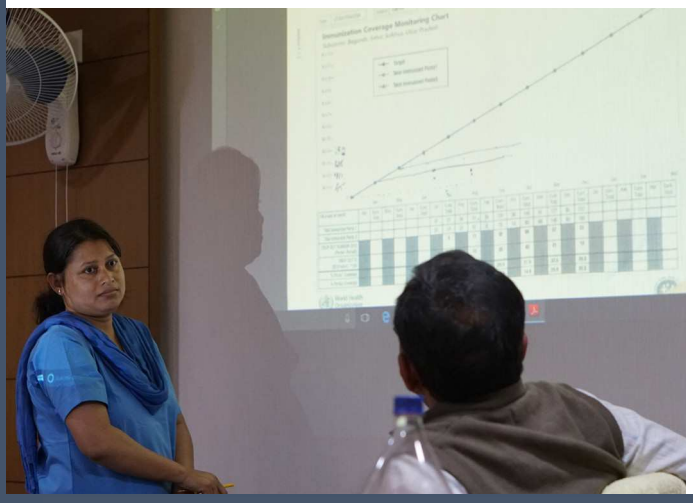

DIPH

The Data-Informed Platform for Health

Structured district decision-making using local data

MONITORING REPORT
Cycle 1: February - July 2016

South 24 Parganas
West Bengal, India

DATA INFORMED PLATFORM FOR HEALTH

MONITORING REPORT

South 24 Parganas Health District, West Bengal, India

Cycle 1: February – July 2016

THE WEST BENGAL UNIVERSITY OF HEALTH SCIENCES Estt:2003

KNOWLEDGE TO ACTION phfi PUBLIC HEALTH FOUNDATION OF INDIA

IDEAS Evidence to improve maternal & newborn health

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

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LIST OF TABLES

LIST OF ABBREVIATIONS

ACMOH	Assistant chief medical officer of health
ANC	Antenatal care
ANM	Auxiliary nurse midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi worker
BAF	Block ASHA facilitator
BCC	Behaviour change communication
BEmOC	Basic Emergency Obstetric Care
BMOH	Block medical officer of health
BPHC	Block Public Health Centre
BPHN	Block public health nurse
BSU	Blood Storage Unit
CD	Child Development
CDC	Community Delivery Centre
CDPO	Child development project officer
CEmOC	Comprehensive Emergency Obstetric Care
CINI	Child in Need Institute
CMOH	Chief medical officer of health
DAF	District ASHA facilitator
DAM	District accounts manager
DH	District hospital
DIPH	Data Informed Platform for Health
DMCHO	District maternity and child health officer
DP	Delivery point
DPC	District programme co-ordinator
DPMU	District Programme Management Unit
DPO	District programme officer
DSM	District statistical manager
Dy. CMOH-I	Deputy chief medical officer of health-I
Dy. CMOH-II	Deputy chief medical officer of health-II
Dy. CMOH-III	Deputy chief medical officer of health-III
FLW	Frontline worker
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
IEC	Information, education and communication
IMNCI	Integrated Management of Neonatal and Childhood Illness
IPHS	Indian Public Health Standards
JSSK	Janani Shishu Suraksha Karyakaram
MCH	Maternal and child health
MCTS	Mother and Child Tracking System
NGO	Non-governmental organisation
PHC	Public Health Centre
PHN	Public health nurse
PHPC	Public health programme co-ordinator
PRD	Panchayat and Rural Development
PRI	Panchayati Raj Institution
RH	Rural hospital
S24PGS	South 24 Parganas
SBA	Skilled birth attendant
SDH	Sub-divisional hospital

SHIS	Southern Health Improvement Samity
SNSU	Sick Newborn Stabilisation Unit
VHND	Village Health and Nutrition Day
VHSNC	Village Health, Sanitation and Nutrition Committees

1. INTRODUCTION

Data Informed Platform for Health (DIPH)		
Cycle no.	1	
District	South 24 Parganas Health District	
Duration	February – July 2016	
Theme	Improving the coverage of institutional delivery	
Steps involved	Step 1	**Assess:** The DIPH stakeholders conducted the situation analysis based on the *District Programme Implementation Plan 2015/16*, the ANANDI programme guidelines and the Health Management Information System (HMIS) coverage indicators (Department of Health and Family Welfare, 2015; Office of the District Magistrate and UNICEF, 2015; MoHFW, 2016a). The DIPH stakeholders identified the coverage indicator gaps and selected the theme 'Improving the coverage of institutional delivery' for Cycle 1 of the DIPH. For theme identification, there was no data from the non-health departments, as they do not maintain any data for the theme.
	Step 2	**Engage:** The theme leader for Cycle 1 was from the health department. The primary responsibility belonged to the health department with supportive roles provided by the departments of Child Development (CD) and the Panchayat and Rural Development (PRD) as well as non-governmental organisations (NGOs) who trained frontline workers (FLWs) in the district. Majority of participants were from the health department. Representation from the district administration and CD was poor. This was due to the State Assembly elections and the vacant post of the child development project officer (CDPO) during DIPH Cycle 1. Moreover, NGOs and private for-profit organisations did not receive an official invitation to take part in the DIPH process.
	Step 3	**Define:** The DIPH district stakeholders identified 11 problems based on the following: identification and reaching out to the target population; service provision; staff requirement; and supervision needs. Further, they prioritised 14 actionable solutions to address the 11 problems, in keeping with the capacity of the district stakeholders to achieve the DIPH cycle.
	Step 4	**Plan:** The stakeholders developed 20 action points and assigned responsibilities across departments within a given time frame. Majority (80%) of responsibilities are with the health department and the remaining (20%) responsibilities are with the non-health departments.
	Step 5	**Follow-up:** Of the 20 action points, all started within the given DIPH cycle with 15% completed within the given time frame. The remaining action points (85%) that did not complete or start received a new timeline. The theme leader monitored the progress through communication via telephone and from monthly reports from the blocks.

2. METHODS

	Data sources	Lead among DIPH stakeholders	Time frame
1	**Step 1: Assess** Form 1A.1: Data extraction from state and district health policy documents Form 1B: Health system capacity assessments	Theme leader of the DIPH Cycle 1	09 February 2016
2	**Step 2: Engage** Form 2: Engage	Theme leader of the DIPH Cycle 1	17 February 2016
3	**Step 3: Define** Form 3: Define	Theme leader of the DIPH Cycle 1	17 February 2016
4	**Step 4: Plan** Form 4: Plan	Theme leader of the DIPH Cycle 1	19 February 2016
5	**Step 5: Follow-up** Form 5: Follow-up	Theme leader of the DIPH Cycle 1	20 July 2016
6	**Record of Proceedings – Summary Tables** Form A.2.1: Record of Proceedings – summary for DIPH Step 4 Form A.2.2: Record of Proceedings – summary for DIPH Step 5	Recorded by the DIPH district co-ordinator, South 24 Parganas (S24PGS) Health District	February − July 2016
7	**In-Depth Interviews with Stakeholders** Form A.3.1: Chief medical officer of health (CMOH)	Interviewed by the DIPH district co-ordinator, S24PGS Health District	13 May 2016
	Form A.3.2: District maternity and child health officer (DMCHO)	Interviewed by the DIPH district co-ordinator, S24PGS Health District	27 May 2016

3. FINDINGS

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

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

3.1 Utilisation of data at district level

3.1.1 Status of data utilisation

Based on the *District Programme Implementation Plan 2015/16* and coverage indicators in the HMIS (Department of Health and Family Welfare, 2015; MoHFW, 2016a), stakeholders identified two themes for the situation analysis and compared the district performance with that of the state. The situation analysis identified the theme 'Improving the coverage of institutional delivery' for DIPH Cycle 1. Stakeholders dropped the theme 'Full immunisation of children below five years of age'. Further, the ANANDI programme guideline − to improve institutional delivery in the district − set the target for the theme (Office of the District Magistrate and UNICEF, 2015). Although non-health departments participated they did not maintain any data for the theme. Thus, theme identification did not involve using data from the non-health departments.

3.1.2 Challenges in data utilisation

Availability of timely and complete data from all relevant departments was a major concern. The data on human resources, training conducted and infrastructure were not stored in a systematic way. These data were from different forms, which were incomplete. There was no data-sharing from private providers and NGOs. Also, the data obtained from sub-district level for monitoring was incomplete. Data-sharing between departments was another major issue.

3.1.3. Proposed solutions

The validation of data, by respective block medical officers of health (BMOHs) at sub-district level, before sending the data to the district was a suggestion to ensure completeness and accuracy of information. The similar level of involvement by other stakeholders (such as CD) was a suggestion by respondents from the health department.

> "Health department is expecting some mechanism or tool that could enable field-level implementation and gathering data in easy and comprehensive manner. Other department's personnel should take similar type of initiative to call us [health department]. Whosoever plays leading role, major responsibility goes with him. And if we get everybody's equal share then they could also take some ownership. Stakeholders like CD department are not minor but a major stakeholder." (CMOH, S24PGS Health District)

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 the district level for decision-making?	A. Selection of the primary theme for the current DIPH cycle	1. Whether the DIPH cycle theme selection was based on HMIS data? (Y/N)	Yes[1]	Form 1B
		2. Whether the DIPH cycle theme selection used any data from non-health departments? (Y/N)	No[2]	Form 1B
		3. Whether the DIPH cycle theme selection was based on health policy and programme directives? (Y/N)	Yes[3]	Form 1A.1
	B. Data-based monitoring of the	4. (Number of action points for which progress is being	15/ 20 = 75[4]	Form 5

[1] As per the HMIS, the institutional delivery was 69% in the selected revenue district (MoHFW, 2016a). This indicates a gap of 21% as per the ANANDI programme guideline (the target set by the programme is 90%) (Office of the District Magistrate and UNICEF, 2015). In Step 1, the stakeholders discussed the severity of the theme from the HMIS data and set the target for the DIPH cycle based on the ANANDI programme (MoHFW, 2016a; Office of the District Magistrate and UNICEF, 2015). (See Form 1B, Sl. No. 2.1.)

[2] The theme selection did not use data from other departments because they do not collect any data on the discussed themes.

[3] A standard situation would need to meet 100% institutional delivery, but the present gap analysis was set on the ANANDI campaign specified for the district and the *District Programme Implementation Plan 2015/16* (District Health Action Plan for 2015/16) (Office of the District Magistrate and UNICEF, 2015; Department of Health and Family Welfare, 2015). (See Form 1B, Sl. No. 1.)

[4] Out of the 20 action points, 15 action points had data monitoring during Cycle 1 (May − June 2016). Specific monitoring indicators were not prepared for five action points during Steps 4 and 5. (See Form 5, Sl. No. 1.1.1 to 1.4.4.)

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

3.2 Interaction among stakeholders

The DIPH study provides a platform for all stakeholders to come together and discuss the challenges on the identified themes. The DIPH process involved considering the role of each stakeholder and the need for all to function together to achieve the target. However, the participation in the DIPH meetings in terms of attendance was only three-quarters compared to those invited.

3.2.1 Interaction between health and non-health departments

The identified theme falls under the direct responsibility of the health department. Hence, majority of participants were from the health department. Though the district magistrate took interest in facilitating official communication to the various departments regarding the DIPH meetings, there was no representation from the district administration during developing the action plan and follow-up meetings. Similarly, the CD participation was also poor, even when making efforts to emphasise the vital role by the CD in achieving the theme. One reason for passive participation by the district programme officer (DPO) (from the Integrated Child Development Services [ICDS] of the CD) was due to increased workload from additional responsibility by the Department of Social Welfare. Majority of the responsibility for achieving action points was with the health department. The non-health departments only had four action points.

[5]The stakeholders could not identify any addition or revision to the health system data in the given DIPH cycle. (See Form 4.)

[6] The stakeholders found no relevant data element to add in the health database as per the prepared action plan. (See Form 5.)

[7]The data for indicators were not readily available on time from the district statistical manager (DSM). In addition, the data on human resources, trainings conducted and infrastructure were not updated timely and stored systematically. These data were from different forms and were incomplete. (See Form 1B, Sl. No. 3.1 to 3.3.)

[8] The latest data (69% for S24PGS Revenue District, based on HMIS key indicators) available during DIPH Step 1 (February 2016) was of December 2015. (See Form 1B, Sl. No. 2.1.)

3.2.2 Interaction between the health department and NGOs

There are a few NGOs such as the Child in Need Institute (CINI) and the Southern Health Improvement Samity (SHIS) that are working in the district. They engage in community awareness and mobilisation for child immunisation and operate Community Delivery Centres (CDC) under the Ayushmati scheme. They are not part of any formal decision-making platform at district level. They were not invited by the district stakeholders for the DIPH process as the district stakeholders stated they do not participate in the overall district planning process and only operate in certain pockets and work on selected topics. To overcome this limitation of NGOs in subsequent DIPH cycles, if the NGO role is identifiable in an action plan then they should receive an invitation to attend the DIPH meetings.

> "Many of the NGOs are Kolkata-based. They are doing job in my district without reaching most extreme part of the district. Areas such as Sundarban are not getting services to the mark. Two to three NGOs are providing services in my district, they are showing their performance report as. Yes, NGOs can be invited as a part of DIPH process. Generally, we seat [discuss] with them once or twice a year." (CMOH, S24PGS Health District)

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

The S24PGS Health District has a share of 26% of the urban population, largely catered by private providers. In spite of playing a significant role in health service provision, the private for-profit organisations are not part of any planning and decision-making bodies at the district. The CMOH does not have the authority to demand data or implementation support from private providers. Acknowledging the importance of private for-profit organisations in sensitising the community, did not create an action point for them. In subsequent DIPH cycles, inviting professional associations such as the Indian Medical Association for achieving their active involvement, can overcome this.

Table 2: Interaction among stakeholders

Purpose	Indicators		Response (Yes/No, proportions)	Sources of information
Whether the DIPH study ensured involvement of stakeholders from different sectors (health, non-health and NGO/private for-profit organisations)	E. Extent of stakeholder participation	1. (Number of DIPH stakeholders present in the planning actions meeting) / (total number of DIPH stakeholders officially invited in the planning actions meeting)	35/45 = 77.8 [9]	Form A.2
		2. (Number of representatives from the health department present in the planning actions meeting) / (total number of DIPH participants in	32/35 = 97.1 [10]	Form A.2

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

		the planning actions meeting)		
		3. (Number of representatives from non-health departments present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting)	2/35 = 5.7 [11]	Form A.2
		4. (Number of representatives from NGOs present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting)	1/35= 2.9 [12]	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)	0/35[13]	Form A.2
	F. Responsibilities assigned to stakeholders[14]	6. (Number of action points with responsibilities of the health department) / (total number of action points for the primary theme of the DIPH)	16/20 = 80[14]	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)	4/20 = 20[14]	Form 4
		8. (Number of action points with responsibilities of NGOs) / (total number of action points for the primary theme of the DIPH)	0/20[15]	Form 4

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

[12] NGOs were not formally part of any district-level meeting. However, the NGO CINI is working in the district, and their co-ordinator was part of the 'Follow-up meeting'. (See Form A.2.1, Sl. No. C2 and Form A.2.2, Sl. No. C2.)

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

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

[15] None invited from NGOs and private for-profit organisations for the DIPH meeting. Since they were not formally part of any district-level meeting, there was no action point for them. (See Form 4.)

		9. (Number of action points with responsibilities of private for-profit organisations) / (total number of action points for the primary theme of the DIPH)	0/20[15]	Form 4
	G. Factors influencing co-operation among health, non-health and NGO/private for-profit organisations to achieve the specific action points in the given DIPH cycle[16]	**10. List of facilitating factors**	1. Active involvement of the deputy chief medical officer of health-III (Dy. CMOH-III) 2. Enthusiasm shown by PRD representative (public health programme co-ordinator – PHPC, Zilla Parishad) 3. Presence of at least one NGO which works directly with the health department on the related theme as of the DIPH	Form A.3
		11. List of challenging factors	1. Lack of co-ordination between different departments (health and CD) in data-sharing 2. Delay in the implementation due to the State Assembly elections 3. Validation of data from other departments such as CD is not happening 4. NGOs and private for-profit organisations are not officially invited to take part in the planning process 5. Data from private for-profit organisations is unavailable 6. Shortage of health care professionals due to unfilled positions 7. Ascribing the sole responsibility of the	Form A.3

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

			DIPH to the health department	

3.3. Progress with action points

3.3.1 Action points accomplished

Out of the 20 action points, three action points had completed within the time frame:

1. Engaging motorised vehicles under Nischay Jan (Janani Sishu Suraksha Karyakram) for free referral transport
2. Establishment of Accredited Social Health Activist (ASHA) corners at facilities having a functional labour room
3. Make a village-wise list of all pregnant women who are due for delivery in the next four months; with focus on areas with high load of home deliveries

For the documentation of the progress of action points, the DIPH research team framed measurable indicators for almost all action points. This helped the theme leader to track the progress for action points from block level. The theme leader monitored the progress through telephone conversations with the relevant personnel. Staff recruitment started only when the State Assembly election was over. The training involved: skilled birth attendant (SBA) training for staff nurses, Integrated Management of Neonatal and Childhood Illness (IMNCI) training for auxiliary nurse midwives (ANMs) and orientation workshops for block ASHA facilitators (BAF). There was no request for funds, government orders/circulars, medicines, other supplies and equipment during the DIPH cycle.

> "So far I have seen the systematic approach of DIPH in finding the extent of duplication of data elements. That could definitely be considered for corrections. Also, we need data from other departments such as CD. We need data from them for our programmes. If DIPH take any endeavour to gather interdepartmental data, or making one comprehensive tool where data from all relevant departments can be accessed. We need data-sharing in a smooth way which is known as data convergence." (CMOH, S24PGS Health District)

The DIPH research team maintained a logbook of the meetings held by the theme leader with the other DIPH stakeholders. The DIPH research team regularly updated the district administration and the chief medical officer of the district.

3.3.2 Action points ongoing

During Step 5, 17 action points were ongoing:

1. Home visits to complete fourth antenatal check-up of all pregnant women with completion of 36 weeks and above in the sub-centre area
2. Documentation of a micro-birth plan of each pregnant woman
3. Engage local influential and religious leaders/Panchayati Raj Institutions (PRIs) to promote benefit of safe delivery care
4. Antenatal care (ANC) visits: minimum of four ANCs

5. Identify the requirement of new delivery points and making them functional
6. Ensure functional labour room, operating theatre, Blood Storage Unit (BSU), essential drugs in labour room, etc.
7. Timely data reporting from private clinical establishments
8. Orientation of service providers: doctors and nurses on rational practices such as identification and management of complicated cases, use of partograph and so on.
9. Filling 921 vacant positions of ASHA and their training
10. Filling 17 vacant positions of first ANM and second ANM as per the norms
11. Filling vacant positions of specialists: obstetrician and gynaecologist; paediatricians; and anaesthetists
12. Timely supportive supervision and on-the-job hand-holding
13. Arranging and holding regular third Saturday meetings at sub-centre
14. Synchronised and interdepartmental participation at fourth Saturday meetings at Gram Panchayat (village level)
15. Supportive supervision at Village Health and Nutrition Day (VHND) meetings
16. Engage rural medical practitioners/informal service providers in community sensitisation and mobilisation of pregnant women for institutional delivery. (Reason: District stakeholders did not show interest in involving informal service providers for health programmes)
17. Recruitment of ICDS supervisors. (Reason: There is a long pending court case involving the CD under which ICDS operates)

A village-wise list prepared of pregnant women who are due were for 13 (out of 16) blocks (action point 1). Pregnant women with fourth antenatal check-up completed by ASHA and ANM to total pregnant women for May − June 2016 is 67% (action point 1). Micro-birth plan preparation is ongoing and birth plan of every pregnant woman documented to total percentage of pregnant women for May − June 2016 is 95% (action point 2). The self-help groups engage in information, education and communication (IEC)/behaviour change communication (BCC) activities such as organising safe motherhood week and so on (action point 4).

As per Mother and Child Tracking System (MCTS) data (MoHFW, 2016b), there is improvement in the third ANC visit (to total registered pregnant women) from 54% (May 2016) to 58% (June 2016) (action point 4). Though stakeholders emphasised the importance of identifying new delivery points, the delay in this process was due to the state election (action point 5). Eight blocks (out of 16) reported full functionality of labour room (action point 6).

The reporting from private establishments is not fully accomplished and only four (out of 16) blocks stated complete reporting. For the whole health district, only 46% of the total private facilities were reporting data on delivery during May − June 2016. The health department pointed out their limited control over the private sector to demand regular reporting (action point 7).

The SBA training for staff nurses, IMNCI training for ANMs and orientation workshops for BAFs were part of routine activities of the health department (action point 8).

The state election delayed staff recruitment (action points 9, 10 and 11). The supportive supervision and on-the-job hand-holding (action point 13) is a continuing process and scheduled for all blocks. There is an improvement on third Saturday meetings where 98% of ASHAs (to the total ASHAs) attended such meetings during May − June 2016 (action point 13). Though there was data collected on interdepartmental co-ordination during the fourth Saturday meeting (action point 14), the PHPC raised concerns over its reliability. A total of 3,164 VHND sessions took place during May − June 2016 (action point 15).

3.3.3 Action points not started

All the action points started during the cycle.

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)	20/20 = 100[17]	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)	3/20 = 15[18]	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)	0/0[19]	Form 5
		4.(Amount of finance sanctioned for the primary theme-specific action points) / (total amount of finance requested as per action	0/0[20]	Form 5

17 All the action points started within the timeline. (See Form 5, Part B, columns: 'Action points'; 'Timeline for completion'; and 'Status of action points'.)

18 Three action points completed as per the action plan, while 17 action points are ongoing during Cycle 1. Along with the 'not-started' action points, the 'ongoing' action points will continue onto Cycle 2. (See Form 5, Part B, columns: 'Action points'; 'Timeline for completion'; and 'Status of action points'.)

19 There was no written directive as per action plan. However, a letter issued by the district magistrate of the S24PGS Revenue District, advised all district health authorities for their support and active involvement in the DIPH.

20 The state government assigned funds for institutional delivery and the ANANDI programme (Office of the District Magistrate and UNICEF, 2015); hence, there was no demand for additional finance in the action plan.

		points of the DIPH primary theme)		
		5. (Units of specific medicine provided for the primary theme-specific action points) / (total units of specific medicine requested as per action points of the DIPH primary theme)	0/0[21]	Form 5
		6.(Units of specific equipment provided for the primary theme-specific action points) / (total units of specific equipment requested as per action points of the DIPH primary theme)	0/0[22]	Form 5
		7.(Units of specific IEC materials provided for the primary theme-specific action points) / (total units of specific IEC materials requested as per action points of the DIPH primary theme)	0/0[23]	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)	33/938 = 3.5[24]	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)	100/1,285 = 7.8[25]	Forms 4 and 5
	J. Factors influencing the achievements as per action points of the DIPH primary theme[26]	**10. List of facilitating factors**	1. The presence and motivation by the DIPH research team acted as a push factor for stakeholders to accomplish the action points	Form A.3

[21] The selected theme did not require procurement of any medicine.
[22] There was no demand of any equipment for the selected theme.
[23] As mentioned in Form 4, under 'Material resources required', there is no specific demand for IEC materials in the action plan. (See Form 4, action points 1.1.4 and Form 5, action point 1.1.4.)
[24] There was a total of 33 staff (ANMs) recruited during Cycle 1. The delay in the recruitment process was due to the state election. Calculation is of the denominator for ASHAs (921) and ANMs (17). Though there were action points for recruiting specialists and ICDS supervisors, there was no number given. (See Form 4, action point 1.3.2 and Form 5, action point 1.3.2.)
[25] The number of human resources to train was not specified by the action plan; total staff trained on a 'training of trainer' mode were 100 (staff nurses = 36, ANMs = 48, and BAFs = 16); the denominator include total posts for staff nurses (672), ANMs (593) and BAFs (20) in the district. (See Form 4, action point 1.2.6 and Form 5, action point 1.2.6.)
[26] Extracted from in-depth interviews with the CMOH and DMCHO. (See Forms A.3.1 and A.3.2.)

			2. Active participation by Dy. CMOH-III, and initiative by the PRD representative (PHPC, Zilla Parishad)	
		11. List of challenging factors	1. Overall delay in the process due to state election 2. Limited participation from non-health departments due to staff shortages 3. Poor interdepartmental convergence	Form A.3

3.4 Sustainability of the DIPH

Analysis of the sustainability of the DIPH process in the district is from in-depth interviews conducted with stakeholders (CMOH and DMCHO – see Forms A.3.1 and A.3.2). The observations of the DIPH research team during the cycle also helped the assessment.

3.4.1 Data source

- The DIPH stakeholders tracked progress of the theme using HMIS (MoHFW, 2016a). Though there is a process to update the HMIS, there are concerns about the timeliness and overall quality of the data (MoHFW, 2016a).
- Data-sharing between health and non-health departments (CD and PRD) is a major challenge. To overcome this, a proposal to make the database of CD online led to some sub-districts implementing this. However, vacant supervisor positions at the CD hampered this process from being functional in all sub-districts.
- Absence of a guideline or mechanism for the private sector to share data with the health department and district administration results in omitting a major portion of the health-related data from private clinics and establishments.

3.4.2 Facilitators within the district

- The DIPH research team developed a good rapport with the stakeholders.
- There were two active personnel from the health department (Dy. CMOH-III) and PRD (PHPC). In addition to this, the other stakeholders found the DIPH process useful and they did not see it as an additional burden.
- There is some level of interaction between stakeholder departments except for CD-ICDS.
- Platforms such as reproductive and child health-Management Information and Evaluation System meeting, Public Health Standing Committee meeting, Health Samity meeting and Maternal Death Review monthly meeting allows incorporation of the DIPH process without creating any additional structure.

3.4.3 Challenges within the district

The major challenges reported by the district stakeholders to sustain the DIPH process involved:

- Interdepartmental co-ordination – The participation of different stakeholders in achieving the action points was not always positive. The view that the DIPH is the sole responsibility of the health department remains
- Vacant positions – There are several vacancies in key positions, which hampered the DIPH process. For instance, there are several vacancies in the supervisor post at ground level and CDPO posts (ICDS). In addition, DPO-ICDS is handling the additional work load of the Department of Social Welfare. This leads to a reduced interest in attending all the DIPH meetings
- Top-down approach – The DIPH process currently involves only district-level stakeholders. However, the implementation of action points need sub-district-level officials and FLWs. Their participation and support is necessary for achieving the action points
- Data issues – Quality of data and timely availability of district-specific data is a major challenge
- Sharing responsibility – The whole process is dependent on one person from a stakeholder department and others are not ready to take on the responsibility
- Hand-holding by the DIPH research team – The district DIPH stakeholders depend entirely on the DIPH research team for conducting the meetings, completing the forms and compiling the follow-up documents

3.4.4 Possible solutions

- Issuing an official letter from the district administration before the next DIPH cycle, can improve the participation of various stakeholders, particularly the non-health departments.
- Theme selection should consider issues relevant to non-health departments, NGO and private for-profit organisations to improve their participation.
- Involving stakeholders at sub-district level such as BMOHs, block public health nurses (BPHNs) and CDPOs during Steps 4 and 5 meetings, will help in better implementation of action points as well as monitoring by the theme leader.
- Orientation of sub-district-level officials, by the theme leader after Step 4, on how they can capture the progress of action points can be helpful in regularising the block-wise reporting.
- Motivating the higher district officials in owning the DIPH.

REFERENCES

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

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

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

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

ANNEXES

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

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

Sl. No.	Particulars		
1	**Source document**[27]*		1. *District Programme Implementation Plan 2015/16*, S24PGS 2. Instructions/directives released by the district administration for the ANANDI campaign
2	**Specific theme 1**		**Maternal health: improve the coverage of institutional delivery**
2.1	Goal setting		To achieve total coverage (100%) of institutional delivery in S24PGS Health District
2.2	Action points	A	Tagging all pregnant mothers with the respective ASHAs
		B	Compulsory home visit by ANM during fourth antenatal check-up
		C	Supportive supervision in all respective health workforce cadres such as ASHAs by ANMs (ANM to be supervised by a health supervisor) and so on
		D	Micro-planning for birth preparedness of each and every mother including Nischay Jan
		E	Complete (100%) tracking of registered pregnant women
3	**Specific theme 2**		**Child health: immunisation**
3.1	Goal setting		Achieving full immunisation (100%) with coverage of all vaccines due in first year of birth
3.2	Action points	A	All births (should be) registered under the MCTS at the place of their birth (facility)
		B	Administration of dose at birth (Bacillus Calmette–Guérin, Polio and Hepatitis B vaccines)
		C	Mobilisation of all children (birth to one year) for immunisation by FLWs
		D	Safe injection practices at immunisation site
*Annual/five-year health plans, specific health policy documents and valid government orders related to public health.			

[27] Table 1, Indicator 3.

Form 1B: Health system capacity assessments

Sl. No.	Particulars				
1	**District demographic details**				***Source***
1.1	Total population		8,161,961		District Census 2011 (statistics are for S24PGS Revenue District) [Office of the Registrar General & Census Commissioner, 2011, *District Census Hand Book 2011*, Government of India, New Delhi, viewed 1 February 2016 www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf]
1.2	Urban population (%)		25.58		
1.4	Scheduled Caste population (%)		30.19		
1.5	Scheduled Tribe population (%)		1.19		
1.6	Population density		819 persons/square km		
1.7	Sex ratio		956 females/1,000 male		
1.8	Total literacy (%)		77.51		
1.9	Female literacy (%)		71.40		
1.10	Number of children under six years		10,25,679		
1.11	Number of women in reproductive age (15-49 years)		1,644,815		District Health Plan 2015/16 [Department of Health and Family Welfare, 2015, *District Programme Implementation Plan 2015/16*, Government of India, South 24 Parganas] HMIS quarterly reporting July – September 2015 [Ministry of Health and Family Welfare (MoHFW) 2016a, *Health Management Information System (HMIS)*, Government of India, New Delhi]
1.12	Key NGOs (public health)		CINI, SHIS		
1.13	Key private stakeholders (public health)				
2	**Requirements as per Indian Public Health Standards (IPHS) and other policy documents**				
	Coverage	***IPHS***	***Data***	***Gap***	***Remarks***

2.1	**indicators**[28]	1. To increase the institutional delivery rate to 90% by March 2016 and sustain it thereafter (ANANDI campaign)	69% for S24PGS Revenue District (HMIS key indicators updated in December 2015 for 2015/16)		(90-69.2) = 21%	Though 100% institutional delivery needs to be achieved in a standard situation, the present gap analysis is based on the ANANDI campaign specified for the district. A total of 70% anticipated deliveries [108,175 in numbers] in 2015/16 are expected to be institutional deliveries [District Health Action Plan for 2015/16]
2.2		1. IPHS: 100% full immunisation of infants and children	86% (MCTS December 2015)		14%	
			Block-wise[a]		***Refer Form 1B.1 below***	
3	**Specific theme 1** (refer to 2.1): **Institutional Deliveries in S24PG health district**					
		Details	***Sanctioned (2014/15)***	***Available/ functional***	***Gap***	***Remarks***
3.1	**Infrastructure**[29]	Sub-centres		593		Infrastructure-related information is retrieved from records of District Programme Management Unit (DPMU), S24PGS Health District
		Public Health Centres (PHCs)		32		Canning-I: Only one BPHC for 3 Lakhs population; more or less same in Canning-II
		Block Public Health Centre (BPHC)		5		
		Rural hospital (RH)		12		
		Sub-divisional hospital (SDH)		2		1. Only two DPs are active in Basanti; other two DPs need to be activated 2. Only one out of four DPs are active in Kultali block 3. More or less similar picture in Joynagar one and two blocks
		State general hospital		4		
		District hospital (DH)	1	1	-	
		Delivery points (DPs)		32		
		Blood Bank/ BSU	7	3	4	Four new BSU sanctioned but yet to function (Vidyasagar, Sonarpur, Basanti and Joynagar-I)
3.2	**General resources**	Finance	Indian rupees 90,616,778 (£1107871.46)			1. Reproductive and Child Health (RCH) Flexible Pool- Maternal Health (INR) 2. Budgetary provisions for different

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

							sub-activities: line-listing of severe anaemic pregnant women, Ayushmati, referral transport, etc. 3. 10,000/ – untied funds for Village Health, Sanitation and Nutrition Committees (VHSNCs) are not utilised properly 4. Budget is sanctioned for SBA and SBA refreshers; however, no provisions for Comprehensive Emergency Obstetric Care (CEmOC) or Basic Emergency Obstetric Care (BEmOC) trainings 5. No exclusive allotment for orientation workshops, trainings and capacity building of the PRD for Rogy Kalyan Samity at District Health Societies, Community Health Centres and PHCs
		Supplies	Referral transport	Sanctioned boat for Gosaba block (CMOH quote)			
			IEC/BCC materials	Standard practice protocols for ANC examination; flipchart, IEC/BCC materials for FLWs			Number of IEC/BCC supplies is not available
			Medicine		**Quantity ordered**	**Quantity Received**	Data for Year 2015/16
				Injection Oxytocin	1,920	2,000	
				Atropine sulphate	5,000	5,000	
				Dextrose solution 5%	35,000	35,000	
				Calcium Carbonate	20,000	15,000	
				Gentamycin Sulphate	12,000	6,845	
				Paracetamol suspension	55,000	55,000	
		Technology		m-health technology is being used (DSM quoted)			Maternal and Child Service messaging: delivery tracking (365 days)

							Sick Newborn Stabilisation Unit (SNSU) messaging
3.3	**Human resources**[30]	ASHA		3,158	2,237	921 (vacant) 10-15% shortfall to persist even after ongoing recruitment	All ASHAs are trained for modules 6 and 7 as well as refresher training completed Human resources records are obtained from office of CMOH, S24PGS Health District
		ANM at sub-centre		593	First ANM: 576 Second ANM: 447	First ANM: 17 (vacant) Second ANM: 146	
		Staff nurse		761	672	89	
		Obstetrician and gynaecologist		20	21	No Gap	
		Anaesthetist		18	08	10	
		Paediatrician		18	14	4	
		Pharmacist		100	60	40	
		General duty medical officer		155	124	31	
		Anganwadi worker (AWW)			9,711		Records retrieved from HMIS quarterly report of July – September 2015
4	**Specific theme 2 (refer to 2.2): Full immunisation of children below one year**						
4.1	**Infrastructure**	Sub-centres		593	593	No Gap	Infrastructure-related information is retrieved from records of DPMU, S24PGS Health District
		PHCs			32		Cold chain points are to be maintained at each facility above sub-centre level
		BPHCs			5		
		RH			12		
		SDH			2		
		SGH			4		
		DH			1		
		Anganwadi Centres			7,963		Records retrieved from HMIS quarterly report of July-September 2015
4.2	**General**	Finance		1. Indian rupees 20777000			No dedicated funds for cold

[30] Table 1, indicator 7

	resources			(£254017.48) for mobilisation of children through FLWs, printing and dissemination activities, vaccine delivery in hard-to-reach areas, micro-planning, etc. 2. Funds allocated for training under immunisation			chain maintenance
		Supplies	**Vaccines**	***Indented (to be used in February 2016)***	***Received (January 2016)***	***(Indented-Received)***	1. No budget approval for implementation of drugs and vaccines distribution management system 2. Difficulties in vaccine carrying to riverine and remote blocks
			Bacillus Calmette Guerin	20,000	30,000	+10,000	
			Oral poliovirus vaccine	59,000	40,000	-19,000	
			DPT/DTP	15,100	15,000	-100	
			Tetanus Toxoid	28,300	30,000	+1,700	
			Measles	19,100	20,000	+900	
			Pentavalent	20,100	20,100	-	
		Technology					No information available
4.3	**Human resources**	ASHA		3,158	2,237	921 (vacant) 10-15% shortfall to persist even after ongoing recruitment	
		ANM at sub-centre		593	First ANM: 576[b] Second ANM: 447	First ANM: 17 (vacant) Second ANM: 146	Human resources records are obtained from office of CMOH, S24PGS Health District
		Staff nurse		761	672	89	
		Paediatrician		18	14	4	
		General duty medical officer		155	124	31	
		Public health nurse (PHN)					
		BPHN					
		AWW			9,711		Records retrieved from HMIS

						quarterly report of July – September 2015

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

Sl. No.	Block Name	Coverage Indicator (MCTS up to December 2015)	
		Theme 1 (Percentage of Institutional Deliveries to Reported Deliveries)	Theme 2 (Number of Fully Immunised Children, 9-11 Months)*
1	Baruipur	76.3	75.9
2	Basanti	46.5	78.9
3	Bhangore-I	90.8	89.4
4	Bhangore-II	91.2	96.6
5	Bishnupur-I	88.3	88.1
6	Bishnupur-II	94.9	82.5
7	Budge Budge-I	93.7	87.3
8	Budge Budge-II	95.4	85.6
9	Canning-I	54.9	87.7
10	Canning-II	50.7	94.9
11	Gosaba	52.2	87.5
12	Joynagar-I	65.5	84.7
13	Joynagar-II	64.8	83.5
14	Kultali	46.1	83.3
15	Sonarpur	94.8	91.7
16	T. M. Block	94.1	77.8

*Number of vaccinated children to total live births registered during April − December 2015

Form 4: Plan

Date of meeting: 19 February 2016
Chairperson: CMOH, S24PGS Health District

Theme 1: Improving the coverage of institutional delivery in S24PGS Health District					
Theme leader: DMCHO					
Number of meeting for the respective theme: First					
Task 1.1: Identification and reaching out to target population	**Actions**[31]	**By whom (responsible official)**[32]	**By when to be completed**	**Resources**	
				Human[a]	**Material**[b]
	1.1.1 Make a village-wise list of all pregnant women who are due for delivery in the next four months; with focus on areas with high load of home deliveries	FLWs (ASHA and ANM)	End of March 2016	Recruiting vacant ASHAs and their training	Non applicable
	1.1.2 Home visits to complete fourth antenatal check-up of all pregnant women with completion of 36 weeks+ in the sub-centre area	ASHA and ANM	Concurrent (as per timeline micro-birth plan of pregnant women)	Supervisors and BPHN to monitor	Non applicable
	1.1.3 Documentation of a micro-birth plan of each pregnant woman	PHN/BPHN	Concurrent (Start at least 4 months before estimated date of delivery and track till end of pregnancy)	ANM to report PHN/BPHN	Non applicable
	1.1.4 Engage local influential and religious leaders/PRIs to promote benefits of safe delivery care	FLWs, health supervisors, PRIs	End of April 2016	VHSNC members	Posters/flipcharts for IEC/BCC activities[33]
Task 1.2: Service provision	**Actions**	**By whom (responsible official)**	**By when to be completed**	**Resources**	
				Human[a]	**Material**[b]
	1.2.1 ANC visits: Minimum four antenatal check-ups: First within 12 weeks Second between 14 and 26 weeks Third between 28 and 34 weeks Fourth between 36 weeks and term	ANM	Concurrent	ASHAs to assist in line-listing and arranging VHNDs; DPO-ICDS to ensure proactive and timely participation by AWWs in community	Non applicable

[31] Table 3, Indicators 7-9.
[32] Table 2, Indicators 6-9.
[33] Table 3, Indicator 7.

				mobilisation for ANC visits	
	1.2.2 Engaging motorised vehicles under Nischay Jan/JSSK for free referral transport	BMOH of respective blocks and Dy. CMOH-III	End of April 2016	Non applicable	Expedite engagement through public-private partnership
	1.2.3 Identify the requirement of new DPs and making them functional	Dy. CMOH-III	By June 2016	Health workforce recruitment and retention as per norms	Labour room, essential medicines and operating theatre
	1.2.4 Ensure functional labour room, operating theatre, BSU, essential drugs in labour room, etc.	Dy. CMOH-III	Concurrent	Retention of specialists: obstetricians and gynaecologists, paediatricians, anaesthetists, etc.	Timely indenting of medicines – funds for same
	1.2.5 Timely data reporting from private clinical establishments	DSM, Dy. CMOH-III and assistant chief medical officer of health (ACMOH) of respective subdivision	Concurrent	Non applicable	Feedback from private sector can be sought later
	1.2.6 Orientation of service providers: doctors and nurses on rational practices such as identification and management of complicated cases, use of partograph and so on	Dy. CMOH-III	By June 2016	Preparing list of all nurses and doctors eligible for orientation	Funds and permission from appropriate state authority
	1.2.7 Establishment of ASHA corners at facilities having a functional labour room	Dy. CMOH-III and Respective BMOH	By April 2016	Non applicable	Space and civil requirements for a room
Task 1.3: Staff need	**Actions**	**By whom (responsible official)**	**By when to be completed**	**Resources**	
				Human[a]	**Material[b]**
	1.3.1 Filling 921 vacant positions of ASHA and their training[34]	District ASHA facilitator (DAF)/ District programme co-ordinator (DPC) and District Recruitment Committee	June 2016	Training of newly recruited ASHAs	Permission from appropriate state authority

[34] Table 3, Indicator 8

	1.3.2 Filling 17 vacant positions of first ANM and second ANM as per the norms[35]	DMCHO/Dy. CMOH-III and District Recruitment Committee	June 2016	Training of newly recruited ANMs	Permission from appropriate state authority
	1.3.3 Filling vacant positions of specialists: obstetricians and gynaecologists., paediatricians and anaesthetists[36]	CMOH/Dy. CMOH-III and District Recruitment Committee	June 2016	Non applicable	Permission from appropriate state authority
	1.3.4 Engaging rural medical practitioners/ informal service providers in community sensitisation and mobilisation	DMCHO and District Recruitment Committee	April 2016	Informal service providers, private practitioners, etc.	Department of Health Family Welfare and Samity to engage other departments
	1.3.5 Recruitment of ICDS supervisors[37]	DPO-ICDS	June 2016	Non applicable	Permission from appropriate state authority
Task 1.4: Supervision	**Actions**	**By whom (responsible official)**	**By when to be completed**	**Resources**	
				Human[a]	**Material[b]**
	1.4.1 Timely supportive supervision and on-the-job hand-holding	Respective BMOH	Concurrent	All staff to be supervised by respective supervisors	Documentation: checklist of supportive supervision
	1.4.2 Arranging third Saturday meetings at sub-centre	ANM/ respective BPHN	Concurrent	ASHA, ANM and AWW	Non applicable
	1.4.3 Synchronised and interdepartmental participation at fourth Saturday meetings at Gram Panchayat	PHPC, Zilla Parishad	April 2016	Gram Panchayat Pradhan, health supervisor, ICDS supervisor and all FLWs	Non applicable
	1.4.4 Supportive supervision at VHND meetings	Respective BAF/ICDS/health supervisor	April 2016	ASHA, ANM and AWW	Preparing due-list of beneficiaries
Task 1.5: Any other	**Actions**	**By whom (responsible official)**	**By when to be completed**	**Resources**	
				Human[a]	**Material[b]**
	1.5.1				

[35] Table 3, Indicator 8
[36] Table 3, Indicator 8.
[37] Table 3, Indicator 8.

	1.5.2				
	1.5.3				

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

Form 5: Follow-up

Date of the meeting: 20 July 2016
Venue: CMOH office, M R Bangur Hospital Complex, S24PGS Health District
Chairperson: CMOH

<table>
<tr><th colspan="8">Part A</th></tr>
<tr><td colspan="8">Theme: Improving the coverage of institutional delivery in S24PGS Health District</td></tr>
<tr><td colspan="8">Theme leader: Dy. CMOH-III</td></tr>
<tr><td colspan="7">1. Number of meetings conducted since the last DIPH meeting by the theme leader: Two</td><td>Two</td></tr>
<tr><td rowspan="2">2. Major stakeholders involved in each meeting</td><td colspan="2">Meeting 1</td><td colspan="2">Meeting 2</td><td>Meeting 3</td><td>Meeting 4</td><td>Meeting 5</td></tr>
<tr><td colspan="2"><u>DATE: 06 June 2016</u>
CMOH, Dy. CMOH-I, -III, DMCHO, BMOHs, BPHNs with presentation of indicators to orient BMOHs</td><td colspan="2"><u>DATE: 20 June 2016</u>
CMOH, Dy. CMOH-III, BMOHs, BPHNs with presentation on reported values of indicators by blocks</td><td></td><td></td><td></td></tr>
<tr><td rowspan="4">3. Comparison of key coverage indicator in the DIPH cycle</td><td></td><td colspan="2">Time 0</td><td>Time 1</td><td>Time 2</td><td>Time 3</td></tr>
<tr><td>Date</td><td colspan="2">December 2015</td><td>May 2016</td><td>June 2016</td><td>July 2016</td></tr>
<tr><td>HMIS</td><td colspan="2">54%</td><td>60%</td><td>60%</td><td>65%</td></tr>
<tr><td>MCTS</td><td colspan="2">64% (Deliveries in public institution/total deliveries reported; 4,303/6,698)</td><td>74% (1,859/2,505)</td><td>70% (2,276/3,239)</td><td>72% (3,297/4,579)</td></tr>
<tr><th colspan="8">Part B</th></tr>
<tr><td rowspan="2">Action points[38]</td><td rowspan="2">Indicators for each action point[39]</td><td rowspan="2">Progress of indicators[40]</td><td rowspan="2">Timeline for completion of action points[41]</td><td rowspan="2">Status of action points[42]</td><td rowspan="2">Person responsible for action points</td><td colspan="2">Suggestions</td></tr>
<tr><td>Revised timeline</td><td>Change in responsibility</td></tr>
<tr><td>1.1.1 Make a village-wise list of all pregnant women who are due for delivery in the next four months; with focus on areas with high load of home deliveries</td><td>a. Number of village listing of pregnant women completed / total village</td><td>List is prepared and kept with respective ANM, BPHN (13 blocks prepared and shared the list)</td><td>End of March 2016</td><td>Completed</td><td>FLWs (ASHAs and ANMs)</td><td></td><td></td></tr>
</table>

[38] Table 3, Indicators 1-9.
[39] Table 1, Indicator 4; Table 3, Indicators 3-9.
[40] Table 3, Indicators 3-9.
[41] Table 3, Indicators 1-2.
[42] Table 3, Indicators 1-2.

1.1.2 Home visits to complete fourth antenatal check-up of all pregnant women with completion of 36weeks+ in the sub-centre area	a. Number of pregnant women in fourth antenatal check-up completed by ASHAs and ANMs / total pregnant women	An accomplished task, providing micro-birth plan is ready. Pregnant women with fourth antenatal check-up completed by ASHAs and ANMs to total pregnant women (%) for May − June 2016 is 67%	No timeline since fourth ANC visit is a concurrent activity However, this was précised along with preparation of micro-birth plan	Ongoing	ASHAs and ANMs	Continue	No
1.1.3 Documentation of micro-birth plan of each pregnant woman	a. Number of birth plan of every pregnant woman documented / total pregnant women b. Number of reminder phone calls made to pregnant women – seven days before estimated date of delivery / total pregnant women	Ready and kept in hardcopy at respective blocks Birth plan of every pregnant woman documented to total pregnant women (%) for May − June 2016 is 95%	Concurrent	Ongoing	PHN/BPHN	Continue	No
1.1.4 Engage local influential and religious leaders/PRIs to promote benefits of safe delivery care	a. Number of IEC activities where local influential/religious leaders and PRIs were engaged	Task is progressing partly; self-help groups and other stakeholders are being engaged for IEC/BCC activities is planned, e.g. safe motherhood week and so on	April 2016	Ongoing	FLWs, health supervisors, PRIs	Continue	No
1.2.1 ANC visits: Minimum four antenatal check-ups: First within 12 weeks Second between 14 and 26 weeks Third between 28 and 34	a. Number of pregnant women registered b. Number of pregnant women given first antenatal check-up within first trimester/ Total pregnant women registered	MCTS data shows progressive increase in ANC visits for third antenatal check-up to total pregnant women registered for May 2016 – 54%, June	Concurrent	Ongoing	ANM	Continue	No

weeks Fourth between 36 weeks and term	c. Number of pregnant women given third antenatal check-up / total pregnant women registered	2016 – 58% Pregnant women given first antenatal check-up within first trimester to total pregnant women registered (%) for May − June 2016 is 82% Pregnant women given third antenatal check-up to total pregnant women registered (%) for May − June is 72%					
1.2.2 Engaging motorised vehicles under Nischay Jan/JSSK for free referral transport	Number of empanelment of at least one vehicle per Gram Panchayat / total Gram Panchayat	Completed, six blocks reported completion	April 2016	Completed	BMOH of respective blocks and Dy. CMOH-III		
1.2.3 Identify the requirement of new DPs and making them functional	Number of new DPs identified / total Gram Panchayat	Ongoing	July 2016	Ongoing	Dy. CMOH-III	Continue	No
1.2.4 Ensure Functional labour room, operating theatre, BSU, essential drugs in labour room, etc.	a. Number of DPs with functional labour room/ total DP b. Number of DPs with functional operating theatre / total DP	Progressive, huge scope of improvement found in observations made by the United Nations Children's Fund Eight blocks reported 100% completion	Concurrent	Ongoing	Dy. CMOH-III	Continue	No
1.2.5 Timely data reporting from private clinical establishments	Number of private facilities reporting delivery data / total private facilities	Few private health facilities are reporting delivery data. Health department pointed their limited control over private sector is a limitation. Private facilities reporting delivery data to total private facilities for May − June 2016 is	Concurrent	Ongoing	DSM, Dy. CMOH-III and ACMOH of respective subdivision	Continue	No

		46%. Four blocks reported 100% reporting					
1.2.6 Orientation of service providers: doctors and nurses on rational practices such as identification and management of complicated cases, use of partograph and so on[43]	a. Name of training/workshop with number of participants b. Execution of training plan for Year 2016/17 (Y/N)	Various training workshops arranged as per plan: 1. SBA training of staff nurses = 20 2. IMNCI training for ANMs/female health visitor = 48 3. Orientation workshop for BAFs = 16 4. SBA refreshers for staff nurses = 16		Ongoing	Dy. CMOH-III	Continue	No
1.2.7 Establishment of ASHA corners at facilities having a functional labour room	Number of ASHA corners established at functional DPs / total DPs	Completed ten blocks reported 100% completion	April 2016	Completed	Dy. CMOH-III and respective BMOH		
1.3.1 Filling 921 vacant positions of ASHA and their training		923 positions are vacant (Target-921)	May 2016	Ongoing	DAF/DPC	Continue	No
1.3.2 Filling 17 vacant positions of first ANM and second ANM as per the norms[44]		33 new ANMs have been recruited (Target-17)	April 2016	Ongoing	DMCHO/ Dy. CMOH-III	Continue	No
1.3.3 Filling vacant positions of specialists: obstetricians and gynaecologists, paediatricians and anaesthetists		On-hold until fresh recruitment due to state elections	June 2016	Ongoing	CMOH/ Dy. CMOH-III	Continue	No

[43] Table 3, Indicator 9
[44] Table 3, Indicator 8

1.3.4 Engaging rural medical practitioners/ informal service providers involved in community sensitisation and mobilisation	Number of informal health care providers were involved	In pipeline	May 2016	Ongoing	DMCHO	Continue	No
1.3.5 Recruitment of ICDS supervisors		DPO-ICDS unavailable	March 2016	Ongoing	DPO-ICDS	Continue	No
1.4.1 Timely supportive supervision and on-the-job hand-holding	a. Number of supportive supervisory visits made by BPHN / total visit planned b. Number of supportive supervisory visits made by BMOH/ total visit planned	In process	Concurrent	Ongoing	Respective BMOH	Continue	No
1.4.2 Arranging and holding regular third Saturday meetings at sub-centre	a. Number of sub-centres where third Saturday meetings conducted / total sub-centres b. Number of ASHAs who attended third Saturday meetings / Total ASHAs in block	Concurrent activity; percentage of ASHAs who attended third Saturday meetings to total ASHAs in block is 98% for May − June 2016 (Attendance of ASHAs 2,187 and 2,176 in the months of February and March 2016 respectively)	March 2016	Ongoing	ANM/ respective BPHN	Continue	No
1.4.3 Synchronised and interdepartmental participation at fourth Saturday meetings at Gram Panchayat		Data for fourth Saturday meetings obtained from Zilla Parishad, but data is not very reliable (PHPC, Zilla Parishad)	April 2016	Ongoing	PHPC, Zilla Parishad	Continue	No
1.4.4 Supportive supervision at VHND meetings	a. Number of AWWs reported to have conducted VHNDs/ Number of AWWs in block b. Number of VHND sessions conducted	In process; AWWs reported to have conducted VHNDs to total AWWs in block (%) for May − June 2016 is 81%.	March 2016	Ongoing	Respective BAF/ICDS/ health supervisor	Continue	No

		Total of 3,164 VHND sessions conducted in May − June 2016					

Note:

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

A.2: Record of Proceedings – Summary Tables

A.2.1: Record of Proceedings – summary for DIPH Step 4			
A. Time taken for each session			
Session	***Time allotted***	***Actual time taken***	***Remarks***
A.1 Briefing	15 minutes	5 minutes	
A.2 Form 4	60 minutes	20 minutes	It was advised by the stakeholders to complete this form referring to the ANANDI document
B. Stakeholder leadership			
B.1 Agenda circulated/invitations sent		Bhushan	
B.2 Chair of sessions		CMOH, S24PGS Health District	
B.3Nominee/volunteer	1. Completing data forms	DIPH research team	
	2. Presenting summary	DMCHO	
	3. Theme leader	DMCHO	
	4. Record of proceedings	Mayukhmala Guha	
C. Stakeholder participation			
C.1 Number of stakeholders invited[45]	Health department	6	CMOH, S24PGS Dy. CMOH-III DMCHO, S24PGS DPC, S24PGS DSM, S24PGS District accounts manager (DAM), S24PGS
	Non-health departments	2	DPO-ICDS PHPC, Zilla Parishad
	District administration	2	ADM Officer-in-charge health
	NGO/Private for-profit organisations	0	Not invited
C.2 Percentage of stakeholder participation (to those invited)[46]	Health department	68% (4)	DPC and DSM were not present
	Non-health departments	100% (2)	
	District administration	0	Absent due to other meeting in the district
	NGO/Private sector	0	Not invited
	Total	60% (6/10)	
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	• ANANDI scheme document can be referred as action plan document of the DIPH	
	Dy. CMOH-III	• In ANANDI programme AWW was not included as a cadre to improve institutional delivery • Both FLWs are concerned of their data, thus lack sharing • Gram Panchayat Pradhan should be sensitised on health	

[45] Table 2, Indicator 1.
[46] Table 2, Indicators 1, 2, 3, 4 and 5.

		programmes for better co-operation	
	DAM	• Fund utilisation at Gram Panchayat level have no tracking system, they do not even submit Utilisation Certificate on time	
	DMCHO	• Consider action plan made under ANANDI campaign in order to improve institutional delivery	
D.2 Non-health departments	PRD	• PRD members suggested synchronised and interdepartmental participation at fourth Saturday meetings at Gram Panchayat	
	ICDS	• AWW should be accepted for promoting health issues • ICDS supervisor positions are vacant which hampers work	
D.3 NGO and private for-profit organisations	Non applicable	Non applicable	NGOs were not invited
D.4 District administration	Non applicable	Non applicable	No one present from district administration
E. Responsibilities delegated to non-health departments and NGOs*			
Type of activities shared	ICDS	To involve AWW in promoting institutional delivery	
	PRD	To involve panchayat members to motivate field workers and community members on institutional delivery	
	NGO	Non applicable	Not present
F. Co-operation/communication between stakeholders*			
Dy. CMOH-III and PRIs	Sensitisation of Gram Panchayat Pradhan on health programmes as often co-operation is missing at field level		
G. Data utilisation			
Not applicable			
H. Suggestion for Developing a Decision-Making guide modification (*Note: suggestions with justification on forms, process*)			
No such comments			

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

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	5 minutes	5 minutes	
A.2 Form 5	20 minutes	20 minutes	
B. Stakeholder leadership			
B.1 Agenda circulated/invitations sent		DIPH research team	
B.2 Chair of sessions		CMOH, S24PGS Health District	
B.3 Nominee/volunteer	1. Completing data forms	Antara	
	2. Presenting summary	Sayan Ghosh	
	3. Theme leader	DMCHO	
	4. Record of proceedings	Antara	
C. Stakeholder participation			
C.1 Number of stakeholders invited[47]	Health department	34	CMOH Dy. CMOH-III DMCHO BMOH BPHN
	Non-health departments	0	Step 5 conducted in health meeting and non-health departments were not part of it
	NGO/Private for-profit organisations	1	CINI co-ordinator
	District administration	0	Due to other meetings going on simultaneously that day at district magistrate's office
C.2 Percentage of stakeholder participation (to those invited)[48]	Health department	82% (28)	It was informed by Dy. CMOH-III that there was less attendance due to other priorities (health camps being organised for World Population Day)
	Non-health departments	0% (0)	
	District administration	0% (0)	Not invited
	NGO/Private for-profit organisations	100% (1)	
	Total	83% (29)	
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	Action points	
	Dy. CMOH-III	Revised timeline, change in responsibility for Form 5 (Cycle 1) action points, and person responsible and timeline for Form 4 (Cycle 2) indicators	
D.2 Non-health departments	PRD	Not present	
	ICDS	Not present	
D.3 NGOs and private for-profit organisations		Non applicable	

[47] Table 2, Indicator 1
[48] Table 2, Indicators 1, 2, 3, 4, 5

D.4 District administration			
E. Responsibilities delegated to non-health departments and NGOs*			
Type of activities shared	ICDS		
	PRD		
	NGO	Non applicable	
F. Co-operation/communication between stakeholders*			
Less interaction			Participants did not interact among themselves as much due to the presence of higher officials
G. Data utilisation			
Not used			
H. Suggestion for Developing a Decision-Making guide modification (*Note: suggestions with justifications on forms, process*)			
Non applicable			

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

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

A.3.1: In-depth interview with CMOH

IDI details	
IDI label	I03_GSN_BG_13May2016
Interviewer	Bhushan Girase, Anns Issac
Note taker	Bhushan Girase, Anns Issac
Transcriber	Bhushan Girase
Respondent details	
Date and time of interview	13 May 2016, 10.55 am to 11.30 am
Name of participant	Dr Asim Kumar Dasmalakar
Gender	Male
Designation	CMOH
Department	Department of Health and Family Welfare
Duration of service in the district	3 years 3 months
Qualification	MBBS, MPH
Years of experience in your present department	26 years (since December 1989) (last position was Dy. CMOH-I Bardhaman District) (first position in the capacity of BMOH)
Membership in committees pertaining to health	Almost all committees Member Secretary – Department of Health and Family Welfare Samity Secretary – School Health Convergence Committee Chairperson – District Maternal and Child Death Review Committee Convener – District Quality Assurance Committee Member – District Task Force (Polio) Member – District Task Force Immunisation Member – District Advisory Committee and District Appropriate Authority

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

Target and goal is usually set by state (authorities). At district level, we generally discuss about available resources (*Taka*-funds) which are received from our peripheral units in different way such as HMIS, MCTS and some other paper-based data reporting. We decide our future course of action based on those reports. This is our original plan of decision-making (effective even before DIPH process).

So far, what I understood from your programme [DIPH] is that you are doing job to streamline the [maternal newborn and child health] data. And I think this is quite useful for us in determining our plan of action. Already we have got some help from this [DIPH] process. Actually, we are collecting huge data from our bottom-line (below district level), but we do not use all of the data. We make use of it as and when necessary. Sometimes we face difficulty [in terms of interpreting the data]… I anticipate that the [DIPH] process, you have adopted, will change this thing [improve the data driven decision-making] in district.

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

Actually, we need data in two forms – our past records and current records. And we should have 100% data (near to 100%) of the concurrent (current) period at our hands. Otherwise there will be difficulties in decision-making (with incomplete data)…

Definitely, situation analysis is the most important part (of the four-Step DIPH process). So far I have seen the systematic approach of DIPH in finding the extent of duplication of data elements. That could definitely be considered for corrections. Also, we need data from (co-personnel) other departments such as ICDS, social welfare and so on. We need data from them for our programmes… If [DIPH] take any endeavour to gather interdepartmental data, or making one comprehensive tool where data from all relevant departments can be accessed… Thus, stakeholders' engagement (second Step of DIPH) is also of equal importance. We need data-sharing in a smooth way which is known as data convergence.

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

Promotion of institutional delivery in S24PGS Health District. Emphasis was given to the action plan of ANANDI programme.

4. What progress through the DIPH have you made to improve the health targets/status in your district?

We focused on few specific blocks. We got achievement in every aspect but not up to our expectations. Nevertheless, two-three blocks performed beyond our expectations, e.g. Canning-II block. If you could see the data indicators of Canning-II for previous seven to eight months, with the 26% institutional deliveries that block was at the bottom not only in the district but probably in the state (West Bengal). But after introduction of ANANDI (and DIPH) activities, rate of home deliveries in Canning-II block is almost zero. Approximately 95% institutional deliveries are happening in that block.

In our theme, institutional delivery is a one indicator. It may occur anywhere either at public or private sector. So how many pregnant women of my district are opting for institutional delivery is very important. Another important aspect was fourth ANC visit by our own staff (FLWs). It was emphasised not only to improve the institutional delivery but also to improve overall health of mother. Through this endeavour, home-based visit by ANM for ANC will reduce the maternal mortality in the form of early detection of pre-eclampsia, severe anaemia. We are trying our best but not getting our desired level of achievement (around 30% to 35%).

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

Yes. If we could able to reduce the duplication of data elements then quality of data (and its utilisation) will increase automatically. It will also reduce the length of list…. Data sheet… Then that data would be much more helpful for the planner. If we have to handle the least number of data that would be better for us. Otherwise, we won't be able to use all the data. And if we try to grab all the components at one same time then won't be able to achieve anything.

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

Actually we are collecting data based on our requirements… requirements of district, state or some other agencies. Many times, some other departments also ask for data from us. Sometimes we collect some data and thereafter won't collect again if there is no need which makes us to forget that indicator. If you [DIPH] can streamline this thing [data duplication and so on] then we can use it for many purposes. We are expecting some tool from you [DIPH] to handle this huge data.

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

At present, data-sharing between different departments is not that much smooth.

The process of general elections in state is going on. Because of which all departments are not in same line. Despite this, we collected huge data at our own and from other departments wherever necessary. ICDS is the department who works on the basis of our performances. They [ICDS] do have their own activities, independent of our role. In our state, they [ICDS] do not share their data to us. We have to collect it from them if required. That is also not happening regularly.

There was a guideline suggesting regular data-sharing between departments. However, they [ICDS] do share their data to their concerned authorities. Sometimes they give one copy to us [health department] that is just for information and not for the validation.

For example, immunisation. Immunisation is the activity dealt by our [health] department. Immunisation is one of the six activities of ICDS department. Their role is mostly related to mobilisation of beneficiaries. They [AWW and ICDS super] collect data from our [sub-centres] centres directly such as number of children vaccinated. They usually fail to gather all data and submit data with less number of coverage. Actually, we keep complete data as we are the one who are actually providing services. They [ICDS] are just sleeping partners. They [ICDS] are not getting the data when they themselves are not attending camps or not bringing children to camps. That is why their data would be lesser than health department's data. Validation of this data is not happening.

Despite the long duration of election in state, public health cell co-ordinator of Zilla Parishad and CDPO of Bishnupur (on behalf of DPO-ICDS) participated in DIPH workshops. However, I doubt that they were able to percolate the action plan to ground level. They will take more time (till the end of model code of conduct of elections).

8. Did the maternal and child health (MCH) NGO sector achieve involvement through the DIPH process?

As regards to our theme of promoting institutional deliveries, their [NGOs working around MCH] engagement/participation is much more effective for us. We expect much more achievement with their participation.

Many of the NGOs are Kolkata-based. They are doing job in my district without reaching most extreme part of the district. Areas such as Sundarban are not getting services to the mark. Two to three NGOs are providing services in my district; they are showing their performance report as well but less number of population of my district is benefited due to migration. It is giving a false belief that we are performing well but in reality the real population of district remain untouched.

Yes, NGOs can be invited as a part of DIPH process. Generally, we seat [discuss] with them once or twice a year. Many NGOs are working in different development sectors, not only in health. We usually make sort of co-operation with the NGOs working in the health sector, e.g. eye operations (blindness, cataract), MCH and NACO [National AIDS Control Organisation] programmes (human immunodeficiency virus).

They [NGOs] could do much more in immunisation. Though we have adequate manpower. In some areas population growth not only due to birth rate but also due to migration is much more. Such huge population cannot be handled by our limited one or two staff. There comes the role of NGOs. However, we are not getting good response from NGOs as regards to immunisation services.

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

The major proportion of population from our district seeks health care from urban area [private sector] of Kolkata. Not getting that data [from private nursing home in urban area] is a major lag. Those private nursing homes are beyond my [CMOH's] jurisdiction. Greater Kolkata belongs to 125% of our district [S24PGS Health District].

Actually we have the act/rule that we could get data (not all) from private sector. But not happening in reality. Being a licensing authority, we can take their [private sector] data as and when required. A tool to get data electronically from private sector could be helpful.

10. What are the challenges faced during the implementation process of the last DIPH cycle?

We are facing some hurdles in our district (which could be common in other districts as well)… [Obtaining] the data from the urban sector (is a big challenge)… [Private sector] is a huge area and there is a huge gap… we don't have any mechanism in getting data from urban area… As regards to my district [S24PGS Health District], approximately 25% to 30% population is living in urban area. And if we fail to get data from such a huge urban [private sector] then we couldn't make comprehensive picture of action plan for the entire district. I think DIPH should look into this matter and think about how to obtain this data.

All sorts of challenges are there, but the main thing is implementation and evaluation of action plan. We can seat [discuss] anytime and call other department's personnel but their wholehearted participation is different and important.

Not as such difficulty in terms of allocating/dedicating time for DIPH process. Actually, we [health department] is expecting some mechanism or tool that could enable field-level implementation and gathering data in easy and comprehensive manner.

Few basic problems such as inadequate full-time staff, they are doing their duties but in the middle of it suddenly got transferred or moved out….

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

Dedicating time for any particular step could always be an issue but if we don't start with anything then we can't go anywhere. We have to start with something at some point.

12. Any suggestions how the DIPH process can be better implemented in your district?

Yes, health department can take lead in organising DIPH activities, issuing letters, inviting other stakeholders. But it could be other way round also. They [other department's personnel] should take similar type of initiative to call us [health department]. Whosoever plays leading role, major responsibility goes with him. And if we get everybody's equal share then they could also take some ownership. Stakeholders like ICDS are not minor but a major stakeholder.

We [health department] probably couldn't do better if asked to implement DIPH process at our own. We [health department] need pushing force to ignite ourselves. Doing at our own strength could lead to forget the steps. Every year, three to four new programmes get introduced… then everybody get attracted/jumped to those new programmes.

A.3.2: In-depth interview with DMCHO

IDI details	
IDI label	I04_GSN_BG_27May2016
Interviewer	Bhushan Girase, Anns Issac
Note taker	Bhushan Girase, Antara Bhattacharya
Transcriber	Antara Bhattacharya
Respondent details	
Date and time of interview	27 May 2016, AM to AM
Name of participant	Dr Shubhabrata Ghosh
Gender	Male
Designation	DMCHO
Department	Department of Health and Family Welfare
Qualification	MBBS; DTMH
Memberships in committees pertaining to health	None

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

Actually the idea is very good. Before taking any decision we have to justify the decision by getting some data, by interpreting that data, what are the important things we have to intervene, what are the important things we have to give… more importance (but at present it is not given more importance). After analysing the data we can only understand that this is a very important thing so we can intervene.

Actually in every state after the introduction of this HMIS… every state is now analysing their data according to the HMIS formats or… the HMIS datasets… and West Bengal is a forerunner in this aspect. West Bengal is now doing very well, analysing this HMIS data regularly, reviewing this data at the state-level quarterly, so in a year we are… [coughing] reviewing… [coughing] this data four times. We are reviewing by calling all the districts, and in the state meeting they underline the factors which we have to give more stress. So in that way it is helping us a lot in taking decision.

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

It is useful but the thing is that, when you are concentrating on a district to do that thing, if you only go for theoretical discussion, then it will not be very much attractive for any health administrator. If you do it with simultaneously analysing the HMIS data, if you find something new, if you find we are not giving stress where it should be given, then it will be more attractive to the health administrator. Otherwise the same kind of analysis we are doing in our district meeting also, so how can you make it more attractive and useful. Frequent analysis and pinpointing the things which we are not giving more stress at the moment, in that way DIPH is useful for taking decision.

Without doing situation analysis you cannot understand the problem, without prioritising the problems which we are facing in our district or in any other district, we cannot give attention to all the programmes at the same time, so these are the basic principles. These are the golden principles and you are following that, which is very good.

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

ANANDI theme is that 100% immunisation for all children that is one of the goal of ANANDI and 100% institutional delivery. Though it is not still achieved but our goal should be like that, that is our focus at this moment.

4. What progress through the DIPH have you made to improve the health targets/status in your district?

For 100% institutional delivery things start from the very base level. Base level means our base level worker [field-level workers] they are the primary worker who can motivate the mother for getting their delivery done in the institution rather than at home, what are the benefits of delivering in an institution, and what are the dangers of delivering a woman in home, they [FLWs] can highlight this thing. There are four ANC and out of that the fourth check-up which is done after 36th week we advise our ASHA and ANM to go to the home of the mother, sit with the mother in the homely atmosphere and discuss the aspects of the delivery, and also with the family members in-laws, father, husband, parents, so that they can take more initiative, they should be more prepared for taking the mother to the institution. For achieving this, the informal discussion should start initially to explain the advantages and disadvantages, then what should be the preparedness that should be ready with them for going to the institution, i.e. birth planning, how far will be the institution, how to go to that institution, what should be the voucher, whether Janani Suraksha Yojana cheque payment and so on, done or not, copy of Janani Suraksha Yojana cheque and a copy of the blank cheque should be there ready with them, in that way the mother and the whole family is now ready to go to the institution, and that is the first step. Second step will be improving the transport system. Nishchoy Jan is operating in every district of West Bengal, and it is giving good service, so the phone number of the Nishchoy Jan should be given to the mother's family so that they can call the Nishchoy Jan at the time of need, and at the same time the institution where she will go for the delivery, that institution should be alert that this kind of mothers can come for delivery.

There are two kinds of institutions one is BEmOC centre and another is CEmOC centre. So in BEmOC all the normal deliveries can be delivered very safely by SBA trained nurse. So all BEmOC birth centres should be staffed by SBA trained nurses and equipped also. So there should be SBA trained staff, newborn care corner, and when the staff is SBA trained she knows all the basic aspects of emergency care and also she knows BEmOC, she knows how to resuscitate the newborn after the delivery. So newborn care corner is established in every BEmOC centre, and in some of the BEmOC centre where there is high load of delivery SNSU is also established, so radiant warmer is there.

Actually, I am giving stress to fourth ANC but all ANCs are equally important. When a mother completes all the four ANCs then she is quite safe for the delivery because if she is identified with any of the complications or a high risk before, she can be referred very early to the institution. Then strengthening the CEmOC centre also so that CEmOC centre is also nearer to the BEmOC centre, and from BEmOC centre if it is required then she can go very quickly to the CEmOC centre. So there is another concept in West Bengal that is called MCH hub. In that there should be a separate ward for mother and a separate ward for child comprising the comprehensive obstetric care for mother and child care. It should have a BSU, a gynaecologist who can perform caesarean section, a paediatric, an anaesthetist all should be available.

In S24PGS Health District, one problem is that in the remote areas we planned to upgrade some BEmOC centre to CEmOC centre but we could not achieve this thing. This is due to sometimes very frequent transfer of medical officers. Actually you can store equipments but the movement of qualified manpower is harmful. When a doctor is posted with some requisite qualification of gynaecology or

obstetrician, he always wants to move to the higher place, so sometimes when the order comes the whole team is displaced. In that way we are now not giving so much importance to improving those RH which we planned before to make it CEmOC centre. Now we are concentrating on the existing CEmOC centre to improve that.

Actually what happens is if there is a continuous flow, SDH and DH are getting importance from all corners because one has to move there. So all things are dumped [posted] there from manpower to everything. The concept is good of CEmOC centre and to upgrade RH to CEmOC centre but sometimes problem is there.

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

Actually DIPH data is concentrating to show that data are showing so many blocks are having so many number of home deliveries. So we can take decision that this sub-centre has areas where more home deliveries are done, so more focus/attention should be given, so that all the mothers should come to the nearest institution for institutional delivery. In that way data is helping us.

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

Apart from HMIS, under MCTS we are getting all sub-centre data. HMIS is also giving and MCTS is also giving, so which sub-centre area is giving more home delivery is available.

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

See, you have already attended so many district meetings and so many district magistrate level meetings also you have attended. When a district magistrate is calling some meeting so every department is present there because it is their obligation to be present in the district magistrate's meeting. But when our CMOH is calling some meeting, so thin attendance is there. In S24PGS Health District now the district magistrate is very strong so he is giving so much importance over this institutional delivery and immunisation. So the things are improving now. For our institutional delivery the last data showed that we were lagging behind by 59% to 61%, now it is already 73%, and our immunisation in both HMIS and MCTS is showing 89% to 91%.

8. Did the MCH NGO sector involvement be achieved through the DIPH process?

See Question 9.

9. Did the private sector achieve involvement through the DIPH process?
You have noticed that there are some private institutions that are giving delivery services in remote areas. It is called as CDC. So in some of the remote blocks they are functioning. And under the Ayushmati scheme some of the nursing homes are giving good services. Regarding immunisation there are some NGOs that are working in the field of mobilising the people, where there is shortage of ASHAs that is in municipality areas mostly. Where there is shortage of ASHAs and other health workers they are motivating the people to bring their children to the immunisation centre.

Those who can afford they can directly go to any nursing home or any higher hospitals. They [private sector] are also reporting institutional delivery. The present achievement is inclusive of all the things but we are not getting all the reports from the private sector. But this CDC and Ayushmati scheme are reporting regularly, they are obligated because they are getting some monetary benefits for that. But private sector are not regularly reporting that is the problem.

Actually in a clinical establishment there is rule that it is mandatory for them to report all public health activities, delivery-related activities and if we can enforce them they are bound to do that.

10. What are the challenges faced during the implementation process of the last DIPH cycle?

For DIPH research associate should think themselves as part of the district health team. Unless you feel like that you will always feel alienated. We always try to include you with us [health department], if you involve yourself with the district health team then you will very easily get access of all the data, and other things which are required for your study. But if you think that we are here to concentrate for the study only then this will affect… I think you [DIPH] have nicely done this for the last six to eight months.

What happens is that during my [DMCHO] Master in Public Health study also, when you go to a new district then they want that you do something for the benefit of their district. While using the data you show us also and have more participation. So this will make better interlinkages.

Both yours [DIPH] and our [health department] goal is same. You [DIPH] want to do it in a different way, we [health department] want to do in the traditional way. If you [DIPH] can invent something new we [health department] can include it.

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

I will only suggest that when you are associated with us [health department], you [DIPH] should be an intimate member of our team. You [DIPH] should always try to make good contact with us. And in that way both your [DIPH] and our [health department] goal is same. So we can reach the same point at the same time. So, the integration is important.

12. Any suggestions how the DIPH process can be better implemented in your district?

What happens is I cannot always give you time separately. If you come to me during a meeting then this happens. So due to administrative prioritisation and circumstances from the state the focus changes. Some new things are also coming up such as reproductive and child health portal piloting.

A.4: Monitoring Format with Definitions

A4.1 Monitoring framework[49]

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

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

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

		government	
	B. Data-based monitoring of the action points for the primary theme of the DIPH	**4. (Number of action points on which progress is being monitored by data) / (total number of action points for the primary theme of the DIPH)** **Action points:** a specific task taken to 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*	Form 5: Follow-up
	C. Revision of district programme data elements for the primary theme of the DIPH	**5. Whether stakeholders suggested a revision/addition to the health system data in the given DIPH cycle? (Y/N)**	Form 4: Plan
		6. (Number of data elements added in the health database as per the prepared action plan) / (total number of additional data elements requested for the primary theme of the DIPH) **Data elements:** operationally, refers to any specific information collected in the health system data forms, pertaining to all six World Health Organization health system building blocks (demographic, human resources, finance, service delivery, health outcome, governance)	Form 5: Follow-up
	D. Improvement in the availability of health system data	**7. Whether the health system data required on the specified theme as per the given DIPH cycle was made available to the assigned person in the given DIPH cycle? (Y/N)** **Assigned person:** as per the cycle-specific DIPH action plan; this can be the theme leader, DSM or any other stakeholder who is assigned with the responsibility of compiling/reporting specified data	Form 1B: Health system capacity assessments
		8. Whether the health system data on the specified theme area is up-to-date as per the given DIPH cycle? (Y/N) ***Up-to-date data*** ***a)*** If monthly data, then the previous complete month at the time of Step 1 of the DIPH cycle ***b)*** If annual data, then the complete last year at the time of Step 1 of the DIPH cycle	Form 1B: Health system capacity assessments
II. Interactions among stakeholders: co-operation in decision-making, planning and implementation Whether the DIPH	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	Form A.2: Record of Proceedings – Summary Table

study ensured involvement of stakeholders from different sectors (health, non-health and NGO/private for-profit organisations)		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; CD; and Department of Social Welfare* • *Private sector stakeholders: NGOs; nursing homes; and large hospitals owned by private entities*	
		2. (Number of representatives from the health department present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting). *Participants in Steps 4 and 5*	Form A.2: Record of Proceedings – Summary Table
		3. (Number of representatives from non-health departments present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting) *Participants in Steps 4 and 5*	Form A.2: Record of Proceedings – Summary Table
		4. (Number of representatives from NGOs present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting) *Participants in Steps 4 and 5*	Form A.2: Record of Proceedings – Summary Table
		5. (Number of representatives from private for-profit organisations present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting) *Participants in Steps 4 and 5*	Form A.2: Record of Proceedings – Summary Table
	F. Responsibilities assigned to stakeholders	**6. (Number of action points with responsibilities of the health department) / (total number of action points for the primary theme of the DIPH)**	Form 4: Plan
		7. (Number of action points with responsibilities of non-health departments) / (total number of action points for the primary theme of the DIPH)	Form 4: Plan
		8. (Number of action points with responsibilities of NGOs) / (total number of action points for the primary theme of the DIPH)	Form 4: Plan
		9. (Number of action points with responsibilities of private for-profit organisations) / (total number of	Form 4: Plan

		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.** **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-	Form 4: Plan

		specific action points) / (total human resources recruitment needed as per action points of the DIPH primary theme)	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