



MCHIP India End-of-Project Report

October 1, 2009–August 30, 2014



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The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health's flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria, nutrition, and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.

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Country Summary: India



| Selected Health and Demographic Data for India | |
|--|-----------|
| GDP per capita (USD)* | \$1,489 |
| Total population* | 1,237,000 |
| Maternal mortality ratio** | 200 |
| Neonatal mortality rate (deaths in first month of life/1,000 births)*** | 32 |
| Infant mortality rate (deaths at 0–12 months of age/1,000 live births)*** | 48 |
| Low birth weight (% of live births)*** | 28% |
| Skilled birth attendant coverage*** | 53% |
| Antenatal care, 4visits or more*** | 51% |
| Immunization coverage (% of infants with third dose of DTP-containing vaccine)*** | 72% |
| Contraceptive prevalence (modern methods)** | 54.8% |
| Unmet need for family planning** | 20.5% |
| Total health expenditure per capita (USD)* | \$61 |
| <i>Sources: *World Bank; **WHO India statistics summary 2002–2012; ***UNICEF 2013.</i> | |

Major Activities by Program Component:

- **RMNCH+A:** Acted as secretariat for the Government of India's Summit on the Child Survival Call to Action in February 2013, and as technical support unit to the MOHFW/NRHM for roll out of RMNCH+A strategy nationally and in six USAID-led states: Jharkhand, Uttarakhand, Haryana, Punjab, Delhi, Himanchal Pradesh.
- **Postpartum Family Planning (PPFP):** Advocated for national PPFP/PPIUCD policy and assisted in rollout in three states with USAID support and in an additional 20 states with leveraged support from other donors; trained service providers, promoted core standards, conducted supportive supervision
- **Pre-Service Nursing and Midwifery Education (PSE):** With India Nursing Council strengthened nursing teaching institutions, including five nodal training centers; revised curriculum; introduced quality standards; improved the capacity of tutors and training quality in ANM Training Centers in Uttarakhand and Jharkhand.
- **Immunization:** Supported the Universal Immunization Program to develop and rollout national policies, strategies, training packages, and job aids; established demonstration districts for cross-training in Uttar Pradesh and Jharkhand; promoted RAPID approach to improving quality of routine immunization services.
- **Newborn Health:** Supported the development of national newborn policies and guidelines; trained health care providers in Uttar Pradesh, Jharkhand, Uttarakhand, and Haryana on essential newborn care and resuscitation (ENCR); and established demonstration sites in five districts.

| | | | | | | |
|--|---|---------------------|---------------|---|------------------|---|
| Program Dates | October 1, 2009–August 30, 2014 | | | | | |
| Total Mission Funding by Area | \$16,776,000 | | | | | |
| Total Core Funding by Area | \$1,248,801 | | | | | |
| Geographic Coverage (in final year of activity) | National | All technical areas | No. of states | 7 | No. of districts | 92 Total districts 32 RMNCH+A Priority Districts |
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Acronyms and Abbreviations

| | |
|----------------|--|
| ANM | Auxiliary Nurse Midwife |
| ANMTC | Auxiliary Nurse-Midwife Training Centers |
| ASHA | Accredited Social Health Activist |
| BCG | Bacillus Calmette-Guerin (Vaccine) |
| CHC | Community Health Center |
| CSO | Civil Society Organization |
| DFID | Department for International Development |
| ENC | Essential Newborn Care |
| ENCR | Essential Newborn Care and Resuscitation |
| FP | Family Planning |
| GNM | General Nurse Midwife |
| GOI | Government of India |
| HMIS | Health Management Information System |
| HTSP | Healthy Timing and Spacing of Pregnancy |
| INC | Indian Nursing Council |
| IUCD | Intrauterine Contraceptive Devices |
| ITSU | Immunization Technical Support Unit |
| KMC | Kangaroo Mother Care |
| LBW | Low Birth Weight |
| MCHIP | Maternal and Child Health Integrated Program |
| MDG | Millennium Development Goals |
| MNT | Maternal and Neonatal Tetanus |
| MNCH | Maternal, Newborn and Child Health |
| MOHFW | Ministry of Health and Family Welfare |
| MVMH | My Village My Home |
| NeVAS | Neonatal Verbal Autopsies Software |
| NBCC | Newborn Care Corners |
| NBSU | Newborn Stabilization Units |
| NIPi | Norway-India Partnership Initiative |
| NMR | Neonatal Mortality Rate |
| NNC | National Nodal Center |
| NSSK | Navjaat Shishu Suraksha Karyakram (National Newborn Care and Resuscitation Initiative) |
| NRHM | National Rural Health Mission |
| OPV | Oral Polio Vaccine |
| PHC | Primary Health Center |
| PIE | Post Introduction Evaluations |
| PIP | Program Implementation Plans |
| PPFP | Postpartum Family Planning |
| PPIUCD | Postpartum Intrauterine Contraceptive Device |
| PSE | Pre-Service Education |
| RAPID | Regular Appraisal of Program Implementation in District |
| RI | Routine Immunization |
| RMNCH+A | Reproductive, Maternal, Neonatal, Child and Adolescent Health |
| SBA | Skilled Birth Attendant |
| SBM-R | Standard Based Management and Recognition |
| SNC | State Nodal Center |
| SUT | State Unified Teams |
| UIP | Universal Immunization Program |
| UNICEF | United Nations Children's Fund |
| UNFPA | United Nations Population Fund |

Acknowledgments

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MCHIP would like to acknowledge the close collaboration and leadership of the Government of India and its Ministry of Health and Family Welfare (MOHFW) and National Health Mission (NHM). Without the vision and support of our principle MOHFW/NHM counterparts: Additional Secretary and Mission Director Ms. Anuradha Gupta, MOHFW; Joint Secretary for Reproductive and Child Health Dr. Rakesh Kumar and Joint Secretary for Policy Dr. Manoj Jhalani, MOHFW; Deputy Commissioners Dr. Himanshu Bushan, Dr. Ajay Khara, Dr. Manisha Malhotra, Dr. Dinesh Baswal, Dr. S.K Sikdar, Dr. Halidar, Dr. P.K Prabhakar, Dr. Sila Deb, and Dr. Sushma Dureja; the achievements described in this report would have been impossible.

MCHIP would also like to acknowledge the other collaborating partners including the Catholic Health Association of India, Federation of Obstetrics and Gynecology Societies of India, the Indian Association of Preventative and Social Medicine, the Indira Gandhi Institute of Medicine and Science, the Indian Medical Association, the Indian Nursing Council, the National Health Mission, UNICEF, UNFPA, Norway India Partnership Initiative (NIPI), Bill and Melinda Gates Foundation, and others.

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Executive Summary

Between 1990 and 2012, India's mortality rate in children less than five years of age declined by more than half (from 126 to 56/1,000 live births). The infant mortality rate also fell steadily (from 88 to 44 deaths per 1,000 live births).¹ The country's maternal mortality ratio also decreased by two-thirds during the last decade (from 370 to 190 per 100,000 live births), and the total fertility rate fell from 3 to 2.4 children per woman. Despite these improvements, at the current rate of decline in maternal mortality and under-five mortality, India will fall short of Millennium Development Goals 4 and 5. With a neonatal mortality rate (NMR) of 31 per 1,000 live births, newborn deaths account for about 55 percent of all child mortality, which is estimated at 56 per 1,000 live births.¹ Given the significant contribution of NMR to the under-five mortality rate, India must reduce newborn deaths if it is to achieve its Millennium Development Goal 4 target of 41 deaths per 1,000 live births. In addition, the major causes of maternal mortality in the country are preventable, and most of the births are inadequately spaced and happen too early in the life of the mother. To improve maternal and neonatal survival, there is an urgent need to focus efforts on healthy timing and spacing of pregnancy through family planning, as well as on the major causes of maternal and neonatal death.

In 2005, the Government of India (GOI) established the National Rural Health Mission (NRHM) with the goal of improving the quality of health centers and health providers and addressing barriers to the delivery of maternal, newborn, and child health (MNCH) services. By channeling funding to state and district health offices for priority programs (Janani Suraksha Yojana [JSY] or conditional cash transfers to encourage institutional births and uptake of, accredited social health activists [ASHAs], and others), NRHM has contributed to increasing institutional deliveries, expanding mechanisms for providing skilled attendance at births, increasing access to postpartum family planning (PPFP) services, strengthening routine immunization standards and services, and scaling up provider knowledge and best practices in newborn care and resuscitation, among others. Despite significant progress since the introduction of the NRHM and the strengthening of national programs (Universal Immunization Program, reproductive health, child health, other), there is still much that needs to be done along the continuum of care.

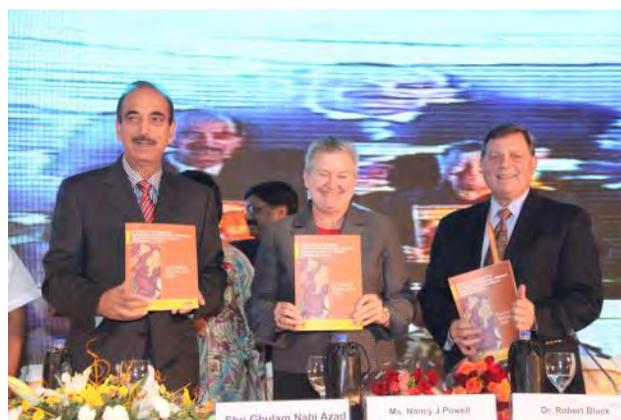
The goal of USAID's Maternal and Child Health Integrated Program (MCHIP) is to assist in scaling up evidence-based, high-impact MNCH interventions to contribute to significant reductions in maternal and child mortality. MCHIP has worked in India since 2009, with national, state, and district-level health departments and national programs as well as development partners to strengthen reproductive, maternal, and child health. The program built on lessons learned from four earlier USAID global technical assistance programs—IMMUNIZATIONbasics, ACCESS, ACCESS/FP, and Save the Children's Saving Newborn Lives. During its first three years, MCHIP India worked with a number of national programs to: (1) revitalize family planning, with an emphasis on PPFP and increasing contraceptive choice by expanding access to postpartum intrauterine contraceptive device (PPIUCD) insertion; (2) reform and strengthen pre-service education for nurses and midwives working through the India Nursing Council; (3) strengthen routine immunization services and support national disease control efforts and the introduction of new vaccines by working with the Universal Immunization Program, and (4) strengthen the national Navjaat Shishu Suraksha Karyakram (National Newborn Care and Resuscitation Initiative, or NSSK) program and develop a package of interventions to improve care for newborns in government health facilities. Programmatic successes include dramatic improvements in access to PPFP in three USAID-supported

¹ World Health Organization. Child Mortality Levels. <http://apps.who.int/gho/data/node.main.ChildMort-2?lang=en> (accessed May 8, 2014).

states and in all districts of the six high-focus states where funding has been leveraged to expand PFPF and revitalize family planning; the establishment of a more robust nursing and midwifery education network, including the establishment of national and state nodal centers for nursing education; the development, demonstration, and rollout of national standards, capacity-building packages, job aids, and tools (best practices) to improve the coverage and quality of routine immunization and the introduction of new vaccines; and the establishment of demonstration sites for training in newborn care and resuscitation and cross-training in “best” immunization practices.

In Program Year 5, after co-hosting the Global Call to Action for Child Survival with USAID, UNICEF, and the Government of Ethiopia, the Government of India held its own National Summit on the Call to Action for Child Survival and launched a new National Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCH+A) initiative. At USAID’s request, MCHIP served as the secretariat for the Call to Action Summit and then worked with the Ministry of Health and Family Welfare (MOHFW)/NRHM to develop and roll out a nationwide RMNCH+A initiative. In the following paragraphs, key achievements are summarized in relation to the RMNCH+A roll out and in each of the project’s programmatic priorities.

Call to Action/RMNCH+A: Following the Global Call to Action co-convened by the United States, Ethiopia, and India in April 2012 in Washington, DC, MCHIP supported India’s National Summit on the Child Survival Call to Action in February 2013. The three-day meeting was attended by global experts, GOI officials, and representatives from state governments, the private sector, and nongovernmental and civil society organizations (NGOs and CSOs). The major conclusion of the conference was that, if the rate of decline in maternal and child mortality is to be accelerated, India must take action across all life stages and should ensure continuum of care. The GOI launched *A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health* (the RMNCH+A initiative) at the National Call to Action Summit. Following that event, the *National Consultation on Intensification of Efforts in High Priority Districts for Improved Maternal and Child Health* was held in April 2013. The meeting was attended by representatives of the MOHFW and various development partners, including USAID, and discussions were held on (1) the roadmap for follow-up to the Global Call to Action, (2) the need for intensification of efforts in high-priority districts (those with a high burden of maternal and child mortality and morbidity), and (3) modalities and mechanisms for harmonizing partner technical assistance for integrated programming and monitoring.



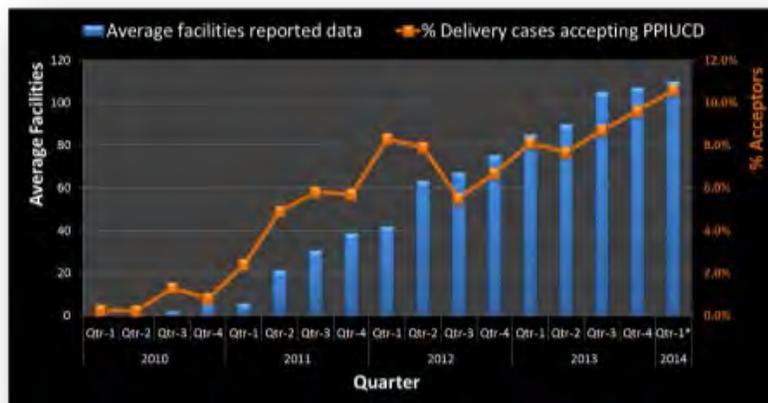
Development partners, including USAID, UNICEF, and UNFPA, realized that they could play a significant role at the national, state, and district levels as the country accelerated the pace of implementation of interventions to reduce maternal, neonatal, infant, and under-five mortality. The partners recognized the need to establish a mechanism for harmonized support to national and state government efforts as they worked toward the Millennium Development and 12th Five-Year Plan Goals. They agreed to shift priorities so that they could commit to the RMNCH+A rollout. This was a paradigm shift toward direct coordination with Government of India and an emphasis on making an impact on policy based on evolving global evidence rather than small-scale, decentralized efforts.

The MOHFW identified 184 high-priority districts (HPDs) across 29 states for the rollout of the RMNCH+A initiative. Lead development agencies working in those states (USAID, the Bill and Melinda Gates Foundation, DFID, UNICEF, UNFPA, and NIPI) agreed to harmonize their efforts in the HPDs and provide technical assistance to state governments. USAID was mandated to support 33 HPDs in six states (Delhi, Haryana, Himachal Pradesh, Jharkhand, Punjab, and Uttarakhand) in the rollout of the strategy. Mechanisms at the national and state levels were put into place, with MCHIP support, including a national RMNCH+A unit and state RMNCH+A units, as well as state unified teams (SUTs).

Postpartum Family Planning: MCHIP India helped to revitalize PFP, emphasizing intrauterine contraceptive devices for use in the immediate postpartum period (within 48 hours of delivery), and advocated for PFP as a maternal and child health intervention through extensive work in training and advocacy. After experiencing the limitations of off-site training, the training process was improved using an innovative approach of training service providers onsite at their own facilities to rapidly saturate the facility with trained providers and hence institutionalize service delivery. Activities were implemented in 117 facilities across three states: Uttar Pradesh, Uttarakhand, and Jharkhand. Through this work, 645,000 women were counseled in PFP, with 43,000 women accepting the PPIUCD as a method for spacing or limiting subsequent births. Strengthening the PFP program with the introduction of the PPIUCD was a shift in the GOI's approach to promoting birth spacing, and the approach is being scaled up throughout the country, with more than 300,000 women provided PPIUCDs since its introduction. Following the encouraging results of this

intervention in the three MCHIP states, the Ministry of Health and Family Welfare decided to scale up the PFP/PPIUCD services to all districts in the six high-focus states of India. The majority of the funds for this scale-up are being derived through the GOI National Health Mission program implementation plans of these states. Technical

assistance to support implementation in 247 districts of the six states (with a total population of 500 million) is being provided by multiple donors, including the Bill & Melinda Gates Foundation, the David & Lucile Packard Foundation, and the Norway-India Partnership Initiative (NIPI).

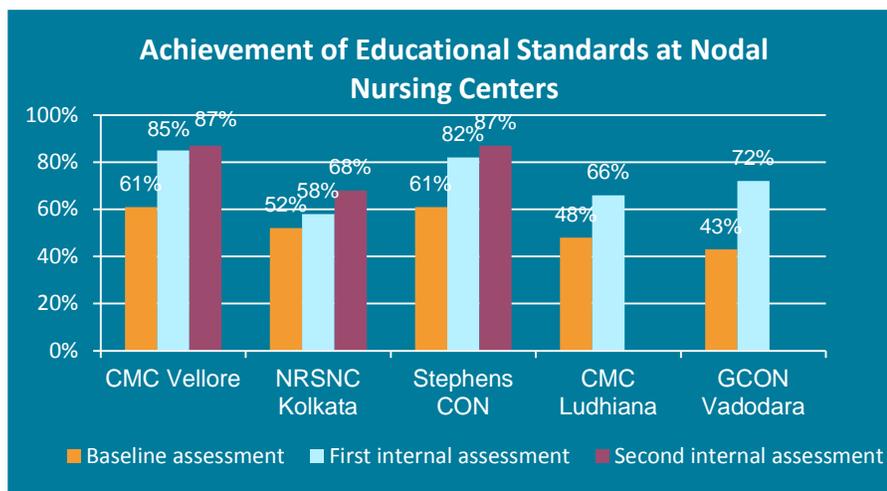


* Data till Feb-14

Status of PPIUCD Services in MCHIP States, 2010–2014

Nursing and Midwifery Pre-Service Education: As one step in strengthening pre-service education (PSE) for nurses and midwives, MCHIP India helped establish a robust and technically focused system, network, and approach for nursing and midwifery education strengthening, marked by the launch of the national nodal center (NNC) for nursing education in Kolkata, and provided technical assistance to four other new NNCs co-located at the country's premier nursing institutions. Each NNC was designed as a key demonstration and training site for the nursing faculty from the region. MCHIP has trained the faculty of 121

schools for auxiliary nurse-midwives and general nurse-midwives (ANMs and GNMs) at the NNC at Kolkata. At the request of the state governments, MCHIP facilitated the development of state nodal centers (SNCs) in Uttarakhand and Jharkhand; these SNCs were created to train the nursing faculty and provide mentorship to ANM/GNM schools within the states. This approach was first taken up by the Government of Bihar, through support from NIPI, to strengthen PSE for the nursing

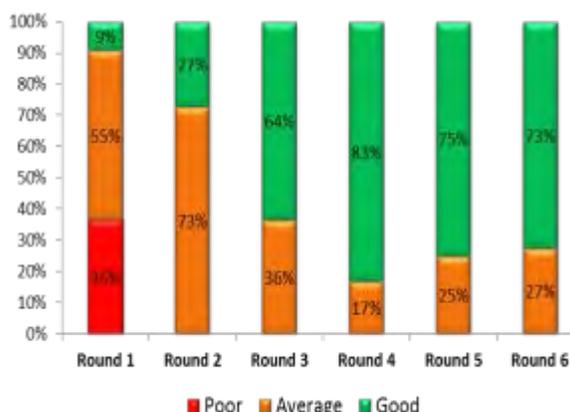


Achievement of Educational Standards at Nodal Nursing Centers

and midwifery cadre in the state. Later, the MOHFW, the GOI, and the Indian Nursing Council (INC) decided to scale up this program model to all high-focus states and have earmarked funds through the respective state program implementation plans (PIPs). NIPI and DFID are supporting this initiative in their respective focus states, which are a part of the 10 high-focus states. Replicating the approach used by MCHIP for establishing the SNC at Dehradun, Uttarakhand, Patna has established a similar SNC at the Indira Gandhi Institute of Medical Science, and 15 participants from ANM/GNM schools have been trained in the first six weeks of training at the SNC.

The approach pioneered by MCHIP was adopted by the MOHFW and INC to develop the “Operational Guidelines for Strengthening PSE for Nursing and Midwifery Cadre in India.” These guidelines provide a comprehensive roadmap that will help program managers, state nursing cells, faculty of the midwifery institutions, and other stakeholders strengthen pre-service nursing and midwifery education throughout the country, particularly in the high-focus states.

Immunization: MCHIP contributed to national-level immunization initiatives, including the Year of Routine Immunization Acceleration, measles camp aigns, maternal and neonatal tetanus (MNT) state-level certifications, and the introduction of new vaccines. In addition, MCHIP worked to build the capacity of the national and state governments and leverage GOI and development partner resources for immunization performance improvement through Regular Appraisal of Program Implementation in District (RAPID). To achieve these goals, MCHIP worked in five low-performing districts to improve the coverage and quality of services, establish demonstration sites, and provide supportive supervision. Successful immunization initiatives have been taken to scale and adopted by state governments. Using the RAPID supportive supervision approach and



RAPID - Grading of Health Facilities Based on Composite Scoring for Quality Indicators, Jharkhand

tool at selected district facilities in Jharkhand and Uttar Pradesh, MCHIP India demonstrated progressive improvement in attainment of quality indicators. Sites in Jharkhand district improved from just 9% of quality indicators achieved in the first RAPID round, to 73% achieved by round six of the process. The approach has now been adapted and scaled up by governments in four states (Haryana, Jharkhand, Madhya Pradesh, and Orissa) and UNICEF in India's largest state, Uttar Pradesh. RAPID is used not only as a quality improvement approach for routine immunization but also for essential newborn care and resuscitation and, in the state of Haryana, to assess the quality of the full RMNCH+A package of care.

Newborn Care and Resuscitation: MCHIP

India helped to select and establish 10 newborn care demonstration sites in Jharkhand and Uttar Pradesh for district-level primary care provider training in newborn care (including the establishment of newborn care corners) as well as resuscitation techniques to reduce neonatal asphyxia. These sites are also used to provide innovative cross-learning opportunities for program managers and health providers from other states and non-MCHIP-supported facilities and districts. Through these efforts, MCHIP trained 1,551 NSSK trainers and health facility workers in essential newborn care/newborn resuscitation.



MCHIP staff member demonstrates correct use of resuscitator

Recommendations: To reinforce and continue progress after the project ends, MCHIP recommends the following strategies:

Continued support to the RMNCH+A initiative should include ensuring effective implementation of key performance indicators/quality indicators and performance-based incentives under the RMNCH+A mandate; ensuring accomplishment of targets set by the GOI under RMNCH+A and the 12th Five-Year Plan; ensuring the availability of quality health services in urban areas; and institutionalizing the involvement of the private sector and CSOs to ensure saturation of services to all areas. USAID and other development partners should strongly advocate to take the RMNCH+A agenda forward and provide technical support to the new government to ensure that all components of RMNCH+A are effectively implemented across the HPDs. USAID and other development partners should orient the new government on evidence-based interventions and suggest corrections to the existing service delivery system and issues related to health systems, governance, and accountability.

Continue to scale up PPF/PPIUCD services, especially to high-delivery load subdistrict-level facilities in states where services have been initiated; increase involvement of ASHA workers in educating clients and their families about PPF/PPIUCD services during ANC and delivery periods; strengthen supportive supervision for family planning services; and incorporate PPF services data into routine data reporting and review mechanisms.

To build on progress in strengthening PSE for nurses and midwives, continue to support the NNCs, SNCs, and ANM/GNM schools—including full recruitment of faculty and faculty capacity-building for ANM/GNM schools; national-level review of the progress in upgrading the ANM/GNM schools and establishing SNCs; and initiation of PSE strengthening activities, mentorship and

support to ANM/GNM faculty, strengthening the teaching infrastructure, supporting students, improving clinical sites, and improving the regulation of educational quality.

Continued progress in India's immunization program calls for sustaining and expanding use of the RAPID supportive supervision process as a tool for continuous quality improvement of services at the district level; disseminating quality improvement protocols and best practices used at demonstration sites by continuing to present them at public health conferences and events and demonstrating them in the states; advocating for best practices to be scaled up by national and international governments and development partners; supporting establishment of demonstration sites in high-priority districts for continuous training and peer-to-peer mentoring; and incorporating My Village, My Home data into routine reporting and data analysis to improve the tracking of infant vaccinations against the established schedules.

MCHIP also recommends establishing demonstration sites for maternal and newborn care in all districts of the focus states, which can then be used for cross-learning for the remaining district facilities; strengthening linkages between communities and facilities; improving the referral system for stabilizing and managing sick newborns; institutionalizing Kangaroo Mother Care for low birth weight babies in facilities where deliveries are taking place and in all newborn stabilization units and SNCs; ensuring support to mothers to continue skin-to-skin care in the home; and institutionalizing newborn immunization before discharge.



Nurse prepares vaccine for infant

Introduction

India's maternal mortality ratio has declined over the last decade (from 370 to 190 deaths per 100,000 live births). However, the rate of decline is insufficient to achieve the Millennium Development Goals (MDGs). The total fertility rate also declined in the last decade, albeit slowly, from 3 to 2.4. Between 1980 and 2012, the infant mortality rate in India fell steadily, from 88 to 44 deaths per 1,000 live births. Substantial gains have also been made in reducing childhood morbidity and mortality through several interventions. In particular, over the past 15 years, with a few exceptions, there has been a relatively uniform and generalized decline in the reported number of cases of the six main vaccine-preventable diseases throughout India. However, in recent years, increased numbers of diphtheria, pertussis, and measles cases have again been detected, and there has been stagnation in the coverage for all major antigens, as well as significant variation of coverage between and within states. Furthermore, India has a neonatal mortality rate (NMR) of 31 per 1,000 live births (WHO 2012), with newborn deaths accounting for about 54% of all under-five mortality (72 per 1,000 live births). The major causes of neonatal death in India are severe infection (36%), preterm birth (25%), and birth asphyxia (23%). Given the significant contribution of the NMR to the under-five mortality rate, to achieve its MDG 4 target of 41 deaths per 1,000 live births, India must reduce newborn deaths.

In 2005 the Government of India (GOI) established the National Rural Health Mission (NRHM) to improve the quality of health centers and providers and address barriers to delivery of maternal, newborn, and child health (MNCH) services. For example, the Indian Public Health Standards for immunization were drafted, and the funding mechanism for immunization was simplified to be more flexible and take a bottom-up planning approach that requires annual district and state program implementation plans (PIPs). The GOI has also addressed maternal health through the Janani Suraksha Yojana scheme, which emphasizes the role of the skilled birth attendant in providing comprehensive reproductive health and MNCH services, especially in rural areas. The GOI also officially expanded the services provided by auxiliary nurse-midwives (ANMs), lady health visitors, and staff nurses to provide skilled attendance at birth and prioritized the strengthening of nursing education to ensure that providers have the capacity to deliver this expanded set of services. Finally, the GOI has drawn on Integrated Management of Neonatal and Childhood Illnesses and launched the Navjaat Shishu Suraksha Karyakram (National Newborn Care and Resuscitation Initiative, or NSSK) program on basic newborn care and resuscitation, both aimed at reducing the NMR. Through the NRHM, the GOI has committed to improving MNCH by addressing all three major causes of neonatal death, ensuring access to family planning (FP) and improving access to lifesaving vaccines.

While taking into account the social and political context of these challenges to maternal and child health, MCHIP India built on lessons learned from four USAID global technical assistance programs: ACCESS, BASICS, IMMUNIZATIONbasics, POPPHI, and ACCESS-FP. MCHIP also continued the Child Survival Technical Support project's assistance to USAID's Child Survival and Health Grants program and its grantees. USAID/India asked MCHIP to continue the work of the IMMUNIZATIONbasics project, while also building on that work to address other critical gaps in MNCH. MCHIP's work in India built on: IMMUNIZATIONbasics' successful work at the national and state levels; the ACCESS project's work to improve the quality of maternal and newborn care in Jharkhand; ACCESS/FP's work to expand access to family planning methods in both Jharkhand and Uttar Pradesh; and the expertise of the highly regarded Saving Newborn Lives network of Indian neonatal specialists and programs. In the final project year, MCHIP drew on lessons learned from these activities to support the GOI's new Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) initiative by supporting the development of national and state RMNCH+A resource units and providing technical assistance.

GOALS AND OBJECTIVES

Over the project's five years in India, MCHIP worked with government and development partners to achieve its overarching goal of improving the health of mothers and their families. In particular, the project targeted improving access to postpartum family planning, strengthening the quality of pre-service education for nurses and midwives, increasing immunization coverage rates, and advocating for improved newborn care training.

Within these technical areas, the project aimed to achieve specific goals. For example, MCHIP supported the GOI's strategy of addressing the unmet need for postpartum family planning (PPFP) services by supporting routine integration of PPFP into MNCH services and revitalizing use of the postpartum intrauterine contraceptive device (PPIUCD). MCHIP strived to achieve its goal of improving MNCH by supporting the Indian Nursing Council (INC) and GOI's comprehensive initiative to strengthen and dramatically expand the foundation of pre-service nursing and midwifery education at the national level, while simultaneously upgrading clinical training capacity in Uttar Pradesh, Jharkhand, and Uttarakhand. MCHIP also collaborated with partners to reduce under-five mortality. To this end, MCHIP's objectives included continuing to improve the capacity of Indian institutions to achieve full immunization coverage by 12 months of age for at least 80% of children, and by co-funding a study assessing the efficacy of a chlorine-based household water treatment product (Aquatabs™) to prevent diarrhea among children less than five years old. Furthermore, MCHIP supported the Ministry of Health and Family Welfare (MOHFW), the USAID bilateral health programs, and the new NSSK in strengthening and expanding access to essential newborn care (ENC), teaching basic resuscitation techniques, and advocating for scale-up of handwashing for newborn health and survival through the national public-private handwashing alliance and integration with other MCHIP India program components.

Finally, in the program's last year, MCHIP assisted the GOI with launching and rolling out an RMNCH+A strategy. Objectives included helping to establish the National Resource Unit to guide and support the MOHFW's rollout of the strategy in six USAID-supported states and 33 high-priority districts (HPDs); providing need-based support on pre-service education for nurses and midwives; supporting PPIUCD, immunization, and newborn care activities; documenting and disseminating promising national, state, and district MNCH practices; and introducing and testing new approaches to more effectively reach target populations with quality RMNCH+A information and services.

MAIN INTERVENTIONS

To achieve the objectives above, MCHIP implemented activities in several areas. In the area of PPFP, MCHIP helped to revitalize the use of the PPIUCD as a maternal health and child survival intervention through extensive work in training and advocacy. Activities were implemented in 117 facilities across three states. Through this work, 645,300 women were counseled in PPFP, with 43,000 women accepting the PPIUCD as a method for spacing or limiting subsequent births.

The program also helped to strengthen pre-service education in nursing and midwifery. MCHIP worked at the national level to develop education and performance/clinical standards together with the INC, and the new standards were rolled out, with the support of state governments, in 22 nursing and midwifery teaching institutions. MCHIP also helped establish the National Nodal Center (NNC) for nursing education in Kolkata and provided technical assistance to four other new NNCs, each designed as a key demonstration and training site. As a result, 121 faculties were trained at India's NNC at Kolkata. MCHIP also aided the development of two state nodal centers (SNCs) and state-level training sites in Uttarakhand and Jharkhand, with 12 nursing tutors trained at the SNC in Uttarakhand in the first batch of six-week training for

faculty of ANM/GNM schools. Simultaneously, MCHIP worked to upgrade 15 general nursing and midwifery (GNM) schools and auxiliary nurse-midwife training centers (ANMTCs) in the state of Jharkhand and Uttarakhand.

The project also contributed to national-level immunization initiatives, including the Year of Routine Immunization Acceleration, measles campaigns, maternal and neonatal tetanus (MNT) state-level certifications, and the introduction of new vaccines. In addition, MCHIP worked to build the capacity of the national and state governments, and leverage GOI and development partner resources for immunization performance improvement through Regular Appraisal of Program Implementation in District (RAPID). To achieve these goals, MCHIP worked in five low-performing districts to improve coverage and quality of services, establish demonstration sites, and provide supportive supervision.

MCHIP also worked with representatives at the national level to incite newborn care policy changes. Specifically, MCHIP conducted a policy analysis of newborn care systems and supported the development of the Kangaroo Mother Care initiative for optimal feeding for low birth weight babies, antibiotic use (gentamycin) and vitamin K guidelines for newborns, and other relevant policies. MCHIP also provided technical assistance to states for the assessment of the quality of newborn care in three district hospitals and nine community health centers, 25 primary health centers, and three additional primary health centers. The project supported 10 demonstration sites in five districts (Deoghar, Jamtara, and Ranchi in Jharkhand; Gonda and Lucknow in Uttar Pradesh) to establish newborn care corners and implement other key policies; through these efforts, MCHIP trained 1,551 NSSK trainers and health facility workers in essential newborn care and newborn resuscitation.

In the project's fifth and final year, its efforts culminated in support for the GOI's new RMNCH+A strategy, launched in early 2013. MCHIP India supported the GOI and development partners in planning and implementing a successful National Summit on Call to Action for Child Survival; provided national-level technical support and monitoring as well as development partner coordination of the RMNCH+A strategy rollout; provided state-level technical support to six states and 30 high-priority districts; and provided harmonized support with other development partners for systems strengthening through gap analysis, planning, block (facility-level) monitoring, and need-based technical assistance.

In conjunction with work in the technical areas discussed above, MCHIP India supported a water purification study in the use of Aquatabs, conducted a Mobile Alliance for Maternal Action landscape analysis, studied FP/immunization integration (postpartum systematic screening) and PPIUCD outcomes at follow-up, assessed the My Village My Home community tool for immunization self-monitoring, and looked at the use of verbal autopsies to better understand newborn deaths.

Major Accomplishments

FROM CALL TO ACTION TO RMNCH+A

As part of its commitment to improving MNCH, India, Ethiopia, and the United States, together with UNICEF, co-convened a global summit, Global Child Survival Call to Action: A Promise to Keep, in Washington, DC, in June 2012. At the summit, India's Honorable Minister for Health and Family Welfare assured the audience that India would remain in the forefront of the global war against child mortality and morbidity.

To follow up on the commitment India made during the summit and to redefine its national agenda, in September 2012 the Government of India created a steering committee and six subcommittees with representatives from the Ministry of Health and Family Welfare (MOHFW) and development partners to carry out specific activities demonstrating India's leadership role and commitment to the issue of child survival. The activities included organization of an India-specific child survival call to action summit and development of a series of technical documents, including an RMNCH+A strategy, a state-specific modeling exercise, and state-specific score cards. The committees also developed mechanisms for involving private sector and civil society organizations in the implementation of RMNCH+A.

In order to galvanize stakeholder efforts, a summit—Call to Action: For Every Child in India—was organized in February 2013. MCHIP served as the secretariat for the summit and coordinated preparation efforts with the GOI, development partners, and other stakeholders.



With support from MCHIP, the GOI developed the Reproductive Maternal Neonatal Child Health and Adolescent (RMNCH+A) strategy, highlighting how reproductive, maternal, and child health are closely linked to the health status of the population. At the summit, the GOI officially launched the RMNCH+A strategy to serve as a roadmap for the states. The consensus at the summit was that while India has made impressive progress, there is a need to focus on key high-impact interventions, with special emphasis on poorly performing areas. This focused approach should lead to substantial gains in the reduction of maternal, neonatal, infant and under-five morbidity and mortality.

The MOHFW identified 184 high-priority districts (HPDs) across 29 states for the rollout of the RMNCH+A strategy. Lead development agencies working across the states (USAID, Bill and Melinda Gates Foundation, DFID, UNICEF, UNFPA, and the Norway-India Partnership Initiative) agreed to harmonize their efforts and provide technical assistance to state governments. USAID was mandated to support 33 HPDs districts in six states (Delhi, Haryana, Himachal Pradesh, Jharkhand, Punjab, and Uttarakhand) in the rollout of the strategy, and indicated that MCHIP should continue to provide relevant direct technical assistance to the GOI and the six assigned states through June 2014.

Activities and Approach

MCHIP has worked on the central, state, and district levels to support the establishment of mechanisms for planning, implementation, and monitoring of the RMNCH+A strategy; helped fast-track strategy rollout through consultative meetings and workshops with the states and districts; conducted district-level gap analysis and facility assessments; initiated block monitoring in the districts; and supported the development of technical documents. Specific areas of activity are discussed below.

Development of National and State-Level Bodies

MCHIP supported the establishment of the national and state-level mechanisms for execution of the RMNCH+A strategy including the national RMNCH+A unit, a nine-member team anchored within the MOHFW, to support the ministry in monitoring the progress of RMNCH+A implementation.

At the state level, MCHIP supported the establishment of state RMNCH+A units in the six USAID supported states. Each unit coordinates RMNCH+A activities across all the HPDs in the state and provides technical assistance to the state program management unit, particularly for planning, implementing, and monitoring of strategies for delivery of priority interventions in the HPDs.

MCHIP also assisted in the development of state unified teams (SUTs) in three of the six supported states (Jharkhand, Himachal Pradesh, and Delhi). The teams are comprised of members from state governments, medical colleges, the state program management unit, and development partners working in the state. Each SUT functions as the overarching technical body supporting and reviewing implementation of the RMNCH+A strategy at the state level. In the remaining three supported states, SUTs have been formed but have not yet been officially launched.

State-Level Meetings

In collaboration with state Departments of Health, Medical Education and Family Welfare, MCHIP organized meetings to orient state officials and other key stakeholders in the RMNCH+A strategy, the focus on HPDs, and the need for a harmonized, integrated approach to implementation and monitoring. Topics of discussion also included the need for additional financial allocations, relaxation of norms for recruitment, upgrading of the health facilities, special incentives for health staff, priority interventions across RMNCH+A, accreditation of private health institutions, improving the public health infrastructure, improving demand for

services, and multi-sectoral planning. MCHIP jointly organized consultative meetings in five of the six supported states from July to October 2013.

District-Level Workshops

MCHIP and USAID representatives participated in district-level RMNCH+A orientation workshops. All key district administrators and officials as well as representatives from development partners and local NGOs also participated. Workshops could not be held at Lahul and Spiti in Himachal Pradesh due to inaccessibility.

MCHIP participated in RMNCH+A orientation workshops in 32 of the 33 HPDs between November 2013 and January 2014.

Development of Technical Documents

MCHIP worked with other development partners to support the development of the following technical documents:

- **Handbook on Improving Maternal and Child Health through RMNCH+A**

Approach: This is a shorter version of the RMNCH+A strategy document, developed to provide focused guidance to a broad range of stakeholders. The handbook is expected to facilitate better understanding of the seemingly complex set of interventions required to make an impact on maternal and child health in India.

- **Guidance Note for Implementation of RMNCH+A Interventions in High-Priority**

Districts: This guidance note was developed to provide information on the process of selecting HPDs. It details roles and responsibilities of development partners and other stakeholders in RMNCH+A implementation.

- **Guidance Note on Block Monitoring:** To ensure that districts get timely support for implementing the most critical interventions, development partners are expected to offer need-based, district-level assistance and work alongside district and block-level stakeholders to identify key bottlenecks and address them systemically.

- **Guidance Note on District-Level Gap Analysis of RMNCH+A Implementation:** This document was developed to provide broad guidance on the processes and expected outcomes of district-level gap analysis. District gap analysis largely focuses on the assessment of gaps in terms of availability, accessibility, utilization, and quality. The results of the initial rapid assessment will provide adequate evidence for the district RMNCH+A implementation plan addressing the key gaps through short-term and mid-term actions.



These documents are being used at the national, state, and district levels to support rollout of the RMNCH+A strategy nationwide.

5 x 5 Matrix and Key Performance and Quality Indicators

To facilitate the process of reaching goals and targets, the MOHFW prioritized five high-impact interventions in the five thematic areas of reproductive, maternal, newborn, child, and adolescent health and key interventions for health system strengthening and cross-cutting

issues. The five interventions and five thematic areas were identified in a 5 x 5 matrix that is being used across the country to improve maternal and child health. To improve performance and quality, the MOHFW also developed key performance and quality indicators for RMNCH+A.

Finalization of Supportive Supervision Checklist

Supportive supervision—to review progress and provide hands-on support to address gaps—was found to be one of the weak links in the implementation of programs under the NRHM. Under the RMNCH+A strategy, the MOHFW has developed a framework for supportive supervision along with facility visit checklists to facilitate supportive supervision visits by program officers at various levels. MCHIP provided technical assistance with finalizing the supportive supervision checklist.

Gap Analysis

MCHIP provided technical assistance with rapid gap analysis at the district level, as conceptualized by the GOI, to assess the current facility infrastructure, human resources, equipment, capacity, and the availability and quality of resources needed to deliver RMNCH+A interventions. The exercise, carried out between October and December 2013, was designed to identify key gaps and provide evidence for district RMNCH+A implementation plans to address these gaps through short-term and mid-term actions. The MCHIP national team conducted joint field visits at 10% of the sites.

Primary data collection was done at 29 district-level facilities, 85 first referral units, 232 non-first referral units, and 361 subcenters. Interviews of key stakeholders at the state and district levels were also conducted to assess the functioning of health systems. In addition, 8,354 community-level interviews were conducted among pregnant women, mothers of under-five children and adolescent girls. Findings were compiled and analyzed to identify critical gaps in service delivery capacity, and were shared with key stakeholders.

Block Monitoring

Under the District Intensification Plan, the block is the primary unit for implementation and management of RMNCH+A interventions. Block capacity is to be developed locally through mentoring support from the district and state management units along with the state RMNCH+A units and SUTs. To ensure timely support for implementation of the most critical interventions, development partners are expected to offer need-based district-level assistance and work alongside district and block-level stakeholders to identify and address key challenges. District-level monitors assigned under USAID/MCHIP visited one block per month in each high-priority district from November 2013.

District-level monitors assigned under MCHIP visited service delivery points in five of the six supported states: first referral units, 24/7 primary health centers (PHCs), community health centers (CHCs), and a sample of designated subcenters. In total, 55 block monitoring visits had been conducted in the USAID/MCHIP states of Haryana, Himachal Pradesh, Jharkhand, Punjab, and Uttarakhand.

Scorecards and Dashboards

National and state scorecards were introduced as a tool to increase transparency and track progress against reproductive and maternal health and child survival indicators related to intervention coverage. The score card refers to two management tools: (1) an HMIS-based dashboard monitoring system and (2) a survey-based child survival score card. The strategy provides for the use of both evaluated and HMIS data for developing survey-based child survival scorecards and an HMIS-based dashboard monitoring system. The survey-based scorecard

provides for assessing performance in terms of outcome and service delivery while the HMIS dashboard aims to catalyze states to use HMIS data for improved decision-making. The scorecards will be updated with new survey data as new data become available, and the HMIS scorecards will be prepared on a quarterly basis.

Initial Findings and Action Plans

Through implementation of key processes and mechanisms, states and districts have made efforts to utilize the data collected and address key gaps in state-level PIPs as well as in district health action plans. Although this process is continuously evolving, action plans are being updated and efforts are already being made to improve service delivery and quality. Gaps commonly identified in the gap analysis process included the following:

Infrastructure

- Lack of habitable staff quarters
- Inappropriate disposal of biomedical waste

Delivery Facilities

- Lack of toilet facilities attached to labor and delivery facility
- Lack of partograph charts
- Stock-outs of key commodities, including magnesium Sulfate, vitamin K, misoprostol, and delivery kits

Newborn Care Services

- Absence of self-inflating bag and mask
- Absence of newborn digital weighing machine
- Absence of mucus extractor and suction tube

Equipment for Laboratory and Other Services

- Lack of blood sugar testing kit
- Lack of urine albumin testing kit

Availability of Essential Medicines

- Stock-outs (during last three months) of amoxicillin/ampicillin
- Stock-outs (during last three months) of betamethasone
- Stock-outs (during last three months) of chloramphenicol eye ointment

Availability of Essential RMNCH+A Commodities

Supply chain management was poor with wide gaps in the availability of required essential drugs and surplus supplies of some of the medicines leaving dead unused stock.

- Stock-outs (during last three months) of IFA tablets (large)
- Stock-outs (during last three months) of IUCD kits (Suraksha)
- Stock-outs (during last three months) of zinc sulfate and vitamin A syrup
- Stock-outs (during last three months) of emergency contraceptive pills
- Stock-outs (during last three months) of oral contraceptive pills

Health Systems

There is a high degree of disparity between the sanctioned staff and staff in-position in many districts. Training mandated under the Maternal and Newborn Health Toolkit guidelines for

specialists and other staff was not provided, which affected the capacity of service providers and the quality of service provision at all levels. Record maintenance was a major issue, especially at the subcenter level, due to lack of awareness among the ANMs of the need to complete the required forms and registers, high patient load, and extensive documentation to be maintained. This affected patient outcomes, project progress, and planning for strengthening services. Major gaps were found in reporting of expenditures and maternal, infant, and neonatal death reviews at all levels. In addition, the following gaps were noted:

- At the district level, no defined policy in place to fill contractual and permanent staff; no retention policy
- Inadequate emergency ambulance service; ambulance staff not trained in provision of emergency care
- No verification or validation checks applied to check quality of data collected at various levels
- Fund flow utilization at district and block level inefficient; delay in release of funds
- Resources not allocated as per the projections made to the state authority
- Non-availability/delay in implementation of guidelines at the district level

Table 1 summarizes some of the actions that states and HPDs have elected to take to address gaps identified during the gap analysis exercise.

Table 1. Changes Made at State/District Level in MCHIP-Supported States Following Gap Analyses/Block Monitoring

| INFRASTRUCTURE UPGRADES |
|--|
| Jharkhand State Health Department took specific action to improve labor room practices in 16 district hospitals, community health centers, and primary health centers across six districts. |
| In three districts of Jharkhand, hospitals have been shifted to new buildings to improve the physical infrastructure. |
| Bed occupancy in malnutrition treatment centers has improved in Lohardaga district in Jharkhand. |
| In Uttarakhand, infrastructure-related gaps are being addressed in the district health plans that are funded by the state government. One short-term action funded by the state is to set up blood storage facilities and training centers in each high-priority district. |
| There was no blood bank in the district hospital of Palwal in Haryana state. After feedback and regular follow-up, the district hospital has procured a license for the blood bank and the recruitment of staff is in process. |
| DELIVERY FACILITIES |
| The ultrasound machine at the maternity home in Mangolpuri (Delhi state) was not functional. MCHIP advocated for the district to make it operational by end of May. |
| In Pauri district (Uttarakhand), gaps identified during block monitoring led to a plan for infrastructure upgrades at delivery points to ensure 24/7 running tap water in the labor room and the purchase of a hydraulic operating theater table and ceiling lights. |
| The Maternal and Newborn Health Toolkit has been made available at all block-level health facilities to help strengthen all delivery points in Uttarakhand to be consistent with national guidelines. |
| A proposal to create a maternal and child health wing at PHC Pilkhi (the PHC facility with the highest case load in the state) has been included in Uttarakhand's 2014 PIP. |
| Partographs were printed and distributed to all facilities in the state of Punjab. |
| NEWBORN CARE FACILITIES |
| Newborn Care Corners (NBCCs) have been established and are operational in eight facilities across six districts in Jharkhand. |

| |
|--|
| NBCCs have been established and provided with essential equipment and commodities at all delivery points in Uttarakhand districts of Tehri Garhwal, Haridwar, and Pauri Garhwal. |
| Two demonstration sites for NBCC have been proposed and one established in Tehri Garhwal district in Uttarakhand. |
| After the dissemination of the guideline on vitamin K in the HPDs, it is now being made available and is used immediately within 1 hour of birth in Punjab state. |
| COMMODITIES |
| Availability of essential equipment and commodities has been improved. In Uttarakhand, the hiring of a district-level logistic manager has been proposed in the PIP to strengthen supply chain management of RMNCH+A commodities. |
| Purchase of key RMNCH+A commodities has been made from the United Funds and provisions under JSSK include the purchase of magnesium sulfate and vitamin K in Uttarakhand. The procurement process for vitamin A and zinc has also been initiated. |
| In Haryana all commodities in the 5 x 5 matrix are now included in the essential drug list; and in Punjab state, after the dissemination of the gap analysis findings, the essential drug list was modified with inclusion of the commodities as per the RMNCH+A 5 x 5 matrix as well. |
| In Mandi and Kinnaur districts of Himachal Pradesh, implementation of the weekly iron and folic acid (WIFS) program has been regularized in some schools after feedback to the authorities of the Education Department and district health officials. |
| HEALTH SYSTEMS STRENGTHENING |
| District health action plans were prepared for the first time in a systematic manner for 11 high-priority districts in Jharkhand state. |
| The Delhi state training calendar did not include training for staff nurses on PPIUCD. Based on block monitoring visits it was found that staff nurses are conducting deliveries, So plans were made and approved by state officials to train staff nurses in PPIUCD. |
| A training needs assessment for health staff has been planned to address training needs in Uttarakhand. |
| A systematic review of existing data sources in Haryana was done by MCHIP; based on some of the recommendations an exercise was conducted to rationalize the various indicators in the HMIS (i.e., reduce indicators that are never reviewed or reported). Development of an integrated portal capturing indicators from various sources across the spectrum of RMNCH+A programs has been initiated. |

Summary and Next Steps

MCHIP has provided comprehensive support in the initiation of the RMNCH+A strategy, from the national level down to the block or facility level. As a result of MCHIP's support, national and state-level units are in place and are actively planning, implementing, and monitoring strategies for delivery of priority interventions in the districts. Through the program's organization of district-level workshops, the buy-in of district officials, which is key to success at the targeted level, has been secured for the RMNCH+A. MCHIP's gap analyses in the states and the HPDs have begun to identify priority areas for rapid implementation of critical interventions. MCHIP has also helped begin the process of improving capacity at the block level for implementation and monitoring of the RMNCH+A strategy.

Under the new government, there may be changes as far as policy and mission structure is concerned, but core interventions under RMNCH+A are expected to remain the same. Since all components of RMNCH+A are based on the continuum of care approach, development partners will advocate for and share the key processes that have been successfully established. They will also share early results from implementation of the RMNCH+A strategy, which will help in taking the RMNCH+A agenda forward with greater rigor and intensity.

POSTPARTUM FAMILY PLANNING SERVICES

The GOI sees family planning as a means of addressing high maternal and newborn mortality as well as stabilizing the population. With this vision, there is greater focus on healthy timing and spacing of pregnancy (HTSP) and the role of postpartum family planning in supporting HTSP. In alignment with this vision and MCHIP's ultimate goal of contributing to the achievement of MDGs 4 and 5 in India, the program provided support to the GOI's strategy to revitalize postpartum family planning with the introduction of the PPIUCD. The strategy addresses the unmet need for postpartum family planning services, beyond sterilization, while also providing advocacy, training, and other support to strengthen PFP. MCHIP's PFP/PPIUCD activities grew out of work by the ACCESS-FP program, which established training sites in four Indian states to help train providers from across the country. MCHIP provided technical support in Jharkhand, Uttarakhand, and Uttar Pradesh when the program was being scaled up. Figure 1 shows the increase in PPIUCD services during the program.

Activities and Interventions

Working with national, state, and local partners, MCHIP carried out advocacy, facilitated training of service providers, helped establish core standards, and conducted supportive supervision. Specific areas of work are discussed below.

Advocacy for PFP and PPIUCD Services

Continuing the advocacy activities begun under the ACCESS-FP program, MCHIP worked to positively influence the attitudes of policymakers, program managers, professional bodies such as the Federation of Obstetric and Gynaecology Societies of India, physicians, and other health care providers about PFP/PPIUCD as a maternal and child health survival intervention. Following MCHIP's advocacy work, the GOI made PFP activities a priority in several sites each in 16 new states, with support from the Bill & Melinda Gates Foundation. The program is now being scaled up in the six high-focus states, and PPIUCD services are included as a key component of the new national RMNCH+A strategy.

Advocacy for FP Counselors

During initial stages of the program, MCHIP hired family planning counselors for district-level sites providing PFP services. These counselors proved to be effective at improving family planning counseling, data collection, and logistics management. Remarkably, they also improved overall service delivery. The GOI took this activity to scale and approved the hiring of FP counselors in all high-focus states. Later, with the launch of the new RMNCH+A strategy, these FP counselors were renamed "RMNCH+A counselors," and their scope of work was widened to include counseling on maternal, newborn, and child health practices.

Support to National- and State-Level PFP Planning and Review

MCHIP provided strategic technical assistance to the Family Planning Division of the Ministry of Health and Family Welfare (MOHFW), supporting monitoring PFP service delivery through regular program review meetings. MCHIP also co-facilitated, with the FP Division and other development partners, national-level planning and review meetings in three successive years (2011, 2012, and 2013). These meetings focused on strengthening existing PFP services and scaling up these services to cover a large beneficiary base. In addition, MCHIP facilitated regular state-level PFP review and experience-sharing meetings in the three targeted states.

Development of Training Resources

MCHIP supported the development of comprehensive training resources, including an e-learning course on PFP/PPIUCDs for service providers, a learning resource package for RMNCH counselors, job aids, and a PPIUCD animation video. The e-learning course reduces

learners' time away from their facility by covering the theory part of PPIUCD training online. The learning resource package for RMNCH counselors consists of a facilitator's guide, RMNCH handbook, and RMNCH counselor flipbook. It is currently being used in training for RMNCH+A counselors across the country.



Examples of the training resource materials developed for PPF program under MCHIP

Training Site Development and Training of Trainers

MCHIP facilitated the training of trainers from Jharkhand, Uttarakhand, and Uttar Pradesh. As a first step, training sites were developed in each state. These training sites were health facilities with existing PPF services and a few service providers willing and able to train others on PPF services. The sites included a mix of teaching institutions and district-level service delivery sites. MCHIP conducted on clinical aspects of PPF/PPIUCD services and teaching skills; strengthened the training infrastructure by providing anatomical models and other teaching aids; and backstopped the initial two to three trainings, providing hands-on support. During the project, nine training sites were developed in Uttar Pradesh, six in Jharkhand, and three in Uttarakhand.

Provider Training

MCHIP facilitated the training of service providers on PPF/PPIUCD services. These clinical trainings were conducted using a three-day agenda focusing on the theory behind PPF, HTSP, PPIUCD services, and key statistics; clinical training on PPIUCD aids for practice insertions; and supervised insertions on clients. MCHIP also provided training of trainers in counseling for FP services, infection prevention, and data reporting for PPIUCD services.

In Uttar Pradesh, MCHIP facilitated the training of 639 providers in clinical PPIUCD services, beginning in September 2012. In Jharkhand, 829 service providers were trained in PPIUCD services, and in Uttarakhand, 247 providers were trained. Initially, most of the service providers trained were medical doctors posted in the target facilities. However, because most deliveries are conducted by nurses and midwives in public sector institutions, these providers were brought into the program and trained in providing PPF/PPIUCD services. Of the 1,715 providers trained, 885 were nurses and midwives. Initially, this training was conducted using MCHIP funds. Later, through its successful advocacy with the national and state governments, MCHIP leveraged NRHM funds to conduct the training. Currently, the training is a regular budget item in the PIPs of all of the states in the country. Some states, through pre-established training sites, are independently planning and conducting training for service providers on PPF services.

Supportive Supervision

MCHIP staff also conducted supportive supervision visits to the targeted facilities. These were meant to provide post-training follow-up and support to service providers at their facilities. The visits focused on reviewing and improving the providers' PPIUCD insertion technique,

reviewing the counseling services and facilitating good-quality counseling, facilitating institutionalization of infection prevention practices, and establishing mechanisms for regular data reporting. More than 850 supportive supervision visits were conducted during the project.

Development of Performance Standards

As a part of the PFPF program in Jharkhand, MCHIP developed a core set of performance standards in partnership with the state government and directly implemented these standards at district hospitals and CHCs in the focus districts of Chaibasa, Giridih, and Simdega. Following successful implementation in these districts, MCHIP provided strategic support to the state for implementation of these standards at 36 health facilities in 24 districts.

Figure 1. Status of PPIUCD Services in MCHIP States, 2010–2014



Program Learning: Onsite Training

One of the most important lessons learned through MCHIP was the value of onsite PFPF/PPIUCD training. Traditionally, a centralized training approach had been used, with providers from various facilities receiving training at a site away from their facility. This approach had several limitations, including the time providers had to spend away from their facilities, the time needed to build a critical mass of trained providers for a facility, and the difficulty of instituting systems changes in the facilities for service delivery and data collection. To address these limitations, MCHIP began training service providers at their own facilities to rapidly saturate the facility with trained providers and hence institutionalize service delivery. Onsite training also provided the opportunity for rapidly sensitizing support staff and facility leaders and improving systems for resource availability and data reporting, which contributed to improved service outcomes. This methodology was used during the last year of the project; a total of 59 such onsite trainings were conducted, with 607 providers trained (this figure is included in the total number of providers trained under the program).



State-level experience sharing workshops in Uttar Pradesh, Jharkhand, and Uttarakhand

Summary and Next Steps

Through a structured program of establishing training sites, conducting centralized and onsite training for service providers from target facilities, and conducting supportive supervision visits, MCHIP facilitated PFP/PPIUCD service delivery in 36 health facilities in Jharkhand (covering all 24 districts), 31 facilities in Uttar Pradesh (covering 23 out of 75 districts) and 50 health facilities in Uttarakhand (covering all 13 districts). Strategically strengthening PFP, MCHIP's PFP program promoted HTSP and supported the GOI's shift in focus from terminal methods to spacing methods. Considering that more than 58% of births in India occur within three years of a previous birth and that the six states with high total fertility rates (including Uttar Pradesh and Jharkhand) contribute to 61% of total maternal mortality in India, this intervention is expected to make a considerable contribution to the reduction of maternal and newborn mortality. As nationwide rollout of the GOI's new RMNCH+A strategy continues, MCHIP's strengthening of PFP and PPIUCD capacity in the supported states provides a strong base on which to build.

STRENGTHENING PRE-SERVICE NURSING AND MIDWIFERY EDUCATION

MCHIP India initiated its work in pre-service education (PSE) in 2010 in partnership with the INC. With a vision to sustainably address the nursing shortage in India, MCHIP used a two-way approach to strengthen nursing teaching institutions in the country. Working with premier nursing institutes, MCHIP created NNCs. At the same time, MCHIP also strengthened grassroots-level ANM/GNM training centers in MCHIP focus states.

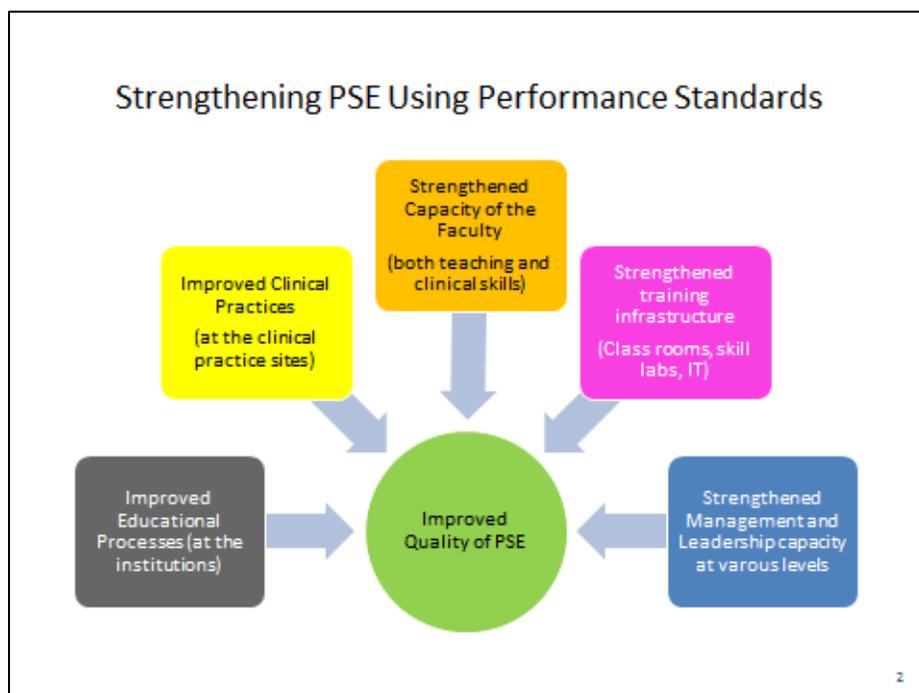
Activities and Interventions

Working with national and state-level government partners, the INC, and educational institutions, MCHIP helped to create mechanisms to strengthen pre-service nursing and midwifery education throughout the country. MCHIP used the Standard-Based Management and Recognition® (SBM-R®) approach to strengthen national-level institutions and link them with grassroots-level ANM/GNM schools for their mentorship. SBM-R is a practical management approach pioneered by Jhpiego for standardizing and improving the quality of health services. Generally implemented at the facility level, SBM-R follows four basic steps: (1) setting performance standards that are constructed around clearly defined service delivery processes or a specific content area, (2) implementing the standards in a streamlined, systematic way, (3) measuring progress to guide the improvement process toward these standards, and (4) rewarding achievement of standards through recognition mechanisms.

Creating National Nodal Centers

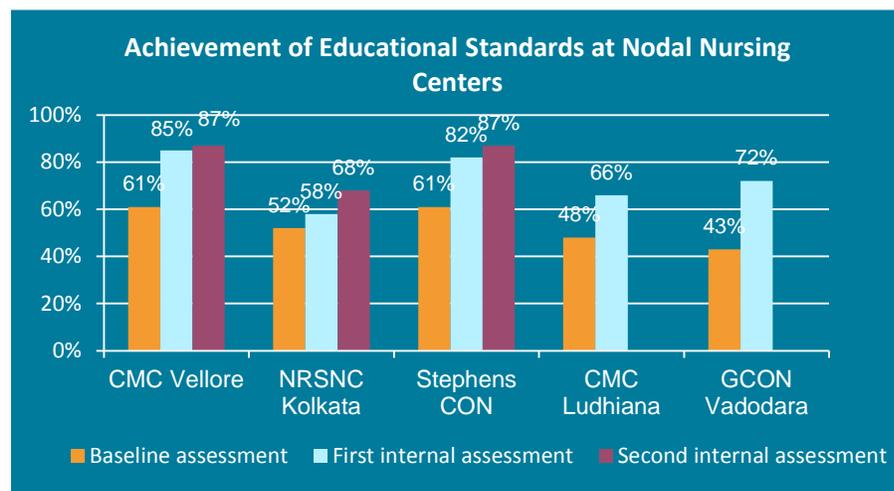
MCHIP created a national technical advisory group for pre-service nursing and midwifery education to review and finalize the educational and clinical performance standards to be used at the NNCs. A memorandum of understanding establishing the roles and responsibilities of the various parties was signed by MCHIP with the INC and the government of the state in which each school was located. These schools were strengthened in terms of educational processes, facility capacity, training infrastructure, and clinical practices at the attached clinical sites (Figure 2). The improvements were achieved through implementation of educational and clinical standards using the SBM-R process.

Figure 2. Strengthening PSE Using Performance Standards



Five NNCs—located at the nursing schools at Nil Ratan Sarkar Medical College in Kolkata, Christian Medical College in Ludhiana, Christian Medical College in Vellore, SSG Medical College in Vadodara, and Saint Stephens Hospital in New Delhi—have been established so far. The NNCs will provide training to nursing faculty from ANM/GNM schools as well as mentorship support in the focus states. Figure 3 depicts the results of baseline and follow-up assessments at the five established NNCs. The NNC at the Nil Ratan Sarkar College of Nursing has been accredited by the INC and is conducting faculty trainings. The remaining NNCs are likely to be operational by end of 2014.

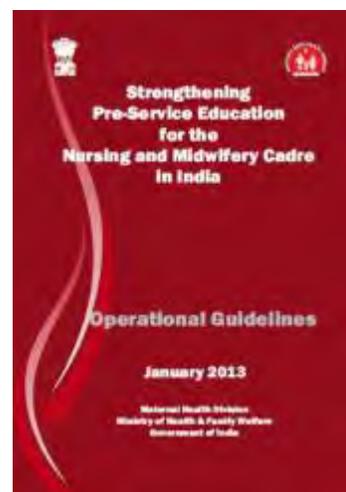
Figure 3. Achievement of Educational Standards at Nodal Nursing Centers



Strengthening the Curriculum at Nursing and Midwifery Teaching Institutions

MCHIP provided technical assistance to the INC to develop a specialized six-week training curriculum for the faculty of ANM/GNM schools in the country. The curriculum includes teaching skills, skilled birth attendance, Integrated Management of Neonatal and Childhood Illness, family planning, prevention of STIs, including HIV, and other performance standards relevant to ANM and GNM schools. MCHIP staff trained the master trainers and provided backstopping for the training.

Over the duration of the project, faculty of ANM/GNM schools from the states of Bihar, Haryana, and Rajasthan, in addition to the MCHIP focus states of Jharkhand, Uttarakhand, and Uttar Pradesh, were trained using this curriculum at the NNC in Kolkata. Ten batches of six-week training courses were conducted, and 121 faculty from ANM/GNM schools were trained. The NNC training coordinators follow up the training by visiting faculty at their respective ANM/GNM schools to provide onsite mentoring and support.



Improving Management, Performance Standards, and Infrastructure at ANM/GNM Schools

MCHIP also implemented performance standards at ANM/GNM schools in Jharkhand and Uttarakhand to strengthen educational processes and clinical practice at the attached clinical institutions. Teaching infrastructure was also strengthened using leveraged NRHM funds. Well-equipped skills labs were established to facilitate a humanistic training approach involving supervised demonstration and practice by students. School management processes were also improved.

Under MCHIP, 10 ANM schools were strengthened in Jharkhand and five ANM and GNM schools were strengthened in Uttarakhand.

Program Learning: Developing State Nodal Centers

As part of a midcourse correction and in line with the requests from state governments and the GOI, MCHIP facilitated the development of state nodal centers (SNCs) in Uttarakhand and Jharkhand. Using the same methodology employed at the NNCs, the SNCs provided mentorship to ANM/GNM schools within the states.

The College of Nursing at Dehradun has been accredited by INC as an SNC, with a score of 72.3% on performance standards. Six-week-long training for faculty of ANM/GNM schools in Uttarakhand has been initiated. The process of strengthening the College of Nursing at Rajendra Institute of Medical Sciences (RIMS) in Ranchi is ongoing; to date, workshops have been conducted in effective teaching skills and clinical skills standardization; a skills lab has been established; and management processes have been strengthened.



SNC at Uttarakhand established through MCHIP support

Upgrading the School of Nursing in Agra

Apart from the overall PSE strengthening program, MCHIP, on request from the INC, provided technical assistance to the government of Uttar Pradesh to upgrade the School of Nursing in Agra to the status of a college of nursing.

MCHIP planning and funding helped enable the refurbishment of the superstructure of the school as well as the identification of rooms for a skills lab. MCHIP and the School of Nursing worked with civil engineers to ensure that the skills lab adhered to INC standards.

Summary and Next Steps

Encouraged by the demonstrated results, the GOI adopted the pre-service strengthening approach and used it to create *Operational Guidelines for Strengthening Pre-service Education for Nursing and Midwifery Cadres in India*, with technical assistance from MCHIP. These guidelines are now being used to strengthen PSE in 10 high-focus states, using NRHM funds.

IMMUNIZATION

The practice of routine immunization reflects the functioning of the primary health care system within any country, state, district, or the block. The implementation of a routine immunization program is a measure access to and use of health services by the community as a whole and serves as an indicator for the effective functioning of the health system within any geographical locale. The routine immunization program in India is the largest in the world in terms of beneficiaries targeted and immunized (with a birth cohort of 27 million infants and 30 million pregnant women²), the logistics and human resources involved, and the geographical spread. Since its inception in 1978 as the Expanded Program of Immunization, the national program has undergone many changes. Key transitions have included the revamping of the program as the Universal Immunization Program (UIP) in 1985; incorporation of the program into the Child Survival and Safe Motherhood program in 1992, the Reproductive and Child Health Program (RCH-I) in 1997, and RCH II under the NRHM in 2005; and being identified as a key strategic component of the recently launched Reproductive Maternal Newborn Child and Adolescent Health (RMNCH+A) strategy.

In spite of more than 25 years of implementation, the Coverage Evaluation Survey (CES) 2009 estimated full immunization coverage at just 61%, with an access gap of 3.5 million targeted children and a follow-up gap of 7.3 million.³ There are wide interstate variations in coverage, which ranges from 87.9% in Goa to 27.8% in Nagaland, and even more profound variations within states, with more than 200 out of 545 districts in the country having full immunization coverage of less than 50%.⁴

To address the gaps and strengthen the program, MCHIP worked to improve the capacity of Indian institutions and development partners at the national and state levels, and implemented evidence-based, high-impact interventions in the focus districts of Jharkhand (Deoghar and Jamtara) and Uttar Pradesh (Banda, Gonda, and Varanasi). To achieve its set goals, the immunization team adopted the key strategic priorities of building the capacity of Indian institutions and stakeholders, working in partnerships, leveraging resources, being catalytic and innovative, and accelerating the scale-up of proven, evidence-based interventions.

Activities and Interventions

At the national and state levels, MCHIP has been integrally involved in framing policies and guidelines and helping to mobilize new resources for routine immunization through state PIP support. At the district level, the project has advocated for innovations and successful approaches to improving the quality and coverage of immunization services, in collaboration with district health department and partners. Specific areas of work are discussed below.

Operational and Policy Support to the Central Level

At the central level, MCHIP supported the drafting and development of key policy guidelines and operational planning aimed at improving the coverage and quality of the immunization program throughout the country. MCHIP was a key partner supporting the national government in undertaking initiatives for program implementation, including the introduction and rollout of new and underutilized vaccines; supporting the planning, implementation, and review of intensification of routine immunization efforts; improving capacity for effective vaccine and logistics management; and strengthening surveillance of vaccine-preventable diseases and adverse events following immunization.

² Government of India. 2011. National Vaccine Policy.

³ UNICEF Coverage Evaluation Survey. 2009. National Fact Sheet.

⁴ International Institute for Population Sciences (IIPS). 2010. District Level Household and Facility Survey (DLHS-3), 2007–08.

Over the entire project duration, MCHIP participated in national-level reviews and evaluations, including the assessment of the Mother and Child Tracking System, maternal and neonatal tetanus (MNT) validations, national cold chain assessments, and post-introduction evaluations (PIEs) for pentavalent vaccine.

MCHIP was also assigned the chair of the Alliance for Immunization in India, a recently launched CSO, and in partnership with Catholic Health Association of India is leading the initiative to increase CSO engagement in the program at the national level and in the state of Jharkhand.

Key contributions included the development of the *Ready Reference Guide for Health Workers*, which was endorsed by the GOI for use across the country, and multiple job aids and tools aimed at supporting health workers in program implementation. Job aids and tools that MCHIP developed have been used in various technical documents and training modules, and have been adopted by the government of Jharkhand. Materials approved for printing in the 2012–2013 PIP include 343,750 job aids, 38,000 My Village My Home tools, and 12,000 *Ready Reference Guide for Health Workers*.

All the activities undertaken at the central level have resulted in improved program management and effective service delivery to the beneficiaries. All of these efforts—including policymaking, program review, and preparation of job aids and tools—are aimed at accelerating the pace of implementation of the routine immunization program in the country, which is ultimately reflected in increased coverage.

Figure 4 shows the result of repeated RAPID rounds leading to improved quality of immunization program at the cold chain points. The graphs represent improvement of cold chain points from poor to average to good and are a reflection of cumulative improvements across the thematic areas of program management, cold chain and vaccines management, recording and reporting, and immunization safety. MCHIP was instrumental in implementing the evidence-based interventions that had a direct impact on improved quality of immunization services. RAPID was one of the approaches adopted.



Examples of policy and training guides



Examples of tools and job aids developed

Assistance with Guidelines, Training, and Advocacy at the State and District Levels

MCHIP worked with state officials and program managers to strengthen state immunization programs through revised guidelines, training, and advocacy. As part of this commitment, MCHIP supported the preparation and review of the state immunization PIPs, as envisaged by the NRHM (now the National Health Mission). This facilitated the leveraging of additional funds for improved service delivery and enabled improvements in training, implementation, and recording and reporting.

MCHIP also facilitated major state-level training, including training of trainers for the measles catch-up campaigns, workshops on adverse events following immunization, training for the rollout of hepatitis B vaccination in the immunization schedule, and training of partner staff from UNICEF and the Micronutrient Initiative. As part of this work, MCHIP facilitated the development of training packages, including modules, guidelines, and facilitators' guides for program managers and frontline staff (e.g., medical officers, vaccine and cold chain handlers, and health workers). These efforts built the capacity of the government and partner officials and staff in routine immunization. In all, 8,132 health functionaries were trained on various aspects of immunization in the focus states of Uttar Pradesh (5,010) and Jharkhand (3,122), which helped to improve program performance in the two MCHIP focus states.

MCHIP developed and conducted advocacy for the use of need-based microplanning tools by program managers to improve reach to the public in the supported states. The program also supported the development and use of report compilation and analysis tools for the measles catch-up and Japanese encephalitis (JE) campaigns.

MCHIP initiated an e-supervision pilot project for routine immunization in the district of Hisar (Haryana state) in collaboration with Dimagi. This approach used mobile handsets to collect data from cold chain points, immunization session sites, and household monitoring, and transferred the data to the cloud server immediately. Program managers could download the real-time data at district and state headquarters for analyzing progress and developing corrective action plans.

HIGH-IMPACT INTERVENTIONS IN FOCUS DISTRICTS

Regular Appraisal of Program Implementation in District

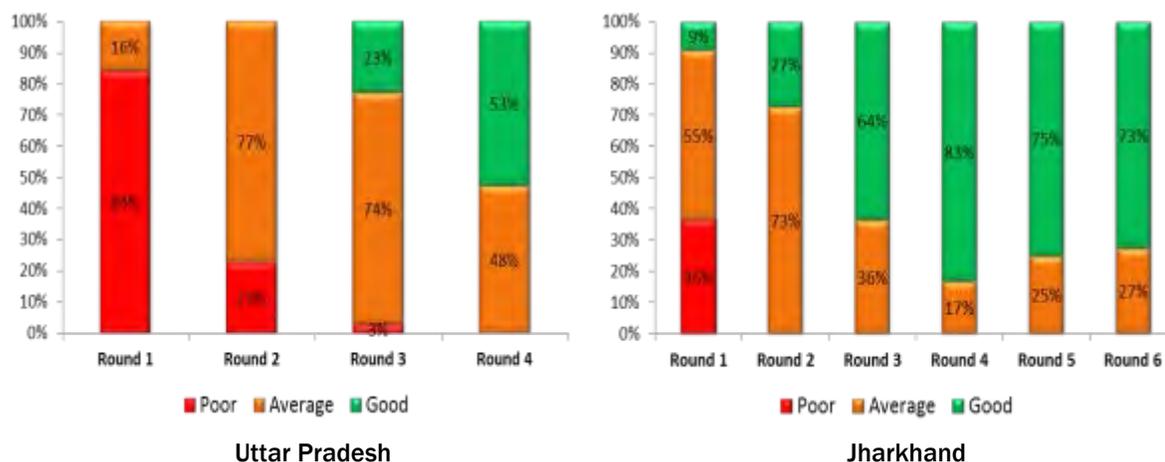
Supportive supervision is a key component of successful implementation and monitoring of any public health intervention. RAPID is a model for assessment and supervision developed by MCHIP to improve the quality of immunization services. Its success has been demonstrated at immunization sites in several districts in India.

RAPID uses a participatory supportive supervision approach to periodically assess facility practices and infrastructure, suggest corrective actions, and support staff to effectively perform their duties according to program benchmarks. The key feature of RAPID is to work with staff to establish goals, monitor performance, recognize good practices, and identify and correct issues on site. Periodic rounds of RAPID provide critical information that program managers can use for making decisions and help to identify measures that can be taken to improve quality at all levels of health system.

MCHIP supported 56 RAPID rounds (32 rounds in Jharkhand, including 12 in focus districts; 24 rounds in Uttar Pradesh, including 12 in focus districts and three in Haryana). The RAPID rounds are now being continued as a part of RMNCH+A intensification efforts. The successive rounds of RAPID have shown progressive improvement across the districts, and the approach has now been adapted and scaled up by governments in four states (Haryana, Jharkhand, Madhya Pradesh, and Orissa) and by UNICEF in Uttar Pradesh. The RAPID assessments have

shown that, in addition to improving immunization service delivery, the approach has contributed to improved overall quality of facility services (Figure 4).

Figure 4. Grading of Health Facilities Based on Composite Scoring for Quality Indicators (RAPID Rounds in MCHIP Focus Districts)



Development of Immunization Demonstration Sites for Cross-Learning

At MCHIP India demonstration sites in the focus districts, health facilities serve as model sites for the implementation of all program practices according to national guidelines. All aspects of the immunization program are included: program management, cold chain and vaccine management, recording and reporting, immunization safety, and waste disposal. These sites serve as cross-learning centers where program managers, cold chain handlers, and other staff members engage in discussions, demonstrations, and participatory learning.



Injection Safety Corner: Before

Eight demonstration sites were developed in the focus districts (three in Jharkhand and five in Uttar Pradesh). Intra- and inter-district cross-learning exercises were conducted in all five focus districts, with 288 health officials and staff (99 in Jharkhand and 189 in Uttar Pradesh) trained in correct practices. Based on positive results, the governments of Jharkhand and Uttar Pradesh asked MCHIP to develop similar centers in the state capitals, and Jharkhand allocated funds for the cross-learning activity through its annual PIPs.

Participants noted that this type of cross-visit is important for learning newer guidelines and practices, and they expressed a wish to participate again. Medical officers in-charge from other sites were eager to apply similar standards at their own health facilities, with continued technical assistance from MCHIP. The trainers at these cross-learning exercises were drawn from the health facilities themselves, with MCHIP team members serving only as facilitators.



Injection Safety Corner: After

Strengthening Newborn Vaccination for Institutional Deliveries

MCHIP provided technical support for strengthening the immunization program in two focus districts in Jharkhand and three districts in Uttar Pradesh between October 2009 and August 2013. During this time it was revealed that only approximately one-third of newborns delivered at government health facilities were receiving bacillus Calmette-Guerin (BCG) vaccine and oral polio vaccine (OPV) zero dose (36.6% and 33.4% of newborns were receiving BCG, and 36.8% and 38.8% were receiving OPV zero dose, in Jharkhand and Uttar Pradesh, respectively). (Because hepatitis B vaccine was included in the immunization schedule only after October 2011, no data were available for it.) To address this problem MCHIP led a targeted intervention focusing on vaccination of all newborns delivered at health facilities with BCG, OPV (zero dose) and hepatitis B (birth dose) for ensuring early immunity. The intervention included early registration to allow tracking for full immunization.



Cold Chain Room: Before



Cold Chain Room: After

With adoption of this easy-to-follow practice, vaccination coverage for these antigens rose substantially (Table 2). The success of this intervention could encourage state-level program managers in Jharkhand and Uttar Pradesh, where clear instructions and guidelines were issued to intervention district officials for ensuring vaccination of all newborns delivered at government health facilities with the three vaccines (BCG, OPV, and Hepatitis B) before the mother is discharged from the facility. To improve compliance with this instruction, another government order in these states linked neonatal vaccination with the three vaccines to the ongoing Janani Suraksha Yojna incentive scheme for promoting health facility births. The order instructed district- and block-level officials to release the Janani Suraksha Yojana cash incentive only after ensuring that a newborn had been vaccinated and issued an immunization card.

Table 2. Progress of Newborn Vaccinations during Intervention

| PERIOD | JHARKHAND (2 DISTRICTS, 13 HEALTH FACILITIES) | | | | UTTAR PRADESH (3 DISTRICTS, 33 HEALTH FACILITIES) | | | |
|---------------|--|--------------|---------------|------------------|--|--------------|---------------|------------------|
| | Total deliveries | BCG coverage | OPV zero dose | Hep B birth dose | Total deliveries | BCG coverage | OPV zero dose | Hep B birth dose |
| Jan–June 2011 | 5,638 | 36.6% | 36.8% | | 30,161 | 33.4% | 38.8% | |
| Jul–Dec 2011 | 9,366 | 66.3% | 61.7% | 12.0% | 46,825 | 53.1% | 53.4% | 1.2% |
| Jan–June 2012 | 8,692 | 76.2% | 69.6% | 69.1% | 31,723 | 55.1% | 69.0% | 59.4% |
| Jul–Dec 2012 | 10,753 | 79.6% | 74.4% | 74.3% | 43,115 | 67.1% | 78.4% | 74.7% |
| Jan–June 2013 | 9,349 | 82.4% | 83.9% | 81.3% | 30,249 | 60.6% | 75.4% | 64.2% |

Support to the Tracking Every Newborn and My Village My Home Initiatives

MCHIP supported the rollout of two community-level innovations for improved reach, tracking, and coverage of all vaccines. Tracking Every Newborn involves the creation of an electronic database of beneficiaries and name-based due lists for tracking at outreach sessions. My Village My Home (MVMH) is a community-level monitoring tool that enables the community to conduct its own monitoring of children's immunization status and take necessary steps to improve coverage.



MVMH has already shown a positive impact on immunization coverage in Jharkhand and has been adopted for use across all immunization sites in the state. The Haryana government has begun scaling up MVMH in the state. The approach has also received buy-in from national-level program managers.

Summary and Next Steps

Through its technical support and ability to leverage government resources for improving program performance, MCHIP has demonstrated very promising results. Through its consistent effort, it has influenced national immunization policies and strategies and mobilized new resources for routine immunization at all levels. The results are a testimony to the fact that improvement has been achieved in planning, management, and monitoring of immunization services in the focus states and at the national level, and the project has also contributed to improved skills and practices among health workers, managers, and partners. In collaboration with the government and partners, MCHIP has demonstrated successful approaches to improving routine immunization coverage in selected districts of the focus states, and these approaches have proven to be sustainable and replicable.

The immunization program in India is currently undergoing a paradigm shift, mainly because India was declared polio-free and the RMNCH+A strategic approach has been implemented. Polio eradication will result in greater emphasis on routine immunization intensification efforts to maintain the polio-free status, and these gains will spill over to the immunization program as a whole. The RMNCH+A strategy puts greater onus on health system strengthening for improvement across technical areas. Routine immunization is an important intervention within the RMNCH+A spectrum. It has provided the platform for implementation of all other maternal and child health programs in India in the past, and it will play a major role in driving RMNCH+A efforts forward. In addition, with new vaccines such as pentavalent, rota, and pneumococcal being introduced and scaled up in the future, the need for technical support to the GOI is ever expanding.

The impact of this shift in India is already being felt by key development partners, who are redefining their strategies. Both the WHO country office and UNICEF have renewed their focus on routine immunization through the Global Alliance for Vaccines and Immunization, and the Bill and Melinda Gates Foundation and Public Health Foundation of India have established an immunization technical support unit (ITSU), which is now functioning as an ancillary unit of the national government.

ESSENTIAL NEWBORN CARE AND RESUSCITATION

Since 2010 MCHIP has worked to support the MOHFW, state health departments, USAID bilateral health programs, and the new NSSK in strengthening and expanding access to ENC and teaching basic resuscitation techniques. MCHIP started its work on essential newborn care and resuscitation (ENCR) in Jharkhand and Uttar Pradesh with the establishment of demonstration sites in five targeted districts. At these sites, the concept of ENCR was put into practice for others to observe so that they could strengthen and expand access to ENC and teach others basic resuscitation techniques.

Activities and Interventions

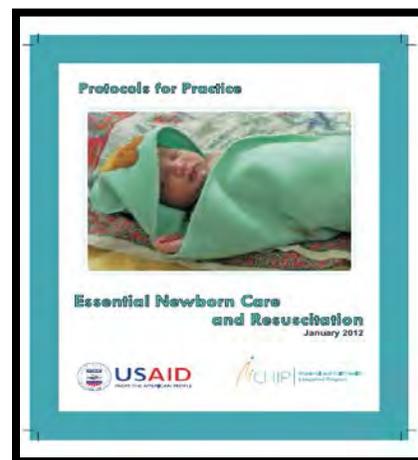
The MCHIP newborn health team collaborated with government partners at the central and state levels to address needs in planning, policy, education, and program assessment. Working with state and local health officials, MCHIP supported facility assessments, helped establish demonstration sites for best practices in ENCR, and built capacity at the state, district, and facility levels. MCHIP also supported innovative learning techniques in the focus states and developed an innovative, low-cost tool for collecting data on neonatal deaths. The tool is a set of instructions on essential newborn care, which can be used by any person with very simple training. Another innovation was peer-to-peer learning whereby health care providers in a facility taught and learned essential newborn care from one another. The idea behind this technique was to create an enabling environment.

National-Level Support on Policy, Guidelines, and Medical Education

In partnership with UNICEF, MCHIP worked with the MOHFW to strengthen national policies and guidelines related to ENCR. The program supported the development and implementation of Integrating Essential Newborn Care as part of India's policies and program guidelines on the use of vitamin K, antenatal corticosteroids and gentamycin, and the promotion of Kangaroo Mother Care (KMC) and optimal feeding for LBW newborns.

MCHIP also contributed to the revision of Participants' Manual for Collaborative Centres, providing expert input on care at birth and adapting the current medical officers' Neonatal Resuscitation Program guidelines to use in the Helping Babies Breathe action plan. In addition, through support from MCHIP, the GOI introduced a postgraduate diploma in management of maternal and child health with the Public Health Foundation of India. MCHIP was part of a core team that the GOI put together to develop the course for program managers, and provided input on newborn health programs. At the national level, MCHIP provided technical input on the Maternal and Newborn Health Toolkit, which will be used to strengthen the quality of both maternal and essential newborn care at health facilities at various levels, districts hospitals, CHCs, and PHCs. The toolkit will help program managers set up state-of-the-art maternal and newborn care facilities.

ENCR was included in the newly launched national RMNCH+A strategy as a key component for reducing neonatal mortality, and it is being rolled out throughout the country. With the continuing efforts of MCHIP, both *percentage of asphyxiated newborns who were successfully resuscitated* and *percentage of delivery points with a functional newborn corner* were included as key performance indicators for essential newborn care and resuscitation services under the RMNCH+A strategy.



Assessment, Advocacy, and Planning at the State Level

A rapid cross-sectional assessment was undertaken for newborn stabilization units (NBSUs) and newborn care corners in six high-burden states that MCHIP has supported. In Orissa, Assam, and Rajasthan, this assessment served as a learning and fact-finding exercise with the objective of supporting the district/state authorities in planning, implementing, and standardizing the quality of newborn care.

MCHIP also contributed to the scale-up and adaptation of newborn resuscitation protocols, the maternal and newborn register, and the child health PIP for the focus states of Jharkhand and Uttar Pradesh. In addition, MCHIP initiatives such as supportive supervision of ENCR, facility readiness exercises, and infant death reviews were incorporated into the state PIPs. Finally, MCHIP supported Punjab in developing a state action plan for the RMNCH+A strategy, and it is being rolled out across the state.

Facility Readiness Assessment Tool

A facility readiness survey was carried out at the beginning and at the end of the program (February 2010 and June 2013). Figure 5 shows the results of the assessments. This assessment was based on 75 indicators across eight parameters: infrastructure, delivery and newborn services, human resources and signal functions, essential drugs, equipment, and supplies, protocols and guidelines, infection prevention and hygiene, and provider knowledge and competency on maternal and newborn care. MCHIP also mapped providers' basic knowledge of essential newborn care and resuscitation. In Figure 5, combined percentage scores are color-coded to serve as a management tool for initiating action.

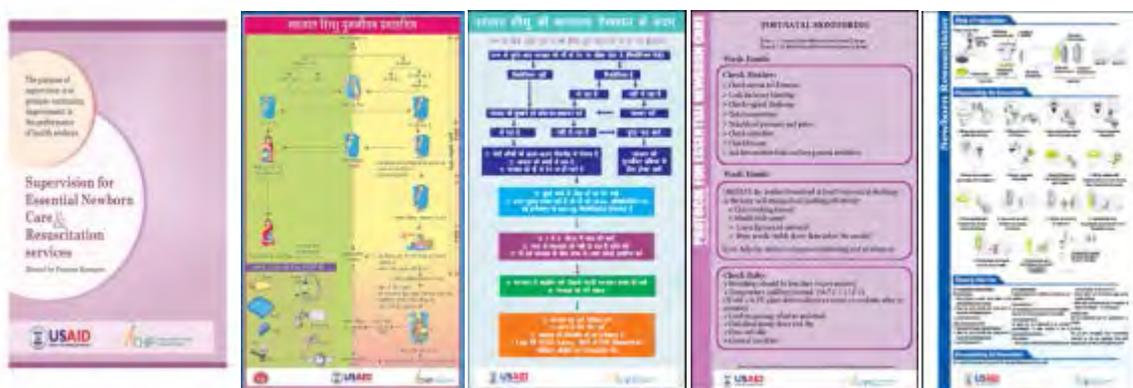
This tool has been adapted as a planning tool by the governments of Haryana and Jharkhand to help them strengthen essential newborn care and resuscitation services. The governments of Himachal Pradesh and Punjab are in the process of adapting the tool for similar purpose within their RMNCH+A framework.

Figure 5. Facility Readiness of the Demonstration Sites, at Baseline and Endline

| Baseline & End line scores of facility readiness exercise of 4 demonstration sites | | | | | | | | | |
|--|----------------------|--------------------------------------|------------------------------------|--------------------------------------|---------------------------------------|---------------------------------|---|----------------------------------|----------------|
| Name of Facility | Baseline Vs End line | Infrastructure | Delivery and newborn Care services | Human Resources and Signal Functions | Essential Drugs, equipment and supply | Register and Client Case record | Protocols and guidelines | Infection prevention and hygiene | Facility score |
| SDH Madhupur | Baseline | 70 | 79 | 75 | 65 | 40 | 40 | 40 | 51 |
| | End line | 75 | 86 | 80 | 85 | 65 | 100 | 65 | 73 |
| Patali GHC | Baseline | 60 | 64 | 30 | 53 | 40 | 40 | 40 | 33 |
| | End line | 75 | 71 | 30 | 75 | 40 | 70 | 75 | 61 |
| District Hospital Jambura | Baseline | 60 | 64 | 30 | 65 | 30 | 40 | 40 | 40 |
| | End line | 75 | 86 | 40 | 85 | 63 | 70 | 40 | 63 |
| PHC Patala | Baseline | 75 | 64 | 50 | 68 | 30 | 40 | 40 | 39 |
| | End line | 75 | 71 | 30 | 70 | 50 | 50 | 50 | 56 |
| | | Red (0% and below) = Poor performing | | Yellow (50%-79%) = Promising | | | Green (80% and above) = Good performing | | |

Establishment of Demonstration Sites

Based on the facility readiness assessment, 10 demonstration sites were selected in Jharkhand and Uttar Pradesh. Realistic facility plans were developed and a three-day skills-based ENCR training was conducted for all district-level primary care providers. Next, skills stations were established at the demonstration sites and equipped with job aids, mannequins, and videos on ENCR and Kangaroo Mother Care so that ANMs could practice their skills. MCHIP also supported the preparation of training videos. Skills stations, videos, checklists, job aids on ENCR, and KMC are the key components of a comprehensive skills lab designed to support health providers in acquiring and upgrading the skills needed for improved quality of ENC, leading to improved health outcomes. The skill stations were initially piloted by MCHIP. Following MCHIP's advocacy and demonstration of the skill stations in newborn care, which included essential newborn care, resuscitation, and Kangaroo Mother Care, the GOI adopted the model for scale-up in 200 districts across the country in the first phase and the remaining districts in later phases. MCHIP provided supportive supervision using quantitative and qualitative checklists to provide ongoing support.

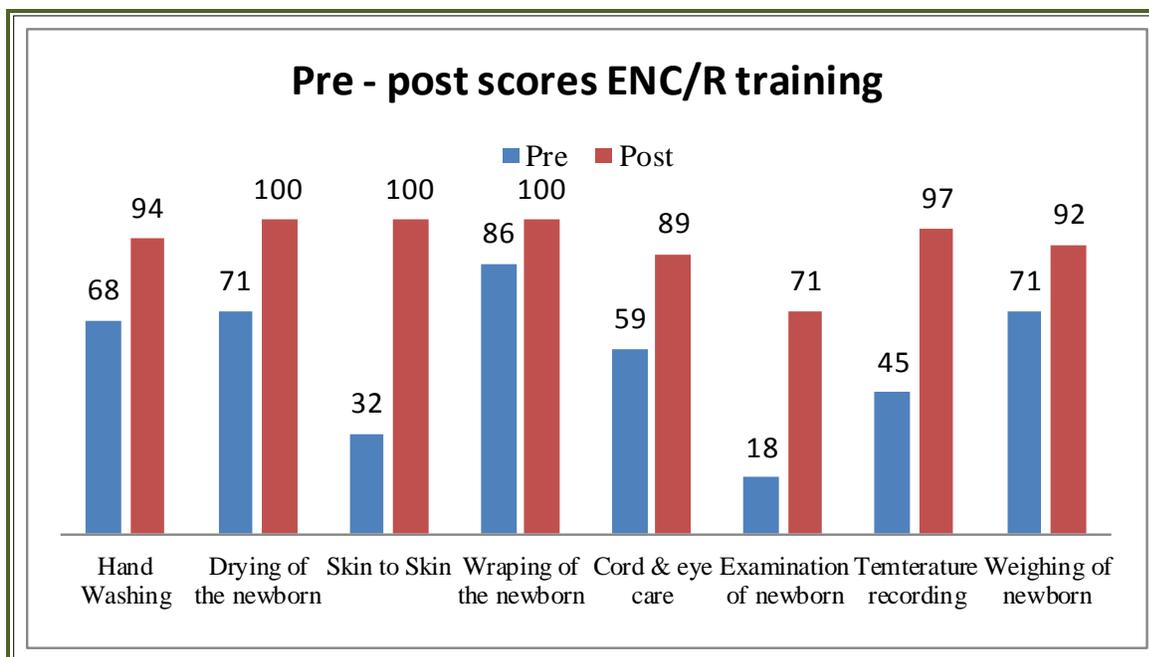


Examples of supportive supervision guide and various job aids for essential newborn care

ENCR Training and Capacity-Building

MCHIP participated in ENCR capacity-building activities at the state, district, and block levels, including strengthening the basic newborn care and neonatal resuscitation content of the Indian Nursing Council pre-service training curricula for nurses, midwives, and ANMs. MCHIP also provided technical assistance to the Child Health Division of the MOHFW for the evaluation of child and newborn health training, as well as a supportive supervision checklist for facilities. Figure 6 shows the pre- and post-training scores of MCHIP's ENC supportive supervision checklists are now being adopted by Jharkhand and Haryana to implement statewide.

Figure 6. Pre- and Post-Training ENCR Scores



Introduction of Neonatal Verbal Autopsies Software (NeVAS)

MCHIP introduced a verbal autopsy tool for neonatal deaths (based on the WHO verbal autopsy tool) for use at the community level in March 2012. The tool uses dual coding for a number of diseases. It uses the terms “most probable diagnosis” and “most possible diagnosis” to come to the cause of death. The two vary on the point of sensitivity and specificity.

The following categories of diagnostic criteria were used in determining probable and possible causes of death:

| | | |
|----------|--------------|---|
| E | Essential | Must be fulfilled to make a diagnosis, but is not sufficient evidence for diagnosis |
| C | Confirmatory | Clinches the diagnosis (if “E” is also fulfilled) |
| S | Supportive | Helps in making differential diagnosis from other possible causes of death, and provides circumstantial evidence to support a diagnosis |

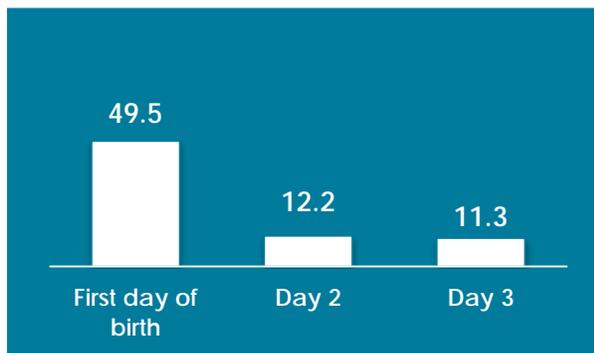
Different combinations of the categories are used for making most possible and most probable diagnoses. The most possible diagnoses have less sensitivity than the most probable diagnoses. Early in the development of the software two experts were engaged to validate the accuracy of the software and fine-tune the process. In a resource-restricted setting in India it is most important to develop a reliable system that could be used again and again without overburdening the already overworked doctors for analyses.

MCHIP adapted the coding system used by the SEARCH team, reworked the coding system to suit the questionnaire, and came up with diagnoses from the questionnaire by involving a panel of experts, so that the reliability and replicability of the diagnoses could be maintained without error. The tool can be used by any person with very simple training (and without a strong medical background), making it both user-friendly and resource-friendly.

District health authorities and accredited social health activists (ASHAs) conducted 113 verbal autopsies. The first 24 hours after birth (day 1) accounted for almost half (49.5%) of all newborn deaths in the first 28 days; 73% of all deaths occurred within the first three days after birth

(Figure 7). The findings from this exercise added immense value to the program by narrowing down the areas that need immediate improvement. The finding that 50% of infant deaths occur within 24 hours of birth underscores the need to improve perinatal and immediate postnatal newborn care. The verbal autopsies revealed an overwhelming 92% of the mothers of deceased newborns had not had complete antenatal care. Kangaroo Mother Care emerged as another area that requires urgent attention, because 34% of the deceased newborns in the verbal autopsy exercise were premature and/or low birth weight.

Figure 7. Verbal Autopsy Findings: Mortality Load on Days 1, 2, and 3



The neonatal verbal autopsy software has been taken up by Earth Institute, Columbia University, to conduct neonatal verbal autopsy in six districts of three states: Andhra Pradesh, Rajasthan, and Jharkhand. The package is readily usable and is available for scale-up in the country.

Coordinated Cross-Learning Initiatives

MCHIP led nine rounds of cross-learning at demonstration sites—one in Haryana state, one in Odisha, Bihar, and Rajasthan, and five for providers from facilities of targeted district and non-targeted districts.



For the districts of Deoghar and Jamtara in Jharkhand, non-MCHIP health facilities asked for the maternal and newborn register, protocols for practice, and the newborn resuscitation protocol for their facilities, and these were provided. The block facilitators trained them on the use of the register. For the state of Haryana, MCHIP provided technical assistance training of trainers in ENCR and for conducting the facility readiness exercise. MCHIP helped survey all facilities in the district of Ambala. For the states of Bihar, Odisha, and Rajasthan, ENCR trainings were conducted in the focus districts and sites have been developed that are modeled on the MCHIP demonstration sites.

Summary and Next Steps



ANM practices resuscitation



ANMs practices cord cutting



MCHIP staff demonstrates correct use of resuscitator

ENCR knowledge, planning, and policy were strengthened at the central level as well as in the six focus states. Ten demonstration sites for ENCR were established in Jharkhand and Uttar Pradesh. A total of 1,551 providers received training in ENCR (including trainers of trainers and health providers) in the two focus states. A total of 21,030 newborns received ENC and 1,105 newborns not breathing at birth were resuscitated at the 10 demonstration sites over a period of 27 months, from March 2011 to June 2013. MCHIP also developed and supported tools for facility assessment and cross-learning to strengthen capacity at the demonstration sites and measure progress, and introduced a tool for collecting neonatal death data to inform policy and programming. Under the GOI's new RMNCH+A strategy ENCR is being scaled up to 184 high-priority districts all over the country. The key indicator will be the percentage of newborns resuscitated successfully.

Program Learning by Cross-Cutting Area

The MCHIP India and headquarters teams identified important cross-cutting issues and questions that were subsequently addressed during program implementation. Some of the issues were addressed through process documentation, other were studies, and still others resulted in compilation of job aids, toolkits, training guides, manuals and others. The key issues and products that the project produced are summarized below under each of the program components.

RMNCH+A

- 1. Approach—Journey from Child Survival Call to Action to RMNCH+A Strategy: A paradigm shift to address the issues of MDGs 4 and 5:** The RMNCH+A strategy has cut across the entire political spectrum and is being rolled out throughout the country. Policymakers and political leaders across the globe will be interested in understanding how the Global Call to Action was taken up by the Government of India and transformed into the RMNCH+A strategy for improving maternal and child health. Although it is still early in the implementation process, significant progress has been made. A case study and video highlighting the importance of government leadership and partner coordination, and an animated video that describes the RMNCH+A Strategy and the continuum of care concept, are being finalized.
- 2. Implementation—Understanding the processes adopted by the Government of India to implement the RMNCH+A strategy at the state and district levels by developing various guidelines and designing interventions:** The RMNCH+A strategy is a comprehensive and holistic life-cycle approach to quality of care. A process document case study on how the strategy was operationalized in programmatic components and implemented at the state, district, and block levels is being finalized. A series of state-level highlights is also being finalized.
- 3. Monitoring and use of data in planning and mid-course correction — Strengthening the use of data for action by improving the quality of data reported and using data for reviewing performance:** The RMNCH+A strategy emphasizes effective use of data for planning, monitoring, and implementation, such as use of HMIS dashboards and coverage data-based scorecards. The dashboards and scorecards have been prepared for the states and are being used in districts and block review meetings for performance improvement. MCHIP also conducted rapid gap analysis at the district level to assess facility infrastructure, human resources, equipment, capacity, and the availability and quality of resources needed to deliver RMNCH+A interventions. To ensure timely support for implementation of the most critical interventions, MCHIP and other development partners offer need-based district-level assistance and work alongside district and block-level stakeholders to identify and address key challenges through block monitoring. The RMNCH+A highlight series, which is being finalized, includes a profile on the use of dashboards and scorecards as well as a profile on block monitoring in Jharkhand State and the use of rapid assessment in Uttarakhand State.
- 4. Quality—Organizing a training at a centrally located area usually results in frontline workers being away from service delivery points, affecting the quality of services they provide.** The RMNCH+A Highlight series being finalized includes a profile on onsite training as a best practice in Uttarakhand state.

Postpartum Family Planning

5. **Use of postpartum systematic screening to increase the accessibility and utilization of PFP counseling and services at outreach immunization clinics in selected MCHIP-supported sites in Jharkhand, India:** The intervention was introduced in one selected block in a two-group study design with one intervention group and one control group. The results of this study will be shared at national/international forums and through a publication. The study has been completed, and the publication is under way.
6. **Post-insertion outcomes and provider and client perspectives on PPIUCD services:** Assessment of PPIUCD services was conducted at selected MCHIP and non-MCHIP sites in the form of a follow-up study, which will be disseminated through a peer-reviewed publication. One of the papers from this study has already been accepted by the journal *Reproductive Health Matters*. Other publications are in progress.
7. **Revitalizing PFP services to address the high unmet need for spacing, especially in the postpartum period, to expand the basket of PFP options:** PFP services have been scaled up to more than 300 facilities throughout India, expanding the PFP options and introducing and strengthening PPIUCD services. The scale-up of PFP/PPIUCD services was done through a multipronged program strategy, and there has been rich program learning related to the strategic approach and process innovation. This process is currently being documented in a report.

Pre-Service Education

8. **Use of performance standards for strengthening quality:** The SBM-R approach was used in strengthening pre-service nursing education and midwifery education. The approach was adopted by the Government of India for scaling up in 10 states. The program will document the process for strengthening PSE, program experiences, and major results. Learning from the program will be disseminated through a program documentation report. Documentation is currently under way.

Immunization

9. **Does the RAPID approach improve quality and coverage in the routine immunization program?** RAPID is a model for assessment and supervision developed by MCHIP. It aims to improve the quality of immunization services and has demonstrated success in several districts in India. The successive rounds of RAPID have shown progressive improvement across the districts and the approach has now been adapted and scaled up by governments in four states and by UNICEF in Uttar Pradesh. In addition to improving immunization service delivery, the RAPID approach has contributed to improved overall quality of facility services, as is evident from the successive rounds of RAPID done by MCHIP in the respective districts. A package of materials, including a video, manual, fact sheets, and success stories, is being finalized.
10. **To what extent does establishing immunization demonstration sites and using them for cross-learning contribute to improving the performance of participating health facilities?** MCHIP India established demonstration sites in focus districts so that selected health facilities could serve as model sites for the implementation of all program practices according to national guidelines. All aspects of the immunization program are included: program management, cold chain and vaccine management, recording and reporting, immunization safety, and waste disposal. These sites serve as cross-learning centers for program managers, cold chain handlers, and other staff members through discussions, demonstrations, and participatory learning. A package of materials, including a video, standard operating procedures, fact sheets, and success stories, is being finalized.

11. **Does streamlining birth doses of vaccines for infants delivered at institutions lead to improved coverage?** The system for vaccinating and recording the infants born in government facilities is lacking, leading to left-outs and dropouts. MCHIP has supported a simple intervention to vaccinate infants in the facilities at birth and follow up with them afterward. This intervention has been prioritized by Government of India and has been implemented by the MCHIP team in its focus states and districts. A package of materials, including a video, guidance note, and success stories, is being finalized.
12. **Does use of the My Village My Home tool improve immunization coverage and timeliness?** MVMH is a community-level monitoring tool that enables the community to conduct its own monitoring of children's immunization status and take necessary steps for improving coverage. A package of materials, including a video, guidance, flyer, and success stories, is being finalized.

Newborn Health

13. **What happens to newborns in the first month of life? Follow-up Postnatal Visits:** A brief entitled "Postnatal care home visits for the newborn in Jharkhand State" is being finalized.
14. **Can a supervisory framework be implemented for ENCR?** MCHIP participated in capacity-building activities on essential newborn care and resuscitation at the state, district, and block levels. MCHIP's ENC supportive supervision checklists are now being adopted by Jharkhand and Haryana for implementation statewide. A brief entitled "Improving quality of care through mentoring and supportive supervision" is being finalized.
15. **What are newborns dying from? Verbal Autopsy:** MCHIP introduced a verbal autopsy tool for neonatal deaths (based on the WHO verbal autopsy tool) for use at the community level. This tool uses dual coding for a number of diseases. It uses the terms "most probable diagnosis" and "most possible diagnosis" to diagnose the cause of death. The tool can be used by any person with very simple training and without a strong medical background, making it both user-friendly and resource-friendly. A brief entitled "What are newborns dying from? Neonatal Verbal Autopsy" is being finalized.

Recommendations and Way Forward

By working with the Government of India and other key partners, MCHIP has catalyzed initiatives to improve maternal, newborn, and child health in India. However, despite the improvements made during the project's five years, further work is needed.

India's new RMNCH+A strategy can be strengthened in a number of areas. The MCHIP India team recommends further refinement of key RMNCH+A processes based on learning from the first year of implementation. Effective implementation of key performance and quality indicators and performance-based incentives under the RMNCH+A mandate must be prioritized to ensure that the GOI targets set out under RMNCH+A and the 12th Five-Year Plan are achieved.

The availability of quality health services in urban areas must be ensured. Greater, more effective coordination should be institutionalized between allied government departments such as Water and Sanitation, Social Welfare, Rural Development, Education, and Urban Development. Urban health dynamics are unique. The Urban Health Mission has been merged with the National Health Mission in order to focus equally on rural and urban health care needs. Urban health programs cannot be replicate rural health programs as the contexts are different. The strong presence of the private sector could be leveraged to improve the quality of health care in urban settings. In rural areas, much needs to be done in the area of nutrition to address the needs of severely anemic women and severely malnourished children. The Government of India is initiating calcium and iron supplementation for improvement of maternal health. Successful operationalization of this effort will require greater convergence with the Department of Women and Child Development, given its presence in every village of India.

RMNCH+A officers should facilitate the involvement of private-sector and civil society organizations in expanding services to cover all areas. Finally, development partner innovations in implementation should be documented and advocated for scale-up.

The first phase of RMNCH+A involved orienting a diverse set of stakeholders to the RMNCH+A strategy, establishing key processes for rolling out the strategy, and building the capacity of different cadres of human resources. Moving forward, MCHIP recommends that USAID focus on the following:

- Facilitating universal access to and coverage of key effective RMNCH+A interventions
- Continuous monitoring, supportive supervision, and feedback mechanisms to improve quality of care and accountability
- Fostering innovations to enhance policy, service delivery, and financing mechanisms
- Advocacy with multiple levels of government to enhance their involvement and promote sustainability and scale-up of best practices

This could be achieved by establishing a program and technical wing at both the state and national level and expanding technical support to the district and block levels. In addition to building the capacity of existing technical consultants on all components of the RMNCH+A strategy, it is important to expand the team of technical consultants so that there is one technical expert for each thematic area of RMNCH+A in each state and at the national level. The program wing could have experts to support health systems strengthening and cross-cutting issues, including addressing issues related to gender, equity, quality of data, documentation of success stories and best practices, human resources, and procurement.

- Strengthening linkages for the continuum of care

- From community to facility (through improved community mobilization and behavior change communication approaches)
- Across the life cycle—for example, development of Anganwadi Centers as village health posts for providing a package of services (antenatal care, line listing of high-risk pregnancies, tracking of anemic women, referrals, etc.)
- Enhancing the capacity of health system (human resources, essential commodities, infrastructure, multi-skill and task shifting)
- Improving intersectoral convergence, particularly with the Departments of Women and Child Development, Education, and Water and Sanitation.

PPFP/PPIUCD services in India should be scaled up to subdistrict-level facilities with high delivery loads in states in which services have been initiated in district-level facilities and training sites have been established. To minimize providers' time away from their facility and to accelerate the time frame for building a critical mass of trained providers for a facility, onsite training of providers should be an integral part of the overall training and mentorship approach. It is also important to strengthen supportive supervision for family planning services with a focus on PPFP/PPIUCD services. In addition, data related to PPFP services should be incorporated into routine data reporting and review mechanisms.

Pre-service nursing and midwifery education in India can be further strengthened by implementing six-week training courses for faculty of GNM/ANM schools at the SNCs in Dehradun (Uttarakhand state) and Ranchi (Jharkhand). It will also be important to develop SNCs as a core component of the overall approach to strengthening PSE in the 10 high-focus states of the country. Vacant positions at the GNM/ANM schools need to be filled via comprehensive recruitment efforts. A national-level review should be conducted on the progress of upgrading ANM/GNM schools and the establishment of SNCs. Initiation of PSE-strengthening activities—for example, mentorship and support to ANM/GNM schools at the NNCs other than Kolkata—is recommended.

Immunization coverage in India can be further strengthened using several strategies. MCHIP recommends the preparation of MCHIP India program learning documents and dissemination of the documents to government and other partners at the national, district, and state levels. RAPID supportive supervision should be continued as a monitoring and mentoring tool for continuous quality improvement of district-level services. To expand their impact, the quality improvement and best practices followed at demonstration sites should be presented at various public health conferences and events. In addition, advocacy for immunization program best practices should be scaled up. MCHIP also recommends incorporating MVMH data into routine data reporting and analysis, for effective tracking of beneficiaries. E-supervision pilot findings will be shared with other partners for scale-up. USAID has over the years prioritized immunization as a core technical area, supporting immunization programs in more than 30 countries across the globe, including India. The immunization support in India through IMMUNIZATIONbasics (2005–2009) and MCHIP (2009–2014) has been recognized and appreciated at all levels by the government and partners. During this period, both IMMUNIZATIONbasics and MCHIP developed evidence-based, high-impact interventions that improved coverage and quality and also strengthened the immunization systems. Keeping the current scenario in perspective, it is imperative for USAID to build on MCHIP's gains by supporting the national and state governments in further scale-up. Continued technical assistance is essential at all levels through focused support to immunization strengthening efforts within the RMNCH+A spectrum.

Several measures are recommended for further strengthening newborn care in India. The MCHIP ENCR team suggests the development of guidelines for monitoring quality issues related to

delivery care, including newborn care, in the states and districts. Demonstration sites for maternal and newborn care should be established in all the districts, which can then be turned into model sites through regular mentoring and supervision and used for cross-learning for other district facilities. Mentoring teams, including representatives of medical colleges and organizations with technical knowledge, should be formed (as envisioned in the Facility Based Newborn Care Guidelines) to provide close monitoring support to health care providers. Kangaroo Mother Care for LBW babies (guidelines on feeding, warmth, etc.) should be institutionalized in delivery facilities and in all NBSUs and SNCs. In addition, support should be provided to mothers to carry on prolonged skin-to-skin care in the home. Referral systems should be improved, and facilities such as NBSUs and SNCs should be designated for stabilizing and managing sick newborns once they have been referred. Finally, at the block level, a “block facilitator” position should be created to establish and strengthen linkages between the community and the facility and to be the catalyst for quality facility-based and home-based newborn care.

USAID should also prioritize and invest in child health issues, including childhood pneumonia and diarrhea, which contribute to a significant number of child deaths in India. USAID could also work with private-sector partners such as the Indian Medical Association, the Federation of Obstetric and Gynaecology Societies of India, Trained Nurses Association of India, and civil society organizations to reach its goals.

Annex 1: Program Learning

| PROGRAM LEARNING TOPIC | RELEVANCE OF TOPIC | PLANS FOR STUDYING, DOCUMENTING, AND DISSEMINATING | RESULTS |
|---|--|--|---|
| Postpartum Family Planning | | | |
| <p>Topic 1. Integration: Use of systematic postpartum screening to increase access to and use of PPFp counseling and services at outreach immunization clinics in selected MCHIP-supported sites in Jharkhand, India</p> | <p>The addition of one simple tool—specific for PPFp—into a reasonably well-functioning service delivery site (for immunization services) will help improve the provision and utilization of FP services at these (immunization) sites, without in any way affecting the existing services. This tool, if validated by the study, will support MCHIP’s efforts to integrate FP services at existing immunization service delivery sites.</p> <p>Level: National, global</p> | <p>The intervention is being introduced in one selected block in a two-group study design, with one intervention group and one control group. The results of this study will be shared at national/international forums through publication.</p> | <p>The study has been completed, and the article is in progress.</p> |
| <p>Topic 2. Quality: Post-insertion outcomes and provider and client perspectives on PPIUCD services</p> | <p>While information about the number and type of PPIUCD insertions is available, not much information related to follow-up findings by providers, provider experience, and client experience is available in India. Globally, there are studies documenting the safety of PPIUCD, comparison of PPIUCD versus interval IUCD, type of IUCD, and technique used for postpartum IUCD insertion, but there are hardly any recently published studies on follow-up of PPIUCD, even though there have been many developments in this method of family planning.</p> <p>Level: National, global</p> | <p>Assessment of PPIUCD services is being conducted at selected MCHIP and non-MCHIP sites in the form of a follow-up study, which will be disseminated through peer reviewed publication.</p> | <p>The study has been completed. One of the papers from this study has already been accepted for the peer reviewed journal <i>Reproductive Health Matters</i>. Other publications under this study are in progress.</p> |
| <p>Topic 3. Scale-up: Revitalizing PPFp services to address the high unmet need for spacing, especially in the postpartum period, to expand the basket of PPFp options</p> | <p>Scale-up of PPFp/PPIUCD services was done through a multipronged program strategy, and there has been rich program learning related to the strategic approach and process innovation. This documentation will help share the learning from the scale-up process with a wider public health audience.</p> | <p>PPFP services have been scaled up to more than 300 facilities throughout India, expanding the basket of PPFp options and introducing and strengthening PPIUCD services. The process is being documented in the form of a report.</p> | <p>The program documentation report is in progress.</p> |

| PROGRAM LEARNING TOPIC | RELEVANCE OF TOPIC | PLANS FOR STUDYING, DOCUMENTING, AND DISSEMINATING | RESULTS |
|---|--|---|---|
| Pre-Service Education | | | |
| Topic 1: Quality: Use of performance standards for strengthening the quality of pre-service education | The intention is to document the program processes, experiences, and major results related to strengthening pre-service education using the SBM-R approach Level: National, global | SBM-R was used to strengthen pre-service nursing and midwifery education. The approach was adopted by the Government of India for scaling up in 10 states. Learning from the program will be used to document the process, experiences, and major results related to strengthening PSE. This will be disseminated through a program documentation report. | The program documentation report is in progress. |
| Immunization | | | |
| Topic 1. Does the Regular Appraisal of Program Implementation in District approach improve quality and coverage of India's immunization program? | Lack of effective supervision contributes to poor quality and coverage of India's immunization program. RAPID has been identified as a high-impact intervention that helps improve the quality and coverage of the program. Audience: Government officials and program managers of subnational, national, and international organizations Level: Subnational, national, regional, and global levels | Category: Program report Location: Jharkhand (Jamtara & Deoghar) and Uttar Pradesh (Banda, Gonda, and Varanasi) Data Source: RAPID checklist datasheets Dissemination: Project dissemination by packaging the whole intervention in hard copy and on websites; also hope to publish article in peer-reviewed journal | Finalizing, editing, and layout in progress (June 2014) on: 1. Manual 2. Checklist 3. Success stories 4. Fact sheets/flyers 5. Synopsis |
| Topic 2. To what extent does establishing immunization demonstration centers and using them for cross learning contribute to raising the performance of participating health facilities? | Inadequate staff performance due to lack of training and awareness of best practices reduces the quality of immunization services. This intervention is believed to have a rapid impact on improving the quality of immunization services. Audience: Government officials and program managers of subnational, national, and international organizations. Level: Subnational, national, regional, and global levels | Category: Program report Location: Jharkhand (Jamtara and Deoghar) and Uttar Pradesh (Banda, Gonda, and Varanasi) Data Source: Demo sites checklist datasheet Dissemination: Project dissemination by packaging the whole intervention in hard copy and on websites; also hope to publish article in peer-reviewed journal | Finalizing, editing, and layout in progress (May 2014) on: 6. Standard operating procedures, RAC checklist 7. Success stories 8. Fact sheets/flyers 9. Synopsis |

| PROGRAM LEARNING TOPIC | RELEVANCE OF TOPIC | PLANS FOR STUDYING, DOCUMENTING, AND DISSEMINATING | RESULTS |
|--|---|---|---|
| <p>Topic 3. Does streamlining of birth doses of vaccines for infants delivered at institutions lead to improved coverage?</p> | <p>The system of vaccinating and recording the infants born in the government facilities is lacking, leading to left-outs and dropouts. MCHIP has supported a simple intervention to vaccinate infants in the facilities at birth and follow them up afterward. This intervention has been prioritized by the Government of India and has been implemented by the MCHIP team in its focus states and districts.</p> <p>Audience: Government officials and program managers of subnational, national, and international organizations.</p> <p>Level: Subnational, national, regional, and global levels.</p> | <p>Category: Program report Location: Jharkhand (Jamtara and Deoghar) and Uttar Pradesh (Banda, Gonda, and Varanasi) Data Source: Labor room registers Dissemination: Project dissemination by packaging the whole intervention in hard copies and on websites; also hope to publish article in the peer reviewed journal.</p> | <p>Finalization, editing, and layout in progress (May 2014) on:</p> <ol style="list-style-type: none"> 1. Guidance note 2. Video 3. Success stories 4. Synopsis |
| <p>Topic 4. Does use of the My Village My Home tool improve immunization coverage and timeliness?</p> | <p>Immunization program is delivered by the health staff and there are few community-level systems to monitor and track individual children for timely vaccination. My Village My Home is a simple tool used at the community level by community members to track the coverage of individual children for timely immunization.</p> <p>Audience: Government officials and program managers of subnational, national, and international organizations</p> <p>Level: Subnational, national, regional, and global levels</p> | <p>Category: Program report Location: Jharkhand (Jamtara and Deoghar) and Uttar Pradesh (Banda, Gonda, and Varanasi) Data Source: MVMH tool data from the Anganwadi Centers Dissemination: Project dissemination by packaging the whole intervention in hard copy and on websites; also hope to publish article in the peer-reviewed journal</p> | <p>Finalizing, editing, and layout in progress (May 2014) on:</p> <ol style="list-style-type: none"> 1. Guidance note 2. Success stories 3. Flyer 4. Synopsis |
| Newborn Health | | | |
| <p>Topic 1. What happens to newborns in the first month of life? Follow-up postnatal visits</p> | <p>This information will be used to improve counseling and management of LBW and post-treatment survival among successfully resuscitated babies at both the facility and the community level.</p> <p>Level: State, national, and global levels</p> | <p>Category: Article, program report Location: Jharkhand (Deoghar and Jamtara District) Data Source: Program service statistics</p> | <p>Article under review at MCHIP HQ (May 2014): “Postnatal care home visits for the newborn in Jharkhand state”</p> |

| PROGRAM LEARNING TOPIC | RELEVANCE OF TOPIC | PLANS FOR STUDYING, DOCUMENTING, AND DISSEMINATING | RESULTS |
|--|---|--|---|
| <p>Topic 2. Can a supervisory framework be implemented for ENCR?</p> | <p>Supportive supervision of health providers is key to ensuring and maintaining their use of newly acquired knowledge and skills. This is not currently done in the two states where MCHIP is working.</p> <p>Level: State MOHs</p> | <p>Category: Article and program report Location: Jharkhand (Deoghar and Jamtara District) and Uttar Pradesh (Gonda District) Data Source: Supportive supervision formats and interview of health providers. Dissemination: Journal of the Indian Association of Preventive and Social Medicine, WHO Bulletin Audience: State program managers, District implementers</p> | <p>Article under review at HQ (May 2014): “Improving quality of care through mentoring and supportive supervision”</p> |
| <p>Topic 3. What are newborns dying from? Verbal autopsy</p> | <p>Neonatal verbal autopsy creates evidence for interventions; it is the answer to the simple question of how to avert neonatal deaths in the future.</p> <p>Level: State, national, and global levels</p> | <p>Category: Article, program report Location: Jharkhand (Deoghar & Jamtara District) Data Source: NeVAS* Data NeVAS* Dissemination: Indian Pediatrics, Health Policy and Planning Audience: Policy makers</p> | <p>In HQ review (May 2014): “What are newborns dying from? Neonatal Verbal Autopsy”</p> |
| <p>Topic 4. RAPID: A supportive supervision approach to improve essential newborn care in Haryana India</p> | <p>A facility readiness tool can also be used as a supervisory tool to improve essential newborn care and resuscitation services.</p> <p>Level: State, national, and global levels</p> | <p>Category: Oral presentation and program report Location: Haryana Audience: Policymakers</p> | <p>Oral presentation at the 14th International Conference on Integrated Care in Brussels, Belgium, April 2014: “Regular Appraisal of Program Implementation in District (RAPID): A supportive supervision approach to improve essential newborn care in Haryana, India”</p> |

| PROGRAM LEARNING TOPIC | RELEVANCE OF TOPIC | PLANS FOR STUDYING, DOCUMENTING, AND DISSEMINATING | RESULTS |
|--|---|--|--|
| RMNCH+A | | | |
| <p>Topic 1. Approach: Journey from Child Survival Call to Action to RMNCH+A Strategy: A paradigm shift to address the issues of MDGs 4 and 5</p> | <p>The RMNCH+A strategy has cut across the entire political spectrum of India and has been successfully rolled out across the country. Policymakers as well as political leaders across the globe will be interested in how the Call to Action transformed into RMNCH+A strategy for improving maternal and child health. Therefore, this topic is very important for a global audience; it shows how India is taking a comprehensive approach and proactive action to tackle the issues of maternal and child mortality and morbidity.</p> | <p>Develop a process document for program implementers and a policy brief for political leaders and policymakers. Location: Regional and national Data Sources: Interviews, existing documents, program reports, etc. Dissemination: Conference and workshop presentations, digital media, online access through search engines, a brief sent to various stakeholders</p> | <p>RMNCH+A process document and RMNCH+A animation video being finalized (May 2014). RMNCH+A Call to Action Story Video approved and final.</p> |
| <p>Topic 2. Implementation: Understand the processes adopted by the Government of India to implement the RMNCH+A strategy at the state and district levels by developing various guidelines and designing interventions</p> | <p>The RMNCH+A strategy deployed a comprehensive and holistic approach to quality of care across the life cycle. A process document on how the strategy was operationalized into programmatic components and implemented at the state, district, and block levels will help stakeholders at the global, national, and regional levels to effectively replicate the strategy in various scenarios.</p> | <p>The RMNCH+A strategy is being implemented in USAID priority states. Activities have been undertaken as per government guidelines. These activities have been documented and will be reviewed and built upon to develop a process document. Location: Six USAID states in India Data Source: Strategy and implementation document Dissemination: Conference and workshop presentations, disseminate through digital media</p> | <p>RMNCH+A process document developed and in review at HQ (May 2014). RMNCH+A Implementation State Highlight Series in final stages of development and HQ review.</p> |
| <p>Topic 3: Monitoring: Strengthening the use of data for action by improving the quality of data reported and using data for reviewing performance</p> | <p>The RMNCH+A strategy emphasizes effective use of data for planning, monitoring, and implementation. This is envisioned through use of both coverage and reported data, such as use of HMIS dashboards and coverage data-based scorecards. The scorecards and dashboards have been prioritized globally and there is evidence-based reporting on the same. The Indian experience needs to be captured and disseminated for national and global audience.</p> | <p>Location: Jharkhand, India Data Source: Program data, existing reports, interviews with key stakeholders Dissemination: Conference and workshop presentations, digital media, and an article in a peer-reviewed journal</p> | <p>The scorecards and dashboards have been prepared for the states and are being used in districts and blocks review meeting for performance improvement. The RMNCH+A Highlight series includes a profile on the use of scorecards and dashboards and a profile on the use of block monitoring in Jharkhand state (in final review as of May 2014).</p> |

| PROGRAM LEARNING TOPIC | RELEVANCE OF TOPIC | PLANS FOR STUDYING, DOCUMENTING, AND DISSEMINATING | RESULTS |
|---|--|---|---|
| <p>Topic 4. Quality: Organizing a training at a centrally located area usually results in frontline workers being away from service delivery points, affecting the quality of services in their facilities. Thus, in Uttarakhand onsite training has been provided at the delivery points to help the frontline workers learn in the field level, resulting in improved quality of services under RMNCH+A at the facility level.</p> | <p>To enhance service uptake and to provide quality services at the facility level, onsite training to staff nurses and ANMs at delivery points is important. This is an important best practice that needs to be scaled up. It will be of interest to the government and other implementing agencies at the national, state, and district levels.</p> | <p>The training is ongoing in a high-priority district of Uttarakhand. This document will be developed simultaneously with the implementation process. Location: Uttarakhand, India Data Source: Program data, observation, and assessment reports Dissemination: Conference and workshop presentations, digital media, program documentation report, and presentations</p> | <p>The RMNCH+A Highlight series includes a profile on onsite training as a best practice in Uttarakhand state (in final review as of May 2014).</p> |

Annex 2: Indicator Matrix

MCHIP monitors the USAID Operational Plan indicators and others that are useful for tracking and managing program activities and their immediate and intermediate results. The table below is MCHIP's updated Performance Monitoring Plan (PMP) for July 2012 to June 2013.

PRE-SERVICE EDUCATION

Goal: To increase the knowledge and skills of ANM graduates from ANMTCs by improving the quality of pre-service education for the nursing and midwifery cadre in India

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | REVISED TARGETS FROM JULY 2013–JUNE 2014 | STATUS AS OF 27 MARCH 2014 |
|---|---|--|---------------|----------------------------------|--|--|
| Number of targeted pre-service educational institutions (NNCs/SNCs/ANMTCs) achieving 80% of educational and clinical standards | This indicator is a measure of the quality of educational processes and infrastructure at ANMTCs and NNCs, disaggregated by type of institution and sections of performance standards (e.g., classroom and teaching standards, clinical instruction standards, educational infrastructure, etc.). | Program records; nursing and midwifery standards assessment tool; SBM-R database | Semi-annually | INC, NNC, ANMTC, and MCHIP staff | 7 out of 8 institutions (NNC, Kolkata; SNC, Jharkhand; SNC, Uttarakhand; ANMTCs (3 in Jharkhand and 2 in Uttarakhand)) | Jharkhand: 2 focused ANMTCs Uttarakhand: 5 ANMTCs |
| Percentage of target pre-service educational institutions (NNCs, SNCs, and ANMTCs) whose faculty use Objective Structured Clinical Examination for student assessment | This indicator is a proxy for quality of educational processes at the NNCs and ANMTCs; to be assessed by INC/MCHIP staff observation and by SBM-R data. | Program records; nursing and midwifery standards assessment tool; SBM-R database | Semi-annually | INC, NNC, SNC, and MCHIP staff | 100% | Jharkhand: None Uttarakhand: 70% |

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | REVISED TARGETS FROM JULY 2013– JUNE 2014 | STATUS AS OF 27 MARCH 2014 |
|---|--|--|---------------|--------------------------------|--|---|
| Percentage of institutions providing competency-based training using simulation models | This indicator is a proxy for the quality of classroom and practical instruction at the NNCs and ANMTCs; to be assessed by INC/MCHIP staff observation and by SBM-R data. | Program records; nursing and midwifery standards; SBM-R database (section 1, standard 14) | Semi-annually | INC, NNC, SNC, and MCHIP staff | This indicator will be discontinued in FY 14 | Jharkhand: 3 focused ANMTCs Uttarakhand: 70% |
| Percentage of institutions in which library is used effectively by student nurse-midwives for independent learning | This indicator is a proxy for quality of school infrastructure and training materials at the NNCs and ANMTCs; to be assessed by INC/MCHIP staff observation and by SBM-R data. | Program records; nursing and midwifery standards; SBM-R database (section 3, standard 8 and 9) | Semi-annually | INC, NNC, SNC, and MCHIP staff | This indicator will be discontinued in FY 14 | Jharkhand: 3 focused ANMTCs; 5 other ANMTCs Uttarakhand: 70% |
| Percentage of targeted institutions with at least two faculty trained on teaching and clinical skills in the INC-approved curriculum for trainers/faculty | Numerator: # of targeted institutions with at least two faculty trained on teaching and clinical skills in the INC-approved curriculum Denominator: # of NNCs and ANMTCs supported by MCHIP | Program records; nursing and midwifery standards; SBM-R database | Semi-annually | INC, NNC, SNC, and MCHIP staff | 100% (8 out of 8 institutions) | Jharkhand: 3 focused ANMTCs; 2 ANMTCs achieved Uttarakhand: 5 ANMTCs scaled up; all 5 ANMTC achieved Uttarakhand: 70% |

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | REVISED TARGETS FROM JULY 2013– JUNE 2014 | STATUS AS OF 27 MARCH 2014 |
|---|--|---|---------------|-------------------|---|---|
| Number of deliveries with a skilled birth attendant (SBA) in USG-assisted programs* | Number of deliveries with a SBA, including a medically trained doctor, nurse, or midwife; traditional birth attendants (TBA) not included. | HMIS/service statistics; supportive supervision reports | Semi-annually | MCHIP staff | Target TBD | Jharkhand: 2 focused ANMTCs (Giridih, Simdega, Chaibasa) Uttarakhand: 70% (Ranipokhari and Gadarpur) |
| Number/percentage of women receiving a uterotonic immediately after birth | This data will be collected from the MCHIP-supported NNC clinical practice sites and hospitals in Jharkhand and Uttarakhand | Facility registers | Semi-annually | MCHIP staff | Discontinued for FY 14 | Jharkhand: None Uttarakhand: 70% |
| Number of women counseled for PPF | The number of women counseled for PPF will be collected at the clinical practice sites of the target NNCs and ANMTCs | HMIS/service statistics; supportive supervision reports | Semi-annually | MCHIP staff | TBD | Data not available |

* Indicates an Investing in People/Operational Plan Indicator

FAMILY PLANNING

Goal: To increase access to quality FP services, including PFP/PPIUCD, through advocacy, introduction of alternative training approaches, and increased integration of PFP with relevant MNCH services

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | REVISED TARGETS FROM JULY 2013–JUNE 2014 | STATUS AS OF 27 MARCH 2014 |
|--|---|---|-----------|---|---|---|
| Number of USG-assisted service delivery points providing FP counseling and services* | Number of service delivery points that provide FP/PPIUCD services, disaggregated, as appropriate, by type of service: sites offering long-acting and permanent methods (IUD, voluntary sterilization); public or private | Program records; hospital registers; facility records; government data; PPIUCD register | Quarterly | Primary data: hospital, facility, health center staff, and SIFPSA Compilation: MCHIP staff | 98 (Jharkhand: 34; Uttarakhand: 28; Uttar Pradesh: 34 until September 2013; West Bengal: 1) | Jharkhand: 36 Uttarakhand: 28 Uttar Pradesh: 31 (6 medical colleges and 25 district woman hospital in 23 districts) |
| Number of FP counseling sessions provided to pregnant/postpartum women at MCHIP-supported sites Modified for FY 13: Number of FP counseling contacts provided to pregnant/postpartum women at MCHIP-supported sites | Pregnant postpartum women receiving FP counseling during ANC or postpartum period or at service delivery sites of other MNCH activities; disaggregated by the period in counseling is given (during ANC or postpartum period, others) | ANC and PPC registers; records; PPIUCD register | Quarterly | Primary data: Hospital, facility, health center staff, and SIFPSA Compilation: MCHIP Staff | No target fixed due to inclusion of newer facilities whose delivery loads are not known | Jharkhand: 55,164 Uttar Pradesh: 201,685 Uttarakhand: 108,198 Total: 365,047 |

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | REVISED TARGETS FROM JULY 2013-JUNE 2014 | STATUS AS OF 27 MARCH 2014 |
|--|--|--|-----------|--|---|--|
| Couple-years of protection in USG-supported programs* | The estimated protection provided by FP services during a one-year period, based on the volume of all contraceptives provided to clients during that period. Couple-years of protection can be calculated by multiplying the quantity of each method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. Disaggregated by method | Hospital registers; facility records; government data; PPIUCD register | Quarterly | Primary data: Hospital, facility, health center staff, and SIFPSA Compilation MCHIP staff | NA | PPIUCD-96,338 Female Sterilization: 502,905 Male Sterilization: 33,215 OCP: 5,865 Condom: 12,576 Interval IUCD: 210,289 ECP: 329 |
| Number of FP counselors trained | This indicator gives the total number of counselors trained by MCHIP | Program records; training reports | Quarterly | MCHIP staff | TBD | Jharkhand: 10 Uttarakhand: 28 Uttar Pradesh:169 |
| Number of sites where newly hired dedicated FP counselor trained through USG support is providing services | This indicator gives the total number of sites where a counselor trained by USG support is providing counseling | Government records; training reports | Quarterly | MCHIP staff | Contingent upon hiring of counselors by state | Jharkhand: 10 Uttarakhand: 28 Uttar Pradesh: 59 |

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | REVISED TARGETS FROM JULY 2013-JUNE 2014 | STATUS AS OF 27 MARCH 2014 |
|--|--|--|-----------|-------------------|---|--|
| Number of USG-assisted facilities where PPIUCD services are introduced | | Hospital registers; facility records; government data; PPIUCD register | Quarterly | MCHIP staff | TBD | Jharkhand: 36 Uttarakhand: 28 Uttar Pradesh: 31 |
| Number of training sites prepared for functionality in PPFPP/PPIUCD in Uttar Pradesh and Jharkhand | Indicates the number of sites that can be potentially used for training providers in PPFPP/PPIUCD. | Program records; training reports | Quarterly | MCHIP staff | Jharkhand: 6 Uttar Pradesh: 8 Total: 14 | Jharkhand (October 2012-September 2013): 1 training site developed Uttarakhand (October 2012-September 2013): 7 training sites developed |
| Number of onsite trainings in PPFPP/PPIUCD conducted in states of Uttar Pradesh and Jharkhand | Indicates the number of trainings at the service delivery sites to ensure operationalization | Program records; training reports | Quarterly | MCHIP staff | 20 | Jharkhand (October 2012-September 2013): 18 onsite trainings conducted Uttarakhand (October 2012-September 2013): 20 onsite trainings conducted |

* Indicates an Investing in People/Operational Plan Indicator

IMMUNIZATION (VACCINE PREVENTABLE DISEASES)

Goal: To continue building the capacity of Indian institutions toward achieving full immunization coverage by 12 months of age for at least 80% of India's children.

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | REVISED TARGETS FROM JULY 2013– JUNE 2014 (WORKING IN 30 HPDS) | STATUS AS OF 27 MARCH 2014 |
|--|---|-----------------------------|-----------|---|---|--|
| Number of new composite demonstration facilities developed and cross-learning visits completed | MCHIP will develop PHCs as cross-learning centers on various best practices related to routine immunization | Staff reports documentation | Quarterly | MCHIP staff with support from government and partners | 4 (1 in each of 4 focus states: Jharkhand, Haryana, Punjab, and Uttarakhand) | Haryana: not developed Uttarakhand: 3 sites identified but not developed Punjab: not developed Jharkhand: not developed after July 13; prior to that, 2 CHCs (Jamtara and Sarwan) developed |

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | REVISED TARGETS FROM JULY 2013– JUNE 2014 (WORKING IN 30 HPDS) | STATUS AS OF 27 MARCH 2014 |
|--|--|---------------------|-----------|---------------------|---|---|
| Number of district-level UIP program reviews conducted for immunization services | MCHIP district staff will conduct periodic reviews to identify gaps, provide support for improvement , and monitor trends in quality improvement | MCHIP staff reports | Quarterly | GOI and MCHIP staff | 12 reviews facilitated | Jharkhand: District Task Force/Special Immunization Week/Village Health Nutrition Days (VHND): 4 District monthly review: 8 State task force: 1 State routine immunization cell: 2 State review: 2 Haryana: MCHIP provided technical inputs in two child health and immunization review meetings |

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | REVISED TARGETS FROM JULY 2013– JUNE 2014 (WORKING IN 30 HPDS) | STATUS AS OF 27 MARCH 2014 |
|---|---|------------------|-----------|-------------------|--|---|
| Number of children under 12 months old who received DPT3 from USG-supported programs* | Number of children under 12 months of age who received DPT3 from MCHIP/USAID-supported facilities | Facility records | Quarterly | MCHIP staff | Total annual target (April 2013– March 2014): 25,760,000 infants Target during July 2013– March 2014: 1,717,333 infants | July 2013– Feb 2014: 12,515,969 infants received DPT3 (73% ⁵ achievement for the duration) |

⁵ Source: “HMIS Data Item Wise Report for - All India” 2013-2014, Data accessed on 28 Mar 2014

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | REVISED TARGETS FROM JULY 2013– JUNE 2014 (WORKING IN 30 HPDS) | STATUS AS OF 27 MARCH 2014 |
|--|---|-----------------|-----------|-------------------|---|--|
| Number of state plans drafted with USG support | State-level annual health plans, including Immunization | Program records | Annual | MCHIP staff | NA | <p>Jharkhand: Provided technical support in preparing:</p> <ul style="list-style-type: none"> 1 state PIP (2014–2017) 6 district health action plans 1 routine immunization financial guideline (2013–2014) <p>Haryana: Supported NRHM Haryana in preparing state PIP</p> <p>Uttarakhand: Supported in preparing state PIP</p> |

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | REVISED TARGETS FROM JULY 2013– JUNE 2014 (WORKING IN 30 HPDS) | STATUS AS OF 27 MARCH 2014 |
|--|--|-------------------------|-------------|---------------------------|---|---|
| Number of rounds of RAPID conducted in the focus districts of Uttar Pradesh and Jharkhand | RAPID is the key activity undertaken by the district-based immunization teams once in 4–6 months to improve the quality of the immunization program and improve coverage. | MCHIP staff reports | Annually | MCHIP staff | Discontinued FY 14 | Jharkhand: Not conducted Uttar Pradesh: Not conducted Discontinued in July 2013 |
| Supporting GOI in program review and evaluation | Assisting the GOI in review of ongoing new initiatives such as routine immunization , measles catch-up program (MCUP) phase 3, maternal and neonatal tetanus elimination (MNTE) validations, and penta PIE | Review reports; records | As required | MCHIP staff with partners | Support in IRI, MNTE, validation, and PIE from national level | Pentavalent PIE and measles 2nd dose evaluation done; national cold chain assessment. |
| Ensuring administration of birth doses of OPV, Hep-B, and BCG in the facilities in focus districts | Number of facilities that initiated the introduction of birth doses of OPV, Hep-B, and BCG vaccines | Reports and records | Ongoing | MCHIP staff | Demonstrate in 6 facilities | Newborn vaccination demonstration at 4 facilities in Jharkhand |

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | REVISED TARGETS FROM JULY 2013– JUNE 2014 (WORKING IN 30 HPDS) | STATUS AS OF 27 MARCH 2014 |
|--|---------------|---|-----------|-------------------|---|--|
| Facilitating and demonstrating RAPID rounds in the HPDs of 6 states | Same as above | MCHIP staff and reports of other development partners | Annually | MCHIP staff | 6 | 4 in Bokaro, Ranchi, Godda, and Dumka |
| Support immunization technical support unit (ITSU) in facilitating/ demonstrating RAPID rounds in 10 districts as per request of GOI | Same as above | Reports from ITSU | Annually | ITSU | 10 | MCHIP was ready, but ITSU did not take it forward so could not be done |
| Support immunization technical support unit (ITSU) in facilitating/ demonstrating RAPID rounds in 10 districts as per request of GOI | Same as above | Reports from ITSU | Annually | ITSU | 10 | MCHIP was ready, but ITSU did not take it forward so could not be done |

* Indicates an Investing in People/Operational Plan Indicator

EARLY NEWBORN CARE/RESUSCITATION (ENCR)

Goal: To support the MOHFW, the USAID bilateral health programs, and the new NSSK in strengthening and expanding access to ENC and teach basic resuscitation techniques

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | TARGET FY 2014 | STATUS AS OF 27 MARCH 2014 |
|--|--|----------------------------|---------------|---|---|-----------------------------|
| Number of districts that have rolled out NSSK training in Uttar Pradesh and Jharkhand | Number of districts with NSSK action plan incorporated in the state PIP | State PIP; program records | Annually | MCHIP staff with support from state governments | 30 | 30 HPDs |
| Number of demonstration facilities established in focus districts | MCHIP will support establishment of demo facilities for ENCR services | Program records | Semi-annually | MCHIP staff and implementation partners | 6 | 6 identified in Uttarakhand |
| Number of newborns treated for birth asphyxia, by type of treatment | Number of newborns managed for birth asphyxia, disaggregated by district Definition of "managed" will be standardized: number of newborns managed with bag and mask will be used as the programmatic working definition | Facility records | Quarterly | MCHIP staff | 100% of newborns with birth asphyxia managed as per the national protocols in 6 demonstration sites in 6 HPDs | Data not available |
| Number of newborns receiving essential newborn care through USG-supported programs* (prioritized facilities in focus districts only) | Number of newborns receiving essential newborn care, including essential preventive care and recognition of danger signs and referral | Facility records | Semi-annually | MCHIP staff | 80% of newborns born in 6 demonstration sites in 6 HPDs | Data not available |

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | TARGET FY 2014 | STATUS AS OF 27 MARCH 2014 |
|---|---|------------------|---------------|-------------------|--|--|
| Quality of NSSK training assessed | Proportion of trainings in which quality is assessed | Program records | Semi-annually | MCHIP staff | 10% of the training load in 6 HPDs | 2 (Jharkhand) |
| Number of districts that rolled out supportive supervision | Number of districts in which supportive supervision is rolled out | Program records | Semi-annually | MCHIP staff | 29 (24 districts in Jharkhand and 1 HPD in other USAID-supported states) | 45 districts (24 districts in Jharkhand; 21 districts in Haryana) |
| Number of NSSK trainings co-facilitated | Number of NSSK trainings co-facilitated by MCHIP staff | Training reports | Semi-annually | MCHIP staff | This indicator will be discontinued in FY-14 | 3 (2 in Jharkhand and 1 in Uttarakhand) |
| Number of one-day refresher trainings of NSSK for providers | Number of NSSK trainings facilitated by MCHIP staff | Training reports | Semi-annually | MCHIP staff | This indicator will be discontinued in FY 14 | 3 |
| Number of one-day refresher trainings of NSSK for master trainers | Number of NSSK trainings facilitated by MCHIP staff | Training reports | Semi-annually | MCHIP staff | 3 (Jharkhand) | None |

* Indicates an Investing in People/Operational Plan Indicator

CROSS-CUTTING INDICATORS

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | TARGET JULY 2013– JUNE 2014 | STATUS AS OF 27 MARCH 2014 |
|--|---|--|-----------|--------------------------|--|---|
| Number of people trained in maternal and newborn health through USG (MCHIP)-supported programs | This indicator includes health professionals, primary health care workers, community health workers, volunteers, and non-health personnel. | Training participant tracking sheets and database (in-service); NNC and ANMTC graduation records (pre-service graduates) | Quarterly | GOI, INC, MCHIP partners | 54 (state training of trainers in Jharkhand) | 114 (96 in Jharkhand and 18 in Uttarakhand) |
| Number of people trained in child health and nutrition through USG (MCHIP)-supported programs* | This includes health professionals, primary health care workers, community health workers, volunteers, and non-health personnel. Data will be disaggregated by type of training related to child health. | Training participant tracking sheets and database (in-service); NNC graduation records (pre-service graduates) | Quarterly | GOI, INC, MCHIP partners | 1,800 in focus states | Jharkhand: 516 Haryana: 275 Uttarakhand: 60 Uttar Pradesh: No trainings after July 2013 as programs were discontinued |
| Number of people trained in FP/RH through USG (MCHIP)-supported programs* | This includes health professionals, primary health care workers, community health workers, volunteers, non-health personnel, and includes training in service delivery, communication, policy and systems, research, etc. | Training participant tracking sheets and database (in-service); NNC graduation records (pre-service graduates) | Quarterly | GOI, INC, MCHIP partners | PPFP: 250 PSE: 30 Total: 280 | Uttar Pradesh (October 2012– September 2013): 136 doctors, 206 nurses, 169 counselors Jharkhand (October 2012– September 2013): Total of 545 people trained (134 doctors, 410 staff nurses, 1 other) |

| INDICATOR | DEFINITION | DATA SOURCE | FREQUENCY | RESPONSIBLE PARTY | TARGET JULY 2013– JUNE 2014 | STATUS AS OF 27 MARCH 2014 |
|---|--|--|---------------|---------------------|--|--|
| Number of functional working groups, task forces, and/or TAGs | Disaggregated by purpose (strengthening pre-service ANMTC; FP service delivery; FP pre-service education; PPIUCD service delivery; commodity storage, others (to be specified). “Functioning” means they are meeting on a regular basis and taking action. | Program records; meeting minutes, participation list | Quarterly | MCHIP staff | PSE: 3 Newborn Care: 3 (National Collaborative Center; Neonatal Action Group; RMNCH+A strategy) | NBC: 3 PSE: 3 |
| Number of national policies drafted with USG support* | Number of national policies developed with MCHIP/USAID support This includes policy documents under all components of the project. | Program records | Annual | MCHIP staff and GOI | Maternal health: 1 | Immunization: none |
| Number of MNCH approaches, reference materials, guides, and tools disseminated with MCHIP support | Number of materials, guidelines, and tools disseminated with MCHIP support, listed by area of focus (e.g., FP, immunization, newborn care, etc.). Includes job aids, curriculum, and other tools. The list of materials will be presented. | Program records | Semi-annually | MCHIP staff | FP: 1 Newborn care: 2 guidelines on ENC and KMC; 4 documents for global program learning | NBC: 2 guidelines (use of antibiotics by ANMs; KMC and optimal feeding for LBW [in progress]) 3 program learning documents (supportive supervision; neonatal verbal autopsy; follow-up of newborn in community) |

* Indicates an Investing in People/Operational Plan Indicator.

Annex 3: Success Stories: A nurse committed to saving lives in remote Jharkhand

Sister Agatha Kiro has been a nurse for more than 37 years and has been working at the Community Health Center, Kolibera for the past six years.



Working in a state which faces several challenges—of poor health indicators, poor infrastructure and threatened by communist guerrilla groups—Sister Agatha finds her biggest challenge to be shortage of manpower. There is no lady doctor at this health center and Sister Agatha, along with her lean team of nurses, is responsible for all the deliveries conducted here. “In working here I have gained a lot of self- confidence because, all in all, it is us who have to do everything.”

Sister Agatha has been trained by MCHIP in providing PPIUCD services to women who choose this postpartum family planning method. “I knew about IUCD but I didn’t know about postpartum IUCD. It is really helping the women. It is easy to insert and easy to accept”, she says and adds, “The rate of early and unsafe miscarriages has reduced and it is helping women in spacing their births.”

One of the big advantages of PPF, says Sister Agatha, is that women get to choose it while still at the hospital as once they go home they’re caught up in many other problems, and revisiting the hospital to adopt a family planning method becomes a low priority. She points out an example. “I have a case now of a lady who has come for her fourth delivery. She had a baby one and a half years ago and we had advised her to choose a family planning method. She said she would get an operation or she would come back for an interval IUCD but she did not return. That is why she is here again to deliver her fourth child.”

MCHIP has been working for the past five years in revitalizing postpartum family planning in India and training healthcare providers in providing postpartum IUCD services. While initially it was mainly the doctors who were being trained in this service provision, it was soon realized that if this program had to reach a critical mass, it was important to train nurses along with doctors and allow them to provide PPIUCD services as well. This was because the nurses were the ones present in the labor rooms, conducting deliveries. Moreover, with a severe lack of doctors in many remote and vulnerable pockets of the country, the nurses are many times the only healthcare providers present to care for the mothers and newborns. Thus, building the capacity of the nurses was extremely essential. Of the 1715 providers trained in PPIUCD services, 885 are nurses.



Sister Agatha is glad that she was one of those nurses trained by MCHIP in PPIUCD services and is being able to provide this long acting, yet reversible, family planning method to many women in need. Thanking MCHIP, she concludes, “The kind of training that we have received helped us in doing our work better and I hope that in the future we will continue to get such trainings.”

RMNCH+A Highlight Series

Strengthening of Essential Newborn Care: Facility Readiness and Supportive Supervision in Haryana



Photo by MCHIP

“Every child has the right to survive. In Haryana when a health facility can be reached in 15 minutes, then why should any child die in Haryana?”

Dr. Suresh Kumar Dalpath, Deputy Director - Child Health, Nutrition and Immunization.

Story Contributors:

Mr. Niraj Agrawal and Dr. Pawan Pathak

JULY 2014

India accounts for one-fifth, or approximately 26 million, of the world’s annual births. Since 1990, India’s infant mortality rate (IMR) has declined steadily, but the neonatal mortality rate (NMR) has stagnated. One third of all infant deaths worldwide continue to occur in India each year. India currently accounts for 29% of all first day deaths globally, approximately 300,000 per year. Most of the 940,000 newborn deaths in India are from preventable causes (Lancet, 2011). To further reduce infant and child mortality, it is crucial for India to focus on significantly reducing newborn death.

Background

The Government of India co-convened the global Call to Action for Child Survival in 2012 with USAID, the Government of Ethiopia and UNICEF, and then hosted its own National Summit to accelerate progress toward Millennium Development Goals 4 and 5 and the health goals of the 12th Five Year Plan. A new, comprehensive Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) Strategy launched at the National Summit is currently being rolled out in all 29 states and 184 high priority districts (HPDs). MCHIP provides technical support to the MOHFW and six state governments for RMNCH+A roll out.

In India, institutional deliveries increased from 67% in 2009 to 84% in 2013. This represents an impressive 15% increase every year since the launch of the National Rural Health Mission in 2005. Haryana State realized that despite the addition of new staff nurses and auxiliary nurse midwives (ANMs), its health facilities were not ready to handle the increased delivery load.

In Haryana, the under-five and infant mortality rates fell from 76 and 59 per 1000 live births in 2003, to 48/1000 and

42/1000 in 2012, respectively. However, as in India overall, neonatal mortality was generally stagnant (31/1000 in 2003, to 28/1000 live births in 2012) and the early neonatal mortality rate had increased. The Government of Haryana reviewed the data and concluded that staff nurses and Auxiliary Nurse Midwives lacked the capacity to manage two major causes of neonatal death--birth asphyxia and respiratory distress. Government of Haryana then took the initiative to reduce newborn deaths using the MCHIP Facility Readiness Tool and supportive supervision, an approach that can be used to analyze the delivery of services, understand the performance of the providers, and then systematically work with them, on-site, to improve their knowledge and skills in essential newborn care and resuscitation (ENCR), with the goal of saving newborn lives and preventing disability.

Adapting RAPID for Newborn Care

MCHIP introduced the Government of Haryana to the Regular Appraisal of Program Implementation in Districts (RAPID) approach for strengthening immunization services. The approach, which includes quarterly district and health facility visits, and on-site training and mentoring, has been adapted in Haryana and used for Essential Newborn Care and Resuscitation and well as immunization.

State Consultation

When approached to provide technical support for newborn services, MCHIP shared its experience establishing ENCR skill development centers and model demonstration sites in Jharkhand with the Haryana State Officials. A state level consultation was organized in January 2013, that included orientation on the use of the facility readiness tool developed by MCHIP to assess health facility preparedness in providing ENCR, evaluate practices of skilled birth attendants during intra-partum care,

and improve the knowledge and practices of ENCR in facilities by providing on-site training and regular follow-up. The consultation included Child Health Officers and Chief Medical Officers from districts in the state, as well as State Program Officers and Deputy Directors. Key decisions taken at the end of the consultation were to hire a team of dedicated child health consultants and to prepare an action plan for assessment of facility readiness and orientation of health service providers. MCHIP supported the development of the action plan and preparation of the scope of work for the child health consultants.

Learning Visit to Jharkhand

As a first step, the newly appointed child health consultants, led by Dr. Suresh Kumar Dalpath, Deputy Director, Child Health, Nutrition and Immunization, Government of Haryana, visited the MCHIP focus districts of Deoghar and Jamtara in Jharkhand state. A one-day orientation on ENCR was conducted to familiarize the team with the training and other technical support provided to health staff to ensure essential newborn care for every newborn and resuscitation support for newborns that are unable to breathe at birth. This was followed by a visit to a Community Health Centre - First Referral Unit, Madhupur in Deoghar district. This facility has a delivery load of nearly 125 births a month, a two-fold increase since MCHIP developed the site as a model newborn care (NBC) demonstration center.

At the demonstration site, the visiting team assessed the ENCR practices at the skill station and received orientation on the peer group-facilitated supportive supervision process established at the center. In addition, other home-based newborn care interventions were shared with the Haryana colleagues including recording and reporting practices which had been strengthened through the introduction of an integrated Delivery and Newborn Register.

Technical support provided to improve ENCR skills and facility readiness focused on:

- Care prior to delivery
- Delivery area to be dust free
- Temperature > 25 degrees Celsius
- Washing of hands with soap and clean water
- Use of double gloves just before delivery and use of newborn care corner
- Immediate newborn care in the first “golden” minute: drying, establish breathing, skin to skin contact, wrapping
- Between 1-60 minutes: delayed cord clamping, support for and establishment of breastfeeding

The team was impressed by the well-managed delivery room, the providers’ demonstration of ENCR on a baby mannequin, and the delivery register that captures data related to delivery and the early postnatal period, including ENCR practice and referral information.

The team also visited the Additional Primary Health Centre, Pabia in Jamtara district. The center is run by three auxiliary nurse-midwives (ANMs) who manage a delivery load of 80 per month and offer services 24 hours a day, 7 days a week (24X7). The skill station developed and facilitated initially by an MCHIP Block Facilitator is set up so that providers can regularly practice and hone their new skills; job aids provided by MCHIP also help to refresh what they learn in on-site training and mentoring. The ANMs conduct supportive supervision, observing the delivery practices of their peers using a checklist and then explaining best practices and discussing the gaps they have observed to help each other improve. The visit to the centers provided an opportunity for the team to observe the on-site practices and processes used at the demonstration sites.

Training, Facility Assessment, and Supportive Supervision

Following the visit, a one-day training of Child Health Consultants was held in March 2013 to orient them about the supportive supervision approach to improving the quality of newborn services. Training focused on ENCR technical content and the facility readiness assessment tool including skill building on facility scoring/ranking to generate a picture of the current conditions in each facility. Consultants were also trained on key skills for data collection including observation and interviewing and a district plan for assessment was also prepared. It was emphasized that information from all facilities would be analyzed to understand the status of newborn care services across districts and the state as a whole and that findings would be used to prioritize districts and facilities for corrective actions, supportive supervision, and mentoring.

Immediately after the training, teams of two investigators and one supervisor were formed. Each team visited two facilities each day for a qualitative and quantitative assessment of facility readiness for ENCR. The quality of essential newborn care provided to neonates immediately after birth and understanding existing knowledge, skills, aptitude, and practices of health providers were the focus of the facility visits. Data was collected on eight parameters [see box] covering 75 critical program indicators using the facility readiness tool. Assessment of facility readiness for newborn care was conducted at 600 delivery points across all 21 districts of Haryana from March 2013 to December 2013. Information was also gathered through interviews with labor room staff and observation of infrastructure and practices. Based on the findings, the ENCR readiness for each facility was scored. Facilities with an average score of <50% were color coded red indicating problem areas, scores of 50-79% were coded yellow as partial achievers, and facilities that scored above 80% were coded green and were designated as high achiever facilities.

Eight parameters of data collection

1. Infrastructure
2. Availability of newborn services
3. Human resources
4. Essential drugs and supplies
5. Protocols and guidelines for ENCR
6. Registers and client case record reviews
7. Infection prevention knowledge and practice
8. Health provider ENCR knowledge and practice

As part of supportive supervision, staff nurses were also oriented on essential newborn care practices using a “Neo Natalie” newborn simulator and job aids which were provided for display in the labor room. Towards the end of each visit, a de-briefing meeting was organized to share findings and recommendations with the Medical Officer In-Charge and other service providers. Together, an action plan for the facility was prepared. Facility reports of findings, recommendations, and the action plan were formally shared with the signature of the Mission Director. Facility heads were advised to report compliance within 30 days. Compliance reports were submitted when actions on all recommendations were accomplished. De-briefing meetings were also held with the Civil Surgeon, Deputy Civil Surgeon, and other district officials to enhance their support and involvement in improving the status of each facility.

Results and Actions

Analysis of baseline data from all 600 facilities revealed that facilities in 10 districts of Haryana scored less than 50%, the lowest performing included Naruaul (39%), Palwal (41%), and Sonipat (43%). Facilities in the districts of Hisar (61%), Rohtak (61%), and Jhajjar (60%) had higher ENCR readiness compared to other districts of Haryana.

As a result of the facility readiness assessment, various actions were taken by the facilities themselves and by the Government of Haryana.

The second round of assessment was initiated in January 2014 in five districts which scored

less than 50%. Improvement was reported in all five districts and their score increased to at or around 60% in all cases.



“Neo Natalie” newborn simulator

One example of dramatic improvement seen during the second round was Primary Health Centre Barwala, District Panchkula, where: the labor room was clean; staff nurses were using personnel protective equipment and had good knowledge of newborn care and use of bag and mask; baby sheets as well as paper for hand drying were sterilized; essential newborn care IEC materials were properly displayed; the newborn care corner and medicine cabinet were well organized; and all necessary drugs and supplies were available in appropriate quantities in the labor room.

Conclusion and Way Forward

Essential newborn care and resuscitation saves newborn lives. Facility readiness assessments, like those carried out in Haryana, help determine the capacity of health facilities to provide necessary care to mothers and their newborns and they establish a baseline that can be used in developing district and block action plans for improving newborn care. Applying the RAPID strategy and conducting multiple rounds of facility/program assessments empowers facility heads and district and state health officials with information and data to guide corrective actions.

Providing supportive supervision during facility visits improves the knowledge and skills of health providers and generates a

greater sense of responsibility to contribute towards improved newborn health and saving lives.

“Every child has the right to survive. In Haryana when a health facility can be reached in 15 minutes, then why should any child die in Haryana?” -Dr. Suresh Kumar Dalpath, Deputy Director - Child Health, Nutrition and Immunization, Government of Haryana

Moving forward, Haryana, through the state budget, plans to appoint a dedicated Child Health Coordinator for each District, who will

be trained in Navjaat Shishu Suraksha Karyakram (NSSK) and ENCR practices. The Coordinator will provide supportive supervision and mentoring support during follow-up visits conducted in three monthly intervals at each facility to ensure that ENCR skills are retained and strengthened and new facility norms are maintained. Also, a change in HR policy has been initiated to ensure non-rotation and retention of trained staff in each facility. ENCR will be integrated with regular facility assessment of maternal health and immunization.

MCHIP would like to thank Dr. Rakesh Gupta, Mission Director, NHM and Dr. Suresh Kumar Dalpath, Deputy Director, Child Health, Nutrition and Immunization, Government of Haryana.

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

Success Story: “RAPID” Implementation in Jharkhand

The immunization program in Jharkhand state in India has achieved tremendous improvements in service quality and coverage. There have been reductions in left outs and drop outs, leading to increased numbers of fully immunized children.

USAID/MCHIP (Maternal and Child Health Integrated Program) has supported Govt. of India in strengthening the Universal Immunization Program (UIP) through technical assistance that includes implementation of a supportive supervision and review approach, known as RAPID (Regular Appraisal of Program Implementation in a District), in Jharkhand state. The RAPID model, developed by MCHIP, helps program managers improve the quality of the immunization program and service delivery, focusing on: program management; cold chain, vaccine and logistics management; immunization safety and waste disposal; recording, reporting and use of data for action.



Figure: Dr. Gunjan, MCHIP Technical Officer, providing on-site orientation during RAPID activity

MCHIP developed standard tools and protocols for RAPID, which it compiled in a toolkit to introduce, plan, carry out, and maintain the activity over time.

The health officials trained as supervisors use this supportive supervision approach for periodically assessing the practices and infrastructure, suggest corrective actions, and support functionaries to effectively perform their duties according to program benchmarks.

This process has contributed to improved quality in immunization services after subsequent RAPID rounds. In Jharkhand,

facilities graduated from 36% poor, 55% average and only 9% good (during round 1) to 27% average and 73% good (during round 6). In addition, the approach has contributed to improved planning, leading to improved coverage as per the findings from the Coverage Evaluation Survey (CES) done by MCHIP in the respective districts.

The RAPID approach empowers the health managers to handle issues in an effective way to achieve improvement in coverage with quality.

Successful scale-up...

In an effort to achieve scale-up of RAPID, MCHIP shared the benefits of this approach with decision makers, donors and program managers. Since 2010, RAPID is implemented in all 24 districts of Jharkhand through government funds. In Uttar Pradesh, RAPID is implemented in 32 districts by UNICEF with the participation of Government Medical Colleges. Government of Haryana also implemented RAPID across all its districts with their own funds. It is also shared across the borders in Kenya, Tanzania, Uganda, Madagascar, DRC and Nigeria.

Annex 4: List of Presentations at International Conferences and Publications

| Document Title | Publication Date | Language | Personal Author | Authoring Organization | Type of Document | Intervention Area / Technical Team |
|--|------------------|----------|-------------------|-------------------------------|------------------|------------------------------------|
| Cross Learning Centers for Routine Immunization: Scaling Up Demonstration Sites with the Government in India | Feb-12 | English | Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Abstract | Immunization |
| Development of Demonstration Sites for Cold Chain Management | Dec-12 | English | Manish Jain | Jhpiego Corp, John Snow, Inc. | Abstract | Immunization |
| Improved Routine Immunization in Jharkhand State, India –The Value of Technical Assistance Validated Through Coverage Surveys | Feb-12 | English | Sachin Gupta | Jhpiego Corp, John Snow, Inc. | Abstract | Immunization |
| Improving Immunization Coverage by Increasing Birth Doses of OPV and BCG in Facility Births: Experiences from Select Districts in Jharkhand and Uttar Pradesh, India | Feb-12 | English | | Jhpiego Corp, John Snow, Inc. | Abstract | Immunization |
| RAPID as a Quality Improvement Model for Routine Immunization Services Through Partnership with Government: Experience from India | Feb-12 | English | Vijay Kiran | Jhpiego Corp, John Snow, Inc. | Abstract | Immunization |
| Strengthening Newborn Vaccination for Institutional Deliveries Experience from Uttar Pradesh | Dec-12 | English | Manish Jain | Jhpiego Corp, John Snow, Inc. | Abstract | Immunization |
| RAPID as a quality improvement model for routine Immunization services through partnership with government: experience from India | Dec-12 | English | Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Activity Brief | Immunization |
| RAPID as a Model of Fostering Partnerships for Effective Supervision of Routine Immunization for Improvement in Quality of Services: Experiences from India | Feb-12 | English | | Jhpiego Corp, John Snow, Inc. | Article | Immunization |
| Can Reduction in Vaccine Wastage Spare Financial Resources for Introduction of New and Expensive Vaccines? | Oct-13 | English | | Jhpiego Corp, John Snow, Inc. | Article | Immunization |

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| Addressing Equity and Reaching the Underserved and Unreached in India | Apr-12 | English | Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Conference proceeding | Immunization |
| Focused Technical Assistance Improves Coverage of Routine Immunization in Jharkhand/India | Mar-12 | English | Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Document | Immunization |
| Providing Technical Assistance for Focused Interventions in Routine Immunization and New Born Care in Jharkhand | Apr-12 | English | Gunjan Taneja | Jhpiego Corp, John Snow, Inc. | Document | Immunization |
| Use of 'My Village my Home' tool to optimize immunization coverage through community linkages | Oct-12 | English | Gunjan Taneja | Jhpiego Corp, John Snow, Inc. | Document | Immunization |
| MCHIP Immunization Support | Feb-13 | English | | Jhpiego Corp, John Snow, Inc. | Flyer | Immunization |
| MCHIP Immunization Support in Jharkhand | Jul-13 | English | | Jhpiego Corp, John Snow, Inc. | Flyer | Immunization |
| Assessment of Routine Immunization Services in Two Districts of the State of Jharkhand (India) | Jan-March 2011 | English | Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Journal Article | Immunization |
| Moving Forward With Strengthening Routine Immunization Delivery as Part of Measles and Rubella Elimination Activities | Apr-13 | English | | Jhpiego Corp, John Snow, Inc. | Journal Article | Immunization |
| Routine Immunization in India: A Perspective | Jun-13 | Hindi | Gunjan Taneja | Jhpiego Corp, John Snow, Inc. | Journal Article | Immunization |
| Good Immunization System at Jamtara | Dec-11 | Hindi | Dr. Sumant Mishra | Jhpiego Corp, John Snow, Inc. | Newspaper article | Immunization |
| Information on Cold Chain | Feb-12 | Hindi | Dr. S Tomar | Jhpiego Corp, John Snow, Inc. | Newspaper article | Immunization |
| Jamtara - An Immunization Model Centre | Dec-11 | Hindi | Dr. Sumant Mishra | Jhpiego Corp, John Snow, Inc. | Newspaper article | Immunization |
| Jamtara - A role Model for Immunization Centre | Jan-12 | Hindi | Dr. Sumant Mishra | Jhpiego Corp, John Snow, Inc. | Newspaper article | Immunization |
| Delivering the Immunization - Promise in India | 2012 | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |
| Establishing Demonstration Center for Cold Chain Management: Experience from Uttar Pradesh, India | 2012 | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |
| Establishing Demonstration Sites for Routine Immunization | Apr-13 | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |
| Expanding Immunization Coverage to Protect Children in India | 2011 | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |

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|--|------------------------|---------|--|-------------------------------|-------------|--------------|
| Immunization Challenges Presented at World Federation of Public Health Associations | | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |
| Indian Officials Visit MCHIP Immunization and Newborn Care Demonstration Sites | 2012 | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |
| Pentavalent Vaccine and It's Introduction in the Universal Immunization Program in India | Oct-09 | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |
| Pentavalent Vaccine- Guide for Health Workers | Jul-05 | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |
| Demonstration Site Success Story | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |
| Demonstration Site Synopsis | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |
| RAPID Case Study: Supportive Supervision Towards Improved Performance and Quality of Services | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |
| RAPID Synopsis: RAPID for Immunization | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |
| MVMH Success Story: Where Every Child Vaccinated is a Building Block | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |
| MVMH Synopsis: Tool for Improving Immunization Coverage | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |
| Newborn Vaccination Success Story: The First and Foremost Ritual | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |
| Newborn Vaccination Synopsis: The High Impact Intervention Institutionalizing Newborn Vaccination | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Publication | Immunization |
| RMNCH+A Process Document (Case Study of Global Call to Action to Present) | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Publication | RMNCH+A |
| RMNCH+A Highlight Story: Capacity Building to Reduce Neonatal Mortality: On-site Training in Uttarakhand | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Publication | RMNCH+A |

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| RMNCH+A Highlight Story: Improving RMNCH+A interventions: Block Monitoring in Lohardaga District, Jharkhand | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Publication | RMNCH+A |
| RMNCH+A Highlight Story: Using Data for Action: Scorecards and Dashboards to Improve Maternal and Child Health in Jharkhand | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Publication | RMNCH+A |
| RMNCH+A Highlight Story: Strengthening Essential Newborn Care: Facility Readiness and Supportive Supervision in Haryana | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Publication | RMNCH+A |
| RMNCH+A Highlight Story: Corrective Action for Improved Service Delivery: Rapid Assessment in Uttarakhand | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Publication | RMNCH+A |
| RMNCH+A Highlight Story: Translating Strategy into Action: MCH Action Plan in Punjab | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Publication | RMNCH+A |
| State Profile: Uttarkhand | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Publication | MCHIP India |
| State Profile: Haryana | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Publication | MCHIP India |
| State Profile: Punjab | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Publication | MCHIP India |
| State Profile: Uttar Pradesh | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Publication | MCHIP India |
| State Profile: Delhi | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Publication | MCHIP India |
| State Profile: Jharkhand | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Publication | MCHIP India |
| State Profile: Himachal Pradesh | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Publication | MCHIP India |
| MCHIP India End of Project Report | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Report | MCHIP India |
| An Index of Job Aids and Tools Developed by the MCHIP India Immunization Team | 1/1/2012 | English | Manish | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| Establishing Demonstration Center for Cold Chain Management: Experience from Uttar Pradesh, India | 1/1/2012 | English | Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Website | Immunization |

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|--|---------------|---------|-------------------|-------------------------------|---------|--------------|
| Establishing Model Routine immunization demonstration center - Experience from Jharkhand India | 1/1/2012 | English | Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| Jharkhand Immunization Success - Power of Partnerships: A Case Study | 2012 | English | | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| MCHIP India Immunization Team Facilitates Orientation and Demonstrations | 2012 | English | | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| MCHIP Work in Routine Immunization Appreciated at National Level in India | 2012 | English | | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| RAPID as a Quality Improvement Model for Routine Immunization Services | 2012 | English | | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| Using Supportive Supervision at Scale in India to Improve Immunization Coverage | 2/1/2012 | English | Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| Can Reduction in Vaccine Wastage Spare Financial Resources for Introduction of New and Expensive Vaccines? | Oct-13 | English | | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| Review of Vaccine Wastage at Rural Primary Health Care Facilities in Three Districts of Uttar Pradesh | 2012 | English | | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| Strengthening and Scale-Up of Nationwide Mother and Child Tracking System (MCTS) Through TEN | Feb-14 | English | | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| Tracking Every Newborn Initiative for Timely Start of Vaccination and Tracking Beneficiaries in Identified Subcenter Areas | Dec-13 | English | | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| Institutionalizing New Born Vaccination Experience from Uttar Pradesh and Jharkhand | Jan-14 | English | | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| 0' OPV and BCG to a newborn in a district hospital | Oct-11 | English | Narayana Holla | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| Immunization Ready Reckoner for Health Workers | Sep-11 | English | Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| Improving UIP in India : Concept note | August 2011 | English | Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| Open vial use (Operational Guidelines) | November 2011 | English | Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| Open Vial Use (operational guidelines); Deaths Due to Vaccination Need Intense Investigations in India | July 2011 | English | Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Website | Immunization |

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|---|------------------------|---------|---|---------------------------------------|---------------|-----------------|
| PHCCHC-level-microplanning-tool-for-immunization | January 2012 | English | Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| Vaccine Wastage | January 2012 | English | Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| Keeping Vaccines in the ILR at PHC/CHCs | Jun-11 | English | Narayana Holla, Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Website | Immunization |
| Evaluation of systematic screening for family planning services among postpartum women attending community-based child immunization and nutrition days in Jharkhand | Anticipated: July 2014 | English | | Jhpiego Corp | Article | Family Planning |
| BA Newborns Cohort Analysis Lessons from India GNHC Presentation | 13-Apr | Eng | Dr. Anju Puri | Jhpiego Coporation, Save the Children | Presentation | Newborn |
| RAPID Support Supervision Approach to Improved ENC in Haryana India | 14-Apr | Eng | Dr Rakesh Gupta, Dr Suresh Kumar Dalpath, Dr Pawan Pathak | Jhpiego Coporation, Save the Children | Presentation | Newborn |
| Outcomes from revitalization of PPIUCD services in India Figo Conference - October 2012 | 12-Oct | Eng | | Jhpiego Corp | Presentation | Family Planning |
| National Perspective of PPF/PPIUCD programming | 12-Dec | Eng | | Jhpiego Corp | Presentation | Family Planning |
| PPFP and PPIUCD Services in India | 13-Sep | Eng | | Jhpiego Corp | Presentation | Family Planning |
| Improving PPF through Supportive Supervision | 13-Oct | Eng | | Jhpiego Corp | Presentation | Family Planning |
| Strengthening PSE and PPF | 13-Dec | Eng | | Jhpiego Corp | Presentation | Family Planning |
| The Ins and Outs of PPIUCD Experience from India | 13-Nov | Eng | | Jhpiego Corp | Presentation | Family Planning |
| PPFP Counseling Presentations for UP & Uttarakhand | 11-Sep | Eng | | Jhpiego Corporation | Presentations | Family Planning |
| PPFP Counseling Presentations for UP & Uttarakhand-Hindi | 11-Sep | Hindi | | Jhpiego Corporation | Presentations | Family Planning |
| Clinical Standards for Improving Quality of MNC | 12-Apr | Eng | | Jhpiego Corp | Poster | Family Planning |
| Scaling Up PPIUCD in india | 12-Sep | Eng | | Jhpiego Corp | Poster | Family Planning |
| Infection Prevention in PPIUCD Services | 11-Oct | Eng | | Jhpiego Corp | Poster | Family Planning |
| Strengthening Pre-Service Nursing and Midwifery Education Ambassador's visit | 13-Oct | Eng | Dr. Bulbul Sood | Jhpiego Corporation | Presentation | PSE |
| PPH Workshop Presentation | 13-Dec | Eng | Vikas Dwivedi | Jhpiego Corporation | Presentation | PSE |

Annex 5: List of Materials and Tools Developed /Adapted by the Program

| Document Title | Publication Date | Language | Personal Author | Authoring Organization | Type of Document | Intervention area / Technical Team |
|---|------------------------|----------|-----------------------|-------------------------------|------------------|------------------------------------|
| Immunization Ready Reference for Health Workers | Sep-11 | English | Dr. Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Handbook | Immunization |
| Year of Intensification of RI-Immunization Ready Reference Guide for Health Workers 2012-2013 | Sep-11 | English | Karan Singh Sagar | Jhpiego Corp, John Snow, Inc. | Handbook | Immunization |
| AEFI Surellience and Response Operational Guidelines | 2010 | English | | Jhpiego Corp, John Snow, Inc. | Job Aid | Immunization |
| Facilitators' Guide: Immunization Handbook for Health Workers | 2011 | English | | Jhpiego Corp, John Snow, Inc. | Job Aid | Immunization |
| Handbook for Vaccine and Cold Chain Handlers | 2011 | English | | Jhpiego Corp, John Snow, Inc. | Job Aid | Immunization |
| Immunization Handbook for Medical Officers | 2009 | English | | Jhpiego Corp, John Snow, Inc. | Job Aid | Immunization |
| Measles Catch Up Immunization Campaign-Guidelines for Planning and Implementation | 6/1/2010 | English | | Jhpiego Corp, John Snow, Inc. | Job Aid | Immunization |
| Operational Guidelines for Hepatitis B Vaccine in Universal Immunization Programme | 2009 | English | | Jhpiego Corp, John Snow, Inc. | Job Aid | Immunization |
| Demonstration Site Manual | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Job Aid | Immunization |
| RAPID Success Story: RAPID Implementation in Jharkhand | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Job Aid | Immunization |
| RAPID Guidelines | Jul-14 | English | | Jhpiego Corp, John Snow, Inc. | Job Aid | Immunization |
| MVMH Manual: A Tool to Optimize Immunization Coverage | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Job Aid | Immunization |

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|---|---------------------------|---------|---------------|---|-------------------------|--------------|
| Newborn Vaccination Manual: A High Impact Intervention | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Job Aide | Immunization |
| Establishing Demonstration Centers for Routine Immunization in Jharkhand | Feb-13 | Hindi | Gunjan Taneja | Jhpiego Corp, John Snow, Inc. | Presentation/ Poster | Immunization |
| RAPID: A Supportive Supervision Model for Improving Quality of Immunization Service | Dec-12 | English | | Jhpiego Corp, John Snow, Inc. | Presentation/ Poster | Immunization |
| Demonstration Site Video | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Video | Immunization |
| RAPID Video | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Video | Immunization |
| MVMH Video | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Video | Immunization |
| Newborn Vaccination Video | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Video | Immunization |
| RMNCH+A Call to Action Animation Story Video | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Video | RMNCH+A |
| RMNCH+A Lifecycle Video | Anticipated: July 2014 | English | | Jhpiego Corp, John Snow, Inc. | Video | RMNCH+A |
| Newborn Care Flyer Call to Action Summit Mahabalipuram | 13-Feb | Eng | | Jhpiego Coperation, Save the Children | Flyer | Newborn |

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| Facility Assessment of Newborn Care Data Collector Manual | 11-Oct | Eng | | Jhpiego Coporation, Save the Children | Manual | Newborn |
| Neonatal Verbal Autopsy Interviewer's Manual | 12-Feb | Eng | | Jhpiego Coporation, Save the Children | Manual | Newborn |
| ENCR Protocols for Practice | 12-Jan | Eng | | Jhpiego Coporation, Save the Children | Manual | Newborn |
| Resuscitation Action Plan (Hindi) | 11-Oct | Hindi | | Jhpiego Coporation, Save the Children | Job aid | Newborn |
| Steps for Sequencing Newborn Care | 11-Oct | Eng | | Jhpiego Coporation, Save the Children | Job aid | Newborn |
| ENC Protocols Job Aid | 11-Oct | Eng | | Jhpiego Coporation, Save the Children | Job aid | Newborn |
| NSSK Training Quality Assessment Checklist | 11-Mar | Eng | | Jhpiego Coporation, Save the Children | Checklist | Newborn |
| Facility Readiness for Newborn Care Assessment Tool | 10-Oct | Eng | | Jhpiego Coporation, Save the Children | Checklist | Newborn |
| Neonatal Verbal Autopsy Checklist | 11-Dec | Eng | | Jhpiego Coporation, Save the Children | Checklist | Newborn |
| Facility Based Newborn Care Operational Training Guidelines | 5-Jul | Eng | | Jhpiego Coporation, Save the Children | National Guidelines | Newborn |
| Operational Guidelines Use of Gentamicin by ANMs for Management of Sepsis | 14-Feb | Eng | | Jhpiego Coporation, Save the Children | National Guidelines | Newborn |
| MCH Action Plan Punjab 2014-2017 | 13-Dec | Eng | | Jhpiego Coporation, Save the Children | Action Plan | Newborn |
| PPFP Counseling Reference Manual Hindi | 13-Jan | Hindi | Sastwai Das | Jhpiego | Manual | Family Planning |

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| PPFP Counseling Facilitator Guide Hindi | 11-Dec | Hindi | Saswati Das | Jhpiego Corporation | Manual | Family Planning |
| PPFP Counseling presentations | 11-Dec | Hindi | | Jhpiego Corporation | Job Aide | Family Planning |
| PPFP Effectiveness Chart | 9-Nov | Eng | | Jhpiego Corporation | | Family Planning |
| ANC Counseling Guide Hindi | 9-Nov | Hindi | | Jhpiego Corporation | Manual | Family Planning |
| CTU Facilitators Guide | 13-Dec | Hindi | Dr. Rashmi Asif | Jhpiego Corporation | Manual | Family Planning |
| CTU Participant Handout | 10-Dec | Hindi | | Jhpiego Corporation | Job Aide | Family Planning |
| Commodity Storage Reference Manual Hindi | 11-Apr | Hindi | Dr. Vineet Srivastava | Jhpiego Corporation | Manual | Family Planning |
| Commodity Storage Facilitators Guide Hindi | 11-Apr | Hindi | Dr. Vineet Srivastava | Jhpiego Corporation | Manual | Family Planning |
| Commodity Storage Presentations Hindi | 11-Apr | Hindi | | Jhpiego Corporation | Training Material | Family Planning |
| PPIUCD Reference Manual | 13-Jan | Eng | | Jhpiego Corporation | Manual | Family Planning |
| PPIUCD Reference Manual_Hindi | 13-Jan | Hindi | | Jhpiego Corporation | Manual | Family Planning |
| PPIUCD Facilitator's Guide | 11-Feb | Eng | | Jhpiego Corporation | Manual | Family Planning |
| PPIUCD Facilitator's Guide_Hindi | 13-Jan | Hindi | | Jhpiego Corporation | Manual | Family Planning |
| PPIUCD Presentation | 11-Mar | Eng | | Jhpiego Corporation | Training Material | Family Planning |
| PPIUCD Presentations_Hindi | 11-Apr | Hindi | | Jhpiego Corporation | Training Material | Family Planning |
| PPIUCD Pre-Insertion Screening | 11-Apr | Eng | | Jhpiego Corporation | Job Aide | Family Planning |
| ANC Counseling Guide Family Planning | 11-Mar | Eng | | Jhpiego Corporation | Job Aide | Family Planning |
| FP ANC Counseling Guide Hindi | 11-Aug | Hindi | | Jhpiego Corporation | Manual | Family Planning |

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| PPIUCD Insertion Steps | 11-Apr | Eng | | | | Family Planning |
| PPIUCD Insertion Steps Hindi | 11-Apr | Hindi | | Jhpiego Corporation | Job Aide | Family Planning |
| Saathiya Leaflet | 11-Sep | Eng | Dr. Ravi | Jhpiego Corporation | Job Aide | Family Planning |
| Saathiya Leaflet-Hindi | 11-Sep | Hindi | Dr. Ravi | Jhpiego Corporation | Job Aide | Family Planning |
| Saathiya Poster | 11-Sep | Eng | | Jhpiego Corporation | Job Aide | Family Planning |
| Saathiya Poster-Hindi | 11-Sep | Hindi | | Jhpiego Corporation | Job Aide | Family Planning |
| Performance Standards for PPFPP Counseling for Private Health Sector Providers | 11-Sep | Eng | | Jhpiego Corporation | Standards | Family Planning |
| PPIUCD Performance Standards for Public Health | 12-May | Eng | | Jhpiego Corporation | Standards | Family Planning |
| IP and IPP QoC Standards | 13-Oct | Eng | | Jhpiego Corporation | Standards | Family Planning |
| Leaflet on PPIUCD for Providers | 14-Mar | Eng | | Jhpiego Corporation | Job Aide | Family Planning |
| Leaflet back to back hindi | 13-Sep | Hindi | | Jhpiego Corporation | Job Aide | Family Planning |
| PPFP Fact Sheet | 13-Oct | Eng | | Jhpiego Corporation | Fact Sheet | Family Planning |
| PNC Poster Hindi | 13-Sep | Hindi | | Jhpiego Corporation | Job Aide | Family Planning |
| IUCD Client Card Gol | 13-Sep | Eng | | Jhpiego Corporation | Job Aide | Family Planning |
| IUCD Client Card Gol Hindi | 13-Sep | Hindi | | Jhpiego Corporation | Job Aide | Family Planning |
| PPIUCD Insertion Register | 12-Dec | Eng | | Jhpiego Corporation | Job Aide | Family Planning |
| PPIUCD Follow-up Register | 12-Dec | Eng | | Jhpiego Corporation | Job Aide | Family Planning |
| Monthly PPFPP PPIUCD Service Report | 12-Dec | Eng | | Jhpiego Corporation | Job Aide | Family Planning |
| Operational Guidelines and Reference Manual for Misoprostol for PPH | 14-Mar | Eng | Dr. Somesh/Dr. Rashmi | Jhpiego Corporation | Training Material | Maternal Health |

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| Operational Guidelines and Reference Manual for Misoprostol for PPH-Hindi | 14-Mar | Hindi | Dr. Rashmi Asif | Jhpiego Corporation | Training Material | Maternal Health |
| Facilitators Handbook for Misoprostol | 14-Mar | Hindi | Dr. Rashmi Asif | Jhpiego Corporation | Training Material | Maternal Health |
| Job-aides and handouts | 14-Mar | Hindi | Dr. Rashmi Asif | Jhpiego Corporation | Job Aide/Handouts | Maternal Health |
| Recording and Reporting Formats | 14-Mar | Hindi | Dr. Rashmi Asif | Jhpiego Corporation | Formats | Maternal Health |
| Training Formats | 14-Mar | Hindi | Dr. Rashmi Asif | Jhpiego Corporation | Formats | Maternal Health |
| 6 weeks LRP Facilitators Guide PSE | 12-Mar | Eng | | Jhpiego Corporation | Manual | PSE |
| 6 weeks LRP Participants Handbook PSE | 12-Mar | Eng | | Jhpiego Corporation | Manual | PSE |
| 6 week LRP Computer Presentation | 12-Mar | Eng | | Jhpiego Corporation | Training Material | PSE |
| 6 week LRP ETS Presentation | 12-Mar | Eng | | Jhpiego Corporation | Training Material | PSE |
| 6 week LRP SMBR Presentation | 12-Mar | Eng | | Jhpiego Corporation | Training Material | PSE |
| 6 week LRP beenfits of FP | 12-Mar | Eng | | Jhpiego Corporation | Training Material | PSE |
| 6 Week LRP FP Counseling | 12-Mar | Eng | | Jhpiego Corporation | Training Material | PSE |
| 6 week LRP week one | Mach 2011 | Eng | | Jhpiego Corporation | Training Material | PSE |
| 6 weeks LRP Participants Handbook | 14-Mar | Hindi | Dr. Rashmi/Dr. Sunita | Jhpiego Corporation | Training Material | PSE |
| 6 weeks LRP Facilitators Guide | 14-Mar | Hindi | Dr. Rashmi/Dr. Sunita | Jhpiego Corporation | Training Material | PSE |
| Presentations for 6 weeks | 14-Mar | Hindi | Princy/Dr. Sunita | Jhpiego Corporation | Presentations | PSE |
| ToT of NNCs Facilitators Guide | 11-Nov | Eng | | Jhpiego Corporation | Manual | PSE |
| Guidelines for conducting ANM's Examination | 13-Aug | Eng | | Jhpiego Corporation | Job Aide | PSE |

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| Operational Guidelines-Strengthening PSE for the Nursing and Midwifery Cadre in India | 13-Jan | Eng | | Jhpiego Corporation | Job Aide | PSE |
| OSCE Assessment and answer key | 13-Oct | Eng | | Jhpiego Corporation | Job Aide | PSE |
| OSCE Assessment and Answer Key_Hindi | 13-Oct | Hindi | | Jhpiego Corporation | Job Aide | PSE |
| Performance Standards for ANM, NNC, SNC | 14-Apr | Eng | | Jhpiego Corporation | Job Aide | PSE |
| Report of Orientation Workshop for State Nursing Program Managers | 13-Jan | Eng | | Jhpiego Corporation | Report | PSE |
| PSE Fact Sheet | 13-Oct | Eng | | Jhpiego Corporation | Fact Sheet | PSE |