Analyzing data collected from national governments and relevant authorities through the questionnaire of the SDG3 GAP monitoring framework

January 2023

Introduction

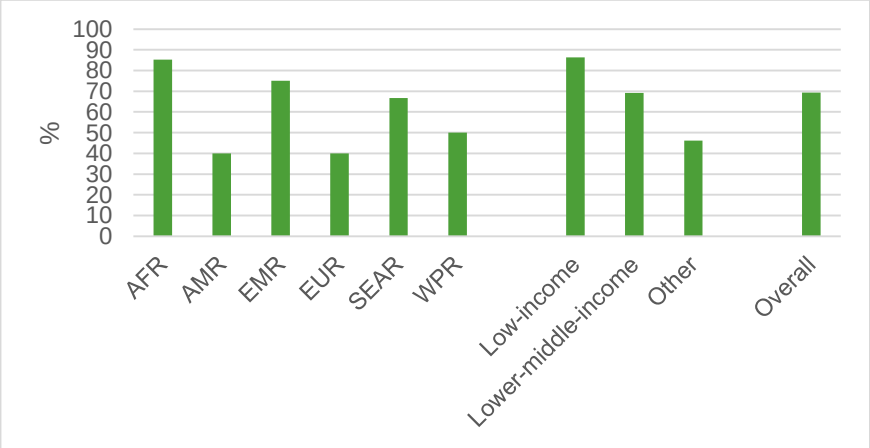
1. In line with the SDG3 GAP monitoring framework, national governments and relevant authorities were asked to provide responses to a short questionnaire on their health coordination environment (see Annex 1).[1] This report presents an analysis of those responses. It starts by describing the responses received and then presents analysis of the quantitative and qualitative data collected. The report also explores how the data collected might be used by agencies for quality improvement purposes, in particular to respond to country suggestions for improvement.

Responses received

2. In October 2021, national governments and relevant authorities were informed about the monitoring framework of the SDG3 GAP. Low- and lower-middle income countries[2] were specifically invited to nominate a focal point to fill out the questionnaire to capture country perceptions of collaboration among development partners. To date, 75 focal points have been nominated and have been invited to respond to the questionnaire through an online platform managed by the WHO-hosted Secretariat of the SDG3 GAP. These include 14 upper-middle- or high-income countries. Among 55 lower-middle-income settings, 39 (71%) nominated a focal point and among 27 low-income countries 22 (82%) nominated a focal point.

3. Of the 75 questionnaires sent out, a total of 52 (69%) have so far been completed. Three quarters of national governments and relevant authorities in low- and lower-middle-income settings that nominated a focal point (46 of 61, 75%) submitted a completed questionnaire. There were high rates of return in AFR (29 of 34, 85%) and EMR (9 of 12, 75%) with modest rates of return in SEAR (4 of 6, 67%) and WPR (2 of 4, 50%) and low response rates in AMR (6 of 15, 40%) and EUR (2 of 5, 40%). Of all the national governments and relevant authorities that nominated a focal point, response rate was highest among low-income countries (19 of 22, 86%), then among lower-middle-income settings (27 of 39, 69%) and then among other countries (6 of 14, 43%) (see Figure 1).

Figure 1: Percentage of national governments and relevant authorities that nominated a focal point who completed a questionnaire: Analysis by WHO region, income group and overall



4. In general, the questions appear to have been well understood with very appropriate responses given.

[1] The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

[2] Throughout this publication, the term "country" should be understood to refer to "countries and territories".

A. Quantitative analysis

5. The questionnaire had six statements to which focal points were asked to respond as to the extent they agreed with each statement. There were two general statements about the health coordination environment followed by four more specific statements. These statements are shown in Box 1.

Box 1: Statements concerning the health coordination environment to which focal points were asked the extent to which they agreed or disagreed

General
The support received from development partners is well-aligned with national plans
Development partners coordinate well with each other over the support they provide

Specific
Development partners provide financial support in line with national budget priorities
Development partners use national monitoring systems and reports
Development partners coordinate their activities, including having a joint technical assistance plan
Development partners make use of national coordination mechanisms and do not seek to establish their own parallel mechanisms

6. The questionnaire and responses to it have some limitations which need to be kept in mind when reviewing the data collected (see Box 2).

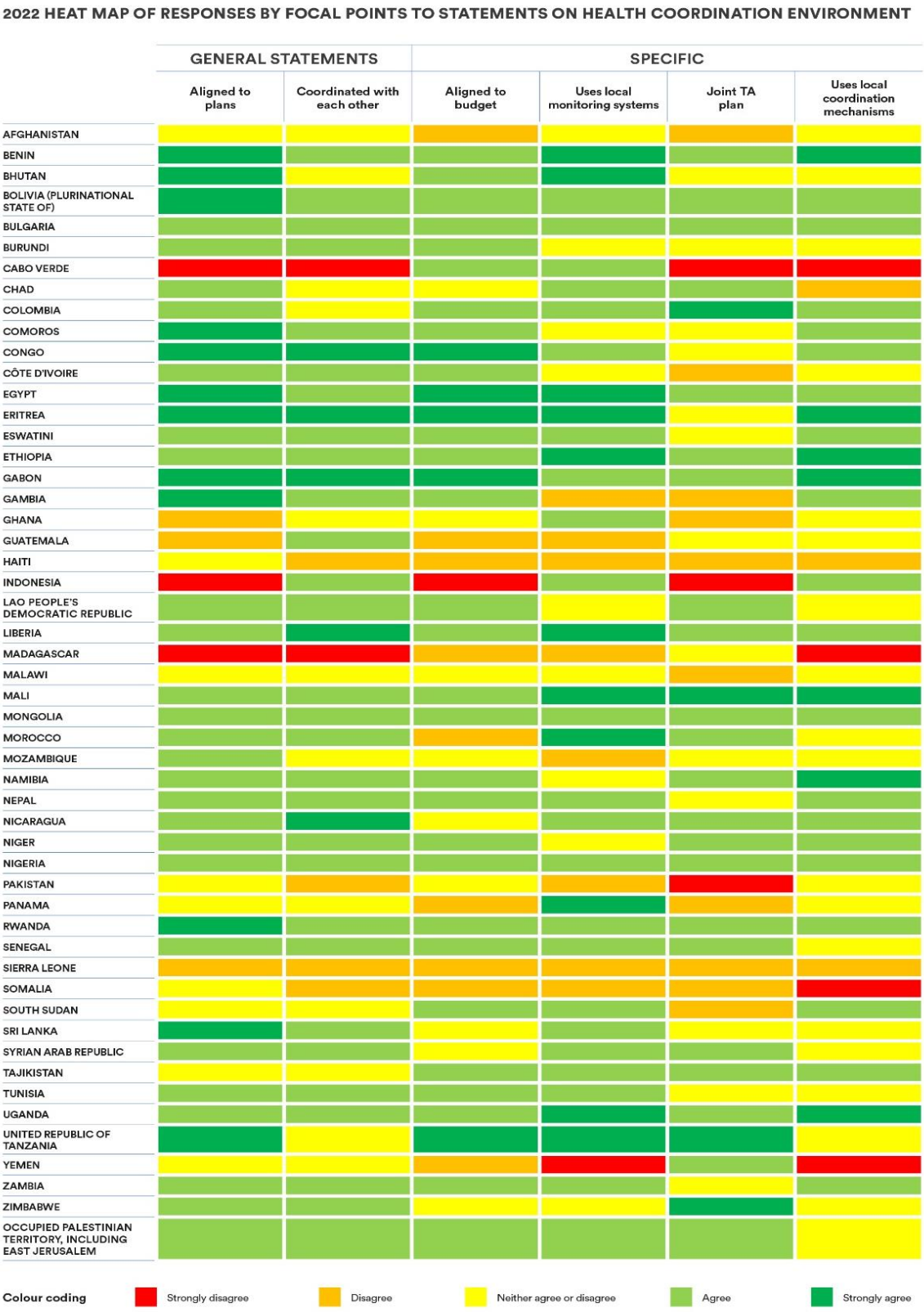
Box 2: Limitations of the questionnaire and responses to it

First, the response rate was less than 100%. In addition, the number of responses is likely to increase with subsequent rounds, especially if responses are seen to lead to improvements. Second, the information is self-reported often by a single, albeit senior, representative nominated by the government. The perceptions reported may not fully reflect the perceptions of other actors or the actual situation. Caution is particularly needed in making inter-country comparisons as different focal points may have answered questions differently. Third, the response may be shaped by social desirability bias, namely a reluctance to express views that might lead to less funding or technical support. The degree to which this may be a factor probably varies from respondent to respondent. In addition, it appears it may apply more to the quantitative (agree/disagree) questions as the qualitative responses provide more frank or critical remarks. It is therefore important to consider the qualitative responses alongside the quantitative ones. Given likely desirability bias, ratings and comments that indicate need for improvement become even more compelling.

7. Table 1 shows the responses received. Colour coding is used as follows – red for strongly disagree, amber for disagree, yellow for neither agree nor disagree, light green for agree and dark green for strongly agree. Focal point assessments will be used to consider trends over time so, in this regard, these responses provide baseline information.

Table 1: Responses by focal points to statements on health coordination environment
(Colour coding – red – strongly disagree, amber – disagree, yellow – neither agree or disagree, light green – agree, dark green – strongly agree)

This table represents responses of a single, albeit senior, respondent from the Ministry of Health (or equivalent), may not represent the perspectives of other stakeholders and may be subject to desirability bias.

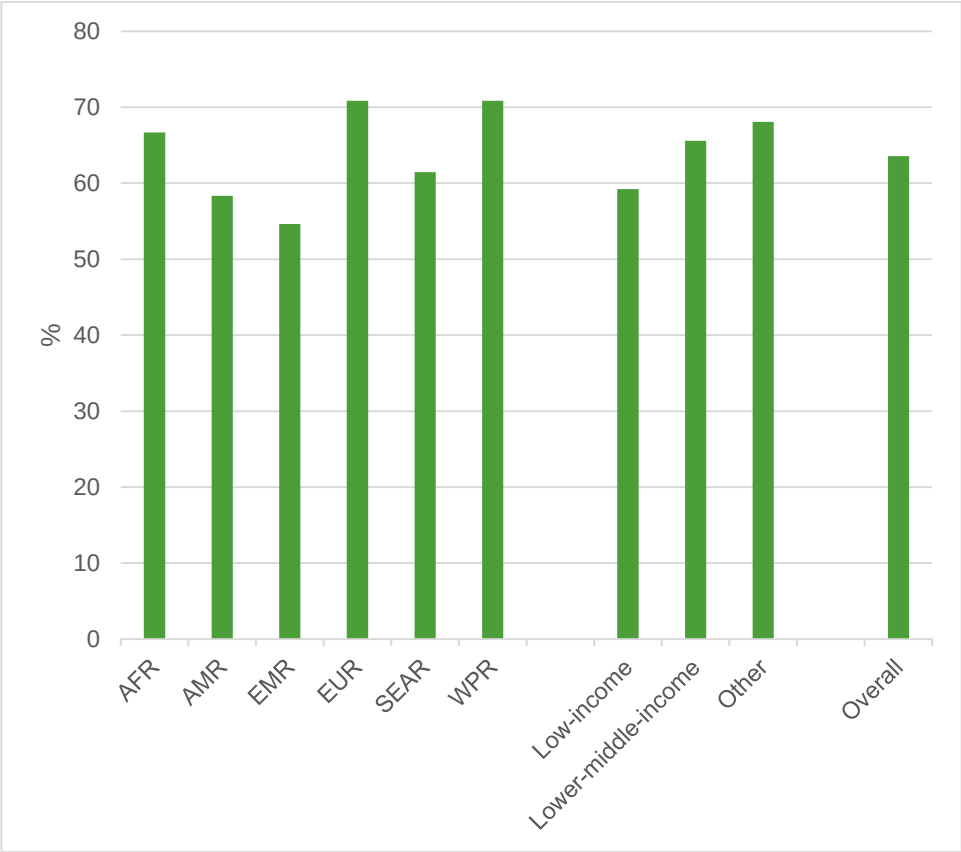


8. Scores have been calculated by converting to numerical values on the basis of strongly disagree being zero, disagree being one, neither agree or disagree being two, agree being three and strongly agree being four. For a national government or relevant authority, across the six statements, this gives a score out of 24 which has then been converted to a percentage. Overall, using this method, scores ranged from 17-92%.

9. It is possible to analyse these scores by WHO region and by income level (see Figure 2). Average scores were 71% for EUR and WPR and 55% for EMR. Some caution is needed in interpreting these figures as numbers of responding focal points, except in WHO's African region (AFR) and Eastern Mediterranean region (EMR), are small (1-6) and, in some regions, including EMR, WHO's Regional Office and Country Offices engaged with MS to explain the nature of the process and the type of responses expected.

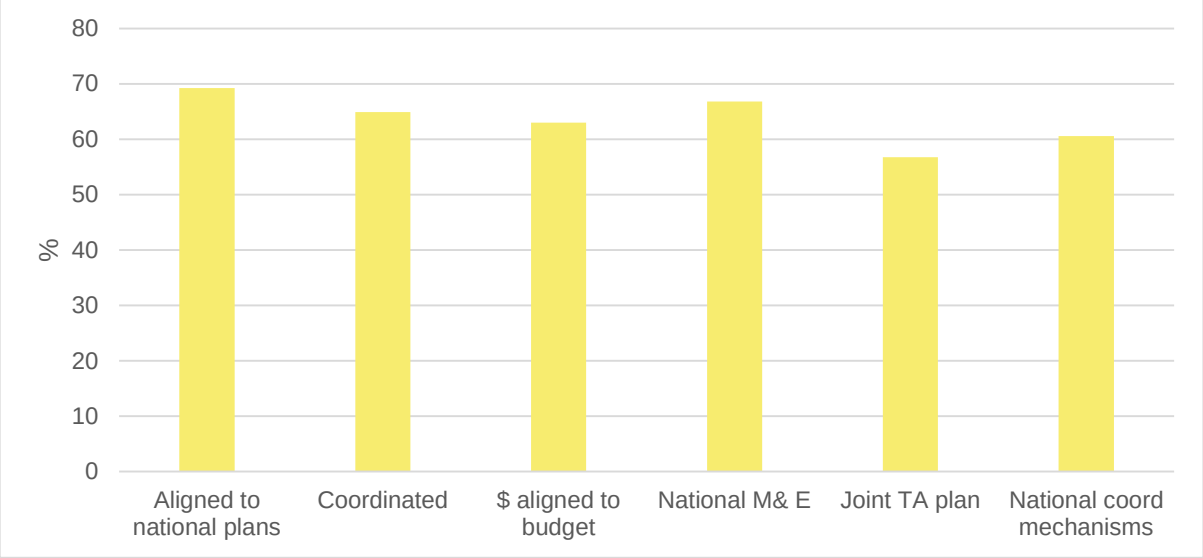
10. In terms of analysis by income group, higher scores were associated with income level. For example, average percentage scores were 59% for low-income countries, 66% for lower-middle-income settings and 68% for upper-middle-income countries.

Figure 2: Percentage score for six questions by WHO region, country income level and overall



11. It is also possible to analyze average scores across all responses by question/statement (see Figure 3). This shows higher scores for the more general questions (67% on average) than the more specific statements (62%) (see Figure 3).

Figure 3: Average scores for each of the six questions/statements across 52 focal points



B. Qualitative analysis

12. In addition, focal points were invited to give free text responses to four questions (Box 3).

Box 3: Questions asked of focal points to which free text responses could be given.

What have been the main successes in terms of development partners aligning their support with national plans and coordinating with each other?

What have been the main challenges in terms of development partners aligning their support with national plans and coordinating with each other?

What corrective measures could be taken to improve alignment by development partners with national plans and coordination with each other?

Is there any information you wish to share with WHO and other multilateral agencies but you do not wish to be made publicly available?

13. These responses have been analyzed as follows:
    - I. Examples of good practice, including anything specific to SDG3 GAP
    - II. Challenges including local factors, agency factors and other factors
    - III. External incentives – focusing on how joint planning, funding, monitoring and evaluation impact alignment and coordination
    - IV. Specific suggestions for corrective measures.

I. Examples of Good Practice

14. A number of examples of good practice were identified (see Box 4).

Box 4: Examples of good practice

- Clear principles on which alignment and cooperation can be based
- A formal agreement between government and development partners for how development assistance will be provided
- An operating framework for how development assistance will be provided
- A document, such as a health sector strategic plan, around which development partners can align their support
- Essential health packages as part of a national health plan
- National coordination mechanisms for the health sector
- Planning matters
- Funding matters
- Joint programming
- Monitoring matters
- Reporting
- Relationships matter
- COVID-19 responses were well-coordinated in some settings
- Evidence of impact
- Specific contributions of the SDG3 GAP

Clear principles on which alignment and cooperation can be based

15. It can be helpful to have clear principles, agreed between national government/relevant authority and development partners which form the basis for development cooperation. These may take different forms in different contexts (see Box 5).

A formal agreement between government and development partners for how development assistance will be provided

16. It can be helpful to have a formal agreement on how development partners and national structures work together to provide development assistance. In Côte d'Ivoire, Niger and Nigeria, such agreements are referred to as a "compact". In Nigeria, the compact includes agreement that development partners align with the implementation of the jointly developed National Strategic Health Development Plan.

Box 5: Guiding principles for development cooperation in different contexts

In Guatemala, signing of the commitments to fulfil the SDGs was seen as promoting positive changes in national and local health policies.

In Ethiopia, development cooperation is based on the principles of "*one plan – one budget – one report*". Specifically:

- *One plan* means that all strategic and annual plans at all levels in the system are consistent with the priorities and targets of the sector plan. Development partners can still have their own internal plans for their own use but this should fit into the *one plan* of the health sector. Annual planning starts with resource mapping, which lists all the planned expenditure in the health sector over the next year, including by government, donors and NGOs, and preparation tool for planning.
- *One budget* means that all funding for health activities is pooled and routed through government channels. The SDG Performance Fund has helped to pool resources from development partners. This has lowered transaction costs for the government. It has also provided flexible resources, consistent with the *one plan and one budget* concept, to provide additional finance to underfunded areas of health sector national strategic plan.
- *One report* focuses on the quality of a number of indicators of data collected regularly at health facility and community level using the routine health management information system (HMIS) and agreed surveys in the Health Sector National Strategic Plan. The health sector HMIS has zero tolerance for any parallel reporting systems in the health system.

In Lao People's Democratic Republic, this is described as shifting from a project-based approach to a programme-based approach. This involves national government and development partners agreeing an overall five-year plan and then developing together specific annual work plans.

In Namibia, development cooperation has always been premised on the Paris Declaration's principles of effective development, namely ownership, alignment; harmonization; managing for Results; and mutual accountability.

In their suggestions for corrective measures, Niger called for compliance with the Paris Declaration.

An operating framework for how development assistance will be provided

17. In addition to a formal agreement or compact, it can be helpful to have a more detailed framework for how development assistance will be provided in a particular context. For some examples, see Box 6.

Box 6: Examples of frameworks for development assistance

In 2007, Ethiopia developed a Health Harmonization Manual (HHM) and updated this in 2020. This outlines a framework for more effective coordination and alignment of programmes within the public sector and with implementing partners and donors in order to help the country make faster progress towards achieving the SDGs and UHC. The intention is that it is to be used by any stakeholder working in the health sector at the woreda, zonal, regional and federal levels. It is particularly relevant for people involved in planning, finance, monitoring and evaluation, health management information systems (HMIS) and technical programmes. In Gabon, strengthening the national consultation framework as part of the response to COVID-19 made it possible to significantly reduce obstacles in terms of aligning the support of development partners with national plans. In Mongolia, the focal point praised the contribution made by the UN Sustainable Development Cooperation Framework for 2023-2027. This was based on the Government's Vision 2050 and the SDG 2030 Agenda for Mongolia and this ensured that support was aligned with the national agenda. In addition, Morocco has a cooperation framework for sustainable development and Senegal has a framework for consultation with all partners which seeks to ensure alignment to country needs. In the Syrian Arab Republic, the focal point identified the UN Strategic Framework as a key tool for coordination between UN partners and government. In Zimbabwe, support was received from WHO, UNICEF, UNFPA, and the Clinton Health Access Initiative (CHAI) in establishing a National Health Sector Coordination Framework.

A document, such as a health sector strategic plan, around which development partners can align their support

18. A central feature of the approach of the SDG3 GAP is that each country should have its own plan as to how it will achieve the health SDGs and it is then expected that GAP agencies and other development partners will then align their support to this plan. Box 7 provides examples of such plans which have a variety of names and take different forms in particular contexts.

Box 7: Examples of national health strategic plans

In the Plurinational State of Bolivia, development partners provided technical assistance to help prepare plans for and the application of the Essential Public Health Functions (FESP) and aligning these with the sectoral plan for 2021-25, Development partners are also providing resources to help implement the plan.

In Comoros, there was alignment and harmonization of priorities and results in the emerging Comoros Plan.

The Republic of the Congo has developed a reference document which sets out all the interventions to be carried out according to the priority needs in the health sector. There are also national strategies for specific health programmes and projects and annual work plans.

In Indonesia, there is considered to be coherence between national plans and strategies and SDG documents including voluntary national reviews, the national action plan (RAN) and metadata. This means there can be integrated monitoring and evaluation.

In Madagascar, development partners give due consideration to relevant sectoral development plans. Technical and financial support is then provided in line with the mandate of each development partner.

In Mali, there was agreement on a single health and social development programme (PRODESS) which was developed and validated under the chairmanship of the government and a coordination meeting between the Department of Health and Public Hygiene and technical and financial partners (PPTF).

In Nicaragua, development is carried out in compliance with guideline number 9 of the National Health Policy.

In Niger, the health development plan (PDS) was aligned with the compact, the common fund framework, the coordination meetings between the Ministry of Public Health (MSP) and technical and financial partners, the annual review of the Ministry for programming and evaluation and the joint MSP/partners mission.

In Sierra Leone, development partners supported the Ministry of Health to have a National Health Summit to develop a workable approach to align the work of development partners with countries priorities.

In South Sudan, development partner work closely with the government in developing project plans for funding. They use the national strategic plan to identify country priorities. A good example was considered to be the Global Fund proposal writing which is considered to be country led.

In Yemen, a key success was considered to be the development of the Humanitarian Response Plan.

In Zambia, some development partners provide support (technical or financial) to develop plans in different sectors.

Essential health packages as part of a national health plan

19. In some countries, as part of the development of a national health plan, particular tools may be developed, such as one or more essential health packages. For example, in Somalia, several development projects supported by development partners are aligned, at least partially, to the essential package of health service (EPHS) delivery.

National coordination mechanisms for the health sector

20. There is a high level of agreement among focal points that effective coordination in the health sector requires a functional coordination mechanism and that this should be led by national government. There is also agreement that this mechanism should be respected and not bypassed or duplicated by development partners. However, such mechanisms may vary widely according to context. In some countries, additional coordination mechanisms between one or more development partners are discouraged as they are seen as duplicative while, in others, such as Burundi, Ethiopia and Malawi, they are actively encouraged provided that they are seen as part of the overall national, government-led coordination mechanism. In some countries, there may be sub-coordination mechanisms on particular diseases or thematic areas, such as sexual and reproductive health. In some countries, there may be a stand-alone health coordination mechanism whereas, in others, it may be part of a broader development mechanism. In some countries, particularly those with federal structures, in addition to national coordination mechanisms, there may be similar mechanisms at sub-national level. Some examples of such mechanisms are given in Box 8.

Box 8: Examples of national health coordination mechanisms

In Burundi, having a coordination mechanism led by the Ministry of Health was seen as being a major success factor as was having mechanisms among certain development partners to coordinate among themselves.

In Colombia, regular meetings are held of the health cluster which includes the national health authority and international development partners present in the country. Their purpose has been to join efforts for the health response for populations affected by emergency situations, including migrants and refugees. The cluster has tried to coordinate resources and has also established sub-clusters focused on sexual and reproductive health, violence against children, and children and adolescents.

In Côte d'Ivoire, there are frameworks between partners and between partners and national actors. This is led by the Ministry of Health and is called the Health Sector Partners Coordination Mechanism.

In Eritrea, there is said to already be a coordination mechanism in place that was established by the Ministry of Finance and National Development who are the lead government agency in this area.

In Ethiopia, there are well-established governance mechanisms for development partners. These include:

- The Development Assistance Group (DAG) consisting of 30 bilateral and multilateral development agencies providing development assistance to Ethiopia. The DAG is described as a supra-sectoral forum for donors to share and exchange information to foster meaningful dialogue with government. The DAG is mostly attended by Heads of Development from various agencies.
- The Health, Population and Nutrition (HPN) donor group unites the donors active in the Ethiopian health sector. The group is co-chaired by representatives from the multilateral and the bilateral donor group.
- SDG Performance Fund (PF) Group is made up of all contributors to the SDG-PF. They have signed the Joint Financing Arrangement (JFA) in combination with their respective bilateral agreements that are compliant with the terms of the JFA. The JFA sets out the jointly agreed terms and procedures for the SDG-PF management.
- The Global Fund business plan is governed by the Country Coordinating Mechanism (CCM). The HPN elects/selects two of its bilateral members to represent bilateral donors in the CCM. The CCM has fixed multilateral representation.
- The Joint Consultative Forum (JCF) is the highest joint governance body to guide, oversee and coordinate the MoH and development partners in implementing the health sector policy and strategies. The general objectives of the forum are to promote dialogue and regular exchange of information; enhance the spirit of partnership between the government, development partners and other stakeholders; and facilitate the implementation, monitoring and evaluation of the health sector transformation plan. The JCF is chaired by the Minister of Health and co-chaired by a HPN co-chair. The Secretariat is operated by the MoH.
- Joint Core Coordinating Committee (JCCC) is the second level of coordination forum that exists between MoH and Donors that meets once a month. The JCCC is chaired by the Director for Policy Planning, Monitoring and Evaluation Directorate (PPMED) and co-chaired by the Partnership and Cooperation Directorate (PCD) Director. The main objective of this forum is to bring high-level technical issues that require discussion and direction by MoH and donors, as well as to provide regular updates to the HPN donors on relevant topics.
- There are a number of Technical Working Groups (TWGs), which also include taskforces, advisory groups, steering committees etc. They may be led by MoH or the agencies. These are forums to discuss technical/operational issues and may be permanent or temporary.

In Gabon, to improve the alignment of development partners with national plans, the Ministry of Health set up a technical and financial partner coordination platform that brings together all stakeholders around national priorities.

21. Once these principles, frameworks, plans and coordination mechanisms are in place, it is essential they are used in the health sector. This may be in a number of key processes, and a few are considered here, namely planning, funding, programming, monitoring and reporting.

Planning matters

22. Joint planning between development partners themselves and particularly between development partners and national government is recognised as an important step in terms of ensuring alignment and coordination. Some examples are given in Box 9.

Box 9: Examples of national governments and development partners planning together.

In Côte d'Ivoire, development partners have participated in and finances the development of national plans. Similarly, national structures are often included when development partners develop their own plans.

In Lao People's Democratic Republic, part of the shift from a project-based approach to a programme-based approach has been the development of a joint annual work plan with development partners according to programmes/sub-programmes of the five-year Health Sector Development Plan which started from WHO's approach.

In Liberia, partners participate in national development planning processes from broader government planning to sector-specific planning in health. UN agencies, for example, aligned their integrated country plan with the National Development Plan.

In Uganda, the joint planning arrangements by government and development partners has been the highlight of success in terms of aligning support with national plans. Partner mapping has also streamlined coordination and harmonized

Funding matters

23. For many low- and middle-income countries, donor financing remains an important source of health funding and this was recognised by some respondents, e.g. from Chad. How this funding is provided is important with focal points expressing preference for a pooled fund, managed by government, which can be used to address national health priorities. While there has been a shift away from such pooled funds in recent years, some countries either still operate such funds, e.g. Nepal and Tanzania or are reinstating them, e.g. Mozambique. Mozambique is taking steps to ensure that the reactivated sector-wide approach has improved coordination and synergies. Nepal has been operating a sector-wide approach, with a pooled fund, for more than 15 years. Multilateral and bilateral organizations are using the pooled fund and the government considers that it produces better delivery of results. In Ethiopia, the SDG performance fund (see Box 5) is an example of a pooled fund. In the United Republic of Tanzania, contributors to the health basket fund plan together with government use common evaluation approaches.

24. Where funding through a pooled fund is not possible, funding provided to support an agreed national budget is appreciated more than funding which is considered "*off budget*". In Mali, the value of regular joint reviews of state-partner budgets was recognised. Clearly, national governments that require donor financing for the health sector need to know which funders can and will provide what funds. In Ghana, the government developed a resource mapping tool with development partners.

Joint programming

25. In many countries, development partners provide financial and technical support to national government and others to implement health programmes. However, in some contexts, some development partners may also implement programmes and, in such cases, there is scope for joint programmes. For example, in Morocco, there are reported to be joint programmes for priority themes. In Tunisia, there was a joint programme in the fight against violence against women.

Monitoring matters

26. Broadly, focal points describe two main types of joint monitoring processes. First, countries may have their own health (management) information systems, e.g. in Chad, Comoros and Haiti, and where such systems exist, development partners are encouraged to use them rather than establishing their own duplicative, parallel systems.

27. In addition, in some countries, e.g. Côte d'Ivoire and Nepal, there is joint monitoring of interventions. For example, in Nepal, the Joint Annual Review has been aligned with the National Annual Review which is considered to help reduce time, cost and other resources as well as to increase ownership. There is also considered to be reduced administrative burden because there is no need for parallel reporting to development partners.

Reporting

28. Clearly, reporting is linked to monitoring and where there are joint monitoring systems, it is easier to produce joint reports, reducing the need for parallel reporting to development partners. For example, in Lao People's Democratic Republic, since 2010, the health sector annual progress report has been approved by the Sector Working Group (Policy Level) for the health sector and it has been sent to the Round Table Meeting led by the Ministry of Planning and Investment and UNDP/UN Resident Coordinator across ten sector working groups.

Relationships matter

29. While documents, structures and processes are important for effective alignment and coordination, there is a need to build effective, mutually-respectful relationships across development partners and between development partners and national government. For example, the focal point for Sri Lanka reported that there is a very cordial relationship between WHO and the Ministry of Health. Most of the technical support needed by the Ministry of Health is provided by WHO.

COVID-19 responses were well-coordinated in some settings

30. While COVID-19 has been extremely challenging, development partners have coordinated well in some contexts. For example, in Benin, the focal point highlighted the leadership role played by WHO in this area including through holding regular coordination meetings. In Gabon, the national response to COVID-19 was considered the main success in terms of aligning the support of development partners with national plans. But other areas where there had been success were also identified and these included tuberculosis, child vaccination and maternal and child health. In Gambia, all development partners came together under the incident management structure to support the government in containing the pandemic. In Namibia, the response to COVID 19 was, and remains, a major success that demonstrates that coordination can yield satisfactory health outcomes. In Somalia, the COVID-19 pandemic response is considered one of the successful areas where the donors have coordinated and aligned their support to the national preparedness and response plan. In Tajikistan, the response to the COVID-19 pandemic was considered an illustrative example of how partners, in concert and coordination with each other and national plans, provided the necessary assistance both to the Ministry of Health and the country as a whole. In the occupied Palestinian territory, including east Jerusalem (hereinafter referred to as the "oPt"), development partners supported the Palestinian Ministry of Health's response to the COVID-19 pandemic both with financial and technical support.

Evidence of impact

31. While the purpose of the questionnaire was not to try to document evidence of impact of better alignment and coordination in the sector, some responses did touch on this topic. For example, in Eswatini, it was considered that alignment had strengthened programming and implementation of primary health care services particularly in the areas of reproductive and child health and that these improvements had been seen at both national and sub-national levels. In Nicaragua, alignment with the national health policy was considered to have improved the quality of health services in an equitable way that guarantees access to

free health services and reduces the gaps in care for vulnerable groups. In Tunisia, the focal point commented that when donors work closely together with their counterparts at the country level, development projects have better outcomes and collaboration is more beneficial to both sides. This success is possible when donors collaborate and align their fiduciary work, disclose any possible conflicts and advise solely in the interest of the beneficiary. In the oPt, the support of development partners to the Palestinian Ministry of Health has been focused on strengthening Primary Health Care programmes towards integrated health service delivery and family health approach.

Specific contributions of the SDG3 GAP

32. Although it was not the purpose of this questionnaire to ask about specific contributions of the SDG3 GAP, the focal point from Colombia referred to this without prompting. In Colombia, several international cooperation organizations that promote the GAP have participated actively and sustainably in the processes of identifying priorities and generating strategies to improve universal access to health and in improving the quality of national and sub-national services, jointly programming the targets and monitoring mechanisms to make progress on SDG 3. Specifically, the recommendations of the accelerators have been taken into account, including approaches focused on human rights, life course and social determinants of health, in defining health priorities and goals towards the fulfillment of the SDGs, seeking to leave no one behind. Recommendations, tools and communication strategies have been designed for the adoption of the GAP and for promoting maternal and perinatal health to move towards fulfilling SDG3 and reducing maternal and child mortality.

33. However, in Madagascar, one of the challenges identified was rigidity of funding in relation to the mandate of some partners meaning that initiatives of the GAP were not financed.

II. Challenges

34. In this section, challenges identified by focal points are considered in three groups, those that relate mainly to local context, those that relate mainly to one or more agencies themselves and finally a group of other factors including those which are external to both the local context and the agencies.

Local factors

Political context

35. Political context may affect the ability to coordinate the health sector. For example, countries affected by instability may find it difficult to provide such coordination. Such instability may be at the macro-political level or may be within key ministries, such as the Ministry of Health. In addition, there may be particular challenges for coordination in federal states where responsibilities for the health sector may not rest with a single national authority but may be a devolved responsibility, e.g. of states or provinces. In such cases, coordination mechanisms are needed not only at the national or federal level but also in states and provinces. Changes in Government, institutional changes in relevant ministries, political climate (including ongoing civil unrest) and other political obstacles were listed as examples which disrupted support and/or made coordination in the health sector more difficult.

Lack of capacity

36. A key challenge, identified by a number of focal points relates to the capacity of government, in general, and the Ministry of Health in particular to coordinate and manage technical and financial support provided to the health sector. Insufficient leadership of sectoral ministries, weak coordination capacities within the Ministry of Health and a general shortage of human resources with the right skill set and skill mix were noted, among others, as examples hampering efficient coordination

37. In addition, in some cases, a general lack of capacity in the health system means that, even if development assistance is better aligned and coordinated, minimal improvements, if any, may be seen in

health care delivery and health outcomes because of weaknesses in the procurement and supply chain process, human resource deployments and data management systems.

Government bureaucracy

38. In some cases, government structures may have high levels of bureaucracy and this may hamper implementation and coordination.

Lack of key elements needed for effective coordination

39. In some cases, countries lack one or more of the key elements identified for effective coordination. For example, one challenge identified was the lack of a comprehensive health plan. Another challenge identified was the lack of a coordination mechanism to periodically review progress on the basis of accepted priorities and agreed indicators.

Failures of coordination

40. Responses documented a number of cases of failure of coordination between or within sectors. Examples provided include challenges, the Ministry of Health faces in coordinating with other agencies in country the Ministry of Health itself. Other examples point to challenges of coordination within the Ministry of Health, such as having multiple entry points for development partners wishing to work with the Ministry of Health, which may lead to challenges in information sharing and coordination within the Ministry. Another example provided highlights challenges in coordinating the actions of individual health units. For example, during the response to COVID-19, there were challenges when heads of medical institutions, particularly from remote, peripheral areas, approached development partners directly to provide the necessary medical devices and personal protective equipment (PPE) bypassing the Ministry of Health. This was considered to have led to duplication of activities and further difficulties.

Agency factors

Application of principles

41. The principles of effective international aid and development requiring alignment with national priorities and coordination with other partners are well-known and not particularly new. One challenge identified relates to partners adhering to these principles, e.g. in Malawi and Zambia. For example, Zambia report that there is limited support towards the principle of One Plan, One Budget and One M&E Framework.

Agency agendas and mandates

42. Several focal points expressed concern that some agencies prioritize their own agendas and mandates even when those things are not considered a priority by the national government or relevant authority. This can lead to perceptions of things having been decided and imposed by development partners rather than being decided by the national government or relevant authority. This is particularly problematic when funds are earmarked for particular purposes resulting in so-called “vertical programmes”. Some examples of such challenges are presented in Box 10.

Box 10: Some agencies pursue their own agendas and mandates even when those issues have not been prioritized by national governments or relevant authority

In Benin, some challenges relate to the fact that some development partners focus on specific issues which may or may not align with national government's priorities.

In Burundi, a challenge was that some development partners want to work on their own priorities without following the National Development Plan.

In Chad, partners sometimes insist on funding particular activities even if not very relevant to the country. This is seen as imposing actions even if they are not in line with the priorities of the country or the government.

In Côte d'Ivoire, concerns were raised about agencies imposing directives from their headquarters.

In Ethiopia, funds are not always provided in a way that is flexible enough to meet government priorities.

In Madagascar, development partners were seen as being too rigid in terms of their mandates.

In Mongolia, individual development partners' mandates were identified as the main challenge and bottleneck. A linked problem was the need for agencies to be able to showcase their success to their own governments.

In Mozambique, sometimes the Ministry of Health feels that some partners have they own agenda, bypassing the established coordination mechanism to implement their plans, making more difficult the coordination among partners and the Ministry of Health. Also, the main bottlenecks in the country are considered to relate to the vertical programme approach, from donors and partners. The high number of partners supporting the health sector, with different goals and approaches, challenges effective coordination among the partners and between them and the Ministry of Health.

In Nigeria, there are new actors or simply actors who have pre-determined mandates by their donors, or interventions that are at variance with the National Plan. This is considered to be mostly due to poor knowledge of the country's health priorities set in the strategic plan.

In Sierra Leone, development partners are reported to have introduced vertical and parallel programmes and structures based on their mandates.

In Uganda, some partners approach government with predetermined interventions and at times advocate that government adopts them yet they are way off the government priorities.

In the oPt, donor support is often fragmented as it is directed to specific programmes according to their agenda.

Coordination between agencies

43. For various reasons, coordination between development partners may not be optimal. For example, in Bhutan, both UNFPA and WHO are supporting cervical cancer elimination efforts. However, the focus of each organization is not clearly delineated leaving room for duplication and misalignment. In Chad, lack of coordination was blamed for duplication of funding to some activities. In Somalia, the fragmentation and poor coordination among the donors and between the donors and the government of Somalia is considered a major bottleneck hampering the alignment of donor support with national priorities.

Geographical distribution of agencies

44. There are challenges related to how agencies, and their work, are distributed in some settings. For example, in Colombia, it has been challenging to ensure that resources are distributed fairly across populations with the greatest needs ensuring that efforts are not duplicated across municipalities and in scattered rural areas. In addition, resources available are not usually sufficient to meet all identified needs. Also, in Nigeria, there have been challenges related to the distribution of partners resulting in patchy distribution of human, material and financial resources to implement the National Plan across the country. Generally development partners are considered to be poorly distributed across the country. As such, while some States have an array or sizable number of partners supporting interventions in their plans, some other States completely lack partner support in the implementation of interventions in their plans.

Work with third parties

45. Focal points report coordination challenges when development partners work through third parties, such as NGOs or other implementing partners, rather than through government. In some cases, these third parties may be another part of national or local government. Some examples of such challenges are shown in Box 11.

Box 11: Some focal points report coordination challenges when development partners work through third parties rather than through national government

In Lao People's Democratic Republic, the government has faced challenges in coordination and control of activities implemented through NGOs, international NGOs and civil society organizations (CSOs). Some development partners provide funding support directly to such organizations and the government has concerns over direct transfer of funds to provinces or other implementers.

In Malawi, most partners channel their support through third party implementation agents leading to a proliferation of partners that are difficult to manage.

In Namibia, sometimes Official Development Assistance, which is provided by development partners, is channeled to government, including NGOs, without being coordinated through the National Planning Commission (NPC). This creates room for non-alignment with national priorities.

In South Sudan, the main coordination challenge is the lack of transparency once the funds have been approved. South Sudan does not manage donor funds and does not have a pooled fund for health. As a result, there is duplication of efforts at times and lack of efficiency on how funds are being managed.

In Tajikistan, during the response to COVID-19, there were challenges when heads of medical institutions, particularly from remote, peripheral areas, approached development partners directly to provide the necessary medical devices and personal protective equipment (PPE) bypassing the Ministry of Health and Social Protection of the Population. This was considered to have led to duplication of activities and further difficulties.

In Zambia, some development partners provide support to sub national level with limited collaboration with the national level which at times results in duplication of efforts.

Parallel coordination mechanisms

46. In some cases, agencies may have their own coordination mechanisms which the national government considers to duplicate or bypass their own mechanisms. For example, in Liberia, international health organizations have their own separate coordination mechanism outside the Ministry of Health framework.

Diverse, difficult and bureaucratic administrative procedures

47. Countries report that even where principles of aid effectiveness are followed and the required elements are in place, there can be challenges in practice because of the varying administrative requirements of different agencies (see Box 12).

Box 12: Agency procedures and administrative requirements can be challenging to comply with

In Comoros, the main problem identified related to heterogeneous procedures and practices among financing and technical partners

In the Republic of the Congo, some partners are considered to have restrictive practices which result in low disbursement rates.

In Côte d'Ivoire, the focal point identified that the administrative, technical and financial procedures of partners are cumbersome and do not favour speed of implementation.

In Ethiopia, the focal point recognized the transaction costs of development funds particularly if there are multiple planning, budgeting and reporting systems.

In Gambia, partners have their own approaches to planning cycles and work plans which may make alignment to government plans difficult.

In Lao Democratic People's Republic, development partners' own cycle and templates for planning, implementation and monitoring and evaluation are needed specifically for bureaucratic approval.

In Morocco, development partners have different implementation procedures which affect the pace of implementation of their work plans.

Namibia noted challenges caused by development partners having different financial years from government.

Niger noted that some partners have their own procedures.

Tunisia noted that some partners' procedures are complex and ambiguous. Administrative burdens can be heavy.

In Uganda, partners have different reporting timelines and implementation periods that are not aligned to the government implementation periods.

Some forms of technical assistance may be inappropriate

48. Some forms of technical assistance may be inappropriate for a particular context but may be all that a particular agency is able to provide at the time. An example of this was the provision of short-term consultancy support in the Plurinational State of Bolivia when longer-term technical assistance was considered to be needed.

Planning matters

49. There are examples of agencies who develop plans without involving national counterparts, for example, in Côte d'Ivoire and, by implication, in Guatemala. In Egypt, preparation of a first draft plan was identified as the main challenge/bottleneck. In Nicaragua, the focal point noted that it had been a challenge to harmonize around national indicators and goals.

Funding matters

50. There are many examples where the way agencies provide funds is considered a challenge (see Box 13). Challenges identified included reluctance or unwillingness to provide money through pooling mechanisms resulting in a shift away from sectoral budget support, providing funding "*off budget*", requirements for matching or counterpart funding, unpredictability of funding, conditions attached to funding and lack of transparency. While these challenges are substantive, perhaps the bigger challenge is the inadequacy of the financial resources available. For example, in Eswatini, low budgets resulted in some activities being stopped or postponed, in Rwanda, there had been a reduction in resources to support interventions on the ground, in Senegal, budgets were considered insufficient and, in the oPt, donor financial support had declined in the last few years.

Box 13: Ways in which agencies provide funds can create challenges

In Burundi, a challenge was identified where some development partners do not want to provide money through the health basket fund.

In the Republic of the Congo, some development partners have required the provision of counterpart funds and this may be problematic.

In Ethiopia, there have been challenges related to the predictability of support provided by development partners.

In Ghana, there has been a shift away from sectoral budget support to having more parallel funding which does not always align with national plans.

In Nepal, development partners expect that, in return for their collaboration, they will be able to apply certain conditions to their funding. Budgets often fluctuate and are inconsistent resulting in unpredictability of funding. Overall, while the pool fund is supported by a few organizations this does not include the major players.

In Somalia, the majority of donor funding for the health sector, with the exception of one supported by the World Bank, is off budget. There is little coordination and input from the government in the decision making and use of these resources. All indications are that this way of working has reduced the efficient use of available resources, accountability and transparency. There are efforts underway to rectify this by promoting the use of the single treasury account system which it is hoped will address this problem.

In Tanzania, funders of specific programmes, e.g. the Global Fund, PEPFAR and Gavi, do align with government but they do not coordinate among themselves and are considered to have their own planning and reporting circles and implementation and monitoring systems.

In Uganda, some partners are not very transparent with their budgets and funding priorities which makes it hard for government to plan for their resources.

In Zimbabwe, the challenges are from those partners that do not want to be part of the Health Development Pooled Fund, e.g. CDC and PEPFAR. They do their own things. The rest are part of the coordination mechanisms of the country.

Supply chain matters

51. The health sector depends on effective supply chains and where these are fragmented and uncoordinated particular problems arise. This can happen when there is no functioning national logistics management information system (LMIS) and partners then establish their own parallel systems, e.g. in South Sudan.

Reporting matters

52. Various challenges relating to reporting have been documented (see Box 14). These include a reluctance of some development partners to share information with other development partners and national government, parallel reporting systems and insufficient focus on collecting and reporting experiences from the field.

Box 14: Examples of challenges in ways development partners report

In Haiti, sometimes partners are reluctant to share information with each other and with national authorities. As a result, partners submit very few technical and financial reports related to the achievement of their interventions.

In Nepal, joint regular monitoring from both the parties is somewhat weak and this may lead to parallel monitoring and reporting efforts.

In Rwanda, one challenge is that there is often not enough time to exchange experiences from the field and this issue has been worsened by constraints as a result of COVID-19.

In South Sudan, some partners are still practicing parallel reporting on health data in spite of the fact that South Sudan has a web based DHS-2 reporting system.

Other factors

53. A few other factors were identified by focal points. These include those factors which occur at the interface between agencies and local contexts. For example, administrative delays were identified as a challenge by the Plurinational State of Bolivia and, in Lao People's Democratic Republic, there are lengthy documentation and approval processes to approve a memorandum of understanding (MOU) which often lead to delays in project implementation. In Côte d'Ivoire, while a compact was signed, it has not been possible to implement or monitor it. In Tunisia, divergent visions were identified as a challenge.

54. In addition, there may be external factors, beyond the control of national governments, relevant authorities or agencies, which may affect alignment and coordination. While responses to COVID-19 were well-coordinated in some contexts (see paragraph 30), in Sri Lanka, it was considered that the attention of ministries of health and development partners were diverted for COVID-19 control and this resulted in routine activities, especially providing technical support, in other areas not being provided to the same degree as before. Specifically, planned technical assistance to cost the National Action Plan for achieving SDG3 was delayed as a result of COVID-19. A similar picture was reported in Eswatini where the COVID-19 response disrupted the continuity of essential health services by overwhelming the health system. In the Syrian Arab Republic, the impact of war was identified as a major challenge. In the oPt, support was largely diverted to the emergency response to COVID-19.

III. Incentives

55. This section briefly considers what responses say about a number of identified incentives which may promote or hinder alignment and coordination. These include joint funding, joint monitoring, joint evaluation and coordination mechanisms.

Joint funding

56. Responses emphasize that the way funding is provided is crucial in determining whether alignment and coordination are positively or negatively incentivized. Overall, respondents favour a pooled fund for health to which development partners can contribute and from which funds can be drawn to finance identified health priorities. However, it is recognized that many development partners are unwilling or reluctant to provide funding through such mechanisms and there has been a trend away from such pooled funds in recent years. In their absence, focal points would like to see funds provided "*on budget*" as much as possible, that is where funds are provided to finance elements identified in the health budget. Provision of earmarked funds "*off budget*" is considered particularly problematic.

57. Given the length of planning cycles, funds that are predictable, long-term, synchronized with local financial years, free of requirements for matched funds and with minimum conditions attached are particularly valued by focal points. Willingness of development partners to share financial information with other development partners and national government, that is financial transparency, is seen as an incentive towards greater coordination.

58. While these issues are each important, the biggest issue is the overall lack of financial resources. It is difficult to deliver a well-coordinated health system in any context without sufficient resources to do so.

Joint monitoring

59. Responses identify two key elements of relevance to the incentive of joint monitoring. First, it is important for development partners to use local monitoring systems such as the health management information system (HMIS) and the logistics management information system (LMIS). It is therefore important that these systems exist and that they function well. In addition, it is crucial that they produce information that development partners need in formats and within time frames required.

60. Second, there is the issue of joint reviews involving national governments, relevant authorities and development partners. Overall, responses emphasized more the importance of developing and using local systems, such as HMIS and relatively few responses focused on joint reviews.

Joint evaluation

61. This incentive was not specifically mentioned in responses although the system of joint reviews might be considered to better fit under this incentive than under joint monitoring.

Coordination mechanisms

62. As with the incentive of joint funding, responses recognize the importance of these mechanisms in ensuring development partner support to health systems is well-aligned to local priorities and well-coordinated with others. It is clear that these mechanisms need to be based around an organizing framework and/or document, such as a national health plan. While there is recognition that such mechanisms should be led by national government or relevant authority, the precise way in which they are structured or operate varies substantially between different contexts. Perhaps the biggest difference is whether mechanisms to coordinate among development partners themselves are seen as part of any such coordination mechanism or parallel/in opposition to such a mechanism. Other differences include the extent to which the coordination mechanism has any sub-mechanisms, for example for particular programmes, specific diseases or thematic areas and/or sub-national mechanisms, particularly in federal states. One particular challenge identified is that the Ministry of Health often lacks capacity to effectively lead and coordinate such mechanisms.

IV. Suggested corrective measures

63. Focal points identified a number of corrective measures to seek to improve alignment and coordination for health. Many of these are context-specific and these are documented in full in Annex 2 (p24). There are some common themes and these are illustrated in Box 15.

Box 15: Summary of suggested corrective measures: Nine key points

1. Recognize that processes should be locally-driven. Development partners to act as collaborators and not decisionmakers
2. There is a need to strengthen capacity of lead ministries, particularly the Ministry of Health, to effectively coordinate the health response
3. Have an agreement or compact between national government/relevant authority and development partners as to how development assistance will (and will not) be provided
4. Ensure coordination mechanisms are in place and are used and respected. These need to be appropriate for the context, for example, including sub-national structures in federal states
5. Develop plans with national government/relevant authority and other development partners based on the national or local health strategy
6. Provide pooled funds where possible. Where this is not possible, ensure funds are provided "*on budget*". Development partners to make funding as predictable, long-term and unconditional as possible.
7. Use local monitoring systems and conduct joint reviews and evaluations where possible.
8. Allow national government/relevant authority sufficient time to respond to requests
9. Learn lessons from coordination of COVID-19 responses

How might responses be used for quality improvement purposes?

64. There is interest in seeing if it is possible to identify country feedback received that could allow actions to improve the quality of support.

Pilot countries

65. One option would be to focus on those countries who first piloted the M&E framework – Colombia, Lao People's Democratic Republic, Malawi, Nepal, Pakistan, Somalia, South Sudan and Tajikistan. Table 2 identifies corrective measures identified in these countries.

Table 2: Corrective measures identified in eight pilot countries

Country	Corrective Measures
Colombia	Develop socialization scenarios of results and impact Promote participatory planning and evaluation actions Generate data quality evaluation processes at all levels
Lao People's Democratic Republic	More strengthened efforts to implement the Vientiane Declaration with DPs Single coordination mechanism led by MOH: all DPs should not create their own coordination mechanism. They should follow the national coordination mechanism. Strengthening development of the joint annual work plan and M&E of it which will lead to better alignment of donors' monitoring and reporting Improving one door system within MOH to streamline coordination and communication between MOH and different DPs Improving data management for donors' support in the health sector (e.g. ODAMIS developed by the Ministry of Planning and Investment and better use of health information system such as DHIS2) Building capacity of both government, partners, and key stakeholders on coordination and communication skills for mutual understanding and better results (For government staff, understanding of aid and development policy/strategy, health care financing, health information management, negotiation and contracting/MOU, and English language are limited).
Malawi	Proposal to move back to the SWAP arrangement and the implementation of aid coordination principles
Nepal	Both the government and the development partners should contribute to all the joint collaborative activities to the best of their capabilities. The parties must prioritize their respective contributions thus giving utmost importance and putting adequate effort to make the end goal successful. Active participation of all the development partners is expected in the "pool fund" in order to ensure the predictability of the financial budget support from development partners. Country moved from unitary to federal system of governance, which has created confusion and difficulty to channelize funds to the province and local levels. So, a joint workout modality for fund channelization to province and local level should be enforced.
Pakistan	Agree on NHSCM. A similar mechanism should also be established in all provinces.
Somalia	Develop a roadmap for strengthening the overall institutional capacity of the government at federal and state level. This could include, but not limited to the training and use of result-based planning and budgeting, health financing, monitoring and evaluation, public financial management, supply chain management and regulatory reforms. Improved coordination with the government and developing a coordinated national plan (namely investment case plan) to ensure alignment and the implementation of the national health priorities. The use of government single treasury system.
South Sudan	Revive the health sector working group coordination meeting Establish the National Health Acount Strengthen the DHIS-2 and LMIS as the main reporting channels for all implementing partners Build the government capacity to take leadership in governance Establish a joint national health planning system
Tajikistan	Establish a robust coordination mechanism at the Ministry of Health level, including strengthening the existing DCC health platform. Development of a single tool for mapping health services provided in different health sectors, in order to avoid duplication of activities and further joint coordinated and fruitful collaboration.

Specific health issues

66. Responses tended not to speak about specific health issues as this initial questionnaire did not ask about these. Possible exceptions included:
    A. Cabo Verde which identified areas needing strengthening including respect for human rights, civic participation, integration of gender equality, reduction of the social inequalities and asymmetries at island level, consolidation of democracy, prioritize the against poverty, hunger, AIDS, and discrimination against women and girls
    B. Eswatini where it was considered that alignment had strengthened programming and implementation of primary health care services particularly in the areas of reproductive and child health and that these improvements had been seen at both national and sub-national levels.
    C. Ghana wished to develop a Universal Health Coverage compact to be signed off by all development partners
    D. In Gabon, the national response to COVID-19 was considered the main success in terms of aligning the support of development partners with national plans. But other areas where there had been success were also identified and these included tuberculosis, child vaccination and maternal and child health.
    E. In the oPt, where the support of development partners to the Palestinian Ministry of Health has been focused on strengthening Primary Health Care programmes towards integrated health service delivery and family health approach.

67. Some countries acknowledged that coordination mechanisms had been particularly strong in relationship to emergencies, e.g. the health cluster in Colombia. This cluster has had effective sub-clusters on topics such as sexual and reproductive health and violence against children. In particular, lessons had been learned in relationship to coordinating responses to COVID-19.

68. There were, many requests for corrective measures on financing including that:

    A. Funds should be more aligned to national priorities, e.g. in Afghanistan and Tunisia
    B. Funds should be more flexible, i.e. less earmarked, e.g. in Bhutan and Eswatini
    C. There should be more transparency in sharing financial reports, e.g. in Benin
    D. Development partners should make details of their financial provision known well in advance
    E. Funds should be refused if they do not fit into the development plans of state institutions, e.g. in Chad
    F. Disbursement procedures should be streamlined and simplified, e.g. in Congo and Côte d'Ivoire
    G. Intermediaries should be eliminated in the provision of funds, e.g. in Congo
    H. Pooled funding should be encouraged and supported by all partners, e.g. in Côte d'Ivoire, Mozambique, Nepal, Zambia and the oPt . In Malawi, the respondent wanted to return to the SWAP arrangement. In Somalia, the focal point wanted to ensure use of a government single treasury system. In South Sudan, the focal point wanted to establish a national health account.
    I. Adequate funds should be provided to allow countries to meet SDG commitments.
    J. Development partners work with government to jointly determine how funds can be channeled to provinces and local levels in a decentralized system, e.g. in Nepal
    K. Ensuring funding of health programmes is tailored towards achieving SDGs, e.g. in Panama

69. There were a few comments related to workforce/human resources including a request from the Plurinational State of Bolivia for greater coordination over the hiring of consultants. In Nigeria, the focal point wanted to ensure a critical mass of health workers, especially at sub-national levels are well conversant with their institutional plans that make up the national plan.

70. Most of the suggestions related to better coordination and working together and it may be premature to conclude that those issues have been resolved or that appropriate coordination structures have been established and are functioning in all settings.

C. Conclusions

71. In conclusion, the findings of the monitoring framework identify concrete actions to strengthen collaboration among multilateral agencies. The findings allow agencies to identify and prioritize contexts where agency alignment with local priorities and coordination with each other may need improvement. In these settings, the qualitative responses will help to initiate specific discussions on particular challenges to collaboration and how these might be overcome. The heat map (Table 1) and qualitative responses provide useful insights into how support for collaboration might be tailored in different settings. Low-income countries were especially responsive in this exercise but face particular challenges in ensuring development partners' support is aligned with their priorities and is well-coordinated. These responses emphasize the importance of aligned and coordinated funding and effective coordination mechanisms as key incentives for effective health coordination in low- and middle-income settings. Finally, these responses provide valuable baseline information that will be used for comparison purposes as further responses are sought over time, hopefully to identify improvements following actions on the part of agencies to strengthen their collaboration in particular contexts.

Annex 1: Questionnaire for National Governments [3]

This document contains a short questionnaire which national governments are asked to complete relating to the coordination among multilateral agencies in relation to the Sustainable Development Goal on health (SDG3) in the country. Some background information and guidance on how to complete the questionnaire follows the questionnaire itself in the form of a brief explanation of the SDG3-GAP and a number of frequently-asked questions. If you have any questions about the questionnaire or need more information, please contact the SDG3 GAP Secretariat or the WHO Country Office.

Country Questionnaire: National Government

Country:
Name of person completing questionnaire:
Designation of person completing questionnaire:
Contact details:

Brief description of organizations and ministries consulted in completing this questionnaire:

Date of completion:

1. To what extent do you agree with the following statement?

A. The support received from development partners is well-aligned with national plans.	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
B. Development partners coordinate well with each other over the support they provide.	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
C. Development partners provide financial support in line with national budget priorities	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
D. Development partners use national monitoring systems and reports	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
E. Development partners coordinate their activities, including having a joint technical assistance plan	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
F. Development partners make use of national coordination mechanisms and do not seek to establish their own parallel mechanisms	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

2. What have been the main successes in terms of development partners aligning their support with national plans and coordinating with each other?

3. What have been the main challenges and bottlenecks in terms of development partners aligning their support with national plans and coordinating with each other?

4. What corrective measures could be taken to improve alignment by development partners with national plans and coordination with each other?

[3] The term “national Government” should be understood to refer to “national governments and relevant authorities”.

5. Is there any information you wish to share with WHO and other multilateral agencies but you do not wish to be made publicly available? If yes, please share it here.

The SDG3 GAP
The Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP)[4] is an agreement between 13 multilateral agencies (Gavi, the Global Financing Facility, ILO, the Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, UNITAID, UN Women, the World Bank, WFP and WHO) and is based on the premise that stronger collaboration contributes to better health through more coherent support to national priorities and plans. Implementation of the GAP is based on commitments by the agencies to

- Engage with countries better to identify priorities and plan and implement together
- Accelerate progress in countries through joint actions under seven programmatic themes, as well as on gender equality and the delivery of global public goods. The seven accelerator themes are (1) primary health care; (2) sustainable financing for health; (3) community and civil society engagement; (4) determinants of health; (5) innovative programming in fragile and vulnerable settings and for disease outbreak responses; (6) research and development, innovation and access; and (7) data and digital health
- Align in support of countries by harmonizing operational and financial strategies, policies and approaches
- Account by reviewing progress and learning together to enhance shared accountability.

Countries were off track to reaching the health-related SDGs and COVID-19 has further exacerbated the situation and caused a reversal of progress for the first time since the adoption of the SDGs in 2015. Accelerating progress is therefore now more urgent than ever. Building on existing country coordination mechanisms, SDG3 GAP provides countries with a platform to support the equitable and sustainable recovery from COVID-19, so that they can accelerate progress once again.
The SDG3 GAP is a self-commitment to work closer together to better support national priorities and plans, of which all governments can make use.

While the principal measure of success under the SDG3 GAP is the achievement of the health-related SDG targets, it is also expected that, by 2023, the Plan will have brought about three major changes, namely (1) better coordination among the agencies in their global, regional and in-county support to countries; (2) a reduced burden on countries as a result of better aligned operational and financial policies and approaches and (3) a purpose-driven collaboration that is integrated into the agencies' organizational cultures, encompassing leadership at global, regional and country levels.

Frequently-asked Questions

What is the purpose of the questionnaire?
The purpose of the questionnaire is to enable GAP agencies obtain better data on the areas of change explained above.

How often will the questionnaire need to be completed?
This questionnaire is intended to be completed annually by national governments.

Is anyone other than national government being asked to complete a questionnaire?
Yes. There are similar questions to be completed by national civil society and the United Nations Country Team. GAP agencies are also being asked to complete a questionnaire.

I/we don't really know much about the SDG3 GAP. Can I still fill in the questionnaire?
Yes, the questionnaire does not require specific knowledge of the SDG3 GAP to complete as it focuses on the overall health coordination environment in the country. The data collected through the questionnaires will be complemented with other reporting, such as country case studies, in preparation of the annual progress report.

Which countries are being asked to complete this questionnaire?

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

This questionnaire is focused on low- and lower-middle-income countries, where most SDG3 GAP agencies are active.

Who should complete this questionnaire?
The questionnaire should be completed by the most senior, relevant public official/civil servant in health, such as a Permanent Secretary, or their delegate, such as a Director of Planning. The national government should decide who is the most appropriate person to complete the questionnaire. The response needs to be formally endorsed on behalf of the government, for example by a senior representative of the Ministry of Health.

It is difficult to answer the agree/disagree questions (#1A-1F). Can I add explanatory comments?
Yes. Please use your answers to the open-ended questions (2 to 4) for this purpose. As question 2 asks about successes, please use this question to explain responses to statements with which you agree. As questions 3 and 4 ask about challenges and bottlenecks and how things might be improved, please use these questions to explain responses to statements with which you disagree.

In our country, there are important coordination issues at sub-national level. How can I reflect those in the questionnaire?
While the questionnaires focus on coordination at the national level, it is recognized that this may be affected by coordination at sub-national level, and that the extent to which this happens and how it happens will vary by individual country context. It is also recognized that this may be a particular issue for large countries and/or those with federal structures. Where these issues are important, it is suggested that they be answered in the qualitative questions 2-4. If there might be different answers to question 1 at national or sub-national level, the respondent should answer question 1 for the national level and then explain any differences in responses to questions 2 to 4.

How will the answers be used?
It is expected that the data gathered will be used in a number of different ways. First, countries will be able to use their own data as they wish, for example to seek to discuss and improve coordination among partners. Second, data gathered will be shared across GAP agencies and with other development partners with the aim of seeking to understand and improve coordination in particular countries. Third, data will also be used globally to allow progress reporting on the GAP and will be publicly available. If there is any information which countries wish to share with WHO and other multilateral agencies but they do not wish to make publicly available, this can be shared in response to question 5.

In answering questions, respondents are asked to give an honest and frank assessment of what the current situation is and not how they think it might be in the future. In some contexts, it may be helpful for development partners, such as WHO Country Offices, to engage with partners in national government to explain and emphasise this point. However, in other contexts, this may be well-understood by government and involvement of development partners could potentially lead to less honest and frank responses.