

## **SUMMARY OF CONCLUSIONS AND ACTION POINTS**

### **Post-High Level Forum on the Health MDGs**

#### **Tunis, 12-13 June 2006**

### **Background**

The aim of the High-Level Forum (HLF) on the Health Millennium Development Goals (MDGs) was to provide an opportunity for candid dialogue between senior policy makers and identify opportunities for accelerating action on the health-related MDGs. The idea for the High-Level Forum emerged from a meeting of development agencies and developing countries that took place in Ottawa, hosted by the Government of Canada, the World Bank and the United Kingdom's Department for International Development (DFID) in May 2003. The HLF was coordinated by a small secretariat provided by the World Health Organization and the World Bank. Forum participants included health and finance ministers and senior officials from developing countries as well as heads of bilateral and multilateral agencies, foundations, regional organizations and global partnerships.

The first High-Level Forum (HLF) on the Health Millennium Development Goals (MDGs) took place in Geneva in January 2004. Discussions focused on resources, aid effectiveness and harmonization, and human resources for health. Action on establishing a global health metrics network was agreed. The second High-Level Forum on the Health MDGs was held in December 2004 in Abuja, Nigeria and co-sponsored by the Government of Nigeria. Key points of discussion covered progress toward the health MDGs in low and middle income countries; MDG-oriented poverty reduction and sector strategies; monitoring performance and tracking resource flows; action on the human resources crisis in health; and health in low-income countries under stress. The third High-Level Forum on the Health MDGs was held in Paris, France, in November 2005. Major topics discussed were: financial sustainability and fiscal space, global health partnerships and aid effectiveness, and health in fragile states.

To continue the dialogue between all partners and begin to move from the consensus generated in Paris to action at the country level, a meeting was held in Brussels, Belgium in February, 2006. The meeting was called to discuss a proposal to improve aid effectiveness and absorption through country-led and results-based processes that improve aid harmonization and alignment, assure sustainable financing, minimize transaction costs, and enhance joint leadership of this work by Ministries of Health and Ministries of Finance.

The Tunis meeting, described below, provided a forum to further develop these concepts and, crucially, to make a transition from consensus to action.

### **Outline of proceedings**

The meeting consisted of six main parts: (a) setting of expectations; (b) country case studies from Rwanda, Democratic Republic of Congo and Ethiopia; (c) an information session on integrated approaches for reaching the health MDGs; (d) relevance of lessons from the Education-for-All Fast Track Initiative to the health sector; (e) reflections on an evaluation of the High Level Forum and options for moving forward; and (f) defining and agreeing on next steps. The background papers for the meeting and summaries of each session are available on the HLF website at <http://www.hlfhealthmdgs.org>.

Participants considered whether and how to translate into practical and urgent action the consensus that emerged from the four prior meetings of the HLF, which are described above.

### **Conclusions**

Participants agreed to take action to speed up progress towards the achievement of the health MDGs. Broadly, these will include support for country-led and regionally supported efforts to prepare, update, finance and implement results-based sectoral strategies that are fully embedded in the macroeconomic

and fiscal planning process of each country. The actions, in turn, require considerable changes in behaviors, both on the part of countries (in terms of fulfilling their responsibilities for stewardship and increasing domestic financing for the health sector) and on the part of donors (in terms of responsiveness to country needs, fulfillment of pledges to harmonize and align aid with country strategies, and to provide long term predictable financing if and as needed).

## Approach

### *Bold, country-led actions*

- Countries will lead the joint effort to scale up progress toward achieving the health MDGs. Donors will support countries on a demand-driven basis. A minimum requirement to receive donor support is a country-led health strategy that: (a) is consistent with the macroeconomic and fiscal policies of the country, (b) articulates specific goals in a results-based framework and (c) aligns the development of health systems and cross-sectoral contributions to the health sector with the achievement of sustainable improvements in health outcomes through a balanced and multi-sector development strategy.
- In most instances, it will be crucial for the country strategy to be grounded in the Poverty Reduction Strategy Paper (PRSP), and integrated into the budgetary and macroeconomic policy framework, including a Medium-Term Expenditure Framework (MTEF) where possible. Special considerations and arrangements will be needed for fragile states that do not have the robust planning processes afforded by PRSPs and MTEFs. Countries and donors will strike a sensible balance between sectoral priorities and broader macroeconomic considerations.
- Donors, including Global Health Partnerships, largely in the context of their existing commitments, will strive to increase the predictability and longevity of their assistance, harmonize with both local and international sources of finance, and align their assistance with country driven strategies and procedures. Donors will provide technical support on a demand-driven basis to assist countries to upgrade their health plans where needed. When a country has taken all reasonable steps to prepare its strategy in the context of the PRSP and the budgetary and macroeconomic policy framework, donors will support the financing and implementation of that strategy. Emphasis will be on building country capacity to develop and upgrade their own health strategies. This is a collective challenge to translate into reality the promise of the Paris Declaration on Aid Effectiveness. It is recognized that Global Health Partnerships need to be fully part of the country process; achieving this might require changes in their current modus operandi.

### *Organization*

Under the principle of “subsidiarity”, actions will only be taken at global levels if they cannot be taken fully and effectively at the country and regional levels. Likewise, decisions agreed at the global level will be translated into actions at the country level, with adaptations to suit local contexts.

### At the country level:

- Countries and donors will use and improve upon existing mechanisms for country-donor compacts. Key considerations include country leadership, particularly for the stewardship of the macroeconomic framework, the development of sectoral policies and increased domestic financing for the health sector. They may also include the provision for a lead donor to co-convene fora for dialogue among policymakers and donor representatives, and to facilitate and streamline the dialogue of the country with its partners, thus reducing transaction costs.
- Collective action would add value though: (i) country-based consensus on national health plans that take into account adaptable frameworks (to be developed) (ii) the assurance of a greater proportion of aid which is predictable, long-term, on plan and on budget, provided under the assumption that governments implement agreed strategies in a transparent fashion; (iii) the mobilization of funds,

preferably non-earmarked, to fill agreed gaps, taking into account fiscal space and multisectoral dimensions; (iv) the promotion of accountability of both countries and donors through independent monitoring; and (v) the facilitation of access to technical and management support to ensure donor alignment with country strategies, processes and plans.

#### At the regional level:

- Donors and agencies representing countries will work towards the strengthening of regional capacity to ensure that countries that need and request it have timely, demand-driven access to technical support and opportunities to exchange experiences.
- More specifically, collective action would add value through: (i) demand-driven support for country led assessments of needs, planning, and budgeting for health outcomes; (ii) the provision of a neutral forum to exchange experiences; (iii) building capacity to manage the process of policy development and donor coordination; and (iv) exploring the potential for a health strategy development fund.
- A regional support team (or similar) will be established for Africa (and located in WHO-AFRO), and possibly another one for Asia. The specific structure, functions and scale of each team will be determined after carefully delineating roles, responsibilities and the level of resources available. It is particularly important to build capacity in a way that transforms regional institutions, such that they can assist countries to scale up for measurable impact on health outcomes.

#### At the global level:

- The fundamental needs are two-fold, and closely related. One is to monitor and facilitate adherence to agreed codes of conduct in a collective endeavor to achieve alignment and harmonization of development assistance with country strategies. The other is to ensure that what is learnt on the basis of country and regional experience feeds back into the policy and operations of donors, global partnerships and foundations. This will include collecting and distributing new information and evidence on the operational aspects of integrating health into macroeconomic and financial planning processes; approaches to the development, costing, evaluation, and financing of health sector strategies; and assessing donor resource flows for health.
- A global support team, however named, would add value by facilitating the collective effort to: (i) define approaches through which countries and partners can hold one another accountable, in line with the DAC/Paris declaration and with emphasis on improving health outcomes; (ii) provide a forum for defining a common agenda for health sector strategy development and implementation; (iii) facilitate the development of an adaptable framework for country-based consensus on a shared agenda; and (iv) identify potential mechanisms for channeling additional funds to countries that are relatively ignored by bilateral donors, and for managing funding discontinuities (e.g. through buffer funds or multi-donor scale-up funds).

Given the urgent need for action, the specific design, TORs and institutional arrangements for a global support team will be finalized as soon as possible, but no later than the end of 2006.

#### **Immediate Next Steps**

- Constitution of a Global Steering Committee to guide the next phase of work, particularly for the rest of CY2006.
- A top priority for the next six months is the preparation of an action plan to support scaling up at the country level. This should include *functions* to support the plan and *institutional arrangements* to perform and support those functions.

- Initiate substantive work at the country level, starting in Rwanda and the other countries discussed in Tunis (DRC and Ethiopia). Forthcoming work will document approaches and best practice for facilitating harmonization and alignment, policy and strategy development in different national circumstances.
- Preparation of a brief summary of key issues related to this work to be discussed when African Ministers of Health meet at the WHO Regional Committee to be held in Addis Ababa in August, 2006.
- Specification of functions, scope of work, organizational, human and financial resource requirements at the regional and global levels, linkages with other regional institutions (e.g., AU, NEPAD, AfDB), initially for the Africa regional support operation, and the exploration of linkages with global actors as appropriate and feasible (e.g., OECD/DAC).