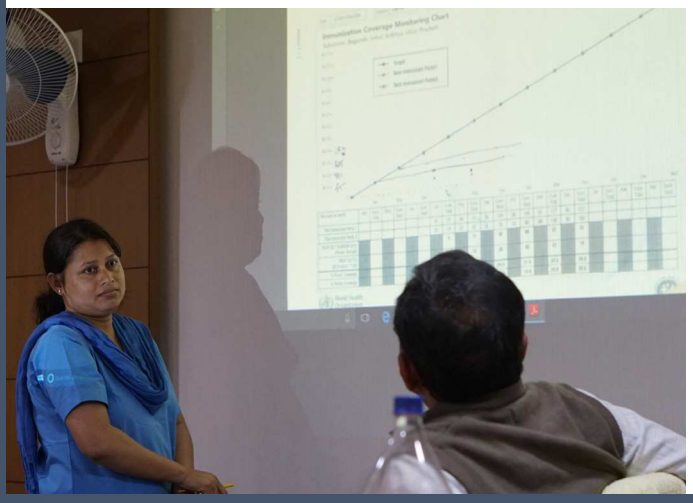

DIPH

The Data-Informed Platform for Health

Structured district decision-making using local data

MONITORING REPORT
Cycle 2: May - September 2016

North 24 Parganas
West Bengal, India

DATA INFORMED PLATFORM FOR HEALTH

MONITORING REPORT

North 24 Parganas, West Bengal, India

Cycle 2: May – September 2016

ACKNOWLEDGEMENTS

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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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LIST OF ABBREVIATIONS

ACMOH	Assistant Chief Medical Officer of Health
ADM	Additional District Magistrate
ADM-G	Additional District Magistrate-General
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BAF	Block ASHA Facilitator
BDO	Block Development Officer
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
CUG	Closed User Group
DAM	District Accounts Manager
DEO	Data Entry Operator
DIPH	Data Informed Platform for Health
DMCHO	District Maternity and Child Health Officer
DPHNO	District Public Health and Nursing Officer
DPO	District Programme Officer
DSM	District Statistical Manager
Dy. CMOH-I	Deputy Chief Medical Officer of Health-I
Dy. CMOH-II	Deputy Chief Medical Officer of Health-II
Dy. CMOH-III	Deputy Chief Medical Officer of Health-III
ELA	Expected Level of Achievement
FLW	Frontline Worker
GUP	Gana Unnayan Parishad
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
IEC	Information, Education and Communication
IMA	Indian Medical Association
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
ODF	Open Defecation Free
PHFI	Public Health Foundation of India
PHN	Public Health Nurse
PHPC	Public Health Programme Co-ordinator
PRD	Panchayat and Rural Development
RCH	Reproductive and Child Health
SHG	Self-Help Group
SHIS	Southern Health Improvement Samity
VHND	Village Health and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee

1. INTRODUCTION

Data Informed Platform for Health (DIPH)		
Cycle no.	2	
District	North 24 Parganas	
Duration	May – September 2016	
Theme	Increase in third antenatal check-ups and improvement in tracking of fourth antenatal check-up	
Steps involved	Step 1	**Assess:** Based on the *District Programme Implementation Plan 2015/16* and Mother and Child Tracking System (MCTS) indicators (Department of Health and Family Welfare, 2015; MoHFW, 2016a), the DIPH stakeholders assessed gaps in service provision and selected the theme in consultation with the non-health departments 'Increase in third antenatal check-up and improvement in tracking of fourth antenatal check-up' for Cycle 2 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 2 was with the health department, while departments of Child Development (CD), the Panchayat and Rural Development (PRD) and district administration shared the supportive responsibilities. Majority of participants were from the health department. The theme leader of Cycle 1 (District Maternity and Child Health Officer – DMCHO) also became the theme leader for Cycle 2. Non-governmental organisations (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 based on: service delivery; workforce; supplies and technology; health information; finance and policy; and governance. They identified ten problems with 50% under 'service delivery'. They formulated 13 actionable solutions to address the ten problems, in keeping with the cycle duration and capacity of the district administration.
	Step 4	**Plan:** The stakeholders developed 13 action points (and 27 indicators) to achieve the target and assigned responsibilities across departments within a given time frame. The Department of Health and Family Welfare had majority of the responsibilities (62%) while the PRD (23%) and CD (15%) shared the remaining responsibilities.
	Step 5	**Follow-up:** The stakeholders attended four meetings before the Step 5 meeting to facilitate the follow-up of the action plan. Out of the 13 action points, nine action points (69%) had completed within the specified timeline. Three action points did not start within the cycle period. The remaining action point received a new timeline. The theme leader monitored the progress through monthly reports (from 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 Form 1B.1: Sub-district level (block) performance of selected indicators	Theme leader of the DIPH Cycle 2	12 May 2016
2	**Step 2: Engage** Form 2: Engage	Theme leader of the DIPH Cycle 2	18 May 2016
3	**Step 3: Define** Form 3: Define	Theme leader of the DIPH Cycle 2	18 May 2016
4	**Step 4: Plan** Form 4: Plan	Theme leader of the DIPH Cycle 2	16 June 2016
5	**Step 5: Follow-up** Form 5: Follow-up Form 5.1: Sub-district-wise performance of indicators	Theme leader of the DIPH Cycle 2	22 September 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 research team, North 24 Parganas (N24PGS)	June – September 2016
7	**In-depth interviews with stakeholders** Form A.3.1: Public Health Programme Co-ordinator (PHPC)	Interviewed by the DIPH research team, N24PGS	19 September 2016
	Form A.3.2: District Programme Officer (DPO)-Integrated Child Development Services (ICDS)		19 September 2016
	Form A.3.3: DMCHO		21 September 2016
	Form A.3.4: District Statistical Manager (DSM)		21 September 2016

3. FINDINGS

Monitoring of the DIPH implementation process focused on four themes:

1. Utilisation of data at district level
1. Interaction among stakeholders such as co-operation in decision-making, planning and implementation
2. 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 DIPH stakeholders used the *District Programme Implementation Plan 2015/16* and the MCTS data (Department of Health and Family Welfare, 2015; MoHFW, 2016a) to assess the gaps in service provision and selected the theme 'Increase in third antenatal check-up and improvement in tracking of fourth antenatal check-up' for Cycle 2 of the DIPH. The stakeholders preferred MCTS over the Health Management Information System (HMIS) as the MCTS reflects the service coverage at community level (MoHFW, 2016a; 2016b). To develop the action plan, the stakeholders referred to the *District Programme Implementation Plan 2015/16*, which spells out the routine activities regarding the selected theme

(Department of Health and Family Welfare, 2015). Though the non-health departments of the CD and PRD have a supportive role with regard to the theme, they do not maintain any systematic record. Hence, during theme identification, stakeholders did not use data from these departments.

The DIPH research team monitored the progress of action points on 27 indicators. The theme leader compiled the monthly reports on these indicators from sub-district level and discussed the progress with the Chief Medical Officer of Health (CMOH). The DIPH research team provided assistance with the follow-up and data compilation.

3.1.2 Challenges in data utilisation

The persisting challenges with data utilisation include: lack of interdepartmental sharing; inefficiencies with the system to monitor the quality of collected data; lack of sharing by NGOs and private for-profit organisations; and delay in collecting, collating and reporting of data. As per procedure, there is a system in place to check the quality of data but following this system does not always happen.

> "At sub-centre level the data is prepared manually by ANM [Auxiliary Nurse Midwife]. This data is checked by BPHN [Block Public Health Nurse] at the block level. Then the data is entered online or offline by Data Entry Operator [DEO]. The generated data is signed by the BMOH [Block Medical Officer of Health] in hard copy and then it is confirmed. This is the procedure. But this is not how it happens actually. How it occurs is, when the sub-centre data comes to DEO, he does not check the quality of data properly and uploads it. No one checks HMIS data at block level and even at hospital level also." (DSM, N24PGS)

The MCTS data, though is real time in nature, does not involve regular compiling at district level (MoHFW, 2016a). Hence, this cycle involves calculating the cumulative figure based on reporting at sub-district level (for more details, see Footnotes 5 and 6).

Other than the routine data collection exercise, there are delays in monthly reporting of progress of action points by some of the sub-district-level stakeholders. The prominent reason is the non-functionality of the data compilation system, i.e. there is no assigned person present for this job. The DEO is a contractual post appointed by the Block Health and Family Welfare Society.

3.1.3. Proposed solutions

To ensure the quality of data, requires the sub-centre level to follow the procedural verification process. Providing training alone would not solve this issue, as the DEOs are not permanent or regular employees of the stakeholder departments. Hence, regular staff, such as the BPHN and BMOH need to take more responsibility and validate the data at sub-district level. Also, some stakeholders (i.e. PRD) proposed a web-based portal to facilitate data use.

"We also seek support from Public Health Foundation of India [PHFI] to prepare a web-based single window (portal) for collecting and analysing data to identify the health issues to be prioritised." (PHPC, N24PGS)

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 and Form 1B.1
		2. Whether the DIPH cycle theme selection used any data from non-health departments? (Y/N)	No[2]	Form 1B and Form 1B.1
		3. Whether the DIPH cycle theme selection was based on health policy and programme directives? (Y/N)	Yes[3]	Form 1A.1
	B. Data-based monitoring of the action points for the primary theme of the DIPH	4. (Number of action points for which progress is being monitored using data) / (total number of action points for the primary theme of the DIPH)	13/13= 100.0[4]	Form 5
	C. Revision of district programme data elements for the primary theme of the DIPH	5. Whether stakeholders suggested a revision/addition to health system data in the given DIPH cycle? (Y/N)	No	Form 4
		6. (Number of data elements added in the health database as per the prepared action plan) / (total number of additional data elements suggested for the primary theme of the DIPH)	0/0 (Nil)	Form 5
	D. Improvement	7. Whether the health	No[5]	Form 1B.1

[1] As recommended by the district to use MCTS data for selection of the DIPH theme (MoHFW, 2016a). Based on the same three coverage indicators selected as: (i) pregnant women registered in first trimester against total registration was 86%, indicates gap of 14%; (ii) pregnant women received minimum three antenatal check-ups was 81%, indicates gap of 19%; and (iii) pregnant women received all four antenatal check-ups was 52%, indicates gap of 48%. (See Form 1B.1 and Form 1B, Sl. No. 2.)

[2] DIPH is primarily seen as the responsibility of the health department. Hence, the theme selection did not use data from other departments. (See Form 1B.1 and Form 1B, Sl. No. 2.)

[3] The *District Programme Implementation Plan 2015/16*, N24PGS emphasises to improve maternal health in the district (Department of Health and Family Welfare, 2015). Thus, to meet this goal requires improving antenatal service coverage. (See Form 1A.1.)

[4](i) Out of the 13 action points, seven action points completed the specified timeline (July − September 2016). (See Form 5, Sl. No.'s 3-8 and No. 10); (ii) to postpone three action points with completion by October 2016 by the district, from discussions during the Step 5 meeting on 22 September 2016. (See Form 5, Sl. No.'s 1-2 and No. 9); and (iii) cancellation of three action points by the district, as these were not relevant in the current perspective from discussions during the Step 5 meeting on 22 September 2016. (See Form 5, Sl. No.'s 11-13.)

[5] The theme-specific (increase in third antenatal check-up and improvement in tracking of fourth antenatal check-up) data collection was by the DIPH research team using the MCTS database (MoHFW, 2016a). There

	in the availability of health system data	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)		
		8. Whether the health system data on the specified theme area is up-to-date as per the given DIPH cycle? (Y/N)	No[6]	Form 1B.1

3.2 Interaction among stakeholders

The formal system of interaction among different stakeholders structures within the hierarchies between and within the departments. Though there are some platforms such as Public Health Standing Committee meetings and District Health Society meetings, the interaction restricts to the roles prescribed by the official structure (i.e. submissions on topics relevant to the particular department and the approval or disapproval by the chair of the meeting). However, the DIPH provided an additional space for the stakeholders to discuss issues in a more flexible manner. Though the hierarchies of formal structure is also reflected in the DIPH meetings, the different steps involved in the DIPH decision-making process facilitated engagement between stakeholders.

3.2.1 Interaction between health and non-health departments

The nature of the theme selected for the cycle influenced the participation in the DIPH meetings. The primary responsibilities of the theme fall under the Department of Health and Family Welfare. Of the total participants in the DIPH meetings, 80% were from the Department of Health and Family Welfare. The representation from non-health departments was 15%. The official order by the district magistrate helped the attendance from different departments. The PHPC (PRD) actively participated throughout the process.

> "There is regular interaction with other departments by way of monthly review meeting, standing committee meeting, etc. This is made possible due to the DIPH process. Though there was interaction, it was irregular previously." (PHPC, N24PGS)

3.2.2 Interaction between the health department and NGOs

Compared to the previous cycle, there was participation from NGOs during the Step 4 meeting. Of the three NGOs invited, two (Sarvik and Gana Unnayan Parishad – GUP) attended the meeting for development of the action plan. But their contribution to the

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were no updates for the MCTS database and they were not stored systematically (MoHFW, 2016a). On the other hand, there were updates on human resources and infrastructure data and these were systematically stored. (See Form 1B, Sl. No.'s 2-3 and Form 1B.1.)

6 The latest data (percentage of pregnant women registered in first trimester against total registration and percentage of pregnant women received minimum third and fourth antenatal check-ups) available during DIPH Step 1 (May 2016) was of March 2015. In this context, note that MCTS is not properly updated because the Ministry of Health and Family Welfare was planning to freeze the MCTS portal due to the introduction of the reproductive and child health (RCH) portal from October 2016 (MoHFW, 2016a). Hence, during Cycle 2 we have used block monitoring reports from block-level officials and the Expected Level of Achievement (ELA) calculated at district level to track the monthly progress since July 2016 to September 2016. (See Form 5.1, Part A Sl. No. 3.)

discussions were poor. The reason could be that their roles are specific based on their involvement in the themes.

> "NGOs are involved in different programmes in the district. Some are conducting training under capacity building programme. Panchayat department has also engaged some local NGOs/community-based organisations to construct sanitary system as well as community sensitisation about open defecation free initiatives in the district. But, there is no such system of sharing data by NGOs right now. Basically, it is needs-based, if required we can involve them." (PHPC, N24PGS)

Also, there are some apprehensions among stakeholders regarding the extent of NGO involvement in the decision-making process.

> "I am not in favour of involving NGOs. Only in two blocks – Bagda and one other – NGOs can be involved. There are many beneficiaries there. Due to lack of manpower in these two areas NGOs can be involved. In other areas such as Barasat where is sufficient manpower, we ourselves should provide the services and not the NGOs." (DSM, N24PGS)

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

There is little interaction between the health department and private for-profit organisations. Even though their share in service provision is significant, they did not take part (uninvited) in any official meetings. The possible reason can be that there is no single representative body of the private for-profit organisations. So stakeholders are not sure about deciding the representatives from private for-profit organisations. The suggestion is that they can invite the district wing of the Indian Medical Association (IMA).

Table 2: Interactions 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)	41/56= 73.2[7]	Form A.2
		2. (Number of representatives from the health department present in the planning actions meeting) / (total number of DIPH participants in the planning actions	33/41= 80.5[8]	Form A.2

[7] 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.)
[8] See Form A.2.1, Sl. No. C2 and Form A.2.2, Sl. No. C2.

		meeting)		
		3. (Number of representatives from non-health departments present in the planning actions meeting) / (total number of DIPH participants in the planning actions meeting)	6/41= 14.6[9]	Form A.2
		4. (Number of representatives from NGOs present in the planning actions meeting) / (total number of DIPH participants in the planning actions meeting)	2/41= 4.9[10]	Form A.2
		5. (Number of representatives from private for-profit organisations present in the planning actions meeting) / (total number of DIPH participants in the planning actions meeting)	0/41= 0[11]	Form A.2
	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)	8/13= 61.5[12]	Form 4
		7. (Number of action points with responsibilities of non-health departments) / (total number of action points for the primary theme of the DIPH)	5/13= 38.5[12]	Form 4
		8. (Number of action points with responsibilities of NGOs) / (total number of action points for the primary theme of the DIPH)	0/13= 0[12]	Form 4
		9. (Number of action	0/13= 0[12]	Form 4

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

[10] NGOs invited for the DIPH meeting were representatives from Sarvik and GUP (who attended), and Southern Health Improvement Samity (SHIS) (who were absent). (See Form A.2.1, Sl. No. C2 and Form A.2.2, Sl. No. C2.)

[11] No private for-profit organisations took part in the DIPH meeting, as they are not formally part of any district-level meeting. (See Form A.2.1, Sl. No. C2 and Form A.2.2, Sl. No. C2.)

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

		points with responsibilities of private for-profit organisations) / (total number of action points for the primary theme of the DIPH)		
	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. Support from district administration in terms of attending the DIPH meeting, issuing guidelines/order and regular follow-ups strengthened the district and sub-district level convergence among health, PRD and CD departments 2. Common platform like convergence meetings, standing committee meetings, Management Information and Evaluation System (MIES) meetings, etc. are now organised in a regular way and share data assessment of programmatic performances for collective decisions and new initiatives 3. Regular active participation by the theme leader and other departments during implementation and follow-up of action points 4. The analytical part especially data collection from different departments i.e. CD, health, PRD helps the district to make good policies to reach the health target/goal effectively	Form A.3
		11. List of challenging factors	1. Time constraint is the main challenge during regular interaction among departments in the district 2. To bring district-level officers in a common table/platform is very difficult due to their involvement in several ongoing programmes in the district 3. About 60% of the population in the district is from urban areas; they are accessing nursing homes, private hospitals for institutional delivery and	Form A.3

			other health care services in the district. But, there is no such data collection mechanism from the private for-profit organisations working in the district 4. Involvement of private for-profit organisations and NGOs in existing health programmes is very poor	

3.3 Progress with action points

3.3.1 Action points accomplished

Out of the 13 action points, ten action points started during the cycle period with nine of these action points accomplished by the meeting in Step 5.

1. Issue a guideline to conduct Village Health and Nutrition Days (VHNDs) in co-ordination with CD.
2. Regularise outreach camps (for proper infrastructure with privacy for pregnant women).
3. Follow-up of Village Health Sanitation and Nutrition Committees (VHSNCs) and fourth Saturday meeting follow-up by district administration.
4. Training plan for frontline workers (FLWs) − ANMs on antenatal care (ANC).
5. ANMs completing at least three antenatal check-ups at sub-centre and visiting homes for fourth antenatal check-ups; and ANMs to submit reports on time.
6. Recruitment of vacant positions: medical officers, ANMS, Accredited Social Health Activists (ASHAs) and other staff (health supervisors and Block ASHA Facilitators [BAFs]).
7. Use of second Tuesday platform at block level to share MCTS data regularly (MoHFW, 2016a).
8. Plan training for Panchayat Pradhan/members (Swasthya Sanchalok).
9. Pursue proposal for procurement of mobile phones and Closed User Group (CUG) connections for ANMs and Anganwadi Workers (AWWs)

3.3.2 Action points ongoing

One action point is continuing onto the next cycle:

1. Involvement of self-help groups (SHGs) in VHND sessions

3.3.3 Action points not started

The remaining three action points could not start within the cycle period and therefore, cancelled during the meeting in Step 5. A change in the district administration (additional district magistrate [ADM] during Cycle 1 transferred to another district) and the chairperson of the meeting in Step 5 along with the theme leader did not find these three action points relevant in the current context.

1. CMOH to pursue with state for insufficient funds supply in the *District Programme Implementation Plan 2015/16* (Department of Health and Family Welfare, 2015).
2. Incentives for ICDS FLWs to attend VHNDs.

3. District administration, CD and CMOH to pursue at state level for approval of funds/guidelines to start referral transport for antenatal check-ups.

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)	10/13= 76.9[13]	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)	9/13= 69.2[14]	Form 5
		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)	2/6= 42.9[15]	Form 5
		4. (Amount of finance sanctioned for the primary theme-specific action points) / (total amount of finance requested as per action points of the DIPH primary theme)	0/0[16]	Form 5
		5. (Units of specific medicine provided for the primary theme-specific action points) / (total units of specific	0/0[17]	Form 5

[13] Not all action points could start during the specified period. Out of the 13 action points, the district cancelled three action points, as these were not relevant in the current perspective during Step 5 meeting on 22 September 2016. (See Form 5, Part B, columns: 'Action points'; 'Timeline'; and 'Status of action points'.)

[14] Out of the 13 action points, nine action points completed the specified timeline (July-September 2016). (See Form 5, Part B, Sl. No.'s 3-8 and No. 10 in column: 'Status of action points'.)

[15] One directive issued by the district magistrate to address two action points: follow-up of VHSNCs and fourth Saturday meeting by district administration; and use of second Tuesday platform at block level to share MCTS data regularly (MoHFW, 2016a). Another note sheet issued to submit proposal in Samity meeting: to pursue proposal for procurement of mobile phones and CUG connections for ANMs and AWWs. Against one action point verbal directive given in MIES meeting to: issue a guideline for conduct of VHNDs in co-ordination with CD. Due to the cancellation of three action points (as these were not relevant in the current perspective), there was no need to issue the remaining three written directives/letters. (See Form 5, Part B, Sl. No.'s 3, 5, 9 and 10 in columns: 'Action points'; 'Indicators'; and 'Progress of indicators'.)

[16] Funds are required to complete two action points, which were cancelled by the district. So, proposals have not been sent to the state. Otherwise, there was no demand for additional funds included in the DIPH action plan. (See Form 5, Part B, Sl. No. 11, 12.13 in columns: 'Action points'; 'Indicators'; and 'Progress of indicators'.)

[17] The selected theme does not require procurement of any medicine. (See Form 5, Part B, columns: 'Action points'; and 'Indicators'.)

		medicine requested as per action points of the DIPH primary theme)		
		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[18]	Form 5
		7. (Units of specific IEC [information, education and communication] 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[19]	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)	41/696= 5.9[20]	Forms 4 and 5
		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)	697/780= 89.36 [21]	Forms 4 and 5
	J. Factors influencing the achievements as per action points of the DIPH primary theme	**10. List of facilitating factors**	1. Involvement of district administration in developing and follow-up of action points 2. Active participation by the theme leader and other departments is the key factor for implementation and regular follow-up of action points 3. Regular follow-up of action points in different monthly meetings at district level	Form A.3

[18] No demands by the action plan. (See Form 5, Part B, in columns: 'Action points'; and 'Indicators'.)

[19] There is no specific demand put for IEC materials in the action plan. (See Form 5, Part B, columns: 'Action points'; and 'Indicators'.)

[20] Human resource recruitment involves: medical officers recruited = 34 out of 48 vacancies; ANMs recruited = 5 out of 60 vacancies; other staff recruited = 2 out of 36 vacancies; no ASHAs recruited until September 2016. (See Form 5, Part B, columns: 'Action points'; 'Indicators'; and 'Progress of indicators' and Form 5.1, action point No. 8.)

[21] The action plan includes training of ANMs on ANC. ANMs will train until September 2016. (See Form 5, Part B, columns: 'Action points'; 'Indicators'; and 'Progress of indicators' and Form 5.1, action point No. 6.)

			4. Analysis of data from different departments i.e. CD, health and PRD helps the district to make good policies to reach the health target/goal effectively 5. Capacity building of non-health FLWs/elected members for improvement of health care services under the DIPH 6. The presence and motivation by the DIPH research team acted as a push factor for stakeholders to accomplish the action points	
		11. List of challenging factors	1. Time constraint is the main challenge during the implementation of the DIPH in the district 2. It is difficult for the district to accomplish all action points within three to four months' time span. This should be at least four to five months after development of action plan 3. To organise the DIPH meeting on time with all district-level officers is very difficult due to their involvement in several ongoing programmes in the district 4. Involvement of private for-profit organisations and NGOs in the DIPH is very poor	Form A.3

3.4 Sustainability of the DIPH

The following analysis is from in-depth interviews with stakeholders as well as observations by the DIPH research team.

3.4.1 Data source

- Timely availability of data is a challenge – updating the MCTS (MoHFW, 2016a) does not occur on a regular basis.
- There is no effective mechanism to ensure verification of data.
- Data-sharing does not happen between health and non-health departments, NGOs and

private for-profit organisations.

3.4.2 Facilitators within the district

- The DIPH research team could build and maintain a good rapport with stakeholders.
- The proactiveness of DMCHO and PHPC from the beginning of the DIPH process helped in engaging with stakeholders.
- The stakeholders are now familiar with the DIPH process and this resulted in active participation in discussions and considerably reduced the time taken in discussions.
- An official letter by the district magistrate ensuring participation of all stakeholder departments.
- The interaction with CD-ICDS improved in Cycle 2 compared to Cycle 1.

> "Actually, he [DIPH district co-ordinator] frequently comes to me, he rings me, so I also discuss with the CDPOs [child development project officer] to know the situation, there is a telephonic conversation and on the spot report providing system is there. It was not there before it, I think." (DPO-ICDS, N24PGS)

3.4.3 Challenges within the district

- There are two health districts within N24PGS Revenue District. But there are constraints in the functioning of one of the health districts – Basirhat – this is due to lack of manpower and difficult geographical features (remote and riverine areas).
- Lack of manpower cuts across departments. The DEO is a contractual post in the health department whereas there are no DEOs for CD-ICDS.
- Time constraint in bringing district-level officers in a common platform is very difficult due to their involvement in several ongoing programmes in the district. The cycle duration of three months is not sufficient to achieve the target.
- Availability and quality of data.
- Though the dependence on the DIPH research team reduced from Cycle 1, stakeholders still require regular follow-up (reminder) by the research co-ordinator.
- Though interdepartmental co-ordination improved, the major share of responsibilities still remains with the health department.
- Involvement of NGOs and private for-profit organisations is unmet.

3.4.4 Possible solutions

- Stakeholders suggest the duration of the cycle needs to extend to four to five months.
- There is a need to verify the quality of data and implementation of action points. The stakeholders suggested joint monitoring system and combined field visits to facilitate this.
- PHPC suggested a web portal to facilitate timely availability of data:

> "It is also very essential to provide quality data to district officials' administration by which they can instruct block officials to implement action points timely. A good web portal and data analysis system will help us to review the entire process in a single click." (PHPC, N24PGS)

- To consider themes that involve more participation by non-health departments.
- To involve sub-district-level stakeholders such as BMOHs, BPHNs, CDPOs during Steps 4 and 5 for better implementation of the action plan.

REFERENCES

Department of Health and Family Welfare 2015, *District Programme Implementation Plan 2015/16*, Government of India, North 24 Parganas.

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

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

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

A. Filled by: DIPH research team
B. Date: 12 May 2016

Sl. No.	Particulars		
A	**Document title***		*District Programme Implementation Plan 2015/16*, N24PGS
A1	**Date of release**		15 September 2015
A2	**Primary theme**		**Increase in third antenatal check-up and improvement in tracking of fourth antenatal check-up**
A3	Goal		Maternal Health: Improvement of antenatal service coverage for pregnant women
A4	Action points specified by the document	1	Registration of all pregnant women by first trimester (within 12 weeks) of pregnancy
		2	Counselling of pregnant women on institutional delivery, nutrition, identification of danger signs, birth preparedness, etc. by health care providers and ICDS
		3	Ensuring fourth antenatal check-up at home by health care providers
		4	Special emphasis on high-risk pregnancy
*Annual/five-year health plans, specific health policy documents and valid government orders related to public health.			

Form 1B: Health system capacity assessments

Sl. No.	Particulars		
1	**District demographic details**		***Source***
1.1	Total area (square km)	4,094	www.north24parganas.gov.in
1.2	Total population	10,009,781	District Census 2011*
1.3	Number of women in the reproductive age group	396,403	District database
1.4	Number of children under five years	957,973	District Census 2011*
1.5	Rural population (%)	42.73	District Census 2011*
1.6	Scheduled Caste population (%)	21.70	District Census 2011*
1.7	Scheduled Tribe population (%)	2.60	District Census 2011*
1.8	Population density (persons/square km)	2,445	District Census 2011*
1.9	Total literacy (%)	84.95	District Census 2011*
1.10	Female literacy (%)	80.34	District Census 2011*
1.11	Key NGOs	1.11.1. SISH	www.shisindia.org, E-mail – mawohab@yahoo.com, Phone – 0091 3218-270245, Fax – 0091 3218 271969
		1.11.2. Sarvik	www.sarvikvivekananda.com, E-mail – office@sarvikvivekananda.com, Phone – +9133 2654 – 2328 / 5112 Fax – +9133 2654 – 5112

		1.11.3. GUP	www.gup-ngo-india.org, E-mail – gup1984@bsnl.in and gup_rch@rediffmail.com, Phone – +91-33-22652403 / 24413421
1.12	Key private for-profit organisations	1.12.1. IMA branch in N24PGS	www.imabarasatbranch.in

2	**Health status at district level**					
	Theme	**Coverage indicators**	***Data***		***Gap (%)***	***Remarks***
			Source	***%***		
2.1	Increase in third antenatal check-up and improvement in tracking of fourth antenatal check-up	1. Percentage of pregnant women registered in first trimester against total registration	MCTS	86	14	
		2. Percentage of pregnant women received minimum three antenatal check-ups	MCTS	81	19	
		3. Percentage of pregnant women received all four antenatal check-ups	MCTS	52	48	
		For sub-district level (block)[a] refer to Form 1B.1				

3	**Theme** (refer to 2.1): **Increase in third antenatal check-up and improvement in tracking of fourth antenatal check-up**						
		Details		***Sanctioned (2016/17)***	***Available/ functional***	***Gap***	***Remarks***
3.1	**Infrastructure**	a. Sub-centre		742	742	0.0	
		b. Public Health Centre		22	22	0.0	
		c. Block Public Health Centre		11	11	0.0	
		d. Rural hospital		1	1	0.0	
		e. Sub-divisional hospital		2	2	0.0	
		f. District hospital		1	1	0.0	
3.2	**General resources**	Finance	RCH flexible pool – maternal health (in Rs.)	90,616,777.78	90,616,777.78	0.0	
		Supplies	Iron Folic Acid tablet strips	48,000	48,000	0.0	
			Tetanus Toxoid injections	42,600	42,600	0.0	
			Blood sugar test kit	38,000	38,000	0.0	
		Technology	Data-capturing units of HMIS and MCTS	12	12	0.0	
3.3	**Human resources**	BMOH		12	12	0.0	
		General duty medical officer		64	62	2.0	
		BPHN		12	12	0.0	
		Public health nurse (PHN)		22	14	8.0	
		Gram Panchayat health supervisor		110	98	12.0	
		ANM		848	781	67.0	
		ASHA		2,309	1,747	562.0	
		AWW		10,245	9,604	641.0	

[#] Please refer to the Form 1B.1 for the sub-district (block) level performance indicator.

* Office of the Registrar General & Census Commissioner 2011, *District Census Hand Book 2011*, Government of India, New Delhi, viewed on 12 May 2016 www.censusindia.gov.in/2011census/dchb/1911_PART_B_DCHB_NORTH%20TWENTY%20FOUR%20PARGANAS.pdf

Form 1B.1: Sub-district level (block) performance of selected indicators*

Sl. No.	Sub-district (block)	Coverage indicators		
		Theme: Increase in third antenatal check-up and improvement in tracking of fourth antenatal check-up		
		Indicator 1** Percentage of pregnant women registered in first trimester against total registration	Indicator 2** Percentage of pregnant women received minimum three antenatal check-ups	Indicator 3** Percentage of pregnant women received all four antenatal check-ups
1	Amdanga	90	82	56
2	Bagda	88	91	45
3	Barasat-I	87	86	50
4	Barasat-II	85	88	71
5	Barrackpore-I	76	82	56
6	Barrackpore-II	73	83	60
7	Bongaon	88	87	44
8	Deganga	88	52	28
9	Gaighata	86	80	61
10	Habra-I	84	86	58
11	Habra-II	86	87	39
12	Rajarhat	86	82	69

*On July 2016; **Source: MCTS

Form 4: Plan

Date of meeting: 16 June 2016
Venue: District Meeting Hall, CMOH office, Barasat, West Bengal, India
Chairperson: District magistrate

Sl. No.	Action points	Responsible department	Person responsible	Indicators for the action points	Unit of target	Target	Target date
1	**Service delivery**						
1.1	Plan training for Panchayat Pradhan/member (Swasthya Sanchalok)	PRD	PHPC, Zilla Parishad	a. Number of training arranged for Panchayat Pradhan and members (Swasthya Sanchalok) in co-ordination with health department / total trainings planned	Number	12	September 2016
				b. Number of Panchayat Pradhan and members (Swasthya Sanchalok) trained on maternal health / total number of Panchayat Pradhan and members (Swasthya Sanchalok)	Number	216	
1.2	Involvement of SHGs in VHNDs sessions	PRD	PHPC, Zilla Parishad with support from additional district magistrate-general (ADM-G)	a. Number of SHGs sensitised to participate in VHND sessions / total number of SHGs working	Number	67	September 2016
				b. Number of sensitisation meetings conducted with SHGs / total meetings planned	Number	13	
				c. Number of VHND sessions conducted in support with SHGs / total number of VHND sessions planned	Number	3,732	

1.3	Issue a guideline to conduct VHNDs in co-ordination with CD	CD	DPO-CD	a. Joint meeting by CMOH and DPO-ICDS with district administration to issue a guideline	Not defined	0	Monthly; September 2016
				b. Number of VHND sessions conducted in presence of AWWs/Total number of VHND sessions conducted	Number	3,732	
1.4	Regularise outreach camps (proper infrastructure with privacy for pregnant women)	Health department	BMOH	a. Number of outreach camps organised with provision of proper arrangement (blood pressure machine, weight machine, foetal heart-rate checks, etc.) for antenatal check-ups / total number of outreach camps organised	Number	1,596	Monthly; September 2016
1.5	VHSNCs and fourth Saturday meeting follow-up by district administration	PRD	PHPC, Zilla Parishad	a. Number of VHSNC sessions monitored / total number of VHSNC sessions planned	Number	3,528	Monthly; September 2016
				b. Issue directive (written) to monitor and submit report on fourth Saturday meeting monitoring	Not defined	0	
				c. Number of fourth Saturday meeting monitored / total number of fourth Saturday meetings conducted	Number	324	
1.6	Training plan for FLWs − ANMs on ANC	Health department	BPHN	a. Number of trainings arranged for FLWs on improvement on antenatal check-up / total number of trainings planned	Number	60	Monthly; September 2016

				b. Number of ANMs trained on improvement on antenatal check-ups / total number of ANMs in position	Number	780	
1.7	ANMs completing at least three antenatal check-ups at sub-centre and visits home for fourth antenatal check-up; ANMs submit reports on time	Health department	BMOH	a. Number of pregnant women registered / total number of estimated pregnant women	Number	12,672	Monthly; September 2016
				b. Number of pregnant women received three antenatal check-ups / total estimated pregnant women eligible for three antenatal check-ups	Number	12,672	
				c. Number of pregnant women received a home visit on fourth antenatal check-up / total estimated pregnant women for fourth antenatal check-up	Number	12,672	
2	**Workforce**						
2.1	Recruitment of vacant positions: medical officers, ANMs, ASHAs and other staff (health supervisors and BAF)	Health department	CMOH (state responsibility)	a. Number of medical officers recruited against the number of vacancies	Number	48	Monthly; September 2016
				b. Number of ANMs recruited against the number of vacancies	Number	60	
				c. Number of ASHAs recruited against the number of vacancies	Number	552	
				d. Number of other staff (Gram Panchayat health supervisor, BAF) recruited against the number of	Number	36	

				vacancies			
3	**Supplies and technology**						
3.1	To pursue proposal for procurement of mobile phone and CUG connections for ANMs and AWWs	Health department	CMOH	a. Submit proposal in next district Samity meeting to approve new connection for 33 ANMs and AWWs	Not defined	0	September 2016
4	**Health information**						
4.1	Use of second Tuesday platform at block level to share MCTS data regularly	Administration	Block development officer (BDO)	a. Number of meetings where MCTS data-sharing recorded / total number of meetings planned	Number	36	Monthly; September 2016
				b. Issue an order by district magistrate	Not defined	0	
5	**Finance**						
5.1	CMOH to pursue with state for insufficient funds supply in the *District Programme Implementation Plan 2015/16,* N24PGS	Health department	CMOH	a. Send proposal to state to clear funds – on a needs basis	Not defined	0	July 2016
5.2	Incentives for ICDS FLWs to attend VHNDs	Health department	CMOH	a. Send proposal in *District Programme Implementation Plan 2015/16*, N24PGS	Not defined	0	September 2016
6	**Policy/ governance**						
6.1	District administration, CD and CMOH to pursue at state level for approval of funds/guidelines to start referral transport for antenatal check-ups	Health department	CMOH	a. Send proposal in *District Programme Implementation Plan 2015/16,* N24PGS	Not defined	0	September 2016
				b. Amount of funds sanctioned against proposed fund	Not defined	0	

Form 5: Follow-up

Date of the meeting: 22 September 2016
Venue: Conference hall, office of district magistrate, N24PGS
Chairperson: District magistrate

Part A

Theme: Increase in third antenatal check-up and improvement in tracking of fourth antenatal check-up

Theme leader: DMCHO

1. Number of meetings conducted since the last DIPH meeting by the theme leader					
2. Major stakeholders involved in each meeting	**Meeting 1**	**Meeting 2**	**Meeting 3**	**Meeting 4**	**Meeting 5**
	2.1 Date	14 July 2016	19 August 2016	22 August 2016	22 September 2016
	2.2 Participants	93	78	32	21
3. Comparison of key coverage indicator(s) in the DIPH cycle	**Indicator (source)**	**Time 0 March, 2015**	**Time 1 July 2016 ***	**Time 2 August 2016 ***	**Time 3 September 2016 ***
	Percentage of pregnant women registered in first trimester against total registration	86	93.02	88.33	47.75
	Percentage of pregnant women received minimum three antenatal check-ups	81	90.72	86.17	48.08
	Percentage of pregnant women received all four antenatal check-ups	52	65.51	58.14	37.50

*Calculation based on: performance reported by blocks/ ELA calculated at district level) *100 as MCTS portal has been halted by the ministry due to the introduction of the RCH portal, but the RCH portal is not updated.

Part B

Sl. No.	Action points	Indicators for the action points	Progress of indicators	Person responsible	Timeline	Status of action points	Suggestions	
							Timeline	Change in responsibility
1	Plan trainings for Panchayat Pradhan/member (Swasthya Sanchalok)	1.1. Number of trainings arranged for Panchayat Pradhan and members (Swasthya Sanchalok) in co-ordination with health department / total trainings planned	0	PHPC, Zilla Parishad	September 2016	Completed	Not applicable	Not applicable

		1.2. Number of Panchayat Pradhan and members (Swasthya Sanchalok) trained on maternal health / total number of Panchayat Pradhan and members (Swasthya Sanchalok)	0					
2	Involvement of SHGs in VHND sessions	2.1. Number of SHGs sensitised to participate in VHND sessions / total number of SHGs working	0	PHPC, Zilla Parishad with support from ADM-G	September 2016	Ongoing – not on target	October 2016	Same
		2.2. Number of sensitisation meetings conducted with SHGs / total meetings planned	0					
		2.3. Number of VHND sessions conducted in support with SHGs / total number of VHND sessions planned	0					
3	Issue a guideline to conduct VHNDs in co-ordination with CD	3.1. Joint meeting by CMOH and DPO-ICDS with district administration to issue a guideline	Yes	DPO-CD	Monthly; September 2016	Completed	Not applicable	Not applicable
		3.2. Number of VHND sessions conducted in presence of AWWs / total number of VHND sessions conducted	64.31%					
4	Regularise outreach camps (proper infrastructure with privacy for pregnant women)	4.1. Number of outreach camps organised with provision of proper arrangement (blood pressure machine, weight machine, foetal heart-rate checks, etc.) for antenatal check-ups / total number of outreach camps organised	86.09%	BMOH	Monthly; September 2016	Completed	Not applicable	Not applicable
5	VHSNCs and fourth Saturday meeting follow-up by district administration	5.1. Number of VHSNC session monitored / total number of VHSNC sessions planned	25.71%	PHPC, Zilla Parishad	Monthly; September 2016	Completed	Not applicable	Not applicable
		5.2. Issue directive (written) to monitor and submit report on fourth Saturday meeting monitoring	Yes					

		5.3. Number of fourth Saturday meeting monitored / total number of fourth Saturday meetings conducted	33.64%					
6	Training plan for FLWs – ANMs on ANC	6.1. Number of trainings arranged for FLWs on improvement on antenatal check-ups / total number of trainings planned	73.33%	BPHN	Monthly; September 2016	Completed	Not applicable	Not applicable
		6.2. Number of ANMs trained on improvement on antenatal check-ups / total number of ANMs in position	89.36%					
7	ANMs completing at least three antenatal check-ups at sub-centre and visits home for fourth antenatal check-up; ANMs submit reports on time	7.1. Number of pregnant women registered / total number of estimated pregnant women	76.37%	BMOH	Monthly; September 2016	Completed	Not applicable	Not applicable
		7.2. Number of pregnant women received three antenatal check-ups / total estimated pregnant women eligible for three antenatal check-ups	74.99%					
		7.3. Number of pregnant women received a home visit for fourth antenatal check-up / total estimated pregnant women for fourth antenatal check-up	53.72%					
8	Recruitment of vacant positions: medical officers, ANMs, ASHAs and other staff (health supervisors and BAF)	8.1. Number of medical officers recruited against the number of vacancies	70.83%	CMOH (state responsibility)	Monthly; September 2016	Completed	Not applicable	Not applicable
		8.2. Number of ANMs recruited against the number of vacancies	8.33%					
		8.3. Number of ASHAs recruited against the number of vacancies	0					
		8.4. Number of other staff (Gram Panchayat health supervisor, BAF) recruited against the number of vacancies	5.56%					

9	To pursue proposal for procurement of mobile phone and CUG connections for ANMs and AWWs	9.1. Submit proposal in next district Samity meeting to approve new connection for 33 ANMs and AWWs	Yes	CMOH	September 2016	Completed	Not applicable	Not applicable
10	Use of second Tuesday platform at block level to share MCTS data regularly	10.1. Number of meetings where MCTS data-sharing recorded / total number of meetings planned	61.11%	BDO	Monthly; September 2016	Completed	Not applicable	Not applicable
		10.2. Issue an order by district magistrate	Yes					
11	CMOH to pursue with state for insufficient funds supply in the *District Programme Implementation Plan 2015/16*, N24PGS	11.1. Send proposal to state to clear funds – on a needs basis	No	CMOH	July 2016	Not started	Not applicable	Not applicable
12.	Incentives for ICDS FLWs to attend VHNDs	12.1. Send proposal in *District Programme Implementation Plan 2015/16*, N24PGS	No	CMOH	September 2016	Not started	Not applicable	Not applicable
13	District administration, CD and CMOH to pursue at state level for approval of funds/guidelines to start referral transport for antenatal check-ups	13.1. Send proposal in *District Programme Implementation Plan 2015/16*, N24PGS	No	CMOH	September 2016	Not started	Not applicable	Not applicable
		13.2. Amount of funds sanctioned against proposed fund						

A.2: Record of Proceedings – Summary Tables

A.2.1: Record of Proceedings – summary for DIPH Step 4			
A. Time taken for each session			
Session	***Time allotted***	***Actual time taken***	***Remarks***
A.1 Briefing	30 minutes	10.50 am – 11.20 am	
A.2 Form 4	60 minutes	11.20 am – 12.50 pm	
B. Stakeholder leadership			
B.1 Agenda circulated/invitations sent		DIPH research team	
B.2 Chair of sessions		CMOH, N24PGS	
B.3 Nominee/ volunteer	1. Completing data forms	Anns	
	2. Presenting summary	Sanghita	
	3. Theme leader	DMCHO	
	4. Record of proceedings	Antara	
C. Stakeholder participation			
C.1 Number of stakeholders invited	Health department	15	CMOH, N24PGS Health District CMOH, Bashirhat Health District District chief medical officer of health-III (Dy. CMOH-III), N24PGS Health District Dy. CMOH-III, Basirhat Health District DMCHO, N24PGS Health District DSM, N24PGS Health District. District accounts manager (DAM), N24PGS Health District. District public health and nursing officer (DPHNO), N24PGS Health District DPHNO,Bashirhat Health District District chief medical officer of health-I (Dy. CMOH-I), Barasat Health District Assistant chief medical officer of health (ACMOH), Sadar, Barrackpore, Bidhannagar, Bangaon and Basirhat
	Non-health departments	14	• DPO-ICDS, N24PGS • CDPO (12 blocks), N24PGS Health District • PHPC (Zilla Parishad), N24PGS
	NGO/private for-profit organisations	3	• SHIS • Sarvik • GUP • Private for-profit organisations not invited
	District administration	3	• District magistrate, N24PGS. • ADM-G, N24PGS • Officer-in-charge health, N24PGS
C.2 Percentage of stakeholder participation (to those invited)	Health department	100% (15/15)	
	Non-health departments	21.4% (3/14)	It was informed by ADM-G that CDPOs could not attend due to other priorities
	NGO/private	66.7% (2/3)	SHIS has not attended the meeting

	for-profit organisations		and their reason is unknown. (No private for-profit organisations present)
	District administration	33.3% (1/3)	Officer-in-charge health did not take any initiative to attend DIPH meetings. District magistrate was unavailable
	Total	60% 21/35	
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	Recruitments for ASHA, PHN, BAF; and monitoring and supervision of ASHA and ANM	
	DMCHO	Action points; training; maternal near miss; and quarterly review meetings	
	Dy. CMOH-III	Convergence meetings to increase community awareness for maternal check-ups	
D.2 Non-health departments	PRD	Convergence meetings will be held regularly from next month onwards	
	CD-ICDS	CDPOs and AWWs will support health officials/workers to achieve all action points on time	
D.3 NGO/private for-profit organisations		None	
D.4 District administration		Implement and follow-up of all action points is very much required	
E. Responsibilities delegated to non-health departments and NGOs*			
Type of activities shared	CD-ICDS	DPO-ICDS and CMOH took joint responsibility to further apply for funds from state for AWWs to attend VHNDs	
	PRD	PRD members trained on health issues by health officials and arranged by PHPC, Zilla Parishad	
	District administration	ADM-G will involve the District Rural Development Cell of PRD to ensure participation of SHGs in VHNDs and other health programmes	
	NGO	none	
F. Co-operation/communication between stakeholders*			
Action plan discussed and finalised with each stakeholder's approval			
G. Data utilisation			
Data on human resources, number of routine meetings by VHSNC and stipulated number of outreach camps were used for setting indicators			
H. Suggestion for Developing a Decision-Making guide modification (*Note: suggestions with*			

justifications on forms, process)
No suggestion from stakeholders

*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	15 minutes	3.30 pm – 3.45 pm	
A.2 Form 5	30 minutes	3:45 pm – 4.15 pm	
B. Stakeholder leadership			
B.1 Agenda circulated/invitations sent		CMOH	
B.2 Chair of sessions		ADM-G, N24PGS	
B.3 Nominee/ volunteer	1. Completing data forms	Not done	Action points that need to be continued discussed
	2. Presenting summary	DMCHO	
	3. Theme leader	DMCHO	
	4. Record of proceedings	Zakir Hossain	
C. Stakeholder participation			
C.1 Number of stakeholders invited	Health department	19	CMOH, N24PGS Health District Dy. CMOH-I, -II, -III, N24PGS Health District DMCHO, N24PGS Health District DPHNO, N24PGS Health District DSM, N24PGS Health District BMOHs (12 blocks), N24PGS Health District
	Non-health departments	1	DPO-ICDS, N24PGS
	NGO/private for-profit organisations	0	Not invited
	District administration	1	ADM-G, N24PGS
C.2 Percentage of stakeholder participation (to those invited)	Health department	94.74% (18/19)	
	Non-health departments	100% (1/1)	
	District administration	100% (1/1)	
	NGO/private for-profit organisations	0	Not invited
	Total	95.2% (20/21)	
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	Discussed the two action points not started: 'involvement of SHGs in VHNDs to track pregnant women and CUG mobile connection for ANMs'	Remaining three action points were cancelled by the district as these were not relevant in their current perspective
	DMCHO		
D.2 Non-health department	CD-ICDS	None	
D.3 NGO/private for-profit organisations		Non applicable	Not invited
D.4 District administration		Administrative approval has been given for the above mentioned two action points	
E. Responsibilities delegated to non-health departments and NGOs*			

Type of activities shared	CD-ICDS	Responsibilities assigned earlier remain same. No changes made during the meeting	
	PRD		
	District administration		
	NGO/private for-profit organisations		
F. Co-operation/communication between stakeholders*			
Discussion on action points prepared earlier Change in responsibilities, timeline and revision of action points made in co-operation with all stakeholders			
G. Data utilisation			
Not done			
H. Suggestion for Developing a Decision-Making guide modification (*Note: suggestions with justifications on forms, process*)			
No suggestions			

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

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

Form A.3.1: In-depth interview with PHPC	
IDI label	I07_GSN_AI_19Sep2016
Interviewer	Anns Issac
Note taker	Anns Issac and Zakir Hossain
Transcriber	Zakir Hossain
Respondent details	
Date and time of interview	19 September 2016
Name of participant	Mr Subimal Dutta
Gender	Male
Designation	PHPC, Public Health Cell, Zilla Parishad
Department	PRD
Duration of service in the district	6 years
Previous position	PHPC, Public Health Cell, Zilla Parishad in Malda district
Qualification	Masters of Social Work Diploma in Business Management
Years of experience in present department	10 years
Membership in committees pertaining to health	Standing Committee of Janaswasthya-O-Paribesh Sthayee Samity, Zilla Parishad

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 is conducted prior to the DIPH and on how it is being conducted presently through the DIPH

The DIPH is happening in the district in very good way. In last two cycles, the steps of DIPH are really 'excellent', because situation analysis, action points, follow-up action, etc. five steps are nicely included in the study. The analytical part especially data collection from different departments i.e. CD, health, PRD helps the district to make good policies at district level and these data also assist us to reach the target/goal of the district.

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 assessment of health system problems
b. Prioritisation of health-related problems at district level
c. Development of action plan
d. Follow-up of action plan

Before DIPH, the district had convergence meetings at sub-centres (third Saturday) and Gram Panchayats (fourth Saturday) to link with other departments for improvement of health status of the district. But, now DIPH is enhancing the convergence process at district level very nicely. Among the five steps the situation assessment is very much useful, because before DIPH the district has not analysed the situation in that way. This helps us to 'frame good plan at district level'. Another step, follow-up of action points is very significant, knocking us about the pending action points that need to complete in schedule timeline.

3. What are the key themes covered in the last DIPH cycle?
Increase in third ANC and improvement in tracking of fourth ANC.

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

Sit together with all department officials and preparation of plan under DIPH have helped the district to improve its health targets/status within a specific timeline. Through DIPH process we have developed common platform at block level to share data and take decisions to reach health targets of the district. With the help of district key officials and PHFI, Hon'ble District Magistrate has issued an order regarding this initiative. We also seek support from PHFI to prepare a web-based single window (portal) for collecting and analysing data to identify the health issues to be prioritised.

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

Before DIPH, data have been used by the district for decision-making, but not in a proper way and also deepness of the data was not present there. So, frankly said that gap was there. Now, it has improved, but still have some lacuna at this juncture.

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

Before DIPH, data from other departments were not collected. The PRD department had own database and we monitored the health programme by using only our database, but not in regular way − 'it was a gap'. But, now we are using data to monitor the action points.

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?

Regular interaction with other departments is now possible by organising monthly review meeting, standing committee meeting, etc. at district level and through DIPH process we are able to interact properly. However, 'now it is much more regularised today'.

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

NGOs are involved to run different programmes in the district. Some NGOs are involved to conduct training under capacity building programme. Panchayat department has also engaged some local NGOs/community-based organisations to construct sanitary system as well as community sensitisation about open defecation free initiatives in the district. But, there is no such system of sharing data by NGOs right now. Basically, it is needs-based, if required we can involve them. This will be helpful for the convergence process at district level.

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?

No common platform for sharing of data from private sector. It is needs-based, if required we can involve them.

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 private sector.

Time constraint is the main challenge during implementation of DIPH in the district. To bring district-level officers in a common table/platform is very difficult due to their involvement in several ongoing programmes in the district.

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

Duration of cycle should be extend to four to five months. As time constraint is our main challenge, we need more time to implement action points.

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

Joint monitoring system, common field visits help to solve problem at grassroots level. It leads to better implementation of DIPH action points.

It is also very essential to provide quality data to district officials/administration by which they can instruct block officials to implement action points timely. ‘A good web portal and data analysis system will help us to review the entire process in a single click’. Raw data from grassroots-level worker are very much significant, if district key officials will get raw data systematically, they can easily monitor performances of ongoing health programmes in the district.

Form A.3.2: In-depth interview with DPO-ICDS	
IDI label	I08_GSN_AI_19Sep2016
Interviewer	Anns Issac
Note taker	Anns Issac and Zakir Hossain
Transcriber	Antara Bhattacharya
Respondent details	
Date and time of interview	19 September 2016
Name of participant	Mr Rajat Majumdar
Gender	Male
Designation	DPO-ICDS, N24PGS
Department	CD
Duration of service in the district	10 months
Previous position	CDPO
Qualification	BSc, BA English
Years of experience in present department	26 years
Membership in committees pertaining to health	1. Executive Committee – Department of Health and Family Welfare Samity 2. Standing Committee of Janaswasthya-O-Paribesh Sthayee Samity 3. District Taskforce 4. District Selection Committee 5. SNID Committee

1. How are health-related decision-making processes under the DIPH happening in your district?

Actually there were meetings together, they were emphasising on it to collect report from CDPOs. Actually it was held before this programme to some extent, not so gorgeously. Now it is performing gorgeously with the help them. Actually he [DIPH district co-ordinator] frequently comes to me, he rings me, so I also discuss with the CDPOs to know the situation, there is a telephonic conversation and on the spot report providing system is there. It was not there before it, I think.

2. Are you finding the DIPH process useful? If yes, then which aspects are you finding particularly useful?

Actually it [DIPH] is very much helpful. This programme is there for first time in West Bengal and we have conducted several meetings here with the help of district magistrate, ADM, health functionaries, ICDS functionaries. Actually we have already done threadbare discussion on it ICDS part, health part and Panchayat part. And actually no doubt the outcome is very much fruitful. As per the direction of our district magistrate we are helping our CDPOs and providing reports as asked by him. Actually we had several meetings in Zilla Parishad, we sat there with CDPOs, with join BDOs. So actually we have done several meetings, we have jointly sat down with district functionaries, block functionaries like joined BDOs, BMOHs, our CDPOs, DPOs and we have already conducted meetings. We have discussed the necessity of this programme, and it is first time the programme is occurring in our state, so we it is very much useful to our CDPOs, and it will be very much useful for developing N24PGS.

Development of action plan I think it is more useful.

3. What progress through the DIPH have you made to improve the health targets/status in your district (from Cycle 1 to Cycle 2) in the last two DIPH cycles?

See there are two health districts here – Revenue District is one but Health District is two. One is Bashirhat and other is Barasat. Actually in case of Barasat it is better. Due to riverine blocks and hurdles in Bashirhat it is difficult to earn result so fast. I hope it will be done better in future. Actually in Barasat situation is okay and every health aspect with ICDS and Panchayat functionaries is being performed in tote. But in Bashirhat District there is some lacunae due to riverine block. There is too much hurdles due to river and there is problem in communication. So there is some difficulty there, I hope it will be overcome in future.

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

Actually, data is very much useful, without data no clarification no report can be done, no PowerPoint presentation can be given and it cannot be deliverable. That is why data is very much essential and with the help of data, district magistrate also keeps in her grip what is the lacunae, what is to be done and what is not done, she can also understand. That is why data is very much useful. Without data nothing cannot be done.

Probe: What is the status of data reporting in N24PGS?

Actually we already inform to Delhi through our department. And health also send the same. Actually common thing is there: severe acute malnutrition, moderately malnourished children, institutional delivery, infant mortality and mothers' mortality. These are the common portion of health and ICDS. For another portion we are supporting health department when there is an institutional delivery that is going to occur, we are supporting ASHA worker, AWW are supporting ASHA worker. For the three trimesters AWW are giving the data, information, condition of the pregnant women. So AWW and ASHA are functioning under the same umbrella. Data is given through health department.

[Added by interviewer: So at the ground level ASHA and AWW are sharing the data but at the district level there is no sharing between health and ICDS.]

Actually in the convergence meeting there is PowerPoint presentation and through this we can share all the matters with health department, Zilla Parishad, Panchayat functionaries, ICDS.

5. Whether data from ICDS is used in monitoring the progress of the action plan in your district?

No, we can utilise data from ICDS, and this can be done fruitful since AWW can work with ASHAs. There are mothers' meeting and every data is lying with AWW. There is VHND-village level convergence meeting that takes place every month. There immunisation takes place and discussion is held with AWW and mothers and pregnant mothers. Everybody comes there. There immunisation, health check-up takes place. This will be more fruitful to tag the malnutrition, increase the number of institutional delivery as well as mother's mortality, antenatal check-up and postnatal check-up.

Probe: How was the reporting by blocks for the previous cycle?

Actually, block do not report. Report takes place from ASHA, AWW through higher personnel to CMOH. ANM through BMOH to CMOH. And another report is going on through AWW to CDPOs to DPOs and DPOs to New Delhi and copy to state government.

Probe: How was the monitoring for the last DIPH cycle action points, in relation to ICDS?

Actually last monitoring was held on breastfeeding week, actually in August from 1 to 7 there is a breastfeeding week, and 2 to 8 September there is a nutrition week. Two programmes were merged together and there threadbare discussion was held and PowerPoint presentation was held with the help of Panchayat and municipalities. Display of nutrient food, display of chart posters were held and several mothers attended and photos were send through WhatsApp to district, as well as to state and district magistrate.

6. Did the DIPH process lead to any change in the working relationship and interaction between the health department and government non-health departments?

I think it is very much fruitful. There is some fruitful activities have already been done because liaising is being maintained with the head of all the departments. That is why it is strengthening. This was a lacunae previously because this liaison person was not available. Through this system it was available. See actually nobody wanted to break the conventional method. But actually when he comes quite frequently because I'm giving him attention, and by giving him too much attention he is also quite close person. So I also say I want to help you. And that is why all departments are doing the same. That is why strengthening of operation is going on. Ultimately programme is doing successful.

7. Did the MCH NGO sector achieve involvement through the DIPH process?

Actually see participation is no doubt fruitful. Nowadays the strength of government staff is reducing day by day. It is not supplemented by newcomers, and new recruitment is not going on. That is why so many vacancies are there. In that case to make up for the lacunae NGO participation is very much better.

There are so many NGOs. Actually in Barackpore subdivision NGOs came and they want to attend the mother's meeting. They sought our permission, and that was given and we said yes, please do it.

Probe: Do they submit their report?

Actually they submit their report to CDPO or their NGOs but they do not give me any copy.

Probe: Do you ask them to support you in your activities?

Yes, I also asked. They have said they submitted the report. And extra effort needs to be done by them. They were seeking some help, and I told them I can give you this type of helps. They said, 'okay sir we are very grateful'. They continued to do their work.

Probe: Have you ever asked NGOs to help in your activities in those areas where there is a lack of human resources in the ICDS department?

Actually ICDS is a community-based activity. Every community, every member, every villager including NGOs may participate in the ICDS. They can help, it is told in our syllabus − ICDS syllabus. That is why we cannot ask them specially to do this. If anybody comes spontaneously we allow it.

8. Did the private sector achieve involvement through the DIPH process?

Actually we do not know of their activities to decrease the number of malnutrition. For this malnutrition we are trying hard from our district level. And in this district with severe malnourishment, the number of severely malnourished is less than 1,000 only. We are fighting to reduce it from our end. But no NGO comes to work hand to hand. Actually previously I worked in Murshidabad District, there are so many NGOs, and we worked hand to hand. We got corporate social responsibility fund from bank, from other government

offices and from there we… in addition to the nutritious food which is provided from the government in addition to that, they also provide nutritious food, and monitor it from their own sector. They also engage supervisors for monitoring parallel to government functionaries. Here, N24PGS is situated very close to Kolkata. So the views are different.

Probe: NGOs are only restricted to that district, it is not for all around West Bengal?

No, actually here NGO is district-based. In this district we have some facility here, Government of India's Nutrition Board is here in Esplanade area. They come here with their technical director, with technical assistants, with other functionaries, they do several programmes. They also give them tiffin, mother's tiffin, AWWs' tiffin. This type of programmes are not held in another district. From nutrition board it comes directly to us. They motivate, they also give us chart, poster, etc. In this financial year, they have already conducted mothers meeting, seminars.

9. What are the challenges and opportunities faced during the implementation process of the last DIPH cycle?

I would say that the lacuna which is going on for a long period, it will bridge the gap. Health department is carrying on their work accordingly with their own concept, ICDS is going on with their own concept. Actually through book they are bridged but practically there are some lacuna. This lacuna will be met up through this.

Probe: Is the DIPH adding extra pressure to its staff or it's already part of work but we streamlined it in a different way?

We have no DEO and this type of work is overburdening if we are asked to do this kind of reporting. If DEO like that is engaged here, that will be helpful and we can give fruitful report.

Probe: Is there a provision for DEOs?

No, actually fund problem is there. Government is not bearing the fund.

Probe: Is there any concern for the quality of data for decision-making?

Actually we like to depend on data. AWWs are trained in different way and when some new programme comes they are trained specially. Data is to some extent real we can say, and in some cases there is wrong data. Then he [DIPH district co-ordinator] tells that data is wrong data, it is to be rectified, then it is rectified.

Probe: For the past two DIPH cycles, is there any equal sharing of responsibilities between different departments?

Actually, health department took special attention and takes emphasis on it. They also tells us to attend and the programme is held in Zilla Parishad or district hospital. We along with the ADM and other CDPOs we attend it. Actually they call it and we share our experience, and in this way we can share. We tell them about our course of action, about our views, facilities, inconveniences and we discuss that.

Actually there was a programme previously, it was an NGO Co-operative American Relief Everywhere. They performed this type of work. They took special initiative, their officers came to the CDPO office, and one day one block they visited. When such happenings happened then it will be fruitful.

Now at present N24PGS is going to be announced second open defecation free district in West Bengal. That is why work is going on in every aspect, and our 10,000 AWWs took the responsibility of it. They are working hard and already good result yielded by our department and district magistrate praises our work very much. And he told it is a well organised and excellent programme. This open defecation free programme is getting priority.

10. Any suggestions how any of the steps involving the DIPH cycle can be improved (name them)?

To engage some DEO and expenditure may be borne by concerned authority. Block-level seminar to be held for AWW and ASHA may be present. In development meeting of BDO there will be discussion in presence of BMOH, BDO and CDPO about that block regarding this programme. Panchayat functionaries should be involved. If Panchayat Sabhapati is involved then Pradhan will be involved. So Panchayat Sabhapati must be involved. Some block-level NGOs should be involved. Mahila samitis, Swasthya Karmadhyaksh of block and Nari o Shishu Karmadhyaksh should be involved.

Special importance should be given to backward riverine blocks in Bashirhat Health District. Meetings should be arranged in pockets where beneficiaries are concentrated and they should be motivated, and they should be sensitised there, by doing this it will improve. Only doing at the district level it will not be fruitful. Involvement of grassroots level is necessary. And results will be resumed if grassroots meetings, seminars are held at least once in a month.

Both ASHA, AWWs health workers are functioning in VHSNC programme. The matter is that AWWs are very poorly paid workers and they are not given any incentives whereas health workers are given incentives. In addition to that, time is so odd, AWW comes at 7.00 am, it is very much difficult for them to go back to their home at 5.00 pm. Health workers are fully paid by government. They are also getting incentive by government in spite of this the programme starts at 12.00 pm, 1.00 pm, 2.00 pm according to their own wish. It is very difficult and this is main lacuna for convergence. AWWs are unwilling to stay for such time without any financial benefit, matter is that.

Actually our AWWs are very ambitious. So poor honorarium in this escalating system of price index that is why they are very much reluctant to further any, if something is given to them they are ready. If some fund is given by the Health District, then AWW is benefited.

Form A.3.3: In-depth interview with DMCHO	
IDI label	I09_GSN_AI_21Sep2016
Interviewer	Anns Issac
Note taker	Anns Issac and Zakir Hossain
Transcriber	Zakir Hossain
Respondent details	
Date and time of interview	21 September 2016
Name of participant	Dr Sukanta Biswas
Gender	Male
Designation	DMCHO
Department	Department of Health and Family Welfare
Duration of service in the district	5.5 years
Previous position	ACMOH
Qualification	MBBS, DPH
Years of experience in present department	5.5 years
Membership in committees pertaining to health	District Development and Monitoring Committee, District Appropriate Authority of Pre-Conception and Pre-Natal Diagnostic Techniques

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

DIPH is happening in the district through enter department convergence. Already the district had different meetings with various departments/stakeholders, but it was not is regular manner. But, exchange of ideas, preparation of different action points and its follow ups as part of DIPH meetings is now possible in the district in a regular manner. Hence, the concept of district level convergence with allied departments i.e. ICDS and Panchayat Raj Institution is now strengthen under the DIPH process.

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 assessment of health system problems
b. Prioritisation of health-related problems at district level
c. Development action plan
d. Follow-up of action plan

DIPH is happening in the district by prioritising some specific issues based on situation analysis with all allied departments, i.e. ICDS and Panchayat Raj Institution. However, development of action plan and the follow-up of action points are the key components in implementation of DIPH in the district − these are very 'important' and 'crucial'. However, DIPH is really a 'great experience' for the district.

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

Increase in third ANC and improvement in tracking of fourth ANC.

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

b. Development of action plan
c. Follow-up of action plan

The interdepartmental convergence has increased not only under DIPH cycles, it reflects in the other segments of health components too. Side-by-side other indicators like immunisation, institutional delivery are also improving through this convergence.

In last two cycles, through development of action plan and its follow ups antenatal check-ups coverage and initiation of early breastfeeding is increasing and now in a 'good shape'. So, DIPH it really beneficial for us as a part of district service delivery system.

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

DIPH meetings are conducted in structured manner. So, we can identify issues and its probable solutions very effectively, as well as outcomes are equally important. This is very much beneficious for the district, i.e. for both health and non-health departments also.

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

Yes, data like MCTS are used in monitoring the progress of the action plan in the district.

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?

Joint participation with other non-health departments under DIPH process has strengthen and the interdepartmental convergence has also been increased. We had Janaswasthya Sthayee Committee meeting in every month, but after initiation of DIPH, the data-sharing concept has been improved.

As a theme leader (Cycles 1 and 2) we are working with other departments i.e. ICDS and Panchayat Raj Institution by 'hand in hand'.

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?

Sixty percent of population in the district is situated in the urban areas. Rather than involvement of NGOs, we should thing about the involvement of private sector as huge institution deliveries are conducting at nursing homes, private hospitals. Thus, NGOs can be involved to capture data from the private sectors as well.

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?

As 60% of population in the district is based on urban areas, they are accessing nursing homes, private hospitals for institutional delivery and other health care services in the district. But, data from the private sector are not capturing though the district don't have such data-capturing mechanism for nursing homes, private hospitals as well. Other thing is mapping of the private sector is very important. So, under DIPH process private sectors can be improved in terms of data-sharing, its analysis to prepare appropriate action for the district and obviously its follow-up by health system is very much important in this regard.

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 private sector.

Other departments, i.e. CD and PRD thought that health is not their concern as health department is working in the district. In several district-level meetings, health department addressed the issue and after starting DIPH the involvement of non-health departments in health sector in improving.

Some action points that prepared in last two cycles are difficult to address at district level, because these need state approval. The health department is planning to put such issues in the District Executive Committee Meeting to be held on 22 September 2016.

Involvement of private for-profit organisations s and NGOs in DIPH is very poor. The district should involve them in proper way.

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

Private for-profit organisations and NGOs should be involved in each step of DIPH. They can help us to identify some specific issues of the district.

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

Capturing data especially from urban areas is now our prime focus. So, NGOs can be involved to capture data from the private sector. Mapping of nursing homes, private hospitals through web-based software is the another aspect. So, under DIPH process private sectors and NGOs can be involved to improve data-capturing process.

Not only rural areas, we should also think about urban areas under DIPH process. In the district, the challenges are mostly in the urban areas.

Form A.3.4: In-depth interview with DSM	
IDI label	I10_GSN_AI_21Sep2016
Interviewer	Anns Issac and Zakir Hossain
Note taker	Zakir Hossain
Transcriber	Antara Bhattacharya
Respondent details	
Date and time of interview	21 September 2016, 14.00 pm
Name of participant	Mr Goutam Maity
Gender	Male
Designation	DSM
Department	Department of Health and Family Welfare
Duration of service in the district	3 years
Previous position	Education department
Qualification	Masters in Computer Science
Years of experience in present department	3 years
Membership in committees pertaining to health	Executive Committee – Department of Health and Family Welfare Society

1. How are health-related decision-making processes under the DIPH happening in your district?

See I told that the decision-making we do from data is all on probability: 95% institutional delivery and 2% home delivery if we say everyone is happy including state and Swasthya Karmadhyakshya. In 2013, home delivery was 13%, and now it is 7%, so reduction was by 6%. But this is not sufficient. But if we have even one home delivery or maternal death then also it is important because even though this numerator is small but it is a crucial indicator. At district level, for vigilance and monitoring committee, MP is the chairperson. Dr Kakoli Ghosh has some proposals such as for handwashing that we successfully achieved. For diabetes-related health camp proposal we conducted that.

I personally check the quality of the HMIS and MCTS data for each one. At sub-centre level the data is prepared manually through the Gram Panchayat supervisor at block level. At block level the data is entered online or offline by DEO. This data is checked by BPHN and then it is uploaded and generated which is signed by the BMOH in hard copy and then it is confirmed. This is the procedure. But this is not how it happens actually.

How it occurs is, when the sub-centre data comes to DEO he does not check the quality of data properly and uploads it. No one checks HMIS data at block level and even at hospital level also.

Several trainings and workshops have been conducted. DEO is a purely contractual post on behalf of Block Health and Family Welfare Samity recruited by the CMOH.

Other than HMIS, I download the reported data for each month and check each indicator. Suppose we have to send command for a new proposal that Government of India has not supplied yet, or any injectable for family planning under the new proposals from United Nations Children's Fund that will start from October, November. So for any cumulative period in the district I find there are 30 in stock. So I have to check and find that which block or hospital has uploaded this data in the first checking. Second checking is for which sub-centre if it's a block, or which Public Health Centre, or may be Block Public Health Centre or

rural hospital. Mostly the mistakes are done for the sub-centre. If it is a hospital then which hospital is doing this mistake? So I prepare a list of the corrections to be made and call the DEO, BMOH, BPHN and reset the data at their level and they correct it or sometimes I correct it already.

They inadvertently enter the data, they do not have the right to change. The printed report is signed by BMOH there… some blocks check their data properly, and some blocks do not ever have such problems. Some poor performing blocks and hospitals have error in data reporting. For the reporting system one is given to state and other to general administration such as ADM, district magistrate or for field visit. So for the meetings and all whatever data is used is going from my end. All DEOs are working with me.

2. Are you finding the DIPH process useful? If yes, then which aspects are you finding particularly useful?

Yes, it is helpful. In Cycle 1, it was exclusive breastfeeding. In second phase, it was up to third ANC check-up. Fourth ANC was told but it was not fulfilled. And third is open defecation free as discussed by the district magistrate.

PHFI meeting that you do quarterly is important. So that meeting is an important platform where we select the theme-related indicators and the performance of each blocks.

In administrative meeting, that occurs before the CMOH meeting, where all the programme managers are there CMOH, Dy. CMOH-I, -II, -III, DMCHO, DPHNO, district programme co-ordinator, DAM, DSM. In this meeting, we do analysis of the overall report where CMOH also asks the programme managers why certain indicator declined, what is the reason for the decline. These reasons are noted and programme managers go for field visits there and also discuss their reasons based on field visit observations. So we always discuss this. Also, we have review meetings and monthly meetings with the facilities where we tell them about the reasons for decline or increase. This way we have achieved certain indicators and certain indicators we have flopped also. Some areas the sub-centre is situated just under a big tree with a chair and table only. Some are in rented place which is also problematic.

Priority setting is important step in DIPH. First, third ANC should be improved then fourth ANC. Stakeholder engagement is very important. Those who are doing the actual work are the ground-level stakeholders, i.e. first ANM and second ANM. When a delivery happens at a sub-centre the ASHA should be also involved. Also in VHND meeting doctor should tell the importance of exclusive breastfeeding.

3. What progress through the DIPH you have made to improve the health targets/status in your district (from Cycle 1 to Cycle 2) in the last two DIPH cycles?

We followed HMIS report for exclusive breastfeeding. So we emphasised on exclusive breastfeeding for all institutional deliveries. In case of caesarean delivery also we emphasised that those children in Sick Newborn Care Unit should be exclusively breastfed. So last report was 98% for exclusive breastfeeding. Earlier it was below 70%. After first phase we achieved 98% out of total reported live births. So we followed the process up to block level. After the first meeting with PHFI, we shared this in the MIES meeting.

In second phase for third ANC, we were below 66% in 2014/15. Now it is 87% as per HMIS data.

There is no place for me to state at state meetings.

Data quality should be checked at sub-centre level by involving the field level staff, not by BMOH and BPHN only. It should be app-based linked to the HMIS portal. It is already there in Andhra Pradesh and some other states. Also geographic information system should be implemented in West Bengal.

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

Not mentioned.

5. Whether data from ICDS is used in monitoring the progress of the action plan in your district?

The convergence with other departments is not complete due to incomplete participation from other departments except health. ICDS participates and its workers are traceable only for pulse polio programme and no other programme. So what data they reported is not known to us [health department].

6. Did the MCH NGO sector achieve involvement through the DIPH process?

I am not in favour of involving NGOs. Only in two blocks Bagda and one other NGO can be involved. There are many beneficiaries there. Due to lack of manpower in these two areas NGOs can be involved. In other areas such as Barasat where is sufficient manpower, no lack of infrastructure then we ourselves should provide the services and not the NGOs.

7. Any suggestions how any of the steps involving the DIPH cycle can be improved (name them)?

To get the proposal accepted for sufficient manpower in order to collect data from private institutions such as nursing homes also. If this can happen along with the proposal from Zilla Parishad in order to get sufficient funds from Zilla Parishad and health and family welfare. Also priority setting should be done. IEC activities and involvement of political leaders, Gram Panchayat members and secretaries should be properly involved in VHND sessions along with ASHA and ANM.

A.4: Monitoring Format with Definitions

A.4.1: Monitoring framework[22]

Purpose	Indicators	Definition	Sources of information
I. Utilisation of data at district level Whether the DIPH study led to 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	**4. (Number of action points on which progress is being monitored by data) / (total number of action points for the**	Form 5: Follow-up

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

- HMIS including MCTS data, health policy/programme directive or both.
- The action points are on the requirements for achieving the primary theme of the given DIPH cycle.
- The prioritisation of the action points is on the feasibility as per stakeholder's decision.
- The monitoring plan of any given DIPH cycle is based 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.

	points for the primary theme of the DIPH	**primary theme of 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 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 health system data forms, pertaining to all six World Health Organization health system building blocks (demographic, human resources, finance, service delivery, health outcome, 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 of specified data	Form 1B: Health system capacity assessments
		8. Whether the health system data on the specified theme area is up-to-date as per the given DIPH cycle? (Y/N) ***Up-to-date data*** ***a)*** If monthly data, then the previous complete month at the time of Step 1 of the DIPH cycle ***b)*** If annual data, then the complete last year at the time of Step 1 of the DIPH cycle	Form 1B: Health system capacity assessments
II. Interactions among stakeholders: co-operation in decision-making, planning and implementation Whether the DIPH study ensured involvement of stakeholders from different sectors (health, non-health and NGO/private for-profit organisations)	E. Extent of stakeholder participation	**1. (Number of DIPH stakeholders present in the planning actions meeting) / (total number of DIPH stakeholders officially invited in the planning actions meeting)** *Participants in Steps 4 and 5* **DIPH stakeholders***:* public and private sector departments, organisations and bodies relevant for the specific cycle of the DIPH **Officially invited**: stakeholders formally being invited to participate for the specific DIPH cycle *In the West Bengal context, for example:* • *Public sector stakeholders: Department of Health and Family Welfare; PRD; and CD* • *Private sector stakeholders: NGOs;*	Form A.2: Record of Proceedings – Summary Table

		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 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 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 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 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 health departments) / (total number of action points for the primary theme of the DIPH)**	Form 4: Plan
		7. (Number of action points with responsibilities of non-health departments) / (total number of action points for the primary theme of the DIPH)	Form 4: Plan
		8. (Number of action points with responsibilities of NGOs) / (total number of action points for the primary theme of the DIPH)	Form 4: Plan
		9. (Number of action points with responsibilities of private for-profit organisations) / (total number of action points for the primary theme of the DIPH)	Form 4: Plan
	G. Factors influencing co-operation among health, non-health and NGO/private for-profit organisations to achieve the specific action points in the given DIPH cycle	**10. List of facilitating factors** **1.** **2.**	Form A.3: In-Depth Interview with Stakeholders
		11. List of challenging factors **1.** **2.**	Form A.3: In-Depth Interview with Stakeholders

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

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

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

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

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Published by The London School of Hygiene & Tropical Medicine