EVALUATION OFFICE
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Evaluation of the WHO Special Programme on Primary Health Care

World Health Organization

Evaluation Brief

Purpose

The WHO Special Programme on Primary Health Care (SP-PHC) was established in 2020 to improve the integration of the Primary Health Care (PHC) approach within WHO. An evaluationof SP-PHC was carried out at the request of the Programme Director to assess the effectiveness of SP-PHC in supporting WHO PHC objectives and to make recommendations for the future towards universal health coverage (UHC).

Focus

The evaluation, spanning from January 2020 to August 2023,assessed SP-PHC across all three levels of the WHO (global, regional, and country), as well as external partners. Its programmatic scope was based on the criteria of relevance,coherence, effectiveness and added value, efficiency, sustainability, and equity, gender, and human rights considerations.

The evaluation did not cover the Resilience and Essential Public Health Functions and the Systems' Governance andStewardship teams, or the Universal Health Coverage Partnership (UHC-P), established in 2011 by WHO.

The focus was solely on the SP-PHC, without evaluating theconfiguration and capacity of WHO departments and functions related to UHC and health systems.

Methods

The evaluation used a theoretical framework based on a theoryof change. A mixed-method approach was employed, combining qualitative and quantitative methods for data collection and analysis, with a strong emphasis on qualitative data. This included document and data reviews, case studies inChile, Kenya, and Tajikistan, as well as key informant interviews and group discussions involving 176 individuals at the global, regional, and country levels. Additionally, an onlinesurvey with 138 respondents generated primary data.

Key Findings

1. Relevance

- The establishment of the SP-PHC was relevant in the contextof limited global progress on PHC and the WHO 13th General Programme of Work (GPW 13) goals and targets, but it has evolved organically in the absence of a specific strategy or theory of change to define its mandate and objectives.
- High expectations for SP-PHC were not accompanied bynecessary attributes for success.
- The placement of SP-PHC within the Universal Health Coverage Life Course Cluster (UHC/LC) has widely been viewed as unsuitable for its cross-cutting role, affecting itsagility, responsiveness, and ability to collaborate.
- The configuration of SP-PHC has moved away from its intended design and role which has created ambiguity regarding its mandate and objectives.
- GPW13 did not include a dedicated outcome for PHC, affecting organizational accountability and collaboration.
- Leadership challenges, including lack of high-level support from WHO senior management, have impacted the programme's success.

2. Coherence

- Challenges existed in establishing a unified understanding of thePHC approach internally and externally.
- WHO existing structures and lines of accountability have limited thedirect access of SP-PHC to countries.
- Some global initiatives were seen as not having enough of a countryfocus, although they were designed to be country-driven.
- Cross-cutting collaborations and agile ways of working have been challenging in part due to organizational culture and structures.
- Alignment with the work of other WHO departments was not clear, leading to perceived overlaps.
- Synergies with development partners were more evident globallythan at the country level.

3. Effectiveness and Added Value

- There is strong demand for country support for advocacy by regional and country missions, a recognized area where the SP-PHCadds value.
- Normative products promoted by SP-PHC are useful, but greater dissemination and technical support were needed for effective application at the country level.
- The most notable reported achievements of SP-PHC are associatedwith activities conducted through the UHC-P, although there is scope to leverage health policy advisers further for PHC.
- The PHC Accelerator contributed to global dialogue on PHC, settingthe stage for more of a focus on country-level impact.
- More technical support is needed to advance the PHC approach atthe country level in multiple areas targeting country partners and WHO staff.

4. Efficiency

- While 40% of the WHO budget is allocated to the pursuit of UHC, global resources for the achievement of PHC outcomes are lacking.In this context, the SP-PHC has raised substantial external and WHOcore resources
- As the role of SP-PHC in pursuing PHC outcomes lacks clarity, thereare diverging views about its resource needs.
- Inefficiencies included delays, duplicative work and insufficient collaboration.

5. Sustainability

- SP-PHC support for country-led PHC policy work is promising, butthere are missed opportunities to leverage wider internal and partner expertise to sustain PHC through multisectoral policy andaction.
- Sustainability issues regarding the UHC-P network of health policy advisers are starting to be addressed.

6. Equity, Gender, and Human Rights

- Equity and human rights were reflected in the SP-PHC technical products and communications, but gender dimensions received lesssystematic attention.
- Resources were targeted towards countries with greaterneeds but not fully equitably.

Main lessons and conclusions

Relevance

Relevant design requiring greater strategic clarity: The original design of the SP-PHC was relevant in a challenging global context, but the SP-PHC lacked a well-defined strategy, theory of change andprogramme-wide work plan. This, coupled with its positioning as a department within WHO and the absence of special conditions to promote operational agility, contributed to confusion both internally and externally about its purpose and cross-cutting mandate.

Moving from original design: The SP-PHC expanded beyond its initial scope, incorporating additional units. Efforts to communicate the rationale behind this expansion have not beenentirely successful, resulting in internal confusion about the programme's objectives, especially at the regional and country levels.
Leadership challenges: The extended absence of the Assistant Director-General and the level of senior support received were not commensurate with the organization-wide emphasis on prioritizingPHC. Uneven relationships with other WHO departments, and managerial complexities linked to the SP-PHC expansion beyond itsoriginal design have significantly affected the SP-PHC trajectory.
Limited organization-wide accountability for and understanding of PHC: Establishing a coherent understanding of the PHC approachhas been challenging, with the prevailing focus remaining on primary care, and less attention to multisectoral action and community empowerment. The absence of PHC- specific progress indicators and targets in the GPW 13 and the WHO accountability framework, presents a missed opportunity to support organizational commitment and action towards PHC.

Coherence

Positive collaborations have been developed and there is an overall need to systematize networking within the SP-PHC andacross WHO departments. The UHC-P has added value to the SP-PHC but retains largely separate ways of working and its structural and functional relationship with the SP-PHC has not been well defined.
Lack of a unified work plan: The current configuration of SP-PHC deviated from its original design, and its unit-based structure lackeda unified work plan. The UHC-P, recognized as successful and responsive to country needs, contrasts with the global nature of other areas of SP-PHC work. The relationship between the UHC-P and the wider SP-PHC is not well defined and this creates ambiguity regarding its "fit". This raises questions about whether the UHC-P should be placed in another department/division, or at a higher level of WHO, which could be more suited to a country-facing, implementation role.

Effectiveness and Added Value

Advocacy and normative products: The SP-PHC advocacy functionadded value globally, raising the profile of PHC. Normative productsand tools promoted by the SP-PHC were useful but required wider dissemination and increased technical support for effective application at the country level.

Efficiency

Resource adequacy and efficiency: Divergent opinions existed onthe adequacy of SP-PHC resources, both in comparison to other WHO departments and for achieving country-level PHC objectives.Challenges included delays, duplicative work and insufficient collaboration with other WHO departments. Efficiency gains were possible through improved collaboration and clearer objectives.

Sustainability

While the SP-PHC, through the UHC-P, provides bottom-up, country- driven support, which is likely to offer greater prospects of sustainability, overall, less attention is being paid to multisectoral action and community empowerment, both important pillars of PHC andcritical for sustainability. Country-driven support for PHC building on existing structures and initiatives emerges as a key factor in enhancing sustainability. Sustainability concerns related to the long-term funding of country-based health policy advisors are beginning to be addressed with changes to contractual arrangements and absorption of positions into WHO core funding.

Equity, Gender and Human Rights

Although key normative products prioritize gender, equity and humanrights, they could be addressed more systematically. Despite efforts to target SP-PHC resources towards countries with the greatest needs, the resources available are not allocated equitably. Several countries demonstrating the lowest UHC service coverage indices are not being prioritized for resources.

Recommendations

1. Prioritize the development of joint accountability for PHC across WHO by ensuring the WHO GPW 14 2025-2028 includes a specific PHCoutcome, output/s and relevant indicators in its results framework, along with accountability embedded in performance frameworks and review processes. This will encourage a cultural shift towards a PHC approach, enhance organizational accountability, drive collaboration and facilitate budget allocations for PHC activities.

2. Develop a clear strategy for a new approach/entity to promote PHC through global advocacy of PHC, policy and strategic partnerships. With the overall objective to promote the PHC approach,and supported by an explicit definition of its contribution to the PHC outcome/s of GPW 14, the strategy should outline a new mandate andset of functions, which add value to WHO by scaling back implementation and shifting towards a more facilitative, service- oriented and collaborative approach. Its focus should be on SP-PHC's positive attributes and core functions including global advocacy, support to the development of GPW 14 PHC outcomes, outputs and indicators, institutionalizing the systematic inclusion of equity, gender and human rights, and promotion of learning across WHO and with partners. The strategy should also facilitate the adoption of more integrated and agile ways of working within the entity itself and with other WHO departments.

3. Overhaul the SP-PHC design, organizational structure and ways of working to ensure the new entity is fit for purpose to implement the strategy. This includes restructuring, resource allocation, agile management, defining roles and leadership attributes. It also suggests a transition plan for existing work units identifying what aspects of the
SP-PHC interventions can be carried forward and/or built upon in the new approach and what areas of work and/or units should be moved toother departments or divisions, and a communication strategy to raise awareness. Develop a transition plan for SP-PHC existing work and units. This will involve identifying what aspects of the SP-PHC interventions can be carried forward and/or built upon in the new approach, and what areas of work and/or units should be moved to other departments or divisions.

4. Support WHO to scale up the PHC approach in response to countrydemand through the development of mechanisms to strengthen learning, staff capacity and ultimately WHO technical support for PHC. This includes creating mechanisms for learning, staff capacity- building, and flexible support for PHC through technical assistance rosters, directories of PHC expertise, strengthening partnerships and systematic knowledge management.
Recommendations are made to WHO in pursuit of its objective to workwith Member States to reorientate health systems towards PHC to accelerate progress towards UHC.

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