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Qualitative findings from Sathi: Mentoring of Primary Health Care teams in Gujarat

Effective delivery of primary health care (PHC) services depends on teams of multidisciplinary health workers operating as a unit. Yet, in India the verticalization of the health system has rendered PHC teams fragmented and they don't function as cohesive units. This note presents findings from a qualitative assessment of a novel pilot program (SATHI) that used a mentoring approach to strengthen how PHC teams function together. The findings show that a well-designed, system-embedded mentoring program can produce meaningful and measurable improvements in team functioning, communication, conflict resolution, and health service delivery, with significant and unexpected benefits for workforce wellbeing and equity within health teams.

Background

PHC services are typically delivered through teams of health workers. Global best practice suggests that multidisciplinary teams are a cornerstone for effective PHC delivery.[1] In India, policy seeks to 'instill a culture of a team-based approach to delivery and quality of health care encompassing preventive, promotive, curative, rehabilitative and palliative care.'[2] However, the potential gains from team-based service delivery have not been fully realized due to the historical verticalization of the health system into condition-specific programs. This verticalization has had two unfortunate effects on PHC teams - first, it has made individual health care workers responsible for specific health conditions rather than seeing themselves as responsible for the broader health of the communities they serve; second, it limits their ability to work as a cohesive unit. Training programs for PHC workers are typically designed for individual cadres rather than for teams, which further limits team cohesion.

Ayushman Arogya Mandirs (SHC-AAM)

- Mandated to deliver 12 comprehensive service packages through team-based approaches.
- SHC-AAM team comprises a Community Health Officer (CHO), Auxiliary Nurse Midwife (ANM), Multipurpose Health workers (MPW – male and female), and community health workers-ASHAs.

Box 1. Core elements of Ayushman Arogya Mandir (AAM)[4]

SATHI Pilot

Towards this, the India Primary Health Care Support Initiative (IPSI) developed and piloted SATHI- a structured 12-month team mentoring program[3]. The pilot was implemented at Sub Health Centres, upgraded as Ayushman Arogya Mandirs (SHC-AAMs), in Bhavnagar district, Gujarat (Box 1). The program was designed and implemented collaboratively by the Indian Institute of Public Health, Gandhinagar (IIPHG); Bhavnagar Government Nursing College; the Bhavnagar Chief District Health Office; the State Health System Resource Centre, Gujarat (SHSRC-Gujarat); All India Institute of Medical Sciences, Delhi (AIIMS-D); and the Johns Hopkins Bloomberg School of Public Health (JHBSPH).

Operational Plan: Mentor pairs (a nurse faculty from the Government Nursing College, Bhavnagar and an AYUSH Medical Officer from the Primary Health Centre in Bhavnagar) mentored two SHC-AAM teams. Each month, mentoring sessions included two in-person visits by the coach pair and one virtual session, delivering 12 structured modules over the pilot period. WhatsApp was also used to maintain an open line of communication between the mentors and their mentees. Pre-decided WhatsApp nudges were given to encourage responses linked to the modules. Figure 1 refers to SATHI's operational design.

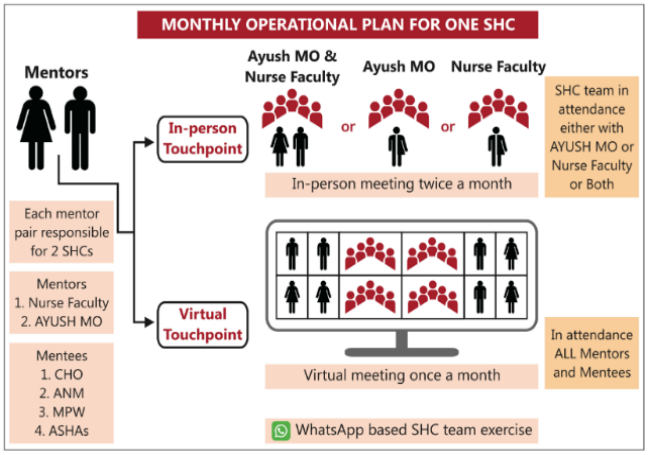

FIGURE 1. SATHI OPERATIONAL DESIGN

SATHI mentoring sessions: Key features

1. Curriculum based on adult learning principles such as reflective and experiential learning.
2. The entire SHC-AAM team mentored together.
3. Hybrid mentoring model with In-person and virtual touchpoints.
4. Phase-wise training of the mentors.
5. Use of WhatsApp, as a platform, for post-session reflection activities.

BOX 2. KEY FEATURES: SATHI MENTORING SESSIONS

Modules and Competencies

SATHI's curriculum was built around a set of team competencies identified through a participatory process involving district health officials, nursing faculty, public health experts, and academic partners. These competencies – the knowledge, skills, and attitudes required for SHC-AAM teams to function effectively – informed the design of structured modules that were used during mentoring sessions. There were 12 modules in total, and each module incorporated adult learning principles, including experiential learning and reflective practice, and was delivered using pedagogical aids such as case studies, flip charts, and activity sheets. In addition to the team competency modules, basic clinical skills were integrated into each module.

Qualitative Evaluation

Methodology

An endline evaluation of the SATHI pilot was conducted in December 2025, following the completion of the 12-month intervention. The evaluation employed a qualitative methodology, using group interviews as the primary data collection method (Table 1). This approach was chosen to capture the nuanced, experiential dimensions of the intervention, such as participants' perceptions of behaviour change, team dynamics, and the program's practical impact on their work.

Mentors	15 (8 AYUSH Medical Officers and 7 nursing faculty)
Mentees	26 (3 CHOs, 7 MPHWs, 2 FHWs, 1 MPHS, and 13 ASHAs)
Supervisors	9 Mentee supervisors (4 MPHS, 3 Medical Officers, and 2 Female Health Supervisors).
Group interviews	12 group interviews; most with specific cadres or respondent categories; 3 with mixed groups.
Analysis	Thematic analysis; findings triangulated across stakeholder groups

TABLE 1. QUALITATIVE EVALUATION SUMMARY

Findings

1. Impact of the SATHI pilot

1.1. Shared understanding of team goals, roles and responsibilities -

Module 3 focused on building a sense of shared responsibility within AAM teams, moving members away from siloed, role-specific work toward collectively owning tasks and outcomes. For many members, it was the first time they truly understood what a team is and how responsibility can be shared across it. The program also shifted attitudes toward ASHAs, whose contributions had previously been undervalued. Through process mapping and group discussions, members came to recognise the ASHA as central to team performance, understanding that their own performance depended on her work. Over time, members also grew to appreciate each other's strengths and work around each other's limitations, helping the team function better as a whole.

1.2. *Communication and information exchange -*

SATHI placed significant emphasis on communication, both within AAM teams and with other stakeholders outside of the AAM. Before the program, information flow was largely vertical, moving from higher authorities down to the MO and CHO, and team members were often unaware of each other's targets or responsibilities. SATHI addressed this by encouraging teams to sit together, review data collectively, and build shared action plans. In some teams, dominant members would monopolise conversations, leaving others unable to contribute. Mentors worked to balance this by emphasising active listening and shared responsibility, and over time, quieter members began to speak up. A particularly meaningful shift was seen in how mentees, especially ASHAs, began communicating with their seniors. Earlier, many were afraid to speak to officers visiting from the district.

1.3. *Decision-making and conflict resolution -*

The module on resolving differences in the workplace equipped team members to recognise what conflict is, acknowledge its impact on work, and develop strategies to address it constructively. Before SATHI, many mentees were unaware that unresolved tension was affecting their performance. SATHI introduced a structured approach, first helping mentees accept that conflict exists, and then, after a gap, equipping them with tools to resolve it. After the module, several teams reported tangible changes. ASHAs who had previously fought over incentive claims committed to working as a team. Beyond the formal curriculum, sitting and eating together during SATHI sessions also played a pivotal role in breaking down interpersonal barriers, something that holds cultural significance in the Gujarati context. The benefits extended beyond the teams themselves. Senior officers noted that fewer complaints and calmer sub-centres made their own work less stressful, suggesting that improvements in team dynamics had a positive ripple effect up the supervisory chain.

1.4. *Team behavioural outcomes -*

Self-management and quality of team process: Team members had little understanding of how to track indicators or identify gaps within their own performance. A strong indicator of behaviour change was the emergence of regular monthly staff meetings across SHC-AAMs. These meetings, attended by all team members, became a space for sharing experiences, discussing work challenges, and planning collectively. Participants also found improved communication within the team resulting from more open discussions around work and challenges. This also resulted in the team strategizing and planning together.

1.5. *Team performance outcomes*

Exposure to the SATHI program appears to have resulted in improved team performance in some areas. Mentees reported better ability to do their work with ease and without stress. Several concrete task performance improvements were attributed to SATHI mentoring: one mentee increased her target achievement in tubal ligations from 3 in a full year before SATHI to 60 in 9 months after it; one SHC-AAM, which was historically underperforming in its targets for the National Programme for Control of Blindness (NPCB) program, reported achieving 100% completion; another completed its TB sputum collection targets; several facilities reported that NCD screening quality and coverage improved. The mentors noted that, while long-term quantitative impact was still early to assess, small but visible improvements with respect to “quality of service” had improved.

1.6. *Data Quality*

Mentors also noted improvements in data reliability, as mentees' changed outlook made them less inclined to fudge figures and more committed to genuine performance.

1.7. *Service integration*

By bringing staff together SATHI created conditions for informal service integration. During Mamta Divas (Village Health Sanitation and Nutrition Day), CHOs also began screening pregnant women for NCD-related concerns, which extended beyond their primary remit. This points to an important finding: team cohesion is an enabling condition for service integration.

1.8. *Relational equity and confidence among ASHAs*

Before Sathi, ASHAs were routinely marginalized in team deliberations, and given orders rather than consulted. Sathi's practice of bringing all cadres within a health facility to come together to sit, eat, and learn as equals disrupted this dynamic. By the programme's end, ASHAs were participating actively in team discussions, being recognised for their knowledge, and describing a new sense of self-worth: "our value has increased — we are

something." Many also reported overcoming longstanding fears — of speaking to senior officials, engaging in group discussions, or working in field contexts they had previously avoided. For several ASHAs from conservative backgrounds, this shift was described as among the most significant outcomes of the entire programme. This finding points to the potential of team-based interventions to address structural inequalities within the health workforce that policy mandates alone have not resolved.

2. Elements of SATHI that contributed to its success:

Several design features had direct consequences for outcomes. These factors also shaped how the intervention was received.

2.1. Selection of Mentors

Mentees felt that nursing college mentors were better because 'they were teachers' and hence their way of explaining things was good. Mentors who are from within the health system (i.e. AYUSH mentors), also had an advantage given their familiarity with the health system, and the potential agency they had to change things for the mentees. Together, the pairing was complementary.

2.2. Mentoring approach

The non-hierarchical, empathetic approach used by the mentors, half of whom were from within the health system, differed from the usual supervisory relationships that characterise relations among health worker cadres. This relational quality was a precondition for the program's content to take hold.

FIGURE 2 AAM TEAM DURING A SATHI SESSION

2.3. Content based on adult learning principles

Across modules, the activity-based pedagogical approach distinguished SATHI from other training programs. The activities, including role-plays, chartwork, local examples, and group exercises, were rooted in adult learning principles. Virtual sessions and WhatsApp nudges were comparatively less engaging, as they lacked the participatory, relational element that made in-person sessions effective.

2.4. District administration as a key stakeholder

The district was involved in designing and implementing the program from the start, which helped address some early challenges pertaining to low attendance. In response, Bhavnagar's Chief District Health Officer (CDHO) made attendance during SATHI sessions mandatory and a top priority for the mentees. This led to a gradual improvement in mentees' attendance.

3. What worked and why

Beyond program design, the evaluation surfaced important lessons about which curriculum elements resonated most with mentees, and why. These findings have direct implications for the design and content of future team mentoring programs.

3.1. Adaptive curriculum

Mentees consistently rated the self-help and wellbeing module as most valuable, for two reasons: it was the first intervention to prioritise health workers' own wellbeing, and it gave them tools to manage it. The module was added in response to explicit mentee demand. This responsiveness strengthened mentees' engagement with the broader curriculum.

FIGURE 3 MENTORING SESSION IN PRACTICE

3.2. *The importance of soft skills as the core of the intervention*

Mentors observed that they were more likely to retain and apply soft skills such as communication, active listening,

and conflict resolution because these produced visible improvements in their daily lives. This finding has important implications for curriculum prioritisation: soft skills are not supplementary to clinical content.

3.3. Active listening as a transformative concept for teams

Before Sathi, team members had limited appreciation for each other's circumstances, and communication was largely directive. Active listening changed this: it enabled members to understand different perspectives, and this skill also laid the foundation for conflict resolution, communication with seniors, and ASHA integration into teams.

3.4. The group process as part of the program design

Sitting and eating together during sessions reinforced the formal content, drawing on a cultural dynamic in Gujarat captured by the saying "those who eat together, their hearts and minds come together." While facility-based team members often eat together, it is less common for ASHAs to join in this activity. This shared experience of discussing challenges, finding solutions, and eating together gave mentees a sense of "teamwork."

Lessons for practice

1. The SATHI experience suggests that mentoring is an effective capacity-building strategy as it supports sustained, context-specific learning that extends beyond knowledge transfer to enable behavioural change. Through continuous engagement, reflective practice, and supportive relationships, mentoring can strengthen team competencies and improve team functioning.
2. Selecting mentors from within the health system yields multiple benefits. System familiarity and contextual knowledge give mentors credibility with their mentees, while a shared institutional context builds the relational foundation necessary for behaviour change. This translates into a strong relational foundation between the mentors and the mentees.
3. A key factor in sustaining engagement was mentees' recognition of tangible professional and personal benefits, including greater confidence, improved teamwork, and better problem-solving.
4. Soft skills should not be seen as supplementary skills. For frontline teams whose effectiveness also depends on how well they work together, these competencies are not peripheral; they are core.
5. Ensuring administrative buy-in is key to the successful implementation of mentoring programs.

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