
Evaluation of the WHO Secretariat's contribution to the health-related Millennium Development Goals

(Volume 1: Evaluation Report)

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Acronyms

ART	Antiretroviral therapy
CCM	Country Coordination Mechanisms
DAH	Development Assistance for Health
EMG	Evaluation Management Group
FENSA	Framework of engagement with non-State actors
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPW	General programme of work
IHP+	International Health Partnership
h-MDGs	Health-related Millennium Development Goals
MDGs	Millennium Development Goals
MTSP	Medium-Term Strategic Plan
NTDs	Neglected Tropical Diseases
OECD	Organisation for Economic Co-operation and Development
PB	Programme budget
PMNCH	Partnership for Maternal, Newborn and Child Health
RBM	Roll Back Malaria Partnership
SDGs	Sustainable Development Goals
TB	Tuberculosis
TOC	Theory of Change
TOR	Terms of Reference
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHA	World Health Assembly

Executive Summary

The evaluation of the World Health Organization (WHO) Secretariat's Contribution to the Millennium Development Goals (MDGs) aims to inform WHO's strategy for the 2030 Agenda on Sustainable Development Goals (SDGs) based on organizational learning drawn from past experience. The evaluation covers the entire life span of MDGs (2000-2015) and assesses the Secretariat's contribution to the health related MDGs (h-MDGs) at the global, regional and country levels. It identifies strengths, weaknesses, challenges and good practices and offers strategic recommendations to inform the WHO Secretariat's approach in responding to the health-related SDGs.

The evaluation addresses five questions in order to determine WHO's contribution to the MDGs:

- *Evaluation Question 1:* How did the WHO Secretariat respond to the adoption of the MDGs?
- *Evaluation Question 2:* Was the Secretariat's response to the h-MDG targets relevant to Member States' needs and consistent with the Organization's mandate?
- *Evaluation Question 3:* What have been the main results of the Secretariat's contributions to the achievement of the h-MDGs as expressed through its six core functions?
- *Evaluation Question 4:* How did the Secretariat work with others to support the achievement of h-MDGs?
- *Evaluation Question 5:* What are the main lessons learned to take into account for the Secretariat's engagement with the health-related SDGs?

The evaluation constructed an ex-post Theory of Change during the inception stage to provide a comprehensive theory-based analytic framework to the evaluation, complemented by an evaluation matrix. It then adopted a mixed method approach comprising a combination of qualitative and quantitative tools, including document review and financial data analysis, key-informant interviews and electronic surveys for key external and internal stakeholders. Country case studies were also performed to provide more detailed insights into the Secretariat's experiences in contributing to the h-MDGs.

The evaluation faced some challenges, which limited the depth and breadth of the data and information collected, such as: the lack of an overarching WHO results framework to systematically report on the Secretariat's contribution; the long recall period; the relatively low response rate to some of the surveys; and changes to the budget and planning structures hampering comparability across the period. Despite these limitations, the evaluation findings are based on sufficient data and information from different sources which were analysed and triangulated for the assessment of the Secretariat's contribution to the h-MDGs. The main findings are summarized below.

Main findings

Evaluation question 1: How did the WHO Secretariat respond to the adoption of the MDGs?

Three MDGs specifically addressed major public health priorities (MDG 4 reduce child mortality, MDG 5 improve maternal health and MDG 6 combat HIV/AIDS, malaria and other diseases) while other significant public health issues were also included as part of broader MDGs (such as MDG 1 eradicate extreme poverty and hunger, MDG 7 ensure environmental sustainability and MDG 8 develop a global partnership for development). As the leading international public health agency, the Secretariat responded to the UN call and gradually focused its efforts towards the achievement

of the MDG goals. Following a World Health Assembly resolution in 2002 which provided an overarching framework to guide the Secretariat's response, the Secretariat engaged on the international scene contributing to the inclusion of initially overlooked health priorities and the repositioning of health issues in a more comprehensive and public health oriented manner than initially envisaged.

However, the Secretariat was much slower to frame its contribution to the health-related MDGs in a concerted and coherent manner within the Organization. The last regional resolution defining priorities to address the h-MDGs was only adopted in 2007.

In the mid-2000s, the Secretariat progressively aligned its general programmes of work and programme budgets to the h-MDGs. This enhanced the visibility of the Secretariat's programmes directly related to the h-MDGs. However, overall, the Secretariat did not show an explicit strong corporate leadership championing the h-MDGs at the three levels of the Organization. Neither did it conceptualize a strategy to ensure that all relevant corporate programmes, regions and countries developed their response in a consistent manner across the h-MDGs.

The MDG approach based on targets and indicators increased the emphasis on tracking health trends in countries. The World Health Assembly mandated the Secretariat to report annually on progress towards the achievement of the h-MDGs. Though this mandate only came in 2008, it gave a strong impetus to enhance collaboration between relevant programmes to strengthen the information and evidence culture of the Organization. The creation of the Global Health Observatory was instrumental in this regard.

The overall MDG design along the lines of specific diseases and targets promoted a vertical/silo response along technical programmes. It enhanced collaboration across the three levels of the Organization within the same technical programmes but there was limited interaction with other programmes. However, differences in programme objectives and in engagement across major offices might have also hampered the extent of collaboration.

This vertical approach had adverse effects on cross-cutting issues, especially when it came to health systems. Limited attention was given to the ability of health systems to cope with the MDG focus on specific health issues. This silo approach was furthermore amplified, at least initially, by limited communication and coordination across the Secretariat's programmes.

Even if not in a strategic and coherent manner, it is clear that, over time, the h-MDGs influenced the Secretariat's ways of working across its three levels and contributed to strengthened collaboration with partners. Finally, it is clear that the Secretariat's response to the h-MDGs at corporate level and the global health discourse influenced each other. At country level, the Secretariat's response was mostly influenced by country health priorities rather than by donor or civil society priorities.

With regard to the level of financial resources, the level of WHO expenditures on the h-MDG areas of work increased steadily between 2000 and 2010 and then stabilized after a slight decline. This raises a question about the Secretariat's ability to attract funding for the h-MDGs and the extent to which it was perceived as a credible partner to achieve the h-MDGs.

Furthermore, the proportion of the Secretariat's h-MDG budget in the overall budget for global development assistance for h-MDGs declined significantly over the period 2000-2015, reflecting a clear challenge for the Secretariat to attract funding for h-MDGs. This was further exacerbated by an increasing dependence of the Secretariat on unpredictable voluntary contributions.

Evaluation question 2: Was the Secretariat's response to the h-MDG targets relevant to Member States' needs and consistent with the Organization's mandate?

Members States found the Secretariat's response to be timely and relevant to their h-MDG related needs; and also well aligned with the epidemiological burden and national priorities of countries. They also recognized the adequacy of the Secretariat's role in terms of setting norms and standards and monitoring the health situation and assessing health trends. There were some inadequacies noted in relation to the Secretariat's role in shaping a relevant research agenda and providing technical support.

While the Secretariat received more funding over the MDG period for other health priorities than for the h-MDGs, there is a consensus that other health priorities were sometimes not adequately addressed because of the priority given to the h-MDGs.

Evaluation question 3: What have been the main results of the Secretariat's contributions to the achievement of the h-MDGs as expressed through its six core functions?

Overall, the contribution of the Secretariat was perceived as at least satisfactory by a majority of Member States and partners. The Secretariat played a key role in shaping the global health agenda and in convening stakeholders in support of the global, regional and national health agendas on the h-MDGs. It was recognized that the Secretariat advanced global policy dialogue, raised the profile of h-MDG priorities and built consensus in support of the h-MDGs. The Secretariat also played a significant role in convening and coordinating stakeholders around key priorities and in engaging partners and hosting partnerships.

A closer analysis of contributions in relation to the six core functions indicated clearly that Member States valued the leadership and advocacy role of the Secretariat as well as its unique role to set norms and standards and develop corresponding guidelines. On the other hand, the core functions which received lower ratings by Member States and partners were the Secretariat's ability to shape a relevant research agenda and stimulate the generation, translation and dissemination of valuable knowledge and its ability to strengthen capacities in countries.

The Secretariat's leadership in monitoring the health situation and assessing health trends was widely recognized by both Member States and partners. Particularly appreciated were the access to improved quality of data and more robust estimation processes and also the strengthened collaboration with partners on joint initiatives, the consolidated data sets on h-MDG progress and the strengthened national health information systems.

The Secretariat's strong branding and credibility as a neutral and quality partner, as well as its recognized convening power were among its major assets, together with its country presence sustained by a close relationship with Member States.

Many partners also identified limitations in the Secretariat's overall positioning, leadership and communication style on the h-MDGs, which possibly reflected a lack of ambition and certainly undermined resource mobilization at all levels.

There was continuous tension between upstream normative work, where the Secretariat's added value is well recognized, and technical support, which was perceived as somewhat weaker, especially at country level, where Member States found the Secretariat sometimes constrained in providing technical support.

Finally, as a result of the Secretariat's vertical approach to addressing the MDGs, non-MDG related programmes lost traction, even though many were recognized as corporate WHO priorities. This included the Secretariat's contribution to strengthening health systems which were the foundations

for achieving the h-MDGs. There was little evidence of structural efforts to counterbalance the vertical design of the h-MDGs, as well as to position other WHO priorities prominently, in particular during the initial years.

Evaluation question 4: How did the Secretariat work with others to support the achievement of the MDGs?

Partnership was a central feature of the MDGs and the number of actors engaged in the health sector increased significantly over the period. Overall, the Secretariat's collaboration with UN agencies was effective at the three levels of the Organization and the Secretariat also initiated a series of partnerships over the period. However, its engagement with non-State actors remained limited. Many considered that the Secretariat should seek to include other partners among its target audience, especially civil society, particularly on equity grounds.

From the partner perspective, while the Secretariat's added value as a convening power was well established, the Secretariat was much less effective when it came to resource mobilization and promotion of accountability.

Collaboration was challenging for both the Secretariat and partners on many fronts. The lack of flexibility in the Secretariat's engagement, coupled with a limited internal culture of collaboration and differences in priorities and goals across major offices, limited accountability and communications, inadequate funding and cumbersome administrative procedures undermined the role of the Secretariat in working with and through partnerships. The lack of clarity of roles and responsibilities among partners, including overlapping mandates, were also seen as challenges for the Secretariat to work effectively with partners.

Lessons learned

Most lessons learned by this evaluation concur with previous evaluations. The Secretariat's leadership and strong convening power represent one of its most recognized core functions. However, the evaluation showed that it has not always played this role as well as it could have. Reasserting the Secretariat's leading and convening role on health issues globally, regionally and nationally stands out as a clear message. Likewise, in order to effectively respond to the SDGs, the Secretariat needs to accelerate the required strategic decisions in order to translate its vision into action and develop a solid communication strategy. The evaluation highlighted the Secretariat's comparative advantage in monitoring the health situation and assessing health trends; and the need to move from a vertical to a horizontal health system approach in order to respond more effectively to support the SDG agenda. Sustainable financing and the development of an explicit results framework based on a robust theory of change to enable the clear demonstration of results are some of the required steps for an effective contribution. In more substantive terms, the evaluation suggested strengthening the Secretariat's capacity to provide cutting edge technical support in countries and clarification of the Secretariat's role on the research agenda.

Recommendations

Recommendation 1: Develop and adopt a corporate strategy to address the SDG agenda across the three levels of the Organization with a particular emphasis at the country level.

- As the leading international public health agency, the Secretariat needs to demonstrate leadership in guiding the international community and supporting countries towards achieving the SDGs.
- The Secretariat's contribution needs to be supported by an overarching framework, guided by a corporate vision, including principles for priority setting, expected results,

means of operation and clear resource mobilisation approach at global, regional and country levels. It also has to be framed by a Theory of Change describing the main changes expected across the three levels of the Organization and the main assumptions to be made to achieve these changes.

- The 13th General Programme of Work should be very explicit about the Secretariat's contribution to SDG achievements and needs to clarify, in particular, targets and indicators of success at country level. In addition, the programme budgets will have to be aligned to the corporate SDG strategy in terms of goals, priority areas, outputs and outcome measurement approaches.
- Internally, this corporate SDG strategy needs to be shared across the three levels of the Organization, and be owned by them. Regional and country offices need to be involved in its development, operationalization and monitoring so that linkages with regional SDG frameworks where they exist as well as with the country cooperation strategies are duly considered.
- Externally, the Secretariat has to develop a strong communication approach in support of the corporate SDG strategy, proposing a strong positioning: i) of the Organization as the leading international agency for advancing SDG3 and contributing to the other SDG goals with a health dimension; and ii) of the country offices so that they actively and effectively support national achievement of the SDGs.

Recommendation 2: Ensure mainstreaming of cross-cutting issues and the ability to champion the SDGs through strengthened collaboration across different programmes and at the three levels of the Organization, in particular at the country level.

- The vertical approach adopted during the MDG period has clearly shown its limitations. It is therefore critically important for the Secretariat to ensure that, when developing its corporate SDG strategy and the 13th General Programme of Work, it avoids this trap learning from past experience. Universal health coverage through a health systems strengthening approach can be useful as the integrated principle of the Secretariat's contributions to the SDGs, particularly in countries. As recommended in document A69/15, "Planning, budgeting, financing and resource allocation" units must design and "provide the incentives needed to drive more collaborative work across the Organization", which may require establishing structural mechanisms to facilitate cross-departmental and cross-sectoral collaboration. A clear definition of roles and functions at each level of the Organization, especially at headquarters where technical areas are sometimes covered by several departments or units, would greatly facilitate such collaboration.

Recommendation 3: Foster cross-sectoral collaboration in order to address health dimensions in all relevant SDGs at the international level with regional and global partners and in countries with relevant ministries and development partners

- Given that intersectoral work is at the core of the SDGs, working and collaborating with cross-sectoral partners will be of critical importance during the SDGs. The Secretariat will need to work across sectors by strengthening existing partnerships and engaging new partners beyond the health sector. To this effect, the Secretariat should use its convening power to strengthen and foster relevant partnerships, bringing together health and non-health actors in support of a cross-sectoral approach to the SDGs internationally and in countries.

- The Secretariat should strengthen its collaboration within the UN community in line with discussions highlighted by the Secretariat¹ which recognizes that “attaining the goals of the 2030 Agenda demands greater emphasis on programmatic cooperation across entities”.
- Furthermore, the Secretariat should expand its network of partners to include not only ministries of health in Member States but also parliamentarians in countries where relevant, civil society and other non-State actors. The Secretariat would benefit from a transparent mechanism for its active engagement with different stakeholders, in particular non-State actors, and there are many expectations with regard to the implementation of the recently approved Framework of engagement with non-State actors during the SDG period.

Recommendation 4: Focus on the comparative advantage of the Secretariat as expressed through its core functions. Strengthen them as required to meet the SDG challenges, especially in countries.

- WHO’s extensive presence in countries, its institutional credibility, and close relationship with Member States give the Secretariat a clear leadership role to broker coordination and partnerships around the SDG agenda at the three levels of the Organization.
- The Secretariat should convene as a neutral broker, develop the adequate norms and standards to meet the SDG challenges, set up an appropriate research agenda, adapt the health monitoring mechanisms to the SDGs targets defined in countries and ensure timely, high standard technical support.
- The adequate capacity of WHO country offices to support Member States effectively in achieving the SDG targets is paramount. As already mentioned by the evaluation of WHO reform, third stage, capacity building in the diplomatic and negotiation domains are critical to support WHO’s convening role - at the three levels of the Organization, and especially at the country level. Hence, the Secretariat should ensure such capacity and its strengthening where needed.
- Its recognized leadership in monitoring the health situation and assessing health trends requires the Secretariat to support countries: in the identification of relevant indicators to measure progress, effectiveness and impact; in the promotion of measurements and reporting for transparency and accountability; in the strengthening of data quality and health information infrastructure; and in the strengthening of capacity building for data systems and information sharing in countries.

Recommendation 5: Ensure the ability of the Secretariat to credibly demonstrate its contribution to the SDGs and measure its results, in particular at the country level.

- It is urgent for the Secretariat to set up a corporate result framework and mechanism for monitoring its contribution to the SDGs in countries against targets. As indicated already in other evaluations, such a system does not yet exist. This mechanism should be aligned with the corporate general programmes of work and programme budgets allowing for corporate performance monitoring. At the country level, the WHO results framework should be in line with the Country Cooperation Strategy and the global results framework.

¹ WHO (2017) document A70/55, para. 4.

1. Introduction

Objectives, scope and key evaluation questions

1. The evaluation of the WHO Secretariat's Contribution to the h-MDGs is one of the Secretariat's priority corporate evaluations for the 2016-2017 biennium approved by the Executive Board. It aims to inform WHO's strategy to contribute to the 2030 Agenda on SDGs, based on organizational learning from the experience of its contribution to the MDGs. All WHO evaluations meet accountability and learning objectives. However, the primary emphasis of this evaluation is on learning at two levels:
 - a. **For the WHO Secretariat:** learning from the experience gained from the h-MDGs, the evaluation findings and recommendations inform:
 - i. The framing/design, planning and operationalization of its contribution to the health-related SDGs and targets, in particular at country-level considering the leading role of countries in the SDGs;
 - ii. The monitoring and evaluation framework to assess the Secretariat's future contribution to the health-related SDGs;
 - iii. The relevant partnerships in which the Secretariat has been engaged to contribute to the h-MDGs.
 - b. **For the Member States:** The evaluation results inform further discussions about the SDG implementation in the design and planning of the general programmes of work (GPWs) and programme budgets (PB) at meetings of the governing bodies.
2. The evaluation assesses the Secretariat's contribution to the h-MDGs at the global, regional and country levels (hereafter, referred to as the three levels of the Organization). It identifies strengths, weaknesses, challenges and good practices and offers strategic recommendations to inform the Secretariat's approach in responding to the health-related SDGs. Annex 1 contains the terms of reference (TOR) for the evaluation, finalized through wide consultation within and outside the Secretariat.
3. The evaluation conforms to the *WHO Evaluation Policy* (2012)² which states that Evaluation is an essential function at WHO, carried out at the three levels of the Organization. It ensures accountability and oversight for performance and results and reinforces organizational learning in order to inform policy for decision-makers and support individual learning. The policy is informed by evaluation best practices as formulated in the *WHO Evaluation Handbook* and the Norms and Standards of the United Nations Evaluation Group (UNEG).
4. The evaluation is of relevance to the Secretariat's senior management at the three levels of the Organization, WHO governing bodies, national health authorities in the Member States, and WHO's key development partners in preparing for, and responding to, the 2030 Agenda on SDGs. The partners and collaborators of the Secretariat will be able to identify strategic areas for their engagement with WHO ensuring a focused approach towards helping Member States to achieve the SDGs. Going forward, experiences and lessons from the Secretariat's contribution to h-MDGs will help in setting realistic targets and implementation arrangements at the three levels of the Organization, including cross-sectoral coordination and collaboration towards helping the Member States in achieving health-related SDGs.
5. The evaluation covers the entire life span of MDGs (2000-2015) and reflects the contribution of the Secretariat to the h-MDGs at the three levels of the Organization through its six core functions: (i) providing leadership on matters critical to health and engaging in partnerships

² WHO (2011) document EB130/5, Add.8.

where joint action is needed, (ii) shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge, (iii) setting norms and standards and promoting and monitoring their implementation, (iv) articulating ethical and evidence-based policy options, (v) providing technical support, catalysing change, and building sustainable institutional capacity, and (vi) monitoring the health situation and assessing health trends.

6. The evaluation addresses five questions in order to determine WHO's contribution to the MDGs:
 - *Evaluation Question 1:* How did the WHO Secretariat respond to the adoption of the MDGs?
 - *Evaluation Question 2:* Was the Secretariat's response to the h-MDG targets relevant to Member States' needs and consistent with the Organization's mandate?
 - *Evaluation Question 3:* What have been the main results of the Secretariat's contributions to the achievement of the h-MDGs as expressed through its six core functions?
 - *Evaluation Question 4:* How did the Secretariat work with others to support the achievement of h-MDGs?
 - *Evaluation Question 5:* What are the main lessons learned to take into account for the Secretariat's engagement with the health-related SDGs?
7. The evaluation mainly considers the relevance and responsiveness of the Secretariat's contribution to country health needs in aiming to achieve the MDGs as well as the effectiveness of its contribution. The evaluation does not assess impact, as attribution of changes in the MDG targets cannot be attributed to the Secretariat alone considering the nature of its response, the evidence base available and the number of actors active in the health sector.

Structure of the report

8. Section 1 of this report outlines the objectives of the evaluation, its methodology, approach, and data sources. Section 2 provides an overview of the context of the MDG initiative and its relationship with WHO. Section 3 contains a presentation of the evaluation findings per each of the evaluation questions. The conclusions, lessons learned and recommendations are then discussed in Section 4. The report is supported by seven annexes (available in volume 2 of the report):
 - Terms of Reference
 - Theory of Change
 - Evaluation matrix
 - Methodology
 - Bibliography
 - Interview guides for each group of stakeholders and the list of stakeholders interviewed
 - Survey questionnaires and results for WHO Member States, for the other external partners and collaborators and for WHO staff.

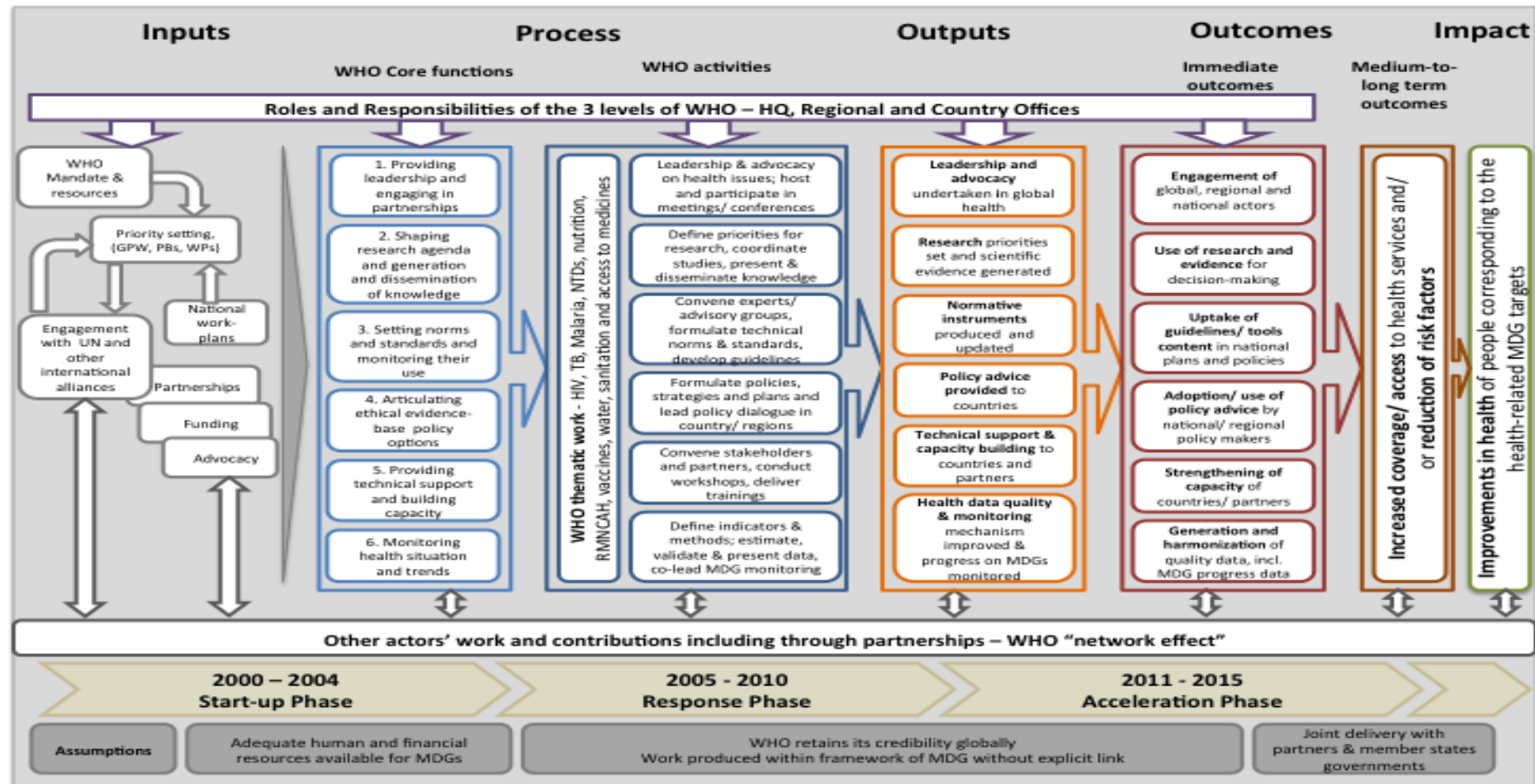
Methodology, approach, data sources and analysis

9. To undertake a comprehensive analysis in responding to the evaluation questions and due to the absence of a structured results framework in WHO during the larger part of the MDG period, the evaluation constructed an ex-post Theory of Change (TOC) during the inception stage (Figure 1). The TOC articulates the Secretariat's contribution to the h-MDGs in the broad sense. The Secretariat's contribution is embedded in the correspondence between the ultimate health targets to which WHO's functional departments aimed to contribute and the h-MDGs goals per se, irrespective of the specific language that was used to define the work (Annex 2).

10. The evaluation also recognizes that, as per the institutional results chain, the Secretariat's accountability ends at the immediate outcome level; at the medium- to long-term outcome and impact level, the Organization takes joint responsibility with the Member States and other development partners.³ Thus, the focus of the evaluation has been on the Secretariat's outputs and immediate outcomes related to the h-MDGs.
11. The evaluation adopted a mixed-method approach comprising a combination of qualitative and quantitative data collection tools and it was structured in four phases (Annex 3 provides details of the evaluation matrix and Annex 4 summarises the methodology):
 - a. **Inception:** During the inception phase the evaluation team conducted a briefing mission in Geneva, interviewed key informants at WHO headquarters, and reviewed strategic documents. On the basis of the TOC and the evaluation questions and sub-questions, the evaluation team developed an evaluation matrix and identified the corresponding data collection method. The inception report was circulated for comments to the Evaluation Management Group (EMG) and it was finalized in December 2016.
 - b. **Data collection:** On the basis of the TOC and evaluation matrix, the evaluation team, in collaboration with the WHO Evaluation Office, developed the data collection tools, and subsequently conducted all internal and external stakeholder interviews and undertook extensive document review. The Evaluation Office distributed the three survey questionnaires to the relevant stakeholder groups.
 - c. **Data analysis:** The evaluation team analysed and appraised in a systematic manner all relevant data collected in order to address the evaluation questions. A structured description of the preliminary results drawn at the end of the data collection phase was submitted to the Evaluation Office for review and redirection of the data analysis.
 - d. **Report writing:** The evaluation team presented the draft results and recommendations to the Evaluation Office. After initial feedback and fact-checking the advanced draft report was shared with the EMG for additional review and feedback. The final evaluation report was then prepared and submitted to the Evaluation Office for approval.
12. Defining the nature and scope of the Secretariat's contribution is central to this evaluation. The ex-post TOC has taken into account the Secretariat's activities at the three levels of the Organization through the Organization's six core functions, as described earlier. The six core functions, as articulated in the Eleventh and Twelfth GPWs, are the guiding tool of WHO's work as well as the critical lens through which the evaluation analyses the Secretariat's contribution to the h-MDGs. The TOC has been extensively used to address each of the evaluation questions as appropriate.
13. **Evaluation Matrix.** Based on consultations during the inception mission and selected document reviews, the evaluation team framed a detailed evaluation matrix capturing the evaluation questions and sub-questions along with measures/indicators, main source of information, data collection method, analysis methodology, and evidence of evaluability. The evaluation matrix served as a basis for developing the data collection instruments, including the list of questions for the key informant interviews with experts within and outside the Secretariat and the surveys with relevant stakeholders (Annex 3).

³ WHO (2014) Twelfth General Programme of Work, Not merely the absence of disease, World Health Organization: Geneva, p.51.

Figure 1: Theory of Change



14. Based on the evaluation matrix, the following methods of data collection were used.

- a. **Document review** (Annex 5 provides a full list of all documents reviewed), including:
 - Governing body reports;
 - GPWs, PBs and other planning, budget and strategic documents of relevance to the evaluation;
 - Technical programme reports; and
 - National planning and strategic documents and selected academic literature.
- b. **Key informant interviews:** The evaluation conducted 52 in-depth interviews with knowledgeable persons from the following groups of stakeholders:
 - Representatives of selected Member States;
 - Representatives of UN agencies, other bilateral and multilateral development partners, global health partnerships, nongovernmental organisations, civil society, professional health care associations, academia, and the private sector; and
 - WHO staff at the three levels of the Organization.

Annex 6 provides the list of stakeholders interviewed and the interview guides used to structure the key informant interviews.
- c. **Online surveys:** The evaluation developed three online surveys in close coordination with the WHO Evaluation Office (Annex 7). These surveys contained a combination of closed and open-ended questions. They were launched on the WHO DataForm (an online secure platform) during February-March 2017. They addressed:
 - (1) Member State representatives;
 - (2) WHO partners and collaborators;
 - (3) WHO staff at the three levels of the Organization.
- d. **Country case studies: There were 12 country case studies.** Countries for case studies were selected on the basis of two main criteria:
 - **Geographical representation** of all six WHO regions; and
 - **MDG achievement** based on country's progress on maternal mortality ratio and under-five mortality as a proxy for disease burden.⁴

The selection also took into account countries with fragile situations. In cases where there were multiple countries available for selection after having applied these criteria, the selection was random (see Table 1).

Table 1. Country selection

MDG achievement	African Region	Region of the Americas	Eastern Mediterranean Region	European Region	South-East Asia Region	Western Pacific Region
Met or on-track	Rwanda	Bolivia	Lebanon		Timor-Leste	
Substantial progress		Haiti		Uzbekistan	India	Viet Nam
No or limited progress	Cameroon		Somalia	Georgia		Philippines

Source: MDG achievement based on data from WHO (2015) World Health Statistics, p.25-37

In blue: countries studied through desk review and interviews; In black: Countries studied through desk review only. Countries in italics are on the 2016 Harmonized List of Fragile Situations <http://pubdocs.worldbank.org/en/700521437416355449/FCSlist-FY16-Final-712015.pdf>.

⁴ The evaluation selected the maternal mortality ratio and under-five mortality because reasonable data on progress is available over time. These are also two MDGs that have received much attention given the magnitude of the related health burden as well as slower progress in many countries.

15. **Budget data reviews:** The evaluation included an analysis of the Secretariat's budget and expenditure data contributing to h-MDGs over the period 2000-2015.
16. **Methodological issues:** The evaluation faced a number of challenges, which limited the depth and breadth of the data and information collected. Key limitations included: (i) the lack of an overarching WHO results framework at the three levels of the Organization to systematically report on WHO's contribution to the h-MDGs, leading to fragmentation of results and difficulties to evaluate against targets; (ii) a series of limitations presented by the data collection methods: the long recall period together with the limited institutional memory of interviewees and respondents of the Secretariat's work on the MDGs in the early years; (iii) a rather low response from all three groups of stakeholders, in particular, the external partners; (iv) the limited response rate for interviews from the Member States, with less than the expected numbers of stakeholders consulted; (v) a document review constrained by the limited availability of relevant headquarters and country-level documents; (vi) the evolution of the budget and planning structures over time, hampering comparability across the period; and (vii) the limited availability of budget and expenditure data at country level. Annex 4 expands on the data challenges. Despite these limitations, the evaluation findings are based on sufficient data and information from different sources which were analysed and triangulated for the assessment of the Secretariat's contribution to the h-MDGs.

2. Context for the evaluation

WHO and the MDGs

17. At the United Nations General Assembly in September 2000, the Heads of State and Government adopted the United Nations Millennium Declaration⁵ and the leaders' vision was expressed in eight time-bound goals, known as the Millennium Development Goals to be achieved by 2015 (Table 2). The 2002 Monterrey Consensus, the 2002 World Summit on Sustainable Development, and the launch of Doha Round of International Trade negotiations affirmed the commitment of countries to attain these goals. The UN Secretary-General commissioned an independent advisory body, the Millennium Project, to develop a concrete action plan to reverse the poverty, hunger and diseases affecting billions of people. The Project came up with a set of recommendations to the Secretary-General in January 2005.⁶ In September 2005 at the UN World Summit, more than 170 Heads of State and Government renewed their unambiguous commitment to the MDGs and agreed to take action to achieve the MDGs by 2015.

Table 2. Health-related MDGs and Targets

MDG Goal	MDG Target
Goal 1: Eradicate extreme poverty and hunger	1C. Halve, between 1990 and 2015, the proportion of people who suffer from hunger
Goal 4: Reduce child mortality	4A. Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
Goal 5: Improve maternal health	5A. Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
	5B Achieve, by 2015, universal access to reproductive health
Goal 6. Combat HIV/AIDS, malaria and other diseases	6A. Have halted by 2015 and begun to reverse the spread of HIV/AIDS
	6B. Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it.
	6C. Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases
Goal 7. Ensure environmental sustainability	7C. By 2015, halve the proportion of people without sustainable access to safe drinking water and basic sanitation
Goal 8. Develop a global partnership for development	8E. In cooperation with pharmaceutical companies, provide access to affordable essential medicines in developing countries

Source: UN Statistics Division (2008)

18. Six of the eight MDGs were aligned with WHO's priorities. In particular, MDGs 4, 5 and 6 targeted the reduction of mortality and morbidity associated with conditions that were among the biggest burden in the least developed countries, such as HIV/AIDS, tuberculosis, malaria, diseases of childhood and child delivery. Other MDGs addressed important health determinants, such as poverty, nutrition, education, empowerment of women and gender equality (MDGs 1, 2 and 3), environmental health (MDG 7) and financing for health and access to medicines (MDG 8). The majority of the h-MDGs have made their way into the SDGs. The SDGs include one specific goal for health – SDG 3 “Ensure healthy lives and promote well-being at all ages” with 13 indicators (Table 3). However, health is also a determinant and contributor to many other SDGs, which highlights the integrated nature of the sustainable development agenda and the need for a concerted response from all sectors.

⁵ <http://www.un.org/millennium/declaration/ares552e.htm>.

⁶ United Nations (2005) Investing in Development: A Practical Plan to Achieve the Millennium Development Goals.

Table 3. Targets in SDG Goal 3

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

Source: Sustainable Development Knowledge Platform <https://sustainabledevelopment.un.org/sdg3>

19. The evaluation reflects on the MDG agenda and on the successes and limitations of MDGs with a focus on understanding the Secretariat's contribution to the h-MDGs at the three levels of the Organization. Overall, the MDGs have been perceived as *"having galvanized concerted action around a limited number of time-bound, measurable and easy to communicate goals."*⁷ There are, however, a number of shortcomings such as the focus on the vertical approach of the health programmes through disease-specific approaches in countries, the limited focus on the importance of health system strengthening, and the focus on aggregate reporting of progress

⁷ WHO (2016) Health in 2015: From MDGs to SDGs, p.192.

rather than the equity dimension.⁸ This section presents the key issues and trends to contextualise the analysis of the Secretariat's contribution to the h-MDGs in three areas: (i) evolution of the global health landscape and support for global health; (ii) evolution of the Secretariat's programme of work and budget during the MDG era; and (iii) progress in h-MDGs over the period 2000-2015.

Evolution of the global health landscape during the MDG era

20. The Secretariat's contribution to the h-MDGs needed to be framed in the context of a rapidly changing global health landscape coupled with an unprecedented increase in resources for health, in particular for the h-MDGs.⁹ In the late 1990s and early 2000s, a series of changes began to take place in the global health architecture with the establishment of new initiatives, in part as a response to the adoption of the Millennium Declaration by Member States. Key initiatives included:

- (i) financing facilities such as the Global Alliance for Vaccines and Immunization (GAVI) (2000), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (2002) and the International Drug Purchasing Facility, UNITAID (2006);
- (ii) disease or issue-specific global partnerships such as the Roll-Back Malaria Partnership (RBM) (1998), the Stop TB Partnership (2001), the Partnership for Maternal, Newborn and Child Health (PMNCH), including the Countdown to 2015 initiative (2005), the International Health Partnership (IHP+) (2007), and the H4+ Partnership (2008), among many others;
- (iii) public-private partnerships for product development such as the International AIDS Vaccine Initiative (1996), the Medicines for Malaria Venture (1999) and the Drugs for Neglected Diseases initiative (2003);
- (iv) bilateral initiatives such as the United States President's Emergency Plan for AIDS Relief (2003) and the President's Malaria Initiative (2005); and
- (v) foundations as a major source of funding for global health priorities such as the Bill and Melinda Gates Foundation.¹⁰

21. The above initiatives and partnerships have direct bearing on the achievement of h-MDGs and hence the evaluation explored their roles throughout the evaluation process.

22. The increase in the number of actors and initiatives in global health also resulted in a massive influx in resources for global health. Between 2000 and 2014, development assistance for health (DAH) increased by an average 11.3 % annually, from US\$ 11.6 billion in 2000 to US\$ 35.9 billion in 2014, with a peak of US\$ 36.5 billion in 2013.¹¹ In relation to the h-MDGs, between 2000 and 2014 a total of US\$ 227.9 billion was mobilised for three h-MDGs (Goals 4, 5 and 6), accounting for 61.3% of all DAH during the same period (see Figure 2).¹²

⁸ Ibid.

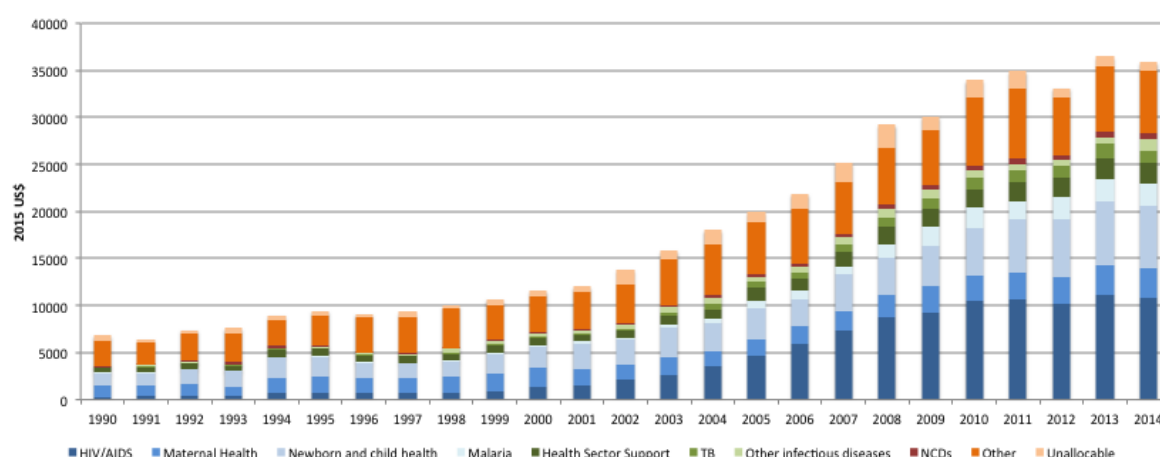
⁹ Institute for Health Metrics and Evaluation (2015) Financing Global Health 2014: Shifts in Funding as the MDG era closes, p.9.

¹⁰ Clift C. (2013) The Role of the World Health Organization in the International System, Centre on Global Health Security Working Group Papers: Chatham House, London.

¹¹ Institute for Health Metrics and Evaluation (2015), p.94-95.

¹² Institute for Health Metrics and Evaluation (2015), p.9.

Figure 2. Development assistance for health by focus area (1990-2014)



Source: Institute for Health Metrics and Evaluation, Financing Global Health, 2014 Report, data from pp. 116-117

Evolution of WHO's programme of work and budget

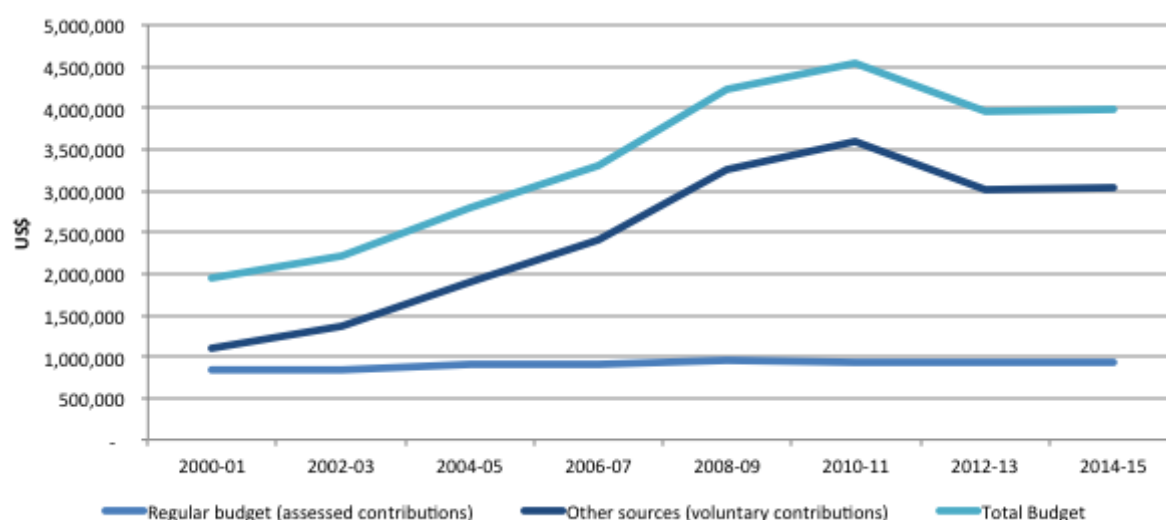
23. Over the MDG period, WHO adopted many World Health Assembly (WHA) resolutions, three GPWs and eight PBs, which provided critical inputs in setting the scope and boundaries of the Secretariat's contribution to the h-MDGs.¹³ In 2008, the WHA requested regular monitoring of progress towards the h-MDGs, and progress reports have been produced by the Secretariat since 2009.¹⁴ Some WHO regional offices also produced progress reports on MDGs with inputs from Member States to provide an overview of progress at the regional level.
24. The emergence of global health initiatives and partnerships in the late 1990s and early 2000s had strategic ramifications for the Secretariat's budget. Over the course of the MDGs, WHO's PB doubled from US\$ 1.9 billion in 2000-2001 to US\$ 3.9 billion in 2014-2015¹⁵ (having reached a peak of US\$ 4.5 billion in 2010-2011) and the composition of funding sources dramatically changed. Although the level of assessed contributions remained constant during 2000-2015, they decreased significantly as a percentage of the total budget (from 43% in the 2000-2001 biennium to 23% in 2014-2015), whilst voluntary contributions (both core and specified) increased rapidly (Figure 3).

¹³ Over the MDG period, there have been no evaluations of the Secretariat's contribution to the MDGs.

¹⁴ WHO (2008) resolution WHA61.18.

¹⁵ WHO (2013) Proposed programme budget 2014-2015, document EB132/27.

Figure 3. WHO Programme budget over MDG period



Source: Analysis using data from WHO PBs, 2000 to 2015.

25. Under the Medium-Term Strategic Plan 2008-2013 (MTSP), the Secretariat adopted a results-based management approach to determine its resource requirements leading to the adoption of an integrated budget, comprising both assessed contributions from the Member States and voluntary contributions.¹⁶ Within this context, the evaluation recognizes that a comparison of the budget and expenditures by the Secretariat's programmes contributing to the h-MDGs is important in order to understand the Secretariat's priority setting in relation to the h-MDGs.

Global progress on h-MDG targets and indicators

26. Member States have made significant progress in achieving the h-MDGs over last the 15 years.¹⁷ For example:

- The proportion of undernourished people in the developing regions declined from 23.3% in 1990-1992 to 12.9% in 2014-2016
- The global under-five mortality rate dropped from 90 to 43 deaths per 1 000 live births between 1990 and 2015
- The number of reported measles cases declined by 67% over the same period and 84% of children worldwide received at least one dose of measles vaccine in 2013 (up from 73% in 2000)
- The maternal mortality ratio declined by 45% worldwide since 1990
- The births assisted by skilled health personnel increased by 59% between 1990 and 2014
- The contraceptive prevalence among women aged 15 to 49, married or in union, increased from 55% in 1990 to 64% in 2015
- The number of people living with HIV receiving antiretroviral therapy (ART) increased from 800 000 in 2003 to 13.6 million in 2014, and ART averted 7.6 million deaths from AIDS between 1995 and 2013
- New HIV infections fell by about 40% between 1990 and 2013
- The global malaria incidence rate fell by 37% and mortality rate by 58% by 2015

¹⁶ WHO (2007) MTSP 2008-2013, p. 11.

¹⁷ United Nations. The Millennium Development Goals Report 2015.

[http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20\(July%2015\).pdf](http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%2015).pdf).

- The tuberculosis mortality rate fell by 45% and the prevalence rate by 41% between 1990 and 2013
 - The population using an improved drinking water source increased from 76% in 1990 to 91% in 2015, and
 - The proportion of people practicing open defecation declined by half since 1990 and worldwide 2.1 billion people have gained access to improved sanitation.
27. The above achievements are impressive but there are substantial differences across regions and countries. In addition, the achievements fell short of the target in a number of areas. The MDGs officially ended in 2015 and a good part of the MDG agenda (including health) has now been included in the 2030 Agenda on SDGs, although the SDGs reflect a different set of global aspirations and implementation challenges.

From h-MDGs to SDGs

28. Since the goal of this evaluation is to inform the Secretariat in framing its contribution to the health-related SDGs, it is worth considering the similarities and points of departure between the h-MDGs and the new development agenda.
29. SDG3, *“Ensure healthy lives and promote well-being for all at all ages”*, with its 13 targets, condenses a broad spectrum of health priority issues. In addition, health is closely linked to many of the other 16 proposed goals, and it also contributes to and benefits from all the other goals. For example, health is a contributor to, and a beneficiary of, poverty reduction, hunger relief and improved nutrition, safer cities, clean water and sanitation, reduction in violence and discrimination against women, and so on. The Secretariat has recognized that the SDGs cannot be seen in terms of a direct expansion from the h-MDGs. The SDGs are substantially different from the MDGs in the way they are expected to operate in health systems and global health.¹⁸ The SDG are interrelated and health matters are underlying most of them. Their interconnection and the recognized importance of health as a goal and a factor for development call for a strong emphasis on fostering integrated work and for focusing on strengthening the foundations and structural dimensions of health systems in the broader sense. Only strong health systems working in interconnected cross-sectoral service environments can deliver on all the SDGs. The SDGs, thus, offer a platform for *“placing health in all sectors of policy-making”*¹⁹ and appeal to enhanced intersectoral work as well as to strong horizontal work within the health sector itself.
30. Furthermore, health systems are central to the sustainable development agenda as exemplified by the SDG emphasis on strengthening universal health coverage. This new paradigm is very different from the one fostered by the MDGs which concentrated on specific health issues.
31. While the h-MDGs focused exclusively on defined public health goals and targets, the SDGs are broader, encompassing social, environmental and economic aspects and **“targets are defined as aspirational and global.”**²⁰ The decision on their specification is left to individual Member States, which own their targets. Each country has the primary responsibility **to set its own national targets** *“taking into account different national realities, capacities and levels of development and respecting national policy space and priorities.”*²¹
32. The focus of the SDGs, as opposed to the MDGs, is not national progress in meeting targets, but **instead** the **egalitarian** progress across all segments of the population, in particular, across the most vulnerable. The emphasis on equity, expressed by the SDG motto of *“no one will be left*

¹⁸ WHO (2016) Health in the 2030 Agenda for Sustainable Development. Document A69/15.

¹⁹ WHO (2017) Progress in the implementation of the 2030 Agenda for Sustainable Development. Document EB140/32.

²⁰ United Nations General Assembly (2015) Transforming our world: the 2030 Agenda for Sustainable Development. Resolution A/RES/70/1.

²¹ Ibid

behind” implies reducing country inequalities, while achieving overall progress in meeting the defined targets.

33. Another differential characteristic of the SDGs with respect to the MDGs is the country-led ownership and increased responsibility in financing their contribution to the global goals. Countries are requested to more definitely **take the lead for** their own development in a context of rapid economic growth of many middle- and low-income economies.²² Furthermore, the global financial context of the post-2015 health agenda is very different from the previous decade of the MDGs. With traditional donor countries’ economies facing increasing difficulties, it seems very plausible that the flows and magnitude of the DAH will change.
34. The final point concerns measurement and monitoring. The emphasis on monitoring characterized the MDG agenda, where tracking of country progress on goal achievement became one of the major incentives for sustaining momentum across the global health community. At the moment, there are no official indicators to measure SDG progress; though the targets are defined in a similar manner to the MDGs offering the possibility of establishing commonly agreed measures of progress. However, one of the guiding principles of the SDGs is that the monitoring process will be voluntary and country led.²³ Hence indicators of progress may be more fluid, and the role of countries in measurement may be more active than in the past. This also represents a major point of departure from the previous agenda.
35. To end, in May 2016, the WHA²⁴ mandated the Secretariat to address the sustainable development agenda with a multi-prong action plan, including: the promotion of a multisectoral approach and improved collaboration across WHO programmes; the reinforcement of WHO’s engagement in the context of the United Nations system-wide strategic planning, implementation and reporting; the development of a long-term plan for maximizing the impact of WHO’s contribution; the development, as appropriate, of SDGs indicators; the support to Member States in strengthening research and development in various fundamental health system domains as well as in strengthening their statistical and monitoring capacities; the enhancement of North-South and South-South cooperation on access to science and innovation; and the support to thematic reviews of progress. This is a broad and ambitious agenda that raises the expectations of this evaluation to provide useful lessons to inform the Secretariat in shaping its contribution to the 2030 Agenda.

²²WHO (2016) Health in the 2030 Agenda for Sustainable Development. Document A69/15.

²³WHO. World Health Statistics 2017: Monitoring Health for the SDGs.

²⁴WHO (2016) Health in the 2030 Agenda for Sustainable Development. Resolution WHA69.11 .

3. Evaluation Findings

36. The findings of the evaluation are presented following the four main evaluation questions and sub-questions identified in the TOR (see Annex 1 for the full list).

Evaluation question 1: How did the Secretariat respond to the Millennium Declaration?

37. The Millennium Declaration, adopted by 189 Member States at the United Nations General Assembly in September 2000, echoed, inter alia, the most pressing global health issues at the time and shaped a global agenda for collective action. Three MDGs specifically addressed major public health priorities (MDG 4 reduce child mortality, MDG 5 improve maternal health and MDG 6 combat HIV/AIDS, malaria and other diseases) while other significant public health issues were also included as part of broader MDGs (such as MDG 1 eradicate extreme poverty and hunger, MDG 7 ensure environmental sustainability and MDG 8 develop a global partnership for development). The WHO Secretariat, as the leading international public health agency, was directly concerned with leading the global response to the h-MDGs. This section assesses how the Secretariat responded to the adoption of the MDGs and discusses the main factors which influenced its response.

Initial response

The World Health Assembly (WHA) mandated the Secretariat to respond to h-MDGs.

38. As early as 2001, the WHA²⁵ noted “*continuing effort to improve the integration of WHO’s work in the ... Millennium Declaration*”. In 2002, the WHA adopted resolution 55.19 entitled “*WHO’s contribution to achievement of the development goals of the United Nations Millennium Declaration*” which provided the Secretariat the overarching mandate to address the h-MDGs. It also requested the Director-General to work in five areas: (i) to generate resources for research to improve health in developing countries; (ii) to consider the recommendations of the Commission on Macroeconomics and Health; (iii) to report on WHO’s strategy for child and adolescent health and development; (iv) to develop a strategy for accelerating progress towards attainment of international development goals and targets related to reproductive health; and (v) to promote reporting on progress towards internationally agreed goals and targets in the area of reproductive health.

39. The WHA mandate was given to the Secretariat more or less at the same time and with a similar scope as those of other UN agencies.²⁶ Following this initial mandate, the WHA adopted resolutions further clarifying the role of WHO.^{27,28} At the regional level, it took some more time for the Regional Committees to adopt their own resolutions defining priorities for the Regional

²⁵ WHO (2001) document A54/32.

²⁶ UNDP’s first Executive Board Resolution on the h-MDGs was in 2002 (EB Decision 2002/8) merely recognizing the role of UNDP in the implementation of the MDGs. Decisions 2003/8 and 2004/8 described UNDP’s role in support of the MDGs. UNIDO’s Resolution on the MDGs was issued at the end of 2003 (GC10/Res3 Role of UNIDO in achieving the Millennium Development Goals, December 2003). See UNDP (2015) Evaluation of the role of UNDP in supporting national achievement of the Millennium Development Goals, UNDP: New York, p.27, and UNIDO (2012) Independent Thematic Evaluation: UNIDO’s contribution to the Millennium Development Goals, UNIDO; Vienna, p.3.

²⁷ WHO (2005). Accelerating achievement of the internationally-agreed health-related development goals, including those contained in the Millennium Declaration. Resolution WHA58.30.

²⁸ WHO (2008) Monitoring of the achievement of the health-related Millennium Development Goals. Resolution WHA61.18.

Directors and Member States to address the h-MDGs, with some Regional Committees issuing relevant resolutions in 2004, and some others as late as 2007.²⁹

There was no explicit reference to the h-MDG priorities in the Tenth General Programme of Work (2002-2005).

40. The h-MDGs reflected major public health issues of the time and as such were already part of the WHO GPW even before the MDG launch. The WHO Director-General reported to the Fifty-fifth WHA in 2002: *"There is already a considerable degree of alignment in the direct health goals as nations drew on the existing body of work to build the Millennium Declaration."*³⁰ Nevertheless, the first GPW of the MDG era, the Tenth GPW 2002-2005, did not include any explicit reference to the MDGs, despite featuring strategies to combat malaria, tuberculosis and HIV/AIDS, and to improve maternal and child health.
41. Reflecting on the lack of explicit alignment early on, existing programmes related to the h-MDGs continued "working as usual" during the early stage of the MDG era given that the MDGs did not demand major shifts in the way the Secretariat was working. Feedback gathered during the interviews suggests that, initially, the Secretariat did not systematically position itself as leader on the h-MDGs. Some interviewees even acknowledged that *"there was no [early] recognition of the potential [of the MDGs]."* Furthermore, there was the initial perception that the MDG agenda pertained mostly to headquarters and regional offices and was possibly a tool for resource mobilisation and advocacy for some programmes.

At the same time the Secretariat played a clear role in strengthening some of the h-MDGs.

42. The Secretariat contributed to the extension of the global development agenda with the emphasis on otherwise overlooked health priorities, such as neglected tropical diseases (NTDs) and reproductive health. In particular, it helped reposition health issues in a more comprehensive and public health-oriented manner, for instance placing newborn health at the centre of MDG 5 and environmental problems (e.g. water supply and sanitation (MDG 7c)) as an integral component of public health.
43. The Secretariat also influenced the refinement of some health-related global goals and targets. Concretely, the Secretariat, guided, among other things, the development of targets for tuberculosis control³¹ and HIV treatment. The Secretariat also took the lead in the global response to MDG 6 with the WHO HIV/AIDS Global Health Sector Strategy (2002) and the launch of the *"3 by 5" Initiative*³² together with UNAIDS (2003). It also included indicators on reproductive health and sanitation.

Initially WHO staff had mixed views on the Secretariat's reaction to the MDG agenda.

44. The staff survey results (Figure 4) reflect their understanding of WHO alignment with the h-MDGs. Indeed, 82% of the staff considered that their department, division or country office's programme of work was already aligned with the h-MDGs in the early stages of the MDG era, while at the same time 84% of the staff considered that their department, division or country office developed a specific response to address relevant h-MDG targets and/or indicators during

²⁹ See PAHO CD45/R3 in 2004; and EUR/RC57/R2 and WPR/NTD58/R2 in 2007.

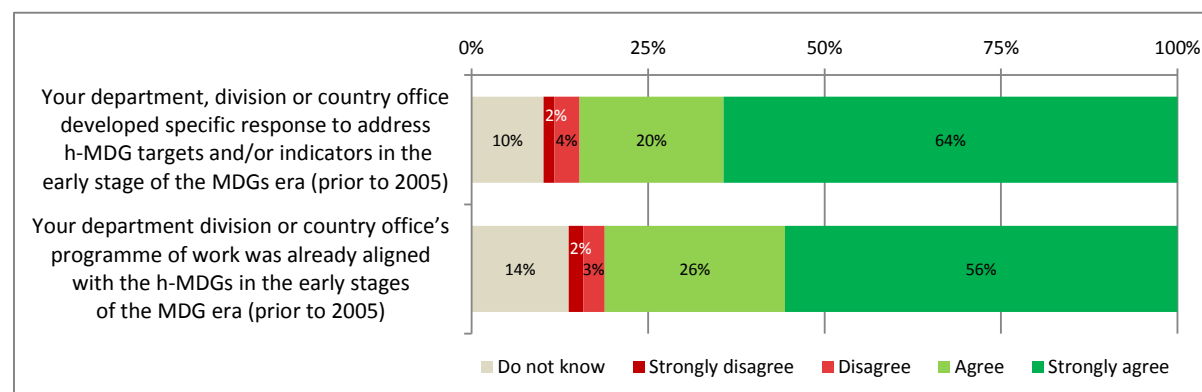
³⁰ WHO (2002) WHO's Contribution to achievement of the development goals of the United Nations Millennium Declaration: Note by the Director-General. Document A55/6, p.2, para.6.

³¹ Dye C, Maher D, Weil D, Espinal M, Raviglione M. Targets for global tuberculosis control. *International Journal of Tuberculosis and Lung Disease* 2006; 10(4); 460-2.

³² The "3 by 5" initiative, launched by UNAIDS and WHO in 2003, was a global target to provide three million people living with HIV/AIDS in low- and middle-income countries with life-prolonging ART by the end of 2005. It was a step towards the GOAL of making HIV/AIDS prevention and treatment accessible for all in need as a human right.
<http://www.who.int/3by5/en/>.

the same period. This seems to indicate that while the Secretariat considered itself already aligned with the h-MDGs, these were also perceived as a unique opportunity to build on and further elaborate a more specific response at target/indicator levels.

Figure 4. WHO staff assessment of the Secretariat's early response (prior to 2005) to the global MDG initiative



Source: WHO staff survey results

The Secretariat's evolving response

There was progressive alignment of the programme of work and budget in the mid-2000s.

45. The PB 2004-2005 showed some degree of alignment of WHO's programmatic goals with the h-MDGs.³³ This initial alignment was subsequently consolidated in the PB 2006-2007 where the h-MDGs served as one of the guiding principles for priority setting: *"priority areas identified on the basis of recent Health Assembly resolutions and global and regional commitments such as the Millennium Development Goals"*.³⁴ Such alignment between WHO priorities and the h-MDGs was further elaborated in the Eleventh GPW which covered a *"10-year period from 2006 to 2015, coinciding with the timeframe for achieving the Millennium Development Goals."*³⁵

46. Despite the explicit mandate given by the 2005 WHA resolution, there is no evidence of *"a coherent and adequately resourced strategy ... for advancing work in the [relevant] areas"*.³⁶ Even though the MTSP 2008-2013³⁷ showed increased alignment with the MDGs, this was unequally achieved across programmes, with some strategic objectives showing convergence at the level of principles and overarching goals, while others reflecting closer convergence at target levels.

The adoption of the h-MDGs later on became the global framework for all relevant programmes.

47. According to most WHO staff interviewed, the h-MDGs became the global framework guiding their relevant work programmes, particularly at headquarters, but also in other major offices. They developed into *"a driving force within departments."* The h-MDGs in turn enhanced the visibility of those areas directly related to the goals. Furthermore, programmes gradually became more aware of the opportunities offered by the h-MDGs and they shaped their priorities

³³ WHO (2003) Programme budget 2004-2005 Part I: Policy and Budget for One WHO, p.1.

³⁴ WHO (2005) Programme budget 2006-2007, p.3.

³⁵ WHO (2005) Engaging for Health, Eleventh General Programme of Work 2006-2015, A Global Health Agenda, Forward.

³⁶ WHO (2005) Accelerating achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration. Resolution WHA 58.30.

³⁷ WHO (2017) Medium-Term Strategic Plan 2008-2013. Available at http://apps.who.int/gb/archive/pdf_files/AMTSP-PPB/a-mtsp_3en.pdf http://apps.who.int/gb/archive/pdf_files/AMTSP-PPB/a-mtsp_1en.pdf.

to more clearly fit with the framework. Most WHO staff interviewed concluded that the h-MDGs helped to focus and accelerate the work of programmes directly related to the goals.

48. A consequence of the MDG model based on targets and indicators was an increased emphasis on tracking, monitoring and reporting progress which also pushed for prioritizing around the selected indicators. The emergence of the Water, Sanitation and Hygiene (WASH) programme is an example. In a similar way, the focus on child mortality led to reshaping the WHO strategy for child health as well as to an acceleration of the work of the immunization programme.

Monitoring and reporting progress on the MDGs became a core part of the Secretariat's response.

49. In 2008, the WHA mandated the Secretariat to report annually on progress towards the achievement of the MDGs,³⁸ following earlier resolutions and documents on the MDGs in 2003, 2005 and 2007. In 2005, WHO launched the World Health Statistics Report and in 2008 established the Global Health Observatory, the major function of which was *"to monitor progress towards attaining the health-related Goals."*³⁹ The heightened focus on reporting provided an impetus to WHO programmes to work together *"to strengthen the information and evidence culture of the Organization"*⁴⁰ and also to support Member States in strengthening the capacities of their health information systems.
50. Most technical departments involved in the MDGs collaborated with the Global Health Observatory, as well as with other UN agencies and development partners, in the production of data estimates. Such collaboration involved regional and country offices and reportedly led to important developments in terms of data quality, data standards and capacity building.

The vertical response from the Secretariat reflected the MDG design.

51. The MDG design along diseases and targets promoted vertical collaboration among the same technical programmes across the three levels of the Organization and limited the functional interactions with other programmes that were less or not at all involved in the MDGs.
52. The evaluation found clear examples of synergy building but mainly among programmes related to similar goals. Thus, the Secretariat adapted some of its structure to facilitate its response to the MDGs. For instance, a new department on HIV/AIDS was established in December 2000 to provide a more strategic Organization-wide response to the HIV/AIDS epidemic.⁴¹ It was followed in 2003 by the creation of a new cluster to foster synergies in addressing the three major communicable diseases (HIV/AIDS, tuberculosis and malaria) and to coordinate more effectively with the GFATM and other global initiatives.⁴² The NTD programmes joined the same cluster.
53. The WHO programmes on Child and Adolescent Health and Making Pregnancy Safer merged in 2010 to build synergies across MDGs 4 and 5. Other adjustments involved the alignment of workplans along MDG targets and indicators, or the appointment of focal points in regional and country offices for coordination and communication with Member States.
54. 77% of the staff surveyed confirmed that their department, division or country office was restructured to reflect adequate attention to the MDGs (Figure 5).

³⁸ WHO (2008) Monitoring the achievement of the health-related Millennium Development Goals. Resolution WHA61.18.

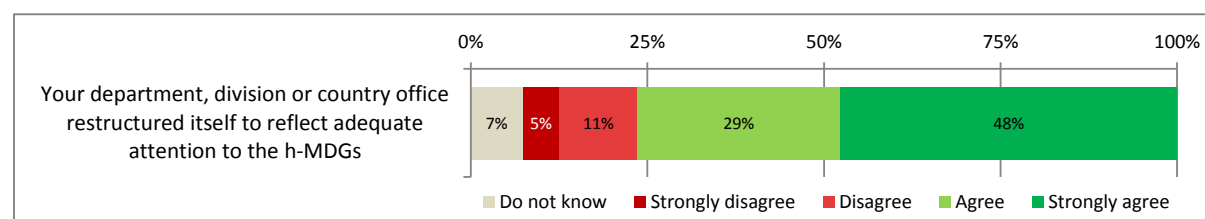
³⁹ WHO (2008) Monitoring the achievement of the health-related Millennium Development Goals, Report by the Secretariat. Document A61/15 page 4, para.18.

⁴⁰ WHO (2007) Strengthening of health information systems. Resolution WHA60.27.

⁴¹ WHO (2002) Follow-up on the UN General Assembly Special Session on HIV/AIDS: Work of WHO, Progress Report. p.5.

⁴² WHO (2004) Strategic Plan for WHO's work in the Roll Back Malaria partnership 2004-2009, p.24.

Figure 5. WHO staff assessment of the internal restructuring to respond to the global MDG initiative



Source: WHO staff survey results

The vertical response had adverse effects on cross-cutting issues.

55. The Secretariat adjusted its organizational structure to facilitate synergies within related areas of work, but in general there were no mechanisms to facilitate cross-departmental work. According to feedback gathered in the evaluation, collaboration relied mostly on goodwill and inter-personal informal relationships and was based on joint planning exercises and meetings to favour communications and sharing of information. The majority of interviewees echoed the benefits of such approaches.
56. Collaboration was amplified along shared objectives but this did not facilitate the advancement of integrated strategies to tackle underlying health system issues in Member States, despite advocacy by the Secretariat for horizontal and integrated action particularly towards strengthening health systems. For instance, some departments sought to overcome this situation by adopting intervention-based approaches beyond disease-specific outcomes. For example, the WHO programme for NTDs promoted an integrated set of interventions rather than specific disease targets; and the WHO programmes on Child and Women's Health adopted the continuum of care approach to guide WHO's work in the area.
57. Nevertheless, overall the Secretariat's response was dominated by an approach imposed by the vertical culture of the MDGs, which relied heavily on voluntary contributions from the Member States.

The vertical response was amplified by limited communication and coordination across programmes during the early years.

58. The Secretariat faced challenges arising from limited communication and collaboration and weak joint planning across major offices, and lack of a designated structure, such as liaison personnel, to facilitate coordination across the Organization on h-MDG work, particularly during the early years of the era.⁴³ A 2004 WHO report indicated *"Coordination of the overall health and development agenda has been constrained by organizational fragmentation within WHO; there is a growing need for*

Adverse effects of vertical programming

The MDG framework has also been criticized for focusing attention and resources on the attainment of particular goals at the expense of others. This is, of course, in the nature of focusing, but the criticism raises important issues nonetheless. The focusing "problem" has been particularly apparent with regard to the health goals, where resources and effort have been directed at strengthening certain disease-specific or "vertical" programmes, often at the expense of broader, cross-cutting investments in health systems that can deal with all health issues in a more integrated manner. This emphasis on vertical approaches has often resulted in separate strategic plans, monitoring mechanisms, funding streams and implementation efforts, with only limited investment in harmonization and alignment across programmes.

Source: WHO, 2016, 'Health in 2015 from MDGs to SDGs'.

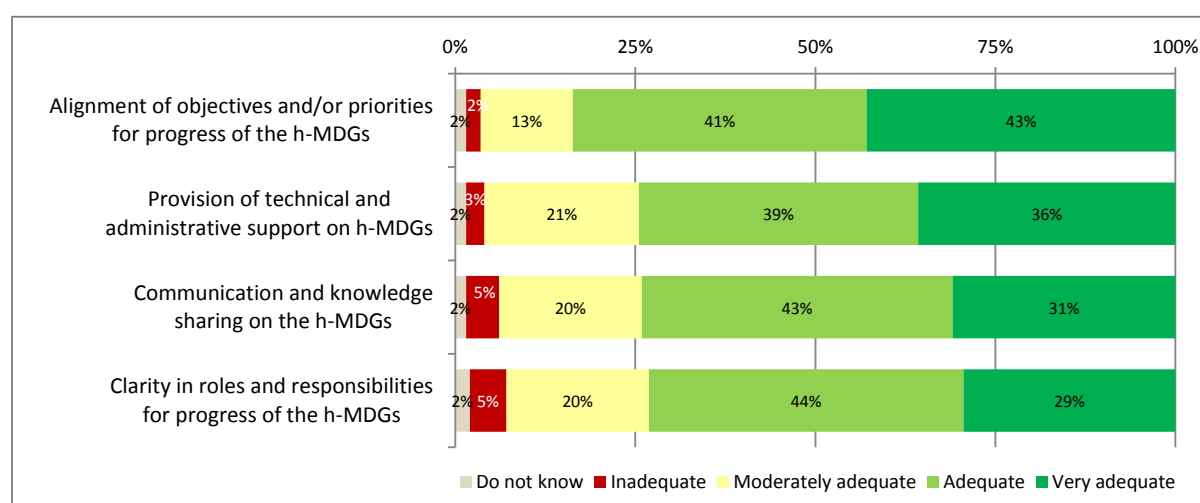
⁴³ WHO (2006) Programme budget 2004-2005 Performance Assessment Report.

interunit and interdivisional collaboration especially in respect of activities for achieving the Millennium Development Goals.”⁴⁴ In some cases those limitations led to duplication of work and to missing potentially beneficial synergies.⁴⁵

The Secretariat’s response was supported by positive collaboration on h-MDGs across the three levels of the Organization.

59. Most people interviewed recognized that the MDGs influenced the ways of working of the Secretariat across its three levels. Furthermore, the majority of concerned WHO staff perceived collaboration on the h-MDGs as adequate or strongly adequate when it came to alignment of objectives and priorities (84%), technical and administrative support (75%), knowledge sharing (74%) and clarity of the roles and responsibilities (73%) across the three levels of the Organization (Figure 6).

Figure 6. WHO staff assessment of the collaboration across the three levels of the Organization in contributing to the h-MDGs



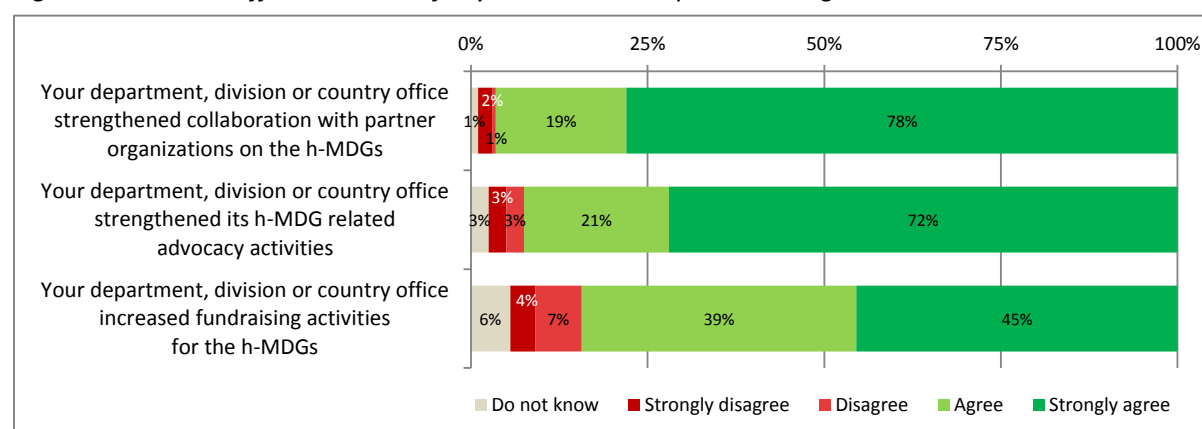
Source: WHO staff survey results

60. The staff survey results (Figure 7) show that almost all (97%) of the departments, divisions or country offices strengthened their collaboration with partner organizations on the h-MDGs (further elaborated in evaluation question 4). 93% strengthened their advocacy activities and 84% increased their fund raising activities. Though it is also worth noting that 11% of the respondents did not find that fund raising activities increased (see further details on fund raising below).

⁴⁴ WHO (2004) Programme Budget 2002-2003 Performance Assessment Report, p.79.

⁴⁵ WHO (2006) Evaluation of WHO’s contribution to “3 by 5”: main report.

Figure 7. WHO staff assessment of key activities to respond to the global MDG initiative



Source: WHO staff survey results

Funding for the MDGs

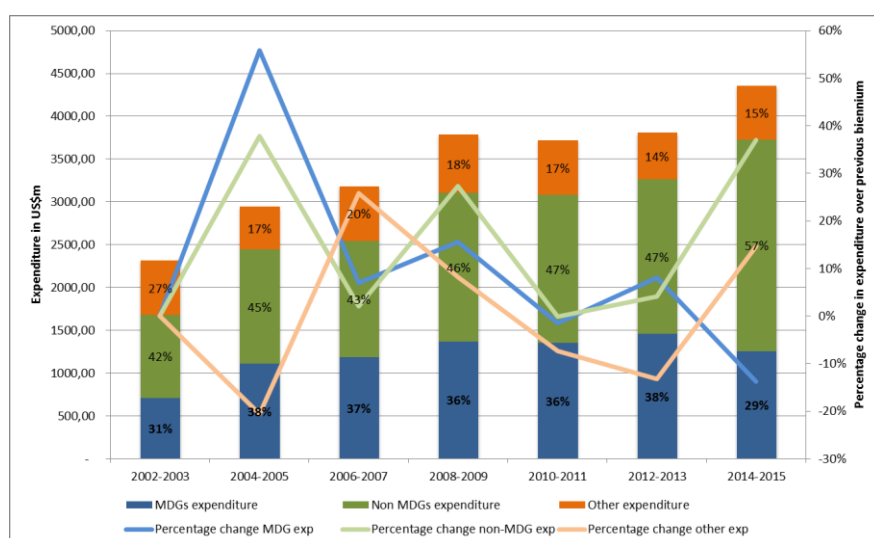
61. The Secretariat's overall budget more than doubled during the MDG period, from US\$ 1.9 billion in 2000-2001 to US\$ 3.9 billion in 2014-2015,⁴⁶ with a peak of US\$ 4.5 billion in 2010-2011. This increase resulted in substantial growth for both MDG and non-MDG related programmes. However, as the MDG budget more than doubled, the non-MDG⁴⁷ budget almost tripled over the 15-year period.
62. However, from 2000 onwards, WHO relied more intensively on voluntary earmarked contributions, while assessed contributions remained constant. The relatively limited availability of unspecified funds constrained the ability of WHO to plan its activities. Several interviewees suggested that it also limited WHO's responsiveness to requests from Member States and the achievement of Organization-wide expected results. Earmarked voluntary contributions tended to be aligned more closely with donor priorities and were less flexible in supporting other WHO priority areas of work. Stakeholders agreed that this resulted in less predictable and highly specified funding flows for WHO programmes at all levels and reinforced the "verticalization" of WHO's work in addition to posing an extra burden due to additional fundraising and donor reporting requirements.
63. The expenditure in real terms for MDG programmes increased substantially and at a faster rate than the overall organizational spending at the beginning of the period until 2005. It then continued growing at a more balanced rate until 2009, and even decreased during 2010-2011 and 2014-2015. Most of the initial increase was due to substantial growth (over 90% increase) of the budget of the three major disease programmes under MDG 6 (HIV/AIDS, tuberculosis and malaria), and particularly of HIV/AIDS in the year after the MDG launch. Expenditure for the rest of the MDG-related programmes took off from the 2004-2005 biennium though at a slower pace.
64. The expenditure for non-MDG programmes increased more steadily from 2000-2001 and surpassed that of the MDG programmes from 2010-2011 onwards.⁴⁸ This raises a question about the Secretariat's ability to attract funding for the h-MDGs. This could be due in part to the influx of various global health initiatives supporting the h-MDGs. Figure 8 shows expenditures for the MDG and non-MDG programmes.

⁴⁶ WHO (2013) Proposed programme budget 2014–2015. Document EB132/27.

⁴⁷ It is worth noting that the categories MDG and non-MDG do not encompass an equal number of programme areas nor address an equal volume of disease burden. The comparison is established to consider trends only.

⁴⁸ The allocation of entire programme lines to specific MDGs categories has some limitations, as not all activities within a budget line pertain to the same category.

Figure 8. WHO expenditures by MDG and non-MDG categories and percentage increase, 2000-2015



Non-MDGs includes: technical programmes such as NCDs, mental health, emergencies, health systems. Other: includes non-technical programmes such as corporate management and other functions. Source: Analysis based on WHO PB data.

Table 4. WHO expenditures per MDG and non-MDG areas of work

Categories	2002-2003	2004-2005	2006-2007	2008-2009	2010-2011	2012-2013	2014-2015
Expenditure							
MDGs expenditure	\$ 710,52	\$ 1.107,38	\$ 1.185,28	\$ 1.369,59	\$ 1.349,64	\$ 1.458,23	\$ 1.256,89
Non MDGs expenditure	\$ 967,57	\$ 1.333,07	\$ 1.360,88	\$ 1.732,30	\$ 1.731,26	\$ 1.801,79	\$ 2.467,62
Other expenditure	\$ 634,31	\$ 503,95	\$ 633,81	\$ 686,23	\$ 636,00	\$ 551,98	\$ 632,97
Total WHO expenditure	\$ 2.312,40	\$ 2.944,40	\$ 3.179,96	\$ 3.788,11	\$ 3.716,90	\$ 3.812,00	\$ 4.357,49
% change							
MDGs	-	56%	7%	16%	-1%	8%	-14%
Non MDGs	-	38%	2%	27%	0%	4%	37%
Other	-	-21%	26%	8%	-7%	-13%	15%
Total % change in expenditure	-	27%	8%	19%	-2%	3%	14%

Non-MDG includes: technical programmes such as NCDs, mental health, emergencies, health systems. Other: includes non-technical programmes such as corporate management and other functions. Source: Analysis based on WHO PB data

External influencers

65. WHO's response to the MDGs should not be looked at in isolation from the global health discourse at the time, the trends in development assistance, and the changes that took place in the global health architecture. All were critical in the framing and articulation of the WHO response.

The Secretariat's increasing budget reflected global trends but lagged behind the substantial growth in DAH.

66. From 2000 to 2010 DAH grew annually by an average 11.4%.⁴⁹ This increase responded to the growing determination of Member States of the OECD Development Assistance Committee for concerted and sustained action to address the developmental challenges of most low-income nations. While health was recognized as a major factor for development and economic growth, the HIV/AIDS epidemic along with the other poverty-related diseases (e.g. tuberculosis, malaria and later NTDs) were considered as major risks to the economic and human development of countries.

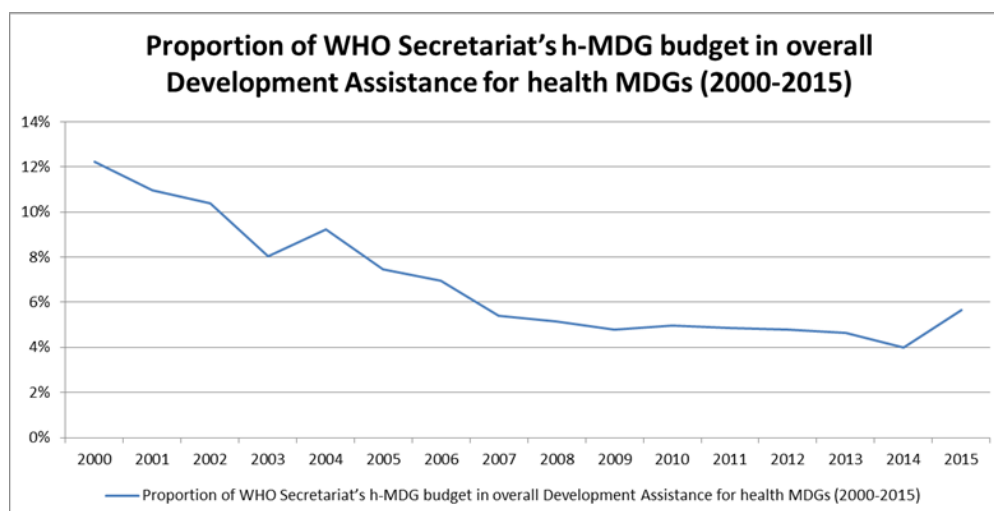
67. From 2010 to 2015, total DAH levelled off and priorities shifted towards child and women's health, while the funding for the three major diseases was contained or even diminished.⁵⁰ The Secretariat benefitted only partially from the global rise in DAH: WHO's DAH allocations doubled

⁴⁹ Institute for Health Metrics and Evaluation (2015), p. 13.

⁵⁰ Institute for Health Metrics and Evaluation (2015), p.94-95.

from US\$ 1.4 billion in 2000 to US\$ 2.1 billion in 2015, peaking at US\$ 2.2 billion in 2010;⁵¹ however, in relative terms, the share of DAH received by the Secretariat diminished significantly over the same period (from 16% in 1990 to 6% of overall DAH in 2015) due partly to the entry of new actors and initiatives in the global health space and possibly to the limited ability of the Secretariat to credibly attract funding (Figure 9).

Figure 9. Proportion of the Secretariat's h-MDG budget in overall DAH for the h-MDGs (2000-2015)



Source: IHME 2015. Note: WHO data excludes the proportion of DAH channelled directly by the Pan American Health Organization.

68. The Secretariat's budget allocation also reflected the global trends, with significant allocations for the three major diseases, HIV/AIDS, tuberculosis and malaria, in the earlier years of the MDG era, and a gradual, although slower, catch-up by the child and women's health programmes since 2008.

WHO was responsive to the global health discourse.

69. Several examples show the mutual influence between the global health discourse and the Secretariat's responsiveness to the MDGs. For example, the Secretariat established the pre-qualification of medicines programme (2001) to *"guide UN agencies and other international organizations with respect to the quality of antiretroviral medicines for supply to low-income countries"*⁵² in the context of strong societal demands for enhanced treatment availability by people living with HIV/AIDS in developing countries⁵³ associated with the market expansion for antiretroviral medicines. Starting in early 2000s, DAC members strongly advocated for the alignment and harmonization of international aid.⁵⁴ The Secretariat participated in these initiatives and, in 2007, co-founded and became the co-host of the International Health Partnership initiative (IHP+) aimed at operationalizing the principles of aid effectiveness in

⁵¹ Institute for Health Metrics and Evaluation (2015) Dataset B1 DAH By Channel of Assistance 1990-2015, <http://www.healthdata.org/policy-report/financing-global-health-2015-development-assistance-steady-path-new-global-goals>.

⁵² WHO (2017) Prequalification of medicines programme, Overview: History and Mission, available at <https://extranet.who.int/prequal/content/overview-history-mission>.

⁵³ Results from the WHO staff survey suggest that global civil society movements had a positive influence on WHO's response to the h-MDGs (80% of WHO staff stated it had either positive or significant positive influence).

⁵⁴ These initiatives include: Rome Declaration on Harmonization in 2002; Paris Declaration on Aid Effectiveness in 2005; Accra Agenda for Action in 2008; and the Busan Partnership for Effective Development Cooperation in 2011. See OECD High Level Fora on Aid Effectiveness: A History <http://www.oecd.org/dac/effectiveness/thehighlevelforaonaideffectivenessahistory.htm>.

response to the need to accelerate progress on the h-MDGs.⁵⁵ In 2010, the launch of the Global Strategy for Women's and Children's Health by the UN Secretary-General catalysed attention to women's and children's health in light of the limited progress being made. The Secretariat led the strategy's implementation.⁵⁶ It also adopted the life-course continuum of care approach to the health of women and children by establishing the Maternal, Newborn, Child and Adolescent Health department.⁵⁷ In the context of increasing accountability to the global strategy, the Secretariat was tasked to convene a Commission on Information and Accountability for Women's and Children's Health aimed at developing a framework to ensure that the *"promises of resources for women's and children's health were kept and that results were measured."*⁵⁸

The changing global health architecture influenced the Secretariat's contribution to the h-MDGs.

70. The MDG era saw the emergence of a number of multilateral and multistakeholder bodies that become essential actors in the global health arena. The GAVI Alliance (2000) and the GFATM (2002), as primarily funding mechanisms, pushed the Secretariat to reposition itself and reinforced its normative and technical support role. The Secretariat played a key role in supporting Member States in the development of funding proposals for GFATM and GAVI and in the in-Country Coordination Mechanisms (CCM), facilitating the coordination of technical support, decision-making on funding proposals and performance monitoring for funded grants. In response to issues raised in relation to the opportunity cost of deploying such functions at country level,^{59,60} WHO and the GFATM signed in 2014 an agreement to support country offices in the development of funding proposals under a new GFATM Funding Model.⁶¹
71. Other multistakeholder bodies, in the form of WHO hosted partnerships, such as the RBM Partnership (1998), the Stop TB partnership (2000), the PMNCH (2005), the International Drug Purchasing Facility, UNITAID, (2006) and others,⁶² became key actors *"driving advocacy and coordinating action"*⁶³ in support of the MDGs, and extended the reach of WHO's work: *"[hosted partnerships] have also provided broader platforms that facilitate the participation and engagement of a variety of stakeholders including governments, intergovernmental organizations, nongovernmental organizations, civil society and the private sector. Furthermore,*

⁵⁵ IHP+ (2007) A Global Compact for achieving the Health Millennium Development Goals, available at https://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Tools/Global_Compact/IHP_Global_Compact_66_countries_May_2016.pdf.

⁵⁶ WHO (2017) Ten years in public health, 2007–2017: report by Dr Margaret Chan, Director-General, p.124.

⁵⁷ WHO (2012) Maternal, newborn, child and adolescent health: progress report 2010–2011: highlights, p.5.

⁵⁸ WHO (2017) Ten years in public health, 2007–2017: report by Dr Margaret Chan, Director-General, p.124.

⁵⁹ *"The establishment of the GFATM is creating significant demands on WHO country offices. WR/LOs and technical staff have been called on to assist in the creation and functioning of CCMs, including facilitating coordination among major stakeholders; to provide technical support in the development of proposals and, where proposals have been successful, to help respond to TRP questions and assist in grant negotiations. As GFATM grants move progress with implementation, the level of demand on country offices is likely to increase dramatically"*. In WHO (2005) Guidance paper on GFATM related activities in WHO, p.13.

⁶⁰ *"The creation of the Global Fund has resulted in a substantial increase in demand for WHO services at country, regional and global levels. This has had serious implications for WHO capacity and resources. For example, some country offices report spending as much as 30% of staff time on Global Fund-related issues over the course of several biennia."* In WHO's Guide on support to countries in accessing Global Fund money (2015). p.70.

⁶¹ WHO (2015) WHO support to countries in accessing and utilizing resources from the Global Fund: A Handbook, April 2015, p.70–72.

⁶² The evaluation notes that a number of such partnerships are no longer housed at WHO. However, the change in hosting arrangements took place at the end of the MDG period.

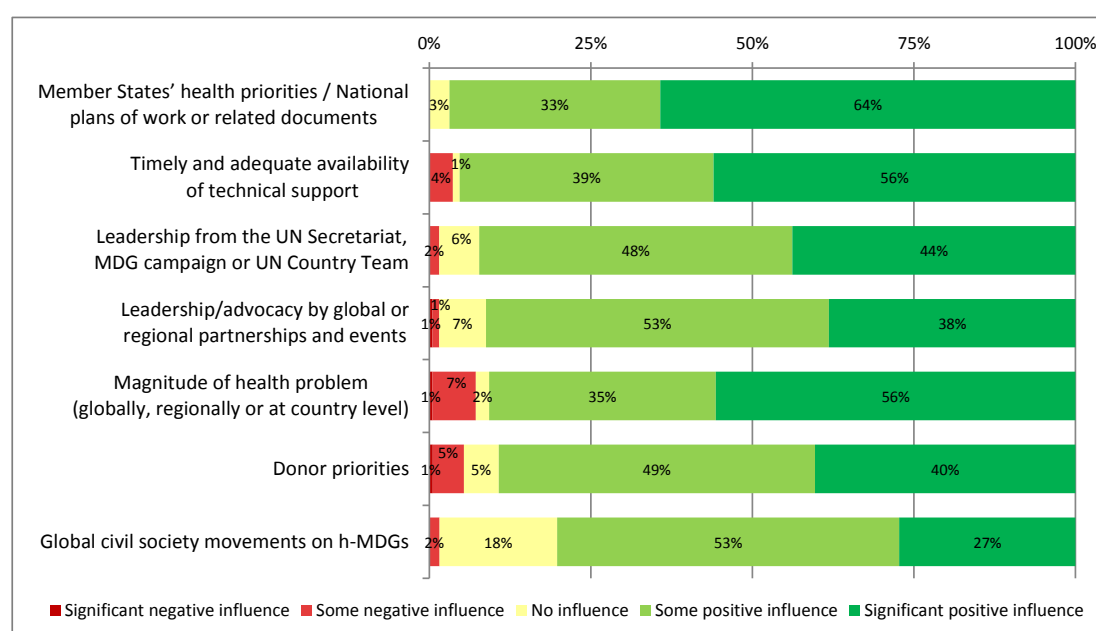
⁶³ WHO (2015) Accelerating progress on HIV, tuberculosis, malaria, hepatitis and neglected tropical diseases. A new agenda for 2016 - 2030. p. 21.

they have successfully mobilized funding commitments to public health initiatives and have galvanised indirect forms of support to WHO programmes.”⁶⁴

Member States’ health priorities were the main external factor influencing the Secretariat’s response to the h-MDGs.

72. According to WHO staff surveyed and confirmed by the countries desk study, the most important factor influencing the Secretariat’s response were the Member States’ national health priorities (97%) and adequate availability of technical support (95%), followed by the leadership from the UN Secretariat, MDG campaigns or UN Country Teams (92%), the leadership /advocacy by partnerships at various levels and the magnitude of health problems (both at 91%). The external factor having the least influence on the Secretariat’s response to the h-MDGs is the global civil society movements, though 80% of the staff still considered they influenced positively the articulation of the Secretariat’s response.
73. While the normative work of WHO was considered strategically important and of extremely high value, there were concerns about WHO’s capacity to meet the needs of Member States with regard to h-MDGs. Given the prominence of other actors in the global health arena, the role of WHO was somewhat diminished.

Figure 10. WHO staff assessment of key external factors influencing the Secretariat’s response to the h-MDGs



Source: WHO staff survey results

Internal influencers

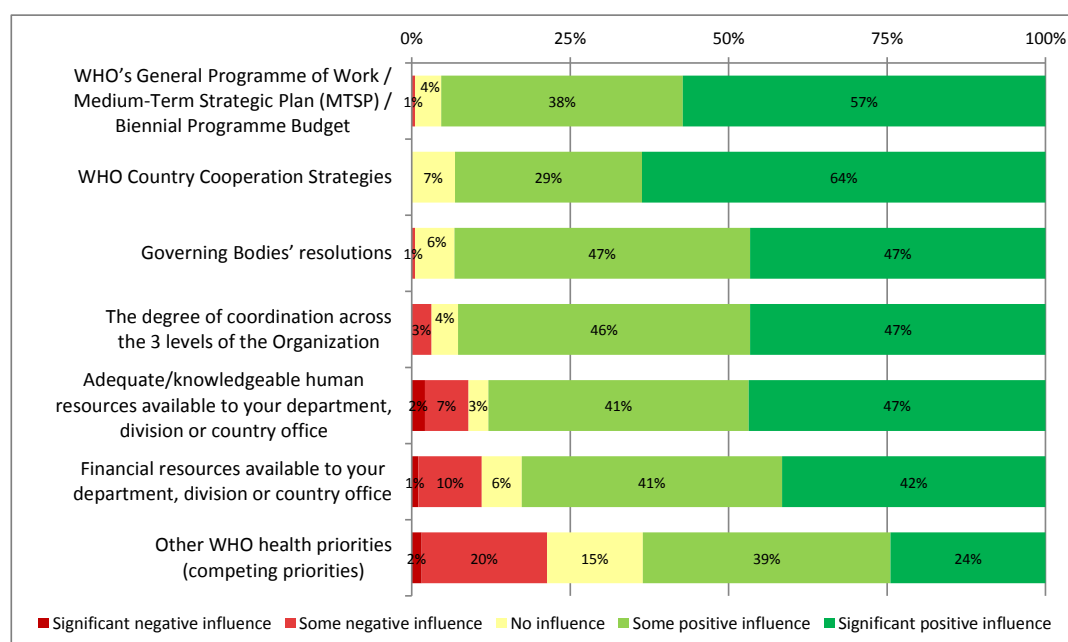
Corporate instruments had a clear positive influence.

74. According to the staff survey results, the governing bodies resolutions, the GPW and biennial PBs and the country cooperation strategies all had a positive influence in the articulation of the Secretariat’s response to the h-MDGs (Figure 11). Although most staff considered that the degree of collaboration across major offices facilitated the Secretariat’s response, some partners noted some divergence in priority objectives challenging the effectiveness of response. They also

⁶⁴ WHO (2012) WHO’s arrangements for hosting health partnerships and proposals for harmonizing WHO’s work with hosted partnerships: report by the Secretariat. Document EB132/5 Add.1, p.4, para.8.

indicated that on occasion there was less clarity on the effective role of each major office and insufficient direct communication between the three levels of the Organization.

Figure 11. WHO staff assessment of key internal factors influencing the Secretariat's response to the h-MDGs



Source: WHO staff survey results

75. On the other hand the staff survey results also showed that for 22% of the respondents the Secretariat's "other health priorities" were competing negatively with their response to the h-MDGs. For about 10% of the staff the financial and human resources available to their department, division or country office also influenced negatively their ability to address the h-MDGs.

Evaluation question 2: Was the Secretariat's response to the h-MDG targets relevant to Member States' needs and consistent with the Organization's mandate?

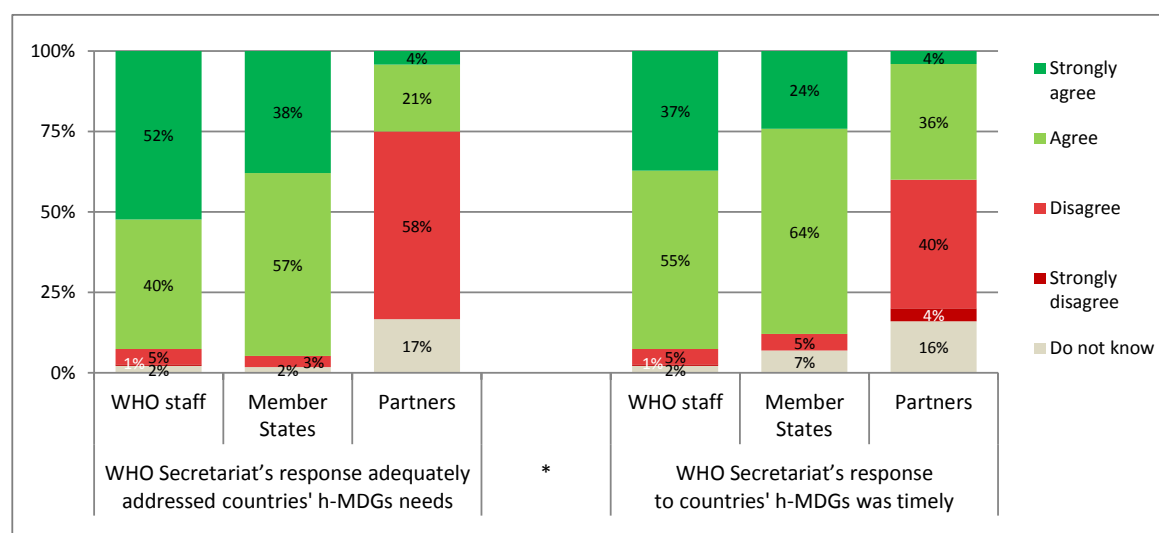
Linkages between the Secretariat's response and Member States' health needs

The Secretariat's response to Member States' h-MDG needs was found relevant and timely by Members States, but less so by partners.

76. The survey results presented in Figure 12 show clearly that more than 90% of WHO staff and Member State respondents found that the Secretariat's response was relevant to Member States' h-MDGs needs. Similarly 88% of Member State respondents found that the Secretariat's response was timely. Nevertheless, during the interviews some Member States expressed concerns with the timeliness of the Secretariat's response, and linked it to cumbersome administrative processes and limited financial resources available, as well as to lack of coordination across major offices.

77. However, partners and collaborators had different perceptions: only 25% considered that the Secretariat's response addressed Member States' h-MDGs needs adequately and 40% of them found the Secretariat's response was timely. This trend was confirmed through the interviews, during which partners underscored that WHO might have fallen short of its potential as the leading agency for health due to excessive caution in decision-making. They also pointed to issues with timeliness and showed less support for the relevance and adequacy of the Secretariat's response to meet country needs.

Figure 12. Stakeholder assessment of the relevance and timeliness of the Secretariat's response in addressing the h-MDGs in countries

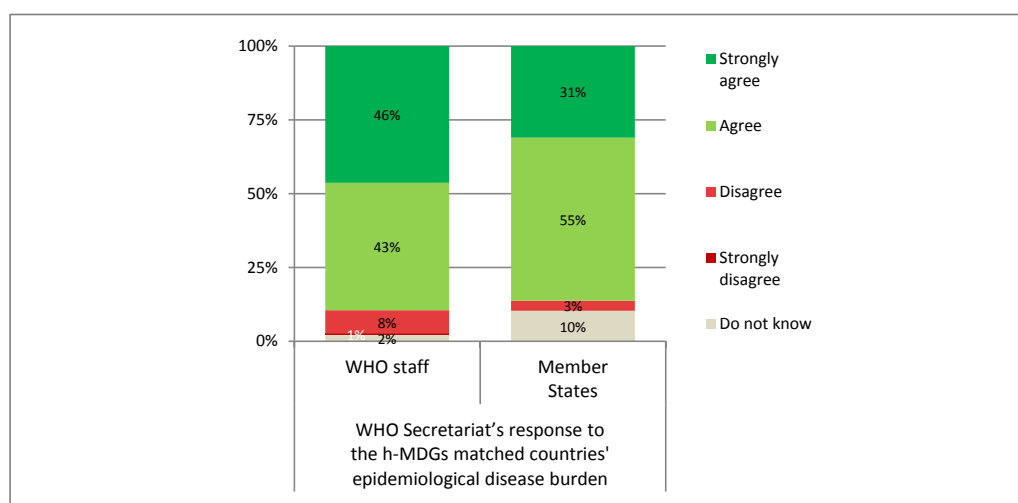


Source: WHO Staff, Member States and partners survey results

The Secretariat's response was aligned with the epidemiological burden and national priorities of countries.

78. 86% of Member State respondents found that WHO's contribution to the h-MDGs was aligned with the epidemiological burden of their countries (Figure 13). This was also confirmed for 83% of the country case studies.

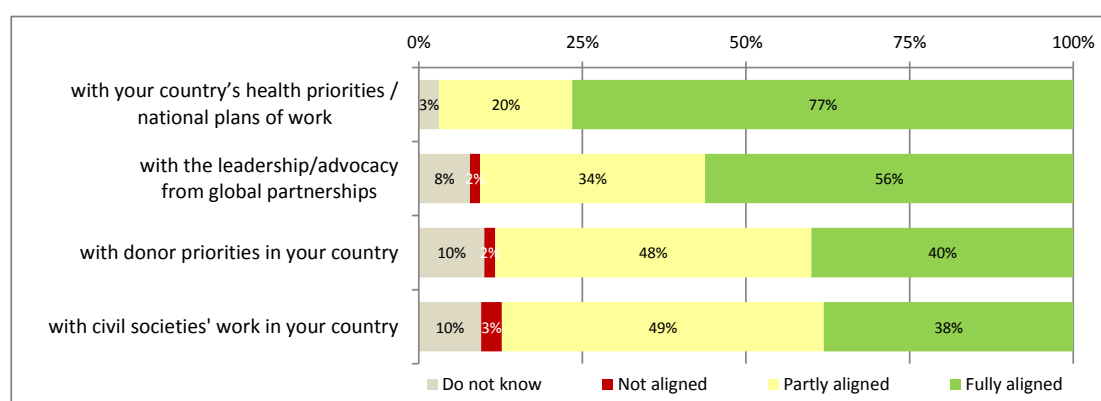
Figure 13. Stakeholder assessment of the level of alignment of the Secretariat's h-MDG response with the epidemiological burden of the countries



Source: WHO Staff and Member States survey results

79. The country case studies compared national health priorities with those of the Secretariat and found that in 50% of the cases there was an explicit alignment between the two. In the other 50% of the cases, it was just not possible to determine if there was an alignment mainly because the documents available to the evaluation team were not explicit enough on the h-MDGs. However, the evaluation team did not find any evidence of misalignment. About 77% of the Member State respondents (Figure 14) confirmed that the Secretariat's response was fully aligned with their national priorities. They emphasized that such a close alignment relied on the good communication and supportive interactions they enjoyed with WHO Representatives and WHO country office officials, and on constructive joint planning within the principles of aid effectiveness.

Figure 14. Member State assessment of the alignment of the Secretariat's response in addressing the h-MDG's



Source: WHO Member States survey results

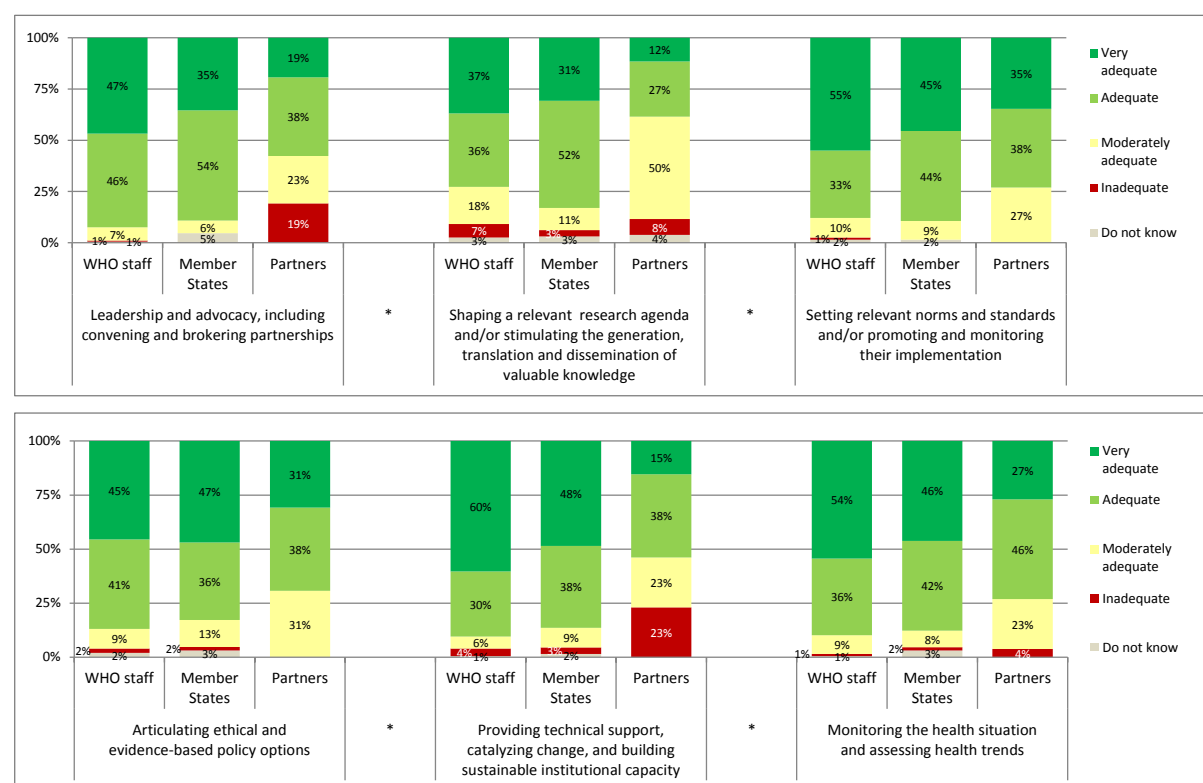
80. Interestingly, the Member State respondents regarded the Secretariat's response to the h-MDGs as less aligned with global partnerships (56%), donor priorities (40%) and civil societies' work in their countries (38%). This confirms the somewhat closer relationship between the Secretariat and Member States and the Secretariat's role to support national health priorities versus other priorities than that of other stakeholders.

Adequacy of the Secretariat's contribution per WHO core function

Overall there has been a very positive assessment of the Secretariat's role to set norms and standards and monitor the health situation and assess health trends.

81. As shown in Figure 15, three-quarters of respondents in each stakeholder group assessed as at least adequate the Secretariat's role to set norms and standards and to monitor health situation and trends. Member States assessed these even more positively (89% of the respondents found adequate the Secretariat's role to set norms and standards and 88% found adequate its role to monitor the health situation and assess health trends).

Figure 15. Stakeholder assessment on the adequacy of the Secretariat's response to the h-MDGs per WHO core function.



There were some inadequacies noted by all stakeholder groups with regard to the Secretariat's role to provide technical support and to shape a relevant research agenda.

82. Though the majority of WHO staff and Member States found the Secretariat's role to provide technical support and shape the relevant research agenda to be at least adequate, it is worth noting that both groups also found that some of it was inadequate (Figure 15). WHO's external partners and collaborators expressed the most doubt about the adequacy of the Secretariat's response to the h-MDGs in respect of these two core functions. Some respondents indicated that the performance of the Secretariat was uneven across country offices, particularly when engaging in implementation roles beyond the Secretariat's comparative advantage.
83. External partners, other than Member States, were in general more critical of the adequacy of the Secretariat in performing its six core functions. In particular, a significant fraction considered that the role of WHO in providing leadership and advocacy as well as technical support, was inadequate.

Prioritizing the h-MDGs versus other health needs

84. WHO's mandate extends beyond the MDG-related programmes to cover other pressing health priorities, such as *"the growing problems attributable to noncommunicable diseases and their determinants."*⁶⁵ WHO's Tenth, Eleventh and Twelfth GPWs, a number of WHA resolutions adopted during the period,⁶⁶ and advances in the implementation of the Framework Convention on Tobacco Control,⁶⁷ the international health regulations,⁶⁸ and emergency preparedness and response to outbreaks and emergencies, among other non-MDG related programmes, confirm that WHO continued to work on other health priorities during the MDG period.

The h-MDGs influenced the Secretariat's ability to address other health needs.

85. WHO continued prioritizing relevant issues across the global health spectrum; however, as the MDGs attracted global interest, other priorities outside the MDG framework lost some traction. For instance, the adolescent health programme was reduced, though some aspects were framed under the reproductive health agenda. Also and despite WHO's rhetoric on the instrumental role of strengthened health systems for MDG achievement,⁶⁹ this area of work lost some degree of traction. *"The strong focus on vertical programmes diverted the attention from more systemic efforts to strengthen health systems. The Ebola crisis of 2013-2014 showed the weakness of health systems which were unable to cope with the emergency situation."* At least 39% of the Member States respondents, but only 17% of the partners and 21% of WHO staff found that the Secretariat's response to the h-MDGs deferred other priorities. About 29% of the Member States respondents considered that important non-MDG health priorities were not addressed because of the Secretariat's response to the h-MDGs. This perception was shared by 33 % of other partners, and 16% of WHO staff. Feedback from interviews indicated that the unprecedented level of advocacy around the MDGs helped to keep them in the spotlight and resulted in less attention being paid to non-MDGs issues, both globally and by the Secretariat.

⁶⁵ WHO (2003) WHO's contribution to achievement of the development goals of the United Nations Millennium Declaration, Report by the Secretariat. Document A56/11, p.3, para.8.

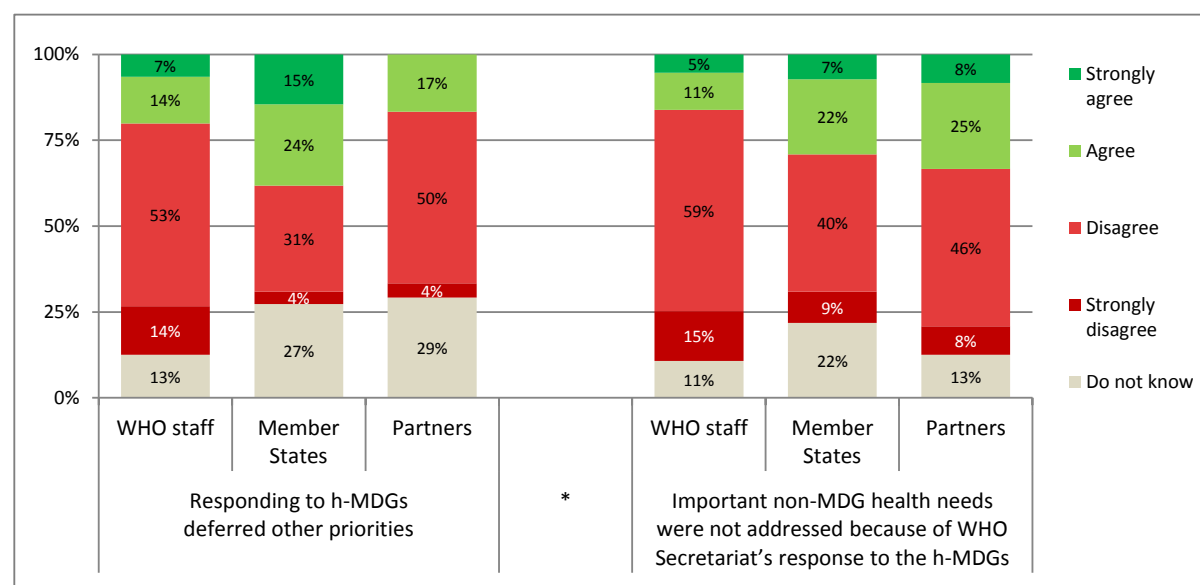
⁶⁶ For example, reducing tobacco use (resolution WHA56.1, 2003), promoting healthy diets and physical activity (resolution WHA57.17, 2004), enhancing health promotion activities (resolution WHA57.16, 2004), Emergency preparedness and response (resolution WHA59.22, 2006), Prevention of avoidable blindness and visual impairment (resolution WHA59.25, 2006), Strategies to reduce the harmful use of alcohol (resolution WHA61.4, 2008), Prevention and control of noncommunicable diseases: implementation of the global strategy (WHA61.14, 2008), Advancing food safety initiatives (resolution WHA63.3, 2010), Global strategy to reduce the harmful use of alcohol (resolution WHA63.13, 2010), Strengthening noncommunicable disease policies to promote active aging (resolution WHA65.3, 2012); The global burden of mental disorders and the need for a comprehensive coordinated response from health and social sectors at the country level (resolution WHA65.4, 2012), and Global action plan on antimicrobial resistance (resolution WHA68.7, 2015).

⁶⁷ Framework Convention on Tobacco Control in 2003, the first treaty negotiated under Article 19 of WHO's constitution.

⁶⁸ The International Health Regulations adopted in 2005 and regularly updated constitutes an agreement between WHO and Member States to work together on global health security. See <http://www.who.int/ihr/about/en/>.

⁶⁹ See Travis, P. et al. (2004) Overcoming health-systems constraints to achieve the Millennium Development Goals, in the Lancet, 364: 900-06 and WHO (2005) Health and the Millennium Development Goals, Chapter 2.

Figure 16. All stakeholder group assessment of the balance of WHO's response across MDG and non-MDG programmes

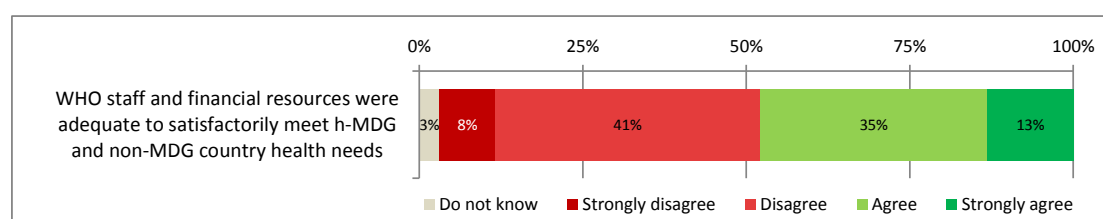


Source: WHO Member States survey results

The Secretariat had inadequate financial and human resources to meet the health needs of Member States.

86. Finally, the evaluation noted that a significant proportion of WHO staff also considered that limited WHO resources, both financial and human, were a significant barrier to meeting country health needs (Figure 17).

Figure 17. WHO Staff assessment of the adequacy of the Secretariat's capacity to meet Member States' health needs



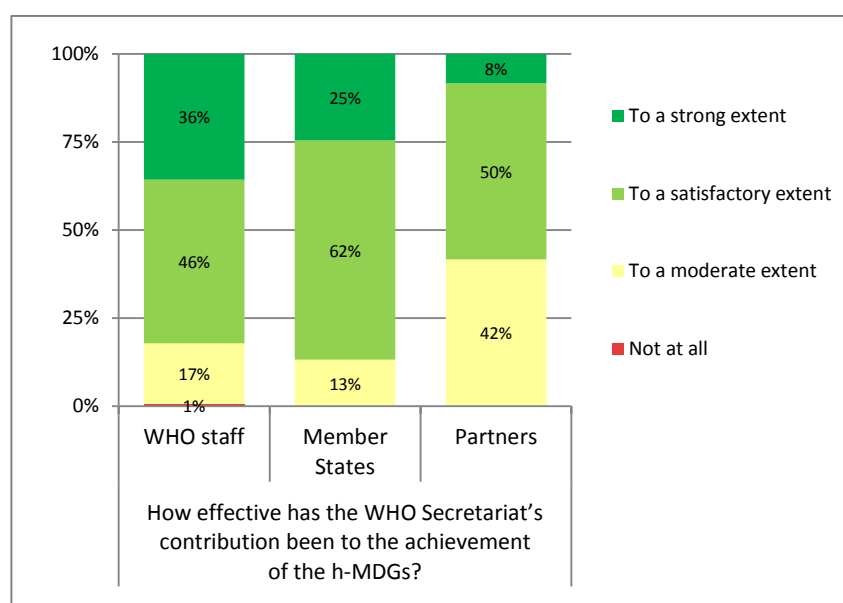
Source: WHO staff survey results

Evaluation Question 3: What have been the main results of the Secretariat's contributions to the achievement of the h-MDGs as expressed through its six core functions?

The overall contribution of the Secretariat was perceived as at least satisfactory by the majority of stakeholders.

87. The effectiveness of the Secretariat's contribution to the MDGs has been widely recognized as positive (Figure 18) by Member States (87%), which is slightly more than WHO staff (82%). To a lesser extent, 58% of partners also assessed the contribution of the Secretariat to the achievement of the h-MDGs as at least satisfactory.

Figure 18. Stakeholder assessment of the effectiveness of the Secretariat's contribution to the achievement of the h-MDG's in countries



Source: WHO staff, Member States and partners surveys results

88. The Secretariat's contribution to the h-MDGs across its six main functions⁷⁰ is described below.

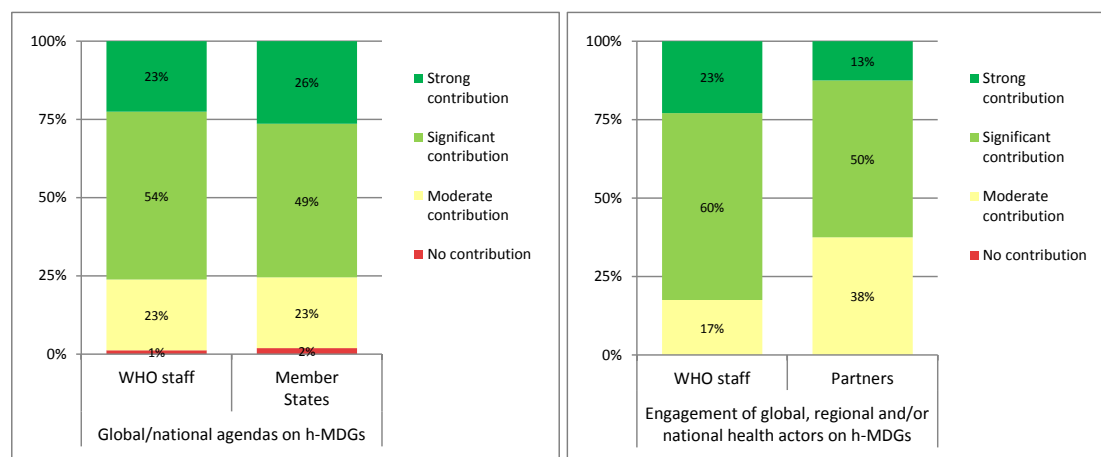
Leadership and engagement with partners

89. **The Secretariat played a key role in shaping the global health agenda and in convening stakeholders** in support of the global, regional and national health agendas on the h-MDGs. Overall, Member States and partners coincided in recognizing the unique position of WHO as the leading international public health agency and its particular convening power role as confirmed in Figure 19.

90. It is striking to see the strong convergence of answers between WHO staff and Member States. More than three-quarters of them found that the Secretariat made at least a significant contribution to the global and national agendas on h-MDGs. About 63% of the partners found that the Secretariat was making at least a significant contribution to the engagement of actors on h-MDGs at various levels which, as would be expected, is less than the assessment of WHO staff (83%).

⁷⁰ Considering the absence of quantified objectives and expected outcomes to assess the extent to which expected outcomes have been achieved, the evaluation is only assessing existing contributions but cannot assess if they represent all that should have been achieved.

Figure 19. Stakeholder assessment of the contribution of the Secretariat to shaping agendas and engagement of actors on h-MDGs



91. The survey results are confirmed by the interviews, country desk studies and documents review which all identified significant Secretariat contributions along the following axes:

- The Secretariat advanced global policy dialogue.** WHO played an important role in convening stakeholders and contributing to the formulation of the MDG targets and the needed global infrastructure. In 2004 and 2005, the Secretariat co-organized, jointly with the World Bank, three high-level forums aiming to build global consensus on priority targets and on strategies to facilitate the global architecture for the MDGs, such as the human and financial resources and their sustainability, aid harmonization, monitoring and evaluation, and global health partnerships.^{71,72,73} According to WHO, *“the High-Level Forum on the Health MDGs helped to achieve a consensus on how to overcome the major constraints impeding country-level scale up in relation to the quantity and quality of aid for health, health systems and human resources, the role of global health partnerships and the special circumstances of fragile States. The challenge now is to translate this consensus into action at country level”*.⁷⁴
- The Secretariat raised the profile of h-MDG priorities and built consensus in support of the h-MDGs.** Throughout the MDG period, the Secretariat raised the profile of key issues to the top of the international health agenda. Key examples include the positioning of NTDs as a core component of MDG 6 (by hosting the Global Partners Meeting on NTDs in 2007⁷⁵ and subsequently producing a roadmap and strategies on NTDs). Similarly, though late in the MDG period, the Secretariat was instrumental in the conceptualization of the Every Newborn Action Plan, which was launched by the Secretariat with several partners in 2014 to advocate for greater investments in newborn health. The Secretariat also advocated for the inclusion of important targets into the MDG agenda, most notably the targets on reproductive health and on sanitation. Although the final results were due to the concerted efforts and the advocacy of

⁷¹ The first High-Level Forum on Health MDGs meeting brought together senior officials from 17 developing countries; 11 bilateral agencies; 8 multilateral agencies; and 9 foundations, regional organizations and global partnerships.

⁷² <http://www.who.int/hdp/hlf/en/>.

⁷³ http://www.paho.org/mdg/index.php?option=com_content&view=article&id=77&Itemid=60&lang=en

⁷⁴ WHO Programme budget 2004-2005 Performance Assessment. P.85.

⁷⁵ The Global Partners' meeting on Neglected Tropical Diseases was held at WHO in Geneva on 19–20 April 2007. Some 200 participants attended the meeting, including representatives of Member States, United Nations agencies, the World Bank, philanthropic foundations, universities, pharmaceutical companies, international NGOs and other institutions dedicated to contributing to the control neglected tropical diseases. *“This meeting declared to the world that control of these diseases deserves high priority on the global public health agenda and still greater determination to deliver appropriate health care to the millions of poor people in need”* in Report of the Global Partners' Meeting on Neglected Tropical Diseases, 2007, A turning point, WHO, p.iii.

many partners, the evaluation's assessment recognized the strong leadership and advocacy role of the Secretariat.⁷⁶

- **The Secretariat convened and coordinated stakeholders around key priorities.** The Secretariat brought together partners and collaborators around critical topics and issues related to the achievement of h-MDGs. Activities included: high-level conferences, expert groups and strategic and technical advisory committees to discuss strategic approaches and provide expert technical advice on MDG policy recommendations;⁷⁷ bringing governments and partners together at regional committee meetings, intergovernmental meetings and other forums in order to raise political buy-in and discuss progress and strategies for the best way forward; and convening and coordinating country partners around h-MDG issues. At country level, the Secretariat often served as the convenor or co-convenor on health, by chairing or co-chairing the UN health clusters and country thematic groups on MDG issues. According to input gathered in this evaluation, these groups enabled the engagement of partners and fostered partner coordination and collaboration in support of the implementation of health plans and strategies of the ministries of health, including those on h-MDGs. As a key partner indicated to this evaluation, *"the convening power of WHO is unique"*.
- **The Secretariat engaged partners and hosted partnerships.** Partner engagement was at the centre of the Secretariat's work on the MDGs: launching high-profile campaigns (such as the "3 by 5" initiative⁷⁸ to scale-up access to antiretroviral treatment in partnership with UNAIDS) and large-scale programmes (such as the Joint Monitoring Programme with UNICEF); acting as a key advocate and partner in global initiatives such as Every Woman, Every Child and IHP+; and collaborating with the pharmaceutical industry to expand the supply of medicines for NTDs. The evaluation found that these concerted efforts helped to rally partners together and advance the MDG agenda by building on the relative strengths of each party. However, the Secretariat's engagement with nongovernmental organizations and civil society was found less prominent despite recognizing their critical role as levers for change.⁷⁹ The Secretariat also hosted a range of global health initiatives such as RBM; the Stop TB Partnership; PMNCH; and UNITAID, among others, which in turn increased its visibility.

Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge

92. The Secretariat's achievements in shaping the research agenda, translating and disseminating knowledge around the h-MDGs was perceived as strongest by Member State respondents (73%) but only 52 % of the partners found the Secretariat's contribution significant.

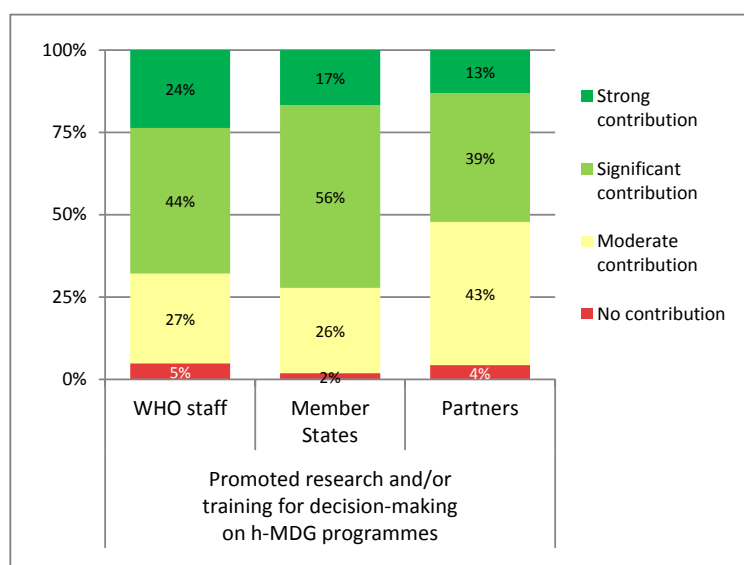
⁷⁶ For example, the evaluation notes that, for the reproductive health indicator, WHO provided the background technical rationale for the indicator to be selected for the target.

⁷⁷ A number of experts groups were formed during the MDG period by the Secretariat, including: Strategic Advisory Group of Experts (SAGE) on Immunization; the Strategic and Technical Advisory Group for Tuberculosis (STAG-TB); and the Malaria Policy Advisory Committee (MPAC).

⁷⁸ The "3 by 5" initiative, launched by UNAIDS and WHO in 2003, was a global Target to provide three million people living with HIV/AIDS in low- and middle-income countries with life-prolonging antiretroviral treatment (ART) by the end of 2005. <http://www.who.int/3by5/en/>.

⁷⁹ As noted in the Eleventh General Programme of Work, p.7: *"Global health partnerships offer the potential to combine the different strengths of public and private organizations, along with civil society groups, in tackling health problems."*

Figure 20. Stakeholder assessment of the contribution of the Secretariat to research and/or training for decision-making on h-MDG programmes



Source: WHO Staff, Member States and Partners survey results

93. Key results included the following:

- The Secretariat advocated for the need for research and, to a lesser extent, helped to define research agendas on h-MDGs.** The Secretariat played a relevant role advocating for robust research on h-MDG issues and for using the evidence generated by research as the basis for policies. In 2004, WHO convened the Ministerial Summit on Health Research entitled “*Bridging the ‘know-do’ gap to achieve the MDGs*”, aiming to identify the priority research needed to reach the MDGs.⁸⁰ The outcome of the Summit was reported in the Mexico City Statement on Health Research, which highlighted that “*research has a crucial but under-recognized part to play in strengthening health systems, improving the equitable distribution of high quality health services, and advancing human development.*”⁸¹ In response to this Summit, in 2005 the WHA adopted resolution WHA58.34 requesting the Secretariat to support mechanisms to enhance the translation of health research findings into policy and practice,⁸² leading to the establishment of the Evidence-Informed Policy Network to “*promote the systematic use of research evidence in health policy-making*”⁸³ and also articulated a strategy on research for health in 2010.⁸⁴ Although the scope of these initiatives exceeded the MDG agenda, they were the result of the earlier Summit. WHO country offices focused on supporting the development of national research agendas, including the identification of research priorities and gaps, and on the establishment of national research units.
- The Secretariat generated and disseminated evidence on the h-MDGs for health-policy making.** The Secretariat was involved in policy research at the three levels of the Organization, including supporting and publishing results in high-profile journals, such as the Lancet series on child survival, or on public health approaches to HIV. The Reproductive Health and Research programme’s main function gravitated around shaping the research agenda and coordinating

⁸⁰ See Ministerial Summit on Health Research, Key Objectives, in <http://www.who.int/rpc/summit/en/index3.html>

⁸¹ WHO (2005) The Mexico City Statement on Health Research. Document A58.22, Annex, p.5, para.3.

⁸² WHO (2005) Ministerial Summit on Health Research. Resolution WHA58.34 para. 4.

⁸³ WHO (undated) What is EVIPNet? Available at http://www.who.int/evidence/resources/what-is-EVIPNet_20160925.pdf?ua=1.

⁸⁴ The draft WHO strategy on research for health was presented at the Sixty-Third WHA (Document A63.22) and finalized in 2012 in the document titled “The WHO strategy on research for health”, available at: http://www.who.int/phi/WHO_Strategy_on_research_for_health.pdf.

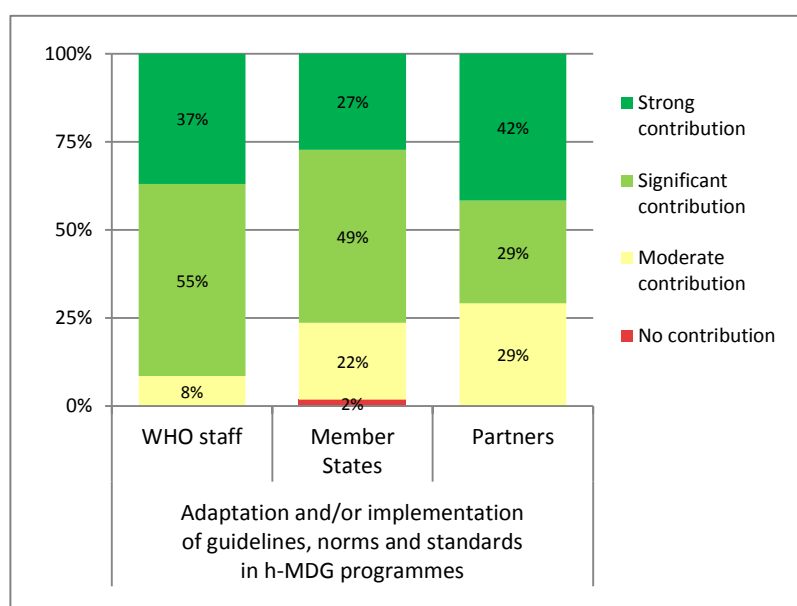
high-profile research in the field of sexual and reproductive health,⁸⁵ which was key in supporting the discussions around MDG 5.B. The Secretariat also supported the conduct of key surveys, needs assessments and other studies in countries on a range of h-MDG topics, and provided technical and financial support for operational research on h-MDGs priorities. This research provided evidence and data critical for Member States' decision-making and for the planning of activities. The evaluation identified several examples of research projects conducted in countries in collaboration with external partners, such as the study investigating the impact of vector resistance to insecticides on the effectiveness of long-lasting insecticide-treated nets, leading to recommending their use. Especially at country level, WHO supported the dissemination of research studies and findings to policy decision-makers. At the global and regional levels, WHO has also regularly updated its websites and databases to ensure the most-up-to date evidence is available and easily accessible.

Setting norms and standards, and promoting and monitoring their implementation

94. The Secretariat's work in setting norms and standards is considered to be one of the most important core functions of the Organization. Most participants in the evaluation highly commended the Secretariat's contribution in this area, considering it one where the Secretariat adds clear value due to the relevance and quality of its recommendations.

95. Figure 21 below confirms a strong alignment between the feedback from partners (71%) and Member States (76%) on the Secretariat's contribution to guidelines, norms and standards in h-MDG programmes. It is where the Secretariat's achievements are considered to be the most significant by the partners.

Figure 21. Stakeholder assessment of the contribution of the Secretariat to adaptations and/or implementation of guidelines, norms and standards in h-MDG programmes



Source: WHO Staff, Member States and Partners survey results

96. Examples of key contributions in this area include:

- **The Secretariat developed evidence-based guidelines, norms and standards on h-MDGs.** In line with its mandate, the Secretariat produced global guidelines, norms and standards on all h-MDG-related issues. The evaluation gathered converging observations with regard to the

⁸⁵ WHO (undated) Sexual and Reproductive Health: Department profile, available at: http://www.who.int/reproductivehealth/about_us/en/.

national adaptation and use of the guidelines by Member States and external partners, and also to the influence that some of the Secretariat guidelines had in changing policy and practice. The evaluation also found that the Secretariat's normative work influenced policies of other development partners. This is recognized by key main stakeholder groups interviewed as a major contribution of the Secretariat as it helped other partner-sponsored work to be based on global guidelines, norms and standards, such as the guidelines for HIV, malaria or tuberculosis testing and treatment, or guidelines for vaccine introduction. According to interviews, the production of guidelines was more efficient towards the end of the MDG period.

- **Support for the adaptation, revision and update of guidelines, norms and standards to the national context.** Assisting Member States in the adoption and adaptation of guidelines, norms and standards on h-MDGs to country contexts has been reported as a major contribution of WHO country offices.
- **Monitoring of guideline implementation.** A number of WHO programmes track and report on the adoption of selected guidelines by Member States, but their actual implementation in terms of whether the intervention is delivered based on the guideline is not monitored. This is possibly due to the lack of a standardized approach to monitoring the implementation of guidelines, norms and standards.

Articulating ethical and evidence-based policy options

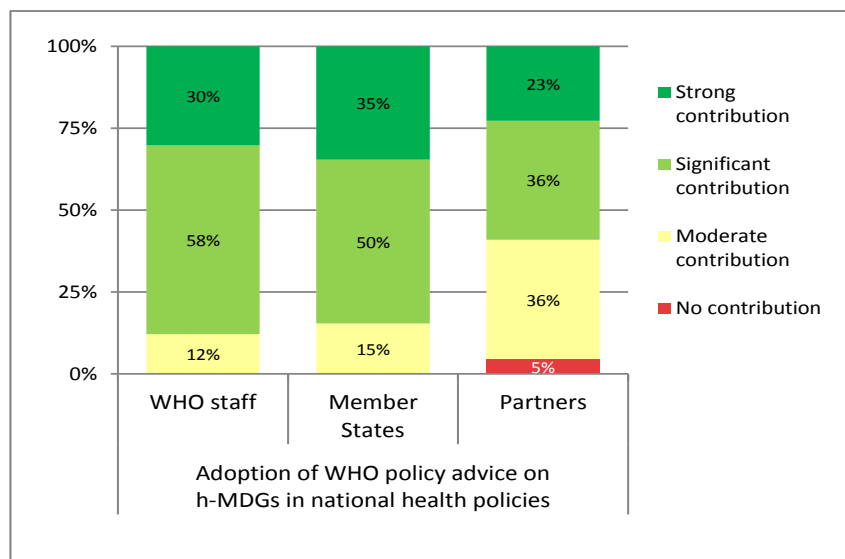
97. Developing evidence-based and practical policy options on the h-MDGs was viewed as a key role of the Secretariat as follows:

- **The Secretariat developed global and regional strategies on the h-MDGs.** The Secretariat produced evidence-based and ethical strategies and policy options at the global level through broad consultation processes and, in most cases, through WHA approval. Soon after the adoption of the MDGs, the Secretariat formulated a number of strategies which provided the global framework for its work, including: the Global Health Sector Strategy for HIV/AIDS 2003-2007; the Stop TB Strategy 2006-2015 with the Stop TB Partnership; the Global Plan to Combat NTDs 2008-2015; the Global Strategy for Infant and Young Child Feeding in 2001; the Strategy for Child and Adolescent Health and Development in 2003; the Reproductive Health Strategy to accelerate progress towards the attainment of the international development goals and targets in 2004; and the WHO Medicines Strategy - Expanding Access to Essential Drugs in 2002; among many others. Many of these strategies were jointly developed with partners. They provided overarching frameworks and detailed policy options, approaches and tools for the response to the various h-MDG issues. Frequently, they were adapted to regional contexts and/or specific plans of actions were developed to guide the region in their implementation.⁸⁶
- **The Secretariat provided policy advice and support for the elaboration of national health policies.** 85% of Member State respondents highly valued the role of the Secretariat in supporting policy dialogue, helping countries to translate global resolutions into specific action and plans at national level. For the Member State respondents this represents the most important contribution by the Secretariat to the results in countries. WHO country offices were engaged in providing policy advice, convening policy discussions among national stakeholders, developing reports/policy briefs based on WHO global and regional sector strategies, and supporting the revision and/or formulation of national technical policies and plans on the h-

⁸⁶ Examples include: Road map for accelerating the attainment of the MDGs related to maternal and newborn health in Africa in 2005; HIV/AIDS Strategy for the WHO Africa Region in 2013; Regional Strategy to Stop Tuberculosis in the Western Pacific region 2011-2015; Regional strategy: from malaria control to elimination, in the WHO European Region 2006-2015; Regional Strategy on nutrition in the Eastern Mediterranean Region 2010-2019; Adolescent and Youth Regional Strategy and Plan of Action in the Americas 2010-2018; Regional Nutrition Strategy: addressing malnutrition and micronutrient deficiencies (2011-2015) in the South-East Asia Region, among others.

MDGs by advocating for and providing national stakeholders with policy options appropriate to local contexts. The Secretariat also provided technical assistance in the elaboration of national roadmaps and/or acceleration plans.

Figure 22. Stakeholder assessment of the contribution of the Secretariat to adoption of WHO policy advice on h-MDGs in national health policies

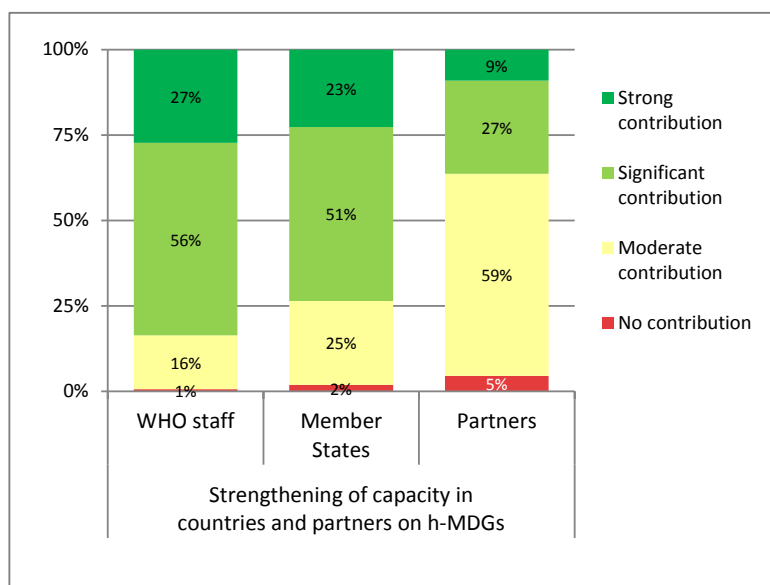


Source: WHO Staff, Member States and Partners survey results

Providing technical support, catalysing change, and building sustainable institutional capacity

98. 74% of the Member State respondents found that the technical support provided by WHO country offices in terms of planning, implementation, monitoring and evaluation of MDG related interventions, as well as in strengthening capacity and developing tools and methodologies, represented at least a significant contribution to the h-MDGs. The majority of partners (59%) on the other hand found the Secretariat's contribution only moderate.

Figure 23: Stakeholder assessment of the contribution of the Secretariat to strengthening of capacity in countries and among partners on h-MDGs



Source: WHO Staff, Member States and Partners survey results

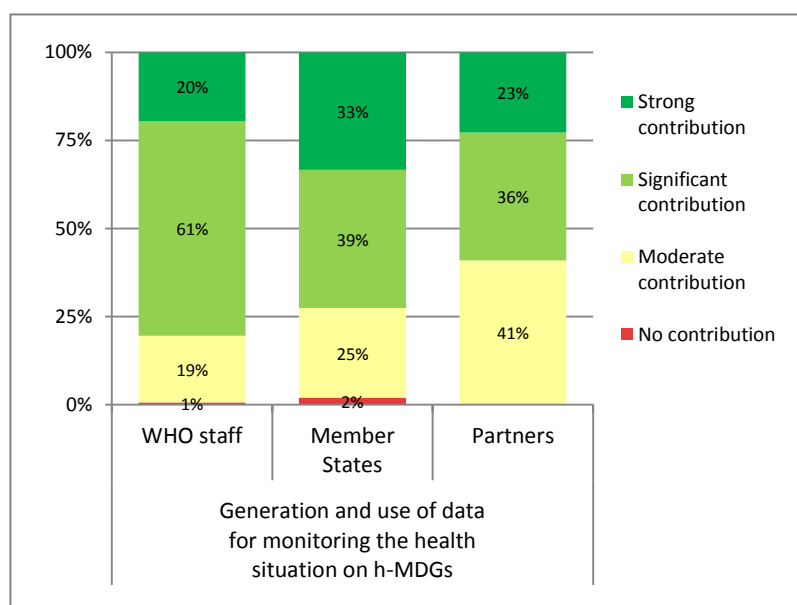
Key contributions pertaining to this functional area included:

- **The Secretariat provided technical support for national policies and interventions.** WHO country offices, with support from regional offices and headquarters, have been at the forefront of this function responding to requests from Member States and providing technical support at the national and subnational levels that are tailored to their specific needs and requests. Notably, WHO country offices assisted Member States in the development of funding proposals for the GFATM and GAVI Alliance influencing the implementation of MDG-related interventions. Member States showed appreciation for the Secretariat's high-quality technical support and responsiveness to their requests in h-MDGs areas of work.
- **The Secretariat undertook capacity building activities at national and sub-national levels.** The majority of the capacity building activities took place at the national level though there was also evidence of capacity building conducted at the subnational level, in districts and healthcare facilities. The Secretariat deployed various training mechanisms, including training of trainers and supportive supervision approaches, and made available tools/toolkits, materials, and knowledge products which strengthened the institutional capacity and technical know-how of national counterparts on h-MDGs.

Monitoring the health situation and assessing health trends

99. Globally the MDGs had a galvanizing effect on promoting monitoring and strengthening of national health information systems to track progress on goal achievement. The evaluation found widespread recognition of the instrumental role played by the Secretariat in monitoring and reporting progress on the h-MDGs: 72% of Member State respondents and 59% of the partners recognized the strong and significant contribution of the Secretariat in this regard.

Figure 24: Stakeholder assessment of the contribution of the Secretariat to the generation and use of data for monitoring the h-MDGs



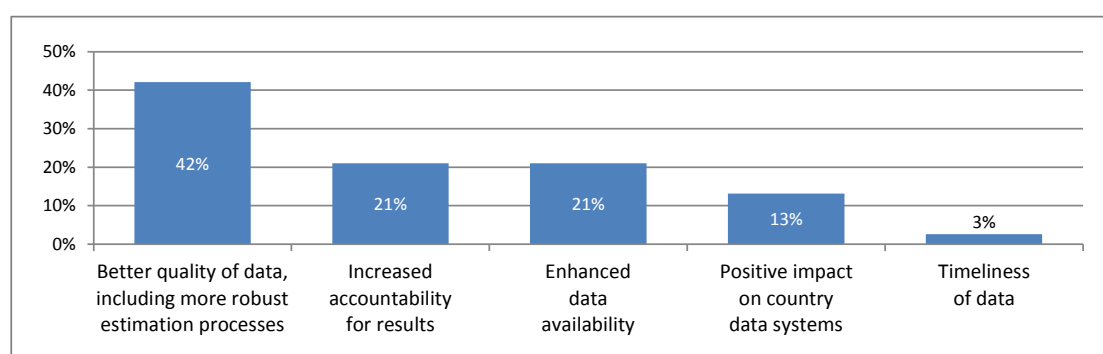
Source: WHO Staff, Member States and Partners survey results

100. The Secretariat contributed to the identification of indicators and measurement tools, data quality control and also to strengthening country capacity in data estimation and measurement. Monitoring progress on the h-MDGs was a key component of WHO's strategy as articulated in WHA resolutions in 2003 and 2005. This role was further strengthened in 2007 with the WHA resolution on "Strengthening of Health Information Systems" and in 2008 with the WHA resolution on "Monitoring achievement of the health-related Millennium Development Goals".

101. The evaluation noted that monitoring was a joint effort of Member States, the UN family and other developmental partners, though the Secretariat played a major role. Its contribution was facilitated by strengthened collaboration in support of the analysis, validation and consolidation of h-MDG data across all the Secretariat's programmes involved in the MDG initiative and at the three levels of the Organization; as well as through collaboration with Member States and WHO partners. Key contributions are detailed hereafter:

- **The Secretariat strengthened methods and approaches for better quality of data.** The Secretariat developed methods, tools and guidance on measurement of indicators, data collection and data analysis for the MDGs which helped to enhance data quality. It emerged from the key informant interviews that the main outcomes of the Secretariat's contribution to the monitoring of the h-MDGs were improvements in data quality, including more robust estimation processes, followed by increased accountability for results and increased data availability (Figure 25). The Secretariat developed modelling techniques and methodologies for periodic estimation of indicators, which led to more robust and reliable data. Some examples are the efforts to develop maternal mortality estimates through the interagency group on maternal mortality led by the Secretariat together with partners (UNICEF, UNFPA, World Bank, and the UN Population Division), as well as the joint child malnutrition estimates produced in collaboration with UNICEF and the World Bank Group, which established common approaches to monitor and estimate MDG indicators.

Figure 25: Member State assessment of outcomes of the Secretariat's contribution to monitoring of h-MDGs in countries



Source: WHO Member States survey results

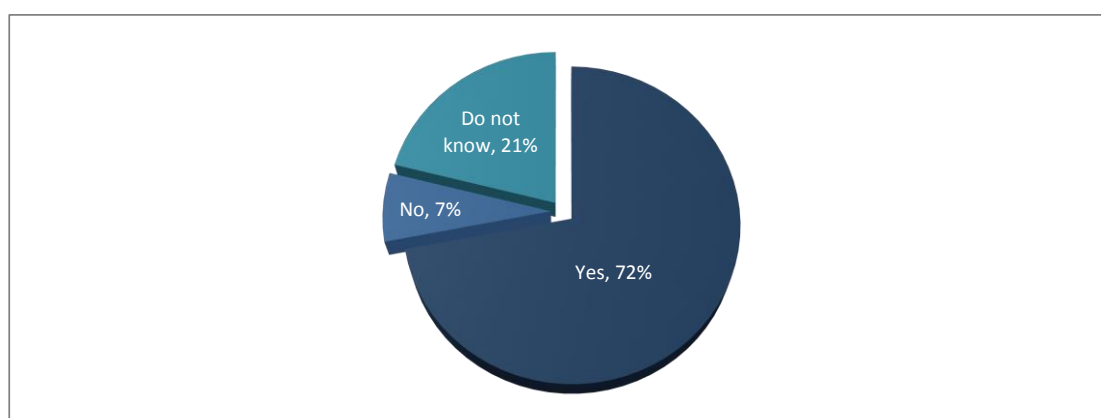
- **The Secretariat collaborated with development partners on joint initiatives,** such as the Joint Monitoring Programme between WHO and UNICEF, which strengthened data availability and quality on water and sanitation, and the Countdown to 2015 involving a large number of partners concerned with child and maternal health, which focused not just on tracking mortality and morbidity data but also included progress on policy adoption and on financing for maternal and child health by countries. The Secretariat also hosted the Health Metrics Network aimed at fostering the strengthening of health information systems at country level. Although discontinued in 2013, the Health Metrics Network contributed to the *“development of a comprehensive framework for health information systems”* as well as promoting the importance of civil registration and vital statistics.⁸⁷
- **The Secretariat consolidated data on h-MDG progress.** As the only global agency covering the whole spectrum of health, the Secretariat provided consolidated data on the h-MDGs. In 2008 the Secretariat established the Global Health Observatory, which became the gateway of health-related statistics, to monitor progress towards the h-MDGs and which is currently *“the*

⁸⁷ WHO (2012) WHO's arrangements for hosting health partnerships and proposals for harmonizing WHO's work with hosted partnerships. Document EB132/5, Add.1, p. 5.

only regular United Nations mechanism that presents comparable data on a large range of health topics from all countries”.⁸⁸ The Secretariat also produced annual flagship reports, such as the World Malaria Report and the Global Tuberculosis Report, which serve as important reference points both for Member States and partners. The evaluation found that these and other reports helped raise the profile of MDG-related diseases and also provided key data on which to base the efforts of Member States and development partners. At the regional level, the Secretariat published regional reports on monitoring progress on the MDGs,⁸⁹ other fact sheets and/or scorecards for the progress of individual Member States on MDGs indicators. Since 2008 and on a biennial basis, the Secretariat presented reports to the World Health Assembly on “Monitoring of the achievement of the health-related Millennium Development Goals”.

- **The Secretariat strengthened national health information systems and data collection.** The Secretariat recognizes health information systems as an essential pillar for MDG achievement.⁹⁰ In 2007, the WHA requested the Director-General to increase “WHO’s activities in health statistics at global, regional and country levels and provide harmonized support to Member States to build capacities for development of health information systems and generation, analysis, dissemination and use of data.”⁹¹ WHO country offices were involved in strengthening information systems, including providing technical support for the conduct of epidemiological surveys related to h-MDGs, which have been subsequently used as the basis of policy dialogue on MDGs issues. The evaluation gathered evidence of the Secretariat’s contribution to strengthening surveillance systems through early warning alert and response systems for communicable diseases and maternal deaths. More generally, the Secretariat supported capacity building to better monitor trends and analyse data (Figure 26).

Figure 26: Member States assessment whether the Secretariat supported their country in the monitoring of h-MDG related indicators



Source: WHO Member States survey results

Success factors and challenges of the Secretariat’s contribution to the achievement of the h-MDGs

102. Contribution to health agendas and engagement of actors on h-MDGs and development of norms and standards are the areas of the Secretariat’s most significant achievements

⁸⁸ WHO (2017) World Health Statistics 2016, Ch. 2, p.3.

⁸⁹ WHO (2007) Health MDGs in South East Asia Region: at a glance; WHO (2010) Achieving the health-related Millennium Development Goals in the Western Pacific Region (2010); WHO (2010) Millennium Development Goals in the WHO European Region, A situational Analysis at the eve of the five-year countdown; WHO (2010) Progress on the health-related MDGs in the African Region in African Health Observatory, Issue 11.

⁹⁰ WHO (2007) Strengthening of Health Information Systems: Report by the Secretariat. Document A60/22, p.1, para 4.

⁹¹ WHO (2007) Strengthening of Health Information Systems. Resolution WHA60.27, p.2, para.3.

recognized by both Member States and partners. The contribution has been possible thanks to the Secretariat's strong branding, its credibility as a neutral and quality partner, and its solid convening power to rally Member States and partners behind the WHO global health agenda. To this end, the WHO country presence is considered a fundamental pillar in support of operationalizing the Secretariat's work. Particularly at country level, many Member States valued the close relationship and regular communication they hold with WHO country offices and consider it as one of the most fundamental assets of the Organization, coupled with the Secretariat's responsiveness to Member States' needs.

103. However, many partners also mentioned limitations in the Secretariat's ways of working. Among these, partners stated that the Secretariat's positioning, leadership and communications style with regard to the h-MDGs and with regard to its own agenda could have been stronger on many occasions. In particular, they considered that the Secretariat could strengthen its role in terms of coordinating, convening and leading other health actors along shared objectives, building on the strengths of each actor. According to partners, these limitations undermined the Secretariat's potential and the effectiveness of its response, as well as its ability to mobilize support and resources, which was also considered weak by several of the key informants interviewed by the evaluation. Some partners thought that the Secretariat could have shown more determination and ambition in setting agendas and demonstrating leadership at both global and country levels.
104. Many also considered that, while the Secretariat's primary focus is to support Member States, it should also seek to include other partners among its target audience, in particular civil society, particularly on grounds of equity, as well as to expand its level of engagement with other actors and partners. Many others considered that the Secretariat did not interact enough with other partners restraining the scope and potential of its work.
105. Some Member States highlighted the tendency of the Secretariat to move into the implementation field and emphasized the risks, particularly as its limited capacity constrained the Secretariat's ability to implement. The Secretariat's added value was seen more upstream at the level of agenda setting, coordination, normative functions, and technical support rather than downstream at implementation level where other organizations are better positioned. They further thought that moving along the continuum towards implementation would be ineffective.
106. The limited resources and technical capacity of the Secretariat, particularly at country level, was one of the most frequently-reported challenges, which allegedly limited the Organization's performance with regard to the h-MDGs. Scarce technical capacity in country offices meant that programmes could not be properly rolled out in countries, or that they were delayed. Stakeholders interviewed by the evaluation felt that country offices faced constraints in receiving technical support from other levels of the Organization due to cumbersome internal procedures, which affected not only the quality and extent of technical support in countries, but also the production of normative work and guidelines, and the participation of the Secretariat in global fora and decision-making environments. Overall they limited the Secretariat's performance and visibility.
107. There were various remarks highlighting limitations and redundancies in internal collaboration across the three levels of the Organization. Several partners underlined that differences in priorities, engagement, communications and coordination across major offices were affecting the speed, consistency and effectiveness of the Secretariat's contribution. The Organization was also characterized by a limited internal culture of collaboration, on occasion leading to the duplication of highly technical work, such as guidelines. Some partners emphasized the lack of accountability of the Secretariat's major offices along the value chain, which undermines its credibility with donors and partners.

108. Finally, the vertical approach of the MDG agenda was considered to have led to significant achievements along disease targets. However, it also undermined sustained and needed change in the health systems of Member States. This approach was also criticized because of its negative impact on internal collaboration within the Secretariat leading to fragmentation of technical assistance.

Evaluation Question 4: How did the Secretariat work with others to support the achievement of the MDGs?

The Secretariat effectively collaborated with other organizations.

109. Working in partnerships was a central feature of the global action around the MDGs. For all h-MDGs, the Secretariat worked with UN agencies and development partners. Partnerships adopted a wide array of forms through various mechanisms, including hosted partnerships, joint technical working groups/consultations, joint publications/statements, joint monitoring and reporting efforts, and joint conferences/high-level meetings at global and regional levels. The Eleventh GPW recognised the importance of working closely with UN agencies to *“facilitate the review, better alignment and focus of WHO activities to achieve the Millennium Development Goals”*.⁹²
110. Collaboration with UN agencies, in particular UNICEF, UNFPA, UNAIDS and the World Bank, was at the core of the Secretariat’s work at the three levels of the Organization. A number of high-profile partnerships were also established with UN partners to support these efforts. In 2015, a Secretariat report to the WHA noted that the *“most notable examples of WHO’s strong and well established collaboration with other United Nations health-related agencies relate to the achievement of the Millennium Development Goals, through the Health 4+ (H4+) partnership, the Every Women, Every Child movement, and the International Health Partnership and related initiatives (IHP+)”*.⁹³
111. At the country level, the Secretariat’s contributions were instrumental in convening and coordinating partners in the health cluster in emergency contexts as well as steering committees and technical working groups on the h-MDGs. The Secretariat also advocated for the *“inclusion of a health component in the United Nations Development Assistance Framework for countries”*, which included MDG-related areas of work,⁹⁴ and participated in large-scale multi-partner programmes.
112. The Secretariat also hosted and launched a series of partnerships at the time of or shortly after the adoption of the MDGs.⁹⁵ The hosted partnerships increased the visibility of h-MDG issues and challenges, enhanced advocacy around the h-MDGs, and brought together partners from various constituency groups, including both State and non-State actors. A WHO report noted that *“WHO-hosted partnerships have been particularly successful in raising the profile of certain critical public health issues on policy agendas through their communication and brand-building efforts. Hosted partnerships have strengthened advocacy efforts by harnessing the contribution of a diverse range of stakeholders and focusing attention on specific issues central to the mandate of the partnership”*.⁹⁶

⁹² WHO (2006) Eleventh General Programme of Work: *“WHO will place particular emphasis on strengthening its collaboration with UNICEF and UNFPA through regular strategic policy and technical dialogue. These collaborations will facilitate the review, better alignment and focus of WHO activities to achieve the Millennium Development Goals. They will also build on WHO’s comparative advantage, and ensure that all levels of the Organization provide coherent support to these efforts.”* p.26.

⁹³ WHO (2015) Collaboration within the United Nations system and with other intergovernmental organizations, Report by the Secretariat. Document A68/50, p.4, para.21.

⁹⁴ WHO (2015) Collaboration within the United Nations system and with other intergovernmental organizations, Report by the Secretariat. Document A68/50, p.3, para.18.

⁹⁵ Hosted partnerships on the h-MDGs included: the RBM Partnership; the Stop TB Partnership; the PMNCH; the International Drug Purchasing Facility, UNITAID; and the Health Metrics Network.

⁹⁶ WHO (2012) WHO’s arrangements for hosting health partnerships and proposals for harmonizing WHO’s work with hosted partnerships: report by the Secretariat. Document EB132/5 Add.1, p.4.

The Secretariat had limited engagement with non-State actors.

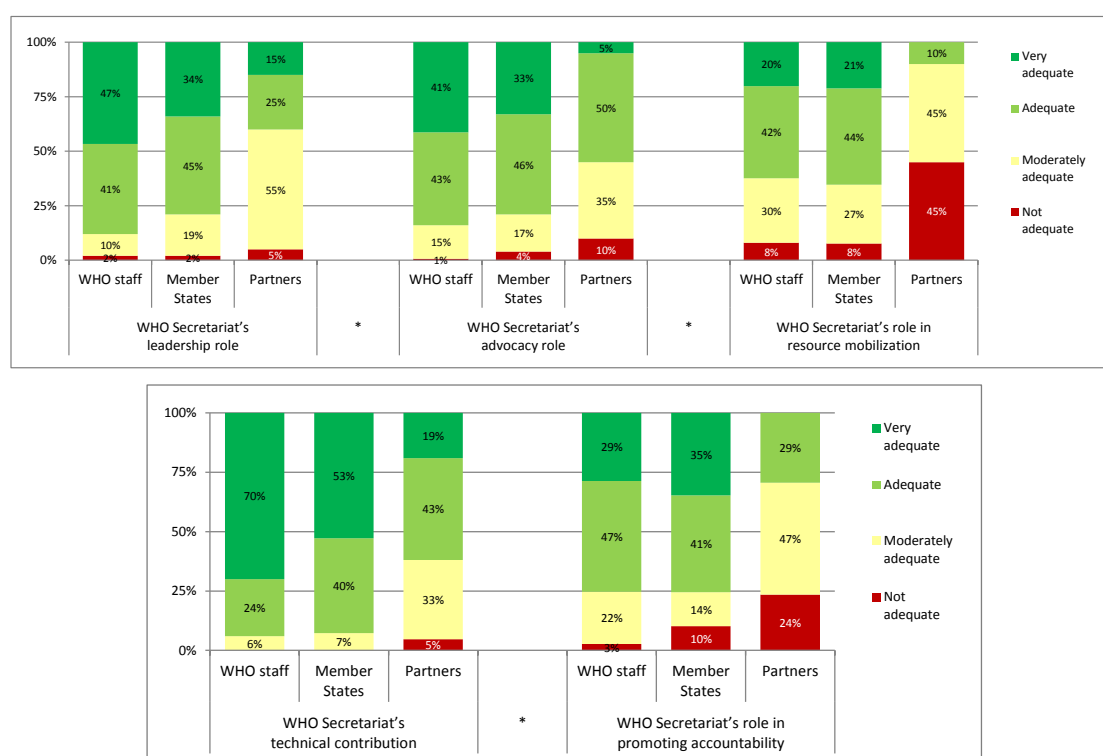
113. The Secretariat's engagement with non-State actors was more limited. However, the evaluation found examples of joint work, such as the collaboration with pharmaceutical companies to support availability and affordability of essential medicines for NTDs or of joint projects in countries partnering with civil society around particular MDG strategies.
114. In 2008, the Secretariat recognized that *"global partnerships have been successful in raising the profile of critical issues, promoting interagency work and involving civil society and the private sector. However, there are now between 75 and 100 global health partnerships and initiatives; the global health environment has become increasingly fragmented and transaction costs faced by governments have increased."*⁹⁷
115. In 2010, the Secretariat adopted the *"Policy on WHO's engagement with Global Health Partnerships and Hosting Arrangements"* aimed at providing a framework to guide the Secretariat's engagement with partners and harmonizing the Secretariat's work with hosted partnerships. To address the above challenges, the Secretariat also carried out periodic reviews on hosted partnerships to document key issues and address challenges. Furthermore, stakeholders noted the importance of building trust and ensuring the principles of collaboration are set out clearly and openly as the basis for successful partnerships.
116. Several stakeholders shared expectations that the recently approved Framework of engagement with non-State actors (FENSA) will be an important mechanism for strengthening the collaboration with non-State actors in support of the SDGs.

Mixed assessment of the added value of Secretariat's work with partners.

117. Partners recognized that the Secretariat has been a useful forum for the MDGs based on its recognized convening power and capacity to act as an honest broker. The Secretariat's coordinating role in countries and globally was widely recognized.
118. Figure 27 below shows the assessment of WHO staff, Member State respondents and partners of the adequacy of the Secretariat's role with partners. The majority of Member States responding to the survey considered that the Secretariat's work was adequate or very adequate across all functional roles and activities. The Secretariat's technical contribution, followed by its advocacy role, were the roles most valued by all stakeholders. Conversely, Member States and other partners considered that the Secretariat's work with partners in terms of resource mobilization was the least adequately performed. About 45% of the partners found the Secretariat's role in resource mobilization inadequate and 24% of them also considered inadequate its role in promoting accountability. In fact, less than half of the external partners considered that the Secretariat's contribution was adequate in any of its roles, other than in terms of its technical contribution and advocacy role.

⁹⁷ WHO (2008) Monitoring the achievement of the health-related Millennium Development Goals, Report by the Secretariat. Document A61/15 page 5, para.23.

Figure 27. Stakeholder assessment of the adequacy of the Secretariat's role working with partners

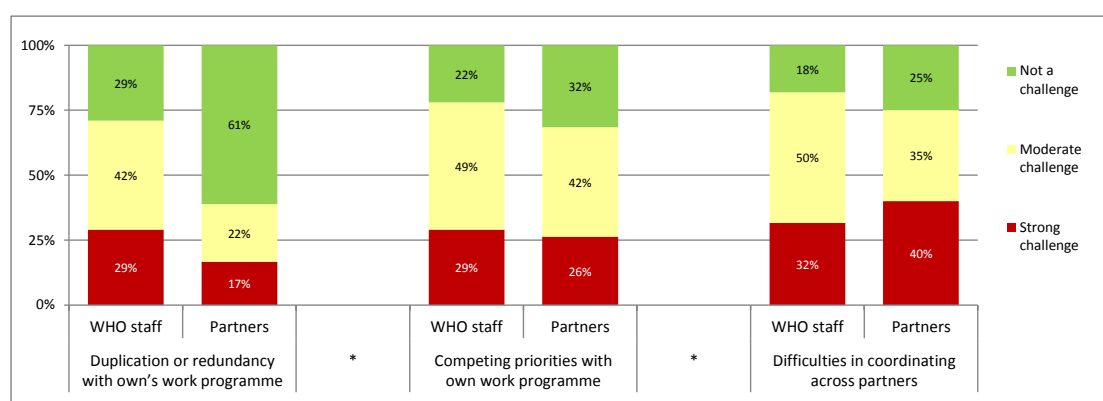


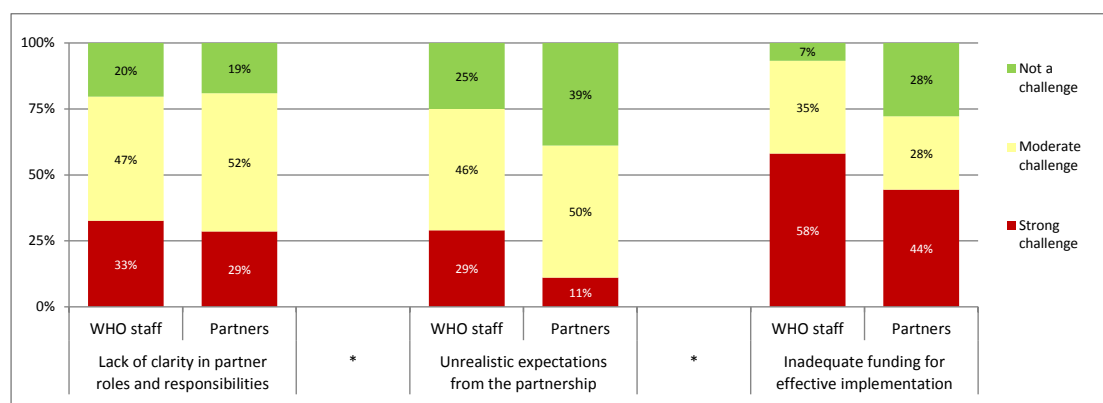
Source: WHO staff, Member States and partners survey results

Challenges in working with partners

119. The survey results, confirmed through interviews, showed that, for both WHO staff and partners, the most important challenges for the Secretariat to work effectively in partnerships around the MDGs were related to inadequate funding for implementation of activities followed by difficulties in coordinating across partners. The lack of clarity of roles and responsibilities among partners and WHO, together with competing priorities were also identified as important challenges (Figure 28).

Figure 28: Stakeholder assessment of the main challenges for the Secretariat in working with partners





Source: WHO staff and partners survey results

120. Most partners interviewed highlighted the following major categories for improvement.

- **Difficulty in coordinating across partners** was perceived as one of the strongest challenges. Some partners found that there was a lack of structured coordinating mechanisms or a strategy to favour joint work and that not enough was being done to harness the relative strengths and potential synergies of working in partnerships. Some considered that “*had WHO worked building on the strengths of its partners, more efficiency could have been achieved*”. Some partners indicated that a lack of understanding of each other’s strengths, coupled with a culture of adopting unilateral decisions, led to more competitiveness rather than to collaborative environments. Partners considered that there was a need for a more coordinated effort and cohesion based on the comparative advantage of each partner rather than competition.
- **Leadership and stronger dialogue with partners in countries.** Partners also emphasized the need for a stronger leadership role by the Secretariat at country level, focusing more on country level coordination and collaborative work with implementing agencies.
- **Inadequate funding for effective implementation** was viewed as the strongest challenge for effective collaborative work. The proliferation of partnerships led to increased competition for resources, especially at country level. It was perceived that some donors/funders redirected their funding from the Secretariat to other partners.
- **Lack of clarity of roles and responsibilities and overlapping mandates.** Interviews indicated frequent overlaps in mandates and functions between the Secretariat and some partners, leading to duplication, fragmentation or redundancy. This was particularly true for hosted partnerships, which suffered from a lack of clarity in the division of labour between the Secretariat and other partners, resulting in overlapping areas of work.
- **Lack of flexibility in engagement.** The bureaucratic processes and rigidity of roles, together with limited funding were strong limitations to full participation of the Secretariat in the dynamics of multistakeholder partnerships.
- **Insufficient engagement with civil society, nongovernmental organizations, private partners and others.** Many partners considered that the Secretariat did not engage sufficiently with a wide array of stakeholders. A key challenge was the lack of a clear framework of engagement. In addition, partners also emphasized the lack of awareness by the Secretariat of the potential that other partners might offer leading to unrealistic expectations and lack of trust. Partners recommended that the Secretariat be more proactive in its interactions, not limiting its engagement to Member States but also seeking to include civil society.
- **Internal competition.** Difficulties in internal collaboration across Secretariat departments, divisions and major offices, including different priorities and internal competition for funding, visibility and ownership, were perceived as important challenges for collaborative work externally. Some partners highlighted difficulties: i) to establish stable and flexible

relationships with the Organization; ii) to have a consistent leadership and a shared agenda across the Secretariat; iii) to have flexible communication through various entry points; and iv) to work on shared workplans across the three levels of the Organization.

- **Weak accountability, limited communications and information sharing.** Partners indicated that the lack of accountability, coupled with limited information sharing and official communications at the three levels of the Organization, did not help in building relationships with the Secretariat during the life of projects. There is a need for stronger communications and greater clarity concerning the Secretariat's role.
- **Governance and administrative challenges for hosted partnerships.** WHO-hosted partnerships had their own independent governance boards which did not fully interact with the governance structure of the Secretariat, thereby limiting alignment on policy and technical issues.⁹⁸ Respondents also suggested that the requirements for WHO-hosted partnerships to follow the Secretariat's internal rules and procedures, often seen as cumbersome and bureaucratic, led to some challenges in the management of the partnerships.

⁹⁸ WHO (2012) WHO's arrangements for hosting health partnerships and proposals for harmonizing WHO's work with hosted partnerships: report by the Secretariat. Document EB132/5 Add.1, p.7-9.

4. Conclusions, lessons learned and recommendations

121. The findings developed in the previous section led to a certain number of conclusions and lessons learned which, taken together, support five recommendations considered critical to strengthen the Organization's contribution to the 2030 Agenda on SDGs.

Conclusions

Secretariat's response to the adoption of the MDGs

122. The UN Millennium Declaration embodied a vision for development that generated momentum for Member States and major global actors to work towards the achievement of global goals. The Secretariat, as the leading international public health agency, responded to the UN call and gradually focused its efforts towards the achievement of the MDG goals.
123. WHO's governing bodies provided as early as 2002 an overarching framework to guide the Secretariat's response, after which the Secretariat engaged on the international scene, contributing to the inclusion of initially overlooked health priorities, such as NTDs, and the repositioning of health issues in a more comprehensive and public health oriented manner than initially envisaged.
124. However, the Secretariat was much slower to frame its contribution to the health-related MDGs in a concerted and coherent manner within the Organization. The last regional resolution defining priorities to address the h-MDGs was only adopted in 2007. Despite a 2005 WHA resolution requesting the development of a coherent and adequately resourced strategy, it was never developed.
125. In the mid-2000s, the Secretariat progressively aligned its GPWs and PBs to the h-MDGs. This enhanced the visibility of the Secretariat's programmes directly related to the h-MDGs. However, overall, the Secretariat did not show an explicit strong corporate leadership championing the h-MDGs at the three levels of the Organization. Neither did it conceptualize a strategy to ensure that all relevant corporate programmes, regions and countries developed their response in a consistent manner across the h-MDGs.
126. The MDG approach based on targets and indicators increased the emphasis on tracking health trends in countries. The WHA mandated the Secretariat to report annually on progress towards the achievement of the h-MDGs. Though this mandate only came in 2008, it gave a strong impetus to enhance collaboration between relevant programmes to strengthen the information and evidence culture of the Organization. The creation of the Global Health Observatory was instrumental in this regard.
127. The overall MDG design along the lines of specific diseases and targets promoted a vertical/silo response along technical programmes. It enhanced collaboration across the three levels of the Organization within the same technical programmes but there was limited interaction with other programmes. However, differences in programme objectives and in engagement across major offices might have also hampered the extent of collaboration.
128. This vertical approach had adverse effects on cross-cutting issues, especially when it came to health systems. Limited attention was given to the ability of health systems to cope with the MDG focus on specific health issues. This silo approach was furthermore amplified, at least initially, by limited communication and coordination across the Secretariat's programmes.
129. Even if not in a strategic and coherent manner, it is clear that, over time, the h-MDGs influenced the Secretariat's ways of working across its three levels and contributed to strengthened collaboration with partners. Finally, it is clear that the Secretariat's response to the h-MDGs at corporate level and the global health discourse influenced each other. At

country level, the Secretariat's response was mostly influenced by country health priorities rather than by donor or civil society priorities.

130. Internally, strategic documents such as the GPWs and the PBs played a key role in the Secretariat's response, while limited human and financial resources and other competing priorities constrained its contribution to the h-MDGs.
131. With regard to the level of financial resources, the level of expenditures increased steadily between 2000 and 2010 and then stabilized after a slight decline. This raises a question about the Secretariat's ability to attract funding for the h-MDGs and the extent to which it was perceived as a credible partner to achieve the h-MDGs.
132. Furthermore, the proportion of the Secretariat's h-MDG budget in the overall budget for global development assistance for h-MDGs declined significantly over the period 2000-2015, reflecting a clear challenge for the Secretariat to attract funding for h-MDGs. This was further exacerbated by an increasing dependence of the Secretariat on unpredictable voluntary contributions.

Relevance of the Secretariat's response

133. At country level, the Secretariat's contribution was found relevant and timely by Member States but much less so by partners. The Secretariat's response reflected by and large the national h-MDGs priorities and the epidemiological burden of countries. Alignment with donor and civil society priorities in-country took place, though to a lesser extent.
134. The adequacy of the Secretariat's role to set norms and standards as well as to monitor the health situation and assess health trends was largely recognized by both Member States and partners, while the Secretariat's ability to provide technical support and to shape a relevant research agenda was considered as less adequate, particularly by partners.
135. While the Secretariat received more funding over the MDG period for other health priorities than for the h-MDGs, there is a consensus that the other health priorities were sometimes not adequately addressed because of the priority given to the h-MDGs.

Secretariat's main results

136. The analysis of results per core function showed an uneven level of performance. On the positive side, a large majority of Member States and partners found the Secretariat's contribution to the achievements of the h-MDGs in countries satisfactory.
137. A closer analysis of contributions in relation to the six core functions indicated clearly that Member States valued the leadership and advocacy role of the Secretariat as well as its unique role to set norms and standards and develop corresponding guidelines. On the other hand, the core functions which received lower ratings by Member States and partners were the Secretariat's ability to shape a relevant research agenda and stimulate the generation, translation and dissemination of valuable knowledge and its ability to strengthen capacities in countries.
138. The Secretariat's leadership in monitoring the health situation and assessing health trends was widely recognized by both Member States and partners. Particularly appreciated were the access to improved quality of data and more robust estimation processes and also the strengthened collaboration with partners on joint initiatives, the consolidated data sets on h-MDG progress and the strengthened national health information systems.
139. The Secretariat's strong branding and credibility as a neutral and quality partner, as well as its solid convening power were among its major assets, together with its country presence sustained by a close relationship with Member States.

140. Many partners also identified limitations in the Secretariat's overall positioning, leadership and communication style on the h-MDGs, which possibly reflected a lack of ambition and certainly undermined resource mobilisation at all levels.
141. There was continuous tension between upstream normative work, where the Secretariat's added value is well recognized, and technical support which was perceived as somewhat weaker, especially at country level where Member States found the Secretariat sometimes constrained in providing technical support.
142. Finally, as a result of the Secretariat's vertical approach to addressing the MDGs, non-MDG related programmes lost traction, even though many were recognized as corporate WHO priorities. This included the Secretariat's contribution to strengthening health systems which were the foundations for achieving the h-MDGs. There was little evidence of structural efforts to counterbalance the vertical design of the h-MDGs, as well as to position other WHO priorities prominently, in particular during the initial years.

Collaboration with partners

143. Partnership was a central feature of the MDGs and the number of actors engaged in the health sector increased significantly over the period. Overall, the Secretariat's collaboration with UN agencies was effective at the three levels of the Organization and the Secretariat also initiated a series of partnerships over the period. However, its engagement with non-State actors remained limited. Many considered that the Secretariat should seek to include other partners among its target audience, especially civil society, particularly on equity grounds.
144. From the partner perspective, while the Secretariat's added value as a convening power was well established, the Secretariat was much less adequate when it came to resource mobilization and promotion of accountability.
145. Collaboration was challenging for both the Secretariat and partners on many fronts. The main mutually reinforcing challenges impeding effective collaboration included:
- Inadequate funding for effective implementation: the proliferation of new actors meant increased competition for resources and increasingly fragmented collaboration.
 - Difficulties in coordination and lack of clarity in partners' roles and responsibilities resulted in competition and lack of transparency.
 - Internal competition within the Secretariat negatively affected credible engagement with external partners.

Key lessons learned for the Secretariat's engagement on the SDGs

146. Most lessons learned by this evaluation concur with those of previous evaluations such as the evaluation of WHO's presence in countries and the evaluation of WHO reform third stage.
147. **Reasserting the Secretariat's leading and convening role on health issues globally, regionally and nationally.** The Secretariat's leadership and convening power is one of its most recognized core functions. However, the evaluation showed that it has not always played this role as well as it could have, namely to develop and convey a strategic corporate vision for the global leadership of the h-MDGs in a context where the number of partners increased. Therefore the need to demonstrate the Organizations' comparative advantage as global leader and convenor; as well as adequate resourcing in countries to enable them to play such roles, and the need for coordination and collaboration based on added value and complementarity (for instance within the UN family) were found critically important.
148. **Translating the vision into action.** While the Secretariat had an early mandate to address the MDGs and it did contribute to the refinement of the global goals and targets, it was much

slower internally to champion the h-MDGs in an integrated manner across the three levels of the Organization and across the goals. Despite its mandate, it lacked an overarching vision and strategic plan to bring coherence to its contribution. As the SDG era has already started, there is an obvious risk that the Secretariat will again take significant time to set its vision and align its planning structures and technical programmes in order to develop the strategic roadmap for its contribution to the new global agenda. The MDG experience suggests the need to accelerate the required internal processes and strategic decisions in order for the Secretariat to be able to provide a prompt and coherent contribution to the SDG in line with WHO's mandate. It should be noted though that some regions are moving swiftly and the Regional Office for the Western Pacific for instance has already developed an SDG action framework.

149. **A clear comparative advantage in health situation monitoring.** The experience gained during the MDG period provides the Secretariat with a clear comparative advantage to build upon in order to maintain its leading role in the monitoring of all health targets for the SDGs. In 2016, WHO together with partners launched a new multistakeholder effort, the Health Data Collaborative, aimed at strengthening health information systems in countries and ensuring harmonization of data in support of the SDGs.
150. **Moving from a vertical to a health system approach.** The vertical approach introduced by the MDGs negatively affected collaboration and synergies with health issues that were not directly targeted by the MDGs and favoured vertical collaboration across the three levels of the Organization, which excluded health systems and other cross-cutting issues. As the SDGs are more comprehensive it is unlikely that the competition observed between MDG and non-MDG priorities will be the same. Indeed as health systems and other programme areas which were not part of the MDGs are now at the core of the health SDG agenda, there is a real opportunity for the Secretariat to revisit its approach and engage across all programmes and levels of the Organization to meet the SDG challenges. However, a sustained emphasis on the achievement of specific targets and indicators as part of the new SDG agenda may lead to new vertical/silo approaches as seen in the MDG era.
151. **Sustainable financing.** It is striking to observe that, while overall DAH increased over the period, the Secretariat attracted a continuously decreasing proportion of this funding over the same period which could be due in part to the influx of various global health initiatives supporting the h-MDGs. However, both partners and Member States expressed some reservations about the Secretariat's ability to attract more flexible funding for health.
152. **Credible demonstration of results.** While it has been possible for the evaluation to document achievements it has not been possible to demonstrate the level of effectiveness of the Secretariat's contribution. The lack of an explicit results framework for the Secretariat's work on the MDGs coupled with the existing management systems do not allow for framing and qualifying/quantifying expected outcomes and outputs so that they can be monitored and progress reported in a credible way.
153. **Cutting edge technical support where and when required.** This core function did not contribute as satisfactorily as it should have done, particularly at country level. It is important for the Organization to ensure timely cutting edge technical support in countries requiring it, knowing that the expectations are different in upper-middle-income countries and in fragile low-income countries.
154. **Clarifying the Secretariat's role on the research agenda and stimulating the generation, translation and dissemination of valuable knowledge.** Perceived as underperforming by stakeholders it will be important for the Secretariat to clarify its role in this regard, especially considering the strong expectations in this area to support the SDG.

155. **Strengthened communication.** Many of the challenges identified during the course of the evaluation could have been mitigated, both internally across programmes and levels of the Organization and externally with Member States and partners, through strengthened communication approaches and channels.

Recommendations

156. The conclusions and lessons learned lead naturally to a few strategic recommendations geared toward a relevant, effective and efficient contribution of the Secretariat to the SDGs, in particular in countries recognizing and supporting the leadership role of Member States in this regard. To this effect the evaluation makes the following recommendations.

Recommendation 1: Develop and adopt a corporate strategy to address the SDG agenda across the three levels of the Organization with a particular emphasis at the country level.

157. As the leading international public health agency, the Secretariat needs to demonstrate leadership in guiding the international community and supporting countries towards achieving the SDGs. *“WHO is in a strong position to support the development of better systems to improve health, within and beyond the health sector, given the Organization’s normative role in health”*.⁹⁹ Resolution EB138.R5 requests the Director-General *“to take the leading role, facilitate international cooperation and foster coordination in global health at all levels, particularly in relation to health system strengthening, including essential public health functions, supportive of the achievement of the health-related Sustainable Development Goals and targets”*.
158. The Secretariat’s contribution needs to be supported by an overarching framework, guided by a corporate vision, including principles for priority setting, expected results, means of operation and clear resource mobilisation approach at global, regional and country levels. It also has to be framed by a Theory of Change describing the main changes expected across the three levels of the Organization and the main assumptions to be made to achieve these changes.
159. The 13th GPW should be very explicit about the Secretariat’s contribution to SDG achievements and needs to clarify, in particular, targets and indicators of success at country level. In addition, the programme budgets will have to be aligned to the corporate SDG strategy in terms of goals, priority areas, outputs and outcome measurement approaches (documents EB140/32 and A69/15 recognize the need for budget alignment to SDGs).
160. Internally, this corporate SDG strategy needs to be shared across the three levels of the Organization, and be owned by them. Regional and country offices need to be involved in its development, operationalization and monitoring so that linkages with regional SDG frameworks where they exist as well as with the country cooperation strategies are duly considered.
161. Externally, the Secretariat has to develop a strong communication approach in support of the corporate SDG strategy, proposing a strong positioning: i) of the Organization as the leading international agency for advancing SDG3 and contributing to the other SDG goals with a health dimension; and ii) of the country offices so that they actively and effectively support national achievement of the SDGs.

⁹⁹ WHO (2017) document EB 140/32, para. 21.

Recommendation 2: Ensure mainstreaming of cross-cutting issues and the ability to champion the SDGs through strengthened collaboration across different programmes and at the three levels of the Organization, in particular at the country level.

162. The vertical approach adopted during the MDG period has clearly shown its limitations. It is therefore critically important for the Secretariat to ensure that, when developing its corporate SDG strategy and the 13th GPW, it avoids this trap learning from past experience. Universal health coverage through a health systems strengthening approach can be useful as the integrated principle of the Secretariat's contributions to the SDGs, particularly in countries. As recommended in document A69/15, "*Planning, budgeting, financing and resource allocation*" units must design and "*provide the incentives needed to drive more collaborative work across the Organization*", which may require establishing structural mechanisms to facilitate cross-departmental and cross-sectoral collaboration. A clear definition of roles and functions at each level of the Organization, especially at headquarters where technical areas are sometimes covered by several departments or units, would greatly facilitate such collaboration.

Recommendation 3: Foster cross-sectoral collaboration in order to address health dimensions in all relevant SDGs at the international level with regional and global partners and in countries with relevant ministries and development partners

163. Given that intersectoral work is at the core of the SDGs, working and collaborating with cross-sectoral partners will be of critical importance during the SDGs. The Secretariat will need to work across sectors by strengthening existing partnerships and engaging new partners beyond the health sector. To this effect, the Secretariat should use its convening power to strengthen and foster relevant partnerships, bringing together health and non-health actors in support of a cross-sectoral approach to the SDGs internationally and in countries.

164. The Secretariat should strengthen its collaboration within the UN community in line with discussions highlighted by the Secretariat¹⁰⁰ which recognizes that "*attaining the goals of the 2030 Agenda demands greater emphasis on programmatic cooperation across entities*".

165. Furthermore, the Secretariat should expand its network of partners, to include not only ministries of health in Member States but also parliamentarians in countries where relevant, civil society and other non-State actors. The Secretariat would benefit from a transparent mechanism for its active engagement with different stakeholders, in particular non-State actors, and there are many expectations with regard to the implementation of the recently approved Framework of engagement with non-State actors during the SDG period.

Recommendation 4: Focus on the comparative advantage of the Secretariat as expressed through its core functions. Strengthen them as required to meet the SDG challenges, especially in countries.

166. WHO's extensive presence in countries, its institutional credibility, and close relationship with Member States give the Secretariat a clear leadership role to broker coordination and partnerships around the SDG agenda at the three levels of the Organization.

167. The Secretariat should convene as a neutral broker, develop the adequate norms and standards to meet the SDG challenges, set up an appropriate research agenda, adapt the health monitoring mechanisms to the SDGs targets defined in countries and ensure timely, high standard technical support.

¹⁰⁰ WHO (2017) document A70/55, para. 4.

168. The adequate capacity of WHO country offices to support Member States effectively in achieving the SDG targets is paramount. As already mentioned by the evaluation of WHO reform, third stage, capacity building in the diplomatic and negotiation domains are critical to support WHO's convening role - at the three levels of the Organization, and especially at the country level. Hence, the Secretariat should ensure such capacity and its strengthening where needed.
169. Its recognized leadership in monitoring the health situation and assessing health trends requires the Secretariat to support countries: in the identification of relevant indicators to measure progress, effectiveness and impact; in the promotion of measurements and reporting for transparency and accountability; in the strengthening of data quality and health information infrastructure; and in the strengthening of capacity building for data systems and information sharing in countries.

Recommendation 5: Ensure the ability of the Secretariat to credibly demonstrate its contribution to the SDGs and measure its results, in particular at the country level.

170. It is urgent for the Secretariat to set up a corporate result framework and mechanism for monitoring its contribution to the SDGs in countries against agreed targets. As indicated already in other evaluations, such a system does not yet exist. This mechanism should be aligned with the corporate general programmes of work and programme budgets allowing for corporate performance monitoring. At the country level, the WHO results framework should be in line with the Country Cooperation Strategy and the global results framework.