World Health Organization

Joint evaluation of the Global Action Plan for Healthy Lives and Well-being for All

(SDG3 GAP)

ANNEXES

Gavi · Global Financing Facility · International Labour Organization · The Global Fund · UNAIDS · UNDP · UNFPA · unicef · Unitaid · UN Women · World Bank Group · World Food Programme · World Health Organization

CONTENTS

ANNEX 1: Terms of reference

Terms of Reference of the Joint Evaluation of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP).

25 July 2023

1) Introduction

The 2030 Agenda for Sustainable Development, was adopted by all United Nations Member States in 2015 [1], as a global partnership to achieve sustainable peace and prosperity. Among its 17 Sustainable Development Goals (SDGs), SDG3 aims to "Ensure healthy lives and promote well-being for all at all ages"[2]. Ensuring healthy lives and promoting wellbeing for all at all ages is essential for leading dignified lives, and is intrinsically linked to poverty reduction, education and environmental sustainably: as such it is critical to achieving progress on the 2030 Agenda. As both physical and mental health is an integral aspect of human capital and a precondition, driver and outcome of sustainable development, SDG3 is linked to approximately 59 health-related targets across the SDGs and the pledge to leave no one behind.

National leadership is the core of the SDG agenda and global partnerships are critical to support Member States in achieving standards of healthy lives and promoting equitable well-being for all ages. The 2030 Agenda pledge to "leave no one behind" exhorts that progress on the SDGs requires the inclusion of all the different groups of people, especially the marginalized and most vulnerable,

[1] In 2015, the UN general assembly adopted resolution 70/1. Transforming our world: the 2030 Agenda for Sustainable Development https://undocs.org/en/A/RES/70/1 which outlines strengthen the means of implementation and how revitalize the Global Partnership for Sustainable Development tackling several systemic issues which are common to each of the Goals.

[2] Targets are that:

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

including the over 70 million people forcibly displaced. Eight years into the 2030 Agenda is an opportunity for stakeholders to take stock of what has been achieved, facilitating factors and challenges, and what remains to be done, to determine a path forward.

In 2017, the System-Wide Outline of Functions and Capacities of the UN Development System pointed out that SDG3 had the second highest level of expenditure and personnel compared to the other 16 SDGs. Yet despite multiple efforts[3] "*to achieve better coordination, fragmentation is an enduring feature of the global health landscape that undermines the effectiveness of health programmes*" and puts the achievement SDG related of its targets at significant risk[4]. In 2019, the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP) was launched during the High-level week of the UN General Assembly between the first SDG Summit and the first HLM on UHC to support countries to accelerate progress on the health -related SDG targets through a closer collaboration of its signatory agencies. The GAP is intended to leverage the 13 agencies' individual mandates, comparative advantages, and capacity more effectively for enhanced collective results in countries.

Furthermore, three years after the outbreak of the COVID-19 pandemic, a succession of mutually reinforcing crises and a challenging global context are putting the multilateral development system under pressure. Multilateral development finance is stretched across an ever-expanding list of priorities, ranging from humanitarian crisis response to the provision of global and regional public goods. The urgent nature of these crises requires renewed efforts to strengthen the financial capacity of the multilateral development system but should not divert attention from other parts of the reform agenda, such as the need to reduce the fragmentation of the multilateral architecture.

In this context, it is critical for decision-makers at the global, regional and national level to understand whether SDG3 GAP is contributing to national SDG acceleration efforts by improving collaboration and coordination among its signatory agencies[5] in alignment with country led national health plans and strategies, areas of improvement, lessons that can be scaled or expanded, where and how to better streamline development partners support and how the effectiveness could be further enhanced through reinforcing and complementary steps by other actors such as Member States.

While there have been significant efforts to measure progress towards the achievement of the health-related SDG targets and indicators (including the World Health Statistics[6] report, latest status of the progress towards the Triple Billion targets, the World Health Data Hub), limited efforts have been made to understand how the collective contributions of multilateral agencies can support countries in accelerating progress on the health related SDG targets and on how progress in strengthening collaboration and alignment can be measured (e.g. through the SDG3 GAP monitoring framework including the government questionnaires) Overall, while progress has been made in improving data

[3] Among others, in 2007 IHP+, an international partnership that aimed to improve effective development cooperation in health to help meet the Millennium Development Goals. In 2016, IHP+ transformed into UHC2030 to respond to the health-related Sustainable Development Goals and expanded to include health systems strengthening to achieve universal health coverage.

[4] Spicer, N., Agyepong, I., Ottersen, T. et al. 'It's far too complicated': why fragmentation persists in global health. Global Health 16, 60 (2020). https://doi.org/10.1186/s12992-020-00592-1.

[5] The signatories to the SDG3 GAP are Gavi, the Vaccine Alliance; Global Financing Facility for Women, Children and Adolescents (GFF); Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); International Labor Organization (ILO); Joint United Nations Programme on HIV/AIDS (UNAIDS); United Nations Development Programme (UNDP); United Nations Population Fund (UNFPA); United Nations Children's Fund (UNICEF); Unitaid; United Nations Entity for Gender Equality and the Empowerment of Women (UN Women); World Bank Group; World Food Programme (WFP); and World Health Organization (WHO).

[6] The World health statistics report is World Health Organization's (WHO) annual compilation of the most recent available data on health and health-related indicators for its 194 Member States. The 2022 edition features the latest data for 50+ indicators from the Sustainable Development Goals (SDGs) World health statistics 2022: monitoring health for the SDGs, sustainable development goals (who.int).

for monitoring of SDG, there are still significant gaps in geographical coverage, timeliness, and disaggregation[7]. Furthermore, to date, there have been few evaluations related to single or collective agency interventions related to the health-related interventions related to SDG3 and no joint evaluation. However, it is worth mentioning, the People Pillar synthesis, in particular, as it includes SDGs 1 - 5. https://www.sdgsynthesiscoalition.org/

But halfway to 2030, the agenda is in peril and progress to achieve the SDGs is off track[8]. "*Even before COVID-19, the world was off track on major health-related indicators. Now, it is even further behind, and many countries face a range of overlapping health crises stemming from the impact of the pandemic, war, food insecurity and climate change. Economic conditions are also placing significant pressure on domestic and external financing for development. While other approaches, such as data and delivery for impact and innovation in products, services, and financing, are also needed, enhanced collaboration within the multilateral system is more important than ever to help accelerate progress towards the SDGs and make the most efficient and effective use of available resources*"[9].

2) Evaluation object

The Global Action Plan for Healthy Lives and Wellbeing for All (SDG3 GAP) is a set of 4 commitments by 13 multilateral agencies that play significant roles in health, development, and humanitarian responses to help countries accelerate progress on the health-related SDG targets, through strengthening collaboration across the agencies to take joint action and to produce joint deliverables and provide more coordinated support aligned to country owned and led national plans and strategies. Thus, enhancing shared accountability.

The goal of the Plan is to support countries in accelerating progress towards the health-related SDGs, by supporting countries' efforts, using a Primary Health Care (PHC) based approach, through closer collaboration across the multilateral agencies active in health and stronger alignment to national plans and priorities. Its ultimate goal in therefore an acceleration of progress toward the achievement of the health-related SDG targets by 2030.

GAP signatories' agencies are guided by four commitments:

- Engage with countries better by jointly aligning their support around country owned and led national priorities and plans and implementing together.
- Accelerate progress in countries through joint actions and joint deliverables under specific accelerator themes and on gender equality and global public goods.
- Align, by harmonizing their operational and financial strategies, policies, and approaches in support of countries' equitable and resilient recovery towards the health-related SDGs.
- Account, by reviewing progress and learning together to strengthen collaboration and to enhance shared accountability.

SDG3 GAP agencies provide joint support to countries along seven "accelerator themes" and on gender equality, facilitated by interagency communities of practice in these areas. These accelerator areas constitute cross-cutting areas were a number of SDG3 GAP agencies are active and in which

[7] Progress towards the Sustainable Development Goals: Towards a Rescue Plan for People and Planet SDG_Progress_Report_Special_Edition_2023_ADVANCE_UNEDITED_VERSION.pdf.
[8] SDG_Progress_Report_Special_Edition_2023_ADVANCE_UNEDITED_VERSION.pdf.
[9] According to the 2023 progress report on the Global Action Plan for Healthy Lives and Well-being for All (who.int).

progress in each thematic area could contribute to accelerating overall progress on the health-related SDG targets. Work at the country level increasingly spans several accelerators, for example on PHC and sustainable financing, while also helping to strengthen data systems, promote equity and gender equality, and bring innovation to scale. Agencies are committed to consistently promote action on gender equality in all the accelerator themes.

By 2023, the midpoint of the 2030 Agenda for Sustainable Development intends to have brought about the three major changes:

- Better coordination among the agencies in their global, regional and in-country support to countries
- A reduced burden on countries as a result of better aligned operational and financial policies and approaches; and
- A purpose-driven collaboration that is integrated into the agencies' organizational cultures, encompassing leadership at global, regional and country levels."

Following its launch in 2019, SDG3 GAP signatories commissioned a joint evaluability assessment[10] in 2020. It's overall findings noted that:

"a) 4 of the 12 strategic elements are in place and in need of improvement
b) 2 of the 6 technical elements are in place and in need of improvement
c) None are fully in place and working well. As a consequence, the GAP is not yet sufficiently evaluable in a way that will make on-going monitoring and evaluation efforts meaningful for the partners' learning, continued improvement, and mutual accountability to each other as partners. It does not yet have the requisite elements in place (e.g. a theory of change (ToC), shared data and information systems, joint planning opportunities etc.) to be meaningfully evaluated with robust evidence on whether it has succeeded in its ambitious effort."

To address this, in Q4 2020 the SDG GAP signatories developed a ToC (annex 1) and in Q1 2021 strengthened the monitoring and evaluation framework which was then piloted in Q2 and used as a basis to develop annual report. [11]

SDG3 GAP signatory agencies committed to conduct a joint evaluation in 2023 which intends to assess collaboration, enhance shared accountability and identify lessons learned. Evidence from the evaluation would feed into the Boards and inform other relevant processes, such as the July 2024 High Level Political Forum (HLPF). Considering the evaluation will only be initiated in Q3 2023, it will only be completed in 2024 and will feed into next year's HLPF.

While an MTR of the SDG3 GAP was originally planned in 2021 and referred to in the 2020 evaluability assessment it did not take place. Instead, the SDG GAP Secretariat tracked and published

[10] In 2020, a Joint Evaluability Assessment was commissioned and managed by a Steering Group comprising representatives of the independent evaluation offices of all signatory agencies with the main objective to determine the extent to which the key strategic and technical elements for the partnership to succeed were in place. The main objective of the JEA was to determine the extent to which the key strategic and technical elements for the GAP partnership to succeed are in place, thus supporting signatory agencies to pre-emptively address the identified outstanding gaps before they become problems. The JEA report provides an early, rapid and light-touch independent assessment of the key elements of partnership at the very outset of the GAP initiative and includes six recommendations emanating from its analysis. For more information refer to the joint-evaluability-assessment-of-the-sdg3-global-action-plan---report.pdf (who.int).

[11] Monitoring framework (who.int) and SDG3 progress reports (who.int).

progress to the evaluability assessment management response considering the MTR would come too early in 2021 and in 2022 would be too close to the joint evaluation.

In view of the independent evaluation planned for 2023, signatory agencies undertook a self-assessment through the 2023 progress report on SDG3 GAP[12], reflecting candidly on what has worked and what has not worked since the SDG3 GAP was launched in 2019. The report noted that stronger collaboration in the multilateral system is needed and more important than ever. This will help accelerate progress on the SDGs and make the most efficient and effective use of available resources.

The report emphasizes that SDG3 GAP has created an improvement cycle for collaboration on health in the multilateral system, which elevates the voices of countries by surveying them on how well the agencies work together to support national priorities. The GAP is also providing supportive structures for collaboration on health among 13 signatory agencies working in and beyond the health sector. It notes that while there has now been some level of engagement on one or more of the SDG3 GAP accelerator themes in 67 countries, the depth of engagement varies considerably, and the commitments made by the signatory agencies at the global level have not yet fully translated to closer collaboration in all the countries engaged.

Even if management did not make any formal commitments to implement these, the report makes six recommendations (see Annex 3) to further strengthen collaboration on health in the multilateral system and help countries to accelerate progress on the health-related SDG targets: continuing SDG3 GAP as an improvement cycle for health in the multilateral system; maintaining SDG3 GAP as an platform for collaboration; continuing to foster collaboration at country level on primary health care, sustainable financing, equity and data, and exploring new thematic issues such as zero dose communities and climate resilient health systems; jointly applying new approaches at country level such as delivery for impact; re-engagement of civil society; and strengthening incentives for collaboration through stronger political leadership and governance direction and increased resources for collaboration.

The independent evaluation may use this self-assessment as a starting point, including by reviewing the recommendations put forward by the agencies. It will also seek to identify missing information specially at the outcome level engaging Member States throughout the process, given their central role in setting incentives for collaboration across the multilateral agencies which signed up for the SDG3 GAP.

3) Proposed evaluation purpose, objectives, users, and expected use

Purpose

Overall, the purpose of this joint evaluation is to inform partners' learning, continued improvement, and mutual accountability to each other as partners. As stated in the commitments, signatory agencies of SDG3 GAP are committed to reviewing progress and learning together to strengthen collaboration and to enhance shared accountability. Being both learning and accountability oriented, the evaluation will identify areas where signatories are performing well as well as those where they need to improve the coherence between their actions and commitments so that they can better support countries to advance in their health-related SDGs. While there is considerable focus on how

[12] 2023 progress report on the Global Action Plan for Healthy Lives and Well-being for All (who.int).

to measure progress using indicators, the evaluation must go beyond measurement, to consider whether progress is equitable, coherent, effective, and sustainable.

Evidence from the evaluation is intended to strengthen partnerships and collaboration among multilateral agencies related to health-related SDG targets and beyond (including at the political, programmatic and oversight level). It may identify:

- How closer collaboration of SDG3 GAP agencies is/can effectively contributing/e to ensure healthy lives and promote well-being for all at all ages.
- Areas to enable further improvement in terms alignment and coordination across the SDG3 GAP signatory agencies and other development partners in health, including by looking at the role of the Boards, Member States and donors in setting incentives for which support or hinder closer collaboration and better alignment (such as stronger political leadership, governance direction and funding for collaboration).
- Ways to scale up tools and good practices which foster closer collaboration across agencies, accelerator areas and other focus areas .

Objectives

Overall, the evaluation will assess the whether the signatory agencies have strengthened their collaboration by engaging with countries better to identify priorities, and to plan and implement together; harmonizing operational and financial strategies, policies and approaches; reviewing progress and learning together to enhance shared accountability; and, accelerating progress in countries through joint actions under seven programmatic themes, and on gender equality and delivery of global public goods[13], with the aim contributing toward an acceleration of progress on the health-related SDG targets in countries.

The theory of change (see annex 1) will be used as a framework to understand how the SDG3 GAP signatory agencies work together and have contributed to its goals namely accelerated progress towards the health-related SDG, leaving no one behind, including in the context of countries' efforts to recover and rebuild from Covid-19 by strengthening their collaboration.

As such the evaluation will review whether signatory agencies have jointly achieved the desired outcomes :

1. Countries receive better coordinated and more effective support, better aligned with their priorities, from GAP agencies
2. Improved access to more equitable quality PHC and sustainably financed national health plans and priorities, including in fragile settings
3. More equitable and inclusive progress towards health-related SDGs
4. Improved PHC through enhanced uptake of innovations and availability and use of timely and reliable health disaggregated data (both at national and sub-national levels) for decision making

More specifically the evaluation will assess to what extent the SDG3 GAP collaborative approach and shared accountability among 13 signatory agencies is effectively and coherently strengthening:

[13] In line with the commitments put forward jointly as a self-commitment by the 13 signatory agencies in the 2019 Stronger Collaboration, Better Health – Global Action Plan for Healthy Lives and Well-being for All document and subsequent updates through joint reports and guiding documents especially of the recommendations of the 2023 progress report.

- Alignment to national health plans and priorities,
- Countries' (including fragile settings) PHC plans through technical and financial support,
- Multisectoral action on determinants of health, community and civil society engagement and gender responsiveness through country support
- Health data and scaling of innovation,
- Gender equality and responsiveness

It will review the self-assessment put forward jointly by the 13 SDG3 GAP agencies in preparation of the independent evaluation, including its analysis on what worked and what didn't work and the six recommendations to scale things that worked and address those which didn't work.

Finally, it will recommend what sustained and transformative action, both nationally and internationally, is needed to fully leverage closer collaboration and shared accountability in the multilateral system to support countries in accelerating progress toward SDG3 and the other health-related targets.

Intended users and use of the evaluation

The **primary users** of this evaluation are the 13 signatory agencies, member state representatives, Executive Boards, Principals, senior management, and staff involved in the SDG3 GAP at various levels (including the HQ, regional and country office level) who are expected to respond to its findings and recommendations. The **secondary users** include other representatives of national governments' (including representatives of the President/Prime Minister's Office, National Parliament, Ministries of Foreign Affairs and / or development, Ministries of Health, Ministries of Planning and of Finance, Ministries of Gender, Ministries of Youth, Ministries of Education) other development partners including bilateral donors and implementing partners and civil society. Other SDG alliances may also be included as secondary audience.

This evaluation is also of interest to donors and implementing partners, both governmental and non-governmental, as well as beneficiaries and communities, as a mechanism to strengthen transparency, share experiences, and identify lessons learned. Lessons learned will help public sector accountability and accelerate progress towards health-related SDGs at the country level.

Key stakeholders, such as member state representatives and signatory agency staff, are expected to be part of the evaluation reference group from the inception phase to strengthen validity and buy-in of the process. In addition, when possible, the evaluation will include meaningful participation of duty bearers (governments) and rights holders (when possible also civil society and programme beneficiaries) to promote ownership and use of evaluation findings.

To foster closer collaboration across the multilateral agencies active in health and stronger alignment to national plans and priorities, emerging findings and recommendations of the evaluation will be presented both at the national and global level. At national level, they will inform the development and implementation of national health and development plans and Voluntary National Reviews (VNRs). At global level, they should feed into the 2024 SDG HLPF and into the deliberations of the governing bodies of UN and multilateral agencies.

Overall, the evaluation findings, conclusions and recommendations will be used to improve the effectiveness, coherence, and sustainability of SDG3 GAP approach and to guide joint interventions at country, regional and global level. The evaluation should provide insights on how to strengthen collaboration in the multilateral systems, improve partnerships between GAP signatories, and inform joint interventions supporting Member States to accelerate progress in achieving the health-related SDG targets. The recommendations will also help inform preparations of the 2024 HLPF and the UN

summit for the future. The UNGA/HLPF, Governing Bodies (such as Executive Boards) of signatory agencies, the Summit for the future could use the evaluation as a basis for their policy discussion to improve multilateral collaboration and support SDG acceleration efforts and provide guidance to key stakeholders. Findings and lessons learned may also feed into national governments, including ministries of planning, finance and health, funding partners of the signatory agencies decision-making as well as to promote the acceleration of SDG3 agenda from global to the local level (by civil society actors, etc.). Finally, the evaluation is intended to serve as a public learning and accountability tool for all who are supposed to benefit from the SDG 3 GAP

Evidence from the evaluation may also inform the discussion on the global health architecture, the development policies and strategies of signatory agencies' global, their implementation plans, and approaches to support country level work. It should also inform advocacy to accelerate progress on the health-related SDG targets and leveraging of partnerships in all regions with national governments, civil society, bilateral and other multilateral agencies. It will also suggest ways to improve the incentives at play for closer collaboration and shared accountability to improve the multilateral system capacity to collectively deliver in support of countries and -explore, to the extent possible, ways to strengthen the global health architecture.

4) Scope of the evaluation

Time scope

September 2019 to December 2023.

Organizational level scope

SDG3 GAP signatory agencies' Country Offices, Regional Offices, UNCT and HQs mainly.

It is expected that the evaluation will include participation of the following:

- SDG3 GAP signatory agencies' offices in each of the countries to be visited
- SDG3 GAP signatory agencies, Principals, other senior staff in HQ engaged in the initiative
- members of the executive boards of the SDG3 GAP agencies
- Member States
- Government counterparts in each country, including Ministry of Planning, Ministry of Finance and Ministry of Health, Ministry of Gender, Ministry of Youth, Ministry of Education
- Other major partners,
- Civil society and other implementing partners

Geographical scope

The evaluation's geographical scope is global and country specific. It will include 5 the 67 countries that were engaged under the SDG3 GAP and 2 country case studies where non concerted efforts have occurred. A specific focus will be placed on countries for which case studies have been produced: https://www.who.int/initiatives/sdg3-global-action-plan/progress-and-impact/case-studies. the team should only visit a representative sample of these countries To select countries the evaluation team could use a sampling strategy that puts demonstrable change at country level as key, discernible output and work back from there (almost like a contribution analysis). Countries that perceive there is a tangible change should be considered as a starting point.

The purpose of choosing 2 study countries where non concerted effort have occurred is precisely to fill an evidence gap and not duplicate efforts. To the extent possible, these countries should include fragile, low- , and lower- middle- as well as selected upper-middle-income countries where signatory agencies are providing support either through humanitarian or development interventions. When selecting country cases it is important to consider that the different agencies have different operating models – e.g. Unitaid, the Global Fund, Gavi do not have country presence, UN women operates more from regional hubs. Most of the agencies are active in LICS and LMICS- even if operating from HQ only.

Further scoping of the evaluation

At the beginning of the evaluation the team should assess the status of the strategic and technical elements reviewed in the evaluability assessment and the extent to which its recommendations have been assessed. This will help the evaluation team determine extent to which partnership is functioning to succeed in accomplishing its goal and to meaningfully evaluate the SDG gap.

5) Methodology and approach

Overall design and approach

The methodology described in this section is indicative and the independent external team that will be hired to conduct this evaluation is expected to adapt the approach and propose adjustments needed to undertake the assignment. These can include additions to the evaluation design; approaches to be adopted; appropriate sampling strategy; data collection and analysis methods; and an evaluation framework. The proposals should also refer to methodological limitations and mitigation measures.

The design of the evaluation will be non-experimental and adopt a theory based and developmental approach in assessing the effectiveness, coherence, and sustainability of the SDG3 GAP against its intended outcomes (see ToC in annex 1). During the process, the evaluation team will assess strategies for each intervention component, validate their coherence and help gather evidence to stimulate reflection to inform the next phase of SDG3 GAP among the 13 signatories and countries supported.

As the evaluation object is complex, it is recommended that the team maps the different dimensions that characterize SDG3 GAP and the system in which it operates to understand the competing priorities of 13 signatory agencies and stakeholders they partner with, as well as causality and change as it unfolds. Once evaluators map these different dimensions, they could unpack and reassemble the evaluation approach selecting units of analysis and the best evaluation approach for each unit and reassemble the individual findings into a whole before going back to the big picture.

Thus, the team should identify specific methods addressing aspects of complexity in the evaluation design and implementation (Bamberger et al., 2016). If the team opts for this approach, it could first unpack the evaluand, the inter-SDG interface and apply the criteria selectively and as appropriate to each component. To do so, the evaluation team could facilitate the refresh of the ToC (annex 1) with stakeholders and review the monitoring framework and the different kind of indicators specifically identified for the main outcome areas (see annex 1 and table 1 below).

Table 1: Summarized monitoring framework

TOC level	Country experience	Country perceptions	Agency perceptions	Context monitoring	Process monitoring	Risk monitoring
Goal/Impact				✓✓		
Outcomes	✓✓	✓✓	✓	✓		
Outputs	✓	✓	✓✓		✓	
Inputs			✓			
Risks						✓
Assumptions			✓			

Area within red box denotes scope of monitoring framework

With a strong focus on utilisation, the approach of the evaluation will concentrate on engaging with the principal users of the evaluation process and report, focusing on utilization and use of the findings and recommendations by all key stakeholders. Primary users are signatory agencies at the global while secondary users will be at country level, and focal points in national government health ministries and departments, representatives at sub-regional and national level and, as far as possible, key stakeholders including implementing partners and civil society. The evaluation process and recommendations are intended to trigger ownership mainly headquarters level. The evaluators should suggest how they will engage with each user group and specify the purpose. It is strongly recommended they use iterative feedback loops throughout the evaluation.

Mixed data collection methods will be used as far as possible. Discussions with stakeholders will provide qualitative evidence. To answer the overarching and specific evaluation questions the evaluation team will draw from the available data from the SDG3 GAP joint evaluability assessment, the four SDG3 GAP progress reports (see annex 3), its 21 case studies and other sources such as the Future of Global Health Initiatives process case studies entitled 'Re-imagining the Future of Global Health initiatives' [14], the World Health Data Hub, and Multilateral Organization Performance Assessment Network (MOPAN) reviews as well as other SDG joint evaluations. Participating evaluators would review the current ToC and monitoring framework to consider a "contribution analysis approach" particularly around questions of effectiveness, and other relevant approaches for stakeholder consultation that generate useful qualitative and quantitative data on key issues.

The methodology is expected to be innovative, gender responsive and enable rigorous and systematic data collection and rigorous analysis, to emerging good practices which could be replicated in other countries.

The evaluators will assess the options and describe in detail the suitable methods to meet the purpose, scope, and objectives of this evaluation. The methodology will be further refined in the inception phase.

Overall, the evaluation requires an analysis at the national, regional and global levels. Considering the strategic focus of this multi-stakeholder partnership, it is expected that evidence will be collected primarily through an extensive/comprehensive desk review, including agencies policies and strategies, complemented by key informant interviews, focus group discussions and online surveys of key internal and external stakeholders. Other data or information, which is deemed to be

[14] Future of Global Health Initiatives process | What we do | Wellcome.
Re-imagining the Future of Global Health initiatives - Geneva Centre of Humanitarian Studies.

necessary to answer evaluation questions, can also be gathered from a review of secondary sources, such as: programme documents, annual progress reports, or monitoring records available with SDG3 GAP secretariat and signatory agencies. In addition, the evaluation could adopt a realist approach selecting countries reporting reduced burden and accelerated focus as cases. These case would focus on context-mechanism and outcome

Triangulation

Considering evaluation findings, conclusions and recommendations are to be used for organizational learning, informed decision-making, and accountability; findings should be based on triangulated evidence, and conclusions and recommendations should derive from the findings. Multiple sources should be used to ensure that the findings can be generalized to the response and were not the results of bias or the views of a single agency or type of actor. Three types of triangulation methods are envisaged: 1) cross reference of different data sources (interviews and documentation) from country, regional and global levels, 2) triangulation through the different stakeholder consultation, and 3) review by SDG3 GAP signatories' staff and consultation with government key respondents during the report drafting process and at the validation meeting. Triangulation should allow the team to determine how much weight to put on diverse sources of information The triangulation efforts will be tested for consistency of results, noting the inconsistencies do not necessarily weaken the credibility of results, but may reflect the sensitivity of different types of data collection methods. This is to ensure validity, establish common threads and trends, and identify divergent views.

The evaluation must follow the UNEG Norms and Standards for Evaluations (2016) and its Ethical Guidelines. It should also respect the **UNEG Guidance on integrating Human Rights and Gender Equality in Evaluation** and the **UN-SWAP Evaluation Performance Indicators**.

Below are preliminary evaluation questions which will be finalized with the contractor during the inception phase. Prioritization of questions, additional sub-questions, and any new areas of enquiry will also be developed and discussed during the inception phase

6) Evaluation criteria and questions

The evaluation overarching questions and the specific questions will focus on i) **Effectiveness**, ii) **Coherence**, and iii) **Sustainability** of SDG3 GAP both at the national and global level. These questions are aligned to the ToC (annex 1) and these criteria are expected to be aligned with the evaluation criteria of the Organization for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC).

The evaluation will not look at the impact or efficiency of SDG3 GAP because these criteria are not directly linked with the main objectives of this evaluation and analyzing these aspects would imply the use of a complex methodology that lies beyond the scope, budget, and timeline for this evaluation.

The evaluation criteria and questions may be commented on and adjusted by the bidders in their technical proposal. They will be finalized during the inception phase, including prioritization of questions, more specific sub-questions, and any additional areas of enquiry. The final decisions will be made based on the following principles: feasibility, importance and priority, usefulness, and timeliness.

Overarching questions

To what extent did SDG3 GAP contribute to better health for people?

- To what extent has SDG3 GAP accelerated progress and supported countries towards achieving the SDG 3 12 targets and 28 targets of other SDGs related to health (leaving no one behind)?
- To what extent are signatory agencies' operational, and financial strategies, policies and approaches coherent, effective and sustainable? Are these sufficiently aligned, effectively avoiding duplications and driving efficiencies to strengthen country health systems?
- To what extent currently the signatory agencies are jointly collaborating and mutually accounting towards strengthening the country's health systems?
- To what extent have SDG3 GAP signatory agencies collectively helped health systems and countries and jointly accounted to recover from the negative impacts of the COVID-19 pandemic?

Specific questions

Effectiveness

- To what extent has/is SDG3 GAP achieved/expected to achieve, its objectives, and its results, including any differential results across countries? Which outcomes are better/less achieved? Why?
- To what extent are the SDG3 GAP signatory agencies contributing to deliver, or likely to deliver, results in an economic and timely way? When do SDG3 GAP signatory agencies collectively enable the better use of existing resources (technical, financial and human), including local coordination mechanisms?
- Which collaboration mechanisms are more effectively accelerating progress at the country level? Which are less effective? Why? What extent these collaborating mechanisms are accounting their performance?
- Have the SDG3 GAP signatory agencies strengthened their collaboration in providing joint technical and financial support for countries' PHC-oriented health system strengthening plans and health financing?
- To what extent is gender equality and responsiveness effectively strengthened through joint support by the SDG3 GAP signatory agencies?
- To what extent did the recommendations put forward in the 2023 progress report titled "What worked? What didn't? What's next" resonate with stakeholders to better leverage collaboration to drive progress on the health-related SDG targets in countries?

Coherence:

- Has SDG 3 GAP provided a solid foundation for stronger coherence in terms of better alignment and coordination and mutual accountability across development partners in health? How does it complement international partnerships such as IHP+/UHC 2030?
- How much are SDG3 GAP signatories fostering joined-up approaches at the country level? Have they improved the coherence of their interventions at the country level? Have these joint approaches/deliverables are consistent? When haven't they done so?
- When do countries receive better coordinated, more effective support, that is better aligned with their priorities, from SDG3 GAP signatory agencies both at the national and subnational level?

Sustainability

- To what extent is the SDG3 GAP sustainable and helping countries recover from the negative impacts of the COVID-19 pandemic?
- To what extent have signatory agencies managed to promote integrated investments in global health security and universal health coverage?
- Have SDG3 GAP signatory agencies joint support helped countries achieve equitable and inclusive progress towards health-related SDGs?
- Which SDG3 GAP tools and approaches need to be scaled up to improve the collaboration of the SDG3 GAP agencies to support countries in achieving the health-related SDG targets?

The final version of the evaluation questions will be determined during the inception phase by the evaluation team in agreement with the evaluation reference group after discussions with key stakeholders and the initial document review. Annex 2 includes a matrix referencing sections 3 (objective) and (evaluation criteria and questions) of the concept note brings together the function, dimension, main questions and sub-questions and criteria.

7) Evaluation management and governance

The evaluation will be commissioned and managed jointly by the WHO Evaluation Office together with 3 to 4 representatives of the independent Evaluation Offices of other agencies and a "focal point" of the remaining agencies which are signatories of the SDG3 GAP, which will form a Management Group.

The WHO evaluation manager will serve as the lead/coordinating manager for the Evaluation Management Group. This Group will select the evaluation team, facilitate the access by the evaluation team to information sources during the inception and data collection phases, manage the process, review, and approves the inception report and the draft reports, manage the validation and stakeholder engagement process, and take the measures to ensure the use of evaluation by different intended user groups. It will ensure the overall quality assurance of the evaluation in adherence with United Nations Evaluation Group (UNEG) norms and standards, including maximum independent and impartiality of the evaluation. It will provide the necessary support to the evaluation team during the evaluation exercise (finalization of methodology, facilitation of the evaluation process, identification of relevant documentation and data).

To ensure the independence and credibility of the evaluation, this evaluation will be conducted by an external independent evaluation team. The evaluation team will have appropriate knowledge of the subject of the evaluation and skills mix, as well as relevant experience in performing similar joint evaluations either specifically on SDGs or based on partnerships between multilateral agencies.

An Evaluation Reference Group (ERG) will be established to ensure the evaluation's relevance, accuracy and utility through consultation and validation process. It will ensure that the exercise reflects the perspectives of relevant stakeholders, benefits from the highest level of technical knowledge from subject matter experts on SDG3 and evaluation, and from the engagement, support, and ownership of key stakeholders throughout the process.

The Reference Group will not be responsible for managing the exercise or for making decisions. The Reference Group is an advisory body. The exercise will be managed by the WHO Evaluation Office. The Evaluation Management Group will coordinate the work and inputs of the Reference Group and make all final decisions.

Activities

The Reference Group members will:

1. Provide comments on the draft terms of reference
2. Participate in the key meetings (remotely or in-person) with the evaluation team.
3. Assist in identifying internal and external stakeholders to be consulted during the evaluation process.
4. Facilitate the communication and coordination between their respective section/division/areas of influence and the evaluation team, including gathering inputs from them to the deliverables submitted to them, facilitating links with others undertaking similar work or engaging in strategic thinking on how to improve collaboration to help accelerate SDG3 progress, and assisting the evaluation team in accessing relevant literature and documentation.
5. Peer review all key deliverables (including the inception report, draft country case studies, draft synthesis report and final reports) and provide advice and comments. For country case studies signatory agencies should check the practicability and the acceptability of recommendations.
6. Advise on and support the implementation of the communication and dissemination plan, including by suggesting/supporting relevant dissemination events. Contribute to dissemination of the findings of the evaluation. Play a key role in learning and knowledge sharing from the evaluation results.
7. Advise on the management response to the evaluation, when appropriate.

A consultative group with Member States and Executive Boards should also be established.

Members of this group will receive executive brief and ensure findings are used for policy improvement and accountability

8) Evaluation phases, time frame and deliverables

The evaluation is expected to have three defined phases with specific deliverables attached to each phase which the independent evaluation team contracted is expected to complete:

Phase1. Inception report, to clarify objectives and ensure good mutual understanding of the evaluation and its objectives, and adaptation of evaluation questions if needed. To finalize the inception report, a validation and consultative process is expected before the end of phase 1 involving country offices and the HQ offices as well as the reference group.

Phase 2. Data collection and Analysis, includes two clear separate stages: (a) the in-depth desk review including program countries monitoring reports, to include country level information, and key informant interviews, online surveys, and SDG3 GAP draft country case study reports for primary data collection; and (b) data analysis and triangulation of data to arrive at findings and conclusions. Validation of initial findings will be done through an in-country workshop that will take place with key stakeholders to ensure recommendations are viable, aligned with any developments, and forward looking.

Phase 3. Report drafting and dissemination, will include an initial draft to be shared with the Evaluation Reference Group for comments, and a final report which will incorporate comments to the draft report as well as discussion from the workshop. A comment matrix will ensure that all comments are addressed, although they will not necessarily be incorporated into the final document to guarantee independence of the evaluation team.

The evaluation results will be shared with the primary and secondary users through the final evaluation report. Additionally, workshops with key partners will be held in each country at the end of the missions. During this virtual workshop, the evaluation team will present the key evaluation findings and results and discuss the operationalization of the recommendations towards ensuring that the findings are shared and understood. The results may also be shared with other organizations. Additionally, as an accountability exercise, it would be good for country offices to share the findings of the report with national partners. A documented presentation prepared by the evaluation team may be used for this purpose.

A tentative time frame for the evaluation and expected deliverables is provided below (tentative schedule based on the duration and delivery dates). The evaluation must be completed within 52 working weeks over a 15-month period. This might be subject to change.

Key milestones and **deliverables**	**Date**
TOR finalized	25 July 2023
Selection and contracting of evaluation team	15 August 2023
Kick off meeting	4 September, 2023
Draft inception report (IR)	30 September 2023
Presentation of IR to EMG/ERG/Member State's missions	16 October 2023
Final IR	30 October 2024
Data collection	Nov 2023-February 2024
Data Processing, Analysis, and Validation	Dec 2023-March 2024
Draft synthesis report	April 2024
Quality assurance	2-4 weeks in total
Presentation of key findings and recommendations to EMG/ERG/Member State's missions in Geneva	June 2024
Presentation of Final Evaluation Results and Recommendations on the margins of the HLPF (HLPF will be in July). September might see Summit for the Future	September 2024
Final report	28 October 2024
Dissemination	Nov-Dec 2024

9) Report structure

Inception Report Proposed Structure (maximum 15 000 words excluding annexes):

I. Presentation of the Context and Object of Evaluation

II. Purpose, Objectives and Scope of the Evaluation

III. Reconstruction of the Theory of Change (see annex 1)

IV. Evaluation Framework (evaluation criteria and questions), with an evaluation matrix (disaggregating each evaluation criterion, with evaluation questions, indicators, information

sources and methods of gathering information); it is recommended to share the example in Annex 1 as an annex to all the ToR

V. A complete Methodology section, including:

an explanation and rationale of the methodological design; sample and list of people to interview and sites to visit; data collection tools (questionnaire, interview guidelines, etc.); limitations and mitigation measures; ethical considerations; data analysis (how the data will be analyzed, what technique will be used, software, etc.); dissemination of the evaluation.

VI. A Work Plan and description of the role and responsibilities of each team member

VII. Deliverables and Quality Assurance

Final Evaluation Report Proposed Structure (maximum 20 000 words excluding annexes):

I. Executive Summary (max. 5 pages)

II. Background and Context and object of the evaluation

III. Purpose, objectives and scope of the Evaluation

IV. Evaluation criteria and questions

V. Detailed Methodological Framework

VI. Limitations of the Evaluation

VII. Ethical considerations

VIII. Findings: analysis of data according to the evaluation questions and evaluation criteria

IX. Conclusions: should be firmly based on evidence and analysis, be relevant and realistic, with priorities for action made clear.

X. Suggestions for improving the M&E framework

XI. Recommendations: action-oriented recommendations for preparing the management response.

XII. Lessons learned

XIII. Annexes, including terms of reference, evaluation tools, records of data collection (TOR, Theory of Change, Evaluation Matrix, Data collection tools used including key informant interviews, online surveys, SDG3 GAP case studies for each country, list of interviews conducted, list of documents consulted, and other relevant documents).

Two hard copies and the electronic version of the final evaluation report must be delivered in English. This final evaluation report must be of high quality and subject to clearance from WHO and the reference group.

Therefore, the evaluation inception and final reports must be compliant with UNEG Norms and Standards.

All deliverables must be in professional level standard English. The must be language-edited/proofread by a native speaker.

10) Profile of the evaluation team

Qualifications/Experience

For this evaluation WHO and its partners will contract an institution (consulting firm, research institute or a vendor with similar capacities), which will offer a core team of qualified evaluation professionals. Based on their understanding of the task, the team may choose to enlist additional expertise as they see fit, including subcontracting with national evaluation partners for field-based activities; however, in the interest of time it is envisioned that the team will include one team leader and 2 or 3 team members to allow for field missions, if possible, to take place in parallel. The Evaluation team should be composed of a gender-balanced team of researchers and technical experts with strong expertise in qualitative methods of data collection, comprising the following qualifications:

Team leader profile

The team leader should have proven experience in past evaluations. References are required. He/she will be responsible for managing and leading the evaluation team, undertaking the data collection and analysis, as well as report drafting, presentation to stakeholders and dissemination.:

Required skills for Team Lead:

- Post-graduate University degree in Evaluation, Social sciences or another relevant field
- Proven experience minimum ten years in conducting evaluations and research;
- Excellent and proven knowledge of evaluation designs and approaches on joint initiatives in development and humanitarian settings
- Proven experience leading a multi-country evaluation team
- Experience facilitating and collecting information, preferably with children and youth
- Knowledge of the equity and gender approaches and their application;
- Fluency in English and French (oral and written) required
- Good ability to write reports clearly and concisely.
- Excellent interpersonal skills with ability to work in a multi-cultural environment

Desirable:

- Previous experience with multi-country evaluations and SDGs evaluations within the UN system and multilateral system is an asset
- Previous experience working with the UN and/or SDG3 GAP signatory agencies programmes is an asset
- Previous common experience between proposed team members is a plus

Required skills for the team:

- All team members should have a degree in the social sciences, economics, international development or other relevant disciplines with at least a Bachelor's Degree and 5-7 years relevant experience
- The evaluation team must count with the support of at least one local evaluator for each of the countries where missions will take place.

The Team will need to include expertise in the following areas:

- Experience with SDG3 evaluations and joint evaluations
- Proven experience minimum five years in conducting evaluations and research;
- Proven experience in facilitating and collecting information with vulnerable groups
- Knowledge of human-rights and gender-based approach to development. It is expected that at least one of the team members has a strong track record of evaluating gender equality.
- Experience assessing humanitarian response
- Knowledge of Results-Based Management and mutual accountability
- Good ability to write reports clearly and concisely.
- Fluency in English and French (oral and written) required
- Strong analytical skills to compile and consolidate a variety of inputs and produce concise and easy-to-understand documents
- Good understanding of UNEG norms and standards for Evaluation and other international evaluation standards.
- Experience working in countries of interest

Desirable:

- Experience in the countries included in the evaluation
- Experience undertaking multi-country evaluations
- Familiarity with SDG 3 GAP signatory programmes and interventions is an asset
- Previous experience with multi-country evaluations and evaluations within the UN system is an asset

The technical proposal should highlight which member(s) of the Evaluation team possesses each required or desired competencies above. Sample of previous evaluations in English is required for the team lead. All team members should provide references.

The evaluation team is responsible for its own travel arrangements, own travel insurance, including medical evacuation, and for its own security arrangements. Under a corporate contract for services, the company does not fall under UN security management arrangements. All costs should be included in the financial proposal. It is recommended that a description of the role and responsibilities of each team member and an explanation of his or her competencies (i.e. matching the required skills) be provided.

11) Workplan

The final workplan will be determined in the inception phase, this provides an estimate of the envisioned workload (evaluation timeline). A workplan table should be developed by the evaluation team including the details and proposed milestones and dates to conduct the different evaluation activities and planned data collection.

12) Assessment and scoring of proposals

TECHNICAL PROPOSAL

Technical proposals will be assessed using the assessment grid maximum score of **100 points.** Technical proposals scoring less than 70 points will be considered non-responsive and will therefore be rejected.

The content of the bidders' technical proposal should include:

A. Table of contents

B. **Narrative description of the bidding institution's experience and capacity in the following areas:**

- SDG evaluations
- Multi-country evaluations, studies and research
- Evaluations done for SDG3 GAP signatories and any other major UN agency

C. **List of similar/relevant past and ongoing assignments carried out by the bidder in the past 7 years.** WHO may contact reference persons for feedback on services provided by the bidders.

D. Full reports or preferably links to full reports listed as examples of relevant past and ongoing assignments of the bidder (at least 3) on which the proposed key personnel directly and actively contributed or authored.

E. **Methodology.** It should minimize repeating what is stated in the ToR. There is no minimum length. If in doubt, ensure sufficient detail. Required content is as follows:

- Understanding of, and comments on, the context and rationale for the evaluation, and on SDG3 GAP, and the evaluation scope, criteria, and questions.
- Understanding of, comments on, and in-depth analysis of the aspects of complexity, potential challenges, risks and ethical issues related to this evaluation exercise.
- Proposed evaluation design and methodology, with a sufficient level of detail on each phase and activity of the evaluation process, including on data to be collected to answer the detailed evaluation questions, envisaged data collection and analysis methods, the proposed sampling methodology and criteria to select the areas to be visited or remotely consulted, as well as the duration of the country visits and the number of evaluation team members participating. Attention should be paid to the issue of stakeholder participation; mix of qualitative and quantitative data and methods; data accuracy and triangulation.
- Comments and additional details details/suggestions on deliverables and management arrangements described in the ToR, if any
- Internal management and quality assurance procedures
- The presence of any local researchers or other not formally full-time members of the bidding institution should be indicated, with a description of how they will be engaged, trained, supported and supervised.

F. Workplan, which will include, as a minimum requirement, the following:

- Detailed workplan based on that proposed in the ToR, with comments and proposed adjustments, if any. It must be consistent with the general workplan and the financial proposal.

G. Evaluation team:

- Summary presentation of proposed experts
- Description of support staff, if any (number and profile of research and administrative assistants
- Level of effort of proposed experts by activity. It must be consistent with the financial proposal.
- CV of each expert proposed to carry out the evaluation.

The technical proposal will be assessed with the following criteria:

Maximum Points	Description
15	Company reliability and relevant experience (years of experience undertaking this type of assignment; thematic and geographically relevant previous experience.) If available hyperlinks and references should be provided. The organization profile and capacity (aptitude, availability, previous experience (2-3 samples of work in last 3 years), references, multi-country presence or proposed partnership, administrative and logistic support) will be reviewed.
40	Proposed methodology, evaluation framework, work plan and limitations (with alternatives) for meeting the deliverables in the ToR. Key consideration will be given to the comprehensiveness, clarity, relevance, logic, rigor, realism, practicality, creativity and level of effort.
45	Team profile and capacity (experience, qualifications, references, mix and complementarity of expertise, availability, time allocation) Key consideration will be given to the team leader and team members' experience: relevance in terms of geographic and thematic experience and experience in conducting evaluations in conducting evaluations in humanitarian settings and of multi-sector programs for children. CVs should include links to relevant evaluations as well as references (3) for each team member and if available for the company.

FINANCIAL PROPOSAL

The total amount of points allocated for the financial component is **100 points.** The proposal should include a detailed budget:

- Consultant fees and number of days per team member
- Travel costs (as per UN guidelines) with explanation of budget assumptions with regard to planning, team composition, field work, etc.

- Any other expenses (including insurance, etc.)

For the final selection, the maximum number of points will be allotted to the lowest price proposal that is opened and compared among those invited firms/institutions which obtain the threshold points in the evaluation of the technical component. All other financial proposals will receive points in inverse proportion to the lowest price; e.g.:

Score for financial proposal X = (Max. score for financial proposal (100 Points) * Price of lowest priced proposal) / Price of proposal X

Total obtainable technical (70% of score) and financial score (30%) : 100

The Bidder(s) achieving the highest combined technical and financial score will (subject to any negotiations and the various other rights of WHO) be awarded the contract(s).

The Financial Proposal must be organized in such a manner that it reflects the inputs shown in the technical proposal and distinguishes between professional costs and estimated reimbursable costs against approved expenses. Well defined and itemized details for all estimated costs that the bidders consider to be reimbursable should be provided.

Travel, if applicable

- Please note that travel to specific countries will be decided based on need and mutual agreements with the relevant WHO country offices.
- The selected bidder will be responsible for all travel costs – flights, daily subsistence allowance, etc. Any travel involved should be budgeted according to UN Travel Standards as a ceiling[15] and UN daily subsistence allowances.[16]

The Financial Proposal shall include a cost breakdown for the work phases as per the ToR, detailing the types of roles proposed and person days required, and related expenses and any other cost elements deemed relevant.

The proposal shall include a payment schedule linked to clearly defined milestones.

All prices/rates quoted must be exclusive of all taxes as WHO is a tax-exempt Organization.

The format shown below is suggested for use as a guide in preparing the Financial Proposal. The format includes specific expenditures, which may or may not be required or applicable but are indicated to serve as examples.

[15] See https://hr.un.org/sites/hr.un.org/files/handbook/AI%202013%20-%20%203%20%20%5BOfficial%20Travel%5D_1.doc.
[16] http://icsc.un.org/ (all countries and destinations can be found by navigating on the map).

Name[17]	Team leader (insert name)	Team member (insert name/function)	Team member (insert name/function)	Team member (insert name/function)		
Daily rate (US$)						
Phase	***N° of days***	***N° of days***	***N° of days***	***N° of days***	***Total N° of days***	***Total cost (US$)***
Inception phase						
Data collection phase						
Reporting phase						
Dissemination						
Total N° of days						
Total professional costs						
Total travel costs						
Total other costs (please explain)						
Total evaluation cost						

13) Budget

The total estimated budget for this evaluation is US$ 300 000. In principle, the evaluation should be co-financed by WHO and some of the 13 signatory agencies' evaluation offices including WHO.

[17] Extra columns can be added according to number of team members.

Annex 1: Theory of Change

GOAL	**Accelerate progress towards the health-related SDGs, leaving no one behind, including in the context of countries' efforts to recover and rebuild from COVID-19**										
OUTCOMES	**Countries receive better coordinated and more effective support, better aligned with their priorities, from GAP agencies**				**Improved access to more equitable quality PHC and sustainably financed national health plans and priorities,**			**More equitable and inclusive progress towards health-related SDGs**			**Improved PHC through enhanced uptake of innovations and availability and use of timely and reliable health data for decision making**	
OUTPUTS	1a. Country perspectives provided on the collective performance of GAP signatory agencies	1b. Collaboration among country- facing teams across GAP agencies incentivized and institutionalized	1c. Collaborative fora, including Principals group, Sherpa group and accelerator working groups established and functional	1d. Joint progress report on how implementation of the GAP help countries to accelerate progress towards SDGs in COVID-19 era and other joint communications	2a. Essential primary care improved and more equitable and public health functions strengthened through joint support of countries by GAP agencies	2b. Key health financing functions strengthened through joint support of countries by GAP agencies	2c. Essential primary care and public health functions strengthened and more equitable in fragile settings and during outbreaks through joint support of countries by GAP agencies	3a. Engagement of communities and civil society in health strengthened through joint support by GAP agencies	3b. Multisectoral action on determinants of health, strengthened through joint support of countries by GAP agencies	3c. Equity, Gender equality and responsiveness and human rights-based approach strengthened across all outcomes through joint support of countries by GAP agencies	4a. Health innovations scaled through joint support of countries by GAP agencies	4b. Health data systems improved through joint support of countries by GAP agencies
	Gender equality and responsiveness strengthened across all outcomes through joint support of countries by GAP agencies											
INPUTS	**Stronger organizational norms and culture of collaboration in support of countries among GAP agencies.**				**Stronger collaboration among GAP agencies in providing technical and financial support for countries' in health financing and prioritizing PHC, including in fragile settings.**			**Stronger collaboration among GAP agencies in supporting countries on determinants of health, community and civil society engagement, equity and gender related-barriers and responsiveness.**			**Stronger collaboration among GAP agencies in supporting countries on health data and scaling of innovation.**	
RISKS & BARRIERS	Overarching risks include a lack of incentives for closer collaboration, a lack of institutionalization of the GAP collaboration within agencies and a lack of country engagement and ownership and leadership											
	• Lack of leadership and support by Principals • Lack of agencies' willingness to change organizational norms • Competing demands by financiers/donors which complicate moving towards a common approach • Lack of incentives for staff for a more collaborative way of working • Lack of external support for closer collaboration among agencies • Attention focused on COVID-19-related mechanisms • Poor implementation, monitoring and evaluation • Lack of engagement of key stakeholder				• Countries do not see the added value of GAP • Countries operating in emergency mode due to COVID-19 • Economic impact of COVID-19 imposes fiscal constraints on financing essential health services and preparedness • Countries do not prioritize the most cost-effective public health interventions in PHC approaches for achieving health-related SDGs			• Different core mandates, governance and funding cycles limits opportunities to align funding around national plans • Conflict/Political instability • Lack of political will and institutional structures (countries do not prioritize gender equality, shrinking civic space, lack appetite to address commercial determinants, ensure human rights, including right to health, and facilitate accountability) and lack of understanding of those gender and socio-economic barriers towards reaching missed communities			• Lack of inclusion of communities and civil society in governance bodies of GAP agencies limits credibility • Lack of agreement how to best engage communities and civil society from decision-making to service delivery and monitoring • Lack of disaggregated data and subnational data, and lack of support to strengthen data systems in countries • Lack of agreement on how best to scale innovation for impact	
ASSUMPTIONS	By leveraging the complementary strengths and resources of the 12 multilateral GAP agencies and strengthening their collaboration the GAP agencies better support countries and help to accelerate progress on the health-related SDGs. They do so by: • engaging with countries to identify priorities and plan and implement together; • accelerating joint action under the seven accelerator themes and gender equality; • aligning operational and financial strategies, policies and approaches where this is possible and makes sense; and • accounting for progress, learning together and enhancing shared accountability.											

Annex 2: Evaluation matrix linking the function, dimension, main questions, sub-questions and evaluation criteria

Function	Dimension	Main questions	Sub questions	Criteria
Strengthened coordination	A collaborative approach among multilateral agencies.	Where is it coherently, effectively, and sustainably accelerating progress and supporting countries towards achieving the health-related SDG targets leaving no one behind?	Where has SDG3 GAP provided a solid foundation for stronger coherence in terms of better alignment and coordination across all development partners in health? How does it complement international partnerships such as IHP+/UHC 2030? How much are SDG3 GAP signatory agencies fostering joint approaches at the country level? When have they improved the coherence of their interventions at the country level? When haven't they done so? When do countries receive better coordinated, more effective support, that is better aligned with their priorities, from SDG3 GAP signatory agencies	Coherence

			both at the national and subnational level?	
Reduced burden on countries	In-country health plans and priorities providing an operating model in support of country-level collaboration work.	To what extent are signatory agencies' operational and financial strategies, policies and approaches aligned, effectively avoiding duplications and driving efficiencies to strengthen country health systems?	When has/is SDG3 GAP achieved/ expected to achieve its objectives, and its results, including any differential results across countries? Which outcomes are better/less achieved? Why? Where are SDG3 GAP signatory agencies contributing to deliver, or likely to deliver, results in an economic and timely way? • To what extent do SDG3 GAP signatory agencies collectively enable the better use of existing resources, including local coordination mechanisms? Where and when have SDG3 GAP signatory agencies effectively improved PHC,	Effectiveness

			sustainable financing, equity, strengthened national data systems and enhanced the uptake of innovations? When have they not done so? • Where has access to more equitable quality PHC and sustainably financed national health plans and priorities improved with SDG3 GAP support? When have SDG3 GAP signatory agencies jointly used local coordination mechanisms and helped increase domestic funding for health in MICS?	
Promoted a change in organizational culture.	Countries' (including fragile settings) PHC plans through technical and financial support,	Same as the first main question.	How much have the SDG3 GAP signatory agencies strengthened their collaboration in providing joint technical and financial support for	Effectiveness

	Multisectoral action on determinants of health, community and civil society engagement and gender responsiveness through country support Gender equality and responsiveness		countries' PHC-oriented health system strengthening plans? Which collaboration mechanisms are more effectively accelerating progress at the country level? Which are less effective? To what extent is gender equality and responsiveness effectively strengthened through joint support by the 13 SDG3 GAP signatory agencies?	
Contributed to better health for people.	Health data and scaling of innovation, contributing to better health for people	**To what extent is SDG 3 GAP contributing to better health for people?** To what extent has SDG3 GAP helped health systems and countries to recover from the negative impacts of the COVID-19 pandemic? **What sustained and transformative action is needed to deliver on SDG 3?**	When have SDG3 GAP signatory agencies helped countries overcome the absence/uncertainty of national and subnational data to reach those further left behind? To what extent have they jointly strengthened national and subnational monitoring and evaluation systems? To what extent is the SDG3 GAP sustainable and helping countries recover from the	Sustainability

			negative impacts of the COVID-19 pandemic? To what extent have signatory agencies managed to promote integrated investments in global health security and universal health coverage? When and where has SDG3 GAP support helped countries achieve equitable and inclusive progress towards health-related SDGs? Which SDG3 GAP tools and approaches need to be scaled up to achieve the SDG health-related targets?	

Annex 3: Towards SDG3 GAP 2.0: Six recommendations (from the 2023 SDG3 GAP progress report)

Based on the lessons learned from SDG3 GAP to date, the SDG3 GAP agencies recommend the following:

Sustaining and bringing to scale the elements of SDG3 GAP that are working

1. **To further strengthen the SDG3 GAP improvement cycle for health in the multilateral system so** that it amplifies country voices and helps to shift power dynamics in favour of countries, the SDG3 GAP Secretariat and signatory agencies should continue to support the cycle's three key elements:

    a. The SDG3 GAP Secretariat should roll out the second round of country questionnaires by the end of 2023 and repeat the process at least biennially, making efforts to strengthen the representativeness of country responses and support agencies in translating data (including the heat map) into action for improved collaboration at the country level.
    b. SDG3 GAP signatory agencies should make incentives and resources available to catalyse stronger collaboration in line with country-led plans, policies and financing.
    c. The SDG3 GAP Secretariat should continue to publish an annual progress report, including country case studies to document improvements and good practices in collaboration.

2. **To maintain SDG3 GAP as an effective platform for collaboration on health in the multilateral system:**

    a. The SDG3 GAP Secretariat and signatory agencies should retain the current structure of the agency focal points group and the accelerator working groups/clusters, emphasizing the centrality of primary health care, supported by sustainable financing and data, alignment with national plans and budgets, and a strong focus on equity, the determinants of health, innovation and fragile and vulnerable settings.
    b. Principals of the signatory agencies should meet annually to review and discuss the SDG3 GAP progress report.

3. **To better focus work under SDG3 GAP at the country level and foster greater cross-accelerator collaboration in countries:**

    a. The SDG3 GAP Secretariat and signatory agencies should further emphasize approaches such as joint missions, joint communications to country-facing teams from SDG3 GAP principals and agencies, and closer communication and engagement with United Nations resident/humanitarian coordinators, United Nations country teams and other health partners.
    b. The SDG3 GAP Secretariat and signatory agencies should develop concepts for, and jointly implement, coordinated action in specific thematic areas with clear and measurable targets, while continuing to enable country leadership and build local capacity, including for health partner coordination. This includes continuing to build on sustainably financed primary health care with a strong equity component and integration of disease-focused programs and may also involve supporting more narrowly focused thematic areas that address multiple vulnerabilities, such as "zero-dose" communities and building resilient

health systems in the face of the climate crisis, pandemics and other health threats. Further discussion is needed among agencies on relevant approaches and timelines in these areas, beginning at the global level.

Addressing the elements of SDG3 GAP that are not working

4. **To further enhance collaboration at the country level**, the SDG3 GAP agencies should test new approaches, such as the delivery for impact approach, with a view to supporting country-led coordination platforms and aligning with country funding cycles and priorities.

5. **To strengthen civil society and community engagement in SDG3 GAP**, the SDG3 GAP Secretariat and signatory agencies should convene consultations with civil society and communities by September 2023 to explore their interest in contributing to work under the SDG3 GAP and discuss, as appropriate, the modalities of civil society and community engagement, including the potential role of a civil society/community questionnaire under the SDG3 GAP monitoring framework.

6. **To strengthen incentives in the three key areas of political leadership, governance direction and funding for collaboration:**

    a. The SDG3 GAP Secretariat and signatory agencies should work with Member States to develop and implement an approach to strengthening ownership by and accountability to countries/Member States and support consistency across the relevant governing bodies of the signatory agencies and other global health coordination initiatives.
    b. Following publication of the annual SDG3 GAP progress report, each relevant governing body (board or its equivalent) of the SDG3 GAP agencies could, at the request of its members, review the report and country-level coordination and alignment, including considering ways to strengthen implementation of the SDG3 GAP commitments (e.g. by assessing contributions towards broader health-related SDG progress). Chairs of the agencies' relevant governing bodies may consider meeting as a group to discuss the report and issues related to mutual accountability among the agencies.
    c. Signatory agencies should follow countries' recommendations on how to strengthen alignment and collaboration and demonstrate, on an annual basis, what efforts are being mobilized to drive and deepen collaboration, including through dedicated capacity and incentives (e.g., funding, job descriptions and performance assessments), flexible resources, and the use of joint funding opportunities.

Annex 4: Political endorsements of the SDG3 GAP

- ***EU - Global Health Strategy*** (Paper released by the EU COM, November 2022): "The EU will continue to advocate for strong collaboration and setting shared goals, for example under the Global Action Plan for Healthy Lives and Well-being for All" (under principle 18: Strengthen engagement with key global health stakeholders, page 25).

- ***WHO EB Decision 152/5*** adopted by the 76th WHA n preparation of the UHC HLM in Jan/Feb 2023: "REQUESTS the Director-General to: [...] to support the implementation of the Global Action Plan for Healthy Lives and Well-being for All in order to accelerate progress towards health-related Sustainable Development Goal targets, through collaboration across the relevant United Nations and non-United Nations health-related agencies, with coordinated approaches and aligned support for Member State-led national plans and strategies;" (OP 2.7, Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage (who.int))

- **German Parliament:** Motion of the German Parliament on the occasion of the 75th Anniversary of WHO (12 May 2023):

"In a complex geopolitical environment, a stronger, more effective, accountable, independent and sustainably funded WHO at the core of the multilateral system is more necessary than ever. (European Global Health Strategy, 2022). Particularly in view of the fragmentation of the global health architecture with numerous global health actors, the WHO must be able to play a leading and coordinating role as envisaged in The Global Action Plan for Healthy Lives and Well-being for All (SDG 3 GAP). However, this requires the willingness of global health actors to recognise the clear leadership role of the Organisation and of Member States to prioritise a multilateral approach to global and regional health issues. This is the only way to jointly address current and future international health challenges."[...] "Requests the Government to" [...] "Continue to advance the implementation of the SDG3 GAP to improve collaboration among participating organisations, ensure complementarity and the best possible interaction of their contributions, and strengthen WHO's capacity to act, lead and coordinate in the field of public health;" (Source: 2006712.pdf (bundestag.de), pages 3 and 4 – German only)

- **G7 Health Ministers communique from 14 May 2023:** "We commit to continuing our political, technical and financial support to existing initiatives such as UHC2030, and the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP)." (under para 31, "Strengthening of alignment of global health initiatives in support of country priorities public[1]private partnership for global health", page 12, https://www.mhlw.go.jp/content/10500000/001096403.pdf)

- In a **joint statement delivered at the 76th WHA**, by Belgium, Denmark, Finland, France, Germany, Ghana, Ireland, Netherlands, Norway, Portugal, Slovenia, Spain and the UK congratulated the agencies on the launch of the 2023 progress report, welcomed the self-assessment undertaken on what had worked and what had not and expressed their support for the six recommendations put forward. They furthermore expressed their readiness to work with WHO and the other agencies to implement these recommendations.

ANNEX 2: Evaluation Matrix

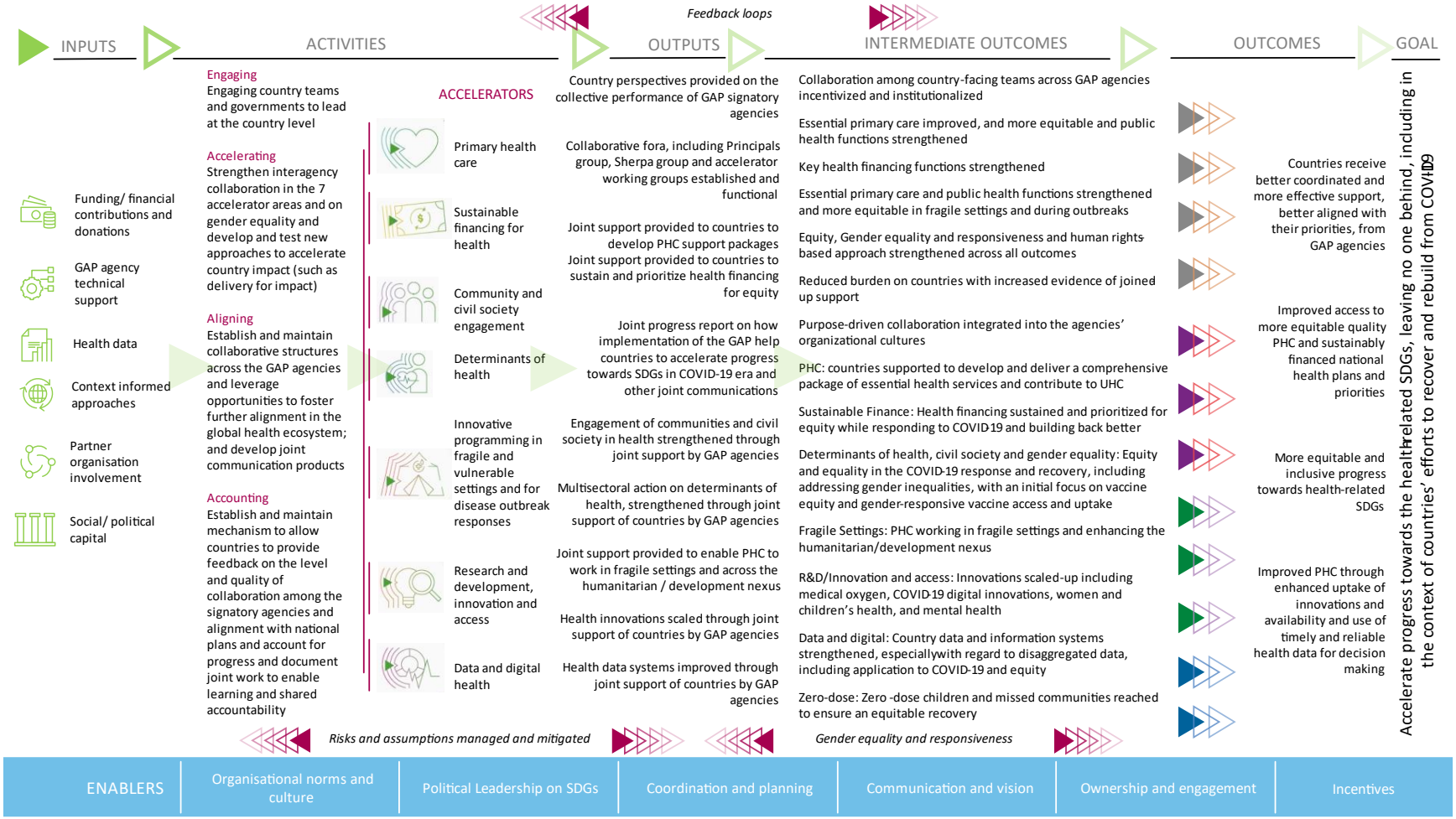
Evaluation Criteria	Key Evaluation Question	Sub-question	Data collection method	Stakeholders
Coherence	1.1 To what extent has there been a shared understanding and ownership of the SDG3 GAP and its purpose and intended results (a) by signatory agencies? (b) by countries?	1.1.1 To what extent has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans, and countries' ownership of health coordination mechanisms?	KIIs, country studies, survey, document review	GAP Secretariat, GAP Principals Group, GAP Focal Points (ex-Sherpa), other stakeholders in the GAP agencies, GAP agencies' country-facing teams, government
	1.2 To what extent have signatory agencies' operational and financial strategies, policies and approaches incentivized and enabled coherent, effective and sustainable collaboration?	1.2.1 To what extent has SDG3 GAP provided signatory agencies with a solid foundation for stronger coherence in terms of better alignment and coordination? At a global/regional/country level?	KIIs, country studies, document review	GAP Secretariat, GAP Principals Group, GAP Focal Points (ex-Sherpa), GAP Accelerator working groups, GAP agencies country facing teams, Government, CSOs, other in-country partners, private sector, donors, other external stakeholders
		1.2.2 To what extent has the SDG3 GAP complemented and added value to international partnerships such as IHP+/UHC 2030?	KIIs, country studies	GAP Secretariat, GAP Focal Points (ex-Sherpa), GAP Accelerator working groups, GAP agencies' country-facing teams, other external stakeholders
			KIIs, country studies, document review	GAP Secretariat, GAP Principals Group, GAP Focal Points (ex-Sherpa), GAP Accelerator working groups, GAP agencies' country-facing teams
	2.1 To what extent has/is SDG3 GAP achieved/expected to achieve its intended objectives and results?	2.1.1 To what extent have SDG3 GAP results differed across countries/by outcome/by accelerator/by approach?	KIIs, Country Studies,	GAP Secretariat, GAP Principals Group, GAP Focal Points (ex-Sherpa), GAP Accelerator working groups, other

Effectiveness			document review	stakeholders in the GAP agencies, GAP agencies country facing teams, government, CSOs, other in-country partners, private sector, donors, other external stakeholders
		2.1.2 What factors (positive and negative) have affected the achievement of SDG3 GAP results?	KIIs, country studies, survey, document review	GAP Secretariat, GAP Principals Group, GAP Focal Points (ex-Sherpa), GAP Accelerator working groups, other stakeholders in the GAP agencies, GAP agencies' country-facing teams, government, CSOs, other in-country partners, private sector, donors, other external stakeholders
		2.1.3 To what extent have the signatory agencies effectively utilized the SDG3 GAP to strengthen countries' national health priorities and health systems? Which collaboration mechanisms have been more effective in accelerating progress to SDG3 GAP objectives?	KIIs, country studies, document review	GAP Secretariat, GAP Accelerator working groups, other stakeholders in the GAP agencies, GAP agencies' country-facing teams, government, CSOs, other in-country partners, private sector, donors, other external stakeholders
	2.2 To what extent has SDG3 GAP accelerated progress and helped agencies support countries towards achieving the 12 SDG3 targets and 28 targets of other SDGs related to health?		KIIs, country studies, survey, document review	GAP agencies' country-facing teams, government, CSOs, other in-country partners, private sector, donors, other external stakeholders
	2.3 To what extent has gender equality and responsiveness, equity and inclusiveness been effectively strengthened through joint support by the SDG3 GAP signatory agencies?	2.3.1 To what extent has the implementation of SDG3 GAP helped countries achieve gender, equitable and inclusive progress towards health-related SDGs?	KIIs, country studies, survey, document review	GAP Secretariat, GAP Principals Group, GAP Focal Points (ex-Sherpa), GAP Accelerator working groups, other stakeholders in the GAP agencies, GAP agencies' country-facing teams, government, CSOs, other in-country partners, private sector, donors, other external stakeholders

	2.4 To what extent have the SDG3 GAP accelerators supported the achievement of intended results?	2.4.1 Has the relevance and prominence of the SDG3 GAP accelerators changed over time? Why and how?	KIIs, country studies, document review	GAP Secretariat, GAP Focal Points (ex-Sherpa), GAP Accelerator working groups, other stakeholders in the GAP agencies, GAP agencies' country facing-teams, government
		2.4.2 To what extent are accelerators 'owned' by and relevant to signatory agencies' work?	KIIs, country studies	GAP Accelerator working groups, other stakeholders in the GAP agencies
	2.5 To what extent have SDG3 GAP signatory agencies collectively enabled better use of existing resources (technical, financial and human), including local coordination mechanisms?	2.5.1 To what extent have the SDG3 GAP supporting signatory agencies collaborated to deliver, or likely to deliver, results in an economic and timely way?	KIIs, Country Studies	GAP Secretariat, GAP Principals Group, GAP Focal Points (ex-Sherpa), GAP Accelerator working groups, other stakeholders in the GAP agencies, GAP agencies' country-facing teams
		2.5.2 To what extent has the SDG3 GAP incentivized signatory agencies to work more effectively through local coordination mechanisms?	KIIs, country studies	GAP agencies country facing teams, Government, CSOs, other in-country partners, private sector, donors, other external stakeholders
		2.5.3 To what extent has increased alignment between agencies driven efficiencies to strengthen countries' national health priorities and health systems and catalyzed the use of resources?	KIIs, country studies	GAP agencies' country-facing teams, government, CSOs, other in-country partners, private sector, donors, other external stakeholders
		2.5.4 To what extent has the SDG3 GAP catalytic funding provided by WHO to some of its country offices supported the greater achievement of results?	KIIs, country studies, document review	GAP agencies' country-facing teams, government
		2.5.5 To what extent has the SDG3 GAP provided signatory agencies with incentives for increased collaboration at the country level?	KIIs, country studies, document review	GAP Secretariat, GAP Principals Group, GAP Focal Points (ex-Sherpa), GAP Accelerator working groups, GAP agencies' country-facing teams
	2.6 How are SDG3 GAP results monitored and accounted for?	2.6.1 To what extent has the SDG3 GAP monitoring framework adequately captured results achieved?	KIIs, Country Studies, survey,	GAP Secretariat, GAP Principals Group, GAP Focal Points (ex-Sherpa), GAP

			document review	Accelerator working groups, GAP agencies' country-facing teams, government
		2.6.2 To what extent are results for SDG3 GAP captured and accounted for in signatory agencies' own results frameworks?	KIIs, document review	GAP Principals Group, GAP Focal Points (ex-Sherpa), GAP Accelerator working groups, other stakeholders in the GAP agencies, GAP agencies country facing teams
		2.6.3 To what extent did the recommendations put forward in the 2023 progress report enable stakeholders to better leverage collaboration to drive progress on the health-related SDG targets in countries?	KIIs, document review	GAP Secretariat, GAP Principals Group, GAP Focal Points (ex-Sherpa), GAP Accelerator working groups
		2.6.4 To what extent has there been sufficient leadership and accountability for SDG3 GAP by signatory agencies?	KIIs, country studies, document review	GAP Secretariat, GAP Principals Group, GAP Focal Points (ex-Sherpa), GAP agencies country facing teams
Sustainability	3.1 To what extent are SDG3 GAP outcomes sustainable?		KIIs, country studies	GAP Secretariat, GAP Principals Group, GAP Focal Points (ex-Sherpa), GAP Accelerator working groups, other stakeholders in the GAP agencies, GAP agencies country facing teams, Government, CSOs, Other in country partners, Private sector, Donors, Other external Stakeholders
	3.2 To what extent has the SDG3 GAP supported signatory agencies to collectively helped countries recover from the negative impacts of the COVID-19 pandemic?		KIIs, country studies, survey, document review	GAP Secretariat, GAP Principals Group, GAP Focal Points (ex-Sherpa), GAP agencies' country-facing teams, Government, CSOs, other in-country partners, private sector, donors, other external stakeholders

ANNEX 3: Theory of Change



ANNEX 4: Data collection tools

The table below offers a “menu” of questions for different stakeholders that can be tailored/prioritized to a person’s role, recognizing we will not ask all questions to all stakeholders.

4a: Remote KIIs (Global)

Key Question	Sub question	GAP Secretariat	Board	GAP Principals Group	GAP Focal Point	GAP Accelerator WGs	Other Stakeholders in GAP agencies	GAP agency regional/country facing teams	Member states and donors	Other external stakeholders

1.1To what extent has there been <u>shared understanding and ownership</u> of the SDG3 GAP and its purpose and intended results (a) by signatory agencies? (b) by countries?	<u>1.1.1 To what extent has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans and countries' ownership of health coordination mechanisms?</u>	What were the key motivations for you of the SDG3 GAP? Could you describe what the SDG3 GAP purpose and intended results are? How has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans?	What were the key motivations for you of the SDG3 GAP? How has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans?	What were the key motivations for you of the SDG3 GAP? Could you describe what the purpose and intended results are of the SDG3 GAP? How has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans? How has it supported countries' ownership of health coordination mechanisms?	Could you describe what the purpose and intended results are of the SDG3 GAP? How has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans? How has it supported countries' ownership of health coordination mechanisms?	Could you describe what the purpose and intended results are of the SDG3 GAP? How has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans? How has it supported countries' ownership of health coordination mechanisms?	Have you heard about the SDG3 GAP? If so, what do you think the purpose and intended results are? How has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans? How has it supported countries' ownership of health coordination mechanisms?	Could you describe what the purpose and intended results are of the SDG3 GAP? How has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans? How has it supported countries' ownership of health coordination mechanisms?	Have you heard about the SDG3 GAP? If so, what do you think are its purpose and intended results? To what extent has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans and countries' ownership of health coordination mechanisms?	Have you heard about the SDG3 GAP? If so, what do you think its purpose and intended results are?

1.2 To what extent have signatory agencies' operational, and financial strategies, policies and approaches incentivized and enabled coherent, effective and sustainable collaboration?	1.2.1 To what extent has SDG 3 GAP provided signatory agencies with a solid foundation for stronger coherence in terms of better alignment and coordination? At a global/regional/country level?	What contribution has the SDG3 GAP made, if any, to better alignment, coordination and mutual accountability among agencies at the global regional and country levels?	What contribution has the SDG3 GAP made, if any, to better alignment, coordination and mutual accountability among agencies at global regional and country levels?	What contribution has the SDG3 GAP made, if any, to better alignment, coordination and mutual accountability among agencies at country/regional levels?	What contribution has the SDG3 GAP made, if any, to better alignment, coordination and mutual accountability among agencies in the country?	What contribution has the SDG3 GAP made, if any, to better alignment, coordination and mutual accountability among agencies at the global level? At the country level?	What contribution has the SDG3 GAP made, if any, to better alignment, coordination and mutual accountability among agencies at the global level? At the country level?	What has been the contribution of the SDG3 GAP, if any, to better alignment, coordination and mutual accountability among agencies at global level? At country level?		
	1.2.2 To what extent has the SDG3 GAP complemented and added value to international partnerships such as IHP+/UHC 2030?	What was done to ensure complementarity of SDG3 GAP with other international partnerships such as IHP+/UHC 2030 at the global level?	What was done to ensure complementarity of SDG3 GAP with other international partnerships such as IHP+/UHC 2030 at global level?	What was done to ensure complementarity of SDG3 GAP with other international partnerships such as IHP+/UHC 2030 at the country, regional level?	What was done to ensure complementarity of SDG3 GAP with other international partnerships such as IHP+/UHC 2030 at country/regional level?	To what extent has SDG3 GAP complemented other international partnerships such as IHP+/UHC 2030?			To what extent has the SDG3 GAP complemented international partnerships such as IHP+/UHC 2030?	

	1.2.3 To what extent has the SDG3 GAP provided signatory agencies with incentives for increased collaboration at a global/regional/country level?	Has the SDG3 GAP provided signatory agencies with any incentives for increased collaboration at a global/regional/country level? What and how?	Has the SDG3 GAP provided signatory agencies with any incentives for increased collaboration at a global/regional/country level? What and how?	Has the SDG3 GAP provided signatory agencies with any incentives for increased collaboration at a global/regional/country level? What and how?	Has the SDG3 GAP provided signatory agencies with any incentives for increased collaboration at a global/regional/country level? What and how?	Has the SDG3 GAP provided signatory agencies with any incentives for increased collaboration at a global/regional/country level? What and how?	Has the SDG3 GAP provided signatory agencies with any incentives for increased collaboration at a global/regional/country level? What and how?	Has the SDG3 GAP provided signatory agencies with any incentives for increased collaboration at a global/regional/country level? What and how?		
2.1 To what extent has SDG3 GAP achieved/is expected to achieve its intended objectives and results?	2.1.1 To what extent have SDG3 GAP results differed across countries/by outcome/by accelerator/by approach?	What have the key achievements been in terms of: *(as relevant)* *1. Countries receiving better coordinated support from SDG3 GAP partners* *2. Improved access to PHC and sustainable financing for health* *3. More equitable and inclusive*		What have the key achievements been in terms of: *(as relevant)* *1. Countries receiving better coordinated support from SDG3 GAP partners* *2. Improved access to PHC and sustainable financing for health* *3. More equitable and inclusive health outcomes* *4. Enhanced uptake of*	What have the key achievements been in terms of: (*as relevant)* *1. Countries receiving better coordinated support from SDG3 GAP partners* *2. Improved access to PHC and sustainable financing for health* *3. More equitable and inclusive health outcomes* *4. Enhanced*	What have the key achievements been in terms of: (*as relevant)* *1. Countries receiving better coordinated support from SDG3 GAP partners* *2. Improved access to PHC and sustainable financing for health* *3. More equitable and inclusive health outcomes* *4. Enhanced*	What contributions have SDG3 GAP signatory agencies made to *(as relevant)* *1. Countries receiving better coordinated support from SDG3 GAP partners* *2. Improved access to PHC and sustainable financing for health* *3. More equitable and*	What have the key achievements been in terms of: (as relevant) *1. Countries receiving better coordinated support from SDG3 GAP partners* *2. Improved access to PHC and sustainable financing for health* *3. More equitable and inclusive health outcomes* *4. Enhanced uptake of innovations (e.g., health systems innovations, new products, new ways of delivering products, streamlining health care to provide for an end-to-end package of care)* *5. Reliable health data*		

		health outcomes *4. Enhanced uptake of innovations (e.g., health systems innovations, new products, new ways of delivering products, streamlining health care to provide an end-to-end package of care)* *5. Reliable health data*		*innovations (e.g., health systems innovations, new products, new ways of delivering products, streamlining health care to provide an end-to-end package of care)* *5. Reliable health data*	*uptake of innovations (e.g., health systems innovations, new products, new ways of delivering products, streamlining health care to provide an end-to-end package of care)* *5. Reliable health data*	*uptake of innovations (e.g., health systems innovations, new products, new ways of delivering products, streamlining health care to provide an end-to-end package of care)* *5. Reliable health data*	*inclusive health outcomes* *4. Enhanced uptake of innovations (e.g., health systems innovations, new products, new ways of delivering products, streamlining health care to provide an end-to-end package of care)* *5. Reliable health data*			
	2.1.2 What factors (positive and negative) have affected achievement of SDG3 GAP's results?	What factors have been facilitating and hindering factors for the achievement of results at country/regional/national level?		What factors have been facilitating and hindering factors for the achievement of results?	What factors have been facilitating and hindering factors for the achievement of results?	What factors have been facilitating and hindering factors for the achievement of results?	What factors have been facilitating and hindering factors for the achievement of results?	What factors have been facilitating and hindering factors for the achievement of results?		

	2.1.3 To what extent have the signatory agencies effectively utilized the SDG3 GAP to strengthen countries' national health priorities and health systems? Which collaboration mechanisms have been more effective in accelerating progress to SDG3 GAP objectives?	Which collaboration mechanisms are more effectively accelerating progress on SDG3 GAP objectives at the country level? To what extent have SDG3 GAP signatory agencies provided joint technical and financial support for PHC? To what extent have they collaborated on health financing reforms?		What are collaboration mechanisms currently in place in country x? Which of those is more effective in accelerating progress on SDG3 GAP objectives at the country level? To what extent have SDG3 GAP signatory agencies provided joint technical and financial support for PHC? To what extent have they collaborated on health financing reforms?	What are collaboration mechanisms currently in place in country x? Which of those is more effective in accelerating progress on SDG3 GAP objectives at the country level? To what extent have SDG3 GAP signatory agencies provided joint technical and financial support for PHC? To what extent have they collaborated on health financing reforms?	To what extent have the SDG3 GAP signatory agencies strengthened their collaboration in providing joint technical and financial support for countries' PHC-oriented health system strengthening plans and health financing?		Which collaboration mechanisms are more effectively accelerating progress on SDG3 GAP objectives at the country level? To what extent have SDG3 GAP signatory agencies provided joint technical and financial support for PHC? To what extent have they collaborated on health financing reforms?		
2.2 To what extent has SDG3 GAP accelerated progress and helped agencies support countries towards achieving the 12		To what extent has SDG3 GAP accelerated progress and helped agencies support countries towards achieving the 12 SDG3	To what extent has SDG3 GAP accelerated progress and helped agencies support countries towards achieving the 12 SDG3	To what extent has SDG3 GAP accelerated progress and helped agencies support countries towards achieving the 12 SDG3 targets and 28 targets of other SDGs related to health?	To what extent has SDG3 GAP accelerated progress and helped agencies support countries towards achieving the 12 SDG3 targets and 28 targets of other SDGs	To what extent has SDG3 GAP accelerated progress and helped agencies support countries towards achieving the 12 SDG3 targets and 28 targets of other SDGs	To what extent has SDG3 GAP accelerated progress and helped agencies support countries towards achieving the 12 SDG3	To what extent has SDG3 GAP accelerated progress and helped agencies support countries towards achieving the 12 SDG3 targets and 28 targets of other SDGs related to health?	To what extent has SDG3 GAP accelerated progress and helped agencies support countries towards achieving the 12 SDG3	To what extent has SDG3 GAP accelerated progress and helped agencies support countries towards achieving the 12 SDG3

SDG3 targets and 28 targets of other SDGs related to health?		targets and 28 targets of other SDGs related to health?	targets and 28 targets of other SDGs related to health?		related to health?	related to health?	targets and 28 targets of other SDGs related to health?		targets and 28 targets of other SDGs related to health?	targets and 28 targets of other SDGs related to health?
2.3 To what extent has gender equality and responsiveness, equity and inclusiveness been effectively strengthened through joint support by the SDG3 GAP signatory agencies?	2.3.1 To what extent has the implementation of SDG3 GAP helped countries achieve gender, equitable and inclusive progress towards health-related SDGs?	What have been key actions and achievements from SDG3 GAP signatory agencies on addressing gender inequities in health? And in addressing health equity and health financing issues?		What are gender inequities issues in relation to health in the country/region? What have SDG3 GAP signatory agencies done to address them? What results were achieved? And health equity and health financing issues?	What are gender inequities issues in relation to health in a country? What have SDG3 GAP signatory agencies done to address them? What results were achieved? And health equity and health financing issues?	What have been key actions and achievements from SDG3 GAP signatory agencies on addressing gender inequities in health? And health equity and health financing issues?	What have been key actions and achievements from SDG3 GAP signatory agencies on addressing gender inequities in health? And health equity and health financing issues?	What have been key actions and achievements from SDG3 GAP signatory agencies on addressing gender inequities in health? And health equity and health financing issues?	What have been key actions and achievements from SDG3 GAP signatory agencies on addressing gender inequities in health? And health equity and health financing issues?	What have been key actions and achievements from SDG3 GAP signatory agencies on addressing gender inequities in health? And health equity and health financing issues?
2.4 To what extent have the SDG3 GAP accelerators supported the achievement of intended results?	2.4.1 Has the relevance and prominence of the SDG3 GAP accelerators changed over time? Why and how?	How useful have accelerators been? How has this evolved over time? Have some accelerators been more effective in supporting the achievement		How useful have accelerators been? How has this evolved over time? Have some accelerators been more effective in supporting the achievement of results than others? Why?	Are you aware of the accelerator's mechanism? If so, how useful has it been to achieve progress on health outcomes? Have some accelerators been more effective in	How useful have accelerators been? How has this evolved over time?			Are you aware of the accelerator's mechanism? If so, how useful has it been to achieve progress on health outcomes? Have some accelerators	

		of results than others? Why?			supporting the achievement of results than others? Why?				been more effective in supporting the achievement of results than others? Why?	
	2.4.2 To what extent are accelerators 'owned' by and relevant to signatory agencies' work?			How widely is the accelerator known and supported in your organization?	How widely are the accelerator known and supported in your organization	How widely are the accelerator known and supported in your organization?				

2.5 To what extent have SDG3 GAP signatory agencies collectively enabled the better use of existing resources (technical, financial and human), including local coordination mechanisms?	2.5.1 To what extent have the SDG3 GAP supporting signatory agencies collaborated to deliver, or likely to deliver, results in an economic and timely way?	What resources have been dedicated to SDG3 GAP activities? Did those resources deliver expected results in a timely manner? To what extent has GAP enabled your organization to collaborate with others to deliver results in an economic and timely way?		What resources have been dedicated to SDG3 GAP activities? Did those resources deliver expected results in a timely manner? To what extent has the GAP enabled your organization to collaborate with others to deliver results in an economic and timely way?	What resources have been dedicated to SDG3 GAP activities? Did those resources deliver expected results in a timely manner?	What resources have been dedicated to SDG3 GAP activities? Did those resources deliver expected results in a timely manner?	What resources have been dedicated to SDG3 GAP activities? Did those resources deliver expected results in a timely manner?	What resources have been dedicated to SDG3 GAP activities? Did those resources deliver expected results in a timely manner?	What resources have been dedicated to SDG3 GAP activities? Did those resources deliver expected results in a timely manner?	
	2.5.2 To what extent has the SDG3 GAP incentivized signatory agencies to work more effectively through local coordination mechanisms?	To what extent have SDG3 GAP partners strengthened coordination mechanisms for health?		To what extent have SDG3 GAP partners strengthened coordination mechanisms for health?			To what extent have SDG3 GAP partners strengthened coordination mechanisms for health?	To what extent have SDG3 GAP partners strengthened coordination mechanisms for health?	To what extent has the SDG3 GAP incentivized signatory agencies to work more effectively through local coordination mechanisms?	

	2.5.3 To what extent has increased alignment between agencies driven efficiencies to strengthen countries' national health priorities and health systems and catalyzed the use of resources?			Are there examples of gains in efficiency from improved collaborations between SDG3 GAP partners? Examples?				Are there examples of gains in efficiency from improved collaborations between SDG3 GAP partners? Examples?	Are there examples of gains in efficiency from improved collaborations between SDG3 GAP partners? Examples?	
	2.5.4 To what extent has the SDG3 GAP catalytic funding provided by WHO to some of its country offices supported the greater achievement of results?	To what extent has the SDG3 GAP catalytic funding provided by WHO supported the greater achievement of results?		How much catalytic funding did your agency receive? How was it used and what did it contribute to?				To what extent has the SDG3 GAP catalytic funding provided by WHO supported the greater achievement of results?	How much catalytic funding did your agency receive? How was it used and what did it contribute to?	

	2.5.5 To what extent has the SDG3 GAP provided signatory agencies with incentives for increased collaboration at a country level?			To what extent has the SDG3 GAP provided signatory agencies with incentives for increased collaboration at a country level?	To what extent has the SDG3 GAP provided signatory agencies with incentives for increased collaboration at a country level?	To what extent has the SDG3 GAP provided signatory agencies with incentives for increased collaboration at a regional/ country level?		To what extent has the SDG3 GAP provided signatory agencies with incentives for increased collaboration at a country level?		
2.6 How are SDG3 GAP results monitored and accounted for?	2.6.1 To what extent has the SDG3 GAP monitoring framework adequately captured results achieved?	How have you monitored SDG3 GAP results? How adequately are SDG3 GAP results captured?		How have you monitored SDG3 GAP results? How adequately are SDG3 GAP results captured?	How have you monitored SDG3 GAP results? How adequately are SDG3 GAP results captured?			How have you monitored SDG3 GAP results? How adequately are SDG3 GAP results captured?		
	2.6.2 To what extent are results for SDG3 GAP captured and accounted for in signatory agencies' own results			How aligned are the SDG3 GAP monitoring framework and your organizational M&E framework?	How aligned are the SDG3 GAP monitoring framework and your organizational M&E framework?			How aligned are the SDG3 GAP monitoring framework and your organizational M&E framework?		

	frameworks ?									
	2.6.3 To what extent did the recommendations put forward in the 2023 progress report enable stakeholders to better leverage collaboration to drive progress on the health-related SDG targets in countries?			To what extent did your organization use and implement recommendations from the 2023 progress report?	To what extent did your organization use and implement recommendations from the 2023 progress report?	To what extent did your organization use and implement recommendations from the 2023 progress report?				
	2.6.4 To what extent has there been sufficient leadership and accountability for SDG3 GAP by signatory agencies?	Has there been sufficient leadership and accountability for SDG3 GAP by signatory agencies?	Has there been sufficient leadership and accountability for SDG3 GAP by signatory agencies?	Has there been sufficient leadership and accountability for SDG3 GAP by signatory agencies?	Has there been sufficient leadership and accountability for SDG3 GAP by signatory agencies?	Has there been sufficient leadership and accountability for SDG3 GAP by signatory agencies?		Has there been sufficient leadership and accountability for SDG3 GAP by signatory agencies?	Has there been sufficient leadership and accountability for SDG3 GAP by signatory agencies?	

3.1 To what extent are SDG3 GAP outcomes sustainable ?		To what extent has the SDG3 GAP encouraged signatory agencies to make integrated investments in global health security and universal health coverage?	To what extent has government ownership of and engagement with SDG3 GAP been adequately fostered?	To what extent has government ownership of and engagement with SDG3 GAP been adequately fostered? Are there examples of joint investment or additional resources among signatory agencies of SDG3 GAP in country X? To what extent has the SDG3 GAP contributed to this?	To what extent has government ownership of and engagement with SDG3 GAP been adequately fostered?			To what extent has government ownership of and engagement with SDG3 GAP been adequately fostered? Are there examples of joint investment or additional resources among signatory agencies of SDG3 GAP in country X? To what extent has the SDG3 GAP contributed to this?		
3.2 To what extent has the SDG3 GAP supported signatory agencies to collectively help countries recover from the negative impacts of the COVID-19 pandemic?		Has the SDG3 GAP helped signatory agencies to collectively help countries recover from impacts of the COVID-19 pandemic? How?		Has the SDG3 GAP helped signatory agencies to collectively help countries recover from impacts of the COVID-19 pandemic? How?	Has the SDG3 GAP helped signatory agencies to collectively help countries recover from impacts of the COVID-19 pandemic? How?	Has the SDG3 GAP helped signatory agencies to collectively help countries recover from impacts of the COVID-19 pandemic? How?	Has the SDG3 GAP helped signatory agencies to collectively help countries recover from impacts of the COVID-19 pandemic? How?	Has the SDG3 GAP helped signatory agencies to collectively help countries recover from impacts of the COVID-19 pandemic? How?	Has the SDG3 GAP helped signatory agencies to collectively help countries recover from impacts of the COVID-19 pandemic? How	

4b: Country Study KIIs

1.1 To what extent has there been a shared understanding and ownership of the SDG3 GAP and its purpose and intended results (a) by signatory agencies? (b) by countries?	1.1.1 To what extent has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans and countries' ownership of health coordination mechanisms?	Could you describe what the SDG3 GAP purpose and intended results are? How has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans? How has it supported countries' ownership of health coordination mechanisms?	What were the key motivations for you of the SDG3 GAP? How has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans?	Could you describe what the SDG3 GAP purpose and intended results are? How has it supported countries' ownership of health coordination mechanisms?	Could you describe what the SDG3 GAP purpose and intended results are? How has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans? How has it supported countries' ownership of health coordination mechanisms?	Could you describe what the SDG3 GAP purpose and intended results are? How has it supported countries' ownership of health coordination mechanisms?	What were the key motivations for you of the SDG3 GAP? Have you heard about the SDG3 GAP? If so, what do you think are its purpose and intended results? To what extent has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans and countries' ownership of health coordination mechanisms?	Have you heard about the SDG3 GAP? If so, what do you think are its purpose and intended results?

Key Question	Sub question	GAP agency country facing teams	Government	CSOs/CBOs	Other in country partners	Private sector	Member states and donors	Other external stakeholders
1.2 To what extent have signatory agencies' operational, and financial strategies, policies and approaches incentivized and enabled coherent, effective and sustainable collaboration?	1.2.1 To what extent has SDG3 GAP provided signatory agencies with a solid foundation for stronger coherence in terms of better alignment and coordination? At a global/regional/country level?	What has been the contribution of the SDG3 GAP, if any, to better alignment, coordination and mutual accountability among agencies at country level?	What has been the contribution of the SDG3 GAP, if any, to better alignment, coordination and mutual accountability among agencies at country levels?	What has been the contribution of the SDG3 GAP, if any, to better alignment, coordination and mutual accountability among agencies at country level?	What has been the contribution of the SDG3 GAP, if any, to better alignment, coordination and mutual accountability among agencies in the country?			
	1.2.2 To what extent has the SDG3 GAP complemented and added value to international partnerships such as IHP+/UHC 2030?	What was done to ensure complementarity of SDG3 GAP with other international partnerships such as IHP+/UHC 2030 at global level?	What was done to ensure complementarity of SDG3 GAP with other international partnerships such as IHP+/UHC 2030 at global level?		What was done to ensure complementarity of SDG3 GAP with other international partnerships such as IHP+/UHC 2030 at country/regional level?		To what extent has the SDG3 GAP complemented international partnerships such as IHP+/UHC 2030?	
	1.2.3 To what extent has the SDG3 GAP provided signatory agencies with incentives for increased collaboration at a	Has the SDG3 GAP provided signatory agencies with any incentives for increased collaboration at country level? What and how?				Has the SDG3 GAP provided signatory agencies with any incentives for increased collaboration at country level? What and how?		

	global/regional/country level?							
2.1 To what extent has SDG3 GAP achieved/is expected to achieve its intended objectives, and results?	2.1.1 To what extent have SDG3 GAP results differed across countries/by outcome/by accelerator/by approach?	What have been key achievements in terms of: (as relevant) *1. Countries receiving better coordinated support from SDG3 GAP partners* *2. Improved access to PHC and sustainable financing for health* *3. More equitable and inclusive health outcomes* *4. Enhanced uptake of innovations (e.g., health systems innovations, new products, new ways of delivering products, streamlining health care to provide for an*	What have been key achievements in terms of: (as relevant) *1. Countries receiving better coordinated support from SDG3 GAP partners* *2. Improved access to PHC and sustainable financing for health* *3. More equitable and inclusive health outcomes* *4. Enhanced uptake of innovations (e.g., health systems innovations, new products, new ways of delivering products, streamlining health care to provide for an*	What have been key achievements in terms of: *(as relevant)* *1. Countries receiving better coordinated support from SDG3 GAP partners* *2. Improved access to PHC and sustainable financing for health* *3. More equitable and inclusive health outcomes* *4. Enhanced uptake of innovations (e.g., health systems innovations, new products, new ways of delivering products, streamlining health care to provide for an*	What have been key achievements in terms of: (*as relevant)* *1. Countries receiving better coordinated support from SDG3 GAP partners* *2. Improved access to PHC and sustainable financing for health* *3. More equitable and inclusive health outcomes* *4. Enhanced uptake of innovations (e.g., health systems innovations, new products, new ways of delivering products, streamlining health care to provide for an*	What have been key achievements in terms of: (*as relevant)* *1. Countries receiving better coordinated support from SDG3 GAP partners* *2. Improved access to PHC and sustainable financing for health* *3. More equitable and inclusive health outcomes* *4. Enhanced uptake of innovations (e.g., health systems innovations, new products, new ways of delivering products, streamlining health care to provide for an*		

		end-to-end package of care) *5. Reliable health data*	*end-to-end package of care)* *5. Reliable health data*	*end-to-end package of care)* *5. Reliable health data*	*end-to-end package of care)* *5. Reliable health data*	*end-to-end package of care)* *5. Reliable health data*		
	2.1.2 What factors (positive and negative) have affected the achievement of SDG3 GAP's results?	What factors have been facilitating and hindering factors for the achievement of results?	What factors have been facilitating and hindering factors for the achievement of results?	What factors have been facilitating and hindering factors for the achievement of results?	What factors have been facilitating and hindering factors for the achievement of results?	What factors have been facilitating and hindering factors for the achievement of results?		
	2.1.3 To what extent have the signatory agencies effectively utilized the SDG3 GAP to strengthen countries' national health priorities and health systems? Which collaboration mechanisms have been more effective in accelerating progress to SDG3 GAP objectives?	Which collaboration mechanisms are more effectively accelerating progress on SDG3 GAP objectives at the country level? To what extent have SDG3 GAP signatory agencies provided joint technical and financial support for PHC? To what extent have then collaborated on health financing reforms?	Which collaboration mechanisms are more effectively accelerating progress on SDG3 GAP objectives at the country level? To what extent have SDG3 GAP signatory agencies provided joint technical and financial support for PHC? To what extent have then collaborated on health financing reforms?			To what extent have the SDG3 GAP signatory agencies strengthened their collaboration in providing joint technical and financial support for countries' PHC-oriented health system strengthening plans and health financing?		
2.2 To what extent has SDG3 GAP accelerated progress and helped agencies support countries		To what extent has SDG3 GAP accelerated progress and helped agencies support countries	To what extent has SDG3 GAP accelerated progress and helped agencies support countries	To what extent has SDG3 GAP accelerated progress and helped agencies support countries	To what extent has SDG3 GAP accelerated progress and helped agencies support countries	To what extent has SDG3 GAP accelerated progress and helped agencies support countries	To what extent has SDG3 GAP accelerated progress and helped agencies support countries	To what extent has SDG3 GAP accelerated progress and helped agencies support countries

towards achieving the 12 SDG3 targets and 28 targets of other SDGs related to health?		towards achieving the 12 SDG3 targets and 28 targets of other SDGs related to health?	towards achieving the 12 SDG3 targets and 28 targets of other SDGs related to health?	towards achieving the 12 SDG3 targets and 28 targets of other SDGs related to health?	towards achieving the 12 SDG3 targets and 28 targets of other SDGs related to health?	towards achieving the 12 SDG3 targets and 28 targets of other SDGs related to health?	towards achieving the 12 SDG3 targets and 28 targets of other SDGs related to health?	towards achieving the 12 SDG3 targets and 28 targets of other SDGs related to health?
2.3 To what extent has gender equality and responsiveness, equity and inclusiveness been effectively strengthened through joint support by the SDG3 GAP signatory agencies?	2.3.1 To what extent has the implementation of SDG3 GAP helped countries achieve gender, equitable and inclusive progress towards health-related SDGs?	What are gender inequities issues in relation to health in the country? What have SDG3 GAP signatory agencies done to address those? What results were achieved? And health equity and health financing issues?		What are gender inequities issues in relation to health in the country? What have SDG3 GAP signatory agencies done to address those? What results were achieved? And health equity and health financing issues?	What are gender inequities issues in relation to health in a country? What have SDG3 GAP signatory agencies done to address those? What results were achieved? And health equity and health financing issues?	What have been key actions and achievements from SDG3 GAP signatory agencies on addressing gender inequities in health? And health equity and health financing issues?		
2.4 To what extent have the SDG3 GAP accelerators supported the achievement of intended results?	2.4.1 Has the relevance and prominence of the SDG3 GAP accelerators changed over time? Why and how?	How useful have accelerators been? How has this evolved over time? Have some accelerators been more effective in supporting the achievement of results than others? Why?	Are you aware of the accelerator's mechanism? If so, how useful has it been to achieve progress on health outcomes? Have some accelerators been more effective in supporting the achievement of results than others? Why?	Are you aware of the accelerator's mechanism? If so, how useful has it been to achieve progress on health outcomes? Have some accelerators been more effective in supporting the achievement of results than others? Why?	Are you aware of the accelerator's mechanism? If so, how useful has it been to achieve progress on health outcomes? Have some accelerators been more effective in supporting the achievement of results than others? Why?	Are you aware of the accelerator's mechanism? If so, how useful has it been to achieve progress on health outcomes? Have some accelerators been more effective in supporting the achievement of results than others? Why?	Are you aware of the accelerator's mechanism? If so, how useful has it been to achieve progress on health outcomes? Have some accelerators been more effective in supporting the achievement of results than others? Why?	
	2.4.2 To what extent are accelerators 'owned' by and relevant to	How widely are the accelerator known and supported in your organization?		How widely is the accelerator known and supported in your organization?	How widely are the accelerator known and supported in your organization	How widely are the accelerator known and supported in your organization?		

	signatory agencies' work?							
2.5 To what extent have SDG3 GAP signatory agencies collectively enabled the better use of existing resources (technical, financial and human), including local coordination mechanisms?	2.5.1 To what extent have the SDG3 GAP supporting signatory agencies collaborated to deliver, or likely to deliver, results in an economic and timely way?	What resources have been dedicated to SDG3 GAP activities? Did those resources deliver expected results in a timely manner? To what extent has the GAP enabled your organization to collaborate with others to deliver results in an economic and timely way?	What resources have been dedicated to SDG3 GAP activities? Did those resources deliver expected results in a timely manner?				What resources have been dedicated to SDG3 GAP activities? Did those resources deliver expected results in a timely manner?	
	2.5.2 To what extent has the SDG3 GAP incentivized signatory agencies to work more effectively through local coordination mechanisms?	To what extent have SDG3 GAP partners strengthened coordination mechanisms for health?	To what extent have SDG3 GAP partners strengthened coordination mechanisms for health?	To what extent have SDG3 GAP partners strengthened coordination mechanisms for health?	To what extent have SDG3 GAP partners strengthened coordination mechanisms for health?	To what extent have SDG3 GAP partners strengthened coordination mechanisms for health?		

	2.5.3 To what extent has increased alignment between agencies driven efficiencies to strengthen countries' national health priorities and health systems and catalyzed the use of resources?	Are there examples of gains in efficiency from improved collaborations between SDG3 GAP partners? Examples?		Are there examples of gains in efficiency from improved collaborations between SDG3 GAP partners? Examples?	Are there examples of gains in efficiency from improved collaborations between SDG3 GAP partners? Examples?		Are there examples of gains in efficiency from improved collaborations between SDG3 GAP partners? Examples?	
	2.5.4 To what extent has the SDG3 GAP catalytic funding provided by WHO to some of its country offices supported the greater achievement of results?	To what extent has the SDG3 GAP catalytic funding provided by WHO supported the greater achievement of results?	To what extent has the SDG3 GAP catalytic funding provided by WHO supported the greater achievement of results?	How much catalytic funding did your agency receive? How was it used and what did it contribute to?	How much catalytic funding did your agency receive? How was it used and what did it contribute to?	How much catalytic funding did your agency receive? How was it used and what did it contribute to?		
	2.5.5 To what extent has the SDG3 GAP provided signatory agencies with incentives for increased collaboration at a country level?	To what extent has the SDG3 GAP provided signatory agencies with incentives for increased collaboration at a country level?	To what extent has the SDG3 GAP provided signatory agencies with incentives for increased collaboration at a country level?	To what extent has the SDG3 GAP provided signatory agencies with incentives for increased collaboration at a country level?	To what extent has the SDG3 GAP provided signatory agencies with incentives for increased collaboration at country level?	To what extent has the SDG3 GAP provided signatory agencies with incentives for increased collaboration at country level?		

2.6 How are SDG3 GAP results monitored and accounted for?	2.6.1 To what extent has the SDG3 GAP monitoring framework adequately captured results achieved?	How have you monitored SDG3 GAP results? How adequately are SDG3 GAP results captured?	How have you monitored SDG3 GAP results? How adequately are SDG3 GAP results captured?				How have you monitored SDG3 GAP results? How adequately are SDG3 GAP results captured?	How have you monitored SDG3 GAP results? How adequately are SDG3 GAP results captured?
	2.6.2 To what extent are results for SDG3 GAP captured and accounted for in signatory agencies' own results frameworks?	How aligned are the SDG3 GAP monitoring framework and your organizational M&E framework?		How aligned are the SDG3 GAP monitoring framework and your organizational M&E framework?	How aligned are the SDG3 GAP monitoring framework and your organizational M&E framework?			
	2.6.3 To what extent did the recommendations put forward in the 2023 progress report enable stakeholders to better leverage collaboration to drive progress on the health-related SDG targets in countries?	To what extent did your organization use and implement recommendations from the 2023 progress report?					To what extent did your organization use and implement recommendations from the 2023 progress report?	
	2.6.4 To what extent has there been sufficient leadership and accountability for	Has there been sufficient leadership and accountability for SDG3 GAP by	Has there been sufficient leadership and accountability for SDG3 GAP by				Has there been sufficient leadership and accountability for SDG3 GAP by	Has there been sufficient leadership and accountability for SDG3 GAP by

	SDG3 GAP by signatory agencies?	signatory agencies?	signatory agencies?				signatory agencies?	signatory agencies?
3.1 To what extent are SDG3 GAP outcomes sustainable?		To what extent has government ownership of and engagement with SDG3 GAP been adequately fostered? Are there examples of joint investment or additional resources among signatory agencies of SDG3 GAP in country X? To what extent has the SDG3 GAP contributed to this?	To what extent has government ownership of and engagement with SDG3 GAP been adequately fostered?	To what extent has government ownership of and engagement with SDG3 GAP been adequately fostered?	To what extent has government ownership of and engagement with SDG3 GAP been adequately fostered?	To what extent has government ownership of and engagement with SDG3 GAP been adequately fostered?	To what extent has government ownership of and engagement with SDG3 GAP been adequately fostered?	To what extent has government ownership of and engagement with SDG3 GAP been adequately fostered?
3.2 To what extent has the SDG3 GAP supported signatory agencies to collectively help countries recover from the negative impacts of the COVID-19 pandemic?		Has the SDG3 GAP helped signatory agencies to collectively help countries recover from impacts of the COVID-19 pandemic? How?	Has the SDG3 GAP helped signatory agencies to collectively help countries recover from impacts of the COVID-19 pandemic? How?	Has the SDG3 GAP helped signatory agencies to collectively help countries recover from impacts of the COVID-19 pandemic? How?	Has the SDG3 GAP helped signatory agencies to collectively help countries recover from impacts of the COVID-19 pandemic? How?	Has the SDG3 GAP helped signatory agencies to collectively help countries recover from impacts of the COVID-19 pandemic? How?	Has the SDG3 GAP helped signatory agencies to collectively help countries recover from impacts of the COVID-19 pandemic? How	Has the SDG3 GAP helped signatory agencies to collectively help countries recover from impacts of the COVID-19 pandemic? How?

4c: Online survey questionnaire

Country-level Stakeholder Survey: Joint Evaluation of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP)

INTRODUCTION PAGE

Thank you for agreeing to take part in this survey, which is being implemented as part of the independent joint Evaluation of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP). IOD PARC was commissioned by WHO to conduct the evaluation and this survey is one of various data collection methods being used to gather views on the implementation of the GAP.

The SDG3 GAP goal is to help countries accelerate progress on the health-related Sustainable Development Goals (SDGs) targets, through a set of commitments to strengthen collaboration across the agencies to take joint action and provide more coordinated and aligned support to country owned and led national plans and strategies.

The signatories to the SDG3 GAP are Gavi, the Vaccine Alliance; Global Financing Facility for Women, Children and Adolescents (GFF); Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); International Labour Organization (ILO); Joint United Nations Programme on HIV/AIDS (UNAIDS); United Nations Development Programme (UNDP); United Nations Population Fund (UNFPA); United Nations Children's Fund (UNICEF); Unitaid; United Nations Entity for Gender Equality and the Empowerment of Women (UN Women); World Bank Group; World Food Programme (WFP); and World Health Organization (WHO).

The purpose of the survey is to gather country-level perspectives on the effectiveness, coherence and sustainability of the SDG3 GAP.

Participation in the survey is entirely voluntary, and your responses are fully confidential and anonymous. No personally identifiable information is captured, and the survey results will be used alongside other lines of evidence to inform our analysis for the evaluation.

No questions are compulsory, but we encourage you to answer as many as you are able to.

The survey will take around 30 minutes to complete.

PRELIMINARY QUESTIONS

The purpose of these questions is to identify which stakeholder category you belong to and your familiarity with the SDG3 GAP. Your responses will help us to develop a disaggregated analysis of the survey's results and explore potential similarities or differences of views within or between key stakeholder groups.

1. **Please select the stakeholder group type you identify most closely with below:**

- SDG3 GAP signatory agency (Please specify)
- CSO
- Government
- Donor
- Other (Please specify)

2. **Which country are you based in? [drop down list]**

3. **Have you heard of the SDG3 GAP?**
    - **Yes**
    - **No**

4. **How familiar are you with the content and objectives of the SDG3 GAP?**
    - **Very familiar**
    - **Familiar**
    - **Unfamiliar**
    - **Very unfamiliar**

5. **How familiar are you with its implementation and operation within your country?**
    - **Very familiar**
    - **Familiar**
    - **Unfamiliar**
    - **Very unfamiliar**

Please elaborate on your answer or give examples

PART 1: EFFECTIVENESS

The following questions ask you for your perceptions relating to the effectiveness of SDG3 GAP.

1. In your opinion, has closer collaboration under the SDG3 GAP accelerated progress and supported your country towards achieving the following SDG3 targets?

1) Maternal mortality: by 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births; 2) Neonatal and child mortality by 2030: end preventable deaths of newborns and children under 5 years of age

- Yes, completely agree
- Yes, somewhat agree
- Neither agree nor disagree
- No, somewhat disagree
- No, completely disagree

Please share briefly why you selected this response (optional)

2) Infectious diseases: by 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, and combat hepatitis, waterborne diseases and other communicable diseases.

3) Noncommunicable diseases: by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment, and promote mental health and well-being.

4) Sexual and reproductive health: by 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and program

5) Universal health coverage: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all

6) Medicines and vaccines: support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries. Provide access to affordable essential medicines and vaccines

7) *Health financing and workforce: substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries.*

8) Emergency preparedness: strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

2. a) Which 3 targets have seen the most progress?

[Multiple choice list; select 3]

Please share briefly why you selected this response (optional)

b) Which targets have seen the least progress?

[Multiple choice list; select 3]

Please share briefly why you selected this response (optional)

3. a) Which factors have positively affected the achievement of results?

- Political will/government ownership
- Visible and engagement leadership
- Competing demands for prioritization
- Behavioral change
- Resources (funding)
- Resources (human)
- Capacity of staff
- COVID-19 pandemic
- Conflict/unrest
- Special country contexts (please specify)
- Others [please specify)

3. b) Which factors have negatively affected the achievement of results?

- Political will/government ownership
- Lack of leadership
- Competing demands for prioritization
- Behavioral change

- Resources (funding)
- Resources (human)
- Capacity of staff
- COVID-19 pandemic
- Conflict/unrest
- Special country contexts (please specify)
- Others [please specify)

4. To what extent there has been adequate monitoring of SDG3 Gap results?

- To a large extent
- To a moderate extent
- To a small extent
- To a very small extent

To no extent

Please share briefly why you selected this response (optional)

PART 2: COHERENCE

The following questions ask you for your perceptions related to the coherence of SDG3 GAP.

1. To what extent has there been a shared understanding and ownership of the SDG3 GAP and its purpose and intended results by the government?

- To a large extent
- To a moderate extent
- To a small extent
- To a very small extent
- To no extent

Please share briefly why you selected this response (optional)

2. To what extent has there been a shared understanding and ownership of the SDG3 GAP and its purpose and intended results by the signatory agencies?

- To a large extent
- To a moderate extent
- To a small extent
- To a very small extent
- To no extent
- I do not know/not applicable

Please share briefly why you selected this response (optional)

3. To what extent has the SDG3 GAP supported the increased alignment of signatory agencies' interventions with national priorities and plans and countries' ownership of health coordination mechanisms?

- To a large extent
- To a moderate extent
- To a small extent
- To a very small extent
- To no extent

Please share briefly why you selected this response (optional)

PART 3: SUSTAINABILITY

The following questions ask you for your perceptions relating to the sustainability of SDG3 GAP.

a. To what extent would you agree with these statements?

1) The SDG3 GAP signatory agencies have helped health systems and countries to recover from the negative impacts of the COVID-19 pandemic.

- To a large extent
- To a moderate extent
- To a small extent
- To a very small extent
- To no extent

Please share briefly why you selected this response (optional)

2) The SDG3 GAP signatory agencies have helped countries to achieve gender, equitable and inclusive progress towards health-related SDG.

- To a large extent
- To a moderate extent
- To a small extent
- To a very small extent
- To no extent

Please share briefly why you selected this response (optional)

ENDING QUESTIONS

Is there anything further you think it would be useful for us to know, or that you would like to share with the Evaluation team?

FINAL PAGE

Thank you for sharing your valuable insights with us! This evaluation intends to result in useful learning for the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP).

Could we contact you directly to clarify any of your comments and responses? If so, please share your email below.

ANNEX 5: Country aide memoires and summaries

Acronyms

CCM	Country Coordination Mechanism	**ODA**	Official Development Assistance
CO	Country Office	**OECD**	Organisation for Economic Co-operation and Development
COVID-19	Coronavirus disease 2019	**PAHO**	Pan American Health Organization
DANE	National Statistics Department	**PEPFAR**	U.S. President's Emergency Plan for AIDS Relief
CSO	Civil Society Organization	**PHC**	Primary Health Care
EPS	Primary Health Entities	**RCO**	Resident Coordinator's Office
ERG	Evaluation Reference Group	**RO**	Region Office
FARC	Revolutionary Armed Forces of Colombia	**SDG**	Sustainable Development Goal
GAP	Global Action Plan	**SGSSS**	General System of Social Security in Health
GBV	Gender Based Violence	**SRH**	Sexual and Reproductive Health
GDP	Gross Domestic Product	**TB**	Tuberculosis
GFF	Global Financing Facility for Women, Children and Adolescents	**TOC**	Theory of Change
GHO	Global Health Observatory	**UHC**	Universal Health Coverage
HIV	Human Immunodeficiency Virus	**UN**	United Nations
HMIS	Health Management Information System	**UNAIDS**	Joint United Nations Programme on HIV/AIDS
HQ	Headquarters	**UNCT**	United Nations Country Team
IDB	Inter-American Development Bank	**UNDP**	United Nations Development Programme
ILO	International Labour Organization	**UNFPA**	United Nations Population Fund Sexual & Reproductive Health Agency
JEA	Joint Evaluability Assessment	**UNICEF**	United Nations Children's Fund
KIIs	Key Informant Interviews	**USAID**	United States Agency for International Development
LGBTQI+	Lesbian, gay, bisexual, transgender, queer and intersex	**USD**	United States Dollar
M&E	Monitoring & Evaluation	**UNSDCF**	United Nations Sustainable Development Cooperation Framework
MMR	Maternal Mortality Rate	**UN-SWAP**	United Nations System-wide Action Plan
MNCH	Maternal, Neo-natal and Child Health	**WB**	World Bank
MOH	Ministry of Health	**WFP**	World Food Programme
NCD	Non-Communicable Diseases	**WHO**	World Health Organization
OCHA	Office for the Coordination of Humanitarian Affairs		

5.1: Colombia Country Study

INTRODUCTION

The Joint Evaluation of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), has been commissioned by the SDG3 GAP signatory agencies. Established in 2019, the SDG3 GAP is a set of commitments by 13 multilateral agencies (GAVI, GFF, ILO, the Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, UNITAID, UN Women, World Bank, WFP, WHO) to strengthen their collaboration. Under the SDG3 GAP, agencies commit to align their ways of working to provide more streamlined support to countries and reduce inefficiencies. It offers a platform to improve collaboration among the significant stakeholders in global health, with specific but complementary mandates.[1] Although referred to as a global plan, the added value of the SDG3 GAP is intended to lay in more effectively coordinated support, action and progress at a country level.

The acceleration of progress on the health-related SDGs is geared through seven accelerators: i) Primary Health Care; ii) sustainable finance for health; iii) community and civil society engagement; iv) determinants of health; v) innovative programming in fragile and vulnerable settings for disease outbreak responses; vi) research, development, innovation and access; and vii) data and digital health. In Colombia, the selected accelerators are determinants of health and civil society and community engagement.

PURPOSE, OBJECTIVE AND SCOPE

The purpose of the evaluation is to inform the signatory agencies' learning, continued improvement and mutual accountability to each other as partners. The objective of this evaluation is to assess the coherence, effectiveness, and sustainability of the SDG3 GAP collaboration efforts – at the country, regional and global levels – in accelerating country progress on the health-related SDG targets.

To this extent, the SDG3 GAP evaluation seeks to assess the extent to which signatory agencies have strengthened their collaboration to:

- engage with countries better to identify priorities;
- jointly plan and implement programs;
- harmonize operational and financial strategies, policies and approaches;
- review progress and learn together to enhance shared accountability; and,
- accelerate progress in countries through joint actions on the health-related SDGs.

The temporal scope of this evaluation is the period September 2019 to March 2024. It has been conducted at the global level and includes a series of 'deep dive' country case studies, of which one is Colombia. The deep dive country studies serve as a tool in this evaluation to explore questions of process, experience, relationship and actors in context, including a better understanding of barriers and facilitators to activities as directly experienced. This document serves as an aide memoire for the Colombia study.

METHODOLOGY

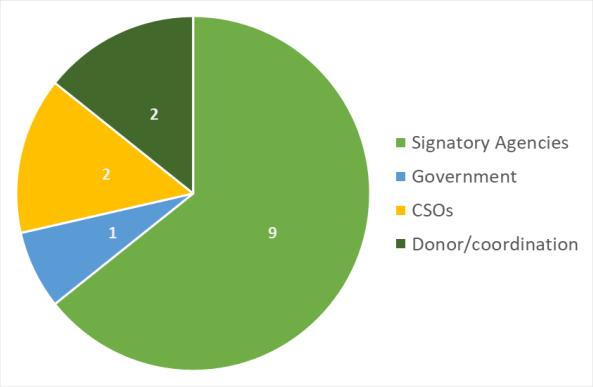
The evaluation uses a theory-based approach, using a reconstructed theory of change that reflects the common understanding of the evaluation team and SDG3 GAP agencies represented in the Evaluation Reference Group (ERG) of the SDG3 GAP. Given the nature of the SDG3 GAP, an enabling mechanism to support better use of existing resources, a contribution analysis based on testing expected change pathways and assumptions is particularly adapted to the object of the evaluation.

[1] https://www.who.int/initiatives/sdg3-global-action-plan

The Colombia case study adopted a mixed methods approach using both quantitative and qualitative data sources. Quantitative data reviewed includes health epidemiological and health-financing data, sourced from the Global Health Observatory[2], the World Bank SDG data bank[3] and the Global Burden of Disease country data.[4] A qualitative review of documents was also conducted as part of this case study.

Primary data was collected remotely between 8 April and 8 May 2024, in Spanish by two members of the evaluation team. The views of a range of stakeholders, both directly involved in the SDG3 GAP and relevant to the scope of work were sought to ensure maximum representation of a diversity of perspectives. A total of 14 respondents were consulted through interviews conducted with signatory agency staff, government stakeholders from the ministry of health, and civil society organizations working in the field of health. Gender-disaggregation of respondents indicate that there was a stronger representation of women among respondents, as 5 (36%) of the respondents were male and 9 (65%) were female.

Figure 1: Interviews per category of respondents



This draft case study will be finalised based on stakeholder feedback and used to inform the global evaluation report.

COUNTRY CONTEXT

Colombia borders with Brazil, Ecuador, Panama, Peru, and Venezuela. By the year 2000, Colombia's population stood at 39.21 million inhabitants, and by 2023, it had risen to 52.08 million, reflecting a notable increase of 32.8%.[5] About 18% (9.3 million people) of the population live in rural areas.[6] In 2023, the life expectancy at birth reached 77.5 years, surpassing the regional average for the Americas and showing an increase of 6.2 years since 2000.[7]

With a GDP per capita of $6,624, Colombia is considered a middle-upper income country.[8] It has witnessed strong economic growth in the past decade, above 7.3% of GDP annual growth[9] and the economy is projected to expand 1.3 percent in 2024.[10]

Despite this overall positive economic situation, Colombia faces several socio-ecomomic and political challenges that affect health outcomes. Since the onset of the Venezuelan crisis in 2015, the country has received an estimated 2.89 million migrants and refugees from Venezuela, as well as an increasing number of migrants in transit.[11] Colombia is also home to

[2] https://www.who.int/data/gho
[3] https://databank.worldbank.org/source/sustainable-development-goals-(sdgs)
[4] https://www.healthdata.org/research-analysis/gbd
[5] The World Bank in Colombia: Colombia Overview: Development news, research, data | World Bank
[6] https://data.worldbank.org/
[7] The World Bank in Colombia: Colombia Overview: Development news, research, data | World Bank
[8] https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=CO
[9] GDP growth (annual %) - Colombia | Data (worldbank.org)
[10] The World Bank in Colombia: Colombia Overview: Development news, research, data | World Bank
[11] IOM (2024) Colombia crisis response plan, https://crisisresponse.iom.int/response/colombia-crisis-response-plan-2023-2024

around 90 indigenous communities, 71 of which are considered at imminent risk of physical and cultural extermination.[12] Indigenous communities experience specific challenges in terms of accessing health care, including distance and difficult travel conditions to health centres, discrimination, language barriers and lack of culturally appropriate services. The country is still recovering from the aftermath of a violent civil conflict. Following a decades-long internal conflict, the Government of Colombia and the Revolutionary Armed Forces of Colombia (FARC) signed a peace agreement in 2016.

Despite Colombia's robust economic growth, significant inequities and inequalities persist. The country's GINI coefficient, a measure of income inequality, was 54.8 in 2022[13], indicating it remains one of the most unequal nations in Latin America. Although Colombia's Human Development Index (HDI) value for 2022 was 0.758[14], categorizing it as having high human development and ranking it 91st out of 193 countries, inequality-adjusted HDI (IHDI) reveals a stark contrast. The IHDI drops to 0.568[15], reflecting a 25.1 percent loss in human development due to inequality. This is underscored by disparities in education and healthcare access, where only 41%[16] of people are satisfied with the availability of quality healthcare, well below the OECD average of 67%. Out-of-pocket health expenditures have increased, now constituting 14% of total health spending, and while this is lower than the OECD average of 18%, it indicates a financial burden on individuals[17]. Poverty rates show a nuanced picture; national poverty decreased from 39.7% in 2021 to 36.6% in 2022, yet extreme poverty stagnated at 13.8%[18]. Regional disparities are stark, with poverty rates among women, indigenous populations, Afro-descendants, and Venezuelan migrants significantly higher than the national average. Additionally, economic recovery post-COVID-19 has been uneven, with labour market improvements primarily benefiting urban areas and not significantly aiding youth, women, or rural communities. Structural challenges, including low-quality education, territorial disparities, and inadequate job quality, continue to limit upward socioeconomic mobility, necessitating comprehensive reforms to reduce inequality and accelerate poverty reduction.

In line with those challenges, Colombia's national development plan indicates that key priorities for the country are the peace and justice agenda, nutrition and environment and climate action.[19]

HEALTH STATUS

There has been progress on SDG3 targets in Colombia since 2015, including a reduction in maternal, neo-natal and under-five mortality rates; in incidence of HIV infections and in adolescent fertility rate. Progress has been reversed in other areas, with increased TB incidence and reduced infant vaccination coverage as illustrated in Table 1 Key SDG3 indicators for Colombia. Source: UN Statistics Divisionbelow. A key challenge in Colombia remains the health inequalities affecting marginalized populations such as indigenous populations, people of African descent, dispersed rural populations, migrant and LGBTQI+ populations.

Table 1 Key SDG3 indicators for Colombia. Source: UN Statistics Division[20]

Indicator	2015	2021	Progress
MMR per 100 000 live births	70.01	74.76	

[12] OHCHR (2024) Declaración final del Relator Especial de las Naciones Unidas sobre los derechos de los Pueblos Indígenas, Francisco Calí Tzay, al concluir su visita oficial a Colombia https://www.ohchr.org/sites/default/files/documents/issues/indigenouspeoples/sr/statements/20240315-sr-ipeoples-oem-statement-colombia.pdf
[13] The World Bank Gini index – Colombia: https://data.worldbank.org/indicator/SI.POV.GINI?locations=CO
[14] UNDP Country Data: Specific country data | Human Development Reports (undp.org)
[15] UNDP Country Data: Specific country data | Human Development Reports (undp.org)
[16] OECD Colombia Health at a Glance: health-at-a-glance-Colombia-EN.pdf (oecd.org)
[17] OECD Colombia Health at a Glance: health-at-a-glance-Colombia-EN.pdf (oecd.org)
[18] World Bank Poverty and Inequality Platform: pip.worldbank.org/country-profiles/COL
[19] Departamento Nacional de Planeación (2022) Plan Nacional de Desarrollo 'Colombia, potencia mundial de vida' 2022-2026 https://www.dnp.gov.co/plan-nacional-desarrollo/pnd-2022-2026
[20] Sustainable Development Report: https://dashboards.sdgindex.org/profiles/colombia/indicators

Neonatal mortality rate	8.5	6.99	
Under-5 mortality per 1000 live births	15.6	12.85	
TB incidence per 100 000	31	41	
HIV infections per 1000	0.19	0.17	
Risk of dying from main NCDs	10.33%	9.73%	
Traffic deaths per 100 000	17.97	15.42	
Adolescent fertility rate	64.9	52.60	
Births attended by skilled health personnel	95.9	98.8	
UHC coverage (%)	76	78	
Surviving infants who received 2 WHO-recommended vaccines	91	86	
Subjective well-being	6.4	5.9	

*Direction of arrows indicate “on track or maintaining SDG achievement” (up), “score moderately improving, insufficient to attain goal” (horizontal), and “score decreasing” (down).

**Colour indicates “SDG achieved” (green), “challenges remain” (yellow), “significant challenges remain” (orange), and “major challenges remain” (red).

HEALTH SYSTEM AND HEALTH FINANCING

The main challenge for the health system in Colombia is to improve universal health coverage, with special emphasis on improving the availability of human resources for health and reaching out to specific populations with greater vulnerability. Geographical inequities in health are high, with some territories impacted by violence and armed groups where it is difficult to provide health services.

The General System of Social Security in Health (SGSSS) is responsible for ensuring PHC coverage and access to health care. It is based on a regulated market model of health insurance delivered through Primary Health Entities (EPS). They must provide a Health Benefits Plan guaranteeing coverage to all affiliated members. Given the current difficulties in reaching equitable health coverage through this system, the Colombian government has attempted to reform it through partial nationalization, but the reform has not yet been approved by the Congress. At the regional level, Colombia is one of the countries supported by the initiative on strengthening PHC by the World Bank and the Inter-American Development Bank (IDB).

In 2023, Colombia's per capita health expenditure was $1,640, significantly lower than the OECD average of $4,986[21]. This disparity highlights the challenges Colombia faces in matching the health investment levels of other OECD countries. Additionally, private investment in health is minimal, with only 1% of the 200 companies contributing to the SDGs focusing

[21] https://www.oecd.org/colombia/health-at-a-glance-Colombia-EN.pdf

on health and social services.[22] Despite officially joining the OECD on 28 April 2020, Colombia lags in key health metrics. While the average OECD health expenditure as a percentage of GDP rose from 8.8% in 2019 to 9.7% in 2021 due to the pandemic, it is estimated to have decreased to 9.2% in 2022.[23] During the pandemic, Colombia established a central government fund for the COVID-19 response, allocating approximately 40% of its resources to health for testing, treatment and vaccination, underscoring the increased role of government schemes in financing health during crises.[24]

FINDINGS

Coherence

Despite some actions taking place implementing the SDG3 GAP in Colombia the scheme appears mostly unknown to respondents and has had limited traction in the country.

Some actions were undertaken to disseminate the SDG3 GAP framework. PAHO in collaboration with the RCO held a launch meeting during UNCT where a letter from the agency representatives requesting signatory agencies to work in a coordinated manner to accelerate SDG targets was presented. Reviewing the SDG3 GAP, agencies selected some SDG3 targets to focus their joint work on, notably on reducing maternal, neo-natal and under-five mortality, and other targets related to zero hunger (SDG2) and gender equality (SDG5). Catalytic funding was provided through PAHO, which served to support the extension of an existing joint initiative with UNFPA, UNICEF and WFP on maternal mortality in indigenous communities to integrate these new objectives (more detail provided in the Effectiveness section on this).

Beyond these activities however, it appears that awareness of the SDG3 GAP has been limited in Colombia. Awareness is low among all types of stakeholders in the country, and there is a consensus that there was little to no communication on this plan beyond the initial presentation to the UNCT. Internal communication within the agencies from regional and HQ level seems to have been absent. According to a signatory agency, part of this was due to the fact that agencies were already coordinating satisfactorily, and the SDG3 GAP only served as a reminder to them. Many stakeholders expressed that existing efforts should be analyzed before signing new frameworks to avoid redundancy. They recommended that new frameworks should be designed from the bottom up, taking into account the experience and contextual understanding of what is needed among country-level implementers.

The UNCT in Colombia is formed by 21 agencies, funds and programmes and five support offices. The UN presence in the country includes a humanitarian team under OCHA coordination, a human rights office and a verification mission mandated by the UN Secretary General to verify that the terms of the 2016 peace agreement are respected. Key efforts centre on SDG16 peace, justice and strong administration, SDG5 relating to gender equality and SDG 10, reduction of inequalities.25 SDG3 GAP agencies' coordination with and alignment to government's priorities is governed by a structured framework and system from the Government. Since 2015, a national strategy on international cooperation describes how interagency efforts and collaboration with the government are to take place in Colombia.[26] Key elements of the architecture described in this strategy are presented in Figure 2: Health Coordination Mechanisms in Colombia. The UNSDCF cooperation framework is the first level of coordination between the UN and the government. Collaboration with government essentially takes place at the technical level through technical platforms ('mesas'). Such platforms for the health sector are lacking, although thematic ones exist on maternal health or nutrition. There is also a thematic working group chaired by the Department of SRH in the Ministry of Health (MoH). Overall, health agencies appear to mostly use bilateral relations to plan their work with MoH. While the government's coordination at operational and technical levels

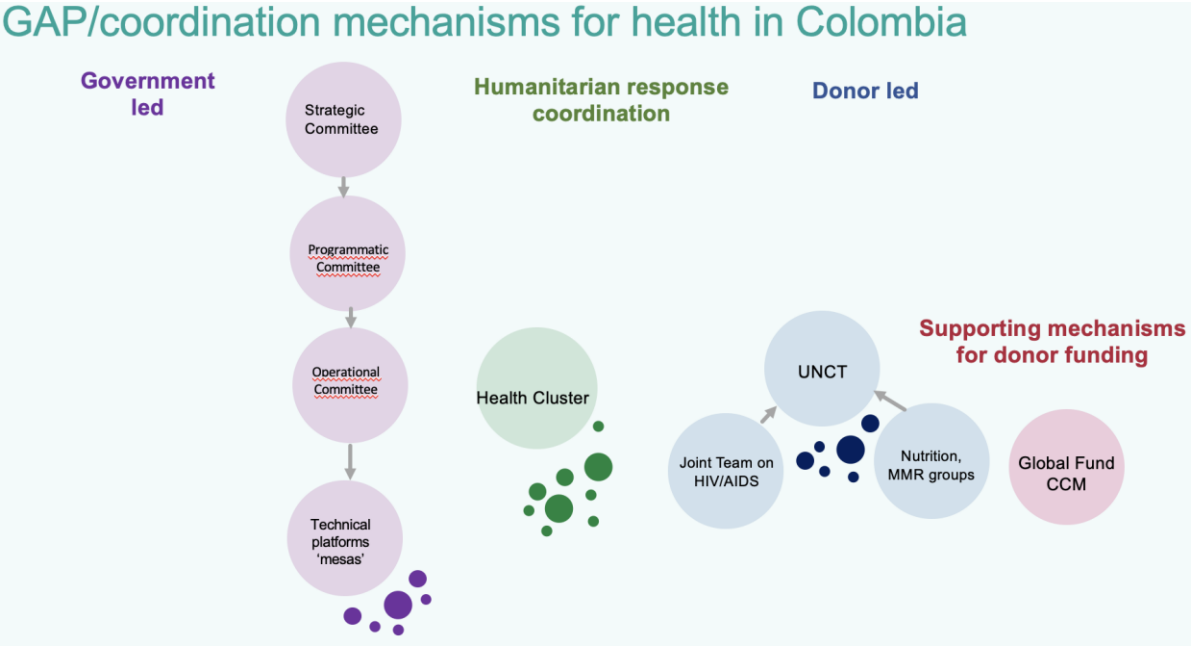
[22] Departamento Nacional de Planeación (year unknown) Una mirada a los resultados de la contribución del sector privado a los ODS
[23] https://www.oecd.org/colombia/health-at-a-glance-Colombia-EN.pdf
[24] https://www.oecd.org/colombia/health-at-a-glance-Colombia-EN.pdf
[25] UN Colombia (2022) Annual report https://minio.uninfo.org/uninfo-production-main/684443ba-a2b2-48d9-bbdb-9c6893d8736b_ONUInforme_Anual_de_Resultados_Alta_Calidad_WEB.pdf
[26] Agencia Presidencial de Cooperación Internacional de Colombia (2022) Estrategia nacional de cooperación internacional de Colombia 2023-2026 https://www.apccolombia.gov.co/sites/default/files/2023-11/ENCI_2023.pdf

allows better coordination of agencies at territorial level, a level of duplication and missed opportunities for synergies, including at the level of developing and implementing M&E systems, persist. According to some SDG3 GAP respondents, the lack of an overall health coordination platform with government also affects dialogue and engagement at the time of defining and advocating for joint priorities.

In terms of coordination among signatory agencies, as in other countries, agency-specific coordination mechanisms are in place: the Global Fund's country coordination mechanism (CCM), UNAIDS's Joint Team and planning processes of USAID and PEPFAR where the Ministry of Health as well as other agencies are participating. A health cluster mechanism is present under OCHA through which SDG3 GAP signatory agencies coordinate the humanitarian health response, with sub-clusters on SRH, migration, violence, epidemics and natural disasters. There is also an SDG monitoring group, which is led by UNFPA together with the national statistics department (DANE) in which PAHO participates. Technical groups meet on maternal health and nutrition, and each individual agency develops its own country programme based on their mandate and aligned to the UNSDCF. It is noteworthy that the UNCT does not have an active results group on health and there is no formally recognizable platform within the UNCT to define joint actions to support the health sector and the PHC agenda.

Views on PAHO's leadership among health agencies were nuanced. Respondents unanimously acknowledged the leadership of the agency during the COVID-19 response, as well as recognizing its key role in coordinating with MoH. PAHO's work appears well aligned to government's priorities on equitable access to health through the PHC, addressing social determinants, reduction of MMR, and implementing a plan to decelerate mortality from acute malnutrition. However, cooperation with PAHO has focused on bilateral, technical assistance and has lacked a fully developed platform to coordinate with other agencies active in the health sector in order to fulfil its convening and coordinating role to support the implementation of the SDG3 GAP.

Figure 2: Health Coordination Mechanisms in Colombia



Effectiveness

In Colombia, the SDG3 GAP has contributed to its objectives of promoting joint programme planning and implementation and accelerating progress through joint action on the health SDGs. Catalytic funding managed by PAHO from 2021 contributed to scaling up an existing PAHO programme, "Maternal Health for All: Indigenous Communities in Colombia", implemented at the territorial level in collaboration with PAHO, UNFPA, WFP and UNICEF. The four agencies designed an inter-agency programme based on each agency's mandate and carried out joint actions such as mobilization and capacity building work with the government. SDG3 GAP catalytic funding has allowed the agencies to extend the inter-agency

strategy to SDG2 on zero hunger, road safety and eliminating gender-based violence (SDG5). However, there is no evidence that joint planning and action on health SDGs has been strengthened beyond these programmatic interventions.

In particular, catalytic investments do not appear to have been directed to health sector coordination, alignment and advocacy. Therefore, the SDG3 GAP's contribution to engaging with the Government of Colombia to identify joint health priorities, harmonizing inter-agency operational and financial strategies, and improving shared accountability has been limited.

There are opportunities for agencies to invest efforts in these areas. One key concern is that health is not high on the political agenda. The National Development Plan focuses on four thematic areas: total peace, climate change, zero hunger and reindustrialization. This is reflected in low investment in health by both the government and the private sector. According to the OECD[27], in 2023 Colombia spent $1640 per capita on health, well below the OECD average of $4986. Regarding private investment in health, a 2021 report on SDG progress, highlights that only 1% of the 200 companies that contributed to the SDGs focused on activities related to health and social services[28]. This relatively lower priority given to the health sector is reflected in the GAP agencies' focus. At the UN country team level, the UNSDCF framework includes health-related outcomes in a cross-cutting manner across the key areas of peace, migration and technical assistance for accelerating catalytic action on the SDGs, but as noted above there are no specific high-level results on health or coordination platform dedicated to health in the UNCT.

In order to address challenges in the health sector, respondents from SDG3 GAP signatory agencies highlighted the need for upstream initiatives beyond programmatic interventions. For example, through joint-advocacy and dialogue with the government in order to refine the definition of joint-priorities on health and identify points of entry with other key priorities of the government to work in a multi-sectoral approach to health, peace and development challenges.

JOINT SUPPORT TO GENDER EQUALITY, EQUITY AND INCLUSIVENESS

There is a strong focus from the government's cooperation strategy on supporting gender equality, equity and inclusiveness. The strategy includes principles of feminist and intersectional cooperation to guide the work of agencies. It also focusses on ensuring the participation of territories and geographical equity.[29]

The intersectional aspect of gender and other factors of health inequities is demonstrated by differential results in maternal mortality ratio between the general population and indigenous and Afro-Colombian populations. By 2016, the highest maternal mortality ratios were found among these populations, reaching values of 195.89 and 156.84 deaths per 100 000 live births, respectively, as compared to 70 for the general population. The programme implemented by PAHO in collaboration with UNFPA, UNICEF and WFP have focused on demonstrating a successful approach to closing this gap, however gains from this programme have not yet been scaled up beyond its areas of implementation through government investment or other scale-up programmes. The growing gap in life expectancy at birth among regions, from 14.18 years in 2015 to 15.11 years in 2021 illustrates that geographical inequities may not yet be impacted by such interventions at population level.

A key issue in terms of gender equality related to violence against women. In this field, the interventions of SDG3 GAP agencies have focussed on economic empowerment of women and psycho-social support. Gaps remain in terms of including access to justice, improving safe spaces and case management of survivors and addressing the trafficking dimension of the issue in a multi-sectoral, coordinated manner. Particular vulnerability of women living with disabilities to gender-based violence has also been highlighted by civil society respondents.

[27] https://www.oecd.org/colombia/health-at-a-glance-Colombia-EN.pdf
[28] Departamento Nacional de Planeación (year unknown) Una mirada a los resultados de la contribución del sector privado a los ODS

[29] DNP (2022) Estrategia Nacional de Cooperación Internacional de Colombia 2023-2026

PROGRESS ON ACCELERATORS

Determinants of health

The reconstructed theory of change suggests that multisectoral action on determinants of health would be strengthened through joint support by SDG3 GAP agencies. This would lead to more equitable health interventions including during COVID-19 mitigation and recovery phase, leading to more inclusive progress towards health-related SDGs. This pathway is partly verified from evidence on COVID-19 response as well as from joint initiatives from SDG3 GAP agencies focusing on addressing geographical and cultural determinants of health.

Key health determinants in Colombia include geographical disparities, with rural, scattered populations, indigenous groups and people of African descent most disadvantaged. Security and public order issues also sometimes pose barriers to effective implementation in certain areas. There are examples of collaborations among SDG3 GAP signatory agencies on health determinants. ILO and UNFPA collaborate on promoting SRH in young rural workers. The joint programme on reducing maternal mortality in indigenous communities implemented by PAHO, UNFPA, UNICEF and WPF focussed on addressing cultural barriers to accessing health services, ensuring that health personal was trained and equipped to offer culturally-appropriate services to mothers from indigenous communities, including having local languages translators, appropriately set up clinics to respect traditional birth practices, and having trained community workers to sensitise families on hospital deliveries.

These promising initiatives illustrate that SDG3 GAP agencies in Colombia have focussed their efforts on addressing health inequalities stemming from determinants of health. Doing so in a systematic manner remains however challenging. An SDG3 GAP respondent highlighted the difficulties in implementing health programmes while applying the 'leaving no-one behind' principle. Such approach requires much more costly and time-consuming interventions in contexts that need the most support, where communities in rural areas are affected by armed conflict, violence, less access to resources, health infrastructure, education or the Internet. These issues are compounded by the fact that Colombia, as an upper-middle-income country, has less access to ODA investment.

In this way, addressing determinants of health to reach to most disadvantaged segments of the population require adjusting the targets and ambitions of programmes usually geared to reaching the greatest number of people at the lowest cost, as well as constant engagement with government to align priorities and ensure that public investment is directed to the areas and groups identified as having the greatest needs.

CIVIL SOCIETY AND COMMUNITY ENGAGEMENT

The SDG3 GAP reconstructed theory of change indicates that engagement of communities and civil society in health would be strengthened through joint support by GAP agencies. This in turn would contribute to equity, gender equality responsiveness and human-rights based approaches being strengthened across outcomes and equitable COVID-19 response and recovery interventions, leading to more equitable and inclusive progress towards health-related SDGs.

While there is evidence that SDG3 GAP agencies have collaborated to some extent with civil society organizations, for example order to ensure appropriate delivery of activities in different territories, collective action to strengthen civil society and align partnerships approaches were not documented as part of this evaluation.

SDG3 GAP respondents outlined that civil society organizations contribute valuable insights and advocacy skills in support of their objectives. Their deep understanding of the context and system renders advocacy and lobbying efforts more effective. The strength of civil society organizations (CSOs) in health is uneven. CSOs working on HIV have a longer history, with stronger competencies and stable, more sustainable networks and organizations. In contrast, CSOs working on universal access to services are less well-structured, according to an SDG3 GAP respondent.

Civil society respondents consider that agencies sometimes tend to consider them as beneficiaries, and do not sufficiently recognize their strengths and contribution. They report interest in engaging beyond a consultative role into social contracting through which they can become community-based service providers on preventing gender-based violence, promoting breastfeeding or sensitizing communities on obesity and other risk factors for NCDs. Some GAP agencies report

using consultancies as a way to build capacity among consultants from civil society. Some agencies like UNICEF report dedicated efforts to strengthen community participation so that these communities can become agents of their own health by knowing their rights and organizing themselves. While agencies individually recognize and support their civil society partners, these efforts do not appear to be well coordinated or aligned to bring sustainable, at-scale change in the capacity of civil society actors.

AGENCIES COLLECTIVELY ENABLING BETTER USE OF RESOURCES

As noted above, the joint programme between PAHO, UNFPA, UNICEF and WPF on reducing maternal mortality in indigenous women undoubtedly led to better coordination of resources and reduced duplication, hence contributing to more efficient use of resources. Overall, however, respondents from government and civil society considered that UN agencies' funding for health was often tied to specific topics and lacked flexibility. One respondent from a GAP agency also reported that use of specific indicators defined at the programme level rather than macro indicators sometimes hindered collaboration to collectively progress on SDGs.

MONITORING OF SDG3 GAP RESULTS

The main reporting mechanism is the annual SDG3 GAP progress report, which includes a health map covering six dimensions against which all SDG3 GAP countries have reported in 2022 and 2023. These dimensions are 'scored' by national government focal points against a scale, indicating their degree of agreement on the extent to which progress was made. For Colombia, these indicate satisfactory or highly satisfactory (light and dark green) progress on budget, use of local monitoring systems, joint technical assistance plan and use of local coordination mechanisms in 2022 and 2023. The area 'coordinated with each other' was scored as stagnating (yellow) over the period, with alignment to plans reported to have improved from stagnating to satisfactory between 2022 and 2023. This assessment is difficult to interpret, given that it is self-reported and not accompanied by a narrative explanation of the score given. The process to arrive at the score is also not described.

Table 2: SDG3 GAP Heat Map Results for 22/23

Year	Criteria					
	Aligned to plans	Coordinated with each other	Aligned to budget	Uses local monitoring systems	Joint TA plan	Uses local coordination mechanisms
2022						
2023						

One issue raised by the respondent is the lack of a specific monitoring framework for global initiatives such as the SDG3 GAP. Using indicators that are part and parcel of the organization's existing work causes confusion as to what contribution can be attributed by the SDG3 GAP, and what has already taken place independently of it.

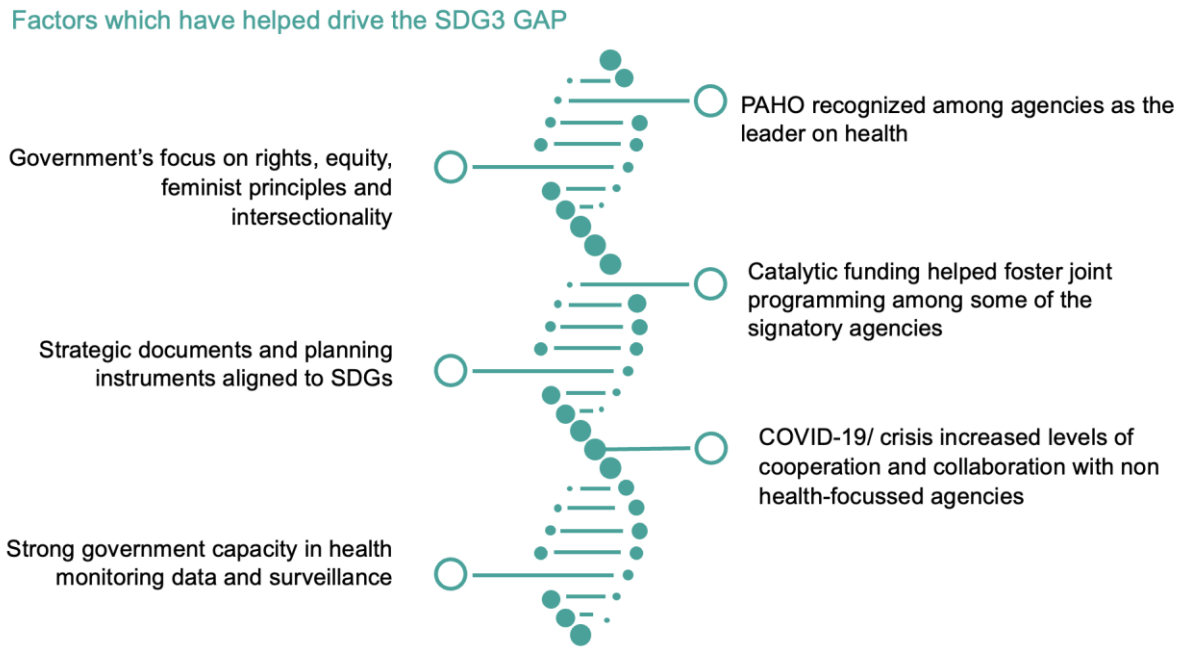
Sustainability

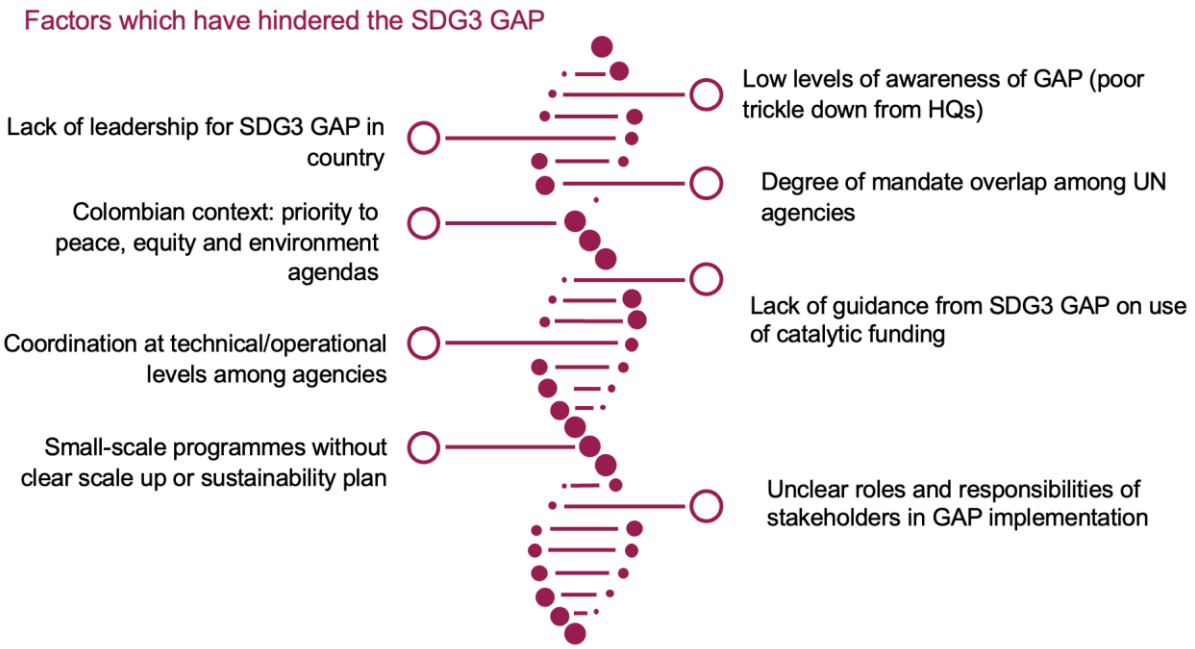
Sustainability of joint efforts to improve PHC coverage and health results has been a weak point in health interventions. Both GAP agencies and government respondents report that the Colombian Government has been critical of the small-scale, unsustainable nature of health programmes delivered by agencies. Lack of strong partnership with government at the time of designing a scale up plan for interventions lead to a situation where agencies only have scant resources for direct implementation of pilot programmes, resulting in a multiplication of localized projects and consultancies. While the joint efforts on improving maternal health in indigenous communities has been highlighted as a success by both government and GAP agencies implementing it, questions were raised about its sustainability. MoH respondents called for

increased dialogue and consultations to develop country-wide efforts and design common priorities. Given the specific context of Colombia, a higher middle-income country with high management capacity in the MoH, there is need to adapt the type of support provided to a facilitating, supportive role of agencies where gaps are identified in implementing the national health strategy. Another key bottleneck to sustainability, as mentioned above, is the relatively low visibility of the health agenda in Colombia compared to other key priorities such as peace, nutrition and climate change.

The COVID-19 response required UN agencies to develop new partnerships beyond the health specialist agencies. Under the leadership of PAHO, UN and other health specialized agencies held frequent meetings during the pandemic to ensure alignment of the COVID-19 response to government priorities. Non-health-focused agencies such as UNDP and ILO have collaborated closely with PAHO on producing and distributing PPE and organizing safe return to work after the pandemic. While coordination in health improved during the pandemic, according to most respondents, this broadened coordination does not seem to have been sustained after the pandemic, as non-health focused agencies returned to other priorities beyond health.

ENABLING FACTORS AND STUMBLING BLOCKS FOR THE SDG3 GAP





AREAS OF CONSIDERATION GOING FORWARD

Country level

Area of consideration going forward
Strategic
Strengthen the strategic coordination role of PAHO, to go beyond programmatic work and technical assistance, to play a leadership role among agencies and foster dialogue on health priorities with the government
Foster a consultation process with the government in order to improve strategic alignment on key health issues
Institutional
Consider developing a health group in the UNCT to coordinate efforts on PHC and reduction of health inequalities

Global level

Area of consideration going forward
Strategic
Better communicate the partnership modalities among agencies involved in health, especially where there are overlapping mandates
Operational
Maintain catalytic funding, but provide clear direction to direct efforts to facilitation of overall health coordination work and promoting institutional change

ANNEX 5.1.1. Bibliography

Agencia Presidencial de Cooperación Internacional de Colombia (2022) Estrategia nacional de cooperación internacional de Colombia 2023-2026

Departamento Administrativo Nacional de Estadística (2022) Guía sobre la disponibilidad de información territorial para los objetivos de desarrollo sostenible

Departamento Administrativo Nacional de Estadística (year unknown) Medición al Progreso de ODS en Colombia Metodología OCDE

Departamento Administrativo de la Función Pública (2015) Decreto 280 de 2015, "Por el cual se crea la Comisión Interinstitucional de Alto Nivel para el alistamiento y la efectiva implementación de la Agenda de Desarrollo Post 2015 y sus Objetivos de Desarrollo Sostenible (ODS)."

Departamento Nacional de Planeación (year unknown) Una mirada a los resultados de la contribución del sector privado a los ODS

Departamento Nacional de Planeación (2022) Plan Nacional de Desarrollo 'Colombia, potencia mundial de vida' 2022-2026

Ministerio de Salud (2022) Plan Decenal de Salud Pública PDSP 2022 – 2031

Naciones Unidas Colombia (2019) Análisis Conjunto de país, Sistema de las Naciones Unidas en Colombia

Naciones Unidas Colombia (2020) Marco de Cooperación de las Naciones Unidas para el desarrollo sostenible Colombia 2020-2023

Naciones Unidas Colombia (2022) Informe Anual de Resultados

UNFPA/DANE Guía para la medición y reporte de los indicadores globales en el Marco de Cooperación de las Naciones Unidas para el Desarrollo Sostenible

WHO (2021) Maternal health for all: indigenous communities in Colombia

ANNEX 5.1.2. Respondents consulted

Organisation	Participation
GAP agencies	
PAHO	3
UNFPA	2
UNDP	1
WFP	1
UNAIDS	1
ILO	1
UNICEF	1
UNWOMEN	1
Government stakeholders	
Ministry of Health	1
Civil Society Organizations	
Liga para la prevención de la violencia vial	1
Mujer Denuncia	1

5.2: Ethiopia Country Study

OBJECT OF EVALUATION

This Ethiopia county study is one of five case studies undertaken to inform the Joint Evaluation of the SDG3 Global Action Plan for Accelerating Health. The Joint Evaluation of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), has been commissioned by the GAP signatory agencies. Established in 2019, SDG3 GAP is a set of commitments by 13 multilateral agencies (GAVI, GFF, ILO, the Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, UNITAID, UN Women, World Bank, WFP, WHO) to strengthen their collaboration. Under the SDG3 GAP, agencies commit to align ways of working to provide more streamlined support to countries and reduce inefficiencies. It offers a platform to improve collaboration among the significant stakeholders in global health, with specific but complementary mandates[30] Although referred to as a Global plan, the added value of the SDG3 GAP is intended to lay in more effectively coordinated support, action and progress at a country level.

The GAP evaluation seeks to assess the extent to which signatory agencies have strengthened their collaboration to:

- Engage with countries better to identify priorities;
- Jointly plan and implement programs;
- Harmonize operational and financial strategies, policies and approaches;
- Review progress and learn together to enhance shared accountability; and,
- Accelerate progress in countries through joint actions on the health-related SDGs.

OBJECTIVE AND SCOPE

The objective of this evaluation is to assess the coherence, effectiveness, and sustainability of the SDG3 GAP collaboration efforts – at the country, regional and global levels – in accelerating country progress on the health-related SDG targets. The 'deep dive' country studies are intended to serve as a tool in this evaluation to explore questions of process, experience, relationship and actors in context, including a better understanding of barriers and facilitators to activities as directly experienced.

The temporal scope of this evaluation is the period from September 2019 to March 2024, and includes global, regional and country perspectives from SDG3 GAP signatory agencies' country offices or country focal points, regional offices, UN country team and headquarters, as well as the participation of member states, government counterparts, other partners, including civil society and other implementing partners.

APPROACH AND METHODOLOGY

The evaluation uses a theory-based approach to 'test' the SDG3 GAP theory of change (ToC)[31] and to explore the extent to which progress is being made towards outcomes, the adequacy of the monitoring approach and how well the ToC captures change as a result of signatory agency interventions. A mixed-methods approach has been used for the Ethiopia country study with 24 KIIs and FGDs conducted with the signatory agencies, government, development partners and other stakeholders such as civil society and community groups, and a review of 25 documents.

Table 3: Respondent Types

Respondent type	Number interviewed[32]

[30] SDG3 GAP website at https://www.who.int/initiatives/sdg3-global-action-plan
[31] See inception report
[32] The below denotes the number of interviews rather than the number of respondents interviewed.

Signatory Agencies	8
UNRCO	1
Government	6
Other UN agency	2
Civil Society	3
Donors	2
Other	2

The country study was conducted by two members of the evaluation team for five working days, as well as follow up remote interviews. Following the Ethiopia country study, the team held a debriefing meeting with key stakeholders to present and validate emerging findings, check data accuracy and to identify any data gaps. This draft country study has been developed to provide a record of the visit and present findings against the three evaluation criteria to inform the overall evaluation report and will be finalised based on stakeholder feedback and used to inform the global evaluation report.

In terms of limitations, the most significant was the low level of awareness of the SDG3 GAP at country level; meaning that, with the data gathered, it is not possible to answer a large number of the evaluation questions. Where practicable, the evaluation team has gathered data regarding the quality and nature of alignment, collaboration and coordination between signatory agencies and multilateral organizations, so as to identify areas where the SDG3 GAP or similar could be impactful to address current challenges.

COUNTRY CONTEXT

Ethiopia has a large population of 126.5 million people and is the second most populous nation in Africa.[33] A low-income country,[34] Ethiopia ranks 175th globally in the Human Development Index, with an estimated 77.04 million Ethiopians living in multidimensional poverty.[35]

There are large variations between the regions in the country, in terms of their geography, population, demography, poverty levels, proportion of population who are vulnerable or displaced and security. These factors contribute to inequities in access to health services, health indicators, and immunization levels, a priority which is recognized in National Health Equity Strategic Plan for 2021 to 2025.[36]

Since 2018, the country has experienced an increase in ethnic tension and conflict, involving both internal and external actors across a number of Ethiopia's regions, with Oromia, Tigray and Somali regions particularly affected.

The current Ethiopia health system operates within a three-tiered structure, with primary level healthcare consisting of 17 561 local health posts at kebele level, and 3706 district health centres at woreda level. The country contains a total of 353 hospitals,[37] split between primary hospitals at zone level, and general hospitals and specialized hospitals at the regional and national level.

In the last three decades, Ethiopia has made huge progress in healthcare provision, with expanding access to primary healthcare, and reductions in morbidity and mortality. However, intra-regional disparities in healthcare provision and

[33] https://www.worldbank.org/en/country/ethiopia/overview
34 World Bank (2023), World Bank Group country classifications by income level for FY24 (July 1, 2023- June 30, 2024), Accessed: https://blogs.worldbank.org/opendata/new-world-bank-group-country-classifications-income-level-fy24
[35] UNDP (2022), Human Development Report 2021/22
[36] Ministry of Health – Ethiopia (2020), National Health Equity Strategic Plan 2020/21 – 2024/25, Accessed: https://www.afro.who.int/sites/default/files/2022-08/National%20Health%20Equity%20Strategic%20Plan-June%2027.pdf
[37] Ministry of Health – Ethiopia et al. National and subnational coverage and other service statistics for reproductive, maternal, newborn and child health using health facility data and surveys ETHIOPIA Brief synthesis of the analyses Countdown to 2030 / GFF / UNICEF / WHO workshop, Accessed: https://www.countdown2030.org/wp-content/uploads/2023/02/Ethiopia-Overall-Country-Report-July-2022-v2-Draft.pdf

health outcomes persist, and the country is still working towards achieving universal health coverage (UHC).[38] In response to these challenges, the Ministry of Health Ethiopia has developed a multifaceted National Health Equity Strategic Plan for the period 2020/21-2024/25[39] with attached resources of US$ 479.64 million.

Ethiopia has shown long-term improvement in health outcomes, but despite this, deaths of children from preventable diseases such as pneumonia, diarrhoea, measles, malaria, neonatal problems and malnutrition are still very high. An estimated 80% of morbidities in mothers and children are caused by communicable diseases, including vaccine-preventable diseases. Recent drought, floods, conflict have triggered a surge in disease outbreaks, including cholera, malaria, measles, and dengue fever, along with rising levels of acute malnutrition.[40]

The health sector in Ethiopia is guided by its Health Sector Transformation Plan (HSTP-II) 2020/2021-2024/2025, which aims at improving the health of its population through the realization of accelerating progress towards Universal Health Coverage (UHC), protecting people from emergencies, creating Woreda transformation and making the health system responsive to people's needs and expectations. To measure progress towards these objectives, HSTP-II targets are aligned with the country's national 10-year development plan and international targets such as the Sustainable Development Goals (SDGs).

In terms of health sector coordination, as the below figure indicates, there are a multitude of existing health coordination mechanisms:

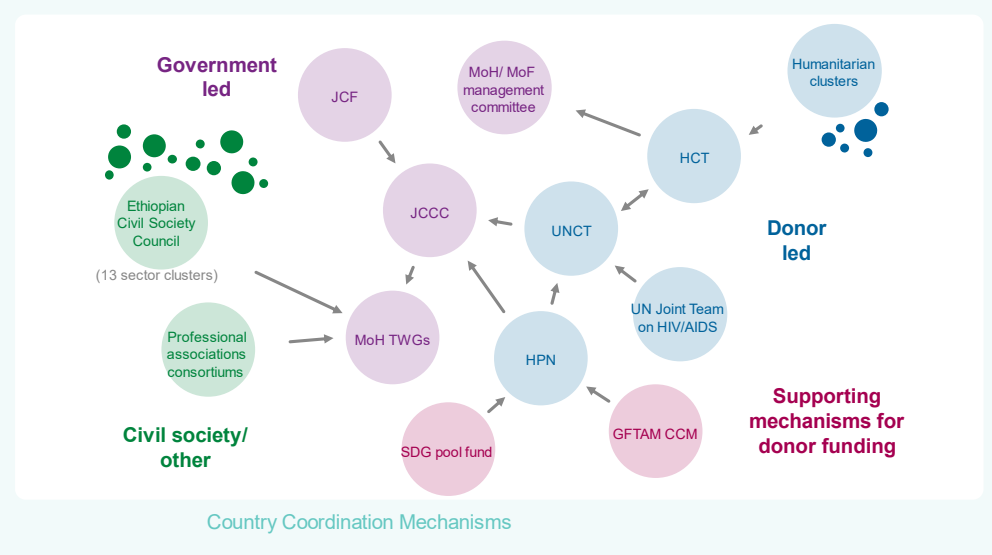


Figure 3: Health Coordination Mechanisms

According to stakeholders interviewed, the most effective and frequently meeting are the JCCC (MoH-led) and the HPN (partner-led). The MoH holds regular Joint Steering Committee (JSC) meetings every two months, and Executive Committee Meetings take place with agencies every two weeks. These platforms are intended to support the health sector by regularly reviewing and monitoring the performance against set targets and make timely decisions. Joint Consultative Forum (JCF) meetings are held regularly between MoH and donors. The Joint Core Coordinating Committee (JCCC) meetings between MoH and developing partners address technical and operational issues. The Health Sector Transformation Plan outlines that the effectiveness of these is limited due to high turnover of leadership at all levels, which has affected the overall

[38] Ministry of Health – Ethiopia (2020), National Health Equity Strategic Plan 2020/21 – 2024/25, Accessed: https://www.afro.who.int/sites/default/files/2022-08/National%20Health%20Equity%20Strategic%20Plan-June%2027.pdf
[39] Ministry of Health – Ethiopia (2020), National Health Equity Strategic Plan 2020/21 – 2024/25, Accessed: https://www.afro.who.int/sites/default/files/2022-08/National%20Health%20Equity%20Strategic%20Plan-June%2027.pdf
[40] World Health Organization (2023), WHO expresses concern for escalating public health needs in Ethiopia, Accessed: https://www.afro.who.int/countries/ethiopia/news/who-expresses-concern-escalating-public-health-needs-ethiopia?country=30&name=Ethiopia

implementation, monitoring, and evaluation of the health sector plan, as well as weak institutional capacities, low ownership and governance mechanisms, and suboptimal integration of vertical and horizontal components.[41]

FINDINGS

Coherence

The evaluation team found that there was a very low level of shared understanding and ownership of the SDG3 **GAP** and its purpose and intended results by both signatory agencies and national partners. In the context of Ethiopia, there does not appear to have been a clear mechanism for translating the SDG3 GAP as a global initiative to country level, country level plans and actions, or clarity SDG3 GAP leadership or who 'owns' and is responsible/accountable for the SDG3 GAP. None of the stakeholders interviewed were aware of outreach or communications regarding the SDG3 GAP from either the SDG3 GAP Secretariat or signatory agencies. Furthermore, individual WHO stakeholders (and not all) were the only group to have any awareness of the SDG3 GAP, and this was because of them having worked in other contexts where the SDG3 GAP had been socialized more. Respondents with explicit roles regarding coordination (health cluster team, UNRCO) were unaware of the SDG3 GAP.

However, the government's Health Sector Transformation Plan (HSTP-II) 2020/1-2024/5 is well aligned to the SDGs, with a particular focus on accelerating progress towards UHC and health financing, given Ethiopia is planning to move towards becoming a lower middle-income country over the next five years, and that external financing is likely to continue to decline.[42] This is supported by a National Health Equity Strategic Plan,[43] which aims to address disparities in access, coverage and quality of high impact interventions among regions, zones, woredas and health facilities. Consensus among stakeholders interviewed was that there is strong alignment between health-focused signatory agencies and the government's own health priorities and plans.

Given stakeholders' lack of familiarity with the SDG3 GAP, the evaluation was unable to identify evidence that the SDG3 GAP has provided signatory agencies with a solid foundation for stronger coherence in terms of better alignment and coordination. There is limited evidence to show signatory agencies' operational, and financial strategies, policies and approaches incentivize coherent, effective and sustainable collaboration; nor is SDG3 GAP consistently referenced or present in agency-specific strategies and plans. That said, there are a number of other mechanisms at the country level that have provided foundations for greater coherence of inter-agency collaboration and coordination (as outlined in the context section).

While the SDG3 GAP does not appear to have specifically provided incentives in the Ethiopian context for enhanced coordination, alignment and collaboration (i.e. no catalytic funding, no SDG3 GAP human or financial specific resources, no SDG3 GAP country plan, no SDG3 GAP badged activities), a number of broader incentives were identified, including:

- Examples of joint programming. The UNFPA-UNICEF Joint Programme on the elimination of Female Genital Mutilation was thought to have incentivized collaboration, as it had enabled participating agencies to make efficiencies and cost savings, further the geographical scope they worked in and enhance their learning.
- Funding mechanisms such as the SDG Performance Fund (SDG PF), which is a pooled funding mechanism managed by the Federal Ministry of Health are perceived by government stakeholders as further enhancing and incentivising alignment as the government has more flexibility to align it to its own priorities which may be less prioritised by donors (such as NCDs and mental health).
- The Health Harmonization Manual and Guideline,[44] which is approved by donors and government was being revised at the time of the CS visit with support from GFF and is accompanied by a diagnostic assessment.[45] This

[41] Health Sector Transformation Plan (HSTP-II) 2020/1-2024/5 https://faolex.fao.org/docs/pdf/eth208376.pdf
[42] Health Sector Transformation Plan (HSTP-II) 2020/1-2024/5 https://faolex.fao.org/docs/pdf/eth208376.pdf
[43] National Health Equity Strategic Plan 2020/21-2024/25
[44] Alignment Framework: Ethiopian Harmonized Action Plan, February 2023
[45] Alignment Diagnostic Assessment Consolidated Findings: Ethiopian Pilot Report

reflects a key effort by one of the SDG3 GAP signatory agencies to support better alignment of the health sector partners by promoting the 'one plan, one budget, one report' principle, and focus on strengthening government leadership. The report establishes a baseline of a country's alignment status applying a diagnostic assessment tool and a maturity model along the three alignment sub-domains.

- The COVID-19 pandemic was perceived as having been a significant driver for enhanced coordination, as it created an imperative for organizations to work together, flexibly and rapidly to respond. However, whist a number of stakeholders spoke positively about coordination during the pandemic, there was a sense that organizations had returned to a 'business as usual' approach with more siloed ways of working.
- The opportunity for joint advocacy by partners to government was cited as an incentive to alignment and coordination as partners were able to lobby government more effectively. An example provided was in terms of gender-based violence (GBV) work in emergency contexts, where UN agencies were able to raise awareness on this to the government through the humanitarian cluster. As a result, this area of work has been recognized as a shared priority, becoming one of the areas tracked under Pillar 1 of the UNSDCF and being relatively well-funded in the humanitarian response. Non-health aspects of GBV were reported to be less consistently supported.

Stakeholders interviewed also identified a number of structural disincentives to alignment, coordination and collaboration, including:

- Frequent competition between agencies for resources and competing mandates which discouraged coordination and led to a lack of transparency/trust on resources for health.
- Competition was exacerbated by certain donor behaviours; in some cases, a lack of coordination between humanitarian and development funding streams was noted, with a lack of communication within the donor organizations.
- A lack of explicit accountabilities for agencies to coordinate and align was highlighted as 'ways of working' were often not included or reported on in results frameworks and there was little awareness of how to measure this.

While these are not specific to the SDG3 GAP, they serve to illustrate some of the structural challenges regarding coordination, collaboration and alignment that the SDG3 GAP or similar to address going forward.

Effectiveness

Given the lack of awareness of the SDG3 GAP reported by respondents and the fact that the evaluation was unable to identify any specific SDG3 GAP activities, it is not possible to measure any specific results that the SDG3 GAP has achieved or contributed to.

The SDG3 GAP Progress Report heat map indicates highly positive results regarding the health coordination environment in Ethiopia, as presented in Table 2 below. As noted in the progress reports, this is a subjective assessment, and the wording of the questions does not specifically ask respondents to attribute results to SDG3 GAP. The identity of the questionnaire respondents was unclear at the country level, as no government officials interviewed had any knowledge of it. Because of the lack of awareness of SDG3 GAP at a country level and the lack of identified activities linked to SDG3 GAP, it is not possible to assess the contribution of SDG3 GAP to these results.

Table 4: SDG3 GAP Heat Map Results for 2022-2023

Year	Criteria					
	Aligned to plans	Coordinated with each other	Aligned to budget	Uses local monitoring systems	Joint TA plan	Uses local coordination mechanisms
2022						
2023						

The levels of alignment, coordination and collaboration were instead attributed to:

- Strong government ownership and capacity at a federal level to set national strategy, to convene donors and to hold agencies and donors to account. While several respondents noted that capacity of government in this area may have been stronger in the past, they highlighted good examples of government-led coordination on key health priorities. The Multi-donor Compact for family planning, first signed by the Government and UNFPA, allowed mobilizing four additional donors to bridge the gap on acute family planning needs.
- The Joint Country Coordination Committee (JCCC) (MoH-led) and the HPN (partner-led) were cited as amongst the most effective coordination mechanisms, which provided a communication and engagement platform for development actors for information sharing, joint planning and alignment.
- While the humanitarian situation in Ethiopia creates some challenges in terms of coordination, it was perceived as also helping, in some cases, drive 'coordination by necessity' as organizations were forced to collaborate to respond to crises.
- The Resource Mapping and Expenditure Tracking Tool, developed by the government to track both domestic and donor resources, is a relatively new innovation but is seen as a key mechanism as part of the health financing reform for mutual accountability between the government and partners.

However, there were a number of factors identified which were considered to have a negative impact on alignment, coordination and collaboration. They included:

- As outlined in Figure 1, there are a multitude of health coordination mechanisms in Ethiopia. A number of stakeholders highlighted potential duplication and inefficiency as a result of this; often the same designated staff member attends multiple meetings for each of the different mechanisms, which overlap (particularly for technical working groups). In contrast, meetings for a particular mechanism are attended by a different stakeholder each time, leading to a lack of follow-up on agreed actions. Coordination meetings were also not always timely and in some cases, stakeholders reported, were not attended by senior colleagues with decision-making power.
- While the MoH at the federal level was perceived as having high levels of capacity to coordinate, this was thought to have been negatively impacted by the recent HR transformation plan in the ministry, which had led to high levels of staff turnover and changes to roles. It was also reported that there were varying levels of capacity at a decentralized level.
- The multi-sectoral health response is well outlined in the National Sector Development Plan; and the Ministry of Finances and of Planning and Development are closely involved in tracking the health sector budget and performance. However, government respondents from different ministries, as well as SDG3 GAP signatory agencies, have indicated that the multi-sectoral health response coordination is weak, in particular in terms of integrating work on health equity, gender and social determinants of health across relevant to line ministries. This is also reflected in the lack of involvement of non-health specialist SDG3 GAP signatory agencies in the health coordination platforms.
- Repeated emergencies and conflict in Ethiopia have had a significant impact on the health system, leading to the destruction of facilities during conflict, resources being diverted to emergencies, less government oversight of humanitarian resources compared to development, challenges in access and health emergencies surveillance and in obtaining accurate data and due to weaknesses in humanitarian-development nexus approaches.
- While Ethiopia has the Resident Coordinator Office and the UNSCDF, this is relatively nascent and does not yet have sufficient buy-in across agencies to support effective coordination.
- Data and the quality of health information was cited as a challenge as there are data gaps and data quality challenges. The lack of joint surveys and different methodologies used by agencies was also highlighted as a gap.

- There were gaps noted in the alignment of planning of technical assistance provided by agencies, leading to duplication or needed posts being unfunded.
- Some stakeholders in signatory agencies observed that there have been some gaps in leadership in key agencies (and relationships with government) during the time period under review, and these gaps are cited as having created challenges at times in coordination and alignment. This includes the Ethiopia government expelling the heads of seven agencies in 2021,[46] and the fact that WHO has had an acting rather than permanent country representative for the last two years.

Achievement of SDG3 Targets

As the table below indicates, there has been positive performance across a number of the key SDG3 targets in Ethiopia between 2015 and 2021. As stated previously though, there is no evidence that the SDG3 GAP has contributed to these improvements.

Indicator	2015	2021
MMR per 100,000 live births	399.2	266.7 (2020)
Under-5 mortality per 1000 live births	62.4	46.8
TB incidence per 100 000	192	119
HIV infections per 1000	0.19	0.12
Surviving infants receiving 2 WHO recommended vaccines	56	54
UHC coverage (%)	37	38 (2019)
Medical doctors/10 000	0.25 (2009)	1.04 (2020)

It is also important to note that health data availability and quality was cited as a significant challenge in almost all interviews with stakeholders. The most recent (mini) Demographic Health Survey was completed in 2019 and that the results presented above are a projection, with the next survey planned for next year.[47] Therefore, is not possible to determine the full extent of how these results may have been affected by the COVID-19 pandemic or recent conflicts.

There are no Ethiopia-specific results linked to the SDG3 GAP reported in any of the progress reports, with the exception that the 2022 report references a study by UNDP, UNFPA, UNICEF, UN Women, WHO, UNU-IIGH and UNAIDS on "What Works in Gender and Health in the United Nations: Lessons Learned from Cases of Successful Gender Mainstreaming across Five UN Agencies", which includes reference to Ethiopia. This study, however, covers the period from 2001 onwards and so the results cannot be clearly linked to the SDG3 GAP.

Contribution of GAP agencies on cross-cutting accelerator themes

The 2022 SDG3 GAP Progress report highlights the Research and Development, Innovation and Access accelerator as being the key focus in Ethiopia. However, the evaluation was unable to identify any specific activities or results with regards to this accelerator.

GAP signatory agencies in Ethiopia have undertaken significant work on PHC and sustainable health financing, two of the seven GAP accelerator themes. The evaluation's ToC offers a model to test proposed pathways through which GAP agencies are expected to contribute to PHC and sustainable health financing results.

[46] https://press.un.org/en/2021/sc14657.doc.htm
[47] Mini Demographic and Health Survey 2019

PHC accelerator

According to the evaluation's reconstructed theory of change, GAP agencies are expected to support countries to develop PHC support packages of essential services to contribute to UHC. This would lead to improved access to more equitable quality PHC services, thus contributing to more equitable and inclusive progress towards health-related SDGs.

This pathway has been partially verified in Ethiopia. GAP signatory agencies have invested significant resources in supporting direct health services provision at primary care level. UNICEF and WHO support to Ethiopia's COVID-19 response has been effective in ensuring the continuity of essential health services, contributing to 97% of health facilities continuing to provide essential health services during the COVID-19 pandemic, according to the UN annual report of 2022. WHO, UNICEF and UNFPA also supported the MoH in preparing the Health Sector Transformation Plan II and the review of the Essential Health Service Package (EHSP) in 2019.[48] A key strategy for implementing the Health Transformation Plan is the Ethiopian National Healthcare Quality Strategy (NHQS). The strategy outlines that partners working on vertical or technical programmes are expected to integrate their efforts in one plan. Hence, there is a strong drive from the MoH to ensure the coordination of efforts from partners in supporting PHC services.

These efforts have improved availability of health services in key areas, contributing to improving health outcomes in some areas. In particular, the reduction in maternal, under-5 and infant mortality rates, as well as the decline in morbidity and mortality from communicable diseases such a malaria, HIV, tuberculosis and vaccine-preventable diseases are attributed to the strengthening of PHC services[1]. However, available data on health care personnel and coverage of services point to enduring gaps in primary health care services availability and access (see Table 1).

Sustainable Health Financing

According to the reconstructed ToC, a key expected output in terms of sustainable financing from the GAP is to improve joint support to countries on health financing for equity. As a result, health financing functions would be strengthened, with a focus on equity and recovery from COVID-19. This would, in turn, lead to improving access to health and having the national health plans and priorities sustainably financed.

With support of health partners such as the World Bank, the healthcare financing strategy has been revised to achieve UHC in the country. Initiatives have been implemented to enhance the financial risk protection system for accessing essential health services. They include high-impact interventions free of charge through an exemption programme; subsidization of more than 80% of the cost of care in public health facilities; implementation of community-based health insurance (CBHI) schemes; and full subsidization of the very poor through fee waivers for both health services and CBHI premiums.

GFF has supported the development of a Harmonized Action Plan for progressing towards "One plan, One Budget and One report". For alignment of health financing efforts, this translates into improving resources mapping and tracking of expenditures through the DHIS 2, enhancing the collaboration between MoH and Ministry of Finance, mobilizing resources, increasing the amount of external resource flow to the health system through direct budget support such as the SDG Partners Fund, and enhancing the alignment of development partners to use government systems.

However, these efforts on alignment are still nascent and available data does not reflect progress on domestic health financing and mobilization of external resources to support the health system. According to the SDG voluntary national review (VNR) of 2022, the share of government budget allocated to the health sector increased from 7.8% in 2016 to 10.5% in 2021, below the 15% target of the Abuja Declaration. While households covered under the CBHI program increased in the last six years, the UNSDCF (2020) mentions that less than 5% of the population is covered by any form of health insurance.

[48] Ethiopia Ministry of Health (2021) National Health Transformation Plan II

Sustainability

As outlined previously, given the lack of awareness of the SDG GAP at a country level, there were no specific outcomes identified linked to the SDG3 GAP and so it is not possible to assess sustainability. However, the evaluation is able to identify a number of relevant considerations around the sustainability of alignment and coordination efforts by SDG3 GAP signatory agencies.

Ensuring adequate health financing remains a key challenge going forward in Ethiopia as the country moves to becoming a lower middle-income country over the next five years.[49] The 2022 Health Financing Progress Matrix assessment found that although there is strong leadership and coordination in the sector as a whole, there are deficits at different levels in terms of leadership and coordination to achieve health financing goals due to the different challenges faced by facilities' and institutions' governing body processes. It recommends "well organized implementation plans should be developed at all levels of the health system to strengthen capacity to analyse health financing requirements, implement new strategies, and monitor and evaluate progress in health financing policy implementation."[50] The health system continues to rely on out-of-pocket (OOP) expenditure and external funding, representing circa one-third of total health expenditure respectively. The percentage of total government recurrent expenditure allocated to health is low at 4.8% and has remained fairly constant over the past decade. Shifting from reliance on OOP payments, donor funding and voluntary contributions, to the increasing role of government health budgets would help make health financing more equitable and sustainable as Ethiopia graduates to middle-income status.

In addition, on the health partners side, while respondents widely acknowledge the need for the government to lead planning and budgeting of the health response, funding practices by health partners do not always align to this principle. The assessment conducted as part of the GFF-supported initiative on revising the health harmonization manual[51] highlights that funds channelled through the SDG pool fund have been decreasing over the past few years, while financial support to the health sector was increasingly channelled through off-budget support. This may highlight the tension between long-term system strengthening and the need for agencies to account for accelerating progress on health outcomes through targeted programmes.

Areas of consideration going forward

At the country level, the following considerations should be addressed:

- Given the relative nascency of the UNRCO and UNSDCF, it would be helpful to consider how this existing mechanism can be supported more effectively to foster coordination and joint advocacy.
- Recognizing the context of protracted and successive emergencies in Ethiopia, it would be important to consider how a mechanism like the SDG3 GAP could contribute to strengthening interlinkages between development and humanitarian work in terms of planning, data sharing, coordination and collaboration. Recognising Ethiopia's size and diversity of its population, epidemiology and the current conflicts, as well as its decentralized health system, consideration of how a mechanism like the SDG3 GAP can contribute to strengthening regional/woreda level coordination going forward would be helpful.

At the global level, the following considerations should be addressed:

- Given low levels of awareness and traction of the SDG3 GAP in Ethiopia, it would be helpful to consider how global commitments such as SDG3 GAP will be institutionalized to be effective at country level going forward. For example, should commitments have country-specific action plans, designated resources, and how regional offices could better support the socialization of global commitments like SDG3 GAP in countries. Additionally, it would be helpful to consider how the meaning and actions required by the SDG3 GAP could be communicated effectively to country teams.

[49] Ayal Debie, Resham B. Khatri and Yibeltal Assefa, Contributions and challenges of healthcare financing towards universal health coverage in Ethiopia: a narrative evidence synthesis, 2022
[50] WHO Health Financing Progress Matrix assessment Ethiopia 2022 Summary of findings and recommendations
[51] A Alebashew, E Yilma (2022) Alignment diagnostic assessment consolidated findings: Ethiopia report

- At both the global and country levels, clearer articulation of the intended results of the SDG3 GAP, along with measurable contributions to country-level outcomes, would enhance its implementation and facilitate better integration of coordination and alignment into agencies' M&E frameworks.
- Exploring whether and how mechanisms like the SDG3 GAP can complement and support key country-level alignment initiatives, such as Ethiopia's recent GFF-supported harmonization plan, which aims to foster meaningful partnerships among stakeholders, ensure country ownership, revitalize efforts toward harmonization, and improve aid effectiveness. Additionally, it examines how joint programming and joint reporting can be further incentivized
- Recognizing that there are a number of challenges cited around coordination which go beyond a single country or context, further consideration should be given to how a mechanism like the SDG3 GAP can be used as an advocacy tool to address structural challenges affecting coordination like donor behaviour, joint accountability and issues of agencies' mandate overlap.

5.3: Jordan Country Study

EXECUTIVE SUMMARY

Country case studies are one of a range of data collection methods used to gather data on the implementation of the SDG3 GAP for the Joint Evaluation. As part of the Jordan country study, more than 50 key informants were interviewed 17-21 March 2024. Evaluation questions were adapted to the Jordanian context and more than 80 documents were shared by signatory agencies for review prior to and during the country visit. Debriefs and validation presentations were made following the visit.

The Jordan country study finds that SDG3 GAP has not found traction in Jordan. While the signatory agencies have aligned well their efforts around the country's priorities via national strategic plans, this is a well-established practice and cannot be attributed to the SDG3 GAP. Indeed, this review showed that the development of Joint Work Plans has been done more for compliance purposes rather than focusing on genuine areas of potential cooperation. Likewise, there is little evidence that in Jordan that the SDG3 GAP has accelerated progress through joint actions and/or deliverables, supported the country in a resilient recovery toward the health-related SDGs, nor prompted reviews and learning to enhance accountability. That is not to say that the principles of alignment, harmonization, information sharing, and accountability are not being applied in Jordan, but rather they were done in the absence of an active SDG3 GAP environment.

The enablers[52] for successful implementation of the SDG3 GAP are not sufficiently embedded. Understanding and ownership of SDG3 GAP is uneven at the country level, with diminishing visible leadership from the signatory agencies' headquarters having slowed GAP implementation. There is very limited understanding of GAP objectives, results and corresponding indicators. A clear disconnect between the intent of the global commitment made by signatory agency Principals and country implementation is noted. Likewise, a lack of guidance for the country and poor trickle down of information from HQs coupled with a lack of political-level engagement with SDG3 GAP was noted as having slowed GAP implementation. COVID-19 pandemic and the subsequent urgent need to respond was identified as the primary catalyst and main driver for enhanced inter-agency co-ordination and collaboration: coordination and collaboration by necessity.

The use of country-level Joint Work Plans, developed to support Jordan's UN Sustainable Development Cooperation Framework (UNSDCF) has not yet significantly improved collaboration and coordination, with silos remaining. The mechanics of the joint work plans have not yet facilitated highly coherent and nor harmonized operational and financial strategies, policies, and approaches for inter-agency collaboration. Jordan does not receive SDG3 GAP catalytic funding. Nonetheless, documentary evidence shows a high level of alignment in strategic documents and planning instruments with national strategies and plans. There is limited evidence to show signatory agencies' operational, and financial strategies, policies and approaches incentivize coherent, effective and sustainable collaboration nor is SDG3 GAP consistently referenced/present in agency specific strategies and plans. No heat map data is available to show progress against the indicators.[53] There are no Jordan-specific results linked to the SDG3 GAP reported in any of the progress reports.

In relation to engagement and coordination with national counterparts, there are strong working relationships between signatory agencies and the MoH, Ministry of Planning and International Cooperation (MOPIC) and other national government counterparts. A constellation of coordination mechanisms, which include key stakeholders beyond the SDG3 GAP signatory agencies and provide opportunities for information sharing and inter-sectoral co-operation. Coordination platforms for the Jordan health sector are increasingly led by national counterparts. General SDG tools are being utilized to improve mutual accountability (e.g. Voluntary National Review), with joint accountability focused primarily where there are joint programmes. Nonetheless, the health sector remains fragmented.

[52] Ownership and engagement; communication and vision; incentives; political ownership; organisational norms and standards; coordination and planning

[53] Aligned to plans; Coordinated with each other; Aligned to budget; Uses local monitoring systems; Joint TA plan; Uses local coordination mechanisms

SDG3 GAP Accelerators topics have provided opportunities to collaborate on specific technical areas (e.g. PHC; data/ digital health; NCDs; mental health; immunization), though there is very limited evidence to isolate SDG3 GAP's contribution to demonstrate accelerated progress towards achieving the SDG3 targets. Given this limited awareness, socialization and explicit implementation of SDG3 GAP initiatives, it is highly probable that any potential momentum of SDG3 GAP will not be sustained in the medium- to long-term unless further deliberate action is taken. The SDG3 GAP Accelerators do provide a potential framework for inter-agency coordination in Jordan; specifically, on PHC, social determinants of health, data and digital health, heath financing, and community and civil society engagement.

INTRODUCTION

The Joint Evaluation of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), has been commissioned by the GAP signatory agencies. Established in 2019, SDG3 GAP is a set of commitments by 13 multilateral agencies (GAVI, GFF, ILO, the Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, UNITAID, UN Women, World Bank, WFP, WHO) to strengthen their collaboration for better health. Under the SDG3 GAP, agencies commit to align their ways of working to provide more streamlined support to countries and reduce inefficiencies. It offers a platform to improve collaboration among the significant stakeholders in global health, with specific but complementary mandates.[54] Although referred to as a Global plan, the added value of the SDG3 GAP is intended to lay in more effectively coordinated support, action and progress at a country level.

The acceleration of progress on the health-related SDGs is geared through 7 Accelerators: i) Primary Health Care; ii) sustainable finance for health; iii) community and civil society engagement; iv) determinants of health; v) innovative programming in fragile and vulnerable settings for disease outbreak responses; vi) research, development, innovation and access; and vii) data and digital health.

PURPOSE, OBJECTIVE AND SCOPE

The purpose of the evaluation is to inform signatory agency's learning, continued improvement and mutual accountability to each other as partners. The objective of this evaluation is to assess the coherence, effectiveness, and sustainability of the SDG3 GAP collaboration efforts – at the country, regional and global levels - in accelerating country progress on the health-related SDG targets.

To this extent, the SDG3 GAP evaluation seeks to assess the extent to which signatory agencies have strengthened their collaboration to:

- engage with countries better to identify priorities;
- jointly plan and implement programs;
- harmonize operational and financial strategies, policies and approaches;
- review progress and learn together to enhance shared accountability; and,
- accelerate progress in countries through joint actions on the health-related SDGs.

The temporal scope of this evaluation is the period September 2019 to March 2024. It has been conducted at the global level and includes of a series of 'deep dive' country case studies, of which one is Jordan. The 'deep dive' country studies serve as a tool in this evaluation to explore questions of process, experience, relationship and actors in context, including a better understanding of barriers and facilitators to activities as directly experienced. This document serves as an aide memoire for the Jordan study.

Overall, the purpose of this joint evaluation is to inform partners' learning, continued improvement, and mutual accountability to each other as partners. Because signatory agencies of the SDG3 GAP are committed to reviewing progress and learning together to strengthen collaboration and to enhance shared accountability, the evaluation will identify areas

[54] SDG3 GAP website https://www.who.int/initiatives/sdg3-global-action-plan

where signatories are performing well, as well as those where they need to improve the coherence between their actions and commitments so they can better support countries to advance in their health-related SDGs.

METHODOLOGY

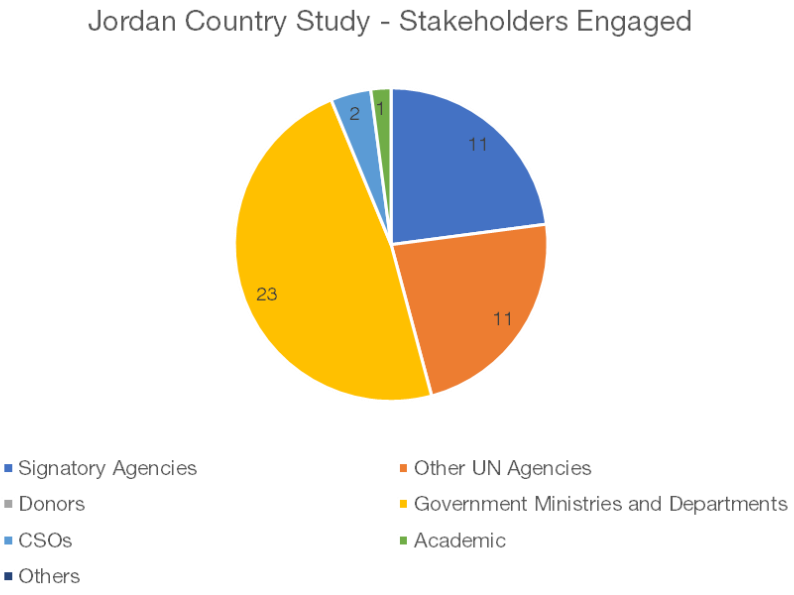
The evaluation uses a theory-based approach, using a reconstructed theory of change that reflects the common understanding of the evaluation team and SDG3 GAP agencies represented in the Evaluation Reference Group (ERG) and Evaluation Management Group (EMG) of the SDG3 GAP. Given the nature of the SDG3 GAP, an enabling mechanism to support better use of existing resources, a contribution analysis based on testing expected change pathways and assumptions is particularly adapted to the object of the evaluation.

The Jordan case study adopted a mixed methods approach using both quantitative and qualitative data sources. Quantitative data reviewed includes health epidemiological and health-financing data, sourced from the Global Health Observatory[55], the World Bank SDG data bank[56] and the Global Burden of Disease country data.[57] A qualitative review of more than 80 documents was also conducted as part of this case study.

Primary data was collected during a country visit conducted between 17-21March 2024 by two members of the evaluation team for five working days in Jordan, followed by remote follow up interviews. The views of a range of stakeholders, both directly involved in the SDG3 GAP and relevant to the scope of work were sought to ensure maximum representation of a diversity of perspectives. Over 50 respondents were consulted through a series of semi-structured interviews and group discussions conducted with signatory agency staff, government stakeholders from the Ministry of Health and Ministry of Planning and International Cooperation (MOPIC), civil society organization, professional associations and academia working in the field of health and other relevant donors active in the health sector. Debriefs and validation presentations were made following the visit. The number of stakeholders interviewed as part of the Jordan country study are given in Figure 1.

This aide memoire has been developed to provide a record of the visit and present findings against the three evaluation criteria (effectiveness, coherence, and sustainability) to inform the overall evaluation report.

Figure 1: Jordan country study stakeholder engagement



[55] https://www.who.int/data/gho
[56] https://databank.worldbank.org/source/sustainable-development-goals-(sdgs)
[57] https://www.healthdata.org/research-analysis/gbd

COUNTRY CONTEXT

Jordan is nestled in the heart of the Middle East, boasting a rich tapestry of socio-political, demographic, and economic dynamics. Jordan is a constitutional monarchy; King Abdullah II is the reigning monarch. The country has made strides towards democratization, with parliamentary elections held regularly. Yet, Jordan grapples with regional conflicts, notably with multiple refugee crises (e.g., Syrians, Iraqis, Palestinians), and most recently the Israel-Hamas conflict,[58] which strains its resources and social fabric. Jordan hosts an estimated 1.3 million Syrian refugees (12% of the country's population), providing a "public good for the wider global community".[59] The country has maintained a steady average growth rate of 2.5% over the past decade; currently at 2.4% of GDP annual growth.[60]

Demographically, Jordan hosts a diverse population. While the majority are Arab, there are significant Circassian, Chechen, and Armenian communities. The influx of Syrian, Iraqi and other refugees has added to this diversity, challenging infrastructure and services but also highlighting Jordan's generosity in hosting those in need.[61] Economically, Jordan faces challenges despite efforts to diversify its economy. Dependent on foreign aid, tourism, and limited natural resources, it navigates high unemployment, particularly among youth. Initiatives promoting entrepreneurship and renewable energy aim to spur growth and economic stability is a central focus within the Jordan Economic Modernization Vision (JEMV). [62] Within the JEMV one of the pillars for success is Quality of Life and a sub-component to this pillar is healthcare. All national-level documents (e.g., strategies, policies, etc.) are developed with reference to the JEMV.

Jordan's health sector presents a complex landscape shaped by its unique demographic and economic factors. The country's health system comprises both public and private sectors, with the ministry of health overseeing public healthcare, guided by the national Health Strategy. Various private providers also offer services yet are not well integrated into the overall health care system. In recent years, Jordan has made strides in health care infrastructure, expanding hospitals and clinics to improve accessibility. Spending on healthcare as a percentage of GDP averaged between 7.5% to 8% during the 2015-2020 period.[63]

Despite these advancements, challenges persist. One significant issue is the strain on resources due to hosting a large number of refugees, particularly from neighbouring Syria.[64] This influx has tested the capacity of Jordan's health system, leading to increased demand for services. In Jordan, refugees access healthcare through dual systems: one funded by humanitarian aid and the other by the Jordanian government. Humanitarian aid supports clinics and health services specifically tailored for refugees, offering essential care and medication. Meanwhile, refugees also utilize Jordan's public health system, benefiting from subsidized or free treatment alongside Jordanian citizens. This dual approach ensures refugees receive adequate healthcare, alleviating the burden on both humanitarian agencies and the Jordanian healthcare system. It underscores the collaborative effort to address the health needs of vulnerable populations while maintaining the integrity of Jordan's healthcare infrastructure. Through the Health Development Partners Forum (HDPF), agencies advocated for the affordable access to public health facilities for refugees; establishing the Multi-Donor Trust Fund and within it the Jordan Health Fund for Refugees, which reversed the previous refugee decrees (in terms of rates they had to pay) to the uninsured Jordanian rate (the fund pays the difference for all non-Jordanians). The Jordan Health Fund is a special account held by the MoH and has US$109 million; started in 2018 via a joint bilateral agreement (MOPIC, USAID, and Denmark); with oversight provided by committee (USAID, WB, Germany/GF, Qatar, EU, Italy, and more recently Canada who contributed US$30 million to the trust fund).

In terms of health status, Jordan faces typical challenges found in many middle-income countries, such as non-communicable diseases (NCDs) like diabetes and cardiovascular conditions. Mental health is also a growing concern, with

[58] Jordan's King Abdullah II has clearly stated that Jordan will not accept any refugees as a result of the conflict as that would be a violation of Jordan's 1994 peace treaty with Israel.
[59] The World Bank in Jordan:https://www.worldbank.org/en/country/jordan/overview
[60] The World Bank in Jordan:https://www.worldbank.org/en/country/jordan/overview
[61] Per latest estimates from UNHCR (https://data.unhcr.org/en/country/jor), Jordan hosts more than 700,000 refugees or approximately 7% of its population.
[62] https://www.jordanvision.jo/en
[63] https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=JO
[64] More than 85% of refugees in Jordan are Syrian (https://data.unhcr.org/en/country/jor).

efforts being made to address stigma and improve access to mental health services. While Jordan did have more than 1.7 million cases of COVID-19 during the pandemic (and slightly more than 14 000 COVID-related deaths), per stakeholder feedback and research,[65] because of its quick and coordinated response, including the roll-out of the COVID-19 vaccine, impacts on related health indicators (e.g., excess morbidity and mortality) were limited and were mainly seen among the elderly. In other words, while the pandemic did affect Jordan's advances toward the SDG3 goals, those effects were modest and the country should, with a concerted effort, be able to regain some, if not all, of the lost progress.

Table 5: Key SDG3 indicators for Jordan. Source: UN Statistics Division[66]

Indicator	2015	2020	Progress
MMR per 100 000 live births	46.13	41.3	
Under-5 mortality per 1000 live births	20.1	14.6	
Risk of dying from main NCDs	14.9%	15.3% (2019)	
UHC coverage (%)	70	65	
Medical doctors/10 000	27.41	25.13 (2019)	
Proportion of population with health expenditures above 10% of total household expenditure	2.29% (2010)	6.36 (2018)	

To improve the health sector, Jordan is focusing on reforms to enhance efficiency, quality, and equity of care. For example, Jordan's recently launched (March 2023) health strategy for 2023-2025 has as its vision the establishment of an integrated healthcare system to and improve equitable access to diagnostic, treatment, rehabilitation, and palliative care. Goals within the strategy include improving digital transformation, information technology, infrastructure, supply and financial management; improving primary, secondary, and tertiary care services; and improving the efficiency of human resources. These areas align with the JEMV's goals of expanding access to better services for all citizens and through these efforts, Jordan aims to achieve better health outcomes for its population while navigating the complexities of its health care landscape.

FINDINGS

The findings below are presented against the evaluation criteria and respond to the overarching evaluation questions.

6.1. Coherence

Understanding and ownership of SDG3 GAP is uneven at the country level. Few respondents had a comprehensive awareness of SDG3 GAP, though many stakeholders referred to the commitments and priorities/ principles of SDG3 GAP and how these have been enacted by signatory agencies. Cited examples include the UNICEF-WHO mental health joint workplan; UNICEF-WHO school health programming; WHO and IOM (non-signatory) cooperation in TB programming as part of the Global Fund (signatory) grant; and micro-nutrient deficiency joint programming with UNIECF-WHO-UNFPA. Jordan does not receive SDG3 GAP catalytic funding.

[65] https://pubmed.ncbi.nlm.nih.gov/34617910/
[66] SDG Country Profile Tajikistan: https://unstats.un.org/sdgs/dataportal/countryprofiles/tjk#goal-3

Key informants across stakeholder groups when asked in interviews what the purpose of the SDG3 GAP is, and what its results and achievements in Jordan had been to date, concluded that SDG3 GAP has not found significant traction in Jordan, following the global launch in 2019, citing a range of factors hindering progress. They include:

- low levels of awareness of SDG3 GAP across signatory agencies and government counterparts;
- an unclear vision of what success for the SDG3 GAP should look like and unclear roles and responsibilities of signatory agencies in terms of implementing the SDG3 GAP at a country level;
- limited incentives to reinforce organizational cooperation, initiative fatigue and competing priorities at the country level;
- lack of country contextualization and an absence of guidance to translate global plan to national action;
- fragmented information sharing across the signatory agencies.

Whilst SDG3 GAP was created to strengthen inter-agency collaboration, key informants across the stakeholder groups pointed to the COVID-19 pandemic and the subsequent urgent need to respond as a key catalyst and main driver for enhanced coordination and collaboration starting in 2020. While key informants noted that these efforts may have waned since, they still remain better than pre-COVID.

Efforts to enhance inter-agency collaboration in country are present, managed through the UNRCO through a range of mechanisms, including the UNSDCF, which sets out coherent collaborative strategies and approaches. However, the use of Joint Work Plans amongst UN agencies has not yet significantly improved collaboration and coordination, with silos remaining. From signatory agencies there is a perception that the mechanics of the Joint Work Plans as part of the UNSDCF have not yet facilitated highly coherent and nor harmonized operational and financial strategies, policies, and approaches for inter-agency collaboration, though the potential for greater inter-agency collaboration exists should conditions be conducive.

Documentary evidence shows a high level of alignment in strategic documents and planning instruments with national strategies and plans. There is limited evidence to show signatory agencies' operational, and financial strategies, policies and approaches incentivize coherent, effective and sustainable collaboration nor is SDG3 GAP consistently referenced/present in agency specific strategies and plans.

There is a constellation of coordination mechanisms, which include key stakeholders beyond the GAP signatory agencies, and provide opportunities for information sharing and inter-sectoral co-operation, seeking to reduce the risk of duplication. These coordination mechanisms provide opportunities to engage with countries better by jointly aligning their support around country owned and led national priorities and plans and implementing together. This includes, for example, the Health Development Partner Forum (co-chaired by WHO and USAID); the Humanitarian Health Sector Working Group (co-chaired by WHO and UNHCR), which has a series of active sub-groups, including mental health and social support; the H6 Partnership, which harnesses the collective strengths of the UNFPA, UNICEF, UN Women, WHO, UNAIDS, and the World Bank Group to support country leadership and action for women's, children's and adolescents' health.

However, the health sector remains fragmented, characterized by a diversity in providers. It includes public, private, and non-governmental sectors, each offering varying levels of care. Public hospitals and clinics form the backbone of the system, providing subsidized services to citizens and refugees. Private hospitals cater to those who can afford higher fees, offering more specialized care. NGOs operate clinics focused on marginalized populations, including refugees. This diversity creates challenges in coordination and resource allocation and reflects a complex interplay of public policy, market forces, and humanitarian imperatives. Jordan's health landscape therefore requires continued vigilance to ensure unified approaches from the signatory agencies. Recognizing the fragmented nature of the health sector, efforts have been made by signatory agencies and national counterparts to address this (e.g. UHC Roadmap; Mental Health Roadmap; Pharmacovigilance Roadmap; National Strategies); nonetheless challenges remain.

While not always described as such, the SDG3 GAP Accelerators topics have provided opportunities to collaborate on specific technical areas (e.g. PHC; data/ digital health; NCDs; mental health; immunization). For example, the World Bank

and WHO have been core partners in examining the digital health space and providing solutions which the World Bank will support through an upcoming initiative. Similarly, WHO has served as a focal point for PHC efforts both with other signatory agencies (e.g., UNICEF, UNFPA, etc.), non-signatory agencies (UNHCR), government counterparts, and other external development partners (e.g., USAID).

Effectiveness

The SDG3 GAP objective of better alignment and coordination among agencies have seen progress in Jordan; however, the linkages between the SDG3 GAP and the observed changes are tenuous. In relation to engagement and coordination with national counterparts, there are strong and effective working relationships between signatory agencies and the MoH, Ministry of Planning and International Cooperation (MOPIC) and other national government counterparts; with a drive to build capacity and capability of these from signatory agencies. Coordination platforms for the Jordan health sector are increasingly led by national counterparts (e.g. SDG3 National Team and HDPF, supported by USAID and WHO). Likewise, there are a range of coordination platforms for engagement of civil society and to dialogue with government (e.g. Jordan INGO Forum (JIF); Jordan National NGO Forum (JONAF); and the Jordan Strategic Humanitarian Committee (JoSH). Two of the main facilitating factors for ensuring the effectiveness of this coordination, per key informants, are that the push to have national counterparts lead the platforms has resulted in a stronger unified country-owned vision, and because of the country's size (e.g., a population of slightly more than 11 million), many key stakeholders have pre-existing and long-standing professional relationships which enables open discussions and more rapid decision-making.

The establishment of a designated MoH focal point for SDG3 and the Project Management, Planning and International Cooperation Directorate (PMU) has provided a focal point for coordination and collaboration, enhancing national ownership, though this is not directly linked to SDG3 GAP implementation. However, one potential risk is that only a small number of people in the unit are focused on SDG3; political support may wane or disappear and staff turnover remains a challenge to ministries and agencies across the health sector.

Across all stakeholder groups, there is limited understanding of GAP objectives, results and corresponding indicators. In many interviews key informants wanted to know what effective implementation of the GAP should look like. Where there was awareness and understanding of SDG3 GAP, key informants perceived that there had been diminishing visible leadership and this had slowed GAP implementation progress at a country level. In Jordan, the evaluation team found a clear disconnect between the intent of the global commitment made by signatory agency Principles and country implementation with a lack of guidance for the country and poor trickle down of information from HQs. These weak enabling factors were noted by key informants as having significantly hindered implementation. Likewise, the evaluation team found a lack of political-level engagement with SDG3 GAP had slowed GAP implementation progress at a country level. With such challenges, there is very limited evidence to isolate SDG3 GAP's contribution to demonstrate accelerated progress towards achieving the SDG3 targets. Notwithstanding this, tools are being utilized to improve mutual accountability (e.g. Voluntary National Review), with joint accountability focused primarily where there are joint programs (e.g. UNICEF/ WHO). There is scant evidence that the SDG3 GAP has had a significant contribution in terms of accelerating progress on SDG targets. Rather, achievements on improving SDG targets are arguably more linked to vertical programme interventions that have provided targeted investment to services delivery in those areas.

Progress on Accelerators

A range of SDG3 GAP accelerators are covered by agencies in Jordan, including PHC, health financing and data and digital health.

Primary Health Care

According to the reconstructed ToC, a key PHC-related output from the SDG3 GAP would be joint support to countries to develop PHC support packages of essential services to contribute to UHC. This would lead to improved access to more equitable quality PHC services, and more equitable and inclusive progress towards health-related SDGs.

The Government of Jordan is committed to improving health service coverage and ensuring financial protection for its population through progress towards UHC as indicated in SDG 3, Target 8 by 2030. The COVID-19 pandemic showed the importance of strengthening PHC, which requires a strong, efficient and resilient subnational health system to address the threats of the interruption of essential health and social services (e.g. immunization, HIV, nutrition, prevention and control of NCDs and mental health). Even though the country is committed to strengthening PHC, additional efforts are needed as a result of prevailing challenges. WHO is supporting the Ministry of Health through the PHC Measurement and Improvement Initiative to jointly enhance the PHC system. WHO, together with the Ministry of Health and United States Agency for International Development (USAID), is co-chairing the Health Development Partner Forum, focusing on aligning the efforts of international partners with the national agenda. WHO continues to support the Ministry of Health to ensure that PHC acts as the entry point to strengthen the overall health system in efforts to achieve the SDG agenda. This support includes school health and occupational health, as these services are an integral component of PHC and were severely affected by the COVID-19 pandemic. It is not clear whether the SDG3 GAP made a direct, significant contribution; or whether this work would have been undertaken in any event.

Sustainable health financing

According to the reconstructed ToC, a key sustainable financing output from the SDG3 GAP would be joint support to countries to prioritize health financing for equity. As a result, health financing functions would be strengthened, with a focus on equity and building back better in the aftermath of COVID 19. This would lead to improving access to health and having the national health plans and priorities sustainably financed. Health financing has indeed been a key priority in Jordan's health sector. The Government of Jordan is committed to improving health service coverage and ensuring financial protection for its population through progress towards UHC by 2030, as indicated in SDG 3, target 8. The need for a strengthened health financing function has been reflected in national health policies as in the Ministry of Health's Strategic Plan 2018–2022; and 2023–2025. Health financing strategies have focused on revenue, effective organization and pooling of resources, prepayment mechanisms, and strategic purchasing. Efforts have sought to address Jordan's capacity to ensure sustainability of the health financing function. WHO support in this area has included institutionalizing National Health Accounts and tracking the financial risk protection indicator as part of the SGD agenda. Working on these functions has sought to ensure equitable and sustainable health financing and protection against catastrophic payments for the entire population. In recent years, WHO has partnered with national and international partners to support the health financing function. The large EUTF award supported work in this area until 2023 and was complemented by the ongoing UHC-Partnership agreement. Significant work has been conducted to develop Jordan's strategy for health financing and to identify the Essential Benefit Package. It is not clear whether the SDG3 GAP played a significant contributor factor; or whether this work would have been undertaken in any event.

Data and the quality of health information

According to the reconstructed ToC, this accelerator would translate into joint support to national health data systems by SDG3 GAP agencies. This would result in better health data and information system, including disaggregated data allowing to track health equity and LNOB. This would contribute to reaching health related SDG targets by ensuring that decisions are taken based on timely and reliable health data.

Data and the quality of health information was cited as an ongoing issue in Jordan as there are non-standardized metrics used, data gaps and data quality challenges. Efforts to improve the quality and unification of health data are underway, supported by signatory agencies, and should facilitate enhanced coordination and accountability (e.g., the Department of Statistics is working on data unification, and the World Bank has been developing a program of work to support health data digitization) with technical inputs coming from some signatory agency partners such as WHO.

There are active measures in place to address issues of gender inequality and inclusion for both patients and providers. UNFPA, as the signatory agency focal point for gender, collaborated on a study on gender in relation to sexual health / reproductive health and found large inequalities in terms of geographical location between the governates. These issues could be addressed through the task force on gender and/or by working with the National Center for Women.

Monitoring of SDG3 GAP results

The main reporting mechanism is the annual SDG3 GAP progress report, which includes a health map covering six dimensions against which all SDG3 GAP countries have reported in 2022 and 2023. These dimensions are 'scored' by national government focal points against a scale indicating their degree of agreement on the extent to which progress was made. No heat map data is available to show progress against the indicators for Jordan. There are no Jordan specific results linked to the SDG3 GAP reported in any of the Progress reports.

6.2. Sustainability

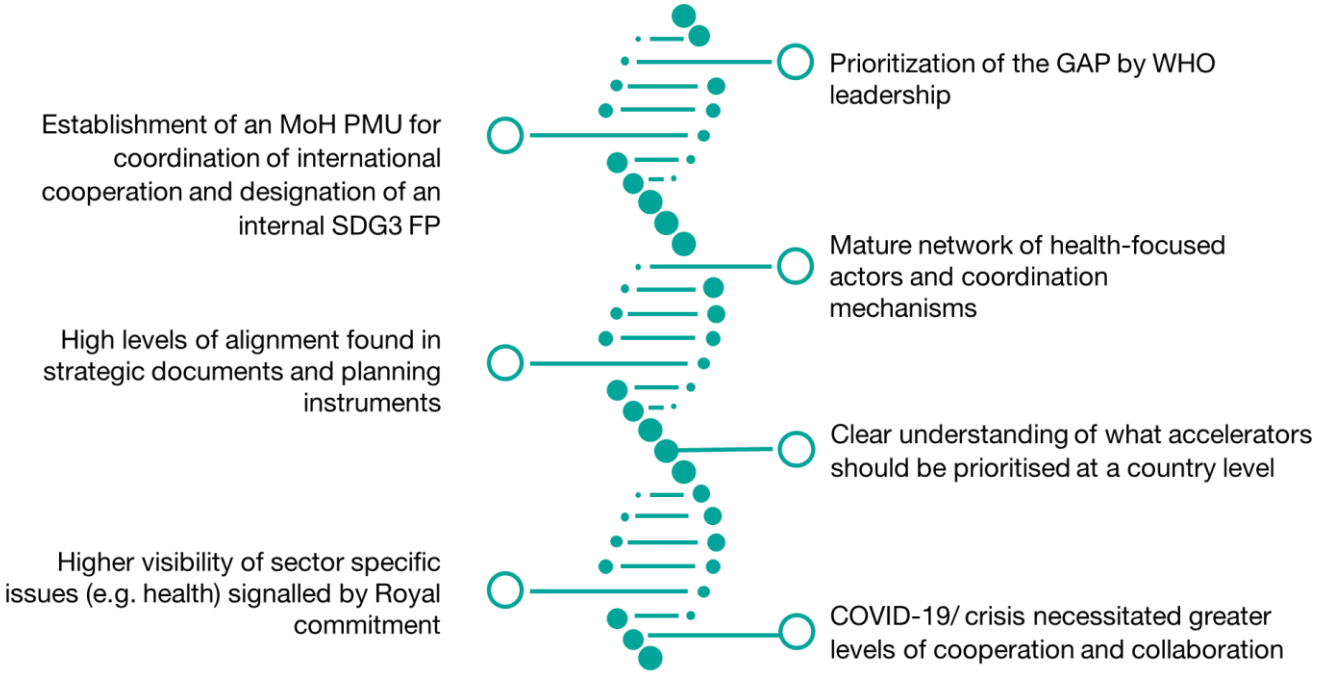
As outlined previously, given the lack of awareness of the SDG GAP at the country level, there were no specific outcomes, nor any specific benefits identified linked to the SDG3 GAP and so it is not possible to assess sustainability. Given this limited awareness, socialization and explicit implementation of SDG3 GAP initiatives, it is highly probable that any momentum of SDG3 GAP will not be sustained in the medium- to long-term unless further deliberate action is taken.

Nonetheless, based on key informant inputs across the stakeholder groups, the SDG3 GAP Accelerators do provide a framework for inter-agency coordination in Jordan; specifically, on PHC, social determinants of health, data and digital health, heath financing, and community and civil society engagement.

7. Factors which have helped drive the SDG3 GAP

During the interviews with key informants, a range of factors were identified as having supported SDG3 GAP implementation at the country level. The figure below highlights these factors.

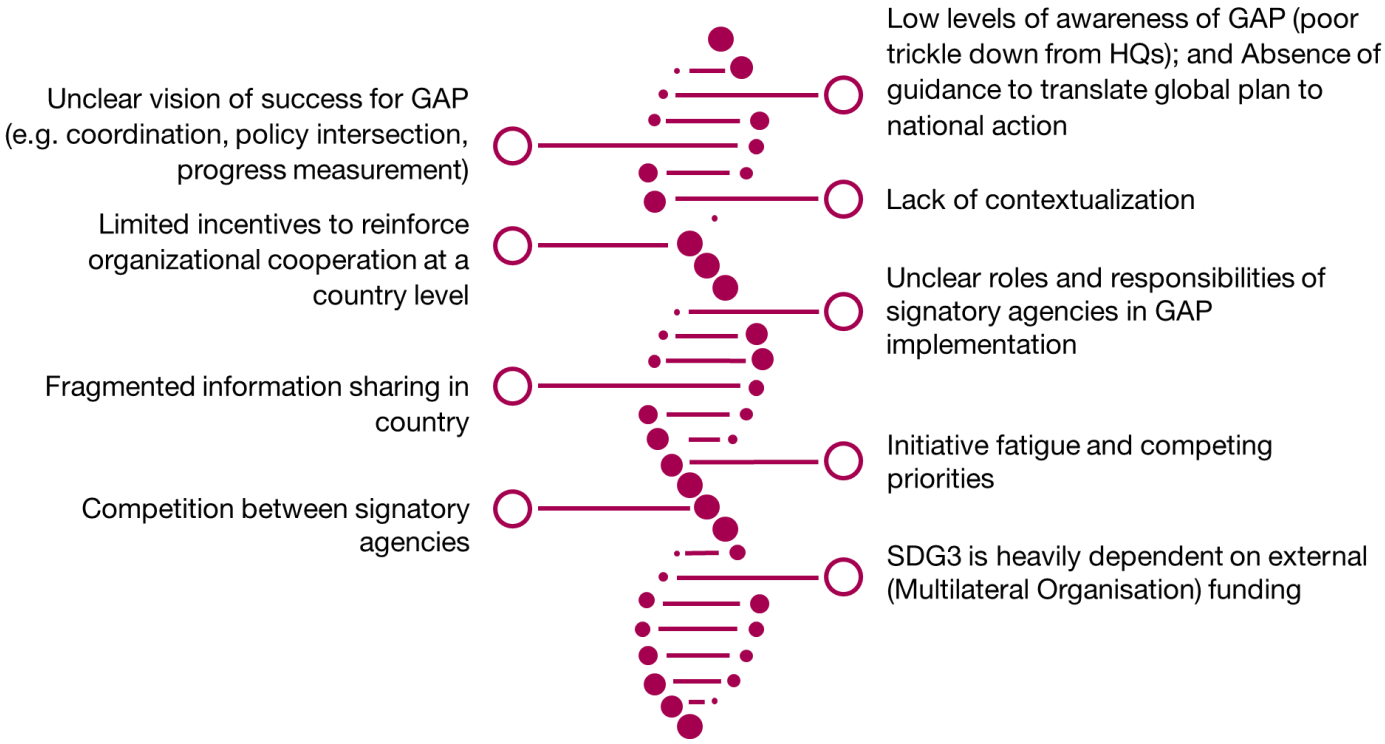
Figure 2: actors helping SDG3 GAP implementation



8. Factors which have hindered the SDG3 GAP

There have been a range of factors identified as having hindered SDG3 GAP implementation at a country level. The figure below highlights these.

Figure 3: Factors hindering SDG3 GAP implementation



9. Areas of consideration going forward

At the country level, the following considerations should be addressed:

- the MoH needs additional support/ technical advice from WHO to develop its leadership in relation to SDG3.
- strategic and planning discussions related to health need to be led by specialised technical experts from within the MoH and with inputs from other knowledgeable and relevant stakeholders (e.g., WHO, UNICEF, UNFPA).
- the Jordan context necessitates a specific implementation plan for SDG3 GAP to fulfil the needs of stakeholders.
- there is a need to ensure the linkages with non-health focused agencies both within the Jordanian government (e.g., between MoH, MOPIC, MoF, etc.) and within signatories (e.g., between WHO, UNICEF, UNFPA, etc. versus ILO, WFP, UNWOMEN) are strengthened with the MoH and WHO leading these efforts respectively;
- there are opportunities to strengthen forums and working groups, beyond information-sharing towards the goals of SDG3 GAP.

5.4 Nigeria Country Study

INTRODUCTION

The Joint Evaluation of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), has been commissioned by the SDG3 GAP signatory agencies. Established in 2019, SDG3 GAP is a set of commitments by 13 multilateral agencies (GAVI, GFF, ILO, the Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, UNITAID, UN Women, World Bank, WFP, WHO) to strengthen their collaboration. Under the SDG3 GAP, agencies commit to align their ways of working to provide more streamlined support to countries and reduce inefficiencies. It offers a platform to improve collaboration among the significant stakeholders in global health, with specific but complementary mandates.[67] Although referred to as a Global plan, the added value of the SDG3 GAP is intended to lay in more effectively coordinated support, action and progress at a country level.

The acceleration of progress on the health-related SDGs is geared through seven accelerators: i) Primary Health Care; ii) sustainable finance for health; iii) community and civil society engagement; iv) determinants of health; v) innovative programming in fragile and vulnerable settings for disease outbreak responses; vi) research, development, innovation and access; and vii) data and digital health.

PURPOSE, OBJECTIVE AND SCOPE

The purpose of the evaluation is to inform signatory agency's learning, continued improvement and mutual accountability to each other as partners. The objective of this evaluation is to assess the coherence, effectiveness, and sustainability of the SDG3 GAP collaboration efforts – at the country, regional and global levels – in accelerating country progress on the health-related SDG targets.

To this extent, the SDG3 GAP evaluation seeks to assess the extent to which signatory agencies have strengthened their collaboration to:

- Engage with countries better to identify priorities.
- Jointly plan and implement programs.
- Harmonize operational and financial strategies, policies and approaches.
- Review progress and learn together to enhance shared accountability; and,
- Accelerate progress in countries through joint actions on the health-related SDGs.

The temporal scope of this evaluation is the period September 2019 to March 2024. It is being conducted at the global level and includes of a series of 'deep dive' country case studies, of which one is Nigeria. The 'deep dive' country studies serve as a tool in this evaluation to explore questions of process, experience, relationship and actors in context, including a better understanding of barriers and facilitators to activities as directly experienced. This document serves as an aide memoire for the Nigeria study.

APPROACH AND METHODOLOGY

The evaluation uses a theory-based approach, using a reconstructed theory of change (Annex 1) that reflects the common understanding of the evaluation team and SDG3 GAP agencies represented in the Evaluation Reference Group (ERG) of the SDG3 GAP. Given the nature of the SDG3 GAP, an enabling mechanism to support better use of existing resources, a

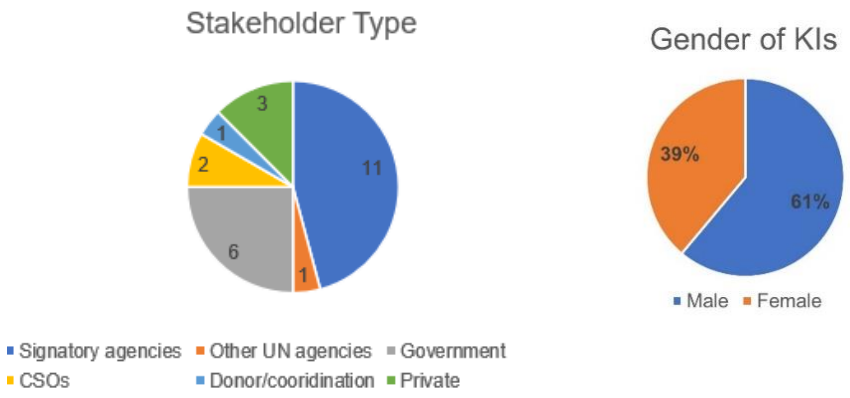
[67] Stronger Collaboration, Better Health; Global Action Plan for Healthy Lives and Well-being for All: https://www.who.int/initiatives/sdg3-global-action-plan

contribution analysis based on testing expected change pathways and assumptions is particularly adapted to the object of the evaluation.

The Nigeria case study adopted a mixed-methods approach and both primary and secondary data collection methods. An extensive document review of 24 key documents (Annex 2) was conducted and a range of KIIs with key stakeholders conducted both in person and remotely during a country visit to Abuja between 8th-15th of March 2024 by one of the core team members, accompanied with local consultant research support and also a Senior Advisor of UNAIDS independent evaluation office, since UNAIDS hosted the Nigeria country case study. A debrief and validation presentation was conducted remotely following the visit to present and validate emerging findings, check data accuracy and identify any data gaps.

Figure 1 shows the country study participants per stakeholder type and gender. 24 interviews were conducted in total and included 54 participants altogether. Of these interviews, 11 were with GAP signatory agencies,[68] one was with another UN agency and 12 were with other partners. A list of KIIs is provided in Annex 3. Gender-disaggregation of participants indicate that 61% of KIs were male and 39% were female.

Figure 4: Respondents per category and gender



In terms of limitations, the most significant was the low level of awareness of the SDG3 GAP at country level; meaning that with the data gathered, it was not possible to answer directly a large number of the evaluation questions. Where practicable, the evaluation team has gathered data regarding the quality and nature of alignment, collaboration and coordination between signatory agencies and multilateral organizations, so as to identify areas where the SDG3 GAP or similar could be impactful to address current challenges.

COUNTRY CONTEXT

Nigeria is the largest country in sub-Saharan Africa in terms of both population and economy. In 2022, the population stood at 218 million[69] and the country is both growing and urbanising; it is expected to be the third most populous country in the world by 2050 and the share of the population living in cities is expected to rise to 70% from 9.4% in 1950.[70] The country is highly decentralised, comprised of 36 states and the Federal Capital Territory (FCT).

ECONOMY

Economic growth has been strong over the last decade at above 7%; though this is now stagnating. The World Bank reported GDP to be US$472.62 billion and GDP per capita to be 2162.6 in 2022.[71] Net ODA received in 2022 stood at

[68] These 11 interviews covered 8 signatory agencies
[69] The World Bank data Nigeria: https://data.worldbank.org/country/NG
[70] UN HABITAT (2023) Nigeria Country brief: Achieving sustainable urbanization.
[71] The World Bank data Nigeria: https://data.worldbank.org/country/NG

US$4.44 billion[72] which was 1% of GNI. National health expenditure remains low; the government spent just 4.4% of its total general expenditures on health during 2016-2019, thus falling short of the 15% commitment of African Union members as part of the 2001 Abuja Declaration.[73] Financing for health in Nigeria comes mostly from three sources. The government (Federal, State and LGA) covers 15%. Private employers and donors finance up to 9% of health expenditure and the remaining 76% of health financing is covered by households.[74]

UN PRESENCE

There are currently 25 UN agencies with a presence in Nigeria, which includes eight of the SDG3 GAP signatory agencies. The UN is implementing 279 Key Programmatic Interventions during the ongoing programme cycle in Nigeria and 67 of these for SDG 3[75]. Of US$428.8 billion available resources for the UN in Nigeria for 2024, by far the greatest proportion has been allocated towards SDG3 at 38.9%.[76]

HEALTH CONTEXT

Despite progress on some health-related SDG 3 indicators including reduction in maternal and child mortality rates[77] and improved access to safely managed WASH services, many of the SDG3 targets are not on track for Nigeria. Table 1 shows progress towards key SDG3 indicators in the country.

Table 6: Key SDG3 indicators for Nigeria[78]

Indicator	2015	2021	Progress
MMR per 100 000 live births	1113.4	1047 (2020)	
Under-5 mortality per 1000 live births	126.4	110.8	
Population using safely managed drinking water service	24.97%	28.42%	
Population with basic HWF	30.2	30.9	
Population using safely managed sanitation service	27.49	31.28%	
Malaria incidence per 1000 at risk per year*GHO	294.11	306.46	
TB incidence per 100 000 *GHO	219	219	
HIV infections per 1000	0.581	0.342	
Risk of dying from main NCDs	17.8	16.9	
UHC coverage (%)	39	38	
Medical doctors/10 000	4.43 (2016)	3.95	
Domestic health expenditure per capita (current US$) *WB	96.28	69.76 (2020)	

The Office of the Senior Special Assistant to the President on Sustainable Development Goals (OSSAP-SDGs) commissioned an independent evaluation of SDG3 with technical and financial support from UNICEF, conducted between 2020-2021.[79] It

[72]The World Bank data Nigeria: https://data.worldbank.org/indicator/DT.ODA.ALLD.CD?end=2022&locations=NG&start=1960&view=chart
[73] OSSAP-SDGs & UNICEF (2022) Healthy lives in Nigeria: Evaluation of the Effectiveness and Impact of SDG3.
[74] OSSAP-SDGs & UNICEF (2022) Healthy lives in Nigeria: Evaluation of the Effectiveness and Impact of SDG3.
[75]United Nations Nigeria: https://nigeria.un.org/en/sdgs/3
[76] United Nations Nigeria: https://nigeria.un.org/en/sdgs/3
[77] Ndamobissi et al. (2023) Progress Towards SDG3 Healthy Lives in Nigeria.
[78] United Nations SDG Country Profile Nigeria: https://unstats.un.org/sdgs/dataportal/countryprofiles/nga
[79] OSSAP-SDGs & UNICEF (2022) Healthy lives in Nigeria: Evaluation of the Effectiveness and Impact of SDG3.

found there to be 'major challenges' in relation to SDG3, with progress towards the goal overall stagnating,[80] partially hindered due to the implications of COVID-19[81] such that the country is unlikely to achieve SDG3 by 2030.[82] The main barriers to progress are largely to do with the health system[83] access to financing and healthcare remain largely unequal with access and quality positively correlated with wealth Nigeria demonstrates very low levels of public financing for health consequently having very high out-of-pocket spending on health care, which was 77% in 2017, much higher than the WHO recommended target of 12-15%.[84]

There is limited access to and poor quality of PHC and this is perpetuated by inadequate capacities of local governance for PHC. Given the country's decentralized structure, state and local governments have the major responsibility for action in meeting SDG targets, but with governance especially at the local government level requiring significant improvements.

FINDINGS

The findings below are presented against the evaluation criteria and respond to the overarching evaluation questions. Given the limited awareness of and uptake of the GAP in Nigeria, it is not possible to answer all the evaluation questions and/or attribute findings to the SDG3 GAP in Nigeria. Examples of initiatives and collaboration/coordination that has been done 'in the spirit' of the GAP are drawn upon.

Coherence

KIIs across the stakeholder group demonstrated an uneven, but generally limited, level of awareness and understanding of the SGD3 GAP in Nigeria. This was observed within six of the eight signatory agencies present in Nigeria. A common view was that there are too many global initiatives within health (and in general) that are initiated from the global level in the UN and expected to be operationalized at the country level. This creates confusion and a lack of appetite for the uptake of new initiatives. Signatory agency KIs gave specific examples of previous global initiatives similar to the SDG3 GAP such as H6 and H6+,[85] and it was frequently emphasized that they thought a second wave of the GAP should be avoided.

The evaluation team noted however, that although a shared understanding and ownership of the SDG3 GAP in itself is limited, there is a definite common understanding and consensus of the most pressing health issues and priorities in Nigeria, reflected in the strong commitment of federal government and other stakeholders towards achieving SDG3 targets – even though this was not always "branded" as the GAP. In 2019, a ranking and prioritization exercise was undertaken by the Office of the Senior Special Assistant to the President on Sustainable Development Goals (OSSAP-SDGs) to identify the priority SDGs for independent evaluation in Nigeria. SDG3 came first with the top score (followed by SDG 4,1,5 and 8 respectively).[86] There was evidence from KIIs with government stakeholders and development partners that the UN has played a key role in the last five years within the health landscape, identifying specific GAP signatory agencies' role, for example UNICEF and UNDP's assistance in the SDG3 evaluation.

The evaluation team also noted that signatory agencies without an explicit health mandate have a key role to play in health too; examples were given from UNDP and UN WOMEN within the signatory agencies: UNDP's role on the UN Basket fund and also collaborating with WHO to bring solar power to hospitals using touch lights for caesarean section; UN WOMEN's work around harmful practices in Nigeria that affect health and on access to SRH services. Beyond the GAP, signatory agencies examples were provided from UNODC, who for example conducted a health needs assessment of women in

[80] UN Nigeria (2022) Common Country Analysis
[81] COVID-19 induced shocks and its implications for human capital development: https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-024-02119-1
[82] UN Nigeria (2022) Common Country Analysis
[83] OSSAP-SDGs & UNICEF (2022) Healthy lives in Nigeria: Evaluation of the Effectiveness and Impact of SDG3.
[84] UN Nigeria (2022) Common Country Analysis
[85] The H6 partnership (formerly H4+) is a joint, global initiative between UNFPA, UNICEF, UN Women, WHO, UNAIDS, and the World Bank Group, intending to increase the volume and coherence of technical support, policy engagement, advocacy and investments; minimizes overlap and duplication and deepens collaboration to improve outcomes in sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH).
[86] Yunusa (2022) Country led SDGs evaluation: Insights from Nigeria. PowerPoint presentation

prisons in 2023.[87] GAP agencies could give further consideration as to how best to work alongside agencies beyond the GAP who do not have core health mandates.

There was evidence of coherent strategies and approaches within signatory agencies and the wider stakeholder group that are assisting stronger collaboration in the health sector, and a recognition from the government that signatory agency work is generally well aligned to national priorities in health, although this is not necessarily directly attributable to the SDG3 GAP. Nigeria has a legal framework, strategic plans and organizations/agencies that include the components and objectives of SDG3 at the federal, state, and local government area (LGA) levels. Key amongst them is the recently launched Sector Wide Approach (SWAp) for Basic Health Care Provision Fund (BHCPF), which KIs talked positively about. It is considered a major entry point for bringing sector actors, including the signatory agencies, together to work efficiently and effectively towards SDG3. KIIs noted, however, that WHO was not involved in the development of the SwAP. This presents an opportunity in the future to ensure active engagement and involvement, and WHO could liaise with FMoH to determine how best they can work together and to also ensure the principles of working and the "spirit" of the GAP are captured. Other strategies to note are National Primary Health Care Development Agency (NPHCDA), Nigeria's Strategy for Immunization and PHC System Strengthening (2018–2028) (NSIPSS), Community Health Influencers, Promoters & Services (CHIPS), the National Health Act (2014), Health Sector Next Level Agenda (2019–2023), the National Health Sector Strategic Plan II (2018–2022) and the National Health Policy (2016). The SDG3 (targets 3.1 and 3.2) are fully streamlined within the current National Strategic Health Development Plan (NSHDP II) and are part of its Strategic Pillar Two (Increased utilization of the Essential Package of Health Care Services), and within Priority Area 4 (Reproductive, Maternal, Newborn, Child and Adolescent Health plus Nutrition). WHO's and other signatory agencies' work is framed around such strategies showing coherence to national priorities, even if not directly because of the GAP.

While national programmes seem well designed, action plans and operationalization at the service delivery level have notable weaknesses, stemming from shortage of funds, poor access to key health services, and low quality of care.[88] The UN in Nigeria is strengthening its support through provision of technical support to OSSAP-SDGs for SDG3 and beyond. The United Nations Sustainable Development Cooperation Framework (UNDSCF) for Nigeria 2023-2027 (proceeded by the United Nations Development Assistance Framework (UNDAF) has a strong health component. Other key country planning tools include the WHO CCS and the Transformation Initiative.

[87] UNODC (2023) National Situation and Health Needs Assessment of Women in Custodial Centres in Nigeria
[88] UN Nigeria (2022) Common Country Analysis

Effectiveness

Achievement of intended objectives/results: Among the signatory agencies and across the wider stakeholder groups, there is limited understanding of the intended outputs and outcomes of the SDG3 GAP. This suggests that, although there is notable progress towards some of these outcomes in Nigeria, such as improved access to more equitable quality PHC, this is not directly attributable to the GAP. There has been some contribution from GAP agencies for example WHO and GAVI's achievements in immunization (later described in Box 2), but no clear evidence to suggest their work in this area is strengthened because of the GAP – rather these initiatives likely would have been conducted regardless of the GAP. Efforts have been made towards the outcome around better coordinated and more effective support, mainly evidenced in the preparation of the Global Fund Grant Cycle 7 (GC7), which was mentioned by stakeholders within signatory agencies, government and CSOs as a positive example of collaboration and coordination towards a successful output – the GC7 proposal – due to the different inputs and roles these stakeholders had in contributing towards its development which has led to new rounds of grant funding for the country to use towards their programming for HIV and TB. There was strong evidence of community consultation and involvement in the process too including with key populations in the context of HIV/AIDS and vulnerable groups i.e., youth and women.

Box 1

Case example: COVID-19 Basket fund

This flagship project was a UN and Governmental initiative launched under the 'Delivering as One framework' to bring sector actors within the country together to mobilise resources and scale up surveillance, testing, isolation, contact tracing, infection prevention and control for COVID-19. It specifically was designed to complement ongoing efforts to mobilise resources in support of the National COVID-19 Multi-Sectoral Pandemic Response Plan, developed by the Presidential Task Force on COVID-19.

Under the COVID-19 Basket fund, UNFPA implemented the "Engaging Civil Society Organizations to reverse the negative impact of COVID-19 on equal access to essential health services" project which is aligned to the 'Determinants of Health' and 'Civil Society & CSO engagement' accelerators. Likewise, the Risk Communication and Community Engagement (RCCE) project aimed to mitigate the socio-economic consequences of GBV and COVID-19 also contributing to the 'determinants of health' accelerator,

Another notable example is the COVID-19 Basket fund (see Box 1),[89] which was cited by KIs across four signatory agencies and within two government departments as one of the best examples of what can be done in collaboration.

Strengthening of gender equality, equity and inclusiveness. Nigeria faces numerous challenges to do with both gender inequality, with key gender issues being noted around GBV and MCH. These challenges are exacerbated in some geographical pockets due to prevailing cultural norms and accessibility to PHC. Key concerns around equity and inclusiveness, in addition to the aforementioned, are around UHC in Nigeria and the costs of healthcare and the new SWAp seeks to help address this. The links between SDG3 and, particularly SDG 5, are well documented[90] and were also noted during KIIs with various, active measures currently in place to address them. There persists a firm commitment for gender mainstreaming within UN activities within the UNCT, reflected specifically in the current cooperation framework which has an outcome dedicated to gender and women's empowerment with specific indicators that speak to health. KIs within signatory agencies frequently cited the EU-UN 'Spotlight Initiative' as a good example of how agencies are coordinating and collaborating towards SDG3. The Spotlight initiative seeks to end GBV, other harmful practices and related SRHR issues. It addresses specific health issues such as obstetric fistula[91] and explicitly states SDG3 as one of five SDGs to which it

[89] UNDP Nigeria: https://www.undp.org/nigeria/press-releases/un-nigeria-launches-covid-19-basket-fund-support-government-response; UNFPA (2021) Engaging Civil Society Organizations to reverse the negative impact of COVID-19 on equal access to essential health services" Project. Report of the Endline Evaluation; UNFPA (2022) Nigeria 8th Country Programme (2018-2022): Final Evaluation Report. Volume 1: Main Report

[90] OSSAP-SDGs & UNICEF (2022) Healthy lives in Nigeria: Evaluation of the Effectiveness and Impact of SDG3.

[91] UNFPA (2022) Nigeria 8th Country Programme (2018-2022): Final Evaluation Report. Volume 1: Main Report

contributes,[92] however specific GAP contribution to such efforts and initiatives for addressing gender and inequity issues, including the alignment and partnership of signatory agencies on this, is not clear. Box 4 provides more insight about the Spotlight Initiative.

SDG3 GAP Accelerators

Of the seven SDG3 GAP accelerators, the focus in Nigeria has been on Sustainable Financing and Primary Health Care, and the evaluation has found that signatory agency activities have been aligned to these accelerators in particular, to help achieve results even if this has not been officially done under the GAP.

Primary Health Care

According to the reconstructed ToC (Annex 1), a key PHC-related output from the SDG3 GAP would be joint support to countries to develop PHC support packages of essential services to contribute to UHC. This would lead to improved access to more equitable quality PHC services, and more equitable and inclusive progress towards health-related SDGs. There has been progress towards this in recent years throughout Nigeria, particularly in light of challenges faced across the country given decentralized governance and fragmentation.

PHC revitalization is now featured explicitly in the presidential health reform,[93] with the aim to have at least one functional PHC[94] in each of Nigeria's 774 wards as a means of improving access to quality UHC and services for the entire population. Recent reforms such as the National Health Insurance Authority Bill (2023), the Basic Healthcare Provision Fund (BHCP) (2023) and the Healthcare Industrialization Programme (2023) are key for facilitating this accelerator, in addition to that of sustainable financing. Although there was no evidence of WHO and GAP agency involvement in the presidential reform, it is considered a lever to closing the gap in "zero dose" children. Box 2 describes signatory agency work in this area.

Box 2

***Case example*: 'Big Catch up' initiative**

A notable example of signatory agency and government collaboration on an initiative towards the PHC accelerator is in the area of immunization. The National Primary Health Care Development Agency (NPHCDA) and partners including WHO and UNICEF developed an Immunization Recovery Plan (2022-2025) and a "Big Catchup" initiative specifically targeting zero-dose children to provide them with essential vaccinations.

Notably, there was also collaboration towards creating a data system to identify zero-dose communities, combining data from various sources such as immunization records, health facilities, surveys, and community data at the sub-national level which links clearly to the 'Data and Digital Health' accelerator, which KIs generally identified as a challenge and opportunity for leverage. This collaboration to reach zero-dose children has also led into the development of the Community Health Influencers, Promoters and Services (CHIPS) initiative which forms part of the federal government's community engagement strategy, and again links to another accelerator – Community & CSO engagement.

Sustainable Financing

As per the reconstructed ToC (Annex 1), a key sustainable financing output from the SDG3 GAP would be joint support to countries to prioritize health financing for equity. As a result, health financing functions would be strengthened, with a

[92] UNWOMEN et al. (2023) EU-UN Spotlight Initiative Interventions and Impacts in Nigeria (2019 – 2023).
[93] WHO (2023) Update on the SDG3 Global Action Plan. 20th June 2023. WHO information Session for Member States. PowerPoint presentation.
[94] UN Nigeria (2022) Common Country Analysis

focus on equity and building back better in the aftermath of COVID-19. This would lead to improving access to health and having the national health plans and priorities sustainably financed.

Health care costs are covered predominantly by individuals as household out-of-pocket expenditure (76%) and the government covers only around 15% of costs.[95] There has been progress towards sustainable health financing in recent years though with government general health expenditure doubling between 2016-2019[96] and the launch of the Legislative Network for Universal Health Coverage in Nigeria in 2017, though these both predate the GAP. The previously mentioned BHCP is managed by the new SWAP via real or notional pooling of all available funds, and the Nigeria health care industrialization fund is a specially dedicated pool of funds to drive investment in the healthcare value chain.[97] Given the recency of these funds/initiatives, it is premature to assess their effectiveness in contributing to GAP outcomes, but it is apparent that they are important factors to the overall enabling environment for progress towards SDG3, and signatory agency collaboration with federal government. Box 3 provides more detail on signatory agency collaboration towards sustainable financing for health from a social protection lens as was discussed in KIIs.

Box 3

Case example: Joint Programme on Social Protection

A good example of GAP agency collaboration, which includes not health mandated agencies is ILO, WFP, UNDP and UNICEF's implementation of the JOINT Programme on Social Protection, funded by the joint SDG fund. US$2 million was invested in cash transfers, capacity building, health insurance and operational and overhead costs at both federal and state levels and helped support the institutionalization of social protection in Nigeria through development of the Social Protection bill and also the National Health Insurance Law which ensures all workers including those from the informal sector have access to health care. ILO also supported policy addressing HIV work related discrimination.

Determinants of Health

The reconstructed ToC indicates multisectoral action on determinants of health, strengthened through joint support of GAP agencies to be a key output for this accelerator. The nature of signatory agency's work in Nigeria addressing prevailing socio-economic issues with direct and indirect links to health showcases various examples under this accelerator, and KIIs recognised that health should be viewed holistically. One example of a joint work between UNFPA and UNAIDS in Nigeria is the 'Joint programme for the elimination of FGM' which, in 2021 exceeded key programme results relating to integrating FGM into sex education and life skills programmes for girls, and the denouncement of FGM by religious and community leaders.[98] This programme has also worked with youth-led and community organizations. Another notable example of work within this accelerator is the Spotlight Initiative (see Box 4).

Box 4

***Case example*: Spotlight Initiative**

The Spotlight Initiative is a global partnership between the EU and UN aiming to eliminate all forms of GBV and harmful traditional practices such as FGM – prevailing determinants of health in Nigeria. Signatory agency participation consists of UNDP, UNWOMEN, UNFPA and UNICEF, also working alongside UNESCO and a wealth of other national partners within the Federal Government. KIIs cited this also as a flagship programme and good example of collaboration towards health-related issues for women and girls in Nigeria, and there has been documented progress in strengthening legislative and policy frameworks for eliminating VAWG in the country. A key output of the initiative which also links to the digital and data accelerator is the 'National Data Situation Room' and 'Data Dashboard' which has been successfully adapted by the Ministry of Women Affairs and Social Development as the official national tool to collate data on VAWG, GBV and HP across different sectors.

[95] OSSAP-SDGs & UNICEF (2022) Healthy lives in Nigeria: Evaluation of the Effectiveness and Impact of SDG3.
[96] Ndamobissi et al. (2023) Progress Towards SDG3 Healthy Lives in Nigeria
[97] Federal Ministry of Health and Social Welfare (2023) Nigeria's Health Sector Renewal. PowerPoint presentation.
[98] UNFPA Nigeria: https://www.unfpa.org/sites/default/files/resource-pdf/Nigeria.pdf

Community & CSO engagement

A key output for this accelerator as per the Toc (Annex 1) would be for GAP agencies to jointly support and foster engagement of communities and CSOs in the health sector. The evaluation team overall found evidence of engagement between signatory agencies and CSOs in Nigeria, but further room for improvement and opportunity to further utilise these networks was noted by all the stakeholder groups – specifically by CSOs themselves for example through wider stakeholder engagement with the Health Sector Reform Coalition (HSRC), and ensuring that there is intentional CSO inclusion throughout all stages of an activity or initiative including at the planning stage and not just implementation. Opportunity for further engagement with the private sector was also noted during the visit and GAP agencies could give consideration as to how to best leverage partnership with both CSOs and Private Sector in the future.

Data and Digital Health

The Toc (Annex 1) articulates a key output for this accelerator to be the improving of health data systems through joint support of GAP agencies. KIIs with both signatory agencies, government and private sector stakeholders indicated this accelerator is an opportunity for Nigeria to capitalize on moving forwards on progress towards SDG3. There persists a general dissatisfaction with Nigeria's Health Management Information System (HMIS) and its inability to provide comprehensive, quality health information when needed to guide evidence-based decisions.[99] WHO's current CCS for 2023-2027 encompasses a strategic priority to build institutional capacity for research and also information and data systems or use of digital technologies,[100] in alignment with pillars from the government Health Sector Renewal Investment Programme.

Examples from the Spotlight Initiative (Box 4) and the Big Catch Up (Box 2) feed into this accelerator and KIIs from signatory agencies such as UNFPA gave additional examples such as 'U-Plan', and a private sector organisation MTN highlighted their 'Y'ello Doctor Mobile Medical Intervention' – a project designed to provide free primary healthcare services including consultations, medications, treatment, female hygiene and ante-natal packs to people in semi-urban and rural communities through mobile clinic trucks[101] – as an example of their action towards both SDG 3 and SDG 17, and whereby there is potential for collaboration with WHO.

Collective use of resources and coordination mechanisms: Document review and KIIs revealed a range of structures and coordination mechanisms/platforms in place for health that are a combination of government led (such as the OSSAP-SDGs, SWAp, NCH and various TWGs), UN led (such as the Joint Team on HIV/AIDS, UNCT), donor led (Development Partners Group on Health ((DPG-H)) and also from Civil Society (Health Sector Reform Coalition (HSRC)). There was evidence to indicate that some of these are better known and utilized than others, such as the Joint Team on HIV/AIDS and 2022-26 UBRAF which was frequently cited by signatory agency KIIs as a mechanism in place to unite the efforts of its eleven participating agencies – of which eight are GAP agencies too – and goes beyond HIV to cover other health issues such as TB too. However, the evaluation notes overall a disconnect between the identification of these structures and a common view amongst any KIs that there lack coordination mechanisms for health, which suggests these structures are not well known and maximally operationalized. GAP agencies could, therefore, seek to strengthen accountability mechanisms for coordination and collaboration by reviewing what mechanisms are already in place and active in Nigeria and determining how the SDG3 GAP can leverage them.

One example provided by a signatory agency which highlights the need for improving coordination was around the recent (February 2024) destruction of 2 million polio vaccine doses and medical equipment during a fire at the State Central Medical Store in Gombe. KIs expressed frustration that, upon receiving notification of the incident and the call for donor and development partner assistance, there was a lack of means to effectively coordinate and respond, with key staff

[99] WHO (2018) WHO Third Generation Country Cooperation Strategy (CCS) 2018-2022
[100] Note the evaluation team have not had access to the 2023-27 CCS; this information came from KIIs.
[101] MTN: https://www.mtn.ng/foundation/yello-doctor-mobile-medical-intervention-scheme/

members within the agencies attempting to liaise and communicate with each other through WhatsApp but not through any previously established and operating platforms. More generally, the issue of 'siloed working and competition for resources across the UN in Nigeria was frequently cited as a challenge in KIIs.

Monitoring and accountability of SDG3 GAP results: Given the lack of awareness of the SDG3 GAP reported by many respondents, and the fact that the evaluation was unable to identify many specific SDG3 GAP activities, it is challenging to identify specific results that the SDG3 GAP has achieved or contributed to. There was no evidence of any specific monitoring on signatory agency alignment/coordination, nor any specific meetings and platforms specifically for the SDG3 GAP.

The SDG3 GAP Progress Report[102] heat map indicates positive results regarding the health coordination environment in Nigeria, as presented in Table 2. However, as noted in the progress reports, this is a subjective assessment by the signatory agencies and the wording of the questions does not specifically ask respondents to attribute results to the SDG3 GAP. It was not clear from interviews with government about the identity of respondents to the questionnaire because no one interviewed from government was aware of the questionnaire. Given this, the lack of awareness of SDG3 GAP at a country level, and the lack of identified activities linked to SDG3 GAP, it is not possible to assess the contribution of the SDG3 GAP to these results.

Table 2: SDG3 GAP Heat Map Results for 2022-2023

Year	Criteria					
	Aligned to plans	Coordinated with each other	Aligned to budget	Uses local monitoring systems	Joint TA plan	Uses local coordination mechanisms
2022						
2023						

There is confusion and inconsistency among signatory agencies regarding monitoring and accountability for GAP results in Nigeria. While some agencies indicated their M&E frameworks are aligned to the overarching country/UN framework, and that they use the SDG3 indicators to guide their programming and monitoring, these are not specifically SDG3 GAP indicators and there was also a common misunderstanding/confusion between SDG3 GAP results and *gaps* to achieving SDG3. WHO and SDG GAP agencies in Nigeria could thus seek to ensure that the core elements, targets and indicators from the GAP are included in other existing country frameworks and plans to ensure consistency and that signatory agencies are working towards the same.

Sustainability

Sustainability of outcomes: Given the limited level of awareness and ownership of SDG GAP at the country level across the stakeholder groups, including within signatory agencies, it is not possible to link specific outcomes and activities to the GAP in itself and thus difficult to assess sustainability of SDG GAP outcomes in any causal manner. That said, the strong and improving collaborations between signatory agencies and the government was identified frequently by KIs a key factor for sustainability of health-related initiatives and interventions within the country as a whole. Fragmentation and decentralisation, given the governance structure in Nigeria, is a risk for sustainability but KIs suggest this could be mitigated somewhat through the new SWAp – but it is currently too early to tell.

COVID-19 Recovery: The COVID-19 pandemic, whilst debilitating for Nigeria's heath status and the wider health system was seen by KIs as an important learning opportunity and a "reawakening" for government and other sector actors of the need to focus on general HSS – including UHC and PHC, whilst also considering the resilience of such systems. As

[102] WHO (2023) What worked? What didn't? What's next? 2023 progress report on the Global Action Plan for Healthy Lives and Well-being for All

previously mentioned, COVID Basket Fund was frequently cited as a good example of collaboration and joint working within the UN and beyond in Nigeria.

Factors which have helped and hindered coordination and SDG3 GAP implementation in Nigeria

During the interviews with key informants, a range of factors were identified as having supported coordination and SDG3 GAP implementation at the country level. These are presented in Figure 2. Likewise, a range of factors as having hindered SDG3 GAP implementation at a country level were also identified and these are presented in Figure 3.

Figure 2: Factors that have helped drive SDG3 GAP and general coordination in Nigeria

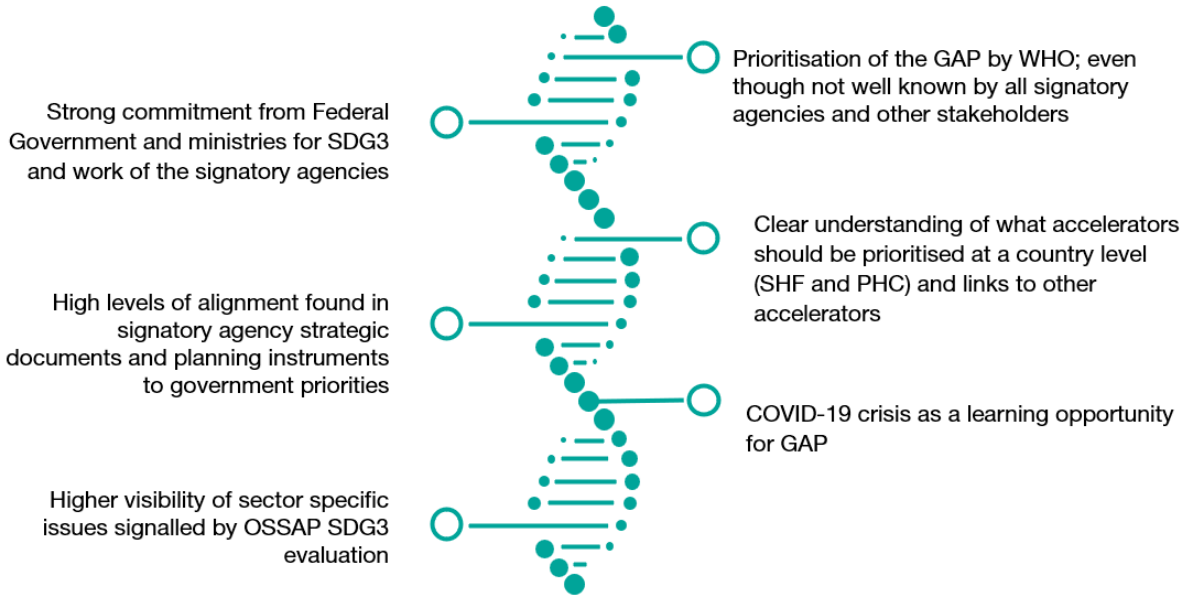
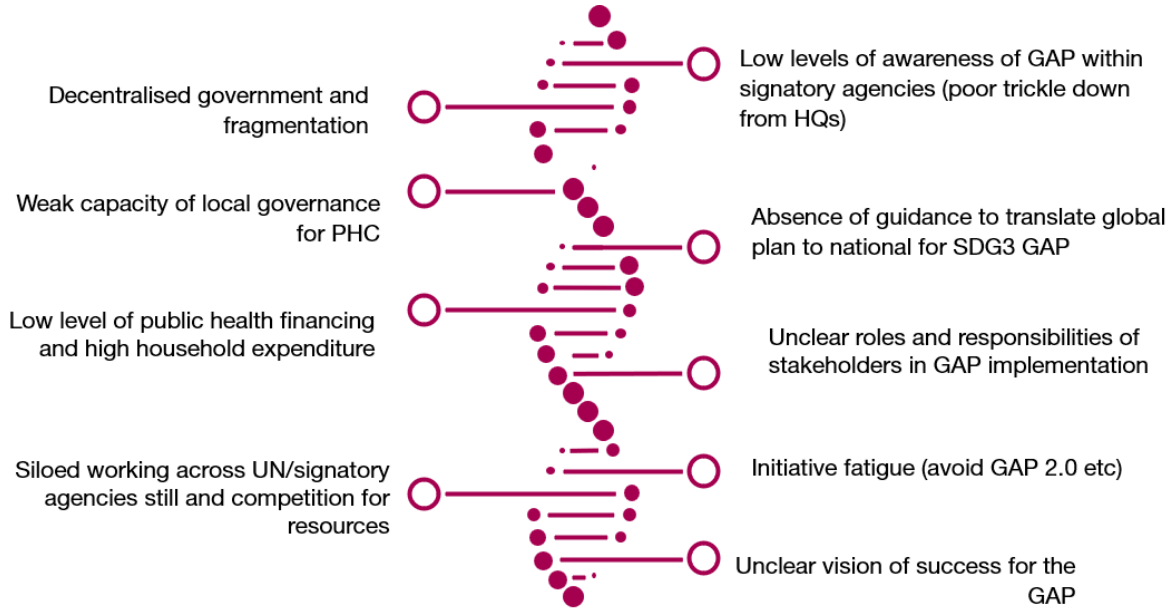


Figure 3: Factors that have hindered SDG3 GAP and overall coordination in Nigeria



Areas of consideration going forward

Given the lack of uptake and appetite for the SDG3 GAP in Nigeria – although in recognition that but that UN agencies, government and stakeholders are making efforts to align and position their working towards progress to SDG3 – the evaluation team do not feel it is appropriate to make specific recommendations at the country level for Nigeria in terms of SDG3 GAP. The evaluation team note though those recommendations presented in the country led "SDG-3 Healthy Lives" evaluation around governance and accountability, health financing, capacity strengthening and revitalization of PHC[103] remain relevant and valid for Nigeria at the time of conducting this case study.

Learning from the Nigeria case study has been used to suggest areas of consideration for the SDG3 GAP at the global level as follows:

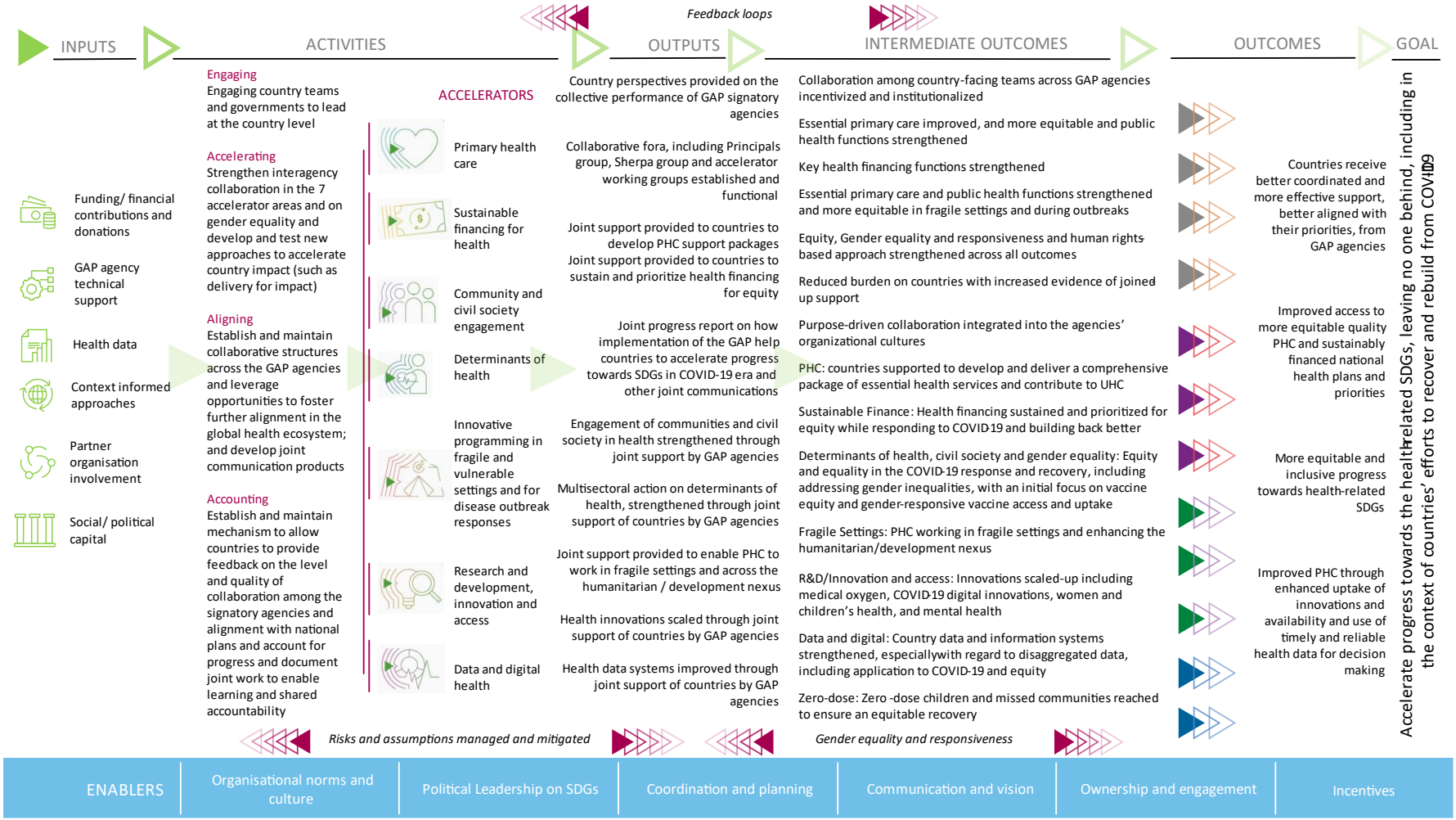
- Global initiatives such as SDG3 GAP that are expected to be operationalised at the country level need to have clear accountability lines and division of labour, roles and responsibilities with lead/host agencies and all signatories. Signatory agencies need to better communicate how global initiatives and frameworks should be translated to country-level results and implementation.
- Small countries may have better buy in to such initiatives than larger and/or more complex ones. Consideration should be given to the specifics of operationalization in large countries, particularly ones with highly decentralized structures. In these cases, focus on the state rather than federal level may improve traction and uptake.
- A clearer articulation of the results intended to be achieved by the SDG3 GAP or similar and of how its contribution to country-level results can be measured would support its implementation. Consider designing a simple common results framework to track coordination of global frameworks like the SDG3 GAP and alignment as part of agencies' M&E frameworks.

[103] OSSAP-SDGs & UNICEF (2022) Healthy lives in Nigeria: Evaluation of the Effectiveness and Impact of SDG3.

Acknowledgements

The evaluation team expresses their gratitude to all stakeholders who participated in KIIs during this country study from the Federal Ministry of Health as well as various signatory agencies in Nigeria, CSO and private sector entities. Particularly thanks are also given to WHO in Nigeria and to UNAIDS for hosting the visit.

ANNEX 5.4.1: Reconstructed Theory of Change



ANNEX 5.4.2: Documents Reviewed

Year	Title	Type
2022	Federal Ministry of health and Social Welfare. Nigeria's Health Sector Renewal … towards a healthy and prosperous Nigeria Now!	PowerPoint slide deck
2022	UNITED Nations Nigeria: Common Country Analysis	Report
2021	Independent Evaluation of SDG3 Healthy Lives Evaluation in Nigeria, Draft1 Report: Key Findings and Recommendations for review, discussions & feed-back comments	PowerPoint slide deck
2021	Independent Evaluation of SDG3 Healthy Lives Evaluation in Nigeria. Final Report	Evaluation
2021	Healthy Lives in Nigeria: Evaluation of the Effectiveness and Impact of SDG-3	Evaluation
2018	Second National Strategic Health Development Plan 2018-2022	Strategy
2014	National Health Act 2014	Act
2016	National Health Policy 2016: Promoting the Health of Nigerians to Accelerate Socio-economic Development	Policy/Guidelines
2023	National Health Insurance Authority; operational Guidelines 2023	Policy/Guidelines
2021	National Health Insurance Authority Act 2021	Act
2018	WHO Third Generation Country Cooperation Strategy (CCS) 2018-2022	Strategy
2023	Update on the SDG3 Global Action Plan	PowerPoint slide deck
2023	Progress Towards SDG3 Health Lives in Nigeria	Academic paper
2022	Country Led SDGs Evaluation: Insights from Nigeria	PowerPoint slide deck
2014	WHO Cooperation Strategy (CCS) 2014-2019	Strategy
2023	National Situation and Health Needs Assessment of Women in Custodial Centres in Nigeria	Report
2018	Brief for the Honourable Minister of Health on the Health Partners Coordinating Committee (HPCC)	Report
2021	Engaging Civil Society Organizations to reverse the negative impact of COVID-19 on equal access to essential health services" Project. Report of the Endline Evaluation	Evaluation
2022	Mid-term Evaluation of European Union (EU) support to the United Nations One United Nations (UN) Response Plan to COVID-19 in Nigeria	Evaluation
n. d	SDG3 Health Lives Evaluation: Key Evaluation Results by the Six Criteria	PowerPoint slide deck
2022	UNFPA Nigeria 8th Country Programme (2018-2022): Final Evaluation Report. Volume 1: Main Report	Evaluation
2022	UNFPA Nigeria 8th Country Programme (2018-2022): Final Evaluation Report. Volume 2: Annexes	Evaluation

2023	UN HABITAT Nigeria Country brief: Achieving sustainable urbanization.	Report
2023	EU-UN Spotlight Initiative Interventions and Impacts in Nigeria (2019 – 2023)	Report

ANNEX 5.4.3: List of KIIs

Signatory Agencies

Organisation	Role	M	F	Participation	Format
UNAIDS	Country Rep, Technical staff	3		Evaluation team, UNAIDS EVL	In-person
UNFPA	Deputy Representative; Technical staff	4		Evaluation team, UNAIDS EVL	Hybrid
WHO	Country Rep; Technical staff	3		Evaluation team, UNAIDS EVL	In-person
UNICEF	Country Rep.; Technical staff		1	Evaluation team, UNAIDS EVL	In-person
UNICEF	Technical staff	2		Evaluation team	In-person
UNDP (courtesy call)	Country Rep; Technical staff		3	Evaluation team, UNAIDS EVL	In-person
UNWOMEN	Country Rep		1	Evaluation team, UNAIDS EVL	In-person
WFP	Technical staff		1	Evaluation team	In-person
UNWOMEN	Technical staff		1	Evaluation team	In-person
UNDP	Technical staff	2	2	Evaluation team	Remote
ILO	Country Rep; technical staff	1	2	Evaluation team, UNAIDS EVL	Remote

Other UN agencies

Organisation	Role	M	F	Participation	Format
UNODC	Technical staff		1	Evaluation team	In-person

Government

		M	F		
NACA	DG; Technical staff	3	2	Evaluation team, UNAIDS EVL	In-person
OSSAP-SDGs	Technical staff	1		Evaluation team, UNAIDS EVL	Remote
NASCP	Technical staff	1		Evaluation team, UNAIDS EVL	Remote
MoH	Deputy Director	1		Evaluation team	Remote
MoH Dep Family planning	Deputy Director	1		Evaluation team	Remote
MoH – Malaria NMEP	National coordinator	1		Evaluation team	Remote

CSO/CBOs

		M	F		
Health Sector Reform Coalition	Head of organisation; other staff	3	2	Evaluation team,	Hybrid
NEPWHAN	Staff	2		Evaluation team, UNAIDS EVL	Remote

Private Sector

		M	F		
CHI	Staff	2	2	Evaluation team	Remote
MTN	Staff	1	1	Evaluation team	Remote
Health Care Federation Nigeria	Staff	1	2	Evaluation team	Remote

Donors/donor coordination groups

CCM	Tajudeen Ibrahim	Evaluation team, UNAIDS EVL	Remote

5.5 Pakistan Country Study

INTRODUCTION

The Joint Evaluation of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), has been commissioned by the SDG3 GAP signatory agencies. Established in 2019, SDG3 GAP is a set of commitments by 13 multilateral agencies (GAVI, GFF, ILO, the Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, UNITAID, UN Women, World Bank, WFP, WHO) to strengthen collaboration. Under the GAP, agencies commit to align their ways of working to provide more streamlined support to countries and reduce inefficiencies. It offers a platform to improve collaboration among the significant stakeholders in global health, with specific but complementary mandates.[104] Although referred to as a Global Plan, the added value of the SDG3 GAP is intended to lay in more effectively coordinated support, action and progress at the country level.

The acceleration of progress on the health-related SDGs is geared through seven accelerators: i) Primary Health Care; ii) sustainable finance for health; iii) community and civil society engagement; iv) determinants of health; v) innovative programming in fragile and vulnerable settings for disease outbreak responses; vi) research, development, innovation and access; and vii) data and digital health.

PURPOSE, OBJECTIVE AND SCOPE

The purpose of the evaluation is to inform signatory agency's learning, continued improvement and mutual accountability to each other as partners. The objective of this evaluation is to assess the coherence, effectiveness, and sustainability of the SDG3 GAP collaboration efforts – at the country, regional and global levels - in accelerating country progress on the health-related SDG targets.

To this extent, the GAP evaluation seeks to assess the extent to which signatory agencies have strengthened their collaboration to:

1. Engage with countries better to identify priorities.
2. Jointly plan and implement programs.
3. Harmonize operational and financial strategies, policies and approaches.
4. Review progress and learn together to enhance shared accountability; and,
5. Accelerate progress in countries through joint actions on the health-related SDGs.

The temporal scope of this evaluation is the period from September 2019 to March 2024. It is being at the global level and includes of a series of "deep dive" country case studies, including Pakistan. The country studies serve as a tool in this evaluation to explore questions of process, experience, relationship and actors in context, including a better understanding of barriers and facilitators to activities as directly experienced. This document serves as an aide memoire for the Pakistan study.

APPROACH AND METHODOLOGY

The evaluation uses a theory-based approach, using a reconstructed theory of change that reflects the common understanding of the evaluation team and SDG3 GAP agencies represented in the Evaluation Reference Group (ERG) of the SDG3 GAP. Given the nature of the SDG3 GAP, an enabling mechanism to support better use of existing resources, a contribution analysis based on testing expected change pathways and assumptions is particularly adapted to the object of the evaluation.

[104] https://www.who.int/initiatives/sdg3-global-action-plan

A mixed-methods approach has been used for the Pakistan country study with a review of key documents and 25 KIIs and 3 FGDs conducted with the signatory agencies, government, development partners and other stakeholders, such as civil society and community groups.

The country study was conducted by two members of the evaluation team over five working days, as well as follow-up remote interviews. Pakistan was selected due to it being one of the global pilot countries for the implementation of the GAP, with a focus on the Primary Health Care (PHC) and Health Financing Accelerators.

Following the Pakistan country study, the team held a debriefing meeting with WHO and UNICEF stakeholders to present and validate emerging findings, check data accuracy and to identify any data gaps. This country study has been developed to provide a record of the visit and present findings against the three evaluation criteria to inform the overall evaluation report and will be finalized based on stakeholder feedback.

A key limitation of this case study is that the evaluation team were only able to interview federal stakeholders and in Sindh province and as such, findings presented pertaining to the provincial level reflect the perspectives of stakeholders in Sindh province only.

COUNTRY CONTEXT

Pakistan has a large population of roughly 235.8 million people in 2022, and is the fourth most populous nation in Asia.[105] The 2023/2024 UNDP Report places Pakistan in the 'low' human development category with a Human Development Index (HDI) value of 0.540 and global ranking of 165 out of 193 countries.[106]

Pakistan has made significant progress towards reducing poverty between 2001 and 2018 with the expansion of off-farm economic opportunities and increased inflow of remittances. However, with growth slowing, the World Bank estimates 40% of people in Pakistan live below the poverty line.[107]

Pakistan is divided into four provinces (Punjab, Sindh, Khyber Pakhtunkhwa (KP) and Baluchistan) and 3 administrative regions/units (Islamabad Capital Territory (ICT), Gilgit Baltistan (GB and Azad Jamu Kashmir (AJK), each with its own distinct cultural, linguistic, and historical context. Each province has its own provincial government responsible for local governance, development, and administration.

There are large variations between the provinces in the country in terms of their geography, population, demography, poverty levels, proportion of population who are vulnerable or displaced, and security. These factors contribute to inequities in access to health services, health indicators, and immunization levels, a priority which is recognized in the national health strategy. There are several core areas which are influencing the overall developmental landscape of Pakistan: political instability, economic precariousness, disaster management and increased insecurity.

Political instability: General elections were recently held in February 2024, but no single party can get the majority and there is coalition government in place. The result was achieved against a backdrop of instability that permeates the political sphere with accusations of corruption and election rigging being widespread.

Precarious economic situation: The origins of Pakistan's economic challenges stem from a combination of factors, including the worldwide disruptions caused by the COVID-19 pandemic, disturbances in global supply networks, and geopolitical tensions, notably the conflict between Ukraine and Russia, which has adversely affected food and energy security in developing countries. This convergence of circumstances has thrown the country into economic turmoil, characterized by diminishing purchasing ability, declining foreign exchange reserves and increasing social unrest.[108]

[105] https://data.worldbank.org/indicator/SP.POP.TOTL?locations=PK
[106] https://hdr.undp.org/data-center/specific-country-data#/countries/PAK
[107] https://www.worldbank.org/en/news/press-release/2024/04/01/pakistan-implementing-an-ambitious-credible-and-clearly-communicated-economic-reform-plan-critical-for-robust-recovery-p
[108] World Bank (2023) Pakistan Development Update October 2023

Pakistan is grappling with record inflation and ballooning unemployment, for which it no longer reports data. With foreign exchange reserves dwindling, Pakistan has become reliant on IMF bailouts and is increasingly at risk of default.[109]

Prone to shocks: In 2022, flooding engulfed a third of Pakistan, impacting 33 million individuals, with half of them being children.[110] The floods wreaked havoc on water infrastructure in affected regions, compelling over 5.4 million people to depend solely on polluted water from ponds and wells. [111] At the forefront of the climate crisis, Pakistan grapples with significant impacts affecting both its populace and regions. Over 60% of Pakistan's population resides in rural areas, relying on the land for sustenance and income.[112]

Increased insecurity: Pakistan continues to face multiple sources of internal and external conflict. Extremism and intolerance of diversity, and dissent have grown. Regionally, Pakistan faces a resurgence of extremist groups along its border with Afghanistan, which has raised tensions with Taliban-led Afghanistan. Attacks by Islamist militants, notably the Tehrik-i-Taliban Pakistan (TTP) and Islamic State of Khorasan Province (ISKP), targeting law enforcement officials and religious minorities, killed dozens of people in 2023.[113] Despite a declared ceasefire on the Line of Control in Kashmir in 2021, relations with India remain vulnerable to crises that pose a threat to regional and international security.

HEALTH SYSTEM AND EPIDEMIOLOGICAL CONTEXT

Pakistan Health System

Pakistan's health system ranks 124th out of the 169 countries included in global surveys.[114] Pakistan's healthcare system is a mix of public and private sector providers, with significant variations in access, quality and affordability across different regions and socioeconomic groups. At a national level, the federal government develops health policy and vision, but the delivery of health services is devolved to the provincial level, and then at the district level.

The public sector healthcare system aims to provide healthcare services through a tiered healthcare delivery system and various public health interventions. At the foundational level, it comprises Basic Health Units (BHUs) and Rural Health Centres (RHCs), embodying the essence of PHC. Community participation is a key aspect of the extension of health services to rural areas and urban slums through the deployment of 110 000 “lady health workers” covering almost 60% to 65% of the target population, as well as community midwives, community health champions and vaccination volunteers.

Secondary care encompasses first and second referral facilities, offering acute, ambulatory, and inpatient care through Tehsil Headquarter Hospitals (THQs) and District Headquarter Hospitals (DHQs). Tertiary care involves teaching hospitals.[115]

From 1971 to 2022 the total number of highly qualified and skilled people including health care professionals who migrated from the country is 6 019 888. [116] In 2021, there were 266 430 doctors and 121 245 nurses in Pakistan. In terms of facilities, there were 1 276 hospitals, 5 558 BHUs, 736 RHCs, 5 802 Dispensaries, 780 Maternity and Child Health Centres, and 416 TB centres in Pakistan.[117]

Health Outcomes

Pakistan has seen a long-term improvement in health outcomes, with the current life expectancy for Pakistan in 2019 being 65.61 years, increasing from 60 in the year 2000.[118] Furthermore, infant mortality rates have also reduced, with rates

[109] https://www.cfr.org/global-conflict-tracker/conflict/islamist-militancy-pakistan#:~:text=Separatist%20and%20extremist%20movements%20have,links%20to%20the%20Afghan%20group.
[110] https://www.unicef.org/emergencies/devastating-floods-pakistan-2022
[111] ibid
[112] https://data.worldbank.org/indicator/SP.URB.TOTL?locations=PK
[113] https://www.hrw.org/world-report/2024/country-chapters/pakistan
[114] https://www.statista.com/statistics/1376359/health-and-health-system-ranking-of-countries-worldwide/
[115] https://www.emro.who.int/pak/programmes/service-delivery.html
[116] Meo SA, Sultan T. Brain drain of healthcare professionals from Pakistan from 1971 to 2022: Evidence-based analysis. Pak J Med Sci. 2023 Jul-Aug;39(4):921-925. doi: 10.12669/pjms.39.4.7853. PMID: 37492337; PMCID: PMC10364271.
[117] ibid
[118] https://dashboards.sdgindex.org/map/goals/sdg3

being 76.16 in 2015 compared to 63.33 in the year 2020.[119] Despite this, deaths of children from preventable diseases such as pneumonia, diarrhea, measles, malaria, neonatal problems and malnutrition are still very high. A recent surge of infectious diseases in Pakistan is mainly due to the recent extreme flooding in the country. This led to an increase in vector-borne diseases including dengue and malaria. Childhood immunization is the only one of the SDG3 targets Pakistan is on course to achieve at the rate of current progress.[120] However, the increase in vaccine-preventable diseases provides evidence of disruption in immunization during the COVID-19 pandemic and period of flood response. The annual coverage of routine immunization in Pakistan remains far below the optimal coverage of 95% as recommended by the WHO. While social determinants of health and SDGs are specific pillars of the National Health Vision 2016-2025. Pakistan ranks as 132/146 in terms of gender disparities in health and survival, reflecting a lack of focus on social determinants of health and gender-sensitive approaches to the provision of health care services.[121]

Table 7: Key SDG3 Indicators for Pakistan[122]

Indicator	2015	2020	Rating	Trend
MMR per 100 000 live births	187.4	154.2 (2020)		↗
Under-5 mortality per 1000 live births	76.18	63.33		↗
TB incidence per 100 000 *GHO	270	264		→
Life expectancy at birth	64.18	65.61 (2019)		→
Surviving infants who received 2 WHO recommended vaccines	72%	81%		↗
UHC index	41	45 (2019)		→

FINDINGS

Coherence

SDG3 GAP signatory agency respondents had varying degrees of awareness and understanding of the SDG3 GAP. In Pakistan, eight of the 13 signatory agencies have been involved in SDG3 GAP initiatives in Pakistan and focal points from each of the agencies working at a federal level were aware of the SDG3 GAP.[123] However, beyond these focal points, there was less awareness and engagement with the SDG3 GAP; with engagement and awareness in WHO and UNICEF, for example, largely concentrated in the Health Systems Development (HSD) Unit and health teams with lack of engagement with broader partners for a multisectoral health response (i.e. the SDG3 GAP partners not exclusively focused on health (i.e. UN WOMEN, ILO). At the provincial level, where health services are implemented, none of the signatory agency respondents interviewed were aware of the SDG3 GAP. Similarly, understanding and awareness of the SDG3 GAP by government respondents was also mixed, with a few respondents within the Ministry of Health (MoH) at the federal level aware, but not all, and with no awareness of the SDG3 GAP by provincial MoH stakeholders.

In contrast to most other countries studied for this evaluation, a mechanism to operationalize SDG3 GAP commitments in county has been developed in Pakistan. In 2020, the eight signatory agencies formed a national 'SDG3 GAP Coordination Committee' which aimed to "enhance and harmonize coordination among GAP Partners engaged in the health sector in Pakistan and accelerate country progress on the health-related SDG targets."[124] While the ToR sets out this group was

[119] ibid
[120] ibid
[121] https://www3.weforum.org/docs/WEF_GGGR_2024.pdf
[122] https://dashboards.sdgindex.org/map/goals/sdg3
[123] WHO, UNICEF, UNFPA, World Bank, GFF, Gavi, Global Fund and UNAIDS
[124] ToR, Partner Coordination Committee, SDG3 GAP Pakistan

intended to meet quarterly, committee meeting minutes demonstrate that it has instead met annually.[125] The committee was intended to enhance collaboration between the in-country GAP partners. However, signatory agency respondents indicated the committee has largely been a platform for information sharing regarding the work of the respective agencies that has taken place. While this was perceived as useful, a number of interviewees felt that there were missed opportunities for the group to be more strategic and to have engaged further in joint planning, advocacy and programming. At a provincial or district level in Sindh Province where health services are delivered, there is no such equivalent coordination mechanism to facilitate and support collaboration and alignment.

The timing of the launch of the SDG3 GAP in Pakistan was seen as fortuitous by stakeholders and the accelerator model helped to provide a "hook" to strengthen coherence in terms of better alignment and coordination as primary health care (PHC) and sustainable financing for health were already increasing in prominence as government priorities.

The UN Sustainable Development Cooperation Framework (UNSDCF) acts as the key overarching framework to align agencies, though UNCT respondents were not aware of the SDG3 GAP specifically. The SDG3 GAP is not consistently referenced/ present in agency specific strategies and plans. Whilst there was no specific evidence identified that signatory agencies' operational, and financial strategies, policies and approaches incentivize coherent, effective and sustainable collaboration, there was a general consensus amongst signatory agency and government respondents that support from signatory agencies is largely aligned to key government priorities such as PHC & UHC, health financing maternal health and immunization, with polio and the expanded immunization programme being highlighted by interview respondents as areas where high levels of coordination for planning have strengthened capacity and outreach.

Data availability, quality and use were highlighted as key challenges by stakeholders across respondent types, particularly since health has been devolved to provinces as there is a lack of an integrated national health information system (HIS), with many vertical systems. A number of stakeholders highlighted that there remained a need for integrated and aligned investments to support the strengthening of HIS and that this would have been a useful area for the SDG3 GAP to focus on. This was highlighted as particularly important given that the private sector provides around 70% of healthcare services in Pakistan, but data from the private sector is not routinely shared with the government.

As part of the National Health Support Program (NHSP), a number of the SDG3 GAP agencies have started efforts to address this (GFF, World Bank, Gavi, UNFPA, as well as BMGF) working on strengthening HIS.

In terms of coordination of the health sector, the UNRC convenes a "Development Partners" group of key health actors, which includes a number of the SDG3 GAP signatory agencies (e.g. WB, GFF, GF, Gavi), as well as the Foreign, Commonwealth and Development Office (FCDO) and the Bill and Melinda Gates Foundation (BMGF). There is also the SDG3 GAP Coordination Committee, as well as a government UHC Coordination Platform (consisting of federal and provincial ministers for health and donors); this, however, does not meet regularly. The last meeting was in July 2023 and a number of government and signatories' agencies representatives interviewed hope to revitalize it. It was reported that there is also the "Population Council", a coordination mechanism for reproductive health which is considered by signatory agencies to be more effective. There is also the PHC Service Delivery and Financing Working Group created to drive forward the SDG3 GAP accelerators in Pakistan and an array of technical working groups on specific health-related issues. However, a number of signatory agency respondents felt that these existing mechanisms are quite ad hoc and could be more strategic, rather than used mainly for information sharing. It was also noted that there were missed opportunities for joint strategic planning, programming and advocacy to government. The prioritization of gender and associated health impacts was highlighted, for example, as an area where stronger advocacy to government would be useful going forward given the gender context in Pakistan.

The frequent changes in government in recent times were cited by a number of interviewees from government and signatory agencies as a challenge to coordination because agencies had to "start from zero" in relationship-building each time with government representatives. Sequencing and planning cycles of the different signatory agencies were also noted by government key informants as a challenge in ensuring alignment between agencies.

[125] Ibid, and Minutes of the SDG3 GAP Partner Coordination Committee on GAP November 2020, august 2021, August 2022, June 2023.

However, there is no current functioning government-owned mechanism at a federal level, whereby coordination of the health sector takes place routinely with government, signatory agencies and development partners, or with the private sector and civil society partners. This was noted by stakeholders interviewed as a key gap.[126]

In times of emergency or during the COVID-19 pandemic, the government was seen by a number of interviewees from signatory agencies and the private sector to take a greater role in coordinating the health sector. Overall coordination was under the National Coordination Committee (NCC) and chaired by the Prime Minister. The NCC was operationalized by a national command and operation centre. In a development context, the government is perceived by stakeholders interviewed as being reactive in doing this, rather than proactive. A number of interviewees outlined that these coordination mechanisms were often driven by personalities; when an engaged person was at the helm then they were more active, but if this person left then at times the mechanism faded away, rather than having been institutionalized. In Sindh province, stakeholders also noted the lack of a government (or partner) coordination mechanism or provincial-level plan to coordinate the health sector at the provincial level. Interviewees cited that there are limited opportunities for provincial stakeholders to feed into or engage with national-level planning for health.

Effectiveness

The SDG3 GAP Progress Report heat map shows consistently low perceptions of the health coordination environment in Pakistan, as displayed in Table 2 below, with all ratings falling below satisfactory across the two years of available data.[127] As noted in the progress reports themselves, this is a subjective assessment, and the wording of the questions does not specifically ask respondents to attribute results to the SDG3 GAP. It was not clear from interviews with the government who the respondents to the questionnaire were as no one interviewed from government was aware of the questionnaire. The questionnaire was also only issued at a national level, and so the perspectives on health coordination at a provincial level were not included.

Table 8: Heat Map

Year	Aligned to plans	Coordinated with each other	Aligned to budget	Uses local monitoring systems	Joint TA plan	Uses local coordination mechanisms
2022						
2023						

As outlined in Table 2, there has been limited progress with regards to key SDG3 indicators in Pakistan, with childhood immunization the only SDG3 target likely to be met at current progress rates. With no evidence of government perception of improved coordination among signatory agencies and limited improvement in health outcomes, there is limited evidence that the SDG3 GAP has contributed to accelerating progress towards SDG3 targets. It is also important to note, as well, that health data availability and quality was noted as a significant challenge in almost all interviews and the last demographic health survey was in 2017-2018. Therefore, it is not possible to determine the full extent of how these results may have been affected by either the COVID-19 pandemic or recent contextual challenges affecting Pakistan.

Contribution of GAP agencies to cross-cutting accelerator themes

The 2022 SDG3 GAP Progress Report highlights the Primary Health Care (PHC) and Sustainable Financing for Health Accelerators as being the two selected for the SDG3 GAP partners to pursue in Pakistan.[128] According to the evaluation's reconstructed theory of change (ToC), GAP agencies are expected to support countries to develop PHC support packages of essential services to contribute to UHC. This would lead to improved access to more equitable quality PHC services, therefore contributing to more equitable and inclusive progress towards health-related SDGs. For sustainable financing for

[126] Stakeholders noted that previously there was an Inter-agency coordination Committee chaired by secretary health, however this is now dormant
[127] SDG3 Global Action Plan Progress Report, 2022 and 23
[128] SDG3 Global Action Plan Progress Report, 2022

health, a key expected output in terms of sustainable financing from GAP is to improve joint support to countries on health financing for equity. As a result, health financing functions would be strengthened, with a focus on equity and recovery in the aftermath of COVID-19. This would in turn lead to improving access to health and national health plans and priorities sustainably financed.

The selection of these two accelerators was highly relevant as in its National Health Vision 2016-2025,[129] Pakistan had already stressed the importance of PHC as one of the foundations of health system reforms with the creation of a Universal Health Coverage Benefit Package (UHC BP) planned and federal and provincial governments having prioritized PHC strengthening as it is the foundation to achieve UHC. In 2018, Pakistan signed the UHC 2030 Global Compact, committing to advancing UHC, as part of the country's efforts to achieve the health-related SDGs. However, trend analysis of the UHC Service Coverage Index shows improvements are happening at a relatively slow pace from 40% in 2015 to 52% by the end of 2022 with significant disparities across the country.[130]

Sustainable financing for health was highlighted by all respondents as a key need going forward as domestic general government health expenditure (% of general government expenditure) is low (4.57% in 2021), having fallen from 5.2% in 2020.[131] Out-of-pocket health expenditure within the same period has increased from US$55.44 per capita in 2020, to US$57.5 per capita in 2021.[132] Pakistan spent 1.2% of its gross domestic product (GDP) on the public health sector in 2020-2021 as compared to 1.1% in 2019-2020, which is not a significant increase when viewed in terms of GDP percentage, and was largely driven by increased COVID-19 expenditure.[133] ODA for health has also stagnated in recent years and the government's "Status of Health Financing Pakistan 2023" report highlights the need for "additional international investment to catalyse advancements, strengthen health systems, support government efforts in tackling low revenue generation, support government efforts in tackling low revenue generation, and strengthened capacities for health-financing functions essential for UHC" and highlights the importance of global partnerships such as the WHO Global Action Plan, UHC 2030, Gavi, GFF and the Global Fund are instrumental in guiding Pakistan through its current health financing challenges.[134] The Brief on Health Budget Analysis 2023-24[135] highlights that while the government has demonstrated a commitment to maintaining and moderately increasing health sector spending, there is room for a more aggressive investment strategy to address the gaps in health care service delivery, infrastructure and public health preparedness.

GAP partners seized the opportunity to work on the PHC and the SFH accelerators with the intention of enhancing and harmonizing coordination among GAP partners engaged in the health sector in Pakistan to accelerate country progress on the health-related SDG targets. Originally there were two working groups to support the implementation of these accelerators; the PHC working group and the sustainable financing working group, but over time they have merged into one working group. There were mixed feelings from respondents as to whether this had been a helpful move. Some signatory agencies felt it was a helpful move as the two topics were mutually reinforcing; others felt the group's focus was now too broad and that there was less concrete action from the group.

Key activities and most significant contributions of the working groups as identified in interview and document reviews have been:

1. Since 2020, the Pakistan WHO country office has received US$330 000 of SDG3 GAP catalytic funding[136] which has been used to fund the activities of SDG3 GAP Coordination Committee and this is considered pivotal by WHO staff in supporting SDG3 GAP initiatives.
2. In 2023, for example, these funds were used for supporting the government in implementation of UHC benefit package in prioritized districts through PHC strengthening for integrated service delivery. This also included piloting PHC Oriented Model of Care by WHO in 2 districts. Funding also supported the efforts of the government

[129] Pakistan National Health Vision 2026-25
[130] Trend Analysis of the UHC Service Coverage Index 2023
[131] https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS?locations=PK
[132] https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=PK
[133] Pakistan Economic Survey 2021-22
[134] Status of Health Financing Pakistan 2023
[135] Brief on Health Budget Analysis 2023-24, Palladium, OPM, FCDO
[136] 2020: 150,000, -2021: 100,000, 2022: 30,000, 2023: 50,000 (figures provided the SDG3 GAP secretariat)

in development of a comprehensive Health Financing framework to mobilize and pool resources for implementation of UHC BP as well as the development of the national digital health framework which sets out a plan to digitize the healthcare sector in Pakistan.[137]

3. A high-level "primary health care for universal health coverage" (PHC4UHC) mission on 1–5 March 2021, which united eight SDG3 GAP partners in Pakistan to review the status of PHC and sustainable health financing and advise on a model of care to ensure effective implementation of the UHC Benefit Package.[138] On this occasion, federal and provincial governments representatives and SDG3 GAP partners signed a joint statement in support of enhancing PHC towards UHC in Pakistan. Based on this mission, WHO supported government to pilot the PHC Oriented Model of Care in two districts (ICT & Charsadda).

4. Support to the Ministry of National Health Services, Regulations and Coordination (MoNHSR&C) in partnership with the Provincial / Area Departments of Health and partners has finalized an evidence based Universal Health Coverage (UHC) benefit package for Pakistan.

5. Signatory agencies supported the development of National Digital Health Framework, and then a Health Financing Framework, including consultative meetings at the provincial level. The development of the Framework has been supported by a fiscal space analysis (World Bank), health system financing assessment (World Bank), strengthening of public financial management for health (World Bank), TA for national health financing expert (WHO), a health financing matrix (WHO) and a cross-programmatic efficiency analysis (Gavi, Global Fund and WHO). It also involved support for organizing a high-level international mission on health financing by a high-level expert from International Health Policy Program, Ministry of Public Health, Thailand to review, comment and provide technical recommendations for the draft National Health Financing Framework.[139]

6. The National Health Support Program (NHSP) launched by the World Bank (US$437 million) aims to strengthen primary health care systems and to accelerate national efforts towards universal health coverage. This initiative brings together GFF, the Global Fund, Gavi and the Bill and Melinda Gates Foundation. The money goes directly to the finance department of each province and then the health department requisitions funds, so the sustainability and increased domestic resource mobilization for primary healthcare in theory will increase.

7. Signatory agencies have supported revisions to the Lady Health Workers (LHW) Strategic Plan (2022-28), in line with the National Health Vision (2016-25) with a focus on PHC and SFH and the creation of an Essential Packages of Health Services (EPHS). The Essential Package of Health Services (EPHS) is being implemented in a phased manner. Implementation has begun in 12 priority districts and will be expanded to 28 more districts in the next five years. The National Health Support Programme (NHSP) funded by the World Bank aims to enhance the implementation of the EHPS.

Factors affecting the implementation of SDG3 GAP

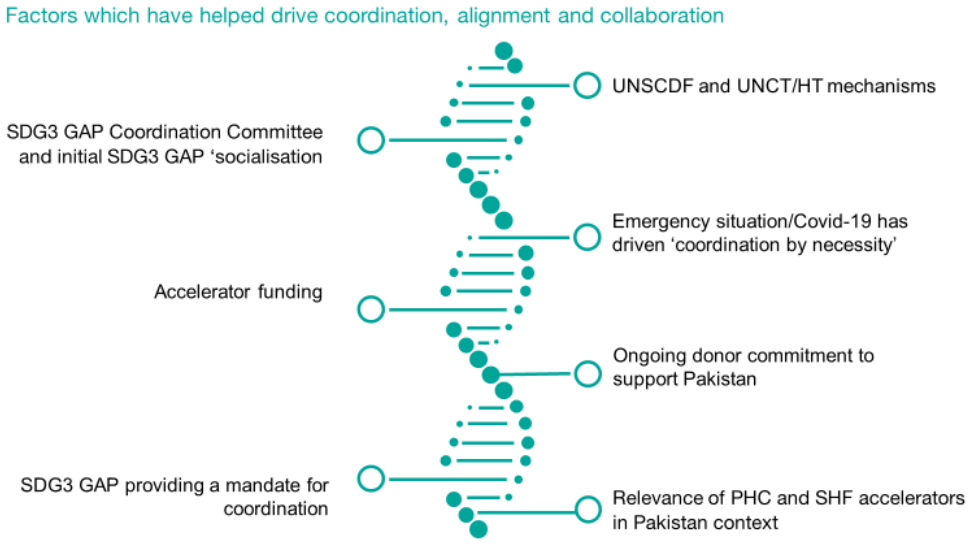
As figure 3 below indicates, a number of factors have been identified from interviews and document review which have supported the implementation of the SDG 3 GAP in Pakistan and effective coordination more broadly. They include:

- The creation of the SDG3 GAP Coordination Committee to convene signatory agencies for information sharing and the initial socialization of the SDG3 GAP, meaning that there is a greater awareness of the SDG3 GAP and its purpose in Pakistan compared to most case study countries.
- One of the helpful aspects of the SDG3 GAP highlighted in interviews was that it gave agencies a legitimate mandate to convene and was intended to increase accountability for coordination.
- The accelerator funding received has supported a number of the activities undertaken.
- The relevance of the PHC and SFH accelerators from the outset in Pakistan and the fact they provided a useful entry point for SDG3 GAP activities.

[137] WHO. 2024. SDG3 GAP Catalytic Funding for WHO Country Offices – Reporting Template 2023
[138] Pakistan Progress Report: Implementation of SDG-3 & Global Action Plan for Healthy Lives & Well being
[139] SDG3 GAP Catalytic Funding Report, 2024, SDG3 GAP Recovery Challenge Report 2022

- Strong coordination evidenced in COVID-19 and in emergencies (floods).

Figure 5: Enabling Factors



The evaluation also noted a number of factors have hindered coordination or results achieved by the SDG3 GAP, including:

8. The fact that the SDG3 GAP efforts have remained relatively siloed within certain teams in WHO and UNICEF rather than broader engagement and ownership by each signatory agency. There is a perception from some signatory agencies that the coordination between different thematic and disease teams in WHO could be strengthened.

9. The lack of strong government-owned and led health coordination mechanisms; the information sharing focus rather than strategic planning in some existing mechanism. As highlighted in the 'PHC for UHC' Mission to Pakistan Key Findings and Recommendations in March 2021, there does not seem to be a clear mapping of the different coordination mechanisms, their respective, mandates, constituents and which should be supported and rejuvenated. The report also highlighted the importance of ensuring the creation of parallel coordination foras at the provincial level, which mirrors national mechanisms with clear ToRs and with linkages to district coordination arrangements.

10. The overlap between the mandates of agencies and the fact that this creates competition for resources; this can foster mutual mistrust and a lack of transparency regarding resources.

11. Ownership of SDG3 GAP was mentioned by interviewees as a challenge for the reporting of SDG3 GAP achievements in progress reports, which are largely focused on WHO's role and contribution.

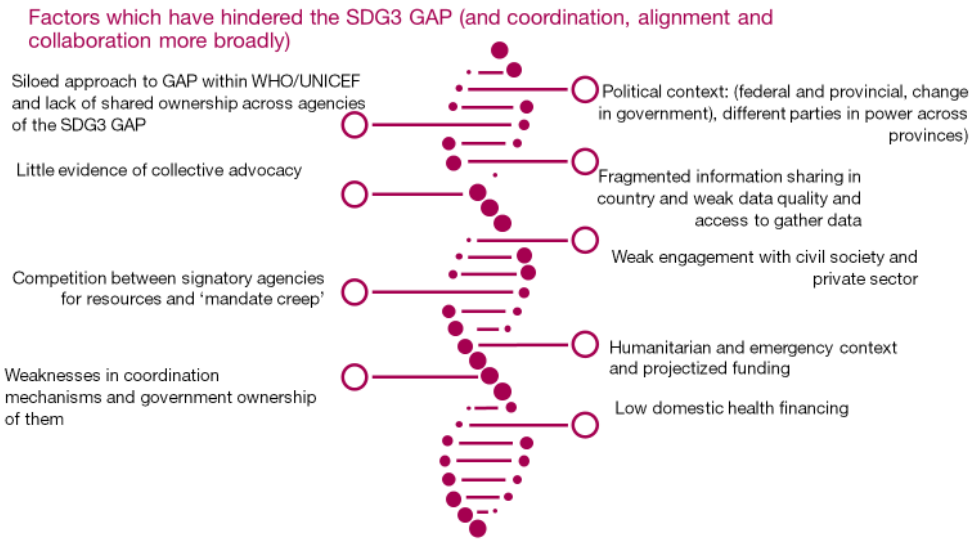
12. The perception by a number of interviewees from agencies and the private sector of a lack of government capacity and strategic vision, agenda-setting, holding partners to account and ownership of health coordination.

13. The changing political situation and associated instability are frequently highlighted by key stakeholders as a major challenge in terms of government ownership.

14. Evidence from key informant interviews shows there is fragmented and weak data availability, quality and use for health data and the lack of information sharing, feedback loops within the HIS system from the provincial to the federal level. Increased involvement and support of development partners to support HIS strengthening efforts was highlighted as a recommendation in the "PHC for UHC" Mission to Pakistan Key Findings and Recommendations in March 2021.[140]

[140] 'PHC for UHC' Mission to Pakistan Key Findings and Recommendations, March 2021.

Figure 6: Hindering Factors



Sustainability

As outlined previously, given the lack of specific outcomes identified linked to the SDG3 GAP[141] means that it is not possible to assess sustainability. However, the evaluation is able to identify a number of relevant considerations around sustainability of the alignment and coordination efforts by SDG3 GAP signatory agencies.

Given the health financing context in Pakistan, the development of a health financing framework and strategy is significant; it will be important going forward for SDG3 GAP agencies to consider what is needed to support the implementation of this strategy and work to support government accordingly, as well as to support the monitoring of the implementation of the strategy and its roll-out and socialization at a provincial level.

Similarly, the UHC benefit package piloted in prioritized districts through PHC strengthening for integrated service delivery and the PHC Oriented Model of Care are positive moves forward and have significant opportunity to generate impact and the achievement of health outcomes but need to be properly funded to be sustainable.

For sustainability, it will be key for the government to set a clear agenda at federal and provincial levels and hold partners to account to support this. Having ownership of coordination mechanisms will be key also going forward for sustainability. Several interviewees noted that the varied approaches and limited transparency regarding responsibilities could be seen as beneficial by the government and those focused on specific diseases, as it might enable access to a broader range of external funding sources. They suggested that greater collaboration among agencies would help align perspectives on how resources are managed and planned.

The SDG3 GAP catalytic funding has been key to support SDG3 GAP activities but going forward finding ways to embed coordination costs of coordination efforts within core budgets, rather than a reliance on catalytic funding will enhance its sustainability.

Areas of consideration going forward

At the country level, the following considerations should be addressed, whether for the continuation of the GAP or to enhance coordination more broadly

[141] As mentioned under effectiveness, with no evidence of government perception of improved coordination amongst signatory agencies and limited improvement in health outcomes, there is limited evidence that the SDG3 GAP has contributed to accelerating progress towards SDG3 targets.

Area of consideration for Pakistan going forward
STRATEGIC
HIS as a key area requiring attention going forward especially for scaling up DHIS2 and harmonizing multiple parallel reporting systems.
Strengthen approaches to building and working through national and federal systems to enhance sustainability.
Further joint programming efforts between SDG3 GAP signatory agencies to reflect each agency's comparative advantages and maximize efficiencies.
Moving from strategies and frameworks to supporting their implementation and ensuring provincial engagement and relevance, as well as financing.
Improve multisectoral approaches to consider the impact of social determinants of health (gender, social protection).
Pakistan should move to having aligned national and federal health plans, with aligned M&E frameworks linked to national and provincial budgets.
OPERATIONAL
More regular and strategic coordination with representation and participation of senior leadership from both government and signatory agencies.
Conduct a comprehensive mapping of coordination mechanisms at national and provincial levels and identify those that remain relevant and can be built upon and/or revitalized.
Creation of parallel coordination foras on the provincial level which mirror effective national mechanisms (strengthened as indicated) with clear ToRs and with linkages to district coordination arrangements.
INSTITUTIONAL
Incentivizing and strengthening government ownership and engagement in health coordination.
Ensure engagement of federal and provincial level actors in development of signatory agency plans and in coordination.
Increase engagement with the private sector, particularly when looking at HIS investments.

At the global level, the following considerations should be addressed:

Area of consideration going forward
STRATEGIC
Ensure that coordination and alignment can be monitored and measured as part of agencies' M&E frameworks to increase accountability for results.
Develop joint advocacy plans globally with clear line of sight to develop capacity and joint-advocacy messages at RO and CO levels.
Advocate for signatory agencies to help lift bottlenecks for coordination at country level which go beyond a single country (e.g., competition between agencies, alignment between development and humanitarian funding sources).
OPERATIONAL
Signatory agencies headquarters to better communicate to their country teams on global commitments like GAP and what it means in terms of commitment/expectations/resources.
Ensure signatory agencies have dedicated HR/activity resources to support coordination and alignment functions.

INSTITUTIONAL

Ensure there are mechanisms for global commitments to translate at the country level.

Incentivize joint programming and joint reporting.

Require partners to demonstrate contribution to national capacity and alignment to national plans.

ANNEX 5.5.1: People Consulted

Name	Designation/Title	Organization
Ms Ellen thome	Technical Officer	WHO
Dr Qudsia Uzma	Technical Officer	WHO
Shahzad Alam	Technical Officer	WHO
Ms Memoona Sadia	Technical Officer	WHO
Dr Shahnawaz	M&E Officer	WHO
Dr Nouman	Technical Officer	WHO
Ms Masooma Butt	Technical Officer & Lead	WHO
Dr Naveed Asghar	NPO	WHO
Dr Farha	NPO	WHO
Ms Sadia Iqbal	Resource Moblization Officer	WHO
Dr Yasmine Challoub	Senior Immunization Manager OIC Chief of Health	UNICEF
Dr Nabila Zaka	Health Manager	UNICEF
Dr Muhammad Jaohar Khan	Health Specialist HSS and Emergencies	UNICEF
Ms Melissa Corkum	Chief of Polio	UNICEF
Dr Inoussa Kabore	Deputy Representative UNICEF Pakistan	UNICEF
Mr Abdullah Fadil	Country Representative UNICEF Pakistan	UNICEF
Ms Fahmida Iqbal	Gender Specialist	UNICEF
Ms Sadaf Zulfiqar	Social Policy Specialist	UNICEF
Ms Asiya Ashraf Chaudhry	Wash Specialist	UNICEF
Mr Anteneh Girma Minas	Chief of Nutrition	UNICEF
Mr Ali Mirza	Health Specialist	World Bank
Ms Yuki Takemoto	UNAIDS Country Director Pakistan & Afghanistan	UNAIDS
Dr Rajwal Khan	Strategic Information Adviser UNAIDS	UNAIDS
Dr. Abid Qaiyum Suleri	Executive Director	SDPI
Dr. Razia Safdar	Advisor	SDPI
Mr. Syed Wasif Ali Naqvi	Head of Advocacy / Head of the Center for Health Policy and Innovation	SDPI
Imran	PC	UNRCO
Saleem Sheikh	HAO	UNOCHA
Ayaz Raja	Sr. liaison Coordinator	IOM
Dr Tehmina Bada	Migration Health physician	IOM
Dr Binish Nawaz	NHPSS	IOM
Dr Badar Munir	Technical Officer	WHO
Dr Kamal Asghar	Health specialist	UNICEF
Khurram Arslan	Humanitarian project analyst	UNFPA
Jalil Ali		WFP
Prem B Chand		UNICEF

Dr Abdul Bari Khan	President IHHN	
Dr Syed Zafar Zaidi	CEO	IHHN
Dr mah Talat	Executive Director	CHD, IHHN
Dr Saba Shahid	Chair paediatrician	
Syed Mashood Rizvi	Executive Director	IHHN
Dr Zafar Zaidi	CEO	IHHN
Dr. Syed Asad Ali	Chair Department of Community Health Sciences	AKU
Dr. Zahid Memon	Section Head Health Systems and Policy	AKU
Dr. Sara Saleem	Section Head Reproductive Health	AKU
Dr. Zafar Fatmi	Section Head Environmental	AKU
Dr. Muhammad Zia ul Haq	Senior Instructor	AKU
Dr. Wardah Ahmad	Senior Instructor	AKU
Dr. Abdul Wahab Hassan	Director Projects	Shifa Hospital
Mr. Taimoor Shah	Chief Operating Officer	
Breshna Orya	Senior Health Finance Specialist Health Finance Department Strategy Investment and Impact Division	Global Fund
Carrie Gheen	Senior Country Manager	Gavi

ANNEX 5.5.2: Bibliography

Meo SA, Sultan T. Brain drain of healthcare professionals from Pakistan from 1971 to 2022: Evidence-based analysis. Pak J Med Sci. 2023 Jul-Aug;39(4):921-925. doi: 10.12669/pjms.39.4.7853. PMID: 37492337; PMCID: PMC10364271.

'PHC for UHC' Mission to Pakistan Key Findings and Recommendations, March 2021.

Brief on Health Budget Analysis 2023-24, Palladium, OPM, FCDO

Minutes of the SDG3 GAP Partner Coordination Committee on GAP November 2020, august 2021, August 2022, June 2023.

Pakistan Economic Survey 2021-22

Pakistan National Health Vision 2026-25

Pakistan Progress Report: Implementation of SDG-3 & Global Action Plan for Healthy Lives & Well being

SDG3 GAP Catalytic Funding Report, 2024, SDG3 GAP Recovery Challenge Report 2022

SDG3 Global Action Plan

SDG3 Global Action Plan Progress Report, 2022

SDG3 Global Action Plan Progress Report, 2022 and 23

Status of Health Financing Pakistan 2023

ToR, Partner Coordination Committee, SDG3 GAP Pakistan

Trend Analysis of the UHC Service Coverage Index 2023

WHO. 2024. SDG3 GAP Catalytic Funding for WHO Country Offices – Reporting Template

World Bank (2023) Pakistan Development Update October 2023

https://dashboards.sdgindex.org/map/goals/sdg3

https://dashboards.sdgindex.org/map/goals/sdg3

https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS?locations=PK

https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=PK

https://data.worldbank.org/indicator/SP.POP.TOTL?locations=PK

https://data.worldbank.org/indicator/SP.URB.TOTL?locations=PK

https://hdr.undp.org/data-center/specific-country-data#/countries/PAK

https://www.cfr.org/global-conflict-tracker/conflict/islamist-militancy-pakistan#:~:text=Separatist%20and%20extremist%20movements%20have,links%20to%20the%20Afghan%20group.

https://www.emro.who.int/pak/programmes/service-delivery.html

https://www.hrw.org/world-report/2024/country-chapters/pakistan

https://www.statista.com/statistics/1376359/health-and-health-system-ranking-of-countries-worldwide/

https://www.unicef.org/emergencies/devastating-floods-pakistan-2022

https://www.worldbank.org/en/news/press-release/2024/04/01/pakistan-implementing-an-ambitious-credible-and-clearly-communicated-economic-reform-plan-critical-for-robust-recovery-p

https://www3.weforum.org/docs/WEF_GGGR_2024.pdf

5.6 Somalia Country Study

INTRODUCTION

The Joint Evaluation of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), has been commissioned by the SDG3 GAP signatory agencies. Established in 2019, SDG3 GAP is a set of commitments by 13 multilateral agencies (GAVI, GFF, ILO, the Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, UNITAID, UN Women, World Bank, WFP, WHO) to strengthen collaboration. Under the SDG3 GAP, agencies commit to align their ways of working to provide more streamlined support to countries and reduce inefficiencies. It offers a platform to improve collaboration among the significant stakeholders in global health, with specific but complementary mandates.[142] Although referred to as a Global Plan, the added value of the SDG3 GAP is intended to lay in more effectively coordinated support, action and progress at the country level.

The acceleration of progress on the health-related SDGs is primarily through seven accelerators: i) Primary Health Care; ii) sustainable finance for health; iii) community and civil society engagement; iv) determinants of health; v) innovative programming in fragile and vulnerable settings for disease outbreak responses; vi) research, development, innovation and access; and vii) data and digital health.

PURPOSE, OBJECTIVE AND SCOPE

The purpose of the evaluation is to inform signatory agencies' learning, continued improvement and mutual accountability as partners. The objective of this evaluation is to assess the coherence, effectiveness, and sustainability of SDG3 GAP collaboration efforts – at the country, regional and global levels – in accelerating country progress on the health-related SDG targets.

To this extent, the evaluation seeks to assess the extent to which signatory agencies have strengthened their collaboration to:

- engage with countries better to identify priorities;
- jointly plan and implement programs;
- harmonize operational and financial strategies, policies and approaches;
- review progress and learn together to enhance shared accountability; and
- accelerate progress in countries through joint actions on the health-related SDGs.

The temporal scope of this evaluation is the period from September 2019 to March 2024. It has been conducted at the global level, and includes two remote country studies, one of which is Somalia. The country studies serve as a tool in this evaluation to explore questions of process, experience, relationship and actors in context, including a better understanding of barriers and facilitators to activities as directly experienced. This document serves as a summary note of the key findings for the Somalia remote country study.

METHODOLOGY

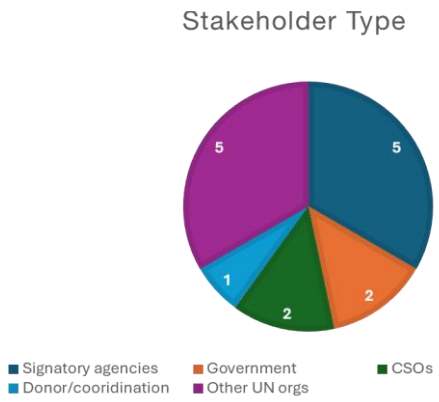
The evaluation uses a theory-based approach, using a reconstructed theory of change that reflects the common understanding of the evaluation team and SDG3 GAP agencies represented in the Evaluation Reference Group (ERG) of the SDG3 GAP. The Somalia study adopted a mixed-methods approach using both quantitative and qualitative data sources. Quantitative data reviewed includes health epidemiological and health-financing data, sourced from the Global Health

[142] https://www.who.int/initiatives/sdg3-global-action-plan

Observatory,[143] the World Bank SDG data bank[144] and the Global Burden of Disease country data.[145] A qualitative review of documents was also conducted as part of this case study.

Primary data was collected from remote interviews in March and April 2024 by two members of the evaluation team. The views of a range of stakeholders, directly involved in the SDG3 GAP and relevant to the scope of work, were sought to ensure maximum representation of a diversity of perspectives.

Figure 7: Interviews by stakeholder type



The evaluation team engaged a small sample of stakeholders, comparative to other country studies, conducting a total of 12 interviews with signatory agency staff, government officials from the Ministry of Health and civil society organizations (CSOs) working in the field of health, and relevant donors active in the health sector. It was noted by the WHO focal point for this case study from the outset that there was little awareness of the SDG3 GAP among stakeholders and this may have influenced responses to requests for engagement.

This means that there has been limited opportunity to triangulate the findings presented in this summary report. However, its findings will be triangulated in the evaluation against those from other country studies and other data sources. An additional limitation of this study is that stakeholders interviewed had limited or no knowledge or understanding of the SDG3 GAP, and this has limited the ability to address the specific questions agreed for this evaluation using the available evidence.

This draft summary note will be finalized based on stakeholder feedback and used to inform the evaluation report.

COUNTRY CONTEXT

Officially the Federal Republic of Somalia, Somalia is the easternmost country in continental Africa. The country is on the Horn of Africa and is bordered by Ethiopia to the west, Djibouti to the northwest, the Gulf of Aden to the north, the Indian Ocean to the east, and Kenya to the southwest. Somalia has the longest coastline on Africa's mainland. Somalia has a population of 17.6 million with 47% of its population living in urban areas.[146] Somalia is classified as a least developed country, with 2.4% GDP growth (annual %).[147] Somalia has one of the most complex and protracted crises anywhere in the world, and for the past 30 years has experienced political instability and conflict, coupled with environmental and economic shocks. These crises have resulted in widespread displacement, food insecurity and high levels of poverty. Food insecurity presents a major challenge, with 43.4% of the population experiencing severe food insecurity and only 41% having access to basic sanitation services. Five consecutive rainy seasons have failed, affecting over 8 million people. Since 2021, more than 1.7 million people have been displaced by drought, and the most recent drought has led to 90% of the country in extreme drought conditions.[148] The economy of the country is highly dependent on foreign aid, both humanitarian and development aid, and diaspora remittances make it hard for the government to increase domestic investment in health, education and other social sectors. Somalia received US$2.3 billion of ODA in 2021. Around 6% of this was allocated to health and 32% to addressing humanitarian need.[149]

[143] https://www.who.int/data/gho
[144] https://databank.worldbank.org/source/sustainable-development-goals-(sdgs)
[145] https://www.healthdata.org/research-analysis/gbd
[146] https://data.worldbank.org/indicator/SP.POP.TOTL?locations=SO
[147] https://data.worldbank.org/country/somalia
[148] https://civil-protection-humanitarian-aid.ec.europa.eu/where/africa/somalia_en#:~:text=For%20decades%2C%20Somalia%20has%20endured,been%20displaced%20by%20the%20drought.
[149]https://public.tableau.com/views/OECDDACAidataglancebyrecipient_new/Recipients?:embed=y&:display_count=yes&:showTabs=y&:toolbar=no?&:showVizHome=no

HEALTH CONTEXT

Between 2012 and 2019, life expectancy in Somalia steadily increased from 53 to 57 years of age, but since 2019, this has declined again to 55 years old.[150] Within the same time period, Somalia was making progress in improving mother and child health indicators, with maternal mortality rates decreasing from 862 to 606 per 100 000 live births between 2012 and 2019, although they have since risen to 621 in 2021, as detailed in Table 1 below. Under five mortality rate also decreased from 134.5 in 2015 to 111.8 per 1000 live births in 2021.[151] Of the nine indicators for SDG3 where data is available on the Sustainable Development Report, only one has a positively decreasing score, six scores are stagnating or negatively increasing at less than 50% of the required rate and only two score as moderately improving, but insufficient to attain the goal.[152] The Global Health Security Index in 2021 (the most recent report) ranks Somalia as the lowest in the world, 195th out of 195 countries.[153] In 2020, there were two healthcare workers per 100 000 people, compared to the global standard of 25 per 100 000.[154]

Table 9 Key SDG3 indicators for Somalia[155]

Indicator	2015	2021	Progress
MMR per 100 000 live births	760.9	620.7	
Under-5 mortality per 1000 live births	134.5	111.8	
TB incidence per 100 000	274	250	
Universal health coverage (UHC) index of service coverage	24	27	
Surviving infants who received 2 WHO-recommended vaccines	42	42	
Medical doctors/10 000	Date not available		
Domestic health expenditure per capita	Data not available		

Somalia faces high vulnerability to disease outbreaks, including acute watery diarrhea, cholera, and suspected measles. Since early 2024, reported cholera cases have tripled compared to the three-year average, with a case fatality rate of 1.2%—exceeding the WHO emergency threshold. Outbreaks are worsened by high child malnutrition rates, access to clean water and poor sanitation.[156]

The significant weaknesses in the health system were compounded by the COVID-19 pandemic, due to a high caseload, fewer people accessing health services due to risk of infection, overcrowding in IDP settlements, availability of health staff and interruptions to the delivery of health services. As noted in the table above, a number of key health indicators have deteriorated since 2019, likely attributable to the pandemic.

[150] https://data.worldbank.org/country/somalia
[151] https://dashboards.sdgindex.org/profiles/somalia/indicators
[152] https://dashboards.sdgindex.org/profiles/somalia/indicators
[153] https://ghsindex.org/#l-section--countryranksect
[154] CORONA VIRUS - COVID-19 COUNTRY PREPAREDNESS AND RESPONSE PLAN (CPRP)
[155] https://dhttps://ghsindex.org/#l-section--countryranksectashboards.sdgindex.org/profiles/somalia/indicators
[156] https://reliefweb.int/report/somalia/somalia-2024-awdcholera-outbreak-flash-update-no2-24-march-2024

FINDINGS

Coherence

SDG3 GAP signatory agencies' respondents had limited or no awareness and understanding of the SDG3 GAP. Among government counterparts consulted there was no awareness of the SDG3 GAP. Where there was some limited awareness, this was linked to having heard of the SDG3 GAP in relation to other countries respondents had worked in. Low awareness levels are likely due to the lack of evidence, based on interviews, of any specific plan or mechanism to adapt the SDG3 GAP to the Somali context, as well as limited internal communication on the SDG3 GAP among signatory agencies and their country offices. However, documents provided by the SDG3 GAP Secretariat indicate that the WHO Country Office in Somalia received SDG3 GAP catalytic funding of US$100 000 USD in 2022 to support its convening and coordination role in the health sector. Interviews confirmed the funding was used to convene meetings with SDG3 GAP partners.

There is limited evidence that the SDG3 GAP has contributed to incentivize alignment among agencies' strategies at the country level. Given the humanitarian context and high levels of need in Somalia, the Health Cluster is key to coordinating the health response. Although, it was noted in interviews that this can be more of a conduit for information sharing rather than driving joint planning and coordination. The UN Humanitarian and Country Teams were also cited as key to supporting coordination. The government has recently "reinvigorated" its own health coordination mechanism which is viewed positively by interviewees.

Several interviewees pointed out that given the context much of the health work is humanitarian rather than development focused, which means that interventions can be projectized and there is not a long-term vision for health offered by the government. Different planning timeframes and funding cycles were also noted by signatory agency respondents as challenges to alignment and coordination.

The potential relevance of a mechanism like the SDG3 GAP was highlighted by several respondents as a potentially useful advocacy tool to donors for shared health priorities, as well as to support more joined-up approaches between development and humanitarian partners. A number of stakeholders highlighted that the aid architecture in Somalia is in a transitional phase, with the Ministry of Health trying to further embed donor support to health within its own structure. The government is perceived as ambitious and keen to take back the leadership role that has been taken up by UN agencies and INGOs. However, signatory agencies and donors noted that gaps in the government's capacity to coordinate remain at both a federal and state level.

Effectiveness

Monitoring of the SDG3 GAP results

The main reporting mechanism is the annual SDG3 GAP progress report, which includes a health map covering six dimensions against which all SDG3 GAP countries have reported in 2022 and 2023. However, as noted in the progress reports themselves, this is a subjective assessment, and the wording of the questions does not specifically ask respondents to attribute results to SDG3 GAP. It was not clear from interviews with government who the respondents to the questionnaire were as no one interviewed from government was aware of the questionnaire or having completed it. Given this, the lack of awareness of SDG3 GAP at a country level and the lack of identified activities linked to SDG3 GAP, it is not possible to assess the SDG3 GAP's contribution to these results. For Somalia, the scores provided indicate that there are certainly challenges regarding coordination and alignment of signatory agencies, and in particular regarding the use of local coordination mechanisms.

Table 2: SDG3 GAP Heat Map Results for 22/23

Year	Criteria					
	Aligned to plans	Coordinated with each other	Aligned to budget	Uses local monitoring systems	Joint TA plan	Uses local coordination mechanisms

Whilst the heat map notes that that alignment, coordination, use of local systems and joint planning as ongoing challenges, a WHO press release in September 2020 notes that *"Somalia is one of the countries where progress under the GAP is most advanced and where its added value has been most clearly demonstrated"*.[157] This view however was not substantiated through interviews with stakeholders and does not seem aligned to the heat results or progress on the SDG3 indicators. It is also evidence of some of the challenges that have been noted more broadly around how results under the SDG3 GAP have been reported.

Extent of SDG3 GAP's contribution to SDG3 Targets

As highlighted in Table 1, there is scant evidence that the SDG3 GAP has had a significant contribution in terms of accelerating progress on SDG targets, with a number of SDG3 indicators worsening since 2019, likely due to the COVID-19 Pandemic. Accessing data to measure health outcomes was noted as a significant challenge in Somalia by interviewees from signatory agencies and donors, given data availability, quality, paucity and use for decision-making. This was thought to have been further compounded by the political situation (i.e. data sharing and access between Somalia and its autonomous regions). Interviewees also highlighted the lack of up-to-date needs analyses to inform programming decisions and planning.

Joint support to gender equality, equity and inclusiveness

Gender equality, equity and inclusiveness was noted by donors and signatory agencies as one of the key priorities, given high rates of GBV, FGM and cultural norms regarding women's access to health. According to some stakeholders, the needs are clear but practical implementation remains very challenging. Interviewees felt that government will and political motivation to address this appear to be lacking. KIIs indicated that there is limited communication between the Ministry of Women and Human Rights Development and the Ministry of Health. The SDG3 GAP does not seem to have had a focus in Somalia in this regard.

Progress on Accelerators

The primary health care and the research and innovation accelerators are highlighted as being the key focus in Somalia according to the 2022 progress report. Based on feedback in KIIs, the Sustainable Health Financing accelerator also seems to be a key focus.

Sustainable health financing

According to the reconstructed ToC, a key sustainable financing output from the SDG3 GAP would be joint support to countries to prioritize health financing for equity. As a result, health financing functions would be strengthened, with a focus on equity and "building back better" in the aftermath of COVID-19. This would lead to improving access to health and having the national health plans and priorities sustainably financed. The evaluation noted from interviews with signatory agencies that the World Bank had recently supported the Ministry of Health to establish a health financing unit. While this is in its nascency, this will be important going forward to build capacity in this area as the government increases its ownership and health leadership.

PHC

According to the reconstructed ToC, a key PHC-related output from the SDG3 GAP would be joint support to countries to develop PHC support packages of essential services to contribute to UHC. This would lead to improved access to more

[157] https://www.who.int/news-room/feature-stories/detail/somalia-building-a-stronger-primary-health-care-system

equitable quality PHC services, and more equitable and inclusive progress towards health-related SDGs. The following progress was observed:

- The 2022 SDG3 GAP Progress report notes that WHO and UNICEF have supported the federal and state ministries to conduct campaigns to improve vaccine uptake and reach zero-dose children. It details also that in March 2021, the Ministry of Health presented to the GAP PHC accelerator working group the valuable contributions of joint and coordinated support by GAP signatory agencies in several fields including the COVID-19 response and work to strengthen the essential package of health services and related health system components. This, however, was not referenced in any interviews with stakeholders.
- Interviewees highlighted that the government, with support from WHO has also updated the Essential Package of Health Services framework in 2020. Prior to the SDG3 GAP, WHO had worked with the MoH to develop a roadmap for UHC.
- Government stakeholders outlined that it has undertaken a mapping exercise of PHC support to the country to avoid duplication in the primary health care sector and ensure underfunded areas can be addressed. Government interviewees perceive that the two major donors, the World Bank and FCDO, now seem to be coordinating better.
- There is also the Damal Caafimaad PROJECT, which is funded by World Bank and is one of the biggest projects with regards to public health care in Somalia. The Government of the Federal Republic of Somalia, through the Federal Ministry of Health, is implementing the Improving Healthcare Services in Somalia under the "Damal Caafimaad" Project, with financing from the World Bank. The four-year project is intended to contribute to Essential Package of Health Services (EPHS 2020) implementation aimed at improving the coverage of essential health and nutrition services in project areas and strengthen the stewardship of the Ministries of Health in Somalia. The Damal Caafimaad Project, funded by the World Bank, has three key components: (i) Expanding the coverage of a prioritized EPHS in selected geographic areas; (ii) Strengthening Government's stewardship to enhance service delivery; and (iii) Project Management, M&E, Knowledge Management, and Learning. The Project will focus on expanding an essential package of high-impact health and nutrition services across the population in project target regions within available resources and service delivery capacity, and also aims to develop the Federal and State Ministries of Health capacity to act as stewards of the health sector.

Research and innovation

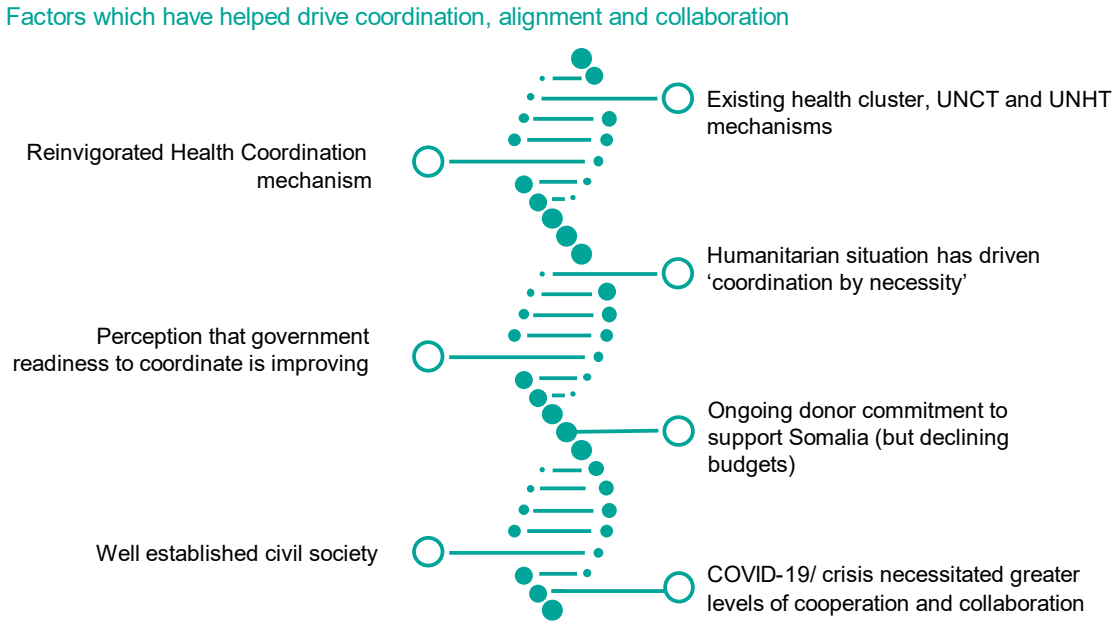
There was limited reference to the research and innovation accelerator in interviews. However, the SDG3 GAP 2021 Progress Report noted that in 2021, WHO, working with the SDG3 GAP innovation accelerator working group, Grand Challenges Canada and the Somali Ministry of Health, piloted an innovative solar-powered oxygen delivery system to address oxygen supply surge needs for COVID-19 and beyond, including for pneumonia, one of the main infectious disease killers of children.[158] Following the successful piloting, the innovation is now being taken to scale across the country with resources from a wider range of partners and working with the UN Resident/Humanitarian Coordinator.

Enabling factors and hindering factors for the SDG3 GAP

The below figures highlight a number of factors which have enabled and hindered the implementation of the SDG3 GAP, or coordination, alignment and collaboration more broadly.

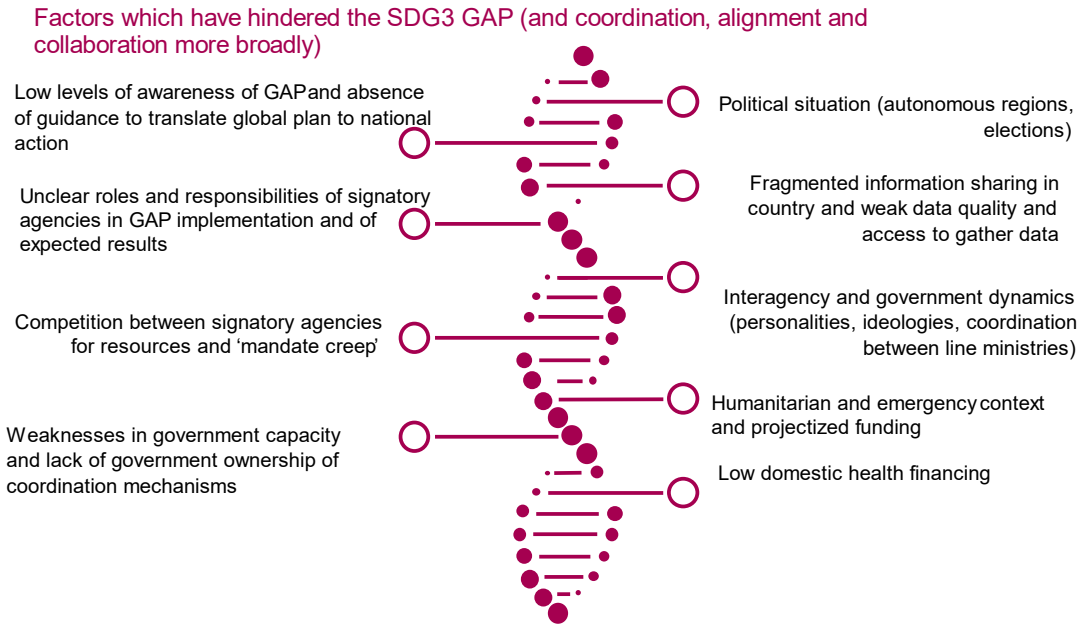
[158] Stronger Collaboration for an Equitable and Resilient Recovery towards the health-related sustainable goals: 2021 Progress report

Figure 8:Enabling Factors



The most challenging factor noted around coordination, alignment and collaboration in Somalia are most certainly the political, economic and social context, as well as the repeated emergencies and fragility. The below figure highlights a number of the key factors that have hindered either the application of the SDG3 GAP, or which hinder coordination more broadly.

Figure 9: Hindering Factors



Sustainability

As outlined previously, given the lack of awareness of the SDG GAP at a country level, and specific outcomes identified linked to the SDG3 GAP (beyond those in the progress report), it is not possible to ascertain the sustainability of these outcomes. However, the evaluation is able to identify a number of relevant considerations around sustainability of the alignment and coordination efforts by SDG3 GAP signatory agencies.

- Given the government's low investment in health (around 2% was quoted in interviews), the reliance on external funding for health is going to remain necessary for the foreseeable future and as such, there will be an increasing

need for the government to step into the coordination role within the health sector and set an agenda, systems and processes that donors can trust and support.

- Signatory agency and donor stakeholders report the challenges of working in the Somalia context given the need to coordinate with the governments of both Somalia and the autonomous regions of Somaliland and Puntland
- Interviewees from donor and signatory agencies highlighted the lack of private sector engagement in health coordination mechanisms given the significant role they play in the provision of services.
- Challenges were noted with regards to the effectiveness of the Government health sector coordination mechanism as meetings are meant to be held quarterly, but they have not been held since July of 2023. In addition to this, there is a Donor Health Group, although this mainly includes traditional, 'western' donors and there is limited integration with emerging or middle eastern donor or visibility of their investments.
- There is a lack of transparency and visibility over where and how funds are allocated and this can lead to duplication (individuals being paid twice), or to needed posts unfilled.

Areas of consideration going forward

At the country level, the following considerations should be addressed:

Area of consideration going forward
Strategic
Recognising the context of protracted and successive emergencies in Somalia, it would be important to consider how a global mechanism like the SDG3 GAP could contribute to strengthening interlinkages between development and humanitarian work in terms of planning, data sharing, and coordination and collaboration. As noted in the 2021 SDG3 GAP Progress report, further effort to translate GAP commitments made at the global level into closer collaboration and reduced fragmentation among partners at country level, with country offices mandated to respond to country needs.
Operational
Given the complexity of the working environment, global frameworks such as SDG3 GAP require specific implementation plans to be effectively operationalised.
Institutional
Recognising Somalia's size and its fragile state status and political context, consideration of how a mechanism like the SDG3 GAP can contribute to building government capacity to coordinate, align and encourage cooperation between development partners is necessary. The MoH needs additional support/ technical advice from WHO to develop its leadership in relation to SDG3.

At the global level, the following considerations should be addressed:

Area of consideration going forward
Strategic
At both a global and a country level, clearer articulation of the results intended to be achieved by the SDG3 GAP or similar and of how its contribution to country-level results can be measured would support its implementation as well as consideration of how coordination and alignment can be better integrated into agency's M&E frameworks.
Operational

Given the low levels of awareness and traction of the SDG3 GAP in Somalia, it would be helpful to consider going forward how global commitments such as SDG3 GAP are to be institutionalized to be effective at country level. For example, whether they should have country-specific action plans, designated resources and how regional offices could better support the socialization of global commitments like SDG3 GAP in countries. Additionally, it would be helpful to consider how actions required by the SDG3 GAP could be communicated effectively to country teams.

Institutional

Recognizing that there are a number of challenges cited around coordination which go beyond a single country or context, there could be further consideration as to how a mechanism like the SDG3 GAP can be used as an advocacy tool to address structural challenges affecting coordination like donor behaviour, joint accountability and issues of agencies' mandate overlap.

Signatory agencies need to better communicate how global initiatives and frameworks should be translated to the country level for results and implementation.

5.7 Tajikistan Country Study

INTRODUCTION

The Joint Evaluation of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), was commissioned by the SDG3 GAP signatory agencies. Established in 2019, SDG3 GAP is a set of commitments by 13 multilateral agencies (GAVI, GFF, ILO, the Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, UNITAID, UN Women, World Bank, WFP, WHO) to strengthen their collaboration. Under the SDG3 GAP, agencies commit to align their ways of working to provide more streamlined support to countries and reduce inefficiencies. It offers a platform to improve collaboration among the significant stakeholders in global health, with specific but complementary mandates[159]. Although referred to as a global plan, the added value of the SDG3 GAP is intended to lie in more effectively coordinated support, action and progress at a country level.

The acceleration of progress on the health-related SDGs is geared through seven accelerators: i) Primary Health Care; ii) sustainable finance for health; iii) community and civil society engagement; iv) determinants of health; v) innovative programming in fragile and vulnerable settings for disease outbreak responses; vi) research, development, innovation and access; and vii) data and digital health.

Tajikistan joined the SDG3 GAP as a pilot country in 2019, focusing on sustainable health financing. SDG3 GAP agencies also collaborate on other accelerators, namely the development of the health care workforce, PHC and data and digital health as part of SDG3 GAP in Tajikistan.

PURPOSE, OBJECTIVE AND SCOPE

The purpose of the evaluation is to inform signatory agencies' learning, continued improvement and mutual accountability to each other as partners. The objective of this evaluation is to assess the coherence, effectiveness, and sustainability of the SDG3 GAP collaboration efforts – at the country, regional and global levels - in accelerating country progress on the health-related SDG targets.

To this extent, the SDG3 GAP evaluation seeks to assess the extent to which signatory agencies have strengthened their collaboration to:

- engage with countries better to identify priorities;
- jointly plan and implement programs;
- harmonize operational and financial strategies, policies and approaches;
- review progress and learn together to enhance shared accountability; and,
- accelerate progress in countries through joint actions on the health-related SDGs.

The temporal scope of this evaluation is the period September 2019 to March 2024. It has been at the global level and includes of a series of 'deep dive' country case studies, of which one is Tajikistan. The 'deep dive' country studies serve as a tool in this evaluation to explore questions of process, experience, relationship and actors in context, including a better understanding of barriers and facilitators to activities as directly experienced. This document serves as an aide memoire for the Tajikistan study.

[159] https://www.who.int/initiatives/sdg3-global-action-plan

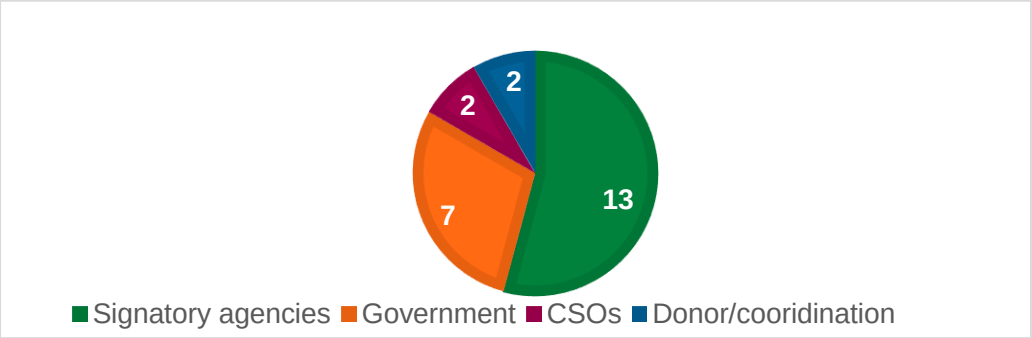
METHODOLOGY

The evaluation uses a theory-based approach, using a reconstructed theory of change that reflects the common understanding of the evaluation team and SDG3 GAP agencies represented in the Evaluation Reference Group (ERG) of the SDG3 GAP. Given the nature of the SDG3 GA, an enabling mechanism to support better use of existing resources, a contribution analysis based on testing expected change pathways and assumptions is particularly adapted to the object of the evaluation.

The Tajikistan case study adopted a mixed methods approach using both quantitative and qualitative data sources. Quantitative data reviewed includes health epidemiological and health-financing data, sourced from the Global Health Observatory[160], the World Bank SDG data bank[161] and the Global Burden of Disease country data.[162] A qualitative review of documents was also conducted as part of this case study.

Primary data was collected during a country visit conducted between 8th-15th of March 2024 by two members of the evaluation team for five working days in Tajikistan, followed by remote follow up interviews. The views of a range of stakeholders, both directly involved in the SDG3 GAP and relevant to the scope of work were sought to ensure maximum representation of a diversity of perspectives. A total of 49 respondents were consulted through 24 interviews conducted with signatory agency staff, government stakeholders from the Ministry of Health and Ministry of Finances, civil society organization working in the field of health and other relevant donors active in the health sector. Where necessary, interviews were conducted with the support of a translator. A focus group discussion was held with WHO staff, and the evaluation team also participated as observers to a partner coordination meeting (the Development Coordination Council (DCC) Health). Gender-disaggregation of respondents indicate that there was a balanced representation of men and women among respondents, as 26 (53%) of the respondents were male and 23 (47%) were female.

Figure 10: Interviews per category



At the end of the visit, the team held a de-briefing meeting with key stakeholders to present and validate emerging findings, check data accuracy and identify any data gaps. This draft case study will be finalised based on stakeholder feedback and used to inform the global evaluation report.

COUNTRY CONTEXT

Tajikistan is a landlocked, mountainous country formerly part of Soviet Union, from which it gained independence in 1991. Over two thirds of the country's population live in rural areas (72.9%) and are engaged in agricultural production[163]. Tajikistan is classified as a lower middle-income country. It has witnessed a strong economic growth in the past decade,

[160] https://www.who.int/data/gho
[161] https://databank.worldbank.org/source/sustainable-development-goals-(sdgs)
[162] https://www.healthdata.org/research-analysis/gbd
[163] UN Tajikistan (2022) The Government of Tajikistan & United Nations Sustainable Development Cooperation Framework 2023-2026

above 7.1% of GDP annual growth[164]. In 2022 the population stood at around 10 millions, GDP was USD10.5 billions and GDP per capita was 1054.7 USD[165]. According to a WHO EURO report[166] during 2000–2015, support from the United Nations and other development partners in achieving the Millennium Development Goals contributed to reducing the poverty rate from 81% in 1999 to 31% in 2016. Overall progress however coexists with mounting inequalities in the country. The UN country assessment at the basis of the UNSDCF notes that gender-based discrimination and exclusion exist at many levels in Tajikistan, and that traditional gender roles are still widespread as demonstrated in a range of indicators including early marriage, low labour force participation, unequal access to land and assets, unpaid care work and GBV.[167] Civil space has been drastically limited in Tajikistan, with over 700 CSOs being dissolved in the past year[168]. The UN is very active in the health sector in Tajikistan; UN and its partners are supporting 41 activities for SDG 3 out of a total of 112 activities.[169] Other key partners in the health sector include the EU, GAVI, GIZ, the Global Fund and USAID.

HEALTH STATUS

Despite progress on some key health-related SDG targets, many of the SDG3 targets are not on track in the country (see Table 1).

Between 2000 and 2019, life expectancy in Tajikistan increased by 3.9 years, reaching 67.6 years for men and 71.5 years for women[170]. The country has demonstrated substantial progress in improving mother and child health indicators. Maternal mortality rates decreased from 20.38 to 16.63 per 100,000 live births between 2015 and 2021. Under-five mortality rate also decreased from 37.4 in 2015 to 31.4 per 1000 live births in 2021[171].Tajikistan is undergoing an epidemiological transition, with the overall disease burden shifting from communicable to noncommunicable diseases (NCDs). NCDs are the leading cause of death in Tajikistan[172] representing eight out of the top ten causes of death in the country, the first two being ischemic heart disease and stroke.

Table 10 Key SDG3 indicators for Tajikistan. Source: UN Statistics Division[173]

Indicator	2015	2021	Progress
MMR per 100,000 live births	20.38	16.63	
Under-5 mortality per 1000 live births	37.4	31.4	
TB incidence per 100,000 *GHO	86	78	
HIV infections per 1000	0.113	0.099	
Risk of dying from main NCDs	29.5%	28.3% (2019)	
UHC coverage (%)	68	67	

[164] The World Bank in Tajikistan: https://www.worldbank.org/en/country/tajikistan/overview#1
[165] The World Bank in Tajikistan: https://www.worldbank.org/en/country/tajikistan/overview#1
[166] WHO (2020) Health-related SDG targets in Tajikistan: implementation of policies and measures for health and well-being
[167] UN Tajikistan (2022) The Government of Tajikistan & United Nations Sustainable Development Cooperation Framework 2023-2026
[168] https://www.ohchr.org/en/press-releases/2024/03/tajikistan-un-expert-criticises-dissolution-700-ngos#:~:text=In%20November%202023%2C%20the%20Tajik,over%20an%2018%2Dmonth%20period.
[169] United Nations Tajikistan: https://tajikistan.un.org/en/sdgs/3/key-activities#sdg-tab-content
[170] WHO Global Health Observatory life expectancy at birth
[171] SDG Country Profile Tajikistan: https://unstats.un.org/sdgs/dataportal/countryprofiles/tjk#goal-3
[172]Global Burden of Disease (2023) Tajikistan country profile
[173] SDG Country Profile Tajikistan: https://unstats.un.org/sdgs/dataportal/countryprofiles/tjk#goal-3

Medical doctors/10,000	2.2 (2000)	1.7 (2014)	
Domestic health expenditure per capita (current USD) *WB	23.05 (2014)	18.33 2022)	

HEALTH SYSTEM AND HEALTH FINANCING

The Tajikistan health system presents ongoing challenges. The UHC Index has stagnated since 2015 around 67, and resources for health indicators such as medical doctors/10,000 populations are on a decreasing trend. There are also important geographical inequalities in the distribution of human resources for health: the highest density is observed in Dushanbe, where there are around 83.2 doctors per 10,000 population, whereas there are only 11.6 doctors per 10,000 population in the Khatlon oblast[174]. Tajikistan is also facing a deficit of doctors for specific specialties such as family doctors. Migration of healthcare workers outside the country is one of the reasons for observed shortage of qualified human resources, an issue compounded by the low salaries of the healthcare workforce of Tajikistan.

Government health investment is low at around 8% of GDP in 2020[175], the lowest per capita in WHO Europe region. A publicly financed basic benefit package (BBP) of services has been developed and started to be rolled out, however many people fall outside the eligibility scope. The health sector is heavily dependent on foreign investment, with a net disbursement of total official development assistance received for medical research and basic health sectors increasing from 26.5 million to 83.5 million of constant 2021 dollars between 2015 and 2021[176].

FINDINGS

Coherence

SDG3 GAP signatory agencies respondents had varying degrees of awareness and understanding of the SDG3 GAP. Some agency respondents were cognisant of the SDG3 GAP, for example through their involvement with the initiative at HQ level, while others had heard of the SDG3 GAP but considered that since the launch in 2019, the initiative had gradually lost momentum. The 2020 report by WHO EURO *Health-related SDG targets in Tajikistan: implementation of policies and measures for health and well-being* provides a detailed analysis of the status of SDG3 in Tajikistan and identifies priorities to progress on the SDG3 GAP objectives. Nonetheless, there is little/no evidence of follow up to this diagnostic exercise, with most issues identified not seeing any follow up action.

In SDG3 GAP agencies outside WHO, there appears to be a disconnect between the commitment to the SDG3 GAP at global level and country teams. There were scant reports of internal communication on the SDG3 GAP among signatory agencies to their country offices. In particular, the mechanism to translate the SDG3 GAP at country level was unclear. The majority of respondents considered however that a mechanism like the SDG3 GAP, if it had a clear implementation pathway at country level, would be highly relevant to address ongoing issues of coordination and alignment in the health sector.

Among government counterparts consulted there was no awareness of the SDG3 GAP.

The most visible mechanism to translate the SDG3 GAP in Tajikistan has been the catalytic funding of 50,000 to 100,000 USD annually provided to WHO to support its convening and coordination role in the health sector. This flexible funding dedicated to coordination has enabled WHO to mobilise GAP agencies around key priorities on health financing, human

[174] Ministry of Health (2023) Prioritized Tajikistan Prioritized Action Plan 2024-2026
[175] The World Bank: https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=TJ
[176] https://unstats.un.org/sdgs/dataportal/countryprofiles/tjk#goal-3

resources for health and digitalization, including through the convening of the Development Coordination Council (DCC) working group on Health.

While there is no clear implementation mechanism among SDG3 GAP agencies outside of WHO to support its implementation, there is evidence that the SDG3 GAP has enabled better alignment among agencies in Tajikistan through supporting the role of WHO as a convener of the health sector partners' coordination. The catalytic funding provided to WHO has allowed WHO to dedicate staff time to effectively mobilise the partner-led coordination platform called the DCC Health.

The DCC health is considered as one of the most active DCC groups[177] in the country and the main health sector coordination platform. Its five subgroups are aligned to the SDG3 GAP accelerator themes. This mechanism is well linked to the Results Group on Health within the UNCT, co-led by WHO and UNICEF and to the Joint Annual Review (JAR) which is currently the most active government-led platform for overall health sector coordination. There are other mechanisms that seem less well integrated with the DCC health such as the Global Fund's CCM and the UNAIDS Joint Team. The cluster mechanism is activated from the Rapid Emergency Assessment and Coordination Team (REACT) which is the permanent government-humanitarian community disaster risk management partnership for Tajikistan.

A retreat for the DCC health was organized in 2023 using SDG3 GAP catalytic funding, which provided a platform for key actors in the health sector to discuss joint priorities. SDG3 GAP also provided flexible funding for facilitating government coordination meetings, and also sensitization activities on SDG3 GAP. High level policy dialogues were organized, for example in February 2024 on affordable healthcare and medicines and on access to medicines. These efforts have arguably contributed to fostering alignment and coordination among key health partners beyond bilateral discussions around specific programmes.

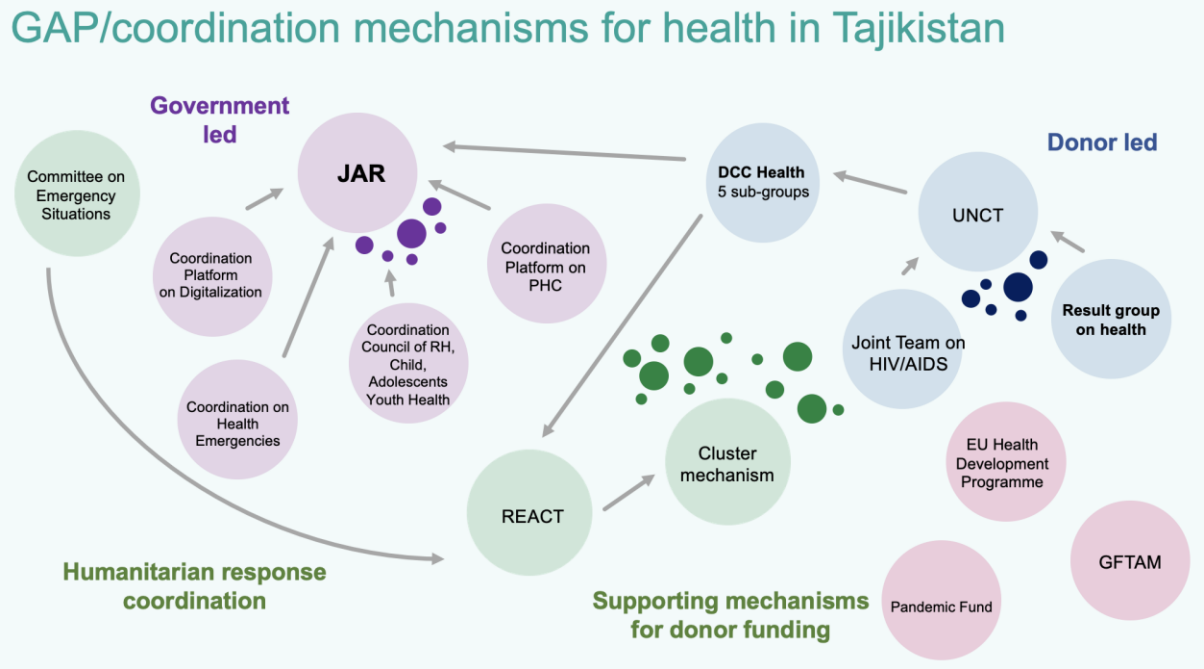


Figure 11: Health Coordination Mechanisms in Tajikistan

[177] There is a total of 14 DCC working groups, falling in the categories of sustainable development, human development (which includes the DCC Health) and Economy and Private sector development.

However, agencies without an explicit health mandate such as ILO, UNWOMEN and UNAIDS are not well integrated in the multisectoral health sector coordination. There are also key agencies beyond SDG3 GAP signatories that are actively involved in the health sector in Tajikistan, such as GIZ and the EU.

A main issue with the health coordination architecture in Tajikistan is the weak role of the Ministry of Health in steering these mechanisms. Although the Ministry is present as an observer in the DCC Health, convenes the JAR and chairs the CCM, the procedures led by government are described as more high-level discussions, focused on formal information sharing rather that open, decision-making platforms. There is however a strong commitment and openness from the Ministry of Finances and Ministry of Health officials consulted to improve the effectiveness of coordination by government in the health sector. However, this is hampered by a lack of human resources and budget capacity of the MoHSPP at central level. The 2020 EURO report on Tajikistan highlighted the lack of engagement of the decentralised level in health coordination, with most planning and consultation processes taking place centrally. Civil Society, while represented in the CCM, is largely absent from the coordination platforms and the discussions. This reflects an adverse political climate and shrinking civil space that mean that *"CSOs are very quiet"* in the words of a SDG3 GAP agency respondent.

There is some evidence of the contribution of SDG3 GAP on enabling WHO to build the MoHSPP's capacity to take ownership of the coordination of the health response. The Joint Annual Review (JAR) mechanism is thus convened by the Ministry of Health with support from WHO which is gradually handing over the organization and agenda setting to the Ministry. One agency respondent considered that holding these annual sessions was an achievement in itself, developing a joint accountability mechanism between the Government and partners on the implementation of the National health strategy. Another key achievement in this respect is the Joint Statements on Sustainable Health Financing and PHC, which are reference documents endorsed by the Government and development partners and have contributed to laying out a common ground on mutual commitments from the Government and health partners.

While there is some evidence that global commitments such as the SDG3 GAP may have contributed to incentivize alignment among agencies' strategies at country level, no evidence was found of efforts to align the operational and financial procedures and policies of agencies. The different planning timeframes, disbursement and reporting processes by agencies were noted as hindering factors by government and SDG3 GAP respondents in terms of effective health sector support, and no evidence was gathered by the evaluation that these had been influenced in any way by the SDG3 GAP commitment.

Effectiveness

Extent of GAP's contribution to intended results

The SDG3 GAP objective of better alignment and coordination among agencies have seen progress in Tajikistan; however, the linkages between the SDG3 GAP and the observed changes are tenuous. In particular, the contribution of SDG3 GAP appears modest within the constellation of initiatives on alignment in the health sector in Tajikistan. These initiatives are pursuing very similar objectives to the SDG3 GAP in country, with the same agencies, but they differ from the SDG3 GAP in nature, in that they are funded programmes. Key recent initiatives in this respect include the EU-funded programme *Health for all in Tajikistan: strengthening health governance and financing* implemented in partnership between GIZ, UNICEF and WHO on improving UHC, and the GFF work on health financing and alignment of health partners around one Prioritized Action Plan (PAP) to implement the National Health Strategy. The World Bank has launched an important project called 'Millati Solim' in 2023. This project of around 50 million USD is implemented up to 2028 in 25 districts by the Ministry of Health. As part of the design of this project, a mapping of other actors in the health sector was done to leverage their technical support for the programme and involve them in initial discussions. Key partners identified for complementarity include EU, WHO, GIZ, USAID, UNFPA, UNICEF, Aga Khan Foundation and CDC.

These efforts have arguably fostered better alignment between health partners. But there were diverging views among respondents involved in those initiatives on the SDG3 GAP contribution to those, suggesting that there may have been an indirect contribution of the SDG3 GAP. While some respondents considered that there was no direct link with the SDG3 GAP, others have described the SDG3 GAP as an 'umbrella' facilitating better alignment within these other initiatives. The pathways through which SDG3 GAP may have influenced broader alignment efforts include the DCC Health coordination as

well as technical assistance by WHO. For example, WHO has been supporting the MoH with the development of an M&E plan for the health sector strategy, to which the M&E framework of the new World Bank programme Millati Solim, is aligned. The World Bank programme also integrates the scale up of the MoH/WHO pilot project in five districts on Basic Benefits Healthcare Package in its design.

There is scant evidence that the SDG3 GAP has had a significant contribution in terms of accelerating progress on SDG targets. Rather, achievements on improving SDG targets related to MNH and infectious diseases such as TB and HIV are arguably more linked to vertical programme interventions that have provided targeted investment to services delivery in those areas.

Joint support to gender equality, equity and inclusiveness

There are positive examples of SDG3 GAP agencies supporting civil society participation in the health sector: UNWOMEN has supported women networks on documenting gender inequalities and UNAIDS has piloted and scaled up with MoHSPP a Community Lead Monitoring system of health services to improve services quality from patients' perspective. WHO has undertaken work to document issues of access to health care for people living with disabilities. ILO and WHO have also collaborated on issues of PSEA and gender discrimination in the health workforce. The UN Resident Coordinator has played a role when requested by agencies to raise human rights related concerns with the government at higher level.

Despite these initiatives, there is little joined-up work from SDG3 GAP agencies to advocate on gender equality and health equity issues. The SDG3 GAP does not appear to have contributed to either addressing or raising awareness on those issues. Questions of gender and equity are primarily seen in the prism of expanding geographical coverage of services in rural areas and addressing financial barriers to health services. According to both SDG3 GAP agency and civil society respondents, many health partners appear reticent to advocate on human rights, stigma and discrimination issues to avoid undermining relationship with the Government. Civil society respondents have considered that SDG3 GAP agencies could do more to support them in the current climate, in particular through facilitating a dialogue with government, and supporting the recognition of their role in the health system including through 'social contracting' mechanisms that would help make civil society organisations' work more visible to the government.

Progress on Accelerators

The key sustainable health financing accelerator is the main focus of SDG3 GAP signatory agencies in Tajikistan. Other accelerators the agencies have been active on include PHC and data and digital health.

Sustainable health financing

According to the reconstructed ToC, a key sustainable financing output from the SDG3 GAP would be joint support to countries to prioritize health financing for equity. As a result, health financing functions would be strengthened, with a focus on equity and building back better in the aftermath of COVID 19. This would lead to improving access to health and having the national health plans and priorities sustainably financed.

Health financing has indeed been a key priority in Tajikistan's health sector. A resource mapping and expenditures tracking exercise supported by the World Bank and the GFF has allowed the MoF and MoHSPP to capture data on 24 development partners working in the health sector. Importantly, GFF has supported the development of a three-year costed Prioritized Action Plan (PAP). This plan aligns to the SDG3 GAP accelerators through strategic directions such as Improving Access, Quality, and Responsiveness of Primary Health Care and Achieving sustainable financing. Despite important planned investment from the World Bank through Millati Solim, this plan is currently largely underfunded, as Tajikistan has little fiscal space for health and partners' contributions cannot cover the funding gap.

In this context, there is potential for the SDG3 GAP to contribute to the achievement of expected results of the PAP through fostering broader buy-in and alignment in its implementation. The Joint statement in support of health financing transition in the Republic of Tajikistan is considered a strong advocacy tool to further mobilise public financing for health which may be instrumental in implementing the PAP. The SDG3 GAP has been instrumental in securing the Joint Statement, both

through the WHO coordination and through providing a global framework for GAP agencies to achieve a joint commitment at country level.

PHC and human resources for health

According to the reconstructed ToC, a key PHC-related output from the SDG3 GAP would be joint support to countries to develop PHC support packages of essential services to contribute to UHC. This would lead to improved access to more equitable quality PHC services, and more equitable and inclusive progress towards health-related SDGs.

There is some evidence of such process in Tajikistan. The country is facing important challenges in developing PHC, transitioning from the soviet era system which was highly centralised and hospital based to a PHC focused health system focussing of extending family medicine in rural areas. Key issues include the lack of trained health care staff in rural areas and the poor state of health care infrastructures.

SDG3 GAP agencies have contributed to establishing a shared diagnosis and roadmap to address the issue of PHC services coverage, through a Joint statement of the Ministry of Health and Social Protection of Population and development partners on strengthening primary health care in Tajikistan. The SDG3 GAP has been an important contributing factor to the joint statement, in particular through the facilitation of WHO. However, other important initiatives on PHC are not related to GAP. In particular, SDG3 GAP agencies have supported the development of a Basic Benefit Package including PHC services, which took five years to negotiate and currently covers 21% of the population. In addition, there is an increasing PHC focus among agencies that traditionally were supporting vertical disease specific programmes. The HIV roadmap by UNAIDS describes a new approach to HIV response focussing on sustainability through strengthening government leadership to invest in health care system transformation for achieving and sustaining both HIV-specific target and broader SDG3 targets.[178]

Data and digital health

According to the reconstructed ToC, this accelerator would translate into joint support to national health data systems by SDG3 GAP agencies. This would result in better health data and information system, including disaggregated data allowing to track health equity and LNOB. This would contribute to reaching health related SDG targets by ensuring that decisions are taken based on timely and reliable health data.

This pathway is only partly verified in Tajikistan. To date, Tajikistan's HMIS remains very fragmented. Tajikistan does not yet have a nationwide electronic patient record system. The quality of reporting and data in the DHIS2 is a concern. The MOHSPP uses data from national sources as well as from the last DHS in 2017 and other surveys for the assessment of progress on SDGs, based on historical trends. Respondents report that health data can also be a sensitive topic, and there may be use of different data sources between governments and partners[179]. Disaggregated data collection and analysis, by gender and other stratification factors (e.g. rural/urban, disability) is incomplete.

While there is an increasing degree of joint support from SDG3 GAP agencies and others to the country's HMIS, there are also important contextual and internal factors to the agencies that have hampered alignment and effective support to improve health data. Agencies have invested in the HMIS, but in a piecemeal, duplicative manner, setting up parallel data collection and reporting systems associated to specific programmes. As a result, the HMIS is fragmented between different disease-programmes, resulting in uneven quality and timeliness of data. MoHSPP respondents consider that areas that receive more donor support (vaccination, TB and HIV, MNCH) have better data, whilst others like NCDs and mental health are data weak.

SDG3 GAP agencies and other health partners in Tajikistan have increasingly attempted to remedy this situation. Initiatives include WHO/MOHSPP *Roadmap for Improving Health Information System and Digital Health in Tajikistan until 2027* (draft),

[178] UNAIDS (2023) Tajikistan country-level exercise on Development of Sustainability Roadmap for the HIV Response 2024

[179] The national health plan mentions that between 2000 and 2019, life expectancy in Tajikistan increased by 6.8 years, reaching 73 years for men and 76.9 years for women. GHO numbers indicate for the same period that life expectancy increased by 3.9 years, reaching 67.6 years for men and 71.5 years for women. For the purpose of this report, we have relied on GHO data.

but also a 5-10 years plan by World Bank on digitalization within and beyond the health sector, and GIZ/USAID funding to upgrade and digitalise health data reporting systems, among others. From the evaluation team's observation during the DCC health meeting, there seems however to be a consensus among agencies about this diagnostic and the way forward to remedy the situation through better alignment and coordination. However, the issue of digitalization in Tajikistan is wide ranging and goes beyond the health sector. This field is currently poorly coordinated, and in the health sector there are still many players without a clear coordinated approach to their efforts.

Agencies collectively enabling better use of resources

Evidence relating to efficiency gains from the SDG3 GAP is limited. This is due to the fact that government coordination mechanisms in the health sector are not well developed, so partners rely either on their own platforms (DCC health, CCM) or on bilateral discussions with their counterparts in the government to fulfil this function.

The weak human resources and management capacity of the Ministry of Health has led to sub-optimal use of resources by partners. For example, many donors like GIZ, EU or the Global Fund do not channel their funds through the Ministry. There is a 'virtual' budget alignment exercise based on the costed Prioritized Action Plan, but disbursements channels are multiple. Millati Solim, a key project in terms of financial volume in the health sector is managed through a specially set-up Project Management Unit to ensure that the Ministry of Health is able to comply with accountability requirements of the Bank.

Monitoring of SDG3 GAP results

The main reporting mechanism is the annual SDG3 GAP progress report, which includes a health map covering six dimensions against which all SDG3 GAP countries have reported in 2022 and 2023. These dimensions are 'scored' by national government focal points against a scale indicating their degree of agreement on the extent to which progress was made. For Tajikistan, these indicate satisfactory (light green) progress on four dimensions, and stagnating progress (yellow) on two areas. This assessment is difficult to interpret, given that it is self-reported and not accompanied by a narrative explanation of the score given. The process to arrive at the score is also not described. In addition, several respondents considered that successes reported in the narrative of the report may only be loosely related to the SDG3 GAP, and the causal link between the cause and effect are not well explained in the report.

Table 11: SDG3 GAP Heat Map Results for 22/23

Year	Criteria					
	Aligned to plans	Coordinated with each other	Aligned to budget	Uses local monitoring systems	Joint TA plan	Uses local coordination mechanisms
2022						
2023						

In terms of the agencies' own reporting, WHO and UNAIDS reported tracking their contribution to improved coordination and alignment as part of their core functions. However, other organizations were not directly tracking their work on alignment at country level beyond reporting on joint programmes. Coordination and alignment were seen under the prism facilitating the achievement of programme targets, rather than a specific dimension to be reported on.

Sustainability

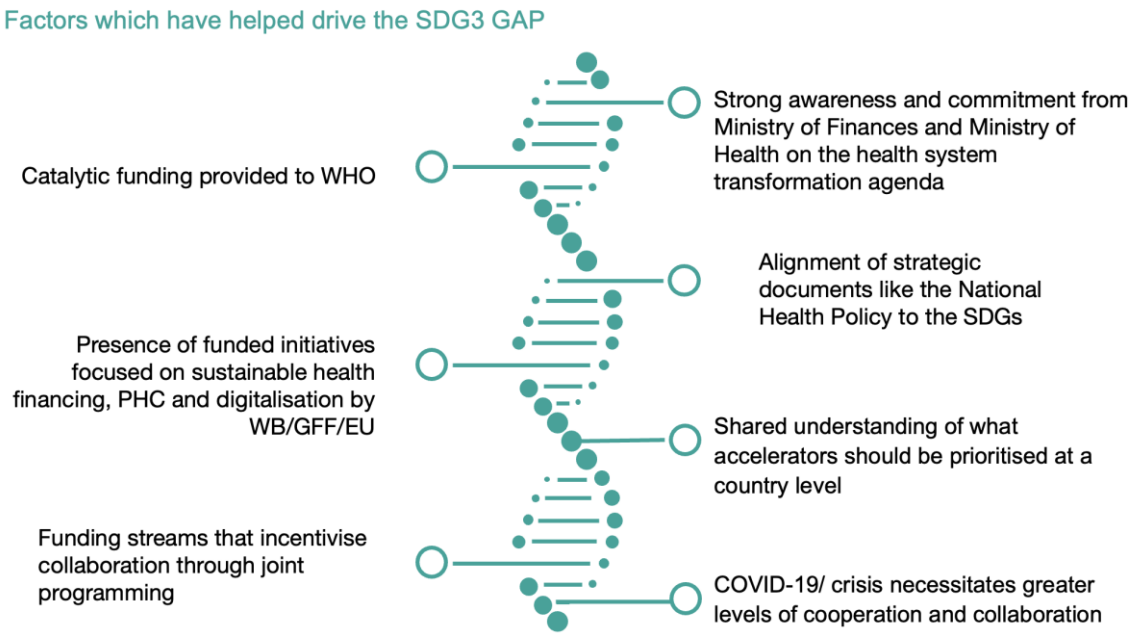
Some of the outcomes that can be traced either from the SDG3 GAP or from SDG3 GAP agencies' work on alignment and coordination more broadly show promising potential for sustainability. There is increasing alignment in the diagnostic and priorities of both government and development partners. Key documents like the Prioritized Action Plan, Millati Solim

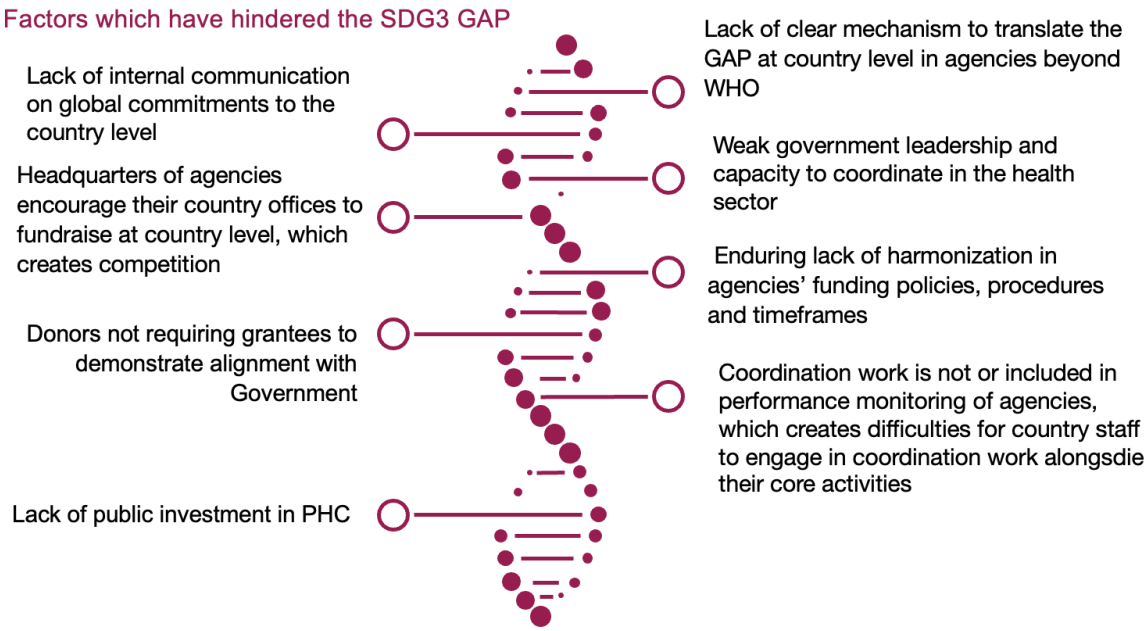
project document and UNSDCF present references to national targets and indicators and shared approaches to support UHC and PHC services, increasingly identifying the roles of other agencies in supporting their own objectives. The Ministry of Finance has been actively participating in efforts on health financing alongside the Ministry of Health, demonstrating good government buy-in for health financing reforms. Health partners, including those with disease specific mandates such as the Global Fund, have increasingly recognized and invested in addressing structural issues of government capacity and health system strengthening as a necessary condition to achieve disease-specific targets.

There are however concerns regarding the sustainability of health sector strengthening efforts in Tajikistan. The leadership and capacity of the Ministry of Health to drive agendas such as the Minimum Benefit Package, digitalization of the HMIS, and health financing reform remain weak. Despite per capita growth investment in health over the past decade, government investment in health remains low, at around 8% of GDP. This limits the ability of the MOHSPP to play key functions in coordination at national and sub-national level, and questions the ability of health sector partners to implement the planned reforms, in a context of shrinking ODA. In addition, the policies of key health financing agencies like the Global Fund or USAID impede direct budget support through pooled funding mechanisms, which limit the availability of flexible funding to support government's capacity. The fact that the main coordination platform, the DCC health, is a partner-led platform also raises concerns in terms of long-term sustainability and influence of the health coordination efforts. Lastly, the context of shrinking civil space is a key concern in terms of sustainably reducing health inequities, including gender inequalities, in health. In this context, partnerships with CSOs by SDG3 GAP agencies have largely been limited to services provision/implementing partner modalities. Agencies such as Global Fund, UNAIDS, UN WOMEN have attempted to involve civil society in advocacy efforts with government. Civil society organizations interviewed would welcome more support from SDG3 GAP agencies to promote their inclusion in coordination mechanisms and foster collaboration with the government.

Despite dire consequences, the COVID-19 pandemic has contributed to better coordination of health actors in Tajikistan. Agencies such as the World Bank, WHO and EU have supported the Government of Tajikistan to develop their COVID-19 Country Preparedness and Response Plan in March 2020, creating a small group meeting weekly to share information and monitor progress on procurement of supplies and equipment. However, the pandemic has delayed further significant progress on health reforms. Another longer-term consequence of the pandemic has been to bring focus on the disaster preparedness work, and in particular on developing the laboratory capacity of the country, which was developed during COVID-19 has benefitted from increased support in recovery phase.

Enabling factors and stumbling blocks for the SDG3 GAP





Areas of consideration going forward

Country level

Area of consideration going forward
Strategic
Strengthen leadership of MoHSPP to coordinate key actors on health financing of the basic benefit package, HIS. Possible avenues for this are supporting long terms consultancy in relevant departments and advocating for MoHSPP to call regular coordination meetings. Strengthen the coordination on digitalization through an effective, government-led to remedy existing duplications.
Operational
Support the MoH with tools for coordination of health partners. For example, the mapping of the budget can be expanded on to include mapping of activities at national and sub-national levels. Improve the JAR process to enhance conducive environment, ownership, and mutual accountability. Moving away from presentation-based sessions to a learning process directly feeding in the next planning cycle.
Institutional
Consider revitalizing the national coordination committee for health, currently serving as the Global Fund CCM, to federate all health sector actors including civil society: • Provide an avenue for civil society to participate more systematically in health coordination beyond the CCM thematic areas of work • Advocate to MOHSPP for the committee to be revitalised

Improve synergies between coordination mechanisms: DCC Health, UNSDFCR RG on Health, UN Joint Team on HIV, REACT.

Ensure that ToRs of different coordination mechanisms are reviewed and mapped against the key needs for coordination in health, ensuring that there are mechanisms for alignment between them.

Improve the linkages with non-health focussed agencies with DCC health: e.g. ILO, UN WOMEN.

Ensure that all agencies active in the health sector are invited and well informed to identify possible synergies with health-focussed agencies.

Global level

Area of consideration going forward
Strategic

Advocate for donor agencies to help ease bottlenecks for coordination at the country level:

- Incentivize joint programming and joint reporting
- Require partners to demonstrate contribution to national capacity and alignment to national plans
- Fund the HSS/system and coordination function
- Transition to budget support funding modalities
- More joined up fundraising at the country level instead of competing

Consider how the impact of global frameworks like SDG3 GAP can be better monitored and measured at the country level.

Agree a "coordination tax" to feed in a country-level pool fund, recognizing that effective coordination by government benefits all.

Develop joint advocacy plans globally with clear line of sight to develop capacity and joint advocacy messages at regional and country levels.

Operational

Maintain catalytic funding for coordination.

Institutional

Ensure there are mechanisms for global commitments to translate at country level. Communicate with country teams on global commitments like SDG3 GAP and what it means for them.

Design a simple common results framework to track coordination of global frameworks like the SDG3 GAP and alignment as part of agencies' M&E frameworks.

Work to align and streamline reporting frameworks and mechanisms between SDG3 GAP agencies.

Provide dedicated HR/activity resources to the country office to support coordination and alignment functions.

Liaise with the RCO mechanism to support joint advocacy work on gender equality, human rights and civil society participation at the country level.

ANNEX 6: Bibliography

- Colombia Potencia de lá vida (2023). Estrategia Nacional de Cooperación Internacional de Colombia 2023-2026.
- Ethiopia. (2018). Macroeconomic Impact of Financing the SDGs.
- Ethiopia. (2018). Terms of Reference of the SDG Task Force_080818.
- Ethiopia. (n.d.). Alignment Diagnostic Assessment Report.
- Ethiopia. (n.d.). Final Action Points for Presentation-Government.
- Ethiopia. (n.d.). Final Ethiopian Harmonized Action Plan.
- Ethiopia. (n.d.). Proposed priority action plans.
- Función Pública (2015). Decreto 280 de 2015: Comisión ODS Colombia.
- Global Fund. (2022). Catalytic Funding to Country Offices 2022 - 2023
- La salud es de totos Minsalud. (2022). Plan decenal de salud pública 2022-2031.
- La salud es de totos Minsalud. (n.d.). Guía disponibilidad de información ODS territorial COL.
- MERQ Consultancy PLC (2021). CBHI Impact Assessment.
- Ministry of Health - Ethiopia (2019-2020). Health Accounts Report.
- Ministry of Health – Ethiopia (n.d.). National Health Promotion Strategic Plan.
- Ministry of Health – Ethiopia. (2020-2024). National Health Equity Strategic Plan.
- Ministry of Health – Ethiopia. (2021). Health Sector Transformation Plan.
- Ministry of Health – Ethiopia. (2021). Special Bulletin_FINAL_2021.
- Ministry of Health - Ethipoia (2021). Final Draft Household Model Report, January 22, 2021.
- Ministry of Health (2015). Annual Performance Report 2015 EFY_Final.
- Ministry of Health and Social Protection of Population (n.d.). Joint Partners Statement on Primary Health Care.
- Ministry of Health and Social Protection of Population of the Republic of Tajikistan. (2018-2020). HMIS Roadmap.
- Ministry of Health and WHO. (2022). Health Financing Report.
- Ministry of Health Ethiopia. (2021). Annual Performance Report, October 22, 2021.
- Ministry of Health Zambia. (2020). Attendance List, HPCC 27 February 2020.
- Ministry of Health Zambia. (n.d.). Brief for the Honourable Minister of Health on the HPCC.
- Ministry of National Health Services Regulations & Coordination. (2017). National Health Vision Report.
- Ministry of National Health Services, Regulations & Coordination. (2023). Health Budget Analysis Report.
- Ministry of National Health Services, Regulations & Coordination. (2023). Health Financing Snapshot.
- Ministry of National Health Services, Regulations & Coordination. (2023). Status of Health Financing Report.
- Ministry of Planning and Development. (2022). VNR 2022 Ethiopia Report.
- National Administrative Department of Statistics. (2022). Medición del progreso de los ODS en Colombia 2022.
- Nigeria Ministry of Health. (2018-2022). National Health Strategic Plan (extended to 2025).
- Nigeria National Health Insurance Authority. (2021). Act.

- Nigeria National Health Insurance Authority. (2023). Operational Guidelines.
- Nigeria. (2014). National Health Act.
- Nigeria. (2016). National Health Policy.
- Nigeria. (2022). Progress Towards SDG3 Healthy Lives in Nigeria.
- Pakistan. (2018). National Health-Related SDGs Indicators, Milestones, and Targets.
- Pakistan. (2020). GAP Progress Report.
- Pakistan. (2021). Country Progress Report on SDG3 and GAP Implementation.
- Pakistan. (2022). SDG3 GAP Recovery Challenge Reporting Template.
- Region: Regional Health Alliance strengthens collaboration towards better health: Uniting to accelerate progress towards the health-related SDGs.
- Responses to C.L.37. (2021): AFRO – Benin, Burundin, Cabo Verde, Chad, Comoros, Congo, Cote d'Ivoire, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. AMRO-PAHO: Bolivia, Colombia, Guatemala, Haiti, Nicaragua, and Panamá. EMRO: Afghanistan, Egypt, Morocco, Pakistan, Somalia, Syrian Arab Republic, Tunisia, and Yemen. EURO: Bulgaria and Tajikistan. SEARO: Bhutan, Indonesia, Nepal, and Sri Lanka. WPRO: Laos People's Democratic Republic and Mongolia.
- SDG Corporate Tracker Colombia (n.d.). Documento SDG-CT_VF.
- Sustainable Development Solutions Network. (2023). Sustainable Development Report 2023.
- Tajikistan. (2023). Prioritized Action Plan, March 24, 2023.
- Tajikistan. (2023). Prioritized Investment Plan, March 24, 2023.
- Tajikistan. (2023). Sustainable Development Report 2023.
- Tajikistan. (n.d.). Lusaka-Agenda.
- Tajikistan. (n.d.). Reforming Primary Health Care to Reach Universal Health Coverage.
- Tajikistan. (n.d.). Signed Joint Statement on Health Financing Reforms.
- Tajikistan. (n.d.). Terms of Reference of the DCC Working Group on Health.
- Tajikistan. (n.d.). Towards Universal Coverage of Maternal Health Services.
- The state of development effectiveness evidence for health: where are the gaps, where is there richer evidence and what are the trends? 3ie's Development Evidence Portal (2023)
- The World Bank. (2023). Millati Solim.
- The World Bank. (n.d.). Program for Action and Development (PAD).
- UNAIDS Tajikistan. (n.d.). Sustainability Presentation.
- UNDAF. (2018). UNDAF Mid-Term Review Final Report, November 2018.
- UNDP. (2021). Guidance Note and Checklist for Tackling Gender-Related Barriers to Equitable COVID-19 Vaccine Deployment https://www.healthdatacollaborative.org/
- UNFPA Colombia. Naciones Unidas Colombia. (n.d.). Guía de medición de los ODS en Colombia.
- UNFPA Ethiopia. (n.d.). Regions Factsheet.
- UNFPA Nigeria. (2021). Endline Evaluation Report of the EU Support to UN Response Plan to Covid-19 in Nigeria.

- UNFPA Nigeria. (n.d.). 8th Country Programme Evaluation Final Report, Vol 1: Main Report.
- UNFPA Nigeria. (n.d.). 8th Country Programme Evaluation Final Report, Vol 2: Annexes.
- UNFPA Nigeria. (n.d.). Mid-Term Evaluation of EU Support to UN Response Plan to Covid-19 in Nigeria.
- UNICEF Nigeria. (n.d.). SDG3 Evaluation Summary.
- United Nations Country Team Colombia. (2024). UNCT Colombia, Feb. 2024.
- United Nations Ethiopia. (2022). UN 2020-2022 Report.
- United Nations Ethiopia. (2022). UNSDCF Results Report 2020-2022.
- United Nations Pakistan. (2021). One UN Report.
- United Nations Pakistan. (2023-2027). UNSDCF Final Report.
- United Nations Tajikistan. (n.d.). Annual Report EN One UN.
- United Nations. (2022). UNCT SWAP Annual Review 2022.
- United Nations. (2023). UNSDCF Governance Structure Overview.
- UNODC Nigeria. (2023). National Women's Research Report.
- UNODC Nigeria. (n.d.). National Situation and Health Needs Assessment of Women in Prison.
- Vivid Economics. (n.d.). Final Ethiopia SDG Baseline Report.
- Vivid Economics. (n.d.). Final Ethiopia SDG Needs Assessment Report.
- WHO and UNICEF Nigeria. (2021). SDG3 Health Evaluation in Nigeria Final Report, September 30, 2021.
- WHO and World Bank Methodology (2023). Brief Trend Analysis of UHC Index-E4H VF.
- WHO Ethiopia. (2022). Annual Report.
- WHO Ethiopia. (n.d.). Country Cooperation Strategy Assessment (CCA).
- WHO Expanded Programme on Immunization. (2022). EPI Annual Report.
- WHO Nigeria. (n.d.). Country Cooperation Strategy III Final Design.
- WHO Nigeria. (n.d.). SDG3 Evaluation in Nigeria: Key Findings and Recommendations.
- WHO Nigeria. (n.d.). SDG3 Healthy Lives in Nigeria.
- WHO. (2018). Addressing the health-related SDGs in the Eastern Mediterranean
- WHO. (2019). Stronger Collaboration, Better Health Global Action Plan for Healthy Lived and Well-being for All
- WHO. (2020). Joint Evaluability Assessment of the Global Action Plan for Healthy Lives and Well-being for All
- WHO. (2020). Management response to Joint Evaluability Assessment
- WHO. (2020). Overview of GAP Operating Model
- WHO. (2020). Positioning the SDG3 GAP for country impact in the COVID-19 era
- WHO. (2020). SDG3 GAP Progress Report
- WHO. (2020). Stronger collaboration, better health: 2020 progress report on the Global Action Plan for Healthy Lives and Well-being for All
- WHO. (2020). Theory of Change
- WHO. (2021). 2021 SDG3 GAP catalytic funding – Thematic Challenge

- WHO. (2021). Application template SDG3 GAP catalytic funding “PHC-led equitable recovery to the SDGs through stronger collaboration” For country Offices
- WHO. (2021). Circular Letter C.L.37.2021 (English, Chinese, Arabic, French, Russian and Spanish)
- WHO. (2021). Progress report on the Global Action Plan for Healthy Lives and Well-being for Al
- WHO. (2021). SDG3 GAP Progress Report
- WHO. (2021). SDG3 GAP: Supporting an equitable and resilient recovery towards the health-related Sustainable Development Goals
- WHO. (2021). Stronger collaboration for an equitable and resilient recovery towards the health-related Sustainable Development Goals: 2021 progress report on the Global Action Plan for Healthy Lives and Well-being for Al
- WHO. (2022). Accelerating SDG progress through collaboration – 2023 challenge. Application template for SDG3 GAP catalytic funding for WHO Country Offices
- WHO. (2022). Addressing the health-related SDGs in the Eastern Mediterranean Region: Regional Health Alliance strengthens collaboration towards better health
- WHO. (2022). Catalytic Funding to Country Offices 2022 – 2023
- WHO. (2022). Ethiopia Healthcare Financing Report.
- WHO. (2022). Joint Action Plan 2022-2023
- WHO. (2022). Letter from SDG3 Principals to Country-Facing Teams
- WHO. (2022). Management response to SDG3 GAP Joint Evaluability Assessment recommendations – as of May 2022
- WHO. (2022). SDG3 GAP agencies’ contributions for joint recovery strategy
- WHO. (2022). SDG3 GAP Progress Report
- WHO. (2022). Stronger collaboration for an equitable and resilient recovery towards the health-related Sustainable Development Goals, incentivizing collaboration: 2022 progress report on the Global Action Plan for Healthy Lives and Well-being for Al
- WHO. (2023). Analyzing data collected from national governments and relevant authorities through the questionnaire of the SDG3 GAP monitoring framework
- WHO. (2023). chief declares end to COVID-19 as a global health emergency https://news.un.org/en/story/2023/05/1136367
- WHO. (2023). Health Information System Roadmap.
- WHO. (2023). Progress Report on the Global Action Plan for Healthy Lives and Well-being for All in Ethiopia 2023.
- WHO. (2023). SDG3 GAP Countries Global Overview
- WHO. (2023). SDG3 GAP Country Case Studie https://www.who.int/initiatives/sdg3-global-action-plan/progress-and-impact/case-studies
- WHO. (2023). SDG3 GAP Progress Report
- WHO. (2023). The state of development effectiveness evidence for health: where are the gaps, where is there richer evidence and what are the trends? 3ie’s Development Evidence Portal
- WHO. (2023). What worked? What did not? What is next? 2023 progress report on the Global Action Plan for Healthy Lives and Well-being for All

- WHO. (2024). Final SDG3 GAP Country Office Catalytic Funding Reporting Template.
- WHO. (May 2021). Monitoring Framework: May 2021 Approved for piloting
- WHO. (no date). Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP): Induction slide deck for country-facing teams of the SDG3 GAP agencies
- WHO. (no date). Stronger Collaboration, Better Health Global Action Plan for Healthy Lives and Well-being for All Strengthening collaboration among multilateral organizations to accelerate country progress on the health-related Sustainable Development Goals: An Overview
- WHO. SDG3 GAP Progress Report, Aligning for country impact. (2024) saw an increase to 69 countries, compared to the previous 67. https://dashboards.sdgindex.org/map/goals/sdg3
- WHO. SDG3 GAP. (2024) annual report p. 16
- World Bank. (2007). World Bank Sourcebook for Evaluating Global and Regional. Partnership Programs Sourcebook for Evaluating Global and Regional Partnership Program: Indicative Principles and Standards
- World Bank. (2018). World Bank Group Support to Health Services: Achievements and Challenges. An Independent Evaluation
- World Bank. (2020). The World's Bank: An Evaluation of the World Bank Group's Global Convening
- World Bank. (2023). FY24 List of Fragile and Conflict-affected Situations: https://thedocs.worldbank.org/en/doc/608a53dd83f21ef6712b5dfef050b00b-0090082023/original/FCSListFY24-final.pdf

ANNEX 7: Interviewees

Remote KIIs

Organisation	Stakeholder Type	Role	Name
WHO	Secretariat	Senior Adviser, Director, Organizational Change (TIC)	Søren Brostrøm
WHO	Secretariat	Technical Officer	Hendrik Schmitz Guinote
WHO	Secretariat	Technical Officer	Mwenya Kasonde
WHO	Secretariat	Communications Consultant	Akunda Pallangyo
WHO	Secretariat		Hélène Binet
World Bank	Signatory Agency Principal	Head Global Health, Nutrition and Population	Monique Vledder
UNITAID	Signatory Agency Principal	Deputy Executive Director	Philippe Duneton
Global Fund	Signatory Agency Principal	Head - Strategic Investment and Impact Division	Marijke Wijnroks
Global Fund	Signatory Agency Principal		Peter Sands
UNFPA	Signatory Agency Principal	ASG and Deputy Executive Director (Programme)	Diene Keita
ILO	Signatory Agency Principal	Assistant Director	Manuela Tomei
WFP	Signatory Agency Focal Point	Partnerships Officer	Benjamin Syme
World Bank	Signatory Agency Focal Point	Senior Economist for Health	Kent Ranson
UNICEF	Signatory Agency Focal Point	Associate Director Health	Fouzia Shaffique
UNITAID	Signatory Agency Focal Point	Manager for Multilateral and Bilaterial	Eva Maria Nathanson
UNAIDS	Signatory Agency Focal Point	Director of Science, Services and Systems for All	Simaga Fode
GFF	Signatory Agency Focal Point	Deputy Executive Global Health	Bruno Rivalan

GAVI	Signatory Agency Focal Point	Director - Public Policy Engagement	Anamaria Bejar
Global Fund	Signatory Agency Focal Point	Senior Advisor, Health Finance Department	Emi Inaoka
UNFPA	Signatory Agency Focal Point	Global Coordinator	Hemant Dwivedi
UNFPA	Signatory Agency Focal Point	Coordination Adviser, Youth and Demographic Dividend	Soyoltuya Bayaraa
UNDP	Signatory Agency Focal Point	Policy Specialist	Roy Small
UNWOMEN	Signatory Agency Focal Point		Nazneen Damji
ILO	Signatory Agency Focal Point	Technical Specialist Health Services Sector	Maren Hopfe
ILO	Signatory Agency Focal Point	Head - Public and Private Services Unit	Oliver Liang
WHO	Other Stakeholders in GAP Agency	Health and Multilateral Partnerships	Jiangang Nie
WHO	Other Stakeholders in GAP Agency	Health Financing Unit	Matt Jowett
WHO	Other Stakeholders in GAP Agency		Raymond Bruce Alyward
WHO	Other Stakeholders in GAP Agency	Senior External Relations Officer	Igor Pokanevych
World Bank	Other Stakeholders in GAP Agency	Senior Global Health Consultant	Katri Betram
UNICEF	Other Stakeholders in GAP Agency	Health Section portfolio (PHC/SDG3 GAP)	Ann Robins
UNICEF	Other Stakeholders in GAP Agency	Chief, Programme Coordination	Alanna Khalil
UNICEF	Other Stakeholders in GAP Agency	Evaluation Specialist	Simon Bettighofer
UNICEF	Other Stakeholders in GAP Agency	Senior Evaluation Specialist for Institutional Effectiveness	Erica Mattellone
UNITAID	Other Stakeholders in GAP Agency	Director of Results	Vincent Bretin
UNIAIDS	Other Stakeholders in GAP Agency	Testing and Treatment	Gang Sun
GAVI	Other Stakeholders in GAP Agency	Director – Health Systems & Immunisation Strengthening	Alex de Jonquieres
GAVI	Other Stakeholders in GAP Agency	Director – Strategy Funding & Performance	Johannes Ahrendts
GAVI	Other Stakeholders in GAP Agency	Head – Strategy Design & Delivery	Quentin Guillon

GAVI	Other Stakeholders in GAP Agency	Head – Measurement and Strategic Information	Dan Hogan
GAVI	Other Stakeholders in GAP Agency	Senior Manager – Partnerships & Grants	Susan Branker Greene
UNFPA	Other Stakeholders in GAP Agency	SRHR Adviser, Geneva Office	Petra ten Hoope-Bender
UNDP	Other Stakeholders in GAP Agency	Mary Jreidini	Ms. Maria Walter
UNDP	Other Stakeholders in GAP Agency	Regional Strategic Planning Advisor	Rima El Hassani
UNDP	Other Stakeholders in GAP Agency	Policy Specialist	Elfatih Abdelraheem
ILO	Other Stakeholders in GAP Agency	Senior Technical Specialist, Gender, Equality, Diversity and Inclusion	Afsar Syed Mohammed
WHO	Accelerators	PHC Special Programme	Tova Tampe
WHO	Accelerators	External Relations Officer	Taina Nakari
WHO	Accelerators - Research and Innovation	Innovation Hub	Louise Agernsap
WHO	Accelerators	DDI	Craig Burgess
UNICEF	Accelerators	Health Specialist	Rei Takesue
GAVI	Accelerators - Sustainable Finance for Health	Director of Immunization Financing and Sustainability	Benjamin Loevinsohn
UNAIDS	Accelerators - Sustainable Finance for Health	Integrated Services and systems for HIV and Health	Ani Shakarishvili
UNAIDS	Accelerators - Community/Civil Society Engagement	GIPA	Carlos Garcia de Leon
World Bank	Accelerators - Gender Focal Point	Senior Health Specialist	Charlotte Nielsen
UNICEF	Regional Stakeholders	ROSA Health Specialist	Adriana Rietsema
GAVI	Regional Stakeholders	Director – High Impact Countries	Tokunbo Oshin
UNFPA	Regional Stakeholders	Regional Health Systems Adviser	Jyoti Tewari
ILO	Regional Stakeholders	Chief Technical Adviser - Social Protection, Asia	Marielle Phe Goursat
FCDO	Bilateral Doners	Health Advisor	Jo Keatinge
German Federal Ministry of Health	Bilateral Doners	Head of Unit, Global Health	Björn Kümmel
Other		Future of Global Health Initiatives	Linda Muller

Other		Former WHO Advisor	Peter Singer
Other		SDG3 GAP Consultant	Roger Drew

Country Studies KIIs

Colombia

Organisation	Stakeholder Type	Role	Name	KII / FGD
ILO	National PAM Agency	Director of the ILO Andean Office	Italo Cardona	KII
League Against Road Violence	National PAM Agency	Director	Mary Bottagisio	KII
Ministry of Health and Social Protection (MSPS)	National PAM Agency	Coordinator of the Sexuality, Sexual Rights and Reproductive Rights Group	Ricardo Luque	KII
PAHO	National PAM Agency	DUS/HL Adviser	Evelyne Degraff	KII
PAHO	National PAM Agency	National SRH Consultant	Catherine Rodríguez	KII
PAHO	National PAM Agency	VBG National Consultant	Juliana Martha Iregui	KII
PAHO	National PAM Agency	Deputy Representative	Maria Ines Salamanca Vidak	KII
UN Women	National PAM Agency	SRH Adviser	José Luis Wilches	KII
UNFPA	National PAM Agency	Representative	Luis Mora Fernández	KII
UNICEF	National PAM Agency	Protection Coordinator	Salua Marcela Osorio Mrad	KII

UNDP	National PAM Agency	Deputy Representative	Alejando Pacheco	KII
WFP	National PAM Agency	Deputy Country Director – Support Units	Rossella Bottone	KII
Women's Coporation	National PAM Agency	Director	Alejandra Vera	KII

Ethiopia

Organisation	Stakeholder Type	Role	Name	KII or FGD
Consortium of Reproductive Health Association (CORHA)	Civil Society Organisation	Executive Director	Abebe Kebede	KII
Ehtiopian Health Insurance Services	Private Sector	Deputy Director General	Dr Muluken	KII
Ethiopian Public Health Association	Civil Society Organisation	Executive Director	Dr Alemayehu Mekonne	KII
Ethiopian Public Health Association	Civil Society Organisation	M&E Officer	Amsale Ayele	KII
Gates Foundation	Donors in-country/Donor coordination groups bodies	Health and Nutrition Work	Susna De	KII
ILO	SDG3 GAP Agencies	Country Representative	Alexio Musindo	KII
Ministry of Labour	Government	Labour Inspection and Occupational Safety and Health Desk Head	Tiumezgi Berhe	KII
Ministry of Women and Social Affairs	Government	Director	Seleshi Tadesse	KII
MoH (Ministry of Health)	Government	Maternal, Child & Adolescent Health Service	Mr Biruk & Mrs Bethlehem	FGD
MoH (Ministry of Health)	Government	LEO, Disease Prevention and Control	Dr Hiwot Solomon	KII
MoH (Ministry of Health)	Government	HIS and Data Use Director	Shegaw Mulu Tarekegn	KII
MoPD	Government	Director, Planning and Research Directorate	Habtamu Takele	KII
Population Services International	Civil Society Organisation	Policy Officer	Dr Patrick Olomo	KII
RCO	SDG3 GAP Agencies	Head of Office	Hanna Schmitt	KII

RCO	SDG3 GAP Agencies	Data Management Officer	Esete Berile Faris	KII
UN Women	SDG3 GAP Agencies	Programme Specialist	Addisalem Befekadu	KII
UNAIDS	SDG3 GAP Agencies	Country Director	Francoise Ndayishimiye	KII
UNAIDS	SDG3 GAP Agencies	Joint UN HIV Team Network of People Living with HIV (NEP plus) Network of Women Living with HIV (NNPWE) Network of Adolescent and Youth Living with HIV (ASK US) Ethiopian National Disability Action Network (ENDAN)		FGD
UNAIDS	SDG3 GAP Agencies			
UNAIDS	SDG3 GAP Agencies			FGD
UNAIDS	SDG3 GAP Agencies			
UNAIDS	SDG3 GAP Agencies			
UNDP	SDG3 GAP Agencies	Programme Specialist, Health and Environment (EU Project)	Yu Ding	KII
UNFPA	SDG3 GAP Agencies	Deputy Representative and Humanitarian Programme Coordinator	James Okara Wanyama	KII
UNFPA	SDG3 GAP Agencies	Operations Manager	Taiwo Oluyomi	KII
UNFPA	SDG3 GAP Agencies	Programme Specialist	Dr Mahbub Ali	KII
UNHCR	SDG3 GAP Agencies	Senior Public Health Officer	Dr Florah Bukania	KII
UNICEF	SDG3 GAP Agencies	Chief Health	Daniel Ngemera	KII
UNICEF	SDG3 GAP Agencies	Health and Nutrition Specialist	Taha Al-Mulla	KII
UNICEF	SDG3 GAP Agencies	Health Officer	Andarge Abie Ayele	KII
WHO	SDG3 GAP Agencies	Coordinator Strategic Health Policy and Planning	Dr BeyjoyP Nambiar	KII
WHO	SDG3 GAP Agencies	Health Cluster Coordinator	Sacha Bootsma	KII
World Bank	SDG3 GAP Agencies	Senior Health Specialist	Enias Baganizi	KII
World Bank	SDG3 GAP Agencies	Senior Operations Officer	Roman Tesaye	KII

Jordan

Organisation	Stakeholder Type	Role	Name	KII or FGD
FDA	Government	Head of Drug Registration Department	Dr. Maha Jaghbeer	KII
FDA	Government	Director of Rational Drug Use and Pharmacovigilance	Jaber	KII
IMC	INGO	Country Director	Dr. Ahmad Bawaneh	KII
IOM	UN Agency	Program Officer	Hiba Abaza	KII
IOM	UN Agency	Senior Technical Officer	Md Saiful Qayyum	KII
JNC	Government	Community Health Nursing	Professor Hani Nawafleh	KII
MoH (Ministry of Health)	Government	Assistant Professor	Dr. Mohammad Alqaddoumi	KII
MoH (Ministry of Health)	Government	Director of the Directorate of Health Awareness and Information	Dr. Ghaith Owais	KII
MoH (Ministry of Health)	Government	Director of Project Management, Planning and International Cooperation	Eng. Huda Ababneh	KII
MoH (Ministry of Health)	Government	Head of Strategic Planning	Lubna Thaher	KII
MoH (Ministry of Health)	Government		Yara	KII
UN RCO	UN	Data Management and Results Monitoring/Reporting Specialist	Nihal Kanaan	KII
UN RCO	UN	Senior Economist	Cengiz Cihan	KII
UNFPA	Signatory Agency	SRH Programme Analyst	Ali Gharabil	KII
UNHCR	UN	UNICEF Area Representative	Adam Eltayeb Khalifa	KII
UNHCR	UN	Head of Data Analysis group	Shahzad Asghar	KII
UNICEF	UN	Monitoring Section Head	Butyana Al Khatheeb	KII
USAID/Jordan	Donor	Health Office Director	Bethany Haberer	KII
USAID/Jordan		Deputy Director	John McKay	KII
USAID/Jordan		Agreement Officer's. Representative (AOR)	Nagham Abu Shaqra	KII
USAID/Jordan		Project Management Specialist, Population & Family Health Office	Rawan Qurashi	KII

USAID/Jordan		Senior Population and Family Health advisor/Population and Family Health	Maysa Al Khateeb	KII
WHO	Signatory Agency	Public Health Officer (Health Promotion and Determinants) ·	Ala Al Shiek	KII
WHO	Signatory Agency	Noncommunicable Diseases Officer	Dana Darwish	KII
WHO	Signatory Agency	WHO Representative	Dr. Jamela Al-Raiby	KII
WHO	Signatory Agency	Monitoring And Evaluation Officer	Dr. Nazeema Sheerin Muthu	KII

Nigeria

Organisation	Stakeholder Type	Role	Name	KII or FGD
CCM	Donor	Acting Executive Secretary	Tajudeen Ibrahim	KII
CHI	Private Sector	Associate Director	Adekemi Gbolade	FGD
CHI	Private Sector	Primary Manager	Ashiru Abubakar	FGD
CHI	Private Sector	Program Manager, Vaccines Program, Iterative learning and Improving access	Nchinjoh Sangwe Clovis	FGD
CHI	Private Sector	Associate, PHC	Peace Oruma	FGD
Health Federation Nigeria	Private Sector	President	Dr Pamela Ajayi	FGD

Health Federation Nigeria	Private Sector	Vice president also country director for Pharmacies	Njide Ndili	FGD
Health Federation Nigeria	Private Sector	Program Manager	Peter	FGD
Health Sector Reform Coalition	Civil Society Organisation	Coalition member	Juliana Aribo	FGD
Health Sector Reform Coalition	Civil Society Organisation	Chairperson	Chika Offor	FGD
Health Sector Reform Coalition	Civil Society Organisation	Coalition member	Aminu Garba Magashi	FGD
Health Sector Reform Coalition	Civil Society Organisation	Coalition member	Dr Abdullahi Mohammed	FGD
ILO	Signatory Agencies	Technical Personnel, HIV	Ogheneruno Onosode	FGD
ILO	Signatory Agencies		Danjuma Emmanuel	FGD
ILO	Signatory Agencies	Country Director	Phala Vanessa	FGD
Former Ministry of Health	Government	Deputy Director	Zakariyyah Mohammed	KII
Former Ministry of Health	Government	National Malaria Coordinator	Godwin Ntadom	KII

MTN	Private Sector	Project Coordinator	Joseph Akpata	FGD
MTN	Private Sector	Project Coordinator	Adaku Ndukwe	FGD
NACA	Government	Director General	Dr Gambo Aliyu	FGD
NACA	Government	Deputy Director	Esther Ikomi	FGD
NACA	Government	Head of policy, planning and stakeholder coordination	Dr Ndukwe	FGD
NACA	Government	Community prevention and care services	Dr James	FGD
NACA	Government	Performance management and resource mobilization	Mrs Yinka	FGD
NEPWHAN	Civil Society Organisation	National Coordinator	Abdulkadir Ibrahim	FGD
NEPWHAN	Civil Society Organisation	National M & E Officer	Efosa Godwin Edegbe	FGD
OSSAP-SDGs	Government	Special Advisor to the President on SDGs	Dr Bala	KII
UN Women	Signatory Agencies	Country Representative	Beatrice Eyong	KII
UN Women	Signatory Agencies	Normative standards, coordination	Patience Ekeoba	KII

		and partnerships		
UNAIDS	Signatory Agencies	Country Director	Leo Zekeng	KII
UNDP	Signatory Agencies	Country Representative	Elsie Attafuah	KII
UNFPA	Signatory Agencies	Assistant Representative	Andat Dasogot	FGD
UNFPA	Signatory Agencies	Gender	Dr. Babatunde Adelekan	FGD
UNFPA	Signatory Agencies	Family planning team lead	Dr Joachim Chijide	FGD
UNFPA	Signatory Agencies	Deputy Country Director	Francis Kuawu Koessan	FGD
UNICEF	Signatory Agencies	Country Representative	Christian	KII
UNICEF	Signatory Agencies	Chief of Health and HIV/AIDS	Eduardo Celades	FGD
UNICEF	Signatory Agencies	Health Specialist	Emmanuel Emedo	FGD
UNDOC	Signatory Agencies	Deputy Representative	Dr Uduak Daniel	KII
WFP	Signatory Agencies	Head of Nutrition	Darline Raphael	KII
WHO	Signatory Agencies	Country Director	Dr Walter Kazadi Mulombo	KII

Pakistan

Organisation	Stakeholder	Role	Name	KII or FGD
WHO	Signatory Agency	Coordinator - Polio	Dr Zainul Abedin	KII
WHO		Technical Officer - HPLC	Ms Ellen Thome	KII
WHO		Technical Officer - MHNCH	Dr Qudsia Uzma	KII
WHO		Technical Officer - Health promotion/NCDs	Shahzad Alam	KII
WHO		Representative/Head of mission	Dr Luo Dapeng	KII
WHO		Technical Officer - NCDs	Ms Memoona Sadia	KII
WHO		M&E Officer - EPI	Dr Shahnawaz	KII
WHO		Technical Officer - EPI	Dr Nouman	KII
WHO		Technical Officer & Lead - GER/SDGs	Ms Masooma Butt	KII
WHO		GAP Focal Point	Muhammad Naveed Asghar	KII
WHO		NPO - HSD	Dr Naveed Asghar	KII
WHO		NPO - WHE	Dr Farha Sabih	KII

WHO		Resource Moblization Officer - RM	Ms Sadia Iqbal	KII
UNICEF	Signatory Agency	Senior Immunization Manager OIC Chief of Health	Dr Yasmine Challoub	KII
UNICEF	Signatory Agency	Health Manager	Dr Nabila Zaka	KII
UNICEF	Signatory Agency	Health Specialist HSS and Emergencies	Dr Muhammad Jaohar Khan	KII
UNICEF	Signatory Agency	Chief of Polio	Ms Melissa Corkum	KII
UNICEF	Signatory Agency	Deputy Representative UNICEF Pakistan	Dr Inoussa Kabore	KII
UNICEF	Signatory Agency	Country Representative UNICEF Pakistan	Mr Abdullah Fadil	KII
UNICEF	Signatory Agency	Gender Specialist	Ms Fahmida Iqbal	KII
UNICEF	Signatory Agency	Social Policy Specialist	Ms Sadaf Zulfiqar	KII
UNICEF	Signatory Agency	Wash Specialist	Ms Asiya Ashraf Chaudhry	KII
UNICEF		Chief of Nutrition	Mr Anteneh Girma Minas	KII
World Bank	Signatory Agency	Health Specialist	Mr Ali Mirza	KII

World Bank	Signatory Agency	Senior Health Specialist & Health Economist	Jahanzeb Sohail	KII
UNAIDS	Signatory Agency	UNAIDS Country Director Pakistan & Afghanistan	Ms Yuki Takemoto	KII
UNAIDS	Signatory Agency	Strategic Information Adviser UNAIDS	Dr Rajwal Khan	KII
SDPI	Research Organisation	Executive Director	Dr. Abid Qaiyum Suleri	Group Interview
SDPI		Advisor	Dr. Razia Safdar	
SDPI		Head of Advocacy / Head of the Center for Health Policy and Innovation	Mr. Syed Wasif Ali Naqvi	
UNRCO	UN agency	PC	Imran	Group Interview
UNOCHA	UN agency	HAO	Saleem Sheikh	
IOM	UN agency	Sr. liaison Coordinator	Ayaz Raja	
IOM	UN agency	Migration Health physician	Dr Tehmina Bada	
IOM	UN agency	NHPSS	Dr Binish Nawaz	
WHO	Signatory Agencies	Technical Officer	Dr Badar Munir	
UNICEF		Health specialist	Dr Kamal Asghar	
UNFPA		Humanitarian project analyst	Khurram Arslan	

WFP		Food Security Climate Change & Nutrition Officer	Jalil Ali	
UNICEF		Chief of Field Office	Prem B Chand	
IHHN	Private Sector	President IHHN	Dr Abdul Bari Khan	Group interview
IHHN		CEO	Dr Syed Zafar Zaidi	
IHHN		Executive Director	Dr mah Talat	
IHHN		Chair pediatrician	Dr Saba Shahid	
IHHN		Executive Director	Syed Mashood Rizvi	
IHHN		CEO	Dr Zafar Zaidi	
AKU	Academic	Chair Department of Community Health Sciences	Dr. Syed Asad Ali	Group Interview
AKU		Section Head Health Systems and Policy	Dr. Zahid Memon	
AKU		Section Head Reproductive Health	Dr. Sara Saleem	
AKU		Section Head Environmental	Dr. Zafar Fatmi	
AKU		Senior Instructor	Dr. Muhammad Zia ul Haq	
AKU		Senior Instructor	Dr. Wardah Ahmad	

Shifa Hospital	Private Sector	Director Projects	Dr. Abdul Wahab Hassan	
Shifa Hospital		Chief Operating Officer	Mr. Taimoor Shah	

Somalia

Organisation	Stakeholder Type	Role	Name	KII or FGD
Caafimad plus Consortium	CSO representatives	Consortium Director	Dr Robert O. Nyanga	KII
Embassy of Canada / GCC	Donors representatives: co-chairs of the Somali Health Donors Group (SHDG)	Senior Development Officer	Elisha Ogonji	KII
Embassy of Switzerland / SDC	Donors representatives: co-chairs of the Somali Health Donors Group (SHDG)	Regional Health Advisor (Horn of Africa)	Corinne Corradi	KII
Gavi	SDG3 GAP Agencies	Senior Country Manager	Patience MUSANHU	KII
GFF	SDG3 GAP Agencies	Senior Health Specialist	Tawab HASHEMI	KII
Global Fund	SDG3 GAP Agencies	Fund Portfolio Manager	Job MURIUKI	KII
Health Cluster	Cluster Mechanism Stakeholders	Health Cluster Coordinator	Erna VAN GOOR	KII
IOM	UN	Head of Agency	Frantz CELESTIN	KII
Ministry of Health (MoH)	Government	Director of Policy and Planning	Abdifatah Ahmed Mohamed	KII
Ministry of Health (MoH)	Government	Head of Governance and Stewardship Unit	Abdullahi Nur Guraash	KII
Somali NGO Consortium	CSO representatives	Director	Nimo Hassan	KII
UK - FCDO	Other bilateral donors	Health Adviser, Humanitarian Health Education and Resilience Team	Caroline Mwangi-Otieno	KII
UN RCO	UN	Data Management and Results Monitoring/Reporting Officer	Ahmed Abdi	KII
WHO	SDG3 GAP Agencies	Health Policy Advisor	Marina MADEO	KII
World Bank	SDG3 GAP Agencies	Health Specialist	Abdisalam Bahwal	KII

Tajikistan

Organisation	Stakeholder type	Role	Name	KII or FGD
WHO	GAP signatory agency	UNV	Lenara Appas	FGD
WHO	GAP signatory agency	Communication Officer	Feruza	FGD
WHO	GAP signatory agency	WHE influenza (PIP), HIV, hepatitis, lab and diagnosis	Abdullakhad Safarov	FGD
WHO	GAP signatory agency	Digital Health	Shodiya Mirhidarova	FGD
WHO	GAP signatory agency	Infection prevention and control	Jayreen	FGD
World Bank	GAP signatory agency	Senior Economist	Mirja Channa Sjoblom	KII
UNWOMEN	GAP signatory agency	Country Programme Manager	Malika Jurakulova	KII
UNICEF	GAP signatory agency	Chief of Health	Tony	FG
UNICEF	GAP signatory agency	Health Officer	Shahlo Shakarova	FG
UNICEF	GAP signatory agency	Chief of Planning ME	Mubin	FG
UNFPA	GAP signatory agency	Managing MNH, SRHR	Ravshan Tohirov	KII

UNFPA	GAP signatory agency	FP commodity security and humanitarian	Rhurshed	KII
UNAIDS	GAP signatory agency	CD	Aziza Hamidova	KII
SpinPlus	CSO	Harm Reduction Specialist	Pulod Dzhamolov	KII
WHO	GAP signatory agency	Head of Office	Victor Olsavszky	FGD
WHO	GAP signatory agency	Health Policy Advisor	Ilker Dastan	FGD
WHO	GAP signatory agency	Communications and Partnerships	Judith Sprunken	FGD
WHO	GAP signatory agency	NPO, Public Health Officer	Parvina Makhmudova	FGD
WHO	GAP signatory agency	NPO, Health Policy	Malika Khakimova	FGD
ILO	GAP signatory agency	Senior Workers Specialist	Gocha Alexandria	FGD
ILO	GAP signatory agency	Capacity Building of Trade Unions	Miranda Fajerman	FGD
ILO	GAP signatory agency	Senior Specialist in Employers' Activities	Vladimir Curovic	FGD
ILO	GAP signatory agency	National Coordinator of ILO	Aminov Sobir	FGD
GIZ	Donors representatives	MD, Gynaecologist	Lola Olimova	FGD

GIZ	Donors representatives	Continuous education building PHC integrated systems	Muazamma Dzhamalova,	FGD
GIZ	Donors representatives	Digital Health Advisor	Thomas Piekarzyk	FGD
GFTAM	GAP signatory agency	Portfolio Manager	Faizan Darwan	KII
GFTAM	GAP signatory agency	Sustainability Transition Specialist	Natalia Manic	KII
GFF	GAP signatory agency	Health Specialist Liaison Office	Nargis Maqsudova	KII
GFF	GAP signatory agency	DC Senior Health Specialist WB GFF	Tawab Hashemi	KII
MoHSPP	Government	First Deputy, Head of Reforms, PHC and International Affairs	Dr. Bandaev	KII
MoHSPP	Government	Reforms and PHC Unit	Mannonov O	KII
MoHSPP	Government	First Deputy MOHSPP	Dr Ghafur Mukhsinzoda	KII
Tajikistan Network of WLWH	CSO	Head of organisation	Takhmina Haidarova	KII
MoHSP	Government	Head of the Economics and Budget Planning Department	Zaynullo Sharifov	KII

MoHSP	Government	Deputy	Saidali Hafizov	KII
World Food Programme	GAP signatory agency	Head of Programmes	Maria Tsvetkova	KII
GAVI	GAP signatory agency	Senior Programme Manager	Leo Karrer	KII
GAVI	GAP signatory agency	Programme Manager	Timor Cherikov	KII
MoHSP	Government	Chief Specialist of HIS	Manuchehr Shamsullozoda	KII
MoHSP	Government	Senior specialist	Mr Manuchehr	KII
ASuGRT	Government	Head of Data, tariffs, key surveys Department	Abdulvali Nabizoda	KII
Inter-Agency Expert Group	Government	Health Financing Specialist	Farrukh Egamov	KII
UNDP	GAP signatory agency	Country Representative	Lenni Montiel	KII
UNDP	GAP signatory agency	Project manager for the GF project	Soma Orbelyan	KII
MoF	Government	Deputy Minister of Finance	Mr Sarvar Qurboniyon	KII
MoF	Government	Head of the Budget Planning and Social Sector Department.	Ms Mehrinamo Jonmamazoda	KII

ANNEX 8: Inclusion of SDG3 GAP within signatory agencies own results frameworks table

Signatory Agency	Reference to SDG3 GAP in results framework	Reference to coordination, collaboration or health in results framework
WHO	The GAP is not mentioned in the GPW 13, 2019-24, as this was developed before the SDG3 GAP began in 2018.[180] However, reference to the GAP is made in the Proposed programme budget 2024–2025 under Output 4.1.1, Output 4.2.1.[181/182/183]	*Output 4.2.1. Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level and its associated outputs* is where WHO's results on partnership, coordination etc. are reported. Whilst the SDG3 GAP accelerators are not referred to specifically, the accelerator themes are evident within WHO's Programme Budget and results reporting.[184]
UNICEF	The GAP is not referenced in UNICEF's results framework.[185]	There is limited reference to measuring the effectiveness of interagency coordination/collaboration, apart from with regard to UNICEF's management of cluster mechanisms (which does not include health). Whilst the GAP accelerators are not referred to specifically, intended results pertaining to the PHC accelerator which UNICEF co-leads, are articulated.
World Bank	The GAP is not mentioned in the World Bank's overarching results scorecard. It is referenced in its health 'Future Directions' document with regards to its work with Gavi and the Global Fund on the GAP's Sustainable Financing Accelerator, although there are no specific results articulated.[186/187]	Outcome Area Three of the WB's scorecard focuses on healthier lives. There are no specific indicators with regards to partnership or coordination.[188]
Gavi	There is no explicit reference to the GAP in Gavi's 5.0 Measurement Framework.[189]	There are no specific indicators with regards to partnership or coordination in the measurement framework. There are specific indicators aligned to the accelerator themes of sustainable financing for health, equity, health data and primary health care.

[180] WHO Thirteenth General Programme of work, 2019-23
[181] WHO, Proposed programme budget 2024–2025
[182] Number of countries receiving technical support through WHO hosted partnerships on data and delivery aligned with country priorities (Health Data Collaborative and Global Action Plan for Healthy Lives and Well-being for All (SDG 3 GAP))
[183]Number of countries with improved collaboration among the multilateral agencies active in health, as evidenced through engagement under the WHO-convened Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP) and documented through the SDG3 GAP monitoring framework, case studies, country feedback and annual reports
[184] WHO, Proposed programme budget 2024–2025
[185] Integrated Results and Resources Framework of the UNICEF Strategic Plan, 2022–2025
[186] NEW WORLD BANK GROUP SCORECARD FY24-FY30, Driving Action, Measuring Results, (Updated April 9th, 2024)
[187]Preventing, preparing for, and Responding to Disease Outbreaks and Pandemics Future Directions for the World Bank Group
[188] NEW WORLD BANK GROUP SCORECARD FY24-FY30, Driving Action, Measuring Results, (Updated April 9th, 2024)
[189] Gavi 5.0 Measurement Framework (2021-25)

Global Fund	There is no explicit reference to the GAP in the Global Fund's Strategy Framework.[190]	There are no specific indicators with regards to partnership or coordination in the measurement framework. There are specific indicators aligned to the accelerator themes of sustainable financing for health, equity, health data and primary health care (e.g., Catalyze domestic resource mobilization for health to meet the urgent health needs for SDG 3).
UNAIDS	The UNAIDS Programme Budget describes that it will work to implement the Global AIDS Strategy through a broad array of partnerships including the GAP but there are no specific results pertaining to the SDG3 GAP.[191]	There are no specific indicators with regards to partnership or coordination in the measurement framework. There are specific indicators aligned to the accelerator themes of civil society, sustainable financing for health, equity, health data and primary health care.
UNFPA	There is no explicit reference to the GAP in UNFPA's Integrated results and resources framework.	There are a number of indicators regarding the functioning of interagency coordination mechanisms for GBV and SRHR. UNFPA also tracks the number of countries in which it contributes to joint initiatives and its joint programming. There are specific indicators aligned to the accelerator themes of sustainable financing for health, equity, health data and primary health care.
UNDP	There is no explicit reference to the GAP in UNDP's results framework.[192]	There is a specific outcome pertaining to health (1.4 Equitable, resilient and sustainable systems for health and pandemic preparedness), which includes indicators pertaining to primary healthcare. There is a specific outcome with regards to UN coordination and coherence.
GFF	There is no explicit reference to the GAP in GFF's results framework.[193]	There is a no specific outcome pertaining to coordination or partnership, although coordination is identified as one of the 'drivers' of GFF results. There are specific indicators aligned to the accelerator themes of sustainable financing for health, equity, health data and primary health care.
UNITAID	UNITAID's 2023-27 Strategy references GAP. The strategy comprises three strategic objectives (the third focusing on inclusive and demand driven partnerships) that underpin its overall vision "Equitable access to health innovations to ensure healthy lives and promote well-being for all" that is implicitly aligned with the SDG3.[194]	UNITAID has a performance framework comprising KPIs and other performance analysis that is mapped to its 2023-2027 Strategy and Objectives with specific KPIs on partnership.[195] Indicators relevant to PHC and civil society engagement accelerators are included.
ILO	There is no explicit reference to the GAP in ILO's Programme Budget for 2022-23. [196]	Under Output 2.4. Increased capacity of Member States to apply sectoral international labour standards, the Programme Budget states that ILO will advocate for ILO sector-specific standards, codes of practice, guidelines and other tools as an essential vehicle to achieve the SDGs, including

[190] The Global Fund Strategy Framework (2023-28)
[191] UNAIDS 2022–2026 UNIFIED BUDGET, RESULTS AND ACCOUNTABILITY FRAMEWORK (UBRAF)
[192] Integrated results and resources framework (IRRF) STRATEGIC PLAN 2022-2025
[193] GFF Monitoring strategy
[194] UNITAID Results Framework 2021
[195] Ibid
[196] ILO, Programme and budget for the biennium 2022–23

		through partnerships with other UN system specialized agencies, multilateral organizations and coordination mechanisms, particularly those with a sectoral focus, such as WHO amongst others.
WFP	There is no explicit reference to the GAP in WFP's Corporate Results Framework.[197]	WFP has a specific result in its Corporate Result Framework on 'Engage in Effective Partnerships', including with entities in the UN system and support for UNDS reform.
UN Women	There is no explicit reference to the GAP in UN Women's results framework.[198]	Its results framework has a specific output with regards to UN system coordination on GEWE.[199] In terms of indicators relevant to the accelerators, there is one with regards to women's decision-making on SRHR, on GBV and of course on GEWE.

[197] WFP Corporate Results Framework (2022-25)
[198] UN Women Strategic Plan 2018 – 2021 Integrated Results and Resources Framework
[199] Output 1: Enhanced coordination, coherence and accountability of the UN system for commitments to gender equality and women's empowerment

ANNEX 9: Modifications to the evaluation questions and rationale

Overarching evaluation questions	Rationale for change	Suggested evaluation Question	Suggested sub question
To what extent has SDG3 GAP accelerated progress and supported countries towards achieving the SDG 3 12 targets and 28 targets of other SDGs related to health (leaving no one behind)?	We have integrated the overarching questions into the key evaluation questions with associated sub questions against the evaluation criteria		
To what extent are signatory agencies' operational, and financial strategies, policies and approaches coherent, effective and sustainable? Are these sufficiently aligned, effectively avoiding duplications and driving efficiencies to strengthen country health systems?			
To what extent currently the signatory agencies are jointly collaborating and mutually accounting towards strengthening the country's health systems?			
To what extent have SDG3 GAP signatory agencies collectively helped health systems and countries and jointly accounted to recover from the negative impacts of the COVID-19 pandemic?			
To what extent has/is SDG3 GAP achieved/expected to achieve, its objectives, and its results, including any differential results across countries? Which outcomes are better/less achieved? Why?	Separated into question and sub questions for clarity (addresses outputs and outcomes in ToC)	To what extent has/is SDG3 GAP achieved/expected to achieve, its intended objectives, and results?	To what extent have results differed across countries?
			What factors (positive and negative) have affected the achievement of results?
			In which outcomes has most progress been achieved? And Why?
	Additional questions added in accelerators (addresses accelerators in ToC)	To what extent have the SDG3 GAP accelerators supported the achievement of intended results?	Has the relevance and prominence of accelerators changed over time? Why and how?
			To what extent are accelerators 'owned' by and relevant to signatory agencies' work?

			Have some accelerators been more effective in supporting the achievement of results than others? Why?
	Moved here from overarching questions as a key question in effectiveness	To what extent has SDG3 GAP accelerated progress and supported countries towards achieving the SDG 3 12 targets and 28 targets of other SDGs related to health (leaving no one behind)?	
	Separated question for clarity.	To what extent are the signatory agencies currently jointly collaborating towards strengthening the country's health systems?	Which collaboration mechanisms are more effectively accelerating progress to SDG3 GAP objectives at the country level?
			To what extent have the SDG3 GAP signatory agencies strengthened their collaboration in providing joint technical and financial support for countries' PHC-oriented health system strengthening plans and health financing?
To what extent are the SDG3 GAP signatory agencies collaborating to deliver, or likely to deliver, results in an economic and timely way? When do SDG3 GAP signatory agencies collectively enable the better use of existing resources (technical, financial and human), including local coordination mechanisms?		To what extent have SDG3 GAP signatory agencies collectively enabled the better use of existing resources (technical, financial and human), including local coordination mechanisms?	To what extent are the SDG3 GAP signatory agencies collaborating to deliver, or likely to deliver, results in an economic and timely way?
	Separated out questions for clarity		To what extent have SDG3 GAP signatory agencies collectively enabled the better use of local coordination mechanisms?
			To what extent has increased alignment between agencies driven efficiencies to strengthen country health systems and catalysed the use of resources?
			To what extent has the SDG3 GAP catalytic funding provided by WHO supported the greater achievement of results?

	Added questions around results as was highlighted as an enquiry area in interviews	How are SDG3 GAP results monitored and accounted for?	To what extent has the SDG3 GAP monitoring framework adequately captured results achieved?
			To what extent are results for SDG3 GAP captured and accounted for in signatory agencies' own results frameworks?
			To what extent has there been sufficient leadership and accountability for SDG3 GAP by signatory agencies?
Which collaboration mechanisms are more effectively accelerating progress at the country level? Which are less effective? Why? What extent these collaborating mechanisms are accounting their performance?	Moved to a sub question		
Have the SDG3 GAP signatory agencies strengthened their collaboration in providing joint technical and financial support for countries' PHC-oriented health system strengthening plans and health financing?	Moved to a sub question		
To what extent is gender equality and responsiveness effectively strengthened through joint support by the SDG3 GAP signatory agencies?	Added gender responsiveness to this question for clarity	To what extent is gender equality and gender responsiveness effectively strengthened through joint support by the SDG3 GAP signatory agencies?	
To what extent did the recommendations put forward in the 2023 progress report titled "What worked? What did not? What is next" resonate with stakeholders to better leverage collaboration to drive progress on the health-related SDG targets in countries?	Reworded for clarity.	To what extent did the recommendations put forward in the 2023 progress report enable stakeholders to better leverage collaboration to drive progress on the health-related SDG targets in countries?	
Has SDG3 GAP provided a solid foundation for stronger coherence in terms of better alignment and coordination and mutual accountability across development partners in health? How does it complement international partnerships such as IHP+/UHC 2030?	Added question as was a key theme highlighted in inception enquiry.	To what extent is there a shared understanding and ownership of the SDG3 GAP and its purpose and intended results a) by signatory agencies? B) by countries?	
	Broken down from existing questions	To what extent signatory agencies' operational, and financial strategies, policies and approaches incentivize and enable coherent, effective and sustainable collaboration?	

		To what extent has SDG 3 GAP provided a solid foundation for stronger coherence in terms of better alignment and coordination and mutual accountability across development partners in health?	
		To what extent has the SDG3 GAP complemented international partnerships such as IHP+/UHC 2030?	
How much are SDG3 GAP signatories fostering joined-up approaches at the country level? Have they improved the coherence of their respective interventions at the country level? Are these joint approaches/deliverables consistent? When haven't they done so?	Deleted second part as covered in question above. Not sure what is meant by them joint approaches being consistent. Reworded sub question	To what extent are SDG3 GAP signatories fostering joined-up approaches at the country level?	
When do countries receive better coordinated, more effective support, that is better aligned with their priorities, from SDG3 GAP signatory agencies both at the national and subnational level?	Reworded for clarity and to address enablers as articulated in ToC	What are the enabling factors that drive countries to receive better coordinated, more effective support, which is better aligned with their priorities, from SDG3 GAP signatory agencies both at the national and subnational level?	
To what extent is the SDG3 GAP sustainable and helping countries recover from the negative impacts of the COVID-19 pandemic?	Have split into 2 sections	To what extent are SDG3 GAP outcomes sustainable?	To what extent has government ownership of and engagement with SDG3 GAP been adequately fostered?
	Removed jointly accounted (accountability covered in questions on results reporting)	To what extent have SDG3 GAP signatory agencies collectively helped health systems and countries to recover from the negative impacts of the COVID-19 pandemic?	
To what extent have signatory agencies managed to promote integrated investments in global health security and universal health coverage?	Question needs to relate to the GAP explicitly. Have reframed.	To what extent has the SDG3 GAP encouraged signatory agencies to make	

		integrated investments in global health security and universal health coverage?	
Have SDG3 GAP signatory agencies joint support helped countries achieve equitable and inclusive progress towards health-related SDGs?	No change	To what extent has the implementation of SDG3 GAP helped countries achieve equitable and inclusive progress towards health-related SDGs?	
Which SDG3 GAP tools and approaches need to be scaled up to improve the collaboration of the SDG3 GAP agencies to support countries in achieving the health-related SDG targets?	Should come out implicitly in findings elsewhere so have removed		

ANNEX 10: Progress by SDG3 GAP country[200]

SDG GAP Country	2023 SDG Index Score	2023 SDG Index Rank	SDG3: Good Health and Well-Being	
Afghanistan	49.0	158		→
Albania	73.5	54		↗
Azerbaijan	73.5	53		↗
Bolivia	68.9	87		→
Brazil	73.7	50		↗
Burkina Faso	52.4	153		→
Burundi	53.9	147		→
Cameroon	55.1	139		→
Central African Republic	40.4	165		→
Chad	45.3	164		→
Chile	78.2	30		↗
Colombia	70.1	76		↗
Comoros	51.7	154		→
Congo	48.6	159		→
Costa Rica	73.6	52		↗
Côte d'Ivoire	62.3	120		→
Democratic Republic of the Congo	48.6	159		→
Djibouti	52.7	150		→
Dominical Republic	72.1	62		→
Egypt	69.6	81		↗
Equatorial Guinea				→
Eritrea				↗
Ethiopia	54.5	144		↗
Gabon	63.1	113		→
Gambia (the)	58.3	129		→
Ghana	61.8	122		↗
Haiti	52.6	152		→
Honduras	62.9	116		↗
Iran (Islamic Republic of)	69.1	86		↗
Jamaica	69.6	82		→
Jordan	69.9	77		→
Kenya	60.9	123		→
Kyrgyzstan	74.4	45		↗
Lao People's Democratic Republic	63.0	115		↗
Lebanon	67.5	95		→

SDG GAP Country	2023 SDG Index Score	2023 SDG Index Rank	SDG3: Good Health and Well-Being	
Liberia	49.9	157		→
Madagascar	50.3	156		→
Malawi	56.3	135		↗
Mali	58.0	131		→
Mauritania	57.2	133		→
Mauritius	68.0	93		→
Moldova (Republic of)	78.6	25		↗
Mongolia	64.7	106		↗
Morocco	70.9	70		↗
Mozambique	52.7	149		→
Myanmar	60.4	125		→
Namibia	64.3	109		↗
Nepal	66.5	99		↗
Nicaragua	64.8	104		↗
Niger	48.3	161		→
Nigeria	54.3	146		→
Pakistan	59.0	128		→
Papua New Guinea	53.6	148		→
Rwanda	60.2	126		→
Sao Tome and Principe	62.7	119		→
Senegal	61.8	121		↗
Sierra Leone	55.7	137		→
Somalia	48.0	162		→
South Sudan	38.7	166		→
Sri Lanka	69.4	83		↗
Sudan	48.6	160		→
Tajikistan	69.2	85		↗
Timor-Leste				↗
Turkmenistan	68.5	91		→
Uganda	55.0	141		↗
Ukraine	76.5	38		↗
Yemen	46.8	163		→
Zambia	54.3	145		↗
Zimbabwe	55.6	138		→

Legend	
green	Goal Achievement
yellow	Challenges remain
orange	Significant challenges
red	Major challenges
grey	Insufficient data

↑	On track or maintaining achievement
↗	Moderately Increasing
→	Stagnating
↓	Decreasing

[200] https://dashboards.sdgindex.org/map/goals/sdg3

Any enquiries about this evaluation should
be addressed to WHO Evaluation Office
Email: evaluation@who.int
Website: Evaluation (who.int)