

MCHIP Country Annual Report: India

October 1, 2012-September 30, 2013



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Major Accomplishments

- Supported the initiative of Indian Nursing Council (INC) and the Government of India (GoI) to strengthen and expand the foundation of pre-service education at the national level, while setting up state nodal centers of excellence and upgrading ANMTC clinical training capacity in Jharkhand and Uttarakhand.
- Addressed the unmet need for postpartum family planning (PPFP) services by supporting integration in routine MNCH services and revitalizing immediate postpartum intrauterine contraceptive device (PPIUCD) insertions.
- Supported the MOHFW, USAID bilateral health programs and the new National Newborn Care and Resuscitation Initiative (NSSK) in their efforts to strengthen and expand access to essential newborn care (ENC), and teach basic resuscitation techniques.
- Built the capacity of the MOHFW's National Immunization Program, the state health departments and their many Indian and external partners toward achieving and sustaining full immunization coverage by 12 months of age for at least 80% of India's children.
- Worked across the fields and with of government and NGO partners to initiate activities under the GoI's new Reproductive, Maternal, Child Health plus Adolescents (RMNCH+A) Strategy at the national and state levels.

Program Learning

During Program Year (PY) 5, the team analyzed data from a study on the use of Postpartum Systematic Screening (PPSS) during Village Health and Nutrition Days (VHNDs). The primary objective of the study was to measure the effects of the use of the PPSS tool on provision of and referral for PPFP services to women in their first year postpartum who come to the VHND sites to have their children vaccinated. The study suggests that the PPSS tool, in addition to training of ANMs and ASHAs in PPFP counseling, at VHND sites increases acceptance of FP methods, along with not negatively effecting acceptance of immunization services, compared with training them in PPFP counseling alone.

MCHIP's Essential Newborn Care (ENC) team led efforts to validate verbal autopsy (VA) tools and led discussions on tools, processes, and results. Experts from UNICEF,

INCLEN, the National Neonatal Forum, national Collaborative Centers and the Department Head from Aligarh Muslim University and Gwalior medical College came together to lead these efforts. As a result, the Verbal Autopsy tool was accepted, 67 verbal autopsy data sets were validated and the Logic framework for Neonatal Verbal Autopsy software (NeVas) was finalized. With this tool, 47 new cases of VA were investigated, bringing the total number of VAs investigated under MCHIP to 115. The ENC team also completed a systematic analysis of delivery point care at facilities with neonatal stabilization units in the states of Rajasthan, Orissa, Tamil Nadu, Assam, West Bengal and Gujarat. The objective of the assessment was to assess the availability of 24x7 services at these delivery points and quality of care being provided to the newborns at the time of birth and in the post natal wards.

Activities supporting Regular Appraisal of Program Implementation in a District (RAPID) also continued during PY5. To date, six RAPID rounds have been facilitated and have led to a sustainable improvement in quality of services in implementation districts.

Program Year 5 Major Accomplishments

Improved Pre-Service Education (PSE) for the Nursing and Midwifery Cadres

At the national level, MCHIP continued to support the National Nodal Centre (NNC), NRS Kolkata and backstopped key activities during six weeks of training for the 40 Auxiliary Nurse Midwife/General Nurse Midwife (ANM/GNM) faculty from Jharkhand, Bihar, Rajasthan, Uttar Pradesh and Uttarakhand. These trainings focused on effective teaching skills, Skilled Birth Attendance, integrated management of neonatal and childhood illness, family planning, prevention of STIs including HIV and the Performance Standards for the ANM training Centers. MCHIP also provided technical assistance (TA) to the Ministry of Health and Family Welfare (MOHFW) to develop the operational guidelines for strengthening Pre-Service Nursing and Midwifery Education. As a follow-up, 38 officers from 10 High-Focus states were oriented to the operational guidelines, the detailed steps for establishing SNCs and how to strengthen ANM and GNM schools during a two-day workshop.

At the state level, the college of nursing in Dehradun, Uttarakhand was inaugurated and was certified by INC as the State Nodal Centre (SNC) for Uttarakhand. In Jharkhand, significant progress has been made towards the proposed State Nodal Centre at the College of Nursing Ranchi, where adherence to educational standards has already improved from 40% at baseline to 70% through the mentorship and support of MCHIP. Also in Jharkhand, MCHIP provided TA to the state government to strengthen three Auxiliary Nurse Midwife Training Centers (ANMTCs). MCHIP donated models and equipment to strengthen skills labs, organized three clinical skill standardization workshops, and continued to conduct supportive supervision visits to facilitate improvement in classroom teaching, clinical instruction and practice, and training infrastructure organization. Finally, in Uttar Pradesh, MCHIP supported the upgradation of the School of Nursing in Agra into a College of Nursing and conducted regular follow-up visits with the new principal. As a result, the school's teaching infrastructure has been reorganized, the library was improved, internet facility initiated and interviews conducted for additional faculty.

Increased Access to High-Quality FP Services

During PY5, MCHIP provided TA to the Family Planning Division, MOHFW to develop key materials for improving family planning training at the national level, including the development of a Learning Resource Package (LRP) consisting of a facilitator's guide, RMNCH handbook and RMNCH counselor flipbook. The LRP was used during the first batch training of 27 RMNCH counselors in Uttar Pradesh (UP). MCHIP also supported the MOHFW in development of an E-Learning course packages for PFP/PPIUCD services. The final version of the course has been submitted to the MOHFW and the course is expected to be hosted on the National Institute of Health and Family Welfare (NIHFW) website.

MCHIP continued to support the Family Planning Division and to advocate for the scale-up of PPIUCD at the state level. In Uttar Pradesh MCHIP established five new training sites, bringing the total to 9, and trained 386 providers (147 doctors and 239 nurses) in PFP/PPIUCD services in the PY5. During the last quarter, MCHIP closed-out and transitioned activities in UP.

With the Government of Jharkhand (GoJ), MCHIP developed and disseminated a core set of performance standards to 21 district hospitals, and supported implementation of Family Planning service delivery standards at 12 health facilities in 3 focus districts. During the PY5 397 providers (104 doctors and 293 nurses) were trained in PFP/PPIUCD services.

Also at the state level in Uttarakhand, MCHIP helped introduce PPIUCD services in an additional 12 facilities, trained 90 nurses and 45 doctors in PPIUCD Clinical Training in Uttarakhand. The team conducted regular supportive supervision visits to all the facilities and facilitated the hiring of 24 RMNCH counselors.

Contributed to Full Immunization Coverage Efforts

MCHIP supported several key Vaccine Preventable Disease (VPD) activities during PY5. For example, the team participated in the assessment of MCTS (Mother and Child Tracking System) organized by the MOHFW and Immunization Technical Support Unit-Public Health Foundation of India to assess the MCTS progress and prepare a roadmap for improvements. Nationally, MCHIP is also involved in specialized evaluations such as the 'National Effective Vaccine Management' and Maternal and Neonatal Tetanus Elimination (MNTE) validation. Additionally, MCHIP participated in the Measles Catch-Up Campaigns, supported scale up of the second dose of the Measles and Pentavalent vaccine in six additional states, started an 'Esupervision' model for RI and numerous other national and state level campaigns and workshops.

This year, MCHIP supported the GoI in organizing two SEPIO review meetings on the Intensification of Routine Immunization activities and acts as the core team for preparation of the "Induction Training Course" for state EPI officers. In related work, MCHIP developed a four-day course on training State EPI Officers (SEPIOs) and participated in meetings to finalize course material on 'Cold Chain and Vaccine Management.' For this activity, the MCHIP team reviewed four chapters, and reviewed two chapters to finalize the NIPI-UNOPS' E-Learning course in immunization for health managers.

Additionally, MCHIP provided technical support to several states. In particular, MCHIP provided TA to the development of Routine Immunization (RI) Program Implementation

Plan (PIP) in Jharkhand and Uttar Pradesh and worked to leverage more than Rs. 77 million (approximately 1,423,830 USD) for scale-up of MCHIP high impact interventions. The team also facilitated sessions during the PIP training of 45 District Program Management Units (DPMUs) in preparation of District Health Action Plans (DHAPs) for RI in the focus states. Furthermore, the team participated in and supported the strengthening of RI at state and district levels by giving inputs in district review meetings and field reviews.

Supported Essential Newborn Care (ENC) and Basic Resuscitation Initiatives

MCHIP actively supported the GoJ and the Government of UP (GoUP) in the preparation of the Newborn Health Component of Child Health PIP 2013-2014. Accepted recommendations in Jharkhand include newborn kits, Vitamin K, 3 batches of NSSK State Training of Trainers (TOT) for 54 new master trainers and 3 batches of refresher training for 69 existing master trainers. Leveraged funds in Jharkhand amount to roughly 39.8M Rupee (\$650,000) for newborn activities. In UP, the state government also included key recommendations in their PIP, such as: supportive supervisions of ENC/R in 42 priority districts, Vitamin K, 75 neonatal ambulances and the inclusion of ASHA facilitators for every 20 ASHAs. In UP and Jharkhand, MCHIP supported training of a total of 348 health personnel in NSSK, provision of essential newborn care to 6551 newborns at 10 demonstration sites, resuscitation of 244 newborns with birth asphyxia, and institutionalization of skin-to-skin care for newborns.

Contributed to Child Survival Call to Action and launch of the national RMNCH+A Strategy

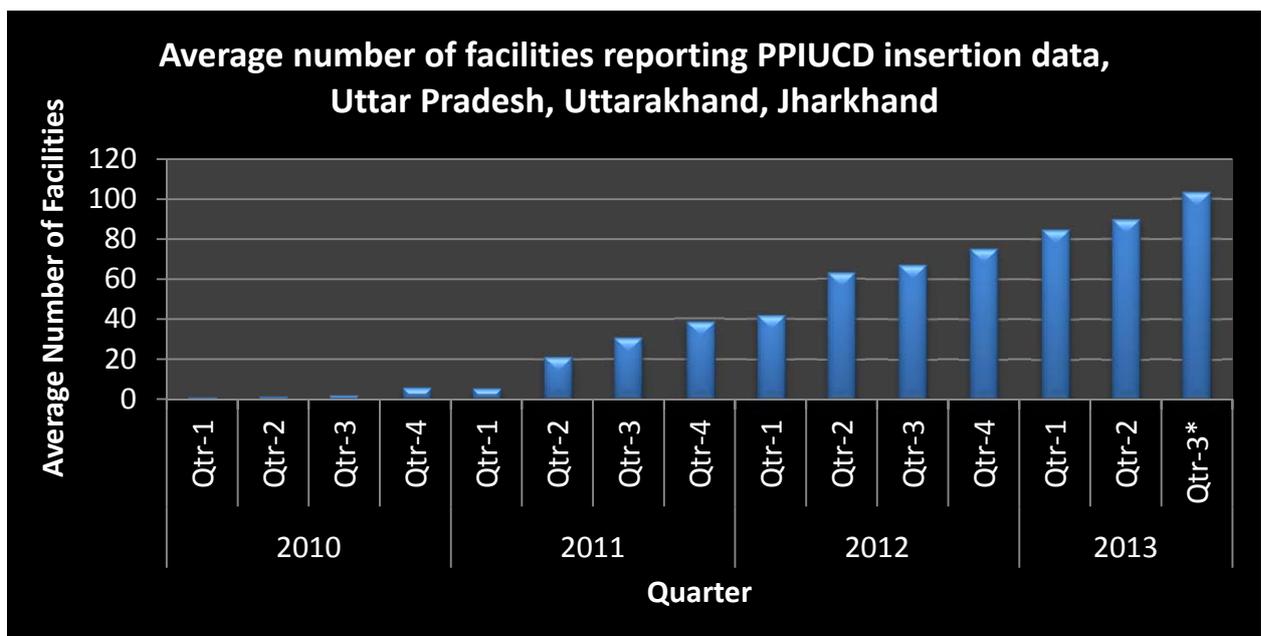
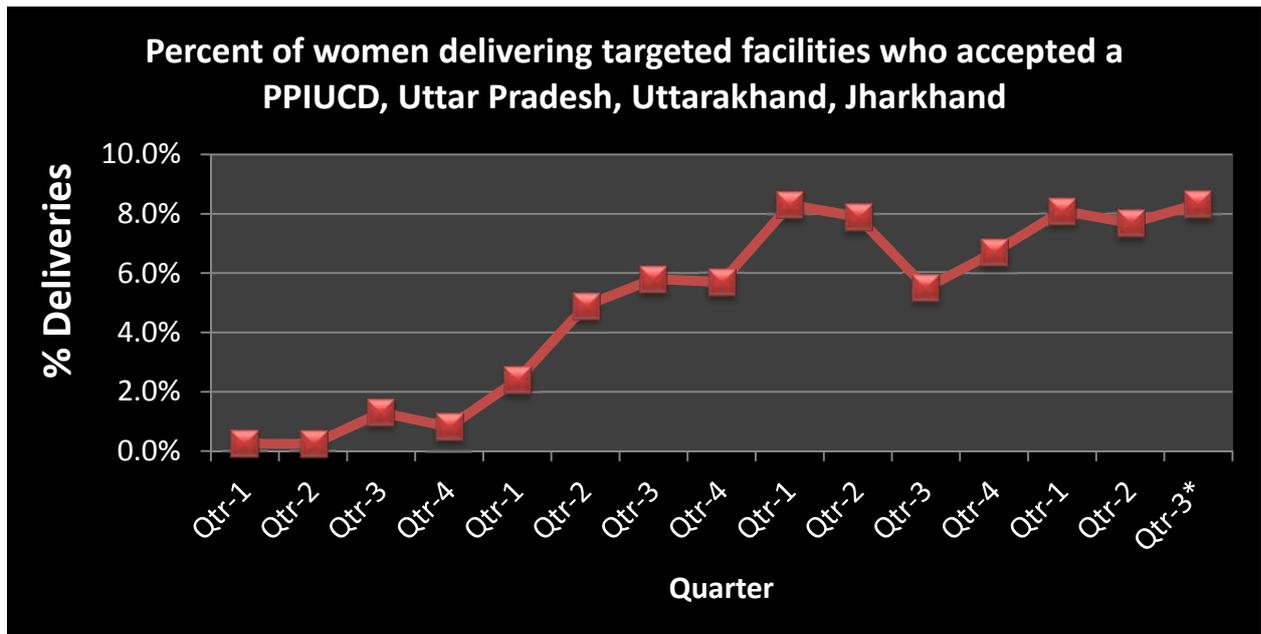
MCHIP served as a secretariat to the February 2013 “Child Survival Call to Action” (CSC2A) led by the GoI, in partnership with USAID and UNICEF, in Mahabalipuram. During the meeting, the MOHFW formed six sub-committees, supported and coordinated by MCHIP, to develop roadmaps and technical documents, i.e. RMNCH+A strategy, State-specific data modeling, State-specific score cards and mechanisms for involving the private sector, civil society and faith based organizations (FBOs), for the Child Survival Call to Action. During the summit, the Government of India launched the new RMNCH+A Strategic roadmap, which emphasizes the need for evidence-based planning, prioritizes additional NRHM funding to support high priority states and districts and, for the first time, focuses on adolescent health. The event marked the beginning of a strengthened relationship between the GoI and MCHIP.

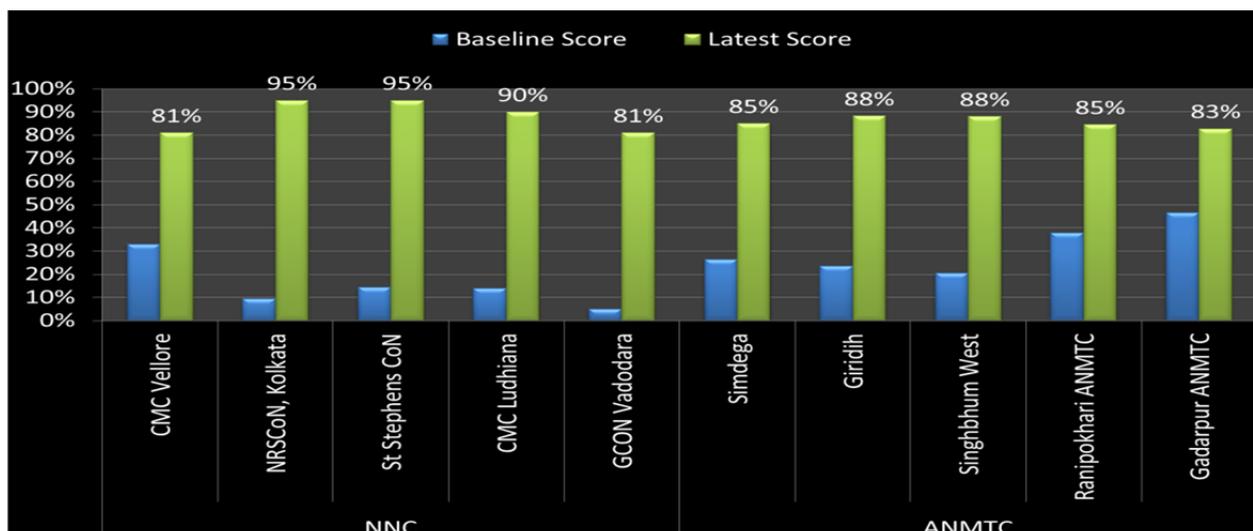
The GoI, with the support from MCHIP, identified 184 high priority districts (HPDs) across 29 states of India in which to intensify efforts using a life-cycle approach through Continuum of Care. These HPD were allocated to various development partners (USAID, UNICEF, DFIC, BMGF, NIPI & UNFPA) to roll-out the RMNCH+A strategy and intensification efforts through providing technical assistance to National and State Governments. MCHIP is working as the nerve center to the initiatives and support coordination between the GoI, States and Development Partners. MCHIP is working to establish a National RMNCH+A Unit (NRU) to track and monitor the progress on RMNCH+A initiatives at National and state level.

As a result of MCHIP’s key technical support and leadership during the development of the strategy, the project has been identified as a key implementing partner for national and state-level RMNCH+A activities in India. In this new role, MCHIP will: (1) hire and second staff to the RMNCH+A Campaign’s National Resource Unit (NRU); (2) establish and manage four State RMNCH+A Unit offices (SRU) to serve the six USAID-led states; (3) continue to provide supplemental technical support at national, state and district

level in the project's traditional areas of expertise --pre-service nursing and midwifery education (PSE), revitalizing family planning in the context of MNCH and increasing post-partum FP options (PPFP), immunization and new vaccine introduction (RI/NUVI) and newborn health (NB); and 4) coordinate with national and state government health officials and with other DPs to ensure that a full, integrated package of RMNCH+A technical support is available in each state and in the 30 High Priority Districts in the six states, in particular.

Graphs/Charts





Challenges and Opportunities

MCHIP India underwent several changes this year, most significantly to the structure of the team's workplan and approach. These changes resulted from a shift in the GoI's strategy for addressing MNCH and the introduction of the RMNCH+A Strategy. As indicated above, MCHIP has been identified as a key implementing partner for rolling-out the RMNCH+A Strategy. As such, we have re-evaluated our approach to ensure that we are able to provide needed support to the GoI and state governments in development of the National and State Resource Units, while still ensuring that we are able to deliver on previously agreed upon interventions and technical assistance.

Success Story/Personal Narrative

A "Precious Life" is One of Many Saved by MCHIP Training in Jharkhand.

Palojori, India—Alima and Lukhman will never forget the day a skilled birth attendant (SBA) saved the life of their daughter, Razia. It was not always certain that their daughter would survive her birth at the Primary Health Centre at Palojori, but thanks to Manju Devi, an SBA trained by MCHIP in essential newborn care and resuscitation, their story has a happy ending.



When Alima's labor pain started, a community health worker brought her to the facility. This was Alima's second pregnancy, and it had gone smoothly so far. However, when she gave birth, the newborn did not cry or breathe.

Manju, who was assisting the delivery, quickly took action. She informed Alima of the situation, cut the baby's cord, and started resuscitating the newborn. And when simulation and suction did not work, she used a bag and mask for resuscitation. Thanks to her skilled efforts, little Razia started crying after a few seconds. A precious life had been saved!

Alima and Lukhman come from Dumaria village, which falls in the Palojori block of Deoghar district. Palojori is one of the remote blocks in Deoghar, situated nearly 65 kilometres away from a main town. A tribal dominated population with subsistence farming as its main occupation, much of the workforce migrates to other states in search of jobs. It has its only Primary Health Centre at Palojori, which serves a large population. It was recently upgraded to a Community Health Centre.

Palojori CHC was identified as one of MCHIP's demonstration sites and, since October 2011, a number of capacity building activities have been undertaken. These efforts were made to establish the center as a learning site for high-quality newborn care and other health services—not only for the district, but for the entire state of Jharkhand.

The training for providers includes essential newborn care and resuscitation, followed by regular supportive supervision to ensure that they have acquired mastery over the newly acquired skills. It was due to this training that Manju knew exactly what to do when Razia did not breathe after birth.

All the staff members (auxiliary nurse-midwives) who conduct deliveries are trained in essential newborn care, including hands-on resuscitation practice on baby mannequins and regular practice sessions at skills stations. This mentoring support helps them gain the necessary confidence to do resuscitation procedures whenever required.

Today, Razia—whose name means "the chosen one"—is healthy and thriving. A coy smile appears on Alima's face as she carries her precious baby in her lap and describes in her own language how she and her husband have cared for the three-month-old to help her grow and stay healthy. Razia was brought to the CHC for a follow up visit by her parents, where the provider reassured them that all is well with their baby.

And Razia is not alone. Many more babies are getting a second chance at life with the help of the trained providers at Palojori CHC. Between November 2011 and September 2012, 20 babies were helped to breathe through simulation, suction, or bag and mask.

These trained providers are now encouraging their peers to learn and deliver. Their stories of success are spreading to the community, slowly motivating members to come for institutional deliveries. There is a growing confidence that in case of any emergency, the staff at the facilities will save their babies.

Tamina Bibi and her husband Majid decided to give birth to their first born at the facility and are glad they did:

“We are happy that we took the decision to go for the delivery at the hospital. Had we opted for a home delivery, we could have lost our only child as the traditional attendant would surely have declared our child dead as he did not cry at birth and did not breathe either. It is only due to the machine used in the hospital that we are able to have our first child after 12 years of marriage!”

Family Planning Counselor in India Helps Women Avoid Her Own Hardships



Haldwani, India—Nineteen-year-old Kamala came to the Haldwani Women’s Hospital looking for Chandra Bisht, the hospital’s family planning (FP) counselor. “She was carrying her nine-month-old in her lap, and the moment I helped her sit, tears started rolling down her eyes,” recalls Chandra.

Worry and fatigue clearly written on her face, Kamala said she was pregnant again and her husband, the sole earning member of her family, had been out of a job for many months. In her position, Chandra has seen many such cases—of women becoming mothers too early, of repeated pregnancies, and of a complete lack of awareness about the risks of closely spaced pregnancies on the health of mothers and children.

“This is a government hospital and most of the people who come here are poor, with little or no education. The need to counsel them on the benefits of postpartum family planning (PPFP) is very high,” Chandra said.

She spoke to Kamala and her husband about various FP methods that they could use immediately after Kamala gave birth. This would give her control over her own fertility, Chandra said, preventing her from getting pregnant again unless she wished to, and giving her the necessary time to heal and focus on her family. She discussed the benefits of the postpartum intrauterine contraceptive device (PPIUCD), a safe and long acting (up to 10 years) FP method, which can be inserted immediately after delivery. A reversible option, the PPIUCD can also be removed whenever required.

“I assured [Kamala] that if she faced any problems, I would be there to help,” Chandra said, noting that the couple chose to use a PPIUCD after their discussion. “I feel happy when a woman so in need of FP gets convinced and adopts an FP method.”

Chandra was hired and trained by USAID’s flagship Maternal and Child Health Integrated Program (MCHIP) to strengthen PPFP services in India. In the state of Uttarakhand, 13 other counselors were also hired and trained in counseling skills, and have made a tremendous impact on the uptake of PPFP services where they are stationed. This success prompted the State government to employ these counselors under the National Rural Health Mission (NRHM), and now 13 additional counselors have been hired and are being trained by MCHIP.

In less than two years as a counselor at the hospital, Chandra is changing the perception of PPFP, proof that good counseling can have a positive impact on FP uptake. During her tenure, the number of women at the hospital accepting PPIUCDs every month has increased from an average of 29 to 81. Those who know her give much of this credit to Chandra’s abilities to listen well—to the women themselves as well as their families—and to communicate in the local language. And because the Women’s Hospital at Haldwani is surrounded by mountains, many women come only for delivery and not

during the antenatal period. Therefore, Chandra takes every opportunity to communicate with women and their families about PFP each time they come in.

“If a client gets followed-up well, she will talk about her positive experience to her family and friends. Such feedback will increase the demand for PFP, including PPIUCD, as these women would listen to a satisfied client more than us,” she said.

And Chandra understands these women’s needs and concerns well. She grew up in the same district and faced many of the same challenges in her own life: “I got married very early, right after high school and became a mother soon after. My marriage broke down and I had to return to live with my mother. I had to face several hardships. I had the responsibility of this little child and no source of income. I educated myself while doing odd jobs and eventually became a teacher.”

Chandra’s own hardships have made her determined to help the women of her community live better lives. And many other FP counselors who come from humble households feel similarly. At a recent State gathering, one such counselor said: “We get to know the lives of the women in the community and the challenges they face on a daily basis more closely. Counseling these women to adopt FP methods that will help improve their conditions has increased our self-worth.”

The Indian Government is recognizing the important role that counselors play in providing information and helping women and their families to understand the health benefits of FP. As a result, the Government is now expanding their scope of work across the country to include other important areas of maternal and child health.

Ms. Anuradha Gupta, Additional Secretary and Mission Director, NRHM, Government of India writes: “It has been observed that good practices related to mothers, newborns, child health and family planning are adopted and continued when clients make decisions by themselves based on accurate information. Effective counseling is a means, which empowers clients to seek what is best for them and to exercise their rights to good quality maternal, newborn, child health, and FP services.”

It takes many factors to make a success of a public health program. In India, where more than 55,000 women die due to childbirth every year, and where more than one million babies die before reaching their first birthdays, strengthening PFP services has become a major health priority. And counselors like Chandra are playing an increasingly vital role in helping women and their families get the information they need to improve their lives.

Regular Appraisal of Program Implementation in District (**RAPID**)

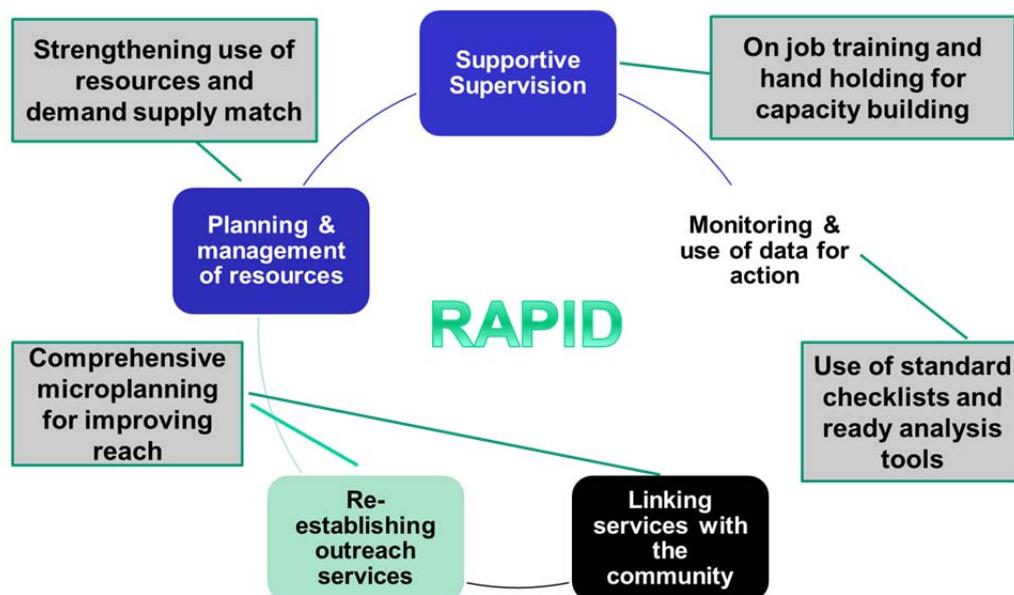
Innovation for improving quality of immunization services through supportive supervision

RAPID is an integrated supportive supervision model piloted with encouraging results in 5 focus districts of UP and Jharkhand. Objective was to integrate RED components within one intervention in order to:

- Empower program managers and build capacity
- Improve quality of program management and services
- Ensure sustainability in resource constraint settings

- Explore feasibility of replication to other health programs

Integration of RED components:



Expected results:

Immediate: Improved program management & Improved practices at facility and outreach sessions

Intermediate: Effective, safe and timely immunization service delivery

Long term: Reduction in VPD related mortality, morbidity & disability

The model has to be Replicable, Sustainable & Scalable

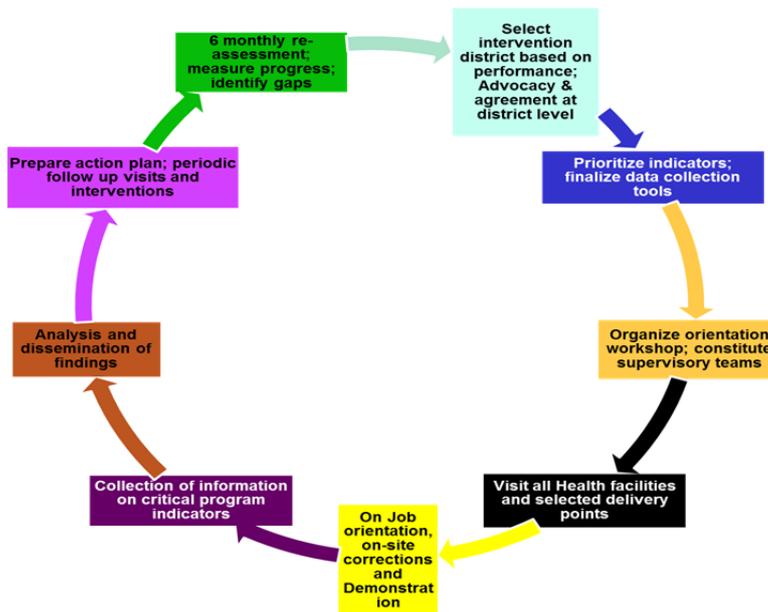
Approach: RAPID is based on principles of supportive supervision

- Identify “what is working” and encourage workers
- Understand the problems & gaps with health staff
- Handle issues in non-threatening way
- On site corrections using locally available resources
- Demonstrate correct practices for capacity building
- Share feedback for corrective actions
- Follow up of issues by program managers

Overview of process:

- Identify critical bottlenecks and indicators
- Develop standard checklists, analysis framework and dissemination strategy
- Conduct periodic assessments at facility & outreach level to monitor performance and measure improvement
- Implement on site corrections and capacity building
- Share the results with program managers and staff and co-facilitate action planning
- Between assessments support in
- Hand holding, on job orientation, supportive supervision

- Develop demonstration sites to orient and motivate staff
- Advocate for optimal use of available resources



RAPID Process: Analysing processes, Measuring outcomes & Changing practices until you get it right



Establishing Demonstration Sites:

- Identified facilities developed as demo sites to serve as cross learning centers for concerned staff members.
- Integrated sites for all immunization related thematic areas were developed over a period 6-8 months.
- These sites facilitated capacity building through interactive discussions, demonstrations and participatory learning.
- Standardized readiness assessment checklists for different thematic areas were used to track progress & sustainability.
- Cross learning visits were organized between RAPID rounds for on-site orientation

Approach:

- Implementation of correct practices in integrated manner
- Utilization of available resources, funds and locally feasible solutions in best possible manner
- System strengthening and capacity building through supportive supervision
- Enhanced ownership and active involvement and district and block level officials
- Providing scope for local adaptation and innovations
- Feasibility of replication to other health facilities and programs

Demonstrable changes:

Injection safety corner: Before



After



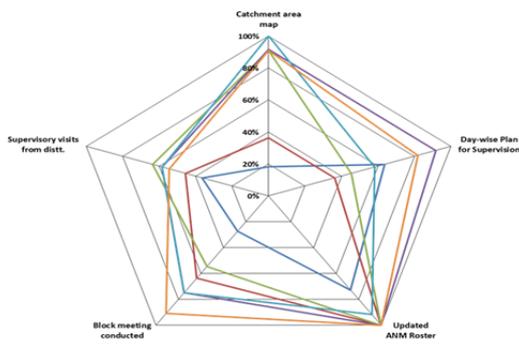
Cold chain room: Before



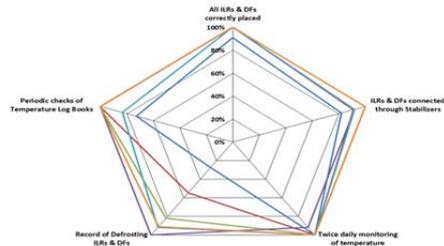
After



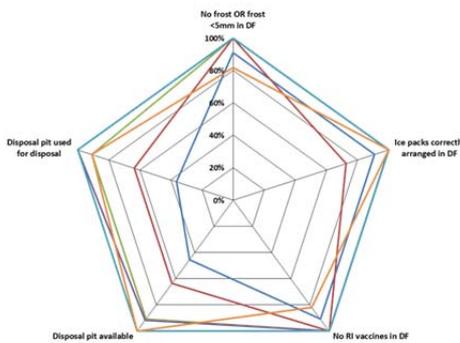
Results: Jharkhand Program Management



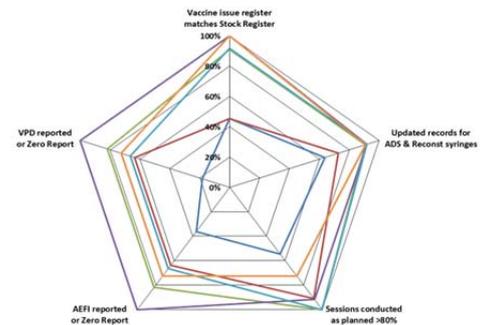
Cold chain management



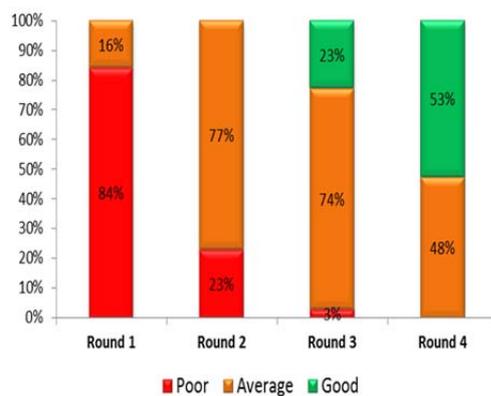
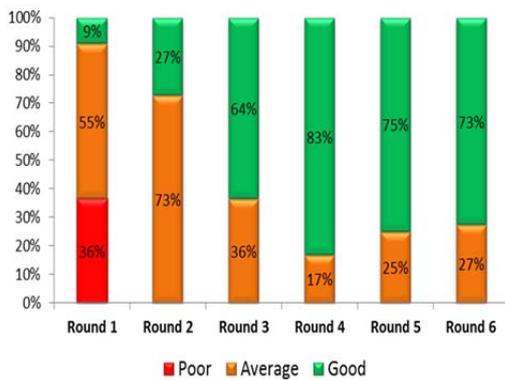
Waste disposal



MIS



Results: Overall facility ranking for Jharkhand (n-11) and Uttar Pradesh (n-39)



Led by results, Govt. of Jharkhand scaled up RAPID in all 24 districts through NRHM funds (2011-12 & 2012-13). In UP, being rolled out in 32 poor performing districts (out of total 75) along with UNICEF. Govt. of Haryana is scaling up RAPID in all the districts of Haryana. Also piloted by State Govt. of MP and Odisha

MCHIP Spearheading Government of India's Ambitious RMNCH+A Strategy – An Engagement Renewed

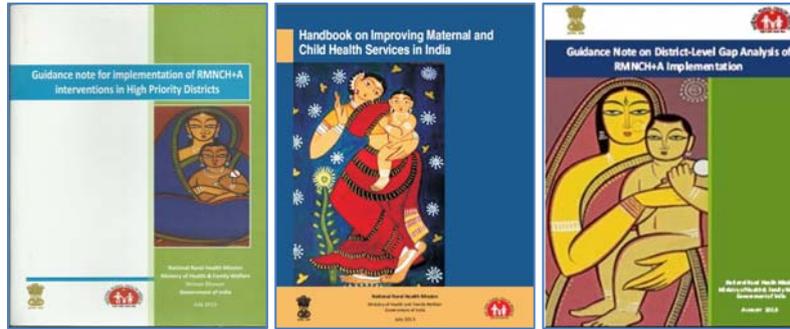
Washington, DC – The ‘Global Call to Action for Child Survival’ held in the US capital witnessed a strong reaffirmed commitment by India’s Union Minister for Health and Family Welfare, Shri Ghulam Nabi Azad for putting a stop to preventable child deaths in the country. India’s leadership brought together efforts from central and state governments, and expertise from private sector, civil society, media, multi-lateral organizations, donor agencies and development partners towards developing a strategic roadmap for the country to achieve MDG 4 and 5.



In short, the “Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health,” or RMNCH+A, is an innovated approach launched by the Health Minister during ‘National Call to Action: Child Survival Summit’ held in February 2013 at Mahabalipuram, India. This strategy lays specific emphasis on evidence based planning, prioritization and 30% extra NRHM budgetary support to poor performing districts. For the first time, there is a focus on adolescent health, creating and leveraging partnerships, and implementing lifecycle approaches and continuum of care to bring a synergistic effect to the outcomes and impact.

This historical National Call to Action Summit jointly organized by USAID and UNICEF was backed by untiring efforts from MCHIP team, which played the forerunner role with planning , organizing, and ensuring a streamlined roll out of interventions outlined in the RMNCH+A strategic framework. Months before the summit, MCHIP on behest of Govt. of India initiated dialogue with different departments and stakeholders, matching the frequencies, and worked in partnerships for drafting RMNCH+A strategic document. Collating and prioritizing spectrum of interventions as envisaged under different national and state driven programs, and transforming them in a framework was a herculean task in itself for which MCHIP gained wide appreciation from all players, particularly for achieving this in timely and quality manner.

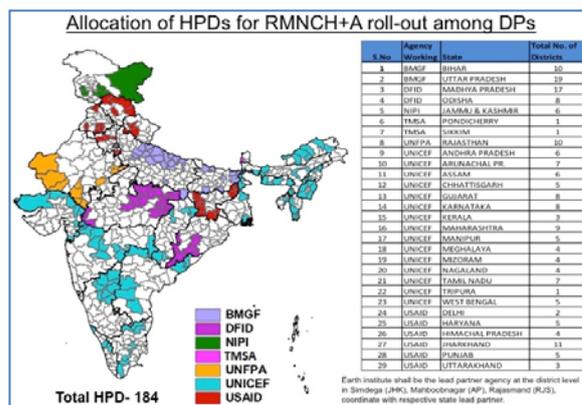
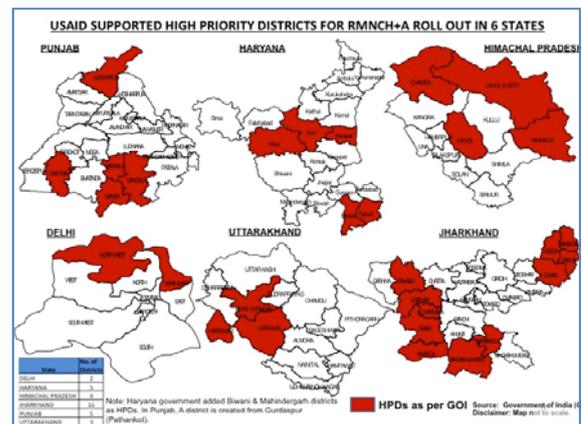
This marked a beginning of renewed engagement between National Government and MCHIP and was followed by association of its technical expertise in identification of 184 high priority districts (HPD) across all states of the country and introducing score cards for monitoring and reviewing the progress or RMNCH+A activities in these HPDs. The unique approach of using district-wise score cards (as suggested by MCHIP’s technical team) was in fact a generation’s leap over the conventional methods because score cards utilize public and private sector data to assess performance both in terms of outcomes and service delivery.



The management and organizational skills of MCHIP, in addition to its technical knowledge of different thematic areas, paved the way for project team to establish a National RMNCH+A Unit (NRU) within the Ministry of Health and Family Welfare to function under the overall guidance of Mission Director (NRHM), other senior officials and program managers to synchronize the efforts in different states. The RMNCH+A strategy seeks a unified and harmonized technical assistance from the development partners assigned to coordinate activities in specific states. USAID (supporting MCHIP) was identified as the State Lead Partner for six states (viz. Haryana, Punjab, Delhi, Uttarakhand, Himachal Pradesh and Jharkhand) and MCHIP team was assigned responsibility to achieve the objectives and establish State RMNCH+A Units and State Unified Response Teams.

MCHIP also played a pivotal role in the development of other national policy and guideline documents including the “Handbook on Improving Maternal and Child Health through RMNCH+A Approach” for a range of stakeholders like Ministers, District Collectors, District Magistrates, Principals and Faculty members from mentoring institutions and Chief Medical Officers; “Guidance note for implementation of RMNCH+A interventions in High Priority Districts” and “Guidance note on district level gap analysis of RMNCH+A implementation”.

Undaunted by the achievements and appreciation from all levels, the team never paused and is still working to add quality in all its endeavors, overlooking the horizon where India successfully accelerates child survival and maternal health in near future and beyond 2015.



Country: India

Reporting Period: October 2012-September 2013