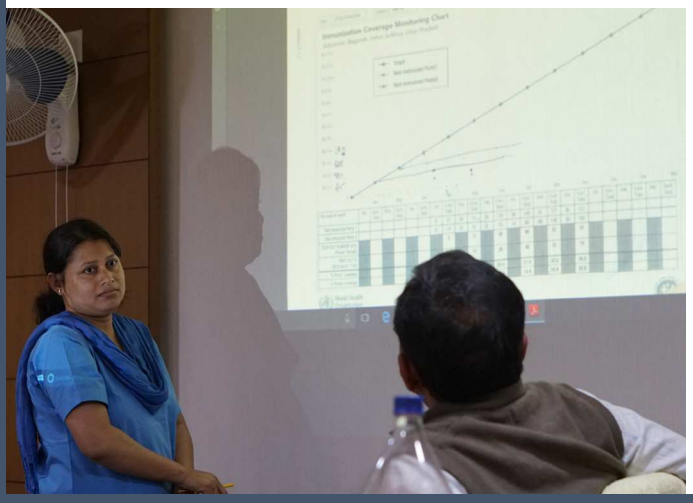

DIPH

The Data-Informed Platform for Health

Structured district decision-making using local data

MONITORING REPORT
Cycle 2: June - November 2016

Diamond Harbour
West Bengal, India

DATA INFORMED PLATFORM FOR HEALTH

MONITORING REPORT

Diamond Harbour Health District, West Bengal, India

Cycle 2: June – November 2016

ACKNOWLEDGEMENTS

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KNOWLEDGE TO ACTION phfi PUBLIC HEALTH FOUNDATION OF INDIA

IDEAS Evidence to improve maternal & newborn health

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

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LIST OF ABBREVIATIONS

ACMOH	Assistant Chief Medical Officer of Health
ADM	Additional District Magistrate
ADM-G	Additional District Magistrate-General
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BAF	Block ASHA Facilitator
BAM	Block Accounts Manager
BCC	Behaviour Change Communication
BDO	Block Development Officer
BMOH	Block Medical Officer of Health
BPHN	Block Public Health Nurse
CD	Child Development
CDPO	Child Development Project Officer
CMOH	Chief Medical Officer of Health
CUG	Closed User Group
DEO	Data Entry Operator
DHHD	Diamond Harbour Health District
DIPH	Data Informed Platform for Health
DMCHO	District Maternity and Child Health Officer
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-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
IPHS	Indian Public Health Standards
MCH	Maternal and Child Health
MCTS	Mother and Child Tracking System
NGO	Non-Governmental Organisations
PHFI	Public Health Foundation of India
PHN	Public Health Nurse
PHPC	Public Health Programme Co-ordinator
PMSMA	Pradhan Mantri Surakshit Matritva Abhiayan
PRD	Panchayat and Rural Development
RCH	Reproductive and Child Health
S24PGS	South 24 Parganas
SHG	Self-Help Group
SHIS	Southern Health Improvement Samity
UNICEF	United Nations Children's Fund
VHND	Village Health and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee

1. INTRODUCTION

Data Informed Platform for Health (DIPH)		
Cycle no.	2	
District	Diamond Harbour Health District	
Duration	June – November 2016	
Theme	Improving the quality of antenatal care	
Steps involved	Step 1	**Assess:** Aligning with the Prime Minister's safe motherhood programme *Pradhan Mantri Surakshit Matritva Abhiayan* (PMSMA) (MoHFW, 2016a), the DIPH stakeholders assessed gaps in service provision and selected the theme in consultation with the non-health departments 'Improving the quality of antenatal care (ANC)' for Cycle 2 of the DIPH. They utilised data from the Mother and Child Tracking System (MCTS) and the Health Management Information System (HMIS) (MoHFW, 2016b; 2016c). As the non-health departments do not maintain data to the theme indicators, the situation assessment only used data from the Department of Health and Family Welfare.
	Step 2	**Engage:** The primary responsibility for Cycle 2 was with the Department of Health and Family Welfare, while departments of Child Development (CD) and the Panchayat and Rural Development (PRD) 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 private for-profit organisations did not receive an official invitation to take part in the DIPH process.
	Step 3	**Define:** Based on the theme, the stakeholders identified 17 problems and prioritised them under the following: service delivery; workforce; supplies and technology; health information; and policy and governance. Majority of the problems (41%) were under 'service delivery'. They formulated 23 actionable solutions to address the identified problems, in keeping with the cycle duration and capacity of the district administration.
	Step 4	**Plan:** The stakeholders developed 23 action points (and 45 indicators) to achieve the target and assigned responsibilities across departments within a given time frame. Majority of the responsibilities (65%) were for the Department of Health and Family Welfare, whereas the CD (30%) and PRD (5%) shared the remaining responsibilities.
	Step 5	**Follow-up:** Stakeholders attended a meeting before the Step 5 meeting to facilitate follow-up of the action plan. Out of the 23 action points, 22 action points (96%) started during the cycle period. Twenty action points (87%) had completed within the specified timeline. The two remaining action points received a new timeline. One action point did not start during the cycle period, the non-responsiveness of a concerned stakeholder (CD) led to the cancellation of this action point. The theme leader monitored the progress through monthly reports (from district personnel responsible for each action point).

2. METHODS

Sl. No	Data sources	Lead among DIPH stakeholders	Time frame
1	**Step 1**: **Assess** Form 1A.1: Data extraction from state and district health policy documents Form 1B: Health system capacity assessments Form 1B.1: Sub-district level (block) performance of selected indicators	Theme leader of the DIPH Cycle 2	15 June 2016
2	**Step 2: Engage** Form 2: Engage	Theme leader of the DIPH Cycle 2	15 June 2016
3	**Step 3: Define** Form 3: Define	Theme leader of the DIPH Cycle 2	15 June 2016
4	**Step 4: Plan** Form 4: Plan	Theme leader of the DIPH Cycle 2	16 June 2016
5	**Step 5: Follow-up** Form 5: Follow-up	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, Diamond Harbour Health District (DHHD)	June – November 2016
7	**In-Depth Interviews with Stakeholders** Form A.3.1: Child Development Project Officer (CDPO)	Interviewed by the DIPH research team, DHHD	03 October 2016
	Form A.3.2: Dy. CMOH-III, DHHD		20 October 2016
	Form A.3.3: Public Health Programme Co-ordinator (PHPC)		21 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 'Improving the quality of ANC'. The PMSMA, during June 2016, aimed at providing free health check-ups and treatment to all pregnant women across the country (MoHFW, 2016a). The stakeholders utilised data from MCTS and HMIS to assess the gaps in antenatal services (MoHFW, 2016b; 2016c). 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. Therefore, theme identification did not involve using data from the non-health departments.

3.1.2 Challenges in data utilisation

The major hindrance with data utilisation was the non-sharing of information between departments. Also, there was no mechanism to ensure data from private providers and NGOs. Though some of the departments collect large volumes of data, they do not analyse the data as they have no training on analysis.

> "Analysis of data is very much important. In ICDS [Integrated Child Development Services] we are used to collect data on huge numbers of indicators. But we are not been able to review all of those. We always focusing on the some of the core indicators. Now that review is started with the DIPH project." (CDPO, DHHD)

> "Block officials just submit the reports prepared by some other person like Data Entry Operator [DEO], Public Health Nurse [PHN] or Block Accounts Manager [BAM]. But now [after introduction of DIPH] they started to look into the reports." (Dy. CMOH-III, DHHD)

3.1.3. Proposed solutions

The position of district statistical manager (DSM) of the District Programme Management Unit (DPMU), National Health Mission was vacant. The DSM of South 24 Parganas (S24PGS) therefore, had additional responsibility to support the DHHD. The group proposed filling the post of DSM on a temporary basis from the existing staff to support the DHHD. This was a concern raised during Cycle 1, but no action has taken place until now.

Table 1: Utilisation of data at district level

Purpose	Indicators		Response (Yes/No, proportion)	Source of information
Whether the DIPH study led to the utilisation of the health system data or policy directive at district level for decision-making?	A. Selection of the primary theme for the current DIPH cycle	1. Whether the DIPH cycle theme selection was based on HMIS data? (Y/N)	Yes[1]	Form 1B
		2. Whether the DIPH cycle theme selection used any data from non-health departments? (Y/N)	No[2]	Form 1B
		3. Whether the DIPH cycle theme selection was based on health policy and programme directives? (Y/N)	Yes[3]	Form 1.A.1
	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 using data) / (total number of action points for the primary theme of the DIPH)	23/23 = 100[4]	Form 5

[1]The theme selection used data from MCTS and HMIS (MoHFW, 2016b; 2016c).

[2]The non-health departments (PRD and CD) motivate people for antenatal check-up; however, they do not maintain any data on the discussed theme. Hence, they could not contribute data during theme selection.

[3]The DIPH stakeholders adhered to the components of the recently introduced scheme of the Prime Minister's safe motherhood programme (PMSMA) (MoHFW, 2016a).

[4] Indicators developed and monitored for all action points.

	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(0/0) [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)	Yes[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)	Yes[8]	Form 1B

3.2 Interaction among stakeholders

The DIPH process provides a platform for different stakeholder departments (health, non-health, NGO and private for-profit organisations) to come together and discuss the public health concerns at the district. However, the participation and interaction among the different stakeholders are often less than satisfactory.

3.2.1 Interaction between health and non-health departments

Majority of participants (81%) were from the Department of Health and Family Welfare. The CD only took part during Step 4 and the district administration only took part during Step 5. Fifteen out of the 23 action points were under the responsibility of the health department while the CD shared seven action points and the PRD shared only one action point. This indicates that participants still perceive the DIPH as a health department initiative.

> "There is a co-ordination system (for departments) exist in paper. Though there is huge a scope to enhance the interaction between health and non-health departments, it is not explored till now. This theoretical process is initiated with the DIPH. All the line departments (who are responsible for action points) are involved in the process, starting from Steps 1 to 5. While other departments participate only in the initial planning phase, and keep a distance from implementation and monitoring." (Dy. CMOH-III, DHHD)

[5]Though stakeholders discussed the quality of data available, there was no suggestion to revise any data element.
[6]There was no suggestion to add data elements.
[7]Data on the specific indicator were available from MCTS and HMIS (MoHFW, 2016b; 2016c). (See Form 1B, Sl. No. 3.1 and 3.3.)
[8]The data on theme-specific indicator (coverage of third and fourth ANC) were up-to-date as MCTS and HMIS follow a monthly reporting system (MoHFW, 2016b; 2016c). (DSM post was vacant in DHHD. DSM of S24PGS having the additional charge).

3.2.2 Interaction between the health department and NGOs

There are a few NGOs such as Southern Health Improvement Samity (SHIS), Kamdevpur Rural Development Society, Sundarban Social Development Committee, Child in Need Institute, and Sabuj Sanghaand Sarbik Vivekanand that provide training to Accredited Social Health Activists (ASHAs) and run Community Delivery Centres in a few blocks. However, the district authorities felt that no single NGO covers the whole district and, hence, did not take interest in inviting them to the DIPH meeting. The United Nations Children's Fund (UNICEF) has a programme with the district. Their co-ordinator is present at the office but does not have any interaction with the DIPH project.

> "In many issues they [NGOs] provide support to the government […] There are called in some meetings because of the government order. But the suggestions or the reports submitted by them are not accepted. While the organisations like PHFI [Public Health Foundation of India] and UNICEF are well accepted because of their organisational status […] Branding [of NGO] also is an issue." (PHPC, S24PGS)

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

There was no interaction between the private sector and other DIPH stakeholders. A major gap highlighted by stakeholders was the absence of a specific reporting structure for monitoring of private players by the district health department.

> "No need to involved private sector if we can utilise the NGO and government properly." (PHPC, S24PGS)

Table 2: Interactions among stakeholders

Purpose	Indicators		Response (Yes/No, proportions)	Source of information
Whether the DIPH study ensured involvement of stakeholders from different sectors (health, non-health and NGO/private-for-profit organisations)	E. Extent of stakeholder participation	1. (Number of DIPH stakeholders present in the planning actions meeting) / (total number of DIPH stakeholders officially invited in the planning actions meeting)	64/73 = 87.6[9]	Form A.2
		2. (Number of representatives from the health department present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting)	59/73 = 80.8[10]	Form A.2
		3. (Number of representatives from non-	7/73= 9.6[11]	Form A.2

[9]The invitees that took part in Steps 4 and 5 were less than the total invitees. The CD took part only in Step 4 and the district administration took part only in Step 5.

[10]Majority of participants were from the health department.

[11]Representations from CD, PRD and the district administration was minimal.

		health departments present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting)		
		4. (Number of representatives from NGOs present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting)	0 (0/73)[12]	Form A.2
		5. (Number of representatives from private for-profit organisations present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting)	0 (0/73)[13]	Form A.2
	F. Responsibilities assigned to stakeholders[14]	6. (Number of action points with responsibilities of the health department) / (total number of action points for the primary theme of the DIPH)	15/23 = 65.2[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)	8/23 = 34.8[15]	Form 4
		8. (Number of action points with responsibilities of NGOs) / (total number of action points for the primary theme of DIPH)	0 (0/23)[16]	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 (0/23)[17]	Form 4
	G. Factors influencing co-operation among health,	**10. List of facilitating factors**	1. Chief medical officer of health (CMOH) is very supportive 2. Theme leader of Cycle	Form A3

[12]Though there were a few NGOs, stakeholders did not officially invite them.

[13]There was no participation from the private sector.

[14]Majority of the action points were with the Department of Health and Family Welfare.

[15] Non-health departments shared the responsibility for eight of the action points.

[16] The DIPH process did not directly involve the NGOs.

[17] The DIPH process did not involve the private for-profit organisations.

	non-health and NGO/private for-profit organisations to achieve the specific action points in the given DIPH cycle		2 (Dy. CMOH-III) is a very knowledgeable person and has interest in the DIPH process	
		11. List of challenging factors	1. Non-co-operation from the CD is a challenge. Even though they discussed several concerns, the implementation of corresponding action points was poor. They were reluctant to share the monthly reports 2. There are changes in the responsibilities of the block medical officer of health (BMOH), which delayed some of the activities at field level 3. Though there is interaction between the PRD and the Department of Health and Family Welfare at district level, it is almost non-existent at sub-district level	Form A3

3.3 Progress with action points

3.3.1 Action points accomplished

Out of the 23 action points, 22 action points started during the cycle period and 20 action points had completed by the Step 5 meeting.

1 Specify the responsibilities of frontline workers (FLWs) and other stakeholders.
2 Recognition of good work/job by FLWs.
3 Prepare, share and review the list of pregnant women (by ASHA, auxiliary nurse midwife [ANM], Anganwadi worker [AWW]) in third Saturday meeting or any other meeting).
4 Sensitisation activities (i.e. information, education and communication [IEC], counselling) for pregnant women/family and community (by PRD, CD and the Department of Health and Family Welfare).
5 Wall writing for generating awareness among community members for early registration and Janani Suraksha Yojana benefits.
6 Provide refresher training and discuss in monthly meeting the signs and symptoms of high-risk pregnancy.
7 Sub-centre-wise reporting of high-risk cases identified by the ANMs.
8 Conducting supportive supervision by block-level officials and periodically by district-level officials.

9 Monthly reporting on field visit on how many mothers contacted and status of risk factors back-checked by block-level officials.
10 Counselling-related reporting: number of pregnant women counselled; on what issue; are they convinced; and any follow-up carried out to know the positive changes?
11 Village Health and Nutrition Day (VHND) planning and implementation by health department, CD and PRD with equal responsibility.
12 Efficient use of time by data entry staff at block level with supervision by block-level officials.
13 Alternate internet connectivity for specific area.
14 Sample review of data for quality improvement.
15 Ensuring timely reporting of data/submission of Mother and Child Protection cards for data entry
16 Recruitment of staff – proposal to state to sanction and process recruitment
17 Proposal for training/refresher courses at district/block levels for ICDS workers
18 Departmental co-ordination required for capacity building of block-level staff (health department and ICDS)
19 Issues on sharing with state and national level an online portal
20 Training for data entry (for ICDS staff)

3.3.2 Action points ongoing

The following two action points are ongoing and continuing onto the next cycle:

1. Proposal to state to purchase baby weighing machines for ICDS
2. Proper planning of VHND along with ICDS in fixing the place and timings of the VHNDs

3.3.3 Action points not started

One action point did not start during Cycle 2:

1. Propose to district magistrate/state to issue guidelines for AWWs

This action point was the shared responsibility of the CD. However, due to their limited responsiveness, even after repeated follow up, resulted in cancelling the action point following discussions with the district magistrate.

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)	22/23 = 95.65[18]	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)	20/23 = 86.95[19]	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[20]	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[21]	Form 5
		5. (Units of specific medicine provided for the primary theme-specific action points) / (total units of specific medicine requested as per action points of the DIPH primary theme)	0/0[22]	Form 5
		6. (Units of specific equipment provided for the primary theme-specific action points) / (total units of specific equipment	0/0[23]	Form 5

[18]Out of the 23 action points, 22 action points started within the cycle under the Department of Health and Family Welfare (15 action points), CD (six action points) and PRD (one action point). The CD was responsible for the remaining one action point.

[19]Out of the 23 action points, 20 action points completed by Step 5. Two action points are ongoing and on target. One action point not started.

[20]No written letter/directive issued by the district or state authority. All communications were via telephone or verbal.

[21]No request for finance made during Cycle 2.

[22] There was a requirement of Iron Folic Acid and Tetanus Toxoid for this particular theme. The supply was more than the requirement, so district authority did not maintain a specific record.

[23] No specific equipment required as per the selected theme.

		requested as per action points of the DIPH primary theme)		
		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[24]	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)	365/600= 60.83[25]	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)	4,705/7,500= 62.7% [26]	Forms 4 and 5
	J. Factors influencing the achievements as per action points of the DIPH primary theme	**10. List of facilitating factors**	1. Since it was Cycle 2, the stakeholders were familiar with the process 2. The theme is on a regular activity, which reduced the risk of additional work on stakeholders 3. District-level stakeholders were able to visualise the positive changes as per the goal. The review and progress of indicators motivated them further	Form A.3
		11. List of challenging factors	1. No reports received from ICDS. Only two sub-districts (Kulpi and Patharpratima) submitted reports for July and August 2016, and these too were incomplete 2. Irregularity in monthly reporting; need to send several reminders to some specific blocks 3. Community/sub-district-	Form A.3

[24]There was planning for behaviour change communication (BCC) activities, but no demand for IEC materials on the theme as the availability was not highlighted as an issue during the Step 4 meeting.

[25]Recruitment of staff was an issue highlighted by the CD. The achievement was 60.83% of the targeted recruitment during the cycle period.

[26]The action points specified training of staff and the coverage reported was 63%.

			level ownership of the process is a challenge. Ground-level staff (e.g. DEOs) considered the DIPH reporting as extra work	

3.4 Sustainability of the DIPH

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

3.4.1 Data source

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

3.4.2 Facilitators within the district

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

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. Also, PRD faces staff shortages.
- 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.
- Availability and quality of data.
- Though the dependence on the DIPH research team reduced from Cycle 1, the stakeholders still require regular follow-up (reminder) by the research co-ordinator.
- Though the interdepartmental co-ordination is improving, 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 suggest a 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, block public health nurses (BPHNs) and CDPOs during Steps 4 and 5 for better implementation of the action plan.

REFERENCES

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.

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

ANNEXES

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

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

Document title:	PMSMA Guidelines, Indian Public Health Standards (IPHS)
Date of release:	15 June 2016
Goal as stated in the document:	1. Increase 5% in registration of all pregnant women (from baseline) 2. Increase coverage of third antenatal check-up (100% of registered pregnant women) 3. Improve tracking of fourth antenatal check-up (up to 60%) 4. Increase the identification of high-risk pregnant women and referrals to ANC clinic 5. Total coverage (100%) of all mandated vital examination and laboratory tests for all registered pregnant women 6. Total distribution (100%) of Iron Folic Acid tablets and Tetanus Toxoid 2/booster to registered pregnant women 7. Completeness of counselling to pregnant women in terms of coverage and content
Action points specified by the document	
1	Identification and registration of all pregnant women by first trimester of pregnancy
2	Minimum three antenatal check-ups to all registered pregnant women
3	Ensuring fourth antenatal check-up to all pregnant women
4	Identification of high-risk pregnant women and prompt referral
5	Distribution of Iron Folic Acid tablets and Tetanus Toxoid 2/booster dose
6	Every pregnant woman to be counselled individually or in groups, on: nutrition; rest; safe sex; birth preparedness; identification of danger signs; advice on institutional delivery; family planning; early initiation and exclusive breastfeeding; and child immunisation

Form 1B: Health system capacity assessment

SI. No.	Particulars			
1	**District demographic details**	**Information**	**Source**	**Source detail**
1.1	Total area(square km)	4,094	District Demography	http://north24parganas.gov.in/n24p/page.php?nm=Demography
1.2	Total population	10,009,781	District Census Handbook − 2011	http://www.censusindia.gov.in/2011census/dchb/1911_PART_B_DCHB_NORTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.3	Number of women in reproductive age (15-49 years)	396,403	Eligible Couple Contraceptive Register	http://www.censusindia.gov.in/2011census/dchb/1911_PART_B_DCHB_NORTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.4	Number of children under five years	957,973	District Census Handbook – 2011	http://www.censusindia.gov.in/2011census/dchb/1911_PART_B_DCHB_NORTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.5	Rural population (%)	42.73	District Census Handbook − 2011	http://www.censusindia.gov.in/2011census/dchb/1911_PART_B_DCHB_NORTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.6	Scheduled Caste population (%)	21.70	District Census Handbook − 2011	http://www.censusindia.gov.in/2011census/dchb/1911_PART_B_DCHB_NORTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.7	Scheduled Tribe population (%)	2.60	District Census Handbook – 2011	http://www.censusindia.gov.in/2011census/dchb/1911_PART_B_DCHB_NORTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.8	Population density (persons/square km)	2,445	District Census Handbook − 2011	http://www.censusindia.gov.in/2011census/dchb/1911_PART_B_DCHB_NORTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.9	Total literacy (%)	84.95	District Census Handbook – 2011	http://www.censusindia.gov.in/2011census/dchb/1911_PART_B_DCHB_NORTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.10	Female literacy (%)	80.34	District Census Handbook – 2011	http://www.censusindia.gov.in/2011census/dchb/1911_PART_B_DCHB_NORTH%20TWENTY%20FOUR%20PARGANAS.pdf

1.11	**Key NGOs**	
	NGO name	**Contact details**
1.11.1	Gana Unnayan Parishad	Ms Sutapa Dewanji, Assistant Secretary Cum Director; www.gup-ngo-india.org, E-mail – gup1984@bsnl.in & gup_rch@rediffmail.com, Phone – +91-33-22652403 / 24413421
1.11.2	Sarvik	www.sarvikvivekananda.com, E-mail – office@sarvikvivekananda.com, Phone – +9133 2654 – 2328 / 5112 Fax – +9133 2654 – 5112
1.11.3	SHIS	Md Wahab, Director, www.shisindia.org, E-mail – mawohab@yahoo.com, Phone – 0091 3218-270245, Fax – 0091 3218 271969

1.12	**Key private stakeholders**	

	Private stakeholder name	Contact details		
1.12.1	Indian Medical Association – branch in North 24 Parganas	Dr Tapan Kr. Biswas, President; www.imabarasatbranch.in		

2	Expected coverage as per IPHS				
	Theme	Coverage indicators	Source	Data	Gap
	Increase in three antenatal visits and improvement in tracking fourth antenatal visit	Pregnant women registered in first trimester to total ANC registration (%)	MCTS	86	14.00
		Pregnant women who had at least three antenatal check-ups to total ANC registration (%)	MCTS	81	19.00
		Pregnant women who had four antenatal check-ups to total ANC registration (%)	MCTS	52	48.00

3 Theme: Increase in three antenatal visits and improvement in tracking fourth antenatal visit					
	Details	*Sanctioned (2014/15)*	Available / functional	*Gap*	
3.1Infrastructure					
3.1.1	Sub-centre	742	742	0	
3.1.2	Public health centre	22	22	0	
3.1.3	Block public health centre	11	11	0	
3.1.4	Rural hospital	1	1	0	
3.1.5	Sub-divisional hospital	2	2	0	
3.1.6	District hospital	1	1	0	
3.2 General resources					
3.2.1 Finance					
3.2.1.1	Reproductive and child health (RCH) Flexible Pool – Maternal Health	90,616,777.78	90,616,777.78	0	
3.2.2 Supplies					
3.2.2.1	Iron Folic Acid tablet strips	48,000	48,000	0	
3.2.2.2	Tetanus Toxoid injections	42,600	42,600	0	
3.2.2.3	Blood sugar test kit	38,000	38,000	0	
3.2.3 Technology					
3.2.3.1	Data capturing units of HMIS and MCTS	12	12	0	
3.3 Human resources					
3.3.1	BMOH	12	12	0	
3.3.2	General duty medical officer	64	62	2	
3.3.3	BPHN	12	12	0	
3.3.4	PHN	22	14	8	
3.3.5	Gram Panchayat health supervisor	110	98	12	
3.3.6	ANM	848	781	67	
3.3.7	ASHA	2,309	1,747	562	
3.3.8	AWW	10,245	9,604	641	

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

SI. No.	Sub-districts	Theme name: Improving the quality of ANC		
		Coverage indicators		
		Pregnant women registered in first trimester to total ANC registration (%)	Pregnant women who had at least three antenatal check-ups to total ANC registration (%)	Pregnant women who had four antenatal check-ups to total ANC registration (%)
1	Amdanga	90.00	82.00	56.00
2	Bagdah	88.00	91.00	45.00
3	Bongaon	88.00	87.00	44.00
4	Barasat-I	87.00	86.00	50.00
5	Barasat-II	85.00	88.00	71.00
6	Barrackpur-I	76.00	82.00	56.00
7	Barrackpur-II	73.00	83.00	60.00
8	Deganga	88.00	52.00	28.00
9	Gaighata	86.00	80.00	61.00
10	Habra-I	84.00	86.00	58.00
11	Habra-II	86.00	87.00	39.00
12	Rajarhat	86.00	82.00	69.00

Form 4: Plan

Total number of action points planned:		23
Responsibilities of different stakeholders		
	Department of Health and Family Welfare:	15
	CD:	7
	PRD:	1
	District administration:	

	Action points	Responsible stakeholder	Person responsible	Indicators		Unit of target	Target	Target date
1.Service delivery								
1.1.1	Plan training for Panchayat Pradhan/members	PRD	PHPC, Zilla Parishad	**a.**	Number of training arranged for Panchayat Pradhan and members (Swasthya Sanchalok) in co-ordination with the health department / total number of trainings planned	Number	12	September 2016
				b.	Number of Panchayat Pradhan and members (Swasthya Sanchalok) trained on maternal health /total number of Panchayat Pradhan and members (Swasthya Sanchalok)	Number	216	
1.2.1	Involvement of Self-help groups (SHGs) in VHND sessions	PRD	PHPC, Zilla Parishad with support from additional district magistrate-general (ADM-G)	**a.**	Number of SHGs sensitised to participate in VHND sessions / total number of SHGs working	Number	67	September 2016
				b.	Number of sensitisation meetings conducted with SHGs / total number of meetings planned	Number	13	
				c.	Number of VHND sessions conducted in support with SHGs / total number of VHND sessions planned	Number	3,732	

	Action points	Responsible stakeholder	Person responsible	Indicators		Unit of target	Target	Target date
1.2.2	Issue a guideline for conduct of VHNDs in co-ordination with CD	CD	District programme officer (DPO) – Women and Child Development and Social Welfare	**a.**	Issue a guideline jointly by CMOH and DPO-ICDS with district administration	Number	1	September 2016
				b.	Number of VHND sessions conducted in presence of AWWs / total number of VHND sessions conducted	Number	3,732	
1.3.1	Regularise outreach camps (proper infrastructure with privacy for pregnant women)	Department of Health and Family Welfare	BMOH	**a.**	Number of outreach camps organised with provision of proper arrangement (blood pressure machine, weight machine, foetal heart-rate check, etc.) for antenatal check-ups / total number of outreach camps organised	Number	1,596	Monthly; September 2016
1.4.1	Village Health Sanitation and Nutrition Committees (VHSNCs) and fourth Saturday meeting follow-up by district administration	PRD	PHPC, Zilla Parishad	**a.**	Number of VHSNC sessions monitored / total number of VHSNC sessions planned	Number	3,528	Monthly; September 2016
				b.	Issue a directive (written) to monitor and submit report on fourth Saturday meeting monitoring	Number	1	
				c.	Number of fourth Saturday meeting monitored / total number of fourth Saturday meetings conducted	Number	324	
1.5.1	Training plan for FLWs and ANMs on ANC	Department of Health and Family Welfare	BPHN	**a.**	Number of training arranged for FLWs on improvement on antenatal check-up / total number of trainings planned	Number	60	Monthly; September 2016
				b.	Number of ANMs trained on improvement on antenatal check-ups / total number of ANMs in position	Number	780	

	Action points	Responsible stakeholder	Person responsible	Indicators		Unit of target	Target	Target date
1.5.2	ANMs completing at least three antenatal check-ups at sub-centre and visits home for fourth antenatal check-up; submit reports on time	Department of Health and Family	BMOH	**a.**	Number of pregnant women registered / total number of estimated pregnant women	Number	12,672	Monthly; September 2016
				b.	Number of pregnant women received three antenatal check-ups / total estimated pregnant women eligible for three antenatal check-ups	Number	12,672	
				c.	Number of pregnant women received a home visit for fourth antenatal check-up / total number of estimated pregnant women for fourth antenatal check-up	Number	12,672	
2.Workforce								
2.1.1	Recruitment of vacant positions: medical officers, ANMs, ASHAs and other staff, e.g. health supervisors and block ASHA facilitator (BAF)	Department of Health and Family Welfare	CMOH (state responsibility)	**a.**	Number of medical officers recruited against the number of vacancies	Number	48	September 2016
				b.	Number of ANMs recruited against the number of vacancies	Number	60	
				c.	Number of ASHAs recruited against the number of vacancies	Number	552	
				d.	Number of other staff (Gram Panchayat health supervisor, BAF, PHN and ICDS supervisors) recruited against the number of vacancies	Number	36	
3.Supplies and technology								
3.1.1	To pursue proposal for procurement of mobile phone and Closed User Group (CUG) connections	Department of Health and Family Welfare	CMOH	**a.**	Submit a proposal in the next district Samity meeting to approve new connections for 33 ANMs and AWWs	Number	1	September 2016

	Action points	Responsible stakeholder	Person responsible	Indicators	Unit of target	Target	Target date
	for ANMs and AWWs						
4.Health information							
4.1.1	Use of second Tuesday platform at block level to share MCTS data regularly	District administration	Block development officer (BDO)	**a.** Number of meetings where MCTS data-sharing recorded / total number of meetings planned	Number	36	Monthly; September 2016
				b. Issue an order by district magistrate	Number	1	
5.Finance							
5.1.1	CMOH to pursue with state for insufficient funds supply in *District Programme Implementation Plan 2015/16**	Department of Health and Family Welfare	CMOH	**a.** Send a proposal to state to clear funds – on a needs basis	Number	1	July 2016
5.1.2	Incentives for ICDS and FLWs for attending VHNDs	Department of Health and Family Welfare	CMOH	**a.** Send a proposal in *District Programme Implementation Plan 2015/16*	Number	1	September 2016
6.Policy/governance							
6.1.1	District administration, CD and CMOH to pursue at state level for approval of funds/guidelines to start referral transport for antenatal check-ups	Department of Health and Family Welfare	CMOH	**a.** Send a proposal in *District Programme Implementation Plan 2015/16*	Number	1	September 2016
				b. Amount of funds sanctioned against proposed fund	Number	0	

* Department of Health and Family Welfare 2015, *District Programme Implementation Plan 2015/16*, Government of India, New Delhi.

Form 5: Follow-up

Part A

Theme: Improving the quality of ANC

Theme Leader: DMCHO

Number of meeting for the respective theme: 1

2. Major stakeholders involved in each meeting

Sl. No.	Date	Participants	Number of Participants
1	14 July 2016	District magistrate, CMOH, DMCHO, Dy. CMOH-III, deputy chief medical officer of health-I (Dy. CMOH-I), district public health and nursing officer, DPO-ICDS, PHPC - Zilla Parishad, DSM, district ASHA facilitator , RCH co-ordinator, Rashtriya Swasthya Bima Yojna co-ordinator, computer assistant – RCH, BMOH and BPHN, joint block development officer and CDPO of 22 blocks	93
2	19 August 2016	CMOH, Dy. CMOH-I, district public health and nursing officer, DPO-ICDS, PHPC - Zilla Parishad, DSM, district ASHA facilitator, RCH co-ordinator, Rashtriya Swasthya Bima Yojna co-ordinator, computer assistant – RCH, BMOH and BPHN, joint block development officer and CDPO of 22 blocks	78
3	22 August 2016	CMOH, DMCHO, Dy. CMOH-III, Dy. CMOH-I, district public health and nursing officer, DSM, district ASHA facilitator, RCH co-ordinator, Rashtriya Swasthya Bima Yojna co-ordinator, computer assistant – RCH, District Accounts Manager (DAM), accounts officer, assistant chief medical officer of health (ACMOH) of two subdivisions, superintendents of hospitals, BMOH and BPHN of 12 blocks	32
4	22 September 2016	District magistrate, ADM-G, CMOH, DMCHO, Dy. CMOH-III, Dy. CMOH-I, district public health and nursing officer, DSM, district ASHA facilitator, RCH co-ordinator, district accounts manager, accounts officer , ACMOH of two subdivisions, superintendents of hospitals, BMOH and BPHN of 12 blocks	21

	3. Comparison of key coverage indicator(s) in the DIPH cycle		Time 0	Time 1	Time 2	Time 3	Graph
		Date	March 2016	July 2016	August 2016	September 2016	

		Source				
a	Pregnant women registered in first trimester to total ANC registration (%)	MCTS	86	93.02	88.33	87.38
b	Pregnant women who had at least three antenatal check-ups to total ANC registration (%)	MCTS	81	90.72	86.17	88.75
c	Pregnant women who had four antenatal check-ups to total ANC registration (%)	MCTS	52	65.51	58.14	67.14

Part B

Total action points − planned	23
Total action points − Not started	1

Part B	
Total action points − planned	23
Total action points − Ongoing not on target	
Total action points − Ongoing on target	2
Total action points − Completed	20

Sl. No.	Action points	Indicators		Target	Progress of indicators	Person responsible	Timeline	Status of action points	Further follow-up suggestions	
									Timeline	Change in responsibility
1.1.1	Plan training for Panchayat Pradhan/members	**a**	Number of training arranged for Panchayat Pradhan and members (Swasthya Sanchalok) in co-ordination with health department / total number of trainings planned	12	100	PHPC, Zilla Parishad	September 2016	Completed		
		b	Number of Panchayat Pradhan and members (Swasthya Sanchalok) trained on maternal health / total number of Panchayat Pradhan and members (Swasthya Sanchalok)	216	86.57					
1.2.1	Involvement of SHGs in VHNDs sessions	**a**	Number of SHGs sensitised to participate in VHND sessions / total number of SHGs working	67	0	PHPC, Zilla Parishad with support from ADM-G	September 2016	Ongoing − not on target	October 2016	Same
		b	Number of sensitisation meetings conducted with SHGs / total number of meetings planned	13	0					
		c	Number of VHND sessions conducted in support with SHGs / total number of VHND sessions planned	3,732	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
1.2.2	Issue a guideline for conduct of VHNDs in co-ordination with CD	**a**	Issue a guideline jointly by CMOH and DPO-ICDS with district administration	1	0	DPO, Women and Child Development and Social Welfare	September 2016	Completed		
		b	Number of VHND sessions conducted in presence of AWWs / total number of VHND sessions conducted	3,732	75.96					
1.3.1	Regularise outreach camps (proper infrastructure with privacy for pregnant women)	**a**	Number of outreach camps organised with provision of proper arrangement (blood pressure machine, weight machine, foetal heart-rate checks, etc.) for antenatal check-ups / total number of outreach camps organised	1,596	99.62	BMOH	Monthly; September 2016	Completed		
1.4.1	VHSNCs and fourth Saturday meeting follow-up by district administration	**a**	Number of VHSNC sessions monitored / total number of VHSNC sessions planned	3,528	50.77	PHPC, Zilla Parishad	Monthly; September 2016	Completed		
		b	Issue a directive (written) to monitor and submit report on fourth Saturday meeting monitoring	1	0					
		c	Number of fourth Saturday meeting monitored / total number of fourth Saturday meetings conducted	324	64.51					
1.5.1	Training plan for FLWs, ANMs on ANC	**a**	Number of training arranged for FLWs on improvement on antenatal check-up / total number of trainings planned	60	76.67	BPHN	Monthly; September 2016	Completed		

Sl. No.	Action points	Indicators		Target	Progress of indicators	Person responsible	Timeline	Status of action points	Further follow-up suggestions	
									Timeline	Change in responsibility
		b	Number of ANMs trained on improvement on antenatal check-ups / total number of ANMs in position	780	96.15					
1.5.2	ANMs completing at least three antenatal check-ups at sub-centre and visits home for fourth antenatal check-up; submit reports on time	**a**	Number of pregnant women registered / total number of estimated pregnant women	12,672	89.58	BMOH	Monthly; September 2016	Completed		
		b	Number of pregnant women received three antenatal check-ups / total estimated pregnant women eligible for three antenatal check-ups.	12,672	88.55					
		c	Number of pregnant women received a home visit for the fourth antenatal check-up / total number of estimated pregnant women for fourth antenatal check-up	12,672	63.6					
2.1.1	Recruitment of vacant positions: medical officers, ANMs, ASHAs and other staff (health supervisors and BAF)	**a**	Number of medical officers recruited against the number of vacancies	48	70.83	CMOH (state responsibility)	September 2016	Completed		
		b	Number of ANMs recruited against the number of vacancies	60	11.67					
		c	Number of ASHAs recruited against the number of vacancies	552	0					
		d	Number of other staff (Gram Panchayat health supervisor, BAF, PHN and ICDS supervisors) recruited against	36	5.56					

Sl. No.	Action points	Indicators	Target	Progress of indicators	Person responsible	Timeline	Status of action points	Further follow-up suggestions	
								Timeline	Change in responsibility
		the number of vacancies							
3.1.1	To pursue proposal for procurement of mobile phone and CUG connections for ANMs and AWWs	**a** Submit a proposal in the next district Samity meeting to approve new connections for 33 ANMs and AWWs	1	0	CMOH	September 2016	Completed	October 2016	Same
4.1.1	Use of second Tuesday platform at block level to share MCTS data regularly	**a** Number of meetings where MCTS data-sharing recorded / total number of meetings planned	36	75	BDO	Monthly; September 2016	Completed		
		b Issue an order by district magistrate	1	0					
5.1.1	CMOH to pursue with state for insufficient fund supply in *District Programme Implementation Plan* 2015/16*	**a** Send a proposal to state to clear funds – on a needs basis	1	0	CMOH	July 2016	Not started	-	Discontinued
5.1.2	Incentives for ICDS FLWs for attending VHNDs	**a** Send a proposal in *District Programme Implementation Plan* 2015/16	1	0	CMOH	September 2016	Not started	-	Discontinued

Sl. No.	Action points	Indicators	Target	Progress of indicators	Person responsible	Timeline	Status of action points	Further follow-up suggestions	
								Timeline	Change in responsibility
6.1.1	District administration, CD and CMOH to pursue at state level for approval of funds/guidelines to start referral transport for antenatal check-ups	**a** Send a proposal in *District Programme Implementation Plan 2015/16*	1	0	CMOH	September 2016	Not started	-	Discontinued
		b Amount of funds sanctioned against proposed fund	0	0					

* Department of Health and Family Welfare 2015, *District Programme Implementation Plan 2015/16*, Government of India, New Delhi.

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, welcome and introduction	5 minutes	5 minutes (approximately)	Total 2 hours 15 minutes session 2.00 pm – 4.15 pm
A.2 Form 4	2 hours	2 hours	
A.3.Concluding remarks	10 minutes	5 minutes (approximately)	
B. Stakeholder leadership			
B.1 Agenda circulated/invitations sent	CMOH, DHHD		Letter issued and circulated to all stakeholders
B.2 Chair of sessions	CMOH, DHHD		
B.3 Theme leader	Dy. CMOH-III, DHHD		
B.4 Record of proceedings prepared by	DIPH research team – Antara Bhattacharya		
C. Stakeholder participation			
C.1 Number of stakeholders invited	Health department	9	CMOH, DHHD Dy. CMOH-III, DHHD Dy. CMOH-I, DHHD DMCHO, DHHD District programme co-ordinator, DHHD
	Non-health departments	7	ICDS supervisor, Magrahat-II, CDPOs from Mathurapur-II, Kulpi, Magrahat-I, Parthapratim, Kakdwip and one other block
	NGO/private for-profit organisations	0	
	District administration	0	
C.2 Percentage of stakeholder participation (to those invited)	Health department	55.6% (5/9)	
	Non-health departments	28.6% (2/7)	
	NGO/private for-profit organisations	Non applicable	
	District administration	0 (0)	
	Total	43.8% (7/16)	
D. Stakeholder involvement (*Note: Record everyone's viewpoint; if someone did not raise any concern, record it also)*			
D.1 Issues discussed by health department representatives	CMOH, DHHD	• Improving the quality of ANC check-up to identify high-risk mothers • Need awareness and report from Gram Panchayat level • Tagging/tracking of pregnant women with ASHAs and ANMs	
	Dy. CMOH-III, DHHD	• Need to improve the coverage and quality of third antenatal check-ups to	

		identify more high-risk mothers • ASHA should be more responsible and provide counselling to mothers during ANC services regularly	
D.2 Non-health departments	CDPO, Mathurapur-II	• Supervision and recruitment of staff is necessary • AWW and ASHA should be more actively participating in arranging the third Saturday meetings and mobilising mothers to these meetings • Baby weighing machines needed	
D.3 NGO/private for-profit organisations		Non applicable	
D.4 District administration		Non applicable	
E. Responsibilities delegated to non-health departments and NGOs*			
Type of activities shared		Non applicable	
F. Co-operation/communication between stakeholders*			
Stakeholder from health department and ICDS	Agreed on each other's points throughout the session		
G. Data utilisation			
During situational analysis the discussion was based on the following data elements: HMIS − status as on 27 May 2016 MCTS − status as on 29 May 2016			
H. Suggestion for Developing a Decision-Making guide modification (*Note: suggestions with justifications on forms, process*)			

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

Form 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	12.30 pm − 12.35 pm
A.2 Form 5	20 minutes	35 minutes	12.35 pm − 1.10 pm
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, ACMOH, Superintendent, BMOH, BPHN, PHN, DPMU
	Non-health departments	-	
	NGO/private for-profit organisations	-	
	District administration	3 (Swasthya Karmadhyaksha district magistrate, additional district magistrate – ADM)	Due to other meetings that day at the district magistrate's office, the district magistrate and ADM attended the Samity meeting but 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 for-profit organisations	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 needed	
D.2 Non-health departments	PRD	Non applicable	
	ICDS	Non applicable	
D.3 NGO/private for-profit organisations		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 of the 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

A.3.1: In-depth interview with CDPO

IDI details	
IDI label	114_GSN_SG_03Oct2016
Interviewer	Sayan Ghosh
Note taker	Sayan Ghosh
Transcriber	Sayan Ghosh
Respondent details	
Date and time of interview	3 October 2016
Name of participant	Mr Haridas Das
Gender	Male
Designation	CDPO
Department	CD
Duration of service in district	5+ years
Previous position	CDPO, Bhagobhanpur-I, Murshidabad
Qualification	BSc, BEd
Years of experience in present department	15+ years
Membership in committees pertaining to health	Multiple committees at block level and ASHA Selection Committee

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

We are having very limited knowledge about the DIPH. As there was no discussion or any information provided to us during the district meeting of ICDS, which conducted by DPO and chaired by ADM [development] of S24PGS. All CDPOs attended that meeting. Even that DIPH-related issues were not discussed in the RCH-Management Information and Evaluation System meeting at block level. There was no direction from district about the DIPH as a follow-up of any discussion.

When I attended the meeting called by CMOH on 15 June 2016, then only got to know about the DIPH. How the situation analysis done, how to identify the issues and priority things and accordingly. Next the action plan and related indicators for monitor the growth. For the district, I got a letter [DPO] to provide reports on a list of indicators for the months of July, August and September 2016.

There were a presentation on DIPH and followed by a discussion the district level during District Health and Family Welfare Samities Meeting [heard from others], as I was not present at that meeting.

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

d. Follow-up of action plan

To me DIPH is a very useful tool. In ICDS there are many formats. And modification of the reporting formats are going on. Previously there was monthly progress report, now new rapid reporting system introduced. Reporting format reduced a lot. Very specific and to the point reporting has been introduced. All the duplications in the reporting are been avoided. It was a very positive changes, which reduce the work load of our AWWs. Because all the reports are primarily collected by them. It was also our fault, that we are not been able to maintain and keeping the records properly. So every time we have to ask the AWWs for provide the same report in various format. From that aspect the DIPH is important. There are some concrete indicators for which reports from health departments is linked with our report. Or both the departments have to submit the reports. But if we tally those reports it shows different results. There are many cause behind that mismatching. That is the gap in reporting period. For majority of indicators Health and Family Welfare department is 20th of every month and for CD that is 30th of the month. The workers there was a huge workload for reporting, and we are not been able to review that every time.

So the main thrust should be on to reduce the reporting load to the workers. Only important and most needed reports should be given priority. Reports are not prepared only for the sake of reporting. You can see my whole room is covered by reports. So in that aspect DIPH will play a very vital role to identify the most important issue and how to give thrust on those.

So DIPH's goal to make doable planning for specific area with the information/data collected. But honestly, I am also not been able to follow the reporting timeline due to other involvement. Though I have prepare the report of DIPH for the month of July and August 2016, and that is a very crisp and useful report. By which we can understand the majority of the work we are performing in a time span.

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

The focus of the ICDS is nutrition along with that health is a major concern. On that aspect we have to co-ordinate with Department of Health and Family Welfare. But the problem is the children are not only focus for the Department of Health and Family Welfare. And they are also not that much interested to work on the nutrition issues. So the co-ordination in between this two department is very much important. In the DIPH that process has started.

Still there are some conflict exists. As an example there was a difference in the growth monitoring charts of health and ICDS. Same child can be shown normal in the growth chart of ICDS and moderate as per health's growth chart. Which was a major technical error. In many cases we may have identify a specific child as a severely malnourished child and refer to the medical officer for Nutrition Rehabilitation Centre, but according to their parameter that particular child is not needs admission at the Nutrition Rehabilitation Centre, and retuned back. That's create confusion among our workers and also to the community.

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

Analysis of data is very much important. In ICDS we are used to collect data on huge numbers of indicators. But we are not been able to review all of those. We always focusing on the some of the core indicators. Now that review is started with the DIPH project.

On the overall nutrition status, district magistrate have taken an initiative to start distribution of supplementation food. That will help to recover the malnourished child to normal grade of nutrition status. Panchayat also provide support into that. But that was not a regular programme. That supplementation helped quickly recover of the nutrition status. In Kulpi block there was 360 malnourished children, now it come down to 60 within three to six months' time period. If any data fabrication is happened, it not more than 5% to 6%. There are 60 to 65 malnourish children out of 24,000 children (approximately) that can easily monitored through DIPH process.

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

District magistrate regularly monitor the data and setting those priority. He takes regular updates from DPO. The concept of supplementary nutrition is come from him [district magistrate]. But the departmental priority was set by the higher authority. So we have to maintain two reports. In that aspect we can take advantage from DIPH, currently that was not happened. For this also district should take the initiative, we will follow that.

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

Yes, at least for my block I review data to know the progress of the project. At the district level also the data has been used for monitoring of both Department of Health and Family Welfare and CD. The monitoring was done by the district magistrate. From that monitoring there was a huge improvement on the institutional delivery and nutrition status of the children under five years.

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

No response.

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

One project of ICDS at Bhagar-I block run by NGO. Technical and financial support provided by the CD department. Otherwise that is no link with NGOs in DIPH. But involvement of NGO can improve the quality of service. There was a huge shortage of staff. Monitoring can be conducted properly with the support of the NGOs staff.

So involvement of the NGOs is very much needed. By that, the department can overcome the storage of human resource. Which is the main hindrance to achieving the goal of the project. Because the recruitment process is hold on by a stay order from court. By that time we can utilise the support from the NGOs for the development of the children.

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

No response.

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.

Main challenge is shortage of staff and with that lack of monitoring opportunity. There are five supervisors out of 17 sanctioned post. AWW 348 out of 362. And 331 helper out of 362 sanction post. All the 362 centres are operational with this staff strength. So there are no chance for detailed monitoring and quality checking. Only the data for some major indicators can be done. No quality checking is possible. Same regarding the reporting factors, as DIPH is asking for reports in some new indicators, it is become difficult for us to maintain the time line for reporting.

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

No specific suggestion was given by the CDPO. Only if we can thrust on the co-ordination issues with department of Health and Family Welfare and PRD can improve the quality of outcome. Now they the co-ordination in between the departments are very limited. Especially at the mid-level (sub-district/block). At the village the ground-level workers are worked very closely, there were no co-ordination issues, only the problem is the hierarchy among them. In generally ASHA and AWW are follow the instructions of the ANM. But form the next level under the co-ordination is an issue. No one is ready to share their plan of action with others.

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

Probe: BUT not limited to：

a. Frequency of the cycle

b. Engagement of all stakeholders

More involvement of medical officer is required for the community. May be they are not able to take time. Mainly ANMs are conducted the health check-up. If medical officers are attend the field level camps and VHND sessions that will help the field level service providers to enhance the quality service to the community. If that can be monitored by the DIPH process.

Previously the monthly chart for Rashtriya Bal Swasthya Karyakram team will shared with the ICDS. So accordingly AWWs accompany with them or if there is any case, they can bring them to the team. So necessary examinations can be done. And if needed Rashtriya Bal Swasthya Karyakram doctors can refer then to the block/district hospitals. Further treatment can be done there. But now no micro-plan was shared with ICDS. That also be include into the DIPH process for streamlining.

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

IDI details	
IDI label	115_GSN_SG_20Oct2016
Interviewer	Sayan Ghosh
Note taker	Sayan Ghosh
Transcriber	Sayan Ghosh
Respondent details	
Date and time of interview	20 October 2016
Name of participant	Dr Prabir Ghosh Dostidar
Gender	Male
Designation	Dy. CMOH-III
Department	Department of Health and Family Welfare
Duration of service in district	6 Months
Previous position	Dy. CMOH-III, Hoogly District
Qualification	MBBS
Years of experience in present department	31+ years
Membership in committees pertaining to health	Multiple committees at block level and ASHA Selection Committee

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

DIPH is a new initiative in the district. It was started before I joined in the district. The objective of the research is very unique. But like any new initiative, it will take some time to influence the system. I think that DIPH have already overcome the teething problem. Now it is well known to the block-level service providers. The district-level stakeholders are participated in the steps of DIPH. DIPH research (which having steps like situation analysis, stakeholder engagement, priority setting, development of action plan and follow-up of action plan) is helping them to plan in a better way. We have made block-wise planning to overcome the challenges they are facing to provide the quality of antenatal service. There was a decreasing trend of early identification of the pregnant women. Which can be easily overcome by the more communication with the community by the ground-level service providers. That has been planned here, under DIPH action plan and we got a positive result. So obviously it is well-accepted initiative. But on the other hand, some problems also observed. There are some reporting related casual attitude of block-level officials are been identified. We have follow up them very closely and hope that will be overcome soon.

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

It is very short time to judge efficiency of the DIPH process. But from the DIPH reports, visit and the points reported by the blocks some positive changes identified. We have compare the data with HMIS and MCTS (which points are related to the indicator), where the problems identified, inform the concern authority for rectification accordingly. Those points are discussed once again in the monthly meeting with BMOH and BPHN. Identify the possible way out from the problem also noted down the action points decided for the specific problem.

That also review in the next meeting. Then the block-level officers shared those points at the block-level Management Information and Evaluation System meeting and had detailed discussion on that. By that planning process become stronger. For identify other effect of the DIPH process will take some more time to understand.

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

The key theme addressed by the DIPH is the inconsistency in reporting. Like they have reported on some indicator in the DIPH reports and for the same indicators and same reporting period they have reported different figures in HMIS or MCTS. That has been identified from the DIPH process and addressed regularly. Hope to resolve shortly. That's why I say it will take some more time to address all those issues.

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

The main issue is related to reporting and maintain the timeline of that. Ideally there should be one report on which we can depend. For any central government review they always depends on the HIMS data. But at state level, MCTS is the main data source for review. Now RCH portal introduced. It will be a new platform. And many of the indicators are common. That increase confusions. So we need a common platform like DIPH. From where we can access all the relevant documents and data.

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

The DIPH enhance the thinking process. Initially block officials only submit reports made by some other person like DEO or PHN or BAM. But now they have started to look into the reports. Report analysis and accordingly fixing of plan of action is the main achievement till now from the DIPH. But we expect much more. Like involvement of stakeholders in that plan, all the error will be rectified by them. So district will receive a report with minimum corrections needed. So we just adding those data and can submit to the state.

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

Yes, that data in using for monitoring in both ways. The block-level officials also review that and at the district level we also monitoring that. And in the district meetings blocks can identify the problems in their reports. They spontaneously said that there is specific problem in reporting of an indicator, so we should ignore that, they will provide a revised report. By that they are started to identify the loopholes at their area of operations – may be physical or technical.

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

There was a co-ordination system exist at the paper. There are huge scope to enhance the

interaction between health and non-health departments. Which was not explored by the departments. That theoretical process has been initiated with the DIPH. All the line departments are been involved in the process, starting from the situational analysis, priority settings, stakeholder engagement, planning of actionable points and follow-up for progress. Other departments participated in the initial planning phase, but from implementation and monitoring they are not participated. Like in this cycle [Cycle 2] there was reports expected from ICDS, but we received very few incomplete reports. So that is not a positive sign. But in the meeting the ICDS departments have put many important issues, which are not addressed in practice.

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

There are no NGO involved till now. Third party assessment is very much important. But that is a policy-level decision. So I will not comment on that.

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

Not involved in the process. For ANC, all are accessing the government services at the rural level. So almost 98% to 99% ANC registration are happened. So no need to involve the private sector for the theme.

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

Like any new programme, to implement DIPH process we faced some challenges. The first and foremost challenges we are facing is related to reporting. Regular and timely reporting from some of the blocks. There are many reporting formats, they have to report monthly in various timeline. But we noticed that for some of the blocks we have to send reminder for every reports.

Another issue is the quality of reports. On the same indicators they are reported different figures in different reports. So the district authority have to check those reports thoroughly. Many times there are inconsistency observed in between a reports. So they should be careful before submit the report to the district. The linkage of data driven planning at the block level is still under process. They are not used to review the data regularly. The have to regularise immediately.

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

The DIPH process is seems to be a useful process. The only thing is can be done for maintain the quality of report is district level cross-checking of the reports submitted by the blocks. We have to involve the block people in the process, so they also can follow the same procedure for validation of sub-block level data. There was no such concept, but after DIPH process

starts, they have understand the importance of the data validation. So that is the only point now we can suggest which will improve the quality of the DIPH process.

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

As we are analyse the data at the district level, along with that is PHFI can conduct some field visit at the block level to identify the issues reported to reporting, planning and implementation. That can cross validate the reports. The time span is another issue. If one theme can follow up for 8 to 12 months then we can surely expect positive changes. Time span is very important for regularisation of the factors or resolve the issues. If PHFI can hand-hold the block people how to analysis, monitor, plan and implement from the data generated, that will be a very good opportunity for them to increase the quality of the programme.

A.3.3: In-depth interview with PHPC

IDI details	
IDI label	116_GSN_SG_21Oct2016
Interviewer	Sayan Ghosh
Note taker	Sayan Ghosh
Transcriber	Sayan Ghosh
Respondent details	
Date and time of interview	21 October 2016 at 11.45 am
Name of participant	Dr Mritunjay Jana
Gender	Male
Designation	PHPC, Zilla Parishad
Department	PRD
Duration of service in district	7+ years
Previous position	Project co-ordinator in an NGO at Malda
Qualification	DHMS, PGDIGC
Years of experience in present department	7+ years
Membership in committees pertaining to health	Sthai Samity – Education and Public Health

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

I am having some idea about the process. But I was not involved in the whole process. Specially the implementation part. Some of the parts of the process I have taken part. For those aspect I am having good idea. In the situational analysis, how the review was conducted, then selection of them, followed by the stakeholder engagement, actionable points and indicators for monitor the progress of the action points. I have taken a very active role in the situational analysis and planning of the cycle. I felt the process very interesting and useful.

I have given thrust on the identification of the problem. So we can plan accordingly and can have maximum impact at the district. But I have some question about the identification process of a theme. It was a pre-define theme. The process DIPH having plenty of opportunity to identify the gaps in the government system, but for pre-define theme the process was not utilised properly.

To many of the participants it was just a research. But they are unable to understand the strength of the DIPH process. As the senior most officers of the government and district have given thrust on the issue and CMOH also wanted to continue with the issue of institutional delivery and in the next cycle ANC. So there are scopes which we have not utilised. We have missed out many important points if we follow a pre-determine theme.

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

The process DIPH give emphasis it's a totally new thought in the government sector. On one in the sector have thought about this type of integrated planning. Who are involve in the process are taking active role. There was no planning system exist down the line (below the district level), which was introduced by the DIPH. It also recognised by the district-level

officials. So the need was well recognised but there was no scope. Many be the effect of DIPH will take some times, but we cannot ignore the positive vibes flow from the DIPH process. The process carried a new challenge or inspiration among the government servants. This type of planning can be done and can be implement is a new pathway for them.

Utilisation of data is another contribution of the DIPH. How the data can be monitor, how to analysed the data. Quality of the data and verify the quality also important under this project. How that help us to identify the problem, how to plan for counter that problem. And finally how to monitor the progress is been shown by the DIPH study. So value of the data is may be known to them, but they were not able to utilised that due to workload. When the discussion started, the CMOH or the person leading the process started analysing situation. So apart from the project objective importance of the data are established by the DIPH.

So when we are working on a theme, maybe there are some progress happens or not but utilisation of data is the outcome for the district people. And in future the utilisation of data will be increase. The project is looking into the future actions.

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

Maternal health-related issues are covered by the theme. In first cycle institutional delivery and in the second cycle quality of care for ANC. And the linkage in between line departments how they are providing support each other to reach the target.

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

Answer already given in Question 1.

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

There are very few changes we can identify. Especially in the PRD, utilisation of data is very limited. In one hand, the reporting system is very week on the other hand the officials chose not having the attitude to review the data reported by Panchayats and plan accordingly. But for the DIPH it will happen. It is difficult to break the systems in government departments. So it may take time for institutionalisation of the DIPH process. We are not been able to sensitise all level of stakeholders.

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

As PRD is not directly responsible for the theme, but Health and Family Welfare department is doing the monitoring. From my personal experience they are using data for monitoring. That was a regular system for them. But I am having some difference of opinion from the Health and Family Welfare department. The monitoring was done as per the priority of the department. So they are focusing on the some major indicator at the district level. But when

you are going to the ground level, interaction with direct field-level stakeholders and beneficiaries then that format will not work as a tool for monitoring. From my experience, I know that for each and every level there are different situation and according to that they have to plan for. Different problems, various problems are exist, so it will be difficult to use the same monitoring tool. So it is important to increase the knowledge level of the monitoring process. We may have that, but not using that. As a service holder we always follow the guideline. So at the field level situation where the socioeconomic situation is different, we have to use different type of monitoring system. So Department of Health and Family Welfare monitor the process as per guideline, and so there are gaps exist in the monitoring process. It is the gap in the system.

As an example if we can consider the case of CD, monitoring for Anganwadi Centre we can monitor the attendance of the children, availability of the registers, etc. which is a part of the monitoring. But we are not review the quality aspect of the service provisions. Another aspect is the quantity of the supplies are reported, the shortage in the quantity is reported, but no further action taken why the quantity is less than the supply. How to overcome that? So there is a gap in the system, otherwise year by year the problem will not persist. Quality is a big issue. Gap analysis was not done.

So there is a need for review of the monitoring system. Strategy-wise it should be revised. They are not been given to that privilege to flexible monitoring. Expected monitoring result we are not been able to see.

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

I am having two points in this aspect of interdepartmental relationship. As per government orders, meetings are organised. All level of convergence meeting are organised as per schedule. But the result of the meeting was nil. As a proof block-level convergence meeting is a regular activity, organised on fourth Saturday of the month. But instead of that BMOH does not know what Panchayat people is doing. Convergence meeting is become a routine activity. We are not able to utilise the idea of convergence.

There is a huge gap in between presence and participation of the convergence meeting. That's wise sharing of the concept, issues or the field level problems are not been addressed.

Another issue is number of convergence meeting. There are many convergence meetings are schedule at the district and block level. So officials are not present in all the meetings and they used to send some junior representative. For a person due to his/her work load, number of convergence meetings and reporting to the higher level officials is become very difficult to give expected result within a time frame. So it needs a review, which are very important. And who are the person been involve in that meeting, what are the other responsibility he/she having. So need to review the situation from the practical aspects. That's why the ground reality are not come out.

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

It should be included in the convergence meeting. NGO is a part of the system. In many issues they are provide support to the government and in other way government people also provide support to the NGOs. Higher level accept that but at the ground level people is still not wholeheartedly accepted that. There are been called in a meeting because of the government order. But the suggestions or the reports submitted by them it not accepted or well recognised by them. On other side organisations like PHFI or UNICEF are well accepted because of the organisational status. Those are seems to a part of the government. Especially UNICEF, because of their financial status. Branding also is an issue.

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

No need to involved private sector if we can utilise the NGO and government properly.

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

The main challenge is the co-ordination issues in between the line department. On which we already talked during the monitoring issues.

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

This type of work are very much needed for enhancing the capacity of the workforce. If we can review the number of convergence meeting organised and output from them we received. The growth is not compare with the target previously. Now that has been done. So proper participation from all line department is needed. So third party review is very much important. If you can continue the work with various department and then for some more time, three months is very short time for that implementation.

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

If DIPH cycle can improve the motivation and responsibility of the government people it can be the finest change. Freedom for monitoring without any pressure from anybody. So they can review fearlessly with the help of DIPH.

More close linkage with other government department can increase the outcome of the research activities and also capacity of the government system.

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 form of an official letter or circular issued by the district/state government*	Form 1A.1: Data extraction from state and district health policy documents
	B. Data-based monitoring of the action points for the primary theme of the DIPH	**4. (Number of action points on which progress is being monitored by data) / (total number of action points for the primary theme of DIPH)** **Action points:** a specific task taken to achieve a specific objective	Form 5: Follow-up

[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.

		In the DIPH context: a specific action, arisen from the stakeholder discussions during Steps 3 and 4, to achieve the target of the given DIPH cycle	
	C. Revision of district programme data elements for the primary theme of the DIPH	**5. Whether stakeholders suggested a revision/addition to health system data in the given DIPH cycle? (Y/N)**	Form 4: Plan
		6. (Number of data elements added in the health database as per the prepared action plan) / (total number of additional data elements requested for the primary theme of the DIPH) **Data elements:** operationally, refers to any specific information collected in 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 study ensured involvement of stakeholders from different sectors (health, non-health and NGO/private for-profit organisations)	E. Extent of stakeholder participation	**1. (Number of DIPH stakeholders present in the planning actions meeting) / (total number of DIPH stakeholders officially invited in the planning actions meeting)** *Participants in Steps 4 and 5* **DIPH stakeholders*:*** public and private sector departments, organisations and bodies relevant for the specific cycle of the DIPH **Officially invited:** stakeholders formally being invited to participate for the specific DIPH cycle *In the West Bengal context, for example:* • *Public sector stakeholders: Department of Health and Family Welfare; PRD; and CD* • *Private sector stakeholders: NGOs; nursing homes; and large hospitals owned by private entities*	Form A.2: Record of Proceedings – Summary Table
		2. (Number of representatives from the health department present in the	Form A.2: Record of Proceedings – Summary

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

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

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

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

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