

High Level Forum on Health Independent Evaluation

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Executive Summary

The High Level Forum was a unique mechanism for taking stock of the status of health MDGs and deepening and understanding of global health issues. It was unusual in being time-bound (three meetings), small and informal to promote candid discussion, informed by well-prepared documentation and enriched by participation from outside the health sector (Ministers of Finance, the IMF). Participants interviewed for the independent evaluation uniformly felt the HLF process had been excellent and the discussions deepened their understanding of critical issues such as fiscal space, human resources for health, donor harmonization and measurement. The HLF process produced specific outcomes for improved global health partnerships and accelerated the development of initiatives on health metrics and human resources. The HLF had no real impact on “scaling up” resources for health systems or harmonizing collaboration at the national level. As there has been little improvement in the health MDGs in low-income countries, a consensus emerged at the end of the HLF on the need to focus at the country level, although the means remain uncertain. There was also a sense that the HLF mechanism should be replicated periodically at the global level to track progress, address emerging issues and build a sense of mutual accountability. The evaluation suggests possible mechanisms for maintaining the momentum of the HLF at both the global and national levels.

INTRODUCTION

1. The High Level Forum (HLF) consisted of a series of three meetings of senior policymakers in Geneva (January 2004), Abuja (December 2004) and Paris (November 2005) to take stock of major issues in the health sector and progress in the realization of the Millennium Development Goals (MDGs) for health. It was designed as an opportunity for policy-level staff from donor agencies, development partners and representatives from developing countries to increase their understanding of global health issues and build a consensus on ways to accelerate progress. To encourage open discussion, the HLF was deliberately designed to be informal, limited in size, flexible, off-the-record and temporary.
2. At the final meeting in Paris, participants requested an independent evaluation of the HLF experience, to assess the usefulness and impact of this unusual mechanism.

BACKGROUND

3. In May 2003, representatives from several development agencies met in Ottawa to discuss challenges to improving health outcomes in developing countries. They were particularly concerned with (i) the limited progress in realizing the health-related MDGs, especially in low income countries, (ii) the extraordinary expansion of global funding of health and the proliferation of disease-specific “vertical” programs and multiple donor partnerships (WHO indicated it was a member of more than 70 separate “partnerships”),

and (iii) the need to scale-up support for national health systems for improved health service delivery.

4. The group considered several alternatives for intensifying attention to global health issues, including a health sector equivalent to the Fast Track Initiative for primary education. They decided that another special program on health or more technical meetings were not the answer. Instead, they designed an unconventional approach—a series of informal meetings of high-level representatives from development agencies and governments, acting on their own behalf and limited in number—to promote candid and focused discussion of constraints to progress on the health MDGs and possible ways forward.

5. The HLF effort was managed by a “light” temporary Secretariat composed of staff from WHO and the World Bank. The meetings were informed by a series of background papers commissioned by the Secretariat and guided by technical working groups and an Advisory Group for the HLF as a whole. The cost of the HLF—for consultants, travel, conference facilities and other direct costs—is estimated at about \$2.5 million, excluding the cost of the WHO/World Bank Secretariat staff and the time of most HLF participants.

6. The agenda for the meetings evolved as the HLF progressed. The first meeting concluded that the subsequent meetings should focus on up-stream policy issues. Over time, six principal themes emerged:

- **Scaling up**—Increasing aid flows, especially for improving national health systems;
- **Harmonization of global health partnerships**—Improving aid “architecture” for health and rationalizing management of vertical programs at both global and local levels;
- **Fiscal space**—Increasing budget resources for the health sector within the context of overall development priorities, poverty reduction strategies and medium-term expenditure frameworks;
- **Measurement**—Enhancing the capacity of countries to measure and monitor health activities and outputs and generate evidence-based results;
- **Human resources for health**—Addressing the critical shortage in numbers and skills of health workers; and
- **Fragile states**—Analyzing the special needs of particularly vulnerable countries.

7. The meetings in Geneva, Abuja and Paris were attended by 50-60 principal participants, including heads of agencies, representatives from multi-lateral and bilateral donor institutions, development agencies, global partnerships, foundations and finance and health ministers from more than a dozen developing countries.

8. The final HLF meeting in Paris concluded that the series should end but the momentum that had been generated and the collaborative spirit that had been

demonstrated should be maintained in other ways. No consensus emerged on the way forward in Paris or at the final meeting of the Advisory Committee in Brussels in February 2006, but participants concurred that the effort had been worthwhile and the benefits should be sustained.

THE HLF EVALUATION

9. Ken Grant and Daniel Ritchie, consultants, were engaged in January 2006 to carry out the independent evaluation.

10. **Objectives.** The Terms of Reference (TORs) of the evaluation (attached) request an assessment of four principal aspects of the HLF experience:

- The appropriateness of the initial objectives of the HLF and their continued relevance over the lifetime of the Forum
- The processes by which the HLF products were delivered
- The relevance and quality of the products, and
- The results and impact of the Forum.

11. The TORs include a request for recommendations on mechanisms to foster a continuing dialogue on key health issues and other means to carry the agenda forward.

12. **Methodology:** The evaluation was carried out at intervals between early February 2006 and late May 2006. The process consisted of:

- **structured interviews** with about 60 individuals associated with the HLF from developing countries, donor agencies, technical agencies, global health partnerships and foundations. The list of individuals interviewed is attached. Interviews were conducted in person in Brussels, Geneva, London, Paris and Washington, and by telephone with colleagues in Copenhagen, Dhaka, Dublin, Oslo, Seattle and The Hague. Developing country representatives were interviewed during the WHO World Health Assembly in May 2006 in Geneva;
- **Documentation review** of the papers prepared for the three meetings, the presentations made and the minutes of the sessions;
- **Background material review** related to the progress in realizing the health MDGs, aid flows and related initiatives such as the Fast Track Initiative for primary education; and
- **Participation in the final Advisory Committee meeting** on February 7, 2006.

THE ASSESSMENT

A. The relevance of the original objectives and their evolution over the meetings

13. The evaluation team asked each of the individuals interviewed what they understood were the basic objectives of the HLF, and to what degree these objective had been realized. There was a very clear and consistent understanding of the basic purpose—to provide a mechanism where senior-level policy makers to take stock of the challenges in the health sector in an informal environment and explore ways to address fundamental constraints to realization of the MDGs for health.

14. There was also a consensus among interviewees that the HLF had addressed the most critical global health issues. The Geneva meeting had identified four key issues that remained the focus of subsequent meetings—scaling up support for national health systems, aid effectiveness and donor harmonization, measurement and human resources for health. The Abuja meeting added the subject of health in fragile states, which many respondents felt was less effectively addressed than the other topics overall. The scaling up issue evolved into consideration of “fiscal space” and the place for health in national health budgets. The topic of Global Health Partnerships was also added to the Abuja agenda.

15. The initial meeting in Ottawa had recognized that to accelerate realization of the MDGs, most action needed to be taken at the country level. The value of the HLF was felt to be to “facilitate learning at the global level from good practice on the ground, and to consider ways in which actions by governments and agencies can support nationally-led processes.” [Framework Document for Ottawa Meeting, May 2003]. Toward this end, representatives from more than 20 developing countries participated in the three forums. Most interviews acknowledged that there had been less focus on national-level issues than on the global “aid architecture” and other donor-related issues. Ministers of Health and Finance provided insights into their reality on the ground and benefited individually from the experience, but this did not translate into new approaches at the national level. Moreover, turnover among participants was great, and only three of more than thirty representatives from developing countries attended both the Abuja and Paris meetings.

16. On balance, the interviews demonstrated a very clear and consistent understanding of the purpose of the HLF, the correct focus on fundamental issues and an effective effort to honor the values of the HLF—informality, candor and mutual respect.

B. The processes by which the HLF products were delivered

17. The evaluation team was asked to assess the effectiveness of the HLF process—the preparation and conduct of the three meetings, the selection of participants, the functions of the Advisory Group and working groups, the role and working relationship of the WHO-World Bank Secretariat, the documentation, communications strategy and the success in realizing the basic intention for open, honest debate.

18. There was almost unanimous agreement that the process had worked very well. The correct policy issues had been identified and limited in number to permit substantive discussion. Senior policy makers were able to discuss these issues in an informal setting

with the help of substantive background papers. Because they were deliberately not decision-making meetings, the HLF avoided that the normal UN-style format of formal contributions by each agency and prepared speeches.

19. The background papers had been commissioned by the Secretariat and reviewed and improved by the technical working groups and the Secretariat. The quality assurance mechanism was effective. The working papers were generally of a high quality. The evaluation team found the papers to be substantive, pitched at the right policy level, aimed in part to inform health specialists about non-health issues and often added real value to the global debate, especially on issues of donor collaboration, fiscal space and measurement.

20. The three meetings were all well organized—the right length (two days), a format blending presentations with discussion and generally the right participants. The presence of the IMF and several Ministers of Finance added particular value by framing the health sector issues within the context of broader economic and fiscal challenges. The participation of the Gates Foundation was also felt to be refreshing, bringing a new and important partner to a table of familiar faces.

21. Some expressed the view that there could have been more country representation. Civil society organizations were also not invited (and expressed their disappointment during the Paris meeting). Generally, the respondents found the HLF had managed effectively the difficult balance between inclusion and the small size needed for openness and informality. Most of the issues were about global practices and donor behavior and consequently the participation was weighted toward the development partner community.

22. There was general agreement that an informal joint Secretariat of WHO and the World Bank was the right approach and demonstrated the ability of the two institutions to collaborate effectively. It generally had worked well. There were occasional tensions, but no more than to be expected when two agencies working in the same area and based on different continents are asked to work together without a clearly defined division of responsibility. The “light” secretariat approach meant that most members added the Secretariat functions to their normal substantive work load. The administration was very labor-intensive, dealing with the complexities of organizing the meetings, ensuring the right participation and the quality of the documentation. It demonstrated the contradiction of a “light” secretariat managing a heavy agenda. The high level of satisfaction over the process and the HLF in general expressed in virtually every interview is a tribute to the commitment and hard work of the individual members of the Secretariat, and the leadership of Andrew Cassels in WHO and Jacques Baudouy in the World Bank.

23. The careful preparation and collaborative relationship that had characterized the three HLF meetings began to deteriorate after the Paris meeting, when there was no clear consensus on the road ahead. The WHO and Bank Secretariat members differed over the best way to translate the work of the HLF to the national level, and the final Advisory Meeting in February 2006 was a disappointing anticlimax. Most interviews, including

members of the Secretariats, felt the WHO-World Bank collaboration and leadership in the HLF had been one of its most valuable benefits and needed to continue.

C. The relevance and quality of the HLF products

24. The evaluation team reviewed the documents prepared for each of the three Forums as well as several of the background documents reviewed at working meetings such as the McKinsey Report on Global Health Partnerships. As indicated above, we found the documentation to be unusually “accessible.” Most of the papers were brief, focused, written for an informed, senior-level audience. Most interviewees commended the quality of the documentation.

25. They also noted:

- The written material did not often get explicit reference in the discussions,
- The reports had in several instances been used within their own agencies as source material for policy papers,
- The documentation did not typically get circulation or attention within their organizations beyond the participants in the HLF, and
- While figures for recording hits on the website were not tracked until April 2006 it was still being regularly accessed with over 7000 hits in April and almost 4000 in the first half of May 2006.

D. The results and impact of the Forum

26. The HLF mechanism was a process. It was not intended as a decision-making body nor did it expect to have specific results apart from raising the level of understanding, seeking to develop a consensus on addressing critical issues and providing additional momentum for initiatives already underway.

27. While attribution is very difficult, and the HLF was only one of a number of simultaneous mechanisms where the issues were considered, the interviews broadly felt that the HLF had contributed to progress in several areas that would not have occurred, or occurred as quickly, without the Forum.

(i) Harmonization and Global partnerships

28. There was general agreement that the most significant result of the HLF was progress on harmonization among development partners. It provided the mechanism to translate the intentions of the Paris Declaration into tangible guidance for global partnerships in health. The forum was the venue for discussing the McKinsey/Gates report on the impact of global partnerships at country level. It raised awareness in donors and key global partnerships of the impact at country level of multiple global health initiatives. The result has been a set of principles for global health partnerships which have been agreed by the Boards of the Health Metrics Network, Stop TB and GAVI, and has been further discussed at a recent meeting of GAVI and the GFATM. The Global

Fund pointed out that it considerably changed their thinking on how to work at country level and resulted, for example, in their participation in their first Sector-wide Approach Project (SWAP), in Mozambique. It did not result in any structural changes to “aid architecture” as a whole, but certainly stimulated thinking among donors of the consequences of raising money vertically while needing to spend it horizontally within countries for maximum impact.

(ii) Measurement

29. While the Health Metrics Network was in the process of being set up before the HLF and would have happened in any event, the Forum helped give exposure to the process. The Gates Foundation said the HLF made them realize the importance of the health metric network and reinforced their decision to become a major funder. This work is proceeding well.

(iii) Fiscal Space

30. The funding of national health budgets and health systems was becoming a prominent issue just as the HLF came into being. The HLF Secretariat commissioned and circulated papers on fiscal space that were frequently cited as best examples of the quality of papers produced. The presence of the IMF and Ministers of Finance allowed the debate on these issues to go beyond the health sector and highlighted the competing claims that the health sector faces. The IMF was able to address misconceptions about the conditionality of Fund programs at country level.

(iv) Human Resources

31. Human resources for health was an issue in all three Forums and characterized as a crisis. During the period of the High Level Forum the issue rose to the top of the health sector development agenda and recognized as perhaps the single greatest constraint to successful implementation of the MDGs. Both bilateral agencies and the EC reported that the HLF helped them develop their thinking in this field and recognize the need to increase resources in this area. During the course of the HLF, WHO--with bilateral support--created the international Alliance for Human Resources. The Chair of the Alliance stated categorically it would not have happened without the HLF.

(v) Fragile States

32. “Fragile states” was not one of the original topics, but even in Geneva it became apparent that these countries comprised a significant number of countries where MDG progress was poor. The papers presented to the Abuja and Paris meetings set out the issues, defined the present position and helped bring the issue into focus, but did not suggest a way forward. However the OECD DAC Fragile States Group has initiated work on service delivery in fragile states, including health sector specific work, and will build on the effort carried out by the HLF.

(vi) Scaling up/Sustainable finance

33. Many of those interviewed felt that a key original aim of the HLF had been to take forward the work of the Commission on Macroeconomics and Health and discuss how best to scale up resources for health at the national level. They saw the HLF as being an opportunity to make the case to stakeholders outside the health sector for investment in health for poverty reduction. They also saw it as a forum for discussing with those outside the sector the systemic issues that needed to be addressed to ensure that countries could absorb increased funding for the health sector, and use it effectively and efficiently.

34. There was perhaps less progress in this area than any other issue in the Forum. Those we interviewed outside the health sector did not feel that the case for increased funding for health has been made effectively. While the progress on harmonization and fiscal space and human resources will have a positive impact on improving delivery at country level, there are still no definitive proposals at the global level to scale up financial resources to the level recommended by the Macroeconomic Commission for Health. Indeed there is no consensus on its recommendations as to the level of per capita public spend on health required by low income countries.

35. In addition, while there is general agreement on the need in low-income countries for an increased focus on health systems strengthening, there was no clear consensus as to how this best could be achieved.

36. The Forum produced no specific papers on scaling-up or increased investment in generic health systems strengthening, or mechanisms for doing so. A proposal was put forward immediately after Paris by the World Bank and a follow-up paper discussed at the last meeting of the HLF Advisory Committee two months after Paris. It proposed a “brokering facility,” providing facilitation teams to selected countries on a demand-driven basis to work on these issues. It was not fully supported and further work is ongoing and will be presented to a meeting in Tunis in early June. As indicated above, the failure to achieve consensus on the way forward may be that—unlike all the other papers presented to the HLF—the brokering facility note was not the subject of detailed joint work in a technical working group.

37. While there has not been progress towards the level of funding recommended by the Macroeconomic Commission on Health, there has been a significant increase in development spending on health although almost all of this has been through global partnerships. OECD/DAC report that spending on health including reproductive and population health but not emergency aid and debt relief was 14.3% of total aid expenditure in 2002 and 11.1% in 2004. The latest Global Monitoring Report indicates that total global funding for health has grown by more than \$ 3 billion in the past five years, virtually all of it for vertical programs. At the same time, funding for national systems work has stagnated or even declined. World Bank funding for health, nutrition and population actually has declined from 9% of total Bank lending in FY 03 to less than

6% in FY05. Funding for health systems declined from \$502 million in FY03 and \$547 million in FY04 to \$462 million last year (FY05).

38. One relevant area where progress has been made is in sustainability. Debate on this issue increased during the period of the HLF and several agencies reported that the HLF had influenced their thinking on this issue. There is real evidence of progress, with bilateral agencies committing to longer time-frames and GAVI offering ten year support through the international vaccine facility.

Missing Aspects

39. The agenda of the HLF was rightly selective. It could not cover all issues. One substantive issue not covered was the increasing role of private expenditure in funding health care, and in the private (both for-profit and not-for-profit) sector in delivering it. While almost all the high-value public goods are financed and delivered by the public sector, the private sector is important. Poor households spend significant amounts of household expenditure on accessing poor quality health care and countries need to address this issue.

40. There was no formal communication process developed for disseminating the papers prepared for the HLF or its discussions. The HLF website is excellent, with all the key papers and a record of all three meetings as well as the process of the HLF. Those who use it find it valuable. However knowledge of its existence is patchy and it has not had the impact it warrants.

41. There was no formal process for sharing the outputs with international agencies, global partnerships and countries that were not present. A volume of the HLF papers is to be published. At the moment, however, it is unclear if and how the best practices for global partnerships for example will be taken up by those active at country level.

42. While most of the issues discussed will either be taken forward within the agencies involved in the HLF or by a specific agency some still require further work. They include:

- Harmonization – ensuring all relevant global partnerships adopt the best practice principles. While DAC is responsible for taking forward the Paris harmonization agenda it does not work at the sector level. We understand that there are plans for publishing a summary of the McKinsey findings and a companion piece on global health partnership principles,
- Scaling up and health systems strengthening –the issues set out above, and
- The role of the private sector.

43. Lastly, there was no clear way forward as to how the outstanding issues and any new issues would be addressed in the future. And yet, this question consumed a major portion of the interviews with the evaluation team. We set out options below.

MOVING FORWARD

The HLF

44. There was almost total consensus that making the HLF time-limited was right and contributed to its success. However there was also a consensus that it had been a valuable experience and the benefits of this unique mechanism should not be lost. It was suggested that it would be worthwhile to repeat the exercise at irregular intervals – perhaps every two to three years—as new issues arise and long-standing issues warrant stock-taking.

45. There was also a broad consensus that the focus of the global health community must now be at the national level. The issues discussed at the HLF--financial flows, fiscal space, human resources, donor behavior, measurement—needed to be worked out within countries.

46. The evaluation team suggests consideration of actions in the future at the global and national level.

(i) At the global level

47. We recommend initiating a single High Level Forum again in about two and a half years time i.e. three years after the Paris meeting. It would be an appropriate time to review progress on the health MDGs. Responsibility for organizing it should again be given jointly to WHO and the World Bank. The following lessons should be built into the process

- The secretariat needs to be properly resourced with full time dedicated members. A budget of about \$500,000 would be appropriate. The secretariat should focus on the technical content of the meetings and participants. Professional meetings organizers should do the logistics.
- Two days would continue to be the appropriate duration. The morning of the first day should reflect progress on the issues covered in the last HLF as well as reviewing overall progress on the MDGS. No more than three issues felt to be currently relevant to progress on the MDGs should be addressed.
- The secretariat should be in place one year before the meeting. Its budget should allow it to commission the necessary papers. Because it is important that the issues being addressed are shared within both organizations it is not recommended that a single site be chosen for the secretariat but that they again should be based in their respective organizations.

- The Advisory Group worked well except country representation needs to be strengthened. Again it should be in place one year before the meeting. We recommend that there should be technical working group for the new issues and independent reviews commissioned for reviewing progress on the issues covered in the last HLF.
- It will again be important to limit participation in the HLF to about 60 individuals half of whom should come from country level. They should be senior policymakers both from the wider development community as well as the health sector. Those from the country level should be split 50-50 between Ministries of Health and Finance. At a global level a representative approach needs to be taken for bilaterals, multilaterals and foundations backed by a good communication strategy. There also should again be representation from the IMF.
- To ensure this actually takes place one organization should now take responsibility for putting the process into practice in 2007 –eighteen months from now.

(ii) At the national level

Scaling up/health systems strengthening.

48. Scaling up investment and strengthening health systems are so interdependent that they need to be addressed together. While significant sums of money can be channeled through global partnerships, there also needs to be significant investment in general health care. In addition, unless there is investment in the health systems that deliver both disease specific and more general health care, the MDGs will not be achieved. We do not propose to go into the details as to how that can be achieved but propose options for mechanisms for taking the agenda forward.

49. Views of those interviewed ranged from a ‘do nothing’ approach to a fast track initiative for health similar to that in education. The latter were in a small minority. The vast majority of those interviewed felt that there was no place for yet another initiative in health and that existing mechanisms could be strengthened to deliver in this area.

50. The options are:

(a) Do nothing.

51. Those in favor of this option felt quite strongly that (i) there were already too many global initiatives in the sector; (ii) the HLF process had already contributed to the thinking and practice of agencies; (iii) any action had to be country-led; (iv) considerable capacity already existed for support to countries by agencies at country level, and (v) a lot was already happening. This includes the commitment to specific investment by the

Global Fund and GAVI in health systems at country level and numerous anecdotal examples of good practice in individual countries.

52. However, there is actually very little understanding of what is actually happening at the national level. There has been no formal mapping carried out on a country-by-country basis. Apart from a few country case studies, most evidence of good or bad practice is anecdotal. There is no systemic approach to country support to ensure all countries can access the necessary support for health systems strengthening or the necessary funds for scaling up to achieve the MDGs. Consequently, “doing nothing” is not a viable option in our view.

(b) A fast-track initiative for health

53. The Fast Track Initiative (FTI) for education has been effective. Participating countries have seen an average increase of 42% in primary school enrollments and international funding has grown rapidly. The FTI has two central funds that countries can access to prepare strategic plans which allow donors to invest rapidly in the provision of primary education. The FTI also supports capacity building, monitoring and knowledge generation. It is run jointly by the World Bank and UNESCO with a small secretariat and budget. It would appear to work well. A similar fund could be set up for health. While there are a plethora of separate mechanisms for providing funds and technical support for specific disease based interventions, there is none for health systems that provide the glue to deliver them.

54. However, there was very little support for this approach among the individuals interviewed. They noted the plethora of vertical initiatives in health. Health care delivery is more complex than providing primary education. There already are agencies that countries can draw on for technical support and funding. And there is no lack of health sector plans in most countries. The evaluation team interviewed members of the FTI Education Secretariat. The fundamental problem in primary education has been the lack of global funding, which the FTI is designed in part to stimulate. By contrast, the health sector has significant global funding in the aggregate (almost as much as education even though it is typically a much smaller share of GDP or national budgets). An FTI for health would be needed less for generating additional resources than for providing support for resource allocation and rationalization and other technical assistance for capacity building. On balance, the evaluation team does not believe an FTI for health is warranted.

(c) Building on existing organizations and processes

55. There is general agreement that further progress in health needs to be country-driven by governments with support from development partners operating in the country. The process of a Sector Wide approach (SWAp) for planning and financing provides the necessary framework to allow collaboration to take place. It is already happening in a number of countries to a certain extent but not to the scale required in any country. At the moment, effective cooperation and collective action is more dependent on the individuals

involved rather than on systems in place. A process needs to be established, both to provide further support for scaling up when countries ask for it but also to identify those countries which are not asking or receiving such support and need further help. This should come by encouraging existing development partners to provide that support rather than a new mechanism.

56. Ensuring that this happens requires global leadership, which should come from existing agencies. The two international agencies with principal responsibilities in this area are the World Bank and WHO. Both have difficulties in that the central units in each organization (that provided the HLF Secretariat) are not responsible for implementing policies and projects at the country level. However, promoting collaboration with operational units is not insurmountable. The central functions in both organizations work need to strengthen their existing organizational capacity and promote more effort at country level in health systems. This is a principal theme of the new World Bank health sector strategy being developed.

57. We recommend that the HNP anchor of the World Bank and the EIP cluster of WHO develop a common work program in this area setting out their respective areas of expertise and responsibilities and develop proposals for taking it forward in their respective organizations at country level. We do not think a separate secretariat is necessary for this to work but a memorandum of understanding on joint working in health systems strengthening could strengthen the process. Both organizations should budget appropriately for joint work in this area.

58. There are two specific pieces of work that could kick-start this joint effort. The first would be a mapping exercise looking at low income countries to identify those who appear to have the building blocks for scaling up in place e.g. a SWAP or similar, who appear to have adequate in country development partner support and those who do not. This would either validate a 'do nothing' more approach or identify a need for action in specific countries.

59. The second would be to identify two or three countries and, working through existing in-country mechanisms, identify the measures required to ensure delivery of the health MDGs. One could be country in a good position to scale up the other a poorer performer. Both would require specific funding. Donors could participate in a steering group for the work.

CONCLUSIONS

60. The High Level Forum fully met the expectations of its organizers for an informal, time-limited mechanism to review the constraints to achieving the health MDGs. The HLF helped build a consensus and advance the agenda on critical issues facing the global health system. It did so in a collaborative, professional and cost-effective fashion. Virtually all of the 60 participants interviewed commended the effort, the process and the overall results.

61. At the same time, the participants also recognized that there has been very little progress on achieving better health outcomes, particularly in lower income countries. The levels of infant mortality, maternal mortality, HIV infection, the incidence of malaria and other communicable diseases has not materially changed in the past three years. Funding for support to national health systems has also stagnated even as support for vertical programs has more than doubled in the past three years, putting even greater stress on national health delivery systems.

62. The participants acknowledged that the HLF effort will have been wasted if the progress made on harmonization, measurement, human resources for health and fiscal space at the global level is not translated to a concentrated, collaborative effort at the national level. While there is as yet no consensus on the way forward, there are existing mechanisms at the local level that can be used. Piloting approaches in specific countries should be a next step.

63. Participants also suggested the HLF mechanism had been sufficiently valuable at the global level that consideration should be given to a reprise in 2-3 years time, with the same informal, open process, professional preparation and the joint leadership of WHO and the World Bank. The evaluation team believes the HLF was a refreshing and effective mechanism to focus attention on critical issues and build a sense of accountability for collaboration. It should be continued.

Attachments

- Annex 1 Terms of Reference for the Evaluation
- Annex 2 List of Individuals Interviewed

Annex 1

TERMS OF REFERENCE FOR THE EVALUATION

Background

The High-Level Forum on the Health MDGs (HLF) was established at a meeting organized by CIDA, DFID, and the World Bank in May 2003 in Ottawa. The World Bank and WHO were asked to facilitate the process and subsequently formed a small secretariat for this purpose.

The objective of the Forum was to provide an informal opportunity for senior policy-makers from national governments and development organizations to identify opportunities for accelerating progress towards the health MDGs. Improvements in health indicators had been slow, lagging behind other areas such as education and poverty reduction. At the same time, new opportunities were emerging: the level of resources pledged for development assistance in health was rising dramatically, an increasing number of actors were becoming involved in global health, and certain aspects of health, in particular communicable diseases, were attracting a great deal of political attention. These trends, which have continued since the start of the Forum, provided the context in which the Forum was established.

Discussions at the Forum were to take place in a spirit of mutual accountability between donors, recipient countries and technical agencies, focusing on a small number of topics identified as critical for making progress towards the MDGs. The focus was on challenges and actions which can be taken at country level. However, the intrinsic value of the Forum was to facilitate learning at a global level, and to consider ways in which actions by governments and development partners can support nationally-led processes.

The Forum met three times: in Geneva in January 2004, in Abuja in December 2004, and in Paris in November 2005. Prior to the meetings, an Advisory Group provided direction to the Secretariat on background work and advised on the focus of the presentations and discussions at the Forum. At its third and final meeting, the HLF Secretariat was asked to initiate a review to evaluate the impact of the HLF, with inputs from the HLF Advisory Group.

Areas to be covered in the evaluation

The evaluation will review: (1) Whether the HLF achieved its objectives as originally envisaged (see below), and whether these objectives sustained their relevance over the course of the Forum's three meetings; (2) the processes by which the HLF products (such as background papers, working groups, and the Forum) were delivered; (3) the relevance and quality of its products; (4) and the results and impact of the Forum. The evaluation is

also intended to inform discussions on future alternative mechanisms for supporting a structured dialogue on key issues in global health.

The review of the objectives of the HLF will include an assessment of the rationale for establishing the Forum and its guiding principles; which were to:

- Create a forum in which senior decision-makers in governments and development agencies can take stock of challenges in a spirit of responsibility and mutual accountability;
- Reach consensus on constraints to progress and how these can be addressed by participants in the Forum;
- Derive legitimacy and influence from the personal standing of participants, who would be acting through their own organizations, rather than having a Forum as a decision-making body;
- Ensure meetings are set up to allow informality and real exchange of ideas;
- Establish a 'light touch' Forum secretariat (managed by the World Bank and WHO), ensure high level participation, balanced regional representation and the presence of key development agencies

The review of the HLF process will include an assessment of the various bodies associated with the Forum and their support activities. It should consider the following points:

- Joint WHO-World Bank Secretariat: how well did this function? How were activities financed? What problems were encountered and how was the Secretariat able to resolve them?
- Preparation of Forum meetings: how were topics for discussion selected? What was the nature of the consultative process for preparing and organizing Forum meetings?
- Advisory Group and Working Groups: how did the Advisory Group and various working groups function?
- Communications strategy and website: how effective and appropriate was the communications strategy?
- Organization and conduct of Forum meetings: how well were meetings organized? To what extent was it possible to adhere to the principles of informality and frankness in Forum meetings? Did the nature of meetings change over time? Was the objective of involving an increasing number of finance ministers/ministries and heads of development agencies (rather than heads of health in development agencies) met? To what extent was the objective to bring participants to the Forum whose personal standing ensured influence realized?

Did participants primarily speak in their individual capacity or did they represent their organizations?

The review of the products HLF will assess the quality and relevance of the background analyses prepared for the HLF:

- How relevant and useful were the background studies? How important were the documents to guide and frame discussion at the Forum meetings?
- Did the chosen topics cover and capture the key issues in global health today?
- Did documents and reports provide a basis for further policy action by participants?
- Although the primary intent of the Forum documents was to guide discussions, is there any evidence of the Forum documents being influential beyond HLF participants?

An assessment of the results of the Forum will include a review of the immediate impact on the work of participating agencies and partnerships, as well as an assessment of the potential longer-term impact of the work of the Forum:

- To what extent have the needs/gaps originally identified been addressed? What topics have been successfully dealt with and have moved forward? Were Forum meetings the best way to take these themes forward? What were the limitations of the Forum?
- Has the Forum been conducted in the spirit of frankness and mutual accountability, as intended? How has this mutual accountability manifested itself?
- Has there been a notable evolution from HLF1 to HLF3? What lessons have been learned along the way?
- How influential has the Forum been? Is there any evidence of changes in thinking / policy in the institutions and ministries participating? Did participants carry forward the policy dialogue which took place at the Forum within their own organizations? How far have the ideas and debate generated by the Forum penetrated beyond the small circle of participants?
- Is any of the HLF work agenda being taken into account by other fora such as the OECD/DAC SLM and HLF, UN Meetings, Development Committee?
- Is there a remaining agenda that needs to be addressed and how can it be taken forward? What are the perspectives of different stakeholders on this?
- What alternative mechanisms exist to foster and support a structured dialogue on key issues in Global Health?

Process of the evaluation

The evaluation will be carried out by consultant(s) not directly connected with the HLF Secretariat, between January and March 2006.

The principal methodology of the evaluation should be key informant interviews, conducted in person and by telephone, with relevant stakeholders. It will be particularly important to secure interviews with senior participants in the HLF, in order to judge the extent of its influence. Other relevant interviewees might include: donor agencies not participating; and, within invited agencies, departments not closely involved in HLF preparation. Given the nature of the evaluation, which will depend on perceptions and judgments, a team of two consultants may be used.

A detailed inception report for the evaluation should be presented to the final meeting of the HLF Advisory Group, on 7 February 2006 in Brussels.

Annex 2

LIST OF INDIVIDUALS INTERVIEWED

Interviewee	Organization	Position
In Washington:		
James Adams	World Bank	Vice President, Operations Policy
Ed Bos	World Bank	Lead Population Specialist, HDNHE
Katja Janovsky	World Bank	Consultant, HDNHE
Alex Shakow	World Bank	Author GF-WB Report, Consultant
Ok Pannenburg	World Bank	Senior Adviser, AFTHD
Philip Hay	World Bank	Communications Specialist, HDNOP
Peter Heller	IMF	Deputy Director
Sangeev Gupta	IMF	Deputy Director
Keith Hansen	World Bank	Senior Manager, LSCHH
Elizabeth Lule	World Bank	Manager, MAPAfrica
Jean-Louis Sarbib	World Bank	Sr. VP and Head, HN Network
Jacques Baudouy	World Bank	Senior Director, HDNHE
Bob Prouty	World Bank	Acting Manager, FTI Education
Tim Evans	WHO	Assistant Director General (by audio)
George Scheiber	World Bank	Consultant, HDNHE
Ali Forder	DFID Dhaka	Health Adviser (by audio)
Christian Baeza	World Bank	Author, Health Strategy, LCSHH
Sarah Cliffe	World Bank	Manager Fragile States, OPCFS
Alison Gillies	World Bank	Adviser, OPCFS
Alan Gelb	World Bank	Director, DECVP
Margaret Thalwitz	World Bank	Director, Global Partnerships
Agnes Soucat	World Bank	Lead Economist, AFTHD
Pablo Gottret	World Bank	Lead Economist, HDNHE
Miriam Claeson	World Bank	Project Coordinator, South Asia Region
Paul Ehmer	USAID	Health Specialist
Bob Emery	USAID	Health Systems Specialist
Silvia Raw	IDB	Health Specialist
In Geneva:		
C. Abou-Zahr	WHO	Coordinator, Evidence and Information for Policy
Rebecca Dodd	WHO	Technical Officer, Evidence and Information for Policy (Department)
Brenda Killen	WHO	Coordinator, Evidence and Information for Policy, Health and Development (Department)
Paolo Piva	WHO	Adviser, Evidence and Information for Policy, Health and Development (Department)
Penelope Andrea	WHO	Technical Officer, Evidence and Information for Policy (Department)
Dr Phyllidia Travis	WHO	Health Systems Adviser, Evidence and Information for Policy (Department)

Julian Lob-Levyt	GAVI	Executive Secretary
Andrew Jones	GAVI	Senior Programme Officer, Programme Funding
Dr Ian Smith	WHO	Adviser to the Director General
Dr Andrew Cassels	WHO	Director, Health Policy Development and Services
Dr Francis Omaswa	WHO	Special Adviser, Human Resources for Health
Bernard Schwartlander	Global Fund	Director, Strategic Information and Evaluation
Daniel Low-Beer	Global Fund	Senior Manager, Strategic information and evaluation
Dr Andrew Nordstrom	WHO	Assistant Director General, General Management
J Phumaphi	WHO	Assistant Director General, Family and Community Health
Pilar Mazzetti Soler	Peru	Minister of Health
Francisco Songane	WHO	Former Minister of Health, Mozambique
Joy Phumaphi	WHO	Former Minister of Health, Botswana
Cecil Max Haverkamp	WHO	Program Officer, Health Policy
In Paris:		
Richard Manning	OECD	DAC Chair
Paul Isenman	OECD	Development Consultant, formerly Head of the Policy Co-ordination Division of the DAC Secretariat
Kaori Miyamoto	OECD	Advisor, Director's Office, Development Cooperation Directorate
Dr Frédéric GOYET	Ministère des affaires Etrangères-France	Chef du Bureau de la Santé (CID/DCT/HSA)
In London:		
Louisiana Lush	DFID	Senior Health and HIV Advisor
By phone:		
Ali Forder	DFID	Health Advisor
Sigrum Mogedal	Ministry of Foreign Affairs, NORWAY	Senior Adviser; HIV/AIDS Ambassador
Jorn Heldrup	Danish International Development Agency (DANIDA)	Senior Health Adviser
Reina Buijs	Ministry of Foreign Affairs, The Netherlands	Head Social Policy Division, Social and Institutional Development
Finn Schleimann	Danish International Development Agency (DANIDA)	Chief Technical Adviser, Health & Education Section, Technical Advisory Services
Dr Marcos Antonio Espinal	WHO	Executive Secretary, Stop TB
Dr Timothy Evans	WHO	Assistant Director General, Evidence and Information for Policy
R De Vos	Ministry of Foreign Affairs, The Netherlands	Head , Department of Social and Institutional Development
Stewart Tyson	DFID	Head of Profession, Health and Human Development Group

Cathy Cahill
David Fleming

Gates Foundation
Gates Foundation

Senior Program Officer
Director, Global Health Strategies

