India’s annual birth rate stands at about 26 million, but nearly a million babies die before they even reach one month of age. As the neonatal period is only 28 days, neonatal mortality contributes about two thirds of all infant deaths (IMR 50, SRS 2009) and about half of all deaths (U5MR 69, SRS 2008) in children under age 5 years.

India has been steadily reducing its infant mortality rate from 58 per thousand live births in 2004 to 50 per thousand live births in 2009. But there is less impact on the reduction of neonatal mortality which fell from 37 in 2004 to only 35 in 2008. Mortalities during in the first seven days of an infant’s life have shown the least progress.

Given these trends, Government of India has come to appreciate that to meet its Millennium Development Goal (MDG) obligations, more effort is needed to reduce Neonatal Mortality, especially in the initial 7 days of life. With the advent of the Janani Suraksha Yojana (JSY) scheme greater numbers of babies are being delivered at health facilities. This has increased the burden on medical staff, who not only must deal with larger volumes of mothers and babies, but staff are also encouraged to keep mothers and babies in the facility for at least 48 hours.

Norway India Partnership Initiative (NIPI) through the National Rural Health Mission (NRHM) aims to reduce neonatal mortality by working along the continuum of care, strengthening newborn and related maternal health to provide technical assistance where required and also to provide catalytic funding for approved innovations. The continuum of care involves maintaining health care both at the community and facility levels to ensure linking across the crucial times of care giving as well as linking across the places where care is delivered. Linking interventions in this way is essential because it can minimise health related expenditure by allowing increased efficiency, increased absorption of mothers and babies into the system, and offers opportunities for promoting associated healthcare matters e.g. newborn, postnatal and postpartum care.

NIPI channels funds from the donor, the Government of Norway through NRHM and three UN agencies viz. UNOPS, WHO and UNICEF. The strategic focus of NIPI consists of three main areas of:

- Quality services for mother and child
- Enabling mechanisms
- Learning and sharing

Since 2009, NIPI has been catalyzing NRHM with a special focus on:

- Community based care
- Facility based care
- Immunization

The implementation of Integrated Management of Neonatal and Childhood Illness (IMNCI) and Home Based Psot Newborn Care (HBPNC) have increased health monitoring coverage of mothers and newborns in their own communities. Recent research conducted by Public Health Foundation of India (PHFI) on NIPI interventions suggested bringing these aspects of health care together, facility and community, to improve referral systems and follow up post discharge, in order that the continuum of care is maintained has a significant impact on infant survivability.
The combined benefits of Yashoda (facility based maternal assistants) and ASHA (Community based health activists) on newborn care showed that the dual exposure of mothers to both Yashoda and NIPI trained ASHA had an incremental effect on newborn care indicators, in both counselling and practice. For example, mothers in one NIPI focus district were three times more likely to have received counselling on keeping the baby warm compared to mothers in the control district. Similarly, birth registration was two and a half times greater among mothers who had dual exposure to Yashoda and ASHAs in the same focus district compared to mothers in control districts. These results suggest that NIPI interventions on the whole have resulted in improved information among mothers and better outcomes for the newborn.

Simply promoting facility-based newborn care has significant potential to improve newborn survival. In another study the Lancet estimates that health-facility based interventions can reduce neonatal mortality by as much as 25-30% (Lancet 365:977-88).

If NIPI is to assist Government of India to achieve national health targets and Millennium Development Goals to bring down childhood mortality, it will remain committed to finding ways to make existing health systems function so as to improve quality new born care services and provide quality health care for women, infants and young children under the NRHM and its reproductive and child health program (RCH II).

**RESULTS REPORTING FOR 2011**

*The Annual Report for the year 2011 is being presented along the results based framework.*
UNOPS LFA PROGRAMME

ACTIVITIES FOR YEAR 2011

UNOPS LFA undertook a number of activities in the year 2011. The highlights for the year 2011 included the following:

Yashodas
- An annual assessment of YASHODAs was conducted in Dhenkanal, Ganjam, Jagatsinghpur & Mayurbhanj Districts of Orissa in 2011.
- Thematic training of Yashodas was started in Rajasthan by Breastfeeding Promotion Network of India (BPNI)

Home Based Post Natal Care (HBPNC) & Mobile Money Transfer (MMT)
- Five days HBPNC training has been completed in the States of Rajasthan and Orissa
- HBPNC software capturing home visits undertaken by Accredited Social Health Activists (ASHAs) has been completed and orientation of the Data Entry Operators (DEOs) undertaken
- Supportive supervision for HBPNC programme has made headway through a Third Party in the States of Bihar, Orissa and Rajasthan
- Development of MMT Implementation manual and video documentation for advocacy has been completed

Sick NewBorn Care Units (SNCUs) & Routine Immunisation
- Capacity building of Paediatricians and Nurses of SNCUs from the States of Orissa and Madhya Pradesh has been completed. The training has been provided by Institute of Post Graduate Medical Education and Research (IPGMER)
- Development of training materials for ANM/Nurses to work in Newborn Stabilization Units
- Development of training materials for managers in monitoring of Routine Immunizations
- Training of health managers in monitoring of Routine Immunization
- Setting up of the Hoshangabad SNCU as ‘Training and Treatment Centre’
- Establishment of Level II SNCU in Narsinhapur District, Madhya Pradesh
- Model cold chain store established in Hoshangabad District, Madhya Pradesh

Techno-Managerial Support
- Training Child health managers in Routine Immunisation monitoring conducted

District Training Centres (DTCs)
- Supported the establishment of District Training Centres in the State of Bihar
- A survey on public private partnership for child health care services was conducted by Health Access International in the State of Bihar
- An MoU was signed between JHPIEGO and the SHS Bihar for the improvement of quality of pre service nursing education in 19 ANM training centres, 6 GNM schools of nursing along with one nursing college

OUTPUTS

The resulting outputs of the above mentioned activities are illustrated below:
By the end of the year 2011, 8037 ASHAs have been trained on HBPNC 5 days’ package in the States of Rajasthan and Orissa. 60 batches of the 5 days training has been completed under the supervision of the State Institute of Health and Family Welfare, Rajasthan.

For real time information to be available, HBPNC has been developed. In order to address the issue of poor connectivity at Block level, an offline version of the software has also been developed. Around 120 Data Entry Operators (DEOs) have undergone an orientation and sensitization workshops across 9 NIPI focus Districts in the States of Rajasthan, Orissa and Bihar.

An SNCU-Toolkit and 3D videos focusing on SNCUs have been developed. Immunization modules for the Programme Managers have been developed.

Uniform standardised registers for the ANMs, AWWs and ASHAs in the context of routine immunization have been developed and printed to be used in Narsinhpur District, Madhya Pradesh. 10,000 Booklets on Routine Immunization for ANMs, ASHAs and Yashodas were printed.

All MCH Coordinators in NIPI Supported Districts of Orissa have been trained. Supportive supervision has been initiated for the MCH Coordinators in Orissa.

Approx 82,247 mothers and newborns have been provided counselling & care at health facilities by 362 Yashodas in 13 NIPI districts.

**INTERMEDIATE OUTCOMES**

In 2011, approx 203,983 mother newborn dyads were provided PNC visits by 13,572 ASHAs. Based on the population covered by ASHA, over all PNC coverage was 76%. On an average each ASHA has covered 15 mothers -newborn in a year.

Some success stories from the field are captured below.

**Story 1**

**QUALITY OF HEALTH SERVICES: IMPROVED COLD CHAIN STORES AND PRACTICES: HOSHANGABAD, MADHYA PRADESH, INDIA**

Better vaccine storage system for improvement in vaccine quality.

Experience in Hoshangabad district of Madhya Pradesh has shown that it is possible to upgrade and maintain a world-class vaccine and cold chain store at district level in India.

UNOPS-LFA provided technical assistance and catalytic resource support to the overall NRHM budget. This led to District health officials and managers transforming the Hoshangabad district vaccine store into one of the best district level cold chain and vaccine store in the country. NIPI UNOPS contributed by design support, capacity building and facilitating the organization of the district cold chain store.

Some of the features of the district vaccine store include the following:
• A well organized warehouse with separate functional areas for vaccine storage, dry space, repair workstation, office space and document archival room.

• Infrastructure and equipment are in place for easy access, loading, unloading of supplies, back-up power supply, provision for safety from fire and other hazards.

• Trained personnel are available for vaccine and cold chain management, supervision of field cold chain stores, carrying out repairs and undertaking record keeping and documentation. During leaves or absence, other staffs are trained and act as back-up.

• The best practices for vaccine arrival, storage, transportation, handling, distribution and record keeping are followed at this store.

• Display of job aids, stock positions, vaccine distribution route maps, immunization session rosters, emergency plans and program monitoring charts.

After the completion of the work, an Essential Vaccine Management assessment was undertaken by immunization partners in Madhya Pradesh. Hoshangabad district vaccine store scored high on the 9 global indicators (Vaccine Arrival Procedures, Vaccine Storage Temperature, Cold and Dry Storage Capacity, Infrastructure: Building, Cold Chain Equipment, Maintenance of Infrastructure, Stock Management, Distribution, Vaccine Management, Information System and Supportive function).
ENABLING MECHANISMS: MOBILE MONEY TRANSFER FOR ASHA

TIMELY AND RELIABLE PAYMENTS TO ASHA; HELPING IN IMPROVING EFFICIENCY OF THE HEALTH SYSTEM:

ASHA is the community link worker reaching out to mothers and newborns in rural India with Home Based Past Natal Care for NIPI and other health services under the NRHM. She has undergone training and is entitled to performance incentive payments. However, the State Health Society Bihar was confronted with issues related to payments such as:

1. Inconsistencies, irregularities and delays in payments resulting in lack of motivation and commitment amongst ASHAs
2. Administrative burden related to distribution of payments
3. Lack of systematic recording of payments to ASHA for various activities.

UNOPS-LFA initiated a pilot project towards timely payments of ASHA worker’s incentives in Sheikhpura district of Bihar using Mobile Money Transfer (MMT) system. The project is steered by State Health Society Bihar (SHSB), with technical support from Eko Aspire Foundation (Business Correspondent) and State Bank of India (SBI) and with funding and support from UNOPS-LFA Programs. The changes in the payment system also addresses the other accounting issues and lead to overall improvements in efficiency, transparency and overview of funds and activities in the blocks.

Benefits and improvements in the Health System from using the MMT system:

ASHA receives timely and reliable payments for the schemes she participates in. In addition, the new systems and the processes developed to ensure payment to ASHAs was seen as having additional benefits:

- Increased transparency and accountability
- Improved overview of ASHA activities and payments – tracking ASHAs and identification of inactive workers.
- Improved efficiency
- Standardized accounting saves time and effort.
- Female empowerment through financial inclusion. ASHAs average monthly income has increased by 60% from Rs. 1265 to Rs. 2012 in one year. 75% of ASHAs are keeping savings in their accounts.

Since December 2010 more than Rs. 90 Lakhs incentive payments has been distributed to the ASHAs in the district. Based on the experience from the pilot the intervention is being expanded to 6 other districts; Nalanda, Jehanabad, Rothas, Vaishali, Bhagalpur and Samastipur.
LEARNING AND SHARING: COMPREHENSIVE NEWBORN CARE PACKAGE OF NIPI TO BE IMPLEMENTED STATEWIDE IN HARYANA

UNOPS-LFA district based newborn care package along the continuum of care advocates for reducing the neonatal mortality by providing optimal care to newborn at home through ASHAs and at facility through a birth companion & mother’s aid named Yashoda and care of sick newborns through SNCU chain.

The learning & sharing of the aforementioned concept resulted in it being adopted by Government of Haryana for statewide implementation in 2011 with technical support from UNOPS-NIPI & NNF. The partnership between Government of Haryana, NNF & UNOPS-NIPI officiated through a Memorandum of Agreement in December 2011 in which UNOPS-LFA and NNF as agreed to provide the Newborn Care related technical assistance by extending educational, training and operational documents and trainings.

UNOPS-LFA with help from NNF have successfully facilitated establishment of a team of State level trainers on HBPNC & Yashoda in Haryana, who are skilling ASHAs & Yashodas respectively.

Till date around 12000 ASHAs have been imparted initial 2 day Home Based Post Natal Care training. Yashoda scheme in Haryana have envisaged placement of 148 Yashodas in 21 district hospitals and their 5 days training will be completed by end of April 2012.

UNOPS-LFA has also facilitated Govt of Haryana to access NNF’s expertise for capacity building of their SNCU staff and till date 144 SNCU staff across 6 districts have been trained in Facility Based Newborn Care.

Documentation and Publications

- Technical report submitted to MoHFW on “Operational Status of Special Newborn Care Units (SNCUs) in India”
- Online Catalogue of “Repository on Maternal Child Health”
- E-learning modules for Programme Managers on Immunization
- Monitoring and assessment of Facility-based Newborn Care (FBNC) in coordination with Child Health division of MoHFW
UNICEF undertook a number of activities in the year 2011. Key activities for the year 2011 were:

**Routine Immunization**
- Supported implementation of the campaign for Measles second dose in 150 districts of India
- Development of training material for Cold Chain handlers
- Cold chain and vaccine management assessments at State/ Districts stores
- Capacity building of program managers for vaccine and cold chain management
- Established National Cold Chain and Vaccine Management Resource Centre
- Development of Communication strategy and material for immunization
- Training of Trainers (ToT) for the cold chain handlers facilitated across the State of Bihar
- In collaboration with Medical colleges, a total of 173 vaccine storage points were visited for assessment of Cold chain equipment management and vaccine & logistic management practices
- Supported training of 150 master trainers for training of cold chain handlers in the State of Madhya Pradesh
- Review of cold chain technicians of all 30 districts completed in the State of Orissa. Review of district and regional vaccine and logistics managers of all 30 districts has also been completed. Cold chain handlers trained in 30 districts across the State leveraging NRHM resources. Cold Chain inventory compiled in the State of Orissa

**Community Based NewBorn and Child Care**
- IMNCI monitoring system is in place in collaboration with PGIMER, Chandigarh
- Harmonized IMNCI with community based newborn and childcare provided by ASHAs (IMNCI Plus)
- In the State of Bihar, a pool of 103 district ToTs created in 9 new IMNCI districts.
- Capacity building of District ASHA Coordinators, Block ASHA Facilitators & PHC ASHA Supervisors for providing supportive supervision to ASHAs for implementing IMNCI has been undertaken in the State of Rajasthan
- CCSP-Supportive Supervision being implemented in 5 districts of the State of Uttar Pradesh
- Field monitoring of IMNCI and VHND implementations by IMNCI and Child Health coordinators in 18 districts completed
- Developed institutional partnership with PHFI, KIMS Medical college & MKCG Medical college for strengthening in-service IMNCI implementing, training and monitoring in the State of Orissa
- Three institutional partnerships with medical colleges forged for strengthened field monitoring of the IMNCI program

**Facility Based NewBorn Care**
- SNCU collaborative centres conducted 10 batches of observership for SNCU staff from NIPI focus States
- Mentoring visits performed in health facilities across Orissa, Rajasthan, and Madhya Pradesh
• In the State of Bihar, process of operationalization of 26 SCNU has been initiated
• Training undertaken of 46 Doctors and Nursing staff from 8 Community Health Centres (CHCs) located in Southern Rajasthan
• Supported the setting up of Newborn Care Corners across 5 Districts of Rajasthan
• Technical support provided to the State Government of Madhya Pradesh for scale up at ground level of SNCUs through periodic field visits for site assessment, planning and designing of individual units, monitoring progress of work and resolving bottlenecks in operationalization by coordinating with State. Resulted in operationalisation of 5 more units in 2011 with the total number increasing to 32
• SCNU software piloted in Guna and Shivpuri Districts in 2010 has been adopted under NRHM for State wide replication across all units
• Support has been provided for the establishment of 3 units in Medical Colleges to function as training resource centre in the State of Orissa
• Facility based Integrated Management of Neonatal and Childhood Illnesses (F-IMNCI) has been rolled out in the State of Orissa

**District and Block Planning, Management and Support**

• Capacity building workshop undertaken for mid-managers and Faculty from Medical Colleges on child health with support from WHO and School of Public Health, PGIMER, Chandigarh
• In the State of Uttar Pradesh, UNICEF has supported the development of District Programme Implementation Plans (PIPs) across 18 Divisional HQ Districts. Evidence based child survival interventions have been included in the District PIPs
• Techno managerial support has been provided to the Divisional and District Health officials in the State of Uttar Pradesh by way of placement of 18 Divisional Consultants along with Data Assistants
• In the State of Madhya Pradesh, the State IMNCI Cell and District IMNCI and Child health coordinators are facilitating the roll out of key interventions along the Continuum of Care approach. Focus areas include IMNCI, Zinc ORS, Referral transport, and SCNU
• In the State of Orissa, UNICEF has contributed towards development of the sections on Child Health, Routine Immunization and Maternal Health PIPs at the State and District levels
• State wise four quarterly reviews of Skilled Birth Attendance (SBA), IMNCI, Routine Immunization and Facility Based Newborn Care (FBNC) programmes have been undertaken

**OUTPUTS**

Some key outputs as a result of the key activities undertaken by UNICEF in 2011 are indicated below:

• Across the NIPI States, 85 % of the Primary Health Centres (PHCs) have a functional cold chain point
  o In Bihar, 96 % of PHCs are with functional cold chain equipment
  o In Rajasthan, 94.7% of the PHCs have a functional cold chain (1488/1570)
  o In the State of Uttar Pradesh, all PHCs are with functional cold chain equipment (174/174)
  o 82.14% percent Primary Health Centres (PHCs) with functional cold chain equipment are present in the State of Madhya Pradesh (1150/ 1400)
• 9000 cold chain handlers have been trained across the country in the past six months
• 16 cold chain Technicians in the State of Uttar Pradesh received training on ILR & DF repair and maintenance at NCCVMRC, NIHFW, Delhi
• Communication strategy on immunization and Pentavalent vaccine developed
• In Uttar Pradesh, significant progress was made in terms of micro planning, coordination between health and ICDS officials (Block level meetings between health and ICDS increased from 14 % to 37 %) in 15 districts
• AEFI reporting and VPD reporting increased from 3 % and 6 % to 46 % and 49 % during 2011 in the State of Uttar Pradesh.
• Proper maintenance of temperature of CCE improved from 74 % to 84 % in all facilities,
• In the year 2011, in the State of Uttar Pradesh, a total of 41,349 RI sessions were monitored and 368,050 house to house assessments were done. A total of 112,895 RI sessions were monitored by Government officials and partners (WHO-NPSP, UNICEF, MI, MCHIP and CORE). Out of the planned sessions, 93 % RI sessions were held and out of the held sessions, 90% were held as per microplans.
• In Orissa, percentage of PHCs with functional cold chain equipment has shown improvement from 68 % to 100%
• As a result of IMNCI across 433 Districts, 63.3% newborns have been reported to have been visited three times within 10 days of birth1
• Operational SNCU/ total districts: Bihar- 10/ 38, Orissa-16/30, Rajasthan-35/33, Uttar Pradesh-6/72, Madhya Pradesh-32/50, Total-99/223 (44 % approx.)

Some success stories from the field are provided below.

**Nurse Midwives Bring New Life to Villages**

Nurse-midwife Sanju Kaim got a little bonus on her first day on the job. That morning she delivered not one baby girl, but twins. She was alone in the maternity ward, having just reported for her first day of duty as an auxiliary nurse midwife in Jhagar village’s small health centre.

“When she arrived she was quite afraid but now she is happy and is taking things well,” Niranjana says of the girl. The young nurse-midwife speaks with the authority of someone who has already delivered at least 600 babies.

She was a bit nervous. Just 23, she had worked only briefly before as a beauty parlour attendant. But now here she was, responsible for the health and well-being of young mothers who would rely on her to bring new life into the world.

“I knew I had studied hard to be a midwife and was well-prepared to do this job,” Sanju recalls. “But I admit that I was surprised that day.”

A heavily pregnant woman arrived in the ‘Janani Express’ (Maternity Express), the district’s free mini-van service available 24-hours a day, seven-days a week. The mother had already been bouncing along rural backroads for almost an hour, travelling from the village of Ratanagar, about 20 kilometers away. By the time, she arrived at the maternity ward, she was almost fully dilated, says Sanju.

The woman made it to the delivery room and only moments later, Sanju was holding the

1 PGIMER, UNICEF, WHO IMNCI Q3 2011 report
babies who were each barely two kilograms. “I was so happy to do this,” she says now. “I had no regrets about joining this field, because it is so good to help children and their mothers. It gives me a lot of pride.”

Sanju, now 24, delivered about 200 babies last year, and is just one of dozens of young midwives striving to make a difference in Madhya Pradesh, where the infant and maternal mortality rates are among the highest in India.

Now with UNICEF’s support, the state government has created a network of health sub-centres offering around-the-clock, safe delivery services to women from remote villages who otherwise would be at greater risk giving birth at home.

In Sanju’s maternity ward, new mother Reena Dhakad, 20, smiles from underneath a heavy blanket as she tends to her baby boy born just two hours earlier. Her mother-in-law, Ramkali, 49, says the sub-centre services are far superior to the days when women gave birth on the floor at home. If mother or child had difficulties, many died, she says.

“Previously we had no choice but to go to district hospital which was more than 50 kilometres away,” says Ramkali.

Sanju Kaim, 24 has delivered about 200 babies last year and she is just one of dozens of young midwives striving to make a difference in Madhya Pradesh, where the infant and maternal mortality rates have long been among the highest in India.

Kilometres away at another sub-centre in Fatehgarh village, nurse-midwife, Niranjana Parihar, 25, tends to new mother, Panabai Saharia, 20, and her baby girl swaddled in bright red, yellow and green scarves.

“When she arrived she was quite afraid but now she is happy and is taking things well,” Niranjana says of the girl. The young nurse-midwife speaks with the authority of someone who has already delivered at least 600 babies.

Niranjana was barely 21 when she first came to work at this sub-centre, which is one of the state’s most remote. There are no movie houses here, and she is far from her family. But she enjoys the work immensely and has the companionship of friend and fellow nurse, Kamla Kaim, 27.

“We help each other at work and in our free time, we watch our daily TV soaps, or I sketch,” Niranjana says with a quiet smile.

“It is young service providers like Sanju and Niranjana who play a crucial role in making these programmes a success,” says Dr. Tania Goldner, chief of UNICEF’s Madhya Pradesh office. “Young service providers are making a difference and giving women and children a better chance of survival.”

(Diana Coulter- JHAGAR, India, 8 March 2011)
SECOND ROUND IN MEASLES VACCINATION CAMPAIGN ALLOWS CHILDREN TO ‘CATCH-UP’ IN INDIA

In November of 2010, the Government of India, supported by UNICEF and WHO, launched the measles ‘catch-up’ campaign with the aim of reaching 134 million children in 14 high risk Indian states, to prevent an estimated 60,000 to 100,000 child deaths annually.

Recently, the second dose of the measles vaccine was administered to children at outreach sites all across the country, and for those who missed out on their first scheduled dose at nine months, they were given a chance to ‘catch up’ with those children who have already received it.

Measles is a highly contagious respiratory illness and a leading cause of death among young children worldwide, despite the fact that a safe and effective vaccine has been available for 40 years. In the first few weeks after contracting measles, a child’s immune system weakens and this can lead to severe health complications, such as pneumonia, diarrhoea and encephalitis.

Mr. Kapurji Rupaji, principal at Dabhipur School in the western Indian state of Gujarat, is well aware of the severity of the disease. He has received special orders to ensure that each student is informed about the measles catch-up campaign.

“During such a school session, we make sure that all children under 10 receive the measles vaccine,” he said.

Challenges and setbacks

However, not all schools readily receive the campaign vaccinators and this can cause problems. When this happens, proactive direct engagement with the parents must take place.

“Some parents wrote back to us that they do not want their children to be vaccinated,” explained Dr. Tapasvini R. Acharya, Health Supervisor at the Primary Health Centre in Dabhipur. “We will try to convince them so that they willingly brought their children for vaccination.”

Ms. Manju Joshi is an Auxiliary Nursing Midwife working at the Vaghrol Public Health Centre (PHC). The PHC is the cornerstone of the rural healthcare system in India and it relies on the dedication and expertise of trained paramedics like Manju to coordinate with other frontline health workers to mobilise women and children to the center for vaccination.

“We got the message from the PHC about the forthcoming measles campaign,” said Ms. Joshi. “We prepared a list of villages and schools and mapped the total number of children anticipated, syringes and needles needed and the number of booths.”

Ensuring vaccine safety

The measles campaign lasted three weeks. While school children between the ages of five and 10 years of age were targeted in the first week, non-school going children were reached in the second and third weeks at the outreach sessions.

Cold chain management is an integral part of the routine immunization program. During Village Health and Nutrition Days, the vaccine vials are transported from vaccine storage units in the state capital of Ahmedabad and carefully preserved in specially designed carriers that are kept at the optimum temperature.
"On the back of the tally sheet, we write the mixing time and the batch number of the vial, the name of the manufacturer, the expiry date, and the names of the children who have received the vaccine from that vial," explained Dr. Acharya.

Severe reactions following measles immunisation are rare. Minor reactions such as fever and rashes follow within 6-12 days and usually subside naturally. However, most adverse events following immunisation that occur are the result of programme or human errors. This is why training of vaccinators for safe injection practices is an essential aspect of the second dose of measles campaign.

(Sonia Sarkar-DABHIPUR, India, 1 November 2011)

LEARNING AND SHARING

A number of peer reviewed journal articles, research studies, policy briefs, manuals on NIPI related child health interventions: 1 Policy brief on “Newborn Health in Bihar” as part of the year of the newborn have been brought out. In the NIPI Focus States, new interventions piloted and shared with Government system include monitoring of 80 high delivery load health facilities and Supportive Supervision of service providers for improved peri-natal care through Concurrent Monitoring Cell in Rajasthan. This led to further improvement in quality of peri-natal services in these institutions.

Modelling for strengthening routine Immunization through structured monthly reviews and capacity building continues. In Orissa, post discharge newborn survival tracking system in all functional SNCU II units in phased manner.

WHO

INPUTS/ ACTIVITIES

CHILD HEALTH

The focus of WHO has been on capacity building of health personnel. With the focus being on expansion of pre service IMNCI, Training of Trainers (TOTs) have been completed across all Government Nursing Colleges of Orissa. The State Nodal Centre for Pre Service IMNCI teaching in Nursing colleges and ANMTCs has been identified. Training package integrating Infant and young child feeding with IMNCI has been developed and pilot testing has been conducted. Additionally, training package for 'Facility Based Management of SAM children' developed and piloted.

On Essential Newborn Care, self learning tools – webinars have been developed and disseminated. Short Program Reviews (SPRs) of child health interventions have been conducted in the States of Rajasthan and Bihar.

Furthermore, training modules on child health for program managers have been designed and developed. Integrated modules focus on child health, maternal health, adolescent health, nutrition and immunization.

Moving onto the aspect of Village Health & Sanitation Committees (VHSCs), capacity building of the same on aspects related to monitoring of RCH services has been conducted. Community monitoring tools have been developed and field tested.
Studies on malnutrition have been initiated. Specifically, for the study on ‘determination of appropriate value of mid upper arm circumference (MUAC) for identification of Severe Acute Malnutrition (SAM) children with weight for height as reference among Indian population, a technical advisory group has been established and made functional. The study has been initiated across 5 sites.

MATERNAL HEALTH

The support to Quality Assurance cells across NIPI States continues. This support is being provided by the National Nodal Centre. Under this aspect, the faculty members have been trained to determine the quality of trainings being undertaken. For the implementation of accreditation guidelines, mapping of the health facilities have been completed and the process for accreditation has been initiated.

In order to strengthen ‘Skilled Birth Attendants’ training for ANMs and Nurses, the State Nodal Centres have been identified in two NIPI States viz., Madhya Pradesh and Orissa. The training of the master trainers has been completed in these 2 States. The Nursing faculty have been trained also. Skills Labs have been set up.

OUTPUTS

Capacity building of health personnel on pre Service IMNCI, EmOC was carried out. Self learning tools on child health have been developed and uploaded. Capacity of mid level managers has been enhanced on aspects related to planning and implementation of child health interventions. Communication process of monitoring under the National Rural Health Mission (NRHM) has been initiated across NIPI Focus States. Training of ANMs and Nurses on Skilled Birth Attendance was conducted. A compendium focusing on different models on management of SAM children in India has been developed and disseminated.

OTHER ACTIVITIES

The NIPI Secretariat focused on a number of activities in the year 2011. Since Betul as a NIPI Focus District was included in 2010, a baseline was conducted in 2011. This baseline was conducted to maintain uniformity and consistency with the earlier baseline undertaken in 2009 for 12 NIPI Focus Districts. As a programme assurance unit, the progress of the NIPI programme was continuously monitored. For ensuring systematic and robust data on NIPI Interventions, a Data Management Information System (DMIS) was planned and the process for the development of the same initiated. One of the key interventions under the UNOPS LFA programme- Yashodas- was assessed to understand the role and impact of Yashodas as facility based workers.

Gender as a cross cutting issue, was a key focus area. A Gender Manual was developed and disseminated in the State of Rajasthan. A qualitative assessment of the innovative project ‘Save the Baby Girl’ project started in Kolhapur District, Maharashtra was initiated to understand the scope and potential for prototyping in NIPI Focus Districts. PC&PNDT cell at MoHFW was strengthened.

Under the umbrella of Operational Research, two studies initiated in 2009-2010 came to a closure with the results being disseminated.
## NIPI Programme Overall Expenditure to 2011

### NIPI Fund Allocations and Projection till 2013 (USD) @ 5.71

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<td>4,173,297</td>
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<td>UNOPS Secretariat</td>
<td>8,756,567</td>
<td>893,169</td>
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<td>6,087,109</td>
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<tr>
<td>UNOPS LFA</td>
<td>17,513,134</td>
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<tr>
<td>Addendum I for NIPI-UNOPS</td>
<td>1,751,313</td>
<td></td>
<td></td>
<td>1,707,530</td>
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<td>NIPI LFA Addendum II</td>
<td>8,756,567</td>
<td>3,415,061</td>
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<td>NIPI OR and Monitoring</td>
<td>87,565</td>
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<td></td>
<td>51,570</td>
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<tr>
<td>BPNI- Seed</td>
<td>17,513</td>
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<tr>
<td>NIPI MTR</td>
<td>87,565</td>
<td></td>
<td></td>
<td>17,107</td>
</tr>
<tr>
<td>Answers / Fafo</td>
<td>630,472</td>
<td>126,534</td>
<td></td>
<td>630,472</td>
</tr>
<tr>
<td>PHFI / UiO</td>
<td>746,059</td>
<td>149,256</td>
<td></td>
<td>746,059</td>
</tr>
<tr>
<td>NIPI RNE</td>
<td>25,394,045</td>
<td></td>
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<td>48,034</td>
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<tr>
<td>PHFI</td>
<td>1,926,444</td>
<td>883,884</td>
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<td>883,884</td>
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<tr>
<td><strong>Total USD</strong></td>
<td><strong>100,168,118</strong></td>
<td>6,711,336</td>
<td>-350,262</td>
<td><strong>52,946,430</strong></td>
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</tbody>
</table>
Partner expenditure reports
UNOPS LFA  Expenditure up to Dec 2012

Total Available Funds: **USD 21,881,560**

**Actual Expenditure Incurred USD**

<table>
<thead>
<tr>
<th>Year</th>
<th>Project Cost</th>
<th>Management Fee</th>
<th>Fee</th>
<th>Total Amount Req.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>Same as 00054184</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>10,368,900</td>
<td>518,445</td>
<td>10,887,345</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>4,572,128</td>
<td>228,608</td>
<td>4,800,736</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>864,665</td>
<td>43,233</td>
<td>907,898</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>2,972,703</td>
<td>149,412</td>
<td>3,122,115</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>19,718,094</strong></td>
</tr>
</tbody>
</table>

a) the incurred expenditure and management fee is **USD 19,718,094**
b) the total funding recorded including interest is **USD 21,881,560**
c) the interest earning recorded is **USD 125,685**
d) the net cash on hand is **USD 2,163,466**
### UNICEF Expenditure up to Dec 2012

<table>
<thead>
<tr>
<th>State</th>
<th>Allocated Amount USD</th>
<th>Req Amount USD</th>
<th>Expended Amount USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bihar</td>
<td>309,065</td>
<td>308,228</td>
<td>304,639</td>
</tr>
<tr>
<td>Delhi</td>
<td>1,232,742</td>
<td>1,191,920</td>
<td>1,032,115</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>464,000</td>
<td>428,266</td>
<td>391,672</td>
</tr>
<tr>
<td>Orissa</td>
<td>208,000</td>
<td>267,528</td>
<td>237,255</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>350,000</td>
<td>233,703</td>
<td>219,328</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>820,250</td>
<td>598,778</td>
<td>416,612</td>
</tr>
<tr>
<td>Technical Assistance</td>
<td>705,299</td>
<td>673,572</td>
<td>532,742</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,089,356</strong></td>
<td><strong>3,701,995</strong></td>
<td><strong>3,134,363</strong></td>
</tr>
</tbody>
</table>

### GENERAL EXPENDITURE (USD) UNICEF

<table>
<thead>
<tr>
<th></th>
<th>Prior Years’ Expenditures</th>
<th>Curr Year’s Expenditures</th>
<th>Funds Committed</th>
<th>Implementation To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy &amp; Programme</td>
<td>3,864,628.45</td>
<td>1,555,818.55</td>
<td>0.00</td>
<td>5,420,447.00</td>
</tr>
<tr>
<td>Consultants</td>
<td>1,328,454.34</td>
<td>1,331,624.76</td>
<td>0.00</td>
<td>2,660,079.10</td>
</tr>
<tr>
<td>Freight</td>
<td>144,479.89</td>
<td>16,175.76</td>
<td>0.00</td>
<td>160,655.65</td>
</tr>
<tr>
<td>Furn &amp; Equipment</td>
<td>5,792.76</td>
<td>0.00</td>
<td>0.00</td>
<td>5,792.76</td>
</tr>
<tr>
<td>International posts</td>
<td>27,049.13</td>
<td>0.00</td>
<td>0.00</td>
<td>27,049.13</td>
</tr>
<tr>
<td>Local Posts</td>
<td>661,798.45</td>
<td>553,624.57</td>
<td>0.00</td>
<td>1,215,423.02</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td>273,432.89</td>
<td>51,680.23</td>
<td>0.00</td>
<td>325,113.12</td>
</tr>
<tr>
<td>Other Staff Costs</td>
<td>910,958.94</td>
<td>83,540.59</td>
<td>0.00</td>
<td>994,499.53</td>
</tr>
<tr>
<td>Programme Assistance</td>
<td>3,815,003.80</td>
<td>345,735.97</td>
<td>0.00</td>
<td>4,160,739.77</td>
</tr>
<tr>
<td>Travel</td>
<td>209,376.09</td>
<td>51,055.16</td>
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<td>260,431.25</td>
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<tr>
<td>Sub Total</td>
<td>11,240,974.74</td>
<td>3,989,255.59</td>
<td>0.00</td>
<td>15,230,230.33</td>
</tr>
<tr>
<td>Programmable</td>
<td>11,240,974.74</td>
<td>3,989,255.59</td>
<td>0.00</td>
<td>15,230,230.33</td>
</tr>
<tr>
<td>Cost Recovery 7.0 %</td>
<td>786,868.27</td>
<td>279,247.92</td>
<td>0.00</td>
<td>1,066,116.19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12,027,843.01</strong></td>
<td><strong>268,503.51</strong></td>
<td><strong>0.00</strong></td>
<td><strong>16,296,346.52</strong></td>
</tr>
</tbody>
</table>

Implementation To Date: 17,261,475.02
Programmable + 7% Cost Recovery 16,296,346.52
Balance of Funds Received 965,128.50
<table>
<thead>
<tr>
<th></th>
<th>to Dec 2011</th>
<th>US Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distribution (Income)</td>
<td>1,189,663</td>
<td></td>
</tr>
<tr>
<td>Encumbrances</td>
<td>159,782</td>
<td></td>
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<tr>
<td>Expenditure</td>
<td>283,707</td>
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<tr>
<td>Balance</td>
<td>746,174</td>
<td></td>
</tr>
</tbody>
</table>

**NIPI Secretariat- Expenditure Statement to 2011**

Total Available funds: **USD 5,982,562**

Actual Expenditure Incurred USD

| 2007 Project Cost      | 6,851,663   |            |
| Management Fee         | 342,584     | 7,194,247  |
| 2008 Project Cost      | (5,210,316) transfer of LFA related 2007-2008 expenditure (negative expenditure) | (5,470,832) |
| Management Fee         | (260,516)   |            |
| 2009 Project Cost      | 770,946     |            |
| Management Fee         | 38,539      | 809,485    |
| 2010 Project Cost      | 1,286,605   |            |
| Management Fee         | 64,331      | 1,350,936  |
| 2011 Project Cost      | 964,210     |            |
| Management Fee         | 47,360      | 1,011,570  |
| TOTAL Amount Req.      |             | 4,895,406  |

a) the incurred expenditure and management fee is **USD 4,895,406**
b) the total funding recorded including interest is **USD 5,982,562**
c) the interest earning recorded is **USD 253,689**
d) the net cash on hand is **USD 1,087,156**