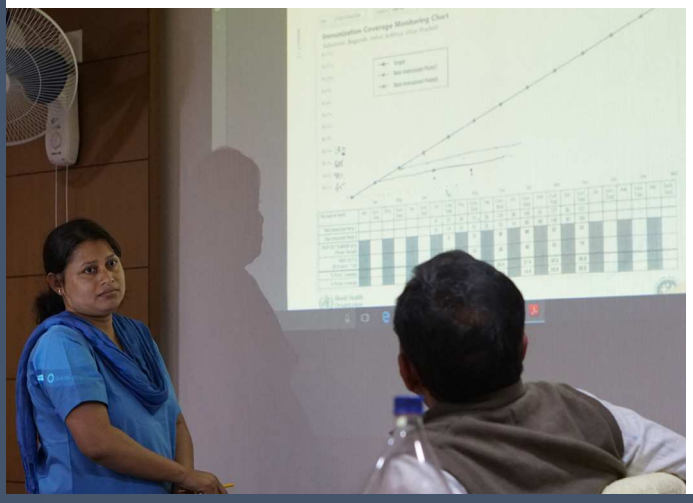

DIPH

The Data-Informed Platform for Health

Structured district decision-making using local data

MONITORING REPORT
Cycle 1: January - April 2016

North 24 Parganas
West Bengal, India

DATA INFORMED PLATFORM FOR HEALTH

MONITORING REPORT

North 24 Parganas, West Bengal, India

Cycle 1: January – April 2016

THE WEST BENGAL UNIVERSITY OF HEALTH SCIENCES Estt:2003

KNOWLEDGE TO ACTION phfi PUBLIC HEALTH FOUNDATION OF INDIA

IDEAS Evidence to improve maternal & newborn health

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

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ACKNOWLEDGEMENTS

IDEAS Team (LSHTM)
DIPH Lead: Dr Bilal Iqbal Avan
PI: Prof Joanna Schellenberg
Country Team (India – PHFI)
Lead: Dr Sanghita Bhattacharyya
Research Associate: Dr Anns Issac
District Co-ordinator: Ms Mayukhmala Guha
State Partner (West Bengal)
Ministry of Health and Family Welfare
West Bengal University of Health Sciences (Prof Bhabatosh Biswas, Vice Chancellor)

LIST OF TABLES

LIST OF ABBREVIATIONS

ACMOH	Assistant chief medical officer of health
ADM	Additional district magistrate
ADM-G	Additional district magistrate-general
ANM	Auxiliary nurse midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi worker
BAF	Block ASHA facilitator
BCC	Behaviour change communication
BMOH	Block medical officer of health
BPHN	Block public health nurse
CD	Child Development
CDPO	Child development project officer
CMOH	Chief medical officer of health
DAF	District ASHA facilitator
DAM	District accounts manager
DEO	Data entry operator
DIPH	Data Informed Platform for Health
DMCHO	District maternity and child health officer
DPC	District programme co-ordinator
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-III	Deputy chief medical officer of health-III
FBNC	Facility-based newborn care
FLW	Frontline worker
HBNC	Home-based newborn care
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
ICTC	Integrated Counselling and Testing Centre
IEC	Information, education and communication
IMA	Indian Medical Association
IMNCI	Integrated Management of Neonatal and Childhood Illness
IPHS	Indian Public Health Standards
IYCF	Infant and Young Child Feeding
MCH	Maternal and child health
MCTS	Mother and Child Tracking System
MIES	Management Information and Evaluation System
N24PGS	North 24 Parganas
NGO	Non-governmental organisation
NSSK	Navjat Shishu Suraksha Karyakram
NUHM	National Urban Health Mission
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
PHN	Public health nurse
PHPC	Public health programme co-ordinator
PRD	Panchayat and Rural Development
RCH	Reproductive and child health
RSBY	Rashtriya Swasthya Bima Yojna
SBA	Skilled birth attendant

SDO	Sub-divisional officer
SNCU	Sick Newborn Care Unit
VHND	Village Health Nutrition Day
VHSNC	Village Health, Sanitation and Nutrition Committee

1. INTRODUCTION

Data Informed Platform for Health (DIPH)		
Cycle no.	1	
District	North 24 Parganas	
Duration	January – April 2016	
Theme	Initiation of breastfeeding within one hour of birth and promotion of exclusive breastfeeding until six months	
Steps involved	Step 1	**Assess:** Based on the *District Programme Implementation Plan 2015/16* and Health Management Information System (HMIS) indicators (Department of Health and Family Welfare, 2015; MoHFW, 2016), the DIPH stakeholders identified the coverage gaps and selected the theme in consultation with the non-health departments 'Initiation of breastfeeding within one hour of birth and promotion of exclusive breastfeeding until six months' for Cycle 1 of the DIPH. As the non-health departments do not maintain data to the theme indicators, the situation assessment only used data from the health department.
	Step 2	**Engage:** The primary responsibility for Cycle 1 was with the health department, while the departments of Child Development (CD) and the Panchayat and Rural Development (PRD) shared the supportive responsibilities. The theme leader selected for Cycle 1 was from the health department. Majority of participants were from the health department. Representation from the district administration and CD were poor, and the post of district programme officer (DPO) at the CD was vacant during DIPH Cycle 1. Though participants acknowledged the presence of non-governmental organisations (NGOs) in the district, both NGOs and major private for-profit organisations did not receive an official invitation to take part in the DIPH process.
	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. The stakeholders identified ten problems with eight actionable solutions to address the ten problems, in keeping with the capacity of the district administration and the time frame of the DIPH cycle.
	Step 4	**Plan:** The stakeholders developed 21 action points to achieve the target and assigned the responsibilities across departments within a given time frame. The maximum share of responsibilities (71%) was with the health department and the remaining share of responsibilities (29%) was with the non-health departments.
	Step 5	**Follow-up:** Reviewing the status of achievement for the 21 action points occurred at the end of DIPH Cycle 1. Within the given time frame, 57% of action points had completed. The remaining action points received a new timeline. Out of the remaining action points, 33% could not start due to the State Assembly election during the cycle period. The theme leader monitored the progress through communication via telephone with the district personnel responsible for each action point.

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 of the DIPH Cycle 1	06 January 2016
2	**Step 2: Engage** Form 2: Engage	Theme leader of the DIPH Cycle 1	08 January 2016
3	**Step 3: Define** Form 3: Define	Theme leader of the DIPH Cycle 1	08 January 2016
4	**Step 4: Plan** Form 4: Plan	Theme leader of the DIPH Cycle 1	13 January 2016
5	**Step 5: Follow-up** Form 5: Follow-up	Theme leader of the DIPH Cycle 1	29 April 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, North 24 Parganas (N24PGS)	January – April 2016
7	**In-Depth Interviews with Stakeholders** Form A.3.1: Chief medical officer of health (CMOH)	Interviewed by the DIPH district co-ordinator, N24PGS	12 May 2016
	Form A.3.2: District maternity and child health officer (DMCHO)	Interviewed by the DIPH district co-ordinator, N24PGS	12 May 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 identified two themes for the situation analysis based on the *District Programme Implementation Plan 2015/16* and coverage indicators in the HMIS (Department of Health and Family Welfare, 2015; MoHFW, 2016). Using the HMIS data to compare the district performance with the state on the breastfeeding indicators showed that the district is lagging behind (MoHFW, 2016). Therefore, from the results of the situation analysis the stakeholders selected the theme 'Initiation of breastfeeding within one hour of birth and promotion of exclusive breastfeeding until six months' for DIPH Cycle 1. Though non-health departments participated, they do not maintain data for the theme; therefore, theme identification did not involve using data from the non-health departments.

3.1.2 Challenges in data utilisation

There were issues with availability, timeliness and quality of data at district level. Only data used for routine reporting and part of the HMIS receive regular updates (MoHFW, 2016).

Also, there was no data-sharing from private providers and NGOs. As a result, stakeholders did not have comprehensive data for the district during the meeting.

3.1.3. Proposed solutions

The indicator 'Newborns breastfed within an hour of birth' was not available with the district stakeholders during the time of theme selection. Hence, they considered inclusion of this indicator in the labour room register as one of the action points. The district stakeholders, during the situation analysis, identified gaps in the district data sources and found ways to address these data gaps within the DIPH process.

> "Data collection is a concurrent process going on from ages but after DIPH intervene in the district, we are able to highlight more gaps in data of different departments. But the problem is that there is no directive or policy how to reduce the gap in reality. My suggestion would be to notify this situation to the state authority [by DIPH research team] so a policy can come out in which data convergence should be happening. Now we know the gaps but we require a concrete policy or mechanism to sort out the issue." (CMOH, N24PGS)

To facilitate monitoring of action points, the CMOH and theme leader of the district planned specific and clear indicators for the subsequent cycles. Monitoring of action points can involve using existing district programme data. In addition, the theme leader envisaged stakeholder training for sub-district-level representatives.

Table 1: Utilisation of data at district level

Purpose	Indicators		Response (Yes/No and 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	4. (Number of action points for	11/21 = 52.4[4]	Form 5

[1] As per HMIS, early initiation of breastfeeding (within one hour of birth) was 81% in the selected district. This indicates a gap of 20% (as per the Indian Public Health Standards – IPHS) (MoHFW, 2012). In Step 1, the stakeholders discussed the severity of the theme based on the data from HMIS (MoHFW, 2016). (See Form 1B, Sl. No. 2.1.)

[2] The DIPH is still thought of as the responsibility of the health department. Hence, the theme selection did not use data from other departments. Moreover, no other department collects data on the selected theme.

[3] There is a guideline for Infant and Young Child Feeding (IYCF) practices by the Government of India (MoHFW, 2013) which clearly points out the importance of initiation of breastfeeding within one hour of birth as well as exclusive breastfeeding. Further, the IPHS emphasise 100% coverage of newborns breastfed within one hour of birth (MoHFW, 2012). (See Form 1A.1, Sl. No.1.)

[4] Out of the 21 action points, five action points had data-based monitoring during Cycle 1 (January − April 2016). Six action points had to be postponed to post-April 2016 and also used data-based monitoring.

	monitoring of the action points for the primary theme of the DIPH	which progress is being monitored using data) / (total number of action points for 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)	Yes[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)	1/1 = 100[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). The overall response to the DIPH meetings in terms of attendance was less than three-quarters.

3.2.1 Interaction between health and non-health departments

Majority of participants were from the health department. The representation from district administration, other than the additional district magistrate (ADM) who attended one meeting, was poor. The officer-in-charge, health of district administration did not attend any of the DIPH meetings, the possible reason may be that he could not visualise his role in the DIPH process. There was no participation from the Integrated Child Development Services (ICDS) as the post of DPO was vacant during DIPH Cycle 1. Though there are two health districts under the N24PGS administration, the representation from the Basirhat Health District was less than satisfactory, as most of the positions were vacant during DIPH Cycle 1. As the theme identified for the cycle is under programme(s) managed by the health department, the health department had primary responsibility. Out of the 21 action points, only six action points were for the non-health departments.

[5]The stakeholders discussed the issues of availability, timeliness and reliability of data at district level. They suggested the addition of one item to the district health register. (See Form 4, Sl. No. 1.1.1.)

[6]The stakeholders suggested adding one item 'the number of newborns started breastfeeding within one hour of birth' in the labour room register (public health facilities). (See Form 5, Sl. No. 1.1.1.)

[7]The theme-specific (breastfeeding) data collection was by the DIPH research team from the HMIS database (MoHFW, 2016a). The details of which were not readily available with the district statistical manager (DSM). Further, the data on human resources, training and infrastructure were not updated and stored systematically. These were from different forms and all were incomplete. (See Form 1B, Sl. No. 3.1 and No. 3.3.)

[8]The latest data (percentage of newborns breastfed within an hour of birth) available during DIPH Step 1 (January 2016) was of April 2014 − March 2015. (See Form 1B, Sl. No. 2.1.)

To ensure better participation of officials from non-health departments in subsequent cycles, stakeholders suggested issuing an office order/circular from the office of district magistrate to specified departments.

3.2.2 Interaction between the health department and NGOs

There are a few NGOs in the district that are participating in operating the Community Delivery Centre under the Ayushmati scheme. But they were not part of any formal decision-making platform at district level and were not invited by the district stakeholders to participate in the DIPH process. The reason for not involving NGOs was that these NGOs do not participate in the overall district planning process as their operation limits to a few select pockets and to specific topics. During the stakeholder meeting, there was a need to visualise specific roles of NGOs for the subsequent DIPH cycle. To ensure participation from the NGO sector, a suggestion put forward was to identify NGO roles with specific action points.

> "NGOs can be involved as they are already working in the district. But the problem is there no such NGO in N24PGS who is covering the whole district. We have to call two to three NGOs who are working on different area in the district. Their work is totally programme-specific. If we call them for a meeting they will come for sure but how that will be beneficial for whole district is a bit doubtful." (DMCHO, N24PGS)

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

The N24PGS has a large share (57%) of urban population, mainly catered by private providers. Though they play a significant role in health service provision, the private for-profit organisations are not officially part of any planning and decision-making bodies at district level. The CMOH does not have authority to demand data or implementation support from the private providers. Though the private for-profit organisations had no assigned responsibility, stakeholders did acknowledge their involvement in sensitising the community. Hence, there was an action point planned 'to sensitise the private providers on the identified theme', but this did not complete within the designated time frame. To overcome the limitations of non-achievement and looking at the overwhelming presence of private clinics, there is a need to invite professional associations in subsequent DIPH cycles.

Table 2: Interaction among stakeholders

Purpose	Indicators		Response (Yes/No, proportions)	Sources 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)	18/28 = 64.3[9]	Form A.2
		2. (Number of representatives from	13/18 = 72.2[10]	Form A.2

[9]The participation involved calculating the invitee list and attendance list of Steps 4 and 5, along with the Record of Proceedings. (See Form A.2.1, Sl. No. C1-C2 and Form A.2.2, Sl. No. C1-C2.)
[10]See Form A.2.1, Sl. No. C2 and Form A.2.2, Sl. No. C2.

		the health department present in the planning actions meeting) / (total number of DIPH participants present in 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)	5/18 = 27.8[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)	0/18[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)	0/18[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)	15/21 = 71.4[13]	Form 4
		7. (Number of action points with responsibilities of	6/21 = 28.6[13]	Form 4

[11]Non-health departments invited were from CD-ICDS, PRD and the district administration. (See Form A.2.1, Sl. No. C2 and Form A.2.2, Sl. No. C2.)

[12]None invited from NGOs for the meeting. (See Form A.2.1, Sl. No. C2 and Form A.2.2, Sl. No. C2.)

[13]None invited from the private sector for the DIPH meeting, as they were not formally part of any district-level meeting. (See Form A.2.1, Sl. No. C2 and Form A.2.2, Sl. No. C2.)

[14] For each action point, the DIPH stakeholders, based on their job responsibilities, assign a person from the department (health, non-health, NGO and private for-profit organisations) responsible for completing the action points within the designated time frame. (See Form 4, column: 'Person responsible'.)

		non-health departments) / (total number of action points for the primary theme of the DIPH)		
		8. (Number of action points with responsibilities of NGOs) / (total number of action points for the primary theme of the DIPH)	0/21[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)	0/21[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 on a regular basis as per government guidelines 3. Active participation of DMCHO, and enthusiasm shown by PRD representative	Form A.3
		11. List of challenging factors	1. Shortage of health care professionals due to unfilled positions 2. Time constraint of representatives to attend the follow-up meetings 3. Lack of specific guidelines to ensure participation of all the related departments / stakeholders in the health decision-making process 4. NGOs and private for-profit organisations do not officially receive an	Form A.3

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

			invitation to take part in the planning process 5. Ascribing the sole responsibility of public health concerns to the health department	

3.3 Progress with action points

3.3.1 Action points accomplished

Among the 21 action points, twelve action points had completed within the designated time frame:

1. Introduction of one data element for 'initiation of breastfeeding within one hour' in the labour room logbook in public facilities
2. To issue a directive for counselling by frontline workers (FLWs), the Anwesha counsellors/Integrated Counselling and Testing Centre (ICTC) counsellors for birth preparedness
3. To issue a directive for involvement of Staff Nurses and Medical Officers for facility-based newborn care (FBNC) to counsel on early initiation of breastfeeding
4. To issue a directive for supportive supervision provided by the district (Deputy Chief Medical Officer of Health-III [Dy. CMOH-III], district public health and nursing officer [DPHNO] and DMCHO) or block officials (Block Medical Officer of Health [BMOH], Block Public Health Nurse [BPHN], Public Health Nurse [PHN], Health Supervisors and Child Development Project Officer [CDPO]) during Village Health Nutrition Day (VHND) sessions; with special emphasis on exclusive breastfeeding
5. To issue a directive to CDPOs to ensure counselling of pregnant and lactating mothers on exclusive breastfeeding at all Anganwadi centres (AWCs)
6. To issue a directive on counselling of mothers on exclusive breastfeeding during Urban Health Nutrition Day
7. To issue a directive for emphasis on supportive supervision at village and block level by district officials
8. Arrangement of needs-based refresher training for existing staff on data entry and reporting
9. Theme-related training for Medical Officers, Staff Nurses, Auxiliary Nurse Midwives (ANMs), Health Supervisors and Anganwadi Workers (AWWs)
10. Introducing a tracking register for Village Health, Sanitation and Nutrition Committees (VHSNCs) to capture home delivery
11. Engaging rural medical practitioners in promotion of exclusive breastfeeding.
12. Proposal of a district-specific data-based software for Maternal And Child Health (MCH) indicators

Since it was the first experience for both the DIPH research team and the associated stakeholders, there was no clear understanding of the documentation and monitoring of action points at the beginning of DIPH Cycle 1. As a result, majority of the indicators (mentioned in

the monitoring format) did not clearly specify the denominator (i.e. measureable targets were not set and the objective was to capture mainly 'yes/no' of the action point status). Subsequently, from the next cycle onwards, the DIPH research team added measurable indicators to the action points, which could help the theme leader to track the progress for each action point. The theme leader monitored the progress through communication via telephone with the concerned personnel. There were a few staff recruited at district level, but the positions were not specific to the selected theme or action point. The State IYCF Cell provided training to women counsellors (to counsel mothers attending antenatal clinics at sub-centres) and nurses (who will further train the FLWs). Sub-district-wise data entry operators (DEOs) received refresher training and advised to report the early initiation of breastfeeding indicator. There were no special requests for funds, government orders/circulars, medicines, other supplies and equipment during DIPH Cycle 1.

> "The DIPH process is very useful as we can converge data from different sectors in relation to the subject, which is under consideration. We are comparing data between sectors. We are trying to find the gap by analysing all the data. DIPH is helping us a lot to analyse the gaps in data from different sectors [health, CD, PRD].)" (CMOH, N24PGS)

Active presence and follow-up by the DIPH researcher with the theme leader catalysed the stakeholders in achieving the action points. The DIPH research team maintained a logbook of the meetings held with other district DIPH stakeholders. The DIPH research team along with the theme leader regularly updated the district administration and the chief medical officer of the district, which contributed to their increased interest in the DIPH process and achieving the action points as per timeline.

3.3.2 Action points ongoing

During Step 5, two action points were ongoing:

1. Place Accredited Social Health Activist (ASHA) and block ASHA facilitator (BAF) in position as per standard State guidelines (DoHFW, 2012)
2. Expedite recruitment of vacant positions

The reason for delay in completion of the action points was unavailability of staff due to engagement in the state election process that coincided with the DIPH cycle.

3.3.3 Action points not started

Eight action points did not start during Step 5:

1. Linking data captured by private facilities by sensitising the owners of private nursing homes and making it a criteria for licensing and renewing. (Reason: the private sector is huge and diverse, and there is no organised platform/association for them. Hence, it was difficult to find a single representative to communicate the action point)
2. Establishment of IYCF corner at delivery points in all government facilities and municipal hospitals. (Reason: non-availability of guidelines for the establishment of the IYCF corner)

3. Collaborating with the district information culture office to promote exclusive breastfeeding through behaviour change communication (BCC) activities (road play, puppet show, etc.). (Reason: due to the state election, the activities could not start)
4. Involvement of NGO in promotion of exclusive breastfeeding at girls' college. (Reason: no NGO identified)
5. Strengthen the platform of standing committee meetings among departments for data-based planning (Reason: the standing committee was non-functional due to the state election)
6. Arrangement of mobility support for district and block officials for continuous supervision. (Reason: funds not approved by the state due to the state election)
7. Demonstration of exclusive breastfeeding to lactating mothers by a skilled birth attendant (SBA) and FLWs trained in Integrated Management of Neonatal and Childhood Illness (IMNCI)

The main reasons identified for non-initiation of some of the action points were lack of proper guidelines and the delay due to the state election in April 2016. For instance, there was an action point on 'strengthening the platform of standing committee meetings between departments for data-based planning'; however, there was no mention about implementation strategy of the same. Another action point for 'establishing IYCF corners at delivery points' could not happen due to lack of clear guidelines from the state.

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)	14/21 = 66.67[16]	Form 5
	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)	12/21 = 57.14[17]	Form 5
		3. (Number of written directives/letters issued by the district/state health authority as per action plan) / (total number of written	0/0[18]	Form 5

[16] Not all action points could start during the specified period and the delay in the overall process was due to the state election. The remaining eight action points are continuing onto the subsequent cycle. (See Form 5, Part B, columns: 'Action points'; 'Timeline for completion'; and 'Status of action points'.)

[17] Twelve action points completed as per the action plan, while two actions points are ongoing during Cycle 1. Along with the 'not started' action points, the 'ongoing' action points are continuing onto Cycle 2. (See Form 5, Part B, columns: 'Action points'; 'Timeline for completion'; and 'Status of action points'.)

[18] No written directive needed issuing from the district and state authorities; all communications from the district to the blocks/FLWs regarding the theme were either via telephone or direct during meetings. (See Form 5, Part B, columns: 'Action points'; 'Indicators for each action point'; and 'Progress of indicators'.)

		directives/letters by the district/state health authority planned as per action points of the DIPH primary theme)		
		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 primary theme-specific action points) / (total human resources recruitment needed as per action points of the DIPH primary theme)	Not specified[23]	Forms 4 and 5
		9. (Number of human resources trained for the primary theme-specific action points) / (total human	94/916 = 10.3[24]	Forms 4 and 5

[19]The state government assigned funds for the IYCF as part of routine activities; hence, there was no demand for additional funds included in the DIPH action plan. (See Form 5, Part B, columns: 'Action points'; 'Indicators for each action point'; and 'Progress of indicators'.)

[20]The selected theme does not require procurement of any medicine. (See Form 5, Part B, columns: 'Action points'; 'Indicators for each action point'; and 'Progress of indicators'.)

[21]Not demanded by the action plan. (See Form 5, Part B, columns: 'Action points'; 'Indicators for each action point'; and 'Progress of indicators'.)

[22] Though mentioned in Form 4, under 'Material resources required', there is no specific demand put forth for information, education and communication (IEC) materials in the action plan. (See Form 4, action points 1.1.2 to 1.1.3, 1.2.2 to 1.2.5 and 1.2.8 and Form 5, Part B, columns: 'Action points'; 'Indicators for each action point'; and 'Progress of indicators'.)

[23]There was a total of 33 staff recruited during Cycle 1. But the action plan did not specify the number of staff to recruit. Also, the recruitment was general i.e. applicable across health services and was not theme-specific. (See Form 4, action point 1.3.2 and Form 5, action point 1.3.2.)

[24] There were no numbers specified by the action plan; total staff trained on a 'training of trainer' mode were 94 (DEOs = 22, staff nurses = 60 and female councillors = 12); the denominator includes total posts for staff nurses (882), female councillors (12) and DEOs (22) in the district. (See Form 4, action points 1.3.1 and 1.3.3 and Form 5, action points 1.3.1 and 1.3.3.)

		resources training requested as per action points of the DIPH primary theme)		
	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 2. Support from the district administration 3. The presence and motivation by the DIPH research team acted as a push factor for stakeholders to accomplish the action points 4. Active participation by the DMCHO, the theme leader and initiative by PRD representative	Form A.3
		11. List of challenging factors	1. Overall delay in the process due to state election 2. Limited participation from non-health departments due to staff shortages 3. Monitoring indicators for follow-up were not in place at the beginning 4. Poor availability and quality of data affected usage for monitoring of action points 5. Top-down approach: the DIPH process focuses at district level, however, the implementation needs to strengthen at lower levels (e.g. sub-district)	Form A.3

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 DMCHO – 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 HMIS is receiving regular updates in the district and the DIPH stakeholders track progress of the themes selected based on the HMIS (MoHFW, 2016). However, stakeholders raised concerns about the quality of data.

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

- There was no sharing of data from other departments (CD and PRD) with the health department and district administration. There is a proposal to make the data captured by CD online and districts are implementing the same.
- Similarly, there is no guideline for the private sector to share data with the health department and district administration.

3.4.2 Facilitators within the district

- The DIPH research team developed a good rapport with stakeholders.
- There were three active personnel from three departments, namely, DMCHO (health department), public health programme co-ordinator (PHPC) (PRD), and additional district magistrate-general (ADM-G) (district administration). The district stakeholders found the DIPH process very useful and they did not see it as an additional burden to their existing responsibilities.

> "It is not an issue, all these are our work only. DIPH is just tuning our work, and I do not think there will be any issue to devote five to six hours' time in a quarter for all the activities. If we see exclusive breastfeeding has come up from 80% to 90%, which means our district is benefiting. So it's a good thing." (DMCHO, N24PGS)

- Except with ICDS, there were good interactions between stakeholder departments.
- A few platforms such as reproductive and child health (RCH)-Management Information and Evaluation System (MIES) meeting, Public Health Standing Committee meeting, Health Samity meeting, and Maternal Death Review monthly meeting exist which allow the incorporation of the DIPH process without creating any additional structure.

3.4.3 Challenges within the district

The district stakeholders mentioned the following major challenges to sustain the DIPH process:

- Interdepartmental co-ordination – The participation in the DIPH meeting and responsibilities shared by non-health departments (PRD and CD) were unsatisfactory. The view that the DIPH is the sole responsibility of the health department remains
- Vacant positions – There are several vacancies in key positions, which may hamper the DIPH process. For instance, the district lead post for ICDS, CD is vacant and a personnel as deputy from the Department of Land, is handling the additional responsibilities. They did not take much interest in the DIPH process. Moreover, there are several vacancies such as a supervisor and CDPO posts under ICDS, CD
- Top-down approach – The DIPH process currently involves only district-level stakeholders. However, sub-district-level officials and FLWs carry out the implementation of action points. Therefore, their participation and support is necessary for achieving the action points
- Streamlined process – There is a need to streamline the process further, as there are several forms where some of the items are repetitive
- Data issues – Quality and availability of district-specific data is an issue. Even the

mandatory forms are not stored systematically

- Sharing responsibility – The whole process is dependent on only one person from a stakeholder department – not all are ready to come forward and share responsibilities.
- Hand-holding by the DIPH research team – The district DIPH stakeholders depend entirely on the DIPH research team for conducting the meetings, completing the formats and compiling the follow-up documents

3.4.4 Possible solutions

- To ensure participation of various stakeholders, particularly the non-health departments, it is necessary to bring out an official letter from the district administration, before the next DIPH cycle.
- Moreover, themes that require the involvement of non-health and NGO/private for-profit organisations can be included to ensure better participation from these stakeholders.
- Involving sub-district-level stakeholders such as BMOHs, BPHNs, CDPOs during Steps 4 and 5 meetings, will help the theme leader to follow up on the progress of action points based on block-level data shared by sub-district-level officials.
- After Step 4 and after the development of the action plan, the theme leader needs to orient the block officials and those responsible from non-health departments about the process of capturing progress data and the timelines to follow.
- By creating a digital interface of the DIPH Forms, the theme leader and the district administration can track progress of the cycles.
- Motivating the district magistrate to own the DIPH process and take interest in monitoring activities. Also, designating a nodal officer (from district administration) will help in ensuring the participation of all stakeholders and in removing the concept of the DIPH as a health department activity.

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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]**		*District Programme Implementation Plan 2015/16*, N24PGS
2	**Specific theme 1**		**Initiation of breastfeeding within one hour of birth and promotion of exclusive breastfeeding until six months**
2.1	**Goal setting**		To promote exclusive breastfeeding in the financial year 2015/16
2.2	**Action points**	a	Awareness generation through IEC and BCC on IYCF practices
		b	Navjat Shishu Suraksha Karyakram (NSSK) training for staff nurses
		c	Training on NSSK, IMNCI and IYCF for health providers
		d	Promotion of home-based newborn care (HBNC)
		e	
3	**Specific theme 2**		**Maternal health**
3.1	**Goal setting**		Improving coverage of fourth antenatal check-up
3.2	**Action points**	a	Organising RCH outreach camps – 1,500 camps
		b	Observing monthly VHNDs
		c	Line-listing and follow-up of severely anaemic women
		d	Reducing home delivery
		e	Training of SBA
		f	
*Annual/five-year health plans, specific health policy documents and valid government orders related to public health.			

[26] Table 1, Indicator 3.

Form 1B: Health system capacity assessments

Sl. No.	Particulars					
Part 1: District demographic details						***Source***
1.1	Total population	10,009,781				*District Census 2011* [Office of the Registrar General & Census Commissioner, 2011, *District Census Hand Book 2011*, Government of India, New Delhi, viewed 5 January 2016, www.censusindia.gov.in/2011census/dchb/1911_PART_B_DCHB_NORTH%20TWENTY%20FOUR%20PARGANAS.pdf]
1.2	Rural population (%)	42.73				
1.3	Urban population (%)	57.27				
1.4	Scheduled Caste population (%)	21.7				
1.5	Scheduled Tribe population (%)	2.6				
1.6	Population density	2,445/square km				
1.7	Sex ratio	955				
1.8	Total literacy (%)	84.06				
1.9	Female literacy (%)	80.34				
1.10	Number of children under five years	957,973				
1.11	Number of women in reproductive age (15-49 years)					
1.12	Key NGOs (public health)					
1.13	Key private for-profit organisations (public health)					
Part 2: Requirements as per IPHS						
2.1	**Coverage Indicators**[27]	***IPHS***	***Data***		***Gap***	***Remarks***
		Early initiation of breastfeeding within one hour of birth	District	80.5% newborns were breastfed within one hour of birth (HMIS 2014/15)	**19.5%**	
			Block-wise	*Please refer the form supplement 1.3.1 below*		
Part 3: Specific theme 1 (refer to 2.1): **Exclusive breastfeeding**						
		Details	***Sanctioned (2014/15)***	***Available/ functional***	***Gap***	***Remarks***
3.1	**Infrastructure**[28]	Sub-centre	742	742	No gap when number is considered	A total of 165 are in rented place with inadequate space for a newborn corner
		IYCF corner	23	19	4	Needs to be verified
3.2	**General resources**	Finance	18.09 lakhs (£22119.43)	13.05 Lakhs (£15956.80) (released till date)		The funds are allocated for total IMNCI activities
		Supplies				
		Technology				

[27] Table 1, Indicators 1, 2 and 8.
[28] Table 1, Indicator 7.

3.3	**Human resources**[29]	ASHA	4,084	3,138	946	Recruitment is ongoing
		ANM at sub-centre	742	726	16	First ANM on June 2014
		Staff nurse		882		Need to be collected
		AWW		6,800 (urban)		Needs to be verified from DPO-ICDS

[29] Table 1, Indicator 7.

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

Sl. No.	Block Name	Coverage Indicator for Theme 1 (Exclusive Breastfeeding)*
1	Amdanga	100
2	Baduria	96.3
3	Bagdah	98.5
4	Barasat-I	100.2
5	Barasat-II	100
6	Barrackpore-I	95.6
7	Barrackpore-II	96.5
8	Basirhat-I	99.2
9	Basirhat-II	112.2
10	Bongaon	87.9
11	Deganga	89.4
12	District headquarters	74.5
13	Gaighata	96.3
14	Habra-I	94.4
15	Habra-II	99.5
16	Haroa	99.9
17	Hasnabad	99.7
18	Hingalgunj	99.8
19	Minakha	99.4
20	Rajarhat	100
21	Sandeshkhali-I	95.6
22	Sandeshkhali-II	106.4
23	Swarupnagar	99.3

*Percentage of newborns breastfed within one hour of birth to total live births – 2014/15, HMIS

Form 4: Plan

Date of meeting: 13 January 2016
Chairperson: CMOH, N24PGS

Theme 1: Initiation of breastfeeding within one hour of birth and promotion of exclusive breastfeeding until six months					
Theme leader: DMCHO, N24PGS					
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 Comprehensive data collection: Introduction of one element for 'initiation of breastfeeding within one hour' in the labour room logbook in public facilities[32]	Assistant chief medical officer of health (ACMOH) of respective subdivision	February 2016 to commence reporting	Non applicable	Non applicable
	1.1.2 Counselling by FLWs, Anwesha counsellor/ICTC counsellor for birth preparedness[33]	Dy. CMOH-III	February 2016	ICTC counsellor; Members of PRD and VHSNC could orient	1. Posters are available which require distribution among councillors 2. Flipcharts on exclusive breastfeeding and IYCF practices (funding for flipcharts required) 3. Planning for training of FLWs
	1.1.3 Involvement of staff nurses and doctors for FBNC[34]	DMCHO	February 2016	Non applicable	1. Funding for flipcharts needed 2. Planning for training of medical officers and staff nurses
	1.1.4 Introducing a tracking register for VHSNCs to capture home delivery	District programme co-ordinator (DPC), Zilla Parishad	March onwards	Subcommittee of VHSNC (district collector)	Printing of tracking register is required
	1.1.5 Linking private facilities data capturing during licensing and sensitising owners of private nursing homes of Pre-Conception and Pre-Natal Diagnostic	DMCHO Dy. CMOH-III	End of February 2016	Outsourcing (consultant) for data from private sector	Private sector's view and suggestions – can consider this later

30 Table 3, Indicators 7-9.
31 Table 2, Indicators 6-9.
32 Table 1, Indicator 5.
33 Table 3, Indicator 7.
34 Table 3, Indicator 7.

	Techniques (PCPNDT)				
Task 1.2: Service provision	**Actions**	**By whom**	**By when**	**Resources**	
				Human[a]	**Material[b]**
	1.2.1 Place ASHA and BAF in position as per standard IPHS guidelines	Sub-divisional officer (SDO) of respective subdivisions	March 2016	Non applicable	Non applicable
	1.2.2 Supportive supervision of VHND sessions emphasising exclusive breastfeeding[35]	DMCHO with DPO-ICDS	January 2016	Non applicable	IEC materials provision at VHND sessions
	1.2.3 Ensure counselling of pregnant mothers on exclusive breastfeeding at AWC[36]	DPO-ICDS		Non applicable	Provide IEC materials at AWC
	1.2.4 Demonstration of exclusive breastfeeding to lactating mothers by SBA and FLWs trained in IMNCI[37]	DPHNO	March 2016	Non applicable	IEC materials at delivery centres and training on IMNCI and SBA
	1.2.5 Establishment of IYCF corner at delivery points in government facilities and municipal hospitals[38]	Superintendent/ BMOH	June 2016	Additional staff nurse needed to run IYCF centre	Funds required for IEC materials
	1.2.6 Engaging rural medical practitioners in promotion of exclusive breastfeeding	PHPC, Zilla Parishad with BAF	June 2016	Expedite the recruitment of BAF	Training of rural medical practitioners
	1.2.7 Collaborating with the district information culture office to promote exclusive breastfeeding through BCC activities (road play, puppet show, etc.)	DMCHO	March 2016	Non applicable	Funds for BCC activities
	1.2.8 Counselling of mothers on exclusive breastfeeding during Urban Health Nutrition Days (Table 3, Indicator 7)	DMCHO	March 2016	Fill vacant posts of FLWs	Funds for IEC materials
	1.2.9 Involvement of NGO in promotion of exclusive breastfeeding at girls' college	DMCHO	June 2016	Non applicable	Funds for BCC activities
Task-1.3: Staff-need	**Actions**	**By whom**	**By when**	**Resources**	
				Human[a]	**Material[b]**
	1.3.1 Arrangement of needs-based refresher training for existing staff on data entry and reporting[39]	DSM	March 2016	Non applicable	Handbook material for DEOs

[35] Table 3, Indicator 7.
[36] Table 3, Indicator 7.
[37] Table 3, Indicator 7.
[38] Table 3, Indicator 7.
[39] Table 3, Indicator 9.

	1.3.2 Expedite recruitment of vacant positions[40]	CMOH/ DPC	March 2016	Non applicable	Non applicable
	1.3.3 Training of medical officers, staff nurses, ANMs, health supervisors and AWWs[41]	DMCHO	June 2016	Non applicable	Non applicable
Task-1.4: Supervision need	**Actions**	**By whom**	**By when**	**Resources**	
				Human[a]	**Material[b]**
	1.4.1 Strengthen the platform of standing committee meetings among departments for data-based planning	Swyastha Karmadhyaksha	March 2016	Non applicable	Non applicable
	1.4.2 Emphasis on supportive supervision at different levels	Dy. CMOH-III	March 2016	DEO for supportive supervision	Funds for DEO
	1.4.3 Arrangement of mobility support for supervision at all levels	CMOH	June 2016	Non applicable	Funds for mobility
Task 1.5: Any other	**Actions**	**By whom**	**By when**	**Resources**	
				Human[a]	**Material[b]**
	1.5.1 Proposal of a district-specific data-based software for MCH	CMOH	March 2016	DEO	Funds for software development and maintenance

[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.

[40] Table 3, Indicator 8.

[41] Table 3, Indicator 9.

Form 5: Follow-up

Part A					
Theme: Initiation of breastfeeding within one hour of birth and promotion of exclusive breastfeeding until six months					
Theme leader: DMCHO					
1. Number of meetings conducted since the last DIPH meeting by the theme leader: Five					
2. Major stakeholders involved in each meeting	**Meeting 1**	**Meeting 2**	**Meeting 3**	**Meeting 4**	**Meeting 5**
	MIES meeting – 25 January 2016 Health- CMOH, DMCHO, Dy. CMOH-III, Dy. CMOH-I, DPHNO DSM District ASHA facilitator (DAF) RCH co-ordinator Rashtriya Swasthya Bima Yojna (RSBY) co-ordinator Computer assistant RCH District accounts manager (DAM) Accounts officer ACMOH (of five subdivisions) Superintendent of hospitals BMOH and BPHN (of 22 blocks) ICDS-0	National Urban Health Mission (NUHM) review meeting – 21 January 2016 Health- DMCHO Medical officer and ANM of urban health	NUHM review meeting – 22 February 2016 Health- DMCHO Medical officer and ANM of urban health	Health- CMOH, DMCHO Dy. CMOH-III, Dy. CMOH-I, DPHNO DSM DAF RCH co-ordinator RSBY co-ordinator Computer assistant RCH DAM Accounts officer ACMOH (of five subdivisions) Superintendent of hospitals BMOH and BPHN (of 22 blocks) ICDS-0 PRD-0	Meeting with ADM-G – 29 April 2016 <u>No of participants</u>: District administration-1 Additional district magistrate-general (ADM-G) Health-5 CMOH, DMCHO, DPHNO, N24PGS and Basirhat DSM ICDS-1 DPO-ICDS MIES meeting – 20 March 2016 PRD-1 PHPC, Zilla Parishad

	PRD-0					
3. Comparison of key coverage indicators in the DIPH cycle			**Time 0**	**Time 1**	**Time 2**	**Time 3**
	Indicator	**Date**	January 2016	February 2016	March 2016	April 2016
	Number of newborns started breastfeeding within one hour of birth delivered at facilities	**HMIS**	5,391/6,441 (83.69%)	3,934/5,184 (75.88%)	3,387/4,858 (69.72%)	3,744/5,331 (70.23%)

Part B

Action points[42]	**Indicators for each action point**[43]	**Progress of indicators** [44]	**Timeline for completion of action points**[45]	**Status of action points**[46]	**Person responsible for action points**	**Suggestions**	
						Revised timeline	**Change in responsibility**
1.1.1 Comprehensive data collection: introduction of one element for 'initiation of breastfeeding within one hour' in the labour room logbook in public facilities[47]	Directive given including the column to collect early initiation of breastfeeding report from labour room logbook	Data element is included in labour room logbook of public facilities	February 2016 to commence reporting	Completed	ACMOH of respective subdivision	Non applicable	Non applicable
1.1.2 To issue a directive given for counselling by FLWs, the Anwesha counsellor/ICTC counsellor for birth preparedness	Directive given to BMOHs for counselling on birth preparedness by female councillor	Yes, during MIES meeting	February 2016	Completed	Dy. CMOH-III	Non applicable	Non applicable

42 Table 3, Indicators 1-9.
43 Table 1, Indicator 4; Table 3, Indicators 3-9.
44 Table 3, Indicators 3-9.
45Table 3, Indicators 1-2.
46 Table 3, Indicators 1-2.
47 Table 1, Indicator 6.

1.1.3 Directive given for involvement of staff nurses and doctors for FBNC to counsel on early initiation of breastfeeding	Directive given to superintendent of hospitals to involve staff nurses and doctors at FBNC to counsel exclusive breastfeeding	Yes, during MIES meeting	February 2016	Completed	DMCHO	Non applicable	Non applicable
1.2.2 Directive for supportive supervision provided by district (Dy. CMOH-III, DPHNO, DMCHO) or block officials (BMOH, BPHN, PHN, supervisors, CDPO) during VHND sessions; special emphasis on exclusive breastfeeding	Directive for supportive supervision given	Non applicable	January 2016	Completed	CMOH/ ADM-G	Non applicable	Non applicable
1.2.3 Issuing a directive to CDPOs to ensure counselling of pregnant and lactating mothers on exclusive breastfeeding at AWCs	Directive given to CDPOs to inform AWW to counsel pregnant and lactating mothers on exclusive breastfeeding	Yes, during monthly CDPO meeting		Completed	DPO-ICDS	Non applicable	Non applicable
1.2.4 Demonstration of exclusive breastfeeding to lactating mothers by SBA and FLWs trained in IMNCI	Training has imparted to SBA and FLWs on IMNCI	IMNCI training was given to few FLWs; it will be continuing throughout the year	March 2016	Completed	DPHNO	Non applicable	Non applicable
1.2.8 Directive on counselling of mothers on exclusive breastfeeding during Urban Health Nutrition Day	Directive sent to medical officers of urban areas to start counselling mothers during	Yes, over telephone by the theme leader	March 2016	Completed	DMCHO	Non applicable	Non applicable

	Urban Health Nutrition Day sessions						
1.3.1 Arrangement of needs-based refresher training for existing staff on data entry and reporting	Number of DEOs trained for refresher training (Table 3, Indicator 9)	From block, 22 DEOs were trained in March 2016	March 2016	Completed	DSM	Non applicable	Non applicable
1.3.2 Expedite recruitment of vacant positions (Table 3, Indicator 8)	Number of vacant positions filled general nurse midwife Sick Newborn Care Unit (SNCU)	1	March 2016	Ongoing	CMOH DPC	June 2016	CMOH DPC
	DEO	6					
	Medical officer (SNCU) DPC	3 1 (Basirhat)					
	BAF	22 were recruited but none were placed due to state election					
1.3.3 Training of medical officers, staff nurses, ANMs, health supervisors and AWWs	Number of staff nurses and female councillors trained on IYCF	12 female councillors and 60 staff nurses were trained in March 2016 (Table 3, Indicator 9)	June 2016	Completed	DMCHO	Non applicable	Non applicable
1.1.4 Introducing a tracking register for VHSNCs to capture home delivery	Number of tracking registers printed and distributed in VHSNC	Draft tracking register is prepared and	March onwards	Completed	DPC, Zilla Parishad	Non applicable	Non applicable

		finalised for printing					
1.4.2 Directive issued for emphasis on supportive supervision at village and block level by district officials	Directive given for supportive supervision during outreach camps and counselling sessions at clinic	No, not issued as a directive from district but already mentioned in state directive	March 2016	Ongoing	Dy. CMOH-III	Non applicable	Non applicable
1.5.1 Proposal of a district-specific data-based software for maternal and child health	Non applicable	Non applicable	March 2016	Completed	CMOH	Non applicable	Non applicable
1.1.5 Linking data captured by private facilities during licensing and sensitising owners of private nursing homes of PCPNDT	Number of private facilities sensitised on reporting of early initiation of breastfeeding after delivery Number of private facilities started data reporting	Non applicable	End of February 2016	Not started	DMCHO Dy. CMOH-III	Non applicable	Non applicable
1.2.1 Place ASHA and BAF in position as per standard IPHS guidelines	Number of ASHA and BAF recruited	BAF were selected but no recruitment was held	March 2016	Ongoing	SDO of respective subdivisions	June 2016	ADM-G District magistrate
1.2.5 Establishment of IYCF corner at delivery points in government facilities and municipal hospitals	Number of IYCF corner established at the facility	Non applicable	June 2016	Not started	Superintendent/ BMOH	Non applicable	Non applicable
1.2.6 Engaging rural medical practitioners in promotion of exclusive breastfeeding	Number of rural medical practitioners trained to promote	Non applicable	June 2016	Not started	PHPC, Zilla Parishad with BAF	Non applicable	Non applicable

	exclusive breastfeeding						
1.2.7 Collaborating with the district information culture office to promote exclusive breastfeeding through BCC activities (road play, puppet show, etc.)	Number of BCC activities done on exclusive breastfeeding	Non applicable	March 2016	Not Started	DMCHO	June 2016	No
1.2.9 Involvement of NGO in promotion of exclusive breastfeeding at girls' college	Number of NGOs involved in promotion of breastfeeding in college	Non applicable	June 2016	Not started	DMCHO	Non applicable	Non applicable
1.4.1 Strengthen the platform of standing committee meetings among departments for data-based planning	Non applicable	Non applicable	March 2016	Not started	Swasthya Karmadhyaksha	June 2016 (after state election)	Non applicable
1.4.3 Arrangement of mobility support for district and block officials for continuous supervision	Non applicable	Non applicable	June 2016	Not started	CMOH	June 2016	Non applicable

Note:

1. **Meetings**: Meetings called by the theme leader for discussing the progress of action points (can be part of other district meetings, but a dedicated time devoted); telephonic 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	10 minutes	10 minutes	
A.2 Form 4	1 hour	30 to 40 minutes (approximately)	Due to time constraint of all participants meeting ended early
B. Stakeholder leadership			
B.1 Agenda circulated and invitations sent		Swasthya Karmadhyaksha	
B.2 Chair of sessions		CMOH, N24PGS	
B.3 Nominee/ volunteer	1. Completing data forms	DIPH research team	
	2. Presenting summary	CMOH and DMCHO	
	3. Theme leader	DMCHO	
	4. Record of proceedings	Mayukhmala	
C. Stakeholder participation			
C.1 Number of stakeholders invited[48]	Health department	11	CMOH, N24PGS CMOH, Basirhat Dy. CMOH-III, N24PGS DMCHO, N24PGS Dy. CMOH-III, Basirhat DPC, Basirhat DSM, N24PGS DAM, N24PGS *Dy. CMOH-I* *DPHNO, N24PGS* *DPHNO, Basithat Health District* *(on CMOH request)*
	Non-health departments	3	DPO-ICDS SwyasthaKarmadhyaksha PHPC, Zilla Parishad
	District administration	2	ADM-G Officer-in-charge health
	NGO/private for-profit organisations	0	Not invited
C.2 Percentage of stakeholder participation (to those invited)[49]	Health department	(8) 72%	Basirhat CMOH due to illness DPC Basirhat due to other engagement Reason of DAMs absence unknown
	Non-health departments	(2) 67%	DPO-ICDS
	District administration	0	ADMs absence due to other schedule Officer-in-charge health did not attend despite confirming

[48] Table 2, Indicator 1.
[49] Table 2, Indicators 1, 2, 3, 4 and 5.

			attendance over telephone
	NGO/private for-profit organisations	0	Not invited
	Total	(10) 63%	
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, N24PGS	• ICTC councillors (human immunodeficiency virus councillors) should council in absence of the female councillor	
	DMCHO, N24PGS	• Private facilities licensing (both new and renewal) should be conditioned with timely data reporting	
	Dy. CMOH-III, N24PGS	• Training can be arranged for capacity building of councillors and other health workers	
	Dy. CMOH-III, Basirhat		No issues raised
	Dy. CMOH-I, N24PGS	• Unused Health Systems Development Initiative column in labour room logbook can be modified to early initiation of breastfeeding • Sensitisation workshop for private sectors	
	DPHNO, N24PGS	• Anwesha councillors (female councillors) should council the mothers in addition to ANMs • Use of IEC materials for spreading awareness	
	DPHNO, Basirhat		No issues raised
	DSM, N24PGS	• Outsourcing of dedicated personnel to capture timely data	
D.2 Non-health department	PRD	• Use of tracking registrar of VHSNC to capture exclusive breastfeeding	
	ICDS	Non applicable	Not attended
D.3 NGO and private for-profit organisations			
D.4 District administration	District magistrate		
	ADM		
	Officer-in-charge health		
E. Responsibilities delegated to non-health departments and NGOs*			
Type of activities shared	ICDS	Non applicable	
	PRD	Distribution of tracking registers to VHSNCs for data	Requires funds from Zilla Parishad for printing

		capturing	
	NGO	Non applicable	
F. Co-operation/communication between stakeholders*			
Action plan was discussed and finalised with each stakeholder's approval			
G. Data utilisation			
Non 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	10 minutes	5 minutes	
A.2 Form 5	30 minutes	20 minutes	Instead of Form 5, a simplified handout prepared specifically for this meeting and discussed
B. Stakeholder leadership			
B.1 Agenda circulated and invitations sent		CMOH, N24PGS	CMOH issued a notice for meeting
B.2 Chair of sessions		ADM-G, N24PGS	
B.3 Nominee/ volunteer	1. Completing data forms	Non applicable	
	2. Presenting summary	Mayukhmala	
	3. Theme leader	DMCHO, N24PGS	
	4. Record of proceedings	Sayan and Bushan	Prepared by Mayukhmala
C. Stakeholder participation			
C.1 Number of stakeholders invited[50]	Health department	8	CMOH – Barasat and Basirhat Health District, DMCHO, Dy. CMOH-III, Barasat and Basirhat Health District DPHNO, Barasat and Basirhat Health District, DSM
	Non-health departments	2	DPO-ICDS PHPC, Zilla Parishad
	NGO/private for-profit organisations	Non applicable	Not invited
	District administration	2	ADM-G Officer-in-charge health
C.2 Percentage of stakeholder participation (to those invited)[51]	Health department	(5) 63%	CMOH, Basirhat due to other work Dy. CMOH-III, Barasat and Basirhat due to other work
	Non-health departments	(2) 100%	
	District administration	(1) 50%	Officer-in-charge health was not present and reason unknown
	NGO/private for-profit organisations	Non applicable	
	Total	(8) 67%	Out of 12 participants, 8 were present for the meeting
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	Inclusion of NGO in data collection through tender process	CMOH to intervene wherever their comments are required; not proactive

[50] Table 2, Indicator 1.
[51] Table 2, Indicators 1, 2, 3, 4 and 5.

	DMCHO	• Awareness generation of pregnant women and lactating mothers by AWW and DPO-ICDS to take initiative • IMNCI training was completed as per action plan • Involvement of NGOs in PCPNDT awareness generation • IEC materials prepared by the United Nations Children's Fund on IYCF	As a theme leader they were very proactive and discussed all important points regarding follow-up
	DSM	None	Not proactive at all
	DPHNO (Barasat and Basirhat)	None	Not proactive at all
D.2 Non-health departments	PRD	Tracking registrar will be distributed to VHSNC after election	They had shown the draft tracking registrar to ADM-G, which includes column of exclusive breastfeeding
	ICDS	None	New DPO-ICDS joined but did not comment as in earlier meetings they were not present
D.3 NGO and private for-profit organisations		Non applicable	Not invited
D.4 District administration	ADM-G	• ADM queried the use of the AWC data on exclusive breastfeeding • Asked to explore chances of including the private sector in the future • IEC/BCC materials procurement should be done	Proactive and enquired about each action point which was not completed
E. Responsibilities delegated to non-health departments and NGOs*			
Type of activities shared	ICDS	To inform CDPOs to promote early initiation of breastfeeding and exclusive breastfeeding	
	PRD	To make use of tracking register after state election	
	NGO	Non applicable	
F. Co-operation/communication between stakeholders*			
Not done			Most of the stakeholders remained silent to maintain hierarchy; they only responded if something was asked by the ADM-G
G. Data utilisation			
Not used			
H. Suggestion for Developing a Decision-Making guide modification (*Note: suggestions with justifications on forms, process*)			
Non applicable			

*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	I01_GSN_AI_12May2016
Interviewer	Anns Issac, Mayukhmala Guha
Note taker	Mayukhmala Guha
Transcriber	Mayukhmala Guha
Respondent details	
Date and time of interview	12 May 2016; 1.30 pm
Name of participant	Dr Pralay Acharya
Gender	Male
Designation	CMOH
Department	Department of Health and Family Welfare
Duration of service in the district	2 years 4 months
Previous position	Dy. CMOH in West Medinipur District
Qualification	MBBS, DPH, MA
Years of experience in present department	26 years
Membership in committees pertaining to health	District Development and Monitoring Committee, Committee of District Judge, District Appropriate Authority of PCPNDT

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 how it is being conducted presently through the DIPH

It is a good thing going on since DIPH intervene in the district, focusing more on health factors.

The DIPH process is very useful as we can converge data from different sectors in relation to the subject which is under consideration. We are comparing data between sectors. We are trying to find the gap by analysing all the data. DIPH is helping us a lot to analyses the gaps in data from different sectors (health, ICDS and PRD).

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

Not explained.

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

In previous section we are having IYCF practices as the theme.

4. What progress through the DIPH have you made to improve the health targets/status in your district? Probe: Please elaborate how DIPH is useful in:

a. Identifying the health issue to focus on

b. Development of action plan

c. Follow-up of action plan

In beginning of the first cycle, there was a gap of 20% found in early initiation of breastfeeding indicator. To achieve 100% we have given IYCF training to staff and procure various IEC materials related to breastfeeding awareness. Not only that, we have also tried to establish IYCF corners which should be useful for mothers to learn basic of breastfeeding. We are hoping that there will be improvement (gap will be reduced) which can be tell from further data analysis.

The theme of IYCF was discussed in various meetings, this is an ongoing process, and special boost is required for more encouragement. If we talk about sustainability then not only we, DIPH should also come up with ideas how this process can be sustainable. As we are already busy with lots of work, it's quite impossible to concentrate specially onto something. We need something to push us constantly to do the work in such a manner.

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

Data collection is a concurrent process going on from ages but after DIPH intervene in the district, we are able to highlight more the gaps in-between data of different departments. But the problem is that there is no directive or policy how to reduce the gap in reality. My suggestion would be to notify this situation to the state authority [by DIPH research team] so a policy can come out in which data convergence should be happening. Now we know the gaps now but we require a concrete policy or mechanism to sort out the issue. *"I am requesting you to bring this information in notice of state authority for a concrete solution."*

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

The suggestion is that there is a requirement of supportive supervision. Data is a way of checking quantitative aspect but to ensure quality like improvement in behavioural change of beneficiaries such as a mother can be trained on good attachment, proper holding of a child during breastfeeding and so on. Basic of breastfeeding's should be taught to mothers. On probing there is a need of monitoring of qualitative aspects.

On asking if data is triangulated or verified at district, CMOH replied that quality of data is often verified randomly by district authorities (during visit to facilities or during various meetings) but that is only restricted to quantitative checking. He accepted that currently health department cannot ensure about quality of data as there is no such tool/mechanism available.

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. Is data shared between the departments?
c. Did frequency of interaction increase since the last DIPH?

Not explained.

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?

Not explained.

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?

Private sector involvement can be done through Indian Medical Association [IMA] or Indian Paediatric Association of the district as they conduct Continuing Medical Education [discussion arranged in specific meetings] on various topics [he mentioned those programme includes topic of IYCF also]. The health department officials also participate in such programmes. Private sector can be involved through this platform. Those NGO who are working on the different health-related activities in the district such as leprosy, Revised National Tuberculosis Control Programme or PCPNDT programme they can also be involved for spreading awareness. We can call all the private organisations in one common platform to disseminate information. We shall try to arrange this, already convergence is going on different public health activities such as dengue or malaria but IYCF is not on the list. Only public sector is concerned about practising IYCF.

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.

The main challenge is the sustainability of the programme [DIPH]. In a year there can be different outbreak during different season, so there is a higher chance of losing focus *on less important activity such as IYCF*. Even the community is not giving much acknowledgement to IYCF activities as of now, in emergency situation the health department can easily deviate from the original activity by focusing more on the then emergency. But we are hoping through DIPH process we will be able to concentrate more on these activities.

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

In my opinion, the steps so far we used in the process are all good, we do not need to change or include anything new. From each step with help of data analysis we can easily find out the gaps, thus, set targets according to the subject (theme).

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

As we already talked sustainability of DIPH beyond the project time frame remains as major challenge. More specifically, inter-sectoral convergence is of a more crucial part. You can see these are health-related activity so we [the health department] can engage ourselves in the activity for our own interest and provide time for it [on probing he said] …giving five to six hours' time in a quarter must not be an issue. But the other departments (such as district administration, PRD or ICDS) may or may not be able to provide equal time as health department.

A.3.2: In-depth interview with DMCHO

IDI details	
IDI label	I02_GSN_SB_12May2016
Interviewer	Sanghita Bhattacharyya, Mayukhmala Guha
Note taker	Anns Issac
Transcriber	MayukhmalaGuha
Respondent details	
Date and time of interview	12 May 2016; 10.30 am
Name of participant	Dr Sukanta Biswas
Gender	Male
Designation	DMCHO
Department	Department of Health and Family Welfare
Duration of service in the district	5 years
Previous position	ACMOH
Qualification	MBBS, DPH
Years of experience in present department	5 years
Membership in committees pertaining to health	District Development and Monitoring Committee, District Appropriate Authority of PCPNDT

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 conducted presently through the DIPH

The exercise with DIPH is really going well as what we were doing wasn't streamlined. The theme was 'early initiation of breastfeeding and exclusive breastfeeding' and we are observing the practice during field visits. Even in hospitals we are showing mothers the basics of breastfeeding and while observing we are asking mothers to show how they are doing it. Earlier we found a gap in early initiation of breastfeeding (which was not reflected in our data) but with this specific theme we are hoping it would show better result in future.

Convergence process is very important so we are following it in the process, we are able to generate awareness among other sectors such as ICDS and PRD, in any meeting (official or unofficial) we are discussing how to improve more, and it's very beneficial. They are also showing interest in displaying IEC materials as they understood improvement of MCH care is really important. I think in future it will be more helpful.

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 are using HMIS data for gap analysis since the beginning of the system. We are also conducting field visits and monthly meeting to find out the same but it was kind of a whimsical process (not co-ordinated with each other). After implementation of DIPH process, it has been streamlined. Now we are more focusing on indicator-based data analysis such as analysis of input or output indicator to see the effect in outcome indicator.

I think the most important step of DIPH process is the situational analysis as it is the basis to understand the current situation. Until we are able to understand the need, it's impossible to step

further so in my view situational analysis is the ultimate step of any survey or any study.

3. What are the key themes covered in the last DIPH cycle?
Exclusive breastfeeding for first six months was the theme for the last DIPH cycle. Along with that early initiation of breastfeeding within one hour is another key area indicator which was covered under the same theme.

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

What we are doing earlier is in our job schedule. But all the time we cannot fixed target for specific indicator as it is a continuous process. For example, HMIS data is fluctuating a lot throughout the year sometimes it shows 80% sometimes 90%, so it's difficult to set target depending solely on data. But after this process, target fixing can be done.

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

DIPH process is all about using data but there was a problem identified. Mostly we were using HMIS data for analysis not Mother and Child Tracking System (MCTS) data. The problem of using HMIS data is that its facility based data and as you know in N24PGS half area is under urban population so we are capturing just a part of the district under HMIS, whereas MCTS is beneficiary-based data; each beneficiary are captured under this. Though sometimes we are considering District Level Household Survey-4 or National Family Health Survey-4 data or any survey it's not the current one as survey was conducted minimum two to three years back. Even in semi-urban area also HMIS data is not useful as most of the people not using public facilities over there. So from now on, we have to incorporate MCTS data for gap analysis or progress review from the next cycle.

Though in our district timely updating of MCTS data is very poor as only two DEOs are placed at district level for the whole district. Sometimes they even pulled out for other tasks such as election or any specific health programme. Another problem is poor net connection in remote block. But from the last month we are calling block-wise DEOs and other staff at the district to update the MCTS as soon as possible.

6. Whether data is used in monitoring the progress of the action plan in your district?
There is a difference between the term monitoring and supervision. Yes, we have used data while monitoring the progress. But that limited to meeting or planning purpose (in paper). In reality while at field for supervision hardly any data is used for progress review. This is the same picture across stakeholders (both health and non-health department).

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. Is data shared between the departments?
c. Did frequency of interaction increase since the last DIPH?

I do not think anything has changed since introduction of DIPH, it is same before and after introducing of DIPH. Earlier also we used to be in touch with other departments for many programmes and this kind of interaction is vastly depends on person to person. Only you can say that now all the departments (health and non-health both) doing the gap analysis of the district at a common platform.

[On probing how the interaction can be more improved from next cycle]

It's a tricky question, I personally interact with other stakeholders for follow-up of action plan, but it depends how other will be doing this activity.

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

NGOs can be involved as they are already working in the district. But the problem is there no such NGO in N24PGS who is covering the whole district. We have to call two to three NGOs who are working on different area in the district. Their work is totally programme-specific. If we call them for a meeting they will come for sure but how that will be beneficial for whole district is a bit doubtful. ADM-G is looking after all the NGOs in the district so we may contact ADM (Treasury) for further involvement of NGOs. NGOs are also interested to work with us so we can find out the way how we can make this beneficial.

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

To involve private sector (facilities) is a major challenge as there is no concrete rules and regulations to control them. We are just issuing licences to them under PCPNDT act or renew of registration certificate. While giving C-licence, the nodal officer visits the facility for verification or further recommendation, that's all. But there is no comprehensive rule by which we can tell them what to do or not to do such as to bind the fees of doctors or some other things.

I am not sure how this issue can be solved. We may have to approach ADM-G for her involvement. We can also contact IMA but in N24PGS there are several branches (kanchrapara, halisahar, barasat, etc.) so we may have to ask state level to approach central IMA. There is a need of a policy to carry it out from central branch. The central IMA can fix action plan which can be carried out through the branches of the organisation.

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 the DIPH
b. Availability of data to monitor progress
c. Active involvement of different government departments, district administration, NGO and the private sector

Other departments also extending their helping hands, but sometimes data collection may get delayed as certain themes may not be on priority list of other departments. Anything is challenged if you see that way, but if you want to point out specifically I think the exact delivery of messages to bottom level should be monitored. Suppose what we are discussing in meeting, whether DPO-ICDS is providing the same message to CDPOs, block level officers of ICDS, or not required to be checked which is not possible in the current structure .

Another major challenge as we discussed is involvement of private sector in the process. Such as data collection from public sector (from 13 hospitals and 22 blocks) is not an issue but to get the same data from private sector is not possible. Even a child is delivered at medical college of Kolkata, whether information on early initiation of breastfeeding was given or the mother counsel for practising exclusive breastfeeding at house no one knows. This is because lack of structured monitoring system. To collect this data, conducting survey is the only way. In HMIS data, it may show 95% of exclusive breastfeeding but whether it's true or not who will ensure. Urban data is not available at health department.

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

You [DIPH research team] are only discussing with us [district-level officials] but you should also involve periphery level such as BMOH, ACMOH or Panchayat members of low indicators block would be useful. As an external agency you can see the gap in services better than government-level officials. I think this little change is required. It will be helpful.

Even at ICDS department we should attend CDPO meetings where we can interact with them directly. We are following top-down approach but we should also think about bottom-up approach.

There are NGOs working at ground-level such as Southern Health Improvement Samity, Gana Unnayan Parishad who are running Community Delivery Centre, you may directly contact them for work at community.

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

We are going to take maternal mortality reduction in next cycle. Already Maternal Death Review is going on in district, all staff are trained to report maternal death even through telephonic information. CMOH is reviewing all maternal death in every month. To have a concrete idea you [DIPH research team] should also be present in the meeting. In these meetings we review the exact cause of maternal death. The causes are mainly of three types those are: delay one (non-identification of danger signs such as high blood pressure of pregnant mothers); delay two (shifting mother to facility); and delay three (delay in treatment of facility). Apart from that we also track behind reasons for death such as completion of three or four antenatal check-ups, high-risk pregnancy identification by the ANM, danger signs identification by family members/ASHA and so on. You can link the theme (maternal mortality reduction) with all these activities (action plan). In monthly review meeting, we discuss all these points for each maternal death. On asking, they informed there is no such specific date for the meeting, we fixed it based on availability of the district officials.

[Apart from that the DIPH research team member Dr S. Bhattacharya asked if DIPH process can be going on beyond the intervention time frame. They added]

There are already so many meetings going on, people are already overburdened so if it's possible to engage five to six hours in a quarter for all the four Steps. [The DMCHO answered very positively] It is not an issue, all these are our work only, you are just tuning our work, and I do not think there will be any issue to devote five to six hours' time in a quarter for all the activities. If we see exclusive breastfeeding has come up from 80% to 90% that means our district is benefiting so it's a good thing.

[The DIPH research team member Dr S. Bhattacharya also asked if there is importance of a dashboard in the future. They also explained what the dashboard is and we are planning to develop it in future. The DMCHO thinks that it would be helpful to have one software to triangulate data and set further goals.]

A.4: Monitoring Format with Definitions

A4.1 Monitoring framework[52]

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 the 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	**4. (Number of action points on which progress is being monitored by data) / (total number of action points for the**	Form 5: Follow-up

[52]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 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.

	primary theme of the DIPH	**primary theme of the DIPH)** **Action points:** a specific task taken to 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 World Health Organization 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 the 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 cycle of the DIPH **Officially invited**: stakeholders formally 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;*	Form A.2: Record of Proceedings – Summary Table

		and CD • *Private sector stakeholders: NGOs; nursing homes; and large hospitals owned by private entities*	
		2. (Number of representatives from the 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*	Form A.2: 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 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
		12. 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.

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Contact us

Bilal Avan - Scientific Lead
Bilal.Avan@lshtm.ac.uk
--
Joanna Schellenberg- IDEAS Project Lead
Joanna.Schellenberg@lshtm.ac.uk

Public Health Foundation of India
Web: phfi.org
Twitter: @thePHFI
Facebook: thePHFI

West Bengal University of Health Sciences
Web: wbuhs.ac.in

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