Learning Question 1: *What are the contributions of systems thinking approaches and tools to changes in health system outcomes? How do systems thinking approaches affect health system outcomes?*

Strengthening District Health Planning

HEALTH SYSTEMS STRENGTHENING ACCELERATOR

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Context

- Strength of a health system is reflected in the capacity of its functionaries to effect changes at the local level to close quality and equity gaps.
- Therefore, Government of India has mandated development of District Health Action Plans (DHAP) to drive the resources and budget through Program Implementation Plan (PIP)
- There exists much disparity at the district level and every district needs a customized plan.
- Currently, despite decentralization of the process most plans take final form at the state level and is merely a revised version of the previous plan. Decentralized planning in states and districts in the development of DHAP is mostly ad hoc and non-evidence based.
- District plans, often, do not address local priorities and are not contextual to the realities.
- Furthermore, there is lack of capacity among health program managers in planning and use of available data leading to poor reflection of local health priorities.
- To cap it all, a lack of autonomy or decision space limits the use of district-specific evidence.
- Studies have pointed to the need to develop capacity for planning, prioritizing, transparency, and accountability among program managers at the district level.
- Aspirational Districts are a special focus of the Government of India as these are poor-performing districts that lag national averages on socio-economic indicators in terms of health and development.

Activity Description

RMNCHA Action Agenda Using Strategic Approach (**RAASTA**) is an adapted program review tool used to capacitate program officers to make health plans using available data. Through a six-step process, they are guided to prioritize, examine intervention coverage in their district, link it with health system building blocks, identify problems, opportunities and solutions and arrive at recommendations, most of which were incorporated in the state program implementation plan (PIP).

RAASTA Steps

Step-1
Reviewing health goals, objectives and outcomes to determine state priorities.

Step-2
Reviewing coverage of RMNCH+A interventions based on NFHS and district HMIS data –assessing the extent to which various interventions are reaching beneficiaries in district.

Step-3
Assessing status of Activity areas - advocacy, human resources, supply & logistics, referral pathways, communication, supervision and quality of data.
Deciding reasons for failure or unsatisfactory implementation

Step-4
Listing interventions/packages that require attention to improve coverage across the RMNCH+A spectrum and from this they summarize the main problems for further analysis.

Step-5
Analysing the main problems, and their causes. Proposing solutions for effective implementation and recommendations for the work plan.

Step-6
In the sixth and final step the proposed actions were presented to the Mission Director, senior state and district officials for their support and commitment and inclusion in PIP.

- The activity involved regional and district-level program managers in a carefully planned and structured participatory **3 days' workshop** facilitated by the project staff to generate prioritized action plans.
- The workshops were conducted for 24 Aspirational Districts across 4 states and **24 DHAPs were developed** in alignment with the PIP cycle. Additionally, DHAPs were developed for 2 non-aspirational districts of state Madhya Pradesh later in the year.
- A blended format with use both of participatory workshop and a **digital tool 'eRAASTA' was used. The e RAASTA tool was developed** to facilitate better time utilization and convenience for data collation and analysis. The digital tool has e version of the worksheets to be used and also serves as a repository of district data.

Activity Impact

26 DHAPs were prepared for districts in states of Jharkhand (19), Uttarakhand (2), Haryana (1), Punjab (2) and Madhya Pradesh (2)

Examples of results obtained from RAASTA steps

1 Where are we going? Priority health areas
- Slow reduction in NMR & MMR
- Slow reduction in Still birth rate per 1000 population
- Slow reduction in Perinatal Mortality Rate
- Reduction in TFR in vulnerable geographies

2 Are interventions reaching women, new-born and children? Interventions with low coverage
- Low coverage of full ANC
- Low coverage of deliveries by skill birth attendants
- Low coverage of Zinc in the children with diarrhoea.
- Low coverage of mothers/newborns who had a care contact in the first 2 days after delivery
- Low coverage of babies below 200 gm who received KMC
- Lower institutional delivery rate
- More number of women aged 15 to 19 years who are already mothers

3 How well are program activities being implemented?
Status of implementation (fully, partially or not at all) and their reason along with Strengths and Weaknesses listed for all activities listed below -
- Advocacy , HR Recruitment
- Training / HR development
- Strengthening supplies of medicines and equipment
- Strengthening referral pathways
- Communication/ developing community support
- Supervision, Monitoring, Data Availability, Quality and review, feedback, death audits

E.g. WIFS- Advocacy for regular supply of IFA syrup and tablets. Interdepartmental coordination among health, education and ICDS

4 Identify the main problems the program has faced?
- Low ANC due to shortfall of ANM and their supportive supervision and lack of early registration due to behavioural practices. **Packages** - VHSND, HWC, PMSMA
- Non- functional 24X7 NBSU due to shortage of HR and their training and supervision.
Packages – FBNC

5 What are the solutions and recommendations?
Based on the summary of all the 4-steps converted to recommendations for the State. e.g. – Hiring of one computer assistant in PHC Bisru, Orientation of 1122 ASHAs on new PMSMA guidelines and use MCH card as counselling tool, Training of Supervisors on PMSMA, Mobility support for supportive supervision, MDR and CDR topic in each monthly meeting.

6 What are the next steps for acting on recommendation?

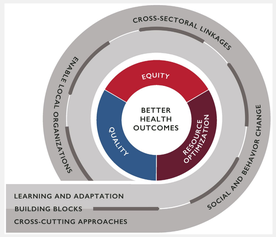
The vulnerable population including large tribal areas in the 26 districts that the activity impacted include	
❖45.8 M total population	❖ 1 M infants
❖1.1 M pregnant women	❖4.1 M under 5 children.

Examples of RAASTA Recommendation included in the State PIP

State Priorities Uttarakhand	Priority Intervention	Prioritized Problems	Recommendations included in State PIP
Accelerate reduction in NMR	Facility Based Newborn Care	Vacant HR Positions	Recruitment of Staff Nurses and Medical Officers Recruitment of ANMs for Vacant Subcentres
Reduce IMR & U5MR with focus on addressing Childhood Illness, Wasting & Anemia in Children	Home Based Care of Young Child (HBYC)	Supplies of medicines and equipment for outreach services	Procurement of essential commodities for Diarrhea pneumonia management (ORS, Zinc and Antibiotics) Procurement of multi modal pulse oximeter
State Priorities Jharkhand	**Priority Interventions**	**Problems Identified**	**Recommendations Included in State PIP**
Significant reduction of NMR	KMC and early initiation of breast feeding	KMC in the facilities including SNCUs	Introduce Family Participatory Care training for SNCU staff
Reduce Maternal, Childhood, Adolescent Anaemia & Obesity in urban areas	Anemia Mukt Bharat	Identification of severely anemic pregnant women	Strengthening Anemia screening at VHSND-ANM incentive for line listing and follow up of severely anemic women

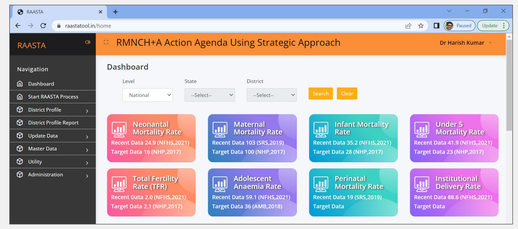
Number of recommendations aroused from the action plan and included in the state PIPs and key problem statements derived under thematic heads were as follows-

Maternal Health	Neonatal and child health	Family planning and adolescent health	New activities in RMNCH+A
23	24	4	15



Facilitators

- Aligning the activity with the government budgetary cycles helped in involvement and interest of all stakeholders , and many recommendations with evidence- based justifications derived from the RAASTA workshop were included in the state PIPs.
- The **e RAASTA tool** developed by the project helped in data collation and analysis and gave more time for discussions
- The participatory approach in a workshop mode , and involvement of stakeholders from District and Block led to active discussions during the review process and threw up different perspectives and solutions for local issues
- Willingness and acceptance of several new priority activities which were identified through RAASTA workshop and were guided by evidence , by state authorities for budgetary allocation facilitated ownership and acceptance of the activity.
- The workshop itself presented opportunities for immediate feedback as each group worked on individual district worksheets with facilitators.
- The tool was developed adapting the WHO program review tool and was advocated to the state governments through presentations. The states expressed interest in conducting the review.
- Aspirational Districts being a key priority of Government of India , helped in acceptance of the recommendations and actions suggested in DHAPs



Challenges

- The 3-day workshop provided limited time for discussions across all RMNCHA thematic groups. It is suggested that in the future to have a 5-day workshop ensuring sufficient time for discussion.
- Collection of data and Data analysis takes up much time. The project developed a digital tool **e-RAASTA** that facilitates prior analysis of data providing more time for developing recommendations.
- Non availability of data for some indicators at the district level was circumvented by using state-level data for such indicators or deriving estimates
- District level data from surveys was often outdated and did not reflect the current situation
- Fixed resource envelope earmarked for each state limited the number of activities derived during workshop which could be included in PIP

Evidence

- One of the states (Uttarakhand) has already included the RAASTA workshop as an approved budgeted activity for preparation of district plans prior to budgetary cycle , for all the districts in the next financial year.
- State decision-makers showed great receptivity to the workshop and acceptance of the action plans. Highlighting their perspective on RAASTA in their words **"In this workshop, we learned to analyze gaps in our planning system. As managers, we now have a new perspective on the use of and flow of the data." said District Program Manager, Haridwar (Uttarakhand).**
- The project through a qualitative study understood the participants' perception of the activity and its impact (https://onlinelibrary.wiley.com/doi/10.1002/hpm.3290).
- RAASTA was perceived as a participatory process allowing two-way communication. A district program coordinator reported having a sense of personal involvement as the subject matter was closely related to their work, **"What I think is the work plans we came out with, the discussion we had, it was based on our feed back and I felt that something good will come of this. Since the PIP was close, I felt myself being more involved".**

Lessons Learned

- Developing programme capacity at the sub-national level is essential for decentralised planning and prioritisation
- Being guided to examine data from the perspective of planning facilitates willingness to use data
- Developing evidence-based health plan is the first step towards achieving evidence-based intervention coverage using continuum of care approach leading ultimately to achievement of health goals.
- A culture of listening and responding to those highlighting local problems and solutions needs to be cultivated and nurtured among policymakers.
- The RAASTA activity provides opportunity to harness local, contextual knowledge on the same platform to understand available data and link them to global evidence-based intervention
- A participatory form of planning and capacity building before the PIP process helps in collective ownership for deriving action plans
- Support in RMNCH+A program planning can be consolidated through this mechanism that builds capacity of health planners and programmers to use evidence in health action planning. Potential impact will be felt on efficient use of human resources and data resources within the public health system to deliver maximum coverage to the most vulnerable populations.

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