Question 2: *What are effective and sustainable mechanisms or processes to integrate local, community, sub-national, national, and regional voices, priorities, and contributions into health system strengthening efforts?*

Putting the locals into action : Health system strengthening model in vulnerable geographies of India

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Organization: SAMVEG Project supported by USAID (*1. IPE Global Limited, 2. JSI India, 3. World Health Partners*)

HEALTH SYSTEMS STRENGTHENING ACCELERATOR

Context

- The reduction in maternal, newborn, child, and adolescent mortality and stillbirths are attributed to the increased coverage of high-impact, evidence-based interventions. District functionaries ostensibly have a major responsibility to develop evidence-based local plans for RMNCAH based on the program strategies developed at the national level. However, **implementation challenges related to equity, Quality, and optimal resource utilization** at the sub-national level have led to poor coverage of essential interventions. Although these interventions are simple and effective, their population-based coverages are sub-optimum and usually below 90%. Well-planned and managed programs are more likely to improve intervention coverage and thus reduce maternal, newborn, and child mortality and morbidity and achieve Sustainable Development Goals (SDG) by 2030. [1]
- NITI Aayog of the country started a flagship initiative to uplift 112 backward districts named aspirational districts (AD) that need to catch up in specific **development parameters of health and nutrition, education, agriculture and water resources, financial inclusion, skill development, and basic infrastructure**. The heightened need for capacity at the district level was expressed at a steering committee meeting- Aspirational Districts of the MoHFW in 2019. It was proposed that development partners support DHAP in AD for evidence-based effective data usage to address local bottlenecks[2]
- District planning and implementing health plans for RMNCAH in India are ad hoc and non-evidence-based (Figure-1). The noninvolvement of all stakeholders (Implementers from all Levels of the Health system, Private providers, Professional bodies, Local Development partners, Academia), lie at the heart of ad hoc planning. [3]

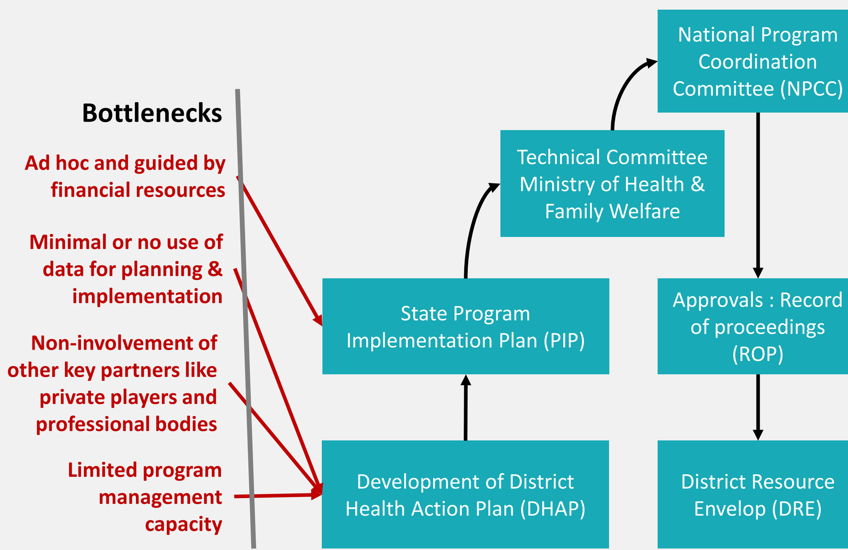


Figure 1: Existing Planning Process & bottlenecks

Previous year's funds also determine priorities to a large extent. Although decentralization in health program planning has had several years of existence in India, local data and needs are not represented. Often, district plans are based not on local priority but on national health goals.

The significant bottlenecks identified by the project →

1. Weak public health program planning capacity at the local level.
2. Sub-optimal involvement of stakeholders, including the private sector.
3. Inadequate collection and use of data for action.

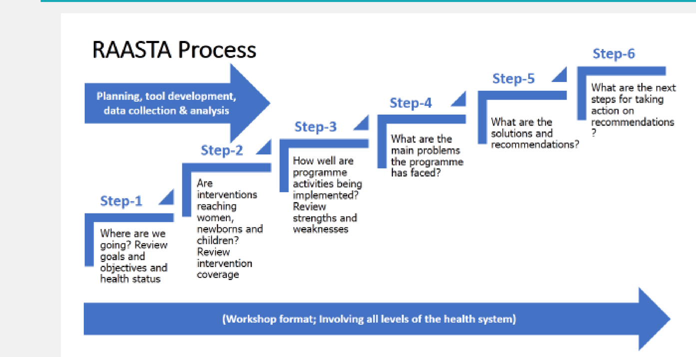
1. Improving maternal and newborn health and survival and reducing stillbirth – Progress report 2023 - World Health Organization
2. https://www.niti.gov.in/aspirational-districts-programme
3. Abhay Shukla, Renu Khanna, Nitin Jadhav, Using community-based evidence for decentralized health planning: insights from Maharashtra, India, *Health Policy and Planning*, Volume 33, Issue 1, January 2018, Pages e34–e45, https://doi.org/10.1093/heapol/czu099 | Avan BI, Berhanu D, Umar N, Wickremasinghe D, Schellenberg J. District decision-making for health in low-income settings: a feasibility study of a data-informed platform for health in India, Nigeria and Ethiopia. *Health Policy Plan*. 2016;31 Suppl 2(Suppl 2):ii3–ii11. doi:10.1093/heapol/czw082 | Bhattacharyya S, Berhanu D, Taddesse N, et al. District decision-making for health in low-income settings: a case study of the potential of public and private sector data in India and Ethiopia. *Health Policy Plan*. 2016;31 Suppl 2(Suppl 2):ii25–ii34. doi:10.1093/heapol/czw017

Activity Description

25 Vulnerable Districts (Jharkhand, Uttarakhand, Haryana, Punjab, HP)-Covering around 3.5 million MNCH population

Key Problems	Approach	Solution	Key Outcomes	Impact
1. Weak public health program planning capacity at the local level. 2. Sub-optimal involvement of the partners, including the private sector. 3. Inadequate collection and use of data for action.	1. Strengthen the local planning capacity through an innovative tool in vulnerable geographies. 2. Partnerships with local private sector networks(Private players (Providers, NGO, Professional bodies, manufacturers, and academia) 3. Use local data to visualize availability, accessibility quality and community knowledge bottleneck	1. RAASTA -Local planning process 2. Total Market Approach involving local private players 3. Data for gap analysis and visualization for Quality Improvement	1. Districts Evidence-based health implementation plans developed with local stakeholders. 2. Local Partnerships forged with (Professional Bodies, Local innovator, Pharmaceutical, Device manufacturer, MS Creator and academic institution) 3. FRU Quality Care Index and MNCH Factsheets developed in districts	Health System Strengthening with improvement in MNCH indices in 25 Aspirational Districts

RAASTA local planning process -To strengthen the planning process for improving access, equity, and quality involving State and district functionaries from all health system levels, Professional bodies, development partners, academia, and NGOs.



Activities conducted to develop an evidence-based workplan using RAASTA Process –

- Finalization of Tools for RAASTA Process.
- Review of country RMNCHA guidelines and strategy documents.
- Data collection and compilation from different sources.
- Participants across key government functionaries and program managers at the sub-district level, health workers from primary, secondary, and tertiary levels, the development sector, and private communities involved.
- District health action plan developed for 25 districts using RAASTA steps.

Total market approach involving local private players- To increase equitable and sustainable access to effective interventions through partnerships, Private players (Professional bodies, Innovators, Drug suppliers, private manufacturers, academic institutes, and local NGO

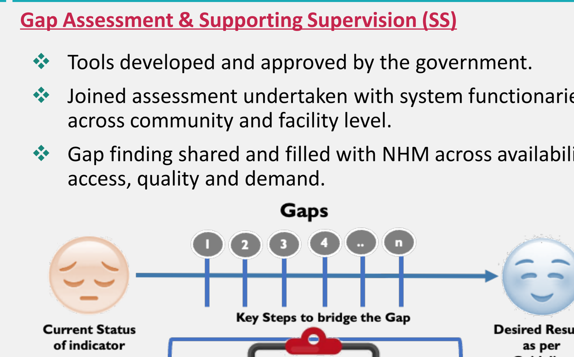
Need-Based Demonstration Models

- **INNACCEL**: Strengthening management of Respiratory Distress in neonates with a focus on the use **of CPAP device**
- **PREGNA**: Strengthening PPH Readiness & Care using **pre-assembled Uterine balloon tamponade**
- **FERRING**: Strengthen AMTSL - PPH Prevention using **carbetocin**
- **FOGSI & IAP**: Establishing thematic consortiums for strengthening the private sector in the use of **Antenatal Corticosteroids and Promoting Family Centered Care**
- **Laderal – Learning management system (LMS) for community workers** strengthening home visits.
- **Maternity Foundation**: **Safe Delivery App an LMS for care around birt**h for health workers at facility level

Data for gap analysis and visualization- For Quality Improvement through collection and analysis for action by key government functionaries

Gap Assessment & Supporting Supervision (SS)

- Tools developed and approved by the government.
- Joined assessment undertaken with system functionaries across community and facility level.
- Gap finding shared and filled with NHM across availability, access, quality and demand.



FRU Quality Care Index (FQCI)

- Tool developed for FRU Quality Care Index
- FQCI generated across 25 intervention districts.
- Color coded gap analysis shared with facilities for improvement

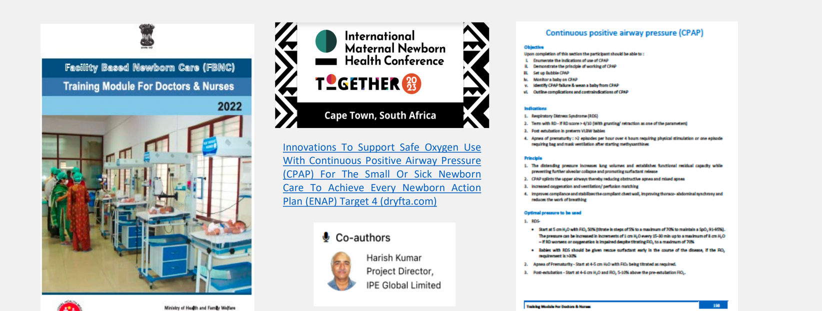
Activity Impact

1. RAASTA local planning process

- Local issues related to equity, access and quality with resource optimization developed in 25 districts with vulnerable population.
- Capacity development of program managers from 4 States and 25 Districts for developing implementation plans strengthened using RAASTA tool.
- RAASTA learning shared with Global Communities through 2 scientific publications
- IPE Global after taking technical assistance from SAMVEG developed 'RMNCAH Short program review" for WHO-SEARO
- The project is providing technical assistance to different partners i.e., WHO, UNICEF, NHRC for scale-up in entire country.
- State have made financial provisions for developing evidence based workplan from next financial cycle.

2. Total market approach

- Bubble CPAP model led to quality improvement for care of sick and small newborn with respiratory distress in 7 districts. CPAP has now been included in the National Guidelines of the country "Facility Based Newborn Care (FBNC) – Training module for doctors & nurses for the entire country. This model has been scaled up in another state of India (ASSAM) with technical support from SAMVEG project.
- Learning of bCPAP implementation model shared in Global MNHI conference in Cape Town.
- Improving the quality of PPH management has been accomplished in 9 facilities of 2 States through its model using UBT. This model is in the process of scale-up in 2 another states Punjab & MP. In addition, model for prevention of PPH with use of carbetocin implemented in one state and has been endorsed by professional bodies for private providers and is under active consideration for possible scale-up in public health system of country.
- The partnership with professional bodies has led to the scale up of capacity building of private health provider on family centered care and optimal use of antenatal corticosteroid for improving equity, access and quality amongst private providers in 2 states.
- **Learning management system (LMS) for community workers** strengthening capacity of community health workers with their own resources for improving quality, equity and access through home visits scaled up in 2 States.
- Safe Delivery App LMS for strengthening capacity of health workers for providing care at birth has been scaled up countrywide by the public health system



3. Data for gap analysis

- Data for gap analysis and visualization for Quality Improvement identified 12,872 quality gaps which led to strengthening them and so far, 5004 Gaps addressed.
- FRU Quality Care Index scaled up in Jharkhand State.

Mission Director NHM, Jharkhand – Scale up FQCI in entire State

Evidence

NITI Aayog (National Institution for Transforming India, Government of India) a think tank, knowledge and innovation hub tracks progress through an independent evaluation and HMIS progress in district for equity, access, quality and resource optimization. The current weightage of different component of Health is shown in Chart-1.

The performance of the districts are available in the public domain portal named "Champions of Change".

The project used the information for its own analytics to measure the progress depicted in Figure-1 and Figure-2.

Chart-1: Weightage of Different Health Components

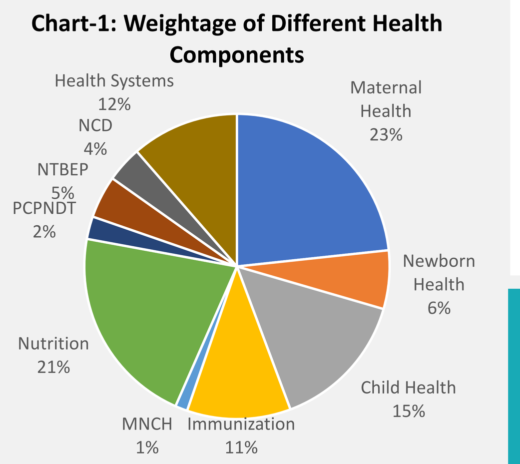
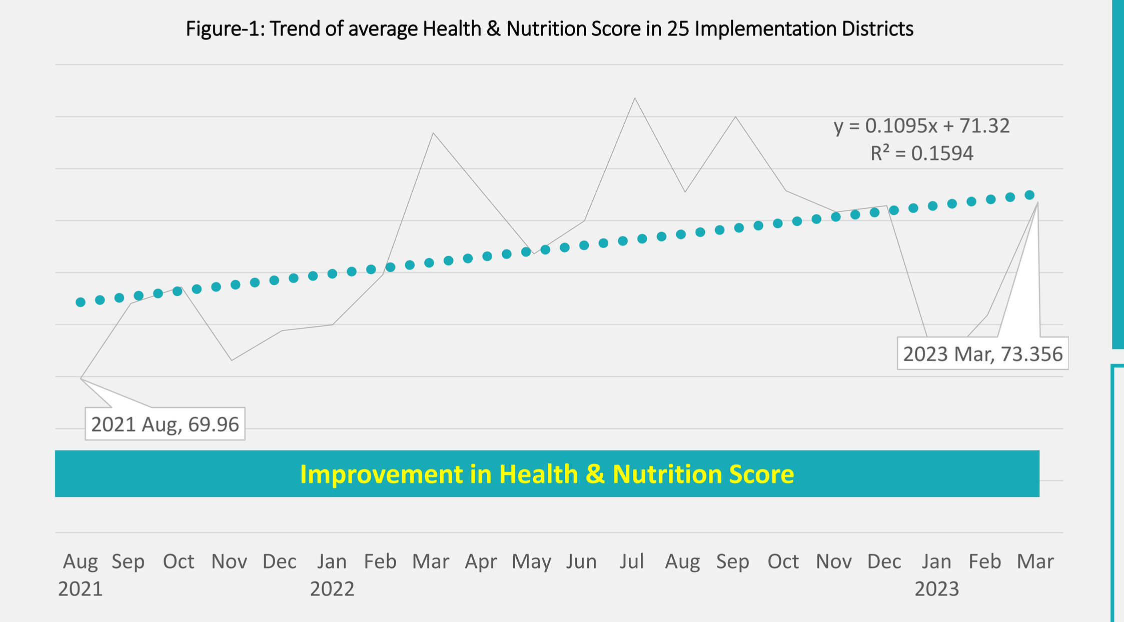


Figure-1: Trend of average Health & Nutrition Score in 25 Implementation Districts



The 3-pillar assisted in Improvement in equity, quality and resource mobilization to the tune of INR 1092 Million approved in PIP for 2022-23. ***(Source: State ROP)***

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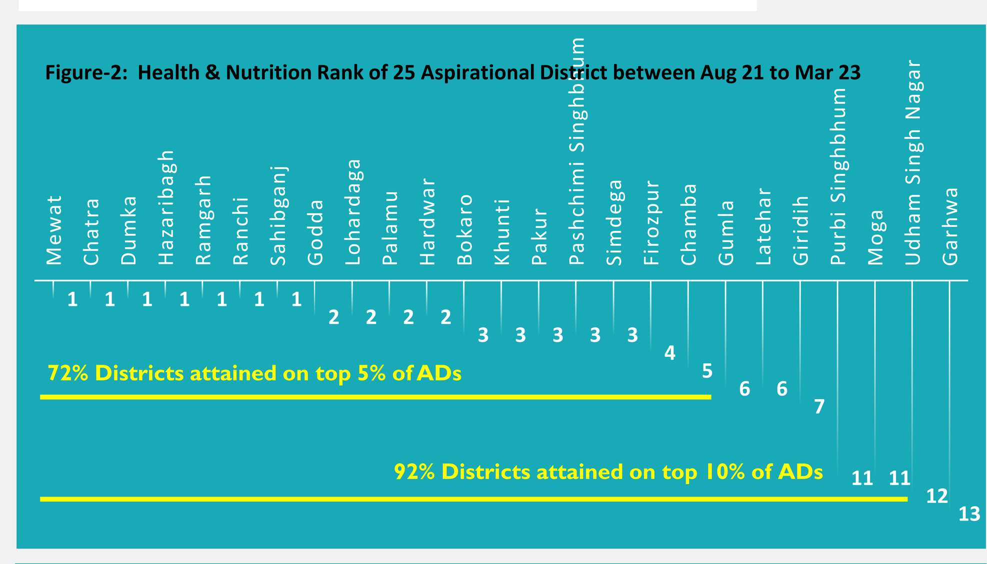
TABLE 1 Number of recommendations included in state PIP

	Maternal health	Neonatal and child health	Family planning and adolescent health	New activities in RMNCH + A
Jharkhand	9	11	2	8
Uttarakhand	14	13	2	7

https://onlinelibrary.wiley.com/doi/10.1002/hpm.3290

Figure-2: Health & Nutrition Rank of 25 Aspirational District between Aug 21 to Mar 23



NITI Aayog

Top 5 Districts Based On Health & Nutrition Rank

1. Ramgarh, Jharkhand
2. Godda, Jharkhand
3. Hazaribagh, Jharkhand
4. Pashchimi Singhbhum, Jharkhand
5. Sahibganj, Jharkhand

All Top-5 Districts in March-23 are SAMVEG implementation districts

Source: http://championsofchange.gov.in

Facilitators

- Aligning the activity with the government implementation plan development cycles helped create stakeholders' ownership.
- The participatory approach and the involvement of stakeholders from the District and sub-district levels led to active participation during the review process and identifying vulnerable geographies.
- The e RAASTA Review presented opportunities for immediate feedback on individual district worksheets with facilitators.
- The e RAASTA tool developed by the project helped in data collation and analysis and saved time for discussions.
- Willingness and acceptance of activities for solving access, equity, and quality bottlenecks, led to budgetary reallocations.
- The tool was developed by adapting the WHO program review tool and was advocated with the state governments through presentations. The states expressed interest in conducting the review and led the whole process.
- Aspirational Districts being a key priority of the Government of India helped in the acceptance of the recommendations.
- Creating win-win partnerships with Locals-professional bodies, private manufacturers, pharma companies, academic institutes, and NGOs.
- Assisting the government with the development of checklists and using approved checklists for determining gap identification related to the quality of care.
- Sharing gaps in a systematic way for easy visualization and actions related to availability, accessibility, quality, and demand as a health system building block
- Constant sharing of analytical reports to generate actions from the key decision-makers.

Challenges

- Collection of data, nonavailability, and Data analysis is a time-consuming and resource-intensive process.
- District and sub-district-level large population-based survey data is often outdated and does not correctly reflect the current situation.
- A fixed resource envelope earmarked for each state limited the number of recommendations derived during the workshop.
- Lack of local capacity to identify key problems for developing innovative models.
- Procurement mechanism from private manufacturers.

Lessons Learned

- The RAASTA process provides opportunity to harness local, contextual knowledge on the same platform to understand available data and link them to global evidence-based intervention
- Use of standard planning tools strengthen the development of evidence-based implementation at the subnational level.
- There is a need to strengthen the development of program management capacity of local program managers is essential for decentralised planning and prioritisation.
- Identification of the right problems assists in rapid scale-up. (e.g., Equity Quality and Access gaps identified by RAASTA)
- Aligning with the country and global priorities assists government ownership. (e.g., Non availability of CPAP and preassembled UBT)
- Selecting local private players results in timely after sale service. (Local CPAP Device manufacturer)
- Engaging local communities and getting input from subdistrict level functionaries assists in removing equity gaps.(RAASTA Participants)
- Sharing analysed reports with key decision maker builds better trust for sustainability. (Gap analysis checklists)
- Using technology for key identified gaps helps in improving quality. (CPAP for managing respiratory distress in new-borns)