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3<sup>rd</sup> MEETING OF THE GLOBAL PARTNERSHIP  
ROLL BACK MALARIA

Geneva, Switzerland  
2 – 3 February 2000

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CONSOLIDATING PROGRESS  
AND  
MOVING TO SCALE WITH ACTION  
IN COUNTRIES

April 2000  
WHO, Geneva

Founding Partners:



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## REFLECTIONS FROM THE PROJECT MANAGER

For me, this third meeting of the RBM partnership was an exceptional event. The WHO-based *partnership secretariat* hosted over a hundred visitors from different partner Governments, agencies, Organisations, Companies and Institutions. Delegates from countries, staff from development assistance agencies, and colleagues from WHO country, regional and headquarters office invested much time and energy in creating the environment for a rewarding event.

Before the meeting, many people (particularly from WHO regional offices and headquarters) worked hard to develop a programme that would lead to the involvement of all partners. We wanted to provide an opportunity for the involvement of both those who have been at the core of the partnership, and those who are newly engaged.

The Partnership secretariat planned for partners to work together to achieve several important outcomes:

- We wanted partners to shape the future of the partnership
- We wanted partners to examine the role being played by WHO in relation to the partnership, and to indicate how WHO at all levels could make the partnership more effective
- We hoped partners would agree that there is consensus on RBM strategies
- We hoped partners would agree on technical issues that most need concerted attention
- We wanted partners to explore how strategies for RBM action are being considered and implemented within groups of countries where the pattern of malaria illness, its consequences, and responses to it are similar
- We wanted to agree concrete ways to move to scale-with action in countries and we hoped to reach consensus that this should be the focus following this meeting.

It seems to me that these objectives were fulfilled. I hope that representatives of partners agree. I sense that more partners see the effort as progressing well but all are aware that these are just at the beginning stages. There is much more to be done. We need now, more than ever to maintain the momentum and energy. To do this we will focus on country level action to achieve the outcomes, and this depends on synchronised action from all partners.

My sincere thanks to those of you who actively participated and made this a successful event.



Dr David Nabarro

## B. EXECUTIVE SUMMARY

### *Participation*

Enthusiasm and commitment to Roll Back malaria was evident in the high level, and number of partners represented. The meeting was attended by close to 200 participants. In addition to United Nations organisations, 19 endemic country governments were represented, including the participation of 7 Ministers of Health. Seventeen bilateral agencies, 3 development banks and numerous international and regional NGOs, foundations, corporate groups, and research institutions were also actively involved.

### *Method of work*

To enable the large number of partners' representatives to have the maximum opportunity to interact with each other, and to pursue the issues relevant to them, time in plenary and the number of plenary presentations were limited.

To facilitate interaction the meeting was organised along four distinct "Tracks" with Participants indicating which Track they would like to follow. The four Tracks were:

- a. Ensuring that the Global Partnership supports effective action in Countries
- b. Consensus on information in the RBM Partnership
- c. Support to address technical needs in country
- d. Moving to scale to meet the challenge of halving the malaria burden in the next 10 years.

Each Track made recommendations that were presented and further discussed during the final plenary.

### *Important Progress*

- The Global Partnership now has strong roots in many malaria-affected countries and partner governments had much to contribute to the meeting. We heard of excellent progress in presentations by Mekong countries, the Gambia, Benin, Tajikistan, Afghanistan and in discussion with colleagues from Eritrea, Kenya, Zambia etc.
- Advances have been made in systems to track this progress. Chronicling this information clearly and succinctly, and disseminating it within the partnership is a key to future progress.
- Discussions between the RBM Cabinet Project and a leading pharmaceutical manufacturer which markets the only fixed-dose combination with an artesunate derivative available to date have led to this drug being made available at \$1 US per child treatment course. A price which is a fraction of the current private sector price of this drug.
- There is broad ownership and enthusiasm within the Roll Back Malaria Partnership. High level political commitment has been sustained – particularly in Africa – where a heads of State Summit on Roll Back Malaria is being organised and hosted by the Nigeria President on April 25<sup>th</sup> 2000.

### *Important agreements*

Partners agreed that:

- their collective goal is to halve the world malaria burden by the year 2010, through a set of agreed priorities implemented at community level within the context of health sector and human development.
- the Global Partnership should continue as an outcome-oriented network held together by agreed principles and shared values
- global partners need more of a country and inter-country focus in all our work. Now is the time to consolidate approaches and strategies and put them in practice.
- The African Summit on Roll Back Malaria in Abuja should be prepared jointly to ensure highest possible commitment.

### C. GOALS AND APPROACH

The Roll Back Malaria effort was launched in July 1998. The partnership built on significant global and regional commitment in the few years immediately prior to this. It recognised the efforts of many individuals and organisations that have been active in trying, for decades, to tackle malaria under difficult conditions. The last 18 months have been a time of preparation, ensuring consensus, establishing building blocks, and supporting nascent action to Roll Back Malaria in countries.

The 3<sup>rd</sup> Meeting of the Global Partnership to Roll Back Malaria, held on Feb 2-3, 2000 in Geneva, Switzerland, marked the end of the 18-month preparatory period. Here the partners reaffirmed the collective goal to halve the world malaria burden by the year 2010 through a set of agreed priorities. These include:

- Access to insecticide treated materials (especially mosquito nets) for people at risk, and relevant vector control strategies,
- Early diagnosis and treatment of malarial illness with safe and effective antimalarial drugs.
- Preventative intermittent treatment for pregnant women in highly endemic areas, particularly in primigravidae, and
- Better prediction and response to malaria epidemics

The approach of the Roll Back Malaria partnership has been to deliberately support political movements for poverty reduction through better health at community, country, regional and global levels. Communities at risk and national governments are central partners in Roll Back Malaria. Partnerships within each environment, have established their own linkages at each level rather than following any global blueprints. The role of the Secretariat is to serve the interests of partners. It takes the lead in spelling out agreed principles for the partnership. These principles are best synthesised in attachment 1

The goal, strategy and approach form the central building block for the partnership. They have been established through consensus and based on the best available evidence – a process that was accomplished in the first year. During its preparatory phase, other building blocks have emerged.

Partners have agreed that:

- Critical RBM actions/elements be implemented in different settings
- these critical actions/elements are reflected in agreed plans for monitoring and evaluation.
- the balance between critical action varies between different groups of countries (inter-country groups).

Partners acknowledged that in many countries there is a perceptible change in the way we work. Presentations from Benin, The Gambia and Mekong highlighted promise in tackling malaria and the unique aspects of partnership in these countries, which is making progress possible.

### ***Benin***

The Roll Back Malaria movement in Benin has been built on ongoing programmes and support from WHO and French Co-operation since 1992. The present partnership heavily involves additional international and bilateral organisations. There is strong representation from NGOs using their advantages to promote ITNS. Intersectoral action with the Ministry of Education and the Ministry of Communication has been important as has collaboration with health sector reform efforts ongoing since 1995.

### ***The Health for Peace Initiative:***

This Subregional initiative is taken forward by Senegal, The Gambia, Guinea Bissau, and Guinea to ensure a coordinated response to:

- Malaria
- National Immunization Days
- Management of epidemics and emergencies
- Monitoring of HIV/AIDS and STIs

It operates on the fundamental principle of "Health as a bridge linking countries for social and economic development within a peaceful environment"

**RBM Mekong Initiative** encompasses six countries where 150 million people are at risk. It capitalises on existing collaborative efforts to tackle malaria and uses strong collaboration between WHO and UNICEF in the region. In this region, experienced countries are assisting others. The sub-regional initiative also tackles important technical issues such as the emergence and spread of multi-drug resistance.

During discussions we recognised that in the past 18 months we have reached important milestones. However, many partners would agree that the difficult task of consolidating partnerships and proceeding to the next critical stage of implementation and country action is still ahead. It is through this focus, *now*, that we will realise the goal we have set for ourselves.

## D. DISCUSSION AND DEVELOPMENTS

### *i) Ensuring that the Global Partnership supports effective action in countries*

- Partners felt that the RBM partnership functioned best as an outcome-oriented network bound by shared goals, values and principles. To achieve the goals set out, the partnership needs to remain as inclusive as possible. This will allow new partners and energy to be infused, and the partnership to evolve as contexts change.
- At global and regional level, it was felt by many that the Partnership's organising principles illustrate the "strength of weak ties". It was suggested that at country level and below these partnerships and their activities must be more clearly articulated and focused to enhance synergies and reduce fragmentation. Partners felt that at country level the Roll Back Malaria partnership needs to work with existing partnerships, co-ordinating and minimising development of new structures.
- There was broad enthusiastic ownership for the RBM partnership at global level and in many countries. However, we need to continue to build a sense of ownership in other countries. The RBM Secretariat will continue to support countries and catalyse action without promoting itself as the key executive agency.
- At global level, partners could benefit from a better understanding of their roles, focus, and comparative advantage. The Secretariat has a key role in this – working with new partners to define their role, and to follow up on issues proactively.

### *ii) Information in the RBM Partnership*

Meeting participants explored the needs and uses for information within the partnership and discussed the development of systems for generating and communicating information, and reporting on progress.

The three partnership-based systems include:

- Country partnership tracking: *to follow actions to Roll Back Malaria and the evolution of partnerships.*
- Framework for monitoring and evaluation: *to examine process and impact.*
- Web-based information system

Partners endorsed the **RBM Web Information System** as a powerful and innovative communication tool which addresses the strategic needs of RBM. They committed to sharing ownership of the site and agreed to the importance of the system as a central resource that complements their existing web sites. Partners endorsed the objective of the web site which allows communities of users manage their own contributions to the RBM Web Information system. This was endorsed and partners agreed to leverage their existing in-country Internet resource development programs for capacity building and infrastructure development. Partners agreed that they will work together to ensure that 25% of malaria endemic countries are using the RBM Web Information System by April 2001. -

Partners agreed that the work done so far on the **Country Tracking System** is moving in the right direction and all partners will need to contribute. We will need to work continuously on developing appropriate tools, taking account of existing tools/systems, keeping track of partners as RBM evolves and using this information to ensure the strength of the partnership. Monthly feedback of information by different means will be necessary.

The initial work on the **Monitoring and Evaluation System** by a RBM group provides an excellent basis on which to proceed. While the global framework is suitable for most situations, the list of indicators and data collection tools will need to be developed at national

levels. Thus far, there is a lack of monitoring for malaria in pregnancy. The complexity of access to effective treatment (geographical, cultural, economic, etc.) has meant that some further work will have to be done to ensure it is properly addressed. Sources of data will need to be well identified at national level including:

- Routine statistics (needs strengthening)
- Demographic surveillance system (INDEPTH)
- Community and HH surveys (MICS, DHS, etc.)
- Health facility assessments (IMCI surveys, etc.)
- Review of documents (country epidemiological profile etc.)

The use and sharing of data at all levels is crucial; but the capacity to do so needs to be strengthened

We need to use “higher” technologies (such as GIS) as and when appropriate and strengthen networking and co-ordination of partners at many levels to achieve consolidation of key indicators on:

- Malaria mortality
- People at risk sleeping under ITNs, particularly Underfives
- Children (adults) with fever getting appropriate Rx within 24 hrs
- Availability of 1<sup>st</sup> and 2<sup>nd</sup> line antimalarials in healthcare facilities.

### *iii) Addressing technical needs in countries*

Participants were provided with an opportunity to review key technical interventions. From a technical standpoint moving to scale focuses on the following issues:

- Home management, especially for children
- Improving malaria management in health systems
- Insecticide treated nets and vector control
- Malaria in pregnancy
- Epidemic management in complex emergencies

New developments, strategies and proposals in addressing diagnosis, treatment and home management were discussed and partners highlighted the need to pursue issues of:

- Combination therapy to enable appropriate advice to be given to national governments. The use of combinations of antimalarial drugs (as opposed to single drugs) for the treatment of malaria is being considered as a means of dealing with the increasing problem of resistance to antimalarial drugs. Meeting the cost of such combination treatment, (which is much higher than single drug therapy) and issues such as compliance and logistics for access are some of the many challenges for roll back malaria. Discussions were held between the RBM Project in WHO and a leading pharmaceutical manufacturer which markets the only fixed-dose combination with an artesunate derivative available to date, namely artemeter and lumefantrin. This has led to the drug being made available at 1 US\$ per child treatment, a price which is a fraction of the current private sector price for this drug.
- Severe malaria and treatment at the district level
- District level management of malaria where malaria management for children should be integrated with IMCI

Discussions on prevention focused on approaches and immediate issues to address with respect to: insecticide treated materials, malaria in pregnancy, vector control, DDT, epidemics and complex emergencies, vaccines and micronutrient supplementation.

Discussions culminated in:

- The types, skills and level for capacity development that are essential for rolling back malaria in the long term;
- The needs and modalities of extending technical support within the Roll Back Malaria partnership. These discussions recognised that several mechanisms already exist which are important to build on. The use of technical support networks pursued by the Roll Back Malaria partnership is seen as a positive development to draw and synthesise expertise from across institutions and countries. Many felt strongly that these networks are required at all levels (global, regional, country) with strong involvement from endemic country experts. More clarity is still needed on how partners can support and consolidate efforts around technical issues, and more emphasis on mobilizing the networks which are not yet fully operational.
- In the areas of research, stronger collaboration is needed between RBM, TDR, MIM and other research institutions. The RBM Secretariat has a key role in translating this research into policy. In this the Secretariat needs to provide a platform for greater support of social science and economic research.

*iv) Moving to scale to meet the challenge of halving the malaria burden in the next ten years*

This topic was central to many other tracks, and discussed extensively during the plenary. Discussions during this meeting “Track” focused on brokering partnerships in the areas of:

- 1) private sector and civil society
- 2) communications and advocacy
- 3) health sector development and some approaches that will be useful in addressing issues in this challenging area.

Track discussions were supplemented with strong input from the Kenyan government and with a short film produced by the bilateral agency DFID. Together they demonstrated the difficulties associated with access to quick, appropriate, affordable treatment. The Kenyan Minister of Health helped elucidate the problems of a response that focuses solely through the health sector.

Partners are now impatient to see evidence of “scaling up” of agreed RBM actions, and are looking hard for ways to do this in a manner that empower people and strengthens government capacity.

- Partners acknowledged that we all look good if we can show progress, even if this is the result of the initiative of one of us. The secretariat has a role to help other partners demonstrate this progress.
- They highlighted the need to work with opportunities to mobilise national and international resources – such as HIPC and debt relief – that can work through sector development efforts. It is necessary to provide visible and achievable outcome objectives and indicators for health sector reform to support this work.
- Partners felt that there is evidence that many NGOs are ready to move to scale with ITNs in their priority countries, especially if they are made to feel part of a concerted partnership action.
- Moving to scale has its own implication for the Roll Back Malaria communication strategy. There is a need for synthesised communication efforts among the four founding partners and others with a heavy involvement in communications and advocacy. It was agreed that a meeting between partners would be organised prior to the Abuja African Heads of States meeting.

## E. MOVING FORWARD TO ROLL BACK MALARIA

We are 18 months down the road. As I sit with you today, I sense that many of my hopes are being fulfilled. You have set about coordinated working in a unique way. This is not a partnership held together by strong agreements and a rigid structure. This is not a governing body with a tight agenda and procedures. It's a partnership that is based on a shared commitment and common approach. For some this loose structure is discomfoting. I see it differently. I read, the other day, in the *Journal Foreign Policy* that the Roll Back Malaria Partnership is an example of the strength of weak ties". I was most reassured –what we are doing is recognised by others.

-Director General, WHO, Dr. Gro Brundtland

### *i) Implications for the RBM Partnership*

The partnership, with strong support and information from the Secretariat, needs to re-double its efforts so that endemic countries, not yet engaged in RBM will be actively involved.

The regional offices of development agency partners represent a real comparative advantage and added value in helping the partnership do this. Their positive involvement is critical in empowering and supporting countries. A negative stance would undermine progress badly. Given the decentralisation in the World Bank, UNICEF, UNDP, WHO, USAID, DFID, and others – development agency partners have had to work really hard to bind together, headquarter, regional and country offices in support for country level action. This is not straight forward, and more time is needed to accomplish this fully.

Partners have indicated that they can move further to identify inter-country RBM initiatives that are moving (or under development) and help to establish these as viable entities. They can work together to identify – clearly – key issues for partnership support in each group of countries. This inter-country and country focus is a must for 2000.

The partners need to bring together thinking and action among a range of priorities for poor people's health (malaria, maternal health, HIV and TB, for example). Ongoing initiatives such as IMCI and making pregnancy safe can benefit from the emphasis on country and community action to roll back malaria and there needs to be continued clarity on the roles and synergies between RBM and these initiatives.

### *ii) Implications for the work of the Secretariat*

There are (as always) things that the Secretariat can do more of, or do better. In the RBM partnership, WHO functions as secretariat and as a partner whose comparative advantage is to synthesise best practice and offer consistent technical guidance. This "dual function" can be confusing both to other partners and to people in WHO, but it appears preferable to have one partner acting as secretariat as opposed to having an isolated and independent secretariat.

All partners, including WHO and the Secretariat, need more of a country focus in our work. The Secretariat must maintain an emphasis on tracking progress and monitoring action and must do this by using information and regular reports on progress captured by WHO, and other agencies' country offices. The Secretariat will do all it can to support this process and consolidate results but is dependent on receiving regular information and update from all partners.

Our tracking modalities need to be clear and simple with results disseminated widely throughout the partnership. These results can be translated into clear, short messages to support advocacy purposes. Our communications will be designed to elicit feedback so as to encourage the evolution of the partnership in a way that reflects the interests of all.

The Secretariat will do more to help the private sector and NGO groups be engaged in the partnership and must also work hard on its links with existing partners. It must work to broker relationships, measure progress and help develop systems that enable agencies be fully engaged and effective. Many partners felt that we would all benefit by better articulating the roles and advantages of various partners and progress.

Within WHO, significant progress has been made to ensure that all colleagues active on RBM have a clear place in the WHO RBM Project. This has been articulated in the WHO RBM composite work plan. We need to continue this process and ensure full regional and country engagement. This involves communicating information in a way that is transparent and honest. These are core principals for the partnership and ones that are equally important within WHO.

The partners appeared positive on the role of WHO as Secretariat but we will benefit by opening up the process more to partners active in the partnership. In this spirit, the World Bank has offered to host the next meeting of the Global Partnership in 2001.

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All presentations and Track recommendations are available on at [WWW.RBM.WHO.INT](http://WWW.RBM.WHO.INT)

### **Proposal: The Goals and Principles of the RBM partnership**

#### **Goals:**

To enable people and communities to halve the burdens they experience as a result of malaria by the year 2010 through

- Intensified application of existing tools for malaria control
  - Use of insecticide-treated mosquito nets and materials by all children and pregnant women in endemic areas
  - All persons at risk of malaria to be able to access, and use, effective treatment ideally within 8 hours, and certainly within 24 hours, of the onset of symptoms
  - All pregnant women at risk to receive preventive (PIT) therapy
  - All countries (and communities) at risk of malaria epidemics to be able to respond effectively within one week of an outbreak being confirmed
- Development and rapid deployment of novel, cost effective products, approaches and interventions

#### **Principles:**

To achieve these goals, current efforts must be greatly intensified and made much more effective, building on promising initiatives already underway and learning lessons from the past. The action must be Global with a special emphasis in Africa due to the enormous burden carried by that region.

- There will be stronger emphasis on enabling people, and their communities, to make decisions and take actions that safeguard their health and improve their well-being in a sustainable manner (*people at risk* are at the centre of Roll Back Malaria).
- Successful efforts to Roll Back Malaria will be characterised by more effective activity within communities, with an increased focus on the needs of poor and marginalised groups, and greater involvement of public and private entities within and outside government, from health and other sectors (*the movement* to roll back malaria)
- Roll Back Malaria movements will depend on functioning local-level and national health services: this implies continued, and stronger, action to improve responsiveness, quality and coverage of health care for all high-burden illness experienced by poor people, through health sector (and sub-sector) development (RBM promotes *health sector development*)
- Roll Back Malaria movements will also be influenced - both positively and negatively - by what happens outside the health sector: this implies much more emphasis on inter-sectoral initiatives for human development (RBM calls for *inter-sectoral action*)
- Those involved in Roll Back Malaria movements will only be able to work together in harmony if the institutions (whether within countries or from outside) who offer political, financial, or technical backing co-ordinate more effectively and strive to agree on intentions and strategy (The basis of Roll back malaria is functional and flexible *partnerships* at local, national, inter-country and global levels)



### 3<sup>rd</sup> MEETING OF THE GLOBAL PARTNERSHIP TO ROLL BACK MALARIA

Executive Board Room, WHO/HQ  
Geneva, 2-3 February 2000

#### PROVISIONAL GOAL, BACKGROUND, OBJECTIVES, EXPECTED OUTCOMES and METHOD OF WORK

##### Provisional Goal

To review progress made by the RBM Global Partnership during the eighteen month preparatory period with the purpose of providing guidance on strategies, roles, responsibilities and the implementation of effective partnerships action in countries – all to meet the challenge of halving the malaria burden by 2010.

##### Background

**Third in a series of meetings undertaken during the preparatory period with the following focus:**

- 1<sup>st</sup> meeting            Consolidating support for rolling back malaria  
(Hosted by WHO HQ, in Geneva, December 8 - 9 1998)
- 2<sup>nd</sup> meeting            Consensus on key concepts, issues and solutions, strengthened  
by a review of progress in Africa  
(Hosted by WHO HQ/AFRO, in Harare, 30 June - 1 July 1999)
- 3<sup>rd</sup> meeting            Preparatory phase progress, forms of association and partnership  
development for effective action to move to scale in countries  
(Hosted by WHO HQ, in Geneva, 2-3 February 2000)

##### Objectives And Expected Outcomes Of The Meeting

1. Review of progress made by the RBM partnership in contributing to reduced malaria burdens among people in affected countries, to global advocacy, to strategic research and to the development of new cost-effective interventions.
2. Report on progress made by the Cabinet Project during the RBM partnership's preparatory period.
3. Recommendations about means for developing the Global Partnership so that it effectively supports a massive scale up of actions to roll back malaria - through debate and review of ways in which the partnership is operating.
4. Identification of partners' information needs, options for the development of information tools, and potential systems to manage information and communicate within the partnership.
5. Review of recent developments on technical aspects of malaria control, recommending ways in which the partnership can help build capacity within countries whilst providing technical support through appropriate systems.

##### Method Of Work

1. The meeting will appoint its Chairperson and Rapporteur whilst WHO will provide the Secretariat.
2. During plenary there will be a presentation by the WHO project manager on progress of the RBM Global Partnership and three focused presentations which illustrate the development and potential of RBM partnerships regionally and in country.
3. There will be discussion during plenary focusing on priority strategic issues.
4. The meeting will divide into four tracks based work undertaken by, and core functions of the RBM Global Partnership. Participants in each track will focus on consensus building and guidance for the partnership.
5. Participants will spend the substantial portion of time within the selected meeting track.
6. There will be a presentation of issues paper in each of the four tracks. In some cases the tracks may be further sub-divided. Track agendas will be finalised in consultation with key partners and regional counterparts.
7. The final plenary will provide concrete guidance, recommendations and in some cases presentation of brokered partnerships to effectively implement action which supports the decrease in malaria burden in affected countries.



### 3<sup>rd</sup> MEETING OF THE GLOBAL PARTNERSHIP TO ROLL BACK MALARIA

Executive Board Room, WHO/HQ  
Geneva, 2-3 February 2000

#### WEDNESDAY, 2ND FEBRUARY 2000

- 08:00 – 08:45 Registration, Executive Board Room
- 08:45 – 08:55 **Dr David Heymann** , Executive Director, Communicable Diseases (Welcome)
- 08:55 – 09:05 **Dr Gro Harlem Brundtland**, Director-General, World Health Organisation (Open and Introduction of Chairs)
- 09:05 – 09:10 Welcome from Co-Chairs:  
(Day 1) Dr. Ebrahim Samba, Regional Director, WHO Africa Regional Office
- 09:10 – 09:15 Dr. Mina Mauerstein-Bail, Manager, UNDP
- Meeting Arrangements
- 09:15 – 09:45 Progress Report (Part 1). Partnership Develop and Progress in Countries  
Dr. David Nabarro, RBM WHO Cabinet Project Manager
- 09:45 – 10:10 Discussion
- 10:10 – 10:30 *Coffee and tea break*
- 10:30 – 10:50 Progress Report (Part 2). Overview of WHO Cabinet Project Secretariat Functions and Development of Systems to Support the Partnership
- 10:50 – 11:10 Discussion
- Presentations on Partnership Initiatives
- West Africa
- 11:10 – 11:25 - Health for Peace Initiative: **Hon. Abdoulie M. Sallah**  
Secretary of State for Health, The Gambia
- 11:25 – 11:40 - Roll Back Malaria in Benin: **Prof. A. Massougbojji**  
Président de la cellule de lutte contre le Paludisme, Benin
- 11:40 – 11:55 • RBM Mekong, **Dr. Valaikanya Plasai**, ACT Malaria, Thailand
- 11:55 – 12:15 Discussion
- 12:15 – 14:00 *Lunch break*

#### WEDNESDAY, 2ND FEBRUARY 2000

- 14:00 – 14:30 Plenary (EB Room) Presentation of Track TORs
- 14:30 – 17:30
- Developing Effective RBM Partnerships (Track A – Salle A)  
Chairs: Dr. Zeinab El Bakri, African Development Bank  
Dr. Duff Gillespie, Global Bureau, USAID
  - Information in RBM Partnerships (Track B – EB Room)  
Chairs: Dr. Antoine Kaboré, DDC, AFRO  
Prof. Somchai Loorareesuwan, SEAMO-TROP MED
  - Technical Issues Relevant to RBM Partnerships (Track C – Salle C)

Chairs: Dr. Gerald Keusch, Multilateral Initiative on Malaria  
Prof. Lateef Salako, Technical Subcommittee on Roll  
Back Malaria, African Heads of State Summit, Nigeria

- Going to Scale (Track D – Salle B)  
Chairs: Dr. Ok Pannenberg, World Bank  
Ms. Caroline Sergeant, DFID

*Coffee and tea will be served at 15:30 pm outside main track rooms*

18:30 – 20:00 *Cocktail and Light Buffet, WHO Restaurant*

**THURSDAY, 3<sup>RD</sup> FEBRUARY 2000**

- 9:00 – 9:15 WELCOME Day 2 – Issues from Day 1 (Plenary Executive Board Room)  
Co-Chairs (Day 2): Dr. Hussein Gezairy, Regional Director, EMRO  
Dr. David Alnwick, Chief Health Section, UNICEF
- 9:15 – 9:30
- Confirming Commitment and Action: African Heads of State Summit in Abuja, Nigeria: **Honorable Tim Menakaya**, Minister for Health, Nigeria
- 9:30 – 13:00
- Tracks in progress (Part 2)
- Chair: Dr. Hussein Gezairy presides
- 14:00 – 14:15
- Report Back and Recommendations from Tracks
- Guidance on what we need to make the partnership work to support more effective country action (Presentation by **Track A**)
- 14:15 – 14:30
- Proposals for Going to Scale to meet the challenge of decreasing the burden of malaria by half in the next ten years (Presentation by **Track D**)
- 14:30 – 14:50 Discussion
- 14:50 – 15:10 **Coffee and tea**
- 15:10 – 15:20 Demonstration of Roll Back Malaria World Wide Web Developments
- Chair: Dr. David Alnwick, presides**
- 15:20 - 15:35
- Building Consensus on Information Needs, Systems, Management and Uses (Presentation of Track B)
- 15:35 – 15:50
- Guidance on key areas of technical support and recommendations for partnership support systems that can help build human and institutional capacity (Presentation of Track C)
- 15:50 – 16:10 Discussion
- 16:10 – 16:15 Summary and Consensus on Next Step, Dr. David Nabarro
- 17:00 – 17:20
- Closing Statements:
- WHO, Regional Directors
  - World Bank
  - UNICEF
  - UNDP
  - Project Manager
- 17:20– 17:30 Closing Remarks from the Director General

**Name & Organization**

**Bilateral Organizations**

**Belgium**

Dr. Jacques LARUELLE, Senior Programme Officer (Public Health), Direction Générale de la Coopération Internationale, Belgian Administration for Development Cooperation, ex AGCD - G61.13, Services des Nations Unites, Brederodestraat 6, 1000 Bruxelles, BELGIQUE

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