

PRIMARY HEALTH CARE IN THE WORLD BANK'S COVID-19 MULTIPHASE PROGRAMMATIC APPROACH PORTFOLIO RESPONSE

DISCUSSION PAPER

June 2022

Cameron Feil
Jasmine Vicencio
Manuela Villar Uribe
Federica Secci



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*The Extent to Which Pandemic Response Activities Were
Planned at the Primary Health Care Level within the World
Bank's COVID-19 MPA Projects*

CAMERON FEIL, JASMINE VICENCIO, MANUELA VILLAR URIBE, FEDERICA SECCI

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Health, Nutrition, and Population (HNP) Discussion Paper

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Health, Nutrition, and Population (HNP) Discussion Paper

Primary Health Care in the World Bank's Multiphase Programmatic Approach Portfolio Response

The Extent to Which Pandemic Response Activities Were Planned at the Primary Health Care
Level within the World Bank's COVID-19 MPA Projects

Cameron Feil,^a Jasmine Vicencio,^a Manuela Villar Uribe,^a Federica Secci^a

^a PHCPI Focal Point, The World Bank Group, Washington, DC, United States

Paper prepared for research by the Primary Health Care Performance Initiative (PHCPI)
financed by the Bill and Melinda Gates Foundation

Abstract: Soon after the World Health Organization (WHO) declared a pandemic, the World Bank made available rapid financing to strengthen countries' ability to respond to COVID-19 through a multiphase programmatic approach (MPA). The MPA's immediate objective is to prevent, detect, and respond to the COVID-19 pandemic. By July 2020, the World Bank's board of directors had approved financing for 74 countries. This evaluation aims to determine the extent to which response activities were planned at the primary health care (PHC) level, and the extent to which PHC was leveraged within the first wave of MPA projects was determined by the number of PHC activities listed in the project components and indicators. Of 74 projects evaluated, 70 (94 percent) had at least one PHC-related activity listed in the components. Frequently planned activities at the PHC level primarily included surveillance, handwashing, and community engagement-related activities. MPA projects did not prioritize a commitment to maintaining essential service delivery at the PHC level. Several projects showed a greater commitment to integrating response activities at the PHC level, including Côte d'Ivoire, Egypt, Liberia, and Papua New Guinea, Senegal, the Republic of Congo. Notably, except for Egypt and Papua New Guinea, these projects were in countries that have been affected or threatened by the Ebola pandemic. These countries emphasized the integration of pandemic response activities at the community level. Overall, this evaluation highlights three takeaways: (1) the most common project activities related to PHC focused on surveillance, community engagement, and disease prevention; (2) among MPA projects, those in the sub-Saharan African region integrated more pandemic response activities at the PHC level than did other regions; and (3) maintaining essential primary health care services was not a priority among MPA projects in the initial phase of the response.

Keywords: Primary Health Care, COVID-19, World Bank, Multiphase Programmatic Response, World Bank Projects

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Correspondence Details: Cameron Feil, cfeil@worldbank.org.

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ACKNOWLEDGMENTS

All authors are extremely grateful to the PHCPI team, and particularly Jaime Bayona, for their feedback and contributions throughout the development of this report. The authors would like to thank Gianluca Cafagna specifically, as his extensive reviews were of great help in the progress of this project. We would also like to thank Simone Wahnschafft and Latifat Okara for their support and contributions through the data analysis processes. The reviewers would like to thank both Sara Halstead and Sulzhan Bali for their extensive feedback on the report.

The authors are grateful to the World Bank for publishing this report as an HNP Discussion Paper.

PART I – INTRODUCTION

Maintaining primary health care (PHC) services and system functions are essential during a pandemic. The World Health Organization (WHO) stated that primary care is “the essential foundation for a global response to COVID-19,” emphasizing primary care’s role in diagnosis, coping, and reducing the demand for hospital services (WHO 2020d). Investing in PHC systems extends beyond health emergencies—as investing in PHC systems is the best investment a country can make toward achieving universal health coverage (UHC) (WHO 2019b).

PHC is not only essential for effective management and response to health emergencies but also critical for risk reduction and preparedness (Redwood-Campbell and Abrahams 2011). Evidence from the Ebola epidemic in Sierra Leone showed that pulling health care workers away from essential services reduced patients’ ability to access health services, resulting in higher mortality rates than those from the virus (Sochas, Amos Channon, and Nam 2017). A recent study modeled the effects on maternal and under-five mortality because of disruptions to health care systems and food supplies across low- and middle-income countries (LMICs) during the COVID-19 pandemic. The study estimated that a 15 percent decrease in coverage for essential reproductive, maternal, newborn, and child health services (RMNCH) would cause an additional 253,500 child deaths and 12,190 maternal deaths—while a 45 percent reduction in RMNCH services would cause an additional 1,157,000 child deaths and 56,700 maternal deaths (Robertson et al. 2020).

Strong PHC is critical for ensuring that the health care system remains resilient throughout the COVID-19 pandemic. Kruk et al. (2015) define health system resilience as “the capacity of health actors, institutions, and populations to prepare and effectively respond to crises; maintain core functions when a crisis hits, informed by lessons during the crisis, reorganize if conditions require it. Health systems are resilient if they protect human life and produce good health outcomes for all during a crisis and its aftermath” (Kruk et al. 2015). Therefore, PHC can contribute to health systems’ resilience through COVID-19 diagnosis, management, and treatment. PHC further contributes to health system resilience through the continuation of essential health care services—including routine vaccination; RMNCH services; and the diagnosis, management, and treatment of infections and noncommunicable diseases (NCDs). Both functions—COVID-19 diagnosis, management, and treatment, along with the continuity of essential health services—are important for reducing the burden on secondary and tertiary care providers and supporting good health outcomes during the COVID-19 pandemic.

The COVID-19 pandemic has caused severe disruptions to the delivery of essential PHC services. In August 2020, WHO published the results of the Pulse Survey, which collected data on disruptions to essential health services across 105 countries from March to June 2020. Countries experienced an average disruption to half of 25 tracer conditions. The most frequently disrupted services occurred at the primary care level, including routine immunization and outreach (70 percent of countries reported disruptions), family planning and contraception (68 percent), NCD disease diagnosis and treatment (69

percent), and treatment for mental health disorders (61 percent) (WHO 2020b). The results from the second round of the Pulse Survey were released in April 2021, finding that COVID-19 is continuing to cause extensive disruption to essential health services delivery, as more than 90 percent reported disruptions to the 25 tracer conditions (WHO 2020b). Furthermore, in September 2020, the Partnership for Evidence-Based Response to COVID-19 conducted a survey of 24,000 households across 18 African Union states, finding that 22 percent of respondents or a respondent's household member reported skipping a visit to health services during the pandemic. Moreover, the survey found that 38 percent of respondents had trouble accessing medication during the pandemic (PERC 2020). In September 2020, the Global Financing Facility reviewed data from 63,000 health facilities, finding major disruption to essential health services for women and children globally. The most affected services at the onset of the pandemic included childhood vaccination and outpatient consultations (GFF 2020).

On March 11, 2020, the World Health Organization officially declared the COVID-19 pandemic (Cucinotta and Vanelli 2020). Prior to the declaration, on February 3, 2020, the WHO released a global strategy document, the *Strategic Preparedness and Response Plan* (SPRP). The SPRP is “intended to help guide the public health response to COVID-19 at national and subnational levels, and to update the global strategy to respond to the COVID-19 pandemic” (WHO 2020a). The SPRP has been revised two additional times in May 2020 and in February 2021. The original SPRP outlined eight core pillars to an effective COVID-19 response. The May 2020 update included a ninth pillar titled *maintaining essential services*. While the most recent February 2021 edition included a tenth pillar designated to the delivery of vaccines. The 74 multiphase programmatic approach (MPA) projects were approved between April and June 2020. Therefore, the activities in the MPA were planned before the inclusion of the ninth pillar, maintaining essential services.

The World Bank Group (WBG) has responded to the COVID-19 pandemic by offering financial and operational support to client countries. In June 2020, the World Bank released its COVID-19 Crisis Response Approach (World Bank Group 2020a). The Crisis Response Approach outlines the World Bank's strategy to support countries in addressing the ongoing COVID-19 crisis and to provide strategic direction for the transition to economic and social recovery. The strategic objectives are described through its four pillars: *saving lives threatened by the pandemic; protecting the poor and vulnerable; securing foundations of the economy; and strengthening policies and institutions for resilience based on transparent, sustainable debt and investments*. These four pillars will be addressed across three phases of the crisis: Relief, Restructuring, and Resilient Recovery. The Crisis Response Approach also recognizes the importance of coordination and cooperation between countries and international organizations—including with the International Monetary Fund (IMF), multilateral development banks, United Nations (UN) agencies, foundations, parliamentarians, the private sector, and community service organizations (CSOs).

The World Bank approved 74 MPA projects, implemented by the Health, Nutrition, and Population (HNP) practice, between April 1, 2020, and July 1, 2020. These

projects are embedded within the *saving lives threatened by the pandemic* pillar of the World Bank’s Crisis Response Approach. The MPA projects provide rapid financing to assist countries to immediately prevent, detect, and respond to the COVID-19 pandemic (World Bank Group. 2020b). The COVID-19 MPA projects align with the World Bank’s mission to end extreme poverty and boost shared prosperity. Additionally, the projects utilize a multisectoral public health approach, aiming to improve health care system capacity. The MPA projects are highly coordinated efforts between the World Bank and the WHO, as the MPA project objectives are anchored in the core pillar presented in the WHO’s SPRP strategy.

The World Bank’s MPA response offers countries a comprehensive framework to which specific country operations could be linked over time, increasing flexibility and adaptability throughout the response to the crisis (World Bank Group 2017). The approved projects include a variety of measures and activities aimed at reducing the economic and health impacts of COVID-19 on the population’s health and the country’s economy. These measures and activities are provided through a “menu” of options that countries and regional organizations can use to tailor their response package. This menu consists of five components: Emergency COVID-19 response, Strengthening Multisector National Institutions and Platforms, Supporting National and Subnational Prevention and Preparedness, and Implementation Management and Monitoring and Evaluation.

The COVID-19 MPA projects reviewed in this assessment are a part of the World Bank’s Health, Nutrition, and Population portfolio. The HNP portfolio aims to support countries in achieving universal health care coverage by strengthening PHC systems and providing quality, affordable health services (World Bank Group 2020c). Thus, this evaluation will help us understand the extent to which the emergency phase of the World Bank’s COVID-19 MPA response aligns with the World Bank’s long-term objective of strengthening systems for UHC, starting with PHC.

PART 2 – METHODOLOGY

QUESTIONS OF INTEREST

This evaluation aims to identify if the 74 COVID-19 MPA projects—approved from April 1, 2020, to July 1, 2020—included pandemic response activities at the PHC level of care. Specifically, this evaluation aims to answer the following questions of interest:

1. Did approved MPA projects plan to implement pandemic response activities at the PHC level?
2. Did MPA projects emphasize maintaining or increasing access to essential PHC services?

Integrating response activities on the PHC will not only contribute to a more effective pandemic response, but also contribute to building resilient health systems for future health emergencies. Also, understanding *if* and *how* activities at the PHC level were included in the World Bank’s COVID-19 MPA projects will inform future

World Bank projects and responses to pandemics and, more broadly, health emergencies.

SOURCES OF INFORMATION

This analysis used two sources of data. Firstly, the data for this analysis were extracted from ‘SAP’ software using the “ISR Report for PDO Ratings and Indicators,” which collates the most recent Implementation Status Report (ISR) inputs for each project as of the date requested from the system. This report includes key project information, including Project Development Objectives (PDOs), components, and corresponding indicators, as well as financial information, all of which are updated as the project progresses and reflect any changes made throughout. For projects where ISR data were not available, generally projects that had not started implementation within six months of the date of extraction, the relevant data were taken from the Project Appraisal Documents (PADs) via the Operations Portal.

Secondly, the primary source used to extract information about project activities was Project Appraisal Documents. PADs are formal documents developed by the World Bank and the client country that summarize project details, logistics, and objectives. Ongoing COVID-19 MPA projects were identified, and the relevant data were manually recorded into an excel spreadsheet. Information from the PADs was collected; a full list of the 74 MPA projects can be viewed in **Appendix 1**.

As mentioned, the project’s loan commitments were extracted from the SAP database. As of April 1, 2021, a total of 18 MPA projects had received additional financing. Due to the complexity of and ongoing changes to project financing throughout the pandemic, the additional financing commitments *are not* included in the loan commitments calculations presented in this evaluation. The 18 MPA projects that have received additional financing commitments are noted in **Appendix 1**.

ANALYTICAL APPROACHES

Identifying PHC activities and indicators were the two key analytical approaches in this analysis. First, key PHC terms were defined. The key terms were used to identify PHC activities within the project’s components and subcomponents. Second, the team classified all PHC indicators into the most appropriate Primary Health Care Performance Initiative (PHCPI) Conceptual Framework domains and subdomains (**See Appendix 2**). Together, these two exercises bring to light how pandemic response activities are integrated at the PHC level and contribute to the MPA’s objectives. One caveat to note is that project descriptions and indicators used may not necessarily have been fully explicit and comprehensive in including activities carried out at the PHC level, given the tight timeline and constraints under which the initial wave of projects was developed.

Identification of Key PHC Terms

A list of key terms was developed to identify activities at the PHC level within the MPA projects. Upon establishing a common definition of PHC (Box 1), key terms were proposed by PHC experts within the PHCPI team. Secondly, the list of key terms proposed by PHCPI was cross-mapped to previous work outlining key activities and functions performed at the PHC level during a pandemic and shared internally by the

World Bank’s Joint External Evaluation (JEE) unit. The complete list of key terms can be viewed in **Table 1**. It is important to note that the terms were expanded upon when used to identify projects. For example, when searching for activities using the term “NCDs,” related terms such as “noncommunicable diseases,” or specific diseases such “diabetes,” and “COPD” (chronic obstructive pulmonary disease) were also included, if identified. It is also important to note that “surveillance” activities were only documented if specific actions were noted at the primary care or community level.

Table 1: Key Terms

Service Delivery – Preventative and Curative Activities
<i>Maintaining essential health care services, Vaccines, Hygiene practices, Mental health, Primary care services, HIV, TB, Malaria, RMNCH, NCDs, Family medicine, Nutrition, Diarrhea, Pneumonia, Antenatal care, Growth monitoring</i>
Community-Engagement Activities
<i>Community engagement, Handwashing, Essential community services, Community health workers, Essential pharmaceutical/Medicines/Medical equipment/Supplies/PPE, Primary health care, Nurses, Premiums, User-fee removal, Financing benefit packages, Surge capacity, Mobile testing units, Provider networks, Community-based programs, Core health service delivery</i>
Public Health and Surveillance Activities
<i>Surveillance, Disease prevention</i>

Source: Author’s Calculations

Notes: PPE = Personal preventive equipment.

Box 1: PHCPI Definition of Primary Health Care

Primary Health Care is 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

Upon reaching a consensus for the key terms used to identify activities within projects, these key terms were placed into three categories: **service delivery (curative and preventative), community engagement, and public health and surveillance**. The team reviewed the component and subcomponents to identify the presence of key PHC key terms. Once identified, the terms were used to search the project components and subcomponents. All identified terms required further interpretation to ensure the identified activity was within the scope of PHC. The list of assumptions and irrelevant terms can be found in **Appendix 3**.

Indicator Classification

The PHCPI Conceptual Framework was used to classify and evaluate the program development objective and intermediate outcome indicators included in the MPA projects (Veillard et al. 2017). Both PDO indicators and intermediate results indicators were extracted from each approved MPA project. All project indicators were evaluated to determine if they measured a PHC activity. If so, the indicator was mapped to the most appropriate PHCPI conceptual framework domains (Systems, Inputs, Service Delivery, Outputs, and Outcomes) and subdomains. The total number of PHC Indicators within an MPA project helped to identify which components of the PHC system were levered, and the extent to which key response activities occurred at the PHC level.

Loan Commitments

The total amount of loan commitments allocated to components with PHC activities were identified. The total loan commitments for each MPA project were included in the extracted SAP file. Each project within the SAP file disaggregated total loan commitments by components. Therefore, the loan commitment amounts could be divided between components containing activities at the PHC level and components that did not. When available, subcomponent loan commitments containing response activity at the PHC level could also be identified. Overall, this project did not conduct a full evaluation of project procurement plans. Instead, due to time and expertise constraints, this evaluation broadly captures the allocation of project financing to activities on the PHC level within COVID-19 MPA projects.

There are two important considerations for interpreting the loan commitments. Firstly, only the PADs of projects were analyzed and not cross-checked with procurement plans. Therefore, the *actual* disbursed amounts toward PHC-related activities are not accounted for. Rather, this analysis demonstrates the prioritization of loan commitments to PHC-related activities. Secondly, 18 identified MPA projects had received additional financing as of April 1, 2021—totaling US\$316 million. The additional financing commitments were not included in the loan commitments calculations presented in this evaluation. The 18 MPA projects that have received additional financing commitments are noted in **Appendix 1**.

UNDERSTANDING INFORMATION

The frequency of key terms and indicators within the project determined the extent of PHC within the MPA projects. The key terms were used to identify activities at the PHC level within MPA projects, while the indicators identified measurement of PHC activities within MPA projects. Both the activities and indicators were evaluated based on if they occurred in a project. For example, this evaluation counted the number of projects containing a specific activity or indicator. Projects containing relatively more activities and/or indicators were considered to have a higher emphasis on PHC.

For a fair evaluation of projects, thresholds were established for key terms and indicators to identify projects with a relatively high emphasis on PHC. For the activities, a threshold of projects containing at least four PHC activities was set. For indicators, a low- and high-end threshold was set due to the relatively low proportion of

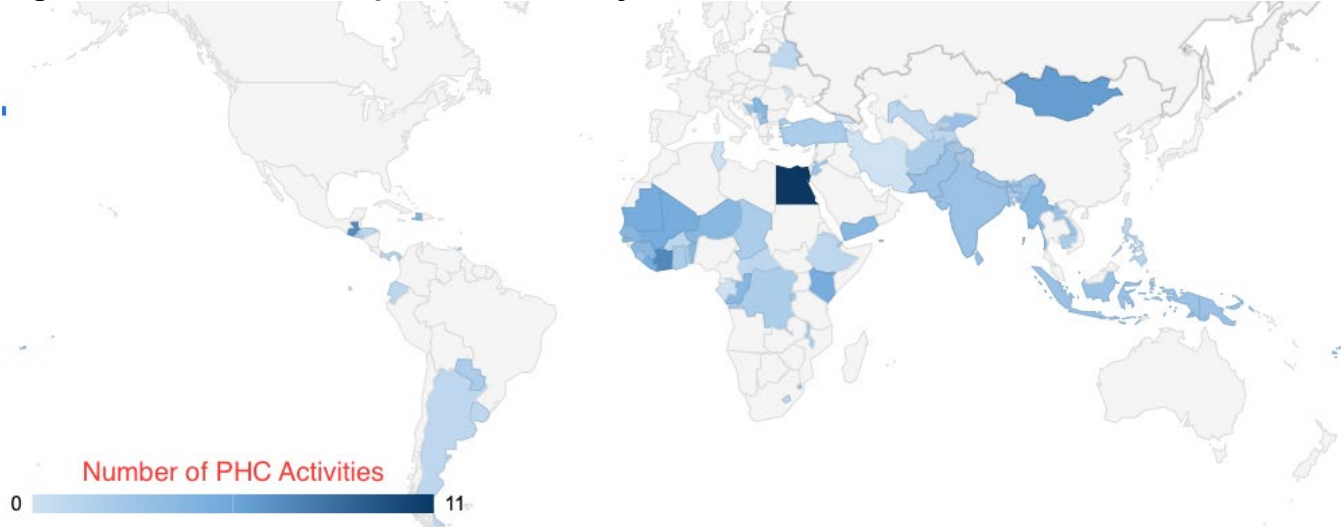
PHC indicators compared to non-PHC indicators within projects. A low-end threshold was set at three PHC indicators per project, and a high-end threshold was set at five PHC indicators per project.

Projects meeting required thresholds for both the indicator and key terms were selected for a comprehensive review of the project's components and activities. The purpose of this exercise was to identify projects emphasizing PHC and to better understand how PHC activities were included into a country's MPA response.

PART 3 – RESULTS

Of the 74 COVID-19 MPA projects, 70 projects (94 percent) included either at least one PHC activity within their components or a PHC-related indicator. The regional distribution of the evaluated projects was 27 in Sub-Saharan Africa Region (AFR) (36.0 percent), 11 in East Asia and Pacific (EAP)(14.0 percent), 11 in Europe and Central Asia (ECA) (14.0 percent), 10 in Latin America and Caribbean (LCR) (13.5 percent), 9 in South Asia (SA) (12.0 percent), 7 in Middle East and North Africa (MENA) (9.5 percent). **Figure 1** shows a map of MPA projects and the density of PHC activities.

Figure 1: PHC Activities per MPA Country



Source: Authors' Calculations

KEY TERMS ACTIVITIES

A total of 68 out of 74 projects (92 percent) contained at least one response activity at the PHC level within their components or subcomponents. Table 2 contains the full list of results for key terms.

Table 2: Results for Key Terms

Key terms	Percentage of projects (%)

Service delivery activities—Curative and preventive

Maintaining essential health care services	8 (11.0%)
Vaccines	7 (9.5%)
Hygiene practices	7 (9.5%)
Mental health	5 (7.0%)
Primary care services	4 (6.0%)
HIV	2 (3.0%)
TB	1 (1.5%)
Malaria	1 (1.5%)
RMNCH	1 (1.5%)
NCDs	1 (1.5%)
Family medicine	0 (0%)
Nutrition	0 (0%)
Diarrhea	0 (0%)
Pneumonia	0 (0%)
Antenatal care	0 (0%)
Growth monitoring	0 (0%)

Community-engagement activities

Community engagement	34 (46.0%)
Handwashing	27 (36.0%)
Essential community services	13 (17.0%)
Community health workers	10 (13.5%)
Essential pharmaceutical/medicines/medical equipment/supplies/PPE	8 (11.0%)
Primary health care	6 (8.0%)
Nurses	5 (7.0%)
Premiums	2 (3.0%)
User-fee removal	1 (1.5%)
Financing benefit packages	1 (1.5%)
Surge capacity	1 (1.5%)
Mobile testing units	1 (1.5%)
Provider networks	1 (1.5%)

Community-based programs	0 (0%)
Core health service delivery	0 (0%)
Public health & surveillance	
Surveillance systems	48 (65%)
Disease prevention	9 (12%)

Source: Authors' Calculations

Notes: HIV = Human immunodeficiency virus; TB = Tuberculosis; RMNCH = Reproductive, Maternal, Newborn, and Child Health; NCDs = Noncommunicable diseases; PPE = Personal protective equipment.

Handwashing, community engagement, and surveillance were the most frequent activities planned at the PHC level in MPA projects. We identified community-engagement activities in the components and subcomponents of 34 projects (46 percent), making it the most frequently planned service delivery activity. Community-engagement activities were frequently planned in connection with community-based surveillance, health communication, and disease-prevention activities such as handwashing. We found handwashing activities in over a third of projects (36 percent). These activities included the promotion of handwashing practices and the distribution of handwashing kits. Of the projects including handwashing activities, nearly half of them occurred in projects in the AFR.

We identified surveillance activities in the components of 48 (65 percent) projects, making it the most frequent PHC activity in MPA projects. The emphasis on implementing surveillance activities within the COVID-19 MPA projects is unsurprising, as surveillance systems are essential to pandemic preparedness and response. Other response activities accompanied nearly all projects containing surveillance activities at the PHC level. Specifically, only five countries included “surveillance” as their only PHC activity. This is important to consider as surveillance activities may extend beyond the PHC level, incorporating all levels of care and governance at the national and subnational levels, although this evaluation only accounted for surveillance activities if the PAD described specific actions at the primary care or community level. In LMICs, effective surveillance systems begin at the community level, making it an essential function of PHC systems during a pandemic response.

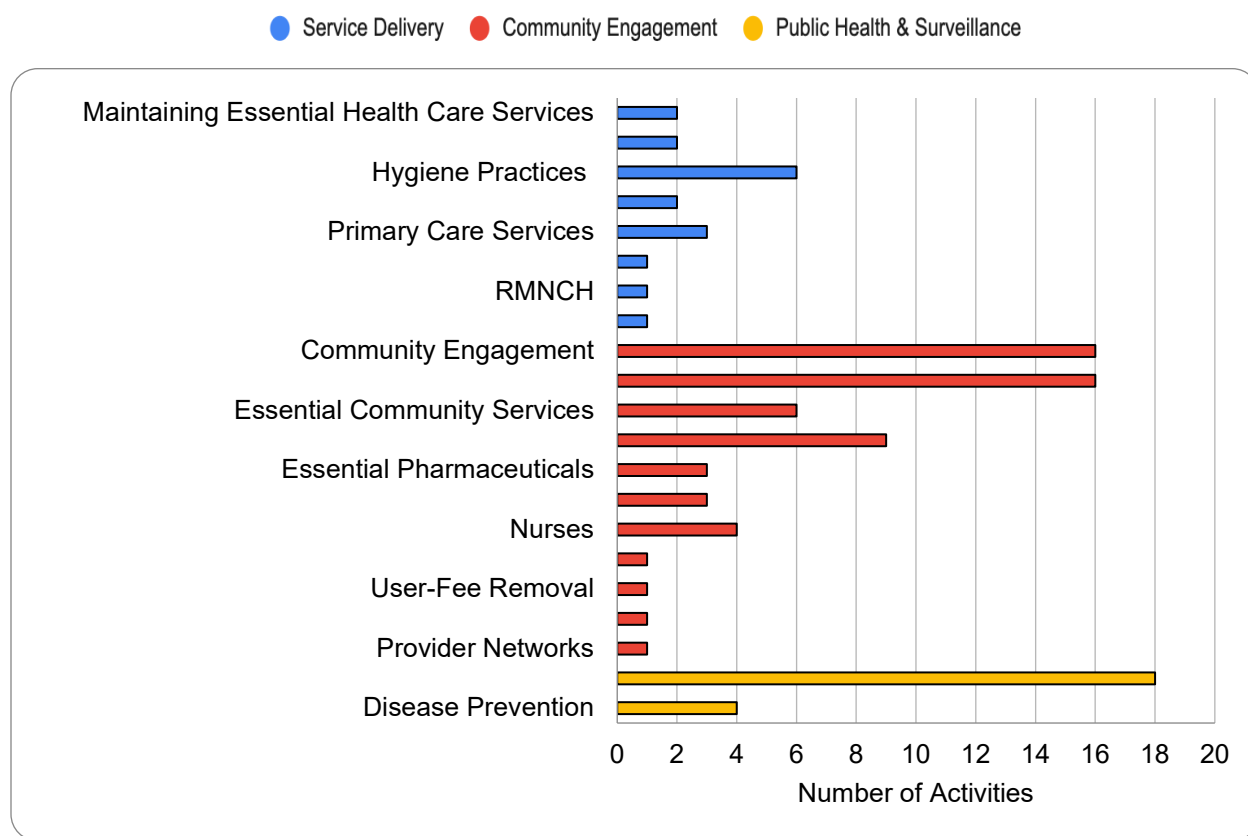
There was a low emphasis on curative and preventive PHC service delivery activities within the scope of COVID-19 MPA projects. Overall, there are very few activities focusing on maintaining essential services—as only 11 percent of projects mention this activity explicitly. Moreover, only 1.5 percent of projects included vaccine- and immunization-related activities, while specific services relating to tuberculosis (TB) (1.5 percent), human immunodeficiency virus (HIV) (3.0 percent), malaria treatment (1.5 percent), and RMNCH (1.5 percent) were present in a few projects. Meanwhile, zero projects contained activities relating to the curative and preventative treatments for or related to diarrhea, pneumonia, pregnancies, and family medicine. The lack of emphasis on leveraging PHC services delivery is furthered by the low proportion of projects containing “essential community services” (17 percent), and “essential pharmaceutical” (11 percent) activities.

The MPA projects did not emphasize increasing access to PHC services. The lack of activities promoting access to PHC services is reflected by the relatively low number of health financing–related activities. This included specific activities relating to premiums (3.0 percent), user-fee removal (1.5 percent), and financing benefit packages (1.5 percent). Further, only 13.5 percent of projects contained activities that employ community health workers (CHWs).

The lack of activities designed to help client countries maintain essential services continue to deliver specific primary care services, and reduce barriers to access, suggests that the MPAs do not emphasize PHC service delivery. This was expected given the original scope of the MPA and the SPRP framing did not originally include a component focusing on maintaining essential health care service delivery. In addition, it does not necessarily indicate that activities related to PHC were in fact not implemented, through projects or more broadly within the government response. Notwithstanding the reasons, the analysis shows that support toward regular PHC activities is not explicitly included in the scope of those initial projects.

A total of 21 (28 percent) projects contained more than four response activates at the PHC level. Projects with more than four different PHC activities were identified for further analysis and included the following countries: Egypt (11), Kiribati (7), Guatemala (7), Côte d'Ivoire (7), Mongolia (6), Mali (5), Kenya (5), Marshall Islands (5), Mauritania (5), Liberia (5), the Gambia (5), Senegal (4), Niger (4), Benin (4), the Republic Of Congo (4), Serbia (4), Yemen (4), Ethiopia (4), Papua New Guinea (4), Myanmar (4), Haiti (4), and Guinea (4). Further, 13 out of 21 (67 percent) projects identified as having more than four PHC activities results are in countries located in the AFR region—suggesting that projects implemented in AFR include a higher number of service-delivery and community-engagement activities within their COVID-19 MPA response. The frequency of activities is identified in **Figure 2**. A full list of corresponding key terms within each country/project is included in **Appendix 4**.

Figure 2: Activities among Projects with Four+ Activities in Components (N = 21)



Source: Authors' Calculations

Notes: HIV = Human immunodeficiency virus; RMNCH = Reproductive, Maternal, Newborn, and Child Health; NCD = Noncommunicable disease.

PHC INDICATORS INCLUDED IN PROJECT RESULTS FRAMEWORKS

A total of 68 (92 percent) COVID-19 MPA projects contained at least one PHC indicator. Table 3 shows the frequency of projects containing a PHC indicator, presented by PHCPI domains and subdomains, including examples of specific indicators in projects. In total, 55.0 percent of MPA projects contained at least one Service Delivery indicator, followed by Systems indicators (40.5 percent), Inputs indicators (38.0 percent), and Outputs indicators (32.0 percent). Zero outcome indicators were recorded in the MPA projects. This is because measuring outcomes, such as population health measures, are typically measured over longer periods of time—falling outside of the MPA’s scope. When examining the indicators on the subdomain level, the most common PHC indicators were Population Health Management (43 percent), Adjustment to Population Health Needs (38 percent), Effective Service Coverage (37 percent), Drugs and Supplies (20 percent), High-Quality Primary Health Care (19 percent), and Workforce (12 percent).

Table 3: PHC Indicators in Project Results Frameworks

PHCPI domains	Frequency of Indicators by subdomains	Examples of indicators included in sub-domain
Systems – 30 (40.5%)	Governance and Leadership – 3 (4%)	“Infection prevention protocols developed for all nonreferral facilities,” “Policies, guidelines, or regulations outlining multisectoral health approach,” “Health facilities with pandemic preparedness and response plan”
	Adjustment to Population Health Needs – 28 (38%)	“Sociocultural risk factor assessment for COVID-19,” “Country-adopted nonpharmaceutical interventions,” “Media with COVID-10 information disseminated,” “National communication strategy,” “National surveillance strategy,” “National health information–reporting platform developed”
Inputs – 28 (38%)	Drugs and Supplies – 15 (20%)	“Health facilities with PPE and hygiene materials,” “Targeted facilities received select drugs due to increase demand,” “Health facilities with designated medical equipment and supplies to provide essential services”
	Facility Infrastructure – 5 (7%)	“PHC facilities with X-ray machines,” “Facilities with access to safe drinking water and sanitation,” “Number of modular functional clinics,” “Number of health facilities with access to improved health care waste–management facilities,” “Increased storage capacity for COVID-19 buffer stocks and essential medicines”
	Information Systems – 2 (3%)	“Percentage of health facilities connected to a centralized health information management database and communication system to support telehealth services,” “Platform for events and community-based surveillance developed”
	Workforce – 10 (14%)	“Community health workers trained on surveillance,” “Health workers trained for community surveillance,” “Community-based nurses and PHOs trained on COVID-19,” “Community volunteers trained by project,” “Community-based surveillance training”
Service Delivery – 41 (55%)	Population Health Management – 32 (43%)	“Communication and engagement strategy,” “Contextualization of communication strategy,” “Individuals reached with tailored information,” “Risk communication and community-engagement strategies,” “Adoption of community nonpharmaceutical interventions,” “Surveillance mechanism for community-based reporting”
	High-Quality PHC – 14 (19%)	“Referral system for COVID-19 patients established”
Outputs – 24 (32%)	Effective Service Coverage – 24 (32%)	“Proportion of contacts/suspected cases traced, tested, and treated”; “handwashing kits distributed”; “people reached through hygiene promotion activities”

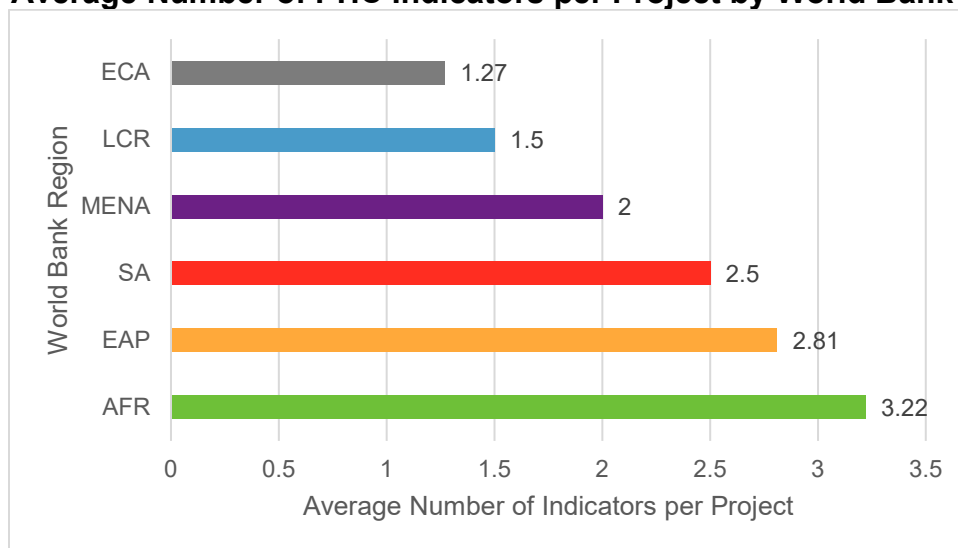
Source: Authors’ Calculations

Notes: PPE = Personal protective equipment; PHC = Primary health care; PHOs = Provincial health officers.

Projects in the AFR region had the highest average number of PHC indicators per project (3.22), followed by projects in the EAP (2.81) and SA (2.50) regions. MPA projects in MENA (2.0 per project), LCR (1.5 per project), ECA (1.25 per project), and

MENA (2.0 project) regions contained significantly fewer PHC indicators per project (Figure 3). Consistent with the findings from the description of activities, MPA projects in the AFR region include more PHC indicators within their results framework than projects in other regions.

Figure 3: Average Number of PHC Indicators per Project by World Bank Region



Source: Author's Calculations

Notes: AFR = Sub-Saharan Africa; EAP = East Asia and Pacific; SA = South Asia; MENA = Middle East and North Africa; LCR = Latin America and Caribbean; ECA = Europe and Central Asia.

Thirty-one MPA projects (41 percent) contained over three PHC indicators, of which nine projects (12 percent) had over five PHC indicators (Table 4). Consistent with the frequency of activities and the average number of indicators per project, most MPA projects containing over three indicators were in the AFR region. This finding supports that COVID-19 MPA projects in the AFR region contain a greater emphasis on PHC relative to other regions. The low proportion of projects with over three PHC indicators in the LCR, ECA, and MENA regions shows that MPA projects in these regions are less likely to emphasize PHC.

Table 4: PHC Indicators by Region

Projects with 3+ PHC Indicators	
AFR	Burkina Faso; Burundi; Benin; Central African Republic; Congo, Chad; Dem. Rep.; Côte d'Ivoire; Congo, Rep.; Kenya; Ethiopia; Ghana; the Gambia; Lesotho; Liberia; Mali; Niger Papua New Guinea; Senegal; Sierra Leone;;
LCR	Ecuador, Guatemala
EAP	Fiji, Indonesia, Kiribati, Samoa
SA	Afghanistan, Bangladesh, Bhutan, India, Nepal

PHC-INTENSIVE COVID-19 MPA PROJECTS

A total of 13 projects contained over four PHC activities and three PHC indicators, of which 80 percent were in Western and Central Africa. The MPA project countries containing three or more PHC-related indicators and four or more different activities were Benin; the Republic of Congo; Côte d’Ivoire; Guatemala, Kenya, Kiribati, Mali, , and Niger, , and. Projects containing five or more PHC-related indicators and four different activities included Egypt, , Liberia, the Gambia, Papua New Guinea, and Senegal. **Table 5** provides an overview of these projects. We reviewed the components of these identified projects to further understand how PHC activities were emphasized in the MPA projects’ components.

Table 5: Breakdown of Identification Process

Total projects	4+ Key terms	3+ Indicators	Both thresholds	Countries
75	21	31	13	Papua New Guinea; Benin; Congo, Rep.; Côte D’Ivoire; Egypt; the Gambia; Guatemala; Kenya; Kiribati; Liberia; Mali; Niger; Senegal

Source: Author’s Contributions

Three trends emerged in the review of components and subcomponents of the 13 selected projects. First, all projects include surveillance-related activities within their components. This typically refers to the establishment and use of public health or community-based surveillance systems. Second, the 13 projects contain community-engagement activities. These activities refer to several actions designed to prevent, detect, and respond to COVID-19 that are implemented at the community level. The various actions identified include engaging with community stakeholders and leaders to improve communication and promote disease-prevention activities. The community-based approach aligns highly with PHC core principles, particularly in that services and decision-making should be highly connected to the needs of local communities. Finally, many identified projects iterate maintaining essential health care services delivery, although they do not provide details on *how* this will be done. Rather, the components discuss strengthening secondary and tertiary facilities to respond to increased demand for health services because of COVID-19.

Failing to strategically plan how essential services will be maintained across the first level of care is a major gap in COVID-19 MPA projects. This finding reflects the lack of service delivery activities in the 13 projects. For example, only two projects mentioned specific diseases, such as HIV, NCDs, TB, and malaria, while there was a complete absence of diarrhea- and pneumonia-related services. These results reflect a potential gap in the first edition of the WHO SPRP strategy (published February 2020), which highly influenced the design of COVID-19 MPAs, as the core pillar of *maintaining*

essential services was not included until the second edition of the SPRP, after the initial planning phase of the MPA projects.

Of the 13 PHC-intensive projects, seven were found to strongly emphasize and incorporate response activities at the PHC level: the Republic of Congo, Côte d'Ivoire, Egypt, Liberia, Mali, Senegal, Papua New Guinea, and. These projects differ from most MPA projects, as they consistently incorporate and emphasize response activities at the PHC level. In particular, the seven selected projects strongly emphasize response activities at the community level, such as the development of tailored information campaigns promoting infection prevention and control and leveraging community health workers to educate high-risk groups. Overall, these projects illustrate how PHC activities can be leveraged to help achieve the PDOs of MPA projects, even in this first phase of the support. The following section summarizes how each project planned, incorporated, and emphasized response activities at the PHC level.

[The Republic of Congo Emergency Response Project \(P173851\)](#)

The Republic of Congo's COVID-19 MPA's scope included a health system–strengthening approach. The project explicitly emphasized “psychosocial care,” particularly accounting for the specific needs of children and pregnant and lactating women. PHC facilities were mentioned—regarding the implementation of equipment to transition PHC centers into isolation and ICU facilities. Lastly, the project had an entire component related to community engagement, emphasizing the importance of trust and of implementing community-level surveillance and warning systems, and focusing on preventive activities such as handwashing.

[Côte d'Ivoire COVID-19 Strategic Preparedness and Response Plan \(P173813\)](#)

Côte d'Ivoire's COVID-19 MPA components emphasized a community-based approach, with a strong focus on community engagement and community-based surveillance. Various activities integrated into these projects include the training of community health workers for COVID-19 case detection and monitoring. Moreover, included within the components was the procurement of essential vaccines to ensure that basic health services are maintained. Additionally, Côte d'Ivoire's MPA project focused on handwashing as a reliable public health measure, (e.g., distribution of handwashing kits, and promotion of handwashing practices among the general public). Lastly, the project included a three-month enrollment into universal health coverage to expand health care coverage and eliminate financial barriers to care.

[Egypt COVID-19 Emergency Response \(P173912\)](#)

Egypt's COVID-19 MPA project leveraged public health measures, particularly focusing on the implementation of a national behavior change communication campaign, training health care workers for infection prevention and control, and enforcing nonpharmaceutical disease-prevention measures. The national behavior change campaign promoted preventative measures such as handwashing, social distancing, and mask-wearing. While CHWs were specifically targeted to be trained on infection-prevention and control measures. The public health measure activities were focused on the community level—including leveraging existing community institutions and

organizations to promote public health measures. Egypt's MPA project strongly emphasized gender equity by targeting women's groups to promote public health measures. An important activity at the PHC level within Egypt's COVID-19 MPA was the development of a national strategy to protect high-risk groups, including the elderly, pregnant women, inhabitants of urban slums, people with NCDs, infants, and people with compromised immunity. It is important to note this, as the identification of these subpopulations will be most efficiently identified and managed through PHC providers.

Liberia COVID-19 Emergency Response Project (P173812)

Liberia's COVID-19 MPA emphasized integrating response activities at the PHC level in both its components and indicators. The project components reflect a strong emphasis on community engagement, mentioning the training of community health assistants (included as community health workers) for community surveillance. Further, Liberia's MPA specifically mentioned the promotion of handwashing methods. Lastly, Liberia mentioned the elimination of financial barriers to promote access to health care services.

Papua New Guinea COVID-19 Emergency Response Project (P173834)

Papua New Guinea's COVID-19 MPA components strongly emphasized community engagement. Community-engagement activities were combined with prevention activities such as handwashing, promoting preventative behaviors, and community surveillance. These activities were included in the project results frameworks, as indicators measured the dissemination of health-promotion information, inputs for provincial surveillance teams, and the total number of community-engagement strategies in local response plans. Also, Papua New Guinea explicitly mentioned "primary care" in reference to the clinical management of mild COVID-19 cases.

Senegal Emergency COVID-19 Relief Project (P173838)

Senegal's COVID-19 MPA strongly emphasized integrating pandemic response activities focused on PHC. The activities identified in the project components and subcomponents through the activities were community-based surveillance, maintaining essential services, training CHWs, and promoting handwashing as an infection-prevention and control measure. Further, both the training of community health workers and the promotion of handwashing activities are included, suggesting that these activities are considered integral to achieving the project's objectives.

Mali COVID-19 Response Project (P173816)

Mali's COVID-19 MPA had a strong emphasis on community engagement and maintaining essential services at the PHC level. Mali's project had an entire component specific to community engagement and disease-prevention activities. This emphasized the use of community health workers to reach the general population. This component mentioned training community health workers specifically for reaching rural communities. Additionally, Mali had a component dedicated to improving access to health care services. While primarily focused on COVID-19 cases, the component explicitly

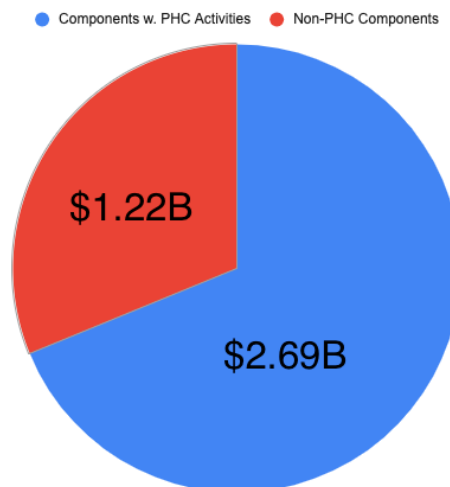
mentions that it was supporting access to ensure that essential services were not “crowded out.”

The integration of pandemic response activities at the PHC level suggests a select number of projects value PHC as an integral part of achieving MPA objectives. Most notably, the seven projects discussed here contained at least one component or subcomponent with community-based services. The community-based approach was commonly connected with engagement strategies, surveillance, and prevention activities such as handwashing. Further, these projects consistently included highly specific PHC activities such as integrating and training community health workers, emphasizing high-risk populations, and removing financial barriers to accessing essential PHC services. All these projects contained either community health workers or PHC activities, suggesting that these are key identifiers of PHC across projects. Although never explicitly stated, analyzing the components of the selected projects reveals that PHC was at the very least a consideration in the planning process in these select COVID-19 MPA projects.

PROPOSED LOAN COMMITMENTS

The total financing for the 65 COVID-19 projects was US\$3.90 billion. For components containing PHC activities, the total financing was \$2.69 billion, 69 percent of all COVID-19 MPA loan commitments (Figure 4). In total, 35 projects included the allocation of loan commitments to subcomponents. The total loan commitments allocated to these 35 projects’ subcomponents was \$425 million, while the total cost of all subcomponents containing at least one PHC activity was \$255.8 million, equaling 60 percent of the total subcomponent costs. These allocations of loan commitments to PHC are not precise, as they have not been cross-referenced with project procurement plans. However, this information does provide a general understanding of how MPA project loan commitments are to different levels of care.

Figure 4: Loan Commitment Allocation to Components Containing PHC Activities



Source: Author's Calculations

PART 4 – DISCUSSION

This review of the portfolio offers insights into the extent to which activities are integrated at the PHC level in the first phase of the World Bank’s COVID-19 MPA projects. The PHCPI conceptual framework domains were used to classify project indicators, identifying the number of indicators measuring PHC across the MPAs. Identifying this enables a greater understanding of how PHC activities are being used to achieve the objectives of preventing and responding to COVID-19. Analyzing the alignment, consistency, and trends between project activities and indicators provides a clearer understanding of the extent to which response activities are planned at the PHC level across the World Bank’s COVID-19 MPA projects.

TAKEAWAY 1: RESPONSE ACTIVITIES AT THE PHC LEVEL EMPHASIZE SURVEILLANCE, COMMUNITY ENGAGEMENT, AND DISEASE PREVENTION

Most response activities planned at the PHC level in COVID-19 MPA projects are focused on surveillance, community engagement, and disease prevention. Further, nearly all COVID-19 MPA projects included surveillance activities. This was unsurprising and positive, as focusing on human population–based surveillance has been cited as the most efficient and effective way to prevent and respond to pandemics (Holmes, Rambaut, and Andersen 2018). However, surveillance activities occur across a variety of scopes, including national, subnational, and community levels. Many activities in national and subnational surveillance could be placed outside the scope of PHC, while community-engagement activities were more of an approach consisting of a set of specific actions. Regardless, community-engagement activities were commonly connected to PHC activities such as community-based surveillance and handwashing. The high number of projects containing community-engagement activities is reassuring for several reasons. First, community engagement is an essential component to delivering effective and equitable PHC services and is widely considered a defining feature of PHC. Second, evidence from the Ebola epidemic suggests that communities should be at the forefront of pandemic response (Holmes, Rambaut, and Andersen 2018). Particularly, increased levels of community engagement in the Ebola epidemic have been linked with declining infection rates and more culturally appropriate policy decisions (Coltart et al. 2017). Hopefully, the integration of these types of activities in World Bank projects shows that lessons learned from prior epidemics are being incorporated into project design.

TAKEAWAY 2: MPA PROJECTS IN THE AFR REGION INTEGRATED PANDEMIC RESPONSE ACTIVITIES AT THE PRIMARY HEALTH CARE LEVEL MORE FREQUENTLY

These results consistently demonstrate that MPA projects located in the AFR region place a greater emphasis on PHC compared to other regions. While most MPA projects evaluated occurred in this region, the MPA projects located in the AFR region included more PHC activities and indicators compared to other regions. Over half of the 13 PHC-intensive projects were in the AFR region—and more specifically in Central and West Africa. These projects were in Benin, Côte d’Ivoire, the Republic of Congo, the Gambia, Liberia, Mali, Nigeria, Senegal, and Sierra Leone. This is particularly relevant, as an Ebola virus epidemic occurred in this area from 2013 to 2016 and has continued to persist in the Democratic Republic of the Congo from 2018 to 2020 (WHO 2019a; CDC 2019). A further review of the PADs of the MPA projects in Benin, Côte

d'Ivoire, and the Republic of Congo, revealed that the importance of the continuity of essential service delivery during an epidemic were key lessons from the Ebola epidemic. Most notably, Côte d'Ivoire's MPA explicitly mentioned the importance of prioritizing continuous essential service delivery within its pandemic response activities. Further, both the MPA projects in the Republic of Congo and Benin contain an explicit focus on building health system capacity, alluding to increases in mortality from neglected essential services for HIV, malaria, and tuberculosis during the Ebola epidemic. Additionally, Benin's MPA mentioned the impact that the Ebola epidemic had on mothers and children under-five, stating they would be the most significantly impacted in terms of morbidity and mortality from the COVID-19 pandemic. Lastly, Benin, Côte d'Ivoire, the Republic of Congo, Liberia, Senegal, and Sierra Leone all list surveillance and community engagement as lessons learned from the Ebola epidemic. The lessons learned from previous World Bank projects appear to be successfully applied, as the lessons from the Ebola epidemic in affected countries were considered and contributed to the framing of the COVID-19 MPA responses.

The selected MPA projects in AFR countries included “community engagement” within their components. As previously mentioned, “community engagement” often referred to an overarching approach connected with many PHC activities such as surveillance, handwashing, and community health workers. Also, these projects mention either primary care, community health workers, or increasing access to health services in some capacity. This may suggest an underlying commitment to ensuring essential services are maintained during the pandemic. However, it may allude to the existing health care system structures and capacity in these countries. Particularly, many low-income countries lack the necessary capacity to focus their response on secondary and tertiary levels of care. Therefore, the response activities implemented at the PHC level are the most effective way to respond to the COVID-19 pandemic. This may explain why there is a higher relative emphasis on PHC across projects located in West and Central African countries, as PHC is typically the main point of contact and hub for care coordination within their health care systems (WHO 2018). Also, the percentage of government health spending allocated to PHC demonstrates these countries may have previously committed to strengthening PHC prior to the COVID-19 pandemic. Countries with available data include Côte d'Ivoire, the Republic of Congo, Liberia, Niger, Mali, and Senegal. Among these countries, the commitment of total health financing toward PHC ranges from 46.7 to 77.5 percent (PHCPI 2020), further evidence that these countries have made previous commitments to building the capacities of their PHC systems.

TAKEAWAY 3: MAINTAINING ESSENTIAL PHC SERVICES WAS NOT A PRIORITY IN THE FIRST PHASE OF COVID-19 MPA PROJECTS

Overall, COVID-19 MPA projects did not prioritize activities designed to maintain and promote access to essential health care services at the PHC level. This is supported across all the dimensions of the analysis conducted. Specifically, only 28 projects (37 percent) contained a key term referring to “essential health care services” or “pharmaceuticals” in the context of PHC services. When “maintain essential services” was listed within the project components, the PADs provided no guidance or plan outlining how essential services would be maintained during the pandemic. Further, a recent World

Bank Technical Assessment of MPAs published in November 2020 analyzed the financing of MPA projects. The results from the report allude to the general lack of emphasis on integrating pandemic response activities at the PHC level. A major takeaway from the report was the lack of investment toward maintaining essential services, as this was not included as a core pillar to pandemic response in the original version of the WHO's SPRP, resulting in few counties planning and costing for these activities (World Bank 2020). Additionally, there was lack of support to maintain essential service delivery across MPA projects.

For the delivery of essential PHC services to be maintained, projects need to prioritize activities designed to reduce supply-side barriers. However, this is clearly not integrated into COVID-19 MPA projects, reflected in the lack of Service Delivery, Inputs, and Outputs indicators. This suggests that the projects do not include support to PHC service delivery, such as surge staffing at the first level of care. Instead, COVID-19 MPA projects prioritize training existing staff to manage critical COVID-19 cases. This is particularly concerning, as previously discussed, given that redistributing staff away from essential services had deadly unintended consequences (Sochas, Amos Channon, and Nam 2017). However, the lack of activities focusing on PHC service delivery may be in response to an anticipated decreased demand for essential services, as people may be less willing to utilize health care for fear of infection. Moreover, it is important to mention that the global pandemic response is an iterative process. This is supported by the WHO Pulse Survey, which found that essential service disruptions were attributable to both supply- and demand-side factors. Notably, 76 percent of countries reported reductions in attendance for outpatient services, while 48 percent and 33 percent of countries noted decreased demand for essential services due to lockdown measures and financial difficulties, respectively. While notable supply-side factors contributing to reductions in essential service delivery included staff redeployment to provide COVID-19 relief (49 percent), a lack of personal protective equipment (PPE) availability (44 percent), facility shutdowns and closures (33–41 percent), and limited supply of medical equipment and products (30 percent) (WHO 2020c).

The COVID-19 MPA missed a key opportunity to integrate proven mechanisms to improve the response to COVID-19 while improving access to essential PHC services. Especially concerning is the relatively few projects (13.5 percent of all projects) containing activities and indicators including community health workers (CHWs). The lack of CHW activities illustrates the limited measures taken to increase access to essential PHC service delivery on both the supply and demand sides. The role of CHWs is to provide outreach PHC service delivery along with essential public health activities, such as community engagement and promoting healthy behaviors (Javanparast et al. 2018). Therefore, CHWs are a supply-side mechanism that can be leveraged in LMICs to support the continuation of essential services and respond to the lower demand caused by the pandemic. Also, CHWs have strong community ties and can be a powerful mechanism for promoting preventative behaviors such as handwashing and physical distancing, along with combatting misinformation. Examples from the Ebola epidemic in Central and West Africa suggests that CHWs can lead to improved outcomes and essential service delivery during an epidemic. An analysis from the Ebola epidemic found

that CHWs were essential for continuing to deliver PHC services (Miller et al. 2018). Research from the COVID-19 pandemic highlights the importance and role of community health workers during the COVID-19 pandemic, emphasizing CHWs' effectiveness in health promotion, surveillance, and the management of COVID-19 (Wiah et al. 2020). Thus, the lack of reference to the involvement of CHWs across World Bank COVID-19 MPA projects may reveal a lost opportunity to leverage an effective network to ensure continuous essential PHC health service delivery, as well as to promote preventative measures such as handwashing and physical distancing. It is also important to mention that MPA projects could leverage community-engagement activities and initiatives to encourage individuals to access essential health services during the pandemic.

The low-level emphasis on increasing coverage and access to essential PHC services is supported by the lack of financing-related indicators and activities across MPA projects. Increasing financing for PHC services enables improved coverage and access to essential health services delivered at the first level of care by expanding benefits packages and by reducing financial barriers to services. Only four projects mentioned the removal of financial barriers and increased access to essential health care: Cote d'Ivoire, Liberia, Mali, and North Macedonia. The lack of PHC-related financing activities demonstrated that increasing access and coverage to PHC services was rarely considered and not a priority across COVID-19 MPA projects. Again, this may reflect the objectives of the MPA and an overall lower demand for essential services due to COVID-19—as promoting measures to reduce the risk of contracting the COVID-19 virus may encourage individuals to not seek care at primary health care facilities.

PART 5 – POLICY IMPLICATIONS

The COVID-19 pandemic presents an unprecedented challenge for health systems and economies worldwide, and for the global community that is expected to support countries as they grapple with the pandemic and its effects. Yet, it also offers a unique opportunity to take bold actions at the intersection of responding to the immediate threat of the COVID-19 pandemic and to better prepare health systems in the wake of future shocks and emergencies. In addressing both these issues, it accelerates progress toward UHC.

While, overall, the World Bank is committed to supporting countries toward achieving UHC, in the context of the first wave of MPA projects, this link to UHC was not particularly emphasized. This portfolio review shows that the World Bank and participating governments clearly did not prioritize integrating activities at the PHC level during the first phase of the response to COVID-19. This suggests a “know-do-gap,” as the importance of maintaining and leveraging strong PHC systems during pandemics is well-documented from previous epidemic experiences. In response, we strongly suggest that future health system–strengthening efforts between the World Bank and partner countries support PHC systems, with a specific focus on the capacities required to continue essential service delivery in the face of a health shock.

However, it is important to consider that the primary objective of MPA projects was to respond to the immediate needs of COVID-19 and that in addition to COVID-19 MPA projects, the World Bank may have supported governments' responses through other existing activities in the portfolio, including preexisting projects, restructuring and additional financing of existing operations, and nonlending technical assistance, within and outside the HNP portfolio. These other means of support may have already included preexisting commitments to strengthening essential PHC services, therefore leading to their exclusion within the COVID-19 MPA projects per se. Regardless, the lack of emphasis and prioritization toward activities at the PHC level across COVID-19 MPA projects is important to note so that future pandemic response and emergency planning can better incorporate these approaches from the planning phase.

Future health system–strengthening activities should focus on building the capacities of the PHC system, which would allow for a more seamless transition of functions in the wake of a health emergency. Specifically, a resilient PHC system is one that has the ability to simultaneously maintain essential functions *and* respond to any unforeseen health emergency. Thus, it is important to consider that future health projects and improvement efforts in partner countries must consider integrating resilience activities into larger health system–strengthening efforts, as countries with strong PHC systems across a range of economic contexts have shown strong responses to the COVID-19 pandemic. For example, Lal et al. (2020) highlighted how specific regions in Italy and Singapore with robust PHC systems performed comparatively better than other regions with lower-capacity PHC systems. PHCPI has also identified how previous PHC-strengthening efforts in Colombia and Vietnam have contributed to stronger COVID-19 responses. Specifically, the Colombian experience demonstrates how previous investment in strengthening PHC system capacities, such as evolving service delivery models to include innovative practices such as telehealth, has enabled more efficient uses of health care staff and resources during the pandemic. These examples illustrate the importance of prioritizing PHC strengthening within larger universal health coverage initiatives and ensuring that pandemic response activities are embedded within these initiatives (World Bank Group 2020d).

PART 6 – LIMITATIONS

This evaluation is subject to several limitations. First, the study does not examine the full extent to which PHC activities are supported by other actors and are more generally embedded within government responses. Even if absent from World Bank projects, other donors and partner organizations may have taken on the role of strengthening PHC during the COVID-19 response in each country. Second, additional financing for COVID-19 may have been allocated toward ongoing World Bank projects that are contributing to health systems strengthening, including PHC. Those projects have not been included in this review. The third limitation of this study is that it does not fully consider the specific health care system context of each country. As previously mentioned, income levels and maturity of the health system may result in varying levels of health system capacity and the overall organization of service delivery, ultimately shifting the priorities and activities

used to respond to the COVID-19 pandemic. Particularly, low-income countries may rely more heavily on PHC and a community-based system compared to middle- and high-income countries. Lastly, PHC can be defined in different ways, resulting in several ways in which the activities identified within projects could be recorded or not recorded as PHC activities. While the PHCPI definition of PHC was adopted, some of the identified activities within projects lacked descriptions, making them challenging to classify.

PART 7 – CONCLUSION

The COVID-19 pandemic has created an unprecedented global crisis—global actors, countries, organizations, and health systems are learning as the pandemic continues to progress. While no response is perfect, it is important to understand the strengths and weaknesses of pandemic responses to inform future health system strengthening and pandemic-preparedness efforts. Particularly, this evaluation will help to further refine the role of PHC within an emergency response, identifying activities and actions at the PHC level that prepare health systems to respond to shocks. While information from this evaluation is specific to the context of the COVID-19 pandemic, its lessons extend beyond this pandemic and can inform health care systems—strengthening initiatives, health emergency planning, and response efforts.

Previous experiences support that PHC has an important role in the response, management, and preparedness of a health care system to epidemic and pandemic threats. This would include integrating activities such as prevention and detection, case management, and risk communication, in combination with supporting the inputs and actions required to maintain the delivery of essential health services. It is important to recognize that investing in PHC systems not only leads to more resilient health care systems in the face of health and economic shocks, but also contributes to countries achieving UHC.

Overall, findings of this study reveal that the extent to which pandemic response and preparedness activities were planned at the PHC level is low across the 74 MPA projects. However, a select number of MPA projects included greater emphasis on PHC activities. These projects were disproportionately in the AFR regions previously affected by Ebola. We found that PHC-intensive projects integrate relatively more activities at the PHC level into their MPA projects—with an emphasis on community engagement, essential service delivery, and surveillance.

The first wave of MPA projects represents a missed opportunity to leverage PHC to strengthen the COVID-19 response. This has important short- and long-term implications, as countries have realized that a response that fully integrates the PHC system is a more effective and sustainable one to manage COVID-19 and could have benefited from the use of external support, including from the World Bank, to strengthen capacity and preparedness of their health care system for the longer term, starting with PHC.

Appendix 1: Projects Included in This Review

Project Information Document	Project name	Country	PHC-focused activities (key terms)	PHC indicators	Received additional financing as of April 1, 2021
P173775	Afghanistan: COVID-19 Emergency Response and Health Systems Preparedness Project	Afghanistan	✓	✓	
P173767	Argentina: COVID-19 Emergency Response Project	Argentina	✓	✓	
P173757	Bangladesh: COVID-19 Emergency Response and Pandemic Preparedness Project	Bangladesh	✓	✓	
P173828	Belarus: Emergency COVID-19 Response Project	Belarus	✓	✓	
P173839	Benin: COVID-19 Preparedness and Response Project	Benin	✓	✓	✓
P173787	Bhutan: COVID-19 Emergency Response and Health Systems Preparedness Project	Bhutan	✓	✓	
P173809	Bosnia and Herzegovina: Emergency COVID-19 Project	Bosnia and Herzegovina	✓	✓	
P173858	Burkina Faso: COVID-19 Preparedness and Response Project	Burkina Faso	✓	✓	
P173845	Burundi: COVID-19 Preparedness and Response Project	Burundi	✓	✓	
P173857	Cabo Verde: COVID-19 Emergency Response Project	Cabo Verde	✓	✓	✓
P173815	Cambodia: COVID-19 Emergency Response Project	Cambodia	✓	✓	
P173832	Central African Republic: COVID-19 Preparedness and Response Project	Central African Republic	✓	✓	
P173894	Chad: COVID-19 Strategic Preparedness and Response Plan (SPRP)	Chad	✓	✓	
P173851	Republic of Congo: COVID-19 Emergency Response Project	Congo, Rep.	✓	✓	
P173813	Côte d'Ivoire: COVID-19 Strategic Preparedness and Response Plan (SPRP)	Côte d'Ivoire	✓	✓	

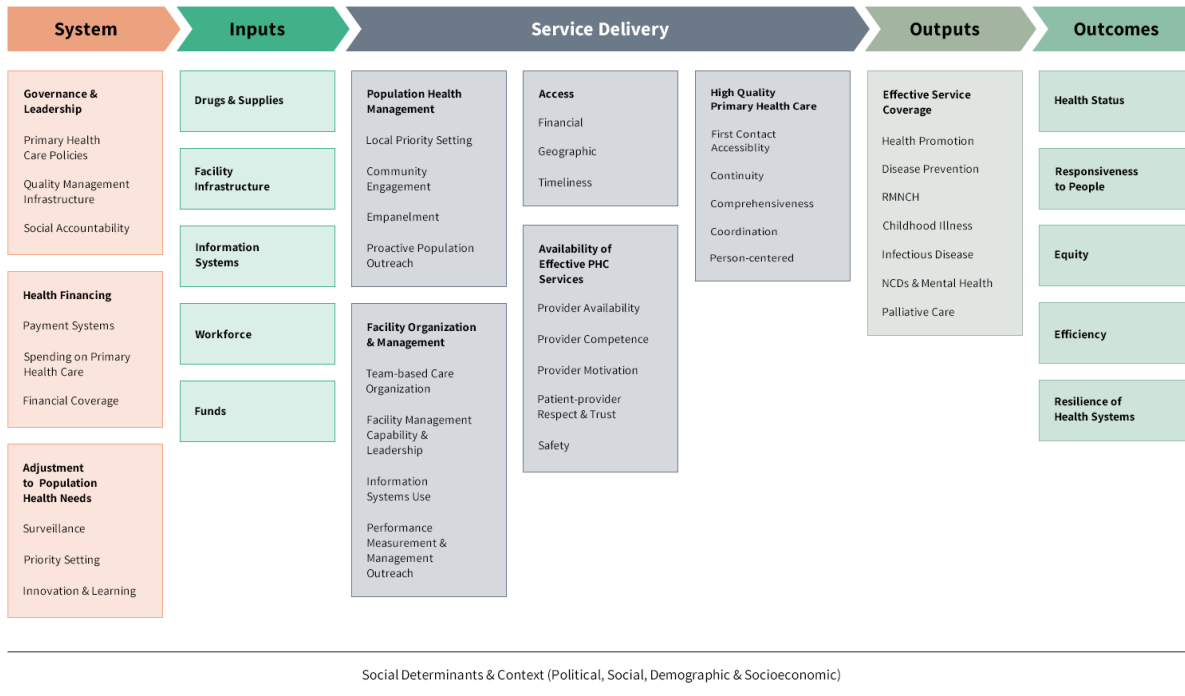
P173825	Democratic Republic of Congo: COVID-19 Strategic Preparedness and Response Plan	Congo, Dem. Rep.	✓	✓	
P173807	Djibouti: COVID-19 Response	Djibouti	✓	✓	✓
P173773	Ecuador: COVID-19 Emergency Response Project	Ecuador	✓	✓	
P173872	El Salvador: COVID-19 Emergency Response Project	El Salvador	✓	✓	
P173912	Egypt: COVID-19 Emergency Response	Egypt	✓	✓	
P173750	Ethiopia: COVID-19 Emergency Response	Ethiopia	✓	✓	
P173883	Eswatini: COVID-19 Emergency Response Project	Eswatini	✓	✓	✓
P173903	Fiji: COVID-19 Emergency Response Project	Fiji	✓	✓	
P173927	Gabon: COVID-19 Strategic Preparedness and Response Plan (SPRP)	Gabon			
P173798	The Gambia: COVID-19 Preparedness and Response Project	The Gambia	✓	✓	✓
P173911	Georgia: Emergency COVID-19 Response Project	Georgia			
P173788	Ghana: COVID-19 Emergency Preparedness and Response Project	Ghana	✓	✓	✓
P173854	Guatemala: COVID-19 Response	Guatemala	✓	✓	
P174032	Guinea: COVID-19 Preparedness and Response Project	Guinea	✓	✓	
P173811	Haiti: COVID-19 Response	Haiti	✓	✓	
P173861	Honduras: COVID-19 Emergency Response Project	Honduras	✓		
P173836	India: COVID-19 Emergency Response and Health Systems Preparedness Project	India	✓	✓	
P173843	Indonesia: Emergency Response to COVID-19	Indonesia	✓	✓	
P173994	Iran: COVID-19 Emergency Response Project	Iran			

P173972	Jordan: COVID-19 Emergency Response	Jordan	✓	✓	
P173820	Kenya: COVID-19 Emergency Response Project	Kenya	✓	✓	✓
P174219	Kiribati: COVID-19 Emergency Response Project	Kiribati	✓	✓	
P173819	Kosovo: Emergency COVID-19 Project	Kosovo	✓	✓	✓
P173766	Kyrgyz Republic: Emergency COVID-19 Project	Kyrgyz Republic	✓	✓	
P173817	Lao PDR: COVID-19 Response Project	Lao People's Democratic Republic	✓	✓	
P173939	Lesotho: COVID-19 Emergency Preparedness and Response Project	Lesotho	✓	✓	
P173812	Liberia: COVID-19 Emergency Response Project	Liberia	✓	✓	
P173806	Malawi: COVID-19 Emergency Response and Health Systems Preparedness Project	Malawi	✓	✓	
P173801	Maldives: COVID-19 Emergency Response and Health Systems Preparedness Project	Maldives	✓	✓	
P173816	Mali: COVID-19 Emergency Response Project	Mali	✓	✓	✓
P173887	Marshall Islands: COVID-19 Emergency Response Project	Marshall Islands	✓	✓	
P173837	Mauritania: COVID-19 Strategic Preparedness and Response Plan (SPRP)	Mauritania	✓	✓	
P173776	Moldova: Emergency COVID-19 Response Project	Moldova			✓
P173799	Mongolia: COVID-19 Emergency Response and Health System Preparedness Project	Mongolia	✓	✓	
P173902	Myanmar: COVID-19 Emergency Response Project	Myanmar	✓	✓	✓
P173760	Nepal: COVID-19 Emergency Response and Health Systems Preparedness Project	Nepal	✓	✓	
P173846	Niger: COVID-19 Emergency Response Project	Niger	✓	✓	

P173916	North Macedonia: Emergency COVID-19 Response Project	North Macedonia	✓	✓	
P173796	Pakistan: COVID-19 Emergency Response and Effectiveness Project	Pakistan	✓	✓	
P173881	Panama: COVID-19 Emergency Response	Panama	✓	✓	
P173834	Papua New Guinea: COVID-19 Emergency Response Project	Papua New Guinea	✓	✓	
P173805	Paraguay: COVID-19 Emergency Response Project	Paraguay	✓		
P173877	Philippines: COVID-19 Emergency Response Project	Philippines	✓	✓	
P173855	Rwanda: COVID-19 Emergency Response Project	Rwanda	✓	✓	✓
P173920	Samoa: COVID-19 Emergency Response Project	Samoa	✓	✓	
P173783	São Tomé and Príncipe: COVID-19 Emergency Response Project	São Tomé and Príncipe	✓	✓	✓
P173838	Senegal: COVID-19 Response Project	Senegal	✓	✓	
P173892	Serbia: Emergency COVID-19 Response Project	Serbia	✓	✓	
P173803	Sierra Leone: COVID-19 Emergency Preparedness and Response Project	Sierra Leone	✓	✓	
P173867	Sri Lanka: COVID-19 Emergency Response and Health Systems Preparedness Project	Sri Lanka	✓	✓	✓
P173765	Tajikistan: Emergency COVID-19 Project	Tajikistan	✓	✓	✓
P173880	Togo: COVID-19 Emergency Response and Systems Preparedness Strengthening Project	Togo	✓	✓	
P173989	Trinidad and Tobago: COVID-19 Response Project	Trinidad and Tobago	✓	✓	
P173945	Tunisia: COVID-19 Response Project	Tunisia			
P173988	Turkey: Emergency COVID-19 Health Project	Turkey	✓	✓	

P173876	Uruguay: COVID-19 Emergency Response Project	Uruguay	✓		
P173827	Uzbekistan: Emergency COVID-19 Response Project	Uzbekistan	✓	✓	✓
P173800	West Bank and Gaza: COVID-19 Emergency Response	West Bank and Gaza	✓	✓	✓
P173862	Republic of Yemen: COVID-19 Response Project	Yemen, Rep.	✓	✓	

Appendix 2: PHCPI CONCEPTUAL Framework



Source: The Primary Health Care Performance Initiative

Notes: PHC = Primary health care; RMNCH = Reproductive, Maternal, Newborn, and Child Health; NCDs = Noncommunicable diseases.

Appendix 3: Assumptions from Key Terms

<i>“Vaccines”</i>
Of the 6 vaccine-specific activities included, 4 referred to the “preparedness and procurement of vaccines,” 3 referred to “essential health care services,” 1 referred to “stockpiling” and 1 referred to “immunization.”
<i>“Community Health Workers”</i>
Of the 8 “community health workers” activities, 3 were related to “community preparedness,” 3 to “community surveillance,” and 1 to “training.” Lastly, one instance found “community health assistants,” which was included as a community health worker.
<i>“Community Engagement”</i>
The 29 “community-engagement” activities were all connected to either a public health, health promotion, disease prevention or surveillance-related activity to be classified as primary health care.
<i>“TB, Malaria, and HIV “</i>
For the 1 activity related to “TB,” “Malaria,” and “HIV,” they were all in the same component and country, referring to maintaining essential services for these diseases.
<i>“Nurses”</i>
1 activity related to “Nurses” and primary health care, referring to the training of nurses for infection prevention and control. There were 3 irrelevant nursing terms, referencing hazard pay for nurses directly involved in COVID-19 treatment, and 1 referring to training nurses for the intensive care unit (ICU).
<i>“Essential”</i>
Essential was searched and divided for simplicity. This led to 10 “maintaining essential community services” activities; 5 “maintaining essential health care services”; 1 “essential health service delivery”; 1 “finalizing the essential health care package” (all combined); 4 “essential pharmaceuticals,” which referred to providing insulin, antibiotics, or other relevant drugs for patients with comorbidities; 1 “essential PPE [personal protective equipment] to primary health care workers” (combined). There were 21 irrelevant terms, which referenced communication, social support, workforce, protective equipment, essential items, and essential care for non-PHC.
<i>“Primary Care”</i>
Of the 4 “primary care” activities, 2 referred to the “clinical management of mild cases,” and 2 to “linking primary care providers.” While there were 3 irrelevant terms, which referred to inputting intensive care units or specialized care into the primary care facilities.
<i>“Primary Health Care”</i>
The 1 “primary health care” activity was connected with “community public health teams.” There were 5 irrelevant terms, referencing ICUs or specialized care in the primary care facilities.
<i>“Surge Capacity”</i>
The 1 “surge capacity” activity was classified based on a reference to “frontline health care workers.” However, 12 “surge capacity” results were irrelevant, having no connection to PHC.
<i>“Financing Benefit Package”</i>

The 1 “Financing benefit package” term result refers to the elimination of financial barriers for health insurance.

“Mental Health”

Of the 4 “mental health”–related activities, 3 were related to the “provision of mental health services,” while 1 was related to “mental health for health care workers.”

“Disease Prevention”

Of the 4 “disease prevention” key terms, 2 refer to “preventative actions” and two refer to “health/disease prevention” education and public health prevention.

Source: Author’s Calculations

Appendix 4: Countries with 4+ Activities in Components (N =17)

<p>P173883 – Egypt COVID-19 Response Project (N =11) “Handwashing,” “Hygiene practices,” “HIV,” “RMNCH,” “NCDs,” “Community engagement,” “Community health workers,” “Essential community services,” “Essential pharmaceuticals,” “Nurse,” “Surveillance,” “Disease prevention”</p>
<p>P174219 – Kiribati “Handwashing,” “Hygiene practices,” “Maintaining essential services,” “Essential pharmaceuticals,” “Provider Networks,” “Referral pathways”</p>
<p>P173854 – Guatemala “Handwashing,” “Mental health,” “Hygiene practices,” “Community engagement,” “Community health workers,” “Surveillance,” “Disease prevention”</p>
<p>P173813 – Côte d’Ivoire COVID-19 Strategic Preparedness and Response Project (N = 7) “Vaccines,” “Community health workers (2x),” “Community engagement (2x),” “Premiums,” “Nurses,” “Handwashing (2x),” “Surveillance”</p>
<p>P173799 – Mongolia COVID-19 Emergency Response and Health System Preparedness Project (N = 6) “Primary care,” “Community health workers,” “Essential pharmaceuticals,” “Community engagement,” “Nurses,” “Surveillance”</p>
<p>P173816 – Mali COVID-19 Response Project (N = 5) “Primary care,” “Community health workers (2x),” “Maintaining essential community services,” “Community engagement,” “User-fee removal,” “Surveillance”</p>
<p>P173820 – Kenya COVID-19 Emergency Response Project (N = 5) “Hygiene practices,” “Community health workers,” “Community engagement,” “Surveillance (2x),” “Disease prevention”</p>
<p>P173887 – Marshall Islands RMI COVID-19 Emergency Response Project (N = 5) “Mental health,” “Maintaining essential services,” “Community engagement,” “Handwashing,” “Surveillance (5x)”</p>
<p>P173837 – Mauritania COVID-19 Strategic Preparedness and Response Project (N = 5) “Community health workers,” “Maintaining essential community services,” “Mobile testing units,” “Handwashing,” “Surveillance”</p>
<p>P173812 – Liberia COVID-18 Emergency Response Project (N = 5) “Community health workers,” “Community engagement,” “Eliminate financial barriers,” “Primary health care,” “Handwashing”</p>
<p>P173987 – The Gambia COVID-19 Preparedness and Response Project (N = 5) “Essential health care package,” “Community engagement,” “Handwashing,” “Surveillance,” “Disease prevention”</p>
<p>P173838 – Senegal Emergency COVID-19 Relief Project (N = 4) “Community health workers (2x),” “Maintaining essential health care services,” “Handwashing (3x),” “Surveillance”</p>
<p>P173846 – Niger COVID-19 Emergency Relief Project (N = 4) “Maintaining essential health care services,” “Community engagement,” “Handwashing (3x),” “Surveillance(3x)”</p>
<p>P173839 – Benin COVID-19 Emergency Relief and Response Project (N = 4) “Community engagement,” “Primary health care,” “Handwashing,” “Surveillance”</p>
<p>P173851 – The Republic of Congo Emergency Response Project (N = 4) “Maintaining essential community services,” “Community engagement,” “Handwashing (2x),” “Surveillance”</p>
<p>P173892 – Serbia COVID-19 Response Project (N = 4) “Maintaining essential community services,” “Community engagement,” “Handwashing (2x),” and “Surveillance”</p>
<p>P173876 – Yemen COVID-19 Response Project (N = 4) “Vaccines,” “Community engagement,” “Nurses,” “Surveillance”</p>

<p>P173834 – Papua New Guinea COVID-19 Emergency Response Project (N = 4) “Primary care,” “Community engagement (3x),” “Handwashing,” “Surveillance (2x)”</p>
<p>P173811 – Haiti COVID-19 Response (N = 4) “Community engagement,” “Handwashing,” “Hygiene practices,” “Surveillance”</p>
<p>P173902 – Myanmar COVID-19 Emergency Response Project (N = 4) “Immunization,” “Maintaining essential health care services,” “Primary health care,” “Nurses”</p>
<p>P174291 – Guinea COVID-19 Preparedness and Response Project “Handwashing,” “Hygiene practices,” “Essential community services,” “surveillance”</p>

Source: Author’s Calculations

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Soon after the World Health Organization (WHO) declared a pandemic, the World Bank made available rapid financing to strengthen countries' ability to respond to COVID-19 through a multiphase programmatic approach (MPA). The MPA's immediate objective is to prevent, detect, and respond to the COVID-19 pandemic. By July 2020, the World Bank's board of directors had approved financing for 74 countries. This evaluation aims to determine the extent to which response activities were planned at the primary health care (PHC) level, and the extent to which PHC was leveraged within the first wave of MPA projects was determined by the number of PHC activities listed in the project components and indicators. Of 74 projects evaluated, 70 (94 percent) had at least one PHC-related activity listed in the components. Frequently planned activities at the PHC level primarily included surveillance, handwashing, and community engagement-related activities. MPA projects did not prioritize a commitment to maintaining essential service delivery at the PHC level. Several projects showed a greater commitment to integrating response activities at the PHC level, including Côte d'Ivoire, Egypt, Liberia, and Papua New Guinea, Senegal, the Republic of Congo. Notably, except for Egypt and Papua New Guinea, these projects were in countries that have been affected or threatened by the Ebola pandemic. These countries emphasized the integration of pandemic response activities at the community level. Overall, this evaluation highlights three takeaways: (1) the most common project activities related to PHC focused on surveillance, community engagement, and disease prevention; (2) among MPA projects, those in the sub-Saharan African region integrated more pandemic response activities at the PHC level than did other regions; and (3) maintaining essential primary health care services was not a priority among MPA projects in the initial phase of the response.

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1818 H Street, NW
Washington, DC USA 20433



Telephone: 202 473 1000
Facsimile: 202 477 6391
Internet: www.worldbank.org
E-mail: feedback@worldbank.org