

Twentieth RBM Partnership Board Meeting

Wednesday, May 11, – Friday, May 13, 2011.




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Twentieth RBM Partnership Board Meeting

Friday, May 13, 2011

Special Ministerial Board Session

Time	Agenda item	Presenter
09.00-10.30	Special Ministerial Board Session <ul style="list-style-type: none">• Implementation of the 2010 Call to action: Ban on oral artemisinin based monotherapy• Sustainable financing for malaria control• Impact of GF reform on malaria control• Concluding remarks	Board Chair Minister Kenya Minister Namibia Exec. Director GF Hon. Steven O'Brian
10.30-11.00	Break	
11.00-12.30	Special Ministerial Board Session Continued	
12.30-14.00	Lunch Briefing <ul style="list-style-type: none">• 2015 GMAP Objectives and Targets• Overview Country Score cards• WHO treatment recommendations for severe malaria• Stockholm POPs Convention	Co-Chair TPTF ALMA WHO/GMP Idem 

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BAN ON ORAL ARTEMISININ MONOTHERAPIES

Hon. Beth W. Mugo, MP
Minister for Public Health and Sanitation
Kenya

Special Session of African Ministers of Health
20th RBM Partnership Board Meeting
Geneva, 11-13 May 2011



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Background (1)

- On April 25th 2000, African Heads of State and Government meeting in Abuja committed to **reduce malaria cases in deaths on the continent by 50%** by 2010 through scaling up and universal coverage of malaria control interventions including sound treatment strategies for malaria cases
- The development of resistance to artemisinins is a major threat to global public health and progress in malaria control and elimination and the achievement of **resolution WHO/AFRO/RC59/R3** concerning Accelerated Malaria Control Towards Elimination in the Africa Region;
- We should also consider MDG "6" that commits all UN members states to "halt by 2015 and reverse the incidence of HIV, tuberculosis and **malaria**"



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Background (2)

- We the Ministers of Health of the African Continent, congregated at the Special Ministerial Session of the 18th Roll Back Malaria (RBM) Partnership Board Meeting in 2010 and committed to:
 1. Implementing the WHA resolution 60.18, of May 2007, urging all WHO member states to deploy ACTs and progressively withdraw oral artemisinin monotherapies from the market
 2. Actively engaging the private sector in stopping the production and marketing of oral monotherapies
 3. Supporting the local manufacture of ACTs and other malaria commodities
- It is with this background that today we report on progress with regards the banning of oral artemisinin-based monotherapies in Africa.



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Nine steps for the removal of monotherapies

BOX 5.7

RECOMMENDED STEPS TO REMOVE ORAL ARTEMISININ-BASED MONOTHERAPY MEDICINES FROM THE MARKET		
ACTION	TASK	TIMELINE
Step 1	Agreement on time frame for phasing out oral artemisinin-based monotherapies in synchrony with large-scale implementation of artemisinin-based combination therapies (ACTs).	Immediate
Step 2	Suspension of new approvals of marketing authorizations for oral artemisinin-based monotherapies.	Immediate
Step 3	Suspension of import licences for artemisinin or its derivatives (as Active Pharmaceutical Ingredient (API) or Finished Pharmaceutical Products (FPP)) to domestic companies exclusively marketing oral artemisinin-based monotherapies.	3–4 months
Step 4	Large-scale deployment of ACTs in the public sector and communication to prescribers and consumers to move away from monotherapies generally associated with external funding for procurement (e.g. from Global Fund or other sources). All subsequent timelines are conditional on this.	Time X
Step 5	Widespread availability and affordability of subsidized ACTs in the private sector, as expected in countries participating to the Affordable Medicine Facility.	Time Z
Step 6	Withdrawal of marketing authorization and of manufacturing licences for oral artemisinin-based monotherapies as FPPs.	6 months after time X
Step 7	Suspension of export license for oral artemisinin-based monotherapies as FPPs.	6 months after time X
Step 8	Complete elimination of oral artemisinin-based monotherapy medicines as FPPs from the market.	10–12 months after time X
Step 9	Active recall of oral artemisinin-monotheapies from the market.	3 months after time Z

Source: WHO Malaria report 2010



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Step 1: Artemisinin Combined Therapies (ACT) is first line treatment of non-complicated malaria in all Africa countries

ADOPTION OF POLICIES FOR MALARIA TREATMENT IN WHO AFRO

Policy	African Countries
Number of <i>P.falciparum</i> endemic countries	42
ACT used for treatment of <i>P.falciparum</i>	42
ACT is free of charge for all age groups in public sector	24
ACT is free of charge for only < 5 years in public sector	5
ACT delivered at community level	25
Pre-referral treatment with quinine/artemether IM/ artesunate suppositories	32
Therapeutic efficacy monitoring is undertaken	25

Source: WHO Malaria report 2010



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Step 2: Suspension of new approvals of marketing authorizations for oral artemisinin monotherapies

Region	2009	2011
Central Africa	-	4
Eastern Africa	10	11
Southern Africa	10	10
West Africa	-	12
TOTAL	20	39



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Step 3: Suspension of import licences for artemisinin or its derivatives

Region	2009	2011
Central Africa	-	4
Eastern Africa	8	9
Southern Africa	10	10
West Africa	-	7
TOTAL	18	30



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Step 4: Large-scale deployment of ACTs in the public sector and communication to prescribers and consumers to move away from monotherapies

Region	2009	2011
Central Africa	-	4
Eastern Africa	8	9
Southern Africa	9	10
West Africa	-	15
TOTAL	17	38



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Step 5: Widespread availability and affordability of ACTs in the private sector

Region	2009	2011
Central Africa	-	0
Eastern Africa	0	4
Southern Africa	0	2
West Africa	-	4
TOTAL	0	10



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Step 6: Withdrawal of marketing authorization and of manufacturing licences for oral artemisinin-based monotherapies

Region	2009	2011
Central Africa	-	4
Eastern Africa	0	7
Southern Africa	4	5
West Africa	-	5
TOTAL	4	21



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Step 7: Suspension of export licence for oral artemisinin based monotherapies

Region	2009	2011
Central Africa	-	4
Eastern Africa	0	0
Southern Africa	0	0
West Africa	-	3
TOTAL	0	7



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Step 9: Complete elimination of oral artemisinin-based monotherapies from the market

Region	2009	2011
Central Africa	-	-
Eastern Africa	-	-
Southern Africa	1	1
West Africa	-	-
TOTAL	1	1



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Step 8: Active recall of oral artemisinin-monotherapies from the market

Region	2009	2011
Central Africa	-	4
Eastern Africa	0	2
Southern Africa		
West Africa	-	2
TOTAL	0	8



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Progress on Implementation

- In 2010, no country in the African region issued any manufacturing or marketing license for artemisinin monotherapies
- **African National Drug Regulatory Authorities** are today conducting random inspections to both public and private pharmacies and health facilities to look for banned medicines including artemisinin monotherapies
- **Community information** and education campaigns on the continent have increased awareness of ACTs and support the ban on monotherapies



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Progress on implementation

- Most of the 39 pharmaceutical companies still manufacturing oral artemisinins in 2010 were in India
- The Drug Controller General of India (DCGI) took decisive action and directed the state drug regulatory authorities to cancel the licence of such manufacturers and stop the export of artemisinin as a monotherapy
- Subsequently, reports from India, indicate that the number of companies willing to comply with WHO recommendations is rapidly increasing



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Challenges:

- The capacity to enforce the ban or discourage illegal stocking of these medicines varies from country to country.
- Governments need to do more to empower national drug-regulatory authorities to clamp down on offending companies
- Lack of expertise and inadequate staffing weakens the capacity of national drug regulatory authorities in Africa to comply with WHO recommendations and enforce the ban



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Way Forward

I would like to congratulate you my colleagues on the work done so far and take this opportunity to call on you to:

- Re-evaluate progress within your countries and commit to the total ban on the sale of oral artemisinins with immediate effect
- Advocate politically for the strengthening of drug regulatory authorities by building capacity of personnel to enforce licensing and marketing bans, and also to conduct surveillance to ensure the removal of counterfeit and substandard products.
- Strengthen procurement and supply chain management for ACTs to ensure constant availability within both public and private sectors



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Asante sana
Thank you
Merci
Obrigado



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Sustainable malaria financing in controlled low endemic settings

Ministerial session: Roll Back Malaria Partnership

Dr Richard Nchabi Kamwi, MP

Minister for Health Namibia

May 2011



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Overview

Transmission is being reduced

Potential for resurgence exists

Sustained funding for successful countries is crucial

- Making the case to donors
- Discovering new sources and mechanisms to improve funding
- Work with national governments on country-specific solutions



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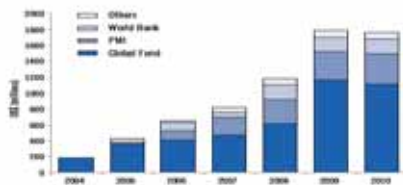
Successful countries are increasingly reducing malaria transmission to low levels
 Some countries are moving towards elimination; for others sustained control is the goal
 BUT this fragile success needs to be seen in a challenging context of global funding

Reduction in cases between 2000-09

Decrease in cases >50%	Decrease in cases 25-50%	Limited evidence of decrease
AFRICAN REGION		
Algeria		Angola
Cape Verde		Benin
Botswana		Burkina Faso
Madagascar		Burundi
Namibia		Cameroon
Sao Tome and Principe		Central African Republic
South Africa		Chad
Swaziland		Congo
Eritrea		Cote d'Ivoire
Rwanda		Democratic Rep. Congo
Zambia		Equatorial Guinea*
		Ethiopia†
		Gabon
		Gambia*
		Ghana
		Guinea
		Guinea-Bissau
		Kenya*
		Liberia
		Malawi
		Mali
		Mauritania
		Mozambique
		Niger
		Nigeria
		Senegal
		Sierra Leone
		Togo
		Uganda
		United Rep. of Tanzania*
		Zimbabwe

Countries with low transmission have a GDP per capita more than double the average of sub-Saharan African countries

Global Malaria Funding



Note: Figures from WHO World malaria Report 2010

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Challenges

Out of sight, out of mind: A perception that the job is done given the low number of cases and deaths

Limited Resources: global malaria funding has likely peaked

Unpredictability: donor funding is often short-term, making planning difficult

Solutions

Make the case for sustainable financing

Domestic funding should not be shifted to other (underfunded) disease areas

Donors need to continue funding malaria even in new low burden countries

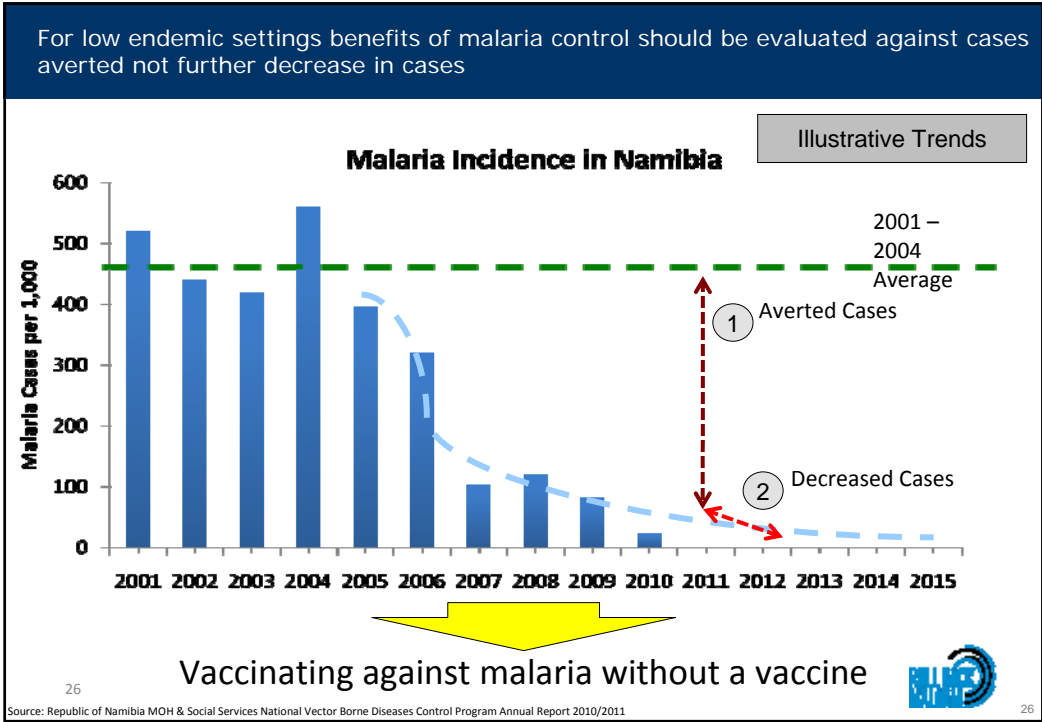
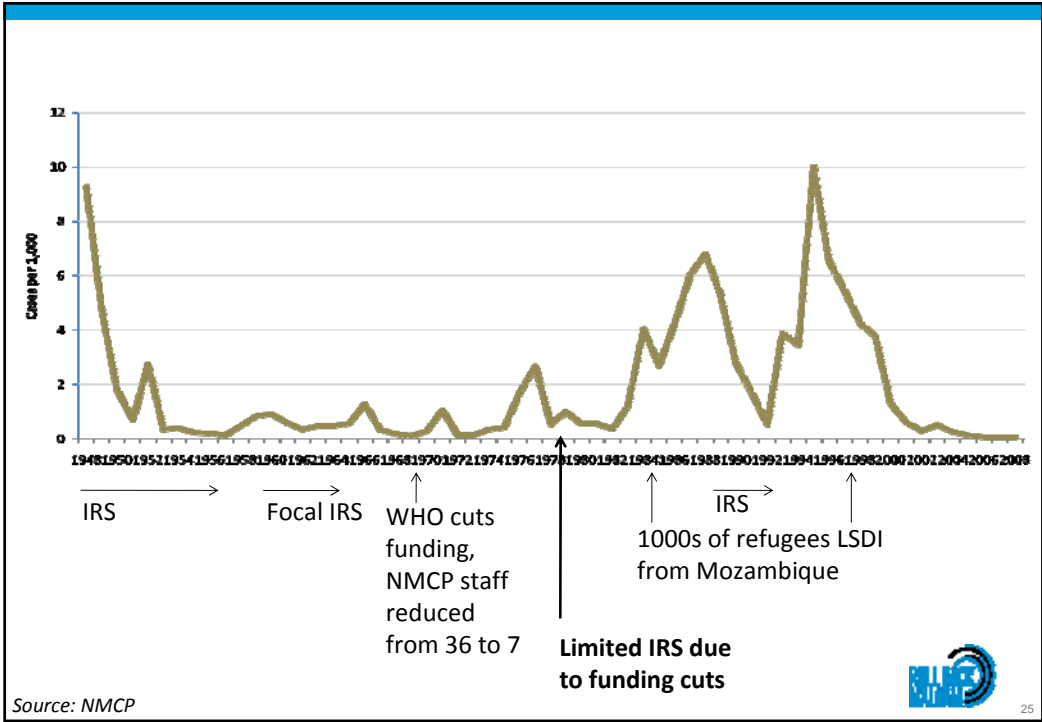
Find stable sources of malaria financing:

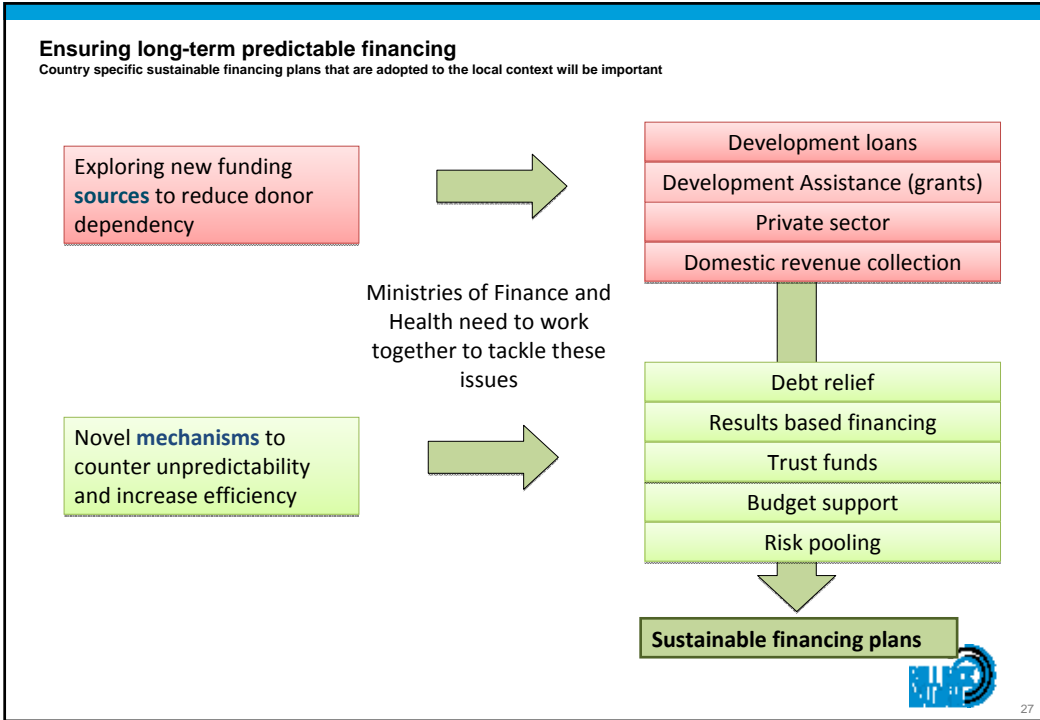
Potential *sources* of funding (including domestic)

Novel *mechanisms* to ensure predictable long-term funding



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- These are some initial ideas being put forward by malaria programs
- 1 **Push on delivery (mechanism)**
 - Define a prevalence target for national governments. If they stay below this target they get steady bulk financing
 - Tax code (source)**
 - Revise the tax code to provide tax breaks for private sector companies to support the malaria program
 - Solidarity funds (mechanism)**
 - Consider pooled funds for purchase of antimalarials that draw contributions from a variety of sources including the private sector
 - 2 **Health insurance (source + mechanism)**
 - Provide contributions from national or community-based health insurance schemes to support the malaria program
 - 3
 - 4
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Conclusion

- 1 Malaria can be controlled and in some places maybe eliminated
- 2 However, successful control does not mean that “the job is done” & as long as a competent vector is present malaria **WILL** resurge if control is relaxed
- 3 In low controlled-low endemic malaria countries, the return on investment needs to be evaluated against cases and death averted
- 4 Low burden does not mean lower financial needs; malaria control will initially be as equally costly as scale up; resources cannot be shifted away from the malaria program when burden drops

Malaria control in controlled low endemic settings = Vaccinating against malaria without a vaccine



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Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

The Comprehensive Reform Agenda of the Global Fund

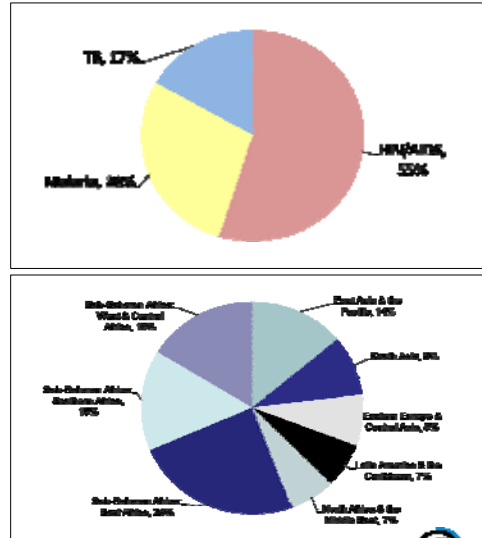
20th RBM Partnership Board Meeting
Prof. Michel Kazatchkine



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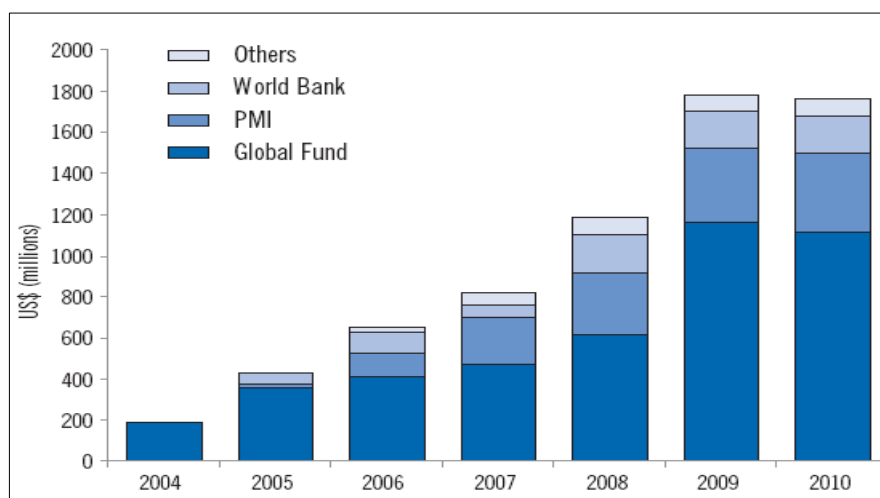
Global Fund portfolio, end-March 2011

- \$22.1 billion approved
- \$13.4 billion disbursed
- 507 active grants
- 150 countries
- 58% sub-Saharan Africa
- 90% low and low-middle income countries



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Commitments of major international malaria funders, 2004-2010



WHO World Malaria Report 2010



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Malaria results

Between 2002 and the end of 2010, Global Fund supported programs achieved

Insecticide treated nets: 160 million distributed

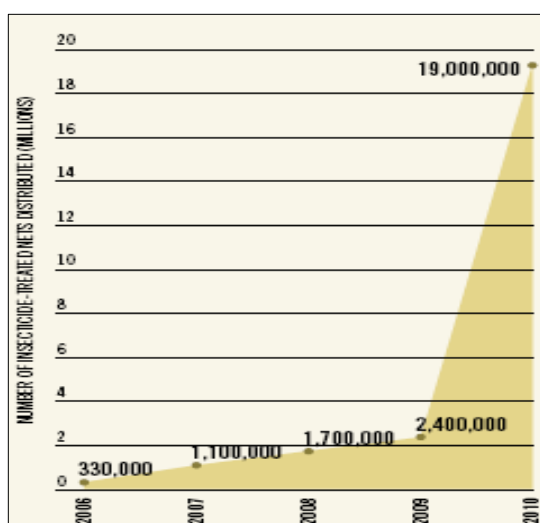
Indoor residual spraying: 31 million times

Malaria Treatment: 170 million cases treated in accordance
with national treatment guidelines



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Cumulative ITNs distributed by Global Fund-supported programs in Nigeria 2006-2010



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The Comprehensive Reform working group (CRWG) 1

- **Replenishment Year 2010 (the Hague/New York):** Secretariat presentation of the “agenda for a more efficient and effective Global Fund”, including the new grant architecture initiated in 2008/2009. Update presented in Sofia.
- **December 2010 (Sofia):** the Board establishes a “Comprehensive Reform working group”:
 - **Board Chair and Vice-chair**
 - **Implementer bloc**
 - **Donor Bloc**
 - **Partners**
 - **Global Fund Secretariat**



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CRWG outputs 1: the Plan for Comprehensive Reform

Nine reform objectives to ensure strategic direction

1. **Enhanced fiduciary control and risk management**
2. **Improved resource allocation and increase value for money**
3. **Improved proposal development and review process**
4. **Improved grant management/reduced transaction costs**
5. **Improved Global Fund internal management**
6. **Improved partnerships and in country structures**
7. **Improved governance**
8. **Enhanced resource mobilization**
9. **Increased sustainability and efficiency**



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CRWG outputs 2: recommendations in five selected areas

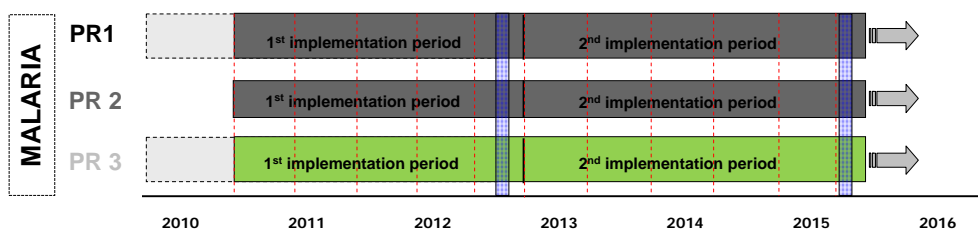
Five reform areas for Board consideration

1. Fiduciary control and risk management
2. Value for money
3. The Global Fund business model
4. Partnerships
5. Governance



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On-going reforms: new grant architecture



- Roll-out on track and ahead of projections
- 60 single streams of funding (SSFs) signed
- 11 malaria SSFs including Tanzania, Guinea-Bissau, Gambia
- Round 10 signing wave will drive consolidation into SSFs: app. 100 additional SSFs expected by end 2011
- Periodic reviews: new process ready to be applied on time to earliest single streams of funding in Q4
- Consolidated proposals: mandatory as of Round 11



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On-going reforms: Country team approach (CTA)



- CTA launch in 13 countries high impact countries
- 65 country team members trained
- Scale up of CTA to and additional 20 countries
- Second Country team training
- Complete scale up to a total of 46 countries
- Performance management and evaluation



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On-going reforms: fiduciary controls and risk management

- **Strengthened fraud prevention**
 - Portfolio wide risk assessment and risk management planning
 - Improved monitoring of higher risk expenditures
- **Strengthen fraud detection:**
 - LFA: adapted terms of reference, improved tools and guidance
 - Strengthened GF and LFA staff training and accountability
- **Strengthened fraud response:**
 - Commitment to zero tolerance policy: includes continued strict use of grant suspension, termination and additional safeguards
 - Inter-agency action plan on drug theft



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On-going reforms: other areas

- **Strengthened performance-based funding**
- **Strengthened Secretariat management**
 - **Strengthened management of human resources (Q2 review)**
 - **IT: process automation (Q3 review)**
 - **New Quality Assurance and Support Services Unit**
 - **Organizational structure review (completed April 2011)**
- **In-country:**
 - **Strengthening CCM capacity, performance and accountability**
 - **Strengthened partnership: strategic collaboration plans in selected countries, with improved coordination of TA**



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Global Fund Strategy 2011-16

- Objective 1: **Save** 20 million more lives
- Objective 2: **Double** the current rate of decline of new infections for each disease
- Objective 3: **Maximize** the impact of Global Fund investments beyond AIDS, TB and malaria, particularly for women and children
- Objective 4: **Maximize** value for money, increasing efficiency and effectiveness
- Objective 5: **Promote** human rights and access for all
- Objective 6: **Reinvigorate** the partnership
- Objective 7: **Sustain** the gains we have made



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Twentieth RBM Partnership Board Meeting
Friday, May 13, 2011

Special Ministerial Board Session

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Twentieth RBM Partnership Board Meeting
Friday, May 13, 2011

7th Board Session: Outcomes

Time	Agenda item	Presenter
14.00-16.00	1) Outcomes of Ministerial Session 2) Identification and prioritization of building blocks for 2012-2013 Partnership Work Plan 3) Ad Hoc Resolutions 4) Summary Board Decisions	Board Chair Performance WS Board Chair Idem
16.00-16.30	Break	
16.30-17.30	1) Venue and date 21st RBM Partnership Board meeting 2) AOB	Board Chair Board Chair
17.30	Closure of the Board Meeting	
18.00	Alma Score Card, Cocktail & Dinner, Starling Hotel	



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Twentieth RBM Partnership Board Meeting

Ministerial Session

Friday, May 13, 2011.



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1st Session

Ban on monotherapies

Clear progress in policy and regulatory steps

Clear progress in scaling up access to diagnosis and treatment

Countries still need to complete last steps and fully implement all policy®ulatory steps taken

Stopping the sale and export by India's ban of production and export has and will have global impact



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2nd session

Sustainable Financing

As malaria burden reduces there is a tendency for malaria funding to reduce.

Donor malaria funding is unpredictable and often burden linked.

Domestic financing is central element of sustaining progress in malaria control.

Explore innovative funding mechanism in support of domestic resource mobilization.



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3rd session

Global Form Reform

Allocation of funding to maximize impact

Streamlining and shortening internal processes to rapidly sign grants and speed up disbursements

Revitalization of partnerships to ensure maximum value of GF investments in countries.

Value for money – maximize impact of interventions at the lowest cost.

Zero tolerance for fraud and misuse of funds



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Session Summary

Reducing bureaucracy does not equal reducing transparency and accountability

Develop domestic and regional financing strategy to sustain control achievements

Government leadership to ensure national regulatory authorities are empowered to implement policies

Partners remain committed to the Global Fund and will continue to fund malaria control.

Country ownership and political leadership is the key to progress in the fight against malaria.



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6th Board Session:

Identification and Prioritization of Strategic Building Blocks for the 2012 RBM PWP Based on GMAP Implementation Overview and Revised GMAP Objectives, Targets and Milestones

Performance Work Stream

20th RBM Board Meeting
Geneva, May 11-13, 2011



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Overview

Board endorsement (or guidance) is requested on:

- ❑ Proposed building blocks for 2012 RBM Partnership Work Plan
- ❑ High-level direction of the tentative outputs
- ❑ Suggested approach to prioritization of outputs
- ❑ Entities responsible for:
 - Priority setting
 - Work Plan development and implementation
 - Monitoring of implementation



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Summary of Progress to Date

Performance Work Stream

- Unable to establish full dashboard to guide the 2012 Partnership Work Plan development, due to limited data reported by partners to complete GMAP Implementation Overview

Task Force on Priorities and Targets

- Recommended GMAP objectives, targets, milestones and priorities for the period 2012-2015

- RBM Secretariat identified **building blocks and tentative outputs for 2012 Partnership Work Plan**, based on recommendations of Task Force on Priorities and Targets
- **Prioritization of building blocks and associated outputs** will guide RBM Mechanisms in the development of 2012 PWP aligned with the anticipated income



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Proposed Building Blocks for 2012 Partnership Work Plan (in Support of GMAP implementation)

1. Financing
2. Disease Control Programmes
3. Commodity Supply and Distribution
4. R&D
5. Advocacy
6. Programme Coordination
7. Technical Standards
8. Convene, Coordinate & Facilitate Communication



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Building Blocks and Example of Tentative Outputs (1/2)


Building Block	Tentative Output (Example)	Responsible
1. Financing	Dedicated regional financing strategy mechanism in support of: <ul style="list-style-type: none"> •cross-border malaria control action •pre-elimination •GPARC implementation 	Resource Mobilization Sub-Committee
2. Disease Control	Good malaria control practices for each intervention mainstreamed into national health plans	Vector Control WG, Case management WG, and Malaria in Pregnancy WG OR Merged new working group OR Harmonization Working Group.
3. Commodity Supply & Distribution	Closed commodity gap between production capacity and country requirements	Procurement and Supply Management Working Group



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Building Blocks and Example of Tentative Outputs (2/2)

Building Block	Tentative Output (Example)	Responsible
4. R&D	Research underpinning all GMAP strategies	New Implementation Alignment WG OR WHO
5. Advocacy	Malaria as high profile development agenda	Malaria Advocacy Working Group
6. Program Coordination	Country roadmaps	Sub-Regional Networks
7. Technical Standard	Normative and standard setting capacity of WHO aligned with need of malaria control partners	WHO
8. Communication	Convened, coordinated and facilitated communication among Partners and Mechanisms	Secretariat



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Prioritization of Partnership Work Plan Output

Suggested Prioritization Approach

- Prioritization occurs within each GMAP milestone.
- This can be executed, for example, by focusing on high burden, low income countries that will benefit most from a given PWP output.

•Prioritization across PWP outputs (privileging certain outputs over others) is likely to reduce the overall effectiveness of PWP outputs

•The suggested prioritization approach is consistent with the recommendations of Task Force on Priorities and Targets and of Task Force 2.



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Additional Consideration

1

Each Mechanism should be responsible for at least one output (linked to a PWP Strategic Building Block)

2

In the case that # Mechanisms exceeds # outputs, one of the following may take place:

- If appropriate, an output may be divided into components and allocated to Mechanisms
- Some Mechanisms may be merged temporarily (for 2012) into a single working group

3

RBM Partnership currently has no entity mandated to review strategic priority setting and output definition in relation to Partnership Work Plans.



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Board Decision Point

The Board is requested to endorse the following:

- The direction of the Building Blocks and the associated outputs for development of 2012 RBM Partnership Work Plan
- Proposed prioritization approach
- Endorse the accountability for 2012 Partnership Work Plan (PWP), as follows:
 - Priority setting for 2012 PWP: NEW COMMITTEE
 - Development and Implementation of 2012 PWP with Targets: Secretariat, SRNs and Working Groups
 - Monitoring of 2012 PWP Implementation: Finance Work Stream



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ANNEX:

**Building Blocks and Tentative Outputs
of
RBM Partnership Work Plan**



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Building Block 1: Financing

#	Tentative Output	Responsible
1	Resource mobilization strategy to close global GMAP financing gaps	Resource Mobilization Sub-Committee
2	Dedicated regional financing strategy mechanism in support of: <ul style="list-style-type: none"> •cross-border malaria control action •pre-elimination •GPARC implementation 	Resource Mobilization Sub-Committee
3	Resource mobilization to close country roadmap funding gaps, supporting Global Fund round 11 and National Strategy Applications.	Harmonization Working Group



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Building Block 2: Disease Control Programmes

#	Tentative Output	Responsible
4	Good malaria control practices for each intervention mainstreamed into national health plans	Expanded mandate to Vector Control WG, Case management WG, and Malaria in Pregnancy WG OR Merged new working group promoting "Mainstreaming of implementation of Good Malaria Control Practices" OR Expanded mandate to the Harmonization Working Group.



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Building Block 3: Commodity Supply and Distribution

#	Tentative Output	Responsible
5	Closed commodity gap between production capacity and country requirements	Procurement and Supply Management Working Group



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Building Block 4: R&D

#	Tentative Output	Responsible
6	Research underpinning all GMAP strategies	New Implementation Alignment Working Group managed by the Research & Academia constituency OR WHO on behalf of Partnership with strong engagement of the Research & Academia constituency

Building Block 5: Advocacy

7	Malaria as high profile development agenda	Malaria Advocacy Working Group
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Building Block 6: Program Coordination

#	Tentative Output	Responsible
8	Country roadmaps	Sub-Regional Networks
9	Country roadmaps that are effectively implemented	COUNTRY PARTNERSHIPS OR MECHANISM TO BE DEFINED
10	Fast-tracked resources to support alignment of country roadmap milestones with global GMAP objectives	MECHANISM TO BE DEFINED OR Through MANDATING the FINANCIERS FORUM
11	Record of progress achieved by and monitored impact of malaria control community in GMAP implementation	WHO, Performance Work Stream & MERG



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Building Block 7: Technical Standards

#	Tentative Output	Responsible
12	Normative and standard setting capacity of WHO aligned with need of malaria control partners	WHO

Building Block 8: Convene, Coordinate & Facilitate Communication

13	Convened, coordinated and facilitated communication among Partners and Mechanisms to implement: <ul style="list-style-type: none"> •Knowledge Management Strategy •Operating Framework •By-Laws 	Secretariat
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16.30-17.30	1) Venue and date 21st RBM Partnership Board meeting	Board Chair
	2) AOB	Board Chair
17.30	Closure of the Board Meeting	
18.00	Alma Score Card, Cocktail & Dinner, Starling Hotel	



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Twentieth RBM Partnership Board Meeting
Friday, May 13, 2011

7th Board Session: Outcomes

Time	Agenda item	Presenter
14.00-16.00	1) Outcomes of Ministerial Session 2) Identification and prioritization of building blocks for 2012-2013 Partnership Work Plan 3) Ad Hoc Resolutions 4) Summary Board Decisions	Board Chair Performance WS Board Chair Idem
16.00-16.30	Break	
16.30-17.30	1) Venue and date 21st RBM Partnership Board meeting 2) AOB	Board Chair Board Chair
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Twentieth RBM Partnership Board Meeting

Geneva, 11-13 May 2011

21st RBM Partnership Board Meeting

Timing & Venue

Secretariat

For Decision



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Two meetings a year

Usually:

- **3 day meeting**
- **1st meeting in May in Geneva (Switzerland) just prior the WHA**
- **2nd meeting in November-December in an endemic country**



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Previous Meetings

13th RBM Board Meeting: Addis Ababa, Ethiopia

15th RBM Board Meeting: New Delhi, India

17th RBM Board Meeting: Rio de Janeiro, Brazil

19th RBM Board Meeting: Lusaka, Zambia



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Suggested Venue

China

Cambodia

DR Congo

Others?



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Timing – Planning Events, Holidays, Commemorations...

7 November – Tabaski (Eid El Adha)

Wednesday 16 to Friday 18 November

24 November – Thanksgiving

1 December – World AIDS day

4 to 8 December – American Society of Tropical Medicine and Health (ASTMH)

- **Monday 12 to Wednesday 14 December**
- **Wednesday 14 to Friday 16 Decembre**

15 December – World Malaria Report launch

Monday 18 to 20 Wednesday December

Others?



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Costing

Venue	Travel (% of total cost)	Venue (% of total cost)	Secretariat (% of total cost)	TOTAL
China	42.6%	30.9%	26.6%	129'598
Cambodia	43.2%	29.8%	27%	132'256
Africa	33.6%	37.8%	28.6%	141'196
Switzerland	51.8%	48.2%	0.0%	203'838



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Requested Board Action

**Decide on timing and venue
of its next meeting**



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Twentieth RBM Partnership Board Meeting
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