

# Evaluation of UNICEF work in primary health care (PHC)

Terms of Reference (ToR) – April 2024

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## Background

The UNICEF Evaluation Office located in New York Headquarters (HQ) provides leadership and oversight of the evaluation function in the organization. As such, it manages independent, corporate evaluations and other evaluative activities and supports the evaluation function at decentralized level (country and regional offices) through quality assurance, technical assistance, and national capacity development. The work of the Evaluation Office is guided by the UNICEF Evaluation Policy<sup>1</sup> and the Plan for Global Evaluations (PGE)<sup>2</sup>, both Executive Board-approved documents. As part of that Plan for the period 2022-2025, the Evaluation Office will conduct an evaluation of UNICEF primary health care (PHC). Per the PGE, this evaluation should be submitted to UNICEF's Executive Board in 2024.

## Context

Strong primary health care (PHC) systems are the cornerstone of resilient health systems that can provide universal access to health, and lead to achievement of the Sustainable Development Goals (SDG 1-3). The seminal event for PHC came in 1977 with the Alma Ata declaration on PHC which focused on members states building primary healthcare systems, especially in countries with underdeveloped systems. In October 2018, 40 years after the Alma Ata declaration, the Global Conference on Primary Health Care brought together heads of state and heads of government to endorse a new declaration in Astana, Kazakhstan. The Astana Declaration adopted a wider scope with member states reaffirming their commitment to primary health care as a cornerstone of sustainable health systems for the achievement of universal health coverage and the health-related Sustainable Development Goals.

As initially outlined in the 1978 Declaration of Alma-Ata and reaffirmed again 40 years later (2018) in a joint WHO/UNICEF vision paper and guidance, primary health care is:

*“a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people’s needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people’s everyday environment”.*<sup>3</sup>

Based on 40 years of accumulated experience, this comprehensive definition integrates three key synergistic components:

- a. comprehensive integrated health services that cover primary care as well as referrals to secondary/tertiary care.
- b. multi-sectoral policies and actions to address the upstream and wider determinants of health and
- c. engaging and empowering individuals, families, and communities for increased social participation and enhanced self-reliance in health, including nutritional promotion and food supply.

The WHO-UNICEF “Operational Framework for Primary Health Care - Transforming Vision into Action” was published in 2020<sup>4</sup> and introduces a set of 14 levers (see Table 1) considered necessary to translate the global commitments made in the Declaration of Astana<sup>5</sup> into actions and interventions.

**Table 1: Levers of the WHO-UNICEF operational framework for primary health care**

<b>Core strategic levers</b>	
<i>Political commitment and leadership</i>	Political commitment and leadership that place PHC at the heart of efforts to achieve universal health coverage and recognize the broad contribution of PHC to the SDGs
<i>Governance and policy frameworks</i>	Governance structures, policy frameworks and regulations in support of PHC that build partnerships within and across sectors and promote community leadership and mutual accountability.
<i>Funding and allocation of resources</i>	Adequate funding for PHC that is mobilized and allocated to promote equity in access, to provide a platform and incentive environment to enable high-quality care and services and to minimize financial hardship.
<i>Engagement of community and other stakeholders</i>	Engagement of communities and other stakeholders from all sectors to define problems and solutions and prioritize actions through policy dialogue
<b>Operational levers</b>	
<i>Models of care</i>	Models of care that promote high-quality, people-centred primary care and essential public health functions as the core of integrated health services throughout the course of life.
<i>Primary health care workforce</i>	Adequate quantity, competency levels and distribution of a committed multidisciplinary primary health care workforce that includes facility-, outreach- and community-based health workers supported through effective management supervision and appropriate compensation
<i>Physical infrastructure</i>	Secure and accessible health facilities to provide effective services with reliable water, sanitation and waste disposal/ recycling, telecommunications connectivity and a power supply, as well as transport systems that can connect patients to other care providers.
<i>Medicines and other health products</i>	Availability and affordability of appropriate, safe, effective, high-quality medicines and other health products through transparent processes to improve health.
<i>Engagement with private sector providers</i>	Sound partnership between public and private sectors for the delivery of integrated health services.
<i>Purchasing and payment systems</i>	Purchasing and payment systems that foster a reorientation in models of care for the delivery of integrated health services with primary care and public health at the core.
<i>Digital technologies for health</i>	Use of digital technologies for health in ways that facilitate access to care and service delivery, improve effectiveness and efficiency, and promote accountability.
<i>Systems for improving the quality of care</i>	Systems at the local, subnational and national levels to continuously assess and improve the quality of integrated health services.
<i>Primary health care-oriented research</i>	Research and knowledge management, including dissemination of lessons learned, as well as the use of knowledge to accelerate the scale-up of successful strategies to strengthen PHC-oriented systems.
<i>Monitoring and evaluation</i>	Monitoring and evaluation through well-functioning health information systems that generate reliable data and support the use of information for improved decision-making and learning by local, national and global actors.

Lessons that consistently emerge from the COVID-19 pandemic point to the need for greater investment in stronger primary health-care systems to protect against future pandemics<sup>1,2</sup> Particularly, community health workers are noted as making a difference in establishing trust in government instructions, extending services, and in relaying scientific information. Their role includes further bolstering the health-peace link and relationship at the village and community level. Equity issues arise as women constitute almost 60% of the health workforce and front-line workers, though they were not seen as included in most COVID-19 response structures.

<sup>1</sup> The Independent panel for pandemic preparedness and response. May 2021. COVID 19: make it the last pandemic. World Health Organization.

<sup>2</sup> United Nations Children’s Fund Executive Board. Update on COVID-19 vaccination and the progress achieved through the COVID-19 Vaccine Delivery Partnership. First regular session 2023 7–10 February 2023 Item 6 (b) of the provisional agenda.

The pandemic also focused attention on the role of primary health care in responding to a pandemic or epidemic while also maintaining a continuity of service without straining the health systems. In this context, strengthening Primary Health Care (PHC) systems can positively impact COVID-19 response and recovery while also laying the foundational framework necessary for achieving Universal Health Care (UHC), thus preparing countries to address any other future anticipated health challenges. This holistic approach is critical for meeting commitments to the health-related Sustainable Development Goals (SDGs) by 2030, as UHC ensures that all individuals and communities receive the health services they need without suffering financial hardship, which is essential for comprehensive health coverage and the resilience of health systems<sup>3</sup>.

### Primary health care in UNICEF strategy

PHC strengthening was not clearly prioritized in UNICEF's Strategic Plan 2014-2017. More recently, and particularly since the 2018 Astana Declaration, UNICEF has given increasing attention and support to strengthening resilient PHC systems, and this shift can be seen in UNICEF's global strategies. Despite PHC not previously being prioritized, it is now explicitly described and prioritized in UNICEF's new corporate SP for 2022-2025, as follows:

*“To build sustainable results, the organization will focus on strengthening resilient primary health care systems – especially in fragile contexts – that deliver a package of services, supplies and support that holistically address health, nutrition, development, and well-being. Alongside maternal, newborn and child health and nutrition, including immunization and HIV/AIDS, this package will cover early childhood development, non-communicable diseases, mental health, sexual and reproductive health, violence and injury prevention, and environmental health.”*

Below the level of the corporate strategy, sector strategies (i.e., health, WASH, nutrition) consistently point to linkages with primary health care and how cross-sector linkages or multisectoral programming contribute to results across sectors.

In the **Health Strategy 2016-2023**<sup>4</sup>, primary health care was represented as underlying a priority programme area (i.e., 'maternal, newborn, child health') and labelled as a '*focus on equitable access to quality primary health care*'. Throughout the Strategy, a stronger and more consistent focus emerges around strengthening health systems, as one of three approaches contributing to its goals and vision. Primary health care is defined there, in part, as

*'An integral part both country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process'*.

Aligned with the Sustainable Development Goals, particularly Goal 3, the Strategy adopts a life-cycle approach, integrating health with nutrition, sanitation, and education. That Strategy also stresses the cross-sectoral linkages required to improve health outcomes and the role that the health system can play as a platform to deliver other interventions, including WASH, HIV, and nutrition. Reliance on other sectors, including supply (e.g., strengthen health supply chain systems, delivery of supplies in emergencies, support innovations and market shaping of products), water supply and sanitation; and for C4D, which addresses community engagement, demand generation, social accountability, and

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<sup>3</sup> UNICEF. Optimizing PHC from policy to practice.

<sup>4</sup> UNICEF Strategy for Health 2016-2030. Programme Division. August 2016.

social and behavior change. In further considering these linkages with other programme areas, the Health Strategy identified those programme linkages<sup>5</sup> underpinning the ‘focus on equitable access to quality primary health care’. In the table below, several of those linkages, specifically identifying, appear.

Table 2: Health Strategy (2016-2030), multi-sectoral linkages and primary health care

Among the programme linkages	Relation to PHC
<b>Early childhood development (ECD)</b>	<ul style="list-style-type: none"> <li>interventions and services as part of comprehensive antenatal, newborn and <a href="#">primary health care</a></li> </ul>
<b>WASH</b>	<ul style="list-style-type: none"> <li>Strengthen capacity of health facilities and delivery of WASH interventions and service through <a href="#">primary health care platforms</a></li> </ul>
<b>Nutrition</b>	<ul style="list-style-type: none"> <li>Maternal nutrition; exclusive breastfeeding; adequate under-5 nutrition are critical components of quality antenatal, newborn and young childcare</li> </ul>
<b>Social and behavior change [C4D (from 2016 document)]</b>	<ul style="list-style-type: none"> <li>Demand generation, social and behavior change, community engagements, social accountability</li> </ul>

The **Strategy for Water, Sanitation and Hygiene 2016-2030**<sup>6</sup> employs a life-cycle model to depict when and how WASH can contribute to key outcomes across the life-course of a child, and how education and health systems can help deliver wider public health outcomes in WASH. The Strategy identified the need to ‘do better’ in relation to working inter-sectorally.

WASH in institutions is a multi-sectoral approach and UNICEF priority aimed at improving access to WASH in schools and health care facilities (HCFs) as part of the SDG 6 agenda of universal access as well as in support of SDG targets relating to health, education, and gender equality. Regarding improved access in health care facilities, the WASH Strategy commits UNICEF to continue work with WHO and ministries of health to formulate, promote and support viable approaches for ensuring adequate WASH in HCFs with a focus on facilities providing maternal and newborn health services. UNICEF also contributes to the solarization of primary health facilities with activities prioritized across levels.

Most recently, these efforts are supported by Global Task Force on WASH in Health Care facilities and the Global Framework for Action guiding country action on WASH, electricity, and waste management in HCFs. Co-led by UNICEF and WHO, all partners to contribute to reporting on the new UNGA resolution that will result in a global report on action in 2025.

The **Nutrition Strategy 2020-2030**<sup>7</sup> also points to multi-sector, multi-system capacities as essential to achieving nutrition results. The Strategy names five systems, including health, that must be capacitated to deliver nutrition-specific interventions at every stage of life and support healthy growth and development. Needed health system investments include improving the nutrition knowledge and skills of primary health care workers and delivering services during pre- and postnatal health care contacts to prevent malnutrition (e.g., support for breastfeeding, complementary feeding, micronutrient supplementation, dietary counselling, and maternal nutrition).

The Nutrition Strategy recognizes that results achieved by other programmes contribute to realizing children’s right to nutrition by fostering an enabling environment in which children, adolescents and women benefit from diets, services and practices that protect, promote and support optimal nutrition.

<sup>5</sup> Figure 2. Programme areas span children’s life stages and are multi-sectoral, page 25.

<sup>6</sup> United Nations Children’s Fund. (UNICEF). Strategy for Water, Sanitation and Hygiene 2016-2030. Programme Division. August 2016.

<sup>7</sup> United Nations Children’s Fund. (UNICEF). Nutrition, for Every Child: UNICEF Nutrition Strategy 2020–2030. UNICEF, UNICEF, New York

The Strategy cites strengthening primary health care services for children and women as a contributor to improved pregnancy outcomes, including birthweight, and the prevention and treatment of infection in children and women. Utilization of the primary health care system appear throughout the Nutrition Strategy programmatic priorities including as:

- strengthening breastfeeding counselling and support services in primary health care through facility- and community-based programmes that include package of interventions for the prevention of all forms of undernutrition.
- improving the use of antenatal care contacts as opportunities to deliver nutrition counselling and services to pregnant women through the primary health care system.
- strengthening facility- and community-based capacities to provide the continuum of care for children with wasting.

All sector strategies observe the capacity and expertise that UNICEF has in education, health, nutrition, social policy, and other sectors and its access to key partner networks in these areas. Strategies assume continued use of UNICEF’s long-standing and extensive multi-sectoral capacity to contribute to the key sectoral priorities. For example, the WASH Strategy relies, in part, on UNICEF leadership roles in health and education to help ensure that WASH is institutionalized within these sectors.

UNICEF country offices have long supported Primary Health Care (PHC) strengthening, emphasizing the necessity of adapting operational strategies and technical advice to align with the specific needs and contexts of each country and region, thereby ensuring effective and sustainable PHC enhancement. Thus, the interpretation of PHC’s conceptual frameworks, approaches, institutionalization, in addition to technical advisory must be taken into consideration when examining the difference at the regional and country office levels. To describe these efforts, the Evaluation Office conducted preliminary analyses using internal performance data (SMQs/CSI) and natural language processing techniques to assess the breadth of application of the Operational Framework levers across UNICEF Country Offices.

Based on review of the Country Programme Documents (CPDs) active between 2018 and 2021, regions differed in their inclusion of PHC strengthening activities (Figure 1). With the East and Southern Africa region leading with three-quarters of all CPDs referencing PHC strengthening. In contrast, in the Latin America and Caribbean region, less than 20% of CPDs similarly made mention.

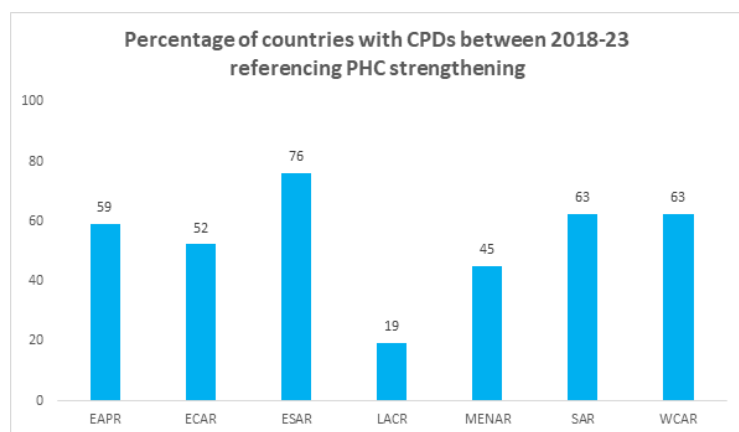


Figure 1

Analysis of the 2022 CSI data determined the percentage of UNICEF country offices (2021, 2022) in each region that reported to be advocating, contributing, or leading efforts in each of the 14 specific levers of PHC strengthening. Results are depicted in Annex 1, illustrated by a heat map.

According to the SMQ data, the South Asia and West and Central Africa regions have the highest number of countries that lead efforts in the majority of the levers. East Asia and the Pacific, Latin America and the Caribbean, and the Middle East and North Africa regions show less prioritization in

PHC strengthening as reported than other regions. These results are in line with what was observed in the analysis of Country Programme Documents as depicted in Figure 1.

Country Offices most frequently reported a role in supporting the PHC workforce. The levers least likely to be implemented by UNICEF Country Offices were engagement with private sector, purchasing payments, and PHC oriented research. Levers that have received relatively greater efforts from UNICEF country programmes were support for governance and policy frameworks, funding and allocation of resources, models of care, digital technologies, and systems for maintaining quality of care.

These figures reflect decades of UNICEF investment and programming to bring life-saving, cost effective interventions to children in developing countries – initially through the child survival and development focus of the 1980s-90s (e.g. focused on Growth monitoring, vitamin A supplementation ORS, Breastfeeding, Immunization) and subsequently, the MDG era (2000-2015) emphasized a decrease child and maternal mortality by scaling up coverage of high impact interventions, often delivered via vertical programs. Post pandemic, there is consensus on the need to prioritize community based primary health care, of which community health workers are key, as critical to achieving universal health coverage (SDG3).

In support of these priorities, a global initiative, the Community Health (CH) Roadmap was launched as an innovative collaboration between traditional multilateral and bilateral donors, private funders, and global health leaders<sup>8</sup> to better align existing resources and to attract new resources to community health and support countries in achieving their goals for PHC, UHC and SDG3. The roadmap works in close collaboration with respective ministries of health and country stakeholders across 15 focus countries to identify community health national investment priorities that strengthen primary health care. These needs and priorities become the basis for advocacy with partners and donors for greater investment.

In 2019, a Global Action Plan for Healthy Lives and Well-Being for All (SDG 3) was launched to achieve better coordination and reduce fragmentation in the global health landscape seen as impeding programme effectiveness and putting SDG achievement at risk. Thirteen agencies, including UNICEF, are signatory to the GAP which aims to leverage the agencies' individual mandates, comparative advantages, and capacity more effectively thereby supporting countries to accelerate progress on the health -related SDGs. The SDG3 GAP will undergo an independent evaluation in 2024.

Most recently (2023), UNICEF and its partners launched the Community Health Delivery Partnership with the aim to leverage new investments in community health workers (CHWs), as well as improve equitable access to PHC and aligned support. It does this by ensuring CHWs receive the salary, support, and supplies they need to deliver vital health and nutrition services. A key component of the strategy is investing in women, who make up 75 per cent of the community health workforce. Fair compensation for women frontline workers was identified as a serious problem<sup>9</sup>. By providing the community health care workforce with the right support, including equitable pay, quality education and training, and a safe working environment, important action is also taken to help to reduce gender inequality. Primary Health Care is the overarching strategy for UNICEF to contribute to the CHDP.

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<sup>8</sup> including USAID, the World Bank, the WHO, the Bill & Melinda Gates Foundation, The Rockefeller Foundation, UNICEF, and Office of the WHO Ambassador for Global Strategy

<sup>9</sup> UNICEF Executive Director Catherine Russell's remarks at the first regular session of the UNICEF Executive Board. As delivered. 06 February 2024.

## Evaluation Purpose, Objectives and Scope

### Purpose:

The evaluation of UNICEF work in Primary Health Care (PHC) will be undertaken with a dual purpose of learning and accountability. From a learning perspective, the evaluation aims to distill insights and best practices from programs and initiatives of UNICEF and its partners, shedding light on effective strategies for strengthening primary health systems. By examining outcomes against benchmarks and targets, *the evaluation holds UNICEF accountable for the resources invested, fostering transparency, and informing future decision-making.* The evaluation will gauge how UNICEF's initiatives have adapted to evolving environments, addressed emerging challenges, and capitalized on opportunities. With PHC explicitly prioritized in UNICEF's 2022-2025 strategic goals, the evaluation could be instrumental in facilitating necessary adjustments.

### Objectives:

The main objectives of this evaluation are:

1. *To assess UNICEF's support for PHC vis-a-vis governments, other partners, and beneficiaries, and how that support aligns with PHC vision and priorities.* The evaluation will examine patterns in UNICEF's approach to PHC, factors that have influenced it, and its role vis-a-vis other partners, as well as its service outcomes at population level.
2. *Using WHO-UNICEF operational guidance, the evaluation will assess UNICEF's relevance, effectiveness and impact regarding strategies, investments, and activities across key strategic and operational levers.* The evaluation will identify lessons learned, key barriers and challenges that impede UNICEF's contribution to results for children.
3. *To assess the performance of UNICEF's work in support of strengthening PHC across countries.* Using standards in performance measures for PHC systems, the evaluation seeks to evaluate the achievement of stated objectives and targets and informing future planning and decision-making. The goal is to gain insights that inform evidence-based decision-making and improve future interventions in primary health care strengthening.

### Scope:

The key aspects of the evaluation scope are summarized below:

Table 3: Summary of Scope

<b>Geographical Scope:</b>	The evaluation will cover UNICEF's support for Primary Health Care (PHC) in programme countries with country deep dives focused on specific PHC strategic and operational levers. The intent would be to include countries from each of the 7 UNICEF regions.
<b>Time Frame:</b>	Broadly, the evaluation will cover the period from 2018 to the present. The period 2018-2021 will be examined for the purposes of context and stage-setting. The period 2022-2023 and present will examine, in a formative manner, changes in UNICEF's prioritization and approach to PHC.
<b>Thematic Focus:</b>	Per the UNICEF Strategic Plan, PHC is seen, in part, as an integrated package of services which includes maternal, newborn and child health and nutrition, immunization and HIV/AIDS and that will also cover early childhood development, non-communicable diseases, mental

	health, sexual and reproductive health, violence and injury prevention, and environmental health. Thematically, this evaluation will broadly use the WHO-UNICEF Operational Framework and will selectively focus on specific strategic and operational levers for deep dives studies.
<b>Settings</b>	Reflective of the settings where UNICEF works, the evaluation will cover development programming and humanitarian and fragile settings.

The primary audience for the evaluation is the UNICEF Programme Group, notably Health, WASH and Nutrition sections and networks, and the Regional and Country Office health teams. Audiences will be considered more specifically as part of stakeholder mapping. It will provide valuable insights to all partners involved in accelerating progress towards the SDG 3 goals and targets.

**Evaluation criteria and questions**

The evaluation is guided by issues identified during scoping which are reflected throughout the key evaluation questions. OECD/DAC evaluation criteria are adapted, applied, and integrated into lines of inquiry as highlighted below. Evaluation criteria to be used in this evaluation are relevance, coherence, efficiency, effectiveness, sustainability, and scale; evidence generation and use<sup>10</sup>.

Consistent with UNICEF’s strategic intent – to strengthen delivery of a package of services, supplies and support that holistically address health, nutrition, development, and well-being - the evaluation adopts a comprehensive and multi-sector approach, focusing on an integrated assessment of sectors and programs encompassing nutrition, water and sanitation, and health. Consequently, the following evaluation questions are designed to assess multi-sectoral approaches, individual programmatic sectors implemented (e.g., WASH in health care facilities) and their junctures with primary health care system.

**Key Evaluation Questions**

The following evaluation criteria and questions apply:

Relevance: UNICEF contributions to primary health care are responsiveness to the needs of key stakeholders with focus on vulnerable and excluded groups, an understanding of context and adaptation as needed to changing contexts and conditions.

- To what extent does UNICEF engage with host country governments to focus and prioritize its work in the area of primary healthcare?
- To what extent are UNICEF-supported efforts to strengthen primary health care aligned with country-defined needs and priorities?
- To what extent do UNICEF efforts focus on priority gaps and address the needs of vulnerable populations? How well have gender, disability, age, AAP and human rights standards and commitments been integrated into primary health care programmes?
- To what extent and how are the specific needs and challenges of fragile and emergency contexts addressed, where relevant? To what extent do UNICEF-supported primary health

<sup>10</sup> OECD (2021), Applying Evaluation Criteria Thoughtfully, OECD Publishing, Paris, <https://doi.org/10.1787/543e84ed-en>

care programmes address the humanitarian/development/peace nexus? What were the facilitators, drivers, and barriers?

Coherence: UNICEF engages in strategic partnerships around primary health care and works effectively with partners through coordination and synergized implementation.

- What are the different types of stakeholders and partnerships that UNICEF country offices engage with to strengthen PHC (govts, DPs, CS, private sector)?
- How coherent are UNICEF global strategies, plans and actions within the wider partner landscape for primary health care strengthening?
- To what extent does UNICEF's role and position at the global, regional, and country level in primary health care reflect its comparative advantage?
- What partnership modalities have been most constructive? What is going well? What is not going well? What lessons can be learned? What are opportunities for improvement?

Efficiency: UNICEF utilizes resources (human and financial) to generate results in primary health care in an economic and timely way.

- Does UNICEF convert its resources, available across levels, into results at output and outcome levels?
- To what extent does UNICEF have the right people, systems, financing and structures in place to effectively strengthen PHC across settings?
- To what extent do current arrangements (people, systems, financing, structures) position UNICEF to use its comparative advantages in strengthening PHC?
- To what extent is UNICEF's staff capacity adequate for providing leadership, advocacy, and technical guidance/support for PHC at various levels? What factors drive or constrain effective performance?
- How clear and well-aligned are multi-sectoral program activities amongst different divisions and offices within UNICEF? How well have HQ and ROs supported country offices?
- How adequate is UNICEF's internal coordination including integration and convergence of sectoral program components and sectors (e.g., social protection)?
- To what extent have UNICEF Country Offices included efforts to strengthen PHC in their CPDs and agreements?
- To what extent does UNICEF multi-sectoral planning and programming guidance support the organization's prioritization of PHC strengthening?
- What needs to be done to address gaps, if any, in staff/institutional capacity to achieve goals that UNICEF has set to strengthen primary health care?

Effectiveness: UNICEF actions to strengthen primary health care achieve its objectives and results in measurable change for vulnerable and at-risk populations.

- How effective are UNICEF country multi-sectoral programs in achieving intended results in PHC? Which strategies and interventions have been used effectively by UNICEF to strengthen PHC in various contexts?
- To what extent do contextual factors affect multi-sectoral program effectiveness in UNICEF supported PHC programmes? What are the key factors and conditions associated with

program effectiveness? What lessons can be drawn for strengthening UNICEF's strategies and plans for PHC?

- What have been the main successes and areas for improvement in the topics (levers) specified for deep dives (i.e., engaging communities and stakeholders, PHC workforce, infrastructure, quality of care, etc.)?

Sustainability and scale: UNICEF actions to strengthen primary health care generate tangible benefits that continue, or are likely, to continue.

- To what extent have sustainability considerations (technical, financial, institutional) been integrated in PHC program design and implementation phases by UNICEF and its counterparts?
- How adequate is UNICEF's approach and contribution to effectively support scale-up of proven PHC approaches?
- To what extent are results sustainable or likely to be sustained?
- To what extent and what ways did UNICEF contribute to strengthen community systems and community engagement to strengthen PHC and improve resilience?
- To what extent did UNICEF support local ownership and local capacity development?
- Are there any risks related to the sustainability of gains achieved in PHC strengthening in various contexts that UNICEF must address?

Evidence generation and use: UNICEF generates and utilizes evidence, from a variety of sources and methods, to inform on progress and needed course corrections.

- How adequately has UNICEF monitored and evaluated its contributions to PHC?
- How adequate are monitoring and accountability mechanisms to inform program managers on the effects of programs on marginalized groups?
- To what extent does the use of data, implementation research and evaluation contribute to decision-making at global, regional, and country levels? How could evidence-based action be strengthened?
- To what extent is implementation research utilized as a test approach or correct course? What factors promote or hinder the use of operations/implementation research to support PHC programming?
- To what extent has UNICEF contributed to and made effective use of the global evidence base on PHC?

### Evaluation approach and methods

The evaluation will employ a mixed-methods approach, combining qualitative and quantitative methods. Data will be collected through document reviews, interviews, and quantitative data analysis (secondary, survey, internal monitoring) to ensure a comprehensive assessment.

The evaluation will use a mix of qualitative and quantitative methods to answer the proposed evaluation questions. *Qualitative methods* will provide the evaluation with insight into roles that UNICEF played, and key influencing factors in varied contexts and from differing perspectives. *Quantitative methods* will help to unpack and assess UNICEF's operations and associated changes

or trends in results. *Deep Dive Case studies* (See Section 8 for more details) will use a mix of qualitative and quantitative methods to maximize the depth of insights into the evaluation questions, provide a comprehensive and granular picture of the actions of UNICEF and partners and their effects, and extract lessons that can be applied more broadly to programming. The proposed methods are detailed below and will be finalized during the inception period. An evaluation matrix will map each method to the relevant evaluation question.

UNICEF's internal monitoring data includes information on expenditures, strategic level indicators as well as outcomes and outputs. We have conducted a mapping exercise to identify indicators that are relevant to PHC strengthening (Appendix 1). Analysis of these variables can partially answer questions related to UNICEF's activities on different levers of PHC strengthening. Qualitative analysis of country-level annual progress reports, statements of progress, and select evaluation reports can also provide insights into UNICEF's activities, progress, as well as barriers in terms of PHC strengthening.

### Inception Phase

During the inception period, a detailed evaluation methodology including an evaluation framework will be developed based on consultation, document review and exploration of possible approaches that will yield credible and timely evidence. **The geographical scope of the different analyses (case studies, quantitative and qualitative analysis) will also be finalized through these deliberations and review.** The inception report will include an evaluation framework and matrix as well as detailed methodology, draft evaluation toolkit and outlines for evaluation products. More specifically, the Inception Report should:

- Present the overarching Theory of Change that will be used to guide the evaluation.
- Present the final set of evaluation questions and sub-questions within the proposed scope of the evaluation.
- Conduct a stakeholder analysis to define priorities for key informant interviews.
- Specify the design of the evaluation, including tools that will be used for data collection and the analytical methods used to respond to the evaluation questions.
- Identify data sources (secondary, internal monitoring, operational) that will be used as part of the methodological design of the evaluation.
- Examine and ensure the availability of any data proposed for analysis.
- Detail the framework for analyzing and synthesizing data collected from various sources including use of triangulation.
- Present a detailed work plan, specifying the responsibilities, organization and time schedule for the evaluation process including country visits, analysis and report preparation.
- Present the approach to be used for quality assurance throughout the evaluation.

### Desk review: UNICEF documents and internal and external data sources

A document repository has been created for the purposes of the evaluation and access will be shared with the evaluation team during the inception phase. This repository will include all relevant UNICEF internal data, such as country office annual reports, country program documents, financial expenditure data, and country progress monitoring data. The information shared will be reviewed and analysed (as much as possible) during the inception phase to determine the need for additional information and to

finalize a detailed evaluation plan. It is expected that document review will use structured tools and templates for compilation and analysis. Applications of data science may be appropriate to examine and analyze available documentation, particularly to gather insights from the large number of internal reports and documents. The UNICEF Evaluation Office has engaged in the application of data science methods for analyzing internal documents in previous evaluations. Relevant code and other technical resources can be provided if needed. Below is a list of the different documents and data sets (not exhaustive) that will be shared during the desk review phase:

- UNICEF Strategy Documents in WASH, Health, and Nutrition
- UNICEF Evaluation and Research Reports
- Annual activities and progress reporting in both narrative (e.g., Country Office Annual Reports, Results Assessments Module, reports to UNICEF Executive Board) and quantitative forms (e.g., results reporting for outputs and outcome indicators)
- Annual expenditure data
- Performance indicators in WASH, Health, and Nutrition
- For selected countries: national development plans, evaluation, research, and studies conducted by government and partners, health management information systems.
- Independent reporting mechanisms and other external databases where needed.

In addition to reviewing the provided internal documents and data, the desk review phase will include a thorough review of existing national or global secondary quantitative datasets relevant to PHC strengthening. This will be key to identifying specific evaluation questions, if any, that will be answered via quantitative analysis. For example, country level data from the [Vital Signs Profile](#), a WHO-UNICEF initiative can be useful in examining country-level trends in terms of performances on PHC levers at the country level. The evaluation will include a secondary analysis of such relevant, available information to specifically address and answer evaluation questions. Where applicable, the identified secondary data and analysis should be integrated with UNICEF internal data on activities, performance, and expenditure, to generate comprehensive and critical insights. Teams should be prepared to examine these data sources thoroughly during inception, identify their potential use against evaluation questions; and be capacitated to conduct secondary data analysis during implementation.

### Key informant Interviews

Key informant interviews (KII) constitute an important evidence-generating tool for this evaluation. Interviews will allow for in-depth examination of perceptions, relationships, context and key contributing factors among UNICEF and key partners at all levels (global, regional, and country). The KII process will be informed by a stakeholder mapping conducted during the inception phase. During the inception phase, key staff from HQ divisions, Regional Offices (ROs) and select Country Offices (COs) and a few external experts and stakeholders will be interviewed for orientation.

During implementation, semi-structured interviews conducted remotely or in-person with internal and external stakeholders at the global, regional, and country level, including program specialists. The deep dive case studies will require KIIs among UNICEF staff in the Country Office, government

counterparts, partner agencies, implementing partners, front-line and community-based health workers, CSOs, academics, and others, where appropriate.

### Country visits, field observation and focus group discussions

It is anticipated that field visits to countries will be required to fully address the evaluation questions and criteria. The evaluation team will gather quantitative and qualitative information through field visits and focus group discussions during country visits. Interviews and/or focus group discussions will be held with selected partners, decision/policy makers, managers and service providers as guided by the stakeholder mapping conducted during inception.

The evaluation will require field visits within countries, which should be guided by tools (e.g., observation and use of checklists) and consider use of remote and electronic means of reaching intended respondents (e.g., front-line health workers) through e-surveys or polls. When organising field visits and interviews, attention will be given to ensure gender balance and representation of all population groups.

A selection of countries for a series of deep dive case studies will be initiated before the inception phase (See below Section 6.5 for details). Preliminary analyses of countries vis-a-vis strategic and operational indicators will be conducted to determine eligibility criteria for selection, in addition to other factors (e.g., expenditures, programming profile, performance, regional distribution) which will require liaising and coordination between HQ, regional and country offices. This methodology for these deep dives as detailed below, ensures a focused investigation into areas critical for enhancing PHC systems. This approach allows for the more in-depth investigation of multi-sectoral programming effects, including nutrition, water and sanitation, and community engagement, thereby offering actionable insights to improve health services for vulnerable populations.

### Deep Dive Case Studies

Multi-country deep dive case studies on UNICEF's programming are crucial to comprehensively understand the impact on the quality and coverage of primary health care (PHC) services and facilities. These detailed investigations enable the identification of specific mechanisms through which these programs influence PHC outcomes, shedding light on best practices, challenges, and areas for improvement. By closely examining the integration and effectiveness of these interventions, stakeholders can derive actionable insights to enhance PHC systems, ensuring more equitable and effective health services for vulnerable populations. The selection of the deep dives will be conducted through consultation with UNICEF program colleagues for integration into the inception phase and report.

The methodology for such deep dives in a case study structure will focus on selected areas of programming, covering the multi-sectoral nature of UNICEF work (e.g., nutrition, water and sanitation, community engagement programs) relative to primary health care quality and coverage. The deep dives are designed to provide in-depth insights into how these interventions influence health outcomes. It will involve a thorough, structured investigation into the operational challenges and successes of

UNICEF's initiatives, aiming to uncover the mechanisms behind their impact on PHC systems. This approach starts with the careful selection of cases from diverse geographic locations where UNICEF's programs have been notably integrated with PHC systems, considering the intensity of interventions and the variability in PHC infrastructure to ensure a comprehensive analysis across different contexts. Country deep dives will also evaluate how Primary Health Care (PHC) work is orchestrated across different country office (CO) settings, considering factors such as relative financial investments, the adoption of PHC as an operational framework in their Country Programme Documents (CPD).

A selection of Strategic and Operational Levers will guide the deep dive. Currently it is proposed that five deep dives are conducted which would address the following:

- Of the *Strategic Levers*, deep dive on engagement on community and other stakeholders<sup>11</sup> and a second deep dive on either funding and allocation of resources or governance and policy frameworks.
- Of the *Operational Levers*, deep dives on primary health care workforce and physical infrastructure (specifically regarding WASH and solarization in health care facilities), and either systems for improving the quality of care or digital technologies for health.

Deep dives will be guided by embedded theories of change developed to conceptualize the expected influence of multi-sectoral programming on indicators of PHC quality and coverage. These frameworks are intended to serve as a guide, identifying the key components of program implementation—from inputs and activities to outputs and outcomes—within the PHC context. Underlying assumptions will also be detailed and tested. Data collection will employ a mixed-methods strategy, combining qualitative insights from interviews and focus groups with quantitative data from UNICEF internal program monitoring data.

Data analysis integrates thematic analysis of qualitative data and statistical analysis of quantitative data, identifying patterns and themes that explain the programs' effects on PHC. This comprehensive analysis will construct a detailed understanding of how and why UNICEF's programming influences health outcomes. The findings will be synthesized into detailed case study reports that narrate the programs' stories, from their design and implementation to their impacts and challenges. These reports are structured around the conceptual frameworks, providing a contextualized account of each program's interaction with PHC systems, and highlighting comparative lessons, effective strategies, and areas for improvement. Finally, the dissemination and application of the deep dives through briefs and presentations are intended to inform policy recommendations and guide UNICEF program improvements.

These deep dive country case studies are estimated to require a core team member in-country for at least seven days accompanied with a UNICEF evaluation staff member. Country visits should be

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<sup>11</sup> Check Evaluation for SBC for content.

guided by a protocol which will be shared with the UNICEF Country Office to ensure productivity of the visits, accompanied with a list of identified key informants.

### Use of questionnaire-based surveys

It is expected that some of the data required for the evaluation will be gathered through use of electronic web-based survey. Given the breadth of UNICEF programming across countries and sectors, scope and timing of the survey will be determined during the inception phase. The evaluation team is expected to have demonstrable experience with electronic survey tools for yielding credible data under time and budget constraints. Time for required ethical review of data collection tools and instruments should be considered.

### Data analysis

Data analysis will proceed with consolidation of information drawn from each method through use of an evidence matrix which also serves for triangulation. Triangulation both across and within categories of data sources will be a key analytical technique for this evaluation – for example, the results of the online surveys and selected program, operational and monitoring data will be compared and triangulated with the opinions and experiences related by key informants in the field case studies. UNICEF welcomes the use of diverse and innovative evaluation methods, and this will be considered in the selection of evaluation proposals. This said, the following methods of data analysis and synthesis are encouraged to be used:

- Qualitative analysis of key-informant interviews- identifying themes and key insights
- Descriptive analysis of available quantitative data (external) relevant to PHC levers and outputs, to examine trends across time and geography.
- Descriptive analysis of quantitative data on UNICEF's performance related to PHC strengthening (this will involve identification of relevant outputs and outcome indicators from UNICEF's results framework, prior to analyzing the data).
- Descriptive analysis of UNICEF expenditure data relevant to PHC strengthening.
- Qualitative analysis of UNICEF internal monitoring data on performance (narratives and reports), either using traditional qualitative methods or data science methods.
- The separate analytical components will be triangulated and/or integrated to produce comprehensive answers to our evaluation questions. The inception paper will detail the analysis plan for each method and the overall approach to the triangulation and synthesis.

### Methodological limitations

Given the wide geographical and thematic scope of this evaluation, we anticipate few limitations with the methodological approaches. The team should provide, to the extent possible, a detailed list of potential limitations and during the inception phase. At the same time, efforts should be made to address methodological challenges using innovative approaches. For example, we recognize that the expected analysis will involve the reviewing and assessment of a large amount of quantitative as well

as qualitative text data. Particularly for qualitative/text data, traditional analytical methods might be limiting, with regards to high resource requirements. To address this, we encourage the use of relevant and robust data science methods (natural language processing) that can allow for quick processing and analysis of vast amounts of text data. Where applicable, semantic search methods, or more advanced machine learning methods can be used to analyze reports and performance narratives.

## Ethical considerations

The guidance documents mentioned below are those that the evaluation (team) is expected to comply with:

- United Nations Evaluation Group (UNEG), Norms and Standards for Evaluation in the UN System 2016<sup>12</sup> (including impartiality, independence, quality, transparency, consultative process).
- Ethical Guidelines for UN Evaluations.<sup>13</sup>
- UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis.<sup>14</sup>

The evaluation should incorporate the human rights-based approaches and gender perspectives.

Country level work is not expected to involve data collection from vulnerable children and community members. Nonetheless, consistent with United Nations Evaluation Group (UNEG) norms and standards, the UNEG Ethical Guidelines and UNEG Code of Conduct and the UNICEF Procedure on Ethical Standards in Research, Evaluation and Data Collection and Analysis, the evaluation will ensure:

- Respect for rights of individuals and institutions: The evaluation team will accord informants the opportunity to participate voluntarily while maintaining their anonymity, and to make an independent decision to participate without pressure or fear of penalty (informed consent/assent). Also, interviewers will assure respondents that information would be confidential, and that reports would be written such that responses/contributions would not be traced back to them. Interview notes and any recordings will be accessible to the team members only.
- Respect for cultural identities and sensitivities: Variances in ethnicities, culture, religious beliefs, gender, disability, age will be respected. As a result, evaluation processes will be mindful of cultural settings, developmental status and evolving capacities/ages of children and other stakeholders, and the needs of the respondents and rights-holders that programmes are supposed to serve.
- Professional responsibilities and obligations of evaluators: The evaluation team will exercise independent judgement and operate in an impartial and unbiased manner. During data collection, any sensitive issues and concerns will be addressed through the appropriate mechanisms and

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<sup>12</sup> UNEG, *Norms and Standards for Evaluation*, 2016. Available at: <http://www.unevaluation.org/document/detail/1914>

<sup>13</sup> UNEG, *Ethical Guidelines*, 2008. Available at: <http://www.unevaluation.org/document/detail/102>

<sup>14</sup> UNICEF, *Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis*, 2021, [Branded Procedure Template \(unicef.org\)](https://www.unicef.org/branded-procedure-template)

referral pathways. A protection protocol will be in place for each setting where data collection involves children and community members.

Per Evaluation Office standard procedure, the evaluation design will undergo a third-party ethical review during the inception phase. The possibility of seeking in-country approval by the competent national authorities will be studied.

## Evaluation management structure

The evaluation will be conducted by an external evaluation team to be recruited by UNICEF's Evaluation Office (EO) through the (LTA/evaluation). The evaluation will be managed by the Evaluation Office, UNICEF New York HQ. Direct supervision is provided by an Evaluation Specialist at the EO supported by a Senior Evaluation Specialist. The Evaluation Office will be responsible for the day-to-day oversight and management of the evaluation and for management of the evaluation budget. It will assure the quality and independence of the evaluation and guarantee its alignment with UNEG Norms and Standards and Ethical Guidelines, provide quality assurance checking that the evaluation findings and conclusions are relevant, and recommendations are implementable, and contribute to the dissemination of the evaluation findings and follow-up on the management response.

The evaluation manager is the primary interface between the Evaluation Office and the evaluation team. The manager role involves day-to-day support to all aspects of the evaluation process, including facilitating access to data, providing input to key methodological and strategic choices, and managing the evaluation budget. The evaluation manager may participate in key informant interviews and other activities during implementation. The evaluation manager provides a first quality review (i.e., zero draft) of all evaluation tools and deliverables presented by the evaluation team before key deliverables are shared with the Evaluation Reference Group or other stakeholders.

Staff of the UNICEF Evaluation Office are independent from UNICEF management and operations. As part of their guidance and quality assurance role, Evaluation Office will provide quality assurance on all evaluation tools and documents based on the (United Nations Evaluation Group) UNEG's and UNICEF's norms, standards, ethical guidelines, processes, and tools. This includes assessment of gender, equity, and human rights responsiveness of the evaluation. The evaluation team will be familiarized with these and is expected to observe them during the entire evaluation process.

As a guide to quality assurance expectations, the selected firm will conduct the first level of quality assurance of all evaluation deliverables (including drafts) prior to submission to the evaluation manager. The second level of quality assurance of the evaluation deliverables will be conducted by the evaluation manager, UNICEF Evaluation Office ('zero draft'). This review proceeds the submission of deliverables for to any advisory group. The third level of quality assurance of the evaluation report will be conducted by the evaluation reference group (draft). Once approved, the final evaluation report will be submitted to the UNICEF's global evaluation reports oversight system for an independent quality review. The report and the review will be made publicly available.

An Evaluation Reference Group will be created to serve as an advisory organ for the evaluation. These Reference Groups bring together a mix of UNICEF managers, advisors, and external experts from among the key stakeholders. Members will provide substantive technical inputs, will facilitate access to documents and informants, and will ensure the high technical quality of the evaluation products as



mid-level staff with experience in the areas of data collection both qualitative and quantitative, data handling and management and analytical methods. The team is expected to be balanced in terms of gender and geographic origin.

Team Leader credentials:

- Strong team leadership and management track record (at least 10 years) and commitment to delivering timely and high-quality evaluation products.
- Extensive evaluation expertise (at least 10 years) with strong mixed-methods evaluation skills.
- Background in public health, or other relevant discipline, including sound knowledge of public health and policy; familiarity with other sectors, namely WASH, nutrition, health systems or community systems will be an asset.
- Familiarity with specific aspects of UNICEF work to strengthen primary health care, health systems strengthening and/or community-based health systems.
- Knowledge of the UN's human rights, gender equality and equity agendas and experience in applying these to evaluation.
- Demonstrated ability to manage remote teams and keep assignments on-track and delivered timely.
- Excellent interpersonal and communication skills; ability to interact with various stakeholders and to concisely express ideas and concepts in written and oral form.
- Language proficiency: Fluency in English is mandatory; good command of French is desirable.

Senior team member credentials:

- Extensive experience (of at least 10 years) in evaluation and/or policy research with mixed-methods including but not limited to formative evaluations, theory-based evaluations, and comparative case studies.
- Subject matter expertise (of at least 10 years) in areas pertinent to UNICEF work in the area of primary health care, health systems strengthening, community-based health systems.
- In-depth understanding of current issues in countries' implementation of primary health care; priorities and programs; and of the partner landscape.
- Excellent analytical and quick problem-solving skills, along with exceptional writing and communication abilities to manage complex ideas and competing stakeholder expectations in multiple projects.
- Hands-on experience in collecting and analyzing quantitative and qualitative data.
- Knowledge of the UN's human rights, gender equality and equity agendas and application in evaluation.
- Commitment and willingness to work in a challenging environment and ability to produce quality work under limited guidance and supervision.
- Good communication and people skills; ability to communicate with various stakeholders and to express ideas and concepts concisely and clearly in written and oral form.
- Language proficiency: Fluency in English is mandatory; good command of French and/or Spanish is required across the team.

Junior evaluator/researcher:

- At least 3 years of progressively responsible experience in both qualitative and quantitative data analysis.
- Experience in supporting senior evaluators in ensuring use of consistent interview protocols, templates for recording and reporting on interviews, standard case study report formats and a comparative table of findings.
- Strong quantitative skills and experience with analysis of varied forms of data
- Familiarity with issues regarding primary health care.
- At least 3 years of experience in knowledge management for evaluation, information technology and data management.
- Expertise in handling collaborate teamwork software, online surveys, document repositories, bibliography software and databases.

While bidders may propose their own combination of team profiles /experts to carry out the proposed work, an illustration of LOE distribution across these team profiles/categories is included below.

*Table 6: Illustrative allocation of level of effort across phases*

	Inception	Data collection (KIs/doc. review)	Country visits	Analysis	Prelimin. Findings	Report/ Finalize	Total
Team Leader	4	13	10	10	8	20	65
Senior Expert (s)	10	39	20	20	11	31	131
Evaluation Specialist (s)	4	15	10	10	4	4	47
Junior Evaluator/Researcher	4	15	10	10	4	4	47
In-country evaluators	-	--	75	10	--	--	85
Back-office support (including quality control)	3	--	3	--	2	2	10
<b>Total</b>	<b>25</b>	<b>82</b>	<b>128</b>	<b>60</b>	<b>29</b>	<b>61</b>	<b>387</b>

## Approvals

**Prepared by:**



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Uyen Kim Huynh  
Innovation Specialist  
Date: 7 April 2024

**Endorsed by:**



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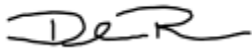
Beth Plowman  
Senior Evaluation Specialist  
Date: 09 April 2024

**Approved by:**

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Robert McCouch  
Director of Evaluation  
Date: April 2024

**Reviewed by:**



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Dalma Rivero  
Operations Officer  
Date: April 2024

Annex 1: Analysis of UNICEF countries reported to be contributing, or leading efforts in the specific levers of PHC Strengthening data (2021-2022): Regional Comparisons (Data as reported by COs for SMQs/CSIs)

	# of countries	Governance and policy framework		Funding and allocation of resources		Engagement of community and other stakeholders		Models of PHC care		PHC Workforce		Physical Infrastructure		Medicines and Health Products		Engagement with private sector		Purchasing payments		Digital technologies		Systems for quality care		PHC oriented research		Monitoring and evaluation	
		2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022
EAPR	27	37.0	40.7	40.7	51.9	29.6	48.1	44.4	48.1	44.4	55.6	59.3	66.7	85.2	85.2	18.5	29.6	25.9	37.0	44.4	55.6	40.7	51.9	29.6	40.7	48.1	55.6
ECAR	21	66.7	85.7	61.9	95.2	57.1	90.5	76.2	100.0	76.2	100.0	57.1	71.4	57.1	57.1	28.6	28.6	42.9	42.9	76.2	90.5	66.7	85.7	66.7	52.4	71.4	76.2
ESAR	21	90.5	100.0	90.5	100.0	90.5	90.5	90.5	95.2	90.5	100.0	85.7	85.7	81.0	90.5	76.2	71.4	71.4	81.0	90.5	100.0	90.5	95.2	90.5	85.7	90.5	85.7
LACR	36	38.9	63.9	38.9	58.3	38.9	61.1	41.7	52.8	41.7	61.1	50.0	38.9	36.1	47.2	30.6	41.7	16.7	16.7	38.9	50.0	38.9	52.8	36.1	41.7	33.3	55.6
MENAR	20	60.0	75.0	65.0	60.0	35.0	65.0	55.0	75.0	50.0	70.0	60.0	70.0	60.0	65.0	35.0	45.0	50.0	50.0	65.0	80.0	50.0	75.0	50.0	65.0	60.0	70.0
SAR	8	100.0	100.0	100.0	100.0	87.5	100.0	100.0	100.0	100.0	100.0	100.0	87.5	87.5	87.5	62.5	87.5	75.0	75.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
WCAR	24	91.7	95.8	87.5	95.8	83.3	95.8	87.5	95.8	91.7	95.8	95.8	83.3	91.7	95.8	66.7	70.8	58.3	79.2	83.3	91.7	83.3	95.8	87.5	79.2	91.7	91.7
Overall	157	63.1	75.8	63.1	75.8	55.4	74.5	65.0	75.8	65.0	79.0	68.2	67.5	67.5	72.6	42.0	49.0	42.7	49.0	65.0	75.8	61.1	74.5	59.2	60.5	64.3	72.0

Red represents a lower % of countries focusing on the specific levers, while green represents higher % of countries (gradient color scale).

