

**ESTABLISHING  
A GLOBAL  
PARTNERSHIP  
TO  
ROLL BACK MALARIA**

**FIRST PARTNERS' MEETING**

Geneva  
8 and 9 December 1998  
at the  
World Health Organisation  
Executive Board Room

DRAFT REPORT  
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The meeting was planned and managed by Dr Pene Key, Short Term Consultant to the Roll Back malaria Project, together with the rest of the RBM team, under the supervision of Dr Tore Godal, Acting Project Manager. This report was prepared by Jenny Hill of the Malaria Consortium, in conjunction with David Nabarro, the current Project Manager (who takes responsibility for its contents).

## 1. PRELIMINARY PLAN FOR THE GLOBAL PARTNERSHIP TO ROLL BACK MALARIA: MEETING CONCLUSIONS

- 1.1 A global partnership was formally established on 9 December 1998 to intensify the international effort to reduce the malaria burden – to *Roll Back Malaria*.
- 1.2 Participants at this first **Partners' Meeting** represented national governments, UN systems agencies, development banks, non-governmental organisations, private sector and bilateral donors.
- 1.3 Within the limits of their authority, they committed themselves and their organisations to the establishment of country-level partnerships to Roll Back Malaria. Where possible they would work within the context of these partnerships
- 1.4 The principles of a country *Roll Back Malaria* partnership are that:
  - i. National governments determine the goals, strategy, organisation and operating procedures for Rolling Back Malaria;
  - ii. A country partnership to Roll Back Malaria is usually set up at the invitation of a country's Head of State;
  - iii. It involves a situation assessment and strategy development process led by the National Authorities and involving potential partners;
  - iv. Partners' support for Rolling Back Malaria is provided, where possible, within the context of the *sector-wide approach to health development*;
  - v. Partners work to common objectives, using agreed strategies, in a transparent manner;
  - vi. Within the context of these principles, attempts are made to ensure that partners have sufficient flexibility and autonomy to make the fullest possible contribution to Rolling Back Malaria.
- 1.5 At the country level, WHO will help to ensure that the partnership is a success through providing a range of focussed inputs. These are offered through the WHO Roll Back Malaria (RBM) *Cabinet Project*. This involves personnel within WHO headquarters (from all nine clusters), WHO regional offices, and WHO country offices.

- 1.6 The WHO RBM project will contribute to country partnerships by offering help in several areas, including:
- i. possible agreements and means of working
  - ii. materials for advocacy
  - iii. help with developing a consensus on strategy– ensuring that options considered are based on best available evidence
  - iv. capacity building
  - v. lesson learning from other countries and from other programmes
  - vi. support for monitoring progress, and
  - vii. brokering resources [looking for new channels as well as existing ones].
- 1.7 WHO regions are key elements of the RBM project, contributing to country partnerships. They may offer other support for national and local-level action within countries.
- 1.8 At global level, WHO will set up a small ‘partners’ group’ to help the Global RBM Partnership evolve, and to provide guidance to the WHO Roll Back Malaria Project, which supports the partnership. The project will develop strong linkages between partners through the use of advanced communication technology.
- 1.9 To reduce malaria suffering and death rates substantially, funding mechanisms are needed:
- to enable countries to implement new malaria and health sector development activities
  - to ensure that key components of RBM – such as the Medicines for Malaria Venture, the Tropical Disease Research Programme, and the Multilateral Research Initiative on Malaria deliver the desired products
  - to build WHO's ability to support partnerships – through in-country action, technical resource networks, international monitoring and global advocacy
- 1.10 WHO's role is to support the partnership and make it effective, ensuring that it has the greatest likelihood of mobilising cash,

information and other vital resources within the context of what is needed. Current plans for the partnership do not envisage a long-term dedicated financing mechanism unless this is demanded by all. Funding is urgently required for short term needs.

- 1.11 The RBM partnership will need to mobilise substantial additional resources – approximately \$200 million per annum for country level action, together with resources for the WHO Roll Back Malaria Project.
- 1.12 Political support for partnerships will need to be sustained via:
  - information and technical agreements
  - reviews of work, with quick reports of results
  - high level advocacy
  - continued championing and marketing of the idea

**In summing up, Dr Brundtland, WHO Director General:**

- 1.13 Expressed her gratitude for the groundswell of support for the basic concept, objectives and approaches to be taken, in Rolling Back Malaria.
- 1.14 Emphasized the importance of capitalising on the current momentum to get Roll Back Malaria implemented on the ground.
- 1.15 Underlined the importance of Roll Back Malaria as a pathfinder in identifying new ways for partners in International Health to work together effectively.
- 1.16 Stressed that Roll Back Malaria - as a pathfinder within the organization, and as a cabinet project - is expected to develop new ways of working between WHO clusters, regions and country activities.
- 1.17 Pointed out that Roll Back Malaria presented a broad institutional challenge, going far beyond those concerned with malaria at HQ, regional, and country offices.

## 2. INTRODUCTION

The meeting of partners to 'Roll Back Malaria' (RBM) was opened by Dr David Heymann, Executive Director of the Communicable Diseases cluster, on behalf of the Director General. Dr Heymann described the positioning of the Roll Back Malaria project, initiated by the Director General to facilitate intensified efforts and look at new ways of controlling malaria, within WHO. RBM is a project of Cabinet, has a house in the Communicable Diseases programme, and draws on expertise in other WHO clusters such as Emergency and Humanitarian Action, Health Systems Development and Health Technology and Pharmaceuticals.

Ambassador Store described WHO's renewal process, a result of the Director General's pledge to reform the organisation following her election at the WHA in May 1998. Led by a senior management team, regrouping of programmes and activities began on 21st July 1998, the day the Director General took office: 50 programmes have been regrouped into 9 clusters, then reduced to 35 departments, and the organisation is in the process of appointing new directors. Other fundamental changes are the introduction of staff mobility and rotation, so that Headquarters is more inspired by countries and the organisation becomes 'one WHO'; transparency of budgets at all levels of the organisation; and bringing management support closer to technical programmes and actions to improve efficiency and consistency. As a Cabinet project, RBM is defined as a pathfinder, teaching WHO how to work across programmes, across the house, and how to develop co-ownership among partner agencies and among countries.

Dr David Heymann nominated the Chair - David Nabarro, Head of Health and Population Division, UK Department for International Development; the Vice Chair - Dr Z Maiga, Secretary General of the Ministry of Health, Mali; and the Rapporteur - Dr Madeleine Leloup, Ministry of Foreign Affairs, France.

The meeting was attended by 41 representatives of national and government agencies, 19 representatives of regional and international organisations, 8 representatives of WHO regional offices and 8 members of the RBM Secretariat (see list of participants in Annex 2).

### **3. ESTABLISHING A GLOBAL PARTNERSHIP**

#### **3.1 Reasons for the Partnership**

##### **The Malaria Burden: problems and issues - Dr Fred Binka**

Malaria affects 100 countries world wide, causing 300-500 million clinical cases per year, over 80% of which are in Africa, and one million deaths per year, over 95% of which are in children under five years in Africa. Severe forms of the disease result in neurological sequelae and disability, the extent of which is probably underestimated but which no doubt has a significant impact on cognitive learning especially among children. The malaria situation is worsening: malaria has been reintroduced to areas where eradication was achieved in the 1950s and 60s; malaria is now found in areas previously free of the disease; and the number of epidemics in Africa, Southeast Asia and South America are increasing.

Perhaps the major threat to the control of malaria is the development of drug resistance - to sulphadoxine-primethamine and mefloquine in South East Asia and to chloroquine and, more recently, to sulphadoxine-pyrimethamine in Africa. Other major problems in the control of malaria are poor access to health care and issues associated with delivery, including: under utilisation of public health facilities and high use of the formal and non-formal private sector, poor availability of antimalarials in public health facilities and high costs.

Contributions to help countries tackle the malaria burden, from external sources, totalled US\$287.5 million in 1997<sup>1</sup>. Sources included Development Banks (US\$172 million), Bilateral agencies (US\$32 million), Multilateral agencies (US\$15 million), research institutions (US\$4 million), NGOs (US\$16 million) and the private sector (US\$6 million).

##### **Background to RBM and Preparatory Phase - Dr Tore Godal and David Nabarro**

Political and financial commitments to malaria have seen a significant increase in recent years, and particularly in the last two years, as illustrated by the number of new malaria initiatives. These include the Africa Initiative on Malaria (AIM), the Multilateral Initiative on Malaria, the Director General's special fund for accelerated action in Africa and new co-operation with the private sector, such as the Medicines for Malaria Venture. There have been a number of significant political statements by political bodies including the G8 countries, four UN agencies, the OAU and most recently by WHO's newly elected Director General.

The basic concept of RBM is to address a priority problem within the context of health sector development, intersectoral collaboration and community action. WHO will

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<sup>1</sup> Martinez J, Hill J and Meek S (1998) Global Coordination of Malaria Control Efforts - issues and options for supporting country strategies. A study commissioned by WHO/CTD

provide strategic direction to a global partnership to make the best use of available resources through the RBM project.

Objectives of the RBM partnership are to:

- Significantly reduce the global malaria burden through improving people's access to interventions adapted to local needs
- Achieve results through effective support to health sector development
- National goals to be set by countries based on situation analysis and feasibility assessment
- Global targets will be set from aggregated national goals at the end of the RBM preparatory phase (end 1999)

Expected results at the end of the RBM project period are:

- Significant reductions in poor people's burdens due to malaria: ideally halving of malaria mortality by 2010
- Improvements in people's access to effective anti-malaria interventions adapted to local needs and contexts
- National health sectors, and other sectors associated with human development, respond better to requirements of poor people in relation to malaria
- The RBM approach contributes to the effectiveness of actions by other groups within and outside WHO

Intermediate objectives for 2001 for:

- 1) country level action,
- 2) the Global RBM Partnership,
- 3) synergy within WHO and associated bodies,
- 4) monitoring, review and reporting,
- 5) development and deployment of new tools,
- 6) advocacy, resource mobilisation and the provision of assistance for RBM.

The RBM approach will be to build on current efforts, with the Africa Initiative on Malaria as the spearhead, and the Global Malaria Control Strategy, based on regional, epidemiological and health systems needs and focus on community and district level action. The first priority will be areas of high transmission in Africa, followed by countries experiencing epidemic malaria and malaria endemic countries in other regions. Investment will also be made in research and development of new tools that can help short term gains.

### **3.2 Existing Partnerships**

#### **Analysis of country-level partnerships for health**

Country level experiences of coordinating international assistance for better health were presented for Uganda (Dr P Byaruhanga), Zambia (Dr JJ Banda), India (Dr Shiv Lal), Vietnam (Prof Pham Manh Hung), the Democratic Republic of Congo (Dr Mathey Boo) and Mali (Dr Maiga).

Uganda is attempting to consolidate their health services after years of political turmoil in the 1970s and early 1980s. A resource flow map for inputs to the health sector in Uganda highlights the problem which results with multiple inputs of several different donors, each with different objectives, leading to uncoordinated, duplicated efforts realising limited impact. Steps are now being taken to improve and simplify resource co-ordination through a single clearing house in the Ministry of Finance, from where earmarked beneficiaries can access resources, i.e. through Sector Wide Approaches (SWAs). However, there are many challenges that have yet to be addressed to advance this approach.

Zambia has introduced a partnership of cosponsors for district health services, where funds from central donor accounts are managed by a Central Board of Health (CBOH) district account. Districts then receive funds from the CBOH account as well as from central MOH on a quarterly basis. Cooperating partners also adhere to joint planning and monitoring missions and operate according to jointly agreed standards of financial and administrative management systems. The system is well planned and locally driven, allowing districts a large degree of freedom. Funding delays are however a problem.

India spends more than one third of the government health budget on malaria. Initial experiences following the revision of the national malaria control strategy in line with the Global Malaria Control Strategy have been encouraging - the disease is largely contained. However, more than 70% of malaria cases go to the private sector for treatment of variable quality and there is need to educate the community combined with effective multisectoral coordination at the community level and continuing updating of private medical practitioners.

In Vietnam, in the period between 1991 and 1997, the number of malaria deaths has been reduced by 97%, the number of malaria outbreaks by 92%, and the number of malaria cases by 59%. The success of the National Malaria Control Programme is due to strong leadership and organisation of the programme by government, realistic objectives and appropriate technical measures. The National Health Programme is directed and implemented by MOH with the coordination of the Ministry of Planning, Investment and Finance. Administration and management of resources are decentralised to local levels. International donors undergo a process of acceptance and then work with the Steering Committee of the Malaria Control Programme to undertake needs assessments, strategy development and planning of malaria activities. Differences in the fiscal years and financial management regulations between the

government and its partners causes delays in addition to which there is limited management capacity of MOH staff.

DRC has undergone a number of much needed changes with regard to donor coordination. Currently health sector inputs are coordinated by an interagency committee, with subcommittees for malaria and other programmes. The committee is currently changing its method of working.

### **Analysis of global and regional Partnerships for Health - Dr Penelope Key**

An analysis of existing global and regional partnerships which have had varying degrees of success was undertaken in order to identify key characteristics of successful programmes of relevance to establishing the RBM partnership mechanism. Some of these have a public health mandate (polio eradication, UNAIDS) while others address other sectors such as agriculture or the environment. There is a wide spectrum of existing partnership structures and governance, ranging from the tightly governed, legally binding group at one end to the loose stakeholder coalitions at the other end. In the middle sit a large group with a degree of governance and structure, but having a flexible operating modality. The degree of ownership by, or involvement of, countries as equal partners varies from virtual exclusion to full, such as the Intergovernmental Forum on Chemical Safety.

Partnerships whose prime purpose or mandate is for raising and managing financial resources, usually centrally operated, tend to be tightly governed, with strict membership rules, legal agreements, management staff and tight criteria for allocation of funds. Partnerships whose primary mandate is co-ordination of strategies and activities, with action taking place at country level, tend (though not always) to be looser, informal coalitions of stakeholders, where secretariat functions are undertaken by programme staff. Partnerships with secretariats that are autonomous or independent of programme management tend to demonstrate better ownership by the partners, but they have sustainability problems.

Where resource mobilisation and management functions are integral to programmes, as in WHO TDR and HRP and WHO GPVI, this has a real cost in terms of staff time and detracts from programme achievements. It appears that there is value in out-placing this function to an independent Partnership Structure; Resource mobilisation must be planned and continuous. Involvement of private (commercial) sector agencies as full members of partnerships may dictate the partnership structure. WHO, for instance, has regulations which exclude their full (voting) membership of certain official committees.

A high-profile Civil Society Champion is invaluable for continued advocacy and resource mobilisation. The roles of each Partner organisation should be defined clearly from the start. Building the partnerships requires time and effort. Continued, consistent information and updating of partners about programme progress is essential. Personal rapport is needed between partners at a high level. Political commitment in endemic countries must be maintained. Inter-sectoral support in countries is vital to public health programmes and requires involvement of the Head of State to succeed.

Regional Partnerships have shown considerable success. The West Africa OCP is the outstanding example. This is firmly sited in the tight governance group. One longstanding collaboration in Asia (SEMEO-TROPED) is institution-based but has proved its worth, the second (ACTMalaria) has started well but long term funding is a problem. Regional partnerships will be challenged by agencies' differing regional definitions. In the case of malaria, boundaries based on epidemiological types are more logical. Cross-regional representation is invaluable.

Proposals are made for possible structure of the RBM partnerships based on past experiences and lessons learned.

## **4. ISSUES IN ESTABLISHING THE RBM PARTNERSHIP: Summary of Discussions**

The presentations summarised above provoked active discussion among participants concerning the important issues in establishing the RBM partnership mechanism. There was excellent participation by all participants and particularly by country representatives - ministers, malaria programme managers and representatives of non-government agencies - who were alert in responding to what the donors were saying. This lively interaction was one of the highlights of the meeting. This section attempts to summarise the issues raised during this discussion.

The RBM project of WHO has been initiated for a five year period in order to establish and consolidate WHO structure, leadership and partnerships to 'roll back malaria'. During the lifespan of the WHO project, the RBM partnership must become highly effective to ensure continuity of intensified efforts at the end of the WHO project. The success of the RBM partnership in terms of its impact on malaria will be dependent on its ability to sustain intensified action in Malaria Endemic Countries over a 20 to 30 year period. Within WHO, the RBM project will become integrated into ongoing activity within five years.

RBM will address malaria in the context of health sector development. The RBM partnership must therefore find ways to address the different status of health sector development and reform in different countries. It must also ensure that Health Sector Development and malaria technical issues are brought together, for example, to ensure that pharmaceutical policy, and drug resistance issues, are properly handled within the health sector context, and that malaria related action takes account of the low salaries of health workers. Partners will therefore have to become immersed in significant health sector issues. Results of the RBM partnership will be assessed in terms of health sector development-related outcomes as well as malaria outcomes.

However, action through the health system is only a part of controlling malaria. The RBM partnership needs to find viable entry points for malaria control especially to engage households and to mobilise whole societies. As a first step, the partnership must involve the poor and the rest of civil society in dialogue about Rolling Back Malaria by involving those NGOs which articulate demands and interests of civil society. The challenge is to ensure effective communications between all groups interested in Rolling Back malaria: several of these do not communicate effectively with each other at present. The partnership needs to combine focused thinking with a sophisticated, response - which goes beyond health care systems. This response must also engage the private sector at all levels - from multinational entities to local shopkeepers.

In addition to a broad response to tackling malaria, RBM needs to take account of other issues besides malaria. Malaria is only part of the burden carried by poor people, particularly by women. The RBM partnership needs a proper understanding of the causal relationship between poverty and malaria and of other social and economic issues

which affect the poor. This will require the development of appropriate gender and poverty strategies for RBM.

Financial contributions to national malaria control activities have often been poorly aligned to the burden posed by malaria, and the related needs of poor people. The RBM partnership must develop a rational approach to ensure that resource flows within countries, and through partners, are aligned with the burden of malaria. Funding contributions as well as strategies need to be based on regional, epidemiological and health systems needs. Focus must be on community and district level action; and this will require simplified, timely and transparent funding channels which allow districts the freedom to manage their own funds. The challenge for the partnership will be how to intensify action for malaria through a common pot/basket to avoid the complex situation found in Uganda and other countries. It is however recognised that not all partners will be able to channel funds through SWAps, and flexibility of funding mechanisms will be needed. The RBM partnership will also have to find effective means to garner untapped resources in both the public sector and the private sector.

Clarity of roles within the partnership is essential from the outset. Countries should be central to the partnerships at all levels and especially at country level; this will be government or indeed other recognised institutions responsible for States or parts of States. Co-ordination at country level will be critical to the success of RBM: the organisational issues on malaria work at country level within MOH and between MOH and other service providers need to be clearly understood and addressed by the partnership. Partnerships need to be sensitive to local conditions and draw on existing country experiences.

While WHO has a core role to play in the partnership at global level, other partners may have comparative advantages at country and regional levels and this needs further discussion. The partnership will need to learn lessons from other programmes both within and beyond the sector, and from region to region. The role of the WHO project - at Headquarters, Regions and Country level - to support the Global RBM partnership is therefore likely to be different depending on context. A partner will be a partner at every level: once a partner at global level, this applies at country and regional level, and partners must speak with one voice at every level. The ways in which partnerships operate at different levels will differ, and they must not be too complicated, rigid or time consuming. The objectives of the partnerships at each level need to be realistic. Criteria for success in the short, as well as the long, term are required so that the partnership can demonstrate progress.

Advocacy for RBM must go beyond malaria and address other causes of mortality, inequity and poverty. Furthermore, justification for support must always combine human rights with hard economics. This broad approach will be central to the partnership's advocacy role. Advocacy at community level is also needed in order to mobilise the people affected by malaria, who have become refractory to the disease. There needs to be a clear link between local and international advocacy, with messages originating at the grassroots. A northern champion for the RBM partnership is needed.

Once political will is mobilised, challenges for the RBM partnership are how to translate political will, both of the international community and from malaria endemic countries, into precise and concrete action and how to garner regional and country perspectives on how the RBM partnership should work.

## **5 ROUND UP SESSION**

- 5.1 During the round-up session with Dr Brundtland, very strong and broad support was expressed for the Roll Back Malaria initiative, and the underlying approach, including;
- the strong linkage to health sector development
  - the need to engage various partners, NGO's, Civil Society and various types of health providers at the local level
  - adding value and investment to research efforts for the development of new and better tools through MMV, MIM and TDR
- 5.2 There was strong support for the leadership role of WHO in taking the global RBM partnership forward.
- 5.3 WHO was requested to take a leadership role on Roll Back Malaria and to take the partnership forward in a flexible way, building on current structures, rather than building new ones.
- 5.4 Partners were satisfied with the way Roll Back Malaria had been taken forward during 1998, and noted the commitment already expressed by Governments in affected countries, Civil Society Institutions, Donor countries, the private sector, the UN system's Agencies and Development Banks.
- 5.5 Some partners proposed a follow-up meeting of the full group towards the end of 1999.

## **Annex 1**

### **Planned outcomes of the meeting (prepared November 1998)**

1. Agreement on purpose, operation and possible structure of the partnership
2. Frameworks for country-level agreement on:
  - synchronising partners' strategies
  - resource mobilisation, flow and provision in a transparent and coherent manner
  - Monitoring and review of partnership action, financial accounting, communications and maintenance of partnerships
3. Agreement on approaches to international advocacy, public relations and political action in relation to RBM
4. An understanding of the roles and responsibilities of different partners, and an examination of the need for governance and/or legal instruments
5. A shared understanding of the role of the WHO-RBM project in relation to the global partnership
6. Plans for taking forward the partnership

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Dr Hans Remme, RBM

## **Agenda**

### **Tuesday, 8 December**

#### **0830 – 0900 Registration**

#### **0900 - 0915 Opening and Introductions**

- Dr David L. Heymann, Executive Director, Communicable Diseases

#### **0915 – 1000 WHO Renewal: progress and challenges**

- Ambassador J.G. Støre, EXD, DGO

Appointment of Chair / Rapporteur  
Meeting Objectives

#### **1000 - 1045 The Malaria Challenge**

1. The malaria burden world-wide; problems and issues  
Present Contributions to Malaria Control
    - Dr F. Binka, WHO/RBM Team
  2. Roll Back Malaria: The preparatory phase
    - Dr Tore Godal, Acting Project Manager, WHO/RBM
- Discussion

#### ***1045 - 1100 Coffee Break***

#### **1100 - 1300 Global Partnerships for national and local action**

3. Existing mechanisms for coordinating international assistance for better health
    - Country perspectives; experiences and lessons learned
      - Zambia Dr J.J. Banda
      - Uganda Dr Philip Byaruhanga, Minister of State for Health
      - UNDP, India, Mali & Vietnam as discussants
- Existing Global and Regional Partnerships

- Dr P.J. Key, WHO/RBM Team and  
Dr Ok Pannenborg, The World Bank

- Discussion

### **1300 – 1430 Lunch Break**

#### **1300 Poster Session commences in Foyer:**

Represented Agency's Work Plans for support to RBM / Malaria Control for 1998/99 and beyond  
Technical posters

#### **1430 - 1600 Establishing the RBM partnership**

4. The purpose, operation and possible structure of the partnership  
- Dr P. J. Key, WHO/RBM Team  
  
Possible organization for the RBM-African Initiative for Malaria  
- Dr A. Kaboré, Director of Communicable Diseases,  
WHO/AFRO
5. An understanding of the roles and responsibilities of different partners  
- Mrs M.-H. Mathey-Boo, WHO/AFRO
6. How the bi-lateral agencies can best participate  
- Dr Dennis Carroll, USAID
7. The Role of Local Government and Civil Society  
- Ms F. Issaka, Ghana

- Discussion

#### **1600 – 1615 Tea Break**

#### **1615 – 1745 continue discussion**

#### **1800 – 2000 Reception in French Restaurant**

## **Wednesday, 9 December**

### **0900 – 0945 Advocacy and Public Relations**

8. Approaches to international advocacy, public relations and political action in relation to RBM - Dr David Alnwick, UNICEF
- Discussion

### **0945 – 1030 RBM Funding**

9. Funding and financial arrangements for long term support for RBM Country programmes - Dr Ok Pannenborg, The World Bank

### **1030 – 1100 Coffee Break**

### **1100 – 1230 Potential for Frameworks at country, regional and global levels:**

- synchronising partners' strategies and plans
- resource mobilisation, flow and provision in a transparent and coherent manner
- monitoring and review of partnership action, financial accounting, communications and maintenance of partnerships

### **1230 – 1400 Lunch Break**

### **1400 – 1530 Plans for taking forward the partnership**

10. Institutional Structure
  - An RBM partnership secretariat
  - A standing committee
  - Governance and/or legal instruments
  - Global/regional/block/National stakeholder meetings

### **1530 – 1545 Tea Break**

### **1545 – 1700**

- Conclusions and Recommendations

### **1700 Closure**