
WHO Special Programme on Primary Health Care

Preliminary evaluation report



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This evaluation was managed and quality controlled by Marie Bombin, Senior Evaluation Officer, with contributions from Ye Li, WHO Evaluation Office.

Acronyms

ADG	Assistant Director General (WHO)	NGO	non-governmental organization
COVID-19	Coronavirus disease	OECD	primary health care
EQ	evaluation question	PHC	WHO/UNICEF PHC Accelerator
HSR	Alliance for Health Policy and Systems Research	PHC-A	primary health care measurement framework and indicators
GAP	Global Action Plan for Healthy Lives and Well-being for All	PHCMFI	Resilience and essential public health functions unit
GAVI	The Vaccine Alliance	REPHF	sustainable development goals
GPW	General Programme of Work	SDG	The Global Action Plan for Healthy Lives and Well-being for All
GHI	Global Health Initiative	SDG 3 GAP	The Global Action Plan for Healthy Lives and Well-being for All
ADG	Assistant Director General (WHO)	SGS	Systems Governance and Stewardship (unit)
COVID-19	Coronavirus disease	SP-PHC	WHO Special Programme on Primary Health Care
EQ	evaluation question	ToC	theory of change
HSR	Alliance for Health Policy and Systems Research	ToR	terms of reference
GAP	Global Action Plan for Healthy Lives and Well-being for All	UHC	Universal Health Coverage
GAVI	The Vaccine Alliance	UHC-P	Universal Health Coverage Partnership
GPW	General Programme of Work	UHC/LC	Universal Health Coverage Life Course Division
GHI	Global Health Initiative	UN	United Nations
HPA	health policy advisor	UNAIDS	Joint United Nations Programme on HIV/AIDS
JWT	Joint Working Team	UNICEF	United Nations Children's Fund
KI(I)	key informant (interview)	WHO	World Health Organization
MoH	ministry of health		

Glossary of key terms

Term	Definition
Communities	Groups of people that may or may not be spatially connected, but who share common interests, concerns or identities. These communities could be local, national or international, with specific or broad interests. ^a
Community engagement	A process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes. ^b
Comprehensiveness of care	The extent to which the spectrum of care and of available resources responds to the full range of health needs of a given community. Comprehensive care encompasses health promotion and prevention interventions, as well as diagnosis and treatment or referral and palliation. It includes chronic or long-term home care and, in some models, social services. ^c
Empowerment	The process of supporting people and communities to take control of their own health needs resulting, for example, in the uptake of healthier behaviours or an increased ability to self-manage illnesses. ^c
Essential public health functions	The spectrum of competences and actions that are required to reach the central objective of public health — improving the health of populations. This document focuses on the core or vertical functions: health protection, health promotion, disease prevention, surveillance and response, and emergency preparedness. ^c
Health system	All organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, family caregivers; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; and occupational health and safety legislation. The WHO health system framework identifies six health system "building blocks": leadership and governance, health financing, health workforce, health services, health information systems, and medical products, vaccines, and technologies. ^d
Health benefits packages	The type and scope of health services that a purchaser buys from providers on behalf of its beneficiaries. ^c
Integrated health services	The management and delivery of health services so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services through the different care functions, activities and sites within the health system. ^c
Multisectoral action on health	Policy design, policy implementation and other actions related to health and other sectors (for example, social protection, housing, education, agriculture, finance and industry) carried out collaboratively or alone, which address social, economic and environmental determinants of health and associated commercial factors or improve health and well-being. ^c
People-centred care	An approach to care that consciously adopts the perspectives of individuals, carers, families and communities as participants in and beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care also requires that people have the education and support they need to make decisions and participate in their own care. ^c
Primary care	A key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care. ^c
Primary Health Care	A whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities. ^c
Primary health care-orientated systems	Health system organized and operated to guarantee the right to the highest attainable level of health as the main goal, while maximizing equity and solidarity. A primary health care-orientated health system is composed of a core set of structural and functional elements that support achieving universal coverage and access to services, these services being acceptable to the population and enhance equity. ^c
Service package	A list of prioritized interventions and services across the continuum of care that should be made available to all individuals in a defined population. It may be endorsed by the government at national or subnational levels or agreed by actors where care is by a non-State actor. ^c
Synergy	The interaction of elements which, when combined, produce a total effect that is greater than the sum of the individual elements.
Universal Health Coverage	Ensuring access for all people to needed promotive, preventative, resuscitative, curative, rehabilitative and palliative health services, which are of sufficient quality to be effective, while also ensuring that the use of these services does not expose any users to financial hardship. ^c
Vertical programmes	Health programmes focused on people and populations with specific (single) health conditions. ^c

Sources:

- a) Community engagement: A health promotion guide for Universal Health Coverage in the hands of the people. Geneva: World Health Organization; 2020 (<https://www.who.int/publications/i/item/9789240010529>, accessed 24 June 2023).
- b) WHO community engagement framework for quality, people-centred and resilient health services. Geneva: World Health Organization; 2017 (<https://www.who.int/publications/i/item/WHO-HIS-SDS-2017.15>, accessed 24 April 2023).
- c) Operational framework for primary health care. Geneva: World Health Organization and United Nations Children's Fund; 2020 (<https://www.who.int/publications/i/item/9789240017832>, accessed 24 April 2023).
- d) Everybody's business: Strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization; 2007 (<https://www.who.int/publications/i/item/everybody-s-business----strengthening-health-systems-to-improve-health-outcomes>, accessed 24 June

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
<p>Relevance</p> <p>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</p>	<ul style="list-style-type: none"> ▪ 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. ▪ 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.
<p>Coherence</p> <p>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?</p> <p>EQ 1.3: How coherent is the design of the SP-PHC (its objectives, activities, products) “externally” with wider development partners and country partners?</p>	<ul style="list-style-type: none"> ▪ 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.

Criteria and EQs	Key findings
	<ul style="list-style-type: none"> ▪ 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.
<p>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?</p>	<ul style="list-style-type: none"> ▪ 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 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.
<p>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)?</p>	<ul style="list-style-type: none"> ▪ 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.

Criteria and EQs	Key findings
<p>Sustainability EQ 2.5: How sustainable are the SP-PHC interventions PHC?</p>	<ul style="list-style-type: none"> ▪ 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 supported the inclusion of gender, equity and human rights considerations across its core functions and technical products?

- Equity and human rights are systematically reflected in SP-PHC technical products and communications, but there is less systematic attention to gender dimensions.
- 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.

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; and
- **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.

1. Introduction

1.1 Background and context

In 2015, WHO Member States set out an ambitious agenda for a safer, fairer and healthier world through the development of the Sustainable Development Goals (SDGs), which came into force in 2015. Health for all, through Universal Health Coverage (UHC) (1), is the foundation of efforts to reduce social and gender inequities and a demonstration of governments' commitment to improving the health and well-being of all people. To this end, Member States have committed to primary health care (PHC) (2), an approach to strengthening health systems that is centred on people's needs, as the cornerstone to achieving UHC that will deliver high-quality affordable health care to everyone, especially the most vulnerable.

PHC is at the heart of several global accords including the Declaration of Astana (2018) (3), the accompanying World Health Assembly resolution WHA72.2 in 2019 (4), the 2019 Global Monitoring Report on UHC (5) and the recent Political Declaration on UHC (6). In addition, PHC-orientated health systems (2) are at the centre of WHO's Thirteenth General Programme of Work 2019–2025 (GPW13). This sets out three interconnected policy priorities and targets for meeting the current strategy's goal of healthy lives and well-being for all – the Three Billion Targets (7). The Fourteenth General Programme of Work 2025–2028 (GPW14), currently under development, continues to stress the fundamental importance of PHC to achieving the next strategy's goal of promoting, providing and protecting health and well-being for all people everywhere (8).

The vision document accompanying the Astana Declaration lists three interrelated and synergistic components that form the basis of a comprehensive approach to PHC (the "PHC approach"):

- integrated services with an emphasis on primary care and essential public health functions
- multisectoral policy and action
- empowered people and communities.

The COVID-19 pandemic and its human, social and economic toll exposed the inadequacies of many countries' health systems. It also demonstrated that making health systems resilient to achieve UHC and developing health security are interdependent and complementary health goals. Building health system resilience requires a high-performing health system orientated towards PHC; the ability to sustain essential health services for all, even during an emergency response; and investment in the essential public health functions, with emergency risk management capacities. COVID-19 has highlighted the need to enhance health security through a renewed focus on PHC. Thus, the role of the PHC approach can be clearly articulated within the global health security dialogue, including a strong effort on investment.

Since 2015, the rapid pace of key demographic, epidemiological, environmental, economic, technological and scientific changes has had profound implications for health, well-being and health systems. Countries are facing a worsening environment for achieving better health outcomes and increasing demand from populations for inclusive, equitable health services. These challenges are contributing to slower global progress towards achieving the 2030 targets, with nearly all the SDGs being off track, including for UHC (1).

Whilst the PHC approach has been a long-standing concept, the practical challenge of radically reorientating health systems towards PHC to achieve UHC is often complex. WHO's GPW13 and draft GPW14 focus on accelerating country impact and progress towards UHC by supporting countries in navigating these transitions.

1.2 Evolution and description of SP-PHC

Rationale for establishing the SP-PHC

Building on the momentum for PHC renewal that followed the Declaration of Astana¹ (3) and the need to achieve the GPW13 Three Billion targets,² the SP-PHC was created in January 2020 to support better integration of WHO's work on the PHC approach across all levels of the Organization. The establishment of the SP-PHC was also driven by the Transformation Agenda, which aimed to make WHO more "fit for purpose" to deliver on the GPW13 goals and targets and to develop a more aligned operating model for the Organization's three levels.^{3,4}

SP-PHC vision and original design features

Concept Notes on the SP-PHC,^{5,6} the PHC Manifesto,⁷ Memorandum⁸ and other documents – such as the Director General's report, Universal Health Coverage: moving together to build a healthier world(9) – discuss the vision and intended operation of the SP-PHC.⁹ According to the Manifesto, "The vision of the SP-PHC is to support Member States in their journey to achieve healthy lives and well-being for all by building people-centred, resilient and sustainable PHC-oriented health systems that uphold the right to health, promote social justice, empower individuals and communities and address the determinants of health." According to a draft Concept Note, the SP-PHC objective is to "provide cutting edge technical leadership through a one-stop, 3 level network that supports the implementation of PHC".¹⁰

The SP-PHC was designed in this context as an "agile, integrated platform to connect the triple billion targets, increase technical coherence and synergies, and adopt a new way of working".^{11, 12}

With enhanced flexibility, the SP-PHC aimed to renew and promote the PHC approach with governments, UN agencies, financing institutions and external development partners; demonstrate a more integrative way of working across the three levels of WHO as a holistic cross-cutting platform; and offer tailored implementation support to countries to enable them to reorientate their health systems towards PHC. Ultimately, the SP-PHC strives to contribute to progress in achieving UHC and SDG 3 and to improving health and well-being for all, leaving no one behind.

The documents referred to above indicated that the design was inspired by agile management principles.^{13, 14} These focused on delivering products and services that engage and respond to the end users (namely regions and countries) and emphasized one multidisciplinary team that would work in a holistic and integrative manner. A matrix approach was envisioned to facilitate joint work, task shifting and holistic programme management. The Memorandum suggested the flexibility of bringing in specialists for thematic areas, creating additional staff positions to respond to emerging needs, and maximizing technical expertise across the Organization. The Memorandum also recommended moving the already well

¹ The 2018 Astana Declaration aimed to address disparities in PHC programmes and health outcomes both within and between countries.

² The GPW13 emphasizes PHC's central role in achieving its three interrelated priorities and Triple Billion targets and identifies internal strategic shifts necessary to achieve the targets, including an enhanced focus on country impact and more integrated ways of working.

³ World Health Organization, Evaluation of WHO transformation, unpublished work (2021).

⁴ World Health Organization, PHC Special Programme slide set (undated), shared with the evaluation team in November 2023.

⁵ World Health Organization, SP-PHC Human Resource Concept Note, unpublished note (2020).

⁶ World Health Organization, PHC Concept Note Draft, unpublished draft (n.d.).

⁷ World Health Organization, On the road to Universal Health Coverage, unpublished document; (n.d.).

⁸ World Health Organization, Memorandum. Subject: Organigramme and concept note for the Special Programme on PHC, unpublished memorandum (2020).

⁹ The team notes that multiple 'foundational' documents and slide sets from 2019/2020 exist that explain the design and objectives of the SP-PHC but in slightly different ways. As far as the team is aware, there is no one definitive and agreed document on the SP-PHC design, objectives and functions.

¹⁰ World Health Organization, PHC CN Drafr8719, unpublished draft (n.d.).

¹¹ World Health Organization, On the road to Universal Health Coverage, op. cit.

¹² World Health Organization, PHC Special Programme slide set, op. cit.

¹³ Agile ways of working are defined by the Harvard Business Review as follows: "Agile methods focus on enabling teams to deliver work in small increments, thus delivering value to their customers faster. Because the team continuously evaluates project requirements, plans, and results, it can make changes rapidly. Agile ways of working are characterized by rapid, iterative development cycles, facilitate early end-user engagement, and promote cross-functional collaboration".

¹⁴ An introduction to agile ways of working (adapted from a pre-read prepared for the WHO Global Management Meeting, 10–12 December 2018, Nairobi, Kenya).

established UHC-P¹⁵ and Joint Working Team (JWT)¹⁶ (10) into the SP-PHC to help translate the vision of PHC for UHC into action and to enhance country impact.

The original design of the SP-PHC identified three interdependent functions, which serve as the basis for organizing the programme's work. These functions are:

- providing a “one stop mechanism” for PHC support to countries, based on an agile network approach across the three levels of WHO and putting into action the Operational Framework for PHC;
- measuring impact and generating and promoting PHC-oriented evidence and innovation with a sharper focus on people left behind; and
- promoting PHC renewal through policy leadership, advocacy and strategic partnerships.

Internal contextual factors

Since its establishment, the SP-PHC has evolved organically amid challenging circumstances, marked notably by the arrival of a new Director from outside the Organization in March 2020, within days of the COVID-19 pandemic lockdown in Geneva. The lockdown slowed down interactions with new colleagues regarding the programme's development and scoping. The new Director was appointed with a limited number of staff to support the start-up and development of the programme (the Director, one P5 Advisor and a shared administrative assistant); this situation continued until January 2021. This period also coincided with the untimely loss of the Assistant Director-General of the Department of Universal Health Coverage Life Course Division (UHC/LC), the visionary behind the SP-PHC, who conceptualized its purpose, function and implementation. The post remained vacant until May 2023, with the Deputy Director-General acting as the Assistant Director-General, thus holding three positions at that time.

Department structure

In its early days, the SP-PHC was set up as a department within the WHO headquarters' UHC/LC Division and was structured into three units as follows:

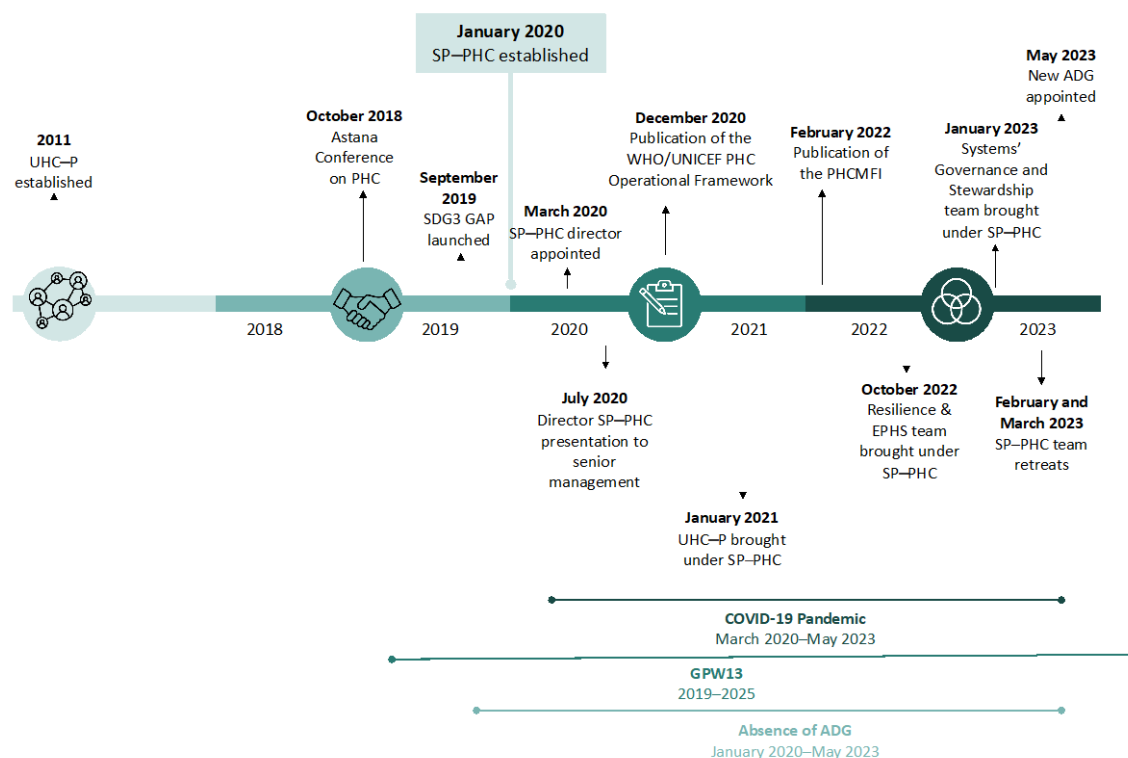
- **Evidence and Innovation unit** – generating/capturing evidence and scaling up PHC innovation with a sharper focus on people left behind;
- **Policy and Partnership unit** – defining a new era of PHC on the road to UHC and making it fit-for-purpose through partnerships at global, regional and country levels; and
- **Country Impact Unit** – contextualizing and operationalizing the PHC approach for implementation support to Members State (including the UHC-P and the JWT).

As the SP-PHC has matured, it has expanded. This growth includes the absorption of the UHC-P from early January 2021 as well as two additional teams: Resilience/Essential Public Health Functions (REPHF) in October 2022 and Systems' Governance and Stewardship (SGS) in January 2023. The evolutionary journey of the SP-PHC is depicted in the timeline below (Fig. 1) along with major internal and external contextual factors.

¹⁵ The UHC-P is a donor-funded fully flexible resource that supports countries' progress to UHC through work on health system strengthening and PHC; see <https://extranet.who.int/uhcpartnership/content/what-uhc-p>

¹⁶ The Joint Working Team for Universal Health Coverage is the vehicle for the new “United for health” approach. It is a virtual team of country office, regional office and WHO headquarters focal points assembled to aid UHC country support plans.

Fig. 1. Timeline representation of SP-PHC development, evolution and context



US\$ 9.8 million in salary costs and US\$ 8 million for programmatic activities (see Findings on efficiency, below).¹⁷

Table 1: SP-PHC staffing levels by unit as of 15 May 2023 – Filled positions

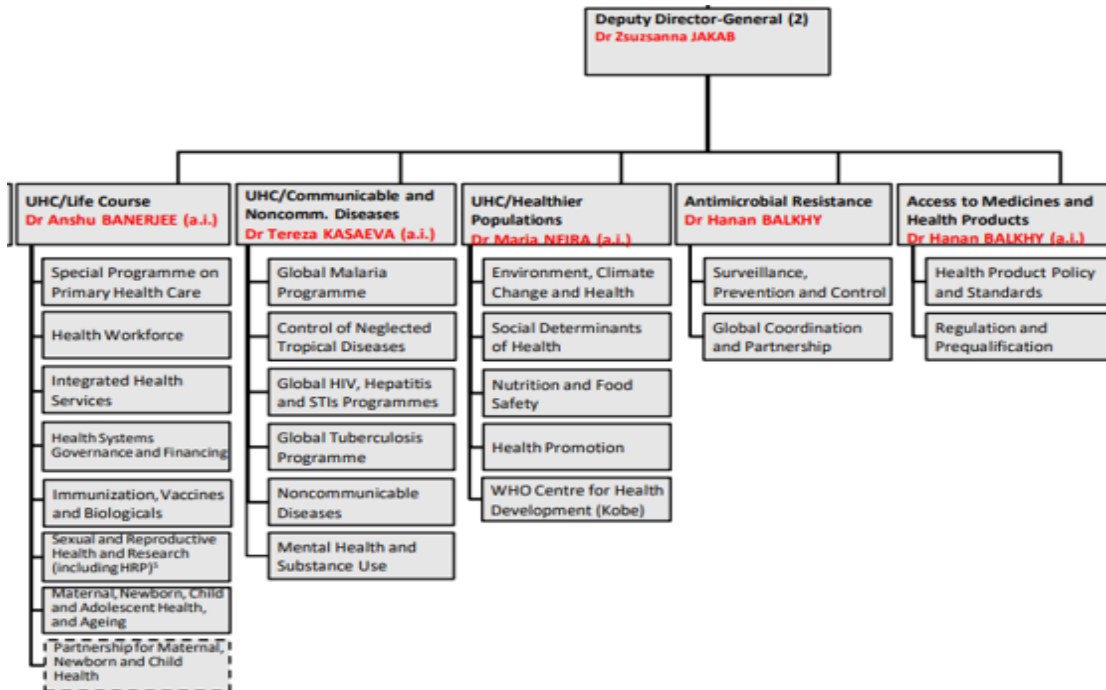
SP-PHC Unit	No. of Professional staff	No. of General staff	No. of seconded staff	No. of Junior Professional staff	Total
Policy and Partnership Unit	1	0.5		1	2.5
Evidence and Innovation Unit	1	0.5			1.5
Country Impact Unit	5	1	1		7
Systems' Governance and Stewardship	6	1		1	8
Director's Office	4	2			6
SP-PHC Total number of staff					25

¹⁷ Based on data shared by the WHO Secretariat.

The SP-PHC is one department of eight situated in the WHO Headquarters UHC/LC Division. It is positioned alongside other related departments, which have been organized largely around WHO’s building block approach to health systems and service delivery departments, such as Integrated Health Services ; Health Workforce; Maternal, Newborn, Child and Adolescent Health; and Aging.¹⁸ Prior to the creation of the SP-PHC, the work on PHC, including for Astana 2018, was developed by the Integrated Health Services Department; this has had ramifications for how it is viewed by Integrated Health Services and departments within the UHC/LC Division.

The SP-PHC does not have a separate governing body (although the UHC-P, which sits within the SP-PHC, does): the SP-PHC Director reports directly to the Assistant Director-General of the UHC/LC (see Fig. 2).

Fig. 2. Positioning of the SP-PHC in the WHO Headquarters organigram, as of 1 January 2023



Source: based on WHO Headquarters organigram, January 2023

SP-PHC activities

The current activities/intervention areas undertaken by the SP-PHC are detailed in Table 2 below.

Table 2: Current SP-PHC activities/intervention areas

Workstreams/intervention areas identified in SP-PHC documentation and implemented by the SP-PHC

Cross-cutting intervention areas implemented by all staff within SP-PHC and the Director’s Office

- Operationalization of PHC Operational Framework
- Communication and advocacy strategy (relevant to all units but spearheaded by Policy and Partnership Unit)
- Leadership, visibility, high level advocacy.

¹⁸ World Health Organization, Organizational chart for UHL, unpublished chart (n.d.), provided to the evaluation team.

Evidence and Innovation Unit

- PHCMFI
- Implementation solutions
- Country case study compendium
- WHO academy course on PHC
- Scaling Innovation.

Policy and Partnership Unit

- PHC-Accelerator/The Global Action Plan for Healthy Lives and Well-being for All (SDG 3 GAP) and other partner engagement and collaboration, for example with UHC 2030
- PHC-Global Health Initiatives
- Living Partnerships for PHC, specifically Collaborating Centres on PHC
- Strategy Advisory Group on PHC.

Country Impact Unit

- UHC-Partnership and JWT
- One network for putting Operational Framework into action
- Reinforcement of regional priorities.

Sources: various, including Policy and Partnerships Unit SP-PHC: 2023 Springboard Plan; SP-PHC Updates of 7 July 2022 and updated slide set.

Target audience of the SP-PHC

According to reviewed founding documents, the SP-PHC is intended to influence WHO Headquarters departments and structures as well as WHO Regional Offices and to embed PHC within existing programmes, departments and initiatives. External partners – such as other UN organizations and Global Health initiatives – are also expected to be affected by some specific SP-PHC activities.

There is a level of ambiguity regarding the country focus of the SP-PHC. Routine support through the UHC-P reaches a total of 125 countries (11). In May 2023, as part of a broader initiative, the objective was for more than 45 WHO Country Offices to receive intensified support on UHC using a PHC approach.¹⁹ To date, only 10 countries have received intensified PHC support. However, it is important to note that support for high level advocacy and other activities is provided by the SP-PHC to additional countries on an ad-hoc basis, according to country requests and opportunities.^{20, 21}

1.3 Objectives and scope of the evaluation

This final report for the Preliminary Evaluation of the WHO SP-PHC builds on the findings and recommendations of previous relevant reviews and evaluations of WHO and PHC (for example (12, 13)). It aims to generate learning that can be used to

¹⁹ Strengthening country capacity for measurable impact – 45+ countries on an accelerated track PB 2022–2023. Unpublished PowerPoint presentation (23 January 2023).

²¹ As reported by KIs of the SP-PHC, and as noted in the case of Chile (see country case study).

enhance the SP-PHC's future implementation and performance, as well as inform relevant discussions and decisions both within WHO and with partners.

Under its terms of reference (ToR), this evaluation has **two main objectives** (see Annex 1):

1. to assess how the SP-PHC is supporting better integration of efforts towards WHO's PHC objectives at global, regional and country level through its three main functions, workstreams and activities. This includes:
 - reviewing how the SP-PHC engages and promotes the coherence of the WHO PHC approach and interventions at global, regional and country levels within WHO and with wider partners;
 - identifying and documenting key achievements, enabling factors, challenges, and lessons learned from country contexts;
 - assessing how the SP-PHC approaches the equity and sustainability of health gains for the most vulnerable populations; and
2. to make recommendations for the way forward of the SP-PHC to fulfil its mandate for sustained progress on UHC and the SDGs.

The programmatic **evaluation scope** is concerned with three key areas, which have been explored through the evaluation approach, methodology and questions in line with the approved inception report:

1. **Relevance and coherence:** This area is concerned with the design of SP-PHC and whether this design and the SP-PHC activities undertaken are appropriate, relevant and fit for purpose to support achieving the SP-PHC's mandate, both within WHO and with external partners.
2. **Efficiency, effectiveness and sustainability:** This area is concerned with the implementation of SP-PHC activities, specifically how resources are used, any progress and potential achievements of the SP-PHC and the sustainability of SP-PHC activities.
3. **Equity, gender and human rights:** This is concerned with how well the SP-PHC supports the inclusion of equity, gender and human rights considerations across its core functions and technical products.

The final inception report for the evaluation outlined the key functions, workstreams and interventions of the SP-PHC that were "in scope" and "out of scope" (see Table 3 for a summary).

Table 3: Scope – Functions, workstreams and intervention areas

Scope considerations for functions, workstreams and intervention areas as identified in SP-PHC documentation and agreed in the evaluation's inception report ^a	
Areas considered in scope for the evaluation	Scope restrictions
<p>Cross-cutting intervention areas implemented by all staff within SP-PHC</p> <ul style="list-style-type: none"> • PHC Operational Framework operationalization • communication • leadership and visibility of PHC 	<p>Universal Health Coverage Partnership (UHC-P): As per the Inception Report, the evaluation did not assess the UHC-P as the latter has its own separate governing body and reviews/evaluations. Instead, it considered how the SP-PHC had enhanced the value of the UHC-P and vice versa.</p> <p>The two new workstreams of the SP-PHC: The REPHF team and SGS were not considered part of the scope of this evaluation. This was in line with the ToR for the evaluation, which only mentions three units/workstreams (Evidence and Innovation; Policy and Partnership; and Country Impact units). However, as stated in the Inception Report, these workstreams are considered in the wider conclusions and recommendations for the SP-PHC, as appropriate.</p> <p>A focus on the SP-PHC: In line with the ToR, the evaluation was focused on the SP-PHC. Its scope did not extend to assessing the configuration and capacity of WHO's departments and functions as they relate to UHC and health systems.</p>
<p>Evidence and Innovation Unit</p> <ul style="list-style-type: none"> • PHC measurement framework and Indicators (PHCMFI) • implementation solutions • WHO academy course on PHC • Scaling Innovation • Global Report on PHC 	
<p>Policy and Partnership unit</p> <ul style="list-style-type: none"> • PHC-Accelerator (under the SDG3 GAP) • PHC-Global Health Initiatives (GHIs) 	
<p>Country Impact Unit</p> <ul style="list-style-type: none"> • UHC-Partnership and Joint Working Team (JWT) • Reinforcement of regional priorities 	

Temporal and geographical scope: The timeframe for the evaluation was from the inception of the SP-PHC in 2020 to the end of August 2023. Its geographical scope involved the three levels of WHO (global, regional and country levels) and external key partners.

EQs: EQs (EQs) as presented in the ToR were modified during the inception phase in consultation with the SP-PHC and the WHO evaluation office. The aim was to align them more closely with emerging issues identified during the inception period and to recognize data limitations. Annex 3 presents the rationale for amending EQs.

Nine EQs, as detailed in Table 4 below, were identified and agreed with the SP-PHC in the approved evaluation inception report. They are largely structured around relevant OECD Development Assistance Committee (DAC) evaluation criteria (14), with the exception of the question related to gender, equity and human rights. The full evaluation matrix can be found in Annex 4.

^a The evaluation team notes that additional areas have been worked on by the SP-PHC since the evaluation's inception, including the PHC Investment Planning (with a focus on PHC assessment and identification of needs, gaps and priorities for investment) carried out by the Evidence and Innovation Unit. This area of work was identified through a request to the SP-PHC for an updated workplan (received August 2023) but was considered out of temporal scope for the evaluation (January 2020–August 2023) and coincided with the end of the evaluation's data collection phase.

Table 4. EQs

1: Relevance and coherence
<p>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 GPW13?</p> <p>1.2. How compatible is the design of the SP-PHC internally across WHO at global, region and country levels?</p> <p>1.3. How coherent is the design of the SP-PHC “externally” with wider development partners and country partners (e.g., UNICEF, other UN agencies, Global Fund, GAVI, World Bank, governments; non-governmental organizations (NGOs), civil society organizations, others)?</p>
2: Efficiency, effectiveness and sustainability
<p>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?</p> <p>2.2. To what extent are SP-PHC activities being implemented as intended and achieving or expected to achieve their objectives and results?</p> <p>2.3. How efficiently are SP-PHC resources being utilized (e.g., are activities being implemented in a timely and economic way)?</p> <p>2.4. How is the SP-PHC adding value to the work of WHO and external partners at global, regional and country levels?</p> <p>2.5. How sustainable are SP-PHC interventions?</p>
3: Gender, equity and human rights
<p>3.1. How well has the SP-PHC supported the inclusion of gender, equity and human rights considerations across its core functions and technical products?</p>

The evaluation was coordinated with a concurrent evaluation of “*the UNAIDS Joint Programme contribution to strengthening HIV and Primary Health Care outcomes: interlinkages and integration on PHC*”, which was conducted by Euro Health Group. There was an intentional overlap of evaluation team members and evaluation reference group members between the two evaluations as well as synergies on data collection methods, data analysis and reporting. This evaluation report is applying examples from the UNAIDS evaluation findings where applicable and relevant to the EQs.

1.4 Evaluation approach

Evaluation design and approach

The evaluation team opted for a non-experimental design since the nature of the object – a department within WHO, which drives interventions at a global level and thus potentially influences countries, partners and internal structures broadly – was not amenable to randomization or case control designs or the use of any other counterfactual scenarios, such as through a quasi-experimental design. Furthermore, with no specific results framework for the SP-PHC’s work, with limited results reporting and with an evaluation and its formative component that are both complex, the most suitable design is a theory-driven evaluation. This is an appropriate approach to identifying key drivers of change and any barriers or challenges that may hinder progress.

A theory-based approach to the evaluation

In the absence of an existing theory of change (ToC) for the SP-PHC, the evaluation team's first step was to develop and agree on a ToC with the SP-PHC that could articulate the relationship between SP-PHC inputs and interventions, and how and why these were expected to bring about change and contribute to country outcomes and impact. Development of the ToC was informed by a review of PHC frameworks and SP-PHC-related design and work planning documents. The aim was "back map" the results chain from impact and outcomes to inputs and thus develop the assumptions to be tested.

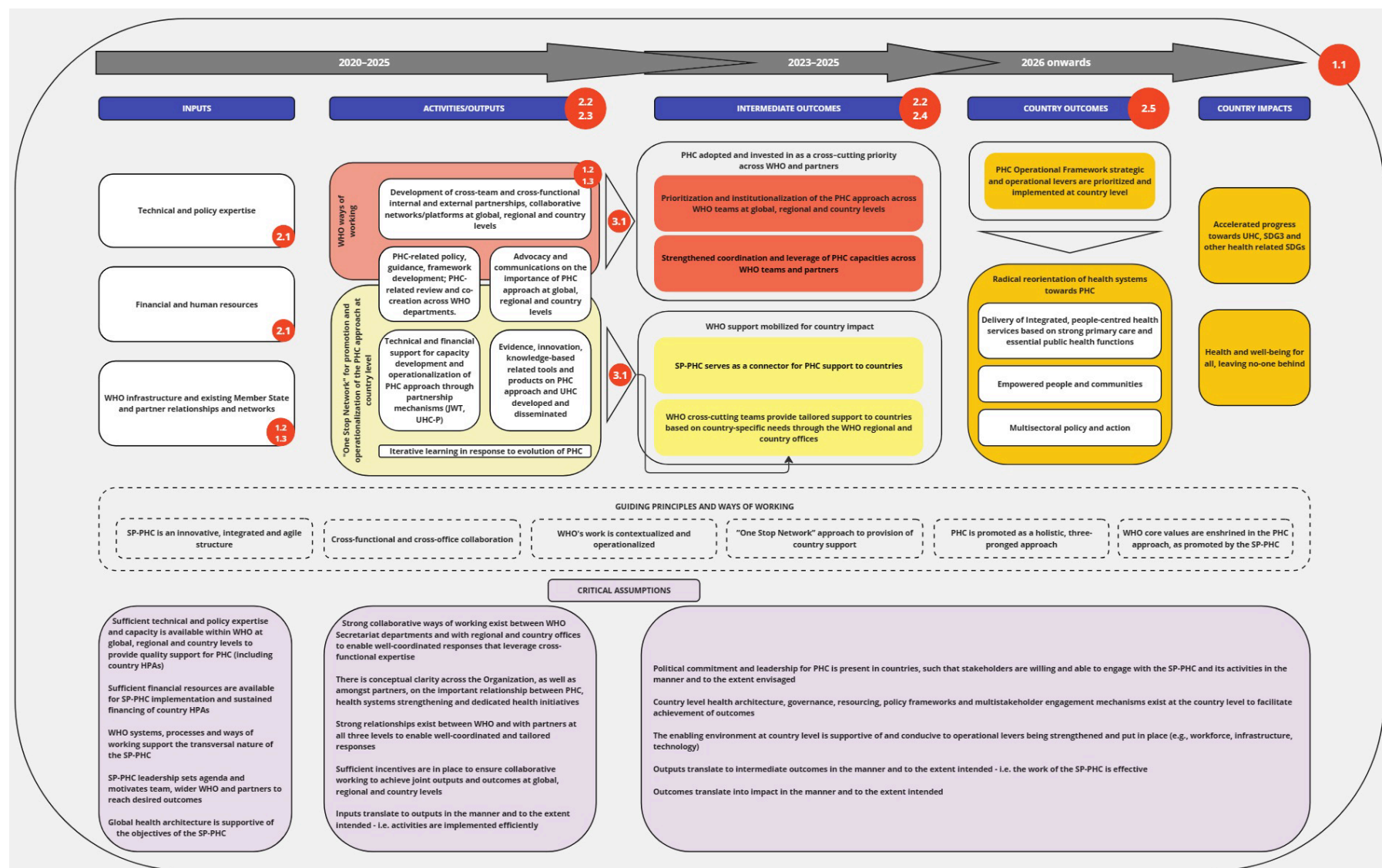
The evaluation team empirically tested the links in the causal chain laid out in the ToC as well as the assumptions on which the ToC was based. The team analysed the evidence at each stage of the chain to assess whether the relationships in the logic chain were occurring, and whether assumptions were sound/held true.

The ToC was used in all the phases of the evaluation.

- In the inception phase, the ToC informed the construction of the evaluation matrix (Annex 4) and the development of tools for data collection. It played an important role in fostering a shared understanding of how the SP-PHC's activities and outputs were expected to work, aligned with the EQs.
- During the data collection phase, the ToC was used to identify evidence gaps. It guided the evaluation team in refining KI questions to focus on specific assumptions. Additionally, it functioned as a tool for the team to periodically review emerging findings at key junctures.
- At the analysis stage of the evaluation, the ToC served as a tool for assessing the evidence against the EQs by testing the assumptions. It enabled the team to develop an overarching assessment of how, why and to what extent the results chain was being realized.
- For the evaluation report, each findings section includes a short assessment of the ToC and its assumptions in relation to the findings for the EQ. A final overall assessment is provided in Section 2.7.

The final version of the agreed ToC with mapped EQs and underlying assumptions is presented in Fig. 3 below.

Fig. 3. Constructed ToC for the SP-PHC with mapped EQs



Gender, equity, social inclusion and human rights based responsive evaluation

The evaluation incorporated gender, equity and social inclusion and human rights principles in its design and implementation to ensure that due consideration was given to assessing potential gender and equity concerns. This was achieved through:

- designating a team member responsible for leading efforts to integrate this approach throughout the evaluation's methods, tools, analysis and findings;
- dedicating an EQ (EQ 3.1) to gender, equity and social inclusion and human rights aspects of the SP-PHC's working practices, including reviewing whether SP-PHC products and prioritization processes have comprehensively integrated gender, equity and social inclusion and human rights criteria and considering the implications of any such absence of focus;
- formulating KII questions to capture the extent to which gender, equity and social inclusion responsiveness was considered in the design and implementation of SP-PHC actions;
- seeking equal representation of the views of men and women in the sample of interviewees and monitoring for any gender representation bias among survey respondents and their possible implications (The gender disaggregation of respondents is presented in the methods section.);
- providing disaggregated data presentation and analysis whenever available, although SP-PHC activities were generally not reported with any disaggregation, and no specific results with disaggregation of data were available;
- ensuring confidentiality and upholding ethical standards (15) to ensure protection of human rights during the conduct of the evaluation; and
- having a gender-focused team with several women in senior roles.

1.5 Evaluation methodology

Data collection and analysis methods

The evaluation used a mixed method approach combining qualitative and quantitative methods for data collection and analysis. The evaluation relied extensively on qualitative data due to:

- the absence of a specific strategy for the SP-PHC with accompanying monitoring and evaluation framework;
- the limited availability of quantitative indicator data for results monitoring (i.e., only activity-based milestones in workplans); and
- the subject of the evaluation, which makes qualitative data invaluable in uncovering sensitivities and giving voice to any organizational experiences of the SP-PHC that are not documented but are essential to exploring how and why change has or has not occurred.

Document and data review

A comprehensive and structured review of secondary data was conducted. These included key declarations, policies, strategies, frameworks, normative guidance, plans, reports, evaluations, reviews, budgets and SP-PHC webinars since 2020. The evaluation team requested relevant information needed to carry out the evaluation. The document review provided some information on the "what" of the SP-PHC and its main areas of work, but with few tangible results available. A complete list of the documents reviewed can be found in Annex 7.

KIIs and group discussions

Sampling strategy: KIIs were purposively selected to ensure that data sources were as illustrative as possible and knowledgeable about the SP-PHC and its products, so as to support the generation of evidence necessary to address the EQs and develop recommendations. At the global and regional level, the WHO evaluation office in collaboration with the

evaluation team and with input from the SP-PHC developed an initial list of KIs based on a stakeholder mapping (Annex 2). Furthermore, as data were collected and continuously analysed, additional informants were recruited to provide more insight on emerging themes. A limited number of interviewees were identified through “snowball” sampling. At country level, KIs were also purposively selected and identified through a stakeholder mapping developed in consultation with the WHO country office.

Conduct and tools: Interviews with stakeholders at global and regional levels (and some countries) were conducted virtually through 73 interviews/small group discussions, whereas interviews and focus group discussions at country level were conducted face-to-face in the three case study countries. Interview guides for the principal stakeholder groups were developed and adapted to different global, regional and country contexts and audiences, based on the EQs and the ToC assumptions. Interviewers were able to probe during the interview, which allowed for an inductive approach and for certain questions to be explored in greater depth. The order and the actual wording of the questions were also flexible. The advantage of applying this approach is that it makes interviewing of several different persons systematic and comprehensive by delineating the issues to be covered, while still allowing for probing and new themes to emerge. The use of probing elicited rich, deep data from informants.

Description of informants: Altogether, 176 people had an opportunity to share their experiences and opinions, of which 42% identified as female. The evaluation reached saturation with very little new information generated and repetition of issues/themes during the final interviews – an important sign of sampling adequacy adding rigour in qualitative research (16). A summary of the number of KIs by main stakeholder group and level (global, regional and country) is found in Table 5, below. Most informants were WHO staff (55%), followed by international partners/donors (17%). A detailed list of all KIs at global, regional and country levels is available upon request from the WHO evaluation office.

Table 5: Number of informants interviewed or participating in focus group discussions, by stakeholder group and level

	Global level	Regional level	Country level (excluding country case studies)	3 country case studies	Total number of informants
WHO	35	17	10	30	92
Other UN agencies	4	0	0	2	6
Governments	N/A	N/A	0	16	16
Civil society	1	0	0	1	2
International partners/donors	18	0	0	12	30
Academia	3	0	0	2	5
Health facility	N/A	N/A	0	25	25
Total number of informants	61	17	10	88	176

In October and November 2023, debriefings were also carried out to discuss the draft findings, conclusions and recommendations. These included a briefing with the Assistant Director-General and the SP-PHC team and a stakeholder workshop including heads of health systems from regional offices as well as heads of health systems departments in the UHL division.

Country case studies

A structured case study approach in three countries provided more detailed information and analysis of SP-PHC interventions, achievements and challenges across different contexts. It enabled a more comprehensive, nuanced understanding of SP-PHC support and contribution to reorientating health systems towards PHC. The countries for this evaluation were purposively selected in consultation with the SP-PHC and regional offices based on the criteria outlined in Box 1.

Box 1. Summary of sampling strategy for country case study

Country case study sampling

- **Criteria 1:** Regional and contextual diversity. The emphasis was on countries from different regions representing various PHC contexts and stages of progress towards UHC.
- **Criteria 2:** Level of engagement with SP-PHC. The emphasis was on countries that have some recent knowledge and experience of engaging with the SP-PHC: through support from the UHC-Partnership (UHC-P), through a Canadian PHC system strengthening grant, through collaboration with WHO and UNICEF in the PHC Accelerator (PHC-A) of the Global Action Plan for Healthy Lives and Well-being (SDG GAP), through PHC Implementation Solutions, through piloting PHC measurement, and countries with a strong political agenda on health reform focusing on PHC.
- **Criteria 3:** Potential to generate learning. The emphasis was on countries with results or a possibility to generate learning on promoting any of the following 14 strategic and operational levers of the WHO/UNICEF PHC operational framework, and any efforts on PHC measurement.

Based on the above criteria, the following countries were selected:

Country	Region
Chile	Region of the Americas
Kenya	African Region
Tajikistan	European Region

Data collection methods for country case studies included a document and data review; KIIs; focus group discussions; and, in some cases, clinic visits. The three country case study reports are included in a separate evaluation document, Volume II: Country reports. Findings from case study reports are reflected throughout this report where applicable and have served as a triangulation point.

Online survey

An online survey was conducted to generate further insights from country and regional levels. Sampling strategy: Recognizing the ambiguity in the SP-PHC target countries (see section 1.2), the online survey focused on WHO country offices and six WHO regional offices with a resident HPA. These were identified as critical to lead PHC efforts at country and regional levels; they were being funded by the UHC-P under the SP-PHC. The survey also targeted additional relevant WHO staff in these countries, including, in every case, the WHO country representative.

Survey questions and conduct: A set of 29 questions was formulated and translated from English to Spanish and French. The questions were distributed using the Survey Monkey, an online survey tool. The survey included 27 questions²³ that focused on respondents' level of agreement with 19 different statements on 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.

The survey was sent to 190 WHO HPAs and WHO country representatives in 98 countries, some of which forwarded the survey to Ministry of Health representatives. The survey was open from 21 July to 31 August 2023. Three reminder emails were sent to survey respondents during this period.

²³ Four additional questions related to the ongoing UNAIDS reevaluation of the Joint Programmes contribution to primary health care integration and interlinkages were also inserted into the survey to maximize synergies between the two evaluations. However, the results are not elaborated here as they were HIV focused.

Survey respondents: 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. 46% of all respondents identified as female. It was not possible to calculate a precise response rate as the survey was further disseminated by WHO. However, for the directly targeted survey recipients, the response rate was 52%.

The survey questions along with the key results and data analysis can be found in Annex 5. They have been analysed and referenced throughout the report findings, where applicable.

Data analysis

For all data collected through the methods described above, the evaluation team employed a range of approaches to analyse, validate and synthesize the evidence, including the ToC and its underlying assumptions.

Quantitative analysis of available financial data was carried out in relation to EQ 2.1, which focuses on understanding SP-PHC resources and allocation for the biennia 2020–2021 and 2022–2023, UHC-P resourcing since 2012 and the number of countries supported. Other quantitative analyses included survey data. Quantitative survey data were analysed in Excel. Relevant results were disaggregated by respondent type (WHO staff vs. non-WHO staff and HPA vs. other WHO staff). After disaggregation, the sample was generally too small to conduct chi-square tests to assess differences across respondent type (HPA/other WHO staff).

Qualitative data from primary data sources – such as KIIs, focus group discussions and survey data as well as secondary qualitative data – were analysed using content analysis methods with coding of data against EQs. All raw data were collected in evidence matrices based on the assumptions and EQs. This ensured the analysis considered and triangulated all relevant secondary and primary data, thereby reducing the risk of evaluation bias, and improving the robustness of findings. The subsequent process involved a reflective process to derive overarching themes (such as departmental positioning within the WHO organigram as a barrier, lack of incentives to collaborate, etc.). This thematic frame ensured that findings could be directly linked to relevant EQs and that themes could be drawn out to generate a robust synthesis of views, while allowing space for evolving coding should important new themes emerge from the analysis. The evaluation team primarily used a deductive coding approach based on codes grounded in the EQs and the ToC assumptions.

Triangulation. The evaluation team relied on triangulation both across and within categories of data sources. For example, it triangulated the responses of different KIs at global, regional and country levels to ensure that differences of experiences and opinions were not lost in the analysis and that evidence was supported across the KI categories. Coding all qualitative data and populating the evaluation evidence matrix by EQ supported the triangulation process. The information obtained through KIIs and group discussions was also triangulated and compared with the document and country case study reports. Similarly, the results of the online survey were compared and triangulated with the opinions and experiences related by KIs and with document review. Triangulation in the analysis thus took place at multiple levels, which included:

- data drawing on multiple sources of information from document review, KIIs, focus group discussions, online survey results and country case studies;
- respondent types (for example, across the three levels of the Organization, external partners and other different categories of stakeholders).

The evaluation team systematically assessed the strength of evidence gathered from multiple data sources to generate the evaluation findings. This required consideration of both the quality and quantity of evidence.²⁴ The robustness rating shown in Table 6 was used by the evaluation team for the findings section by applying the colour-coded evidence ratings against the summaries of key findings.

²⁴ Triangulation: the extent to which a range of evidence (e.g. documentary evidence, feedback from stakeholders, etc.) points to the same finding. Quality: reliability of the data and information collected as well as the significance of the source of evidence.

Table 6. Strength of evidence rating

Rating	Assessment of key findings by strength of evidence
Strong (1)	Evidence consists of multiple data sources (which enables triangulation from at least two difference sources) of good quality, and/or evidence is repeated by multiple KIs from different stakeholder categories.
Moderate (2)	Evidence consists of multiple data sources (which enables triangulation from data sources) of acceptable quality, and/or the finding is supported by fewer data sources of good quality.
Limited (3)	Evidence consists of few data sources across limited stakeholder groups (limited triangulation) or is generally based on data sources that are viewed as being of lower quality.

Ethics protocol

All KIIs were conducted on a voluntary basis, with informed consent. Confidentiality was maintained through a unique identifier coding system for each KI. Audio recordings of interviews were only made with permission. All interview notes and potential audio recordings were stored on a project-specific Microsoft SharePoint owned by Euro Health Group. No citations in the final evaluation report are traceable to a specific person or their titles or functions.

Participation in the online survey was on a voluntary basis. Names of respondents were not noted through the survey, and no data were traceable to a specific person or their title or function in the evaluation report.

Evaluation limitations and mitigation measures

Highlighted in Table 7 below are the key limitations encountered during the evaluation process and the related mitigation strategies that will help in the interpretation of this report. Despite these limitations, the evaluation team found strong overall evidence supporting the findings and related conclusions and recommendations.

Table 7. Evaluation limitations and mitigation measure

Limitation	Mitigation
<p>Lack of strategic framework for the SP-PHC</p> <ul style="list-style-type: none"> • With no ToC, strategy, outcome-orientated workplans or M&E indicators, and with limited results reporting of the SP-PHC (beyond the UHC-P), it has been challenging to conduct a proper effectiveness analysis. • SP-PHC target countries not clearly identified, with ambiguous information having been received. This had implications for the selection of case study countries and online survey respondents. • Very limited disaggregation of data was available, which limited the extent to which the evaluation could be truly gender, equity and social inclusion responsive. 	<ul style="list-style-type: none"> • The evaluation team assessed progress against workplan milestones and analysed the ToC, including the assumptions underlying change. • The evaluation included some specific questions regarding certain interventions in KIIs to validate content, progress and any reported results associated with the intervention. • Target countries for the survey were cross-checked several times against different sources of data to determine the final list of countries.
<p>Financial data</p> <ul style="list-style-type: none"> • Access to timely and comprehensive financial data such as budget and expenditure reports, was limited, and aligning activities with financial data was difficult. • This, coupled with the few reports documenting results for SP-PHC activities (beyond the UHC-P), limited the evaluation’s ability to assess the efficient use of funding and related results. 	<ul style="list-style-type: none"> • Financial data made available to the team were discussed through a Zoom session with the SP-PHC team to help explain the data. Additional email clarifications also took place to enable the team to understand the data limitations. Additional requests for data and reported results were sent to regional offices, though responses were limited. • Caveats have been made in the report to account for the limited data available.
<p>KIIs</p> <ul style="list-style-type: none"> • The evaluation methods applied are generally prone to both selection and social desirability bias.²⁵ 	<ul style="list-style-type: none"> • Introduction of selection bias was minimized by ensuring a diversity of informants, a relatively large number of informants/ respondents and saturation. • To mitigate the impact of social desirability bias and to stimulate honesty and truthful answers, all informants, including survey respondents, were guaranteed confidentiality. • Triangulation was applied during the analysis to minimize bias by comparing information between different categories of KIIs, the document review and the survey results.

²⁵ Social desirability bias: respondents may distort information to present what they perceive as a more favourable impression.

Country case studies

- The small number of case study countries and the context-specific nature of PHC in those countries limited the evaluation team's ability to conduct cross-country synthesis and draw conclusions on how the findings might be applied to other settings.
- A rather weak knowledge of the SP-PHC and its activities/products at country level was observed in two of the three countries studied.
- There was a limited set of SP-PHC-related activities in the case study countries. Activities were also recent, forcing the case studies to focus on a short timescale, with some activities not having started implementation. This limited the analysis of progress and results.
- Case studies were used to generate examples of learnings and provided a triangulation point with other sources of evidence for all the EQs.
- The SP-PHC provided a rationale for the selection of the three case study countries, which was followed up through at least three preparatory calls with countries by the evaluation team to reinforce the rationale and explain which activities were supported by the SP-PHC. This helped identify the right informants, and probing was then applied to get information relevant to the SP-PHC.
- As identifying results was difficult, case studies focused on activities and, where possible, the potential results.

Online survey

- Information bias, which is typical in cross-sectional surveys, has affected 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. Most SP-PHC engagement and support at country level had also been received through the UHC-P (62% of respondents had received UHC-P funding), and this is believed to have affected replies to other survey questions on the SP-PHC (respondents mistaking SP-PHC for UHC-P exclusively, therefore showing more awareness and positive results), making it difficult to attribute results to SP-PHC activities beyond the UHC-P.
- The sample size was too small to allow for a chi-square test (statistical analysis of differences across respondent groups).
- Triangulation was applied during the analysis to minimize this bias by comparing information across different categories of KIs, the document and data review and the survey results.
- The evaluation team carefully interpreted survey results with these limitations in mind and relied less on survey questions where qualitative comments implied that the response was made with UHC-P rather than the SP-PHC in mind.
- Disaggregation of data was analysed with a view to assess any trends in differences.

2. Evaluation findings

This section presents evaluation findings structured according to the OECD DAC criteria of Relevance, Coherence, Effectiveness, Efficiency and Sustainability (17). The corresponding EQs are stated at the beginning of each section.

2.1 Relevance

The findings presented in the following sections relate to EQ1.1: 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 GPW13?

In line with the OECD DAC criteria, this question considers the evidence for how the SP-PHC responds to global, country and institutional needs; it includes a strong focus on the design of the SP-PHC and how suitable this is for supporting its mandate. There was considerable evidence available to generate findings for this question, mainly of a qualitative nature, with data sources being interviews with different categories of KIs, reviewed documents and some case study findings.

Key findings related to relevance (EQ1.1)

- 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 its success.
- The SP-PHC's placement within the Universal Health Care 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 SP-PHC mandate and objectives, which has contributed to a weak understanding and awareness of it.
- 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 SP-PHC success.

Evidence was rated as strong (1)²⁶ for all key findings presented above.

²⁶ Evidence consists of multiple data sources (which enables triangulation from at least two difference sources) of good quality, and/or evidence is repeated by multiple KIs from different stakeholder categories.

Theory of Change assessment for relevance/EQ1.1

Relevant assumptions underpinning the ToC in relation to EQ1.1 include:

- WHO systems, processes and ways of working support the transversal nature of the SP-PHC; and
- WHO leadership sets the agenda and motivates the team, wider WHO and partners to reach the desired outcomes of the programme.

These are important for ensuring the output: cross-team and cross-functional internal and external partnerships and collaborative networks/platforms at global, regional and country levels are developed, which is necessary for the achievement of the intermediate outcomes.

Summary assessment:

The evidence for the assumptions not *holding true* is strong. The findings indicate that while the original design was relevant, WHO systems and processes have not been sufficiently flexible to enable the SP-PHC to deliver on its mandate.²⁷ The SP-PHC leadership has also experienced challenges in setting the direction of the programme and establishing new ways of working with wider WHO and partners, in part due to the prolonged absence of a dedicated senior manager to support the SP-PHC.

Finding 1: 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. There was strong endorsement both from WHO staff and external partners of the rationale and timing for the SP-PHC's creation, and high expectations for the programme.²⁸ A flagship programme dedicated to PHC with special status under the Director-General was perceived by multiple stakeholders internal and external to WHO to enhance PHC visibility and significance and resonated with the commitments made by the global community to accelerate country progress towards UHC. Internally, there was initial strong support for having an entity focused on PHC, and the SP-PHC provided an important place for this to happen. The COVID-19 pandemic was a further argument for the SP-PHC's continued relevance.

Finding 2: The SP-PHC's original intervention areas – country impact, policy and partnerships, evidence and innovation – are relevant and broadly align with GPW13 priorities and with the original SP-PHC vision and functions. The areas of work initially identified for the SP-PHC align with the core functions of WHO and the GPW13 priority areas. They also largely respond to the SP-PHC needs and expectations as identified through consultations with WHO Headquarters and Regional Offices in March–July 2020 as well as with World Health Assembly resolutions and decisions, and policy and programme documents reviewed at the time.²⁹

Finding 3: The SP-PHC has evolved in the absence of a specific strategy or ToC to define what it is trying to achieve and how to achieve it. The guiding strategy for the SP-PHC has been the WHO's GPW13 with its associated scorecard methodology to track progress. While foundational documents describe the broad strategic direction and intentions of the SP-PHC (see section 1.2 and footnote 20) these are high level and do not include indicators or targets. A specific SP-PHC strategy guiding the direction, objectives, outcomes and means to achieve them has not been developed. Confusion over what the SP-PHC does and what it is aiming to achieve has been worsened by the absence of a strategy underpinned by a ToC that clearly articulates the SP-PHC contribution to GPW13 goals as well as the lack of a programme-wide workplan for how to achieve these goals.

Finding 4: The prioritization of PHC within WHO and high expectations for the SP-PHC have not been accompanied by special attributes to enable the SP-PHC's success. WHO's existing *special programmes* are typically designed to address technically deprioritized or underfunded areas and tend to be managed as projects, with

²⁷ The exception being the UHC-P, which has its own mechanisms for enabling its work.

²⁸ The sources of triangulated evidence for this finding are multiple KIs from different stakeholder categories, including WHO staff within HQ and at regional level and external development partners or UN agencies, and documentary evidence, such as World Health Organization, Special Programme on Primary Health Care Human Resources Concept Note, unpublished note (16 October 2020).

²⁹ The Special Programme on Primary Health Care Human resources concept note, op.cit..

earmarked funding, distinct governance structures, programme-specific advisory bodies and specific reporting lines.³⁰ Except for the UHC-P (which has many of these features), the SP-PHC lacks these attributes, and there is no distinction of the SP-PHC from other WHO departments in terms of financial resource allocation, positioning or governance.

Flexible recruitment practices, and additional staff necessary to support agile working, have not been forthcoming. The SP-PHC has experienced capacity issues with a significant number of vacant positions and lengthy recruitment processes (for example, recruiting a P6 reportedly took 12 months). Vacant positions within the SP-PHC's organizational structure have been filled largely by transferring staff from other departments. While this has enabled the absorption of existing staff without incurring additional costs to WHO, there has been minimal extra capacity provided that is specifically tailored to SP-PHC needs.³¹

Evidence from KIIs at global and regional level recognized that the political impetus for PHC played a key role in establishing the SP-PHC, but the lack of special conditions to support its mandate suggests that the label "special" was primarily a profiling exercise. The following quote articulates some dimensions of this finding:

"There are no special resources, the SP-PHC is the same as other departments, no extra status. The different special programmes in WHO had big budgets. This was what was expected for the SP-PHC, to be an agile and robust programme."

The lack of special status is still a current issue for the SP-PHC. Documented action points for senior leadership that emerged from the 2023 SP-PHC retreat are related to achieving special status: for example, arranging regular meetings with the Director-General to review status, progress and bottlenecks faced by the SP-PHC in achieving its mandate; deciding on a special fast track recruitment process; and agreeing a special resource allocation.³²

Finding 5: The SP-PHC's structural positioning and reporting arrangements have been considered unsuitable for its mandate and functions. The position of the SP-PHC within the UHC/LC Division alongside other health system departments is widely seen by KIIs at headquarters and regional offices as unsuitable for the Programme's mandate and functions. It is also contrary to the higher-level positioning (under the Director-General) that was first envisioned and that might have helped facilitate and legitimize the transversal role of the SP-PHC.³³

The decision to place the SP-PHC in UHC/LC Division aimed to address structural challenges in reporting and accountability lines to senior management, specifically to the Assistant Director-General. The move has been considered by some KIIs in the SP-PHC and other departments at headquarters to have introduced additional clearance layers that hinder the SP-PHC's agility and responsiveness, for instance by memoranda going through several senior managers before they can be approved, thus taking considerable time to clear.³⁴ Furthermore, the position and reporting arrangements have impacted on the SP-PHC's ability to address silos and extend reach to WHO areas, such as communicable and noncommunicable diseases and emergency preparedness and response. The following quotation reflects the mismatch between the mandate of the SP-PHC and its position in WHO's architecture:

"There is a disconnect between stated mandate and position of SP-PHC which sends mixed messages in an organization where bureaucracy determines how staff live day to day."

Finding 6: The SP-PHC has moved away from its intended design and is playing different roles, creating ambiguity regarding its mandate, vision and objectives. It is widely recognized by the SP-PHC, other KIIs at WHO

³⁰ World Health Organization, Memorandum on the Special Programme on Research, Development and Research Training in Human Reproduction, unpublished memorandum (2012).

³¹ The sources of data and triangulated evidence for this finding include the SP-PHC organigram and KIIs with SP-PHC and wider WHO staff, primarily at global level.

³² World Health Organization, Action Points Emerging from Q1 2023 Retreat of the Special Programme on Primary Health Care, unpublished internal document (n.d.).

³³ Data sources triangulated for this finding come from different groupings of KIIs within WHO HQ, Regional Offices, WHO-related entities such as the Alliance for Health Policy and Systems Research, and some external funders. The Action Points Emerging from Q1 2023 Retreat, op. cit., Feb also specifically mention the need to connect with senior WHO leadership on the most effective placement of the SP-PHC at headquarters to meet its envisaged mandate in working across the Organization (as part of the high-level prioritization of PHC).

³⁴ The evaluation team was presented with examples of memoranda taking more than a month to be approved.

headquarters and regional offices as well as documentary evidence³⁵ that the Programme has moved away from its original design as a small, potentially agile team, and is now a larger programme and department within the UHC/LC division. This has occurred in part through the absorption of additional units from other departments (the SGS and REPHF), which have mandates and functions extending beyond PHC to broader health systems and which are involved in normative work – areas not considered to be part of the SP-PHC’s original mandate, scope or functions.

Although the SP-PHC newsletter provides an explanation of the purpose of integrating the SGS (and the REPHF) (18), the rationale for the move is still unclear to many Kis across the Organization. ***There is also considerable ambiguity regarding the SP-PHC’s mandate, direction, objectives and functions, as noted by WHO Kis across the three levels as well as external partners. The following KI quotation reflects on the rationale for the absorption of the SGS into the SP-PHC.***

“The incorporation of the governance people in the SP-PHC is not clear, why not health financing team? Why not integrated health services? What is the rationale behind this incorporation of the governance team? This needs to be communicated better. We (at the regional office) are a bit puzzled by this”.

Finding 7: There have been missed opportunities to communicate the mandate and objectives of the SP-PHC, and this has contributed to a weak understanding and awareness of the Programme. Insufficient communication to explain the absorption of the units mentioned above highlights a broader problem with SP-PHC communication, which is widely considered to be less than optimal. The SP-PHC has a draft communications strategy that is largely focused on PHC messages,³⁶ yet there is robust evidence from KIIs across the three levels of WHO, external partners, case studies (see below) and survey data³⁷ for the need to substantially improve communication and transparency around the SP-PHC itself. This includes a clear explanation of its mandate and objectives, key programme components, staff responsibilities and focal points, and how the SP-PHC and UHC-P relate to each other. The following quotation from a KI highlights the communication issue:

“I don’t really know the aims of the SP-PHC, I Googled it but couldn’t find a clear answer. There are poor communications with external partners. I have worked with many of the SP team members, and they are good at their jobs, but transparency is a major issue at the SP, and WHO overall”.

On this point, a review of SP-PHC-related documents, supported by evidence from KIIs,³⁸ indicates that there are multiple and often interchangeable terms to describe the SP-PHC, including “cross-cutting initiative” “one stop shop”, “one stop mechanism”, “one stop network”, “integrated platform”, “integrated network”, “technical programme”. Few documents are sufficiently unpacked to explain the final agreed purpose of the SP-PHC, its components, and how it should work across departments to achieve its objectives. Evidence gathered from two of the evaluation’s case study countries (Kenya and Tajikistan) indicated a very low level of awareness within WHO regional offices and wider country partners of the SP-PHC and its interventions, beyond the UHC-P, and highlighted that communication regarding the SP-PHC was largely confined to “higher” levels.

Finding 8: The current WHO strategy (GPW13) does not include a dedicated outcome for PHC that could incentivize PHC accountability and collaboration. At WHO strategy level, KIIs across the three levels highlighted that the GPW13, which significantly influences resource allocation and activity prioritization, currently does not have a dedicated outcome for PHC that could serve as a catalyst for general programme resource allocation to PHC and help organizational buy-in. WHO-wide indicators and reporting mechanisms related to PHC specifically, as well as process indicators for interdepartmental collaboration, are not integrated into WHO’s accountability frameworks. Some WHO KIIs across the three levels have suggested that having PHC as a primary objective in GPW14 and developing and mainstreaming related indicators and performance mechanisms could create stronger incentives for collaboration and would give the SP-PHC “teeth” to better fulfil its mandate. Case study evidence from Tajikistan and Kenya endorsed the need for stronger incentives to be created to support the prioritization of PHC, with WHO KIIs in Kenya indicating that they would be more inclined to include PHC-related plans and activities if it was clearly prioritized in WHO’s strategy. In some instances, however, the evaluation notes that a strong PHC-related drive is coming from Member State countries, especially

³⁵ In addition to the KII findings across the three levels of the Organization that expressed this view, the UHC/LC organigram depicts the SP-PHC alongside other departments in the UHC/LC division. See also the Special Programme on Primary Health Care Human Resources Concept Note, op. cit., for the original vision.

³⁶ World Health Organization, Special Programme on Primary Health Care; communications strategy 2022, unpublished internal document (n.d.).

³⁷ Survey data indicates that 39% of all respondents are very familiar with the SP-PHC. For WHO staff who are not HPAs, this figure is 34%.

³⁸ Different ways of describing the SP-PHC can be found, for example, in the already cited WHO Special Programme on Primary Health Care; communications strategy 2022; Primary Health Care on the road to Universal Health Coverage and SP-PHC Memorandum. Most notable was the plethora of terms and different understandings of KIIs to describe what they thought the SP-PHC was.

following COVID-19 and economic crises, which has positively influenced PHC-related activities.

Finding 9: Leadership for the SP-PHC has faced challenges. The leadership has faced challenges in developing the programme as per the original design. This is in part due to the prolonged absence of an Assistant Director-General to offer guidance and support in shaping the Programme’s vision and strategic direction, but also to collaboration with other departments, which has remained uneven across the Organization.

The expansion of the SP-PHC has introduced management complexity within it. This has raised concerns about the SP-PHC leadership, the cohesion of the team and the strategic direction for the Programme. However, the SP-PHC leadership and management PHC extend beyond the role of a single individual; with the long-term absence of an Assistant Director-General for the UHC/LC Division, the Organization’s prioritization of PHC has not been matched with the high-level support required to ensure SP-PHC success.

2.2 Coherence

The findings presented in the following sections relate to EQ1.2: How compatible is the design of the SP-PHC “internally” across WHO at global, regional and country levels? And EQ1.3: How coherent is the design of the SP-PHC “externally” with wider development partners and country partners? Findings relevant to EQ 2.4,³⁹ which is concerned with how the SP-PHC is adding value, are integrated in this section, as appropriate.

In line with the OECD DAC Criteria, these questions consider how well the SP-PHC “fits” within WHO structures and considers synergies and interlinkages between the SP-PHC and its work with other parts of the Organization. Findings on the internal coherence and alignment of the SP-PHC itself are also included. Additionally, the questions consider the extent to which the work of the SP-PHC is influencing and/or harmonizing the work of other partners, particularly donor partners.

There was considerable evidence available for the generation of findings related to question 1.2 but less so for EQ1.3. Data sources were qualitative: interviews with different categories of KIs, reviewed documents and some findings from case studies.

Key findings related to coherence (EQ1.2 and EQ1.3)

- The SP-PHC has faced challenges in establishing a unified and coherent understanding of the PHC approach internally and with external partners.
- The 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 its original design.
- The UHC-P plays a critical role in SP-PHC operations, 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.

Evidence was rated as strong (1)⁴⁰ or moderate (2)⁴¹ for the findings above.

³⁹ 2.4 How is the SP-PHC adding value to the work of the WHO and external partners?

⁴⁰ Evidence consists of multiple data sources (which enables triangulation from at least two different sources) that are of good quality, and/or evidence is repeated by multiple KIs from different stakeholder categories.

⁴¹ Evidence consists of multiple data sources (which enables triangulation from data sources) of acceptable quality, and/or the finding is supported by fewer data sources of good quality.

Theory of Change assessment for coherence/EQs 1.2 and 1.3

Relevant assumptions underpinning the ToC for EQs 1.2 and 1.3 include that:

- sufficient incentives are in place to enable collaborative working;
- strong collaborative ways of working exist between WHO Headquarters departments and Regional and Country Offices to enable coordinated responses and with partners at all three levels;
- there is conceptual clarity across WHO and with partners regarding PHC; and that
- the SP leadership sets the agenda and motivates the team and wider partners to reach the desired outcome.

These assumptions are important for the translation of inputs to the following output: developing cross-team and cross-functional internal and external partnerships and collaborative networks/platforms at global, regional and country levels. This in turn is necessary for achieving intermediate outcomes.

Summary assessment: The evidence for the assumptions *holding true* is mixed. The findings indicate that WHO's headquarters and three-level structure and its competitive operating environment can impact on cross-cutting collaboration across the Organization. However, with funding support and formalized coordination mechanisms in place (such as for the UHC-P), collaboration across the three levels and with wider partners can be achieved. There is strong evidence that the assumption on conceptual clarity on PHC across WHO and with partners does not hold and that a unified understanding of PHC remains out of reach. The associated output also remains to be achieved across the whole of the SP-PHC, with evidence pointing to difficulties in bringing SP-PHC units together, given with the absence of a Programme-wide strategy/roadmap and workplan.

Finding 10: The SP-PHC has faced challenges in establishing a unified and coherent understanding of the PHC approach internally and with external partners.

Much time and effort have been spent articulating the three pillars of the PHC approach to ensure cohesive messaging. Although WHO documents are relatively consistent in their outward advocacy for the PHC approach, there seem to be different interpretations of what PHC is. It has thus proved difficult to achieve alignment and a shared understanding of the PHC approach within WHO and with external partners, which has implications for coordination and collaboration. Case study evidence from Kenya indicates that the understanding of PHC varies across country office departments, with some equating it to community health and others to integrated service delivery. Notably, the case study, supported by survey findings,⁴² identified a demand for specific training on the PHC approach for WHO staff. The following quotation highlights the point that a coherent understanding of PHC is difficult to achieve:

"Everyone has very different ideas of PHC, but we need to know what we are talking about to be able to convince partners that it needs to be a priority."

The prevailing interpretation of the PHC approach focuses on integrated service delivery at primary care level. For example, the intentional focus of WHO's European Centre for Primary Health Care is on service delivery as a practical and relevant approach to supporting countries in the region. There is increased attention being paid by the SP-PHC to pillar two and three of the PHC approach – multisectoral action and empowering communities – as evidenced through UHC-P reports of support to these areas (19, 20), the PHC Global Report (21) and the PHC leadership course.⁴³ However, KIs from the three levels of WHO and external partners have highlighted opportunities to equip these two pillars with more operational meaning.⁴⁴ Development partners have also defined PHC differently, as reflected in their organizational

⁴² Survey findings indicate that 73% of WHO respondents (58) have not received any training or capacity-building activity in PHC from the SP-PHC.

⁴³ World Health Organization, A capacity-building course on PHC: 'strengthening PHC leadership', unpublished document (n.d.), , shared by SP-PHC.

⁴⁴ Triangulated sources of evidence include KIIs with WHO staff across the three levels of the Organization and with some external partners, as well as SP-PHC unit workplans shared with the evaluation team.

strategies and publications. The Global Fund Strategy 2023–2028 predominantly frames PHC in terms of integrated service delivery (22). Similarly, Gavi 5.0 focuses on service delivery, referencing the need to strengthen the PHC platform to support countries extending immunization services to reach under-immunized and zero-dose children (23). By contrast, the World Bank’s flagship publication “*Walking the talk: Reimagining primary health care after COVID-19*” adopts WHO’s more comprehensive definition of PHC, but also introduces a new definition of “fit-for-purpose” PHC, which reimagines PHC with a specific set of attributes outlined in the report (24).

There was a strong body of opinion from all levels of WHO and external partners that excessive time had been spent by the SP-PHC conceptualizing the PHC approach, at the cost of supporting country implementation. They noted that many regions and countries had already developed relevant policy documents and health strategies that include PHC as the road to UHC but urgently need funding and implementation support to action them.

Finding 11: Existing WHO structures and lines of accountability can limit the SP-PHC’s direct access to countries. The intended design of the SP-PHC’s one network approach was to work directly with countries. Except for the UHC-P, and to a lesser extent the SDG Global Action Plan (GAP) PHC-A, WHO’s three-level structure can hinder the SP-PHC’s direct interaction with country level. Survey data for this evaluation indicates that for all WHO staff, 84% would reach out to regional office staff for technical support on PHC-related matters. In addition, although country offices have the mandate to carry out WHO’s core PHC functions with programmatic and technical support from regional offices and headquarters, the capacity of country offices (and to some degree regional offices) to implement PHC often depends upon the human and financial resources available. KIs and survey respondents from both levels have highlighted that having greater autonomy, including being able to deploy short term assignments to meet priority PHC needs, would make it easier for them to carry out their respective roles.

It is not surprising that there is variability in how the SP-PHC engages with and supports regional offices and countries in the different regions. Some WHO regional and country level KIs have expressed confusion about the processes and channels for PHC-related requests (namely, whom to contact where for what). On this point, there is some evidence from KIs at WHO headquarters and with regional office staff that the “one network approach” has created an additional layer to be negotiated and that this can act as a filter *for technical support requests: some countries* bypass the SP-PHC altogether and go directly to technical departments at headquarters to ensure a connection with wider expertise. Others, however, have reported clear communication and collaboration. Evidence from the case study in Chile demonstrates how the Pan American Health Organization, the Chile Country Office and the SP-PHC have been successfully collaborating to provide high-level political, policy and technical support. This was notably the case during a joint mission including the Director, SP-PHC and the Health System Strengthening Regional Director at the inception of national reforms for a universal health system (see also Section 2.4).

Regional offices have taken up the mandate for PHC to varying degrees. The WHO European Centre for Primary Health Care is an example of the implementation of the PHC programme through its innovative “Let’s Talk Primary Health Care Talk Show”, PHC Demonstration Platform and substantial technical support. The South-East Asia Regional Forum for PHC-orientated health systems brings together Member States and partners – such as academic institutions and development and implementation partners – to capture operational learning and carry out joint activities (25). Yet the contribution of the SP-PHC to these efforts is not evident. There are further reports of the WHO Regional Office for the Eastern Mediterranean expressing an interest in developing a similar kind of programme to the SP-PHC at regional level.

Finding 12: 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. Except for the UHC-P, which is acknowledged for its “bottom up” approach that is closely aligned with country needs and priorities, feedback from WHO regional and country KIs, along with input from external partners, identified the global focus of some of the SP-PHC initiatives and products as less suitable for meeting country needs. Often these initiatives and products require significant contextualization to be useful (see Section 2.3). Specific examples highlighted by KIs include the SDG GAP PHC-A and “Implementation Solutions”. The PHC-A has been characterized as not translating global dialogue into country action as

described in Box 2 (see also findings in Effectiveness section). The perception of the PHC-A being globally driven persists despite the fact that it is structured so that countries are invited to lead a discussion among the GAP's 13 multilateral agencies where they share their own priorities and needs and use the platform for agencies to align their technical and financial support with the stated priorities.

Whilst evidence from regional KIs and the Kenya case study (carried out by country experts) acknowledged the promise of Implementation Solutions, the shared view of most KIs was that it was principally a globally driven initiative. WHO KIs expressed a desire for greater involvement of end-users in the co-design and implementation phase. Findings from a recent WHO evaluation on the normative role at country level endorse this, noting that where country users provide input into (normative) products, they have greater ownership, and the products are more adapted to their intended users.⁴⁵

In a broader context, WHO KIs at both regional and country levels underscored the necessity to redirect PHC efforts away from globally driven approaches and advocated for greater decentralization of funding and decision-making so as to empower countries. This would enable greater PHC-related coordination, experimentation and learning, with a focus on tailoring interventions to the unique needs and contexts of individual countries. The following quotations from KIs illustrate some of these points:

"A lot of the efforts have not reached the country level but remain at headquarters. Countries know what they need, they just need to be given the resources and they need to be consulted."

"The SP-PHC doesn't really do things for me, I do things for the SP-PHC by providing for upstream needs".

Box 2. The SDG GAP PHC Accelerator

In 2019, under the GAP, PHC was identified as an accelerator theme for collaboration and joint action amongst the 13 signature agencies to accelerate progress in achieving the health-related SDG target. Stronger collaboration on PHC at the global level was envisaged to facilitate coordination in countries through existing national and subnational mechanisms, joint situation analysis and prioritization prompted by the national health planning cycle.

A set of complementary joint actions on PHC at country level and global/regional level to be supported by the PHC-A were outlined from the outset, although the PHC-A workplan has evolved based on feedback from regions and countries through the SDG 3 GAP monitoring process. UNICEF and WHO have served as the co-chairs of the PHC-A, and activities of the PHC-A fall within the wider Strategic Collaboration Framework between WHO and UNICEF signed in 2020. The SP-PHC moved into the role of co-chair upon its creation. It has leveraged the PHC-A as an opportunity to amplify technical resources on PHC (e.g. the PHC Operational Framework, UCH Service Package Delivery and Implementation (SPDI) Tool, COVID-19 Vaccine and PHC Integration Tool, Immunization for PHC Framework for Action, the PHCMFI, the PHC and COVID-19 case studies and the PHC-GHI Toolbox).

While there are some limited examples of PHC-A action at country level, there is strong evidence from both internal and external KIs indicating that the PHC-A is perceived to be designed mainly as a global platform for information gathering and sharing with limited country impact.

⁴⁵ World Health Organization, WHO normative role at country level: draft final report, unpublished draft (n.d.).

Finding 13: Developing cross-cutting collaborations has been challenging, in part due to WHO's organizational culture and structures.

KI and documentary evidence acknowledges the challenge of coordinating and collaborating across WHO departments due to WHO's hierarchical structures and organizational culture.⁴⁶ Operating as a department within this environment, the SP-PHC has been viewed by global-level KIs as being in competition with other departments for resources, including those departments working on PHC issues with which it is expected to collaborate closely, most notably the Integrated Health Services department, Health Workforce, Health Financing. This competitive dynamic is problematic, leading to two-way trust issues, with implications for collaboration and joint working.

As per the SP-PHC's mandate, collaborations with WHO Headquarters departments and networks have developed, or are in the process of developing: for example, with the Innovation Department; Impact for Delivery; the Alliance for Health Policy and Systems Research (e.g. on the recently published PHC-related case studies and dissemination webinars); with the WHO Director-General's Office and External Relations and Governance Division on the PHC investment platform; with the UHC communicable and noncommunicable diseases team through a collaboration platform and joint workplan and activities.⁴⁷ SP-PHC staff provide inputs into technical meetings and products to enable a focus on PHC. This is evidenced through recent guidance, which reflects a stronger PHC "lens" in programming joint products focused on immunization (26), TB(27) and HIV, for example. There is also evidence showing SP-PHC technical inputs for recently released normative guidance (28-30). However, KI evidence from different categories of stakeholders indicates that collaborations have been slow to develop, appear quite ad-hoc and have struggled to break down silos or galvanize cross-cutting action and accountability for PHC. While the UHC-P has financial resources and a long-established formalized mechanism to support coordination and collaboration across the three levels of WHO and with wider government and development partners, no such mechanism exists for the wider SP-PHC programme, and there are no funds internally (WHO core funds) to support and incentivize Programme collaboration and integration.

KIs at WHO Headquarters and Regional Offices have highlighted the absence of a strategic framework for guiding SP-PHC engagement, collaboration and operational arrangements with other parts of the Organization, and the need for the SP-PHC to be much more proactive in coordinating and collaborating, particularly with other WHO Headquarters departments, including those that work on the levers outlined in the Operational Framework. A review of the SP-PHC workplans and confirmed through discussions with the SP-PHC indicates that the Policy and Partnership Unit has undertaken a stakeholder mapping of existing engagements with the SP-PHC, which will inform the development of an engagement strategy to guide future collaborations.

KIIs with senior management, WHO KIs at global and regional levels and some external development partners point to the SP-PHC not consistently reacting to opportunities to promote and align PHC within and across the Organization and with external partners, which could demonstrate its added value. A concrete example cited includes the perceived late inputs and missed opportunity to promote the Operational Framework in Global Fund funding request processes. While there is evidence that the SP-PHC has developed activities, working groups and outputs related to its work on PHC and GHIs,⁴⁸ the evaluation team has not been able to establish the benefits of those activities. The team recognizes the increased prominence of PHC in the most recent Seventy-sixth World Health Assembly (31); however, it is unclear how the SP-PHC contributed to these documents.

KIs and survey respondents reported that supporting the integration of disease-specific approaches is challenging. This is due in part to strong financial and institutional incentives that maintain the status quo but also to the lack of consensus and understanding of PHC, primary care and integration, which has hampered the advancement of the integration agenda (32). The following quotation from a KII articulates this point:

⁴⁶ Triangulated evidence from different categories of KIs within WHO (HQ, RO, CO), case study evidence and documents such as World Health Organization, Evaluation of WHO Transformation, Vol 1, op.cit.

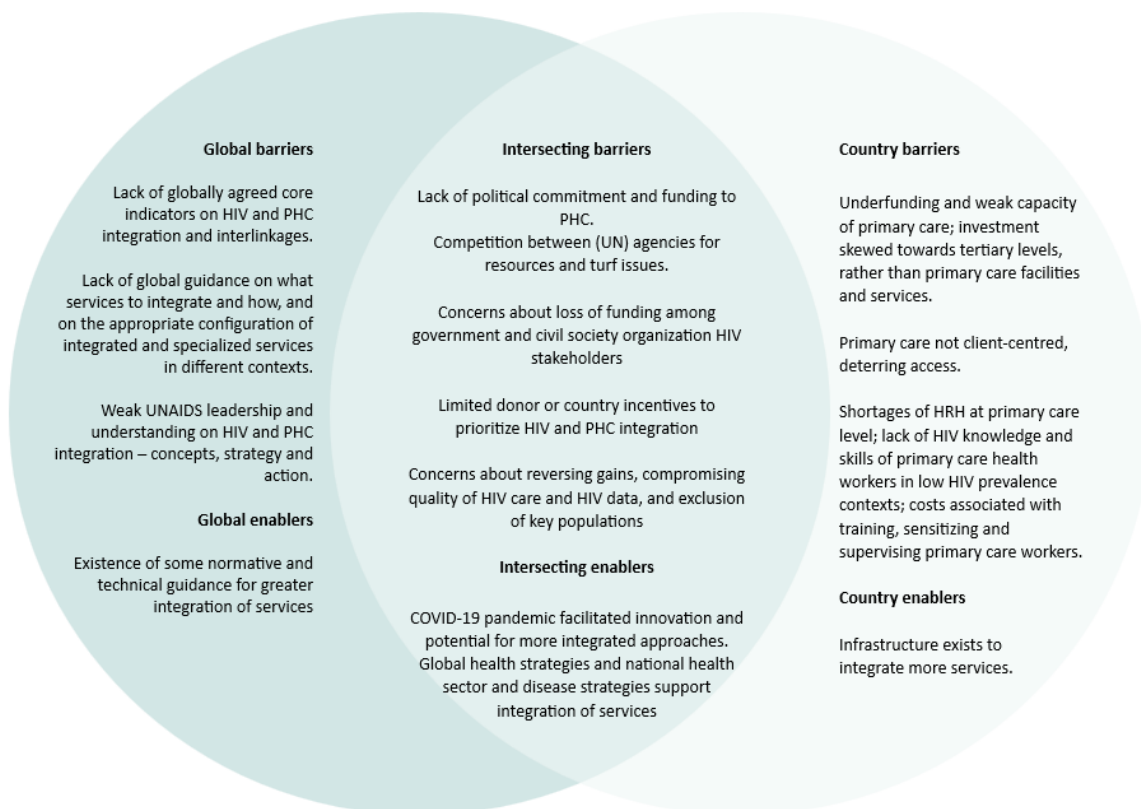
⁴⁷ World Health Organization, Collaboration note: UCN and Special Programme on PHC, unpublished note (March 2023), shared with the evaluation team in November 2023.

⁴⁸ The Policy and Partnership Unit workplan includes workstreams on PHC and GHIs, PHC and GF/RSSH, and PHC and Immunization with GAVI.

“Better understanding of the PHC approach within WHO, especially in disease-specific/intervention-specific programmes, is important. This is painfully lacking and often the promotion of the PHC approach is perceived as an attempt to use their dedicated resources for a broader scope which is not in their performance framework”.

Findings from the recent independent evaluation of the UNAIDS Joint Programme’s contribution to HIV and PHC interlinkages and integration indicate multiple existing enablers and barriers to applying a PHC approach to HIV responses (see Fig. 4).

Fig. 4. Enablers and barriers to applying a PHC approach to HIV responses (32)



Finding 14: The alignment of the SP-PHC’s work with other WHO departments remains unclear, leading to overlaps and duplication. A review of the SP-PHC’s workplans, case study evidence and feedback from KIIs across the three levels of WHO highlights the SP-PHC’s growing work in “implementation”. This has raised concerns about the SP-PHC’s unclear roles and responsibilities and its added value as well as about the duplication of work of other parts of WHO, including departments or entities that are better placed to do the work.

Case study evidence from Kenya shows that focal points exist in technical departments in WHO Headquarters for areas that are closely related to the SP-PHC, including for PHCMFI and the Division of Data, Analytics and Delivery for Impact for data strengthening initiatives. On a practical level, this creates confusion over whom to contact and for what purpose. On a more strategic level, it reflects gaps in coordination and a lack of clarity on how the SP-PHC fits with other departments, including within the same division. This also raises questions over who “owns” certain products and has a responsibility to follow up on utilization at country level.

Finding 15: The configuration of the SP-PHC is not aligned with its original design. The PHC Manifesto⁴⁹ envisaged core experts within the SP-PHC working together as a network that also connected expertise from the three levels of WHO. As currently configured, the SP-PHC consists of units operating with their own workplan, activities and, in some cases, resources. There is no unified SP-PHC workplan that communicates the *sum of the parts*, meaning the combined aim and desired impact and network effect of these different units in relation to SP-PHC objectives.

There are some examples of “whole unit” collaboration within the SP-PHC: the development of the PHC Academy course, which involved all units providing inputs on modules; the partnership mapping work, which has worked across the units to develop a partner engagement strategy; and inputs and reviews of the Global Report on PHC, which reflect whole unit collaboration and the engagement of wider experts across WHO.⁵⁰ However, overall the unit-based approach reflects a more traditional modus operandi within WHO and is at odds with the SP-PHC’s original design, which offered a more integrated way of working and a more agile management style.

The SP-PHC recognizes the challenges inherent in unit-based operations, siloed work and the need to integrate, unify and develop cross-SP-PHC synergies, of which there are some example at country level between the UHC-P and PHC-A (see Section 2.3). The SP-PHC has tried to address these issues through recent retreats,⁵¹ which have been organized to strengthen understanding of the its vision and mission, foster trust and connection within the group, including with the new units, and identify cross-unit projects with more effective implementation strategies. There are mixed reports from SP-PHC staff on the extent to which the outcomes of the retreats have been operationalized.

The following quotation from a KII illustrates a point regarding the internal configuration of the current SP-PHC:

“There are very good people at the SP-PHC, but they are not set up in the right way; they have not been set up to do the coordination and collaboration function.”

Finding 16: 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. The UHC-P, situated in the Country Impact Unit, operates with a distinct project-orientated model that is separate from the wider SP-PHC. It includes an independent governing body, dedicated donor funding, a separate governance and accountability mechanism through the Joint Working Team and country live monitoring sessions, and a separate communications strategy, newsletters, website and logo.

The UHC-P is widely recognized as a successful instrument, which can raise donor resources and demonstrably respond to country needs while leveraging the three levels of WHO. The UHC-P adds value to the SP-PHC, which is evident through its staff, technical expertise and flexible use of funding and mechanisms that support more integrated and coordinated approaches. Countries and external partners particularly appreciate the UHC-P’s bottom-up approach, as evidenced in the evaluation case studies, which demonstrate the UHC-P’s alignment with country needs. This contrasts with other aspects of the wider programme, which are more global in nature, such as the SDG GAP PHC Accelerator (see Box 2).

Despite the success of the UHC-P and the clear advantage its work brings to the SP-PHC, the structural and functional relationship between the UHC-P and the SP-PHC is not well defined. This creates ambiguity over the “fit” of the UHC-P within the SP-PHC. The initial absorption of the UHC-P into the SP-PHC was widely reported as problematic and created tensions internally and with external partners/funders, some of whom questioned the placement of UHC “below” PHC and felt there had been little communication from senior management on the rationale for the move.⁵²

There is a clear widespread view both within and outside of WHO that the SP-PHC is the UHC-P, with much less awareness and knowledge of the broader objectives and scope of SP-PHC activities. This is illustrated in the following quotations from KIIs:

⁴⁹ World Health Organization, On the road to Universal Health Coverage, op.cit.

⁵⁰ Engagement annex of experts for the review of the Global Report on PHC 2023, shared with the evaluation team in November 2023.

⁵¹ World Health Organization, SP-PHC outcomes: programme retreat, unpublished slide shows, (February and March 2023).

⁵² The data source for this finding was different categories of KIIs (WHO HQ and regional staff and external partners), whose responses were triangulated.

“It is unclear where the UHC-P ends, and the SP-PHC starts.”

“I think my interaction has been a lot, but it was never clear if I was dealing with the SP-PHC in Geneva or if the UHC-P was under the SP-PHC. This is a confusion that we’ve had.”

WHO documentation states that the SP-PHC is working in more than 125 countries in six WHO regions supported by the UHC-P (11). Thus, HPAs are now an integral part of the SP-PHC, at least in theory. The disaggregated analysis from the survey showed that HPAs at country or regional levels were more familiar with key PHC frameworks and tools such as the PHC Operational Framework than other WHO staff: 73% of HPA respondents indicated familiarity with the Operational Framework and 67% with the PHCMFI, compared to other WHO staff (55% and 56%, respectively). Yet the survey also noted that 28% of HPAs (11 out of 39) reported limited or no knowledge of the SP-PHC. There is also some evidence that HPA job descriptions have not been systematically updated to explicitly reflect their roles as SP-PHC members (see Box 3 on the Kenya case study).

Box 3. HPA job descriptions

The HPA job description has not changed since the SP-PHC began in 2020. While the existing job description references technical assistance for PHC policies and strategies that support UHC, it does not explicitly refer to the SP-PHC or new initiatives, such as PHC Implementation Solutions or the PHCMFI, which HPAs are or may become involved in. In the case of Kenya, the resident HPA was not informed that the position had moved under the SP-PHC and was not offered new trainings on PHC.

Source: Kenya country case study

Finding 17: 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. The evaluation team looked at the consistency of the SP-PHC's work with wider development partners both at global and country level. At global level, there are synergies between the SDG GAP, UHC-P and UHC 2023, mainly in the form of high-level meetings, which aim to improve coordination and alignment at country level in principle. However, the evaluation evidence at this level is mixed. In Kenya, external KIs were unaware of the SP-PHC prior to the evaluation and did not consider WHO as one of the main players in PHC activities (like UNICEF, African Medical and Research Foundation (AMREF), and the United States Agency for International Development), in part because WHO does not participate in the Development Partners for Health in Kenya platform where PHC is discussed. By contrast, KIs in Tajikistan were aware of and actively involved in partnership platforms and activities under the UHC-P and SDG3 GAP, which are being implemented in Tajikistan through the SP-PHC.

2.3 Effectiveness

The findings presented in this section relate to the EQs 2.2: To what extent are SP-PHC activities being implemented as intended and achieving or expected to achieve their objectives and results? and EQ 2.4: What is the added value of the SP-PHC?

In line with the OECD DAC criteria, this question is concerned with the extent to which SP-PHC interventions are expected to achieve their results. It has not been possible to conduct a robust efficiency and effectiveness analysis or identify SP-PHC contributions to higher level results due to a range of factors (see findings below). Instead, the evaluation team assessed

progress made in implementing activities against milestones in available workplans and any emerging achievements of the SP-PHC.

Key findings related to effectiveness (EQ2.2) and added value (EQ2.4)

Effectiveness and added value

- 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 SP-PHC results and effectiveness has, however, been challenging.
- There is strong demand for country support for advocacy and regional and country missions. This is recognized as an area where the SP-PHC adds value.
- There is evidence to support the usefulness of normative products promoted by the SP-PHC, but greater dissemination and increased technical support to 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 HPAs further for PHC.
- The PHC-A has contributed to a global dialogue on PHC, but there is limited evidence of its impact and added value at country level.
- More technical support is needed to advance the PHC approach at country level in multiple areas targeting country partners but also WHO staff.

Evidence was rated as strong (1)⁵³ or moderate (2)⁵⁴ for key findings presented above.

Theory of Change assessment for Effectiveness EQ2.2 and Added Value EQ2.4

Relevant assumptions underpinning the ToC for EQs 2.2 and 2.4 include:

- that outputs translate to intermediate outcomes in the manner and to the extent intended in other words, that the work of the SP-PHC is effective.

This assumption is critical to achieving all intermediate outcomes, country outcomes and impacts.

Summary assessment: The evidence to assess whether this assumption *holds* is weak. This is due to very limited reporting on the achievement of results and on outcomes in particular. This is a function of weak monitoring systems and processes; as implementation progresses, it is also limited itself, given the early stage of the SP-PHC. However, some activities, such as the UHC-P and global advocacy, appear to be effective in mobilizing support for greater country impact. Further up the results chain, the ToC positions the prioritization and implementation of the Operational Framework as critical to achieving country outcomes. However, evidence suggests that, whilst this product has some utility, additional familiarization and practical support to help countries use the guidance is critical for a transformation of health systems to take place.

Finding 18: The SP-PHC is progressing on implementing workplans, with achievements noted particularly in its advocacy role and promotion of normative products, despite some delays. Identifying SP-PHC results and effectiveness has, however, been challenging. The evaluation inception report noted the SP-PHC'S relatively short time frame of operation and the resulting probability that identifying results and their contribution to higher level outcomes will be challenging. This has proved to be the case, due to the following factors:

⁵³ Evidence consists of multiple data sources (which enables triangulation from at least two different sources) that are of good quality, and/or evidence is repeated by multiple KIIs from different stakeholder categories.

⁵⁴ Evidence consists of multiple data sources (which enables triangulation from data sources) of acceptable quality, and/or the finding is supported by fewer data sources of good quality.

- There are no predetermined and measurable outcomes for the SP-PHC's work, which complicates assessing results/achievements.
- SP-PHC workplans tend to be input and output-oriented and currently do not shed light on potential outcomes. Furthermore, the workplans do not adequately capture the breadth of SP-PHC activities, which makes it difficult to determine whether activities carried out have added value or whether resources are focused on the "right" things.
- Some SP-PHC activities are still waiting to be developed or published or launched. As a consequence, some aspects of SP-PHC work have yet to come to fruition.
- There has been limited availability of results reports; and connecting funding sources to outputs and outcomes is problematic, partly due to WHO disbursement and reporting requirements. Case study evidence from Tajikistan and Kenya highlights these points (see Box 4).
- The absence of an overall SP-PHC-wide workplan, the lack of clear objectives and outcomes for the SP-PHC previously mentioned as well as limited milestones and reporting on progress complicates an effectiveness assessment of whether activities have been implemented as intended and have achieved or will achieve their expected results.

Box 4. Challenges of identifying line of sight between funding sources, activities and potential results

The **Kenya case study** identified that WHO Kenya Country Office does not have access to complete information on SP-PHC funding awarded to the Country Office from the Regional Office, which leaves staff unclear over what funds (UHC-P and GAP PHC-Accelerator) should be used for what purpose: *"Funding stops in Geneva and at the regional office... they can dispatch an amount of money for implementation of a programme for which you have no idea of how the proposal was designed."*⁵⁶ Reports on activities and expenditures are then sent to WHO Regional Office for Africa, which compiles them for Headquarters, and the final narrative reports are not generally sent back to the Country Office.

Source: Kenya country case study report

The **Tajikistan case study** identified that UHC-P funds are reported to donors using a template that outlines key milestones, narrative, visibility and communication. However, no reports exist that summarize activities, progress and results for activities under the wider SP-PHC. This makes it difficult to separate the work and contribution of the SP-PHC from those of other programmes, especially when funds from other partners are also being used for the purpose of PHC.

Source: Tajikistan country case study report

Instead of a robust effectiveness analysis, the evaluation team conducted a review of status against workplan milestones and any emerging achievements. The team received an SP-PHC-wide workplan slide deck in April 2023 and an updated version in August 2023. The Policy and Partnership unit also provided a more comprehensive workplan with updates (the Springboard Plan) (33), dated April and August 2023. The team also reviewed a separate joint WHO and UNICEF workplan for the PHC-A. Workplans for SGS, REPHF and the UHC-P were not accessed, not being within the scope of this evaluation.

There was noticeable variation in the quality and detail of SP-PHC workplans. The SP-wide workplan/slide deck offered a basic overview of activities with limited detail on implementation progress, while the Policy and Partnership unit workplan provided more substance for the unit's workstreams, milestones/deliverables and progress against planned interventions. The evaluation team also notes that workplans do not adequately capture the breadth of SP-PHC activities, including areas where it is perceived to add value, such as high level PHC meetings, and PHC country missions which are mentioned in SP-PHC newsletters, KI accounts and evaluation country case studies (see below for elaboration).

An analysis of reported progress on the SP-PHC workplans alongside programme expenditures, supplemented through interviews, suggests that progress is being made albeit with delays (in almost half of all workplan activities). A lack of

capacity/understaffing in the SP-PHC is reported to be a key reason for delays. Overall, members of the SP-PHC team members and other KIs within WHO Headquarters and Regional Offices acknowledged a mismatch between the level of ambition for the SP-PHC and the human resources available to fulfil its mandate.

Table 8. Snapshot of implementation on work plans using green, amber and red to denote progress.

	Amount budgeted to each unit (US\$)	2020–2021	2022–2023	Activities and implementation progress		
				Financial reporting 2022–2023 ⁵⁵	Workplan/anecdotal reporting	Summary of reporting and information from KIIs and online survey respondents
Policy and Partnership Unit	Programme activities	52 547	452 246	Global PHC policy and advocacy: 106% of funds utilized.	Global PHC policy and advocacy: evidence of regular meetings, technical updates, country and policy dialogues, PHC-A on track. Global Health Initiative (GHI) and toolkit: on track.	<p>PHC partnership activities: Systematic mapping conducted with colleagues across the SP-PHC has led to the development of a strategy for informing and prioritizing engagement with key PHC stakeholders.⁵⁶</p> <p>PHC collaborating centres: Memoranda of Understanding in progress, recent increased focus on new collaborating centres with Southern based institutions.⁵⁷</p> <p>PHC communication and advocacy: Regular newsletters prepared, podcast in the making, SP-PHC communication strategy still in draft version/unclear status.⁵⁸</p> <p>GHIs: PHC-GHI toolbox developed to assist Member States to optimally use GHI support. Version 2.0 of the GHI Toolbox being designed, and draft design note prepared.⁵⁹</p> <p>WHO/UNICEF PHC Operational Framework: See findings in this section on effectiveness.</p>
	Human resources	102 759	766 224	PHC partnership activities: 74% of funds utilized.	PHC partnership activities: Some delays but implementation taking place.	
Evidence unit	Programme activities	163 748	1 515 268	PHC global reports: 78% of PHC global report: on track. budgeted funds utilized.	Implementation solutions: Progress slower than expected at first but accelerated and underway in 2023. With initial synthesis produced from case studies.	<p>PHC Global report: European Observatory commissioned to do the work on behalf of SP-PHC with inputs from the Programme. Report on track - released October 2023.⁶⁰</p> <p>Implementation solutions: See section 2.2.</p> <p>Scaling innovation not yet off the ground but a critical area for countries and PHC. Planned work with Innovation Department intended to trigger visit later this year. One team member of SP-PHC Evidence and Innovation unit and 40% of time shifted to being focal point for PHC Investment Platform/Regional Development</p>
	Human resources	184 344	735 967	Knowledge management and capacity-building: 84% of funds utilized. Technical networks coordination: 81% of funds utilized.	PHCMFI: Delayed launch but work now underway. Case study compendium: awaiting publication. Academy course: very delayed but being finalized.	

⁵⁵ The budget is for the 2022–2023 biennium. Financial utilization of this total budget is at mid–2023.

⁵⁶ PPU SP-PHC springboard plan, SP-PHC updates 7 July 2022 and updated slide set, ops. cit.

⁵⁷ PPU SP-PHC springboard plan, SP-PHC updates 7 July 2022 and updated slide set, ops. cit.

⁵⁸ SP-PHC newsletters, PPU SP-PHC springboard plan, SP-PHC Updates 7 July 2022 and updated slide set, ops. cit..

⁵⁹ PPU SP-PHC springboard plan, SP-PHC updates 7 July 2022 and updated slide set, ops. cit.

⁶⁰ Information obtained through KIIs.

				<p>Strategy for collaboration – PHC collaborating centres: launch delayed but work now underway.</p>	<p>Bank financing but with trade-offs on innovation work.⁶¹</p> <p>PHCMFI: See section below.</p> <p>Case study compendium: unclear progress; compilation of links for case studies ready but has not yet launched as a compendium, unclear how it will be used going forward.⁶²</p> <p>PHC Academy course – begun with much delay.⁶³ Includes a comprehensive set of modules⁶⁴ but concerns over whether intended audience (senior level MoH, etc.) will have time to use/participate in the extensive course.</p>
Country Impact Unit	Programme activities	81 126	3 449 054	<p>JWT/UHC-P implementation: 29% of funds utilized.</p> <p>PHC country support: 23% of funds utilized.</p> <p>PHC global report: 94% of funds utilized.</p>	<p>Workplan not accessed by the evaluation team.</p> <p>UHC-P: evaluation scope restrictions, thus team mainly looked at synergies with the remaining SP-PHC work, which have been further explored in this section.</p>
	Human resources	1 827 229	3 285 607		
PgM	Programme activities	545 836	570 028	<p>Leadership and programme management: 35% of funds utilized.</p> <p>JWT/UHC-P management: 76% of funds utilized.</p>	<p>Not clear which activities fall here as no workplan was received. Team assumes that country missions and high-level events are part of SP-PHC programme management activities.</p>
	Human resources	819 410	2 920 323		

Despite challenges in assessing effectiveness and concrete results, some important emerging achievements of the SP-PHC have been identified. These mainly relate to the SP-PHC’s advocacy role and promotion of normative products as well as the results from the UHC-P. This will be further elaborated on below.

Finding 19: There is strong demand for SP-PHC support for PHC advocacy and regional and country missions, and this is acknowledged as an area where the SP-PHC adds value. The SP-PHC has helped raise the profile of PHC within WHO and globally through convening Ministers of Health at international meetings and leveraging the Director of the SP-PHC and other senior management through regional and country visits. These activities are reported to help legitimize regional frameworks, bring “weight” to the promotion of PHC at regional and country level and support the generation of political commitment and action for high level reforms. Furthermore, evidence from the survey and some KIIs across the three levels of WHO indicated growing demand for this type of support. For example, almost one third of all

survey respondents requested further support from the SP-PHC on high level advocacy for the PHC approach at country level. The following quotations support this:

⁶¹ Information obtained through KIIs.

⁶² PHC case study compendium (Excel document).

⁶³ Information obtained through KIIs.

⁶⁴ World Health Organization academy course PHC curriculum, unpublished PowerPoint presentation (n.d.).

“We rely on the SP-PHC for high-level global events. The SP-PHC organizes these at a global level, and this is very helpful for the region. The SP-PHC gives a constant global advocacy push, and this makes a huge difference to us.”

“The SP-PHC has done well on advocacy and making a noise about PHC.”

“The high-level mission was very impactful and gives legitimacy with a delegation from Geneva and sends signal of alignment as well, important for political commitment.”

Successful high level PHC joint advocacy missions of the SP-PHC that included cross- departmental participation were noted in Colombia,⁶⁵ Chile⁶⁶ and Pakistan (34). A more detailed recent example from the Chile country case study is provided in Box 5 below.

Box 5. Example of SP-PHC engagement on high level advocacy for PHC in Chile

The Chile country case study is a good example of how the SP-PHC and the three levels of WHO collaborated to advance PHC. Regional and country WHO staff identified a critical policy window in the ongoing discussions on Chilean PHC Health Reform and organized a high-level mission to Chile with the participation of the SP-PHC Director and Pan American Health Organization health system staff from the regional office. This visit was seen as an important advocacy instrument, which would help boost political commitment, provide high level technical advice and support the reform processes. The visit was followed up with several continued advocacy efforts, including the SP-PHC organizing in close collaboration with the WHO Regional Office for the Americas/Pan American Health Organization country office, MoH and Ministry of Foreign Affairs of Chile, the Chilean Government’s presentation on PHC (Chile’s Government’s vision and commitment to PHC reform in Chile). The event was organized on 23 September 2023 at the margin of the United Nations General Assembly high-level meeting on the political declaration of UHC. These efforts were complemented with UHC-P funding to support follow-on activities and are a strong example of synergizing across the SP-PHC.

Informants from other regions and countries mentioned the following conditions which help support successful outcomes of country missions: being politically “savvy” and being able to identify opportunities and allow early and thoughtful planning of missions, including engaging country stakeholders at an early stage; building on previous or existing PHC investments or funded interventions; where possible and appropriate, having joint missions with participation across WHO departments and levels, to make a range of expertise available; supporting context-specific recommendations and follow-up mechanisms.

Finding 20: There is evidence supporting the utility of normative products promoted by the SP-PHC but greater dissemination and increased technical support to facilitate their effective application are still needed. The PHC Operational Framework and PHCMFI have been adopted, positioned and promoted by the SP-PHC as central to much of its work and as key to supporting countries to radically reorientate their health systems towards PHC. The promotion of the Operational Framework has taken place through mechanisms such as the UHC-P and PHC-A and by sensitizing external partners such as the Global Fund, World Bank, GAVI, UNAIDS to the Framework, including identifying opportunities for joint working. In the case of the Global Fund, the Operational Framework has been referenced in the Information Note for Resilient and Sustainable Systems for Health for the allocation period 2023–2025 (35). For GAVI, it is reported by the SP-PHC that GAVI’s Immunization for PHC Framework for Action was informed by the Operational Framework.⁶⁷

⁶⁵ KIs and survey respondents.

⁶⁶ See Chile country case study.

⁶⁷ World Health Organization SP-PHC, PHC Operational Framework and PHCMFI: partner use and connectivity: examples, unpublished document (n.d.), provided by the SP-PHC and received 23 October 2023.

The Operational Framework has enabled consistent messaging on the levers of PHC from the SP-PHC and within WHO, and many KIs within WHO perceive this to be useful and valuable, namely by offering a globally endorsed, evidence-based toolkit. This is expressed by a KI: *“We now have a tool for PHC. The Operational Framework is helping operationalize the Declaration of Astana.”*

More than 90% of online survey respondents found the Operational Framework useful as a practical guide for advancing PHC at country level (“agree” or “strongly agree”), and 48% reported that the Framework had been used in national planning processes (see Table 9 below). Country case studies found that the Operational Framework has helped to make the work of the SP-PHC and ongoing health reforms in Chile and Kenya better understood. In Chile, the Operational Framework is reported to support better integration of the work of the regional office divisions.

Table 8. Responses to online survey question

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% (0)	2.8% (2)	5.6% (4)	62.9% (44)	29.6% (21)	71
...has already been used for national planning processes?	1.4% (1)	18.3% (13)	32.4% (23)	38.0% (27)	9.9% (7)	71
...is going to be used in national planning processes?	0% (0)	7.4% (5)	27.9% (19)	54.4% (37)	10.3% (7)	68
...has been used to support investment decisions on PHC at national level?	0% (0)	16.9% (12)	40.9% (29)	32.4% (23)	9.9% (7)	71

However, there are concerns about the extent to which WHO Country Office staff and partners are familiar with the Operational Framework. This was highlighted through online survey comments where 54% of WHO staff at country level other than HPAs were familiar with it. Multiple comments were related to the need to improve the dissemination of the Operational Framework, and for clearer guidance and training regarding its operationalization, as well as stronger linkages across departments to effectively support its implementation. This finding is endorsed in a recent WHO evaluation on normative products, which also indicated that normative products do not consistently provide guidance on how to implement and monitor them, thus reducing their usefulness.⁶⁸

The evidence on the usefulness of the PHCMFI is mixed, with the majority (81%) of survey respondents finding it a practical tool for countries to assess, track and monitor PHC efforts. This contrasts with the evidence from non-survey sources, including KIIs across WHO and with external partners, who viewed the PHCMFI as operationally complex, requiring a prioritization process at the country level. This was also observed in the Kenya country case study, Kenya having been one of the first countries to embark on using the PHCMFI. As with the Operational Framework, survey data supports the need for increased exposure to the measurement framework and more technical support for its application.

⁶⁸ World Health Organization, Evaluation of WHO’s normative function at country level: draft final report, unpublished report (n.d.).

Finding 21: The most notable reported achievements of SP-PHC are associated with activities conducted through the UHC-P.⁶⁹ Reviews and reports of the UHC-P have provided evidence of results and benefits of the UHC-P (19, 20).⁷⁰ The evaluation team noted that most examples of added value of the SP-PHC reported through the online survey, through KIIs across the three levels of WHO and with external partners and through documents reviewed related to the UHC-P – notably the ability to use highly flexible and multi-year funding, and the role of the HPAs. Survey respondents reported that there has been more focus on PHC through the UHC-P activities since it was included in the SP-PHC in 2020: 61% of respondents agreed or strongly agreed with this statement.⁷¹

Country case studies provide a more mixed picture on the utilization and leveraging of UHC-P funds for PHC advancement. In Chile and Tajikistan, there is robust evidence of strategic and complementary use of UHC-P funds for PHC; in Kenya, this is less apparent. There are instances of synergies being derived at country level between different areas of the SP-PHC's work namely the UHC-P and the GAP PHC-A, as reported in Tajikistan and documented in Pakistan (see Box 6 for more detailed examples).

Box 6. Strategic use of UHC-P funding for PHC at country level

In Tajikistan, the flexible use of UHC-P and SDG 3-GAP funds is allowing WHO to respond to ad-hoc requests arising from the MoH or from the WHO Regional Office for Europe. The flexibility of the funds also allows synergies to be created between the SP-PHC workstreams, with “requests” from the PHC Accelerator being brought to UHC-P for funding.

Source: Tajikistan case study report

The UHC-P grant is reported to be significant for supporting PHC in Chile and complements World Bank initiatives. The UHC-P funding includes support for developing governance and policy frameworks, models of care and local financing mechanisms and to train, consult, inform, document and disseminate good practices nationally and internationally.

Source: Chile case study report

Resources were described as a limitation for PHC-related activities in the WHO Kenya Country Office. KIIs found that the WHO PHC agenda was not well-financed compared to other programmatic areas. As UHC-P funding is necessary to cover ongoing projects in the UHC/LC cluster, KIIs stated that they were limited in funding broader PHC initiatives. That said, UHC-P funding is generally viewed as flexible and more catalytic than other sources of funds.

Source: Kenya case study report

In Pakistan, the UHC-P, through the Country Office and with support from the WHO Office for the Eastern Mediterranean, facilitated the Joint GAP “PHC for UHC Mission to Pakistan” in March 2021. This was co-hosted by the Government of Pakistan and brought together two GAP Accelerators –Sustainable Financing and PHC. Participants included federal and provincial government, Gavi, the Global Fund, Global Financing Facility, UNAIDS, World Bank and UNICEF, as well as other local and international development partners and civil society organizations. At the conclusion of the mission, the GAP partners issued a joint statement renewing their commitment to a more aligned approach to PHC for UHC and to developing an action plan to deliver on the commitments. This is reported to have served as a catalyst for piloting a “PHC-oriented model of care” in two districts. Despite the synergies between the accelerators, missed opportunities to leverage on WB funded health system projects were noted by KIIs at Country Office level.

⁶⁹ As stated in the early section on the scope of the evaluation, UHC-P activities and results were not considered in scope as the UHC-P has its own evaluations and review processes.

⁷⁰ Results-oriented monitoring report, Health system strengthening for universal health coverage (UHC) programme phase IV (2019–2022).

⁷¹ While the evaluation team identified clear efforts to advance PHC within UHC-P projects in recent years, this orientation might have occurred anyway, given the momentum and revitalization of PHC since the Astana Declaration and the COVID-19 pandemic. The absence of a counterfactual scenario makes it difficult to provide robust evidence.

In the Regional Office for South-East Asia, UHC-P funds have been reported as being fundamental to PHC activities at regional and country levels.

While the value added of HPAs promoting PHC at country level is widely acknowledged, there is some indication that their capacity could be more systematically leveraged for PHC. In addition to earlier findings on gaps in familiarity with the SP-PHC and training needs for HPAs in the PHC approach, some external partners expressed the concern that HPAs have not been fully engaged in Global Fund Grant Cycle 7 and Gavi Full Portfolio Planning processes. This is reported to have hindered the bridging of health systems and disease-specific programmes to advance PHC collectively.

The Canada Grant of Can\$ 55 million to strengthen PHC systems in the context of COVID-19 over the period 2021–2024 (36),⁷² managed by the UHC-P, aims to support a stronger focus on resilient health systems and PHC actions in 10 targeted countries.⁷³ A recent results report⁷⁴ provides examples of a range of activities funded under the grant and details progress made overall. As yet, there are few outcomes or independently verified results; however, perceptions in the WHO Regional Office for South-East Asia and Sri Lanka are that the grant, though small, has been critical to supporting countries and driving the PHC agenda across the region. The Kenya case study reported some results as detailed in Box 7 below; these cannot be entirely attributed to the Canada Grant since several funding sources were contributing to the activity.

Box 7. SP-PHC Canada Grant results in Kenya

Historically, Kenya has faced challenges in counting births, deaths and causes of deaths through a civil registration system. The latest Kenya Vital Statistics report showed that 14% of births and 45% of deaths were unregistered (2021). During COVID-19, the country faced challenges in counting excess deaths due to the lack of robust Civil Registration and Vital Statistics reporting. The Ministry of Interior approached WHO Kenya for assistance in urgently strengthening their civil registration and vital statistics system.

With funding from the SP-PHC Canada Grant and other sources, WHO supported CRVS strengthening in Kenya by enhancing data surrounding excess mortality, risk factors associated with severe illness and death from COVID-19, and epidemiological trends. By July 2021, a rapid mortality surveillance (RMS) was implemented in six counties with high burden of COVID-19, increasing the coverage of death and cause-of-death registration. By June 2022, there were several reported results:

- 31 000 deaths had been notified using the RMS system;
- disaggregated RMS data revealed trends in mortality data by location, gender and age; and
- improved mortality data allowed for more evidence-based COVID-19 response measures and health initiatives.

Source: Kenya country case study report

Finding 22: The PHC-A has supported a global dialogue on PHC, but there is limited evidence that this is effective in bringing about change and impact at country level. KI and documentary evidence⁷⁵ finds that the SP-PHC has contributed to improving the coordination of the PHC-A at global level in collaboration with the co-lead agency UNICEF, through regular meetings with global partners. However, KIs within WHO and external partners raised significant concerns about the added value and effectiveness of the PHC-A as a global mechanism that can bring about change at country level. Where examples have been cited, they tend to focus on the same small handful of countries, such as Pakistan and Somalia. The lack of progress is attributed in part to difficulties at country level in aligning partners, different

⁷² Canada Department of Foreign Affairs, Trade and Development. Grant arrangement between the Department of Foreign Affairs, Trade and Development (DFATD) and the World Health Organization (WHO), 2019.

⁷³ Bolivia, Ghana, Kenya, Mali, Mongolia, Pakistan, South Sudan, Sri Lanka, Sudan and Ukraine.

⁷⁴ World Health Organization, PHC intensified support project: end of Phase 1 Report (April 2021–March 2023).

⁷⁵ Sources of triangulated data include KIIs with SP-PHC staff and external partners, including UNICEF; multiple documents for the PHC-A were reviewed from 2020–2023, including minutes from meetings and country presentations, SDG GAP progress reports.

accelerators and workplans and in assigning roles, resources and distribution of activities between agencies. This has translated into inadequate follow-up after joint missions and limited shared accountability to advance the work.

A 2023 recommendation from the SDG GAP Progress Report suggested that “to further enhance collaboration at the country level, agencies should test new approaches, such as the delivery for impact approach, with a view to supporting country-led coordination platforms and aligning with country funding cycles and priorities” (37). A demonstrable added value of the PHC-A is yet to be clearly established, and the forthcoming evaluation of the SDG 3 GAP will play a crucial role in determining its future direction. The quotations below reflect some of the issues arising with the current SDG GAP and PHC-A:

“The [PHC-A] platform does not work as expected. Some meetings and recommendations, but hardly any real change at country level, where more powerful drivers are funding, attribution, and power.”

“The accelerators are interdependent. The [PHC-A] platform does not offer a tool for measuring achievements and attributing them to the collective work.”

“This is a very WHO-centred approach, bringing countries to the PHC-A to present, but how are those countries chosen, as GAP is not well known at country level.”

Notwithstanding these issues, the SDG GAP 2023 Progress Report noted some achievements of the PHC-A at country level since 2020 for example strengthening agency collaboration in Afghanistan in the face of the many challenges at the humanitarian-development nexus. The SP-PHC has also provided some examples of country action in Pakistan and Somalia (see Box 8).⁷⁶ The Tajikistan case study also documents some achievements. The Kenya case study, by contrast, shows limited action at country level and ambiguity on how Kenya was selected as a PHC-A country (see Box 8).

Box 8. Findings related to the PHC-A at country level

The SDG 3 GAP partners have been engaged in consultations and strategic dialogue in **Pakistan** with federal and provincial governments on the provincial adaptation of an essential package of health services (EPHS). As a consequence, all provinces except one have localized EPHS within their plans. Joint work has also led to partners (the World Bank, Global Financing Facility, Global Fund, Gavi and the Gates Foundation) aligning their upcoming portfolios and supporting a National Health Support Programme. WHO has piloted the implementation of EPHS using a PHC-oriented model of care approach in selected districts, with its experience potentially informing EPHS implementation and scale-up across the country.

WHO and Gavi colleagues are reported to have worked together on the development of Gavi’s Full Portfolio Planning process in **Somalia**, which was submitted in August 2023 and leverages the PHC-GHI toolkit. A series of discussions have taken place on the development of a Country Compact in Somalia. Following a workshop organized by the World Bank, an internal WHO working group has been established to develop a draft of the country compact, including with UHC2030. A draft of the compact is underway, and a zero draft version should be released by UHC Day.

Since its introduction in **Tajikistan**, the SDG 3 GAP funding has been used to: strengthen WHO leadership to maintain its leading role as a technical agency and improve the dissemination of findings and recommendations for the work being done; enhance internal communication (links to WHO leadership) to strengthen the WHO Country Office to be a stronger office in general; reinforce coordination between partners for better health system governance by strengthening both the Development Coordination Council Health platform and its use, thus furthering coordination and collaboration in the health development sector; and organize high level dialogues, retreats, roundtables and

⁷⁶ Although the evaluation team is reporting these developments, KI evidence for Somalia is very mixed on the effective role of the PHC-A in Gavi processes. The team has not been able to explore the role of the PHC-A in developing the country compact.

workshops that have been instrumental in advocating for health, promoting the PHC approach and facilitating UHC discussions, resource mobilization and achievements.

Source: Tajikistan country case study

The benefits of the PHC-Accelerator are not yet clear to KIs from WHO **Kenya** and SDG 3 GAP partners. Concerns included the need for clarity on the selection criteria that informed Kenya's inclusion and a better understanding of the objectives of the technical working groups and partnership activities. KIs identified the main activity to date as being a presentation at a Global PHC-Accelerator Webinar in June 2023, in which MoH representatives, WHO and UNICEF gave an update on PHC progress in Kenya and SDG3 GAP partner contributions. However, KIs have expressed that they have yet to see the benefits of this involvement and follow-up after the presentation.

Source: Kenya country case study

Finding 23: More technical support is needed to advance the PHC approach at country level in multiple areas.

In addition to supporting the country use and implementation of guidance/tools, country survey data, case studies and regional and country KI evidence identified other gaps where countries could benefit from increased technical support. These include health financing (linked to PHC, health reforms, essential health packages, public-private mix), technical support for integrating disease-specific programmes into PHC, and support for community engagement and multisectoral action. There is also strong demand, from within WHO, for high level advocacy for PHC and capacity-building of staff to better understand the PHC approach and to support the operationalization of PHC-related policies at country level (see also survey analysis in Annex 5).

2.4 Efficiency

The findings presented in this section relate to EQs 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 these are adequate for the SP-PHC to achieve its mandate? and 2.3.: How efficiently are SP-PHC resources being utilized?

In line with the DAC evaluation criteria on efficiency, this section explores aspects related to resourcing of the SP-PHC and assesses if activities were implemented in a timely and economic way. Analysis for this section was hampered by financial data gaps and WHO financial systems. It was difficult to determine a true budget, to compare budget and expenditure data and to interpret spending on human resources (that is, to understand the translation of inputs into outputs). Furthermore, without any specific outcomes/result areas for the SP-PHC, any assessment of efficiency as defined by OECD DAC – as “the extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way” (14) – was severely compromised. As such, it was not possible for the evaluation team to conduct a robust efficiency analysis; instead, the evaluation provides an assessment of SP-PHC resourcing and signposts areas of efficiency/inefficiency.

Key findings related to efficiency (EQs 2.1 and 2.3)

- 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 of 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 as 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 to achieve 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.

Evidence was rated as strong (1)⁷⁷ for all key findings presented above.

Theory of Change assessment for Efficiency/EQ2.3

Relevant assumptions underpinning the ToC for EQ2.3 include that:

- inputs translate into outputs in the manner and to the extent intended in other words that activities are implemented efficiently.

This assumption is critical for the achievement of ToC outputs related to advocacy and communications, PHC guidance and implementation support, which are necessary to achieve the desired intermediate outcomes: WHO mobilized support for country impact; PHC adopted and invested in as a cross-cutting priority.

Summary assessment: While lack of clarity on what the SP-PHC's outputs should be hindered this assessment, the available evidence suggests that this assumption *does not fully hold*, with delays to implementation progress, often due to reported capacity issues. Other findings of inefficiency in the work of the SP-PHC support this assessment, such as capacity constraints, duplicative working, insufficient collaboration and examples of non-optimal conduct of meetings.

The WHO's GPW13 and Programme Budget place significant emphasis on the pursuit of UHC. Strategic Priority 1 of the GPW13 is *One Billion more people benefitting from UHC*, which accounts for 39% of the revised Programme Budget for 2022–2023, equivalent to almost US\$ 2 billion (38). This is allocated across WHO departments at the global level and between global, regional and country levels.⁷⁸ A strong PHC approach is considered the foundation of UHC.

Finding 24: The global budget for the SP-PHC is almost US\$ 18 million for the 2022–2023 biennium. As shown in Fig. 5, the amount budgeted for the 2020–2021 biennium was US\$ 3.8 million, consisting of US\$ 2.9 million in salary costs and US\$ 0.8 million in budget for programmatic activities. This increased dramatically for the 2022–2023 biennium, in part as the SP-PHC became established, to US\$ 17.8 million, consisting of US\$ 9.8 million in salary costs and US\$ 8 million in budget for programmatic activities (which includes consultant costs). These figures refer to the global SP-PHC budget and do not capture associated regional or country budgets, such as for the country HPAs, which is reflected in Country Support (Work) Plans – see below Fig. 6.

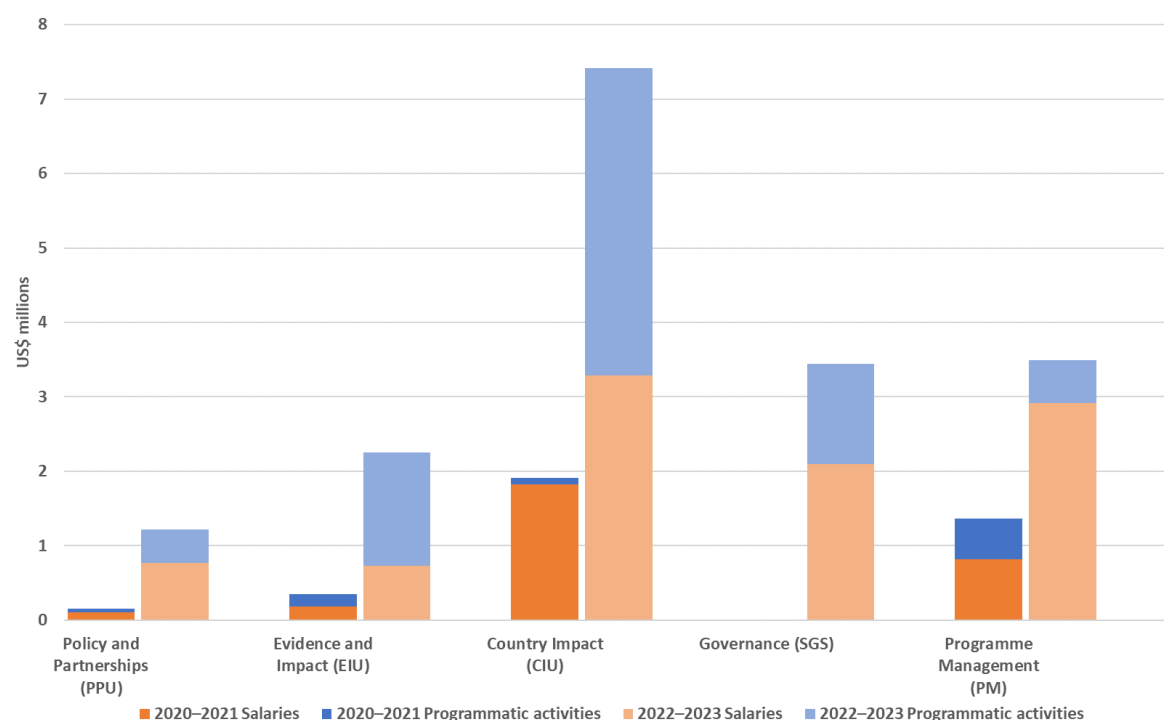
The increase in budget across biennia is spread across the technical units that make up the SP-PHC but driven by an increase in budget for the Country Impact Unit of the SP-PHC and the inclusion of new units, namely REPHF (which sits within the Country Impact Unit) and SGS. The increase across years is also driven by a substantial increase in salary costs and the number of staff employed through the SP-PHC, which is around 40 for 2022–2023.⁷⁹ Although the Programme Budget for 2024–2025 has been agreed at a high level, the costed workplan for the SP-PHC has not yet been finalized (39).

⁷⁷ Evidence consists of multiple data sources (which enables triangulation from at least two different sources) that are of good quality, and/or evidence is repeated by multiple KIIs of different stakeholder categories.

⁷⁸ WHO Headquarters consists of 12 divisions and 50 departments/programmes, eight (8) of which are in the UHC/Life Course Division.

⁷⁹ The SP-PHC organigram for 2022–2023 notes six positions within the SP-PHC Director's office; six positions in Policy and Partnerships; three in Evidence and Innovation; 17 in Systems, Governance and Stewardship; and eight in Country Impact. World Health Organization, PHC Special Programme Organigram 2022–2023 (2023).

Fig. 5. WHO SP-PHC amount budgeted by 2020–2021 and 2022–2023 biennium⁸⁰



Source: Data shared by the WHO Secretariat.

Finding 25: The resource envelope for the SP-PHC is determined by several factors, including external fundraising and factors internal to WHO. It is not, however, fully reflective of needs. The WHO programme budgeting process is complicated but essentially involves a bottom-up workplan development and costing exercise, and a top-down/centrally made allocation of available resources across programme areas/units.⁸¹ The total resource envelope is subject to fundraising and the overall level of resources available to be spent by WHO in each biennium. The allocation of available resources across WHO units is based on a few factors. Firstly, the voluntary contributions raised are allocated thematically or specifically for each unit’s work – for the global SP-PHC budget in 2022–2023 these account for almost 70% of total.⁸² Flexible funds are then allocated to each unit to ensure that salary costs are covered.⁸³ The remaining funds are then prioritized across programmatic activities, while making sure that all units receive at least some allocation. For the global SP-PHC budget in 2022–2023, flexible funds account for around 30% of the total.

In some instances, programmes have a funding gap between the initial bottom-up workplan costing and the amount allocated and budgeted. In 2020–2021 there was a programme budget ceiling for the SP-PHC as it was still being set up. A funding gap of around US\$ 200 000 in 2022–2023 was noted, which was mostly related to the newly absorbed SGS unit. The recent gap is minor; however, it is understood that WHO units are not always able to reflect their full funding needs in the workplan costing. This is due to internal parameters and/or pressure to keep the funding gap as low as possible so as not to assume the budget space that other units may be able to use – this has been described as a game of financial “hide

⁸⁰ Some additional raised resources for SP-PHC relate to the 2023–2023 biennium but are not reflected in the dataset used to generate Figure 5 or the figures quoted above.

⁸¹ For the 2020–2021 biennium, this was one central costed plan for the SP-PHC. For the 2022–2023 biennium, a plan was developed for each of the units within the SP-PHC – i.e. the Policy and Partnership unit, Evidence and Innovation unit, Country Impact Unit (systems Governance and Project Management – as part of a strategy to ensure resources are secured from different funding sources.

⁸² This refers to Voluntary Contributions Specified and Voluntary Contributions Thematic, in turn.

⁸³ Flexible funds refer to assessed contributions, core voluntary contributions and programme support costs.

and seek". Some KIs noted that the actual funding gap for the SP-PHC is much larger than the above figures suggest, although financial needs have not been fully analysed or calculated.

Finding 26: Resourcing of the SP-PHC at the global level is widely considered to be problematic, but often for different and sometimes conflicting reasons. KIs raised several issues with the fundraising and allocation approach for the SP-PHC and its overall resource envelope. Central to this is how well funded stakeholders consider the SP-PHC to be. Most KIs interviewed, including those within the SP-PHC, described a set of hugely ambitious outcomes that require full and proper resourcing to be achieved, which had not been allocated to the SP-PHC. Many described the SP-PHC as the Director-General's vision but without the means to achieve it. Other KIs, particularly those not employed by/through the SP-PHC, described a degree of resentment towards a very well-resourced programme relative to other WHO units (with the perception that the high SP-PHC budget had reduced resources for other units).

This divergence in opinion is partly related to a lack of clarity on where the SP-PHC's funds are sourced from – this information was not provided to the evaluation team, which has limited analysis. It is also related to how stakeholders view the SP-PHC and what its role should be in the pursuit of PHC outcomes. KIs outside the SP-PHC often referred to the original vision of an agile and lightly staffed SP-PHC that operated mainly through other WHO units, which would hold the bulk of the budget. However, in practice the SP-PHC holds a significant global budget and, in line with the incentives created by WHO's internal financial budgeting system (where salary costs are prioritized over programmatic activities), a high number of staff have been recruited or mainly transferred from other departments. Converging these viewpoints and providing a definitive answer as 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 works with other partners to achieve joint objectives.

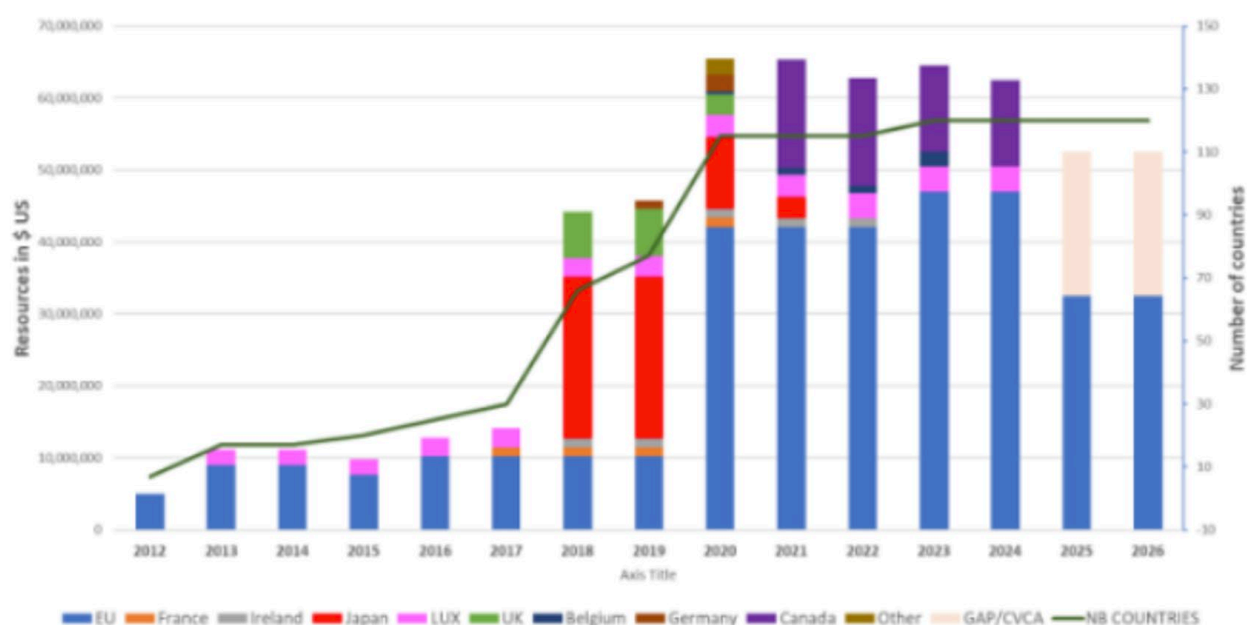
Finding 27: WHO resource allocation for PHC at the regional and country level (which are not captured in the findings above) is unclear, as is the extent to which it acts as a constraint to programmatic progress. The SP-PHC sits at the global level, but the extent to which it allocates resources to the regional and country level is unclear. This is largely considered to be driven by donor grant requirements (for example through funding for HPA posts – see below). From the country perspective, there is often little visibility of where funding comes from and what it is intended for, which has implications for results. In Kenya, stakeholders described a situation where funding was provided at short notice for very specific tasks and with short deadlines, but with no explanation as to what the broader strategic goals of the project(s) were.

The SP-PHC has attracted some new donors, including Canada. Some KIs noted that the overall resources available for PHC at the regional and country level were not the primary constraint to progress being made. Rather, issues related to planning and prioritization made spending money at the regional and country level challenging. Other stakeholders raised concerns about a lack of productivity and/or implementation progress at the regional and country level, with the need to ensure that financial resources were spent and spent well. The Kenya and Tajikistan country case studies suggest that resources are, however, a limitation. For example, in Kenya, the PHC agenda was not considered to be well financed compared to other issues, with SP-PHC funding retained within the UHC/LC due to resource constraints.

Finding 28: The UHC-P's resourcing of HPAs at the country level is viewed as important. Through the UHC-P, HPAs have been posted in countries since 2012. As shown in Fig. 6 below, this has grown to 120 countries in 2023. The UHC-P was positioned within the SP-PHC on its establishment in 2020, which has coincided with a shift in the resource base for the UHC-P. Notably, funding from the EU grew from 2020 onwards, while funding from Japan and some other donors declined.

Although the HPA positions were overwhelmingly considered to be positive, issues were raised in relation to their high annual cost and dependence on donors to fund them. While WHO may, in future, plan to integrate these costs into its own budget as salary costs, this does pose a risk that donors may end their support earlier than they would have done otherwise (see findings on sustainability).

Fig. 6. Funding for the UHC-P and the number of countries supported (2012–2026)



Source: Documentation shared by WHO Secretariat

Finding 29: Efficiency analysis was hampered by limited financial data, limited specific results and difficulties pairing activities to expenditures, yet the evaluation team identified areas of inefficiencies mainly related to an unclear role division and lack of alignment.

The evaluation team noted areas of inefficiencies mainly reported through KIIs at all three levels, coupled with documentary evidence which related to:

- delays in implementing activities (see Table 8);
- examples of overlapping roles and responsibilities between the SP-PHC and other departments in WHO, limited coordination between SP-PHC units (in the evaluation scope) and with wider departments, and limited sharing or co-creation of workplans (see section 2.2. Coherence);
- recipients not systematically being engaged in co-designing work, which make outcomes of questionable character (see section 2.2. Coherence); and
- conduct of meetings, which were frequently reported by KIIs at country and regional levels, including in case study countries, to be called at late notice and at inconvenient times for some countries and regions (late evening/early morning due to time-zone differences). These aspects reportedly made it difficult for countries and regions to prepare or be available. Furthermore, meetings frequently covered the same ground and, in the case of the PHC-A meetings at global level, are considered to be more *show and tell* than action-orientated, with questionable added value.

The following quotations present selected examples of the language used by KIIs for such observed inefficiencies:

“There are no clear lines to indicate who is responsible for what - causing duplication and tension between the SP-PHC and other departments.”

“UHC, SP-PHC and other divisions are working on many of the same subjects – very little alignment and integration, instead fragmentation, duplication, and competition.”

“There is duplication and lack of alignment. Not good use of resources.”

2.5 Sustainability

The findings presented in this section relate to EQ 2.5: How sustainable are the SP-PHC interventions?

In line with the DAC evaluation criteria on sustainability, this question is concerned with the extent to which the benefits of the interventions are likely to continue. Given the status of intervention implementation under the SP-PHC, evidence for the findings is limited and draws upon qualitative data sources, principally the document review, KIIs and case study material.

Key findings related to sustainability (EQ2.5)

- 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.

Evidence was rated as strong (1)⁸⁴ or moderate (2)⁸⁵ for key findings presented above.

Theory of Change assessment for sustainability /EQ2.5

Relevant assumptions underpinning the ToC for EQ2.5 include that:

- policy commitment and leadership for PHC is present in countries, so that stakeholders are willing to engage with the SP and its activities in the manner and to the extent envisaged;
- country level health architecture, governance, resourcing, policy frameworks and multistakeholder engagement mechanisms exist at the country level to facilitate achievement of outcomes; and that
- the enabling environment at country level is supportive of and conducive to operational levers being strengthened and put in place (such as workforce, infrastructure, technology).

These assumptions are both critical to the translation from intermediate outcomes into country outcomes and the achievement of sustainable country impacts.

⁸⁴ Evidence consists of multiple data sources (which enables triangulation from at least two different sources) that are of good quality, and/or evidence is repeated by multiple KIIs of different stakeholder categories.

⁸⁵ Evidence consists of multiple data sources (which enables triangulation from data sources) of acceptable quality, and/or the finding is supported by fewer data sources of good quality.

Summary assessment: The available evidence, which is strong, suggests that there is political leadership and policy support for PHC at the country level, as evidenced through the Astana Declaration and broad-based follow-up commitments to PHC. Countries have also broadly expressed a desire for support on advancing PHC at the country level, including through the UHC-P and SP-PHC. There is more mixed evidence on the extent to which an enabling environment and broader supportive architecture (particularly resourcing) is in place across different country settings, with case studies indicating that these factors acted as barriers to making progress on PHC in some countries.

Finding 30: SP-PHC interventions aimed at increasing political commitment to PHC and policy change informed by country demand are potentially more sustainable. The SP-PHC's engagement and coordination of high-level PHC events, such as the Astana conference in October 2023, regional PHC high-level events and country level political advocacy, have been effective in generating commitments and declarations as noted in KIIs from multiple regions (WHO Regional Offices for Africa, the Eastern Mediterranean, and Europe, the Pan American Health Organization, the WHO Regional Offices for South-East Asia and the Western Pacific). Technical support to policy and strategy development and health financing reforms were other areas noted with the highest potential for sustainability. Country-driven support that builds on existing structures and initiatives was further highlighted as being more sustainable than Geneva-led initiatives (see example from country case studies in Box 9 below).

Box 9. Country perspectives on the sustainability of SP-PHC interventions from case studies

Bottom-up initiatives from WHO **Kenya** and the government were seen as more sustainable than top-down initiatives from WHO Headquarters. Some KIIs noted that initiatives from headquarters, such as the PHCMFI, PHC-Accelerator and PHC Implementation Solutions, *“are not as sustainable as those requested by the government, such as technical support for policy, strategy and guidance development and UHC-P and SDG 3 GAP-funded initiatives.”*

Source: Kenya country case study

KIIs and documentary evidence suggests that SP-PHC support, building on previous support, was instrumental in garnering political commitment for a PHC-orientated health system in **Tajikistan** and in supporting the health financing reform towards a PHC system.

Source: Tajikistan country case study

The UHC-P funds build upon existing initiatives in **Chile**, strengthening and scaling them up, thus allowing sustainable progress and achievement of results, which is crucial to the government and WHO agendas. The development of a set of scalable models of care is likely to make the interventions of the SP-PHC sustainable.

Source: Chile country case study

The evaluation team noted examples of PHC informed policies in place at country level, which were not implemented or not financed. Stronger linkages between the SP-PHC and the WHO Health Financing department were further identified by informants as important for generating sustainable results.

Finding 31: Sustainability concerns regarding the funding and operations of the UHC-P are being addressed. Currently, the HPA positions are entirely donor funded through the UHC-P. The recent ROM review of the

UHC-P from 2021⁸⁶ notes the integration of the UHC-P within WHO structures and processes as a crucial element of sustainability. More recently, and as reported by the UHC-P,⁸⁷ two important elements have been introduced to support greater sustainability of the HPA role: conversion from short term to fixed term arrangements and the appointment by the Director-General of an Action Results Group that has outlined a new organizational chart for country offices, with a Core Predictable Country Presence that includes HPA positions and is to be funded under the regular budget. If successful, this will mean increased sustainability (and additional flexible resources for activities).

Finding 32: The evaluation team found less evidence of SP-PHC activities that promote the PHC approach pillar for multisectoral collaboration, yet this is perceived as important for the effectiveness and sustainability of PHC (40). While there is growing attention within the SP-PHC to these two pillars of the PHC approach (see findings in the section on Relevance), there are missed opportunities to do more in this area, given the in-house expertise of the global HIV Department, and as a Co-sponsor of the Joint Programme of UNAIDS, where multisectoral approaches and community engagement and empowerment are niche areas. High level policy engagement on “Health in All Policies” requires concerted efforts of relevant WHO departments, such as the Department of Social Determinants of Health, which could forge collaborations with the SP-PHC.

2.6 Gender, equity and human rights

The findings presented in this section relate to EQ 3.1: How and to what extent has the SP-PHC supported the inclusion of equity, gender and human rights consideration across its core functions and technical products (such as development of frameworks, indicators, data collection, tools and analytical methods to inform decision-making, and the selection of countries for intensified support)?

Evidence for the findings in this section draws upon qualitative and quantitative data sources, principally the document review, KIIs and case study material.

Key findings related to equity, gender and human rights (EQ3.1)

- Equity and human rights are systematically reflected in SP-PHC technical products and communications, but there is less systematic attention to gender dimensions.
- There is some evidence of WHO and the SP-PHC's resources being targeted towards countries where needs are greatest, but not in a fully equitable manner.

Evidence was rated as strong (1)⁸⁸ or moderate (2)⁸⁹ for key findings presented above.

Finding 33: Whereas equity and human rights are systematically reflected in SP-PHC technical products and communications, there is less systematic attention to gender dimensions. Key normative products promoted by the SP-PHC, including the PHC Operational Framework (2) and the PHCMFI (41), accord specific priority to

⁸⁶ ROM Report Health systems strengthening for universal health coverage programme phase IV 2019–2022.

⁸⁷ The evaluation team has included this evidence as reported by the UHC-P but has not been able to triangulate it with other sources of data.

⁸⁸ Evidence consists of multiple data sources (which enables triangulation from at least two different sources) that are of good quality, and/or evidence is repeated by multiple KIIs of different stakeholder categories.

⁸⁹ Evidence consists of multiple data sources (which enables triangulation from data sources) of acceptable quality, and/or the finding is supported by fewer data sources of good quality.

gender, equity and human rights dimensions. This includes guidance on how to ensure proper attention to such dimensions and promote collection and monitoring of disaggregated data on health status and service coverage indicators (by age, sex, wealth quantile, education, geography, displacement status, disability, ethnicity, migrant status, etc.). The WHO Academy course draft curriculum⁹⁰ includes a mini module on gender, equity and human rights. The PHC-A has a strong focus on leaving no-one behind, which was also documented in PHC-A meeting reports. This is well aligned with one of the main rationales for implementing a PHC approach, namely, to ensure that health services are equity-orientated, gender-responsive and human-rights-based. Likewise, the evaluation team found strong evidence of references to equity, the right to health, reaching those furthest behind, and gender dimensions reflected in SP-PHC communication, including speeches, webinars and newsletters. The Chile country case study shows evidence of equity-based targets for access and coverage under the Rural Health interventions in the UHC-P grant.⁹¹

Other SP-PHC products and outputs, such as the draft communication strategy from 2022,⁹² include limited or no mention of gender and human rights in their messaging around PHC. There also appears to be a missed opportunity to highlight gender through the UHC-P. A 2021 review of the UHC-P⁹³ found a lack of gender focused activities, outputs, outcomes and indicators, recommending enhanced emphasis on gender dimensions and a gender strategy for the UHC-P. The case study from Tajikistan also highlighted concerns about limited attention to gender issues.⁹⁴

Finding 34: There is some evidence of WHO and the SP-PHC's resources being targeted towards countries where needs are greatest, but not in a fully equitable manner.

In May 2023, WHO increased its Country Initiative budget for intensified support to countries on UHC using a PHC approach by US\$ 120 million. This was allocated to more than 45 priority country offices (at present 60 countries) – with the regional offices mainly selecting countries to receive support.^{95, 96} As shown in Fig. 7, this includes some (but not all) of those countries listed as having the lowest service coverage index – a key SDG 3 indicator related to achieving UHC.⁹⁷ It also includes some countries with a relatively high service coverage index. KIs noted that WHO's (and the SP-PHC's) ability to prioritize countries was constrained by political considerations, often at the regional level. This was also the case with the allocation of resources through the UHC-P, for instance with resources being allocated even to high-income and upper-middle income countries. The equal split across countries in the WHO African Region irrespective of size or need was also a source of frustration for a large, decentralized country like Kenya, with significant need for support. This was identified in the Kenya case study, specifically relating to the Canada grant.

⁹⁰ WHO academy course- PPT, Primary health care: Leading health system transformation toward UHC and the SDGs

⁹¹ See Chile country case study report (Vol. II).

⁹² World Health Organization, Universal Health Coverage Partnership communications strategy: 2020–2022, unpublished document (2021).

⁹³ ROM review UHC-P, ROM Report [unpublished]. World Health Organization; 2022.

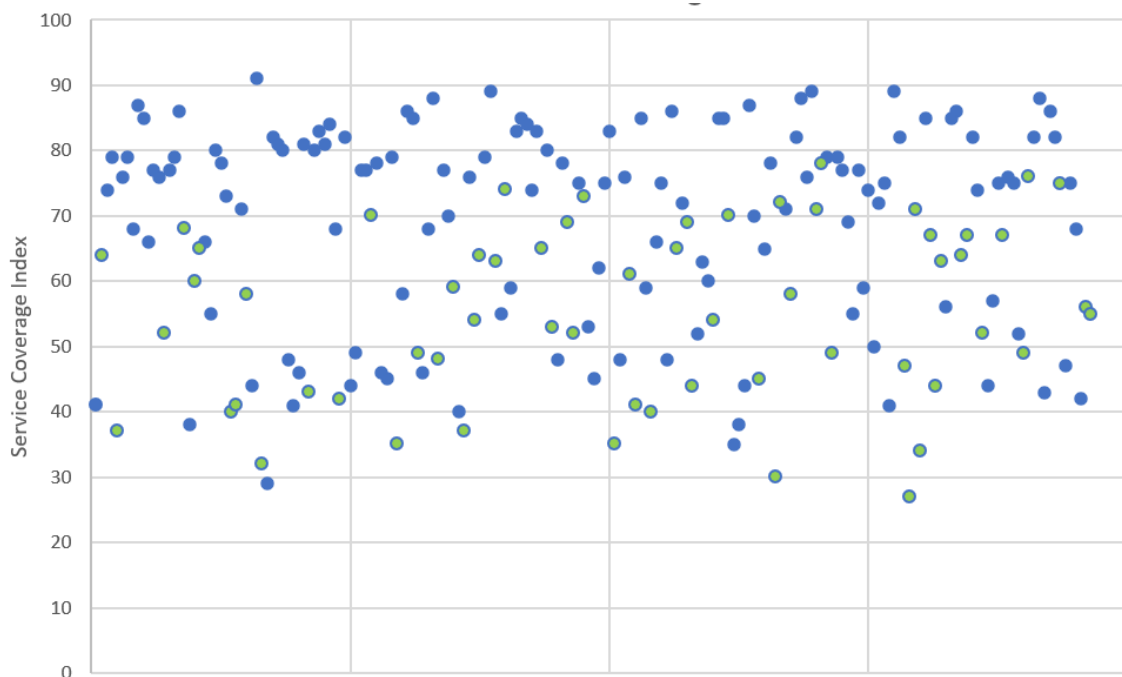
⁹⁴ See Tajikistan country case study report (Vol. II).

⁹⁵ Albania, Angola, Bangladesh, Belize, Bhutan, Bolivia, Burkina Faso, Burundi, Cambodia, Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo, Egypt, Ethiopia, Gabon, Ghana, Guatemala, Guinea-Bissau, Haiti, Honduras, India, Islamic Republic of Iran, Jordan, Kenya, Kyrgyzstan, Lao People's Democratic Republic, Lebanon, Madagascar, Maldives, Mali, Mauritania, Mongolia, Morocco, Mozambique, Nepal, Nicaragua, occupied Palestinian territory, Pakistan, Papua New Guinea, Paraguay, Philippines, Republic of Moldova, Romania, Rwanda, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Syrian Arab Republic, Tajikistan, Timor-Leste, Tunisia, Uganda, Ukraine, Uzbekistan, Zambia, Zimbabwe.

⁹⁶ Strengthening country capacity for measurable impact - 45+ countries on an accelerated track PB 2022–2023. PowerPoint presentation, DPM meeting 23 January 2023.

⁹⁷ To measure the service coverage dimension of UHC (SDG 3.8.1), a basket of representative essential health services are considered an index score. They include indicators related to reproductive, newborn, maternal and child health, infectious diseases, noncommunicable diseases, and service capacity and access.

Fig. 7. UHCSCI index of 192 countries (latest available data) and overlap with “WHO intensified support countries”



Green dots: WHO countries (offices) prioritized for intensified support (45+ Country Initiative).
 Blue dots: WHO countries (offices) *not considered* for intensified support through the 45+ Country Initiative
 Data source for Service coverage Index: Tracking universal health coverage: 2023 global monitoring report.
 Geneva: World Health Organization and International Bank for Reconstruction and Development / The World Bank; 2023

Using resources from the Canada Grant and the European Investment Bank PHC investments, the SP-PHC plans further intensified support to 25 of these countries between 2022 and 2024 (13 in WHO’s African Region, 1 in the Region for the Americas/the Pan American Health Organization, 8 in the Eastern Mediterranean, 1 in Europe, 1 in South-East Asia and 1 in the Western Pacific).⁹⁸ Yet some countries with a very low UHC service coverage index (such as Benin, Chad, Niger and Nigeria, which are all below the 40% UHC service coverage index) are not targeted through intensified support from WHO (see Fig. 7). This is consistent with feedback provided through the survey that some countries, notably small island states, had not been prioritized for support on PHC despite needing need such support and also presenting below 50% on the UHC service coverage index score (Fig. 7 – countries not shown). The evaluation team notes that other selection criteria, such as government priority to advancing PHC and opportunistic policy windows, are also important in this selection. However, it would be important for WHO to reconsider support to small island states (due to complex infrastructure) and conflict-affected countries – all of which are in dire need of embracing the PHC approach – as well as countries with the lowest UHC SCI index.

⁹⁸ World Health Organization, Intensified support draft country list, unpublished document (2023).

2.7 Overall assessment against the Theory of Change

The findings in the previous section have been informed by the ToC, which was used most recently by the team during the evidence review and analysis phase. In addition to the summary assessments of the ToC against each of the DAC evaluation criteria presented in the findings section, the following overarching points were arrived at.

- Based on the evidence, the ToC accurately captures the work of the SP-PHC – its inputs, activities and outputs, and the theory for how change was expected to occur.
- The evidence indicates that inputs translated into activities and outputs, with the SP-PHC workplans largely being implemented, albeit with some delays.
- Translating outputs into intermediate outcomes is more evident for the UHC-P, which has been a successful connector across the three levels of WHO and with partners, and a provider of implementation support using flexible funding. There is less evidence of this from the wider SP-PHC, although evaluation evidence points to instances of its mobilizing regional and country action, for example through global and regional advocacy, country missions and normative products. Overall, however, the evidence points to the need for more practical action and support to countries in reorientating their health systems towards PHC in order to demonstrate results.
- A lack of evidence on the achievement of country outcomes is also due to other factors.
 - A lack of results reporting is compounded by challenges in attributing results to sources of funding.
 - The Operational Framework has been positioned as key to leveraging change at country level and generating outcomes, but evidence suggests that this will require substantial training and practical support to countries in using the guidance.
 - The SP-PHC's scope of work for the reorientation of health systems is largely focused on the delivery of the first prong of the PHC approach, namely the integrated, people-centred health services at primary care level, rather than the other two prongs that are integral to the PHC approach promoted by WHO. Even with primary care delivery, evidence points to the need for greater service integration. Overall, WHO is promoting a comprehensive approach for which it is only well placed to deliver support for one of the prongs; furthermore, country and external funders are also largely investing in primary care rather than the broader approach.
- Country impacts are not assessed as part of this evaluation, but global reports point to health-related SDG targets being off track, including for UHC.
- Some of the guiding principles proved to be aspirational.
 - For example, the findings in the report indicate that as the SP-PHC evolved, it moved far from the original vision of being an innovative, integrated and agile structure.
 - Cross-functional and cross-office collaboration has been limited.
 - The one-stop network approach to providing country support is mainly relevant to the UHC-P, and there is less evidence of the approach working for the wider SP-PHC.
- There is evidence that most assumptions underpinning the ToC, from inputs to country outcomes, appear not to hold in practice (see assessment provided under each findings section, above).

3. 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 SP-PHC’s original design 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 operations and its positioning as a department within WHO have compounded these concerns, contributing 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, and 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 SGS and REPHF, has contributed to ambiguity in its 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. The absence of transparent and comprehensive information regarding the SP-PHC itself has also 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 its trajectory and adherence to its original design. At higher Organizational level, the extended absence of an ADG 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 central 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. 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, there has not been systematic or significant networking overall 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 WHO Headquarters departments and networks, but galvanizing cross-cutting collaboration on the real issues faced at country level has been a struggle. The collaborations have taken time to develop, have been quite ad-hoc and have strained to break down silos and enhance action and accountability for PHC. Poorly defined roles and responsibilities, potentially 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 SP-PHC's current configuration 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 its interventions. The UHC-P, recognized as successful and responsive to country needs, contrasts with the global nature of other areas of the 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", raising questions about whether the UHC-P should be placed in another department/division or at a higher level of the Organization, which could be 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 resource needs for achieving country level PHC objectives. A critical factor contributing to 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, less attention is being paid overall 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 HPAs 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 room to improve attention to the gender dimensions of the SP-PHC work, and in applying an equity lens to 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 their 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 with 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.

Overall, the SP-PHC has provided a useful advocacy function, but 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 (such as 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.

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

1. 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;
2. the absence of a clear strategy, objectives functions and value proposition for the current approach vis-à-vis the rest of the Organization and external partners;
3. an appropriate design that can efficiently and effectively deliver on its strategy and contribute to country PHC outcomes; and
4. learning and capacity gaps that need addressing to support countries and WHO staff in developing, adopting and implementing evidence-based PHC policies and reforms.

4. Recommendations

With a line of sight from the findings to conclusions, the following recommendations are made to WHO in pursuit of its objective of working with Member States to radically reorientate 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 the WHO's GPW14 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: GPW14 Task Force Lead with ADG UHC/Life Course and SP-PHC. Timeframe: Immediately

Rationale: Clearly articulating WHO's desired outcome and output/s for PHC in WHO's GPW14 2025–2–2028 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, 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 incentivize 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 UHC/Life Course, SP-PHC. Timeframe: Next six months

Rationale: The absence of a strategy and ToC 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 upon a shared vision and understanding of the purpose, objectives and value proposition. It should be supported by a ToC 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, build on the strengths of the SP-PHC and resolve some of its challenges. In developing the strategy, broader consideration of the relationships and departments involved in UHC, PHC and health systems strengthening may be necessary.

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 approach to promoting a PHC approach;
- **ensuring more integrated and agile**⁹⁹ ways of working within the entity itself and with other WHO departments; and
- **considering core functions** as part of the vision and strategy, including:
 - global, regional and country advocacy support;
 - Providing support to GPW14 strategy development on PHC outcome, outputs and indicators;
 - institutionalizing systematic attention to the equity, gender and human rights dimension of PHC and to applying an equity lens in prioritizing country requests for support;
 - facilitating a collaborative learning agenda with other WHO departments and other levels of the Organization and 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 levels of WHO to the relevant expertise in headquarters departments as and when they arise.

Recommendation 3: Overhaul 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. The following steps are recommended to make certain that the new entity is fit for purpose, with an enabling environment in place to facilitate success, notably:

⁹⁹ See Harvard Business Review definition in footnote 14..

- **a leaner, structured 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 SP-PHC approach;
- **a fit-for-purpose team** structure to guarantee appropriate human and financial resources are available at the point of creation;
- **an operating model** to support the new approach and the concept of agile management and 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;
- **clear roles and responsibilities** for the entity vis-à-vis other parts of WHO and a shift in ways of working towards a service-orientated culture;
- **the leadership attributes** required for success;
- **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;
- **a revised PHC communication and knowledge management strategy** (including messaging, web, social media, knowledge sharing), which 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; and
- **an approach that builds 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, by developing 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 with the prioritization and implementation of PHC, as well as capacity gaps of WHO staff expected to prioritize PHC. While the SP-PHC is being overhauled, these recommendations will also require attention; they will probably fall outside of the mandate of the new entity and thus the task of others.

- **Mechanisms should be created to support the implementation of PHC activities** by technical departments, and countries and regions need to be supported to enable more flexible responses to country needs (for example, countries to contract-in the support they need from internal or outside sources; technical support to be provided for more sustained periods of time).
- **A technical assistance PHC/UHC roster mechanism should be developed** 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). This is likely to be more feasible at regional level.
- **A directory of WHO Headquarters and Regional Office staff should list 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 contact for expertise.

- **The existing capacity of HPAs** should be pivoted **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 (such as ministries of finance and social sectors, not just ministries of health).
- **A more systematic learning and knowledge management function should be developed to support the operationalization of PHC** so 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 knowledge management strategies, such as more interactive webinars and sessions that target *real life* issues (for example, successful approaches to tackling bottlenecks in specific areas of PHC).

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