**TRAINING MANUAL FOR FACILITATOR**

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

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

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**Executive Summary**

This manual has been developed as a practical guide for medical and paramedical staff working in Primary Health Care (PHC) canters of Pakistan. It focuses on strengthening capacities in governance, leadership, monitoring and evaluation (M&E)—core areas that directly contribute to improved service delivery, accountability and patient outcomes at the community level.

The training program spans three days and combines presentations, case studies, role-plays, group exercises and practical assignments. The goal is to enhance the ability of PHC staff to apply governance principles, practice effective leadership and utilize M&E frameworks to guide decision-making.

Scope of this manual includes: Governance in Health: Introduction to concepts, WHO framework, key principles (accountability, transparency, equity, participation) and their application to PHC settings. Leadership in Health: Understanding leadership versus management, leadership styles, teamwork, motivation, communication and conflict resolution within PHC teams. Monitoring & Evaluation: Basics of M&E, tools and indicators for PHC, data collection and reporting systems (e.g., DHIS2, EPI, LMIS) and frameworks for evidence-based decision-making.

Implementation approach of this manual includes, Interactive Training Methods: Group work, role-play, case studies and hands-on exercises to ensure practical understanding. Contextual Relevance: Examples drawn from Pakistan’s PHC system, such as immunization accountability, maternal health reporting and community health programs. Alignment with National Priorities: The content is aligned with Pakistan’s National Health Vision, Universal Health Coverage (UHC) goals and Sustainable Development Goals (SDGs).

The purpose of this training is that by the end of this training, PHC medical and paramedical staff would be able to uphold ethical and governance standards in service delivery, to apply effective leadership styles to build motivated, high-performing PHC teams, to accurately collect, record and report health data for improved accountability, to develop and use simple M&E frameworks for planning, monitoring and decision-making and to contribute actively to achieving UHC and SDGs through strengthened PHC systems.

**TRAINING MATERIAL:**

**Trainers Manual**:

A detailed guide (hard and soft copies) as how to conduct each session along with necessary training material will be provided to each facilitator.

**Participants Manual**:

This booklet will be provided to each participant (both hard and soft copies) containing all the necessary information for future reference.

**How to use this manual?**

This manual is designed as a practical training resource for medical and paramedical staff working in Primary Health Care (PHC) centers. It is structured in a way that allows both trainers and participants to benefit fully through guided sessions, interactive activities and real-life examples.

**The Objectives of this training are:**

By the end of this training, medical and paramedical staff of Primary Health Care (PHC) centers will be able to:

1. **Understand Governance in Health Systems**
   1. Define governance and explain its role in improving PHC services.
   2. Apply WHO’s governance framework and key principles (accountability, transparency, participation, equity).
2. **Strengthen Leadership Skills**
   1. Differentiate between leadership and management in healthcare.
   2. Recognize and apply different leadership styles suitable for PHC settings.
   3. Practice teamwork, motivation, communication and conflict resolution strategies.
3. **Apply Monitoring & Evaluation (M&E) Approaches**
   1. Describe the basics of monitoring and evaluation in health programs.
   2. Use tools and indicators to measure PHC performance.
   3. Develop and apply simple M&E frameworks for PHC activities (e.g., immunization, ANC, nutrition).
4. **Improve Data Management and Decision-Making**
   1. Accurately collect and report health data (using registers, DHIS2, EPI, LMIS).
   2. Analyze and interpret local health data to identify problems and solutions.
   3. Use data for evidence-based decision-making and local action planning.
5. **Enhance Service Delivery and Community Trust**
   1. Uphold ethical and governance standards in PHC service provision.
   2. Promote patient-centered care and community participation.
   3. Contribute to achieving Universal Health Coverage (UHC) and Sustainable Development Goals (SDGs) through strengthened PHC

**Potential workshop Participants include:**

Primary Healthcare Workers including Medical Officer, Medical Technician, Lady Health Visitor & Lady Health Supervisors Program Managers of district and provincial health departments Organizations working on primary health care improvement.

**Expected Outcomes:**

After completing this training, participants (medical and paramedical staff of PHC centers) are expected to apply Governance Principles and to demonstrate accountability, transparency and ethical standards in PHC service delivery, to strengthen Leadership and Teamwork to show improved leadership and communication skills to manage teams and resolve conflicts effectively, to use Monitoring & Evaluation Tools, to accurately collect, report and analyze PHC data using standard tools and indicators. Moreover, to develop Practical M&E Frameworks and design simple frameworks to monitor key PHC activities (e.g., immunization, maternal health, nutrition).

Furthermore, to promote Evidence-Based Decision-Making by utilizing data and reporting systems to guide planning, resource allocation and problem-solving at PHC level. Enhance Quality of Care & Community Trust to deliver more patient-centered, efficient and reliable services aligned with national health priorities. Contribute to National & Global Goals, Support progress towards Universal Health Coverage (UHC) and Sustainable Development Goals (SDGs) through improved PHC governance and performance.

**Training Agenda**

Complete details for each module and its sessions with information about methodology, different interactive activities and resource materials required are listed in detail. In this manual, Participatory techniques are adapted to make learning as hands-on as possible. Handouts and annexure have also been provided to aid in conducting the training. The training agenda has been made flexible for the trainers. The training agenda is set for 2 days for healthcare providers working in primary settings including BHUs, RHCs, Civil Dispensaries, Category-C and Category-D hospitals.

**A. Facilitation Methods**

Trainers should apply adult learning principles while considering the participants' varying levels of experience in the healthcare delivery system. An effective trainer will leverage the skills and. personalities within the group to create an engaging and productive workshop. The following participatory training methods can be beneficial:

**i. Power Point Presentation**

Often referred to as the "presentation method," this approach has faced criticism for being facilitator-centered and making participants passive listeners. However, it can be effective, particularly when introducing new or unfamiliar topics. The facilitator should present information in a way that encourages group interaction, promoting an interactive learning environment. To enhance presentations, the facilitator can use anecdotes, humor, handouts, PowerPoint slides, audio-visual materials and ask questions to engage participants.

**ii. Brainstorming**

Brainstorming encourages quick, collaborative discussions on a topic, fostering creativity and generating ideas swiftly. It’s particularly useful for building consensus around contentious issues, with points raised during the session often recorded on a flip chart.

**iii. Real Life Experience Sharing**

This method allows selected participants or guest speakers to share relevant life experiences that connect to the topics being discussed, adding a personal touch to the content. It’s important to ensure that speakers stay on topic and adhere to their allotted time.

**iv. Small Group Discussion**

The primary goal of small group discussions is to maximize participation and foster new insights among participants. Groups of four or five are ideal, as they allow for more personal interaction, reduce intimidation and encourage idea exchange. Considerations for group work include the topic, objectives, assigned tasks, desired participation level, available resources, time 5management, group composition (including gender) and seating arrangements. Each group should have a chairperson and a note-taker, with key points recorded on a flip chart for reporting back to the larger group. The facilitator should then synthesize and clarify any emerging issues.

**v. Case Study**

In this method, participants analyze a real or fictional case in small groups before discussing it with the larger group. The facilitator presents the case details and invites participants to propose solutions and share their opinions without dictating the best answer or critiquing contributions.

**vi. Role Play**

Role play is a dynamic method that promotes participation and creativity by simulating real-life scenarios. Participants are assigned hypothetical situations and act according to their assigned roles, while non-participants observe and critique. After the role play, the facilitator leads a discussion to reflect on the experience. It’s helpful to establish a time limit of 5 to 10 minutes for the exercise and to record key takeaways on a flip chart.

**B. Logistic Support:**

Training arrangements should be made well in advance and all necessary equipment and supplies should be arranged. Required training equipment include:

1. Laptop, projector & un-interrupted power supply
2. Flip Flowcharts with Stand
3. Colored Markers, Sticky Notes
4. Necessary Stationary Required for participants (Writing pad, pen, pencil etc)
5. Required No. of pre-test and post-test questionnaires copies
6. Required No. of participants handouts

**C. Preparatory Checklist for the trainer**

The trainer should:

1. Thoroughly understand the training manual's content.
2. Review the training objectives, session outlines and activities for each session, including

learning goals, time, resources and trainer instructions as detailed in the manual.

1. Familiarize themselves with the session slides, particularly those with presentations.
2. Review the pre/post-test and course evaluation forms and prepare copies for all

participants.

1. Make copies of handouts, role-play scenarios and checklists to ensure all audio-visual

equipment is functional.

1. Check the training venue, including seating arrangements, lighting and fans or air

conditioning (for summer).

1. Create flip flowcharts as needed for the sessions and write the daily agenda on them.



**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 adShortstrative 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**

### **Duration:**

### **30 minutes**

### **Session Type:**

Opening and Orientation Session

### **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.**

### **Session Objectives:**

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

1. Describe the **purpose and objectives** of the training.
2. Explain the **importance of leadership, governance and M&E** in strengthening PHC.
3. Understand how these skills contribute to achieving **Universal Health Coverage (UHC)** and **Sustainable Development Goals (SDGs)**.
4. Identify their **roles and expectations** as active participants and change agents in PHC systems.

### **Session Overview:**

This opening session sets the stage for the two-day training. It introduces the purpose, structure and expected outcomes, linking leadership, governance and monitoring & evaluation (M&E) with improved health service delivery.

The facilitator helps participants reflect on their current practices, challenges and leadership potential and how developing these skills can improve teamwork, data use and accountability in primary health care facilities.

### **Key Content Outline:**

|  |  |
| --- | --- |
| ****Topic**** | ****Key Points / Discussion Summary**** |
| ****1. Purpose of the Training**** | * Strengthen the capacity of PHC workers in leadership, governance and M&E. * Build skills to manage facilities effectively, use data for decision-making and promote teamwork. * Align with provincial and national health priorities (KP Health Policy, NHV 2025). |
| ****2. Importance of Leadership in PHC**** | * Leadership at all levels — not limited to titles. * Key behaviors: initiative, communication, motivation, teamwork. * Example: LHV leading community tracking of high-risk pregnancies. |
| ****3. Importance of Monitoring and Evaluation (M&E)**** | * Monitoring = routine tracking of activities; Evaluation = assessing relevance, effectiveness. * Role of DHIS2/HMIS in improving decision-making. * M&E as a tool for accountability and learning. |
| ****4. Linkages with UHC and SDGs**** | * Leadership ensures direction; M&E ensures progress. * PHC as foundation for achieving UHC and SDG 3 (Health and Well-being). |
| ****5. Training Overview & Participant Expectations**** | * Three modules: Leadership & Governance, M&E, Integration & Application. * Emphasize participation, sharing experiences, group work. |
| ****6. Role of PHC Workers in Strengthening Health Systems**** | * Leadership and data use by MOs, LHVs, Supervisors, Managers. * Every worker as a change agent improving community trust and service delivery. |
| ****7. Reflection Questions**** | * Why are leadership and M&E important for PHC? * How can you apply M&E in your daily work? * What leadership qualities are most important in KP? * What are your personal expectations from this training? |

### **Facilitation Methods:**

* **Interactive presentation:** Introduce key concepts using slides or flipcharts.
* **Group discussion:** Participants share what leadership means in their context.
* **Brainstorming:** Ask participants to list daily challenges and how leadership or M&E can address them.
* **Experience sharing:** Invite 1–2 participants to share examples of local leadership in PHC.

### **Training Materials:**

* PowerPoint slides with session objectives
* Markers and sticky notes for group work
* Participant Manual (for reference)
* Training agenda handouts

### **Facilitator Tips:**

* Begin with an **icebreaker** (e.g., “A leader I admire and why”).
* Link participant responses to **leadership qualities** and **data-driven decision-making**.
* Emphasize that leadership is **not positional** — everyone can lead in their scope.
* Use local examples from **KP PHC facilities** for relevance.
* Keep the tone participatory and motivational to set a positive tone for the workshop.

### **Key Message**

“Good leadership ensures direction; effective monitoring ensures progress — together, they make Universal Health Coverage a reality.”

## **SESSION 1.1**

# **CONCEPTS OF LEADERSHIP and MANAGEMENT**

### **Session Summary:**

### **Duration:**

60 minutes

### **Session Type:**

Interactive Presentation with group discussion

### **Session Objectives**

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

1. Define the concepts of **leadership** and **management** in the context of health systems.
2. Differentiate between the roles and functions of leaders and managers in Primary Health Care (PHC).
3. Explain how leadership and management complement each other in improving health service delivery.
4. Reflect on their own roles as both leaders and managers in PHC settings.

### **Session Overview**

Effective leadership and management are the driving forces behind a strong health system. In PHC, where workers face real-world challenges such as limited staff and resources, success depends on how well individuals can **lead teams, manage systems and uphold governance principles**.

This session helps participants understand that leadership and management are **distinct yet interdependent** — leadership gives **direction and motivation**, while management ensures **order, planning and efficiency**. Both are crucial to achieving **Universal Health Coverage (UHC)** and the **Sustainable Development Goals (SDGs)**.

### **Session Outline**

|  |  |
| --- | --- |
| ****Topic**** | ****Key Points / Discussion Summary**** |
| **1. Introduction to Leadership** | * Leadership is the process of influencing people toward achieving shared goals. * It focuses on **vision, motivation, communication and inspiration**. * A good leader inspires trust, promotes teamwork and adapts to change.   **Example:** A Lady Health Visitor mobilizing her team to reach unvaccinated children despite limited resources. |
| **2. Introduction to Management** | * Management is the process of **planning, organizing, coordinating and controlling** resources to achieve specific objectives. * It ensures that the right things are done, at the right time, using the right resources. * Managers focus on **systems, structures and performance monitoring**.   **Example:** A Medical Officer scheduling staff duty and ensuring medicine stock availability. |
| **3. Relationship between Leadership and Management** | * Leadership and management complement each other leadership sets **direction**, management ensures **implementation**. * Strong health teams require both leadership (to inspire) and management (to operationalize). |
| **4. Why Both Are Needed in PHC** | * PHC faces complex challenges that require adaptability, innovation and accountability. * Leadership helps teams stay motivated; management ensures results. * Both contribute to better governance, service quality and community trust. |
| **5. Reflection Questions** | * How do you see your own role as a leader or manager? * Which qualities do you associate more with leadership and which with management? * How can combining both make your work more effective? |

### **Facilitation Methods**

1. **Interactive Presentation**
   * Present the definitions and roles of leadership and management using flipcharts or slides.
   * Emphasize examples from PHC settings in Khyber Pakhtunkhwa.
2. **Group Discussion** 
   * Divide participants into small groups (4–5 members).
   * Ask them to discuss:

“Think of a time when your team succeeded in solving a problem. What leadership and management skills were used?”

* + Each group shares one example.

1. **Short-Presentation with Comparison Table** 
   * Use a short visual table comparing **Managers vs. Leaders**:

|  |  |  |
| --- | --- | --- |
| ****Functions**** | ****Managers**** | ****Leaders**** |
| ****Focus**** | Processes & results | Vision & people |
| ****Approach**** | Plan, organize, control | Inspire, motivate, influence |
| ****Goal**** | Efficiency & order | Innovation & change |
| ****Question Asked**** | “How and when?” | “What and why?” |
| ****Timeframe**** | Short-term | Long-term |

1. **Reflection & Wrap-Up** 
   * Summarize key learning points.
   * Highlight that “In PHC, every manager must be a leader and every leader must manage effectively.”

### **Facilitator Notes**

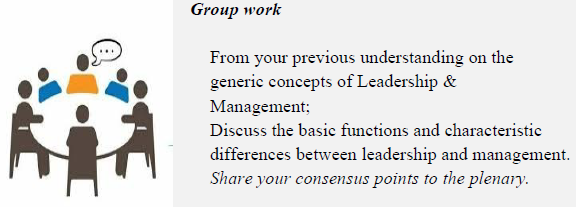
* Encourage participants to give **local examples** from their own facilities.
* Avoid jargon — relate concepts to **daily challenges** (medicine shortages, staff posting/transfer, patient flow).
* Reinforce that **leadership is not a position but a behavior** — anyone can lead through initiative.
* Conclude with a motivational statement linking leadership and management to **community health impact**.

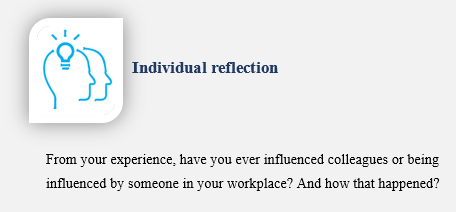
### **Key Message:**

“Leadership provides vision; management provides structure. When both works together, Primary Health Care becomes stronger, more efficient and more people-centered.”

**Group Activity/Individual Reflection:**

Participants discuss their understanding of leadership and management, identify key differences and share insights with the group.





**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 |
| **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:

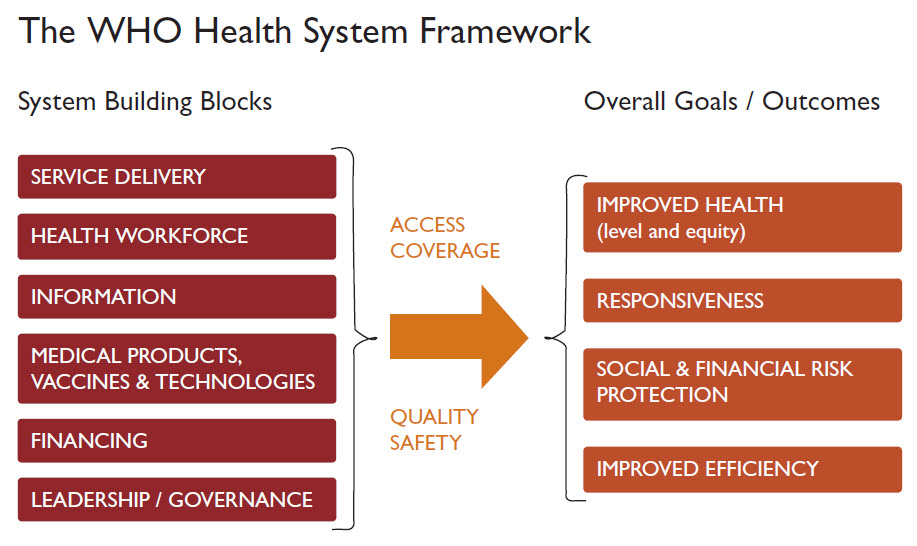
* ***Accountability*:** Decision-makers are answerable for their actions.
* ***Transparency:*** Processes and data are open and accessible.
* ***Equity:*** Services are fair and available to all.
* ***Rule of Law:*** Policies and standards are followed.
* ***Participation:*** Communities and stakeholders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

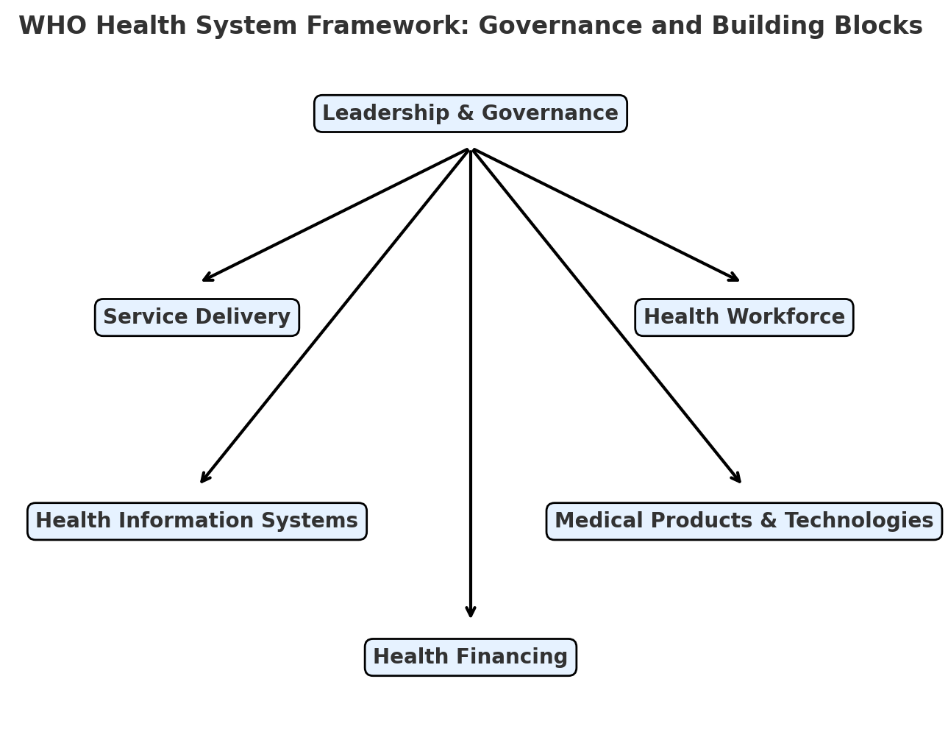
It builds **trust** between health providers and communities — an essential ingredient for Universal Health Coverage.

|  |  |  |
| --- | --- | --- |
| ****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.



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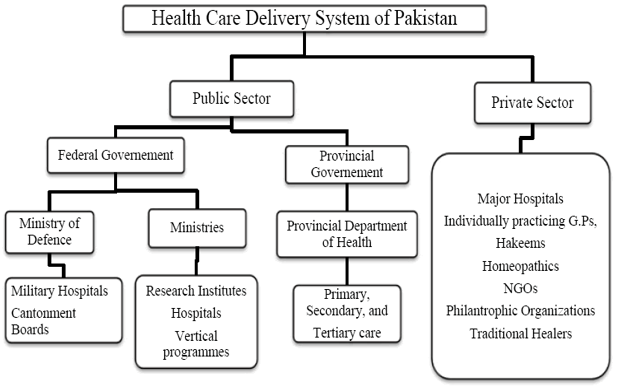
|  |  |  |
| --- | --- | --- |
| ****WHO Building Block**** | ****Description**** | ****Role of Leadership and Governance**** |
| ****Service Delivery**** | Quality and equitable services provided to all. | Leaders ensure effective planning, supervision and quality improvement. |
| ****Health Workforce**** | 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. |

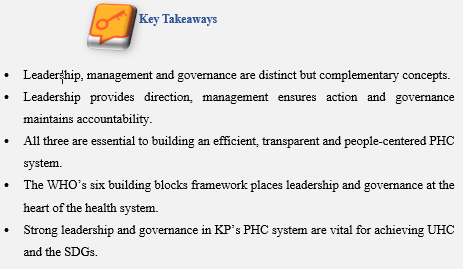
Without leadership and governance, all other components risk being weak or fragmented. Strong leadership ensures coordination and governance maintains trust and accountability in the system.

### **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)**

### **Session Overview:**

### **Session Duration:** 60 minutes

### **Session Type:**

Interactive presentation, self-assessment and group discussion

### **Session Objectives**

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

1. Describe different **leadership styles** and their key characteristics.
2. Identify how leadership styles influence **team performance and motivation** in PHC.
3. Recognize their own **dominant leadership style** through reflection or self-assessment.
4. Discuss the **core competencies** required for effective leadership in health settings.
5. Apply situational leadership principles to real-life PHC challenges.

### **Introduction**

Leadership is about influencing others to achieve shared goals. In PHC settings, leaders face daily challenges—ranging from limited human resources to community health issues—that demand flexibility in their leadership approach.

This session introduces participants to major **leadership styles**, helps them identify their **personal leadership tendencies** and explores the **competencies** needed to lead effectively in dynamic healthcare environments like Khyber Pakhtunkhwa (KP).

### **Session Contents Outline**

|  |  |
| --- | --- |
| **Topic** | **Key Points / Discussion Summary** |
| **1. Understanding Leadership Styles** | Leaders may use different approaches based on context and team dynamics. Common leadership styles include:  **a. Autocratic:**  **b. Democratic/Participative:**  **c. Transformational:**  **d. Transactional:**  **e. Laissez-faire:** |
| **2. Applying Leadership Styles in PHC** | Different situations call for different leadership styles.  **Example 1:** In an outbreak, an autocratic style ensures quick decisions.  **Example 2:** During community health planning, a democratic style encourages participation.  **Example 3:** For long-term improvements, transformational leadership sustains motivation. |
| **3. Leadership Competencies in PHC** | Key competencies for health leaders include:  • **Vision and strategic thinking** – seeing the bigger picture.  • **Communication and teamwork** – engaging others effectively.  • **Decision-making and problem-solving** – analyzing data and acting confidently.  • **Emotional intelligence** – managing self and others under stress.  • **Accountability and integrity** – ensuring transparency in service delivery. |
| **4. Self-Assessment of Leadership Style** | • Distribute a short **Leadership Style Questionnaire** (prepared in handouts).  • Participants identify their dominant style and discuss in small groups how it helps or limits them in PHC practice. |
| **5. Linking Leadership to PHC Outcomes** | Effective leadership at facility level leads to:  • Better staff morale and retention.  • Improved service delivery.  • Greater community trust and participation.  • More efficient use of limited resources. |

### **Facilitation Methods**

1. **Interactive Presentation** 
   * Present definitions and features of each leadership style using slides or flipcharts.
   * Give **local examples** (e.g., handling vaccination drives, flood response, or outreach campaigns).
2. **Group Activity: Leadership Scenarios** 
   * Divide participants into 3–4 groups.
   * Give each group a real-life **PHC scenario** (e.g., managing staff conflict, medicine stockout, or poor community participation).
   * Ask them to discuss:  
     Which leadership style would be most effective and why?
   * Each group presents briefly.
3. **Self-Assessment** 
   * Distribute the **Leadership Style Self-Assessment Tool**.
   * Ask participants to score themselves and reflect on which style fits their behavior.
   * Facilitate a short discussion on how they can **adapt styles** for better results.
4. **Short Presentation on Competencies** 
   * Discuss essential leadership competencies in PHC.
   * Highlight importance of **empathy, accountability and communication**.
5. **Reflection and Wrap-Up** 
   * Ask:
     + “Which leadership style do you use most often?”
     + “Which competency do you want to strengthen after this training?”
   * Summarize: Effective leaders **adapt their style** according to team needs and situation.

### **Facilitator Notes**

* Encourage participants to share **real experiences** rather than textbook answers.
* Use **examples from PHC in KP** (e.g., outreach under challenging terrain or coordination with community elders).
* Emphasize that **no single leadership style is perfect** — flexibility and self-awareness are key.
* Reinforce the message: “Leadership is about influencing, not commanding.”
* If time allows, play a short **role-play** demonstrating two contrasting leadership styles (autocratic vs. democratic) and ask participants to reflect on outcomes.

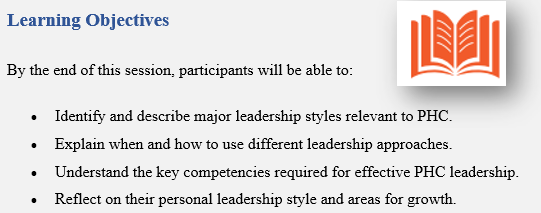
### **Key Message:**

“Effective leaders in PHC know when to direct, when to involve and when to inspire.  
Leadership is not about power — it’s about purpose, people and performance.”

### **Session Details:**

### **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?

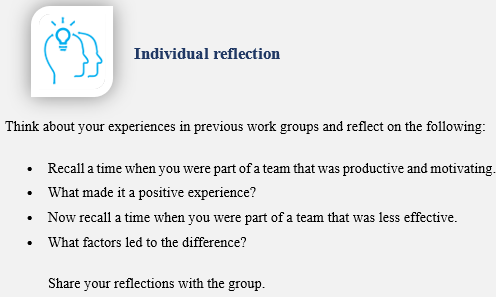
### **5. Applying Leadership Styles in Real-Life PHC Scenarios**

|  |  |  |  |
| --- | --- | --- | --- |
| ****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. |

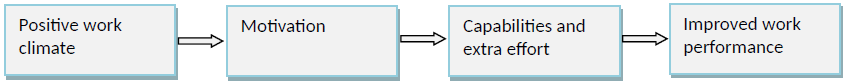
**Work Climate and Effective Communication**

**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**

### **Session Duration:**

60 minutes

### **Session Type:**

Interactive discussion, case examples and group activity

### **Session Objectives**

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

1. Define the concept of **governance** in the context of the health sector.
2. Describe the **principles of good governance** and their importance in Primary Health Care (PHC).
3. Explain how governance practices influence **service delivery, accountability and community trust**.
4. Identify examples of **good and poor governance** from their own work context.
5. Propose practical strategies to strengthen governance in PHC facilities.

### **Session Overview**

Governance determines how decisions are made, implemented and monitored in the health system. In PHC, good governance is essential for ensuring **transparency, accountability, equity and participation**.

For PHC workers in Khyber Pakhtunkhwa (KP), governance is not limited to policy-level decision-makers — it involves every staff member who manages resources, maintains records, reports data and interacts with the community. This session helps participants understand governance principles and explore how they can apply these in daily practice to improve service delivery and build community confidence.

### **Key Content Outline**

|  |  |
| --- | --- |
| ****Topic**** | ****Key Points / Discussion Summary**** |
| ****1. What is Governance in Health?**** | • Governance refers to how decisions are made, who makes them and how they are carried out.  • It includes policies, systems and processes that ensure health services are effective and fair. |
| ****2. Principles of Good Governance**** | The World Health Organization identifies key principles:  • **Transparency** –  • **Accountability** – • **Participation** –  • **Equity and Inclusiveness** – • **Rule of Law** –  • **Effectiveness and Efficiency** – |
| ****3. Governance in PHC: Why It Matters**** | • Ensures health services reach those most in need.  • Improves coordination between facility staff, district management and community representatives.  • Supports data-based decision-making and efficient use of funds. |
| ****4. Example (KP Context)**** | In a Rural Health Centre in Chitral, the facility in-charge established a public noticeboard displaying medicine stock status and DHIS2 indicators. This transparency-built trust, reduced complaints and improved accountability among staff. |
| ****5. Common Governance Challenges in PHC**** | • Lack of clear roles and responsibilities.  • Poor data quality or delayed reporting.  • Limited community engagement.  • Inefficient use of resources.  • Weak accountability mechanisms. |
| ****6. Strengthening Governance at Facility Level**** | • Regular staff meetings and open communication.  • Display of service charters and information for public awareness.  • Transparent management of medicine stocks and funds.  • Inclusion of community representatives in facility health committees.  • Regular supervision and performance reviews. |

### **Facilitation Methods**

1. **Interactive Presentation** 
   * Introduce the definition and importance of governance in PHC.
   * Use simple visuals or a flowchart showing how governance links to **service delivery and community trust**.
2. **Group Discussion: Governance in Action** 
   * Ask participants: “What does good governance look like in your facility?”
   * Note responses under categories such as transparency, accountability and participation.
   * Summarize how these principles contribute to quality care and efficiency.
3. **Case Study Analysis** 
   * Present a short case example (e.g., a facility with missing records, or one with strong community oversight).
   * Divide participants into small groups.
   * Task: Identify governance gaps and suggest actions to improve.
   * Groups share findings with the class.
4. **Short Presentation: Principles of Good Governance** 
   * Reinforce six WHO principles of good governance.
   * Relate each principle to **real PHC situations in KP** (e.g., reporting through DHIS2, use of LMIS for stock control).
5. **Reflection & Wrap-Up** 
   * Ask participants to identify **one governance practice** they can strengthen in their own facility.
   * Summarize key message: Good governance is everyone’s responsibility.

### **Facilitator Notes**

* Use **local examples** of both good and poor governance to make the session relatable.
* Encourage honest sharing — emphasize learning rather than blame.
* Link discussion to **accountability frameworks**, such as regular data reporting or facility management committees.
* Highlight that **governance strengthens leadership and M&E**, forming the backbone of health system performance.

### **Suggested Practical Activity: Governance Mapping Exercise**

**Objective:** Help participants visualize governance gaps and opportunities.  
**Instructions:**

1. In small groups, draw a simple table with three columns:
   * What works well in our facility?
   * What needs improvement?
   * What actions can we take?
2. Ask each group to focus on one principle (e.g., transparency or participation).
3. Display outputs for collective discussion.

### **Reflection Questions**

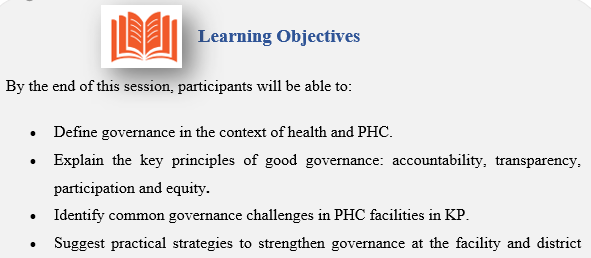
1. How does good governance contribute to improved PHC service delivery?
2. Which governance principle is most challenging to implement in your facility — and why?
3. What specific action can you take to make your facility more transparent and accountable.

### **Session Detail Contents:**

### **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**

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. |

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)**

**Duration:** 60 minutes  
**Session Type:** Interactive discussion, case examples and group activity

### **Introduction**

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

Health managers and workers in Khyber Pakhtunkhwa (KP) often face conflicts arising from workload distribution, communication gaps, differing opinions, or overlapping roles. Developing conflict competence helps individuals, teams and organizations manage differences positively and build stronger collaboration.

This session helps participants understand the principles of conflict competence, practical skills for collaboration and steps to manage conflict constructively in PHC settings.

### **Session Objectives**

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

1. Define the concept of conflict and its relevance in PHC.
2. Identify common sources of conflict in health facilities.
3. Explain principles of constructive conflict management.
4. Apply strategies to prevent and resolve conflict effectively.
5. Practice conflict resolution through a group activity and case study.

### **Session Overview**

Conflict can arise from miscommunication, workload pressure, resource constraints, role ambiguity, or differing opinions. When managed effectively, conflict: Poorly managed conflict, however, can disrupt teamwork, lower motivation and negatively affect patient care.

### **Key Content Outline**

|  |  |
| --- | --- |
| Topic | Key Points / Discussion Summary |
| 1. Understanding Conflict | • Conflict occurs naturally in teams. • Types include interpersonal, role-based, resource-based and organizational conflicts. |
| 2. Common Sources of Conflict in PHC | • Workload distribution • Role ambiguity or overlapping responsibilities • Communication gaps • Resource shortages (staff, medicines, equipment) |
| 3. Principles of Constructive Conflict Management | • Address issues early before escalation • Focus on interests, not personalities • Promote open communication and active listening • Encourage collaboration and joint problem-solving • Seek mutually acceptable solutions • Maintain professionalism and respect |
| 4. Strategies to Manage Conflict | • Clear role definition and task allocation • Regular team meetings and feedback sessions • Facilitate mediation or dialogue for unresolved issues • Encourage shared decision-making • Document agreements and follow up • Provide training on interpersonal skills and conflict resolution |
| 5. Example (KP Context) | In Swabi, two LHVs disagreed over outreach session schedules. The facility in-charge organized a discussion, clarified roles and developed a shared timetable. Cooperation improved and outreach coverage increased. |

### **Facilitation Methods**

1. **Interactive Presentation**
   * Introduce the definition of conflict and its relevance in PHC.
   * Use visuals to show sources of conflict and possible outcomes if managed constructively or poorly.
2. **Group Discussion: Sources of Conflict**
   * Ask participants: “What conflicts have you encountered in your facility?”
   * List examples on a flipchart and categorize (workload, communication, resources, etc.).
   * Discuss how conflicts affected teamwork, service delivery and patient care.
3. **Case Study Analysis (20 min)**
   * Present a scenario (e.g., staff disagreement over stock management or task allocation).
   * Divide participants into small groups.
   * Task: Identify the conflict type, underlying causes and propose strategies to resolve it.
   * Each group shares findings for discussion.
4. **Short Presentation: Conflict Management Principles**
   * Reinforce key principles: early resolution, collaboration, respect, focusing on interests and follow-up.
   * Relate principles to PHC situations in KP, including role clarification and supportive supervision.
5. **Practical Activity: Conflict Resolution Role-Play**
   * Participants pair up or form small groups.
   * Each group receives a mock conflict scenario (e.g., absenteeism, stock disputes, patient complaint handling).
   * Role-play a resolution discussion using active listening, negotiation and problem-solving.
   * Debrief: Discuss challenges, effective strategies and lessons learned.

### **Reflection & Wrap-Up**

* Ask participants to identify one conflict management practice they can apply in their facility.
* Summarize key message: Constructive conflict management strengthens teamwork, improves service delivery and enhances trust among staff and the community.

### **Facilitator Notes**

* Use local examples to make the session relatable.
* Encourage honest sharing while emphasizing learning, not blame.
* Highlight the link between conflict management, leadership and M&E—teams that resolve conflict effectively can implement evidence-based decisions more efficiently.

### **Suggested Practical Activity: Conflict Mapping Exercise**

**Objective:** Identify conflict areas and develop strategies to manage them.

**Instructions:**

1. In small groups, create a table with three columns:
   * Common conflicts in your facility
   * Impact on staff and service delivery
   * Strategies to prevent or resolve the conflict
2. Assign each group a specific type of conflict (e.g., resource-based or interpersonal).
3. Present outputs for collective discussion.

### **Reflection Questions**

1. What are the most common sources of conflict in your facility and how do they affect service delivery?
2. How can you apply constructive conflict management to improve teamwork?
3. Give an example of a conflict that could have been resolved better using the principles learned today.

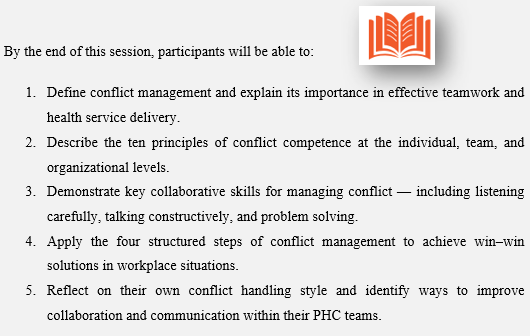
### **Session Detailed Content**

### **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.

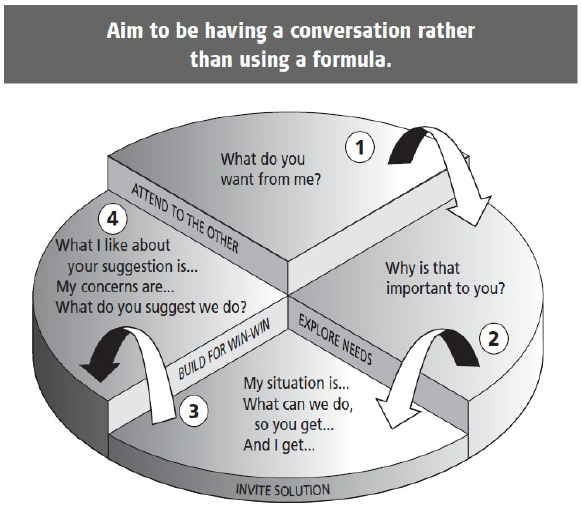
|  |  |
| --- | --- |
| ****Principle**** | ****Description**** |
| 1. **Self-Awareness** | Recognize your emotions, triggers and reactions during conflict. Awareness allows better control and thoughtful responses. |
| 2. **Empathy** | Understand others’ perspectives and emotions, especially colleagues 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**

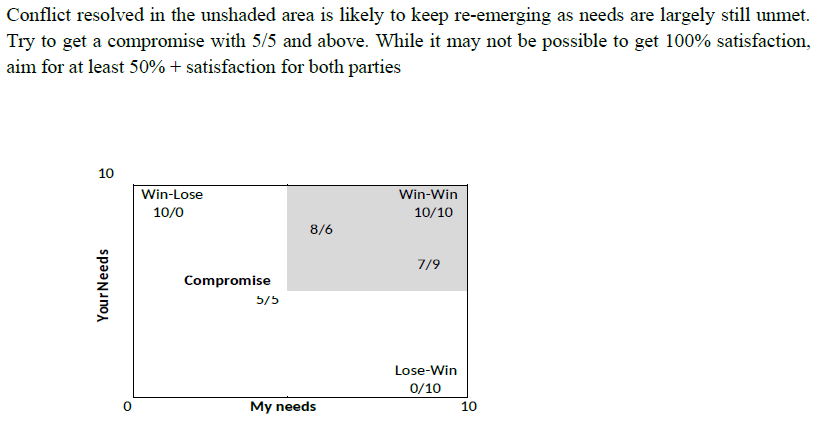
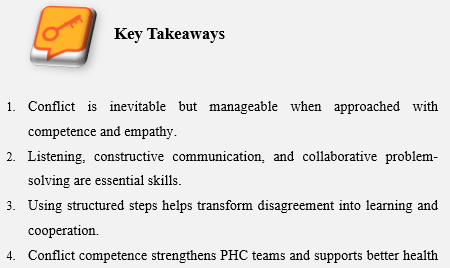
***Purpose:***  
To help participants apply the steps and principles of conflict management through role play.

***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**

**Duration:** 60 minutes  
**Session Type:** Interactive discussion, case examples and group activities

### **Session Objectives**

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

1. Describe the roles and responsibilities of health teams in PHC.
2. Explain key principles of effective team leadership.
3. Identify strategies to motivate, coach and build commitment among team members.
4. Recognize methods to manage change, resolve challenges and maintain quality and equity.
5. Apply practical techniques to lead high-performing teams in real PHC settings.

### **Session Overview**

Leading health teams goes beyond assigning tasks. It involves:

* Inspiring commitment and trust,
* Coaching staff to achieve their potential,
* Encouraging collaboration and accountability,
* Managing change and maintaining quality, equity and high performance.

In KP PHC settings, leaders—Medical Officers, LHVs, facility managers and supervisors—must navigate challenges such as resource constraints, high patient loads and diverse community needs. This session equips participants to guide teams effectively, creating motivated, resilient and high-performing health teams.

### **Key Content Outline**

|  |  |
| --- | --- |
| Topic | Key Points / Discussion Summary |
| **1. Understanding Health Teams in PHC** | - Health teams are multidisciplinary: MOs, LHVs, CHWs, technicians. - Team success depends on collaboration, clear roles and mutual accountability. - High-performing teams improve service delivery, efficiency and patient satisfaction. |
| **2. Principles of Effective Team Leadership** | - Clear vision and shared goals. - Trust, transparency and fairness. - Role clarity and delegation. - Recognition and motivation of staff. - Coaching and mentoring for skill development. |
| **3. Building Commitment and Motivation** | - Encourage participation in decision-making. - Celebrate achievements and recognize contributions. - Provide feedback that is constructive, specific and actionable. - Support professional growth through training opportunities. |
| **4. Leading Through Challenges and Change** | - Anticipate and manage conflicts proactively. - Adapt workflows and processes to changing needs. - Communicate changes clearly and involve staff in implementation. - Foster resilience during breakdowns or high-pressure situations. |
| **5. Ensuring Quality, Equity and Accountability** | - Monitor key indicators and KPIs regularly. - Promote equitable service delivery across all population groups. - Hold regular team meetings for reflection and problem-solving. - Support continuous learning and improvement. |
| **6. Example (KP Context)** | - In a BHU in Abbottabad, a team struggled with stock management. The facility in-charge implemented weekly team huddles, delegated roles, coached staff on LMIS use and recognized performance. Result: timely reporting, fewer stockouts and improved morale. |

### **Facilitation Methods**

1. **Interactive Presentation**
   * Introduce team leadership principles and their importance in PHC.
   * Use visuals showing team roles, workflow and collaboration.
2. **Group Discussion: Team Dynamics**
   * Question: “What makes your team perform well and what are the challenges?”
   * Categorize responses (motivation, communication, trust, role clarity).
   * Discuss implications for leadership.
3. **Case Study Analysis** 
   * Scenario: “Staff absenteeism and low motivation affecting outreach services.”
   * Small groups identify problems, leadership gaps and propose solutions.
   * Groups present findings; facilitator links to leadership strategies.
4. **Short Presentation: Coaching and Inspiring Teams**
   * Cover coaching, feedback, trust-building and recognition techniques.
   * Relate to real PHC examples in KP (e.g., supervising LHVs, mentoring CHWs).
5. **Practical Activity: Team-Building Simulation** 
   * Groups work on a mock scenario (e.g., improving ANC coverage with limited staff).
   * Tasks: assign roles, plan actions, motivate team, address potential conflicts.
   * Present and discuss how leadership influenced team performance.
6. **Reflection & Wrap-Up**
   * Participants identify one leadership behavior they will implement to strengthen their teams.
   * Summarize key message: **“Effective leadership inspires, supports and empowers teams to achieve better health outcomes.”**

### **Facilitator Notes**

* Emphasize that leadership is practical and situational, not just theoretical.
* Use local examples to make content relatable.
* Encourage participants to share personal experiences and challenges.
* Reinforce link between team leadership, M&E and quality service delivery.

### **Suggested Practical Activity: Team Leadership Exercise**

**Objective:** Apply leadership principles to strengthen team performance.  
**Instructions:**

1. Divide participants into small groups (4–5).
2. Provide a scenario (e.g., missed targets in immunization outreach).
3. Groups plan a strategy:
   * Assign roles and responsibilities.
   * Identify motivational or coaching strategies.
   * Suggest solutions to potential conflicts or challenges.
4. Present findings to the class; facilitator provides feedback.

**Reflection Questions:**

1. How can you motivate your team to achieve shared goals?
2. Which leadership skill will most improve your team’s performance?
3. Share an example of a situation where coaching could improve outcomes.

### **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.

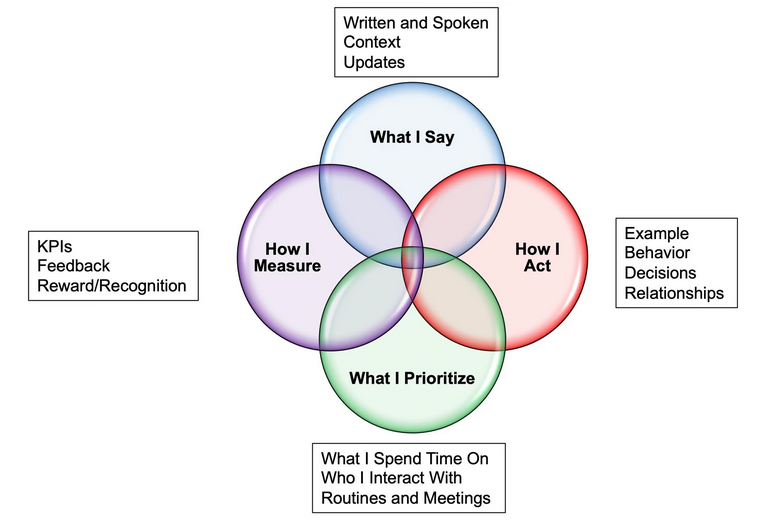
***Key Learning:***

“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)**

**Duration:** 60 minutes  
**Session Type:** Interactive discussion, case examples, group activity

### **Session Objectives**

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

1. Describe the roles and responsibilities of health teams in PHC.
2. Explain key principles of effective team leadership.
3. Identify strategies to motivate, coach and build commitment among team members.
4. Recognize methods to manage change, resolve challenges and maintain quality and equity.
5. Apply practical techniques to lead high-performing teams in real PHC settings.

### **Session Overview**

Effective leadership in PHC is about inspiring, guiding and supporting teams to achieve shared goals. Leaders must foster collaboration, provide coaching, maintain trust and promote accountability. This session equips participants with practical strategies to motivate teams, manage challenges, resolve conflicts and sustain high performance.

### **Session Outline**

|  |  |
| --- | --- |
| Topic | Key Points / Discussion Summary |
| **1. Understanding Health Teams in PHC** | - Multidisciplinary teams include MOs, LHVs, CHWs and technicians. - Team effectiveness depends on collaboration, role clarity and accountability. - Strong teams improve service delivery and staff morale. |
| **2. Principles of Effective Team Leadership** | - Clear vision and shared goals. - Trust, transparency and fairness. - Role clarity and delegation. - Coaching and mentoring. - Recognition and motivation. |
| **3. Building Commitment and Motivation** | - Encourage participation in decisions. - Celebrate achievements. - Provide constructive feedback. - Support professional growth and learning. |
| **4. Leading Through Challenges and Change** | - Anticipate and resolve conflicts. - Adapt workflows and processes. - Communicate changes clearly. - Foster resilience under pressure. |
| **5. Ensuring Quality, Equity and Accountability** | - Monitor KPIs and service delivery indicators. - Promote equitable access for all populations. - Conduct regular team meetings for problem-solving. - Support continuous learning and improvement. |
| **6. Example (KP Context)** | - BHU in Abbottabad improved stock management and outreach performance by weekly team huddles, role delegation, coaching and recognition. Result: timely reporting, fewer stockouts and higher team morale. |

### **Facilitation Methods**

1. **Interactive Presentation** 
   * Introduce team leadership principles and their relevance in PHC.
   * Use visuals showing team structure and workflows.
2. **Group Discussion: Team Dynamics** 
   * Question: “What makes your team perform well and what challenges do you face?”
   * Categorize responses: communication, motivation, role clarity, trust.
3. **Case Study Analysis** 
   * Scenario: Low motivation and absenteeism affecting outreach services.
   * Small groups identify leadership gaps and propose solutions.
   * Groups present findings; facilitator links to leadership strategies.
4. **Short Presentation: Coaching and Inspiring Teams** 
   * Cover coaching techniques, feedback, trust-building and recognition.
   * Relate examples from KP PHC facilities.
5. **Practical Activity: Team-Building Simulation** 
   * Mock scenario (e.g., improving ANC coverage with limited staff).
   * Groups assign roles, plan actions, motivate team and address conflicts.
   * Present plans; facilitator provides feedback.
6. **Reflection & Wrap-Up** 
   * Participants identify one leadership behavior they will implement.
   * Key message: **“Effective leadership inspires, supports and empowers teams to achieve better health outcomes.”**

### **Suggested Practical Activity: Team Leadership Exercise**

**Objective:** Apply leadership principles to strengthen team performance.  
**Instructions:**

1. Divide participants into small groups (4–5).
2. Provide a scenario: missed targets in immunization outreach.
3. Groups plan a strategy:
   * Assign roles and responsibilities.
   * Identify motivational or coaching strategies.
   * Suggest solutions to conflicts or challenges.
4. Present findings to the class; facilitator provides feedback.

### **Reflection Questions**

1. How can you motivate your team to achieve shared goals?
2. Which leadership skill will most improve your team’s performance?
3. Share an example where coaching could improve outcomes in your facility.

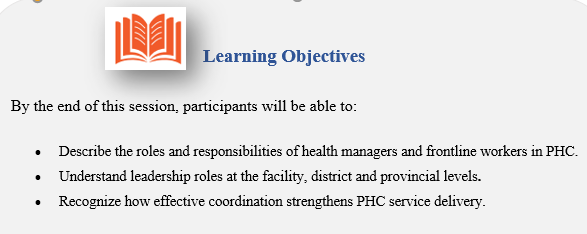
### **Facilitator Notes**

* Use local examples to make content relatable.
* Encourage sharing of experiences and challenges.
* Emphasize the link between team leadership, M&E and service quality.
* Reinforce that leadership is practical, interactive and ongoing.

### **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:

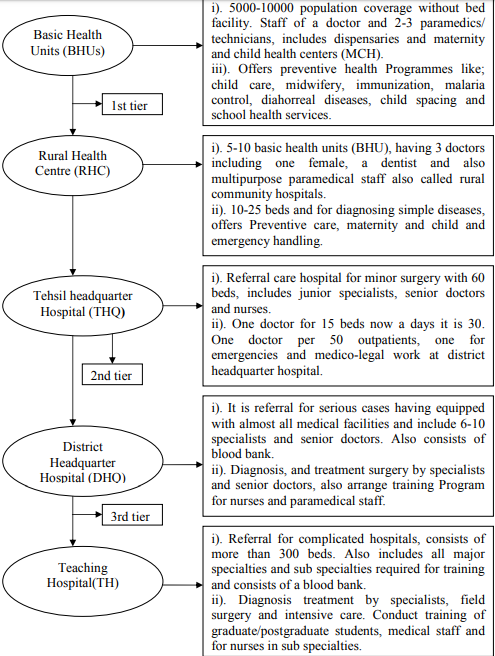
* Improve service delivery at the community level.
* Enhance leadership, governance and monitoring systems.
* Promote equitable access to care and progress toward **UHC.**

### **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.

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### **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.

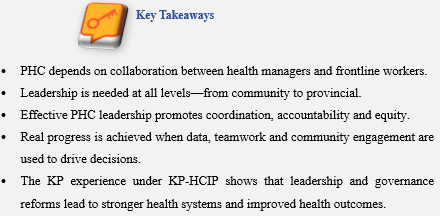
* LHWs provide door-to-door preventive care, collect vital health data and mobilize communities for immunization.

***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.

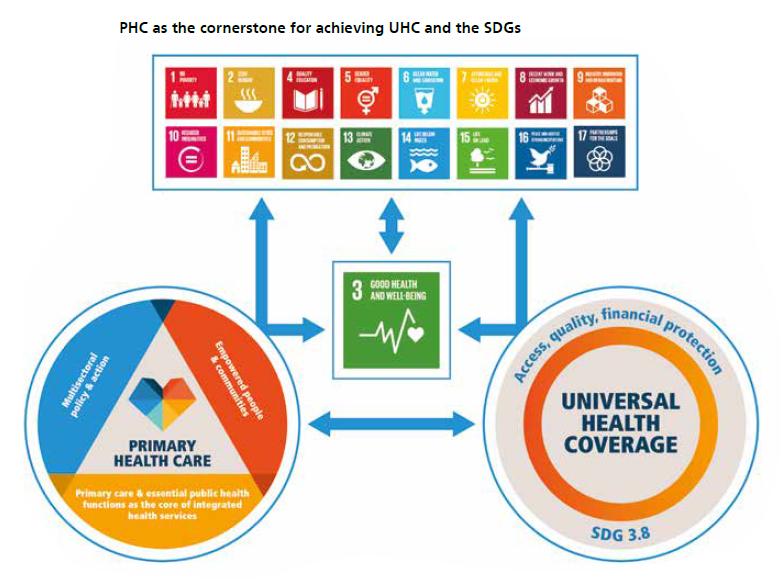
* Facilities with poor immunization coverage received targeted supervision and resources.

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

**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 the backbone of effective health system management. In Primary Health Care (PHC), they ensure that services are not only implemented but also improved continuously based on evidence.

Begin the session by reminding participants that **“What gets measured, gets managed.”** M&E is not about fault-finding—it’s about learning and improving performance.

**Facilitator Tip:**

Engage participants by asking: “How do you currently track whether your health activities are going as planned?” Record examples such as immunization records, stock registers, or supervisory checklists on a flipchart.

**Key Message**

M&E supports accountability, learning and better decision-making at all levels of the health system—from the facility to the province.

## **SESSION 2.1**

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

### **Session Overview**

This session introduces participants to the fundamental concepts of Monitoring and Evaluation (M&E) in the context of Primary Health Care (PHC). Participants will explore the differences between monitoring and evaluation, understand their importance in PHC programs and discuss how M&E contributes to better decision-making and improved service delivery.

## **Facilitator Preparation**

* Review examples from **District Health Information System (DHIS2)** reports or local PHC performance data for illustration.
* Prepare flip charts with two columns labeled **“Monitoring”** and **“Evaluation”** for a comparative activity.
* Have markers, sticky notes and printed handouts with definitions and examples ready.
* Be familiar with KP’s **Health Reforms and Human Capital Investment Project (HCIP)** priorities.

## **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)**, 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 differ and why both are necessary for improving health programs and outcomes.

### **Facilitator Tip**

Begin the session by asking:

“When you hear the term monitoring and evaluation, what comes to your mind?”

Note participants’ responses on a flip chart. Use this to link to the formal definitions later.

## **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 needing improvement in health programs.  
M&E ensures that health services achieve their intended results—such as reducing maternal mortality, increasing immunization coverage, or improving patient satisfaction.

Together, M&E provide evidence for **better planning**, **resource allocation** and **accountability**.

|  |  |  |  |
| --- | --- | --- | --- |
| Term | Definition | Focus | Frequency |
| ****Monitoring**** | Continuous collection and analysis of information to track progress of activities against set plans. | Activities and outputs | Ongoing (monthly/quarterly) |
| ****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) |

### **Facilitator Tip**

Display this table on a slide or flip chart and ask participants to give **examples** of monitoring and evaluation from their own facilities. Encourage them to think of routine reports (monitoring) versus special reviews or assessments (evaluation).

## **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 skilled deliveries
* 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.

**Example:**

In a BHU in District Swabi, monitoring data revealed that vaccination coverage for children under one year dropped by 15% over two months. The manager found that the vaccinator had been transferred and not replaced promptly. Through effective monitoring, the issue was identified early and resolved.

### **Facilitator Tip**

Ask:

“What are some indicators you regularly monitor at your facility?”

“What tools or registers do you use to collect this information?”

Discuss how timely monitoring can prevent service delivery breakdowns.

## **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 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:

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

***Example:***

An evaluation of the Community Midwives Program in KP found that while many midwives were trained, retention in rural areas was low due to lack of incentives and supervision. These findings helped revise the program to better support and motivate midwives.

### **Facilitator Tip**

Divide participants into small groups.

Give each group a **PHC intervention** (e.g., immunization, TB control, nutrition).

Ask them to identify **what could be monitored** and **what could be evaluated**.

Have them present briefly to the group.

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

Monitoring and Evaluation are distinct but complementary. Monitoring provides real-time information for daily management, while evaluation gives deeper insights for long-term planning.

|  |  |  |
| --- | --- | --- |
| 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) |

### **Facilitator Tip**

Use the analogy of a **journey**:

Monitoring is like checking your GPS regularly to ensure you’re on track. Evaluation is looking back at the journey to assess whether it was worth it and what you could do better next time.

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

M&E ensures PHC programs are **effective**, **equitable** and **responsive**.

Key benefits include:

* **Improved Performance:** Regular monitoring tracks progress and identifies gaps.
* **Evidence-Based Decision-Making:** Data guides planning and budgeting.
* **Accountability:** Ensures transparency in use of resources.
* **Learning and Improvement:** Evaluations generate lessons for the future.
* **Alignment with Global Goals:** Supports progress toward **SDG 3 (Good Health and Well-being)** and **UHC**.

### **Facilitator Tip**

Share an example of how good data led to a successful program improvement (real or simulated).  
Encourage participants to share how data from DHIS2 or LMIS influenced a decision in their facility.

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

In KP, M&E systems such as **DHIS2** and **LMIS** collect and report data from PHC facilities. However, challenges include:

* Incomplete or inaccurate reporting
* Delays in submission
* Limited data use for planning

Strengthening M&E capacity among PHC staff can improve:

* Data quality and timeliness
* Planning and supervision
* Coordination across health levels
* Responsiveness to community needs

### **Facilitator Tip**

Show participants a sample **DHIS2 report** (anonymized).

Ask: “What decisions could you make based on this data?”

Discuss how data can move from reports to real action.

## **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?

### **Facilitator Tip**

Encourage open discussion on these reflection questions.

Summarize by highlighting that effective M&E is not only about data collection—it’s about **using data to make better decisions** and **improve health outcomes**.

## **SESSION 2.2**

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

### **Session Overview**

This session introduces participants to the structure and functions of the Monitoring and Evaluation (M&E) framework in Pakistan’s health sector, with a focus on Khyber Pakhtunkhwa (KP). Participants will learn how the framework connects community, facility, district, provincial and national levels; the role of digital health information systems; key indicators; reporting mechanisms; and opportunities to improve data use for decision-making.

## **Introduction**

A strong M&E framework is essential for **effective service delivery, accountability and performance monitoring**. It provides a structured approach for collecting, analyzing and using information to guide decisions and strengthen Primary Health Care (PHC).

**Facilitator Tip:**

Ask participants: “Why do you think PHC programs sometimes fail even when services are available?”

Guide discussion toward the importance of **accurate data collection, timely reporting and informed decision-making**.

## **1. What is an M&E Framework?**

An M&E framework defines the structure for systematically measuring health program performance. It clarifies:

* **What to measure** (indicators)
* **How and when** to measure it (data sources and frequency)
* **Who measures** it (roles and responsibilities)
* **How the data is used** (decision-making and reporting)

**Facilitator Tip:**

Use a simple PHC example such as a vaccination program to illustrate inputs, activities, outputs, outcomes and impact.

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

Pakistan’s health sector uses several digital systems to support M&E:

|  |  |  |
| --- | --- | --- |
| System | Full Form | Purpose / Function |
| DHIS2 | District Health Information System (Version 2) | Routine health service data collection, analysis and reporting. |
| HMIS | Health Management Information System | Tracks patient records, service delivery and facility performance. |
| LMIS | Logistics Management Information System | Tracks medicines, vaccines and supplies to prevent stockouts. |
| EPI-MIS | Expanded Program on Immunization – MIS | Monitors immunization coverage and cold chain functionality. |

***Facilitator Tip:***

Show screenshots of DHIS2 dashboards and LMIS tools. Discuss how each system contributes to the M&E framework.

## **3. M&E Framework in KP Health Sector**

The KP Department of Health, through the DGHS M&E Cell, manages data across the province:

***Key Functions at Each Level:***

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

***Facilitator Tip:***

Draw a diagram showing **data flow from facility → district → province → national**.  
Highlight participants’ roles in ensuring data reaches decision-makers accurately and on time.

## **4. Key Indicators in KP PHC**

The M&E framework monitors Key Performance Indicators (KPIs) across several domains:

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

***Facilitator Tip:***

Encourage participants to identify which KPIs are **most relevant to their facility** and discuss why timely data is critical.

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

**Key Steps in Data Reporting:**

1. Facility staff record data in registers or DHIS2.
2. Monthly reports are compiled and sent to district offices.
3. District M&E officers review, validate and provide feedback.
4. Provincial units analyze data and produce dashboards for decision-making.
5. Feedback loops ensure facilities improve data quality and service delivery.

***Facilitator Tip:***

Ask participants: “Can you share an example when using M&E data helped improve a service at your facility?”

Discuss real-life applications of data-driven decision-making.

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

***Challenges:***

* Incomplete or delayed reporting
* Limited staff capacity in data analysis and interpretation
* Inconsistent feedback and supervision
* Parallel reporting systems causing duplication

***Opportunities:***

* Digital transformation through KP-HCIP
* Mobile and tablet-based data collection
* Integration of DHIS2, LMIS and HRMIS
* Capacity-building programs for data use and performance monitoring

***Facilitator Tip:***

Ask participants to reflect on one challenge they face and one opportunity to improve M&E at their facility.

## **Reflection Questions**

1. How does M&E data from your facility contribute to provincial health planning?
2. What challenges do you face in data reporting or validation?
3. How can DHIS2 data be used to improve performance at your health facility?

## **Key Takeaways**

1. A strong M&E framework **connects all levels** of the health system for decision-making and accountability.
2. Digital systems like **DHIS2, LMIS, HRMIS and EPI-MIS** are essential tools for real-time data collection and analysis.
3. Clear indicators, reporting mechanisms and feedback loops are critical for **timely, accurate and actionable data**.
4. PHC staff play a central role in **ensuring data quality and using information** to improve service delivery.
5. Addressing challenges and leveraging opportunities in M&E strengthens **health outcomes and progress toward UHC and SDGs**.

## **SESSION 2.3**

## **DEVELOPING AND USING INDICATORS**

### **Session Overview**

This session introduces participants to the concept of indicators in Primary Health Care (PHC), their types, how to develop SMART indicators and how to use Key Performance Indicators (KPIs) effectively for monitoring, evaluation and decision-making. Participants will understand how to link indicators to data sources and use them to improve service delivery and health outcomes.

### **Facilitator Preparation**

* Prepare flip charts or slides with **types of indicators and SMART criteria**.
* Collect **sample KPIs from local PHC facilities** for discussion.
* Bring **registers, DHIS2 screenshots, LMIS and HRMIS reports** to illustrate real data sources.
* Prepare an exercise where participants **identify and improve an indicator from their own facility**.

## **Introduction**

Indicators are **specific measures that track progress toward health program objectives**. They allow health managers and frontline workers to:

* Monitor service delivery
* Evaluate outcomes
* Make evidence-based decisions

***Facilitator Tip:***

Ask participants: “Why do you think measuring health services is important? Can numbers really improve patient care?”

Guide discussion toward understanding the practical role of indicators in everyday decision-making.

## **1. Types of Indicators**

Indicators can be classified based on what they measure:

|  |  |  |
| --- | --- | --- |
| Type | Definition | PHC Examples |
| Input | Resources used for program implementation | Number of trained LHVs, availability of vaccines, budget allocation |
| Output | Direct services or products delivered | Number of antenatal care visits, immunization sessions conducted, health education sessions |
| Outcome | Short- or medium-term effects on target population | % of pregnant women receiving 4 ANC visits, % of children fully immunized by age 1 |
| Impact | Long-term changes in health status | Reduction in maternal mortality ratio, under-five mortality, prevalence of stunting |

***Facilitator Tip:***

Use a **real PHC program example**, e.g., immunization campaign, to show **input → output → outcome → impact** progression.

## **2. SMART Indicators**

Indicators should meet the **SMART criteria** to be practical and actionable:

|  |  |  |
| --- | --- | --- |
| Element | Meaning | Example (PHC) |
| S – Specific | Clearly defines what is measured | % of pregnant women receiving at least 4 ANC visits |
| M – Measurable | Can be quantified reliably | Number of immunization sessions per month |
| A – Achievable | Realistic within available resources | Increase facility-based deliveries by 10% in 12 months |
| R – Relevant | Directly linked to program objectives | Monitoring vaccination coverage to reduce measles outbreaks |
| T – Time-bound | Clear timeframe for achievement | Reduce stockouts of essential medicines to <5% in six months |

***Facilitator Tip:***

Conduct a group exercise: Give participants **sample indicators** and ask them to **rewrite them using SMART criteria**.

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

KPIs are a set of **critical indicators** that measure performance and progress toward health system goals.

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

***Facilitator Tip:***

Ask participants to **identify 2–3 KPIs most relevant to their own facilities** and discuss why they are important.

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

For M&E to be effective, indicators must be linked to **reliable data sources** and assigned responsibilities:

|  |  |  |
| --- | --- | --- |
| 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 |

***Facilitator Tip:***

Use a **small group exercise**: Participants map 3–5 indicators from their facility to the data source and responsible staff.

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

Indicators are **actionable tools**, not just reporting requirements. They help PHC staff:

* Identify gaps in service delivery
* Determine staff training needs
* Allocate resources effectively
* Track progress toward UHC and SDG 3
* Ensure accountability and transparency

***Facilitator Tip:***

Encourage participants to share examples of **how using indicators has led to improvements** in their own work.

## **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 are most important for improving PHC services in your area?

## **Key Takeaways**

* Indicators are **essential for monitoring, evaluation and decision-making** in PHC.
* **Input and output indicators** track implementation; **outcome and impact indicators** evaluate effectiveness.
* SMART indicators make measurement **practical, achievable and time-bound**.
* KPIs focus on **critical aspects of service delivery, outcomes and system functionality**.
* Linking indicators to **data sources and responsibilities** ensures accurate reporting and actionable insights.
* Active use of indicators strengthens **service quality, accountability and progress toward health goals**.

## **SESSION 2.4**

## **MONITORING AND EVALUATION PLAN**

### **Session Overview**

This session helps participants understand the fundamentals of **Monitoring and Evaluation (M&E)**, including:

* The difference between monitoring and evaluation
* Developing and using indicators
* Key components of an M&E plan
* Applying numerator and denominator concepts
* Establishing baselines and targets

By the end of the session, participants will be able to develop a **simple M&E plan** for a health program or facility-level action plan.

### **Facilitator Preparation**

* Prepare flip charts/slides with **monitoring vs evaluation examples**, **indicator types** and **M&E plan template**.
* Gather sample facility-level data (ANC visits, immunization coverage, FP clients).
* Print **worksheets for indicator development and baseline calculation exercises**.
* Prepare **small group activities** with examples from maternal health, immunization, nutrition and family planning.

## **Introduction**

Monitoring and Evaluation are essential tools that allow health managers and teams to:

* Track program progress
* Identify challenges
* Make evidence-based decisions
* Improve service delivery and accountability

***Facilitator Tip:***

Ask participants to share examples of times when monitoring or evaluation helped improve a service at their facility. Highlight real-life impact.

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

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

***Facilitator Tip:***

Use a simple analogy: Monitoring is like **checking your speed while driving**, evaluation is **reviewing the whole trip to see if you reached your destination efficiently**.

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

An **indicator** is a measurable variable showing progress toward results. It answers:

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

***Example:***

% of women attending at least four antenatal visits

***Facilitator Tip:***

Show a real example from DHIS2 or facility registers to make it relatable.

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

A good indicator should be:

* **Valid** – Measures what it is supposed to measure
* **Reliable** – Produces consistent results
* **Precise** – Clearly defined and measurable
* **Relevant** – Linked to program objectives
* **Comparable** – Can be compared over time or locations
* **Timely** – Measured at appropriate intervals
* **Feasible** – Data can be collected easily and affordably

***Facilitator Tip:***

Ask participants to evaluate a few indicators and discuss which characteristics are missing.

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

|  |  |  |
| --- | --- | --- |
| Component | Description | Example |
| Indicator | The variable being measured | % of fully immunized children |
| Definition | How it is measured | Number of children aged 12–23 months who received all recommended vaccines ÷ total children aged 12–23 months |
| Baseline & Goal | Starting point and target | Baseline: 60%; Goal: 80% in one year |
| Data Source | Where data will come from | Facility registers, DHIS, household surveys |
| Collection Method | How data is 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.

* **Numerator:** Subgroup showing the result (e.g., women receiving HIV testing)
* **Denominator:** Total relevant population (e.g., total ANC attendees)

***Example:***

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

Calculation: 280 ÷ 300 = 0.93 → 93% coverage

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

|  |  |
| --- | --- |
| Level | Example Data Sources |
| Policy/Government | Official reports, policy documents, national budgets |
| 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**, helping to set realistic targets and track progress.

***Example:***

Baseline: 150 new family planning clients/month

Goal: 225 new clients/month → Target = 50% increase

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

*Group Exercise*

***Instructions:***

1. Divide into small groups.
2. Select one health service area (maternal health, immunization, nutrition, etc.).
3. Develop one indicator, specifying:
   * Definition
   * Numerator & denominator
   * Baseline, data source, frequency
4. Present indicators to the class.

***Debrief Questions:***

* Was the indicator valid and reliable?
* Was data readily available?
* How can this indicator help track progress?

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

**Type:** Individual or Pair Exercise

***Scenario:***

280 women received Cervical Cancer Screening counseling out of 600 ANC attendees over six months.

***Tasks:***

1. Calculate the indicator value.
2. Interpret the result.
3. Suggest an action to improve performance.

## **Key Takeaways**

* M&E is essential for **continuous learning, accountability and evidence-based decision-making**.
* Indicators are the **“road signs”** showing progress toward results.
* A good indicator is **valid, reliable, precise, relevant and feasible**.
* Baselines and targets help assess **change and program success**.
* Understanding numerators, denominators and data sources is critical for **accurate measurement and reporting**.

## **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.

### **Session Overview**

This session introduces participants to:

* Key **data collection tools and sources** in PHC
* Principles of **data quality assurance**
* Practical steps for **verification and validation of data**
* Common **challenges in data collection** and solutions
* KP-specific quality assurance mechanisms in PHC

By the end of the session, participants will be able to ensure **accurate, timely and reliable data** for decision-making.

### **Facilitator Preparation**

* Prepare flipcharts/slides with **data collection tools, sources and data quality attributes**.
* Bring **sample registers, DHIS2 screenshots, LMIS forms and facility reports** for exercises.
* Prepare worksheets for **verification and validation exercises**.
* Prepare **group activity scenarios** to simulate common data quality challenges.

### **Introduction**

Data is the backbone of effective Monitoring and Evaluation (M&E). In PHC, **accurate, complete and timely data** allows managers and frontline staff to:

* Track service delivery
* Make evidence-based decisions
* Improve health outcomes

***Facilitator Tip:***

Begin by asking participants what data they collect in their facility and how they use it for decision-making.

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

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

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

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

High-quality data must meet the following criteria:

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

**Facilitator Tip:** Use real examples of poor vs good quality data to highlight impact.

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

Verification and validation ensure that reported data is **accurate, complete and credible**.

**Steps for Verification:**

1. Compare **registers with reports**
2. Cross-check **key indicators** (ANC visits, immunization, stock levels)
3. Conduct **spot checks** of random records
4. Supervisory visits by **district M&E officers**
5. Provide **feedback and corrective action**

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

In District Peshawar, DHIS2 showed higher immunization coverage than registers. Verification revealed data entry errors, which were corrected after training.

**Facilitator Tip:** Conduct a **mock verification exercise** using sample registers.

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

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

**Facilitator Tip:** Ask participants to share challenges they face in data collection and reporting.

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

Mechanisms to ensure quality in KP PHC:

* **Monthly facility-level reviews:** In-charges review registers/reports before submission
* **District verification:** M&E officers conduct audits, cross-check reports, provide feedback
* **Provincial dashboards:** DGHS monitors completeness, timeliness and accuracy via DHIS2
* **Training and capacity building:** Periodic refresher courses for health workers

**Key Point:** QA ensures data is **trustworthy, actionable and useful**.

## **Activity 1: Data Verification Exercise**

***Instructions:***

1. Divide participants into small groups.
2. Provide **sample facility data (registers vs monthly report)**.
3. Identify discrepancies and calculate key indicators.
4. Present findings and suggest **corrective actions**.

***Debrief Questions:***

* What discrepancies were found?
* How can verification improve service delivery?
* What steps can prevent errors in future data collection?

## **Reflection Questions**

1. What tools do 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** improved a service or corrected a mistake.

## **Key Takeaways**

* Accurate and reliable data is the foundation of **effective M&E**.
* Standardized tools and proper reporting ensure **consistency and comparability**.
* Verification and validation exercises improve **data credibility and trust**.
* Regular training and supportive supervision strengthen **data quality**.
* High-quality data enables **evidence-based decision-making** and improved health outcomes.

## **SESSION 2.6**

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

### **Session Overview**

This session focuses on how to **interpret, visualize and use M&E data** to make evidence-based decisions in Primary Health Care (PHC).

Participants will learn to:

* Understand what data trends mean for service delivery
* Use visualization tools for quick interpretation
* Link evidence to planning, improvement and resource allocation

**Facilitator Tip:** Emphasize that **data collection is only useful if it informs action**. Share local KP examples wherever possible.

### **Introduction**

M&E data is valuable only when used to **inform decisions**. In PHC, using data helps:

* Identify gaps in service coverage
* Monitor program performance
* Plan interventions and allocate resources effectively

**Facilitator Tip:** Ask participants: “Can you recall a time when data helped improve a service in your facility?” This sets the stage for practical discussion.

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

Data interpretation involves understanding **what the numbers actually mean** and how they relate to program goals. Key questions 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:***

DHIS2 shows only 60% of children in a union council have full immunization. Managers can investigate causes like vaccine stockouts, inaccessible areas, or low awareness and plan corrective actions.

**Facilitator Tip:** Use local DHIS2 data snapshots to illustrate trends and gaps.

## **2. Data Visualization**

Visualization helps communicate findings clearly and supports **rapid decision-making**.

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

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

Using data effectively allows PHC teams to:

* Reallocate staff or resources to underperforming facilities
* Conduct targeted training for health workers
* Adjust outreach schedules for low-coverage areas
* Plan procurement based on real-time LMIS stock data

***Case Example:***

Rwanda uses routine M&E data to adjust immunization campaigns. Dashboards identify low-performing districts, triggering targeted outreach. Result: Higher immunization coverage and reduced child mortality.

**Facilitator Tip:** Encourage participants to think of KP-relevant examples from their facilities.

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

**Objective:** Practice interpreting M&E data and planning interventions.

***Instructions:***

1. Form groups of 4–5 participants.
2. Each group receives a **mock DHIS2 dataset** with ANC visits, immunization coverage and stock levels for 5 BHUs.
3. Identify **key gaps or trends**.
4. Develop a short **action plan** addressing the gaps, including:
   * Which service/indicator needs improvement?
   * What interventions will be implemented?
   * How will progress be monitored?
5. Present findings to the class (5–7 minutes per group).

***Debrief Questions:***

* What gaps did you identify?
* What similarities/differences existed between groups’ findings?
* How can these findings inform **real decisions in PHC**?

**Facilitator Tip:** Reinforce the link between **data analysis and practical decision-making**, emphasizing timely corrective action.

## **Reflection Questions**

1. How can data from your facility guide improvements in service delivery?
2. Which visualization tools are 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.

## **Key Takeaways**

* Data is only valuable if **interpreted and acted upon**.
* Visualizations make **trends and gaps easy to understand**.
* Evidence-based planning ensures **resources are allocated efficiently**.
* Using M&E data regularly improves **service delivery, accountability and health outcomes**.
* Data-driven decision-making strengthens **PHC responsiveness** to community needs.

**MODULE THREE**

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

### **Introduction**

Effective leadership and strong Monitoring & Evaluation (M&E) are critical for enhancing health services and achieving better outcomes in Primary Health Care (PHC). Leadership provides **direction, motivation and oversight**, while M&E ensures decisions are **evidence-based, targeted and measurable**.

This module guides participants on how to **integrate leadership and M&E skills** into everyday PHC management. Key activities include:

* Supervising and mentoring staff
* Analyzing and interpreting health data
* Identifying gaps in service delivery
* Implementing practical solutions to operational challenges

The module adopts a **hands-on, problem-solving approach**, helping health managers and frontline staff turn knowledge into concrete actions that:

* Strengthen PHC service delivery
* Improve efficiency and resource use
* Enhance accountability and teamwork

By linking **leadership with data-driven decision-making**, PHC teams can better plan, monitor and adapt interventions, contributing to **Universal Health Coverage (UHC)** and advancing **Sustainable Development Goal 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 guide decision-making
* Strengthening accountability, teamwork and problem-solving at facility and district levels
* Improving health outcomes through practical, evidence-based interventions

**SESSION 3.1**

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

### **Introduction**

Effective health management in Primary Health Care (PHC) relies on the integration of **leadership skills** and **Monitoring & Evaluation (M&E)** capabilities.

* Leadership provides **direction, motivation and oversight**, creating a culture of continuous improvement.
* M&E provides **data-driven insights** to identify gaps, monitor performance and guide decisions.

This session helps participants understand how leadership and M&E work together to **strengthen PHC services, improve performance and enhance health outcomes**.

### **Learning Objectives**

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

1. Explain the role of leadership in using M&E data for effective health management.
2. Apply M&E data to identify gaps and prioritize interventions in PHC.
3. Use accountability mechanisms to ensure action is taken based on evidence.
4. Practice decision-making using real-world data scenarios.

### **Session Content**

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

PHC leaders—including Medical Officers, LHVs, facility managers and health supervisors—play a crucial role in translating data into action:

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

***Example:***

A BHU in Swabi observed only 55% of pregnant women received 4 ANC visits. Using DHIS2 data, the facility in-charge identified low-performing villages, conducted community outreach and supervised LHVs. Coverage improved to 78% in three months.

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

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

* **Identify trends and gaps:** Assess service indicators like ANC coverage, immunization rates and stock availability.
* **Prioritize interventions:** Allocate resources to areas with the greatest need.
* **Evaluate effectiveness:** Determine if programs achieve results and adjust strategies.
* **Promote transparency:** Share findings with teams, districts and communities to build trust.

***Example:***

In Thailand, district health officers use routine M&E data to identify villages with low immunization coverage. Targeted outreach campaigns and supervisory visits increased vaccination rates, with public dashboards ensuring accountability.

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

Effective leadership ensures **M&E findings translate into action**:

***Decision-Making Examples:***

* Allocate staff and supplies to underperforming facilities.
* Adjust outreach schedules based on coverage data.
* Provide training to address knowledge or skill gaps.

***Accountability Mechanisms:***

* Regular review meetings with facility and district staff.
* Use performance dashboards to track progress.
* Conduct supportive supervision and provide feedback.
* Publicly report key indicators to promote transparency.

**Key Point:** Leaders are accountable for using data to **drive improvements in health services**.

### **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. Provide each group with a **mock PHC dataset** (e.g., ANC visits, immunization coverage, OPD attendance, stock levels).
3. Tasks for groups:
   * Identify key gaps or areas needing improvement.
   * Decide on **three priority actions** based on the data.
   * Assign roles and responsibilities for implementation.
4. Present action plans to the class and explain **how data informed your decisions**.

***Debrief:***

* Highlight the link between **leadership, M&E and accountability**.
* Discuss how evidence-based decisions lead to improved PHC performance.

### **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 key leadership tool in Primary Health Care (PHC) that ensures teams perform effectively, follow standards and continuously improve services.  
Unlike traditional inspection, it emphasizes **guidance, mentoring and problem-solving** rather than punitive measures.

This session introduces participants to:

* Conducting **facility performance reviews**,
* Using **supportive supervision checklists** and
* Providing **constructive feedback** to PHC staff.

Effective supervision strengthens accountability, teamwork and health outcomes.

### **Learning Objectives**

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

1. Explain the purpose of performance reviews and supportive supervision.
2. Conduct structured facility performance reviews using data and observation.
3. Apply a supportive supervision checklist to assess key areas.
4. Provide constructive and actionable feedback to staff.
5. Practice supportive supervision in a simulated setting.

### **Session Content**

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

Supportive supervision helps PHC teams to:

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

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

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

Steps for systematic facility reviews:

1. **Planning:** Schedule and communicate review visits with facility staff.
2. **Data Review:** Examine DHIS2 reports, registers, LMIS data and KPIs.
3. **Observation:** Check service delivery points, equipment, medicines and patient flow.
4. **Staff Interviews:** Understand challenges and offer coaching opportunities.
5. **Feedback Session:** Discuss findings constructively, highlight achievements and suggest improvements.
6. **Action Planning:** Agree on corrective actions, assign responsibilities and set timelines.

***Example:***

A supervisor in Swabi noted low immunization coverage due to stockouts. They worked with the facility in-charge to improve LMIS reporting, plan outreach sessions and assign staff for monitoring. Coverage improved within two months.

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

A checklist ensures supervision is **systematic, consistent and comprehensive**.

|  |  |  |
| --- | --- | --- |
| Domain | Items to Review | Notes/Comments |
| Service Delivery | ANC, immunization, OPD, 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, SOP adherence | Are staff confident and competent? |
| Supplies & Equipment | Medicine stocks, vaccines, equipment | Are resources available when needed? |
| Infrastructure & Hygiene | Cleanliness, patient flow, waiting areas | Does the facility meet Shortmum standards? |
| Community Engagement | Outreach sessions, health education | Are community needs addressed? |

**Tip:** Use the checklist as a **guide, not a judgment tool**, focusing on mentoring and problem-solving.

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

Effective feedback should be:

* **Specific:** Clearly identify what is being reviewed.
* **Objective:** Base comments on observations and data.
* **Balanced:** Highlight achievements before addressing gaps.
* **Actionable:** Provide recommendations and 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.”

### **Practical Activity: Supervision Visit**

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

***Instructions:***

1. Divide participants into pairs: one as **supervisor**, the other as **facility staff**.
2. Each pair receives a **mock facility report and scenario** (e.g., low ANC coverage, stockouts, absenteeism).
3. Conduct a **10-minute supervision visit**:
   * Review 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 build 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**

Strong leadership in Primary Health Care (PHC) relies on effective teamwork and communication. Multidisciplinary teams—including Medical Officers, LHVs, health technicians and community health workers—must collaborate 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.

### **Learning Objectives**

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

1. Explain the importance of teamwork in PHC.
2. Apply collaborative decision-making processes within their teams.
3. Use strategies to motivate and engage staff.
4. Identify and resolve conflicts constructively.
5. Apply effective communication techniques in team interactions.

### **Session Content**

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

PHC teams operate 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:** All members contribute to facility and district goals.
* **Problem-solving:** Teams collectively identify gaps, propose solutions and implement improvements.
* **Staff motivation:** Supportive teams increase morale and reduce burnout.

***Example:***

In a BHU in Haripur, a team of Medical Officer, LHV and CHWs organized outreach immunization sessions. Through regular team meetings and task sharing, coverage improved from 60% to 85% within three months.

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

Encouraging all team members to participate improves ownership and implementation. Steps:

1. Identify the issue (e.g., low ANC attendance).
2. Gather relevant data from registers, DHIS2 and field reports.
3. Brainstorm solutions collaboratively.
4. Evaluate options considering feasibility, resources and impact.
5. Agree on a collective course of action.
6. Assign roles and responsibilities and monitor progress.

**Key Point:** Inclusion of the whole team builds ownership and increases success.

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

Leaders can improve motivation by:

* **Recognition:** Acknowledge good performance publicly.
* **Supportive supervision:** Provide guidance rather than punishment.
* **Inclusion:** Involve staff in decision-making.
* **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 to discuss achievements and challenges. Staff meeting performance targets received recognition, which improved motivation and service delivery.

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

Conflict is natural but can disrupt services if unmanaged. Steps for resolution:

1. Identify the source of conflict (e.g., miscommunication, workload, resources).
2. Listen actively to all perspectives.
3. Address issues early before escalation.
4. Focus on solutions, not blame; encourage compromise.
5. Follow up to ensure agreements are implemented and relationships restored.

***Example:***

In Swabi, two LHVs disagreed on outreach schedules. The facility in-charge facilitated a discussion, clarified responsibilities and created a shared timetable, improving teamwork and outreach coverage.

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

Good communication ensures clarity and engagement. Key skills:

* **Active listening:** Pay attention, summarize, clarify.
* **Clear messaging:** Use simple, concise language.
* **Non-verbal communication:** Appropriate body language and tone.
* **Feedback:** Constructive and respectful.
* **Conflict prevention:** Communicate expectations clearly.

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

### **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 has dropped by 30% this month.”**
3. Each group:
   * Discuss the problem collaboratively.
   * Brainstorm solutions.
   * Assign roles and create a Short action plan.
4. Present findings to the class (5–7 minutes per group).
5. Facilitator provides feedback on **team collaboration, communication and decision-making**.

### **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,
* Establishing follow-up mechanisms and
* Ensuring continuous improvement.

Participants will also reflect on their learning and commit to applying these lessons in real-world settings.

### **Learning Objectives**

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

1. Develop structured action plans for their PHC facilities.
2. Set SMART performance targets and select follow-up indicators.
3. Establish mechanisms for regular review, follow-up and accountability.
4. Reflect on learning and consolidate personal and team commitments.
5. Apply action plans to improve health service delivery and outcomes.

### **Session Content**

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

An action plan is a roadmap to address gaps and strengthen service delivery. Key steps:

1. **Identify priorities:**

Use M&E data, supervision findings and team inputs to select focus areas.

1. **Define objectives:**

Specify desired outcomes (e.g., increase ANC coverage, reduce stockouts).

1. **Set SMART targets:**

Ensure objectives are Specific, Measurable, Achievable, Relevant and Time-bound.

1. **Assign responsibilities:**

Clearly define which team members are accountable for each action.

1. **Determine resources needed:**

Identify human, financial and logistical requirements.

1. **Establish timelines and milestones:**

Decide when actions will be implemented and progress reviewed.

***Example:***

A BHU in Nowshera aims to improve immunization coverage:

* ***Objective:*** Increase full immunization from 65% → 85% in six months.
* ***Actions*:** Weekly outreach sessions, improved vaccine stock reporting, CHWs assigned to high-risk households.
* ***Responsible*:** LHV supervises outreach; MO oversees reporting.
* ***Resources:*** Vaccine supply, transport, community mobilization support.
* ***Follow-up*:** Monthly review meetings to track progress.

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

Follow-up ensures accountability and progress tracking. Steps:

* **Select indicators:** Choose 3–5 key indicators per priority area.
* **Define targets:** Base on baseline data; aim for realistic but challenging goals.
* **Schedule reviews:** Conduct monthly/quarterly performance reviews with staff.
* **Adjust actions:** Use 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 helps participants review learning and plan concrete actions:

* **Group Discussion:** Share lessons learned, challenges faced and anticipated impact.
* **Individual Reflection:** Write down 3 concrete actions to implement in facilities.
* **Peer Sharing:** Present action points to colleagues for feedback and accountability.

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

To ensure lasting impact:

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

**Facilitator Tip:** Encourage participants to sign a **commitment pledge** outlining actions to implement over the next 3–6 months.

### **Practical Activity: Facility Action Plan Exercise**

**Objective:** Apply leadership and M&E skills to develop a concrete action plan.

***Instructions:***

1. Divide participants into small groups or work individually.
2. Review facility M&E data and supervision findings.
3. Develop a structured action plan including:
   * Priority areas
   * SMART objectives and targets
   * Responsibilities and resources
   * Follow-up mechanisms and timelines
4. Present action plans to the class for discussion and feedback.

### **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?