

## 1.10. Italian development cooperation on health: contradictions and good intentions

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### *Introduction*

Although reform bills have been repeatedly presented to Parliament over the years, Italian cooperation with Developing Countries (DCs) is still governed by Law no. 49/87, which states, among other things, that development cooperation “aims to meet primary needs and first and foremost to save human lives”. In 1989 Italy’s *Direzione Generale per la Cooperazione allo Sviluppo* [Directorate General for Development Cooperation] (DGCS) at the Ministry of Foreign Affairs (MAE) adopted guidelines for its activities in the health sector<sup>1</sup>. It emphasized primary health care as an integrated strategy towards achieving Health for All, an objective set by the Declaration of Alma Ata in 1978, which was later included in the wider strategy of the fight against poverty<sup>2</sup>. With this objective as a basis, Italian development cooperation within the social and health sectors has for many years been guided by an emphasis on prevention, community participation, appropriate technology, a cross-sectoral approach and the promotion of local self-sufficiency. These guidelines, which have never been updated, also include promoting equity in the distribution and access to health resources; primary health care has been a pillar of Italian health policy for many years, both in Italy’s own national health system and in its development cooperation activities. These concepts are mentioned in the most recent Italian development cooperation reports<sup>3</sup>, which insist on the adoption of an “interdisciplinary approach that sees health not only as a fundamental human right, but also as an essential factor for overall social and economic development”<sup>4</sup>. However the trend in recent years at international level has seen Italy seemingly abandon its traditional systems-based approach for the promotion of single-issue and disease-oriented initiatives, such as the Global Fund for the fight against AIDS, Tuberculosis and Malaria (GFATM). Health is one of the many sectors where Italy’s Official Development Assistance (ODA) is implemented both bilaterally, (i.e. Italy cooperates directly with partner countries with intervention run by the DGCS or entrusted to Non-Governmental Organizations (NGOs), Regions, local organizations, universities and public bodies), and multilaterally by working with the European Union (EU) and international organizations.

### *The scale of Italian aid*

Italy consistently underperforms in terms of volume of assistance, falling well

below both EU and UN parameters, which are measured as a ratio between Official Development Assistance (ODA) and Gross Domestic Product (GDP). The EU mainly employs its development cooperation to support health programmes, which are also governed by binding objectives. At a summit in Barcelona in March 2002, 15 EU Member States (EU15) agreed to work towards a figure of 0.33% ODA/GDP by 2006 and then reach the UN target of 0.7% by 2015. In 2005, these figures were revised and the new target set to 0.51% ODA/GDP for EU15 countries and 0.17% for new Member States (EU10), which were to be achieved by 2010. This meant that an overall contribution of 0.56% was to be made by 2010<sup>5</sup>. In 2006 only Greece (0.17%), Italy (0.20%), Portugal (0.21%) and Spain (0.32%) had not reached the objective set for that year. Italy's figures can be found in its *Documento di Programmazione Economica e Finanziaria* [Economic and Financial Planning Document] (DPEF 2003-2006). In 2007 Spain increased its contribution to 0.41% of GDP, but Italy reduced its contribution even further to 0.19%, alongside Greece (0.16%) and Portugal (0.19%); note that Belgium (-11%), France (-16%), Sweden (-3%) and the United Kingdom (-29%) also reduced their contribution. Italy's exceptional peak in 2005 (**Table 1**) is actually only apparent as it is mainly due to debt forgiveness rather than to a real increase in aid volume, which net of debt forgiveness actually fell again by 42% between 2005 and 2006<sup>6</sup>.

If we take a closer look at resources earmarked for health, in 2005 Italy donated 4.7% of the total, which would seem to place it above average in terms of aid provided by countries in the Development Assistance Committee (DAC), a part of the Organization for Economic Cooperation and Development (OECD); in 2006, however, it was well below average with 3.8%. In actual fact, if we also look at the investment in population and reproductive health, which other countries record separately, Italy's contribution is well below average in both years (**Table 2**)<sup>7</sup>. Italian cooperation, however, has never provided particularly large quantities to activities that are strictly defined as "population". As Italy's declared strategy is primary health care, it is more worrying to note a drop in the volume of aid in that area.

Table 1. Evolution of Italian ODA between 2001 and 2006.

Year	US\$ (million)	% GNP
2001	1627	0.15
2002	2332	0.20
2003	2433	0.17
2004	2462	0.15
2005	5091	0.29
2006	3641	0.20
2007	3929*	0.19

\* of which 570 to cancel debt.

Source: OECD/DAC.

Table 2. Percentage of ODA involved in health and population activities in some OECD/DAC countries between 2005 and 2006.

Sector	Canada		France		Germany		Italy		USA		Average DAC	
	2005	2006	2005	2006	2005	2006	2005	2006	2005	2006	2005	2006
Health	4.7	8.0	4.7	2.7	2.0	2.6	4.7	3.8	4.4	5.6	4.5	4.7
(of which PHC)	2.9	6.1	2.9	1.8	1.4	1.6	2.8	1.1	4.0	4.9	2.6	2.9
Population	6.3	1.9	6.3	0.0	2.0	2.4	0.4	0.2	6.6	11.7	3.2	4.1
Total	11.0	9.9	11.0	2.7	4.0	5.0	5.1	4.0	11.0	17.3	7.7	8.8

Source: OECD/DAC.

We should point out that OECD/DAC figures do not include health activities carried out in multisector interventions; nor do they include intervention classed as emergency or humanitarian aid, of which health activities comprise a significant part in some cases. It is also worth remembering that the emergency aid channel is often abused as it is used for initiatives that are anything but emergency. If we look at all of the initiatives underway in 2006, regardless of the year they began, only 7% of overall health financing was earmarked for emergency initiatives<sup>8</sup>. Although the duration of emergency projects is not supposed to last more than one year, the figures shown cover several years, consequently the percentage of health assistance provided through emergency funding is in fact higher. Furthermore, OECD/DAC figures show total ODA and therefore, as far as Italy is concerned, not only the ODA resources channelled through the DGCS, which is vested by law with the authority to coordinate and carry out cooperation activities.

In 2006 Italian cooperation was involved in 157 social and health initiatives in 45 countries<sup>9</sup>. DGCS figures include all of the initiatives underway regardless of the implementing organization (local governments, Italian public bodies, DGCS direct management, NGOs, international organizations)\*, financing methods (donation or credit) and year of decision or project launch. However they only provide a snapshot of the whole situation and are not particularly useful for evaluating trends. This denotes a lack of ability (or desire) to turn data, readily available on computer, into statistics. This snapshot, however, does offer points for criticism. A surprising 28% of financing are loans, although financing is channelled towards social and health initiatives. Africa continues to be the top priority region and it receives a growing percentage of total health aid (**Table 3**). The total amount of resources channelled through international organizations is just as volatile (**Table 4**), as illustrated by the voluntary contributions to the World Health Organization (WHO): 7,283,258 euro in 2003; 1,850,000 in 2004; 14,137,500 in 2005; and nothing in 2006\*\*.

\* Financing to the GFATM is excluded.

\*\* Source: Ministry of Foreign Affairs, DGCS, *Sistema informativo cooperazione* [Cooperation Computer System] (SIC), 2008. Data processed by the authors.

Table 3. Italian Cooperation for Development in the health sector: net funding by geographical area - Euro (millions).

<i>Geographical Area</i>	2003	%	2004	%	2005	%	2006	%
Central Africa	15,785	12.6	4,571	16.1	11,040	23.1	6,089	17.5
Southern Africa	11,336	9.1	10,015	35.4	19,013	39.8	10,124	29.1
Latin America and Caribbean	2,002	1.6	3,007	10.6	2,354	4.9	2,301	6.6
Asia and Pacific	2,199	1.8	1,901	6.7	3,116	6.5	1,551	4.5
Mediterranean Basin and Middle East	2,739	2.2	2,806	9.9	4,355	9.1	2,196	6.3
Western Europe and Mediterranean	1,288	1.0	3,860	13.6	1,454	3.0	11,925	34.3
Indivisible	89,500	71.7	2,161	7.6	6,472	13.5	616	1.8
<i>Total</i>	124,847	100	28,321	100	47,802	100	34,803	100

Source: Ministry of Foreign Affairs, DGCS, Cooperation information system - CIS, 2008. Elaborated by the authors.

Table 4. Italian Cooperation for Development in the health sector: net funding by funding channel - Euro (millions).

<i>Channel</i>	2003	%	2004	%	2005	%	2006	%
Bilateral	27,334	21.9	23,265	82.2	23,960	50.1	33,904	97.4
Multi-bilateral	6,605	5.3	1,605	5.7	6,833	14.3	900	2.6
Multilateral	90,908	72.8	3,451	12.2	17,009	35.6	0	0
<i>Total</i>	124,847	100	28,321	100	47,802	100	34,804	100

Source: Ministry of Foreign Affairs, DGCS, Cooperation information system - CIS, 2008. Elaborated by the authors.

### *Strategies and experiences*

For many years, health initiatives involving Italian Cooperation have been founded on two basic policies<sup>10</sup>: supporting national health systems, and supporting local health systems and decentralization processes. Recently, however, initiatives have focused more on fighting individual pandemics. Much has been made of Italy's contribution to the GFATM. Between 2002 and 2005, Italy contributed an overall total of 404 million euro to the fund<sup>11</sup>, which shifted a significant amount of Italian health aid to the multilateral channel. Paradoxically, this move risked weakening its cooperation with the international organizations that dealt with the governance of global health policies, in particular WHO, whose coordinating role Italy had always acknowledged in the past<sup>12</sup>.

Regarding bilateral initiatives, many of which existed before this change of direction, Italian health cooperation in some developing countries continues to employ an integrated approach towards health and to support the development of

national health systems. This approach also includes providing technical assistance to Ministries of Health<sup>13</sup>. Since 1997, however, there has been growing interest in the so-called Sector Wide Approach (SWAp)<sup>\*\*\*</sup>, which entails a reduction in the more traditional project-based approach and the involvement of Italian cooperation with other donors<sup>14</sup>. The 2004 Report to Parliament stated that under this scheme “in 2003 the first sector wide programmes were launched, contributing 15 and 10 million euros over a three-year period to the national health development plans of Ethiopia and Uganda respectively, through general budget support (Channel I) and directly managed technical assistance (Channel III)”<sup>15</sup>. More recent reports based on these two experiences read that contributions to state health sector budgets had been extended to Mozambique, the Palestinian Territories, Niger and Burkina Faso<sup>16</sup>. By contrast, the most recent OECD/DAC peer review in 2004 illustrated the tendency of Italian cooperation to favour a project-based approach within bilateral channels, even when addressing cross-sector issues such as the fight against poverty and AIDS, and the promotion of female empowerment. The OECD highlighted how the difficulties and inconsistencies associated with this type of approach were exacerbated by the chronic shortage of human resources and the fragmentation of aid. In 2004 the overall number of beneficiary countries in all sectors receiving Italian ODA was 118, five more than on the previous peer review<sup>17</sup>.

#### *New trends: the Global Fund and the Global Public-Private Partnerships*

Although Italian cooperation recognizes the importance of some specific health issues, more generally it has always believed that these issues should not be addressed with earmarked resources and vertical programmes, but with a systems-based approach to health. First and foremost, this approach entails ensuring universal access to efficient and effective health services through suitable strategies and intervention in both national and local health plans. In recent years, however, despite continual international calls to integrate intervention with national health plans and to align donors so that, among other things, resources can be optimized<sup>18</sup>, international attention is once more focusing on individual infectious diseases and in particular on HIV/AIDS, Malaria and Tuberculosis, mainly through the GFATM<sup>19</sup>. Although Italy has traditionally shunned the selective approach, it has nevertheless followed suit. The 2005 report to parliament on cooperation activity revealed that Italy’s new commitment placed it “among the world’s leading countries in the fight against pandemic disease. The aforementioned 404 million

<sup>\*\*\*</sup>Under SWAp, international agencies contribute to the financing of the entire sector, sacrificing their priorities and projects. In return, they have the right to participate in the drafting of national development policies and in decision-making regarding the destination of resources. Participation in SWAp programmes comes in a range of forms: financial participation in the national budget of the beneficiary country (called Channel I); direct contribution to the Ministry of Health budget (Channel II); and the direct implementation and financing of activities included in the health plan drawn up by national authorities and undersigned by all donors (Channel III).

euro for the GFATM provided between 2000 and 2005 should be added to the 80 or so million euro for other initiatives financed through the bilateral and multilateral channel”<sup>20</sup>. Today support for GFATM, which was devised during Italy’s presidency of the G8 and launched in January 2002<sup>21</sup>, is one of Italian cooperation’s main channels of development intervention, and certainly the main one for health. During the Global Fund replenishment conference in London on 6 September 2005, Italy pledged to contribute 130 million euro 2006 and 130 million euro in 2007. The volume of those contributions enabled Italy to remain among the Fund’s main donors (joint fourth place with Japan, behind France, the US and the UK) and to keep a permanent seat on the GFATM board, alongside the US and Japan<sup>22</sup>. Furthermore, for 2008 Italy pledged to contribute 200 million euro to the Fund, according to a forecast report in 2007<sup>23</sup>. In 2006, however, no contributions were made to the GFATM, nor were any voluntary contributions made to WHO; Italy eventually made up for this by settling all of its 2005 pledges in 2007 and honouring the pledges for 2008 in advance<sup>24</sup>. Given Italy’s chronic difficulty in honouring GFATM agreements, a bill was presented to set up a GFTAM fund, which would ensure financing for several years at a time<sup>25</sup>. The authors believe that it would be wrong to draw up ad hoc laws when the operational shortcomings of Italian cooperation are due to the weaknesses in its structure, which has needed a complete overhaul for more than decade<sup>26</sup>. See below.

In line with this logic, Italy has at the same time supported other multilateral initiatives that come under the Global Public-Private Partnerships (GPPPs): WHO’s Roll Back Malaria programme, for which Italy earmarked about 3 million euro between 2004 and 2005<sup>27</sup>; the Global Polio Eradication Initiative, to which Italy pledged to donate 14 million dollars in three years; and the Stop TB Initiative, which was financed with 3.5 million euro through WHO<sup>28</sup>. Nor can we overlook a series of initiatives to set up new market mechanisms that aimed to generate financing for development, and for health in particular. These initiatives, run under the auspices of the Ministry of Economics and Finance, were set up after debate on financing development at the Monterrey summit in 2002. On impetus from the Global Alliance for Vaccines and Immunization (GAVI), Italy promoted at the G8 a mechanism called Advance Market Commitment (AMC), which involves donors pledging to finance the purchase of future vaccines that the pharmaceutical industry commits to producing in accordance with predefined criteria<sup>29</sup>. Italy contributed almost half of the financing for the first pilot project that aimed to accelerate the development of a new vaccine against pneumococcal disease. Canada, Norway, Russia, the UK and the Bill & Melinda Gates Foundation<sup>30</sup> also contributed alongside Italy to the overall total of 1.5 billion dollars. Italy also joined the International Financing Facility for Immunisation (IFFIm), which was launched by the UK government in 2006. The IFFIm introduced another mechanism that entailed issuing bonds in order to collect funds that would enable GAVI to purchase pharmaceuticals and vaccines. The forecast and planning report for 2007 showed that Italy was one of the first countries to equip itself with legislation to finance the IFFIm, “envisaging, in the 2006 budget, a total fund of 504 million euro until 2025”<sup>31</sup>. In September 2007, alongside other bilateral and multilateral donors, Italy

undersigned an initiative by British Prime Minister Gordon Brown to set up an International Partnership for Health, which aimed to support health systems and foster coordination among major donors. This approach intended to solve the problems created by the GPPPs, which many partners of this new initiative support and still enthusiastically promote<sup>32</sup>.

### *Institutional weaknesses*

According to a number of observatories, the MAE's inability to manage funds effectively lies behind Italy's recourse to international organizations and its participation "in a number of multilateral initiatives, often in partnership with the private sector and employing a vertical approach, that aim to solve specific problems without actually starting paths towards structural change"<sup>33</sup>. The observatories believe that this problem is not only a characteristic of health cooperation, but of ODA as a whole; the answer lies in a "reform of the cooperation system which provides resources that not only meet commitments quantitatively, but ones that can be pledged and spent". This reform must be put off no longer.

After Senate approval in September 1999, the end of the XIII Legislature in March 2000 interrupted the parliamentary path of an initial attempt to reform Law no. 49/87. At the same time bureaucracy at the *Farnesina*, Italy's Foreign Ministry, was also energetically obstructing reform. The matter was dropped during the XIV Legislature, although Parliament's other house could have continued to debate the reform. With the XV Legislature, some choices by the Prodi government seemed to mark renewed interest in helping Italian cooperation out of the economic and strategic crisis that had been tormenting it for some time. A glimmer of hope was provided by the appointment of a Deputy Minister for Cooperation, the earmarking of additional budget funds for cooperation, recommendations in the most recent DPEF, and a new draft reform being debated in the Senate<sup>34</sup>. However the fall of the government put an end to the reform process.

The bill drafted during the XV Legislature included the principles of the OECD and of the Declaration of Paris on Aid Effectiveness. The bill also included some new ideas, the main ones being the establishment of an ad hoc agency that would implement government-established objectives and manage resources, thus separating the political line from the programmatic and operational one. This fledgling agency, however, was not supposed to manage all of the funds earmarked for ODA; indeed, a large part was to remain under the control of the Ministry of Finance. Other hallmarks of the bill were that it prohibited the use of ODA funds for military operations (already envisaged by the current law) and adopted the principle of fully untying funds from Italian enterprises, i.e. enabling cooperation projects to use, even exclusively, goods and services produced in the beneficiary countries. The bill had also been drafted on close collaboration and extensive talks with civil society, mainly in the shape of a vast network of associations and local bodies that had been dealing with development assistance for decades. At the time of writing, it is unknown whether the current government will continue with the

reform of Law no. 49/87 and, if it does, whether it will use this draft as a basis or start from scratch with new principles. These new principles may include promoting an autonomous role for Italy's *Protezione Civile* [Civil Protection] for emergency interventions or a reduction in the proportion of public funds in order to focus more on private ones.

### *Decentralized cooperation*

Over the last twenty years, decentralized cooperation has developed considerably because it is envisaged by Law no. 49/87 and it has been promoted by the European Commission with a specific line of financing. Decentralized cooperation is development cooperation carried out by regions, provinces and municipalities, individually or jointly, and in association with organized civil society, such as universities, trade unions, local health authorities, small and medium enterprises, social enterprises and NGOs. Promoters of decentralized cooperation praise its advantages, which include community participation thus ensuring bottom-up cooperation; direct contact between providers and recipients of aid, skipping state bureaucracy; dialogue between the civil societies of various countries; human-scale projects with results that are easy to check and re-plan; greater focus on human development than on economic growth; and achievement of small but long-lasting changes. Obviously it also has its detractors; their arguments against include fragmented interventions and lack of coordination; possible inconsistencies with national/local policies and strategies; assistance logic that does not go to the root of problems; variable interventions in conjunction with variable policies and power relationships between and within local bodies that promote decentralized cooperation. Unfortunately it is too difficult to say which opinion is right, and the situation is probably too complex for an overall assessment. The fact remains that initiatives are multiplying and that a host of administrative levels are involved: regions for instance are heavily involved in this field of cooperation with specific laws, plus short- and long-term planning documents. Below are just some examples. Making a full list would be an impossible task considering the myriad of actors involved, consequently we make no pretence that this list is complete.

- Emilia Romagna provides from 1 to 4 million euro a year for about one hundred projects in around 20 countries in Africa, the Middle East, Latin America, and Eastern Europe. About half of these projects are for emergency interventions. The vast majority of these projects cover health, including controlling infectious diseases, supplying drinking water and the mental and physical rehabilitation of conflict victims<sup>35</sup>.
- Veneto also provides 1 to 3 million euro a year for decentralized cooperation, which encompasses intensive health cooperation work in about 15 countries, including initiatives to promote Primary Health Care, emergency intervention, salvaging hospital equipment, treating those in need in Veneto hospitals, training of health workers<sup>36</sup>.
- Toscana invests almost 20 million euro a year in peace and international cooper-



ation, with about 3 million euro of this total going towards health cooperation projects. Alongside these resources are those of bodies and private enterprises, volunteer associations and religious institutions. Notable health intervention includes offering specialized treatment in Tuscan hospitals to more than 4,000 Palestinian children and support to a heart surgery centre opened in Sudan by *Emergency*<sup>37</sup>.

- The smaller regions provide smaller amounts, but they are increasing each year. Contributions from Friuli Venezia Giulia rose from 574,000 euro in 2004 to 1.1 million in 2005 and to 1.5 million in 2006<sup>38</sup>. Although the number of projects is proportionally smaller, their dissemination by number of countries, by sector and by activity type in each sector is most certainly not. In 2007 Lazio financed about a dozen health projects in Madagascar (women's health and radiology); Ecuador (medicine for indigenous communities); Cameroon (drinking water); Argentina (paediatric department); Kenya and Tanzania (vaccinations); Bolivia (nutrition); Eritrea (prevention); Lebanon (dental clinic); Senegal (waste water management); and Brazil (health care for forest populations)<sup>39</sup>.

### *Conclusions*

Italian health cooperation brims with the good intentions of a host of individuals, associations and institutions working in the field. It also includes a range of single and laudable initiatives. Its scope of success, however, is limited especially if observed from a general perspective and in the long-term. This is partly due, as it is in many other countries, to a lack of serious attempts to evaluate policies, plans, projects and priorities in terms of both results and impact. Italy's lack of overall success, e.g. in the global context, can also be explained by the enormous fragmentation of programmes and interventions caused by the myriad of actors, each with their own points of view and objectives. There are, however, also specifically Italian flaws: the lack of modern legislation that can stimulate attempts to correct the inadequacy of evaluation instruments, and the complete lack of coordination for the construction and implementation of joint, consistent and effective strategies. Furthermore, Italy certainly does not shine for its generosity in terms of overall ODA; the decentralized cooperation of its local bodies, institutions and associations, though very generous, is anything but coordinated. Any improvement in health cooperation must start with adequate funds that are coordinated and strategically oriented. It is unlikely that the crumbs Italian cooperation scatters will have any impact on the health of people, such as those in Sub-Saharan Africa, who lack the very essentials.

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<sup>35</sup> [www.spaziocooperazionedecentrata.it/2006/index.asp](http://www.spaziocooperazionedecentrata.it/2006/index.asp) consulted on 21/05/08.

<sup>36</sup> [www.regione.veneto.it/Servizi+alla+Persona/Sanita/Rapporti+Socio+Sanitari+Internazionali/Cooperazione+decentrata.htm](http://www.regione.veneto.it/Servizi+alla+Persona/Sanita/Rapporti+Socio+Sanitari+Internazionali/Cooperazione+decentrata.htm) consulted on 21/05/08.

<sup>37</sup> [cooperazione.formez.it/sections/regioni/toscana](http://cooperazione.formez.it/sections/regioni/toscana) consulted on 21/05/08.

<sup>38</sup>

[www.regione.fvg.it/rafvgrapportieuropeinternazionali/areaArgomento.act?dir=/rafvg/cms/RAFVG/AT11/ARG17/](http://www.regione.fvg.it/rafvgrapportieuropeinternazionali/areaArgomento.act?dir=/rafvg/cms/RAFVG/AT11/ARG17/) consulted on 21/05/08.

<sup>39</sup> [www.regione.lazio.it/web2/contents/cooperazione/](http://www.regione.lazio.it/web2/contents/cooperazione/) consulted on 21/05/08.