DIPH

The Data-Informed Platform for Health

Structured district decision-making using local data

MONITORING REPORT
Cycle 3: September 2016 – March 2017

Diamond Harbour Health District
West Bengal, India

DATA INFORMED PLATFORM FOR HEALTH

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ACKNOWLEDGEMENTS

IDEAS Team (LSHTM)
DIPH Lead: Dr Bilal Iqbal Avan
PI: Prof Joanna Schellenberg

Country Team (India – PHFI)
Lead: Dr Sanghita Bhattacharyya
Research Associate: Dr Anns Issac
District Co-ordinator: Mr Sayan Ghosh

State Partner (West Bengal)
Ministry of Health and Family Welfare
West Bengal University of Health Sciences (Prof Bhabatosh Biswas, Vice Chancellor)

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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
ANM	Auxiliary nurse midwife
ARI	Acute respiratory infections
ASHA	Accredited Social Health Activist
BMOH	Block medical officer of health
BPHN	Block public health nurse
CD	Child Development
CMOH	Chief medical officer of health
DHHD	Diamond Harbour Health District
DIPH	Data Informed Platform for Health
DMCHO	District maternity and child health officer
DPO	District programme officer
DSM	District statistical manager
Dy. CMOH	Deputy chief medical officer of health
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
IEC	Information, education and communication
IMCI	Integrated Management of Childhood Illness
MCTS	Mother and Child Tracking System
NGO	Non-governmental organisation
PHPC	Public health programme co-ordinator
PRD	Panchayat and Rural Development
WHO	World Health Organization

1. INTRODUCTION

Data Informed Platform for Health (DIPH)		
Cycle no.	3	
District	Diamond Harbour Health District	
Duration	September 2016 – March 2017	
Theme	Prevention and treatment of acute respiratory infections	
Steps involved	Step 1	**Assess:** The Diamond Harbour Health District (DHHD) stakeholders adhered to the *Handbook: IMCI Integrated Management of Childhood Illness* (WHO, 2005) and assessed the gaps in service provision using the Health Management Information System (HMIS) (MoHFW, 2016) and selected the theme: 'Prevention and treatment of acute respiratory infections (ARI)' for Cycle 3. ARI is a seasonal issue and one of the major causes of child mortality. As the non-health departments do not maintain data to the theme indicators, the situation assessment used data only from the Department of Health and Family Welfare.
	Step 2	**Engage:** The primary responsibility for Cycle 3 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-II (Dy. CMOH-II) became the theme leader for Cycle 3. 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 six problems and prioritised them under the following: service delivery; workforce; supplies and technology; health information; and policy and governance. Majority of the problems (33%) were under 'service delivery'. They formulated nine 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 nine action points (and 22 indicators) to achieve the target and assigned responsibilities across departments within a given time frame. All the responsibilities were for the Department of Health and Family Welfare.
	Step 5	**Follow-up:** Stakeholders attended five meetings before the Step 5 meeting to facilitate follow-up of the action plan. All action points (100%) started during the cycle period. Two action points (22%) had completed within the specified timeline. The seven remaining action points received a new timeline. The theme leader monitored the progress through monthly reports (from district personnel responsible for each action point).

2. METHODS

Sl. No	Data sources	Lead among DIPH stakeholders	Time frame
1	**Step 1**: **Assess** Form 1A: Document and database checklist Form 1A.1: Data extraction from state and district health policy documents Form 1B: Health system capacity assessments	Theme leader of the DIPH Cycle 3	19 September 2016
2	**Step 2: Engage** Form 2: Engage	Theme leader of the DIPH Cycle 3	19 September 2016
3	**Step 3: Define** Form 3: Define	Theme leader of the DIPH Cycle 3	19 September 2016
4	**Step 4: Plan** Form 4: Plan	Theme leader of the DIPH Cycle 3	20 September 2016
5	**Step 5: Follow-up** Form 5: Follow-up	Theme leader of the DIPH Cycle 3	21 March 2017
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, DHHD	September 2016 – March 2017
7	**In-Depth Interviews with Stakeholders** Dy. CMOH-II	Interviewed by the DIPH research team, DHHD	10 February 2017
	Block medical officer of health (BMOH), Patharpratima block		15 February 2017

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 selected the theme for Cycle 3 from the health department's observation of an increase in ARI during winter. They used the data from HMIS (MoHFW, 2016) to identify gaps in service provisions. However, no data on the number of ARI cases identified and referred for treatment was available for review in the HMIS. The only indicator available in the HMIS was: 'Hospitalisation of under-five children due to severe ARI' (MoHFW, 2016).

ARI increases during the winter season. It is essential to identify the severity of the infection among newborns and children to prevent loss of life due to ARIs. Therefore, in Cycle 3 the theme selected was: 'Prevention and treatment of ARI'. The coverage indicator selected was:

'Number of under-five children admitted with ARI'[1] (MoHFW, 2016). ARI-related activities are predominantly the responsibility of the health department. The non-health departments have a supportive role in awareness generation, but do not maintain any data. Therefore, theme identification used data from only the health department.

3.1.2 Challenges in data utilisation

The major hindrance with data utilisation was the non-availability of the data on ARI. The data collected was at ground level but not reported to block or district levels. 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 data analysis.

> "The data collected from sub-districts are not analysed properly." (Dy. CMOH-II, DHHD)

3.1.3. Proposed solutions

The position of district statistical manager (DSM) in the District Programme Management Unit, National Health Mission was vacant. The DSM of South 24 Parganas holds the additional responsibility to support the DHHD. The group proposed filling the post of DSM to support the DHHD. This was a concern raised during Cycle 1 and Cycle 2, 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)	No[2]	Form 1B: Health system capacity assessment
		2. Whether the DIPH cycle theme selection used any data from non-health departments? (Y/N)	No[3]	Form 1B: Health system capacity assessment
		3. Whether the DIPH cycle theme selection was based on health policy and programme directives? (Y/N)	Yes[4]	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	4. (Number of action points on which progress is being monitored using data) / (total number of	9/9 = 100[5]	Form 5: Follow-up

[1] HMIS item number 12.9 (MoHFW, 2016).

[2]The theme was suggested by the health department stakeholders from their experience in the district and considering the severity of ARI during winter. They used the available indicator from HMIS (MoHFW, 2016). (See Form 1B.)

[3]The non-health departments (PRD and CD) do not maintain any data on this issue. Hence, they could not contribute data during theme selection. (See Form 1B.)

[4]The DIPH stakeholders adhered to the components of the *Handbook: IMCI Integrated Management of Childhood Illness* (WHO, 2005). (See Form 1A.1.)

[5] Progress of all nine action points have been monitored by using data. (See Form 5.)

	the DIPH	action points for the primary theme of the DIPH)		
	C. Revision of district programme data elements for the primary theme of the DIPH	5. Whether stakeholders suggested a revision/addition to the health system data in the given DIPH cycle? (Y/N)	No[6]	Form 4: Plan
		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) [7]	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)	No[8]	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)	No[9]	Form 1B: Health system capacity assessments

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, this specific theme had very limited opportunity for health and non-health department co-ordination. The participation and interaction among the different stakeholders was often less than satisfactory.

3.2.1 Interaction between health and non-health departments

Majority of participants (98%) were from the Department of Health and Family Welfare. The public health programme co-ordinator (PHPC) from the PRD attended the DIPH meetings. There was no participation from the CD and district administration. All nine action points were the responsibility of the health department. This indicates that participants still perceive the DIPH as a health department initiative.

[6]There was no suggestion to revise any data element. (See Form 4.)
[7]There was no suggestion to add data elements. (See Form 5.)
[8]Only the data on hospitalisation with severe ARI was available from HMIS (MoHFW, 2016). (See Form 1B.) The number of cases identified came from the Sub Centre reporting format submitted by the auxiliary nurse midwives (ANMs).
[9]The only indicator available in the HMIS was: 'Hospitalisation of under-five children due to severe ARI' (MoHFW, 2016) which was up-to-date in the HMIS monthly reporting system (MoHFW, 2016). (See Form 1B.)

"Involvement of non-health departments is not up to the mark. Health department is not getting proper support from them. They are not equally involved in the DIPH process." (Dy. CMOH-II, DHHD)

3.2.2 Interaction between the health department and NGOs

There are a few NGOs such as Southern Health Improvement Samity, 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. But they are not involved in the prevention and identification of ARI cases. So, the district stakeholders did not take interest in inviting them to the DIPH meeting. The United Nations Children's Fund has a programme with the district. Their co-ordinator was present at the office but did not have any interaction with the DIPH project.

However, during the DIPH process, the district recognised the importance of NGO involvement in validating the programme data.

"External support from leading NGOs is required to validate data in the district." (Dy. CMOH-II, DHHD)

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

Like in previous cycles of the DIPH, there was no interaction between the private for-profit organisations and other DIPH stakeholders. A major gap highlighted by stakeholders was the absence of a specific reporting structure for monitoring of private organisations by the health department.

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)	61/66 = 92.4[10]	Form A.2: Record of Proceedings – Summary Tables
		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)	60/61 = 98.4[11]	Form A.2: Record of Proceedings – Summary Tables
		3. (Number of	1/61 = 1.6[12]	Form A.2:

[10]The participation was calculated from the invitee list and attendance list of Steps 4 and 5, which was prepared along with the Record of Proceedings. (See Forms A.2.1 and A.2.2, Sl. No. C1-C2.)
[11]Majority of participants were from the health department. (See Forms A.2.1 and A.2.2, Sl. No. C2.)

		representatives from non-health departments present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting)		Record of Proceedings – Summary Tables
		4. (Number of representatives from NGOs present in the planning actions meeting) / (total number of DIPH participants present in the planning actions meeting)	0/61 = 0[13]	Form A.2: Record of Proceedings – Summary Tables
		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)	0/61 = 0[14]	Form A.2: Record of Proceedings – Summary Tables
	F. Responsibilities assigned to stakeholders[15]	6. (Number of action points with responsibilities of the health department) / (total number of action points for the primary theme of the DIPH)	9/9 = 100.0[14]	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)	0 (0/9)[16]	Form 4: Plan
		8. (Number of action points with responsibilities of NGOs) / (total number of action points for the primary theme of the DIPH)	0 (0/9)[17]	Form 4: Plan
		9. (Number of action points with responsibilities of private for-profit organisations) / (total	0 (0/9)[18]	Form 4: Plan

[12]There were no representations from PRD, CD and district administration. (See Forms A.2.1 and A.2.2, Sl. No. C2.)

[13]Though there were a few NGOs, stakeholders did not officially invite them. (See Forms A.2.1 and A.2.2, Sl. No. C2.)

[14]There was no participation from the private sector. (See Forms A.2.1 and A.2.2, Sl. No. C2.)

[15] All the action points were with the Department of Health and Family Welfare. (See Form 4, column: 'Person responsible'.)

[16] Non-health departments did not share any responsibility for action points. (See Form 4, column: 'Person responsible'.)

[17] The DIPH process did not directly involve the NGOs. (See Form 4, column: 'Person responsible'.)

[18] The DIPH process did not involve the private for-profit organisations. (See Form 4, column: 'Person responsible'.)

		number of action points for the primary theme of the DIPH)		
	G. Factors influencing co-operation among health, non-health and NGO/private for-profit organisations to achieve the specific action points in the given DIPH cycle	**10. List of facilitating factors**	1. The chief medical officer of health (CMOH) was very supportive. He considered that this cycle was a baseline for judging the efficiency of pentavalent vaccines 2. Theme leader of Cycle 3 (Dy. CMOH-II) found the DIPH a platform for sharing information across all departments	In-Depth Interviews with Stakeholders
		11. List of challenging factors	1. Non-co-operation from the CD department is a challenge. Also, the district authority was not able to attend the meetings 2. Lack of motivation of some of the BMOHs affected the reporting quality 3. Though there was interaction between the PRD and the health department at district level, it was almost non-existent at sub-district level	In-Depth Interviews with Stakeholders

3.3 Progress with action points

3.3.1 Action points accomplished

All nine action points started during the cycle period and two action points had completed by the Step 5 meeting.

1. Monthly review of reported data at district level.
2. Validity of the data at district level.

3.3.2 Action points ongoing

Seven action points are continuing to the next cycle:

1. On-site training at block level for ANMs
2. Monitoring supervision by BMOHs/block public health nurses (BPHNs) based on the monitoring tool
3. Monitoring supervision by the assistant chief medical officer of health (ACMOH) based on the monitoring tool

4. Refresher training for ANMs and health supervisors
5. Monthly review report of the Utilisation Certificate
6. Compilation of sub-centre level information on reported cases of ARI
7. Letter to be sent to the managing director of the National Health Mission

3.3.3 Action points not started

All nine action points started during the cycle period.

Table 3: Progress with action points

Purpose	Indicators		Response (Yes/No, proportions)	Sources of information
Are the action points planned for the DIPH primary theme achieved?	H. Action points initiated	1. (Number of primary theme-specific action points initiated within the planned date) / (total number of primary theme-specific action points planned within the specific DIPH cycle)	9/9 = 100.0[19]	Form 5: Follow-up
	I. Action points achieved	2. (Number of primary theme-specific action points completed within the planned date) / (total number of primary theme-specific action points planned within the specific DIPH cycle)	2/9 = 22.2[20]	Form 5: Follow-up
		3. (Number of written directives/letters issued by the district/state health authority as per action plan) / (total number of written directives/letters by the district/state health authority planned as per action points of the DIPH primary theme)	0/1 = Nil[21]	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)	0/0 = 0[22]	Form 4: Plan and Form 5: Follow-up
		5. (Units of specific medicine provided for the primary theme-specific action points) / (total units	0/0 = 0[23]	Form 4: Plan and Form 5: Follow-up

[19] All nine action points were the responsibility of the Department of Health and Family Welfare and initiated during the specified period. (See Form 5, 'Action points', 'Timeline' and 'Status of action points'.)

[20]Out of the nine action points, two action points had completed by the Step 5 meeting. Six action points are ongoing and on target as the district decided to continue them. One action point is ongoing and not on target. (See Form 5, 'Action points', 'Timeline' and 'Status of action points'.)

[21]A written letter needs to be issued by the district. Apart from this, all communications were via telephone or through verbal communications. (See Forms 4 and 5, 'Action points', 'Indicators'.)

[22]No request was made for finance during Cycle 3. (See Forms 4 and 5, 'Action points', 'Indicators'.)

[23]The selected theme did not require the procurement of any medicine. (See Forms 4 and 5, 'Action points', 'Indicators'.)

		of specific medicine requested as per action points of the DIPH primary theme)		
		6. (Units of specific equipment provided for the primary theme-specific action points) / (total units of specific equipment requested as per action points of the DIPH primary theme)	0 (0/0)[24]	Form 4: Plan and 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)	0 (0/0)[25]	Form 4: Plan and 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)	0 (0/0)[26]	Form 4: Plan and 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)	1,331/1,868 = 71.3% [27]	Form 4: Plan and Form 5: Follow-up
	J. Factors influencing the achievements as per action points of the DIPH primary theme	**10. List of facilitating factors**	1. The stakeholders were familiar with the DIPH process 2. The selected theme is perceived as important to the district 3. District-level stakeholders were able to visualise the positive changes as per the goal. The review and progress of indicators motivated them further	In-Depth Interviews with Stakeholders
		11. List of challenging factors	1. Non-co-operation of the CD department 2. Irregularity in monthly reporting; need to send several reminders to	In-Depth Interviews with Stakeholders

[24]There was no specific equipment required as per the selected theme. (See Forms 4 and 5, 'Action points', 'Indicators'.)

[25]There was no specific demand for information, education and communication (IEC) materials in the action plan. (See Forms 4 and 5, 'Action points', 'Indicators'.

[26]There was no plan for staff recruitment during the cycle period. (See Forms 4 and 5, 'Action points', 'Indicators'.)

[27]The action point specified training of staff and the coverage reported was 71%.

			some specific blocks 3. Community/sub-district-level ownership of the process is a challenge. Ground-level staff (e.g. data entry operators) 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 HMIS does not occur on a regular basis. Only the reproductive and child health data receives regular updates.
- There is no mechanism in practice to ensure the quality of data.
- Not all information collected at field level reports to district level.

3.4.2 Facilitators within the district

- The DIPH research team developed a good rapport with stakeholders.
- The proactiveness of the CMOH and the Dy. CMOH-II (theme leader) from the beginning of the DIPH process helped in engaging with stakeholders.
- The stakeholders are now familiar with the DIPH process and this has reduced the time taken for discussions.
- The stakeholders found the DIPH as a monitoring tool to improve the health status of the district.

> "DIPH is a tool for monitoring of activities for better outputs. Regular monitoring system has been strengthened." (BMOH, Patharpratima block)

- Introduction of the DIPH digital interface helps the district to assess the health performances efficiently.

> "For health professionals, graphical presentation makes the process more interesting and it is possible through introduction of DIPH digital interface." (Dy. CMOH-II, DHHD)

3.4.3 Challenges within the district

- Lack of manpower cuts across departments. The data entry operator is a contractual post in the health department. Also, PRD faces staff shortages.

> "DHHD is one of the remote districts in the state of West Bengal and for that reason frequent turnover/transfer of human resources (doctors, staffs, etc.) is the major problem compared to other districts." (Dy. CMOH-II, DHHD)

- The distance from the district headquarters led to hurdles in bringing the district-level

officers in a common platform.

- Ensuring the quality of data.
- Though the dependence on the DIPH research team reduced from Cycles 1 and 2, block-level stakeholders still require follow-up (reminder) by the theme leader.
- Though the interdepartmental co-ordination is improving, the major share of responsibilities still remains with the health department.

3.4.4 Possible solutions

- Systematic analysis of programme data and sharing will help the district in effective decision-making. This analysis has begun under the DIPH process but needs to be continued.

> "The data collected from sub-districts are not analysed properly. DIPH helps in the data analysis aspect of the district. The quality of service delivery is linked with the same. Hence, DIPH brings out the quality aspect in the district very efficiently." (Dy. CMOH-II, DHHD)

- There is a need to verify the quality of data and the implementation of action points at field level. The stakeholders suggest a joint monitoring system and combined field visits to facilitate this.
- The Health Samity meeting is one significant platform for district decision-making. The DIPH should focus on this.

> "Maximum decisions have taken during Samity meeting, in consultation with district magistrate, Panchayat functionaries and representatives from ICDS [Integrated Child Development Services]. This is a common forum for discussion and we got good results." (Dy. CMOH-II, DHHD)

- To consider themes that involve the participation by non-health departments.
- To involve sub-district level stakeholders such as BMOHs, BPHNs and child development project officers during Steps 4 and 5 for better implementation of the action plan.
- There is a need for behaviour change communication with health officials and frontline workers, although this has started under the DIPH process.

> "DIPH leads to behaviour change of health officials and frontline workers through monitoring/follow-up of action points regularly." (Dy. CMOH-II, DHHD)

REFERENCES

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

World Health Organization (WHO) 2005, *Handbook: IMCI Integrated Management of Childhood Illness*, WHO, Geneva, viewed on ???? http://apps.who.int/iris/bitstream/10665/42939/1/9241546441.pdf

ANNEXES

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

Form 1A: Document and database checklist

Date of meeting:	19 September 2016
Venue of meeting:	District programme co-ordinator, Nation Health Mission
Chairperson of meeting:	CMOH

Sl. No.	Document	Availability (Y/N)	Source
1. Policy and planning documents			
1.1. State level			
1.1.1	State Health Plan / Programme Implementation Plan	Yes	DSM
1.1.2	Health on the March	Yes	Dy. CMOH-III
1.1.3	Indian Public Health Standards	Yes	DSM
1.1.4	Pradhan Mantri Surakshit Matritva Abhiayan Guidelines	Yes	Dy. CMOH-III
1.2. District level			
1.2.1	District Health Plan / Programme Implementation Plan	Yes	District programme co-ordinator
1.2.2	Financial Management Report	Yes	District accounts manager
1.2.3	ANANDI Programme Guidelines	Yes	Dy. CMOH-III
2. Management and services provision			
2.1. Health department			
2.1.1	HMIS	Yes	DSM
2.1.2	Mother and Child Tracking System (MCTS)	Yes	DSM
2.1.3	Mandatory disclosure forms	Yes	Dy. CMOH-I
2.2. Non-health departments			
2.2.1	CD data	Yes	District programme officer (DPO)-ICDS
2.2.2	PRD data	Yes	District public health co-ordinator, Zilla Parishad
2.3. Private sector (private for-profit organisations and NGOs)			
2.3.1	NGOs data	No	
2.3.2	Private service providers data	No	
3. Large scale district level surveys			
3.1	District Level Household and Facility Survey	Yes	DSM
3.2	District Census Handbook	Yes	DSM

No. of documents available: 14

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

A. Filled by: PHPC
B. Date: 26 October 2016

PART A	
Document title:	HMIS database
Date of release :	19 September 2016
Goal as stated in the document:	Identification and classification of ARI cases and their management
Action points specified by the document:	
• 100% identification of ARI cases and their classification • Sensitisation and orientation of the service providers	

PART B	
Document title:	*Handbook: IMCI Integrated Management of Childhood Illness*, WHO
Date of release:	2005
Goal as stated in the document:	To prevent and manage the leading causes of serious illness and mortality in young children
Action points specified by the document:	
• To cover the most serious childhood illnesses typically seen at first-level health facilities • To make the guidelines consistent with national treatment guidelines and other policies • To make the guidelines feasible to implement through the health system and by families caring for their children at home	

Form 1B: Health system capacity assessments

Date of meeting:	19 September 2016
Venue of meeting:	Office of the CMOH, DHHD
Chairperson of meeting:	CMOH

1.	Information about the district			
	District demographic details	**Information**	**Source**	**Source details**
1.1	Total area (square km)	2,391	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.2	Total population	3,238,887	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.3	Number of women in reproductive age group (15-49 years)	561,103	MCTS	Website is now merging to reproductive and child health portal
1.4	Number of under-five children	364,639	HMIS	https://nrhm-mis.nic.in/hmisreports/frmstandard_reports.aspx
1.5	Rural population (%)	98.6	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.6	Scheduled Caste population (%)	30.2	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.7	Scheduled Tribe population (%)	1.2	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.8	Population density (persons/square km)	1,373	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.9	Total literacy (%)	76.6	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf
1.10	Female literacy (%)	71.4	District Census Handbook	http://www.censusindia.gov.in/2011census/dchb/1917_PART_B_DCHB_SOUTH%20TWENTY%20FOUR%20PARGANAS.pdf

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

1.12	**Key private for-profit organisations**	
	Name of the organisation	Contact details

2.	**Expected coverage for the identified theme**						
	Theme	**Coverage indicators**		**Current Status**	**Expected Status**	**Gap**	**Source**
2.1	Prevention and treatment of ARI	2.1.1	Number of under-five children admitted with ARI (HMIS item number 12.9)	309	200	-109.00	HMIS

3. Theme:- Prevention and treatment of ARI

	Details	Sanctioned (2014/15)	Available / functional	Gap
3.1. Infrastructure				
3.1.1	Sub-Centres	475	475	0
3.1.2	Primary Health Centres	28	28	0
3.1.3	Block Primary Health Centres	4	4	0
3.1.4	Rural hospital	9	9	0
3.1.5	Sub-divisional hospital	1	1	0
3.1.6	District hospital	1	1	0
3.2. General resources				
3.2.1. Finance				
3.2.1.a	-			
3.2.2. Supplies				
3.2.2.a	Amoxicillin	15,000	15,000	0
3.2.2.b	Gentamicin	12,000	12,000	0
3.2.3. Technology				
3.2.3.a	-			
3.3. Human resources				
3.3.1	ASHAs	2,619	2,411	208
3.3.2	First ANM	475	468	7
3.3.3	Second ANM	475	379	96
3.3.4	BPHN	13	13	0
3.3.5	Public health nurse	15	15	0
3.3.6	General duty medical officer	103	90	13

Form 4: Plan

Date of meeting:	20 September 2016
Venue of meeting:	Office of the CMOH, DHHD
Chairperson of meeting:	CMOH
Theme leader of cycle:	Dy. CMOH-II
Theme:	Prevention and treatment of ARI
Total number of action planned	9
Responsibilities of different stakeholders	
Department of Health and Family Welfare	9

	Action points	Responsible stakeholder	Indicator		Target (in number)	Timeline
1. Service delivery						
1.1.1.	On-site training at block level for ANMs	Department of Health and Family Welfare **Person responsible:** BMOH	**a.**	Proportion of on-site training conducted (%) Description: Number of on-site training conducted against the total number of training planned	65	December 2016
			b.	Proportion of ANMs trained (%) Description: Number of ANMs attended the on-site training against the total number of ANMs in position	834	
1.2.1.	Monitoring supervision by BMOHs/BPHNs based on the monitoring tool	Department of Health and Family Welfare **Person responsible:** BMOH	**a.**	Proportion of supervisory visits conducted (%) Description: Number of supervisory visits conducted against the total visits planned	312	December 2016
			b.	Proportion of sessions monitored during supervisory visits (%) Description: Number of sessions monitored during supervisory visits against the total number of sessions planned	624	
			c.	Proportion of ANMs able to differentiate three types of ARI (%) Description: Number of ANMs able to differentiate three types of ARI against the total ANMs in position	834	
1.2.2.	Monitoring supervision by the ACMOH based on the monitoring tool	Department of Health and Family Welfare **Person responsible:**	**a.**	Proportion of supervisory visits conducted by the ACMOH (%) Description: Number of supervisory visits conducted by the ACMOH to the total number of visits planned	30	December 2016
			b.	Proportion of blocks visited by the ACMOH (%)	30	

	Action points	Responsible stakeholder	Indicator		Target (in number)	Timeline
		ACMOH		Description: Number of blocks visited by the ACMOH out of the total number of blocks		
			c.	Proportion of quality assessments conducted by the ACMOH (%) Description: Number of assessments conducted by the ACMOH on quality of service provided from identifications to treatment of ARI out of the targeted number of cases	180	
2.Workforce						
2.1.1.	Refresher training for ANMs and health supervisors	Department of Health and Family Welfare **Person responsible:** BMOH	**a.**	Proportion of refresher training conducted (%) Description: Number of refresher training conducted to the total number of training planned	13	December 2016
			b.	Proportion of health supervisors trained (%) Description: Number of health supervisors participated in the refresher training against the total health supervisors in position	200	
			c.	Proportion of ANMs trained (%) Description: Number of ANMs participated in the refresher training against the total ANMs in position	834	
3. Supplies and technology						
3.1.1.	Monthly review report of the Utilisation Certificate	Department of Health and Family Welfare **Person responsible:** BMOH	**a.**	Proportion of Utilisation Certificate of Ampicillin received (%) Description: Utilisation Certificate of Ampicillin used for treatment against estimated usage	78	December 2016
			b.	Proportion of Utilisation Certificate of Gentamicin received (%) Description: Utilisation Certificate of Gentamicin against estimated usage	78	
4. Health information						
4.1.1.	Compilation of sub--centre level information on reported cases of ARI	Department of Health and Family Welfare **Person responsible:** BMOH	**a.**	Proportion of ARI identified by ANMs (%) Description: Number of ARI identified by ANMs against total estimated cases	3,360	December 2016
			b.	Proportion of ARI identified by ASHAs (%) Description: Number of ARI identified by ASHAs against total estimated cases	1,200	
			c.	Proportion of ARI with pneumonia (%)	2,740	

	Action points	Responsible stakeholder	Indicator		Target (in number)	Timeline
				Description: Number of ARI with pneumonia against total estimated cases		
			d.	Proportion of ARI with severe pneumonia (%) Description: Number of ARI with severe pneumonia against total estimated cases	1,370	
			e.	Proportion of ARI with very severe pneumonia (%) Description: Number of ARI with very severe pneumonia against total estimated cases	450	
4.1.2.	Monthly review of reported data at district level	Department of Health and Family Welfare **Person responsible:** Dy. CMOH-II	**a.**	Proportion of monthly reviews conducted at district level (%) Description: Number of monthly reviews conducted at district level against planned	6	December 2016
4.1.3.	Validity of the data at district level	Department of Health and Family Welfare **Person responsible:** BMOH	**a.**	Proportion of monthly validations of ARI data at block level (%) Description: Number of monthly validations conducted on ARI data reported at block level against estimated	78	December 2016
			b.	Proportion of monthly validations of ARI data at district level (%)	78	
5. Finance						
6. Policy and governance						
6.1.1.	Letter to be sent to the managing director of the National Health Mission	Department of Health and Family Welfare **Person responsible:** CMOH	**a.**	Request letter to the managing director of the National Health Mission, regarding inclusion of data on ARI Description: Issue a request letter to the managing director of the National Health Mission, on the importance to include and analyse data on reported ARI cases in the monthly reporting system	1	November 2016

Form 5: Follow-up

Date of meeting:	21 March 2017
Venue of meeting:	CMOH Office, DHHD
Chairperson of meeting:	CMOH
Theme leader of cycle:	Dy. CMOH-II

Part A

Theme:	Prevention and treatment of ARI
Number of meetings for the respective theme:	5

1. Major stakeholders involved in each meeting

Sl. No.	Date	Number of participants
Meeting 1	10 October 2016	23 participants: CMOH, Dy. CMOH-I, -II, -III, ACMOH (Kakdwip and Diamond Harbour Sub-Division), BMOHs and BPHNs
Meeting 2	11 November 2016	39 participants: CMOH, Dy. CMOH-I, -II, District maternity and child health officer (DMCHO), ACMOH (Kakdwip and Diamond Harbour Sub-Division), BMOHs and BPHNs
Meeting 3	22 December 2016	32 participants: CMOH, Dy. CMOH-II, -III, DMCHO, ACMOH (Kakdwip and Diamond Harbour Sub-Division), BMOHs and BPHNs
Meeting 4	10 January 2017	34 participants: Dy. CMOH-II, DMCHO, ACMOH (Kakdwip and Diamond Harbour Sub-Division), BMOHs and BPHNs
Meeting 5	10 February 2017	39 participants: CMOH, Dy. CMOH-II, ACMOH (Kakdwip and Diamond Harbour Sub-Division), BMOHs and BPHNs

2. Comparison of key coverage indicator(s) in the DIPH cycle			**Time 0**	**Time 1**	**Time 2**	**Time 3**	**Graph View**
		Date	September 2016	October 2016	November 2016	December 2016	
2.1.1	Number of under-five children admitted with ARI (HMIS item number 12.9)		41	62	36	48	

Part B

Total action points − Planned	9
Total action points −Not started	0
Total action points − Ongoing not on target	1
Total action points − Ongoing on target	6
Total action points − Completed	2

Sl. No.	Action points	Indicators		Target (in number)	Progress of indicators (%)	Person responsible	Timeline	Status of action points	Further follow-up suggestions	
									Timeline	Change in responsibility
1.	**Service delivery**									
1.1.1	On-site training at block level for ANMs	**a**	Proportion of on-site training conducted (%)	65	75.38	BMOH	December 2016	Ongoing – on target		
		b	Proportion of ANMs trained (%)	834	83.09					
1.2.1	Monitoring supervision by BMOHs/ BPHNs based on the monitoring tool	**a**	Proportion of supervisory visits conducted (%)	312	55.13	BMOH	December 2016	Ongoing – on target		
		b	Proportion of sessions monitored during supervisory visits (%)	624	27.4					
		c	Proportion of ANMs able to differentiate three types of ARI (%)	834	46.16					
1.2.2	Monitoring supervision by the ACMOH based on the monitoring tool	**a**	Proportion of supervisory visits conducted by the ACMOH (%)	30	0	ACMOH	December 2016	Ongoing – on target		
		b	Proportion of blocks visited by the ACMOH (%)	30	0					
		c	Proportion of quality assessments conducted by the ACMOH (%)	180	0					
2.	**Workforce**									
2.1.1	Refresher training for ANMs and health supervisors	**a**	Proportion of refresher training conducted (%)	13	100	BMOH	December 2016	Ongoing – on target		
		b	Proportion of health supervisors trained (%)	200	53					
		c	Proportion of ANMs trained (%)	834	63.79					
3.	**Supplies and technology**									
3.1.1	Monthly review report of the Utilisation	**a**	Proportion of Utilisation Certificate of Ampicillin received (%)	78	10.26	BMOH	December 2016	Ongoing – on target		

Sl. No.	Action points	Indicators		Target (in number)	Progress of indicators (%)	Person responsible	Timeline	Status of action points	Further follow-up suggestions	
									Timeline	Change in responsibility
	Certificate	**b**	Proportion of Utilisation Certificate of Gentamicin received (%)	78	5.13					
4.	**Health information**									
4.1.1	Compilation of sub--centre level information on reported cases of ARI	**a**	Proportion of ARI identified by ANMs (%)	3,360	66.07	BMOH	December 2016	Ongoing – on target		
		b	Proportion of ARI identified by ASHAs (%)	1,200	55.25					
		c	Proportion of ARI with pneumonia (%)	2,740	21.79					
		d	Proportion of ARI with severe pneumonia (%)	1,370	3.72					
		e	Proportion of ARI with very severe pneumonia (%)	450	1.11					
4.1.2	Monthly review of reported data at district level	**a**	Proportion of monthly reviews conducted at district level (%)	6	0	Dy. CMOH-II	December 2016	Completed		
4.1.3	Validity of the data at district level	**a**	Proportion of monthly validations of ARI data at block level (%)	78	44.87	BMOH	December 2016	Completed		
		b	Proportion of monthly validations of ARI data at district level (%)	78	0					
5.	**Finance**									
6.	**Policy and governance**									
6.1.1	Letter to be sent to the managing director of the National	**a**	Request letter to the managing director of the National Health Mission, regarding inclusion of data on ARI	1	0	CMOH	November 2016	Ongoing – not on target		

Sl. No.	Action points	Indicators	Target (in number)	Progress of indicators (%)	Person responsible	Timeline	Status of action points	Further follow-up suggestions	
								Timeline	Change in responsibility
	Health Mission								

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 1 hour 40 minutes session 11.20 pm – 1.00 pm
A.2 Form 4	2 hours	1 hour 25 minutes	
A.3.Concluding remarks	10 minutes	10 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-II, DHHD		
B.4 Record of proceedings prepared by	DIPH research team – Sayan Ghosh		
C. Stakeholder participation			
C.1 Number of stakeholders invited	Health department	8	CMOH, DHHD Dy. CMOH-I, DHHD Dy. CMOH-II, DHHD Dy. CMOH-III, DHHD DMCHO, DHHD District programme co-ordinator, DHHD, ACMOH, DHHD and Namkhana Block
	Non-health departments	2	DPO-ICDS, South 24 Parganas, PHPC, Zilla Parishad
	NGO/private for-profit organisations	0	
	District administration	0	
C.2 Percentage of stakeholder participation (to those invited)	Health department	75.0% (6/8)	
	Non-health departments	0.0% (0/2)	
	NGO/private for-profit organisations	Non applicable	
	District administration	0 (0)	
	Total	60.0% (6/10)	
D. Stakeholder involvement (*Note: Record everyone's viewpoint; if someone did not raise any concern, record it also*)			
D.1 Issues discussed by health department representatives	CMOH, DHHD	• Improving the early identification of ARI cases • Training needed for ANMs to differentiate the three types of ARI and taking action accordingly • Reporting ARI cases to know the implications of the pentavalent • Considering the cycle as the baseline for the pentavalent vaccine usage and its effectiveness	

	Dy. CMOH-II, DHHD	• Need to improve the coverage and reporting on ARI • All grassroots-level service providers should have good knowledge on the aspect • Relation with the Integrated Disease Surveillance Programme reporting • Regular monitoring by the supervisory staffs (BMOH, BPHN, etc.)	
D.2 Non-health departments		Non applicable	
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	Non applicable		
G. Data utilisation			
During situational analysis the discussion was based on the following data elements: HMIS − status as on 20 September 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	11.20 am − 11.25 am
A.2 Form 5	2 hours and 30 minutes	2 hours and 15 minutes	11.25 am − 1.40 pm
B. Stakeholder leadership			
B.1 Agenda circulated/ invitations sent		CMOH	
B.2 Chair of sessions		CMOH, DHHD	
B.3 Nominee/ volunteer	1. Completing data forms	Sayan Ghosh	
	2. Presenting summary	Dy. CMOH-II	
	3. Theme leader	Dy. CMOH-II	
	4. Record of proceedings	Sayan Ghosh	
C. Stakeholder participation			
C.1 Number of stakeholders invited	Health department	54	Dy.CMOH-I, -II, -III DMCHO ACMOH Superintendents BMOHs BPHNs Public health nurses District Programme Management Unit staff
	Non-health departments	2	DPO-ICDS PHPC, Zilla Parishad
	NGO/private for-profit organisations	-	
	District administration	-	
C.2 Percentage of stakeholder participation (to those invited)	Health department	100% (54)	
	Non-health departments	50% (1/2)	
	District administration	0% (0)	
	NGO/private for-profit organisations	0% (0)	
	Total	98.2% (56)	
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 and Dy. CMOH-II	• Each action point discussed with justification of the reports submitted by the blocks • Out of the nine action points two had completed • The remaining seven action points will carry forward for the next three months • Importance of validation of data	
D.2 Non-health departments	PRD	• Full support will be provided by the PRD	
	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	ICDS	Non applicable	Responsibility not assigned to

shared	PRD	Non applicable	non-health departments. They will support the health department as per need
	NGO	Non applicable	
F. Co-operation/communication between stakeholders*			
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: Monitoring Format with Definitions

A.3.1: Monitoring framework[28]

Purpose	Indicators	Definition	Sources of information
I. Utilisation of data at district level Whether the DIPH study led to utilisation of the health system data or policy directive at district level for decision-making?	A. Selection of the primary theme for the current DIPH cycle	**1. Whether the DIPH cycle theme selection was based on HMIS data? (Y/N)** **Health system data:** statistical information collected either routinely or periodically by government institutions on public health issues. This includes information related to provision and management of health services. This data can be from the health department and/or non-health departments *In the West Bengal context, the main data sources will include HMIS and MCTS*	Form 1B: Health system capacity assessments
		2. Whether the DIPH cycle theme selection used any data from non-health departments? (Y/N) **Non-health departments:** government departments, other than the health department, which directly or indirectly contributes to public health service provision *In the West Bengal context, this includes PRD and CD*	Form 1B: Health system capacity assessments
		3. Whether the DIPH cycle theme selection was based on health policy and programme directives? (Y/N) **Health policy:** refers to decisions that are undertaken by the state/national/district to achieve specific health care plans and goals. It defines a vision for the future which in turn helps to establish targets and points of reference for the short- and medium-term health programmes **Health programme:** focused health interventions for a specific time period to create improvements in a very specific health domain *In the DIPH West Bengal context: any health-related directives/guidelines/ government orders in the form of an official letter or circular issued by the district/state government*	Form 1A.1: Data extraction from state and district health policy documents
	B. Data-based monitoring of the action points for the	**4. (Number of action points on which progress is being monitored by data) / (total number of action points for the primary theme of the DIPH)**	Form 5: Follow-up

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

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

	primary theme of the DIPH	**Action points:** a specific task taken to achieve a specific objective *In the DIPH context: a specific action, arisen from the stakeholder discussions during Steps 3 and 4, to achieve the target of the given DIPH cycle*	
	C. Revision of district programme data elements for the primary theme of the DIPH	**5. Whether stakeholders suggested a revision/addition to 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 WHO health system building blocks (demographic, human resources, finance, service delivery, health outcome, governance)	Form 5: Follow-up
	D. Improvement in the availability of health system data	**7. Whether the health system data required on the specified theme as per the given DIPH cycle was made available to the assigned person in the given DIPH cycle? (Y/N)** **Assigned person:** as per the cycle-specific DIPH action plan; this can be the theme leader, DSM, or any other stakeholder who is assigned with the responsibility of compiling/reporting of specified data	Form 1B: Health system capacity assessments
		8. Whether the health system data on the specified theme area is up-to-date as per the given DIPH cycle? (Y/N) ***Up-to-date data*** ***a)*** If monthly data, then the previous complete month at the time of Step 1 of the DIPH cycle ***b)*** If annual data, then the complete last year at the time of Step 1 of the DIPH cycle	Form 1B: Health system capacity assessments
II. Interactions among stakeholders: co-operation in decision-making, planning and implementation Whether the DIPH study ensured involvement of stakeholders from different sectors (health, non-health and NGO/private for-profit organisations)	E. Extent of stakeholder participation	**1. (Number of DIPH stakeholders present in the planning actions meeting) / (total number of DIPH stakeholders officially invited in the planning actions meeting)** *Participants in Steps 4 and 5* **DIPH stakeholders***:* public and private sector departments, organisations and bodies relevant for the specific cycle of the DIPH **Officially invited**: stakeholders formally being invited to participate for the specific DIPH cycle *In the West Bengal context, for example:* • *Public sector stakeholders: Department of Health and Family Welfare; PRD; and CD* • *Private sector stakeholders: NGOs; nursing homes; and large hospitals*	Form A.2: Record of Proceedings – Summary Tables

		owned by private entities	
		2. (Number of representatives from the health department present in the planning actions meeting) / (total number of DIPH participants in the planning actions meeting) *Participants in Steps 4 and 5*	Form A.2: Record of Proceedings – Summary Tables
		3. (Number of representatives from non-health departments present in the planning actions meeting) / (total number of DIPH participants in the planning actions meeting) *Participants in Steps 4 and 5*	Form A.2: Record of Proceedings – Summary Tables
		4. (Number of representatives from NGOs present in the planning actions meeting) / (total number of DIPH participants in the planning actions meeting) *Participants in Steps 4 and 5*	Form A.2: Record of Proceedings – Summary Tables
		5. (Number of representatives from private for-profit organisations present in the planning actions meeting) / (total number of DIPH participants in the planning actions meeting) *Participants in Steps 4 and 5*	Form A.2: Record of Proceedings – Summary Tables
	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.**	In-Depth Interviews with Stakeholders
		11. List of challenging factors **1.** **2.**	In-Depth Interviews with Stakeholders

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

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

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

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

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Contact us

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

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

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

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