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

**9th August 2013**

**Pullman King Power Hotel, Bangkok, Thailand**

Co-chairs: Dr Chanvit Tharathep, Professor Arjen Dondorp

Minutes taken by: David Gandy

Attendees are listed in Appendix “attendance list BKK RSC.pdf”\*

\*Absent: Dr. Cynthia Maung (Mae Tao Clinica). Civil society organisations were thus not represented at the meeting. Mr. Louis de Gama (board member of the GFATM representing civil society), will be contacted to ensure civil society representation at the next RSC meeting. Additional attendees not listed in the participants list include Dr. Wichai Satimai (BVBD Thailand) and Dr. Aye Aye Thwin (USAIDS).

**Introduction & scene setting**

Arjen Dondorp opened the meeting with a brief introduction to underline the importance of stopping the spread and preventing de-novo emergence of artemisinin resistant (AR) *P. falciparum* malaria *(Pf)* in the GMS.

* A lesson from recent history is that chloroquine resistance emerged in exactly the same area as artemisinin resistance, then spread westward and crossed the ocean to Africa, where it has caused a large increase in malaria morbidity and mortality in African children in the 90’s.
* Until better in-vitro tests and molecular markers become available, the AR phenotype is defined clinically by it much slower clearance from the peripheral blood. It has been shown in several areas that emergence of the AR slow clearance phenotype is a prelude to ACT failure, in area with a concomitant increase in resistance to also the partner drug. Failure rates are now around 25-30% with DHA-PQP in Western Cambodia and with artesunate-mefloquine on the Thai-Myanmar border. Although all these areas have currently low malaria transmission, this might well be ‘silence before the storm’, and with increasing failure rates transmission is likely to increase.
* There is increasing consensus that in order to eliminate the problem of artemisinin resistance, *Pf* malaria has to be eliminated from regions with AR, as the most resistant parasites will be the ‘last man standing’. If the elimination effort is stopped too early, malaria will resurge, and consequently with a much higher proportion of resistant parasites.

The programme under discussion involves a grant of US$ 100 million over three years, with the aim to contribute to a wide range of interventions contributing to the goal of eliminating Pf malaria in the Greater Mekong Sub-region (GMS).

Alan Magill noted that in the concept note a clear distinction needs to be made between **containment** and **elimination**. It was briefly discussed that indeed effective containment means the elimination of Pf from areas with artemisinin resistance. However, depending on local transmission intensity, current control measures in place and other factors, timelines and interim goals will vary by area.

**Discussion and establishment of the Terms of Reference (TOR) for the RSC and Organizational structure**

* The group had not had very much time to review the document of proposed by-laws as these were only circulated two days prior to this meeting.
* It was suggested that the current document was probably too extensive and complex and should be simplified to be workable
* Eva Christophel informed the group about WHO’s Emergency Response to Artemisinin Resistance (ERAR) regional hub based in Phnom Penh. This hub will host the secretariat to the GF-RAI, and **it was agreed that the different and complimenting roles of the ERAR and the GF-RAI structure need to be clearly defined in the concept note**.
* Michael O’Dwyer highlighted that the concept note needs to clearly define the structure of this program and the way it compliments the work of the Country Co-ordinating Mechanisms (CCMs) in each country. He introduced the concept of “subsidiarity” and noted that there are likely to be occasions when the GF-RAI Regional Steering Committee and individual CCMs will need to come to a joint agreement on specific issues, and will need to work closely with Local Fund Agents (LFAs).
* Urban Weber stated on behalf of the Global Fund that the current suggestion of by-laws were a draft prepared by the consultant, and that they could be revised. He also stated that **the by-laws do not need to be finalised before the concept note is submitted**.
* The group expressed the need to define the objectives and mandate of the GF-RAI Regional Steering Committee, and the CCMs. One particular concern was for the GF-RAI to keep its focus, and there was concern regarding expanding the current remit beyond the governance of the current proposal) in paragraphs 8 and 17 of the by-laws**. It was agreed that the TOR of the RSC should state that the remit of the RSC focuses on the governance and implementation of the current program**.
* Eva Christophel identified the Committee’s primary mandate as:

1) secure the grant,

2) get the program implemented,

3) ensure that M&E is robust

* The group discussed staffing requirement for the secretariat. Eva Christophel mentioned that impact assessment of the program will overlap with activities in the WHO ERAR hub. **It was agreed that the relation between the RAI secretariat and the WHO ERAR hub should be clearly defined in the TORs to avoid overlap in activities.**
* With reference to paragraph 28 in the by-laws it was indicated that the RAI secretariat should have a senior person, preferably with an epidemiological background, who can be involved in the day-to-day management of the program and collate and present impact and other indicators to facilitate information flows. The current budget allocation for staffing of the GF-RAI secretariat in Phnom Penh was regarded as inadequate (it only pays for 2 relatively junior staff) and should be increased. **It was agreed that once the TORs of the Committee have been finalised, the committee should review the staffing requirement and associated budget allocations of the GF-RAI secretariat and reach agreement via flying minute.**
* A sub-committee was established to look at the Terms of Reference of the Committee, consisting of Michael O’Dwyer, Dr Wichai Satimai, Rd. Sok Touch and Eva Christophel.
* After long discussion a vote was taken and **it was agreed that the Oversight Committee and the Independent Oversight Support Group** **should be replaced by a single Independent Review Team** who will undertake annual monitoring and evaluation of the program, complementary and independently from the oversight functions of the P.R.. It was noted that this independent review team is part of the M&E mechanism, and not part of the governance structure.
* With regard to M&E it was pointed out that monitoring should not be regarded as ‘policing’ but be designed to help the implementers in the field to improve the quality of their work, and without imposing lots of administrative tasks. Evaluation should focus on the goals set to reach at the end of the 3 year program, implying that these goals need to be well defined.
* The discussion then focused on tackling malaria in mobile border populations and it was agreed that the approach taken by the program will need to be flexible to undertake activities locally appropriate activities as defined by the setting in different parts of border regions, and that part of the Regional Steering Committee’s work should be to reconcile issues on either side of an international border, by working with the relevant CCMs. Since these transborder issues will differ greatly between the different border regions (Thai-Myanmar, Thai-Cambodia, southern Vietnam-Cambodia/Laos) Michael O’Dwyer made the suggestion to establish sub-committees each overseeing the activities in in a specific border region and work with CCMs and existing structures on issues specific to these areas. The committee was very supportive of this idea, but a vote on the establishment of these subcommittees was postponed until the regional and transborder activities were more clearly defined in the final version of the CN.

**Selection and roles of the Principal Recipient(s)**

Urban Weber provided the RSC with information on the timelines regarding the application:

* **3rd week of August** –second round of “early engagement” by the Technical Review Panel (TRP) on the contents of the CN
* **6th September** – deadline for submission of the concept note to the GFATM in Geneva. By then the CN will need to have been endorsed by all the CCMs as well as the RSC. This date is non-negotionable.
* **3rd - 6th October –** TRP review-meetings of the concept note
* **7th October – December** – Global Funds Grant Approval Committee will work with the Principle Recipient on grant documents and work plan.
* **December** – grant approval and signing of the contract before year’s end.

Urban Weber also stated that the names of the TRP members who will review the concept note will not be made public, but said that they do include malaria experts. Should the TRP request clarifications after their meeting in early October they will be sought through a formal process.

There was some discussion about whether there should be one or two Principle Recipients responsible for managing the grant (the idea had previously been suggested for NGOs to have a separate PR). The country representatives felt that having 2 PRs would increase the administrative costs of the program, and could lead to confusion. **A vote was cast is favour have having only one PR (7 in favour, 2 against, 1 abstention).**

Before a vote was cost on selection of the PR, the representatives from UNOPS (Dr Sanjay Mathurand and Dr Eisa Hamib) were extensively questioned. In their responses it was stated that:

* They plan to implement the program using a modest scale up of staffing. This will be possible as they will maximise the use of UNOPS “Shared Services” division in Yangon, making use of economies of scale to keep costs down.
* In Yangon UNOPS expects to employ one international member of staff and “a few” national staff.
* In each country UNOPS expects to employ one national as co-ordinator (these posts will work closely with their respective national malaria control program).
* Where possible UNOPS wants to work through existing country level partners that play the role of PRs for country-level grants from the Global Fund. The management of the regional component still needs to be determined.
* The Global Fund will negotiate about the % charged for indirects. Currently the charges levied on the UNOP’s managed grant in Myanmar is 6.5% for programme activities and 4% on procurement.
* It is too early to know what level of management charge there is likely to be in total from the PR and SRs, but Urban Weber stated that 15-20% was normal.

The RSC was reminded by Urban Weber that if the Committee had problems with UNOPS, the Global Fund would moderate. Ultimately it retains the authority to change the PR if UNOPS was found to be deficient in its implementation of the Programme. One concern expressed by Dr. Rattanaxay Pethsouvanh and Jason Lane was that the lack of an alternative in candidate for the role of PR was not according to the best selection process.

After long discussions **there was a unanimous vote to approve UNOPS-Myanmar as the Principle Recipient, provided that a number of requirements set by the RSC be met by UNOPS**. These points, which will have to be assured by the Global Fund during their contract negotiations with UNOPs, include:

* UNOPS must use existing facilities to undertake the work; no new offices will be established.
* UNOPS and the Global Fund must strive to contain indirect cost at no more than 15% in total.
* UNOPS must strive to deliver the programme using a lean management structure, particularly in terms of staffing. This was highlighted with reference to the high number of staff that UNOPS has for its role as PR in Cambodia, where they have attracted staff away from government positions. The committee felt strongly that such a situation should not be repeated under this regional program.
* UNOPS needs to ensure that the maximum amount of funding possible goes to direct costs. The Global Fund will be very stringent in this regard.
* UNOPS must ensure that the grant does not become in anyway Myanmar-centric in spite of the facts that operations will be run from Yangon.

**Current status of the concept note (CN) and next steps**

Kevin Palmer presented an outline of the current draft CN. Points for revision and other comments were articulated by several RSC members:

* A need for identifying the 3-year goal of the program, which will vary by country/ area since malaria transmission intensity, current measures in place, and other factors vary greatly by country and area.
* In should be stated that in Tier 1 and Tier 2 areas the program should add to creating a greater level of awareness at the community level.
* The CN should stress the importance of effective real-time management-information since this will be key to ensuing effective implementation of the program.
* Part of ensuring sustainability of activities is to have effective structures on place. This program needs to emphasize that it will strengthen existing structures as much as possible.
* The plan should ensure that the funded activities will be appropriately targeted to Tier 1 and 2 areas. In some provinces designated as Tier 1, there will e.g. no transmission in some of the districts; some districts will be Tier 2, etc. Dr. Siv Sovannaroths indicated that this level of targeting already happens in Cambodia, so he didn’t see a problem with the current wording in the concept note.
* Some information from country’s CCMs was still missing in the current draft of the CN and will need to be added.
* The CN will have to demonstrate that there is no overlap with the National Global Fund grants that have already been awarded to each country. Kevin Palmer indicated that this information was already provided in one of the excel sheets. More detail will be difficult to provide.
* The CN will need to add some information about the number of mobile people in each country/border region.
* It would be good to clarify how the overall cost of US$ 500 million for long-term action to eliminate AR *Pf* was arrived at. It was stated that the gap analysis performed by the WHO only gives a rough estimate.
* It should be more clearly stated that funding of IRS will be very limited under the current proposal (**only** as a **reactive** tool, when responding to an outbreak of Pf).
* With the wide implementation of bed nets, the challenge is how to prevent biting (=transmission) between 6pm and roughly 10pm (when people go to bed). Possible interventions mentioned in the CN (repellents, larval control, anti-adult measures, barriers, environmental modification, protective clothing) lack currently good evidence of their effectivity and will thus not be supported by the program currently. It was stated that for reasons of clarity, all the possible interventions mentioned in the CN which will not be implemented in the current program should be moved to an ‘annex’.
* Different countries have different attitudes towards the practicality of doing DOTs – it should be stated in the CN that this needs to be reconciled at a country level. The use of incentives for village malaria/ health workers (VMW) could help to increase the implementation of DOTs.
* Developing adequate networks of VMWs in this program will provide a system suitable for implementation of other malaria elimination activities in the future. With decreasing malaria transmission, VMWs will have to evolve into Community Health Workers (i.e. treating more than just malaria). However this is somewhat controversial in some of the countries who allow VMWs to treat malaria only. It was thought that this aspect should not be addressed by the current program at this point.
* Alan Magill expressed that the use of DOTS and VMWs are a very strong part of the concept note and encourages countries to try it and not be scared of failure – and that to be truly innovative it should be recognised that potential failure is part of the process.
* Currently the CN does not contain a concrete strategy to reach mobile populations, which are in general a high risk group for acquiring malaria and contribute to spread of resistance. The area specific approaches need to be worked out in more detail. It has been allowed by the GFATM that the detail on this part of the CN can be worked out later, that is after submission beginning of September.
* The CN should make it clear that diagnosis and treatment and other services will be offered to anybody who needs them, independent of their legal status, etc. They will be universal.
* Dr. Siv Sovannaroths would be happy for Cambodia to implement the provision of “standby treatment” to forest goers, but will have to await whether this will become an official recommendation in the next edition of the malaria treatment guidelines from the WHO.
* Arjen Dondorp and Alan McGill noted that the impact indicators of the program will have to include both *P.f*. malaria incidence and prevalence measures. Cross sectional surveys using filter paper blood spots in a high-throughput PCR platform would be an adequate method to measure prevalence – the country representatives were supportive of this idea but only on the understanding that it should come from the regional (not country) budget allocations.
* Arjen Dondorp also highlighted the importance of using the programme as a valuable opportunity for undertaking research (modelling, epidemiology, efficacy studies) that could be used to inform the programme and follow on activities. However the country representatives feel that there is limited budget space for operational research (OR) within the programme. Susann Roth noted that intellectual property issues would need to be addressed if OR was included within the programme, which was agreed on by other RSC members.
* Dr Aye Aye (USAID) noted that we need to identify what OR will be most important for the programme and Michael O’Dwyer asked for a potential mechanism for setting priorities since this might be outside the competence of the RSC. Arjen Dondorp stated that the WHO TEG on antimalarial drug resistance, which as a quite broad representation of the research community, provides a list of priority research on AR, which could serve as a starting point.
* It was stated that a flexible pot of research funds should be very valuable to enable quick responsive research to address important emerging issues (the example was cited of the two year delay in setting up a project to test alternative ACTs in Western Cambodia where DHA-PQP is failing due to lack of available funds). Issues need to be resolved about how the governance of this money would be managed, but it was suggested that the RSC with technical advice from the WHO and their advisory committees could guide this.
* Jason Lane noted that at the moment the concept note does not have a strong enough narrative regarding vision and goals of the program and urged that the next draft needs to be clear regarding priorities interventions identified for each country.
* An important regional activity will be sharing up-to-date impact data between countries. Other important information systems which could be implemented regionally include programmes for logistics management information systems to avoid stock-outs and for measuring performance of health workers. Eva Christophel noted that given the “Emergency Response” nature of the program information will need to be as much up-to-date as possible (not monthly reporting). In relation to this Dr Chanvit Tharathepthat mentioned that the program should then be selective about which data should be available in real-time. Susann Roth stated that the ADB is now preparing a health and trust fund which might provide an opportunity to fund systems for information sharing. Where possible the computer systems should build on existing systems.
* With regard to High-risk groups the Global Fund has agreed that detailed planning can be developed after the submission of the concept note

A small sub-committee writing group was formed to support Kevin Palmer in finalising the concept note. The members include: Arjen Dondorp, Dr. Pongwit Bualombai and Alan Magill.

The aim is to finalise the **concept note by the 31st August** so that it can be reviewed and approved by all national CCMs in time for the submission to the Global Fund on 6th Sept. Before this the concept note will be circulated another 2 times to the whole RSC for comments and approval.

**Implementation arrangements**

The selection of the implementing partners (SSRs) for the country components of the CN is still undecided. The implementation of the activities listed in the country component will be guided by the country CCMs, who will have to ensure adequate transparency of the selection process, as assessed by the RSC. The PR will need to assess the capacity of SSRs.

The process and selection of implementing partners for the regional component has not been defined yet, and will also depend on the concrete activities which will be selected for the regional component in the final version of the CN.

UNOPS stated that they would soon start visiting the countries to discuss implementation.

**Any Other Business & Next steps**

The **next meeting** of the RSC should be held in January, and thereafter every six months.