Evaluation of the WHO Special Programme on Primary Health Care

Annexes

World Health Organization

WHO/DGO/EVL/2025.31

Cover page photo credit: KENYA: WHO Malaria Vaccine Implementation Programme visit, February 2023, WHO/Fanjan Combrink

Contents

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Independent Evaluation Team
Clare Dickinson, Team Leader
Maiken Mansfeld Jacobsen, Deputy Team Leader
Erin Ferenchick, Evaluation specialist
Matthew Cooper, Evaluation specialist
Finja Daegling, Evaluation specialist

Evaluation Management
Marie Bombin, Senior Evaluation Officer, WHO Evaluation Office
Ye Li, Evaluation Officer

Evaluation Reference Group
Experts from Member States, civil society organizations, private sector (trade associations), academia, philanthropy and from three WHO regional offices and headquarters.

Annex 1: Terms of Reference

Preliminary evaluation of the Special Programme on Primary Health Care

Terms of Reference – DRAFT 24 January 2023

I Background

1.1. WHO and Primary Health Care

a. Definition

1. Primary health care ("PHC") [1], as outlined in the 1978 Declaration of Alma-Ata and again 40 years later in the 2018 WHO/UNICEF document "A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals", is defined as "a whole-of-society approach to health that aims to ensure the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and preferences (as individuals, families, and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation, and palliative care, and as close as feasible to people's everyday environment.

2. This comprehensive definition of PHC incorporates three inter-related and synergistic components (Fig. 1):

Figure 1: Three components of PHC

- Integrated health services: Meeting people's health needs through comprehensive promotive, protective, preventive, curative, rehabilitative, and

[1] WHO/UNICEF document "A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals", 2018

palliative care throughout the life course, strategically prioritizing key health care services aimed at individuals and families through primary care and the population through public health functions as the central elements of integrated health services;

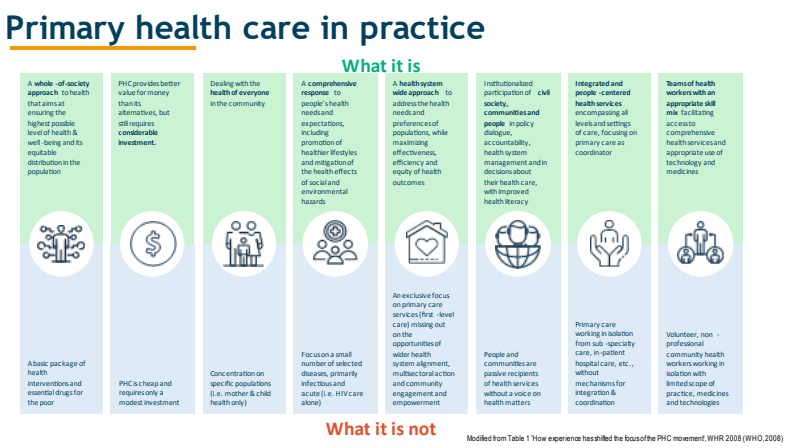
- Multisectoral policy and action: Systematically addressing the broader determinants of health (including social, economic, and environmental factors, as well as individual characteristics and behavior) through evidence-informed policies and actions across all sectors; and
- Empowered people and communities: Empowering individuals, families, and communities to optimize their health, as advocates for policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and caregivers.

3. Nested within the overarching definition of PHC are three inter-related and synergistic components, namely:
    - **Meeting people's health needs** through comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course, strategically prioritizing key health care services aimed at individuals and families through primary care and the population through public health functions as the central elements of integrated health services;
    - Systematically **addressing the broader determinants of health** (including social, economic and environmental factors, as well as individual characteristics and behaviour) through evidence-informed policies and actions across all sectors; and
    - **Empowering individuals, families, and communities** to optimize their health, as advocates for policies that promote and protect health and well-being, as co-developers of health and social services, and as self-care sponsors and caregivers.[2]

4. In these ways, PHC is clearly differentiated from the closely related term "primary care", which is the organization of essential health services principally at the first level of care. As such, primary care is one important element of PHC, but is also clearly distinguished from the much broader concept of PHC as an overall approach to health.

[2] Ibid., pp 2-4.

Figure 2: PHC in practice



b. Background

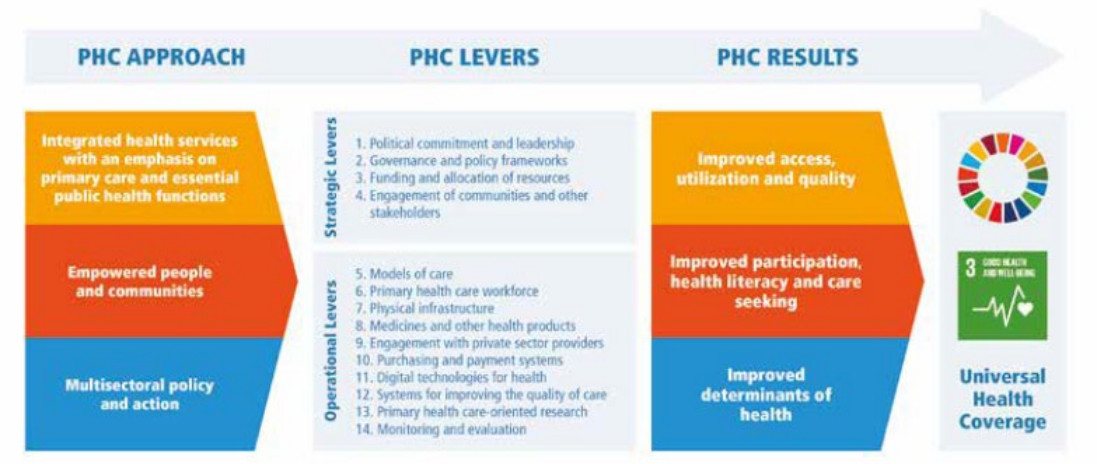
5. Building on the principles of the Declaration of Alma-Ata, the 2018 Declaration of Astana and the World Health Assembly resolution WHA72.2 (2019), reaffirmed Member States' commitment to PHC as a cornerstone of sustainable health systems for the achievement of universal health coverage ("UHC") and the health-related Sustainable Development Goals ("SDGs"). PHC is at the core of WHO's Thirteenth General Programme of Work, 2019–2023 (to be extended to 2025), with its triple focus on promoting health, keeping the world safe and serving the vulnerable.

6. WHO and UNICEF developed an Operational Framework for Primary Health Care[3] in 2020 to translate the global commitments made in the Declaration of Astana into actions and interventions to accelerate progress in strengthening PHC-oriented systems. The framework lays out 14 interdependent, inter-related and mutually reinforcing levers, including four core strategic levers: political commitment and leadership, governance and policy frameworks, funding and allocation of resources, and the engagement of communities and other stakeholders. The framework is also supported by the development of Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens[4] and of a compendium of case studies documenting the implementation of levers and related outcomes.

7. Finally, the framework proposes a Theory of Change for PHC, a cornerstone of sustainable health systems for the achievement of universal health coverage ("UHC") and the health-related Sustainable Development Goals ("SDGs").

[3] Its primary audience is national, and where appropriate, subnational government leaders. The operational framework is also aimed at informing the actions of other country- and global-level actors, such as non-State actors, including funders and civil society. Following consultation with, and input from, Member States, the draft operational framework is submitted for consideration by the Seventy-third World Health Assembly in 2020.
[4] Ibid., pp 2-4

Figure 3: Theory of change



8. The Global Action Plan for Healthy Lives and Well-being for All ("SDG3 GAP"), established in 2019, brings together 13 multilateral health, development and humanitarian agencies to address challenges around alignment, acceleration and assessing results by strengthening collaboration, joint action and more coordinated and aligned support to country owned and led national plans and strategies. The PHC "Accelerator" seeks to focus more synergistic efforts in cross-cutting areas where significant progress can be achieved by identifying assisting governments to identify bottlenecks and strengthen systems "levers", to build and expand service delivery models that include the most vulnerable groups.

1.2. WHO's Special programme on primary health care

9. Following a Review of 40 years of Primary Health Care implementation at country level conducted by the WHO Evaluation Office in 2019, WHO established a Special Programme on PHC ("SP") in 2020, at the time of the COVID-19 pandemic, to provide better integration across all levels of the Organization.

10. The SP has defined three main interconnected functions and workstreams:

Figure 2: Three core functions of the SP- PHC

11. Core activities of the SP include:

- The UHC Partnership, one of WHO's largest platforms for international cooperation to help deliver WHO's support and technical expertise in advancing UHC with a PHC approach in around 120 countries (a population of at least three billion people[5]);
- Enabling the alignment of technical products on PHC, drawing on the technical and policy expertise across WHO, in health systems areas, disease and life-course programmes and health emergencies.
- The development of the PHC measurement framework and indicators[6] (for reporting on country progress in PHC as part of UHC monitoring), and the PHC country case study compendium as described in the Operational framework for PHC[7].
- Reinforcement of regional priorities to support the renewal of PHC in tandem with regional offices

12. The PHC Accelerator (PHC-A) of the SDG3 Global Action Plan for Healthy Lives and Well-Being for All (SDG3 GAP) brings together 13 multilateral agencies to align support for countries in their efforts to advance PHC for UHC and ensure a resilient recovery from the COVID-19 pandemic. The PHC-A also works to integrate and align the Every Woman Every Child Agenda within the SDG3 GAP.

[5] Other partners include PHCPI and UHC2030. The PHC Performance Initiative (PHCPI) is a partnership dedicated to transforming the global state of PHC. UHC2030 provides a global platform and space for multiple stakeholders to connect, work together and influence national and international commitments.
[6] PHC measurement framework and indicators: monitoring health systems through a primary health care lens;
[7] In the COVID-19 context, this has included the development of the WHO position paper: Building health systems resilience for UHC and health security during the COVID-19 pandemic and beyond.

II Objective and purpose

13. This formative evaluation, requested by the Director of the SP, is part of EVL workplan 2022-2023. Building on the findings and recommendations of the 2019-2020 review of 40 years of PHC *(1)*, and on other relevant evaluations and reviews, it will assess how the SP, through its three main functions and workstreams, and its activities, has thus far contributed to better integration of efforts towards PHC objectives at global, regional and country level and make recommendations for the way forward. The evaluation will identify enabling factors and challenges and draw lessons learned from country and disease-specific contexts that can be scaled up in the future. Finally, the evaluation will make recommendations for the way forward of the SP to fulfill its mandate for sustained progress towards UHC/PHC and the SDGs.

14. This evaluation will accordingly be of a primarily formative and forward-looking nature. It ultimately aims to generate learning that can be used to enhance implementation and programme performance, as well as to inform relevant discussions and decisions both within WHO and with partners.

III Scope, approach and methods

15. The overall process and methodological approach will follow the principles set forth in the WHO Evaluation Practice Handbook *(2)* and the United Nations Evaluation Group Norms and Standards for Evaluation and Ethical Guidelines for Evaluation *(3*). The evaluation will also adhere to WHO's cross-cutting evaluation strategies on gender, equity, vulnerable populations and human rights, and include, to the extent possible, disaggregated data and analysis.

16. Guided by the United Nations Evaluation Group (UNEG) evaluation criteria of relevance, effectiveness, efficiency, coherence, and sustainability, the evaluation will:
    - document key achievements, enabling factors, challenges, gaps, and areas for improvement;
    - review how the SP engages and promotes coherence of WHO approaches and interventions at the global, regional and country level;
    - analyse how the SP works with UN partners and other stakeholders at the global, regional and country level to advance the PHC agenda;
    - assess how the SP approaches equity and sustainability of health gains for the most vulnerable populations.

17. The evaluation will aim to provide answers to five key high-level questions:

Evaluation criterion	High level evaluation questions
Relevance	To what extent are the SP's mandate, design, objectives, functions/workstreams and activities, adequate both in terms of enabling intensified support to countries and catalysing global efforts for PHC? How does the SP provide technical assistance, participate in advocacy and dialogue, responding to country and regional-level demands (e.g. country visits)?

Effectiveness	What has been the contribution of the SP to WHO's work on PHC in terms of implementing the WHO GPW13 at global level, and at the country level, across a multi-layered and multi-partner global landscape of cross-cutting networks? Which factors have influenced implementation to date? What challenges have emerged?
Efficiency	To what extent are resources (financial and human) of the SP adequate to implement its workplan? Are advocacy/communication and resource mobilization efforts adequate to support the SP mission? How efficiently is the SP managing resources? Are the governance structures, processes and mechanisms in place adequate?
Coherence	To what extent has the SP contributed to strengthening the coherence of contributions towards the PHC agenda within WHO, with global external partners and at country level? How does the SP enable meaningful engagement and learning from partners at different levels to promote PHC approach, and enhance synergies for greater coherence of operations? Are there any overlaps and/or untapped complementarities within WHO and with external partners?
Gender, equity, and human rights	To what extent has the SP promoted PHC at national and global level to leave no one behind (i.e. the most vulnerable populations)? How does PHC support inclusion of equity considerations in the development of frameworks, indicators, data collection tools and analytical methods to inform decision-making?

18. A range of specific sub-questions will be developed to address each evaluation question by the evaluation team during the inception phase in consultation with the evaluation reference group. The evaluation will propose a theory of change (TOC) for the SP based on the Operational Framework for PHC to clarify the expected outputs of the SP and to facilitate prioritization of the evaluation questions and on discussions with key stakeholders. The inception report will include the ToC and an evaluation matrix with a description of the methods to be used to address each evaluation question and data sources. Innovative evaluation methods are welcome and will be devised in consultation with the evaluation team.

19. The evaluation will use a combination of quantitative and qualitative methods, to be proposed and approved during the inception phase, including:

- a desk review of available documentation, using the Review of 40 years of primary health care (PHC) implementation at country level conducted by EVL in 2019/2020 (*1)*, evaluation reports and evaluability assessments, strategic documents, policies, guidance and implementation and/or monitoring reports produced by WHO and partners;
- key informant interviews/focus group discussions with stakeholders at global, regional and country level, and including WHO, partnerships and partner organizations; relevant technical staff at the global, regional and country levels; country programme managers, relevant Ministry officials and other civil society partners;
- an online survey/questionnaire with specific stakeholders (considering feasibility questions to ensure responses; could include relevant technical staff at the global, regional and country levels, country officials and programme staff, and partners); and
- a number of country case studies (from a representative sample of countries, one per affected WHO region, including countries where WHO has initiated policy dialogues). The selection of countries will be purposive, with some regional representation, and will be finalized during the inception phase in coordination with the evaluation management group for the evaluation of HIV integration into PHC.

- a case study on coherence of vertical disease programme and PHC approaches, using the example of the HIV programme in conjunction with the evaluation of HIV integration into PHC.

20. Challenges and limitations concerning data availability, and traceability of indicators and milestones will be acknowledged in the inception report. At the country level specifically, data quality maybe uneven across countries and may not enable adequate disaggregation of activities.

IV Evaluation management

21. The evaluation will be managed by the WHO Evaluation Office (EVL) who will be steering the evaluation in line with relevant UNEG norms and standards. EVL will provide support and oversight to/for the evaluation team during the evaluation exercise (finalization of methodology, facilitation of the evaluation process, identification of relevant documentation and data), and will ensure overall quality assurance of the evaluation. EVL will also ensure coordination with the joint evaluation of HIV integration into PHC.

22. An Evaluation Reference Group (ERG) composed of technical representatives of SP, and of the HIV department, RO focal points and other partners will provide technical advice throughout the evaluation and will:
    - Review the present ToRs and evaluation questions
    - Review the inception report and the final report
    - Act as a source of knowledge for the evaluation

23. The ERG will be kept informed throughout the evaluation process and consulted at key junctures of the evaluation process.

24. The evaluation will be conducted in coordination with the concomitant joint evaluation of integration of HIV into PHC, undertaken by UNAIDS in partnership with UNICEF, UNFPA and WHO. Synergies will be developed between both evaluations to maximize complementarities and limit overlaps. This will enable the conduct of joint data collection and country case studies for optimal use of resources /stakeholders involvement, and cross fertilization of findings and conclusions. Specifically, country case studies will be selected in coordination with the joint HIV evaluation EMG based on a representative sample of countries: per WHO region, and including countries where WHO has initiated policy dialogues.

V Evaluation team

25. The evaluation will be carried out by a consortium of consultants, offering the mix of evaluation experience and expertise (to form the basis for the skills and profiles for individual team members):
    - Relevant professional qualification, preferably at the academic (master's or PhD) level;

- At least 10 years of experience in conducting evaluations preferably in the areas of public health/economics or development and experience in country-level programme evaluations;
- Demonstrated knowledge of public health programmes in general and PHC issues, social protection, universal health coverage;
- Strong knowledge of country response to public health epidemics, e.g. COVID-19, HIV, Tuberculosis etc;
- Proven experience with qualitative and quantitative data collection methods, analysis of data relevant to social protection and experience in handling data limitations;
- Ability and track record of bringing gender equality, human rights and other equity issues into an evaluation including data collection and analysis;
- Previous experience with evaluation for UN and/or other multilateral organizations;
- Strong interpersonal skills and ability to work with people from different backgrounds to deliver high quality products within a short time period;
- Excellent writing, analytical and communication skills in English, and ability of some team members to work and communicate in French and Spanish.

26. National consultants may support the data collection at the country level as needed.

27. The evaluation team will be responsible for:
    - Designing, planning and implementing the evaluation, drafting the evaluation report, using the approach to be agreed in the inception report, and for delivering in accordance with the ToRs specifications and timeline;
    - Consulting and liaising, as required, with EVL, and relevant partners to ensure satisfactory delivery of all deliverables;
    - Scheduling and conducting all meetings, interviews, and focus group discussions with stakeholders.

28. The consultants are expected to carry out the evaluation with a high degree of independence and manage their own travel and other administrative arrangements.

VI Evaluation deliverables

6.1. Inception report

29. During the inception phase, the contracted evaluation team will develop and inception report that will detail the evaluators' understanding of what is being evaluated and why, including a reconstructed TOC, an agreed set of questions and showing how each evaluation question will be answered by way of: proposed methods; proposed sources of data; and data collection procedures. The inception report should include an evaluation matrix, proposed schedule of tasks, activities and deliverables and final list of countries for case studies (country data collection).

30. The inception report will be submitted to EVL, and presented to the ERG and main stakeholders of the evaluation.

6.2. Draft evaluation report

31. The draft evaluation report will be submitted to EVL and presented to the ERG and evaluation stakeholders for review and inputs. It will contain preliminary findings and conclusions.

6.3. Stakeholder workshop PowerPoint presentation

32. The evaluation team will present the main findings, conclusions and recommendations based on the draft evaluation report to the main stakeholders of the evaluation (Power Point presentation).

6.4. Final evaluation report with evaluation executive summary

33. Based on the comments received on the draft evaluation report, the final evaluation report will include and executive summary, the evaluation findings, evidence-based conclusions and recommendations in response to the evaluation questions and be submitted to EVL in English. Case study reports will be included as an annex to the final report.

VII Evaluation timeline

34. The tentative evaluation timeline will:

- Development of the terms of reference for the evaluation: December 2022 – January 2023
- Selection of evaluation team: February 2023
- Kick-off: February-March 2023
- Inception report: March -April 2023
- Data collection: May-June 2023
- Draft report: 30 July 2023
- Stakeholder workshop presentation: September 2023
- Final report: 30 September 2023

VIII Special terms and conditions

35. This evaluation will comply with UN norms and standards for evaluation and ensure that ethical safeguards concerning the independence of the evaluation will be followed. Please refer to the UNEG code of conduct: http://www.unevaluation.org/document/detail/100

36. Once approved, the evaluation report will be posted on EVL website at (www.who.int/about/evaluation/en/), together with the management response. All draft and final outputs, including supporting documents, analytical reports and raw data should be provided in electronic form. All data and information received

from WHO for this assignment must be treated confidentially and are only to be used in connection with the execution of these ToRs. All intellectual property rights arising from the execution of these ToRs are assigned to WHO. Use of the data for publication and other presentation can only be made with the agreement of WHO. Key stakeholders can make appropriate use of the evaluation report in line with the original purpose and with appropriate acknowledgement.

Annex 1
Recommendations of the Review of 40 years of primary health care (PHC) implementation at country level (EVL, 2020)

1. WHO should continue to harness its convening role to foster intersectoral collaboration in the various forms described in the review, both at the global policy level and in individual countries in its support to governments.

2. In its normative role, WHO should continue to lead in the development of standards and policy and operational guidelines for the further implementation of primary health care pursuant to the commitments outlined in the Astana Declaration and, by extension, the 2030 Agenda for Sustainable Development and Sustainable Development Goals.

3. In its technical cooperation role, WHO should tailor its capacity-building efforts to the specific primary health care-related areas requiring further support identified in specific countries, for example, strategy development and implementation, health systems strengthening, Health in All Policies, health legislation, health financing, health technology assessment and management, human resources for health, community health approaches, research to improve service delivery, and monitoring and evaluation of primary health care implementation through support to voluntary national reviews or other means.

4. In its advocacy role, WHO should identify and target the specific primary health care-related issues requiring such advocacy in individual countries, for example by advocating for increased health expenditure, identifying specific policy gaps requiring action and emphasizing the need for greater intersectoral collaboration and greater equity.

5. In fulfilling all of these roles, WHO should enhance its support to evidence-based policy action, for instance by supporting systematic research and evidence generation to support policy-making in health, and documenting and disseminating lessons and best practices.

Annex 2: Stakeholder mapping

Main categories of key stakeholders for the evaluation

Level	Key stakeholders
Global/ regional level	• WHO HQ staff from SP-PHC • WHO HQ staff from Universal Health Coverage Life Course Division: Health Governance and Financing, Health Work Force, Integrated Health Services, Immunizations, Vaccines and Biologicals • WHO HQ staff from other Divisions with strong links to PHC: Emergency Preparedness/Response and UHC/Communicable and Noncommunicable Diseases, innovation, and others as appropriate related to PHC networks • Regional WHO staff (such as PHC focal points or staff closely involved in SP-PHC implementation) • Regional-level HPAs funded through the UHC-P • HQ representatives from PHC-Accelerator (WHO and UNICEF as Co-Chairs) and other partners: Global Fund, Gavi, World Bank, Global Financing Facility, United Nations Population Fund , UNAIDS, United Nations Development Programme • Bilateral organizations and/or funders of UHC-P: United States Agency for International Development; French Development Agency; German Ministry for Economic Cooperation and Development/German Development Cooperation; French Ministry of Foreign Affairs; UK Foreign, Commonwealth and Development Office; Canada) • Development partners and foundations: Bill & Melinda Gates Foundation, PHC performance initiative • Civil society organizations with PHC mandates: Jhpiego, PATH, International Federation of Red Cross and Red Crescent Societies, African Forum for Primary Health Care • Academia and advisory groups: London School of Hygiene and Tropical Medicine Gates Ventures' PHC TAG and others related to PHC academic leadership course/collaborating centres • Other PHC/UHC related platforms and networks: UHC 2030, Social Health Protection Network, Health Data Collaborative, Alliance for Health Policy and Systems Research, Interagency Task Force on Noncommunicable Diseases
Country level	• MoH/ministry of finance officials, and representatives from national public health institutions • WHO Country Office staff (such as staff closely involved with SP-PHC implementation) • Country-level representatives from PHC-Accelerator partners: UNICEF, World Bank, Global Financing Facility, United Nations Population Fund , UNAIDS • Country-level HPAs funded through the UHC-P • Development/implementing partners • Health care providers • civil society organizations/NGOs/communities

Annex 3: Evaluation matrix

1: Design (Relevance and Coherence): These questions are concerned with the design of the SP-PHC and whether it is appropriate and relevant to support the achievement of the SP-PHC's intended purpose. Integral to the design is the coherence of the SP-PHC and the degree to which this strengthens the promotion of PHC within WHO and with external partners.

EQs	Areas of inquiry	Key assumptions	Performance indicators	Sources of evidence
EQ 1.1 How appropriate is the design of the SP-PHC for achieving its aims and objectives and for supporting the wider aims of the GPW13?	• SP-PHC approaches, objectives, workstreams and associated actions/responses according to country needs and context • SP-PHC-related governance structures, leadership, management, and structural arrangements • SP-PHC positioning within WHO, 3-level collaboration, and collaboration within the SP-PHC • WHO ways of working systems, processes, structures	• The SP-PHC has a strategy, monitoring and evaluation framework or ToC with a clear vision, objectives and expected outcomes/results for its work on PHC; it monitors progress and clearly supports the GPW13 • The SP-PHC uses a bottom-up approach, with priorities and interventions informed by needs at country and regional levels • The SP-PHC leadership sets the agenda and motivates the team and influences/leverages wider-WHO and partners to reach desired outcomes • WHO ways of working, systems, processes and structures enable and facilitate SP-PHC work and accountability	• Evidence of a common vision, understanding of and objectives for the SP-PHC and its contribution to WHO strategy • Evidence of comprehensive involvement of regions and countries in the design, aim and interventions of the SP-PHC* • Evidence that the SP-PHC is designed to function as an agile coordination structure that is able to respond rapidly using flexible instruments of support • Evidence of active management and development of the SP-PHC, including accountability structures with PHC leadership, appropriate team structures, clear roles and	Data and document review Interviews and group discussions with key stakeholders *Online survey Country case studies

EQs	Areas of inquiry	Key assumptions	Performance indicators	Sources of evidence
		• The organization and management of the SP-PHC is facilitating its aims and objectives • The SP-PHC has effective mechanisms for coordination and collaboration with other WHO departments and with WHO regional and country offices • Sufficient incentives are in place to ensure collaborative working to achieve joint outputs and outcomes at global, regional and country levels	responsibilities, aligned with achieving SP-PHC objectives • Evidence of strong relationships between WHO Headquarters departments, with cross-functional expertise on PHC being leveraged • Evidence that appropriate mechanisms for coordination and collaboration on PHC within WHO across the three levels (country, regional and global) are in place and being implemented* • Evidence of appropriate design of the SP-PHC in promoting the implementation of the PHC operational framework	
EQ 1.2 How coherent is the design of the SP-PHC (its objectives, activities, products) 'internally' across WHO	• Harmonization, alignment and level of complementarity of related WHO strategies, approaches and interventions for promoting the PHC approach	• The SP-PHC objective and intervention areas are aligned with and contribute to achieving key corporate global targets • Country-level and	• The SP-PHC interventions and approaches support the objectives of the WHO GPW13 • Evidence of shared priorities and actions for the	Data and document review Interviews and group discussions with key stakeholders

at global, region and country levels?	• Nature and influence of SP-PHC engagement across WHO departments	regional PHC frameworks, strategies and action plans are aligned with the vision, aims and objectives of the SP-PHC, including the PHC approach • SP-PHC engagements lead to a harmonized understanding of the PHC logic across the Organization	PHC approach between SP-PHC and other relevant WHO departments at HQ • Evidence of conceptual clarity across the Organization on the important relationship between PHC, health systems strengthening and dedicated health initiatives* • Evidence of coherence of key global, regional and country strategies and action plans on PHC approach*	*Online survey Country case studies
EQ 1.3. How coherent is the design of the SP-PHC (its objectives, activities, products) 'externally' with wider development and country partners (e.g. UNICEF, other UN agencies, Global Fund, Gavi, World Bank, Governments; NGOs, civil society organizations, other)?	• Harmonization, alignment and complementarity of policy and interventions, potential synergies[8] • Nature and influence of SP-PHC engagement with Partner	• Strong relationship within WHO and with partners • The SP-PHC has effective mechanisms for coordination and collaboration with external partners on PHC	• Evidence that mechanisms and partnerships are in place and are actively promoting effective coordination and collaboration on the PHC approach at global and country level * • SP-PHC actions are aligned and harmonized with the objectives and actions of other global partners, partnerships and external funders • Evidence that guidance, tools and frameworks promoting the PHC approach developed by the SP-PHC are being	Data and document review Interviews and group discussions with key stakeholders *Online survey Country case studies

[8] The evaluation team's definition of synergies is the interaction of two or more agents, resources or activities such that the product/outcome is greater than the sum of its parts (1+1>2).

			used by partners to align technical support and financial investments at country level* • Evidence on conceptual clarity across key partners on the important relationship between PHC, health systems strengthening and dedicated health initiatives* • PHC approach put into action through country partner implementation of evidence based PHC guidance, policies and frameworks*	

2: Implementation (efficiency and effectiveness): These questions are concerned with the implementation of the SP-PHC, specifically how resources are being utilized, what progress and achievements have been made through implementing the SP-PHC's activities thus far, and what factors are helping or hindering SP-PHC performance.

EQs	Areas of inquiry	Key assumptions	Performance indicators	Sources of evidence
2.1 What resources are available (UHC-P and non UHC-P financial resources and human/technical expertise), and are they adequate	• Budgets and HR plans for the SP-PHC and resources across WHO to support alignment with SP-PHC work • Technical capacity • Resource mobilization • Efforts • Stakeholder	• Sufficient financial, human and other resources to support the aims and objectives of the SP-PHC • Sufficient technical and policy expertise is available within WHO at global, regional and country levels to provide quality support to	• Evidence of sufficient staffing levels and technical expertise to promote PHC in WHO's 3 levels* • Evidence that financial and human resources have changed since 2020 in relation to further evolution of SP-PHC and	Data and document review Interviews and group discussions with key stakeholders *Online survey Country case studies

EQs	Areas of inquiry	Key assumptions	Performance indicators	Sources of evidence
for the SP-PHC to achieve its aims and objectives?	perspectives on SP-PHC skills and capacities, and the degree of traction/leverage that SP-PHC staff hold and why.	countries in reorientating health systems towards PHC	promotion of PHC approach • Resource mobilization plans are in place and fully funded for successful implementation of SP-PHC interventions. • Evidence that the SP-PHC has the capacity to respond to a country's technical support needs with rapidity and flexibility • Evidence that HPA job descriptions are orientated to team membership of the SP-PHC and the promotion of PHC approach	
2.2 How efficiently are resources utilized?	• Organizational structures and human resource utilization • 3-level collaboration/ decentralization • Partnership synergies • UHC-P and other country grant allocations/ expenditures	• Department structure, human resource planning and job descriptions are complementary • 3-level collaboration model reflects an efficient use of resources • Partnerships are leveraged for technical support and investments in PHC	• Clear division of roles, responsibilities and 'reach' of SP-PHC through staff/units from WHO Headquarters to country level • Relevant partners/partner ships and platforms are leveraged for promoting PHC* • Evidence of synergies generated across partners in	Data and document review Interviews and group discussions with key stakeholders *Online survey Country case studies

EQs	Areas of inquiry	Key assumptions	Performance indicators	Sources of evidence
			support of PHC • UHC-P funding and non-UHC-P sources are increasingly allocated to support reorientation of health systems towards PHC (compared to before the SP-PHC was established) • Grant funds channelled through SP-PHC to countries that have a high expenditure rate with expected results achieved	
2.3. What progress has been made in implementing the SP-PHC workplans?	• Progress on implementation of workstreams/intervention areas • Outputs and intermediate outcomes achieved	• Policy landscape is conducive to promoting the PHC approach • Enabling environment is conducive to promoting the PHC approach • Workplans have been implemented as planned	• Evidence that SP-PHC workplans have been implemented as planned (activities have been completed against the joint workplan) • Evidence that SP-PHC has supported PHC levers and documented change as a result of support • Evidence that expected outputs have been generated from workplan implementation and used as intended • Evidence of	Data and document review Interviews and group discussions with key stakeholders *Online survey Country case studies

EQs	Areas of inquiry	Key assumptions	Performance indicators	Sources of evidence
			contextualized support to countries for the operationalizatio n of the PHC approach (timing and sequencing, nature of support, appropriate expertise)* • Evidence that the SP-PHC functions as an agile coordination structure able to respond rapidly with flexible instruments of support* • Evidence of better integration of efforts towards WHO's PHC objectives at global, regional and country level* • Evidence of achievements or changes that have resulted from SP-PHC support at global, regional and country levels*(ways of working across WHO and partners, country impact)	
2.4 How is the SP-PHC adding value to the work of WHO and	• Added value aspects (e.g. partnerships, advocacy, convening power, cross-fertilization,	• The SP-PHC with its specific focus on promoting the PHC approach adds value to the work of WHO across the	• SP-PHC coordination, generated products, processes (such as country dialogues) and	Data and document review Interviews and group discussions with key stakeholders

EQs	Areas of inquiry	Key assumptions	Performance indicators	Sources of evidence
external partners at global, regional and country levels?	technical expertise, etc.)	Organization and to external partners.	technical support are considered useful at country level and have resulted in action* • Evidence of SP-PHC frameworks in place and countries and partners coalescing financial and technical support around them • Evidence of synergies generated across partners as a result of SP-PHC engagement (e.g. Global fund, Gavi, etc.) • Evidence that the SP-PHC support has acted as a catalyst for change in working practices across the Organization and country operationalizatio n of frameworks, etc.* • Evidence that SP-PHC interventions are strategic and leverage WHO's comparative advantage (normative guidance, policy development, learning, convening power, etc.) and have generated positive change	*Online survey Country case studies

EQs	Areas of inquiry	Key assumptions	Performance indicators	Sources of evidence
			at global, regional and country levels	
2.5 How sustainable are the interventions of the SP-PHC?	• Sustainability aspects in the design and implementation of SP-PHC work/activities • Financial sustainability	• SP-PHC interventions support change processes that embed PHC approach and/or are a catalyst for more sustainable change at country level.	• Evidence that SP-PHC supports building political commitment to PHC orientated health systems and financing those systems • Evidence of SP-PHC support to more sustainable integrated systems and services for health, including addressing the integration of vertical/issue-specific programmes into PHC and UHC • Evidence that stakeholders perceive SP-PHC interventions as contributing to supporting sustainable change at country level* • Plans in place to ensure predictable and sustainable financing for the SP-PHC, including for HPAs*	Data and document review Interviews and group discussions with key stakeholders *Online survey Country case studies

3: Gender, equity and human rights: This question is concerned with how well the SP-PHC is addressing the most vulnerable populations in its promotion of PHC.				
EQs	**Areas of inquiry**	**Key assumptions**	**Performance indicators**	**Sources of evidence**
3.1 How and to what extent has the SP-PHC supported the inclusion of gender, equity and human rights considerations across its core functions and technical products?	• Gender, equity and human rights considerations in produced normative guidance and PHC indicators, WHO academy course content, selection of country case studies, etc. • Stigma and discrimination aspects • Selection of countries for intensified support • UHC-partnership allocation of resources • Involvement of civil society/ communities	• Technical products and core functions of the SP-PHC reflect gender, equity and human rights concerns • Gender, equity and human rights-sensitive analytical methods used for decision-making and prioritization processes • The SP-PHC has engaged strategically with civil society/ community representatives at all levels	• Evidence of SP-PHC strategic intervention areas/activities being designed with the final aim of "leaving no-one behind" • The SP-PHC has systematically addressed gender, equity and human rights considerations (incl. promoted tracking of disaggregated data across all normative guidance produced and Capacity-building initiatives - WHO academy course) • Evidence of a gender, equity and human rights lens applied to selection of countries for intensified support, and through the UHC partnership funding allocation processes • Evidence that SP-PHC case studies document action at country level to address barriers to accessing health services for vulnerable populations (country case studies) • Evidence of civil	Data and document review Interviews and group discussions with key stakeholders *Online survey Country case studies

EQs	Areas of inquiry	Key assumptions	Performance indicators	Sources of evidence
			society partners/ community representatives being involved at all levels (global, regional and country)* • Results of implementation are likely to support enduring effects in relation to equity, gender and human rights issues.	

Annex 4: Online survey analysis

Online survey purpose and sampling strategy

An online survey was conducted to generate further country and regional level insights to the preliminary evaluation of the WHO SP-PHC.

The respondents for the survey were purposely sampled and targeted, mainly from WHO country offices which had resident WHO HPAs as well as from among staff working on PHC across six WHO regions. The survey was sent to 190 HPAs (at country or regional levels) and WHO Country Representatives across 98 countries – some of which forwarded the survey to other relevant WHO, ministry of health and UN representative staff.

Survey questions

The survey included 27 questions[9] that focused on respondents' level of agreement with 19 different statements related to familiarity with the SP-PHC (defined as including activities of the UHC-Partnership); engagement with the SP, the relevance and coherence of SP-PHC activities/normative guidance, and results and sustainability aspects. The survey also included open-ended questions related to the SP-PHC results, needs and requested support going forward. Definitions of the PHC approach, primary care and UHC were provided in the introduction to the survey. Some questions required a mandatory response, others were optional and depended on familiarity with the SP-PHC, its products and activities.

Survey conduct

Survey questions were translated from English to Spanish and French. The survey was distributed using the "Survey Monkey", an online survey tool. The survey was open to respondents from 21 July to 31 August 2023. Three reminder emails were sent to targeted respondents during this period. Responses were provided anonymously without any identifiers.

Survey response rate

In total, 138 responses were received, representing all six WHO regions and 56 of the 98 targeted countries. Most respondents (71%) represented WHO at country or regional level; 30% of these were HPAs. Of the remaining respondents, most represented ministries of health or other UN organizations. It was not possible to calculate a precise overall response rate as the survey was disseminated by WHO. However, of the directly targeted survey recipients the response rate was 52%.

Analysis of data

[9] Four additional questions which related to the ongoing UNAIDS revaluation of the Joint Programmes contribution to primary health care integration and interlinkages were also inserted into the survey to maximize on synergies between the two evaluations. However, the results are not elaborated here as they were very HIV-focused.

Quantitative data was analysed in Excel. Some results were disaggregated by respondent type (WHO staff vs. non-WHO staff as well as HPA vs. other WHO staff). After disaggregation, the sample was generally too small to conduct chi-square testing and assess differences across respondent type (HPA/other WHO staff). Qualitative survey data was analysed using content analysis and coding of data against EQs.

Limitations/bias

Selection bias, such as non-response bias, is likely to have affected results. However, the relatively high response rate and wide representation of countries and regions suggest that this was not causing major bias. Another type of bias, information bias, which is typical in cross-sectional surveys is assessed to have had a larger impact on results. The fact that most respondents were WHO staff (71%) constitutes an inherent risk of bias towards presenting a WHO programme in a more positive light. Furthermore, and this is critical to the interpretation of results, the majority of SP-PHC engagement and support at country level had been received through the UHC-P (62% of respondents had received funding though the UHC-P), which is believed to have affected replies to other survey questions on the SP-PHC (respondents mistaking SP-PHC as exclusively the UHC-P and therefore showing more awareness and positive results). This made it difficult to attribute results on relevance and coherence to SP-PHC activities beyond the UHC-P. The evaluation team has taken these limitations into consideration in the findings section.

Section 1: Overview analysis

A. Overview of the survey respondents background and demographics (questions 1–3)

In the initial three questions of the survey, respondents were asked to indicate their gender, the country or region where they were located, and the organization for which they worked .

Table 5.1 Survey results – gender, organization and country (Q1–Q3)

Survey questions	Quantitative results
Q1: Please indicate your gender.	46% Female, 54% Male, 0% Other
Q2: In which country or regional office are you based?	Responses received from a total of 56 different countries and from six WHO regional offices. Overrepresentation, compared to other countries/regions, was noted from: - WHO Regional Office for Africa (14% of total respondents), - WHO Regional Office for the Eastern Mediterranean (13%) - Ethiopia (4%) - Cambodia (4%)
Q3: Please indicate what type of organization you work for.	WHO HPA: 31% (n=43) WHO other than HPA: 41% (n=56) Other UN organizations: 6% (n=8) Other: 22% (n=31) - mainly MoH representatives

B. Overview of qualitative and quantitative survey responses (questions 4–27)

There were four exclusively qualitative, open-ended questions in the survey (Q12, 24, 25, 26); five quantitative questions with the option to elaborate qualitatively (Q15, 17, 19, 21, 23); and 15 strictly quantitative questions (Q4–11, 13, 14, 16, 18, 20, 22, 27). A summary of the responses can be found in Table 2 below, with disaggregated replies presented as relevant followed by more detailed results in section two.

Survey question	Summary analysis of qualitative responses[10]	Respondent group (n)	Quantitative results
Q4 and Q9[11]: How familiar are you with the WHO Special Programme on Primary Health Care (SP-PHC, including the UHC-P) and its actions/interventions?	N/A	All respondents (n=100)	13% (13) have not heard about the SP-PHC, 19% (19) are not familiar with it, 29% (29) are somewhat familiar 39% (39) are very familiar with the SP-PHC
		WHO HPAs (n=43)	7% (3) have not heard about the SP-PHC, 23% (10) are not familiar with it, 23% (10) are somewhat familiar 46% (20) are very familiar with the SP-PHC
		WHO staff other than HPAs (n=50)	16% (8) have not heard about the SP-PHC, 16% (8) are not familiar with it, 34% (17) are somewhat familiar 34% (17) are very familiar with the SP-PHC
		Non-WHO staff (n=7)	29% (2) have not heard about the SP-PHC, 14% (1) are not familiar with it, 29% (2) are somewhat familiar 29% (2) are very familiar with the SP-PHC
Q5 and Q10[12]: To what extent have you or your organization engaged with/received support from the SP-PHC, including the UHC-Partnership (UHC-P), which is within the SP-PHC?	N/A	WHO staff (n=92)	2% (2) have never engaged, 11% (10) had very limited engagement, 28% (25) some engagement, 47% (44) substantial engagement 12% (11) do not know the SP-PHC
		Non-WHO staff (n=7)	0% (0) have never engaged, 14%(1) had very limited engagement, 28% (2) some engagement, 28% (2) substantial engagement 28% (2) do not know the SP-PHC
	N/A	All WHO staff (n=79)	5% (4) do not feel part of the SP-PHC team

[10] Based on most frequent responses/comments.
[11] Results provided aggregated for these two questions as they were similar but targeted different groups of respondents.
[12] Results provided aggregated for these two questions as questions they similar but targeted different groups of respondents.

Survey question	Summary analysis of qualitative responses[10]	Respondent group (n)	Quantitative results
Q6[13]: To what extent do you feel part of the SP-PHC team?			21% (17) feel partially part of the team, 30% (24) feel part of the team, 33% (26) feel very much part of the team 10% (8) have no opinion
		WHO HPAs (n=39)	5% (2) do not feel part of the SP-PHC team 15% (6) feel partially part of the team, 33% (13) feel part of the team, 38% (15) feel very much part of the team 8% (3) have no opinion
		WHO staff other than HPAs (n=40)	5% (2) do not feel part of the SP-PHC team, 27% (11) feel partially part of the team, 27% (11) feel part of the team, 27% (11) feel very much part of the team 13% (5) have no opinion
Q7[14]: If you need technical support on PHC-related matters, would you: (NB: several options could be ticked)	N/A	All WHO staff (n=79)	84% (66) would reach out to regional office staff for support, 42% (33) would reach out to SP-PHC staff for support, 28% (22) would reach out to other HQ staff 6% (5) have no opinion
		WHO HPAs (n=39)	90% (35) would reach out to regional office staff for support, 38% (15) would reach out to SP-PHC staff for support, 33% (13) would reach out to other HQ staff 5% (2) have no opinion
		WHO staff other than HPAs (n=40)	78% (31) would reach out to regional office staff for support, 45% (18) would reach out to SP-PHC staff for support, 23% (9) would reach out to other HQ staff 8% (3) have no opinion
Q8[15]: Have you received any training or participated in any capacity-building activity on the PHC approach,	N/A	All WHO staff (n=79)	23% (18) received training or capacity-building activity on PHC 73% (58) have not received any training or capacity-building activity on PHC 4% (3) do not know
		WHO HPAs (n=39)	31% (12) received training or capacity-building activity on PHC

[13] Question for WHO staff only.
[14] Question for WHO staff only.
[15] Question for WHO staff only.

Survey question	Summary analysis of qualitative responses[10]	Respondent group (n)	Quantitative results
organized by the SP-PHC, since 2020?			67% (26) have not received any training or capacity-building activity on PHC 3% (1) do not know
	N/A	WHO staff – other than HPA (n=40)	15% (6) received training or capacity-building activity on PHC 80% (32) have not received any training or capacity-building activity on PHC 5% (2) do not know
Q11: What type of technical support and engagement have you or your organization received from the SP-PHC since 2020? (list of options – see section 2)	N/A	All respondents (n=92)	The majority of respondents reported that their engagement with the SP-PHC was through UHC-P activities: - 62% (57) had received financial support from the UHC-P - 39% (36) had been participating in live monitoring sessions under the UHC-P - 38% (35) reported support for/engagement in development of PHC country support plans See more detailed results in section 2 below.
Q12: What notable achievements or results has the SP-PHC support contributed to?	The most frequently stated achievements were: 1. Activities funded by the UHC-P such as: - development of national PHC strategies/frameworks and UHC roadmaps - funding of HPAs 2. Advocacy resulting in improved PHC commitment of government	All respondents who provided comments (n= 49)	N/A
Q13: To what extent do you agree that: - Regional/country level support on the PHC approach has improved since the SP-PHC was established in 2020. - Collaboration across the 3 levels of WHO (HQ/Regional/count	N/A	All respondents (n=92)	More than 60% responded that country and regional level support on the PHC approach had improved since the SP-PHC was established. However, significant bias is expected on results that relate to this question. The fact that most SP-PHC engagement and support had been received through the UHC-P is believed to have affected replies to other survey questions such as Q13 around the SP-PHC

Survey question	Summary analysis of qualitative responses[10]	Respondent group (n)	Quantitative results
ry) on the PHC approach is effective. - SP-PHC interventions contribute to supporting sustainable change focused on PHC approach at country level. - The SP-PHC functions as an agile PHC coordination structure to aid country implementation support – able to respond rapidly with flexible instruments of support. - The SP-PHC involves/consults with civil society partners/community representatives sufficiently. - Plans are in place to ensure sustainable financing for the WHO HPAs currently supported under the UHC-partnership.			(respondents mistaking SP-PHC as UHC-P only and therefore showing more awareness and positive results), making it difficult to tease out relevance, coherence and results from activities beyond the UHC-P. Replies to this question thus need to be interpretated in that light and with caution to attribute results to the SP-PHC beyond the UHC-P. See more detailed results in section 2 below.
Q14: Are you familiar with the *Operational framework for primary health care: Transforming vision into action*, developed by WHO/UNICEF in 2020?	N/A	All respondents (n=118)	60% (71) are familiar and 40% (47) are not familiar.
Q15: *The Operational framework for primary health care*: - is helpful for countries as a practical guide in advancing PHC at country level - has already been used for national planning processes	The most frequently stated remarks in relation to the PHC *Operational framework* were: - It represents a good guiding and reference tool. - Countries have not been sufficiently	All respondents (n=71)	92% (65) of those familiar with the *Operational framework* agreed that it is helpful for countries as a practical guide in advancing PHC at country level. See result details in section 2 below.

Survey question	Summary analysis of qualitative responses[10]	Respondent group (n)	Quantitative results
- is going to be used in national planning processes	exposed to the framework. - There needs to be more effective collaboration around its implementation.		
Q16: Are you familiar with the *Primary health care measurement framework and indicators: Monitoring health systems through a primary health care lens*, developed by WHO/UNICEF in 2022 (PHCMFI)?	N/A	All respondents (n=117)	56% (66) are familiar and 44% (52) are not familiar.
Q17: To what extent do you agree that the PHCMFI: - includes relevant indicators - aligns with current monitoring and evaluation mechanisms of the national health system - aligns with current UHC and SDG monitoring frameworks and guidance at national level - is a practical framework/tool for countries to assess, track and monitor PHC performance - includes feasible and relevant proposed disaggregation to cover equity aspects - is planned to be or has already been used at country level	The most frequently mentioned remarks: - Useful tool, but mainly for public health systems (not so relevant if private sector is strong) - Technical implementation support is needed - Seems top-down/need to adapt the indicators which are not currently in the national PHC monitoring plan	All respondents (n=66)	70% (46) of those familiar with the PHCMFI reported that it is a practical framework/tool for countries to assess, track and monitor PHC performance. See more details on results in section 2 below.

Survey question	Summary analysis of qualitative responses[10]	Respondent group (n)	Quantitative results
Q18: Are you familiar with the SDG3 Global Action Plan (GAP) PHC-Accelerator (PHC-A)?	N/A	All respondents (n=116)	65% (75) are familiar and 35% (41) are not.
Q19: SDG3 GAP PHC-A: To what extent do you agree that: - The SP-PHC is leveraging the PHC-A to support greater country impact. - The PHC-A is managed and coordinated in an effective manner by the SP-PHC (through co-leads WHO and UNICEF). - The PHC-A is synergistic with the other WHO activities at regional or country level. - The PHC-A is an effective platform that is enabling greater agency coordination and action at the country level for PHC, beyond initial country dialogues.	- Provided opportunity for advocating for the PHC/UHC - Accelerator work is independent/platform not working as expected	All respondents (n=75)	53% (40) agreed that the PHC-A is managed and coordinated in an effective manner by the SP-PHC (through co-leads WHO and UNICEF). 65% (49) agreed that the PHC-A is synergistic with the other WHO activities at regional or country level. See more details in section 2.
Q20: Are you familiar with the UHC-Partnership?	N/A	All respondents (n=116)	77% (89) are familiar and 23% (27) are not.
Q21: To what extent to do you agree that: - The UHC-Partnership is managed and coordinated by the SP-PHC using a bottom-up approach. - The UHC-Partnership is managed and coordinated by the SP-PHC in an effective manner.	The most frequent remarks were: - The programme is much appreciated, flexible and strengthened the PHC approach. - Its funding of health policy advisors is critical. - Countries lagging behind on UHC need more attention with	All respondents (n=89)	Of those familiar with the UHC-P: - 76% agreed that the UHC-Partnership is enabling country level action on the PHC approach and the reorientation of health systems to PHC. - 61% agreed that there has been more focus on the PHC approach through the UHC-Partnership activities since it was subsumed under the SP-PHC - 52% agreed that the UHC-Partnership is managed and coordinated by the SP-PHC in an effective manner.

Survey question	Summary analysis of qualitative responses[10]	Respondent group (n)	Quantitative results
- There has been more focus on the PHC approach through the UHC-Partnership activities since it was subsumed under the SP-PHC in 2021. - The UHC-Partnership is enabling country level action on the PHC approach and the reorientation of health systems towards PHC.	technical and financial support.		- 53% agreed that the UHC-Partnership is managed and coordinated by the SP-PHC using a bottom-up approach.
Q22: To what extent do you agree that: - The SP-PHC has enabled conceptual clarity on the PHC approach across the three levels of WHO. - This clarity is reflected in the way the PHC approach is put at the centre of the key policy and planning documents (strategies related to the health sector in the country). - The SP-PHC has promoted effective WHO coordination and collaboration on the PHC approach across the three levels of the Organization. - The SP-PHC ensures relevant partners/partnerships and platforms are leveraged to promote the PHC approach. - The SP-PHC promotes coherence on the PHC approach and alignment in key regional and country	N/A	All respondents (n=113)	58% (65) agreed that the SP-PHC has enabled conceptual clarity on the PHC approach across the three levels of WHO. 54% (61) agreed that the SP-PHC ensures relevant partners/ partnerships and platforms are leveraged to promote the PHC approach. NB: Significant bias is expected on results that relate to this question, see also Limitations section. See more results in section 2, which should be interpreted with caution and cannot unequivocally be attributed to SP-PHC activities beyond the UHC-P.

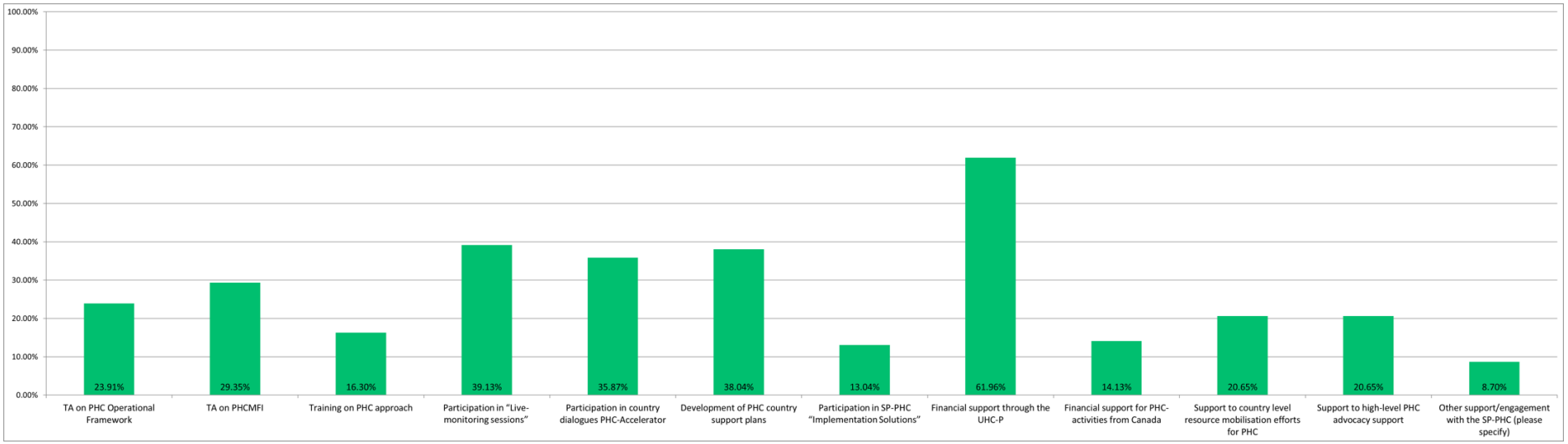
Survey question	Summary analysis of qualitative responses[10]	Respondent group (n)	Quantitative results
strategies and action plans. - The SP-PHC has utilized its convening power to promote PHC at country/regional levels. - Through HPAs at country and regional level, the SP-PHC enables sufficient technical capacity to promote the PHC approach.			
Q23: To what extent do you agree that the following areas need more attention from the SP-PHC to advance on the PHC approach at the country level? • TA • standards, policies, guidelines • high-level advocacy • Other (see full list in section 2 below)	Other areas noted: - support development of specific inter-sectoral standards/algorithms - digital transformation - work with disease-specific programmes	All respondents (n=113)	86% (97) agreed that there is a need for more technical support on the PHC approach at country level. 84% (95) agreed that there is a need for standards, policy and operational guidelines for the implementation of the PHC approach at country level. 84% (95) agreed that there is a need for high-level advocacy for increased political commitment to the PHC approach at country level. See more result details in section 2.
Q24: Any other comments, opportunities or recommendations for the WHO Special Programme on PHC you would like to share?	The most frequent comments were: - Need to focus more on countries in crisis/Leave no one behind approach for prioritization of countries - Aligning initiatives to country needs and context - Need for capacity-building on PHC	All respondents who provided comments (n=49)	N/A
Q25: In your opinion, what is the **ONE** thing that the SP-PHC needs to do in 2024–2025 biennium to support the PHC approach and the reorientation of health	Technical areas for support: - health financing – linked to PHC, Health reforms, costing, health benefit packages	All respondents who provided comments (n=78)	N/A

Survey question	Summary analysis of qualitative responses[10]	Respondent group (n)	Quantitative results
systems at the country level?	- integrating vertical programmes - community engagement - multisectoral action and policy Other requested support areas: - high level advocacy - enhance integration and synergies with other initiatives - technical assistance - financial assistance - Capacity-building of WHO staff and others		
Q26: What would be the **top three** priorities to reorientate health systems towards PHC in your country, and why?	The most frequent comments were: - strengthen the integration of vertical programmes - mobilize national and international resources for the financing of primary health care - address shortages of health workers and Improve health facility infrastructure	All respondents who provided comments (n=78)	N/A
Q27. To what extent do you agree that HIV investments (infrastructure, learnings, tools, etc.) have been leveraged for broader health gains/strengthening the PHC	N/A	All respondents (n=86)	36% (31) agreed that HIV investments (infrastructure, learnings, tools, etc.) have been leveraged for broader health gains/strengthening the PHC. See further details in section 2 below.

[1] Based on most frequent responses/comments.
[1] Results provided aggregated for these two questions as they were similar but targeted different groups of respondents.
[1] Results provided aggregated for these two questions as questions they similar but targeted different groups of respondents.

Section 2: Detailed responses to selected questions

Q11. What type of technical support and engagement have you or your organization received from the SP-PHC since 2020? (tick all that apply)



Q13. To what extent do you agree that:

	Strongly disagree		Disagree		Neutral		Agree		Strongly agree		Total
- Regional/country level support on the PHC approach has improved since the SP-PHC was established in 2020.	3.26%	3	3.26%	3	32.61%	30	52.17%	48	8.70%	8	92
- Collaboration across the 3 levels of WHO (HQ/regional/country) on the PHC approach is effective.	0.00%	0	4.40%	4	34.07%	31	51.65%	47	9.89%	9	91
- SP-PHC interventions contribute to supporting sustainable change focused on PHC approach at country level.	0.00%	0	6.52%	6	30.43%	28	47.83%	44	15.22%	14	92
- The SP-PHC functions as an agile PHC coordination structure to support country implementation support – able to respond rapidly with flexible instruments of support.	2.17%	2	4.35%	4	47.83%	44	38.04%	35	7.61%	7	92
- The SP-PHC involves/consults with civil society partners/ community representatives sufficiently.	0.00%	0	13.04%	12	57.61%	53	25.00%	23	4.35%	4	92
- Plans are in place to ensure sustainable financing for the WHO HPAs currently supported under the UHC-partnership.	1.09%	1	8.70%	8	41.30%	38	40.22%	37	8.70%	8	92

Q15. To what extent do you agree that the *Operational framework for primary health care: Transforming vision into action*, developed by WHO/UNICEF in 2020:

	Strongly disagree		Disagree		Neutral		Agree		Strongly agree		Total
Is helpful for countries as a practical guide in advancing PHC at country level.	0.00%	0	2.82%	2	5.63%	4	61.97%	44	29.58%	21	71
Has already been used for national planning processes.	1.41%	1	18.31%	13	32.39%	23	38.03%	27	9.86%	7	71
Is going to be used in national planning processes	0.00%	0	7.35%	5	27.94%	19	54.41%	37	10.29%	7	68
Has been used to support investment decisions on PHC at national level.	0.00%	0	16.90%	12	40.85%	29	32.39%	23	9.86%	7	71

Q17. To what extent do you agree that the PHCMFI:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
Includes relevant indicators	0.00%	0.00%	4.69%	75.00%	20.31%	64
Aligns with current monitoring and evaluation mechanisms of the national health system	0.00%	9.23%	26.15%	56.92%	7.69%	65
Aligns with current UHC and Sustainable Development Goals (SDG) monitoring frameworks and guidance at national level	0.00%	3.03%	15.15%	63.64%	18.18%	66
Is a practical framework/tool for countries to assess, track and monitor PHC performance	0.00%	1.52%	18.18%	59.09%	21.21%	66
Includes feasible and relevant proposed disaggregation to cover equity aspects	0.00%	1.52%	22.73%	65.15%	10.61%	66
Is planned to be/or has already been used at country level	0.00%	6.06%	33.33%	51.52%	9.09%	66

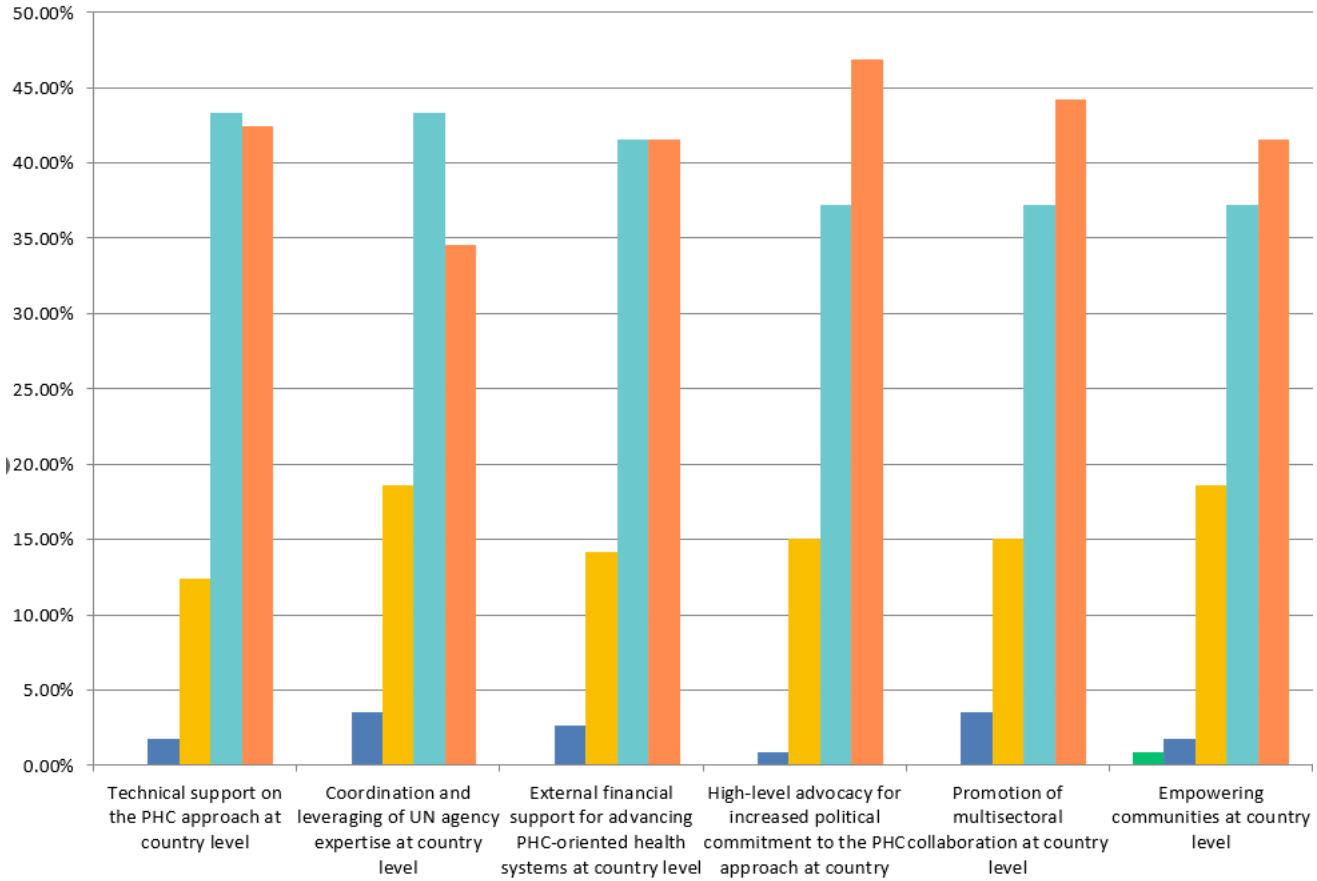
Q19. To what extent do you agree that (SDG3 GAP PHC-Accelerator)

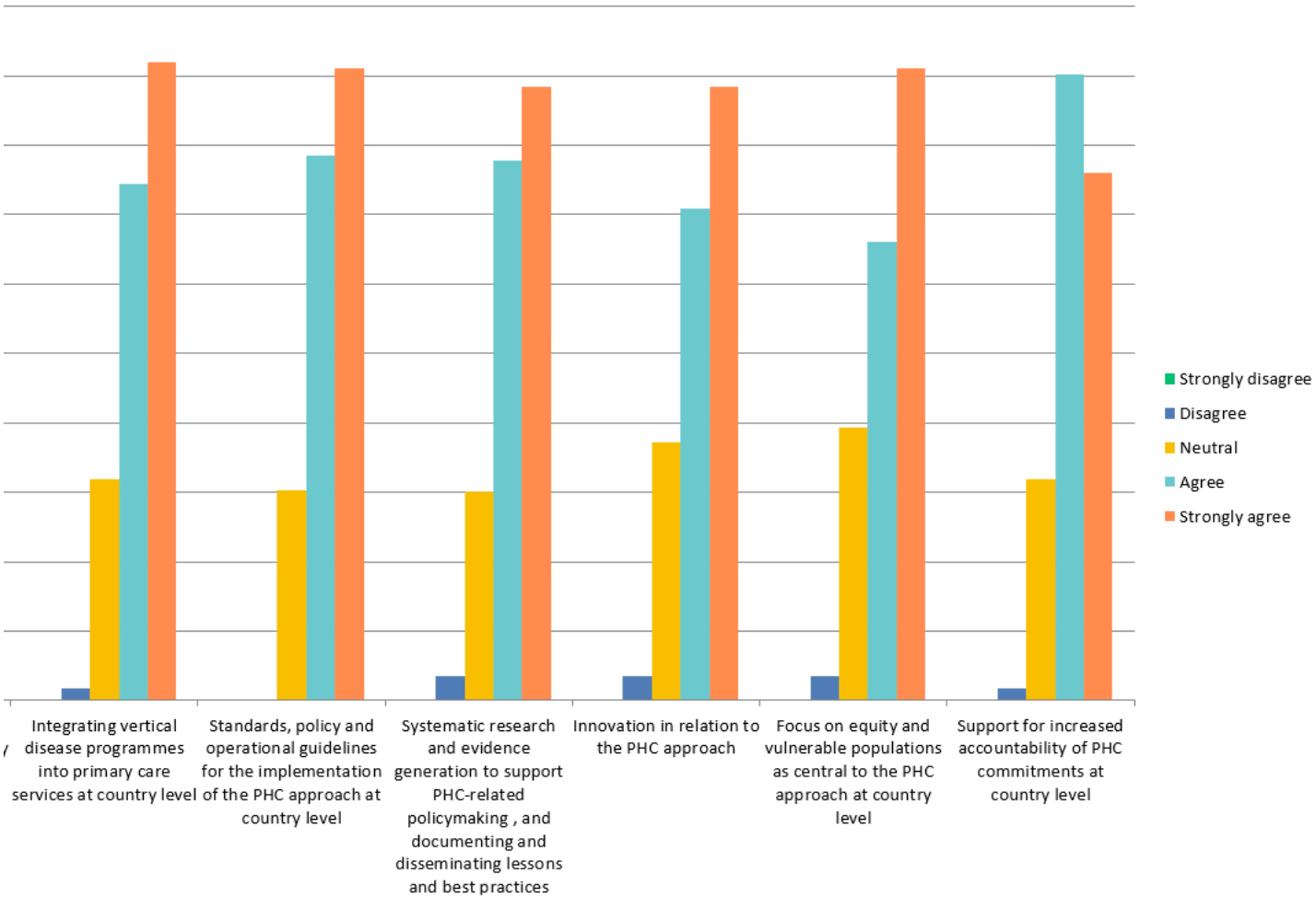
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
The SP-PHC is leveraging the PHC-A to support greater country impact.	0.00%	4.00%	24.00%	58.67%	13.33%	75
The PHC-A is managed and coordinated in an effective manner by the SP-PHC (through co-leads WHO and UNICEF).	0.00%	4.00%	42.67%	45.33%	8.00%	75
The PHC-A is synergistic with the other WHO activities at regional or country level.	0.00%	4.00%	32.00%	54.67%	9.33%	75
The PHC-A is an effective platform that is enabling greater agency coordination and action at the country level for PHC, beyond initial country dialogues.	0.00%	6.67%	30.67%	52.00%	10.67%	75
What notable achievements or results at the country level has the PHC-A contributed to? Please add any comments you wish to share on the PHC-A.						14

Q22 To what extent do you agree that:

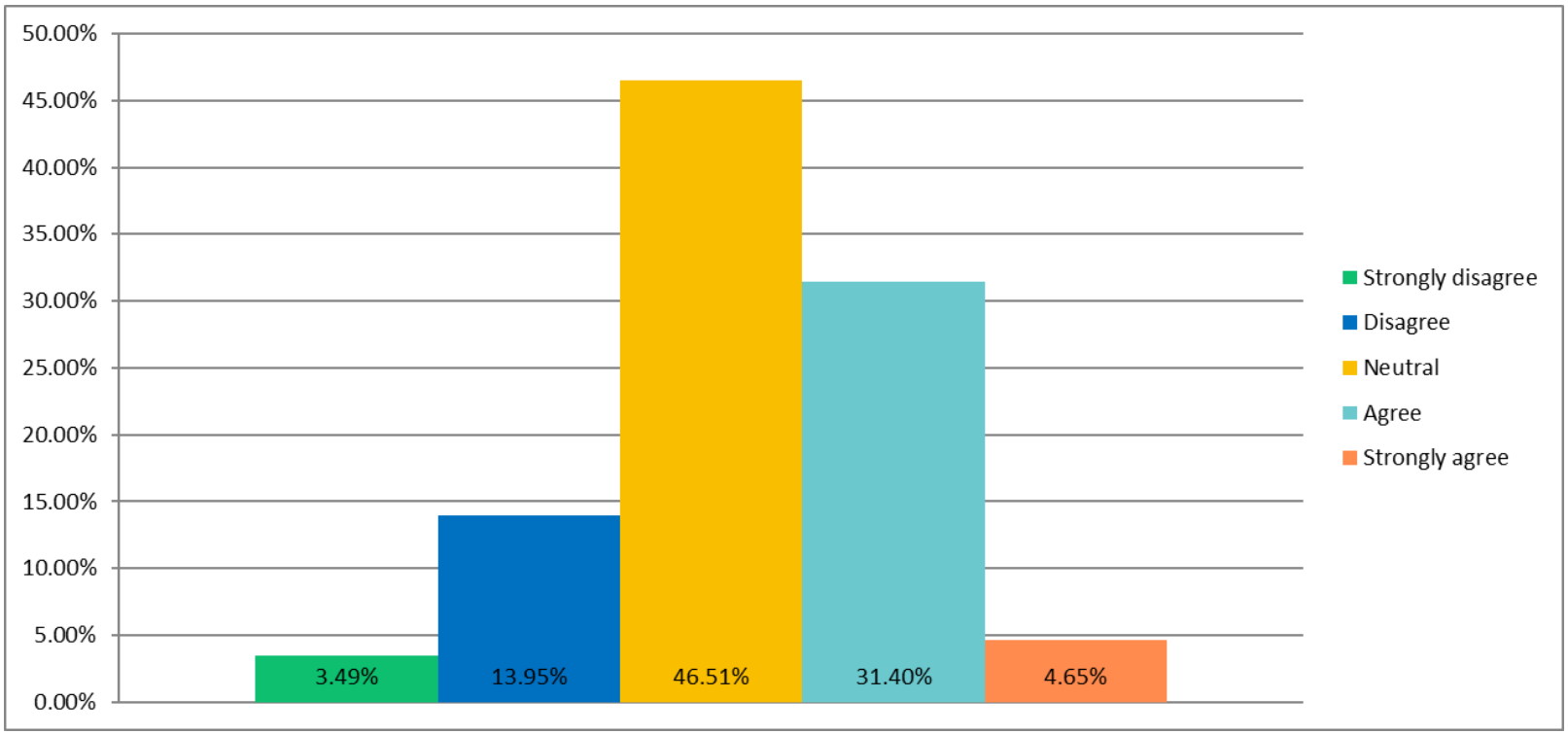
	Strongly disagree		Disagree		Neutral		Agree		Strongly agree		Total
The SP-PHC has enabled conceptual clarity on the PHC approach across the three levels of WHO.	2.65%	3	4.42%	5	35.40%	40	49.56%	56	7.96%	9	113
This clarity is reflected in the way the PHC approach is put at the centre of the key policy and planning documents (strategies related to the health sector in the country).	2.68%	3	2.68%	3	33.04%	37	50.89%	57	10.71%	12	112
The SP-PHC has promoted effective WHO coordination and collaboration on the PHC approach across the three levels of the Organization.	1.77%	2	4.42%	5	32.74%	37	52.21%	59	8.85%	10	113
The SP-PHC ensures relevant partners/partnerships and platforms are leveraged to promote the PHC approach.	1.79%	2	3.57%	4	40.18%	45	47.32%	53	7.14%	8	112
The SP-PHC promotes coherence on the PHC approach and alignment in key regional and country strategies and action plans.	1.79%	2	2.68%	3	34.82%	39	51.79%	58	8.93%	10	112
The SP-PHC has utilized its convening power to promote PHC at country/regional levels.	1.82%	2	2.73%	3	40.00%	44	47.27%	52	8.18%	9	110
Through HPAs at country and regional level, the SP-PHC enables sufficient technical capacity to promote the PHC approach.	2.68%	3	4.46%	5	31.25%	35	52.68%	59	8.93%	10	112

Q23. To what extent do you agree that the following areas need more attention from the SP-PHC, to advance on the PHC approach at the country level?




Integrating vertical disease programmes into primary care services at country level
Standards, policy and operational guidelines for the implementation of the PHC approach at country level
Systematic research and evidence generation to support PHC-related policymaking , and documenting and disseminating lessons and best practices
Innovation in relation to the PHC approach
Focus on equity and vulnerable populations as central to the PHC approach at country level
Support for increased accountability of PHC commitments at country level
Strongly disagree
Disagree
Neutral
Agree
Strongly agree

Q27. To what extent do you agree that HIV investments (infrastructure, learnings, tools, etc.) have been leveraged for broader health gains/strengthening the PHC approach?



Annex 5: Options for the way forward

The evaluation team developed three preliminary 'options' to help inform WHO's discussions on the new approach to be adopted in the future. A description of each option is provided in the box and table below, which summarizes the key features in response to the main issues and conclusions of the evaluation and highlights additional pros, cons and general assumptions for each option. The three options were not mutually exclusive, and different elements could be combined to form a hybrid option. The evaluation team presented the three developed options to the SP-PHC and the ADG UHC/LC in the process of arriving at the final recommendations.

Description of options

Option 1: Create a Global PHC Engagement Hub

A Global PHC Engagement Hub is created to act as a global focal point for PHC, which also retains a global advocacy role. The Hub enables a leaner structure, mandate and function, which is aligned with the SP-PHC's original vision and positioned under the Office of the Director General. It has a clear internal strategy and unified workplan that scales back current activities and moves away from the unit-based organization of its work towards a task-orientated team approach. This option will require significantly fewer staff than under the SP-PHC construct, who task-share to foster an agile working environment. The Hub is facilitative, service-orientated and collaborative and shifts away from implementation and coordination.

The Hub is focused on performing the following functions: responding to global and regional advocacy needs and related communications for PHC; providing support to WHO on strategy development for PHC; facilitating a collaborative learning agenda with work being carried out in other WHO Headquarters departments, the three levels of WHO and partners; convening and/or organizing dissemination events as required/requested; supporting external partnership building and collaborations for PHC; and connecting technical support requests from the three levels of WHO to the relevant WHO Headquarters departments as and when they arise.

The UHC-P, PHC-A, REPHF and SGS are positioned outside of the Hub, most likely within a department in UHC/LC Division.[16] No direct implementation support is performed through the Hub. The mandate, roles, responsibilities and ways of working are articulated both internally and externally through clear communication, which gives the Hub both legitimacy and visibility. Additional levers, such as access to flexible funding, may be available as appropriate to support collaboration.

Option 2: Create Regional PHC Hubs

Regional PHC Hubs are established in ROs to support PHC prioritization and implementation closer to end users, and thus support greater country impact. ROs maintain autonomy in terms of how/if they wish to establish a Hub, and the Hubs are funded through regional budgets.

[16] Without a wider assessment of UHC and of WHO's health system strengthening structures and functions, the evaluation team cannot state specifically where these should be positioned. This point is also relevant for Options 3 and 4.

Description of options

The Regional Hubs focus on performing the following functions: responding to country advocacy needs and related communications for PHC; facilitating and/or directly providing technical support to countries by drawing down on WHO Headquarters technical capacity in relevant departments and/or through a regional technical support pool; monitoring regional PHC trends; facilitating a collaborative learning agenda at regional and country level; and mobilizing resources for PHC.

In this model, the UHC-P remains at WHO Headquarters but is moved to another department in UHC/LC Division, though HPAs posted at the regional level collaborate closely with countries and the Hubs. The PHC-A, REPHF and SGS also move to an existing department/s, possibly in the UHC/LC Division.

There may be merit in having a PHC focal point in WHO Headquarters for regions to refer to and for high-level information on PHC, and to support regional or country advocacy efforts, as required. This function may also help in representing WHO in global PHC-related fora and convenings with the wider development partners. The mandate, roles and responsibilities and ways of working of the Regional Hubs are articulated both internally and externally to wider development partners through clear communications for global, regional and country visibility.

Option 3: Remove the specific entity for PHC prioritization and move to joint accountability for PHC across all departments

In Option 3, there is no dedicated entity at WHO Headquarters or RO level to support PHC prioritization. Instead, shared responsibility for PHC, through GPW14, is embedded across all divisions and departments and within individual job descriptions and department workplans, with clear performance metrics. This offers an alternative approach to engendering a shift in culture across the Organization, whereby all staff treat PHC as a way of working and a means by which broader health systems and UHC objectives can be achieved.

There are output/outcome indicators in the GPW14 results framework that incentivize this work, and accountability sits with the Director-General, Regional Directorss and WHO representatives, respectively. WHO may also consider identifying department focal points for PHC to strengthen accountability. The UHC-P, PHC-A, REPHF and SGS are positioned within an existing department/s, probably in the UHL/LC Division. Technical support requests are directed to ROs and the most relevant departments at WHO Headquarters, as appropriate. The WHO strategy and embedding of PHC for UHC is articulated both internally and externally to wider development partners through clear communication by the ADG.

Table A6.1 : Overview of considerations and possible implications of options

Feature and response to conclusions	Option 1: Global PHC Engagement Hub	Option 2: Regional PHC Hubs	Option 3: Joint accountability for PHC across all departments
Objective:	Provides a service across the Organization to support the prioritization and promotion of PHC.	Places resources and decision-making closer to countries to enhance country impact.	Engenders a shift in culture across the Organization whereby all staff treat PHC as a way of working and a means to achieve broader health systems and UHC objectives.

Feature and response to conclusions	Option 1: Global PHC Engagement Hub	Option 2: Regional PHC Hubs	Option 3: Joint accountability for PHC across all departments
Conclusion 2: Signals PHC as a strategic priority	Raises the profile of PHC, as well as demonstrating that WHO is acting on the known issues of the SP-PHC.	Promotes PHC agenda closer to countries but may create the perception of a gap at the global level.	Correctly communicated, this would demonstrate that WHO is prioritizing PHC through institutional embedding in GPW14, with shared responsibility and accountability for PHC throughout the Organization.
Conclusion 7: Enables a global advocacy function	Elevates the global advocacy function.	Would lose this function, although a focal point for PHC at WHO headquarters may assume a global advocacy role.	Potentially diminished centralized global advocacy function.
Conclusion 4 and 5: Clarifies mandate, roles, responsibilities and ways of working	New SP-PHC strategy provides clarity on the mandate and functions of the Global Engagement Hub. Repositions PHC and gives 'special attributes' to its ways of working. Tensions around competition for resources and staff are removed, and management burden is simplified. Accountability sits with Hub/Office of the Director General.	Each Regional PHC Hub has a mandate, strategy and objectives aligned to WHO's overarching global strategy and vision. Accountability sits with Regional Directors.	Strengthened PHC focus in GPW14 clarifies this for the entire Organization. Accountability for PHC sits with ADG, Regional Directors and WHO representatives.
Conclusion 3: Enables strengthened leadership	Leadership capacity is built to succeed and signals a reset.	Leadership and accountability for PHC is strengthened at regional level. A global focal point for PHC may be required at headquarters.	Requires Director-General and most senior WHO leaders to prioritize this agenda. Has the potential to shift how the organization fundamentally approaches PHC.
Conclusion 5: Fosters cross-departmental collaboration	Removes tensions between departments and can work to establish relationships. The Global PHC Engagement Hub is service-oriented (i.e. it acts as a facilitator and connector). Scope and design are aligned with original vision. There may be potential to access flexible	Removes tensions between departments at WHO Headquarters but could introduce them at regional level.	Changes the dynamic, removing competition and engenders shared accountability across the three levels of WHO.

Feature and response to conclusions	Option 1: Global PHC Engagement Hub	Option 2: Regional PHC Hubs	Option 3: Joint accountability for PHC across all departments
	funding to support joint working, as appropriate.		
Conclusion 7: Enhances focus on country impact	No role in direct implementation support may create distance between the global and regional and country levels. However, a learning agenda function and connector role should enable the Global PHC Engagement Hub to stay on top of and help orientate departments on country issues.	Enables a closer working relationship with countries. HPAs at regional level may help capacitate Regional PHC Hubs. Regional PHC Hubs help orientate WHO Headquarters work to regions, which better reflect country needs. Work and/or products are co-created with countries to enable tailored guidance, support and learning.	Fully embedding responsibility and accountability for PHC across all departments enhances focus on country impact but will need the right structures and incentives to succeed.
Additional pros	Addresses significant issues raised through evidence and operates more in line with original design of SP-PHC. Reduces cost of SP-PHC management.	Aligns with WHO's Transformation Agenda and strategic shifts to better enable and capacitate Regional and Country Officers. Regional PHC Hubs generate more integrated approaches to PHC across RO departments.	Reduces costs of SP-PHC management and issues with current design and implementation. Respects the principle that making progress on PHC requires a change of culture across the Organization, not necessarily a dedicated programme.
Additional cons	Potential for the Global PHC Engagement Hub to overextend reach and grow as experienced by the SP-PHC. Success is heavily dependent upon leadership and team. There is limited evidence that a dedicated programme such as this can enact the required change in organizational culture towards PHC.	May require additional fundraising. SP-PHC staffing implications.	Significant risk that this approach becomes 'business as usual' (i.e. departments continue to work in silos at global level) and PHC is no-one's responsibility if there is not strong leadership. Little progress may be made. Different interpretations of PHC remain, and this may affect department/ programme work in PHC.

Feature and response to conclusions	Option 1: Global PHC Engagement Hub	Option 2: Regional PHC Hubs	Option 3: Joint accountability for PHC across all departments
	SP-PHC staffing implications.		May require internal capacity-building on PHC approach. SP-PHC staffing implications.
Assumptions	There is strong internal political will and sustained commitment for PHC. An enabling context with faster approvals and flexible reporting requirements is in place at WHO Headquarters to facilitate agile and responsible working. The Global PHC Engagement Hub retains connections with the UHC-P enabling bidirectional sharing of PHC issues and connections, as appropriate. GPW14 strengthens roles and responsibility for PHC at global level across all departments.	There is strong internal political will and sustained commitment for PHC. Regional Officers buy in to the approach and are committed to establishing Regional PHC Hubs with outlined functions. Adequate capacity at regional level to deliver. Financial and human resources shift from global to regional/country level. GPW14 strengthens roles and responsibility for PHC at global level across all departments. GPW14 strengthens roles and responsibility for PHC at global level across all departments.	There is strong internal political will and sustained commitment for PHC. GPW14 results framework has output/outcome indicators that drive accountability for PHC. Appropriate management structures and incentives are in place for collaborative working and shared accountability.

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Any enquiries about this evaluation should be addressed to:
Evaluation Office, World Health Organization
Email: evaluation@who.int
Website: Evaluation (who.int)