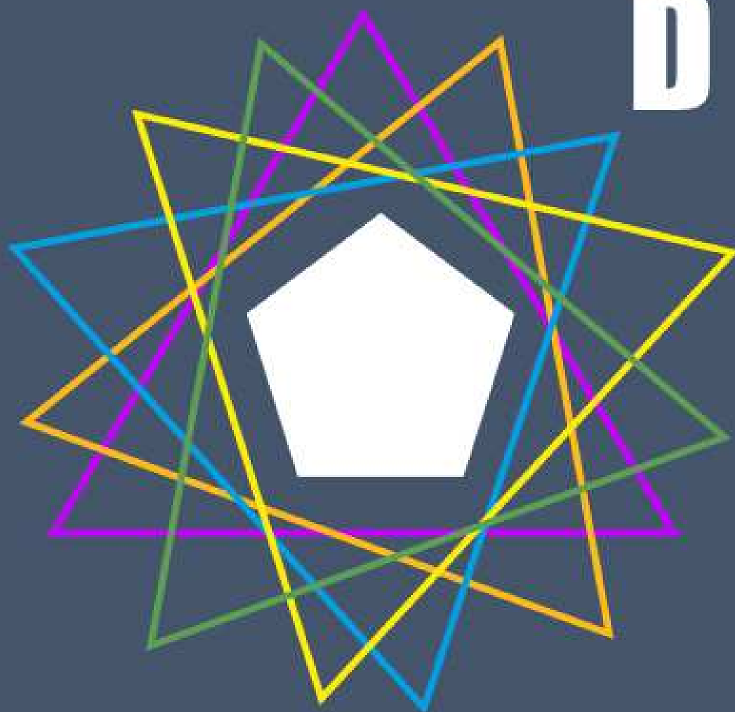

DIPH

The Data-Informed Platform for Health

Structured district decision-making using local data

MONITORING REPORT
Cycle 1: July - November 2016

South 24 Parganas
West Bengal, India

DATA INFORMED PLATFORM FOR HEALTH

MONITORING REPORT

South 24 Parganas, West Bengal, India

Cycle 2: July – November 2016

PUBLIC HEALTH FOUNDATION OF INDIA

IDEAS Evidence to improve maternal & newborn health

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

TABLE OF CONTENTS

LIST OF TABLES II

LIST OF ABBREVIATIONS III

1. INTRODUCTION 1

2. METHODS 2

3. FINDINGS 2

3.1 Utilisation of data at district level 2

3.1.1 Status of data utilisation 2

3.1.2 Challenges in data utilisation 3

3.1.3. Proposed solutions 3

3.2 Interaction among stakeholders 4

3.2.1 Interaction between health and non-health departments 4

3.2.2 Interaction between the health department and NGOs 4

3.2.3 Interaction between the health department and private for-profit organisations 5

3.3. Progress with action points 7

3.3.1 Action points accomplished 7

3.3.2 Action points ongoing 7

3.3.3 Action points not started 8

3.4 Sustainability of the DIPH 10

3.4.1 Data source 10

3.4.2 Facilitators within the district 10

3.4.3 Challenges within the district 10

3.4.4 Possible solutions 10

REFERENCES 11

ANNEXES 12

A.1: DIPH FORMS OF STEP 1 (FORM 1A.1, FORM 1B, AND 1B.1), STEP 4 (FORM 4) AND STEP 5 (FORM 5) 12

A.2: RECORD OF PROCEEDINGS – SUMMARY TABLES 25

A.3: TRANSCRIPTS OF IN-DEPTH INTERVIEWS WITH STAKEHOLDERS 29

A.4: MONITORING FORMAT WITH DEFINITIONS 37

ACKNOWLEDGEMENTS

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

LIST OF TABLES

Table 1: Utilisation of data at district level....3
Table 2: Interactions among stakeholders....5
Table 3: Progress with action points....8

LIST OF ABBREVIATIONS

ACMOH	Assistant chief medical officer of health
ADM	Additional district magistrate
ANC	Antenatal care
ANM	Auxiliary nurse midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi worker
BAM	Block accounts manager
BMOH	Block medical officer of health
BPHN	Block public health nurse
CD	Child Development
CDPO	Child development project officer
CINI	Child in Need Institute
CMOH	Chief medical officer of health
DAM	District accounts manager
DEO	Data entry operator
DHHD	Diamond Harbour Health District
DIPH	Data Informed Platform for Health
DMCHO	District maternity and child health officer
DSM	District statistical manager
Dy. CMOH-III	Deputy chief medical officer of health-III
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
IEC	Information, education and communication
IMA	Indian Medical Association
MCTS	Mother and Child Tracking System
NGO	Non-governmental organisation
PHN	Public health nurse
PHPC	Public health programme co-ordinator
PMSMA	Pradhan Mantri Surakshit Matritva Abhiayan
PRD	Panchayat and Rural Development
S24PGS	South 24 Parganas
SHG	Self-help group
SHIS	Southern Health Improvement Samity
SSDC	Sunderban Social Development Centre
UNICEF	United Nations Children's Fund
VHND	Village Health and Nutrition Day

1. INTRODUCTION

<table>
<tr><th colspan="3">Data Informed Platform for Health (DIPH)</th></tr>
<tr><td>Cycle No.</td><td colspan="2">2</td></tr>
<tr><td>District</td><td colspan="2">South 24 Parganas Health District</td></tr>
<tr><td>Duration</td><td colspan="2">July – November 2016</td></tr>
<tr><td>Theme</td><td colspan="2">Improve the coverage of fourth antenatal check-up</td></tr>
<tr><td rowspan="5">Steps involved</td><td>Step 1</td><td>Assess: Based on the Prime Minister’s safe motherhood programme Pradhan Mantri Surakshit Matritva Abhiayan (PMSMA) (MoHFW, 2016a), the DIPH stakeholders assessed gaps in service provision from the District Programme Implementation Plan 2015/16 and the Mother and Child Tracking System (MCTS) (Department of Health and Family Welfare, 2015; MoHFW, 2016b). Theme selection, in consultation with the non-health departments, was to ‘Improve the coverage of fourth antenatal check-up’ for Cycle 2 of the DIPH. As the non-health departments do not maintain data to the theme indicators, the situation assessment only used data from the health department.</td></tr>
<tr><td>Step 2</td><td>Engage: The primary responsibility for Cycle 2 was with the health department, while the departments of Child Development (CD), Panchayat and Rural Development (PRD) and the district administration shared the supportive responsibilities. Majority of participants were from the health department. The deputy chief medical officer of health-III (Dy. CMOH-III) became the theme leader for Cycle 2. Non-governmental organisations (NGOs) and major private for-profit organisations did not receive an official invitation to take part in the DIPH process.</td></tr>
<tr><td>Step 3</td><td>Define: The DIPH district stakeholders prioritised action points to achieve the targets based on: service delivery; health information; and finance. They identified ten problems with 60% under ‘service delivery’. They formulated six actionable solutions to address the ten problems, in keeping with cycle duration and capacity of the district administration.</td></tr>
<tr><td>Step 4</td><td>Plan: The stakeholders developed six action points (and 18 indicators) to achieve the target and assigned responsibilities across departments within a given time frame. All the responsibilities were with the Department of Health and Family Welfare.</td></tr>
<tr><td>Step 5</td><td>Follow-up: The stakeholders attended two meetings before the Step 5 meeting to facilitate the follow-up of the action plan. Out of the six action points, only two action points (33%) had completed within the specified timeline. The remaining action points received a new timeline. The theme leader monitored the progress through monthly reports (from district personnel responsible for each action point).</td></tr>
</table>

2. METHODS

Sl. No	Data sources	Lead among DIPH stakeholders	Time frame
1	**Step 1: Assess** Form 1A.1: Data extraction from state and district health policy documents Form 1B: Health system capacity assessments Form 1B.1: Sub-district level (block) performance of selected indicators	Theme leader of the DIPH Cycle 2	04 July 2016
2	**Step 2: Engage** Form 2: Engage	Theme leader of the DIPH Cycle 2	04 July 2016
3	**Step 3: Define** Form 3: Define	Theme leader of the DIPH Cycle 2	04 July 2016
4	**Step 4: Plan** Form 4: Plan	Theme leader of the DIPH Cycle 2	20 July 2016
5	**Step 5: Follow-up** Form 5: Follow-up	Theme leader of the DIPH Cycle 2	10 November 2016
6	**Record of Proceedings – Summary Tables** Form A.2.1: Record of Proceedings – Summary for DIPH Step 4 Form A.2.2: Record of Proceedings – Summary for DIPH Step 5	Recorded by the DIPH research team, South 24 Parganas (S24PGS)	June – September 2016
7	**In-Depth Interviews with Stakeholders** Form A.3.1: District accounts manager (DAM)	Interviewed by the DIPH research team, S24PGS	28 September 2016
	Form A.3.2: District statistical manager (DSM)		29 September 2016
	Form A.3.3: Dy. CMOH-III		26 October 2016

3. FINDINGS

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

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

3.1 Utilisation of data at district level

3.1.1 Status of data utilisation

The DIPH stakeholders adhered to the components of the recently introduced scheme of the Prime Minister's safe motherhood programme (PMSMA) (MoHFW, 2016a) and identified the theme for Cycle 2 as 'Improve the coverage of fourth antenatal check-up'. The PMSMA, introduced during June 2016, aims at providing free health check-ups and treatment to all pregnant women across the country (MoHFW, 2016a). The stakeholders utilised data from the *District Implementation Plan 2015/16* and the MCTS to assess the gaps in antenatal services (Department of Health and Family Welfare, 2015; MoHFW, 2016b). Development of the theme was in consultation with the non-health departments; however, the non-health departments do not maintain data regarding the identified theme. Compared to Cycle 1, the stakeholders are aware of the significance of data and occasionally they highlighted the health issues with the support of statistical information.

"[…]under each step of the cycle, analysis was conducted[…] Previously, we used to conduct a huge analysis for all the indicators after receiving the data from the blocks[…] A streamlining of the data processing happened under DIPH, which is very much needed." (DSM, S24PGS)

3.1.2 Challenges in data utilisation

The challenges of data utilisation also continued to Cycle 2. Timely availability and completeness of data from all relevant departments is still a major concern. Also, data on human resources, trainings conducted and infrastructure are not stored systematically. There is no data-sharing from private providers and NGOs, other than those who enrolled with government programmes. There therefore, needs to be improvement in data-sharing between departments.

"The information from NGOs and private sector, who are involved with government programme can be accessed properly… But data from other registered and non-registered nursing homes are not available. We raised this issue in several meetings. But nothing has happened till now." (DSM, S24PGS)

3.1.3. Proposed solutions

The chief medical officer of health (CMOH) suggested a regular verification of data at block level before sending it for compilation at the district. Also, the monthly review of selected data elements, as part of the DIPH process at district level reproductive and child health meetings, enable the health department to identify gaps. There needs to be similar verification by non-health departments.

Table 1: Utilisation of data at district level

Purpose	Indicators		Response (Yes/No and proportion)	Source of information
Whether the DIPH study led to the utilisation of the health system data or policy directive at district level for decision-making?	A. Selection of the primary theme for the current DIPH cycle	1. Whether the DIPH cycle theme selection was based on HMIS data? (Y/N)	Yes[1]	Form 1B
		2. Whether the DIPH cycle theme selection used any data from non-health departments? (Y/N)	No[2]	Form 1B
		3. Whether the DIPH cycle theme selection was based on health policy and programme directives? (Y/N)	Yes[3]	Form 1A.1
	B. Data-based monitoring of the	4. (Number of action points on which progress is being	6/6 = 100[4]	Form 5

[1] As per MCTS, percentage of pregnant women received minimum of four antenatal check-ups was 25% in the selected health district (MoHFW, 2016b). This indicates a gap of 75%. (See Form 1.B, 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 theme.

[3] The present gap analysis focuses on the Prime Minister's safe motherhood programme (PMSMA), which implies 100% improvement in the coverage of fourth antenatal check-up for all registered pregnant women (MoHFW, 2016a). (See Form 1A.1, Sl. No. 1.)

[4] Data monitoring occurred for all six action points during Cycle 2 (August − October 2016). (See Form 5.)

	action points for the primary theme of the DIPH	monitored by 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 additional 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

Facilitating multi-stakeholder co-operation is one of the main objectives of the DIPH. However, the existing bureaucratic framework and rigid hierarchies pose several challenges.

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 are from the health department. The participation from non-health departments is poor. No one from the departments of CD and PRD participated in Steps 4 and 5 Cycle 2 meetings. However, the PRD representative attended Steps 1, 2 and 3 meetings. The health department holds all responsibility for achieving the action points.

3.2.2 Interaction between the health department and NGOs

A few NGOs are working in the district; however, they are not part of any decision-making process. The NGO, Child in Need Institute (CINI) is currently working with the district health department and therefore, invited to the DIPH meeting. Their district co-ordinator formally attended the meeting, but did not take part in any discussions.

[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 be included in the health database as per the prepared action plan. (See Form 5.)

[7]The data for indicators are not readily available on time from the DSM. In addition, the data on human resources, trainings conducted and infrastructure are not updated timely and stored systematically. These data are from different forms and were incomplete. (See Form 1B.)

[8] The latest data (25% for S24PGS Health District based on MCTS key indicators) available during DIPH Step 1 (July 2016) is for May 2016. (See Form 1B, Sl. No. 2.1.)

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

The district has a significant share of urban population catered by private for-profit providers. However, there is no interaction between government departments and the private sector on a regular basis. The health department has limited interaction with private providers to provide/renew licences for private clinics/maternity homes.

Table 2: Interactions among stakeholders

Purpose	Indicators		Response (Yes/No, proportions)	Sources of information
Whether the DIPH study ensured involvement of stakeholders from different sectors (health, non-health and NGO/private for-profit organisations)	E. Extent of stakeholder participation	1. (Number of DIPH stakeholders present in the planning actions meeting) / (total number of DIPH stakeholders officially invited in the planning actions meeting)	86/90 = 95.6 [9]	Form A.2
		2. (Number of representatives from the health department present in the planning actions meeting) / (total number of DIPH participants in the planning actions meeting)	82/90 = 91.1 [10]	Form A.2
		3. (Number of representatives from non-health departments present in the planning actions meeting) / (total number of DIPH participants in the planning actions meeting)	3/90 = 3.3 [11]	Form A.2
		4. (Number of representatives from NGOs present in the planning actions meeting) / (total number of DIPH participants in the	1/90= 1.1 [12]	Form A.2

[9] The participation involved calculating the invitee list and attendant list of Steps 4 and 5 meetings, 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] Majority of representatives are from the health department. (See Form A.2.1, Sl. No. C2 and Form A.2.2, Sl. No. C2.)
[11] The non-health departments invited are CD-Integrated Child Development Services (ICDS), PRD and district administration. (See Form A.2.1, Sl. No. C2 and Form A.2.2, Sl. No. C2.)
[12] NGOs are not formally part of any district-level meeting. However, as CINI works with the district they took part in the meeting. (See Form A.2.1, Sl. No. C2 and Form A.2.2, Sl. No. C2.)

		planning actions meeting)		
		5. (Number of representatives from private for-profit organisations in the planning actions meeting) / (total number of DIPH participants in the planning actions meeting)	0/90 (Nil)[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)	6/6 = 100[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)	0/6 (Nil)[14]	Form 4
		8. (Number of action points with responsibilities of NGOs) / (total number of action points for the primary theme of the DIPH)	0/6 (Nil)[15]	Form 4
		9. (Number of action points with responsibilities of private for-profit organisations) / (total number of action points for the primary theme of DIPH)	0/6 (Nil)[15]	Form 4
	G. Factors influencing co-operation among health, non-health and NGO/private for-profit organisations to achieve the specific	**10. List of facilitating factors**	1. District magistrate is keen to improve the health status of the district and actively support	Form A.3

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

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

[15] There is no action point chosen for NGOs and the private sector. (See Form 4.)

	action points in the given DIPH cycle[16]		the DIPH 2. Good rapport between the DIPH research team and district stakeholders 3. Presence of an NGO in the district	
		11. List of challenging factors	1. The DIPH still considered as a health department activity 2. Shortage of staff 3. Timely availability of data and issues with quality	Form A.3

3.3. Progress with action points

Almost half of the action points (three out of six) relate to service delivery. The theme leader reviewed the monthly progress reports from the blocks and provided feedback to accomplish the action plan.

3.3.1 Action points accomplished

All six action points started during the cycle period, but only two actions points had completed by the Step 5 meeting.

- Target low performing block and conduct a meeting on third week to review basic indicators of antenatal care (ANC) such as early registration, third antenatal check-up and fourth antenatal check-up.
- Secure sanction from state authorities for recruitment of staff for key positions.

The block-wise review of selected indicators achieved more than 100% coverage, indicating that the target set is less than the average. There was a total of ten personnel (data entry operators [DEOs], block public health nurses [BPHNs], and block medical officers of health [BMOHs]) recruited during the cycle period. The recruitment process is still ongoing.

3.3.2 Action points ongoing

Four action points are continuing onto the next cycle:

- Identify and target high-risk pregnant women (targeting 10% of high-risk pregnant women for service delivery)
- Plan Village Health and Nutrition Day (VNHD) sessions in convergence mode with participation of the health department, ICDS, PRD, NGOs and self-help groups (SHGs), etc.

[16] Extracted from in-depth interviews with stakeholders. (See Forms A.3.)

- Review planning and execution process of data entry by meeting with DEOs from low performing blocks
- Evaluate funds allocation and expenditure for community awareness of fourth antenatal check-up by blocks

3.3.3 Action points not started

All action points started during the cycle period.

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)	6/6 = 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)	2/6 = 33.3[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 points of the DIPH primary theme)	0/0 (Nil)[20]	Form 5
		5. (Units of specific medicine provided for the primary theme-specific action points) /	0/0 (Nil)[21]	Form 5

[17] All six action points started within the timeline. (See Form 5, Part B, columns: 'Action points'; 'Timeline for completion'; and 'Status of action points'.)
[18] Two action points completed as per the action plan. The 'ongoing' ones will continue onto the third cycle. (See Form 5, Part B, columns: 'Action points'; 'Timeline for completion'; and 'Status of action points'.)
[19] There are no written directive demands as per action plan. However, a letter issued by the district magistrate of S24PGS Revenue District, advised all district health authorities for their support and active involvement in the DIPH.
[20] The state government has assigned funds for institutional delivery, ANC check-up incentives for Accredited Social Health Activists (ASHAs) and the ANANDI programme. As a result, there are no demands for additional finance in the action plan.
[21] The selected theme did not require procurement of any medicine.

		(total units of specific medicine requested as per action points of the DIPH primary theme)		
		6. (Units of specific equipment provided for the primary theme-specific action points) / (total units of specific equipment requested as per action points of the DIPH primary theme)	0/0 (Nil)[22]	Form 5
		7. (Units of specific IEC [information, education and communication] materials provided for the primary theme-specific action points) / (total units of specific IEC materials requested as per action points of the DIPH primary theme)	0/0 (Nil)[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)	10/10 = 100[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)	0/0 (Nil)[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. Active interest of district magistrate 2. The selected themes are aligning with the ongoing initiatives in the district 3. Persistent follow-up by the DIPH research team	Form A.3
		11. List of challenging factors	1. Lack of co-ordination between different stakeholder departments 2. Delays in implementation of action points 3. Require hand-	Form A.3

[22] There are no demands for 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.)

[24] As per the action plan, there was a total of ten staff recruited (DEOs, BPHNs and BMOHs). (See Form 5, action point 2.1.1.)

[25] There is no training for staff suggested by the action plan. (See Form 5.)

[26] Extracted from in-depth interviews with stakeholders. (See Forms A.3.)

			holding by the DIPH research team	

3.4 Sustainability of the DIPH

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

3.4.1 Data source

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

3.4.2 Facilitators within the district

- The DIPH research team could build and maintain a good rapport with stakeholders.
- The stakeholders are now familiar with the DIPH process and this resulted in better participation.
- An official letter by the district magistrate ensuring participation of all stakeholder departments.

3.4.3 Challenges within the district

- Lack of manpower cuts across departments. The DEO is a contractual post in the health department whereas there are no DEOs for CD-ICDS.
- Time constraint in bringing district-level officers in a common platform is very difficult due to their involvement in several ongoing programmes in the district. The cycle duration – three to four months − is not enough to achieve the target.
- Availability and quality of data.
- Though the dependence on the DIPH research team reduced from Cycle 1, the stakeholders still require regular follow-up by the research co-ordinator.
- Though the interdepartmental co-ordination is improving very slowly, the major share of responsibilities are still with the health department.
- Involvement of NGOs and private for-profit organisations is unmet.

3.4.4 Possible solutions

- There is a need to verify the quality of data and implementation of action points. The stakeholders suggested joint monitoring system and combined field visits to facilitate this.
- To consider themes that involve more participation by non-health departments.
- To involve sub-district level stakeholders such as BMOHs, BPHNs, child development project officers (CDPOs) during Steps 4 and 5 for better implementation of the action plan.

REFERENCES

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

Ministry of Health and Family Welfare (MoHFW) 2016a, *Pradhan Mantri Surakshit Matritva Abhiyan*, Government of India, New Delhi, viewed on 25 April 2016, www.nrhmhp.gov.in/sites/default/files/files/PMSMA-Guidelines.pdf

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

ANNEXES

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

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

Document title:	PMSMA Guidelines
Date of release:	02 May 2016
Goal as stated in document:	Increase in fourth ANC coverage up to 70% (current – 42%)
Action points specified by document	
1	Tracking and tagging of pregnant women with ASHA and auxiliary nurse midwife (ANM)
2	To review the action plan provided to ANM in first Saturday meeting and stress given on fourth ANC check-up
3	Responsibility given to health supervisor in monitoring fourth antenatal check-up at home
4	To target the low performing block and conduct a meeting in third week of each month to review basic indicators of ANC such as early registration, three antenatal check-ups and fourth antenatal check-up
5	Review of planning and execution for data entry for timely update of MCTS format – meeting with low performing block to make them understand basics of data interpretation

Form 1B: Health system capacity assessments

1.	Information about the district			
	District demographic details	**Information**	**Source**	**Source detail**
1.1	Total area (square km)	9,960	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.2	Total population	8,161,961	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.3	Number of women in reproductive age group (15-49 years)	1,644,815	District Health Plan/*District Programme Implementation Plan 2015/16*	Eligible Couple Contraceptive Register
1.4	Number of children under five years of age	1,025,679	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.5	Rural population (%)	74.4	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.6	Scheduled Caste population (%)	30.2	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.7	Scheduled Tribe population (%)	1.2	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.8	Population density (persons/square km)	819	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.9	Total literacy (%)	77.5	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.10	Female literacy (%)	71.4	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf

1.11	**Key NGOs**	
	Name of NGO	**Contact details**

1.11.1	CINI	Dr. Samir Narayan Chowdhuri, Director, Daulatpur, P.O. Pailan Via Joka, 24 Parganas (S) Pin – 700 104, West Bengal, India Tel: +91 33 2497 8192/8206/8251/8641 Fax: +91 33 2497 8241 Email: cini@cinindia.org
1.11.2	Sunderban Social Development Centre (SSDC)	Ranajit Manna, Secretary, Vill: Sultanpur P.O: Krishnanagar Via: Ghateswar 24 Parganas(South) West Bengal 743343 India phone : 03174 – 277286
1.11.3	Southern Health Improvement Samity (SHIS)	MA Wohab, Director, Village: Kanthalia, P.O.: Bhangar, P.S.: Kashipur, District: South 24 Parganas, West Bengal, India Pincode : 743502 Phone : 0091 3218-270245, Fax : 0091 3218 271969 Email – mawohab@yahoo.com
1.11.4	Sabuj Sangha	Ansuman Das, Secretary, Village and P.O.: Nandakumarpur District: South 24 Parganas Pin:743349 West Bengal, Phone: +91 33 2441 4357 Mobile: +91 983 1001655 Email: director@sabujsangha.org
1.12	**Key private for-profit organisations**	
	Name of organisation	**Contact details**
	-	-

2.	**Expected coverage for the identified theme**						
	Theme	**Coverage indicators**		**Current status**	**Expected status**	**Gap**	**Source**
2.1	Improve the coverage of fourth antenatal check-up	2.1.1	Percentage of pregnant women received minimum four antenatal check-up	25.20	100	74.80	MCTS

3. Theme:- Improve the coverage of fourth antenatal check-up				
	Details	**Sanctioned (2014/15)**	**Available/functional**	**Gap**
3.1 Infrastructure				
3.1.1	Sub-centres	593	593	0
3.1.2	Primary Health Centres	32	32	0
3.1.3	Block Primary Health Centres	5	5	0
3.1.4	Rural hospital	12	12	0
3.1.5	Sub-divisional hospital	2	2	0
3.1.6	District hospital	1	1	0

3. Theme:- Improve the coverage of fourth antenatal check-up				
	Details	**Sanctioned (2014/15)**	**Available/functional**	**Gap**
3.1.7	Delivery points	32	32	0
3.2 General resources				
3.2.1 Finance				
3.2.1.a	Institutional delivery (Indian rupee)	14,749,000	14,749,0000	
3.2.1.b	For Janani Shishu Suraksha Karyakaram (Indian rupee)	57,839,000	57,839,0000	
3.2.2 Supplies				
3.2.2.a	Injection Oxytocin	1,920	1,920	0
3.2.2.b	Dextrose solution 5%	35,000	35,000	0
3.2.2.c	Calcium Carbonate	20,000	20,000	0
3.2.2.d	Paracetamol suspension	55,000	55,000	0
3.2.2.e	Gentamycin Sulphate	12,000	12,000	0
3.2.3 Technology				
3.2.3.a	m-health technology	1	1	0
3.3 Human Resources				
3.3.1	ASHA	3,158	2,237	921
3.3.2	First ANM	593	576	17
3.3.3	Second ANM	593	447	146
3.3.4	Anganwadi worker (AWW)	10	9	1
3.3.5	Obstetrician and gynaecologist	20	21	-1
3.3.6	Paediatrician	18	14	4

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

Sl. No.	Block name	Theme (Cycle 2 S24PGS Health District): Improve the coverage of fourth antenatal check-up											
		First trimester registration to total ANC registration (%)		Pregnant women received minimum of three antenatal check-ups (%)		Pregnant women received minimum of four antenatal check-ups (%)		Pregnant women received Tetanus Toxoid 1 to total ANC registration (%)		Pregnant women received Tetanus Toxoid/2 or booster to total ANC registration (%)		Pregnant women received 100 Iron Folic Acid tablets to total ANC registration (%)	
		HMIS	*MCTS*	*HMIS*	*MCTS*	*HMIS*	*MCTS*	*HMIS*	*MCTS*	*HMIS*	*MCTS*	*HMIS*	*MCTS*
1	**Baruipur**	83.9		63.3	51.9		26.1	88.5	90.3	105.6	73.3	88.6	63.0
2	**Basanti**	76.5		65.1	24.0		2.4	89.5	82.1	101.0	32.3	61.3	29.9
3	**Bhangore-I**	82.8		69.9	43.2		12.0	89.1	18.4	107.4	16.7	53.8	36.6
4	**Bhangore-II**	82.5		75.3	51.4		23.1	99.1	99.6	94.5	52.0	96.6	99.6
5	**Bishnupur-I**	86.1		67.5	56.9		28.8	91.7	83.8	88.1	63.8	75.5	71.9
6	**Bishnupur-II**	87.2		72.7	52.1		25.5	96.1	79.8	95.3	64.9	76.3	72.3
7	**Budge Budge-I**	89.5		61.8	73.8		28.8	78.5	98.4	78.0	82.7	73.3	97.9
8	**Budge Budge-II**	88.9		68.1	75.0		47.3	102.4	87.9	92.0	84.4	90.3	88.7
9	**Canning-I**	77.5		56.4	62.1		21.8	86.5	75.6	118.9	66.6	79.5	74.3
10	**Canning-II**	79.4		61.6	61.7		27.2	90.3	85.9	103.0	72.8	62.2	82.7
11	**Gosaba**	82.7		75.7	37.9		17.6	85.5	79.1	100.0	51.5	81.2	35.2
12	**Joynagar-I**	88.0		76.2	78.2		48.0	83.0	81.5	102.5	75.6	82.9	93.7
13	**Joynagar-II**	78.9		75.9	26.6		12.9	86.9	71.9	98.8	45.1	91.8	55.6
14	**Kultali**	79.1		66.3	74.0		32.4	86.6	89.1	87.2	78.6	89.2	74.0
15	**Sonarpur**	85.1		71.0	78.2		44.0	86.5	86.8	86.5	83.5	91.7	89.5
16	**T.M.**	86.0		64.6	68.9		44.7	73.5	81.6	69.3	73.2	70.0	74.2

*Source: Health Management Information System (HMIS) data May 2016/17 status as on: 30 June 2016 and MCTS data status as on 30 June 2016.

Form 4: Plan

Theme:	Improve the coverage of fourth antenatal check-up
Total number of action planned	6
Responsibilities of different stakeholders	
Department of Health and Family Welfare	6

	Action points	Responsible stakeholder	Indicator	Target	Timeline
1.Service delivery					
1.1.1	Target low performing block and conduct a meeting on third week, to review basic indicators of ANC such as early registration, third antenatal check-up and fourth antenatal check-up	Department of Health and Family Welfare **Person Responsible:** BPHN /public health nurse (PHN)	**a.** Proportion of early registered pregnant women (%) **b.** Proportion of pregnant women completed three antenatal check-ups (%) **c.** Proportion of pregnant women completed fourth antenatal check-up (%)	9,600 10,550 9,000	October 2016
1.2.1	Identify and target high-risk pregnant women (targeting 10% of high-risk pregnant women for service delivery)	Department of Health and Family Welfare **Person Responsible:** BPHN	**a.** Proportion of high-risk pregnant women identified by ASHA and ANM (%) **b.** Proportion of new cases of hypertension detected in pregnant women (%) **c.** Proportion of eclampsia cases managed during delivery (%) **d.** Proportion of pregnant women with severe anemia	1,100 400 100 600	October 2016

	Action points	Responsible stakeholder	Indicator		Target	Timeline
				treated at institution (%)		
1.3.1	Plan VHND session in convergence mode with participation of the health department, ICDS, PRD, NGOs, SHGs, etc.	Department of Health and Family Welfare **Person Responsible:** BMOH, CDPO, public health programme co-ordinator (PHPC)	**a.**	Proportion of VHND sessions held (%)	3,500	October 2016
			b.	Proportion of participants for each VHND session (%)	18,800	
			c.	Proportion of participants from the health department for each VHND session (%)	2,000	
			d.	Proportion of representatives from ICDS for each VHND session (%)	3,500	
			e.	Proportion of participants from PRD for each VHND session (%)	500	
			f.	Proportion of participants from SHGs for each VHND session (%)	280	
2.Workforce						
2.1.1	Secure sanction from state authorities for recruitment of staff for key positions	Department of Health and Family Welfare **Person Responsible:** District Recruitment Cell	**a.**	Recruitment for DEO, BPHN, BMOH (%)	0	October 2016
3.Supplies and technology						

	Action points	Responsible stakeholder	Indicator		Target	Timeline
4.Health information						
4.1.1	Review planning and execution process of data entry by meeting with DEOs from low performing block	Department of Health and Family Welfare **Person Responsible:** BMOH	**a.**	Number of data entry per day by DEO for registered pregnant women (%)	2,500	October 2016
			b.	Number of data entry per day by DEO for registered child (%)	3,000	
5.Finance						
5.1.1	Evaluate funds allocation and expenditure for community awareness of fourth antenatal check-up by blocks	Department of Health and Family Welfare **Person Responsible:** Block accounts manager (BAM)	**a.**	Unspent balance for training for community awareness of fourth antenatal check-up	0	October 2016•
			b.	Unspent balance for IEC materials for community awareness of fourth antenatal check-up	0	
6.Policy/governance						

Form 5: Follow-up

Part A	
Theme:	Improve the coverage of fourth antenatal check-up
Number of meeting for the respective theme:	2

1. Major stakeholders involved in each meeting

Sl. No.	**Date**	**Number of participants**
Meeting 1	20 July 2016	38
Meeting 2	19 August 2016	48

2.	**Comparison of key coverage indicator(s) in the DIPH cycle**	**Time 0**	**Time 1**	**Time 2**	**Time 3**	**Graph**
	Date	May 2016	June 2016	July 2016	August 2016	
2.1.1	Percentage of pregnant women received minimum four antenatal check-ups	25.2	28.62	27.5	21.93	View Graph

Part B	
Total action points – planned:	6
Total action points – Not started:	0
Total action points – Ongoing not on target:	2

Part B	
Total action points − planned:	6
Total action points – Ongoing on target:	2
Total action points – Completed:	2

Sl. No.	Action points	Indicators		Target	Progress of indicators	Person responsible	Timeline	Status of action points	Further follow-up suggestions	
									Timeline	Change in responsibility
1.	**Service delivery**									
1.1.1	Target low performing block and conduct a meeting on third week, to review basic indicators of ANC such as early registration, third antenatal check-up and fourth antenatal check-up	**a**	Proportion of early registered pregnant women (%)	9,600	12,271	BPHN/PHN	October 2016	Completed	No	No
		b	Proportion of pregnant women completed three antenatal check-ups (%)	10,550	12,307					
		c	Proportion of pregnant women completed fourth antenatal check-up (%)	9,000	11,511					
1.2.1	Identify and target high-risk pregnant women (targeting 10% of high-risk pregnant women being for service delivery)	**a**	Proportion of high-risk pregnant women identified by ASHA and ANM (%)	1,100	244	BPHN	October 2016	Ongoing – on target	March 2017	No
		b	Proportion of new cases of	400	123					

Sl. No.	Action points	Indicators		Target	Progress of indicators	Person responsible	Timeline	Status of action points	Further follow-up suggestions	
									Timeline	Change in responsibility
			women (%)							
		c	Proportion of eclampsia cases managed during delivery (%)	100	4					
		d	Proportion of pregnant women with severe anaemia treated at institution (%)	600	2					
1.3.1	Plan VHND session in convergence mode with participation of health department, ICDS, PRD, NGOs, SHGs, etc.	**a**	Proportion of VHND sessions held (%)	3,500	3,340	BMOH, CDPO, PHPC	October 2016	Ongoing – on target	March 2017	No
		b	Proportion of participants for each VHND session (%)	18,800	18,596					
		c	Proportion of participants from the health department for each VHND session (%)	2,000	2,055					
		d	Proportion of representatives from ICDS for each VHND session (%)	3,500	2,791					
		e	Proportion of participants from PRD for each VHND session (%)	500	62					
		f	Proportion of participants from SHGs for each VHND session (%)	280	33					

Sl. No.	Action points		Indicators	Target	Progress of indicators	Person responsible	Timeline	Status of action points	Further follow-up suggestions	
									Timeline	Change in responsibility
2.	**Workforce**									
2.1.1	Secure sanction from state authorities for recruitment of staff for key positions	**a**	Recruitment for DEO, BPHN, BMOH (%)	10	100	District Recruitment Cell	October 2016	Completed	No	No
4	Health Information									
4.1.1	Review planning and execution process of data entry by meeting with DEOs from low performing block	**a**	Number of data entry per day by DEO for registered pregnant women (%)	2,500	2,292	BMOH	October 2016	Ongoing – not on target	No	No
		b	Number of data entry per day by DEO for registered child (%)	3,000	1,997					
5.	**Finance**									
5.1.1	Evaluate funds allocation and expenditure for community awareness of fourth antenatal check-up by blocks	**a**	Unspent balance for training for community awareness of fourth antenatal check-up	0	0	BAM	October 2016•	Ongoing – not on target	No	No
		b	Unspent balance for IEC materials for community	0	0					

Sl. No.	Action points	Indicators	Target	Progress of indicators	Person responsible	Timeline	Status of action points	Further follow-up suggestions	
								Timeline	Change in responsibility
		check-up							

A.2: Record of Proceedings – Summary Tables

Form 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	5 minutes	2.35 pm – 2.40 pm	Total 25 minutes
A.2 Form 4	20 minutes	2.40 pm – 3.00 pm	
B. Stakeholder leadership			
B.1 Agenda circulated/invitations sent		DIPH research team	
B.2 Chair of sessions		CMOH, S24PHS Health District	
B.3 Nominee/ volunteer	1. Completing data forms	Antara Bhattacharya	
	2. Presenting summary	Sayan Ghosh	
	3. Theme leader	Dy. CMOH-III	
	4. Record of proceedings	Antara Bhattacharya	
C. Stakeholder participation			
C.1 Number of stakeholders invited	Health department	30	CMOH, Dy. CMOH-III, District maternity and child health officer (DMCHO), District programme co-ordinator, BMOH (12 blocks), PHN (2), BPHN (12 blocks)
	Non-health departments	2	PHPC, DPO
	NGO/private sector	1	Co-ordinator, CINI
	District administration	-	
C.2 Percentage of stakeholder participation (to those invited)	Health department	93% (28)	It was informed by Dy. CMOH-III that less attendance is due to other priorities (health camps being organised for World Population Day)
	Non-health departments	0% (0)	
	District administration	-	
	NGO/private sector	100% (1)	
	Total	88% (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	Action points, and person responsible and timeline for Form 4.1 (Cycle 2) indicators	
	BMOH, Kultali	Action point 1.6.1 in Form 4.1 (Cycle 2)	
D.2 Non-health departments	PRD		
	ICDS		
D.3 NGO/private sector	-		
D.4 District administration	-		
E. Responsibilities delegated to non-health departments and NGOs*			
Type of activities shared	ICDS		
	PRD		
	NGO		
F. Co-operation/communication between stakeholders*			

G. Data utilisation			
H. Suggestion for Developing a Decision-Making guide modification (*Note: suggestions with justifications on forms, process*)			
	No suggestions		

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

Form A.2.2: Record of Proceedings – summary of DIPH Step 5			
A. Time taken for each session			
Session	***Time allotted***	***Actual time taken***	***Remarks***
A.1 Briefing	5 minutes	12.30 pm – 12.35 pm (5 minutes)	Total time taken 40 minutes
A.2 Form 5	20 minutes	12.35 pm – 1.10 pm (35 minutes)	
B. Stakeholder leadership			
B.1 Agenda circulated/invitations sent		DIPH research team	
B.2 Chair of sessions		District magistrate, S24PGS	
B.3 Nominee/ volunteer	1.Completing data forms	Antara Bhattacharya	
	2.Presenting summary	Antara Bhattacharya	
	3. Theme leader	Dy. CMOH-III	
	4. Record of proceedings	Antara Bhattacharya	
C. Stakeholder participation			
C.1 Number of stakeholders invited	Health department	54	Dy. CMOH-I, -II, -III, DMCHO, Assistant chief medical officer of health (ACMOH), Superintendent, BMOH, BPHN, PHN, District Programme Management Unit
	Non-health departments	-	
	NGO/Private sector	-	
	District administration	3 (Swasthya Karmadhyaksha, district magistrate, additional district magistrate – ADM)	Due to other meetings going on simultaneously that day at district magistrate's office, the district magistrate and ADM attended the Samiti meeting and left early
C.2 Percentage of stakeholder participation (to those invited)	Health department	100% (54)	
	Non-health departments	0% (0)	
	District administration	100% (3)	
	NGO/private sector	0% (0)	
	Total	100% (57)	
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	Dy. CMOH-I (acting CMOH)	Data validation by BMOHs is needed	
D.2 Non-health departments	PRD	Non applicable	
	ICDS	Non applicable	
D.3 NGO/private sector		Non applicable	
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*			
			Most communication and decisions are from higher officials since the Samity

			meeting is also a district review meeting
G. Data utilisation			
Not used			
H. Suggestion for Developing a Decision-Making guide modification (*Note: suggestions with justifications on forms, process*)			
	No suggestions		

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

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

A3.1: In-depth interview with DAM

IDI details	
IDI label	111_GSN_AB_28Sep2016
Interviewer	Antara Bhattacharya
Note taker	Antara Bhattacharya
Transcriber	Antara Bhattacharya
Respondent details	
Date and time of interview	28 September 2016
Name of participant	Mrs Rakhi Changder
Gender	Female
Designation	DAM, S24PGS
Department	Health
Duration of service in the district	10 years
Previous position	-
Qualification	M.Com, CA (Final)
Years of experience in present department	10 years
Membership in committees pertaining to health	None

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

Data-based decision-making is being done, and decision-making process has definitely improved. For example, the funds allotted for Janani Shishu Suraksha Karyakaram whether they are correct or not, how much fund should be allotted and for which purpose that we can cross-check through MCTS. It's not that we are taking all financial decisions based on MCTS or DIPH data, but we can cross-check that whether the utilisation of funds is being done or not, and whether funds are being wasted or not. The purpose for which funds have been given, whether it is being used for that. For fourth ANC, we do not have a specific fund for that, but under Janani Suraksha Yojana funds for fourth ANC-related activities is covered. For fourth ANC check-up the pregnant woman does not get any financial benefit.

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

Follow-up of action plan is important, I think. For example, in case of maternal death, whether all the maternal deaths have been audited that needs proper follow up. This I think is little difficult.

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

After the formation of different health districts for S24PGS and Diamond Harbour Health District (DHHD), the accounts related fund monitoring came very much in grip. Since earlier S24PGS was a large district with so many programmes and expenditures for them, management of funds and maintaining accounts data for all the blocks was difficult. The challenge I would say, for the new district that has been formed, some work or programmes that are in pipeline yet can have difficulty in getting funds on time. And since we cannot have inter-district fund transfer that can be a difficulty. Since state has also told us to meet the fund

requirements for some health programmes if funds are not immediately available, from the available resources. So always the fund flow will be smooth cannot be expected. But overall the formation of health districts has helped a lot. Since already due to Sunderban area there are many programmes running in the district. So as a result it is difficult to cater to these programmes for the programme officer and DAM.

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

Yes, prioritisation of health-related problems is being done by us since there is a time factor, so prioritisation needs to be done so that to know which needs to be done earlier.

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

Interdepartmental workflow has certainly improved. At the Panchayat level whether it has increased or not, I can say I have seen their involvement in block-level meetings at some places I visited. But a marked level of involvement from Panchayat is not there. I have not noticed any active participation from their end.

I think general administration has good working relationship and interaction with health at the district level. At block level there are some short comings.

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

Yes, the NGOs also have a training schedule e.g. for ASHA training conducted by CINI based on the block achievement list shared in the monthly district meeting (Samity meeting) prepared by UNICEF [United Nations Children's Fund]. This creates a healthy competition among blocks also to perform better. This was DIPH process and follow-up for blocks is helpful.

Some reports are submitted by the NGOs such as ASHA training report is collected by me from them. Also sometimes when UNICEF provides fund for certain programmes such as Integrated Management of Neonatal and Childhood Illness, then we also have to give the report to UNICEF based on the utilisation. We submitted the utilisation report to UNICEF in their specific format.

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

The circulation of meeting dates for knowledge of all participants should be done seven to ten days earlier. Regarding engagement of all stakeholders, it is fine.

For accounts data, I think an online website/database or portal should be developed related to the programmes where expenditure details can be entered and, fund flow and available funds can be checked, very similar to health data. This should be updated and entered at block and district levels. This will be very helpful for account management in the district.

A3.2: In-depth interview with DSM

IDI details	
IDI label	112_GSN_AB_29Sep2016
Interviewer	Antara Roygatak
Note taker	Antara Royghatak
Transcriber	Sayan Ghosh
Respondent details	
Date and time of interview	29 September 2016; 2.44 pm
Name of participant	Mr Salil Baral
Gender	Male
Designation	DSM, S24PGS and DHHD
Department	Department of Health and Family Welfare
Duration of service in the district	10+ Years
Previous position	Private sector
Qualification	BSc, MCA
Years of experience in present department	10 years
Membership in committees pertaining to health	None

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

As such there was no visible distinguish difference can be observed from the DIPH process. It is a process, which was already started in the government system. The document collected during the DIPH process were also maintained before the initiation of the DIPH cycles. But the difference is, now it is become more structured, the block people maintained it properly, so easy to access if needed. Under DIPH a system was built to maintain the process and structured the documentation. Data usage and analysis are going on the same process (started before DIPH). So overall there was no such difference.

Another point is new, under each step of the cycle analysis was conducted. Which is very useful tool. Previously we used to conduct a huge analysis for all the indicators after receiving the data from the blocks. After that we found many times, the analysis of each indicator are not needed. So a streamlining of the data processing is happened under DIPH. Which was very much needed.

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

The steps of each cycles of DIPH is useful. Out of the five steps 'follow-up of the action points' is the most valuable/important step for me. Other steps we are normally follow (not as steps wise) in our regular programme cycles, but regular follow-up of action points is become a challenge to us. Which was done very rigorously first in the ANANDI programme. Now that started in the DIPH programme. Follow-up and sharing of feedback to the stakeholders is very much important. Which is started by reviewing the achievement of action points in each cycle and follow-up for progress in every month. As an example, specific indicator of MCTS uploaded by the block, it is necessary every month to review the development and discuss that in the next meeting and goal set up for upcoming month. Which was not possible every time for all the districts. So quarterly updating the data is a very much needed initiative by DIPH. Because it cannot be visible every month. There should be a monthly monitoring options to monitor the monthly progress.

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

Fourth ANC updating is the theme for Cycle 2.

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

DIPH is a process. Under that process there are developmental tools for supporting action. Those tools are utilised for regular monitoring. Specific follow-up of the issues can give good result. Like fourth ANC, it was not properly followed up and reported. There was a huge gap observed. Which become a challenge for increase institutional delivery. From that aspect increase in fourth ANC it's important, where ANM supposed to visit her home for antenatal check-up. During that ANM orient them once again on the preparedness for institutional delivery. Which will lead to a safe delivery. Starting from last menstrual period to delivery of a child, the action plan developed through MCTS. That can be follow day by day. ASHA and ANM can motivate her and the family to access the services provided by the government sector. Not to choose the home delivery or service from private nursing homes. All the skilled birth attendant trained nurses and doctors are there to provide quality service. But that monitoring is not done properly. So it create the scope of development for DIPH. And on that DIPH is working.

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

There are data available and we used to analysis that. But by the DIPH process more indicator-specific analysis was conducted. This analysis is helping the district to identify the priority areas. Like from those data we can identify the Canning-I, -II and Basanti as under developed, where huge number of home delivery were conducted. On the basis of those data we started constant follow-up, like mothers meetings, community meetings. Extra emphasis given to the concern BMOHs for motivate community towards institutional delivery. From that the institutional delivery increase and that has been monitored by the data sets.

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

Yes, DIPH is a data-based monitoring process. The data are indicator-specific and depending the action plan made to boost up a specific indicators. Which generally found low performing in the MCTS and HMIS. Which are the performance monitoring indicators. So after making action plan for that particular indicator, some performance indicators are identify for monitoring the progress of those action points. Which are mainly numeric data and those are monitored regularly to know the progress of the action points. That also been shared in the monthly reproductive and child health-Management Information and Evaluation System meetings. So all the blocks can know there status.

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

To increase institutional delivery, obviously Panchayat is playing a major role. Without the involvement of PRD, this type of the development is not possible. ICDS also having role in school health. They [ICDS] sharing data for identification of pregnant women and school health programme. On that basis we [Department of Health and Family Welfare] have reviewed the progress. In the convergence meeting all the data are shared across the departments. There are many convergence meetings happened under the supervision of district magistrate, like standing committee, vigilance committee, development meeting it is become a common and compulsory across the departments. So all the issues are covered in those meetings.

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

The information from NGOs and private sector, who are involved with government programme can be accessed properly. Like data from Community Delivery Centre and Ayushmoti nursing homes are analysed regularly. But other registered and unregistered nursing home data are not accessible to us. We had various meeting and in multiple forums we have raised the issue of the data access from the private sector. But still now that is not happened. If we are consider the institutional delivery data, it can increase 5% to 6% even some cases for up to 10% (in DHHD or Canning subdivision), where huge numbers of private nursing homes conducted institutional delivery. People believes that quality of service is better in private sector then the government-run hospitals. As per the district figures are concern, about 20% of the institutional deliveries conducted at nursing homes, Ayushmoti and Community Delivery Centre. And in the DIPH process also we are not been able to collect those data.

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

Already answered in previous question.

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

After divide into two separate health districts as DHHD and S24PGS, administratively it was easy to manage. But due to lake of human resource the quality of work suffers. Sometime delay also happens due to lake of human resources, as DHHDs post of DSM is vacant.

MCTS portal already separated but HMIS is a common portal, if that also divide into separate district then it will be easy to monitor the district wise performance. Now I am looking into both of the district, so not facing any problem. But in future when DSM appointed at DHHD,

then it can create confusion among two DSM for HMIS data uploading.

DIPH should not having a separate reporting system. It should merged with other existing reporting system. Otherwise it will be an extra work load to the DEOs.

Unable to involve the private sector for analysis of the situation at the district level.

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

The five steps of DIPH are very scientific approach from planning to monitoring and implementation. But practically it is difficult to follow the process, due to multiple meetings planned under the steps. If the number of meetings can be reduced then it will be a more acceptable to the system.

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

More involvement of other sector is very much needed. If CD and PRD are depends on health department for data access. That is not acceptable. All of them are equally responsible towards the community. So they have to generate the data by them and share with other line departments.

The DIPH process should not be dependent on a specific human resource (like DSM). Because that particular post having many others responsibility. So it can have a point person, but responsibility should be distributed across the departments. By that the co-ordination will increase and DIPH can have a better result.

A3.3: In-depth interview with Dy. CMOH-III

IDI details	
IDI label	113_GSN_AB_26Oct2016
Interviewer	Antara Bhattacharya
Note taker	Antara Bhattacharya
Transcriber	Antara Bhattacharya
Respondent details	
Date and time of interview	26 October 2016
Name of participant	Dr Bhaskar Baishnab
Gender	Male
Designation	Deputy CMOH-III, S24PGS
Department	Health
Duration of service in the district	1 year
Previous position	ACMOH
Qualification	MBBS, DPH
Years of experience in present department	More than 16 years
Membership in committees pertaining to health	Membership from Indian Medical Association (IMA) for registered doctors

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

Under DIPH we are using our data to prioritise. In a resource poor district like S24PGS we have to prioritise and target specific agenda so that with low resources we can reach maximum people and those areas where it is maximum needed. So this has been helped by DIPH.

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

All the steps are important. Because the situation analysis is according to the performance report and manpower data, human resources status. Prioritisation is where it is most needed. Then developing action plan based on who are the stakeholders and how to approach the manpower resources most effectively and then follow up of what we have done. First situation analysis and then prioritisation is more important.

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

In institutional delivery still there are lots of areas where lot of home deliveries are occurring per block. More than 1,000 home deliveries are there in almost three or four blocks. So these blocks need to be prioritised and the mothers to be reached to give them the message that they should come for institutional delivery. Also immunisation is an important area where more efforts have to be given to identify and target the missing children who cannot be registered for immunisation. This can be for many different reasons and also this represents a major section of missing children from immunisation schedule. To track these missing children no record or line list is there or capturing of data is done anywhere.

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

Yes, some places have the resources but the performance is not so up to the mark and some places are there where human resources are not being utilised up to the maximum level. So after the situation analysis this can be identified and used to help in identifying the priorities.

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

Yes, it was being done and now it is followed more effectively. We use the data for analysing whether the target is being fulfilled and then we fix some target for the service providers and then we analyse their performance and we set them a new target.

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

It has helped to some extent because convergence was already there but this DIPH has improved it little more. Because convergence was there but sometimes the other departments were reluctant. During this DIPH process they became more interested and they participated. It helped in data-sharing between inter-departments. It was there but DIPH process enhanced it.

7. Did the maternal and child health NGO sector achieve involvement through the DIPH process?

NGOs were not directly involved. And private sector is not much involved in this district.

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

DIPH process challenge is we should be more vocal. DIPH process is being done within few stakeholders at district level. So we have to involve the block-level and grassroots-level stakeholders more. Because still BMOH and block-level stakeholders are not taking much interest as we thought they would take.

We can call ACMOH also at least subdivision level. The ACMOH level tier is little underutilised since we directly call the BMOHs for the meetings. But as per norm first sub-divisional meeting then the ACMOHs will represent their respective subdivisions. So we can try this in DIPH where we involve the ACMOHs and the ACMOHs call the meetings of the blocks under their subdivision. ACMOH then should come and tell the district what they have done. So this thing, involvement of the ACMOHs we can start in the DIPH process.

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

Involvement of ACMOHs – the middle tier for the meetings. We are directly calling the BMOHs but if ACMOHs call the BMOHs and we go over there for the meeting. Later ACMOH come to the district and gives their feedback for respective blocks it will be better.

A.4: Monitoring Format with Definitions

A.4.1: Monitoring framework[27]

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

[27]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.

	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 DIPH)** **Action points:** a specific task taken to achieve a specific objective *In 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 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 of specified data	Form 1B: Health system capacity assessments
		8. Whether the health system data on the specified theme area is up-to-date as per the given DIPH cycle? (Y/N) ***Up-to-date data*** ***a)*** If monthly data, then the previous complete month at the time of Step 1 of the DIPH cycle ***b)*** If annual data, then the complete last year at the time of Step 1 of the DIPH cycle	Form 1B: Health system capacity assessments
II. **Interactions among stakeholders: co-operation in decision-making, planning and implementation** Whether the DIPH study ensured involvement of stakeholders from different sectors (health, non-health and NGO/private for-profit	E. Extent of stakeholder participation	**1. (Number of DIPH stakeholders present in the planning actions meeting) / (total number of DIPH stakeholders officially invited in the planning actions meeting)** *Participants in Steps 4 and 5* **DIPH stakeholders*:*** public and private sector departments, organisations and bodies relevant for the specific cycle of the DIPH **Officially invited:** stakeholders formally being invited to participate for the specific DIPH cycle	Form A.2: Record of Proceedings – Summary Table

organisations)		*In the West Bengal context, for example:* • *Public sector stakeholders: Department of Health and Family Welfare; PRD; and CD* • *Private sector stakeholders: NGOs; nursing homes; and large hospitals owned by private entities*	
		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 action points for the primary theme of the DIPH)	Form 4: Plan
	G. Factors influencing co-operation among	**10. List of facilitating factors** **1.** **2.**	Form A.3: In-Depth Interview with Stakeholders

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

		trained for the primary theme-specific action points) / (total human resources training requested as per action points of the DIPH primary theme)	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.** **3.**	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.

Follow us

IDEAS
Web: ideas.lshtm.ac.uk
Twitter: @LSHTM_IDEAS
Facebook: MaternalAndNewBornHealth

Contact us

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

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

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

Published by The London School of Hygiene & Tropical Medicine
Copyright IDEAS 2017