



Outcome Harvesting Highlight: Primary Health Care Performance (PHC-PM) Activity

BACKGROUND

Strengthening primary health care (PHC) remains one of the most effective pathways to improving public health and advancing universal health coverage (UHC). Yet many districts continue to struggle to translate data into clear priorities and actionable steps—supported by the necessary leadership, management, and governance capacities—to strengthen systems and improve health outcomes. The PHC Performance Management (PHC-PM) Activity, through its PHC Leadership Development Program (PHC-LDP) addresses this gap by equipping district health management teams (DHMTs) in Ghana’s Akwapim South and North Tongu districts and Rwanda’s Bugesera and Gicumbi districts with the leadership, decision-making, and accountability needed to advance more resilient and equitable PHC systems.

To understand how the Activity’s approach influences performance, a midline evaluation used an outcome harvesting approach—an adaptive method that identifies, verifies, and analyzes changes in behaviors, relationships, and practices that emerge during implementation. This approach focuses on what has changed, how it changed, and the Activity’s contribution to those shifts. Data were collected through key informant interviews and focus group discussions with stakeholders across all four participating districts.¹

KEY RESULTS

- DHMTs demonstrated stronger leadership and coordination, improving communication, supervision, peer learning, and problem-solving within and across teams. 
- Data use improved markedly, with routine dashboards and validation processes increasing data accuracy, accountability, and evidence-based decision-making.
- Catalytic grants accelerated implementation of locally driven solutions, addressing equipment, logistics, service delivery gaps, and human capacity through targeted training and supervision.
- Enhanced collaboration with community health workers and volunteers supported community mobilization efforts, improving participation and support for PHC activities in their districts

Together, these results highlight how structured leadership development, data-driven planning, and peer learning can catalyze sustained improvements in PHC performance and outcomes. See Figure 1 for an overview of the PHC-LDP.

ABOUT THE PROJECT

PHC is the foundation of resilient and equitable health systems. Strong local leadership is essential to ensuring accessible, high-quality care that responds to community needs. In Ghana and Rwanda, national and district health authorities are strengthening health system performance through the PHC-PM Activity—an initiative led by government partners and implemented with local institutions, with support from the Gates Foundation and technical partners including MSH. At the heart of the model are four interlinked components, each designed to reinforce district leadership, evidence-based decision-making, and sustained PHC system improvement:

1. Leadership development
2. Operational data & integrated dashboards
3. Ongoing monitoring, evaluation, and learning (MEL)
4. Catalytic grant funding

Through adaptive performance management cycles, district health authorities continuously analyze, monitor, learn, and adapt—maturing over time into effective stewards of district health systems. The PHC-PM Activity is a collaboration between MSH, Ubor Institute (Ghana), Building Systems for Health (Rwanda), Three Stones International (Rwanda), HISP Ghana, Zenysis, and district and national health authorities.

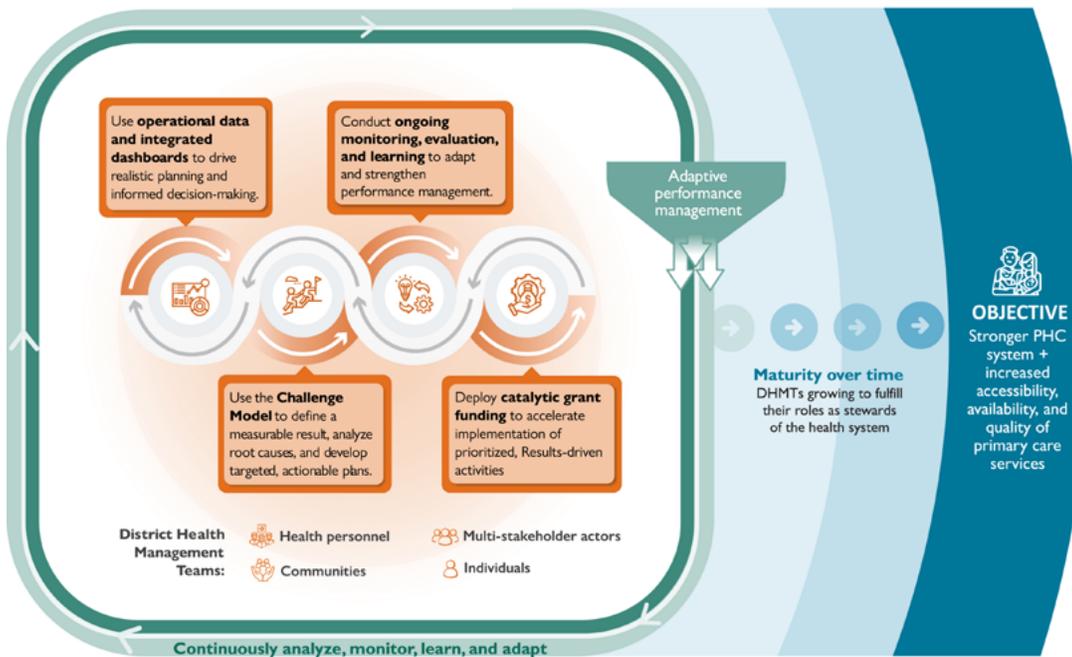


Figure 1: PHC-PM Project Overview
 Primary Health Care Leadership Development Program in Ghana and Rwanda

KEY QUESTIONS & METHODS

The outcome harvesting exercise was led by country partners Ubora Quality Institute (Ghana) and Three Stones International (TSI) (Rwanda). Each partner led the designing of useful harvest questions (Step 1), identification of data sources (Step 2), engaging social actors and change agents (Step 3), validating key findings (Step 4) and analyzing results (Step 5).



MSH, TSI and Ubora began by identifying key harvest questions to guide the outcome harvesting exercise. These questions (summarized below) probed the link between the PHC-PM activity and observed changes within DHMT behaviors, performance management practices and service delivery outcomes:

Since the start of the Activity’s implementation, what outcomes—both positive and negative, intended and unintended—have been observed?

How have any lessons and approaches from the Activity been applied to other health challenges not addressed in LDP action plans?

To what extent have the Activity’s interventions contributed to these outcomes?

What other enabling or constraining factors help explain these outcomes, and what challenges had to be overcome?

Stakeholders of interest included facility in-charges, public health nurses, community representatives (e.g. community health volunteers and community health management committee members), staff from faith-based institutions, and other key DHMT staff. These stakeholders were classified as change agents, social actors and/or validators based on their role, and assigned to Steps 3 or 4 accordingly.

Data was collected through key informant interviews (KIIs) and focus group discussions (FGDs) with stakeholders in all four project districts. KIIs and FGDs were analyzed using a thematic coding approach to extract key themes and patterns. Findings were supplemented by a review of existing sources e.g. PHC-PM baseline assessment, PHC-LDP findings and available country databases, and validated by district stakeholders.

“ We used not to work together as a team. I wasn’t interested in what another unit is doing. But now the story is different. We work together and hold each other accountable as we assign roles”

– Akwapim South, Ghana

OUTCOMES IDENTIFIED

Analysis of KIIs in each country revealed multiple outcomes tied to the PHC-PM Activity. The study team organized these outcomes by theme and classified them as intended vs. unintended, and positive vs. negative. Validators then assessed each outcome, assigning strong validity when most primary and secondary sources corroborated the finding, medium validity when some primary sources confirmed it, and weak validity when primary sources provided limited support. The following table lists identified outcomes in each country.



✓ Intended ⊕ Unintended | 👍 Positive 👎 Negative | Validation: ★★★★ Strong ★★★ Medium ★ Weak

GHANA	RWANDA
<p>Increased overall leadership skills and knowledge at all levels of care</p> <p>✓ 👍 ★★★★★</p>	<p>DHMT meetings are more frequent</p> <p>✓ 👍 ★★★★★</p>
<p>Increased equipment availability and service delivery capacity at all levels of care</p> <p>✓ 👍 ★★★★★</p>	<p>DHMT meeting attendance rates have increased, and members participate more actively during meetings</p> <p>✓ 👍 ★★★★★</p>
<p>Skills gained from the program have enhanced data quality/capture and use at all levels (DHMT and facilities)</p> <p>✓ 👍 ★★★★★</p>	<p>DHMT meetings are more efficient, structured and geared towards improving PHC</p> <p>✓ 👍 ★★★★★</p>
<p>Availability of means of transport for health workers has increased community outreach services, and health worker visibility, thereby bridging access gaps and expanding reach</p> <p>✓ 👍 ★★★★★</p>	<p>DHMT composition is more diverse and open (technical experts are invited)</p> <p>✓ 👍 ★★★★★</p>
<p>Creating a burning platform (i.e. sense of urgency) among health workers ignited a desire to do things differently, causing a shift in their behavior toward service delivery</p> <p>✓ 👍 ★★★★★</p>	<p>HR and financial operations in the health centers (HCs) have improved (e.g. procurement, paying of salaries on time, personnel files)</p> <p>✓ 👍 ★★★</p>
<p>Team-based service delivery strengthened</p> <p>✓ 👍 ★★★★★</p>	<p>More pregnant women attend ANCI visits in the HCs</p> <p>✓ 👍 ★★★</p>
<p>Overall PHC improvement and service delivery due to knowledge gained, revamping accountability and monitoring mechanisms causing a shift in attitude towards work</p> <p>✓ 👍 ★★★★★</p>	<p>Improved data management skills result in more timely and complete reports to the district office</p> <p>✓ 👍 ★</p>
<p>Involvement of the community has improved their participation and support for primary care services through volunteering, advocacy, mobilizing, and donation</p> <p>⊕ 👍 ★★</p>	<p>DHMT members collaborate more closely and effectively</p> <p>⊕ 👍 ★★★★★</p>
<p>Engagement of the community and the consistency in service delivery has improved their confidence in local health services</p> <p>⊕ 👍 ★★</p>	<p>Community health workers (CHWs) have more capacity and feel more empowered to support community mobilization in their districts</p> <p>⊕ 👍 ★★</p>
<p>Health workers have understood the role traditional birth attendants (TBAs) play in skilled delivery, fostered linkage with TBAs and referral, enhancing community health</p> <p>⊕ 👍 ★★</p>	<p>Collaboration between the HCs has improved (e.g. exchanging equipment, heads meet on a more regular basis)</p> <p>⊕ 👍 ★★</p>
<p>Increased workload as a result of intensive action plan implementation</p> <p>⊕ 👎 ★</p>	<p>Referrals of pregnant women from HCs to the hospitals are more targeted; the triage is more effective</p> <p>⊕ 👍 ★★</p>

DISCUSSION

Outcome harvesting demonstrated that the PHC-PM Activity introduced significant changes to DHMT operations and strengthened PHC systems in two districts in both Ghana and Rwanda. Findings covered both performance management outcomes, as well as changes in key PHC areas as a result of the project's activities.



GHANA

✓ **Enhanced leadership skills**

A key outcome cited in both North Tongu and Akwapim South was enhanced leadership capacity at all levels, including the DHMT and sub-district teams (Outcome 1). Following the December 2023 launch of the PHC-LDP, DHMT staff in both districts proactively reorganized their teams by assigning roles based on individual strengths, eliminating confusion and improving operational efficiency. Deliberate use of behavioral self-assessment tools, which emphasized shifts in attitudes and practices, also contributed to strengthening leadership capacity.

✓ **Impact of catalytic grants**

Overall PHC and service delivery improvement efforts were similarly transformative in both districts (Outcomes 2, 3, 7, 8), addressing critical infrastructure gaps. For example, in Akwapim South, the procurement of computers for capturing NHIS reimbursement data reduced NHIS claim rejections from 10% to 4% between 2024 and 2025. In North Tongu, newly acquired delivery sets, blood pressure apparatus, and motorbikes helped reduce neonatal mortality and increase outreach activities, thereby enhancing PHC access and quality of care.

✓ **Data capture and utilization**

Both districts also made marked progress in data capture and utilization (Outcome 5), resulting in improved accuracy in data-driven decisions and resource allocation in both districts. In Akwapim South, DHMTs started using dashboards, validation teams, and data subgroup oversight to improve data quality and accountability. Similarly, in North Tongu, the integration of data capture tools, including dashboards and regular validation, corrected errors (e.g., anemia cases adjustments) and shifted practices towards evidence-based planning.

✓ **Community activities and MNCH outcomes**

Integrated interventions—including pregnancy schools, community-based demonstrations, and strengthened linkages with TBAs and community volunteers—significantly advanced maternal, newborn, and child health (MNCH) outcomes (Outcome 9). In Akwapim South, anemia in pregnancy dropped from 36% to 26.6%, confirmed through data triangulation. In North Tongu, unsafe home deliveries decreased.

These changes demonstrate how community engagement bridges gaps between formal health systems and traditional practices.

✓ **Shift in capacity and staff behavior**

Behavioral changes among health workers were also evident in both districts (Outcome 9). Health workers adopted compassionate, client-centered care—particularly for pregnant women—and DHMTs collaborated with community volunteers to plan outreaches, resulting in improved PHC outcomes. In North Tongu, staff adopted integrated service delivery (e.g., combining ANC and FP services), while in Akwapim South, they demonstrated proactive problem-solving and strengthened teamwork through biweekly feedback sessions. These shifts enhanced service delivery efficiency, reduced missed opportunities for healthcare, and improved overall PHC outcomes in both districts.

“The nurses are now very visible in the community. We frequently see them sitting with community members at home visits and outreaches, they also hold food demonstration and health education at pregnancy schools for pregnant women, as well as hold adolescent club activities.”

– North Tongu, Ghana

RWANDA

✓ **DHMT performance**

DHMT meetings became more frequent, inclusive, and efficient, leading to improved DHMT performance overall. Through the PHC-PM catalytic funds, DHMT members can meet more frequently to analyze and address the most prominent PHC community challenges. In addition to more frequent meetings and inclusive participation, systematic planning and follow-up of activity implementation—largely driven by the DHMT focal point, a new role that emerged as a result of the Activity—improved meeting efficiency.

✓ **MNCH services**

In both districts, the PHC-PM activity contributed to MNCH improvements via training of health center staff. Health center nurses and midwives received training on ultrasound use for monitoring pregnancies and assessing referral needs, preventing maternal and child deaths. In Bugesera, the PHC-PM Activity contributed to improving MNCH services by mobilizing and building community health worker (CHW) capacity to ensure that pregnant women, mothers, and children receive necessary and timely healthcare. In Gicumbi, CHWs were also mobilized to increase antenatal care visits and services, particularly anemia testing of pregnant women.

✓ **Data management and use**

The PHC-PM activity created demand for quality data from DHMTs to understand district health issues and prioritize interventions. During the PHC-LDP's first cycle, both districts used a project dashboard to identify gaps in data quality and completeness. This prompted feedback loops between health center data managers and DHMTs, allowing staff to correct inaccuracies and address data completeness issues. For example, the Bugesera DHMT addressed gaps in the availability of data managers by identifying staff acting as data managers outside their roles in health centers. This synergy improved data management skills, timely and complete reporting, and data use for decision making.

“As a data manager, there have been noticeable improvements in data collection and analysis. Every month, we conduct data analysis where we also identify any errors and correct them. DHMT has greatly helped us resolve many issues, as in the past, the data often contained many errors, making it difficult to address them. However, with their support in data quality, the data provided is now reliable.”

– Gicumbi, Rwanda

✓ **Health center management and operations**

Internal and external audits in Gicumbi identified the need for better health center management and operations to address barriers to sustainable healthcare services. Through the PHC-PM activity, the DHMT trained health center heads and accountants and created an enabling environment for collaboration and knowledge exchange. These initiatives improved human resource and financial management through systematic documentation and filing; operationalized procurement and tender committees; more rigorous recruitment processes; compliance with financial management procedures; and timely payments for healthcare services and salaries. The PHC-PM Activity helped organize rounds of management meetings cross health centers, where representatives made field observations and learned from each other. These collaborations increased staff and vendors' motivation to contribute to sustainable quality healthcare services.

“My main takeaway from this program of which I'm thankful for is that it has made us more efficient in solving primary health issues and improved the quality of our work as health providers. The program helped us identify those issues that we had no idea where to start in solving them and assisted us in better planning and solving them.”

– Bugesera Rwanda

CONCLUSIONS

While outcomes were definitively linked to project activities, DHMTs expressed concerns about sustaining PHC-LDP practices into existing structures after the project and catalytic grant funding conclude. Key opportunities to address this and ensure progress is maintained include inter-district learning and increased community engagement, as well as adequate capacity strengthening to support these efforts. Stakeholders also noted the opportunity to further enhance action planning through longer trainings and increase mentoring and supervision.

Despite these questions around sustainability, all four districts cited notable shifts in their management practices, as well as health outcomes in key PHC areas of interest. Further project efforts will build upon and explore the themes identified in this exercise, specifically sustainability, decision-making behind the use of catalytic funds, dashboard use, and community engagement.



The outcome harvesting exercise demonstrated the PHC-LDP's potential to improve health outcomes and management practices while underscoring the need for long-term investments in local capacity, team-based learning, and sustainable funding.

Endnotes

I Wilson-Grau, R., Peersman, G., and Herft, N. (2022, August). Outcome Harvesting. https://www.betterevaluation.org/en/plan/approach/outcome_harvesting