Minutes of the fifth meeting of the Regional Steering Committee

(RSC) for the Global Fund Regional Artemisinin-resistance Initiative (RAI)

9 April 2015

Settha Palace Hotel, Vientiane, Lao PDR

Minutes taken by: Amélie Joubert, Executive Secretary

Attendees - Appendix 1

Agenda – Appendix 2

List of acronyms – Appendix 3

H.E. Prof. Eksavang Vongvichit, Minister of Health of Lao PDR, gave an opening speech, highlighting the importance of the artemisinin resistance issue and the need to address specific cross-border challenges in the region. He expressed his appreciation to RSC for choosing Lao PDR as a venue and wished the group a successful meeting.

Prof. Arjen Dondorp (Chair) introduced the new RSC Vice-Chair for ASEAN, Professor Trinh Quan Huan from Viet Nam and welcomed new RSC members. The following people have joined the RSC as voting members since our last meeting: Eric Fleutelot (France / Development Partners), Dr. Ly Sovann (Cambodia / CCM) and Dr. Benedict David (DFAT / Development Partners).

The minutes of the last RSC meeting (30 September 2014, Nay Pyi Taw) were endorsed.

Conflict of interest: Mr. Promboon Panitchpakdi (civil society representative) announced that he would not participate in discussions relating to the ICC because his organization applied for funding. All members submitted their conflict of interest forms, which are available upon request.

1) Update on RAI Country Components

a) Launch of new RAI website (www.raifund.org)

Dr. Attila Molnar (Programme Director, UNOPS) introduced the new RAI website (recently launched). Among other features, the website allows funding partners and implementers to show project-level detail of activities on a regional map. Currently data is available on the website for all donor-funded activities in Myanmar (USAID/PMI, Global Fund, 3MDG…). Other countries and partners are encouraged to share their data to complement the website information.

Discussion:

- Information on the RAI website is not surveillance data but grant-related (project) data, i.e. donor-funded activities only. Countries retain the possibility to decide what level of detail they wish to show.
- The RAI website is an initiative from UNOPS as regional PR, implemented within the limitations of its current capacity/resources, and aims to serve information-sharing among RAI implementers and other interested partners in the region. It does not seek to substitute broader data-sharing efforts in the region for which additional resources and an expanded mandate (beyond RAI) would be needed.
- It was suggested that usage of the website be tracked to provide an indication of how many people would make use of such information.
- In parallel, it would be important for partners/implementers to advocate for its use to ensure the best use of this important information & communication tool. Lessons learnt from the tool could be used for broader co-ordination efforts.

b) Progress update on Country Components / Reprogramming (UNOPS)

Dr. Attila Molnar (UNOPS) gave a presentation on progress under the RAI Country Components as well as on the reprogramming process which was just completed (*presentation available*). Despite some start-up delays in 2014, acceleration and catch-up in second half of 2014 is promising. During the reprogramming, UNOPS and co-PRs/SRs sought to ensure by working with partners that there was complementarity and no overlap. Savings (14.7m USD across five countries) were reallocated for the remaining grant period (until end 2016) in a strategic fashion and according to guidance from RSC on Mobile and Migrant Populations (MMPs), military, and the broader GMS elimination agenda. A fine-tuning exercise may be needed in early 2016 based on the GMS elimination national plans, but it should not be a major exercise. Focus in 2015 should be on implementation and catching up on 2014 delays.

Discussion:

- The GMS elimination strategy is moving forward and countries are aware of its key content – there is no need to wait for the draft to be completed as such before implementation can move ahead (WHO/ERAR).
- The use of mosquito repellents was observed in some areas during field visits (Civil Society). These are not being funded under RAI. While there is a limited evidence-base to recommend the widespread use of individual repellents, they may serve as an appropriate complementary vector control measure (with LLINs) for some specific groups (e.g. rubber tappers or other groups working outdoors at night-time). Further technical guidance may be needed.
- Non-compliance of ACTs is critical factor in drug resistance. Ensuring and measuring compliance of doctors/clinics with national (first-line) treatment guidelines is a challenge. Under RAI, Directly Observed Treatment (DOT) is being implemented but there are challenges for MMPs which we can expect will continue and will be reflected in the underperformance of PF indicators. UNOPS is accumulating experience in this area to inform the technical discussion but additional guidance will be needed in order to appropriately reach this target group: WHO/ERAR is leading discussions in this area.

- The RAI Performance Framework indicator on "#/% of cases tested" (currently reaching 100%) is somewhat misleading: we can likely anticipate that all suspects will be tested (and as such, 100% of the target will systematically be met). It is suggested that additional measures such as blood examination rate, and slide/RDT positivity rates be considered to complement this indicator, as feasible.

c) Progress Update on Country Components: presentations from national programs

The five RAI national programs (Lao PDR (Dr. Rattanaxay Phetsouvanh), Viet Nam (Dr. Nguyen Quang Thieu), Cambodia (Dr. Siv Sovannaroth), Thailand (Dr. Sanchai Chasombat) and Myanmar (Dr. Aung Thi)) gave a presentation on their implementation status and challenges (*presentations available)*.

Several common issues/observations were noted as follows:
- Several areas in the region saw an increase in cases in 2014 (Champasack (Lao PDR), Pursat (Cambodia), Gia Lai (Viet Nam), Ubon Ratchatani (Thailand)). It is at this moment not clear if this is linked to increased treatment failure rates with ACTs.
- Countries often cited challenges to implement DOT, follow-up and ensure treatment adherence, particularly among MMPs, who are difficult to access and for whom little data is available.
- Several countries have experienced delays in receiving disbursements and signing sub-grantee agreements, which has delayed implementation. The Global Fund and PR UNOPS are asked to accelerate the final steps of the reprogramming/signing process.
- Countries also often struggle with high turnover of staff and difficulties to recruit qualified personnel to support program implementation.
- LLIN distribution was delayed in several countries but it is anticipated that during the first half of 2015 there will be a catching up on this activity.
- Countries are facing issues with changes in drug policy / treatment regimens, and need support for a common drug policy. Is there a role for RSC to support this?
- Lack of collaboration/coordination with and between stakeholders (including donors) continues to pose a challenge for national programs.
- Artemisinin monotherapies are still manufactured and exported by some countries; however, work is being done to halt this.

Discussion:
- Tailoring of lessons per country is important, i.e. the same does not work in Cambodia, Thailand and Lao PDR for example.
- There is a need for TES data to be closely followed and implications for implementation to be available on a timely basis (e.g. updating of Tier map).
- It is not clear to what extent the observed increase in falciparum malaria in some provinces relate to drug resistance but it is important to monitor effectiveness of drugs in these areas particularly. Flexibility to change treatment regimens is necessary and this may be a topic for further inputs from technical partners. Any increase of resistance is not a measure of the failure of elimination efforts (i.e. we can expect some level of resistance to subsist with elimination efforts, since the last remaining parasites will be the most resistant).

- There is a need for flexibility to allocate funding in case of outbreaks. The Global Fund can support special requests for outbreaks on short notice within the current RAI funding , if a brief explanatory note is provided (to be submitted by co-PRs/SRs through PR/UNOPS). A more detailed modus operandi or outbreak response mechanism may be needed, to be discussed with Global Fund, ERAR and UNOPS. ADB also has emergency funds available and it could be explored how to use these on lending basis.
- Further technical guidance on DOT, follow-up and treatment adherence is needed. How can this best be ensured and measured? ERAR would be best placed to take the lead on this.
- A comprehensive analysis (which is not stakeholder-dependent) of gaps and needs for future reprogramming of funds (and financing more generally) may be needed. Could WHO/ERAR take the lead on this?
- There is a need for the RSC to discuss how to support integration of malaria programs/activities into the broader health systems, also related to the fact that the number of malaria patients will decrease in the elimination phase of the disease.
- Strategies for elimination need to be supported by appropriate social responses also, which would serve to bridge the gap in reaching MMPs and other hard-to-reach communities.
- Collaboration with China: WHO/ERAR convened a cross-border meeting between Yunnan province and Myanmar in December 2014. This led to the development of a cross-border collaboration plan which remains unfunded – RAI is not currently considered as an adequate source of funding for this plan (Global Fund). It is suggested that domestic sources of funding (in China) be explored.
- RSC needs to play a greater role in resource mobilization. There is high political commitment from regional leaders and stakeholders generally, but it needs to be translated in adequate levels of financing for malaria elimination in the region – RAI and Global Fund alone cannot be expected to support this. Sustainability mechanisms also need to be discussed, especially for hard-to-reach communities and non-government groups which are being supported through RAI. It is suggested to plan for additional time at the next RSC meeting to discuss these issues.

2) RAI Independent Review (Terms of Reference)

Prof. Arjen Dondorp (Chair) presented the draft TORs for the independent review of the RAI, planned for September/October 2015. This work follows a consultancy recruited for RSC through the French 5% initiative in March 2015 (*presentation available*).

A few key points on the review were highlighted as follows:
- The independent review aims to provide an assessment of the following three areas: progress made towards the strategic goals of the RAI (i.e. "*Contribute to the elimination of falciparum malaria in the Greater Mekong Sub region, and prevent the emergence or spread of artemisinin resistance to new areas"),* success of implementation of projects funded under RAI (and identify bottlenecks/issues to be addressed in the remaining grant period), RAI governance structure and effectiveness of RSC in its oversight role.
- It is anticipated that three consultants will be needed for 6 to 8 weeks. The review will be based on desk review of documents, key informant interviews as well as field visits.

- It is proposed to constitute a RSC reference group, the role of which would be to oversee the review process, be easily accessible and provide feedback to the consultants as needed. The RSC reference group will select and recruit the consultants through the ERAR Hub where the team will be embedded, to reduce duplication of efforts (*See minutes of 3rd RAI RSC meeting*, *28 March 2014*).

Discussion:
- "Value-for-money" analysis should be considered as one of the review areas, as well as an assessment of whether the RAI RSC could be used as a mechanism to oversee funding from other funding sources in the region. However, the review is not meant to replicate the recent report (Jim Tulloch) on the organizational structure of the malaria elimination agenda.
- The review consultants will need to consider the changing strategic/policy context in the region. Financial sustainability of the grant should also be examined– if possible the team could include health financing expertise.
- It will be important not to duplicate efforts of the LFA and PR in reviewing grant progress/results. We may wish to be cautious in including a review of impact indicators which goes beyond RAI: there will likely be issues of attribution. However a systematic evaluation of impact is needed in the region if we want to monitor progress of the elimination effort, and this is proposed as a starting point. Data for impact indicators in the first year would be considered only as baseline values.
- The evaluation should not only take into account the budget allocation for the different activities, but also the actual scale of implementation that was achieved during the evaluation period.
- The specific value-added of RAI (especially ICC) as an investment should be considered as part of the review. A specific assessment of what is being done for MMPs and affected communities should also be included.
- The review could also consider whether the grant indicators for RAI are also appropriate for measuring progress.
- The review could assess how effectively the RAI mechanism undertakes lesson learning.
- We may wish to consider the appropriate timing of the next RSC meeting in relation to the review exercise: would it be possible to have review outcomes by the time of the next meeting?

Decision point: The TOR draft will be fine-tuned based on the inputs from the RSC through the working group established at a previous RSC meeting, composed of the RSC Chair, Walter Kazadi (WHO/ERAR) and Mark Fukuda (PMI/USAID). A final version will be circulated to RSC for comments/no-objection by end of April.

3) RAI support for ERAR pharmaceutical activities

Dr. Walter Kazadi (ERAR Hub Coordinator) presented the detailed request for funding under the RAI Inter-Country Component (ICC), which represents approximately 400k USD. This request is part of a larger 2-year workplan of activities under ERAR (3m USD) and which has yet to be funded.

With this smaller contribution ERAR is proposing to prioritize a few activities from the original workplan, subject to fine-tuning as needed following feedback from RSC and Global Fund. ERAR Hub has also been

supporting countries to include the pharmaceutical component in the country components (reprogramming) as well, and is working to ensure that there is no overlap between the activities proposed under ICC and in the country components. ERAR Hub has also reached out to other organizations working in these areas (e.g. PSI, USP Pharmacopeia, ADB/RMTF) to get a sense of where gaps may remain.

Discussion:
- The amount available for ERAR under ICC is based on the prioritization of ICC activities voted in November 2014. It was acknowledged at the time (and also in the ICC Concept Note) that the full amount needed for ERAR could not be funded through RAI.
- During the negotiation process, it will be important to clarify the specific deliverables for the activities funded under ERAR and ensure that specific outputs can be tracked during implementation.

Decision point: A revised version of the ERAR workplan will be circulated shortly and RSC members are asked to submit their final comments, if any, within one week. RSC comments will be shared with UNOPS and the Global Fund, to be taken forward / addressed during the negotiation phase.

4) RAI Inter-country component: Round 1 SRs (Community Partners International, Medical Action Myanmar and Shoklo Malaria Research Unit)

Prof. Arjen Dondorp (Chair) presented the current allocation of funding under the Inter-Country Component, based on amounts committed and earmarked to date and based on the priorities selected for funding in November 2014 by the RSC (*presentation available*). An envelope of 4.45m USD has been earmarked for the extension of the Round 1 SRs (based on 1.5y extrapolation of current budgets) and an envelope of 4.6m USD is available for allocation to new SRs (Round 2).

Dr. Attila Molnar (UNOPS) gave an update of progress under the three Sub-Recipients selected in March 2014 for implementation of activities under the ICC at the Thai/Myanmar border (in Myanmar) – *presentation available*.

Agreements were initially signed for one year (July 2014 – June 2015), and implementation of activities actually started in September 2014, with significant catching up by end of March 2015. Budget absorption is 40%, but quickly catching up. Community engagement is showing to be essential. TMT is being done only in places where there are malaria posts (in addition to being identified as hotspots for malaria transmission). Proportion of the population qPCR positive for malaria is very high in some areas (MAM). CPI has been delayed, due to high reliance on local partners. There have been procurement delays owing to slow administrative/importation clearance procedures. A first round of TMT was conducted by SMRU.

Community engagement/convincing people to undergo TMT has been challenging in some places, e.g. where they had been targeted for other MDA or vaccination campaigns. Mapping has taken longer than expected, and with hard-to-access areas, implementers are experiencing logistical challenges also.

Implementers have advised in favour of maintaining a strong network of Malaria Posts, and in the future to broaden the scope of the village health workers to also treat other illnesses.

Within hotspot villages (defined with 40% threshold), a minimum of 80% of the population is targeted for TMT. No adverse episodes (side effects) were reported so far. A follow-up qPCR will be done after third round of TMT is completed. Interpretation of results will only be possible afterwards, i.e. March 2016 at the earliest.

It was highlighted that timelines are very tight to complete negotiations for both "Round 1" and "Round 2" SRs under the ICC: at best these grants can be extended/signed by 1 July 2015 (in less than 3 months), leaving 1.5 year for implementation.

Discussion:
- Collaboration and communication between these ICC SRs and the national malaria control program of Myanmar should be strengthened, data-sharing in particular. There are uncertainties for implementation in these areas due to fluctuating political context and tensions.
- In general, ICC implementers are asked to share data on a near-real time basis with NMCPs, including prevalence data which may be collected through these projects.
- A new MOU with the government of Myanmar may be required and country RSC members may be able to play a role in supporting this process.
- Indicator data for the TMT component could be more detailed to show coverage of TMT per village (i.e. proportion of population tested by qPCR). It is acknowledged that there is no official threshold to define "hotspots". This definition is highly dependent on the method for detection used, and this will need further discussion (currently 40%).
- It is too early to draw conclusions on the TMT activities and their overall impact on the elimination of P. falciparum. Completion of the current projects will be crucial to provide this information. Further results will be needed before a recommendation for further scale-up of the TMT activities can be made.
- The current pilots will serve to inform future policy. We are at the mid-point in the process and unless there are significant concerns based on the evidence at hand, there is no reason to halt the process mid-way.
- A detailed analysis of implementation challenges (e.g. community engagement, ethnic issues) could be provided by the SRs to inform implementation of a subsequent phase or fine-tuning of the strategy. Several issues may need to be further clarified: cut-off point (hotspots), appropriate timing/season. The independent review could also examine these issues.
- Discussions should take place to examine potential expansion of these activities to the Thai side of the border.
- All ICC activities remain subject to the approval of the relevant national authorities and it is recommended that RSC ensure endorsement by CCMs as well.

Decision point:
An extension of grants for the three current ICC Sub-Recipients is agreed (for an additional 1.5 year and within a total available ceiling of 4.45m USD), subject to the following conditions:
- All ICC SRs should submit project data on a timely basis to the NMCP;

- TMT activities can be continued and completed in accordance with the initially approved plans, but no expansion of these activities can be approved without further review by the RSC.

Action point:

- Prevalence data from TMT studies in Myanmar is to be shared with the national malaria programme and incorporated within the malaria prevalence survey, which is being funded by PMI and the 3MDG Fund.

5) RAI Inter-country component: Round 2 proposals

Dr. Walter Kazadi (ERAR Hub Coordinator and chair of ICC review panel) presented the panel recommendations for discussion by the RSC. The panel consisted of representatives from civil society, private sector, WHO and development partners. A total of 11 proposals were screened for eligibility and reviewed. Targeted implementation areas (in accordance with Call for Proposals TORs) included: Laos/Thailand/Cambodia border areas, Cambodia/Viet Nam border areas, Myanmar/India border areas. Terms of Reference of the Call for proposals are available upon request.

Reviewer guiding principles focused on the extent to which the proposals were in line with the ICC Terms of Reference, whether applicants had adequate organizational capacity to swiftly start implementation of activities in the proposed target areas, malaria-specific expertise and experience, proposed engagement with communities, collaboration with national program partners, and cost-efficiency analysis of the proposed budget.

Some proposals were well scored but not deemed equally strong in all of the individual country/activity components. In addition to the scoring process, the panel also needed to consider complementarities in geographical coverage between the proposals, with a view to avoiding any significant coverage gaps or duplication. Proposal adjustments recommended by the panel reflect these discussions (see below).

Although national programs were invited to provide feedback during the review process, there was limited time to discuss implications of this feedback on the panel recommendations. National program colleagues were invited to provide their feedback during the meeting.

Discussion:

- It was noted that ICC applicants had not systematically consulted with national programs during the development of proposals. This will need to be addressed during the negotiation phase by applicant organizations in collaboration with the Global Fund and UNOPS. In some cases, updated MOUs with MOH will be needed.
- Where possible, it is encouraged to ensure collaboration and coordination between funding recipients on both sides of the border areas, particularly in southern Lao PDR (Champasack, Attapeu) with Ubon Ratchathani (Thailand).
- It is also suggested that implementers work closely with national programs on both sides to harmonize activities with the national funding budget.

- Collaboration should also be sought by non-State Ethnic and/ or Autonomous Health Authorities as appropriate. - The implementation of TMT in Myanmar under the MAM proposal should be subject to the review of results (as discussed in previous agenda item). It is noted that this represents a minor portion of this proposal as it is not the main activity.
- There may be duplication of some activities with activities funded under the Country Components and this should be carefully examined during the negotiation phase. Available savings under the ICC and country components could also be considered as sources of funding for new ICC activities.

Decision points:
The following proposals were approved in accordance with the panel recommendations, subject to the specific conditions outlined below:

1) Malaria Consortium-led multi-border area proposal is approved, subject the following conditions to be addressed during the negotiation phase:

- Proposed sub-component for Lao PDR, including activities proposed for implementation by French Red Cross, should be removed;
- Proposed sub-component for Myanmar, including activities proposed for implementation by Myanmar Medical Association (MMA), should be removed;
- Proposed program management budget of Malaria Consortium should be adjusted downwards to reflect the above changes and further efficiencies should be identified to achieve no less than a 40% reduction of the same;
- Indicative amount: 1.2 to 1.3 million USD

  Note: remaining implementation area for the above includes three provinces of Cambodia (Stung Treng, Preah Vihear, Rattanakiri) and Ubon Ratchatani province in Thailand.

2) Medical Action Myanmar (MAM) proposal #2 to conduct activities at the Myanmar border with India (North and West Sagaing) is approved, subject the following conditions to be addressed during the negotiation phase:

- Proposed program management costs should be reviewed critically and reduced where possible;
- The implementation of the TMT component will be conditional upon further review by RSC of TMT data from Round 1;
- Indicative amount: 1.5 to 2 million USD

3) Cambodia Health Partners Consortium (CHPC) proposal #1 to implement activities at the Cambodia border with Lao PDR (Stung Treng, Preah Vihear) is approved, subject to the following conditions to be addressed during the negotiation phase:

- Proposed activities in Cambodia should be reviewed critically for potential duplication with activities in approved Malaria Consortium proposal- where redundant, proposed activities should not be funded;

- Proposed activities to be implemented in Cambodia will be submitted to the Cambodia national program (CNM) for review and confirmation within 1 month that activities can be implemented in Cambodia;
- Indicative amount: 0.3 to 0.6m USD

4) Cambodia Health Partners Consortium (CHPC) proposal #2 to implement activities at the Cambodia/Viet Nam border (in western provinces of Viet Nam) is approved conditionally, subject to the review and confirmation by NIMPE, within one month, that activities can be implemented on the Viet Nam side (indicative amount: 0.7 to 0.8m USD)

5) Based on the above, it is estimated that approximately 0.5m to 1m USD will remain available for funding under ICC. The RSC recommends awarding the remaining amount to fund a portion of the Lao MOH proposal. In accordance with the panel recommendations, PR-UNOPS and the Global Fund will seek clarifications from the applicant (and implementing partners) and will address, during the negotiation phase, the following concerns:

- Some of the activities proposed were deemed more appropriate for funding through the Country Component and should be removed (e.g. drug regulation enforcement);
- The specific cross-border component of the proposal, keeping in mind the ICC TORs, should be prioritized and should complement, rather than substitute, Country Component funding;
- The panel also encourages Lao-based implementers to collaborate with other partners funded under this ICC round to seek complementarities in approaches and to coordinate activities, where possible and as appropriate.

Details of activities proposed by the above implementers are available upon request. Indicative amounts are based on the assumption that grant agreements will be signed for 1.5 year (July 2015 – December 2016).

The panel report included additional general recommendations as follows:

- As a general pre-requisite to signing any funding agreement, the legal basis for operations (e.g. MOU, registration in country) should be in place. If not already the case and subject to the support of relevant government authorities (as well as non-state authorities, as appropriate), this needs to be secured within an acceptable timeframe after the RSC approval of the proposal.
- As a general point, it was also agreed that during negotiations, PR-UNOPS and the Global Fund should seek to achieve the most cost-efficient allocation of resources across activities and between proposed funding recipients/implementers, as necessary (e.g. reducing program management costs).
- Panel also recommends that implementing partners in Myanmar, in collaboration with Myanmar national authorities, explore possible cross-border collaboration with Indian health authorities as appropriate to strengthen the response to artemisinin resistance along the shared Myanmar/India border.

6) Civil Society engagement (update from Louis Da Gama, Promboon Panitchpakdi)

In December 2014, a meeting of civil society organizations from the region took place in Bangkok, supported by RBM and the RSC Secretariat, where all CSO representatives from CCMs of the five RAI countries were invited (30-40 attendees). A Lao PDR specific consultation took place in Vientiane on 8 April, the day before this meeting.

The purpose of these meetings is for civil society organizations in the region to share lessons learned, identify common issues to be addressed, and to create platform for feedback. At the December meeting, there was an agreement to develop a regional civil society platform for malaria, with a focus on transparency, good governance & accountability. This should also serve to strengthen links between CSOs in national CCMs and provide a platform for feedback to the RSC. A funding proposal is under development which will be submitted shortly to the French 5% initiative.

Feedback from visit to Thai/Myanmar border (American Refugee Committee project sites):
Malaria posts visited could only do testing where government staff was also there (i.e. 4 of 10 posts). The average testing rate was 4-5 people per day. Other posts provided BCC only, and referrals to the nearest clinic (in some cases, 25km away), without any possibility to follow up. There had been delays in LLIN procurement and some issues with LLIN distribution were also observed (over allocation of nets in some places, and low allocation elsewhere). Geographical mapping of MMPs is used as basis for distribution but the data appears to be outdated by the time distribution occurs. There may also be issues of double-counting of data through different donors.

Discussion:
- Increasing the voice of civil society for malaria is important. NGOs have a social capital under HIV and this could easily be extended to malaria.
- Discussion on increasing access to health services needs to include civil society. Sustainability for these NGOs beyond RAI should also be considered as a key issue.
- While mechanisms for collaboration/coordination with NGOs exist (e.g. International Health Partnership (IHP+) platform), there are sometimes challenges to coordinating effectively. There is also a need to ensure that NGO work is incorporated as part of a broader national plan.

7) Regional data sharing

RSC Chair provided a brief update on developments in this area. Following discussions at the last RSC meeting (Sept. 2014), a provisional envelope of 500k USD was earmarked under the ICC for the development of a regional data-sharing platform. BIOPHICS (through BVBD) had submitted a proposal for funding and it was agreed at the September 2014 meeting that the proposal needed further fine-tuning and discussion with stakeholders (specifically WHO/ERAR and ADB).

Considering that ERAR Hub was developing plans for a similar platform there was a consensus that we should avoid duplication of efforts – ERAR and BIOPHICS were invited to discuss collaboration based on

their complementary roles (ongoing). BIOPHICS would play primarily a technical role (providing the IT business solution, training users, etc.) while ERAR Hub has a broader mandate to coordinate data sharing efforts and host the data on behalf of the national programs, who retain ownership in the platform. It was also suggested to contact ADB which have been interested in this particular area.

8) Updates from partners

ERAR Hub (Dr. Walter Kazadi): finalization of regional elimination strategy is ongoing, and will soon be shared for broad online consultation. By next week, the final version will be submitted to MPAC, for approval at next World Health Assembly (May 2015).

APMEN (Dr. Maxine Whittaker): APMEN was founded 6 years ago with funding from DFAT/Gates Foundation, and is now expanding its funding base. At the 7th APMEN meeting in Hoi An, the statement for a Malaria free Asia Pacific by 2030 was endorsed. The work of APMEN focuses on advocacy for malaria elimination, aiming for increased political commitment & domestic funding. APMEN also seeks to support the translation of business cases into tools which can be used in country including at sub-national level (province, district). P.Vivax will be kept on the malaria agenda. APMEN is also working with partners on drug resistance advocacy and is co-financing malaria elimination trainings with WHO (capacity building), and training leaders on malaria elimination. In addition to several technical working groups, APMEN aims to strengthen collaboration with other agencies (including non-health), based on the greater need for inter-sectoral approaches, and greater integration of malaria services.

ADB (Dr. Susann Roth- *briefing note available*): The Regional Malaria and Other Communicable Disease Threats Trust Fund (RMTF), established in 2013, has been developed to scale-up responses to key challenges in combatting malaria and other communicable diseases in Asia and the Pacific. The main strategic areas of the RMTF are: strengthening regional leadership on Malaria and other CD threats (e.g. through APLMA), leveraging additional financial resources for malaria through the development of a regional financing platform for malaria/other CDs, increasing the availability and use of quality-assured commodities (building on the recommendations of the APLMA quality malaria medicine and technology task force), increased availability of quality information and improving the regional evidence base for malaria elimination (through data collection), reduce malaria and other CD impacts of large-scale development projects.

APLMA (Dr. Ben Rolfe, *presentation available*): Following the declaration of the East Asia Summit 2014, APLMA is supporting the development of a roadmap for achievement of elimination by 2030 in the Asia Pacific and to implement the recommendations of the APLMA Task forces (including Access to Quality Medicines task force and Regional Financing for Malaria Task Force), to be endorsed at the next East Asia Summit (22 November 2015). Work in 2016 will continue to focus on the following areas: APLMA scorecard (accountability framework for regional heads of government), financing mechanisms/platforms, policy processes to support regional public goods in quality and access to commodities, improving business processes, accountability and governance.

Gates Foundation (Dr. Bruno Moonen): GMS is one of three priority regions for the Gates Foundation. In GMS, they have invested primarily in some operational research and the ERAR Hub, and are moving into investing into implementation as well. They are supporting the roll-out of managerial/operational support to MOHs in the region through the Clinton Health Access Initiative (CHAI) for 10 countries, based on requests for assistance formulated by countries. Smaller projects in the region include work with MORU and with UCSF (in Viet Nam), in Myanmar with University of Maryland, AFRIMS group in Thailand focus on armed forces, PSI work in the plantation sector and PSI's artemisinin monotherapy replacement project. In particular, a scale-up of ACT Watch surveys in the region is planned and which will be relevant to the RAI component on elimination of monotherapies. They will also be presenting evidence for review to the MDA reference/review group of WHO (April meeting), with a hope that these discussions can influence policies for elimination more broadly. Gates Foundation is also supporting the APLMA Secretariat.

9) Any other business, next meeting

In continuation with discussions from the last meeting, a briefing note on activities targeting the military under the RAI Country Components was circulated for review/endorsement by RSC members (developed by Dr. Mark Fukuda, USAID/PMI). No objections were stated to the proposed list of activities (*paper available*).

In addition, a summary of activities currently funded under the RAI Country Components for Migrants and Mobile Populations (MMPs) was developed by ERAR Hub (Dr. Deyer Gopinath), for RSC information (*paper available*). Further work to develop a regional strategy for MMPs is still ongoing under the ERAR Hub.

Note/reminder: All country component activities should be endorsed by national CCMs.

Next meeting:
- Viet Nam has been asked whether they could host the next RSC meeting
- Timeline could be adjusted for the independent review (e.g. late October instead of early October?)
- If possible, harmonization of meeting plans with other partners (e.g. APLMA, WHO ERAR) could be explored to reduce the need for travel and ensure complementarity of agenda items.