

EVALUATION OF A NATIONAL HEALTH PROGRAMME AT THE PRIMARY CARE LEVEL

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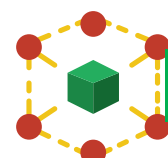
Abstract

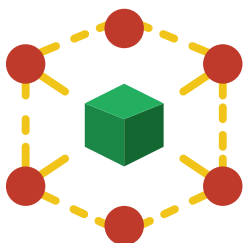
National health programmes are often judged by whether planned activities were completed, yet effective evaluation at the primary care level requires a broader view. Primary care is where many national policies become real services: vaccination, maternal and child health, screening, infectious disease control, chronic disease management, health education and referral. This narrative review explains how a national health programme can be evaluated at this level using a practical framework that connects resources and implementation processes with service coverage, quality, equity, continuity and health outcomes. The review emphasizes the value of mixed methods because routine statistics can show what happened, while interviews, observation and community feedback help explain why it happened. Key evaluation dimensions include relevance, effectiveness, efficiency, quality, accessibility, equity, sustainability and resilience. WHO and UNICEF's primary health care measurement framework provides a useful basis for selecting context-appropriate indicators across inputs, processes, outputs, outcomes and impact. A good evaluation should not simply produce a score; it should help frontline teams identify gaps, learn from local strengths and make practical changes. The article concludes that programme evaluation is most useful when it is continuous, participatory and linked to decision-making rather than treated as an end-of-project exercise.

Keywords

Primary health care; national health programme; programme evaluation; monitoring; health indicators; quality of care; equity; health systems; universal health coverage; community participation

1. Introduction





National health programmes are designed to translate public-health priorities into organized action. They may focus on immunization, tuberculosis control, maternal health, nutrition, noncommunicable diseases, school health, mental health or other priorities. However, the success of a national programme is rarely determined at the national headquarters alone. It is experienced at health centres, outreach sessions, community clinics and referral points where people meet the health system.

Primary care therefore provides a particularly important level for evaluation. It shows whether a programme is reaching the intended population, whether services are available and acceptable, whether providers have the resources to deliver them, and whether people actually benefit. WHO and UNICEF describe primary health care as a broad approach combining integrated health services, multisectoral action and empowered people and communities, with quality, equity and resilience considered across the measurement framework. [1,2]

Evaluation is different from routine monitoring. Monitoring asks whether activities and indicators are moving as expected. Evaluation asks the deeper questions: Was the programme relevant? Did it work? For whom did it work? What helped or hindered implementation? Was it efficient and sustainable? A strong primary-care evaluation brings these questions together and turns findings into decisions.

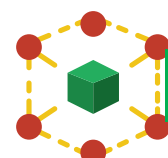
2. What Does Programme Evaluation Mean at Primary Care Level?

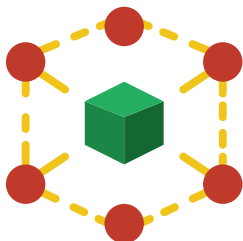
Programme evaluation is a systematic process of judging the value, implementation and results of an intervention. At primary care level, the unit of analysis may be a clinic, health centre, catchment population, district or network of facilities. The evaluator can examine both programme performance and the local context in which performance occurs.

A useful evaluation follows a results chain: resources are provided, activities are implemented, services are produced, people use those services, and health outcomes change. Importantly, the chain is not automatic. Staffing shortages, medicine stock-outs, transport barriers, workload, social norms, financing and community trust can interrupt the pathway. Evaluation should therefore examine both results and the mechanisms behind them.

Table 1. Core dimensions for evaluating a national programme at primary care level

Dimension	Main question	Examples of evidence
Relevance	Does the programme address important local needs?	Burden of disease, community priorities, policy objectives



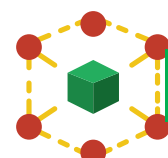


Effectiveness	Is the programme achieving intended results?	Coverage, treatment success, disease control, outcome trends
Efficiency	Are resources being used well?	Cost per service, staff time, wastage, productivity
Quality	Are services safe, appropriate and people-centred?	Clinical standards, waiting time, continuity, patient experience
Equity	Who is reached and who is left behind?	Disaggregated coverage by sex, age, income, geography or vulnerability
Sustainability	Can benefits continue over time?	Financing, workforce, local ownership, supply systems
Resilience	Can services continue during shocks?	Service continuity during outbreaks, disasters or supply disruption

3. Building an Evaluation Framework

WHO's primary health care measurement framework recommends selecting a manageable set of indicators that fit national and local priorities rather than attempting to measure everything. The framework spans the results chain and places quality, equity and resilience across the system. [1,2]

For a national programme, the evaluation plan should begin by defining the programme theory: what the programme is trying to change, how activities are expected to produce change, and which assumptions must hold true. Once this is clear, indicators can be selected for inputs, processes, outputs, outcomes and impact.



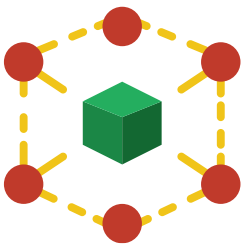


Figure 1. A practical evaluation pathway for a national health programme

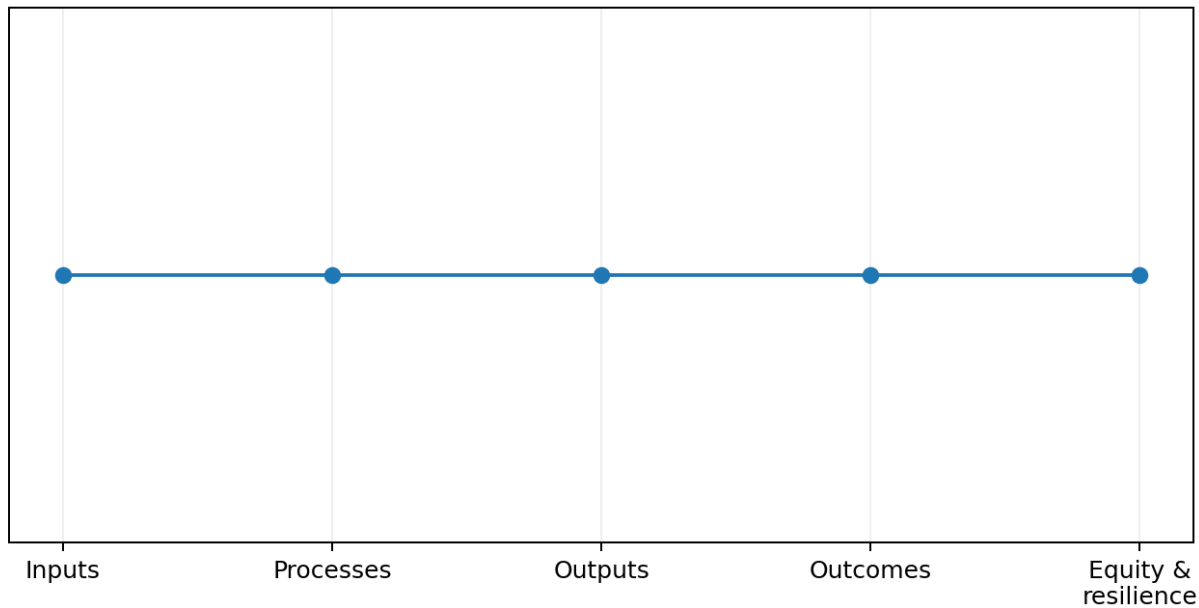


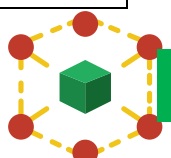
Figure 1. A practical evaluation pathway. The sequence is conceptual and can be adapted to the programme being assessed.

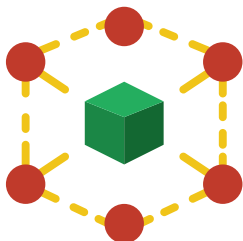
4. Indicators Used in Primary Care Evaluation

Indicators are useful because they convert broad programme objectives into measurable signals. A balanced dashboard should include more than service counts. For example, the number of consultations may rise while quality falls because staff are overburdened. Similarly, high average coverage can hide poor access among remote communities. Indicators should therefore be interpreted together and, whenever possible, disaggregated to reveal differences between population groups.

Table 2. Example indicator set for a national primary-care programme

Level	Indicator example	Why it matters
Input	Percentage of facilities with required staff	Shows readiness to deliver the programme
Input	Availability of essential medicines/supplies	Identifies supply constraints
Process	Proportion of staff receiving programme training	Assesses implementation capacity
Output	Service coverage among target population	Shows whether services are reaching people





Quality	Adherence to clinical or programme standards	Shows whether services are delivered appropriately
Equity	Coverage gap between highest- and lowest-served groups	Makes inequalities visible
Outcome	Control or improvement in the target health condition	Shows whether services are making a difference
Experience	Patient-reported satisfaction or respectful care	Captures the user's perspective

Figure 2. Example dashboard for programme review (illustrative data)

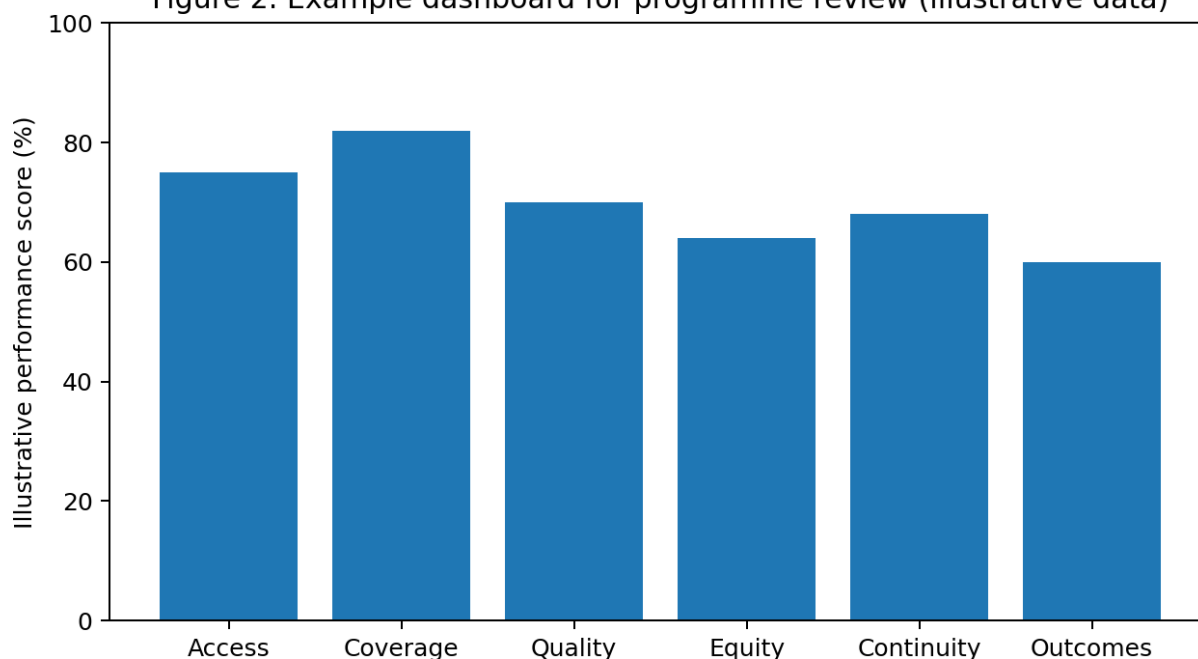
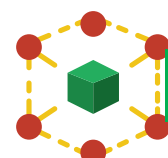
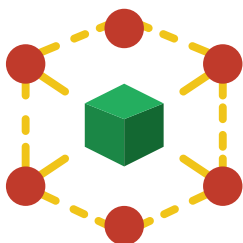


Figure 2. Example primary-care programme dashboard using illustrative—not measured—performance values.

5. Data Sources and Methods

A practical evaluation uses multiple data sources. Routine health information systems can provide monthly or quarterly service data. Facility assessments can examine staffing, equipment, medicines, infection-prevention practices and readiness. Patient records may provide information on continuity and clinical outcomes. Household or community surveys can identify people who never reached the





facility. Qualitative interviews and focus groups can explain barriers that numbers alone cannot reveal.

WHO's technical specifications for the PHC measurement framework emphasize clear indicator definitions, numerator and denominator rules, possible disaggregation and appropriate data sources. [2] This is important because an indicator is only useful when different facilities interpret and calculate it consistently.

A mixed-methods design is often particularly valuable. Quantitative data can answer 'how much' and 'how often', while qualitative information can answer 'why' and 'how'. For example, a low vaccination rate may reflect hesitancy, but it may also reflect clinic hours, transport difficulties, missed outreach sessions or vaccine supply problems. Evaluation should distinguish among these explanations before recommending a solution.

6. Evaluating Access, Coverage and Continuity

Access is the starting point for most primary-care programmes. Evaluation should consider geographic distance, opening hours, affordability, availability of services, cultural acceptability and whether people know how to obtain care. Coverage should be examined not only as a national average but also across districts and population groups.

Continuity is equally important. A programme may achieve high initial contact but lose people during follow-up. Chronic disease care is a clear example: diagnosis, treatment initiation, medicine availability, follow-up and referral must work as a connected pathway. Evaluators should therefore track drop-off between stages of care rather than focusing only on the first service contact.

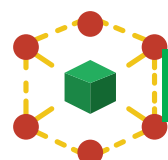
7. Evaluating Quality of Care

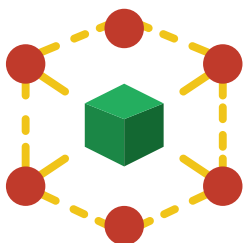
Quality at primary care level has several dimensions. Services should be clinically appropriate, safe, timely, people-centred and coordinated. Quality evaluation can combine record review, direct observation, clinical audits, waiting-time measurement, medicine availability and patient experience.

An important lesson is that quality should not be reduced to provider performance alone. A health worker cannot consistently deliver a high-quality service if essential medicines are unavailable, staffing is inadequate or referral systems do not function. Evaluation should therefore look at the system conditions surrounding frontline practice.

8. Equity and Community Participation

National programmes can appear successful while leaving certain groups behind. Equity-focused evaluation asks who benefits, who does not, and why. Useful disaggregations may include age, sex, residence, socioeconomic position, disability or other locally relevant characteristics, provided that data collection is ethical and protects privacy.





Community participation strengthens interpretation. People can identify practical barriers that are invisible in facility statistics, such as inconvenient clinic schedules, communication problems, stigma or concerns about respectful treatment. WHO's PHC approach explicitly recognizes empowered people and communities as one of its three major components. [1]

9. Efficiency, Financing and Sustainability

Evaluation should also consider whether programme resources are being converted into useful services. Efficiency does not simply mean spending less. It means achieving appropriate results with available resources while maintaining quality and equity. Measures can include cost per beneficiary, staff time, stock wastage, duplication between programmes and avoidable referral costs.

Sustainability asks whether the programme can continue after temporary funding, external technical assistance or special campaigns end. Programmes embedded in routine primary care, supported by stable financing, trained local staff, reliable information systems and community ownership are more likely to last.

10. Common Challenges in Programme Evaluation

Evaluation at primary care level faces several practical problems. Data may be incomplete or delayed, indicators may be interpreted differently, and frontline workers may experience reporting fatigue. Another challenge is attribution: health outcomes are influenced by many factors, so a change cannot automatically be credited to one programme.

Political and organizational pressures can also influence evaluation. A programme may be viewed as successful because it met administrative targets even when population-level benefit remains uncertain. Independent methods, transparent definitions and triangulation of multiple sources help reduce this risk.

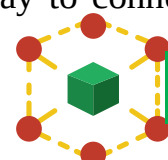
11. From Evaluation Findings to Action

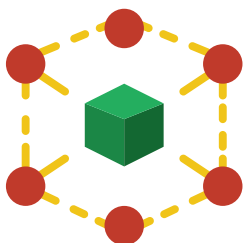
An evaluation becomes valuable when findings lead to improvement. Results should be discussed with programme managers and frontline teams, not simply sent upward as a report. Each major gap should ideally be linked to an action, responsible person or team, timeline and follow-up indicator.

For example, if evaluation finds repeated medicine stock-outs, the response may involve forecasting, procurement, inventory management and redistribution rather than simply instructing health workers to improve performance. Similarly, if coverage is low in remote areas, outreach schedules, transport and community partnerships may be more relevant than additional classroom training.

12. Discussion

Primary-care evaluation is most useful when it combines a health-system perspective with the everyday reality of service delivery. The WHO framework provides a structured way to connect





system capacity and service delivery with health outcomes while keeping quality, equity and resilience visible. [1,2]

The 2024 WHO primer on implementing PHC emphasizes that strengthening primary care requires attention to governance, financing, human resources, medicines, infrastructure and digital health, alongside service delivery. [3] This supports an important evaluation principle: programme performance should be interpreted in the context of the system that is expected to deliver it.

Recent evaluation work on WHO's Special Programme on Primary Health Care also illustrates the value of examining relevance, coherence, effectiveness, efficiency, added value, sustainability and equity rather than relying on a single outcome measure. [4] At national and district levels, the same logic can help decision-makers move from reporting activity to learning about implementation.

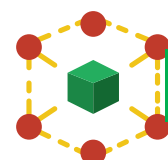
13. Recommendations

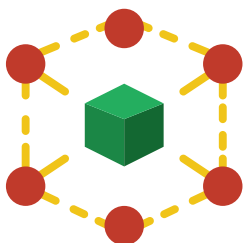
- Define a small, balanced set of indicators before implementation and align them with programme objectives.
- Combine routine quantitative data with facility observation, record review and community or patient feedback.
- Disaggregate important indicators to identify geographic and social inequalities.
- Use standard indicator definitions and strengthen data-quality checks at facility and district levels.
- Review results regularly with frontline teams and use findings to make practical corrective actions.
- Evaluate quality, equity, resilience and user experience alongside service coverage.
- Build evaluation into routine programme management instead of treating it as a one-time event.
- Protect confidentiality and use data ethically, especially when collecting information about vulnerable groups.

14. Conclusion

Evaluating a national health programme at the primary care level is not simply an exercise in counting services. It is a way of understanding whether national intentions are being translated into accessible, equitable, high-quality care for real communities. A strong evaluation examines resources, implementation, coverage, quality, outcomes, user experience and the distribution of benefits. It also asks why results differ between places and groups.

The most useful evaluation is practical and continuous. When data are reliable, indicators are balanced, communities are heard and findings are linked to decisions, evaluation becomes a tool for learning rather than judgement alone. In this way, primary-care evaluation can help national





programmes become more responsive, sustainable and capable of moving health systems closer to universal health coverage.

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