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End Review of The Norway-India Partnership Initiative (NIPI), Phase III

End Review

Hera - Giorgia Lattanzi

Norad

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END REVIEW OF THE NORWAY-INDIA PARTNERSHIP INITIATIVE (NIPI), PHASE III

Final report

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Giorgia Lattanzi

Kardinaal Mercierplein 2
B-2800 Mechelen
Belgium
hera@hera.eu www.hera.eu Tel +32 3 844 59 30

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS

ANC	Antenatal Care
ANM	Auxiliary Nurse and Midwife
AR/VR	Augmented Reality/Virtual Reality
ASHA	Accredited Social Health Activist
CH	Child Health
CHO	Community Health Officer
COVID-19	Coronavirus Disease 2019
CURE	Centre for Urban and Regional Excellence
DHIS	District Health Information Software
DSS	Decision Support System
ECD	Early Childhood Development
ETAT	Paediatric Emergency Triage Assessment and Treatment
FPC/KMC	Family Participatory Care/Kangaroo Mother Care
GFF	Global Financing Facility for Women, Children and Adolescents
GoI	Government of India
HBYC	Home-based Care for Young Children
HDU	High-dependency Unit
HPV	Human Papilloma Virus
HSS	Health Systems Strengthening
HWC	Health and Wellness Centre
IMNCI	Integrated Management of New-born and Childhood Illnesses
IMR	Infant Mortality Rate
IPHS	India Public Health Standards
J&K	Jammu and Kashmir
M&E	Monitoring and Evaluation
MFA	Ministry of Foreign Affairs, Norway
MH	Maternal Health
MMR	Maternal Mortality Ratio
MNCH	Maternal, New-born and Child Health
MoHFW	Ministry of Health and Family Welfare, India
MoU	Memorandum of Understanding
NCD	Non-Communicable Diseases
NH	Neonatal Health
NHM	National Health Mission
NHSRC	National Health Systems Resource Centre
NIPI	Norway India Partnership Initiative
NMR	Neonatal Mortality Rate
Norad	Norwegian Agency for Development Cooperation
NSSK	Neonatal resuscitation; Navjaat Shishu Suraksha Karyakaram
OECD DAC	Organization for Economic Cooperation and Development, Development Assistance Committee
PHC	Primary Health Care
PIP	State Programme Implementation Plan
PMNCH	Partnership for Maternal and Child Health
QA	Quality Assurance
QoC	Quality of Care
RMNCH+A	Reproductive, maternal, new-born, child plus adolescent health
RMNCH	Reproductive, maternal, new-born, child health

RNE	Royal Norwegian Embassy
SDG	Sustainable Development Goal
SHS	State Health Society
SNCU	Special New-born Care Units
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollars
UT	Union Territory
WHA	World Health Assembly
WHO	World Health Organization

1 EXECUTIVE SUMMARY

Introduction

This report presents the findings of the end review of Phase III of the Norway-India Partnership Initiative (NIPI). NIPI has been implemented in India since 2006, with the aim of supporting improved maternal, neonatal and child health, promoting innovation and documenting best practices by providing technical assistance to the Ministry of Health and Family Welfare (MoHFW) and the National Health Mission (NHM). NIPI III is supporting the MoHFW at central level and the NHM in five Indian States/Union Territories (UTs), and it does so through a national team and five state-level teams. Its objectives are to: 1. To scale up the learning and best practices in India: Strategic, technical assistance to the intensified districts for scaling up if already demonstrated best practices; 2. Innovation Hub: Establish an innovation hub that will identify and test promising health system innovations in the fields of maternal and new-bornd and child health (MNCH); and 3.Global dissemination of NIPI Document best practices in maternal, new-born and child health carried out under the National Health Mission and NIPI, to be shared for global dissemination and learning.

The review took place between August and November 2023. It was commissioned by Norad, and its purpose was to: 1) Assess the Relevance, Effectiveness and Efficiency of NIPI III in relation to the agreed Phase III objectives; 2) Review the success factors of the NIPI model of implementation at the state level, and the perception of the program as a technical support partner at both central and state level, and 3) Assess the level of sustainability created thus far within the context of among others the cooperation with MoHFW the and in the supported states. The review is equally tasked with examining four cross-cutting issues, and namely anti-corruption, environment and climate change, gender equality and human rights. Data collection included document review, interactions with key stakeholders, and a field mission to India, and data was analysed using a mixed methods approach.

Key findings by review area

Review area 1: Relevance

NIPI III objectives, activities and products (e.g., tools and guidelines) are aligned to national policies and strategies in the fields of MNCH, and to standards and initiatives aimed at monitoring and improving quality of care. Health service provision related interventions being scaled up with NIPI III Techno-managerial support have a clearer contribution link to national priorities, in particular mortality reduction and overall improved health status of mothers, new-borns and children. NIPI III objectives appear relevant also at supported state/UT level, even though insufficient evidence was available.

Review area 2: Effectiveness

Available information suggests that NIPI III objectives have largely been met, and in most cases surpassed, with an expected positive impact of activities undertaken under objectives 1 and 2 primarily on maternal, new-born and child heath as well as with regards to availability and quality of health services provided in the supported states/UTs. Documenting of good practices has been performed, but could however be meaningfully strengthened by reflecting more in depth on outcome level changes and unique features of the NIPI model. Flexibility of NIPI activities allows to effectively address emerging needs voiced at state or national levels.

Scaling up of interventions and innovations supported by NIPI III was achieved, in selected cases also at national level, and more generally beyond the target districts. Activities were further amplified with an increased number of innovations being piloted as compared to what originally planned.

Success factors of the NIPI III model reside primarily in its lean structure and in the close and trusted working relationship with the National Health Mission. Implementation of activities is further enabled by the remarkable alignment between NIPI and NHM/MoHFW goals, as well as by the high-level political support and commitment to the achievement of shared MNCH goals.

Bottlenecks to implementation and scaling up of NIPI activities weren't adequately documented, however the COVID-19 pandemic and a change of implementing partner at the onset of Phase III significantly slowed down activities. Other issues negatively impacting implementation are related to acceptance of individual interventions and innovations, insufficient institutional capacity among counterparts, health workforce and data quality and availability.

Review area 3: Efficiency

NIPI III financial efficiency could not be adequately appraised through available information. Overall budget spending rate has been ranging between 74 and 100%, and salaries of NIPI III staff consistently represent the largest spending item, in line with the programmatic focus on provision of technical assistance.

Stakeholders have an overall positive perception of NIPI III's financial efficiency, considering that achieved results are more than commensurate with spending. Technical assistance provided through NIPI III is considered efficient, relevant and adequate to meet state/UT needs. Human resources employed by NIPI are reported to have the technical and managerial skills necessary to efficiently execute their tasks.

Review area 4: Sustainability

Sustainability prospects appear positive for interventions that have already been scaled up and institutionalised through inclusion of state annual programme implementation documents. Availability of funds within the NHM is one of the key enablers for sustainability of benefits generated through NIPI, with a reported investment from India 26 times higher than resources contributed by NIPI III. However, innovations that have only recently been scaled up or are being piloted may not outlive the end of NIPI support, primarily as a result of a lack of institutional capacity within the NHM, which represents the primary bottleneck for NIPI III sustainability. He review found that, in contrast with what foreseen in its programme document, NIPI III did not operationalise its foreseen handover and exit plan.

Review area 5: Cohesive cooperation/ownership

NIPI appears to be contributing to state and national goals. Stakeholders have extremely positive perceptions of NIPI as a technical partner that works side by side with the NHM without pushing an agenda of its own. NIPI's high standing is revealed, amongst other things, by its participation to strategic analysis and decision-making processes at state and at national level. NIPI's embeddedness in the NHM allows for frequent and fluid interaction with the counterpart, however it may be at the same time fuelling an excessive reliance on technical advisors posted by the Partnership.

Review area 6: Cross-cutting issues

Anti-corruption, climate change and the environment, gender equality and women's rights, and human rights were not explicitly considered in NIPI's design or objectives. However, the programme has had some positive repercussions, in particular related to empowerment of female health workers and collection and use of disaggregated data for decision-making.

Review area 7: Future directions

A NIPI Phase IV seems likely, and it could continue to focus on its core technical areas, where institutional memory is in place, and necessary skills are already within the programme. Stakeholders suggested that

non-communicable diseases, a life course approach to MNCH, quality of care and digital health could be technical areas for potential additional support.

NIPI III has shown potential for replicability in the Indian context, however it does not appear realistic to envision replication in other country contexts at this stage, before a solid knowledge base is built through in-depth appraisals and documentation processes.

Recommendations

1. If a continuation of the programme was approved, the following are recommended for consideration:
    a. It does not seem advisable for NIPI to embark in new technical areas (e.g. NCDs, adolescent health, etc), as the approved NHM extension until 2026 timeframe would not allow to devise adequate implementation approaches, nor to achieve results also considering the magnitude of the target populations and of the disease burden. Expanding to new technical areas could only be achieved through a renewed commitment to long-term support, which may then be best portrayed as a new partnership altogether;
    b. A new phase should focus on consolidating the gains achieved to date, and aim at filling the remaining gaps related to the institutionalisation of interventions currently tested under objective 2 and in particular of the innovation hub, creation of sustainable capacity within the NHM to manage the programme, and better documentation and diffusion of NIPI's model and of the good practices implemented in collaboration with the NHM. In addition, NIPI's ongoing efforts in support of quality of care have shown promising application and could potentially be brought forward in a new phase. Development of technical and strategic documents could become a standalone outcome, separate from documenting and disseminating good practices.
    c. While replication outside India seems premature, a new NIPI Phase could focus on expanding the coverage and scaling up of relevant innovations included in previous phases to other geographic areas, for example the North-East of the country, or areas with high maternal and child mortality.
    d. A potential NIPI Phase IV needs to include a clear and realistic exit strategy, one that can be implemented in the three years running until the conclusion of the NHM.
    e. As part of the exit strategy, consider how to transfer current NIPI´s function as provider of strategic technical assistance to another existing national institution, for example the NHSRC. This technical assistance should be backed by an adequate budget put forth by the GoI, so to be able to continue providing strategic support to states/UTs and MoHFW.
2. Capacity gaps should also be assessed regularly, and addressed as feasible. It is paramount that a potential Phase IV focuses on sustainable capacity strengthening, privileging collaboration and handing over, to substitution and hand-holding.
3. Reaching out to the most vulnerable and marginalised groups has already been started under NIPI III , and if a Phase IV was approved, NIPI could make a more explicit attempt at impacting on cross cutting issues, and in particular by explicitly supporting India put into practice a leave-no-one-behind approach that is already at the core of national policies.
4. In the event of continuation of NIPI programme, its planning , monitoring, reporting and learning functions need to undergo an in-depth strengthening process. Without compromising the lean format of the annual meeting, formal annual progress reporting should be in line with elements

requested in the grant general conditions, including documenting challenges, mitigation measures, risk assessment. Reports should also include outcome-level narrative and reflections in addition to the current comprehensive list of activities carried out, clearly documenting examples of increased capacity resulting from NIPI/NHM collaboration.

5. Systematising and documenting lessons learned from NIPI implementation, throughout its phases but especially in Phase III, and bringing to light the most crucial features of its model, would be a crucial step to determine whether replication is possible. Documentation to be done in a structured and systematic way, and potentially with a view to allow independent adaptation of the NIPI model in other contexts.
6. Building on existing success, NIPI could explore avenues for dissemination of good practices, ideally privileging existing global partnerships (e.g. the Partnership for Maternal, New-born and Child Health - PMNCH) and global or south-south networks (e.g. WHO Quality of Care Network, of which India is already a member). If rigorously documented, good practices promoted by NIPI could be raised to the Global Financing Facility for Women, Children and Adolescents (GFF).
7. NIPI could better target its external communication efforts, producing shorter and interactive newsletters. Similarly, in order to engage external readers, the website could present a short and appealing annual summary content (e.g. long story format) providing clear and accessible examples of NIPI's contribution to national and global health goals.

2 BACKGROUND AND RATIONALE

2.1 CONTEXT

Key features of the Indian health system

The Indian health system is decentralised, with health being a state-level subject as foreseen in the Constitution of India. The **Ministry of Health and Family Welfare (MoHFW)** is responsible for defining national goals and providing oversight to state-level implementation. The National Health Policy provides goals, prioritisation and overall approach for the country, and under this umbrella states define their own priorities and actions, which are translated into state programme implementation plans (PIPs). States are also responsible for the delivery of health services. Implementation funds are provided by the Government of India (GoI) and allocated to the states/union territories (UT). States/UTs receive part of the available funds based on results-based financing principles.

Launched in 2005, the **National Health Mission (NHM)** is a programme tasked with supporting the MoHFW progress towards the achievement of improved health outcomes in the country. Its current funding runs up to 2026. Initially focussed on rural contexts, the NHM now also encompasses urban areas. A Digital Health Mission initiative was also recently launched. The NHM's main programmatic components include Health System Strengthening, Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. The NHM envisages achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs[1]. The NHM is represented at state/UT level.

Key maternal, new-born and child health indicators

India is undergoing a rapid epidemiological transition, with an increasing burden represented by non-communicable diseases, which also account for the first three main causes of mortality in the country, followed by diarrheal disease and neonatal disorders[2]. However, communicable diseases remain prevalent, and maternal, new-born and child health (MNCH) still represent a key priority area despite marked progress achieved over the last decades, as represented in figure 1 below (*source: WHO 2022*).

Figure 1. Selected maternal, child and adolescent health indicators

	1990	1993	1995	1999	2000	2005	2010	2013	2015	2018	2019–2020
Adolescent fertility rate (births per 1000 women aged 15–19 years)[1]	98.8	90.6	83.7	70.2	66.8	50.8	34.7	25.1	19.1	12.1	–
Neonatal mortality rate (per 1000 live births)[1]	57.4	53.8	51.5	46.4	45	38.1	32	28.3	25.9	22.6	–
Infant mortality rate (per 1000 live births)[1]	88.6	82.2	78	69	66.7	55.7	45.1	38.8	34.9	29.7	–
Under-5 mortality rate (per 1000 live births)[1]	126.2	116.1	109.5	95.4	91.8	74.5	58.2	49.1	43.5	36.3	–
Maternal mortality ratio (per 100 000 live births) (modelled) – national not available[2]	556[3]	NA	NA	NA	370	286	210	175	158	113 (2016–18) SRS[5]	–
% stunting[4]	NA	52 under 4 years of age[4]	NA	46 under 3 years of age[4]	NA	48 under 5 years of age[4]	NA	NA	38.4 under 5 years of age[4]	NA	22.5 under 5 years of age[4]
% underweight[4]	NA	53 under 4 years of age[4]	NA	47 under 3 years of age[4]	NA	43 under 5 years of age[4]	NA	NA	35.8 under 5 years of age[4]	NA	23.7 under 5 years of age[4]

Along with a generalised reduction in relevant mortality indicators, it can be observed that neonatal mortality has been decreasing at a slower pace than infant mortality, and represents an ever-increasing share of it.

[1] From www.nhm.gov.in
[2] WHO SEARO, India Health Systems Review (2022)

National policies and strategies

The reduction of maternal, neonatal and infant mortality is amongst the key objectives of the **2017 National Health Policy**[3], which also identifies the adoption of a primary health care (PHC) approach as a key step towards achieving universal health coverage (UHC). Amongst the policy objectives, are "*Assuring availability of free, comprehensive primary health care services, for all aspects of reproductive, maternal, child and adolescent health and for the most prevalent communicable, non-communicable and occupational diseases in the population"* and "*Mortality by Age and/ or cause: a. Reduce Under Five Mortality to 23 by 2025 and MMR from current levels to 100 by 2020; b. Reduce infant mortality rate to 28 by 2019; c. Reduce neo-natal mortality to 16 and still birth rate to "single digit" by 2025*"[4].

The **2013 Reproductive, Maternal, New-Born, Child Plus Adolescent Health (RMNCH+A) Strategy**[5] is based on a continuum-of-care approach and defines integrated packages of services for different stages of life, along with considerations on health systems strengthening (HSS) needs for RMNCH+A service delivery. This last HSS for RMNCH+A consideration is equally present in the 2017 Health Policy. Goals of the Strategy include reduction of infant mortality rate and maternal mortality ratio, and amongst its objectives are increased antenatal and postnatal care provision, increased availability of perinatal care services within facilities, increased exclusive breastfeeding rates. The document puts a special emphasis on priority actions to be executed in high focus districts, and in order to reach vulnerable populations (urban disadvantaged and tribal).

In 2017, following the orientation of the RMNCH+A Strategy and based on results of the National Family Health Survey (NFHS4), the Government of India launched the **District Intensification Plan,** with a view to improving maternal and child health outcomes in 102 low-performing districts. This Plan proposes a set of approaches to strengthen RMNCH+A service delivery, and namely: (1) introduction of dedicated midwifery services for family planning, MNCH; (2) augmenting quality of facility based MNCH services (Labour room Quality Improvement Initiative [LaQshya], labour room strengthening, emergency care for children and family participatory care for new-borns); and (3) implementation of extended community based care (home based extended infant care, follow up of sick and small new-borns in infancy). The plan includes provision for integrated training package for maternal, new-born and child health for providers and demand generation activities such as intensified campaigns and behaviour change communication (BCC) activities. Similarly, the **2018 Aspirational Districts Programme**[6] targets the 112 most under-developed districts across the country, and intends to expedite their transformation. Progress is measured across 49 Key Performance Indicators (KPIs) under five domains: Health & Nutrition, Education, Agriculture & Water Resources, Financial Inclusion & Skill Development and Infrastructure. These indicators are monitored and district ranking reported by the NITI Aayog, a resource centre supporting the GoI on several matters.

Finally, the **2014 India New-born Action Plan (INAP)** equally emphasises the need to strengthen results in the reduction of neonatal mortality and of stillbirths, supporting the implementation of evidence-based interventions that would allow to address these two phenomena, with an additional effect on maternal mortality reduction. INAP's targets include the reduction of neonatal mortality to single digit by 2030, which can only be achieved with "universal*, equitable, and high-quality coverage of comprehensive care for every woman and new-born in the country*[7]".

[3] Available at https://main.mohfw.gov.in/sites/default/files/9147562941489753121.pdf
[4] Obj. 2.3.1 A, and 2.4.1.2 respectively
[5] Available at https://nhm.gov.in/images/pdf/RMNCH+A/RMNCH+A_Strategy.pdf . While the strategy targets are set for 2017, the document still remains valid.
[6] see https://niti.gov.in/aspirational-districts-programme
[7] INAP, page 42

2.2 THE NORWAY INDIA PARTNERSHIP INITIATIVE (NIPI)

The Norway India Partnership Initiative[8] (NIPI) is an innovative, catalytic, and strategic program that was inaugurated in 2006 to support India's efforts to reduce maternal, new-born and child mortality. During the last 17 years, NIPI has been implemented in three distinct phases, presented in Figure 2 below.

Figure 2. Overview of NIPI phases

Source: NIPI brochure

In the current Phase III, which is the focus of this end-review, NIPI provides technical assistance to the MoHFW and to the NHM of five Indian states/UTs, targeted because of their under-performing in MNCH indicators. NIPI focusses its activities in selected aspirational districts for each state/UT.

The NIPI contract is managed by the Royal Norwegian Embassy (RNE), New Delhi, on behalf of the Norwegian Ministry of Foreign Affairs (MFA). The NIPI III model is described in greater detail in Section 4 of this report

2.3 PURPOSE OF THE END-TERM REVIEW

The purpose of the review is both to document results achieved and capture learning on best practices arising from NIPI III implementation (2018-2023), proposing options for future directions following the foreseen conclusion of NIPI III at end 2023. Objectives of the review are to:

- Assess the Relevance, Effectiveness and Efficiency of NIPI III in relation to the agreed Phase III objectives;
- Review the success factors of the NIPI model of implementation at the state level, and the perception of the program as a technical support partner at both central and state level;
- Assess the level of sustainability created thus far within the context of among others the cooperation with the MoHFW and in the supported states.

[8] https://www.nipi-cure.org/about-us.php

The review is equally tasked with examining four cross-cutting issues, and namely anti-corruption, environment and climate change, gender equality and human rights. The review has been requested by the Norwegian Agency for Development Cooperation (Norad). Terms of reference (TORs) for the end review are presented in Annex 6.

3 APPROACH AND METHODOLOGY

The end review employed a mixed methods approach, with a strong focus on qualitative data collection and analysis. Data collection has been carried out through three processes, happening in parallel, and namely:

1. document review
2. field visit (10-17 September 2023), and
3. guided conversations with key stakeholders (in person and online)

Review questions and sources

Based on indications provided in the terms of reference, and following interactions with Norad and the RNE, 20 specific review questions were agreed for this review, distributed across seven domains. These are presented below, along with the main data sources used to address them.

DOMAIN	REVIEW QUESTIONS	DATA COLLECTION
1. Relevance	1.1 Were all NIPI III objectives relevant to the National Health Mission and to MoHFW, Government of India? If not, why? 1.2 Were all NIPI III objectives relevant to the five supported States? If not, why?	Document review Guided conversations Field visit
2. Effectiveness	2.1 To what extent were NIPI III key results achieved as planned? 2.2 If not, what caused a deviation from the original planning?	Document review Guided conversations
	2.3 What were the key enablers in the implementation of programme activities? 2.4 What were the key challenges and bottlenecks in the implementation of programme activities?	Document review Guided conversations Field visit
	2.5 To what extent were NIPI-supported innovations scaled up by State Governments? 2.6 To what extent were NIPI-supported innovations scaled up by the MoHFW? 2.7 What were the success factors allowing to scale up? 2.8 What were identified bottlenecks to scaling up?	Document review Guided conversations Field visit
3. Efficiency	3.1 Were available financial resources used efficiently during NIPI III implementation? 3.2 Was the technical assistance provided through NIPI delivered efficiently, and was it relevant to states and MoHFW? 3.3 Did the technical assistance provided through NIPI staff meet the quality requirements and needs of supported states? Of MoHFW?	Document review Guided conversations

4. Sustainability	4.1 What is the likelihood that benefits generated by NIPI III will last after the programme ends? 4.2 What have been key success factors and bottlenecks to ensure sustainability of NIPI III?	Document review Guided conversations
5. Cohesive cooperation	5.1 What were the key contributions of NIPI to the mission and goals of the NHM at national and/or state level?	Document review Guided conversations Field visit
	5.2 How is NIPI perceived as a technical development partner at national and state level?	Document review Guided conversations Field visit
6. Cross-cutting issues	6.1 To what extent were cross-cutting issues (anti-corruption, climate change and environment, gender, human rights) taken into consideration in the design and implementation of NIPI III?	Document review Guided conversations
7. Future directions	7.1 If the NIPI program were to continue, what would be the key possible strategic work areas in between Norway and India in Health beyond 2023 for attainment of SDGs?	Document review Guided conversations
	7.2 How can Norway and India take forward this successful model of development cooperation for replication beyond India and globally?	Document review Guided conversations

Data collection

Relevant **documents** have been retrieved through online searches and shared by NIPI and/or RNE throughout the review. Documents incorporated in the review include but are not limited to: relevant national and state policy and strategy documents; documents establishing NIPI Phase III and programmatic documents (e.g. letters of intent, MoUs, grant agreements, concept notes, project proposals and outlines, results frameworks, etc.); Minutes of NIPI III annual meetings, annual reports, progress reports; Audit reports and financial statements; Evaluation reports for NIPI Phase II. A total of 123 documents were analysed as part of the review process (this does not include the documents screened but excluded as not relevant, nor the notes of interactions with key stakeholders). These are listed in Annex 1.

A **field visit to India** took place between 10 and 17 September 2023, allowing to interact with key stakeholders at national, state and district levels, with the RNE, NIPI central team, and with three NIPI teams (National, Odisha, Rajasthan). Throughout the visit, it was possible to observe implementation of NIPI-supported innovations at community and facility levels in the supported states of Odisha and Rajasthan. Following the field visit, additional **guided conversations** took place remotely with key stakeholders. Annex 2 presents the **conversation guide** used for all interactions, both during the mission and online. The guide was shared in advance with all stakeholders who participated remotely, as well as with a subset of those with whom interaction took place during the field visit. Notes were taken during all conversations, and the vast majority of conversation were recorded, after obtaining agreement of the subjects. Detailed notes of all conversations and of presentations received during the field visit were included in the analysis. A total of **60 key stakeholders** participated in the guided conversations, either individually or as a group, representing a vast array of institutions and organisations, both at national and state level. This is presented in in Annex 3.

Data analysis and reporting

Available qualitative data (documents, conversation/presentation notes) has been analysed using the MAXQDA[9] content analysis software, applying a set of 52 codes covering all agreed review questions. Available financial data has been analysed using MS Excel. Findings have been triangulated across available sources, and resulting findings are presented in Section 5 of this report.

3.1 LIMITATIONS

- Not all requested essential documentation and information could be made available in a useable and timely fashion needed for inclusion in review, despite multiple requests. This had a negative impact on the review process, undermining the strength of certain findings. This is noted as appropriate in the findings section of this report.
- Strong limitations of the NIPI planning, monitoring, reporting and learning functions resulted in essential information not being available, and methodological challenges. The discrepancies and misalignment between results framework(s), annual workplans, and activities reported upon, added to reporting performed primarily at activity/output level seriously affected data interpretation, in particular for the effectiveness review domain.
- The vast majority of interactions with key stakeholders took place in presence of national and state level NIPI teams (and of RNE and Norad representatives during the field visit). This may have in some cases prevented those consulted to present their views openly. An attempt at mitigation was made for online interviews, however the same issue resurfaced. Impartiality and transparency of the responses are therefore likely biased, a fact that may undermine strength and reliability of the findings.
- With the NHM website being malfunctioning during most of the review, it is possible that some key information on state-level priorities was potentially not found during the document review. State-level strategic and policy documents were requested to NIPI/RNE, but were not received.

4 OVERVIEW OF NIPI III

In September 2017, and following a request from the Indian MoHFW, the Norwegian MFA and the MoHFW signed a letter of intent for a third phase of NIPI. The letter clarifies that the partnership should include maternal, new-born, child and adolescent health, as well as health systems strengthening, and be aligned with the 2017 India health policy, with a view to reaching the Sustainable Development Goals (SDGs). The letter equally specifies that the upcoming phase shall build on experiences gathered during NIPI I and NIPI II and take the GoI Intensification Plan for Accelerated Maternal and Child Survival as a starting point.

A subsequent Memorandum of Understanding (MoU) between MFA and MoHFW further specifies three objectives for NIPI III:

1. To scale up the learning and best practices in India: Strategic, technical assistance to the intensified districts[10] for scaling up if already demonstrated best practices.
2. Innovation Hub: Establish an innovation hub that will identify and test promising health system innovations in the fields of maternal and new-born and child health (MNCH).

[9] www.maxqda.com

[10] Also referred to as aspirational districts in this report, are low-performing districts identified by the GoI as requiring intensified action and support from states and other partners. There is total of 112 aspirational districts in India, and their progress is measured across 49 key performance indicators. See https://niti.gov.in/aspirational-districts-programme

3. Global dissemination of NIPI Document best practices in maternal, new-born and child health carried out under the National Health Mission and NIPI, to be shared for global dissemination and learning.

As an overarching principle, the MoU states that NIIPI III activities shall aim at fulfilling goals and objectives of the NHM and be carried out with full participation of State Governments and other stakeholders.

4.1 NIPI III IMPLEMENTING PARTNERS

NIPI III.A:

In March 2018, the contract for phase 3 of NIPI was awarded to Jhpiego, for a total amount of 73 million Norwegian Kroner (approximately 6.5 million USD, at November 2023 exchange rates). The initial project duration was foreseen for the period April 2018 to end 2021. However, the contract was rescinded, and Jhpiego concluded implementation in June 2019. This implementation period has subsequently been referred to as NIPI III.A.

NIPI III.B

A new call for proposals was launched, and the Centre for Urban and Regional Excellence (CURE, an affiliate of IPE Global) was awarded a contract to implement the remainder of NIPI III (also referred to as NIPI III.B). CURE was already an implementing partner during Phase II of NIPI. The NIPI III.B contract had a total value of 50 million Norwegian Kroner (approximately 4.5 million USD, at November 2023 exchange rates). This contract had foreseen duration for the period July 2019 to June 2021. Two results frameworks were produced during phase III.B, covering 2019-2021, and 2021-2023 respectively to accommodate for the inclusion of a fourth objective related to the COVID pandemic, as well as for a two year no-cost extension that brought end of implementation date to end of 2023.

Considering that very limited activities could be implemented during NIPI III.A, this report focuses primarily on NIPI III.B and unless otherwise specified, findings refer to NIPI III.B.

4.2 NIPI III OBJECTIVES

As presented in its project document, the goal of NIPI III is to "*contribute to achieving the SDGS and GoI's National Health Policy (2017) goals for MNCH*".

NIPI III.A

During NIPI III.A, the programme was working on the following objectives:

1. Strategic, technical assistance (TA) for scaling up of identified NIPI best practices.
2. Strengthening innovation development capacity on MNCH within the public health system.
3. Document best practices in MNCH under the NHM and NIPI.

In the NIPI III.A results framework submitted by Jhpiego, the three objectives were further articulated through 3 outcomes and corresponding 7 outputs.

NIPI III.B

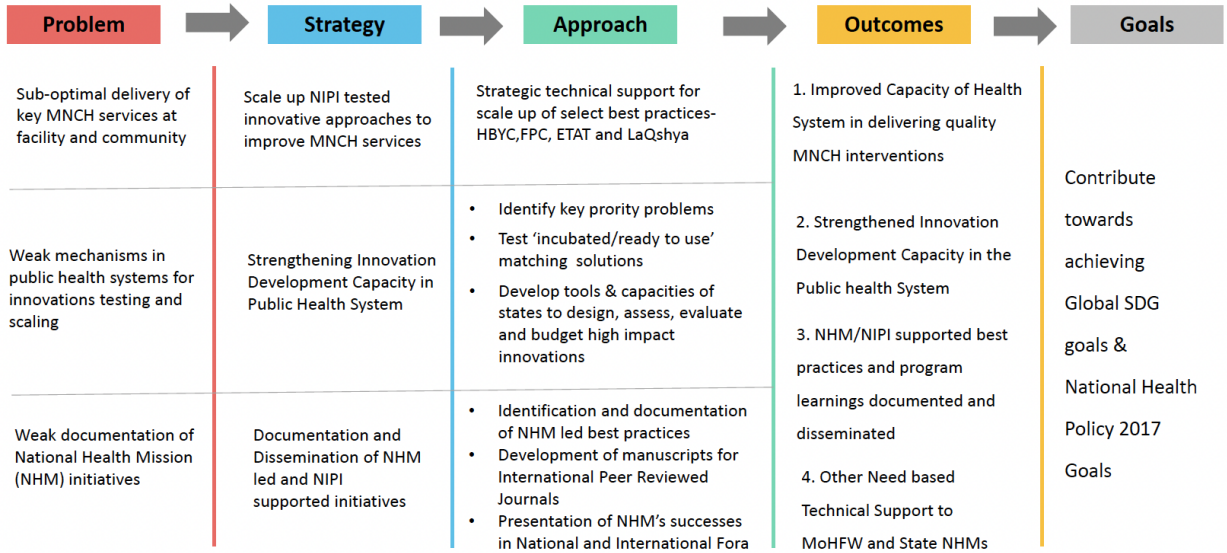
NIPI III (III.B) is currently working on the following three objectives, in line with what agreed in the MoU:

1. Provide strategic technical assistance in scaling up of demonstrated best practices in NIPI supported states.
2. Strengthen Innovation Development Capacity through establishment of Innovation Hub in the public health systems.
3. Documentation and Dissemination of National Health Mission (NHM) and NIPI interventions.

In 2020, with the emergence of the COVID-19 pandemic, it was agreed by the two Governments to add COVID-19 needs based support as a new and time-limited objective *(4. COVID -19 to MoHFW and State NHM and Need based Support to RNE and MoHFW)*, whose COVID component has been concluded. Under this objective NIPI keeps on delivering other needs-based assistance to partner states and to the MoHFW.

The theory of change for NIPI III.B is presented in Figure 3 below.

Figure 3. NIPIII Theory of Change



Source: NIPI III.B Project document

The **results framework initially submitted by CURE for the period 2020-2021** consisted of 3 outcomes and 5 outputs, to be measured with a total of 27 indicators (impact, outcome, output). The results framework refers to expansion of NIPI additional states under outcome area 1 (scaling up of NIPI interventions, up to 11 states were mentioned therein with numbers varying according to the intervention). However, following discussions with MoHFW and the proposed new expansion states, it was determined best not to pursue such expansion.

The **2021-2023 results framework** is structured around 4 outcomes (Outcome 4 related to COVID-19 support and needs-based support added), and one output added under Outcome1: 1.4, Technical support provided for implementation of aspirational district Program in Jammu and Kashmir [11]; Outcome 2 has now a specific output on creation of the Innovation Hub (2.1), and another on application of digital health platforms and of the decision support system (2.3) not foreseen in the earlier version; and Outcome 3 has a new output (3.2) on state/UT publication and dissemination capacity being built. The framework presents a total of 28 indicators (outcome and output level), most of which only measure the number of states/UTs supported. The 2021-2023 framework does not include baseline information, does not reference impact nor intermediate outcomes, and misses indicators related to contribution to national policies or to the achievement of India's SDG targets. The results framework is presented in Annex 4.

After discussion with the RNE and CURE, and in view of NIPI's reporting mechanisms, it was agreed that the review would focus on the latest results framework (2021-2023), which is the most updated and is still valid and being implemented at the time of the review.

[11] This is however understood as support to the implementation of the RMNCH+A strategy in the UT.

4.3 NIPI III IMPLEMENTATION MODEL

NIPI III has its **geographic focus** in the states/UT of Bihar, Odisha, Madhya Pradesh, Rajasthan and Jammu and Kashmir, where innovations are tested in selected districts, and then brought to scale at state and national level. In 2020, NIPI estimated its reach as to 5.4 million women and 11 million under 5 children in the five supported states.[12] As agreed with MoHFW, NIPI activities are concentrated in a subset of districts (aspirational districts) in each supported state/UT, representing between 9% to 34% of the total of districts in the state/UT. In each state/UT, all existing aspirational districts are involved in NIPI activities. This is presented in Table 1 below.

Table 1. NIPI geographic coverage

State/UT	N districts	NIPI-supported aspirational districts	NIPI supported districts, % of total
Bihar	38	13	34%
Jammu and Kashmir	22	2*	9%
Madhya Pradesh	52	8	15%
Odisha	30	10	33%
Rajasthan	33	5	15%
Total	175	38	22% (average: 21%)

** In addition, NIPI tasked by MoHFW with state-wide support for implementation RMNCH+A Strategy*

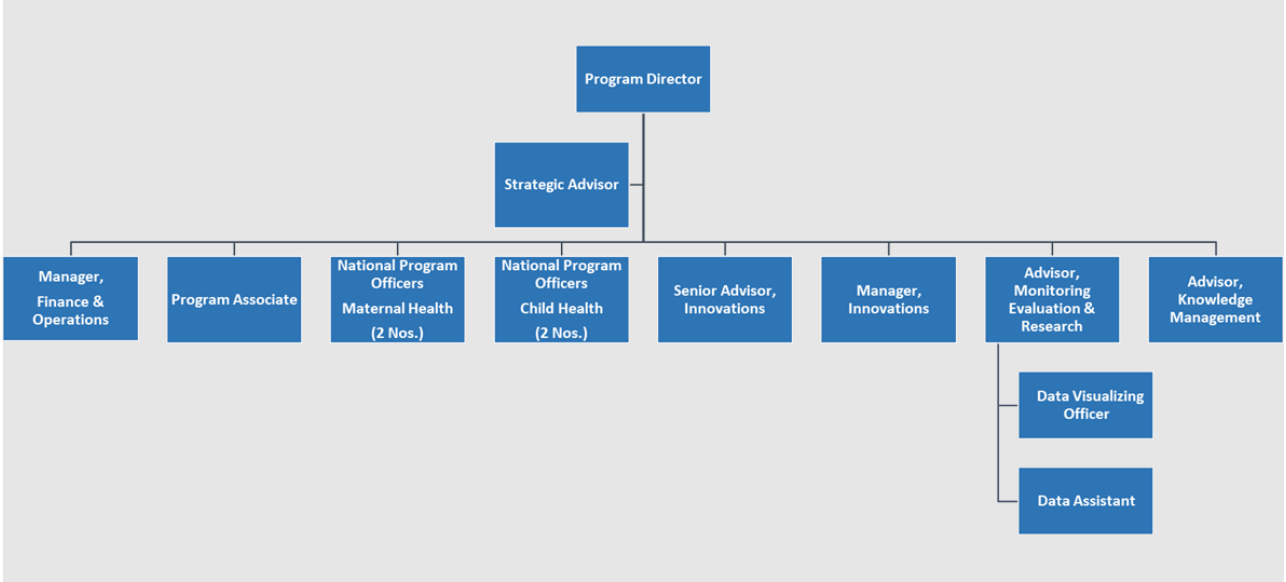
NIPI's collaborative engagement includes working with the GoI, state Governments and NHM to effectively generate ownership and increase commitment at all levels. NIPI works closely with **the Ministry of Health & Family Welfare (MoHFW), Government of India, NHM/State Health Societies (SHSs)**[13] of NIPI supported states. NIPI also collaborates ad-hoc with health resource centres (including the NHSRC - National Health Systems Resource Centre), Norwegian and Indian Institutes (e.g. medical colleges), and other capacity building institutions.

The NIPI programme is implemented through **one national team, and five state-level ones** (one per state/UT). The original composition of the central level NIPI team (national) is presented in figure 4 below. This team, composed of senior thematic experts, has reportedly extensive experience in taking innovation to scale with the objective of ensuring sustainability of the interventions. Individual members equally have knowledge of the MoHFW and of NHMs.

12 NIPI Summary Results Report Submitted to RNE 2020

13 State Health Societies are the state-level representation of the National Health Mission. In this report, they are also referred to as State NHMs.

Figure 4. National NIPI team



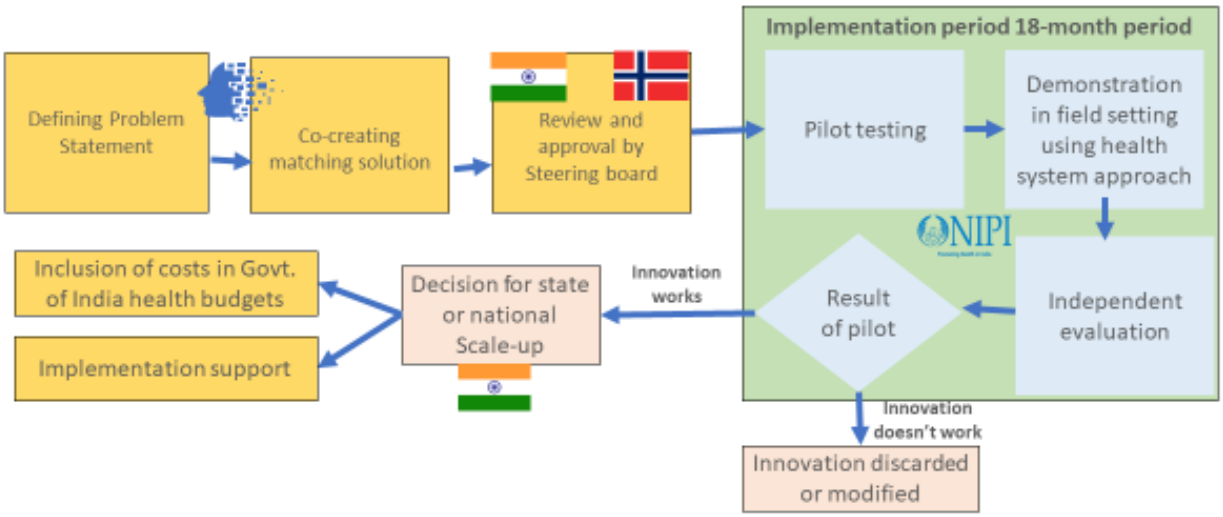
Source: NIPI III.B Project document

At the state level, NIPI teams are smaller, and embedded within the NHM (office space is provided to NIPI teams within the NHM building/campus). NIPI state teams are composed by a team leader (State Lead), two Programme officers (MH, CH), one Innovations Officer, and one Programme Coordinator. At the time of the review, several NIPI staff had left their positions as the grant implementation period was coming to an end.

NIPI model

Figure 5 below represents the NIPI model. Problem statements/public health priorities are identified by supported states/UTs (via their NHM), and possible solutions identified jointly with NIPI through the development of a concept proposal. Once the proposal is approved by the Steering Board, the innovation is pilot-tested and implemented, and potentially brought to scale if the independent evaluation (conducted by NIPI/CURE) is positive, and state NHMs/MoHFW are favourable to scaling up state- or nation-wide.

Figure 5. The NIPI model



Source: NIPI presentation, 2023 results seminar

An **Annual Meeting**, co-chaired by the Secretary Health and Family Welfare, MoHFW, the Norwegian Ambassador, is held on an annual basis. The five participating states/UTs are represented, typically by high ranking NHM officials. Annual meetings are typically held towards the end of each implementation year.

During these meetings, a summary of activities implemented in the relevant reporting period is presented. The Annual Meeting also approves financial statements for the previous year, and the annual workplan and budget for the year ahead. No annual meeting was held in 2019, as the contract with CURE had only recently been signed in October of that year.

NIPI III-supported interventions and innovations

Under its objectives 1 and 2, NIPI III has promoted the scaling up or testing of a series of interventions and innovations, which are presented in the table below.

Table 2. Overview of NIPI III-supported interventions and innovations

Interventions promoted under Objective 1

Intervention	Brief description
Home Based Care For Young Child (HBYC) program	The program promotes provision of comprehensive community-based care to the infants. Accredited Social Health Workers (ASHAs, female community-based workers) conducted four additional home visitation at 3, 6, 9 and 12 months of age for all infants, in addition to mandatory six home visitation provisioned under the HBNC program.
Family Participatory Care/ Kangaroo Mother Care (FPC/KMC)	The program aimed to empower families by creating a conducive environment where providers and family members work together to ensure the wellbeing and survival of the most vulnerable new-borns. The program built upon Kangaroo Mother Care (KMC) and optimal feeding practices for sick new-borns and low birth weight babies.
Paediatric Emergency Triage Assessment and Treatment (ETAT)	Aims to strengthen emergency paediatric services in referral and district hospitals through establishing a systematized process for triage and treatment of sick children. The approach includes strengthening of infrastructure; ensuring logistics and equipment, and capacity building of health functionaries.
LaQshya certification of delivery points	Supporting health facilities in the supported states/UTs to meet the quality standards identified in the LaQshya programme (Improving Quality of Care in Labour Room and Maternity Operation Theatres)
Harmonised Child Health Training Packages	Development of training packages for a range of health cadres

Innovations promoted under Objective 2

Innovation	Brief description
Decision Support System (DSS)	Decision support system for frontline health worker for practicing evidence-based care by assessing severity of symptoms timely and provide appropriate clinical decisions including pre-referral management. DSS has been piloted in three four districts of three states of Bihar, Madhya Pradesh and Odisha.
IPHS Planning cum Assessment tool	ODK based data collection tool for evaluations and assessments of health facilities for IPHS compliance. The tool was piloted in the union territory of Jammu and Kashmir.
Geospatial Mapping of Births, Deaths and Health Services	Geospatial mapping to determine distribution of live births, maternal deaths and access to facility-based health services in the state of Rajasthan.
Setting Innovation Hubs in the States	State innovation hub is a structured mechanism within NHM for internalization of innovation ecosystem in NHM.
AR/VR New-born resuscitation training package	Development of a Virtual Reality and Augmented reality-based training package on new-born resuscitation. The technology enabled multi-users at distinct locations to simultaneously observe, interact and practice newborn care related skills with experts at instructor sites in a virtual setting.

Innovation	Brief description
Self-sampling for cervical cancer screening	Home-based screening program for primary Human Papilloma Virus (HPV). Under the intervention, women aged 30-65 years (approx. 182 per 1000 population), were provided a self-diagnostic HPV kit home based screening for cervical cancer.
QR code enabled Mother and Child Protection (MCP) cards	NIPI has introduced QR code enabled Mother and Child Protection (MCP) cards and QR code scanning functionality in the ANMOL (Auxiliary Nurse Midwife Online) application. Upon scanning the QR code, ANMs get immediate access on the beneficiary details and their due services.
AI- based triaging tool for covid	Artificial Intelligence (AI) powered smartphone-based tool for triaging COVID-19 suspect cases using signature cough sounds acoustics. The core idea was inspired by prior studies that show cough can be used for diagnosis of a variety of respiratory illnesses.
Monitoring dashboard for NITI Aayog indicators	Dashboard developed on WHO accredited DHIS-2 platform. This dashboard helps officials, administrators, and program managers in visualizing and monitoring progress on key 31 Health and Nutrition indicators of NITI Aayog up to block level in union territory of Jammu and Kashmir.

5 KEY FINDINGS

This section presents key findings, by review domain and, within that, by review question.

As noted in the limitations section (Section 3.1), strength of evidence was varying, in particular because NIPI III.B planning and reporting mechanisms presented several shortcomings that made not always possible to assess compliance with what was originally planned. This happened in particular because of a fundamental mismatch between indicators included in the results framework and reporting content of annual and progress reports, which is done primarily at output/activity level. While NIPI implementation advances steadily, it is lacking a systematic documentation and discussion of challenges encountered, and a clear and rigorous recording of forward-looking annual targets and baseline figures to be used as a basis for reporting. The results framework is also not updated to reflect all major ongoing groups of activities.

5.1 REVIEW DOMAIN 1: RELEVANCE

5.1.1 WERE ALL NIPI III OBJECTIVES RELEVANT TO THE NATIONAL HEALTH MISSION AND TO MOHFW, GOVERNMENT OF INDIA? (QUESTION 1.1)

All NIPI objectives are well aligned with national health priorities in the field of MNCH and beyond, and relevant to the MoHFW and NHM of India, as their achievement would contribute to progress towards goals set in national policies, and more broadly towards the Sustainable Development Goals (SDG).

The scaling up of proven, evidence-based MNCH interventions promoted though Objective 1 is relevant to the National Health Policy objective on MNCAH service provision, reduction of maternal, under-five, infant and neonatal mortality. NIPI is similarly contributing to the implementation of a PHC approach, including through the empowerment and training of different cadres of health workers, such as ASHAs.

Relevance of NIPI for national priorities is further exemplified by the fact that several NIPI-supported interventions are listed in the RMNCH+A and in the INAP as key to reducing mortality and morbidity of target populations, including Special new-born care units (SNCUs), follow up of discharged new-borns at community level (SNCU+), Kangaroo mother care (KMC), Home-based new-born care (HBNC), new-born resuscitation (Navjaat Shishu Suraksha Karyakaram or NSSK in Hindi) training, Early Childhood Development (ECD, delivered as part of HBYC), tracking of anaemic women and children, 48h postpartum care (e.g. Yashoda), and more generally promotion of quality of care.

Similarly, the National Health Mission includes multiple NIPI-supported interventions amongst the child health programmes[14], while guidelines developed with NIPI support are equally listed in the NHM child guidelines page[15], testifying not to the relevance of NIPI Objective 1, but also to its achievements.

NIPI-supported interventions and innovations related to quality of care assessments, such as support to LaQshya certification for labour rooms and the development of the Indian Public Health Standards (IPHS)[16] assessment tool are relevant and contribute to national efforts to improve quality of service provision and standardise performance in several domains in health facilities at all levels of the Indian health system. With these interventions, NIPI is indirectly contributing to the achievement of priority actions identified in the INAP, which include provision of comprehensive EmONC and improved quality of care for institutional deliveries.

The prioritisation of maternal, new-born and child health at national level (and as a consequence, at state level) was also evidenced through interactions with key stakeholders, who concurred on identifying neonatal mortality as a fundamental unresolved issue. All stakeholders described NIPI as fully aligned to national priorities, noting how its objectives and the activities carried out by the programme are addressing identified challenges and SDG targets. In addition, NIPI's geographic focus on aspirational districts within states that present higher mortality and morbidity rates can be considered in and of itself a strategic contribution to accelerate progress and therefore achieve the National Health Policy.

5.1.2 WERE ALL NIPI III OBJECTIVES RELEVANT TO THE FIVE SUPPORTED STATES? (QUESTION 1.2)

Evidence supporting these findings was somewhat limited, as additional state-specific policy and strategy documents defining state health priorities could not be retrieved.[17] However, it is essential to note that multiple strategic documents for NIPI supported states/UTs were developed as part of NIPI Objective 3. Examples include, and are not limited to, Odisha State Strategy for Accelerated Reduction of Maternal and Child Mortality (2021 – 2025), the Jammu and Kashmir Roadmap for Reducing Infant Mortality Rate to Single Digit (2018-22), the 2022 strategy for Improving Maternal Survival in Madhya Pradesh, the Accelerating New-born Survival in Rajasthan Strategy Document (2022-2025), and the Accelerating Neonatal Survival, Foundation for the future 2025 strategy for Bihar. This illustrates how NIPI objectives are relevant in these geographies, as all supported states/UT identify these populations as focal for their health programmes. Therefore, NIPI is not only aligned with state objectives, but also plays a crucial role in supporting states and UTs in identifying their health goals and related actions.

Several stakeholders recognised how the creation of state innovation hubs could have the potential to transform the health landscape in India and more so at state level, by creating an impartial and objective procedure to evaluate and test approaches, promoting bottom-up knowledge generation, and allowing to address locally-identified needs with locally-generated innovation concepts.

In several occasions, as documented by official letters directed to NIPI, the highest health authorities of the supported states/UTs have requested NIPI to provide their support in the development of specific project/innovations that responded to state own priorities. Such an example is the COVID-19 dashboard

[14] NHM, Child Health Programmes https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1179&lid=363
[15] Guidelines for COVID Care for children and adolescents, HBYC, and FPC are all available on the NHM website https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1182&lid=364 . The HBYC guidelines acknowledge NIPI support.
[16] The IPHS were revised in 2022, and the Government of India intends 50 percent of its facilities to be IPHS compliant by 2025. Thematic areas included I n IPHS are availability of services, infrastructure, human resource, drugs and diagnostics, equipment, quality assurance and capacity building.
[17] The NHM website, where this information would have been available along with State PIPs, has been malfunctioning throughout the review. Strategy documents additional to those developed by NIPI were requested to inform the review, but not received.

developed by NIPI the UT of Jammu and Kashmir, its integration with MoHFW's *Arogya Setu* Dashboard (contact tracing) and *Swasthya Nidhi* surveillance dashboard.

In addition, NIPI own reports and interactions with key stakeholders illustrate a strong relevance of NIPI objectives for the supported states/UTs. Whether at the NIPI Annual Meetings or through individual interactions, representatives of state health institutions all concurred in recognising the value of NIPI, and the capacity of this programme to support the NHM in maternal and child health, and beyond.

5.2 REVIEW DOMAIN 2: EFFECTIVENESS

5.2.1 TO WHAT EXTENT WERE NIPI III KEY RESULTS ACHIEVED AS PLANNED? (QUESTION 2.1)

It appears that throughout its Phase III, NIPI has been very successful and appears to have overall achieved its key objectives related to the scaling up of proposed evidence-based interventions, the testing and adoption of innovations, the documentation of good practices, and the needs-based support offered during and beyond the height of the COVID-19 pandemic. However, the review found that insufficient detailed information is available on the expected activities and targets for NIPI III.B implementation. It is therefore not entirely possible to examine whether key results were achieved *as planned*. In the absence of clear, forward-looking annual targets for each activity, it is also not possible to determine to what extent these targets have been met (or exceeded).

This section discusses selected highlights by NIPI Objective, and is based on the 2021-23 results framework, and on results reported to the RNE and MoHFW, while a detailed overview of achieved results is provided in Annex 5, presenting an overview of results provided by NIPI for 2019-2023. According to this overview, most targets have been met or surpassed.

Objective 1: Provide strategic technical assistance in scaling up of demonstrated best practices in NIPI supported states/UTs.

Interventions foreseen under this objective were implemented across the supported states/UTs, and the overall targets set in the results framework were met or exceeded, as presented in Annex 5. The magnitude of scaling up is also discussed further in Sections 5.2.5 and 5.2.6.

Under objective 1, NIPI supported the states/UTs in **expanding four key interventions, one of which community based (HBYC), and the remaining three facility-based (FPC/KMC, ETAT, LaQshya).** Strengthening of obstetric high-dependency units was also supported though this objective. NIPI implemented a series of key activities to promote the scaling up, and in particular by supporting orientations and training of trainers, reviews and assessments of implementation of these interventions, and by supporting states in the preparation of costed programme implementation plans (PIPs). Available programme reporting allows to witness a sustained implementation and scaling up of these evidence-based initiatives, but programme annual and progress reports reviewed do not discuss impact/outcome level changes, such as observed improvement in quality of trainings and service provision.[18] Interactions with key stakeholders evidenced positive results, for example an observed decrease in facility-based mortality of paediatric patients following establishment of ETAT, better growth and health monitoring and overall health status of children from districts implementing HBYC. In 2022, NIPI reported that 27,900 mother-new-born dyads had received FPC/KMC. It can be assumed that mothers and families would retain and further apply

[18] Periodic assessments and evaluations of individual interventions/innovations carried out by NIPI were not included in the document sources for this review

new-born care principles learned through the educational sessions, this contributing to improved new-born health.

Under this objective, NIPI also supported the **development and dissemination of five training packages** (New-born stabilisation units -NBSU; neonatal resuscitation – NSSK; integrated management of childhood illnesses – IMNCI; facility-based integrated management of childhood illnesses - FIMNCI for medical officers & Nurse, for a total of 13 Training modules), largely exceeding the intended target of two packages. Information on the operationalisation of these guidelines was not available for this review.

In the UT of **Jammu and Kashmir, NIPI also supported the operationalisation of the RMNCH+A Strategy** as lead development partner. This support was delivered through development of district health action plans, assessment of district hospitals and sub-district health facilities against national quality standards (National Quality Assurance Standards - NQAS, IPHS), and review meetings took place.

Objective 2: Strengthen Innovation Development Capacity through establishment of Innovation Hub in the public health systems

Under Objective 2, a total of nine innovations were supported and tested across participating states/UTs, far exceeding the four foreseen in the results framework (Innovation Hub, DSS, digital health platforms, innovation toolkit). Some key results are discussed below.

Innovation hubs concept notes have been approved and funds put forward in all supported states/UTs, and a Hub has been operationalised in Madhya Pradesh, Odisha and Rajasthan, with a total of 41 proposals submitted and evaluated. In 2023, the Innovation Hub has been approved by the MoHFW for implementation country-wide, and the NHSRC has elaborated guidelines detailing the necessary steps to the creation of state-level Hubs. While the innovation is well received, implementation is too recent to speculate on the expected impact of the Innovation Hub on amplifying local and national innovation capacity.

The **Decision support system (DSS) for frontline workers has resulted in improved diagnosis and referral links for paediatric patients.** This tool is expected to contribute significantly to child health outcomes, as it allows CHOs to accurately diagnose based on identified danger signs and symptoms, promotes rational drug prescription, ensures cases are referred to higher levels of the health system according to need (previously under-referral was observed), and allows CHOs to save time and avoid duplication of patient records.

The **cervical cancer screening through self-collection of HPV samples** has equally had a strong impact in increasing proportion of the target population screened (from approximately 1% to 76% of eligible women), and allowed to determine actual HPV prevalence rate (7%). While with former low screening coverage most cancers would be detected al late stages (3rd or higher), the innovation resulted in much earlier identification of HPV+ and cancer patients, improving survival perspectives. Administered within an urban slum, this innovation has the potential to significantly increase access to treatment, and could over time also improve health seeking behaviour. Stigma towards cancer in fact still represents a challenge, with only 42% of identified patients actually seeking care after the diagnosis despite the health communication messages shared by ASHAs and medical doctors.

The **AR/VR training tool for new-born resuscitation** has been developed in cooperation with *Kalawati Saran Children Hospital*. By allowing multiple trainers to join a session remotely, and through live trainer/trainee interaction, the innovation is expected to contribute to more frequent and better refresher training of health workforce, reducing travel costs for trainers and participants, promoting standardised appraisal, and enabling a broader reach of these educational materials.

Finally, **dashboards were developed to monitor progress in NITI Aayog KPIs for aspirational districts, IPHS and LaQshya compliance, service readiness and utilisation of labour rooms, and anaemia prevalence.**

These tools have been developed by NIPI based on open-source data collection and visualisation tools (ODK, DHIS-2), and collect sex and gender disaggregated data. This information is presented in a user-friendly format, and is being used by states/UTs for to inform decision-making purposes. These dashboards have the potential to contribute to improved resource allocation and prioritisation by providing a real-time, granular picture of key health issues (anaemia prevalence by sex and age groups), progress in health indicators (Aspirational districts, Dashboard) and quality gaps (IPHS, LaQshya).

Objective 3: Documentation and Dissemination of National Health Mission (NHM) and NIPI interventions

Results[19] foreseen under this objective have been achieved, and in some cases surpassed. The **documentation and dissemination of NHM and NIPI best practices took place within and beyond India, including at the World Health Assembly.** This result has been achieved through a series of activities, including development of peer-reviewed papers co-authored by NHM and NIPI, coffee table books, and presentation of NIPI innovations at the National Summit on Good & Replicable Practices and Innovations in Public Healthcare System, and at the Global Digital Health Forum (2021). Multiple NIPI-supported interventions were included in the Reproductive, Maternal New Born Child and Adolescent Health success stories document published by WHO SEARO (2021), while a case study on FPC was presented at the 71st World Health Assembly (2018). The DSS was granted the prize as best MNCH innovation at the 2022 Commonwealth Digital Health Innovation Awards. Co-development of peer-reviewed papers is expected to have contributed to increased research and dissemination capacity at state level.

The NIPI website[20] has been visited by 7,955 users between October 2020 and April 2023, of which close to 89% connecting from India, for a total of 28,607 page views[21]. The website has the potential to be an effective tool to amplify NIPI's achievements. Several **NIPI newsletters** were developed, collating news items presented on the website. Newsletters are typically about 20-pages long, and are available on the website as PDF. The newsletters page specifically received about only 1% of the total page views for the website, it was not possible to determine whether/which newsletters were downloaded, and with which frequency.

The **development of strategy documents for supported states/UTs**, a very prominent part of what was eventually performed under objective 3, was originally not part of this objective and this output has not been included in the results framework[22]. As mentioned in Section 5.1.2, NIPI supported states and UTs to draft and disseminate several roadmaps and strategies related to MNCH and COVID-19 management.

The NIPI proposal included as part of its implementation strategy the dissemination of NIPI best practices and innovations to other countries, in particular by taking advantage of IPE Global's presence outside India[23]. However, this knowledge dissemination approach was not taken forward. Another missed opportunity is the lack of documentation of collaborations and synergistic actions with other development partners, as foreseen in the project document.

Objective 4: COVID -19 to MoHFW and State NHM and Need-based Support to RNE and MoHFW

Objective 4 encompasses all needs-based support provided through NIPI, and allows to build in a strong flexibility component that has been highly appreciated by national and state counterparts. Throughout the COVID-19 pandemic, NIPI has been supporting states through a range of activities, including by contributing to monitoring of vaccination data, training of health workers on COVID-19 management, and by

[19] This objective also includes the evaluation and assessment of NIPI-supported interventions, which is a crucial part of the NIPI model discussed earlier, and in particular of the testing of innovations process. Evaluation and assessment processes seem therefore to be a better fit under Objective 2.
[20] https://www.nipi-cure.org/
[21] source: website statistics shared by the NIPI team, November 2023.
[22] However, development of a strategy does not necessarily contribute to the objective of documenting and disseminating good practices.
[23] IPE Global has country offices in UK, Ethiopia, Kenya, Myanmar, Bangladesh, Nepal and Philippines.

exceptionally procuring personal protective equipment. NIPI was also designated as key partner consortium at the national level for COVID-19 communication strategy, and developed communication and stigma reduction materials for dissemination in supported states/UTs.

Additional needs-based support included multiple activities, such as revision of the INAP, development of various guidelines, support to the Human Milk Bank.

5.2.2 IF RESULTS WERE NOT ACHIEVED AS PLANNED, WHAT CAUSED DEVIATION FROM THE ORIGINAL PLANNING? (QUESTION 2.2)

Available information on implementation planning is insufficient to give an informed answer to this review question, and it is therefore not possible to fully assess whether activities have deviated from original planning. Two factors were identified as having impacted NIPI III execution:

- As recognised by all parties involved in the review, **COVID-19** struck shortly after the start of NIPI III.B and, as it can be expected, the GoI and MoHFW faced the imperative of addressing the pandemic. Pandemic response absorbed most available resources and became the most pressing priority for the country, requiring amongst other things a reconversion of facility and community-based health workforce towards COVID response, with a negative impact on NIPI supported initiatives.
- The **change of implementing partner** also halted implementation for a period, and slowed down activities at the beginning of NIPI III.B. However, a no-cost extension was granted in 2021, to allow NIPI to recover the implementation lag resulting from COVID-19delays.

5.2.3 WHAT WERE THE KEY ENABLERS IN THE IMPLEMENTATION OF PROGRAMME ACTIVITIES? (QUESTION 2.3)

Stakeholder perceptions suggest that a range of enablers were crucial to support the implementation of NIPI activities and, by extension, the achievement of its results. The specificities of NIPI's model and of the interaction with the NHM are reported to have played the most decisive role. Implementation enablers can be grouped around the following recurring themes:

- **A lean model, backed by high-level political commitment.** NIPI teams, at central as well as at state/UT level, are relatively small, and they are reported to be able to easily and seamlessly work with the NHM and supported states/UT. This agile structure is also mirrored in NIPI's governance and in its consensual decision-making procedures, both of which concentrate around the Annual Meetings. Essential to NIPI's capacity to achieve its goals is having high-level representatives of Norway and of MoHFW as co-chairing the Meetings and high ranking NHM officials as participants, a fact that confers a strong political clout to decisions made during these reunions, ensuring these are fruitfully put into effect and followed up closely.
- **Ongoing, bi-directional flow of information and ideas.** Also as a result of the lean implementation structure, NIPI's national team is in constant communication with the state-level ones, a fact that ensures an ongoing exchange of information between the various levels. The central team, with additional support from staff and consultants from CURE/IPE Global as needed, is also available to complement the capacity of state teams, filling in any crucial skills gap encountered, without the need to expand the human resource pool employed by the programme. This flow of information, knowledge and ideas also incorporates perspectives of MoHFW, via the national team, and of the five state NHMs , via their respective teams, resulting in increased effectiveness, cross-pollination and mutual learning.

- **Strong understanding of and close collaboration with NHM**. NIPI's embeddedness in the NHM of supported states/UTs was the most commonly mentioned enabler. Key elements are not only the physical location of NIPI state teams' offices within state NHM premises, but also the fact that most team members are former NHM staff, and have therefore an in-depth understanding of its functioning and priorities, as well as an established professional network. NIPI staff are therefore familiar and easy to reach, and are perceived by many as working as "an extended arm of the NHM".
- **Alignment with national and state priorities.** As a corollary of the above point, one reported unique element differentiating NIPI from other externally supported programmes, is the fact that NIPI is not perceived as promoting an agenda of its own, nor to be representing Norway interests or priorities. On the contrary, stakeholder praise its full alignment to NHM, state and national objectives, and many recognise how NIPI's ability to support NHM with technical and managerial support necessary to achieve its goals has led to increased ownership and buy-in from national institutions, further stimulating implementation and scaling up of interventions.
- **Continuity of the NIPI teams** has been promoted and achieved to a large extent, as several team members have been involved in two or even all NIPI phases. This plays a role not only in enabling the close working relationship with the NHM and across NIPI and health systems levels, but also implies that valuable institutional memory and increasing technical capacity is rooted within NIPI, enabling its teams to provide better and more targeted support to the NHM.
- **Flexibility to respond to changing circumstances and needs.** With the most striking example being the provision of personal protective equipment through NIPI funds when the COVID-19 pandemic hit India, NIPI has over time been able to adapt and meet the needs of MoHFW and supported states/UTs. In this sense, it is particularly valuable the provision of "needs-based support" foreseen under programme Objective 4, which has been employed in the COVID response and beyond. Flexibility of NIPI response and of NIPI teams permeates also the day-to-day working relationship with the NHM, with state stakeholders reporting very high satisfaction with NIPI's capacity and availability to address requests, even under short time requirements, and at times also beyond NIPI's original thematic MNCH focus (e.g. HPV screening).

5.2.4 WHAT WERE THE KEY CHALLENGES AND BOTTLENECKS IN THE IMPLEMENTATION OF PROGRAMME ACTIVITIES? (QUESTION 2.4)

As already indicated, bottlenecks encountered, and solutions adopted to overcome these are not well documented. This, in addition to observed reluctance and/or inability of key stakeholders to identify implementation bottlenecks or other challenges provides scant evidence to address this review question. Despite this critical limitation, it was still possible to identify some implementation bottlenecks, listed below. It is worth mentioning that almost all of these bottlenecks were mentioned only once or a handful of times by stakeholders consulted, a factor which does not allow to generalise these findings.

- Occasionally, significant effort had to be placed into generating acceptance for NIPI-promoted interventions and innovations, whose necessity and added value were not necessarily apparent to institutions and professionals who already had an approach in place to address certain health priorities or issues, despite interventions/innovations being approved by MoHFW and NHM.
- Connected to the previous point, in some cases it was observed how more and better data could have backed the introduction of innovations.

- Related specifically to the HPV self-testing innovation, a persistent challenge is that of mobilising identified HPV cases to undergo treatment. This is linked to widespread stigma associated to cancer, and is being addressed though health education messages being delivered by ASHAs and medical professionals.
- Additional implementation challenges are related to availability of health workforce necessary to implement activities, lack of dedicated physical spaces within facilities (in particular for ETAT and FPC), and workforce capacity to implement certain tasks.
- Regarding development of manuscripts, some challenges were encountered regarding accessibility of data, data quality, and time needed to obtain the necessary authorisations for data use.

Overall, NIPI does not seem to have encountered major obstacles to implementation of activities. This should however be corroborated by additional evidence.

5.2.5 TO WHAT EXTENT WERE NIPI-SUPPORTED INNOVATIONS SCALED UP BY STATE GOVERNMENTS? (QUESTION 2.5)

Specifically with regards to NIPI Phase III, the majority of NIPI-supported interventions and innovations were scaled up by state Governments, on select occasions state-wide. Full details are presented in Annex 5, while key examples are provided below:

- The **Geospatial mapping of access to and utilisation of health services** was tested in one Rajasthan district, and currently expanded to all 33 districts of the state.
- The inclusion of **QR codes on mother and child protection (MCP) cards** has been tested in two districts in Odisha, and is currently adopted state-wide (all 30 districts).
- HBYC, which initially tested in 13 districts in the four supported states, was over time expanded to 149 districts, including in Jammu and Kashmir (J&K was not involved in testing).
- ETAT was scaled up in 14 units in four districts. During COVID- 19, these 14 ETATunits were integrated into Paediatric Intensive Care Units
- FPC/KMC was scaled up in all states, and most notably in Bihar, Rajasthan and Odisha, which at present are implementing FPC/KMC respectively in 38, 56 and 60 units. FPC is now implemented in a total of 169 units across the supported states/UTs.
- The DSS was initially tested in 2 districts (Madhya Pradesh and Odisha), and is now implemented in a total of 46 districts, 30 of which in Odisha.

5.2.6 TO WHAT EXTENT WERE NIPI-SUPPORTED INNOVATIONS SCALED UP BY THE MOHFW? (QUESTION 2.6)

Most NIPI-supported interventions and innovations have been scaled up well beyond NIPI supported states/UT, and in certain cases these have been adopted as a pan-India standard. Some examples are presented below, and a full overview is presented in Annex 5[24]:

- The **Innovation Hub** has been approved for institutionalisation across India, with support of the National Health Systems Resource Centre[25] (NHSRC). In 2023, the NHSRC has developed

[24] Other products developed under Objective 3 (e.g. evaluations and assessments, per-reviewed articles) are reported as being scaled up nation-wide. However, the publication of a document is not considered as a scalable or scaled up interventions for the purposes of this review and these activities are therefore not covered in this Section.

[25] The NHSRC is a think tank established in 2007, and mandated to support the MoHFW. See https://nhsrcindia.org/

guidelines directed to all states, detailing the steps and requirements for the process leading to the creation of state Innovation Hubs.

- The **India Public Health Standard Assessment tool** (IPHS tool) has been pilot tested and evaluated beyond NIPI-supported geographies. Three of the 7 States where the tool was tested were NIPI-supported ones (Andhra Pradesh, Assam, *Bihar*, *Madhya Pradesh*, Maharashtra, Mizoram and *Odisha*). The process has been scaled up country wide.
- The **MusQan guidelines** (paediatric quality of care) and **five training packages** were developed with NIPI support and disseminated at national level.
- The **AR/VR neonatal resuscitation training** was tested n Odisha, and its demonstration scaled at national level.
- Even though not covering the entire country, the **Home Based Care for Young Child (HBYC)** intervention was scaled up to 600 districts across India (78% of country total). This expansion happened across NIPI Phases, with Phase III accounting for 149 of these districts as already mentioned above.

5.2.7 WHAT WERE THE SUCCESS FACTORS ALLOWING TO SCALE UP? (QUESTION 2.7)

Many of the factors that enabled implementation also contributed to creating a conducive environment to scaling up of NIPI interventions, and in particular the close working relationship between NIPI, the MoHFW and the supported States/UTs NHM, the strong political support, and the relevance of NIPI objectives to achieve national and state NHM priorities. A limited number of additional enablers were identified through review of available information. These can be summarised as follows:

- **Availability of financial resources to support scaling up**. A pillar of NIPI's catalytic approach, availability of necessary funds at state and central level was the motor of scaling up processes. NIPI teams played a pivotal role in supporting state NHMs in the development and discussion of state budgets, for inclusion in the annual state Programme Implementation Plans (PIP).
- **Experience and trust built through a long-term commitment**. While this review focuses on NIPI Phase III, it is undeniable and worth noting that the preceding phases have set the ground for a successful implementation period. As an example, interventions being scaled up during Phase III were introduced in earlier NIPI phases. The fact that their implementation had already been tested on the ground, and challenges had been addressed jointly by NIPI and NHM, facilitated the scaling up sought through current Objective 1. This is in line with the design of NIPI phase III.
- **NIPI's mandate and capacity to promote evidence-based, low-cost interventions and to test innovations suitable to state and country needs.** Stakeholders have described NIPI as a risk mitigator, and as "*an NHM for the NHM*"[26]. NIPI is perceived as a safe space to test and incubate innovations, accompanied by a review of results informing the conclusion whether to test further, adopt or reject innovations, which are often locally identified or at any rate adapted to the local context. By virtue of this model, the MoHFW and NHM can shift onto NIPI the more risk-taking testing component and can focus their efforts onto scaling up those initiatives that are found to adequately address country needs.

[26] This refers to NHM's role as a programme aimed at supporting the MoHFW in achieving its goals.

5.2.8 WHAT WERE IDENTIFIED BOTTLENECKS TO SCALING UP? (QUESTION 2.8)

Also in this case, available information is insufficient to identify generalisable findings supported by evidence. As mentioned previously, challenges appear to be documented and analysed only sporadically, and stakeholders would not seem to recall meaningful bottlenecks to scaling up.

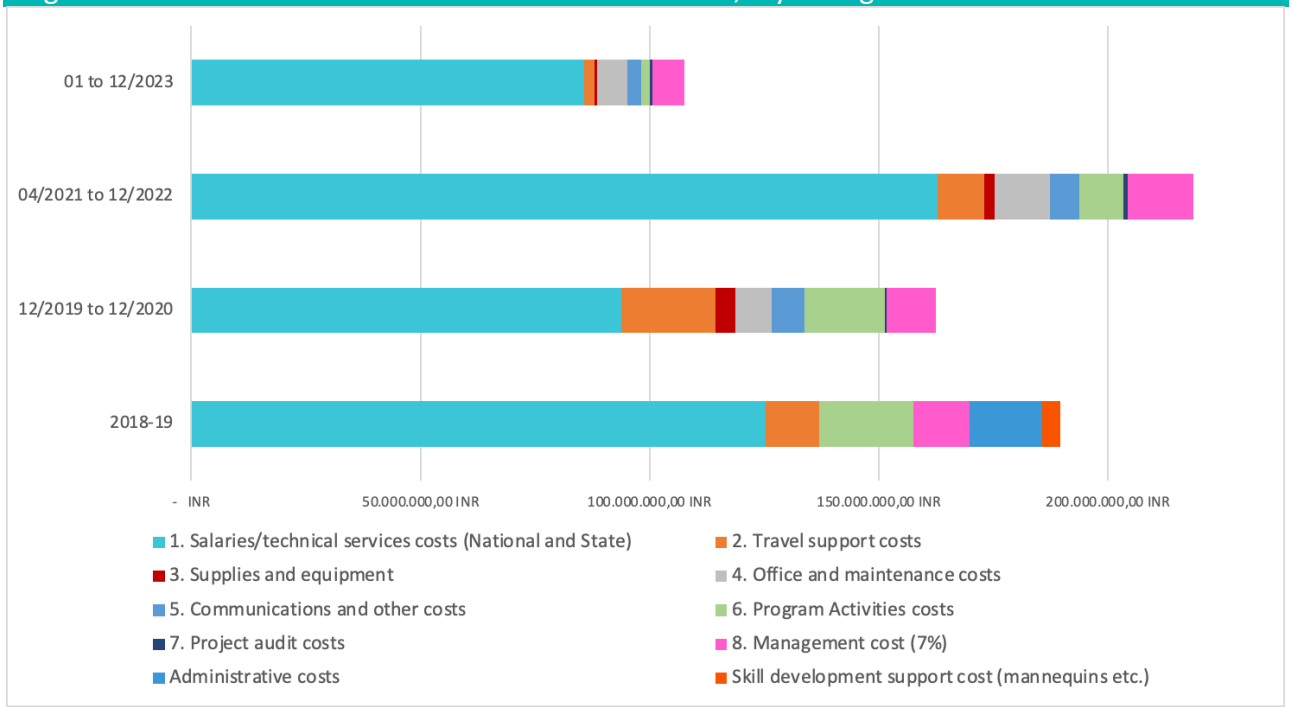
One factor to be taken into consideration and likely to impact/have impacted scalability of interventions and innovations is the remarkable diversity that characterises India, both among and within states/UTs. This diversity encompasses multiple aspects, including those related to geography (remote areas), population size and composition (including challenges related to ensuring service provision to tribal or migrant population), availability of necessary funds (not all states have the same resource envelope), and health workforce availability and capacity.

5.3 REVIEW DOMAIN 3: EFFICIENCY

5.3.1 WERE AVAILABLE FINANCIAL RESOURCES USED EFFICIENTLY DURING NIPI III IMPLEMENTATION? (QUESTION 3.1)

Incomplete information was available to address this review question, and findings are based primarily on summary budgets presented at the NIPI Annual Meeting. These budgets are organised around eight budget lines, and namely 1) salaries of NIPI staff (national and state); 2) travel costs (national and state); 3) Supplies and equipment; 4) Office and maintenance costs; 5) Communications and other costs; 6) Programme activity costs (for all NIPI Objectives); 7) Project audit costs; and 8) Indirect operational costs (7% of total). The figure below presents an overview of the allocations by year and budget lines.

Figure 6. Overview NIPI 3 financial allocations, by budget lines*



** source: figure developed based on available NIPI summary budgets.*

As it can be observed, salaries of NIPI staff represent consistently the highest proportion of total expenditure, ranging between 58% and 80% of the annual total. This can be expected for a technical assistance programme like NIPI, where human resources represent the major input and the bulk of programme activities are implemented with NHM own funds.

Annual budgets for NIPI are variable in overall amount, ranging between 107 and 218 million Indian Rupees (14 and 28 million Norwegian Kroner and 6 and 13 million USD, at November 2023 exchange rates). As noted,

the change of implementing partner and the sudden onset of a global pandemic slowed down implementation and resulted in unspent resources, which became the basis for the no-cost extension granted in 2021. Available annual financial audits for NIPI 3[27] found no irregularities. The relative budget utilisation rate is summarised in the table below.

Table 3. Overview of budget utilisation rates, by line item

Expenditure heads	07/2019 to 12/2020	01 to 12/2021	01 to 12/2022	Average, 07/2019 to 12/2022
1. Salaries (National and State)	94%	94%	101%	96%
2. Travel costs (National and State)	19%	60%	109%	63%
3. Supplies and equipment	34%	60%	52%	49%
4. Office and maintenance costs	92%	89%	93%	91%
5. Communications and other costs	40%	54%	103%	66%
6. Program Activities costs	48%	90%	101%	80%
7. Project audit costs	-	59%	59%	59%
8. Management cost (7%)	74%	88%	100%	87%
Total	**74%**	**88%**	**100%**	**87%**

** source: developed from available NIPI audit reports*

As it can be observed, supplies and equipment, project audit, travel and communications are the budget lines with average lower spending. Reasons for underspending are not further documented and therefore additional analysis cannot be performed.

While most stakeholders felt they were not in the position to assess in detail NIPI's financial efficiency as they were not familiar with available resources, when considering efficiency in a broader sense they had overall very positive views, with a reported perception that NIPI accomplishes large results if compared to the relatively small programme costs. It should be noted however how this perception also looks to results achieved through NIPI's leveraging approach, whereby costs for health service delivery resulting from programme activities are covered by states/UTs.

Some stakeholders considered that insufficient human and financial resources are available to NIPI, when compared with the desired impact or to the intention to expand NIPI activities to a larger scale. Several of them suggested NIPI's support to NHM could expand to cover more districts, with the placement of NIPI staff at district level. However, this suggestion conflicts with the intentionally lean, strategic and catalytic model of the programme.

5.3.2 WAS THE TECHNICAL ASSISTANCE PROVIDED THROUGH NIPI DELIVERED EFFICIENTLY, AND WAS IT RELEVANT TO STATES AND MOHFW? (QUESTION 3.2)

Interactions with key stakeholders revealed a high level of satisfaction with the way NIPI provides technical assistance to the NHM in supported states/UTs. The relevant experience and expertise of NIPI team

[27] Audit report for 2018-2019 was not received, and according to figures presented in the 2019 audit report, it appears that no funds were used in 2019 to perform project audit. An audit report is not available for 2023, as this end- review took place before the end of the financial year.

members were praised, and considered very relevant to augment the capacity of the NHM, and to support the MoHFW.

Some stakeholders reflected on how NIPI activities would typically be completed on time, meeting the required objectives, and as already mentioned be designed and implemented in full alignment with state and national goals. Others suggested that NIPI, by adding expertise and supporting steady implementation, contributed strongly to the achievement of the desired results by the NHM within a shorter timeframe than it would have otherwise been possible.

5.3.3 DID THE TECHNICAL ASSISTANCE PROVIDED THROUGH NIPI STAFF MEET THE QUALITY REQUIREMENTS AND NEEDS OF SUPPORTED STATES? OF MOHFW? (QUESTION 3.3)

Annual meeting minutes and interactions with key stakeholders confirmed a high level of satisfaction with the quality of the technical assistance provided through NIPI. All parties recognised the sound technical skills of the NIPI teams, and several positively evaluated the possibility of having those skills temporarily augmented through the ad-hoc involvement of consultants.

Technical skills and expertise, institutional memory, close familiarity with the NHM, and a close and trusted working relationship all contributed to a very positive assessment of NIPI teams. NIPI teams are involved in the day-to-day work of the NHM, are requested to provide inputs to key strategic documents, PIPs, and other crucial processes. NIPI team members are considered skilled, flexible and versatile, able to provide advice on public health issues and to devise technologically sound approaches to felt needs: a case in point is the development of open-source-based tools for assessment and evaluation of health programmes (IPHS assessment tool[28], geo-mapping dashboard, etc).

5.4 REVIEW DOMAIN 4: SUSTAINABILITY

5.4.1 WHAT IS THE LIKELIHOOD THAT BENEFITS GENERATED BY NIPI III WILL LAST AFTER THE PROGRAMME ENDS? (QUESTION 4.1)

All stakeholders concurred in suggesting that interventions that have been institutionalised and included in PIPs are expected to continue, and their implementation would not be affected if NIPI support was to be interrupted. It was generally recognised how these interventions are now to be considered part and parcel of India's approach to MNCH priorities, and as applicable they could eventually be scaled up at whole-of-state/UT or whole-of-India level. The knowledge and institutional implementation capacity generated through NIPI interventions are in this sense benefits that can be expected to outlive the programme.

Inclusion of interventions in PIPs equally signifies that financial resources are available and have been allocated to support implementation of a given activity. As an example, the supported states/UTs have proposed in the 2022-23 financial year a total of 83.2 million Indian Rupees (approximately 11 million Norwegian Kroner or 1 million USD) for the implementation of the Innovation Hub, and an almost equal amount for the 2023-24 financial year[29]. NIPI reports that the overall financial investment of GoI over Phase III is 26 times higher than resources made available through the programme. This sizeable and continued financial investment contributed by the GoI points at a very likely long-term sustainability of interventions and innovations already scaled up significantly or adopted nation-wide.

On the other hand, a vast majority of stakeholders expressed concerns related to innovations that are still being piloted, or that are at early stage of implementation, such as the Innovation Hub. According to them,

[28] Developed with support from the National Health Systems Health Resource Centre (NHSRC).
[29] As reported in NIPI presentations

while financial resources are already made available by supported states and UTs, these activities may lose momentum, and part of the advances may be lost in the absence of continued technical and managerial support received by NIPI. Furthermore, some stakeholders pointed out that, moving from a process innovation to systemic change is a process that typically takes several years to complete. As an example, while the dissemination of a guideline testifies to the intention of scaling up and sustaining a given approach or intervention, several hurdles could get in the way of its full and correct implementation on the ground.

While considering NIPI's overall implementation strategy and guiding principles, it is however evident that the approaches to sustainability and exit strategy described in the project document have not been put into effect. The project document made an explicit commitment to "*plan for exit from the outset*", and to "*build capacity of managers so that oversight of the program can be transferred to local government institutions. Capacity building in year one will lead to co-management of the program in year two. Complete hand-over to local managers will be achieved at the close of the programme*". This has however not materialised, reportedly because there has not been any clear request for the programme to wind up, with interest for continued NIPI support being voiced by the MoHFW. It is worth considering that sustainable capacity building can and should be pursued (and potentially even more so) in the context of an extended collaboration. Several stakeholders concurred in affirming that an exit plan for NIPI is long overdue, and how this should be carefully planned and executed, in order not to leave a void that could not be filled by local capacity or by other partners.

5.4.2 WHAT HAVE BEEN KEY SUCCESS FACTORS AND BOTTLENECKS TO ENSURE SUSTAINABILITY OF NIPI III? (QUESTION 4.2)

Success factors promoting NIPI's sustainability are primarily related to issues already discussed in previous sections, and can be summarised as follows:

- India's **financial resource availability** has allowed to test and scale up a number of interventions. Adequate budgets have been made available for their implementation, and a shortage of financial resources is not likely nor foreseeable.
- NIPI's **model promotes ownership of interventions** in a number of ways, and especially by requiring states/UTs to allocate funds, promoting identification of public health issues within states and UT/s, and by facilitating the review and testing of locally identified innovations in response to these. This is accompanied by a high political clout associated to NIPI's annual proceedings, a fact that stimulates implementation and follow up.
- **Interventions being scaled up are evidence-based and have already shown results** and suitability to the local health system in their piloting phase. They are therefore institutionalised rapidly, and broadly.

The main bottleneck to sustainability of NIPI benefits is represented by the limited institutional capacity to manage and sustain the innovations. Several state-level stakeholders expressed concern that NIPI absence would represent a major drawback, as a set of activities are de facto delegated to NIPI teams, NHM relying heavily on NIPI's capacity to take on a meaningful and increasing workload. Institutional capacity gaps seem far from being filled, and as already evidenced an adequate capacity building and exit strategy have not been put into place in NIPI Phase III. The NIPI III.B project document also foresaw that *"the staff provided in MoHFW will be transitioned to the country health systems (National Health System Resource Centre, NHSRC)".*

5.5 REVIEW DOMAIN 5: COHESIVE COPERATION

5.5.1 WHAT WERE THE KEY CONTRIBUTIONS OF NIPI TO THE MISSION AND GOALS OF THE NHM AT NATIONAL AND/OR STATE LEVEL? (QUESTION 5.1)

As already been discussed under the relevance section above (Section 5.1), NIPI objectives are closely aligned with national and state level priorities, and synergistic to them, therefore their implementation is in and of itself a contribution to the achievement of these goals. Similarly, Section 5.2 on effectiveness also provides some information on results achieved and magnitude of scaling up, once again representing a contribution to state and national objectives. It should be noted that, in the UT of Jammu and Kashmir, NIPI is active in two aspirational districts with its standard programming, and has also been identified by the MoHFW as the lead development partner for the implementation of the RMNCH+A Strategy, and is therefore likely to have an even higher contribution.

When perceptions of key stakeholders are examined, once again these are extremely positive. Several stakeholders recognised that the NHM and NIPI were created in the same time period (2005 and 2006, respectively), and have evolved together, working side by side, and many consider NIPI to be "*an extended arm*" of the NHM. State-level stakeholders were very appreciative of NIPI's contribution under all objectives. Examples quoted include NIPI's role in the development of programmatic documents (e.g. aspirational districts health action plans, PIPs), strategic ones (under Objective 3, and related to MNCH but also COVID-19), of dashboards that inform prioritisation and resource allocation processes (e.g. IPHS tool, anaemia dashboard/ODK tool), and tools that allow for better and more standardised service provision at community level (e.g. DSS tool).

This review is not powered nor designed to disentangle causality links and ascertain a quantifiable contribution of NIPI to the generalised improvement in maternal, neonatal and child health indicators observed in India, nor in the supported states/UTs. A different methodological approach would be required for such effort, for example that of an impact evaluation including a detailed contribution analysis of disaggregated data comparing supported and non-supported districts and states (counterfactual), bearing in mind that individual NIPI Phases are too short to generate measurable impact on mortality statistics. In fact, it would be advisable that information on generalised reduction of mortality rates in India/in supported states and UTs was not presented as such in NIPI reports before an adequate impact analysis is carried out, as several other factors are contributing to these results, for example support provided by other development partners in MNCH and health more broadly in NIPI-supported states and other Indian states, implementation of several health/MNCH programmes led by MoHFW and NHM, and many other factors and processes external to the health sector (e.g. economic growth, social protection policies, etc).

5.5.2 HOW IS NIPI PERCEIVED AS A TECHNICAL DEVELOPMENT PARTNER AT NATIONAL AND STATE LEVEL? (QUESTION 5.2)

As mentioned in several instances throughout this report, NIPI enjoys very high consideration across stakeholder groups. This applies not only to the programme as an organisation, but also to its staff, skilled to provide necessary technical and managerial support to their counterparts. This extremely positive appraisal of NIPI was evidenced in all MoHFW and NHM contributions to all Annual Meetings, in official communications, as well as through the interactions that informed this review.

Institutional stakeholders concurred that NIPI is a valid and appreciated development partner. Many considered NIPI to have created a brand for itself within India, and have gained increasing importance, being invited to contribute to numerous strategic processes at both state (strategy development, PIPs, etc) and national level (INAP revision, development of guidelines and training modules, etc.). NIPI concentrates expertise and creates new communication channels: the sharing of ideas and implementation experiences

across supported states/UTs is also positively appraised, along with NIPI's very focused technical approach on MNCH.

As alluded to in earlier sections of this report, stakeholders were very appreciative of NIPI's alignment, and of the fact that NIPI's support is provided in a holistic way, respecting locally identified priorities and not promoting any secondary agenda. Unlike other externally supported programmes, NIPI has been able to work within the system, without creating parallel structures, as foreseen in its model. Other unique features of NIPI are represented by its long-term involvement, allowing to identify and to try out innovations under relatively controlled conditions, and most crucially at the desired pace, while creating a strong working relationship with NHM.

5.6 REVIEW DOMAIN 6: CROSS-CUTTING ISSUES

5.6.1 TO WHAT EXTENT WERE CROSS-CUTTING ISSUES TAKEN INTO CONSIDERATION IN THE DESIGN AND IMPLEMENTATION OF NIPI III?

Cross-cutting issues are mentioned only marginally in the NIPI III.B project outline (gender and environment) and detailed project document (anti-corruption, environment, gender equality and human rights are only included in the risk analysis). NIPI Phase III did not include any activity intended to have an impact on any of these cross-cutting issues, however its implementation has reportedly made some contributions, as detailed further below.

Anti-corruption

The Innovation Hub concept promotes impartiality and implementation/testing of innovations promoted by a range of stakeholders, regardless of their role or of their support networks. This has been considered by some stakeholders as an approach that limits the extent to which decision-making and allocation of funds could be influenced by corruption and nepotism.

Environment and climate change

Stakeholders reported how medical waste generated as a result of NIPI-supported activities is disposed of in compliance with existing rules and regulations. Carbon footprint of NIPI implementation was reduced by carrying out online meetings, limiting field missions for the national team, having state-level teams visit only key districts, and whenever possible by sharing of vehicles with NHM colleagues involved in supervision or other field visits.

Gender equality and women's rights

NIPI III targets women and girls (girl child) primarily with the aim of improving health outcomes and reducing mortality, and not with a view to transform existing gender imbalances. The 2022 annual report mentions that gender analysis and planning is performed as part of NIPI implementation, however this could not be corroborated through available evidence. Gender equality is not promoted through programme hiring practices, as the vast majority of NIPI III staff are males. NIPI III contribution to gender equality and women's rights is delivered through the following:

- By promoting active involvement of all family members (including men) in new-born and child care, NIPI interventions could contribute to change existing gender norms;
- Empowerment of female health workers (ASHAs, CHOs, Yashodas) through training and job aids (e.g. DSS tool) enable them to take on increasing on-the-job responsibility and increasingly participate in decision-making;

- Collection of gender-disaggregate data for service utilisation, for example for SNCUs and ETAT, where gender ratio of inpatient is monitored, and as applicable also with reference to selective abortion;
- Gender-disaggregated data collected through NIPI is also reportedly used for decision-making by partner states' NHM.

Human rights

NIPI III activities encompass a human-rights approach, by increasing access to improved and essential health services for vulnerable, remote and underserved populations; hence advancing the right to health of target populations, and more generally advancement towards national and global goals aimed at reducing inequality and ensuring universal health coverage.

5.7 REVIEW DOMAIN 7: FUTURE DIRECTIONS

5.7.1 IF THE NIPI PROGRAM WERE TO CONTINUE, WHAT WOULD BE THE KEY POSSIBLE STRATEGIC WORK AREAS IN BETWEEN NORWAY AND INDIA IN HEALTH BEYOND 2023 FOR ATTAINMENT OF THE SDGS? (QUESTION 7.1)

In September 2022, the MoHFW Secretary expressed in a letter their appreciation for NIPI's results and for the valuable bilateral cooperation between Norway and India. In the same letter, they informed the RNE that the mandate of the NHM, originally running until 2024, had been extended until 2026. The Secretary noted how a matching extension of NIPI would be beneficial to support both countries' combined efforts to achieve India's national health policy, and the SDGs. In early November 2023, the RNE confirmed the intention of the Norwegian Minister of International Development to extend the partnership until 2026.

Stakeholder perceptions, extremely positive towards NIPI's overall relevance and performance, were equally favourable to an extended collaboration. Most stakeholders concurrent that while much progress has been made, significant gaps still need to be filled for India to be able to reach its MNCH and SDG targets. Also in view of its good performance and existing technical capacity, it was suggested that **NIPI could effectively continue engaging in its core thematic areas, by supporting improved service provision to cover the last mile in improving MNCH and reach underserved populations, promoting and mainstreaming innovation in the health systems, and furthering identification, documentation and dissemination of best practices.** Some considered that NIPI support could potentially be expanded to other geographic areas, for example the North-East of the country. In addition, several technical work areas were mentioned for consideration for a potential NIPI Phase IV, and namely:

- **Non-communicable diseases (NCD) prevention, surveillance and treatment.** Based on the positive example of the HPV self-screening innovation in Odisha, stakeholders referenced in particular breast, oral and cervical **cancers**, which represent about one third of overall cancer morbidity in some of the supported states; as well as to **diabetes** and lifestyle-related NCDs. Stakeholders emphasised how prevention through health promotion and education activities and screening would be crucial in this respect.
- **Life course approach to MNCH, targeting also adolescents.** Stakeholders recognise the need to promote a unified approach to maternal and child health, one that addresses the linkages between the different life phases in line with the national RMNCH+A Strategy. Expanding activities so to augment NHM's capacity to address adolescent health challenges could, in due course, result in healthier mothers and healthier babies.

- **Further involvement in technology-based solutions, in connection with the recent establishment of a Digital Health Mission[30].** Most stakeholders recognised the service provision challenges posed by the current lack of a unique identification and patient tracking system in the country, and some suggested addressing this issue could go great lengths in enabling better health system performance. The development of a unique user interface and of a common patient identifier are amongst the core components of the National Digital Health Mission. When considering technology-based solutions, stakeholders also considered that NIPI could continue promoting innovation in the field of digital health (e.g. AR/VR training).
- **Quality of care, continuum of care.** Work already done by NIPI in these fields (e.g. LaQshya, MusQan, promotion of referral links through the DSS tool, etc) was very positively valued, and several suggested this type of activities could be expanded in order to improve quality of services being delivered, patient experience, and overall health outcomes.

5.7.2 HOW CAN NORWAY AND INDIA TAKE FORWARD THIS SUCCESSFUL MODEL OF DEVELOPMENT COOPERATION FOR REPLICATION BEYOND INDIA AND GLOBALLY? (QUESTION 7.2)

The design and specificities of the NIPI model are, as presented earlier, recognised as key to its success, and no suggestions were made with regards of necessary changes in the way the programme is implemented.

Shared views suggested the need to better document NIPI's success factors, before the programme could hypothetically be replicated elsewhere, and the bare concept of replication outside India was considered avoidable or at any rate premature by most. Considering that NIPI's success is so intrinsically linked to the specificities of the Indian health system (e.g. existence of NHM, decentralised health system, resource availability, mortality and other specific health needs to be addressed, etc.), stakeholders warned that success factors that materialised in India may not emerge in other contexts.

Accurate documentation and broad dissemination of NIPI's results and approaches via existing South-South and global networks (e.g. Quality of Care Network, PMNCH, etc) could pave the way for independent adaptation of the NIPI model by interested countries, with NIPI/NHM potentially serving a remote support function.

It was also highlighted that NIPI could potentially be expanded to other Indian states/UTs, in line with local priorities and opportunity to positively impact critical health outcomes.

6 CONCLUSIONS AND LESSONS LEARNED

Relevance

NIPI III objectives, activities and products (e.g., tools and guidelines) are aligned to national policies and strategies in the fields of MNCH, and to standards and initiatives aimed at monitoring and improving quality of care. Health service provision related interventions being scaled up with NIPI III Techno-managerial support have a clearer contribution link to national priorities, in particular mortality reduction and overall improved health status of mothers, new-borns and children. NIPI III objectives appear relevant also at supported state/UT level, even though insufficient evidence was available.

Effectiveness

Appraisal of NIPI III effectiveness was partially hampered by observed misalignment between planning and reporting tools and processes. Available information however suggests that NIPI III objectives have largely

[30] https://abdm.gov.in/

been met, and in most cases surpassed, with an expected positive impact of activities undertaken under objectives 1 and 2 primarily on maternal, new-born and child heath as well as with regards to availability and quality of health services provided in the supported states/UTs. Documenting of good practices has been performed, but could however be meaningfully strengthened by reflecting more in depth on outcome level changes and unique features of the NIPI model. Flexibility of NIPI activities allows to effectively address emerging needs voiced at state or national levels.

Scaling up of interventions and innovations supported by NIPI III was achieved, in selected cases also at national level, and more generally beyond the target districts. Activities were further amplified with an increased number of innovations being piloted as compared to what originally planned.

Success factors of the NIPI III model reside primarily in its lean structure, capable of communicating and sharing information and innovation across levels of the Indian health system; in the close and trusted working relationship with the National Health Mission. Implementation of activities is further enabled by the remarkable alignment between NIPI and NHM/MoHFW goals, as well as by the high-level political support and commitment to the. achievement of shared MNCH goals. These latter factors also imply strong ownership of the national and state counterparts. NIPI III has been acting as an implementation catalyst, developing a safe space to test innovation and hence mitigating risks, supporting NHM and MoHFW in the long term and from within the system.

Bottlenecks to implementation and scaling up of NIPI activities weren't adequately documented, however the COVID-19 pandemic and a change of implementing partner at the onset of Phase III significantly slowed down activities. Other issues negatively impacting implementation are related to acceptance of individual interventions and innovations, insufficient institutional capacity among counterparts, health workforce and data quality and availability.

Efficiency

NIPI III financial efficiency could not be adequately appraised through available information. Overall budget spending rate has been ranging between 74 and 100%, and salaries of NIPI III staff consistently represent the largest spending item, in line with the programmatic focus on provision of technical assistance.

Stakeholders have an overall positive perception of NIPI III's financial efficiency, considering that achieved results are more than commensurate with spending, and that a relatively small financial investment also had the capacity of strengthening bilateral ties between the two countries. It is however worth noting that implementation of interventions is financed primarily with NHM own funds.

Technical assistance provided through NIPI III is considered efficient, relevant and adequate to meet state/UT needs. Human resources employed by NIPI are reported to have the technical and managerial skills necessary to efficiently execute their tasks. In addition, NIPI teams could count on consultants being contracted as needed to support on specific technical issues.

Sustainability

Sustainability prospects appear positive for interventions that have already been scaled up and institutionalised through inclusion of state annual programme implementation documents. Availability of funds within the NHM is one of the key enablers for sustainability of benefits generated through NIPI, with a reported investment from India 26 times higher than resources contributed by NIPI III:

However, innovations that have only recently been scaled up or are being piloted may not outlive the end of NIPI support, primarily as a result of a lack of institutional capacity within the NHM, which represents the primary bottleneck for NIPI III sustainability.

In contrast with what foreseen in its programme document, NIPI III did not operationalise its foreseen handover and exit plan, and it appears that NIPI has not yet been able to create sufficient, sustainable capacity within the NHM. The heavy reliance of NHM on NIPI for certain tasks appears a process of substitution or health systems support at best, and the "hand holding" approach put in place could be potentially prejudicial to the intended strengthening of the NHM.

Cohesive cooperation/ownership

NIPI appears to be contributing to state and national goals by promoting interventions and innovations that are relevant to advance towards achievement of these targets and that are already producing results. Stakeholders have extremely positive perceptions of NIPI as a technical partner, one that is relevant, has constituted a brand for itself within the MNCH arena, and that works side by side with the NHM without pushing an agenda of its own. NIPI's high standing is revealed, amongst other things, by its participation to strategic analysis and decision-making processes at state and at national level.

NIPI's embeddedness in the NHM is a fact (including with the provision of office space), and NIPI tams are perceived as an extend arm of the NHM. While this is perceived positively and allows for frequent and fluid interaction with the counterpart, it may be however be one of the factors that trigger the substitution and excessive "hand-holding" alluded to earlier, potentially jeopardising sustainability of the programme and success of capacity building efforts.

Cross-cutting issues

Anti-corruption, climate change and the environment, gender equality and women's rights, and human rights were not explicitly considered in NIPI's design or objectives. However, the programme has had some positive repercussions, in particular related to empowerment of female health workers and collection and use of disaggregated data for decision-making.

Future directions

NIPI Phase III seems to have reached its objectives, and a Phase IV would therefore in principle not be necessary, even though both countries have expressed interest in continuing this partnership until potentially the end of the NHM, foreseen for 2026.

However, much ground still needs to be covered so that the achievement of India's MNCH and SDG targets can be accomplished, and if necessary NIPI could continue to focus on its core technical areas, where institutional memory is in place, and necessary skills are already within the programme. Stakeholders suggested that non-communicable diseases, a life course approach to MNCH, quality of care and digital health could be technical areas for potential additional support.

NIPI III has shown potential for replicability in the Indian context, however a systematisation of this model, documenting and analysing success factors and achievements should be conducted before replicability can be realistically appraised. This systematisation and at the same time would create a necessary knowledge base to share the NIPI experience within south-south and global networks, for potential adaptation by other countries. At present, it is felt that NIPI could potentially be expanded to other Indian states/UTs, where he right conditions exist.

Lessons learned

This review has brough to light the following lessons learned:

- The long-term commitment of Norway and India to collaborate towards the achievement of MNCH goals has been crucial to lead to results across NIPI phases, allowing interventions to become institutionalised, while institutional memory was being built;

- NIPI introduced the concept of supporting the local identification and testing of innovations, first on a small scale, allowing to scale up only those innovations that had showed promising results and that were adapted and suited to the specificities of the Indian health system;
- The successful implementation model of NIPI III benefitted from strong ownership and commitment of states/UTs and of MoHFW, who played a crucial role in scaling up innovations;
- NIPI is a successful programme, but its efforts need to be better documented, monitored, and reported upon also with a view to knowledge sharing.

7 RECOMMENDATIONS

1. As mentioned, NIPI III appears to have reached its objectives to a very large extent, and surpassed goals in most cases. Despite those successes, one pending task for NIPI III was the implementation of an exit strategy to ensure continuity beyond the end of the NIPI III support, which did not materialise. If a continuation of the programme was approved, the following are recommended for consideration:
    a. It does not seem advisable for NIPI to embark in new technical areas (e.g. NCDs, adolescent health, etc), as the approved NHM extension until 2026 timeframe would not allow to devise adequate implementation approaches, nor to achieve results also considering the magnitude of the target populations and of the disease burden. Expanding to new technical areas could only be achieved through a renewed commitment to long-term support, which may then be best portrayed as a new partnership altogether;
    b. A new phase should focus on consolidating the gains achieved to date, and aim at filling the remaining gaps related to the institutionalisation of interventions currently tested under objective 2 and in particular of the innovation hub, creation of sustainable capacity within the NHM to manage the programme, and better documentation and diffusion of NIPI's model and of the good practices implemented in collaboration with the NHM. In addition, NIPI's ongoing efforts in support of quality of care have shown promising application and could potentially be brought forward in a new phase. Development of technical and strategic documents could become a standalone outcome, separate from documenting and disseminating good practices.
    c. While replication outside India seems premature, a new NIPI Phase could focus on expanding the coverage and scaling up of relevant innovations included in previous phases to other geographic areas, for example the North-East of the country, or areas with high maternal and child mortality.
    d. A potential NIPI Phase IV needs to include a clear and realistic exit strategy, one that can be implemented in the three years running until the conclusion of the NHM.
    e. As part of the exit strategy, consider how to transfer current NIPI´s function as provider of strategic technical assistance to another existing national institution, for example the NHSRC. This technical assistance should be backed by an adequate budget put forth by the GoI, so to be able to continue providing strategic support to states/UTs and MoHFW.
2. Capacity gaps should also be assessed regularly, and addressed as feasible. It is paramount that a potential Phase IV focuses on sustainable capacity strengthening, privileging collaboration and handing over, to substitution and hand-holding.

3. Reaching out to the most vulnerable and marginalised groups has already been started under NIPI III , and if a Phase IV was approved, NIPI could make a more explicit attempt at impacting on cross cutting issues, and in particular by explicitly supporting India put into practice a leave-no-one-behind approach that is already at the core of national policies.

4. In the event of continuation of NIPI programme, its planning , monitoring, reporting and learning functions need to undergo an in-depth strengthening process. Without compromising the lean format of the annual meeting, formal annual progress reporting should be in line with elements requested in the grant general conditions, including documenting challenges, mitigation measures, risk assessment. Reports should also include outcome-level narrative and reflections in addition to the current comprehensive list of activities carried out, clearly documenting examples of increased capacity resulting from NIPI/NHM collaboration.

5. Systematising and documenting lessons learned from NIPI implementation, throughout its phases but especially in Phase III, and bringing to light the most crucial features of its model, would be a crucial step to determine whether replication is possible. Documentation to be done in a structured and systematic way, and potentially with a view to allow independent adaptation of the NIPI model in other contexts.

6. Building on existing success, NIPI could explore avenues for dissemination of good practices, ideally privileging existing global partnerships (e.g. the Partnership for Maternal, New-born and Child Health - PMNCH) and global or south-south networks (e.g. WHO Quality of Care Network, of which India is already a member). If rigorously documented, good practices promoted by NIPI could be raised to the Global Financing Facility for Women, Children and Adolescents (GFF).

7. NIPI could better target its external communication efforts, producing shorter and interactive newsletters. Similarly, in order to engage external readers, the website could present a short and appealing annual summary content (e.g. long story format) providing clear and accessible examples of NIPI's contribution to national and global health goals.

ANNEX 1: LIST OF DOCUMENTS REVIEWED

Document group	Document
Evaluations NIPI phase 2	Impact Evaluation of Five Initiatives, NIPI Phase 2
	MTR Report NIPI Phase 2
Grant/proposal/project documents	Addendum 1 to MoU - MoHFW & MFA NIPI III 20.10. 2021
	CURE_NIPI PHASE III Project Outline
	Embassy to MoHFW 01 November 2023
	Grant Agreement between Norwegian Ministry & CURE
	Jhpiego_IND-17-0004 NIPI III signed agreement
	Letter of Intent- NIPI III- 28.09.2017
	MoHFW to Embassy 22 Sept 2022
	MoU - MoHFW & MFA NIPI III - 07.06.2018
	NIPI III -Part II General Conditions
	Project Proposal document, NIPI III.B
NIPI Annual meetings	2018 Agenda notes NIPI 3 1st Annual meeting 2018
	2018 Approved Minutes and Annexures NIPI 3 Workplan
	2020 Signed minutes 2nd Annual Metting 2020
	2020.09 Agenda notes NIPI 2nd Annual meeting
	2020.09 NIPI 2nd Annual Meeting Presentation 2020
	2021 Agenda notes NIPI 3rd Annual meeting 2021
	2021 Minutes of NIPI Third Annual meeting 2021
	2021 NIPI 3rPresentationing Presentation 2021MoHFW October 202
	2022 Agenda notes NIPI 4th Annual meeting 2022
	2022 Annual Progress Report during Fourth NIPI Annual Meeting D
	2022 Annual report for NIPI Annual Meeting_oct2022
	2022 NIPI 4th Annual meeting Presentation 2022
	2022 Revised Annual report for NIPI Annual Meeting_2 Dec
NIPI financials	Approved Budgets for NIPI Innovations 2022-24_PPT
	Audit report Jan to Dec 2021
	Audit report Jan to Dec 2022
	Audit report Jul 2019 to Dec 2020
	NIPI 3 Fifth Disbursement Request
	NIPI 3 Second Disbursement Request
	NIPI 3 Seventh Disbursement Request (003)
	NIPI 3 Sixth Disbursement Request
	NIPI 3- Eighth Disbursement Request
	First tranche payment NIPI3b
NIPI interventions and innovations	Communication update

Document group	Document
	Concept Note - SMART ANMOL
	Concept Note Innovation HUB
	Digital Health Solutions- Chatbot for Pediatric COVID-19 case
	Draft Operational Guidelines for State Innovation Hubs 2023
	Geomapping Manuscript Draft
	Improving access and coverage of cervical cancer screening thro
	Innovation Hub, presentation
	NHSRC Innovation Hub and PIPs incorporation v 13012022
	NIPI 3 Overview of results by state, 2019-2023
	NIPI Support for Covid-19 response 11 June
	NITI Aayog Dashboard for JK for National Summit
	Note on IPHS Assessment
	Odisha Evaluation Report_DSS for CHOs
	Odisha Setting up of innovation hub
	Pilot for HPV based Cervical Cancer Screening in Odisha_Draft_1
	QR Code for national innovation summit
	Study Concept_Facilitators Barriers and Factors Influencing Ear
	Summary: All NIPI innovations list 12.04.2023
	VR pre-pilot report Odisha August 2023
NIPI newsletters	2021.07 to 09 NIPI newsletter
	2021.10 to. 12 NIPI newsletter
	2022 10 to 12 NIPI newsletter
	2022.01 to 03 NIPI newsletter
	2022.04 to 06 NIPI newsletter
	2022.04 to 06 NIPI newsletter
	2022.07 to 09 NIPI newsletter
	2023.01 to 06 NIPI newsletter
NIPI overview	Brochure NIPI III C
	Brochure- NIPI III E
	NIPI 3 Concept Note
	NIPI 3 Functioning and structure
	NIPI Phase 3 Concept Note - Norad
	NIPI Theory of Change
	Overview: NIPI work aligned with NHM Priorities 5 Sep
Other sources	2023_Born too soon report, PMNCH
	INAP-progress_card_2020
	India newborn health UNICEF

Document group	Document
	WHO SEARO - India health system review
Policies, strategies, priorities	2013 RMNCH+A Strategy
	2014 India newborn action plan
	2017 District intensification plan
	2017 India national health policy
Results and progress reports	1 NIPI Phase 3 final JHPIEGO Report
	2 NIPI Detailed Results Report submitted to RNE 2020
	2019-20 Annexures to NIPI Progress report
	2022 NIPI 3 Results Report June 2022
	3 NIPI Summary Results Report Submitted to RNE 2020
	4 NIPI Support for Covid-19 response 2020 submitted to MoHFW
	5 NIPI Child Health Report Jan - Dec 2020 Submitted to MoHFW Ap
	6 NIPI Results REPORT submitted to MoHFW June 2022
	NIPI 3 Annual progress report 2020
	NIPI 3 Progress Report Sept 20 to Sept 21
	NIPI 3 Progress Report Sept 20 to Sept 21
	NIPI Takeaway meeting 2022
Results frameworks	CURE NIPI phase 3 Results Framework 2021-2023
	CURE Results Framework -NIPI III 2020-2021
	Jhpiego Results Framework
State -level implementation	Bihar Presentation for SCC 22 May. 2020
	Bihar Proceedings-NIPI-3-SCC-2020
	Bihar State Coordination Meeting draft Agenda Notes - ED
	Brief for NIPI in Rajasthan May 2023
	J&K 2020 Phase 3 Annual Work Plan
	J&K 2020 SCC Agenda Notes 12 Aug 1.1
	Madhya Pradesh SCC Agenda workplan_2020
	Madhya Pradesh Signed Minutes of the Meeting 2020
	Madhya Pradesh Presentation SCC 2021
	NIPI Rajasthan COVID-19 Containment Strategy Management Plan Lo
	Odisha Concept note_Innovation centre
	Odisha SCC notes 2020
	Rajasthan NMR Strategy
State annual reports 2021	Bihar Progress October 2021-October 2022
	Bihar State Annual Progress Report 2021
	J&K Progress October 2021-October 2022
	J&K State Annual Progress Report 2021

Document group	Document
	M.P. Progress October 2021-October 2022
	M.P. State Annual Progress Report 2021
	Odisha Annual Progress Report 2021
	Odisha Progress October 2021-October 2022
	Rajasthan Progress October 2021-October 2022
	Rajasthan State Annual Progress Report 2021
State challenges and learnings	Bihar Challenges and learning
	J&K Challenges Learnings
	MP Challenges and Learning
	Odisha Challenges Learnings
	Rajasthan Challenges and Learnings

ANNEX 2: CONVERSATION GUIDE

Introduction: *This conversation is part of a review process for Phase 3 of the NIPI Programme (2018 to date). Objectives of this review are to assess the relevance, effectiveness, efficiency and sustainability of NIPI III, to identify success factors and areas for improvement of the NIPI implementation model, including in its cooperation with the Ministry of Health and Family Welfare (MoHFW) and National Health Missions, and finally to propose options for future directions. The review has been commissioned by Norad, the Norwegian agency for development cooperation.*

You have been invited to this conversation in view of your experience with the programme: either direct experience, as someone involved in its design and implementation, or indirect as someone familiar with NIPI activities. The objective of this conversation is that of collecting your views and perceptions on NIPI 3.

Confidentiality: *If that is acceptable for you, this conversation could be recorded. This is intended exclusively to facilitate the note-taking process, and the recording will only be accessible to the reviewer you are interacting with. Any notes that will be taken of this conversation will equally be accessible to the reviewer only, and under no circumstances they or the recording will be shared with anyone else. Anything you will say will remain fully confidential, you will not be quoted directly in the review report, and opinions expressed will not be traceable back to you.*

You are free to not respond to any of the questions. Should you not feel comfortable, you can request to interrupt the conversation at any point.

Conversation topics: *Below you will find a proposed conversation guide, showing a range of possible questions organised by key domains, as per the review objectives. Please consider that not all questions may be relevant to you, and that the conversation will focus on topics in line with your familiarity with NIPI 3.*

Domain/Question
Introduction
1. Please introduce yourself, and briefly present your involvement with NIPI.
Relevance
2. From your perspective, were NIPI objectives relevant to the MoHFW? If not, why?
3. From your perspective, were NIPI objectives relevant to the NHM in the supported states? If not, why?
Effectiveness
4. To your knowledge, did NIPI III achieve its intended results?
5. From your perspective, what were key enablers in the achievement of NIPI results? At national level? At state level?
6. From your perspective, what were key bottlenecks in the achievement of NIPI results? At national level? At state level?
7. To what extent were NIPI interventions being brought to scale in your State? At national level? Can you make some examples?
8. What would you identify as key success factors in the scaling up process? Key bottlenecks?
9. What are in your opinion key lessons learned from NIPI implementation, in your State or at national level?

Domain/Question
Efficiency
10. Do you consider that financial resources made available through NIPI were used efficiently?
11. From your perspective, was the technical assistance provided by NIPI delivered efficiently? Was it relevant for the supported states and MoHFW?
12. From your perspective, did the technical assistance and support provided by NIPI teams meet the quality/needs required by supported states? By MoHFW?
Sustainability/ownership
13. From your perspective, what is the likelihood that benefits generated by NIPI III will last after the programme ends?
14. From your perspective, what have been key success factors to ensure sustainability of NIPI III? Key bottlenecks?
Cohesive cooperation/perceptions
15. What would you describe as NIPI III's most important achievements in your State/at national level?
16. In your opinion, has NIPI contributed to the achievement of State/national priorities, in particular for MCH?
17. How would you describe NIPI as a partner in your State? At national level?
18. In your opinion, how do key stakeholders perceive NIPI in your State? At national level?
Cross-cutting issues:
19. To what extent have cross-cutting issues (gender, climate and environment, human rights, anti-corruption) been taken into consideration in the design and implementation of NIPI III?
Future directions
20. If a Phase 4 was approved for NIPI, what do you consider could be key areas of focus, and why?
21. If a Phase 4 was approved, do you consider that the implementation model could be improved in any way?
22. Do you think it would be feasible for Norway and India to replicate NIPI and its successes beyond India? How could this be done?
23. If NIPI was to be replicated, what do you consider would be key success factors, and what could represent a bottleneck?

ANNEX 3: LIST OF STAKEHOLDERS CONSULTED

Name	Designation	Affiliation
Mr C K Mishra	Adviser to Government of India and former Secretary	Government of India
Dr Sadhana	Focal point, Lady Harding Medical College	Government of India
Dr Shobna Gupta	Deputy Commissioner Child Health	Government of India
Dr Sumita Ghosh	Officer on Special Duty, NITI Aayog	Government of India
Maj Gen (Prof) Dr Atul Kotwal	Executive Director, National Health System Resource Centre	Government of India
Ms Vivek Bhardwaj (IAS)	Secretary Mines	Government of India
Prof Dr Sushma Nangia	Professor and Director, Lady Harding Medical College, NCC	Government of India
Dr N. K Sinha	Additional Director and State Immunization Officer	Government of Bihar
Dr. V.P. Rai	State Program Officer-CH	Government of Bihar
Sh. Avinash Kumar Panday	State Program Manager	Government of Bihar
Dr Yunus Mushtaq	State Program Officer Child Health	Government of Jammu and Kashmir
Mr Bupinder Kumar (IAS)	Secretary Health and Mission Director NHM	Government of Jammu and Kashmir
Mr Muneer Ahmed	State M&E Officer	Government of Jammu and Kashmir
Dr Alok Rai	District Child Health Nodal Officer	Government of Madhya Pradesh
Dr Santosh Shukla	Director Health	Government of Madhya Pradesh
Dr. Shailesh Sakalle	Deputy Director, ASHA	Government of Madhya Pradesh
Dr Bijay Mohapatra	Director, Health Services	Government of Odisha
Dr Bijay Panigrahy	Director, Family Welfare	Government of Odisha
Dr Brunda D (IAS)	Odisha Mission Director	Government of Odisha
Dr Niranjan Mishra	Director Public Health	Government of Odisha
Dr Sushant Swain	Additional Director, NCD	Government of Odisha
Ms Shalini Pandit (IAS)	Odisha Commissioner-cum-Secretary	Government of Odisha
Dr Pradeep Chaudhary	Director, Child Health and State Representative	Government of Rajasthan
Dr Sunil Chauhan	Principal Medical Officer, Alwar District	Government of Rajasthan
Soffía Magnúsdóttir Dayal	Head of Visa and Consular Affairs	Iceland Embassy
Dr Somesh Kumar	Country Director	Jhpiego
Cheshta Bajaj	Program Associate	NIPI National team
Devendra Patankar	Data Visualization Officer	NIPI National team
Dileep Kumar Audichya	Finance & Operations Manager	NIPI National team
Dr Ashfaq Ahmed Bhat	NIPI Program Director	NIPI National team
Rajat Khanna	MER Advisor	NIPI National team
Saurabh Bhargava	Knowledge Management Advisor	NIPI National team
Virendar Bora	Data Assistant	NIPI National team
Ashish Kumar Srivastava	Senior Innovations Advisor	NIPI National team
Dr Byomakesh Mishra	State Program Officer, Child Health	NIPI - Bihar Team
Gaurav Kumar	State Program Manager, Bihar	NIPI - Bihar Team

Mr Gaurav Kumar	State Program Manager, Bihar	NIPI - Bihar Team
Rehan Khan	Program Coordinator	NIPI - Bihar Team
Dr Arshid Nazir	Innovation Officer	NIPI - Jammu and Kashmir Team
Dr Jahangir Dar	District Technical Consultant- Baramullah	NIPI - Jammu and Kashmir Team
Dr Mushtaq Ahmad Dar	State Program Manager, Jammu & Kashmir	NIPI - Jammu and Kashmir Team
Dr Sonalika Jamwal	State Program Officer	NIPI - Jammu and Kashmir Team
Umar Nazir	District Technical Consultant- Kupwara	NIPI - Jammu and Kashmir Team
Dr Dipak Ganvir	State Program Manager, Madhya Pradesh	NIPI - Madhya Pradesh Team
Dr Ravindra Singh	Former NIPI team member (currently in UNFPA)	NIPI - Madhya Pradesh Team
Bijay Kumar Panda	Program Coordinator	NIPI - Odisha Team
Deepak Kumar Biswal	State Program Manager	NIPI - Odisha Team
Hiralal Nayak	State Program Officer, Child Health	NIPI - Odisha Team
Dharmendra Kumar	State Innovation Officer	NIPI - Rajasthan team
Mr Pradeep Choudhry	State Program Manager, Rajasthan	NIPI - Rajasthan team
Ram Karan Singh	Program Associate	NIPI - Rajasthan team
Mr Ashwajit Singh	Strategic Advisor	NIPI CURE / IPE Global
Haitham El-Noush	Senior Advisor, Global Health	Norad
Rannveig Rajendram	Department director, Department for business management	Norad
Camilla Dannevig	Senior Advisor	Norway Ministry of Foreign Affairs
Gauri Ganpat Bandekar	Advisor, Health, RNE	Norway Ministry of Foreign Affairs
Hans Jacob Frydenlund	Senior Advisor, former Ambassador to India	Norway Ministry of Foreign Affairs
Marit Marie Strand	Head, Cooperation Section, RNE	Norway Ministry of Foreign Affairs
Helga Fogstad	Executive Director	PMNCH
Anuradha Gupta	President of Global Immunisation	Sabin Vaccine Institute

ANNEX 4: NIPI III RESULTS FRAMEWORK, 2021-2023

LEVEL	EXPECTED RESULT	INDICATORS	TARGET (2021)	TARGET (2022)	TARGET (2023)	Data source	Comments
Outcome 1	Technical assistance support in the scaling up of identified best practices in aspirational districts of five States/UT (HBYC, ETAT, FPC, LaQshya and Roll out of Harmonized Child health training packages.	**Outcome Indicators** 1.1. Number of states supported for operationalization of NIPI innovations (Maternal and ChildHealth)	5	5	5	• State Program Implementation Plans (PIPs) or State Budgets • Child Health Training Packages launched by GoI	**This will measure Objective 1 of NIPIWorkplan on taking NIPI to scalein India**
		1.2. Number of Child Health Training Packages developed and rolled out	5	5	5		
OUTPUT 1.1	Home based care for Young Child (HBYC) program supported in aspirational and non-aspirational districts of 5 States/Union Territory (UT).	**Output Indicators** 1.1.1. Number of states/UT madefinancial provision for implementation of HBYC programme.	5	5	5	• State Program Implementation Plans (PIPs) and State budgets	This will measure contribution of NIPItechnical support and sustainability mechanism
		1.1.2. % Aspirational Districts in states/UT facilitated for trainingMicro-plan preparation.	50%	50%	50%	• Training Micro Plans from ADs	
		1.1.3. % HBYC trainings in AspirationalDistricts of states/UT assessed for quality of training.	10% of the total trainings	10% of the total trainings	10% of the total trainings	• Quality of Training Assessment Reports • DHIS 2	10 % trainings areestablished
		1.1.4. % Aspirational Districts in states/UT assessed during annual periodic assessment onkey HBYC indicators.	50%	50%	50%	• Periodic Assessment Reports • DHIS 2	
		1.1.5. No. of States supported forperiodic program review	5	5	5	• State periodic program review meeting reports	

LEVEL	EXPECTED RESULT	INDICATORS	TARGET (2021)	TARGET (2022)	TARGET (2023)	Data source	Comments
OUTPUT 1.2	FPC, ETAT, LaQshya, supported in aspirational and non-aspirational districts of five states/UT for Improved quality of MNCH facility based services.	**Output Indicators** 1.2.1 Number of states/UT made financial provision for implementation of facility based programs (FPC, ETAT and LaQshya).	5	5	5	• State Program Implementation Plans (PIPs) and Record of Proceedings (RoPs)	
		1.2.2 Number of states/UT supported for state orientations, TOTs, preparationof training micro-plans	5	5	5	• Orientation and training reports on FPC, ETAT and LaQshya. • Training Micro Plans	
		1.2.3 % identified Facilities in Aspirational Districts assessedduring bi-annual periodic assessment of FPC, ETAT and LaQshya.	50% identified of the total functional	50% identified of the total functional	50% identified ofthe total functional	• Quality Assessment reports of FPC, ETAT and LaQshya • DHIS 2	
		1.2.4 No. of States supported for periodic program review	5	5	5	• State periodic program review meeting reports	
OUTPUT 1.3	Harmonized Child Health training packages developedand approved.	**Output Indicators** 1.3.1 Number of harmonized Child Health training packages developed with NIPI support and rolled out in the country.	5	2	2	• Child Health Training modules of GoI • Orientation and Training reports	

OUTPUT 1.4	Technical support provided for implementation of aspirationaldistrict Program in J&K.	**Output Indicators** 1.4.1 Number of aspirational districtssupported for Supportive Supervision visits, roll out of ANMOL and monitoring of NITIAayog health indicators.	2	2	2	• Supportive Supervision Reports of ADs • ADs Periodic Progress Reports • DHIS 2	

LEVEL	EXPECTED RESULT	INDICATORS	TARGET (2021)	TARGET (2022)	TARGET (2023)	Data source	Comments
OUTCOME 2	Strengthening Innovation Development Capacities in thepublic health system in five States/UT.	**Outcome Indicator** 2.1 Number of states supported for Innovation Development Capacity and Digital based Health Solutions.	3	3	3	• State Innovation Meeting Minutes • State capacity building workshopreports • Compendium of State Innovations	**This will measure Objective 2 of NIPIWorkplan on strengthening innovation development capacity in public health system**
OUTPUT 2.1	Innovation Hub / Cell established within publichealth system.	**Output Indicators** 2.1.1 Number of landscape analysis conducted to identify key priority problems on Maternal and Child Health	2	2	2	• MNCH Landscape analysis reports and strategic documents	
		2.1.2 Number of States/UT supported for establishing innovation Hub / Cell within public health system.	2	2	2	• State Innovation Advisory Group meeting reports • State PIPs andRecord of Proceedings (RoPs)	
OUTPUT 2.2	Innovation Toolkit developed	2.2.1 Number of Innovation toolkit developed and enhanced	1	1	1	• Innovation Toolkitand ToR	

OUTPUT 2.3	Digital health platforms/applications and Decision Support System (DSS)developed	2.3.1 Number of Digital Health platforms / applications and Decision Support System (DSS) developed	3	3	3	• Strategic documents and operational guidelines on DHPs and DSS • State Innovation Advisory Group meeting reports • ANMOL • RCH portal	
		2.3.2 Number of States supported with Digital Health platforms and DSS	3	3	3		

LEVEL	EXPECTED RESULT	INDICATORS	TARGET (2021)	TARGET (2022)	TARGET (2023)	Data source	Comments
OUTCOME 3	Documentation and Dissemination of National Health Mission (NHM) and NIPI interventions	**Outcome Indicator** 3.1 Number of NHM and NIPI best practices documented, disseminated and submitted in peer-reviewed journals.	1 best practice 2 publications	1 best practice 2 publications	1 best practice 2 publications	• NHM and NIPI best practices compendium • Scientific Research Papers • NIPI News letter • NIPI Website • Presentations and Abstracts	**This will measure Objective 3 of NIPI Workplan on Documentation and Disseminationof NHM and NIPI best practices**
OUTPUT 3.1	NHM and NIPI best practices and publications documented& disseminated.	**Output Indicators** 3.1.1 Number of NHM and NIPI best practices documented and disseminated	5	3	3	• NHM and NIPI best practices compendium • State workshop reports	
		3.1.2 Number of Scientific research papers developed and submitted for publications.	5	3	3	• Scientific Research Papers	

		3.1.3 Number of presentations in MNCH and related conferences.	2	2	2	• Presentations and Abstracts	
OUTPUT 3.2	State/UT capacity build on documentation and publications.	**Output Indicators** 3.2.1 Number of States/UT supported through capacity building on documentation andpublications	2	2	2	• State capacity building workshop reports	

LEVEL	EXPECTED RESULT	INDICATORS	TARGET (2021)	TARGET (2022)	TARGET (2023)	Data source	Comments
OUTCOME 4	COVID-19 Support and need based Technical Assistance Support to MoHFW and StateNHM of 5 States/UT	**Outcome Indicator** 4.1 Number of States/UT provided support on combatting COVID-19and need based technical assistance	5	5	5	• COVID-19 Assessment reports • COVID-19 vaccination roll out coverage reports, CoWin • DHIS 2	**This will measure Objective 4 of NIPI Workplan on COVID-19 Support and need based TASupport to MoHFWand State NHM**
OUTPUT 4.1	COVID-19 program Strengthened at National leveland in 5 States/UT.	**Output Indicators** 4.1.1 Number of States/UT provided support on S&D communication campaign, assessment, monitoring and vaccination of COVID-19	5	5	5	• Communication briefs and Media creatives • COVID-19 Assessment reports • DHIS 2 • COVID-19 vaccination roll out coverage reports • Coffee Table Book • CoWIn Portal	

OUTPUT 4.2	RBSK program strengthened	**Output Indicators** 4.2.1 Number of States/UT provided support on RBSK	2	2	2	• RBSK state periodic reports	
OUTPUT 4.3	Operationalization of theidentified HDUs/NBSUs	**Output Indicators** 4.3.1 Number of States/UT provided support on assessing and operationalizing HDUs/NBSUs	3	3	3	• HDU assessment reports • NBSU assessment reports	

ANNEX 5: OVERVIEW OF NIPI RESULTS AND SCALING UP (2019-2023)

SN	Interventions / Activities	Initial Testing	Target	Current Status (Scale Up)						
				Bihar	J&K	M.P.	Odisha	Rajasthan	National	Total
Objective 1 (Strategic TA for scaling-up demonstrated best practices)										
1.	Home Based Care for Young Child (HBYC)	13 Districts in 4 States (3 Bihar, 4 M.P., 3 Rajasthan, 3 Odisha)	38 Districts	13	20	52	30	34		149 Districts
2.	Family Participatory Care(FPC)	5 Districts in 4States (1 Bihar, 2 M.P., 1 Rajasthan, 1 Odisha)	38 units	38	7	8	60	56		169 units
3.	Emergency Triage Assessment and Treatment(ETAT)	5 Districts in 4States (1 Bihar, 2 M.P., 1 Rajasthan, 1Odisha)	N.A.	2	7	3		2		14 units (During COVID-19, these 14 ETATunits were integrated into Pediatric Intensive Care Units)
4.	LaQshya Certification of Delivery Points		62 facilities	5	7	6	3	46		67 facilities
5.	Harmonized Child Health Training Packages		2 packages						5 training packages (NBSU, NSSK, IMNCI, FIMNCI MO & Nurse) with 13 Training modules developed	5 packages with 13 Training modules developed

SN	Interventions / Activities	Initial Testing	Target	Current Status (Scale Up)						
				Bihar	J&K	M.P.	Odisha	Rajasthan	National	Total
Objective 2 (Strengthening Innovation Development Capacity and Establishment of Innovation Hub in a public health system)										
1.	Decision Support Systemfor frontline Health workers	2 Districts (1 M.P., 1 Odisha)	N.A.	2	2	8	30	4		46 Districts
2.	VR- Enabled Neonatal Resuscitation Training Package (NSSK)	1 District Odisha	N.A.				1		Demonstration of VR package at national level	
3.	Geospatial Mapping of Access and Utilization of Health Services	1 Rajasthan	N.A.					33 (All Districts)		33 Districts
4.	State Innovation Hubs: Institutional Mechanism of Innovation	Odisha	N.A.	Fund proposed from State Budget	Fund proposed from State Budget	1 (8 proposals submitted and reviewed by Innovation Committee)	1 (19 proposals submitted, 8 approved, 3 under review by Innovation Committee)	1 (14 proposals submitted and4 approved by Innovation Committee)	Country wide scale up by NHSRC	3 State Innovation Hubs operationalized (41 Proposals in 3 States) and 2under constitution
5.	Innovating for SRH using 'Self-Care' Approach	1 district in Odisha	N.A.				2			2 Districts in Odisha
6.	IPHS Tool: Assessment cum planning tool for Indian Public Health Standards (IPHS)	13 districts In J&K	N.A.		20 district	1	1		Country wide scale up by NHSRC	

SN	Interventions / Activities	Initial Testing	Target	Current Status (Scale Up)						
				Bihar	J&K	M.P.	Odisha	Rajasthan	National	Total
7.	Digital Solutions for PublicHealth – QR Codes	2 districts inOdisha	N.A.				30 (All Districts)			30 Districts
8.	Artificial Intelligence (AI) based triaging Tool for COVID-19	2 Districts (1 Bihar, 1 Odisha)	N.A.						1	Submitted to States for scale-up
9.	Monitoring Dashboard for COVID-19 and NITI Aayog indicators	20 Districts in J&K	N.A.		20					20 Districts in J&K
Objective 3 (Document and disseminate best practices under NHM and NIPI)										
1.	Strategy Documents		N.A.	1 (NMR strategy)	2 (IMR, COVID-19 strategy)	1 (Maternal Health strategy)	1 (MNCH strategy)	2 (NMR, COVID-19, strategy)	1 (MusQan Guidelines)	8
2.	Evaluations and Assessments		N.A.	2	6	1	2	2		13 Evaluations
3.	Documentation and dissemination		11	3	5	6	4	1	3	22 abstracts submitted
4.	Publication of research articles		11		2	1	1	1	9	9 papers published and 5 under submission
5.	Program Communication		N.A.		1 (1 Coffee Table Book)			2 (1 Coffee Table Book, 1 Testimonial onCOVID)	29 (3 Success Stories by WHO, 26 Creatives)	32
Objective 4 (COVID-19 & Need-based Support for MNCH and other Public Health Emergencies)										

SN	Interventions / Activities	Initial Testing	Target	Current Status (Scale Up)						
				Bihar	J&K	M.P.	Odisha	Rajasthan	National	Total
1.	Assessment of facilities forCOVID-19		N.A.	6	31	3		3		43 centres assessed in 4 States
2.	Guidelines for Management of COVID-19		N.A.		1			1		2 Guidelines developed
3.	Obstetric High DependencyUnits (HDUs) operationalized		N.A.	1 Training Module	8 HDUs	30 HDUs 1 Training Module	2 HDUs 1 Training Module	1 HDU		41 HDUs operationalized 3Training Modules on HDU
4.	Rashtriya Bal Suraksha Karyakaram (RBSK), Early Childhood Development (ECD) and other Communications Support to MoHFW		N.A.	2 (Diarrhoea control)					3 (2 RBSK and ECD)	5 IEC for StateNHM and MoHFW

ANNEX 6: TERMS OF REFERENCE FOR THE END REVIEW

Terms of Reference

REVIEW OF NORWAY INDIA PARTNERSHIP INITIATIVE (NIPI) PHASE III

REFERENCE NUMBER: IND 3053 IND-19/0009 NIPI 3

GENERAL INFORMATION

The Norwegian Agency for Development Cooperation (Norad) issues a request for proposals from consultants interested in conducting an end-term review of Norway India Partnership Initiative (NIPI) Phase III.

ABOUT NORAD

Norad - the Directorate for Development Cooperation - is a department under the Ministry of Foreign Affairs (MFA) and works to ensure that the world reaches the UN's sustainability goals. This assignment is guided by the inclusive Norway-India Strategy launched by the Norwegian Government in 2009 and India Norway Strategy 2030. The cooperation within health started in 2006 as part of the Millennium Development Goal (MDG) no. 4 and further extended to MDG5 and the current Sustainable Development Goals (SDGs) 3, all concerned with efforts to reduce maternal, new-born and child mortality. More information about the Norad's work in India can be found at https://www.norad.no/ Information about the health initiative can be found at https://www.nipi-cure.org/

Contact person at Norad

Any queries relating to this invitation may be addressed to Norad's contact person: Haitham El-noush at e-mail address heln@norad.no

ABOUT THE ASSIGNMENT

Background

Norway India Partnership Initiative (NIPI) was established in 2006 as a response to reduce the maternal, new-born and child mortality in India in alignment with its National Health Mission (NHM). Towards this, an agreement was signed between the two Prime Ministers of India and Norway. NIPI's aim is to provide strategic, catalytic and innovative support to India's National Health Mission (NHM), by testing scalable innovations in five Indian states of Bihar, Odisha, Madhya Pradesh, Rajasthan and Jammu and Kashmir.

NIPI has evolved in its earlier phases [Phase I-2006-2012 and Phase II-2013-17] in terms of support provided to Government of India and its supported states. Various evaluations of prior two phases have found that it has largely achieved its goal of providing strategic catalytic and innovative support to National Health Mission.

In 2017, Governments of India and Norway agreed that NIPI was an effective program to be continued, and a Letter of Intent (LOI) was signed, and followed by a Memorandum of Understanding (MoU) for a

Phase III for approximately 3 years, and then by mutual agreement extended in 2021 to end 31st December 2023.

NIPI phase III was implemented by two agencies. The first implementing agency was Jhpiego (John Hopkins Program for International Education in Gynecology and Obstetrics, a non-profit). An agreement was signed to implement from April 2018 – April 2021 (i.e. NIPI phase IIIa). The agreement with Jhpiego was discontinued in 2019. The third phase of NIPI (NIPI IIIb) was then taken over and implemented by CURE (Center for Urban and Regional Excellence, the non-profit arm of IPE Global) in June 2019 and is up for completion by December 2023.

NIPI III is currently working on the following three objectives:

1. Provide strategic technical assistance in scale up of demonstrated best practices in NIPI supported states.
2. Strengthen Innovation Development Capacity through establishment of Innovation Hub in the public health systems
3. Documentation and Dissemination of National Health Mission (NHM) and NIPI interventions

In 2020, with the emergence of the COVID-19 pandemic, it was agreed by the two Governments to add COVID-19 need based support as a new and time-limited objective which has been concluded. This is reflected in the relevant budgets and reports, and it should therefore be included in this review.

Purpose of the Review

NIPI will complete its current phase (Phase III) in end December 2023 and its partners intend conducting an end-term review of the current phase. The purpose of the review is both to document results achieved and capture learning on best practices including the NIPI implementation model.

Objectives and Scope of the Review of NIPI Phase III

- Assess the Relevance, Effectiveness and Efficiency of NIPI III in relation to the agreed Phase III objectives[31].
- Review the success factors of the NIPI model of implementation at the state level, and the perception of the program as a technical support partner at both central and state level.
- Assess the level of sustainability created thus far within the context of among others the cooperation with the Ministry of Health and Family Welfare (MoHFW) and in the supported states.

The review shall in addition focus on cross cutting issues including gender equality and environment.

The review shall explore and provide inputs on possible ways forward in India and/or as part of a south-south experience sharing.

The review is a one-time assignment that involves, but is not necessarily limited to, desk review of key innovations and interventions done, stakeholder interviews, and field visits to the NIPI supported state(s) in consultation with the implementing partners.

[31] Suggestive assessment domains and evaluation questions for reviewing the objectives are mentioned as Annexure I

Documents for the review, amongst others*:*

- Letter of Intent (LOI), between the Royal Norwegian Embassy (RNE) in New Delhi and the Ministry of Health and Family Welfare, Government of India dated 28-09-2017.
- Memorandum of Understanding (MoU) between the RNE and the Ministry of Health and Family Welfare, Government of India dated 07-06-2018 and the extension until December 2023
- Agreement between RNE and implementing partner Jhpeigo, dated 27.03.2018.
- Agreement between the RNE and implementing partner, CURE, dated 06-12-2019.
- Addendum Number 1 to the MoU between the Royal Norwegian Embassy in New Delhi and the Ministry of Health and Family Welfare, Government of India dated 20-10-2021.
- Result matrix for NIPI III, Norway India Partnership Initiative Phase III Concept Note, agenda notes and approved minutes of various NIPI annual meetings.
- Annual Project Progress Reports and various documentations produced by NIPI-CURE.
- Various results documentations, articles and other, to be provided.
- Previous formal reviews of the NIPI I and NIPI II, to be provided.

REPORTS

Following reports shall be delivered as part of the assignment:

Inception Note – max 5 pages, due prior to commencement of assignment.

Draft Review Report – 30-50 pages, due one week after review

Final Review Report – 30-50 pages, excluding executive summary and annexes, due one week after receipt of comments from the Norad

Inception Note

This note of maximum 5 pages shall indicate general methodology and approach being followed, and a time schedule.

Draft Report

This report of maximum 50 pages shall outline methodology, key findings, conclusions and recommendations. The reviewer will share the report to key stakeholders and implementing partner for feedback related to (1) correction of factual errors and/or incomplete information presented in the report, and (2) comments/reactions to reviewer's findings, conclusions and recommendations. A deadline of 7 working days will be set for feedback, which should be sent directly to the reviewer, with copies to Norad and Royal Norwegian Embassy in New Delhi.

Final Report

Based on the comments to the draft report, the reviewer shall finalize the report. The report shall be of maximum 50 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.

MEETINGS

The Reviewer shall plan and request assistance from the Norad and Royal Norwegian Embassy in New Delhi in arranging meetings and visits in accordance with the time schedule. The Norad/RNE/implementing partner shall be consulted beforehand for suggestions/advice on useful organizations and persons to meet, though final decisions regarding prioritization of meetings, field visits, etc. shall remain his or her prerogative of the reviewer.

The following three meetings shall be considered must and mandatory for the Reviewer to attend:

A meeting or telephone conference with the Norad to discuss the Inception Note and resolve any issues in its Inception Note.

A briefing meeting with the Norad, RNE and implementing partner upon commencement of the contract.

A debriefing meeting with NIPI implementing partner CURE in New Delhi. The Norad/ RNE will organize this meeting in consultation with the reviewer. Electronic copies of any presentations made by the Review Team at this meeting, i.e. PowerPoint presentation, handouts, summary documents, etc. shall be given to the Norad/RNE.

CHEDULE FOR THE ASSIGNMENT / SIZE OF CONTRACT

The entire process including report writing should be completed within 25 working days. The review is planned for the period of August-October 2023. The final report should be submitted by end of October 2023.

Contract value is estimated at a maximum of NOK

7.1.1.1.1 Annexure 1: NIPI Phase III: Possible Assessment Domains and Evaluations questions

1. **Relevance:**

1.1 Whether all the objectives defined under NIPI phase III (with specific focus to objective 2 of testing innovations) were relevant to the National Health Mission, Government of India and its supported states?

2. **Effectiveness:**

2.1 Whether key results achieved by NIPI Phase III were aligned to the original plans?

2.2 What were the key enablers, challenges and limitations (both extrinsic and intrinsic) in implementing the program activities?

2.3 How was the scalability of innovations designed under NIPI Phase II? How many of them were adapted and successfully scaled-up by the state governments and Ministry of Health & Family Welfare, Government of India? What has been the magnitude (degree) and level of scale-up? What were the success factors?

3. **Efficiency:**

3.1 Whether NIPI has been able to ensure judicious and efficient use of resources and what has worked well?

3.2 Whether desired documentation has been done by implementing partner as per reporting requirements?

4. **Cohesive cooperation and Contribution to National Health Mission:**

4.1 What were the key contributions of NIPI to the mission and goals of the NHM at national and/or state level?

4.2 How is NIPI perceived as a technical development partner at national and state level?

5. **Sustainability:**

5.1 What efforts were made by NIPI to ensure sustainability of innovations and its scale up using resources of Government of India and state National Health Missions?

6. **Future directions:**

6.1 If the NIPI program were to continue, what would be the key possible strategic work areas in between Norway and India in Health beyond 2023 for attainment of SDGs?

6.2 How can Norway and India take forward this successful model of development cooperation for replication beyond India and Globally?