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Team Coaching and Primary Health Care Team Performance – Evaluation of the Sathi team coaching pilot.

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Comprehensive primary health care (PHC) requires multidisciplinary health workers working together as a team. In India, team-based care is limited by the historical verticalization of cadres and services. Further, little attention has been given to how teams function. This note presents results from the evaluation of Sathi, a pilot PHC team coaching intervention, aimed at improving how PHC teams function. Findings demonstrate the feasibility of implementing a coaching intervention in the public health system. Further, coaching improved aspects of team task processes and effectiveness. Key considerations in the implementation of such a PHC team coaching intervention include structural elements of the team present, fidelity to the coaching approach, careful selection and support of coaches and a focus on "softer" team competencies besides "hard" clinical and technical skills.

Background

Delivery of comprehensive primary health care (PHC) requires multidisciplinary health worker teams[1,2]. India's health policies advocate for team-based approaches to service delivery[3]. However, in India, team-based service delivery is undermined by historical verticalization of cadres and services that limit the ability of PHC workers to act as a unit to take care of their community's health. Importantly, though health services are delivered by teams, little attention has been given to strengthening how PHC teams function and work together. In India's hierarchical health system, relationships are based on supervision rather than mentorship; this limits how much PHC teams perceive being supported by higher levels in the health system. [4].



Figure 1: Bhavnagar, Gujarat

Sathi—a pilot team coaching program—was designed to improve team functioning at Ayushman Aarogya Mandirs (AAMs) in Bhavnagar district, Gujarat.

Program Design

Sathi was co-designed and implemented by the India Primary Health Care Support Initiative (IPSI) partners Johns Hopkins University, USA; Indian Institute of Public Health, Gandhinagar; State Health System Resource Center, Gujarat; Government Nursing College, Bhavnagar and the District Health Department, Bhavnagar. Sathi was designed as a 12-month coaching program and implemented from September 2024 to September 2025 in 20 AAM facilities across 4 blocks, with 20 facilities identified as control. The program identified a complementary pair of in-district coaches drawn from faculty at the Government Nursing College, Bhavnagar, and an AYUSH Medical Officer from the district health system (see Figure 1). Each pair coached upto three AAM teams.

Characteristics of AAM teams

Composition: One Community Health Officer (CHO), one Female Health Worker (FHW), one Multi-Purpose Health Worker (MPHW) and 3-5 Accredited Social Health Activists (ASHAs).

Population served: about 3000-5000

Services offered: Package of 12 facility and community-based services including reproductive, maternal, newborn, child and adolescent health; communicable and non-communicable disease services; general outpatient services; eye, ear, nose and throat care; basic oral health care; elderly and palliative services; basic emergency services and basic mental health services.

Key design features of Sathi included:

- Each AAM team received three coaching sessions per month: two in-person at the AAM facility and one virtual.
- Coaching sessions were structured around modules on topics such as communicating effectively, sharing responsibilities, resolving conflicts, measuring team performance, problem-solving, leadership and self-help and wellbeing. All modules

incorporated adult learning principles, task-centric activities and hands-on clinical skills sessions and were responsive to expressed needs of AAM team members.[7]

- Sathi invested significantly in training and valuing its coaches including monitoring of coaching sessions to identify and address implementation challenges, regular post-session check-ins with coaches to troubleshoot issues, and provision of incentives and transport support for coaches to conduct in-person sessions at AAM facilities (see *here* for more details on the design and implementation of Sathi.

Findings

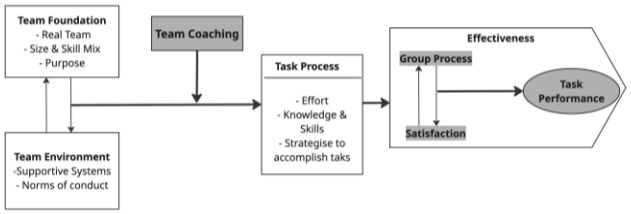


Figure 3: Conceptual model of Sathi

The Sathi evaluation was guided by the Medical Research Council (MRC) framework for process evaluation of complex interventions and the conceptual basis of Sathi (see Figure 3 for conceptual basis)[5 8]. The main outcomes of interest were (1) "Strategies to accomplish tasks" under Task Process, also referred to here as Self Management which further included Collective Responsibility, Monitor Own Performance and Manage Own Performance; and (2) "Quality of Group Process" under Effectiveness which further included Equal Contribution and Team Interaction (see Figure 4). Satisfaction could not be assessed as an outcome due to missing values in the data. The evaluation aimed to understand three aspects of Sathi: perception towards its design features, implementation and effect on outcomes.

Behavioral outcome	Sub component	Definition
Team self management: Team has and exerts authority and accountability for executing, managing its work within a structure and towards purposes set by others.	Collective responsibility	Team members take joint ownership for the team's tasks.
	Monitor own performance	Team uses data to keep track of its own performance.
	Manage own performance	Team strategizes to meet challenges and improve its work.
Quality of team process: Member interpersonal relationships allow the team to work increasingly well together over time.	Equal contribution (added)	Team members contribute equally to team planning.
	Quality of team interaction	Team members interact in ways that contribute to improving team performance.

Figure 4: Outcomes and sub components

Design

- Pre-Sathi, AAM team members perceived their work environment as highly target driven with supervisors focused on target completion and not on providing guidance and support. In such an environment, the AAM team members viewed Sathi as a program meant for them unlike most that catered to the community.

> "All other programs are for the community, but this was the only one for us"

- Coaching sessions provided a platform to the AAM team members to come together. This was however, threatened by staff turnover within teams in some cases.

> "…we sit together, talk happens, some things happen, discussion happens. Otherwise, everyone works in their own place in their own way."

- AAM team members viewed coaching sessions as fun that provided hands on opportunities to learn a new skill. The activities embedded within the coaching sessions distinguished Sathi from traditional trainings.
- Coaches were viewed as teachers and mentors with whom personal and professional challenges could be discussed.
- AAM team members perceived the virtual coaching sessions and WhatsApp group activities as less engaging.

Implementation

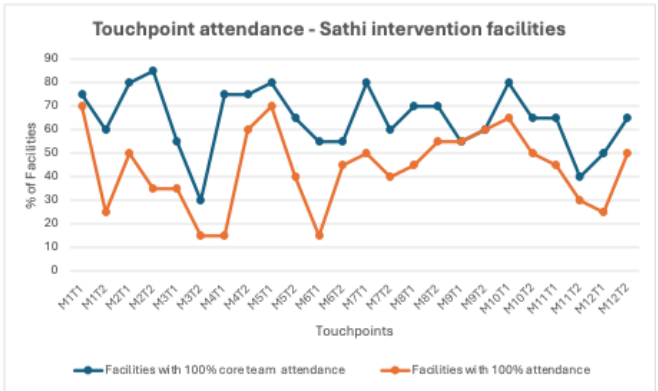


Figure 5: Time trend of AAM team attendance

On average, across the intervention, AAM team attendance was 87% at the coaching sessions though it showed variation over time (see Figure 5). Initial low

engagement in the coaching sessions was due to lack of clarity about Sathi's purpose and competing priorities; Sathi was initially perceived by AAM team members as another government program with targets and monitoring. In response to this, the Chief District Health Officer (CDHO) of Bhavnagar intervened by making sessions mandatory, personally engaging with repeat absentees, rescheduling district trainings, and publicly emphasizing the program's importance. Further, coaches conducted their sessions only if all facility based AAM team members were in attendance.

Effect on outcomes

Based on the distribution of the outcome scores, Figure 6 shows that a higher proportion of intervention facilities were scored in the highest category for each outcome compared to controls.

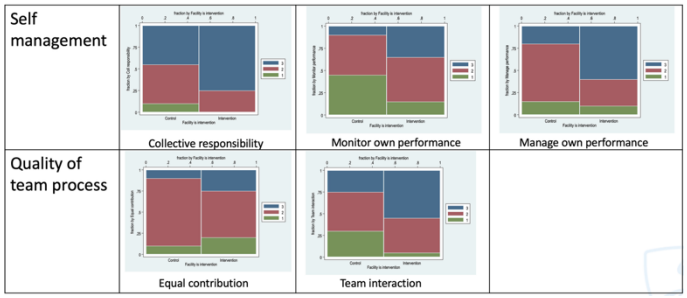


Figure 6: Distribution of outcome sub component scores [blue = 3 (high); red = 2 (medium); green = 1 (low)]

The results from the regression analysis are shown in Figure 7. As per Figure 7(A), for an average AAM team (with average OPD, located an average distance to its Primary Health Center and with average team foundation and environment), the probability of being in a higher outcome class was greater among intervention facilities. The findings were not statistically significant, however. Specifically, intervention facilities had a 23% and 31% greater probability of being in high self-management class and a high quality of group process class compared to control facilities when all other variables are held at their average values. Figure 7(B) shows the results for outcome sub-components, i.e., change in predicted probability of being in the highest outcome sub-component category among intervention facilities compared to control. For example, intervention facilities had a 22% greater probability of being in the highest category (score=3) of monitoring own performance (a sub-component of self management) compared to control when all other variables are held at their average values (p-value<0.05). This finding can potentially be explained by the fact that the Sathi module content focused for 2 months on helping AAM teams understand and measure team performance using routine data sources. Additionally, intervention facilities had a 37% greater probability of being in the highest category (score=3) of team interaction (a sub-component of quality of group process) compared to control when all other variables are held at their average values (p-value<0.05), which too can be potentially explained by the Sathi module content that had a cross-cutting focus on strengthening team relationships. Further, it is likely that outcomes that were more within the sphere of control of the AAM team and relatively less influenced by the larger health system were statistically significant; for example, outcome subcomponents such as collective responsibility and equal contribution may be more challenging to influence given the historical verticalization and systemic reinforcement of cadre roles.

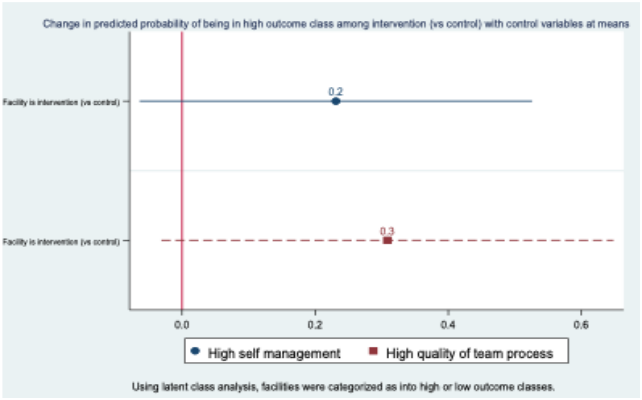
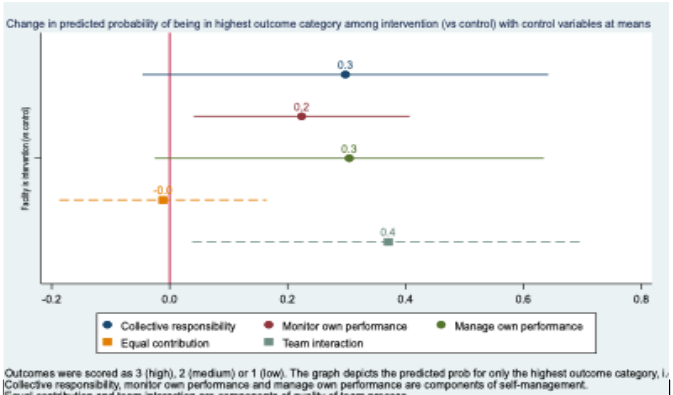


Figure 7(A): Change in predicted probability of being in high outcome class among intervention facilities vs control



outcome sub component category among intervention facilities vs control

Additional potential pathways to influencing the outcomes include:

- Feeling and acting like a team: Coaching sessions provided an opportunity for the AAM team members to get to know each other. Team members started feeling more supported by their teammates.

> "Earlier, I used to feel that this work is mine, I have to do it alone. … Now, whenever I'm confused, after Sathi, I can call anyone and ask them how to do this."

- Communication and empathy: Before Sathi, information flow was fragmented (e.g., ASHAs unaware of CHO's targets). Sathi facilitated greater information sharing and empathy among members. AAM team members also leveraged communication skills to resolve team conflicts.
- Relational equality and self-respect, particularly among ASHAs: Sathi facilitated greater acceptance of ASHAs as part of the team, increased confidence among ASHAs so they could call "senior" team members directly, and speak openly about their challenges. ASHAs also reported greater self-worth, feeling their "value has increased" through Sathi.

> "…most of the ASHA workers … [before Sathi] they only call the FHW. The MPHW or the CHO who are males, they don't call them … now it's not like that … and they talk openly, that this is the problem."

- Learning tools to exert control: Sathi did not change the health system environment within which AAM teams operate but it helped them understand and manage it better, e.g., understanding how incentives are calculated and managing stakeholders.
- Realization of professional benefits: AAM teams reported that following Sathi, tasks were completed faster and felt easier.

> "Earlier, everyone used to work alone. Later, everyone began working together, forming a group. So the work can be done with ease."

- Realization of personal benefits: Team members reported reduced stress, describing Sathi sessions as spaces where alongside professional, personal problems could also be discussed and resolved.

> "If there is a family problem, we talk among ourselves. That brings a solution, and the mind becomes fresh. … by sitting together, 50 to 70 percent of our minds become light."

Methods

Data was collected using three approaches: (1) process documentation of Sathi that included AAM team attendance data from each coaching session as reported by the coaches; (2) structured small group interviews and observations with AAM team members at endline at each intervention and control facility. Data were extracted into a template and each team foundation, team environment and outcome sub component was scored 3 (high), 2 (medium) or 1 (low) at the facility level. Latent class analysis was used to aggregate the outcome sub components into overall outcomes of self-management and quality of team process[9]. Latent class analysis assigned each AAM team into either a high or a low outcome class (e.g., high self managing or low self managing). The numerical outcome class assignment of each AAM team enabled the use of multivariate regression to examine impact of coaching on outcomes of interest. (3) in depth small group interviews at endline with intervention AAM team members, their supervisors and the coaches. A total of 12 interviews were held with 48 respondents. (see *here* for more details on the qualitative in-depth interview results).

Conclusion

This study found that designing and implementing a PHC team coaching intervention is feasible within India's public health system. Such an intervention, however does require the presence of a stable and defined PHC team which is adequately supported by a health system that provides all necessary material resources, information and guidance. Embedding such an intervention within the health system can enable its rapid scale up as has been demonstrated by the Government of Gujarat in the state-wide scale up of Sathi (see *here* for more details on the scale up of Sathi). Key consideration in the implementation of such a PHC team coaching intervention includes fidelity to the coaching approach, careful selection and support of coaches, building in mechanisms to be responsive to the needs of PHC team members and a focus on "softer" team competencies besides "hard" clinical and technical skills. Further, this evaluation contributes to the pool of evidence on team coaching by demonstrating that it can improve aspects of team self-management and effectiveness. Future research should build on these findings to further understand if and how PHC team coaching contributes towards enhancing service delivery or quality of care outcomes.

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