



MINUTES

RBM/BOM/2009/MIN.2

21 DECEMBER 2009

Official document

General distribution

English, French

RBM Board Meeting

Minutes of the 17th RBM Partnership Board Meeting

Windsor Barra Hotel, Rio de Janeiro, Brazil

4 – 5 December 2009

Attendance

Chair

Malaria Endemic Countries: Zambia

Voting Members

Foundations: UN Foundation

Malaria Endemic Countries: Brazil; Cambodia; Kenya; Liberia; Niger; South Africa

Multilateral Development Partners: UNDP; UNICEF; WHO; the World Bank

NGOs: Northern - Malaria Consortium

Southern -

Cameroon Coalition Against Malaria

OECD Donor Countries: France; United Kingdom; United States of America

Private Sector: Sanofi-Aventis; Vestergaard-Frandsen

Research & Academia: Earth Institute, Columbia University,

Non-Voting Ex Officio Members

Executive Director, Global Fund to Fight AIDS, Tuberculosis and Malaria

Executive Director, RBM Partnership

Executive Secretary, UNITAID

The UN Secretary General's Special Envoy for Malaria

Absent *(with regrets)*

Northern NGO and Vice Chair: Johns Hopkins University, Global Program on Malaria

Malaria Endemic Countries: India; Angola

Call to order – Day One

The RBM Partnership Board Chair, the Honourable Minister of Health for Zambia, called the 17th Board meeting to order.

Welcome

The Chair welcomed RBM Partnership Board members and delegates. He was happy to see the meeting held for the first time in the Latin American and Caribbean Region, and thanked the Honourable Minister of Health for Brazil for the privilege of meeting in *A Cidade Maravilhosa* (The Marvellous City) or Rio de Janeiro. He welcomed new colleagues, including: Kenya, representing Intergovernmental Authority on Development (IGAD) countries; South Africa, representing Southern African Development Community (SADC) countries; Niger as the Economic Community of West African Francophone States (ECOWAS) alternate; and Premier Medical Corporation, the new Private Sector alternate.

Official opening

On behalf of the Minister of Health from Brazil, Mr Eduardo Hage, Director for the Department of Surveillance and Health, welcomed the RBM Partnership Executive Director (EXD), Ministers and all other Board members and delegates. He fully supported the meeting agenda with its emphasis on coordinating efforts towards meeting the 2010 universal coverage goals. He hoped that efforts to fight malaria will translate into a decrease in preventable deaths, especially among children, and a curb on the disease's role in perpetuating poverty cycles and inhibiting development. Even as great efforts are made to control and eliminate malaria across the globe, he noted the potential for the effects of climate change to increase endemic areas. Brazil attended the 2008 RBM Partnership Board meetings and this participation has helped promote harmonization. They are focusing on cooperation with neighbouring countries and recognize a need for more regional perspectives e.g. with regard to the increase in *Plasmodium vivax*. They would welcome increased South-South cooperation, including the strengthening of relationships between the Latin American and Caribbean Region and Africa.

Purpose of the meeting

The Chair expected the meeting to ensure that the key recommendations in the report of the recent Independent Evaluation of the RBM Partnership are formulated into concrete guidance for the Partnership that will help accelerate its work in 2010 and towards 2015. The EXD's report would highlight concerns regarding countries' abilities to meet the 2010 targets. However, by the end of the meeting the Partnership would have finalized the 2010 – 2011 Partnership Work Plan (PWP) and budget and so would have a definitive plan of action for 2010. As efforts must be sustained after 2010, Day Two would focus on strategic issues related to achieving 2010 – 2015 targets.

Opening statements

The Northern NGOs welcomed the new Chair on behalf of all Board members.

Board procedures

Thomas Teuscher, RBM Partnership Secretariat, noted that the Board had quorum and recalled the Board operating and voting procedures as outlined in the RBM Partnership Operating Framework and By-Laws. He reminded the Board that, as of the October 2009 electronic vote, the Conflict Of Interest Policy was now adopted. The policy will come into action in January 2010, and all members will need to complete the conflict of interest documentation that is now available.

Next steps

- The Secretariat to implement COI Policy in preparation of the 18th Board meeting

Adoption of the agenda for the 17th Board meeting

The proposed agenda was adopted.

Adoption of the minutes of the 16th Board meeting

Minutes of the 16th RBM Partnership Board meeting were adopted.

The Secretariat noted that the minutes of the 16th RBM Partnership Board meeting had been made available within 14 days of that meeting and that this would be adopted as normal procedure going forward.

Action taken report

Presentation summary

The EXD reviewed the action taken on decision points agreed at the 16th Board meeting.

- The Board was referred to the Finance Committee (FC) agenda item for follow up on the finance decision point.
- The WHO and the Private Sector had reconciled all constituency positions on the Conflict Of Interest Policy by August 2009, and the Executive Committee (EC) recommended an electronic vote during its September call. The policy was adopted on 31 October 2009 and will be implemented from January 2010.
- The 2010 Committee has developed a calendar for 2010 – 2011 reporting and would give more details in a presentation later in the meeting. This work has been incorporated into the draft 2010 – 2011 PWP.
- A report of the 16th Board Special Ministerial Session was sent to participants in June 2009. Country roadmaps have been developed and define the means to overcome the challenges identified in that session. Related actions have been incorporated into the draft 2010 – 2011 PWP.
- An initial expert consultation into drug and insecticide resistance was undertaken by the WHO and broader consultations are ongoing. These consultations have resulted in the draft Operational Resistance Containment Management Strategy shared with the Board during the 17th Board information session.
- The revised Memorandum of Understanding (MOU) on the joint RBM–StopTB–UNITAID Global Fund Board seat was approved by the Global Fund Policy and Strategy Committee (GF-PSC) in October 2009 and by the Global Fund Board in November 2009. UNITAID will hold the Global Fund Board seat for the first year. RBM will hold the Alternate seat and sit on the Programme Implementation Committee (GF-PIC). StopTB will sit on the GF-PSC. As of November 2010, RBM will take the Board seat. UNITAID and RBM attended the Global Fund Board meeting in Addis Ababa. Work has started on a communications strategy to ensure that firm positions on issues relevant to the three Partnerships can be presented to the Global Fund.

Discussion summary

- Global Fund and the United States Government (USG) requested that the Board note that they have given no firm commitment to fund specific RBM Partnership Board commissioned work on resistance, in case of any continuing confusion arising from the 16th Board meeting minutes (p.27).
- The EXD was already alerted to this concern. She suggested that when the strategy documents on resistance are ready, they will be brought to the Board and funding decisions can be discussed further at that point.
- The WHO confirmed that the Board can expect two documents. To date the expert consultations on the drug resistance strategy have been completed and broader stakeholder consultations are ongoing. Expert consultations on the insecticide resistance strategy are to take place during the first half of 2010.

Decision point

The Board acknowledged the Action Taken report.

Executive Director's report

Presentation summary

The EXD thanked all partners who have dedicated their time to driving and supporting the RBM Partnership process. The presentation would be an in-depth summary of progress over 2009, and would be in two parts.

The report is based on a number of key documents including country roadmaps prepared by African countries in response to the challenges identified during the Special Ministerial Session at the 16th Board meeting. The roadmaps will guide planning for universal coverage and will be reviewed regularly.

Part 1: The malaria landscape

Net procurement and coverage continues to increase every year. Based on data from the country roadmaps, 28 countries are on target with the funds necessary to achieve their 2010 goals for long-lasting insecticidal nets (LLIN), while only four countries project shortfalls of more than 60%. One great achievement is that Nigeria now looks set to reach universal coverage of nets in the near future. UNICEF notes that across sub-Saharan Africa, insecticide-treated net use among children has increased significantly to 20% in 2007 from just 2% in 2000, and that 17 countries have achieved five-fold increases in under-5s coverage. This progress must be used to convince people that great strides can be made in 2010. However, implementation is a major issue, with countries requesting additional technical assistance (TA) to enable them to accelerate net procurement, supply and distribution, and to improve utilization rates. The 2010 – 2011 PWP needs to include measures to allow 'catch up' in some countries where there are still major gaps to be closed. Heading into 2010, a number of LLIN scale-up initiatives are now operational: Voluntary Pooled Procurement Services (VPP) – Global Fund; NetGuarantee – Malaria No More; Nothing But Nets Campaign – UN Foundation; and the joint social business venture – BASF Grameen Ltd.

Country roadmaps show that indoor residual spraying (IRS) plays a major role in vector control in some countries, due in large part to support from the President's Malaria Initiative (PMI) for this measure. Ten countries rely significantly on IRS as a vector control strategy. All these countries, except Kenya and Zimbabwe, will have sufficient resources to implement their plans in 2010.

Country data shows that intermittent preventive treatment of malaria in pregnancy (IPTp) coverage remains low despite it being a relatively uncomplicated intervention. The WHO has been leading work on intermittent preventive treatment in infants (IPTi) and policy guidance for its use is in preparation.

Diagnosis is both an immediate priority and an important building block in a long-term strategy on malaria. The WHO recently reformulated its guidelines for the treatment of malaria and now recommends confirmation of malaria through parasite-based diagnosis in all cases prior to instituting treatment. Treatment solely on the basis of clinical suspicion should only be considered when a parasitological diagnosis is not available. The roadmaps show that most African countries still have significant gaps in terms of access to rapid diagnostic tests (RDT).

The global procurement of artemisinin-based combination therapy (ACT) is expected to increase by approximately 12% in 2009 compared to 2008. However, roadmaps indicate that only 28 African countries are on track to reach at least 80% of their defined need in the public sector. According to ACTWatch data from seven countries: only Zambia and Cambodia have reasonable levels of ACT in both the public and private sectors; most anti-malarials continue to be obtained through the private sector (except in Zambia); and artemisinin monotherapy is still widely distributed by the private sector. The Affordable Medicines Facility – Malaria (AMFm) is now launched and providing support for ACT coverage in nine Phase 1 pilot countries. New technology is being used to tackle ACT, RDT and quinine-injectable stock-outs at the district level in the SMS For Life Initiative.

Mounting evidence from countries has confirmed that when high coverage with malaria control interventions is reached, all-cause child deaths are reduced dramatically in line to reach MDG targets. Two years ago, only one or two countries could report impact, now there are growing numbers of countries reporting significant impact.

There have been key meetings focused on malaria research during 2009. Four consortia: the Innovative Vector Control Consortium (IVCC); the Foundation for Innovative New Diagnostics (FIND); the Medicines for Malaria Venture (MMV) and the PATH Malaria Vaccine Initiative (MVI), are currently taking forward specific areas of research and contributing to developing new tools for scale-up and sustained control. The Malaria Elimination Group (MEG) is involved in defining operational research and policy-oriented research for elimination. The Malaria Eradication Research Agenda (MalERA) which focuses on elaborating the research agenda for elimination will publish a White Paper in March 2010.

The elimination agenda has been prominent with, for example, the March 2009 launch of the Elimination Eight Initiative in Southern Africa (E8).

The 2009 World Malaria Day with follow up by the Malaria Advocacy Working Group (MAWG) ensured an increase in malaria media coverage. A high-level advocacy mission to East Africa led by the Special Envoy and a presentation to the United Nations Economic and Social Council (ECOSOC) were among the other initiatives

during 2009 aimed at keeping malaria high on the development agenda. Other advocacy high points included the September 2009 launch of the African Leaders Malaria Alliance (ALMA) and the November 2009 launch of the United Against Malaria (UAM) campaign.

The main malaria donors during 2009 remained: the Global Fund, the World Bank, PMI, UNITAID, DFID, France and the Bill & Melinda Gates Foundation. An estimated US\$2 billion was mobilized from these donors. Together with endemic countries' own contributions and the out-of-pocket contributions from people themselves, a total of around US\$3 billion was raised. Although 2009 has seen new contributions, a gap of about US\$2.7 billion to meet the annual projected requirements to fully fund the Global Malaria Action Plan (GMAP) remains.

The EXD listed the following main strategic challenges going into 2010: insufficient and unpredictable financing; strategic debates around investment in health systems and tightening regulations on pesticide use; drug and insecticide resistance; and how effectively to support implementation at country level.

The EXD also identified some key implementation challenges faced by countries, including: inadequate public health systems; lack of human resources for the scale-up of malaria control activities; low use of interventions such as behaviour change communication (BCC) to improve intervention uptake and adherence; uncertainty of funding commitments and flow of financing; and issues around case management.

Part 2: Final review of the Harmonized Work Plan (HWP) 2009

A traffic light system¹ was used to review progress on HWP 2009 priorities and targets. Globally, over 77% of targets for the core HWG 2009 have been achieved. The EXD focused the presentation on problem areas only.

Priority 1: Strengthen capacity for SUFI in countries

The Malaria Management Business Tool (MMB) was tested in Nigeria. It had been planned to implement the tool in nine countries, but a decision has been taken to wait for the evaluation of the Nigerian experience with the tool before scaling-up its use. Target = red.

Building country capacity to conduct malaria indicator surveys (MIS) was planned, but not many countries requested this support. Target = yellow.

Priority 3: Secure financial resources for countries

Fifty eight per cent rather than the target 70%, of Harmonization Working Group (HWG) supported Global Fund Round 9 applications from countries were successful. Target = yellow.

In retrospect, targeting Round 8 grant sign-off for April 2009 was too ambitious taking into account the complexity of the sign-off process, Global Fund processes and some issues in country. Target = red.

Priority 5: Strengthen access to commodities for malaria control

The MalERA White Paper will now be published in March 2010. Target = yellow.

The EXD was also able to report on a number of targets within the Optimal Harmonized Work Plan which have been reached due to slightly increased resources becoming available during the year.

She concluded that working in partnership has yielded significant results this year, but that countries continue to face major challenges in implementation. Despite the economic crisis, sufficient resources were mobilized towards the RBM HWP 2009 to enable the Partnership to achieve most of its core HWP targets and, in some cases, exceed them. The new 2010 – 2011 PWP will address many of the key implementation challenges that countries face and provide the technical support needed at country level to achieve the RBM targets. She called on partners to use existing momentum and keep moving forward.

Discussion summary

- Board members congratulated the EXD and her team on an excellent report. It showed depth, specificity and leadership. It was enjoyable to see results on impact reported as well as the challenges to be faced.
- The following suggestions were made for additions to the 2009 report: more on the contribution of NGOs; more on the role that governments in endemic countries play in closing funding gaps; more

¹ Green – target met or completed at 75 – 100%. Yellow – target completed at 50 – 74%. Red – target failed or completed at 0 – 49%.

representation of Latin American, Caribbean and Asian countries; more on the significant achievements of the RBM Partnership in Nigeria.

- A request was made for future reports to include a summary of the major events and challenges on the horizon, a prediction of funding for Partnership work going forward, and an indication of what the EXD would like partners to focus on.
- Attention was drawn to the ongoing challenge of securing predictable and sufficient funding, and to the potential opportunities offered by innovative financing mechanisms.
- Board members thought it time for a thorough and updated analysis of the economic returns of investment in malaria.
- There was broad concern that advocating for vertical/disease-specific resources may not be the best strategy going forward and a recommendation that malaria be more strategically positioned with regard to the International Health Partnership (IHP+) and Health Systems Strengthening (HSS). Global Fund commented that, of the three diseases, malaria is currently the smallest component in cross-cutting HSS proposals.
- There is a need to engage with Global Fund, the Global Alliance for Vaccines and Immunization (GAVI) and the World Bank on their joint HSS platform and with governments and partners to ensure that malaria indicators are included in proposals for HSS and sector-wide approaches (SWAp).
- There is a need to show how the fight against malaria fits into the overall context of health development and how it relates to specific areas such as mother and child health.
- A request was made that the RBM Partnership continues to address the issue of climate change.
- Many Board members shared the view that implementation support to countries was now a critical issue. The Global Fund and the Harmonization Working Group (HWG) aim to ensure that Round 9 grants are signed-off within 6 months, and with this money in the system it will be vital to avoid disbursement and implementation delays.
- Board members raised concerns about countries that still have low indicators and lack resources e.g. Chad and Sierra Leone. More attention should be paid to these countries.
- It was noted that much effort had gone into getting an effective Affordable Medicine's Facility – malaria (AMFm) pilot in motion. However, countries should be aware that the November 2009 Global Fund Board agreed that the AMFm must show that it is meeting its objectives in the nine pilot countries before a Board decision can be taken on ramping up the facility. It will be 2012 before that independent evaluation comes before the Global Fund Board, so countries should not build firm plans around the AMFm in the meantime.
- Diagnosis and ACT treatment must rise on the agenda. The effective use of diagnostics in pneumonia was noted as a model for malaria.
- The issue of artemisinin monotherapy use remains extremely worrisome especially in the context of the WHO resistance report.
- Board members noted that IPTp coverage remains unacceptably low. With IPTi coming online as an additional tool, RBM partners should work together to integrate these tools into country programmes.
- Board members cautioned that advocacy for elimination efforts may have got ahead of the reality on the ground. Certification around the elimination of malaria is available through the WHO. It may also be necessary to strengthen tools and processes aimed at assessing the programmatic, financial and political resources available in countries aiming to initiate elimination.
- A call was made for more efforts to include youth advocates in international malaria forums.
- More guidance on community health worker (CHW) interventions was requested along with a request to have communities more involved in programme implementation and data collection.
- Board members considered it vital to look at sustaining messages post 2010 so that the international audience does not lose traction as efforts are refocused towards 2015 and beyond.

Decision point

The Board acknowledged the Executive Director's report.

Response summary as next steps

- The report will be finalized after the 17th Board meeting and after the 15 December launch of the WHO World Malaria Report (WMR) 2009. Board members' comments will be taken into account in the final edit.
- A forward looking 'vision' section will be added and will include, for example: integration of malaria with HSS, analysis of economic returns on investment, innovative financing, the role of communities, climate change. The section should set up further strategic discussions. It will also ensure that the filling of gaps by Malaria Endemic Countries, from all continents, and by NGOs are considered in the report.
- The World Bank will prepare a session on HSS strategic issues for the next Board meeting.

Executive Committee report

Presentation summary

The EXD presented the Executive Committee (EC) report on behalf of the EC Chair who was unable to be at the meeting. The EC has met monthly via teleconference and circulated minutes to all Board members within two weeks of the meeting. The minutes have also been posted on the RBM Partnership website.

Key issues since the 16th Board meeting have been: establishing TOR for the 2010 Committee and ensuring coordinated messaging with the MAWG, the Monitoring and Evaluation Reference Group (MERG) and others as the 2010 target deadlines approach; continuing discussion regarding consultation options among the three partners to the Global Fund Board seat, including how to ensure that all the constituencies of each of the three Partnerships are represented; the framework for financial reporting against the 2010 - 2011 PWP; the Independent Evaluation results and follow-up of the work of the three Task Forces; the Conflict of Interest Policy adoption following an EC review of the document and a recommendation to put it forward for electronic Board vote; providing guidance to the 2010 - 2011 PWP process and target development; and preparation of the agenda for the 17th Board meeting.

Discussion summary

No points of discussion were raised.

Decision point

The Board adopted the Executive Committee report.

Finance Committee report

Presentation summary

The Finance Committee (FC) Chair gave a joint presentation with the Secretariat. The FC has convened seven teleconferences since March 2009 and one face-to-face meeting prior to the 17th Board.

The Secretariat has submitted monthly reports for April – September 2009 as per the 16th RBM Board request and have been using the new template for out of WHO contributions and expenditures. Templates for tracking the funding which does not go through the WHO RBM Partnership account have been developed but have yet to be activated. The Secretariat has provided staffing support and facilitation to the FC.

Board members were referred to three tables summarizing the 2009 financial data. Table 4 showed income (actual) Q1 – Q3 2009 amounting to US\$11,789,678. The source, amount and timing of contributions are detailed in the pre-read². Q4 data will be available to the FC in January 2010. Table 5 showed income and expenditures amounting to US\$5,665,279 for Q1 – Q3 2009. Percent expenditure against budget Q1 – Q3 2009 was 78%. Table 6 summarized cash flow Q1 – Q3 2009 and shows a closing cash balance as of 30 September 2009 of US\$7,184,684.

² Available at <http://workspace.who.int/sites/rbm/board/17th%20RBM%20Board%20Document%20Library/Forms/grouped2.aspx>

The FC Chair thanked all members of the FC and the Secretariat for their tremendous work, and expressed appreciation to the WHO and to Vestergaard-Frandsen who loaned the expertise of their Chief Accountant.

Discussion summary

- Board members noted that the schedule of monthly and quarterly reporting could be considered onerous on the small Secretariat team, and wondered if reporting could be bi-monthly. The FC Chair would consider this in the future, particularly once the new WHO accounts system is providing real-time data. However, for now, fluctuations in income cannot be adequately addressed by quarterly reporting.
- A request was made to include risk management assessments in future financial reports. The Chair noted that the RBM Partnership adopted the WHO financial risk management assessment.
- It was noted that many partners, including endemic countries, are supporting the country roadmaps and that it would be good to see these contributions reflected in RBM Partnership financial reports. The Chair confirmed that the first step in this direction would be to start adding in partner contributions that are given directly to the RBM Partnership mechanisms, and that this data will be available for the 18th Board meeting. A further step would be to look more broadly at how the GMAP is being supported.

Decision point

The Board took note of:

- The actual income (US\$11,789,678) received in the first three quarters of 2009 (Table 4: Income - actual by donor Q1 – Q3 2009);
- The provisional expenditure report (US\$5,665,279) for the first three quarters of 2009 (Table 5: Income & Expenditure by HWP priorities Q1 – Q3 2009);
- The provisional cash position (US\$7,184,684) of the RBM account within the WHO as of 30 September 2009 (Table 6: Cash Flow Q1 – Q3 2009).

Next steps

- The Secretariat will prepare a comprehensive proposal to the FC to further strengthen the financial templates through a comprehensive monthly/quarterly financial management reporting package;
- The FC, with the support of the Secretariat, will consult with RBM Working Group Co-Chairs to implement the informal system for collecting and reporting direct contributions to and expenditures by Working Groups (outside the RBM/WHO account) through use of the FC's approved reporting template;
- The Secretariat will develop a note concerning procedures relating to WHO audit results.

2010 Committee report

Presentation summary

The WHO presented the 2010 Committee³ report on behalf of the Chair who was unable to attend. In 2008, the RBM Partnership GMAP re-stated RBM 2010 goals and targets and the UN Secretary General called for universal coverage of malaria prevention and control by the end of 2010. The 16th RBM Board approved in principle the convening of a high-level event in September 2011, linked to the UN General Assembly, to report on progress towards these targets and to deliver a report to the global community. The 16th Board recommended the establishment of a 2010 Committee to provide strategic direction and Board oversight to the process of delivering the global report and the high-level event. There is much enthusiasm in the RBM community for this opportunity to showcase progress towards the RBM goals.

On the basis of the 2010 Committee TOR, members will aim to make recommendations to the Board regarding the number, type, scope, purpose, audience and key messages and general content to be covered in a series of proposed reports and events. They will guide the resource mobilization efforts of the Board related to 2010 reporting, monitor work plans and budgets, and review draft reports. The overall objective of the 2010 Committee's work remains to keep malaria in the news between now and 2011.

³ Following the note in the Terms of Reference, the RBM Board Oversight Sub-Committee for 2010 Reporting will be referred to as the 2010 Committee.

The process of defining a series of products has started and a matrix showing proposed reports and their content, timing, objective, audience, author and links to other events was shown. A series of shorter reports will culminate in a final, longer report focusing on a decade of progress that will be made available on World Malaria Day 2011. Committee members have identified six reports over which they will have full oversight and which will have common characteristics (structure, language and packaging) as part of a series. They have also started to identify other reports expected during 2010 – 2011 and are hoping that these can be harmonized into a seamless cycle of reporting.

Discussion summary

- It was confirmed that the earliest publication date for the main ‘decade of progress’ report would be September 2011 to allow for the collation and analysis of 2010 data.
- The EXD emphasized the need for harmonization of messages and data. A 2010 Committee role will be to reach out to all those reporting on a global level and to African Union leaders who will be reporting on progress since the Abuja Declaration.
- Board members confirmed that there would be reports published by their individual institutions in 2010/2011, as all have their particular constituencies to report to. However, all were willing to coordinate and harmonize on 2010 reporting. The 2010 Committee will focus on promoting harmonization and not on ‘policing’ others. The RBM Partnership series will focus on a ‘decade of progress’ and this perspective will distinguish the reports from those of other institutions which will have annual timeframes.
- The importance of including implementing countries in all aspects of the planning and preparation of the report series was stressed. It was requested that both governments and NGOs from implementing countries be involved.
- The Special Envoy’s representative informed Board members that the Secretary General will give the 2010 report to the General Assembly. His report should incorporate a summary of progress over the decade and of the relationship between progress on malaria control and progress on the MDGs.
- Finally, the Board agreed that this series of reports must not allow people to think that 2010 is the end of the story. Rather the reports should aim to show what can be achieved in malaria control and on MDGs, especially on overall child survival, when available tools and resources are effectively linked up. The decade of experience series would show what needs to happen to meet targets for 2015 and beyond.

Decision point

The Board adopted the 2010 Committee report.

Next steps

- The 2010 Committee will finalize: the series title and design; the review/approval process for each document; and the advocacy strategy for the release of each report.
- The budget for the report series will be finalized in Q1 2010.
- The Secretariat will recruit additional Endemic Countries representatives to the 2010 Committee.
- The first of the series reports will be ready in time for the Global Fund replenishment meeting.

The Independent Evaluation of the RBM Partnership

Presentation summary

The USG representative outlined the Independent Evaluation process to date on behalf of the Chair of the Performance Sub-Committee (PSC) who was unable to attend. At the 15th RBM Partnership Board meeting, the Board requested a comprehensive, quality evaluation report that would provide both a retrospective and forward-looking analysis of the Partnership. This would be the second external evaluation of the RBM Partnership and would cover the five-year period from 1 January 2004 to 31 December 2008. The RBM Board mandated the PSC to oversee the Independent Evaluation. Thanks must go to all PSC members, especially the PSC Chair Kevin Starace, for guiding this process through so admirably and to Julian Fleet of the Secretariat.

Dalberg consultants were appointed after a competitive bid to carry out the evaluation and a final draft of the evaluation report was reviewed during the Board retreat in Anney in September 2009. The final report was disseminated to the Partnership and posted on the RBM Partnership website.

The Independent Evaluation had the following objectives: to examine the extent to which the RBM Partnership core objectives, structures (Board, Secretariat, WG) and strategic focus are relevant, realistic and sufficient; to examine the added value of the Partnership to the individual efforts of its members and where possible its impact on the overall malaria burden; to examine strengths/weaknesses and recommend ways of improving the impact, effectiveness and efficiency of the Partnership and its structures over the next five years to implement GMAP; and to compare the RBM Partnership's progress with that of other global health partnerships.

The overarching and significant findings of the Independent Evaluation are that:

- “2004 through 2008 has been a period of success for the malaria sector, individual RBM Partners and the RBM Partnership as a whole”;
- “The RBM Partnership has mobilized increased participation of partners and delivered strong ‘value-added’ over individual partner efforts, particularly since the implementation of the Change Initiative in 2006”;
- The Partnership “made its largest contributions in the ... areas (of) ... development of the GMAP ... consensus building, knowledge sharing and coordination, which are areas of comparative advantage for the RBM Partnership”.

Key points identified for the Partnership to address include:

- “Less progress was made over the evaluation period at the country level than at the global level ... country-level challenges received less consistent attention over the evaluation period than global consensus building and alignment of goals”;
- Specific findings and recommendations in the areas of Board planning, fundraising, and accountability;
- Secretariat performance where “funding issues are limiting its effectiveness”;
- Secretariat and WHO joint review of hosting issues every six months.

During the evaluation, the Dalberg team also looked at how the RBM Partnership could do business more effectively. Five potential operating models⁴ for the RBM Partnership were articulated and considered. A hybrid of Model 3 (harness country partnerships) and Model 4 (extend the movement) was proposed as an operating model for the RBM Partnership going forward (the Hybrid Model). The Dalberg team outlined how the Hybrid Model would extend the Partnership's geographic scope, largely by setting standards for affiliation with existing malaria partnership efforts rather than through the creation of new RBM Partnership structures. This approach is consistent with the HSS agenda as it does not create new vertical structures but does embed the fight against malaria more firmly within existing efforts. In summary, the Hybrid Model envisages country-level engagement going forward within a ‘networked model’ in which the RBM Partnership plays a catalytic role vis-à-vis country-level partnerships rather than a more command and control role.

As the evaluation covered the five-year period, 2004 to 2008, a number of recent initiatives carried out in 2009 are relevant to addressing some of the evaluation's recommendations. These were noted in a postscript to the Independent Evaluation report, and include: GMAP implementation; clarification of relationships with hosting organizations; improved financial reporting leading to greater transparency; and more effective functioning of Working Groups (WG) and the strengthening of Sub-Regional Networks (SRN).

During the Board retreat, Board members had discussed the Hybrid Model. In addition, three Task Forces were created to look in more detail at: planning and GMAP implementation including the role of SRN (Task Force 1); accountability within the Partnership (Task Force 2); and WG (Task Force 3).

Task Force reports

Task Force 1 presentation summary

Following the analysis of the 2004 to 2008 period, the Independent Evaluation team recommended that the Board should: increase its role in raising funds; ensure the Secretariat and SRN Focal Points (FP) are fully-funded for a three-year period; increase its role in overseeing Partnership finances; and revise the planning process to ensure activities are fully funded or matched to available funds.

⁴ More information about the five models is available in the *Independent Evaluation of the Roll Back Malaria Partnership 2004 - 2008: Final Evaluation Report*, available at: <http://www.rollbackmalaria.org/docs/RBMexternalEvaluation2009.pdf>

Since the period covered by the Independent Evaluation the publication of the GMAP has strengthened strategic direction for the RBM Partnership and the malaria community as a whole, FC developments have effectively increased the Board's role in Partnership finances, and changes to the 2010 – 2011 PWP planning and budgeting process will ensure that activities will be fully funded or matched to available funds. During 2010 – 2011 PWP discussions it has been agreed that the focus of resource mobilization should be on the targets to be achieved rather than on the mechanisms to be supported.

At the Board retreat, Task Force 1 was therefore requested to develop a GMAP strategic implementation plan for the next three to five years, including: a sustainable fund-raising strategy; an implementation plan for GMAP Phase I; clear responsibilities and accountability of partners driven by time-linked targets; clear strategic and operational roles for SRNs and agreement on the support required for their success. Subsequent discussions and recommendations are detailed in the Task Force 1 report presented to the 17th Board as a pre-read⁵. See p.14 for the adopted Task Force 1 recommendations and next steps.

Task Force 2 presentation summary

At the Board retreat, Task Force 2 was requested to develop a Partnership-wide accountability framework, including arrangements for: Board supervision of budget, work plan and outputs; accountability mechanisms between SRNs and countries; accountability of countries and other partners within the Partnership as contributors to the success of the GMAP; and a mechanism for the Board to contribute to the EXD appraisal. The Task Force 2 Chair referred Board members to the pre-read document⁶ which contained considerable detail on the process and recommendations of Task Force 2.

Task Force 2 members had agreed that it was not possible to develop an accountability framework without first defining the overall role of the Partnership and clear roles and responsibilities for each partner. The Task Force has, therefore, proposed overall roles for the Partnership from which flow proposed roles and responsibilities for the Board, Board Chair, Vice Chair, EXD and Secretariat, WG, SRNs, and for individual partners which differ according to their institutional mandate. Task Force members were not able to reach a consensus on SRN FP reporting lines. The majority Task Force recommendation is that the existing line of accountability from the SRN FP to the Secretariat be broken. However, a number of Task Force 2 members felt strongly that this reporting line should be retained.

Task Force 2 proposed the introduction of a clear accountability hierarchy with three levels of goals. This accountability hierarchy would be used to inform all Partnership planning and reporting processes. To reduce the reporting burden, Task Force 2 proposed the introduction of 'exception' reporting on lower level goals in order to focus on early warning of problems and the tracking of identified problems.

To ensure optimal planning processes, Task Force 2 would shift the planning cycle so that the RBM Partnership Spring Board meeting would focus on strategic decisions related to the work plan and the Fall Board meeting would focus on work plan budget decisions.

Finally, Task Force 2 requested that the Board discuss the engagement of an external organisation to perform an independent, annual review of the Partnership's performance.

See pp.15 for the adopted Task Force 2 recommendations and next steps.

Task Force 3 presentation summary

At the Board retreat, Task Force 3 was tasked with reviewing the TOR of all RBM Partnership WG and their inter-relationships and with recommending clearly-defined objectives and time-limited mandates for the WG.

Task Force 3 recommendations⁷ were organized around three key themes: WG membership; WG TOR; WG websites and knowledge management (KM). Task Force 3 noted that different WG take different approaches with regard to membership. Some have restricted formal membership but invite additional observers. The Secretariat has promoted inclusiveness and recommended a minimum of three endemic country members per WG. Existing WG TOR are quite varied. There appears to be no clear mechanism for review and approval of TOR by the RBM Board. There are no clear time limits to the existence of WG and WG Chairs appeared to

⁵ *Task Force 1: Planning and GMAP implementation. Report to the 17th Board meeting* available at: <http://workspace.who.int/sites/rbm/board/17th%20RBM%20Board%20Document%20Library/Forms/grouped2.aspx>.

⁶ *RBM Partnership Task Force 2 – Accountability; Report to the 17th Board meeting* available at: <http://workspace.who.int/sites/rbm/board/17th%20RBM%20Board%20Document%20Library/Forms/grouped2.aspx>.

⁷ Task Force 3: RBM Working Groups. Presentation available at <http://www.rollbackmalaria.org/mechanisms/boardmeetings.html>

oppose time-limited mandates. Web pages at the RBM Partnership site vary greatly from WG to WG. Some have almost no information or contain out-of-date information. Few have clear products available. As web pages represent the public face of the WGs, this is a problem. One of the main purposes of WG is to share knowledge, yet KM strategy is not generally included in WG TOR and not generally evident on their web pages.

Task Force 3 defined KM as the practice of getting the right knowledge to the right people at the right time so that they can work more efficiently and effectively, including among a widely-dispersed workforce. Some of the many creative KM tools currently available were mentioned e.g. communities of practice. It was noted that KM initiatives should amount to more than static documents on a website.

See p.16 for the adopted Task Force 3 recommendations and next steps.

Discussion summary

- It was noted that the Board could agree to accept the Independent Evaluation recommendations and the proposed Hybrid Model or agree to 'post' these decisions and return to them in 2011. The Board could agree to take note of the Independent Evaluation report for the purpose of signing off the work of the Dalberg team, but did not need to accept all the recommendations for immediate action.
- The emphasis on funding the GMAP and the recommendation that Partnership and Secretariat resources be put towards that goal were welcomed. Board members agreed on the importance of developing a 2010 – 2011 GMAP operational/implementation plan which was necessary to provide all RBM Partnership mechanisms and partners with SMART objectives.
- The suggestion that endemic countries contribute more funding to the fight against malaria was noted. Many African countries are slowly increasing the amount of money they put into health, but this money is most often going into horizontal/HSS approaches rather than vertical programming.
- Board members requested a more detailed description of the Hybrid Model and this was provided by the Private Sector. The Board noted that this was the Private Sector representative's personal interpretation of the model since there was no Dalberg representative present to provide a first-hand explanation.
 - The Dalberg team had noted that, while action to combat malaria must take place at three levels (global, regional and country) the RBM Partnership adds greatest value at the global and regional levels.
 - In the Hybrid Model, RBM Partnership engagement at the global level would continue in its present form. For example, Board members would continue to look into issues that can be addressed at the global level. RBM Partnership roles at the global level (according to the Task Force 2 definition of roles) would be to convene, coordinate, facilitate and communicate.
 - At the regional level, the Hybrid Model envisages a continuing RBM Partnership role in building up and supporting networks, and not just in Africa. Again, RBM-supported SRNs would convene, coordinate, facilitate and communicate.
 - At the country level, the RBM Partnership would leverage already existing country networks rather than attempting to create new RBM Partnership country-level networks which would risk duplicating what is already happening at the country level and would be onerous to fund.
- Task Force 2 members had agreed the use of SRNs (if not the structures for them), but had also sought to define where the RBM SRN would add value and a more intelligent use of resources at sub-regional level. Task Force 2 had, therefore, provided the outline of a detailed SRN/FP accountability structure.
- Potential synergies between SRNs and WHO and UNICEF structures should be explored.
- Northern NGOs proposed that 'agile and flexible' SRN structures were needed to respond most effectively to a diverse and evolving malaria landscape.
- A number of Board members supported retaining the reporting line between the SRN FP and the Secretariat.
- The EXD pointed out that the Independent Evaluation did not recommend that the SRN FP be de-linked from the Secretariat. She noted that experience shows that where a SRN is working well, it will have a relatively stable FP. She reiterated that the first step was to support SRN and their FP effectively, including stabilizing them with two-year contracts. If the SRNs do not function over time despite adequate support, then it will be the time to change. She believes that a situation where the FP is appraised by the SRN Chair, a representative of the SRN hosting organization and the Secretariat will work well. In her opinion, it is vital that the SRN FP is able to represent fairly all constituencies of the broad and diverse RBM Partnership and from this point of view having FPs as part of the Secretariat team was preferable.
- Endemic country representatives would like to see SRN FPs embedded in regional economic and political networks bringing the work of RBM into the political sphere. They also expect SRNs to facilitate the 'voice'

- of endemic countries being heard at Partnership Board level. They would like to see increased representation of endemic countries on the SRN related for a, and on Board Task Forces and Partnership WG.
- Countries in the Latin American and Caribbean Region already have a malaria network in place supported by PAHO/PMI. If strengthened, this network could carry out the same functions as the RBM-supported SRNs in Africa.
 - France noted that they are active in consortium development and would be willing to look at synergies with RBM Partnership SRNs.
 - Board members cautioned that the Partnership has committed itself to targets-based funding decisions, whereas this discussion was perhaps taking the Board towards a focus first on the structural issues related to SRNs ahead of the strategic imperative to have full agreement on the targets for SRN action.
 - The Private Sector reminded the Board that the Annecy retreat recommendations for the work of the three Task Forces had arisen from the strategic starting point of ensuring GMAP implementation.
 - From the EXD report it would appear that one of the most critical areas of action for 2010 will be Global Fund grant signings and implementation. The real work will be at the country level not regional. Therefore, there is a danger of spending time and energy re-structuring at the sub-regional level while country-level support is neglected.
 - The EXD concurs. She does not think that the end of 2009 is a time for re-structuring. It is a time for accelerating efforts and for concrete results.
 - The WHO identified human resource issues as a major concern for 2010, and would like to see partners reducing short-term technical assistance and focusing on how to provide long-term technical assistance.
 - UNICEF requested that the Board consider what action was to be taken to support 'big' countries e.g. Nigeria and the Democratic Republic of Congo (DRC) as a priority for 2010.
 - UNITAID is also discussing hosting arrangements with the WHO and would be interested to share experiences with the RBM Partnership Board.

Proposed revisions to the follow up of Task Force recommendations

- Board members recognized a degree of overlap between the work to date and recommendations of the three Task Forces. The future focus of each Task Force needed to be more clearly defined by the Board.
- Task Force 2 suggested that Task Force 1 issues related to accountability and implementation planning be taken over by Task Force 2 and completed by the 18th Board meeting. Task Force 2 further suggested that Task Force 3 issues related to WG be taken over by Task Force 2 and completed by the 18th Board meeting. Task Forces 1 and 3 agreed to these changes.
- Task Force 2 suggested that the issue of SRN FP reporting lines be taken on by the Secretariat. However, it was felt that there were still too many differences of opinion about this issue around the table and that the Board should consider this issue further rather than pass on the decision to the Secretariat.
- A proposal was tabled for a small group (one representative from each constituency and WG together with Secretariat representatives) to meet immediately after the Day One Board meeting to reach a consensus on outstanding issues related to the Independent Evaluation and Task Force recommendations, especially those concerning the SRNs and FPs, and finalize Task Force mandates/recommendations for adoption on Day Two. The proposal was accepted.

Call to order – Day Two

The Chair reported that the discussions held the previous evening had led to progress on the outstanding issues related to the Independent Evaluation recommendations, Task Force mandates going forward, and the structural issues regarding SRNs and their FPs.

Discussion summary

- The Task Force 2 Chair thanked those who had taken part in the previous evening's discussions, and was happy to report that they had managed to close the gaps on some difficult issues, in particular the SRN FP model and reporting lines. There had been a strong consensus around the proposal to have a flexible SRN FP model rather than 'one size fits all' model. The FP reporting lines issue had been more difficult to settle, and the proposal before the Board was based on an emerging consensus aimed at accommodating the interests of Task Force 2 and the Secretariat. Whatever the Board finally decided, he recommended that an emphasis be placed on SRN performance and value for money, requiring clear key performance indicators (KPIs) to be put in place. It has been proposed that the Secretariat should have a seat on each

SRN Coordinating Committee and that both the SRN Coordinating Committee and the Secretariat should sign off on FP objectives and KPIs.

- Both Endemic Country and NGO delegations requested to be represented on Task Force 2 going forward. The Task Force 2 Chair confirmed that Task Force 2 is an 'open' Task Force, and both delegations are invited to nominate representatives. Task Forces 1 and 3 would also welcome representatives from these constituencies.
- Board members considered the possibility of additional SRNs in other regions. The EXD confirmed that the Board had already given the go ahead for other SRNs, but to date the means to support further networks had not been available. Board members agreed a demand-led approach to SRN development i.e. if a region wants and needs SRNs then efforts will be made to secure the means to support them.
- It was noted that the draft Independent Evaluation report recommendation for a Service Level Agreement (SLA) between the RBM Partnership and the WHO had been dropped during the Board retreat (and in the final Independent Evaluation report) in favour of a six-monthly review process. Now both the SLA and six-monthly review process were proposed within the Task Force 2 work items. He suggested that the Board stick with the retreat decision. If, after two six-monthly meetings, there are still ongoing, unresolved operational issues then perhaps the Board could decide to look at a formal SLA. Task Force 2 would be glad to drop the SLA and focus on constructive, open dialogue.

The Independent Evaluation

Decision point

- The Board took note of the findings and recommendations of the Independent Evaluation of the RBM Partnership;
- The Board did not endorse the Hybrid Model as the model for the RBM Partnership going forward.

Next step

- Further Board discussions on operating model options at a later date.

Task Force 1

Decision point

The Board mandated Task Force 1 to focus on efforts to fully fund the GMAP.

Next steps

Task Force 1 with support from the Secretariat will:

- Develop new TOR for a Resource Mobilization Working Group (RMWG) to secure resources towards full GMAP implementation.
- Create a RMWG to develop the appropriate strategy for funding the GMAP.
- Ensure sufficient funding for a staff member to support the EXD and the RMWG in the above task.
- Engage academia to provide the current economic rationale for increased investment in malaria control.
- Advocate for greater investment into GMAP by endemic countries and by donors not currently in the Partnership.
- Review Board composition and representation to ensure all major financial contributors are represented.

SRN Focal Point model and reporting line

Decision point

- The SRN Focal Point Model will be flexibly adapted to individual sub-regional needs in Asia and South America, building on existing sub-regional mechanisms.
- The SRN Coordinating Committee will set objectives for, and review the performance of, the SRN Focal Points. Both the SRN Coordinating Committee and the Secretariat will sign off on Focal Point objectives and KPI.
- The Secretariat will be a member of each SRN Coordinating Committee.

Task Force 2

Decision point

- The mandate of Task Force 2 is extended to working with the EC, Secretariat and Partnership mechanisms to ensure that the recommendations by the three Task Forces endorsed by the 17th Board are implemented before the 18th Board meeting in 2010.
- Task Force 2 will report back to the 18th Board meeting and submit monthly reports to the EC on progress.
- The mandate of Task Force 2 is extended to identify means for accountability of partners in achieving the GMAP objectives.
- The Division of Roles and Responsibilities in the Partnership as set out in the Task Force 2 report to the 17th Board meeting⁶ is endorsed.
 - a. Roles of the Partnership: convening, coordinating, facilitating and interfacing
 - b. Roles of the various groups of partners
 - c. Roles of the various Partnership mechanisms.
- The Accountability Framework as set out in the above-mentioned document is endorsed.
- The Planning System set out in the above-mentioned document is endorsed.

Next steps

- Task Force 2 with support from the Secretariat will submit monthly reports to the EC on progress towards implementation of the three Task Forces' recommendations and report back to the Board at the 18th Board meeting.
- Task Force 2 with support from the Secretariat will map the Partnership with a view to assessing the accountability of partners in achieving the GMAP objectives
- Task Force 2 with support from the Secretariat will develop a 2010 – 2015 GMAP implementation plan and provide an interim report to the 18th Board and a full report to the 19th Board.
- Task Force 2 will design an accountability structure for the SRN FP in line with the 17th Board decision. The Secretariat will put this in place by the May 2010 Board meeting.
- The Board Chair and Vice Chair with support from the Secretariat will establish a performance appraisal system for the EXD and to work out a system to ensure that this is the primary tool used by the WHO in their annual performance appraisal.
- The EC with support from the Secretariat will develop a five-year Strategic Implementation Plan of GMAP for review by the Board at the May 2010 Board meeting.
- The EC and the FC with support from the Secretariat will have the endorsed Planning Structure in place by the 18th Board meeting.
- The EC and the Secretariat will finalize the 2010 – 2011 PWP taking into account the Task Force recommendations by the 18th Board meeting.
- The Secretariat will build KPI into their reporting once the KPI have been identified by Task Force 2 thus ensuring the Board has the information to measure performance of the Partnership and its mechanisms.
- The Secretariat, WG and SRNs will put in place the reporting and performance review system recommended in the Task Force 2 report and this will be operational by the 18th Board meeting.
- Task Force 2, in consultation with the Secretariat, WG Chairs and SRN Chairs, will develop reporting templates and administrative processes and structures that meet the approved recommendations in the Task Force 2 report.

- The Secretariat, WG Chairs and SRN Chairs will review their roles and work plans, and ensure that they are aligned with the recommendations in the Task Force reports and that any overlaps are identified and resolved.
- Task Force 2, in consultation with the Secretariat, WG Chairs and SRN Chairs, will review and update WG TOR, including membership criteria and procedures, and develop a cycle for review and approval of WG TOR by the RBM Partnership Board.
- Task Force 2, in consultation with the Secretariat, WG Chairs and SRN Chairs, will update Section 4.6 of the RBM Operating Framework on WG. Task Force 2 with support from the Secretariat and the FC will provide at least one year's funding in advance to ensure appropriate contractual arrangements for FPs.
- Task Force 2, in consultation with the Secretariat and SRN Chairs, will ensure that all SRNs function and that the FP have the appropriate reporting relationship with the SRN Chair and Coordinating Committee, the hosting organization and the Secretariat in alignment with the 17th Board decision.
- Task Force 2 with support from the Secretariat will formally evaluate the performance of SRNs and Focal Points one year after implementation of the 17th Board recommendations on SRNs.
- The Chair, Vice-Chair and EXD will set up a regular (6-monthly) meeting with the WHO Director-General to discuss progress on Partnership issues with the hosting relationship and other issues of mutual interest.
- Table a discussion at the 18th Board meeting on the engagement of an external organisation to perform an independent, annual review of the Partnership's performance.

Additional next steps identified during Board discussions

- Ensure appropriate Endemic Country and NGO representation on Task Force 2.
- Explore means to strengthen the existing Latin American and Caribbean Regional Malaria Network.
- Ensure that France has the revised SRN TOR to enable exploration of possible synergies with other consortia.
- Optimize potential synergies between the RBM Partnership structures and mechanisms and existing WHO and UNICEF structures and mechanisms at regional, sub-regional and country levels.

Task Force 3

Decision point

The Board mandated Task Force 3 to focus on the development of a generic RBM Partnership Knowledge Management (KM) Strategy that could be used by the Working Groups and that would enable KM among the Working Groups.

Next steps

- Task Force 3 with support from the Secretariat and WG Chair, will contract a consultant to develop a RBM Partnership KM strategy.
- Task Force 3 with support from the Secretariat and WG Chairs will define a minimum set of documents (e.g. TOR following the new template and including a last revision date, annual work plans, annual evaluations of work plan activities and achievements, meeting agendas and minutes, reference documents and products) to be included on WG web pages.
- Task Force 3 with support from the Secretariat and WG Chairs will agree a deadline by which each WG will have updated the RBM web pages with the minimum set of documents.

2010 – 2011 RBM Partnership Work Plan and Budget

Presentation summary

The EXD presented an overview of the 2010 – 2011 RBM PWP. As agreed during the 16th Board meeting. Three objectives⁸ articulate the PWP in support of full implementation of the GMAP and five priorities for RBM

⁸ After the 16th Board, the timeline of Objective 3 Prepare for Elimination was adjusted so that it now aligns with the 2010 – 2011 PWP timeframe.

Partnership action have been identified. Since the 16th Board meeting, RBM mechanisms have defined eight SMART⁹ targets. The eight targets are spread across the five priorities and the three objectives, although there is a focus on Objective 1: Achieve Universal Coverage. The targets are measurable so that each target can be assessed regularly. They are relevant as they are based on GMAP recommendations and MDGs. Finally, 23 deliverables are planned across the targets. The PWP framework matrix links objectives to targets to deliverables and all RBM Partnership mechanisms.

The EXD handed over to the FC Chair and the Secretariat for a joint presentation of the 2010 – 2011 PWP Budget. The FC Chair reminded the Board that the FC was created to provide oversight of the financial operations of the Partnership mechanisms, greater transparency and full accountability for the use of funds. In following up the Board's requests from the 16th Board meeting, members of the FC have: developed and revised templates for income reporting and cash flow; provided support to the Secretariat to implement the shadow system for better financial tracking, including tracking the money coming direct from partners; reviewed quarterly financial reports and reported back to the EC; guided a revised budget template for income, expenditure and cash flow; and guided a revised budgeting process for income. Budgeting is now monthly. Income and expenditure, within the budgeting template, have been separated out from cash inflow and outflow.

Instead of core and optimal budgets, a single budget based on identified income is presented to allow better tracking, performance monitoring and quality assurance for donor funding. This has involved a move away from 'aspiration' budgeting towards a system that budgets against identified and confirmed funding, while retaining flexibility to seek additional funding to meet targets. This approach was endorsed by the Independent Evaluation. It also reflects the Board's request at the 15th Board meeting in Delhi for a 'real' budget. A verification process has been implemented by the EXD, the Secretariat team and the FC Chair to confirm donor commitments by amounts and by time of transfer. A separate Supplemental Activity Framework to be implemented if additional resources are mobilized is also presented.

The single proposed budget for the 2010 – 2011 PWP was presented to the Board and the summary tables are available in the pre-read¹⁰. Total identified income based on signed donor agreements, written pledges and firm information from donors and net of WHO Program Support Costs (WHO-PSC) for the 2010 – 2011 biennium is projected to be US\$27,290,261, of which US\$21,852,261 is expected to flow through the WHO/RBM account and US\$5,438,000 is expected as direct contributions to Partnership mechanisms outside the WHO/RBM account. All identified income (net of WHO-PSC overhead), as well as estimated carryover, has been budgeted for the 2010 – 2011 PWP. Thus total proposed expenditures for the biennium amount to US\$27,290,261.

Expenditures of identified funds for each Partnership mechanism by the eight targets (A-H) contained in the 2010 – 2011 PWP were presented. Funds expected through and outside the WHO/RBM account were indicated separately. The proposed expenditure budget allocates US\$14,095,500 (52% of the total) to the Secretariat (including SRN FP salaries), US\$6,500,733 to the SRN (24%), and US\$6,694,028 (25%) to the WGs. Consistent with past practice, where donor contributions through the WHO/RBM accounts have not been earmarked to a specific Partnership mechanism, the funds have been allocated to support the functioning of the Secretariat and SRN FP.

Based on identified income, the 2010 - 2011 PWP has been structured around a set of aligned targets which were presented to the Board. Partnership mechanisms have also submitted additional activities and costs which can be considered if additional funding becomes available. The costs of these additional activities are broken out by mechanism and target in a Supplemental Activity Framework. The total amount of the proposed Supplemental Activity Framework is US\$27,528,213 (in addition to the US\$27,290,261 proposed expenditure budget noted above). Thus, the total amount of the proposed budget (based on identified income) and the Supplemental Activity Framework is US\$54,818,474 million for the two-year period 2010 – 2011.

It is also important to consider a prioritization process for any supplemental funding that may be mobilized. The EC might be requested to develop a prioritization methodology for allocation of un-earmarked supplemental funding based on, for example, the calendar of deliverables and/or an impact-oriented approach where only those targets are implemented in a first instance that have the most appropriate response to the

⁹ Specific, Measurable, Achievable, Realistic and Time bound (SMART).

¹⁰ Budget proposal for the 2010 – 2011 RBM Partnership Work Plan available at: <http://workspace.who.int/sites/rbm/board/17th%20RBM%20Board%20Document%20Library/Forms/grouped2.aspx>.

malaria burden in endemic countries and its related issues (key success factors). In allocating funding, the EC would need to take into account the recommendations of the Task Forces.

Finally, it was suggested that a discussion be initiated with the WHO Administration regarding the possibility of reducing Programme Support Costs (WHO-PSC).

Discussion summary

- There was a request that SRNs be fully funded.
- Any potential overlaps in budget should be identified e.g. if SRNs are fully funded then roadmaps should be tracked as a matter of course.
- Global Fund requested that the language in the target on Operational Research and Resistance be clarified. The Global Fund does not have funds for stand-alone research. Any funds for operations research are allocated within country grants.
- The Private Sector does not consider the eight targets as currently defined to be sufficiently SMART. They would also suggest the introduction of three levels of targets in line with the accountability hierarchy proposed in the Task Force 2 report¹⁰ and adopted by the Board.
- France noted that the country roadmaps will be an extremely useful tool for government fundraising across different domains.
- Board members asked for clarification regarding the process for allocation of un-earmarked funding.
- The reality today is that the GMAP is not fully funded. However, the message should be nuanced as huge amounts of money are flowing into the GMAP, and individual partners are making significant contributions outside the Partnership. It must also be made clear that the efforts of the RBM Partnership are just one contribution to the whole.
- Board members asked for an update on whether there were additional resources 'in the pipeline'.
- It would also be useful to explore whether it would be possible to harness funds from already existing Global Fund grants for PWP activities.
- Endemic Countries remain committed to funding malaria, but are unlikely to be able to 'chip in' much towards the PWP. The economic downturn and natural disasters linked to climate change as well as the effects of conflict in some countries have further increased the pressure on limited in-country funds.
- Nevertheless some Board members believed that countries must be strongly encouraged to increase their commitments during the next period and push towards universal coverage. All efforts must be made to avoid external resources becoming an alternative to internal resources.
- Board members agreed that all the indications point to the need for a strong, SMART resource mobilization strategy.
- Global Fund offered to look into the possibility of preparing joint 2010 reports with RBM. Several strong reports would be preferable to multiple individual reports.
- The WHO representative clarified that the review of WHO-PSC charges will apply across all WHO departments as well as to partner arrangements. He did not want to stand in the way of discussions, but wanted to question whether they would be worth the time and effort.
- There was broad agreement that the budget discipline developed here should be cascaded to all mechanisms.
- The USG proposed that the aligned targets, while not ideal, could be approved for now, and that discussions about how to prioritise would be more productive a little further down the line when additional funds are available.

Response summary 2010 – 2011 PWP work plan and budget

- There was only one solid 'pipeline' pledge on the horizon. It would amount to US\$600,000. However, the Secretariat confirmed that they are actively engaged in efforts to broaden the donor base.
- The decisions by two donors to move towards un-earmarked funding were welcomed.
- There was a request that the EC look at the allocation of current un-earmarked funding as well as supplemental un-earmarked funding.
- It was noted that the Secretariat has historically been under-resourced which is why un-earmarked funding has continued to be allocated to the Secretariat. As more support for Partnership activities is requested of the Secretariat, more people and therefore more resources will be needed.
- A related point was raised that if the Secretariat was putting 22 – 25% of their funding towards satisfying the Board, then the Board should review their demands and look at how effectively/efficiently the Board uses Secretariat resources?

- In terms of the message to the outside world, it must be clear that the Partnership will do more in 2010 – 2011 than it has before.
- The new RMWG needs a mandate from the Board so that malaria can be represented at discussions on the GAVI – Global Fund – UNITAID HSS platform in a more constructive manner. The RMWG should also be requested to discuss how innovative financing can be harnessed for malaria.
- Board members agreed that the 2010 – 2011 budgeting exercise had been a significant one and that the era of unfunded mandate has passed thanks to the Board’s strong direction. This would be good for the RBM Partnership’s reputation in that there would be no more promising more than can be delivered.
- The FC Chair thanked Board members for the approval of the two-year PWP and budget. He noted that many Board members had raised the key issue of how to track what is going on in the GMAP as a whole and ensure all are contributing according to the global plan. The first task for the RMWG will be to map out all partner contributions.
- The FC Chair thanked the members of Task Force 1 for their work to date and in advance for the work they will do as they launch the RMWG.
- The FC Chair welcomed new Task Force 1 members, Cambodia and Angola representing Endemic Countries and PATH representing the NGO Sector.

Decision point

- The overall scope of the 2010 – 2011 PWP with three objectives, five priorities, eight targets and 23 deliverables was endorsed.
- 2010 – 2011 PWP targets aligned with projected incomes with historical evidence of mobilized resources and firm pledges validated with donors were approved.
- The proposed RBM 2010 – 2011 PWP budget based on identified income of US\$27,290,261, of which US\$21,852,261 would pass through the WHO/RBM account and the remaining amount would be provided directly to RBM Partnership mechanisms, was approved.
- A ceiling of US\$27,528,213 was approved for the Supplemental Activity Framework for which funds have not yet been identified.

Next steps

- The Secretariat will incorporate final Task Force recommendations into the 2010 – 2011 PWP.
- The Secretariat will make 2010 – 2011 PWP operational by WHO Global Management System (GSM) entry by December 2009.
- The RBM Partnership Board and EC to support the RBM EXD to mobilize successfully full funding of the 2010 – 2011 RBM Supplementary Activity Framework in addition to the Expenditure Budget.
- The EC with support from the Secretariat will develop a system for prioritizing the use of current un-earmarked-funding and additional un-earmarked resources as they become available.
- The FC and Secretariat will support the RBM Partnership Board Chair to review and negotiate the WHO-PSC with the WHO using other Partnerships’ arrangements as potential benchmarks.
- The FC supported by the Secretariat will finalize details on the balance sheet.
- The FC supported by the Secretariat will develop reporting of comparable accrued accounts receivable and accounts payable under current WHO financial guidelines.
- The FC supported by the Secretariat will document a comprehensive budgeting process.
- The FC will review monthly financial reports, as facilitated by the budget, inclusive of the deviation report. The Secretariat will forward all reports due to the FC within 10 working days of the month’s end.
- The FC supported by the Secretariat will review potential tools or templates for better tracking of donor contributions and disbursements through Partnership mechanisms.
- The FC supported by the Secretariat will develop a simple rolling forecast report, which would indicate cash balance end of year given the actual performance year to date combined with updated projections for income and costs per priority for the rest of the year as per Task Force 2 recommendation.

Additional next steps identified through Board discussions

- Any potential overlap in the 2010 – 2011 PWP budgets will be identified by the Secretariat.
- The Secretariat will clarify the language in the target on Operational Research and Resistance (see discussion summary).

- The Secretariat will introduce three levels of targets in the 2010 – 2011 PWP in line with the accountability hierarchy proposed in the Task Force 2 report.
- The FC with the Secretariat will continue to cascade the new budgetary discipline to all mechanisms.
- The new RMWG to seek a mandate from the 18th Board to represent malaria at discussions on the HSS platform and in discussions on how innovative financing can be harnessed for malaria.
- The EXD and Global Fund will explore areas for collaboration on 2010 publications.

Strategic discussions on achieving 2010 – 2015 targets

The Chair outlined the aim of the agenda items to follow. The focus would be on allowing Board members time for in-depth, strategy-oriented discussions on achieving 2010/2015 targets.

World Malaria Report 2009

Presentation summary

The WHO gave a preview of the World Malaria Report (WMR) 2009 which would be launched on 15 December 2009. The principal data source for the report is national programs in 108 endemic countries, and data is up to 2008. The report measures progress towards RBM Partnership/World Health Assembly (WHA) 2010 and MDG 2015 targets.

In 2008, 3.5 billion people around the world remained at risk of malaria; 1.3 billion are estimated to be at high risk, 76% of whom are in Africa. Eighty-five per cent of cases are in Africa and 91% of malaria deaths are in Africa of which 85% are in under-fives. However, overall estimates continue to creep down year on year.

Funding commitments for malaria control increased from US\$0.3 billion in 2003 to US\$1.7 billion in 2009, but still fall short of the US\$ 6 billion required annually to meet GMAP targets. Disbursements are more difficult to track. They are increasing, but there is still a gap. Eighty per cent of external funds go to the WHO African Region. The South-East Asia Region saw the least money per person at risk and the smallest increase between 2000 and 2007. The distribution of funds indicates that the elimination effort for example will be resource limited. A cross-country analysis of the population at risk versus the funding available shows that big countries such as India and China have fewer resources per person at risk than some smaller counties, suggesting that funding is disproportionately concentrated on smaller countries with lower disease burdens. It is good to see that the data confirms that high levels of external assistance are associated with increased procurement of commodities and decreases in malaria incidence. A tremendous increase in resources has been achieved, but the resource gap still needs to occupy the Partnership.

Model-based¹¹ estimates of coverage in 35 high-burden countries show that more African households own an ITN; 31% in 2008 compared with 17% in 2006. Household ITN ownership reached more than 50% in 13 high-burden African countries. The regional average remains low mostly because resources for scale-up in several large African countries are only now being made available. More children (24% in 2008) aged under 5 years are sleeping under an ITN. Although the increase over time in the number of children using nets shows tremendous progress, the percentage is still below the WHA target of 80%. It is exciting to think about how the graphs will look after major net distributions in Nigeria and DRC. All the data point to the importance of efforts to increase coverage in these big countries.

With support from PMI, the use of IRS has increased sharply. The spike on the graph presented was largely due to the scale-up of IRS use in Ethiopia.

Increasing numbers of countries have adopted policies on ACT use and procurement of these anti-malarial medicines increased sharply from 2005 to 2008. Use of ACT is increasing but remains very low in most African countries; fewer than 15% of children aged under 5 years with fever received an ACT in 11 of 13 countries surveyed 2007–2008, well below the WHA target of 80%. There will be a need for better indicators of correct use of ACT, especially as diagnostics become more widely used.

¹¹ Model developed by the Institute for Health Metrics and Evaluation (IHME) using information from household surveys, nets procured from manufacturers and nets distributed by malaria programs.

In 18 high-burden WHO African Region countries for which data were available, 22% of the reported suspected malaria cases were confirmed with a parasite-based test in 2008. When the Partnership considers priorities, universal access to diagnosis and treatment are critical.

In nine household surveys in 2007–2008, 20% of pregnant women received a second dose of IPTp. IPTp should be easy to scale-up and many women are attending antenatal care (ANC) so it is not clear why its use remains so low.

More than a third (9 African countries and 29 outside of Africa) of the 108 malaria endemic countries documented reductions in malaria cases of >50% in 2008 compared to 2000. The number of cases fell least, however, in countries with the highest incidence rates.

With high coverage of malaria-control interventions, four high-burden African countries (Sao Tome and Principe, Eritrea, Rwanda and Zambia) recorded decreases in cases and deaths of >50%, showing that MDG targets can be achieved even in larger countries if there is adequate coverage of key interventions and systems in place.

Large decreases in malaria cases and deaths are mirrored by steep declines in all-cause deaths among children aged less than 5 years. Malaria control can help many African countries reach the MDG target of a two-thirds reduction in child mortality by 2015. A key message from this report is that interventions to fight malaria will help countries meet MDG 6 (combat HIV/AIDS, malaria and other diseases), but will also be the main wedge to meet MDG 4 (decrease child mortality) e.g. pneumonia deaths have been shown to decrease where malaria programming increases, probably mediated via a reduction in anaemia. If anything, the indirect contribution of malaria control to child deaths has likely been underestimated.

The state of malaria control in the world 2008 map may look very different in a few years time, but for now ten countries are implementing nationwide elimination programs of which six entered the elimination phase in 2009. Discussions are ongoing in South Africa with regard to elimination. Several countries have moved in each direction between pre-elimination and elimination. Armenia, Egypt and Turkmenistan moved from elimination to prevention of re-introduction. Mauritius moved into the malaria-free certification phase and the Bahamas have moved back into prevention of re-introduction.

On the basis of the WMR 2009, four priorities for the Partnership's attention were identified.

- The first evidence of resistance to artemisinin was found in 2009. Yet, despite the WHO call for a halt to their use, 37 countries still allow use of oral artemisinin-based monotherapies; most are located in Africa.
- Attention must be oriented towards the countries that account for most malaria cases and deaths.
- Health systems must be strengthened so that they are capable of delivering vector-control interventions, diagnostics for the parasitological confirmation of malaria and treatment with ACT.
- Routine information systems for malaria programme management and disease surveillance and systems for the surveillance of resistance to anti-malarial medicines and insecticides must be developed.

In conclusion, the WMR 2009 provided strong evidence that a renewed global assault on malaria, under way since the turn of the millennium, has been accelerating in the past few years. Heads of state and government, major agencies and private sector representatives, faith and civil society leaders have united behind this plan to ensure full coverage of malaria interventions by 2010 and to achieve near zero preventable malaria deaths by 2015 as a major step towards ultimately eradicating malaria.

Discussion and response summary

- Board members thanked the WHO for an inspiring presentation and an excellent WMR 2009 report. The WHO took all the praise for the WMR 2009 and directed it back to countries. The quality of the report was due to countries' efforts to collect timely, quality data.
- Board members acknowledged that WHO products such as the WMR 2009 and the resistance guidelines presented during the information day showed the WHO at its best. A request was made that the Board note that the success of the Partnership relies on an effective WHO department. The Board needs to support the WHO.
- A key message emerging from the WMR 2009 is that now is not the time to put the brakes on as malaria control will make a critical contribution to ensuring MDG are met.
- The contribution malaria makes to meeting MDGs 6 and 4 were mentioned in the presentation. Board members suggested MDG 1 (eradicate extreme poverty and hunger) should also be picked up on. MDG 2 (achieve universal primary education) can also be included as a significant proportion of cognitive

deficiencies on entry into the school system are due to malaria and of these children only 20% will catch-up by the end of their primary education. The WHO also highlighted the contribution of malaria control efforts to the achievement of MDG 3 (promote gender equality and empower women) in terms of the empowerment of women through strengthening antenatal care and increasing access to malaria diagnosis and treatment. In response to Board members' questions, he thought an argument could perhaps be made that the malaria effort contributes to achievement of MDG 5 (improve maternal health) by leading to an overall improvement in maternal health services, but thinks it unlikely that it will be possible to show a direct link between malaria control and maternal mortality (although, perhaps through anaemia).

- The HIV/AIDS–TB link is now well established and has influenced planning and funding decisions. Is there a link between malaria and HIV/AIDS? Acute malaria does increase viral load and HIV may worsen malaria. However, not in the same explosive reaction that characterises HIV/TB co-infection. It is probably not worth too much investment in researching the issue.
- Strengthening the interface between malaria and child/adolescent health e.g. the packaging of malaria with pneumonia in community-based treatment initiatives, is an important strategy.
- Anecdotal reports of artemisinin resistance were reported earlier than 2009 in Asia and there are also anecdotal reports of such resistance in Africa. It took 10 years before the scientific community took notice of chloroquine resistance, and Board members queried what the WHO was doing to investigate what of significance is going on in terms of artemisinin resistance. The WHO is working with the Ministry of Health on confirmatory studies for artemisinin resistance in a number of settings in Cambodia right now. There is also potential evidence for resistance outside of Cambodia and the WHO has a global plan in place to work with member states as soon as a resistance blip appears on the radar.
- In response to Board members' concerns on scaling-up access to ACT, the WHO proposed the following: fix the public sector, ensuring no stock outs and that people are trained; expand community case management; with the new guidance on diagnosis, ensure that communities take ownership of a paradigm shift in thinking and behaviour so that fever no longer equals malaria but equals the need to seek a differential diagnosis; and look at how to increase the effectiveness of treatment accessed through the private sector.
- It was noted that supply chain management and distribution issues make a huge contribution to implementation success. In many cases, if RDT is available there is no ACT and *vice versa*. A mechanism for PSM quality assurance is needed.
- The Private Sector called for more use of diagnostics to improve forecasting for ACT demand.
- The upcoming WHO guidance on diagnostics will be welcome. There is a need to look at costs and at the feasibility of implementation so that this information can be used in resource mobilization efforts.
- This is not the time to jettison IPTp. There are a number of known reasons why this relatively cheap and useful intervention fails. There is a need for greater input from partners to promote its use and perhaps a need for guidance on when and how to include IPTp as a prevention measure.
- More research on sustaining gains e.g. on replacement of LLINs is needed and more attention should be paid to sustainable approaches e.g. vaccines.
- Efforts to move on elimination in South Africa should be continued in order to show that elimination in Africa is possible and motivate others.
- As transmission falls, 'surveillance, surveillance, surveillance' will become key as immunity drops.
- Board members noted that increases in funding commitments are not being matched by increases in disbursements. This indicates absorption capacity limits and will affect resource mobilization.
- Resource mobilization success brings a responsibility for putting in place strategies for sustaining those funding levels. If financing is not sustained, country gains will be lost. There is a need to get serious about using other platforms e.g. HSS and innovative financing mechanisms.
- Would it be possible and/or useful to define how much money each of the fundamental GMAP partners needs annually?

Next steps identified through Board discussions

- The WMR 2009 report will be central to resource mobilization efforts, especially in a Global Fund replenishment year. Dr Chan has a foreword in the report this year. She looks in a visionary way at how the malaria landscape is changing and how to move forward. The WMR 2009 launch will be at the Palais des Nations, Geneva. The WHO representative will talk to the MAWG Chair about getting key messages out ahead of the launch.
- The Partnership should strengthen data on malaria and overall childhood deaths.

- The WHO has provided the Partnership with a great sound bite: ‘malaria control is the leading wedge to ensure MDG 4 is met’. With this strong card in hand, the World Bank moved that the Partnership strongly engages with innovative financing mechanisms. Malaria must also be positioned so that it is not seen as ‘competing’ for HSS funds and a clear rationale for using a focus on malaria control to strengthen systems must be developed. The Partnership needs a strategy for engaging more productively with IHP⁺.
- The WHO was congratulated on the use of 2008 data in the 2009 report; the 2008 WMR used 2006 data. However, looking ahead to 2010, what could be done to get the 2009 data in and analysed earlier and in time for the high-level report/event? What needs to change and who needs to do it should be identified.
- Links with the private telecommunications sector might lead to innovations aimed at real-time data collection. Could the Partnership provide a platform for promoting this?
- Possible areas for guidelines development include when and how to include IPTp as a prevention measure, community education around the new diagnostic guidelines, and the initiation of elimination.
- A mechanism for PSM quality assurance is needed.

Lessons learnt for sustained control: experiences from the Americas

Presentation summary

There are valuable lessons to be learnt from past experiences with the Eradication Program as countries move from sustained control to elimination.

The Eradication Program was standardized with all participating countries expected to complete four phases in 10 years. This expectation of conformity across contexts and of smooth transitions from one phase to the next had been unrealistic. The Eradication Program’s ‘attack and consolidation’ phases were implemented by the National Malaria Program while the ‘maintenance’ phase was the responsibility of the National Health Service. This led to poor relations between the two. This time round, the aim should be to work together, and this experience is particularly relevant in terms of the current debate around HSS. There was little attention paid to local epidemiology, ecologic, social and cultural barriers. Evaluation was based solely on program activities, with no attention paid to external factors, some of which e.g. the El Niño effect were significant. No consideration was given to potential epidemics. It had been an error to consider consolidation simple and cheap. Having a stand-alone Eradication Program had created a rupture at the transition between control and eradication. Many eradication programs had failed during the consolidation phase where a lower annual parasite index (API) than is currently used had been used as an indicator to move from control to pre-elimination. One of the biggest lessons learnt was that programming must take account of the fact that malaria is not uniformly distributed within countries, so that precise and localized information and indicators are needed to represent a meaningful picture of malaria in a country.

There are currently 21 malaria endemic countries in the Americas, from Mexico to Argentina. Programmes in the region now favour multi-faceted and dynamic strategies to address what are acknowledged to be multi-dimensional and evolving challenges. Components include: malaria prevention, surveillance, early detection and containment of outbreaks; integrated vector management; malaria diagnosis and treatment; promotion of an enabling environment for malaria prevention and control; and HSS/country-level capacity building.

2000–2008 figures show a marked reduction in both *P. falciparum* and *P. vivax*. All countries are using ACT. Marked reductions in mortality and morbidity are seen across the region, except in Venezuela, the Dominican Republic and Haiti where increases could perhaps be due to improved data collection. Major successes in the region include Ecuador, Guatemala, Nicaragua and El Salvador. Big reductions have been seen in Bolivia, a very poor country. The experience in Guyana was noted as a cautionary lesson. DDT crushed malaria in the 1960s, but by 1985 malaria had re-emerged and 40,000 cases were recorded annually. Care must be taken not to repeat this scenario.

It was highlighted that most of the money for malaria in the region is supplied by Governments with additional external support from USAID and the Global Fund.

Data from the region was presented to show how localized analysis could reveal vital information for program planning. It showed for instance that the Dominican Republic and Haiti were the only places where only *P. falciparum* is found, whereas other places also have *P. vivax*. In Brazil, disease burden has been mapped by district so that efforts can be directed to high-burden districts.

Mapping indicates a high disease burden in the Amazon Region. In response, the Amazon Malaria Initiative (AMI)/Amazon Network Surveillance Anti-malaria Drug Resistance was launched and is a partnership involving: PAHO/WHO; USAID; MSH, CDC; USP; Links Media; RTI; and from the Amazon Countries, MOH/ National Malaria Control Programs, National Institutes of Health, quality control laboratories, local research institutes, universities, public health laboratories, etc. Its main areas of action are: HSS and human resources development; health education, public relations, advocacy; research/addressing knowledge gaps (e.g. Peruvian work on RDT efficacy which was used to guide selection of RDT after it was shown that some of the RDTs in use were not detecting the parasite); and the management of the changes needed in reorientation from control to elimination (e.g. stop looking at malaria specific information systems and invest in systems relevant for all health problems). The Initiative aims to: use Indicators while bearing distinct contexts in mind; pay attention to entomological aspects and ensure transmission dynamics are understood at all levels; encourage justification of administrative and political decisions; and develop reference systems for diagnosis and treatment.

In Guyana, a 2008 mapping of malaria cases by place of infection and place of diagnosis showed that people were being infected in mining areas in the interior but were only getting a diagnosis and treatment once they returned to their homes in coastal areas. Thus employment-related population movements and lack of health services in the interior were increasing the risk of the re-introduction of malaria in coastal areas. In Ecuador, studies had looked on a district level at parasite level versus time of initial symptoms to diagnosis.

In conclusion, there is a need to reaffirm the fundamental role of malaria control efforts in contributing to improvements in the population's health. There is a need to understand local epidemiology, develop clear foci and for resolving epidemic problems which could arise. Control should not be seen as the reduction of malaria to a level when it is no longer a public health problem. Thus programmes should be mandated to: continue reducing and eliminate malaria where possible; better understand the possibilities and conditions to maintain areas malaria-free; and better understand the risks of reintroduction and epidemics in order to prevent re-establishment.

Discussion and response summary

- More information about the Hispaniola Initiative in the Dominican Republic and Haiti was requested. The Carter Center has supported a drive towards the elimination of malaria and lymphatic filariasis in Haiti and the Dominican Republic, the Hispaniola Initiative. The burden of disease happens to be along the border of the two countries and work has started in that area. However, there are problems. The burden of both diseases is higher in Haiti than in the Dominican Republic. Diagnosis and treatment are free in the Dominican Republic but not in Haiti. Due to economic disparities, many Haitians are in the Dominican Republic illegally seeking work and these people do not go to health centres to get treatment.
- More information was requested on differences in the severity of symptoms associated with *P. vivax* i.e. some people have few symptoms while others have very severe symptoms. There was not much known about the reasons people have such different symptoms in *P. vivax* areas. One possible problem is that anti-malarial drug counterfeits are a problem. The aim of the Ministry of Health is to have malaria diagnosis and treatment free and accessible so that people will not need to buy them from little shops.

Board resolutions

Eliminating artemisinin monotherapies

Proposed by the USG

The RBM Board recalls Resolution 60.18 of the World Health Assembly in 2007 that calls upon Member States: "to cease progressively the provision in both the public and private sectors of oral artemisinin monotherapies" and "to promote the use of artemisinin-combination therapies". The RBM Board applauds the strong steps taken by some governments to remove oral artemisinin monotherapies from markets, such as through regulatory prohibitions and enforcement measures including the seizure of oral artemisinin monotherapy

stocks from pharmacies and other providers.

Noting that nearly three years has passed since the approval of WHA60.18 and that oral artemisinin monotherapies are still sold to patients in many markets, the RBM Board:

- Urges pharmaceutical manufacturers to cease immediately the marketing and distribution of oral artemisinin monotherapies;
- Requests governments to establish statutory and regulatory prohibitions against the importation and sale of oral artemisinin monotherapies;
- Calls upon national governments to use stronger enforcement measures to expedite the removal of these products from the stocks of pharmacies and other sellers;
- Calls upon donor governments and international partners to provide assistance to affected country governments to strengthen national drug regulatory authorities and enforce these measures;
- Calls upon international financing institutions and other stakeholders to consider the use of incentives, such as preferential purchasing, for companies that are in compliance with the WHO's recommendation to discontinue the marketing and distribution of oral artemisinin monotherapies.

The RBM Board calls upon the Secretariat to present an annual report to its Board meeting each year to provide updates on efforts to comply with the WHO resolution on oral artemisinin monotherapies, and to identify additional potential activities for partners to support.

Discussion summary

- The Honourable Minister from Kenya proposed the addition of a point on support for efforts to promote the pre-qualification of local manufacturers by the WHO as a means for ensuring a sustainable supply of quality products. Other Board members agreed that this was an important measure to encourage local manufacturers to join this effort. Due to the specific technical concerns related to pre-qualification, this addition could not be pursued at the 17th Board. However, the Chair asked permission of the Board to request Kenya to produce a paper on manufacturing in Africa for the 18th Board meeting.
- The Board's attention was drawn to a recent Global Fund meeting on pre-qualification where a single-track process was recommended, regardless of the geographic origin of an application. It was suggested that the report from that meeting be scrutinized before deciding whether its recommendations needed to be strengthened via a new resolution at the next RBM Partnership Board meeting. The Secretariat stands ready to help with the preparation of a document for the Board if it is needed.
- UNITAID considered these are issues to pursue with the Boards of UNITAID, Global Fund and with the WHO International Programme on Chemical Safety (IPCS).
- It was further noted that the aforementioned Global Fund meeting had also looked into certification of national drug regulatory authorities and into twinning strong national drug regulatory authorities with ones still facing problems.

Decision point

The RBM Board will monitor progress and disseminate regular updates on compliance with the WHO resolution and global policy to cease the provision of artemisinin monotherapies.

Next step

- Put in place a mechanism tracking the elimination of monotherapies
- The issue of pre-qualification and local manufacturing will be addressed at the 18th Board meeting and progress on them advanced through a possible resolution based on outcomes of the Global Fund meeting on pre-qualification.

Pharmaceutical and insecticide resistance

Proposed by the USG

The RBM Board applauds the encouraging gains against malaria transmission and illness that numerous countries are reporting, and takes note of the fact that these gains are driven to a great degree by the effectiveness of a limited number of drugs and insecticide products for the treatment and prevention of malarial illness.

The RBM Board therefore notes with alarm the reports of the existence and emergence of artemisinin-resistant malaria in Southeast Asia, and of ongoing concerns about the development of insecticide-resistant malaria vectors.

Understanding that current gains against malaria could be reversed in the future if resistance to these drugs and insecticides is intensified, the RBM Board calls upon partners and countries to take urgent steps to address drug and insecticide resistance. RBM partners and countries, in particular, should support:

- Increased financing and technical support to surveillance activities designed to monitor the potential development and spread of drug and insecticide resistance;
- Efforts by national governments to develop regulatory framework, increase monitoring and enforcement measures to identify and seize drugs and insecticide products that are counterfeit, substandard, or which have expired, and for donor governments and multilateral organizations to support these efforts;
- Efforts to develop new anti-malarial drugs and insecticides to add to the current arsenal of weapons to fight malaria;
- Research efforts for new tools to predict and or avoid resistance mechanisms;
- Measures to improve adherence to effective malaria treatment, including through the expansion of diagnostic testing, provider training, and patient education;
- Effective collaborations among the agriculture, health and environment sectors to promote rational use and disposal of insecticides, to monitor resistance and to mitigate resistance pressure that may come through public health, domestic and agricultural use of the same pesticides.

The RBM Board calls upon the Secretariat to present an annual report to its Board meeting each year to provide updates on this issues, and requests reports on what steps partners are taking to combat resistance, and to identify additional potential activities for partners to support.

Discussion summary

- A request was made for the inclusion of support to research towards new tools for the tracking and mitigation of resistance issues. This addition would underpin efforts to mobilize funding for broader research efforts i.e. those not directly aimed at new product development. The following bullet point was added to the original resolution:
 - Research efforts for new tools to predict and or avoid resistance mechanisms.

Decision point

The RBM Board will monitor progress and disseminate regular updates on all efforts being made to address parasite and vector resistance.

Procurement and Supply Chain Challenges and Systems Strengthening

Proposed by the Endemic Country, NGO and Private Sector constituencies

The RBM Board recognizes that achieving the sustained scale-up of malaria control in all countries and preparing for elimination will require concerted efforts towards strengthening health systems to enable accurate forecasting, effective procurement and stronger supply chain management at the global and country levels.

Noting the importance of translating the increased funding available to countries into commodities delivered to end-users within acceptable timeframes, the Board calls upon partners to address the associated

challenges. The RBM Board recommends the following actions in particular be undertaken without delay:

- Increased efforts to ensure predictable and stable financing including innovative financial and procurement mechanisms to shorten the lead time between funding made available and commodities delivered to the end users;
- Endemic countries include in their national strategic plans, plans to strengthen country level systems for forecasting, procurement, information and supply chain management capacity;
- Increased financing and technical support towards country level capacity building for forecasting, procurement, information and supply chain management systems;
- Efforts to improve market intelligence on global demand and supply for malaria commodities;
- Ensure monitoring of all commodities;
- Enhanced commitment by partners to address procurement and supply management challenges.

The Board is requested to support a strategy to guide action to be taken by the RBM partners and appropriate RBM mechanisms on these challenges.

With the acceleration of work in 2010, it is believed that attention to these issues is essential if the RBM Partnership is to achieve its goals. The resolution proposers are concerned that these issues have not been adequately prioritized or funded.

Discussion summary

- A reference to 'ensuring utilization' of all commodities was considered beyond the scope of what was intended to be covered by the resolution and was dropped from the original text. The following revised sentence was inserted with the agreement of the Board:
 - Ensure monitoring of all commodities.
- The Global Fund stated that many of the requested activities are already taking place. To avoid duplication of effort, Global Fund suggested that the Board change the spirit of the resolution to encourage the Procurement and Supply Chain Management Working Group (PSMWG) to work with other actors to ensure these activities are ongoing.

Decision point

The RBM Board will request the Procurement and Supply Chain Management Working Group to collaborate with key partners to ensure that the recommended actions outlined in the resolution on Procurement and Supply Chain Management Challenges and Systems Strengthening are executed.

Harnessing innovative mechanisms for HSS and diseases control

Proposed by the World Bank, the Global Fund, UNICEF and DFID

Exploring innovative financing mechanisms for HSS and diseases control.

The RBM Partnership Board:

1. Recognizes gains in malaria control made by endemic countries;
2. Notes the importance of strengthening health systems to ensure sustained scale-up and impact on MDG 1, 2, 4, 5, 6 and 8;
3. Urges the RBM Secretariat to engage closely with innovative financing mechanisms being developed with partners to ensure investments in malaria control, strengthen health systems and HSS efforts to help further improve malaria-related efforts and outcomes.

The RBM Partnership Board will closely monitor progress on moving towards this objective and expects reports on progress at the next RBM Partnership Board meeting.

Discussion summary

- France registered a strong concern that the wording of the resolution continues to promote a vertical approach whereas the Board has heard country representatives express support for an increasingly horizontal approach. The World Bank noted that the wording of Point 3 was meant to cover this concern.

- Other Board members were concerned that a very deliberate definition of what the Board understands by the term HSS would be needed ahead of commitment to the resolution as it was presented. Caution was also suggested until the proposed joint platform on HSS has been finalized and can be considered by all constituencies. Others believed that failing to engage on HSS now would be “at our peril”.
- A number of amendments to the resolution were suggested and accepted by the Board. These allowed for the RBM Board to explore the potential opportunities offered by innovative financing mechanisms for HSS while recognizing that the RBM Board has no formal position on malaria and HSS as yet.
- The following revised sentences replaced the original sentences in the resolution with the agreement of the Board:
 - Exploring innovative financing mechanisms for HSS and disease control.
 - Point 3 urges the RBM Secretariat to engage closely with innovative financing mechanisms and the proposed joint HSS platform but a mention of support to these mechanisms was deleted.

Decision point

The RBM Board urges the RBM Secretariat to engage closely with innovative financing mechanisms being developed with partners to ensure that investments in malaria control strengthen health systems and that HSS efforts help further to improve malaria-related efforts and outcomes and to report on progress at the 18th RBM Partnership Board meeting.

Next steps

- The World Bank paper will present a paper on HSS and innovative financing at the 18th Board meeting, and the EXD will liaise with the Global Fund in discussions regarding this paper.
- HSS and innovative financing will be included as items during the 18th Board meeting information day.

High-level country follow-up teams/punch teams

Proposed by the RBM Board Chair

The RBM Partnership Board was requested to:

- Create a specific number of High-Level Country Follow-up Teams (CFUT) for each of the RBM SRNs;
- Establish a standing committee through which the Chair of the Governing Board, the RBM Executive Director and the United Nations Secretary General's Special Envoy for Malaria will be guiding punch teams on a regular basis;
- Task the Secretariat, SRNs and WGs to support this standing committee.

The Board was requested to note the budgetary implication of funding travel for CFUT.

Discussion summary

- The Chair proposed the CFUT as an extra tool to expedite country progress towards meeting 2010 targets. Despite the availability of commodities and other resources, internal challenges and bottlenecks continue to impede the progress of many countries towards achieving universal coverage. The very high-level team members would be able to explain the 2010 targets and actions to presidents in Africa resulting in the necessary political commitment to ensure timely and effective implementation. He explained that meeting presidents face to face and on their home soil would be most effective in his opinion.
- Board members wondered who would invite the CFUT into a country as they were not comfortable with the idea of the team ‘parachuting in’. They would need clarification with regard to the mandate of the teams and feedback on missions. Board members would want CFUT interventions to remain exceptional interventions.
- Board members suggested linking the CFUT with the ALMA initiative in order to engage African leaders into the teams.
- The Honourable Minister of Health for Liberia reminded the Board that the Special Envoy can visit any country and any president to discuss malaria. Therefore a mechanism for high-level discussions already exists. He proposed that the Special Envoy visits countries together with the RBM Partnership EXD and

that visits are planned to coincide with country budget planning processes so that it would be possible to call on presidents and the Ministers of Finance to put a bit more money into the malaria 2010 – 2015 pot.

- The Chair agreed that the proposal by Honourable Minister from Liberia made a lot of sense and that the Board could appeal to the Special Envoy to step up his high-level country visits.
- The Special Envoy's representative to the Board confirmed that the Special Envoy is mandated to undertake just such visits and has already been to 12 countries and met the leaders of 24 countries.

Decision point

The RBM Board urges the United Nations Secretary General's Special Envoy for Malaria together with the RBM Executive Director to continue with high-level visits to countries struggling to meet the 2010 universal coverage targets.

Next step

The RBM EXD will liaise with the Special Envoy to agree priorities for joint high-level missions.

Innovative financing for operation 2010 – 2015

Proposed by the Private Sector

The RBM Board requests the Executive Director with support from the Harmonization Working Group (HWG) to position the RBM Partnership within the dialogue to expand innovative financing models, like Debt2Health and the MassiveGood Effort, with the objective of directing a greater proportion of funding flows to finance necessary malaria resources. \$200,000 has been identified from the Private Sector and earmarked for the support of engagement with innovative financing mechanisms.

Presentation summary

In order to achieve the MDGs and sustain net replacement and ACT continuity, the levels of funding for malaria must increase significantly. Moving forward, successful financing of the GMAP will require funding that is predictable, long-term and sustainable to help mitigate the volatility in aid flows that challenge the current development aid architecture.

Three resource mobilization options are available. Traditional funding mechanisms can be pursued and will continue to play an important part in maintaining momentum and progress. Malaria services must be better integrated into existing health budgets although this will require competition for a larger portion of existing health aid and cannot alone produce the volume of funding needed. Innovative financing mechanisms provide a potential new source of funding to build predictable, long-term, sustainable and scalable funding for health aid. Since 2006, innovative financing mechanisms are estimated to have yielded \$2.5 billion in additional funding, but scale-up of successful models is needed to provide the levels of development finance critical to meeting 2015 goals.

Each of these approaches are important and viable, and none should be considered in isolation. To maintain progress and meet the levels of funding required, the Partnership should be looking at using a combination of all of these sources of finance rather than one or the other.

Decision point

The Executive Director with support from the HWG is requested to position the RBM Partnership within the dialogue to expand innovative financing models, like Debt2Health and the MassiveGood Effort, with the objective of directing a greater proportion of funding flows to finance necessary malaria resources.

Next steps

The EXD with support from the Secretariat and HWG will:

- Debt2Health
 - Work with the Global Fund, to advocate further expansion of the Debt2Health scheme
 - Work with Global Fund when approaching new creditor and beneficiary countries
 - Create an open communication channel between Global Fund and RBM on new opportunities
 - With early information, HWG can continue to support beneficiary countries with robust malaria proposals;
- Airline Levies/MassiveGood
 - Support implementers to access continued funding for malaria control efforts through UNITAID
 - Work with UNITAID to broaden the number of countries subscribing to the airline levy
 - As MassiveGood is launched, advocate with potential stakeholders to broaden the implementation of voluntary contributions.
- Gather the data required to define the magnitude of financing obligations to sustain coverage after 2010 and release the analysis in a report as soon as possible during 2010 and connected with a high-level malaria event.
- Having defined the scope of the problem, engage in high-level dialogue with leaders in the Partnership, malaria community and drivers of innovative financing efforts to discuss the opportunities to expand current mechanisms.

Date and venue of the 18th Board meeting

The Chair noted that the Spring Board meeting is traditionally held in Geneva. Provisional dates are the 12 – 14th May 2010. These dates need to be confirmed as they have already been proposed as dates for the next Global Fund Board meeting¹².

Decision point

The May 2010 Board Meeting will be held in Geneva, Switzerland, dates to be confirmed by the Executive Committee.

Any other business

Global Fund – RBM Partnership coordination

The Global Fund representative felt it was a good moment to celebrate the excellent coordination between the RBM Partnership and the Global Fund. He gave two recent examples. At the recent PSM workshop bottlenecks were identified and discussed in a collaborative manner and agreement reached on the need to build capacity for needs forecasting at country and higher levels. The timely evaluation report from UNICEF, discussed at a meeting in Geneva in early December, on the process by which the HWG had aimed to accelerate Round 8 grant signatures had identified lessons learnt that can be incorporated into institutional policy and cross-agency working.

Princess of Africa film

A film will be made about the life and work of Yvonne Chaka Chaka, the South African singer dubbed the 'Princess of Africa'. She is an UNICEF goodwill ambassador and was recently invited by the Bill & Melinda Gates Foundation to be one of the Champions in the 2010 initiative to combat malaria. If partners have footage to share with the film makers or funds to support the film, they should contact Tim Rockwood (c/o Louis Da Gama Idagama@gmail.com).

New Private Sector focal point

The Private Sector thanked Tom Achoki from the World Economic Forum (WEF) for acting as the Private Sector focal point. Ms Kathrin Bauer of the International Business Leaders Forum (IBLF) will take over the role.

¹² In the meantime, the Global Fund Board meeting dates have been confirmed for April 2010.

19th Board meeting invitation

The Chair noted the invitation from France to hold the 19th RBM Partnership Board meeting in Paris, and passed the invitation on to the EC who would discuss it further.

Closing remarks

The Special Envoy's representative thanked the Chair. He assured Board members that Mr Ray Chambers, the Special Envoy, remains committed to supporting efforts to meet the 2010 targets. The EXD expressed her thanks to all Board members and acknowledged the huge work of those members involved in the EC and all other Board committees and Task Forces. She noted that all members of the Partnership have the right to be satisfied with recent progress as all have been involved in making it happen. She also thanked the Chair on behalf of all Board members and the Secretariat. She passed on heartfelt thanks to all members of her team at the Secretariat for their commitment to the work and asked the Board to continue to support them. In particular she thanked Thomas Teuscher for his input into the Board meeting, the EC, policy issues and the work plan. She thanked especially the Government of Brazil for being an excellent host. The Chair thanked Board members for their support of the Board process and on reaching joint and timely conclusions.

Adjournment

The Board Chair adjourned the meeting.