Minutes of the 8th meeting of the RAI Regional Steering Committee (RSC)
for the Global Fund Regional Artemisinin-resistance Initiative (RAI)

11 October 2016, Siem Reap, Cambodia

Minutes taken by: Amélie Joubert, Executive Secretary

Attendees/participant list - Appendix 1
Agenda – Appendix 2
List of acronyms – Appendix 3
All presentations are available upon request.

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1) Opening remarks

The meeting was opened by His Excellency Dr. Ieng Mouly, Senior Minister in charge of Special Mission, Chair of the National AIDS Authority and Chairman of Cambodia Country Coordinating Committee for the Global Fund.

He expressed his gratitude to development partners and donors who have provided assistance to help reconstruct Cambodia during the past 25 years. For malaria, tremendous progress has been made across the Mekong Sub-region as a whole, however the threat of artemisinin and partner drug resistance remains an issue of international concern, with the countries of the GMS at the front line of the battle.

He noted that Cambodia was moving to become a lower-middle income country, maintaining an annual economic growth of 7%. The Royal Cambodian government recently contributed nearly 4m USD to purchase anti-retroviral drugs for Cambodian HIV/AIDS patients; and the Ministry of Finance decided to earmark nearly 1.6m USD as a counterpart investment to support the transition of Global Fund-financed contracted staff in all three disease programs.

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

a. Membership updates

Following our usual bi-annual rotation (in accordance with ASEAN), the RSC Vice-Chair seat has transitioned from Viet Nam to Cambodia. The Cambodia Ministry of Health has appointed Dr. Ly Sovann, Director of Communicable Disease Control (CDC) Department to occupy the RSC Vice-Chair seat. As a result, the Cambodia MOH/CCM seat is officially made vacant – for this meeting's purpose His Excellency Dr. Ieng Mouly (CCC Chair) represents the Cambodia CCC ad interim.

In August/September 2016, the following members were re-appointed for another 3-year cycle:
- Development partners: DFAT (B. Duce), DFID (J. Bagaria), and France (E. Fleutelot). USAID (B. Nahlen) was appointed as alternate member for the group.
- Regional partners: ADB (G. Servais, S. Roth as alternate)
- Private sector/charity organizations: Bill & Melinda Gates Foundation (C. White, J. Cox as alternate)
- Viet Nam CCM: Dr. Tran Thi Giang Huong, Director General, International Cooperation Department, Ministry of Health

RSC Secretariat also received notification (10 August 2016) from the China National Health and Family Planning Commission that they were withdrawing their voting seat from the RSC. They will continue to be involved as non-voting members through the National Program or as technical experts/observers.

b. Conflict of Interest (COI) declarations & recusals

RSC Chair (A. Dondorp) 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).

c. Follow-up to previous decisions / action items

Most action points from the previous meeting were completed and RSC members informed accordingly. Pending action items included:

- planning a specific session around malaria volunteers/integration: this was raised during the RSC retreat and will be developed in more detail as part of the Concept Note.
- RSC review and endorsement of ICC extension: this is pending submission of documents by PR UNOPS (further details in UNOPS presentation).
- Working group on ACT stockpile / drug access issues: terms of reference for a regional mapping exercise are in preparation, in accordance with the WG recommendations. This analysis will feed into the Concept Note.
- Discussion on operational research priorities (one of the review recommendations): a priority list was developed by a consultant contracted through WHO but it was not possible to organize a presentation of the document as part of the meeting agenda.

Decision point: a small working group will review the proposed priority list and provide feedback/inputs for consideration by RSC as part of the next Concept Note. Suggested members are WHO, RSC Chair/academia, 2 countries + one non-RSC advisor (TBD).

3) RAI Progress Update, Jan-June 2016 (UNOPS, Drs. Attila Molnar, Faisal Mansoor & Eisa Hamid)

a. Country components – *see PPT presentation.*

Summary: RAI RSC has thematized the discourse around malaria in the region, due to its sheer size and its broad multi-stakeholder composition. DG level meetings have been initiated; coordination has improved at country level within partners, and between countries. Community-based services are recognized as the cornerstone of malaria elimination, with a clear need for integration going forward. The policy environment is favorable (e.g. Myanmar expanding the role of VHV, based on push through UHC agenda). RAI has also provided the opportunity for inclusion of new CSO partners and increasing NGO/government collaboration.

The analysis of impact indicators until end 2015 shows that Thailand and Viet Nam are moving steadily towards elimination (with more than 95% of administrative units with Pf incidence below 1/1,000). In MYN over 60% of districts have reached this threshold. Pf incidence in Cambodia increased between 2014 and 2015 – though the picture at subnational level is not uniform, with several areas continuing to see decreasing trends. Concerns remain around the VMW program and data availability/quality. The Annual Blood Examination Rate in Cambodia is below the 5% minimum rate recommended by WHO; all other countries have done relatively well in sustaining a good testing rate. Positivity rates are showing consistent declines; though for Cambodia the data may not be reflective of a declining disease trend.

While data on MMP-specific outcome indicators are not yet available, the program has increased access for MMPs to prevention/diagnostic services through VMW/MP expansion and LLIN distribution. Stockouts were reported in less than 20% of facilities, but this is partial data (no Viet Nam or Cambodia). The quality and completeness of stock data varies across the region, though improvements are noted (e.g. Lao PDR). Cambodia plans to roll-out an SMS-based stock reporting system. Through a recent survey, oAMTs were found in Myanmar, though by law production & sale are illegal. Case investigation and foci response has increased in Myanmar and Viet Nam, which

met their respective targets. Lao PDR has started rolling out this activity and will report in the next period. Thailand has maintained 100% achievement of its targets.

Financial absorption was around 70% overall under the RAI country components, and nearly 85% if commitments are added. Cambodia absorption rate (78%) is largely attributable to procurement expenditure.

PR recommends that submission of the next Concept Note be completed no later than April 2017 in order to ensure sufficient time for the SR selection, grant-making and negotiation phase (to be completed by end of 2017).

Discussion:
- Overall progress is good and all implementing partners are commended for their excellent work so far. We have to keep this momentum going forward, keeping in mind that the task will not become easier (i.e. decreasing disease incidence).
- The situation of the Cambodia program remains a concern, due to unresolved issues around the flow of funds to peripheral levels and VMWs. A mobile payment program is to be rolled out progressively with 60% of the VMW network to be operational by the end of 2016, the rest by end of March 2017. Data collection and reporting overall remains problematic. The MMP survey in Cambodia (delayed) is currently under preparation and results should be expected in April 2017. Among some positive developments, Primaquine was registered and will be delivered to country next month. ASMQ has been distributed in all applicable areas but further supply remains a challenge.
- On the issue of oAMT elimination, there have been good efforts among countries on a regulatory level (as well as in India). However monitoring needs to be continued and oAMT elimination should remain an important priority for the next Concept Note. (**Action item: It is suggested that PSI/ACT Survey provide an update at the next RSC meeting.)**
- The issue of LLIN material selection remains problematic. To date, evidence provided to the Global Fund has not been considered sufficient to allow the flexibility to select polyesther nets, since actual difference in usage rather than preference of material should be addressed. RSC supports a "common sense" argument to be made in favor of polyesther nets in the region, considering their historical use. Global Fund is requesting support from WHO to enable a change in policy. If needed, a rapid research effort on this issue could be funded under ICC.
- National programs appreciate the role of NGOs particularly in coverage of remote areas / communities, as well as monitoring and education of at-risk groups. NGOs are encouraged to work closely with government partners and exchange information/data.

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

Summary: Under the "ICC 1" SRs operating at the Myanmar/Thailand border, 1,436 Malaria posts are now established and functional. MDA was completed in 43 hotspots and Month-12 post-MDA surveys are now ongoing. Initial results on Pf incidence were very promising for both MDA and non-MDA areas (though reductions were more rapid in the former). In the latter, success is largely attributable to the establishment of well-functioning Malaria Posts in peripheral areas which were previously unserved. Recently a review meeting and study tour on the ICC1 projects were organized by MOHS Myanmar with UNOPS' support. A costed extension for ICC1 SRs has been endorsed to maintain the MPs; MDA continuation is put on hold pending further examination of epidemiological results. A high-level meeting of all countries at DG MOH level was hosted by MOH Myanmar in Nay Pyi Taw (5 October 2016); countries pledged their continued commitment to eliminate malaria in the region, exchanged updates on achievements/challenges, and lessons learned for the next cycle[1]. Funding absorption has been high (73%, without including commitments).

[1] Minutes available upon request.

Among "ICC 2" SRs initial progress has been solid, all of them reporting results on diagnosis/treatment in their respective areas – with exception of HPA in Viet Nam, though MOH/registration was eventually completed and activities started in September 2016. In Lao PDR (Champasack), 48 Malaria Posts were established and are now functional. Under the WHO ERAR project, the regional data-sharing platform database in DHIS2 has been established and functional. All ICC2 SRs have submitted requests for no-cost extensions into 2017; these will be reviewed shortly by the Global Fund.

Discussion:
- Future inclusion of MDA in the program will require country-by-country assessments and additional discussions.
- To ensure appropriate absorption of savings in 2017, it is suggested to review the financial status of the grant at the next RSC meeting (for Dec 2016 reporting period) and consider potential re-allocation of remaining savings.

Action items: UNOPS to provide a summary financial table across all RAI components (budget, expenditure, commitments, savings). Additional information is also requested on cost per intervention package (e.g. Malaria posts).

4) Country updates (NMCPs)

Lao PDR/CMPE (Dr. Bouasy Hongvanthong): Laos has seen a 40% reduction in malaria incidence since 2015 but Vivax is increasing now, which is challenging to treat. TES studies are increasingly difficult to implement because of low caseloads. The program is now introducing DHIS2, with support from NFM, RAI, ADB and Gates/UCSF/CHAI. This presents several challenges including insufficient internet debit, lack of qualified staff, etc. Elimination is planned to be conducted in northern provinces, while in Champasack (south) the situation has significantly improved (partially owing to more stringent regulation on wood-cutting activities. 1.3m LLINs were distributed this year from different sources (RAI, NFM, PMI) and coverage has improved among at-risk groups. Coartem (AL) has started losing its efficacy in some areas; the program is discussing a change in regimen (to DHA-PPQ).

Cambodia/CNM (Dr. Huy Rekol, Dr. Siv Sovannaroth): In 2016, the program observed a reduction in cases by 53% compared to 2015 – but there was a noted 75% reduction in reporting from VMWs (which normally represent 50% of cases reported) and 35% reduction in reporting from HFs, making it difficult to conclude on the real status of the malaria situation. Overall disease trend is estimated to be quite similar to 2015 cases. The program continues to experience implementation obstacles and delays, related to conditions imposed by the main donor (e.g. program management framework, cash flow mechanism…). The progressive roll-out of a mobile-payment system for VMWs is being planned, but in areas without mobile payments, cash payments have not been allowed; this will further delay the re-activation of the VMW network. Surveillance and reporting system urgently needs to be re-established. On the positive side, distribution of LLINs was recently completed in 10 provinces. Diagnosis and treatment are still provided by health facilities; while only a third of the VMW network is estimated to still be functional. Private sector data shows an increase in cases in 2016, but this could be an effect of the re-direction of cases from the public sector and VMWs. The program has revised its implementation plans (roll-out of elimination surveillance, VMW scale-up) as a result of these delays; targets originally planned for 2016-2017 in the MEAF (NSP) will be difficult to achieve.

Discussion:

- Given the status of Cambodia in the resistance scenario, reporting of good epidemiological data is very important. The VMW program has to be restarted urgently, and the overall situation remains worrying. CCC Chair: Country-

level partners are following this issue closely and working with the Global Fund, CNM and UNOPS to find solutions.
- The introduction of ASMQ is very good news, but we have to ensure supply of the drug is sustained.
- It is recommended that feasibility be carefully assessed before imposing nationwide measures such as VMW mobile payments; this has an impact at peripheral levels which is significant. A reasonable, phased roll-out plan should be established. The presence of NGO/CSOs at field level could perhaps be leveraged to assist with cash flows issues for the VMW network.

Myanmar/DoPH (Dr. Aung Thi, Dr. Thandar Lwin): Myanmar still has the highest malaria endemicity but sharp decreases continue to be observed over the past 2 years. Around 20,000 NMCP/NGO volunteers are currently working for malaria; this network will continue to expand but their scope of work will be increasingly integrated with other diseases (TB, HIV) and basic health packages (MNCH). As in other countries, MMPs are also key target population for elimination; the program has encouraged the use of forest kits as well as standby treatment (without testing) for specific mobile groups. Though oAMT importation and distribution is banned, up to 27% availability of oAMT has been documented in some areas. This is higher than in previous surveys though the sample is now bigger, and some of these drugs were expired. Treatment of P.Vivax continues to be challenging; a recent survey of PQ adherence in MMPs was only 40%. Private Sector providers do not provide PQ for vivax. Surveillance and M&E systems are being strengthened; the integration of all partner data into one system (DHIS2 platform) is under way – this should be linked to the regional WHO platform. Under ICC1, more timely and complete reporting of NGO partners with NMCP is needed. Joint supervision is recommended to strengthen collaboration in the future. MDA has indeed shown an accelerated decrease in malaria rates and resistant parasites; however the program remains concerned about potential resurgence. ICC programs need to be better coordinated between partners (RSC, MHSCC, MOH, NMCP) and there should be increased alignment/harmonization of activities on the respective sides of the border.

Discussion:
- Specific attention should be given to P.Vivax in the next Concept note.
- Mandatory reporting of data by ICC SRs to NMCPs should be enforced to ensure country ownership. There may be data formatting issues which should be easily resolved.

Thailand/BVBD (Dr. Prayuth Sudhathip, Dr. Wichai Satimai): In the last year, the total malaria caseload was reduced by over 30% (cases dropped to 17,000 of which 66% were Thai, 33% imported, Pf was 20%), but the country experienced an epidemic in 3 districts in the deep South (conflict zones). There is strong political commitment around elimination; a national elimination strategy was approved by the Cabinet last April, and provincial action plans for elimination have been developed. There remain uncertainties around financing from 2017 onwards, and concerns around sustaining political attention with continued reductions in cases. Strategic information will be needed to advocate at political level; a “business case for elimination” is under preparation. There is also a need to decentralize and integrate the national program which is a lot of work. With DHA-PPQ failures in neighboring Cambodia, the program is anticipating potential changes in drug policies and has planned a TES with WHO. Regarding the issue of case management by CSOs in Thailand (raised at the previous meeting): this has been happening under SMRU since 2010, it is suggested that other NGOs learn from them, and develop an action plan. A shift in regimen from ASMQ to DHA-PPQ is underway but there are many concerns around DHA-PPQ resistance. (a study from MORU/ Mahidol University is seeing high failure rates of DHA-PPQ in its Sisaket province project)

Discussion:
- With surveillance in the elimination stage, programs should be able to collect drug efficacy data through routine surveillance rather than through the usual TES.

Viet Nam/NIMPE (Dr. Nguyen Quang Thieu): RAI has made a great impact on both PF and PV in Viet Nam, with a reduction of more than 24% in 2016 compared to 2015. The country is generally well on track for elimination. Considering increasing failure rates in Binh Phuoc province, the national treatment guidelines have been updated with new drugs (ASMQ and AL), and the program is now working with the FDA on registration. Low-dose PQ and PQ for radical cure of Pv present no issues. Collaboration with the private sector is needed to be able to augment the data / visibility of cases. Malaria is mostly among MMPs now, which remains a challenge.

5) **Overview of malaria & resistance in India & Bangladesh** – *see presentations.*

Dr. A.C. Dhariwal, India MOH: Many similar issues are being discussed in India; the program would be grateful to continue exchange of information with the Mekong countries and the work of the RAI RSC should go beyond these 5 countries. India has seen a 70% decrease in malaria over the past ten years (currently 0.5 mln cases per year) and launched a National Framework for Malaria Elimination (NFME) in February 2016 – with the goal of making India Malaria Free by 2027. A key challenge is ensuring adequate priority for malaria compared to other disease control programs. The national program works closely with research institutions as well as NGOs in areas where the government cannot reach populations (e.g. Northeastern states, faith-based organizations). The country also has a VHV-type network (0.9 mln female volunteers in the villages, paid on performance-basis: 1.5 US$ per case). Industrial groups such as Tata and Sun Pharma are also becoming involved in malaria activities in some districts. Artemisinin and partner drug resistance are being monitored closely; no resistance has been detected as of yet but there is a concern that this may emerge in the country soon.

Dr. M. M. Aktaruzzaman, Bangladesh MOH: Bangladesh had a total of 39,719 cases in 2015, and 21,225 cases in 2016 (till August). There has been an overall reduction in cases since 2008, except for a spike in 2014; 2016 case levels are now back down to 2013 levels. Nine districts were declared as low endemic / pre-elimination areas. High endemic areas are mainly along the eastern border. Several NGOs are working with the program, which also includes community clinics / volunteers for testing of fevers. In the 2016-2021 sector-wide program plans, a special focus on hard-to-reach areas (through mobile clinics) will be given. At the moment there has been no evidence of artemisinin or ACT resistance. There is Chloroquine resistance in Pf cases up to 40-70% but it remains fully effective for treatment of Pv.

6) **Debrief from RAI oversight/M&E mission 2016**

Background: As agreed at the last RSC meeting, an additional oversight/M&E mission was conducted in September/October 2016, which was not a comprehensive review but focused on a few key operational issues at field level in 2 selected countries (Myanmar and Viet Nam), including: passive case detection, case investigation/response, services to MMPs. A data quality component was 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.

The full draft reports will be circulated in the coming weeks for additional comments.

a. **RAI implementation quality (S. Hewitt) -** *see presentation*

Despite the issues identified, there were many positive observations and the overall numbers speak to the progress that has been made by these 2 countries in reducing their malaria burden.

The main findings and recommendations are summarized below:

1. Malaria related reporting and data entry requirements in Viet Nam are overly burdensome. Temporary data-entry staff are required at provincial level to operationalize the current system. High-level technical assistance (TA) is recommended for the development of the new malaria information system (MIS).
2. Despite high coverage with village health workers (VHWs), community-based case management for malaria is only available in 2 of the 16 RAI provinces in Viet Nam, while staff in Malaria Posts (MPs) are allowed to provide ACT in some provinces, but not in all. Viet Nam's VHW and MP approaches should be brought in-line with regionally accepted best practice.
3. Rapid diagnostic tests (RDTs) are widely used as well as microscopy (Viet Nam) or instead of microscopy (Myanmar). Quality assurance (QA) for microscopy is not blinded at any level. Microscopy either needs to be revitalized (at least at hospital level) or abandoned.
4. Annual Parasite Incidence (API)-based thresholds for conducting case & focus investigation and focus response are proving problematic. Whether or not to conduct these activities should be based instead on what is practical at each level of the public health network.
5. Indoor residual spraying (IRS) with synthetic pyrethroids is being used in addition to LLINs in both countries. It is suggested to adopt non-pyrethroid insecticides for IRS or target communities with either IRS or LLINs, but not both.
6. The project style approach that has developed in Myanmar has resulted in fragmentation and duplication of effort between different implementing partners. It is recommended to appoint a focal person within the National Malaria Control Programme (NMCP) for each programme area.

Among the main issues, several are also relevant to other countries in the GMS:
1. There is excessive use of LLINs, targeting urban areas and rural areas that have not seen transmission for many years. Targeting of LLINs should be stricted, and stratification approaches revised, to focus on achieving total coverage for people only **in transmission sites**.
2. District and commune staff and VHWs are better placed than provincial and central level staff to estimate the number of mobile people and migrants. It is recommended to introduce bottom-up planning for quantification of long-lasting insecticide treated net (LLIN) and long-lasting insecticide treated hammock-net (LLHN) requirements for MMPs (with support from NGO partners to quantify needs as necessary).
3. Weight group specific packaging for artemisinin-based combination therapies (ACTs) complicates procurement and supply management (PSM) and results in frequent stock-outs and excessive expiry of unused stock. Task manufacturers with developing simplified packaging with blisters that can be cut to size.
4. Using the last three years' data for stratification where the caseload is falling so fast results in an overly cautious appraisal of risk. It is recommended to review stratification approaches in light of rapid reduction in malaria burden.
5. RAI LLHNs are bulky, heavy and separate from the hammock, so are difficult to set up. GF should allow greater flexibility in procurement regulations for LLINs and LLIHNs.

Discussion:

- Several recommendations are not unique to Viet Nam or Myanmar and can be taken forward generally, e.g. LLINs targeting/microplanning, addressing fragmentation/project approach, case investigation approach.
- Viet Nam/NIMPE (Dr. Thieu): Not all provinces have consistently applied national program guidelines on VHWs and this has resulted in discrepancies in approaches. Further engagement at high level with MOH will be needed to address this, but the national program guidelines do enable Malaria Post volunteers to provide testing & treatment.

- Myanmar/VBDC (Dr. Aung Thi): work is ongoing to improve IRS and LLIN coverage / targeting.
- Private Sector / Sanofi (F. Desbrandes): Weight-specific packaging is not the only factor affecting procurement efficiency, there is also the issue of supply chain effectiveness, especially ordering timing. Weight-specific packaging often offers better compliance and usage safety by color-coding and pictograms, however low weight packaging may be difficult to implement. **Action item: refer this issue for discussion within the PSM working group.**

b. Data quality review (T. Zin) - *see presentation*

Overall in both review countries, only minor data issues were identified. Myanmar has a good M&E system; the program is experiencing some issues of timeliness and logistical problems, and turnover/vacancies among key staff positions. Vietnam has some issues with ABER data reporting and denominator calculation, timeliness of reporting from provincial level, but systems are also generally very good.

Main recommendations include:

For Myanmar-
1. Continuing support under WHO data assistant network but while strengthening the national M&E system—integrated reporting should be the final goal;
2. Introducing a pilot project for mobile phone data reporting in areas experiencing difficulties;

For Viet Nam-
1. Providing a small incentive for reporting and monitoring at district-level (short term) but integrating RAI reporting into the national MIS (mid-long term);
2. Four steps for RAI malaria data reporting:
    a. Primary data collection; at HF and MP, and report of primary data and summary to district (monthly);
    b. District (age/sex/species dis-aggregated summary) report to the province (monthly);
    c. Provinces (age/sex/species dis-aggregated summary) report to RAI Central (CPMU) by monthly/quarterly;
    d. RAI Central CPMU (age/sex/species dis-aggregated summary) report to UNOPS (GFATM) by six-monthly;

For both countries-
1. The following activities are recommended for implementation at Health Facility Level:
    - Data quality monitoring checklist, supervision visits, and written feedback.
    - Incentivizing volunteers for reporting & supervision support.
2. For case investigation and foci investigation, it is recommended to:
    a. Speed up SOP development
    b. Conduct village-level micro-stratification
    c. Provide trainings to the Basic Health Staff (if possible to the INGO staffs)
    d. Ensure proper recording of case and foci investigation
    e. Strengthen budget and capacity at VBDC (national program) for foci response
3. More information about MMPs is required beyond existing data, e.g. origin, destination, place of last stayed and days stayed, and treatment history of fever, etc.

7) Preparing for the next regional Concept Note (2018-2020)

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

RAI has been a successful story of country collaboration from the donor perspective. Initial results on impact and outcome are very promising; there has been satisfactory budget absorption, and a good implementation rate. The Global Fund replenishment has been successful (nearly 13b USD) – there will be different funding streams within this amount. Global Fund will continue to make individual allocations per country based on disease/income; in addition to which there is an envelope of "catalytic funding" of 800m USD, in the context of which continued support for the RAI will be decided shortly. The final amounts for RAI and national allocations respectively will become known after decisions are made by the GF Board (late November); though individual country allocations may fluctuate, the overall investment for the region is anticipated to be in the same range as in the previous cycle.

For the RAI a costed one-year extension is under way (where the additional funding commitment represents the 2016 annual budget across all components/SRs, to which savings will be added); this funding is not coming from the new allocation or replenishment (but from an internal portfolio budget optimization process across countries). In March/April 2017, the concept note (Funding Request) should be submitted for the 2018-2020 period[2]. A final decision on the merging of all malaria funding streams into "RAI 2" is expected by the end of October. It is important to note that the principle of country allocation would not be affected by this; national allocations would not be affected through a potential consolidation process.

b. Debrief from the RSC retreat of 10 October (R. Garcia) – see presentation

RSC has reached a good cruising speed and we need to continue in this momentum, with continued engagement and leadership. But does not mean we should relax: it was agreed at the retreat that we need to be more proactive, more focused, and keep the sense of urgency as backbone for the RSC/RAI going forward. We also have to think about sustainability beyond 2020 to when malaria will become invisible. Improved & increased coverage of at-risk populations will be critical, but also sustainability (integration/expanded health package at community level). The RAI Inter-Country Component is recognized as a successful stimulus to countries, and part of the RAI added-value. The private sector needs to be continuously engaged (health providers, drug manufacturers – in the broad sense), and all countries should work to ensure a "zero stock out" goal. Sustained regional coordination and the joint dynamic with partners like APLMA should continue.

Next step: retreat outcomes will be summarized into a "position paper" to be endorsed by RSC in the coming weeks, to serve as high level guidance document for the Concept Note.

Discussion:

- RSC must work to ensure that the process is sufficiently consultative and that there are opportunities for all stakeholders to provide inputs, including implementing organizations, including CSOs.
- Plans/schedules of activities have tentatively been put in place; and the CN writing committee has been established (with a few appointments/nominations pending). Other working groups will be called upon for inputs into specific components (e.g. PSM working group, Operational Research…).
- It is recommended that stakeholders not currently represented on the writing committee (e.g. Development Partners) be given opportunities to engage and feed into the writing process, as feasible.
- It will also be critical to collect accurate and quality baseline data for the concept note inputs (e.g. MMP data/survey information). An analysis of the current funding landscape (external, domestic) will be needed also. Existing NSPs and costing work should serve as a good basis but additional analyses / prioritization work will be needed.

[2] Update Nov. 2016: Funding Request is due for submission on 20 March 2017. The GF has confirmed the consolidation of all malaria funding streams for the RAI countries into a single regional grant.

- For country-specific components of the CN, additional Technical Assistance may be necessary. (Note: Two writing consultants are recruited under RSC / French 5% to do the main narrative (and ICC) but country-by-country annexes, especially in case of a consolidation, will need to be prepared at country level). It is suggested that CCMs, programs and other country partners start discussing TA needs and potential sources as soon as possible.
- The Myanmar-specific Country Component may undergo a lighter process, considering that most of this work has already been done in 2017. Further guidance is expected by GF in due course.

8) Election of RSC Chair (2017-2019 term)

Chaired by Vice-Chair, Dr. Ly Sovann. See RSC "Note on election of chair".

Background: The current Chair, Prof. Arjen Dondorp, was elected in December 2013 for a three-year term. The new term will run from January 2017 until December 2019. A call for nomination of candidates to the Chair seat was made in early September 2016; Prof. Dondorp was nominated and seconded by several RSC members. No alternative candidate was proposed.

Statement of intent and COI declaration (Prof. Dondorp): The work of the RAI Regional Steering Committee is important to support achievement of the GMS region's malaria goals, and the coming months will be especially crucial. Prof. Dondorp is honored and thankful for the support expressed to him by RSC members and other partners in this role. He stated his conflict with regards to one grant Sub-recipient (SMRU), to which his home organization (MORU) is related: he will continue to recuse himself from decision-making when appropriate.

Decision/casting of votes: Prof. Arjen Dondorp is elected for another three-year term as RSC Chair (**14 votes in favor; 1 abstained**).

9) Progress update on the regional data-sharing platform (F. Binka, ERAR Hub)- *see presentation.*

The Regional Data-Sharing Platform ("Mekong Malaria Elimination Database") is under development based on DHIS2; this will be an open-source system. Many partners are already using DHIS2 so this creates greater opportunities for integration and harmonization. The system will allow for integration of data across countries and across diseases (e.g. with HIV and TB). Mapping will be available, as well as charts and customized data sets. For the moment data is being collected monthly and the Hub is hoping to evolve to weekly data. This will include a focus on cross-border area data-sharing. A case-based surveillance pilot is also being supported in Cambodia (Battambang). The next step will be to harmonize the indicator set.

As a more general update: the ERAR Hub is evolving into the Mekong Malaria Elimination-project Hub. WHO will be consulting with all partners and countries to seek feedback on the Hub's future role, its added value (if any), etc. All countries and partners are encouraged to feed into this process, by defining the highest priorities in terms of WHO support, to ensure that the regional WHO function is responsive to existing needs.

Discussion:
- WHO is particularly well placed to play a leading role at regional level on several topics. The articulation of country-level and regional-level needs should help guide donor investments going forward.
- The use of Information and Communication Technologies (ICTs) is appropriate for sharing information regional-country level. However, we have to consider the additional work burden in terms of human resources: data collection is time-consuming. While tools are relatively easy to develop, we have to ask ourselves who will do the job. Regular updates needed from lowest data entry points; but this will not happen without adequate

strengthening of capacity at these levels. This relates closely to the issue of integration of such functions into the broader health system.
- Some countries may require additional assistance to link up existing systems with the regional data platform (e.g. Thailand).
- India MOH (Dr. Dhariwal): India is also interested in DHIS2 and getting TA to build that (sharing the expertise built up in GMS). India would be grateful for additional opportunities to gain knowledge/support from GMS partners, including by joining the RSC.

Decision point: India and Bangladesh are suggested as permanent observers to the RSC.

10) Civil Society update: debrief from CSO workshop & field visit (L. Da Gama)

During the recent CSO workshop (4-5 October, Phnom Penh), a high level set of recommendations (for future funding priorities) were identified, which will soon be finalized and circulated.

The group then undertook a field visit in Cambodia's eastern provinces; the group found that many VMWs were still active, and that private sector provision of ACTs continued (though at a relatively high cost). However some channels (reporting, distribution of LLINs) have broken down due to absence of incentives/meetings. Some RDT and ACT shortages were observed. Further investigation of the field-level situation might be needed to address various supply & service provision bottlenecks.

One good practice identified was an automatic voice-messaging system established by PSK for 3 days to ensure treatment adherence. Other good practices were observed and we should share/expand on those in the future. Follow-up on treatment is problematic however, for Day-7 and onwards especially. Unofficial border crossing points may deserve additional attention compared to "official" crossing sites. Additional cross-border collaboration may be needed between Viet Nam and Cambodian partners in these regions to ensure a service continuum for border-crossers.

The group also visited a plantation site where PSK had a MMW present. Housing/living conditions of plantation workers (including migrants in large numbers) were very poor. NGO partners could be leveraged to get additional buy-in for malaria services and raise awareness among plantation / business owners.

Fragmentation of projects was also observed: the group found 11 different organizations working in malaria control. While we need effective regional coordination, NGOs at national level need to work more effectively with government partners to ensure there is no duplication/overlap in activities.

11) Any other business

Private Sector (F. Desbrandes): François Desbrandes has been nominated by the Private Sector delegation for another term by the PS delegation of the Board.

Next meeting (*updated 3 January*): the next RSC meeting is anticipated to take place on 1 and 2nd March 2017, to be hosted by the Ministry of Health in Myanmar (Nay Pyi Taw).