

**REPORT ON THE SCALING UP FOR BETTER HEALTH (POST-HLF) INITIATIVE.  
FIRST MEETING OF THE STEERING COMMITTEE  
Paris, France, 25-26 September 2006**

## **Background**

The decision to establish a steering committee was taken at the Post-HLF Forum on the Health MDGs, held in Tunis on 12-13 June 2006.

In Tunis<sup>1</sup>, it was agreed that action to speed progress toward the achievement of the health MDGs should be country-focused and country-led, supported by dedicated regional and global operations. Actions would only be taken at global level if they could not be taken fully and effectively at country and regional level. Support was needed to help countries prepare, update, finance and implement results-based sectoral strategies that are fully embedded in the macroeconomic and fiscal planning process. It was also recognized that considerable change in behaviour is needed both on the part of countries, to develop robust and inclusive sector plans and to increase domestic financing for health; and on the part of donors, to better respond to country needs, fulfil pledges to harmonize and align aid with country strategies, and to provide long-term predictable financing. Based on this agreement and subsequent consultations among partner agencies, a draft concept note and a draft outline of a business plan (and consultancies to inform parts of the business plan) were developed. They outlined, respectively, key functions at global, regional and country levels, and an approach for translating that concept into actions during an initial period of two years.

The first meeting of the Steering Committee, reported below, provided a forum to further discuss the concept note, the outline of a business plan and the regional proposal, as well as to start thinking about the key events for the first half of 2007 and the resources needed to start-up activities.

## **The Concept Note**

The Concept Note scoped out actions at regional, global and country level.

### At the global level

In Tunis, it was envisaged that the fundamental needs at the global level are two-fold and closely related. These two needs are: “to monitor and facilitate adherence to agreed codes of conduct in a collective endeavour to achieve alignment and harmonization of development assistance with country strategies” and “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<sup>2</sup>.” To this end, global level work would involve facilitating collective efforts to: explore the feasibility of a forum for donor accountability linked to the

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<sup>1</sup> The Summary of Conclusions and Action Points from the Tunis meeting is available at <http://www.hlfhealthmdgs.org/HLF4Tunis/TunisMeetingReport2006Final.pdf>. Accessed on 3 October, 2006

<sup>2</sup> Ibid.

OECD Development Assistance Committee (DAC); provide a forum for defining a common agenda for health sector strategy development and implementation; facilitate the development of an adaptable framework for country-based consensus on a shared agenda; and to identify potential mechanisms for channelling additional funds to countries that are relatively ignored by bilateral donors along with other efforts, and to manage funding discontinuities.

The Steering Committee endorsed having strong global level functions with links to country level and to the OECD/DAC. This was seen as an important aspect of dealing with harmonization and alignment problems arising at country level, as donors and global health partnerships are principally accountable to the global level.

The Steering Committee endorsed the global level functions presented in the concept note, but had reservations about its focus on new financial mechanisms. Rather the global functions should be: influencing policy and practice; ensuring and facilitating access to high level technical support; and exploring innovation in health sector financing and mechanisms for improving predictability of aid. Participants agreed that in the short-term, better alignment of existing instruments is a priority. In the longer-term global functions should still explore how best to address the issue of 'aid orphans' and a buffer fund.

Participants also recommended that the following functions be included at the global level:

- Providing high-quality synthesis and analysis of alignment gaps and bottlenecks that need to be addressed.
- A convening role (at the right level and based on experience and analysis) for dialogue on allocation of resources in health
- Documenting and communicating progress that has been demonstrated at the country level through “proof of concept”.
- Creating a forum and space.
- Ensuring that global coordination on health plans is linked to global coordination on HIV/AIDS.
- Developing a common analytic framework and set of metrics for health sector performance.
- Harmonization of technical assistance for health.

There was agreement that more analysis on donor behaviour at country level is needed. This will help to better understand aid flows from different donors; learn from what has been achieved and build on this knowledge; and identify gaps and required support. Participants also emphasized the importance of having a clear commitment from donors on what funding is available to achieve the MDGs.

#### At the regional level

It was agreed in Tunis that donors and countries would work to strengthen regional capacity to provide demand-driven technical support to countries, as well as opportunities to exchange experiences. The AfDB, WHO, UNICEF and World Bank have taken forward this commitment by developing a proposal for 'tackling the barriers to scaling up in health'

through a mechanism known as *Program Assistance for Facilitation in Health* (PAFH). The PAFH was presented to African Ministers of Health at the WHO Regional Committee (Addis Ababa, August 2006), where it received strong support. The four agencies resolved to support African countries in a pragmatic fashion, and agreed to discuss the proposal with Steering Committee members during the meeting in Paris.

In Tunis, it was agreed that the process should begin in Africa. At the Steering Committee, there was some concern about the capacity of the organizations involved to deliver the support proposed, and the extent to which a regional structure could solve aid coordination issues. The Ministry of Health of Ethiopia illustrated the issue through reference to problems caused by different procurement procedures of different partners, which can only be solved at HQ level. The Democratic Republic of Congo noted that an over-emphasis on global level work should not compromise the country level and regional support, a point echoed by UNICEF. Burkina Faso noted two main functions: accountability at the country level, in a process to be led by country authorities; and, support from the regional level – the region is a more appropriate locus of coordination in Africa and can facilitate country access to technical support.

The Steering Committee recognized a need to distinguish between those needs that can be met at the regional level and those that require intervention at the global level. They agreed that regional operations have a role, as they are the most appropriate locus for provision of rapid technical assistance to countries. However, they felt that a regional level structure should be backed up by action at global level, particularly on issues of harmonization and alignment, which may be better addressed at the global level; and they stressed that the regional level structure should be developed according to the context, need and function. They also asked that the core group which developed the PAFH be broadened. The four institutions involved indicated that they welcomed the participation of others.

Finally, it was noted that the Asia and Pacific Regions are also interested in taking forward the post-HLF agenda, and that this should proceed in parallel with, rather than follow, work in Africa.

#### At the country level

The Steering Committee made the following points and recommendations on country level activities:

- Activities should be country-led and country-focused, involving all partners and stakeholders that are operating at country level. Activities need to build on what already exists in countries in order to improve it or to implement it in a more structured manner. Lead agencies should not be predetermined, but designated depending on local capacity and context.
- It was suggested that countries can be classified according to different categories which identify the type of technical support and assistance required.
- Even with credible sector development plans, the primary challenge for Ministries of Health in countries is the alignment of different funding modalities for scaling up. In the

design and implementation of such processes, technical support and capacity building are needed. They are provided by different agencies, including national and regional institutions.

- There is much to be learnt from the country level harmonization and alignment process of the Fast Track Initiative (FTI). Most 'FTI' countries have single plans, single reporting systems, and long-term predictable financing. There is also much to be learnt from countries who are trying to integrate health programmes and HIV/AIDS programmes, for example Malawi and Niger.
- The role of non-state actors and the private sector is critical at country level, and needs to be looked at as part of this initiative.
- Australia expressed interest in funding some diagnostic country work in Asia.

### **The draft business plan outline and associated consultancies**

The Steering Committee concluded that some of these consultancies were either not urgent or not essential. The approach to the business plan would be revisited by the World Bank and WHO. A revised approach would be taken further by the Working Group (see Next Steps).

The Steering Committee concluded that the consultancy for new financing mechanisms was not urgent.

### **Conclusion**

In conclusion, the overall purpose of this initiative was supported; however, participants felt that more clarity was needed on how the process will be managed, how success will be measured, the interface among the (country, regional and global) levels, who will be leading it, and who will participate in it. They noted that there were many initiatives which are tackling the same issues, and that this initiative should be inclusive and should explore how it fits with other initiatives, such as the Norwegian Fund for MDG4 which was launched last week in New York, as well as with the agenda of other institutions. It is also vital that it be conceived as an action-oriented and outcome focused initiative.

### **Next steps**

- In the current transitory period and as a pragmatic response to the request coming from Steering Committee members for moving forward, a working group will be established and will start immediately to prepare a proposal on how this initiative will run for the next two years. The proposal prepared by the Working Group will include a plan and mechanisms for engaging with countries, as well as options for an independent secretariat which could include secondments from key partners. The secretariat will support country work on request; it will not drive the process at country level. Options and recommendations will be reported back to the Steering Committee by the end of 2006.

- Country selection: The initial focus of country action will be those countries that have been involved in the Post-HLF process to date (Burkina Faso, DRC, Ethiopia, Madagascar and Rwanda). Other considerations for country selection were also suggested, including eligibility for GAVI Health Systems Strengthening window. Overall, the criteria for country engagement will include country ownership, historical engagement in the process, donor commitment, and the possibility of engaging global health partnerships.
- Several agencies and GHPs expressed willingness to provide financial support to move the agenda forward (Australia, France, Ireland, DFID, The Netherlands, and GAVI).
- No Steering Committee meeting is planned in the coming weeks but in light of preparing its proposal, the Working Group will be informally in touch with Steering Committee members. In addition to e-mail communications, the Working Group will seek opportunities such as the meeting on aid effectiveness in health in the context of the OECD DAC work (Paris, December 4, 2006) to report to the Steering Committee members, a number of whom will participate in that meeting. Information will be circulated as soon as possible and Steering Committee members will be invited to react and formulate suggestions to move the agenda forward.