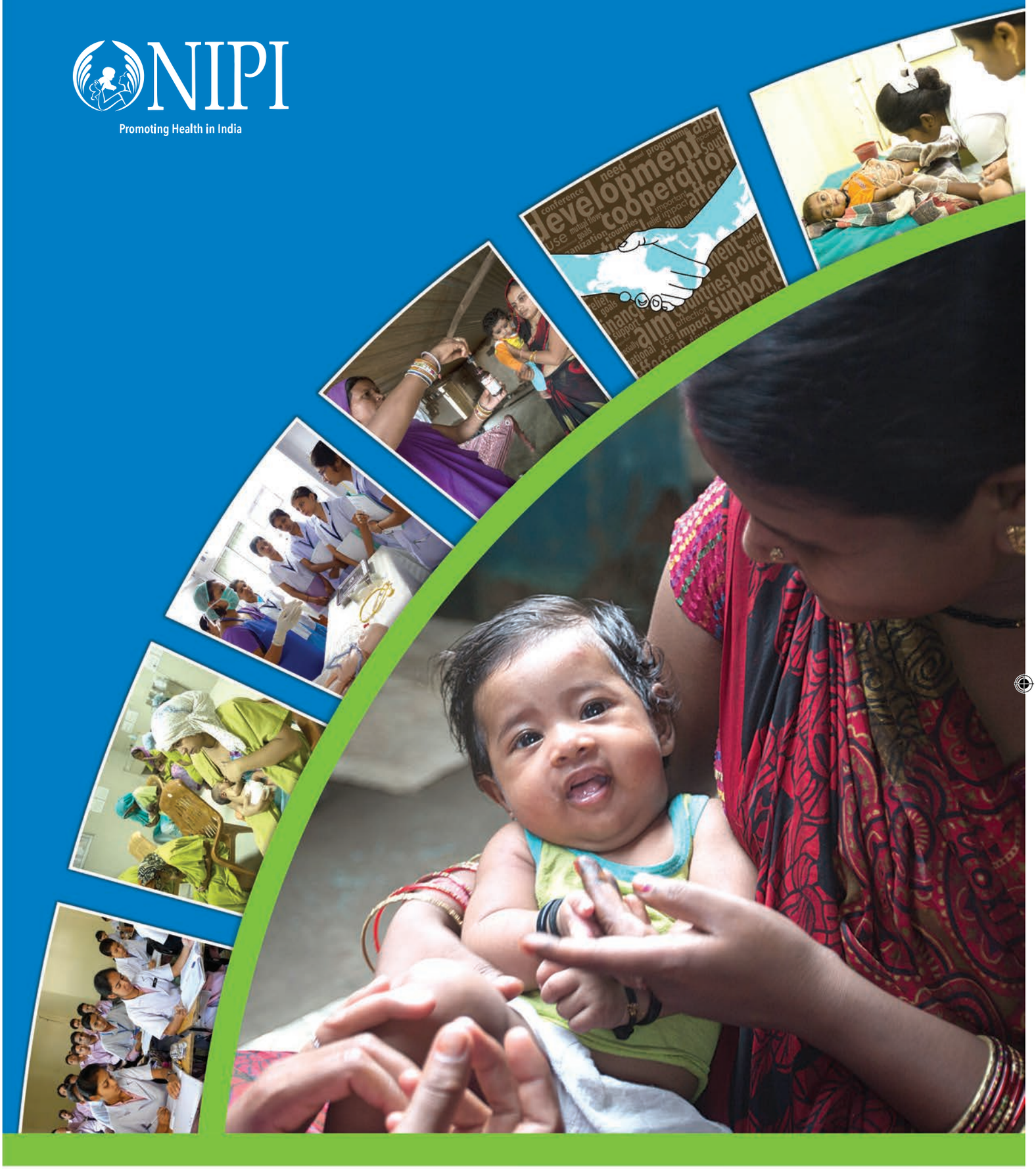
NIPI

Promoting Health in India



Getting Development Cooperation Right

Lessons from the Norway India Partnership Initiative (NIPI) for Maternal and Child Health

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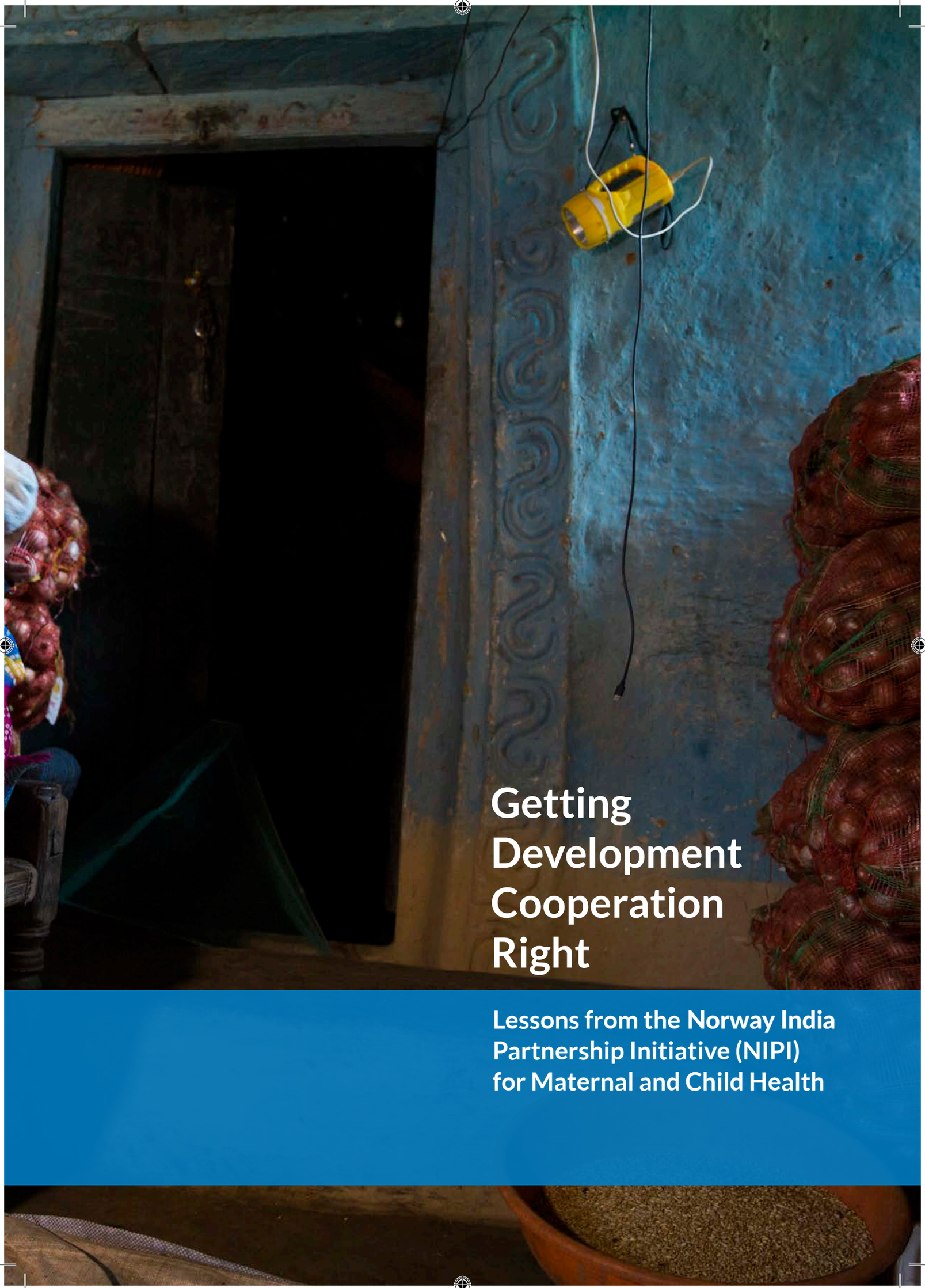

Getting Development Cooperation Right

Lessons from the Norway India Partnership Initiative (NIPI) for Maternal and Child Health

Norwegian Embassy

सत्यमेव जयते

PREFACE

The Norway India Partnership Initiative (NIPI) was established in 2006 through a joint statement by the Prime Ministers of Norway and India. Both the governments agreed that NIPI has achieved tremendous success and its duration has been extended for a period of three more years.

Through this period, the partnership between the two countries has successfully kept its initial promise of providing strategic, catalytic and innovative support to the Indian health care system for improved maternal and child health.

To understand the factors that led to the success of NIPI, a study was commissioned and the results are being shared in this document.

Our hope is that that this document can inspire, how development cooperation can be done in health and in other sectors.

We would like to thank Ministry of Health & Family Welfare, the State Health Societies of Bihar, Jammu and Kashmir, Madhya Pradesh, Odisha and Rajasthan; and the NIPI implementing partners and relevant stakeholders who have been instrumental in making this initiative a success.

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Ambassador of Norway to India

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NIPI
Promoting Health in India

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Acronyms and Abbreviations

ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwife
CU	Coordination Unit (NIPI)
ETAT	Emergency Triage and Training
FCC	Family Centred Care
GNM	General Nurse and Midwife
HBNC	Home Based New-born Care
HPD	High Priority District
IMR	Infant Mortality Rate
J&K	Jammu and Kashmir
JSC	Joint Steering Committee
MDG	Millennium Development Goal
MFA	Ministry of Foreign Affairs, Norway
MMR	Maternal Mortality Rate
MoHFW	Ministry of Health and Family Welfare, Government of India.
MTR	Mid Term Review
NBP	New Born Project
NHM	National Health Mission, Government of India
NIPI	Norway India Partnership Initiative
Norad	Norwegian Agency for Development Cooperation
PAG	Programme Advisory Group
PHFI	Public Health Foundation of India
PIP	State Programme Implementation Plan
PPIUCD	Post-Partum Intrauterine Contraceptive Device
PPFP	Post-Partum Family Planning
PSE	Pre-Service Education (Nursing and Midwifery)
RBSK	Rashtriya Bal Swasthya Karyakram
RMNCH+A	Reproductive, Maternal, New-born, Child and Adolescent Health
RNE	Royal Norwegian Embassy in Delhi
SDG	Sustainable Development Goal
SNCU	Sick New-born Care Unit
SCC	State Coordination Committee
ToT	Training of Trainers
U5MR	Under five Mortality Rate

Contents

1 EXECUTIVE SUMMARY

Executive Summary

The Norway India Partnership Initiative (NIPI) was established in 2006, based on an agreement between the Governments of Norway and India to collaborate towards achieving Millennium Development Goal (MDG) 4 to reduce child mortality, and the associated MDG 5 of reducing maternal mortality in India. NIPI's aim is to provide strategic, catalytic and innovative support to India's National Health Mission (NHM), by testing scalable interventions in districts in five high focus states: Bihar, Odisha, Madhya Pradesh, Rajasthan, and Jammu and Kashmir. Phase I lasted from 2008 through 2012 with a budget of NOK 500 million. Phase II ran from 2013 through 2017, with a budget of NOK 250 million.

During 2017, the Governments of India and Norway agreed that NIPI was effective, and a Letter of Intent for a Phase III with a 3-year duration was signed. In this connection, the Norwegian Embassy decided to document factors that led to the success of NIPI, as a model for development cooperation with the objective of showcasing it as a "good practice" for global learning. This report aims to achieve that goal, based on a review of relevant documents and interviews with key stakeholders.

Maternal and child health situation in India

In 2006, Under 5 Mortality Rate (U5MR) in India was 74 per 1000 live births and MMR 254 per 100,000 live births. Despite great progress, India did not achieve the MDGs in 2015, but did reduce U5MR to 48 per 1000 live births and MMR to 174 per 100,000 live births. India has signed onto the Sustainable Development Goals (SDGs), aiming to achieve a MMR of 70 deaths per 100,000 live births, an U5MR of 25 per 1000 live births and an Infant mortality rate (IMR) of 12 deaths per 1000 live births by 2030.

India has signed onto the Sustainable Development Goals (SDGs), aiming to achieve a MMR of 70 deaths per 100,000 live births

The NIPI model

The partnership is represented by India's Ministry of Health and Family Welfare (MoHFW) and Norway's Embassy in Delhi. Innovations are designed and implemented by national technical partners with high technical expertise and knowledge of the Indian health system, who provide technical support at all levels. Innovations are implemented at state and district level through the country's healthcare structures. A NIPI Coordination Unit provides secretariat services.

The governance structure consists of a Joint Steering Committee (JSC), the central decision-making body, chaired by the Secretary Health of the MoHFW and co-chaired by the Ambassador of Norway in India. A Programme Advisory Group (PAG), is a forum for technical dialogue and coordination between NIPI, NHM and implementing partners. State Coordination Committees (SCC) are constituted in each NIPI state to engage implementing partners with NHM state leadership. The governance structure ensures strong leadership, alignment with government priorities, ownership, and facilitate advocacy and scale up if innovations succeed.

The innovations designed and championed by NIPI are grounded in the Indian context, addressing clear gaps in the system. They use existing health structures and available human resources. They are mostly operational innovations that repackage health delivery to improve quality of care.

When an innovation has been shown to work and is going to be scaled up, national guidelines and training packages are developed, and trainings and ToTs are rolled out. Innovation costs are included in the state's budget and techno-managerial support is provided.

Key achievements of NIPI

01 The main success of NIPI has been the **impressive scaling up** of its innovations. At the end of 2017, 10 out of 11 innovations had some degree of scale up at state or national level (see Annex A). The MoHFW's Improving *Maternal and Child Health Outcomes in India-District Intensification Plan proposes several approaches based on NIPI innovations.*

02 NIPI has established a streamlined mechanism for **Evidence-Based Innovation** testing and scale-up. It has also led to the development of an innovation culture, with an acceptance of the risks of innovations.

03 NIPI's work has contributed to **Health Systems Strengthening.** Innovations have led to policy and guidelines which are key to sustainability and scale up. Health care standards have been strengthened through innovations targeting quality of care, improving performance monitoring and capacity building on health-related and techno-managerial skills.

04 NIPI has resulted in **Leverage** of funds, as a recent study by NIPI shows that for every NOK invested by NIPI, the Government of India (GoI) invested NOK 19.50 from the state health funds for NIPI innovations.

NIPI has demonstrated the key elements of a best practice, as shown in the table below:

Effectiveness

NIPI has achieved scale up of its innovations, which is considered an effectiveness factor for the initiative

Relevance

NIPI has been relevant to MoHFW in designing implementation and evidence creation of need based innovations which are in line with its National Health Policy goals

Efficiency

The NIPI structure has worked efficiently in phase II, with a total investment from NHM funds in the states of 19.5 NOK for every NOK invested by Government of Norway

Sustainability

NIPI has avoided creating parallel structures, instead working through national, state and districts health systems, strengthening them in the process in policy, implementation and data collection and monitoring capacity

Scalability

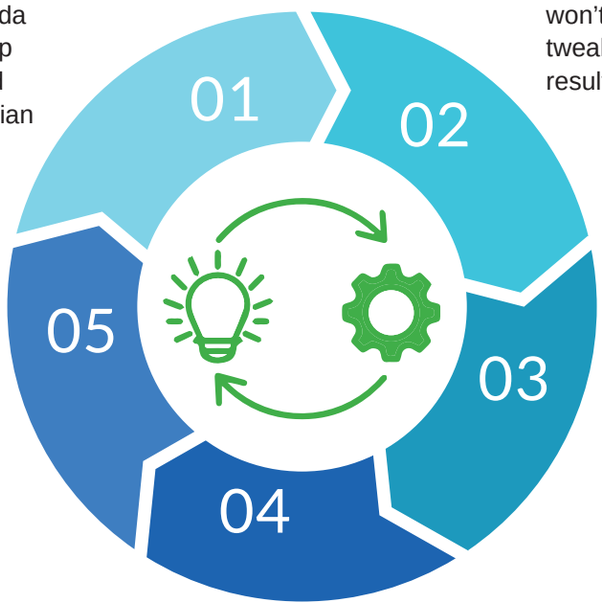
scalability is considered for NIPI innovations from the start. Many NIPI innovations have been scaled up from NIPI districts to state level, to non-NIPI states and even incorporated as policy recommendations at national level.

Lessons learned

NIPI stakeholders have shown willingness to accept and implement feedback over the years. Lessons learned include:

The importance of choosing the right Implementing Partners, aligned with NIPI's agenda and vision, and with deep technical knowledge and understanding of the Indian health care system.

Flexibility and acceptance of Risk, as innovations entail a risk that some interventions won't work, plus there is need for tweaking of programs based on results of pilots.



Advocacy and documentation of activities is key, to facilitate scale up and to showcase NIPI innovations at the global stage.

Strong but flexible Monitoring and Evaluation. NIPI in phase II established strong quantitative monitoring. However, adhering to a rigid 5-year programme document is perhaps not the best model for innovation testing, as new innovations are designed, others tweaked, and yet others stopped.

Finding the right Governance structure. The governance structure was modified from Phase I to Phase II, ensuring clear separation of roles, with a strong decision-making body, the Joint Steering Committee (JSC), a separate technical group, the PAG and including the state health leadership in SCC.

What makes NIPI a successful model of development cooperation?

NIPI has been called a ***"textbook example of development cooperation"***. An analysis, based on the Global Partnership for Effective Development Cooperation Principles, shows that the following elements are key for NIPI's success:

Country ownership and alignment: Emphasized but rarely implemented in development cooperation, these elements are clearly present in NIPI. NIPI's governance structure ensures ownership from the top level down, facilitating translation of proposals into action. Interventions are not donor, but country-driven, designed based on the needs of the country, by local technical experts with knowledge of government's priorities and in close collaboration with national and state government, creating a strong base for successful innovations to be scaled up.

Focus on results: For efforts to have a long-lasting impact on beneficiaries, ***sustainability*** is key. NIPI has avoided the creation of parallel structures and carried out ***implementation through the country's own health systems***, using available human resources, building experience and strengthening healthcare services. The focus has also been on ***simple, low cost innovations based on reorganizations of the health system***, and not on introduction of technology. These innovations strengthen good practices and improve quality. and fit into India's health system. To ensure results, ***flexibility and learning*** have been key, as innovations have been created and tweaked based on needs and results on the ground. Innovations have been based on ***evidence and data driven***, with strong emphasis on quantitative indicators, to measure if innovations are working.

Inclusive and equal partnerships: India's size, financial and technical capacity calls for a more equal cooperation and not a "traditional" north-south agreement. The GoI knows what its needs are and has the financial capacity required to do it, but needs the techno-managerial support provided by the NIPI-financed experts. Norway is seen as a respectful partner not trying to impose its own agenda, nor its own technical expertise, and accepting that the local experts understand India's needs and systems better. The level of respect, trust and collaboration is very high in NIPI, and facilitated by its governance structure which ensures dialogue at all levels of government.

Bringing in **credible technical experts** who understand the needs of the country, the strengths and weaknesses of the system and know how to work at district, state and national level is also a key element of NIPI's success. This has led to a correct interpretation of the Maternal and Child Health (MCH) needs in the country, and allowed working through the government structures and building sustainability.

Transparency and mutual accountability have been facilitated, by the NIPI governance structure. The states feel heard and supported. The implementing partners have a forum to advocate for their innovations. The structure also ensures dialogue and commitment from the highest levels of government and donor, thus preventing the implementing actors from being caught between opposing requests. It establishes a formal system for recording of these commitments, it warrants alignment with government needs and ownership at all levels and it promotes transparency, including in regard to funding and budget allocations.

Acceptance of risk: Development cooperation is inherently risky, but while this is accepted in theory, it rarely is in practice. NIPI has proven that it is possible to accept the risk, learn from failures and reach success. The acceptance of risk by all stakeholders – and particularly the donor, has been key. Learning from failures has been a critical component of NIPI throughout its 10 years. Transparency and mutual accountability have facilitated this risk-taking. At the same time, NIPI has been smart about palliating the risks with its systematic approach to innovations, piloting them first in a few districts. This builds confidence by showing results.

Conclusion

Not all success elements of NIPI are easily reproducible elsewhere. Few developing countries have India's number and level of technical experts, or financial capacity, and not all donor countries have the flexibility and willingness to align with the country's priorities that Norway has shown. Working in an area such as maternal and child health, which enjoys wide support globally, and consensus on the way forward, is also an advantage.

However, many of NIPI's key elements of success are well known and discussed in development cooperation forums. These include country ownership and alignment, working through the country's system to create sustainability, and creating inclusive partnerships that build mutual accountability. The difference is that NIPI has truly embraced these elements in practice and ensured that its organizational structures supported them. Chief among these have been the governance structures and the selection of national technical partners. These are strategies that can be replicated elsewhere.

Many of NIPI's key elements of success are well known and discussed in development cooperation forums.

2

INTRODUCTION AND BACKGROUND

The Norway India Partnership Initiative (NIPI) was established in 2006, based on an agreement between the Governments of Norway and India to collaborate towards achieving Millennium Development Goal (MDG) 4 to reduce child mortality, and the associated MDG 5 of reducing maternal mortality. NIPI is based on India's ambitious health initiative, the National Health Mission (NHM).

NIPI is aimed at facilitating rapid scale-up of quality maternal, neonatal and child health services. It aims to be strategic, catalytic, innovative and flexible, pilot testing innovations in maternal, neonatal and child health in specific districts in five high focus states: Bihar, Odisha, Madhya Pradesh, Rajasthan and Jammu and Kashmir. NIPI also aims to ensure sustainability and scalability of these interventions to facilitate adoption by the Government of India and implementation in further districts and states.

Introduction and Background

NIPI has evolved over two phases. NIPI Phase I ran from 2007 to 2012 with a budget of NOK 500 million and an expenditure of NOK 330 million. The evaluation of these first six years showed that NIPI had largely achieved its objectives of providing strategic, catalytic and innovative support to the NHM and had helped bring forward the new-born health agenda at state and national levels.

The initiative was extended for a further five years, from 2013 to 2017. NIPI Phase II, with a budget of NOK 250 million, continued to focus on maternal and new-born health, especially the continuum of care from facility to home, and capacity building of health personnel. It was made to coincide with the new NHM plan for 2013-2017 which aims to strengthen on-going initiatives and expand the reach towards achieving universal health care.

While at the end of 2016 it was considered that there would be no continuation of NIPI after Phase II, during 2017, both India and Norway decided that the initiative was working effectively and a Letter of Intent for a Phase III with a 3-year duration was signed in September 2017.

2.1 Maternal and child health in India

India has had impressive sustained economic growth in the last decades, which have also led to important gains in human development. Despite great progress, however, many health and development challenges remain[1]. Over 20% of global child deaths occur in India, and 40% of the world's malnourished children live there[2]. This means that any improvements in child survival in India have a huge impact on global indicators. Eight states contribute disproportionately to child deaths: Madhya Pradesh, Uttar Pradesh, Odisha, Assam, Rajasthan, Bihar, Chhattisgarh and Jharkhand.

[1] Sample Registration System- India.

[2] World Bank. Country overview- India.

In 2006, when the Governments of Norway and India agreed to collaborate towards achieving MDG 4 to reduce child mortality, under-five child mortality (U5MR) in India was 74 per 1000 live births. By the end of NIPI Phase I in 2015, U5MR in India had been greatly reduced to 48 per 1000 live births[3], getting close to the MDG target of reducing child-mortality by two-thirds from the 1990 baseline, to 42 per 1000 births by 2015.

As for MDG 5 on improving maternal health, India also achieved impressive results in reducing the Maternal Mortality Rate (MMR). In 1990-91, MMR was 560 per 100,000 live births, and achieving the target of three-quarters reduction from 1990 levels required reducing this 109 by the end of 2015. MDG measures indicate that India's MMR had declined to 167 per 100,000 live births by this time.

India has signed onto the Sustainable Development Goals (SDGs), aiming to achieve a MMR of 70 deaths per 100,000 live births, an U5MR of 25 per 1000 live births and an Infant mortality rate (IMR) of 12 deaths per 1000 live births by 2030. However, India has set for itself an even more ambitious goal, and aims to reduce IMR to a single digit by this date[4].

Table 1. MDGs and SDGs in India

MDG & Targets	Indicator	India 1990	India 2005/6	India 2012/3	India 2015***	MDG Target 2015	SDG Target 2030
MDG 4. Reduce Child Mortality	Under-five mortality rate (U5MR)*	125	74	49	48	42	25
	Infant mortality rate (IMR)*	80	57	40	38	26	12
MDG 5. Improve Maternal Health	Maternal mortality ratio (MMR)**	560+	254	178	174	109	70

[3] UNICEF. Child mortality estimates, U5MR and IMR are per 1000 live births.

[4] India New-born Action Plan, MMR is per 100,000 live births.

3

UNDERSTANDING THE NIPI MODEL

Understanding the NIPI Model

NIPI is a partnership between the two countries, represented, respectively, by India's Ministry of Health and Family Welfare (MoHFW) and the Royal Norwegian Embassy (RNE) in Delhi. The third group of stakeholders is the States, as funds are allocated to the State Health Societies of the 5 participating states.

Innovations are designed by selected national technical partners with high technical expertise and a deep knowledge of the Indian health systems. Even though these technical partners are called "implementing" partners, these organizations do not carry out work with beneficiaries directly. They work closely with the government at all three levels (national, state and district), providing technical support for policy, training, mentoring and monitoring. The work with the beneficiaries is done by the health state or district structures and its own human resources for community and facility-based care.

The last stakeholder is the NIPI Coordination Unit, which creates the link between the implementing partners and the NIPI governance system.

NIPI's governance structure underwent some reorganization in Phase II, based on the recommendations from the Phase I evaluation, in NIPI Phase II it consisted of:

1. The Joint Steering Committee (JSC), which is the central decision-making body, with representatives of the Government of India and MFA, chaired by the Secretary Health of the MoHFW and co-chaired by the Ambassador of Norway to India. State NHM leadership and NIPI Coordination Unit (CU) are invited participants. The JSC meets once a year.
2. The Programme Advisory Group (PAG), which is a forum for technical dialogue and a platform for coordination between NIPI CU, NHM and implementing partners. It reviews progress and presents proposals and advice to the JSC. The PAG meets once a year to prepare the JSC meeting.
3. State Coordination Committees (SCC), constituted in each NIPI state to engage implementing partners with NHM state leadership, and integrate NIPI activities with NHM approaches and strategies, and for technical, managerial and budget planning. Each SCC meets twice a year to review progress and set new goals.
4. A NIPI Coordination Unit which executes decisions made by the JSC and provides secretariat functions to the JSC and PAG. It meets regularly with implementing partners, the MoHFW and RNE.

The set up provides a strong governance and strategic direction group (JSC) with high level leadership (the Secretary Health and Norway's Ambassador), allows for solid endorsement of interventions, solving challenges and moving NIPI forward. It also provides a separate panel technical discussions and coordination (PAG).

The SCCs have been key as well, providing a strong review mechanism allowing for midpoint corrections and surmounting of obstacles encountered thanks to the state level leadership participating in them. It has also created ownership at state level, which is important since India has a decentralized health system, where most resources are allocated through the states.

The governance structure is hierarchical, but ensures alignment with government priorities, ownership, and facilitate advocacy and scale up when innovations succeed.

Financing: Funds flow from the Royal Norwegian Embassy (RNE), via an implementing agency, to the SHS; NIPI CU and the implementing partners. NIPI finances the technical support given by national experts to the states. The NHM state funds also allocate a budget in their Health Plans for NIPI based innovations in NIPI districts – and if scale up is decided, in non-NIPI districts as well-

Figure 1: The structure of NIPI. Stakeholders are shown in green and governance structures in blue. Filled arrows represent participation in said structures and dotted arrows represent invited status. Thick blue bars indicate technical support from implementing partners.

Figure 1: NIPI Governing Structure and implemenation mechanism

3.1 Implementation

NIPI's implementation approach is in many ways unique. Technical support partners design and propose evidence-based innovations. These are discussed in all the formal meeting with all stakeholders and in informal meetings. Afterwards these interventions are proposed to the NIPI Governing board. When approved, this means there is an interest from the MoHFW and the states to scale up the innovation if it works. There is also an engagement from the states to allow the use of state resources (human and financial) to test the innovations in NIPI districts.

This implementation format has some key advantages:

- It facilitates the creation of a **strong partnership** between the technical support partners, the RNE and the NIPI Coordination Unit, and close collaboration and discussion with the Ministry of Health & Family Welfare (MoHFW) and State Health Societies (SHS). Discussions on any innovation start from an early phase, increasing ownership and alignment.
- **Scalability** of the innovations is considered from the start, and is facilitated, if the innovation succeeds, by the NIPI governing structure. Initiatives are implemented within the district and state health structures, which facilitates their adoption at the state-wide and national level, where they can be taken up as government initiatives, in many cases leading to guidelines and implementation manuals.

3.2 Innovations

NIPI has developed a set of innovations for maternal and child health, described in Table 2 below.

Table 2. List of NIPI innovations

Name	Description
Infant and Child Health Innovations	
HBNC+. Home Based New-born Care Plus	HBNC+ involves structured home visitations by community health workers to improve the survival and development of infants to promote and ensure exclusive breastfeeding for six months, ensure continued breastfeeding and complementary feeding, promote routine Immunization, provide counselling for hand-washing, ensure prophylactic distribution of Oral Rehydration Solutions (ORS) and Iron and Folic Acid (IFA), ensure growth monitoring and promoting Early Child Care and Development (ECD).
SNCU+- Sick New-born Care Unit Plus	Aims to provide community care to newborns discharged from newborn care facilities to enhance neonatal survival in India. Community Health Workers and Auxiliary Nurse Midwifes (ANMs) follow-up newborns discharged from Special New Born Care Units (SNCU) at their homes with structured home visitations.
FCC – Family-Centred Care	Aims to empower the family and get it involved in new-born rearing practices at the neonatal unit. FCC creates a developmentally supportive environment for the sick or low weight baby and is responsive to the family needs, helping parents and providers work together to ensure the well-being and survival of the most vulnerable new-borns. It builds upon Kangaroo Mother Care (KMC) and optimal feeding for low birth weight babies.
ETAT- Paediatric Emergency Triage and Treatment	Aims to strengthen emergency paediatric services in referral and district hospitals through establishing a systematized process for triage and treatment of sick children, strengthening infrastructure and equipment, and training packages for nurses and doctors.
Regional New Born Resource Centres	Aims to improve the quality of immediate new-born care in sub-district facilities (comprising New-born Care Corners (NBCCs) at delivery points, as well as New-born Stabilizing Units (NBSUs) and Sick New-born Care Units (SNCUs)
RBSK - Rashtriya Bal Swasthya Karyakram	This is a government led initiative that requested NIPI's support. RBSK is a structured health screening of children for early detection and management of defects at birth, diseases, deficiencies and developmental delays including disabilities. NIPI has supported initial development of resource materials and tools for screening and training and capacity building.
Maternal Health innovations/ strategic support areas.	
PSE - Strengthening of Pre-Service Nursing and midwifery education	Aims to improve the quality of pre-service education for nurses and midwives by: i) establishing State Nodal Centres of Excellence, ii) Improving Educational processes and Infrastructure in Public General Nurse Midwifery (GNM) and Auxiliary Nurse Midwife (ANM) schools state wide; iii) Strengthening clinical skills-development by strengthening the clinical practice sites and iv) Improving teaching and clinical skills of GNM and ANM faculty.
PPIUCD– Post-Partum Intrauterine Contraceptive Device services	Aims to promote and strengthen Post-Partum Family Planning (PPFP) in the months following childbirth by providing Inter Uterine Copper Devices (IUCDs) services and counselling to mothers.
Dakshata – Strengthening quality of care in labour rooms	Aims to improve Quality of Care in labour rooms through: i) Strengthening competency of service providers through training and onsite mentorship ii) Ensuring availability of resources necessary for essential practices, iii) Improving adherence to evidence-based practices through use of WHO Safe birth Checklist, iv) Improving accountability through better data recording, utilization, and reporting
Swasthya Slate	Innovative technology to improve the delivery of Reproductive Maternal New Born Child Health and Adolescent Health (RMNCH+A) services. Swasthya Slate is a tablet device that can be used by a health worker to perform multiple activities related to point of care diagnostics, health promotion and health communication and data collection.
Yashoda	Aims to provide support to mothers and infants in health facilities through incentivized birth companions called 'Yashoda'. They provide emotional support, postnatal counselling on exclusive, breastfeeding, immunization and other essential new-born care components, as well as post-partum family planning.

These innovations designed and championed by NIPI have been presented and praised in several forums. They have certain characteristics that are important for scalability and sustainability:

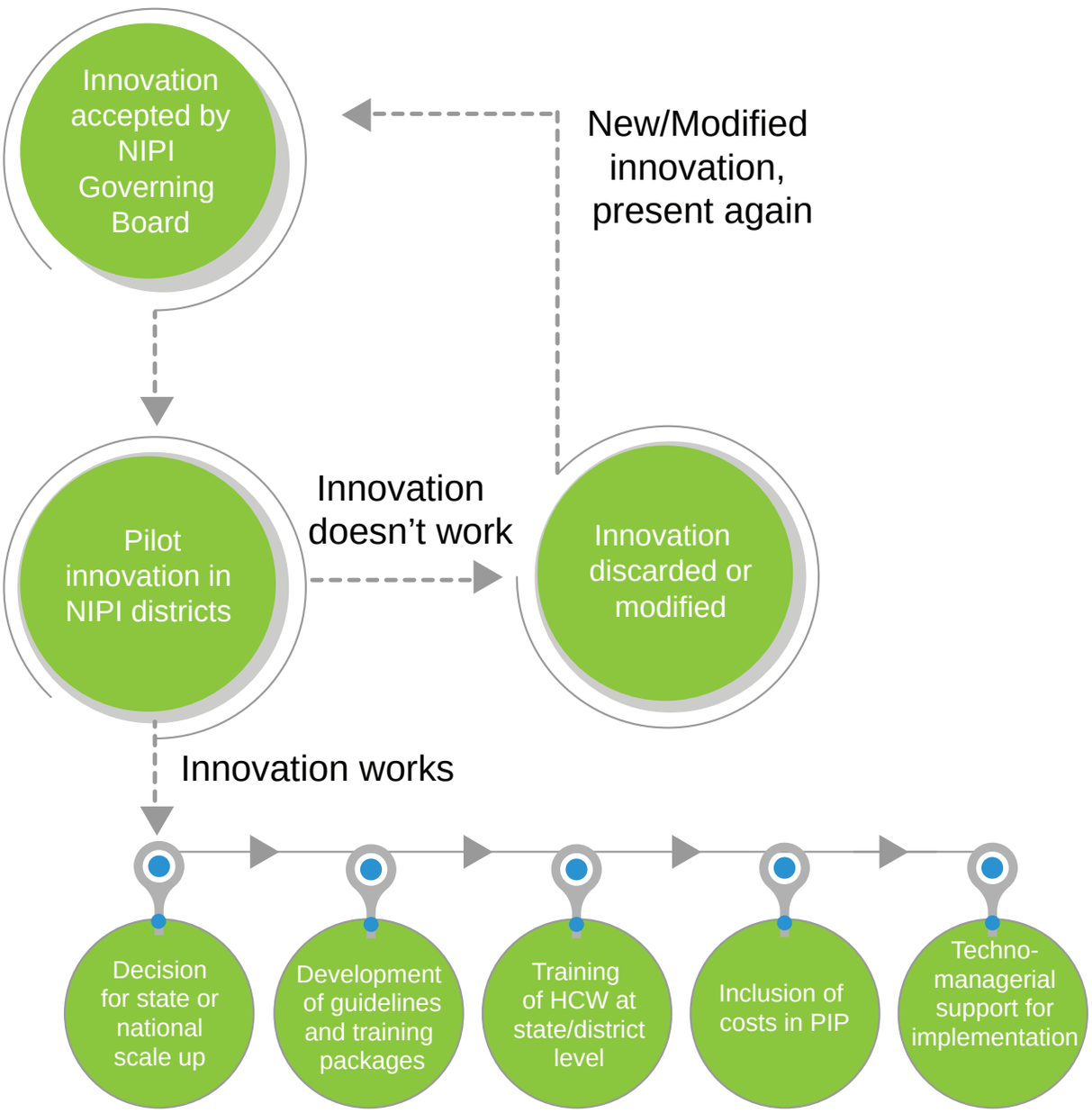
- **Grounded in context:** NIPI innovations are designed by national experts with a deep understanding of the needs of the country, the strengths and weaknesses of the health system and the differences across states and districts in terms of needs, geography, population and maternal and child health indicators. Thus, innovations address identified gaps in the system, and are aligned and adapted to the local context.
- **Using existing health structures:** Innovations are implemented through the existing health systems and use the available human resources, e.g. Home Based New Born Care Plus (HBNC+) is carried out by ASHAs, a health worker already existing in the system, Preservice Nursing education (PSE) helps make sure available professor positions in nursing schools are filled. Innovations also help advocate for targeted financial resources to improve health facilities (e.g. Emergency triage assessment and treatment (ETAT) supports better health facility spaces for children, Dakshata advocates for a minimum of functional equipment in labour rooms).
- **Operational innovations:** At the global level, much of the focus on health innovations have been related to technology, and while NIPI also has also tested technologies, most NIPI innovations focus on testing the "how". The interventions conceptualize innovative approaches to organize health delivery that look to improve quality of care. For example, PSE uses clear standards for improving pre-service nursing education; the New Born Quality Index systematically measures key components for new-born care; ETAT focuses on improving quality in paediatric wards and Dakshata in labour room practices. These innovations, which can be relatively "low cost" compared to technological ones, stem from an understanding of the gaps and needs in health care delivery, provided by the technical experts, many of whom are medical doctors and paediatricians with practical experience in the Indian health services.
- **"Building blocks" innovations:** Some NIPI interventions can be seen also as platforms to which new things can be added, or as "building blocks" that can be incorporated into larger frameworks. For example, PSE can be fitted into a larger context of strengthening human resources for health, and SNCU and ETAT as strengthening of health infrastructure. HBNC+ has proven to be a platform in which to deliver Early Child Development interventions.

Figure 2: A labour room after Dakshata intervention

3.3 Scale up

When an innovation has been shown to work and state and/or national level government are keen on rolling it out, several components need to be put in place to ensure sustainability and facilitate scale up: (i) development of national guidelines and training packages; (ii) training of health care workers and staff at the state and district level, as well as training of trainers; (iii) inclusion of innovation costs and components in the state's PIP and budget; (iv) techno-managerial support at the state and district level to ensure the initiative moves forward and has adequate supervision to be implemented correctly.

Figure 3: Path to scale up of a NIPI innovation



4

KEY SUCCESSES OF NIPI

Key successes of NIPI

4.1 Scale up of innovations

The main success of NIPI has been the impressive scaling up of its innovations. At the end of 2017, 9 out of 11 innovations had some degree of scale up (Annex E). Some innovations, such as Post-Partum Intra Uterine Contraceptive Devices (PPIUCD), have already scaled up nationally and NIPI phased out. Others are being scaled up either to new districts in NIPI states or non NIPI states, some of which have requested support or guidance from NIPI partners.

Most significantly, the Ministry of Health and Family Welfare's (MoHFW's) recent document **improving Maternal and Child Health Outcomes** in India-District Intensification Plan[5], proposes several approaches based on NIPI innovations, such as a Labour room Quality Improvement Initiative [LaQshya] and labour room strengthening (based on Dakshata); emergency care for children (based on ETAT), family participatory care for new-born (based on FCC); and home based extended infant care, follow up of sick and small new-borns in infancy (based on HBNC+ and SNCU+).

4.2 A system for needs-based innovations

The establishment of an innovation culture per se is seen as a key achievement, as there is now an acceptance of the risks of innovations. NIPI's work over 10 years of designing, pilot testing and demonstration of innovations, has created a mechanism for innovation testing and scale-up. The process has become more streamlined, and ensures buy-in and the potential for scale-up from the start, with an understanding on how to proceed with documentation, scale up in the NIPI states, and also transfer to other states.

4.3 Strengthened health systems

NIPI's work has contributed to health systems strengthening through the innovations per se, but also in indirect ways resulting from the technical support work provided for the innovations.

- **Contribution to policy and guidelines:** NIPI partners have collaborated with the MoHFW in the development of over 20 policy documents, guidelines and training manuals (see list in Annex C). The development of these documents is key for sustainability, as they embed the changes in care standards and interventions at the policy level; and for scale up, as it standardizes the innovations and provides needed documentation.
- **Strengthening of care standards:** Many NIPI innovations are based on improving quality of care through standardized performance measures (e.g. clinical skills standardization in Preservice Education (PSE), ETAT's assessment of Quality of Care (QoC) for children in District Hospitals). This, together with NIPI's emphasis on Monitoring and Evaluation[6], establishment of quantitative indicators and targets, and development of tools for periodic assessments, has helped strengthen standards of care.

NIPI partners have collaborated with the MoHFW in the development of over 20 policy documents, guidelines and training manuals.

[5] MoHFW. Improving maternal and child health outcomes in India-District Intensification Plan, 2017.

[6] NIPI has been the subject of several studies, in addition to standard mid-term reviews and process evaluations. These have included: an impact evaluation of the techno-managerial support provided by NIPI in Phase I; an independent evaluation of HBNC+ in Rajasthan in 2015 designed as a case-control study. An impact evaluation of NIPI including HBNC+, SNCU+ and PPIUCD interventions is currently underway.

- **Capacity building:** NIPI partners work in close cooperation with the state and district health stakeholders, resulting in capacity building on techno-managerial skills in government staff and health care workers at state and district level. This indirect capacity building is taking place beyond the explicit trainings that are part of the innovations, and sometimes in areas not necessarily health-related (e.g. support provided for procurement activities, resulting in decreases in the length of the procedures from 2.5 years to 9 months; strengthened data collection and monitoring).

4.4 Leverage of resources

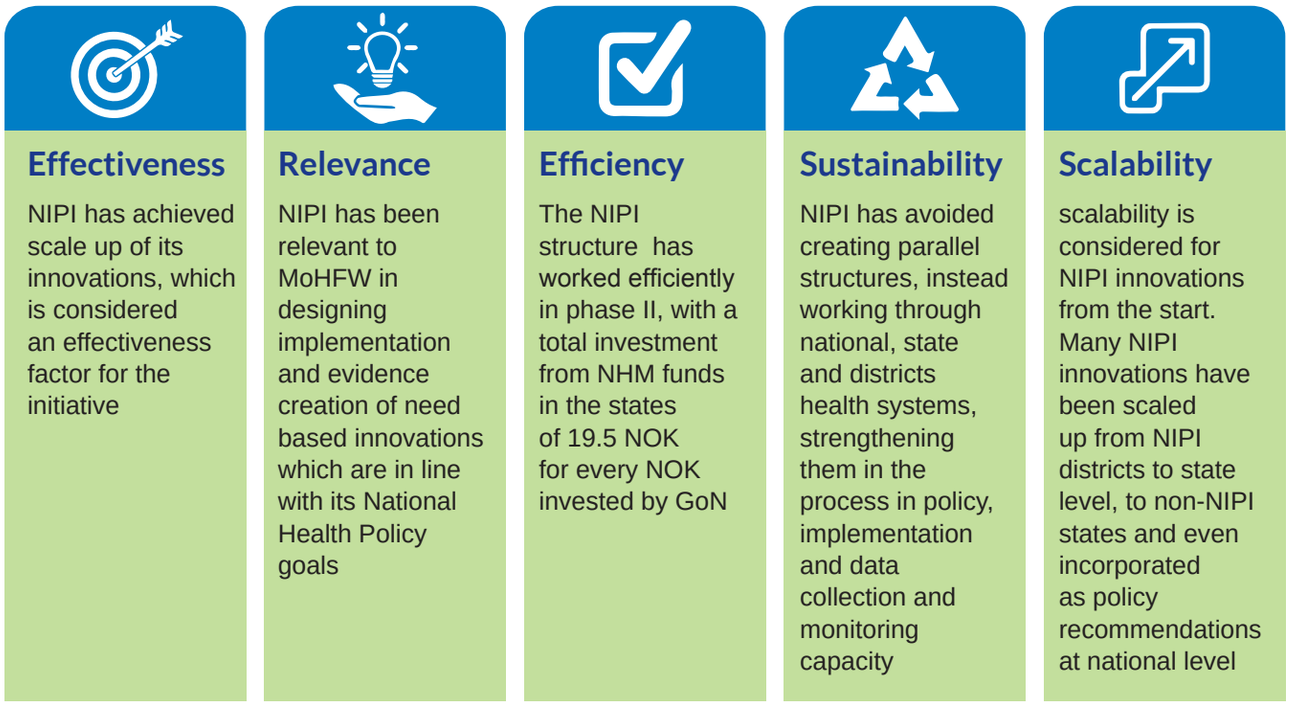
NIPI investments in innovations have resulted in an important leverage of funds from the NHM, the states and other development partners to scale up the initiatives. A report carried out in 2017 shows that in Phase II, for every NOK invested by NIPI, the Government of India (GoI) has invested NOK 19.50 of state health funds for NIPI projects[7], although there are large differences from one intervention to the other (older innovations such as Preservice Education (PSE) have leveraged more resources than newer ones, such as Dakshata).

Moreover, NIPI's techno-managerial support at state level, is thought to have facilitated the expenditure of funds that due to lack of capacity where left unused before[8].

4.5 NIPI as a best practice

Considering these key successes, NIPI fulfils the elements that are usually proposed to describe a "best practice", as shown in Figure 4 below.

Figure 4: Elements of a best practice in NIPI



[7] Leveraging of country/state health resources through implementation of NIPI activities report. 2017.

[8] There is, however, no study yet conducted to support this assertion by stakeholders.

5

LESSONS LEARNED OVER 10 YEARS OF NIPI

Lessons learned over 10 years of NIPI

Throughout the 10 years of NIPI, the partnership has evolved, and changes have been made based on evaluations and reviews, helping to continuously improve the initiative. NIPI stakeholders have shown willingness to accept and implement the feedback over the years. This flexibility has been an important aspect of NIPI.

5.1 Choice of implementing partners

In Phase I, to buffer the perceived risks of working with innovations and channelling the funds through the states, UN agencies were chosen as implementing partners for some of the initiatives. By the end of Phase I, however, positive results with the New Born Project Team changed the perception of risk. Thus, in Phase II, NIPI switched strategies and channelled funds via an agency to the State Health Societies (SHS) for implementation and to national organizations to provide technical expertise, adding to the NBP team by bringing in Jhpiego, which was working with innovations in maternal health (e.g. Post-Partum Intrauterine Contraceptive Devices (PPIUCD) and Public Health Foundation of India (PHFI) with its proposal of Swasthya Slate technology. A lesson learned was that NIPI required flexibility and willingness to switch partners, and that the **choice of technical partners with deep national expertise was key.**

5.2 Flexibility and acceptance of risk

Working with innovation entails a risk that some of the interventions tested will not succeed, meaning that they won't produce good enough results, won't be well received, or won't be scaled up for different reasons. It also means that the donor as well as all other stakeholders need flexibility to accept programmatic changes based on how things are working in the field. This flexibility has been a key lesson. The technical partners have continuously improved their capacity to detect what is not working, and seek to change it, and the donor has shown willingness to accept these changes.

5.3 Strong but flexible monitoring and evaluation

Another key learning from phase I, was the need to strengthen Monitoring & Evaluation (M&E) of the projects. Phase II started with a Program Document and an M&E framework. By the Midterm Review of Phase II, it was clear that both Jhpiego and New born project (NBP) had great capacity for strict quantitative monitoring through rapid assessments and cross-reviews across state-teams, and this allowed for evidence-based results.

Another lesson has been that adhering to a rigid 5-year programme document and an evaluation based on it, is not the best model for NIPI innovations. During NIPI's Phase II, as needs have been detected, new innovations have been designed that were not initially considered (e.g. Dakshata), and others were tweaked (HBNC+), depending on results. NIPI has worked on 5 year-periods but has used yearly plans that are presented to the JSC after reporting on results from the previous year, thus facilitating this flexibility to make programmatic changes from one year to the next

In Phase II, NIPI switched strategies and channelled funds via an implementing agency to the SHS for implementation and to national organizations to provide technical expertise.

Box 1. Examples of strenghtened M&E approaches

Cross-State Periodic Assessments: NIPI New born Project teams from one state perform periodic evaluations and assessments of NBP interventions in others NIPI states, using a standardized tool. These periodic assessments allow for feedback and course correction, without having to wait for external evaluations, and also creates mentoring and learning opportunities.

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

Source: NIPI Phase II Midterm Review.

5.4 Finding the right governance structure

The governance structure is key to the success of NIPI, but it has taken some changes to find the adequate structure. Two important lessons learned have been:

i) Avoid conflict of interest by separating the decision-making body from the implementing partners. For example, in Phase I, the implementing agencies were originally part of the governing board (JSC) but were later removed and only included in Program Advisory Group (PAG) and State Coordination Committees (SCCs),

ii) Establish clear roles for each body to avoid overlap and duplication of efforts. The roles of each governance body have been clearly defined in the Memorandum of Understanding.

Advocacy of the innovations has been key, and the governance structure supports advocacy by the implementing partners

5.5 Advocacy and documentation of activities.

Advocacy of the innovations has been key, and the governance structure supports advocacy by the implementing partners, and the states when they are interested by the initiatives. NIPI's structure facilitates the backing and promotion of interventions that are shown to add value.

Yet another lesson during Phase II has been the importance of strong documentation of activities, not only for advocacy but also for showcasing at the global stage. The last two years of Phase II have strengthened intervention-specific, in-depth documentation of successes and lessons learned, and use of data for academic publications.

6

WHAT MAKES NIPI A MODEL OF DEVELOPMENT COOPERATION?

What makes NIPI a model of development cooperation?

NIPI has been called a ***"textbook example of development cooperation"***. Government stakeholders in India and Norway, as well as technical experts with long experience working with other donors and agencies, have repeatedly praised it. While there are factors that are unique to this partnership and its context, many elements are replicable elsewhere.

The section below discusses the evidence regarding whether NIPI truly is a success, while the following section analyses the elements that make NIPI an effective model of development cooperation.

6.1 Has NIPI been successful?

Stakeholders agree that the final measure of success for NIPI include:

Scale up of the innovations:- Out of 11 innovations that NIPI has developed over these 10 years, 9 have been scaled up either state-wise (to NIPI and non-NIPI states), and sometimes nationally (see Annex E), and 5 have been included in the 2017 District intensification plan for improving MCH outcomes in India.

Policy level changes:- Seven[9] of NIPI's innovations have been incorporated into policy guidelines (see Annex C). This is key for sustainability of the innovations.

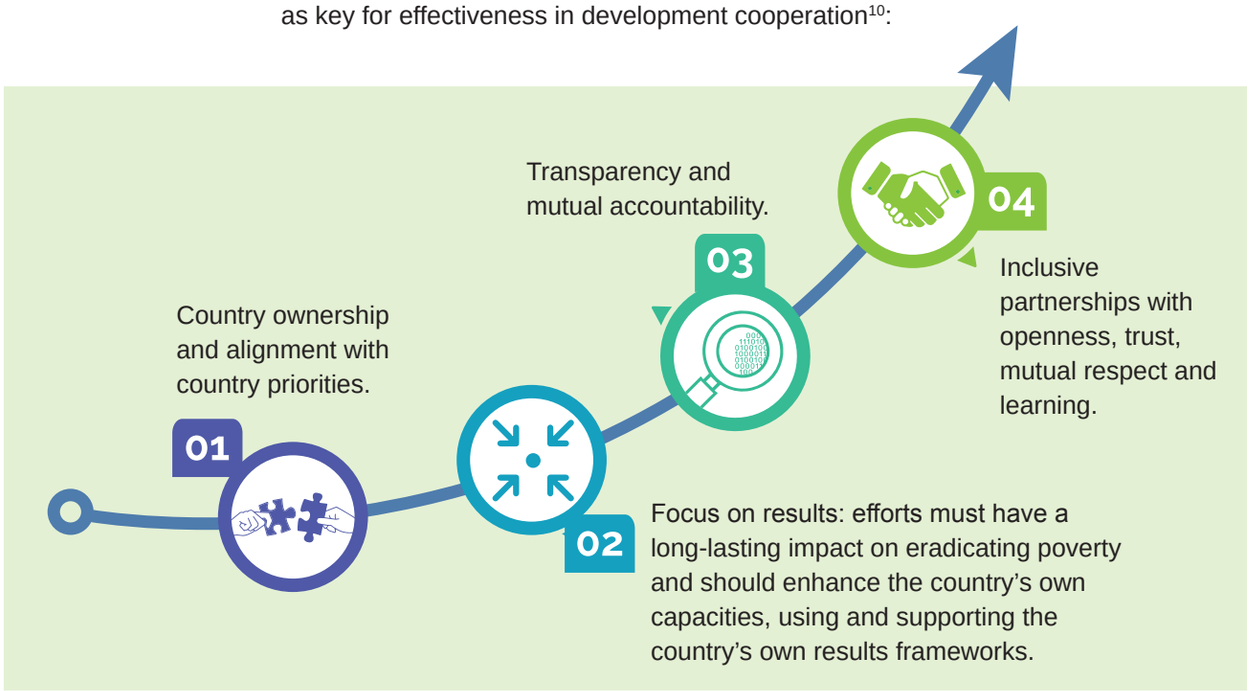
Relevance to both governments:- The fact that NIPI was extended for a Phase II and now even for a Phase III, even though India has decreased the number of development partners it works with and that Norway has moved away in the last years from bilateral cooperation to supporting global efforts, shows the relevance of NIPI to both governments.

Catalytic effect – NIPI has achieved the catalytic effect it sought at its inception, both in terms of policy impact and in leverage of funds.

[9] Five are now included in the 2017 District intensification plan for improving MCH outcomes in India (HBNC+, SNCU+, Dakshata, FCC and ETAT), and national guidelines have been developed for HBNC+, SNCU+, FCC, ETAT, PSE, Dakshata and RBSK.

6.2 What elements make NIPI a model of development cooperation?

The Global Partnership for Effective Development Cooperation considers four principles as key for effectiveness in development cooperation[10]:



Using this analytic framework, we have looked at which elements of NIPI have been key to its success.

6.2.1 Country ownership and alignment.

NIPI showcases the success of the well-known, but rarely implemented concept of letting the country lead. **Ownership** has repeatedly been ranked high as one key element of success for NIPI. NIPI's governance structure ensures that innovations are approved first by the Ministry of Health & Family Welfare (MoHFW) and Royal Norwegian Embassy (RNE), with input from states and national health officers in all three bodies. This ownership from the top level down facilitates translation of proposals into action and creates advocacy and accountability. This ownership has gone hand-in-hand with government commitment to scale up successful innovations, invest NHM funds for its implementation, and incorporate interventions into national policy.

Alignment: Interventions are not donor, but country-driven. They are designed based on the needs of the country, by local technical experts with knowledge of government's priorities and policy planning and in close collaboration with national and state government, creating a strong base for successful innovations to be scaled up.

6.2.2 Focus on results

For efforts to have a long-lasting impact on beneficiaries, sustainability is key, and this means working through the country's own systems and strengthening them. This is what NIPI has done.

[10] Global Partnership for Effective Development Cooperation. Nairobi Outcome Document. Dec 2016

Implementation through country's own health system; Stakeholders state that this component has been one key element for sustainability. NIPI has avoided the creation of parallel structures, seeking to use available human resources. Interventions are based in many cases on improvements (trainings, facilitations, systematization, inventive repackaging) of existing health structures. Also, most of the funding for programme implementation is coming from the states, which incorporate costs of the interventions into their Programme Implementation Plans (PIP) budgets.

While this process is slower and requires understanding and dealing with the system's shortcomings and bureaucracy, it increases ownership, strengthens the health system (directly through interventions and indirectly through techno-managerial support), and stakeholders believe it will prove more sustainable in the end.

Simple, low cost innovations based on reorganizations of the health system, and not on introduction of technology. This goes hand in hand with the alignment with country and not donor priorities. In many instances donor organizations will focus on promoting health technologies or commodities. NIPI, on the other hand, because of the local technical expertise, focused on changing how things are done in the health system to strengthen practices, knowledge and improve quality. As one stakeholder put it, they are "low hanging fruit" interventions. In fact, many of the "innovations" were evidence-based projects that had worked elsewhere, and where repackaged, adapted and standardized to fit into India's health system e.g. Dakshata with checklists for labour room practices, Family Participatory Care (FPC) as a mechanism for operationalization of Kangaroo Mother Care.

It was a deliberate decision that NIPI should operate through the health system and not in parallel, to ensure the systems gained the experience necessary and it became easier to translate innovations into policy.

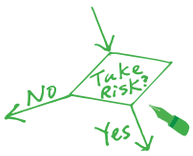
Flexibility and learning: The focus on results also means that whatever is not working needs to change, and thus a rigid 5-year program plan is not necessarily the best solution. NIPI has created an environment of openness and willingness to learn from mistakes. Flexibility also means understanding that the initiatives will not look exactly alike in different states, because states have varying needs of support, technical expertise, etc. The donor has embraced this by accepting flexibility in funds disbursement.

Evidence and data-driven: NIPI innovations have been based mostly in approaches that have already proven useful elsewhere. And in phase II, NIPI has had a strong focus on data. For example, Preservice Education (PSE) is based on a number of indicators that nursing schools aim to achieve at 70% level. Baselines were measured, and rapid assessments are used to quantify improvement. For HBNC+, data is collected by ASHAs, and the project teams put together a data collection system to share with the state governments who have requested it, and has provided support to state governments to use the system.

"We've done it the slow, hard way and this has created unprecedented sustainability"

6.2.3 Inclusive partnerships

This element has to do with partners seen as collaborators and not donor and recipient, and with bringing in different stakeholders (local organizations, decentralized government, civil society, etc) to the project.



"Taking risks should be an inherent part of how to do development cooperation"

National technical expertise: This has repeatedly been named another of the pillars of NIPI's success: Bringing in credible technical experts who understand the needs of the country, the strengths and weaknesses of the system and know how to work with the bureaucracy at district, state and national level. This has led to a correct interpretation of the MCH needs in the country, and thus NIPI providing workable solutions to the GoI. For example, the Strengthening of labour room through training and use of a simple checklist, the incorporation of Family Participatory Care (FPC) to infant care in facilities overwhelmed by lack of staff, and the creation of Emergency Triage Assessment and Treatment (ETAT) units in hospitals where children were often not seen quickly enough. These innovations can only stem from a profound knowledge of the system.

Importantly, the choice of technical partners has been key (see section on Lessons learned). The current ones work together with mutual respect and openness, avoiding duplication and creating synergies between their neo-natal and maternal health expertise. They are willing and able to work through the government structures and build sustainability, and are widely recognized as experts in their fields.

Equal partnership: In NIPI the "traditional" language of development cooperation breaks down. India is a different partner, because of its size, financial and technical capacity and the impact of any work done on Maternal and Child Health (MCH) in India on global indicators. The Government of India (GoI) knows what its needs are and have the financial capacity required to do it but needs the techno-managerial support provided by the NIPI-financed experts. This calls for a more equal cooperation and not a traditional north-south agreement. The level of respect, trust and collaboration is very high in NIPI, and facilitated by its governance structure which ensures dialogue at all levels of government.

Norway as a donor is seen as a respectful partner not trying to impose its own agenda, nor its own technical expertise, and one who accepts that the local experts understand India's needs and processes better. Norway has provided "hands-off" support, but at the same time, the Royal Norwegian Embassy has been willing to sit down and have regular discussions with NIPI CU and implementing partners. This has helped create trust and good will among stakeholders.

6.2.4 Transparency and mutual accountability

The NIPI governance structure has facilitated dialogue, transparency and mutual accountability, and thus, fomented respect and trust between stakeholders. The states feel heard and supported. The implementing partners have a forum to advocate for their innovations and have technical discussions to improve on them. The structure also ensures agreement between the donor and the government first, thus preventing the implementing actors from being caught between opposing requests from the country and the donor.

Breaking down what worked from this governance structure, we find that it:

- Ensured dialogue and commitment from the highest levels of government and donor, and decisions made from the top.
- Established a formal system for recording of these commitments, in the form of official minutes, which has helped when there have been changes in government positions at state or national level.

- Warranted alignment with government needs and ownership at all levels.
- Promoted transparency, including in regard to funding and budget allocations. When there have been difficult decisions to make, the trust and transparency built by this system facilitated those decisions.

As long as these elements are in place, the governance structure in theory could be modified.

NIPI has proven that it is possible to accept the risk, learn from failures and reach success

Acceptance of risk: Development cooperation is inherently risky, yet while this is accepted in theory, it rarely is in practice. Donor result's frameworks normally call for success stories to continue the financial support. There is little space to learn from failures.

Risk is particularly present when testing innovations. NIPI has proven that it is possible to accept the risk, learn from failures and reach success. The acceptance of risk – by all stakeholders but particularly the donor – has been key. Learning from failures has been a vital component of NIPI throughout its 10 years (see section on Lessons Learned), and the stakeholders have been willing to make hard decisions to strengthen outcomes. Transparency and mutual accountability have been key to enable this risk-taking.

Pilot testing of innovations in a few districts: At the same time, NIPI has been smart about palliating the risks with its systematic approach to innovations, piloting them first in a few districts. This builds confidence by showing that it works. It also helps states to understand its benefits, how to implement it correctly, what it requires in terms of resources and how can it be integrated into the other components of the health system. Pilot testing requires accountability and transparency in presenting the results, and commitment to scale up when the pilots succeed.

6.3 Caveats

Not all factors in NIPI are easily replicable elsewhere. Few developing countries have India's number and level of technical experts, or India's financial capacity. Moreover, not all donor countries, due to cultural, political or other issues, have the flexibility and hands-off approach that Norway has showcased in NIPI, along with the willingness to align with the country's priorities.

Moreover, the thematic of the partnership initiative being maternal and child health may create an especially propitious setting, as it is an area where there is strong international consensus and agreement on goals and way forward.

Many successful initiatives also benefit from particularly powerful and committed "champions", and NIPI is no exception. NIPI's founders have stood by the initiative and continued to support it over the 10 years, and new stakeholders have also become strong advocates after getting to know the initiative and its outcomes. Thus, NIPI's successes have become its best advocacy tool.

7

CONCLUSIONS

Conclusions

NIPI, after ten years of existence, can point to successes that can be measured in terms of number of innovations scaled up, the sustainability of these innovations – since many have been made into policy –, its catalytic effect and leverage of funds, and the fact that both governments still find NIPI relevant and wish to continue the partnership.

Many of the key factors behind the success of NIPI are well-known components of effective development cooperation: strong country ownership, avoiding the creation of parallel structures, flexibility of the donor and willingness to align with country priorities, use of local technical expertise and creating inclusive partnerships that build mutual accountability and trust. Unfortunately, these elements are not always implemented in practice.

NIPI has truly embraced these elements and developed structures and mechanisms that support them. Chief among these have been its governance mechanism and organizational structure, and the selection of strong national technical partners, which have been key for country ownership and alignment. These are strategies that can be replicated elsewhere. Technical elements of NIPI, such as the design of evidence-based, context-adapted, operational innovations to improve quality of care, the systematization of the innovation-and -scale-up process, and the strong emphasis on monitoring and evaluation are also elements that can be replicated elsewhere with the right local technical partners.

Finally, one key lesson from NIPI is the capacity to receive and implement feedback in order to keep improving and changing, which has surely been vital for its continued relevance over the years.

The NIPI model has many aspects to showcase in global forums that can demonstrate the way to better cooperation agreements in maternal and child health and other areas.

Annex A: Scale-up of NIPI interventions

Innovation	Scale up			
	NND*	Other states	National	Description
PSE. Strengthening of pre-service nursing and midwifery education (pilot started in Phase I)	Yes	Yes	Ongoing*	Scaled up to non-NIPI districts in NIPI states. Also, in Jharkhand, Assam, Maharashtra, Tamil Nadu, Gujarat, West Bengal, Uttar Pradesh, Uttarakhand, Haryana and Jammu and Kashmir (J&K). Technical support is being given to state government and selected nursing institutions for establishment of Nodal centres. At national level, national guidelines for country-wide scale-up have been developed and all the state have been asked to budget funding requirement through NHM funding. Advocacy on-going for initiation of competency based examinations across states in both public and private sector institutions.
PPFP/PPIUCD. Post Partum Family Planning/ Post Partum Intrauterine Contraceptive Device Services	Yes	Yes	Yes	PPIUCD services already scaled up in all states throughout India. NIPI has phased out
Dakshata (started in 2015)	Yes	Yes	Yes	It has been started in 15 non-NIPI districts in Odisha, 28 in Madhya Pradesh and 27 districts in Rajasthan. Also, started in non-NIPI states of Jharkhand, Maharashtra, Andhra Pradesh, Telangana, Assam, Kerala, Meghalaya, and Nagaland. National Guidelines have been developed. Dakshata and Labour room strengthening is included in Improving maternal and child health outcomes in India-District Intensification Plan, 2017
Swasthya Slate (started in 2014)	No	No	No	The project has been paused and is under audit.
Yashoda (started in Phase I)	Yes	No	No	Yashoda scaled up in all the districts of Bihar and Rajasthan and 15 districts in Odisha. Funding is still continuing with state NHM fundings.
HBNC+. Home Based Newborn Care (started in 2013)	Yes	Yes	Ongoing	HBNC+ has expanded in all four NIPI states in variable number of districts. Country has decided for country wide scale up of HBNC+ for all Low Birth Weight babies and SNCU discharged babies. The Country through NITI Aayog (Planning Commission of India) who reports directly to the PM has now decided in December 2017 for country wide launch of Home Based Infant Care Child home visits included in Improving maternal and child health outcomes in India-District Intensification Plan, 2017

SNCU+. Sick Newborn Care Unit Plus (started in 2013)	Yes	Yes	Ongoing	MoHFW has revised HBNC guidelines of 2014 to include community visitation of discharged SNCU babies to help reduce mortality. Home follow up of sick babies included in Improving maternal and child health outcomes in India-District Intensification Plan, 2017.
FCC - Family-Centred Care (started in 2015)	Yes	Yes	Ongoing	Operational guidelines for FPC were released in 2017 for country wide implementation and budget provisioning through NHM. Family participatory care of newborns in facilities is included in Improving maternal and child health outcomes in India-District Intensification Plan, 2017
ETAT - Paediatric Emergency Triage and Treatment (started in 2015)	Yes	Yes	Ongoing	Operational guidelines (Strengthening Paediatrics care services in District Hospitals) including FCC and ETAT concepts were released in Oct 2015. Scale up in 4 NIPI states in variable number of districts. e.g 42 out of 50 districts in Madhya Pradesh. Emergency care for children in facilities is included in Improving maternal and child health outcomes in India-District Intensification Plan, 2017
Regional Resource Centers for Facility Based New Born Care	NA	Ongoing	Ongoing	The MoHFW has recommended State NewBorn Resource Centers for scale-up using NHM funding.
RBSK - Rashtriya Bal Swasthya Karyakram (started in Phase II)	NA	NA	Yes	This is a government led initiative that requested NIPI's support. NIPI supported the National RBSK Resource Unit placed at National Institute of Health & Family Welfare till May 2015. The RBSK Resource Unit has since been taken over by NHM and NIPI's role is now limited to providing agreed gap funding support.

NOTES: *NND: Non-NIPI districts in NIPI States, NA- Not applicable, Ongoing:
plans and steps for nationwide scale are taking place.

Annex B: Further reading

Non-technical documents

- NIPI. Compendium of Innovations. 2016
- District Intensifications Plan for Improving maternal and child health outcomes in India, 2017.
- New NIPI website. http://www.nipi.org.in/
- Video. Family Centred Care (FCC) - Norway India Partnership Initiative (NIPI). https://youtu.be/28OrApCzE0U.
- Video. Home-Based Newborn Care+ (HBNC+) - NIPI Newborn Project https://youtu.be/sxuHqWQYYdM

Technical documents

- Leveraging of country/state health resources through implementation of NIPI activities report. 2017.
- Impact evaluation of Techno-managerial support
- Rapid Assessment of NIPI's HBNC+ in Rajasthan. 2015
- NIPI Phase I Evaluation. 2013
- Mid Term Review NIPI Phase II. 2016.
- NIPI Strategic direction beyond 2017 report. 2016

Annex C: Policy documents developed with NIPI support

Operational guidelines and other national policy documents, developed by MoHFW with NIPI support

1. Strengthening Pre-Service Education for the Nursing and Midwifery Cadre in India. Operational Guidelines. 2012. (based on PSE innovation).
2. Rashtriya Bal Swasthya Karyakram (RBSK). Child Health Screening and Early Intervention Services under NRHM. Operational guidelines. 2013.
3. RBSK Participant's manual for mobile health teams. 2014.
4. RBSK Resource material. 2014.
5. RBSK Job aids. 2014.
6. Home Based Newborn Care. Operational Guidelines. Revised 2014. (based on HBNC+ innovation).
7. Kangaroo Mother Care and Optimal Feeding of Low Birth Weight Infants. Operational Guidelines. September 2014. (with key components of FCC innovation).
8. Use of Gentamicin by ANMs for management of sepsis in young infants under specific situations. Operational Guidelines. 2014.
9. Operational Guidelines for Facility Based Newborn Care Trainings. 2014.
10. Facility Based Newborn Care Training Module for Doctors and Nurses. 2014.
11. India Newborn Action Plan. 2014.
12. Strengthening Facility Based Paediatric Care. Operational Guidelines for Planning and Implementations in District Hospitals. 2015. (with components of ETAT innovation).
13. Dakshata. Empowering Providers for Improved MNH Care during institutional deliveries. 2015.
14. Vision document for HRH Programmes. 2016.
15. Family Centred Care for Newborn. Training guide. 2016. (FCC innovation).
16. Revised Guidance note for Follow up of LBW and SNCU discharged infants by ASHAs. 2016. (SNCU+ innovation).
17. Injection Vitamin K prophylaxis at birth (in facilities). Operational Guidelines.
18. Framework for Convergent Action towards Comprehensive Care of Children with Developmental Difficulties.
19. MAA. Programme for promotion of breastfeeding. Operational guidelines. 2016.
20. Operational Guidelines for Establishing Sentinel Stillbirth Surveillance System. 2016.

Annex D: Documents reviewed

Technical documents, program and evaluation documents

1. NIPI Phase II Program Document. 2013.
2. NIPI Phase I Evaluation. 2013.
3. NIPI ME Framework Phase II – 25012013 (and slides)
4. Mid Term Review NIPI Phase II. 2016.
5. NIPI. Compendium of Innovations. 2016.
6. Letter from MoHFW Deputy Commissioner Child Health to Mission Directors in States on Revised Guidance Note for follow up of LBW and SNCU discharged infants by ASHAs. 20 October 2016.
7. Leveraging of country/state health resources through implementation of NIPI activities report. 2017.
8. NIPI Strategic direction beyond 2017 report. 2016
9. Norwegian MFA delegation visit. Summary Report. September 2017
10. NIPI CU, Jhpiego and NBP Presentation to MFA delegation. September 2017

MOUs and Partnership agreements

11. MOU between the Govt. Of the Republic of India and the Norwegian Ministry of Foreign Affairs.
12. Letter from Secretary Health to RNE Ambassador on continuation of NIPI, February 2017

Meeting notes and minutes for JSC meetings held between 2013 – 2017

Meeting notes and minutes for PAG meetings held between 2013 – 2017

State documents and minutes – Bihar: 2013 – 2016

State documents and minutes – Madhya Pradesh: 2013 – 2015

State documents and minutes – Odisha: 2013 – 2015

State documents and minutes – Rajasthan: 2013 – 2015

State documents and minutes – Jammu and Kashmir: 2014 – 2015

Annex E: Persons interviewed

Royal Norwegian Embassy (RNE) in Delhi

1. Ms. Rannveig Rajendram, Counsellor
2. Ms. Elsy Samuel, Adviser Health

Government of India and Government of Norway

1. Mr. Tore Godal, Special Advisor, MFA
2. Ms. Noor Khan, Senior Advisor, MFA
3. Ms. Marianne Monclair, Norad
4. Dr. Ajay Khera, Deputy Commissioner Child Health, MoHFW

NIPI coordination unit & implementing partners

1. Dr. Ashfaq Ahmed Bhat, NIPI Coordinator
2. Dr. Bulbul Sood, Country Representative, Jhpiego
3. Dr. Harish Kumar, Project Director, NIPI Newborn Project

Acknowledgement

The study has been conducted by Scanteam, Norway for Royal Norwegian Embassy in New Delhi

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(November 2017 – January 2018)