Evaluation Department

Norad

Evaluation of the Norway India Partnership Initiative

for Maternal and Child Health

Report 3/2013

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Evaluation of the Norway India Partnership Initiative

for Maternal and Child Health

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Cambridge Economic Policy Associates Ltd.

Note on layout and language

The layout of the document has tried to conform to guidelines for accessibility and ease of reading, which require Arial font and left (not full) justification of the text.

The report has tried to avoid unnecessary use of acronyms and abbreviations.

Preface

The Norway India Partnership Initiative (NIPI) was established in 2006 through a joint statement by the Prime Ministers of Norway and India. The vision of NIPI is to provide strategic, catalytic and innovative support to the Indian health care system for improved maternal and child health. The initiative is one out of five bilateral partnerships that Norway has entered into to support the achievement of the health related Millennium Development Goals.

The aim of the evaluation was to take stock of the initiative as it enters its second phase and assess the extent to which the program initiative has met its stated goals and determine its future viability. The evaluation team was asked to describe and analyse the governance structure of NIPI, identify the rationale and logic which guided the selection of interventions, assess whether previous recommendations were followed up, and conduct a process evaluation of selected interventions.

The main finding of the report is that the initiative is perceived as effective by partners with its main value added being its contribution to setting maternal and child health on the Indian agenda. In particular, partners felt that working through existing structures, rather than setting up additional implementing bodies, worked well and should be continued. Partners were also pleased with NIPI's role as testing new and innovative measures to improve maternal and child health. On a less positive note, the initiative did not seem to follow up on many of the recommendations provided through various reviews and studies conducted during the initiative's first phase, including a recommendation to develop a monitoring and results' framework for the initiative. Hence the absence of a results framework during the initiatives first phase makes it difficult to assess whether the initiative has reached its stated objectives with respect to health outcomes, or indeed whether specific NIPI funded activities should be continued.

The Evaluation Department believes that the report provides useful findings and lessons learnt for NIPI's partners at the outset of the second phase of the initiative. We therefore hope that this report will be used actively.

Oslo, September 2013

Tale Kvalvaag
Director, Evaluation Department

Acknowledgements

The evaluation has been conducted by Cambridge Economic Policy Associates (CEPA), in association with the India Development Foundation (IDF).

CEPA has had overall responsibility for the evaluation and is the primary author of the main report and annexes. IDF have contributed to the literature review and participated in two field visits to Bihar and Odisha.

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Annex 4: Core Phase Interview Guide
Annex 5: Field Visit Design and Interview Guide
Annex 6: NIPI Governance Structure
Annex 7: Key Activities and Achievements of UNICEF and WHO
Annex 8: Field Visit Report – Bihar
Annex 9: Field Visit Report – Madhya Pradesh
Annex 10: Field Visit Report – Odisha
Annex 11: Field Visit Report – Rajasthan
Annex 12: Progress on Previous Review Recommendations

Acronyms and Abbreviations[1]

ASHA	Accredited Social Health Activist
CEPA	Cambridge Economic Policy Associates
DAC	Development Assistance Committee
IMR	Infant Mortality Rate
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Rate
MoU	Memorandum of Understanding
NIPI	Norway India Partnership Initiative
NMR	Neonatal Mortality Rate
Norad	Norwegian Agency for Development Cooperation
NRHM	National Rural Health Mission
OECD	Organisation for Economic Cooperation and Development
RCH	Reproductive and Child Health
TFR	Total Fertility Rate
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
U5MR	Under Five Mortality Rate
WHO	World Health Organisation

1 The list of acronyms and abbreviations pertains to both the main report and annexes.

Description of Key Terms

A definition/ description of key terms used in the report that are specific to the Indian health system are provided below.

Accredited Social Health Activist (ASHA)
A community health worker, usually female, appointed by the government to promote health awareness in rural regions and provide basic treatment (referred to as ASHA in this report).

Auxiliary Nurse Midwives
Paid government skilled birth attendants/ health workers, who provide maternal and child care services in rural India; and coordinate and supervise ASHAs.

Community Health Centre
Part of the secondary level of health service in rural India. These provide specialist care and act as referral centres for the Primary Health Centres (see below).

District Level Household and Facility Survey
A household survey at the district level conducted by the International Institute for Population Sciences, Mumbai. The survey focuses on family planning, maternal and child health and healthcare utilisation.

Integrated Management of Neonatal and Childhood Illness
An elaboration of the United Nations Children's Fund (UNICEF) approach to Integrated Management Childhood Illness (IMCI) that includes components of care in the first seven days of a newborn's life. UNICEF's IMCI framework aims reduce illness, mortality and disability for children under five. Its initial components include improving health systems, improving healthcare staff's skills, and improving community and family health practices.

Janani Suraksha Yojana
A government scheme in India under the National Rural Health Mission that aims to reduce maternal and neo-natal mortality rates by institutionalising deliveries for women below the poverty line.

National Institute of Health and Family Welfare
An autonomous technical institute and think tank under the national Ministry of Health and Family Welfare that promotes health and family welfare programmes in India.

National Rural Health Mission (NRHM)
A government programme in India that aims to improve healthcare delivery (referred to as NRHM in this report). Part of its initiatives include training ASHAs and delivering the Janani Suraksha Yojana. The mission focuses on 18 states. The first mission encompassed 2005-2012 and its goals include reducing the infant mortality rate, the maternal mortality ratio, providing universal access to healthcare for women and children, access pro primary healthcare, population stabilisation, prevention of communicable and non-communicable diseases, and others.

Primary Health Centre
State-funded single-doctor clinics in rural areas in India. Some have facilities for minor surgeries and provide services under infant immunisation programmes, pregnancy care programmes, anti-epidemic programmes, etc. There are about 23,000 Primary Health Centres in India.

Programme Implementation Plan
Annual programme implementation plans developed by individual states to achieve the objectives of the National Rural Health Mission. The Programme Implementation Plans contain state plans and budgets, physical targets to measure the success rate with respect to outcomes.

State Health Societies
State bodies that are responsible for the management, allocation, accounting, disbursement of funds and the provision of technical coordination for the implementation of the National Rural Health Mission.

Executive Summary

Executive Summary

Cambridge Economic Policy Associates (CEPA) has been appointed by the Norwegian Agency for Development Cooperation (Norad) to carry out the evaluation of the Norway India Partnership Initiative (NIPI) Phase I.

Background to the Norway India Partnership Initiative

Established in 2006 through a joint statement by the Prime Ministers of Norway and India, the vision of the Norway India Partnership Initiative is to "provide catalytic, strategic support that would make a vital and sustainable difference to the rapid scaling up of quality and equitably delivered child health services in India under the National Rural Health Mission (NRHM)".[2] The initiative focuses on four states (Bihar, Madhya Pradesh, Odisha and Rajasthan); and has been implemented by United Nations Office for Project Services (UNOPS); United Nations Children Fund (UNICEF) and the World Health Organisation (WHO). The budget for NIPI Phase I (2006-12) was NOK 500 million, with actual expenditure being lower at NOK 332 million.

Evaluation Framework and Approach

The evaluation aims to take stock of NIPI as it begins Phase II, focusing on the design, governance and implementation arrangements/ processes (including a process review of two NIPI interventions), and the extent to which it has met its stated goals/ results. Gender, equity, quality and sustainability have been considered as cross-cutting issues for the evaluation. We have adopted a mixed-methods approach for this evaluation including: desk-based review of documents; structured interviews; field visits to the four NIPI focus states; and limited quantitative analysis (based on availability of data).

Evaluation Findings

Policy and design

The selection of the four focus states under NIPI is clear and justified, being amongst the poorest performing states with respect to key maternal and child health indicators and a part of the 18 high focus states of the National Rural Health Mission (NRHM) in India.

However, the selection of the districts within these states has been more nebulous and could have been based on pre-determined criteria. While the intention was to select medium performing districts[3], in practice, these have

2 As noted in the 'Description of Key Terms' above, the National Rural Health Mission is a government programme in India that aims to improve healthcare delivery in 18 focus states.

3 As poor performing districts with poor infrastructure/ human resources might delay implementation and high performing districts might make it difficult for NIPI to advocate replication/ scale up.

been a mix of high, medium and poor performing ones; being selected on an 'opportunistic' basis (e.g. where the administration has been receptive to NIPI, easier to access from the capital city). Nonetheless, the selection was largely driven by the preferences of the respective state governments (rather than being 'imposed' on them).

There is a strong rationale for the selection of the UNOPS supported interventions, however, the selection process could have been more systematic. The NIPI UNOPS interventions are aligned with global evidence on strategies for improving child and maternal mortality; and also relevant in the context of existing delivery gaps in the Indian health systems. However, the selection process has not been systematic in terms of reviewing the feasibility or prioritisation of interventions (e.g. through a cost-benefit analysis); and could have been more participatory in terms of consulting with all relevant stakeholders at the central and state levels.

NIPI is well-aligned with the National Rural Health Mission (NRHM) and state health systems. In line with its design, NIPI works through the Mission e.g. channelling a majority of funds through the State Health Societies. However, not all of its interventions are being sustained/ scaled-up by the Government of India e.g. the Yashoda intervention, some techno-managerial positions.

The relatively low utilisation rate and high administrative costs of the initiative suggest some inefficiencies in the implementation of NIPI. Approximately 80% of the allocated funds have been utilised in Phase I, with utilisation by WHO being particularly low. A conservative estimate of the proportion of management/ administrative costs in the total budget is around 15%, which may be regarded as relatively high.

Governance and management

The NIPI structure of working through implementing partners with local presence is appropriate. NIPI's approach of working through locally based organisations rather than creating an additional parallel structure has been appropriate, as it allows for the leveraging of the strengths and capacities of existing partners in India.

However, with the benefit of hindsight, NIPI could have been more strategic in its selection of partners to align well with its mandate/ objectives. While it was not clear why UNOPS was included as an implementing agency, given its limited experience in the health sector, it has performed well and delivered on some of the key objectives for NIPI. On the other hand, whilst NIPI's partnering with UNICEF and WHO was prima-facie logical and efficient, these did not work well in practice as there was lack of clarity in selection of their areas of work under NIPI. Further, a combination of UN agencies, academic/ research institutions, NGOs etc. could have been considered (as is being proposed for Phase II).

There have been a number of issues with the governance and management arrangements in NIPI Phase I. In particular: (i) the roles of the some key stakeholders have not been clearly defined from the start of the initiative and have evolved over time, creating considerable confusion and inefficiencies; (ii) the initiative has lacked a strong centralised Secretariat to take the initiative forward and facilitate coordination amongst partners; and (iii) while enjoying high-level political support, NIPI's governance structures have been viewed as cumbersome and at times duplicative, with room to streamline and improve their effectiveness.

Implementation – process evaluation of interventions and follow-up on reviews. We have carried out a process evaluation of two key NIPI interventions: (i) the Yashoda intervention, wherein a health worker with a non-clinical background (the 'Yashoda') is appointed in the maternity wards to provide care and counselling services to mothers; and (ii) Home Based Post Natal Care, which is a community based intervention, wherein Accredited Social Health Activist (ASHAs) provide post natal support to mothers through home visits after delivery. Key findings are presented below.

Process evaluation of the Yashoda intervention

As per its intended objective, the role of the Yashodas has been viewed as important in creating a supportive and congenial environment for mothers at the health facilities. The intervention is being funded by the state health budgets in all four focus states after NIPI funding ended in April 2012, although incorporation under the National Rural Health Mission (NRHM) is currently under discussion.

Despite the overall positive views in terms of the utility of the intervention, there have been a number of issues with regards to its implementation as follows:

- While the training provided to Yashodas has been viewed as beneficial, the frequency of training has varied across states, with inadequate provision of refresher training.
- The supervisory structure established for Yashodas under NIPI has enhanced monitoring and supervision and also provided Yashodas with a sense of moral support, however its efficacy has varied across states. Also, key supervisory mechanisms have been discontinued since the take-over of funding by the government.
- The intervention has given an opportunity to many low-income/ disadvantaged women to earn a livelihood. However, contrary to its design, the payment mechanism has not been incentive based in practice, with Yashodas in most states being paid a monthly capped salary. Their payment is regarded as insufficient in relation to their workload. There have also been delays in payments to Yashodas (with this delay increasing with the transition of funding to the state governments).

(cont. next page)

- Contrary to its design, wherein Yashodas were envisaged to look after 4-5 mother-baby cohorts, they have supported around 5-6 times the number on average.

- Yashodas have not been able to focus exclusively on counselling of mothers and have often been made to perform other hospital and administrative duties.

If the Yashoda intervention is to be continued, it would be important that these key issues identified in the process evaluation are considered and rectified, so as to allow for the intervention to deliver more efficiently and effectively on its intended objectives.

Process evaluation of the Home Based Post Natal Care intervention

The Home Based Post Natal Care intervention has facilitated the training of ASHAs in post natal care, and more generally, provided a greater focus on post natal care support, thereby informing the Government of India's decision to scale up the support nation-wide (known as Home Based Newborn Care). Key issues to note in the implementation experience of this intervention are as follows:

- There have been mixed views on the adequacy of the training to ASHAs delivered under this intervention.

- Supervisory support has been aligned with the broader National Rural Health Mission (NRHM) supervisory structure for ASHAs. In addition, NIPI has introduced additional supervisor mechanisms in some states through NGOs, however there is insufficient information on whether this has worked well or not.

- ASHAs do not feel adequately incentivised with the payments for their post natal care services and there have been delays in receipt of payments as well.

- In some states, ASHAs have faced issues in engaging with mothers at home (cultural issues, issues of trust, etc), although our understanding is that this has been improving over time as the ASHA concept has matured.

- There have been issues with lack of availability of post natal care forms and tedious/ difficult format of the form, which will impact the quality of data collection by the ASHAs.

Most of the recommendations made by the Mid-Term Review and the Evaluability Study have not been or only partially implemented. Key areas where there has been no progress include developing a comprehensive programme document for the initiative defining objectives and stakeholder roles; and a monitoring and evaluation strategy and framework. These continued to be issues within NIPI Phase I and have been highlighted in our review as well.

Results

NIPI lacks a prospectively designed results framework, and partner reporting has been inadequate to assess progress. NIPI lacks a results framework, setting out desired outputs, outcomes and impacts of the initiative, and related targets and milestones for the implementing partners. Partner

progress reports do not follow a common format; and report mainly on activity progress rather than results. There has been no attempt to consolidate the various partner reports to assess overall performance/ results of NIPI.

NIPI has largely achieved its objectives of being strategic, catalytic, innovative and flexible, particularly in the case of the UNOPS supported interventions. While the absence of robust monitoring and evaluation arrangements has affected our review, our overall assessment is largely positive.

- NIPI funding has been strategic by virtue of supporting a continuum of care approach, encompassing interventions at the home/ community and facility levels.

- NIPI has been catalytic by accelerating some existing processes/ interventions, that would either have taken longer to materialise or would not have been implemented at scale. However, it has not done enough to document and disseminate its achievements, which is key to sharing lessons and promoting the sustainability and scale up of interventions.

- NIPI has provided a flexible pool of funds to be used based on need, although greater flexibility in supporting additional states/ activities might have been useful, given the changing health priorities in India and that the Phase I funds were not fully utilised.

- NIPI has been innovative by introducing interventions that are: new/ represent a first time implementation in India (e.g. Yashoda intervention), include some new/ novel elements (e.g. Emergency Treatment and Triage areas within Sick New Born Care Units), and while not completely new, may be regarded as process innovations (e.g. Home Based Post Natal Care, in that it helped in institutionalising and scaling up post natal care).

NIPI activities undertaken by WHO and UNICEF have been more in line with their own organisational mandate and country plans rather than furthering the NIPI approach/ interventions. Therefore, although the WHO and UNICEF activities funded by NIPI might help improve child/ maternal health performance, their interventions have been less distinct and 'visible'. More could have been done to use both partners strategically within NIPI's overall mandate, drawing on their specific comparative advantages in the health sector.

NIPI's key value add has been its contributory role in bringing forward the newborn health agenda in India. Our assessment, based on consultations and the state visits (including with government officials), is that NIPI has helped bring forward the newborn health agenda in India. While many concepts/ interventions under NIPI have been discussed within the government previously, NIPI's focus and action/ delivery based approach has fostered greater attention and action on improving newborn health in the country.

Cross cutting issues

Issues relating to gender and equity are implicit in NIPI given its focus on maternal and child health in poor/ lagging India states. However, given their noted importance in the vision of the initiative, NIPI has lacked a more strategic approach to incorporating these aspects in its design and implementation. NIPI has done well on the sustainability and scalability of several of its interventions, although more efforts/ investments are needed to document and disseminate the results of and lessons learnt from the interventions.

Conclusions and Lessons Learnt

NIPI is a very relevant and added value initiative in India, given: its focus on improving maternal and child health, and neo-natal health in particular; approach of providing strategic, catalytic and innovative support across the continuum of care on both home/ community and facility based interventions; and working through the National Rural Health Mission (NRHM) and the state health systems as well as through existing development partners in the country. There have, however, been a number of issues with its key processes (e.g. selection of interventions has not been systematic), governance (e.g. overlap in the functioning of key governance bodies) and management arrangements (e.g. lack of a coordination mechanism between partners at the strategic and operational levels). NIPI has also not performed very well with respect to efficiency, by virtue of low utilisation of its budgeted funds and a relatively high proportion of management/ administrative costs.

Notwithstanding the above issues, NIPI has largely achieved its objectives of providing strategic, catalytic and innovative support to the National Rural Health Mission (NRHM) in India, in terms of its support through UNOPS in particular. The main value add of the initiative as a whole has been its contribution towards bringing forward the neo-natal health agenda in the country. There has been good experience with regard to the sustainability and scalability of several NIPI interventions, with some of them being adopted across the country by the Government of India.

Some key lessons for NIPI to incorporate during Phase II are as follows:

- NIPI's mandate and approach (in terms of focus on providing strategic, catalytic and innovative support for maternal, child and newborn health; and delivery through the Mission and in-country partners) works well and should be continued in Phase II.

- There is however a need for a more structured and participatory approach for selection of interventions.

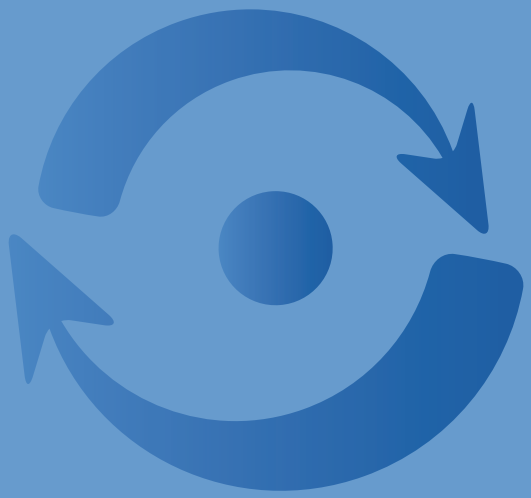
- NIPI needs to clearly define the roles and responsibilities of stakeholders; and establish a coordination mechanism and synergistic approach among partners. It should continue to leverage high level government support, but streamline its governance mechanisms.

- Financial management under NIPI needs to be improved and efforts need to be made to reduce the management/ administrative costs of the initiative.

- NIPI should establish a results framework, clearly defining its overall goal, objectives, outputs, outcomes and impacts (including cross cutting issues of gender, equity, quality and sustainability), and also define how it would consolidate and use partner reports for management decisions and any course corrections.

- There is a need for greater documentation and dissemination of good practices and results, to ensure evidence based scale up of interventions. NIPI could also provide transition funding and support to the Government of India/ state governments to facilitate the sustainability/ scalability of interventions.

Main Report



1. Introduction

Cambridge Economic Policy Associates (CEPA) has been appointed by the Norwegian Agency for Development Cooperation (Norad) to carry out the evaluation of Norway India Partnership Initiative (NIPI) Phase I.

In this section, we present the objectives and scope of the evaluation (Section 1.1), a background to NIPI, including its context (Section 1.2); and the report structure (Section 1.3).

1.1 Objectives and scope of the evaluation

As specified in the Terms of Reference, this is a 'process evaluation' of NIPI Phase I. The aim is to take stock of NIPI as it begins Phase II, focusing on the design of the initiative, governance and implementation arrangements/ processes, and the extent to which the initiative has met its stated goals/ results.[4]

The specific evaluation objectives as described in the Terms of Reference are as follows:

- Describe and analyse the governance structure, roles and cooperation between key actors involved in NIPI Phase I with respect to efficiency, effectiveness and sustainability.
- Identify the rationale and logic which guided the selection of specific targeted interventions within NIPI and the extent to which they reflect the strategic, catalytic, innovative approaches as stipulated in key NIPI documents.
- Assess whether and to what extent recommendations from the Evaluability Study and other relevant reviews have been considered and followed up, specify lessons learnt which may be relevant for the preparation and implementation of Phase II, and evaluate progress made towards delivering a monitoring and evaluation monitoring and evaluation system.
- Conduct a process evaluation of 1-2 targeted interventions that will continue in Phase II.

4 Given the focus on a process evaluation, it is not within scope to undertake a detailed review of the outputs, outcomes and impacts of the NIPI interventions.

It should be noted that the NIPI Phase II agreement has been signed recently and broad design aspects have been agreed. Therefore, as discussed with Norad, the lessons that we draw from our review are more in the nature of refinements or improvements in the planned design and processes, rather than a fundamental re-think of the initiative's structure. A number of key issues/ lessons learnt are already recognised and are being factored into the design of Phase II (as discussed in Section 8).

1.2 NIPI Context and Description

We set out the context for NIPI in terms of the status of maternal and child health in India and the Government of India's National Rural Health Mission (NRHM) programme. We also present a summary of the NIPI Phase I objectives, design and structure.

1.2.1 NIPI context

Status of maternal and child health in India

While infant and child mortality rates in India have been declining over the past few years, there is a growing concern that the rate of decline is not fast enough to achieve the Millennium Development Goal 4 (MDG 4). The table below presents the latest available key statistics on maternal and child health in India, and the corresponding MDG targets.

Table 1.1 Key health indicators[5]

Indicators	2001	2009	MDG targets
Under Five Mortality Rate (U5MR) (per 1,000 live births)	85	64	42
Infant Mortality Rate (IMR) (per 1,000 live births)	66	47	28
Maternal Mortality Rate (MMR) (per 1,00,000 live births)[6]	301	212	109
Total Fertility Rate (TFR)	3.1	2.6	n/a

Some of the main causes of death for children under five in India are neonatal conditions (including sepsis, birth asphyxia and prematurity), pneumonia and diarrhoea.[7]

In addition, the Coverage Evaluation Survey (2009) found that only 61% of all infants were fully immunised and the World Health Organisation (WHO)/ United National Children's Fund (UNICEF) estimates indicate that Diphtheria-Tetanus-Pertussis (DPT3) coverage was 73% in 2010. Another target under MDG 4 is to improve the proportion of one year old children immunised against measles from

5 Ministry of Health and Family Welfare, Government of India., Family Welfare Statistics in India , 2011
6 Maternal Mortality Rate is reported for the years 1999-00 and 2007-09
7 Lahariya, C and V.K. Paul, Burden, differentials, and causes of child deaths in India, *Indian Journal of Paediatrics*. November 2010. 77(11):1312-21. http://www.ncbi.nlm.nih.gov/pubmed/20830536

42% in 1992-93 to 100% by 2015. India is making improvements in this regard, as the percentage of 12-23 months old children immunised against measles has improved from 42% in 1992-93 to 74% in 2009.[8]

Government of India's National Rural Health Mission (NRHM) programme

Recognising the need to improve the availability of and access to quality health care, and achieve a reduction in child and maternal mortality, the Government of India launched the NRHM in 2005. The initiative has a national remit but with a special focus on 18 states, including eight Empowered Action Group states, the North-Eastern states, Jammu and Kashmir and Himachal Pradesh.[9]

NRHM aims to reduce Maternal Mortality Rate (MMR) to 100 per 1,00,000 live births; Infant Mortality Rate (IMR) to 30 per 1,000 live births and Total Fertility Rate (TFR) to 2.1 over its duration (2007-12).[10] It seeks to achieve these goals through a set of core strategies including: enhancing budgetary outlays for public health; decentralising village and district level health planning and management; appointing Accredited Social Health Activists (ASHAs) – a community health worker appointed by the government to promote health awareness in rural regions and provide basic treatment; strengthening the public health service delivery infrastructure, particularly at the village, primary and secondary levels; improving management capacity to organise public health systems and services; promoting the not-for-profit sector to increase social participation; upgrading public health facilities to India Public Health Standards; reducing infant and maternal mortality through the Janani Suraksha Yojana (a programme that aims to encourage institutional deliveries); and mainstreaming Ayurveda, Yoga, Unani, Siddha and Homeopathy (traditional Indian approaches) to facilitate comprehensive and integrated healthcare to rural population.[11]

Going forward, NRHM is being re-constituted as the National Health Mission and will cover both rural and urban areas, while maintaining a focus on the former. Major components of the National Health Mission will be the following: a scheme for providing primary health care to the urban poor; providing greater flexibility to the states to make multi-year plans for systems strengthening; and addressing threats to health in both urban and rural areas through interventions at the primary, secondary and tertiary levels of care.[12]

1.2.2 NIPI Objectives and Design

Objectives and focus areas

The Norway India Partnership Initiative (NIPI) was established in September 2006 through a joint statement signed by the Prime Ministers of Norway and

8 Ghosh Roshni., Khan, A G., Pradesh, R Manas., and Reddy Hamini., India's Progress Towards the Millennium Development Goals 4 and 5 on Infant and Maternal Mortality.

9 The Empowered Action Group states are Uttar Pradesh, Bihar, Madhya Pradesh, Odisha, Jharkhand, Uttaranchal, Rajasthan and Chhattisgarh. The North-eastern states are Sikkim, Assam, Arunachal Pradesh, Nagaland, Manipur, Tripura, Meghalaya, and Mizoram.

10 Ministry of Health and Family Welfare, Government of India, National Rural Health Mission., Framework for Implementation (2005-12).

11 Programme Evaluation Organisation, Planning Commission, Government of India.., Evaluation Study of National Rural Health Mission (NRHM) in 7 States, 2011.

12 Draft 12th Five Year Plan (2012-17), Social Sectors, Volume III.

India, and is based on the understanding between the two governments to collaborate towards reduction of child mortality in India. It is one of five bilateral initiatives of the Norwegian government to support a reduction in child mortality and the attainment of Millennium Development Goal 4.[13]

As per the Project Document[14], the vision of NIPI is to "provide catalytic, strategic support that would make a vital and sustainable difference to the rapid scaling up of quality and equitably delivered child health services in India under the NRHM". Its desired outcomes are linked to the goals of the NRHM and include: (i) sustaining routine immunisation coverage at 80% or more from 2007 onwards[15]; and (ii) saving an additional half a million children each year under the age of five, from 2009 onwards.[16]

The NIPI Project Document, the 2008 Strategy Document and the 'NIPI story' note additional objectives of the initiative in terms of contributing to health systems strengthening and creating a broader platform for generating new and innovative practice, and documenting and sharing the experiences.[17] These documents also recognise the intent of NIPI in providing flexible funding and technical support, and introducing innovative and catalytic interventions in the focus districts.

The 2008 Strategy Document sets out three focus areas for NIPI:[18]

- **Focal Area A - Quality Services for Child Health:** Catalytic interventions related to universal immunisation (cold chain and vaccine management systems), newborn and child health interventions, and related maternal health interventions.

- **Focal Area B - Enabling Mechanisms:** Catalytic interventions relating to techno-managerial support that contribute towards enhancing the overall quality and effectiveness of the programme and strengthening of health systems.

- **Focal Area C - Learning and Sharing of Experiences:** Aimed at developing a learning base and information sharing of the research, pilot projects and models in Focal Areas A and B.

13 Other bilateral initiatives are being implemented in Pakistan, Nigeria, Malawi and Tanzania.
14 NIPI Project Document, Norway-India Partnership to Achieve Millennium Development Goal 4, as forwarded by the Additional Secretary and Mission Director (NRHM) to State Secretaries of Uttar Pradesh, Bihar, Odisha, Rajasthan and Madhya Pradesh on 31 October 2006.
15 The basis for this outcome is not clear as the Coverage Evaluation Survey in 2009 found that only 61% of all infants were fully immunised and the WHO/ UNICEF estimates show DPT3 coverage of 72% for India in 2010.
16 NIPI was envisioned to contribute to the NRHM goals, rather than achieve separately defined outcomes.
17 Norway India Partnership Initiative, Strategy Document, 2008; Norway India Partnership Initiative, The story of NIPI from conceptualising to pilot testing in 13 districts, to scale up of newborn & child health interventions to preparing for second phase, 2012.
18 Initially, the Project Document outlined four focus areas for NIPI: (i) strengthening the NRHM to facilitate the delivery of MDG 4 related services; (ii) testing and introducing new ways for scaling up quality services by primary health workers (ASHA), including their support needs and referral requirements; (iii) recruiting private sector into the delivery of MDG 4 related services; and (iv) exploring new opportunities as they arise during the implementation of NRHM MDG 4 related activities.

Design

The budget for NIPI Phase I for the period 2006-12 (later extended to 2013) was NOK 500m, however actual investments over the period have been lower at NOK 332m. Based on the experiences gained and results achieved in Phase I, NIPI has been extended to coincide with the new NRHM (2013-17). The total budget for Phase II is estimated at NOK 250m.

The initiative focuses on four states – Odisha, Bihar, Rajasthan and Madhya Pradesh. While it was originally planned that the state of Uttar Pradesh would also be included, it was not possible to sign a Memorandum of Understanding (MoU) with the state government (although UNICEF has implemented some activities in the state with NIPI funds).

NIPI Phase I has been implemented through three partners – UNICEF, WHO and United Nations Office for Project Services (UNOPS). UNOPS also provides Local Fund Agent services to the NIPI states (no funds are received directly by the government under NIPI), and has been responsible for staffing and operating the NIPI Secretariat. The areas of work of the three implementing partners in 2011 were as follows:[19]

- **UNOPS** supported a number of the NIPI interventions such as Yashoda, Home Based Post Natal Care, Mobile Money Transfer for ASHAs, Sick New Born Care Units, techno-managerial support to Programme Management Units under NRHM, and District Training Centres.

- **UNICEF** worked in the areas of Integrated Management of Neonatal and Childhood Illness, community based newborn and child care, facility based newborn care, routine immunisation (strengthening cold chain and vaccine management systems), assessment and improvement of quality of care, and district and block planning/ management/ support.

- **WHO** focused on pre-service Integrated Management of Neonatal and Childhood Illness training for health professionals, accreditation systems for facilities carrying out relevant studies, training of Auxiliary Nurse Midwives (including training of trainers), and some work of malnutrition.

1.3 Report Structure

The rest of the report structure is as follows:

- Section 2 presents our evaluation design and methodology, including limitations;

- Section 3-6 present the analysis and key findings on the four evaluation dimensions of policy and design, structure and governance, implementation/ processes and results;

19 Referenced from the NIPI Annual Report (2011) and the Evaluability Study (2010) as well as comments from Norwegian Embassy, New Delhi.

- Section 7 presents some key points on the cross cutting issues of gender, equity, quality and sustainability; and

- Section 8 presents our conclusions and lessons learnt.

The report is supported by the following annexes: Term of Reference for the assignment (Annex 1); bibliography (Annex 2); list of consultations (Annex 3); core phase interview guide (Annex 4); field visit design and interview guide (Annex 5); description of NIPI governance structures (Annex 6); key activities and achievements of UNICEF and WHO (Annex 7); field visit reports for Bihar, Madhya Pradesh, Odisha and Rajasthan (Annexes 8-11); and a summary of progress made on previous recommendations (Annex 12).

Note
Annex 4-12 are to be found in a seperate volume available for download at *www.norad.no/evaluation.*

2. Evaluation Design and Methodology

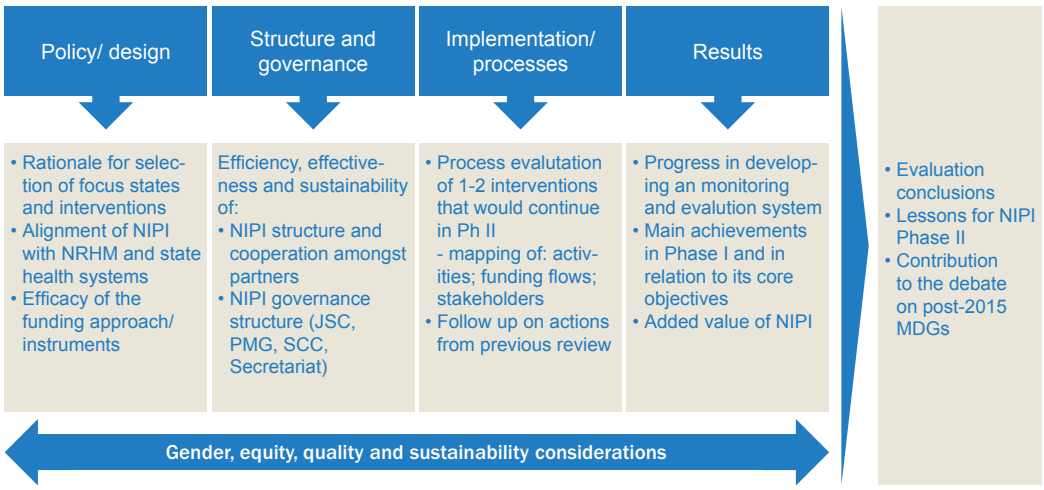
We present below our evaluation framework (Section 2.1); evaluation methods and limitations (Section 2.2); and approach to collating evidence and synthesising (Section 2.3).

2.1 Evaluation Framework

We have structured the evaluation framework along four inter-related dimensions of policy/ design, structure and governance, implementation/ processes, and results (Figure 2.1). This is in line with the evaluation scope and objectives, and incorporates a few additional parameters which we view as important – including an assessment of the efficacy of the funding approach/ instruments and the

added value of NIPI. Gender, equity, quality and sustainability have been considered as cross-cutting issues in the evaluation (with quality, equity and sustainability in particular being key aspects of NIPI's vision). Findings across the four evaluation dimensions have informed the evaluation conclusions and the lessons learnt.

Figure 2.1 Evaluation framework



More details on the specific approach to assessing each of the evaluation dimensions is elaborated in the respective sections below. In particular, Section 5.1 elaborates on our approach to the process evaluation of selected NIPI interventions.

2.2 Evaluation Methods and Limitations

We have employed a mixed-methods approach for this evaluation, encompassing:

- **Desk-based review and analysis.** Our starting point has been a detailed desk-based review of relevant documents including NIPI-specific documents (e.g. the NIPI strategy, project document, agreements with implementing partners, partner annual progress reports, financial reports, other Monitoring and evaluation documents) and relevant broader literature (e.g. Government of India and National Rural Health Mission (NRHM) documents, state level plans and data, journal articles). A bibliography is provided in Annex 2.

- **Structured interviews**. Interviews have been a key source of evidence for a number of evaluation dimensions given lack of data and the qualitative nature of the evaluation. We have conducted structured interviews with a range of stakeholders including Norad, Government of India (national and state level), WHO, UNICEF, UNOPS, Norwegian Embassy, key experts and other relevant stakeholders. Annexes 3 and 4 provide a list of consultations and the interview guide.

- **Field visits.** Field visits have formed an important evidence source, particularly for the process evaluation of the selected NIPI interventions. We have covered all four NIPI focus states, and two districts in each state. We have interviewed the state health and finance departments, implementing partners in the field, health personnel involved in NIPI interventions, health facilities, communities/ beneficiaries, amongst others. Annex 5 presents the field visit design and interview guide. Annexes 8-11 provide summary findings from our four field visits.

- **Quantitative analysis.** We have carried out some limited quantitative analysis – primarily examining information on the NIPI processes (e.g. for disbursement of funds), and available outputs (and any intermediate results) data. Data sources are included in the annex on the bibliography.

Key limitations of our evaluation methods are as follows:

- There has been limited documentation on the NIPI processes in Phase 1, which is the core focus for this evaluation. Therefore, we have primarily relied on our stakeholder consultations for a factual and high-level understanding of NIPI's design and implementation.

- Given that a large number of consultees have been involved in the initiative/ implementation of interventions, there is scope for bias and subjectivity in feedback. We have attempted to minimise the impact of this by triangulating views across stakeholders, to the extent possible. However, given the primarily qualitative nature of the evidence (e.g. related to personality and institutional issues), this has been somewhat challenging.

- Some limitations of the field visits are as follows:

  - There could be potential bias in selecting districts as these were determined in discussion with UNOPS. However the evaluation team has attempted to reduce bias by engaging in a comprehensive discussion with UNOPS and reviewing available data on the districts. In addition, we have covered majority of the NIPI districts (two out of three in each state[20]).

  - There might also be a potential bias in the selection of consultees made available in the districts, as these were pre-arranged by UNOPS. This relates mainly to the ASHAs interviewed in the states, as they were specifically called to the health facilities by UNOPS to meet with us – which could not be avoided given we were unable to contact ASHAs directly.[21]

  - In line with the available time and budget for this evaluation, each of the four state visits was short (about 3 days each). Whilst we covered good ground in terms of districts and consultees, our findings are limited to what we learnt and observed in the time available.

  - Beneficiary (i.e. mothers) interaction has faced some issues given the place and time of interviews (i.e. the hospitals, soon after their delivery). The presence of other stakeholders at times (nurses, family members, Yashodas) might have biased their responses.[22]

- Quantitative analyses has been limited by the availability and quality of data. In particular there has been limited data from NIPI on the use of funds during Phase I (for example, by intervention).

2.3 Approach to Collating Evidence and Synthesising

The evaluation conclusions are based on a collation of the available evidence (drawing on the evaluation methods described above), also assessing the quality (i.e. data quality, type of stakeholder group consulted for a particular evaluation question); and uniformity (i.e. triangulation) of the evidence. This has been supplemented by our informed judgment on the interpretation of the evidence, drawing on our knowledge and experience with evaluations and the Indian health system.

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20 A fourth NIPI focus district was added in 2010 in Madhya Pradesh and not covered during the field visits.

21 We do not view any issues with UNOPS arranging meetings with the government representatives (as we met with key officials in the states/ districts) and health facility staff (including Yashodas) and beneficiaries (as these were 'randomly selected' given that we met who was available at the facility at that time).

22 Nurses/ Yashodas were required to kick start the meetings in the maternity wards as otherwise the mothers would not be open to discussing with external personnel. They were also required to support translation of some interviews where mothers spoke in the local dialect only. Approximately one-third to half of the beneficiary interviews were conducted in the presence of these stakeholders (although this varied by the specific health facility visited in each of the four states). The two-member evaluation team for each state visit sought to split up while interviewing mothers so as to avoid crowd gathering at the interviews (and distract health workers/ Yashodas). It should also be noted that in the Indian context it is very difficult to communicate with young mothers in public without their mothers-in-law listening in or contributing to the conversation.

Our findings have been synthesised to present overall conclusions and lessons learnt for NIPI as it moves into Phase II. The presentation of conclusions has been guided by the Organisation for Economic Cooperation and Development (OECD)/ Development Assistance Committee (DAC) evaluation criteria, adapted to this evaluation as follows:[23]

- **Relevance** is the extent to which the design and objectives of an intervention are consistent with the recipients' requirements, country needs, global objectives and partners' policies. In the NIPI context, we have assessed the extent to which its design and processes are appropriate in the Indian context. We have also assessed the extent to which NIPI has been aligned with the NRHM and national/ state health systems.

- **Effectiveness** refers to the extent to which planned objectives and outputs have been achieved. We have assessed if NIPI's design and processes have contributed positively or negatively to its attainment of its objectives.

- **Efficiency** is an economic term that relates to the ability to deliver desired outputs at the lowest possible cost for a given quality. We have concluded on the cost effectiveness of NIPI as a whole.

- **Impact** refers to the long-term consequences of an intervention. While an impact assessment is not in scope, our focus has been on the extent to which NIPI has attained its objectives of being strategic, catalytic, innovative and flexible.

- **Sustainability** of an intervention is concerned with the extent to which programmes are likely to be continued after donor funding ends. In the NIPI context, we assess the extent to which interventions have been sustained/ scaled up and any issues thereof.

We have employed a 'traffic light' system to report on the performance of NIPI's processes against the five DAC criteria above (Table 2.1). The 'traffic lights' are relative rankings that are intended to present our conclusions on the strength of NIPI's performance. The rating are judgemental and reflect our assessment of the evidence gathered as part of the evaluation.

Table 2.1 Traffic light system for performance assessment

Symbols	Description
G	**Green** indicates that NIPI has performed well against the evaluation criteria. Some refinements/ improvements may however be needed.
A	**Amber** indicates that NIPI has performed reasonably against the evaluation criteria, but considerable improvements should be made.
R	**Red** indicates that NIPI has performed poorly, and immediate and major changes to the initiative are recommended.

23 http://www.oecd.org/dac/evaluationofdevelopmentprogrammes/daccriteriaforevaluatingdevelopmentassistance.htm

3. Policy and Design

3.1 Scope and Approach

We examine the following aspects of NIPI's policy and design: the rationale for selection of the focus states/ districts and interventions (Section 3.2); the alignment of NIPI with the National Rural Health Mission (NRHM) and state health systems (Section 3.3); and the efficacy of the funding approach (Section 3.4).

3.2 Selection of Focus States/Districts and Interventions

The selection of the NIPI focus states is clear and justified given they are amongst the poorest performing states in India with respect to key maternal and child health indicators. The selection of districts has been more nebulous and could have been based on pre-determined criteria, although they have typically been chosen by the state governments rather than a 'top-down' approach.

The rationale for the selection of NIPI interventions is aligned with global evidence on strategies for improvement of child (and maternal) mortality and are generally relevant in the Indian context vis-a-vis the existing delivery gaps in the health systems and services. However, the selection and prioritisation process for the interventions could have been more systematic and inclusive.

3.2.1 Rationale for Selection of States and Districts

NIPI Phase I focused on four Indian states namely Bihar, Madhya Pradesh, Odisha and Rajasthan.[24] These states are a part of the 18 NRHM priority states, comprise a relatively large share of India's total population (c. 24%), and are amongst the poor performing states with respect to key maternal and child health indicators (Figure 3.1).[25] India's success in achieving Millennium Development Goal 4 hinges on the improvement of child health performance in these states, providing a clear basis for their selection.

24 While it was originally planned that Uttar Pradesh would also be included, it was not possible to sign a Memorandum of Understanding (MoU) with the state government. However, UNICEF has been implementing some activities in the state with NIPI funds.

25 These states also have a low sex ratio as compared to the national average (except for Odisha) and comprise a large proportion of disadvantaged population groups – Scheduled Castes / Scheduled Tribes / Other Backward Classes – particularly in Bihar.

Figure 3.1 Health status in NIPI focus states as compared to the all-India average [26]

26 While Bihar performs relatively better than the all India average on neo-natal mortality, it performs poorly on many other social and economic indicators and has always been a laggard state in India.

It could be considered that, given NIPI support is intended to be strategic and catalytic, the selection of states might have been driven not only by need but also by capacity to demonstrate results – for example, selecting high performing states where it could be relatively easier/ faster to demonstrate 'proof of concept'. However, with Government of India's approach to limiting bilateral assistance to strategic/ complementary support, in our view, it may have been politically infeasible to select high performing states. In the Indian context, Bihar and Odisha have been particularly laggard states and external donor assistance has tended to focus on these states (e.g. DFID support to India is focused on these two states as well as Madhya Pradesh[27]; the Gates Foundation provides maternal and child support in Bihar).

The rationale for the selection of the focus districts within these states is however more nebulous and less driven by objective criteria. We understand that the intention was to select medium performing districts, as poor performing districts with poor infrastructure/ human resources might delay implementation; and high performing districts might make it difficult for NIPI to advocate replication/ scale up. However, in actual practice, the selected districts have been a mix of high, medium and poor performing ones; being selected more on an 'opportunistic' basis (e.g. where the administration has been receptive to NIPI, in close proximity to the capital city (and hence easier to access), recipients of economic/ political support). For example, in Bihar, two of three focus districts, Jehanabad and Sheikhpura are naxalite effected, with poor health resources and infrastructure; and the third district – Nalanda – is a reasonably good performing district and a hub of political activities in the state. However, we also understand that this selection was largely driven by the preferences of the respective state governments (rather than being 'imposed' on them).

Other feedback from consultees regarding the choice of districts include:

- NIPI could have selected far flung, remote and the more problematic districts with a larger proportion of disadvantaged population, poorer health indicators, which are in greater need of support

- A state-wide approach may have been more beneficial, rather than focusing on select districts, so as to ensure coordination with the state health systems and delivery channels as a whole.[28]

We are not in complete agreement with these view points. For example, we see merit in not selecting the worse performing districts, given the additional challenges in demonstrating results. Further, we note the challenges with implementing a state-wide approach with a limited budget as well as the need for new interventions to first show 'proof of concept' before being scaled up.

Our assessment is that the selection of districts could have been more logical and based on criteria that should have been agreed at the outset (at both the

27 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67378/india-2011-summary.pdf
28 For example, we understand that the Yashoda intervention was implemented state-wide in Rajasthan by NIPI before state government funding from April 2012

national and state government levels) and followed uniformly across all focus states. Nonetheless, we recognise that the state-driven choice of districts is more preferred than a 'top-down' approach.

3.2.2 Rationale and Process for Selection of Interventions

We focus here on the selection of interventions that have been supported by UNOPS. [29] [30] We analyse the rationale for their selection based on both global evidence as well as the need/ gaps in the Indian context.

NIPI UNOPS has selected a range of interventions across the continuum of care, focusing on a reduction in neo-natal mortality through a mix of home/ community and facility based interventions. While we have not conducted a systematic literature review on the subject, our review of the global evidence-base in relation to these interventions suggests that:

- **NIPI interventions are aligned with some of the core strategies for newborn care.** As early as 1905, the French obstetrician Budin recommended resuscitation, warmth, early and frequent breastfeeding, keeping the baby with his or her mother, hygiene, and prompt recognition and treatment of illness.[31] The Lancet series on neonatal survival suggested that between 41% and 72% of neonatal deaths could be averted if 16 simple and cost-effective interventions were delivered with universal coverage. Among these are adequate nutrition, improved hygiene, antenatal care, skilled birth attendance, emergency obstetric and newborn care, and postnatal home visits to help mothers and infants.[32]

- **NIPI interventions have focused on home/ community and facility based care**. There is considerable evidence on the importance of enhancing facility-based care – for example, a study finds that "by providing comprehensive emergency obstetric and newborn care for births occurring in facilities, 327,200 intrapartum-related neonatal deaths could be averted globally; and with 90% coverage, 613,000 intrapartum-related neonatal lives could be saved, primarily in high mortality settings".[33] In addition, the introduction of home visits as a complementary strategy to facility-based post natal care can improve newborn survival, especially given that mothers and newborns have no contact with a health provider from the point of discharge until the six week postpartum and immunisation visit; and in the case of home births.[34] NIPI's approach of focusing on both home/ community and facility based care can thus be regarded as effective.

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29 The selection of interventions/ areas of work for WHO and UNICEF is discussed in Section 4 and 6.
30 It is also not within our scope to comment on the choice of the specific intervention as compared to alternatives.
31 N. Nair , et al., Improving Newborn Survival in Low-Income Countries: Community-Based Approaches and Lessons from South Asia, PLoS Med 7(4): e1000246. doi:10.1371/journal.pmed.1000246,2010.
32 http://www.who.int/maternal_child_adolescent/documents/lancet_neonatal_survival/en/
33 JE. Lawn , et al., Reducing Intrapartum-Related Deaths and Disability: Can the Health System Deliver?", Int J Gynaecol Obstet. 2009 Oct;107 Suppl 1:S123-42
34 WHO/UNICEF Joint Statement, " Home visits for the newborn child: a strategy to improve survival" accessed at http://www.unicef.org/health/files/WHO_FCH_CAH_09.02_eng.pdf

- **There is insufficient evidence on the role of lay health workers, albeit the available evidence is positive and many countries have adopted this strategy.** Given that there is a shortage of trained human resources, several African and south Asian countries are currently investing in new cadres of community health workers as a major part of their strategies to reach the Millennium Development Goals, in some cases arguing that they reach the poor who are less likely to use health facilities. For example, Ethiopia is training 30,000 community-based health extension workers (women) to focus on maternal, newborn, and child health as well as malaria and HIV. India, Kenya, Uganda, Ghana and South Africa are also involving community health workers in national programmes. Robust evidence regarding the effectiveness of substituting lay health workers for health professionals or the effectiveness of alternative strategies for training, supporting and sustaining lay health workers is missing. However, a summary based on an update of a Cochrane systematic review published by Lewin et al (2010) is as follows – the use of lay health workers in maternal and child health programmes: "probably leads to an increase in the number of women who breastfeed; probably leads to an increase in the number of children who have their immunisation schedule up to date; may lead to fewer deaths among children under five; may lead to fewer children who suffer from fever, diarrhoea and pneumonia; and may increase the number of parents who seek help for their sick child."[35] The importance of the Yashoda and Home Based Post Natal Care interventions may therefore be perceived in this light.

Further, our review of the documentation on the NIPI UNOPS interventions as well as consultations with a range of stakeholders in India (including specifically the national and state government representatives and experts that have examined these interventions in detail) suggests that there is a strong rationale for the interventions, in the context of India's health system. The main summary points are provided in Table 3.1 below.[36] [37]

35 S. Lewin , S. Munabi-Babigumira, C.Glenton, et al., 'Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases (Review), *The Cochrane Library, 2010, Issue 3,* page 3.

36 Detailed rationale has been provided in the NIPI documentation (refer bibliography in Annex 1).

37 Note that we comment here only on the overall need rather than the suitability of the design of the specific interventions.

Table 3.1 Rationale for selection of key NIPI interventions

Interventions	Need in the Indian context
Yashoda/ Mamta	A significant increase in institutional deliveries as a result of the Janani Suraksha Yojana, particularly in the NIPI focus states, has created an additional burden on the health facilities in terms of infrastructure and manpower (e.g. doctors, nurses).[38] Thus, a mechanism was needed at the health facilities to equip mothers with the required knowledge and counsel them on zero dose immunisation; immediate and exclusive breastfeeding; duration of stay at the health facilities; amongst others. The Yashoda intervention was envisioned to provide effective post-partum care and maximise the benefits of Janani Suraksha Yojana during the stay of mothers and newborns in the facilities.[39]
Home Based Post Natal Care	Home Based Post Natal Care, implemented through the ASHAs, presented a logical step in the continuum of care, in that the ASHAs follow up with the mothers and babies after discharge; identify danger signs at an early stage; and refer the baby to a nearby health facility/ Sick Newborn Care Unit, as required. While similar concepts of post natal care existed in India earlier (e.g. Gadchiroli model and UNICEF Integrated Management of Neonatal and Childhood Illness programme), a structured and systematic mechanism at scale for post natal care was needed.
Sick New Born Care Units	Sick Newborn Care Units existed at the state but not at the district level and there was a need to establish a link between the two. With increased referrals from the community through the Home Based Post Natal Care intervention as well as from within the facility, the need to strengthen sick newborn care at different levels was identified as a priority.
Techno managerial support	In addition to medical staff in health facilities, the need for techno-managerial staff to manage the delivery of healthcare and oversee administrative aspects has been a long term weakness in India. NIPI aimed to address this issue by providing a management support mechanism at the state, district and blocks levels.

38 A Concurrent Assessment of Janani Suraksha Yojana in select states (Bihar, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh) by UNFPA (2009) found that 55% of the births in these states during 2008 occurred in an institution, and the direct beneficiaries of the scheme (delivering either at a government facility or in an accredited private facility) were 47%.

39 An evaluation of the Janani Suraksha Yojana scheme in some states (Madhya Pradesh, Rajasthan, Assam, West Bengal, Odisha and Himachal Pradesh) by UNFPA and GTX in 2007 brought out the urgent need for better counselling and care coordination in crowded health facilities for the mother-new-born cohort (Assessment of ASHA and Janani Suraksha Yojana in Rajasthan, Madhya Pradesh and Odisha, April 2007); Assessment of Janani Suraksha Yojana in Assam. CORT. April 2007, Supported by GTZ.)

We have also reviewed the processes involved in selecting the NIPI interventions, and our assessment is that more could have been done in terms of developing a clear and systematic selection process.

Our understanding is that the ideas for the interventions primarily came from senior government officials and evolved through discussions among national/ state health departments and NIPI. As per the NIPI design, these were discussed at the technical level at the Programme Management Group meetings, after which they were approved by the Joint Steering Committee.[40] However:

- Our consultations with NIPI stakeholders (Joint Steering Committee and Programme Management Group members, Norad, NIPI implementing partners) suggest that a methodical/ structured process was not followed as such to review the feasibility or prioritisation (e.g. through a cost-benefit analysis) of the selected interventions. This might imply that certain interventions were approved based on the preferences/ viewpoints of individuals, rather than a carefully considered and comprehensive selection approach.[41]

- The NIPI 2008 Strategy document suggested that NIPI should map out and analyse the constraints that hinder full use of the NRHM funds as well as develop and agree on strategic criteria that would help select and prioritise NIPI interventions. While a suggested framework for this criteria is provided in an annex to the document, our understanding is that these were not systematically used in the selection/ prioritisation of NIPI interventions.[42]

- In addition, it has been questioned by some stakeholders whether decisions on these interventions were taken by consensus, particularly given the Indian context where hierarchy affects interactions and the decision making processes to a significant extent. A few consultees also mentioned that the central government authorities were not adequately consulted on the structuring of some of the interventions – whilst this is not a major issue per se as health is a state subject in India and the Joint Steering Committee/ Programme Management Group were aware of the focus of NIPI, it is viewed as one of the reasons for the lack of national scale-up (through NRHM funding by the Government of India) of some of the interventions such as Yashoda.

40 Refer Annex 6 for a description of these NIPI governance bodies.
41 Our review of the Joint Steering Committee meeting minutes over the years also does not reveal any structured decision making process around the selection of interventions. While the meeting minutes include concept papers for some of the interventions, they do not suggest a detailed deliberation on the pros and cons of the interventions and assessment against possible alternative approaches.
42 Some of these criteria include criticalness to successful implementation of other NRHM activities, leveraging potential to catalyse participation by private sector or civil society, uptake and scale up likelihood within 12-18 months by the state and other operational actors, amongst others.

Thus, while NIPI interventions are generally relevant and aligned with available evidence on strategies for improvement in child (and maternal) mortality, their selection process has not been very systematic or driven by pre-agreed criteria.

3.3 Alignment of NIPI with the National Rural Health Mission (NRHM)

NIPI has generally been well-aligned with the National Rural Health Mission (NRHM) and state health systems, although not all of its interventions are being sustained/ scaled-up by the Government of India.

NIPI has been designed to work in close coordination with NRHM, for example, by channelling the majority of its funds through State Health Societies; and involving key government personnel at the central and state level in the NIPI governance structures43. Further, NIPI has been set up as a flexible initiative that was meant to evolve with implementation experience and the NRHM progress over time – rather than a traditional parallel bilateral development assistance programme.

Our field visits to the four NIPI focus states confirm that it has indeed been well coordinated with the NRHM at the state level, in that it has been implemented through the existing NRHM machinery and systems in the state. For example, all techno managerial personnel recruited by NIPI at the state, district and block levels are placed within the NRHM programme unit; work within the existing NRHM framework; and report to the head of the NRHM/ government unit where they operate. Also, the Home Based Post Natal Care intervention seeks to leverage and build on the role of the existing ASHAs – a health worker cadre created within the NRHM mandate.

However, some consultees have questioned the alignment of NIPI interventions based on their actual/ potential for absorption and scale up by the government. For example, the Yashoda intervention was seen as partially relevant as it is currently being supported by state government budgets and there is a question as to whether it will be incorporated in the NRHM umbrella – there appears to a divided view at the national level as to the merit of creating/ scaling up this additional cadre of non-medical facility based worker across states. Similarly, it is uncertain as to whether the government will absorb all of the techno-managerial staff funded through NIPI.

Also, some state government officials (e.g. in Rajasthan and Bihar) noted that the implementation of a few interventions in select districts/ blocks in the state creates additional pressure on the health system. A preferred approach, in their view, would be for NIPI to adopt a system-wide and state-wide approach (although as noted above, such an approach would not be aligned with NIPI's strategic/ catalytic mandate).

43 The Joint Steering Committee meetings are chaired by the Principal Secretary, Health and Progamme Management Group meetings by the NRHM Mission Director.

3.4 Efficacy of the Funding Approach

While NIPI funds represent a small proportion of the National Rural Health Mission (NRHM) budget, its main value add is the strategic, catalytic and flexible approach to the use of funds. Its use of funds has however not been very efficient, with lower utilisation than budgeted and relatively high administrative/ management costs. NIPI's flexible approach to disbursement (based on need) and timeliness has worked well, but financial management could be improved through better data collection and monitoring of budgets and spending.

The budget for NIPI Phase I was NOK 500 million (US$ 85 million) for five years (2006-11).[44] While the NIPI contribution formed a modest supplement to the total NRHM budget (e.g. the NRHM approved budget for the four NIPI states in 2010-11 was US$ 935 million), the funds were intended to complement national efforts on child and maternal health and accelerate the implementation of NRHM activities by providing strategic, catalytic and flexible support.

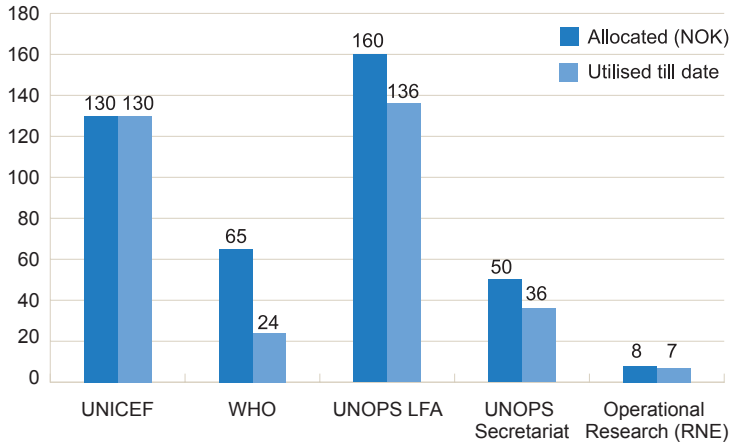
We understand that within the Phase I budget envelope, the Norwegian Embassy was given the flexibility to make annual appropriations to the implementing partners, based on actual needs of the project. The funds allocated to the partners were in line with their agreements and amounted to NOK 413 million (US$ 70 million) or 82% of its total budget.[45] Total utilisation to date has however been lower at NOK 332 million (US$ 56 million) (or 80% of the allocated budget), suggesting some inefficiencies, and we understand that the unspent funds are being carried forward into Phase II.

The figure below summarises the allocation of funds amongst partners, the Secretariat and the Norwegian Embassy (for operational research), and utilisation to date. It is noted that[46]:

- a significant proportion of funds were allocated to UNOPS Local Fund Agent (39%) and UNICEF (31%); and
- utilisation of funds by WHO has been particularly low, at 37% of its allocated budget.[47]

44 This was later extended to December 2012.
45 We are not clear as to why there has been a difference between the total budget and allocated amount.
46 State-level consultations suggest that fund utilisation in the initial period of NIPI was low (as also noted in the Mid Term Review), given that some activities took much longer than anticipated to commence (e.g. training and recruitment), and also due to other factors beyond the control of implementing partners (such as availability of HR; and coordinating with other government activities in the state). However utilisation has improved over the years and all states have utilised a bulk of their available budget. Some discrepancies between allocation and actual spend (as presented in Figure 3.2 above for UNOPS Local Fund Agent) are mainly on account of the states' funding specific activities that were envisaged to be funded under NIPI.
47 We understand that as per the MoU with WHO, a significant proportion of the funds were originally envisaged for measles surveillance activities, which did not eventually take place, resulting in lower utilisation of NIPI funds.

Figure 3.2 NIPI Phase I allocation and disbursements (NOK million) [48] [49]



We have estimated the proportion of management/ administrative costs in the total budget, based on the above allocation data and the Programme Support Costs charged by the three implementing partners (WHO (13%), UNICEF (7%) and UNOPS (5%)). [50] For a total of NOK 355 million (US$ 56 million) allocated to the three implementing partners, NOK 25.5 million (US$ 4.3 million) (or 7%) is for Programme Support Costs. Adding the actual costs of the Secretariat to date, the total estimate is NOK 61.5 million (US$ 12.8 million) or 15% of the total NIPI funds being used for management/ administrative purposes. This is an underestimate at best, as we do not have data on the costs of management/ administration by the Norwegian Embassy as well as the proportion of the implementing partner budgets that have been used for management (e.g. part of the UNOPS budget would have been used to support its offices in New Delhi and the four states). While there are no comparable benchmarks given the specific context and design of different initiatives, we view the administrative costs of the NIPI intervention as being relatively high.

Some additional points to note on our review of the funding approach under NIPI are as follows:

- On the positive side, we note that the MoUs with the implementing partners are as per standard donor funding agreements in terms of financial procedures and partners have informed us that fund disbursement from NIPI has been timely. Further, NIPI's approach of disbursing funds is based on the actual needs of the project, rather than on fixed annual allocations, reflecting its flexible nature. Also, since NIPI's funding is for a five year period, it is useful in terms of predictability of funding for the partners/ beneficiary states.

48 As per data provided to us by the Norwegian Embassy.
49 We were unable to get an annual and activity/ intervention wise breakdown from the partners.
50 Norway India Partnership Initiative., Final Report of the Mid-Term Review, 2010.

- On the less positive side however, we note the following:

  - Detailed financial data (e.g. annual budgets versus spends, spend by intervention/ activity, and spend on non-intervention costs) by each of the implementing partners has not been systematically collected by NIPI. This has limited our analysis on the use of funds (and we understand that this has been an issue within NIPI in general as well, in terms of lack of clarity on how the money has been spent by partners).

  - There has been some criticism about directly funding WHO and UNICEF for their NIPI-related activities (rather than channelling funding to the government as in the case of UNOPS). The criticism stems from the reduced access to funds (and consequently ownership) amongst the government.

4. Structure and Governance

4.1 Scope and Approach

We consider the following aspects under this evaluation dimension: (i) the NIPI structure, in terms of the MoU approach with implementing partners, and the role of and cooperation between key stakeholders (including the Secretariat); and (ii) governance arrangements, in terms of the roles and responsibilities of key governing bodies.

4.2 NIPI Structure

The NIPI structure of working through implementing partners with local presence is appropriate. However it needs to be more strategic in its selection of partners to align better with its mandate/ objectives and institute mechanisms for coordination. NIPI also needs to improve the clarity in the roles and functions of its key stakeholders.

4.2.1 Approach of Working Through Implementing Partners

As against the oft used traditional model of delivery for bilateral assistance, wherein a donor organisation would work through its country office or alternatively appoint or establish a new implementing agency, NIPI has been structured to implement its activities through three UN organisations that have an existing presence in India.

We understand that a number of options for the NIPI structure were considered at the start, however the final structure was determined based on:

- The history of Norwegian bilateral support in India, which was reduced in the early 2000s due to reduced demand from the Government of India for external bilateral assistance (as per our understanding from consultations with Norad). In line with this, it was not feasible to structure NIPI through the Norwegian Embassy in India. Also, such an approach is not preferred by the Norwegian government (with its global policy of reducing the infrastructure for development assistance in countries and working through existing local partners).

- The request by the Government of India to work with the selected UN organisations, given the focus on health and the roles/ health programmes of WHO and UNICEF. In addition, the government

recommended that NIPI work through UNOPS for the role of a Local Fund Agent.

In our assessment, the approach of not working through the Norwegian Embassy in India was appropriate. Notwithstanding the political issues noted above, such an approach might be relatively inefficient as it would require the recruitment of the necessary health sector expertise within the Norwegian Embassy, including having some state presence/ support for oversight of implementation of NIPI interventions. It might also reduce the alignment of the initiative with the National Rural Health Mission (NRHM) and national/ state health systems, as typical bilateral donor assistance is provided and implemented as a 'parallel' stream of funding. In comparison, working through in-country partners is a potentially more efficient approach as it benefits from the experience and capacity of key organisations that have been working in India, including their state-level knowledge, networks and experience.

The selection of UN organisations as implementing partners provided NIPI with a 'safety net' (as quoted by one of the consultees), in terms of their global and Indian health sector experience as well as the appropriate levels of financial/ fiduciary risk management. However, NIPI could also have explored working with reputed academic or research organisations or NGOs/ not-for-profit agencies – as planned under Phase II through an MoU with Jhpiego. Further, while the selection of WHO and UNICEF was based on their child and maternal health work in India as normative and implementing agencies respectively, it is not immediately clear why UNOPS was selected as an implementing agency – especially given its limited experience in the health sector and lack of state presence prior to NIPI.

However, with the benefit of hindsight, while UNOPS had to enhance its capacity using NIPI funds – both through staffing of its central office and field offices in the four focus states, it has performed well and delivered on some of the key objectives for NIPI (refer Section 6). On the other hand, whilst NIPI's partnering with UNICEF and WHO was prima-facie logical and efficient, these did not work well in practice (refer Section below).

Another option that was considered was establishing NIPI in the Ministry of Health and Family Welfare and in close proximity to NRHM. Whilst this may have promoted closer alignment with the government, it is likely to have resulted in greater levels of bureaucracy and delays in implementation. In any case, we understand that this was not considered as a feasible option based on discussions between the Norwegian and Indian governments.

The Mid-Term Review also notes that "for a number of operational and personal reasons", alternative options (as discussed above) were not adopted. We support NIPI's overall approach of working through in-country partners (thereby avoiding the creation of parallel structures). However, the particular choice of partners could have been better assessed in advance in terms of trying to match the NIPI approach, its focus states and selected interventions with the

capacities, priorities and costs of the potential partners. Further, a combination of UN agencies, academic/ research institutions, NGOs etc. could have been considered, as has been done in Phase II.

4.2.2 Roles of and Cooperation Between Key Stakeholders

There are a number of key issues with regard to the roles of and cooperation between key stakeholders:

Lack of defined stakeholder roles and weak Secretariat
We understand that when NIPI was set up, several alternatives for housing its Secretariat were considered. UNOPS was then viewed as the most pragmatic option based on its management capacity and given that the Norwegian Embassy did not wish to be responsible for managing/ administering the initiative. UNOPS therefore had a dual role of housing the Secretariat and serving as the Local Fund Agent.

However, as the initiative progressed, the UNOPS Secretariat was not able to deliver its mandate and was increasingly involved in implementation (as noted in the Mid-Term Review). Consultation feedback suggests that the role/ terms of reference of the Secretariat were not clearly defined, partly as a result of which it has been unable to deliver its functions effectively. Further, largely on account of a weak Secretariat, the Norwegian Embassy had been involved in NIPI's implementation, coordination and administration to a larger extent than planned (and the Mid-Term Review also noted its excessive involvement in the functioning of NIPI).

Following the recommendations of the Mid-Term Review to separate the role of the Secretariat and Local Fund Agent, the capacity of the Secretariat (although still housed at UNOPS) was strengthened by appointment of a Director and other personnel to carry out the coordination functions of the initiative. However, coordination has continued to be an issue for NIPI.

Another area where lack of clarity of roles and weak capacity has impacting performance has been with regards to the management of operational research. While this was initially the responsibility of the Norwegian Embassy, following the recommendations of the Mid-Term Review, this was transferred to the Secretariat and an Operational Research Committee and Sub-Committee were established.[51] However, we understand that the Secretariat did not take up this responsibility effectively (e.g. lengthy procurement procedures were followed, approvals/ processes to commission studies were by passed, etc). In addition, while five thematic areas were identified by the Operational Research Sub-

51 The mandate of the Operational Research Committee was to assess proposals for studies, evaluations, research and surveys, and provide standards for their implementation. The Operational Research Committee was chaired by the Mission Director, Ministry of Health and Family Welfare, and Co-chaired by the India Council of Medical Research. The Operational Research Sub-Committee was set up as a sub-group to provide technical assistance to the Operational Research Committee and identify research agendas in child and maternal health. However, the Joint Steering Committee can approve activities with an embedded research component, if it is a part of an intervention (e.g. baseline and end line surveys), without review of the Operational Research Committee.

Committee for research, only two studies were commissioned by the Secretariat.[52]

In general, it would be expected that an initiative such as NIPI which enjoyed very high levels of political support would have been structured with more clarity in the roles and responsibilities of its various stakeholders and the Secretariat (as also commented in the Mid-Term Review). Lack of clearly defined roles (also in relation to capacity) has resulted in reduced effectiveness in the implementation of the initiative. The absence of a well-functioning centralised coordination mechanism through the Secretariat in particular has resulted in poor alignment of the work of the partners and Monitoring and evaluation of the initiative as a whole.

Lack of clarity on mandate and areas of work by WHO and UNICEF under NIPI

While NIPI's rationale for choosing WHO and UNICEF as implementing partners is understood given their vast health sector experience and capacity in the country, many stakeholders have commented that:

- Both organisations could have been used in a more strategic manner than under Phase I, drawing on their specific comparative advantages in the health sector. For example, it was commented that WHO, given its strong normative role, could have played a strategic role in designing the guidelines and structure of key NIPI interventions.

- It is not clear how specific activities of both partners were selected for funding under NIPI. Several stakeholders have commented that both partners have used NIPI funds to fill in gaps in their existing programme of work, rather than deploying the resources for innovative/ catalytic activities and progressing the NIPI mandate/ interventions.[53]

As also discussed in Section 6.3, the lack of clarity of the role/ work of these partners under NIPI has created some ambiguity on their results in relation to the NIPI mandate.[54]

Lack of effective coordination/ communication between implementing partners

Our consultations suggest that there has been limited coordination amongst the implementation partners. In particular, it has been difficult to discern the role of each partner, and how they have worked in concert to achieve results. The four state visits also suggest a certain level of inefficiency and duplication of efforts by implementing partners. For example, in Rajasthan and Bihar, although both UNICEF and UNOPS were supporting the development of Sick Newborn Care Units with NIPI funds in their respective districts, there was limited coordination between them.

52 We understand that two studies have been commissioned by the Secretariat: Prognosis, Exploratory Research for Identification of Determinants of Neonatal Health; and Rapid Assessment of Yashodas, 2012.

53 For example, UNICEF needs to deliver its Country Action Plans that were not completely aligned with the NIPI mandate.

54 Further, we understand that a number of areas of work agreed under the MoU with WHO were not taken forward. For example, the MoU specifies WHO's role in strengthening surveillance systems for vaccine preventable diseases, especially measles, however, we understand that this was later not approved by the NIPI governance bodies, given that WHO National Polio Surveillance Project was already doing some work in this area.

Our view is that the implementing partners, particularly UNICEF and UNOPS who have field offices/ operations, could have benefitted by planning their NIPI interventions in coordination and developing synergies across their areas of work in the NIPI focus districts.

4.3 NIPI Governance Structure

NIPI has enjoyed high-level support from the Indian government largely on account of the senior composition of its governance structures (at the central and state levels). However, the governance arrangements could be streamlined to enhance efficiency and effectiveness.

We have assessed the effectiveness of the overall design and functioning of the NIPI governance structure and if it is 'fit for purpose'.[55] Key points to note are as follows:

Overlap in the roles of the Joint Steering Committee and Programme Management Group

While the mandate of the two governance bodies was clearly defined at the outset, there has been some duplication and overlap in their functioning, leading to inefficiencies and neither body being able to fulfil its mandate effectively.

- The Joint Steering Committee was intended to be the central decision making body for implementation of NIPI Phase I, providing strategic oversight for the planning, implementation, and dissemination of NIPI.

- The Programme Management Group was convened to provide detailed technical guidance and direction on the integration of NIPI interventions with the NRHM framework. It was originally envisaged that the Group would review the proposals received from the states, and make recommendations to the Committee for approval.

However our review of the Joint Steering Committee and Programme Management Group meeting minutes, and as also supported by a wide range of consultations, suggests that there was an overlap in the issues discussed at two meetings. We understand that given the background and experience of the Committee members, it has often undertaken detailed technical deliberations on NIPI interventions, and thereby in part negating/ duplicating the role of the Group. Similarly, at times key strategic decisions have been discussed and approved at both meetings – resulting in an overlap of functions.

These issues have raised questions as to whether the governance of NIPI is 'too heavy' vis-a-vis its mandate and size of support. Our view is also that there is potential to collapse the roles of the two bodies into one, assuming its membership can be contained to a size that allows for efficient functioning and meaningful discussion.

55 The functions and composition of the key NIPI governing bodies are summarised in Annex 6.

Mixed experience on the efficacy of the State Coordination Committee
Feedback from the four states is that the State Coordination Committee has been a useful and effective forum for discussing implementation plans (e.g. how and when the training should be conducted), reviewing progress of NIPI interventions and discussing key child health issues in the state. In addition, the participation of the Principal Secretary, Health and other development partners in the meetings was noted as useful in terms of leveraging high level political support.

However, there was unanimous feedback that the focus of the State Coordination Committee meetings has been on reviewing the NIPI-UNOPS interventions, with minimal discussion on the UNICEF interventions under NIPI.[56] We were also informed that the Committee meetings are not held on a regular basis. In addition, consultees in some states (e.g. Rajasthan) were not aware of how decisions taken at the Committee inform and influence national level decisions/ discussions at the Joint Steering Committee and Programme Management Group meetings, and requested greater clarity in this regard.

Thus a more comprehensive approach to the State Coordination Committee meetings, including greater linkages with the other governing bodies under NIPI, could help enhance effectiveness.

Mixed views on adequacy of the frequency of Joint Steering Committee and Programme Management Group meetings
The Joint Steering Committee and Programme Management Group meetings are supposed to be held once in every six months. There have been mixed views on the appropriateness of the frequency of these meetings.

- Some note that the limited periodicity of the meetings has been a concern. The two bodies actually meet only once in 7-8 months and on an ad-hoc basis, which has been viewed as inadequate to discuss and resolve the various implementation issues.

- A few have commented that having two bodies composed of senior government and other officials that meet twice a year is inefficient and disproportionate to the small size of the initiative (although the high political profile/ visibility that this awards NIPI vis-a-vis several other donor programmes is recognised).

Conflict of interest and hierarchical issues in the composition of committees
The composition of these committees has raised certain issues:

- **Conflicts of interest**. The Mid-Term Review notes a conflict in the composition of the Joint Steering Committee as WHO and UNICEF not only participate in this governing body, but also receive funds as

56 However, we understand that the coordination and communication between UNOPS and UNICEF has improved over time with active role of these agencies to keep each informed (e.g. Bihar).

implementing partners. Also, the fact that UNOPS is the Local Fund Agent, an implementing partner, and also hosts the Secretariat is a potential conflict. Whilst this may appear to be problematic, it could be handled with the appropriate safeguards in decision making, as is the case in some other multi-stakeholder programmes where implementing partners are also voting members of the governance bodies.[57]

- **Hierarchical nature.** The participation of the high level representatives from the Government of India raises the concern as to whether key decisions were taken by consensus and were inclusive and participative, rather than driven by 'top down' priorities. This is particularly relevant in the Indian context, where hierarchy has a significant influence on the decision making process and the contribution of more junior colleagues to discussions, especially in case of a different point of view or dissent.

In addition, frequent personnel changes in the Health Ministry at the central and state level and the implementing agencies (although not unexpected) adversely affected the focus and working of the initiative and created challenges of institutional memory (e.g. with respect to buy-in and views on the intervention design and processes) and shifting of priorities.

57 For example, the GAVI Alliance Board includes WHO and UNICEF who are also implementing partners for the GAVI work plan. The Alliance has developed a detailed conflict of interest policy to safeguard against any issues.

5. Implementation – Process Evaluation of Interventions and Follow-up on Reviews

5.1 Scope and Approach

We examine the following aspects of NIPI implementation/ processes under this evaluation dimension: a process evaluation of two NIPI interventions (Sections 5.2 and 5.3); and the extent to which recommendations from previous reviews/ evaluations have been considered and followed up (Section 5.4).

On the process evaluations, we have reviewed two key UNOPS supported interventions – Yashoda and Home Based Post Natal Care. The Yashoda is a facility-based intervention, wherein a health worker with a non-clinical background (the 'Yashoda') is appointed in the maternity wards to provide care and counselling services to mothers on key aspects such as weighing of the child, immunisation, and initiation of exclusive and immediate breastfeeding. Home Based Post Natal Care is a community based intervention wherein ASHAs (established under the National Rural Health Mission (NRHM)) provide post natal support to mothers by making home visits after delivery. More details on both interventions are provided in the sections below.

These interventions are amongst the key UNOPS interventions that are also being supported in NIPI Phase II and were selected for the process evaluation on account of presenting:

- a good mix in terms of the nature of the interventions (Yashoda is facility based, while Home Based Post Natal Care is community based); and
- a balance of experience in terms of implementation and scale up (the Yashoda intervention is being partially sustained through state government resources at present, while Home Based Post Natal Care has been adopted/ scaled up nation-wide by the Government of India as Home Based Newborn Care).

The process evaluation has entailed a review of the structure and key processes in the implementation of the two interventions, including[58]:

58 We have used the initial concept notes on 'Shishu ASHA' (the initial name for the Yashoda intervention) and Home Based Post Natal Care provided in the fifth Joint Steering Committee meeting agenda notes as the starting point for the process evaluation. (Norway India Partnership Initiative, Fifth Meeting of the Joint Steering Committee, 11th March 2008, Agenda Papers, 2008).

- a mapping of the key activities/ processes and stakeholders involved in the implementation of the intervention;[59]

- a comparative assessment, both within and across the NIPI focus states to understand any variations in implementation; and

- a review of what has worked well and less well, including factors impacting the execution/ success of the intervention.

5.2 Yashoda[60]

The Yashoda intervention and has largely been viewed as a useful intervention in the four states by all stakeholders, including medical officers, nurses and importantly, the beneficiary mothers (notwithstanding the limitations noted in Section 2.2). As per its intended objective, the role of the Yashodas has been viewed as important in creating a supportive and congenial environment for mothers at the health facilities (e.g. supporting the mother on arrival, counselling on zero dose immunisation, immediate and exclusive breastfeeding, keeping the baby warm).

The intervention is being funded by the state health budgets in all four focus states after NIPI funding ended in April 2012, although incorporation under National Rural Health Mission (NRHM) is currently under discussion.

Despite the overall positive views in terms of the utility of the intervention, there have been a number of issues with regards to its implementation as follows:

- The training provided to Yashodas has honed their skills and given them confidence to deliver their duties effectively. However, the frequency of training has varied across states, with inadequate provision of refresher training.

- The supervisory structure established for Yashodas under NIPI has enhanced monitoring and supervision and also provided Yashodas with a sense of moral support. However, the efficacy of the supervisory structure has varied across states. Also, key supervisory mechanisms have been discontinued since the take-over of funding by the government, which has impacted the efficacy of the intervention.

- The intervention has given an opportunity to many low-income/ disadvantaged (e.g. divorced) women to earn a livelihood. However, contrary to its design, the payment mechanism has not been incentive based in practice (although this hasn't prevented them from providing their services), with Yashodas in most states being paid a monthly capped salary. Their payment is regarded as insufficient in relation to their workload. There have also been delays in payments to Yashodas (with this delay increasing with the transition of funding to the state governments).

59 The first step for a process evaluation is a 'process mapping' which refers to a delineation of the "activities involved in ...[the intervention]; to what standard a process should be completed; and how the success of a ... process can be determined." Ref: GALVmed, Monitoring and Evaluation Framework, 2013.

60 The Yashoda intervention is known as the Mamta intervention in Bihar.

- Contrary to its design, wherein Yashodas were envisaged to look after 4-5 mother-baby cohorts, they have supported around 5-6 times the number on average.

- Yashodas have not been able to focus exclusively on counselling of mothers and have often been made to perform other hospital and administrative duties.

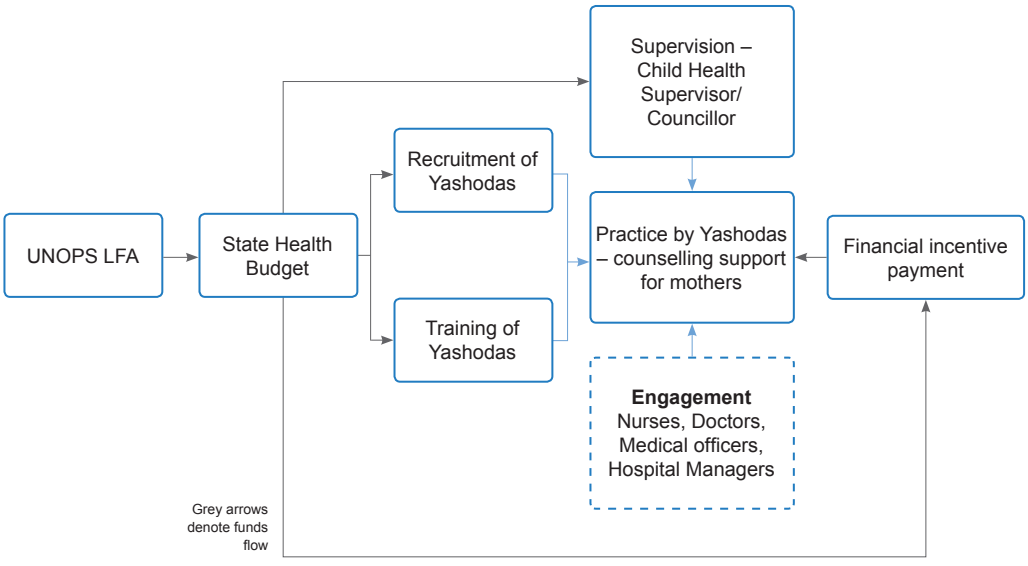
If the Yashoda intervention is to be continued, it would be important that these key issues identified in the process evaluation are considered and rectified, so as to allow for the intervention to deliver more efficiently and effectively on its intended objectives.

5.2.1 Description

The Yashoda intervention was introduced in 2008 in the four NIPI focus states (known as the Mamta intervention in Bihar). Yashoda is a mother's aide, with the role of providing care and counselling to the mothers in the maternity wards in hospitals. She is of a non-clinical background and focuses her counselling on motivating mothers to: weigh the child; provide required/ timely immunisation; initiate exclusive and immediate breastfeeding; and stay back in the health facilities for a period of two days at a minimum. Yashodas also provides counselling on adequate spacing of child births and other information on post natal care services.61 The initiative was designed to be introduced in health facilities where there is a high delivery load.

The figure below presents a schematic of the Yashoda intervention. We describe the key processes of the intervention, followed by our review of what has worked well and less well, drawing on state specific experiences.

Figure 5.1 Schematic of the Yashoda intervention



61 Norway India Partnership Initiative., The Story of NIPI from Conceptualisation to Pilot Testing in 13 Districts, to Scale Up of Newborn and Child Health Interventions to Preparing for Second Phase.

The Yashoda intervention is being funded by the state health budgets in all four NIPI focus states after NIPI funding ended in April 2012 (more details provided below).

5.2.2 Process Mapping

We describe below the main processes relevant for the Yashoda intervention including: recruitment, training, implementation, supervision and payment structure.

Recruitment

The minimum qualifications for a Yashoda, as per the concept note, is as follows: education level of 8th standard, a resident of the village/ locality in which the facility exists, preferably within the age group of 25-45 years, should be willing to carry out newborn care, should have no caste/ religion inhibitions, amongst others. The concept note also states that those with Auxiliary Nurse Midwives/ Traditional Birth Attendant/ nursing training would be given preference for Yashoda recruitment.

During our field visits, we learned that Yashodas in all four states were recruited in response to an advertisement in the newspaper. In Bihar, we were informed that some Mamtas were made aware of this opportunity at the health facilities, where they were working as polio vaccinators. Also, the state government in Bihar passed a directive for all Mamtas to be recruited from the Sant Ravidas community (part of the scheduled caste), soon after the intervention was implemented.[62]

Our consultations with Yashodas suggest that their average educational qualification has varied considerably across the states and districts (Yashodas in Odisha were 10th standard qualified; in Madhya Pradesh, while Yashodas in Hoshangabad were graduates/ post graduates, those in Raisen were 8th standard qualified). The performance level of Yashodas has varied according to their qualifications, with the more educated Yashodas in Madhya Pradesh performing much better than their counterparts in other districts (although other factors have impacted this as well, see below).

Attrition rates among Yashodas has been very low in all states (as we learnt at the health facilities visited).

Training

Yashodas in all four states were given three days of intensive training before the start of their work. They commented that the training was beneficial in upgrading and honing their skills and imbibing them with confidence to delivery their duties effectively. Other hospital staff (doctors, nurses) as well as beneficiaries noted that Yashodas are well aware of the areas where they provide counselling. Only in Odisha, some Yashodas and consultees viewed the training as inadequate, and expressed the need for more comprehensive and hands-on training.

62 Sant Ravi Das community is a scheduled caste in Bihar. Women from this community work as Traditional Birth Attendants. While these Traditional Birth Attendants were involved in deliveries as a part of their previous job profiles, their role was meant to be restricted to the maternity wards under the Mamta intervention.

The number of refresher training sessions conducted for Yashodas has varied across states.

- In Rajasthan, while Yashodas at the district hospital in Dausa were trained only twice in three years; in Alwar they were trained four to five times since the start of the programme.

- In Madhya Pradesh and Odisha, all Yashodas were trained four to five times since the start of the programme.

- In Bihar, while Mamtas at most health facilities were trained once at the beginning of the programme, and again in 2013; Mamtas at some health facilities were not given any formal training and only trained on the job by the Auxiliary Nurse Midwives (e.g. at the Noorsarai Primary Health Centre in Nalanda).

In general, all Yashodas noted the need for more frequent refresher training sessions to upgrade their skills.

Implementation

In general, the implementation of the Yashoda intervention in terms of their role and day-to-day schedule has not varied considerably across states. Some points to note are as follows:

- It was envisaged to place Yashodas in the district hospitals and Community Health Centres with high delivery loads in the first phase of the initiative. Based on experience, appropriate measure would be taken to scale up the intervention in other health facilities as needed. As per the concept note, states can make an exception based on their specific/ local needs. Our field visits highlighted that the states have followed a different approach with regards to the placement of Yashodas – e.g. in Rajasthan, Yashodas are placed at facilities with a delivery load of more than 150 per month (covering district hospitals and Community Health Centres only); however, in Bihar, Mamtas are also placed at the block level Public Health Centers by the state government.

- Yashodas in all states have provided counselling to mothers on similar topics – exclusive and immediate breastfeeding; zero dose immunisation; keeping the baby warm; duration of stay at health facilities; counselling on birth spacing and gender issues.

- Yashodas work in three shifts of morning, evening and night, and are allocated to the maternity wards in each shift. They are provided with certain supporting facilities/ items (like flip charts and birthing kits) to facilitate counselling the mothers. However, we were informed that some of these facilities have been discontinued after end of NIPI funding.[63] All Yashodas have a uniform so they can be easily detected in the wards in case the mothers encounter any issues, and need their assistance.

63 E.g. in Bihar, use of flip charts has been discontinued in some districts; and LCD projectors in the maternity wards to demonstrate the concepts of breastfeeding and immunisation are no longer functional.

Supervisory support

As per the concept note, it was envisaged to place a Child Health Coordinator at the district hospital for daily supervision, coordination and other administrative tasks relevant for the intervention. The administrative issues were to be coordinated by a child health manager at the district level, and junior managers at the block level under the leadership of the doctors. Instituting an appropriate supervisory structure is key to the success of any intervention, especially given the limited levels of supervision in the Indian health system at present.

However, our state visits have indicated that the supervisory structure for Yashodas has varied considerably across states, and across districts and health facilities within states. Moreover, we were informed that a change in the supervisory structure was brought about in most health facilities after the replacement of NIPI funding by state funding in 2012. Following are some key points to note on the supervisory structure in the four focus states:

- **Rajasthan** – The position of a Yashoda supervisor/ coordinator was removed after the commencement of state funding. Yashodas at the district hospital at Alwar are now supervised by an administrative worker; Yashodas at some Community Health Centres in Dausa are supervised by a mix of Lady Health Workers and Auxiliary Nurse Midwives; there is no supervisor for Yashodas at the district hospital in Dausa.

- **Odisha** – While two Yashoda supervisors and one Yashoda Coordinator were tasked with the responsibility of managing Yashodas, these positions no longer exist. Yashodas are now supervised by a mix of doctors and managers at the health facilities. Some facilities have also made ad hoc arrangements by assigning Reproductive, Maternal, Neonatal and Child Health counsellors or family planning counsellors to supervise Yashodas.

- **Madhya Pradesh** – While the Deputy Child Health Supervisors are entrusted with monitoring Yashodas, other hospital staff like doctors and senior nurses also supervise them.

- **Bihar** – A Child Health Supervisor was recruited for supervision of Mamtas at the Nalanda district hospital under NIPI, however this position has now been removed under state funding for the intervention. The supervisory structure created under NIPI has however continued at some health facilities in the state (e.g. in Jehanabad and Noorsarai Public Health Center in Nalanda).

The experience in relation to supervision of Yashodas has therefore varied by state/ district, as well as during and after NIPI support. In some health facilities, supervision has worked fine – even if it has been by another hospital worker (e.g. the ward nurse). But in most facilities visited, supervision has not been adequate, particularly after the intervention was taken over by the state governments. For example, discussions with the Mamtas at the Nalanda district hospital in Bihar suggests that they were more satisfied under the supervision of

the Child Health Supervisor, and also felt a greater sense of moral support in her presence. There were also some changes in practices after the change in the supervisory structure, for example, previously the Mamtas would record details on births in a register that would be checked by the supervisor, but this was discontinued subsequently. In addition, in many cases the hospital staff/ administrative workers who are now entrusted with supervising Yashodas feel overburdened and are not adequately incentivised (e.g. in Rajasthan).

Payment structure

The Yashoda intervention was designed with an incentive-based payment structure (i.e. based on the number of deliveries in the health facility[64]), but this has not been practised in most states (except Bihar).

While Yashodas were earlier paid INR100 (US$ 2) per delivery, their salaries have now been capped in most states. For example, Yashodas in Rajasthan are paid INR3,500 (US$ 70) per month;[65] and Yashodas in Odisha and Madhya Pradesh are paid INR3,000 (US$ 60) per month. However, Mamtas in Bihar are still paid INR100 (US$ 2) per delivery, and are able to earn an average of INR2,500-3,000 (US$ 50-60) per month depending on the number of deliveries.

The capped payment system was introduced as Yashodas started earning more than a trained nurse in the health facility, given the high delivery load. For example, there are 7-8 Yashodas for managing 30-40 deliveries per month in the district hospital in Dausa, Rajasthan; 24 Yashodas for 40-50 deliveries per month in the district hospital in Alwar, Rajasthan; 18 Mamtas for managing 40-50 deliveries per month in the district hospital in Nalanda. As this would result in the perverse incentive of discouraging clinical training (as these staff could get paid higher through a non-clinical profession), a lower level of payment was fixed for Yashodas.

5.2.3 Assessment of Experience and Key Issues

The Yashoda intervention has largely been viewed positively in the four states by all stakeholders, including medical officers, nurses and importantly, the beneficiary mothers. The role of Yashodas is viewed as beneficial in creating a congenial and comfortable environment for the mothers on arrival at the health facilities.

- Health facility staff have noted that there has been a positive step change in the support to mothers since the introduction of the Yashoda intervention.

64 The concept note states the following: "The proposed compensation is INR100 (US$ 2) per newborn, and if the newborn requires care for a longer period, the compensation would be INR150 (US$ 30). However, the compensation package will be finalised on consultation with the states and various other stakeholders in due course."

65 This is primarily because with increase in deliveries, the Yashodas in Rajasthan were getting a payment between INR4000-7000 (US$ 89-90) per month, which was what was given to the trained and skilled Auxiliary Nurse Midwives. Also, Yashodas at the different health facilities were getting varying amounts depending on the number of deliveries. Thus, it was decided to cap their salaries at INR3500 (US$ 70) per month to keep it below what was paid to the trained Auxiliary Nurse Midwives (so as not to disincentivise individuals from undertaking the necessary training for this post, in the face of a potential higher salary for the unskilled Yashoda).

- Our interaction with Yashodas in the four states also suggests that they have provided significant support to the mothers and newborns during the post natal period at the facilities – e.g. supporting and comforting the mother on arrival at the health facilities, counselling on zero dose immunisation, immediate and exclusive breastfeeding, keeping the baby warm, gender counselling (e.g. counseling on treating male and female babies equally), amongst others.

- Consultations with the mothers suggest that they generally look to Yashodas for assistance and support, and are comfortable in their presence. However, it is not immediately clear if the mothers have interacted sufficiently with Yashodas (e.g. some mothers in Bihar and Rajasthan claimed not have to engaged with Yashodas during their entire stay at the hospital). However, we appreciate that this could be a function of many factors, including: (i) low Yashoda to mother ratio, making it difficult for Yashodas to devote sufficient time to each mother at the facility; (ii) lack of awareness on the part of mothers, making it difficult for them to comment on the quality of care at the health facilities. In addition, we were not able to obtain detailed responses from beneficiaries in some health facilities, since they were with their family members, and hesitant to speak in from of them.

A study commissioned by NIPI revealed a number of positive results of the Yashoda intervention in Rajasthan and Odisha (e.g. enabling a significantly higher proportion of mothers to receive post natal checks at the facilities) – albeit with some indicators (e.g. practice indicators - particularly, immunisation, keeping the newborn warm, mothers who were provided food/ water at the post natal wards) not exhibiting much change.[66]

The Yashoda intervention is also valued by the state governments, who are currently funding the intervention in all four states.[67] However, the Yashoda intervention has not yet been included in the state Programme Implementation Plan. Our understanding based on consultations with government officials is that it is uncertain whether the Yashoda intervention will be incorporated under NRHM for several reasons, including: (i) it is not clear if the Yashoda intervention is serving its intended purpose in some cases where they are made to engage in other activities outside the maternity wards; (ii) Yashodas are perceived as the equivalent of ASHAs in the health facilities and are leading to overcrowding of health facilities; and (iii) given that Yashoda is a contractual worker, the government is risk averse to funding another cadre of non-medical HR in the health system. However, the utility of the intervention as a whole is also recognised by some factions of the government, and hence its continuity under the aegis of NRHM is currently under discussion. Our assessment is that the inclusion of the intervention under NRHM will be impacted by the extent to which

66 Public Health Foundation of India., Assessing and Supporting NIPI Interventions, Technical Report, November 2011.

67 However in Madhya Pradesh it remains to be seen if the intervention will be scaled up across the state.

NIPI creates suitable advocacy around the initiative and makes key government officials aware of its intended objectives/ importance.

While the Yashoda intervention has largely been viewed as beneficial in terms of their role in the health facilities, some key issues were raised with regards to the implementation of the intervention, as follows:

- **Delays in receiving payments**. Feedback from Yashodas suggests that there are delays in receiving payments ranging from a few days to a few months (except in Madhya Pradesh, where Yashodas we met did not report any delays in payments).[68] Further, we were informed that these delays had increased when state funding replaced NIPI (e.g. in Rajasthan and Bihar).

- **Insufficient salaries**. Feedback was unanimous from Yashodas in all four states that their salaries were insufficient, given their high workload. In addition, their salaries have remained constant since inception, while all other hospital staff have received annual increments. Also, Yashodas are not entitled to other benefits that government employees are (e.g. no paid maternity leave); and their salaries are reduced in case they take leave (e.g. in Rajasthan and Madhya Pradesh).

- **Need for frequent refresher training.** As noted, the number of refresher training sessions conducted for Yashodas has varied considerably across states, and all Yashodas noted the need for more frequent refresher training to upgrade their skills.

- **Ineffective supervision.** As noted, the supervisory structure for Yashodas has varied considerably across states, districts and health facilities, particularly after state funding replaced NIPI. Most of our visits to health facilities in the four states suggests that the supervision has not worked well and several Yashodas were dissatisfied under the new supervisory structure. Also, there were some changes in practices under the new supervision structure (e.g. discontinuation of filling of a register on each delivery to record information like weight of the child, initiation of breastfeeding, etc).

- **High workload**. We understand that each Yashoda was envisaged to look after 4-5 mothers, however, this has varied substantially across states, and across health facilities in districts. For example, in Rajasthan, Yashodas at some health facilities were looking after 30-40 mothers at a time, and feel overburdened with the workload. In Bihar, Mamtas in the district hospital in Nalanda were managing 30-40 mothers at a time but found the workload manageable, however Mamtas in Jehanabad managing 20-30 mothers commented that they felt overburdened with the workload. The overall perception amongst Yashodas on their workload is

68 However, this could be because the Yashodas in Madhya Pradesh are now on an annual contract with the government as against a three month employment contract under NIPI.

mixed – while some are willing to put in more work, others feel overburdened. Our sense is that the burden of work on Yashodas is quite high, which is likely to have an impact on their quality of work, and motivation to perform their duties effectively.

- **Engaging in other duties.** Initially, the role of Yashodas was meant to be restricted to counselling the mothers/ providing post partum care in the maternity wards. However, the state visits suggest that Yashodas are made to engage in other activities to assist the hospital staff in wards and carry out a range of administrative tasks. Some specific examples include Yashodas been diverted to:

  – Administrative tasks like booking tickets and distributing medicines in the district hospital in Alwar, Rajasthan. Further, four Yashodas have also been deployed to support the Sick Newborn Care Unit staff in that hospital.

  – Support nurses and Auxiliary Nurse Midwives in labour rooms in Bihar and Rajasthan.

  – In Bihar, Mamtas assist nurses in controlling bleeding; changing saline syringes (e.g. in Nalanda), and cleaning maternity wards (e.g. in Jehanabad).

- **Issues faced in counselling.** Yashodas are not able to counsel the mothers properly due to the presence of mothers' attendants at the health facilities, who often tend to interrupt Yashodas during their interaction with the mothers.

- **Presence of ASHAs** *at the facilities*. In some states, ASHAs tend to stay with the mothers at the health facilities, which implies a certain overlap in the role of Yashodas and ASHAs in supporting the mothers at the facilities. This view was widely supported by Auxiliary Nurse Midwives and ASHAs at the facilities in Bihar who commented that mothers feel more comfortable with the ASHAs and seek their support in case of any issues (rather than calling upon the Mamtas). This also renders it difficult for Yashodas to engage effectively with the mothers.

Other issues noted include difficulty in adjusting with other health facility staff as a result of being a new cadre of unskilled worker (e.g. Rajasthan); lack of a designated space in the hospitals despite being based there (e.g. Bihar and Rajasthan); discontinuation of supporting facilities (like birthing kits, flip charts, LCD projectors in maternity wards); and poor quality of services at the facilities (e.g. in Odisha).

If the Yashoda intervention is to be continued, it would be important that these key issues identified in the process evaluation are considered and rectified, so as to allow for the intervention to deliver more efficiently and effectively on its intended objectives.

5.3 Home Based Post Natal Care

The Home Based Post Natal Care intervention has facilitated the training of ASHAs in post natal care, and more generally, provided a greater focus on post natal care support, thereby informing the Government of India's decision to scale up the support nation-wide (known as Home Based Newborn Care).

Key issues to note in the implementation experience of this intervention are as follows:

- There have been mixed views on the adequacy of the training to ASHAs delivered under this intervention.
- Supervisory support has been aligned with the broader National Rural Health Mission (NRHM) supervisory structure for ASHAs. In addition, NIPI has introduced additional supervisor mechanisms in some states through NGOs, however there is insufficient information on whether this has worked well or not.
- ASHAs do not feel adequately incentivised with the payments for their post natal care services and there have been delays in receipt of payments as well.
- In some states, ASHAs have faced issues in engaging with mothers at home (cultural issues, issues of trust, etc), although our understanding is that this has been improving over time as the ASHA concept has matured.
- There have been issues with lack of availability of post natal care forms and tedious/ difficult format of the form, which will impact the quality of data collection by the ASHAs.

5.3.1 Description

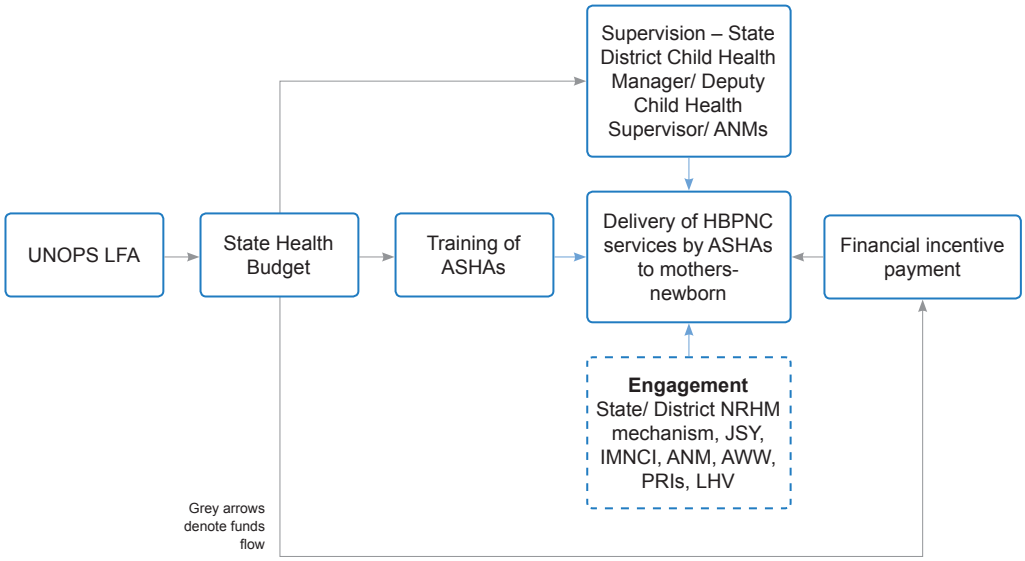
The Home Based Post Natal Care is a community-based intervention wherein ASHAs provide post natal support to mothers by making six home visits between 1 to 42 days after delivery. The intervention starts from one month before the expected delivery date and builds on the Anti Natal Care facilitated by ASHAs under the Janani Suraksha Yojana programme. The eighth month visit is used for preparing the mother for the birth, establishing a birth plan, and motivating the mother and family members for institutional delivery. During the visits post delivery, ASHAs counsel the mother on newborn care and related maternal health aspects; and refer sick newborns to health facilities, as required.

Key components of the Home Based Post Natal Care package are: (i) capacity building of ASHAs; (ii) delivery of basic newborn care at home and identification of danger signs in the newborn and the mother by ASHAs; (iii) creating an enabling environment for ASHAs to provide Home Based Post Natal Care services (provision of incentive to ASHAs; provision of kit; referral transport funds)[69]; (iv) supportive supervision; and (iv) data capture and analysis.

69 The referral fund under NIPI has been discontinued in most states since there was an overlap between the fund and the Janani Express under NRHM launched in 2008. The Janani Express is a transport facility for pregnant women, under which all expectant mothers get free transport facility to health centres and hospitals for delivery. In addition, we were informed that there was some uncertainty whether the ASHAs were handing over the money to mothers under the referral fund.

The figure below presents a schematic of the intervention, highlighting its key processes. We present a process mapping of the intervention, followed by our review of what has worked well and less well, drawing on state specific experiences.

Figure 5.2 Schematic of the Home Based Post Natal Care intervention



This intervention is now being scaled up nation-wide as Home Based Newborn Care by the Government of India, and is based on a the same concept and implementation arrangement as the Home Based Post Natal Care intervention (ASHAs make six home visits within the first 45 days of delivery to examine the newborn and for post partum care of the mother). However, the main difference, as we understand based on consultations, is the use of a different training module under Home Based Newborn Care.[70]

5.3.2 Process Mapping

Training

ASHAs in the NIPI focus districts were given a 2-day induction training before starting home visits to provide post natal care to the mother and newborn. This was followed up by a more intensive five days of Home Based Post Natal Care training that aims to develop the skills of the ASHA in weighing the baby, taking its temperature, and identifying any danger signs in its health.

Several consultees across the four states questioned the relative adequacy of training under Home Based Post Natal Care when compared to Modules 6 & 7 under Home Based Newborn Care, suggesting that the 2+5 day training model was not sufficient for imparting knowledge and hands-on training that is required by ASHAs to undertake their tasks effectively.[71] Consultees at the health

70 The content of these modules covers the following skills for the ASHAs: providing newborn care through a series of home visits which include skills for weighing the newborn, measuring temperature, ensuring the baby is warm, supporting exclusive breastfeeding, assessing if the baby is high risk (e.g. low birth weight), amongst others. The training spans around 20 days.

71 The NRHM training modules 6 and 7 are more rigorous, including training for trainers and a 20 day schedule for ASHAs.

facilities and the ASHAs also felt that the periodicity of refresher training was not adequate. On the other hand, a comparative analysis carried out by Public Health Foundation of India in 2011 of the training material for ASHAs under NRHM and NIPI reveals that the key difference between the two is that NRHM modules 6 and 7 are quite complex in terms of content and language, thereby leading to the possible difficulties in comprehension by ASHAs. The NIPI module appears more user friendly as it is in the form of concise, pictorial booklets on key topics.

Supervisory support

We understand that ASHAs are supervised by health system personnel such as the Auxiliary Nurse Midwives. ASHAs fill a post natal care form after each home visit and the mother or a family member countersigns the form during each home visit). The completed cards are also verified and countersigned by the Auxiliary Nurse Midwives and other supervisors (e.g. Junior Child Health Managers at the Noorsarai Public Health Center in Nalanda, Bihar; supervisors at the nearby health facilities in Rajasthan, Odisha and Madhya Pradesh), before payments to ASHAs are released. In some cases, Auxiliary Nurse Midwives also accompany the ASHAs in their home visits to ensure that they are performing their duties effectively.

NIPI had also hired some agencies to provide supportive supervision to the ASHAs under Home Based Post Natal Care and to ensure quality assurance of the post natal care cards. For example, in Bihar, The AN Sinha Institute of Social Studies, Patna (a social science institute under the Ministry of Education, Government of Bihar) was hired by NIPI for supportive supervision of ASHAs under this intervention. However this does not seem to have been implemented in practice. In Odisha, Paribartan (an NGO), was chosen to provide external support and supervision to the programme for 20 months from April 2010 to March 2012.[72]

Our consultations reveal mixed opinion on the effectiveness of supervision. We understand that not all submitted forms are checked, and supervisors and Auxiliary Nurse Midwives do not always accompany/ oversee the ASHAs on home visits.

While we were unable to get details on how data collected through the post natal care forms is used, we understand that in Bihar, data is compiled at the Public Health Centers, after which it is consolidated at the district level and sent to the state government. This data then feeds into the Health Management Information System . In Odisha, data is aggregated at the block level and fed into an online database.

Implementation

We understand that there has not been much variation across states with regards to implementation. ASHAs are provided with a kit, which includes a

72 In Odisha, the ASHAs are required to maintain a diary in which they note down details of their daily activities. These diaries are reviewed by Auxiliary Nurse Midwives periodically. In addition, Auxiliary Nurse Midwives in Odisha were paid a total of INR100 (US$ 2) under NIPI for two supervisory home visits with the ASHAs, however this practice has now been discontinued.

thermometer; Oral Rehydration Salts packet; paracetamol; weighing scale to physically examine the baby; and flip charts to visually demonstrate danger signs to the mothers. If any health issue is identified, ASHAs refer the babies to the nearby health facilities, and accompany the mothers to the facilities, if required.

Payment structure

The payment structure for the ASHAs differs slightly across the states. Specific examples are as follows:

- In Odisha and Madhya Pradesh, ASHAs are paid INR 250 (US$ 5) for each completed and verified post natal care form. The payment is remitted electronically into their bank accounts.

- In Rajasthan, ASHAs were paid INR200 (US$ 4) under Home Based Post Natal Care for each completed form. Under NRHM, ASHAs are getting a total package of INR600 (US$ 12) comprising INR100 (US$ 2) for anti natal care; INR100 (US$ 2) for institutional deliveries; and INR350 (US$ 7) for child health (which includes payments for post natal care).

- In Bihar, each ASHA looks after 5-6 deliveries in a month on average, and earns INR800 (US$ 16) through the various incentives under NRHM.

5.3.3 Assessment of Experience and Key Issues

In our view, the main value add of this intervention has been in terms of increasing emphasis on post natal care and sensitising mothers on matters related to maternal and newborn/ child care. While the concept of home visits existed earlier (e.g. Integrated Management of Neonatal and Childhood Illness and Gadchiroli model), NIPI went beyond training and implemented post natal care in the four states in a systematic manner. The Home Based Post Natal Care intervention also introduced a follow up mechanism for early identification of danger signs and referral of newborns to facilities, which we understand did not exist earlier.[73]

Consultations with the health workers at the facilities highlights that the intervention has brought about an improvement in child health, with more sick newborn being brought to the health facilities for treatment. Our interaction with the mothers however suggests mixed responses in terms of the benefits of the interventions. For example, in Rajasthan, a few mothers commented that the ASHAs did not make home visits and were unsure of the benefits on the post natal care support provided by ASHAs.

A more robust study on the results of the intervention was commissioned under NIPI and concluded on improvements in terms of a higher proportion of mothers reporting birth registration, weighing their baby and not giving their newborn supplementary food.[74]

73 NIPI is introducing Home Based Post Natal Care+ in Phase II, under which the ASHAs will visit the mothers for up to a year after the birth of the baby.

74 Public Health Foundation of India., Assessing and Supporting NIPI Interventions, Technical Report, November 2011.

Our state visits have brought to light some key issues related to the implementation of the intervention:

- **Issues with the incentive payments:** There are a number of issues with the incentive payments to ASHAs for their work on post natal care, as follows:

  – ASHAs across the four states stated that the incentive paid to them for providing post natal care services is very low. In general, the ASHAs do not feel overburdened with the work, and are willing to work and earn more.

  – There is mixed experience in the states and across the health facilities in districts with regard to delays in payment of incentives. For example, no delays were noted in Odisha and Madhya Pradesh; in Rajasthan, delays in payments varied from a few months to a year. In Bihar, while ASHAs in Nalanda were paid on time (within 8-10 days of submitting the post natal care cards), the ASHAs in Jehanabad had not received their salaries for as long as 6-7 months.

  – In Rajasthan, our discussions with some ASHAs suggested that they did not keep track of the number of post natal care cards they are filling out, and accordingly their payment dues. As such therefore, they have no way of confirming if they are receiving their correct dues every month. Other ASHAs that we engaged with in other states however kept a personal diary recording their dues and confirmed that they have been paid correctly according to the work done by them.

- **Issues faced during home visits.** In some states, ASHAs have faced issues in engaging with mothers at home (cultural issues, issues of trust, etc), although our understanding is that this has been improving over time under NRHM as the ASHA concept has matured. For example:

  – In Rajasthan, ASHAs commented that very often mothers do not let them examine their babies as they fear that ASHAs will cast an ‘evil eye’. As a result, ASHAs have at times filled the post natal care cards based on information provided to them by family members, without examining the baby (implying this may not always be accurate).

  – In Bihar, ASHAs in Nalanda faced no issues in engaging with the mothers, since they belong to the same villages and the mothers are familiar with them. However, ASHAs in Jehanabad commented that the mothers did not understand the importance of home visits, and that they were only performing this job to earn money (rather than focussing on the well-being of the child).

  – ASHAs in Odisha and Madhya Pradesh did not face much difficulty in terms of access to mothers and babies or in relation to caste.

- **Issues related to the post natal care form.** Several issues were faced in states with regards to the post natal care cards used under Home Based Post Natal Care which will impact the quality of data collection by the ASHAs.

  – In Odisha, filling the post natal care form is considered to be tedious, which is likely to have data accuracy implications. It was also reported that some ASHAs were not able to read and write Odiya (the language in which the forms are printed).

  – In Bihar, some ASHAs fill the post natal care data/ information collected during the home visits in a register, since the original format of the card is in short supply, but are paid only after the original card is completed and deposited.

  – In Rajasthan, ASHAs in some places use photocopies of the post natal care cards, due to their lack of availability.

- **Differences in ASHA capabilities.** The education level of ASHAs has some bearing on their ability to deliver services effectively. In Rajasthan, illiterate and elderly ASHAs and those who were hired on the basis on political affiliations and connections were found to be poor on service delivery. In Bihar, some medical officers commented that the ASHA are not always technically equipped to identify certain danger signs (like respiratory rate of newborns, and signs of jaundice). Some consultees felt that ASHAs required training in soft skills given their role as community based health workers. These differences suggest the need to devote greater attention to address the above-noted ASHA recruitment issues.

5.4 Follow-up on Recommendations From Previous Reviews

Most of the recommendations made by the Mid-Term Review and Evaluability Study have not been or only partially implemented.

In this section, we summarise the extent to which recommendations from previous NIPI reviews/ evaluations have been considered and followed up. We have reviewed the recommendations provided in two key documents: (i) the Mid-Term Review (2010); and (ii) Evaluability study (2011).[75] Our assessment on progress is based on consultation feedback during our structured interviews for the assignment.

Our understanding is that most of the recommendations made in both these studies have either not been or only partially implemented. In addition, there is a lack of clarity on the required processes and responsibilities to implement

75 Beth Plowman; Henry Lucas, *"Evaluability Study of Partnership Initiatives: Norwegian support to achieve Millennium Development Goals 4&5"*, Mott MacDonald Limited, February 2011. The Evaluability study was commissioned in 2010 to assess the extent to which the five Norwegian Partnership Initiatives (PIs) can be evaluated in a reliable and credible manner and to make recommendations and propose action plans for impact evaluations to be conducted for the Partnership Initiatives at a later stage.

changes. These continue to be issues within NIPI and have been highlighted in our review as well.

We provide a detailed listing of the key recommendations made in the previous reviews as well as our assessment on progress made in Annex 12. In summary:

Vision and strategy	**Not implemented**
The Mid-Term Review has made a number of recommendations on defining the vision and strategy of NIPI in a clear and comprehensive manner. Whilst there have been attempts at elucidating a clear strategy for NIPI in Phase I, our consultations suggest the need for a better and shared understanding amongst partners/ stakeholders on the NIPI approach and what exactly it is trying to achieve – as demonstrated by their lack of coordination in the implementation of interventions and monitoring and evaluation.	
Management and governance	**Partially implemented**
The Mid-Term Review recommendations to improve the management and governance of the initiative have been partially implemented. In particular, as described in Section 4, the following steps have been taken in Phase I to address key issues in NIPI's governance structure: • Re-organisation of the UNOPS role under NIPI with a clearer separation of the NIPI Secretariat function and Local Fund Agent. • NIPI Secretariat was strengthened with the appointment of a Director and monitoring and evaluation advisor. • A Gender Advisor was recruited and placed in the NIPI Secretariat. However, other key recommendations with regards to improving the coordination mechanisms within NIPI and re-organising the key governance bodies to avoid any conflicts of interest (e.g. with respect to the role of WHO and UNICEF on the governance bodies, as described in Section 5) have not been incorporated.	
Monitoring and evaluation	**Not implemented**
Both the Mid-Term Review and Evaluability Study have made detailed recommendations on the need to develop a comprehensive monitoring and evaluation strategy and framework for NIPI, however this remained a key gap in Phase I, as also unanimously recognised by all stakeholders.	
Research	**Partially implemented**
The Mid-Term Review recommended that NIPI develop a clear research strategy and reduce the engagement of Norwegian Embassy in this area. The former was not implemented, but the latter recommendation was, with the responsibility for research being handed over to the Secretariat. Other recommendations of the Mid-Term Review to improve financial management of the initiative and specific areas of improvement for the technical interventions (including developing a communications strategy for NIPI to help disseminate lessons) have not yet been implemented.	

6. Results

6.1 Scope and Approach

We assess the following aspects under the final evaluation dimension on NIPI's results: (i) progress in developing and operationalising an monitoring and evaluation system (Section 6.2); (ii) main achievements in Phase I, in terms of its objectives of providing strategic, catalytic, flexible and innovative funding (Section 6.3); and (iii) NIPI's 'added value' (Section 6.4).

6.2 Progress in Developing a Monitoring and Evaluation System

NIPI Phase I has not developed an ex-ante and comprehensive results framework to track progress and results achieved. Performance reporting by the implementing partners has been inadequate (and in inconsistent formats) to assess the initiative's progress.

NIPI Phase I has lacked a prospectively designed results framework, setting out the desired outputs, outcomes and impacts of the initiative as a whole, and related targets and milestones for the implementing partners and their supported interventions. In our review of documentation, we note that:

- An monitoring and evaluation framework was attempted as part of the NIPI 2008 Strategy document, however not finalised amongst the partners.
- We were informed that data/ information was collected under a baseline study conducted in 2009, but this was incomplete and not put to any use.
- A NIPI monitoring and evaluation Strategy and Plan document (2010-13) was later prepared which sets out an monitoring and evaluation framework, however we understand that this has not been systematically implemented.
- The Evaluability Study presents a range of monitoring and evaluation indicators reflected across multiple NIPI documents, but notes the absence of a clearly defined results framework.
- The bi-annual progress reports submitted by implementing partners to the NIPI Secretariat do not follow a common format, with partners using their own reporting templates/ content to report progress on NIPI activities. The reports mainly focus on progress made in the completion of funded

activities, i.e. inputs and processes (e.g. number of training sessions delivered) rather than the results achieved. Also, the reports do not support a consideration of whether NIPI as an initiative is achieving its objectives – for example, this could be facilitated by partner reports covering aspects of their work which have been strategic, catalytic or innovative, in line with NIPI's overall objectives.

- There has also been an absence of a standardised approach to measuring issues and progress on the NIPI UNOPS interventions across the four focus states.

- There have been no attempts to consolidate the various reports submitted by the partners in Phase I, with a view to judge the overall performance/ results of NIPI – in terms of outputs, outcomes and impact achieved (or the potential thereof), and to make any management decisions or course corrections on the basis of data/ evidence.

The need for a clear and logically consistent results framework for the initiative (which is aligned with the National Rural Health Mission (NRHM) indicators) cannot be over emphasised. This was an important issue highlighted in the Mid-Term Review as well.

6.3 Main Achievements Under Phase I

NIPI has largely achieved its objectives of being strategic, catalytic, innovative and flexible, particularly in the case of the UNOPS supported interventions. We are unable to comment on individual implementing partner achievements in the face of their differing reporting approaches and the lack of an overall results framework.

6.3.1 Summary of Results Based on Partner Reporting

We present the key recent achievements of the three implementing partners in Box 6.1, with more details on their overall achievements in Annex 7. This is however not a comprehensive presentation of the achievements, as we do not have access to all NIPI implementing partner progress reports. Further, in the absence of a results framework, it is difficult to present the achievements in a consistent and useful manner. We are also unable to comment on the achievements vis a vis objectives without pre-determined targets and milestones.

Box 6.1 Examples of reported recent achievements by partners [76]

The latest semi-annual partner progress reports provide some information on key achievements, including:

UNOPS: state-wide roll-out plan of Yashodas developed in Madhya Pradesh; Sick New Born Care Unit+ programme rolled out in six districts of Rajasthan and Odisha; Sick Newborn Care Unit in Nalanda made operational and started admitting children; Jhpiego facilitated the state nodal centre for building skills of nursing students.

UNICEF: 9,000 cold chain handlers trained across the country; 190 solar freezers installed and functional in inaccessible sites of 15 districts; improvement plans for cold chain logistics system strengthening developed in Madhya Pradesh and Rajasthan; Integrated Management of Neonatal and Childhood Illness being implemented in 433 districts in NIPI states; 56% workers trained in Integrated Management of Neonatal and Childhood Illness implementation districts in NIPI states; 41% community workers trained in providing newborn and child care in five NIPI focus districts; 26% of district hospitals have Sick Newborn Care Units.

WHO: Pre-service Integrated Management of Neonatal and Childhood Illness training in nursing college initiated; integrated package on short programme review of Reproductive Child Health (RCH) developed; integrated RCH module developed; training package for Facility Based Management of Severe Acute Malnutrition children developed and piloted; accreditation process for private sector health providers strengthened.

6.3.2 Extent to which NIPI has met its Objectives

Our main focus under this section is to assess the extent to which NIPI Phase I has been strategic, catalytic, flexible and innovative, drawing on the available definitions for these objectives as provided in the 2008 NIPI Strategy document as well as the broader interpretation of these terms. While the absence of robust ex-ante and ex-post monitoring and evaluation arrangements (as noted above) has impacted our assessment of the results of NIPI, we present our qualitative assessment based on stakeholder feedback and the implementation experience in the focus states.

Strategic in the context of NIPI implies choosing between possible options, selecting what to prioritise based on pre-determined criteria and prior consensus.[77] In terms of this definition, NIPI has not been strategic per se, given that the process of selecting interventions has not been systematic and based on pre-determined criteria or, to a large extent, by consensus (as discussed in Section 3). However, in our view, NIPI has been strategic more generally, by virtue of choosing to support a continuum of care approach for maternal and newborn care as well as creating a link between home, community and facility based care. For example, NIPI has supported the introduction of the Yashoda, Home Based Post Natal Care and Sick Newborn Care Unit interventions – which are in line with the global evidence-base and the specific needs in India (as discussed in Section 3.2.2). Other examples of interventions that have been

76 Sources: Norway India Partnership Initiative-Local Fund Agent [date], " Semi-Annual Report (July-Dec 2012)"; UNICEF (2012), "Progress Report, July-December 2011"; WHO [date], "Progress Report, July-December 2011"

77 NIPI (2008), "Strategic Document".

regarded as strategic are the techno managerial support – foreseeing the requirement of HR and management skills in the existing health systems, NIPI during its strategic planning emphasised the requirement of new techno-managerial cadre at various levels to strengthen the National Rural Health Mission (NRHM).

Catalytic implies being able to initiate, activate or accelerate a process or a set of events that otherwise might not have happened.[78] Our review of the experience of NIPI Phase I in the states as well as stakeholder consultations highlights that NIPI has been very successful in achieving this objective. Its support has helped initiate and accelerate interventions that, while might not have not happened, would definitely have taken longer to implement – and this is a shared view across our consultations. For example, the Home Based Post Natal Care intervention under NIPI has been viewed as a catalytic form of support, in that NIPI helped take forward this intervention in a systematic manner (e.g. delivery of training in a quick and efficient manner and the implementation of the intervention in the four states). While the concept of home visits for post natal care existed earlier, previous models had not been able to achieve the rapid implementation and scale as NIPI – e.g. the Gadchiroli model was implemented on a very small/ localised scale, and UNICEF's Integrated Management of Neonatal and Childhood Illness programme, although implemented on a large scale, focussed extensively on training.

An important element of the assessment of the extent to which NIPI has been catalytic is whether NIPI has helped demonstrate the usefulness of certain actions/ interventions for scale-up. In our view, NIPI could have also done more on developing a comprehensive monitoring and evaluation framework for its interventions which could have helped create an appropriate response mechanism in real time and improved monitoring and accountability processes. Further, as described in Section 4, limited operational research studies have been commissioned under NIPI and thus our view is that not enough has been done by way of documenting and disseminating the results of and lessons learnt from NIPI interventions under Phase I. Such implementation research should be an important area of focus going forward.

There are mixed views on whether NIPI has been **flexible** in its funding approach. We understand that NIPI aims to depart from the traditional approach of bilateral funding and provide a flexible pool of money to be used based on country needs and learning from experience. NIPI funds can be used to fill gaps in government funding, and to undertake activities that are not included in the state Programme Implementation Plans, as long as the interventions are aligned with the NRHM and approved by the relevant central and state government authorities. However, some consultees have pointed out that NIPI could be more flexible in extending support to additional states (beyond the four focus states) with lagging child health indicators. This is particularly important given that health priorities are likely to change over a period of five years, particularly for a

78 Ibid.

large country like India. Further, NIPI could be more open to funding health interventions that arise as priorities over its duration (e.g. infant/ child nutrition which has emerged as a big issue since NIPI was established), especially as some funds under Phase I were not utilised (as long as these meet its defined objectives and funding approach).

In terms of our assessment of whether NIPI has been **innovative**, we first examine the definition of innovation in the NIPI context. The more 'traditional' definition of innovation is something that is entirely new, and possibly more suitable for describing innovations relating to upstream scientific/ product discovery and the like.[79] Another approach to considering innovation is in terms of the specific context of the initiative – for example, DFID notes that "innovation does not necessarily mean 'brand new' but could be an approach applied for the first time in a particular country or countries; or new ways of applying/ adapting/ developing an existing technique or initiative".[80] In our view, NIPI has been innovative in terms of both definitions – in particular:

- There are certain interventions under NIPI that are entirely new and represent a first time implementation in India. Key amongst these is the Yashoda intervention, but in addition, there have also been other new interventions such as the support for the development of District Training Centres (e.g. the refurbishing and upgrading of the centre in Hoshangabad district in Madhya Pradesh); and the Mobile Money Transfer scheme for ASHAs (recognising the need to restructure and streamline the payment processes and standardise financial reporting at the block and district level to improve transparency).

- There have also been new/ novel elements under other interventions such as the introduction of Emergency Treatment and Triage areas within the Sick Newborn Care Units to avoid delays in treatment as well as a neonatal ward and a 'step down ward' where the newborn is kept with mothers. Further, the Sick Newborn Care Unit in Hoshangabad in Madhya Pradesh has instituted innovative elements such as a video-conference linkage with experts in another state for further guidance/ second opinion; and a breast milk bank.

- Some of the NIPI interventions may not represent 'novel' ideas, e.g. the concept of Home Based Post Natal Care has been discussed amongst the government for many years and is also a core part of UNICEF's Integrated Management of Neonatal and Childhood Illness programme. However, the NIPI's support of Home Based Post Natal Care may be regarded as a 'process innovation' in that NIPI has been innovative in implementing post natal care at scale at the community level in the context of the Indian health systems.

79 For example, the oft cited definition of innovation in economics is Schumpeter's description of the term as a production function with reference to new inputs, introduction of a new product (or a qualitative change in an existing product), a new form of organisation, or the opening of a new market, Ref: Schumpeter JA. (1939): "Business cycles (vol I)". New York: McGraw Hill.

80 DFID (2012) "Global Poverty Action Fund (GPAF): Innovation Window Round 4 Guidelines for Applicants", accessed at http://www.dfid.gov.uk/work-with-us/funding-opportunities/not-for-profit-organisations/global-poverty-action-fund/.

We are unable to comment much on whether the activities funded by WHO and UNICEF have met NIPI's objectives of being strategic, catalytic, flexible and innovative, as we do not have adequate information on all of their specific activities funded (across the states) and, in particular, their context (e.g. how these activities fit within their overall programme of work). In general, consultation feedback has suggested that the NIPI-related activities undertaken by WHO and UNICEF were more in line with their own organisational mandate and country plans rather than furthering the NIPI approach/ interventions in particular (whereas UNOPS related activities were specifically designed as NIPI interventions). Therefore, although the WHO and UNICEF activities funded by NIPI might help improve child/ maternal health performance in the states, their interventions have been less distinct and 'visible'. It has been commented that more could have been done to use both partners strategically within NIPI's overall mandate.

6.4 Value Add

NIPI's key value add has been its contributory role in bringing forward the newborn health agenda in India and informing the scale-up of several beneficial interventions that may not have otherwise been implemented/ institutionalised (at least at the observed pace).

A number of aspects of its design/ structure are also of added value including: working flexibly through the National Rural Health Mission (NRHM) framework and in-country implementing partners; securing high-level government support for its activities; and implementing a continuum of care approach, covering home, community and facility based interventions.

In this section, we assess NIPI's value add relative to its counterfactual, drawing on the OECD definition of: "the situation or condition, which hypothetically may prevail for individuals, organisations, or groups were there no development interventions".[81] In the NIPI context, value add may be defined as the progress that might have been achieved in improving child and maternal mortality and related health systems strengthening in India in the absence of NIPI. We also examine added value from the perspective of whether there are any specific features in NIPI's design/ structure that present a preferred/ improved approach as compared to other donors, and more generally, a useful approach in the Indian context. Our approach to the assessment of NIPI's value add is qualitative in nature, based on feedback from stakeholders, rather than a detailed quantitative analysis (which has not been possible in the absence of up-to-date and relevant data and is not within scope).

A number of areas of added value are reflected in the role of NIPI as a strategic, catalytic, flexible and innovative initiative as described in the section above. The key aspect of its value add is however its focus on neonatal mortality in the country. Our assessment, based on consultations and the state visits (including

81 http://www.oecd.org/dac/evaluationofdevelopmentprogrammes/daccriteriaforevaluatingdevelopmentassistance.htm

specifically with national and state level government officials[82]), is that NIPI has helped bring forward the newborn health agenda in India by a few years. While many of the concepts/ interventions under NIPI have been discussed within the government for a number of years, NIPI's focus and action/ delivery based approach has fostered greater attention and action on improving newborn health in the country. This is particularly the case for the Home Based Newborn Care and Sick Newborn Care Unit interventions, that have been incorporated and scaled-up by the government nation-wide.

In addition, we note the following aspects of NIPI's added value in terms of its design/ structure:

- NIPI's approach of working through the NRHM and country health systems is a preferred approach and in line with the Paris aid principles. NIPI has not been designed as a traditional bilateral aid programme, with a separate/ parallel structure of funding and reporting. Rather, it is a flexible pool of funds to be utilised based on identified needs within the NRHM remit. This overall design feature of NIPI has been regarded as an important area of value add, and in line with the Indian government's preferred approach of working with donors.

- NIPI's working through existing health development partners in country rather than creating a new/ stand-alone implementing structure has also been regarded as an important area of value add. While some issues with the approach of working with partners have been identified in Section 4 above, the general approach of donor harmonisation has been of added value.

- NIPI's governance structure, although viewed as a bit onerous/ 'heavy' as discussed in Section 5, has also been regarded as an area of added value, given the inclusivity and ownership created by involving key members of government at all levels. NIPI has enjoyed top-level government support, which has helped facilitate its work.

- NIPI has also added value by virtue of adopting a continuum of care approach and creating a logical link between home/ community and facility based interventions. This 'holistic' approach has been viewed as useful by many stakeholders.

82 It is interesting to note that despite frequent turnover/ changes in roles and responsibilities within the Indian government system, both new and long-time officials in the national and state level health Ministries shared this view.

7. Cross Cutting Issues

In this section, we consider the extent to which the cross-cutting issues of gender, equity, quality and sustainability have been considered in NIPI Phase I.

NIPI needs to develop a structured and focused approach towards incorporating gender, equity and quality issues – especially given their noted importance in the vision of the initiative. While these are all implicit in its interventions, given their focus on maternal and child health in poor/ lagging India states, NIPI needs to be more pro-active in terms of: (i) defining how it will address these issues; and (ii) developing key indicators to track progress on these. NIPI has done well on the sustainability and scalability of several of its interventions, although more efforts/ investments are needed to document and disseminate the results of and lessons learnt from the interventions.

Gender

With respect to the issue of gender, by virtue of focusing on maternal and child health in India, the NIPI initiative as a whole has a strong gender focus. We note that some efforts have been made to consider gender issues within NIPI, including:

- the development of a gender manual for service providers at the grassroots level to understand the linkage between gender biased attitudes, beliefs and practices in the community that affect the equitable provision of maternal and child health services;[83] and
- the appointment of a gender advisor in the NIPI Secretariat, following the Mid-Term Review.

There is limited data/ evidence available (including through consultations) on NIPI's gender-related efforts and results.[84] That said, our assessment is that NIPI could have done more to emphasis gender aspects, both at the level of the initiative and for specific interventions and in particular:

- NIPI could have developed an overall gender strategy, in terms of how it would aim to address gender imbalance issues across the four focus states.

83 The manual was developed based on communities' gender realities in Rajasthan.
84 We have been provided with some gender-wise data for the Sick Newborn Care Units in Rajasthan and need to examine this further.

- While we understand that some gender-specific monitoring and evaluation information has been collected across states (e.g. number of male and female inborns and outborns in the Sick Newborn Care Units; male and female mortality), the information has not been analysed/ utilised per se. For example, prioritisation of males over females in the Sick Newborn Care Units has been noted as an issue, and NIPI has collected data on this as well; however the data could have been used to develop specific approaches to help address the noted imbalance.

A few government stakeholders have commented that although NIPI was keen to improve, gender, it did not have a structured/ focussed approach to address these and we tend to agree with this view. Incorporation of gender issues needs a focused approach in order to deliver results.

Equity

By virtue of working in some of poorest states of India that are lagging in terms of key health indicators and in some districts where there is a high ratio of disadvantaged (Scheduled Castes/ Scheduled Tribes) in the total population, NIPI has contributed to addressing some of the equity imbalances in the country. However, the NIPI districts were a mix of high, medium and low performing districts, with some being chosen based on a 'convenience' principle (e.g. being in close proximity to the state capitals). As such, their selection could have been driven by pre-determined and objective criteria to account for equity issues in a more effective and focused manner.

In addition, similar to our assessment on the cross cutting issue of gender, we believe that if equity is a stated objective for NIPI, there needs to be a clear strategy/ framework for the incorporation of issues within the initiative as a whole as well as for specific interventions. In the absence of this as well as specific data in this regard, it is not possible for us to comment beyond a generic level in terms of whether NIPI has accounted for equity issues.

Quality

It is difficult to assess the issue of quality without a pre-determined definition of the term and a delineation of the expectations within NIPI with regards to quality. We provide some comments below:

- As noted in Section 3, our assessment is that the processes involved in the selection of NIPI interventions and districts in the four focus states have not been clear and systematic. Hence more could have been done to quality assure these processes within NIPI.

- As noted in Section 6, the quality of the monitoring and evaluation information (notwithstanding the absence of an monitoring and evaluation framework for the initiative as a whole) has been a key issue in NIPI Phase I.

Sustainability

Although the concepts of sustainability and scalability are inter-related, we distinguish between the two as follows:

- **Sustainability** refers to the continued funding of an activity from any source (financial sustainability) and where the benefits of the approaches/ interventions can be maintained (programmatic sustainability) after NIPI support

- **Scalability** refers to a situation where an approach/ intervention is increased in size or coverage (i.e. taken up in other geographic areas/ populations of the country)

There is mixed experience on sustainability and scalability of NIPI interventions, with some interventions being adopted and scaled up across the country by the Government of India, while there are others which have not been taken forward. For example:

- The Home Based Post Natal Care intervention has been taken over by the Government of India as Home Based Newborn Care , under which the ASHAs are paid an incentive of INR250 (US$ 5) for making six visits in the first 45 days, and trained under modules 6 and 7 of the government. In addition, the Government of India is also rolling out Sick Newborn care Units across the country.

- On the other hand, while the Yashoda intervention has been sustained/ scaled up by state governments in some of the NIPI focus states, it is uncertain whether the intervention will be incorporated under NRHM and scaled up nation-wide. There has been a variation in experience across states with the intervention being scaled up in all districts in Rajasthan and Bihar; additional districts (apart from the NIPI focus districts) in Odisha; and sustained only in the NIPI focus districts in Madhya Pradesh. In addition, not all techno managerial positions created under NIPI have been absorbed under the National Rural Health Mission (NRHM).

- Other NIPI interventions which have not been sustained after NIPI include the (a) National Child Health Resource Centre (we understand from Government stakeholders that they are not convinced of its effectiveness of functioning and added value)[85]; and (b) fund for referral of babies up to two months of age in case of emergencies (as there was an overlap with an existing intervention under NRHM – the Janani Express – which provided referral transport). The State Child Health Resource Centers in Bihar, Madhya Pradesh and Rajasthan did not perform as expected and were phased out in March 2012, however, the Centre worked well in

85 NIPI funding for the National Child Health Resource Centre stopped in September 2012, after which it has continued to function with support from National Institute of Health and Family Welfare. We understand that National Institute of Health and Family Welfare have made a proposal to the Ministry of Health and Family Welfare for funding the National Child Health Resource Centre, and are currently awaiting their decision.

Odisha and may be sustained by integrating it with a new DFID sponsored knowledge centre.[86]

Thus, in general, there has been a good experience under Phase I in terms of sustaining and / or scaling up NIPI supported interventions. In some cases, the interventions have been on the Government of India's radar and hence NIPI's catalytic push has supported its sustainability/ scalability (e.g. in the case of the Home Based Newborn Care and Sick Newborn Care Units). In other cases, NIPI needs to do more to demonstrate the effectiveness of the intervention through the documentation and dissemination of good practises and results (e.g. the case of the Yashoda intervention).

86 NIPI (2013), Phase II Programme Document'.

8. Conclusions and Lessons Learnt

In this section, we present our overall conclusions on the process evaluation of NIPI Phase I. As described in Section 2, we have followed the OECD DAC evaluation criteria, supplemented by a 'traffic-light' rating of performance. For each criterion, the evaluation conclusions are followed by key lessons learnt, which could inform the final design and functioning of NIPI Phase II. These lessons are either in the nature of the initiative's strengths in Phase I that need to be sustained/ built upon; or suggested improvements/ refinements in the design or implementation approach to better achieve the intended results in Phase II.

Relevance	**Assessment: Green**	G

NIPI's focus on improving maternal and child health, and neo-natal health in particular, is very relevant and of added value in India. Given its limited funds in relation to the Government of India and the National Rural Health Mission (NRHM) budget, NIPI has carved a niche in terms of providing strategic, catalytic and innovative support. In addition, NIPI's approach of working across the continuum of care on both home/ community and facility based interventions aligns well with the global evidence on improving maternal and child health as well as the needs/ gaps in India.

NIPI's relevance is also reflected in its approach of working through NRHM and the state health systems, and through existing development partners in the country (rather than creating a parallel implementation structure). However, its relevance may be questioned in cases where the Government of India has not sustained/ scaled-up NIPI supported interventions (e.g. the Yashoda intervention (although some NIPI states have funded the scale-up through their state health budgets) and some techno-managerial staff).

Lessons learnt:

- **NIPI's mandate and approach work well and should be continued in Phase II.** NIPI should continue to focus on maternal and child health in a strategic, catalytic and innovative manner. It should also continue to work through the Government's National Rural Health Mission (NRHM) and leverage implementation support from existing partners in country, rather than creating a parallel system.

Effectiveness	Assessment: Amber	A

We have examined the effectiveness criteria from the perspective of whether NIPI's design and processes have contributed positively or negatively to the attainment of its objectives. Our assessment is that the basic design of NIPI – in terms of what it aims to do, how it has positioned itself in the Indian context, and its approach of working through in-country mechanisms – has worked well. But there have been a few issues with the processes followed by NIPI in its governance/ management as well as at the intervention level that have impacted its effectiveness. In particular:

- Whilst most NIPI interventions have been relevant, their selection and prioritisation process has not been very systematic, and driven by pre-determined criteria or supported by deliberations among various stakeholders.

- The roles of the some of the key stakeholders (e.g. Secretariat, Norwegian Embassy, UNOPS) have not been clearly delineated from the start of the initiative and have evolved over time, creating considerable confusion and inefficiencies (e.g. the UNOPS Secretariat getting involved in implementation of NIPI activities; changes in the role of the Norwegian Embassy in reaction to a weak Secretariat; dual role of UNOPS in housing the Secretariat and acting as the Local Fund Agent, and later morphing into an implementation partner with state offices).

- The initiative has lacked a strong centralised Secretariat to support coordination amongst partners and take forward certain aspects including operational research. It has also lacked a comprehensive monitoring and evaluation framework and uniform approach to partner reporting.

- While enjoying high-level political support, NIPI's governance structures have been viewed as cumbersome and at times duplicative, with room to streamline and improve their effectiveness.

- There has been limited follow-up on most of the recommendations made by the Mid-Term Review and Evaluability Study, with a lack of clarity on the required processes and responsibilities to implement changes.

Lessons learnt:

- **Need for a more structured and participatory approach for selection of interventions.** A well-defined and methodical approach to the selection of interventions needs to be developed ex-ante, in terms of identifying: (i) key intervention selection criteria; (ii) appropriate evidence base and supporting documents required for the review and prioritisation of interventions/ partner funding proposals; (iii) suitable processes for approval of interventions and their budgets; and (iv) the NIPI stakeholders (at the national/ state level) and governance committees that would be consulted/ involved in the decision on interventions (providing for adequate safeguards for any conflict of interest

among participating implementing agencies). This would ensure better accountability and arguably, improved results for NIPI, as also ensure stakeholder buy-in for the future sustainability/ scale-up of the selected interventions.

- **Need to clearly define the roles and responsibilities of stakeholders in Phase II.** NIPI should develop a comprehensive governance document that elucidates the key roles and responsibilities of the main committees and stakeholders. This should include a well-defined approach for robust reporting, monitoring and evaluation and adequate follow-up on reviews/ evaluations. Any changes to these roles should be agreed following suitable governance procedures and documented clearly for the reference of all concerned stakeholders.

- **Need for a coordination mechanism and synergistic approach among partners.** NIPI Phase II should establish a central mechanism (e.g. through a Secretariat) to coordinate and align the work of the various partners. Key approaches could include scheduling of operational meetings/ partner workshops at the state level to coordinate on interventions and lessons learnt; and sharing of documentation on activity progress/ key issues.[87]

- **NIPI should continue to leverage high level government support, but streamline its governance mechanisms.** An option to enhance governance is to merge the Joint Steering Committee and Programme Management Group, without losing the effective participation from the key government officials. Alternatively, NIPI could consider working through existing health sector coordination mechanisms – for example, GAVI support related discussions and decisions are made through the country's Health Sector Coordination Committee.

Efficiency	**Assessment: Amber/ Red[88]**	

Despite NIPI having a relatively small budget, during the six years of Phase I operations, it has allocated only 82% of its budget to date, of which, approximately 80% has been utilised to date:

- Utilisation of funds allocated to UNOPS Local Fund Agent, which was channelled to the four states, was slow in the initial years (as some activities such as training and recruitment took much longer than anticipated to commence), but improved thereafter - the total UNOPS Local Fund Agent utilisation is 85% of its allocated funds.

- Utilisation of funds by WHO has been particularly low – at 37% of its allocation; however UNICEF has utilised all funds allocated to it. The Secretariat has utilised 72% of its allocated funds.

87 We understand that a Coordination Unit (which will replace the Secretariat) at Norwegian Embassy is expected to facilitate this in Phase II.

88 The United Nations Development Programme states in a response to CEPAS draft report that: "The colour coding does not justify the efficiency and needs to be changed as only expenditure should not be the sole criteria to measure efficiency. Also, the expenditure has to be seen in the context of NRHM taking up funding of some of the NIPI interventions (uptake by the system which was an important criteria of success!)."

In general, we have had limited access to detailed financial data in terms of spend by intervention/ activity, by year (vis-a-vis budget), and by programme versus non-programme costs by each of the implementing partners. Also, as noted in Section 3, our conservative assessment is that the proportion of management/ administrative costs of the total budget is relatively high at around 15%.

The relatively low utilisation rate and high administrative costs of the initiative suggest some inefficiencies in the implementation of NIPI, which could be improved upon going forward.

Lessons learnt:

- **Financial management needs to be improved.** NIPI needs to track its expenditure (vis-a-vis budget and funds allocation) more closely, to ensure adequate utilisation of funds and any mid-term course correction, as may be required. This will also improve accountability of the various partner activities.

- **Reduce management/ administrative costs.** NIPI needs to better manage the share of management and administrative costs within its total budget (including collecting accurate data on this), to ensure that maximum funds are available for interventions/ programme activities. In this regard, it should explore negotiating lower Programme Support Costs charges from its implementing partners (these might be lower for non-UN agencies in any case).

Impact	**Assessment: Green/Amber**	

We consider the impact of the initiative from the perspective of whether it has met its objectives of providing strategic, catalytic, innovative and flexible funding – rather than the traditional definition of impact which refers to the long term consequences of interventions (given the focus of this process evaluation and that it is too early to comment on/ attribute NIPI's impact on child/ maternal health).

Our assessment is that NIPI has performed well on the following objectives:

- NIPI funding has been strategic by virtue of supporting a continuum of care approach – the Yashoda, Home Based Post Natal Care and Sick Newborn Care Unit interventions create a clear link between home, community, and facility based care. In addition, the techno-managerial positions created under NIPI are also a strategic intervention, based on the requirement of general managerial and health administration skills to complement and support the work of the medical staff.

- NIPI has accelerated some of the existing processes and health interventions, that would either have taken longer to materialise or would not have been implemented at scale – demonstrating its catalytic role (e.g. through the Home Based Post Natal Care intervention, NIPI took forward

the concept of post-natal care through home visits in a systematic and focussed manner). However, NIPI has not done enough to document and disseminate its achievements in Phase I, which is key to sharing lessons and promoting the sustainability and scale up of interventions going forward.

- In terms of flexibility, NIPI aims to depart from the traditional approach of bilateral funding by providing a flexible pool of funds to be used based on actual needs of the implementing partners (within a broadly defined mandate). However, NIPI could have been more flexible in extending support to additional states or interventions/ activities in the context of changing health priorities in India (over the 6-year Phase I period), and particularly given that the Phase I funds were not fully utilised.

- Certain innovations under NIPI are new and represent a first time implementation in India (e.g. Yashoda intervention, support for District Training Centres, Mobile Money Transfer scheme for ASHAs). Also, NIPI has introduced some new/ novel elements under other interventions (e.g. the introduction of the Emergency Treatment and Triage areas within the Sick Newborn Care Units). Some NIPI interventions, while not completely new, may be regarded as process innovations (e.g. Home Based Post Natal Care, in that it helped in institutionalising and later scaling up the concept of post natal care through home visits at the community level).

NIPI-related activities undertaken by WHO and UNICEF have been more in line with their own organisational mandate and country plans rather than furthering the NIPI approach/ interventions. Therefore, although the WHO and UNICEF activities funded by NIPI might help improve child/ maternal health performance in the states, their interventions have been less distinct and 'visible'. It has been commented that more could have been done to use both partners strategically within NIPI's overall mandate.

While issues of gender and equity are all implicit in its interventions, given their focus on maternal and child health in poor/ lagging India states, but NIPI needs to be more pro-active in terms of: (i) defining how it will address these issues; and (ii) developing key indicators to track progress on these.

Lessons learnt:

- **NIPI should establish a results framework, clearly defining its overall goal and objectives and outputs, outcomes and impacts.** There is a need for NIPI to establish a results framework, clearly defining its overall goals and objectives; the progression of how its activities will lead to certain outputs and contribute to specific outcomes and impacts (theory of change); and planned targets along with milestones. It is also important to develop a pre-agreed and standardised format for partner reporting that links into the overall NIPI results framework (including capturing results on NIPI's cross-cutting issues of gender, equity, quality and sustainability).[88] This framework should be closely integrated with the Government of India/ National Rural Health Mission (NRHM) systems, to the extent possible, to avoid duplication. Efforts should be made to ensure that the framework is not onerous for the implementing partners and aligned to the extent possible with their reporting systems (i.e. an appropriate balance needs to be struck between the collection of additional information and its use). 'Real-time' data should be collected, along with online reporting of results, where possible.

Sustainability	**Assessment: Green**	G

In general, the experience with regard to the sustainability and scalability of NIPI interventions has been positive. Some of the interventions are being rolled out and adopted across the country by the Government of India (e.g. Home Based Post Natal Care intervention has been scaled up as Home Based Newborn Care under NRHM and the Government is also rolling out Sick Newborn Care Units across the country). On the other hand, a few other interventions have not been scaled up at the national level (e.g. the Yashoda intervention has been scaled up with state government funding in NIPI focus states, but it is uncertain if it will be incorporated under the NRHM umbrella). Some other NIPI interventions like National Child Health Resource Centre and the fund for referral of babies has been phased out, given the noted issues in its implementation.

However, some issues have been reported in the transition of funding from NIPI to the government in terms of: (i) delays in payments (e.g. to Yashodas); and (ii) lack of incorporation of key structural aspects of the interventions (e.g. supervisory support under the Yashoda and Home Based Post Natal Care interventions). In addition, it is important for NIPI to document the evidence on the implementation of interventions and disseminate key findings to garner wide-ranging support for its interventions and thereby increase the potential for

89 We understand that NIPI has put together a draft M&E framework for Phase II, under which results will be measured at three levels: (i) contribution towards district and state level reduction in NRHM indicators; (ii) programme performance as a direct consequence of NIPI interventions; and (iii) catalytic effect of NIPI for uptake of interventions by NRHM. In addition, some overall indicators have also been developed for UNDP and Jhpeigo. However, the mechanism by which the data received from the two agencies is collated into a meaningful format and management accounts generated to inform decision making/ course corrections is not yet in place. In addition, Norad has also commissioned an impact assessment for NIPI Phase II, which would aim to set out an ex-ante framework/ indicators for review and support better tracking of both the baseline and results in Phase II.

sustainability/ scalability. While some studies have been commissioned in NIPI Phase I, our view is that this has not been accorded adequate emphasis.[90]

Lessons learnt:

- **NIPI could provide transition funding to the Government of India/ state governments to facilitate the sustainability and smooth scalability of interventions.** It would be important for NIPI to provide some transition funds and 'handholding' support to the Government of India/ state governments, as required, to ensure the smooth take-over of funding of the intervention by the government and that key value-added aspects of the interventions are not lost.

- **Need for documentation and dissemination of interventions and results, to ensure evidence based scale up.** A clear research strategy needs to be developed in Phase II and appropriate measurement approaches instituted to track progress/ results.[91] NIPI could make additional efforts and allocate some budget towards publishing results/ lessons learnt in peer reviewed journals, conducting dissemination workshops and seminars, and in general, generating knowledge to create more visibility of its interventions – especially given their innovative/ pilot nature. NIPI could also consider setting up an online platform for disseminating information both nationally and globally on what worked well and less well in its interventions.

90 We understand that two studies have been carried out by the Norwegian Embassy – the ANSWERS study on optimal breastfeeding; and 'Assessment of pivotal issues related to infant feeding and child nutrition in India: inputs for improving interventions within NIPI'.

91 For example, this is being done through the commissioning of the impact evaluation in Phase II.

Annexes

Annex 1: Terms of Reference

Evaluation of the Norway-India Partnership Initiative

1. Introduction

With this the Evaluation Department in Norad issues a request for proposals from researchers/consultants interested in designing and conducting a process evaluation of the Norway-India Partnership Initiative (NIPI) phase I.

The Norway-India Partnership Initiative (NIPI) is one out of five bilateral partnerships the Norwegian government has entered into with the intention to contribute to the achievement of the Millennium Development Goals 4 and 5; to reduce child mortality and improve maternal health. The vision of NIPI from the onset was to provide catalytic, strategic support that would make a vital and sustainable difference to the rapid scaling up of quality and equitably delivered child health services in India under the National Rural Health Mission (NRHM).

NIPI (phase I) planned to invest NOK 500 million (US $ 81.1 million) in support of the National Rural Health Mission in four states in India.[1] The funding is channelled through multiple partners including United Nations Office for Project Services (UNOPS), United Nations Children Fund (UNICEF) and World Health Organisation (WHO). No funds are received directly by the Government, except via UNOPS to the State Health Societies in the four states.

The aim of the NIPI partnership (phase I) is to facilitate rapid scale-up of quality child-related health services that are equitable and sustainable with a focus on: a) Strengthening the Government of India's National Rural Health Mission initiative by supporting an independently managed network facilitating delivery of MDG 4 related services, b) Introducing and testing new ways of scaling-up services by community health workers - Accredited Social Health Activists (ASHAs) at the village level in focus states, c) Engaging the private sector in the delivery of MDG 4 related services at all levels, d) Exploring new opportunities as they arise and conducting operational research to establish their value. NIPI further aims to provide flexible support to enable implementation and innovation and to resolve bottlenecks.

1 Actual investments amount to NOK 330 million in the period 2006-2012.

According to the NIPI programme document the following are the three objectives and expected outcomes that NIPI is expected to contribute to:[2]

- Saving an additional half a million under five children each year from 2009 onwards.
- Sustaining routine immunisation coverage rate in the country at 80% or more from 2007 onwards.
- Improving performance of the health system as a whole and development of best procedures for large scale roll-out of interventions addressing MDG 4 also in other countries.

Phase I of the NIPI is coming to an end (2006-2012) and the scope of phase II (2013-2017) is currently being developed. The total budget estimated for phase II is NOK 250 million.

In 2010, both a mid-term review of the NIPI partnership and an evaluability study were conducted. The latter was done in order to assess the extent to which the NIPI activities can be evaluated in a reliable and credible fashion. The study pointed out the existence of numerous sources of data. In November 2011, a technical report "Assessing and Supporting NIPI interventions" was published by the Public Health Foundation of India/University of Oslo.

2. Purpose

The purpose of this tender is to take stock of the Norway-India Partnership Initiative as it enters Phase II and assess the extent to which the program has met its stated goals and determine its future viability.

The evaluation is intended to inform the international and Norwegian public and government about the progress that has been made as a result of the Norway-India Partnership Initiative. This will also be an important contribution to the international debate around the post-2015 MDGs.

The main users of the findings of the evaluations will be the Ministry of Foreign Affairs in Norway (MFA), the Government of India, the programme management and the government structure of the NIPI and other stakeholders who have direct or indirect interest in the subject of this evaluation. In this context, the MFA refers to its political leadership, its officials, the Norwegian Embassy in New Delhi and the Norwegian Agency for Development Cooperation (Norad). NIPI refers to the Secretariat, the Programme Management Group and the Joint Steering Committee. The stakeholders include implementing partners (United Nations programmes and non-governmental organisations).

2 The first two objectives are identical to the objectives of the National Rural Health Mission (NRHM).

3. Objectives and scope

The main objectives of the evaluation are to:

- Describe and analyse the governance structure, roles and cooperation between key actors within NIPI phase I with respect to efficiency, effectiveness and sustainability.

- Identify the rationale and logic which guided the selection of the specific targeted interventions within NIPI and the extent to which they reflect the strategic, catalytic, innovative approach as stipulated in key NIPI documents.

- Assess whether and to what extent recommendations from the evaluability study and other relevant reviews have been considered and followed up, specify lessons learned which may be relevant for the preparation and implementation of NIPI phase 2, and evaluate progress made towards developing a monitoring and evaluation system.

- Conduct a process evaluation of 1-2 specific targeted interventions which will continue in the next phase of NIPI.

- The tenderer is welcome to propose additional objectives which may be relevant and which contribute to the learning process.

4. Methodological Comments and Work Plan

The tenderer is expected to submit a preliminary technical proposal with regard to a mixed-methods process evaluation design of NIPI phase I (2006-2012) on the basis of the information in the ToR and the background documents attached to this tender.[3] A process evaluation in this context is considered to be an evaluation of the internal dynamics of NIPI, their policy and strategic instruments, their implementation mechanisms, their management and cooperation practices, and the linkages between these. Such an evaluation may also consider outputs and other intermediary results. Attention to unintended effects of NIPI in each of the four objectives should be considered.[4]

It is expected that the evaluation questions be closely linked both to the main project objectives and to the objectives of this evaluation. The evaluation shall look at both the structural level of the NIPI and more concretely at the operational level to assess 1-2 selected interventions which will be continued in Phase II. The districts and interventions to be involved in the evaluation will be determined in consultation with NIPI partners. It is anticipated that this will shed light on the relationship between the context and the processes of the NIPI. The

3 Evaluability Study of Partnerships Initiatives, Report 9/2010 Study, Evaluation department, Norad; Final report of the Mid Term Review, 2010. Ashok Dutta, Rani Gera, Antoinette Pirie, Stein-Erik Kruse; Assessing and Supporting NIPI interventions, Technical report, November 2011, Public Health Foundation of India/University of Oslo; Norway India Partnership Initiative (NIPI) Phase II, November 2012.

4 Molund, S., Schill, G. 2007. Looking back, moving forward. Sida evaluation manual. 2nd revised edition. Sida.

proposal should clearly address how the design and methods selected for the evaluation will maximize reliability and validity.

The evaluation will commence with a desk review of NIPI program documents, including previous reviews, will be undertaken with particular focus on the NIPI strategic framework and institutional collaboration, the theory of change or logic model which serves as the basis for the goals set out in the initiative, and the level of implementation fidelity of planned NIPI activities. The evaluation team is also expected to conduct field visits to NIPI to complement the desk review. The purpose of the field visits is to conduct key informant interviews and focus group discussions with respondents on both the supply and demand side of the NIPI, in order to follow-up on the evaluation questions and issues that emerged during the first phase. The tenderer is free to propose alternative methods that have not been suggested here.

The proposals shall follow relevant DAC evaluation guidelines, including a demonstration of how triangulation of methods, and multiple information sources are being used to substantiate findings and assessments. Poorly substantiated findings will not be accepted. In connection with questions where the team does not find sufficient information to make meaningful assessments, the team will list the sources sought and not found and / or describe the type of information sources they would have required to carry out such an assessment.

Cross-cutting issues related to gender, equity, quality and sustainability are expected to be addressed in the tender.

The evaluation team is required to identify local researchers to participate in the evaluation team. The proposed designs shall be submitted in a methodological inception report for the approval by Norad's evaluation department.

5. Budget and Deliverables

The total budget shall not exceed NOK 900 000.

The tenderer shall provide a total budget for the assignment including daily rates of the principal investigators, the time allocated to the local team members, data collection, site visits, researcher time and compensation for travel time used in intercontinental travel (maximum 7 hrs. travel time per intercontinental journey).

The **deliverables** in the consultancy consist of the following outputs:

- **Inception Report:** The inception report will include the proposed design, a summary of all other activities completed during the inception phase, a note on any problems that have occurred and how they were resolved; and a list of any products produced, to be included as annexes to the report. The report should also contain a full annotated list over available data. The inception report shall be prepared and discussed with the stakeholders before approval by Norad's evaluation department.

- **Draft Evaluation Report** for preliminary approval by the Evaluation Report for circulation to the stakeholders. The stakeholders will be invited to comments on structure, facts, content, and conclusions.

- **Final Evaluation Report** Direct travel-cost related to dissemination in India, will be covered separately on need basis, and are not to be included in the tender budget.

All presentations and reports (to be prepared in accordance with the Evaluation Departments guidelines given in Annex A-3 Guidelines for Reports of this document) are to be submitted in electronic form in accordance with the deadlines set in the time-schedule specified under *Section 2 Administrative Conditions* in *Part 1 Tender specification* of this document. The data collected during the study shall be submitted in EXCEL format. The Evaluation Departments retains the sole rights with respect to all distribution, dissemination and publication of the deliverables.

Annex 2: Bibliography

This annex presents a list of key documents and datasets for the assignment.

Documents

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Annex 3: Consultee List

Table A3.1 lists the consultations carried out in the inception and core phases of our work. Stakeholders consulted during the field are listed in the respective state reports.

Table A3.1 Consultation list [5]

Stakeholder	Name	Department/ organisation
Government of Norway	Dr. Tore Godal	Special Health Adviser to the Prime Minister of Norway
Norwegian Agency for Development Cooperation (Norad)	Helga Fogstad	Head of Health, Department of Global Health, Education and Research
	Cliff Wang	Senior Advisor
Royal Norwegian Embassy, New Delhi	Unni Silkoset	Counsellor, New Delhi, India
	Dr. Ashfaq Ahmed Bhat	Senior Advisor Health, New Delhi, India
	Inger Sangnes	Counsellor (Former), New Delhi, India
	Jan Håkon Olsson	Deputy Head of Mission, Head of Development Cooperation, Lilongwe, Malawi (Formerly at Norwegian Embassy, New Delhi)
Ministry of Health and Family Welfare, Government of India	Anuradha Gupta	Additional Secretary, Health and Mission Director, National Rural Health Mission
	P. K. Pradhan	Former Secretary, Health
	Dr. Ajay Khera	Deputy Commissioner, Child Health and Immunisation
	Dr. Prasanna. K. Hota	Former Secretary, Health
	Dr. T. Sunderaraman	Executive Director, National Health System Resource Centre
	Dr. Manpreet Singh Khurmi	National Consultant, Newborn and Child Health

5 Other stakeholders who we contacted but were not available to speak with are Dr Abhay Bang (Society for Education, Action and Research in Community Health (SEARCH)), Dr. Henri van den Hombergh (UNICEF), and Paul Fife (Norad).

Stakeholder	Name	Department/ organisation
National Institute of Health and Family Welfare	Dr. Jayanata K. Das	Director
	Dr. Madhulekha Bhattacharya	Professor and Health, Department of Community Health Administration
NIPI Phase I Implementing Partners	Dr. Paul Francis	South East Asia Regional Office, World Health Organisation (WHO)
	Kiran Sharma	World Health Organisation (WHO)
	Dr. Pavitra Mohan	Formerly with UNICEF
	Dr. Genevieve Begkoyian	Chief Health, UNICEF, India
	Dr. Satish Kumar Gupta	Health Specialist, UNICEF, India
	Dr. Kaliprasad Pappu	Director – NIPI Newborn Project, United Nations Development Programme (UNDP)
Public Health experts	Dr. Beena Varghese	Head, Research Development, Public Health Foundation of India
	Dr. M. K. Bhan	Former Secretary, Department of Biotechnology, Government of India
NIPI	Lalitha Iyer	Former Advisor, Gender, NIPI Secretariat
Other	Dr. Vinod Paul	Head, Department of Paediatrics, All India Institute of Management Sciences (AIIMS)
	Dr. Somesh Kumar	Director, Programmes, Jhpiego, India

EVALUATION REPORTS

3.00 The Project "Training for Peace in Southern Africa"
4.00 En kartlegging av erfaringer med norsk bistand gjennomfrivillige organisasjoner 1987–1999
5.00 Evaluation of the NUFU programme
6.00 Making Government Smaller and More Efficient.The Botswana Case
7.00 Evaluation of the Norwegian Plan of Action for Nuclear Safety Priorities, Organisation, Implementation
8.00 Evaluation of the Norwegian Mixed Credits Programme
9.00 "Norwegians? Who needs Norwegians?" Explaining the Oslo Back Channel: Norway's Political Past in the Middle East
10.00 Taken for Granted? An Evaluation of Norway's Special Grant for the Environment
1.01 Evaluation of the Norwegian Human Rights Fund
2.01 Economic Impacts on the Least Developed Countries of the Elimination of Import Tariffs on their Products
3.01 Evaluation of the Public Support to the Norwegian NGOs Working in Nicaragua 1994–1999
3A.01 Evaluación del Apoyo Público a las ONGs Noruegas que Trabajan en Nicaragua 1994–1999
4.01 The International Monetary Fund and the World Bank Cooperation on Poverty Reduction
5.01 Evaluation of Development Co-operation between Bangladesh and Norway, 1995–2000
6.01 Can democratisation prevent conflicts? Lessons from sub-Saharan Africa
7.01 Reconciliation Among Young People in the Balkans An Evaluation of the Post Pessimist Network
1.02 Evaluation of the Norwegian Resource Bank for Democracyand Human Rights (NORDEM)
2.02 Evaluation of the International Humanitarian Assistance of the Norwegian Red Cross
3.02 Evaluation of ACOPAMAn ILO program for "Cooperative and Organizational Support to Grassroots Initiatives" in Western Africa 1978 – 1999
3A.02 Évaluation du programme ACOPAMUn programme du BIT sur l'« Appui associatif et coopératif auxInitiatives de Développement à la Base » en Afrique del'Ouest de 1978 à 1999
4.02 Legal Aid Against the Odds Evaluation of the Civil Rights Project (CRP) of the Norwegian Refugee Council in former Yugoslavia
1.03 Evaluation of the Norwegian Investment Fund for Developing Countries (Norfund)
2.03 Evaluation of the Norwegian Education Trust Fund for Africain the World Bank
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6.04 Study of the impact of the work of Save the Children Norway in Ethiopia: Building Civil Society
1.05 –Study: Study of the impact of the work of FORUT in Sri Lanka and Save the Children Norway in Ethiopia: Building Civil Society
1.05 –Evaluation: Evaluation of the Norad Fellowship Programme
2.05 –Evaluation: Women Can Do It – an evaluation of the WCDI programme in the Western Balkans
3.05 Gender and Development – a review of evaluation report 1997–2004
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5.05 Evaluation of the "Strategy for Women and Gender Equality in Development Cooperation (1997–2005)"
1.06 Inter-Ministerial Cooperation. An Effective Model for Capacity Development?
2.06 Evaluation of Fredskorpset
1.06 – Synthesis Report: Lessons from Evaluations of Women and Gender Equality in Development Cooperation
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1.07 – Synteserapport: Humanitær innsats ved naturkatastrofer:En syntese av evalueringsfunn
1.07 – Study: The Norwegian International Effort against Female Genital Mutilation
2.07 Evaluation of Norwegian Power-related Assistance
2.07 – Study Development Cooperation through Norwegian NGOs in South America
3.07 Evaluation of the Effects of the using M-621 Cargo Trucks in Humanitarian Transport Operations
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6.08 Evaluation: Evaluation of Norwegian Development Cooperation in the Fisheries Sector
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2.10 Synthesis Study: Support to Legislatures
3.10 Synthesis Main Report: Evaluation of Norwegian Business-related Assistance
4.10 Study: Evaluation of Norwegian Business-related Assistance South Africa Case Study
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6.10 Study: Evaluation of Norwegian Business-related Assistance Uganda Case Study
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11.10 Evaluation: Evaluation of the International Organization for Migration and its Efforts to Combat Human Trafficking
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17.10 Evaluation: Real-Time Evaluation of Norway's International Climate and Forest Initiative. Country Report: Tanzania
18.10 Evaluation: Real-Time Evaluation of Norway's International Climate and Forest Initiative
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2.11 Evaluation: Evaluation of Research on Norwegian Development Assistance
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8.11 Norway's Trade Related Assistance through Multilateral Organizations: A Synthesis Study
9.11 Activity-Based Financial Flows in UN System: A study of Select UN Organisations Volume 1 Synthesis Volume 2 Case Studies
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2.12 Hunting for Per Diem. The uses and Abuses of Travel Compensation in Three Developing Countries
3.12 Evaluation of Norwegian Development Cooperation with Afghanistan 2001-2011
4.12 Evaluation of the Health Results Innovation Trust Fund
5.12 Real-Time Evaluation of Norway's International Climate and Forest Initiative. Lessons Learned from Support to Civil Society Organisations.
6.12 Facing the Resource Curse: Norway's Oil for Development Program
7.12 A Study of Monitoring and Evaluation in Six Norwegian Civil Society Organisations
8.12 Use of Evaluations in the Norwegian Development Cooperation System
9.12 Evaluation of Norway´s Bilateral Agricultural Support to Food Security
1.13 A Framework for Analysing Participation in Development
2.13 Local Perceptions, Participation and Accountability in Malawi's Health Sector

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