LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

Data-Informed Platform for Health

Training Handbook

DIPH
Data Informed Platform for Health

IDEAS

Acknowledgements

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Aim

The overall aim of this training handbook is to provide knowledge, skills and tools for improved decision-making at the district level utilising the available data. It also elaborates on the operationalisation and cyclical implementation of a new strategy called Data-Informed Platform for Health (DIPH) at the district level to promote the use of local data for decision-making, priority-setting and planning.

The target audience for this handbook is the district health officers, both in administrative and managerial roles within health systems. Part A of the handbook covers the four core skills of decision-making, stakeholder engagement, data use, and monitoring health systems performance. Part B, provides an introduction to the DIPH strategy, steps in a DIPH cycle, roles and responsibilities, DIPH operationalisation, and form-filling guides.

The handbook also contains learning activities including simulation exercises, to provide participants with an opportunity to practice and review the information and tools presented during the course.

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PART A

Part A describes the four core skills, which are necessary for sound decision-making by district health administration. These include core concepts of decision-making, stakeholder engagement, data use and the monitoring of health system performance. The first core-skill, decision-making in health systems, describing the types and determinants of decision-making at the district level, and effective decision-making through structured and collaborative processes. The second core-skill, stakeholder engagement, focuses on the types of stakeholders at the district level and the process of stakeholder analysis for effective collaboration. The third core-skill sheds light on the use of data through understanding the sources, potential use and content analysis of health data at the district level. The fourth core skill explains the monitoring of health systems performance by utilising data for problem identification and solution.

There are learning activities for each of the core skills, to make this training an interactive learning process and provide a basis for understanding the DIPH strategy in Part B.

CORE SKILL 1:
DECISION-MAKING

LEARNING OBJECTIVES

By the end of this session, participants should be able to understand:

1.1. **Understand what is meant by decision-making from a health systems perspective**

1.2. **List the types of decisions made at district-level**

1.3. **Identify the determinants of decision-making**

1.4. **Understand what is meant by effective decision-making from the perspective of health system management**

1.5. **Understand how to achieve structured and collaborative decision-making.**

Decision-making is an essential element for leading and managing the district health department. In this section, we will discuss decision-making, and types and determinants of decision-making in health systems followed by a detailed description of the importance and process of structured and collaborative decision-making to make effective decisions.

> *"It doesn't matter which side of the fence you get off on sometimes. What matters most is getting off. You cannot make progress without making decisions."*
>
> Jim Rohn, Author

1.1. What is decision-making in health systems?

Decision-making is a process of deciding something important, especially in a group of people or in a department. A decision is a course of action purposely chosen from a set of alternatives to achieve departmental objectives or goals.

A decision-making process seeks a goal! This goal is almost always part of the overall objectives of a district health department. The process of collecting information on various alternatives, synthesis of information and finally solving a given problem is integral to decision-making.

We make decisions every day without giving them much thought; however, complex and challenging decisions demand more consideration. Decision-making is a critical skill for effective management and governance.

1.2. Types of decision-making at district level

A variety of decisions are made on a routine basis in a district-level administration. These different types of decisions include:

- Decisions related to the **provision of safe and quality health service delivery**, e.g. infrastructure, packages, delivery models, special health campaign days, etc.
- **Human resource** decisions, e.g. workforce policies and standards, database maintenance, performance evaluation, rewards, and sanctions.
- Decisions related to **health information systems**, e.g. HMIS, parallel data reports.

- Decisions related to the purchase and distribution of **medicines and supplies** while ensuring quality and equity.
- **Financial** decisions, e.g. assessing risks, sharing of costs, getting more funds for high impact services.
- **Governance-related** decisions, which include deciding on roles and responsibilities for who is empowered to make which decision, what process they must follow and with whom they must consult.

"Life is a matter of choices, and every choice you make makes you."

John C. Maxwell, Author

Facilitator's Notes:

The World Health Organization's (WHO) health systems blocks for health systems strengthening (HSS) are the basis for all the types of decision-making at district-level mentioned above. Each of the building blocks represents a functional component of the health system which requires decision-making from time-to-time. Effective decision-making is essential to fulfilling the functions of these building blocks thereby achieving the overall objective of improved health of the population.

(Health System (HS) Building Blocks are described in detail under Core Skill 4)

Facilitators should ensure trainees understand the key concepts in the entire handbook by making sessions interactive.

1.3. Determinants of decision-making

Determinants are factors that can affect decision-making. A multitude of determinants can facilitate or impede a decision-making process, including:

- **Hierarchical structure** within a department – this usually determines the specific roles and responsibilities of team members during decision-making activity.
- **Time constraints** – in district health management, decisions are expected to be made and implemented within a set time-frame.
- **Unclear job roles and responsibilities** – uncertainty about who is responsible for compilation and analysis of information and who is responsible for making the final decision.

- **Social norms** – who is/is not (or should/should not) be included in decision-making processes.
- **Personal interests, beliefs, and values** – how important the issue is for the person responsible for making the decision.

- **Managerial years of experience** – a greater number of managerial years usually affects decision-making positively, as it determines the ability to understand most factors that can affect a decision-making process.
- **Motivated (or less motivated) staff** – this can affect the zeal and rigor of compiling and analysing relevant information.
- **Interpersonal issues** – a positive working relationship amongst the team members will influence decision-making positively.
- **Complicated issues** – if an issue requires information from various sources, both within and outside the health department, it can take more time to compile and analyse data, thereby affecting the timeline.

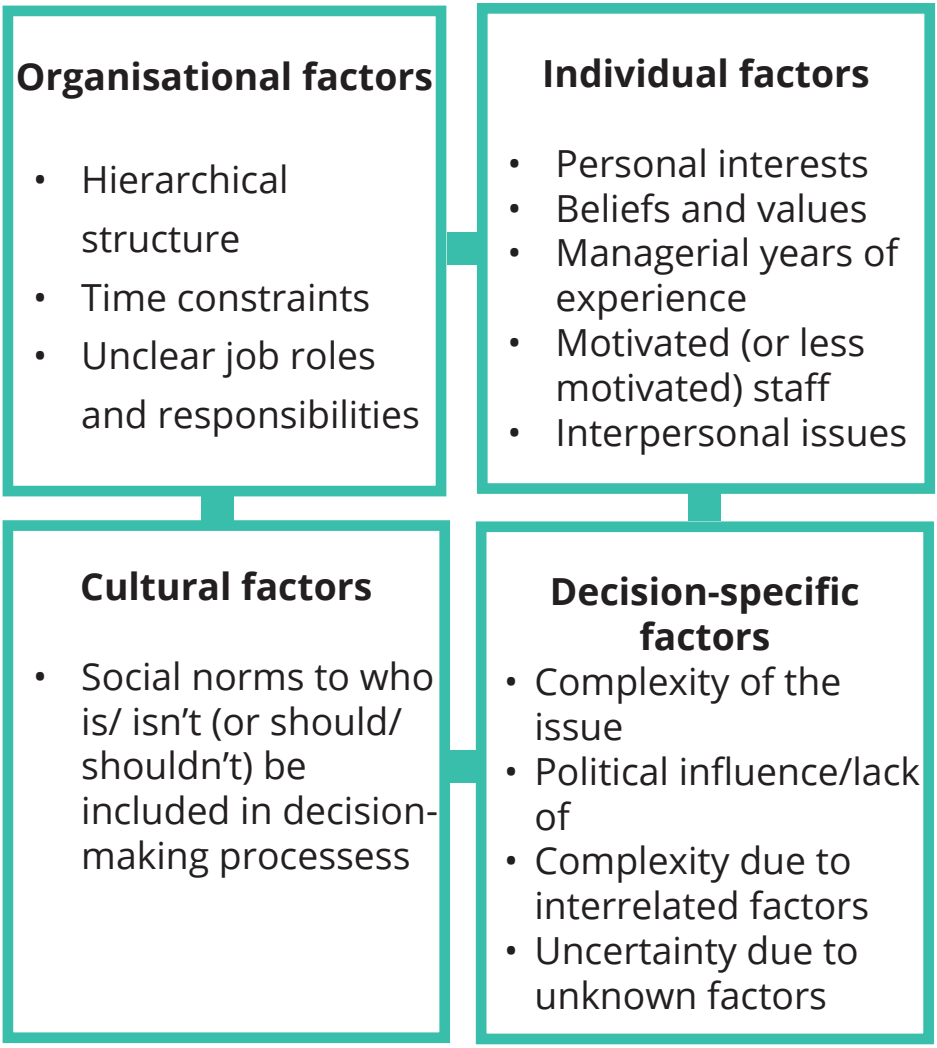
- **Political influence or lack of** – issues that have political backing tend to get given more importance by the district health team and vice versa.
- **Complexity due to inter-related systems** – decisions requiring information and data from another district department can take a longer time due to limited access to data.
- **Uncertainty due to unknown factors** – an unexpected turn of events - for example, an onset of an epidemic, or a natural disaster - can affect the continuity of regular decision-making processes.

Facilitator's Notes:

These determinants can be also grouped as follows:

- *Organisational factors - hierarchical structure, time constraints, unclear job roles and responsibilities*
- *Cultural factors - social norms to who is/is not (or should/should not) included in decision-making processes*
- *Individual factors - personal interests, beliefs and values, managerial years of experience, motivated (or less motivated) staff, interpersonal issues*
- *Decision-specific factors - complexity of the issue, political influence or lack of, complexity due to inter-related factors, uncertainty due to unknown factors*

Figure 1.1: Determinants of decision-making



1.4. Effective decision-making through structured and collaborative processes

A crucial part of decision-making is finding the most effective and efficient method to use in order to make the best possible decisions. Making sound decisions means considering the available evidence from all the possible sources in a structured and organised manner.

Decision-making is routinely done at various departments such as agriculture, women and child health and social care, etc. These departments are making individual efforts to improve the health and living conditions of its population. However, the inclusion of all these departments in the decision-making process is frequently credited with generating more legitimate decision-making processes and effective achievement of health goals in a district.

In this section, we will attempt to understand what effective decision-making is and how can we achieve this through a structured and collaborative process.

a. Effective decision-making

Effective decision-making is a process through which alternatives are reviewed, and the best possible solution is carefully implemented to achieve departmental objectives.

> *"Effective decisions result from a systematic process, with clearly defined objectives, that is handled in a distinct sequence of steps".*[1]

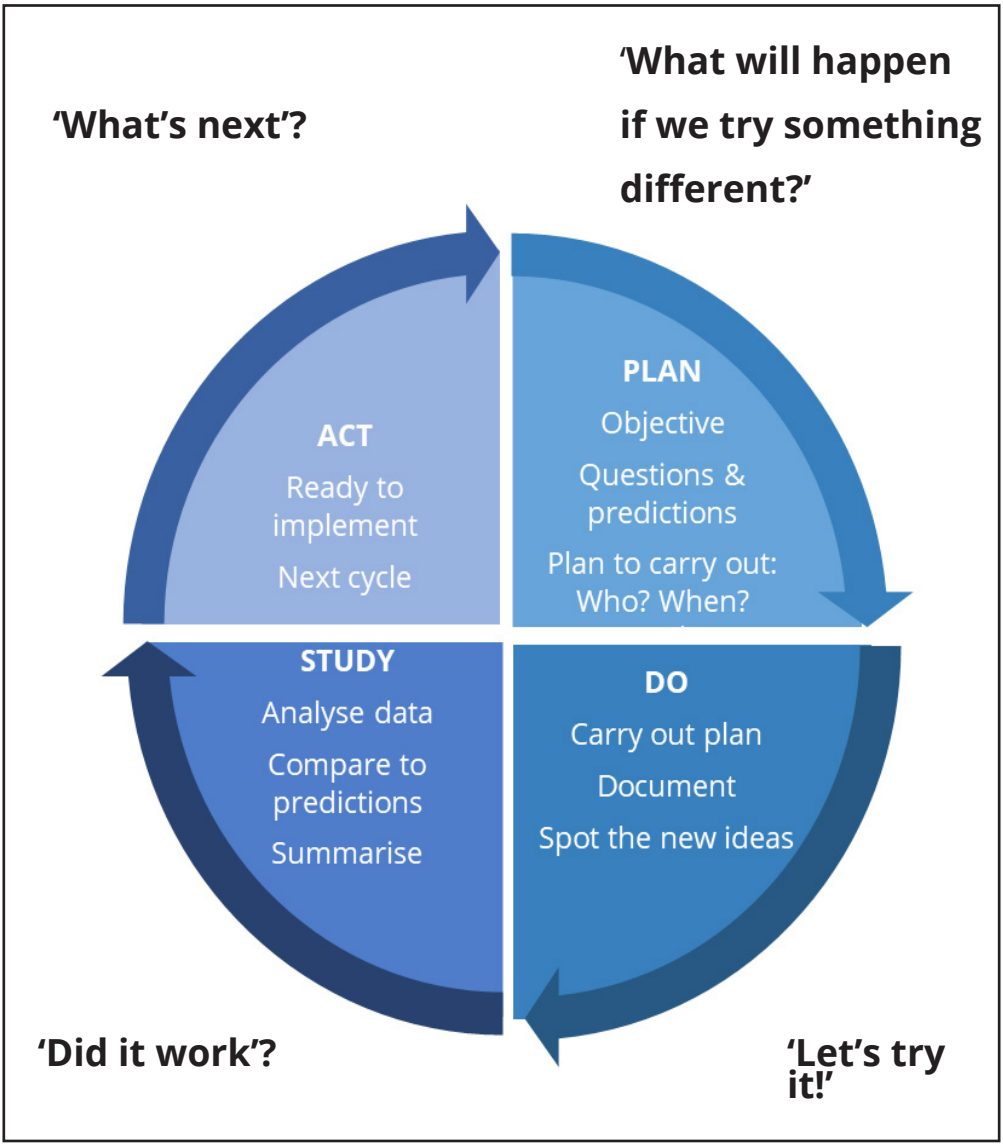
A multitude of decision-making tools and models have been devised by experts in the field of economics, business management, education, environment, health, and social care, etc.[2,3] Most, if not all, have been derived from the Plan-Do-Check-Act (PDCA) model for effective decision-making. The PDCA cycle was initially developed by Walter A. Shewhart to help organisations achieve better results by following a structured process of decision-making for quality improvement. Later, Edwards Deming reintroduced the Shewhart cycle and changed it to PDSA (Plan-Do-Study-Act), as a means of control, to monitor the quality of decision-making and improvements within the organization. The word 'check' was changed to 'study' to ensure a continuous and iterative cycle of analysis and comparison of data for improved decision-making.[4]

PDSA model

The PDSA model is a four-point decision loop that supports quick, effective and proactive decision-making. The four stages of the loop are:

Plan	set the goals; make predictions; plan the cycle (who, what, where, how); identify what data will be required.
Do	carry out the plan; compile the data.
Study	analyse the data; compare data with predictions.
Act	see what changes need to be made in the next cycle; if none, roll out the final decision.

Figure A1.2 PDSA model



A four-stage cyclical learning approach is employed by the users of the PDSA method to make decisions for changes aimed at improvement.

In the ‘plan’ stage a change aimed at improvement is identified, the ‘do’ stage sees this change tested, the ‘study’ stage examines the success of the change, and the ‘act’ stage identifies adaptations and next steps to inform a new cycle. This model is a continuous and iterative cycle that enables collection and synthesis of information and adaptation through contextualisation for improved decision-making.

b. Structured decision-making

Structured decision-making is utilised for a carefully organised analysis of problem(s) in order to reach decisions that are focused on achieving set objectives. The term **'structured'** designates pre-determined steps and procedures before starting the analysis of a problem and the decision-making process. The basic concept of structured decision-making has been derived from the PDSA model described in the section above.

Structured decision-making is often used for simple to complex decision-making.[5] The steps that can be taken in order to reach a decision are:

i. **Understand the problem/issue** – Decide what specific decision must be made?

ii. **Clearly state the objectives** for the process – Objectives must be SMART, i.e. Specific, Measurable, Achievable, Relevant, Time-bound (see facilitator's notes).

iii. **Develop alternative solutions** - This requires explicit enunciation of the alternatives available to the decision maker. Cultural, organisational or political considerations often constrain the range of permissible options, but a structured assessment may lead to creative new alternatives.

iv. **Compare alternatives against the objectives** - in structured decision-making; we predict the consequences of alternative actions or solutions. For a structured decision-making process, alternative solutions may be modelled with scientific computer applications or with personal judgment depending on the available information and quantification desired. Ideally, models are quantitative; however, this is not always essential, the most important thing is that they link actions to consequences.

v. **Trade-offs** – In most complex decisions, where there are multiple objectives, a trade-off, choosing logically between less-than-perfect alternatives, is deemed important. It constitutes determining the relative importance of conflicting objectives and comparing alternatives across multiple attributes to find the 'best' compromise solutions.

vi. **Understanding uncertainty** – In health systems, decision-making is frequently challenged by uncertainty. Choosing among alternatives is far more difficult in these situations. An improved decision-making process predicts and tackles uncertainty explicitly, by understanding the likelihood of different outcomes and evaluating possible consequences.

vii. **Linked decisions** – In health systems, many vital decisions are linked over time. An effective way to deal with linked decisions is to isolate and resolve the near-term issues while compiling the information needed for future decisions.

viii. **Implement final decision**

ix. **Monitor/ follow-up**

The core concepts and steps of structured decision-making are beneficial across all types of decisions: from a district health officer making day-to-day minor decisions, to complex departmental decisions involving multiple decision makers, managers and other stakeholders.

> *"A structured and collaborative approach ensures the quality of the decision-making."*

An effective and structured decision-making approach ensures the quality of the decision-making process. The DIPH framework guides structured decision-making by bringing together vital information, in the form of data from a variety of sources within various public sectors, with an overall goal to achieve health targets for the population.

Facilitator's Notes:

Further clarification of SMART objectives – SMART stands for:

- *Specific (focused)*
- *Measurable (objective, tangible)*
- *Achievable (feasible, attainable)*
- *Relevant (applicable to real issues and the context)*
- *Time-bound (achievable in a specified time)*

Further explore trainee's understanding of the PDSA model at the end of the session.

Note: Public system terminology varies from country to country, e.g. sometimes administrative 'departments' are called sectors, units etc. In the Ethiopian context, the Zonal health administrative office is called 'Zonal health department' whereas the district level health administrative office is called 'Woreda/ district health office'.

c. Structured and collaborative decision-making

Collaborative decision-making is a process focused on how to decide on a course of action articulated between two or more stakeholders such as health, non-health or private-for-profit organisations and non-governmental organisations (NGOs). Through this process, team members and stakeholders share information related to the decision, and agree on and apply the decision-making approach and principles.

Collaborative decision-making aims at combining the input from all stakeholders and making the best choice from an objective standpoint. Collaborative decisions are closely associated with group behaviours, interactions between members, psychological factors that can affect people's thinking, and last but not the least, role distribution.

During the collaborative decision-making process, different stakeholders play various roles, and it is beneficial to assign roles for the different stages; e.g., people or teams responsible for compiling information and data, analysing the data, and those responsible for bringing the decision to a closure.

The stakeholders involved in the decision-making are expected to be prepared to learn, to explore alternatives and to build a common understanding of what constitutes the best available information for estimating consequences and evaluating trade-offs through a structured process.

Facilitator's Notes:

Participants will be asked to do two learning activities (described at the end of all four core skills). The first will be a group activity to identify enablers and challenges for decision-making faced by a district health officer on a given day (e.g. vaccination day). The second activity will focus on recall and discussion of the information shared during the section on structured decision-making.
The session can be further enriched with contextualized and specific local examples.

CORE SKILL 2: STAKEHOLDER ENGAGEMENT

LEARNING OBJECTIVES:

By the end of this session, participants should be able to understand:

2.1. **What is meant by district level stakeholders for health**

2.2. **The types of stakeholders for health at the district level**

2.3. **How to identify the significance of the stakeholder in district level decision-making**

2.4. **How to engage with the district level stakeholders for health**

Stakeholders are individuals who affect or are affected by the health systems decisions and actions.[4] The term, stakeholders, refers to persons, groups or departments that must somehow be taken into account by leaders and managers. This section will describe the meaning, types, and significance of district level stakeholders followed by a discussion on how to effectively engage the stakeholders for health at the district level.

2.1. District level stakeholders for health

Stakeholders for health are individuals, organisations, and departments who have vested interests in the health and well-being of a given population and who can influence decision-making processes, finances, design and implementation of health initiatives.

District level stakeholders include all, but are not limited to the workforce in the respective district departments of health, education, water, electricity, agricultural, roads and transport, finance and planning, etc. They also include health, non-health and private-for-profit organisations and NGOs who are responsible for providing health and health-related services in a given district.

2.2. Types of stakeholders for health at the district level

For any given decision-making process, district level stakeholders can be categorised into primary and secondary stakeholders for the particular issue under consideration.

Primary stakeholder:
This refers to the central stakeholder department responsible for providing direct health services within the identified issue being discussed.

Secondary Stakeholder:
This refers to the stakeholder department responsible for providing supportive services within the identified issue.

2.3. Significance of stakeholders in district level decision-making

Attention to stakeholders is imperative throughout the governance and management process, because success for both public and private district departments and organisations depends on satisfying key stakeholders according to their definition of what is valuable.[6] Too often, a failure to attend to the information and concerns of stakeholders creates flawed thinking, or action that leads to poor performance and outright failure to achieve the end objectives.[7]

Due to the increasingly interconnected nature of the world, district level decision-makers are continuously required to attend to interests and information held by key stakeholders, i.e., primary and secondary. After figuring out what the problem is and what solutions might work, taking stakeholders into account is a crucial aspect of problem-solving.

2.4. How to engage with these stakeholders effectively?

As discussed, under collaborative decision-making, constructive engagement with stakeholders is imperative for the successful implementation of health policies and plans.

The following are preliminary steps to engage with stakeholders effectively:

1. Identify anyone who contributes to, or is affected by decisions.
2. Understand their power to influence the decision-making.
3. Explain their interests and incentives.
4. Facilitate their role in
   - Identifying and understanding priority problems
   - Reviewing evidence
   - Making and implementing decisions [in line with research and other information and data available]

STAKEHOLDER ANALYSIS:

Stakeholders include individuals, community leaders, community groups and other departments who will be affected by health systems decision-making, or who could influence its implementation and outcome.

At the district level, stakeholders are any combination of members of health and non-health district departments, community groups, NGOs and private-for-profit health organisations.

A stakeholder analysis matrix is a technique used for analysing and mapping the stakeholders for an issue or problem. Stakeholder analyses are instrumental in identifying key stakeholders and assessing their power, interest and role to affect the decision-making.

Power:
Power to influence decision-making can come from access to, or control over various support mechanisms, such as money and authority (i.e. designation).

Interest:
Understanding the importance that they attach to the problem can be done by analysing their awareness – indicating the aspirations or concerns of the stakeholder.

Role:
Based on their power and interest, stakeholders can play an instrumental role in accessing vital information which can form the basis of decision-making to address the health issue(s).

The following table shows an example of stakeholders for health service delivery

Table A2.1: Stakeholder Analysis Matrix

Stake-holders	Type of stakeholders (Primary or Secondary)	Power	Interest	Role	Mechanism to collaborate for decision-making
Example: **Nurses & midwives Union**	Primary	High	High	Maintaing working conditions for nurses	Monthly roundtable discussions
Patient Advocacy Group	Primary	Medium	High	Maintaining quality of care for patients	Information and feedback meetings every six months

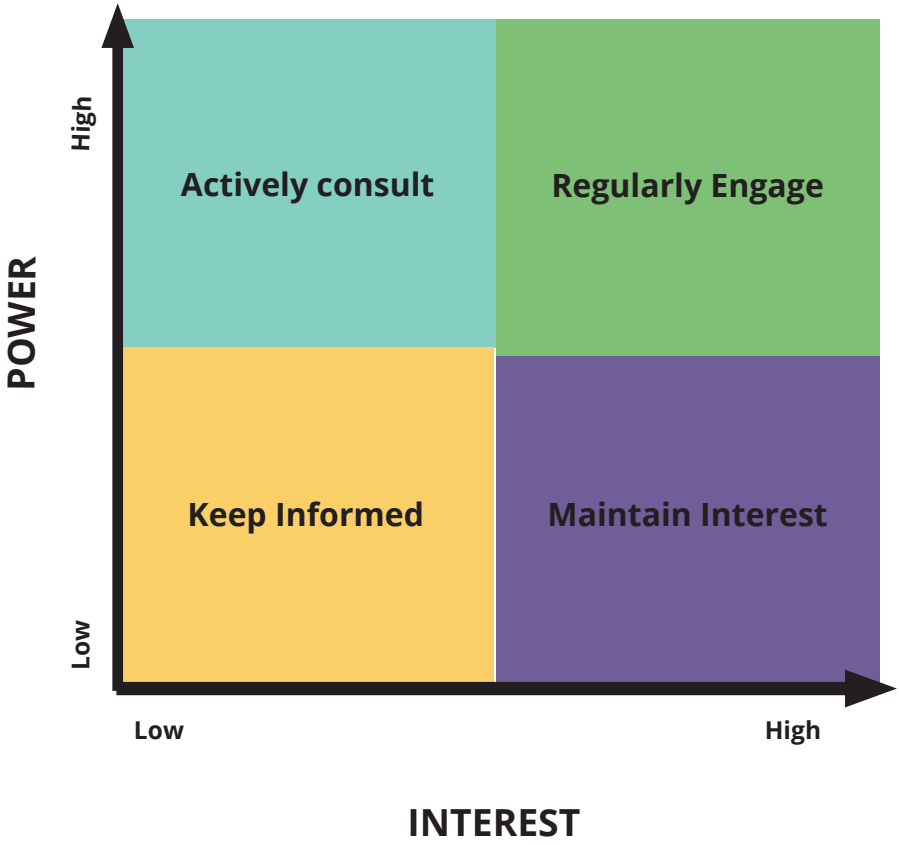
Both primary and secondary stakeholders have different levels of involvement and power that determine how they could promote or hinder decision-making for a problem under consideration. It is crucial that the stakeholder analysis focuses on all dimensions of power, interest and role.

Categorising stakeholders allows you to develop strategies to engage with all stakeholders effectively.

A stakeholder communication plan can also be created once stakeholder mapping is done.

- Stakeholders with high power and high interest should be engaged with regularly,
- stakeholders with low power and low interest will require less regular and detailed communication (however, this does not necessarily mean that they should be ignored!).

Figure 2.2: Power-Interest grid



Facilitator's Notes:

Once all stakeholders are listed in the matrix (page 40), along with information on their type, power, interest and role, they can be also be mapped on power versus interest grid. A power versus interest grid typically helps determine which stakeholders' interests and power bases must be considered to address the problem or issue at hand.

Participants will be asked to do a learning activity (described in detail on page 80.) It will be a brainstorming exercise to identify and map the stakeholders for a chosen health issue within the district health system.

Actively explore the trainee's understanding of the a) Primary and secondary stakeholders differentiation, and b) the Power-Interest Grid.

CORE SKILL 3:
DATA USE

LEARNING OBJECTIVES:

By the end of this session, participants should be able to understand:

3.1 **What is meant by health system data and its sources at the district level**

3.2 **Health data diversity at the district level**

3.3 **The potential uses of health data at the district management level**

3.4 **How to review the content and extent of data available at the district level**

This section will help the participants to understand what health systems data and the different sources for data are at the district level. It will also explain data diversity and the potential use of data at the district management level. The participants will learn how to do a content analysis of health systems data.

"It is a capital mistake to theorize before one has data."

Arthur Conan Doyle (Sherlock Holmes), Author

3.1. What is health systems data?

Health systems data are information and statistics related to health conditions, causes and risks, outcomes, and quality of life of the population. They also include information on availability, quality, cost and safety of health services, along with information on reviews, planning, monitoring and quality improvement within health systems.

At the district level, health systems data are routinely generated at multiple levels within and outside health systems, at community and departmental levels. These data capture information on demographic characteristics, coverage indicators, assessment of health system capacity in terms of infrastructure, general resources (supplies, financing, technology) and human resources (personnel and skills level).

3.2. Sources of health systems data at district level

Health systems data can be accessed through the following sources:

1. **Routine health management information systems (HMIS)** – Provide information on core indicators for coverage, quality, and safety of health services, availability of medicines and supplies, etc.
2. **Non-HMIS reports** – Include data collected by newly introduced services within health systems that are not yet part of HMIS.
3. **Health status and related determinants data collected by non-health departments** – For example, data collected by the district agricultural department can include the nutritional status of children, which is a closely linked indicator for the district health department.

4. **Census** – Provides information on the social and demographic details of the district.
5. **Surveys** – Provide information on specific topics and populations, for example, district level household and facility surveys.
6. **Research studies** – Provide data on the incidence and prevalence of disease(s) in a district.
7. **Disease surveillance** – Tracks the prevalence of specific diseases in a target population over time. These data help to estimate the burden of specific diseases.
8. **Monitoring data** – Provide information that can help improve the provision of health services, access to medicine and supplies, etc.

3.3. What is meant by health systems data diversity?

HMIS at district level usually collect information related to service delivery, resource allocation and health workforce, thereby providing data mainly for coverage and not for management purposes.

However, as mentioned above, health systems data are not limited to the data collected by the district health department, but also include information recorded by the private health sector and other district departments that can affect the health of the population, directly or indirectly. These may include the departments of education, water and sanitation, agriculture, transport, information technology, etc.

According to a study, there is little formal or institutional routine data sharing between the public and private health sectors, and between the health department and other related departments.[6] The study indicates the need to develop a mechanism for routine sharing of essential data by the private health sector and by other non-health government departments at the district level. DIPH provides a platform and mechanism for data sharing across governmental and non-governmental service providers on a regular basis.

3.4. The potential use of health data at the district management level

Data use is a process through which district health managers, decision-makers and stakeholders explicitly consider information in one or more steps of the process of planning, service provision, management, and monitoring. In district health systems, data can be utilized at the following levels:

Facility and district administrative level:

- Assessing the coverage and quality of services
- Planning and managing health services
- Ensuring human resource availability
- Assessing staff performance
- Assessing the performance of a programme or activity

Health service providers including community health workers:

- Identify individual patients/clients and households
- Identify missed opportunities
- Promote continuity of care
- Plan outreach activities
- Follow up on referrals
- Detect early warning signals of disease outbreaks

3.5. How to do a content analysis of health systems data

At the district level, health systems data are routinely collected for all six of WHO's health systems building blocks.[8] As discussed above, data sources include district HMIS, population and demographic surveys, civil registry system and other parallel sources of data; i.e., data recorded by other related departments such as social and welfare, women and child development, agriculture, etc.

It is essential to have a pool of information available, so data can be analysed to retrieve, understand and correlate information for decision-making on issues related to the following functional components of health systems:

- Provision of safe and quality health services
- Human resource management and performance evaluation
- Collection of information on core indicators for health systems
- Purchase and distribution of medicine and supplies
- Financial management
- Planning and supervision for all the above through improved governance

Content analysis of health systems data entails compilation and analysis of data forms from a variety of sources, organised under the functional components of health systems, i.e., health systems building blocks.

Data elements – the smallest named items of data that convey meaningful information for the health issue(s) under consideration – are also selected during content analysis.

Health coverage indicators created by determining which data elements are required to establish the denominator and numerator.
Indicators (percentages, ratios, etc.) are the core of data analysis. Indicators can be created through a possible numerator and denominator for each of the categories and sub-categories of the health systems building blocks.

What are numerators and denominators?
The numerator and the denominator represent two clusters of people, events, or documents that can be compared. The population in the numerator is a subgroup of the population in the denominator. When the numerator is put over the denominator, a fraction (X/Y) is created that can be used to calculate percentages, proportions, and other rates to show how things are changing over time.

The numerator is the

- *actual* number of people who received the service, or the
- *actual* number of people who have developed a certain condition, characteristic or practice.

The denominator is the

- *total* number of people who are anticipated to receive the service, or the
- *total* number of people who can potentially develop certain condition, characteristic or practice.

Facilitator's Notes:

Participants will be asked to do two learning activities (described on page 82). First, a brainstorming exercise to identify and list all the available sources of data within a district and second, a group activity in which the facilitator will share data forms from different sources and ask the participants to carry out a content analysis.

Example:
To calculate the percentage of women receiving HIV counselling and testing in a district in past 6 months, the numerator is the number of women attending antenatal clinics in a district who receive HIV counselling and testing services during those months, and the denominator is the total number of women attending antenatal clinics in that district during the same period.

If we count the number of women who received HIV counselling and testing in the past six months and find that the number is 280, it is difficult to know if that is a significant achievement. However, if we know that 300 women attended antenatal clinics in that district in the past six months, that means 80% percent of those women received counselling and testing services, i.e. among 300 women receiving ANC, 280 received HIV counselling testing ; if 100 women receive ANC, then how many will receive HIV counselling and testing?

CORE SKILL 4:
MONITORING HEALTH SYSTEM PERFORMANCE

LEARNING OBJECTIVES:

By the end of this session, participants should be able to understand:

4.1 **What is meant by health systems at the district level**

4.2. **What is meant by health systems performance**

4.3. **How to assess health systems performance at the district level**

4.4. **How to use the health systems performance framework and data, together for problem solving at the district level**

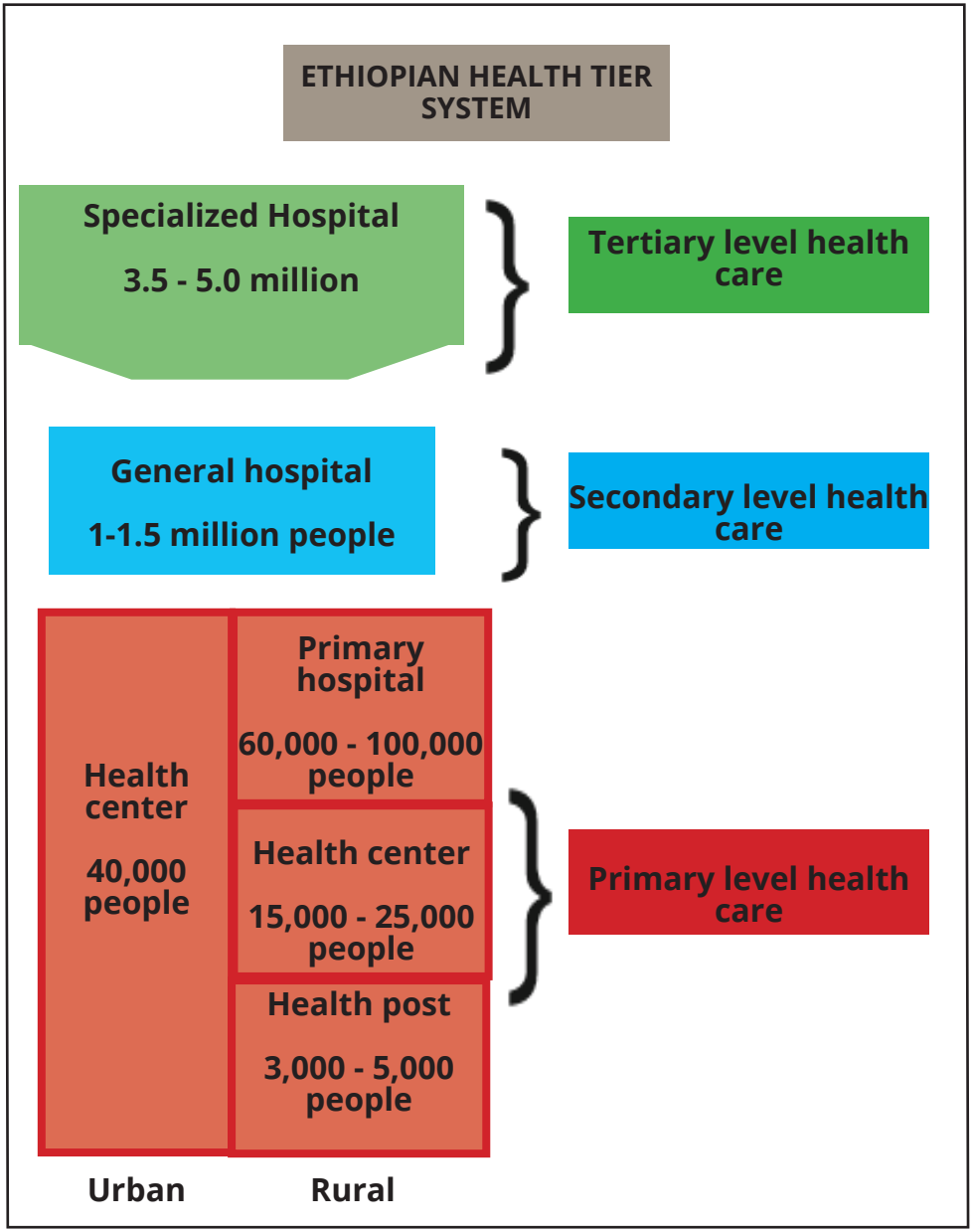
The health system is responsible for delivering quality services to all people, when and where they need them. A sound health system requires a robust management mechanism; a well-trained and committed workforce; reliable information sources on which to base decisions and policies; well-maintained facilities and logistics to deliver quality medicines and technologies. Under this core skill, participants will be given a brief introduction of district health systems, health systems performance and its assessment at district level utilising WHO's six building blocks. Finally, problem-solving by incorporating available data into the health systems performance framework will be explained in detail.

4.1. District health systems

District health systems generally cover one district – an administrative unit. Depending on various factors in different countries, the district council may be wholly or partially responsible for health care in the district. The district health system generally has a responsibility to provide primary health care through planning and delivering a compendium of curative and preventive services, in line with national health policy, in response to health issues and the specific needs of the local population.

Within a district health system, there are primary and secondary levels of health care that need to be supervised, coordinated and supported by a management body. The system also comprises community-level activities, as well as national, regional and district-level vertical programmes, making the overall structure significantly more complicated.

Example of the Ethiopian 3-tier health system:



4.2. Health systems performance

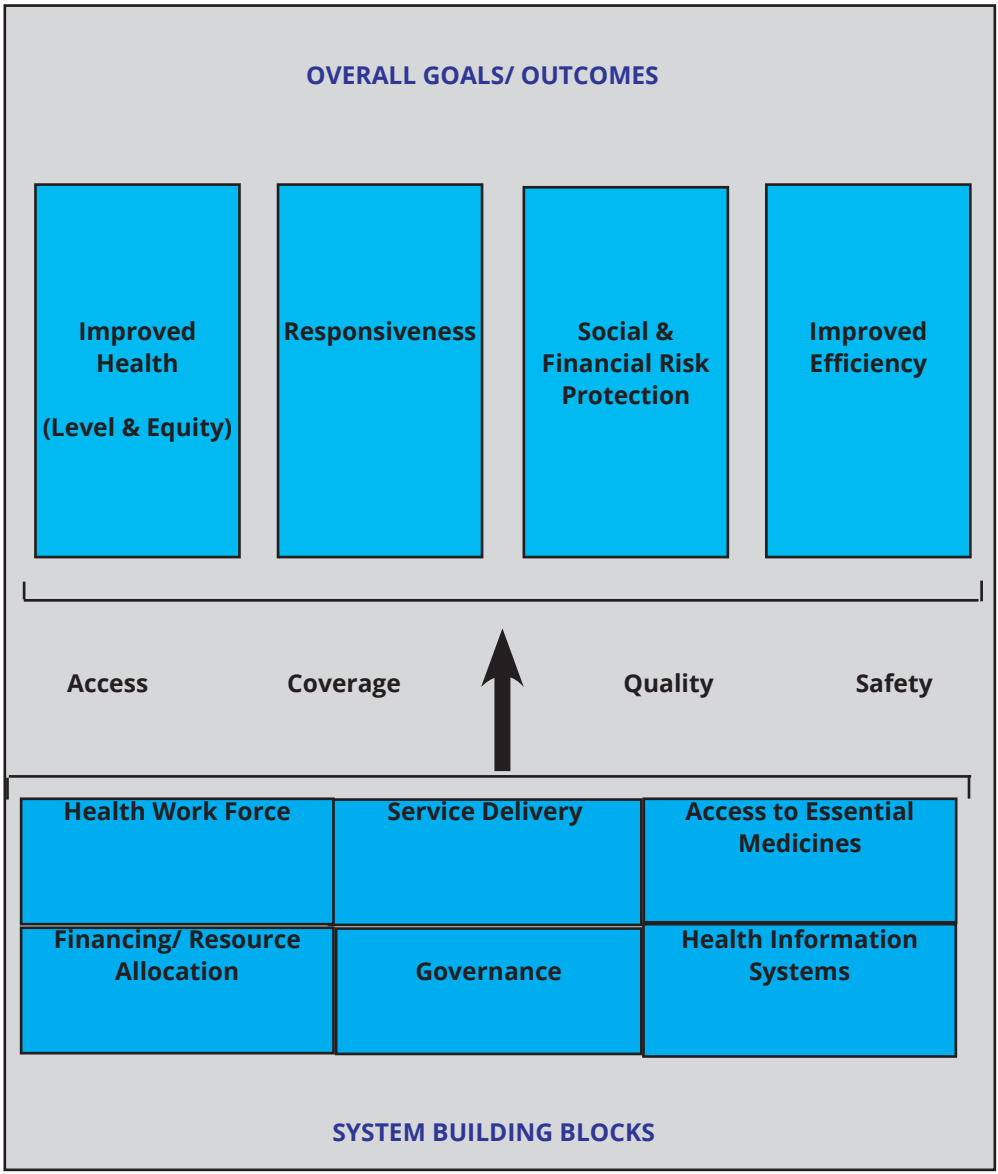
The performance of the health system involves relating goal achievement to what could be attained. Performance measurement helps to understand relationships between the performance of health systems building blocks and the outcome indicators. Responsive and fair health systems require service delivery, appropriate human resources, health information systems, resource allocation and governance to achieve their prime objective, i.e. improved health.

Health systems performance can be enhanced by improving the six functional components of health systems (shown in figure A4.1) and managing their interactions in ways that achieve more equitable and sustained improvements in access and coverage of health services through knowledge and action.

1. **Service delivery** – Good service deliveries provide effective, safe, and quality personal and non-personal health interventions to those that need them, when needed and with minimum waste of resources.
2. **Health workforce** – A well-performing workforce functions in responsive, fair and efficient ways to achieve the best health outcomes possible, given available resources within a district health system.
3. **Health information system** – A well-functioning health information system ensures timely collection, compilation, analysis, dissemination and use of reliable information on core indicators for service provision and health status of the population in a district.

4. **Access to essential medicines** – A well-functioning health system ensures equitable access to essential medicines, vaccines, and other supplies of assured quality, safety, efficacy, and cost-effectiveness, with scientifically sound and cost-effective use.
5. **Health financing/ resource allocation** – A good health financing system, at the district level, ensures an equitable allocation of resources along with raising adequate funds for health, in ways that ensure people can use needed services.
6. **Governance** – At the district level, this involves effective oversight, coalition building, regulation, attention to system design and accountability.

Figure A4.1: The WHO's six building blocks of a health system: Aims and Desirable Attributes



According to the WHO, a health systems performance assessment has the following objectives[9]:

- to monitor and evaluate the attainment of outcomes and the efficiency of a health system in a way that allows comparison over time,
- to develop an evidence base on the relationship between a health system and its performance; and
- to provide the public with information relevant to their well-being.

4.3. What is meant by 'health systems performance' at the district level?

Health systems performance at the district level ensures a contextual and more meaningful understanding of health systems for a district. This helps in aligning performance with specific goals pursued by an individual district to meet the health needs of its population.

The framework (figure A5.1) shows how health inputs and processes (e.g., health workforce and infrastructure) are reflected in outputs (e.g., interventions and available services) that in turn are reflected in outcomes (e.g., coverage) and impact (improved health through efficiency and responsiveness).

The framework also brings together indicators and data sources across the entire process chain, i.e., from "inputs", "outputs" and "outcomes," to "impact." It is designed for health systems performance assessment as a key for decision-making processes.

"Every system is perfectly designed to get the results it gets."

Donald Berwick, Health system specialist

Figure A5.1: Health systems performance assessment framework

A crucial step in health systems performance assessment is the collection of quality data on inputs and processes, outputs, outcomes and the impact of a health programme. Sources for data include routine HMIS, population surveys, civil registration and data from other district departments that directly or indirectly, can affect the outcomes and impact of a given health programme.

4.4. How to use data to identify and solve a problem

For identifying issues and problems, looking for alternative solutions, weighing risk and benefit for each alternative to ultimately making a final decision – health systems data are paramount at every step of the way. Health systems data are used for problem-solving during planning, management and monitoring of the provision of health services and medicine and supplies.

Examples of decisions that are relevant to monitoring could include:

- Deciding if a district is meeting its health objectives – for example, training the stated number of providers for newborn care.
- Deciding what to do to increase the coverage of newborn care services

Related questions can include:

- Has the district met its stated health service delivery targets for newborn care?
- Are the available newborn services meeting the needs of the community in a timely manner?

> *"If you do not understand your role in the problem, it is difficult to be part of the solution."*
>
> David Peter Stroh, Systems Thinking specialist

Data-driven health systems improvement is the core of health systems performance. Routine analyses of data from multiple sources help in identifying the problem(s) at all four levels of processes within a health system, i.e., input, output, outcomes, and impact (as shown in the figure A5.1)

Identifying the problem:

In the initial stages, often the problem is not well-defined. Everyone involved in the programme might have vague ideas about what the problems are, what they need to understand and how they can solve the problems. However, the first step in identifying a problem is to turn these vague ideas into more precise and specific questions that can be answered using data. All relevant stakeholders within district health and non-health departments, and private-for-profit and not-for-profit organisations, play a significant role in identifying the problem.

Planning

The next step is planning - deciding what data to collect and identifying the sources of the data.

Compiling data

This step is about obtaining the data from all the relevant sources within and outside health systems that can have a role in creating or solving the problem under consideration.

Reviewing

To make sense of the data, they are analysed and the information with all the stakeholders involved in the process. This is usually an iterative process with back and forth analysis, and tentative formation of options to solve the problem.

Problem-solving using data

Through review and analysis of the data, comes an understanding what the problem is and what solutions might work. Taking stakeholders into account is the next crucial aspect of problem-solving.

Finally, the problem is addressed by following the steps mentioned in structured decision-making. This includes comparing alternative solutions and making trade-offs to arrive at a legitimate decision, through repeated consultations with all relevant stakeholders.

Follow-up using data

The success of any plan depends on how well it is implemented. Here again, data are essential for further follow-up and continuous assessment of the progress of implementation.

The progress of a programme can be evaluated for:

- Effectiveness: is the health programme achieving its objectives?
- Efficiency: are the desired objectives being achieved with a minimal waste of time and effort?
- Timeliness: are the outputs delivered on time?

Monitoring data are used to track the progress and impact of health initiatives, inform decisions and guide decision-makers at the district level. It underpins the evidence-based decision-making process by collecting and analysing data for problem identification and problem solving. An example of a follow-up template is shown in table A4.2. It includes the following information:

- **Action points** – Consists of all the action points that have been agreed upon to achieve the objectives.
- **Indicators** – The established indicators to assess the progress on action points.
- **Progress of indicators** – Progress or achievement for each action point will be noted down in this column.
- **Responsible person** – Consists of details (name, designation and department) of the person(s) responsible for carrying each action point forward.
- **Timeline** – Consists of an agreed timeline to achieve a target for the action points.
- **Status of action points** – The information on the current status of action points, i.e. not on target, not started, ongoing etc.
- **Further follow-up suggestions** – Revised timelines and any change in responsible person(s) is recorded in this column.

General note: Conventionally, Health Management Information Systems (HMIS) are operational in most health systems.

In some contexts, HMIS have transitioned into more advanced forms. In the Ethiopian context, currently the District Health Information System, 'DHIS-2' is in use.

Table A4.2: Follow-up Template

Action Points	Indicators	Progress of indicators	Responsible person	Timeline	Status of action points	Further follow-up suggestions

"When people know a number of things, and one of them understands how the things are systematically categorized and related, that person has an advantage over the others who don't have the same understanding."

Moshe Chaim Luzzato, Philosopher

Facilitator's Notes:

Participants will be asked to do a learning activity (described at the end of all four core skills). The facilitator will share monitoring reports from district health systems and ask the participants to identify the problem(s). Participants will attempt to create indicators for follow-up.

5. LEARNING ACTIVITIES

ACTIVITY 1: BRAINSTORMING

Title: Determinants of decision-making

Objective: To identify the determinants (challenges and enablers) of decision-making faced by a district health officer on a given day (for example, vaccination day)

Method:

- Divide participants into groups, and distribute pencils and paper to each participant.
- Ask the participants to list the activities of a district health officer on vaccination day.
- Each group will then discuss the types of decisions to be made for each of the activities for that day.
- Ask participants to list the determinants for each of those decisions.
- The facilitator will then ask one participant from each group to present the determinants of decision-making for a district health officer on vaccination day.

Discussion:

- The facilitator will discuss and add more determinants if there are any missing.
- The facilitator will ask the participants to organise these determinants under four broader categories, i.e., organisational, cultural, individual, and decision-specific factors.
- The facilitator will explain that in every decision-making activity, we should keep these four categories in mind. The specific nature of the determinants will keep changing; however, these four levels of categories will always be the same.

ACTIVITY 2: Questions for recall and discussion

Title: Structured decision-making

Objective: To develop an understanding of structured decision-making through discussion.

Method: Divide the participants into groups.

- Distribute pencils and paper to each participant.
- Show the following questions on a slide and ask participants to write down their answers.

i. *What are the main characteristics of structured and unstructured decisions?*

ii. *Which of the following is an unstructured, strategic task?*

a. *Producing a report at the end of a week*

b. *Scheduling a specific health service for the next 6 months (e.g. HIV activities)*

- Ask participants to share their answer for the first question within their group and discuss among themselves.
- The facilitator will then share the answer for the second question and ask participants to check their answers.

Answers for (i)

Characteristics of structured decisions:

- Objectives/ goals are well-defined
- Information/data are obtainable and manageable
- They appear in a well defined context and procedures are known

Characteristics of unstructured decisions:

- The outcomes are uncertain
- They appear in a unique context
- The required information and resources are hard to assess

Answers for (ii)

(a) is an operational and structured decision.
(b) is more of a tactical task and semi-structured, as there are many things known about the problem.

The facilitator will generate discussion to clarify structured decision-making further.

GROUP ACTIVITY: Brainstorming

Title: Stakeholder mapping

Objective: To gain hands-on experience to do stakeholder-mapping for health issues.

Method:

- Divide the participants into groups and distribute pencils and paper to each participants.
- Ask participants to develop a problem statement/ health issue within their district; for example, addressing malnutrition in children under five years of age, or improving the coverage for institutional delivery, etc.
- Ask participants to list all the stakeholders for the health issue in question.

- Share the table for stakeholder analysis matrix and ask the participants to fill all the columns under each category
  - Ask the participants to use this information to make a stakeholder power-interest grid.
  - Ask the participants to share their work with the rest of the groups.
  - Discuss the possible steps involved in the effective engagement of identified stakeholders in each of the four blocks of the power-interest grid.

ACTIVITY 1: Brainstorming

Title: Sources of health systems data

Objective: To identify the sources of health systems data available at district level.

Method:

- Divide participants into groups, and distribute pencils and paper.
- Ask participants to share health issues that they may have come across in their district.

- Ask each group to pick one health issue; for example assessing the gaps in service provision for antenatal care.
- Ask participants to list the types of data required to understand and solve the health issue under discussion.
- Ask participants to think of sources of data for all types of data listed on pages 49 and 50.
- When all the groups have completed the activity, ask them to share their work with the rest of the participants.

ACTIVITY 2: Group Activity

Title: Content analysis of health systems data

Objective: To provide an opportunity to do a content analysis of health systems data.

Method:

- Divide the participants into groups.
- Share data collection forms from a few different sources with participants – data should be from different sources; i.e., district health and non-health departments, private-for-profit and non-profit health organisations.
- Ask participants to do a content analysis of the data.
- When all groups have completed the activity, ask them to share their work with the rest of the participants.

GROUP ACTIVITY : Brainstorming

Title: Data-use for problem-identification and problem-solving

Objective: To develop an understanding of using data to identify and solve a problem.

Method:

- Share a few monitoring reports on coverage of vaccination services for children.
- Ask participants to create indicators based on those reports.
- Discuss how they are going to identify a problem by creating indicators.
- Ask participants to brainstorm for possible solutions to the problem.
- Ask participants to identify which indicators they would use for follow-up.

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PART B

In this section of the handbook, the participants will be provided with an introduction to the DIPH strategy to encourage the use of data for decision-making, priority-setting and planning, at the district level. The overall objectives for Part B of the handbook are to gain knowledge and confidence for a proper operationalisation of the DIPH strategy at the district level and effective use of the DIPH interface.

This section begins with an introduction to the steps in the DIPH cycle, followed by a detailed discussion on roles and responsibilities, along with activities and processes for DIPH operational meetings.

A discussion on the use of primary and supplementary forms and a guide to filling these forms will then follow.

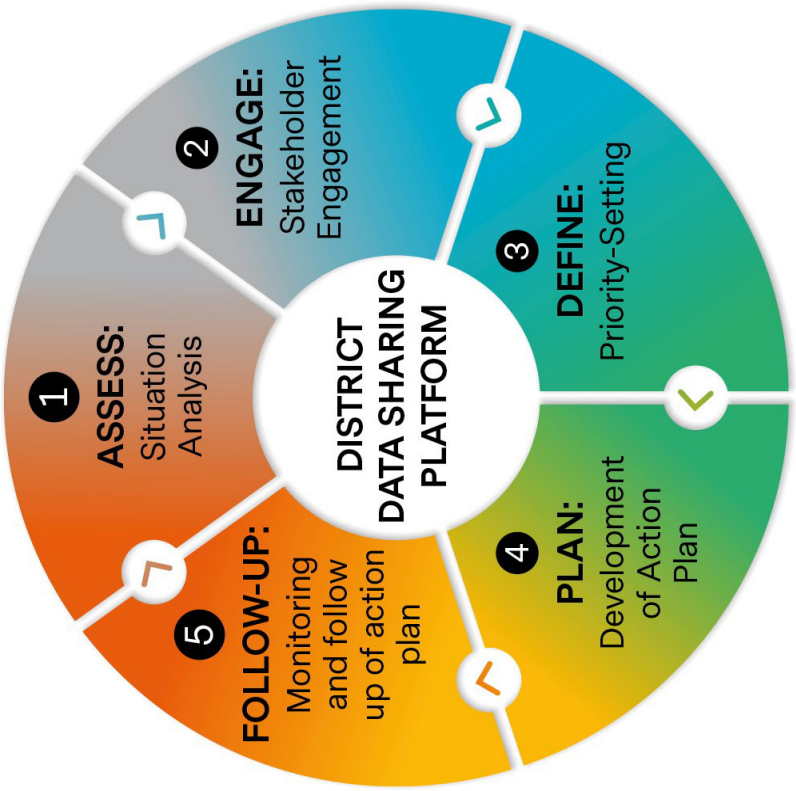
Participants will also take part in form-filling practice sessions, which will provide them with an opportunity to practice and review the information presented in this section. Finally, participants will be shown how to use the DIPH web-based interface on computers, thereby receiving hands-on experience.

6. INTRODUCTION TO THE DIPH STRATEGY

In light of the limited use of local data for health systems planning and decision-making, the Informed Decisions for Actions in Maternal and Newborn Health (IDEAS) project, at the London School of Hygiene &Tropical Medicine, developed the Data-Informed Platform for Health (DIPH). This is a decision-support strategy for district level health systems, which aims to promote data sharing and local data use for health decision-making at the district level. Like structured decision-making, as set out in the core skills for decision-making, the DIPH strategy comprises a structured set of processes in pre-defined steps.

In this section, the intention is to understand the purpose of each step, followed by the job-aids for each of the steps.

Figure B6.1: Steps in a DIPH cycle



6.1. The DIPH steps

The DIPH is a five-step strategy (assess, engage, define, plan, follow-up), which is meant to facilitate the use of district-level data for decision-making. It provides a mechanism for compiling, analysing and utilising local data, while engaging multiple district-level stakeholders for structured decision-making.

Step 1: Assess

In the first step, the current situation in the district is assessed by analysing health systems data, using content analysis skills. This step establishes a theme-specific, detailed and realistic picture.

As we learned in core skill 1 of decision-making, there are a variety of types of decisions that are made on a day-to-day basis for health at the district level, including decisions related to the provision of safe and quality health services, human resources, HIS, medicines and supplies, financial and governance-related decisions. For each DIPH cycle of decision-making, a situation analysis is the first step, to assess the current state-of-affairs for the theme for decision-making. It is done through reviewing health policy and planning documents and performing a general review and content analysis of health systems data.

Step 2: Engage

Stakeholder engagement is the second step in a DIPH cycle. Identify district level stakeholders for each health theme picked out in Step 1. As discussed, (Core Skill 2: Stakeholder engagement), effective engagement with primary and secondary stakeholders is imperative to the success of a health initiative at the district level.

Doing a stakeholder analysis helps to understand the power, influence and role of health and non-health department officials at the district level. This will help the decision-making team to identify the stakeholders and assess their awareness of the health theme under consideration. The stakeholder analysis will not only help to evaluate people's power to influence, but also develop an understanding of the importance that they attach to the health theme, which will be useful for effective coordination and collaborative action.

Step 3: Define

A situation analysis and constructive engagement with stakeholders, enables the identification of the district-specific health themes needing improvement. In the third step, a prioritisation criterion is utilised to address the most immediate health concerns for a district, through structured and collaborative decision-making. Possible solutions and the actions required for each solution are listed through active collaboration with identified stakeholders.

Step 4: Plan

In this step, a list of measurable indicators is drawn up against the theme-specific actions. As discussed earlier (Core Skill 3: Data use), indicators are created for each of the categories and sub-categories for the health theme that were identified in the earlier steps. In addition, action points are identified to improve the selected indicators in this step.

Step 5: Follow-up

The next step in the DIPH strategy is to monitor and follow-up the action plan (Core Skill 4: Monitoring health systems performance). Data are used to track the progress of action plans in terms of time and the person responsible, to inform and guide decision makers. Follow-up will also include problem identification by discussing implementation challenges with the person(s) responsible.

West Bengal – a state in India – utilised the DIPH strategy to meet the challenge of local decision-making for maternal and newborn health. Like most low and middle-income countries, previously there was no structured district decision-making process in West Bengal, limited interaction between departments and little formal district-level data sharing. The DIPH strategy added a structured process of coordination between different district departments and formal data sharing for evidence-based decision-making, planning and resource allocation. The DIPH strategy was embedded within existing district decision-making approaches.

The table on the following page shows a real-life example of a selected theme and the five steps of the DIPH cycle in the state of West Bengal.

The mentioned five steps of the DIPH cycle are undertaken during the DIPH meetings (which will be discussed in detail in section 3) while utilizing the job-aids.

Stepwise description	The DIPH strategy North 24 Parganas District, June - September 2016 Selected theme: Increase the uptake of 3 antenatal visits and improve tracking of a fourth antenatal visit
Step 1: 'Assess' the current situation of the district through a document review of policies and plans and a review of health systems data	Based on a review of the health management information system, district annual implementation plan and electronic mother and child tracking system, stakeholders assessed gaps in service provision and selected a theme.
Step 2: 'Engage' to understand the role of effective coordination and collective action. This includes health and non-health departments in the public sector, as well as the private sector and NGOs.	The Health Department took the lead and the Departments of Women & Child Development and Panchayat & Rural Development, and the District Administration shared the supportive responsibilities.
Step 3: 'Define' the areas to be improved in a cycle.	The stakeholders identified 10 problems, of which 5 related to 'service delivery'. They formulated 13 actionable solutions to address these problems in the subsequent 3 months.
Step 4: 'Plan' by identifying activities that will lead to improvement in the prioritised thematic areas.	The stakeholders assigned responsibilities for each actionable solution across departments: 8 out of 13 to the Department of Health & Family Welfare, 3 out of 13 to the Department of Panchayat & Rural Development.
Step 5: "Follow up" on the implementation and monitoring of the action plan.	Four additional meetings with stakeholders were conducted over the subsequent 3 months to follow-up on the action plan. Out of 13 action points, 7 were completed, 3 were not completed and 3 were not initiated within the specified timeline. A new timeline was assigned for the incomplete action points.

Facilitator's Notes:

Participants will be asked to do a learning activity (learning activity 1 - described at the end of Part B). The facilitator will ask the participants to go through all five steps of DIPH strategy for a selected health issue.

Show the forms to participants using a projector, to give them an overview of the job-aids.

6.2. Job-aids for DIPH

The DIPH strategy provides standardised job-aids for each step, to facilitate the linking of input and process data from health (government and private sector) and non-health departments. The DIPH job-aids help organise and interpret data from multiple sectors around a health issue, so that district leadership and management teams can make systematic use of these data for health decision-making.

The job-aids are data visualisation tools for sharing the status and progress across a district, within and outside the health department. The ability to visualise data collectively is an extremely useful feature of the DIPH. Data can be projected on a large screen for use in DIPH meetings. They also help with data analysis, priority setting, the development of target-based action plans and follow-up, thus helping to achieve the targets for the thematic area prioritised in a specific district.

Table B6.2: Steps in the DIPH cycle and job aids

Job-aids	Description
Primary Forms: Form I Parts A & B Supplementary Forms: 1. A.1, 1.B.1	Form 1 is used for Step 1, 'Assess' in the DIPH cycle Part A helps with identifying the relevant documents and data forms required for the situation analysis in a DIPH cycle, while Part B is for compiling information on demographic characteristics, coverage indicators and a general assessment of district health systems' capacity in terms of infrastructure, human resources, supplies, technology, and resource allocation. Supplementary Form 1.A.1 is used to extract information from national and district health policy and planning documents. Supplementary Form 1.B.1 is for compiling data on the performance of selected indicators for a DIPH cycle
Form 2	Form 2 is used for Step 2, 'Engage' in the DIPH cycle Form 2 guides the collection of information on the primary stakeholder, who will lead the service delivery, and secondary stakeholders who will provide a supportive role for the identified theme in a DIPH cycle.
Form 3	Form 3 is used for Step 3, 'Define' in the DIPH cycle. This form helps with prioritising and defining the areas for improvement, along with details of possible solutions and actions for the identified theme in a DIPH cycle.
Form 4	Form 4 is used for Step 4, 'Plan' in the DIPH cycle In this form, theme-specific actions identified in Form 3 are further split into realistic action points. Indicators for monitoring are set out and recorded in this form. The person(s) responsible, targets and target dates included in this form, for a follow-up.
Primary Form 5	Form 5 is used for Step 5, 'Follow-up' in the DIPH cycle Following-up the action plan and its progress is recorded in Form 5. Revised timelines (if needed) and any change in person(s) responsible are filled in during the fifth step of a DIPH cycle.
Supplementary Form	Supplementary Form 5.1 is used to record all sub-district performance indicators and targets.

7. ROLES AND RESPONSIBILITIES WHEN USING THE DIPH CYCLE

Roles are the positions team members assume or the parts that they play in a DIPH cycle. Responsibilities, are the specific tasks or duties that members are expected to complete as a function of their roles. They are the specific activities or obligations for which they are accountable when they are assigned to a role in a DIPH cycle. In this section roles and responsibilities of the DIPH team are discussed.

The team comprises:

- **Focal person/ chairperson for the DIPH at district level**
- **Theme leader**
- **District level department leads** (health and non-health)
- **DIPH support team**

7.1. Focal person/chairperson for the DIPH at district level

Role: The focal person or chairperson of the DIPH is the lead person for DIPH activities who oversees the process of structured decision-making and provides leadership for the regular functioning of the DIPH strategy within a district. A focal person is usually from the district health administration and facilitates interaction between primary and secondary stakeholders, i.e. district health administration and other stakeholders' departments.

Responsibilities: The responsibilities of a focal person for the DIPH are as follows.

During preparatory phase of the DIPH cycle:

i. Along with district-level leads from stakeholder departments, decide the dates to conduct the five steps of the DIPH strategy.
ii. Finalise and circulate the agenda of the meeting, one week before the start of the DIPH cycle.

When conducting DIPH meetings:

i. Nominate the theme leader for a DIPH cycle based on the identified themes.
ii. Together with this theme leader, decide the theme for the district (step 1 of the DIPH cycle).
iii. Chair meetings for developing an action plan (step 4 of DIPH cycle) and the follow-up of an action plan (step 5 of DIPH cycle).
iv. Conduct a monthly review with the theme leader on the progress of the action plan.

7.2. Theme Leader for a DIPH cycle

Role: Every cycle will have a designated primary stakeholder as the theme leader. He/she is nominated by the DIPH focal person, in discussion with officials from secondary stakeholder departments. Theme leaders are chosen according to the selected themes – one programme officer can be responsible for different health themes, depending on his/her expertise in those areas.

Responsibilities: The theme leader is responsible for the overall execution of cycle-specific DIPH steps. The responsibilities of a theme leader during a DIPH cycle are as follows.

Facilitator's Notes:

There can be different theme leaders for different cycles, or the health district can designate one person as the primary theme leader for the entire duration (year) of the DIPH process.

During the preparatory phase of the DIPH cycle:

i.i. Compile health systems data from different sources for content analysis.
ii. Conduct content analysis and identify data elements to create indicators with the assistance of data managers from the district health department.
iii. Prepare analytical tables of major indicators in the health district, so that the focal person of the DIPH cycle and secondary stakeholder department leads can suggest possible themes. This process is done two weeks before the DIPH cycle.
iv. Circulate the date and agenda for organising the DIPH steps, in consultation with the focal person.

v. Prefill Form 1 for Step 1 before the Step 1 meeting, in close discussion with district leads, i.e. data manager(s) and the leads from stakeholder departments.
vi. Nominate a person to fill the DIPH step forms during meetings.
vii. Organise the venue for the meetings.

Conducting DIPH meetings (Steps 1-4):

i. Leads the discussion and encourages all the members to voice their opinion (see core skill 1 – determinants of decision-making)
ii. Follows-up with the leads from secondary stakeholder departments and provides necessary instructions to capture the status of action-points at the sub-district level.
iii. Allocates 10-15 minutes to discuss the progress of the action plan with the sub-district officials during regular public health meetings at the district level.
iv. Compiles the action-plan status at the district-level and shares this with the DIPH focal person for that cycle.

Follow-up on action points (Step 5):

i.i. Orient the sub-district secondary stakeholders of all the non-health departments regarding the indicators for the follow–up action points and ensure that they share the data each month.

ii. Follow-up with the leads from secondary stakeholder departments and provide necessary instructions to capture the status of the action-points at the sub-district level.

iii. Allocate 10-15 minutes to discuss the progress of the action plan with the sub-district officials during regular public health meetings at the district level.

iv. Compile the action-plan status at the district-level and share with the DIPH focal person for that cycle.

Note: There may be some action-points that need to be followed-up directly with the district, regional or national authorities like district magistrate, regional or national offices for health, and other national offices (such as recruitment, procurement, lobbying for policy change/ bringing out government orders, etc.)

7.3. District-level department leads (health and non-health)

Role: The representatives from primary and secondary stakeholder departments are responsible for highlighting the relevant themes in their area of concern. Managerial leads from the district health department are primary stakeholders, while those from non-health departments usually play the role of secondary stakeholders. Sometimes, it will be appropriate for them to be accompanied by their respective data managers. Managerial leads should participate in every DIPH meeting, and actively contribute to the discussion. The leads of the secondary stakeholder departments are entrusted with monitoring the action-point components assigned to their particular department.

Responsibilities: The responsibilities of district-level department leads (health and non-health) during a DIPH cycle are as follows.

i. Participate in all the DIPH steps and engage in the planning and implementation process.
ii. Assist the theme leader in orienting sub-district personnel to complete the Step 5 forms.
iii. Regular follow-up with the sub-district officials on the completion of action-plans.
iv. Compile and analyse sub-district progress reports and send them to the theme leader on a regular basis.
v. If needed, meet with theme leader and focal person for the DIPH cycle to share progress on the action points.

7.4. The DIPH support team

Role: The DIPH support team comprise training personnel from the London School of Hygiene & Tropical Medicine and country-specific leads for the DIPH. After providing the initial training, their role is hand-holding and problem-solving for the initial few cycles until the strategies are fully embedded in the district for future DIPH-related activities.

Responsibilities: The responsibilities of the DIPH support team are as follows:

i. Orient the district focal person and the theme leader about the DIPH process, based on the training manual.
ii. Orient the district focal person and the theme leader about the DIPH digital interface.
iii. Build the capacity of district health managers to carry out DIPH-related activities, through training.
iv. Ensure a smooth handover of the DIPH process to the DIPH focal person, after hand-holding during the initial DIPH cycle.
v. Guide the theme leader if there is any confusion about the DIPH steps and forms during DIPH meetings.
vi. Share the findings of the cycle's monitoring report with the DIPH district focal person and the cycle's theme leader.

8. DIPH OPERATIONALISATION

Performance review team (PRT) meetings, in Ethiopia, are a major platform for using information and data at the district level. The intention is to embed the DIPH strategy and processes within such existing district-level decision-making platforms. A monitoring report on DIPH Cycle 2 in North 24 Parganas, West Bengal, India (May – September 2016), is an example of where such integration did not happen. It reported limited participation from private (for-profit and not-for-profit) health and non-health district departments in district-level decision-making processes. This meant a lack of inter-departmental sharing, inefficiencies within the district health system to monitor the quality of data collected and a delay in collecting, compiling, analysing and reporting data, effective decision-making was hampered.

If the agenda for the DIPH strategy can be included within PRT meetings (PRTM) and shared with district officials, once operationalised, it will enhance the interaction between health (public and private) and non-health departments (e.g. child development, women development, agriculture, water and sanitation) to improve public health services throughout the district. The District Health Society meeting in India, participatory review meetings and PRTM in Ethiopia are a few examples of existing decision-making platforms that can be used for DIPH operationalisation.

Facilitator's Notes:

Ask participants the names and types of regular review meetings occurring in their districts and emphasize that the DIPH should become a part of those regular meetings. It can be useful to remind participants that public health system terminology can vary with context, e.g. sometimes departments are called 'sectors' or 'unit'.

Purpose of DIPH Meetings

Interaction and discussion for sharing of public health data to take collective decisions and completing the DIPH forms (Forms 1-5) are the major components of these meetings.

Expected Outcome

The DIPH cycle Steps 1-5 are completed by involving district DIPH stakeholders in active collaboration and discussion. Sharing of experiences, success stories and ground realities helps to develop and plan in a more realistic way. These meetings have the potential to increase ownership of the decisions made by participants. Furthermore, they assist in building the capacity and orientation of the stakeholders on various health issues in the district.

In this section, we will discuss the format and activities that need to be done during the DIPH meetings along with the procedures and processes for each step of the DIPH cycle.

8.1 General format of a DIPH meeting

A general format and key activities during a DIPH meeting will be as follow:

a. Introduction:

The session starts with a welcome address to all participants by the focal person or chairperson of DIPH and self-introduction of the participants. All participants should know each other by their names, occupations/ designations, place of posting for better coordination during meeting. This will help them to collaborate effectively during the implementation of action points. As part of this session participants' registration sheet needs to be filled in with signatures.

b. Setting the ground rules

Before the start of meeting, ground rules are established to assist the group and avoid distractions during meeting. The following ground rules can be set:

- Participants should focus on objectives of the meeting.
- Participants should speak one at a time.
- Each session should conclude with feedback from group members.
- All the members should restrict use of mobile phones and no side talk.
- This is a participatory meeting so all participants should contribute.

c. Recap of previous meeting

Participants are asked about the previous meeting. They are reminded of the previous steps to link with the health theme to be discussed in the meeting. All the points will be noted down on a board or chart paper and are referred to during summarisation through pre-prepared power point presentation. It will also assist those participants who missed the previous meeting.

d. Sharing of objective & agenda:

Objective of the meeting is explained to all participants utilising the following:

I. Purpose of the meeting is outlined, and members are reminded why they are in the meeting and what are the expectations from them.
II. Review the objectives and agenda for the session if required.
III. Remind the participants that their contribution will make the meeting a success.
IV. Motivate them to discuss relevant points freely, without any hesitation.

Participants share the primary agenda or topics to be discussed, and all points are written down on a board or chart paper. These points are referred to during consolidation by showing the predetermined agenda and explain the missing links if any. Ensure that everyone knows what will be discussed and they have sufficient background information to make relevant contributions.

e. Review and discussion

The steps of DIPH strategy are carried out through discussion and filling out of the relevant forms for each step.

f. Concluding remarks

At the end of a meeting, it is useful to list the tasks to be accomplished and to assign to participants with a detailed timeline. This action list is sent to all participants in the form of minutes along with a list of key decisions made and important information recorded at the meeting. A tentative date for the next meeting is communicated with a concluding statement from the chairperson and thanking all the participants.

g. Meeting feedback from the Participants

Feedback from the participant is essential for further improvement. It is an opportunity for the DIPH support team to rectify faults, make amends and upgrade the process to fulfil the objective effectively.

8.2. Five steps of DIPH cycle during DIPH meetings

Now, we will discuss how DIPH steps are carried out utilising the job-aids for each of the steps during DIPH meetings.

A. DIPH STEP 1: ASSESS (APPROX. 2 HOUR)

Participants are oriented with the job-aid for the first step of DIPH. As we discussed earlier, form 1 has two parts, A and B with supplementary forms for each of the parts. Form 1, part A needs to be filled in detail at the first DIPH cycle; the subsequent cycles require only updating. The form that was filled up in the previous cycle is shown to participants of the meeting and updates are made according to the feedback received from the participants.

Form 1, part B with supplement table is filled in before the step 1 meeting with close discussion with district data managers and the leads of non-health district departments (i.e. data managers of stakeholder's departments).

Prefilled forms are shared with the participants for an understanding of capacity of the health systems and block-wise performance in selected indicators.

B. DIPH STEP 2: ENGAGE (APPROX. 1 HOUR)

Participants are given an opportunity to identify primary and secondary stakeholders through interactive discussions. Form 2 is filled out which aids the discussion and process of the second step of DIPH strategy. This step requires an understanding of the role of coordination and collaborative action (core skill 1 of decision-making).

A template for interactive discussion for this step is shown on the following page:

Interactive Discussion Part 1	Interactive Discussion Part 2	Interactive Discussion Part 3	Summarisation
Define primary & secondary stakeholders for effective coordination.	Give the participants 10 minutes to note their role & responsibilities in papers (department wise). Give some example (experience, best practices, success stories) for brainstorming	Ask them to share their views one by one (department wise) with feedback/ suggestion by other participants. Fill up form 2 and appreciate innovative ideas	Summarise the whole process by showing the filled-up form 2 Entertain feedback to finalise the form

C. DIPH STEP 3: DEFINE (APPROX. 1 HOUR)

First, the summary of information that is collected on situation analysis and stakeholder engagement is discussed. Forms 1 and 2 that were filled up earlier in the meeting are shown to the participants for a description of health issues, their possible solutions and action plans. Participants are oriented with form 3 for the third step of DIPH.

Information compiled so far is categorised according to HS building blocks:

- Service delivery
- Workforce
- Supplies & technology
- Health information
- Finance
- Policy/ governance

Form 3 is filled out through interactive discussion. After prioritising the areas, possible solutions along with action points in terms of reaching the target population, general resources (supplies, finance, technology) and human resources (personnel and skill level) are set. Priority setting is done with an eye on the resources and mandate available within the district. The whole process is summarised by sharing filled-up form 3 and asking the participants for their feedback to finalise the form.

D. DIPH STEP 4: PLAN (APPROX. 1 HOUR)

For this step, participants are oriented with form 4 during the DIPH meeting. During this step of the DIPH cycle, participants are welcomed to share their experiences regarding their involvement in the existing planning process (types of the plan prepared, last plan prepared, etc.). It helps to identify their expertise in the planning process so they can take part in the planning process rather effectively.

Theme-specific actions identified in form 3 of priority setting are shared with the participants, and they are encouraged to ask open-ended questions for any clarification that they require. Based on form 3, participants are asked to generate action points one by one for each identified solution. Form 4 is filled up and summarised, and participants are asked to give their feedback which is then incorporated. Finally, the district administration representative is consulted to finalise all the forms filled up so far.

E. DIPH STEP 5: FOLLOW-UP (APPROX. 1 HOUR)

During the DIPH meetings that are focussing on follow-up, form 4, that was prepared in the previous meeting through data sharing and collective discussions and decision-making are shared with the participants. The responsible person(s) for each action points is asked to share the information about its implementation status as well as progress to monitor the process. Implementation challenges and issues are discussed and form 5 is filled up simultaneously.

The follow-up period for all action points is decided through discussion with the district administration. Revised timelines are documented and shared if any particular action points seem to require more time than anticipated.

Facilitator's Notes:

Project the forms on a screen during the description of this section or divide the participants into groups of five each and share a computer for an interactive discussion on steps and forms for DIPH. Introduce and familiarise the participants with DIPH interface on computers before the start of the next section.

9. FORM FILLING GUIDES

In this section, a detailed description of forms for each step in a DIPH cycle will be shared along with guidance to fill the forms.

9.1. Form 1, Part A: Document and Database Checklist

This checklist helps to identify the relevant documents and data forms required for the situation assessment of a DIPH cycle. It needs to be filled in detail at the first DIPH cycle of any district. In the subsequent cycles, this checklist requires only updating based on the selected theme of the cycle. The stakeholders of the meeting will aim to make an exhaustive list of all available documents in the district. There is a need to note the online source of data/ document wherever it is applicable.

Supplementary Form, A.1: Data Extraction from State and District health policy documents

Form 1, Part A

Sl. No	Document	Availability	Source	Form Linking
Part 1	**National level policy and planning documents:** It includes annual/five-year health plans, specific health policy documents, or valid government orders related to the identified public health theme	Note whether this document is available or not.	Mention the person at district level with whom the document is available. Mention the web address wherever applicable.	This is the 1st form, so not linked to any previous form.
Part 2	**District level policy and planning documents** Health plans/programme documents, or government orders specific to the district	Same as above	Same as above	Same as above
Part 3	**Health management and services data** The data related to theme-specific coverage indicators, human resources, supplies, etc. from the health department, related documents from non-health departments, as well as data on specific themes from private – for profit and non-governmental organisations (NGOs).	Same as above	Same as above	Same as above
Part 4	**Large-scale district level surveys:** Surveys such as district level household and facility surveys, census, etc. that provide information on the social and demographic details of the district.	Same as above	Same as above	Same as above

9.2. Form 1, Part B: Health System Capacity Assessment

This form captures demographic characteristics, coverage indicators and assessment of health system capacity, in terms of infrastructure, general resources (supplies, finance, and technology) and human resources (skills level and availability of personnel). The theme leader should fill in the form in close discussion with the district data manager(s) and heads of departments (health and non-health), before the Step 1 meeting.

The prefilled forms help the participants to understand the capacity of the health system and the district performance at the beginning of the cycle for the identified theme.

Supplementary Form 1, B.1.: Sub-district wise performance of selected indicators

Form 1, Part B (Section a)

1	Information about the District			
	District Demographic Details	**Information**	**Source**	**Form Linking**
1.1	**Total Area (sq.km)**	Total geographical area of the health district	Latest reference from where the information is collected; provide web link if available	Not linked with any previous forms.
1.2	**Total population**	Total number of people in the health district as per the most recent census		
1.3	**Number of women in reproductive age (15-49 years)**	Total number of women between menarche and menopause (15 to 49 years) in that district as per the recent census, or any other document		
1.4	**Number of children under five years**	Total number of children under five years of age in the health district		
1.5	**Rural population (%)**	Total number of people living in rural areas of the district.		
1.6	**Population density (People/sq.km)**	Total number of people living in an area of one square kilometre in the district according to official documents		
1.7	**Total literacy (%)**	Total number of literate people in the district, as per official documents.		
1.8	**Female literacy (%)**	Total number of literate persons in the district as per official documents.		
1.9	**Key NGOs**	Name the non-government organisations working on health issues in the study district. Mention their contact details (postal and web-address).		
1.10	**Key private stakeholders**	Name the key private facilities and professional organisations in the health district. Mention their contact details (postal and web-address).		

Form 1, Part B (Section b)

2	Expected coverage as per Ethiopian Public Health Standards		
	Heading	**How to fill**	**Form LInking**
2.1	**Theme**	Name of the selected themes for the cycle. It can be more than one theme which will be shortlisted by the stakeholders during initial discussion.	Not linked with any previous forms.
2.2	**Priority**	Out of the multiple theme select one by "1" as the primary theme for the cycle.	It will be linked for all the subsequent forms.
2.3	**Coverage indicators**	All the themes related indicators captured by the state and district level database, which are commonly used at local level to track progress.	The indicators of the primary theme will be linked with form 1.3.1
2.4	**Current value (as per district representative source)**	Data on the selected indicator for the previous month. This is the data source maintained and approved by the district for monitoring progress on this theme.	Data will be linked with point 3 'Time 0'of form 5
2.5	**Expected value**	The expected/desired coverage on the selected indicator as per official documents.	
2.6	**Gap**	The difference between the expected value as per the official documents and the current value of the selected indicator noted in the previous columns. This is calculated automatically.	
2.7	**Source**	A drop-down list of options for selection will appear.	The list box is linked with the document sources listed in Form 1A.

Form 1, Part B (Section c)

3	Theme Name	
	Heading	Form Linking
	Details	Not linked with any forms
	Sanctioned (Number of proposed theme-based facilities)	
	Available/Functional (Number of proposed theme-based facilities)	
	Gap (This is auto generated and shows the difference between those sanctioned those and currently available).	
3.1	**Infrastructure** Infrastructure (Physical infrastructure - primary and secondary health care centres at district level etc. - and theme-specific physical requirements for the health-related theme - e.g. newborn feeding corner, sick and newborn care unit, blood bank.	
3.2	**General Resources** (This refers to theme-specific status of finances, supplies, and technology)	
	Finance (Allocated funds for the different services based on the theme)	
	Supplies (Quantity of different materials needed for providing theme-specific services)	
	Technology (Advancements in technology such as mobile health, software, information-communication platforms, etc., which are required for the theme-specific services)	
3.3	**Human resources** (Primary providers of theme-specific services). Record theme in ascending order.	

9.3. Form 2: Engage

This step includes all those that are part of Step 1. Roles and responsibilities of stakeholders involved in the identified theme are discussed. The form guides the discussion about who will lead on service delivery for the identified theme and which departments will provide a supportive role, keeping in mind their current level of engagement of the district.

Form 2 (Section a)

Sl. No	Particulars		
1	Key Stakeholder		Form Linking
1.1	**Primary Stakeholder**	This refers to the main stakeholder department (health, non-health or private –for profit organisations &NGOs) that are responsible for providing direct services within the identified theme.	To the subsequent points of the same form
1.2	**Secondary Stakeholder**	This refers to the stakeholder department (health, non-health or private –for profit organisations & NGOs) that are responsible for providing supportive services within the identified theme.	
2	**Defining the primary role** (by department), Identify any areas of duplication [Whether primary or secondary, each stakeholder (government and private) needs to identify the services they are providing within the specific theme. Services can include delivery, human resources, training, supervision, infrastructure, medicine and supplies, information collection, or technical support.]		Not linked with any forms
2.1	**Mention the primary role of each department** [Select from the dropdown list of all departments and other organisations mentioned as 'Key Stakeholders']	Can be health or non-health departments, private health care providers and professional organisations, NGOs working the district for the specified theme.	

Form 2 (Section b)

3	**Current effort to address the issue** [On-going departmental activities to address the theme(s) should be mentioned here.]		Not linked with any forms
3.1	**Mention by department, the current effort of the department** [Select from the dropdown list of all departments and other organisations mentioned as 'Key Stakeholders'.]	Can be health or non-health departments, private health care providers, professional organisations, or NGOs working in the district on the specified theme.	
4	**How to enhance engagement and efficiency** [Suggestions for how other departments and the private sector can collaborate to increase coverage and service delivery, to improve coordination and avoid duplication.]		
4.1	**Mention how better engagement can be built between the primary and secondary departments** [Select from the dropdown list of all departments and other organisations mentioned as 'Key Stakeholders']	Can be health or non-health departments, private health care providers, professional organisations, or NGOs working in the district on the specified theme.	
5	**Lead from each department** (One person from each department involved needs to be selected as the main contact person for information on daily theme-specific activities)		
5.1	*Select from the dropdown list of all departments and other organisations mentioned as 'Key Stakeholders' and add the name of each lead.*		

9.4. Form 3: Define

The same stakeholders as in step 2 will attend this meeting to fill out Form 3. While discussing the possible solution and action(s) required to solve issues related to the specified theme, stakeholders need to consider the most feasible ways they can achieve the desired outcomes within a DIPH cycle (4-5 months) and within the resources available to the district administration.

Form 3

Sl. No.	Headings	How to fill up	Form Linking
	Health System building blocks	Will automatically appear	
	Description of the problem from a health system perspective	Note down the different issues/ problems relating to each health system building block relevant to the theme.	
	Possible solution for improvement	Note down the different ways to address each type of problem under each category.	
	Action required (write in priority order)	List the feasible actions required that align with the solution mentioned. Consider which action points are achievable within a DIPH cycle (4-5 months) and within the resources available to the district administration (both human and financial).	
1	**Service Delivery** [The provision of services (direct/primary services, and monitoring of those services) related to the theme and its adequacy (i.e. whether the existing services are adequate to address the problem).]		
2	**Workforce** [Note the people who are directly responsible for providing these services. Include their proportion with respect to the target population size (fair distribution), their skills level to address the issue (competence), comprehension of their roles and responsibilities, and their motivation and incentives to perform (productivity).]		
3	**Supplies & technology** [Availability and adequacy of supplies (training materials, registers, drugs, equipment, vehicle, etc.), and technology (information communication technology, advancements in health care, etc.)]		
4	**Health information** [Note the availability and adequacy of information on health indicators, finance, supplies, human resources, training, etc. Also mention, the type and form of information (breakdown of data, electronic or hard copy data records, and quality/completeness of records) available as per the requirements of the theme.]		
5	**Finance** [Record the availability of funding for the particular theme; and discuss its adequacy to address the issue.]		
6	**Policy/governance** [Information regarding the policy thrust of the specified theme. Is there any specific policy/government order on the theme that is applicable to the particular financial year?]		

9.5. Form 4: Plan

In this form, the theme-specific actions identified in Form 3 are split into realistic action-points.

Form 4 (Section a)

Headings		Form Linking
Total number of actions planned	All the action points from different departments involved for the specific theme.	Will be calculated automatically and will appear after Form 4 is submitted, so no need to fill this section in.
Responsibilities of different stakeholders	Total action points for each department involved for the specific theme.	
Health Department	Total number of action points related to the Health Department.	
Non-health department	Total number of action points related to non-health departments.	
District Administration	Total number of action points related to the Administration.	
Private for-profit organisations	Total number of action points related to private–for profit organisations.	
Non-governmental organisations	Total number of action points related to NGOs.	
Other departments	Total number of action points related to non-health departments.	

Form 4 (Section b)

Sl. No	Health System Building Blocks	**Action points** [action points mentioned in the form 3 will be automatically linked]	**Department responsible** [Department that has the primary responsibility in achieving respective action points] Person responsible [for each completing action point]	**Indicators** [to monitor the progress of the action points.	**Description of indicator** [There should be a numerator and denominator for each indicator]	**Target** [a quantifiable goal for each action point, to be achieved within the completion date.]	**Target date** [The date for competition. A timeline is set within which to execute each action point.]
1	**Service delivery**	The action point under this category mentioned in Form 3 and is linked	The key department responsible for this action point. The person responsible for achieving the specific action point.	The indicator to monitor the progress of this action point.	Description for calculating the indicator.	The target set at district level for the specific action point.	The final date for completing the specific action point.

2	**Workforce**	Same as above	Same as above	Same as above	Same as above	Same as above	Same as above
3	**Supplies & technology**	Same as above	Same as above	Same as above	Same as above	Same as above	Same as above
4	**Health information**	Same as above	Same as above	Same as above	Same as above	Same as above	Same as above
5	**Finance**	Same as above	Same as above	Same as above	Same as above	Same as above	Same as above
6	**Policy/ Governance**	Same as above	Same as above	Same as above	Same as above	Same as above	Same as above

9.6. Form 5: Follow-up

In this form, the follow- up of the action plan, along with its progress are recorded.

Form 5.1. Sub-district performance of indicators

The supplementary Form 5.1 tracks progress at sub-district level. It can be used during discussion, to understand the overall progress of the theme.

Facilitator's Notes:

Show participants the forms on a projector or on their computers, while explaining the guide to fill in each section of the forms. Ask participants to use the interface and try to fill out the forms for a selected health issue (learning activity 2).

Form 5 Follow-up- Part a

Theme			Mention the specific theme
Theme Leader			Mention the specific t leader for this theme
1	**Number of theme meetings**		Total number of meetings where the specific theme was discussed or presented
2	**Major stakeholders involved in each meeting**		
Sl. No	**Date**	**Number of participants**	**Participants**
	Mention the specific meeting date of review	Total number of participants present in the meeting	Designation of participants present at the meeting. [Those interested in the list of the participants can access it from the hyperlink.]

3	Comparison of key coverage indicator(s) in the DIPH cycle		Time 0	Time 1	Time 2	Time 3	Time 4	Time 5	Time 6
		Date	Baseline month	End of monitoring month 1	End of monitoring month 2	End of monitoring month-3	End of monitoring month-4	End of monitoring month-5	End of monitoring month-6
	Indicators are linked to Point 2 of Form 1B			Not linked to any previous form, enter the data manually					
	Mention the DIPH theme	Reference the data source used by the district for monitoring monthly progress of the specific theme	These are baseline data from before the DIPH cycle began in the district	These are data obtained for the first month after the initiation of the DIPH cycle	This is the data obtained for the second month after the initiation of DIPH cycle	These are data obtained for the third month after the initiation of the DIPH cycle	These are data obtained for the fourth month	These are data obtained for the fifth month	These are data obtained for the sixth month

Form 5 - Part B

Total action points planned							
	Total action points – Not started [will be marked with 'Red'] on target [will be marked with 'Pink'] Ongoing on target [will be marked with 'Yellow'] Completed [will be marked with 'Green'] Ongoing not				Total number of all action points to be achieved for the specific theme will be automatically updated		
Action points	**Indicators**	**Progress of indicators**	**Person responsible**	**Timeline**	**Status of action points**	**Suggestions**	
						Revised timeline	**Change in responsibility**
These are linked to Form 4	These are linked to Form 4	Progress or achievements for each action point for the district will appear. This figure updates automatically, as it is linked to Supplementary Form 5.1, where monthly progress for each action points is recorded.	Person responsible for each action point at district level. This is linked to Form 4	Time line will be appear here and is linked to Form 4	The current status of each action point should be mentioned here under these 4 categories: completed, ongoing – on target, ongoing –not on target, not started	If the activity is on-going – not on target or not started, then add a revised time line as suggested in the meeting. The revision is a way of making the action plan more achievable and enabling the stakeholders to have greater ownership of the process	If any change in responsibility was decided, it needs to be recorded

Additional Form 5.1

Action point: (will appear automatically)				Linked to Form 4
Indicator: (will appear automatically)				Linked to Form 4
Monthly	Name of each sub-district, in columns			
	Sub-district 1	**Sub-district 2**	**Sub-district 3**	**Form Linking**
Target	The target will appear for the specific indicator for each sub-district	The target will appear for the specific indicator for each sub- district	The target will appear for the specific indicator for each sub- district	Linked with 'Target' given at Form 4
Select specific month for which data are to be entered	Enter the sub- district data for the chosen month from the dropdown list box	Enter the sub- district data for the chosen month from the dropdown list box	Enter the sub- district data for the chosen month from the dropdown list box	Not linked with any previous forms
Total	Sub-district and district total will be this will be calculated automatically	Sub-district and district total will be calculated automatically	Sub-district and district total will be calculated automatically	

10. LEARNING ACTIVITIES

ACTIVITY 1: Brainstorming

Title:	Five steps of the DIPH strategy
Objective:	To understand the process for each of the step in DIPH steps for a selected health theme, for example, to increase the number of women who receive HIV counselling and testing services in a district during their visits to the antenatal clinics.
Method:	• Divide the participants into groups and give them all pencils and paper. • Ask the participants to discuss and list all the types and sources of data that they will require to do a situation analysis (Assess).

	• Each group will then discuss the types of stakeholders that they need to engage with, from public and private health, and non-health departments (Engage). • Ask participants to list the problems associated with the health theme and to select one, which they would want to address through actionable solutions (Define). • Each group will then discuss the action points, timeline and person/ district/ sub-district/ department responsible for carrying out each action point (Plan). • Ask one participant from each group to present their plans and discuss the possible follow-up plan (Follow-up).

ACTIVITY 2: Form-filling exercise

Title:	Job-aids for the DIPH strategy
Objective:	To understand the how to use the web-based interface to fill in the forms.
Method:	• Participants will either share or have their individual computers for this activity. • Familiarise the participants with the interface before the start of 'form-filling guides' section. • Ask participants to use the same health theme as in Learning Activity 1 to fill the forms as the session progresses. • Answer any uncertainties and queries that participants have, while explaining what information goes into each of the forms.

11. CONCLUSION

This handbook provides participants with the preliminary core skills for decision-making, stakeholder engagement, use of data, and monitoring health system performance. In a decentralised health system, where districts have a reasonable level of autonomy for local level health decision-making, the introduction of the DIPH five-step strategy facilitates the use of local level data for targeted district-level decision-making across multiple health domains.

It provides a mechanism for rapid data analysis and presentation to enhance the use of data by the district administrative and programme leadership for health programme prioritisation and planning, progress monitoring and follow-up across diverse health themes. Through embedding the DIPH strategy effectively into existing district-level meetings, it offers a system for engaging multi-sector stakeholders in structured health decision-making.

The DIPH job-aids are designed to help organise and interpret data from the multiple sectors involved in delivering services around a health issue. The web-based interface is user-friendly with automated features for capturing data from preceding steps, thus, the district team avoids making repeat entries and saves time and effort.

IDEAS aims to improve the health and survival of mothers and babies through generating evidence to inform policy and practice. Working in Ethiopia, northeast Nigeria and India, IDEAS uses measurement, learning and evaluation to find out wat works, why and how in maternal and newborn health programmes.

For more information on the DIPH
www.diphonline.org

Further reading and information
ideas.lshtm.ac.uk
@DecisionData

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