

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

19 November 2015

Sofitel Plaza Hotel, Hanoi, Viet Nam

Minutes taken by: Amélie Joubert, Executive Secretary

Attendees - Appendix 1

Agenda – Appendix 2

List of acronyms – Appendix 3

Outcomes of RSC discussions on RAI review – Appendix 4

Prof. Tran Dac Phu, Director of General Department of Preventive Medicine, gave opening remarks on behalf of the Viet Nam Ministry of Health, noting the significant results achieved in the Greater Mekong Sub-region against malaria. With the adoption of the 2030 elimination goal, supported by Viet Nam's senior leadership, the RSC meeting constitutes an important opportunity to further mobilize support for malaria elimination and all partners are urged to work towards finding solutions to achieve this goal.

Prof. Arjen Dondorp (Chair) noted the recent passing of Dr. Alan Magill, Director of the Malaria Program at the Bill and Melinda Gates Foundation and respected member of the RSC. He was a strong supporter of the joint efforts to make the RAI a success and his invaluable contributions will be missed.

Introduction of special guests: H.E. Ieng Mouly, Senior Minister in charge of Special Mission, Chairman of Cambodia National AIDS Authority, Chair of Country Coordinating Committee (CCC) for Cambodia; Dr. Nafsiah Mboi, APLMA Envoy, former Minister of Health of Indonesia and former Chair of Global Fund Board; and Mark Edington, Head of Grant Management Division of The Global Fund.

Introduction of new RSC voting members: Dr. Thandar Lwin, Director, Disease Control, Dept. of Public Health (Myanmar CCM/MHSCC); Bruno Moonen, Deputy Director for Malaria at the Gates Foundation; Gerard Servais, Senior Health Specialist, ADB; and Jay Bagaria, Health Adviser, DFID UK.

1) RSC administrative decision points

The minutes of the last RSC meeting (9 April 2015, Vientiane) were endorsed.

Conflict of Interest declarations / recusals:

- Prof. Arjen Dondorp (RSC Chair): SMRU is a RAI SR and is the daughter organization of MORU;
- Promboon Panitchpakdi (Civil society representative): Raks Thai Foundation is a RAI SR in Thailand Country Component and RAI ICC.

The draft Conflict of Interest policy (circulated on 4 November) was adopted without comments.

The 2-year Secretariat budget request (circulated on 5 November) was endorsed without comments. This funding request covers the period running from 1 March 2016 to 28 February 2018.

2) RAI Progress Update January-June 2015

a) Update from the PR UNOPS team (*A. Molnar, presentation available*)

Under the Country Components, the overall indicator rating was 70% (B1), with individual country achievements as follows: Cambodia 40%, Myanmar 66%, Laos 79%, Thailand 80%, Viet Nam 78%. Expenditure rates for the five RAI countries varied between 57 % and 79% as of June 2015 only; catch-up in implementation is now expected with increased absorption going forward. Though the LLINs procured this year were polyester nets (due to chance), guidance continues to be needed to address the issue of preferred LLIN materials.

Under the RAI ICC, achievements to date include the establishment of 800 malaria posts, and the completion of a 3rd round of TMT with a high degree of compliance (83-85%), supported by intensive engagement at community level. The final results of the TMT pilots are expected by end of 2016. Budget absorption was high under ICC (84%) despite start-up delays (e.g. ethical approvals). Nearly all funds under the RAI ICC have now been allocated; implementation for the 2d round of approved proposals is expected to start by end of 2015. Two proposals are still pending approvals at national level (HPA-NIMPE in Viet Nam, and MAM in Myanmar).

Discussion:

- Concern was raised on the current rate of expenditures under the RAI (overall 65%) and whether absorption in the remaining grant period will be sufficient.
- The Global Fund and WHO are reviewing the issue of materials for LLINs. This is more an issue of usage rather than user preferences; if sufficient evidence of differential usage is made available, GF policy may be re-examined. Through the Pooled Procurement Mechanism of the Global Fund, some interim procurement of polyester nets may be possible.

Action item: PR UNOPS will provide the village-level breakdown of compliance data for the TMT activities in Myanmar (ICC).

b) Country updates

Viet Nam (Dr. Tran Thanh Duong, NIMPE) – the reduction in cases has been significant to date, but drug resistant malaria has been documented in many places (central/southern VN). RAI has allowed introduction of innovative activities especially to address key populations (e.g. MMPs, under ICC). Some inconsistencies in the guidance between the RAI grant and the NFM were noted; Viet Nam recommends having a single stream of funding from the Global Fund. A small scale study on LLINs was conducted with WHO support, in which a preference for polyester was found; a larger-scale study is in preparation.

Myanmar (Dr. Thandar Lwin, DOPH) – Myanmar has successfully brought down malaria morbidity and mortality but the country still had a 200,000 caseload in 2014. With increasing engagement at regional level, Myanmar is hopeful that domestic funding for malaria will increase in the coming years. Myanmar is preparing for the next 5-year elimination plan, including a micro-stratification analysis and the revision

of national treatment guidelines. Under the RAI there are indicators which are challenging (e.g. DOT, foci investigation), and the need to advocate for more awareness on innovative activities is acknowledged. VHWs, as a central component of service delivery, and surveillance will be critical (a national database is under development). The ICC Round 2 proposal is still pending approval at DOPH but this is being followed up.

Thailand (Dr. Prayuth Sudathip, BVBD) – Overall, malaria cases in Thailand significantly declined (36% reduction from Oct 2014-Sep 2015), but a 5% increase of reported cases among m1 migrants was observed. Population in endemic areas decreased from 1.68 million to 1.3 million. There is an increase of malaria cases along the Thai-Cambodian border especially in Tier 1 (Srisaket and Surin provinces), mainly falciparum. With the discontinuation of GF national allocations after 2016, a transition plan is under development as well as the new national strategic plan. Under the RAI CC most activities have been implemented except bednet distribution (due to delayed procurement).

Cambodia (Dr. Chea Huch, CNM) – Cambodia experienced a solid decline in cases in 2011-2014 but since then some delays in GF funding as well as ADB support have caused a slowing of progress. The first half of 2015 was showing increases in cases of 25% compared to first half of 2014. Based on CNM investigations, population movements are considered the main driver behind the increases. The delayed implementation of RAI is acknowledged; CNM received its first disbursement in January 2015 and subsequently had an agreement gap during the reprogramming negotiations (April-June 2015). However Cambodia was able to use SSF (Single Stream grant) funding to cover activities in RAI target areas.

China (Dr. Xia Zhigui, NIPD) – Indigenous cases represent a small portion of 3,000 cases yearly, with most cases being imported (99%). China is strengthening inter-country cooperation efforts to respond to malaria situation, and now focusing on prevention of re-introduction. Local transmission is still occurring in the China/Myanmar border area; however GF support to HPA activities on the Myanmar side will be interrupted, which is a concern. China requests that this area be considered for funding support as part of RAI ICC program scope.

Laos (Dr. Rattanaxay Phetsouvanh, MOH DCDC) – CMPE was able to bring down incidence in 2015 compared to 2014 (first 7 months of the year); most affected groups are MMPs for which there is still lack of adequate strategies. The increase of P.Vivax cases is source of concern and ongoing studies show issues with RDT sensitivity to Vivax, with high rates of P. Vivax being found through PCR. The forecasting of health products is ongoing with the support of partners (including GF & PMI which is piloting grassroots level surveillance). The top priority of Lao PDR is to flatten the malaria epidemiology in the south. Lao PDR supports the commitment by East Asia leaders to achieve elimination in 2030: "we have to run, but we have to be supported by our partners".

Discussion:

- Where needed in case of outbreaks, the RSC could work in coordination with national CCMs to allow re-allocation of funds under the Country Components of the RAI.

3) RAI independent review report

Background (Chair): The RSC agreed at an early stage that independent oversight of RAI activities would be needed to guide strategic decision making. At the third RSC meeting it was agreed to appoint an independent monitoring group on a consultancy basis – the first review would be done in 2015, and a second review would be conducted at the end of the grant (2016). This exercise covers three main dimensions: implementation of RAI, governance of RAI, and an overview of the epidemiological trends and resistance situation. The review team (3 consultants) visited all 5 RAI countries and met with PR, Co-PRs, SRs and SSRs of RAI as well as CCM members and other partners. The mission also included a site visit in each of the RAI countries.

a) Presentation of draft review report (*J. Tulloch, presentation available*)

Though the review was not intended as an in-depth evaluation of national malaria control programs in the region, it is impossible to separate RAI from the broader context of the NMCPs and other GF malaria grants, which explains that the review report inevitably contains observations which go beyond the remit of the RSC/RAI.

Giving an overall assessment of progress/impact was challenging at this early stage (1.5 year into the grant). It is also acknowledged that a grant of this magnitude would have undergone inevitable start-up delays due to its size and complexity. Rather than examine whether the RAI was funding positive contributions to the malaria elimination effort (which it undoubtedly is), the review team focused on whether programs/partners funded by RAI were doing well enough overall, and at a rate which is acceptable in relation to the RAI's strategic objectives (and which are relevant to the region beyond RAI).

Key conclusions of the report included:

- A lot has been achieved by/through RAI in a short period of time, including the introduction of several new interventions which would be worth scaling up rapidly (e.g. malaria posts, border screening).
- The RSC has generally worked well as a multi-stakeholder, consensus-building body.
- The use of a single PR for the region is considered a good option for now and possibly for the future as well. The advantages of this arrangement include opportunities for transfer of knowledge and increased coherence in programming. The PR also has a potential role to go beyond GF indicator tracking given its M&E experience/competence.
- Under the RAI Country components and despite some start-up delays, Myanmar and Thailand have performed relatively well while Lao PDR and Viet Nam have been slower to get started (with implementation picking up in 2015). The RAI in Cambodia has so far failed to progress due to various reasons that have constrained implementation of key activities by the NMCP.
- Several factors represent challenges to the success of RAI now and in the future, including the lack of malaria "champions" (i.e. political will needs to be translated down to all levels) and decreasing staff motivation in the programs (related to uncertainties around support to health staff and incentives).
- Though it was unavoidable to have several multiple funding streams for GF malaria grants at the time of the RAI's inception, the complexity of this arrangement should be addressed going forward, beginning with a simplification of the GF Secretariat management interface.
- Cambodia's current epidemiological situation is very concerning: cases have been increasing since 2013 and this may have implications for multi-drug resistance (*see Figure 2 from report*). The review considers this the result of a collective failure of all concerned partners.

- The WHO has to play a unique role to support malaria elimination, but due to its own constraints, it has not lived up to partner expectations.
- There is a need to expand the range of partners involved in malaria programs and NMCPs are encouraged to embrace the added value of NGO implementers in particular, who may provide the "last mile" in reaching at-risk groups.
- There is a need for greater understanding of populations at risk of malaria (esp. people working/living in forested areas), and more should be done to reach them. "Learning by doing" should take precedence rather than "learning then doing", in a context of emergency.

For full report conclusions & recommendations: see Executive Summary + Sections 7 and 8 of the Review report.

b) Discussion on report recommendations

Report section 8.1: recommendations for immediate consideration and requiring close collaboration with other partners

Recommendation 1. Of highest priority, take urgent action to address the malaria situation in Cambodia, including rapid resolution of funding and supply chain issues.

Discussion:

- Statement from H.E. Ieng Mouly, CCC Chair: Further consultation will be needed within the CCC at country level on the review recommendations. Cambodia's malaria program is undergoing a transition. CCC Chair recently intervened to address difficulties in Cambodia, also acknowledging the need to build in greater sustainability for the Cambodian programs, given the decline external financing support. The 3 issues which were blocking implementation in Cambodia include: DSA/travel allowances (an agreement has now been reached), human resources sustainability (a transition plan has been agreed), and the delayed signature of the Cambodia NFM malaria grant (now signed). The CCC affirms its commitment to support the full speed of implementation of the program going forward. The CCC supports the recommendation to harmonize the RAI grant with other GF funding streams.
- Though many of these issues fall outside its remit, the RSC should keep abreast of developments which are immediately relevant to the RAI; in the case of Cambodia, RSC and CCC should keep close contact on these issues going forward.
- Funding support may be needed for military troops at the Thailand/Cambodia border; this is in theory possible to finance under RAI (*see also previous RSC decisions on military activities*).

Recommendation 3. Develop realistic and workable guidance on incentives and allowances that can be paid to those implementing malaria elimination activities, involving all concerned stakeholders. Though this is not a unique issue to Global Fund, it is a make-or-break issue, which will become more challenging as we approach malaria elimination. It may be worth examining the value of a surge, short-term effort to eliminate malaria (in which case sustainability is no longer an issue).

Discussion:

- Many NGOs have also raised the need for greater harmonization between donors on what incentives are paid.

- In Cambodia, a transition plan has been put in place following the commitment of the Cambodian government to phase out incentives and contracted staff in the GF-funded programs between now and 2018, though this addresses primarily the issue of incentives at lower level and a gap may subsist at higher levels (CCC Chair).
- Several GF Board constituents have taken a strong position on reducing incentives/allowances. GF shares the concern of the review team about how elimination can be achieved in this context, and will follow the discussions at RSC (and other fora) with interest with the hope that a pragmatic and sustainable approach can be formulated.

Recommendation 2. Across the GMS, improve the targeting, prioritization and rigor of malaria elimination activities. + Recommendation 4. Across the GMS, deploy appropriately qualified and experienced technical support personnel (“malaria elimination facilitators”) in highest priority provinces. The smallpox eradication example shows a success story based on the presence of a large number of advisors at all levels. CHAI is currently working behind the scenes in several GMS countries providing this kind of support. This requires inspirational WHO leadership, and ideally should be managed under WHO auspices; further funding may be needed.

Discussion:

- WHO is planning to restructure the ERAR Hub, and this will include strengthened country level presence/support, especially for surveillance. Elimination is not easy and there are limited people with this experience. Recently GMS countries agreed to form a network for cross-lateral transfer of knowledge, which could be a mechanism for mobilizing technical support.
- Several countries are already thinking about how to strengthen technical support at lower levels, e.g. in Cambodia where elimination committees are being established at provincial level with the support of RAI.
- Technical assistance does not necessarily have to come from another country: within a country, this could be provided from one district to another based on the leadership/experience of a given district.

Recommendation 5. Improve coordination among the development partner supported initiatives

Discussion:

- This is also needed at technical and political levels, and not only financial.
- Any reprogramming exercise within RAI should align with new national strategies (and this should be the same with other supporting donors), though we need to maintain a balance between the required flexibility under RAI and alignment of resources.

Report section 8.2: recommendations for immediate consideration by the RAI

Recommendation 6. Re-introduce a sense of urgency in the execution of the RAI with particular focus on areas where the RAI (and other efforts) are clearly failing, especially those with evidence of increasing treatment failures due to drug resistance. There is an incompatibility between the elimination target of 2030 and the earlier intention to tackle resistance as an emergency (recognized by creation of ERAR Framework).

Discussion:

- It is agreed that there is a danger of losing the sense of urgency. Time has shown that AR is still an

emergency and is no longer theoretical problem, with the emergence of partner drug resistance: this issue needs to be addressed more vigorously. The danger of falciparum malaria becoming almost untreatable also needs to be recognized.

- The RAI review has well spelled out what needs to be done, including coordination/planning, lack of which has caused wasted time and efforts. Partners need to work harder to agree on common guidelines/approaches.
- Countries welcome all technical assistance from partners, but we know that we are limited both in time and resources to implement properly; greater harmonization among donors is needed. Many meetings include technical discussions but when this needs to be translated into funding/budgets, programs are not systematically supported.
- Alignment of funds is critical to reflect the emergency of the situation and to respond to the countries' needs. Within GF/RAI grants some alignment may still be needed and RSC could be involved in supporting the alignment process in collaboration with UNOPS.
- It should be possible to use the RAI grant as an emergency fund in case of outbreaks, etc. GF recognizes the need to be able to react aggressively to malaria outbreaks and is committed to responding quickly as needed. GF also has an emergency fund which would be used in case there is insufficient funding in the RAI, and a rapid supply mechanism for ACTs (2 week turnaround time).
- One way to re-establish a sense of urgency would be to reconsider indicators and targets for the RAI Performance Framework, to be taken up at the highest level then translated downwards in collaboration with WHO and partners.
- A prioritized focus is still needed, as it will not be possible to be in emergency mode everywhere. MPAC recommendations target areas with ACT failure first and this should be the priority focus for RAI investments. The GMS regional elimination strategy does have a prioritization and ongoing stratification in countries will inform this, but we must be strong and quick at the beginning to lower the risk of malaria being exported.

Recommendation 7. Further expand RAI support to addressing malaria in forested areas with poor access to malaria services, including mobile people, military, migrants. The common factor in these populations is forested areas, which should be more of an operational guide for actions than the more commonly used concept of "MMPs".

Discussion:

- Expenditure rates under the ICC are high, which is a positive sign of the NGOs' capacity to implement. NGO partners are currently working in remote villages and reaching hard-to-reach communities, which until now have simply not been reached.
- Additional resources should be made available for this type of activities in case there are savings, whether under the ICC or in the RAI country components. This could potentially include the allocation of savings from a country component to the ICC or to another country.

Recommendation 8. Predict the timing and nature of possible changes to national treatment guidelines based on available evidence on resistance and plan for rapid implementation. Maintain a regional stockpile or effective regional inventory of ACTs available to facilitate rapid change when needed.

Discussion:

- It is generally agreed that having a regional stock of malaria commodities to respond to shortages would be useful, with support of relevant partners (GF, WHO), perhaps even to be expanded to other countries in the region. Flexibility to respond to changes in treatment regimens is recognized as important, anticipating future ACT failures, though this will have to be managed in a cost-effective manner.
- Under the Global Fund 'Rapid Supply Mechanism' (RSM) manufacturers producing drugs for Global Fund recipients have contractually committed to maintaining a permanent stock pile but also to quickly mobilize it for immediate delivery in case of an emergency; this could be an alternative mechanism to the establishment of a regional stockpile.
- Advance planning and coordination of regulatory, customs/importation processes will be required also, based on a comprehensive analysis of bottlenecks, which may not be exclusively procurement-related.
- WHO urges countries in the region to test and document the efficacy of alternative ACTs for which a stock is needed, to enable quick decision-making on policy changes. As a preliminary step, the registration of several ACTs needs to be completed where it has not been done (2-3 per country).
- On treatment guidelines/implementation of policy changes, a rapid assessment could be undertaken by ERAR as part of its pharmaceutical activities (e.g. which drugs are registered, prequalified...).
- If regional-level recommendations are not possible, WHO policy recommendations should take into consideration resistance patterns in neighboring countries, to be implemented in coordination between countries.

Decision point: A working group composed of WHO (TBD), 5 country voting members, and 1 CSO member (P. Panitchpakdi) will review, with the support of GF and UNOPS, the added value and feasibility of establishing a regional stockpile of malaria commodities to be funded by and coordinated through the RAI grant. The working group will report back to the RSC before end of March 2016.

Action item: WHO ERAR to provide rapid assessment on national treatment guidelines and status of registration/prequalification of drugs.

Recommendation 9. Examine, country by country, the reasons why the use of primaquine has not yet been adequately adopted in line with WHO recommended policy across the GMS and support actions to address this situation.

Discussion:

- WHO supports this fully but these are country level policies which RSC alone cannot address.
- Some countries are still hesitant to implement single low-dose primaquine without G6PD testing; WHO reminded partners that low-dose Primaquine can be used even with G6PD individuals.

Recommendation 10. The RSC should continue to prioritize actions to be supported through the ICC but broaden the scope beyond that covered by Calls 1 and 2. The ICC should accelerate the process of calling for proposals. Given the findings of the Review it is suggested that the following be considered:

(10a) Accelerate the development of a regional on-line data-sharing platform that can accommodate current country data but also anticipate the roll-out of DHIS2 in a number of countries. Even before such a platform exists promote and support immediate review of data as it becomes available for planning

and trouble-shooting. Review by the RSC of the forthcoming ERAR Regional Malaria Surveillance Assessment report to determine whether there are selected recommendations that could be supported through the RAI ICC.

Discussion:

- The ongoing work on the shared regional data-platform should continue but it needs to be timely and move more quickly. Data needs to be shared but also acted upon. (See also: ERAR Hub update, below)

Action item: WHO ERAR to provide details on SME assessment work and guidance as needed on potential funding gaps.

(10b) Agree on a short list of immediate priorities for operational research, move to have them funded and monitor progress. Where appropriate 'operations research' should take the place of 'operational research', with programs 'learning by doing' rather than 'learning then doing'.

Discussion:

- A prioritization effort has already been done through the TEG. This included promoting MDA pilot studies, which have been successfully funded under RAI, with positive outcomes. The existing lists of agreed priorities could be examined for potential funding under RAI.

Action item: WHO to provide details and further guidance on existing prioritization.

(10c) Establish an independent regional monitoring and support team that can provide national leaders, NMCP managers and the RSC with an independent assessment of progress towards malaria elimination. It would also be required to provide problem-solving advice/support. This team could conduct data quality audits as part of its brief.

Discussion:

- There are funds available for an independent review exercise in 2016 which could potentially be used for a few oversight missions, but it may be difficult to establish a permanent team.

- The mandate/scope of work of this group needs to be clarified early on to ensure its added value and avoid potential duplication of effort (e.g. with WHO). It would probably benefit from having a mandate that is broader than GF RAI, with TORs developed in collaboration between RSC and other partners (e.g. WHO, APLMA).

- UNOPS conducts regular process & progress monitoring (e.g. counting delivery of bednets) but would benefit from independent inputs (e.g. whether LLINs purchased/distributed are the right type and are being used appropriately).

- Civil society groups would also welcome the idea of a 3rd party observation role. Some issues are not being brought to the attention to the RSC sufficiently, and more focused monitoring of specific issues would be helpful as well as sharing of best practices.

- The RSC Executive Committee could play an oversight committee role, to examine issues every 3 months and address bottlenecks, though national ownership and processes should be kept at the center of priorities.

- We need an early warning system which could be part of the independent monitoring scope.

Decision point: A working group composed of 1 CSO member (P. Panitchpakdi), DFID (J. Bagaria) and WHO ERAR (W. Kazadi) will prepare a first set of draft TORs for the independent monitoring support team, with the support of RSC Secretariat and other partners (e.g. APLMA) as needed. The RAI review consultants could be asked to work on a preliminary draft. The working group will report back to the RSC before end of March 2016.

(10d) More extensively and more proactively monitor and map the extent of resistance to artemisinin and partner drugs across the GMS. This could include:

- collection of filter paper blood samples from all malaria cases across the GMS (starting with hospitals and eventually extending to VMW) for study of parasite population genetics, including mapping of resistance markers. (The laboratory component of this is already funded from other sources).
- more TES sites (where possible and required).

Discussion:

- There is indeed a need for more systematic sampling of bloodspots, not only molecular markers but also gene flow. WHO recommends working more on establishing a process rather than having a specific marker; K13 mapping has limited use in determining treatment policies.
- This sampling could serve an early warning system but to support action we absolutely need data-sharing (between programs and between researchers, other partners and programs).
- Genetic epidemiology from filter paper blood spots can also prove highly valuable in assessing causes of malaria outbreaks.

(10e) Assess the extent to which access to quality diagnostics and medicines for malaria is being addressed effectively by other partners/entities (e.g. WHO, ASEAN Working Groups, APLMA Working Group, Australian DFAT funded project through the Therapeutic Goods Administration) and whether there is a role for RAI.

Action item: WHO ERAR will link up with WHO HQ (A. Bosman) on this topic for further guidance.

(10f) Review the value of DOT for first line treatment and update the approach if required.

Discussion:

- This has been discussed in WHO TEG and there has been limited evidence to date on the effectiveness of DOT. WHO advises that impact of DOT is possible if it can be implemented at 100%, but there is recognition that getting to 100% is cumbersome and not cost-effective. DOT should be continued only if a country/partner has been able to implement satisfactorily.
- For some partners, unsupervised treatment with clear instructions given to patients on Day 1 has resulted in very adequate adherence.

Decision point: The implementation of DOT under RAI should be re-examined on a case-by-case basis in collaboration with WHO; RSC will allow countries/partners to interrupt DOT activities funded under RAI where (and when) deemed appropriate by concerned country-level stakeholders. PR UNOPS will report back on this process at the next RSC meeting.

Report section 8.3: Recommendations concerning RAI governance and management

Recommendation 11. Simplify the interface between the Global Fund and the PR by having one Secretariat team that oversees all malaria activities in the GMS.

Discussion:

- Global Fund agrees that having multiple grants for each country is not the best way forward; this will be re-examined for the next phase of RAI.
- If consolidation of grants is not possible immediately, the Global Fund could already simplify the management arrangements at the GF Secretariat.

Recommendation 12. Maintain the current leadership, composition and structure of the RSC for the remainder of the RAI. Continue the current effort to clarify and facilitate the interaction between the RSC and the CCMs in countries; modify the guidance for membership to ensure that the designated member (or a single nominated alternate) attends the RSC meetings. RSC communication with in-country inter-ministerial Malaria Elimination Task Forces set-up under the APLMA Roadmap should also be ensured.

Action items:

- **RSC Secretariat will ask all RSC constituents to designate official alternates in addition to existing nominated members.**
- **Linkages with APLMA Task forces will be explored in collaboration with APLMA Secretariat.**
- **Representation from Bangladesh and India to be invited as observers to the RSC.**

Recommendation 13. Maintain the current PR for the remainder of the RAI. The Review team proposes consideration of the following for enhancement of the PR's effectiveness:

(13a) Empower the PR to produce a short quarterly "issues paper" that flags the need for urgent attention or problem-solving (whether or not the issue is in the domain of the Global Fund grants being managed) and make it available to all stakeholders through the RSC.

(13b) Revise existing RAI indicators in line with RAI review recommendations.

(13c) Use more process indicators to monitor implementation of RAI activities drawn from recent national malaria M&E frameworks and relevant to current programmatic issues.

Action items:

- **UNOPS will prepare a short "issues" paper for the RSC on a quarterly basis.**
- **UNOPS, with support of RSC Secretariat, will discuss with GF and WHO the possibility of revisiting the RAI PF indicators in accordance with review recommendations.** RSC and review team consultants may be asked to provide further advice/inputs to this process.

4) Preparing for the next phase

a) Update from the Global Fund (M. Edington)

The RAI review confirms that what we set out to do was the right thing and even if implementation has been challenging, esp. in Cambodia, where issues are now being resolved with the much appreciated leadership of CCC Chair.

Discussions are still ongoing on the future of regional programs in the context of the new strategy for

the Global Fund. Though there may be differing views at the GF Board, the value added of a strategic regional proposal such as the RAI has been recognized and funding will not be less for such proposals the next cycle, at a minimum.

A Multi-country option in the future could make sense, retaining country ownership while recognizing that a regional approach is necessary, with regional coordination needed to address the resistance issue. We also have to collectively figure out how funding levels are sustained and increased for this region. For specific at-risk populations, country grants alone are not sufficient. It is likely that more attention will be given to elimination of malaria as well as to cross-border activities in this region.

The RAI will be discussed at the next Grant Approvals Committee (GAC, January 2016) but continuation of funding under RAI is a Board level decision. The exact funding allocation won't be known until Q3-Q4 2016; in this context a 1-year costed extension for RAI could be an option to ensure the transition period. Further clarity on next steps should be available by early 2016.

GF Secretariat supports the shift towards a broader regional elimination strategy and is committed to the continuation of RAI. GF Secretariat is generally confident that funding will be available; discussions are more about the financing mechanisms and structures.

RAI needs to deliver results and spending of funds will be critical, especially in Cambodia. Accelerated implementation/results in the next 1.5 year will improve our chances of renewing funding levels. The anticipated catalytic effect of the RAI on other sources of funding has not taken place and further work is needed in this area with the support of partners. The Global Fund is open to having discussions on innovative funding mechanisms; however there needs to be a demonstrated added value to doing this in the GMS.

The Global Fund is also committed to continued financing for civil society implementers ("dual-track" financing) but has been more successful in HIV/TB than malaria so far. The best way to increase CSO engagement is for NGOs to continue to show convincing results/data.

b) Report suggestions on future program (*see report Section 9*)

Key suggestions for a potential future program include:

- Consolidate all Global Fund malaria financing streams for the five RAI countries into a single multi-country program, composed of several individual country grants in addition to an inter-country grant.
- Distinguish "country components" (routine malaria control & elimination activities, implemented/overseen at country level), "multi-country component" (activities which are defined at regional level but implemented/overseen at country-level, e.g. activities in high priority border areas, access to services for migrants), and "inter-country component" (activities which are defined and implemented/overseen at regional level, e.g. data-sharing, operational research, emergency stockpile).
- All multi-program components would be managed by a single PR and overseen by a Multi-Country Program Steering Committee, analogous to the RAI RSC.

Discussion:

- Civil society organizations need to be involved in governance in addition to implementation, e.g. in policy issues where more work should be done to address key structural barriers. CSOs can play a key role in the future "multi-country component" with countries together to tackle such issues.

- We need flexibility to adapt to the evolving threat, and it would be good to have a mechanism to quickly include financing for other countries in the future. This would be better served by a multi-country concept which can include as many countries as needed.

5) Civil Society update (L. Da Gama, P. Panitchpakdi)

Approximately 45 CSO representatives from all RAI countries met on 17-18 November in Bangkok; this was a follow-up of the December 2014 workshop, to discuss common issues and share best practices, as well as move forward on the creation of a CSO regional malaria platform. This workshop was supported by the RSC, GF and French 5% but additional funding will be needed to sustain this effort in the future.

Summary of discussions:

- RAI (especially ICC) is recognized as an important opportunity to have NGOs involved in cross-border work, producing very interesting results;
- True ownership of the malaria elimination agenda is needed within communities themselves, who are often not genuinely included in governance or bottom-up planning processes. The HIV/AIDS community concept of "nothing for us without us" has not found its way into the malaria agenda. More advocacy is needed around malaria elimination in general and CSOs could play a role.
- There is a need for better collaboration and interaction between CCM/RSC CSOs which will require funding support. RSC could play a mediating role with CCMs when issues are brought to its attention by CSOs at country level.
- Civil society plays a dual role in implementation and in accountability/governance mechanisms, which can cause some friction but there was a plea among members for governments in the region to recognize the added value of civil society as a partner.
- There is a need to focus financial resources on high risk populations, and including some thinking about gender-sensitive programming. Better engagement with the private sector is needed.
- There is a need for effective policy change and addressing structural barriers, including political intervention at high level where needed; this could be an area for RSC and APLMA collaboration with the CSO platform.
- Integration of services will become increasingly important in the elimination phase. VHWs (and similar) should be able to provide additional (non-malaria) diagnostic and treatment services. It is recommended that RSC endorse this approach for funding under RAI as needed.
- Capacity-building for CSOs is also much needed, including the transfer of knowledge from international NGOs to national/local groups.

6) Partner updates

a) WHO ERAR Hub: regional data-sharing (*W. Kazadi, presentation available*)

Data sharing is more important now than ever before; decision-making for elimination needs to be grounded in solid data. WHO ERAR began introducing Business Intelligence but was approached by countries to use DHIS2 because that transition was ongoing in several countries. Risk mapping and stratification data proved difficult to harmonize, though those data were collected separately. ERAR conducted a regional level SME capacity assessment (*available*). There is a need for a system easily accessible to all stakeholders which has informed the development of the ERAR proposal for financing

under RAI, which also includes a capacity-building component at national level. ERAR will also conduct an analysis what is happening with existing platforms but will give an opportunity to countries to use the same system (DHIS2), to minimize their workload.

Discussion:

- The data sharing proposal should be developed from the grassroots level (bottom-up) and should be geared towards action/decision-making rather than data-sharing as an aim in itself.
- Indicators need to be standardized and a unified plan/template for data sharing is necessary for countries.
- DHIS2 is being used for other diseases in the region and this is an opportunity for integration of malaria data.

Action item: the ERAR Hub proposal (approximately 500,000 USD) will be circulated to RSC for no-objection within one week.

b) APLMA update (*B. Rolfe, presentation available*)

The East Asia Summit will take place on 22 November, where 18 heads of government will endorse the APLMA roadmap and discuss regional health security, among other things. Important implications include:

- 6 priorities in the framework (*available*)
- A "whole of government" effort in which each country needs to establish a high-level cross-sectoral coordination mechanism, tasked to report back to the head of government.
- Senior Officials gather once a year to assess progress towards elimination based on dashboard (under development with support of WHO and partners). Many issues discussed at RSC will benefit from this monitoring process.
- Malaria Week: APLMA supports the proposal to collapse several regional malaria meetings to be culminating into a meeting of Senior Officials (for GMS) and which would allow these messages to be taken forward at higher level.

c) ASEAN (*A. Rahmunanda, presentation available*)

It may be useful for concerned partners to participate in ASEAN cluster meetings related to malaria, as this would help align and harmonize with international trends. ASEAN also has an activity component on pharmaceutical activities – including joint activities with regulators (in collaboration with ERAR Hub).

d) ADB (*B. Lochmann*)

ADB in process of preparing regional health security program to improve surveillance and disease control including malaria (covering all RAI countries except Thailand). Starting in 2016, this will also include strengthening of diagnostic capacity and surveillance coordination/collaboration. Under the Regional Malaria Trust Fund, ADB is stepping up investments in disease control (through CDC 2, 9.5m to Lao PDR, Cambodia and Viet Nam). An additional TA program is supporting Myanmar for surveillance/diagnostic systems as well as MMP-targeted activities. ADB also provides support to the APLMA Secretariat, innovative financing mechanisms for malaria elimination, and is working on strengthening HIS, eHealth systems. ADB is also supporting regulatory authorities (FDAs) in countries in

collaboration with WHO and for which a broader implementation plan is in preparation. ADB supports CDC programs primarily (through MOHs) and liaises closely with partners such as WHO to avoid duplication of financing efforts.

Discussion:

- There are concerns on duplication/overlaps in financing; while ADB aims to take a holistic "health systems" approach, the verticality of national malaria programs may prevent them from benefiting from this kind of support and there may be lost opportunities for integration.

e) APMEN (*J. Prachumsri, presentation available*)

APMEN has a number of working groups which convene technical and regional partners, e.g. Vivax Working Group, Vector Control Working Group, Surveillance & Response Working Group. APMEN has a number of capacity-building activities such as APMEN fellowships and various workshops for NMCPs. Recently APMEN and APLMA have agreed on the integration of their respective secretariats in 2016.

f) Gates Foundation (*B. Moonen*)

BMGF continues to support APLMA, WHO ERAR, and CHAI at regional level. A grant was recently approved for PSI to scale-up diagnosis and treatment in the Private Sector in several countries, and ensure that data are integrated into national surveillance. Innovative surveillance mechanisms are being supported, eg. genetic reconnaissance (MORU, Oxford Sanger), as well as malaria elimination modelling work (MORU). Gates Foundation is also part of a broader consortium for malaria to examine questions on elimination strategies (e.g. use of MDA).

Discussion:

- There is a need to clarify and define accountability mechanisms for tracking and coordinating efforts.
- The RAI UNOPS website "donors map" currently contains all activities funded by various partners in Myanmar; data should be provided to UNOPS for other countries.

7) Any other business

Regarding the composition of Executive Committee: the following decision points were adopted:

- **Country representatives on the Executive Committee will rotate every two years.**
- **The current representation (Myanmar/Cambodia, since Dec.2013) is changed to Thailand and Laos (voting members).**
- **Louis da Gama (Civil Society) is appointed as a new member of the Executive Committee.**

The next RSC meeting is tentatively set to take place on the week of 9-13 May 2016 in Bangkok, to be coordinated with WHO and APLMA as part of a broader regional "malaria week".