Mid-Term Review

Norway India Partnership Initiative (NIPI) Phase II

Final Report

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Acronyms and Abbreviations

ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwife
CU	Coordination Unit (NIPI)
DAC	Development Assistance Committee
ETAT	Paediatric Emergency Triage and Treatment ward
FCC	Family Centred Care
GFF	Global Financing Facility in Support of Every Woman Every Child
GNM	General Nurse and Midwife
GoI	Government of India
HBNC	Home Based New-born Care
HMIS	Health Management Information System
HPD	High Priority District
IMR	Infant Mortality Rate
JSC	Joint Steering Committee
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Rare
MoHFW	Ministry of Health and Family Welfare, Government of India.
MTR	Mid Term Review
NBP	New Born Project
NHM	National Health Mission
NIPI	Norway India Partnership Initiative
Norad	Norwegian Agency for Development Cooperation
PAG	Programme Advisory Group
PHFI	Public Health Foundation of India
PPIUCD	Post Partum Intrauterine Contraceptive Device
PPFP	Post-Partum Family Planning
PSE	Strengthening of Pre Service Nursing and Midwife Education
RSBK	***Rashtriya Swasthya Bal Karyakran***
RMNCH+A	Reproductive, Maternal, Newborn, Child and Adolescent Health
RNE	Royal Norwegian Embassy in Delhi
SDG	Sustainable Development Goals
SNCU	Sick New-born Care Unit
SCC	State Coordination Committee
TSU	Technical Support Unit (for innovations)
TTC	Training and Treatment Center
U5MR	Under five Mortality Rate
UNDP	United Nations Development Programme

Description of Key Terms

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.

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

National Health Mission (NHM): A government programme in India that aims to improve healthcare delivery (originally termed National Rural Health Mission, NRHM). Part of it's initiatives include training ASHAs and delivering the Janani Suraksha Yojana. 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. NIPI Phase II coincides with the NHM plan 2013-2017.

Yashoda. A facility-based support worker or birth companion in facilities with high delivery volumes, named after a legendary foster mother of Indian mythology. They provide support and care to mothers and newborns during their stay at these facilities.

Executive Summary

The Norway India Partnership Initiative (NIPI) stems from an agreement between the Governments of Norway and India in 2006 to collaborate towards achieving Millennium Development Goal (MDG) 4 to reduce child mortality, and the associated MDG 5 of reducing maternal mortality. NIPI is focused on providing strategic, catalytic and innovative support to India's National Health Mission (NHM), by testing scalable interventions in in four high focus states: Bihar, Odisha, Madhya Pradesh and Rajasthan (and since 2014, Jammu and Kashmir for RMNCH+A). NIPI Phase I from 2008-2012 showed good results, and the initiative was extended. NIPI Phase II started in 2012, with a 250 million NOK budget over 5 years. NIPI in Phase II has three main goals: 1) Improving and scaling up quality continuum of care interventions at community and facility level in NIPI states; 2) Establishing a mechanism for sustainable institutional collaboration between Norwegian and Indian public and private institutions; and 3) Facilitation of dialogue on global health between Norway and India.

Today NIPI Phase II is at its midterm point and the Royal Norwegian Embassy (RNE) in New Delhi has contracted Scanteam to carry out a mid-term review (MTR) of the initiative's achievements so far.

Scope and Methodology

The review focuses on the *effectiveness* and *efficiency* of NIPI II from January 2013 to date, including a focus on the implementation partners' quality of technical assistance, documentation of activities and financial and administrative management. It also assesses NIPI's *contribution to the National Health Mission* at national and state level, how NIPI is perceived as a technical support partner and „brand", and the benefits of NIPI's implementation mechanism at state level. It further focuses on the degree of *cooperation* with the Ministry of Health and Family Welfare (MoHFW) and implementing partners, including level of *sustainability* created so far. Finally it recommends possible *future directions* for support in maternal and child health post-2017. The review includes a cross cutting focus in *gender equality, environment and anti-corruption* and possible effects.

A mixed-methods approach was adopted for this review, consisting of a desk-based review of relevant documents, interviews with stakeholders and a field visit to two NIPI districts.

Key findings

Effectiveness

- The majority of the lessons learned from Phase I were incorporated into Phase II, which started with a strong Programme Document, a Monitoring and Evaluation (M&E) framework and an improved governance structure with well divided roles and responsibilities. Since then, five new interventions have been added and a few have been dropped, yet the Programme Document has not been updated to reflect this.

- The majority of the interventions (Goal 1) have shown good progress, as measured by targets achieved, despite a slow start in 2013. The level of scaling up is promising, with several interventions already scaled up, to varying degrees.
- Progress has been less consistent for Goal 2. While two collaborations have been set up, there is as yet no established mechanism to ensure sustainable institutional collaboration.
- Effectiveness is difficult to measure for Goal 3, which lacks indicators and targets in the Programme Document.

Efficiency

- Implementation in phase II has shown good efficiency, in part thanks to strong results frameworks and monitoring, which have prevented over-planning.
- Use of funds were low in 2013 but increased in 2014, with an 80% disbursement rate, expected to reach 90% in 2015. The flexibility in the use of funds has been key in ensuring good implementation rates, as funds can be transferred from areas with slow progress to areas progressing well. Only one programme showed considerable overspending (RBSK in 2013).
- Administrative and financial management has been good, with timely reports and meetings by NIPI governance bodies, and a high level of communication and trust between the stakeholders, ensuring that challenges are shared early on.
- There is good transparency in use of funds, but limited knowledge among state and district level stakeholders of whistle-blower mechanisms available to them .
- The quality of technical assistance by implementing partners is high, with partners having strong links and communications with government at national and state level.
- State and local level stakeholders perceive limited opportunities for training and professionalization of NIPI personnel, suggesting that if mechanisms are in place in implementing partners' structures, they are not well know.
- There is good documentation of activities in terms of quantitative data from monitoring frameworks, but use of available data for scientific publications has been limited. There is scope for additional qualitative documentation of activities and lessons learned, particularly success stories and case studies. These areas are considered a priority in the remaining two years.

Contribution to NHM at national and state level

- Innovations contributed by NIPI fall into two categories: testing the "what", i.e. programmatic and technological innovations; and testing the "how", i.e. new operationalizing approaches to improve quality of care.
- The most important contributions to the NHM from NIPI are the techno-managerial support given by implementing partners, and the testing and piloting of innovations with great potential for scalability.

Cooperation and Sustainability

- Governance structures ensure communication and cooperation at national and state level between the donor, the government and implementing partners.
- Relations are very good but opportunities for discussion and collaboration among implementing partners have mostly been limited to the Programme Advisory Group (PAG) and State Coordination Committees (SCC), which amount to missed opportunities for creative problem solving.
- A good level of sustainability of interventions has been created so far due to i) working hand-in-hand with the government and alignment of interventions with government priorities, b) abstaining from creating parallel systems (e.g. for M&E) and using available human resources, c) strong techno-managerial support.

Future Directions

- There is a need for continued support and funding post-2017 in order to increase reductions in maternal, neonatal and child mortality and attain the related SDGs by 2030. Funding is needed for scaling up interventions and, crucially, for testing implementation innovations, as there are very few financing mechanisms for this.
- The government has adequate funding for programmes, but has continued needs beyond 2017 for techno-managerial support. NIPI is currently funding over 180 staff through implementing partners, who are providing this support.
- Norwegian development aid policies have shifted towards global funding mechanisms and away from bilateral funding programs such as NIPI, thus potential funding for NIPI post 2017 is not assured.
- There is a need to address as soon as possible a phase out strategy or post-2017 funding mechanisms for NIPI. Global Financing Facility in Support of Every Woman Every Child (GFF) and "Saving Lives at Birth" are global financing mechanisms in maternal and child health that may prove adequate for funding of innovations.
- A Technical Support Unit for Innovation could be envisaged as a think tank for identification, pilot testing and implementation of interventions, operational research, monitoring and evaluation and other areas, and may

provide a way to recreate the work of NIPI post 2017 and of bringing together the technical experts that are now part of NIPI.

Cross-cutting issues: Gender, environment and anti-corruption

- There are good examples on how these dimensions are being addressed in NIPI, but limited systematic incorporation of them in intervention designs, implementation and M&E. Moreover, anti-corruption is not included in the Programme Document, and there are no clear guidelines or targets for the environment dimension either.
- There is limited knowledge among stakeholders on gender-analysis and gender mainstreaming. Sex-disaggregated data is not being systematically analysed and fed back into the programmes in order to target gender inequalities. The percentage of female staff supported by NIPI through implementing partners is around 30%, highlighting challenges in women recruitment particularly for field positions in India.
- Areas of linkages between environment and health in NIPI interventions include biomedical waste disposal, use of technology to decrease paper waste, infection control and ensuring compliance with environmental standards for development of equipment funded by NIPI.
- NIPI interventions could be helping decrease financial mismanagement and increase transparency due to better monitoring and reporting, a switch to online systems, use of standardized data collection forms and checklists, and empowerment of grassroots workers, although there are no mechanisms in place to measure this.

Recommendations

- Ensure that the close follow up by thePAG, Joint Steering Committee (JSC) and SCCs to all interventions is maintained in the remaining two years, to guarantee achievement of targets by 2017.
- Establish a working group to set up a systematic mechanism for selection of new interventions, ensuring participatory input and avoiding duplication of efforts.
- Reinforce and disseminate opportunities for training and professionalization of NIPI personnel available inside implementing partners' structures by including this area specifically in budgets and workplans.
- Ensure wide communication to staff of the whistleblower mechanisms in implementing partners' structures; provide support and capacity building, where appropriate, to strengthen these systems.
- Review and update the Programme Document for NIPI Phase II to better reflect current state of the initiative, and include clearer targets for goals 2 and 3, based on the three years of experience accumulated. Ensure that the cross-cutting dimensions of gender, environment and anti-corruption are

adequately addressed, with indicators and clear guidelines for incorporation into programmes.

- Enlist experts on gender analysis and mainstreaming, environment and good governance, to ensure these areas are adequately covered in programme design, implementation and M&E.
- Establish an agenda for regular meetings among implementing partners and other NIPI stakeholder that could include working groups focusing on:
    - Strengthening data analysis and publications based on available quantitative data, as well as qualitative documentation of activities, particularly case studies, succes stories and lessons learned. This group would require support by a specialist in methodology and scientific writing.
    - Discussing and researching possibilities for phase out and/or financing sources (e.g. Global Financing Facility Every Woman Every Child) for a post 2017 group Technical Support Unit for Innovations, which would continue the work of NIPI on implementation innovations in maternal and child health, and the techno-managerial support provided to the government for roll out and scale up.
    - Disseminating results and lessons learned and advocating to Government of India, Government of Norway and global development donors to maintain adequate funding for innovative interventions post 2017 in India.

1 Introduction and Background

The Norway India Partnership Initiative (NIPI) stems from an agreement between the Governments of Norway and India in 2006 to collaborate towards achieving Millennium Development Goal (MDG) 4 to reduce child mortality, and was further linked to improving gains in MDG 5 as well, of reducing maternal mortality. NIPI was based on India's ambitious health initiative, the National Rural Health Mission, now called National Health Mission (NHM), and aimed at facilitating rapid scale-up of quality maternal and child health services in four high focus states: Bihar, Odisha, Madhya Pradesh and Rajasthan.

The first phase of the initiative ran from 2007 to 2012, with an expenditure of NOK 330 million. The evaluation of these first six years showed that NIPI had largely achieved its objectives of providing strategic, catalytic and innovative support to the NHM and had helped bring forward the new-born health agenda at state and national levels.

The initiative was extended for a further five years, from 2013 to 2017. NIPI in Phase II focus continues to be maternal and new-born health, especially the continuum of care from facility to home, and capacity building of health personnel in the same states. Today NIPI Phase II is at its midterm point and the Norwegian Embassy in New Delhi has contracted a mid-term review (MTR) of the initiative's achievements so far.

1.1 Objectives and Scope of the Evaluation

The *scope* of the MTR is fourfold:

1. To review the *effectiveness* and *efficiency* of NIPI II from January 2013 to date, including a review of the implementation partners' quality of: a) Technical assistance, b) Documentation of activities, c) Financial and administrative management.
2. Assess NIPI's contribution to the NHM at national and state level including: a) How is NIPI perceived as a technical support partner and "brand" and b) What are the benefits of NIPI's implementation mechanism at state level.
3. Assess the degree of cooperation with the Ministry of Health and Family Welfare (MoHFW) and other partners including level of sustainability created thus far.
4. Recommend possible future direction and support for maternal and child health in India by the Government of Norway beyond 2017.

The MTR shall in addition focus on:

5. Agreement partners' focus on cross-cutting issues and what possible effects have they had on: gender equality, environment and anti-corruption.

1.2 Context for NIPI: Status of maternal and child health in India

In the last decades, India has had impressive sustained economic growth paired with gains in human development. From 1980 to 2010, India's Human Development Index rose by 62%. Despite great progress, in 2011, 22% of the population still lived under the national poverty

line and many health and development challenges remain[1]. Over 20% of global child deaths occur in India and 40% of the world's malnourished children live there[2]. Maternal, neonatal and nutritional causes are the main contributors to low Disability-Adjusted Life Years (DALYs)[3]. Health inequities, along class, gender, ethnic, caste and geographical lines are an on-going challenge. Children from poorer households are 3 times more likely to die before turning 5 years old than those of the richest households; and for each 1,000 live births, ten more girls than boys die before the age of 5. Eight states contribute disproportionately to child deaths: Madhya Pradesh, Uttar Pradesh, Odisha, Assam, Rajasthan, Bihar, Chhattisgarh and Jharkhand.

In 2006, when the Governments of Norway and India agreed to collaborate towards achieving MDG 4 to reduce child mortality, under-five child mortality (U5MR) in India was 74 per 1000 live births. By the end of NIPI Phase I in 2012, U5MR in India was 49 per 1000 live births[4], a very important reduction, but still far from the MDG goal of reducing child-mortality by two-thirds from the 1990 baseline, to 42 per 1000 births by 2015.

Because of the tight relationship between MDG 4 on reducing child mortality and MDG 5 on improving maternal health, NIPI has also focused efforts on the latter goal. India had a Maternal Mortality Rate (MMR) of 560 per 100,000 live births in 1990-91, and achieving the target of three-quarters reduction from 1990 levels required reducing this 109 by the end of 2015. By 2009, India's MMR had declined to 167 per 100,000 live births. Despite these impressive achievements, India did not manage to achieve MDG 5, as suggested by the latest data and projections, and quality of maternal care remains a concern.

Table 1: MDGs 4 and 5 in India

MDG & Targets	Indicator	India 1990	India 2005/6	India 2012/3	Target 2015
MDG 4. Reduce Child Mortality. Target: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Under-five mortality rate (U5MR)*	125	74	49	42
	Infant mortality rate (IMR)*	80	57	40	26
MDG 5. Improve Maternal Health Target. Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	Maternal mortality ratio (MMR)**	560+	254	178	109

Data from Sample Registration System India, unless otherwise indicated. *per 1000 live births, ** per 100,000 live births, + Data from UNICEF

[1] Sample Registration System- India.

[2] World Bank. Country overview- India.

[3] WHO. India WHO statistical profile.

[4] UNICEF. Child mortality estimates.

1.3 From NIPI Phase I to Phase II

The final evaluation of Phase I showed that NIPI had largely achieved its objectives of being strategic, catalytic, innovative and flexible, attaining sustainability and scalability of various NIPI interventions, which were adopted by the Government of India and implemented in further states. Also, it found that NIPI had a key added value of bringing forward the new-born health agenda in India. It recommended that NIPI continued to focus on strategic, catalytic and innovative support, and its strategy of working through the NHM.

It is in this context that NIPI phase II is signed, with a budget of NOK 250 million. NIPI phase II was made to coincide with the new NHM plan for 2013-2017 which aims to strengthen on-going initiatives and expand the reach towards achieving universal health care.

The Programme Document for NIPI Phase II establishes a focus on testing and demonstrating innovations that can improve women's and children's health, and details three main goals:

- Goal 1. Improving and scaling up quality continuum of care interventions at community and facility level in NIPI and selected non-NIPI districts.
- Goal 2. Establishing a mechanism for sustainable institutional collaboration between Norwegian and Indian public and private institutions in women's and children's health
- Goal 3. Facilitation of dialogue on global health between Norway and India

In the programme document, two implementing partners had been chosen to help achieve Goal 1, and a third one was brought in in 2014, these are:

- NIPI New-born Project (NBP), working on community based and facility based care for new-borns through innovative interventions, and other activities.
- Jhpiego, focusing on strengthening of pre-service nurse education, labour room strengthening and post-partum family planning.
- Public Health Foundation of India (PHFI), supporting the implementation of the national Reproductive, Maternal, Newborn, Child Health and Adolescents (RMNCH+A) strategy, and piloting a mobile health technology called "***Swasthya Slate***".

Geographically, the NIPI phase II program document established a focus on the original 4 states that were the focus of NIPI Phase I: Bihar, Odisha, Madhya Pradesh and Rajasthan, and proposed demonstration districts in the states of Jharkhand, Chhattisgarh and Assam. These last 3 states were subsequently dropped. In contrast, Jammu and Kashmir was included in 2014 for PHFI activities only. Some activities are focused on selected "NIPI districts" and others have a state-wide focus.

2 Design and Methodology

Four focus areas were laid out in the term of references, heretofore named Tasks 1-4, completed by a cross-cutting focus on gender, environment and anti-corruption. Two of the four tasks for the MTR can be linked to three DAC evaluation criteria, namely effectiveness and efficiency (Task 1), and Sustainability (Task 3). The other two tasks concern: NIPI's contribution to NHM at national at state level and how NIPI is perceived as a technical support partner (Task 2); and recommended possible future directions and support for maternal and child health in India post 2017 (Task 4). The team developed a set of specific review questions to address each task.

Task 1a. Effectiveness.

a. To what extent has NIPI phase II achieved its goals and specific aims, in accordance with the results framework's activities and indicators?

b. To what extent is it considered that the goals will be achieved by the end of NIPI phase II if the current level of activity is maintained/increased?

c. What were the major factors influencing the achievement/non-achievement of goals?

d. To what extent are the outcomes a result of NIPI Phase II rather than external factors?

Task 1b. Efficiency

a. To what extent have the programme activities delivered as agreed, in relation to established time-frames and inputs received?

b. Has the programme been managed with a reasonable regard for efficiency?

c. What is the adequacy of the quality of technical assistance of implementing partners?

d. Is there an adequate level of documentation of activities, by implementing partners, in relation to signed agreements and commitments?

e. What is the adequacy of administrative and financial management of NIPI and implementing partners?

f. What obstacles have been faced concerning efficiency and how are they addressed?

Task 2. Contribution to the National Health Mission (NHM).

a. What have been the key contributions of NIPI to the mission and goals of the NHM at national as well as state level?

b. How is NIPI perceived as a technical support partner and "brand" at national/state level?

c. What are the benefits/drawbacks of NIPI's implementation mechanisms at state level?

Task 3a. Cooperation

a. What is the degree of cooperation between NIPI, MoHFW and implementing partners?

b. What are the main positive points and short-comings related to establishment of a successful cooperation, perceived by partners in this initiative?

Task 3b. Sustainability

a. To what extent have measures been taken to address the financial and operational sustainability of NIPI interventions beyond the end of the NIPI phase II in 2017?

b. What is the level of ownership of NIPI interventions at district, state and national level?

c. What are the major perceived risks in ensuring sustainability of the initiatives beyond NIPI phase II?

Task 4. Future directions

a. Based on the key areas of success of NIPI Phase II, as well as main challenges remaining in maternal and child health in India, what would be the main future directions by which the Government of Norway may provide support beyond 2017?

b. In which ways can this support be envisaged in order to align with Norwegian development goals, the Indian government plans for the NHM, and the Sustainable Development Goals on health?

Cross-cutting focus: gender, environment, anti-corruption

a. In which ways and to what extent have NIPI and implementing partners incorporated a focus on gender equality, the environment and anti-corruption?

b. What are the possible effects of the NIPI interventions/innovations on gender equality, the environment and anti-corruption measures?

2.1 Methodology

To adress the four tasks, the team used a mixed methods approach including:

Document review. The starting point of the exercise was a detailed review of a number of documents related to NIPI such as formal agreements between the Royal Norwegian Embassy and Indian Ministry of Health and Family Welfare; the terms of reference for the NIPI Joint Steering Committee (JSC), the NIPI Programme Advisory Group (PAG), the NIPI State Coordination Committee (SCC) and the NIPI Coordination Unit and programmatic documents and reports (including past NIPI reviews and evaluations, annual progress reports and JSC, PAG and SCC minutes) A complete list of documents made available to the team is shown in Annex B.

Interviews. Structured interviews with key stakeholders, defined in consultation with the client, were carried out based on a pre-defined conversation guide (Annex D), covering the tasks of the review, but tailored to each informant in order to focus on the most relevant issues of his/her competence. The list of interviewees can be consulted in Annex C, and included individuals at the NIPI Coordination Unit, the Royal Norwegian Embassy, representatives from the implementing partners and government officials at national and state level. State-level interviews were conducted in Bhubaneswar (Odisha) and Bhopal (Madhya Pradesh).

Field Visits. The team conducted two visits to selected district sites. After deliberation with the client, the two sites selected were Raisen in Madhya Pradesh and Alwar in Rajasthan. These sites were decided based on accessibility under time and organizational constraints

and because they provide a picture of how NIPI is perceived in different states. During field visits, interviews were conducted with state and district level stakeholders from implementing partners. Although not originally considered in the inception report, limited informal discussions were also carried out with health personnel involved in NIPI interventions and some beneficiaries, as opportunities allowed. The time-line of the field-work and details of sites visited are presented in Annex E.

Data within and across the three sources was compared, were appropriate, for consistency (triangulation) and repetition (saturation). Collation of the evidence was complemented by analysis from the review team, based on internal discussions, our informed judgement and experience.

2.2 Limitations of the review

- ***Geographical scope***: Two state capitals of the 5 states included in NIPI were visited (Madhya Pradesh and Odisha) ; and two districts, one in each Rajasthan and one in Madhya Pradesh, representing 3 different states visited in total. Importantly, state government officials of Jammu and Kashmir, the only state participating with PHFI as implementing partner, were not interviewed.
- ***Coverage of implementing partners***: The team had good coverage of NBP and Jhpiego activities and interventions. However, the coverage for PHFI was more limited, with interviews restricted to two key PHFI stakeholders at national level. No field programme officers were interviewed. Finally, interviews with PHFI were limited to the Affordable Health Technology division, which implements the ***Swasthya Slate*** intervention. No interviews with stakeholders involved in RMNCH+A programme support were carried out.
- ***Interviews with NHM officials at state level***: Due to end of year activities and meetings, the team had limited discussion time with government stakeholders, particularly in Odisha, and some stakeholders with whom interviews had originally been planned, had to cancel and were not interviewed. Also, some government officials at state level were very new to their positions, both in Odisha and Madhya Pradesh.
- ***No interviews with beneficiaries:*** Due to time and budget constraints, and because this is a mid-term review and not a formal evaluation, interviews with beneficiaries of the interventions (mothers, ASHAs, ANMs) were not considered in the methodology proposed in the Inception Report. However, during field visits, one of the review team members had the opportunity to speak informally to a group of beneficiaries (see Annex E).

3 Key Findings

This chapter presents key findings from the review pertaining to the tasks described in the methodology. To facilitate comprehension of this section and visualization of the linkage with Phase I, the chapter first discusses the implementation of recommendations from the Phase I evaluation into NIPI Phase II, and then describes changes and additions to NIPI in Phase II that are not detailed in the Programme Document.

3.1 Implementation of Recommendations from NIPI Phase I evaluation

A series of lessons learned, based on the evaluation conducted at the end of Phase I, were proposed to strengthen NIPI in Phase II. How they have been addressed in Phase II is shown below.

Table 2. Recommendations from Phase I evaluation and how they were addressed in Phase II

Recommendation	How it was addressed in Phase II
NIPI's mandate and approach work well and should be continued.	NIPI in Phase II has maintained its focus on catalytic and innovative interventions on maternal and child health while working through the NHM and avoiding the creation of parallel systems. To ensure a higher focus on innovation instead of programmatic support, agreements with some implementing partners from phase I (UNICEF, WHO) were not renewed in Phase II, and new implementing partners were selected.
Need for a more structured and participatory approach for the selection of interventions.	While there is clearly a participatory approach in the discussion and approval of proposed interventions (i.e. at the Programme Advisory Group (PAG) and JSC), there does not seem to be a well-defined, methodical approach in the selection of interventions that are proposed. Nevertheless, the choice of interventions appears organic in nature, based on creative extensions of phase I interventions such as Home Based New-born Care (HBNC+) and Sick New-born Care unit (SNCU+), needs detected by implementing partners (e.g. Pre-service nursing education, Family-Centred Care), or request for techno-managerial support for government programs such as RMNCH+A and the ***Rashtriya Swasthya Bal Karyakran*** (RSBK). The proposed interventions, however, clearly address pressing needs or close an existing gap in services.
Need to clearly define the roles and responsibilities of stakeholders in Phase II and streamline its governance mechanisms, while continue to leverage high level government support.	This has been one of the areas of improvement most highly praised by stakeholders that were involved with NIPI since Phase I, and considered to be key in the good functioning and governance achieved so far in Phase II. Clear definitions were laid out for the governance structures in the Memorandum of Understanding for Phase II. The JSC is the central decision-making body, and sets strategic direction. It includes members of the Government of India and the Norwegian MFA, but contrary to Phase I, it does not include implementing partners. It is chaired by the Secretary of Health and Family Welfare, and co-chaired by the Norwegian ambassador to India, and this high level leadership is key in moving the interventions forward and overcoming obstacles. Implementing partners are included in the PAG, which also includes NHM and MFA stakeholders, and is a forum for technical discussions, which provides recommendations to the JSC. The State Coordination Committees (SCCs), with NHM state leadership and NIPI members

	ensures state engagement, and timely "technical, managerial and financial planning, review and feedback"[5].
Need for a coordination mechanism and a synergistic approach among partners.	The NIPI Secretariat from Phase I was changed into a lean NIPI Coordination Unit (CU), which provides secretarial services to JSC, SCC and PAG, increasing visibility of NIPI (e.g. maintaining website), facilitating timely meetings and reports and quality assuring documents. It has defined terms of reference and no implementation role.
NIPI should establish a results framework, clearly defining its overall goal and objectives and outputs, outcomes and impacts.	A Programme Document for phase II, establishing goals, stakeholder roles and an overall results framework was completed in early 2013. A Monitoring and Evaluation Framework was also commissioned. These two documents facilitate the assessment of effectiveness by establishing clear indicators and targets to measure progress, and reports from implementing partners are based on them. Also, an impact evaluation for Phase II, ensuring the proper collection of quantitative and qualitative data, including in control districts, has been initiated and the baseline for the impact evaluation was completed in November 2014.
Need for documentation and dissemination of interventions and results, to ensure evidence-based scale up.	This is an area where, while there have been clear efforts (e.g. good content and continuous updating of the NIPI website http://www.nipi.org.in/), stakeholders agree much more effort is required (see Efficiency section).

3.2 Development of NIPI Phase II

NIPI Phase II started off with a Program Document, a baseline evaluation and a Monitoring framework. However, along the way, some important changes were introduced for Phase II, most notably:

- The Programme document envisaged expanding interventions to 3 more states and concept notes for these three states were developed. However, it was later decided that this would stretch NIPI capacity, particularly in view of the request to support the RBSK programme (see below) and an agreement was made to refocus energy on 4 original NIPI states.

Two additional interventions, not originally considered in the Programme Document, were added after approval of the JSC during the first year of Phase II due to a government request:

- **RBSK (Rashtriya Swasthya Bal Karyakran)** is a national MoHFW programme under the NHM, launched in February 2013, which provides comprehensive screening of children for birth defects, diseases, deficiencies and developmental delays including disabilities. The Government of India requested NIPI to provide technical support by funding a group of technical experts (National RBSK team) for this programme, while the costs of roll out are born by the GoI. NIPI support was also used for development of technical documents and guidelines.

[5] MoU Phase II

- **RMNCH+A implementation in Jammu and Kashmir using *Swasthya Slate* technology.** The RMNCH+A Strategy is a national MoHFW programme under the NHM, launched in February 2013. A total of 184 high priority districts (HPDs) requiring intensified efforts were identified, and each state was assigned one development partner agency to provide the technical support. NIPI was requested to provide this support in the 6 HPDs in Jammu & Kashmir. It was originally agreed that UNDP NBP team would act as implementing partner in this state, but due to operational challenges faced by UNDP in hiring district coordinators, in 2014 PHFI was established as the implementing partner instead. It was decided to pilot test the ***Swasthya Slate***[6] technology developed by the Affordable Health Care Technology Division of PHFI in this setting, as an enabler for strengthening the RMNCH+A strategy through its patient-centred approach.

Moreover, implementing partners have proposed additional interventions as needs have been detected, these include:

- **FCC (Family Centred-Care).** An intervention by the NBP team, aiming to train mothers/families of SNCU babies on infection control precautions in an SNCU, basic handling of baby, hand washing and *kangaroo mother care*. Trained mothers are then allowed inside the SNCU and can help care for their babies. It consists of 4 audio-visual modules in local language.
- **ETAT (Paediatric Emergency Triage and Treatment)**. Approved in 2015 by the JSC, this intervention by the NBP team stems from an analysis of the quality of care for children in district hospitals. This led to the development of a tool of indicators to systematically identify areas that need support, then national guidelines and creation of training packages. ETAT wards are being piloted in 5 facilities and they also include use of the ***Swasthya Slate*** technology.
- **Dakshata.** Approved by the JSC in 2015, it aims to strengthen quality of intrapartum and postpartum maternal newborn care by concentrating in 19 high impact practices in labour rooms, supported by a checklist and training of labour room personnel.

3.3 Effectiveness & Efficiency

3.3.1 Effectiveness

Below we describe effectiveness findings for each of NIPI Phase II goals.

Goal 1. Improving and scaling up quality continuum of care interventions at community and facility level in NIPI and selected non-NIPI districts.

In Phase II, the process to propose new interventions and roll them out has been much more systematic, requiring the development of a concept note explaining the theory of change,

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[6] Swasthya Slate is a tablet device allowing users (ANMs, nurses or physicians) to perform multiple point-of-care diagnostic tests, facilitate health communication, daily scheduling of activities, ongoing learning and digital data capture. It is coupled with training, supervision and monitoring (notably through a proactive call-center that contacts the users regularly).

proposing a results framework, measuring baseline values and defining a clear implementation plan.

Also, the review team found a strong emphasis on monitoring and reporting, with M&E specialists as part of the implementation partners' teams and an upholding of standards for data collection and reporting by the RNE and NIPI Coordination Unit. Reports sent by implementing partners all present qualitative as well as quantitative data and percentage of targets reached. A main concern was to avoid creating a parallel monitoring system to that of the government. Thus, health management indicator system (HMIS) indicators are collected, and monitoring and data collection systems are compatible with the national system.

Box 1. Three examples of innovative M&E approaches in NIPI Phase II.

Cross-state periodic assessments. The NBP team has set up this approach, whereby teams from one state perform periodic evaluations and assessments of NBP interventions in others NIPI states, using a standardized tool. These periodic assessments allow for timely feedback and course correction, without having to wait for external evaluations, and also creates mentoring and learning opportunities.

Pre-service nursing education standards. Jhpiego, together with the Indian Nursing Council, developed a set of standards with which to assess (at baseline and quarterly thereafter) the state of the nursing and midwifery schools. Baseline assessments were conducted by Jhpiego, but as the faculty became more empowered, they have started participating in the assessments.

Paperless data capture. The Swasthya Slate tablet allows ANMs to capture patient information directly on a digital support, thus avoiding the time-consuming and error prone step of capturing paper data.

The emphasis on quantification of results against targets has facilitated reviewing effectiveness. Annual reports show a "slow" start in 2013, with implementation partners focusing on preparation activities, development of trainings and manuals, launching of trainings and conducting baseline assessments. Level of activity and achievement of objectives and targets increased in 2014 for both Jhpiego and NBP, with PHFI ***Swasthya Slate*** also starting activities in that year and mostly achieving its proposed targets. In 2015, three new interventions were launched (FCC, ETAT and Dakshata). For most interventions (old and new), the majority of training outputs were achieved, and for the older interventions, outputs for standards of care (e.g. for PSE), of children visited (e.g. HBNC+, SNCU+), or pregnant women receiving antenatal care (***Swasthya Slate***), also increased significantly, showing the results of investments in previous years. Challenges detected included, most notably:

- Achieving high coverage of follow up of SNCU graduates in SNCU+ interventions, possibly due to lack of incentives for ANMs, although infants can be followed up by ASHAs.
- For RBSK, measurement of effectiveness was harder as it lacks quantitative performance outcomes and targets, relying mostly on activities. However, reports show good coverage of activities.

Unintended consequences. Several stakeholders also commented on positive side-effects or unintended benefits of NIPI Phase II interventions. These come mostly from anecdotal observations as there are no tools in place so far to measure these effects. For example, interviewees from all implementing partners commented on the strengthening of skills of

community- and facility-based health personnel (ASHAs, ANMs, nurses), in skills other than those originally targeted by the training programs, such as management, training and other soft skills. The strict monitoring and evaluation programmes for NIPI interventions are unearthing further gaps in skills and this information is being passed on to the relevant government officials. Also, objective standards and periodic assessments of quality of care and educations have sparkled healthy competition among nursing schools. Unplanned too, is the convergence being seen across some NIPI interventions, such as PSE and Dakshata in labour rooms, and HBNC visits serving to promote PPIUCD.

Some of the unintended consequences have on the other hand, been detrimental. Examples mentioned included the inequities among health personnel created by ASHAs incentive-based payments, and some backlash among ASHAs and other health care workers now requiring incentives for other tasks.

Scalability. For many NIPI stakeholders, the ultimate test of effectiveness of the interventions is their take up and scale up by the government. In this sense, as can be seen in Table 3, results are encouraging, with several interventions beginning to scale up to different degrees at state or national level, and other, more recent ones commanding strong interest from the government for their potential. This scalability success is probably strongly linked to the close collaboration with the government embedded in the NIPI approach and governance structure, which ensures that interventions are in line with government policies and priorities, and are from the start, embedded within the NHM, without creating parallel human resources or M&E systems.

Table 3. State of scale-up of NIPI Phase II interventions.

Innovation	Scale-up
PSE. Strengthening of pre-service nursing and midwifery education (pilot started in Phase I)	It has been scaled up to non-NIPI districts in NIPI states. Also, in Jharkhand, Assam, Maharashtra, Tamil Nadu, Gujarat, West Bengal, Uttar Pradesh, Uttarakhand, Haryana and J&K technical support is being given to state government and selected nursing institutions for establishment of Nodal centres. At national level, technical assistance in development of national guidelines for country-wide scale-up has been provided. Advocacy on-going for initiation of competency based examinations across states in both public and private sector institutions.
PPIUCD. Post Partum Intrauterine Contraceptive Device Services (pilot started in Phase I)	PPIUCD services already scaled up in all states throughout India. More than 1.5 Million PPIUCD insertions have been carried out in the last 3 years throughout.
Dakshata (started in 2015)	It has been started in 15 non-NIPI districts in Odisha, 8 in Madhya Pradesh and 27 districts in Rajasthan. Also started in Jharkhand, Maharashtra, Andhra Pradesh. National Guidelines have been developed.
HBNC+. Home Based Newborn Care (started in 2013)	Has been scaled up to 10 High Priority Districts in Rajasthan,scale up is being planned statewide in all 50 districts in Madhya Pradesh and also planned statewide in Bihar for low-birth weight (LBW) babies. At national level, there is a proposal in advanced stage for scale up of the program to all LBW infants and SNCU discharged newborns, with other development partners also contributing to the advocacy work for this scale up. A sub-intervention, notably prophylactic ORS availability within households, has been scaled up nationwide.

SNCU+. Sick Newborn Care Unit (started in 2013)	MoHFW has revised HBNC guidelines of 2014 to include community visitation of discharged SNCU babies to help reduce mortality. Discussions on-going on whether it can be done by ASHAs or ANMs, and on incentives for ASHAs.
Family-Centred Care (FCC) and Paediatric Emergency Triage and Treatment (ETAT) (started in 2015)	Operational guidelines (Strengthening Paediatrics care services in District Hospitals) including both concepts were released in Oct 2015 and provisions for budgeting in the state Program Implementation plans have been made. NIPI new born project team has been requested to provide technical support for establishment of ETAT in 3 medical colleges of Odisha and regional centres in Bihar. Madhya Pradesh has accepted ETAT and FCC for all district hospital.
Swasthya Slate (started in 2014)	The Swasthya Slate system is being piloted in 5 district hospitals in NIPI states (outside Jammu and Kashmir), as part of ETAT. Other states have shown interest in the technology.

Goal 2. Establishing a mechanism for sustainable institutional collaboration between Norwegian and Indian public and private institutions in women and children's health.

The results framework contemplated the establishment of at least five institutional collaborations by 2017. To date, two collaborations have been solidly established, and others are still under discussion. There is a feeling among concerned stakeholders that this goal has proven difficult, despite repeated efforts at bringing potentially interested partners together at different opportunities. This might be due to lack of grant opportunities to sustain the collaborative research projects when partnerships are formed, and possibly due to interest by Norwegian institutions being more restricted to more academic research with strong potential to being published in high–impact journals. In any case, the efforts towards this goal appear not to be systematic, and there doesn't seem to be as yet, a clear effective mechanism to ensure these collaborations and their sustainability.

Collaborations established so far include:

a) Oslo University Hospital together with FK Norway and JK Lone Hospital in Jaipur , which have established a nurse exchange programme and establishment of a human milk bank.

b) Artic University of Norway and the Institute of Trans Disciplinary Health Sciences and Technology (ITD-HST) in Bangalore.

Goal 3. Facilitation of dialogue on global health between Norway and India.

Compared to the rest of the results framework, the indicator for this goal is vague: "Dialogue on global health and linkages to NRHM priorities explored and activated" which complicates measuring effectiveness. A number of activities have been carried out related to this goal, notably:

- The participation of India's MoHFW, invited from Norway, in the "Innovation Countdown 2030 Reimagining Health Report", an initiative led by PATH and supported by a number of donors, including Norad.
- India participating as the host country of the "Global Call to Action Summit 2015: Ending preventable child and maternal deaths", where NIPI participated as

knowledge partner and donor. Out of 11 Indian interventions highlighted in the "innovations marketplace", 4 were NIPI interventions.

3.3.2 *Efficiency*

In general, efficiency is considered to be high in NIPI Phase II. The new NIPI governance structure was highly praised, allowing for strong decision making processes, close involvement with government, transparency and efficient implementation. The set up allows for a strong technical group (PAG) which includes the implementing partners, a governance and strategic direction group (JSC) with high level leadership allowing for strong endorsement of interventions, implementing partners as facilitators and states as implementers. There is an efficient process to discuss new potential interventions, whereby concept notes are developed and discussed with the RNE and Coordination Unit, before being taken up to the PAG for thorough discussion and vetting. The PAG in turn recommends it to the JSC if considered adequate. At state level, the SCC has become a strong review mechanism allowing for midpoint corrections and surmounting of obstacles encountered thanks to the state level leadership participating in them.

While the NIPI approach of programs working through the NHM at state level creates sustainability, it also sometimes negatively impacts efficiency when there are delays or shortcomings in the NHM. Two examples of this where:

- In some districts, the ETAT and PSE interventions have experienced delays due to limited human resources because of unfilled positions in district hospital paediatricians and nursing school faculty.
- Interruptions in the regular supply of commodities to ASHAs (supplies which are not funded by NIPI), were also reported in some districts, due to delays in disbursement of funds, bureaucratic procurement processes and/or supply chain management issues. Interruptions in payments to ASHAs were also reported.

In these scenarios, NIPIs power to solve the issues is limited to strict follow up of problems by programme officers at state and district level, and advocacy using NIPI's governance structures (SCC, JSC).

Financial management.

In general, the strong emphasis in M&E, and periodic standardized assessments have resulted in more realistic work-plans, timely achievement of objectives and better utilisation of funds by implementing partners. Implementation rate, as reflected in utilization of funds, was low in 2013 but picked up in 2014 to an average of 80%. Financial reports for 2015 were not yet available but interviewees were confident that use of funds would reach 90 to 100% of budgeted amounts. However, some important challenges and shortcomings were detected:

- Delays in implementation of NBP interventions in 2013, due to UNDP procedures for disbursements of funds[7]. Thus, in that year, most of the activities happened at national level (trainings, meetings, development of guidelines and materials), and the programmes fell behind on targets (utilization of funds was 11%, see Table 4). This was solved in 2014 and implementation of activities speeded up, with funds for 2013 being utilized in 2014.
- Overutilization of funds in the RBSK technical support programme, which in 2013 used 173% of budgeted funds.
- Administrative challenges due to the decision by the Embassy to change the admininstration of NBP from UNDP to a consultancy company from January 2016[8].
- Unexpected delays for PHFI ***Swasthya Slate*** when customs in Jammu and Kashmir determined ***Swasthya Slate*** equipment was taxable. Negotiations with government to obtain the necessary permits for tax-free equipment for public health, delayed the roll out by several months, although activities have picked up since.

Table 4. Utilization of funds per year, per implementing partner[9]

Partner	2013	2014
UNDP-NBP	11%	74%
UNDP-RBSK	173%	102%
UNDP-NIPI CU	67%	83%
Jhpiego	37%	72%
PHFI-Swasthya Slate	Not applicable	104%
PHFI- RMNCH+A	Not applicable	84%

Flexibility in use of funds. Several stakeholders commended the flexibility showed by the donor for the use of funds, and suggested this is particularly important in such innovative programs where not all challenges can be foreseen and there is much on-going learning and tweaking of interventions. It allows NIPI to react quickly to government requests, and to move funds from one area to another when progress is stalled in one of them. Deviations from original planning are discussed quickly and presented to JSC. However, this flexibility may also backfire, when specific programs use more resources without adequate communications and prior agreement (e.g. RBSK went significantly over budget in 2013).

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[7] Due to the categorization of NIPI funds at UNDP as direct investment funds, these could not be disbursed to states until activities had been completed, i.e. disbursements against results.

[8] In Phase I UNOPS acted as funding agent for both the NBP and the NIPI secretariat. UNOPS closed offices in India in 2012-2013, and an agreement with UNDP was signed. UNDP allowed continuity in the UN system. As problems arose over the years (poor oversight, delayed administrative support), it was decided to terminate the contract and as of 1 January 2016, both the NBP and the NIPI Coordination Unit are administered by a consultancy company.

[9] Based on data from financial reports included in JSC minutes

Financial management at state level. Budgeting is decentralized to state teams, and this is considered to be more efficient. For the NBP team, all funds go through the NHM at state level, and the state teams had differing views concerning this set up. Some found it to be an advantage, as it limited responsibility, while others felt this made them extremely dependent on the state government, and decreased efficiency, as all procurement has to go through NHM procedures. The review team did receive some complaints about delays in procurements due to NHM rules and regulations, but others commented that NHM had rapid disbursement of funds once expenditures were submitted.

Administrative management.

The donor-implementing partners relation was seen by both sides as being one of trust and open communication, and very different from relations with other donors. While there is periodic reporting and other normal accountability measures, there is also an on-going, informal, close communication. If things are not going according to plan, this is shared early, and thus can be managed more efficiently.

Implementing partners considered NIPI's reporting requirements as reasonable, although they acknowledged that it can become hectic at certain times of the year. Reports and work-plans are normally completed and sent in to the NIPI CU on time, where they are compiled and made available prior to meetings by PAG and JSC. Minutes are available for all meetings, and reviews of these showed that JSC, PAG and SCC meetings have mostly taken place in a timely fashion.

While all stakeholders interviewed showed appreciation for the open communication and coordination in NIPI, interviewees shared some suggestions for improvement, notably:

- To strengthen the NIPI Coordination Unit with further human resources.
- To strengthen communication regarding important changes that may affect staff, in particular with state NBP teams, concerning the change from UNDP to a new non-UN agency, as this has generated apprehension[10].
- To create more opportunities for state and district NIPI personnel to engage with national level stakeholders, both at the respective implementing partner, but also with NIPI Coordination Unit and the RNE. These interactions are seen as very beneficial and rewarding for team members, allowing for informal learning from more senior people, and sharing of grievances. On the other side, these opportunities would allow national stakeholders to have a clearer, first-hand account of issues from state and district level.

There were also suggestions on establishing a mechanism for training and professionalization of NIPI personnel. While it was shared that some ad-hoc opportunities do arise, there does not seem to be a standardized mechanism known by all through which to request these benefits. However, because NIPI is an initiative implemented by partner

[10] By mid-December 2015, when this review exercise took place, no information had as yet been shared with state and district level NBP staff on conditions of employment & contracts, when the change expected to happen at the start of January 2016.

organizations, training and professionalization of staff are areas pertaining to these organizations, and not the NIPI CU or the RNE. However, this finding suggest that training and capacity building opportunities (and/or communication on how to make use of these) at implementing partner agencies could be strengthened, perhaps by providing support to include this area in budgets and workplans. Training of staff could also be seen as important in the context of enhancing sustainability.

Quality of technical assistance by implementing partners.

The perception from the RNE and NIPI CU as well as from government officials is that the chosen implementing partners have a very strong technical and managerial staff, including leading experts in their field, highly recognized nationally/internationally. Also key has been their level of communication and acceptance by the government at national and state level. The New Born Project teams, which at state level are housed within the NHM, have developed strong communication and collaboration with the government. Jhpiego, as an organization, benefits from long experience working with the government, resulting in good communication and recognition by the government at national and state levels. PHFI has entered NIPI more recently and with a more technologically oriented intervention, and is working in Jammu & Kashmir, a state with limited experience working with other development partners, so communication challenges with government have arisen, but have been well managed. All implementing partners have maintained close communication with the RNE and NIPI CU, and fulfilled their reporting duties in a timely fashion.

Documentation of activities

There was wide consensus that there is scope for broader documentation of activities and publications. This was reinforced through the desk review, which revealed many guidelines and training manuals, as well as reviews and evaluations, but limited intervention-specific, in-depth documentation of successes and lessons learned, and limited use of data for academic publications[11].Concerning quantitative data, monitoring frameworks are ensuring good data collection, but there is limited use of this data for analysis and publications (including in academic journals). As for qualitative data, there is scope for more data collection and publication, in particular of success stories and case studies.

However, it is important to take into account that NIPI Phase II is only at its midpoint, and while some interventions have already produced results, others are still ongoing or have started recently.

Transparency.

Transparency was considered to be good, with stakeholders believing that the strict monitoring and reporting contributed to this. A few interviewees shared concerns about the lack of a clearly established whistle-blower mechanism available for NIPI stakeholders to share human resources grievances or suspicions of mismanagement. Because NIPI is a

[11] Some available documents include: a) A report documenting the success of PPFP/PPIUCD intervention, now taken up nationally, which is in revision rounds; b) a scientific article published in Plos One in 2014 about Yashoda intervention (http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0084145)

partnership and staff is hired directly by implementing partners, whistle-blower mechanisms available at the implementing partners' structures should be used. However, these concerns highlight a potential need for wider dissemination and communication on available whistleblower mechanisms and capacity building to improve these. While the open communications and trust in the donor may help to promote disclosures to the RNE or NIPI CU among NIPI stakeholders at national level, it is not clear that this confidence extends to stakeholders at state or district level.

Box 2. Examples of programmatic efficiency by NIPI interventions[12]

Lean training. The pre-existing training module for labour room nurses was purely theory-based and lasted 21 days. The training module being implemented under Dakshata lasts only 3 days, and is a highly standardized hands-on training centred around 19 key practices.

Point-of-care diagnostics. Preliminary analysis done by PHFI suggests that the implementation of Swasthya Slate technology has decreased the overall time it takes for a pregnant woman to undergo all antenatal care tests from 14 days to 40 minutes.

ORS prophylactic availability. Oral Rehydration Salts (ORS) are a highly efficient intervention to prevent dehydration by diarrhoea, but its use in India had been hovering stably at 60% for past years. In HBNC+ districts it has gone up to 80%, and the success is attributed to ASHAs promoting (and ASHA supervisors verifying) availability and knowledge of use of prophylactic ORS in all households.

3.4 Contribution to NHM at national and state level

Innovations contributed by NIPI can be seen as falling into two categories: testing the "what" and testing the "how". The first category refers to innovations in the forms of programmes or technologies, such as HBNC+ or ***Swasthya Slate***. While the second refers to testing new operationalizing approaches that look to improve quality of care, such as strengthening pre-service education or labour room practices.

It is clear from the review exercise that the main contributions of NIPI to the NHM as perceived by all stakeholders are as follows:

1. **Techno-managerial support.** There is a consensus on the importance of the technical support provided by NIPI partners at national and state level. Staff from the different implementing partners participating in NIPI projects has high credentials, experience and knowledge. They are seen as influential, contributing to and being recognized by government at national and state level. Their support and input is requested for various tasks, not always NIPI related (e.g. at state level, NBP staff, which sit inside NHM, have been invited to participate in Child Deaths Autopsy committee and are often solicited for review of documents or other technical inputs). Interestingly, many government stakeholders insisted that the (programmatic) funds provided by NIPI where not that critical for the NHM, but what was key was this technical support. This suggests that not all stakeholders clearly understand that the majority of NIPI funds to implementing partners go towards salaries of this highly regarded technical support staff.
2. **Testing and piloting of innovations with high potential for scalability,** NIPI is seen as a "catalytic and strategic" partner by government stakeholders. While they readily

[12] Sources: key informant interviews.

acknowledge that the funds provided by NIPI are minor in view of the size of funds allocated to the NHM, the way in which they are spent is very strategic, allowing the government to test models that can be replicated, when there are not many sources of funds for this type of experimentation. Moreover, NIPI's mechanism and governance structure helps guarantee that interventions tested will be in line with government priorities and policies, and that scalability is considered from the start. As one government stakeholder put it "contributions that come from NIPI are carefully looked into and very closely monitored, because we know they can add a lot of value". While some see the clearly defined mandate of NIPI as a limitation, the majority of stakeholders interviewed appreciated this focus on innovation.

3. **Interventions do not create parallel systems and thus are sustainable.** NIPI's interventions are mostly based on available human resources inside the state and national systems. Even monitoring and evaluation frameworks and tools are made sure to be compatible with the national HMIS. All this ensures sustainability of the interventions and the ability of other states to take them up if they show value.
4. Other contributions mentioned include bringing new born and maternal health into the agenda and contributing to national policy development through guidelines and manuals.

Perceptions on NIPI as a technical support partner and "brand"

In general, there was much praise for NIPI as a technical support partner, both at state and national level. Its contributions are highly appreciated, along with its flexibility, the degree of communication, and at state level, the willingness of NIPI team members to support and contribute to the NHM.

In terms of branding, the team observed that the term "NIPI" is very well known, from national to state and district level, and even by some ASHAs. This is interesting in view of the diversity of interventions falling under the NIPI banner. The recognition of NIPI was much more evident among interventions of the New Born Project team than among those under Jhpiego. Government stakeholders working in Newborn and Child health were more cognisant of the term NIPI (sometimes equating it to the NBP team) than stakeholders working in maternal health, where the name Jhpiego was invoked more often in connection with NIPI interventions such as pre-service nursing education or PPIUCD. This is probably related to the fact that the NBP team sits inside the NHM at state level and all its projects are supported by NIPI, whereas Jhpiego is an independent organization with programmes supported by other donors as well. In both cases, however, stakeholders comments reveal a sense of government ownership of the interventions. This is in line with the perception of some stakeholders at implementing partners that NIPI under-advertises its role, and is perceived as a "quieter" donor than other development agencies.

The document reviews showed that all manuals and guidelines with NIPI support have visible logos and acknowledgements. The review team's perception was, however, that there is no clear consensus inside NIPI as to the level of "branding" that NIPI wants and how to balance this out with government ownership. No clear strategy for "branding" was laid out in documentation reviewed.

Benefits and drawbacks of implementation mechanism at state level

The implementation mechanism at state level was seen as successful. The two SCC held per year were considered key in allowing for adequate planning, inclusion in budgets, reviewing and accountability. The also were important, because of the high state level leadership present, in de-blocking issues that were delaying progress. Communication is ensured by NIPI officers participating in monthly and quarterly NHM reviews. It is important to remember, however, that the review team visited only 2 states (Odisha and Madhya Pradesh), and thus perceptions in other states may differ.

Interestingly, while state stakeholders commented that the implementation mechanism allows the state to ensure alignment of NIPI interventions with its priorities, some stakeholders at national level worried that this mechanism could result in misalignment with national priorities, or duplication of efforts on what is being tested in other states. It is not clear to the review team, however, how such a situation could arise in view of the PAG and JSC governance structures also in place.

3.5 Cooperation and Sustainability

3.5.1 Cooperation between NIPI, the MoHFW and implementing partners

The NIPI model of cooperation, with a JSC, SCC and a PAG, was highly praised by all partners. One stakeholder commented, "I have yet to see a better partner mechanism".

At national level, NIPI works well with the Ministry thanks to its governance structures, its good communication, familiarity with the programmes and high technical capacity. A few isolated concerns where shared with the review team by national level stakeholders regarding instances were there was a perception of limited sharing of information & communication from the RNE. However, the solid underlying relations allow these issues to be directly discussed among the parties involved.

At state level, the cooperation with the NHM is done through two different models, one where the implementing partner teams are housed within the NHM (e.g. NBP) and another where they are housed independently within their own organizations (Jhpiego)[13]. As it can be seen in table 5, both models have advantages and disadvantages. These different models of NIPI cooperation seem both to work well and were appreciated by governments at state level.

Table 5. Models of cooperation with NHM at state level

Models at state level	Model 1. Team housed inside NHM - New Born Project	Model 2. Team sits in own offices –Jhpiego
Advantages	Allows teams to personally ensure the moving of files through government processes. Creates more contacts and networks. The very close cooperation creates the feeling that the team is "part of NHM".	More independence and does not require to go through government's bureaucratic processes.

[13] Because the team did not visit the state of Jammu and Kashmir, where PHFI operates its intervention, PHFI was not included in this analysis.

Potential disadvantages	Team members requested more frequently for non-NIPI project support and advise (e.g. financial and programmatic, in new-born health, but also in immunisation and nutrition). Some teams mentioned difficulty coping with these expectations. Having to deal with the government bureaucratic procedures for even small procurement needs.	More difficulty in ensuring files are being processed in a timely manner inside NHM, and de-blocking or preventing bottlenecks. Missed opportunities for informal techno-managerial capacity building to NHM staff (?).
How teams have coped with potential disadvantages	Teams have used requests for support as opportunities for informal capacity building and providing techno-managerial support.	Teams have developed strong collaborations with government officials and maintain very close communication.

In terms of **cooperation among implementing partners**, many regretted this as an area of missed opportunities, as there is no formal mechanism, beyond the PAG and SCCs, for discussion of common issues, brainstorming and fostering collaborations. Considering the level of expertise and knowledge among implementing partners, such a mechanism could provide a breeding ground for innovations, convergences and creative problem-solving.

3.5.2 Sustainability

Analysis of documents reviewed and interviews suggest that sustainability is embedded in NIPI's way of functioning, as follows:

- Interventions are chosen hand in hand with the government and are thus aligned with government priorities and policy planning, which is a strong departure point for innovations that work to be taken and scaled up by the government.
- Interventions seek to use available human resources and avoid creating parallel systems, i.e. they based for the most part on improvements (trainings, facilitations, rearrangements, inventive repackaging) of what exists already.
- NIPI's structure (JSC, SCC, PAG) facilitates the advocacy of interventions that are shown to add value.
- The majority of interventions proposed are low-cost in terms of initial investments and supplies; although some do require buying of specialized equipment (e.g. ***Swasthya Slate***), or renovation of infrastructures (e.g. ETAT, PSE).
- NIPI's programmatic approach and cooperation with the government has positive side-effect of capacity building of techno-managerial skills in government staff and health care workers at state and district level (i.e. beyond the explicit trainings that are taking place for health care workers).

However, one main concern for sustainability of NIPI interventions if NIPI funding is not continued after phase II, is the clear need for the techno-managerial support provided by implementing partners. Techno-managerial support was seen as a main contribution of NIPI to the NHM, and many stakeholders estimated that this type of "hand-holding" is needed for another 10-15 years. While it is true that NIPI funds represent a very small fraction of total funds allocated to the NHM, they provide a crucial source of money to hire high-level techno-managerial experts and programmatic staff to provide capacity building, move

programmes forward and ensure adequate monitoring and evaluation. In total, implementing partners used NIPI funds to employ 182 people in 2015, many of them experts in a particular field. Due to government rules and regulations, it would be difficult to retain these technical experts without this funding.

Sustainability of the innovative process. In an altogether different sense, sustainability can be analysed as the sustainability of the innovative process per se. The review team's perception was this type of sustainability can already be observed in NIPI in Phase II, as a number of NIPI innovations have given rise to new ones, based on observed gaps that remain (e.g. SNCU to SNCU+). There has also been an evolution from training of health staff to training of trainers (e.g. SNCU TTC, training of faculty in PSE); and an evolution from survival interventions to improving quality of care.

3.6 Future directions

While showing great advances in maternal and child health in the past years, projections suggest that India nevertheless will have not achieved the MDG targets for goals 4 and 5 by the end of 2015[14]. The SDGs maintain the focus on these two MDGs and propose ambitious targets of reducing, by 2030, the global maternal mortality ratio to less than 70 per 100,000 live births (SDG 3.1), neonatal mortality to 12 per 1,000 live births and under-5 mortality to 25 per 1,000 live births (SDG 3.2). This highlights the need for increased efforts on maternal and child health in the country in order to improve on gains made.

There is a clear consensus among stakeholders of a need for continued support to NIPI interventions, beyond 2017, if sustainability is to be assured. One interviewee aptly used a rocket analogy to describe the process, where Phase I and Phase II have launched the rocket, but it is not yet in orbit, implying that if support ceases, momentum may be lost.

First, support is required for scaling up proven interventions[15], though this aspect can more easily be funded by other donors, but more crucially, to continue testing new interventions, as there is a dearth of funding in this area. Innovations will always be required, and stakeholders consider that India has no institutionalized mechanisms to design and pilot test innovations. This innovation testing was considered important not only for India, but also for the role that India can play in global health, as when we consider its child population, the scalability potential and impact of successful interventions can be huge.

Box 3. Ownership of Patents

While the majority of the innovations piloted under NIPI are not patentable, the work with PHFI and ***Swasthya Slate*** shows that as NIPI evolves, new interventions may be candidates for patents.

It may therefore be important to discuss what the rules should be regarding ownership and benefit rights to innovations that have been largely funded with NIPI resources so that this does not become an issue later on.

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[14] UN India. India and the MDGs, February 2015.

[15] Two references were made to interventions that "failed" at scale up possibly due to early termination of technical support and advocacy from NIPI: Yashodas and National Child Health Resource Center.Although other stakeholders suggested that discussions for scale up or continuation are still ongoing.

Secondly, techno-managerial support is needed. India has an imbalance between the financial resources that it can mobilize domestically, and the techno-managerial resources available to the government (which is not due to a dearth of techno-managerial domestic experts but to government rules and regulations pertaining to hiring practices and salaries). This is the other facet where NIPI support has been key. The group of techno-managerial experts that NIPI has brought together over these 10 years have filled this gap.

Areas where support could be continued

There was no shortage of ideas among stakeholders on which areas should a potential NIPI Phase III focus on. Some of the more frequently raised possibilities were as follows:

- *Geographically:* no consensus on whether the focused approach on limited number of states and districts should be continued or not. Some believe it is a good approach, others encouraged expanding geographical scope. However, many stakeholders agreed that if the scope continued to be limited to a few districts, the choice of districts should be revised, as it was made almost 10 years ago and many of these districts are not high-priority for IMR and MMR anymore.
- *Vulnerable groups*: some vulnerable groups that stakeholders suggested could have priority focus included adolescents and orphans.
- *Health System Strengthening*: focus on improving quality of care, not just in public, but also private institutions, and maintain a focus on interventions that facilitate a continuum of care approach.
- *Technology*: continue testing technological innovations with a potential to improve efficiency of health systems.
- *Urban health*: adapt and test innovations originally conceived for rural areas to growing urban areas and health systems.

Funding sources post 2017 and exit strategies

The review team held specific discussions with RNE and Norad, as well as a group discussion with implementing partners in order to address this point in greater depth.

Norwegian development aid policies have shifted considerably, and today the emphasis is to channel funds through global funding mechanisms (e.g. GAVI, the Global Fund to Combat HIV, TB and Malaria, etc), and away from bilateral funding programs such as NIPI. This limits the possibility of a continuation of NIPI post 2017 (a NIPI Phase III) under the current funding and approach. It is also considered unlikely that global mechanisms such as GAVI or the Global Fund would finance innovations of the type set forth by NIPI.

In light of this, potential alternatives to NIPI funding and organizational approach post-2017 were discussed. The following non-mutually exclusive suggestions emerged:

1. **Global Financial Facility in Support of Every Woman Every Child (GFF)[16].** This brand new global financing mechanism, announced in September 2014 and launched

[16] http://www.globalfinancingfacility.org/

in mid-2015, aims to accelerate efforts to end preventable maternal, new-born, child and adolescent deaths and improve the health and quality of life of these groups. It is conceived as ***smart*** (i.e. evidence-based, high-impact interventions), ***scaled*** and ***sustainable*** financing that will combine domestic, international, public and private funding sources. It is focused on high-burden countries and India has been selected for the second round of financing. The Government of Norway, among other donors, has pledged funds to the GFF and thus participates in its governing body. The national government of the GFF recipient country leads the application process and the in-country initiative once funds have been disbursed. The process for India has just been started so there is time for advocacy and consultation with the Government of India to ensure that a part of these funds is secured for innovation testing. NIPI stakeholders are in a very strong position to lead this advocacy.

2. **Saving Lives at Birth. A Grand Challenge for Development.** These grants stem from a combined funding from USAID, the Government of Norway, the Bill and Melinda Gates Foundation, Grand Challenges Canada, DFID, and KOICA. They seek "innovative ideas that can leapfrog conventional approaches in three main domains: (1) technology; (2) service delivery; and (3) demand side innovation that empowers pregnant women and their families"[17]. It was suggested, however, that this source of funding privileges academic efforts over implementation innovations of the type championed by NIPI. It is nevertheless worthwhile exploring in further depth.

3. **Technical Support Unit for Innovation (TSU).** Envisioned as a think tank or hub for identifying, testing and piloting of innovations, operational research, M&E, and similar areas, it could house many of the technical experts currently engaged in NIPI interventions and harness their knowledge and experience. It could act as the source of the much-needed techno-managerial support for the government on maternal and child health innovations, continuing the line of work started in NIPI. Models for such a TSU already exist in India (e.g. TSU for immunization, supported by the Gates Foundation[18]). Funding could be obtained either through the GFF, other donors or perhaps directly through the government of India. It would be important to ensure that a similar governance structures to the current existing one in NIPI is set up (i.e. with government, donor and implementing partner stakeholders), as this is key in ensuring relevant, scalable and sustainable contributions.

4. **Joint Working Group on Health.** Norway and India maintain bilateral ties through Joint Commission Meetings, which focus on political, commercial and other issues. Working groups are established in specific areas such as hydrocarbons, environment, maritime, higher education, science and technology etc; and they meet regularly. Innovation Norway[19] and RNE have started exploring setting up a Joint Working Group on Health, that would include public and private company initiatives. The

[17] https://savinglivesatbirth.net/apply

[18] https://www.itsu.org.in/

[19] Innovation Norway is "the Norwegian Government's most important instrument for innovation and development of Norwegian enterprises and industry". http://www.innovasjonnorge.no/en/start-page/

possibility of a transition from development aid to private –commercial- funding for NIPI through such an initiative is another avenue that could be explored.

5. **Continued, though greatly decreased funding from Norway.** This possibility, perhaps combined with funding from the Government of India, was also discussed. Despite the evident shift in Norwegian development aid to global funding mechanism, it is not clear if a small amount of bilateral support for a longer phase out of NIPI can be envisaged or not. It was agreed that this possibility should also be explored.

Exit strategies to implement in the remaining two years of Phase II were also discussed, as they are considered key for a successful phase out and eventual planning of a Phase III (under a potentially different approach and funding strategy):

- Set up a work group composed of NIPI stakeholders meeting regularly under a clear agenda, to ensure strategies for phase out and post 2017 funding described above are being systematically explored and followed up.
- Capitalize on the two remaining years of funding in Phase II for a concerted effort on i) analysing and publishing already available (mostly quantitative) data, ii) strengthening qualitative data collection to complement documentation of activities and derive lessons learned and iii) disseminate this information and use it in advocacy efforts for a post 2017 strategy[20]. Take advantage of the capacity already available among implementing partners, and ensure adequate external support for scientific writing and methodological rigour.
- Start discussions with MoHFW on GFF to understand how will the process be managed and thus how can NIPI stakeholders advocate for funds destined to innovations in operational research.
- Maintain strong advocacy to Government of India, Government of Norway and global financing mechanism to press for adequate funding of implementation innovations.

3.7 Cross cutting focus: Gender, Environment and anti-corruption

In general terms, the perception of the review team is that while there are very good examples of how these issues are being addressed by NIPI interventions, there is scope for better, more systematic incorporation of these dimensions into programmatic design, implementation and M&E.

Gender

The Programme Document for Phase II establishes that "NIPI will strive towards taking gender dimensions in everything that will be funded, and thus identify gender issues, examine implications and carry out proper analysis, assessments and evaluations wherever appropriate". It also recognizes that gender responsive strategies need to be state specific, due to different socio-cultural and policy scenarios.

[20] It was agreed that a half-day working session with NIPI stakeholders would be set up in early 2016 to define the research and dissemination agenda for the next two years, and formalize quarterly meetings to push this agenda forward.

The great majority of beneficiaries of the NIPI interventions are women (pregnant women, mothers, ASHAs, ANM and nursing students), and some believe that this alone shows a gender focus, while others understand that more needs to be done.

Some focus on gender-sensitive programming and analysis was observed, such as data-disaggregation by sex, training on gender-issues in health, insistence on a balanced gender ratio in hiring practices. Many programmes have women empowerment components, for example, HBNC empowers ASHAs with training and incentives, and mothers through them; while ***Swasthya Slate*** empowers ANMs through technology. FCC empowers mothers in their caring of their babies, while PPIUCD and Dakshata have a strong emphasis on sexual and reproductive rights of women, emphasizing a client-centred approach (privacy, confidentiality, informed consent, counselling of family).

However, the level of gender focus required by the Programme Document was not observed in either documents, interviews or field visits. The general observations of the review team are as follows:

a. There is a misunderstanding as to what gender-sensitive strategies mean, with a perception by some stakeholders that this means a focus on women exclusively, instead of an analysis of the impact of policies and programmes on women and men, girls and boys, in particular socio-cultural settings, and how these can be designed in order to ensure equal enjoyment of opportunities, resources and rights[21].

b. There is limited knowledge on how gender-mainstreaming can be approached in programme design and implementation. Gender-focus does not figure prominently or systematically in concept notes, work-plans or monitoring and evaluation frameworks.

c. While participatory-approaches are being carried out, and ASHAs, mothers and other beneficiaries are asked for feedback on programmes, it is not clear that these participatory approaches have systematically included focus groups with different community members (e.g. fathers, teenage girls and boys, children), health personnel (e.g. male and female doctors and nurses), students or faculty.

d. While data-disaggregation by sex is being carried out, this information is not being systematically used for analysis, or to feedback into programmes to correct gender inequities.

Finally, while there is insistence by NIPI on gender-balanced hiring practices, women represent only a third of employees hired by implementing partners for NIPI programmes (see Table 4). Stakeholders commented on the sociocultural challenges that surround recruitment of female staff, particularly for field positions. The percentage of female staff in NIPI is in line with the general representation of women in the labour force in India[22].

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[21] Based on the definition in the IASC Gender Handbook, 2006.

[22] 29% in 2013, World Bank data.

Table 4. Percentage of female employees in NIPI teams

NBP	Jhpiego	PHFI	Total
22.9% (8/35)	33.3% (28/84)	28.6% (18/63)	29.7% (54/182)

Environment

The Programme Document of Phase II is not specific as to how the Environment dimension is to be taken into account, beyond pointing out to the bidirectional linkages between health and environment and how health interventions can impact the latter. However, interviewees were quite clear on how some of the interventions are addressing areas were environment and health touch:

- *Biomedical waste disposal*. NIPI trainings, especially at facility level, include a component in adequate biomedical waste disposal practices.
- *Infection control*. Prevention of nosocomial infections by infection control practices is linked to environmental issues of adequate waste disposal, physical separations in wards and smart designs to facilitate hand-washing, adequate use of personal protective equipment and other practices, as well as behavioural changes[23]. Many of these have been considered in facility-based interventions and trainings, such as SNCUs, FCC, ETAT, Dakshata and PSE.
- *Use of technology to decrease paper waste*. While ***Swasthya Slate*** technology virtually abolishes paper records by ensuring digital data capture from the start, other interventions have also reduced paper waste with online M&E systems, and use of mobile phones to photograph and send ASHAs paper-based records.
- *Environmental compliance and certifications*. ***Swasthya Slate*** has made its device ROHS[24] compliant, which certifies that levels of 6 restricted materials (lead, mercury. Cadmium, chromium, PBB; PBDE and phthalates) that are hazardous to the environment, pollute landfills and are dangerous in terms of occupational exposure during manufacturing and recycling, are absent or present in quantities below pre-defined values. The Swasthya Slate team is also looking into environmentally friendly technological waste disposal options.

The review team's analysis is that there is a broader scope for building on these examples, and ensuring a more systematic inclusion of an environment dimension in program design and implementation. The input of experts in these fields would be key in such an undertaking.

Anti- corruption

The cross-cutting focus on anti-corruption is not included in the Programme Document for Phase II. Discussion of this dimension with stakeholders, however, highlighted areas where

[23] Direct observation during field visits, however, suggested that there is room for improvement in infection control practices, many of which would not require substantial investments.

[24] Restriction of Hazardous Substances, European Union Directive 2002/95/EC

NIPI interventions maybe helping to increase transparency, anti-corruption and good governance practices, although there are no specific indicators –or even qualitative evaluations being considered –to measure this. Examples mentioned include:

- The strict focus on monitoring and reporting, and the use of objective indicators and standards in programmes.
- The switch towards online systems (e.g. ***Swasthya Slate***, where data can be traced back even down to the individual who entered the information; development of an online admission process to nursing schools as part of PSE, which may discourage inadequate registration practices).
- The use of checklists and standardized data collection forms (e.g. in labour rooms, where it could discourage unrequired C-sections)
- Empowering of community health personnel and beneficiaries on health rights (e.g. ASHAs and mothers on sexual and reproductive health and rights)

4 Conclusions and Recommendations

This section presents conclusions for each of the tasks set out in the Terms of Reference, followed by related recommendations. Recommendations for related tasks have been grouped together to avoid repetition.

Effectiveness

- There has been good follow up on recommendations made in the final evaluation of Phase I, and this has had a positive impact on effectiveness in Phase II.
  - The governance structures in Phase II have been highly effective.
  - M&E frameworks and strict data collection and reporting requirements have greatly facilitated measurement of progress.
  - While a structured approach for the selection of interventions has not been established, the choice of interventions appears organic in nature; interventions are in line with government priorities, and address clear gaps. There is also a structured and participatory approach in the discussion and approval of proposed interventions.
- The majority of the interventions show good progress despite a relatively slow start in 2013. Output targets for trainings and assessments have mostly been achieved yearly. More downstream targets, such as % children visited by ASHAs or ANMs, standards of care in nursing schools or pregnant women receiving ANC by ***Swasthya Slate***, as can be expected, have shown somewhat slower progress, yet with most targets in line for 2017.
- The state of scale up of interventions is overall impressive, with almost all interventions being considered for scale up by government, or already scaled up to some degree.
- Some interventions originally encountered in the Programme Document for Phase II have been dropped, and new ones have been started. However, there has not been an updating of the Programme Document to reflect this.
- A number of unintended positive consequences, based on empirical observations where shared. These concern mainly indirect skills strengthening and convergence of interventions. There are no mechanisms in place to measure this (either quantitative of qualitative in nature).
- Goal 2 of establishing institutional collaborations between India and Norway, and Goal 3 of facilitation dialogue on Global Health between the two countries have had some progress, but targets are vaguer for these goals so it is harder to measure effectiveness.

Effectiveness- Recommendations

- ➢ Ensure that close follow up is given in PAG, JSC and SCC to all interventions in the remaining 2 years so that obstacles creating delays are addressed, and targets can be achieved by 2017.

- ➢ Establish a working group to set up a systematic mechanism to select interventions, ensuring participatory input and avoiding duplication of efforts across India. This mechanism could be particularly relevant in a post-2017 setting if a TSU for innovations is set up (see Future directions).
- ➢ Review and update the Programme Document for NIPI Phase II to better reflect current state of the initiative, and include clearer targets for goals 2 and 3, based on the 3 years of experience accumulated.

Efficiency

- Overall efficient implementation, helped by results framework and M&E emphasis resulting in more realistic planning and timely achievement of targets.
- Low implementation rates in 2013, but picked up to around 80% in 2014, and expected to be higher in 2015. The flexibility in the use of funds has been key, as funds can be transferred to an area with good progress, when there are delays in other areas.
- Persistent obstacles exists in some interventions due to delays by government in filling hospital or faculty positions, interruptions in incentives paid to ASHAs or in supplies of commodities.
- The use of UNDP as administrative manager for NBP and CU has not been efficient, and the transition to a new host was completed in January 2016. Communication on this transition process was perceieved as insufficient among state and district NBP personnel creating apprehension.
- Good administrative management overall, with timely and systematic reporting based on results framework, regular meetings by governance bodies and continuous informal communication enhancing efficiency, as problems are shared early on.
- Perceptions among state and district personnel of missed opportunities for discussions and informal learning from national-level stakeholders and limited opportunities for formal training and professionalization.
- The quality of technical assistance by implementing partners is high, with partners having strong links and communications with government.
- Use of available data for scientific publications has been limited and there is scope for additional documentation of activities and lessons learned, particularly success stories and case studies.
- Good transparency in use of funds, but limited knowledge among state and district level stakeholders of whistle-blower mechanisms available to them.

Efficiency-Recommendations

- ➢ Strengthen communication mechanisms among NIPI stakeholders and inside implementing partners' structures to ensure adequate dissemination of information down to state and district level personnel, particularly in transition situations.
- ➢ Strengthen opportunities for NIPI state and district staff for informal learning from national level stakeholders (e.g. workshops or one-on-one mentoring during field visits).

- Reinforce and disseminate opportunities for training and professionalization of NIPI personnel available inside implementing partners' structures, perhaps by including this area specifically in budgets and workplans.
- Strengthen documentation of activities and lessons learned, in particular scientific publications using available data and further qualitative data collection (e.g. for success stories and case studies). This can be done by establishing a small working group of NIPI stakeholders, supported by specialist(s) in methodology and scientific writing.
- Reinforce communication and dissemination on whistle-blowing mechanism available inside implementing partners' structures, and provide capacity building to implementing partners in this area, if required.

Contribution to NHM

- Innovations contributed by NIPI can be seen as falling into two categories: testing the "what" (programmatic and technological innovations) and testing the "how" (new operationalizing approaches to improve quality of care).
- By far the most important contributions to the NHM are i) the techno-managerial support given by implementing partners and ii) the testing and piloting of innovations with a great potential for scalability, as they do not create parallel systems.
- Clear recognition of the NIPI "brand" in NBP interventions, less so for Jhpiego interventions. However, all interventions have good level of ownership by government. No clear consensus inside NIPI of what is the adequate balance for NIPI branding.

Cooperation and Sustainability

- The model of cooperation, embedded in the governance bodies of NIPI is highly praised and successful in ensuring alignment of interventions with government priorities and building in scalability.
- There are two models for state-level cooperation, with teams housed inside the NHM (NBP), or independent (Jhpiego). Both have worked well and achieved strong cooperation with the government.
- The communication created between MoHFW and NIPI allows for internal disscusions on disagreements and concerns among the stakeholders.
- Good rapport among implementing partners but opportunities for discussion and collaboration have mostly been limited to PAG and SSC, which, considering the expertise level among implementing partners' staff, could signify missed opportunities for creative problem solving.
- A good level of sustainability and government ownership of interventions has been created so far. This has been based on a) working hand-in-hand with the government and ensuring alignment of interventions with government priorities; b) use of available human resources and abstaining from creating parallel systems and c) close techno-managerial support.

- NIPI has reached a point where there seems to be a sustainability of the innovative process per se, in terms of generating new creative solutions to detected gaps.
- The government has adequate funding for programmes, but has continued needs for techno-managerial support.
- NIPI is currently funding over 180 staff through its implementing partners, many of which are recognized experts in their fields, who are providing this key techno-managerial support.
- Currently, there is no mechanism in place for either a phase out or a post 2017 solution to maintain and build on the gains made by NIPI in the past 10 years. Such a solution would need to: a) continue techno-managerial support to the government, b) test and pilot innovations, c) support scale up of successful intervention, and d) retain the knowledge and expertise accumulated in NIPI stakeholders.

<u>Cooperation & Sustainability- Recommendations</u>

➢ Establish a mechanism and an agenda for regular meetings among implementing partners to foster creative problem solving and establish working groups on: a) strengthening sustainability, b) researching future directions (see below), c) publications and further documentation of activities (see Efficiency).

Future directions

- There is a need for continued support for innovations in maternal and child health, in order to ensure continued reductions in maternal, neonatal and child mortality and attain the related SDGs by 2030.
- Support and funding is required for scaling up interventions and, crucially, for testing and piloting innovations, particular implementation mechanisms and operational research, as there are very few financing mechanisms for this.
- Norwegian development aid policies have shifted towards global funding mechanisms and away from bilateral funding programs such as NIPI, thus potential funding for NIPI Phase III is not assured.
- GFF and "Saving Lives at Birth" are global financing mechanisms in maternal and child health that may prove adequate for funding of innovations.
- A Technical Support Unit for Innovation could be envisaged as a think tank for identifying, testing and piloting innovations (i.e. programmatic approaches), as well as operational research, M&E and other areas, and may provide a way of bringing together the technical experts that are now part of NIPI. It should maintain similar structures to those from NIPI, i.e. including government, implementing partners and donor, and working through the NHM at state level.

<u>Future direction Recommendations</u>

➢ Establish a working group to discuss and research possibilities for a) a phase out strategy and increased sustainability, b) post-2017 financing for implementation innovations in maternal and child health, c) an organization approach (such as a TSU) to foster these innovations which builds on lessons learned from NIPI.

- Use the remaining 2 years of NIPI funding for aggressive publication of available data, further qualitative documentation of activities and lessons learned, and advocacy to Government of India, Government of Norway and global development donors to maintain adequate funding for innovative interventions post 2017.

Cross-cutting focus on gender, environment and anti-corruption

- There are good examples on how these dimensions are being addressed in NIPI, but limited systematic incorporation of them in intervention design, implementation and M&E. The anti-corruption dimension is not included in the Programme Document, and guidelines or targets for the environment dimension are also lacking.
- There is limited knowledge on gender-analysis and gender mainstreaming, with misunderstandings on what gender-sensitive strategies mean and how they can be achieved. Sex- disaggregated data from programmes is not being systematically analysed and fed-back into the programme in order to target gender inequalities.
- There percentage of female staff supported by NIPI through implementing partners is around 30%, so there is still opportunity for improvement in gender-balance, although the socio-cultural challenges involved must be taken into consideration.
- Areas of linkages between environment and health in NIPI interventions include biomedical waste disposal, infection control, use of technology to decrease paper waste and ensuring compliance with environmental standards for development of equipment funded by NIPI. Input from environment and infection-control experts could help strengthen efforts being done in these areas.
- NIPI interventions could be helping decrease corruption and increase transparency due to better monitoring and reporting, switch to online systems, use of standardized data collection forms and checklists, and empowerment of grassroots workers. There are no mechanisms in place to measure these effects.

Cross cutting issues –Recommendations

- Ensure these cross-cutting dimensions are adequately addressed, with indicators and guidelines, in the updated Programme Document. Require implementing partners to follow these guidelines in workplans and M&E frameworks, ensuring collection of adequate data to measure effects, analysis of data and feedback into programmes.
- Bring in experts on gender analysis and mainstreaming, environment and good governance, to ensure these areas are adequate covered in programme design, implementation and M&E and to provide capacity building.

Annex A. Terms of Reference

MID-TERM REVIEW OF NORWAY INDIA PARTNERSHIP INITIATIVE PHASE II - REFERENCE NUMBER: IND 3053.

1. GENERAL INFORMATION

The Norwegian Embassy in New Delhi, hereafter termed the contracting authority, is inviting participation in a competition for a contract to provide consultancy services in connection with a mid- term review of Norway India Partnership Initiative (NIPI). If the Contracting Authority so wishes, negotiations may be opened.

2. ABOUT THE CONTRACTING AUTHORITY

The work of the Royal Norwegian Embassy in New Delhi is guided by the inclusive Norway-India Strategy launched by the Norwegian Government in 2009. The cooperation within health started in 2006 as part of the Millennium Development Goal no. 4 to reduce child mortality. More information about the Norwegian Embassy's work in India can be found at www.norwayemb.org.in Information about the health initiative can be found at www.nipi.org.in.

2.1 Contact person at the contracting authority

Any queries relating to this invitation to tender may be addressed to the contracting authority's contact person: Dr Ashfaq Bhat, at e-mail address emb.newdelhi@mfa.no.

3. ABOUT THE PROCUREMENT

3.1 Object

Background

The Governments of Norway and India agreed in 2006 to collaborate towards achieving MDG 4 to reduce child mortality based on commitments made by the two Prime Ministers. The Norway India Partnership Initiative (NIPI) was based on India's new ambitious health initiative, the National Rural Health Mission (NRHM), and aimed at facilitating rapid scale-up of quality child health services in four high focus states: Bihar, Odisha, Madhya Pradesh and Rajasthan.

The evaluation of the first five years found that NIPI Phase I (2008-12) had largely achieved its objectives of providing strategic, catalytic and innovative support to the NRHM. NIPI has helped bring forward the newborn health agenda both at state and national level. There has been good experiences with regard to the sustainability and scalability of several NIPI interventions, with some being adopted across the country with government funds.

An extension of the initiative to 2017 was formalised with the signing of a Memorandum of Understanding (MoU) in January 2013. NIPI in Phase II continues to focus on maternal and newborn health, especially the continuum of care from home to facility, and capacity building of health personnel in the same states. NIPI has also become the lead development

partner for the Government's Reproductive, Maternal, Newborn, Child Health and Adolescents (RMNCH+A) Strategy in the state of Jammu and Kashmir.

Goals of NIPI phase II

The partnership in focuses on three main goals in Phase II:

1. Improving and scaling up quality continuum of care interventions at community and facility level in NIPI and selected non-NIPI districts.
2. Establishing a mechanism for sustainable institutional collaboration between Norwegian and Indian public and private institutions in areas related to women's and children's health
3. Facilitation of dialogue on global health between Norway and India

NIPI Implementing partners

As Norway does not have a bilateral agreement with India, NIPI is working with three implementing partners: Jhpiego, Public Health Foundation of India (PHFI) and UNDP Newborn Project as the main partners contributing to goal 1. For goal 2, partners are being identified as the initiative is evolving.

While UNDP Newborn Project focusses on the care for newborns and child health, Jhpiego works on strengthening of pre-service nursing education, labour room strengthening and post-partum family planning. Most activities take place in 13 districts in Bihar, Rajasthan, Odisha and Madhya Pradesh, whereas the support to nursing education is pan-state in the four states. PHFI supports the implementation of the national RMNCH+A Strategy activities and pilots a new health technology "***Swasthya Slate***" in six districts of the state of Jammu and Kashmir.

As per the NIPI Project Document 2013-17, UNDP Newborn Project was initially assigned to replicate the activities of Phase I in one district each in the states of Assam, Chhattisgarh and Jharkhand. However, keeping in view the feedback of the states, the governing board of NIPI, the Joint Steering Committee (JSC), decided to discontinue these activities in 2014.

Agreements have been entered by the Government of Norway through the Royal Norwegian Embassy with UNDP, Jhpiego and PHFI for carrying out the interventions under NIPI. Each of the partners has an MoU with the Ministry of Health and Family Welfare (MoHFW) at the national level as well as the Departments of Health and Family Welfare at the state level.

The object of the procurement is to conduct a mid-term review of the Project in line with the needs and scope described in points 3.2 and 3.3 below.

3.2 Description of needs

This is a one-time assignment that involves, but is not necessarily limited to, review of key documents, other documentation developed by the MoHFW and various health partners in India, interviews, and site visits as appropriate to verify findings and conclusions.

The Team Leader is charged with making best use of the Review Team's time and budget to deliver a report complying with assignment requirements specified in this document.

Documents that define NIPI Phase II comprise, amongst others:

- MoU between the Royal Norwegian Embassy in New Delhi and the Indian Ministry of Health and Family Welfare
- Norway-India Partnership Initiative Phase II Programme Document
- Terms of References for (1) NIPI Joint Steering Committee (JSC), (2) NIPI Programme Advisory Group (PAG), (3) NIPI State Coordination Committee and (4) NIPI Coordination Unit
- Process evaluation of NIPI Phase I
- Baseline of impact evaluation of NIPI Phase II
- Agreements between the Royal Norwegian Embassy in New Delhi and (1) UNDP, (2) PHFI, and (3) Jhpiego

3.3 Scope:

1. Review the effectiveness and efficiency of NIPI Phase II from January 2013 till date in relation to the goal hierarchy and inputs. This includes review of the three implementation partners' quality of technical assistance, documentation of activities and financial and administrative management.
2. Assess NIPI's contribution to the National Health Mission at national and state level including
   a. How is NIPI perceived as a technical support partner and "brand"?
   b. What are the benefits of NIPI's implementation mechanism at state level?
3. Assess degree of cooperation with the Ministry of Health and Family Welfare and other partners including level of sustainability created thus far.
4. Recommend possible future direction and support for maternal and child health in India by the Government of Norway beyond 2017.

The review shall in addition focus on:

- Agreement partners' focus on cross-cutting issues including gender equality, environment and anti-corruption and possible effects.

3.4 Reports:

Three English-language, user-friendly reports shall be delivered to the contracting authority in electronic form as part of the assignment

1. Inception Note – max 5 pages, due prior to commencement of field work in India.
2. Draft MTR Report – max 30 pages, due one week after finishing field work in India
3. Final MTR Report – max 30 pages, excl. executive summary and annexes, due one week after receipt of comments from the contracting authority

1. Inception Note

This note of maximum 5 pages shall indicate general methodology and approach being followed, and a time schedule. This note shall be submitted by e-mail by the Team Leader to the contracting authority.

2. Draft MTR Report

This report of maximum 30 pages shall outline methodology, key findings, onclusions and recommendations. To take advantage of proximity to information sources, it is

expected that substantial report-writing shall take place in India prior to departure of international team members.

This report shall be submitted electronically by the Team Leader to the contracting authority. The contracting authority will circulate the report to key stakeholders for feedback related to (1) correction of factual errors and/or incomplete information presented in the report, and (2) comments/-reactions to Review Team findings, conclusions and recommendations. A deadline of 7 working days will be set for feedback, which should be sent directly to the Review Team Leader, with copies to the contracting authority.

3. Final MTR Report

Based on the comments to the draft report, the Team shall finalise the report. The report shall be of maximum 30 pages and include an Executive Summary and relevant annexes (not included in the 30 pages). The list of respondents and any pictures shall be part of the annexures.

The final report can be released publicly upon request to the contracting authority, so protection of individuals shall be taken into consideration in writing of the report.

Intended Users and Use of Report

The report from the MTR shall be directed to three groups of users, as identified in the table below, and written in a manner that promotes use by each group according to respective requirements.

Main user group	Requirements
Group 1. NIPI Joint Steering Committee and NIPI Program Advisory Group	Decision-making for mid-course correction and enhanced catalytic effect, and recommendations for NIPI beyond 2017
Group 2. Royal Norwegian Embassy in New Delhi	Documentation of adherence to, and compliance with contractual obligations and reporting requirements with
Group 3. Implementing partners	Documentation of experiences and lessons learnt to date with recommendations

Meetings

The Review Team shall plan and request assistance from the contracting authority in arranging meetings and visits in accordance with the time schedule. The contracting authority shall be consulted beforehand for suggestions/ advice on useful organizations and persons to meet, though final decisions concerning disposition of Review Team time and prioritization of meetings, field visits, etc. shall remain the prerogative of the Team Leader.

Three meetings shall be considered mandatory for the Review Team to attend:

1. A meeting or telephone conference with the contracting authority to discuss the Inception Note and resolve any issues raised by the Review Team in its Inception Note.
2. A briefing meeting with the contracting authority in New Delhi upon arrival.
3. A debriefing meeting with key NIPI stakeholders in New Delhi prior to the departure of international Review Team members from India. The contracting authority will organise this meeting in consultation with the Team Leader. Electronic copies of any presentations made by the Review Team at that meeting, i.e. PowerPoint slides, handouts, summary documents, etc., shall be given to the contracting authority.

3.5 Schedule for the assignment / size of contract

The entire process including report writing should be completed within 25 working days. The MTR is planned for mid-November 2015 to end-January 2016. The final report should be submitted by 31 January 2016.

Team Composition

The review team shall comprise of a minimum of:

- Team Leader (Norwegian/international)
- Team members (Indian)

A Norad Senior Advisor may also take part in the review team.

The joint Review Team shall together possess the combined ranges of knowledge, skills and experience necessary to adequately address the four themes of the review.

Contract value is estimated at a maximum of NOK 240 000 ex VAT.

3.6 Contract

The following contract type will be used: Standard Government Agreement – Consultancy assignment agreement.

4. DEADLINES AND PROGRESS PLAN

The contracting authority has set up the following time frames for the procurement process:

Activity	Date
Dispatch of invitation to tender	18.09.15
Deadline for receipt of tenders	16.10.15 at 09.00 hrs (Indian time)
Period for evaluation of tenders*	16-23.10.15
Announcement of contract award	26.10.15
Contract signing	27.10.15

**Please be available for negotiations within this time period.*

The right is reserved to make changes in the progress plan.

4.1 Deadline for tenders

Tenders must be received by the contracting authority's contact person by e-mail by the expiry of the deadline for tenders.

4.2 Tender validity period

The tender is binding for 30 days reckoned from the expiry of the deadline for tenders.

5. QUALIFICATION REQUIREMENTS

Paid tax and VAT

Norwegian suppliers are required to present a VAT certificate issued by the collector of taxes and a tax certificate issued by the chief municipal treasurer (Form RF-1244) in the municipality where the supplier has his head office. The tax certificates must not date back more than 6 months reckoned from the expiry of the deadline for tenders.

Declaration on health, safety and environment (HSE declaration)

Any supplier intending to perform work (i.e. services) in **Norway** will be required to present a declaration to the effect that he meets or, if awarded a contract, will meet statutory requirements in Norway relating to health, safety and environment. The HSE declaration must be enclosed with the tender and must be received by the deadline for receipt of tenders and no later. If the declaration is not received by the deadline, the tender may be rejected.

Legally established enterprise

The supplier must enclose a certificate of registration or (in the case of a sole proprietorship) a register printout from the Central Coordinating Register for Legal Entities.

Good conduct

The contracting authority will maintain a rigorous approach to suppliers who can be linked to malpractices. The supplier must confirm that the business has not been convicted of an offence listed in the appendix "Declaration of good conduct". The appendix shall accompany the tender in a fully completed and signed state.

6. MINIMUM REQUIREMENTS

One of the offered consultants must possess knowledge of Hindi language.

7. AWARD CRITERIA / SUPPLIER'S TENDER REPLY

The tenders will be ranked on the basis of an overall assessment of compliance with the award criteria in order to determine which tender is the most economically advantageous. A scoring scale of 1-10 is used.

Tender replies should be drawn up in accordance with point 8.2 and the table below

Award criteria	Weight in %
Price The tenderer shall specify the prices in NOK ex. VAT, including hourly rate, reasonable hotel and food costs within limits of the Norwegian Government's Guidelines for travels abroad (India), and cheapest available ticket for economy flight.	50%
Solution-specific competence The tenderer shall describe for each offered consultant: • Experience in research and evaluation • Assessing results of health projects. • Relevant competence and experience in relation to the needs listed in point 3.2 and submit CVs.	35%
Proposed solution The study will be primarily qualitative in nature (desk review, interviews and analysis). The consultant is required to propose the details of methodology, work plan and approach for the assignment in line with the needs listed in point 3.2.	15%

8. REQUIREMENTS ON TENDERS

8.1 Submission of tenders

Complete tenders must be delivered electronically to the following e-mail address (Marked to Dr Ashfaq Bhat): *emb.newdelhi@mfa.no*

E-mails' subject field should be marked: **"Proposal for mid-term review of NIPI Phase II"**

8.2 Tender structure

Tenders must be written in English. They must be structured as shown below, divided into the chapters shown and in the sequence stated:

0. Tender letter

- Reference number
- Firm's legal name
- Address, enterprise registration number
- Contact person with postal address, e-mail address and telephone number
- Confirmation of tender validity period
- List of all reservations elaborated on in point 3 in the tender
- Conformation of compliance with the general requirements in point 6

1. Documentation of fulfilled qualification requirements; see chapter 5

- VAT certificate issued by the collector of taxes and tax certificate issued by the chief municipal treasurer
- HSE declaration
- Certificate of registration
- Declaration of good conduct

2. Reply to tender documents' chapter 7 – award criteria

- Price
- Solution-specific competence
- Proposed solution

3. **Reservations**

- Any reservations are to be described and priced to enable the contracting authority to analyse and quantify their implications.

9. TREATMENT OF THE TENDERS

9.1 Opening and negotiation

Opening will not be public. The Norwegian Embassy in New Delhi will attend the opening. The tenders are expected to be opened immediately after the expiry of the deadline for tenders. After opening, the contracting authority will evaluate the tenders received against the award criteria set out in chapter 7.

After the initial evaluation the 2-3 best suppliers will be invited to negotiate with the contracting authority. Other suppliers may be invited to negotiate at a later point. Their tenders will remain binding until the expiry of the tender validity period. There will be an opportunity to negotiate on changes or supplementations in respect of all aspects of the tenders. Negotiation will take place in accordance with the general provisions of the procurement legislation, including provisions prescribing equality of treatment, confidentiality and good business practice.

9.2 Return of tenders

The Royal Norwegian Embassy in New Delhis will not return the tenders of tenderers who are not selected.

9.3 Award of contract

The decision on who is to be awarded the contract will be notified in writing by e-mail to all suppliers. The notification will give reasons for the selection made. The agreement is binding once it is signed by both parties.

Annex B. Documents Consulted

Program and Evaluation Documents

1. NIPI Phase II Program Document
2. NIPI Phase I Evaluation
3. NIPI Phase II Baseline for Impact Evaluation
4. NIPI ME Framework Phase II – 25012013 (and slides)

MOUs and Partnership agreements

5. MOU between the Govt. Of the Republic of India and the Norwegian Ministry of Foreign Affairs.

Implementing partner 1- UNDP Newborn (UNOPS?)

6. UNDP-NIPI Newborn Project Proposal for Phase II 2013-2017
7. UNDP-Monitoring and Evaluation for NIPI Newborn Project in Phase II
8. UNDP-NIPI Newborn Project revised budget Mar-Dec 2013
9. UNDP-NIPI Newborn Project detailed budget four states 2013
10. UNDP-NIPI Newborn Project Summary Interventions budget for each state 2013
11. UNOPS-Proposal for introducing district based Newborn care package in Jharkhand. Oct 2012.

Implementing partner 2- Jhpiego

12. Jhpiego -Executive Summary NIPI Concept Note 09072012
13. Jhpiego-NIPI Concept Note 09072012 Strengthening Nursing Midwife Education and Promoting Healthy Timing and Spacing of Pregnancy for Improved MNCH Outcomes: A concept note for collaboration between the Norway India Partnership Initiative and Jhpiego.
14. Jhpiego- NIPI Concept Note Bihar
15. Jhpiego-NIPI Concept Note Madhya Pradesh
16. Jhpiego- NIPI Concept Note Orissa
17. Jhpiego- NIPI Concept Note Rajasthan

Implementing partner 3 – PHFI

18. PHFI- RMNCH+A Project –Jammu and Kashmir – Workplan and Budget 2014-2016
19. RMNCH+A Implementation in Jammu and Kashmir through Swasthya Slate
20. Swasthya Slate Appendix A. Legends and app icons
21. Swasthya Slate Appendix B. Risk and mitigation matrix
22. Swasthya Slate Per year budget

JSC Documents and minutes

23. 2013-Meeting notes for 1st JSC 08012013
24. 2013-Minutes of 1st JSC meeting 08012013
25. 2013-Meeting notes for 2nd meeting of JSC 14082013
26. 2013-Covering letter for 2nd meeting of JSC 4082013 (unsigned, no minutes)
27. 2013- Annexure 1. UNDP NIPI project proposal for Rashtriya Bal Swasthya Karyakram- Aug 2013
28. 2013-Annexure 2. Final proposal Swasthya (same as document No. 19)
29. 2014 - Meeting notes for 2nd JSC meeting 03022014
30. 2014- Minutes of 2nd JSC 03022014
31. 2015- Meeting notes for 3rd JSC meeting 27022015
32. 2015- Minutes of 3rd JSC 27022015
33. 2016- Draft reports from Jhpiego, UNDP and PHFI for 2015

PAG Documents and minutes

34. 2013- Meeting notes for1st NIPI PAG meeting 29012013
35. 2013- Approved Minutes of 1st NIPI PAG meeting 29012013
36. 2013- Meeting notes for 2nd NIPI PAG meeting 02122013
37. 2013- Approved minutes of 2nd NIPI PAG meeting 02122013
38. 2014-Meeting notes for 3rd PAG meeting 16122014 (stated as 4th PAG on document)
39. 2014-Approved minutes of 3rd PAG meeting 16122014

State documents and minutes -Bihar

40. 2013- Meeting notes for 1st SCC Bihar 28052013
41. 2013- Minutes of 1st SCC Bihar 03062013
42. 2013 -Meeting notes for 2nd SCC Bihar 04122013
43. 2014- Meeting notes for 2nd SCC Bihar 23062014
44. 2014- Minutes of 2nd SCC Bihar 23062014
45. 2014- Meeting notes for 3rd SCC Bihar 01122014
46. 2014- Minutes of 4th SCC Bihar 01122013
47. 2015- Meeting notes for 4th SCC Bihar 16072015
48. 2015- Minutes of 4th SCC Bihar 20072013

State documents and minutes –Madhya Pradesh

49. 2013- Meeting notes for 1st SCC Madhya Pradesh 29052013
50. 2013- Minutes of 1st SCC Madhya Pradesh 30052013
51. 2013- Minutes of 2nd SCC Madhya Pradesh 28112013 (no meeting notes)
52. 2014- Meeting notes for 3rd SCC Madhya Pradesh 30062014

53. 2014- Minutes of 3rd t SCC Madhya Pradesh 02072014
54. 2014- Meeting notes for 4th SCC Madhya Pradesh 05112014
55. 2014- Minutes of 4th SCC Madhya Pradesh 05112014
56. 2015- Meeting notes for 5th SCC Madhya Pradesh 02112015
57. 2015- Minutes of 5th SCC Madhya Pradesh 02112015

State documents and minutes –Odisha

58. 2013- Meeting notes for 1st SCC Odisha 24042013
59. 2013- Minutes of 1st SCC Odisha 24042013
60. 2013- Meeting notes for 2nd SCC Odisha 23112013
61. 2013- Minutes of 2nd SCC Odisha 23112013
62. 2014- Meeting notes for 3rd SCC Odisha 02062014
63. 2014- Minutes of 3rd SCC Odisha 03062014
64. 2014- Meeting notes for 4th SCC Odisha 27112014
65. 2014- Minutes of 4th SCC Odisha 27112014

State documents and minutes –Rajasthan

66. 2013- Meeting notes for 1st SCC Rajasthan 02042013
67. 2013- Minutes of 1st SCC Rajasthan 05042013
68. 2013- Meeting notes for 2nd SCC Rajasthan 30102013 (no meeting notes)
69. 2013- Minutes of 2nd SCC Rajasthan 23112013
70. 2014- Meeting notes for 3rd SCC Rajasthan 10062014
71. 2014- Minutes of 3rd SCC Rajasthan 10062014
72. 2014- Meeting notes for 4th SCC Rajasthan 25112014
73. 2014- Minutes of 4th SCC Rajasthan 08122014
74. 2015- Meeting notes for 4th SCC Rajasthan 07072015
75. 2015- Minutes of 4th SCC Rajasthan 07072015

State documents and minutes –Jammu and Kashmir

76. 2014-Meeting notes for 1st SCC Jammu and Kashmir 10122014
77. 2014- Minutes of 1st SCC Jammu and Kashmir 10122014

State documents and minutes –other states

78. 2013- Minutes of 1st SCC Jharkhand 25062013
79. 2013- Minutes of 1st SCC Assam 09072013
80. 2013- Minutes of 1st SCC Chhattisgarh 27092013

Guidelines and strategies

81. A strategic approach for Reproductive, Maternal. Newborn. Child and Adolescent Health (RMNCH+A) in India. 2013. MoHFW, Gov. of India.

82. Five times five matrix for high Impact RMNCH+A Interventions.
83. Strengthening Facility Based Paediatric Care. Operational Guidelines for Planning and Implementations in District Hospitals. 2015. Child Health Division, MoHFW, Gov. of India.
84. Dakshata. Empowering Providers for Improved MNH Care during institutional deliveries. 2015. Maternal Health Division. MoHFW, Gov. of India.
85. Strengthening Pre-Service Education for the Nursing and Midwifery Cadre in India. Operational Guidelines. 2012. Maternal Health Division, MoHFW, Gov. of India.
86. Maternal and Newborn Health Toolkit. 2013. Maternal Health Division, MoHFW, Gov. of India.

Annex C. Stakeholders interviewed

Government officials. National and State level

1. Dr. Rakesh Kumar, Joint Secretary (RCH), Ministry of Health and Family Welfare, MoHFW.
2. Dr. Ajay Khera, Deputy Commissioner Incharge (Child Health), MoHFW
3. Dr. Dinesh Baswal, Deputy Commissioner (Maternal Health), MoHFW
4. Dr. P K Prabhakar, Deputy Commissioner (Child Health), MoHFW.
5. Ms. Shalini Panda, Mission Director (NHM), Government of Odisha
6. Dr. R.N. Panda. Child Health Consultant (NHM), Odisha
7. Dr. Dinabandhu Sahoo. Joint Director Technical (NHM), Odisha
8. Dr. D.K. Panda, Team Leader, SHSRG (NHM), Odisha
9. Dr. Nirmala Dei, Director Family Welfare, Odisha
10. Dr. Lingaraj Mishra, Joint Director Nursing (Education), Odisha
11. Dr Rajshree Bajaj, Deputy Director (Child Health), Government of Madhya Pradesh
12. Dr Archana, Deputy Director (Maternal Health), Government of Madhya Pradesh
13. Dr. Pranati Kumar, Deputy Director, Nursing, Government of Madhya Pradesh

Field visit Alwar, Rajasthan

14. Dr. Hansraj Meena, Chief Medical and Health Officer, District Hospital
15. Dr Bhagwan Sahoy, Principal Medical Officer, District Hospital
16. Dr. Somdatt Gupta, Paediatrician, District Hospital
17. Ms. Sharda Sharma, Nursing In charge, SNCU, District Hospital
18. Dr. M.C. Gupta, Paediatrician, SNCU-TTC, District Hospital

Field visit, Raisen, Madhya Pradesh

19. Ms. Ashalata, Principal of GNM training center
20. Dr. Alok Rai, SNCU and FCC Incharge, District Hospital
21. Dr. Anuk Chhari, ETAT Incharge, District Hospital
22. Dr. Yashpal Singh, RMO, District Hospital

Royal Norwegian Embassy (RNE)

23. Ms Unni Silkoset, Counsellor, RNE
24. Mr Sigvald Hauge Tomin, Deputy Chief of Mission, RNE
25. Dr Ashfaq Ahmed Bhat, Senior Adviser, RNE and NIPI Coordinator

Jhpiego

26. Dr Somesh Kumar, India Program Manager and Deputy Country Director
27. Dr Bulbul Sood, Country Representative
28. Dr. Anita Anasnya, Odisha State Team Leader
29. Dr. Jyoti Samal, Odisha State Programme Officer, Family Planning
30. Dr. Ravi Kumar, Odisha State Programme Officer, Pre-Service Nursing Education
31. Dr. Kaustubh Wagh, Odisha Senior Monitoring and Evaluation Officer
32. Dr. Jyoti, Madhya Pradesh State Team Manager
33. Dr. Rajan Shah, Madhya Pradesh State Programme Officer, Family Planning
34. Dr. Avinash Jaiswal, Programme Officer for Raisen, Madhya Pradesh
35. Prince Jacob , District Programme Officer, Raisen, Madhya Pradesh
36. Dr. Vindu Kumar, Rajasthan State Programme Manager
37. Dr. Kailash Saran, Rajasthan Senior Advisor Programmes
38. Jewel Joseph, Programme Officer Kota, Rajasthan
39. Rovin Sharma, Programme Officer Agmer, Rajasthan
40. Shehaletha Suresan, Programme Officer Lucknow, Rajasthan (ex-PPIUCD Alwar)

New Born Project UNDP

41. Dr Harish Kumar, Project Incharge
42. Mr. Rajat Khanna, Monitoring and Research Officer
43. Dr Anil Nagendra, Senior Programme Officer, MP
44. Dr. Deepak, Monitoring and Evaluation Officer, MP
45. Mr. Sushil Singh, Distric Programme Officer, Raisen, MP
46. Dr Prasant Saboth, Senior Programme Officer, Odhisa
47. Ms. Manjusha Doshi, Programme Officer, Odisha
48. Mr. Tapas Mohanty, Programme Assistant, Odisha
49. Mr. Pradeep Choudhry, Programme Officer, Rajasthan
50. Dr. S.P. Yadav, Senior Programme Officer, Rajasthan
51. Prafull Kr Sharma, District Programme Officer, Alwar, Rajasthan

PHFI

52. Dr Kanav Kahol, Team Leader, Affordable Health Technologies
53. Dr Sunil Raj, Director, Public Health, Affordable Technolgies

Annex D. Conversation Guide

Dear colleague,

Scanteam has been asked by the Royal Norwegian Embassy in Delhi to perform a Mid-Term Review of the Norway-India Partnership Initiative Phase II. In this connection, we would like to have a conversation with you regarding your views and experiences with those parts of the NIPI you are familiar with. All interviews will be confidential. The actual issues that we will look at will depend on which issues you are comfortable discussing with us.

Thank you for your assistance!

Effectiveness :

- What are in your view the key results produced by NIPI in Phase II (or the specific project you are involved in) so far?
  - How do they compare with the original plans?
  - What do you see as the main causes for the positive results (both internal and external factors)?
- Are there important short-comings compared with the original plans?
  - If so, what caused the short-falls (both internal and external factors)?
- Have there been any unintended positive or negative outcomes?
- Do you believe the remaining goals and targets will be achieved by the end of NIPI phase II in 2017 if the current level of activity is maintained/increased?
- Has the project contributed to gender equality? What are the documented effects that you can point to? Can you give examples of activities or outcomes?
- Has the project had a focus in the environment?
  - Has there been interest in the relationship between the environment and health?
  - Have activities been implemented in a manner to ensure environmental protection and adequacy with environmental standards?
  - Can you give examples?

Efficiency:

- Have the programme activities delivered as agreed, in relation to established time-frames and inputs received?
- Have you been able to access the resources promised in a time-efficient and cost-efficient manner? If not, what have been the hurdles?
- Has the overall management of the project been good, transparent, efficient? What has worked well? What, in your view, have been the main inefficiencies or challenges? How could they be improved?
- If there have been issues in administrative or financial matters, what were they?
- Have adequate measures been implemented to facilitate transparency and limit corruption? Can you mention some measures in this sense?

- Have the reporting requirements been reasonable, given the size of the project?
- What has been the quality of technical assistance of implementing partners? Comment for each partner separately.
- Is there an adequate level of documentation of activities, by implementing partners?
- Would you say efficiency has increased, decreased or stayed the same in NIPI Phase II compared to Phase I? Could you give examples related to your perception?

Contribution to National Health Mission:

- What have been, in your view, the key contributions of NIPI to the mission and goals of the NHM at national and/or state level?
- How is NIPI perceived as a technical support partner at national and/or state level? Is NIPI well known at these levels?
- Is NIPI well known at the programme level? Are the NIPI activities clearly branded as such? Can you give us examples?
- What are the benefits/drawbacks of NIPI's implementation mechanisms at state level? What could be improved?

Cooperation:

- In your experience, how good is the cooperation between NIPI, MoHFW and implementing partners? Can you give us an example?
- What are the main positive points and short-comings concerning this cooperation?
- What would be your main suggestion to improve cooperation?

Sustainability:

- In your view, is there an interest from the two parties (Norway and India) in continuing NIPI after 2017? In what ways is this likely to happen? Have possibilities been discussed among partners?
- Which activities and programmes do you think would continue with local, state or national support? What is the level of ownership of NIPI interventions at district, state and national level?
- What are the main ways in which NIPI is addressing financial and operational sustainability of its interventions beyond the end of 2017?
- What funding opportunities could be envisioned for the continuation of activities post 2017? What are their pros and cons?

Future directions:

- Based on the key areas of success of NIPI Phase II, as well as main challenges remaining in maternal and child health in India, what would be the main future directions by which the Government of Norway may provide support beyond 2017?
- In which ways can this support be envisaged in order to align with Norwegian development goals, the Indian government plans for the NHM, and the Sustainable Development Goals on health?

Annex E. Time-line for interviews and field visits

The international consultant was in India during the period 9th to 18th December 2015, and together with the national consultant, the review team followed the plan shown in the table below:

Date	Task	Project visit
Tue 8th Dec	Oslo-New Delhi: Iglesias	New Delhi
Wed 9th Dec	Arrival in Delhi (Iglesias); Team meeting in Delhi; Briefing with client	New Delhi
Thu 10th Dec	First set of interviews in Delhi	New Delhi
Fri 11th Dec	Second set of interviews in Delhi	New Delhi
Sat 12th Dec	Team review of interviews	New Delhi
Sun 13th Dec	Team review of interviews, New-Delhi-state capitals (Bhubaneswar: Iglesias, Bhopal: Chokshi)	Bhubaneswar, Bhopal
Mon 14th Dec	Interviews in state capitals: Bhubaneswar: Iglesias, Bhopal: Chokshi.	Bhubaneswar, Bhopal
Tue 15th Dec	Travel to district sites. Interviews in district sites: Alwar: Iglesias, Raisen: Chokshi. Travel to state capitals	Alwar, Raisen
Wed 16th Dec	State capitals to New Delhi, Team review of interviews, data collation.	New Delhi
Thu 17th Dec	Last set of interviews	New Delhi
Fri 18th Dec	Debriefing meeting with client	New Delhi
Sat 19th Dec	New Delhi-Oslo	

Field visits

- **Raisen (Madhya Pradesh).** Visit to the GNM school and to the district hospital which houses the SNCU, where the SNCU, the labour room, the new paediatric emergency triage and treatment (ETAT) ward and the family-centered care area were visited. A subcenter at Goud was also visited, where the review team member was able to interact with 3 ASHAs, 1 ASHA supervisor and a group of mothers.
- **Alwar (Rajasthan).** First interviews were conducted in the district hospital, with state and district level programme officers from the NBP and Jhpiego teams, along with health and management personnel from the hospital. The SNCU and the labour room were visited, along with the paediatric emergency triage and treatment (ETAT) ward, which is not yet fully operational. Afterwards, a visit was conducted to the GNM, where the IT and skills lab where showcased, along with an on-going IT class.