Evaluation of the WHO Special Programme on Primary Health Care

Executive summary

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Executive summary

Evaluation purpose and scope

The WHO Special Programme on Primary Health Care (SP-PHC) was created in January 2020 to support better integration of WHO's work on the primary health care (PHC) approach across all levels of the Organization. The present evaluation of the SP-PHC was primarily designed for learning and planning purposes. It had two main objectives: 1. to assess how the SP-PHC, through its three main functions, workstreams and activities is supporting better integration of efforts towards WHO's PHC objectives at global, regional and country level; and 2. To make recommendations for the future of the SP-PHC in fulfilling its mandate for sustained progress towards Universal Health Coverage (UHC).

The evaluation covers the period January 2020 to August 2023. The geographical scope of the evaluation has involved the three levels of WHO (global, regional and country levels) and external key partners. The programmatic evaluation scope was concerned with assessing the SP-PHC in the following areas/evaluation criteria: relevance, coherence, effectiveness, efficiency, added value, sustainability and equity, gender and human rights considerations. The evaluation did not assess the Universal Health Coverage Partnership (UHC-P) as it has its own separate governing body and reviews/evaluations, but instead considered how the SP-PHC had enhanced the value of the UHC-P and vice versa. The resilience and essential public health functions (REPHF) team and Systems' Governance and Stewardship (SGS) were also not within the scope of this evaluation. However, these workstreams were considered in the wider conclusions and recommendations for the SP-PHC, as appropriate. Finally, the evaluation was focused on the SP-PHC; its scope did not include assessing the configuration and capacity of WHO's departments and functions as they relate to UHC and health systems.

Evaluation approach and methodology

The evaluation was based on a theoretical framework grounded in a theory of change (ToC), which served as the overall analytical framework for the evaluation. The ToC has informed the evaluation protocol and the development of nine evaluation questions (EQs). The evaluation empirically tested the links in the causal chain laid out in the ToC as well as the assumptions upon which the theory was based.

The evaluation used a mixed method approach combining qualitative and quantitative methods for data collection and analysis and relied extensively on qualitative data. The data collection methods included a document and data review, three country case studies (Chile, Kenya and Tajikistan) and key informant interviews (KIIs) and group discussions at global, regional, and country levels, through which 176 people had an opportunity to share their experiences. Primary data was further generated through an online survey for country and regional levels with 138 respondents.

All data were collected and coded in evidence matrices based on the assumptions and EQs. This ensured the analysis considered and triangulated all relevant primary and secondary data that had been collected, thereby reducing the risk of evaluation bias, and improving the robustness of the analysis. Qualitative data were

analysed using content analysis methods. The evaluation assessed the strength of evidence gathered from multiple data sources against findings.

Limitations

Limitations of the evaluation included the absence of a strategic framework for the SP-PHC, with no dedicated results framework and limited financial and results data which challenged effectiveness and efficiency analyses. Furthermore, the small number and choice of case-study countries limited the evaluation's ability to conduct cross-country synthesis. The online survey was affected by information bias, and the sample size was too small to allow for chi-square tests. Despite these limitations, the implemented mitigation measures allow the authors to be confident in its key findings.

Findings

The following table provides a summary of key findings. Further detail and more findings are found in the relevant sections of the main report.

Criteria and EQs	Key findings
Relevance EQ 1.1: How relevant and appropriate is the design of the SP-PHC for achieving its aims and objectives and for supporting the wider aims of the WHO General Programme of Work (GPW) 13	▪ The establishment of the SP-PHC was relevant in the context of the limited global progress made on PHC, the GPW13 goals and targets, and the need to change WHO ways of working; and the SP-PHC's original intervention areas are relevant and broadly aligned to GPW13 priorities. ▪ The SP-PHC has evolved organically in the absence of a specific strategy or ToC to define what it is trying to achieve and how to achieve it. ▪ The prioritization of PHC within WHO and high expectations for the SP-PHC have not been accompanied by special attributes to enable the programme's success. ▪ The SP-PHC's placement within the Universal Health Coverage Life Course Division (UHC/LC) has widely been viewed as unsuitable for its cross-cutting role, affecting its agility, responsiveness, and ability to collaborate. ▪ The SP-PHC has moved away from its intended design and is playing different roles, which is creating ambiguity regarding its mandate, vision and objectives. ▪ Opportunities have been missed to communicate the mandate and objectives of the SP-PHC, which has contributed to a weak understanding and awareness of the programme.

Criteria and EQs	Key findings
	▪ The current WHO strategy (GPW13) does not include a dedicated outcome for PHC which could help incentivize PHC accountability and collaboration. ▪ Leadership challenges, including lack of high-level support from WHO senior management, have impacted the programme's success.
Coherence EQ 1.2: How compatible is the design of the SP-PHC (its objectives, activities, products) internally across WHO at global, region and country levels? EQ 1.3: How coherent is the design of the SP-PHC (its objectives, activities, products) "externally" with wider development partners and country partners?	▪ The SP-PHC has faced challenges in establishing a unified and coherent understanding of the PHC approach internally, and with external partners. ▪ Existing WHO structures and lines of accountability can limit the SP-PHC's direct access to countries. ▪ Certain SP-PHC initiatives are viewed as globally driven and there is strong advocacy within parts of WHO to shift towards supporting countries for work on PHC. ▪ Developing cross-cutting collaborations and agile ways of working has been challenging, in part due WHO's organizational culture and structures. ▪ The alignment of the SP-PHC's work with other WHO departments remains unclear, with overlaps and duplication. ▪ The configuration of the SP-PHC does not align well with the original design of the programme. ▪ The UHC-P plays a critical role in the operations of the SP-PHC, but it remains uncertain whether it fits well with the programme's other work. ▪ There are synergies between aspects of the SP-PHC's work and development partners at global level, but the evidence is more mixed at country level.
Effectiveness and added value EQ 2.2: To what extent are SP-PHC activities being implemented as intended and achieving or expected to achieve their objectives and results? EQ 2.4: How is the SP-PHC adding value to the work of WHO and external partners at global, regional and country levels?	▪ The SP-PHC is making progress on implementing workplans, with achievements noted particularly in its advocacy role and promotion of normative products, despite some delays. Identifying the results and effectiveness of the SP-PHC has, however, been challenging. ▪ There is strong demand for country support for advocacy, regional and country missions, and this is recognized as an area where the SP-PHC adds value. ▪ There is evidence supporting the utility of normative products promoted by the SP-PHC but greater dissemination and increased technical support to

Criteria and EQs	Key findings
	facilitate their effective application is still needed. ▪ The most notable reported achievements of SP-PHC are associated with activities conducted through the UHC-P although there is scope to leverage health policy advisors (HPAs) further for PHC. ▪ The PHC-A has contributed to global dialogue on PHC but there is limited evidence of its impact and added value at country level. ▪ More technical support is needed in multiple areas to advance the PHC approach at country level, targeting both country partners and WHO staff.
Efficiency EQ 2.1: What resources are available to the SP-PHC (UHC-P and non UHC-P financial resources; human/technical expertise) and what evidence is there to suggest that they are adequate for the SP-PHC to achieve its mandate? EQ 2.3: How efficiently are SP-PHC resources being utilized (e.g. are activities being implemented in a timely and economic way)?	▪ While 40% of WHO's 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 WHO core resources, in large part to fund staff to carry out the work. ▪ This has contributed to divergent opinions on how well resourced the SP-PHC is relative to (a) other departments/units in WHO headquarters; and (b) resource needs to meet country PHC objectives. Central to this is a lack of clarity on what the SP-PHC's role should be in the pursuit of PHC outcomes at country level and alongside other WHO departments. ▪ Converging these viewpoints and providing a definitive answer to whether the SP-PHC has adequate resources to achieve its mandate will require an updated articulation of what the SP-PHC is and how it should work with other partners for the achievement of joint objectives. ▪ While limited data hindered a robust efficiency analysis, inefficiencies were identified which relate to delays in implementation, examples of duplicative work, insufficient collaboration between SP-PHC units and wider WHO departments, and examples of non-optimal conduct of meetings.
Sustainability EQ 2.5: How sustainable are the SP-PHC interventions PHC?	▪ The SP-PHC's support to country-led PHC policy work is promising for sustainability; however, there are missed opportunities to leverage wider internal and partner expertise to sustain PHC through multisectoral policy and action. ▪ Sustainability issues regarding the UHC-P network of HPAs are starting to be addressed.
Equity, gender and human rights EQ 3.1: How well has the SP-PHC	▪ Equity and human rights are systematically reflected in SP-PHC technical products and communications, but there is less systematic attention to gender dimensions.

Criteria and EQs	Key findings
supported the inclusion of gender, equity and human rights considerations across its core functions and technical products?	▪ There is some evidence that WHO and SP-PHC resources are being targeted towards countries where needs are greatest, but not in a fully equitable manner.

Conclusions

Relevance – Summary conclusion:
While its original design was relevant to its context, the SP-PHC has expanded beyond its intended scope without a clear strategic approach or organization-wide accountability for PHC results.

Conclusion 1: The original design of SP-PHC was relevant in the context of the limited global progress made on PHC when it was established but this has not been accompanied by a well-defined strategy, theory of change or programme-wide workplan. The absence of special conditions to promote agility in SP-PHC operations and its lack of positioning as a department within WHO have contributed to confusion, both within WHO and with external partners, over what the SP-PHC does and what it is working towards. This has not been conducive to furthering its cross-cutting mandate.

Conclusion 2: The SP-PHC has moved away from its original design, expanding beyond its intended scope with the incorporation of additional units; insufficient communication about its evolution has caused confusion as to its mandate, role and direction. The expansion of the programme beyond its intended scope, incorporating additional units such as Systems Governance and Stewardship (SGS) and Resilience and Essential Public Health Functions (REPHF), has contributed to ambiguity in the SP-PHC mandate, vision and objectives. Efforts to communicate the rationale behind this expansion have not been entirely successful, resulting in considerable internal confusion about the programme's direction. Additionally, the absence of transparent and comprehensive information regarding the SP-PHC itself, has led to a lack of awareness and understanding of its objectives, workstreams and activities, including at regional and country levels.

Conclusion 3: Leadership challenges have significantly affected the SP-PHC, impacting the SP-PHC trajectory and adherence to its original design**.** At a higher organizational level, the extended absence of an Assistant Director General has been a major factor behind stakeholders describing the level of senior support received as not commensurate with the emphasis on prioritizing PHC. Relationships and collaborations between the SP-PHC and other departments are uneven, while the expansion of SP-PHC has introduced managerial complexities, raising concerns about developing a unified team and providing strategic direction.

Conclusion 4: PHC is key to reaching the GPW13 targets, but a collective understanding of the PHC approach has been difficult to achieve, and there has been limited organization-wide accountability for PHC at all levels of the Organization. Establishing a coherent understanding of the PHC approach has been challenging, both internally and with external partners, with the prevailing focus being on primary care and, less attention being paid overall to multisectoral action and community empowerment. Furthermore, the absence of PHC-

specific progress indicators and targets in the GPW13, cascaded through WHO accountability frameworks to prioritize in their work domains, represents a missed opportunity to support organizational commitment and action for PHC advancement.

Coherence – Summary conclusion:

While there are examples of positive collaborations, overall there has not been systematic or significant networking within the SP-PHC or across 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.

Conclusion 5: Positive collaborations have been developed with some departments and networks at WHO Headquarters, but galvanizing cross-cutting collaboration on the real issues faced at country level has been a struggle. The collaborations have taken time to develop, been quite ad-hoc and struggled to break down silos and enhance action and accountability for PHC. Poorly defined roles and responsibilities – with the potential for causing overlaps with other existing WHO entities that are possibly better suited for certain tasks – have been compounded by challenges posed by WHO's competitive organizational culture and vertical structures. This has contributed to widespread perceptions that the SP-PHC is in competition with other departments for resources and territory. Notably, there is no mechanism (outside of the UHC-P) to guide and support collaboration and strong working relationships.

Conclusion 6: The current configuration of SP-PHC has evolved far from its original design, and it is unclear how the UHC-P "fits" with the SP-PHC's other work. The SP-PHC's unit-based structure with separate plans and interventions is contrary to the vision for a more integrated and agile way of working, and the programme lacks a unified workplan that demonstrates the collective aim and intended impact of the SP-PHC's interventions. The UHC-P, recognized as successful and responsive to country needs, contrasts with the global nature of other areas of the SP-PHC's work. The relationship between the UHC-P and the wider SP-PHC is not well defined, and this creates ambiguity regarding its "fit", raising questions about whether the UHC-P should be placed in another department/division or at a higher level of the Organization potentially more suited to a country-facing implementation role.

Effectiveness – Summary conclusion:

The SP-PHC is adding value mainly through its advocacy work and to some extent through the promotion of PHC guidance and tools. However, much more attention is needed to address real issues faced by countries in operationalizing PHC policies and plans.

Conclusion 7: The SP-PHC has added value through its useful global advocacy function which regions and countries have appreciated, albeit with the recognition that more could be done. The SP-PHC has helped to raise the profile of PHC within WHO and globally, despite continued challenges with different interpretations of PHC. High-level regional and country missions have provided opportunities to support political commitment to advance PHC-related reforms and policies. Normative products/tools promoted by the SP-PHC through its different platforms and activities, including the Operational Framework, have been useful to some extent. However, there is an urgent need for wider dissemination of PHC-related tools and clearer guidance, backed up by significantly increased technical support to address PHC implementation issues at country level.

Efficiency - Summary conclusion:

There is room for efficiency gains based on improved collaboration and clearer objectives.

Conclusion 8: There are divergent opinions on the adequacy of SP-PHC resources (human and financial), both in comparison to other WHO departments and to the needs for achieving country level PHC objectives. A critical factor in these divergences is the lack of clarity regarding the SP-PHC's role in the pursuit of PHC outcomes**.** While the efficiency analysis has faced limitations due to limited data and concrete results, instances of delayed or duplicative work and insufficient collaboration with WHO departments have been identified.

Sustainability – Summary conclusion:

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 of which are important pillars of PHC and critical for sustainability.

Conclusion 9: The evaluation highlights mixed progress in ensuring the sustainability of SP-PHC interventions. 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. The evaluation also points to less attention being paid overall to multisectoral policy, action and community empowerment – which are considered crucial for the effectiveness and sustainability of PHC – and which represent two of the three pillars of the PHC approach.

Equity, gender and human rights – Summary conclusion:

There is scope for improvement in the attention being paid to the gender dimensions of SP-PHC work and in applying an equity lens when prioritizing countries for PHC support.

Conclusion 10: Although key normative products prioritize gender, equity and human rights, they could be addressed more systematically, in particular gender dimensions. Despite efforts to target SP-PHC resources towards countries with the greatest needs, the resources available (for instance for Intensified Support) are not allocated equitably, with several countries that have the lowest UHC service coverage indices not being prioritized for resources. Political considerations at regional level influence the prioritization of allocations based on need, for example with UHC-P funds allocated to high-income countries such as Chile.

Overall, the SP-PHC has provided a useful advocacy function. However, it has struggled to gain credibility and demonstrate its added value within WHO and with external partners. The fact that most SP-PHC activities noted as adding value (for example the UHC-P and pre-existing guidance such as the Operational Framework) were already developed before its creation raises questions about whether the added value stems from the SP-PHC itself or from activities that could be managed by other WHO departments and units,

thus avoiding overlaps.

Recommendations

Among the evaluation's conclusions, four critical gaps underscore the need for a major reset of the current approach and support the rationale for the recommendations that follow:

- the lack of explicit PHC-related country outcomes in WHO's overarching strategy, which could embed and enable shared accountability for PHC results across the Organization;
- the absence of a clear strategy, objectives, functions and value proposition for the current approach vis-à-vis the rest of the Organization and with external partners;
- an appropriate design that can efficiently and effectively deliver on its strategy and contribute to country PHC outcomes; and
- learning and capacity gaps that need addressing to support countries and WHO staff to develop, adopt and implement evidence- based PHC policies and reforms.

The following recommendations are made to WHO in pursuit of its objective to work with Member States in radically reorientating their health systems towards PHC as a means of accelerating progress towards UHC.

Recommendation 1: Prioritize the development of joint accountability for PHC across WHO by ensuring that the WHO GPW 14 (2025–2028) includes a specific PHC outcome, output/s and relevant indicators in its results framework along with accountability embedded in performance frameworks and review processes. *Action: GPW 14 Task Force Lead with ADG UHC/Life Course (UHL)and SP-PHC. Timeframe: Immediately*

Rationale: Clearly articulating WHO's desired outcome and output/s for PHC in WHO GPW14 (2025–2028) will strengthen accountability for results across the Organization. This will help drive strategic collaborations across departments at WHO Headquarters and coordination across the three levels of WHO for joint delivery and monitoring, as well as increase budget allocations for PHC activities across the Organization. Going forward WHO should:

- **Ensure accountability for the PHC approach**: Include in GPW14 a PHC outcome/s, clear specific outputs and relevant indicators for PHC, to ensure accountability for the overall PHC approach for UHC of the GPW14. Integrating the PHC outcome and outputs in the GPW14 results framework will be an incentive for this. Accountability sits with the Director-General, Regional Directors and WHO representatives respectively. WHO may also consider identifying department focal points for PHC to strengthen accountability.
- **Institutionalize a mechanism to track PHC progress** in countries, together with clear performance metrics for the Organization.
- **Engender a shift in culture** across the Organization whereby all staff consider a PHC approach an overarching way of working and a means by which broader health systems, UHC and health security objectives are addressed.

- **Further institutionalize** accountability for the PHC approach in WHO performance frameworks and review processes across all divisions and departments and within individual job descriptions and department workplans.

Recommendation 2: Develop a clear strategy for a new approach/entity to promote PHC through global advocacy of PHC, policy and strategic partnerships. *Action: ADG UHL, SP-PHC. Timeframe: Next six months*

Rationale: The absence of a strategy and theory of change for the SP-PHC has created ambiguity regarding its direction and purpose, objectives, means to achieve them and contribution to GPW13. Developing a clear strategy to reset the SP-PHC and to promote and sustain the prioritization of PHC is necessary. This strategy should be based on a shared vision and understanding of the purpose, objectives and value proposition. It should be supported by a theory of change to explicitly define the contribution to the PHC outcome/s of the next WHO Strategy GPW14. The development of a strategy should be informed by the evaluation findings and should build on the strengths of the SP-PHC and on resolving some of the SP-PHC challenges. In developing the strategy, the relationships and departments involved in UHC, PHC and health systems strengthening may need to be considered more broadly.

The vision and strategy should be informed by the following points:

- **building on the positive attributes** of the SP-PHC, with a stronger focus on global advocacy as well as supporting regional and country advocacy efforts;
- **resulting in a clearer and leaner mandate** and set of functions, which add value to WHO;
- **instituting a cultural shift in ways of working**, scaling back implementation and shifting towards a more facilitative, service-orientated, collaborative promotion of a PHC approach;
- **ensuring more integrated and agile** ways of working within the entity itself and with other WHO departments; and
- **considering core functions** as part of the vision and strategy, including:

    - providing global, regional and country advocacy support;
    - supporting GPW14 strategy development on PHC outcomes, outputs and indicators;
    - Institutionalizing systematic attention to the equity, gender and human rights dimension of PHC and to applying an equity lens in prioritizing countries requests for support;
    - facilitating a collaborative learning agenda with other WHO departments and other levels of the organization and with partners;
    - convening and/or organizing dissemination events as requested;
    - supporting external partnership building and collaborations for PHC; and
    - connecting technical support requests from the three WHO levels to the relevant expertise in headquarters departments as and when they arise.

Recommendation 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. *Action: ADG UHL possibly through a working group. Timeframe: Next six months*

Rationale: The SP-PHC has struggled to show its added value with limited prospects of improvement in its current form. The evaluation findings suggest that fundamental change is needed, and the following steps are recommended to make sure that the new entity is fit for purpose and that an enabling environment is in place to facilitate success, notably by:

- **ensuring a leaner, structure, mandate and function** suitably positioned within the organizational organigram and reporting structures for delivering the objectives, scope and functions, with access to senior level guidance, support and oversight to ensure a sustained overhaul of the SP-PHC approach;
- **developing a fit-for-purpose team** structure and guaranteeing that appropriate human and financial resources are available at the point of creation;
- **putting in place an operating model** to support the new approach and the concept of agile management and agile ways of working, such as more flexible staffing arrangements, a dedicated capacity to manage agile projects, and possibly access to a small pool of funding to facilitate collaborations;
- **defining clear roles and responsibilities** of the entity vis-à-vis other parts of WHO and supporting a shift in ways of working towards a service-orientated culture;
- **determining the leadership attributes** required to ensure success;
- **developing a transition plan** for the SP-PHC's existing work and units, which 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;
- **developing a revised PHC communication and knowledge management strategy** (including messaging, web, social media, knowledge sharing) that effectively communicates and raises awareness of the work of the new approach across the three levels of WHO, with Member States and with external partners;
- **building on the existing partner mapping** exercises to identify and prioritize strategic collaborations.

Recommendation 4: Support WHO in scaling up the PHC approach in response to country demand, through the development of mechanisms to strengthen learning, staff capacity and ultimately WHO technical support for PHC. *Shared action: ADG UHL, SP-PHC and Regional Officers. Timeframe: next twelve months*

Rationale: The evaluation found evidence of country demand for technical assistance in PHC prioritization and implementation, as well as capacity gaps in WHO staff who are expected to prioritize PHC. While the SP-PHC is being overhauled, these recommendations will also require attention and will likely fall outside of the mandate of the new entity and thus the task of others:

- **create mechanisms to support implementation of PHC activities** by technical departments and support countries and regions to enable more flexible responses to country needs (such as countries contracting-in the support they need from internal or external sources; providing technical support over longer periods of time);
- **developing a technical assistance PHC/UHC roster mechanism,** which is probably more feasible at regional levels, for mobilizing support in gap areas identified in the findings (such as financing PHC, integrating disease specific programmes into PHC services, supporting different models of care, multisectoral policy and action, and community engagement);
- **creating a directory of WHO Headquarters and Regional Office staff that lists relevant PHC/UHC competencies** in relation to their health systems and PHC experience, so as to enable staff at different levels of the Organization to know whom to approach for expertise;
- **pivoting the existing capacity of HPAs by strengthening the PHC for UHC agenda** in job descriptions, with an emphasis on strategic partnership working, building PHC synergies with other external funders and UN agencies and promoting PHC in new spaces; and
- **developing a more systematic learning and knowledge management function to support the operationalization of PHC** so as to ensure that all WHO staff, including HPAs, can confidently respond to country PHC needs and support the implementation of the Operational Framework. This is likely to go beyond courses and include more comprehensive sessions on knowledge management strategies.

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