Overview of the Impact Evaluation of Norway India Partnership Initiative (NIPI) Phase-II Programme

About the Norway-India Partnership Initiative (NIPI)

The Norway-India Partnership Initiative (NIPI) aims to contribute towards the achievement of the 4th and 5th Millennium Development Goals to reduce child mortality and improve maternal health. The NIPI programme seeks to provide catalytic support to the Government of India's flagship health programme, the National Rural Health Mission (NRHM) by piloting potential innovations in new-born care, family planning and maternal health in 13 districts in four focus States (Bihar, Madhya Pradesh, Odisha and Rajasthan). The implementing agencies are Jhpiego[1] and the United Nations Development Programme (UNDP).

NIPI Phase-II (2013-2017) builds upon activities introduced in Phase I and includes the following interventions, which are components of the Government's *India New-born Action Plan*[2][3]:

1) Home Based New-born Care Plus (HBNC+)	2) Sick New-born Care Unit Plus (SNCU+)	3) SNCU Systems Strengthening	4) Revitalisation of Post-partum Family Planning (PPFP) services	5) Pre-Service Education (PSE) of Midwifery Cadre
•Extend continuum of care to new-borns from 3 months until 1 year of age •Home Visits by Accredited Social Health Activists (ASHAs) •Promote infant feeding practices, diarrhoea treatment, hand washing, prophylactic iron supplementation, immunisation, growth monitoring and child communication and play	•Extend continuum of care to sick new-borns after discharge from SNCUs until they are 6 weeks of age •Home visits by Auxiliary Nurse Midwife (ANM)/ASHA •Promote compliance with discharge instructions, kangaroo mother care, breastfeeding and child communication and play	•SNCU Systems = New-born Care Corners (NBCCs), New-born Stabilising Units (NBSUs), SNCUs and SNCU-Training and Treatment Centre (TTC) •Capacity building and systems strengthening	•Promote PPFP counselling at health facilities •Promote uptake of Post-partum Intra-Uterine Contraceptive Device (PPIUCD) by facility level medical staff •Delivery of key messages at the community level by ASHAs.	•Strengthen quality of nursing and midwifery pre-service education •Auxiliary Nurse Midwife (ANM) Training Centres (ANMTCs) and General Nurse Midwife (GNM) Schools

About the Evaluation

The evaluation has three core components[4]:

Impact Evaluation	Cost-Effectiveness Analysis	Qualitative Evaluation
•Help NIPI and the Government of India to understand whether the new interventions "work"	•Provide evidence to the Government on whether the interventions are worth committing the resources required to scale	•Help analyse the effectiveness of interventions targeted at health systems strengthening and contextualise the impact evaluation findings

The evaluation will also contribute to an understanding of how feasible it is to evolve existing frontline public health structures under NRHM to deliver more complex and holistic services to the community.

Oxford Policy Management and Sambodhi Research and Communications have been commissioned by the Evaluation Department in the Norwegian Agency for Development Cooperation to do the evaluation.

[1] Jhpiego is an international, non-profit health organization affiliated with The Johns Hopkins University."
[2] Ministry of Health and Family Welfare, Government of India (2014), *'India New-born Action Plan'*
[3] An ASHA is a village-based trained health mobiliser, mobilising community to access health services, and generating awareness. An ANM is a health staff at the health sub-centre level, providing basic promotive and preventive health services and covering multiple villages.
[4] An impact evaluation is a study of the attribution of changes in the outcome to the interventions. Source:3ie (2012), 'Impact Evaluation Glossary', Version 7

Evaluation Methodology

The evaluation uses a **mixed-methods approach** (involving both quantitative and qualitative methods) to assess attributable levels of impact for the interventions. However, two of the interventions, SNCU systems strengthening and Pre-Service Education to the midwifery cadre, will be assessed through qualitative methods only, due to the systems strengthening nature of the interventions.

For the three population-level interventions of HBNC+, SNCU+ and PPFP, the evaluation will attempt to assess how far each intervention reaches along the results chain model i.e. for inputs, processes, outputs, outcomes and impact indicators. The evaluation will combine population level data with project monitoring data, especially for the PPFP intervention, which has its major focus at the facility level. The quantitative evaluation uses a **difference-in-differences** approach, comparing indicator values before and after the interventions in treatment districts and matched control districts within the same States.

Summary of Quantitative Evaluation Methodology (quasi-experimental design)

- Involves **Difference-in-Differences (DiD) Analysis -** measure changes in indicators between treatment and control districts between baseline and endline. Use **Intention-to-Treat (ITT)** analysis - based on the assignment of the initial treatment
- **Repeated Cross-sectional data**
- Treatment and Control groups matched at district and sub-district level
- Primary Sampling Units (PSUs) selected for each sub-district according to Probability Proportional to Size (PPS)

The evaluation design is flexible and designed to mitigate the risks arising from non-uniform and incomplete implementation of interventions and still produce robust impact estimates. The evaluation design allows for measuring the Average Treatment Effect on the Treated (ATT) while also allowing for other potential mitigation strategies such as reduced samples or ex-post propensity score matching based specifications.

Baseline Survey

The baseline survey aims to inform the status of the key indicators of HBNC+, SNCU+ and PPFP to inform both the evaluation and programme design. The baseline process, conducted between December 2013 and January 2014, consisted of a population survey, a health workers survey, SNCU+ follow up survey and a qualitative study.

Population Survey

- Sample Size = 4620 households with mothers of children aged below 2 years across 300 PSUs
- Sample size to ensure Minimum Detectable Effect (MDE) of 5 percentage points at programme level

Health Workers Survey

- Sample Size = 300 ASHAs
- Assess the capacity, skills and knowledge of frontline health workers - programme delivery channels

SNCU+ Follow Up Survey

- Sample Size = 449 sick new-borns admitted to SNCUs across 4 states in the past 6 months preceding the date of survey
- Cross-sectional Cohort Study

Qualitative Study

- 26 Focus Group Discussions (FGDs) with mothers of children below 2 years of age
- 26 In-depth Interviews (IDIs) with ASHAs
- 26 Direct Observations with ASHAs

The key findings from the baseline survey can be found here:
http://www.norad.no/no/evaluering/publikasjoner/publikasjon?key=418371

Way Forward for the Evaluation

- **Mid-line assessment of the programme implementation (**end of year 2015)**:** Consultations with implementing partners will be held and monitoring data checked to assess the coverage of Phase-II as well as confounding Phase-I interventions (in terms of uniformity and quality). This process will be important for the timing of the end-line survey and the finalisation of the evaluation design.
- **End-line survey** (tentatively end 2016)
- **Cost-effectiveness analysis** (tentatively end 2016)
- **Impact Evaluation Report (**tentatively **mid** 2017).