Minutes of the 7th meeting of the RAI Regional Steering Committee (RSC)
for the Global Fund Regional Artemisinin-resistance Initiative (RAI)

11 May 2016, Millenium Hilton Hotel, Bangkok, Thailand

Minutes taken by: Amélie Joubert, Executive Secretary

Attendees/participant list - Appendix 1
Agenda – Appendix 2
List of acronyms – Appendix 3

---

1) Opening remarks

On behalf of the Thailand CCM, **Dr. Anupong Sujariyakul, Medical Physician, Advisory level of Department of Disease Control** (Ministry of Public Health), noted the remarkable achievements of the GMS thus far and ongoing commitment of partners to achieve malaria elimination. However, he reminded us that we should not become complacent and forget the continued threat posed by drug resistance; continued support and engagement will be needed.

2) Introduction / RSC administrative matters (Chair, Prof. Arjen Dondorp)

Introduction of new RSC (voting) members[1]: Ms. Bronwyn Duce, Assistant Director Malaria from the Australian Department of Foreign Affairs and Trade, who is taking over from Benedict David.
Declarations of Conflict of Interest (COI): RSC Chair noted association of his institution (MORU) with one of the RAI SRs (SMRU); P. Panitchpakdi (Civil Society member) also represents a RAI SR (Raks Thai Foundation).
Adoption of minutes of 6th meeting: The last version circulated by Secretariat was endorsed as final. It was agreed to proceed with endorsement of minutes online, on a no-objection basis, in the future.
Update on RSC Secretariat: The RSC Executive Committee agreed to the extension of the secondment of Ms. Amelie Joubert to WHO for one additional year (until Sept. 2017), including the required funding commitment under the RAI ICC.

3) RAI Progress Update, Jan-Dec 2015 (UNOPS, Dr. Attila Molnar)

a. Country components – *see PPT presentation.*

Summary: The updated impact indicator data for incidence in 2015 in Thailand (*revised from PPT*) was 0.18 cases per 1,000 persons/year, reduced from 0.37 in 2014. All countries except Cambodia achieved their targets in reducing the Pf malaria incidence rates, and increased their Annual Blood Examination Rate (ABER) through expanded testing coverage. The overall cumulative absorption of grant funds was 77% at the end of 2015 (39m of 50.5m USD).
In Cambodia, absorption was lowest due to delays in the public sector due to disagreements on requirements, which are now generally resolved. Operational costs for public sector (travel, meetings, daily subsistence allowance (DSA)…) represent a large portion of the RAI grant for Cambodia. Discussions around documentary evidence for travel, in particular, have taken over a year to resolve, as well as persistent issues around incentive payments to staff. This has caused significant implementation delays including for bednet distribution, community-

[1] *Alternates are listed in the participant list.*

level case detection/screening and distribution of diagnostic and treatment supplies, and has prevented the VMW network from reporting data (in the absence of monthly data-collection meetings at health centers). A solution was agreed between the Cambodia CCM (CCC) and GF, with implementation of a "travel plan" requirement; a fiduciary agent was also placed within the program. With the recent signing of MOUs with PHDs, VMW network activity is expected to resume shortly. A previously blocked amount of 1.2m USD is now unblocked and was integrated into the reprogramming, which will also include significant components of the national surveillance plan for elimination (based on the new national strategy). UNOPS is also working with CNM on a program management strengthening framework.

Myanmar's achievements show successful engagement of MOH with ethnic groups and NGO partners more generally. The Myanmar NFM Malaria (national grant) is expiring this year, and a new CN is under preparation for submission in June 2016 (*see also below*). Viet Nam has the highest absorption rates despite several administrative bottlenecks. It is noted that ICC2 project for Viet Nam (NIMPE/Health Poverty Action (HPA)) was still pending registration of the implementing NGO. Laos is experiencing some challenges with budget absorption related to case investigation and foci response.

There were no delays in procurement/supply of commodities, though some issues are still noted, as follows:

- Challenges in forecasting and preparation of specifications. UNOPS is building capacity in programs to define needs, quantification & forecasting.
- Selection of LLIN materials: while sourcing in 2015 resulted in polyesther nets, new tenders are more likely to be polyethylene (though all programs expressed a preference for the former). GF requires additional evidence on net usage (not preference) to change its policy on materials included in specifications and partners are encouraged to support additional research/ evidence-gathering where possible. UNOPS is also working with GF on sourcing at global level (PPM), to see if this could offer options for the region.
- The ASMQ procurement issue was temporarily resolved with the manufacturer for Cambodia but continued sourcing challenges for this product are anticipated.

Discussion:

- Delays in case investigation activities: this is generally a new activity for all countries, and is being rolled out progressively through health facilities in low endemic areas, and later will be implemented also through volunteer networks (VMWs, etc) where appropriate. A number of tools and training modules need to be developed and rolled out before implementation can follow, while at the same time countries have revisited their malaria stratification, which has also caused some delays. Very low numbers of cases in some areas are also a challenge for ensuring uptake and quality of services.

b. Inter-country component – *see PPT presentation*

Summary: Under the Myanmar ICC1 projects, the overall TMT coverage was 72% of populations in target villages (target of 80%), with some variances between the SRs (MAM: 86%, SMRU: 70%, CPI: 56%). Strong compliance requires considerable community-level engagement efforts (and investment). Lower coverage was caused by mobility of populations and sometimes security issues in these areas, as well as the high turnover of malaria volunteers, which require constant supervision and support. Preliminary post-TMT results (months 1 and 3) with qPCR show significant decreases in Pf and Pv prevalence; these results need to be monitored over time and additional post-TMT results are expected by the next progress update. RSC may wish to discuss potential expansion of TMT to adjacent villages with higher burden, to reduce risk of reintroduction to TMT villages.

In addition to the TMT component of these projects, the three partners have collectively established over 1,000 functional community-based malaria posts in hard-to-reach areas, which is a significant achievement. Prevalence data in non-TMT villages in these areas is also showing important decreases which can be attributed to the

implementation of a good quality malaria post ensuring early malaria diagnosis/treatment coverage in these areas. The overall cumulative budget absorption for ICC1 SRs is 77% (3.4m USD of 4.5m USD), noting that commodity portion of budgets (e.g. LLINs) is much smaller than in the RAI country components. This represents slightly over one year of actual implementation after accounting for initial signing delays.
Among "ICC 2" SRs, two projects have started (Lao MOH and MC/Raks Thai) but progress updates will be available only in the next reporting period (Aug-Sept 2016). The Medical Action Myanmar (MAM) project for West Sagaing was recently approved by the MOH and started implementing in April. The HPA/NIMPE project is supported by MOH, but still pending registration of HPA with relevant authorities to operate as an NGO in Viet Nam (People's Aid Co-ordinating Committee, PACCOM). After PACCOM registration, MOH approval can be done swiftly (within one month). Two new agreements were also signed under ICC funding with WHO (ERAR): pharmaceutical activities and regional data-sharing platform (*see ERAR update*).

Discussion:
- Overall progress under ICC1 is significant and the UNOPS team and ICC partners are commended for these achievements. This is a significant opportunity to complement national program activities. We should have the success of ICC in mind when we discuss the CN process for the next phase.
- Delayed approval of MAM (ICC2) project in Myanmar: earlier engagement of RSC with country-level partners is recommended to avoid such challenges in the future.
- Delayed registration of HPA in Viet Nam: After clearly identifying the bottleneck issues, it is suggested to reach out to partners who could leverage their official channels to accelerate the process (e.g. APLMA, WHO) as appropriate. It was noted during the ICC2 review that applicants were required to have a legal status in order to operate in their proposed project area. The extension of the current RAI grant may allow for additional time for the proposal to be implemented; however if this bottleneck is not resolved, RSC should discuss potential re-allocation of the funding envelope. There may be alternative partners to work with malaria program in Viet Nam border areas.

Next steps/actions:
- RSC Secretariat will reach out to WHO/APLMA and discuss options to support registration process for HPA in Viet Nam.
- RSC will review HPA/NIMPE project situation again at the next RSC meeting and determine way forward.

4) Country updates (NMCPs)

Thailand/BVBD (Dr. Prayuth Sudhathip): Cases reported in Jan-May 2016 were reduced by 50% nationwide, especially along Myanmar and Lao borders, though cases have increased in the southern provinces. The National Malaria Strategic Plan was endorsed by the cabinet last month, for roll-out starting in 2017, and an overall goal of elimination by 2024. Integration of case management data from hospitals into MIS is ongoing with USAID support (anticipated to be completed by Q3 2017). Primaquine for radical treatment of Pv malaria is being used based on G6PD testing before treatment. PQ for Pf is being implemented at low dose[2] (without G6PD testing); there have been no reports of adverse events.

Discussion:

2 To reduce transmissibility of treated Pf infections, WHO recommends a single dose of 0.25 mg/kg bw primaquine with ACT for patients with Pf malaria. Testing for glucose-6-phosphate dehydrogenase (G6PD) deficiency is not required. For further details: *http://www.who.int/entity/malaria/publications/atoz/9789241549127/en/index.html)*

- Malaria activity implementation by NGOs in Thailand is currently restricted to IEC/BCC and referrals, because NGO volunteers have not been allowed to do testing/treatment. This creates a challenge for reaching MMPs in particular, which have higher malaria rates than Thai populations (data presented during recent RSC CSO field visit) and which may not be accessing public services in several areas.
- National program notes that coverage of health promotion hospitals and malaria posts in border areas is quite effective but further mapping is needed to improve coverage of public services and malaria posts in Thai/Myanmar border areas (in discussion with SMRU).
- National policy requires that NGO volunteers are trained/accredited by MoPH. Other components of the malaria program require support from NGOs like active case detection for migrants, operational research on outdoor transmission. NGOs and program can work together to map these needs as well as service coverage.
- Community-level health workers need to be embraced as a resource for the malaria programs generally, as part of a multi-sectoral and sustainable approach. All types of informal or formal providers should be harmonized under one system, with support from WHO where needed.

Next steps/actions: BVBD/MoPH and Thailand NGO partners to explore options to include NGO volunteers in government-led trainings where possible, and allow trained NGO volunteers to work under the technical supervision of the ministry at field level.

Cambodia/CNM (Dr. Huy Rekol): The malaria situation in 2016 compared to 2015 shows a decrease of almost 35% in cases; however this data is difficult to interpret due to the lack of VMW reporting for over 6 months. The real burden of cases is difficult to estimate in the absence of a functioning surveillance system. Cambodia is adapting its surveillance system towards elimination, but active surveillance is not implemented yet. Delays in disbursement of funds from partners are delaying implementation. ASMQ delivery was delayed but has now been distributed across the country as well as job aides- including in Tier 2 areas, where the drug may be needed in the future. DHA-PIP was also re-collected from Tier 1 districts and re-distributed in the surrounding Tier 2 districts where it is fully susceptible. Due to resistance, it is anticipated that treatment regimens in Cambodia will change frequently and the program is drawing lessons from the ASMQ experience by trying to anticipate other combination therapies, including with PQ. Low-dose PQ for Pf is adopted in the national treatment guidelines but has not been implemented yet. Coordinated efforts of partners to register Primaquine are also ongoing.

Lao PDR/CMPE (Dr. Bouasy Hongvanthong): The Lao national program is piloting low-dose PQ in three provinces, with G6PD testing before treatment (5% deficiency rates have been found). Under RAI this will be scaled up in the southern part of Laos. After a long procurement and planning process, the program has received 1.3m LLINs (all donors combined) for the next 3 years; microplanning of distribution is ongoing with the support of CHAI. K13 mutations initially found in Champasack have now been documented in neighboring provinces. The program lacks adequate funding to conduct TES in the north. Program coordination at country level has significantly improved with bi-monthly partner meetings (including WHO, PEDA, HPA, donors, etc.). Technical capacity building and trainings for some partners would be useful, especially in the context of elimination. The Lao program suffers from a lack of staff both in quality and number, and requests for technical support from NGOs have created a drain of qualified staff from CMPE to more attractive NGO projects. Going forward, the program also hopes to see the harmonization of all GF funding streams for the country (NFM, RAI CC, ICC) and reducing the reporting/grant management burden so that staff can focus on operations. Case investigation is a new activity, which the program would like to conduct also in the northern part of the country; currently the RAI funding does not cover these areas.
Discussion:
- Lao CSO representatives (CSO workshop) also highlighted a need for more capacity-building/training support. There are also concerns regarding LLIN coverage for MMPs not being sufficient. Transportation support is also necessary at field level for case management/treatment. It is noted that NGO volunteers in Laos can do testing/referrals (but not treatment).

Myanmar/DoPH (Dr. Aung Thi): Myanmar shares similar issues in treating MMPs as Thailand, as border areas are porous and difficult to access. Despite presence of K13 mutant strains in the country, ACTs are still effective according to TES data (over 12 TES sites, including China and India border areas). Several areas with malaria posts have very few cases detected, especially in the non-transmission season. Volunteering for testing/treatment of malaria is on the decline and high turnover is an issue. Myanmar is working on integrated approaches (integrated Community Case Management, iCCM) but the lack of sustainability of funding for non-malaria commodities is a problem. Community volunteer networks also fall outside of the civil service/government system which causes issues of auditing/controls. There is a need to scale-up national capacity for entomological surveillance, as insecticide resistance remains a concern.

Discussion:
- Myanmar CSOs (at CSO workshop) expressed concerns around mobility of populations as problem for service provision and for real-time data availability and reporting. NGOs also experience issues with availability of real-time data to guide operations. With decreasing malaria rates, lower motivation of volunteers was indeed noted, as well as stocking of unused, expired drugs in areas with low incidence.

Viet Nam/NIMPE (Dr. Nguyen Quang Thieu): Viet Nam has undergone a significant decrease in malaria cases over the past year, with a 50% reduction overall in the past 5 years. Early 2016 data shows that 40% reduction in the number of cases compared to 2015. The program had some issues with bednet procurement, relating to materials and procedural delays; bednets are due to arrive in Q3-Q4 of 2016 which is late for distribution. The program has been using low-dose PQ for many years without G6PD testing, as well as for radical treatment of Pv; compliance is an issue for the latter. Failure of ACTs is increasingly observed: initial TES results from last year found that DHA-PPQ failure was 31% at 42 days in Binh Phuoc province, but these data still need to be validated in collaboration with WHO and MORU, following which the NMCP will revise treatment guidelines as required.

Next steps/actions: RSC to plan a specific session around malaria volunteers/integration at the next meeting, to ensure this is adequately addressed as part of the next Concept Note.

5) RAI Reprogramming and extension 2016-2017

Global Fund (I. Gaviria): Secretariat has agreed on a costed allocation of additional resources for a one-year extension from Jan to Dec 2017 (all grant components)[3]. For budgetary purposes recipients were asked to plan based on 2016 budgetary levels (approx. 30m USD in total); the final additional funding commitment from the GF will be calculated based on unspent remaining funds at 2016 end.

a. Workplans & budget for 2016-2017, Country Components (Dr. Faisal Mansoor, UNOPS)

See PPT presentation.
Summary: UNOPS team noted strong ownership and commitment at high levels throughout the reprogramming exercises for all 5 countries. This exercise was aimed at re-allocating unspent funds from 2014-2015 to 2016 activities and was an opportunity to ensure increased absorption as well as alignment to new strategies. Draft documents were partially submitted to GF in April except for Myanmar; in parallel endorsements by national CCMs were requested and are still pending. Additionally countries prepared presumptive budgets for a one-year extension period (based on 2016 budget levels).

[3] *See letter from GF sent to RSC on 5 May 2016 (Guidance on RAI extension).*

In accordance with GF guidance, it was not possible to push a part of the 2014-2015 savings into the 2017 extension period, so priority in the 2016 planning was given to activities which could be implemented swiftly. In accordance with RSC guidance, an effort was made to expand services to MMPs, community-based networks and active surveillance (especially Cambodia). It was also proposed to include a study tour for all RAI countries to see ICC1 activities, and bi-annual regional coordination meetings organized by UNOPS between senior health officials.

Inter-country component: a costed extension into 2017 for ICC1 SRs is available for continuation of activities at existing levels (in accordance with GF guidance on RAI extension). No reprogramming of savings was conducted under the ICC activities because funding absorption is generally very high and any delayed activities will have been caught up in the first half of 2016. ICC2 projects may receive a non-costed extension. Details for the respective extensions of the ICC1 and ICC2 projects will be made available at a later stage.

b. Updates on RAI Performance Framework, Country Components (Dr. Eisa Hamid, UNOPS)

See PPT presentation.

Summary: UNOPS presented its routine M&E and implementation oversight activities, which are based on a risk mapping of partners based on capacity, etc. With the reprogramming exercise, the RAI Performance Framework is being partially updated, in particular: revisiting DOT activities and targets in accordance with RSC/WHO guidance, adding the Annual Blood Examination Rate (ABER) as a standard outcome indicator.

Discussion:

- Given the large amount of additional funds programmed for spending in 2016 in some cases (e.g. Cambodia), there are concerns around the absorptive capacity of implementers, as well as potential delays in GF approvals and finalization of the negotiation process.
- UNOPS: Prioritization of activities has taken absorption capacity into account to the extent possible, and frontloading of procurements in some cases was considered a good option. Experience with GF is usually that activities are considered approved as soon as the grant negotiations are finished, without having to wait for formal amendment to the grant documents (Implementation Letter).
- RSC is asked to give a high level endorsement of the Country Components' reprogramming & extension, but formal endorsement of these remains with the respective national CCMs.
- TMT (Targeted Mass Treatment) component of the ICC1 projects will require further evaluation by RSC and by country-based partners (e.g. MHSCC) before it can be expanded to other areas in Myanmar, noting that this is not yet part of the national malaria strategy. Future funding of these activities will also be discussed.
- The main portion of funds under ICC1 is supporting community-based services (e.g. malaria posts) in these areas and it is agreed that these activities should be continued.

Decision points:

- The RSC endorses in principle the reprogramming and extension of RAI Country Components for one additional year (till end December 2017) based on the high level overview presented by UNOPS. Detailed documentation will be circulated to RSC for no-objection at a later stage, subject to national CCM endorsements.

- The RSC endorses in principle the costed extension of the ICC1 Sub-recipient projects (MAM, CPI, SMRU) for one additional year (till end December 2017). It is agreed that these SRs can continue all activities in accordance with 2016 approved plans with the exception of new TMT activities, which are subject to further review of results in late 2016. Detailed documentation will be circulated to RSC for no-objection at a later stage.

6) Follow-up on RAI review recommendations (1): independent M&E mission for 2016

See draft TORs.

Summary: The RAI will undergo an additional oversight/M&E mission in 2016, which is not a comprehensive review but will focus on a few key operational issues at field level in 2-3 countries, including: passive case detection, case investigation/response, services to MMPs. A data quality component is also included in accordance with RAI review recommendations, with the review of a few routine malaria indicators (not GF specific), such as: tested cases, confirmed cases, cases treated (all sectors), ABER and slide positivity rate. This exercise is planned for completion by Sept/Oct 2016.

Discussion:

- The emphasis on real-time data sharing aspects of surveillance systems will be important during this exercise so that operations can be adapted accordingly.
- Increasing access to data on MMPs and enhancing data-sharing in this area is also important to inform operations and targeting of MMPs in particular.
- The review should include both Country Component and ICC, and government as well as non-government implementers.

Decision point: the RSC endorses the draft Terms of Reference (version 25.04.2016) for the independent review mission of 2016.

7) Follow-up on RAI review recommendations (2): regional stockpile of malaria commodities

See working group report + presentation (S. Schwarte, WHO, on behalf of working group).

Summary: After a detailed review, the working group does not recommend the establishment of a regional stockpile for antimalarial medicines, as there is no quality-assured product currently registered in all 5 countries which would have value in being stockpiled at regional level. In the short term, the priority should be on coordinating efforts at regional level to advocate for and accelerate in-country registration of additional already quality-assured ACTs (and potentially non-ACT malaria medicines), and it is recommended that the RSC engage, with partners where needed, in a dialogue with each country on this topic. Once registration bottlenecks are lifted, the option for a regional stockpile could be revisited, subject to a more comprehensive operational feasibility assessment (and based on the working group's preliminary assessment, a virtual rotating stockpile would be preferable rather than managing a physical stockpile). Additional recommendations of the working group include: for GF and other donors to engage directly with manufacturers in advocating for the specific needs of the GMS, exploring the potential expansion of the Global Fund Rapid Supply Mechanism (RSM), analyzing market dynamics which impact the region, and mapping the other partners involved in this topic (e.g. APLMA, Therapeutic Goods Administration (Australia), WHO, …) to ensure complementarity of efforts.

Discussion:

- Registration of products in-country is subject to the initiative of the manufacturers, thus advocacy (as well as raising awareness) with manufacturers is critical. Where possible, increased flexibility should be requested especially regarding batch sizes (considering low volumes procured in the region).
- WHO: Expansion of the WHO collaborative procedure for registration would be useful and WHO can take the lead in this. National treatment guidelines should be flexible and updated to include at least one second-line ACT regimen in each of the GMS countries. Additionally third-line regimens could be included (quinine/tetracycline). However the NTGs are not a pre-condition to the registration of drugs, which can be done before NTGs are updated. WHO can support making the case for additional regimens but the registration process ultimately depends on the motivation of programs and manufacturers.
- Low volume of demand in the region is a disincentive for manufacturers to register. A more detailed

understanding of needs/forecasting for the region is necessary. It is also noted that a large market of medicines in the private sector (non-Quality Assured products) also exists.
- Regulatory coordination and harmonization efforts should be pursued in collaboration with existing partners (e.g. APLMA), while work on market dynamics is necessary also: UNITAID could be a good partner to engage with on this topic.
- ACTWatch survey funding is expiring and it may be useful to explore whether the data would continue to be of use to partners in the region to support monitoring of drug quality.

Next steps/actions: The Working Group will liaise with the aforementioned initiatives to begin implementing the report recommendations, and will report back at the next RSC meeting.

8) Follow-up on RAI review recommendations (3): RSC governance/membership

See PPT presentation.
Summary: Secretariat (A. Joubert) presented an update on activities in relation to engagement with national CCMs (e.g. debrief visits, CCM survey) and updates regarding RSC membership. Of the total 17 voting seats on RSC, several will undergo renewal in 2016: Regional partners (current: ADB), Private foundations (current: BMGF), development partners (current: AUS, UK, FRA), civil society (2 seats) and the RSC Chair (term ending in Dec. 2016). Membership is for three years, renewable once; the nomination/appointment process varies depending on each constituency. Each constituency/member will be contacted separately by July 2016 and appointments (or re-appointments) will be put forward to RSC for endorsement. New candidates for the aforementioned seats can be proposed by RSC members. Alternates will be designated for each of the RSC seats going forward. The RSC Chair election will be organized at the next RSC meeting (Oct 2016).

Discussion:
- The timeframe for membership renewal coincides with the development of the next RAI Concept Note, which is somewhat inconvenient; however it is preferable to follow the RSC Terms of Reference.
- The civil society constituency has exceptionally agreed that the two incumbent members can extend their term on RSC (expiring in Dec. 2016) until the Concept Note is submitted. The election of two new civil society members will be organized in Q1-Q2 of 2017. It is also proposed that 2 CSO observers be allowed to attend each RSC meeting to support knowledge-transfer.
- Though no change in RSC membership was recommended in the RAI review, CSO representatives wish to increase the number of CSO members if possible in the future.

9) Update from the Global Fund (U. Weber)

The Global Fund Board (26-27 April 2016) approved the new strategy as well as updated eligibility and allocation criteria (details available online), which will broadly continue to be based on disease burden and capacity to pay (GNP levels). Eligibility criteria have not changed for any of the GMS countries. However artemisinin resistance in the GMS is mentioned explicitly in the new GF strategy, and thus it is expected that this will be considered by the Board as an important additional factor when future allocations are decided. Past performance of implementers (e.g. absorptive capacity) is not a factor in the allocation methodology as such but will be taken into account as a qualitative factor (among others) resulting in adjustments of the final allocation amount– GF is encouraging RAI implementers to ensure a high absorption of funds this year under RAI.

The GF Board has also set aside an envelope of “catalytic investments” of globally up to 800 million USD, which will partially support multi-country proposals, though competition will be expected given the size of the existing need

in relation to the amount available. The final catalytic investment envelope amount will be decided by the Board after the replenishment process is completed. Internal policy discussions are ongoing as to how these funds will be allocated; a strategic committee of the Board will review in June 2016 which initiatives should be part of this funding. For the GMS and RAI, the final allocation of funds for the 2018-2020 period remains subject to the replenishment process (and strategy committee recommendations): the replenishment conference will take place in September 2016, and decisions made by the GF Board in November 2016. If funding for the region is sustained at existing levels, the overall envelope would be 250 million USD for the five countries, of which 40% is RAI. Though a reduced replenishment might impact funding levels for the region as a whole (RAI and country allocations), country-specific allocations are more likely to be affected as a result of the allocation criteria, thereby increasing the relative potential share of the RAI. The GF Secretariat is still discussing the potential merging of the regional allocation for GMS with the national allocations; a decision is anticipated in late 2016- early 2017.

As a former "early applicant" the national malaria grant in Myanmar is also ending in December 2016 and a four-year Concept Note for malaria (2017-2020) is in preparation – this consolidates the RAI Country Component with the national (NFM) allocation amount. The RSC is asked to provide inputs into the process as necessary to ensure consistency with the regional approach[4]. A preliminary draft of the Myanmar Concept Note was circulated in early May (138 million USD for 4 years which includes 40m USD from RAI Country Component). Amounts are tentative and subject to revisions once the final replenishment and allocation amount is communicated by the Global Fund. In the Concept Note, 2017 activities for RAI will remain separate (as defined during reprogramming workshops) but will be merged from 2018 onwards. Endorsement of the draft by the national CCM (MHSCC) is anticipated by early June 2016.

Discussion:
- It is important to ensure that the regional approach adopted under RAI is maintained. In particular, specific border areas should continue to be targeted.

Next steps/actions: The draft Concept Note for Myanmar will be circulated to RSC members for comments/feedback within 2 weeks.

10) Preparing for RAI Phase 2: proposed process and next steps (Secretariat) – *see PPT presentation*

Summary: Despite several unknowns regarding the future of the RAI (funding structure, allocation amount(s)), it is suggested to start planning around a tentative process to develop the next Concept Note. Taking the future consolidation of all funding components into a single multi-country proposal for the GMS as a working assumption, the RSC Secretariat presented an overview of the key milestones in the coming months, including the formulation of a high level set of strategic priorities (for discussion at the next RSC in October), to be followed by the development of a draft Concept Note with country-level consultations & dialogue (in Nov-December 2016). Accounting for the December 2017 end date of the grant, the ideal timeframe for the submission of a new Concept Note would be March 2017 (leaving 9 months for the Global Fund/TRP review and grant making processes).

To support this process, it is proposed to form a Concept Note writing committee, which is expected to: formulate high level strategic directions for inputs from RSC (with technical assistance support as needed); provide guidance to CN writing team/consultant(s); provide inputs/feedback on CN drafts; and support the consultation process with

[4] The RSC Chair, WHO member and Secretariat participated in discussions on the Concept Note draft with the Global Fund in April in Yangon.

CCMs, NMCPs, other partners as relevant. It is understood that the writing committee serves primarily to oversee and guide the Concept Note development process; final decisions on the Concept Note content will be subject to reviews/iterations as needed by the RSC membership in full. "Country components" of the multi-country proposal would be developed under the leadership of the respective CCMs, with some guidance from the RSC.

Discussion:
- The CN writing committee should be kept small to be manageable, and constituents which are not represented (e.g. private sector, donors) should be able to engage in country-level discussions and/or within the RSC itself. A regional approach requires a multi-stakeholder approach by definition. Civil society should be engaged throughout the process (at country level and at regional level). This should also include inputs from existing/potential implementing partners/SRs. Country representation on the CN writing committee should be flexible to ensure that the persons appointed have the right profile/technical knowledge.
-It was suggested to organise a RSC subcommittee meeting to discuss higher level guiding principles and priorities for the CN development. An example is the CN being focused on a relatively limited number of key activities striving to be implemented in full, rather than on a long list of endeavors jeopardizing their implementation and oversight.
- Our immediate priority is to agree on a common vision for the next 2-4 years. The next Concept Note should be ambitious and we should not forget our key goal which is to halt/prevent the spread of artemisinin resistance. This has recently translated into a regionwide effort to eliminate malaria altogether, however within the national elimination strategies and the needs identified by countries, we need to pragmatically prioritize what can/cannot be funded by the grant. However the Concept Note could help us formulate what the region needs beyond Global Fund financing alone, which could be leveraged for contributions from other partners/donors also;
- We should explore whether inclusion of Bangladesh and India (areas bordering Myanmar) would be appropriate, though it is noted that these countries may not be aligned with the elimination agenda of the GMS countries, and feasibility assessments for elimination have not been done. Resistance has also not yet been documented in these countries (WHO).
- The Inter-Country Component of the RAI is showing important achievements and the Concept Note should be an opportunity for exploring the scale-up or expansion of similar activities to other areas in the region. It is suggested that ICC SRs be invited to present their activities to the RSC. If possible, we could explore increasing the funding envelope to the ICC/regional component.

Decision point: the final agreed composition of the CN writing committee is as follows: 5 country (government) members, 1 WHO member, 3 CSO representatives, RSC Chair / Secretariat, 1-2 non-RSC advisors.

Next steps/actions:
- RSC Secretariat will circulate a brief Terms of Reference document for the Concept Note writing committee as well as the nominated representatives for the group, subject to discussion with the respective constituents.
- At the next RSC meeting, the RSC will have a specific "brainstorm" session around the strategic vision for the next Concept Note.

11) Member & partner updates

Civil society (L. Da Gama): The CSO representatives attended a field visit in Thailand near the Myanmar border (with World Vision from 5-8 May). Consistent and regular information sharing meetings across borders are either

not happening or do not systematically include NGO partners. More focus is needed on informal border crossing points, with the possibility of doing onsite diagnosis/treatment. Collaboration between the MoPH, local government officials, military and civil society was observed to be excellent. There is a need for greater integration of community services at field level, for example where there are HIV or TB volunteers operating in the same areas.

Private Sector (F. Desbrandes): The Private Sector constituency remains very supportive of regional initiative, as recently acknowledged by the PS delegation at the GF Board. On 10 May, the Corporate Sector organized a side event (*see meeting documents*). The Private Sector can and is playing several key roles in malaria elimination: developing and providing quality commodities, including through PPM projects (e.g. with Population Services International, PSI) and through innovation and work on new molecules (e.g. with Medicines for Malaria Venture, MMV). The private sector also plays a provider role in corporate/business settings through programs for employees (e.g. use of business coalitions like Myanmar Health and Development Consortium). The Private sector can also be a direct implementing partner for the Global Fund (E.g. Shell in the Philippines).

ERAR Hub (M. Aregawi)- *see presentation*.
1) Regional data-sharing platform: The ERAR Hub has started implementing the regional data-sharing project activities approved by RSC under RAI ICC last November, with an initial project end date of December 2016. A set of basic indicators was developed but will be customized based on country needs; it is expected that quarterly reports can be produced starting from Q3 of 2016. The regional data platform will use DHIS2, which is being adopted in several of the GMS countries. Data managers are being recruited and in Cambodia/Myanmar, case-based surveillance is being piloted (DHIS2). Cross-border data-sharing meetings are supported and disease trends monitored in these areas using mapping. Considering the project's delayed start WHO/ERAR is requesting a no-cost extension to complete the proposal activities.
2) Pharmaceutical activities: Activities have not started due to the delayed grant signing and disbursement between UNOPS and WHO; these are due to start by the end of the month. The project has been taken over by WHO/WPRO and is no longer managed by the ERAR Hub. Several adjustments to the proposed activities are being requested (*slide 18*).
3) Update on regional Surveillance & M&E Assessment work: At the request of the RSC, WHO/ERAR was asked to help identify key funding gaps & priorities for future funding by RAI in this area (at country level). Further work will be done on this in line with the elimination strategies of the region. In the meantime the main recommendations from the regional assessment conducted last year included: strengthening SME systems, Human Resource planning and capacity-building, updating and developing appropriate SME tools, data quality management and information sharing, cross-border collaboration on cross-cutting issues for regional actions, and promoting operational research on programmatic issues and challenges relating to SME strengthening.

> **Decision point: The RSC endorses in principle a no-cost extension for the two WHO/ERAR sub-recipient grants, to support the implementation of activities in accordance with the original proposals approved by the RSC for funding.** Proposed adjustments are to be discussed between WHO/ERAR, UNOPS and the Global Fund; any significant changes should be communicated to the RSC for no-objection.

France (E. Fleutelot): The French 5% initiative (managed by Expertise France) recently approved an operational research proposal from MORU for a 3-year program titled *"Molecular and in vitro surveillance of artemisinin combination therapy (ACT) partner drug efficacy in the GMS"* (1m EUR), to be implemented in collaboration with other research institutes in the 5 GMS countries (e.g. SMRU, MORU, Pasteur Institute). The program aims to inform ACT treatment policies in the region, with the following specific objectives: to define the prevalence and distribution of genetic markers of resistance to partner drugs in artemisinin-based combination therapies (ACTs);

to validate molecular markers of resistance with in vitro testing of selected isolates from across GMS; to build sustainable capacity and improve quality of genotypic and phenotypic assessments of antimalarial resistance; and to validate the feasibility of near-real time molecular surveillance to guide policy implementation in resource-limited settings.

APLMA (B. Rolfe): The APLMA Roadmap was endorsed at the East Asia Summit last November. India has moved towards a commitment on elimination and has launched a national plan, with states now developing their respective strategies. Sri Lanka will be certified as malaria free later this year, and the Philippines are increasing domestic financing for malaria. A trilateral partnership between Papua New Guinea, China and Australia has been launched. A regulatory partnership meeting also took place, with a focus on *P. v*ivax especially. A high level task force on resource mobilization and innovative financing is under development. APLMA is merging its secretariat with APMEN at an independent secretariat in Singapore to be established in the fall. On Friday May 13, the APLMA Senior Officials' Meeting (SOM) will take place with the following key objectives: to approve the APLMA dashboard and to agree on annual reporting priorities.

12) Any other business

The next RSC meeting will take place in Cambodia- this is tentatively proposed for the second or third week of October. Subject to feedback from the Cambodia host authorities (and RSC members in case of conflicts), the final dates will be confirmed by July.