World Health Organization

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

REPORT

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

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The collaborative nature of this joint evaluation fostered shared learning and strengthened cooperation, providing a solid foundation for a unified management response. This joint approach reflects a collective commitment to improving the effectiveness of future initiatives, advancing progress toward health-related SDG targets, and fostering stronger partnerships. By emphasizing alignment with health priorities at the country level, the evaluation supports efforts to ensure that global strategies and initiatives are responsive to local needs and contexts, enhancing their impact and sustainability.

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Acronyms and abbreviations

AFRO	WHO Regional Office for Africa
AMRO	WHO Regional Office for the Americas
CSO	Civil Society Organization
EMG	Evaluation Management Group
EMRO	WHO Regional Office for the Eastern Mediterranean
ERG	Evaluation Reference Group
EURO	WHO Regional Office for Europe
EQ	Evaluation question
FCDO	Foreign, Commonwealth & Development Office
GAP	Global Action Plan (SDG3 GAP)
GFF	Global Financing Facility
ILO	International Labour Organization
IHP+	International Health Partnership +
JEA	Joint Evaluability Assessment
KIIs	Key Informant Interviews
M&E	Monitoring & Evaluating
PHC	Primary Health Care
SDG	Sustainable Development Goal
SEARO	WHO Regional Office for South-East Asia
SFH	Sustainable Financing for Health
TOC	Theory of Change
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNSDCF	UN Sustainable Development Cooperation Frameworks
WHO	World Health Organization
WPRO	WHO Regional Office for the Western Pacific

Executive summary

Background

1. The Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP; GAP) has its origin in the 2018 initiative by heads of state (German, Norway, Ghana) to strengthen interagency collaboration to accelerate progress on the health-related targets, set against the background of the resolution adopted by the United Nations General Assembly in 2015 entitled "Transforming our world: the 2030 Agenda for Sustainable Development". That call was echoed in the G20 Osaka Leaders' Declaration, which urged more effective collaboration between international organizations. It is within this context that the GAP was developed.

Evaluation objective, purpose and scope

2. The objective of this evaluation is to assess the coherence, effectiveness and sustainability of the GAP collaboration efforts – at the country, regional and global levels – in accelerating country progress on the health-related SDG targets. The evaluation may be used to inform discussions amongst agency principals regarding the future of the GAP.

3. The evaluation assesses the extent to which signatory agencies have strengthened their collaboration to:

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

4. The temporal scope of this evaluation is the period September 2019 to June 2024. It includes global, regional and country perspectives from 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 major partners and civil society and other implementing partners. The geographic scope of the evaluation spans 67 countries where the GAP approach has been applied.

Methodology

5. The evaluation team employed a non-experimental, theory-based, utilization-focused approach, utilizing a reconstructed theory of change (ToC) and 11 high-level evaluation questions (EQs) structured around three evaluation criteria to interrogate expected changes and possible contributions of the GAP (contribution analysis) to that change – the "how" and "why". Stakeholders were consulted to understand their perspectives on a series of agreed hypotheses that test the GAP intervention logic or causal pathways identified within the ToC, as well as the assumptions underpinning the expected results.

6. Mixed methods of data collection were used (remote interviews, country studies, a survey and a document review) to ensure triangulation of evidence and "traceability" from findings to conclusions to recommendations.

7. A comprehensive document review of core GAP documents, annual and progress reports, signatory agency strategies, GAP accelerator

documents, national development plans and country case study documentation was undertaken, combined with over 70 remote key informant interviews (KIIs) with signatory agency principals, GAP focal points, accelerator members, other signatory agency staff (e.g. regional, Monitoring & Evaluating (M&E), partnerships) and donors. A country-facing survey instrument was deployed, though response rates were low when disaggregated based on familiarity with the GAP. Seven country studies were undertaken, five physical and two remote, with 120+ KIIs conducted at the country level.

8. The evaluation adhered to ethical standards; where applicable, relevant cross-cutting issues of gender, human rights and disability, humanitarian principles, protection, and accountability to affected populations in design, data collection and analysis were considered.

9. Several methodological challenges were encountered and mitigated, including timing and sequencing challenges; limitations to stakeholder engagement and availability; representative regional participation in the country studies; slow survey response rates; and some data paucity issues. These were mitigated by extending out the data collection phase to provide a greater range of opportunities to engage; pragmatic selection of country studies based on agencies' willingness and ability to host, which was endorsed with evaluation management; engagement of the evaluation reference and management group counterparts to identify stakeholders and secure participation; and ongoing WHO support in sourcing documentation, data points and up-to-date financial information.

Key findings

Coherence

Understanding and ownership of the SDG3 GAP

10. There was early buy-in and engagement with the GAP from principals in the signatory agencies at a global level, from its outset. However, the objectives of the GAP and associated interagency collaboration mechanisms have not been sufficiently defined to support a coherent and shared understanding. As a result, there have been divergent and inconsistent interpretations of and approaches to GAP implementation across signatory agencies, particularly at country level.

11. There have been uneven levels of ownership of the GAP between signatory agencies and at different levels of their organizations, as well as limited awareness of the GAP by country governments and national partner stakeholders, resulting from a lack of common understanding of GAP purpose and approach, combined with poor contextualization at a country level.

12. With the advent of COVID-19 early in the life cycle of the GAP and other emerging global priorities and commitments since, as well as concerns regarding the GAP's efficacy, the visibility and seniority of ownership and engagement of the GAP has diminished.

Coherence of operational and financial policies, strategies and approaches

13. While there has been a range of activities to improve the level of coherence of operational and financial strategies, policies and approaches, overall, the level of interagency alignment of these remains insufficient to incentivize meaningful interagency change which improves coordination, drives efficiencies, and avoids duplication, or supports the strengthening of health collaboration mechanisms.

14. There is evidence of a progressive alignment of signatory agencies' strategies and policies with national priorities and plans and an increase in countries' ownership of health coordination mechanisms, though it is not directly attributable to the GAP.

15. The GAP is compatible and provides continuity with a number of previous international health partnerships, having built on their work, leveraged previous efforts and investment and learned lessons from these initiatives. However, the GAP, like its predecessors, has struggled to influence or sufficiently catalyze change on systemic issues affecting coordination such as political leadership, ownership, governance and funding.

16. There has been a lack of external incentives that reinforce organizational cooperation at a country level, which has limited collaboration and hindered progress.

Effectiveness

GAP's achievement of intended objectives and results

17. Given the lack of awareness and ownership of the GAP reported by respondents from countries and GAP signatory agencies, it has been challenging to isolate specific results that the GAP has achieved. The GAP's contribution to alignment and joined-up support to countries has taken place among multiple other initiatives on alignment, including by the GAP agencies themselves.

18. The evaluation finds some evidence that strengthened engagement with countries to determine priorities exists, with signatory agencies engaging in a range of coordination mechanisms chaired or co-chaired by national counterparts, although these are not necessarily attributable to the GAP.

19. The achievement or non-achievement of SDG3 targets cannot be attributed directly to the GAP. The evaluation notes that maternal health, under-five mortality, risk of dying from the main noncommunicable diseases, universal health coverage, TB, HIV and vaccine are critical components of areas where GAP signatory agencies have concentrated resources and efforts. However, the evaluation team finds that while there have been some improvements in these areas between 2015 and 2020, they have generally not been sufficient to meet the set targets. Among the 69 countries noted in the 2024 Progress report where the GAP is being implemented, none have achieved or are on track to achieving SDG3 targets.

GAP accelerators

20. The accelerator groups were envisaged as the key mechanism for GAP signatory agencies to drive collaboration with working groups established at headquarters levels, with communities of practice created to share good practices and plan joint country level initiatives. Out of the seven accelerators, two have been most prominent and active: the Primary Health Care (PHC) and Sustainable Financing for Health (SFH) accelerators. Data and Digital Health has also shown positive signs of traction. COVID-19 amplified the focus on PHC and financing, necessitating signatory agencies and other partners to collaborate and coordinate to deliver a robust response.

Gender equality and responsiveness, equity and inclusiveness

21. Gender equality, health equity and inclusiveness are significant topics in the mandates of all GAP signatory agencies and emphasized from the outset of the GAP. There has been a gender equality working group tasked with integrating a gender equality lens across all accelerators, which was merged in 2021 with the determinants of health and civil society and community engagement accelerators to form the equity cluster. While there were initial activities conducted by the gender working group, the equity cluster can best be described as dormant. This dormancy is attributed to a lack of dedicated human and financial resources among signatory agencies and the high turn-over of focal point staff, as well as a lack of focus on gender within country coordination mechanisms.

22. From the outset of the GAP, engagement with civil society and communities has been weak. Civil society actors and community-based organizations were not included as key stakeholders in the GAP's design or engaged routinely as key stakeholders. The civil society accelerator group was described as having never really gathered momentum and being largely defunct. Its integration into the equity cluster, in 2021, has not served to revitalize the work planned under this accelerator.

Economic and timely delivery of results

23. The evaluation found variations in the economic and timely delivery of results amongst GAP signatory agencies and across countries, including positive examples of how joint efforts involving GAP agencies have led to improved resource optimization, faster response times and innovative financing solutions. The evaluation notes, however, that these are not always linked directly to the GAP. There was evidence to suggest that providing pooled funds where possible would help improve coordination.

24. Regarding timeliness of results, the evaluation team finds that coordinated efforts among agencies enabled faster mobilization of resources and personnel during emergencies at the country and global level throughout the period of implementation, with COVID-19 as the most significant example through, for example, the Access to COVID-19 Tools (ACT) Accelerator and the COVID-19 Basket Fund.

25. Catalytic funding for GAP activities was supported by the Norwegian Agency for Development Cooperation (NORAD) and the German Federal Ministry of Health (Bundesministerium für Gesundheit, BMG). From 2018 to date, total expenditure on the GAP was US$ 11.9 million. Of this, USS$ 4.8 million was expensed at headquarters (with staff costs of USS$ 3.1 million). Progress reports indicate that the catalytic funding provided has in general been successful in helping to catalyze collaboration at the country level through removing blockages, strengthening WHO leadership capacity on SDG3 related work and contributing to a more level playing field. They also show that countries receiving catalytic funding to cover the upfront costs of closer collaboration have been able to leverage and realize gains through increased synergies and efficiencies and stronger partner networks. The high flexibility of the funding is a core strength; the relatively low amounts per country office and the short period of implementation were seen as weaknesses.

Monitoring of GAP results

26. The evaluation team finds a number of weaknesses regarding how GAP results are measured, including that workplans for GAP focal points or accelerator working groups have not been systematically developed; meetings and actions not minuted; efforts to align indicators across agencies not completed; weaknesses in the monitoring framework not eradicated; results overclaimed; country questionnaires assessed subjectively and country team and civil society perspectives not routinely gathered.

27. Joint accountability for GAP results has been highlighted as a major weakness, notwithstanding the positive action taken to develop an appropriate ToC and efforts to strengthen the existing M&E framework, as recommended by the Joint Evaluability Assessment (JEA).

28. WHO is the only signatory agency to have any specific results embedded within its results framework pertaining to the GAP; more generally, six of the 13 agencies have specific results around coordination and/or partnership in their results frameworks. While many of the agencies have indicators relevant to the GAP accelerators, these are not framed in terms of a collective effort.

Sustainability

Sustainability of SDG3 GAP outcomes

29. The context and appetite for globally led initiatives have changed considerably since the GAP's inception, with a primacy on locally led development/ localization seemingly absent from GAP implementation. Given the findings drawn from examining coherence and effectiveness, it is unlikely that any momentum from the GAP can be sustained in the medium- to long-term, though there is recognition of the ongoing need for and relevance of international health partnerships.

30. The evaluation team finds that the potential for sustainability increases where political ownership and strong national capacity and vision to coordinate agencies through costed operational sectoral plans exist and where agencies can position themselves based on their comparative advantage.

Recovery from the negative impacts of the COVID-19 pandemic

31. The GAP had just begun to function when COVID-19 started, and while the pandemic represented a unique opportunity to use the GAP as a platform for increased collaboration, this did not fully materialize. There were examples of strong collaboration and coordination in response to the pandemic in the spirit of the GAP but given the level of awareness and engagement of those involved with the GAP, it is more plausible that this was driven by necessity and context, rather than by the GAP. While there were examples of increased collaboration during the pandemic, this momentum has been somewhat lost since in a return to business as usual with few lessons learned from the experiences of coordinating and collaborating during the pandemic.

Key conclusions

Coherence

32. The evaluation team conclude that, at a global level, the GAP demonstrates compatibility and coherence with current and previous international health partnerships and initiatives, providing evidence of alignment, continuity and opportunities to leverage previous efforts and investments.

33. However, despite early buy-in and engagement with the GAP from principals within the signatory agencies, it has proven more challenging to secure interagency coherence and country engagement.

34. Recognizing that the presence of the signatory agencies varies significantly at country level, with their ability to contribute evenly at this level varying as a result, the evaluation team concludes that GAP efforts to better engage with countries to identify priorities and plan and implement together have not been successful. Engagement at a country level to ensure that the GAP considered both country context and existing coordination mechanisms has been undermined by uneven and often low levels of understanding and ownership of the GAP within and amongst the signatory agencies. This was evident across the organizational levels, with a notably limited awareness and ownership at the country level. This is amplified by weak levels of understanding and ownership in country government counterparts and national partners.

35. The evaluation concludes that there a range of activities has been carried out to improve the level of alignment of operational and financial strategies, policies and approaches supporting countries in their pursuit of efficiency increases and burden reduction on countries overall. However, the level of alignment remains insufficient to incentivize meaningful institutional change which improves

coordination, drives efficiencies and avoids duplication. Where GAP signatory agencies have pursued better use of existing resources (technical, financial and human), this is not primarily driven by the GAP. Other key drivers identified include ongoing UN Development System reform and the maturing of United Nations Country Teams (UNCTs) and United Nations Sustainability Development Cooperation Frameworks (UNSDCF), as well as context. There is a lack of consistent evidence from the evaluation country studies that the GAP has incentivized increases in joint planning and implementation.

Effectiveness

36. The evaluation team asserts that there is insufficient evidence to confidently conclude that the GAP has achieved, or is expected to achieve, its intended objectives and results to accelerate progress towards the SDG3 targets. However, neither has progress towards these targets been overtly hindered by the GAP.

37. While there is some evidence of strengthened engagement with countries to determine priorities and of good practices identified within the PHC, Sustainable Health Financing and Digital Health Accelerators (which have been the most effective and impactful across the seven themes), there is limited evidence to support the claim that the GAP has directly accelerated progress and helped agencies to support countries towards achieving the SDG3 targets, with a predominance of major and significant challenges still faced by countries in achieving these goals.

38. The evaluation concludes that in relation to SDG3 targets there has been some improvement from 2015 to 2020 in maternal health, under-five mortality, risk of dying from the main NCDs, UHC coverage, TB, HIV and vaccine as critical components of areas where GAP signatory agencies have engaged through focused efforts and concentrated resources. However, this has generally not been sufficient to meet the set targets. Among the 69 countries noted in the 2024 Progress report where the GAP is being implemented, none have achieved or are on track to achieving SDG3.

39. There has been a lack of joint accountability for GAP results and inadequacies in how results have been monitored and reported. The evaluation team concludes that weaknesses remain in how GAP accounts for its results, reviews progress and learns to enhance its shared accountability (including how results are measured), that workplans for GAP focal points or accelerator working groups have not been systematically or consistently developed, that efforts to align indicators across agencies were not completed and that weaknesses in the monitoring framework persist.

40. The evaluation concludes that joint accountability for GAP results remains a weakness, notwithstanding the positive action taken to develop a ToC and efforts to strengthen the existing M&E framework, as recommended by the JEA. WHO is the only signatory agency to have any specific results embedded within its results framework pertaining to the GAP; more generally, six of the 13 agencies have specific results around coordination and/or partnership in their results frameworks. While many of the agencies have indicators relevant to the GAP accelerators, these are not framed in terms of a collective effort.

Sustainability

41. The evaluation team concludes that it is unlikely that any of the observed GAP outcomes will be sustained in either the medium- or long-term, given the decline in signatory agency leadership commitment and engagement, competing priorities and the significantly reduced allocation of resources for GAP activities. It is also important to place the sustainability of the GAP and its outcomes within the broader contexts of both the current landscape for global health and the operating

environment for each country, where few countries are on-track to reach SDG3 targets. While there was increased coordination and collaboration during the COVID-19 pandemic, this was largely driven by necessity and context. Momentum has not been maintained and lesson learning from the experience has not yet been sufficiently embedded in approaches to coordination and collaboration.

42. The evaluation team concludes that there has been a range of factors affecting implementation efficacy and effectiveness, including diminishing leadership engagement and visibility at an organizational and principal level since 2019. Furthermore, while government ownership of health-related coordination/collaboration was considered essential at the design stage for the GAP to progress and for results to be achieved at a country level, a lack of political-level engagement with the GAP has hindered progress of health collaborations. The objectives of the GAP and interagency collaboration mechanisms have not been sufficiently defined, leading to divergence in interpretation and approach from the very start.

43. The evaluation team further finds weak mutual accountability between signatory agencies, as noted above, with a lack of GAP outcome indicators comprehensively embedded within signatory agencies results frameworks. While there has been a degree of alignment of signatory agencies' operational/ financial strategies and policies, the approaches, behaviours and enabling factors have been insufficient to drive efficiencies and avoid duplication in strengthening health collaborations. There has been a lack of external incentives that reinforce organizational cooperation at a country level, which has limited collaboration and hindered progress. Existing country-level incentives have neither sufficiently reinforced collaboration nor strengthened existing country coordination models and supported country-facing teams; nor have new incentives been introduced. There is growing fatigue with global partnerships at a country level. Addressing these challenges will be critically important in any pathway forward.

44. In sum, the evaluation team concludes that there remains compelling evidence of the continued relevance and need for strengthened collaboration and better coordination and mutual accountability amongst multilateral agencies and that the need to strengthen governance, accountability, collaboration and coordination for impact on health has only grown since the GAP was created. The evaluation team recognizes that this evaluation comes at a challenging time for health architecture and financing and that reinvigorating multilateralism will be a priority of the Summit of the Future as agencies consider their responses to the fact that SDG 3, like Agenda 2030 broadly, is off track.

45. Overall, though, the evaluation team concludes that there is comprehensive evidence to support the need for a fundamental pivot away from current GAP implementation modality towards other approaches.

Recommendations

46. Based on the evidence of need and conclusions on implementation efficacy, the evaluation team identifies two plausible pathways forward. Both are guided by the evidence and both carry benefits, trade-offs and risks that signatory agencies should consider in developing the management response to this evaluation.

Pathway A: Sunset/close-out the current GAP within a six- to twelve-month period
GAP Signatory agencies – Within the next three months, agencies decide through consultation and then state a shared consensus that sunset and close-out of the current GAP framework is in the collective best interest.

GAP Secretariat – Based on the decision of signatory agencies, the Secretariat will develop a sunsetting and close-out action plan for six to nine months, detailing key activities, reporting milestones and the communications plan to wind down GAP working groups as well as engagement with country and regional focal points and partners.

GAP focal points –GAP Secretariat and existing GAP focal points in signatory agencies will coordinate to develop joint communications to inform.

Pathway B: developing a new framework that retains selected GAP elements.

Signatory agencies – Within the next three months, agencies decide through consultation and then state a shared consensus that the development of a new framework which retains selected elements of the current GAP framework, is in the collective best interest.

GAP signatory agencies – reconfigure the number and composition of signatory agencies, reducing the agencies involved and clearly establishing respective roles and responsibilities in the new framework's development and implementation.

GAP signatory agencies – reconceptualize accountability to develop a strengthened accountability and results framework, with clear division of labour and commitment across agencies to measure and report contribution and collaboration jointly through the new framework.

GAP signatory agencies – reconceptualize and repurpose existing accelerators, focused on the PHC and SHF accelerators and the H6 partnership as 'stand-alone' initiatives.

GAP signatory agencies – redevelop and replenish collaborative catalytic funding, for example, through catalytic funding from pooled resources.

Introduction

This report articulates the findings, conclusions and recommendations from the independent joint evaluation of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP; GAP). It outlines the evaluation's purpose and objectives, stakeholders and primary audience, data collection methods and analytical tools, key findings organized by evaluation criteria, conclusions and recommendations. The report includes the following sections (1):

- Introduction (evaluation purpose and objectives; stakeholders; scope and modifications to the ToR);
- Background, including description of the GAP (what is being evaluated, context of implementation);
- Evaluation methodological approach (including EQs and criteria, data sources, sampling, data collection instruments and limitations);
- Findings, organized by evaluation criteria and key evaluative themes;
- Conclusions; and
- Recommendations: considerations for the way forwards.

Evaluation purpose and objectives

1. The objective of this independent joint evaluation is to assess the collaboration efforts of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP; GAP) in accelerating country progress on the health-related SDG targets. The evaluation considers whether signatory agencies have strengthened their collaboration to:

    - engage with countries better to identify priorities and to plan and implement together;
    - accelerate progress in countries through joint actions and the overarching commitment to advance gender equality and support the delivery of global public goods;
    - align, by harmonizing operational and financial strategies and policies to support countries where this increases efficiency and reduces the burden; and
    - account, by reviewing progress and learning together to enhance our shared accountability.

2. The evaluation uses the evaluation criteria of the Development Assistance Committee of the Organization for Economic Cooperation and Development, namely i) coherence, ii) effectiveness and iii) sustainability to examine the GAP at the national, regional and global level. The evaluation examined progress by signatory agencies towards the intended outcome-level results (2):

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

3. This evaluation of the GAP aims to inform signatory agencies' learning, continued improvement and mutual accountability. The evaluation findings may be used to consider the ways forward for the GAP, including improving effectiveness, coherence and sustainability at country, regional and global level.

Evidence from the evaluation may feed into the strategic planning of the signatory agencies and other relevant processes.

4. The evaluation presents pathway options for strengthening collaboration and coherence in the multilateral system to accelerate progress towards SDG3 and other health-related targets. Recognizing the prominence of gender equality and the SDG pledge to "leave no one behind", the evaluation is gender-responsive and considers how best to include the perspectives of marginalized and vulnerable groups, as described below in the Ethical considerations section.

Evaluation stakeholders

5. As part of the inception period, the independent evaluation team reviewed and mapped major stakeholder groups and individuals to ensure that a cross-section of perspectives was included and a range of different stakeholders consulted, as appropriate, throughout the evaluation process. The stakeholder mapping conducted during the inception also identified different stakeholder groups and their stakes in the evaluation.

6. The key users of this evaluation are:
   - **Primary users,** including the 13 signatory agencies, Member-State representatives involved in GAP agency governance, Executives, Principals, senior management and staff involved in the GAP at various levels (including the headquarters, regional and country-facing function or country focal points). Evaluation Reference Group (ERG) and Evaluation Management Group (EMG) stakeholders have been closely associated with the evaluation process in terms of data collection, findings and conclusions validation and consideration and feedback on the ways forward. They will likewise be involved in responding to the evaluation's recommendations. Ultimately, the evaluation may be used to inform discussions amongst GAP agency Principals on the ways forward.

   - **Secondary users,** including representatives of national governments (such as from ministries of health, foreign affairs and/or development, planning and finance, gender, Youth, education) and other development partners, including implementing partners and civil society. These stakeholders have been involved in the evaluation process as evaluation informants and may be interested in understanding how interagency collaboration can be further improved to allow agencies to be better aligned to national strategies/plans/priorities and promote collective impact of all investments and resources available.

   - **Tertiary users:** Donors and implementing partners, both governmental and nongovernmental, as well as affected populations and communities, as a mechanism to strengthen transparency, share experiences and identify lessons learned.

7. The various users of the evaluation will use it in different ways, including learning, accountability and advocacy.

Evaluation scope and modifications to the terms of reference

8. The temporal scope of this evaluation covers the period September 2019 to June 2024, with data collection conducted until May 2024. It includes global, regional and country perspectives from GAP signatory agencies' country offices or country focal points, regional offices, UN country teams and headquarters as well as the participation of Member States, government counterparts, other major partners and civil society and other implementing partners. The geographical scope of the evaluation spans the 67 countries where the GAP approach has been applied.[1]

9. The primary modification to the Terms of Reference (ToR) relates to evaluation questions (EQs), where the evaluation criteria and sentiment of the overarching questions was retained but questions and sub-questions were revised and further clarified based upon the inception interviews and documentary review. Additional questions were incorporated to test the revised ToC and emerging hypotheses developed as part of the inception phase. Details of these can be found in the Inception Report, though for example, there were no questions in the original s pertaining to the relevance and use of the accelerators,[2] so the evaluation team added a key (To what extent have the GAP accelerators supported the achievement of intended results?) as well as associated sub questions. Similarly, the evaluation team added questions regarding the impact of the GAP catalytic funding provided to some WHO country offices; country ownership; and signatory agency leadership. All modifications have been discussed and approved by the ERG and EMG.

Evaluation Object

10. The GAP has its origin in the 2018 initiative by heads of state (Germany, Norway, Ghana) to strengthen interagency collaboration to accelerate progress on the health-related targets, set against the background of the resolution adopted by the UN General Assembly in 2015 entitled "Transforming our world: the 2030 Agenda for Sustainable Development". Within that resolution are the 17 Sustainable Development Goals (SDGs) with SDG3 focused on health, with a stated purpose to "Ensure healthy lives and promote well-being for all at all ages" (3). Within SDG3 there are 13 targets. However, across the other 16 SDGs there are a number of targets that are also related to health, e.g., "child stunting" under SDG2 or "safe drinking water" under SDG6. In total there are approximately 50 health-related targets across the 17 SDGs. By 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 amongst the SDGs. Despite efforts to achieve better coordination, fragmentation has been an ongoing characteristic of the global health landscape.

11. In response to this finding and the continuing issue of fragmentation, in 2018, the leaders of Germany, Ghana and Norway (and later also the UN Secretary General) requested that the WHO Director General

[1] The 67 SDG3 GAP countries are those that have had some engagement with the GAP as outlined in the 2023 Progress report.
[2] The SDG3 GAP accelerators are (in brief): 1) primary health care; 2) sustainable financing for health; 3) community and civil society engagement; 4) determinants of health; 5) data and digital health; 6) research and development; and 7) innovative programming in fragile and vulnerable settings.

and other multilateral organizations streamline their efforts to better support countries to accelerate progress on SDG3. That call was echoed in the G20 Osaka Leaders' Declaration, which urged more effective collaboration between international organizations. It is within this context that the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP) was developed.

12. The 13 signatories to the SDG3 GAP are: Gavi, the Vaccine Alliance (Gavi); the Global Financing facility (GFF); International Labour Organization (ILO); Global Fund to fight AIDS, TB and Malaria; 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; UN Women; World Bank (WBG), World Food Programme (WFP) and WHO. WFP joined in 2019 and ILO in 2021. While formulating the GAP, the participating agencies identified the seven cross-cutting "accelerator themes" of relevance to their mandates, in which stronger collaboration and joint action offered significant opportunities to fast-track progress in achieving health-related SDG targets. The agencies also began work to align institutional investment case approaches and intended to develop 2023 milestones for health-related SDG targets. Underpinning the GAP was the recognition that national leadership is the core of the SDG agenda and partnerships are critical to support Member States in including other stakeholders in countries (e.g., communities, civil society and the private sector).

13. In 2019, the GAP was launched. The overall objective of the GAP *(4)* was to enhance collaboration between participating organizations to accelerate country progress on the health-related SDG targets. Its approach to date has not been to provide or seek additional financial resources, rather it has been to enable better use of existing resources as a result of improved collaboration, recognizing that each organization has its own unique mandate and area of expertise. Several of the organizations also play important catalytic roles in supporting countries to raise domestic resources for health and attract more public and private sector investment and engagement. Implementation of the GAP was based on four commitments, namely: 1) to engage; 2) to accelerate; 3) to align; and 4) to account. The GAP signatory agencies also set out three interim milestones: 1) better coordination among the agencies in their global, regional and in-country processes; 2) a reduced burden on countries, with increased evidence of joined-up support; and 3) purpose-driven collaboration integrated into the agencies' organizational cultures.

14. Funding for SDG3 GAP activities from 2019 to 2021 was supported mainly through agreements between WHO and the Norwegian Agency for Development Cooperation (NORAD) and the German Federal Ministry of Health (Bundesministerium für Gesundheit, BMG) that included earmarked funding for components of the SDG3 GAP. From 2022, the BMG funding has been earmarked at a higher level for WHO's enabling functions, which has included GAP activities and secretariat support.

15. In addition to the BMG and NORAD grants, WHO has also allocated internal resources to support GAP activities, including senior management resources for SDG3 GAP secretariat and accelerators at WHO headquarters, as well as resources in WHO regional and country offices. These activities are embedded in the overall WHO programme budget, and the value of these additional resources has not been quantified. Since 2018, there has been a total expenditure of US$ 11.9 million in catalytic funding to headquarters, regional offices and country offices, with the greatest proportion (53%) going to country offices. Expenditure for country office activities totalled US$ 5.4 million from 2018 to 2024, and staff costs were over US$ 900 000.

16. Early in the GAP's implementation, a decision was made to commission a Joint Evaluability Assessment (JEA) (5), as it was recognized that such a complex and visible multistakeholder partnership would bear significant risks and that it would be essential to identify early on any gaps in the preconditions for success in the GAP. The JEA specifically focused on the importance of getting country ownership for how the GAP operates, in its enabling and supporting role of helping to provide a ready-made approach to partnership.

Some of the shortcomings within the early GAP implementation identified by the JEA included: 1) the need to reach agreement on how to operationalize the GAP and make it concrete; 2) the lack of a fully specified ToC ; 3) the need to strengthen the M&E framework, including a focus on contribution analysis; 4) the need to address the distinct lack of clear accountabilities (and incentives); and 5) limitations on its resourcing (the GAP has only a small central secretariat function) which assumes that participating agency staff will support the GAP alongside their other responsibilities. Six recommendations were provided within the JEA which sought to address the above-mentioned gaps, with annual progress reports updating on the status of implementation.

17. Since the launch of the GAP in 2019, there have been significant changes in the global context. The COVID-19 pandemic declared by WHO in March 2020 placed extraordinary pressure on health systems and resources globally, causing disruptions to health service delivery and routine immunization and an excess mortality of at least 3 million. The COVID-19 pandemic has also exposed persistent inequalities in access to health care by income, age, race, sex and geographical location and highlighted significant gaps in countries' health information systems. While high-resource settings may have faced challenges relating to overstretched capacity and fragmentation, weaker health systems risked jeopardizing hard-won health and development gains made in recent decades (6). During GAP implementation, there have also been major geopolitical changes, with shifting power balances, growing instabilities, rising polarization and an increasing emphasis on national self-sufficiency, with all regions being affected by major wars, conflicts and crises, which have further complicated international collaboration to advance health and well-being. However, what the COVID-19 pandemic did reveal was the need for increased domestic and external investments in health systems to rebuild them, to make them efficient and functional as well as resilient to future pandemics and global health emergencies, along with the need to further reinforce the functioning of the GAP (7). This further reaffirmed a focus on building communities of practice around accelerator themes to support country-led plans, existing networks and structures (8). Additionally, piloting of efforts around joint funding, monitoring, evaluation, governance and mutual accountability was seen as urgently needed by both participating agencies and Member States.

18. By 2023, halfway to the 2030 SDGs and their related goals, the COVID-19 pandemic was declared to no longer be a global health emergency (9). However, many of the SDGs were clearly off track. In the specific case of SDG3, targets were not going to be met even prior to the pandemic, and post-pandemic progress was shown to be even further behind (7). With these issues in mind, the GAP's fourth annual Progress report focused on what had worked as part of the joint initiative (8). It noted, based on self-reported data, that under GAP the following had worked well:[3]

- an improvement cycle on health in the multilateral system
- supportive structures for collaboration
- several country-specific and thematic approaches.

19. Areas for improvement were also identified, which included:

- translation of the GAP commitments into action at the country level, which had varied considerably;
- civil society and community engagement, which had not been sustained; and.
- the GAP's ability to promote collaboration, especially at the country level, which was limited in the absence of external incentives that reinforce organizational cooperation.

20. ***The Progress report*** also noted six recommendations that needed to be implemented as part of the future of the GAP to hasten progress toward the SDG3 goals.

[3] The 2023 annual report also noted that significant progress had been made on implementing the six recommendations from the JEA.

21. The 2023 GAP Progress report highlights that many of the successes and challenges of the International Health Partnership (IHP+), which ran from 2007 to 2016, have also been experienced by the GAP (8).

22. In this context, it is critical for decision-makers at the global, regional and national level to understand whether and how the GAP is contributing to national efforts to achieve the health-related SDGs. This includes assessing the extent of alignment of the work of signatory agencies with country-led national health plans and strategies; its implementation including its pace and areas of improvement; lessons learned that can be scaled up; how to better streamline development partners' support; and how effectiveness could be further enhanced through other actors. This joint evaluation was planned at inception in 2019 to coincide with the halfway point of the SDGs; thus, the undertaking was timely.

23. The evaluation also takes note of recent emerging agendas and strategies that further highlight the urgent need to reform global health priorities and architecture to better meet the needs and demands of countries and populations. These strategies include the WHO's 14th Global Programme of Work from May 2024, setting out an ambitious agenda for global health; 'Gavi 6.0' from June 2024; and the conclusions of the Future of Global Health Initiatives Process, published in December 2023 as the 'Lusaka Agenda', which emphasizes the continued need for better collaboration among multilateral agencies and global health initiatives.[4]

Methodology

Approach

24. The evaluation team employed a **non-experimental design with a theory-based, utilization-focused approach,** assessing and developing a reconstructed ToC and gearing data collection towards 11 high-level s structured around three evaluation criteria to interrogate expected changes and plausible contribution of the GAP (contribution analysis) to that change.

25. The ToC was reviewed based upon themes emerging from the inception stage where several areas for improvement were identified to be addressed in the reconstructed ToC. These included:

i. The assumptions detailed in the original ToC were limited and did not yet provide sufficient coverage for what is needed. This recognized that one of the key distinguishing features of assumptions is that they describe something that is assumed to already be in place or happening and does not require an intervention or change for it to take place. In the original ToC, these were more about the intent/aspiration of the GAP.

ii. The inputs were more descriptions of enablers and key drivers of results and were primarily focused on GAP agencies. The evaluation team considered it useful to expand and refine them and include partner agencies and national governments.

iii. Specific activities directed towards bringing about outcomes and impact through GAP collaboration appeared largely absent. This 'missing middle' undermined the logical pathways to outputs and outcomes.

iv. The outcomes and goals were clearly articulated, though an opportunity to include intermediate outcomes was present.

[4] The Lusaka Agenda marks the culmination of a 14-month process of engagement that has included multi-stakeholder dialogues in Addis Ababa, Ethiopia (14 June), Wilton Park, UK (4–6 October) and Lusaka, Zambia (26 November).

v. Whilst the ToC clearly orientated the GAP to a post-COVID era, there was further scope to acknowledge other external factors and shocks.
vi. Links to other SDGs were missing, so that the ToC gave the impression that SDG3 is somewhat self-contained. Clearly health and education, financing, labour, environment and conflict are all interrelated, for example, and are areas of work relevant to the signatory agencies.
vii. The ToC was linear in nature, similar to a logic model, and excluded explicit reference to feedback loops.

26. As a result of this review, a reconstructed ToC was developed, which addresses a number of these gaps. This was validated and further refined at the validation meetings on 12 and 13 December 2023 in Geneva.

27. Using the reconstructed ToC, the evaluation team interrogated what changes, if any, have occurred or are likely to occur as a result of the GAP and examine the mechanisms of those changes (i.e., the 'how' and 'why').

28. In reconstructing the ToC, a series of risks, barriers and assumptions underpinning the expected achievement of results were identified and a series of hypotheses developed and validated by the EMG at the inception stage. These hypotheses have been tested throughout the data collection and analysis phases, examined within the evaluation criteria, and highlighted in the findings.

29. Recognizing that there are likely to be multiple causes for any observed change, the evaluation team has considered contextual factors when making inferences about the underlying causes of a particular change and have secured stakeholder perspectives on how this change has been achieved.

30. Since the intended outcomes go beyond what the GAP could possibly achieve as an initiative alone, the evaluation drew on contribution analysis[5] to provide a systematic way to capture evidence of the plausible contribution that an intervention (the GAP) is making to observed outcomes.

31. The evaluation was conducted using a participatory approach, with engagement throughout all phases of the evaluation with both the EMG and the ERG, as well as other relevant stakeholders to understand how different groups might use the evaluation and identify potential dissemination opportunities. The evaluation team presented the inception report at a workshop with both the ERG and EMG to build ownership of the approach.

32. A **mixed methods approach** (remote interviews, country studies, a survey and a document review) was used to ensure triangulation of evidence and traceability from findings to conclusions to recommendations.

33. The evaluation adhered to ethical standards and took into account relevant cross-cutting issues of gender, human rights and disability, humanitarian principles and accountability to affected populations in design, data collection and analysis, where appropriate. It did so by including specific evaluation questions on these cross-cutting themes and adhered to United Nations Evaluation Group Norms and Standards for Evaluation in the United Nations System. In terms of disaggregated data, gender-disaggregated data was not available in relation to progress towards the SDG3 targets. There was no difference observed between male and female respondent perspectives in interviews or the survey.

[5] Contribution analysis is an approach to assessing the performance of policies and programmes towards an outcome or outcomes. It was developed by John Mayne for situations in which designing an experiment to test cause and effect is impractical.

Evaluation questions and criteria

34. The key evaluation questions that are addressed in this evaluation are set out in Table 1.[6]

Table 1. Key Evaluation Questions

EVALUATION CRITERIA	KEY EVALUATION QUESTIONS
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? **1.2** 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? **1.2.2** To what extent has the SDG3 GAP complemented and added value to 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?
Effectiveness	**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? 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? **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? **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 and helped countries achieve gender, equitable and inclusive progress towards health-related SDGs? **2.4** To what extent have the SDG3 GAP accelerators supported the achievement of intended results? **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?

[6] Annex 9 sets out the original evaluation questions and the final evaluation questions as agreed in the inception report.

	2.5.2 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 catalysed the use of resources? **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? **2.6** To what extent are SDG3 GAP results adequately monitored and accounted for?[7] **2.6.1** To what extent has there been sufficient leadership and accountability for SDG3 GAP by signatory agencies?[8] **2.6.2** 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? **2.7** What factors (positive and negative) have affected the achievement of SDG3 GAP results?
Sustainability	**3.1** To what extent are SDG3 GAP outcomes sustainable? **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?

Sampling strategy

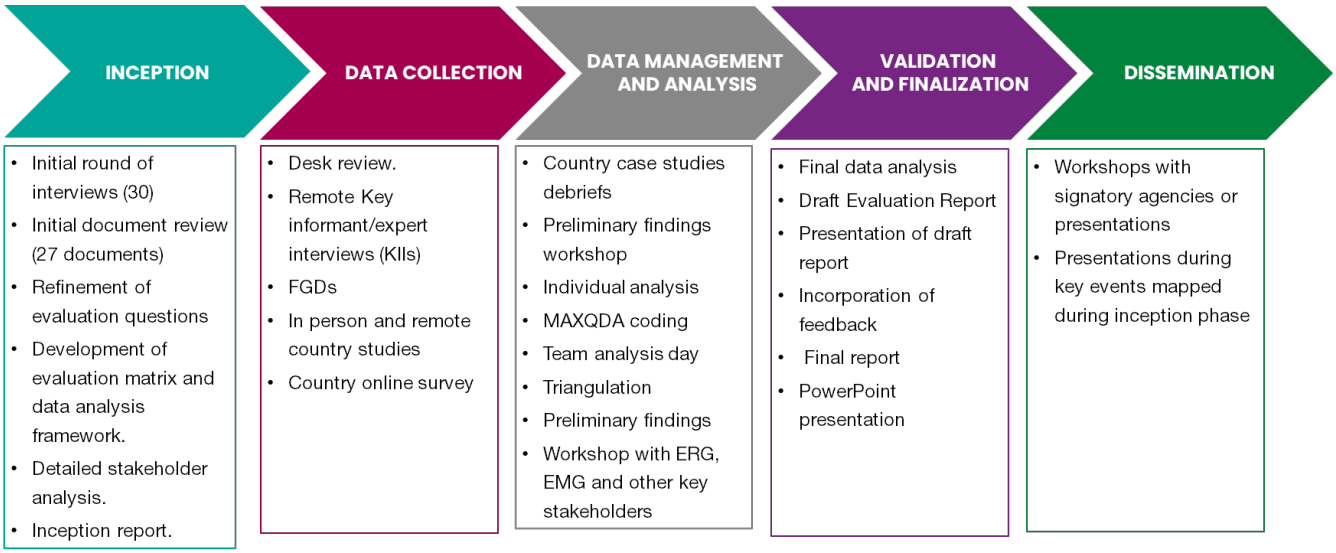
35. To develop a robust sample for the country studies, the evaluation team used a number of criteria applied to the 67 countries, such as the Human Development Index, income status, fragile state classification, number of accelerators, whether there is an existing GAP case study *(10)*, whether WHO country offices have received catalytic funding, the presence or absence of a cluster system, the size of official development assistance for health and the heat map data from the 2023 *Progress report*. By applying these criteria, the evaluation team developed a longlist of 19 countries for the country studies, as well as suggested countries for remote country studies The final list included Ethiopia hosted by UNDP; Nigeria hosted by UNAIDS and WHO; Pakistan hosted by UNICEF and WHO; Jordan and Tajikistan hosted by WHO; and Colombia and Somalia hosted by WHO as remote studies.

36. Country studies were conducted using KIIs and focus group discussions as the primary data collection approaches, alongside documentary review.

[7] In the evaluation matrix, there were two questions. 2.6. How are SDG3 GAP results monitored and accounted for? And 2.6.1. To what extent has the SDG3 GAP monitoring framework adequately captured results achieved? But for clarity and to avoid repetition, these have been merged here.
[8] The original questions 2.6.2 (To what extent are results for SDG3 GAP captured and accounted for in signatory agencies' own results frameworks?) and 2.6.4 have been merged.

Evaluation phases

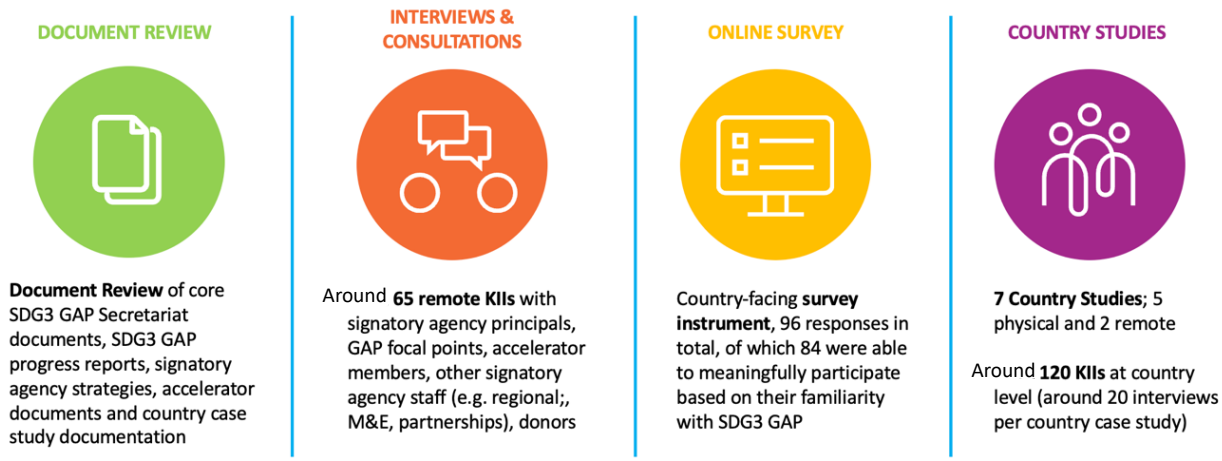
Figure 1: Evaluation phases



37. The evaluation took place over five phases as outlined in Figure 1. The evaluation commenced with a detailed **inception phase** to ensure a shared and agreed understanding of the needs and expectations from this evaluation and to underpin the quality, relevance and utility of the team's work. The team refined the evaluation questions, based on inception interviews, document review and examination of the ToC, and then developed an evaluation matrix as the central organizing framework. The inception phase concluded with the development of an inception report, which was quality assured ahead of submission using UN quality standards and finalized based on EMG/ERG written feedback.

38. During the **data collection** phase, a mixed methods approach was used, whereby multiple methods were used to collect and triangulate qualitative and quantitative data from a range of sources to establish a robust evidence base to inform all aspects of the evaluation, based on the evaluation matrix. Figure 2 presents the volume of data gathered by the evaluation and the key data collection methods.

Figure 2: Data collection tools



39. Once data collection was completed, the team proceeded on to the data management and analysis phase. In this phase, various validation mechanisms where used. For example, at country level, country debriefs took place with regional colleagues often joining, and at global level, preliminary findings were shared with the EMG/ERG as an additional form of data validation and ensuring data accuracy and used as an opportunity to discuss potential recommendations arising from the evaluation. The evaluation framework was employed to analyse data from the main data sources, organizing and tabulating it in relation to the evaluation questions using MAXQDA. The evaluation team identified thematic findings that highlighted factors relevant to the evaluation criteria.

40. Throughout the evaluation, analysis, triangulation and validation took place iteratively, enhancing opportunities for the team to share learning, refine methodology and approach as needed and test and validate working hypotheses, preliminary and final findings, conclusions and options for ways forward. Three types of triangulation methods were applied: cross-referencing of different data sources (interviews, survey and documentation); triangulation within the team through a two-day team analysis session; and the evaluation team members' own process of verification of findings and information post-data collection.

41. The team conducted an evidence confidence review identifying areas which were considered low confidence and thus open to challenge using a Strength of Evidence rating scale.[9] An evaluator assessment and judgement was used based on this scale, with confidence in the triangulation and strength of evidence reinforced during the draft reporting process in validation sessions with the ERM/ERG where there was strong consensus on the resonance of evaluation findings. Inconsistencies in findings, given the varying contexts examined, are acknowledged. These inconsistencies did not necessarily weaken the credibility of the evaluation findings but rather reflect the sensitivity of different data collection methods and the diverse contexts in which the GAP has been implemented.

42. The analysis and triangulation used the lenses of gender, health equity, human rights and disability inclusion where applicable. Each team member conducted individual analysis using all data available, which was coded against s using MAXQDA.

[9] Strength of Evidence rating scale: 4 - Multiple lines and levels of evidence with very strong triangulation; 3 - Multiple lines and levels of evidence, most of which triangulate; 2 - Limited lines and levels of evidence with strong triangulation; or 1 - A single line of evidence, or weak triangulation.

43. To systematically review data and verify and identify key findings as a group, the evaluation team convened for a two-day analysis workshop.

44. The Evaluation Report was developed and has been internally quality assured, following UN quality assurance processes. The report was circulated to the ERG and EMG for feedback over a two-week period, which was consolidated by the WHO Evaluation Manager and checked for consistency so that the evaluation team could address comments and incorporate them into the final draft. The final draft went through a second round of quality assurance, considering the feedback, copyediting and proofing. The final report was submitted with the comments matrix to outline how comments were addressed. Along with the final report, PowerPoint presentations and framing notes/evaluation briefs may be developed so that they can be disseminated with diverse audiences in mind.
The final stage of the evaluation process is the **dissemination by WHO, the GAP Secretariat and signatory agencies** of the evaluation report through workshops and webinars or presentations at a limited number of key events.

Methodological limitations and mitigations

45. A range of mitigation measures were deployed to address the emergence of methodological limitations during the evaluation, as presented in Table 2.

Table 2. Limitations and mitigation measures

Data collection method	Description	Mitigation measure
Country studies	A key limitation for this evaluation is the selection and arrangements for the country studies. While robust sampling criteria was developed and all case study countries were from the longlist, the final sample was influenced by pragmatic considerations (e.g. availability of agencies to host case studies), and the sample was therefore not as diverse as intended. The final sample included three countries from WHO's Eastern Mediterranean region (Jordan, Pakistan, Somalia); two from WHO's African Region (Ethiopia and Nigeria); one from WHO's Americas region (Colombia); and one from WHO's European Region (Tajikistan) resulting in an over-representation of WHO's Eastern Mediterranean Region, no Francophone country and no countries from WHO's Western Pacific or South-East Asia regions. This was highlighted as a significant limitation and discussed with the EMG. A challenge noted in Ethiopia, Nigeria and Pakistan, where the health system is largely devolved to province/state level, was that within the time available, there was limited opportunity to travel beyond the capital city and conduct data collection at the subnational/state level. A further limitation encountered during the country studies was the lack of awareness amongst key stakeholder groups at country level.	Whilst the Eastern Mediterranean region was overrepresented within the sample, the three countries themselves selected within this region are quite different in context (fragility, disease burden, income classification, etc.) and so did still enable consideration of how the GAP has worked in diverse contexts, alongside the further three WHO regions that were covered by the sample. The final country sample was agreed by the EMG. In terms of limited awareness, this was mitigated through the triangulation of data from the other evidence streams. While the team could not travel beyond the capital city in Ethiopia or Nigeria, in Pakistan the team were able to travel to Karachi and note how the GAP had operated in the context of a decentralized health system.

Key informant interviews	The evaluation team was reliant on ERG members to provide lists of stakeholders in a comprehensive and timely way, as agreed in the inception phase Unfortunately, there were a number of agencies where stakeholder lists were not shared or shared after data collection had officially ended. As a result, the evaluation team was not always able to ensure that the perspectives of these agencies are fully reflected in evaluation findings. Furthermore, some respondent types were not represented in data collection (no board members were interviewed, despite a number being contacted) or not well-represented (principals of five signatory agencies were interviewed, stakeholders from five of the seven accelerators reached).	To mitigate the impact of these challenges, the evaluation team sent a series of reminders and leveraged EMG/ERG members to increase participation, as well as extending the deadline for both contacts received and interviews to be completed. Whilst the numbers of interviews completed was less than envisaged, the consistency of findings emerging across respondent types and evidence sources gives confidence in the strength and robustness of evaluation findings; it can be considered that the lack of responsiveness and engagement with the evaluation is a finding in and of itself.
Document Review	The evaluation team was able to identify only a limited number of additional GAP-specific documents that were mentioned during remote KIIs and used them to deepen triangulation of findings, particularly with regards to the accelerators.	The evaluation team was unable to mitigate this limitation but through the process of triangulation (as outlined above), the evaluation team does not feel this had a detrimental impact on the robustness of evaluation finding.
Survey	There were a modest number of survey responses received (96 responses from a potential sample of 1200 in total were received, of which 84 were able to meaningfully participate based on their familiarity with the GAP – equivalent to 7%). The response rate may have been impacted by respondent burden: the evaluation survey to government focal points was sent out soon after the Secretariat had sent out a survey to the same respondent group (which the evaluation team was not made aware of in the inception phase) and, as the evaluation team was not sending the survey to respondents directly, it had no way of knowing which agencies or countries had shared or of sending targeted reminders accordingly. There was also no CSO participation as planned due to no lists of civil society agencies by country being available.	To mitigate the impact of these challenges, the evaluation team sent reminders to encourage ERG and WHO Representative /UN Country Team respondents to share the survey and extended the deadline. The lack of CSO participation remained; despite repeated attempts, this limitation could not be fully mitigated.

Findings

Coherence

Coherence[10]

At a global level, the GAP demonstrates compatibility and coherence with current and previous international health partnerships and initiatives, providing evidence of alignment, continuity and opportunities to leverage previous efforts and investments (e.g. on PHC or data and digital health). Despite early buy-in and engagement with the GAP from principals within the signatory agencies, it has proven more challenging to secure interagency coherence. At the country level, awareness and ownership by government counterparts and national partners is low.

Shared understanding and ownership of the SDG3 GAP (EQ 1.1)

Key findings: **There was early buy-in and engagement with the GAP from principals in the signatory agencies at a global level, from its outset. However, the objectives of the GAP and interagency collaboration mechanisms have not been sufficiently defined to support a coherent and shared understanding. As a result, there have been divergent and inconsistent interpretations and approaches to GAP implementation across signatory agencies, particularly at country level.**
There have been uneven levels of understanding and ownership of the GAP between signatory agencies and at different levels of organizations, as well as limited awareness of the GAP by country governments and national partner stakeholders, resulting from a lack of common understanding of GAP purpose and approach, combined with poor contextualization at a country level.

With the advent of COVID-19 early in the life cycle of the GAP and other emerging global priorities and commitments since, as well as concerns regarding the GAP's efficacy, the visibility and seniority of ownership and engagement of the GAP have diminished.

46. As part of the evaluation of GAP coherence, the evaluation team examined the extent to which there has been a shared understanding and ownership of the GAP and its purpose and intended results both by i) signatory agencies and ii) countries.

47. **Early buy-in and engagement from principals in the signatory agencies at a global level were clearly visible**, though with the advent of COVID-19 early in the life cycle of the GAP and other emerging global priorities and commitments since, the visibility and seniority of leadership involvement have observably diminished. Key informants from all signatory agencies, and at all levels, noted this visibly diminishing leadership. Rotations and changes of staff were also highlighted as a challenge, affecting continuity and ownership.

[10] Strength of Evidence rating scale: 4 - Multiple lines and levels of evidence with very strong triangulation; 3 - Multiple lines and levels of evidence, most of which triangulate; 2 - Limited lines and levels of evidence with strong triangulation; or 1 - A single line of evidence, or weak triangulation.

48. **It has been challenging for GAP signatory agencies to establish country-level buy-in**. The importance of getting country ownership for how the GAP operates was emphasized early in the initiative's life cycle, with both the GAP *(7)* and agency focal point discussions highlighting the ***Engage*** theme of working at country level as critically important. Consistent with the principle of national ownership, the GAP[Error! Bookmark not defined.] highlights the need for countries to coordinate the agencies' joint work at country level and ensure that the work considers the country context and existing coordination mechanisms and is focused on agreed actions. The GAP further details that WHO will support governments in the coordination of country-level activities, leveraging existing UN and other donor coordination arrangements where appropriate, and will help to facilitate joint actions among the agencies at the global/regional level.

49. As part of the assessment of a range of strategic and technical elements, the JEA *(5)* assessed the level of GAP country engagement as "Not yet in place; or very little progress made".

50. The evaluation team recognizes that the presence of the signatory agencies varies significantly at country level, with their ability to contribute evenly at this level varying as a result. From signatory agency interviews, the team finds **persistent uneven levels of understanding and ownership of the GAP within the signatory agencies, across the organizational levels, with notably limited awareness and ownership at country level. This was echoed in levels of understanding and ownership of country government counterparts and national partners, as experienced in interviews with them**. This finding aligns with the 2020 JEA conclusion and is further validated by agencies' self-reporting, such as that reflected in the 2023 *Progress report*, which notes: "Translation of the SDG3 GAP commitments into action at the country level has varied considerably, with some countries and agencies championing efforts, while others have shown rather limited engagement and action… [T]he widespread engagement of United Nations country teams has not yet been achieved." *(8)*

51. At a country level, from evidence synthesized from the country studies, the evaluation team finds **that the GAP has not found significant traction in most countries visited, with the exception of Pakistan and Tajikistan, where greater levels of understanding and ownership of the GAP were more clearly visible**. This appears to be primarily driven by the effective use of catalytic funding in Pakistan and Tajikistan (see *Effectiveness,* below, for more information on the use of catalytic funding in selected countries).

52. The evaluation survey instrument examined the extent to which there has been a shared understanding and ownership of the GAP and its purpose and intended results by the **signatory agencies**. Due to the poor response rate, data from the survey should be interpreted with caution. Nonetheless, responses would seem to indicate some degree of shared understanding and ownership of the GAP by signatory agencies, with over 60% expressing a moderate (44%) or large (20%) extent of understanding, and under 40% noting a small (24%) or very small (12%) extent. There were no notable differences where these responses were disaggregated by region.

53. However, the qualitative data of signatory agency and country partner interviews showed lower positive levels of awareness and ownership, with respondents noting a lack of awareness about the GAP or its implementation in-country. Some noted increased focus and attention on the GAP, but only as a result of this evaluation (i.e., the survey itself or a country study).

54. The evaluation survey instrument further examined the extent to which there has been a shared understanding and ownership of the GAP and its purpose and intended results by the 67 GAP country **governments**.

55. Data from the survey shows an equal split, highlighting that 49% of all respondents indicated a shared understanding and ownership to either a moderate (40%) or a large extent (9%). However, 51% of all respondents were less positive, noting a shared understanding and ownership to either a small (25%), very small (24%) or no extent (1%). There were no notable differences where these responses were disaggregated by region.

Coherence of operational and financial policies, strategies and approaches (EQ 1.2)

Key findings: While there has been a range of activities to improve the level of coherence of operational and financial strategies, policies and approaches, overall, the level of interagency alignment of these remains insufficient in incentivizing meaningful interagency change that improves coordination, drives efficiencies and avoids duplication or supports the strengthening of health collaboration mechanisms.

There is evidence of progressive alignment of signatory agencies' strategies and policies with national priorities and plans and increasing country ownership of health coordination mechanisms.

The GAP is compatible and provides continuity with several previous international health partnerships, having built on their work, leveraged previous efforts and investment and learned lessons from these initiatives. However, the GAP, like its predecessors, has struggled to influence or sufficiently catalyse change on systemic issues affecting coordination, such as political leadership, ownership, governance and funding.

There has been a lack of external incentives that reinforce organizational cooperation at a country level, which has limited collaboration and hindered progress.

56. As part of the evaluation of GAP coherence, the evaluation team examined the extent to which signatory agencies' operational and financial strategies, policies and approaches incentivized and enabled coherent, effective and sustainable collaboration.

57. The GAP *(8)* clearly signals the intent for agencies to align operational and financial strategies, policies and approaches in line with their respective mandates and governance mechanisms, where this contributes to increased effectiveness, efficiency and impact, with each agency working to institutionalize the GAP's spirit and approaches to collaboration at all levels of the agency.

58. **The evaluation team finds that the overall level of interagency alignment of financial and operational strategies and policies has remained insufficient in incentivizing behaviours at country level that improve coordination, drive efficiencies and avoid duplication to strengthen health collaborations, while acknowledging that there has been a range of activities to improve the level of coherence of operational and financial strategies, policies and approaches.**

59. As part of the assessment of a range of strategic and technical elements, in 2020 the JEA noted major differences in structure and partnering modalities across the signatories. It also highlighted the signing of Memoranda of Understanding as an important milestone to solidify agencies' commitment to the GAP partnership, by allowing co-funding to be pursued within groups of agencies, without having to approach

the respective boards for approval through the different steps of the process. The JEA further noted that the GAP supported the acceleration of increased funding alignment and cofinancing support between the agencies.

60. In 2020, the self-reported *Progress report* noted efforts to increase alignment, though it acknowledged that these were driven primarily by existing reform efforts (e.g. United Nations Development System reform or through the shared Global Health Campus in Geneva) at global level. The *Progress report* further noted efforts as part of country engagement and support, such as joint country missions and better information exchange among agencies *(11)*. In 2021 the *Progress report* noted that alignment among GAP agencies was occurring within GAP accelerator working groups and at country level, with the GAP seeking to strengthen and increase alignment in the global health ecosystem by integrating elements of the Every Woman, Every Child agenda and related work by the H6 group of agencies (all of which are GAP signatory agencies) into ongoing collaboration within the accelerators; strengthening multilateral collaboration at the regional level (such as the WHO Eastern Mediterranean Regional Health Alliance in support of the GAP and the WHO European region issues-based coalition on health); learning from previous global collaboration initiatives (International Health Partnership, IHP+); and translating lessons to other SDG collaborations (Global Acceleration Framework for SDG6).

61. In 2022, the *Progress report* notes that alignment of global health initiatives intensified due to COVID-19 and that signatory agencies needed to use resources efficiently. Some of the examples mentioned in the report were efforts to integrate GAP with H6/Every Woman, Every Child and the Health Data Collaborative and to explore synergies with Universal Health Coverage (UHC) 2030. However, to what extent these efforts were fruitful is not clear. The 2023 Health Data Collaborative evaluation report states, “there has been limited visibility of the merger amongst stakeholders, and implementation has not been done in the most strategic or transparent way” *(12)*

62. In 2023, the *Progress report* notes that signatory agencies should follow countries’ recommendations on how to strengthen alignment and coordination 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. Agencies should also continue to work with other related initiatives, such as the GFF Alignment Working Group and Future of Global Health Initiatives, to improve collaboration.

63. The inclusion of agencies which work beyond health (ILO/WFP/UN Women/UNDP) was hailed as positive by signatory agency stakeholders, which recognizes the importance of social determinants of health. However, the evaluation found little compelling evidence of multisectoral coordination being enhanced by the GAP; in some countries, these agencies had had no engagement with the GAP.

Alignment of signatory agencies' interventions with national priorities and plans (EQ 1.2.1)

As part of the evaluation of GAP coherence, the evaluation team examined the extent to which the GAP has supported increased alignment of signatory agencies' interventions with national priorities and plans and country ownership of health coordination mechanisms.

Jordan country study

Coordination platforms for the Jordan health sector are increasingly led by national counterparts (e.g. SDG3 National Team and Health Development Partner Forum), with support provided by WHO and USAID. Likewise, there is 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 main facilitating factors for ensuring the effectiveness of this coordination, according to key informants, are the push to have national counterparts lead the platforms, which has resulted in a stronger unified country-owned vision, and the pre-existing and long-standing professional relationships that many key stakeholders have, which enables open discussions and more rapid decision-making, due to the country's size (e.g., a population of slightly more than 11 million).

64. At a country level the evaluation team finds that, **while there has been progressive alignment of signatory agencies' strategies and policies with national priorities and plans and increasing country ownership of health coordination mechanisms, the approaches, behaviours, incentives and enabling factors have been insufficient to drive efficiencies and avoid duplication to strengthen health collaborations at a country level.**

65. Existing mechanisms to strengthen alignment, including country platforms for achieving the SDGs and the ongoing process of reform in the United Nations Development System, including the establishment of the UNSDCF, are driving alignment. However, signatory agency and country partner stakeholders were not able to articulate or determine the extent to which the GAP had made a notable contribution to that alignment, only to confirm that it was not working against these processes.

66. The survey instrument examined the extent to which the GAP had supported the increased alignment of signatory agencies' interventions with national priorities and plans and country ownership of health coordination mechanisms. The quantitative data shows a more positive response than the country studies or KIIs, with 55% of all respondents noting an increased alignment of signatory agencies' interventions with national priorities and plans and country ownership of health coordination mechanisms to either a moderate (35%) or large extent (20%).

67. However, all remaining respondents (44%) were less positive, noting an increased alignment of signatory agencies' interventions with national priorities and plans and country ownership of health coordination mechanisms to either a small (28%), very small (15%) or no extent (1%).

Complementarity and added value to international partnerships and initiatives (EQ 1.2.2)

The evaluation team finds that the GAP is compatible, and provides continuity, with a number of previous international health partnerships, having built on previous efforts and investment and leveraging learned lessons from these initiatives.

68. In relation to international partnerships and initiatives, there appears to be a repeated rhythm to the launch, implementation and gradual decline in efficacy of global initiatives seeking to strengthen coordination and alignment of multilateral organizations. This can be seen through various initiatives' life cycles, for example the International Health Partnership/ IHP+, which ran from 2007 to 2016 and later evolved into the UHC2023 partnership, which gained ground before slowing down, and similarly the GAP.

This may well be a repeated experience moving forward with, for example, the future of global health initiatives and the Lusaka Agenda. Nonetheless, there is value in each partnership initiative having complemented its predecessor in maintaining a focus on global health, the necessary reforms and shifting the needle on global health issues to strengthen health collaborations. It is clear that the GAP has common purpose and a shared endeavour with past and current international partnerships and has not diverged or been implemented in a way that undermines other initiatives.

69. The GAP has sought to actively learn the lessons from past international partnerships as well as building On a range of existing/pre-existing partnerships. For example, UHC 2030 was noted as "a constant partner" and included in the PHC accelerator of GAP. Like most ambitious global collaborative efforts, the GAP has gained ground and encountered barriers, as noted by the GAP's own progress reporting, with recent international partnerships (such as IHP+) noted as having had very similar set of experiences to the GAP. This suggests that more systemic change – including incentives such as political leadership, governance direction and funding as noted above– is needed to make fundamental progress on collaboration for health. From the evaluation team's perspective, this further shows the constraints on multilateralism in the present political and economic context, where nations are increasingly inward-looking and the UN faces severe resource constraints due to the fiscal environment of donors.

Incentives for increased collaboration at a global/regional/country level (EQ 1.2.3)

70. The evaluation team finds that **while the implementation efficacy of the GAP illustrates that self-commitment by agencies at a global level can to some extent facilitate improvements to collaboration, it can only achieve so much without sufficient external incentives that reinforce collaboration, especially at the country level.** Successive GAP progress reports *(10, 11, 13-16)* identify the challenges regarding the absence of systemic incentives, highlighting that incentives need to be strengthened in three key areas: political leadership, governance direction and funding for collaboration.

71. Recent GAP progress reports *(8)* acknowledge this challenge, recommending that GAP signatory agencies make incentives and resources available to catalyse stronger collaboration in line with country-led plans, policies and financing to ensure that incentives are adequate for meaningful institutionalization to happen.

72. There is a range of factors identified in country visits, KIIs and survey data that have incentivized and driven alignment:

- enabling donor behaviour, including asking agencies to collaborate, programme and report jointly, which opens possibilities to access funding, as well as providing a reputational incentive (i.e., being seen to want to coordinate);
- joint programming exercises resulting in cost efficiencies (e.g., fewer field trips) and opportunities to share learning, incentivizing partnership working;
- strong coordination and push from government (e.g., Ethiopia);
- strong and active engagement from the regional level, for example the Regional Health Alliance (RHA) in WHO's Eastern Mediterranean Region;
- a shared understanding of the value-added by different agencies, allowing agencies to play to their comparative advantage and reduce duplication;
- a focus on policy dialogue, providing enhanced opportunities to advocate for change; and

- necessity-based collaboration and an operating context (e.g., COVID-19) that demands collaboration and coordination in a way that donor-driven or agency-driven initiatives cannot.

73. There is likewise a range of disincentives and factors that have been considered barriers to alignment:

- significant transactional cost, with a lack of resources geared specifically to partnership and coordination in most agencies;
- proliferation of coordination platforms, with insufficient time and initiative fatigue, particularly at country level, leading to a desire to see mechanisms streamlined;
- issues related to transparency and competition, though a lack of coordination between agencies can sometimes be advantageous for governments if there is a lack of transparency as it allows governments and other in-country partners to engage bilaterally with agencies in service to their national priorities and funding requirements;
- donor behaviour, which can at times paradoxically disincentivize collaboration, due to funding modalities (e.g. earmarking or tied funding, which ties agencies to outcome frameworks/results that prevent collaboration); and
- a lack of joint accountability, with no specific outcomes on collaboration embedded within results frameworks.

Effectiveness

Effectiveness [11]

The evaluation finds mixed evidence that the GAP has achieved, or is expected to achieve, its intended objectives and results. While there is evidence of strengthened engagement with countries to determine priorities, and good practice identified within the PHC and SHF accelerators (which have been the most effective and impactful), there is limited evidence to show that the GAP has directly accelerated progress and helped agencies to support countries towards achieving the SDG3 targets. Countries still face a predominance of major and significant challenges in achieving these goals.

[11] Strength of Evidence rating scale: 4 - Multiple lines and levels of evidence with very strong triangulation; 3 - Multiple lines and levels of evidence, most of which triangulate; 2 - Limited lines and levels of evidence with strong triangulation; or 1 - A single line of evidence, or weak triangulation.

The GAP's achievement of intended objectives and results (EQ 2.1)

Key findings: Given the lack of awareness of the GAP reported by respondents from countries and GAP signatory agencies, it has been challenging to isolate specific results that the GAP has achieved. The GAP's contribution to alignment and joined-up support to countries has taken place among many other initiatives on alignment, including by the GAP agencies themselves.

The evaluation finds some evidence of strengthened engagement with countries to determine priorities, with signatory agencies engaging in a range of coordination mechanisms chaired or co-chaired by national counterparts, although these are not necessarily attributable to the GAP.

In relation to SDG3 targets, while the achievement or non-achievement of these cannot be attributed directly to the GAP, the evaluation notes concentrated resources and focused efforts by signatory agencies on such critical components as maternal health, under-five mortality, risk of dying from the main NCDs, UHC coverage, TB, HIV and vaccine. However, the evaluation team finds that while there were some improvements in these areas from 2015 to 2020, they have generally not been sufficient to meet the set targets. Among the 69 countries noted in the 2024 *Progress report* where the GAP is being implemented, none have achieved or are on track to achieving SDG3 targets.

74. As part of the evaluation of GAP effectiveness, the evaluation team examined the extent to which the GAP has achieved, or is expected to achieve, its intended objectives and results. The team also considered the extent to which signatory agencies effectively utilized the GAP to strengthen countries' national health priorities and health systems and analysed which collaboration mechanisms have been more effective in accelerating progress to GAP objectives. Given the limited awareness and uptake of the GAP noted across the country studies and reported more widely, it is not always possible to answer all the s and/or find plausible linkages to the GAP. Where illustrative, examples of initiatives and collaboration/coordination carried out in the spirit of the GAP are drawn on below.

75. As noted in the first section of this report (Coherence), given the lack of awareness of the GAP reported by respondents, it is challenging to isolate specific results that the GAP has achieved. The evaluation team has thus explored a plausible contribution approach, recognizing that there is evidence of GAP signatory agencies contributing to the stated GAP objectives through means that are not directly related to the GAP. This section presents evidence of such plausible contributions and, where evidence is available, highlights areas in which the GAP mechanism has catalyzed or facilitated such results.

76. As detailed in the evaluation's reconstructed ToC, the effectiveness of GAP implementation should be reflected in increased joined-up support that reduces the administrative burden on countries; sustainable financing for PHC and national health plans; more equitable and inclusive progress towards SDG health-related targets; and improved uptake and use of innovations and health data. These issues are examined in more detail below.

Increased joined-up support to countries (EQ 2.1.1)

77. As noted above, GAP signatory agencies committed to aligning their operational and financial strategies, policies and approaches at country level to support the realization of SDG3 targets; with the GAP stating that "this new approach to collaboration will help the agencies move from complementarity to synergy." *(8)*

78. According to signatory agency respondents at global level, increased joined-up support was envisaged to occur through joint missions, engagement of government officials by accelerator working groups, discussion of specific countries by the agencies' principals and a joint letter sent in 2021 by the principals to their country-facing teams.

79. **Activities through which the GAP was meant to effectively foster joint working have been uneven across different countries,** with some notable examples highlighted below. **There is evidence that the joint mission in Pakistan contributed to improved alignment and better engagement of the national government.** A high-level "primary health care for universal health coverage" (PHC4UHC) mission took place in March 2021, in which eight GAP partners participated. The mission served to review the status of PHC and SHF and advise on a model of care to ensure effective implementation of the UHC Benefit Package. On this occasion, federal and provincial governments representatives and GAP partners signed a joint statement in support of enhancing PHC towards UHC in Pakistan. Based on this mission, WHO supported the government in piloting the PHC Oriented Model of Care in two districts. Similar joint missions in Malawi and Nepal were undertaken as part of the Health Data Collaborative and/or data and digital health accelerator.

80. **The GAP has played a facilitating role in improving alignment and joined-up support in some countries, though this has been insufficient.** The 2023 *Progress report* notes that efforts "have not been sufficient to fully translate SDG3 GAP commitments into action for stronger collaboration in all the countries engaged" *(7)*. Several GAP signatory agency **respondents at global level pointed out that a major cause for this lack of alignment is that coordination of agencies at country level requires dedicated human resources as well as seed funding for coordination activities,** as noted above. GAP agency respondents considered the amount provided through catalytic funding too limited; it was also only allocated by WHO to WHO country offices.

81. The **GAP's contribution to alignment and joined-up support to countries has occurred amidst many other initiatives on alignment**, including by the GAP agencies themselves. For example, Ethiopia developed a Health Harmonization Manual *(17)*, which was updated in 2020. This manual outlines a framework for more effective coordination and alignment of programmes within the public sector and with implementing partners and donors to help the country make faster progress towards achieving the SDGs and UHC. The GFF has supported the setting-up of the SDG Performance Fund to pool development partners' resources for health. According to respondents from GAP agencies in Ethiopia, this mechanism has lowered transaction costs for the government and provided flexible resources to underfunded areas of the health sector national strategic plan.

82. In Jordan, the GAP agencies have demonstrated increasing coordination and alignment and have supported the capacity of the national government to lead the health sector coordination. In relation to engagement and coordination with national counterparts, there are strong and effective working relationships between signatory agencies and the Ministry of Health, Ministry of Planning and International Cooperation (MOPIC) and other national government counterparts, with a drive by signatory agencies to build their counterparts' capacity and capability. 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 is a range of coordination platforms for engagement of civil society and dialogue with government (e.g. the Jordan INGO Forum (JIF); Jordan National NGO Forum (JONAF); and Jordan Strategic Humanitarian Committee (JoSH)). While these achievements contribute to the GAP objective of increased joint support, the plausible linkages between the GAP and the observed changes are tenuous. Globally, there are also bilateral efforts between GAP agencies to align their processes and approaches. For example, the Global Fund and GAVI boards have engaged in regular dialogues to align their support at country level, as well as their work on common areas of interest, such as the malaria vaccine. GAVI's grant cycle also now aligns to national health planning cycles in countries, and the organization is looking to transition to using existing national health review mechanisms for reporting purposes, rather than requesting separate grant-specific reports. Likewise, Unitaid has been supporting the Malaria RTS,S Vaccine along with Gavi and the Global Fund *(18, 19)*.

83. From the country case studies, the evaluation team finds some contribution of the GAP to its expected results in Tajikistan in relation to broader health sector coordination and in Pakistan in relation to developing and financing a PHC package, as noted below. However, no such plausible links could be established in the Jordan, Ethiopia, Nigeria and Somalia case studies. The Colombia case study provides evidence of GAP contribution on strengthening an existing collaboration between four GAP agencies, but the scale and sustainability of results are found to be limited.

Contribution to SDG3 targets (EQ 2.1.1)

84. Evidence is not available to conclude whether the GAP has significantly contributed towards health-related SDG targets. Despite some reported improvements in certain indicators, significant challenges persist, highlighting the need for continued global attention.

85. Among the 69 countries noted in the 2024 *Progress report* where the GAP is being implemented, none have achieved or are on track to achieving SDG3, with 87% facing major challenges and 13% facing significant challenges. Although 42% of these countries are experiencing moderate improvements, 61% are stagnating (see Annex 10), and there remains a lack of concrete evidence linking these gains directly to the GAP.

86. Fig. 3 shows the progress on maternal health, under-five mortality, risk of dying from main NCDs, UHC coverage, TB, HIV and vaccine indicators of the countries selected for this evaluation's case studies. These indicators are critical components of the SDG3 targets and represent areas where GAP signatory agencies have concentrated resources and efforts.

87. Despite these targeted efforts, the analysis reveals that while there have been improvements in these areas from 2015 to 2020, they have generally not been sufficient to meet the set targets. The predominance of red in the table underscores the ongoing major challenges faced by countries in achieving these goals. This suggests that while the GAP's focus on these indicators is appropriate, evidence is not available to suggest that the GAP has accelerated progress.

88. Furthermore, the lack of significant traction in most countries indicates that systemic and structural challenges, such as poor coordination, duplication and fragmentation among health agencies, continue to impede progress. These issues hinder the effective implementation of strategies and the optimal use of human and financial resources, resulting in suboptimal outcomes. The variability in progress across different health domains, such as the slower advancements in infectious diseases, health financing and workforce development, further complicates the GAP's overall effectiveness.

Figure 3. Case studies of SDG3 progress (20)

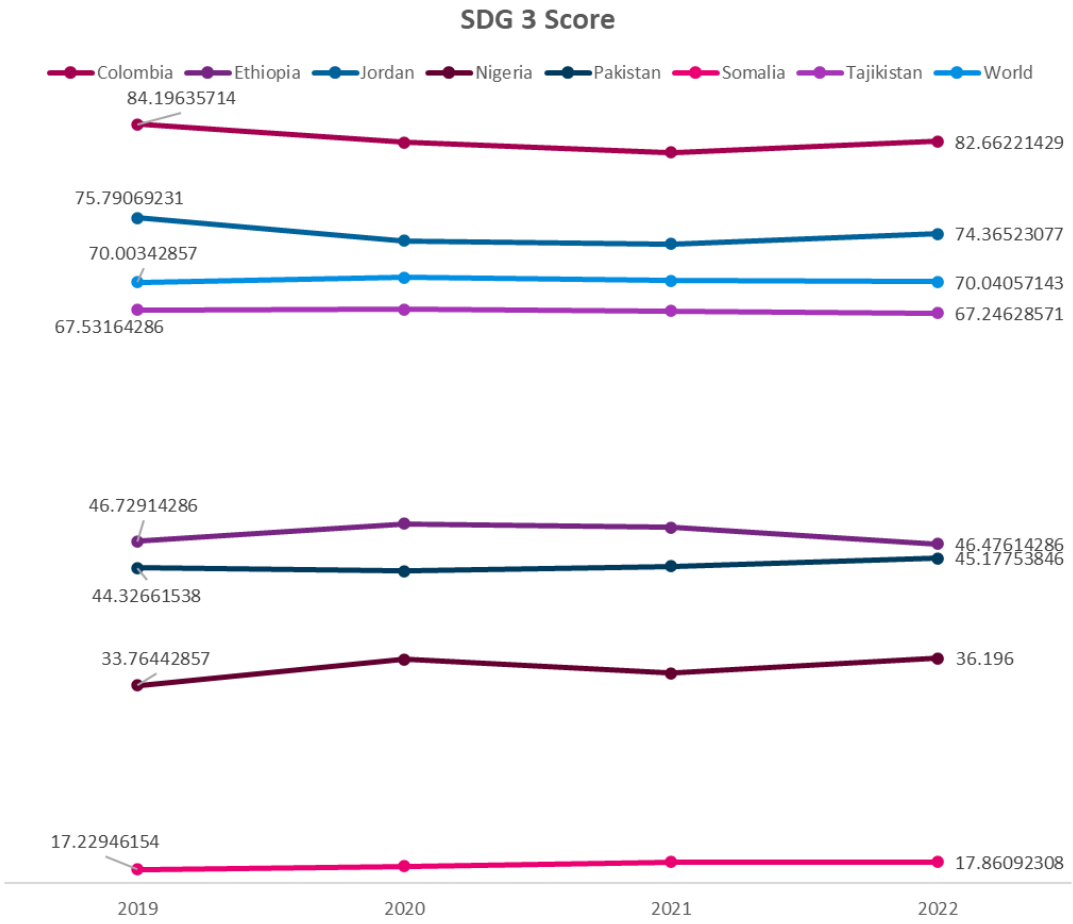
	Colombia			Nigeria			Ethiopia			Jordan			Pakistan			Tajikistan			Somalia		
Indicator	2015	2020	Progress	2015	2021	Progress	2015	2021	Progress	2015	2020	Progress	2015	2020	Progress	2015	2021	Progress	2015	2021	Progress
MMR per 100 000 live births	70.01	74.76	↓	1113.4	1047 (2020)	→	399.2	266.7 (2020)	↑	46.13	41.3	↑	187.4	154.2	↗	20.38	16.63 (2020)	↑	760.9	620.7 (2020)	↗
Under-5 mortality per 1000 live births	15.6	12.37 (2022)	↑	126.4	107.17 (2022)	→	62.4	46.8	↗	20.1	14.14 (2022)	↑	76.18	60.96 (2022)	↗	37.4	30.33 (2022)	↑	134.5	106.13 (2022)	↗
TB incidence per 100 000	31	47 (2002)	↓	219	219 (2022)	→	192	126 (2022)	↗	5.7	3.8 (2022)	↑	270	258 (2022)	→	86	78 (2022)	→	274	246 (2022)	→
HIV infections per 1000	0.19	0.16 (2022)	↑				0.19	0.08 (2022)	↑	0.01	0.01 (2022)	↑				0.113	0.1 (2022)	↑			
Risk of dying from main NCDs	10.33%	9.73%	↑	17.80%	16.90%	↑	17.66	17.1 (2019)	↗	14.90%	15.3% (2019)	↓	30.67%	29.41% (2019)	→	29.50%	28.3% (2019)	→	31.17%	30.41% (2019)	→
UHC coverage	76	80 (2021)	↑	39	38	↓	37	38 (2019)	→	70	65 (2021)	↓	41	45 (2019)	→	68	67	↓	24	27 (2021)	→
Surviving infants who received 2 WHO-recommended vaccines	91	88 (2022)	↓	42	60 (2022)	↗	56	56 (2022)	→	94	76 (2022)	↓	72%	82% (2022)	↗	97	98 (2022)	↑	42	46 (2022)	→

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

89. The nature of the available evidence does not allow for conclusions on the potential contribution of GAP towards achieving the selected health-related SDG targets. However, the evidence does indicate persistent challenges in achieving progress on these targets for the seven countries selected for case studies, five of which fall below the world averages for the SDG3 scores reviewed (see Fig. 4). Furthermore, while three of these countries have seen slight increases in their SDG3 scores during this period, the improvements are not substantial. This trend aligns with the global context, where the world average SDG3 score experienced a minimal rise from 70.00 in 2019 to 70.04 in 2022. Consequently, there is limited compelling evidence to suggest that the GAP has significantly accelerated progress or substantially aided agencies in supporting countries towards achieving the specified health targets.

Figure 4. SDG3 score by country, 2019–2022



Incentives for increased collaboration at country level

90. The GAP sought to offer a key incentive for signatory agencies through the streamlined support to countries and reduction in efficiencies that can be realized. As stated by WHO Director-General, Dr Tedros Adhanom Ghebreyesus, “Although collaboration is the path, impact is the destination.”

91. The evaluation team note that the incentives for signatory agencies provided by effective utilization of the GAP include shared objectives and synergies, funding and resource mobilization and benefitting from shared technical support and learning/best practices. Increased collaboration at the country level includes ensuring country-led approaches, coordinated planning and implementation from signatory agencies and other stakeholders and multisector coordination. Although these incentives exist in theory, the evaluation found there to be insufficient incentives within and among agencies to drive the different ways of working required (2024 *Progress report*, 24) (see earlier findings under 1.2.3 for more insight into the extent to which GAP has incentivized increased collaboration and into disincentives noted during the evaluation).

Signatory agency use of local coordination mechanisms (EQ 2.5.2)

92. The GAP aimed to provide a structured platform for the signatory agencies to strengthen their collaboration on work towards SDG3, with a clear recognition of the need to move towards ”more purposeful, systematic, transparent and accountable collaboration and harmonization” (*GAP*, XV). By promoting joint planning, resource allocation and implementation strategies, the GAP encourages agencies to align their efforts at the local level and the key to doing this is to use coordination mechanisms.

93. The evaluation finds a range of mature and well-established coordination mechanisms functioning within the GAP countries, which are being utilized to varying degrees and levels of effectiveness. However, only in very limited cases are these coordination mechanisms directly linked to the GAP; mostly they pre-existed the GAP or were constructed in the absence of an awareness of the GAP. There is limited evidence of the GAP further incentivizing use of coordination mechanisms. Increased alignment between agencies to support national priorities and strengthening of health systems and catalyse the use of resources appears to be primarily driven by the maturing of UNCTs and UNSDCFs at country levels and through the Delivering as One approach, with both signatory agencies and non-signatory agencies collectively working to drive efficiencies and minimize duplication in both the health arena and beyond. The evaluation finds strong evidence of alignment between agency’s own health strategies and plans and national health priorities. KIIs with both governmental stakeholders and signatory agencies revealed that bilateral conversations between them happen frequently, and generally GAP agencies are well regarded, respected and valued by the government. There was evidence of this being particularly profound in larger countries with more decentralized governance, such as Nigeria.

94. The 2023 GAP *Progress report* highlights the need for coordination mechanisms not only to be in place at the country level but also to be adequately “used and respected”. To facilitate this, coordination mechanisms need to be appropriate for the context, for example, by including subnational structures in federal states. KIIs during the evaluation reinforced this as a key area of improvement moving forward, especially in countries with a highly decentralized government, through requiring more joint meetings and collaboration with the signatory agencies which are still sometimes perceived as working in silo.

95. Acknowledging this, the 2023 *Progress report* recommends “SDG3 GAP signatory agencies should make incentives and resources available to catalyse stronger collaboration in line with country-led plans, policies and financing” (2023 *Progress report*, 11).

96. A clear example of the GAP incentivizing the use of coordination mechanisms was noted in Tajikistan. While there is no distinct implementation mechanism among GAP agencies outside of WHO, there is evidence that the GAP has enabled better alignment among agencies in Tajikistan through supporting the role of WHO as a convenor of the health sector partners’ coordination. The Development Coordination

Council (DCC) Health is considered one of the most active DCC groups[12] in the country and the main health sector coordination platform. Its five subgroups are aligned to the 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 are presently perceived as less well integrated with the DCC Health, such as the Global Fund's Country Coordinating Mechanism and the Joint UN Team on AIDS. Tajikistan's health information system is heavily fragmented and reliant on its own data collection systems, though more efficient data collection has been achieved through use of the DCC Health coordination mechanism. Efforts are also underway to improve government ownership and capacity.

97. Evidence from the country studies highlights that the GAP has not incentivized or led to the use of local coordination mechanisms, for example in Somalia, which has poor results in the 2022–2023 heat map results, as do three other countries: Cabo Verde, Madagascar and Yemen (although the evaluation acknowledges this is self-reporting). KIIs from the Somalia country study indicated that despite government attempts to revive health coordination mechanisms, there has been limited uptake of them and infrequent meetings, as well as opportunities for more effective utilization of other coordination fora such as the Donor Health Group. While the country study in Pakistan noted that a new SDG3 GAP Coordination Committee was created, this was regarded by some key informants in-country as an example of duplicated effort, since the UNRC already convenes a Development Partners group of key health actors, which includes several of the GAP signatory agencies (e.g. WB, GFF, GF, Gavi), as well as the Foreign, Commonwealth & Development Office and Bill & Melinda Gates Foundation. There was also no engagement of the GAP Coordination Committee with the UNCT. Other coordination mechanisms, such as the PHC Service Delivery and Financing working group (created to drive forward the respective GAP accelerators), were also noted by key informants. Overall, signatory agency respondents felt that these existing mechanisms are quite ad hoc and could be more strategic, rather than primarily for information sharing, and noted that were missed opportunities for joint programming and advocacy to government and concerns regarding the sustainability of such mechanisms.

[12] There is a total of 14 DCC working groups, in the categories of sustainable development, human development (which includes the DCC Health) and economy and private sector development.

GAP accelerators (EQs 2.2, 2.4)[13]

Key findings: The accelerator groups have been envisaged as the key mechanism for GAP signatory agencies to drive collaboration with working groups established at headquarters levels, with communities of practice created to share good practices and plan joint county level initiatives. Out of the seven accelerators, two accelerators have been most prominent and active: the PHC and SFH and accelerators. Data and Digital Health has also shown positive signs of traction. COVID-19 amplified the focus on PHC and financing, necessitating signatory agencies and other partners to collaborate and coordinate to deliver a robust response.

On PHC, there is evidence that these efforts have served to effectively improve collaborative work, resulting in better coordination, less duplication of activities and more strategic approaches. For example, in Pakistan, the PHC and SFH accelerators have been merged to contribute to sustainable financing for PHC. In Tajikistan, GAP agencies have contributed to establishing a shared diagnosis and roadmap to address the issue of PHC service coverage.

On SFH, signatory agencies contributed to the development of a Health Financing Strategy, supported by a fiscal space analysis (World Bank), health system financing assessment (World Bank), strengthening of public financial management for health (World Bank), technical assistance for national health financing expert (WHO), a health financing matrix (WHO) and cross-programmatic efficiency analysis (Gavi, Global Fund and WHO).

Despite good practice examples at country level, at a global level major structural challenges and barriers remain to achieving sustainable health financing: a trade-off exists for agencies between investing in quick wins, for example by increasing funding to humanitarian responses and thus being able to demonstrate impact in terms of lives saved, and longer-term health system strengthening where their contribution may be less clearly identified and accounted for.

Relevance and ownership of the SDG3 GAP accelerators (EQs 2.2, 2.4)

98. The accelerator groups were envisaged as the key mechanism for GAP signatory agencies to deliver at country level. Agencies established working groups at headquarters levels, with communities of practice created to share good practices and plan joint county level initiatives. Only two of the accelerators, PHC and SFH, have maintained both their relevance and prominence since the GAP was initiated in 2019. The remaining accelerators have not found comparable traction, though many are still considered at least somewhat relevant. Across the country studies, the relevance of different accelerators was highlighted, e.g. Jordan and Tajikistan focused on data and digital health; Somalia as per progress reports emphasized research and innovation; and Colombia focused social determinants of health and civil society and community engagement. Overall, however, the results for these accelerators were mixed.

99. Both PHC and SFH were given significant prominence at the outset with the commitment to UHC and the need to guarantee that health financing remained secured and, ideally, on an upward trajectory. Key informants noted that some of the driving factors for better ensuring the relevance and prominence of the accelerators included:

[13] The SDG3 GAP accelerators are (in brief): 1) primary health care; 2) sustainable financing for health; 3) community and civil society engagement; 4) determinants of health; 5) data and digital health; 6) research and development; and 7) innovative programming in fragile and vulnerable settings.

- the lead agency(ies) for the accelerator and their commitment to it;
- having an understood purpose and corresponding results attached to the accelerator; and

having a well-structured work plan and established foundations and working practices (e.g. active working group, clear terms of reference, defined meeting outcomes, etc.).

100. PHC and SFH in particular have demonstrated strong ownership by signatory agencies. Ts is, in large part, due to both the backing of the leadership and support from donors. Key informants noted that when the lead agencies for the accelerators are heavily involved, those accelerators tend to be more established and structured and maintain relevance, although this may not translate from the headquarters to country level. One further theme which emerged in regard to the more successful accelerators is that not only were there pre-existing interest and mechanisms at the country level for collaboration, but also financial support: for example, the Bill & Melinda Gates Foundation provided financing that supported sustainable financing (i.e., SFHA) work across several signatory agencies, including the World Bank and others. This support, key informants noted, allowed the leadership of those accelerators to focus more on strategic issues rather than administrative and other routine functions.

101. The COVID-19 pandemic further reinforced the focus on PHC and financing as it obliged the signatory agencies and other partners to collaborate and coordinate to ensure a robust response.

102. One common issue was that apart from PHC and SFH, there was a lack of understanding as to how the accelerators were selected. Key informants expressed an understanding that many of the accelerators were primarily driven by the specific areas of interests of the signatory agencies as opposed to an assessment of need. Further, some key informants believed that the accelerators, contrary to their aim, increased the verticalization of programming in that there was limited formal communication between accelerator groups and this lack of interaction was reinforced by siloed funding flows. A final theme was that the global health landscape has changed dramatically (e.g. the COVID-19 pandemic, the Lusaka agenda, the growing use of AI, etc.) since 2019, when the accelerators were introduced. Moving forward, many key informants believe there will be a need to evolve the accelerators either in terms of the technical areas of focus or by rethinking their purpose so that they mature in relation to the changing global health landscape.

103. As noted above, two accelerators have been most prominent and active: SFH and PHC. It is noteworthy that both the SFH and PHC accelerator groups built on existing initiatives by some of the GAP agencies, for example those dating back to the 1978 Alma-Ata Declaration on PHC and other existing workstreams. They are also complemented by the more recent 2023 Lusaka Agenda, which includes five key shifts. The first centres on stronger contribution to PHC, and the second relates to sustainable domestically financed health services and public health functions. The Data and Digital Health Accelerator has also been active. It too is linked to a pre-existing platform, the Health Data Collaborative, launched in 2016 to align technical, financial and political resources with country-owned strategies for using data to improve health outcomes with a specific focus on SDG targets and communities that are left behind. In contrast, the Determinants of Health, Civil Society and Innovative Programming accelerators were perceived as largely dormant.

104. Since specific intended GAP accelerator results were not well communicated to signatory agency staff, especially country teams, the outcomes are mixed. KIIs and country studies did not provide any clear link between the seven GAP accelerators and any specific intended results. Annex 2 of the GAP includes a list of 46 activities covering all the seven accelerators, but no evidence was identified that those were used to develop plans or that their implementation was tracked systematically. Thus, some signatory agencies'

informants noted that implementation of accelerators was mostly based on "good will", without clear accountability from the agencies.

Primary health care

105. PHC is considered universally by signatory agency stakeholders and countries to be by far the most successful, prominent and relevant accelerator. Part of its initial importance was due to the outcome of the 2018 Global Conference on Primary Health Care in Astana and the corresponding declaration emphasizing the critical role of PHC around the world. As part of the GAP, the PHC accelerator group initially prioritized eight countries for intensified support. This was further expanded to additional countries, so that by 2023 twenty countries were part of its focus. This focus was further highlighted by the COVID-19 pandemic as support for strengthening PHC was seen as vital to the response to the pandemic, subsequent recovery and preparedness for future pandemics. PHC is seen by many key informants (both at the headquarters and country level) as the cornerstone around which all of the other accelerators should be aligned. For example, in Nigeria PHC revitalization is featured explicitly in the presidential health reform with the aim to have at least one functional PHC facility in each of Nigeria's 774 local government areas as a means of improving access to quality UHC and services for the entire population.

106. Signature agency informants additionally point to the leadership role of WHO and UNICEF, as well as the commitment by other participating agencies, as primary drivers in the comparable effectiveness of the PHC accelerator. This consistent and structured engagement includes, for example, weekly meetings, joint reviews of country requests for PHC support and close working relationships with country counterparts, joint assessments of baseline PHC capacity and measurement of progress at twelve months in PHC priority countries, reviews of progress against annual (jointly developed) work plans and quarterly meetings between the co-leads. During its February 2024 retreat, there was a recommitment to the accelerator, as well as recognition of the need to engage more with regional offices to fully utilize the infrastructure of the signatory agencies.

107. The PHC accelerator, with WHO and UNICEF leadership, has provided a valued forum for signatory agencies, especially those which directly fund programming (e.g. the World Bank, Gavi, etc.) to present their PHC approaches, as well as jointly developing a monitoring framework, identifying country priorities and engaging with national stakeholders.

At the country level, almost all the case studies had examples of WHO leading PHC efforts with UNICEF support, providing ownership of this accelerator theme and reinforced by complementary ownership by the host country governments.

108. In the Pakistan country case study, the launch of the GAP was seen as advantageous, with the PHC and SFH accelerators providing a hook to strengthen coherence in terms of better alignment and coordination. A PHC Service Delivery and Financing working group was created to drive these accelerators, though a number of signatory agency respondents felt that these existing mechanisms are ad hoc and could be more strategic, rather than simply focused on information sharing.

109. In Ethiopia, several GAP signatory agencies undertook significant work on PHC and SFH, with GAP signatory agencies investing significant resources in supporting direct health services provision at primary care level. Similarly, with support of health partners such as the World Bank, the health care financing strategy has been revised to achieve the goal of universal health coverage in the country.

110. However, the extent to which the GAP accelerators have contributed to amplifying existing SFH and PHC efforts were questioned by informants at both a global and country level, acknowledging that much of this work was done outside the GAP and, instead, occurred in response to the COVD-19 pandemic using pre-existing health sector coordination platforms.

Sustainable financing for health

111. SFH is considered effective by signatory agency informants, who note that coordination and collaboration mechanisms already existed in many countries to address this issue. Further, some key informants noted that this accelerator had lost focus during recent years as there were few, if any, concrete and measurable results that were to be achieved. Some of the activities supporting this accelerator have included: a cochaired (World Bank and Gavi) bi-weekly meeting mainly for information sharing; monthly, or sometimes quarterly, meetings for all signatory agencies to provide updates, share information and present new initiatives; and smaller group meetings around specific technical topics.

112. At the country level, there has been some progress, though – as noted by signatory agency interviewees – the plausible link to the GAP is once again limited. For example, in Jordan the need for a strengthened health financing function has been reflected in national health policies, as in the Ministry of Health's Strategic Plans with a focus on revenue, effective organization and pooling of resources, prepayment mechanisms, and strategic purchasing. Efforts have been made to address Jordan's capacity to ensure sustainability of the health financing function. WHO support in this area has included institutionalizing National Health Accounts, tracking the financial risk protection indicator as part of the SDG agenda and developing Jordan's strategy for health financing. Informants are not clear whether the GAP played a significant contributing role or whether this work would have been undertaken in any event.

Community and civil society engagement

113. From the outset of the GAP, engagement with civil society has been weak. Civil society actors were not systematically included as key stakeholders in the GAP's design or engaged routinely as key stakeholders. The 2023 *Progress report* states that this is because the added value of a joined-up approach under the GAP was not initially well defined and possibly because the fundraising incentive for individual agencies did not reinforce joint civil society and community engagement *(7)*. It also outlines that the 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 GAP. However, the evaluation found no evidence that this had taken place. Civil society perspectives at a country level were supposed to be gathered as part of the monitoring framework but this has not been undertaken, and it was not possible to include civil society in the survey respondents for this evaluation as there was no contact list available.

114. While there was some initial limited progress in this accelerator in terms of engaging the civil society focal points within the various signatory agencies, the departure of the two original individual organizers resulted in a significant pause in activities and focus. Convening agencies, including their leadership, then de-prioritized this accelerator both in terms of commitment and dedicated staff resources. According to key informants, no further agendas were forthcoming, though some efforts were made to continue to coordinate and convene the group.

115. As with some of the other accelerators, there was a notable lack of understanding of what this group was trying to achieve and where (both technically and geographically) it should focus its efforts. The civil society and community engagement accelerator working group aimed to prepare a global work plan; initiate a global mapping of signatory agencies' engagement policies and practices; support civil society engagement in selected countries in collaboration with the SFH, gender working group and health determinants accelerator, including through support for "inclusion, gender and rights" GAP working groups in those countries; and maintain liaison with communities, civil society and civil society networks as well as through UHC 2030 and its civil society engagement mechanism. However, this group was described by key informants as having never really gathered momentum and being largely defunct. In 2021, it was merged with the gender working group and determinants of health accelerator in the equity cluster as per the evaluability assessment recommendation, but as no additional resources were planned to support this change, it has not served to revitalize it.

116. Only one of the country studies, Colombia, emphasized this accelerator. There is also evidence that GAP agencies have collaborated to some extent to engage with civil society organizations in Nigeria. Here, UNFPA led work on engaging civil society actors in ensuring equal access to essential services during COVID-19, as well as in the mitigation of socio-economic circumstances of the pandemic as part of the social determinants of health and civil society and community engagement accelerators. In terms of promoting human rights at country level, in Tajikistan the shrinking of civic space resulted in the closing down of 700 civil society organizations (CSO) by the government in the past year. This affected many CSOs working to address health equity and rights issues. According to both GAP agency and civil society informants, many health partners appeared reticent to advocate human rights, stigma and discrimination issues in this context to avoid undermining relationship with the government. Civil society informants consider that GAP agencies could do more to support them in the current climate, in particular through facilitating a dialogue with the government and supporting the recognition of their role in the health system. In Colombia, for example, CSOs noted that GAP agencies had not demonstrated increased alignment in terms of their partnership processes and requirements when engaging with them, nor in terms of encouraging the national government to engage civil society organizations in planning processes. There are, however, examples of signatory agencies supporting CSOs and CBOs jointly through other mechanisms not directly linked to the GAP, for example through delivering grants and technical support to such organizations for people living with HIV and networks of other marginalized groups through the Joint UN Team on AIDS in partnership with the Global Fund.

117. Crucially, there is no accountability mechanism through which signatory agencies are measuring their work on engaging with civil society to reach out to marginalized groups and the extent to which they collectively contribute to promoting the development of human rights-based approaches to health.

118. In general, collective action to strengthen civil society and align partnerships approaches was seldom observed. Further, civil society informants consider that the GAP agencies tend to consider them as beneficiaries and do not sufficiently recognize their strengths and contribution.

Data and digital health accelerator

119. Much of the work done as part of this accelerator has been in collaboration with the Health Data Collaborative.[14] For example, three joint country missions (Malawi, Nepal and Pakistan) were planned from mid-2022 to early 2023 to further align technical and financial support amongst agencies *(21)*, with the Malawi and Nepal missions being completed. Recommendations from those missions included better responses to country requests, strengthening alignment efforts among partners and identifying countries for future intensive support. Key informants noted that specific accelerator activities have included ongoing country dialogues with participating countries, weekly technical updates and discussions and specific country activities, though they further noted that there have been variations in activity at both the global and country level, with some time periods of intense activity and others with little (e.g. the accelerator group met six times in 2021 with a drop-off in frequency in subsequent years). As noted previously, two of the country studies, Jordan and Tajikistan, have specific activities related to this accelerator, though the work done to strengthen this area in Jordan has only marginally benefitted from GAP inputs (e.g. the World Bank in Jordan has been developing a programme of work to support health data digitization with technical inputs coming from some signatory agency partners such as WHO). In Tajikistan, the contribution of GAP is more direct, with signatory agencies and other partners attempting to improve the situation through initiatives such as the WHO/MOHSPP Roadmap for Improving Health Information System and Digital Health and a five- to ten-year plan by the World Bank on digitalization within and beyond the health sector.

Determinants of health

120. Evidence of results on the determinants of health accelerator is weak. Only one key informant at the global/headquarters level could provide any feedback on the accelerator and noted that it had been making good progress until recently. Only one of the country case studies, Colombia, focused on this accelerator and did provide some examples of collaboration among the GAP signatory agencies on health determinants (e.g. ILO and UNFPA collaborate on promoting sexual and reproductive health in young rural workers, UNFPA, UNICEF, WHO and WFP have a joint programme focused on addressing cultural barriers to accessing health services.to reduce maternal mortality). At the same time, within several GAP countries, there is demonstration of collaboration on determinants of health involving GAP agencies, but this is not directly linked to the GAP.[15] Undertaking work related to determinants of health in a systematic manner remains crucial yet challenging, as it often requires more costly and time-consuming interventions in contexts that need the most support.

Research and development, innovation and access

121. No global-level key informants were able to provide any substantive feedback on this accelerator. Most informants from all respondent types were only vaguely aware of it, if at all. This stands in contrast to several documents produced in the early stages of the GAP which focused on this accelerator and actions which could be undertaken to ensure its scale-up and utility at the country level. The research and innovation accelerator as highlighted as being the key focus in Somalia according to the 2021 *Progress report*, though the specific contribution of the GAP was less plausible, given the extended engagement with Somalian counterparts which pre-dated the GAP.

[14] The Health Data Collaborative brings together a network of more than 400 partner organizations to provide a collaborative platform that aligns technical, financial and political resources with country owned strategies for using data to improve health outcomes.
[15] See for example the 2024 *Progress report* (pp. 38–39) highlighting joint action and results on determinants of health in countries such as Ghana, Haiti, Malawi, Papua New Guinea, São Tomé and Príncipe, South Sudan, Tajikistan, Uganda and Zambia.

Innovative programming in fragile and vulnerable states and for disease outbreak response

There was limited feedback on this accelerator with key informants noting that it had been fairly insular (i.e., a lack of engagement outside of WHO), with unclear results and low activity. While signatory agency interviewees noted that it appeared to be a relevant and potentially beneficial accelerator, it was considered low in terms of effectiveness and engagement.

Gender equality and responsiveness, equity and inclusiveness (EQ 2.3)

Key finding: Gender equality, health equity and inclusiveness are significant topics in the mandates of all GAP signatory agencies and from the outset of the GAP. There has been a gender equality working group tasked with integrating a gender equality lens across all accelerators, which was merged in 2021 with the determinants of health and civil society and community engagement accelerators to form the equity cluster. While there were initial activities conducted by the gender working group, the equity cluster can best be described as dormant. This dormancy is attributed to a lack of dedicated human and financial resources among signatory agencies and turn-over of focal point staff, as well as a lack of focus on gender within country coordination mechanisms.

From the outset of the GAP, engagement with civil society and communities has been weak. Civil society actors and community-based organizations were not included as key stakeholders in the GAP's design or engaged routinely as key stakeholders. The civil society accelerator group was described as having never really gathered momentum and being largely defunct. Its integration into the equity cluster, in 2021, has not served to revitalize the work planned under this accelerator.

122. As part of the evaluation of GAP effectiveness, the evaluation team examined the extent to which the implementation of the GAP has helped countries achieve gender, equitable and inclusive progress towards health-related SDGs. While gender equality, health equity and inclusiveness are significant topics in the mandates of all GAP signatory agencies, **the evaluation found little evidence that this was comprehensively harnessed by the GAP to foster joint working on promoting gender equity in health and ensuring that gender responsive approaches are integrated across the GAP priority areas.** While specific work took place on integrating gender equality across the different accelerators and to a lesser extent on civil society engagement, there is no evidence that signatory agencies enhanced their collaboration to address disability inclusion or promote human rights-based approaches more broadly through the SDG3 GAP mechanism.

Gender equality

123. The need for promoting collaborations and coherence among UN agencies on the promotion of gender equality is enshrined in various UN frameworks, such as the United Nations System-wide Action Plan (UN-SWAP), which includes an indicator on coherence. This requires agencies to participates in interagency coordination mechanisms on gender equality and the empowerment of women to meet the requirements associated with this performance indicator *(22)*. The requirement for UN agencies to engage in interagency mechanisms to promote gender equality is also upheld by several ECOSOC resolutions, such as Resolution 2004/446F (para 12) which recommends that all interagency mechanisms pay attention to gender perspectives in their work *(23)*.

124. Originally envisaged as a cross-cutting theme across the accelerators, gender equality was promoted by a gender equality working group led by UN Women with the participation of Gavi, GFF, Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, Unitaid, WB, WFP and WHO. The working group had a dual purpose of enhancing support to countries in addressing gender-related barriers to health services access and of providing technical expertise across GAP accelerators to integrate a gender responsive approach with a particular focus on determinants of health. The gender working group was established by inviting gender advisors of signatory agencies to integrate a gender equality responsive lens within other GAP accelerators. Prior to the COVID-19 pandemic, the group identified focal points to ensure that work in each accelerator was underpinned by a gender lens as well as an analysis of social determinants of health. The Evaluation of Gender Integration in the work of WHO *(24)* notes for example that the SDG3 GAP focal point in WHO Eastern Mediterranean Regional Office is also a member of the Gender, Equity and Rights Team of WHO in charge of liaising with country offices to promote the integration of gender equality in their work. During the COVID-19 pandemic, the gender working group obtained support from the UN Gender and Health Hub to write a *Guidance note and checklist for tackling gender-related barriers to equitable COVID-19 vaccine deployment (25)*. According to the 2023 GAP *Progress report*, the working group also established connections with other initiatives working on women and girl's empowerment in health, such as the Every Woman, Every Child initiative (https://protect.everywomaneverychild.org/). **Following the COVID-19 pandemic recovery phase in 2021, however, the gender working group was described by key informants as dormant. Signatory agencies' respondents at global level considered that this was caused by several factors, including the lack of dedicated resources and the turn-over of focal point staff in the signatory agencies.** Respondents from signatory agencies whose mandates extend beyond health

Colombia Country Study

One positive example of GAP contributing to joint working on integrating gender equality responsive approach in health at country level has been the maternal health programme in Colombia, integrating SDG5 target in an existing maternal and neonatal health programme implemented and led by PAHO. After the presentation by PAHO of the principals' letter introducing the GAP to the country teams at the UNCT, the agencies chose to prioritize the gender equality cross-cutting theme and determinants of health accelerator and develop a proposal for improving joint working in these areas using GAP catalytic funding. This led to the integration of SDG5/gender equality related targets in an existing collaborative project mentioned above, Maternal Health for All: Indigenous Communities in Colombia, implemented by PAHO in collaboration with UNFPA, WFP and UNICEF since 2017. It is noteworthy that the country context was conducive to this initiative. In Colombia, there is a strong focus from the government's Cooperation Strategy on supporting gender equality, equity and inclusiveness. This Strategy includes principles of feminist and intersectional cooperation to guide the work of agencies. The impact of gender inequality and other intersectional factors of health inequities are also well documented. In particular, there are differential results in maternal mortality ratio between the general population and indigenous and Afro-Colombian populations. The programme implemented by PAHO in collaboration with UNFPA, UNICEF and WFP has 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. This points to the need for more sustained support from the agencies in terms of technical assistance and resources to foster joint programming on gender equality in health.

highlighted that allocating specific resources to the GAP and to health had been a challenge when there are so many competing priorities and a lack of resource incentives. That includes the challenge of balancing funded health projects with unfunded GAP work. The 2023 *Progress report* highlighted that the gender equality working group had lacked the resources to support close collaboration at country level and in 2021 it was merged with Determinants of Health and Civil Society and Community Engagement into one Equity Cluster *(7)*. This, however, does not seem to have revitalized it or led to a renewal of the groups' activities.

125. As noted above, having a gender focal point in each of the other accelerator groups to ensure a gender lens on all GAP work has had limited success, with the exception of the PHC accelerator where the gender focal point was considered to be engaged and active.

126. At country level in Pakistan, signatory agencies had worked collectively to make the PHC Support Package gender sensitive. However, signatory agency and civil society stakeholders interviewed felt that given the scale of gender inequalities with regards to women's access to health much more collective advocacy could have been carried out by signatory agencies in this regard. This was also highlighted at a global level: there was opportunity for GAP agencies to collectively carry out more advocacy on gender and equity and more broadly together to donors, but this was not pursued robustly.

127. Besides these examples, however, evidence from the country studies point to limited effectiveness in influencing the work of GAP signatory agencies on gender equality across all GAP countries. In particular, the involvement of UN Women in the country health coordinating mechanism appears limited. Respondents involved in the gender equality working group at global level noted that for work on gender equality integration to become more effective, initiatives should be driven by country specific needs and demands rather than driven as a top-down approach from the global level.

Economic and timely delivery of results (EQs 2.5, 2.5.1)

Key findings: The evaluation found variations in the economic and timely delivery of results amongst GAP signatory agencies and across countries, including positive examples of how joint efforts involving GAP agencies have led to improved resource optimization, faster response times and innovative financing solutions. The evaluation notes, however, that these are not aways linked directly to the GAP. There was evidence to suggest that providing pooled funds where possible would help improve coordination.

Regarding timeliness of results, the GAP intends to facilitate quicker response times through pre-existing frameworks for collaboration, especially in emergency and humanitarian situations. The evaluation found that coordinated efforts among agencies enabled faster mobilization of resources and personnel during emergencies at the country and global level throughout the period of implementation, with COVID-19 as the most significant example through, for example, the Access to COVID-19 Tools (ACT) Accelerator and the COVID-19 Basket fund.

Catalytic funding for GAP activities was supported by NORAD and the BMG. Since 2018, total expenditure on the GAP has been US$ 11.9 million. Of this expenditure, US$ 4.8 million was on headquarters (mainly staff costs at US$ 3.1 million, with activity costs at 1.7 million). Progress reports indicate that the catalytic funding provided, in general, has been successful in helping to catalyse collaboration at the country level through removing blockages, strengthening WHO leadership capacity on SDG3 related work and contributing to a more level playing field between both WHO and other signatory agencies, with evidence from the country studies validating this. It is noteworthy that countries receiving catalytic funding to cover the upfront costs of closer collaboration have been able to leverage and realize gains through increased synergies and efficiencies, and stronger partner networks. The high flexibility of the funding was assessed as being a core strength while the relatively low amounts per country office and the short period of implementation were seen as weaknesses.

128. The evaluation notes varying levels of effectiveness in signatory agency collaboration helping to deliver results in an economic and timely manner across countries. There are positive examples of how joint efforts involving GAP agencies have led to improved resource optimization, faster response times and innovative financing solutions. However, once again these are not necessarily plausibly linked to the GAP.

129. A key advantage of the GAP mechanism, and signatory agency collaboration, was intended to be the pooling of resources, with the GAP noting that using joint funding mechanisms could provide additional funds for SDG3: ”agencies will collaborate to identify appropriate opportunities to extend joint grant and loan financing, hybrid funding instruments such as loan buy-downs and parallel and pooled funding mechanisms to substantially increase external funds for health” (p. 59). It was envisaged that agencies could thus leverage greater financial and technical support for health initiatives, reducing overall costs: for example, the joint procurement of vaccines and medications can lower prices due to bulk purchasing. The 2023 *Progress report* suggests that providing pooled funds where possible would help improve coordination and alignment or alternatively that funds are at least provided on budget and are predictable, long-term and unconditional to ensure the delivery of timely and economic results. However, the evaluation identified very few examples of this occurring in practice plausibly linked to the GAP.

130. Regarding timeliness of results, the GAP intends to facilitate quicker response times through pre-existing frameworks for collaboration, especially in emergency and humanitarian situations, in line with the innovative programming in fragile and vulnerable settings and programming in the context of disease outbreaks accelerator. During emergencies, KIIs across the country studies suggested that coordinated

efforts among agencies generally enabled faster mobilization of resources and personnel. One notable example is in relation to the COVID-19 response. During the pandemic, GAP agencies such as WHO, Gavi, GF, WB and Unitadi, collaborated on the Access to COVID-19 Tools (ACT) Accelerator[16] to expedite the development, production and equitable distribution of COVID-19 commodities *(26)*. This collaboration helped streamline resources and efforts, making the response timelier and more cost-effective.

131. Other notable examples during the pandemic include the COVID-19 Basket fund in Nigeria, launched under the Delivering as One framework, and the collaboration of signatory agencies with the government of Kyrgyzstan for the COVID-19 response. However, the evaluation team notes that these examples demonstrate collaboration driven by necessity given the pandemic context and often involving other, non-GAP agency actors.

132. Furthermore, there are also examples of where coordination has not led to the timely and economic achievement of results. In Nigeria, one example provided by a signatory agency was around the recent (February 2024) destruction of two million polio vaccine doses and medical equipment during a fire at the State Central Medical Store in Gombe. Key informants expressed frustration that, upon receiving notification of the incidence and the call for donor and development partner assistance, there was a lack of means to effectively coordinate and respond, with key staff 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 was frequently cited as a challenge in KIIs which hinders the timeliness of response and most economically effective use of resources.

133. Collaborative efforts of signatory agencies WHO and UNICEF (alongside non-GAP agencies such as Rotary International and CDC) through the Global Polio Eradication Initiative have been identified as significantly accelerating the timeline for polio eradication through synchronized vaccination campaigns and sharing resources. The Africa region was certified as wild polio free in 2020, and in 2021 four GAP countries – Liberia, Nigeria, Sierra Leone and Tajikistan (as well as Benin) were verified as being ready to use the new novel oral polio vaccine *(27)*. Again, this is not directly linked to the GAP but has involved GAP agencies within GAP countries. In Nigeria, WHO has indicated that GAP partners are leveraging such previous investments in polio eradication (and COVID-19 response) to now reach "zero dose" children with essential vaccinations as part of the Big Catch-Up Initiative *(28)*, which the evaluation notes as a positive example of timely and effective collaboration.

WHO catalytic funding (EQ 2.5.4)

134. Funding for GAP activities from 2019 to 2021 was supported mainly through agreements between WHO and NORAD and BMG, which included earmarked funding for components for the GAP. From 2022, the BMG funding has been earmarked at a higher level for WHO's enabling functions, including GAP activities and secretariat support.

135. The latest figures provided by the Secretariat, as of June 2024, show that since 2018, total expenditure on the GAP is US$ 11.9 million. Of this expenditure, USD 4.8 million was on headquarters (mainly staff costs at US$ 3.1 million, with activity costs at 1.7 million). Table 3[17] shows a summary breakdown of expenditure each year on headquarters and the different regions, broken down by staff and activity budget lines. The

[16] These should not be confused with the seven SDG3 GAP accelerators.
[17] Tables 2, 3 and 4 have been devised using the latest figures provided to the evaluation team in early June 2024 in the 'SDG Summary Expenditure by year final' excel sheet.

WHO African Region received by far the largest amount of funding across the period 2020–2024 at US$ 3.3 million; the WHO Western Pacific Region was the lowest at US$ 179 000.

Table 3. Yearly breakdown of expenditure for activity and staffing costs by headquarters and region

Year	Breakdown	Headquarters	WHO AFRO Region	WHO AMRO Region	WHO EMRO Region	WHO EURO Region	WHO SEARO Region	WHO WPRO Region
2018	Activity	5 848	-	-	-	-	-	-
	Staff	60 404	-	-	-	-	-	-
	Total	*66 262*	-	-	-	-	-	-
2019	Activity	426 600	-	-	-	-	-	-
	Staff	305 100	-	-	-	-	-	-
	Total	*731 700*	-	-	-	-	-	-
2020	Activity	191 580	*315 946*	89 299	*166 612*	65 181	152 551	11 250
	Staff	440 023	-	-	-	1 642	57 992	-
	Total	*631 602*	*315 946*	89 299	*166 612*	*66 823*	*210 543*	11 250
2021	Activity	368 400	860 632	349 777	461 632	332 569	77 539	118 750
	Staff	727 422	*84 272*	-	-	312	42 008	-
	Total	*1 095 822*	*944 904*	*349 777*	*461 632*	*332 882*	*119 547*	*118 750*
2022	Activity	367 923	584 734	165 263	134 248	80 082	30 520	-
	Staff	700 523	470 115	35 435	29 917	27 917	81 440	-
	Total	*1 068 447*		*200 699*	*164 164*	107 999	111 960	-
2023	Activity	293 288	758 509	390 631	291 388	213 012	57 990	49 952
	Staff	656 987	144 998	-	24 999	45 599	30 000	-
	Total	*950 275*	*903 507*	*390 631*	*316 387*	258 612	87 990	49 952
2024	Activity	114 326	95 680	28 951	15 402	55 497	5 436	-
	Staff	229 214	12 000	-	5 217	20 120	-	-
	Total	*343 540*	107 680	*28 951*	20 619	75 616	5 436	-
Totals	Activity	1 767 975	70 500	875 794	199 997	98 357	-	70 000
	Staff	3 119 673	109 500	35 435	-	1 642	100 000	-
	Grand Total	**4 887 647**	**3 326 886**	**1 059 356**	**1 129 415**	**841 932**	**535,475**	**179 952**
		4 887 647	***7 073 015***					
		11 960 662						

136. GAP documentation recognizes that "Stronger collaboration among multilateral agencies requires dedicated funding to support upfront transaction costs such as staff time, travel and other joint activities, especially at the country level" (2023 *Progress report*, 23).The evaluation notes that catalytic funding for the GAP has been provided by WHO in varying amounts to a range of GAP countries on an annual basis throughout the period of implementation to help the signatory agencies in their collaboration and to accelerate progress towards SDG3.

137. There are case examples showing that when catalytic funding has been provided and used strategically, it has been very beneficial for recipient countries. The high flexibility of the funding was assessed as being a core strength while the relatively low amounts per country office and the short period of implementation were seen as weaknesses.

138. A clear process for allocation of funds was in place and involved a selection committee to review proposals received and decide at global level on the allocation across country offices, based on a set of pre-established criteria.:

- WHO leadership at country level is enhanced (e.g. the role of the country office in supporting the government, convening partners, leveraging partner funds in support of country priorities in line with the SDG3 GAP).
- Stronger collaboration among multilateral agencies is achieved at the country level.
- The proposal builds and expands on ongoing successful SDG3 GAP implementation.
- Complementary internal and external funding are leveraged and increasingly aligned with country priorities and plans.
- A path to increasing equity and how this will be measured is described.
- A clear PHC-led recovery path towards the health-related SDGs is described.

139. Progress reports indicate that the catalytic funding provided has in general been successful in helping to catalyse collaboration at the country level through removing blockages, strengthening WHO leadership capacity on SDG3 related work and contributing "to a more level playing field" between WHO and other signatory agencies. Evidence from the country studies validates this: countries receiving catalytic funding to cover the upfront costs of closer collaboration have been able to leverage and realize gains through increased synergies and efficiencies and stronger partner networks. Examples are as follows:

- **Tajikistan:** The most visible mechanism to translate the GAP in Tajikistan has been the catalytic funding of US$ 50 000 – 100 000 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 mobilize GAP agencies around key priorities on health financing, human resources for health and digitalization, including through the convening of the DCC working group on Health. There is evidence that the GAP has enabled better alignment among agencies in Tajikistan through supporting the role of WHO as a convenor of the health sector partners' coordination. The catalytic funding provided to WHO has allowed it to dedicate staff time to effectively mobilize the partner-led coordination platform called DCC Health. A retreat for DCC Health was organized in 2023 using GAP catalytic funding, which provided a platform for key actors in the health sector to discuss joint priorities. The GAP also provided flexible funding for facilitating government coordination meetings and awareness-raising activities on the GAP. High-level policy dialogues were organized, for example in February 2024, on affordable health care and medicines and on access to medicines. These efforts are perceived to have contributed to fostering alignment and coordination among key health partners beyond bilateral discussions around specific programmes.

- **Pakistan:** Since 2020, the Pakistan WHO Country Office has received US$ 330 000 of GAP catalytic funding,[18] which has been used to fund the activities of the SDG3 GAP Coordination Committee; this is considered pivotal by WHO staff in supporting GAP initiatives. The funds were used for advocacy and consultations for developing the health financing framework, amongst other activities.

- **Somalia:** Somalia received catalytic funding of US$ 100 000 in 2022 to support its convening and coordination role in the health sector. WHO country informants confirmed that this was used to convene meetings with GAP partners, although partners did not reference this initiative explicitly when interviewed.

- **Colombia:** Catalytic funding provided by PAHO from 2021 contributed to scaling up an existing PAHO programme called Maternal Health for All: Indigenous Communities in Colombia, implemented at territorial level in collaboration with PAHO, UNFPA, WFP and UNICEF. The four agencies designed an

[18] 2020: US$ 150 000; 2021: US$ 100 000; 2022: US$ 30 000; 2023: US$ 50 000 (figures provided the GAP secretariat).

interagency programme based on each agency's mandate and carried out joint actions, such as mobilization and capacity- building work with the government. GAP catalytic funding allowed the agencies to extend the interagency strategy to SDG 2 on zero hunger, road safety and eliminating gender-based violence (SDG 5). Therefore, the GAP's contribution to engaging with the Government of Colombia to identify joint health priorities, harmonizing interagency operational and financial strategies and improving shared accountability for health has been more limited. Key informants questioned whether there was a need for clearer guidance as to what catalytic funding should be used for and what it is supposed to do.

- **Nigeria:** Nigeria received US$ 40 000 and 60 000 of catalytic funding in 2021 and 2022 respectively. However, only one informant mentioned catalytic funding and was only able to say that it had been "provided in several initiatives", without providing further detail or insight. Remote informants at both regional and global level also revealed limited awareness on the use and purpose of catalytic funding, including the process for determining which COs receive catalytic funding and how much or whether breakdowns of allocation use are reported by country offices.

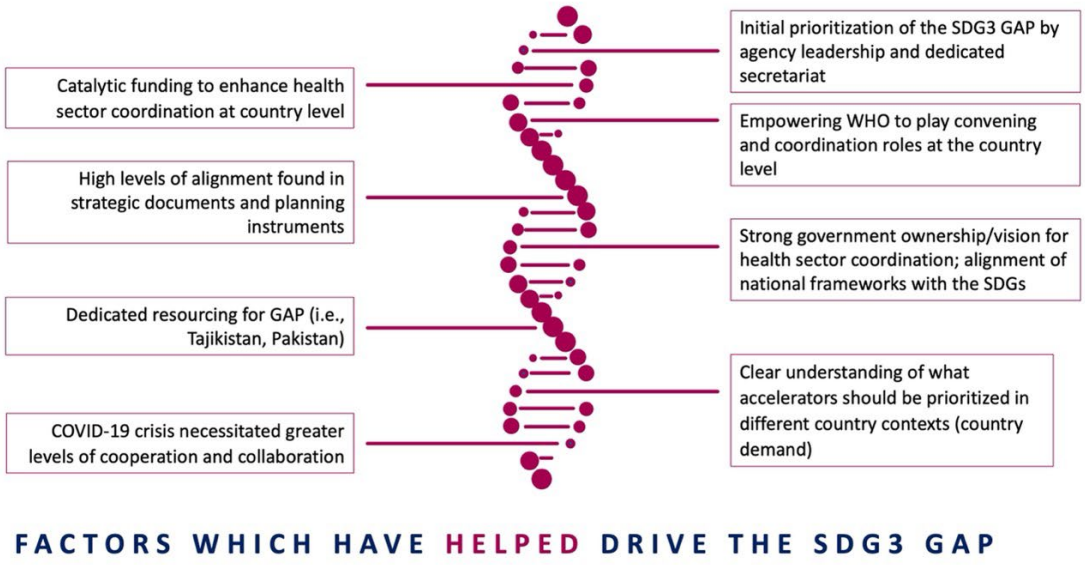
- **Ethiopia:** As part of the country study, no mention of catalytic funding was made, though the allocation figures note that the country office received funding allocations for both activity and staffing costs in the years 2021–2024. It is unclear from available documentation, key informant interviews or other evidence sources how this funding was used.

140. Crucially, key informants noted that the mechanism of catalytic funding itself might also have been more effective if allocating funds to the signatory agencies rather than channelled through WHO only or through external funding (including joint funding opportunities), because this would signal the priority given to increasing synergies by agencies' leadership, boards and funders.

Factors (positive and negative) affecting the achievement of SDG3 GAP results (EQ 2.7)

A number of positive and negative factors have been identified through interviews, country studies and document review which have supported the implementation of the GAP and affected the achievement of results:

Figure 5. Positive factors affecting GAP results

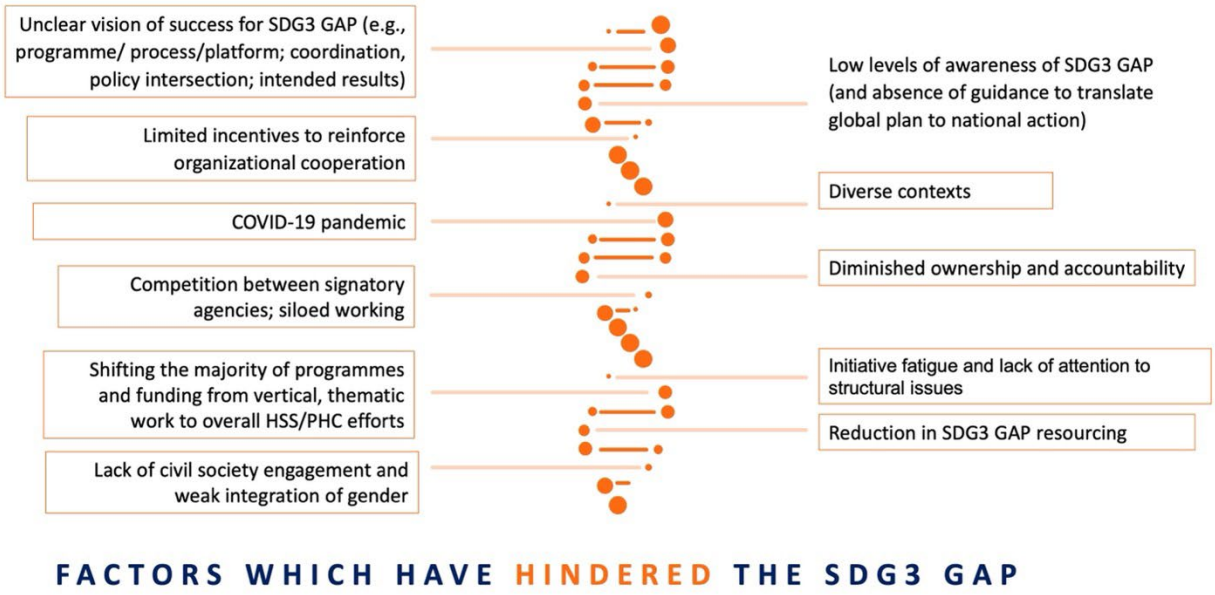


- **Leadership:** One of the key enablers for GAP at the outset was the prioritization and engagement of principals and senior leadership, which helped to drive its initial momentum.
- **Catalytic funding:** The catalytic funding provided by WHO to country offices has helped to enhance health sector coordination at country level and provide designated resources to support collaboration and coordination: for example, human resources in Tajikistan and the set-up of the SDG3 GAP steering committee in Pakistan.
- **Accelerator relevance:** While there has been varied impact and engagement across the accelerators, the PHC, SFH and health data accelerators have all been cited as relevant, and there seems to have been a clear understanding of which accelerator should be prioritized in different contexts.
- **Political leadership:** In contexts where there was a strong government vision, health sector coordination and strong alignment of agencies with national priorities (i.e. in Ethiopia), coordination has been more effective (although not necessarily linked to the GAP).
- **Alignment:** Levels of alignment between GAP partners in strategic documents and planning instruments and with the SDGs more broadly were generally found to be high.

- **WHO's convening role:** WHO has had strong leadership of the GAP, and a number of stakeholders feel it has helped to empower WHO to play its convening and coordination roles at country level with more legitimacy, as the GAP gave it a mandate and other agencies accountability.

- **COVID-19 and emergencies:** The COVID-19 pandemic and other emergencies since 2019 have necessitated greater levels of cooperation and collaboration across the global health landscape and in some contexts the GAP has helped to enhance coordination: for example, during flooding in Pakistan and the COVID-19 Basket Fund in Nigeria.

Figure 6. Negative factors affecting GAP results



Negative factors:

- **Unclear vision for success:** The GAP has, from the outset, lacked a clear vision and ToC regarding what it was trying to achieve and how, and how this could be translated to country level results. Whilst a monitoring framework and ToC have since been developed, there are several ways in which the situation could be improved. There is limited evidence of joint workplans globally or for the specific accelerators and no shared and agreed results are set out for the accelerators which are reported against.

- **Lack of incentives for collaboration and coordination:** The design of the GAP has not sought to address the structural issues affecting coordination or sufficiently considered potential incentives to enhance coordination and collaboration.

- **Low levels of awareness and understanding of the GAP:** As noted throughout the report, low levels of awareness and understanding of the GAP have limited its impact, particularly at country level, where in a number of cases (Colombia, Ethiopia, Nigeria, Somalia) there was very limited awareness of the initiative and no clear mechanism by which the GAP was translated to country level and whereby GAP partners' country teams were held to account for its results.

- **Weak ownership and accountability for the GAP:** At a global level, diminished leadership, lack of accountability, lack of shared vision and shared resourcing and the fact that it was increasingly seen as a "WHO owned" initiative also impeded its implementation and impact.

- **Context:** The context in which the GAP has been applied has had a key impact on the extent to which it has contributed to results. In Somalia, for example, where there is ongoing political instability and where there have been numerous shocks and emergencies over the last few years, the GAP has had limited traction. Stakeholders from all respondent types in interviews attributed this to the fact that organizations were often in "response-mode", which limited the time and space available to do long-term joint planning. The split between development and humanitarian funding streams was also cited as a challenge.

- **COVID-19:** The COVID-19 pandemic has also had a significant impact on the implementation of the GAP. The fact that the pandemic occurred during the GAP's nascency opened two potential pathways: one where the pandemic provided a "proof of concept" for the GAP and the latter became the key "vehicle for coordination" during the pandemic, and another whereby it failed to gather sufficient momentum and to reach its aspirations. As outlined in the report, it was the second pathway that prevailed. The ACT-A accelerator in contrast was perceived as having been more effective.

- **Civil Society Engagement:** One of the factors which has affected the implementation of the GAP has been the lack of civil society engagement from the outset: civil society actors were not included as key stakeholders in the GAP's design or engaged routinely as key stakeholders. Civil society perspectives at a country level were supposed to be gathered as part of the monitoring framework but this has not been undertaken, and it was not possible to include civil society in the respondents for the survey for this evaluation as there was no contact list available. The Civil Society Accelerator working group was described as having never really gathered momentum and being largely defunct. In 2021, it was merged with the gender working group and social determinants of health accelerator, but this has not served to revitalize it.

- **Initiative fatigue:** Signatory agency, government and civil society stakeholders cited initiative fatigue due to the number of global health initiatives that have been launched and implemented and then have gradually declined in effectiveness, without those launching new initiatives seeming to learn the lessons from previous endeavours or to adequately address structural issues affecting global health coordination, such as fragmentation, verticalization and siloed working, competition between agencies and overlapping mandates and the importance of government ownership or donor behaviour.

Monitoring of GAP results (EQs 2.6, 2.6.1, 2.6.2)

Key findings: A number of weaknesses were noted regarding how GAP results are measured, including the fact that workplans for GAP focal points or accelerator working groups have not been systematically developed; meetings and actions not been minuted; efforts to align indicators across agencies not completed; weaknesses in the monitoring framework not removed; and country team and civil society perspectives not routinely gathered. There was also a perceived "overclaiming" of results and the fact that the country questionnaires were assessed subjectively.
Joint accountability for GAP results has been highlighted as a major weakness, notwithstanding the positive action taken to develop an appropriate ToC and efforts to strengthen the existing M&E framework, as recommended by the JEA. WHO is the only signatory agency to have any specific results embedded within its results framework pertaining to the GAP; more generally, six of the thirteen agencies have specific results around coordination and/or partnership in their results frameworks. While many of the agencies have indicators relevant to the GAP accelerators, these are not framed in terms of a collective effort.

141. The GAP sets out a commitment to "review progress and learn together to enhance shared accountability" with Account as one of the four key commitments of the GAP. The survey shows mixed perceptions with regards to the adequacy of GAP results monitoring and accounting. Views from signatory agency stakeholder interviews were generally less positive and noted several challenges in how GAP results have been monitored and accounted for.

142. The GAP sets out that accountability would be provided through quarterly meetings of focal points; signatory agencies reporting to their governing bodies and leadership through annual joint progress reports; the inclusion of country perspectives through case studies and an annual survey; this independent evaluation; and alignment with existing monitoring and evaluation frameworks. An intention to develop specific indicators aligned to the accelerators was also articulated. The JEA highlighted in 2020 that the GAP was not yet sufficiently evaluable in a way that would make ongoing monitoring and evaluation efforts meaningful for the partners' learning, continued improvement and mutual accountability and made a number of recommendations to strengthen this, including: ToC, shared monitoring arrangements, indicators and milestones, shared data and information systems, joint programming opportunities, financial and operational strategy and policy alignment and mapping and understanding of steps towards the 2023 evaluation of the GAP. The GAP ToC and Monitoring Framework were subsequently developed, in late 2020 and early 2021 respectively.

143. In terms of adequacy of the monitoring of GAP results, the evaluation has reviewed and assessed each of these individual aspects of GAP monitoring:

- **Quarterly meetings of the GAP Focal Points:** While there have been regular meetings of the focal points, the exact frequency of these could not been determined as they are not minuted. It is therefore not possible to gauge how well they were attended; what results were reported and how follow-up actions from these meetings were undertaken. There does not seem to be a specific workplan agreed on an annual basis for the GAP against which results could be readily reported.

- **Accelerator working groups:** This was also the case with the working groups for the accelerators, where there also does not appear to have been a consistent development of annual workplans or minutes of meetings which would give an indication of actions and results reported. Moreover, there

has not been a set of outcomes and indicators developed for any of the accelerators that could be reported against to demonstrate GAP results, although several agencies do have relevant outcomes and indicators on themes, albeit not aligned.

- **Alignment of reporting:** Signatory agency informants reported that early on in the GAP life cycle, there was an exercise by signatory agencies to map the contribution of the GAP agencies to SDG3 targets and to then try to increase alignment so that these efforts could be reported collectively, with a common dashboard and diagnostic tool to guide understanding of where countries, the agencies and/or other development partners might have to recalibrate their efforts and where additional focused action might be needed. However, this exercise was never completed, and there was no deliverable or output developed from this process. Several signatory agency informants felt that some agencies "overclaimed" results and took credit for things to which they had not necessarily contributed.

- **Reporting on the GAP**: The evaluation identified WHO as the only signatory agency to have specific results pertaining to the GAP in its results framework, likely because it was the only agency to receive donor funding for the GAP. There has been limited engagement of the signatory agencies' boards with the GAP. The 2023 *Progress report* outlines that the UNICEF board have had one dedicated discussion on the GAP in 2022 and that the World Health Assembly and WHO Executive Board have made regular references to GAP.

- **ToC:** The inception report for this evaluation provides a full analysis and review of the ToC developed for the GAP in 2021 and the extent to which it was adequate to support the monitoring and evaluation of the GAP.[19] Key gaps were identified in the assumptions and external shocks and factors presented, the articulation of inputs and the fact that activities and intermediate outcomes are missing, as are links to other SDGs, and the ToC is presented linearly with unclear feedback loops.

- **GAP Monitoring Framework:** The GAP Monitoring Framework sets out its aims to identify and present credible results of the GAP, but it acknowledges the definitional issues surrounding the GAP (as outlined in the Coherence section, above), given that the GAP describes a way of working, rather than a traditional development programme. The main components of the monitoring framework have been in-depth, qualitative, evaluative case studies; country perceptions captured through annual questionnaires completed by national governments and civil society; and a short global-level questionnaire completed by each agency; and very brief country-level questionnaire completed by the agencies together. This evaluation assesses each of these three components as follows:

    - **Case studies** have been completed for 26 countries *(29)*.[20] While they provide some useful illustrations of activities undertaken under the GAP, these are largely descriptive rather than analytical and evaluative and often lack an inclusion of how results have been achieved and the specific contribution of the GAP and how it has added value. Informants from signatory agencies questioned the utility of the case studies, highlighting that at times they reported on results which were not connected to the GAP. For example, the Somalia case study described solar powered oxygen systems and attributed this to the GAP but informants for the Somalia case study of this evaluation stated that this had not been a direct GAP initiative. In Pakistan, the GAP has clearly provided some momentum to the work reported regarding the PHC and SFH accelerators, but efforts on both themes were already underway before the

[19] See page 13 of the SDG3 GAP Inception Report
[20] Azerbaijan, Brazil, Colombia, Congo, Costa Rica, Côte d'Ivoire, Democratic Republic of the Congo, Ghana, Kenya, Kyrgyzstan, Lao People's Democratic Republic, Nepal, Niger, Nigeria, Madagascar, Malawi, Mali, Mongolia, Mozambique, Pakistan, Rwanda, Somalia, South Sudan, Sri Lanka, Tajikistan, Zimbabwe.

GAP was initiated. There were some tensions described by informants regarding the content of case studies and the fact that, in some cases, agencies felt results were "co-opted" where the GAP had not contributed to the achievement. In some KIIs, case studies were described as a form of "propaganda" to support a justification of the GAP. Some of the examples published as GAP's achievements were described as "hyperbolic" by signatory agency stakeholders: for instance, 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". This view, however, was not substantiated through interviews with government or signatory agency stakeholders and does not seem aligned to the heat results or progress on the SDG3 indicators. This is considered symptomatic of the challenges noted more broadly in how results under the GAP have been reported, particularly early in its life cycle.

- Several challenges have been observed with regards to the annual questionnaires completed by national governments and civil society, which form the basis of the heat maps presented in the GAP *Progress reports* in 2022, 2023 and 2024. Firstly, the questions posed in the questionnaire refer to statements on the health coordination environment more broadly and do not make explicit reference to the GAP. As such, it is challenging to isolate and determine the extent to which the GAP has contributed to the perceptions reported, if at all. For example, in the case of Ethiopia (for 2022 and 2023), each of the criteria are green (agree) or dark green (strongly agree) regarding the health coordination, yet the case study found that there was very little awareness or understanding of the GAP in-country amongst both signatory agencies and government. By contrast, in Pakistan, where there is clearer evidence of greater awareness of the GAP and more activities identified related directly to the GAP, and where more positive perceptions might thus be expected, the results reported in the heat map are less positive *(7, 16)*. Secondly, whilst the perspectives of civil society were intended to be included in this data gathering, in reality this has not occurred, and the questionnaires were only sent to government. Thirdly, the GAP secretariat has been reliant on WHO country teams to identify a focal point for completion of the questionnaire and is thus not able to identify whether the most relevant person with sufficient familiarity of the GAP is completing the questionnaire. The respondent may also change year on year and, as the assessment is subjective, any improvements or worsening of scores may be due to a difference in the perspectives of the individual respondents rather than actual improvements, etc. A further challenge is that different countries have responded to the questionnaire in different years, meaning that progress over time cannot be accurately tracked. Additionally, there are countries included in the heat map who were not included in the list of 67 GAP countries provided by the secretariat such as Namibia *(30)*.

- The short global-level questionnaire to be completed by each agency was not sent out or reported on in the 2022 and 2023 *Progress reports* alongside the country one, despite being an element of the monitoring framework. This has only been undertaken in 2024, with results as yet unavailable.

144. It must be noted that, overall, informants from most signatory agencies felt that the GAP *Progress reports* added little value and were perceived primarily as PR exercises. They were not well disseminated within signatory agencies, and they were perceived by most signatory agency informants as "WHO-owned". The evaluation found examples within the progress reports where similar results had been reported in multiple years. For example, work on the *Guidance note and checklist for tackling gender-related barriers to equitable COVID-19 vaccine deployment* is reported in the 2021, 2022 and 2023 *Progress reports*. There are also examples in the *Progress reports* of results related to initiatives which predate the GAP, as well as initiatives which informants stated were not related to the GAP and were underway already.

145. In terms of the GAP's strategic approach, the evaluation finds that some of the strategic decisions regarding the GAP's implementation are not well documented and that it is challenging to understand the evolution of the GAP through the annual progress reports. For example, the 2020 *Progress report* mentions five countries where the GAP approach had been applied whereas the 2021 *Progress report* seems to have applied a new metric of accelerator "focus countries" and lists a total of 37 (which includes the five documented the previous year through case studies). In the *Progress reports* for the years 2021 to 2024, the definition seems to have evolved further, using broader metrics such as countries where case studies have been documented, countries which have responded to the government questionnaire and countries which has participated in or engaged with accelerator working groups. However, the reports (or any other documentation reviewed) neither set out this evolution clearly nor give a rationale for either the increase or the selection of countries engaged.

Leadership and accountability for the GAP (EQ 2.6.1)

146. Leadership has been insufficiently maintained throughout the GAP life cycle by signatory agencies. From the outset of the GAP, the importance of leadership from the signatory agencies was highlighted as a key condition for the GAP's success, it was also a risk highlighted in the ToC *(2)*. However, the JEA noted that relatively early on in the GAP there were large differences in the leadership drive between the different agencies, with some having relatively strong principal engagement (e.g. GAVI, Global Fund, WFP, UNICEF, GFF, parts of WHO and middle levels of WB) but quite mixed levels of engagement in others (e.g. UNAIDS, UN Women, UNDP, WHO more widely, top levels of WB) *(5)*.

147. Interviews with signatory agency informants indicate that engagement of signatory agencies across the GAP has remained inconsistent and has diminished over time. This is perhaps reinforced by the engagement of signatory agency leadership with this evaluation; as principals from only five agencies took part in interviews, alongside Senior Leadership representatives from a further four agencies[21]. No board members were available for interview from any of the 13 agencies. Since 2020, the signatory agencies' principals' group has met four times: in July, September and November 2020 and in February 2021. The GAP secretariat and agency focal points have not been able to systematically identify an agenda for these meetings that fully capitalizes on principals' contributions *(7)*. Simultaneously, KIIs indicated that the seniority of the signatory agency focal points has also decreased overtime, with a number of those engaging as focal points or in the accelerators being technically focused, rather than having decision-making power to take forward particular initiatives in their agencies.

148. Several potential explanations were put forward by interview respondents and identified through the document review as to why signatory agency leadership for the GAP has diminished:

- The fact that the initiative was set up at the bequest of donors meant that it was perceived by some signatory agencies as "donor-led" and "donor-imposed" and that there was insufficient ownership by some of the signatory agencies from the outset. A contrasting example was provided in terms of the ACT Accelerator – launched in April 2020 to accelerate development, production and equitable access to COVID-19 tests, treatments and vaccines – which was felt to have a more collaborative leadership model, with the principals of agencies engaging regularly and routinely and meeting on a weekly basis.

[21] Global Fund, Unitaid principals and senior leadership from WHO, WB, ILO, UNFPA

- Donor leadership, engagement and investment (both financial and political) has also waned since the GAP's inception with the funding allocated for the GAP reduced significantly and with donors reorientating their focus on the Lusaka agenda; thus, reducing some of the impetus for signatory agencies to coalesce behind the GAP.
- As highlighted earlier in this report, there is limited evidence of tangible outcomes to which the GAP contributed. A number of signatory agency, donor and government interviewees felt that the fact that the GAP had, in their view, failed to deliver results led to several signatory agencies deprioritizing their engagement.
- The 2023 *Progress report* highlighted that "agency culture and leadership, including from the agencies' boards, has not sustainably changed" and that there was an absence of external incentives to support greater collaboration and the prioritization of the GAP by principals, with incentives needing to be strengthened in three key areas: political leadership, governance direction and funding for collaboration.
- While consistent with WHO's convening role, the fact that the GAP secretariat was housed solely within WHO and the fact that donor resources for the GAP were awarded directly to WHO was also perceived by interviewees from some signatory agencies as having had a negative impact on the level of engagement of other signatory agencies' leadership, since the secretariat was not jointly "owned" –other agencies, not having received funding, were not held as accountable for the GAP's success as WHO.

149. Accountability has been similarly insufficient. The GAP sets out that its success would depend on accountability for the commitments made and continuous learning within and across the signatory agencies. It presents "Account" as one of four GAP commitments. It states that signatory agencies and their leadership are formally accountable only to their respective boards or governing bodies and may report informally to their governance bodies on progress under the GAP. In practice, the evaluation has found very little evidence that this reporting is occurring. This aligns with the 2023 *Progress report*, which states that engagement in the work of the GAP and provision of governance direction by the boards of the signatory agencies has been limited and that the GAP *Progress reports* have not been used systematically across the agencies' boards as a tool to strengthen accountability, as originally envisaged. The *Progress reports* were perceived by some signatory agency stakeholders to have weakened accountability as they were thought of as WHO-owned, rather than as a shared endeavour.

150. Whilst the monitoring of the GAP was intended to be light, a number of signatory agency stakeholders highlighted the lack of an accountability framework as a key gap in the GAP's design. There were also no examples provided of GAP focal points being held accountable internally to their own leadership for their work on the GAP.

151. At country level, countries that received GAP catalytic funding were held accountable for this and needed to report on it. However, there has been no structured mechanism for UN country teams or country focused signatory agency staff to account for their work on the GAP.

152. As the table in Annex 8 indicates, WHO is the only one of the signatory agencies to have any specific results within its results framework pertaining to the GAP, and only six of the 13 agencies have specific results for coordination and/or partnership in their results frameworks. While many of the agencies have indicators relevant to the GAP accelerators, these are not framed in terms of a collective effort.

153. A further challenge to ensuring accountability for the GAP's achievements highlighted by signatory agency interviewees was in resourcing: aside from human resources, WHO was the only signatory agency to have

invested financial resources in the GAP, meaning that other agencies had less of a financial stake in its success.

154. The recommendations from the 2023 *Progress report* overlap with those from the JEA, focusing on enhancing collaboration among stakeholders to drive progress on health-related SDG targets. Both sets of recommendations emphasize objectives, continuous review and accountability. The GAP's focus on annual progress reports, maintaining structured coordination among agencies and developing a detailed ToC aligns with JEA's calls for concreteness and effective resource use. However, there is no evidence yet of concrete action on the 2023 *Progress report*'s recommendations.

Implementation of 2023 Progress report recommendations (EQ 2.6.2)

155. One key recommendation is to amplify country voices and shift power dynamics in favour of countries. Biennial country questionnaires and incentives aim to better understand and support country-specific needs, leading to more targeted and effective interventions. Another recommendation emphasizes maintaining the current structure of agency focal points and working groups, promoting stability and coherence and ensuring that stakeholders work towards common goals.

156. The report also advocates for joint missions and communications at the country level to enhance coordination among stakeholders and promote synchronized interventions. Additionally, testing new approaches like the delivery-for-impact approach supports country-led coordination platforms and aligns efforts with national priorities. Engaging civil society and communities through consultations ensures their voices are integrated into health interventions, fostering stronger collaboration and better health outcomes.

157. Despite these recommendations, several challenges have hindered their implementation. Decreased engagement and leadership within the GAP initiative, coupled with a lack of collective accountability, non-presentation of progress reports to governing bodies or leadership within signatory agencies, ongoing resource gaps and staff turnover in the secretariat have collectively hindered progress. Additionally, there is no indication of structured work planning or secured funding to bolster these initiatives, nor have steps been taken to rectify existing disincentives.

158. Steps taken in response to the JEA recommendations include the development and rollout of an M&E framework in 2021 to enhance accountability by tracking progress and documenting improvements. The strategy paper "SDG3 GAP: Supporting an equitable and resilient recovery towards the health-related SDGs," outlines clear objectives and strategies for collaborative efforts. However, full implementation remains incomplete, and several initial concerns persist, such as the absence of effective mechanisms for localizing GAP efforts, insufficient joint accountability measures and difficulties in measuring outcomes. These findings highlight the ongoing need for concerted efforts to address these issues and strengthen the overall impact and effectiveness of GAP.

Sustainability

Sustainability[22]

Given the findings drawn from the examination of coherence and effectiveness, it is unclear whether any momentum from the GAP can be sustained in the medium- to long-term.[23] Recognizing the ongoing need for and relevance of international health partnerships, efforts may need to be targeted towards driving those areas of the GAP which have found traction or pivoted in service of emerging global initiatives (e.g. the Lusaka Agenda, WHO's Global Programme of Work 14, Gavi 6.0).

Sustainability of SDG3 GAP outcomes (EQ 3.1)

Key finding: The context and appetite for globally-led initiatives has changed considerably since the GAP's inception, with locally-led/localization principles seemingly absent from GAP implementation. Given the findings drawn from the examination of coherence and effectiveness, it is unlikely that any momentum from the GAP can be sustained in the medium- to long-term, although the ongoing need for and relevance of international health partnerships is recognized.
The potential for sustainability increases where political ownership, strong national capacity and vision to coordinate agencies through costed operational sectoral plans exist, and agencies can position themselves based on their comparative advantage.

159. It is highly probable that few, if any, of the GAP outcomes will be sustained in either the medium-term or the long-term. As noted previously, the GAP was not well-communicated to participating countries and its envisioned outcomes were neither well-defined nor well-communicated. There was no overall buy-in with the initiative and thus little reference to or incorporation of the GAP into key strategic national documents. For example, in Somalia, which was highlighted in the documentation as having made significant progress around GAP, none of the interviewed key informants had adequate knowledge about the GAP to provide sufficiently informed answers to the questions posed. The evaluation finds that a programme or its outcomes are unlikely to be sustained when there is no understanding as to what is to be sustained. As shown in the previous section on the overall effectiveness of the GAP, few significant outcomes have been achieved that are directly linked to the GAP.

160. It is also important to place the sustainability of the GAP and its outcomes within the broader contexts of both the current landscape for global health and the operating environment for each country. As noted previously, the SDG3 indicators were not on track to be achieved by 2030 even prior to the COVID-19

[22] Figures provided by the GAP secretariat.
23 This is based on the OECD DAC definition of sustainability as "the extent to which the net benefits of the SDG3 GAP continue or are likely to continue".

pandemic, since May 2023, when the pandemic was declared no longer to be a global health emergency, there has been insufficient time for any catch-up to occur. Similarly, the fiscal space for global health funding, depending on the subsector, has either declined or plateaued. It is estimated that, from a peak of US$ 84 billion in 2021, by 2026 development assistance for health will be in the range of US$ 43.7 to 58 billion and may not begin to rise again, albeit slowly, until 2031 (https://vizhub.healthdata.org/fgh/). And there continues to be competition for resources as multiple priorities need to be urgently addressed.

Pakistan Country Study

Given the health financing context in Pakistan, the fact that the GAP partners have collectively supported the development of a health financing framework and strategy is significant; what is needed for it to be sustainable is for 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 role 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.
Government setting a clear agenda at federal and provincial level and holding partners to account to support this and having ownership of coordination mechanisms will be key going forward for sustainability.

161. Where there has been some limited success in establishing conditions which may support the sustainability of the GAP, such as in Tajikistan, there are numerous inherent obstacles to be overcome. The primary limiting factor is the leadership and management capacity of government counterparts. Thus, in Pakistan, where the GAP catalytic funding was able to provide some momentum, including some possible progress toward sustainability, the country's devolved health system has impeded the transfer of the GAP's ideals and skills from the federal level to the lower and very important administrative units, the provinces. Ideally, country-level counterparts would take over and lead the GAP functions to ensure sustainability; however, if they have not been well-prepared to do so, then the likelihood of any continuance of the GAP is near zero.

162. It is also important to note that WHO has received almost US$ 12 million for the GAP since its inception in 2018 from Norway and Germany, with close to US$ 3 million received in 2020, 2021 and 2022 and US$ 1.8 million in 2023. However, this has decreased in 2024 to US$ 200 000. Clearly any continuation of GAP would need to establish an alternative funding source; this significant reduction in funding may mean that countries such as Pakistan are unable to continue GAP activities without the catalytic funding.[24]

163. The evaluation notes the following enablers for sustainability:

- Pre-existing coordination platforms which are government owned and led are critical. For example, in Jordan, the main health sector coordination platforms are only *supported* by external stakeholders while the government counterparts chair these entities. This includes its National SDG3 Team, which logically provides a link to any GAP coordination efforts. While not perfect in execution, it did provide a focal point with which the GAP agencies could interact.

- Communicating the GAP and contextualizing any proposed outcomes and expectations to the specific country operating environment would increase ownership of the initiative. This was a repeated theme amongst all the country case studies. While the accelerators provided an opportunity to customize to a certain extent how the GAP will function in-country, decisions regarding the overall approach needs

[24] Figures provided by the GAP secretariat.

to be bottom-up and country-led and more inclusive than just the few signatory agencies that either have presence or a vested interested in the GAP.

- Refocusing (and possibly increasing) the catalytic funding to ensure that it includes components for leadership and management skills transfer to government counterparts could not only benefit the GAP but other coordination efforts as well. The catalytic funding appears to have had some positive benefits and momentum in the countries in which it was allocated. However, for sustainability purposes, leadership and management skills transfer (and corresponding responsibilities) need to be embedded in the initial programming. For example, in Pakistan, key informants noted the ongoing need for the government to take a leadership (and management) position in terms of both agenda-setting for SDG3 and holding partners accountable for results and coordinating the health sector. It was believed that this fundamental change in behaviour amongst Government of Pakistan counterparts would not only benefit the GAP signatory agencies but both domestic and external health programming as well and have broader benefits to sustainability.

- Ensuring that the GAP evolves with the changing global health landscape remains a priority. Whether the GAP will remain the platform for coordinating SDG3 efforts, at least for the signatory agencies, is unclear. What is readily apparent based on the country case studies and flatlined or reduced global health funding for the near future is that all domestic and external partners will need to ensure that all resources are used as efficiently and effectively as possible. This will, of course, require close coordination to ensure that synergies are achieved, and no duplication occurs. Overlaying this is the recently launched Lusaka Agenda to support the various Global Health Initiatives. It incorporates several of the GAP principles (e.g. coordination, coherence, alignment, etc.) as well as some of the various accelerators (e.g. PHC, SFH and research and development). However, because the Lusaka Agenda is recent, it is still unclear how it will be operationalized and what that means for the GAP. Discussions regarding how Lusaka may (or may not) build upon and possibly link with the GAP should begin as soon as possible as they will provide a signal to how (or if) the GAP will need to evolve. At the very least, there are many lessons learned, including the outcomes of this evaluation, which can feed into that dialogue.

Recovery from the negative impacts of the COVID-19 pandemic (EQ 3.2)

Key finding: The GAP had just begun to function when COVID-19 broke out. While the pandemic represented a unique opportunity to use the GAP as a platform for increased collaboration, this did not fully materialize. There were examples of strong collaboration and coordination in response to the pandemic that were "in the spirit of the GAP" but given the level of awareness and engagement of those with the GAP, it is more plausible that this was driven by necessity and context, rather than the GAP. While there were examples of increased collaboration during the pandemic, this momentum has been lost since in a return to "business as usual" and a lack of lesson learning from the experiences of coordinating and collaborating during the pandemic.

164. The GAP had just begun to function when the COVID-19 pandemic broke out, and as informants from signatory agencies noted, the pandemic represented a unique opportunity to use the GAP as a platform for collaboration. Unfortunately, evidence does not support this. There were examples of strong collaboration and coordination in response to the pandemic that were in "the spirit of the GAP", for instance the COVID-19 Basket Fund in Nigeria as noted above but given the level of awareness and

engagement of the GAP, it is more plausible that this was driven by necessity and context rather than the GAP.

165. Whilst many signatory agency informants discussed increased collaboration during the pandemic, many felt that this momentum was lost after the pandemic in a return to "business as usual". This was the case in Jordan, for example, where interagency cooperation improved during COVID-19 but returned to pre-COVID levels once the intensity of the pandemic subsided, and there was less urgency. Based on this, and other experiences, the evaluation finds that genuine and practical coordination is driven by necessity rather than political motivation or institutional commitment among global health actors. There was general consensus amongst informants that COVID-19 made the PHC, data and SFH accelerator themes increasingly relevant and that this is probably why they have been considered the most effective.

Conclusions

166. Drawing from the evaluative findings above, the following conclusions are drawn aligned to the evaluation criteria, detailing the extent to which signatory agencies have strengthened their collaboration to engage, align, accelerate and account.

Coherence

167. The evaluation team concludes that, at a global level, the GAP demonstrates compatibility and coherence with current and previous international health partnerships and initiatives, providing evidence of alignment, continuity and opportunities to leverage previous efforts and investments.

168. However, despite early buy-in and engagement with the GAP from principals within the signatory agencies it has proven more challenging to secure interagency coherence and country engagement

169. Recognizing that the presence of the signatory agencies varies significantly at country level, with their ability to contribute evenly at this level varying as a result, the evaluation team concludes that efforts to *engage* with countries better to identify priorities and plan and implement together have not been successful. Engagement at a country level to ensure that the GAP considered the country context and existing coordination mechanisms has been undermined by uneven and often low levels of understanding and ownership of the GAP within and amongst the signatory agencies and across the organizational levels, with notably limited awareness and ownership at a country level. This is amplified by weak levels of understanding and ownership in country government counterparts and national partners.

170. The evaluation's conclusion, which is aligned with the GAP's own self-reporting,[25] is that the translation of GAP commitments into country level action has varied considerably, with some countries and agencies championing efforts while others have shown rather limited engagement and action.

171. The evaluation concludes that while there has been a range of activities to improve the level of *alignment* of operational and financial strategies, policies and approaches in support of countries where this increases efficiency and reduces the burden on countries overall, the level of alignment remains

insufficient in incentivizing meaningful institutional change which improves coordination, drives efficiencies and avoids duplication or supports the strengthening of health collaboration mechanisms. Where GAP signatory agencies have pursued better use of existing resources (technical, financial and human), this is not primarily driven by the GAP; other key drivers identified include UN Development System reform and the maturing of UNCTs and UNSDCFs, as well as context. There is a lack of consistent evidence from the evaluation country studies that the GAP has incentivized increases in joint planning and implementation.

Effectiveness

172. The evaluation team concludes that there is insufficient evidence to confidently suggest that the GAP has achieved, or is expected to achieve, its intended objectives and results to ***accelerate*** progress towards the SDG3 targets. However, neither has progress towards these targets been hampered by the GAP.

173. Whilst there is evidence of strengthened engagement with countries to determine priorities, and there are good practices identified within the PHC, SHF and Digital Health Accelerators (which have been the most effective and impactful across the seven themes), there is limited evidence to support the assertion that the GAP has directly accelerated progress and helped agencies to support countries towards achieving the SDG3 targets. Predominantly, countries still face major and significant challenges in achieving these goals. There has been a lack of joint accountability for GAP results and inadequacies in how results have been monitored and reported.

174. The evaluation concludes that, in relation to SDG3 targets, GAP signatory agencies' efforts and resources have been concentrated on maternal health, under-five mortality, risk of dying from the main NCDs, UHC coverage, TB, HIV and vaccine as critical components. While there have been some improvements in these areas between 2015 and 2020, they have generally not been sufficient to meet the set targets. Among the 69 countries noted in the 2024 Progress report where the Plan is being implemented, none have achieved or are on track to achieve SDG3.

175. The evaluation team concludes that weaknesses remain in how GAP ***accounts*** for its results, reviews progress and learns to enhance its shared accountability, including how results are measured. It finds that workplans for GAP focal points or accelerator working groups have not been systematically or consistently developed, that efforts to align indicators across agencies were not completed and that weaknesses in the monitoring framework persist (i.e. the case studies being descriptive rather than analytical, the perceived "overclaiming" of results, the subjective assessment from the country questionnaires and the fact that country team and civil society perspectives were not routinely gathered).

176. The evaluation concludes that joint accountability for GAP results remains a weakness, notwithstanding the positive action taken to develop a ToC and efforts to strengthen the existing M&E framework, as recommended by the JEA. WHO is the only signatory agency to have any specific results embedded within its results framework pertaining to the GAP; more generally, six of the 13 agencies have specific results around coordination and/or partnership in their results frameworks. Whilst many of the agencies have indicators relevant to the GAP accelerators, these are not framed in terms of a collective effort.

Sustainability

177. The evaluation team concludes that any of the observed GAP outcomes are unlikely to be sustained in either the medium- or long-term, given the decline in signatory agency leadership commitment and engagement, competing priorities and the significantly reduced allocation of resources for GAP activities. It is also important to place the sustainability of the GAP and its outcomes within the broader contexts of both the current landscape for global health and the operating environment for each country, where few countries are on track to reach SDG3 targets. While there was increased coordination and collaboration during the COVID-19 pandemic, this was largely driven by necessity and context. Momentum has not been maintained and lesson-learning from the experience has not yet been sufficiently embedded in approaches to coordination and collaboration.

178. Using the reconstructed ToC as the basis for the evaluation, which identifies a series of enabling factors[26] and assumptions necessary for implementation efficacy, the evaluation team concludes that there has been a range of factors affecting implementation efficacy and effectiveness, including diminishing leadership engagement at an organizational and principal level since 2019; and that whilst government ownership of health-related coordination/collaboration was considered essential at the design stage for the GAP to progress and for results to be achieved at a country level, a lack of political-level engagement with the GAP has hindered progress of health collaborations. The objectives of the GAP and inter-agency collaboration mechanisms have not been sufficiently defined, leading to divergence in terms of interpretation and approach from the start.

179. Whilst there has been a degree of alignment of signatory agencies' operational/ financial strategies/policies, the approaches, behaviours and enabling factors have been insufficient to drive efficiencies and avoid duplication in strengthening health collaborations. There has been a lack of external incentives that reinforce organizational cooperation at a country level, which has limited collaboration and hindered progress. Existing country-level incentives have neither sufficiently reinforced collaboration nor strengthened existing country coordination models and supported country-facing teams; nor have new incentives been introduced. There are growing levels of fatigue with global partnerships at a country level. Addressing these challenges will be critically important in any pathway forward.

180. To summarize, the evaluation team concludes that there is compelling evidence of the continued relevance and need for strengthened collaboration, better coordination and mutual accountability amongst multilateral agencies and that the need to strengthen governance, accountability, collaboration and coordination for impact on health has only grown since the creation of the GAP. The evaluation team recognizes that this evaluation comes at a challenging time for health architecture and financing and that reinvigorating multilateralism will be a priority of the Summit of the Future as agencies consider their responses to the fact that SDG3, like Agenda 2030 broadly, is off track.

181. Overall, the evaluation team concludes that there is comprehensive evidence to support the need for a fundamental pivot away from current GAP implementation modality.

182. These conclusions were validated by the ERG and EMG in workshops on 3 July 2024, with participants expressing strong resonance with the evidence, analysis and findings presented by the evaluation team and an appreciation of the considerations and decision points identified in shaping recommendations.

[26] Enablers identified at evaluation inception stage as part of ToC refinements: ownership and engagement; communication and vision; incentives; political ownership; organizational norms and standards; coordination and planning.

Recommendations

183. Based on these conclusions and following discussions with senior leaders from signatory agencies, the evaluation team identified a range of possible scenarios and pathways available.[27]

184. These scenarios and pathways were presented to ERG and EMG members on 3 July, when the full range of options was put forwards for consideration, to allow for reality testing, to ensure relevance and responsiveness to need and evaluative conclusions and to begin to develop some common understanding and joint ownership to take back into agencies' respective constituencies for further examination.

185. Alongside the review of the draft evaluation report, a request to signatory agencies was made to select a preferred pathway forwards.

186. Nine agencies provided a written position by the submission date of this final draft. Five agencies expressed a preference to **sunset/close out** as the pathway forwards (pathway 4), with developing a new framework that retained selected elements of the GAP (pathway 3) as a cautious secondary choice if sunset/close-out was not collectively considered feasible or tolerable. One agency selected pathway 3. One agency selected a combination of pathways 2 (reconceptualization) and 3. Two agencies responded to note that their position would be confirmed in due course; and four agencies did not respond by the time of drafting.

Recommended ways forward

187. Based on the evidence of need and conclusions on implementation efficacy, above, the evaluation team proposes two plausible pathways forwards, both guided by the evidence and both carrying benefits, trade-offs and risks that signatory agencies should consider in developing the management response to this evaluation.

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[27] The following pathway options were put forward for consideration: **Pathway 1: Continuous improvement** – acknowledges that both the need and relevance of the GAP remain significant and continued implementation until 2030 should be enacted within the already established framework, as it has evolved since 2019, and recognizes that adjustments have been carried out in response to previous assessments, and further **minor adjustments and iterations** should continue in response to this evaluation. **Pathway 2: Reconceptualization** – acknowledges that both the need and relevance remain significant, and that implementation should be continued while a **major review of the framework, priorities and its governance** is carried out, based on the findings and conclusions of this evaluation, which could entail radical changes in the number and scopes of accelerators, targeting of countries, reprioritization of catalytic funding and other incentives, redesign of accountability metrics. and recommitment of signatories with potentially fewer agencies. **Pathway 3: New framework** – acknowledges that while the need and relevance remain significant for stronger global health coordination to support countries, the existing GAP framework is not efficacious nor sustainable going forwards and needs to be replaced. This would mean closing the current framework as established in 2019 while continuing to more organically develop agency collaboration towards health-related SDGs in selected areas with viable elements. This option could entail reconceptualizing and repurposing elements such as the PHC and SHF accelerators and the H6 partnership as either stand-alone initiatives or initiatives expanded or developed with other relevant initiatives. Other elements of the SDG3 GAP, i.e. non-functional accelerators and governance structures, would be closed. Existing regional collaboration, that have been inspired by the SDG3 GAP framework, such as the Regional Health Alliance of 17 health, development and humanitarian agencies in the Eastern Mediterranean Region, could also continue to develop, based on regional rather than global engagement. **Pathway 4: Closing or Sunsetting** – acknowledges that while the need and relevance of global health coordination between multilateral agencies is still relevant, implementation in the context of the GAP has not delivered as planned and has lost momentum; also recognizes that there might be a more effective response to need using other existing frameworks or emerging agendas; this would entail closing the GAP within a six- to twelve-month timeframe.

Recommendation A: Sunset/close out (Pathway 4) the current GAP within a six to twelve-month period

Benefits, trade-offs and risks of sunset/close-out

188. Adopting this recommendation signals decisive action based on evidence, reinforcing signatory agencies' ability and willingness to take evidence-based decisions in pursuit of development effectiveness, while extracting meaningful learning for future initiatives. Sunsetting and closing out the current GAP framework allows signatory agencies to pivot effort and resources behind emerging initiatives for greater impact – while recognizing the advent of the Future of Global Health Initiatives, the Lusaka Agenda and principles of *One Plan, One Budget, One M&E framework* and acknowledging that agencies' efforts on alignment is not exclusively attributed to the GAP but includes support to the GAP.

189. Adopting this recommendation minimizes further investment in initiatives with insufficient implementation efficacy and by extension reduces the number of global initiatives, thus recognizing initiative fatigue and country burden, the proliferation of initiatives and country receptivity and absorptive capacity to respond.

190. Adopting this recommendation allows WHO to maintain its global health convening role – aligned to its mandate and leveraging its networks and platforms to convene stakeholders.

191. However, adopting this recommendation may be somewhat challenging politically if not executed with diligence as the evaluation highlights the continued relevance and need for strengthened collaboration, better coordination and mutual accountability amongst multilateral agencies in grappling with obstacles standing in the way of SDG3/Agenda 2030. There are political risks and sensitivities to mitigate as there remains significant political and agency attention to the issues of fragmentation, duplication, effective collaboration and efforts to streamline to better engage with countries in delivering SDG3 and health-related goals and targets. The sunsetting of an initiative to address these issues may be politically unpalatable or difficult to reconcile with obvious need at a time when reinvigorated multilateralism is in the spotlight, and would require coherent, consistent and precise communication. However, the political commitment to the agenda from all agencies remains high and has been demonstrated this past year with political statements and actions under the Lusaka Agenda (health system alignment efforts, increased co-financing opportunities, regional and country dialogues on pathfinder countries). Therefore, the political risk of (perceived) reduced interest in coordination and alignment may be mitigated by engaging under different features in line with the findings of the evaluation.

192. It should also be acknowledged that signatory agencies have made considerable efforts and investments, through the current GAP framework, to strengthen collaboration and drive better coordination in health sector support; a full close-out may make it challenging to allow further benefit/value to be leveraged from these past inputs.

Enacting sunset/close-out

1. GAP signatory agencies – within the next three months, agencies conclude through consultation and state a shared consensus that sunset and close-out of the current GAP framework is in the collective best interest.
2. GAP secretariat – based on the decision point of signatory agencies, secretariat to develop a sunsetting and close-out six- to nine-month action plan detailing key activities, reporting milestones and communications plan to wind down GAP working groups, engagement with country and regional focal points and partners.
3. GAP focal points – coordinate through GAP secretariat and existing GAP focal points in signatory agencies to develop joint communications to inform.

Recommendation B: the development of a new framework that retains selected elements (pathway 3)

Benefits, trade-offs and risks of developing a new framework

193. Adopting this recommendation acknowledges that there is compelling evidence of the continued relevance and need for strengthened collaboration, better coordination and mutual accountability amongst multilateral agencies in progressing SDG3 and health-related goals and targets. It also recognizes that there is evaluation evidence to support the need for a fundamental pivot away from current GAP implementation modality.

194. Adopting this recommendation is more politically palatable and more likely a less challenging pathway to pursue, providing signatory agencies the opportunity to reflect on how they best deliver on the principles and commitments of the GAP whilst seeking to strengthen governance, accountability, collaboration and coordination for impact on health. In radically reshaping the GAP so that a more fit-for-purpose framework can be developed collaboration could be strengthened for impact.

195. Adopting this recommendation acknowledges that there may be reduced transactional costs whilst simultaneously retaining and repurposing elements such as the PHC and SHF accelerators and the H6 partnership as either stand-alone initiatives or initiatives expanded or developed with other relevant initiatives with existing regional collaborations continuing to develop, based on regional rather than global engagement.

Enacting reconfiguration - Development of a new framework that retains selected elements of the GAP

1. GAP signatory agencies – within the next three months, agencies conclude through consultation and state a shared consensus regarding the development of a new framework, whilst retaining selected elements of the current GAP framework is in the collective best interest.

2. GAP signatory agencies – reconfigure the number and composition of signatory agencies, reducing the agencies involved and clearly establishing respective roles and responsibilities in the new framework's development and implementation.

3. GAP signatory agencies – reconceptualize accountability to develop a strengthened accountability and results framework, with clear division of labour and commitment across agencies to measure and report contribution and collaboration jointly through the new framework

4. GAP signatory agencies – reconceptualize and repurpose existing accelerators, focused on the PHC and SHF accelerators and the H6 partnership as stand-alone initiatives

5. GAP signatory agencies – redevelop and replenish collaborative catalytic funding – for example, consider catalytic funding from pooled resources

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