DIPH

The Data-Informed Platform for Health

Structured district decision-making using local data

MONITORING REPORT
Cycle 1: March - June 2016

Diamond Harbour
West Bengal, India

IDEAS
Evidence to improve maternal & newborn health

DATA INFORMED PLATFORM FOR HEALTH

MONITORING REPORT

Diamond Harbour Health District, West Bengal, India

Cycle 1: March – June 2016

PUBLIC HEALTH FOUNDATION OF INDIA

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

TABLE OF CONTENTS

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LIST OF TABLES

LIST OF ABBREVIATIONS

ACMOH	Assistant chief medical officer of health
ANC	Antenatal care
ANM	Auxiliary nurse midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi worker
BCC	Behaviour change communication
BDO	Block development officer
BMOH	Block medical officer of health
BPHC	Block Public Health Centre
BPHN	Block public health nurse
CD	Child Development
CDC	Community Delivery Centre
CDPO	Child development project officer
CINI	Child in Need Institute
CMOH	Chief medical officer of health
DAM	District accounts manager
DEO	Data entry operator
DHHD	Diamond Harbour Health District
DIPH	Data Informed Platform for Health
DMCHO	District maternity and child health officer
DP	Delivery point
DPHNO	District public health and nursing officer
DPO	District programme officer
DSM	District statistical manager
Dy. CMOH-I	Deputy chief medical officer of health-I
Dy. CMOH-II	Deputy chief medical officer of health-II
Dy. CMOH-III	Deputy chief medical officer of health-III
FLW	Frontline worker
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
ICTC	Integrated Counselling and Testing Centre
IEC	Information, education and communication
IPHS	Indian Public Health Standards
JSSK	Janani Shishu Suraksha Karyakaram
KRDS	Kamdevpur Rural Development Society
MCH	Maternal and child health
MCTS	Mother and Child Tracking System
MIES	Management Information and Evaluation System
MNCH	Maternal, newborn and child health
MO	Medical officer
NGO	Non-governmental organisation
PHC	Public Health Centre
PHFI	Public Health Foundation of India
PHPC	Public health programme co-ordinator
PRD	Panchayat and Rural Development
RCH	Reproductive and child health
RH	Rural hospital
RSK	Rogi Sahayata Kendra
S24PGS	South 24 Parganas

SDH	Sub-divisional hospital
SHG	Self-help group
SHIS	Southern Health Improvement Samity
SMS	Short Message Service
SSDC	Sunderban Social Development Centre
UNICEF	United Nations Children's Fund
VHSNC	Village, Health, Sanitation and Nutrition Committee
WHO	World Health Organization

1. INTRODUCTION

Data Informed Platform for Health (DIPH)		
Cycle no.	1	
District	Diamond Harbour Health District	
Duration	March − June 2016	
Theme	Improve coverage of institutional delivery in the Diamond Harbour Health District (DHHD)	
Steps involved	Step 1	**Assess:** Theme identification for Cycle 1 involved using the Health Management Information System (HMIS) (MoHFW, 2016a), the Mother and Child Tracking System (MCTS) (MoHFW, 2016b) and coverage reported by the ANANDI programme (an initiative by the district administration to increase institutional delivery rates) (Office of the District Magistrate and UNICEF, 2015). Stakeholders conducted the situation assessment on coverage gaps and identified the theme 'Improve the coverage of institutional delivery' for DIPH Cycle 1. Non-health departments also attended the meeting. As non-health departments do not maintain quantitative data for the theme, the situation assessment only used qualitative information.
	Step 2	**Engage:** The theme leader for Cycle 1 was from the health department. The primary responsibility for the cycle was with the health department and supportive roles were with the departments of Child Development (CD) and the Panchayat and Rural Development (PRD). Majority of participants were from the health department apart from one representative from the PRD. There was no representation from the district administration or the CD. Non-governmental organisations (NGOs) and private for-profit organisations did not receive an official invitation to the meeting.
	Step 3	**Define:** The DIPH district stakeholders prioritised action points to achieve the targets on: identification and reaching out to the target population; service provision; staff requirement; and supervision needs. Stakeholders identified 15 action points, in keeping with the capacity of the district administration and the time frame of the DIPH cycle.
	Step 4	**Plan:** The stakeholders developed 15 action points to achieve the target and assigned responsibilities across departments within a given time frame. The health department had full responsibility (100%).
	Step 5	**Follow-up:** All 15 action points started within the cycle period. Fourteen action points completed within the designated time frame. The remaining one action point is ongoing. The State Assembly election coincided with the cycle period which affected implementation. The theme leader regularly monitored progress with personnel responsible for each action point in the district.

2. METHODS

Sl. No.	Data sources	Lead among DIPH stakeholders	Time frame
1	**Step 1: Assess** Form 1A.1: Data extraction from state and district health policy documents Form 1B: Health system capacity assessments	Theme leader DIPH Cycle 1	01 March 2016
2	**Step 2: Engage** Form 2: Engage	Theme leader DIPH Cycle 1	02 March 2016
3	**Step 3: Define** Form 3: Define	Theme leader DIPH Cycle 1	02 March 2016
4	**Step 4: Plan** Form 4: Plan	Theme leader DIPH Cycle 1	14 March 2016
5	**Step 5: Follow-up** Form 5: Follow-up	Theme leader DIPH Cycle 1	15 June 2016
6	**Record of Proceedings – Summary Tables** Form A.2.1: Record of Proceedings – summary for DIPH Step 4 Form A.2.2: Record of Proceedings – summary for DIPH Step 5	Recorded by the DIPH district co-ordinator, DHHD	March – June 2016
7	**In-Depth Interviews with Stakeholders** Form A.3.1: Chief medical officer of health (CMOH)	Interviewed by the DIPH district co-ordinator, DHHD	14 June 2016
	Form A.3.2: Deputy chief medical officer of health-II (Dy. CMOH-II)		01 July 2016

3. FINDINGS

The monitoring of the DIPH implementation process focused on four themes:

1. Utilisation of data at district level
2. Interaction among stakeholders such as co-operation in decision-making, planning and implementation
3. Follow-up to ensure accomplishment of action points
4. Sustainability perspective by the DIPH stakeholders

3.1 Utilisation of data at district level

3.1.1 Status of data utilisation

The stakeholders used data from platforms, namely, the HMIS, the MCTS and the coverage reported by the ANANDI programme to identify the theme for DIPH Cycle 1 (MoHFW, 2016a; 2016b; Office of the District Magistrate and UNICEF, 2015). After detailed discussion, the stakeholders selected the theme 'to improve the coverage of institutional delivery in the DHHD'. Though the PRD (a non-health department) participated in the discussion, they were unable to provide data as they have no data collection on institutional delivery. All participants discussed the major issues with data collection and utilisation and found: that quality and timely availability of data were major concerns; there was no mechanism in place to ensure reliability and accuracy of data; and there was no data-sharing among stakeholders related to institutional delivery in the district.

3.1.2 Challenges in data utilisation

Limited access to data was one of the major challenges highlighted by the district personnel. Though identified as a separate health district, the DHHD (a part of the South 24 Parganas [S24PGS] Revenue District) started functioning autonomously only from March 2016 at the start of DIPH Cycle 1. Scarcity of human resources was another reason for not maintaining their own database. The post of the district statistical manager (DSM) was vacant and this affected collation of data from the blocks. Hence, for any data, the DHHD had to seek help from the DSM of the S24PGS Health District.

3.1.3 Proposed solutions

The position of a DSM was vacant in the District Programme Management Unit, National Health Mission. The DSM of the S24PGS Health District received additional responsibility to support the DHHD. The group proposed filling the post of the DSM on a temporary basis from existing staff to support the DHHD.

> "Till date we are used to fix target for sub-district (blocks) from the district itself, but after introducing DIPH process, now sub-district (blocks) are using the format, analysing their capacity and fixing a target for themselves. After receiving data report from them, we are analysing the block progress on a regular basis. Some activities were ongoing earlier also, but was not monitored at all. With the help of DIPH process we are monitoring those indicators." (Dy. CMOH-II, DHHD)

Table 1: Utilisation of data at district level

Purpose	Indicators		Response (Yes/No, proportion)	Source of information
Whether the DIPH study led to the utilisation of the health system data or policy directive at district level for decision-making?	A. Selection of the primary theme for the current DIPH cycle	1. Whether the DIPH cycle theme selection was based on HMIS data? (Y/N)	Yes[1]	Form 1B
		2. Whether the DIPH cycle theme selection used any data from non-health departments? (Y/N)	No[2]	Form 1B
		3. Whether the DIPH cycle theme selection was based on health policy and programme directives? (Y/N)	Yes[3]	Form 1A.1
	B. Data-based monitoring of the action points for the primary theme	4.(Number of action points on which progress is being monitored by data) / (total number of action points for	15/15 = 100[4]	Form 5

[1]The theme selection used data from HMIS, MCTS and the ANANDI programme (MoHFW, 2016a; 2016b; Office of the District Magistrate and UNICEF, 2015). (See Form 1B, Sl. No. 2.1.)

[2]The non-health departments such as PRD and CD motivated people for institutional delivery, but did not maintain any data on the discussed theme. Hence, they could not contribute data during theme selection.

[3]There is a programme, titled ANANDI which is ongoing in the district to improve the institutional delivery (Office of the District Magistrate and UNICEF, 2015). This is an initiative by the district magistrate and implemented with support from the United Nations Children's Fund (UNICEF). The theme selection and target fixing used the data from this programme. (See Form 1A.1, Sl. No.1.)

[4] Indicators developed and monitored for all action points. (See Form 5, Part B, column 3.)

	of the DIPH	the primary theme of the DIPH)		
	C. Revision of district programme data elements for the primary theme of the DIPH	5. Whether stakeholders suggested a revision/addition to the health system data in the given DIPH cycle? (Y/N)	No[5]	Form 4
		6. (Number of data elements added in the health database as per the prepared action plan) / (total number of data elements requested for the primary theme of the DIPH)	0/0[6]	Form 5
	D. Improvement in the availability of health system data	7. Whether the health system data required on the specified theme as per the given DIPH cycle was made available to the assigned person in the given DIPH cycle? (Y/N)	No[7]	Form 1B
		8. Whether the health system data on the specified theme area is up-to-date as per the given DIPH cycle? (Y/N)	No[8]	Form 1B

3.2 Interaction among stakeholders

The DIPH study provides a platform for discussing the need for and the challenges involved in bringing together different stakeholders (health and non-health departments, NGO and private for-profit organisations). However, the overall attendance at the DIPH meetings was less than three-quarters with poor representation from non-health departments.

3.2.1 Interaction between health and non-health departments

As majority of participants were from the health department, the primary responsibility for action points was with this department. Therefore, the health department took responsibility of all 15 action points. Though officials from the PRD were present in all meetings (DIPH cycle steps) and were ready to take up the supportive role in improving institutional delivery in the district, they did not take direct responsibility of any action point. The representation from the district administration and the CD was lacking throughout DIPH Cycle 1. In all steps, poor co-ordination between the departments was evident. Even the district official reported poor/unsatisfactory co-ordination between frontline workers (FLWs) such as Accredited Social Health Activists (ASHAs) and Anganwadi workers (AWWs).

> "We have a regular monthly meeting with district magistrate (CMOH and district magistrate) - development planning meeting. After DIPH, we have seen that general administration could

[5]Though stakeholders discussed the quality of data available, there was no suggestion to revise/add any data element.

[6]There was no suggestion to add any data element.

[7]Data regarding the specific indicator were available from HMIS and MCTS (MoHFW, 2016a; 2016b). However, information on human resources, training, functioning facilities, etc. were incomplete. (See Form 1B, Sl. No. 3.1 and No. 3.3.)

[8]The data on theme-specific indicators (coverage of institutional delivery) were up-to-date as MCTS follows a monthly reporting system (MoHFW, 2016b). However, information on related aspects such as human resources, trained staff, etc. did not receive any updates. (DSM post was vacant. DSM of S24PGS having the additional responsibility). (See Form 1B, Sl. No. 2.1, No. 3.1 and No. 3.3.)

help us in many ways in improving institutional services. The planning format reveals that we are not getting satisfactory help by BDOs [block development officers] we have submitted report to district magistrate that BDO should help us in minimum ways to improve the institutional delivery in district." (Dy. CMOH-II, DHHD)

"There is already interaction between departments, but all these are very mechanical. No one feels that a mother is their responsibility. The ownership is really missing, even same thing I have noticed in CD worker." (CMOH, DHHD)

3.2.2 Interaction between the health department and NGOs

There was a collective decision not to assign any tasks to NGOs as district officials from the health department felt it was not useful for the selected theme.

"World Health Organization (WHO) is working in immunisation area, I feel that as ASHA workers are already working in the field, NGO involvement is not much needed. In resistance area, NGO can intervene but I am not sure how much that will be effective. NGO mobilisation for immunisation is not required because we are already working in a system." (CMOH, DHHD)

3.2.3 Interaction between the health department and private for-profit organisations

From the discussions, the health department and private for-profit organisations had limited interaction. A major gap identified by the group was the absence of specific reporting structures for monitoring of private players by the district health department. Only one organisation was providing telemedicine services in the district, but they were reporting to the district administration. Even nursing homes were not reporting to the district health officials. As a result, the group strongly recommended putting in place a specific reporting system for the private sector for regular monitoring.

Table 2: Interaction among stakeholders

Purpose	Indicators		Response (Yes/No, proportions)	Source of information
Whether the DIPH study ensured involvement of stakeholders from different sectors (health, non-health and NGO/private for-profit organisations)	E. Extent of stakeholder participation	1. (Number of DIPH stakeholders present in the planning actions meeting) / (total number of DIPH stakeholders officially invited in the planning actions meeting)	11/26 = 42.3[9]	Form A.2
		2. (Number of representatives from the health department present in the planning actions meeting) / (total number of DIPH participants present in	9/11 = 81.8[10]	Form A.2

[9]The representation from the invitees in Steps 4 and 5 was low. (See Form A.2.1, Sl. No. C1-C2 and Form A.2.2 Sl. No. C1-C2).

[10]The health department took initiative since the beginning of the DIPH process. The Dy. CMOH-II was very active and the CMOH chose him as the theme leader. (See Form A.2.1, Sl. No. C1-C2 and Form A.2.2, Sl. No. C1-C2.)

		the planning actions meeting)		
		3. (Number of representatives from non-health departments present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting)	2/11 = 18.2[11]	Form A.2
		4. (Number of representatives from NGOs present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting)	0/11[12]	Form A.2
		5. (Number of representatives from private for-profit organisations present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting)	0/11[13]	Form A.2
	F. Responsibilities assigned to stakeholders[14]	6. (Number of action points with responsibilities of the health department) / (total number of action points for the primary theme of the DIPH)	15/15 = 100[13]	Form 4
		7. (Number of action points with responsibilities of non-health departments) / (total number of action points for the primary theme of the DIPH)	0/15[13]	Form 4

[11]For the non-health departments, representatives from PRD and CD attended one meeting each. (See Form A.2.1, Sl. No. C2 and Form A.2.2, Sl. No. C2.)

[12]There are a few NGOs such as Southern Health Improvement Samity (SHIS), Kamdevpur Rural Development Society (KRDS), Sundarban Social Development Centre (SSDC), Child in Need Institute (CINI) and Sabuj Sanghaand Sarbik Vivekanand that provide training to ASHAs and run Community Delivery Centres (CDC) in a few blocks. However, the district authorities felt that no single NGO covers the whole district and so did not take interest in inviting them to the DIPH meeting. (See Form A.2.1, Sl. No. C2 and Form A.2.2, Sl. No. C2.)

[13]There was no participation from NGOs and private for-profit organisations. Participation from the non-health departments was poor and the entire responsibility for the action points was with the health department. (See Form A.2.1, SI. No. C1 and Form A.2.2, SI. No. C1.)

[14]Each action point had a person assigned from the stakeholder departments. They were responsible for completing the action points within the allotted time. (See Form 4, column: 'Person responsible'.)

		8. (Number of action points with responsibilities of NGOs) / (total number of action points for the primary theme of the DIPH)	0/15[13]	Form 4
		9. (Number of action points with responsibilities of private for-profit organisations) / (total number of action points for the primary theme of the DIPH)	0/15[13]	Form 4
	G. Factors influencing co-operation among health, non-health and NGO/private for-profit organisations to achieve the specific action points in the given DIPH cycle[15]	**10. List of facilitating factors**	1. Support from the district administration in initiating convergence between departments of health, PRD and CD 2. Presence of common platforms such as Jana-Swasthya meeting (Health Standing Committee) where different departments meet as per government guidelines 3. Active participation of Dy. CMOH-II (theme leader), and active participation of the public health programme co-ordinator (PHPC) (PRD representative)	Form A.3
		11. List of challenging factors	1. Lack of communication and co-ordination among the non- health departments, especially Integrated Child Development Services (ICDS) of CD 2. Shortage of health care professionals due to unfilled positions 3. Time constraint of representatives to attend and follow up	Form A.3

[15] Extracted from in-depth interviews with CMOH and Dy. CMOH-II. (See Forms A.3.1 and A.3.2.)

			all meetings 4. Lack of specific guidelines to ensure participation of all related departments/stakeholders in the health decision-making process 5. NGOs and private for-profit organisations did not receive an official invitation to take part in the planning process 6. Ascribing the sole responsibility of public health concerns to the health department	

3.3 Progress with action points

3.3.1 Action points accomplished

Out of the 15 action points, fourteen action points completed within the time frame:

1. List of villages (Gram Panchayat-wise) with high load of home deliveries were shared with the Rogi Sahayata Kendra (RSK)/emergency department of the delivery point. This list was also made available to block-level functionaries and officials
2. Orientation of newly recruited medical officers (MOs)
3. Behaviour change communication (BCC) activities to generate awareness among pregnant women and their family members through local awareness generation meetings and mothers' meetings
4. Sending reminder Short Message Service (SMS) to pregnant women through the MCTS system (MoHFW, 2016b)
5. Dissemination of success stories regarding institutional delivery because a "Happy mother is the best IEC (information, education and communication)"
6. Collecting information on unidentified pregnant women during the third Saturday meeting (health and CD) and follow up during fourth Saturday meeting (health, CD and PRD)
7. Recruitment of MOs, auxiliary nurse midwives (ANMs), ASHAs and other vacant posts
8. Sensitisation of FLWs on patients who miss a period (confidence generation among FLWs to undertake complete responsibility of pregnant women until term delivery)
9. Reporting the attendance of personnel from various departments at the fourth Saturday meeting
10. Refresher training for in-service nursing staff on maternal, newborn and child health (MNCH)

11. A common understanding on the issue for all supervisory staff (MO onwards) on the third Saturday of every month (sub-divisional hospital [SDH], rural hospital [RH] and Block Public Health Centre [BPHC]), monitored by district-level officials
12. Orientation of supervisory staff on MNCH-related Government Orders of state and national level during the third Saturday meeting (once a month with a date fixed by the respective superintendent/BMOH)
13. Monitoring of performance of FLWs and related issues by third party involvement, e.g. UNICEF's role in the ANANDI programme (Office of the District Magistrate and UNICEF, 2015)
14. Orientation of contractual staff recruited under different programmes of the MNCH, e.g. Anwesha and Integrated Counselling and Testing Centre (ICTC)

Block monitoring formats needed developing and then circulated among block officials. The block medical officers of health (BMOHs) though oriented on the format, were not motivated enough to send monitoring reports to the district officials on time. However, the situation has improved over time and the theme leader is continuously monitoring the progress.

> "I can say that there is much improvement after introducing DIPH process in the district but obviously it's not 100% perfect." (Dy. CMOH-II, DHHD)

3.3.2 Action points ongoing

Though all action points started within the given cycle period, the State Assembly election (in April 2016) affected the implementation of the action plan. During the stages of Step 5, one action point was ongoing:

1. Recruitment under CDC or direct recruitment for 24-hour electricity supply and maintenance

3.3.3 Action points not started

All action points started within the designated timeline.

Table 3: Progress with action points

Purpose	Indicators		Response (Yes/No, proportions)	Sources of information
Are the action points planned for the DIPH primary theme achieved?	H. Action points initiated	1. (Number of primary theme-specific action points initiated within the planned date) / (total number of primary theme-specific action points planned within the specific DIPH cycle)	15/15 = 100[16]	Form 5
	I. Action points achieved	2. (Number of primary theme-specific action points	14/15 = 93.33[17]	Form 5

[16] All 15 action points started within the cycle period. (See Form 5, Part B, columns: 'Action points'; 'Timeline for completion'; and 'Status of action points'.

[17] Out of the 15 action points, fourteen action points completed during Cycle 1. One action point is ongoing. (See Form 5, Part B, columns: 'Action points'; 'Timeline for completion'; and 'Status of action points'.

		completed within the planned date) / (total number of primary theme-specific action points planned within the specific DIPH cycle)		
		3. (Number of written directives/letters issued by the district/state health authority as per action plan) / (total number of written directives/letters by the district/state health authority planned as per action points of the DIPH primary theme)	0/0[18]	Form 5
		4. (Amount of finance sanctioned for the primary theme-specific action points) / (total amount of finance requested as per action points of the DIPH primary theme)	0/0[19]	Form 5
		5. (Units of specific medicine provided for the primary theme-specific action points) / (total units of specific medicine requested as per action points of the DIPH primary theme)	0/0[20]	Form 5
		6. (Units of specific equipment provided for the primary theme-specific action points) / (total units of specific equipment requested as per action points of the DIPH primary theme)	0/0[21]	Form 5
		7. (Units of specific IEC materials provided for the primary theme-specific action points) / (total units of specific IEC materials requested as per action points of the DIPH primary theme)	0/0[22]	Forms 4 and 5
		8. (Number of human resources recruited for the	Not specified[23]	Forms 4 and 5

[18]There was no written letter/directive issued from the district or state authority. All communications were either verbal or via telephone. (See Form 5, Part B, columns: 'Action points'; 'Indicators for each action point'; and 'Progress of indicators'.

[19]No request made for finance during Cycle 1. (See Form 5, Part B, columns: 'Action points'; 'Indicators for each action point'; and 'Progress of indicators'.

[20] There was no requirement of medicine as per the selected theme. (See Form 5, Part B, columns: 'Action points'; 'Indicators for each action point'; and 'Progress of indicators'.

[21] There was no specific equipment required as per the selected theme. (See Form 5, Part B, columns: 'Action points'; 'Indicators for each action point'; and 'Progress of indicators'.

[22]Planned BCC activities, but no demand made for IEC materials on the theme, as availability was not an issue highlighted during the meetings. However, they could not distribute to all the sub-centres/delivery points due to lack of supply. (See Form 4 and Form 5, 1.1.1.)

[23]There was staff recruitment during the cycle period, although not theme-specific. The action plan did not specify the number of staff to be recruited. (See Form 4, action points 1.3.1 and 1.3.2 and Form 5, action points 1.3.1 and 1.3.2.)

		primary theme-specific action points) / (total human resources recruitment needed as per action points of the DIPH primary theme)		
		9. (Number of human resources trained for the primary theme-specific action points) / (total human resources training requested as per action points of the DIPH primary theme)	32/32 = 100[24]	Forms 4 and 5
	J. Factors influencing the achievements as per action points of the DIPH primary theme[25]	**10. List of facilitating factors**	1. Though in varying capacity, all the invited government departments took part in performing their roles (CD did not receive any specific responsibility, because they had not attended any of the meetings) 2. The presence and motivation by the DIPH research team acted as a push factor for stakeholders to accomplish the action points 3. Active participation by Dy. CMOH-II, the theme leader and initiative by PHPC, Zilla Parishad (PRD representative)	Form A.3
		11. List of challenging factors	1. Overall delay in the process due to state election 2. District administration was busy in the election procedure 3. Being the first cycle, the stakeholders as well as the DIPH research team took time to learn the process during implementation 4. Reduced participation from non-health departments were due to reasons such as staff shortages 5. Poor availability and quality affects the use of data that need addressing 6. Lack of awareness about the importance of	Form A.3

[24]Though the action points specified staff training, there was no specific number of trainings given for human resources by the action plan. Data entry operators (DEOs) of blocks received refresher training and specifically asked to send data on the DIPH indicators. (See Forms 4 and 5, action points 1.3.3 to1.3.4, 1.4.2 and 1.5.1.)

[25]Extracted from in-depth interviews with CMOH and Dy. CMOH-II. (See Forms A.3.1 and A.3.2.)

			good quality of data, e.g. even the BMOH did not look into the data reported	

3.4 Sustainability of the DIPH

Analysis of the sustainability of the DIPH process in the district is from in-depth interviews conducted with stakeholders (CMOH and Dy. CMOH-II – see Forms A.3.1 and A.3.2) as well as from observations of the DIPH research team.

3.4.1 Data source

- The DIPH theme leader tracked progress of the themes based on the HMIS, which receives regular updates (MoHFW, 2016a). However, stakeholders expressed their concern over the quality of the data. The post of DSM was vacant in the district and relied on the DSM of S24PGS Health District for support, which they did not provide all the time. Hence, presenting a huge challenge for the district.
- There was no sharing of data from other departments (CD and PRD) with the health department or the district administration. But after the DIPH initiative, PRD started to share their monthly data with other departments. The web-based reporting system of CD will commence shortly.
- There was no sharing of data from the private sector with the health department or the district administration. There are no guidelines to ensure such a data flow.
- A new reproductive and child health (RCH) reporting portal is under process.

3.4.2 Facilitators within the district

- The DIPH research team created good rapport with stakeholders. The theme leader and CMOH are keen on bringing a positive change in the district and extended their support to ease the implementation process in the district.
- There is good interaction between all stakeholder departments except CD. The PHPC has shown a keen interest in the process.
- The presence of certain platforms such as RCH-Management Information and Evaluation System (MIES) meeting, Public Health Standing Committee meeting, Health Samity meeting, and Maternal Death Review monthly meeting facilitated the incorporation of the DIPH process into the routine system without creating any additional structure.

3.4.3 Challenges within the district

Though there were several facilitating factors, the district officials highlighted the following challenges in ensuring sustainability of the DIPH process:

- Interdepartmental co-ordination – Stakeholders consider the DIPH as largely the responsibility of the health department. Hence, the unsatisfactory participation of non-health departments (PRD and CD) in the DIPH meetings
- Vacant positions – Several key positions in the district were vacant and this hampered the DIPH process. For instance, the DSM post was vacant, and this affects the compiling and reporting of data at district level
- Top-down approach – Presently, only district-level stakeholders engage in the DIPH

process. However, sub-district-level officials and FLWs carry out the implementation of action points. Therefore, their participation and support is crucial for successful completion of the action points

- Data issues – Quality and availability of district-specific data is an issue. Even the mandatory forms are not maintained and stored systematically
- Sharing responsibility – This depends mostly on one person from the stakeholder department. All other participants are unwilling to share the responsibilities
- Streamlined process – There is a need to revise the DIPH implementation process as there are several forms where some of the items are repetitive
- Hand-holding by the DIPH research team – The district DIPH stakeholders depend heavily on the DIPH research team for conducting meetings, completing forms and compiling the follow-up documents

3.4.4 Possible solutions

- Greater emphasis on the DIPH by the district administration would increase the participation of various stakeholders. Before the next DIPH cycle, it is necessary to bring out an official letter by the district magistrate, directing the non-health departments to actively participate in the DIPH meetings.
- It is important to include themes (malnutrition, sanitation, etc.) which are of interest to other stakeholders to ensure better participation from non-health departments, NGOs and private for-profit organisations.
- Involving sub-district-level stakeholders such as BMOHs, block public health nurses (BPHNs) and child development project officers (CDPOs) during the meetings (Steps 4 and 5) will ensure better implementation of the action plan. It will also help the theme leader in the follow-up of action points as the intention is to share this with block-level stakeholders.
- There is a need for conducting orientation training of block-level officials and representatives from non-health departments on ‘monitoring progress of action points’. The theme leader can start this process immediately after Step 4.
- Creating a digital interface (DIPH Forms) will ease the progress tracking during the DIPH cycles.
- Ensuring district ownership of the DIPH is necessary to actively involve the district during the planning and implementation stages of the cycle. Designating a nodal officer (from within the district administration) will be useful in ensuring participation of all stakeholders and in removing the concept of the DIPH as a sole responsibility of the health department.

REFERENCES

Ministry of Health and Family Welfare (MoHFW) 2016a, *Health Management Information System (HMIS)*, Government of India, New Delhi.

Ministry of Health and Family Welfare (MoHFW) 2016b, *Mother and Child Tracking System (MCTS)*, Government of India, New Delhi.

Office of the District Magistrate & UNICEF 2015, *ANANDI Programme Guidelines (under Sundarini Project)*, Government of India, South 24 Parganas.

ANNEXES

A.1: DIPH Forms of Step 1 (Form 1A.1, Form 1B and Form 1B.1) Step 4 (Form 4) and Step 5 (Form 5)

Form 1A.1: Data extraction from state and district health policy documents

Sl. No.	Particulars		
1	**Source document*[26]**		Directives released by district administration regarding the ANANDI campaign
2	**Specific theme 1**		**Maternal health – institutional delivery**
2.1	Goal setting		To improve the coverage of institutional delivery in the DHHD
2.2	Action points	A	Focus on poor performing blocks (total seven blocks: Kulpi; Mathurapur-I; Mandirbazar; Kakdip; Magrahat-I; Diamond Harbour-I; Magrahat-II) with less coverage of institutional delivery than the district average [74%])
		B	Micro-planning for birth preparedness (i.e. identification and tracking of pregnant women, tagging with the respective ASHAs and AWWs, line-listing of Nischay Jan in their locality)
		C	Mobilisation of pregnant women for safe delivery care practices (by ASHAs, AWWs, PRD representatives, etc.)
		D	Ensuring the fourth antenatal check-up by ANMs at home and its monitoring by public health nurses/BPHNs
		E	Involving AWWs in a timely arrangement of antenatal care (ANC) clinics, Village Health Nutrition Days, identification of anaemic pregnant women and referral to respective health facilities
		F	Ensuring physical accessibility to health facilities, especially in the riverine areas (PRD to ensure road facilities and functioning of boat service)
		G	Ensure 24-hour functionality of delivery points
3	**Specific theme 2**		
3.1	Goal setting		
3.2	Action points	A	
		B	
		C	
4	**Specific theme 3**		
4.1	Goal setting		
4.2	Action points	A	
		B	
*Annual/five-year health plans, specific health policy documents and valid government orders related to public health.			

[26] Table 1, Indicator 3.

Form 1.B: Health system capacity assessments

Sl. No.	Particulars					
1	**District demographic details**					***Source***
1.1	Total population		816,1961			District Census 2011 (Statistics are for S24PGS Revenue District) [Office of the Registrar General & Census Commissioner, 2011, *District Census Hand Book 2011*, Government of India, New Delhi, viewed on 15 February 2016, www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf]
1.2	Rural population (%)		74.4			
1.3	Urban population (%)		25.6			
1.4	Scheduled Caste population (%)		30.2			
1.5	Scheduled Tribe population (%)		1.2			
1.6	Population density		819 persons/square km			
1.7	Sex ratio		956			
1.8	Total literacy (%)		77.5			
1.9	Female literacy (%)		71.4			
1.10	Number of children under five years		1,025,679			
1.11	Number of women in reproductive age (15-49 years)		Need to find out			
1.12	Key NGOs		SHIS, KRDS, SSDC, CINI, Sabuj Sangha, Sarbik Vivekanand.			
1.13	Key private for-profit organisations		GloCal Healthcare (telemedicine)			
2	**Requirements as per Indian Public Health Standards (IPHS) or state-/district-specific policy documents**					
		IPHS/policy document	***Data***		***Gap***	***Remarks***
2.1	**Coverage indicators**[27] (improve the coverage of institutional delivery)	1. To increase the institutional delivery rate to 90% by March 2016 and sustain it thereafter (ANANDI campaign) 2. To achieve 100% institutional delivery rate by October 2016 (ANANDI campaign)	District	73.6% (MCTS updated in December 2015 for 2015/16) 67.4% (HMIS – December 2015)	**16.4%** **22.6%**	The present gap is based on the ANANDI target (90%)
2.2		**Block-wise**[a]	Kulpi	66.3%	**23.7%**	Seven blocks with low coverage than the district average of 73.6% are
			Mathurapur-I	66.4%	**23.6%**	

[27] Table 1, Indicators 1, 2 and 8.

			Mandir Bazar	68.7%	**21.3%**	considered for high focus (as specified by the ANANDI campaign)
			Kakdwip	69.1%	**20.9%**	
			Magrahat-I	69.8%	**20.2%**	
			Diamond Harbour-I	70.0%	**20.0%**	
			Magrahat-II	73.5%	**16.5%**	
3	**Specific theme 1** (refer to 2.1):**Improve the coverage of institutional delivery**					
		Details	***Sanctioned (2014/15)***	***Available/ functional***	***Gap***	***Remarks***
3.1	**Infrastructure**[28]	Sub-centres	475	475	0	
		Public Health Centres (PHCs)	Not available	28		
		BPHCs	Not available	4		
		RH	Not available	9		
		SDH	1	1	0	
		State general hospital	0	0	0	
		District hospital	1	1	0	
		Delivery points (DPs)	32	23	**9**	1. Most of the non-functional DPs have an inadequate number of doctors 2. A 24-hour PHC but non-functional DPs: Ramchandranagar; Bardrone, Mohanpur; Baribhangabad; Paschim Bhawanipur; and Dholtikari 3. PHCs but non-functional DPs: Ghatbakultala; and Mahendraganj 4. Around 22 DPs have functional labour rooms with a functional Newborn Care Corner 5. Around 16 DPs are with a functional operating theatre 6. Only two DPs: district hospital; and Kakdwip SDH have functional blood banks or blood storage units
3.2	**General resources**	Finance	1. Rs. 90.39 Lakh (£110523.78) approved for			• Adequate funds are available • Expenditure is more than the approved budget on Janani Shishu

[28] Table 1, Indicator 7.

			institutional delivery with separate allocations for rural/urban 2. JSSK funds are approved for referral transport, free drugs and diagnostic services 3. Rs. 43.8 Lakh (£53556.16) approved for boats in Sundarban area 4. Funds approved for various trainings, e.g. skilled birth attendant, refreshers, Basic Emergency Obstetric Care, Comprehensive Emergency Obstetric Care and so on			Suraksha Karyakaram (JSSK) referral transport (quoted by Dy. CMOH-II) • No fund allocation for sensitisation and alliance building with the Indian Medical Association, Judicial functionaries and civil society/NGO • No allocation of budget for orientation workshops, trainings and capacity building of PRD for RSK at district health societies, Community Health Centre and PHC
		Supplies	**Drug**	**Issued Quantity**	**Closing stock**	Data retrieved from stock management information system, updated on 23 February 2016 for Year 2015/16 As per Dy. CMOH-I, there were no shortages of medicine
			Folic Acid IP 5 mg tablets	2,005	47,995	
			Atropine sulphate	750.50	479.50	
			Dextrose solution 5%	30,435	11,490	
			Calcium carbonate	22,510	17,490	
			Gentamycin Sulphate	2,055	445	
			Misoprostol	1,050	950	
			Paracetamol 325 + Ibuprofen 400 mg	92,520	17,480	

			tablets			
		Technology	MCTS and HMIS are in use m-Health for maternal death reporting			
3.3	**Human resources**[29]	ASHA	2,619	2,200	419	
		First ANM	475	468	7	
		Second ANM	475	379	96	
		Staff nurse	-	310	-	Exact sanctioned numbers are not available at present Need to follow up with Dy. CMOH-II
		Obstetrician and gynaecologist	-	8	-	
		Anaesthetist	-	4	-	
		Paediatric	-	3	-	
		Pharmacist	-	15	-	
		General duty medical officer	-	86	-	
		AWW	2,443	4,096	-	Exact sanctioned numbers need to be confirmed with the district programme officer (DPO)-ICDS, CD

[a]Please refer to Form 1B.1 for block-wise performance of indicator.

[29] Table 1, Indicator 7.

Form 1B.1 Block-wise performance of selected indicators

Sl. No.	Block name	Coverage indicator for theme 1: institutional delivery (MCTS December 2015) (%)
1	Kulpi	66.3
2	Mathurapur-I	66.4
3	Mandir Bazar	68.7
4	Kakdwip	69.1
5	Magrahat-I	69.8
6	Diamond Harbour-I	70.0
7	Magrahat-II	73.5
8	Sagar	74.1
9	Mathurapur-II	76.3
10	Patharpratima	78.1
11	Diamond Harbour-II	82.0
12	Namkhana	84.1
13	Falta	86.2

Form 4: Plan

Date of meeting: 14 March 2016
Chairperson: CMOH, DHHD

Theme 1: Improve coverage of institutional delivery in the DHHD					
Theme leader: Dy. CMOH-II					
Number of meeting for the respective theme: First					
Task 1.1: Identification and reaching out to target population	**Actions**[30]	**By whom**[31]	**By when**	**Resources**	
				Human[a]	**Material**[b]
	1.1.1 BCC activities to generate awareness among pregnant women and their family members through local awareness generation meetings and mothers' meetings[32]	FLWs (ASHAs, ANMs and AWWs) and health supervisors	July 2016	Recruiting vacant ASHAs and AWWs and their training; refresher training Gram Panchayat Pradhan	Non applicable (IEC materials are available with FLWs. There is no other need)
	1.1.2 Sending reminder SMS to pregnant women through the MCTS system	Health supervisor with help from DEOs	March 2016	Non applicable	Verification of contact numbers of beneficiaries
	1.1.3 Sharing the Gram Panchayat-wise list of villages with high loads of home deliveries with the RSK/emergency department of the delivery point. List available with the block	BPHN and BMOH	March 2016	Non applicable	Need to establish RSK in all block facilities (in process) Need to refine list
	1.1.4 Dissemination of success stories regarding institutional delivery because a "Happy mother is the best IEC"	FLWs (ASHAs, ANMs and AWWs) and pregnant women who delivered at public institutions; Village, Health, Sanitation and Nutrition Committee (VHSNC) members	Concurrent	VHSNC members need to be oriented on their job commitment towards health-related activities Need to ensure full functionality of VHSNCs (only 70% are functional; 25% training completed)	Posters/flipcharts for IEC/BCC activities (design provided by National Health Mission and funds also available; only need to make printing according to need)
Task 1.2: Service provision	1.2.1 Collect information on unidentified pregnant women during third Saturday meeting (health and CD) and follow up during fourth Saturday meeting (health, CD	ANM, BPHN and BMOH; information to be shared with BDO	Concurrent	Non applicable	Non applicable

30 Table 3, Indicators 7-9.
31 Table 2, Indicators 6-9.
32 Table 3, Indicator 7.

	and PRD)				
	1.2.2 Sensitisation of FLWs on patients who missed a period (confidence generation among FLWs to undertake complete responsibility of pregnant women until term delivery)	FLWs Assistant chief medical officer of health (ACMOH) of subdivision	By May 2016	Non applicable	Funds needed (could be sought from state or the District Health and Family Welfare Samity)
	1.2.3 Reporting the attendance of personnel from various departments at the fourth Saturday meeting	ACMOH	Start from March 2016	Physical presence in the meeting	
Task 1.3: Staff needs	1.3.1 Recruitment of MOs, ANMs, ASHAs and other vacant posts[33]	District Recruitment Committee	After election		
	1.3.2 Recruitment under CDC or direct recruitment for 24-hour electricity supply and maintenance[33]	District Recruitment Committee	After election		
	1.3.3 Orientation of newly recruited MOs[34]	Dy. CMOH-I, -II and -III	April 2016	Non applicable	Non applicable
	1.3.4 Refresher training for in-service nursing staff on MNCH[34]	DMCHO and Dy. CMOH-III	June 2016	Non applicable	Non applicable
Task 1.4: Supervision	1.4.1 A common understanding on the issue for all supervisory staff (MO onwards) on the third Saturday of every month (SDH, RH, BPHC) and monitored by district-level officials	District-level programme managers	Concurrent	All staff to be supervised by respective supervisors	Printed guidelines, standard operating procedures, etc. in the local language, e.g. immunisation process and related rules and concept of public health
	1.4.2 Orientation of supervisory staff on MNCH-related Government Orders of state and national level during the third Saturday meeting (once a month with a date fixed by the respective superintendent/BMOH)[34]	District-level programme managers	Concurrent	All staff to be supervised by respective supervisors	National Health Mission/national and state Government Orders and related rules and concept of public health
	1.4.3 Monitoring of performance of FLWs and related issues by third party involvement (UNICEF's role in the ANANDI programme)	BMOH, BPHN, district-level programme officers and programme managers	Started from third week of March 2016, but this will be an ongoing process	Non applicable	Format for reporting; funds

[33] Table 3, Indicator 8.
[34] Table 3, Indicator 9.

Task 1.5: Any other	1.5.1 Orientation of contractual staff recruited under different programmes of the MNCH, e.g. Anwesha and ICTC[34]	Block-level programme managers	June 2016	Non applicable	Funds required for training

[a]Theme-specific requirement of health workforce and their skill development should be recorded here.
[b]Material resources include information related to medical supplies, finance and infrastructure.

Form 5: Follow-up

Date of meeting: 15 June 2016
Venue: CMOH office, DHHD
Chairperson: CMOH, DHHD

Part A						
Theme: Improve coverage of institutional delivery in the DHHD						
Theme leader: Dy. CMOH-II						
1. Number of meetings conducted since the last DIPH meeting by the theme leader					**Three**	
2. Major stakeholders involved in each meeting	**Meeting 1**	**Meeting 2**		**Meeting 3**	**Meeting 4**	**Meeting 5**
	Date: 15-16 March 2016 CMOH Dy. CMOH-I, -II, -III ACMOH (Kakdwip and DH) All BMOHs and BPHNs	Date: 20 April 2016 (RCH-MIES meeting) CMOH Dy. CMOH-I, -II and -III ACMOH (Kakdwip and DHHD) All BMOHs and BPHNs		Date: 20 May 2016 (RCH-MIES meeting) CMOH Dy. CMOH-II and -III ACMOH (Kakdwip and DHHD) All BMOHs and BPHNs		
3. Comparison of key coverage indicators in the DIPH cycle (**Percentage of institutional delivery**)		**Time 0**		**Time 1**	**Time 2**	**Time 3**
	Date	December 2015		February 2016	March 2016	April 2016
	HMIS	67.4		76.4	80.0	79.9
	MCTS	4,391/5,804 (75.7%)		3,591/4,606 (78%)	3,113/3,998 (77.9%)	2,852/4,731 (60.3%) (not fully updated)

Part B						
Action points[35]	**Indicators for**	**Progress of**	**Timeline for**	**Status of**	**Person responsible**	**Suggestions**

[35] Table 3, Indicators 1-9.

	each action point[36]	indicators[37]	completion of action points[38]	action points[39]	for action points	Revised timeline	Change in responsibility
1.1.1 BCC activities to generate awareness among pregnant women and their family members through local awareness generation meetings and mothers' meetings	a. Number of pregnant women registered against the estimated target	95%	July 2016	Completed	FLWs (ASHA, ANM and AWW) and health supervisors		
	b. Number of awareness generation meetings conducted with number of participants	On average 369 meetings/month/ block					
	c. Topics discussed in the meetings	Two to three topics in a month (most frequent topics are: ANC; birth preparedness; and advantage of institutional delivery)					
1.1.2 Sending reminder SMS to pregnant women through the MCTS system	a. Number of revised list of phone numbers submitted sub-centre-wise out of total sub-centre	More than 90% of sub-centre submitted the list	To start by March 2016 and to be maintained concurrently	Completed	BPHN/health supervisor with help from DEOs		
	b. SMS sending process started	Reported yes (on the updated list)					
1.1.3 Sharing the Gram Panchayat-wise list of villages with high loads of home deliveries with the	a. List of Gram Panchayats with high load of home	All the blocks submitted (100%)	March 2016	Completed	BPHN and BMOH		

[36] Table 1, Indicator 4; Table 3, Indicators 3-9.
[37] Table 3, Indicators 3-9.
[38] Table 3, Indicators 1-2.
[39] Table 3, Indicators 1-2.

RSK/emergency department of the delivery point. List is available with the block	delivery prepared by ANM						
	b. This list to share with facility centres	All the blocks shared the list with facility centres					
	c. Delivery centres refer this list for not sending back pregnant women until delivery has happened	Reported yes					
1.1.4 Dissemination of success stories regarding institutional delivery because a "Happy mother is the best IEC"	a. Success stories disseminated regularly	Reported yes	Concurrent	Completed	FLWs (ASHA, ANM and AWW) and pregnant women who delivered at public institutions; VHSNC members		
	b. Number of unwilling mothers influenced by the success stories	Total of 67 during March-May 2016, i.e. on average two mothers per block					
1.2.1 Collect information on unidentified pregnant women during third Saturday meeting (health and CD) and follow up during fourth Saturday meeting (health, CD and PRD)	a. Number of cases identified in the third Saturday meeting	Reported 'yes'	Concurrent	Completed	ANM, BPHN and BMOH; information to be shared with BDO		
	b. Gram Panchayat-wise sharing of this information for CD and PRD for follow-up	Yes, new cases identified					
1.2.2 Sensitisation of FLWs on patients who missed a period (confidence generation among FLWs to undertake complete responsibility of pregnant women until term delivery)	a. Number of FLWs oriented on the counselling issues to the total number of FLWs in position	The orientation is continuing (numbers not available)	May 2016	Completed	FLWs, ACMOH of subdivision		
1.2.3 Reporting the attendance of personnel from various departments at the fourth Saturday meeting	a. Department and designation-wise reporting of the actual presence during the fourth	Reporting started in May	March 2016	Completed	ACMOH		

	Saturday meeting						
1.3.1 Recruitment of MOs, ANMs, ASHAs and other vacant posts	a. Number of MOs recruited against the number of vacancies	Process started for recruiting 15 MOs	After election	Completed	District Recruitment Committee		
	b. Number of ANMs recruited against the number of vacancies	Process started recruiting four ANMs					
	c. Number of ASHAs recruited against the number of vacancies	Process started					
	d. Number of other positions recruited against the number of vacancies	Process started					
1.3.2 Recruitment under CDC or direct recruitment for 24-hour electricity supply and maintenance	a. Number of CDC appointed against the number of DPs needed for 24-hour electricity support	Proposal for three DPs submitted to the state.	After election	Ongoing	District Recruitment Committee		
1.3.3 Orientation of newly recruited MOs	a. Number of newly recruited MOs oriented	Done	April 2016	Completed	Dy. CMOH-I, -II and -III		
1.3.4 Refresher training for in-service nursing staff on MNCH	a. Presence of the FLWs out of total FLWs in position	Done	Concurrent	Completed	District-level programme managers		
	b. Issue discussed.	Not specified					
1.4.1 A common understanding on the issue for all supervisory staff (MO onwards) on the third Saturday of every month (SDH, RH, BPHC) and monitored by district-level officials	a. Fix a monthly date for the orientation meeting and inform accordingly to the district	Done and informed	Concurrent	Completed	District-level programme managers		
	b. Participants in the meeting out of	Yes, 100% for all blocks					

	total number of MOs expected						
	c. Presence of district-level facilitator with designation	No complete information					
1.4.2 Orientation of supervisory staff on MNCH-related Government Orders of state and national level during the third Saturday meeting (once a month with a date fixed by the respective superintendent/BMOH)	a. Presence of the FLWs out of total FLWs in position	All FLWs (100%)	Concurrent	Completed	District-level programme managers		
	b. Issues discussed	Institutional delivery, Janani Suraksha Yojana, ANANDI Programme.					
1.4.3 Monitoring of performance of FLWs and related issues by third party involvement (UNICEF's role in the ANANDI programme)	a. Number of individual monitoring conducted by the third party agency	Conducting regularly	Started from third week of March but will be an ongoing process	Completed	BMOH, BPHN, District-level programme officers and programme managers		
	b. Major findings from this monitoring	UNICEF reported sharing with blocks and district					
	c. Corrective action taken	No information					
	d. Results of the corrective action	No information					
1.5.1 Orientation of contractual staff recruited under different programmes of the MNCH, e.g. Anwesha and ICTC	a. Number of orientation conducted topic-wise with type and number of contractual staff	Regularly conducted	June 2016	Completed	Block-level programme managers		

Note:

1. **Meetings**: Meetings called by the theme leader exclusively for discussing the progress of action points; telephone or email enquiries with individual stakeholders do not count
2. **Progress of indicators**: Enter the cumulative figure/percentage/ (Y/N) whichever is applicable for the whole of the health district
3. **Status of action points:** Enter completed/ongoing/not started

A.2: Record of Proceedings – Summary Tables

A.2.1: Record of Proceedings – summary for DIPH Step 4			
A. Time taken for each session			
Session	***Time allotted***	***Actual time taken***	***Remarks***
A.1 Briefing	30 minutes	20 minutes	All participants were on time
A.2 Form 4	60 minutes	40 minutes	A very structured discussion and completed within timeline
B. Stakeholder leadership			
B.1 Agenda circulated/invitations sent		DIPH research team	
B.2 Chair of sessions		CMOH, DHHD	
B.3 Nominee/ volunteer	Completing data forms	Bhushan	
	Presenting summary	Sayan	
	Theme leader	Dy. CMOH-II	
	Record of proceedings	Mayukhmala	
C. Stakeholder participation			
C.1 Number of stakeholders invited[40]	Health department	9	1. CMOH, DHHD 2. Dy. CMOH-I, DHHD 3. Dy. CMOH-II, DHHD 4. Dy. CMOH-III, DHHD 5. District maternity and child health officer (DMCHO), DHHD 6. District programme co-ordinator, DHHD 7. District accounts manager (DAM), DHHD 8. Additional CMOH-I 9. Additional CMOH-II
	Non-health departments	2	1. PHPC, Zilla Parishad, S24PGS Health District 2. DPO-ICDS, CD
	District administration	2	1. Additional district magistrate-development 2. Officer-in-charge health
	NGO/private for-profit organisations	0	Not invited
C.2 Percentage of stakeholder participation (to those invited)[41]	Health department	44.4% (4/9)	The persons invited but not present: 1. Dy. CMOH-I, DHHD 2. Dy. CMOH-III, DHHD 3. DMCHO, DHHD 4. DAM, DHHD
	Non-health departments	50% (1/2)	1. DPO-ICDS did not participate
	District administration	0% (0/2)	Informed that they will not be participating due to busy schedule
	NGO/private for-profit organisations	0%	Not invited
	Total	38.5 % (5/13)	
D. Stakeholder involvement (*Note: Record everyone's viewpoint; if someone did not raise any concern, record it also)*			
D.1 Issues discussed by health department	CMOH	• Chairperson of meeting • Pointed out the need of birth	

[40] Table 2, Indicator 1.
[41] Table 2, Indicators 1-5.

representatives		preparedness • How to increase the performance of poor performing blocks • Training and orientation needs of all level of staff • Linkage between health, administration and PRD • Discussed each and every aspect of form content	
	Dy. CMOH-II	• Orientation and training of newly recruited MOs to ensure quality service delivery from the beginning • Third party verification of health department's performance	
	BMOH, Falta block (uninvited participant)	• Pradhan can influence community people to opt for institutional delivery especially in the areas with high home deliveries	
D.2 Non-health departments	PRD	• Role of Gram Panchayat Pradhans for awareness generation among community people • Non-participating tendency of the Gram Panchayat Pradhans in fourth Saturday meeting	
	ICDS-CD	Non applicable	Not present
D.3 NGO and private for-profit organisations		Non applicable	Not invited
D.4 District administration		Non applicable	Not present

E. Responsibilities delegated to non-health departments and NGOs*			
Type of activities shared	CD	Non applicable	Not present
	PRD	Reporting the participants in the fourth Saturday meeting	
	NGO	Non applicable	Not invited
F. Co-operation/communication between stakeholders*			
Not Applicable			
G. Data utilisation			
Not Applicable			
H. Suggestion for Developing a Decision-Making guide modification (*Note: suggestions with justifications on forms, process*)			
None			

*Some of these sections are specific to certain DIPH steps only.

A.2.2: Record of Proceedings – summary for DIPH Step 5			
A. Time taken for each session			
Session	***Time allotted***	***Actual time taken***	***Remarks***
A.1. Briefing, welcome and introduction	5 minutes	5 minutes (approximately)	Total 40 minutes session (10.10 am to 10.50 am)
A.2. Form 5	30 minutes	30 minutes	
A.3.Concluding remarks	5 minutes	5 minutes (approximately)	
B. Stakeholder leadership			
B.1 Agenda circulated/ invitations sent	CMOH, DHHD		Letter circulated to all stakeholders
B.2 Chair of sessions	CMOH, DHHD		
B.3 Theme leader	Dy. CMOH-III, DHHD		
B.4 Record of proceedings prepared by	DIPH member (AB)		
C. Stakeholder participation			
C.1 Number of stakeholders invited[42]	Health department	9	1. CMOH, DHHD 2. Dy. CMOH-I, DHHD 3. Dy. CMOH-III, DHHD 4. DMCHO, DHHD 5. Assistant CMOH, Kakdwip 6. Assistant CMOH, DHHD subdivision 7. District programme co-ordinator, DHHD 8. DAM, DHHD 9. District public health and nursing officer (DPHNO), DHHD
	Non-health departments	2	1. PHPC, Zilla Parishad, S24PGS Health District 2. DPO-ICDS, CD
	NGO/private for-profit organisations	0	Not invited
	District administration	2	1. Additional district magistrate-development 2. Officer-in-charge health
C.2 Percentage of stakeholder participation (to those invited)[43]	Health department	55.6% (5/9)	Not present: 1. DAM, DHHD 2. Assistant CMOH, Kakdwip 3. Assistant CMOH, DHHD subdivision 4. DPHNO, DHHD
	Non-health departments	50% (1/2)	Not present: PHPC <u>Uninvited participants</u>: CDPOs from: 1. Mathurapur-II 2. Kulpi 3. Magrahat-I

[42] Table 2, Indicator 1.
[43] Table 2, Indicators 1-5.

			4. Parthapratim 5. Kakdwip 6. one other block
	NGO/private for-profit organisations	0%	Not invited
	District administration	0% (0/2)	Informed inconvenient due to busy schedule
	Total	46.2% (6/13)	
D. Stakeholder involvement (*Note: Record everyone's viewpoint; if someone did not raise any concern, record it also)*			
D.1 Issues discussed by health department representatives	CMOH, DHHD	• Improving the quality of ANC is needed for identifying high-risk mothers • Need awareness and reports from Gram Panchayat level • Tagging/tracking pregnant women with ASHAs and ANMs	
	Dy. CMOH-III, DHHD	• Need to improve the coverage and quality of third ANCs to identify more high-risk mothers • ASHA should be more responsible and provide regular counselling to mothers during ANC services	
D.2 Non-health departments	CDPO Mathurapur-II	• Supervision and recruitment of staff is necessary • AWW and ASHA should more actively participate in arranging the third Saturday meetings and mobilising mothers to attend these meetings • Baby weighing machines are needed	
D.3 NGO and private for-profit organisations		Non applicable	None present
D.4 District administration		Non applicable	None present
E. Responsibilities delegated to non-health departments and NGOs*			
Type of activities shared		Non applicable	
F. Co-operation/communication between stakeholders*			
Stakeholder from health department and CD	Agreed on each other's points throughout the session		
G. Data utilisation			
The progress was assessed on the basis of: HMIS – status as on 27 May 2016 and MCTS – status as on 29 May 2016			
H. Suggestion for Developing a Decision-Making guide modification (*Note: suggestions with justifications on forms, process*)			
None			

*Some of these sections are specific to certain DIPH steps only.

A.3: Transcripts of In-depth Interviews with Stakeholders

A.3.1: In-depth interview with CMOH

IDI details	
IDI label	I05_GSN_AI_14June2016
Interviewer	Anns Issac and Sayan Ghosh
Note taker	Sayan Ghosh
Transcriber	Mayukhmala Guha
Respondent details	
Date and time of interview	14 June 2016
Name of participant	Dr Somnath Mukherjee
Gender	Male
Designation	CMOH
Department	Department of Health and Family Welfare
Duration of service in the district	2 years
Previous position	Superintendent, MR Bangur Hospital
Qualifications	MBBS, MD
Years of experience in present department	24 years
Membership in committees pertaining to health	District Development and Monitoring Committee, Committee of District Judge, District Appropriate Authority of Pre-Conception and Pre-Natal Diagnostic Techniques

1. How are health-related decision-making processes under the DIPH happening in your district? Probe:
a. General impression
b. If there is any difference observed on how health-related decision-making was conducted prior to the DIPH and on how it is being conducted presently through the DIPH

In the last DIPH cycle, we have workshop, we have training with BMOH and BPHNs, earlier they were not able to understand but after meeting, now it has been solved.

It is too early to comment as there are so many meetings ongoing already, BMOHs are not that much oriented in DIPH process itself. Involvement of the general admin along with the health especially the facility managers of blocks is just now started, this directive is given to them. Hopefully in near future we can see some change.

I felt data collection, meetings as per the format is already in the process, nothing new in this. Another NGO is working in the district, supporting blocks in attaining institutional delivery and immunisation targets; more at the facility level, so you can look after quality improvement at the sub-centre level. As maternal or infant death is a concern, there is a higher rate of preterm birth so infant mortality rate is increasing if quality of service (birth preparedness mainly) can be improved at sub-centre level, then only we can think of healthy mother and healthy child, which is the goal of the National Health Mission. Awareness generation is already in the process, that only can be augmented, but some people need to intervene at the sub-centre level to supervise their work procedure. Fundamental thing is that you have to have a very good knowledge while working in health sector, unless you cannot give appropriate service. The health workers not updating their knowledge giving excuse of overburden, but that cannot go for long run.

I personally feel that from your reports we can see in black and white that what exact scenario is, but with your intervention at sub-centre will be a breakthrough, improvising the quality of service they provide. I believe they will get inspired by you and they will feel enthusiastic, as

their current supervisor having knowledge block and also unwilling to provide quality time to them.

My suggestion would be that you should visit block-level officials and have interview with them to get their point of view as well.

On asking whether they can be called in district, CMOH advised better to go to block and have interview, not only with BMOH but also with BDO and Sabhapati of block to understand their actual need. We want "healthy mother and healthy baby" so how to improve the situation, where are the lacuna of service. As I said if you visit sub-centre, you can see blood pressure machine not working, in Mother and Child Protection card haemoglobin level noted as 12 for all trimester. Earlier home delivery in S24PGS Health District was higher 61% or 68% now it has come down to 27%. So now we have to look for quality. If you see Bardhaman or Hoogly they have much lower than S24PGS Health District, if you point out education level it's almost same. So maybe the health workers are not motivated and awareness is also an issue, but at the same time awareness should be generated by health workers. I feel you can search out the issues. If you seat [discuss] with two different district and block officials and even compare situation at village level, then you may find the cause. For example, in Sagar institutional delivery is very low. There are stigma like Muhammadans aren't interested to institutional delivery but in other district they are doing. Because of the location of the house, involvement of DHHD is pretty low. No health workers stay in and around the area, they are outside of the locality. For example, in Magrahat, Sagar, Patharpartima, Kulpi, all these workers mostly stay at Baruipir, Sonarpur or even as far as Behala. Why I am specifically comparing S24PGS Health District with Hoogly District as, Deputy-III CMOH earlier worked in Hoogly, so he was explaining his experience of that district. There people work target based which is missing in DHHD. They [the other district people] have been sensitised like that way only.

2. Are you finding the DIPH process useful? If yes, then which aspects are you finding particularly useful? Probe for each steps:
a. Conducting situation analysis for health system problems
b. Prioritisation of health-related problems at district level
c. Development of action plan
d. Follow-up of action plan

He said too early to comment on Questions 2 and 4.

3. What are the key themes covered in the last DIPH cycle?

Not asked (only one theme identified).

4. What progress through the DIPH have you made to improve the health targets/status in your district? Probe: Please elaborate how the DIPH is useful in:
a. Identifying the health issue to focus on
b. Development of action plan
c. Follow-up of action plan

See response to Question 1.

5. Did the DIPH process help in using data to identify priorities of the district?

See response to Question 1.

6. Whether data is used in monitoring the progress of the action plan in your district?

See response to Question 1.

7. Did the DIPH process lead to any change in the working relationship and interaction between the health department and government non-health departments? Probe:
a. Did the process help in joint participation in identifying priorities for the district, developing plan and joint monitoring of the plan?
b. Was data shared between the departments?
c. Did frequency of interaction increase since the last DIPH?

There is already interaction in-between departments, but all these are very mechanical. No one feels that a mother is their responsibility. The ownership is really missing, even same thing I have noticed in CD worker. But this people never have worked that way. You need to do lot of ground work, the reason cannot be solely find out from data collection. Till date lot of stigmas (unavailability of female doctors or presence of backward class) are going around. In other district, scenario is same but they are much more aware because of involvement of health worker. I have seen during Japanese Encephalitis programme, in Sonarpur block, the first ANM rapport is so good. There is one Madrasa, where 16 children did not want to take immunisation though BMOH intervened they did not take immunisation until ANM give consent.

8. Did the maternal and child health (MCH) NGO sector achieve involvement through the DIPH process? Probe:
a. What are the challenges in bringing the MCH NGO sector in joint planning for health issues in the district?
b. How can these issues be solved?

WHO is working in immunisation area, I feel that as ASHA workers are already working in the field, NGO involvement is not much needed. In resistance area, NGO can intervene but I am not sure how much that will be effective. NGO mobilisation for immunisation is not required because we are already working in a system.

There are other demands raised by local people to the immuniser such as no jobs, poor condition of road, etc. In my idea, ASHA should be the one who do the mobilisation for immunisation as they are the local people.

NGO working in the area would be an additional help, same as Public Health Foundation of India (PHFI) working in the area. But these will not help to find the root cause of such poor performance of the district. Multiple mobilisation is always proven to be helpful to reduce the workload, but before that, a root cause need to be find. NGO should help to find out the lacunae.

[At the end of the interview, again he mentioned]

That UNICEF is going to the labour room and reviewing, in sub-centre level if NGO can

review, there lies the support of NGO. Observation and hands-on training shall be done by NGO such as by you [PHFI]. If you ask them about waste management they are unable to speak out as they are not hammered every day. The lack is in daily monitoring.

9. Did the private sector achieve involvement through the DIPH process? Probe:
a. What are the challenges in bringing the private sector in joint planning for health issues in the district?
b. How can these issues be solved?

He did not mention anything about the private sector.

10. What are the challenges faced during the implementation process of the last DIPH cycle? Probe: describe challenges in terms of (BUT not limited to):
a. Dedicating time to conduct DIPH
b. Availability of data to monitor progress
c. Active involvement of different government departments, district administration, NGO and private sector

See responses to Questions 1 and 7.

11. Any suggestion how any of the steps involving the DIPH cycle can be improved (name them)? Probe: BUT not limited to:
a. Frequency of the cycle
b. Engagement of all stakeholders

See responses to Questions 8 and 12.

12. Any suggestion how the DIPH process can be better implemented in your district?
Probe: BUT not limited to:
a. Frequency of the cycle
b. Engagement of all stakeholders

On probing by interviewer, CMOH agreed that engaging the block officials, lower level workers and make action plan in their presence would be a good idea. You can also visit another district, say Hooghly and find the reason why S24PGS Health District is still behind from other districts. If monitoring and supervision is not regularised in DHHD, again home delivery will be on rise. I think in other district the entire team is working effortlessly, the Rashtriya Bal Swasthya Karyakram/Anwesha Clinic is also working there, so if we can implement their good practices in this district there is a higher chance of improvement.

However, there is clearly a lack of motivation. No training or workshop can improve the situation.

A.3.2: In-depth interview with Dy. CMOH-II

IDI details	
IDI label	I06_GSN_SG_01July2016
Interviewer	Sayan Ghosh
Note taker	Sayan Ghosh
Transcriber	Mayukhmala Guha
Respondent details	
Date and time of interview	01 July 2016; 10.30 am
Name of participant	Dr Swagatendra Narayan Basu
Gender	Male
Designation	Dy. CMOH-II
Department	Department of Health and Family Welfare
Duration of service in the district	1 year 7 months
Previous position	Superintendent, Bhatpara hospital
Qualification	MBBS, DPCT and Diploma in Public Health
Years of experience in present department	15+ years
Membership in committees pertaining to health	District Health and Family Welfare Samity

1. How are health-related decision-making processes under the DIPH happening in your district? Probe:
a. General impression
b. If there is any difference observed on how health-related decision-making was conducted prior to the DIPH and on how it is being conducted presently through the DIPH

Till date, we used to fix target for blocks from the district itself. But after DIPH process, now blocks are using the format, analysing their capacity and fixing a target for themselves. After receiving data report from them, we are analysing the block progress on a regular basis. Some activities were ongoing earlier also but was not monitored at all by block or district, with the help of DIPH process we are monitoring those indicators. For example, mothers meeting is a regular activity to be conducted by block level, wasn't monitored, it was just a routine work for them, but now it has got much more attention as we monitor this activity regularly.

2. Are you finding the DIPH process useful? If yes, then which aspects are you finding particularly useful? Probe for each steps:
a. Conducting situation analysis for health system problems
b. Prioritisation of health-related problems at district level
c. Development of action plan
d. Follow-up of action plan

We found the DIPH process is very useful for the district to improve district indicators.

3. What are the key themes covered in the last DIPH cycle?

Not asked (only one theme identified).

4. What progress through the DIPH have you made to improve the health targets/status in your district? Probe: Please elaborate how the DIPH is useful in:
a. Identifying the health issue to focus on
b. Development of action plan
c. Follow-up of action plan

Answer provided under Question 1.

5. Did the DIPH process help in using data to identify priorities of the district?

Answer provided under Question 1.

6. Whether data is used in monitoring the progress of the action plan in your district?

Answer provided under Question 1.

7. Did the DIPH process lead to any changes in the working relationship and interaction between the health department and government non-health departments? Probe:
a. Did the process help in joint participation in identifying priorities for the district, developing plan and joint monitoring of the plan?
b. Was data shared between the departments?
c. Did frequency of interaction increase since the last DIPH?

Yes, we have a regular monthly meeting with district magistrate (CMOH and district magistrate) − development planning meeting. After DIPH, we have seen that general administration could help us in many ways in improving institutional services. The planning format reveals that we are not getting help by BDOs, we have submitted report to district magistrate that BDO should help us in minimum ways to improve the institutional delivery in district. The general administration can use Mahatma Gandhi National Rural Employment Guarantee Act project such as land filling or cleaning up of facility. For example, during rainy season, water logging is a major issue, mother and even general patients facing problem to reach health facilities. So here land soiling is a much needed activity to be done by BDOs. Very soon we are going to have a meeting with sub-divisional officers to sort this kind of issue with reports that has already been submitted to district magistrate. Now there are other issues also such as there is no toilet in some public facilities, patient parties facing problem while getting service from that particular facilities. The district magistrate specifically ordered for construction of toilet at public facilities for public use. All these things are coming up from these reports.

8. Did the MCH NGO sector achieve involvement through the DIPH process? Probe:
a. What are the challenges in bringing the MCH NGO sector in joint planning for health issues in the district?
b. How can these issues be solved?

Couple of NGOs are working in the district on MCH. In Magrahat-I and II block, one NGO is helping us [KRDS] and another NGO has recently submitted a new mobilisation plan. Apart from that, another NGO is working in Kulpi (can't remember the name). On asking whether a telemedicine programme [Corporate Social Responsibility Programme] is going on in any island of the DHHD, he said in Mousumi Bagdah one such programme is ongoing, but I am not fully aware of their activity and its impact on MCH as they directly report to district administration.

9. Did the private sector achieve involvement through the DIPH process? Probe:
a. What are the challenges in bringing the private sector in joint planning for health issues in the district?
b. How can these issues be solved?

Not explained.

10. What are the challenges faced during the implementation process of the last DIPH cycle? Probe: describe challenges in terms of (BUT not limited to):
a. Dedicating the time to conduct DIPH
b. Availability of data to monitor progress
c. Active involvement of different government departments, district administration, NGO and private sector

In Cycle 1, we have seen that there is a correlation problem in data at the block level. One set of data is not correlated with another same set of data. For example, now there's one report in front of me in Madhabnagar they have given estimated registration of pregnant women of 525 but they have actually registered 643 women for delivery. So there is a problem in baseline data. Another thing they have planned 283 mothers' meeting, where they attended 1,014 pregnant women. Now the issue is minimal budget is required to conduct such meetings, flexi budget cannot be used in these kind of activities. We have also planned for mother's day (innovative thinking) where mothers, who have delivered at the hospital, will share their experiences as "happy mothers" but to continue this we require rural fund support. As we have just started as…

I can say everywhere much improved after introducing DIPH process in the district but obviously it's not 100% improvement. Sending SMS from MCTS portal is not that much useful as of now, the ANM inboxes getting full of garbage notification as she is getting notified for activity of ASHA, notification of mothers registered under her, notification for her work everything, but not getting a real time notification that a mother has missed her fourth ANC check-up. This is a technical issue which require immediate solution. The DEO of block and district are trying to solve this but it is very slow as the process is ongoing simultaneously. We need some outsource people who could work on this and change the phone number for receiving this urgent SMS of missing fourth ANC check-up of a mother. This would be really helpful.

11. Any suggestions how any of the steps involving the DIPH cycle can be improved (name them)? Probe: BUT not limited to:
a. Frequency of the cycle
b. Engagement of all stakeholders

See response for Question 12.

12. Any suggestions how the DIPH process can be better implemented in your district?
Probe: BUT not limited to:
a. Frequency of the cycle
b. Engagement of all stakeholders

The data reporting system should be in a way that even simple Excel files can be uploaded in the server easily. It will make the whole work easier and can be shared across all sectors [general administration] such as directly with district magistrate, it's better than sharing offline information [current process] as district magistrate can directly look into the current data. Online data can show current situation of any block, so that where the problem lies can be notified easily, that's how general administration can be also more involved in the process.

We can also ask for funds to State Samity for conducting mothers' meetings (for which currently fund is not available at the district) or even to mobilise mothers by NGOs/self-help groups (SHGs) in unserved population. Currently there is a vacancy of 400 ASHAs in the district that simply indicates that 400,000 population is not being served by health department. Involvement of SHG would be beneficial as incentive amount will also be less than ASHAs, such as we can give Rs.100 (£1.22) for mobilising mothers by SHGs whereas ASHAs get a fixed incentive of Rs. 300 (£3.67) per mother. We can actually go for this if we get fund support from state. The problem is that a concrete technical project plan is required to make this happen but we are much busy with office work. Here, PHFI can help us in forming a detail project plan with all budget details. If need, they can represent it to state where we don't have to know all the nitty-gritty of the project.

A.4: Monitoring Format with Definitions

A.4.1 Monitoring framework[44]

Purpose	Indicators	Definition	Sources of information
I. Utilisation of data at district level Whether the DIPH study led to the utilisation of the health system data or policy directive at district level for decision-making?	A. Selection of the primary theme for the current DIPH cycle	**1. Whether the DIPH cycle theme selection was based on HMIS data? (Y/N)** **Health system data:** statistical information collected either routinely or periodically by government institutions on public health issues. This includes information related to provision and management of health services. This data can be from the health department and/or non-health departments *In the West Bengal context, the main data sources will include HMIS and MCTS*	Form 1B: Health system capacity assessments
		2. Whether the DIPH cycle theme selection used any data from non-health departments? (Y/N) **Non-health departments:** government departments, other than the health department, which directly or indirectly contributes to public health service provision *In the West Bengal context, this includes PRD and CD*	Form 1B: Health system capacity assessments
		3. Whether the DIPH cycle theme selection was based on health policy and programme directives? (Y/N) **Health policy:** refers to decisions that are undertaken by state/national/district to achieve specific health care plans and goals. It defines a vision for the future which in turn helps to establish targets and points of reference for the short- and medium-term health programmes **Health programme:** focused health interventions for a specific time period to create improvements in a very specific health domain *In the DIPH West Bengal context: any health-related directives/guidelines/government orders in form of an official letter or circular issued by the district/state government*	Form 1A.1: Data extraction from state and district health policy documents
	B. Data-based monitoring of the action points for the primary theme of the DIPH	**4. (Number of action points on which progress is being monitored by data) / (total number of action points for the primary theme of the DIPH)** **Action points:** a specific task taken to	Form 5: Follow-up

[44]For prototyping in West Bengal, India, there is only one primary theme selected for each DIPH cycle.

- HMIS including MCTS data, health policy/programme directive or both.
- The action points are on the requirements for achieving the primary theme of the given DIPH cycle.
- The prioritisation of the action points is on the feasibility as per stakeholder's decision.
- The monitoring plan of any given DIPH cycle is on: (i) health system data, e.g. from HMIS and health policy/programme documents from which the theme-specific information is from Form 1A.1; and (ii) monitoring the progress of action points using the specified DIPH format.

		achieve a specific objective *In the DIPH context: a specific action, arisen from the stakeholder discussions during Steps 3 and 4, to achieve the target of the given DIPH cycle*	
	C. Revision of district programme data elements for the primary theme of the DIPH	**5. Whether stakeholders suggested a revision/addition to the health system data in the given DIPH cycle? (Y/N)**	Form 4: Plan
		6. (Number of data elements added in the health database as per the prepared action plan) / (total number of additional data elements requested for the primary theme of the DIPH) **Data elements:** operationally, refers to any specific information collected in the health system data forms, pertaining to all six WHO health system building blocks (demographic, human resources, finance, service delivery, health outcome and governance)	Form 5: Follow-up
	D. Improvement in the availability of health system data	**7. Whether the health system data required on the specified theme as per the given DIPH cycle was made available to the assigned person in the given DIPH cycle? (Y/N)** **Assigned person**: as per the cycle-specific DIPH action plan; this can be the theme leader, DSM, or any other stakeholder who is assigned with the responsibility of compiling/reporting specified data	Form 1B: Health system capacity assessments
		8. Whether the health system data on the specified theme area is up-to-date as per the given DIPH cycle? (Y/N) ***Up-to-date data:*** ***a)*** If monthly data, then the previous complete month at the time of Step 1 of the DIPH cycle ***b)*** If annual data, then the complete last year at the time of Step 1 of the DIPH cycle	Form 1B: Health system capacity assessments
II. Interactions among stakeholders: co-operation in decision-making, planning and implementation Whether the DIPH study ensured involvement of stakeholders from different sectors (health, non-health and NGO/private for-profit organisations)	E. Extent of stakeholder participation	**1. (Number of DIPH stakeholders present in the planning actions meeting) / (total number of DIPH stakeholders officially invited in the planning actions meeting)** *Participants in Steps 4 and 5* **DIPH stakeholders***:* public and private sector departments, organisations and bodies relevant for the specific DIPH cycle **Officially invited**: stakeholders formally being invited to participate for the specific DIPH cycle *In the West Bengal context, for example:* • *Public sector stakeholders: Department of Health and Family Welfare; PRD; and CD* • *Private sector stakeholders: NGOs, nursing homes; and large hospitals owned by private entities*	Form A.2: Record of Proceedings – Summary Table
		2. (Number of representatives from the	Form A.2:

		health department present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting) *Participants in Steps 4 and 5*	Record of Proceedings – Summary Table
		3. (Number of representatives from non-health departments present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting) *Participants in Steps 4 and 5*	Form A.2: Record of Proceedings – Summary Table
		4. (Number of representatives from NGOs present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting) *Participants in Steps 4 and 5*	Form A.2: Record of Proceedings – Summary Table
		5. (Number of representatives from private for-profit organisations present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting) *Participants in Steps 4 and 5*	Form A.2: Record of Proceedings – Summary Table
	F. Responsibilities assigned to stakeholders	**6. (Number of action points with responsibilities of the health department) / (total number of action points for the primary theme of the DIPH)**	Form 4: Plan
		7. (Number of action points with responsibilities of non-health departments) / (total number of action points for the primary theme of the DIPH)	Form 4: Plan
		8. (Number of action points with responsibilities of NGOs) / (total number of action points for the primary theme of the DIPH)	Form 4: Plan
		9. (Number of action points with responsibilities of private for-profit organisations) / (total number of action points for the primary theme of the DIPH)	Form 4: Plan
	G. Factors influencing co-operation among health, non-health and NGO/private for-profit organisations to achieve the specific action points in the given DIPH cycle	**10. List of facilitating factors** **1.** **2.**	Form A.3: In-Depth Interview with Stakeholders
		11. List of challenging factors **1.** **2.**	Form A.3: In-Depth Interview with Stakeholders
III. Follow-up: Are the action points planned for the DIPH primary theme achieved?	H. Action points initiated	**1. (Number of primary theme-specific action points initiated within the planned date) / (total number of primary theme-specific action points planned within the specific DIPH cycle)**	Form 5: Follow-up
	I. Action points achieved	**2. (Number of primary theme-specific action points completed within the planned date) / (total number of primary theme-specific action points planned within the specific DIPH cycle)**	Form 5: Follow-up

		3. (Number of written directives/letters issued by the district/state health authority as per action plan) / (total number of written directives/letters by the district/state health authority planned as per action points of the DIPH primary theme)	Form 5: Follow-up
		4. (Amount of finance sanctioned for the primary theme-specific action points) / (total amount of finance requested as per action points of the DIPH primary theme)	Form 5: Follow-up
		5. (Units of specific medicine provided for the primary theme-specific action points) / (total units of specific medicine requested as per action points of the DIPH primary theme)	Form 5: Follow-up
		6. (Units of specific equipment provided for the primary theme-specific action points) / (total units of specific equipment requested as per action points of the DIPH primary theme) ***Equipment*:** technical instruments, vehicles, etc. provided to achieve the DIPH action points	Form 5: Follow-up
		7. (Units of specific IEC materials provided for the primary theme-specific action points) / (total units of specific IEC materials requested as per action points of the DIPH primary theme)	Form 4: Plan Form 5: Follow-up
		8. (Number of human resources recruited for the primary theme-specific action points) / (total human resources recruitment needed as per action points of the DIPH primary theme)	Form 4: Plan Form 5: Follow-up
		9. (Number of human resources trained for the primary theme-specific action points) / (total human resources training requested as per action points of the DIPH primary theme)	Form 4: Plan Form 5: Follow-up
	J. Factors influencing the achievements as per action points of the DIPH primary theme	**10. List of facilitating factors** **1.** **2.**	Form A.3: In-Depth Interview with Stakeholders
		11. List of challenging factors **1.** **2.**	Form A.3: In-Depth Interview with Stakeholders

Find out more at **ideas.lshtm.ac.uk**

The Data-Informed Platform for Health is a project implemented in collaboration between the IDEAS project, the Public Health Foundation of India and the West Bengal University of Health Sciences.

The IDEAS project is based at the London School of Hygiene & Tropical Medicine and works in Ethiopia, Northeastern Nigeria and India. Funded by the Bill & Melinda Gates Foundation, it uses measurement, learning and evaluation to find out what works, why and how in maternal and newborn health programmes.

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