takes about 10-15 years. MVI has different categories of vaccine candidates at various stages of development in its pipeline. Many are based on recombinant proteins designed to target the parasite at different stages in its lifecycle: either before the parasite emerges from the liver (pre-erythrocytic vaccine candidates) or after it has emerged from the liver into the blood stream (blood-stage). Another approach is based on attenuating or weakening the parasite in its pre-erythrocytic stage. A third approach seeks to use other pathogens that have been weakened so as not to cause disease – such as viruses or bacteria – to deliver the vaccine component (usually a recombinant protein).

The most advanced candidate in MVI's portfolio, GlaxoSmithKlines's RTS,S, is completing a Phase II program and is expected to enter a Phase III trial soon. Studies to date among adults in developed countries and among adults, infants and young children in Africa, have shown RTS,S to provide a partial level of protection: 50% against severe malaria, 30% against clinical malaria. The Phase III trial will involve 16,000 infants and young children in 10 clinical sites in seven African countries.

If all goes well, this vaccine will be submitted for approval by the appropriate authorities as early as 2011 and could be available for use soon after that. Already, however, we are working to develop a next-generation vaccine that will fulfil that 2025 target by having at least 80% efficacy. While continuing efforts to scale up the use of current interventions is very important, I would like to encourage you not to forget the necessity of continuously investing in the future so that we finally win the fight against this disease.

NEW DEVELOPMENTS IN BED NETS

Effective and sustainable malaria control requires improved technologies of existing control tools. Bed nets are very effective measures of malaria control. It has been proved that properly used, insecticide-treated nets can cut malaria transmission by up to 90% and reduce child deaths by a fifth.

But as with malaria therapies, also prevention tools like bed nets have to deal with increasing resistance of vectors against active ingredients and chemicals.

Background of the new technology net

Insecticide resistance in mosquitoes is a very old problem, first recorded in 1947, but very poorly documented through a lack of monitoring. Moreover, there is also a lack of data regarding the mechanisms of resistance of different vector species to address the problem of cross resistance and multiple-resistance.

There have been no new classes of insecticides introduced for mosquito control for over 20 years. WHO recommends only synthetic pyrethroids for use in bed nets because they are the only class of chemicals that both have a rapid knock-down effect and a safe use in the close human proximity. Despite the fact that research for new classes of chemicals is ongoing, we still have a long way to go until these new classes will be available. Furthermore, it will only be a matter of time until resistances occur for these new chemicals as well. Consequently, research and development will be a continuous task for the decades to come.

Insecticide resistance today

Insecticide resistance appeared in major insect vectors from every genus and to every chemical class of insecticide, including microbial drugs and insect growth regulators. There are different types of resistances, which can be differed in metabolic resistance with different enzyme groups involved, which are toxifying the insecticide and resistances due to altered target sites of the insecticide.

“Research and development will be a continuous task for the decades to come.”

Dr Helen Pates Jamet

Vestergaard Frandsen,
Denmark

Years	WHO approved insecticides		
1940-45	DDT		
1946-50	Lindane		
1951-55	Malathion		
1956-60			
1961-65	Fenitrothion	Propoxur	
1966-70	Chlorpyrifos-methyl		
1971-75	Pirimiphos-methyl	Bendiocarb	Permethrin
1976-80	Cypermethrin		
1981-85	Alpha-cypermethrin	Cyfluthrin	
	Lambda-cyhalothrin	Deltamethrin	Bifenthrin
1986-90	Etofenprox		
1991-95			
1996-00			
2001-05			

■ Organochlorines ■ Carbamates
■ Organophosphates ■ Pyrethroids

The problem is exacerbated by extensive use and misuse of the same insecticides in agriculture. The resulting resistances threatened the long-term ability to control insect vectors and moreover have a large impact on re-emergence of vector borne diseases until today.

PermaNet 3.0 - a new generation bed net

In order to cope with insecticide resistances and making bed nets more effective, Vestergaard Frandsen developed a new technology bed net, which consists of different materials of the roof and the sides, also treated with different chemicals.

PermaNet 3.0 is the first Long Lasting Insecticide Treated Mosquito Net (LLITN) which is active against resistant mosquitoes due to DM and synergist combination on the roof.

SUMMARY OF THE PANEL DISCUSSION

Achieving Long-Term Availability of Malaria Control Measures

Achieving long-term availability of malaria control measures is an important milestone on the way to defeat malaria and therefore reaching the MDGs. In this context it is vital that all existing tools are accessible. Moreover, reaching MDG6 will not be possible without increased efforts in the research and development of more effective as well as new tools. What control measures are there and what tools are needed in the future? Which new products have been developed? How can these measures be accessed by the people most in need? What steps towards this goal have been done so far? And what is the role of the private sector in this regard? These issues were discussed between international representatives of private sector enterprises and Public Private Product Development Partnerships (PPDPs) as well as NGOs from Sub-Saharan Africa in the framework of the panel discussion held at the second day of the International Conference "Joining Forces, Synergising Action: Sustainable and innovative ways of ensuring long-term availability of malaria prevention and treatment measures by 2015". The panel discussion was moderated by Sunil Mehra (Malaria Consortium, UK) who promoted a lively and interesting exchange of perspectives.

Research and development of effective and accessible antimalarial drugs is one of the key areas in which PPDPs are involved. "We are trying to develop antimalarials on the highest international standards. Quality is part of what we do" emphasised Dr Chris Hentschel (Medicines for Malaria Venture/MMV). The Geneva-based organisation is specialised on the research and development of anti-malarial drugs that have advantages over the anti-malarials already available on the market. "I don't think innovation should stop until we have reached our ultimate objective, which is malaria eradication" Hentschel stated. Moreover, Chris Hentschel pointed out that low costs of raw materials is a key factor to ensure the availability of drugs in the long-run and that the real aim of R&D is to bring down the price of the product without subsidies.

"Long-term availability of control measures, means not only the product itself, but the supply chain, integrated vector management, insecticide resistance management, training of IRS teams in endemic countries."

In this context Ann-Marie Sevcsik (Drugs for Neglected Diseases initiative/DNDi) agreed that PPDPs have to be needs-driven by nature. Likewise, she underlined that effective partnerships and early management to help making drugs available are vital for ensuring long-term availability of treatment tools, referring to the that forces have to be joined in the context of idea exchange in order to strengthen delivery on the ground.

Robert Farlow (BASF) emphasised the great need for new insecticides, which is recognised by the private industry. At the same time companies struggle with the return on investment when researching for poverty related diseases. "If we look at the global market for public health insecticides, traditionally the market did not justify a company developing a product solely for public health. The only way to justify that investment, was to take a compound that had agricultural uses and secondarily develop it for public health where appropriate" said Farlow. In the context of the recent increase in funding and under the precondition that it is really sustainable over time, private companies have to evaluate whether the market is really going to justify investment in research and development in a larger time span, Farlow pleaded. Moreover, Farlow maintained the importance of the delivery side: "There is a need of ▶



280 million nets by 2010 and the orders have not been placed yet. If we wanted to have that number of nets available by 2010 we should have scaled up efforts yesterday. Obstacles in delivery to the end user need to be abolished. We need to deliver on time.”

Gerhard Hesse (Bayer) described a paradigm shift for chemical companies, which started developing new technologies and taking them to the countries in need and furthermore also engaged in strengthening local production. “If we talk about long-term availability of control measures, we do not only talk about the product itself, but the supply chain (including supply of services), integrated vector management, insecticide resistance management, training of IRS teams in endemic countries”, said Hesse.

Investments in the research and development of new malaria control measures could be justified through the strive of private companies for innovation leadership and the commitment to corporate social responsibility, Hesse declared.

Some of the key questions within the discussion were how to engage the private sector more fully and how to harness the energy of the private sector? Stephen Phillips (ExxonMobil) described three kinds of companies active in Africa: the suppliers (pharmaceutical companies, insecticide and bed net manufacturers), management consultancies and big multinational operators like Exxon, altogether having 300.000 employees in Sub-Sahara Africa alone. Malaria transmission areas coincide with oil and gas resources in Africa; therefore companies have experiences with malaria, stated Steven Phillips. Malaria is an obvious business threat (to employee health and productivity, to investments and assets) and developing a workplace program is just mandatory.

Phillips emphasised that the private sector can bring in a lot more than supply chain management and business planning such as partnership and project management in order to make these multi-national and multi-sectoral partnerships work.

Availability of control measures has various implications on the implementation side and cannot work without committed actors on the grass-roots level in order to reach the people in need. “If the people at the grass-roots level are not involved and do not know how to use malaria prevention and treatment measures, long-term availability cannot be obtained. If we cannot fill the gap between international donors and experts and local communities we will not achieve our goals”, stressed Koffi Toussah. Additionally, Toussah indicated that net-distribution has to be combined with awareness raising for malaria and its prevention and treatment, that illiteracy and not existing beds are a problem as it is with distribution to the rural areas. “Don’t ask, lets act: join forces with the local communities is essential to reaching a public health impact. In order to get the full benefit of the investment, we have to ensure maximum reach and maximum use” as Toussah concluded.

The panellists confirmed that long-term availability of malaria control measures comprises different tools and different actors. Without increased efforts by international donors and private enterprises in terms of providing financial means, political commitment and expertise for research and development of medicines to combat poverty related diseases, as well as an increase of effective and sustainable partnerships for development and delivery, the battle against malaria will be lost.

By Antje Mangelsdorf



Chris Hentschel, Robert Farlow, Steven Phillips, Ann-Marie Sevcsik, Koffi Toussah. Gerhard Hesse

MULTILATERAL FINANCING FOR POVERTY-RELATED DISEASES – THE GFATM PERSPECTIVE

A new way of doing business

The Global Fund is an independent, transparently and accountably operating Public Private Partnership (PPP) mandated to raise and disburse substantial new funds and to achieve sustained impact on HIV/AIDS, tuberculosis and malaria.

The Global Fund:

- Supports programs that evolve from national plans to fill critical gaps at country level
- Recognizes only a country driven, coordinated approach for proposal development and implementation
- Its core function remains that of financing, disbursing and managing new funds
- Relies on its **partnerships** with other development and technical partners, civil society and the private sector to support countries in delivering effective programs and services to communities in need

Global Fund Resources

The total pledges available through 2010 are 18.5 billion USD, from which approximately 9.17 billion USD have been paid in already. The Global Fund has approved proposals with a volume of 10.08 billion USD, 5.2 billion USD have been disbursed so far. From 2008-2010 the Global Fund provides 9.7 billion USD for ongoing and new programs. After Round 7 of proposals malaria programs in 78 countries and with 146 components have been supported. The total amount of money that has been obligated in grants is about 1.8 billion USD for the first two years of the grants and over the 5 year phase about 5.6 billion USD is totally available for malaria. Since the set up of the United Nations Millennium Development Goals, wherein fighting HIV/AIDS, malaria and tuberculosis is one of the eight goals, we have seen a 20-fold increase in international funding for malaria control from about 50 million USD in 2000 to 841 million USD in 2005. New major funding initiatives launched by the World Bank and the United States of America in 2005 suggest that resources for malaria control will continue to increase. The **share** of the Global Fund in 2005 was **64%** of this international funding, whereas 22% came

“Since the set up of the United Nations Millennium Development Goals we have seen a 20-fold increase in international funding for malaria control.”

from bilateral, 13% from multilateral programs and 1% from private sources. According to the latest financial resources estimates to attain international malaria goals, published by WHO in August 2007, a total of US\$ 38 to 45 billion will be required from **2006 to 2015**. The average cost during this period is **US\$ 3.8 to 4.5 billion per year**.

Successful example of PPP: Lubombo Region

The Lubombo Spatial Development Initiative is a collective development project of the governments of Mozambique, South Africa and Swaziland to develop the Lubombo Region (which straddles the three countries) into an economic zone. This Global Fund grant builds on a **highly successful public/private partnership between BHP Billiton and the regional malaria commission**. The successful program was approved in Round 2 and expanded in Round 5. The main activities include vector control, particularly through IRS, strengthening surveillance and health system capacities and providing prompt and effective.

Signs of Impact:

- Malaria incidence reduced by 87-96 percent
- 82-87 percent reduction in malaria mortality and hospital admissions in four years
- Parasite prevalence among children under five declined by 53-94 percent

Challenges

- (1) Scale up in operational capacities on the delivery system side is essential to meet increased financing needs. Moreover, the advocacy focus has to be switched to the delivery side as well and ensuring that this keeps up with the funding.
- (2) Maintaining interest in sustaining a low-level of malaria versus rapidly reducing malaria hence rapid progress is often due to extraordinary methods such as mass campaigns.
- (3) How to build national capacity for routine implementation?
- (4) How to assure that malaria control is an integral part of the routine health system and national planning?
- (5) What is our malaria goal: Control, elimination, or eradication? How do we assure that these are the country goals? During the last two years announced goals range from disease control, elimination of deaths, 50% death reduction, 80% coverage, 85% coverage and 100% coverage. This whole range of different goals has profound impact of country programs and strategies.



Dr Mark Grabowsky

Malaria Coordinator,
The Global Fund to Fight
AIDS, Tuberculosis and
Malaria, Switzerland

INNOVATIVE FINANCING MECHANISMS

How to raise money for malaria control?

We have seen a dramatic increase in funding for Africa during the last 20 years. But at the same time, resource needs for tackling malaria worldwide are estimated to increase from about 2.8 billion USD in 2006 to 3.6 billion USD annually until 2010. There is a large gap between international resources provided (USD 600 million in 2005) and financing needs which cannot be filled by endemic countries alone. Domestic funding will always stem from taxation and there will be the usual priorities set by the respective governments.

Additionally, out of pocket expenditures including user fees remain inequities and a barrier to access for the poor. And then, we have the private and voluntary pre-payments insurance which represents only about 3% of the total expenditures for health in Sub-Saharan Africa. In order to fill the financing gap for malaria, additional funding has to come from the international community as well. The estimated need of financial resources to tackle malaria is not an impossible amount to mobilise. Despite demanding the provision of additional financial resources, our advocacy focus also has to be on aid effectiveness. Above all, funding has to be predictable. Moreover, we have to adhere to the Paris Declaration on Aid Effectiveness and we cannot drop the emphasis on good governance, capacity building, accountability and transparency. In addition to that, partnership between the different actors is absolutely vital, but even more vital is that these partnerships agree to a unified approach, the unity of purpose and the unity of that we are doing the right thing in order not to undermine the confidence of the donors. Having a realistic vision, having targets and raising expectations but not to over promise in order to maintain the level of funding, even after the curve has reached its exponential point is essential in this context. Hence, the confidence of donors will lead to sustained funding.

Innovative Financing Mechanisms

Aid Guarantee Facility

- Suggested to protect recipient countries from the effects of delayed or halted funding

“If you get it right for malaria, you actually get the whole health system right. Let malaria be the leader of what we try to achieve in so many other areas.”

Debt Conversion

- Arrangement, whereby creditors forego future debt repayments on the condition that the money saved is used for financing the MDGs targets

International Financing Facility

- Frontloading aid by issuing bonds guaranteed against future aid commitments
- Aims to increase predictability of aid and to provide a boost to help reach MDGs

Unitaid

- International Drug Purchase Facility launched September 2006
- Current donors – France, Norway, Brazil, Chile, UK
- Aims to reduce drug prices through bulk buying and making use of the flexibilities allowed to developing countries in the WTO's intellectual property rights rules

Air ticket solidarity levy

- Tax on air travel, the funds from which are hypothecated to fund UNITAID
- Implemented by France, Chile and soon Brazil
- Expected to generate more than Euro 200 million in the first year

Public Private Partnerships

- Account for 75% of neglected disease drug R&D
- Challenge: Underutilization of PPPs for ideological reasons
- But: PPPs are one of the best inventions for sharing risks

Action is needed now!

Action needs to be taken now, as with every day of delay more than 4,500 people die of a disease that can be treated and prevented. The international community must take a two-pronged approach to financing the achievement of malaria-related MDGs, ensuring:

- that increased funding is predictable and sustainable;
- and that available resources will be effectively deployed.

Moreover, innovative financing mechanisms have to be implemented before they are perfect in theory. We need Africa and Europe together to come up with more money and more innovative ways to use both effectively so that the totally avoidable scourge on mankind which is malaria can be defeated and treated. We must go for the early win and recognise that it is a long finish.



Stephen O'Brien

MP, Chairman of UK All-Party
Parliamentary Group

SPEAKERS' CVS

Addicks, Dr Karl

Dr Karl Addicks, MP, is Member of the German Parliamentary Committee of Economic Cooperation and Development and spokesperson on development policy for the Liberal Democrats (FDP). A member of the Liberal Democrats since 1989, he became Member of the German Parliament in 2004. Dr Addicks worked as company doctor in Nigeria, Iraq, China and Morocco from 1987 to 1999. Besides managing a surgery in Germany, he continued to work in the field of development cooperation by supervising a GTZ health project in Morocco. Due to his professional background as a medical doctor for general and tropical medicine, he is very interested in the linkage between health and development issues.

Bonsmann, Christoph

The pharmacist Mr Christoph Bonsmann works for the German medical aid organisation action medeor and is head of the department of Pharmacy and Development Cooperation. One of his major tasks is the transfer of pharmaceutical technology to East Africa. In Tanzania he set up a non-profit pharmaceutical wholesaler. Medicines are bought from regional manufacturers, which have been inspected and approved beforehand. Currently, he works on a project financed by the European Commission, which includes the setting up of a pharmaceutical factory in Northern Tanzania for the production of high quality antiretrovirals.

Chiguzo, Athuman Nyae

Mr Athuman Chiguzo is Project Coordinator and Malaria Technical Officer of the Sustainable Health Care Foundation (SHEF) since 2006. He also holds the position of Vice-chairman of the Kenya NGOs Alliance Against Malaria (KeNAAM) which brings together over 60 non-governmental organisations (NGOs). KeNAAM seeks to enhance collaboration through networking in programs which aim to prevent, control and reduce the socio-economic impacts of malaria. As a member of the Global Fund malaria community delegation, Mr Chiguzo has profound experience with international programmes against

malaria. He used to work for different development organisations and the Ministry of Health in Kenya. Mr Chiguzo obtained his MSc in Control of Infectious Diseases at the London School of Hygiene and Tropical Medicines (University of London).

Coll-Seck, Prof Awa-Marie

Prof Awa-Marie Coll-Seck is Executive Director of the Roll Back Malaria (RBM) Partnership. RBM is a global partnership founded in 1998 by WHO, UNDP, UNICEF and the World Bank, with the goal of halving the world's malaria burden by 2010. Prior to this appointment, Prof Coll-Seck was Minister of Health of the Republic of Senegal (2001-2003). From 1996 to 2001, she served as a director at the Joint United Nations Programme for HIV/AIDS (UNAIDS) at its headquarters in Geneva (Switzerland). As director of the UNAIDS Department of Country and Regional Support, she coordinated and mobilised the UN system's response to the epidemic while supervising UNAIDS staff serving throughout Africa, Asia, Eastern and Central Europe, Latin America and the Caribbean. After earning a degree in medicine from the University of Dakar, she served for nearly twenty years as a specialist in infectious diseases in leading hospitals in Dakar, Senegal and Lyon (France). In 1989, she was appointed Professor for Medicine and Infectious Diseases at the University of Dakar and Chief of Service for Infectious Diseases at the University Hospital in Dakar.

da Gama, Louis

Mr Louis da Gama is a malaria activist for Global Health Advocates since 2006 and has campaigned both globally and at country and community level for greater financial resources from the donor community to fight malaria. In 2003 Mr da Gama was seconded to the Massive Effort Campaign working on advocacy for AIDS, TB and Malaria and advocacy to support the Global Fund. He also led the Drop the Malaria Tax Campaign for Massive Effort to hold African leaders accountable for promises made at Abuja declaration in 2000 and facilitated the setting up of the Malaria Foundation International

European Office in 1998, working on increasing transparency and accountability of funds and on resource mobilization for fighting malaria. Mr da Gama is a member of several initiatives and working groups, e.g. Roll Back Malaria (RBM) working groups, a member of the Communities delegation to the Global Fund board representing the malaria community, a member of the Community delegation to the UNITAID board, a member of the WHO GMP Strategic Advisory Group (STAG) and a member of the advisory board of the World Bank Malaria Booster programme. He also serves as strategic adviser to the European Alliance Against Malaria EAAM and the UK Coalition against Malaria CAM.

Farlow, Dr Robert

Dr Robert Farlow works for the BASF Company as manager for Global Research Insecticide Field Biology since February 2004. He started his career at BASF in July 2000 as manager for Insecticide Project Management and then manager for Global Insecticide and Nematicide Development. Dr Farlow has 25 years of experience in the agrochemical industry in areas of research and development, management and strategic planning and is a key contributor to research and development, planning and implementation of business strategies. By education, Dr Farlow is entomologist and received his Ph.D. on Entomology and Experimental Statistics at Mississippi State University (USA).

Gabriel, Silvio

Mr Gabriel is Executive Vice President and General Manager of Malaria Initiatives at Novartis. In this role, Mr Gabriel has direct responsibility for managing the Novartis initiative on malaria. Mr Gabriel's responsibilities encompass all aspects of the antimalarial drug Coartem from development, production and supply to marketing, life cycle management and alliance management with external stakeholders to ensure supply of this lifesaving drug to millions of patients. Mr Gabriel assumed his current role in 2005 from his previous position as Head Novartis

Pharma Region Europe which included Africa and the Middle East. He joined the company in 1983 and started his career in various positions at the headquarters in Switzerland, Brazil, Portugal and Germany. After completing his studies in economics with honours at the University of Zurich, Mr Gabriel was active in the areas of finance, controlling and strategic planning in different companies in Switzerland and the USA.

Grabowsky, Dr Mark

Dr Mark Grabowsky is a medical doctor and epidemiologist and serves as the Malaria Coordinator at the Global Fund for AIDS, TB and Malaria. He provides technical advice on malaria programming within the Global Fund and works with partners to provide a Global Fund perspective on new initiatives. Prior to coming to the Global Fund in 2006, Dr Grabowsky worked at the American Red Cross where he managed the measles initiative, at WHO in Uganda where he was a medical officer for immunizations, at the National Institutes of Health in Washington where he was the Chief of AIDS Vaccine Testing and Chief of AIDS Prevention Research. He received his medical training at the Medical College of Virginia and Johns Hopkins School of Public Health. His first experience with malaria was as a Peace Corps volunteer teacher in Kenya thirty years ago.

Hentschel, Dr Chris

Dr Chris Hentschel is President and Chief Executive Officer of the Medicines for Malaria Venture (MMV) in Geneva, Switzerland. MMV is a not-for-profit foundation that aims to facilitate the discovery, development and delivery of affordable new drugs for the treatment of malaria. Dr Hentschel graduated in biochemistry from King's College in London (UK) and obtained a doctorate from the same institution. His early career focused on basic biomedical research at the Imperial Cancer Research Fund in London, as a lecturer at the Swiss Federal Institute of Technology (ETH) in Zurich, and finally as a Fogarty Fellow at the National Institutes of Health in Bethesda (MD), USA.

Hesse, Dr Gerhard

Dr Gerhard Hesse is Business Manager Vector Control at Bayer Environmental Science in Lyon. He is a member of several WHO expert groups like GCDPP (Global Collaboration for the Development of Public Health Pesticides) and used to be a member of the private sector constituency in the Roll Back Malaria (RBM) Partnership board, the Vice Chairman of the RBM board and the Private Sector Advisor to the World Bank's Booster Programme for Malaria Control. By education, Dr Hesse is a medical entomologist and a doctor in natural sciences.

Kilian, Dr Albert

Dr Albert Kilian is Director Monitoring and Evaluation at the Malaria Consortium with focus on all aspects of M&E and research. In addition, his post is covering malaria control design and implementation as well as policy development including work with the private sector. He works with the Malaria Consortium since 2005. As a public health expert (infectious disease control), malaria expert and paediatrician, he has 17 years of work experience in public health and spent 10 years working in developing countries on disease control projects and programmes as well as health systems mainly in Uganda and Liberia. Moreover, he worked as Senior Planning Officer for Disease Control in the headquarters of GTZ. Dr Kilian is a member of several national associations and societies of tropical medicine and a member of the Roll Back Malaria (RBM) Partnership Technical Network on Malaria and the Technical Review Support Group of the GFATM. Dr Kilian obtained his doctorate at the University of Hamburg in 1988 and holds a Master of Public Health from Johns Hopkins School of Hygiene and Public Health in Baltimore (USA).

Killick, Susan

Mrs Susan Killick is responsible for the Africa output of the English Service of Deutsche Welle (DW) and joined the Africa English Service of Radio DW. Subsequently she headed the Africa Desk for several years. Mrs Killick grew up in Johannesburg (South

Africa) and was mainly educated in the United Kingdom. Mrs Killick studied Drama and German at the University of Bristol and the Justus Liebig University in Gießen (Germany). She went on many trips to Africa, among others, for two co-productions in Nigeria as well as in Ghana and Zambia.

Lehmann, Dr Dietrich

Dr Dietrich Lehmann is Director-General in the Federal Ministry for Economic Cooperation and Development, responsible for general administration, the Berlin Office and Co-operation with Public and Private Institutions in Germany since November 1998. From 1983-1987 he was Head of Division (European Affairs) in the Ministry for Federal Affairs of the State of North-Rhine Westphalia (NRW). Moreover, he was group manager for the co-ordination of affairs of the Bundestag (Federal Parliament) and the Bundesrat (Chamber of Representatives of the federal Laender) from 1987-1993, Chief of office in the Ministry for Federal Affairs and permanent representative of the plenipotentiary of the State of NRW to the Federal Government in 1994 before obtaining the post of chief of office with central responsibility for personnel, budget and organisation in Bonn, Berlin and Brussels in the Ministry for Federal and European Affairs, which he held from 1995-1998.

Loucq, Dr Christian

Dr Christian Loucq directs the PATH Malaria Vaccine Initiative (MVI), which seeks to accelerate the development of malaria vaccines and to ensure their availability and use in developing countries. Dr Loucq has more than 30 years of experience in medicine, pharmaceuticals, vaccines and global health. His professional experience spans the globe: born and educated in France, he has lived and worked in Algeria, Belgium, Chad, China, India, the Netherlands, Niger, Switzerland, Thailand and the United Kingdom. Mr Loucq has managed vaccine businesses in China, India and Thailand and has been involved in most stages of vaccine development. He worked with large vaccine companies, such as GlaxoSmithKline and Sanofi Pasteur, as

well as with biotech companies including Rhein Biotech and Acambis. He has extensive experience partnering with local governments, building public-private partnerships and setting up local private collaborations. Dr Loucq earned his state doctorate of human medicine at the University of Paris and holds a diploma of Public Health and Tropical Medicine from the University of Aix-Marseilles.

Mehra, Sunil

Mr Sunil Mehra brings over 20 years of experience of working with USAID, DFID and other donor programmes and projects. Currently, the Executive Director at the Malaria Consortium, Mr Mehra is recognised for strategic planning and programme development in areas of maternal health, child health, community development and communications. Mr Mehra has worked in over 20 countries in East and South Asia, the Middle East and Africa. Mr Mehra is specialised in leading cross-cultural teams; development, management and monitoring and evaluation; design and implementation of marketing and communications strategies; institutional development; human resources development including competency-based and problem-based methodologies.

Mockenhaupt, Dr Frank P.

Dr Frank Mockenhaupt is deputy director at the Institute of Tropical Medicine and International Health at Charité University Medicine in Berlin since 2006. In 2001, he became head of the Malaria Research Group at the Institute of Tropical Medicine in Berlin which supervises and conducts clinical-epidemiological studies on malaria in Ghana. In his position, he is also responsible for supervision and the research lab. He started as a research associate in 1997 by conducting different clinical-epidemiological studies on malaria in Nigeria and Ghana for the Institute of Tropical Medicine in Berlin and the Department of Infectious Diseases at Charité University Medicine in Berlin. He graduated in Tropical Medicine and Public Health (DTMPH). Dr Mockenhaupt is particularly interested in the genetics of hosts regarding

resistance and susceptibility, treatment and drug resistance, pathophysiology of malaria in pregnancy and interaction with non-communicable diseases.

Mocumbi, Dr Pascoal

Dr Pascoal Mocumbi is the high representative of the European and Developing Countries Clinical Trials Partnership (EDCTP) since March 2004. EDCTP is a coalition to accelerate the development of new clinical interventions to fight HIV/AIDS, malaria and tuberculosis in developing countries, particularly in sub-Saharan Africa, and to generally improve the quality of research in relation to these diseases. Dr Mocumbi was Prime Minister of the Republic of Mozambique from 1994 to 2004. Prior to that, he headed the Ministry of Foreign Affairs during eight years and the Ministry of Health for six years. He received his medical degree from the University of Lausanne and practiced medicine as an obstetrician and gynaecologist in hospitals throughout Mozambique. Dr Mocumbi also plays an active role in several global health initiatives, serving on the board of the International Women's Health Coalition (IWHC) and the Medicines for Malaria Venture (MMV).

O'Brien, Stephen

Stephen O'Brien (51) has been Conservative Member of Parliament for Eddisbury since July 1999 and is Shadow Minister for Health. From May to December 2005, he served as the Shadow Minister for Higher Education & Skills. From 2003 to 2005, he was Shadow Secretary of State for Industry. Previously, he held the posts of Shadow Minister for the Treasury, an Opposition Whip, Acting Director of the Leader's Office and Parliamentary Private Secretary to the Party Chairman. Having gained his MA degree in law at Cambridge University, Stephen qualified as a solicitor practising international commercial law in the City of London until 1988. For the next 10 years he was International Director and Group Company Secretary of FTSE 100 Redland PLC (building material producers). He is Chairman of the All Party Parliamentary Malaria Group, as well as the All Party Group on Tanzania, and Vice-Chairman of the Aid,

Trade and Debt Group. In a voluntary capacity he is Director of the Liverpool School of Tropical Medicine and also the Chairman of the Malaria Consortium (a UK based NGO delivering malaria programmes in many countries across sub-Saharan Africa, Asia and the Americas). Stephen is married to Gemma (a registered nurse) and has three children.

Pates Jamet, Dr Helen

Mrs Helen Pates James is a medical entomologist and working as a project manager in the innovation centre at Vestergaard Frandsen. She has spent 6 years working in Tanzania on mosquito behaviour attractance and repellence and also resistance, especially for *Anopheles gambiae*.

Phillips, Dr Steven C.

Dr Steven C. Phillips is the Medical Director of Global Issues and Projects at Exxon Mobil Corporation where his responsibilities include overseeing the corporation's „outside-the-fence“ community and public health programmes throughout its global operations. In this capacity, he has worked closely with governments, NGOs, UN agencies, multilateral, faith-based and community organizations as well as the private sector in fostering public-private partnerships as a development platform to address urgent global health priorities. Dr Phillips received his B.S. and M.D. degrees from Stanford University. He did his post-graduate training in Internal Medicine at the University of California (San Francisco), received a Master of Public Health from UCLA and is certified in Internal Medicine and Occupational Medicine. Prior to joining Exxon, Dr Phillips served in the US Public Health Service and was assigned to the Epidemic Intelligence Service of the Center for Disease Control in Atlanta. Dr Phillips is a member of the American College of Physicians and a Fellow of the American College of Epidemiology. He currently serves on the boards of the Roll Back Malaria Partnership, Malaria NO MORE™ and the World Economic Forum's Global Health Initiative. He is also a member of the Harvard School of Public Health's Leadership Council

and the advisory panels of Medicines for Malaria Ventures, Episcopal Relief and Development's „NetsforLife“ Initiative, the World Bank Malaria Booster Programme and the International Strategic Advisory Group of the Global Business Coalition on HIV/AIDS, TB and Malaria.

Potter-Lesage, Peter

Mr Peter Potter-Lesage is an international finance and banking executive with over 15 years of experience, particularly in the not-for-profit finance sector. Specialised in the areas of treasury, foreign exchange, control and cash management operations, he was formerly responsible for global relations with international organisations and institutions at a major Swiss bank.

Sevcsik, Ann-Marie

Ms Sevcsik is Communication Manager of Drugs for Neglected Diseases Initiative (DNDi). DNDi was established in 2003 by seven organisations from around the world. It is an independent, needs-driven, not-for-profit entity which will develop new drugs or new formulations of existing drugs for patients suffering from the most neglected communicable diseases – diseases that fall outside the scope of market-driven research and development (R&D) because they do not constitute a profitable market.

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Mr Miodrag Soric was named Editor-in-Chief of DW-RADIO in January 2006. Previously, he had the same position in the Central/Eastern Europe, South-Eastern Europe, Africa/Middle East Services and DW-RADIO's Asia Programme. Mr Soric is currently responsible for all radio programmes which are broadcasted all around the world. Previously, Mr Soric, among other posts, was editor on duty for the Political Affairs and Business Department of the DW Central Service as well as programme adviser to former Director-General Dieter Weirich. In 1995, Mr Soric was named head of the Russian Service. Mr Soric graduated in Slavonic studies, political sciences and German language and literature studies at the Universities of Cologne, Kiev and Moscow.

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Mr Koffi Toussah is Secretary General of the association „Amitié et action pour le développement“ which has been active in the fight against malaria for four years. The association is a partner organisation of action medeor. As civic educator, he was chairing the civic education association „Centre d'Observation et de Promotion de l'Etat de Droit“ (COPED) for six years. In addition, Mr Toussah gained experience in health training and sensitisation, e.g. through leading sensitisation and leprosy detection campaigns throughout Togo, with the help of the German organisation Aktion Canchanabury for about 14 years. Mr Toussah was Chief Commissioner of the Scouts Association in Togo and Vice President of the African Youth Network. Professionally Mr Toussah was appointed technical counsellor of the Ministry in charge of local communities in 2006 after teaching English language in high schools.

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Mr Walterfang is the Chief Executive Officer of Kenya NGOs Alliance Against Malaria (KeNAAM) since 2003. He has over 14 year experience working with NGO-FBO-CBOs, government, private sector, academia, bilateral, and multilateral organisations. His experience includes working within the health sector, food security and youth affairs. As Chief Executive Officer of KeNAAM, Walterfang played an active part in enhancing Civil Society Organizations relations with those of the Governments nationally and with the neighbouring countries through networks dealing with malaria such as the Eastern Roll Back Malaria Network. Mr. Walterfang has also served as a CSO resources person reviews and consultancies on the functioning of the Global Fund. He is also a member of many technical working groups within the Kenya National Malaria Control Program and International Malaria Advocacy Groups such as Movement Against Malaria In Africa-MAMA. Mr Walterfang did his MA in Communication Studies at the School of Communication Studies at the University of Leeds (UK) in 1996 and his BA

in Political Science (economics/international relations) and Psychology at the University of Victoria (Canada). Currently, Mr. Walterfang is completing a scholarship award by Coca Cola and the United States International University on transformational leadership with the NGO sector, an Executive Msc Organizational Development.

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FINAL COMMUNIQUÉ

INTERNATIONAL MALARIA CONFERENCE

APRIL 21ST-22ND 2008, BONN, GERMANY

On April 21st and 22nd 2008, 120 participants from 20 African, European and Northern American countries came together for the International Malaria Conference “**Joining Forces, Synergising Action – Sustainable and Innovative Ways of Ensuring Long-Term Availability of Malaria Prevention and Treatment Measures by 2015**”.

We, the participants of the International Malaria Conference, strongly commit ourselves to the fight against malaria and poverty. We are deeply concerned about the human suffering and loss of life malaria causes worldwide.

We acknowledge the progress that has been made in the fight against malaria in the last decade. However, international efforts have to be scaled up if global malaria targets are to be met by 2015.

On the occasion of the first World Malaria Day on April 25th 2008, we appeal to the international community to join forces, synergise action, maximise efforts and mobilise all existing resources in order to:

- Achieve the United Nations Millennium Development Goals (MDGs);
- Support the effective implementation of the Abuja Plan of Action in 2000;
- Reinforce the targets set up in the Abuja Declaration in 2001;
- Hold G8 Heads of State accountable to their promises made in previous G8 Declarations, including especially the declarations agreed to in 2005, 2006 and 2007.

Acknowledging the efforts that have been made in developing effective tools to control malaria, we urgently request the international community to implement the following recommendations in order to achieve universal access to malaria prevention, diagnosis and treatment by 2015:

1. Malaria Control and Health System Strengthening

Health systems have a critical role to play in delivering malaria control interventions. In order to ensure that they reach the people in need, we urge the international community to:

- Reinforce integrated health service delivery at the primary and secondary level by strengthening capacities of local health personnel, as well as civil society and communities, at the grass roots level;
- Support health education to increase public awareness and understanding in affected countries, and to strengthen the capacity of the people in malaria-endemic countries to effectively control the disease;
- Support capacity building in-country, including strengthening of National Drug Authorities and universities – latter to encourage a higher output of pharmacists and technicians trained in pharmacy or related sciences.

2. Availability of Medicines – Local Production and Procurement

Local production of anti-malarials and other malaria control tools in Africa should be supported and strengthened. We therefore call upon the international community to:

- Set up technological focal points in three regions in Africa (East, South and West) by 2010, to coordinate and assist local manufacturers in meeting the needs of local populations;
- Enable appropriate technology transfer, North–South, through partnerships among local manufacturers and the World Health Organisation (WHO), non-governmental organisations (NGOs), and industries from the North;
- Encourage local production through support – including financial support – for incentives, such as grants for technology transfer and low-interest loans for local manufacturers;

3. Current Distribution Systems – Do They Reach the Poor and Disadvantaged?

Considering available strategies, we believe that reaching internationally agreed-upon prevention targets is feasible, provided that we move away from “doing business as usual”, particularly with respect to distribution. We therefore challenge the international community and governments of affected

countries alike to:

- Support national partnerships among all stakeholders, including civil society and the commercial sector, to rapidly increase coverage of existing malaria prevention (the “Scaling up for Investment” – SUFI – approach);
- Supply the necessary commodities, whether free of charge or at highly subsidized prices, and support the strengthening of distribution systems and use of all available channels – including NGOs, for example – to ensure access for those most in need;
- Provide resources for awareness raising and behavior change communications about use of interventions, as well as for monitoring and evaluation of these activities.

4. Sustainable Financing – Alternative and Innovative Mechanisms

Achieving the international community’s goals for malaria, including relevant MDGs, by 2015 will require increased funding, on a sustained basis. To this end, we call upon the international community – and in particular the G8 and other donor nations – to fully fund existing mechanisms that support malaria control and to establish and fund additional innovative mechanisms that can help to ensure continued and sustainable growth in malaria control efforts, including the provision of existing and new interventions. Moreover, we call upon the international community to:

- Commit to long-term pledging to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) by 2010;
- Support the AMFm (Affordable Medicines Facility for Malaria) to ensure that the best drug therapies, such as Artemisinin-based Combination Therapies (ACTs), are affordable and available in the private sector;
- Take advantage of other innovative mechanisms, such as the International Finance Facility, to support existing and new interventions for combating malaria;

- Put in place incentives, such as tax deductions and/or exemptions, to encourage the provision of funds through Corporate Social Responsibility programs and financial contributions by individuals;
- At the national level, demonstrate commitment to malaria control measures through concrete measures, such as putting in place budget lines for malaria control programs.

5. Research and Development – New Initiatives

New tools are needed to ensure the long-term success of malaria control efforts, especially if the long-term goal of eradication is to be achieved. We strongly urge the international community – including, in particular the G8 and other donors, to:

- Increase and sustain investments in research and development (R&D) for new tools, including basic research, drugs, diagnostics, vaccines, insecticides, and effective mechanisms for delivery;
- Support Public Private Partnerships (PPPs)/Product Development Partnerships (PDPs) and their potential synergies;
- Make malaria research an integral part of global programmes, such as the Global Change Programme in Germany;
- Create a global research fund.

6. Additional recommendations for the G8 and the European Union

With respect to the G8, we applaud the commitment made by the G8 in 2007 to provide \$60 billion to address health-related needs in sub-Saharan Africa, including support for health systems strengthening and efforts to fight AIDS, tuberculosis and malaria.

We look to the G8 for their continued leadership in addressing the needs of sub-Saharan Africa, in partnership with African governments, communities and civil society of the malaria-endemic countries.

To this end, we urge the G8 to reaffirm now their support for this level of funding and to take steps to ensure that this commitment and its objectives are fulfilled. In addition to the recommendations noted elsewhere in this communiqué, we ask the G8 to:

- Report on progress toward fulfilling this financial commitment since the 2007 Summit and agree to measure and publish progress on funding and action at each subsequent G8 Summit;
- Identify in 2008 a timeframe for reaching the goal of \$60 billion in health funding for sub-Saharan Africa, with an emphasis on “front-loading” the provision of funding for increased impact;
- Identify, in cooperation with governments, communities and civil society in Africa, tangible areas for health-related development initiatives, with an emphasis on such issues as human resource needs, supply chains, and other aspects of health system strengthening;
- Commit to increases in funding for R&D into the new tools needed to combat malaria, including drugs, diagnostics, insecticides, and vaccines, keeping pace with increases in development cooperation and funds.

With respect to the European Union as well as EU Member States and the commitments made in the “Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007-2011)” (PfA) there is an urgent need to increase efforts to scale up interventions in order to fill the financing gap for malaria. In addition to the other recommendations noted in this communiqué, we urge the European Union as well as EU Member States to:

- Increase technical assistance to partner countries, with particular regard to civil society organisations, in support of their work with the GFATM and to enhance efficiency in implementation;
- Adopt malaria as an equal high priority cause in its development cooperation, and research, policies;
- Fully implement the Paris Declaration on Aid Effectiveness by taking steps to strengthen coordination among bilateral and multilateral institutions and with the Country Coordinating Mechanisms (CCMs) of the GFATM.

Signed by:

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