PHC PERFORMANCE MANAGEMENT (PHC-PM) ACTIVITY (2023-2026)

STRENGTHENING FOUNDATIONS, DRIVING IMPACT: A MODEL FOR DISTRICT-LED PRIMARY HEALTH CARE TRANSFORMATION

Rwanda and Ghana | May 2026

Primary health care (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 strengthened health system performance through the PHC Performance Management (PHC-PM) Activity, an initiative led by government partners and implemented with local institutions, with support from the Gates Foundation and technical partners including Management Sciences for Health (MSH).

The Activity, implemented from 2023 to 2026, was designed to support District Health Management Teams (DHMTs) in both countries to:

- Take greater ownership of PHC performance: setting priorities, reallocating resources, and leading local improvements;
- Use data to identify service gaps, track progress, and guide decision-making;
- Strengthen coordination with communities and health providers, ensuring care is responsive and aligned with local needs;
- Drive tangible results in areas such as maternal and newborn health services, essential medicine availability, and data quality; and
- Demonstrate a scalable model of district-led leadership and adaptive management with potential to inform national policy.

This bulletin highlights the PHC-PM model, Activity achievements, and opportunities for scaling impact.

IMPACT AT A GLANCE

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Action plans implemented over four cycles of the PHC Leadership Development Program (PHC-LDP), anchored to a locally prioritized desired measurable result (DMR) spanning skilled delivery, immunization, maternal and child health, service readiness, and health information systems

$400K +

Catalytic grant funding provided to districts: modest, flexible resources that enabled DHMTs to translate local priorities and data insights into action, addressing PHC gaps not covered by routine budgets

100% (4)

Districts that improved routine data quality scores, building the evidence base DHMTs need to identify gaps, set priorities, and track progress across PHC improvement cycles

12

Strongly validated positive outcomes identified across Ghana and Rwanda, including improved leadership skills, DHMT efficiency, health worker transportation, and equipment availability at all levels of care

ABOUT PHC-PM

In many low- and middle-income countries, DHMTs are tasked with translating national policies into local action, often operating with limited data, decision-making authority, or financial resources. The PHC-LDP addresses this challenge by equipping DHMTs with tools, autonomy, and support to lead performance improvement.

Through adaptive performance management cycles, DHMTs continuously analyzed, monitored, learned, and adapted, maturing over time into effective stewards of district health systems.

The PHC-PM Activity was a collaboration among MSH, partners in Ghana (Ubora Institute, HISP), partners in Rwanda (Building Systems for Health, Three Stones International, Zenysis), and district and national health authorities.

CORE COMPONENTS OF THE PHC-PM MODEL

At the heart of the model were four interlinked components, each designed to reinforce district leadership, evidence-based decision-making, and sustained PHC system improvement.

1. LEADERSHIP DEVELOPMENT:

Using the Challenge Model, DHMTs and facility teams defined a shared vision for stronger PHC. They then defined DMRs that reflected that vision, assessed the current situation, identified root causes and obstacles, and designed focused, actionable plans to achieve meaningful improvements.

- Approximately every six months, DHMTs led structured performance improvement cycles, defining priorities, analyzing root causes, implementing actions, reviewing data, and adapting strategies based on lessons learned.
- With district-level coaching, DHMTs applied learning to strengthen day-to-day planning, supervision, and service delivery.
- Stronger leadership, accountability, and team-based approaches improved clarity of roles and ownership of results
- District actions were better aligned with national health priorities through more targeted, evidence-informed planning

> *"The grants let us test solutions our data identified—like neonatal kits—without waiting for central approval."*
>
> **— Bugesera DHMT Finance Lead**

2. OPERATIONAL DATA AND INTEGRATED DASHBOARDS:

District teams used a combination of operational data and integrated dashboards—built on national platforms like Ghana's District Health Information Management System II (DHIMS2) and Rwanda Health Analytics Platform (RHAP)—to identify service gaps, guide realistic planning, and track progress over time. Designed in collaboration with DHMT members, these tools supported more informed decision-making and fostered a culture of shared accountability. This approach:

- Leveraged national systems while incorporating locally relevant data sources
- Co-designed with DHMTs to reflect district spriorities and improve usability
- Used to identify bottlenecks, monitor performance, and guide corrective actions, track indicators, and adjust workplans

- Institutionalized routine performance reviews using PHC data with more frequent, structured DHMT meetings

3. ONGOING MONITORING, EVALUATION, AND LEARNING (MEL)

The MEL approach was built for learning and adaptation not just accountability. These practices ensured that districts could use evidence not only to report results, but to improve them.

- MEL partners supported data interpretation, guide documentation, and facilitated reflection.
- Insights were shared across learning platforms, informing decision-making within districts, sparking peer learning across districts, and shaping cross-country exchange and national policy dialogue.
- Outcome harvesting helped DHMTs connect improvements to the intervention (what's working and why)[1]
- Improved data literacy and use (district level) supported evidence-based decision-making and performance tracking.
- Increased collaboration and exchange of best practices across districts helped strengthen peer learning.
- The Activity contributed to global PHC knowledge through abstracts and thought leadership.

4. CATALYTIC GRANTS FUNDING

Each district deployed catalytic grant funding to accelerate implementation of their action plans to address system gaps identified through data and planning.

- Grants were flexible but tied to clear, measurable milestones within each six-month improvement cycle and aligned with approved action plans.
- DHMTs managed procurement, implementation, and reporting with clear requirements.
- Funds supported a range of activities, including outreach, supervision, training, and essential equipment.
- Enhanced financial autonomy and decision space at the district level through catalytic grants enabled locally driven solutions.

The model shifts power to districts, fostering local ownership while ensuring alignment with national priorities and local realities.

LOOKING AHEAD: PRIORITIES FOR SUSTAINING AND SCALING THE PHC-LDP APPROACH

1. **Institutionalize PHC-LDP performance management practices** by embedding routine data reviews, action planning, and leadership approaches within existing systems

2. **Sustain PHC-LDP gains by fostering local ownership and peer** networks to continue learning and adaptation through DHMT structures

[1] Outcome harvesting is an evaluation approach that identifies observed changes and works backward to determine how an intervention contributed. It is particularly useful in complex settings where attribution is not straightforward.

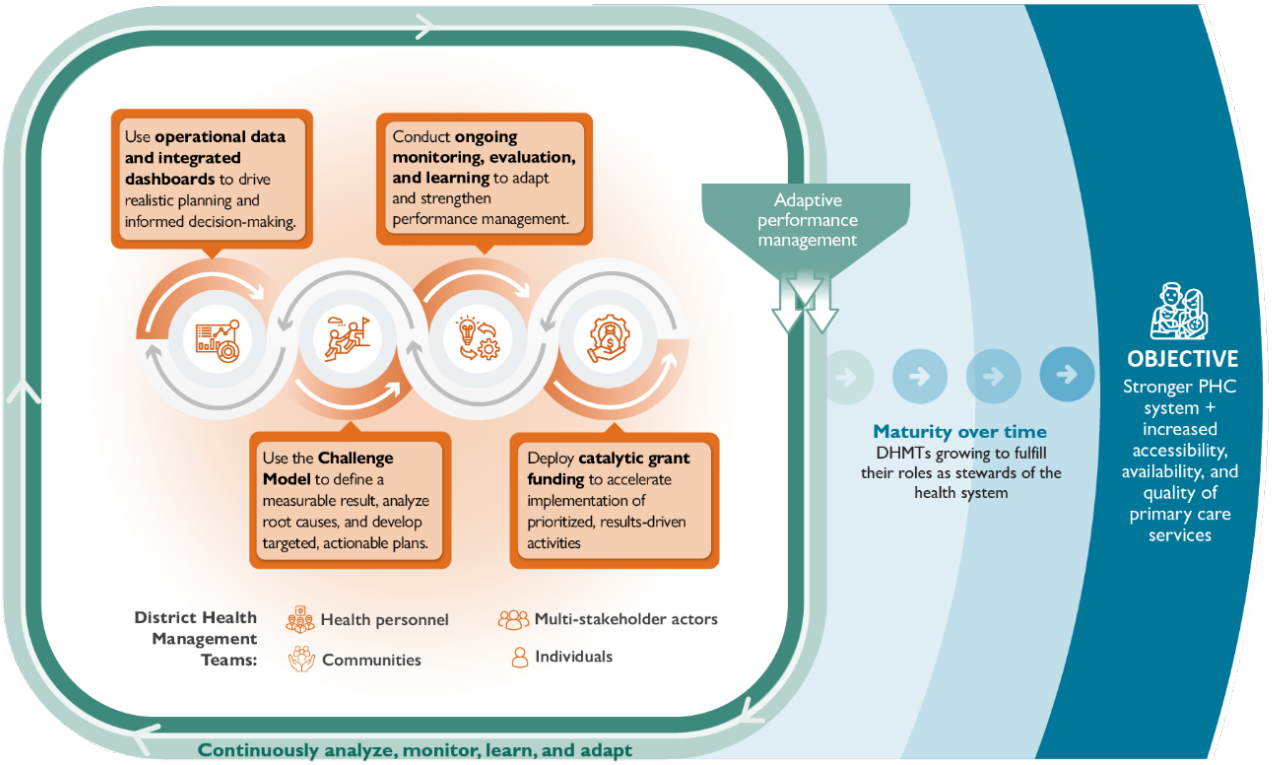
3. **Integrate and scale PHC-LDP data-driven decision-making** by expanding use of dashboards and routine data within national systems

4. **Enable national uptake and scale of PHC-LDP** by using district-level evidence to inform policies, planning, and supervision structures

5. **Position the PHC-LDP as a global public good** by packaging and disseminating tools, approaches, and evidence across low- and middle-income countries

6. **Explore AI-enabled performance management within PHC-LDP** by assessing use of large language models to interpret data, analyze root causes, and inform decisions.

Primary Health Care Leadership Development Program (PHC-LDP) in Ghana & Rwanda



PHC-PM ACTIVITY PARTNERS

- **DHMTs:** Led the PHC-LDP by using data; driving targeted action; engaging communities, health personnel, and multisectoral actors; and continuously adapting to improve performance and system stewardship
- **MSH:** Grants administration and cross-country coordination
- **Ubora Institute (Ghana):** PHC-LDP coaching and MEL
- **Building Systems for Health (Rwanda):** Performance improvement
- **Three Stones International (Rwanda):** MEL
- **HISP (Ghana)** and **Zenysis (Rwanda):** Dashboard integration
- **Ministries of Health:** Policy alignment and scale-up

COUNTRY SPOTLIGHT: GHANA

Districts: Akwapim South (Eastern Region) & North Tongu (Volta Region)
Partners: Ubora Quality Institute (performance improvement, monitoring, evaluation, and learning), HISP Ghana (dashboard development and training)

In Ghana, the DHMT is responsible for planning, coordinating, supervising, and monitoring the delivery of health services at the district level, using routine data to guide performance improvement and decision-making. From March 2024 to December 2025, DHMTs used the PHC-LDP to address key priorities within service delivery and DHMT function. Several assessments were conducted throughout the duration of the Activity to understand its impact, including assessing DHMT function, data use, behaviors, and lessons learned.

What DHMTs Prioritized

Skilled Delivery & Newborn Care
- *Improve skilled delivery*
- *Reduce neonatal mortality*
- *Reduce anemia in pregnancy at 36 weeks*

Immunization Coverage
- *Improve measles-rubella (MR) 2 coverage*
- *Reduce variation between MR and RTS,S (malaria) doses*[2]

Service Utilization
- *Increase family planning acceptor rate*
- *Improve outpatient per capita*
- *Reduce National Health Insurance Scheme (NHIS) claim rejection rate*

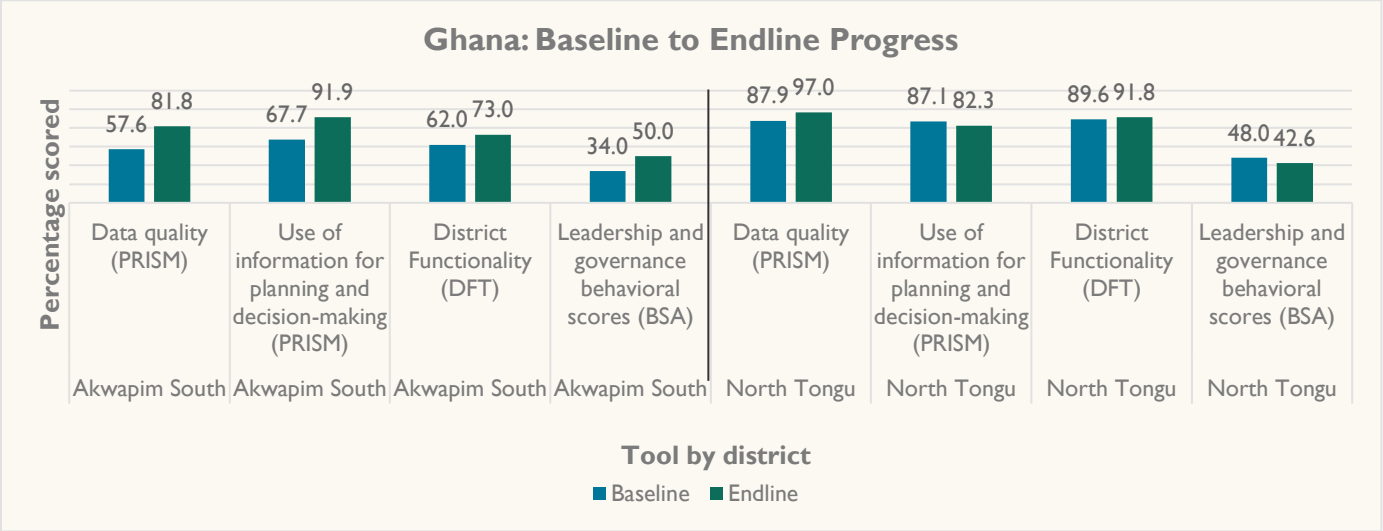
PHC Service Readiness
Reduce stockouts of essential commodities

Selected Results[3,4]

North Tongu		Akwapim South	
Increase skilled delivery Feb – Dec 2025	63.6% → **89.6%**	***Increase skilled delivery*** Mar 2024 – Dec 2025	26% → **35%**
Reduce anemia in pregnancy at 36 weeks Mar 2024 – Dec 2025	36.4% → **25.6%**	***Improve outpatient per capita*** Mar 2024 – Dec 2025	0.62 → **0.99**
Increase FP acceptor rate Aug 2024 – 2025	30.3% → **39%**	***Improve MR2 coverage*** Aug 2024 – Dec 2025	63% → **74%**
Decrease MR2 & RTS, S4 Aug 2024 – Dec 2025	17.3% → **7%**	***Reduce NHIS claim rejection rate*** Mar 2024 – Dec 2025	17.3% → **4%**

[2] Measles-rubella vaccines and RTS,S doses (vaccination against malaria) are often delivered concurrently; discrepancies in vaccination rates reflect opportunities to ensure stronger routine immunization.
[3] Data collection used three tools in both countries: The Performance of Routine Information System Management (PRISM) assessment was conducted to measure the status of routine information system data quality and use. The District Capacity/Functionality Assessment was conducted to evaluate the status of team-based approaches in alignment with DHMT's functional role. The Leadership, Management, and Governance Behavioral Self Assessment evaluated application of leadership, management, and governance behaviors.
[4] Data pulled from Ghana's DHIMS2.

Figure 1. Endline Assessment Results in Ghana (Mar 2024 – Jan 2026)



How Change Happened

- Both districts strengthened DHMT functionality and data use over the course of implementation.
- Improvements were iterative and sustained, with progress observed across cycles and process indicators as well as in final DMR results.
- Data quality, completeness, and reporting improved, enabling more consistent use of information for planning and decision-making.
- Leadership and governance practices strengthened significantly, with gains in participation, coordination, and accountability.
- Core systems (supervision, coordination, and reporting) remained strong while highlighting targeted gaps for further strengthening (e.g., routine data use and documentation).[5]

What we learned

Qualitative assessments conducted at Activity endline identified insights from DHMTs, health service users, and health workers within the following themes:

- **Community engagement:** Community engagement was cited as essential in Ghana; however, persistent NHIS misconceptions, inconsistent medicine availability, and transport constraints limited outreach, which was compounded by underutilization of community leaders in North Tongu.
- **Catalytic grants:** Flexible grants addressed longstanding gaps (procurement, training, and transportation) and strengthened expenditure tracking, though questions remain on sustaining grant-funded activities.
- **Data and dashboard use:** While dashboards were used consistently in review meetings and for facility feedback, connectivity issues in Akwapim South and perceived redundancy with DHIMS2 in North Tongu posed barriers to routine use.
- **Sustainability:** Budgetary constraints remain the primary barrier to sustaining PHC-LDP practices; proposed plans focus on long-term community ownership and establishing quarterly support mechanisms.

[5] Overall, variations in survey participants across implementation cycles, including the introduction of new staff who had limited exposure to the PHC-LDP, may have influenced the overall behavioral scores, especially in North Tongu.

COUNTRY SPOTLIGHT: RWANDA

Districts: Bugesera District and Gicumbi District
Partners: Building Systems for Health (performance improvement), Three Stones International (monitoring, evaluation, and learning), Zenysis (dashboard development and training)

The DHMT in Rwanda coordinates and oversees district health service delivery, translating national health ministry policies into action through local planning, supervision, and resource management. Between March 2024 and December 2025, DHMTs in Rwanda engaged in the PHC-LDP to strengthen primary health care service delivery and improve DHMT functionality. A series of assessments were conducted to evaluate its impact, covering DHMT functionality, data use, leadership behaviors, and lessons learned.

What DHMTs Prioritized

Maternal & Child Health

- *Reduce neonatal mortality*
- *Improve coverage of first antenatal care visits (ANC1)*
- *Improve anemia testing*
- *Reduce malnutrition in children under age 2*

Health Systems Management

- *Improve record-keeping and contract/asset management*
- *Improve leadership, management and governance practices*

Service Availability

- *Dental care services*
- *Eye care services*

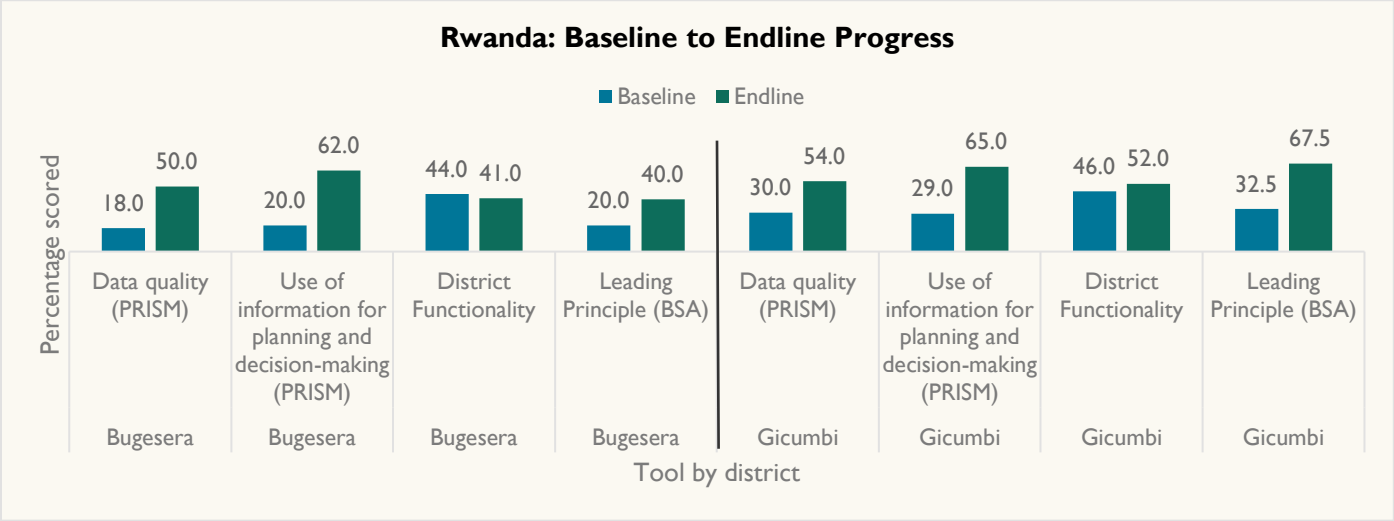
Health Information Systems

- *Improve health facility reporting & data accuracy*
- *Improve health post reporting in Health Management Information System (HMIS)*

Selected Results

Bugesera		Gicumbi	
Reduce neonatal mortality (per 1,000 live births) Mar – Sep 2024, Jun – Dec 2025	11.6 → **7.8**	***Reduce malnutrition (stunting) in children <2*** Mar 2024 – Dec 2025	23.6% → **16.2%**
Improve ANC1 coverage Mar – Sep 2024, Jun – Dec 2025	35% → **56%**	***Improve dental care service availability*** Sep 2024 – Dec 2025	**2,167** additional patients reached
Health facilities providing monthly reports Oct 2024 – May 2025	80% → **100%**	***Improve eye care service availability*** Sep 2024 – Jun 2025	**4,744** additional patients reached
		Improve anemia testing in pregnancy Mar 2024 – Aug 2024	78% → **96%**

Figure 2. Endline Assessment Results in Rwanda (Mar 2024 – Jan 2026)



How Change Happened

- **Data quality and use improved significantly in both districts,** reflecting sustained investment in information systems.
- **Progress was consistent and multi-layered,** visible not just in final DMR scores but throughout implementation cycles via process indicators, suggesting systemic rather than one-off gains.
- **DHMT functionality showed overall positive results:** both districts experienced improvements in their overall functionality.[6]
- **Leadership and governance strengthened in both districts**, with improvements in planning, participation, and self-assessment scores.
- **PHC outcomes diverged by district**: Bugesera outpaced national trends on neonatal mortality and ANC1 coverage, while Gicumbi's outcomes largely tracked the national average.

What We Learned:

End-of-project qualitative assessments with DHMTs, beneficiaries, and health workers yielded the following insights across four themes as in Ghana:

- **Community engagement:** Increased mobilization around ANC and outreach generated demand that outpaced available staff and equipment, addressed through specialist-led outreach in Gicumbi and new equipment purchases in Bugesera
- **Catalytic grants:** Grants enabled DHMTs to pilot new services, procure equipment, and strengthen training and supervision, filling gaps where no dedicated budget lines existed.
- **Data and dashboard use:** RHAP dashboards were used primarily in DHMT coordination and quarterly meetings; routine use outside formal settings remained limited by low user confidence, restricted access, and RHAP/DHIS2 discrepancies.
- **Sustainability:** PHC-LDP strengthened evidence-based decision-making within national priority constraints; sustainability risks center on staff shortages and budget gaps once Activity funding ends.

[6] Overall DHMT functionality increased in both districts; however, there was a modest decline in the supervision component (Gicumbi) due to staff changes which contributed to a discontinuation of presentations on stockouts during routine coordination meetings.

OUTCOME HARVESTING

As part of the Activity's midline evaluation, an outcome harvesting exercise was conducted in both countries. This approach observes changes (or outcomes) at the district level and systematically ties them back to specific components of the intervention.

Findings covered both performance management outcomes as well as changes in key PHC areas as a result of the project's activities. Through analysis of key informant interviews in each country, the study team identified several changes that occurred due to the PHC-PM Activity:

- **Ghana:** The PHC-LDP in Ghana resulted in different DHMT practices, staff flexibility in duties and schedules, and integration of family planning services into home visits, which led to improvements in outpatient attendance rates and skilled delivery rates in both districts.
- **Rwanda:** There was increased meeting frequency (from quarterly to monthly), enhanced meeting attendance and participation, and improved collaborative culture. Those improvements supported better planning and implementation. As a result, both districts demonstrated more targeted and evidence-informed referrals of pregnant women from health centers to hospitals and, in Gicumbi, a specific increase in ANC1 visits.

Outcomes were grouped via theme and classified as intended vs. unintended; positive vs. negative; and strong, medium, or weak validity.[7] Table 1 lists identified outcomes in each country.

Table 1. Identified outcomes resulting from the PHC-PM Activity

Intended | Unintended | Positive | Negative | Validation: ★★★ Strong ★★ Medium ★ Weak

Ghana	Rwanda
Staff demonstrate increased overall leadership skills and knowledge at all levels of care. ✓ | 👍 | ★★★	DHMT meetings are more frequent. ✓ | 👍 | ★★★
Facilities show increased equipment availability and service delivery capacity at all levels of care ✓ | 👍 | ★★★	DHMT meeting attendance rates have increased, and members participate more actively during meetings. ✓ | 👍 | ★★★
Skills gained from the program have enhanced data quality/capture and use at all levels (DHMT and facilities). ✓ | 👍 | ★★★	DHMT meetings are more efficient, structured and geared towards improving PHC. ✓ | 👍 | ★★★
Availability of means of transport for health workers has increased community outreach services, and health worker visibility, thereby bridging access gaps and expanding reach. ✓ | 👍 | ★★★	DHMT composition is more diverse and open (technical experts are invited). ✓ | 👍 | ★★★

[7] Outcome validity was classified as strong if outcomes were corroborated by most primary and secondary sources; medium if they were validated by some primary sources; and weak if they were not validated by primary sources.

Ghana	Rwanda
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. 	Human resource and financial operations in the health centers improved (e.g., procurement, paying of salaries on time, personnel files). 
Team-based service delivery strengthened. 	More pregnant women attend ANC1 visits in health centers. 
Overall improvement in PHC and service delivery due to knowledge gained, led to revamped accountability and monitoring mechanisms causing a shift in attitude towards work 	Improved data management skills result in more timely and complete reports to the district office. 
Involvement of the community improved its participation in and support for primary care services through volunteering, advocacy, mobilizing, and donation. 	DHMT members collaborate more closely and effectively. 
Community engagement and consistency in service delivery improved confidence in local health services. 	Community health workers have more capacity and feel more empowered to support community mobilization in their districts. 
Health workers better understood the role traditional birth attendants play in skilled delivery and fostered linkages with and referrals to them, enhancing community health. 	Collaboration among health centers improved (e.g., exchanging equipment, heads meeting more regularly) 
Workloads increased as a result of intensive action plan implementation. 	Referrals of pregnant women from health centers to the hospitals are more targeted, and triage is more effective. 

Ultimately, DHMTs in all four districts cited notable shifts in their management practices, as well as health outcomes in key PHC areas of interest. 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.