**TRAINING MANUAL FOR PARTICIPANTS**

KHYBER PAKHTUNKHWA- HUMAN CAPITAL INVESTMENT PROJECT

**GOVERNANCE, LEADERSHIP, MONITORING & EVALUATION IN PRIMARY HEALTHCARE SETTINGS**



**Activity:** Governance, Leadership, Monitoring & Evaluation in Primary Healthcare Settings

**Project Name:** Khyber Pakhtunkhwa Human Capital Investment Project

(KP-HCIP)

**Sponsored by:** World Bank

**Adapted from:** National & International Guidelines

**Implemented by:** Department of Health, Khyber Pakhtunkhwa, Pakistan

**Table of Contents:**

### **MODULE ONE: UNDERSTANDING LEADERSHIP & GOVERNANCE IN PHC**

* **Session 1.1:** Concepts of Leadership and Management
* **Session 1.2:** Leadership Styles and Competencies in Primary Health Care
* **Session 1.3:** Principles of Good Governance in Health
* **Session 1.4:** Conflict Management and Collaboration in Primary Health Care
* **Session 1.5:** Leading the Health Team
* **Session 1.6:** Role of Health Managers and Frontline Staff in Strengthening PHC

### **Module Two: Monitoring and Evaluation in Primary Health Care**

* **Session 2.1:** Introduction to Monitoring and Evaluation Concepts
* **Session 2.2:** Monitoring and Evaluation Framework in the Health Sector
* **Session 2.3:** Developing and Using Indicators
* **Session 2.4:** Monitoring and Evaluation Plan
* **Session 2.5:** Data Collection and Quality Assurance
* **Session 2.6:** Using M&E Data for Decision-Making

### **Module Three: Applying Leadership, Monitoring & Evaluation for Improved Health Outcomes**

* **Session 3.1:** Integrating Leadership and M&E for Effective Health Management
* **Session 3.2:** Performance Review and Supportive Supervision
* **Session 3.3:** Team Building and Communication in PHC Settings
* **Session 3.4:** Action Planning, Follow-Up and Sustaining Improvement

**Acknowledgement**

The development of the *Leadership, Monitoring and Evaluation in Primary Healthcare Settings* training manual has been made possible through the concerted efforts and collaboration of multiple partners under the Khyber Pakhtunkhwa Human Capital Investment Project (KP-HCIP), supported by the World Bank. This manual reflects the shared vision and commitment of the Department of Health, Khyber Pakhtunkhwa and its development partners to strengthen the foundations of Primary Health Care (PHC) as a cornerstone for achieving Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs).

We extend our deepest gratitude to the Directorate General Health Services (DGHS), the KP-HCIP Project Management Unit (PMU) and all technical experts, trainers and health professionals who have contributed their expertise, experience and valuable insights to the development of this manual. Special appreciation is extended to the primary healthcare teams, health facility managers and frontline health workers, for delivering essential health services in communities across Khyber Pakhtunkhwa. Their role in improving health outcomes and ensuring equitable access to quality care is very important toward universal health coverage in the province.

This manual has been developed as a practical guide and capacity-building resource for healthcare providers, managers and supervisors at all levels of the primary health care system. It aims to equip them with essential leadership, monitoring and evaluation skills necessary to strengthen health system performance and ensure accountability.

Through effective leadership and good monitoring and evaluation mechanisms, healthcare workers can play a transformative role in improving service delivery, optimizing resource use and ensuring quality care. Aligned with the broader goals of KP-HCIP and the SDGs, this collaborative effort represents a step forward in building a resilient, people-centered health system — one that empowers health workers, engages communities and advances Khyber Pakhtunkhwa’s vision for a healthier, more equitable future.

**Message from the Chief Minister, Khyber Pakhtunkhwa**

It gives me great pleasure to extend my warm regards to all participants and stakeholders of the *Training Module on Leadership, Monitoring and Evaluation in Primary Healthcare Settings* under the Khyber Pakhtunkhwa Human Capital Investment Project (KP-HCIP), supported by the World Bank.

This initiative represents an important step toward strengthening our primary health care system — the foundation of equitable, accessible and people-centered healthcare. Strong leadership and effective monitoring and evaluation are essential to achieving Universal Health Coverage (UHC) and advancing the Sustainable Development Goals (SDGs), particularly those focused on health, equity and sustainable development.

By empowering our healthcare workforce with leadership and data-driven management skills, we are fostering accountability, improving service delivery and ensuring that every individual has access to quality care. This training reflects our collective commitment to building a resilient health system that meets the evolving needs of our communities.

I encourage all participants to actively engage in this program and apply the knowledge gained to strengthen primary health care at every level. Together, we can move closer to our vision of a healthier, more inclusive and prosperous Khyber Pakhtunkhwa.

Thank you.

**Mr. Sohail Afridi**

**Chief Minister**

**Khyber Pakhtunkhwa**

**Message from the Health Minister, Khyber Pakhtunkhwa**

Dear Colleagues and Stakeholders,

It gives me great pleasure to share my appreciation for the *Training Module on Leadership, Monitoring and Evaluation in Primary Healthcare Settings*, developed under the Khyber Pakhtunkhwa Human Capital Investment Project (KP-HCIP) with the support of the World Bank.

This initiative reflects our strong commitment to strengthening Primary Health Care (PHC) as the cornerstone of Universal Health Coverage (UHC) and a key driver in achieving the Sustainable Development Goals (SDGs). By building the leadership and analytical capacity of our healthcare workforce, we are ensuring that health services are not only more efficient and accountable but also equitable and people-centered.

Empowered health leaders at all levels are essential for improving service delivery, optimizing resources and ensuring that every citizen — regardless of location or income — has access to quality healthcare. I encourage all participants to engage fully, share their experiences and apply the lessons learned to strengthen PHC delivery across the province.

Together, let us continue advancing toward a healthier, more resilient and inclusive Khyber Pakhtunkhwa.

**Mr. Ihtesham Ali**

**Health Minister**

**Message from the Director General Health Services of Khyber Pakhtunkhwa**

Dear Esteemed Health Professionals,

It is a pleasure to extend my warm greetings to all participants of the *Leadership, Monitoring and Evaluation in Primary Healthcare Settings* training, organized under the KP-HCIP with support from the World Bank.

Primary Health Care remains the foundation of our health system and a critical pathway toward achieving Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs). Strengthening leadership, monitoring and evaluation capacities within PHC is vital for improving service delivery, ensuring accountability and making informed, evidence-based decisions that directly benefit communities.

This training program aims to empower our frontline health professionals and managers to take ownership of health outcomes, lead effectively and foster a culture of continuous improvement within their teams. I urge all participants to make the most of this opportunity to enhance their skills and contribute to building a stronger, more responsive health system for Khyber Pakhtunkhwa. Let’s play our valuable role in improving health status of a common man.

**Dr. Shahid Yunis**

**Director General Health Services, Khyber Pakhtunkhwa, Pakistan**

**Message from Project Director, KP-HCIP**

It gives me great pleasure to introduce this training module on Leadership and Monitoring Evaluation for Primary Health Care (PHC) staff. Strong health systems are built on the foundation of effective governance, skilled leadership and robust accountability mechanisms. At the heart of these systems are our doctors, nurses, paramedics and community health workers, who translate policies into meaningful services for people.

This module has been designed to strengthen the knowledge and skills of medical and paramedical staff working in PHC canters. By engaging in interactive sessions, case studies and practical exercises, participants will gain tools to improve decision-making, enhance teamwork and apply simple yet powerful approaches to monitoring and evaluation.

The training is fully aligned with the National Health Vision of Pakistan and contributes directly to our country’s commitment to achieving Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs). By improving service quality, accountability and community trust, PHC centers will be better equipped to address the health needs of our population.

I encourage all participants to actively engage, share experiences and take ownership of this learning journey. The skills you gain here are not just for the training room—they are practical tools to transform how health services are delivered in your communities.

**Dr. Muhammad Bilal**

**Project Director, KP-HCIP, Pakistan**

**Glossary:**

**Accountability**

The obligation of health workers and managers to explain decisions, justify actions and accept responsibility for outcomes.

**Community Participation**

Involvement of community members in planning, implementing and evaluating health services to ensure relevance and acceptance.

**Conflict Resolution**

Methods used to address disagreements constructively within health teams to maintain collaboration and service quality.

**Data Collection**

Systematic process of gathering information (e.g., patient records, service statistics, surveys) for monitoring health programs.

**Decision-Making**

The process of selecting the best course of action, based on evidence, to improve health services.

**Ethical Standards**

Professional rules and principles (honesty, confidentiality, respect, non-discrimination) guiding medical and paramedical staff.

**Evaluation**

Assessment of whether health interventions achieve intended objectives, focusing on effectiveness, impact and sustainability.

**Governance (in health)**

How decisions are made, implemented and monitored in health systems, ensuring accountability, transparency, responsiveness, equity and participation.

**Indicators**

Specific, measurable variables (e.g., immunization coverage rate) used to monitor performance of health programs.

**Leadership**

The ability to inspire, influence and guide individuals or teams toward achieving shared health goals.

**Leadership Styles**

Approaches leaders use to guide and motivate (e.g., transformational, transactional, participatory, autocratic).

**Management**

Planning, organizing and controlling resources to achieve specific health objectives, distinct from leadership.

**Monitoring**

Continuous tracking of program implementation to ensure activities are on schedule and meeting targets.

**Motivation**

Factors that inspire individuals to perform effectively and remain committed to their work.

**Primary Health Care (PHC)**

Essential health services delivered at the first level of contact, including prevention, treatment and community health promotion.

**Quality of Care**

Health services that are safe, effective, patient-centered, timely, efficient and equitable.

**Sustainable Development Goals (SDGs)**

A set of 17 global goals adopted by the UN

**Teamwork**

Collaborative effort of health staff to achieve common goals, ensuring efficient, patient-centered care.

**Transparency**

Openness in decision-making and sharing of information with staff, patients and communities.

**Universal Health Coverage (UHC)**

Ensuring that all people receive needed health services (prevention, treatment, rehabilitation) without financial hardship.

**WHO Governance Framework**

The World Health Organization’s model outlining principles and functions of governance in health systems.

# List of Abbreviations

|  |  |
| --- | --- |
| **Acronym** | Full Form |
| **ANC** | Antenatal Care |
| **BCC** | Behavior Change Communication |
| **BHU** | Basic Health Unit |
| **CHW** | Community Health Worker |
| **DHIS2** | District Health Information System, version 2 |
| **DHMT** | District Health Management Team |
| **DGHS** | Directorate General Health Services |
| **DoH** | Department of Health |
| **EPI** | Expanded Program on Immunization |
| **GDP** | Gross Domestic Product |
| **GIS** | Geographic Information System |
| **GoKP** | Government of Khyber Pakhtunkhwa |
| **HCIP** | Human Capital Investment Project |
| **HIS** | Health Information System |
| **HMIS** | Health Management Information System |
| **HRH** | Human Resources for Health |
| **HRM** | Human Resource Management |
| **HSS** | Health System Strengthening |
| **ICT** | Information and Communication Technology |
| **IEC** | Information, Education and Communication |
| **KPI / KPIs** | Key Performance Indicator(s) |
| **KP-HCIP** | Khyber Pakhtunkhwa Human Capital Investment Project |
| **LHS** | Lady Health Supervisor |
| **LHW** | Lady Health Worker |
| **LMIS** | Logistics Management Information System |
| **LQAS** | Lot Quality Assurance Sampling |
| **M&E** | Monitoring and Evaluation |
| **MIS** | Management Information System |
| **MoNHSR&C** | Ministry of National Health Services, Regulations & Coordination (Pakistan) |
| **NCD / NCDs** | Non-Communicable Disease(s) |
| **NHS** | National Health Strategy (Pakistan) |
| **NGO** | Non-Governmental Organization |
| **OPD** | Outpatient Department |
| **PDSA** | Plan–Do–Study–Act (Cycle for Quality Improvement) |
| **PHC** | Primary Health Care |
| **PHFMC** | Provincial Health Facilities Management Company |
| **PMU** | Project Management Unit |
| **PPP** | Public–Private Partnership |
| **QA** | Quality Assurance |
| **QI** | Quality Improvement |
| **QoC** | Quality of Care |
| **RHC** | Rural Health Centre |
| **SDG / SDGs** | Sustainable Development Goal(s) |
| **SMART** | Specific, Measurable, Achievable, Relevant, Time-bound (Indicators) |
| **SOP** | Standard Operating Procedure |
| **SWOT** | Strengths, Weaknesses, Opportunities and Threats |
| **TOR** | Terms of Reference |
| **UHC** | Universal Health Coverage |
| **UHS** | Universal Health System |
| **UNICEF** | United Nations International Children’s Emergency Fund |
| **VHC** | Village Health Committee |
| **WASH** | Water, Sanitation and Hygiene |
| **WHO** | World Health Organization |



**Introduction to Manual**

Health managers and supervisors need to regularly update their skills to perform well and help achieve national and global health goals. Today’s health system is more complex than ever before. It faces many challenges — changes in disease patterns, limited resources, population growth, new technologies and higher expectations from the public.

To manage these challenges, health managers must have strong **leadership, management and governance skills.** The skills needed today are very different from those required ten years ago. However, many health managers in low- and middle-income countries have not received formal training in these areas during their studies.

In many cases, **young health professionals** are taking on leadership and managerial roles without proper preparation. They need practical skills to lead teams, manage resources, make evidence-based decisions and deliver better health services. Unfortunately, most leadership and management training programs are still limited in number and scale.

The **World Health Organization (WHO)** identifies **leadership and governance** as one of the six key building blocks of a strong health system. The other building blocks include:

* Service delivery
* Health workforce
* Health information systems
* Medical products, vaccines and technologies
* Health system financing

Leadership and governance are essential because they ensure that all the other parts of the health system work well. According to WHO, good leadership and governance mean having clear policies, effective supervision, teamwork, accountability and a system that supports improvement.

Different assessments have shown that there are major gaps in leadership and management skills in the health sector. Strengthening these skills can help improve service delivery, use of resources, coordination and implementation of health policies and reforms — especially in a **decentralized primary healthcare system**.

For this reason, **capacity building in leadership, management and governance** is very important. This training manual for **Primary Health Care (PHC) workers in Khyber Pakhtunkhwa** aims to help fill those gaps. It provides simple, practical guidance to strengthen leadership, improve decision-making and enhance accountability at the community and facility levels. Through this training, PHC workers will be better prepared to lead teams, manage programs effectively and contribute to building a stronger, more responsive and people-centered health system in Khyber Pakhtunkhwa.

**Target audience:**

The Governance, Leadership, Monitoring and Evaluation (M&E) module is designed for Primary Health Care (PHC) professionals who play key roles in managing and delivering health services at the community and facility levels. The target audience includes Medical Officers, Lady Health Visitors (LHVs), Medical Technicians, Health Facility Managers, Supervisors and Health Managers from the Department of Health.

These professionals are central to improving service delivery, ensuring accountability and promoting evidence-based decision-making within the health system. Medical Officers lead health teams and oversee the implementation of primary healthcare programs. LHVs and Medical Technicians provide essential frontline services, community health education and data reporting, which are vital for effective monitoring and evaluation.

Health Managers and Supervisors at various administrative levels are responsible for guiding teams, ensuring quality of care, managing resources and supporting data-driven planning and performance review.

**Training Manual Contents:**

Each module in the manual is divided into sessions and activities, each with clear objectives to guide the learning process. Every session includes a defined aim, a list of necessary materials and equipment, an estimated time frame and step-by-step instructions for execution. Some activities may require preparatory work ahead of the training session. To enhance learning, the sessions are supported by handouts, PowerPoint presentations, case studies and classroom exercises, all of which are designed to facilitate engagement and reinforce key concepts.

**Scope and implementation guidelines:**

This 2-day training program is designed to build the capacity of primary health care doctors and paramedical staff in leadership monitoring & evaluation (M&E). Its scope extends to strengthening accountability, transparency, teamwork and evidence-based decision-making at the primary health care level. The training emphasizes practical skills such as identifying governance gaps, applying effective leadership styles and using M&E tools to improve service delivery and patient outcomes. Implementation should involve interactive methods including case studies, group discussions and role plays to ensure active participation and contextual learning. Doctors and paramedics are expected to apply these skills in their daily practice by promoting collaborative leadership, ensuring ethical governance in patient care and utilizing monitoring data to enhance health system performance. Continuous follow-up, supportive supervision and integration of these practices into routine PHC operations are recommended for sustainability.

**Support and Alignment with National Plan of Pakistan**

This training agenda directly supports the Government of Pakistan’s commitment to strengthening Primary Health Care (PHC) under the National Health Vision (2016–2025) and aligns with the objectives of Universal Health Coverage and the Sustainable Development Goals (SDGs). By focusing on leadership monitoring & evaluation, the program reinforces the national priority of improving accountability, service quality and health system responsiveness at the grassroots level. It complements the Essential Package of Health Services (EPHS) by empowering doctors and paramedics to deliver people-centered care, ensure efficient use of resources and apply evidence-based decision-making. Through capacity building of PHC teams, this initiative contributes to the broader goals of reducing health disparities, enhancing community trust in the health system and achieving targets set in Pakistan’s national and provincial health sector strategies.

**MODULE ONE**

**UNDERSTANDING LEADERSHIP & GOVERNANCE IN PHC**



## **SESSION**

# **INTRODUCTION AND OBJECTIVES OF THE TRAINING**

### **Introduction**

Strong leadership, good governance and effective monitoring and evaluation (M&E) are the backbone of a resilient primary healthcare (PHC) system. In Khyber Pakhtunkhwa, PHC workers face a variety of challenges—ranging from limited resources and geographical barriers to growing community health needs. To meet these challenges, healthcare staff must develop the right leadership and management skills, supported by data-driven decision-making through M&E.

This training module on **Leadership, Monitoring and Evaluation in Primary Health Care Settings** has been developed under the **Khyber Pakhtunkhwa Human Capital Investment Project (KP-HCIP),** supported by the **World Bank**. It aims to strengthen the skills of PHC managers and frontline healthcare providers so they can effectively plan, manage and evaluate health services for better outcomes.

Effective leadership ensures that health teams are motivated, guided and aligned toward achieving a common vision — healthier communities. Monitoring and evaluation provide the tools to track progress, measure impact and continuously improve healthcare delivery. When combined, **leadership** and **M&E** drive accountability, equity and better health for all.

This session will introduce the training, its goals and how leadership and M&E contribute to **Universal Health Coverage (UHC)** and the **Sustainable Development Goals (SDGs)** — particularly **SDG 3: Ensure healthy lives and promote well-being for all at all ages.**

### **1. Understanding the Purpose of the Training**

This training has been designed for **Primary Health Care workers in Khyber Pakhtunkhwa,** including **Medical Officers, Lady Health Visitors (LHVs), Health Technicians, Supervisors and Health Managers**. These professionals are the foundation of the healthcare system and play a crucial role in ensuring that communities receive accessible, quality and people-centered services.

The main purpose of the training is to **build capacity** in leadership, governance and M&E so that participants can:

* Manage health facilities more effectively.
* Use data for decision-making and planning.
* Foster teamwork and accountability at all levels of PHC.
* Contribute to achieving provincial and national health targets.

Leadership and M&E are not separate technical skills—they are part of a **continuous improvement cycle** that enables health teams to learn, adapt and respond to community needs.

### **2. Importance of Leadership in Primary Health Care**

Leadership in PHC is about **guiding teams, making evidence-based decisions and ensuring that health services are equitable and efficient**. It is not limited to people with administrative titles—every healthcare worker can demonstrate leadership by:

* Setting a positive example.
* Taking initiative to solve local problems.
* Motivating others and promoting teamwork.
* Communicating effectively with colleagues and the community.

In the context of **Khyber Pakhtunkhwa**, strong leadership is particularly vital because PHC facilities often serve as the first and sometimes only point of contact for people in rural and remote areas. A skilled and motivated leader can ensure that these facilities deliver continuous and quality care despite challenges such as limited staffing, resources, or infrastructure.

***Example:***

A Lady Health Visitor who organizes her team to track high-risk pregnancies in her catchment area is practicing leadership. By mobilizing resources and engaging the community, she helps prevent complications and promotes safe motherhood — a key contribution to achieving UHC and SDG 3.

### **3. Importance of Monitoring and Evaluation (M&E)**

Monitoring and Evaluation are essential tools for **tracking progress, identifying gaps and improving health outcomes.**

* ***Monitoring*** is the routine collection and analysis of data to measure whether activities are being implemented as planned.
* ***Evaluation*** is the systematic assessment of the relevance, efficiency and effectiveness of health programs.

In PHC settings, M&E helps:

* Track service delivery (e.g., immunization coverage, antenatal visits).
* Measure health outcomes (e.g., reduction in maternal or child mortality).
* Identify areas needing improvement.
* Support accountability and transparency.

In Khyber Pakhtunkhwa, data collected through systems such as **DHIS2 (District Health Information System 2)** and **HMIS (Health Management Information System)** are vital for planning and decision-making at both facility and district levels. PHC workers play a key role in ensuring the accuracy and timeliness of this data.

### **4. Linkages with Universal Health Coverage (UHC) and SDGs**

Universal Health Coverage (UHC) means that all individuals and communities receive the health services they need without suffering financial hardship. Leadership and M&E are essential to achieving UHC because they help:

* Improve the **quality and equity** of services.
* Strengthen **accountability** in service delivery.
* Ensure that resources are used **efficiently and transparently.**
* Track progress towards achieving **SDG 3 (Good Health and Well-being)** and other health-related SDGs.

In Pakistan, the **National Health Vision 2025** and the **Khyber Pakhtunkhwa Health Policy** align with the global UHC agenda. Strengthening PHC through effective leadership and M&E supports these goals by ensuring that health services are **accessible, affordable and people-centered.**

***In short:***

“Good leadership ensures direction; effective monitoring ensures progress; together they make UHC a reality.”

### **5. Training Overview and Participant Expectations**

This two-day training will cover three main modules:

1. ***Understanding Leadership and Governance in PHC***

(What leadership and good governance mean in healthcare settings.)

1. ***Monitoring and Evaluation in PHC***

(How to collect, interpret and use data for decision-making.)

1. ***Applying Leadership and M&E for Improved Health Outcomes***

(How to integrate leadership and M&E into daily practice at PHC facilities.)

During the training, participants will engage in:

* **Interactive lectures** to introduce key concepts.
* **Group discussions and role plays** to share experiences.
* **Practical exercises** to design indicators, analyze data and plan actions.

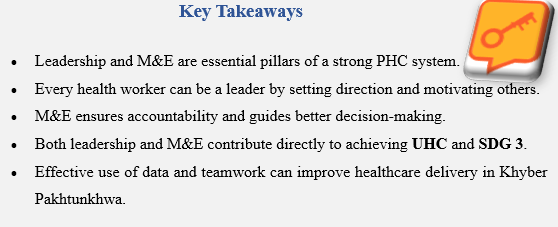
Participants are expected to:

* Attend all sessions actively.
* Share their field experiences openly.
* Collaborate in group activities.
* Apply lessons learned in their own facilities after training.

### **6. Role of PHC Workers in Strengthening Health Systems**

Every PHC worker contributes to leadership and M&E through daily actions:

* ***Medical Officers*** ensure that clinical and administrative functions run smoothly.
* ***LHVs and Technicians*** provide essential care and maintain accurate records.
* ***Supervisors and Managers*** coordinate activities, review data and guide teams.

By developing leadership and M&E skills, PHC workers help bridge the gap between **policy and practice.** They become change agents who improve service delivery, community trust and health outcomes in their areas.

### **Reflection Questions**

1. Why are leadership and monitoring important for improving PHC services?
2. How does leadership at the facility level contribute to achieving UHC?
3. What are your personal expectations from this training?
4. How can you apply M&E in your daily work at the facility?
5. What leadership qualities do you think are most important for PHC workers in KP?

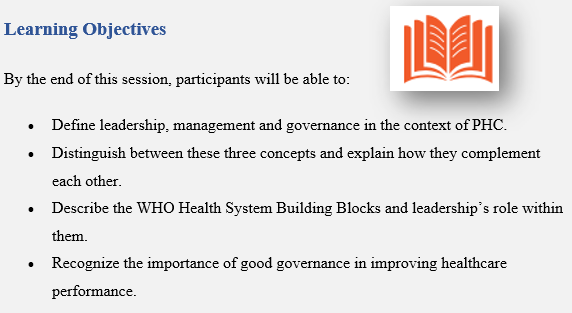
## **SESSION 1.1**

# **CONCEPTS OF LEADERSHIP and MANAGEMENT**

### **Introduction**

Effective health service delivery in any country depends on how well leadership, management and governance are practiced at every level of the health system. In **Primary Health Care (PHC),** where healthcare workers are directly in touch with communities, these three concepts play an especially critical role.

In Khyber Pakhtunkhwa, PHC workers often face multiple challenges — limited staff, inadequate supplies, geographical barriers and increasing health demands. Despite these constraints, many health workers continue to serve with dedication and creativity. What makes this possible is strong **leadership**, efficient **management** and transparent **governance.**

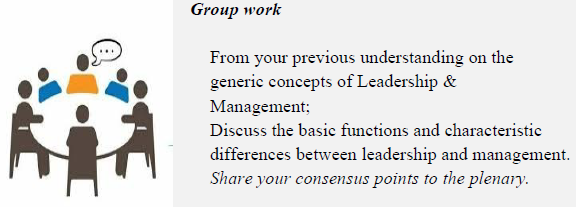
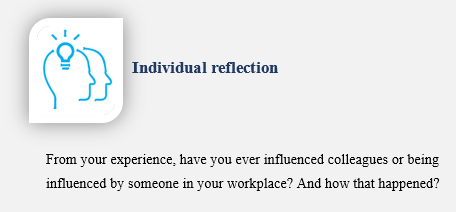
Together, these three forms the foundation of a well-functioning health system — one that ensures **accountability, quality and equity** in healthcare services. Understanding how leadership, management and governance differ — and how they work together — is the first step toward improving health outcomes and achieving **Universal Health Coverage (UHC)** and the **Sustainable Development Goals (SDGs).**

### **1. Basic Concepts of Leadership and Management**

This section introduces the **core concepts of leadership and management**, highlighting their similarities and differences. Both are essential processes in guiding teams toward achieving health goals, but leadership emphasizes **influence, vision and motivation**, while management focuses on **planning, organizing and coordinating resources**.

**Group Activity:**

Participants discuss their understanding of leadership and management, identify key differences and share insights with the group. (Time: 10 minutes)

**Leadership** is defined as a process in which an individual influence a group to achieve a common goal (Northouse, 2016).

**Essential Components of Leadership:**

|  |  |  |  |
| --- | --- | --- | --- |
| ****Concept**** | ****Definition (Simple)**** | ****Key Focus**** | ****Example in PHC Context (KP)**** |
| ****Leadership**** | The ability to influence, inspire and guide others toward achieving shared goals. | Vision, motivation, change, innovation. | A medical officer encouraging teamwork and community participation to improve immunization coverage. |
| ****Management**** | The process of planning, organizing, coordinating and controlling resources to achieve results. | Efficiency, planning, resource use, supervision. | A Lady Health Supervisor ensuring supplies, schedules and reports are properly managed at a BHU. |

These three components are **interdependent** — leadership gives direction, management provides structure and governance ensures accountability.

“Leadership sets the vision, management turns vision into action and governance keeps everyone accountable.”

### **2. Relationship Among Leadership and Management**

Although these functions are distinct, they overlap significantly in practice:

* ***Leadership*** focuses on setting a **vision** and motivating others.
* ***Management*** ensures that this vision is translated into **plans and actions.**

For example, in a **Basic Health Unit (BHU):**

* The **Medical Officer** may provide leadership by identifying a community health issue (low vaccination rates).
* The **Facility In-charge** manages by planning outreach sessions, assigning staff and monitoring progress.
* The **District Health Office** governs by ensuring transparency, resource allocation and reporting mechanisms.

Thus, success in PHC depends on the **balance and interaction** among these three elements. Without leadership, there is no direction. Without management, there is no implementation. Without governance, there is no accountability.

### **3. Leadership in Health Systems**

Leadership in the health sector involves guiding teams, influencing behavior and fostering collaboration for better outcomes. A strong health leader:

* Sets a clear vision for improving services.
* Inspires others to take responsibility and act ethically.
* Adapts to challenges using data and feedback.
* Promotes equity and community participation.

In Khyber Pakhtunkhwa, many PHC leaders have demonstrated resilience during emergencies such as floods, disease outbreaks and pandemics. Their ability to **mobilize teams, engage communities** and **coordinate responses** shows how leadership directly affects community health outcomes.

“Effective health leadership transforms limited resources into lasting impact.”

### **4. Management in Primary Health Care**

Management ensures that available resources — human, financial and material — are used efficiently to deliver quality services. It involves **planning, organizing, staffing, implementing, supervising and evaluating** activities.

**Key functions of management in PHC include:**

1. ***Planning:*** Setting priorities and developing action plans for services such as immunization, maternal care and NCD management.
2. ***Organizing:*** Assigning roles and responsibilities among staff.
3. ***Staffing*:** Ensuring the right number of qualified personnel are available.
4. ***Implementing:*** Carrying out planned activities according to schedule.
5. ***Supervising:*** Monitoring staff performance and providing feedback.
6. ***Evaluating:*** Measuring progress against targets and identifying gaps.

***Example:***

A PHC manager develops a monthly plan for outreach immunization, ensuring that vaccines, cold-chain equipment and staff schedules are ready. She also reviews data from DHIS2 to adjust the next month’s activities. This is management in action.

### **Managerial Roles**

The figure illustrates the three main categories of managerial roles—**Interpersonal, Informational and Decisional**—which together describe the key responsibilities of a health manager. Effective health facility management requires balancing all these roles to ensure quality service delivery, teamwork and accountability.

### ***1. Interpersonal Roles***

These roles involve building and maintaining relationships with staff, partners and the community.

* **Figurehead:**  
  Represents the health facility in official functions, community meetings, or government events. Demonstrates professionalism and promotes institutional values.
* **Leader:**  
  Guides and motivates health workers, sets performance expectations and fosters a supportive work environment for better patient care.
* **Liaison:**  
  Connects with other departments, organizations and community stakeholders to coordinate health activities and share resources effectively.

### ***2. Informational Roles***

These roles focus on gathering, processing and sharing important data for decision-making.

* **Monitor:**  
  Collects and reviews information on facility performance, disease trends and staff activities to ensure services meet standards.
* **Disseminator:**  
  Shares relevant information—such as policy updates or new health guidelines—with staff to maintain informed and effective teams.
* **Spokesperson:**  
  Communicates the facility’s achievements, challenges and needs to higher management, health authorities and the community.

### ***3. Decisional Roles***

These roles involve making strategic and operational decisions to improve health outcomes.

* **Entrepreneur:**

Initiates innovations such as community outreach programs or digital health records to improve service delivery.

* **Disturbance Handler:**

Manages conflicts, emergencies, or unexpected challenges like outbreaks or staff shortages efficiently and calmly.

* **Resource Allocator:**

Ensures fair and efficient use of budgets, equipment and human resources according to priorities.

* **Negotiator:**

Works with partners, staff, or community representatives to reach agreements that benefit the facility and patients.



### **Characteristic Differences Between a Manager and a Leader**

A **Manager** is a formally appointed person responsible for ensuring that tasks are completed efficiently and resources are used effectively. Managers focus on planning, organizing, coordinating and monitoring work performance to achieve set targets within an organization.

A **Leader**, on the other hand, is someone who **influences and inspires others** to willingly pursue shared goals. Leadership is not limited to position—it is about vision, motivation and the ability to guide people toward achieving meaningful outcomes.

The table below summarizes the key differences between managers and leaders:

### **Table: Comparison Between Managers and Leaders**

|  |  |  |
| --- | --- | --- |
| ****Functions / Characteristics**** | ****Managers**** | ****Leaders**** |
| **Primary Focus** | Manage complexity | Inspire change |
| **Core Activities** | Plan, organize, budget | Motivate and align people |
| **Role with Staff** | Direct and supervise | Empower and develop |
| **Approach to Problems** | Control and monitor | Encourage innovation |
| **System Orientation** | Administer and maintain | Challenge status quo |
| **Time Orientation** | Short-term focus | Long-term vision |
| **Questioning Style** | Ask “how” and “when” | Ask “what” and “why” |
| **Style of Work** | Imitate established methods | Innovate new approaches |
| **Guiding Principle** | Do things right | Do the right things |

Both managers and leaders play essential roles in the effective functioning of Primary Health Care (PHC) systems. **Managers** ensure structure, stability and accountability through proper planning, organization and control of resources, while **leaders** inspire vision, motivate teams and drive positive change in challenging environments. An effective PHC professional must therefore **combine managerial efficiency with leadership inspiration** — doing things right while also doing the right things to achieve sustainable health outcomes.

### **Governance in Health Systems**

**Governance** is about how decisions are made, who makes them and how responsibilities are shared. In health systems, it ensures that decisions and resources serve the public interest fairly and effectively.

According to **WHO**, good health governance includes:

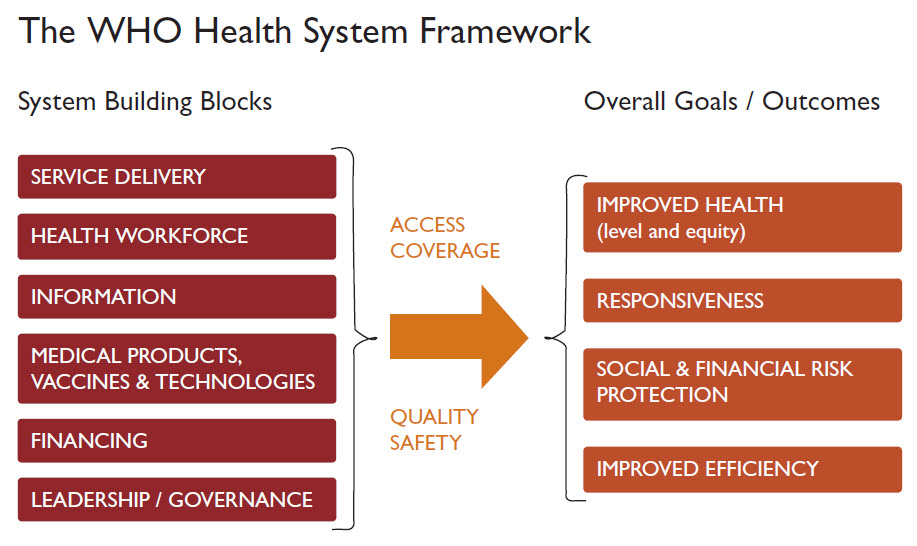
* ***Accountability*:** Decision-makers are answerable for their actions.
* ***Transparency:*** Processes and data are open and accessible.
* ***Equity:*** Services are fair and available to all.
* ***Rule of Law:*** Policies and standards are followed.
* ***Participation:*** Communities and stakeholders have a voice.

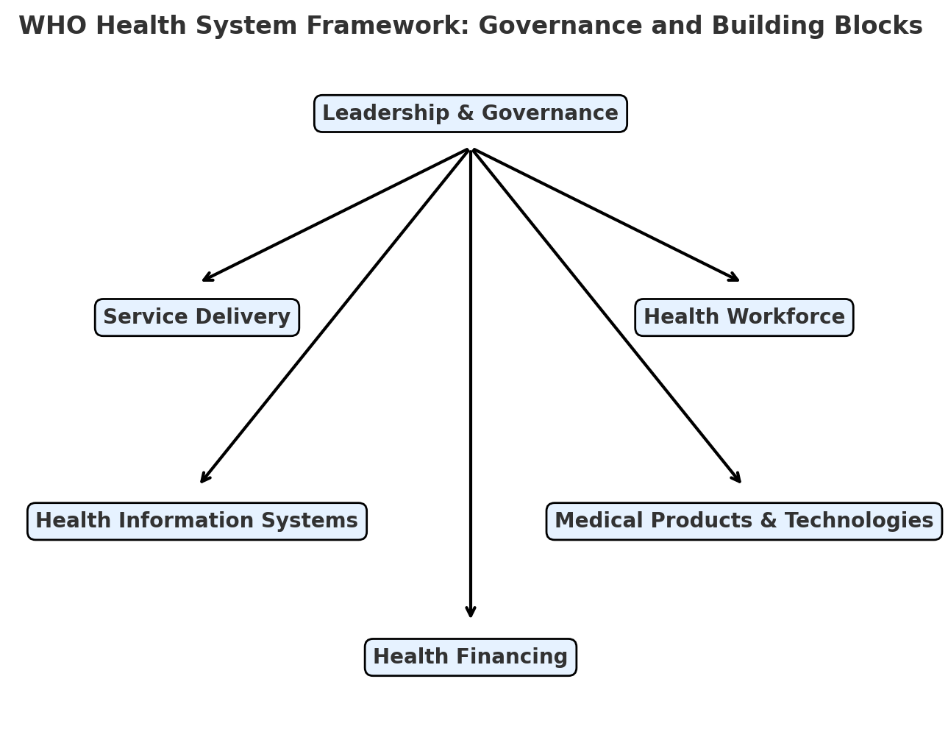
It builds **trust** between health providers and communities — an essential ingredient for Universal Health Coverage.

|  |  |  |
| --- | --- | --- |
| ****Principle of Good Governance**** | ****Meaning**** | ****Example in PHC Setting**** |
| Accountability | Taking responsibility for results. | Facility in-charge reviews data with district supervisor. |
| Transparency | Sharing information openly. | Public display of services and fees at the facility. |
| Participation | Engaging community in decisions. | Involving local health committees in health campaigns. |
| Equity | Fair access to care. | Ensuring women and remote populations get equal services. |
| Rule of Law | Following established policies. | Implementing treatment guidelines and ethical practices. |

### **6. WHO Health System Building Blocks**

The **World Health Organization (WHO)** identifies **six interrelated building blocks** of a health system. Leadership and governance form the foundation that enables the other five to function effectively.



****

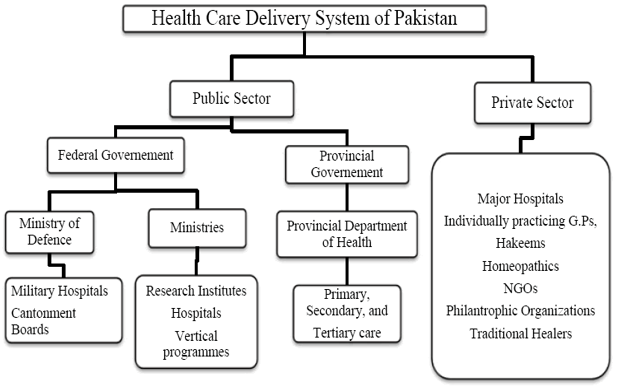
|  |  |  |
| --- | --- | --- |
| ****WHO Building Block**** | ****Description**** | ****Role of Leadership and Governance**** |
| ****Service Delivery**** | Quality and equitable services provided to all. | Leaders ensure effective planning, supervision and quality improvement. |
| ****Health Workforce**** | Skilled and motivated personnel. | Leadership motivates, supports and manages performance. |
| ****Information Systems**** | Reliable data for decision-making. | Governance ensures data accuracy, confidentiality and use. |
| ****Medical Products, Vaccines and Technologies**** | Availability and safety of essential supplies. | Leaders manage logistics and accountability for use of resources. |
| ****Health Financing**** | Adequate and fair funding. | Governance ensures transparency and efficiency in financial management. |
| ****Leadership and Governance**** | Stewardship, policy, oversight and coordination. | Provides direction, accountability and vision across all building blocks. |

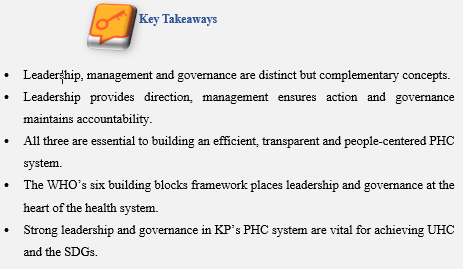
Without leadership and governance, all other components risk being weak or fragmented. Strong leadership ensures coordination and governance maintains trust and accountability in the system.

### **7. Importance in the Context of KP and Pakistan**

In Pakistan — and particularly in Khyber Pakhtunkhwa — health sector reforms emphasize decentralization and local empowerment. PHC facilities now have greater responsibility for planning and performance. This makes leadership, management and governance skills more important than ever.

* **Provincial health policies** emphasize integrated service delivery and data-driven decisions.
* **District Health Offices** are responsible for coordinating M&E and ensuring standards.
* **Frontline workers** represent the system to the community and must uphold transparency and trust.



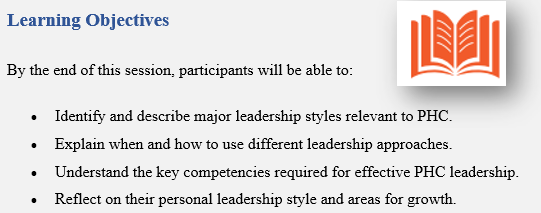
By strengthening these competencies at the PHC level, KP moves closer to achieving **UHC** and **SDG 3 (Good Health and Well-being)** — ensuring that no one is left behind.

## **SESSION 1.2**

# **LEADERSHIP STYLES AND COMPETENCIES IN PRIMARY HEALTH CARE (PHC)**

### **Introduction**

Leadership is not just about holding a position — it is about **influencing people to achieve a common goal**. In health systems, especially at the **Primary Health Care (PHC)** level, leaders must be able to adapt to challenges, motivate teams and guide change even in difficult circumstances.

Health workers and managers in **Khyber Pakhtunkhwa (KP)** work in diverse and often challenging environments. To be effective, they need to use the right leadership approach depending on the situation — whether managing staff shortages, community resistance, or implementing new health initiatives.

This session helps participants recognize different **leadership styles** and understand which approaches are most effective in PHC settings. It also guides participants to reflect on their own leadership style through a **self-assessment exercise.**

### **1. Understanding Leadership Styles**

Different situations require different types of leadership. There is no single “best” style — effective leaders are flexible and choose the approach that best fits the people, context and challenges they face.

Below are **three leadership styles** that are particularly relevant in primary health care:

|  |  |  |
| --- | --- | --- |
| ****Leadership Style**** | ****Description (Simple)**** | ****When Useful**** |
| **Transformational Leadership** | Inspires and motivates others to achieve a shared vision and go beyond their personal interests. | When there is need for change, innovation, or improving motivation. |
| **Adaptive Leadership** | Adjusts strategies and actions based on changing conditions or unexpected challenges. | During crises, emergencies, or limited resources. |
| **Participatory (Democratic) Leadership** | Involves team members and stakeholders in decision-making to build ownership. | When teamwork and local input are essential. |

**Note:** A good leader often blends these styles. For example, during an outbreak, a PHC manager may be **adaptive** in adjusting plans, **transformational** in motivating staff and **participatory** in engaging the community.

### **2. Why Leadership Styles Matter in PHC**

The way a leader behaves directly influences:

* **Team performance and morale**
* **Community trust and participation**
* **Efficiency of service delivery**
* **Achievement of targets and indicators**

For example, a **directive leader** may achieve quick results but can lower team morale if used continuously. In contrast, a **participatory leader** may take longer to decide but builds stronger, more committed teams.

Balancing flexibility, empathy and accountability is therefore essential.

### **3. Leadership Competencies for PHC**

Leadership competencies are the **knowledge, skills and attitudes** that enable effective leadership. PHC leaders and managers must develop these to handle complex health challenges.

|  |  |
| --- | --- |
| ****Leadership Competency**** | ****Description**** |
| **Vision and Strategic Thinking** | Setting clear goals aligned with health priorities. |
| **Communication and Influence** | Sharing information effectively and inspiring others. |
| **Decision-Making and Problem-Solving** | Using evidence and judgment to make sound choices. |
| **Team Building and Motivation** | Fostering trust, collaboration and morale among staff. |
| **Adaptability and Resilience** | Remaining calm and effective under pressure or change. |
| **Ethics and Accountability** | Promoting transparency, fairness and responsible behavior. |
| **Community Engagement** | Involving community members in identifying needs and solutions. |

Building these competencies strengthens leadership at all levels of PHC and contributes to achieving **SDG 3 (Good Health and Well-being)** and **Universal Health Coverage (UHC).**

### **4. Self-Assessment of Leadership Style (Interactive Exercise)**

***Purpose:***  
To help participants identify their dominant leadership style and areas for improvement.

***Instructions for Participants:***

1. Read each statement in the table below and tick ✔ the response that best describes how you usually act at work.
2. Count the number of ticks in each column to find your most dominant style.
3. Reflect on how this style helps or limits you in your current role.

|  |  |  |  |
| --- | --- | --- | --- |
| ****Statement**** | ****Transformational**** | ****Adaptive**** | ****Participatory**** |
| I inspire others with a shared vision. | ✔ |  |  |
| I adjust plans easily when situations change. |  | ✔ |  |
| I encourage my team to share their ideas. |  |  | ✔ |
| I focus on motivating and empowering others. | ✔ |  |  |
| I remain calm and flexible in crises. |  | ✔ |  |
| I value input from staff and community members. |  |  | ✔ |
| I like introducing new ideas or improvements. | ✔ |  |  |
| I make decisions after understanding all perspectives. |  |  | ✔ |
| I can handle stress and uncertainty well. |  | ✔ |  |
| I support others in developing their skills. | ✔ |  |  |

**Interpretation:**

* The column with the most ✔ marks represents your **dominant leadership style.**
* Reflect on how this style supports teamwork and performance in your PHC facility.
* Discuss with peers: When might you need to adapt your style for better results?

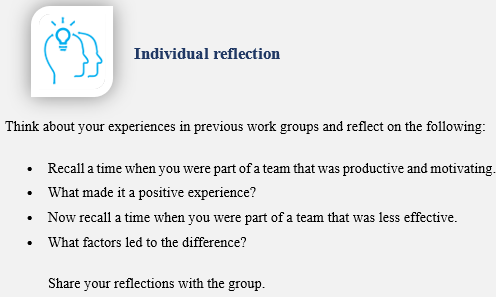
### **5. Applying Leadership Styles in Real-Life PHC Scenarios**

|  |  |  |  |
| --- | --- | --- | --- |
| ****Scenario**** | ****Challenge**** | ****Most Suitable Style**** | ****Leader’s Action**** |
| Low immunization coverage in a remote area. | Staff demotivated and community reluctant. | Transformational + Participatory. | Motivate team, involve community elders, set achievable targets. |
| Sudden disease outbreak (e.g., dengue or measles). | Urgent need for reorganization of services. | Adaptive. | Adjust duty rosters, manage supplies, coordinate response. |
| Introduction of new reporting system (e.g., DHIS2 updates). | Staff unfamiliar with new system. | Participatory. | Train staff, involve them in feedback sessions, monitor progress. |

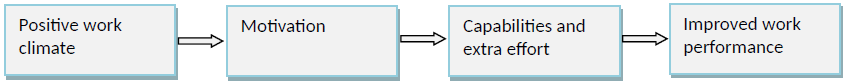
**Work Climate and Effective Communication**

**A. Understanding Work Climate**

Work climate refers to the overall atmosphere, mood and experience of a workplace—what it *feels like* to work there. It reflects how staff perceive their environment, their colleagues and management practices. A positive work climate fosters motivation, collaboration and performance, while a negative climate can lead to low morale, absenteeism and poor results.



**B. Link Between Work Climate and Performance**

When people work in a supportive environment, they are more likely to perform better.

**C. Factors Influencing Work Climate**

Work climate is shaped by several organizational and social elements:

1. *Management Strategy and Structure* – Clear job roles, fair policies and recognition of good performance.
2. *Technical Environment* – Adequate tools, staffing and skill development opportunities.
3. *Managerial Practices* – Fair supervision, constructive feedback and trust-based leadership.
4. *Culture and Shared Values* – Teamwork, respect and open communication.

**D. Effective Communication and Feedback**

Good communication is essential for maintaining a healthy work climate. Managers and team members must engage in active listening and provide constructive feedback.

A positive work climate—built on open communication, fair leadership and mutual respect—creates an environment where staff feel valued, motivated and empowered to deliver quality health services.

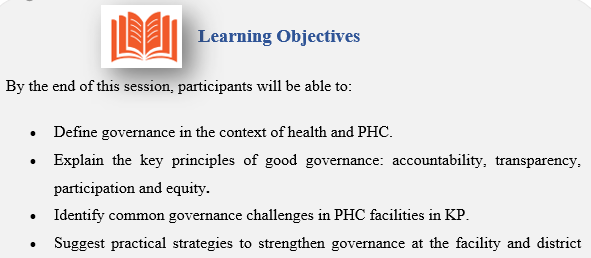
## **ESSION 1.3**

# **PRINCIPLES OF GOOD GOVERNANCE IN HEALTH**

### **Introduction**

Good governance is the **foundation of an effective health system**. It ensures that resources are used fairly, policies are implemented transparently and people receive quality health services.  
In simple terms, governance means **how decisions are made, who makes them and how they are carried out.**

In **Primary Health Care (PHC)**, good governance ensures that health facilities function smoothly, community needs are met and health programs contribute to **Universal Health Coverage (UHC)** and the **Sustainable Development Goals (SDGs).**

In **Khyber Pakhtunkhwa (KP),** PHC managers and staff work in diverse contexts—from urban centers to remote rural areas. This makes governance both challenging and essential. Transparent decision-making, accountability and community participation are vital for achieving health equity and improving service delivery.

### **1. What is Health Governance?**

Governance in health refers to the **processes and systems** through which decisions are made, implemented and monitored in the health sector. According to the **World Health Organization (WHO),** governance and leadership are one of the **six building blocks of a health system**. Good governance ensures that all these components work together effectively and fairly.

***In simple words*:** Governance in health is about making sure that the right decisions are made by the right people, at the right time, for the right reasons — and that those decisions are carried out properly.

### **2. Principles of Good Governance in Health**

|  |  |  |  |
| --- | --- | --- | --- |
| ****Principle**** | ****Meaning**** | ****What it looks like in PHC**** | ****Example from KP Context**** |
| ****Accountability**** | Holding individuals and institutions responsible for their actions, decisions and use of resources. | Regular reporting, monitoring and evaluation of performance. | PHC staff submitting timely DHIS2 reports and addressing gaps identified by supervisors. |
| ****Transparency**** | Openness in how decisions are made and resources are managed. | Sharing information about budgets, plans and results with staff and communities. | Facility in-charge displaying medicine stock list and service delivery data on notice boards. |
| ****Participation**** | Involving stakeholders—especially communities—in decision-making and planning. | Encouraging input from staff, CHWs and local communities in health planning. | Facility committees meeting quarterly to discuss service delivery improvements. |
| ****Equity**** | Ensuring fair access to health services for all, especially the most vulnerable. | Prioritizing services for underserved or remote populations. | Mobile health camps in hard-to-reach areas of Upper Dir or Kohistan. |

These four principles form the **core of good governance**. Together, they create trust, improve service delivery and ensure that the health system is fair and effective.

### **3. Why Governance Matters in PHC**

Good governance directly affects the **quality, accessibility and efficiency** of primary health services.

When governance is strong:

* Health facilities operate transparently.
* Staff feel motivated and accountable.
* Communities trust and use health services.
* Resources are used efficiently and reach those in need.

However, weak governance can lead to:

* Poor resource management.
* Inefficient service delivery.
* Low staff motivation.
* Inequity and reduced public trust.

***Example:***

If a health facility does not regularly share information about its budget or medicine availability, communities may lose trust, leading to reduced service utilization.

### **4. Governance Challenges in PHC (KP Context)**

Despite progress under the **Health Department KP** and **KP-HCIP,** several governance challenges remain in PHC facilities. These challenges can differ across districts, but common ones include:

|  |  |  |
| --- | --- | --- |
| ****Governance Challenge**** | ****Description**** | ****Potential Impact**** |
| **Limited accountability mechanisms** | Weak supervision, lack of performance tracking or feedback. | Poor service quality and inefficiency. |
| **Inadequate transparency** | Insufficient sharing of financial or operational information. | Community mistrust and misuse of resources. |
| **Low participation of community members** | Facility or district plans made without community input. | Services may not meet local needs. |
| **Weak coordination between sectors** | Poor collaboration between health, nutrition, WASH and education departments. | Fragmented services and missed opportunities. |
| **Resource constraints** | Delayed supplies, insufficient staff or funds. | Interrupted service delivery. |
| **Political and administrative influence** | Appointments or decisions made without merit. | Reduced efficiency and morale. |

Addressing these challenges requires both system-level reforms and leadership at the facility level.

### **5. Strengthening Governance in PHC**

Health managers and PHC staff can play an active role in improving governance by applying simple but effective strategies:

|  |  |  |
| --- | --- | --- |
| **Strategy** | **Action at Facility Level** | **Expected Outcome** |
| **Promote Accountability** | Regularly review facility performance using KPIs and DHIS2 data. | Improved reporting and service quality. |
| **Ensure Transparency** | Share facility plans, targets and budgets openly with staff and community. | Builds trust and reduces complaints. |
| **Encourage Participation** | Hold monthly staff meetings and quarterly community consultations. | Increases ownership and local relevance. |
| **Advance Equity** | Identify and prioritize vulnerable populations in service plans. | Fair and inclusive health services. |
| **Use Data for Decision-Making** | Analyze routine data for gaps and trends. | Evidence-based management. |
| **Build Partnerships** | Strengthen collaboration with NGOs, local government and private providers. | Integrated and sustainable services. |

These actions align with the **Health Sector Strategy (KP)** and contribute to achieving **UHC** and **SDG 3 (Good Health and Well-being).**

### **6. Case Example: Governance in Action**

***Scenario:***  
A Basic Health Unit (BHU) in southern KP noticed repeated medicine shortages and complaints from the community.

***Action Taken:***

* The facility in-charge began displaying medicine stocks publicly.
* A community health committee was formed to monitor supply and feedback.
* Monthly review meetings were introduced to track service data and complaints.

***Result:***

* Improved transparency and accountability.
* Reduced stockouts by 40%.
* Increased community trust and service utilization.

This example shows that small, practical steps can make a big difference when governance principles are applied consistently.

### **Reflection Questions**

1. How does governance affect the quality of PHC services in your facility?
2. Which governance principle do you think needs the most improvement in your area?
3. How can you promote accountability and transparency in your daily work?
4. What mechanisms can help communities participate more effectively in health decisions?
5. How do governance improvements support Universal Health Coverage (UHC)?

### **SESSION 1.4**

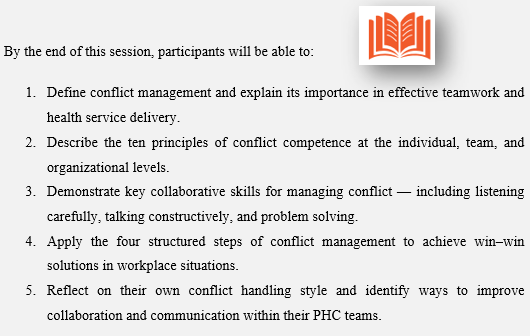
### **CONFLICT MANAGEMENT AND COLLABORATION IN PRIMARY HEALTH CARE (PHC)**

### **Introduction**

Conflict is a natural and unavoidable part of teamwork — especially in Primary Health Care (PHC), where professionals work under pressure, with limited resources and diverse community expectations. Effective conflict management does not mean avoiding disagreement; it means addressing it constructively so that relationships, trust and service delivery improve rather than deteriorate.

Health managers and workers in Khyber Pakhtunkhwa often face conflicts arising from workload distribution, communication gaps, differing opinions, or role overlaps. Developing conflict competence helps individuals, teams and organizations to manage these differences positively and build stronger collaboration. This session helps participants understand the **principles of conflict competence**, **skills for collaboration** and **steps to manage conflict constructively** in PHC settings.

### **Session Objectives**

****

### **1. Understanding Conflict Competence**

**Conflict competence** is the ability to develop and use cognitive, emotional and behavioral skills that enhance productive outcomes of conflict while reducing harm.  
It applies at **three levels** — **individual**, **team** and **organization**. Below are the **Ten Principles of Conflict Competence**, with brief explanations relevant to PHC contexts.

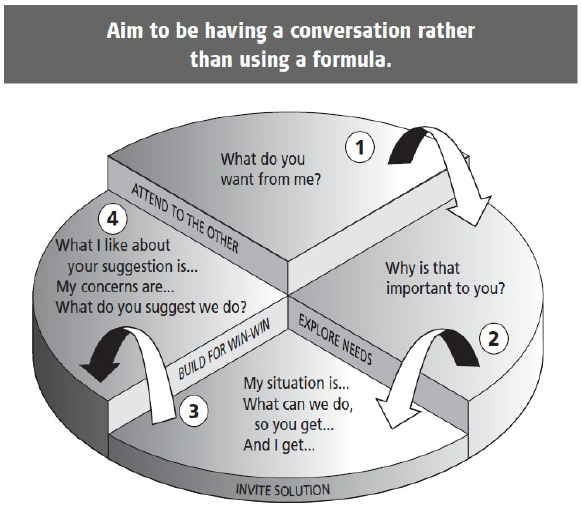
|  |  |
| --- | --- |
| ****Principle**** | ****Description**** |
| 1. **Self-Awareness** | Recognize your emotions, triggers and reactions during conflict. Awareness allows better control and thoughtful responses. |
| 2. **Empathy** | Understand others’ perspectives and emotions, especially colleagues or patients under stress. Empathy builds mutual respect. |
| 3. **Emotional Regulation** | Stay calm and composed, even when discussions get heated. Avoid impulsive words or actions that escalate conflict. |
| 4. **Active Listening** | Listen to understand, not just to reply. It shows respect and helps uncover the root cause of disagreement. |
| 5. **Constructive Communication** | Use clear, respectful and non-blaming language. |
| 6. **Problem-Solving Orientation** | Move from “who is right” to “what will work.” Look for solutions that meet shared goals. |
| 7. **Collaboration and Team Spirit** | Encourage shared ownership of solutions within the team. Collaboration builds long-term trust. |
| 8. **Learning from Conflict** | Reflect on each conflict as an opportunity to improve systems, communication and teamwork. |
| 9. **Fairness and Transparency** | Ensure that decisions and processes are open, consistent and equitable. This builds organizational credibility. |
| 10. **Accountability and Follow-Up** | Take responsibility for one’s role in conflict and ensure agreed actions are implemented and reviewed. |

### **2. Key Skills for Collaboration During Conflict Management**

|  |  |
| --- | --- |
| ****Skill**** | ****Description and Application**** |
| **1. Listen Carefully** | Give full attention to the speaker without interrupting. Show you understand by summarizing or reflecting their points. In PHC settings, listening builds trust between managers and health workers. |
| **2. Talk Constructively** | Use positive and respectful language. Express concerns using “I” statements (e.g., “I feel concerned when…”) instead of blame. Constructive talk prevents defensiveness. |
| **3. Problem Solving** | Identify the real issue, brainstorm solutions and evaluate them together. Focus on mutual interests like patient safety, efficiency and teamwork, not individual wins. |

### **3. Steps of Effective Conflict Management**

Conflict management is not about winning or losing — it is about creating understanding and achieving the best possible outcome for everyone involved. The following **four steps** provide a structured approach for PHC leaders and staff.



|  |  |
| --- | --- |
| ****Step**** | ****Description and Example**** |
| **Step 1: Attend to the Other Person First** | Begin by acknowledging the other person’s viewpoint and emotions. Example: “I can see this situation is frustrating for you.” This helps reduce tension and opens dialogue. |
| **Step 2: Explore the Need Behind the Want** | Go deeper into what each person truly needs (e.g., respect, recognition, clarity) rather than their surface demands. This build understanding of underlying motivations. |
| **Step 3: Invite the Other’s Solution** | Ask for their ideas: “What do you think could work?” This shows respect and encourages joint ownership of the solution. |
| **Step 4: Build a Maximum Win–Win Solution** | Combine both perspectives to develop a solution where everyone gains something important. In PHC teams, this ensures sustainable collaboration and patient-centered outcomes. |

### **4. Group Activity: Practicing Conflict Competence**

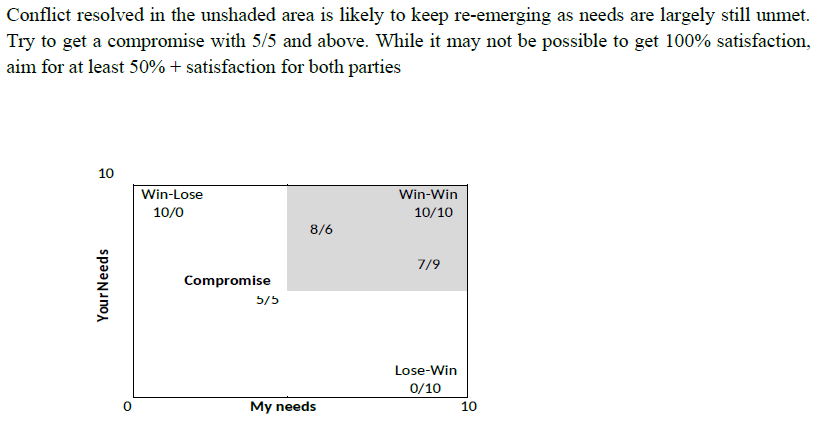
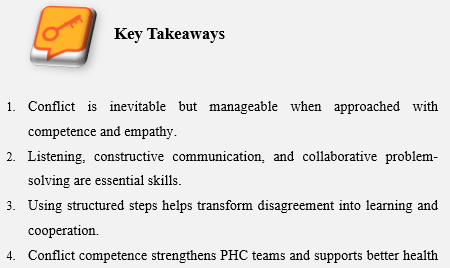
***Purpose:***  
To help participants apply the steps and principles of conflict management through role play.

***Instructions for Participants:***

1. Divide into groups of 4–5 members.
2. Each group selects a PHC-related conflict scenario (e.g., duty roster dispute, staff communication breakdown, or vaccine supply issue).
3. Identify how the ten principles and four steps can be applied to resolve it.
4. Present your discussion briefly to the class.

***Debrief Questions:***

* Which principle was hardest to apply?
* What skill helped most in reducing tension?
* How can these practices improve teamwork in your facility?



## **Activity: Group Role Play – Handling Conflict at the PHC Facility**

**Duration:** 30 minutes

**Method:** Group Role Play and Discussion

**Materials:** Flip charts, markers, activity sheet

### **Scenario: “The Case of the New Facility In-Charge”**

At a rural primary healthcare center, tensions have arisen between the newly appointed Facility In-Charge (a young Medical Officer) and a senior Lady Health Visitor (LHV) who had been managing operations before his appointment. The LHV feels overlooked and believes her years of experience were not recognized, while the new In-Charge feels that staff are not cooperating with him and are resistant to change. The District Health Officer (DHO) has noticed that service delivery has declined and community complaints have increased.

The DHO has called a **meeting** with both staff members and another senior Medical Technician to discuss and resolve the issue.

### **Instructions for Participants:**

1. Divide into **three groups**:
   * **Group A:** District Health Officer (facilitator/mediator)
   * **Group B:** Facility In-Charge (new leader)
   * **Group C:** Lady Health Visitor (senior staff)
2. Each group should:
   * Read their **role card** (below).
   * Prepare how they will present their viewpoint in the discussion.
   * Use **problem-solving questions** to guide the conversation:
     + What is the current situation?
     + What is the real cause of the problem?
     + What options exist for resolving it?
     + What would be the most constructive way forward?
3. The DHO (Group A) will facilitate a **10-minute negotiation**, encouraging respectful communication and identifying shared goals.

### **Role Cards**

***Group A: District Health Officer (Mediator)***

Your role is to explore the conflict impartially, encourage both sides to express their views and guide them toward a mutual solution.

* Listen actively and maintain neutrality.
* Identify key issues and possible misunderstandings.
* Suggest steps for rebuilding trust and collaboration.

***Group B: Facility In-Charge (New Leader)***

You are enthusiastic but feel challenged by the resistance from senior staff. You want to establish authority but also build teamwork.

* Express your frustrations constructively.
* Recognize the experience of senior staff while explaining your leadership approach.
* Be open to feedback and collaboration.

***Group C: Senior LHV (Experienced Staff)***

You feel undervalued after years of service and believe the new In-Charge lacks community understanding. You want your contributions to be acknowledged.

* Explain your feelings respectfully.
* Suggest how your experience can support the new leadership.
* Be open to new ideas and mutual learning.

### **Instructions for Observers:**

**Observe the role play and note:**

* **Positive actions or behaviors** that helped reduce conflict.
* **Negative actions** that increased tension or misunderstanding.
* **Effective negotiation techniques** used by the mediator.

### **Reflection Questions:**

After the role play, discuss the following as a group:

* What were the main causes of conflict in this scenario?
* How was communication used to resolve (or worsen) the issue?
* What leadership qualities are most useful in managing workplace conflict?
* How can such conflicts be prevented in your own PHC settings?

### **Key Learning Point:**

Effective conflict management in primary healthcare settings relies on **open communication, empathy and collaborative problem-solving**. Leaders and team members must learn to address disagreements constructively, focusing on shared goals—**improving service delivery and community trust**.

## **SESSION 1.5**

## **LEADING THE HEALTH TEAM**

### **Introduction**

Effective leadership in health systems is not limited to managing people—it involves inspiring, coaching and empowering teams to achieve shared goals. At the Primary Health Care (PHC) level, leaders must guide their teams through challenges, support individual growth and build trust and accountability to ensure quality and equitable service delivery.

This session focuses on the practical aspects of leading teams, including **coaching to support others, gaining commitment, building high-performance teams, inspiring trust, managing change, ensuring quality and equity and leading through breakdowns.** Through interactive exercises, participants will reflect on their leadership roles and practice skills that create motivated, committed and high-performing PHC teams.

### **Session Objectives**



## **1. Coaching to Support Others**

### **A. Coaching Principles**

Coaching is a supportive conversation aimed at helping others reach their goals.  
An effective coach builds **trust**, listens actively, asks guiding questions and enables others to reflect and take ownership of their performance. Coaching is about **developing people**, not directing them.

### **Activity 1: Exploring Coaching**

**Type:** Individual Reflection and Group Exercise

**Duration:** 30 minutes

***Instructions:***

1. Individually, think of someone you consider your best coach or mentor.
2. Write down the key qualities that made this person effective on sticky notes.
3. Share your notes with your team and identify common attributes of good coaches.

***Group Role Play:***

* Enact two short coaching role plays:
  + **Bad Example:** Supervisor criticizes without listening.
  + **Good Example:** Supervisor listens, asks questions and guides discovery.
* Discuss:
  + How did the person being coached feel in each case?
  + Which behaviors improved motivation and learning?

***Key Message:***

Good coaching is built on **listening, inquiry and empathy**—not criticism or control.

### **B. Three-Person Coaching Exercise**

***Instructions:***

* Form triads (groups of three).
* Rotate roles: **Coach, Coachee and Observer**.
* The coachee shares a real challenge; the coach listens and asks questions (no advice).
* Sample coaching questions:
  + What are you trying to achieve?
  + What obstacles are you facing?
  + What support do you need?

***The Observer Notes:***

* Was the coach supportive and attentive?
* Did they ask thoughtful questions and avoid giving direct solutions?
* Was the coachee more motivated afterward?

***Debrief:***  
Discuss what makes coaching effective and how it can be used in your PHC setting.

### **C. Coaching Using the OALFA Technique**

|  |  |
| --- | --- |
| ****OALFA Step**** | ****Description**** |
| **Observe** | Understand the situation and the staff member’s context. |
| **Ask** | Use open-ended questions to explore challenges and goals. |
| **Listen** | Pay attention to both words and feelings expressed. |
| **Feedback** | Give constructive, specific and supportive feedback. |
| **Agree** | Conclude with clear, mutually agreed actions for improvement. |

***Key Takeaway:***

OALFA helps create a structured, trust-based coaching dialogue that promotes learning and accountability.

## **2. Gaining Commitment, Not Just Compliance**

Leaders can direct compliance—but great leaders **inspire commitment**. While compliance ensures rules are followed, commitment fosters genuine motivation, creativity and teamwork.

|  |  |
| --- | --- |
| ****Compliance**** | ****Commitment**** |
| Follows instructions | Believes in the goal |
| Motivated by supervision | Motivated by purpose |
| Short-term focus | Long-term engagement |
| External control | Internal drive |

***How Leaders Inspire Commitment:***

* Share a **common vision** and align it with personal goals.
* Build **trust** and model integrity.
* **Recognize contributions** and celebrate success.
* Maintain **open communication** and continuous feedback.

1. **Creating High-Performance Teams**

A high-performing team combines diverse roles and perspectives to achieve shared results.  
Each member contributes differently through four essential roles.

|  |  |
| --- | --- |
| ****Team Role**** | ****Function**** |
| ****Initiate**** | Propose new ideas and start action. |
| ****Follow**** | Support and implement team decisions. |
| ****Oppose**** | Question or challenge ideas to improve them. |
| ****Observe**** | Reflect on team dynamics and progress. |

**Activity 2: Team Role Simulation**

* In small groups, assign each member a team role (Initiate, Follow, Oppose, Observe).
* Discuss a real PHC problem (e.g., absenteeism, service delays).
* Observe how each role contributes to the discussion.
* Reflect: What happens when one role is missing or overplayed?

***Key Learning:***

Balanced roles ensure creativity, accountability and shared ownership of results.

## **4 Inspiring Others**

### **A. Building Trust**

Trust is the foundation of effective leadership and teamwork. It encourages open communication, collaboration and performance.

**Activity 3: Inspire Through Trust**

**Duration:** 10 minutes

1. Think of someone you trust and someone you do not.
2. Reflect on what each person did to earn or lose your trust.
3. Discuss in pairs: How can you apply trust-building practices in your team?

***Key Points:***

* Be consistent and transparent.
* Keep commitments.
* Show empathy and fairness.

### **B. Acknowledging Others**

Acknowledgment motivates and strengthens relationships. Recognizing even small efforts enhances morale and unity.

**Activity 4: Inspire Through Acknowledgment**

* Each participant completes the sentence **“I acknowledge you for…”** for every team member.
* Share acknowledgments aloud.
* Discuss how recognition impacts motivation.

***Key Learning:***

Sincere appreciation builds confidence, strengthens teamwork and promotes a positive work climate.

## **5 Managing Change and Producing Results**

Change is constant in health systems—new programs, technologies, or community expectations.  
Leaders must guide teams through emotional and practical transitions.

|  |  |
| --- | --- |
| ****Change Stage**** | ****Leader’s Role**** |
| **Denial** | Provide information and clarity. |
| **Resistance** | Listen empathetically; allow expression of feelings. |
| **Exploration** | Encourage experimentation and new ideas. |
| **Commitment** | Support ownership and celebrate progress. |

**Activity 5: Managing Change Role Play**

* In pairs, act out a supervisor helping a resistant staff member accept a new health policy.
* Discuss what leadership behaviors supported acceptance.

***Key Message:***

Managing change requires patience, empathy and communication.

## **6. Ensuring Quality and Equitable Health Services**

**Quality** means providing safe, effective, patient-centered and timely care. **Equity** ensures that such quality care reaches everyone—regardless of gender, income, or geography.

**Leaders ensure quality and equity by:**

* Promoting **equal access** to essential services.
* Encouraging **consistent standards** across all facilities.
* Engaging communities in **decision-making and feedback**.
* Upholding **fairness, transparency and accountability.**

***Reflection:***

How can you ensure your facility provides equitable care for vulnerable populations?

## **7. Leading Through Breakdowns**

Breakdowns are moments when progress stops or challenges arise—but they also create opportunities for learning and improvement. Instead of blame or avoidance, effective leaders view breakdowns as pathways to **breakthroughs**.

|  |  |
| --- | --- |
| ****Common Reaction**** | ****Effective Leadership Response**** |
| Ignoring or denying the issue | Acknowledge and define the problem |
| Blaming others | Encourage shared responsibility |
| Loss of teamwork | Rebuild trust and communication |
| Avoiding accountability | Promote reflection and action |

**Activity 6: Turning Breakdowns into Breakthroughs**

**Duration:** 15 minutes

* Share a recent team breakdown (missed target, communication failure).
* As a group, identify how leadership could transform it into learning.

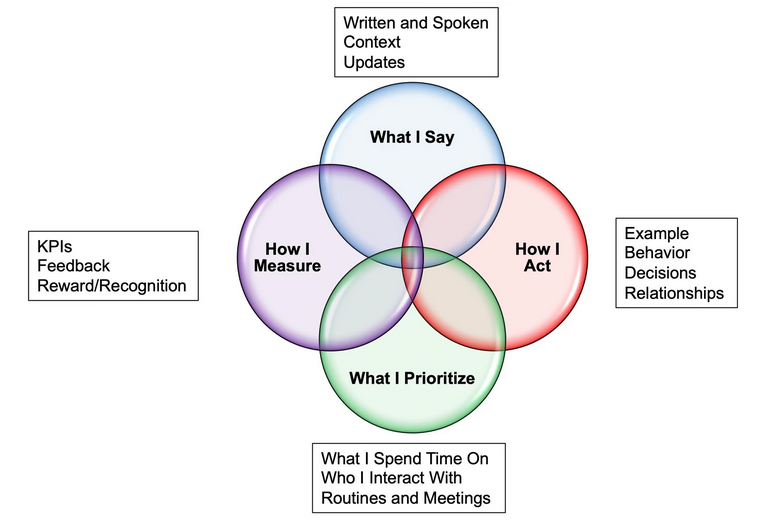
***Key Learning:***

“No commitment, no breakdown.” The greater the goal, the greater the opportunity for growth.

## **8 Shadowing in Leadership Development**

**Shadowing** allows emerging leaders to observe and learn directly from experienced senior leaders in real settings. It bridges theory and practice, helping participants see leadership in action.

***Process Overview:***

1. Pair trainees with senior health leaders for 1–2 weeks.
2. Observe meetings, decision-making and stakeholder interactions.
3. Participate gradually under supervision.
4. Reflect daily and document learning in a portfolio.

***Expected Outcomes:***

* Real-life understanding of leadership behaviors.
* Practical skills in problem-solving, team management and communication.
* Stronger confidence in applying leadership principles in PHC facilities.

### **Key Takeaways**

* Leading teams in PHC requires balancing **guidance, empathy and empowerment**.
* **Coaching and trust-building** are at the heart of team development.
* High-performance teams thrive on **diverse roles, open communication and shared purpose**.
* Leadership during **change and breakdowns** transforms challenges into opportunities.
* Ensuring **quality and equity** in health care reflects ethical, visionary leadership.
* **Shadowing** bridges classroom learning with real-world leadership practice.

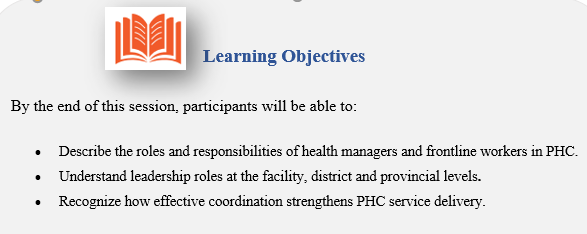
## **SESSION 1.6**

# **ROLE OF HEALTH MANAGERS AND FRONTLINE STAFF IN STRENGTHENING PRIMARY HEALTH CARE (PHC)**

### **Introduction**

A strong **Primary Health Care (PHC)** system is the backbone of any effective health service delivery network. It brings essential health services closer to the people, particularly in remote and underserved areas. In **Khyber Pakhtunkhwa (KP)**, PHC facilities such as **Basic Health Units (BHUs), Rural Health Centres (RHCs) and Community Health Centers (CHCs)** play a vital role in promoting health, preventing disease and providing curative services.

However, the success of PHC depends greatly on the **leadership, commitment and coordination** of both health managers and frontline staff. Health managers provide **strategic direction and oversight**, while frontline workers are the **face of the health system**—they engage directly with communities, deliver services, collect data and report health trends. Together, they ensure that PHC functions efficiently and equitably.

This session explores how health managers and frontline staff contribute to strengthening PHC in the context of **Universal Health Coverage (UHC)** and **Sustainable Development Goal 3 (Good Health and Well-being).**

### **1. Overview: The PHC System in Pakistan and KP**

Pakistan’s health system is built on a **three-tier structure:**

1. ***Primary level*:** Basic Health Units (BHUs), Rural Health Centres (RHCs), Maternal and Child Health Centres (MCHCs) and dispensaries.
2. ***Secondary level*:** Tehsil and District Headquarters Hospitals.
3. ***Tertiary level*:** Specialized and teaching hospitals.

**Primary Health Care (PHC)** is the foundation. It focuses on **promotion, prevention, treatment and rehabilitation** at the community level. In **KP**, PHC services are being strengthened under the **Khyber Pakhtunkhwa Human Capital Investment Project (KP-HCIP)** and the **Integrated Health Project**, aiming to:

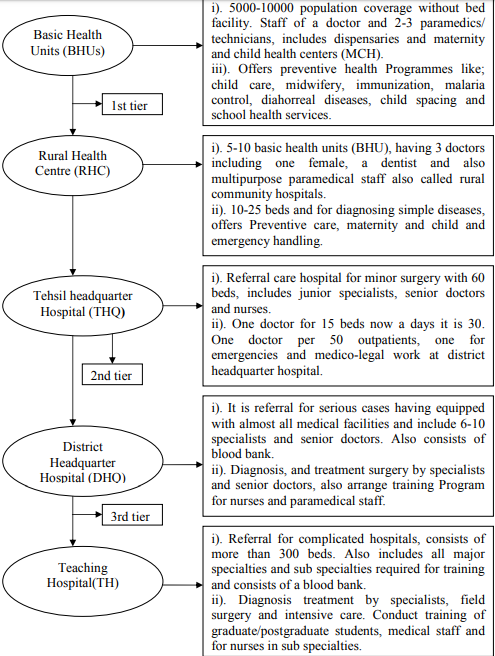
* Improve service delivery at the community level.
* Enhance leadership, governance and monitoring systems.
* Promote equitable access to care and progress toward **UHC.**

### **2. Key Roles in Strengthening PHC**

PHC involves a team-based approach where every member has a defined role.  
The table below summarizes major roles and responsibilities across different levels.

|  |  |  |
| --- | --- | --- |
| ****Level**** | ****Key Actors**** | ****Leadership Role**** |
| ****Facility Level**** | Medical Officer, Lady Health Visitor (LHV), Medical Technician, Community Health Worker (CHW) | Lead health teams, ensure data quality, promote teamwork and maintain community trust. |
| ****District Level**** | District Health Officer (DHO), District Supervisors, Health Managers | Strategic leadership in planning, budgeting and policy implementation. |
| ****Provincial Level**** | Directorate General Health Services (DGHS), Health Department, Program Directors | Policy-level leadership, system strengthening and stakeholder coordination. |

At every level, **leadership and coordination** are essential for ensuring that health services reach people effectively and equitably.

****

### **3. Role of Health Managers in PHC Strengthening**

Health managers provide the **vision and direction** needed to make PHC effective. Their roles include:

* ***Planning and Coordination:***

Developing operational plans, aligning facility goals with district and provincial strategies and ensuring coordination across programs (EPI, MNCH, NCDs, Nutrition).

* ***Resource Management:***

Efficiently managing human resources, medical supplies and finances.

* ***Supervision and Mentorship:***

Conducting supportive supervision visits to monitor performance, provide feedback and mentor frontline staff.

* ***Data-Driven Decision-Making:***

Using DHIS2 and other health information systems to track performance and guide improvements.

* ***Community Engagement:***

Building trust with local communities, listening to feedback and responding to their health needs.

* ***Ensuring Accountability and Transparency:***

Promoting ethical practices, timely reporting and transparent use of resources.

### **4. Role of Frontline Health Workers in Strengthening PHC**

Frontline workers are the **link between the health system and the community.** Their roles include:

* ***Service Delivery*:** Providing basic curative, preventive and promotive care, especially for maternal, child and infectious diseases.
* ***Health Education and Promotion*:** Counseling families on hygiene, nutrition, vaccination and lifestyle changes.
* ***Community Mobilization:*** Engaging community leaders and volunteers in health campaigns.
* ***Data Collection and Reporting*:** Maintaining registers, reporting through DHIS2 and ensuring accurate documentation.
* ***Monitoring and Feedback*:** Identifying local health challenges and reporting them to higher levels for action.
* ***Building Trust:*** Creating a positive relationship with the community to encourage service use and adherence to health advice.

Frontline workers are not just service providers—they are **community leaders** in promoting health and social change.

### **5. Leadership at Different Levels of the Health System**

Leadership roles differ at each level but are **interconnected** and **complementary:**

|  |  |  |  |
| --- | --- | --- | --- |
| ****Level**** | ****Leadership Focus**** | ****Key Functions**** | ****Example**** |
| ****Facility Level**** | Operational Leadership | Managing day-to-day activities, ensuring staff performance, reporting and patient satisfaction. | A Medical Officer ensuring daily DHIS2 data entry and organizing staff meetings. |
| ****District Level**** | Strategic and Supervisory Leadership | Overseeing facility performance, coordinating logistics and resource allocation. | DHO reviewing facility performance indicators and providing supportive supervision. |
| ****Provincial Level**** | Policy and System Leadership | Setting priorities, budgeting and monitoring province-wide targets. | DGHS launching provincial M&E framework for PHC performance improvement. |

Effective communication between these levels ensures better alignment and accountability throughout the health system.

### **6. Case Examples from Pakistan and KP**

#### **Case 1: Strengthening PHC Leadership in Swat District (KP-HCIP Initiative)**

Under KP-HCIP, Swat district implemented a **leadership and governance strengthening program** for facility in-charges.

* Monthly coordination meetings were introduced.
* Data review sessions helped identify underperforming areas.
* Frontline workers received refresher training on recordkeeping and patient counseling.  
  **Result:** Service coverage increased by 18% in six months and community satisfaction improved.

#### **Case 2: Lady Health Worker Program (National Model)**

The **LHW Program** is a landmark example of how trained community-based workers can extend PHC services.

* LHWs provide door-to-door preventive care, collect vital health data and mobilize communities for immunization.

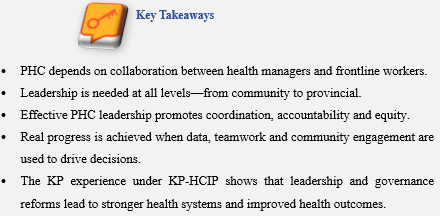
***Result*:** Significant improvements in maternal and child health indicators across rural Pakistan.

#### **Case 3: Data-Driven Decision Making in Mardan District**

District Mardan used DHIS2 dashboards to track performance across BHUs.

* Facilities with poor immunization coverage received targeted supervision and resources.

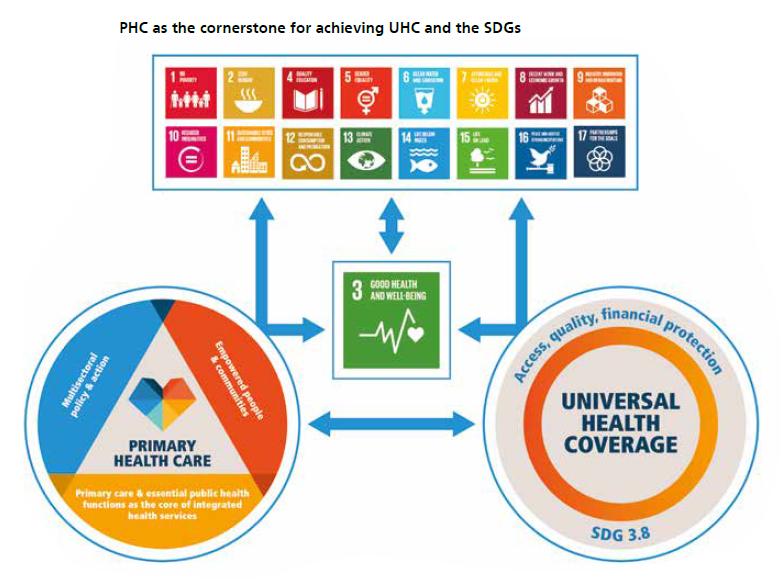
***Result:*** A 12% improvement in full immunization rates within one year.

These examples highlight how **strong leadership, effective coordination and use of data** can significantly improve PHC outcomes.

**MODULE TWO**

**MONITORING AND EVALUATION IN PRIMARY HEALTH CARE**

### 



**MODULE TWO**

**MONITORING AND EVALUATION IN PRIMARY HEALTH CARE**

### **Introduction**

Monitoring and Evaluation (M&E) are essential tools for ensuring that health programs achieve their goals efficiently and effectively. In the context of **Primary Health Care (PHC),** M&E helps health managers and frontline workers understand how services are being delivered, what challenges exist and how performance can be improved for better health outcomes.

In **Khyber Pakhtunkhwa (KP),** PHC facilities such as **Basic Health Units (BHUs)** and **Rural Health centers (RHCs)** play a critical role in providing essential health services to communities. To strengthen these services, there is a growing need for a strong culture of evidence-based decision-making—where data from routine monitoring and evaluation is used to guide planning, supervision and service improvement.

This module is designed to help PHC staff and health managers build practical knowledge and skills in **Monitoring, Evaluation and Decision-Making (M&E-DM)**. It will focus on how to collect, analyze and use health information to track progress, identify problems early and take corrective actions.

### ***Purpose of M&E in PHC***

Monitoring and Evaluation are not just technical processes—they are **leadership tools** that ensure accountability, transparency and continuous improvement.

* ***Monitoring*** means regularly tracking the implementation of health activities and services to see if things are going as planned.
  + Example: Checking the number of antenatal care visits, immunizations, or stock of essential medicines at a BHU.
* ***Evaluation*** is a deeper analysis that helps understand whether the program is achieving its intended results and why.
  + Example: Assessing whether a community outreach program has reduced malnutrition or increased immunization coverage.

Together, M&E provide information that supports decision-making at **facility, district and provincial levels**, ensuring that health interventions are efficient, equitable and effective.

### **Why M&E Matters for PHC Workers**

At the primary health care level, **timely and reliable data** helps health workers and managers make better decisions every day.

It enables them to:

* Monitor progress toward national and provincial health goals (including **Sustainable Development Goal 3: Good Health and Well-being**).
* Identify gaps in service delivery and areas needing support.
* Improve supervision and staff performance.
* Strengthen accountability and transparency.
* Advocate for resources and policy improvements.

In KP, systems such as the **District Health Information System (DHIS2)** are used to collect and report PHC data. However, many health workers face challenges in data recording, reporting and use. Strengthening their capacity in M&E will help build a **culture of data-driven decision-making** at all levels.

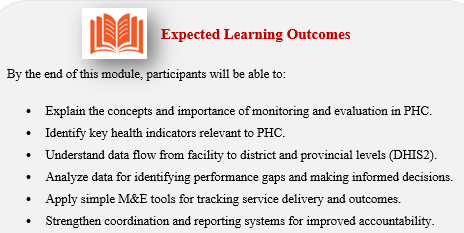
### ***The Link Between Leadership and M&E***

Effective leadership and good governance depend on **accurate information**. Leaders who understand and use M&E are better equipped to plan, prioritize and manage resources. Monitoring and evaluation enable leaders to:

* Make **informed decisions** rather than assumptions.
* Promote **accountability** through transparent reporting.
* Encourage **participatory management** by involving teams in data analysis and problem-solving.
* Foster **continuous learning** and adaptation of strategies.

In short, **leadership and M&E go hand-in-hand**—strong leaders rely on data and strong M&E systems depend on leadership support.

### **Focus of This Module**

This module provides an overview of the **M&E framework in primary health care**, practical skills for **data collection and interpretation** and tools for **decision-making and feedback**.  
Participants will engage in interactive discussions, group exercises and real-life examples from KP and other regions.

### **Relevance to KP Context**

Under the **Khyber Pakhtunkhwa Human Capital Investment Project (KP-HCIP),** the provincial government emphasizes strengthening health system governance and accountability through better monitoring and evaluation. This includes:

* Improving data quality at the facility level.
* Enhancing reporting consistency through DHIS2 and LMIS.
* Building the capacity of health managers and PHC staff in data analysis and use.

By integrating M&E into day-to-day management, PHC facilities can become more responsive, transparent and effective in delivering health services to the people of KP.

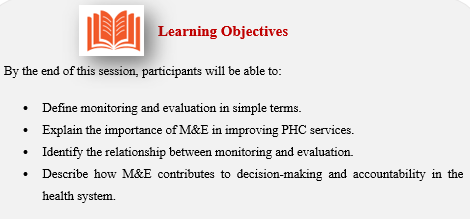
## **SESSION 2.1**

## **INTRODUCTION TO MONITORING AND EVALUATION CONCEPTS**

### **Introduction**

Monitoring and Evaluation (M&E) are important tools that help health workers, managers and decision-makers understand whether health programs are working as planned and achieving their goals. In the context of **Primary Health Care (PHC)**, M&E ensures that essential health services—such as immunization, maternal care, nutrition and disease prevention—are delivered effectively and reach the people who need them most.

In **Khyber Pakhtunkhwa (KP),** where health services are being strengthened under initiatives like the **Human Capital Investment Project (HCIP)** and other reforms, M&E plays a central role in improving accountability, service quality and decision-making at all levels—from community health posts to the provincial health department.

This session will help PHC staff understand what monitoring and evaluation mean, how they are different and why both are necessary for improving health programs and outcomes.

### **1. What is Monitoring and Evaluation (M&E)?**

Monitoring and Evaluation (M&E) are closely related processes used to track progress, measure performance and identify areas that need improvement in health programs.

M&E helps ensure that health services and interventions achieve their intended results—such as reducing maternal mortality, increasing immunization coverage, or improving patient satisfaction.

Together, monitoring and evaluation provide evidence for better planning, resource allocation and accountability.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ****Term**** | ****Definition**** | ****Focus**** | ****Frequency**** | ****Purpose in PHC**** |
| ****Monitoring**** | Continuous collection and analysis of information to track progress of activities against set plans. | Activities and outputs | Ongoing (monthly/quarterly) | To check if services are being delivered as planned. |
| ****Evaluation**** | Systematic and objective assessment of a completed or ongoing program to determine its relevance, efficiency, effectiveness and impact. | Results and outcomes | Periodic (mid-term, annual, or end-line) | To assess what worked, what didn’t and why. |

### **2. What is Monitoring?**

**Monitoring is** a **continuous process** of collecting and analyzing data about how a program is being implemented. It allows managers to compare what is actually happening with what was planned.

In PHC, monitoring includes tracking:

* Number of patients visiting health facilities.
* Stock levels of essential medicines and vaccines.
* Number of antenatal care visits or deliveries attended by skilled staff.
* Outreach sessions conducted by community health workers.
* Facility cleanliness, staffing and functionality.

Monitoring provides **early warning signs** when progress is slow or targets are not being met. For example, if data shows a drop-in immunization coverage in a union council, health managers can quickly investigate the cause and take corrective action.

#### **Example (KP Context):**

In a BHU in District Swat, monitoring data revealed that vaccination coverage for children under one year dropped by 15% over two months. On review, the manager found that the vaccinator had been transferred and not replaced promptly. Through effective monitoring, the issue was identified early and the position was filled to restore service delivery.

### **3. What is Evaluation?**

**Evaluation** is the **systematic and objective assessment** of a project, program, or policy to determine its relevance, effectiveness, efficiency and sustainability.

Unlike monitoring—which is ongoing—evaluation is usually conducted **at specific points,** such as mid-term or end of a program, to assess the overall performance and impact.

In PHC, evaluation helps answer important questions such as:

* Did the program achieve its objectives?
* Were resources used efficiently?
* What worked well and what should be improved next time?
* How did the program affect the health of the target population?

#### **Example (KP Context):**

An evaluation of the **Community Midwives Program** in KP found that while many midwives were trained, retention in rural areas remained low due to lack of incentives and supervision. These findings helped the health department revise the strategy to provide improved support and motivation for midwives.

### **4. Relationship Between Monitoring and Evaluation**

Monitoring and evaluation are different but complementary processes.  
Monitoring provides **real-time information** to guide daily management, while evaluation provides **deeper insights** for long-term planning and policy formulation.

|  |  |  |
| --- | --- | --- |
| **Aspect** | **Monitoring** | **Evaluation** |
| **Timing** | Continuous (during implementation) | Periodic (mid-term or after completion) |
| **Main Purpose** | To check progress | To assess results and impact |
| **Focus** | Inputs, activities, outputs | Outcomes and impacts |
| **Data Source** | Routine reports, DHIS2, supervision checklists | Surveys, interviews, focus group discussions |
| **Responsibility** | Facility in-charges, district health officers | Provincial health department, external evaluators |
| **Decision Level** | Operational (short-term) | Strategic (long-term) |

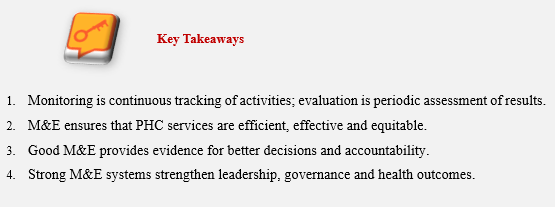
### **5. Importance of M&E in PHC Programs**

Monitoring and Evaluation help ensure that PHC programs are effective, equitable and responsive to community needs. Some key benefits include:

* ***Improved Performance*:** Regular monitoring helps track progress and address gaps early.
* ***Evidence-Based Decision-Making*:** Data guides planning, budgeting and resource allocation.
* ***Accountability*:** M&E ensures transparency in how resources are used and results are achieved.
* ***Learning and Improvement:*** Evaluations provide lessons for future program design.
* ***Alignment with National and Global Goals*:** M&E helps track progress toward **Universal Health Coverage (UHC)** and **Sustainable Development Goals (SDG 3 – Good Health and Well-being).**

### **6. M&E in the Context of KP’s Primary Health Care**

In Khyber Pakhtunkhwa, M&E systems such as **DHIS2 (District Health Information System 2)** and **LMIS (Logistics Management Information System)** are used to collect and report routine health data from PHC facilities. However, challenges remain—such as data accuracy, incomplete reporting and limited use of data for decision-making. Strengthening M&E capacity among PHC staff and health managers can improve:

* Data quality and timeliness.
* Use of information for planning and supervision.
* Coordination between district and provincial health offices.
* Responsiveness of PHC services to community needs.

### **Reflection Questions**

1. How would you explain the difference between monitoring and evaluation to a colleague?
2. Can you share an example from your facility where monitoring helped improve a service?
3. Why is it important for PHC staff to actively participate in M&E processes?

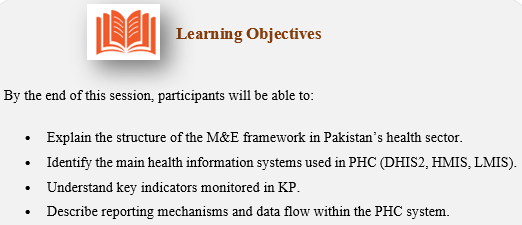
## **SESSION 2.2**

## **MONITORING AND EVALUATION FRAMEWORK IN THE HEALTH SECTOR (PAKISTAN CONTEXT)**

### **Introduction**

A strong **Monitoring and Evaluation (M&E) framework** is the backbone of any effective health system. It provides the structure, tools and processes needed to collect, analyze and use information for decision-making and accountability.

In Pakistan and particularly in **Khyber Pakhtunkhwa (KP),** the M&E framework connects all levels of the health system — from **community health workers and Basic Health Units (BHUs) to District Health Offices (DHOs)** and the **provincial Directorate General Health Services (DGHS).** This framework helps track progress toward national and global goals such as **Universal Health Coverage (UHC)** and the **Sustainable Development Goals (SDG 3 – Good Health and Well-being).**

For primary healthcare workers, understanding how this M&E framework functions is essential for improving data quality, ensuring timely reporting and strengthening service delivery.

### **1. What is a Monitoring and Evaluation Framework?**

An **M&E Framework** provides a structured approach for collecting, analyzing and using data to measure program performance and progress toward health goals.

It defines:

* **What to measure** (indicators)
* **How and when to measure it** (data sources and frequency)
* **Who will measure it** (responsibilities at different levels)
* **How the data will be used** (decision-making and reporting)

In PHC, an M&E framework ensures that health facilities systematically record and report essential data on services like immunization, maternal and child health, outpatient care, family planning and communicable disease control.

### **2. National and Provincial M&E Systems**

Pakistan has established several digital health information systems to strengthen data management and support M&E functions. These systems provide real-time data for decision-making, policy development and resource allocation.

|  |  |  |
| --- | --- | --- |
| ****System**** | ****Full Form**** | ****Purpose/Function**** |
| ****DHIS2**** | District Health Information System (Version 2) | Collects, analyzes and reports routine health service data from all public health facilities. |
| ****HMIS**** | Health Management Information System | Focuses on patient records, service delivery and performance monitoring at the facility level. |
| ****LMIS**** | Logistics Management Information System | Tracks the availability and use of medicines, vaccines and supplies to prevent stockouts. |
| ****EPI-MIS**** | Expanded Program on Immunization – Management Information System | Monitors vaccine coverage, cold chain functionality and immunization sessions. |
| ****HRMIS**** | Human Resource Management Information System | Tracks health workforce deployment, training and performance. |

These systems work together to create a **comprehensive M&E framework** that supports decision-making across the health system.

### **3. M&E Framework in Khyber Pakhtunkhwa (KP) Health Sector**

In **Khyber Pakhtunkhwa**, the Department of Health has made significant progress in strengthening the M&E system through integration and digitalization. The **DGHS M&E Cell** oversees data management, supervision and reporting from all districts.

Each district health office consolidates data from Basic Health Units (BHUs), Rural Health Centers (RHCs) and hospitals through **DHIS2**, which serves as the central data platform.

The M&E framework in KP focuses on three main functions:

1. ***Data Collection and Reporting*** — through standardized registers, tally sheets and electronic platforms.
2. ***Data Analysis and Validation*** — at facility and district levels to ensure accuracy and completeness.
3. ***Data Use for Decision-Making*** — by facility in-charges, DHOs and provincial planners to improve health outcomes.

#### **Figure: Simplified M&E Data Flow in KP Health System**

|  |  |  |
| --- | --- | --- |
| ****Level**** | ****Main Activities**** | ****Reporting Tool/System**** |
| ****Community/Facility Level**** | Data collection, service recording, monthly reporting | Registers, DHIS2 online/offline forms |
| ****District Level**** | Data compilation, validation, feedback, supervision | DHIS2 Dashboard, LMIS |
| ****Provincial Level**** | Aggregation, analysis, policy use, feedback | DHIS2, HMIS, LMIS, EPI-MIS |
| **National Level** | Consolidated national reporting and SDG/UHC tracking | DHIS2 National Dashboard, Health Indicators Portal |

### **4. Key Indicators in KP’s Primary Health Care System**

The **Department of Health KP**, through its M&E system, regularly monitors a set of **Key Performance Indicators (KPIs)** to measure the performance of PHC facilities. These indicators are linked to national priorities and SDG targets.

|  |  |  |
| --- | --- | --- |
| ****Domain**** | ****Indicator Example**** | ****Source/System**** |
| **Maternal Health** | % of women receiving at least 4 ANC visits | DHIS2 |
| **Child Health** | % of children fully immunized by 12 months | EPI-MIS/DHIS2 |
| **Communicable Diseases** | % of malaria positive cases treated according to protocol | DHIS2 |
| **Non-Communicable Diseases** | % of hypertensive patients under regular follow-up | DHIS2 |
| **Health Workforce** | Facility vacancy rate (Doctors, LHVs, Technicians) | HRMIS |
| **Logistics and Supplies** | Stockout rate of essential medicines and vaccines | LMIS |
| **Service Utilization** | OPD attendance per 1,000 population | DHIS2 |
| **Quality and Supervision** | Number of supervision visits conducted per quarter | M&E reports |

### **5. Reporting Mechanisms and Data Use**

Effective M&E relies not just on collecting data but also on **using it for action**. Reporting mechanisms ensure timely transmission of information from the grassroots level to decision-makers.

***In KP’s PHC system:***

* Facility staff compile and submit **monthly reports** via DHIS2 or manual forms.
* District M&E officers review, verify and consolidate reports.
* Feedback is shared with facilities to improve data quality and service delivery.
* Provincial M&E units analyze data trends and prepare performance dashboards for the Health Department and development partners.

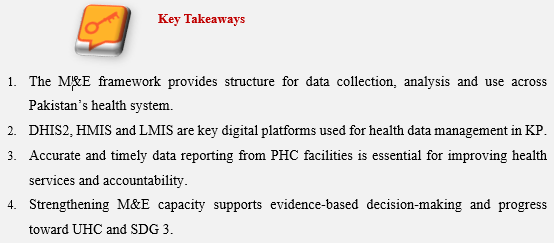
Regular review meetings at district and provincial levels help ensure **data-driven planning, resource allocation and performance monitoring.**

### **6. Challenges and Opportunities in KP’s M&E Framework**

***Challenges:***

* Incomplete or delayed reporting from some PHC facilities.
* Limited capacity of staff in data analysis and interpretation.
* Inconsistent feedback and supervision.
* Parallel reporting systems leading to duplication.

***Opportunities:***

* Ongoing digital transformation under **KP-HCIP** and **Health Reforms.**
* Increased use of mobile and tablet-based data collection tools.
* Integration of DHIS2 with LMIS and HRMIS for better coordination.
* Capacity-building programs on data use and performance monitoring.

**Reflection Questions**

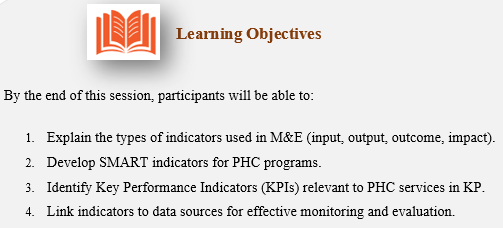
1. How does the M&E data collected at your facility contribute to provincial health planning?
2. What are the main challenges you face in data reporting or validation?
3. How can you use DHIS2 data to improve performance at your health facility?

## **SESSION 2.3**

## **DEVELOPING AND USING INDICATORS**

### **Introduction**

Indicators are **specific measures** that help us understand whether health programs are achieving their objectives. In **Primary Health Care (PHC),** indicators are critical for monitoring service delivery, evaluating program outcomes and informing decision-making.

Developing the right indicators ensures that health workers and managers can track progress, identify gaps and make evidence-based improvements. This session introduces the **types of indicators**, the concept of **SMART indicators** and how to use **Key Performance Indicators (KPIs)** effectively in PHC programs.

### **1. Types of Indicators**

Indicators are usually classified into **four types**, depending on what aspect of the program they measure:

|  |  |  |
| --- | --- | --- |
| ****Type**** | ****Definition**** | ****Examples in PHC**** |
| **Input Indicators** | Measure the resources used for program implementation. | Number of trained LHVs, availability of vaccines, budget allocated for health programs. |
| **Output Indicators** | Measure the direct products or services delivered by the program. | Number of antenatal care visits, number of immunization sessions conducted, number of health education sessions held. |
| **Outcome Indicators** | Measure the short- or medium-term effects of program activities on the target population. | % of pregnant women receiving 4 ANC visits, % of children fully immunized by age 1, % of patients screened for hypertension. |
| **Impact Indicators** | Measure long-term changes in health status or conditions resulting from the program. | Reduction in maternal mortality ratio (MMR), reduction in under-five mortality rate, prevalence of stunting or malnutrition among children. |

**K*ey point:***

Input and output indicators help **monitor program implementation**, while outcome and impact indicators are used in **evaluation t**o assess the effectiveness of interventions.

### **2. SMART Indicators**

To be useful, indicators should follow the **SMART criteria:**

|  |  |  |
| --- | --- | --- |
| ****SMART Element**** | ****Meaning**** | ****Example in PHC**** |
| ****S – Specific**** | Clearly defines what is being measured. | “Percentage of pregnant women receiving at least 4 ANC visits.” |
| ****M – Measurable**** | Can be quantified or assessed reliably. | “Number of immunization sessions conducted per month.” |
| ****A – Achievable**** | Realistic based on available resources and context. | “Increase facility-based deliveries by 10% in 12 months.” |
| ****R – Relevant**** | Directly linked to program objectives or health outcomes. | “Monitoring vaccination coverage to reduce measles outbreaks.” |
| ****T – Time-bound**** | Has a clear timeframe for achievement | “Reduce stockouts of essential medicines to less than 5% within six months.” |

SMART indicators make monitoring and evaluation **practical and actionable** for facility staff and managers.

### **3. Key Performance Indicators (KPIs) in PHC**

**KPIs** are a set of critical indicators that track performance and progress toward health system goals. In PHC, KPIs focus on service delivery, health outcomes and system functionality.

***Examples of KPIs in KP Primary Health Care:***

|  |  |  |  |
| --- | --- | --- | --- |
| ****Domain**** | ****Indicator (KPI)**** | ****Frequency/Target**** | ****Data Source**** |
| **Maternal Health** | % of pregnant women receiving at least 4 ANC visits | Monthly / ≥80% | DHIS2, ANC register |
| **Child Health** | % of children fully immunized by age 1 | Monthly / ≥90% | EPI-MIS, DHIS2 |
| **Family Planning** | Contraceptive prevalence rate (CPR) | Quarterly / increase by 5% annually | DHIS2, facility records |
| **Communicable Diseases** | % of suspected malaria cases tested and treated according to guidelines | Monthly / 100% | DHIS2, malaria register |
| **Non-Communicable Diseases** | % of hypertensive patients under follow-up | Monthly / ≥70% | DHIS2, NCD register |
| **Health Workforce** | % of facilities with full staffing per HRMIS | Quarterly / ≥90% | HRMIS |
| **Logistics and Supplies** | % of facilities without stockouts of essential medicines | Monthly / ≥95% | LMIS |
| **Service Utilization** | OPD visits per 1,000 population | Monthly / trend analysis | DHIS2 |
| **Quality of Care (QoC)** | % of facilities conducting routine supervision visits | Quarterly / 100% | Supervision checklist, M&E reports |

### **4. Linking Indicators to Data Sources**

To ensure that M&E is effective, indicators must be linked to **reliable data sources.**

***Examples in PHC (KP context):***

|  |  |  |
| --- | --- | --- |
| ****Indicator**** | ****Data Source**** | ****Responsible Staff**** |
| ANC coverage | ANC Register, DHIS2 | LHVs, Medical Officers |
| Immunization coverage | EPI Register, DHIS2 | Vaccinators, CHWs |
| Medicine stockouts | LMIS | Pharmacists, Facility In-charges |
| Staff availability | HRMIS | HR Manager, DHO |
| OPD attendance | OPD Register, DHIS2 | Medical Officers, Data Entry Operators |

By linking indicators to specific data sources and responsibilities, health workers can **collect accurate data, report timely and use the information for decision-making**.

### **5. Importance of Indicators in Decision-Making**

Indicators are not just numbers—they guide **daily decisions and strategic planning** in PHC:

* Highlight gaps in service delivery (e.g., low ANC coverage in a union council).
* Identify training needs (e.g., staff underperforming in vaccination sessions).
* Allocate resources effectively (e.g., medicines, vaccines, or human resources).
* Track progress toward provincial and national health targets, including **UHC** and **SDG 3**.
* Support accountability and transparency in health services.

***Key point:*** Health managers and PHC staff should actively **use indicators to improve service delivery** rather than just reporting them for compliance.

### **Reflection Questions**

1. Identify one indicator from your facility that could be improved—what steps would you take?
2. How can SMART indicators help your team monitor progress effectively?
3. Which KPIs do you think are most important for improving PHC services in your area?

## **SESSION 2.4**

## **MONITORING AND EVALUATION PLAN**

### **Introduction**

Monitoring and Evaluation (M&E) are essential tools for tracking progress, identifying challenges and ensuring that health programs achieve their intended results. In leadership and management for health, M&E helps managers and teams make evidence-based decisions, improve service delivery and ensure accountability at every level.

### **Session Objectives**

By the end of this session, participants will be able to:

1. Explain the difference between monitoring and evaluation.
2. Define what an indicator is and describe the characteristics of a good indicator.
3. Identify key components of an M&E plan (indicator, definition, baseline, data source, frequency, responsibility).
4. Apply numerator and denominator concepts in calculating indicators.
5. Develop a simple monitoring and evaluation plan for a health action plan.

### **Session Content**

#### **1. Understanding Monitoring and Evaluation**

* **Monitoring** is the regular tracking of progress over time to ensure activities are being implemented as planned.
* **Evaluation** is the assessment of the extent to which results have been achieved and understanding why certain results occurred or did not occur.

|  |  |  |
| --- | --- | --- |
| Concept | Purpose | Example |
| **Monitoring** | Tracks ongoing progress and implementation | Monthly reporting of immunization coverage |
| **Evaluation** | Judges overall performance and outcomes | Assessing reduction in maternal mortality after a program |

#### **2. Indicators — The “Road Signs” of Progress**

An **indicator** is a measurable variable that shows progress toward achieving results. It tells us:

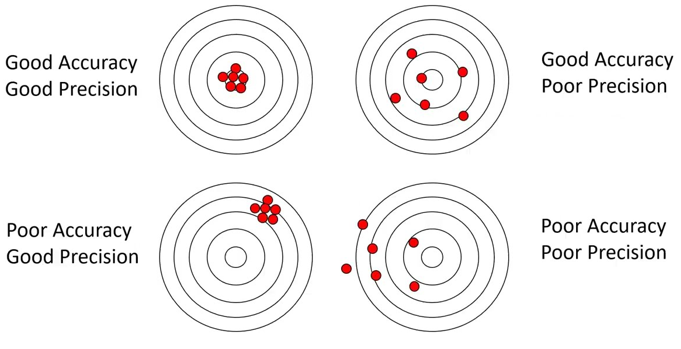
* Where we are now (baseline),
* How far we have gone (progress) and
* How far we need to go (target).

***Example:***  
Indicator: Percentage of women attending at least four antenatal visits. It tells us how many women are using antenatal services — a key sign of maternal care quality.

#### **3. Characteristics of Good Indicators**

A good indicator should be:

* **Valid** – Measures what it is supposed to measure.
* **Reliable** – Produces the same result when measured repeatedly.
* **Precise** – Clearly defined, specific and measurable.
* **Relevant** – Linked directly to program objectives.
* **Comparable** – Can be compared over time or across locations.
* **Timely** – Measured at appropriate intervals.
* **Feasible** – Data can be collected easily and affordably.



#### **4. Key Components of an M&E Plan**

|  |  |  |
| --- | --- | --- |
| Component | Description | Example |
| **Indicator** | The variable being measured | % of fully immunized children |
| **Definition** | Detailed explanation of what and how it is measured | Number of children aged 12–23 months who received all recommended vaccines divided by total children aged 12–23 months |
| **Baseline & Goal** | Starting point and target value | Baseline: 60%; Goal: 80% in one year |
| **Data Source** | Where data will come from | Facility registers, DHIS, household survey |
| **Collection Method** | How data will be gathered | Monthly tally sheets, client records |
| **Frequency** | How often data is collected | Monthly or quarterly |
| **Responsibility** | Who collects the data | Health Information Officer, Facility In-charge |

#### **5. Numerators and Denominators**

Indicators are often expressed as **ratios or percentages** using numerators and denominators.

* **Numerator:** Subgroup showing the result (e.g., number of women receiving HIV testing).
* **Denominator:** Total relevant group (e.g., total women attending ANC).

***Example:***

280 women received HIV counseling and testing out of 300 ANC attendees.

→ **280 ÷ 300 = 0.93 = 93% coverage**

#### **6. Data Sources for M&E**

Data can be collected from different levels:

|  |  |
| --- | --- |
| Level | Example Data Sources |
| **Policy/Government** | Official reports, national budgets, policy documents |
| **Service Delivery** | Facility records, HMIS, training records, quality assessments |
| **Population** | Census data, surveys, surveillance systems |
| **Individual** | Medical records, interviews, observation |

**7. Baseline — The Starting Point**

A **baseline** shows the current status before interventions begin. It helps to:

* Set realistic goals and
* Track progress over time.

***Example:***

Baseline: 150 new family planning clients per month (2024)

Goal: 225 new clients per month by end of 2025 → Target = 50% increase from baseline

### **Activity 1: Indicator Development Exercise**

**Duration:** 30 minutes

***Instructions:***

1. Divide into small groups.
2. Each group will select one **health service area** (e.g., maternal health, immunization, nutrition).
3. Develop one indicator following the steps below:
   * Define the indicator clearly.
   * Identify numerator and denominator.
   * Determine baseline, data source and frequency.
4. Present your indicator to the class and discuss whether it meets the characteristics of a good indicator.

***Debrief:***

* What made your indicator valid and reliable?
* Was data easily available?
* How can it help you track progress in your area?

### **Activity 2: Baseline Calculation Practice**

**Duration:** 20 minutes

**Type:** Individual/Pair Exercise

***Scenario:***

In a rural health center, 280 women received Cervical Cancer Screening counseling out of 600 ANC attendees over six months.

* Calculate the indicator value.
* Interpret the result.
* Suggest an action to improve performance.

### **Key Takeaways**

* Monitoring and evaluation are essential tools for continuous learning and accountability.
* Indicators act as guideposts to measure progress toward results.
* A good indicator is valid, reliable, precise and easy to measure.
* Baselines and targets help teams assess change and success.
* M&E ensures that health programs remain on track and achieve equitable, quality results.

## **SESSION 2.5**

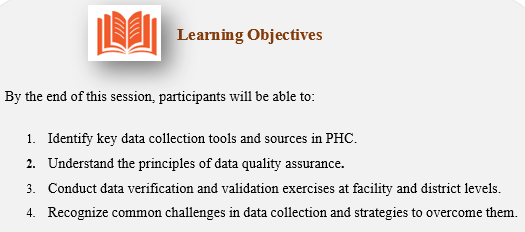
## **DATA COLLECTION AND QUALITY ASSURANCE**

### **Introduction**

Accurate, timely and reliable data is the foundation of effective **Monitoring and Evaluation (M&E).** In **Primary Health Care (PHC),** collecting quality data ensures that managers and frontline staff can monitor service delivery, make informed decisions and improve health outcomes.

In **Khyber Pakhtunkhwa (KP),** data collection is conducted at multiple levels—community, facility, district and provincial. Quality assurance processes, including **data verification and validation exercises**, are critical to maintain trust in the system and to support evidence-based decision-making.

This session introduces participants to **data collection tools and sources**, explains how to ensure **data quality** and provides practical exercises to verify and validate data.



### **1. Tools and Sources of Data in PHC**

Data in PHC programs are collected through multiple **tools and sources**, depending on the type of service or indicator being measured.

|  |  |  |  |
| --- | --- | --- | --- |
| ****Data Type**** | ****MoV****  Means of Verification | ****Purpose**** | ****Responsible Staff**** |
| ****Patient Service Data**** | ANC, PNC, OPD and immunization registers | Track service delivery and coverage | LHVs, Medical Officers, Vaccinators |
| ****Facility Reports**** | Monthly facility reports, DHIS2 online submissions | Consolidate facility-level data for district and provincial analysis | Facility In-charges, Data Entry Operators |
| ****Stock and Logistics Data**** | LMIS forms, stock cards, supply chain dashboards | Monitor availability of medicines, vaccines and supplies | Pharmacists, Storekeepers |
| ****Surveys**** | Household surveys, health facility assessments | Collect data on health outcomes and service utilization | M&E Officers, Supervisors |
| ****Community Data**** | CHW reports, outreach session logs | Track community-based services and outreach coverage | Community Health Workers (CHWs) |

***Key Point:*** Using standardized tools ensures **consistency and comparability** of data across facilities and districts.

### **2. Principles of Data Quality Assurance**

High-quality data must meet the following criteria:

|  |  |  |
| --- | --- | --- |
| ****Attribute**** | ****Definition**** | ****Example in PHC (KP context)**** |
| **Accuracy** | Data reflects what actually happened | Number of children vaccinated matches the register |
| **Completeness** | All required data fields are filled | ANC register contains all patient visits |
| **Timeliness** | Data is reported within the required timeframe | Monthly DHIS2 submissions by 5th of each month |
| **Consistency** | Data is comparable over time and across sources | OPD attendance recorded similarly across all BHUs in a district |
| **Reliability** | Data can be verified and trusted | Cross-checking stock levels against LMIS forms |

***Key Point:*** Poor data quality can lead to wrong decisions, misallocation of resources and reduced trust in health programs.

### **3. Data Verification and Validation Exercises**

Verification and validation exercises ensure that reported data is **accurate, complete and credible.** These exercises involve **cross-checking, observation and sample audits.**

**Steps for Data Verification in PHC:**

1. ***Compare Registers with Reports:*** Ensure that monthly facility reports match the primary registers.
2. ***Cross-check Indicators:*** Validate key indicators such as ANC visits, immunization coverage, or stock levels.
3. ***Spot Checks*:** Select random patient records or sessions to verify accuracy.
4. ***Supervisory Visits:*** District supervisors or M&E officers conduct visits to review data collection practices and provide feedback.
5. ***Feedback and Corrective Action:*** Identify discrepancies, provide guidance and implement corrections.

***Example (KP Context):***

During a supervision visit in District Peshawar, an M&E officer noticed that the number of fully immunized children reported in DHIS2 was higher than the register. A verification exercise revealed errors in data entry at the facility. The officer provided training on proper register use and corrected the records in DHIS2.

### **4. Common Challenges in Data Collection**

|  |  |  |
| --- | --- | --- |
| ****Challenge**** | ****Impact**** | ****Possible Solution**** |
| Missing or incomplete data | Reduces reliability and affects decision-making | Use standard registers and train staff regularly |
| Delayed reporting | Hinders timely analysis and corrective action | Set clear deadlines and monitor compliance |
| Errors in data entry | Leads to inaccurate performance indicators | Double-entry verification and supervisory checks |
| Lack of capacity | Staff unable to analyze or use data effectively | Conduct in-service training and refresher courses |
| Multiple reporting systems | Duplication and confusion | Integrate reporting through DHIS2 and LMIS |

### **5. Data Quality Assurance in KP PHC System**

In KP, quality assurance mechanisms are integrated into the PHC system:

* ***Monthly facility-level reviews:*** Facility in-charges review registers and reports before submission.
* ***District-level verification*:** M&E officers cross-check reports, conduct random audits and provide feedback.
* ***Provincial dashboards:*** DGHS uses DHIS2 dashboards to monitor completeness, timeliness and accuracy of facility data.
* ***Training and capacity building:*** Health workers receive periodic training on data collection and reporting.

***Key Point*:** Effective quality assurance ensures that PHC data is **trustworthy, actionable and useful for decision-making.**

### 

### **Reflection Questions**

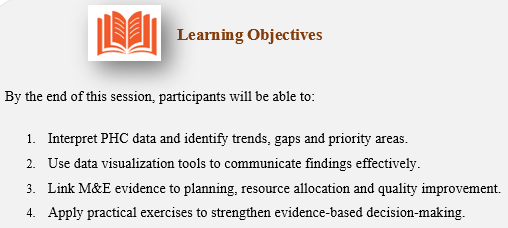
1. What are the main tools you use to collect PHC data at your facility?
2. How can you ensure that the data you report is accurate and complete?
3. Share an example where data verification helped improve a service or correct a mistake in your facility.

## **SESSION 2.6**

## **USING M&E DATA FOR DECISION-MAKING**

### **Introduction**

Collecting data is only the first step in **Monitoring and Evaluation (M&E).** The true value of M&E lies in **using data to make informed decisions** that improve health services, optimize resource allocation and enhance patient outcomes.

In **Primary Health Care (PHC)**, health managers and frontline staff can use data to **identify gaps in service delivery, monitor program performance and plan interventions**. This session introduces methods for **data interpretation, visualization** and linking evidence to decision-making, both at the facility and district level.

### **1. Interpreting M&E Data in PHC**

Data interpretation involves understanding **what the numbers mean** and how they relate to program goals. It is important to ask:

* Are services reaching the target population?
* Are there areas with low coverage or poor performance?
* What trends are emerging over time?
* How do KP indicators compare to national targets or SDG benchmarks?

***Example:***  
If the DHIS2 data shows that only 60% of children in a union council have received full immunization, health managers can investigate reasons—such as stockouts, inaccessible areas, or low community awareness—and plan corrective actions.

### **2. Data Visualization**

Visualizing data helps communicate findings clearly and supports **rapid decision-making**. Common methods include:

|  |  |  |
| --- | --- | --- |
| ****Visualization Type**** | ****Use in PHC**** | ****Example**** |
| ****Bar Chart**** | Compare coverage across facilities or districts | Immunization coverage by BHU in a district |
| ****Line Graph**** | Show trends over time | ANC visits trend over 12 months |
| ****Pie Chart**** | Show proportions | Percentage of patients with hypertension vs. diabetes |
| ****Dashboard**** | Consolidate multiple indicators for quick review | DHIS2 KPI dashboard for KP PHC services |

***Tip:*** Simple, clear visuals are often more effective than complex graphs for frontline staff.

### **3. Linking Evidence to Planning and Improvement**

**Evidence-based decision-making** ensures that interventions address actual gaps and improve health outcomes. In PHC, this may include:

* Reallocating staff or resources to underperforming facilities.
* Conducting targeted training for health workers in specific areas.
* Adjusting outreach schedules or mobile health services for communities with low coverage.
* Planning procurement based on real-time stock data from LMIS.

**Case Example:**

In ***Rwanda***, the Ministry of Health uses routine M&E data to adjust immunization campaigns. Dashboards visualize district-level vaccination coverage, identify low-performing areas and trigger targeted outreach. This evidence-based approach has contributed to **high immunization rates and reduced child mortality.**

### **4. Activity: Analyzing PHC Data for Action**

***Objective*:** Practice interpreting and using M&E data to make decisions.

***Instructions:***

1. Form groups of 4–5 participants.
2. Each group receives a **mock DHIS2 dataset** showing ANC visits, immunization coverage and stock levels for 5 BHUs.
3. Identify **key gaps or trends** in the data.
4. Prepare a **short action plan** addressing the gaps. Include:
   * Which service or indicator needs improvement?
   * What interventions will you implement?
   * How will you monitor progress?
5. Present findings to the group (5–7 minutes per group).

***Debrief:*** Discuss similarities and differences between groups’ findings and emphasize the importance of data-driven decisions in PHC.

### **5. Key Takeaways**

### **Reflection Questions**

1. How can data from your facility guide improvements in service delivery?
2. Which visualization tools would be most useful for presenting PHC data to your team?
3. Share an example of a decision that could be improved by better use of M&E data.

**MODULE THREE**

**APPLYING LEADERSHIP, MONITORING & EVALUSTION FOR IMPROVED HEALTH OUTCOMES**



### **Introduction**

Effective **leadership** and robust **Monitoring & Evaluation (M&E)** are essential for improving health services and achieving better health outcomes in **Primary Health Care (PHC).** While leadership provides direction, motivation and oversight, M&E ensures that decisions are **evidence-based, targeted and measurable.**

In this module, participants will learn how to **integrate leadership and M&E skills** into daily PHC management. This includes supervising staff, analyzing data, identifying gaps in service delivery and implementing practical solutions to challenges.

The module emphasizes a **hands-on, problem-solving approach**, helping health managers and frontline staff translate knowledge into **real-world actions** that strengthen service delivery, improve efficiency and enhance accountability.

By linking leadership with data-driven decision-making, PHC teams can **better plan, monitor and adapt** interventions, ultimately contributing to **Universal Health Coverage (UHC)** and advancing the **Sustainable Development Goals (SDG 3 – Good Health and Well-being)** in Khyber Pakhtunkhwa.

**Key Focus Areas:**

* Applying leadership principles to manage PHC teams and facilities effectively.
* Using M&E data to identify gaps, set priorities and make informed decisions.
* Strengthening accountability, teamwork and problem-solving at the facility and district levels.
* Enhancing health outcomes through practical, evidence-based interventions.

**Learning Outcome:**

At the end of this module, participants will be able to **apply leadership and M&E skills** to improve PHC service delivery, address operational challenges and contribute to better health outcomes in their communities.

**SESSION 3.1**

**INTEGRATING LEADERSHIP AND M&E FOR EFFECTIVE HEALTH MANAGEMENT**

### **Introduction**

Effective health management in **Primary Health Care (PHC)** requires a strong combination of **leadership skills** and **Monitoring & Evaluation (M&E)** capabilities. Leaders play a critical role in guiding teams, ensuring accountability and creating a culture of **continuous improvement**. Meanwhile, M&E provides the **data-driven insights** necessary to identify gaps, monitor performance and inform decisions.

In this session, participants will learn how **leadership and M&E complement each other** to strengthen PHC services, improve performance and enhance health outcomes.

### 

### **1. The Role of Leadership in Using Data**

PHC leaders—including **Medical Officers, LHVs, facility managers and health supervisors**—have several responsibilities:

* ***Set priorities and goals*:** Use M&E data to identify underperforming services or gaps.
* ***Motivate and guide teams*:** Encourage staff to achieve targets and maintain quality standards.
* ***Facilitate problem-solving*:** Use evidence to identify root causes and implement solutions.
* ***Monitor performance*:** Track progress against indicators, KPIs and targets.

**Example (KP context):**

A BHU in **Swabi** noticed that only 55% of pregnant women were receiving 4 ANC visits. The facility in-charge used DHIS2 data to identify low-performing villages, conducted community outreach sessions and supervised LHVs. After 3 months, coverage improved to 78%.

### **2. Using M&E Data for Performance Improvement**

**M&E data** provides a roadmap for **evidence-based management:**

* ***Identify trends and gaps*:** Look at service delivery indicators such as ANC coverage, immunization rates and stock availability.
* ***Prioritize interventions*:** Allocate resources where they are needed most.
* ***Evaluate effectiveness:*** Determine if programs are achieving intended results and adjust strategies accordingly.
* ***Promote transparency:*** Share findings with teams, district management and communities to build trust.

***Example:***

In ***Thailand***, district health officers use routine M&E data to identify villages with low immunization coverage. Supervisory visits and targeted outreach campaigns have increased vaccination rates while maintaining accountability through public dashboards.

### **3. Decision-Making and Accountability Mechanisms**

Strong leadership ensures that M&E findings are **translated into action:**

* ***Decision-making:***
  + Allocate staff and supplies to underperforming facilities.
  + Adjust outreach schedules based on population coverage data.
  + Implement training where gaps in knowledge or skills are identified.
* ***Accountability mechanisms:***
  + Regular review meetings with facility and district staff.
  + Use of **performance dashboards** for tracking progress.
  + Supervision and supportive feedback to staff.
  + Public reporting of key indicators to promote transparency.

***Key Point:*** Accountability ensures that leaders are not only informed but also **responsible for acting on data** to improve health services.

### **4. Practical Activity: Data-Driven Decision Exercise**

***Objective*:** Apply leadership and M&E to make evidence-based decisions.

***Instructions:***

1. Divide participants into small groups (4–5 per group).
2. Each group receives a **mock PHC dataset (**ANC visits, immunization coverage, OPD attendance, stock levels).
3. Tasks:
   * Identify **key gaps or areas needing improvement.**
   * Decide **three priority actions** based on data.
   * Assign roles and responsibilities for implementation.
4. Present the plan to the group and discuss **how data informed your decisions.**

***Debrief*:** Highlight the importance of linking leadership, M&E and accountability in real-world PHC management.

### **Reflection Questions**

1. How can you, as a PHC leader, use facility data to improve service delivery?
2. What accountability mechanisms are currently in place and how can they be strengthened?
3. Give an example of a decision that could benefit from better use of M&E data in your facility.

## **SESSION 3.2**

## **PERFORMANCE REVIEW AND SUPPORTIVE SUPERVISION**

### **Introduction**

**Supportive supervision** is a critical leadership tool that ensures health teams perform effectively, adhere to standards and continuously improve service delivery. Unlike traditional inspection, supportive supervision focuses on **guidance, mentoring and problem-solving** rather than punitive measures.

Performance reviews and facility-level supervision help identify gaps, improve accountability, strengthen teamwork and ultimately enhance **health outcomes** in Primary Health Care (PHC) settings.

This session introduces participants to **conducting facility performance reviews, using supportive supervision checklists** and providing constructive feedback to PHC staff.

### 

### **1. Purpose of Performance Reviews and Supportive Supervision**

Supportive supervision serves multiple purposes in PHC:

* ***Assess performance:*** Review progress against KPIs, targets and service delivery indicators.
* ***Identify gaps:*** Detect issues in service provision, staff performance, or resource availability.
* ***Provide guidance:*** Offer on-the-job coaching to strengthen skills and knowledge.
* ***Foster teamwork*:** Encourage collaboration, communication and problem-solving.
* ***Ensure accountability*:** Align facility practices with national guidelines, KP policies and UHC objectives.

***Key Point:*** Supervision is most effective when it is **regular, structured and participatory**, emphasizing learning and improvement.

### **2. Conducting Facility Performance Reviews**

Facility reviews involve **systematic assessment** of services, processes and staff performance. Steps include:

1. ***Planning*:** Schedule regular reviews and communicate with facility staff.
2. ***Data Review:*** Examine DHIS2 reports, registers, LMIS data and KPIs.
3. ***Observation:*** Visit service delivery points, check equipment, medicines and patient flow.
4. ***Staff Interviews:*** Understand challenges and provide coaching opportunities.
5. ***Feedback Session:*** Discuss findings constructively, highlight achievements and suggest improvements.
6. ***Action Planning:*** Agree on corrective actions, responsibilities and timelines for follow-up.

***Example (KP context):***

During a facility review in **Swat**, a supervisor noticed low immunization coverage due to frequent stockouts. The supervisor worked with the facility in-charge to improve LMIS reporting, plan community outreach and assign staff to monitor vaccine stocks. Follow-up showed improved coverage within two months.

### **3. Supportive Supervision Checklist**

A **checklist** ensures supervision is systematic, consistent and comprehensive. Key areas to include:

|  |  |  |
| --- | --- | --- |
| ****Domain**** | ****Items to Review**** | ****Comments / Notes**** |
| ****Service Delivery**** | ANC, immunization, OPD services, NCD follow-up | Are services provided according to guidelines? |
| ****Data and M&E**** | Register accuracy, DHIS2 reporting, KPIs | Are records complete and timely? |
| ****Staff Performance**** | Knowledge, skills, adherence to SOPs | Are staff confident and competent? |
| ****Supplies and Equipment**** | Medicine stocks, vaccines, functional equipment | Are resources available when needed? |
| ****Infrastructure & Hygiene**** | Cleanliness, patient flow, waiting areas | Does the facility meet minimum standards? |
| ****Community Engagement**** | Outreach sessions, health education | Are community needs addressed? |

***Tip:*** Use the checklist as a **guide, not a judgment tool.** Focus on identifying challenges, mentoring staff and recommending improvements.

### **4. Providing Constructive Feedback**

Feedback is a crucial component of supportive supervision. Effective feedback should be:

* ***Specific:*** Clearly identify what is being reviewed.
* ***Objective:*** Base comments on observations and data, not personal opinions.
* ***Balanced*:** Highlight achievements before discussing gaps.
* ***Actionable:*** Provide recommendations and suggest next steps.
* ***Collaborative:*** Engage staff in problem-solving rather than dictating solutions.

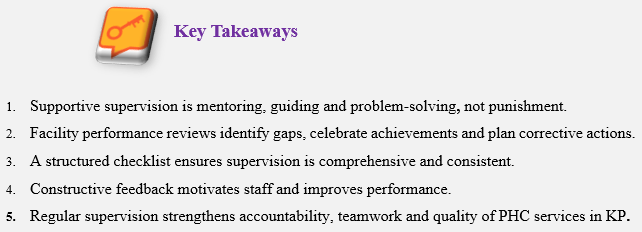
***Example:***  
“Your ANC documentation is complete and up-to-date. However, immunization stockouts are affecting coverage. Let’s work together to improve LMIS reporting and plan community sessions to reach missed children.”

### **5. Practical Activity: Conduct a Mini-Supervision Visit**

***Objective*:** Apply supportive supervision skills in a simulated setting.

**Instructions:**

1. Divide participants into **pairs**: one acts as the supervisor, the other as facility staff.
2. Each pair receives a **mock facility report and scenario** (e.g., low ANC coverage, stockouts, staff absenteeism).
3. Conduct a **10-minute supervision visit:**
   * Review the data and registers.
   * Observe and assess mock service points.
   * Provide constructive feedback using the checklist.
4. Swap roles and repeat.
5. Debrief as a group: discuss challenges, lessons learned and key takeaways.

***Key Learning:*** Practical exercises strengthen confidence in conducting real-world supportive supervision and performance reviews.

**Reflection Questions**

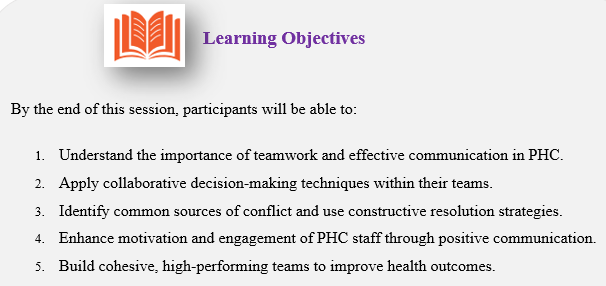
1. How can you make supervision more supportive rather than punitive in your facility?
2. Which areas in your PHC facility require regular performance review?
3. Share an example of a supervision practice that improved service delivery in your context.

## **SESSION 3.3**

## **TEAM BUILDING AND COMMUNICATION IN PHC SETTINGS**

### **Introduction**

Effective **teamwork and communication** are essential components of strong leadership in **Primary Health Care (PHC).** Health services are delivered by multidisciplinary teams, including **Medical Officers, LHVs, health technicians and community health workers** and require collaboration to achieve shared goals.

Good communication strengthens relationships, fosters **collaborative decision-making**, resolves conflicts and motivates staff. This session focuses on **team-building strategies**, communication techniques and conflict resolution skills to improve service delivery and staff satisfaction in PHC settings.

### **1. Importance of Teamwork in PHC**

PHC teams work under challenging conditions—limited resources, high patient loads and diverse community needs. Strong teamwork leads to:

* ***Improved service delivery:*** Coordinated efforts ensure timely, quality care.
* ***Shared responsibility:*** Everyone contributes to achieving facility and district goals.
* ***Problem-solving:*** Teams can identify gaps, propose solutions and implement improvements collectively.
* ***Staff motivation*:** Supportive teams increase morale and reduce burnout.

**Example (KP context):**

In a BHU in ***Haripur***, a team including a Medical Officer, LHV and CHWs collaborated to organize outreach immunization sessions. Through regular team meetings and task sharing, coverage improved from 60% to 85% within 3 months.

### **2. Collaborative Decision-Making**

Collaborative decision-making encourages **all team members to participate** and share their insights. Steps include:

1. **Identify the issue or decision required** (e.g., low ANC attendance in a catchment area).
2. **Gather relevant data** from registers, DHIS2 and field reports.
3. **Brainstorm solutions** with all team members.
4. **Evaluate options** considering resources, feasibility and potential impact.
5. **Agree on a course of action** collectively**.**
6. **Assign roles and responsibilities** and monitor progress.

**Key Point:** Involving the whole team builds ownership and increases the likelihood of successful implementation.

### **3. Motivating Teams in PHC**

Leaders can motivate teams using strategies such as:

* ***Recognition:*** Acknowledge good performance publicly.
* ***Supportive supervision:*** Provide guidance and mentorship rather than punishment.
* ***Inclusion*:** Involve staff in decision-making and planning.
* ***Professional growth:*** Encourage training and skill development.
* ***Positive work environment*:** Promote respect, cooperation and open communication.

**Example:**  
A facility in ***Peshawar*** held monthly team meetings where achievements and challenges were discussed. Staff who met performance targets received certificates and recognition. Motivation improved, reflected in higher patient satisfaction and service delivery.

### **4. Conflict Resolution in PHC Teams**

Conflict is natural in any workplace but can negatively affect service delivery if unmanaged. Effective conflict resolution involves:

1. ***Identify the source of conflict:*** Miscommunication, workload, resource constraints, or personal differences.
2. ***Listen actively:*** Understand each party’s perspective.
3. ***Address issues early:*** Resolve conflicts before they escalate.
4. ***Focus on solutions, not blame*:** Encourage compromise and collaborative problem-solving.
5. ***Follow up:*** Ensure agreements are implemented and relationships restored.

**Example:**  
In **Swat**, two LHVs had disagreements over scheduling outreach sessions. The facility in-charge facilitated a discussion, clarified responsibilities and developed a shared timetable, improving teamwork and outreach coverage.

### **5. Effective Communication Skills**

Strong communication ensures **clarity, understanding and engagement.** Key skills include:

* ***Active listening:*** Pay attention, summarize and clarify.
* ***Clear messaging*:** Use simple, concise language.
* ***Non-verbal communication*:** Maintain appropriate body language and tone.
* ***Feedback*:** Provide constructive, respectful feedback.
* ***Conflict prevention:*** Communicate expectations and responsibilities clearly.

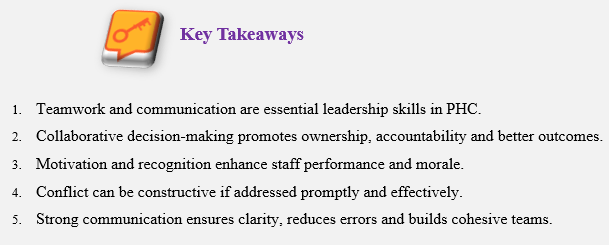
**Tip:** Regular team meetings, briefings and debriefings foster communication and collaboration.

### **6. Practical Activity: Team Problem-Solving Exercise**

**Objective:** Strengthen collaborative decision-making and communication skills.

**Instructions:**

1. Divide participants into **small groups (4–5).**
2. Provide a **scenario**: e.g., “ANC attendance in your facility has dropped by 30% this month.”
3. Each group:
   * Discuss the problem collaboratively.
   * Brainstorm possible solutions.
   * Assign roles and create a **mini action plan.**
4. Present findings to the class (5–7 minutes per group).
5. Facilitator provides feedback on **team collaboration, communication and decision-making.**

**Key Learning:** Teamwork, open communication and inclusive decision-making improve PHC service delivery and staff engagement.

### **Reflection Questions**

1. How can you improve communication within your PHC team?
2. Give an example of a conflict in your facility and how it could be resolved constructively.
3. How can you involve your team in decision-making to improve service delivery?

## **SESSION 3.4**

## **ACTION PLANNING, FOLLOW-UP and SUSTAINING IMPROVEMENTS**

### **Introduction**

The ultimate goal of leadership and M&E training is to translate knowledge and skills into **practical actions** that improve service delivery and health outcomes in **Primary Health Care (PHC).** This session focuses on **developing facility-level action plans, setting performance targets and establishing follow-up mechanisms** to ensure continuous improvement.

It also provides an opportunity for **reflection**, consolidating learning from the training and committing to applying these lessons in real-world settings.

### 

### **1. Developing Action Plans for Facilities**

An action plan is a **structured roadmap** for addressing identified gaps and improving service delivery. Key steps include:

1. ***Identify priorities:*** Use M&E data, supervision findings and team inputs to select key areas for improvement.
2. ***Define objectives*:** Specify what the facility aims to achieve (e.g., increase ANC coverage, reduce stockouts, improve data reporting).
3. ***Set SMART targets*:** Ensure objectives are **Specific, Measurable, Achievable, Relevant and Time-bound.**
4. ***Assign responsibilities:*** Clearly identify team members responsible for each action.
5. ***Determine resources needed:*** Identify human, financial and logistical requirements.
6. ***Establish timelines and milestones*:** Decide when actions will be implemented and progress reviewed.

**Example (KP context):**

A BHU in **Nowshera** notices low immunization coverage. The action plan includes:

* Objective: Increase full immunization coverage from 65% to 85% within six months.
* Actions: Conduct weekly outreach sessions, improve vaccine stock reporting and assign CHWs to high-risk households.
* Responsible: LHV supervises outreach, MO oversees data reporting.
* Resources: Vaccine supply, transport and community mobilization support.
* Follow-up: Monthly review meetings to track progress.

### **2. Setting Performance Targets and Follow-Up Indicators**

Effective follow-up ensures accountability and progress tracking. **Key steps include:**

* ***Select relevant indicators*:** Choose 3–5 key indicators for each priority area (e.g., ANC coverage, immunization rate, stock availability).
* ***Define targets*:** Use baseline data to set realistic yet challenging goals.
* ***Schedule reviews:*** Conduct monthly or quarterly performance reviews with staff.
* ***Adjust actions:*** Use feedback and monitoring results to adapt interventions as needed.

**Example Table: Performance Targets for PHC Facility**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ****Priority Area**** | ****Indicator**** | ****Baseline**** | ****Target**** | ****Review Frequency**** | ****Responsible**** |
| ANC coverage | % of pregnant women completing 4 visits | 55% | 80% | Monthly | LHV, MO |
| Immunization | % of children fully immunized | 65% | 85% | Monthly | CHWs, LHV |
| Stock management | % of essential drugs available | 70% | 95% | Bi-weekly | MO, Pharmacist |

### **3. Reflection and Consolidation**

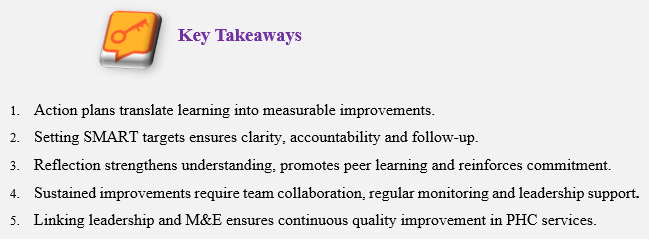
Reflection allows participants to **review learning, share experiences and plan personal and team commitments**. Key activities include:

* **Group Discussion:** Participants discuss key lessons learned, challenges faced and how the training will influence their work.
* **Individual Reflection:** Participants write down **3 concrete actions** they will implement in their facilities.
* **Peer Sharing:** Participants share action points with colleagues for feedback and accountability.

### **4. Commitment to Apply Lessons**

To ensure the training leads to **real impact**, participants should:

* Present their **facility action plans** to supervisors or district health managers.
* Use M&E data regularly to track progress and guide decisions.
* Foster **team collaboration** to achieve targets.
* Continue learning and improving leadership, communication and problem-solving skills.

***Facilitator Tip:*** Encourage participants to **sign a commitment pledge** outlining the actions they will take in their facilities over the next 3–6 months.

### **Reflection Questions**

1. What are the top three actions you will implement in your facility after this training?
2. How will you ensure accountability for these actions within your team?
3. How can your action plan contribute to **better health outcomes and UHC goals** in KP?