

**FOLLOW-ON MEETING TO THE POST-HIGH LEVEL FORUM
ON THE
HEALTH MDGs**

Tunis, Tunisia
June 12-13, 2006

Rapporteur Notes

Monday, June 12

Session One – Participant Expectations: What do the Organizations Represented Want from the Meeting?

Chairs: Julian Lob Levyt (GAVI)
Jean Damascène Ntawukukiryayo (Minister of Health, Rwanda)

The welcoming remarks summarized the key themes to emerge from the series of HLF meetings:

- Commitments on quality and quantity of DAH are not being realized
- Global commitments on harmonization and alignments are not being realized fast enough at country level. Aid continues to be tied to specific projects rather than health sector strategy, making it difficult for governments to plan for long-term. Disease-specific interventions needed support overall health systems strengthening,
- Making the case for health continues to be important - to this end, demonstrating results is a priority and health information should be considered as a global public good
- Effective multi-sectoral approaches to improve health are lacking.
- We need to improve health in the full range of contexts, including fragile states
- Much more attention should be paid to the role of the non-state sector

The point was made that the HLF Consensus does not have a long shelf life. We therefore need to leave Tunis with a clear, time-bound process for converting this consensus into a programme of action. A decision just to hold another meeting should be considered a failure. The need to act quickly means that it will be impossible to develop the perfect plan, but this should not prevent us from moving forward: we must learn by doing.

Participant's expectations: proposals

- Over the next two days a process should be agreed for harnessing the widespread political support for scaling up in health
- It was proposed that within the next six months an *action and implementation plan* for supporting scaling up at country level should be developed. This should include looking at what *functions* are required to support the plan, and in turn, what *institutional arrangements* are required to support these functions.
- Politically, a clear political statement on the way forward will be needed much more quickly.

- Development of the plan must at this stage remain multi-institutional, rather than embedded within any particular institution. However, division of responsibilities between institutions needs to be clarified.

Remaining questions to be discussed over the next two days include:

- Do we need a new initiative, such as an FTI health? Or, should we continue to work within existing frameworks
- If a new initiative is established, how to ensure that it is coherent with the multiple existing health financing channels
- Equally, is there a special case to be made for scaling up in health, or should we be looking at solutions that seek to scale up across the MDGs?
- What should be the criteria for selecting countries for scale up?
- Should we be focusing on a small number of pilot countries (5-7), or a much larger number? One solution may be to work across a number of countries, but intensively in a small learning set.
- Should we designate a lead agency for each 'pilot' country?
- Should the focus be exclusively on Africa, or should it include other low-income countries, e.g., in south Asia?
- How to ensure the involvement of regional institutions?
- How to ensure that efforts to scale up donor assistance are complemented by domestic resource allocation?
- How to ensure that the principle of subsidiarity is maintained, ie that no decision is made at a global level if it can be made instead at country level.

Session Two – The Case of Rwanda

Presenters: Jean Damascène Ntawukukiryayo (Minister of Health, Rwanda)
Ernest Rwamucyo (Ministry of Finance, Rwanda)

Chairs: Eric Buch (NEPAD)
Neil Squires (EC)

Introduction: The session’s content was based on a background paper entitled “Scaling Up to Achieve the Health MDGs in Rwanda: A Background Study for the High-Level Forum Meeting in Tunis June 12th-13th 2006.” There were three presentations:

1. ‘Scaling Up to Achieve the Health MDGs in Rwanda’ presented by Ernest Rwamucyo, Director General for Development Planning Ministry of Finance and Economic Planning.
2. ‘Scaling Up to reach the MDGs in Rwanda’ presented by Dr. Jean-Damascene Ntawukuliryayo, Minister of Health, Rwanda.
3. ‘Aid Effectiveness in Rwanda’ presented by Ernest Rwamucyo.

The Chair requested that both presenters and participants focus their comments and questions on clear actions and lessons, key processes, and what would be needed to be reflected from this session in a six month work planning effort, if a decision to move forward with a collaborative process is taken by meeting participants.

Presentations: The three presentations highlighted the macroeconomic and fiscal situations including the importance and forms of donor aid, health sector financing and gaps in financing for achieving the MDGs, country planning and budgeting processes, and donor coordination mechanisms and the strengths and weakness of current donor harmonization and alignment efforts. The presentations highlighted the planning and budgeting framework, efforts to improve management of domestic and foreign resources, Rwanda’s 2020 macro-framework, implications for external financing, and managing the risks of increased aid. It was clear that the country had comprehensive and well integrated macro and sectoral planning process which coordinated short, medium, and long-term development objectives in the context of PRSPs, MTEFs and annual budget processes. Growth and social sectors are the GOR’s top priorities. Rwanda has undertaken a series of public sector management reforms resulting in a transparent and generally well functioning, decentralized budget execution processes. There is also a comprehensive results-based M&E process in place to evaluate performance.

Data were presented on future growth potential, poverty, domestic revenue mobilization efforts, and the levels of investment in public infrastructure. It was clear that even under the highly unlikely scenario of growth doubling, it is unlikely that Rwanda will meet the poverty reduction MDG. It was also apparent that there are large infrastructure investment needs and domestic resource mobilization is limited. Data were also provided showing the importance of ODA in terms of overall government revenues (\$400 million, 26 percent of GNI, and, accounting for almost half the GORs budget even excluding off-budget aid) and the need for massive, and

unrealistically large, increases in donor assistance (even under the most optimistic scenarios) for the MDGs to be achieved. It was also made clear that this aid needed to be long-term, predictable, provided through budget support - not projects, and better aligned with country systems and country plans in order to reduce the substantial transactions costs and distortions faced by the country in managing such aid.

In terms of the health sector per se, there is a well integrated Health Sector Strategic Plan (HSSP) that is fully integrated with the annual budget process, PRSP, MTEF, and country's long-term development goals. The health share of the GOR budget has increased from 2.5% in 1998 to 10% in 2005. The plan is based on high impact evidence-based interventions, decentralized implementation, performance-based resource allocation, an evolving social health insurance mechanism, and collaboration with donors through a Health Sector Cluster. Donor support for health is quite significant having increased from \$49 million in 2003 to \$106 million in 2005. However, only 14% of the funding is used directly by the central government, 12 percent goes to local governments, 55% goes directly to NGOs, and 19% goes for development partner management (actually 27% of total (i.e., donor and country) spending). In addition, since the bulk of the funds go for projects, aid has created massive regional distortions with aid ranging from almost \$12 per capita in some regions to less than \$2 per capita in others. Aid is also highly skewed by program with \$47 million for HIV/AIDS (in a country with an HIV prevalence rate of 3 percent), \$18 million for malaria, and only \$1 million for IMCI (partially resulting in the GOR being able to provide only 2 of 12 life-saving maternal, neonatal, and child health interventions). These increases in aid have also resulted in a proliferation of donors, which now number some 21 plus over 40 NGOs.

In order to meet the MDGs, a costed plan was presented which would result in health spending needing to increase by some \$20 per capita from its current \$14 level. A six step approach was presented along with calculations showing how even under the most optimistic growth and aid scenarios the country would at best be able to cover only half this gap. Making better use of current and likely future aid commitments is critical and various measures to do this, most relying on better donor harmonization and alignment were presented.

The country is in the process of adopting this month a comprehensive set of aid policies designed to assure closer harmonization and alignment, ultimately resulting in a joint action plans with all donors that are designed to remedy the harmonization, alignment, fragmentation, verticalization, etc. problems. The GOR also developed a draft compact based on their education sector strategy that could serve as the basis for their participation in a Brokering Services Process. This would entail mutual accountability, a results framework, M&E, etc.

Discussion: Many of the comments reflected questions concerning clarifications of issues such as: scaling up to deal with the HRH problem; the details on the internal budget and external aid coordination mechanisms in the GOR; changes in donor behaviors that are necessary to deal with the harmonization and alignment agenda; questions about the lead donor and whether there is a need for a Global Brokering Secretariat; the comment that virtually all the future fiscal space would need to come from external assistance grants; appropriate steps for sequencing the reform; observations that the big donor money was not where it was needed but what would happen if it went into broad budget support – would the government still continue its domestic-revenue-

based support of the sector; would donors buy-in to the proposed compact; there appears to be a need to have an aid ‘do no harm principle’; queries on multi-sectoral tradeoffs – particularly education and gender issues; agreement of the difficulty for the GOR to manage its health sector when only 14% of health aid is directly spent by the central government; questions about the viability, affordability, and sustainability of the proposed insurance system when a SHI approach hasn’t really worked on a broad scale anywhere in Africa; agreement that the project funds were not helping build health systems; vertical programs siphoning off needed staff from MOH; issues of the role of private/non-state sector; questions of whether the 6 step investment program adequately will deal with maternal, newborn, and child health; several participants insisted that many of the questions raised really needed to be answered by the donors at the table, not the country; how are the funding and results from NGOs monitored as this is off budget; and GOR is being severally challenged by the inappropriateness of the aid instruments vs country priorities and problems.

GOR officials responded quite openly and factually to the questions, providing details on HRH, the coordination processes, multi-sectoral tradeoffs, private sector/NGO interfaces, and what exactly they need and hope to get from donors through their proposed new aid harmonization and alignment process to improve aid effectiveness and reduce transaction costs. Interestingly, no donors at the table responded to the direct questions raised by both other country participants as well as donors as to why donors were not aligning themselves with these processes and why so little aid was flowing through general budget support.

It was generally acknowledged that the Rwanda case was not a question of leadership – indeed in most areas – planning, prioritization, public sector management, macro-micro linkages, performance-based results, M&E, transparency, etc. the GOR is doing everything right. The rather pregnant unanswered question was why aren’t the donors harmonizing and aligning with the country-owned, well thought through strategy? One of the chairs put this conundrum most vividly when he stated:

- Country has made major accomplishments
- There is clear evidence of effective, country-based, Africa leadership
- Specific proposals have been put on the table by the GOR, which is more than willing to engage in discussions fully reflective of the Paris Declaration
- MOF and MOH are working together seamlessly
- Yet, development partners are silent
- What more do countries need to do for development partners to change their behavior?

The session Chair pointed out that the Blair Commission had recommended that 40 percent of new ODA should be focused on health. Given the Rwanda situation, what will donors have to do to assist countries in using that aid effectively and inline with country-led and driven priorities? In particular:

- We have Africa commitment
- We have excellent MOF and MOH coordination with the GOR fully committed and monitoring its performance in a results based framework

- Nevertheless, there is a large fiscal gap which even under the most optimistic scenarios of a doubling of economic growth and external aid could only at best be halved by 2015. Equally problematic is that about half of the gap (i.e., some \$10 per capita) results from the costs of HIV/AIDS treatments and this is in a country with a prevalence rate of only 3 percent
- High transactions costs and disproportionate allocations toward specific diseases resulting from large vertical programs are distorting country priorities
- Funding is creating large within country regional equity imbalances
- Sustainable financing needs to be tied holistically to an effective delivery system, which deals with physical infrastructure, HRH, and clarity of the role of the private sector.

Perhaps if time permitted, the GOR could have provided more detailed and/or convincing answers to a few of the questions, particularly on the costs of the maternal, newborn, and child health program and how it fits into the 6 step reform agenda as well as the feasibility and sustainability of the new insurance system. However, the glaring unanswered question from the session was clearly: *why haven't donors changed their behaviors to reduce the major distortions and transactions costs that are being imposed on a country that has taken effective leadership including macroeconomic management and appears to be doing almost everything right? Are donors capable of changing their behaviors even in the most compelling cases? Would there be some value from a "Brokering Services" Process in this regard?*

Session Three – The Case of DRC

Presenters: Constantin Miaka Mia Bilenge (Ministry of Health, DRC)
Hyppolite Kalambay Ntembwa (Ministry of Health, DRC)

Chairs: Francis Omaswa (GHWFA)
Francisco Songane (PMNCH)

Presentation: The presentation insisted on four dimensions:

1. *The historic legacy:* DRC had a robust health system (with a dense network of hospitals and health centers, good health indicators) until the 1980's; then, it was ruined by a succession of political, economical and social crisis and conflicts. The State had no control of the system, the health system became very fragmented with districts offering global programs and all conditions were met for a "verticalization" of health systems. There was a significant boom of the for-profit private sector and "health care for sale" (the "pump" system, or informal taxation), an institutional inflation and a distortion of services (from 306 to 515 districts) and an overproduction of human resources (from 17 to 58 university and training centers; from 618 doctors trained in 2001 to 1700 in 2004. 2500 doctors trained in 2005 at 2 universities). Donors reacted by judging the system ("It's corrupt and it does not work"), by creating parallel systems for rapid results and parallel systems to gather data; there was a lack of focus on support and capacity building, sometimes conflict relation developed with structures donors should support. A multiplicity of donor coordination mechanisms emerged and donors organized themselves within Multi-donor group for health (GIBS) which also contributed to fragmentation.
2. *Definition of a health strategy:* In 2005, DRC authorities designed a health strategy which focuses on district development, re-defines the roles of the central and intermediary levels, rationalizes the financing and the human resources policy and aims at strengthening intra-intersectoral coordination. DRC officials insisted on four specificities of the strategy: actions undertaken to stop inflation and distortion effects (i.e. limitation of the number of medical schools); start from operational problems in the field and progressive development of districts; actions aiming at reducing fragmentation of the donor negotiation process and recent shift from program to system funding.
3. *Lessons learnt:* DRC officials emphasized the rapid effects of the strategy thanks to a broad consensus, to an endogenous process, to the mobilization of the institutional memory and through the piloting of projects at both national and provincial levels. There's an ongoing redefinition of large projects financed by GHPs.
4. *Vision of DRC for the future:* DRC officials stressed the importance of rebuilding the health sector as a contribution to rebuilding the State and this will take time. They felt that the responsibility and the challenge for the country and donors in the health sector is more than controlling a sum of diseases and is about health system strengthening and it will cost money to achieve this goal. Donors need to understand that the State is still fragile; they need to be

flexible and align their internal incentives, make long term and predictable commitments and need to look at Human Resources issues and institutions not just at programs and technical issues.

Discussion: The following questions/comments and answers arose during the discussion.

- Shouldn't the country strategy take advantage and build on individual and institutional survival strategies and NGOs involvement instead of rebuilding the State as it was before? DRC officials indicate that the objective of the reform is to set a system that performs well and to guarantee good quality of health care.
- More comprehensive data is important for donors to make decisions and for donor coordination. DRC officials recognized that there are data issues.
- Donor support across Rwanda and DRC varies significantly. One donor representative expressed the view that efficiency increases when there's a strong presence and pressure of donors in a country, referring to Rwanda. One participant thought that DRC stands where Rwanda used to be 10 years ago. Donor coordination works well in Rwanda, a country which is already ready to move further on alignment and harmonization with different donors. In DRC, donors need to provide sustained and long-term support. The more active donors should push for other to join efforts of budget support.
- Contrast between the strong will of coordination at the country level and the difficulties deriving from the absence of budget support and basic mechanisms; one participant felt that there's a need to look at possible arrangements for donors "shadow alignment".
- Opportunity for realignment and adjustment: How can we have global partnerships (GAVI, GFATM) adjusted to new context and reinforce the system? DRC officials indicated that there are ongoing efforts to reorient GFATM support through round 6 within the strategy; there are health systems related areas in which donors need to invest more.
- What are the core functions of the State in DRC in the health sector? DRC officials indicated that the mission of the State is the definition of norms and regulation.
- HRH proliferation: one participant felt that what remains to be achieved is good use of health personnel and there's a need to think of salary structure and limitations to recruit these personnel. DRC officials presented their efforts to rationalize and prevent proliferation of health trained institution and engage in their accreditation.
- Improved communication and decentralization are crucial for the success of the strategy. DRC officials stressed also the importance of these dimensions, particularly the second one which is embedded in the new constitution
- How does the strategy integrate HIV/AIDS interventions? DRC officials indicated that they would like HIV/AIDS interventions to be more integrated within the global

packages.

- Results of the strategy are already significant and need to be supported. The international community needs to sustain its support and send signal to this post-conflict country.

Co-Chairs commended the exemplary results of DRC that were obtained in a very limited time and their efforts to move out from conflict situation to reconciliation and to set a reform and a unified health plan. They called on donors to support effectively and rapidly the country.

Session Four – The Case of Ethiopia

Presenter: Nejmunidin Kedir Bilal (Ministry of Health, Ethiopia)

Chairs: Louise Holt (Canada)
John Cutler (Global Fund)

Presentation: The presentation discussed Ethiopia's health sector performance and constraints. Key points include the following:

- Per capita health expenditure is approximately US\$5 (2000). Public share of total health expenditures is lower than the average for the Sub-Saharan Africa (SSA) region, although domestic revenue as a percent of GDP and government expenditures on health as a percent of GDP are higher than the regional average.
- Large funding gaps exist for health systems strengthening, infrastructure, human resources for health (HRH), and maternal and child health.
- However, since the Health System Development Plan (HSDP) was initiated in 1997/98, progress has been made on health outcomes related to child health, maternal mortality, immunization, and HIV/AIDS.
- Ethiopia has a PRSP and a costed health sector strategic plan aligned with the MDGs.
- Harmonization and alignment are priorities for the government. Partners signed a “code of conduct” with the government in 2005.
- However, donor fragmentation remains a problem in spite of efforts designed to address this, such as the MDGs Performance Fund – a US\$64 million source of pooled funds from five donors, which is used to procure essential commodities and equipment. More focus is needed on moving toward sector budget support and pooled funding, as well as more flexible funding that can be tailored to country needs.

Discussion: Several comments and clarification questions arose during the post-presentation discussion, centering on the steps the government needs to take to increase government funding for the health sector, strengthen health management information systems, mitigate the human resource for health crisis, and improve coordination and alignment among donors.

- Participants sought clarification on the extent to which the Ethiopian government is willing to prioritize health by increasing the allocation of domestic resources to health, noting that donors will consider such an increase an indication of the government's commitment to the sector. Mobilizing domestic revenues for health is particularly important given that long-term predictable financing for health is more of a vision than a reality at the current time. The volatility of donor funding, its short term nature, and donor tendencies to “turn off the tap” of funding flows - particularly for the social sectors - means that countries must allocate domestic resources to health to support the sector when donor funding decreases.
 - Ethiopia noted that because health is primarily donor-funded, the government is not motivated to increase the share of the budget allocated for health. Health is viewed as a sector that is externally funded – for the government, a disincentive exists to allocate more domestic revenues to health.

- With fiscal decisionmaking authority being decentralized, districts are permitted to allocate resources to whatever priority they choose. However, health is frequently not funded at the district level. If the resource envelope were harmonized, the overall budget allocation to health might increase.
- Prioritizing current strategies in extending health services to the population is necessary given limited domestic resources and the unpredictability and volatility of donor funding. However, gains from investments in previous steps are not lost when new strategies are prioritized. Each step builds on the previous investment.
- Strengthening and expanding health management information systems are a challenge. Integrating disparate systems into one national system into which donors would invest is particularly challenging in the face of many vertical programs.
 - Ethiopia noted that one of the strategic issues within the health system development plan is MIS. A functional information system is crucial but the health information system in Ethiopia is very weak because there are no standardized indicators or data collection tools. Vertical programs have weakened the effort to develop a national health information system because staff at the district level are burdened with the monitoring and evaluation reports required by donors. An international consulting firm has been hired to conduct a needs assessment.
 - A key question is whether donors are really ready to integrate their procedures and streamline their indicators to participate in a national health information plan.
- Significant funding gaps remain, especially if funding for HIV/AIDS is excluded. In particular, the human resource for health crisis is being addressed in Ethiopia but room for improvement remains. For example, training is needed for 30,000 health workers and health posts for 5,000 people need to be built. In the last two years, approximately 10,000 health workers have been trained. There is less of a problem at the community level. Of the approximately 5,000 needed health officers, 2,000 have been enrolled. Massive scaling up of training will be an inevitable option. Ethiopia will have to effectively utilize the resources they have trained.
- With the large role played by donors in Ethiopia's health sector, integrating current efforts such as the MDG Performance Fund and the health system development plan with other donor's efforts will become increasingly important. Opportunities may exist through pooled purchasing – although some donors are restricted from pooling funds – as well as through new financing mechanisms.

Chair's Session Summary

- Linking priorities of health sector with broader macroeconomic framework of countries.
- Harmonization and alignment. How do commitments translate into getting behind country level plans in a way that is flexible? How do we do this in the context of fragile states? How can gap between HIV/AIDS and rest of health system be bridged? Accountability – how does global community hold itself accountable for actions? What mechanisms can be employed and how can these mechanisms be aligned at country and global level?

- Continuity of donor funding is needed to allow countries to plan for the health sector over the long term.
- How can robust sector strategies be developed to really make a difference on the ground? What are key functions the governments have to take? HIS, HRH, infrastructure. Look at experiences from elsewhere as well as health.
- Consider these questions as we move forward. At what level can we act as we go forward?

Tuesday, June 13

Session One – Taking Stock

Chairs: Jacques Baudouy (WB)
Andrew Cassels (WHO)

Staff of WHO (Andrew Cassels) and the World Bank (Jacques Baudouy) gave brief summaries of the previous day's sessions, based on feedback received from session chairs and rapporteurs. In reviewing the country case studies, the World Bank discussed that the studies pointed to both good news and not-so-good news. Some countries have prepared health sector plans with results frameworks, but donors have not always been forthcoming with sufficient financing needed to provide long-term support for these plans, which cannot be funded solely from domestic sources. The challenge for the meeting will be to outline a plan for the next six months that stresses mutual accountability for making progress towards the MDGs.

WHO summed up three major themes from the discussions of the previous day. First, the link between the macro framework and health sector financing needs to be established in all country plans. Second, harmonization and alignment are critical for scaling up country health spending. Third, the following elements need to receive priority: strengthening health systems to address issues such as human resources for health; financing; health infrastructure; and government implementation capacity needs to receive priority.

In the subsequent discussion, the centrality of mutual accountability was reinforced by several participants, but it was also pointed out that there is a need to be specific, as some of donors have already committed to making long-term budget support available. Continued pressure on the development partners to live up to commitments could be a useful aspect of a facilitation service, as the experience in some countries has shown that overall public health expenditures have declined in some countries where commitments had been made. The requirement of sound data, including health systems metrics such as national health accounts, were said to be a requirement. Distortions created by donor financing, such as earmarked funding for HIV/AIDS, and resulting distortions across country government institutions, also need to be addressed. Furthermore, donors should make sure that technical advice should not contain mixed messages regarding priorities and costing. An important issue is how more effective coordination can be obtained, and how changes in donor behavior can be enforced.

Session Two – Education for All - Fast Track Initiative: Lessons for the Health Sector

Introduction: Jean-Louis Sarbib (WB)

Chairs: Reina Buijs (Netherlands)
P. Abdoulaye Nitiema (Burkina Faso, Ministry of Health)

This session looked at the experience of the Education for All Fast Track Initiative, and the lessons it might offer for accelerating progress towards the health MDGs and scaling up in the health sector.

Presentation: The Education for All Fast Track Initiative for Education (EFA FTI) arose from frustration that international commitments on Universal Primary Education (UPE) were not being met. The World Bank convened a meeting in June 2002 to catalyse action, which agreed to launch FTI.

Immediate action was needed so the process involved learning by doing. Initial analytic work identified characteristics of countries that had achieved UPE, and informed ideas on scaling up. Eligibility criteria were agreed with a commitment to support all countries meeting these. The challenge was to ensure sufficient resources to meet this commitment. A catalytic fund was set up to provide resources for 'aid orphans'. This fund also helped donors to support for education in countries where they did not have a bilateral programme.

The attached flow chart outlines the process for assisting countries through FTI. (*Refer to PowerPoint slide titled EFA FTI Process.*) Key features include an education sector plan linked to the PRSP; an accountability mechanism for donors in-country; and technical and financial support for countries. The FTI Secretariat (8-10 people) in Washington provides back-up (see www.fasttrackinitiative.org). FTI is governed by a steering committee, co-chaired by the head of G8 and a rotating non-G8 donor. It reports to the World Bank only on administrative matters. On substantive issues it reports to the steering committee and co-chairs.

After a slow start, FTI has gained momentum. It now has 50 donor participants; 20 countries' education plans have been endorsed; in-country commitments to education have risen by 40%; and it plans to reach 60 countries by 2008. The focus has switched from just raising numbers in school to raising the quality of education. And the catalytic fund has increased to \$500m of commitments and can respond within 4 months.

But the most notable achievement is the accountability mechanism for donors to education - based on mutually agreed rules among the partners. OECD/DAC has cited it as an example of best practise in the implementation of the Paris principles on harmonization and alignment.

Comments and Conclusions: Participants found the presentation informative, interesting and relevant for scaling up health. It was agreed that the following important lessons from FTI should be applied to health:

- Country-based implementation.
- Inclusivity - reaching aid orphans and fragile states; involving civil society.
- Strong links to the PRSP and national planning processes.
- Learning-by-doing.
- Mutual accountability mechanisms that can change behaviour.
- A catalytic function.

But it was also noted that an initiative in health would face different challenges. Given the high level of fragmentation in health - including several 'vertical' fast tracks - any initiative would need to develop mechanisms to bring partners together. This is additionally complicated because funding for health is often channelled outside government systems. It would be important - and challenging - to define a credible health sector plan. And what would be the eligibility criteria for support? How would countries be chosen?

Session Three – High Level Forum Evaluation and Options for Moving Ahead

Presentation: Ken Grant (HLSP Institute)

Chairs: Marie-Odile Waty (France)
Constantin Miaka Mia Bilenge (DRC, Ministry of Health)

Presentation: Ken Grant presented the independent evaluation of the HLF. It concludes that the HLF has had a significant and positive influence on donor behaviour and on the wider policy debate on how to achieve the health related MDGs. This was achieved through high level participation, informal discussion, excellent background papers, and a focus on a limited agenda of key issues. It had been stronger in addressing donor harmonisation and alignment issues than country issues, and participation reflected that, with a lack of continuity in Government representation. Examples of positive influence from the presentation and subsequent discussion include:

- Harmonisation and alignment: Decision to apply the Paris principles to the Global partnerships, specific examples of changed behaviour by GFATM, GAVI.
- Information systems: acceleration of health metrics network, with funding from Gates Foundation identified as a direct result of their participation in HLF.
- Human resources: establishment of the Global health workforce alliance.
- Fiscal space: although the agenda is unfinished, there is increased recognition and understanding of the issues, and HLF has had some influence on movements towards longer-term commitments backed by innovative financing mechanisms.

The evaluation recognises the need to focus, but points out that HLF has not addressed the non-state sector issues, and that communication of HLF analysis and findings could have been stronger. It also points to an unfinished agenda relating to:

- Fragile states: this is a relatively new addition to the agenda, and is unfinished business.
- Scaling up: the HLF has as yet had little real impact on scaling up health systems and financial support at country level.

In moving forward, the presentation identifies three main options:

- i. Do nothing. This option has some support given the proliferation of global initiatives, but is rejected by most interviewees because of clear evidence that progress is insufficient to achieve the MDGs.
- ii. Adapt the 'Fast track Initiative' model used in education, an option for which the evaluation finds little support, although there is some support for introducing a standard process and framework for assessing the readiness of countries to receive enhanced funding for their health sector plans.
- iii. Build on what exists, the option with most support. Key elements of the recommendations by the evaluators involve a comprehensive 'mapping' of country status, improved global coordination under World Bank and WHO leadership with a particular challenge to make the case for supporting health systems rather than specific

diseases, and peer review and mutual accountability including a review of progress in a further HLF meeting in 2008.

Discussion: Participants commended the quality of the evaluation, and there was broad support for the findings. The ‘do nothing’ option was rejected, and most participants supported options building on what exists. The institutional arrangements required would depend on first reaching agreement on the functions needing to be performed.

Throughout the discussion, the importance of country-led processes was stressed, and the need for improved two-way communication between HLF discussion and country experience. Where the existing country process was moving forward successfully, as in Rwanda, the HLF role could be to support the Government process by responding as positively as possible to the Aid Policy and the proposed ‘compact.’ In other cases, countries may need help to put in place effective plans and institutional structures.

There was support by several participants for the need to ‘map’ the current status of country plans and institutions against systematic criteria. Some participants wished to go further and propose some process of formal endorsement that might help to unlock additional finance, although others stressed the need to avoid undermining country ownership and country-driven processes. It was stressed by several participants that additional funding should come from existing mechanisms and the establishment of new funds should be avoided, although some means needed to be found for ensuring adequate support for countries with sound plans but few donors.

One of the criteria that needs to be assessed is the degree of country commitment to the health sector. There is concern that donor focus on health can be offset by reduced allocation of Government funds. Participants recognised that this partly reflects the problem that donor funding for health does not support the Government plan, leading to a Ministry of Finance perception that health is generously funded while key Ministry of Health priorities are underfunded. It was suggested that the dialogue within Governments on these issues needs to be strengthened, possibly through joint meetings of African finance and health ministers, or by adding the issue to the meeting of the African Partnership Forum, which brings together representatives of the heads of state of the G8 and of 20 African countries.

There was strong support for finding ways to support scaling up of health systems, and recognition that with just 9 years to 2015, this needs to happen in a large number of countries. Demand-led technical assistance may be required to support those countries that have yet to develop a sound, costed plan. There was some support for involving regional structures in this process.

There was support for a further meeting of the HLF, and for an HLF role in donor peer review, although one participant stressed that a three year gap may be too long given the speed at which the landscape was changing.

Chair's Summary: Participants endorsed the positive conclusions of the evaluation. There is unfinished business with respect to harmonisation and alignment in support of health systems, and bringing together ministries of finance and health to discuss fiscal space.

The 'do nothing' option was ruled out by all speakers in favour of building on existing mechanisms. In defining the future framework, the sector wide approach and human resources development should be central. Mapping countries according to how advanced they are could be helpful in identifying countries where additional aid commitments are needed. It is important to ensure that health is a Government priority linked to the PRSP and the MTEF. At the country level, capacity building has not been sufficiently emphasized. At the global level, it remains important to bring the various constituencies together. An accountability mechanism for development partners needs to be defined, covering development partners and global institutions. Country experience needs to be better represented in future arrangements.