August 8, 2022
Eros Hotel, New Delhi

COMPREHENSIVE PRIMARY HEALTHCARE ALLIANCE

Knowledge Series: Reimagining District as a Unit of Health Care Delivery
First Partner Consultation on Designing District-level Interventions

Consultation Report

Reimagining District as a Unit of Health Care Delivery Designing District Interventions
Partner Consultation by the Alliance for Comprehensive Primary Healthcare
8 August 2022

1. Context and Background

The CPHC Alliance, aims to draw on collective knowledge, efforts and resources to engage multi-sectoral stakeholders, transform political will into action, increase financing of primary health care, and enable the aggregation and advocacy of evidence-based models of Comprehensive Primary Healthcare in India.

Responding to member requests, the first consultation on District Health interventions was held virtually on 15 June, 2022 with the participation of 9 organizations, composed of members of the CPHC Alliance as well as extended networks, with the intent of fulfilling this objective of consolidating and harnessing the power of the collective.

Based on the inputs shared by the attendees of the said session, three areas were identified as the core themes for this ongoing series of consultations on district level health interventions, i.e., **design, governance and financing**, among other topics.

The second consultation on ***'Designing District-level Initiatives'*** was accordingly organized as an in-person session in New Delhi on 8 August, 2022 with 15 organizations in attendance, including key strategic and implementation partners within the network of the CPHC Alliance.

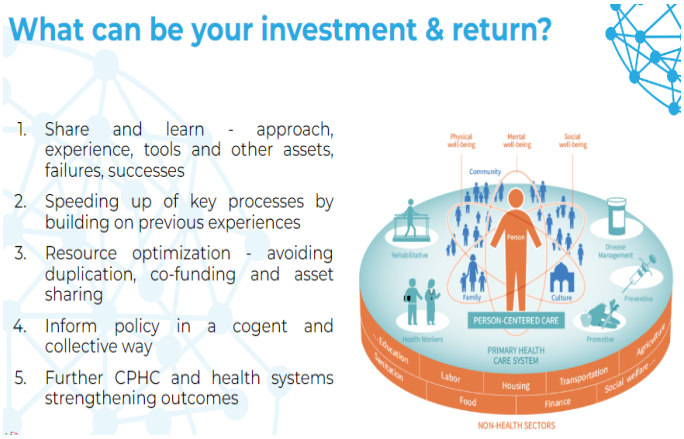
The primary objective of the session was to distill learnings from the health-focused, district-level interventions of the participating organizations, with a focus on the design process to integrate and improve upon for future initiatives of this nature.

The consultation was therefore structured in the form of plenary discussions, interactive exercises and co-creation activities to understand the methodologies and tools involved in this process to learn from the past to design better interventions for the future.

2. Highlights from the consultation

2.1 Welcome Note:

The consultation began with context-setting by Shiv Kumar, Founder Director, Catalyst Group on the objective and approach of the session - Distilling learnings from district-based health interventions, and to leverage forums like this to accelerate the agenda of Comprehensive Primary Health Care (CPHC) through collective learning. He also shared the larger objective of this learning series leading to a playbook for district-level health interventions that could serve as a public resource at a sectoral level by any stakeholders, taking into account the due complexities involved in this topic.



An overview of the Comprehensive Primary Health Care (CPHC) Alliance was provided by Alka Shinghal Pathak, Chief of Party - Learning4impact, Swasti, including its vision and mission as well as overall focus areas and current opportunities within the space for members and stakeholders. A brief update on the learning series as well as the rationale for focusing on the district as a unit of intervention were also covered during this segment.

Dr. Anuradha Jain, Advisor - Health Systems Strengthening, USAID set the context for commencing the session through her welcome note, wherein she acknowledged the wealth of knowledge and expertise among the participating organizations in the room. She highlighted the following areas as the core threads of learning that could be identified and distilled further for the benefit of the attendees and to advocate for the goal of CPHC:-

- The process adopted by the attendees in their respective district-level interventions, including tools and documentation approaches;
- The data sets prioritized by them during the implementation of the said interventions;
- The decision-making process that accompanies the design of the said interventions;
- The return on investment observed upon adopting these approaches;
- Whether any course correction or changes were made to these approaches accordingly and the rationale for the same; and
- Insights on the funds that could potentially be unlocked going forward and whether more resources could be raised for these initiatives.

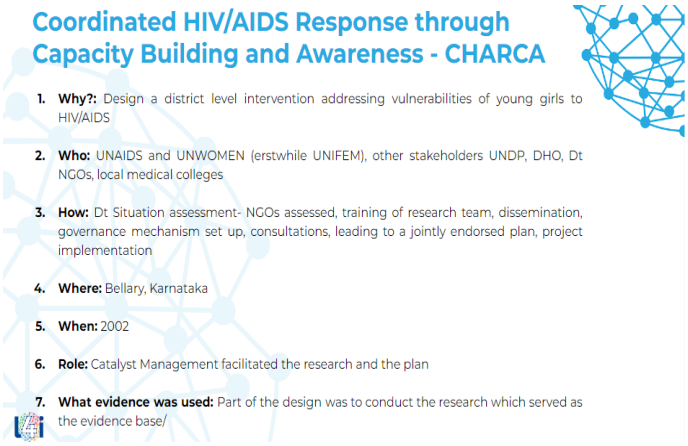
2.2 Inventory of experiences with District Interventions:

Shiv Kumar, Founder Director, Catalyst Group commenced the first segment to map and inventorize the various experiences of participating organizations with respect to district interventions along with Dr. Angela Chaudhuri, Lead - Health, Catalyst Group.

Broadly, the attendees were asked to cover key lessons, do-s and don't-s, tools, approaches, methods and overall best practices for their chosen intervention which was:

- Focused on health and at the district level;
- Involving either one or multiple diseases or other broader lens on health systems strengthening;
- Led by any stakeholder on lead *(government, civil society, private sector or a combination of these)*;
- Wherein the role of the participating organization could be across any vertical *(funding, technical support, implementation, etc.)*

Dr. Chaudhuri provided an illustrative example to the attendees on this exercise through the Coordinated HIV/AIDS Response through Capacity Building and Awareness (CHARCA) and Indore City initiatives of Swasti.



The attendees were thereafter requested to identify a district-level intervention of their organization and to utilize a case-story approach to explain why it gave them optimal results using the framework of the following questions:-

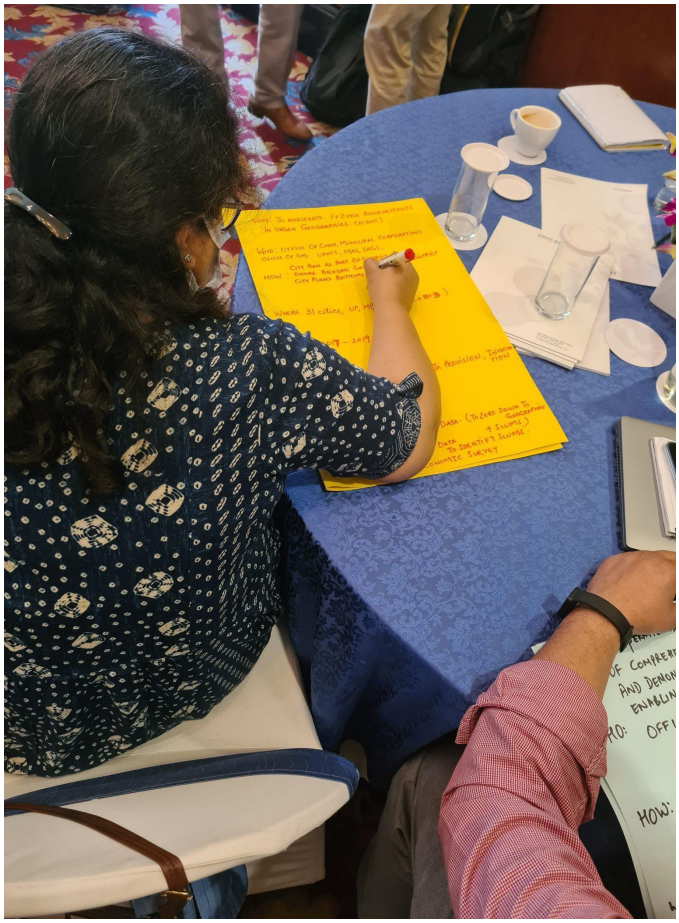
a. **Why** *(Objective / Vision)*;
b. **Who** *(Prime mover, stakeholders involved)*;
c. **How** *(Process)*;
d. **Where** *(Location)*;
e. **When** *(Year)*;
f. **Their role**; and
g. **What evidence was used**

The various initiatives mapped by the participating organizations either individually or in groups have been digitally archived by Swasti and can be accessed here.

2.3 Deep Dive on Building Blocks for Successful Design

Based on the interventions mapped by the attendees during the aforementioned segment, three thematic areas emerged as the way forward for the deep dive on successful design:-

- Data and learning
- Urban interventions
- Rural Interventions



Accordingly, the participating organizations were composed into three breakout groups focusing on one of the said thematic areas with an appointed facilitator, wherein they were instructed to identify around ten key lessons across various categories: ***Do-s, Don't-s, Neutral advice and Inventory tools, approaches, principles, methods used***.

The summary of the aforementioned learnings from the three groups has been shared below:-

- ***Data and Learning*: Crypto Relief Fund, NHSRC, RTI International**

1. Collaboration with the state and obtaining requisite approvals: This is a non-negotiable factor, especially with respect to the state MD-NHM. Involving reputed institutions to get more acceptance and buy-in from state governments is one approach to enable this.

2. **Building goodwill with state government:** This is influenced by the kind of partners the organization is associated with, your designs, data qualities, and timeliness of activities are factors contributing to the state approval of academic institutions as partners;

3. **Clarity in communication and expectation-setting with government and other stakeholders:** The theory of change through the intervention should be planned and communicated clearly and effectively to the state as well as relevant stakeholders for their buy-in and inputs;

4. **Identifying champions at the state and district level and developing strategic partnerships:** To own and and support the cause and to avoid duplication of efforts and working in silos

including intersectional coordination with other ministries and departments such as NHSRC, NIHFW etc.

5. **Utilization of existing evidences and district-level data:** From various sources such as NFHS, community surveillance, IDSP, etc., to feed into planning and enable better design;

6. **Involvement of community and community platforms:** To ensure community participation and accountability *(such as NHSNC/MAS & JAS), for* coordination with respect to innovations and best practices as well as for the purpose of enabling a bottoms-up approach where the district stakeholders should be involved in planning.

7. **Documentation and accessibility of data and technology:** To enable evidence-based decision making;

8. **Capacity building of the DPMs & District Health Societies:** To translate evidence to plans;

9. **Avoid tussle between individual egos including institutional logos**: Prioritizing collaboration towards the cause than being sidelined due to organizational priorities in terms of visibility, profile etc;

10. **Tools, approaches and methods identified in this regard include:**
    a. Supportive supervision checklists
    b. Tripartite MOUs
    c. Focus group discussion tools.
    d. Best practices/innovations identified or developed by CPHC-ILCs
    e. In-depth interviews tools
    f. Geospatial mapping for identifying access and demographics:
    g. Data visualization tools for presentations
    h. Innovations such as the NHSRC website *(under their knowledge management division)*
    i. Mathematical modeling tool
    j. Net-mapping tool to identify stakeholder and influence

- ***Urban Interventions:*** **USAID, PSI, WISH**

1. **Stakeholder identification and integration:** There is a need to involve stakeholders at all levels *(ward, block etc.,)* to ensure appropriate flow of information and improve decision making. This can be done by mapping key stakeholders, engaging with them to understand their perspectives and integrate their inputs into the design process.

2. **Triangulation of correct datasets to focus on SROI:** It is necessary to utilize existing data such as NFHS, HMIS, IDSP, etc. to feed into planning. But focus on micro data sets as well;

3. **Identifying distinction between *'felt needs'* and *'perceived needs'* while designing**: If the needs of the community are not being included and addressed, then the intervention and its design is unlikely to be successful. Hence, problem statements need to be demystified in general.

4. **Leveraging existing systems and approaches to avoid duplication of efforts:** Instead of reinventing the wheel or starting afresh;

5. **Including 'implementation science' from inception:** That is, approaches to documentation, measurements, rationale for the same, etc. are critical for scaling up

6. **Moving past 'one-size-fits-all' approaches:** The needle has shifted towards tailored approaches to enable successful adoption and results;

7. **Prioritizing urban areas and governance:** Urban areas have been the 'neglected child' as dedicated people are absent and the governance model needs to be fixed overall;

8. **Exit strategy for private sector needed:** Sustainability plans should be put in place at the design and implementation stage accordingly;

9. **Moving towards formal level institutional engagement:** One should not invest completely in informal decisions for decision making; and bring in the cadence of more formal documentation like MoUs and other agreements;

10. **Tools, approaches and methods identified in this regard include:**
    a. Approach paper for urban related projects;
    b. Learning Management System to manage and crusade around;
    c. Data triaging;
    d. Stakeholder Analysis and priority setting;
    e. Communications matrix to determine a curated approach to messages being sent to different audiences;
    f. Simple and accessible advocacy tools;
    g. Baseline tools for needs assessment;
    h. Resource Mapping; and
    i. Tools for amplification and deterrence

- ***Rural Interventions:*** **Piramal Swasthya, World Bank, CRF, WISH, BMGF, Jhpiego**

1. **Demonstration of innovations**
    a. Ample space for contextualization of the guidelines and tools need to be given in the design, as implementation approaches, monitoring tools etc. developed centrally may not always address local needs.
    b. Critical services/areas need to be identified for more impact. Scalability of the implementation model is another important factor for consideration while designing innovations.
    c. Further, consolidation of learnings is important before scaling up interventions.
    d. As far as possible, technology innovations need to be introduced on the existing platforms. While they can be integrated on several applications; however, the challenge is that the government functionaries are not open to such ideas.

2. **Stakeholder Engagement and Structured Gap Assessment**

a. The district health machinery needs to be involved in gap analysis and co-designing of solutions/innovations to address the identified gaps. The gap assessment exercise should be structured.

b. Building collaboratives at the Panchayat level and identifying champions and influencers from different segments of the society is important from a demand generation perspective.

c. It is also important to engage the state health machinery and get their sign off for the models proposed to be piloted.

d. Having defined mechanisms in place to involve stakeholders and avoiding creation of new forums, while leveraging the existing ones should be the way forward.

3. **Demand Generation**
   a. Understanding what attracts clients to the facilities is important at the design phase.
   b. Identifying key community stakeholders to support demand generation is key. They need to be involved in the monitoring of implementation. Some potential community stakeholders include:
      i. Hyperlocal NGOs
      ii. Religious leaders
      iii. Youth Organizations/ Youth leaders/ influencers
      iv. Panchayats
      v. SHGs
      vi. Local Media for building positive influence

4. **Human Resources**
   a. It should be ensured that new models/innovations, scale up etc. do not burden the frontline workers. Instead, it should make their life and work easier.
   b. Incentivize ASHAs/FLWs for playing a role in the process.
   c. Additional HR made available as part of the new models/innovations should not take over/duplicate the role of the existing health systems staff. Else, the system will collapse once the support is withdrawn.
   d. HR-heavy models need to be pursued with caution. Ideally, the models should be lighter and designed to achieve maximum impact with minimum HR footprint.
   e. Operationalization of models does not end with training of the staff. Continuous handholding and mentoring are also important.

5. **Enabling full scope of CPHC:** CPHC is yet to be comprehensive in its true sense. Services related to mental health, non-communicable diseases, tuberculosis, eye health etc. are yet to be fully integrated; however, the primary focus needs to be on MCH.

6. **Tendering and supply chain management:** There is a limit to what can be done at the district level; however, there is a clear need for such support at the state level.

7. **Strengthening and streamlining the referral mechanisms:** From primary to tertiary level has been identified as an area having enough scope for innovations.

8. **Expanding the scope of various e-learning initiatives to function as state learning labs:** While these initiatives were introduced to address capacity-building needs in the context of COVID-19, their scope now needs to be expanded to include other thematic areas such as MCH, MCD, TB etc. including materials on processes, case studies, best practices etc.

9. **Integration of Gender Equity and Social Inclusion (GESI):** This is another critical factor that needs to be factored into the design of innovations and interventions.

10. **Criticality of customization of interventions:** While the district can be a unit for change, if there is no mass customization, the chances of the interventions failing are highly likely.

3. Conclusions and Next Steps

3.1 Way forward:

The summary of the aforementioned learnings from the deep-dive was presented by Shiv Kumar, Co-founder, Catalyst Group. Thereafter, brief inputs were sought from the participants regarding the next session of the consultation series and whether any of the attending organizations would like to take on the role of a co-chair.

- **Date of next session:** 29 September, 2022
- **Format:** In-person
- **Location:** New Delhi
- **Theme:** Governance
- **Co-chair:** Piramal Swasthya offered to take up the role of co-creating this session along with Swasti.

Further, there was overall consensus on the need to move in the same direction to build each other's work and further the agenda of Comprehensive Primary Health Care, with forums such as this learning series being catalytic platforms to build a narrative for the sector. Some of the highlights of the discussions and inputs shared by attendees in the concluding segments of the session include:

- ***Importance of asset mapping***: Access to information in this regard was identified as a critical aspect of district-level planning. Without awareness of the work being done by the attending organizations as well as others at a sectoral level, duplication of efforts would not be minimized. The possibilities of collaboration and effective knowledge exchange between stakeholders would therefore be diminished.

- ***Necessity of co-creation mindset:*** The importance of balancing the conflict between *'logos and egos'*, wherein the emphasis should remain on achieving a common, collective outcome as opposed to individual organizational agendas was a theme that resonated strongly with the attendees.

- ***Utilizing data as a unit of action:*** Ensuring the authenticity of data and developing approaches to use it as a unit of action should be a focus area in planning district-level interventions. Further, the cultural elements within the system should also be considered with respect to assessing data and not just the statistical or quantitative elements. This is with due

consideration to the fact that data in such cases would not necessarily be reflective of a singular truth and could therefore be subject to interpretation and contextualization.

- ***Focus areas to further the CPHC agenda:*** Looking at other elements of the healthcare system like quality of care should also be prioritized with respect to CPHC approaches at the district level. The focus should be on the development of a comprehensive framework to strengthen systems and processes, supported by data and technology and integrating all relevant stakeholders. Capacity building, technical support, identification of good practices and innovations, research for evidence generation and involvement of community on several platforms must be duly prioritized as part of the larger agenda to ensure comprehensive primary health care.

3.2 Partner Inputs:

Further suggestions shared by the attendees regarding the consultation series have been captured as follows:-

- **Dr. Krishna Rao, Johns Hopkins University (JHU)** : Beyond governance and finance, it would be essential to have a convening around measurements. Further, organizations would gain from the mapping and landscaping of demonstrations that have taken place. It is also important to arrive at a comprehensive definition of *'district'*.

- **Hardeep Singh Bambrah, Piramal Swasthya:** In addition to enabling an accessible repository to all participating organizations on their respective areas of work, another area of value-addition that the secretariat could consider working on is a design framework.

- **Dr. Rajiv Tandon, RTI India:** Based on the structure provided by the discussions from the session, the way forward would be to define a theory of action and change for CPHC accordingly.

- **Manmohan Singh, Piramal Swasthya:** The participating organizations and secretariat could decide on 7-10 districts where they could work together and demonstrate proof of concept of collaboration and scale within a defined time frame, as one of the key pathways for the Alliance.

- **Ramnath Ballalla, Crypto Relief Fund:** It is possible to miss the microcosm of health systems, especially in the context of day-to-day resilience of health systems in these discussions. Therefore, it is important to consider how we can solve their problems and enable them to be resilient. On this note, CRF is setting up a fund to bring this design approach to the forefront.

- **Dr. Anuradha Jain, USAID:** Intersectoral convergence is an area of concern as it either becomes too broad to handle or too narrow to address. Therefore, deciding on certain contours with respect to the intersectoral approach would be essential which could be done collectively by this group of organizations as well. Also, there is a systems thinking tool that the *'Building Healthy Cities'* project has used, which would be relevant across districts for designing interventions. USAID could enable access to this tool with the permission of the partner.

4. Annexures

4.1 Agenda

Content	Facilitator/Presenter
Welcome Note	- Anuradha Jain, Technical Advisor - Health System Strengthening, USAID / India - Alka Singhal Pathak, Chief of Party, Learning4impact - Swasti - Shiv Kumar, Founder Director, Catalyst Group
Inventory of experiences of District interventions	- Shiv Kumar, Founder Director, Catalyst Group - Angela Chaudhuri, Lead - Health, Catalyst Group
Building Blocks for Successful Design: Deep Dive	Shiv Kumar, Founder Director, Catalyst Group
Summarized Lessons	Shiv Kumar, Founder Director, Catalyst Group
Next steps	Shiv Kumar, Founder Director, Catalyst Group

4.2 Participating Organizations and Attendees

1. Alka Shinghal Pathak, Swasti
2. Angela Chaudhuri, Catalyst Group
3. Aparna Suresh, Catalyst Management Services
4. Alok Ranjan, Bill and Melinda Gates Foundation
5. Anuradha Jain, USAID
6. Ayesha Siddiqua Nawaz, Piramal Swasthya
7. Binali Suhandani, Catalyst Management Services
8. Dinesh Songara, WISH Foundation
9. Divyarth Bansal, Crypto Relief Fund
10. Guru Rajesh Jammy, World Bank
11. Hardeep Singh Bambrah, Piramal Swasthya

12. Harshita Agarwal, Swasti
13. Kallana Gowda, Swasti
14. Krishna Rao, Johns Hopkins University
15. Madhavi, Johns Hopkins University
16. Manmohan Singh, Piramal Swasthya
17. Neeraj Agrawal, Jhpiego
18. Neha Kashyap, RTI International
19. Neha Parikh, Swasti
20. Nidhi Dubey, Piramal Swasthya
21. Nina Badgaiyan, Asian Development Bank
22. Piyush Jha, Jhpiego
23. Rajani Ved, Bill and Melinda Gates Foundation
24. Rajesh Singh, WISH Foundation
25. Rajiv Tandon, RTI International
26. Ramnath Balalla, Crypto Relief Fund
27. Ravneet Kaur, Swasti
28. Sainath Banerjee, Population Services International
29. Sheena Chhabra, World Bank
30. Shiv Kumar, Catalyst Group
31. Soumitra Mandal, NITI Aayog
32. Swati Mahajan, PATH
33. Suman Bhardwaj, NHSRC
34. Taruna Juneja Gandhi, NHSRC
35. Vipin Joseph, Swasti