

A Novel Team Coaching Model to Improve Primary Health Care Team Performance in India

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Background

Primary health care (PHC) services delivered through multi-disciplinary teams of healthcare workers is global best practice for delivering comprehensive and integrated care. Health policy in India also emphasizes team-based approaches to delivering PHC¹. However, the potential of team-based PHC is undermined because traditionally PHC team members have focused on specific diseases/programs, which limits health workers functioning “as a unit” to achieve targets, or having collective responsibility for the health of their communities. The introduction of the new Mid-Level Health Provider (MLHP) cadre at sub- health centres under the Ayushman Bharat programme further highlighted the need for building cohesive PHC teams.

In response to these structural limitations, the India Primary Health Care Support Initiative (IPSI) developed a novel coaching program (“Team Coaching”) for primary health care teams at the Sub-Health Centre Ayushman Arogya Mandir (SHC-AAM) level (see Box 1). This team coaching model is inspired by learnings from organizational theory and the experience of industry in coaching teams to improve task performance². The Team Coaching model aims to strengthen team processes of SHC-AAMs teams (see Figure 2) by establishing a systematic, deliberate relationship between coaches and AAM team members. Coaches from within the health system (e.g. PHC Medical Officer) have regular structured meetings with AAM teams to strengthen competencies (knowledge, skills) and improve their ability to plan to achieve service delivery targets. An added benefit of team coaching, particularly in hierarchical health system

contexts, is that it moves supervisors of health workers from a purely monitoring role to a mentoring and coaching role.

Box 1 – Sub Health Centre Ayushman Arogya Mandir (SHC AAM)

What is SHC-AAM – SHC-AAM is a clinic based at the primary care level which caters to about 5000 population and is at the very base of India’s public health system pyramid. It is required to provide 12 packages of health services (preventive and curative) to its catchment population as per the Ayushman Bharat Health and Wellness Programme of the Government of India.¹ West Garo Hills district in Meghalaya (Figure 1) has 68 SHC-AAMs and 11 Primary Health Centres.³

AAM Team – Mid level health provider (MLHP), Auxiliary Nurse Midwife (ANM), Accredited Health Activist (ASHAs,) Grade 4 employee (cleaner + guard), Surveillance Officer, ASHA Facilitator

Team Coaching in Meghalaya

The Team Coaching model is currently being implemented in the West Garo Hills district of Meghalaya. Meghalaya is situated in the eastern part of India (Figure 1). West Garo Hills district has a population of 4.6 Lakh people and borders Bangladesh.

1 National Health Systems Resource Centre, Ministry of Health and Family Welfare, Government of India (2018). Operational Guidelines for Comprehensive Primary Health Care through Health and Wellness Centers.

2 Hackman, J. R., & Wageman, R. (2005). A theory of team coaching. *Academy of management review*, 30(2), 269-287.

3 Source - <https://meghealth.gov.in/phc.html>



FIGURE 1: MAP OF MEGHALAYA STATE WITH HIGHLIGHTED WEST GARO HILLS DISTRICT

The model is being implemented as a pilot program at 27 SHC-AAMs, across four blocks. The Team Coaching program began in November 2026 and is expected to conclude by June 2026. The Indian Institute of Public Health, Shillong, and Johns Hopkins University, with support from the District Administration of West Garo Hills, have jointly conceptualised, designed, and implemented this initiative.

This note details the conceptual framework and the processes developed to implement this coaching programme in Meghalaya.

Conceptual Framework of the Team Coaching Model for Primary Health Care Teams

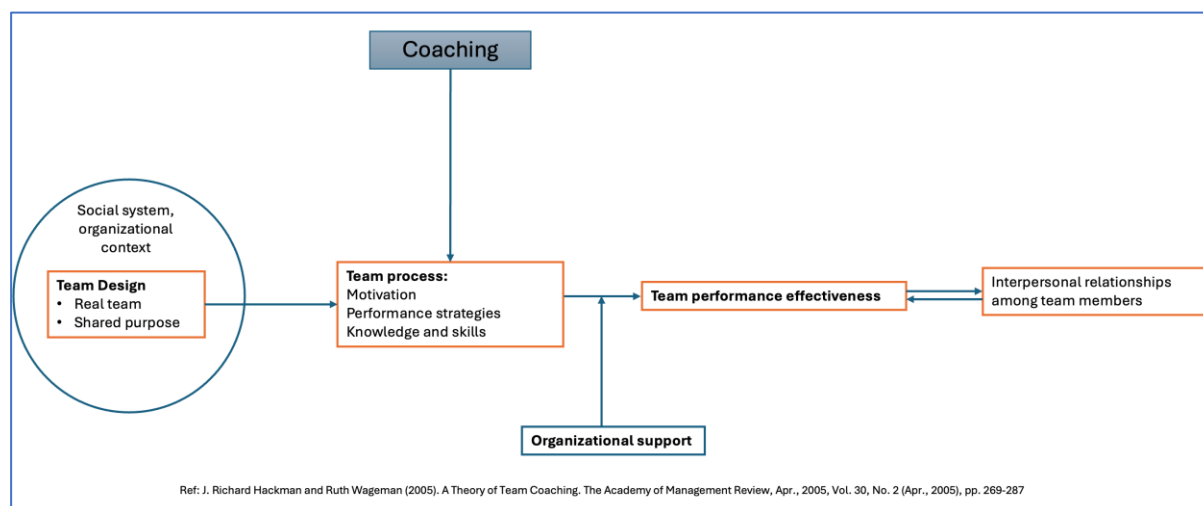


FIGURE 2 CONCEPTUAL FRAMEWORK FOR TEAM-BASED COACHING

In the conceptual model of team-based coaching (Figure 2), key team process – motivation, strategies used to achieve tasks, and the knowledge and skill of team members – impact effectiveness of team performance such as achieving task goals (e.g. targets for screening for hypertension). These team processes are a function of the structure or ‘design’ of the team – a real team (e.g. has stable membership) that has a clear shared purpose, as well as the organizational context (e.g. incentives or support for performance) within which the team operates. Coaching can help improve team processes, but only if the structural elements and organizational context is conducive.

For coaching to be effective in improving team performance effectiveness (e.g. achieving task performance goals/targets), appropriate design of the team is a necessary condition. For example, team membership must be clearly defined, there should be no or minimal turnover among team members, team members must have a shared purpose such that corresponding tasks require team members to take collective responsibility and work together. Further, the level of organizational support that the team receives influences the effectiveness of coaching. Examples of organizational support include recognition and incentives, educational support, availability of material resources and easy access to data/information.

Key features of the Coaching Intervention

Operational Design

The 8-month long team coaching intervention is being implemented in a hybrid model (2 in-person and 1 virtual session every month). The **coaches** are selected from within the health system and from the supervisory cadres of AAM teams - PHC Medical Officer, AYUSH Medical Officer, ANM Supervisor, Lady Health Visitor, Block Extension Educator. These coaches work in pairs and are responsible for 2-4 SHC AAMs each.

The **in-person coaching sessions** take place at the SHC-AAMs and can typically last 2-3 hours. All SHC-AAM team members join the coaching together. In addition to these on-site sessions, a monthly **virtual session** brings together all SHC-AAM teams and their coaches. This one-hour virtual session is taken by a subject expert usually from within the district or state health department. Figure 3 shows the design of the Team Coaching pilot.

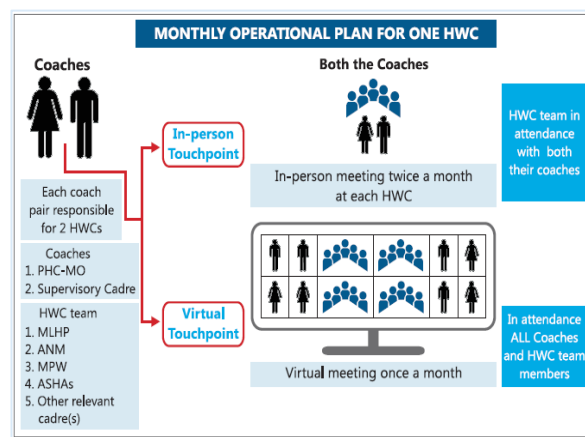


FIGURE 3 OPERATIONAL DESIGN OF THE COACHING INTERVENTION

Content of coaching

There are 8 modules designed for the intervention on which the coaches are trained. The modules are designed to align in content with the conceptual model (Figure 2). The content uses adult learning principles such as reflective activities and experiential learning, in addition to role plays and other activities. Some of the main themes of the modules are a) Understanding teams and teamwork, b) Sharing responsibility, c) Team Collaboration, d) Team Purpose, e) Team Performance, f) Team Planning and g) Effective Communication and reflection.

Each session has a **hands-on clinical session** where key clinical skills are demonstrated by the coaches. The coaches train teams in skills such as measuring height, weight and pulse, measuring blood pressure, process for bio-medical waste management, etc.

Training of coaches

Training for the coaches is done in a phased manner where three trainings over an eight-month period have been organized. This ensures retention of the content, opportunities to clarify issues and course correction. In addition, before every in-person coaching session, a call is organized where the coaches are given the opportunity to prepare for the session the following day.

Monitoring of coaching intervention

To support the coaches, IIPH-S and JHU teams routinely visit the facilities. With the help of Kobotool box⁴, coaches can input the time they have spent at the facility. During pre-scheduled calls, coaches can share their feedback on the modules and coaching session post the completion of each session.

⁴ KoboToolbox is an open-source software used to collect, analyze, and manage data for surveys, monitoring, evaluation, and research

Learnings from the Implementation

1. Scalability: By training a cohort of coaches from within the health system in the district, the program ensures scalability. We designed the program such that all coaches were drawn from the supervisory cadres of the SHC-AAM teams, i.e. from the Primary Health Centre or other supervisors.
2. Shift from supervision to a mentoring or coaching relationship: Traditionally, supervisors within the health system have played a monitoring role. In the Team Coaching program, teams for the first time, have begun to sit together with their coaches, who are there not as supervisors but as mentors/coaches, to help the team perform better.
3. Value of on-site clinical demonstrations: Teams appreciate hands on clinical sessions being imparted to them at their facilities.
4. Challenges to implementation of team coaching
 - Human resource constraints: There are few Medical Officers to coach the SHC AAM facilities due to human resource constraints. Other supervisory cadres are usually stretched for time. However, by keeping the coaching schedules flexible, the coaches can schedule sessions as per their and their facilities convenience.
 - Staff transfers and turnover: Frequent transfers and leaves taken by core team members at the SHC-AAMs make coaching efforts harder.
 - Language diversity: Various languages are spoken in WGH District (English, Bengali and Garo). This makes undertaking a coaching session quite challenging.



FIGURE 4 COACHING SESSION IN-PROGRESS – A COACH DEMONSTRATING CLINICAL SKILLS

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