Evaluation Department

Norad

Evaluation of the Norway India Partnership Initiative

for Maternal and Child Health

Annexes 4-12
Report 3/2013

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Design: Siste Skrik Kommunikasjon
ISBN: 978-82-7548-777-1

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September 2013

Cambridge Economic Policy Associates Ltd.

Table of Contents

ANNEX 4: CORE PHASE INTERVIEW GUIDE

This annex presents the interview guide used for consultations with stakeholders in the Core Phase. The guide also provided an introduction to the evaluation, however this has not been included below for brevity.

Interview questions

1. What is the rationale for selection/ 'theory of change' of each of the NIPI interventions? What has been the process in designing these initiatives?
2. Are the NIPI interventions aligned with National Rural Health Mission (NRHM) objectives and the health systems of the states where they are implemented?
3. What are your views on the efficacy of NIPI's funding approach? Please comment on the appropriateness of the size and terms of NIPI funding; its approach to selecting funding partners and allocating resources; and its disbursement process.
4. What aspects of NIPI's governance and management structure work well and not so well? Are the roles and responsibilities of the various agencies involved defined clearly and executed as planned?
5. To support our detailed 'process evaluation' of the two NIPI interventions of Yashoda and Home Based Post Natal Care, could you please comment on the:
    a. Activities/ processes (and timelines, as relevant) entailed in the implementation of the interventions from funding to execution, and reporting/ monitoring.
    b. Stakeholders involved in each activity, including the specific role of the NIPI institutional bodies and implementing partners.
    c. Any variations and innovations in the design/ implementation of the interventions by state.
    d. Factors that have worked well and not so well, including those impacting execution/ success of specific activities.
    e. Lessons on intervention design and implementation that may be relevant for Phase II of NIPI.
6. To the extent that you are aware, have recommendations from previous reviews and evaluations been incorporated into the NIPI structure and processes?
7. Has NIPI been successful in providing *strategic*, *catalytic, flexible* and *innovative* funding to the NRHM? What is its added value with respect to other donor funding for health in India?
8. Could you comment on NIPI's progress in developing and implementing an effective M&E system at the state and district level? Do you have any suggestions on how to improve M&E of NIPI activities?

9. Is NIPI's allocation of resources equitable and does it take account of/ address gender and equity related disparities?
10. What has been the experience in sustaining and scaling up NIPI interventions? What is the potential for sustainability/ scalability post NIPI funding and what might some key factors driving success in this area?
11. What are your suggestions to improve NIPI's effectiveness and efficiency, as it commences Phase II?

ANNEX 5: FIELD VISIT DESIGN AND INTERVIEW GUIDE

This annex summarises the objectives and approach/ structure of the field visits as well as provided the field visit interview guide.

Objectives of field visits

The primary objective of the field visits has been to solicit views of the key stakeholders on their experience with and performance of NIPI interventions in the states.

In line with our evaluation framework, the interviews have gathered feedback on the design of NIPI (including the rationale for selected interventions, alignment with NRHM/ state health systems in practice); efficacy of governance and management approaches; the process evaluation of the Yashoda and Home Based Post Natal Care interventions and any key recommendations going forward.

Approach to field visits

Each field visit has been carried out by a two member team and has been structured for a period of 3-4 days.

In each state, we have covered the capital city (to meet with the government officials and state level NIPI implementing partners), and two of the three NIPI UNOPS focus districts. These districts have been selected in discussion with UNOPS, comprising one good and one poor performing district in each state to enable us to collect information on varying experiences. At the district level, we have visited the District Hospitals, Community Health Centres and Primary Health Centres, where possible, and interviewed the health centre staff/ health workers; Yashodas, ASHAs; and beneficiaries available at the facilities and in the field.[6]

Interview guide

We present below the types of questions discussed with: (i) Government/ NRHM officials at state and district level; (ii) state-level NIPI implementing partner representatives (WHO, UNICEF, UNOPS); (iii) Yashodas; (iv) ASHAs; (iv) beneficiaries; and (vi) hospital staff/ health workers.

The guide was developed for CEPA's reference and was not shared with the consultees. The questions were tailored and structured appropriately (e.g. avoidance of use of jargon and complex terms, administered in local language) when directed at consultees. In general, our approach to interviews has been to avoid any leading questions and provide required background where needed in support of our questions.

[6] A consultee list for each state visit is included with the field visit reports. We have noted the number of Yashodas, ASHAs and beneficiaries consulted in each state but do not provide their names. In some cases, it was difficult to note down their names (due to rapid consultations with each stakeholder one after the other) and hence we have consulted with a greater number than noted in the reports.

Interview questions

Part 1: Government/ NRHM officials at state and district level

The focus of the interviews will be to understand the state-specific context and 'fit' of NIPI, in terms of alignment with state health systems, as well as benefits secured through NIPI activities and funding. We would aim to meet with the state/ district officials and NRHM officials, as feasible, and the specific questions below may differ accordingly.

1. What have been the trends and key issues for infant, child and maternal mortality in your state? Could you also comment on the strengths and weaknesses of the state public health systems/ infrastructure in this regard? In this context, has there been any added value of NIPI's intervention and if yes, please describe how?
2. What was the rationale for selection of focus districts in your state for NIPI interventions?
3. What have been the implications of NIPI interventions in terms of: (i) alignment/ coordination with the state health plans and objectives, and other donor programmes in the states; and (ii) any positive or undesirable effects on the health systems?
4. To the extent that you are aware, to what extent has your state and relevant agencies participated in the governance and management of NIPI (e.g. in the State Coordination Committee and Programme Management Group meetings)? What has been the experience in terms of member participation and frequency of these meetings? What is the nature of issues discussed and what are your views on the functioning and usefulness of these meetings?
5. We would like to understand how the state government uses the NIPI funds, in terms of the processes involved in:
    - Allocation of funds by UNOPS to the State Health Societies.
    - Distribution of funds to the district/ blocks.
    - Reporting on the use of funds (and any unused funds).
6. To support our detailed process evaluation of the two NIPI interventions of Yashoda and Home Based Post Natal Care , could you please comment on:
    - How do these two interventions fit with other Maternal and Child Health interventions in the state? For example, do you see the added value of the Yashoda initiative in the face of increasing institutional deliveries under Janani Suraksha Yojana and the consequent strain on the infrastructure capacity to support deliveries and newborn care?
    - What has worked well and less well in these two interventions, in terms of the design and implementation, and factors impacting execution/ success of specific activities?
7. Has NIPI been successful in encouraging strategic, flexible and catalytic approaches?
    - Strategic in the context of NIPI implies choosing between possible options, selecting what to prioritise based on pre-determined criteria with prior consensus.
    - Catalytic implies being able to initiate, activate or accelerate a process or a set of events that otherwise might not have happened.

- Flexibility implies the use of money based on country needs.

8. Could you highlight areas of innovation within specific NIPI interventions in your state?
9. What aspects of each of the following NIPI interventions have worked well and less well in your state?
    - UNOPS: Sick New Born Care Unit ; Immunisation; Mobile Money Transfer; Techno-managerial support; District Health Training Management Unit
    - UNICEF: Integrated Management of Neonatal and Childhood Illness, community based newborn and child care, facility based newborn care, routine immunisation (strengthening cold chain and vaccine management systems), assessment and improvement of quality of care, and district and block planning/ management/ support.
    - WHO: pre-service Integrated Management of Neonatal and Childhood Illness training to health professionals, training of Auxiliary Nurse Midwives (including training of trainers), accreditation system for facilities carrying out relevant studies, malnutrition.
10. What has been the experience in sustaining and scaling up NIPI interventions in your state? What is the potential for sustainability/ scalability post NIPI funding and what might some key factors driving success in this area?
11. Do you have recommendations to improve the above interventions in terms of their design and implementation?
12. What are the other socio-economic factors (e.g. cultural reasons, class inequalities, exclusion[7]) that reduce barriers to access health services in the state? Do NIPI interventions take account of/ address these gender and equity related disparities in the state?

Part II: State-level NIPI implementing partner representatives (WHO, UNICEF, UNOPS)

The focus of these questions will be to understand how the state-level partner representatives are involved in the management and implementation of NIPI in the state. Majority of the questions from Part I above will also be relevant for these interviews, and we propose some additional questions as below.

UNOPS

1. What is the rationale for the selection of each of the NIPI interventions?
2. How does the UNOPS structure (i.e. in terms of the central office in Delhi and representatives in the four states) work in practice, and are there any issues/ challenges that you would like to highlight in this regard?

[7] Exclusion in terms of the target population and on religious basis.

UNICEF representatives

1. What are the main focus areas of UNICEF support under NIPI in the state? What is the rationale for the selection of these interventions in the state and how were these ascertained?
2. What is the added value of the NIPI funds for the implementation of the UNICEF programme of work in the respective state?

Part III: Yashodas

The focus of these meetings would be to understand the role and experience of Yashodas under NIPI, and the design and implementation process of the Yashoda intervention.

1. How is the Yashoda intervention structured, including the recruitment, training, interaction with beneficiaries, supervisory and monitoring structure?
2. What is the role of the Yashodas in terms of supporting pregnant women on arrival at the health facilities (e.g. counseling mothers on care of the newborn including initiation of breastfeeding, immunisation, spacing between child births, giving equal attention to boy and girl babies, etc)?
3. On average, how many newborns/ deliveries are managed by each Yashoda?
4. How are Yashodas recruited, including criteria for selection (e.g. educational qualifications, background, etc)? Is there high turnover of Yashodas – if so, what are the reasons?
5. What has been the experience with training of Yashodas (e.g. what is the structure/ process for training? How often does a Yashoda receive training?). Has the training provided the Yashoda with adequate knowledge to deliver support to beneficiaries?
6. How does the process for financial payment to the Yashodas work in practice? Is the value of incentives sufficient, and given on a timely basis? What are the average monthly earnings for Yashodas?
7. Could you highlight the issues/ challenges encountered with regards to interacting with the beneficiaries/ mothers at the health facilities?
8. How is the role of Yashodas different from that of the ASHAs under NRHM and Home Based Post Natal Care? Is there any conflict/ overlap between the two?
9. Do you think the Yashodas are well placed to provide hospital based care given their work is in the facility (rather than the field/ communities, as is the case with the ASHAs)? Are there any benefits – for example – in terms of better access/ familiarity than the ASHAs with the hospital staff?
10. What is your perception of what has worked well and less well in the Yashoda intervention? Do you have any recommendations on what can be improved in the design and implementation of the intervention?
11. What do you view as the benefit, if any, of the Yashoda intervention, over and above Government efforts of the Janani Suraksha Yojana scheme (for example, increased satisfaction among mothers, improvements in immediate breastfeeding, duration of stay of the mothers at the health facilities, etc.)?

12. Is the Yashoda able to deliver her tasks easily or does she face any major constraints in delivery (e.g. pressure to perform duties of other hospital staff)?

Part IV: Accredited Social Health Activists (ASHAs)

The focus of these meetings would be to understand the role and experience of ASHAs under NIPI, and the design and implementation process of the Home Based Post Natal Care intervention. Questions 8-9 under Part III will also be covered with the ASHAs.

1. Have the ASHAs been able to cope with the workload given increased institutional deliveries under Janani Suraksha Yojana?
2. How is the Home Based Post Natal Care intervention structured, including supervisory, monitoring and training support?
3. What is the role of the ASHAs with regards to providing support to mothers and newborns at home (e.g. identification of danger signs, timely referrals, etc)?
4. How often do the ASHAs visit the homes of mothers after they leave from the health facilities?
5. How is the capacity building of ASHAs carried out? What are your views on the ASHA training module (2 days plus 5 days)?
6. How is the role of ASHAs under NRHM different from their role under Home Based Post Natal Care, in terms of providing support to mothers?
7. What has been the impact and value add of the Home Based Post Natal Care intervention in terms of counseling mothers and newborn care and related maternal health aspects?

Part V: Beneficiaries

The focus of these questions would be to understand the experience of beneficiaries of the NIPI interventions. We aim to interview the beneficiaries on an individual and group basis, as feasible.

1. Are you aware of the NIPI interventions and its benefits, and how were you made aware of these interventions?
2. Could you comment on the quality of care and efficiency of service delivery that you have access to at the health facilities, and has this improved with the introduction of Yashodas? Have the Yashodas been successful in filling in the critical gap for providing the required support in the labor rooms, immediate care of newborn, immunisation, immediate breastfeeding, counseling on nutrition, care of underweight babies, etc.?
3. Have you faced any issues/ challenges in getting assistance from the Yashodas in the health facilities?
4. Are you satisfied with the services provided to you by the Yashodas and ASHAs? Have you experienced any differences in their service based on socio-economic factors like caste, religion, etc.?
5. What are the services provided by ASHAs during the home visits (e.g. weighing the baby, identifying any danger health signs)?

6. Have the ASHA's visits to assist mothers and newborn been timely? Are the frequency of visits adequate to address the various issues that may arise after coming home from the health facilities?
7. Do you have any recommendations to improve the services provided by ASHAs and Yashodas under the two interventions to improve the quality of services provided?

Part VI: Hospital staff/ health workers

The focus of these questions will be to understand the perspective and experience of the hospital staff/ health workers of the NIPI interventions (particularly Yashoda). Questions 2-3 and 7-12 under Part III are relevant for the hospital staff, and we propose a couple of additional questions:

1. How would you describe the quality of care and service delivery provided at your health facility and has this improved over time and particularly, with the introduction of Yashodas?
2. Do you have any recommendations to improve the services provided by Yashodas at the health facility?

ANNEX 6: NIPI GOVERNANCE STRUCTURE

The table below describes the functions and composition of the key NIPI governing bodies.

Table A6.1: NIPI governance structure

Structure	Objectives	Composition
Joint Steering Committee	Central decision making body that coordinates and provides oversight on NIPI planning and implementation	Chaired by the Health Secretary, Ministry of Health and Family Welfare, Government of India. Co-chaired by the Health Secretary and the ambassador of Norway. Members include representatives from NIPI states, implementing partners, Secretariat, Norwegian Embassy, Norwegian Ministry of Foreign Affairs[8], , and National Institute of Health and Family Welfare .[9]
Programme Management Group	Technical group that oversees and directs integration of NIPI activities with NRHM operational framework; discusses key technical issues; reviews progress; and makes recommendations to the Joint Steering Committee for decisions	Chaired by the NRHM - Mission Director, with membership from the NIPI partners and the states.
State Coordination Committee	Helps align NIPI efforts with State NRHM agenda.	Chaired by the Principal Secretary, Ministry of Health and Family Welfare and includes the State Directors, Reproductive and Child Health , representatives from implementing agencies, the Norwegian Embassy and the NIPI Secretariat.

[8] Norad has participated in the Joint Steering Committee meetings as an invitee.
[9] Based on the 12th meeting of the Joint Steering Committee, 10 December 2011.

ANNEX 7: KEY ACTIVITIES AND ACHIEVEMENTS OF UNICEF AND WHO

The table below presents the key activities and achievements of UNICEF and WHO under NIPI Phase I.

Table A7.1: Activities and achievements of UNICEF and WHO

Activities	Activities/ achievements
UNICEF[10]	
Immunisation	• Ten states conducted Effective Vaccine Management assessments from 2007-12 with NIPI support which resulted in development of improvement plans, with short and long term plans of action. • National communication strategy and operational guideline developed and shared with states to develop state specific communication plans during the recently held national Intensification of Routine Immunisation and communication workshops.
Facility based newborn care	• *Training of service providers.* Partnerships with National Neonatology Forum enabled UNICEF to support training of service providers (doctors and nurses). • *Mentoring.* In collaboration with the Ministry of Health and Family Welfare, UNICEF supported mentoring of the Sick Newborn Care Units sites across the NIPI states. • *Monitoring of performance.* In Odisha and Madhya Pradesh, appropriate systems put in place (including software) to monitor performance of Sick Newborn Care Units across the states. UNICEF created models of follow-up, screening and early intervention of newborns discharged from Sick Newborn Care Units in Madhya Pradesh and Rajasthan. • *Developing norms, standards, training tools and guidelines*: ○ supported development of operational guidelines for facility based newborn care. ○ coordinated preparation of the Facility Based Newborn Care training module, now approved by the Ministry of Health and Family Welfare. ○ engaged State Health Transport Organisation, Pune to develop a training programme and module on maintenance of Sick Newborn Care Unit equipment; and trained refrigerator mechanics and bio-medical engineers in Rajasthan and Bihar. • *Knowledge management and documentation:* In partnership with the Public Health Foundation of India, policy briefs were developed on two key issues related to quality of care in Sick Newborn Care Units (human resources and equipment maintenance). Evidence on the impact of facility based newborn care on newborn survival and lessons from scale up was published.
Assessment and improvement of quality of care	Piloted quality assessment and improvement of first referral units and 24X7 Public Health Centres in Rajasthan, Madhya Pradesh, and Bihar.

[10] NIPI Progress and workplan for 2012, as provided by UNICEF in India.

Activities	Activities/ achievements
Community based newborn and child care	• Contributed to scale-up through quality assurance of training; monitoring of programme performance and developing innovative models of supportive supervision; collated evidence on different models of supportive supervision; and developed guidelines for supportive supervision.[11]
Strengthened management	• Strengthened community and facility based newborn and childcare services by engaging with and building skills of state and district managers. • In collaboration with partners, UNICEF developed two training programmes for mid-level managers – a short course of eight days and a Postgraduate Diploma on maternal and child health with the the Public Health Foundation of India.
WHO[12]	
Pre service Integrated Management of Neonatal and Childhood Illness training operationalised in the country with a focus on NIPI districts	• Curriculum and handbook for medical students developed. • Existing in-service training tool adapted and utilised for nursing students and Auxiliary Nurse Midwives, and incorporated in the Skilled Birth Attendant training plan. • Training of trainers completed in all NIPI states. • Regular pre-service education for medical students being carried out in Odisha for the last three years. In Rajasthan, medical colleges initiated pre-service Integrated Management of Neonatal and Childhood Illness Management in 2011.
Enhancing reproductive and child health (RCH) programme management skills	• Draft module of integrated RCH programme managers course developed. • Draft intervention module - "Implementation Model for strengthening Maternal and Newborn Health services in district Bharatpur, Rajasthan using health systems approach under NRHM" developed and reviewed by stakeholders, and is awaiting finalisation.
Quality Assurance Cells for specialised training in maternal health programmes established and functional at national and state level	• Guidelines for certification of medical colleges to function as training centres for Emergency Obstetric Care and Life Saving Anesthetic Skills developed and adapted by state governments including NIPI states. • Quality Assurance Cells established at the national and state levels and institutionalised under NRHM. • Assessors in the NIPI states trained and field activities completed in Odisha, Rajasthan, Madhya Pradesh, Uttar Pradesh and Bihar.
System established and operational for accreditation of private service provider facilities in the country with special focus on NIPI states	• Accreditation guidelines for private health facilities for providing reproductive and child health services and training developed and disseminated. • Guidelines piloted in two states - Madhya Pradesh and Odisha

[11] The cost of training was borne by NRHM.
[12] WHO NIPI Report December 2006-December 2012.

Activities	Activities/ achievements
Facility and community based management of Severe Acute Malnutrition in childhood strengthened	• Training package adapted and piloted for strengthening pre-service Infant and Young Child Feeding. • Collaborative study on "Determinants of under-nutrition in children and assessment at different levels of health care" completed in October 2009. • "Determination of Appropriate Value of Mid-Upper Arm Circumference to Identify Severe Acute Malnutrition Children with Weight for Height as Reference in Indian Population" - a Multi-site Study - Proposal development and statutory clearances completed. To be submitted to the WHO South East Asia Regional Review Committee for clearance before commencement. • Proposal for compendium on best practices on management of Severe Acute Malnutrition children submitted by Department of Nutrition, AIIMs and is under review.

ANNEX 8: FIELD VISIT REPORT – BIHAR

1. Introduction

This annex presents key findings from our field visit to Bihar during 22-24 April 2013. We have covered the capital city of Patna (to meet with the Government officials and the state level NIPI implementing partners) and two of three NIPI UNOPS focus districts of Nalanda and Jehanabad (to meet with the Mamtas, ASHAs, beneficiaries and other health workers). In Nalanda, we visited the District Hospital and Noorsarai Primary Health Centre. In Jehanabad, we visited the District Hospital.[13]

The report is structured as follows: Section 2 provides a background on the state health and financing profile; Section 3 presents a summary of the NIPI interventions in Bihar; Section 4 presents our findings on the four evaluation dimensions of NIPI's policy/ programme design, governance, implementation/ processes, and results; and Section 5 sets out our conclusions from the field visit. A list of consultations is provided at the end.

2. Bihar health profile and financing

Bihar is one of India's poorest states and the third most populous, constituting 8.6% of the country's total population.[14] 80% of its population lives in rural areas and 41.4% is below the poverty line. The sex ratio of the state is 921 females per thousand males which is less favourable than the national average of 933 per 1,000 males (Census 2001 data).[15] The population of Scheduled Castes households as per National Health Family Survey 3 (2005-06) is 18.7% and Other Backward Classes comprise 58.6% of the state's total population.

Bihar ranks among the lowest in the country on indicators related to primary health infrastructure and reproductive and child health care (District level Household Survey, (2002-04). The table below provides the key health indicators for Bihar (including the three NIPI focus districts).

Table A8.1: Key health indicators for Bihar (2009 data, unless otherwise noted)[16]

Indicator	Bihar	Nalanda	Jehanabad	Sheikhpura	India
Infant Mortality Rate (IMR) (per 1000 live births)	48 (SRS 2010)	52	53	58	47
Neo Natal Mortality (NMR) (per 1000 live births)	31 (SRS 2010)	27	31	31	34
Under Five Mortality Rate (U5MR) (per 1000 live births)	72	80	67	76	64
Total Fertility Rate (TFR)	3.7	3.5	3.4	4.0	2.6
Maternal Mortality	305	207	255	244	212

[13] The detailed itinerary was developed in consultation with UNOPS and based on proximity of locations and ease of access in the available time.
[14] Ministry of Health and Family Welfare, Government of India., Family Welfare Statistics in India, 2011.
[15] State Health Society, Department of Health and Family Welfare, Patna, Bihar, Project Implementation Plan, 2011-12.
[16] Ministry of Health and Family Welfare, Government of India., Approval of State Programme Implementation Plan, 2012-13: Rajasthan; Data for the districts is taken from: Office of the Registrar General and Census Commissioner, India, Ministry of Home Affairs, Government of India, Annual Health Survey 2010-11, Fact Sheet.

Indicator	Bihar	Nalanda	Jehanabad	Sheikhpura	India
Rate (MMR) (per 100,000 live births)[17]					

In addition, as per the UNICEF Coverage Evaluation Survey (2009) full immunisation coverage in Bihar was 49%, as compared to a national coverage of 61%.

The table below presents the total funds approved and spent under NRHM in Bihar over the period 2005-11.[18] It indicates a significant divergence between the funds allocated and expenditure incurred in the initial years, however, this gap has reduced over time.

Table A8.2: Funds approved and spent under NRHM - INR million, USD provided in brackets

Year	Funds received	Expenditure
2005-06	1240 (US$ 24m)	380 (US$ 7.6m)
2006-07	3805 (US$ 76m)	920 (US$ 18.4m)
2007-08	4150 (US$ 83m)	2370 (US$ 47.4m)
2008-09	6450 (US$ 129m)	3390 (US$ 67m)
2009-10	6260 (US$ 125m)	5620 (US$ 122m)
2010-11	9830 (US$ 196m)	7020 (US$ 140m)

In addition to NIPI, development partners for health in the state include UNICEF, Bill and Melinda Gates Foundation, DFID and UNFPA. Some examples of their areas of work include:

- UNICEF activities include support for routine immunisation, including immunisation campaigns for polio, zinc and oral rehydration, and training of skilled birth attendants, creation of sick newborn care units in states, neonatal stabilisation units at the block level and training of health workers in villages.
- Bill and Melinda Gates Foundation activities include maternal health and child nutrition, immunisation, family planning, water, sanitation and hygiene.
- *UNFPA* support has encompassed technical support in planning, implementation and monitoring of NRHM interventions in the state, including annual planning for NRHM, family planning, monitoring and evaluation.

3. NIPI interventions in Bihar[19]

The NIPI programme in the state was initiated by the signing of the Memorandum of Understanding (MoU) between UNOPS (represented by the Director, NIPI Secretariat) and the Government of Bihar in December 2007, and activities were initiated in 2008-09. NIPI interventions through UNOPS are implemented in three districts in Bihar – Nalanda, Sheikhpura and Jehanabad. The key NIPI-UNOPS activities in the three districts comprise the following:

- Mamta intervention - deployment of Mamtas in district and sub-divisional hospitals (based on delivery load).[20]

[17] MMR figures are reported for 2007-09. MMR is reported together for Munger (comprising Bugusarai, Khagaria, Munger, Sheikhpura and Jamui); Patna (comprising Nalanda, Patna, Bhojpur, Buxar, Kaimur); and Magadh (comprising Jehanabad, Aurangabad, Gaya and Nawada).

[18] Government of Bihar., Economic Survey, 2011-12.

[19] Odisha Joint Steering Committee Meeting, 10th December 2011, NIPI.

- Strengthening the home based post natal maternal and neonatal care services for institutional and assisted home deliveries through ASHAs through the Home Based Post Natal Care intervention.
- Setting up Sick Newborn Care Units at the three District Hospitals and strengthening new born care units, namely the Newborn Stabilising Units at the Community Health Centres and Newborn Care Corners at the Primary Health Centre level.
- Mobile Money Transfer aimed at timely, hassle free and reliable payment of ASHA incentives in Sheikhpura district. The project is steered by the State Health Society, with technical support from Eko Aspire Foundation and State Bank of India. Under this intervention, a savings account is opened for the ASHAs in an assigned bank, with the help of locally based agent of the bank, known as Customer Service Point. Usually, the Customer Service Point is located in or near a Primary Health Centre or ASHAs village of residence, where the ASHA can make account related cash transactions at the Customer Service Point outlet and can operate her bank account using a mobile phone, since her mobile number is linked with her bank account.[21] [22]

Other NIPI-UNOPS interventions in the state include establishing a flexible community referral fund for babies up to two months; techno managerial support at the state, district and block level; strengthening pre-service education for nursing and mid-wife cadre with support from Jhpiego; capacity building of paediatricians and nurses of Sick Newborn Care Units at the Institute of Post Graduate Medical Education and Research, Kolkata.

In addition, UNICEF has deployed NIPI resources in the state to establish and operationalise a Sick Newborn Care Unit in the Vaishali district; providing techno managerial support for training under Integrated Management of Neonatal Childhood Illness programmes in the five UNICEF districts;[23] and packaging of zinc tablets and ORS. A major part of the NIPI funds are being used by UNICEF for the Integrated Management of Neonatal Childhood Illness programme. UNICEF is also supporting the government in rolling out the Home Based Post Natal Care intervention by way of technical assistance, as the intervention is now being rolled out in the five UNICEF districts as well. UNICEF works in five focus districts in Bihar.[24]

4. Evaluation findings

This section presents our findings from the field visit on the four evaluation dimensions of NIPI's policy/ programme design; governance; implementation/ processes; and results.

[20] The Mamta intervention is the same as the Yashoda intervention in the other NIPI focus states. Mamtas were also deployed at the Block level Primary Health Centres after the intervention was scaled up by the state government.
[21] NIPI UNOPS., Mobile Money Transfer, Process Manual, 2012.
[22] We understand that the intervention was meant to be piloted in Nalanda, however this has not been possible due to insufficient Customer Service Points in the district, which might render it difficult for the ASHAs to withdraw money.
[23] In 2010, Integrated Management of Neonatal and Childhood Illness was piloted in five UNICEF districts, after which the Government decided to scale it up to 20 districts. Thus, UNICEF through NIPI funds is supporting the government to scale up this programme by providing technical support through planning, implementation, monitoring, hiring consultants, etc.
[24] The five UNICEF districts which fall under UNICEF in Bihar are Vaishali, Bhagalpur, Gaya, Purnea and Darbhanga.

4.1 Policy/ design

Rational for selection of districts

Bihar is one of the lowest performing Indian states in terms of most key health indicators. For example, it constitutes the highest TFR at 3.9 and also recorded the lowest immunisation coverage. Thus, the rationale for selection of Bihar under NIPI is clear.

There are mixed views on the appropriateness on the selection of the three NIPI focus districts in the state. We understand that the three districts were selected on the basis of: (i) poor health indicators, particularly infant and neo natal mortality; (ii) being strategically located in close proximity to Patna, thereby facilitating access; (iii) absence of other development partners as to as prevent duplication of efforts; and (iv) high proportion of disadvantaged population, thus aiming to improve equity in the state. However, some consultees noted that there are other worse performing districts with poorer health indicators (particularly IMR, MMR and U5MR), located in remote areas which are in greater need of support. While Jehanabad and Sheikhpura are Naxal affected districts, have poor resource and health facilities, Nalanda is a better performing district and is also the hub of political activities (thereby seeking high level political patronage).

Alignment of NIPI policy and design with NRHM

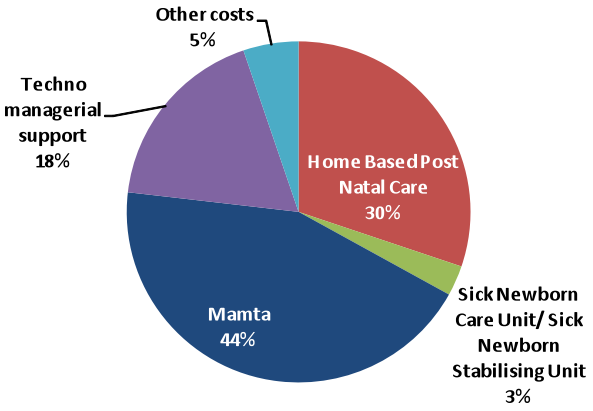
In general, all NIPI interventions in Bihar are well aligned with NRHM by virtue of being implemented through the existing NRHM structures. Consultations suggest that while alignment of NIPI with NRHM has its advantages (e.g. greater sense of ownership at the state and district level; greater potential for scale up), it also results in certain inefficiencies and delays as it is subject to the bureaucratic government procedures.

Some consultees also suggested that NIPI should consider extending its support to other districts in the state by scaling up existing interventions, since the government is not always in a position to scale up intervention in the light of other priorities.

Efficacy of funding

Feedback from the UNOPS and UNICEF suggests that fund disbursement was timely. The figure below presents the funds spent by UNOPS for the period 2008-13 (up to Dec 2012). As can be seen from the figure below, the majority of UNOPS funds have been used for the Mamta and Home Based Post Natal Care interventions, followed by techno-managerial support and Sick Newborn Care Units.

Figure A8.1: Expenditure as per intervention from 2008-13 (upto Dec 2012) (US$mn)[25]



Source: NIPI UNOPS state office

4.2 Structure and governance

NIPI structure and cooperation amongst partners

Consultations with UNOPS and UNICEF suggests a certain degree of duplication in the activities carried out by the two partners. For example, while both UNICEF and UNOPS were supporting the development of Sick Newborn Care Units in different districts in Bihar with NIPI funds (UNICEF in Vaishali and UNOPS in the three NIPI districts), there was no effective communication or coordination of activities between the two agencies. Coordination between the two partners has however improved over time. We understand that UNOPS and UNICEF have now established their own internal coordination mechanism, to ensure ongoing communication and effective coordination between the two agencies.[26]

Efficacy of the State Coordination Committee

The State Coordination Committee meetings are held once in six months and the committee is viewed as a useful forum for discussing progress of NIPI interventions, and deciding the way forward. The participation of all development partners in the State Coordination Committee (including UNFPA and BMGF) was viewed as useful, in that it facilitates better coordination and avoids duplication of activities in areas of newborn and child health.

It was noted that the focus of the meetings has been more for the NIPI-UNOPS interventions, with not much time being devoted to discussing UNICEF activities.

In addition, we were informed that the state government has recently established a State Newborn Care Committee, wherein all development partners including NIPI-UNOPS, UNICEF, BMGF participate and discuss key newborn and child health issues/ gaps in the state. The committee serves as a useful platform for discussing child health interventions in the state; policy changes; planned versus actual progress, amongst others. However, the processes,

[25] Other costs includes support for immunisation, and untied funds for providing technical assistance under the NIPI interventions (e.g. expenditure incurred for attending meetings, supporting techno-managerial staff under NIPI, etc).
[26] For example, the key UNOPS person keeps UNICEF informed of the activities they are undertaking, the progress made, amongst others, and vice-versa.

timelines and frequency of these meetings are yet to be streamlined and at present are conducted on an ad hoc basis.

4.3 Implementation/ processes

We provide a summary of our review of the process implementation of the Mamta and Home Based Post Natal Care interventions in Bihar.

4.3.1 Mamta

With the introduction of the Janani Suraksha Yojana (intervention under NRHM, wherein mothers are incentivised for deliveries in government health facilities), the number of deliveries at District Hospitals and Community Health Centres in Bihar increased considerably over the period 2008-09. In support of providing better health services to the newborn and mothers, the Mamta intervention was introduced by NIPI-UNOPS in the three districts of Nalanda, Sheikhpura and Jehanabad at the District Hospitals, and the sub-divisional hospitals (First Referral Units). The intervention was later scaled up by the state government to all 38 districts through the state budget, after which Mamtas were also placed at the block Primary Health Centres, with lower delivery load. However, the Mamta intervention is not included in the NRHM state Programme Implementation Plan in Bihar, since it has not yet been incorporated under NRHM.

Following are some key points to note on the description and process mapping (including recruitment, training, supervision, implementation and payment structure) of the Mamta intervention, and our views on what has worked well and less well under the intervention.

- **Recruitment.** Consultations with the Mamtas suggest that while some of them were recruited in response to an advertisements in newspaper, others were working as polio vaccinators in hospitals, where they were made aware of this opportunity. Mamtas were initially recruited based on certain minimum qualifications (e.g. 8th standard education level, residing within 5kms from the hospital). However, soon after the intervention was implemented, the state government passed a directive for all Mamtas to be recruited from the Sant Ravidas community (from the scheduled caste) in Bihar.[27] We were informed that Mamtas from the Sant Ravidas community who have previously received training as Traditional Birth Attendants were given preference for recruitment over the others. While as Traditional Birth Attendants they were involved in deliveries, their role was meant to be restricted to the maternity wards under the Mamta intervention. The attrition rate of the Mamtas has been very low, in that most Mamtas have continued with their jobs since inception.[28] Moreover, the health facilities have the flexibility to recruit additional Mamtas (depending on the workload), with the approval of the civil surgeon.
- **Training.** Mamtas at most facilities were given three days of intensive training at the start of the programme, and were also trained recently in 2013. However, Mamtas at some health facilities (e.g. Noorsarai Primary Health Centre in Nalanda) were not given any formal training, and are only trained on the job by the Auxiliary Nurse Midwives. In

[27] Sant Ravidas community in Bihar is a scheduled caste. Women from this community work as Traditional Birth Attendants, and are well aware of maternal and child health issues in general.
[28] E.g. in Nalanda, only one Mamta had left for a better opportunity while the rest have continued to work since inception.

general, all Mamtas expressed the need for more rigorous and frequent refresher training to hone and upgrade their skills further.

- **Supervisory support.** We understand that a Child Health Supervisor was recruited for supervision of the Mamtas under NIPI, however, this position has now been removed after NIPI funding was replaced by the state funding. Following are some key points to note on the supervisory structure for the Mamtas:
    - Mamtas at the District Hospital in Nalanda are now supervised by the hospital manager (discussions with the Mamtas suggest that they were more satisfied under the supervision of the Child Health Supervisor, given that she was a woman and this gave them a greater sense of moral support).
    - Other supervisory mechanisms created for the Mamtas under NIPI has continued in some health facilities – e.g. Mamtas continue to be supervised by the Junior Child Health Manager at the Noorsarai Primary Health Centre in Nalanda, and by the Block Child Health Manager in the District Hospital in Jehanabad. Feedback from Mamtas at these health facilities suggests that they are satisfied with the support provided to them by these personnel.[29]
    - While it was originally envisaged for the Mamtas to fill a register on each delivery to record information like weight of the baby; duration of stay at the health facilities, etc, we understand that this practice has now been discontinued at some health facilities, particularly after the position of the Child Health Supervisor was removed.[30]
- **Implementation.** Mamtas work in three shifts of morning, evening and night, and are allotted wards. They are equipped with flip charts to facilitate their counselling work. Further, maternity wards are equipped with LCD projectors to demonstrate the concepts of breastfeeding, immunisation, etc to the mothers. Consultations with the hospital staff suggests that some mothers belonging to high socio-economic backgrounds tend to give informal payments to the Mamtas (e.g. old clothes) if they are satisfied with the services provided by them, which in turn motivates the Mamtas to work harder to deliver their duties effectively.
- **Payment structure.** Mamtas at the district level and sub-divisional hospitals were funded by NIPI, whereas Mamtas at the block level Primary Health Centres were always paid through the state health department. Further, after the state government funding replaced NIPI funding in 2012, all Mamtas are paid through the state health department.

Experience under the Mamta intervention

The Mamta intervention was viewed as beneficial by all stakeholders consulted. Feedback from the hospital staff suggests some benefits of the intervention in terms of early initiation of breastfeeding; improvements in immunisation; improvements in cleanliness and hygiene

[29] The Junior Child Health Manager and Block Child Health Manager are still funded by NIPI in the two districts.

[30] For example, while Mamtas at the district hospital in Nalanda do not fill any register; Mamtas at the Primary Health Centre in Nalanda are required to fill the register daily. In Jehanabad, information collected by the Mamtas is compiled using a software developed by NIPI.

conditions; increased duration of hospital stay, amongst others.[31] Prior to the Mamta intervention, while Auxiliary Nurse Midwives and family planning counsellors used to perform a similar function, they were not able to devote sufficient time to the beneficiaries.

Below, we present some key issues raised with regards to the implementation of the Mamta intervention in Bihar:

- *Conflict with ASHAs at the health facilities.* ASHAs tend to stay with the mothers at the health facility during their entire stay, resulting in an overlap in the role of Mamtas and ASHAs in terms of providing moral and emotional support to the mothers. Our interaction with the mothers and Auxiliary Nurse Midwives at the health facilities suggests that that the mothers feel more comfortable and satisfied in the presence of the ASHAs, given that the ASHAs belong to the same villages. Feedback from the ASHAs also suggests that the mothers usually encourage them to stay with them at the health facilities and seek their support for any problems.[32]
- *Delays in receiving payments.* With the transfer of funding for the intervention from NIPI to the state government, there has been a delay of a few months in making payments to the Mamtas.
- *Mixed views on workload.* There were mixed views on the level of workload for the Mamtas, with some Mamtas commenting that the workload was high (e.g. District Hospital at Jehananad), while the others willing to take on more work, if provided a higher salary.[33].
- *Insufficient salaries.* Mamtas are paid an incentive of INR100 (US$ 2) per delivery, with the total amount being distributed amongst the Mamtas in the facility on a monthly basis. Feedback from the Mamtas suggests that on an average, they earn INR2,500-3,000 (US$ 50-60) per month, depending on the number of deliveries. This amount was noted as highly insufficient by all Mamtas, given their workload.
- *Engaging in other activities.* While the Mamta intervention was initiated with the intention of providing post partum care to mothers in the facility, in many cases they have been made to support Auxiliary Nurse Midwives in the labour rooms and assist other hospital staff in activities such as controlling bleeding; changing saline syringes (e.g. Nalanda); and cleaning maternity wards (e.g. Jehanabad).
- *Discontinuation of supporting facilities for Mamtas.* A number of supporting facilities/ items provided to Mamtas under the NIPI support have now been discontinued. For example, Mamtas were provided with flip charts and birthing kits (comprising a macintosh, diapers, etc) to facilitate them to perform their duties more effectively, however these

[31] While mothers are generally encouraged to stay in the hospital for a period of 48 hours, this has not been possible in some cases where there is a shortage of beds (e.g. in some Primary Health Centres).

[32] ASHAs also commented that some mothers agree to come to the health facilities for delivery only on the condition of being accompanied by the ASHA during their entire stay. While the ASHAs are not given any additional incentive to stay with the mothers at the health facilities, they often tend to do so because they stay very far away from the health facilities, and it thus turns out to be economical for them.

[33] For example, there are 18 Mamtas for managing 30-40 deliveries in the district hospital in Nalanda, and 10 Mamtas for managing 30 deliveries at the Noorsarai Primary Health Centre in Nalanda, but find the workload quite manageable. There are 18 Mamtas for managing 22 deliveries a month in the Jehanabad district hospital, who find themselves quite overburdened with the high workload.

have now been discontinued after NIPI funding stopped in 2012. LCD projectors set up in maternity wards by NIPI are also not functioning anymore.[34]

- *Lack of space in hospitals*. Mamtas in the District Hospital in Jehanabad do have not an area to sit in the hospital, resulting in some of them being forced to keep their belongings (e.g. handbags) in the maternity wards.
- *Overcrowding*. Given that the ASHAs tend to stay with the mothers at the health facilities for their entire stay in some cases, this has led to overcrowding of maternity wards.[35]

4.3.2 Home Based Post Natal Care

The intervention was initiated in the three NIPI districts in 2009. It was funded by NIPI until March 2012, after which it has been taken over by the state government. This is now being rolled out as Home Based Newborn Care by the Government of India across the country.

Following are some key points to note on the description and process mapping (including training, supervision, implementation and payment structure) of this intervention, and our views on what has worked well and less well in the intervention.

- **Training**. ASHAs were given 2 + 5 days of training using the NIPI module in 2009. Feedback from ASHAs suggests that the training was very beneficial, in that it helped in imparting the relevant knowledge in terms of identifying danger signs; filling the post natal care card, amongst others. However the number of refresher training sessions conducted has varied – while ASHAs in Nalanda were trained only in the beginning of the programme in 2009; the ASHAs in Jehanabad have been trained twice since inception. In general, all ASHAs noted the need for more refresher trainings on a regular basis. In addition, some medical officers at the health facilities commented that the ASHAs are not always well equipped to identify certain danger signs (e.g. respiratory rate of the newborns, and signs of jaundice), which implies the need for more training sessions. We understand that the ASHAs are now being trained using modules 6 & 7 of the government, which is slightly different from the NIPI training module.
- **Supervision**. Some key points to note on the supervision of the intervention, include:
    - ASHAs fill out the post natal care cards and submit these to the Auxiliary Nurse Midwives/ Junior Child Health Managers at the Primary Health Centres after completion of six visits, who also verify and countersign the cards.[36] Under NRHM, there is now one ASHA facilitator for the supportive supervision of 20 ASHAs, and she also accompanies the ASHAs on at least the first visit. The card is then countersigned by the ASHA facilitator and the Auxiliary Nurse Midwife.
    - ASHAs are accompanied by the Auxiliary Nurse Midwives and Junior Child Health Managers on their visits, to ensure that they performing their duties effectively. The AN Sinha Institute was hired by NIPI for supportive supervision

[34] For example, while flip charts are still used in Jehanabad district hospital, they are no longer in use in Nalanda; birthing kits are no longer distributed to Mamtas.
[35] We were informed that a separate waiting for the ASHAs has been set up in some Primary Health Centres in Jehanabad.
[36] Consultations with the ASHAs suggest that they deposit 3-4 completed post natal care cards at a time, but are now being encouraged to deposit them on an ongoing basis.

of ASHAs under Home Based Post Natal Care, however it is not clear if this was implemented in practice.

  - The data/ information collected in the post natal care cards is compiled at the Primary Health Centres, after which it is compiled at the district level and sent to the state. This data then feeds into the Health Management Information System . NIPI had developed a software for compiling the post natal care data (e.g. number of newborn weight recorded; newborn deaths in a month; number of ASHAs with thermometers, etc). While this software is still being used in Jehanabad, its use has been discontinued in Nalanda.

- **Implementation**. ASHAs are provided with a kit, which includes a thermometer; ORS packet; paracetamol; weighing scale to physically examine the baby, and are also provided with flip charts to visually demonstrate danger signs to the mothers. ASHAs refer the babies to the nearby health facilities, and also accompany the mothers to the health facilities, if required.
- **Payment structure**. On an average, one ASHA looks after 5-6 deliveries in a month, and earns INR800 (US$ 16) through the various incentives under NRHM.[37] Feedback from ASHAs suggests that they find the workload manageable, and are willing to put in more effort to earn more.

Experience under the Home Based Post Natal Care intervention

Our observation, based on consultations with the hospital staff and state level representatives is that this intervention has helped improving child health by virtue of providing a mechanism for early identification of danger signs in newborns and for making immediate referrals. In addition, it has also contributed to an improvement in immunisation coverage. Prior to Home Based Post Natal Care, there was no mechanism for making home visits in the state.

Some key issues in implementation were noted as follows:

- *Delays in receiving payments*. While ASHAs in Nalanda were paid on time (within 8-10 days of submitting the post natal care card), ASHAs in Jehanabad had not received their salaries for as long as 6-7 months.
- *Difficulty in engaging with mothers*. Consultations with the ASHAs suggest a mixed view on the ease of being able to engage with the mothers during the home visits. For example, ASHAs in Nalanda did not have any issues in engaging with the mothers, given that the mothers are familiar with them and also trust them, since they belong to the same village. However ASHAs in Jehenabad commented that mothers did not understand the importance of home visits, and tend to think that the ASHAs are doing this job only to earn money, and not for the well being of their children (and hence creates issues of trust between the ASHA and mother).
- *Insufficient post natal care cards*. In some cases, ASHAs fill the post natal care data/ information collected during the home visits in a register, since the original format of the cards is in short supply. However, we were informed that payments to the ASHAs are

[37] E.g. INR600 (US$ 12) for Janani Suraksha Yojana; INR150 (US$ 3) for family planning; INR250 (US$ 5) for Home Based Post Natal Care.

processes only after the original cards are at deposited at the Primary Health Centres. This also leads to delays in making payments to the ASHAs.

4.3.3 Other NIPI interventions

The box below presents some key points to note on the Sick Newborn Care Unit intervention in Bihar.

Box A8.1: Experience under Sick Newborn Care Units in Bihar

NIPI has set up two Sick Newborn Care Units in Nalanda and Jehanabad, and the evaluation team has had the opportunity to examine both these units.

The unit in Nalanda was officially launched in February 2013, although it has been functioning since November 2012. The unit comprises 14 beds; a triage area (a 'wait and watch area' where the babies are first examined to check where they need to be referred); a training room (where the mothers are trained by doctors and nurses on how to breastfeed and are informed about the protocols of the Sick Newborn Care Units); and a neonatal ward consisting of six beds. Doctors and nurses at the unit were given 14 days of training at the Institute of Post Graduate Medical Education and Research at Kolkata which was viewed as extremely beneficial.

We understand from consultations that the occupancy rate of the unit at present is about 85%, given that the unit started functioning only recently, and not too many people are aware of its existence. In addition, we were informed that more inborn than outborn babies are brought in (usually from Sheikhpura and other nearby Primary Health Centres). In general, the unit is functioning effectively, however, the following key issues were noted:

- *Lack of HR*. The unit is run by three doctors; 10 staff nurses; three Auxiliary Nurse Midwives; one lab technician; and some 4th grade staff[38]. We understand that initially four paediatricians were hired to run the unit, of which one doctor has left. Given that these doctors have multiple responsibilities in terms of managing the unit; managing the OPDs; and attending to emergencies, there is no dedicated round the clock doctor for managing the unit. In addition to hiring round the clock doctors, consultees also expressed the need for more nurses; one pathologist and more 4th grade workers.
- *Drug procurement*. As per the guidelines passed by the state government, all patients in the hospitals are given drugs free of charge. However, there is a need for further clarity on who will purchase the drugs/ medicines for the newborns brought to the unit.
- *Inadequate infrastructure planning*. While the unit in Nalanda has a generator, there is a need to ensure continuous supply of fuel, given the high frequency of power cuts in the area.
- *Need to implement protocols*. Feedback from the unit staff suggests that the unit protocols in terms of maintaining cleanliness (e.g. washing hands with soap, etc) are not being followed.

In general, all stakeholders commented that the unit has proved to be a useful mechanism in saving newborn lives, given that prior to this, sick newborns were referred to Patna Medical College for treatment, and there was no facility at the district level to take care of them. Consultations also suggest that operationalisation of the unit has also resulted in a shift from private to public facilities, given that neonatal care is expensive in private facilities, and also sometimes lacks the required infrastructure.

While the unit is Jehanabad has been set up, it is expected to be functional by June 2013. It comprises eight beds and has a similar structure to the unit in Nalanda. The unit staff in Jehanabad have received training, and all equipment has been procured, however, they are awaiting a generator/ transformer. At present, the sick newborns from the Jehanabad District Hospital are taken to the Newborn Care Corner in the District Hospitals, which is also supported by NIPI.

4.4 Results

Our view, based on consultations is that the main value add of NIPI in Bihar has been in the area of neo natal mortality. In addition to the key achievements noted above on the Mamta, Home Based Post Natal Care and Sick Newborn Care Unit interventions, other NIPI achievements in Bihar include:

- *Strengthening of the nursing sector*. NIPI has helped in strengthening the nursing sector in Bihar, by supporting the existing Auxiliary Nurse Midwife training centres and General

[38] These are lower level unskilled workers.

Nursing and Midwifery centres, which we understand was previously not given adequate attention in the state.

- *Techno managerial support*. NIPI techno managerial support at the state, district and block level was viewed as extremely beneficial by all consultees.[39] However, it was suggested that going forward NIPI should have a clear cut, consistent and stable HR policy which defines the tenure of the recruited personnel. For example, some HR appointed under NIPI were removed a year after recruitment. This tends to create additional burden on the state, and also leads to wastage of resources invested in training of HR.
- *Immunisation*. While we have not undertaken a detailed study of the data on immunisation coverage in the districts, consultations with district officials suggests that NIPI has contributed to improving immunisation coverage in Nalanda and Jehanabad by virtue of providing monitoring and supervisory support for immunisation activities. For example, Junior Child Health Managers hired by NIPI make house visits in districts to check immunisation cards; collect children for vaccination; and ensure that the children are immunised on time.

5. Summary findings

Given that Bihar is one of India's poorest states, and ranks among the lowest in the country on key child and maternal indicators, NIPI interventions focusing on a reduction in neonatal mortality in the state have been very relevant. NIPI is well aligned with NRHM in the state, resulting in greater ownership and responsibilities of stakeholders, but at the same time faces some inefficiencies resulting from government bureaucracy.

The State Coordination Committee has served as a useful forum for reviewing NIPI interventions, with effective participation of other development partners. There are certain inefficiencies and duplication in activities of implementing partners, suggesting the need for a more coordinated approach to ensure greater impact under NIPI (although coordination has improved somewhat over time).

Stakeholder feedback in the state suggests a positive view of the utility of the Mamta intervention, albeit with some overlap with the role of the ASHAs when they stay on in the health facilities to support new mothers. A number of key issues have been highlighted with the implementation of the intervention namely, insufficient and delayed payment of salaries, use of Mamtas for a number of tasks beyond their mandate and discontinuation of some supporting facilities (e.g. flip charts, birthing kits) for their work. On the other hand, the Home Based Post Natal Care intervention has demonstrated some clear benefits in terms of contributing to reducing neo natal deaths in the state, by virtue of increased referrals through ASHAs. While the Sick Newborn Care Unit intervention is still at an early stage in the state, techno managerial support and immunisation intervention under NIPI have also been viewed as beneficial, and have yielded good results.

[39] For example, Junior Child Health Managers appointed by NIPI at the district and block level were given the responsibility of looking after the Mamtas; compiling and verifying the post natal care data; amongst others, and in general looking after child health programmes at the district and block level.

List of consultations

Table A8.3: List of consultations

Organisation	Name of consultee and designation
State level implementing partners	Dr Ghanshyam Sethi, OIC – Health Cluster, Health Officer, Child Survival, UNICEF Office for Bihar, UNICEF
	Dr Pankaj Mishra, Senior Programme Officer, NIPI Newborn Project, UNOPS, Patna
	Mr Jaikishan, Programme Assistant (previously Deputy Child Health Manager in Shiekhpura), UNOPS
State level health representatives	Dr D K Raman, Additional Director, Reproductive and Child Health (RCH), NRHM
	Mr Ashok Kumar Singh, Administrative Officer
	Mr Gaurav Kumar, Deputy Director, RCH, NRHM
	Mr Sanjay Kumar, Secretary, Health and Executive Director, NRHM
District and block level representatives	Anyas Kumar, Deputy Child Health Manager, Nalanda
	Dr Shailender Narayan, Additional Chief Med Officer (CMO), Sadar Hospital, Nalanda
	Dr. Rajender Chaudhary, District Immunisation Officer, Nalanda
	Dr Ashok Kumar, Assistant Professor, Pediatrics, Nalanda
	Nirbhay kumar, District Account Manager, Nalanda
	Dr. Anjani Kumar, Nodal officer Sick Newborn Care Unit, Nalanda
	Dr. Avdhesh Sinha, Medical Officer in Charge, Primary Health Centre, Noor Sarai, Nalanda
	Phulodevi, Auxiliary Nurse Midwife, Nalanda Noorsarai, Primary Health Centre
	Dr Vijaykumar Singh, Medical Officer in Charge, Nalanda Noorsarai Primary Health Centre
	Bablum Kumar, Junior Child Health Manager, Nalanda Noorsarai Primary Health Centre
	Dr. Mirajhussain, Medical Officer, Sadar Hospital and Sick Newborn Care Unit, Jehanabad District Hospital
	Ravi Shankar, District Planning Coordinator, Jehanabad District Hospital
	Dr. Brajbhusan Sharma, District Immunisation Officer, Jehanabad District Hospital
	Budhdev Prasad, District Child Health Manager, Jehanabad District Hospital
	K K Jha, DHS, NRHM, Jehanabad District Hospital
	Priyanka, Hospital Manager, Jehanabad District Hospital
Mamtas	We consulted with 9 Mamtas at the Nalanda district hospital, Noorsaria Primary Health Centre and Jehanabad District Hospital
ASHAs	We consulted with 10 ASHAs at the Noorsarai Primary Health Centre in Nalanda and the Jehanabad District Hospital
Beneficiaries	We consulted with 10 beneficiaries at the Nalanda district hospital, Noorsarai Primary Health Centre at Nalanda and the Jehanabad District Hospital

ANNEX 9: FIELD VISIT REPORT – MADHYA PRADESH

1. Introduction

This annex presents key findings from our field visit to Madhya Pradesh during 15-17 April 2013. We have covered the capital city of Bhopal (to meet with the Government officials and the state level NIPI implementing partners) and two of the four NIPI focus districts of Hoshangabad and Raisen (to meet with the Yashodas, (ASHAs, beneficiaries and other health workers). In Hoshangabad district, we visited the District Hospital in Hoshangabad town, the Civil Hospital in Itarsi town, and Sub-Health Centre at Sankheda village. In Raisen district, we visited the District Hospital at Raisen town, and the Community Health Centre at Garatganj.[40]

The report is structured as follows: Section 2 provides a background on the state health and financing profile; Section 3 presents a summary of the NIPI interventions in the state; Section 4 presents our findings on the four evaluation dimensions of NIPI's policy/ programme design, governance, implementation/ processes, and results; and Section 5 concludes. A list of consultations is provided at the end of this report.

2. Madhya Pradesh health profile and financing

According to the 2001 census, the population of Madhya Pradesh is 72.6m, which represents 6% of India's population. The sex ratio is 930 (compared to the country average of 940) and the ratio of the rural and urban population is 78:22. 37.4% of the state's population lives Below the Poverty Line compared to the national average of 26.1%.[41]

The population of the scheduled castes and scheduled tribes is 9.2m and 12.2m respectively, which constitutes 15.2% and 20.3% respectively of the state's population, as compared to a national average of 16.2% and 8.2%.[42]

As seen in the table below, key health indicators for Madhya Pradesh (including the three NIPI focus districts) are higher (i.e. worse-off than) the national average.

Table A9.1: Key health indicators (2009 data, unless otherwise noted)[43]

Indicator	Madhya Pradesh	Hoshangabad	Raisen	Narasimhapur	India
Infant Mortality Rate (IMR)(per 1000 live births)	67	68	68	68	47
Neo natal mortality (NMR) (per 1000 live births)	44	49	54	47	34
Under five mortality rate (U5MR) (per 1,000 live births)	85	80	99	77	64
Total fertility rate (TFR)	3.1	2.7	3.7	3.3	2.6

[40] The detailed itinerary was based on proximity of locations and ease of access in the available time for the field visit.
[41] National Census 2001.
[42] Scheduled Castes and Scheduled Tribes are two groups of "historically disadvantaged" people recognised in the Constitution of India. According to the UNDP (2004-05), human development indicators are 29% lower for Scheduled Castes and 54% lower for Scheduled Tribes when compared to non-Scheduled Castes/ Tribes communities.
[43] Office of the Registrar General and Census Commissioner, India, Ministry of Home Affairs, Government of India., Annual Health Survey 2010-11, Fact Sheet.

Indicator	Madhya Pradesh	Hoshangabad	Raisen	Narasimhapur	India
Maternal Mortality Rate (MMR) (per 100,000 live births)[44]	310	296	287	310	212

In addition, as per the UNICEF Coverage Evaluation Survey (2009) full immunisation coverage in Madhya Pradesh was 42.9%, as compared to a national coverage of 61%.

The state NRHM budget for 2012-13 was INR 3.1bn (US$ 56.5m). Several development partners are active in the state including UNFPA, UNICEF, Ipas and Population Foundation of India. Some details/ examples of their areas of work include:[45]

- *UNFPA* support to the state in 2012-13 was in three broad areas - reproductive health; sex selection; and population and development. Interventions include enhancing community capacities; capacity building of NGOs; and raising awareness in tribal areas.
- *UNICEF* works in collaboration with the state government on a range of interventions in health, nutrition, education, child protection, water and sanitation, and children and AIDS.
- *Ipas* works to prevent deaths and morbidities due to unsafe abortions. To address the high incidence of unsafe abortions in the state, Ipas provided technical assistance to the state government in implementing the comprehensive abortion care (CAC) programme.
- *Population Foundation of India* supported the preparation of state Project Implementation Plan and District Health Action Plans for the urban health component of the National Health Mission .

3. NIPI interventions in Madhya Pradesh

NIPI UNOPS has been working in the districts of Hoshangabad, Narsingpur and Raisen since 2008, and in the tribal district of Betul since 2010. Key NIPI UNOPS interventions and their current status in the state include:

- *Community based services through delivery of Home Based Post Natal Care :* UNOPS began providing support to home based post natal maternal and neonatal care services for institutional and home deliveries through ASHAs in 2009.
- *Improving maternal and newborn care in the facility through Yashoda:* Yashodas, or volunteer mothers' aides, have been deployed at District Hospitals and some Community Health Centres in the state (based on delivery load) since 2008. This intervention in the four NIPI districts has been taken up under state health funding since November 2012. There are currently 112 Yashodas providing care to mothers and newborns in 15 facilities in the four focus districts.
- *Child Health Manager support:* NIPI UNOPS has facilitated the placing of District and Block Child Health Managers[46] in the four districts. These managers are part of the

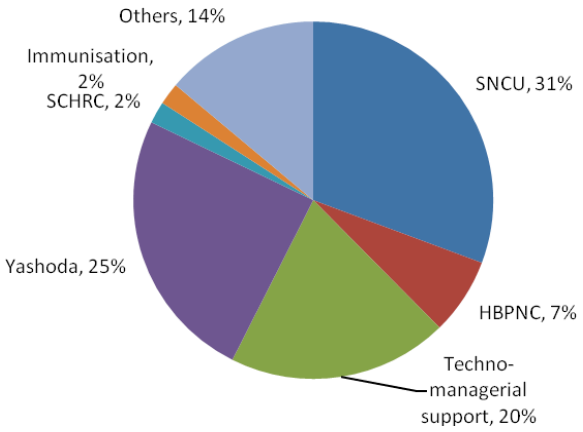
[44] MMR numbers are average figures for the period 2007-09. MMR data is reported at the Division level. Data presented here reflect MMR for Narmadapuram (Hoshangabad), Bhopal (Raisen) and Jabalpur (Narasimhapuram).
[45] State Health Society, Madhya Pradesh., State Programme Implementation Plan, 2012-13 (2nd Draft).
[46] The role of the Managers is particularly useful in Cold Chain and Logistics Management for Immunisation for which they have been especially trained. They have been part of immunisation tracking and will work towards improving immunisation levels in hard to reach areas.

district and block Programme Management Units and assist with the management of the Maternal and Child Health programs. In 2012-13, more work was proposed to integrate the managers fully with the district and block programme management.

- *Sick Newborn Care Units :* Sick Newborn Care Units have been established at District Hospitals in Hoshangabad, Raisen and Narsignpur. The unit at Hoshangabad is both a treatment and training centre for unit staff from other NIPI (and non-NIPI) districts in Madhya Pradesh. New Born Stabilisation Units [47] have been established in Community Health Centres with high delivery loads.
- *District Health Training and Resource Centres:* A Training Management Centre is being supported through NIPI UNOPS in Hoshangabad and Narsingpur.
- *Flexible funding:* NIPI UNOPS provides untied funding to the state, districts, and blocks. The support can be used to fill gaps in funding, and undertake activities that have not previously been discussed in the state Programme Implementation Plan.

The figure below provides a snapshot of the percentage of funds spent in the four NIPI districts on different interventions over the period April 2008 - March 2012. [48] The total amount spent during this period was INR 95.8m (US$ 1.7m).

Figure A9.1: NIPI UNOPS disbursement of funds, April 2008 – March 2012 (INR 95.8m)



Source: NIPI UNOPS state office

UNICEF uses NIPI funds for a broad range of activities in the state; about 20% of UNICEF's annual budget for the state is contributed by NIPI. In Phase I, NIPI funds were used to establish Sick Newborn Care Units in two districts (being different from those covered by UNOPS), and for UNICEF's Integrated Management if Neonatal and Childhood Illness programme in the state. UNICEF also provided techno-managerial support through the State Child Health and District Child Health Coordinators, partly using NIPI funds.

4. Evaluation findings

This section presents our findings from the field visit on the four evaluation dimensions of NIPI's policy/ programme design; governance; implementation/ processes; and results.

[47] Newborn Stabilising Units are scaled down versions of Sick Newborn Care Units with lesser number of beds, but have a round-the-clock medical officer, radiant warmers, phototherapy kits, resuscitation kits, etc. They refer sick newborn to Sick Newborn Care Units as required.
[48] Activities in Betul commenced in April 2010.

4.1 Policy/ design

Rationale for selection of districts

The selection of the three districts of Hoshangabad, Raisen, and Narasingpur was based on their being medium performing districts, making it easier to demonstrate the efficacy and viability of pilot interventions. The addition of Betul was on account of its sizeable tribal population. Some consultees noted that NIPI could have chosen to implement the interventions in more problematic and far flung districts (but our view is that it is difficult to demonstrate proof of concept/ scalability in such districts).

Alignment of NIPI policy and design with NRHM

All NIPI interventions in Madhya Pradesh are implemented through the NRHM machinery and thus aligned with NRHM activities at the state level. NIPI interventions were seen as relevant at the district and block levels as they helped fill gaps in service delivery (e.g. Yashodas counselling mothers in maternity wards), develop required health infrastructure (e.g. Sick Newborn Care Unitss and District Training Centres), provide strategic assistance through techno-managerial support, and provide flexible funding for innovative initiatives (e.g. the Early Intervention Clinic[49] in Hoshangabad).[50]

However some consultees have questioned the alignment of NIPI interventions with NRHM based on their actual/ potential for absorption/ scale up by the government. For example, the Yashoda initiative was seen as only partially relevant as it has not been scaled up as part of the NRHM nation-wide, although the Ministry of Health and Family Welfare has allowed states the discretion to scale up the Yashoda intervention using state health budgets. Further, it is uncertain whether the government will absorb techno-managerial staff. Some consultees also suggested that NIPI could help expand selected interventions across the entire state, thereby creating a greater impact.

While there is an advantage of NIPI working through NRHM – for example, in terms of increased transparency and accountability as the donor funding is channelled through the government system rather than in parallel, there is also a disadvantage in that NIPI has to adhere to the government procedures which can at times be bureaucratic and result in considerable delays.

Efficacy of funding

Feedback from the government, UNOPS and UNICEF suggests that fund disbursement was timely, and no issues were noted in this regard.

The District Health Societies send their resource requirements for each intervention to State Coordination Committee. The committee aggregates the requirements at the state level and a request is made at the Joint Steering Committee. Post approval, funds are released by NIPI to

[50]The Early Intervention Clinics aim to improve the quality of life of children between the ages of 0 and 3. A multidisciplinary team screens and treats children for deficiencies related to reaching, rolling, crawling, and walking. Children are also screened for retardation and deficiencies in eyesight and hearing.

UNOPS, which in turn releases funds to the states for inclusion in the NRHM state budget, and as represented in the state Programme Implementation Plan.

In the case of UNICEF and WHO, NIPI disburses funds to them directly at the national level, and funds are allocated by them to the states thereafter.

4.2 Structure and governance

NIPI structure and cooperation amongst partners

Our assessment suggests that there have been some inefficiencies and duplication of efforts in the implementation of interventions. For example, UNICEF's Integrated Management of Neonatal and Childhood programme and UNOPS' Home Based Post Natal Care has significant overlap in that they both focus on post natal care UNICEF and UNOPS suggest that there was no real overlap, as a result of a demarcation of the districts in which they operate. Our view, however, is that greater convergence could have been sought between the two initiatives. Further, greater synchronisation/ homogenisation could have been pursued for the Sick Newborn Care Unit intervention across the state as the units developed by UNICEF in the non-UNOPS districts were similar to those in the NIPI-UNOPS districts.

Efficacy of the State Coordination Committee

The State Coordination Committee is chaired by the Principal Secretary for Health. Members include senior government officials and a broad range of stakeholders including the Mission Director, (MD) NRHM, Directors of state health departments related to child and maternal health, and UNOPS and NIPI Secretariat representatives. It is used as a forum for reporting on and discussing key issues and interventions (e.g. need for funding, need for interventions, how they should be implemented).

While stakeholders view the State Coordination Committee as an effective platform for discussing child health issues, some consultees noted that it might be more useful for the committee to meet at least twice a year in order to make changes in funding allotments and activities planned for the year. Other NIPI implementing partners are represented in committee meetings, but their role is restricted to mainly discussing the UNOPS interventions.

4.3 Implementation/ processes

In this section, we provide a summary of our review of the process implementation of the Yashoda and Home Based Post Natal Care interventions in Madhya Pradesh.

4.3.1 Yashoda

After the implementation of the Janani Suraksha Yojana, the number of institutional deliveries (at District Hospitals and Community Health Centres) in Madhya Pradesh increased significantly to 81%[51], presenting a challenge for providing high quality services in health facilities. The Yashoda initiative was introduced to provide better health care support for mothers in the

[51] State Health Society, Madhya Pradesh, State Programme Implementation Plan, 2012-13 (2nd Draft).

facilities. Currently 112 Yashodas are working in 15 facilities at the district and sub-district level in the state.

We understand that the state government has taken over the intervention in the four NIPI districts in 2013, and is now funding all activities under this programme. However, it remains to be seen if the interventions would be scaled up throughout the state. Some consultees were of the opinion that the intervention was expensive and scaling up across the state may not actually be necessary as there are already an adequate number of councillors in the health system.

Process mapping

Following are some key points regarding the recruitment, training, supervision and implementation experience of the intervention.

- **Recruitment.** Yashodas were recruited based on responses to an advertisement in the newspaper, after which they were interviewed and selected on the basis of certain qualifications (e.g. minimum qualification of 8th standard). Their level of qualification varies across districts. For example, the Yashodas at Hoshangabad were mainly graduates and post-graduates, while the Yashodas in Raisen were 8th standard pass students. The attrition rates amongst Yashodas seem to be quite low - the Yashodas we consulted with had all been on rolls since 2008 when the intervention was introduced.
- **Training.** All Yashodas were given three days of intensive training before the start of the programme. In addition, in 2013, some Yashodas were also given gender-related training. Feedback from Yashodas suggests that the training has been extremely beneficial, in that it imparted the relevant skills and knowledge, and helped them in delivering their duties effectively. All Yashodas have been given refresher training four to five times since the start of the programme. According to the 2012-13 Programme Implementation Plan, the skills of the Yashoda were to be enhanced to include identification of danger signs in the newborn and the mother, and also counselling for family planning – although Yashodas consulted as a part of this study had not received this training.
- **Supervision.** We understand that while several health facility staff, including doctors and senior staff nurses, supervise/ monitor Yashodas, the Deputy Child Health Supervisors at the facilities are entrusted with the key supervision role. All Yashodas are required to complete a register on each delivery to record information like initiation of breastfeeding, number of days stayed in the hospital, weight and sex of the baby, immunisation, amongst others. This register is cross-checked by both the senior staff nurse and the Deputy Child Health Supervisor. There was variable experience in the efficacy of supervision – with some health facilities visited claiming that supervision has worked very poorly. In the 2012-13 Programme Implementation Plan, it was proposed that all Yashodas would be assessed using a structured assessment method by teams nominated for the purpose by the state. The purpose of the assessment would be to identify the best performing Yashodas for rewards and the poor performing ones for re-training. It is not clear if these assessments have taken place.
- **Implementation.** Yashodas work in three shifts: morning, evening and night and use a flipchart that was provided to them in 2008 to impart counselling to mothers at the

facility. All Yashodas wear a pink overcoat that makes them easily recognisable in the maternity ward. Our interaction with them suggests that they seem to have performed their tasks effectively – e.g. comforting the pregnant woman on arrival, providing emotional support in the labour room, counselling mothers on care of newborn, including initiation of breastfeeding, immunisation, counselling the mothers and family members on importance of giving equal attention to the boy and girl child.

- **Payments.** Yashodas are paid a fixed amount of INR3,000 (US$ 60) a month.[52] Yashodas uniformly lamented the fact that the emolument has not been revised upwards since 2008, while that of other facility staff on government roles had increased regularly. Yashodas welcomed the uptake of the intervention by the government as they are now on annual contracts with the government as against three month employment contracts that was in practice under NIPI. Yashodas did not report any delays in payments, which are made electronically into their bank accounts.

Experience under the Yashoda intervention in Madhya Pradesh

The Yashoda intervention was generally viewed positively by all stakeholders, and considered beneficial in filling a critical gap by providing a support system for the newborn, and counselling to mothers. The intervention has played an important role in addressing strains on the health system that have resulted from an increase in institutional deliveries (after the introduction of the Janani Suraksha Yojana scheme). Feedback from the mothers suggests that they generally trust Yashodas, and seek their support in case they encounter any problems. However, it is not very clear if the mothers have interacted sufficiently with Yashodas or if they follow instructions given by Yashodas once they leave the medical facility.

The table below presents the key performance indicators for Madhya Pradesh provided to us by UNOPS. We do not have data on NIPI and other districts or pre- and post-NIPI intervention to compare results. Further, the lack of reliable baseline data makes it difficult to ascertain the impact of the intervention. The figures in the table below suggest that the state's key indicators on maternal and child health were generally high in 2012, which at least in part is likely to have been as a result of the Yashoda intervention.

Table A9.2: Key performance indicators - Yashoda

Key performance indicator	July-Dec 2012
Percentage of mothers staying at least 24 hours at the health facility after birth	81
Percentage of mothers initiating breastfeeding within first hour of birth	95
Percentage of neonates weighed at birth	96
Percentage of neonates immunised for zero-dose polio	96
Percentage of neonates immunised for BCG	97

Source: UNOPS state office

[52] The intervention was envisages as an incentive based volunteering scheme where the Yashoda was to be paid INR 100 for each mother-child cohort. This mode of payment was replaced with a fixed a fixed payment scheme after a few months of operation.

Some key themes that our consultations revealed are as follows:

- *Education levels and Yashoda efficacy*. The efficacy of Yashodas differs across districts and by their education background. For example, Yashodas in Hoshangabad who were graduates or postgraduates were seen as very competent vis-à-vis those from Raisen who mainly met the minimum qualification of 8th standard pass. Education levels also have a bearing on the adequacy of training received by Yashodas.
- *High workload*. Each Yashoda was envisaged to take care of the needs of five mothers at any given time, although the actual number of mothers cared for by a Yashoda ranges from 8 to 25.[53] Further, Yashodas, in some facilities, are called on to perform tasks in other wards and carry out administrative tasks amongst others.

4.3.2 Home Based Post Natal Care

Home Based Post Natal Care was designed to address the challenge of reducing perinatal and neonatal deaths in India through a system of follow-up by ASHAs of mother-child cohorts post home or institutional delivery. This intervention was initiated in Madhya Pradesh in the three NIPI districts of Hoshangabad, Narasingpur, and Raisen in 2009, and in Betul in 2010.

Process mapping

Following are some key points on training, supervisory support and implementation experience of the intervention.

- **Training.** ASHAs underwent a 2-day induction training before starting home visits to provide post natal care to the mother and newborn. This was followed up by a more intensive five days C training that aims to develop the skills of ASHA in weighing the baby, taking its temperature, identifying danger signs in the newborn, amongst other skills. The 2+5 days training module developed by NIPI under this intervention was viewed as very useful by most stakeholders, including the ASHAs, and until December 2010, 3,000 ASHAs had received training. However, a few consultees questioned the relative adequacy of training under Home Based Post Natal Care when compared to Modules 6 & 7 under Home Based Newborn Care, suggesting that the 2+5 day training model was not sufficient for imparting knowledge and hands-on training that is required by ASHAs to undertake their tasks effectively.
- **Supervision.** The ASHAs fill a printed form on each visit which is also signed by mothers/ family attendants. The completed form is deposited with the Auxiliary Nurse Midwives/ supervisor at the health facilities. These forms are then verified and passed onto officials at the block level. ASHA visits are verified by the Auxiliary Nurse Midwives/ supervisors at times to ensure that the they are performing their duties effectively. Consultations with beneficiaries reveal that ASHAs have been able to detect health complications and refer mothers and children to health facilities. However, some facility based health staff are sceptical about ASHAs' abilities to identify health complications.

[53] The delivery load at the facilities covered in our field visit range from 250 to 550 deliveries a month.

- **Implementation.** ASHAs are provided a kit which includes a weighing scale and thermometer to examine the baby. In case of any danger signs, the ASHAs refer the newborn to a nearby health facility, and sometimes even accompany the mothers to the facilities. Our visit revealed that, although Home Based Post Natal Care has been replaced by Home Based Newborn Care, ASHAs in Hoshangabad continue to use the Home Based Post Natal Care form, while the ASHAs in Raisen use a Home Based Newborn Care form.
- **Payments.** Our consultations reveal that the ASHAs are largely aware of the number of completed forms submitted by them under various health schemes and keep track of the amount that is due to them for their services. Our consultations did not reveal any problems regarding payments by the state for post natal care services. ASHAs are paid INR 250 (US$ 5) electronically into their bank account for each completed and verified form.

Experience under the Home Based Post Natal Care intervention in Madhya Pradesh

ASHAs are viewed as an integral part of the health delivery system and as trusted aides by mothers and their families. The perception of mothers in terms of the quality of services provided by the ASHAs and the benefits was largely positive. However, we acknowledge that some of the beneficiaries are not fully aware of the benefits of post natal care and therefore unable to make judgements on the efficacy of the ASHAs.

In our view, the main value add of this intervention has been in terms of increasing emphasis on post natal care. Based on consultations with health workers at the Primary Health Centres and Community Health Centres, we understand that this intervention has brought about an improvement in child health, with more newborns being brought to the health these facilities for treatment, given that the ASHAs identify the danger signs at an early stage; motivate mothers to take their children to the health facilities; and accompany them to the facilities in some cases. Till December 2010, 8,000 mothers and babies had been provided with post natal care support in Narsinghpur, Hoshangabad and Raisen.

Despite the fact that Home Based Newborn Care replaced Home Based Post Natal Care relatively quickly, the intervention is viewed as the first to address post natal care, and usher in the continuum of care approach to child health in the state. Stakeholder consultations suggest that while not a new intervention as such, Home Based Post Natal Care helped focus on post natal care specifically as compared to Integrated Management of Neonatal and Childhood Illness, and has thus brought post natal care to the attention of the Government. Also, the kits issued to ASHAs under Home Based Post Natal Care are still being used under Home Based Newborn Care.

Some key issues revealed in our consultations are:

- *Duplication of effort and potential for conflict.* We understand that there is some overlap between the responsibilities of ASHAs on the one hand, and Auxiliary Nurse Midwives, Anganwadi Workers and Yashodas on the other, resulting in some friction. A few consultees however are of the opinion that the overlap in responsibilities is necessary/

beneficial because long term behaviour change in society requires constant 'hammering' of ideas through as many channels as possible.

- *Differences in ASHA capabilities.* Understandably, there is some variance in ASHAs' ability to deliver heath services. This could be a result of their inherent capabilities and their education/ training. While we understand that such differences are reducing over time, continuous training and refresher courses could help in ensuring high quality health services.

4.3.3 Other NIPI interventions

This sub-section discusses issues surrounding other NIPI initiatives in Madhya Pradesh. The box below presents some key points to note on the Sick Newborn Care Unit intervention in Madhya Pradesh

Box A9.1: Experience under the Sick New Born Care Units in Madhya Pradesh

NIPI UNOPS has set up one Sick Newborn Care Unit in each of the four focus districts along with 13 New Born Stabilisation Units .

The Sick Newborn Unit in Hoshangabad is a treatment cum training centre and includes innovations such as a video conferencing facility linking it with Institute of Post Graduate Medical Education and Research, Kolkata and establishment of a breast milk bank at the facility. The unit in Hoshangabad was set up in 2010, and is considered a model unit.

In general, all stakeholders commented that Sick Newborn Care Units and Newborn Stabilisation Units have been beneficial in reducing neonatal mortality, and has particularly benefitted premature babies, babies with hypothermia, amongst others. NIPI's contributions towards fine tuning Sick Newborn Care Units protocols is viewed as catalytic. Consultees felt that in the absence of NIPI, procurement of instruments and other infrastructure for use within the unit might have taken longer

However, certain issues were noted with regard to the Sick Newborn Care Units:

- *HR shortages.* We understand that staff from Sick Newborn Care Units and Newborn Stabilisation Units were sent to the Institute for Post Graduate Medical Education and Research for training. However, since the staff were on temporary contracts, they left their roles at these units on securing better employment either within the government system or in the private sector. This left the facilities short on trained manpower and they are currently functioning with permanent and contract staff who have been trained on the job.
- *Lack of an efficient transport link with the new-born corners, Newborn Stabilisation Units and Sick Newborn Care Units* Consultees felt that although babies were regularly referred to newborn corners, Newborn Stabilisation Units and Sick Newborn Care Units, the ambulances (Janani Suraksha Express) that transport babies to centres that are more capable of providing newborn care could be improved to enhance the chances of child survival.
- *Gender discrepancies.* While we do not have sex disaggregated date for Sick Newborn Care Units, consultations suggest that a larger number of male babies are brought to the units than girls when babies develop complications when at home, or are born in private hospitals/ at home.

Some additional points on other NIPI interventions include:

- The flexible component of NIPI funds is considered useful by several stakeholders. A predetermined corpus of flexible funds are allocated to each of the districts as part of the Programme Implementation Plan. District officials, under guidance from the District Magistrate, can use these funds to fund ad-hoc activities which are in line with NIPI's objectives. For example, in Hoshangabad, flexible funds were used to fund a part of the Early Intervention Clinic (funds were also provided by the Departments of Social Justice and Health, amongst others) that addresses the physical and mental health of babies in their first three years of life. Flexible NIPI funds were also used to upgrade the vaccine store in Hoshangabad. Our consultations however revealed that these flexible funds were

not put to use in an optimal manner in other districts, its use being largely a function of the leadership and capacity at the district level.

- NIPI support to refurbishing and upgrading the District Training Centre at Hoshangabad considered both innovative and beneficial.
- The sustainability of some of the techno-managerial support funded under NIPI is at risk. While some positions have been absorbed by the state government, others are currently under decision. In particular, several district and block level techno-managers have not yet been absorbed by the government, even though their contracts under NIPI have been terminated.

4.4 Results

The main value add of NIPI in Madhya Pradesh is that it has helped to bring forward in time the neonatal health agenda, and has provided momentum to newborn health in Madhya Pradesh. It has been viewed as innovative in terms of the introduction of interventions such as Yashoda. Apart from this intervention, NIPI's added value has been mainly viewed in terms of accelerating existing programmes and ideas within NRHM. All stakeholders consulted felt that NIPI interventions have contributed to an improvement of maternal and child health indicators in the state. However, given the duration of Phase 1, the limited area covered by the interventions, and the interventions being a part of the larger government health system, it is difficult to attribute any result specifically to one or all NIPI interventions.

5. Summary findings

NIPI interventions in Madhya Pradesh have emphasised the continuum of care approach to maternal and newborn health. Despite its limited funds as compared to the NRHM, NIPI has played a strategic and catalytic role. By aligning well with the NRHM, NIPI has been able to build significant buy-in from the government, thereby increasing the potential of scaling up successful interventions across the state.

NIPI UNOPS however, could have engaged more with UNICEF and coordinated better on interventions so as to reduce duplication of efforts and create synergies. Further, NIPI's choice of districts does not seem to have a strong rationale. While the State Coordination Committee is functional in Madhya Pradesh and is an important forum for discussion on issues related to child and maternal health, its role and purpose could be made clearer to all stakeholders. Stakeholders also felt that the committee should convene more often.

The Yashoda intervention has helped in fill a critical gap in relation to counselling/ supporting mothers at facilities with high delivery load. Nonetheless, it has not been scaled up across the state and is supported by the state only in the four NIPI focus districts. Home Based Post Natal Care was scaled up as the government sponsored Home Based Newborn Care programme and is viewed as having paved the way for post natal care in the state. Both Yashoda and Home Based Post Natal Care have room for improvement in key implementation processes, especially with regards to training and supervision. While the field visit focused specifically on these two interventions, our consultations reveal that other NIPI interventions like Sick Newborn Care Units and techno-managerial support have also worked well, although the latter is not yet being supported by the government for scale-up.

List of consultations

Table A9.3: List of consultations[54]

Category	Name of consultee
NIPI implementing partners	Dr. Amita Chand, Senior Programme Office, UNOPS-NIPI
	Surya Prakash Dixit, Programme Assistant, UNOPS-NIPI
	Dr. Gagan Gupta, Health Specialist, UNICEF
State level heath system stakeholders	Dr. K L Sahu, Director – Public and Health Services, Directorate of Health Services, Government of Madhya Pradesh
	Dr. Manohar Agnani, Former Mission Director, NRHM
	Vipin Shrivastav, State Cold Chain Officer, Government of Madhya Pradesh
	Dr. Santosh Shukla, Deputy Director – Immunisation, Government of Madhya Pradesh
	Dr. Rajshree Bajaj, Deputy Director – Child Health, NRHM
	Dr. Ajay Khare, Deputy Director – ASHA, NRHM
	Dr. Jayashree Chandra, Former Deputy Director – Child Health, NRHM
	Dr. J L Mishra, Director, NRHM
	Amit Jain, State Programme Manager (in-charge), NRHM
District and Block level health system stakeholders	Dr. Sudhir Jesani, Chief Medical and Health Officer, Hoshangabad
	Dr. Vinay Dubey, Civil Surgeon, Hoshangabad
	Dr. Sharad Gupta, Nodal Officer, Hoshangabad
	I. Pigga, District Training Officer, Hoshangabad
	Sahilender Shukla, District Training Coordinator, Hoshangabad
	Sonali Jonathan, Nursing Coordinator, Hoshangabad
	Vineet Agnihotri, Block Child Health Manager, Hoshangabad
	Vishesh Dubey, Block Child Health Manager, Hoshangabad
	Priyank Dubey, Block Child Health Manager, Hoshangabad
	Kamlesh Kapse, Data Entry Operator, Hoshangabad
	Dr. Udham Sahu, Sector Medical Officer, Sankheda, Hoshangabad
	Dr. Sunil Mantri, Block Medical Officer, Kesla, Hoshangabad
	Dr. Shashi Thakur, Chief Medical and Health Officer, Raisen
	K P Singh, District Child Health Manager, Raisen
Yashodas	We consulted with 11 Yashodas in Madhya Pradesh
ASHAs	We consulted with 10 ASHAs in Madhya Pradesh
Beneficiaries	We consulted with 10 beneficiaries in Madhya Pradesh
Others	Pankajakshi Nair, Deputy Child Health Supervisor, Hoshangabad
	Gobind Chande, Anganwadi Worker, Hoshangabad
	Kumudh Tiwari, Auxiliary Nurse Midwife, Hoshangabad
	Aboli Gore, Deputy Team Leader MCH, Madhya Pradesh -TAST

[54] While we have consulted with beneficiaries; Yashodas and ASHAs at all the health facilities, we were unable to understand all their names.

ANNEX 10: FIELD VISIT REPORT – ODISHA

1. Introduction

This annex presents key findings from our field visit to Odisha between 29 April-2 May 2013. As a part of the field visit, we have covered the capital city of Bhubaneshwar (to meet with the Government officials and the state level NIPI implementing partners) and two of three NIPI UNOPS focus districts of Angul and Sambalpur (to meet with the Yashodas, ASHAs, beneficiaries and other health workers).

In Angul district, we visited the District Hospital in Angul town and the Community Health Centre at Bantala. In Sambalpur district, we visited the District Hospital at Sambalpur town, and the Community Health Centre at Themra and the Primary health centre at Parmanpur.[55]

The report is structured as follows: Section 2 provides a background on the state health and financing profile; Section 3 presents a summary of the NIPI interventions in Odisha; Section 4 presents our findings on the four evaluation dimensions of NIPI's policy/ programme design, governance, implementation/ processes, and results; and Section 5 sets out the conclusions from the field visit.. A list of consultations is provided at the end.

2. Odisha health and financing profile

According to the 2001 census, the population of Odisha is 41m, representing about 3.4% of the country's population. The decadal population growth for the state from the period 2001-11 was 13.97%. The sex ratio in Odisha is 978, which is above the national average of 940. About 17% of the state's population lives in urban areas, increasing by 27% in the last decade. Scheduled Tribes constitute 22.1% of the state's population, representing 9.7% of the total tribal population of the country. Scheduled Castes comprise 16.5% of the state's population.

As can be seen from the table below, key health indicators for Odisha (including the three NIPI focus districts) are above the national average. The NIPI focus districts are relatively better performing districts in the state.

[55] The detailed itinerary was based on proximity of locations and ease of access in the available time for the field visit. We ensured that none of the links in the implementation plan is left out and the team could obtain an all round view of the process.

Table A10.1: (2009 data, unless otherwise noted)[56]

Indicator	Odisha	Angul	Jharsuguda	Sambalpur	India
Infant Mortality Rate (IMR) (per 1000 live births)[57]	61	50	51	56	47
Neo natal mortality (NMR) (per 1000 live births)	43	31	41	35	34
Under five mortality rate (U5MR) (per 1000 live births)	84	60	58	73	64
Total fertility rate (TFR)	2.4	2	2	2.2	2.6
Maternal Mortality Rate (MMR) (per 100,000 live births)[58]	259	253[59]			212

In addition, as per the UNICEF Coverage Evaluation Survey (2009) full immunisation coverage in Odisha was 59.5%, as against a national coverage of 61%.

According to the 2012-13 Programme Implementation Plan of the NRHM, the budget for 2012-13 was INR 10.78bn (US$ 195.9m).

Several development partners work in the area of health in the state as described below[60]:

- *UNICEF* is working with the Government of Odisha to strengthen health workers' training, improve and extend institutional care for newborns, and ensure mothers receive skilled birth attendance. UNICEF is a partner in the roll-out of infant and young child nutrition practices which focuses specifically on seven out of the thirty districts of the state where the current breastfeeding and complementary feeding practices are very low.
- Other major donors present in the state include UK Department for International Development (UK-DFID), Danish International Development Agency (DANIDA), the European Union (EU), and UNFPA. Their support is related to various aspects of NRHM.

3. NIPI interventions in Odisha

A Memorandum of Agreement was signed on December 13, 2007 by Secretary Health and Family Welfare, Govt of Odisha and UNOPS. NIPI's focus districts are Angul, Sambalpur and Jharsuguda.

Key UNOPS Local Fund Agent interventions in the state include:

[56] Office of the Registrar General and Census Commissioner, India, Ministry of Home Affairs, Government of India., Annual Health Survey 2010-11, Fact Sheet.
[57] Odisha has the second highest IMR in the country, with Madhya Pradesh accounting for the highest (62).
[58] MMR figures are reported for 2007-09.
[59] MMR is reported together for the entire Northern Division of Odisha, and includes Angul, Samlbalpur and Jhasuguda.
[60] *CARE India* is supporting the NRHM in nine districts in the state on training of trainers for capacity building of the Gaon Kalyan Samitis (GKS). The Village Health and Sanitation Committee, one of nine institutional mechanisms under NRHM, is known as Gaon Kalyan Samiti in Odisha. It is envisaged as a facilitating body for all village level development programmes and comprises of representatives from the village.

- *Home Based Post Natal Care by ASHA:* UNOPS began providing provided support to home based post natal maternal and neonatal care services for institutional and home deliveries through ASHAs support in the three NIPI focus districts in 2009.
- *Yashoda:* Yashodas, or volunteer mothers' aides, were deployed at health facilities with a high load in 15 districts in 2009.[61] The intervention was taken over by NRHM in these 15 districts in 2012-13. We understand that scaling up of Yashoda across the state under NRHM was proposed in for 2012-13, but was not sanctioned by the Government of India. It has been proposed that the intervention be scaled up across the state in the Programme Implementation Plan for 2013-14.
- *Techno-managerial support:* UNOPS has facilitated the placing of District and Block Child Health Managers in the three focus NIPI districts. These managers are part of district and block Programme Management Units and assist with the management of the Maternal and Child Health programmes in the districts. Three District Child Health Managers) along with 22 Block Child Health Managers were hired to oversee NIPI interventions in the three focus districts. Twelve District Child Health Managers were hired to oversee the Yashoda intervention in the 12 non-focus districts.
- *Sick Newborn Care Units:* These units have been established at District Hospital in the three NIPI focus districts. Newborn Stabilisation Units have been established in Community Health Centres with high delivery loads.
- *State Child Health Resource Centre:* UNOPS provided support to State Institute of Health and Family Welfare for setting up the State Child Health Resource Centre.[62] From documentation provided to us by the state office[63], we understand that the Centre offered two certificate courses through IGNOU[64] for nursing personnel and the library contained more than 150 books both in the form of soft and hard copies.
- *Routine Immunisation support:* NIPI has supported the Department of Family Welfare in immunisation by funding the appointment of 11 operators-cum-High Skilled Helpers, four of whom are at the state level and seven at Regional Vaccine Stores in the districts of Ganjam, Kandhamal, Koraput, Sambalpur, Bolangir, Sundargarh and Balasore.
- *Flexible funding:* UNOPS provided flexible funding at the state, district, and block levels in the three focus districts. These funds are not earmarked for any specific activities in the state plan and are meant to support interventions based on local needs (with local decision making). An amount of INR 36.8m (US$ 0.67m) was disbursed as flexible funding in Odisha in NIPI Phase 1; INR 7m (US$ 0.13m) to the state, INR 7m (US$ 0.13m) to each of the three focus districts, and INR 0.4m (US$ 0.007m) each to 22 blocks.

[61] The districts are Angul, Balasore, Dhenkanal, Ganjam, Jagatsinghpur, Jajpur, Jharsuguda, Keonjhar, Koraput, Mayurbhanj, Puri, Rayaguda, Sambalpur, Kalahandi, Malkangiri

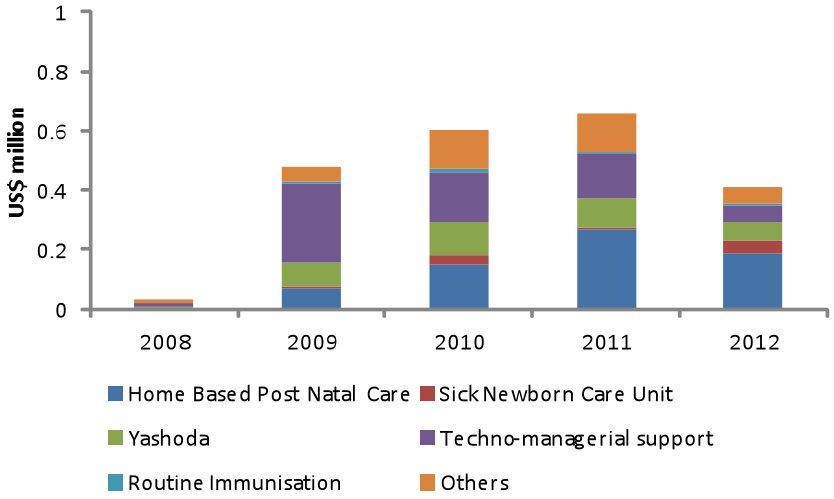
[62] This was envisages primarily as on online repository. We understand that a website (www.schrcodisha.org) was set up in this connection. The website is currently not functional.

[63] Support to State Institute of Health and Family Welfare for setting up State Child Health Resource Centre, UNOPS

[64] Indira Gandhi National Open University

The figure below provides a summary of the funds spent in Odisha on different interventions for the time period 2008-12. The total amount received by the state during this period was INR 148.5m (US$ 2.7m) and expenditures amounted to INR 119.7m (US$ 2.1m), leaving an unspent balance of INR 28.83m (US$ 0.5m).[65]

Figure A10.1: UNOPS Local Fund Agent disbursement of funds[66]



Source: UNOPS state office

UNICEF has used NIPI funds for a broad range of activities in 16 districts in the state between 2007-12 including: system strengthening of the Government of Odisha leading to establishment of State Maternal and Child Survival Cell at state level and functional District Maternal Child Survival Cells in 16 high IMR districts; scaling up of the Integrated Management of Neonatal and Childhood Illness programme state-wide; piloting innovations on Facility Based Child Health intervention in the districts of Mayurbhanj and Koraput and technical support for scaling up; strengthening of cold chain and vaccine logistics management; and providing techno-managerial support to Health Department for acceleration of maternal and child survival activities. NIPI was a major contributor to UNICEF's state budget between the period 2007-12 as can be seen in Table A10.2.

Table A10.2: NIPI contribution to UNICEF

Year	NIPI contribution (US$m)	Percentage of UNICEF state budget
2007	0.42	49.5
2008	0.53	75
2009	0.45	29.5
2010	NA	NA
2011	0.22	30.7
2012	0.27	36.9

Source: UNICEF Odisha state office

[65] Funds flow statement December, UNOPS 2012

[66] Others includes expenditures on recruitment and training of staff, review and technical meetings, Behaviour Change Communication / Information, Education and Communication, untied funds, support to State Institute of Health and Family Welfare, District Training Centres.

4. Evaluation findings

This section presents our findings from the field visit on the four evaluation dimensions of NIPI's policy/ programme design; governance; implementation/ processes; and results.

4.1 Policy/ design

Rational for selection of districts

In Odisha, the economically better performing districts are poor in key health indicators such as IMR, NMR and MMR; whereas the economically poorer tribal districts are relatively better off in terms of health. The NIPI focus districts are medium-level performers in terms of health indicators in the state. The selected districts have been a part of the recent spate of industrialisation in the state and consequently have faced reduced external risks such as Naxalism; geographical obstacles of access; literacy levels and infrastructure. This may suggest some selection bias in terms of convenience of working in these districts.

Alignment of NIPI policy and design with NRHM

All NIPI interventions in Odisha are implemented through the existing NRHM machinery and are thus aligned with NRHM at the state level. Further, NIPI interventions were seen as relevant as they helped fill gaps in service delivery and provided needed infrastructure. Another important indicator of the alignment of NIPI with NRHM is the fact that the UNOPS office is co-located with the state NRHM office. We understand this allows for close coordination with the NRHM and helps foster better understanding of the needs of the state.

However some consultees have questioned the alignment of NIPI interventions. The relevance of Home Based Post Natal Care was seen as limited as the Government of India has now replaced both Home Based Post Natal Care and Integrated Management of Neonatal and Childhood Illness in the state with Home Based Newborn Care. Further, it is uncertain whether the government will absorb techno-managerial staff into its health system. Some consultees suggested that while the Yashoda intervention was innovative in that it filled an important gap in counselling in the maternity ward, it could have been better aligned as there is a requirement for assistance for a broader range of activities in the maternity ward, including assistance in delivery rooms and in emergency situations.

Efficacy of funding

Feedback from the government, UNOPS and UNICEF suggests that fund disbursement was timely, and no issues were noted in this regard.

Our consultations reveal that it is very difficult to ascertain how funds have actually been used on the ground. While it is possible to track how much funds have been allocated for a certain intervention (or aspects of an intervention), it is difficult to track actual expenditure. This information is not collected by NIPI on a regular basis.

4.2 Structure and governance

Efficacy of the State Coordination Committee

The State Coordination Committee is used as a forum for discussing key issues for implementation and reporting on progress. The committee meets every six months and is chaired by the Principal Secretary for Health. Attendees include Mission Director NRHM, Directors of health departments related to child and maternal health, development partners in the state (including UNICEF, WHO, UK-DFID), and state and national NIPI officials. The role of other development partners is restricted to discussing child and maternal health issues; and they are not involved in discussions related to specifics of different UNOPS interventions.

NIPI structure and cooperation amongst partners

Stakeholders have commented that greater efforts could have been to foster coordinated working between NIPI implementation partners. For example, with UNICEF focusing on Integrated Management of Neonatal and Childhood Illness training in specific districts and UNOPS funding Home Based Post Natal Care training in other districts, the state as whole was receiving different types of training support in different districts. As both programmes are closely related, greater efficiencies could have been secured – for example: the Integrated Management of Neonatal Childhood Illness programme had provided training in maternal and child health to Anganwadi Workers across several districts in Odisha, and UNICEF was working towards expanding the initiative across the state. However, by looking to work only with ASHAs, the Home Based Post Natal Care potentially lost the opportunity to capitalise on skills that had already been developed in about 30,000 (out of approximately 70,000) Anganwadi Workers across the state.

Monitoring and Evaluation

Data is collated at the block level by Block Child Health Managers from the NRHM Management Information System and this data is forwarded to District Child Health Managers who then forward it to the state UNOPS office. Data is then analysed and a report is created for submission to the national UNOPS office. Health data is submitted on a monthly basis around the 10th of every month.

Semi-annual reports on key performance indicators are prepared as well. Our consultations revealed that a Management Information System existed under the NHRM, but government officials as well as UNOPS staff at the state level were not aware of its existence and that it could be accessed easily over the internet. Data that is collected is therefore under-utilised. The monitoring system could be strengthened by real-time online verification and feedback mechanism from the district and state level.

The state UNICEF office prepares and submits bi-annual reports in a standardised format. These reports contain details on activities planned and supported using NIPI funds, outputs and key performance indicators (where available), and financial data.

4.3 Implementation/ processes

In this section, we provide a summary of our review of the process implementation of the Yashoda and Home Based Post Natal Care interventions in Odisha.

4.3.1 Yashoda

The proportion of institutional deliveries of total deliveries in Odisha is 71.3%.[67] Yashoda was introduced at health facilities with a high load in 15 districts in 2009 and the intervention was taken over by NRHM in these 15 districts in 2012-13.

Description and process mapping

Following are some key points to note regarding the recruitment, training, supervision and implementation experience of the intervention.

- **Recruitment.** The Yashodas were recruited based on responses to advertisement given in the newspaper, after which they were interviewed orally and selected on the basis of certain qualification criteria (e.g. minimum qualification of 8th standard). Our consultations reveal the average qualification of Yashodas is 10th standard pass. The attrition rates amongst Yashodas is quite low. At the facilities visited by our team, only one Yashoda had resigned from her position in order to become an Auxiliary Nurse Midwife. We understand that in some districts, NGOs were entrusted with recruitment.
- **Training.** All Yashodas were given three days of intensive training before the start of the programme and provided with refresher trainings four to five times since the start of the programme. Both Yashodas and other consultees were of the opinion that the level of training of Yashodas was inadequate given the role they actually play at the facility; this is a result of a mismatch between what the Yashoda was envisaged as and what the health system required in terms of gap filling. Yashodas also felt that they needed more hands-on refresher trainings in order to carry out their tasks better. They would also liked to be trained in a wider range of activities related to child and maternal care given the kinds of tasks they are currently performing at the health facility.
- **Supervision.** We understand that while several staff including doctors and managers at facilities supervise/ monitor Yashodas, there is currently no dedicated staff supervising the work of the Yashodas. Initially, two Yashoda Supervisors, and one Yashoda Coordinator were tasked with supervising Yashodas. Their role included checking the registers (recording of information such as initiation of breastfeeding, number of days stayed in the hospital, weight and sex of the baby, and immunisation amongst others) filled out by Yashodas as well as guiding Yashodas in their tasks. We understand that the position of Yashoda Supervisors was abolished two years ago, and the position of Yashoda Coordinator was abolished a year ago. Some facilities have made ad-hoc arrangements by assigning RMNCH Councillors or Family Planning Councillors to supervise Yashodas. Supervision is currently inadequate at health facilities. The District Child Health Managers who were initially hired to oversee the intervention have now

[67] Bishnupada Sethi, Annual Health Survey - Key Highlights for Odisha, Odisha Review, September 2012

been absorbed by the NRHM. Our consultations reveal that their scope of work has increased under NRHM. Their supervisory capacity is strained and they have very little time to supervise the intervention in a meaningful way.

- **Implementation.** The Yashodas work in three shifts: morning, evening and night and use a flipchart that was provided to them in 2008 to impart counselling to mothers at the facility. Yashodas wear a pink or blue overcoat that makes them easily recognisable in the maternity ward.
- **Payments.** Yashodas are paid a fixed amount of INR 3,000 (US$ 55) a month. Payments are made electronically into their bank accounts between the 1st and the 10th of every month under NIPI support.. Yashodas uniformly lamented the fact that the emolument has not been revised upwards since 2009. They also noted that they were not provided maternity leave or other benefits like other full-time government employees. Yashodas reported a 20-30 day delay in payments since the intervention has been taken over by the NRHM.

Implementation experience

The Yashoda intervention was generally viewed positively by all stakeholders, and considered extremely beneficial in filling a critical gap by providing a support system for the newborn and counselling support for mothers. The intervention has played an important role in addressing strains on the health system that have resulted from this increase in institutional deliveries. Our consultations revealed that attrition at the staff nurse level is as high as 40% in some facilities. Yashodas are, although not envisaged to fill gaps in the health system as a result of a shortage of nurses, seen as important gap fillers in the delivery room and maternity ward.

Our interaction with the Yashodas suggests that they seem to have performed their tasks effectively. However, some consultees are of the opinion that Yashodas are not doing a good enough job when it comes to counselling on family planning and birth spacing. Feedback from the mothers suggests that they generally trust the Yashodas, and seek their support in case they encounter any problems. However, it is not very clear if the mothers have interacted sufficiently with the Yashodas or if the mothers follow instructions given by Yashodas once they leave the medical facility. Our consultations revealed that Yashodas have played an important role in increasing the duration of mothers' stay at the facility; mothers, especially those from tribal areas, are keen to return to their homes immediately after delivery. Further, we understand that Yashodas have had some role in drawing more mothers from the upper castes to government facilities.[68]

While consultees uniformly agree that Yashodas have positively impacted neonatal/ infant mortality, it is difficult to ascertain the actual impact or attribute health indicator improvements (Table A10.3 below on relevant data in recent years does not suggest any discernible trend). The lack of metrics or systems to track behavioural change in mothers once they leave the facility also reduces the ability to measure the impact of the intervention. Another constraint is the lack of baseline data.

[68] Consultees suggested that one of the main reasons was the incentive paid to mothers under Janani Suraksha Yojana, but the comfort of having Yashodas in the wards is also said to have contributed in some part.

Also, several of Yashodas' tasks overlap with other health system functionaries' tasks, making attribution difficult. Another compounding factor is that due to the high delivery load, there is pressure on the facilities to send mothers home as early as possible. Our examination of hospital records revealed that mothers were kept in hospitals for an average of 30 hours after delivery in case of normal births. This likely reduces the impact Yashodas have on mothers.

Table A10.3: Key performance indicators - Yashoda[69]

Key performance indicator	Jan-June 2010	July-Dec 2010	Jan-June 2011	July-Dec 2011	Jan-June 2012	July-Dec 2012
Percent mothers staying at least 24 hours at the health facility after birth	83	53	64	63	66	64
Percent mothers initiating breastfeeding within first hour of birth	85	81	88	86	88	91
Percent neonates weighed at birth	96	95	97	100	97	98
Percent neonates immunised for zero-dose polio	90	90	89	87	88	92
Percent neonates immunised for BCG	84	81	89	89	86	91

Source: UNOPS state office

Some key themes on the implementation experience of the Yashoda intervention that our consultations revealed are:

- *High work load.* As per design, each Yashoda was to take care of the needs of 5 mothers at any given time. The actual number of mothers cared for by a Yashoda ranges from 9 to 15. Further, Yashodas, in some facilities, are also called on to perform tasks like cleaning the maternity ward and assisting in delivery rooms. The delivery load at the facilities covered in our field visit range from 250 to 600 deliveries a month. Yashodas also complained that while sanitary facility of the mother is their task, often the cleaning staff never listen to them and they were averse to performing these tasks themselves.
- *Potential conflict of interest with ASHAs.* There is potential for some conflict between ASHAs and Yashodas in terms of ownership over care for the mother. Yashodas state that ASHAs accompany pregnant mothers at the facility and then go back to their respective villages, and that it is they who care for the mothers. ASHAs, on the other hand, insist that they stay back in the maternity ward often as the mothers know them better and want them to stay back as a result. Block and village level health workers, including ASHAs, were of the opinion that Yashodas extract money from mothers in the maternity ward for providing services.
- *Changes post NRHM take over.* We understand that since NRHM has taken over the funding for the intervention, Yashodas have not been able to replace flipcharts once they have become worn out. They have also not been supplied aprons, soaps, and slippers

[69] These indicators relate to the 15 districts.

amongst other items that had been provided when the intervention was under NIPI support. Yashodas also noted that the monthly meetings of all Yashodas in the facility that used to be helpfully organised under NIPI had been stopped since takeover under NRHM. Also, Yashodas had been provided infrastructure like cupboards, chairs, and tables under NIPI, and these are now decrepit and have not been replaced under NRHM.

4.3.2 Home Based Post Natal Care

Perinatal and neonatal deaths have been a matter of concern in India, and also in Odisha. Home Based Post Natal Care was designed to address the challenge of reducing perinatal and neonatal deaths through a system of follow-up by ASHAs of mother-child cohorts post home or institutional delivery. This intervention was initiated in the three NIPI districts of Angul, Sambalpur, and Jharsuguda in 2009.

Description and process mapping

Following are some key points to note on training, supervisory support and implementation experience of the intervention.

- **Training.** ASHAs were provided a seven day training. The 2+5 days training module developed by NIPI under this intervention was viewed as very useful by all stakeholders, including the ASHAs. The ASHAs were trained on several aspects including how to fill the post natal care form, how to physically examine the baby (e.g. checking weight and temperature), and how to identify danger signs in the newborn.

  The 2+5 day training model was viewed as inadequate by some consultees for imparting knowledge and hands-on training that is required by ASHAs to undertake their tasks effectively. They drew attention to the fact that some ASHAs were at best 5th or 6th standard pass, and this called for a more intensive training which was lacking under Home Based Post Natal Care. They also felt that ASHAs required training in soft skills as much of their work involved working with people in complex social situations. All ASHAs consulted as a part of the field visit stressed on the need for more/ continuous training.

- **Supervision.** The ASHAs fill a printed form on each visit which is also signed by mothers/ family attendants. The form is then deposited with the Auxiliary Nurse Midwives/ supervisor at the health facilities on being completed. These forms are then verified and passed onto officials at the block level. ASHA visits are verified by the Auxiliary Nurse Midwives/ supervisors at times to ensure that the ASHAs are performing their duties effectively. We understand that Auxiliary Nurse Midwives were paid INR 100 (US$ 2) (INR 50 (US$ 1) for each visit) for two supervisory visits to the mother's home under Home Based Post Natal Care. This incentive has been removed under Home Based Newborn Care, and is likely to reduce the Auxiliary Nurse Midwive's incentive to supervise ASHAs. We understand from our consultation that Paribartan, an NGO, was chosen to provide external support and supervision to the programme for 20

months from April 2010 till March 2012.[70] We also understand that the ASHAs are required to maintain a diary in which they note down details of their daily activities. These diaries are reviewed by Auxiliary Nurse Midwives once in a while.

- **Implementation.** ASHAs are provided a kit which includes a weighing scale and thermometer to physically examine the baby. In case of any danger signs, the ASHAs refer the newborn to a nearby health facility, and sometimes even accompany the mothers to the facilities.
- **Payments.** Our consultations reveal that the ASHAs keep a count of the number of completed forms submitted by them under various health schemes and keep track of the amount that is due to them for their services. Our consultations did not reveal any problems regarding payments by the state for post natal care services. ASHAs are paid INR 250 (US$ 5) for each completed and verified form electronically into their bank accounts.

Implementation experience

The perception of mothers in terms of the quality of services provided by the ASHAs and the benefits was largely positive. However, we acknowledge that some of the beneficiaries are not fully aware of the benefits of post natal care and are therefore unable to make judgements on either the benefits of post natal care or the efficacy of the ASHAs. In our view, that main value add of this intervention has been in terms of increasing emphasis on post natal care and in sensitising people on matters related to maternal and child care. Our consultations reveal that it is too early to say if the intervention brought about an improvement in child health as it was under operation for only about two years. However, some consultees acknowledged the fact that ASHAs who had been trained under Home Based Post Natal Care were more receptive to training under Modules 5 and 6 currently being used under Home Based Newborn Care. Further, Home Based Post Natal Care paved the way for the reporting format used under Home Based Newborn Care. Consultees noted that since the introduction of post natal care in the state there has been improved reporting, increased referral of mothers and newborns, and decreased home deaths.

The table below presents key performance indicators provided to us by UNOPS. There is no discernible trend in the data. Further, the lack of reliable baseline data also makes it difficult to ascertain the impact of the intervention.

[70] Paribartan's responsibilities included: regular field visits by Block Supervisors and Zonal Coordinators appointed by Paribartan; supervision by Zonal Coordinator and support to block supervisor; monitoring by the state team of the technical agency and sharing with district health authority/NRHM unit and NIPI on progress and challenges; identification of case study and documentation of best practices; support district NIPI -NRHM team during Trainer's training; liaisoning and coordination with health administration for effective programme intervention; sharing of progress in ASHA sector level meeting; sharing of monthly progress with the block level meeting and preparation of future course of action in consultation with the block level officials i.e. Block Programme Officers, Block Child Health Managers, Medical Officers; and analysis of consolidated report of zonal coordinators and block supervisors.

Table A10.4: Key performance indicators – Home Based Post Natal Care

Key performance indicator	Jan-June 2010	July-Dec 2010	Jan-June 2011	July-Dec 2011	Jan-June 2012	July-Dec 2012
Percent of post natal care coverage against reported delivery	58	67	79	70	52	25
Percent of mothers identified with danger signs	NA	NA	NA	1.5	2.9	1.7
Percent of mothers referred to health facility with danger signs	1	2	1.5	1.3	2.9	1.7
Percent of neonates identified with danger signs	NA	NA	NA	5.7	6.8	3.9
Percent of neonates referred to health facility with danger signs	5	5	4.3	5.2	6.8	3.9
Percent of neonates breastfed within first hour of birth	93	96	81	95.5	89.2	60.9
Percent of neonatal deaths reported in submitted Home Based Post Natal Care card	NA	NA	NA	2.4	1.6	0.8
Percent of institutional deliveries among reported Home Based Post Natal Care card	NA	NA	NA	NA	80.9	70.9

Source: UNOPS state office

Some key themes that our consultation revealed are:

- *Difficulty in filling up post natal care form.* The current form, under Home Based Newborn Care, is considered tedious compared to the form that was in use under Home Based Post Natal Care. While the key data points that the ASHA collects is not very different under both, the former requires additional fields to be filled in by the ASHA. This is likely to have data accuracy implications. It was also reported that some ASHAs were not able to read and write Odiya, the language in which the forms are printed, properly.
- *Observations by Paribartan.* In its monthly reports over the period August 2010 till March 2012, Parbartan noted that many ASHAs either did not have thermometers or weighing scales or did not take them along during home visits. Further, a significant number of ASHAs did not carry their flipcharts on home visits, and it was also reported that ASHAs did not always make home visits on the designated days. Only a small proportion of completed post natal care forms were verified by Auxiliary Nurse Midwives.

4.3.2 Other NIPI interventions

This sub-section discusses issues surrounding other NIPI initiatives in Odisha. The box below presents some key points to note on the Sick Newborn Care intervention in Odisha.

Box A10.1: Experience under Sick New Born Care Units in Odisha

There are 25 Sick Newborn Care Units in Odisha, three of which were set up by NIPI. NIPI has set up one unit in each of the three focus districts between 2007 and 2009. All stakeholders commented that Sick Newborn Care Units and New Born Stabilisation Units have been extremely beneficial in reducing neonatal mortality. Ten more Sick Newborn Units are currently planned in the state under NRHM support.

Key issues were regarding Sick Newborn care Units are:

- *Attrition of staff*. We understand that staff from Sick Newborn Care Units and Newborn Stabilisation Units were sent to the Institute for Post Graduate Medical Education and Research for training. However, since the staff were on temporary contracts, they left their roles at theses units on securing better employment either within the government system itself or in the private sector. This left the facilities short on trained manpower and they are currently functioning with permanent and contract staff who have been trained on the job.
- *Procurement and supply chain issues*. NIPI, on the basis of the Sick Newborn Care Units in its focus districts, is seen as a key enabler for setting up units by aiding in procurement and supply chain apart from technical assistance and financial support. Poor procurement and supply chain are commonly identified as impediments to the proper functioning of units set up under the NRHM. Some consultees saw a greater role for NIPI in the state in terms of providing support for units across the state.

Key points related to other NIPI interventions noted in our consultations include:

- Techno-managerial support provided by UNOPS has been successful in Odisha in that all 14 District Child Health Managers and 22 Block Child Health Managers have been taken over by the NRHM as of July 2010.
- The State Child Health Resource Centre was in operation for two years and was discontinued thereafter as a consequence of a change in NIPI policy; UNOPS state office is not aware of the reason behind the change in policy.
- The flexible component of NIPI funds has not been used well in Odisha, and this is largely attributed to a lack of vision and leadership at the district administration level. It is also understood that the leadership at the district level often does not have exposure to public health issues, and therefore is unable to decide on the use of funds.

4.4 Results

The main value add of NIPI in Odisha is that it has helped to bring forward in time the neonatal health agenda, and has thus provided momentum to the concept of newborn health in Odisha. Stakeholder consultations suggest that while not a new intervention as such, Home Based Post Natal Care brought post natal care to the attention of the Government and along with Yashoda helped develop the continuum of care approach to maternal and child health in the state.

Our consultations reveal that all stakeholders feel NIPI interventions have contributed to improvement of maternal and child health indicators in the state. However, given the duration of Phase 1, the limited area covered by the interventions, and the interventions being a part of the larger government health system, it is difficult to attribute any result specifically to one or all NIPI interventions.

NIPI implementing partners are appreciative of the flexible and strategic nature of NIPI's funding. For example, untied funding from NIPI allowed UNICEF to take forward a broad range of interventions including Integrated Management of Neonatal and Childhood Illness, Sick Newborn Care Unit, and techno-managerial support.

5. Summary findings

In summary, NIPI interventions in Odisha have provided impetus to the continuum of care approach for maternal and child health. By aligning with the NRHM, NIPI has been able to build significant buy-in from the government health system, thereby increasing the chances of scaling-up successful interventions across the state.

However NIPI's choice of districts does not seem to have a strong rationale. While the State Coordination Committee is functional in Odisha and is looked at as an important forum for discussion issues related to child and maternal health in the state, its role and purpose could be made clearer to all stakeholders. Further, we believe NIPI UNOPS could have engaged more with UNICEF and coordinated on interventions so as to reduce duplication of efforts and create synergies.

Both Yashoda and Home Based Post Natal Care have worked well in Odisha. The Yashoda intervention has helped in filling in the critical gap at facilities with high delivery load. Nonetheless, it remains to be seen if this intervention will be scaled-up across the state. The Home Based Post Natal Care helped fast-track post natal care in the state. The intervention was not in place for very long as it was replaced by the government sponsored Home Based Newborn Care programme. Both Yashoda and Home Based Post Natal Care, while considered relevant and useful, have room for improvement especially with regards to training and supervision.

List of consultations

Table A10.4: List of consultations

Category	Name of consultee
State level stakeholders	Dr. Ajoya Kumar Mishra, Programme Officer, UNOPS
	Manjusha Doshi, Programme Officer, UNOPS
	Tapas Mohanty, Programme Assistant, UNOPS
	Dr. Meena Som, Health Officer, UNICEF
	Susanta Kumar Nayak, Senior Consultant, NRHM
	Dr. R. N. Panda, Consultant – Child health, NRHM
	Adwait Pradhan, Senior Programme Manager, NRHM
	Dr. Dinakar Panda, Team Leader, State Health Services Resource Centre
District and Block level stakeholders	Dr. B. Pradhan, Chief District Medical Officer, Angul
	Chakradhar Jena, District Programme Manager, Angul
	Aswini Mishra, District Maternal and Child Health Coordinator, Angul
	Dr. P. M. Raut, Medical Officer, Sick Newborn Care Unit – District Hospital, Angul
	Amita Samand, Staff Nurse, Sick Newborn Care Unit – District Hospital, Angul
	Madhusmita, Block Programme Manager, Community Health Centre Bantala, Angul
	Aswini Mahanand, District Maternal and Child Health Coordinator, Sambalpur
	Avinansh Nanda, Block Programme Manager, Community Health Centre Themra, Sambalpur
	Chandan Kumar Goswami, Block Accounts Manager, Community Health Centre Themra, Sambalpur
	Sanath Kumar Behera, Block Data Manager, Community Health Centre Themra, Sambalpur
Other health system functionaries	Vivekanand Nayak, Multipurpose Health Worker – Male, Angul
	Sarojini Sahu, Multipurpose Health Worker – Female, Angul
	Ranjita Mishra, Multipurpose Health Supervisor – Female, Angul
	Saritanjali, RMNCH Councillor, District Hospital, Angul
	Dr. M. Swain, AYUSH Doctor, VHND, Primary Health Centre Parampur, Sambalpur
	Prabhati Hota, Multipurpose Health Worker – Female, Sambalpur
	Dr. Goswami, Medical Officer, Primary Health Centre Parampur, Sambalpur
	Dr. Saroj Kumar Sahu, Medical Officer, Primary Health Centre -New Sangramal, Sambalpur
	Maharathi Nanda, Child Development Project Officer – Haneshwar, Sambalpur
Yashodas	We consulted with 7 Yashodas in Odisha
ASHAs	We consulted with 5 ASHAs in Odisha
Beneficiaries	We consulted with approximately one dozen beneficiaries

ANNEX 11: FIELD VISIT REPORT – RAJASTHAN

1. Introduction

This annex presents the key findings from our field visit to Rajasthan during 10-12 April 2013. We covered the capital city of Jaipur (to meet with the Government officials and the state level NIPI implementing partners), and two of the three NIPI focus districts of Dausa and Alwar (to meet with the Yashodas, ASHAs, beneficiaries and other health workers). In Dausa, we visited the Government Children District Hospital; Community Health Centre in Lavan and Lalsot; a Primary Health Centre in Ramgarh; and a village called Chandsen. In Alwar, we visited the Zenana District Hospital.[71]

The report is structured as follows: Section 2 provides a background on the state health and financing profile; Section 3 presents a summary of the NIPI interventions in Rajasthan; Section 4 presents our findings on the four evaluation dimensions of NIPI's policy/ programme design, governance, implementation/ processes, and results; and Section 5 sets out our conclusions from the field visit. The list of our consultations is provided at the end

2. Rajasthan health profile and financing

According to the 2001 census, Rajasthan comprises 5.5% of India's total population and the ratio of the rural and urban population is 77:23. About 13.7% of the states' rural population is considered Below Poverty Line ; and the corresponding figure for urban areas is 19.8%. The sex ratio is 921 compared to the country average of 933. The population of the scheduled castes and scheduled tribes are 9.1m and 7.1m respectively, which constitute 17.1% and 12.6% respectively of the state's population, and are higher than the national averages of 16.2% and 8.2%.[72]

As seen in the table below, most key health indicators for Rajasthan (and its three NIPI focus districts) are above the national average.

Table A11.1: Key health indicators for Rajasthan (2009 data, unless otherwise noted)[73]

Indicator	Rajasthan	Alwar	Dausa	Bharatpur	India
Infant Mortality Rate (IMR) (per 1000 live births)	55 (SRS 2010)	59	57	55	47
Neo Natal Mortality (NMR) (per 1000 live births)	40 (SRS 2010)	35	33	42	34
Under Five Mortality Rate (U5MR) (per 1000 live births)	69 (SRS 2010)	82	87	75	64
Total Fertility Rate (TFR)	3.1 (SRS 2010)	2.9	2.8	3.2	2.6

[71] The detailed itinerary was developed in consultation with UNOPS and based on proximity of locations and ease of access in the available time.
[72] Rajasthan has one of the largest concentrations of SC and ST population in the country. State Health Society (NRHM), Rajasthan, Directorate of Medical Health and Family Welfare, Rajasthan., State Programme Implementation Plan, 2011-12.
[73] Ministry of Health and Family Welfare, Government of India [date]., Approval of State Programme Implementation Plan, 2012-13: Rajasthan; Data for the districts is taken from: Office of the Registrar General and Census Commissioner, India, Ministry of Home Affairs, Government of India., Annual Health Survey 2010-11, Fact Sheet.

Indicator	Rajasthan	Alwar	Dausa	Bharatpur	India
Maternal Mortality Rate (MMR) (per 100,000 live births)[74]	318	319[75]		292	212

As per the UNICEF Coverage Evaluation Survey (2009), full immunisation coverage in Rajasthan was 54%, lower than the national coverage of 61%.

The table below presents the total funds approved and spent under NRHM in Rajasthan for the period 2005-11.[76] The data indicates that there was a significant under-spend of funds approved in the initial years, however, this gap has reduced over time.

Table A11.2: Funds approved and spent under NRHM - INR million (USD provided in brackets)

Year	Approved Programme Implementation Plan	Expenditure
2005-06	922m (US$ 18m)	148m (US$ 2m)
2006-07	2,998m (US$ 60m)	1,079m (US$ 21m)
2007-08	6,085m (US$ 121m)	3,343m (US$ 66m)
2008-09	9,808 (US$ 196m)	9,204 (US$ 184)
2009-10	10,100m (US$ 202m)	9,894 (US$ 197m)
2010-11	11,933m (US$ 238m)	7,427 (US$ 148m)

In addition to NIPI, development partners for health in the state include UNICEF, UNFPA and WHO, who are actively involved in the Reproductive and Child Health (RCH-II)/ NRHM. Some examples of their areas of work include:

- UNFPA has supported the training and monitoring of Skilled Birth Attendants , Family Planning Action Plan, and capacity building of programme managers, amongst others.
- UNICEF has provided technical inputs for preparing the draft Programme Implementation Plan, strategic support for Infant and Young Child Feeding, and HR capacity building, amongst others.

3. NIPI interventions in Rajasthan[77]

The NIPI programme in the state was initiated by the signing of a Memorandum of Agreement between UNOPS (represented by the Director, NIPI Secretariat) and the Government of Rajasthan on 14th December 2007, and activities commenced in 2008-09. NIPI interventions through UNOPS are implemented in three districts in Rajasthan – Alwar, Dausa and Bharatpur. UNICEF works across the state, and specifically in the remaining 30 of a total of 33 districts (funding data is discussed as part of our evaluation findings below).

The key NIPI-UNOPS activities in the three districts have been designed to strengthen the efforts of the state under NRHM and comprise the following:

- Deployment of Yashodas at all District Hospital and some Community Health Centres in the state (based on delivery load).

[74] MMR figures are reported for 2007-09.
[75] MMR is reported together for Jaipur (including Jhunjhunun, Alwar, Dausa, Jaipur, Sikar).
[76] Ministry of Health and Family Welfare., State Programme Implementation Plan, 2011-12.
[77] Odisha Joint Steering Committee Meeting, 10th December 2011, NIPI.

- Strengthening the maternal and neonatal home based post natal care services after the institutional/ assisted home deliveries through ASHAs.
- Setting up Sick Newborn Care Units at District Hospitals and Sick Newborn Stabilising Units at Community Health Centres.

Other NIPI-UNOPS interventions include the Shishu Raksha Fund (flexible fund for referral of babies up to two months in case of emergencies); techno managerial support at the state, district and block level; support for immunisation coverage; campaigns for Behaviour Change Communication ; State Child Health Resource Centre; and Post Partum Intrauterine Contraception Service.

In addition, UNICEF has deployed NIPI resources in the state to establish and operationalise Facility Based Newborn Care Units, and provides techno managerial support for training under the Integrated Management of Neonatal and Childhood Illness programme in some districts. While Integrated Management of Neonatal and Childhood Illness programme was demonstrated in two districts in Rajasthan by UNICEF in 2005-06, it was scaled up to nine districts under NIPI, after which the government decided to scale it up to all 33 districts in the state, with techno managerial and technical support from UNICEF.

4. Evaluation findings

This section presents our findings from the field visit on the four evaluation dimensions of NIPI's policy/ programme design; governance; implementation/ processes; and results.

4.1 Policy/ design

Rationale for selection of districts

While the rationale for selection of Rajasthan under NIPI is clear, there are mixed views on the appropriateness of the selection of the three districts.[78]

We understand that the three districts were selected on the basis of being: (i) medium performing districts with the existence of some NRHM infrastructure and capacity, so as to be able to demonstrate proof of concept; and (ii) located in close proximity to the capital city of Jaipur, and thereby facilitating access. However, some consultees noted that NIPI could have chosen larger, more problematic and far flung districts, which are in greater need for support (although, in our view, demonstrating the proof of concept and scalability potential of NIPI's interventions in such districts may have proved more challenging).

Alignment of NIPI policy and design with NRHM

All NIPI interventions in Rajasthan are implemented through the NRHM machinery (for example, all HR and techo-managerial positions were recruited through the Mission, but their salaries were funded through NIPI), and are thus well-aligned with NRHM. However, some consultees noted that greater alignment could be facilitated at the district and block levels if NIPI

[78] Rajasthan accounts for a high proportion of India's burden of child and maternal mortality, and poses an enormous challenge in implementation, given its socio-economic status, large inequalities, and weak health systems.

adopted a broad-based health systems approach, as individual interventions tend to put additional pressure on existing health systems (in terms of infrastructure and HR).

In addition, it was suggested that NIPI could help expand/ scale up selected interventions across the entire state, rather than initiating several activities in a few districts only (we note however that the Yashoda intervention was scaled up across the state with NIPI funds, after which it was taken over by the state government in 2012) This would help NIPI create a greater impact, and make the interventions more sustainable and well integrated with the state health systems. We understand that this was discussed at the first Programme Management Group meeting for NIPI Phase II.

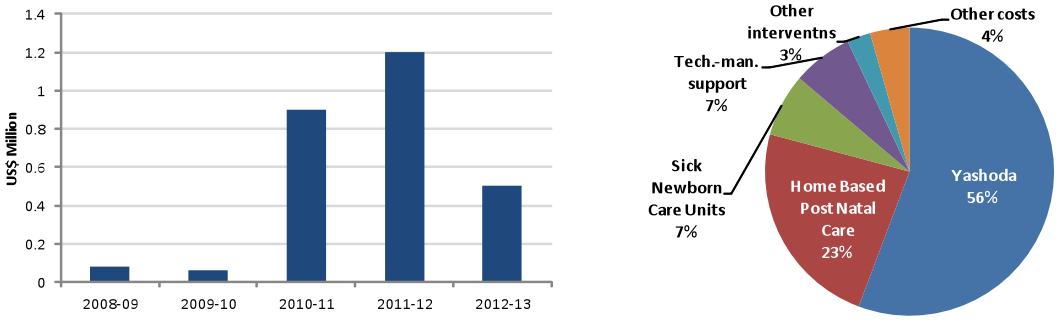
Efficacy of funding

Feedback from UNOPS and UNICEF suggests that fund disbursement from the Norwegian government was timely, and no issues were noted in this regard.

A preliminary analysis of the data provided to us by UNOPS (as per the table below) suggests that fund utilisation in the initial period has been low, given that some activities took much longer than anticipated to commence (e.g. training and recruitment), and due to other factors beyond the control of the implementing partners (e.g. lack of availability of HR, need for coordination with other parallel programmes of the Government).

Figure A11.1 presents the funds spent by UNOPS over the period 2008-13 (up to December 2012) and by intervention. As evident, after an initial slow start, spending has increased from 2010-11. The majority of UNOPS funds have been devoted to the Yashoda intervention, followed by Home Based Post Natal Care.

Figure A11.1: UNOPS annual spend (US$m; left hand side figure); spend by activity (right hand side figure)[79]



Funds spent by UNICEF over the period 2008-12 are INR1.6m (US$ 0.03m). UNICEF budgeted amounts closely match actual annual expenditure, averaging to roughly INR 0.29m (US$ 0.005m) p.a.

4.2 Structure and governance

NIPI structure and cooperation amongst partners

Our observation is that there is a certain level of inefficiency and duplication of efforts by the implementing partners in the state, suggesting the need for a more synergistic approach. For

[79] Other interventions include spending on immunisation, the State Child Health Resource Centre and gender activities. Other costs include operationl expenses like salaries of staff, expenses for meetings, and workshops.

example, although both UNICEF and UNOPS were supporting the development of Sick Newborn Care Units through NIPI funding in their respective districts of focus, there was limited coordination between them. Also, UNICEF has provided Integrated Management of Neonatal Childhood Illness training in some of the districts where UNOPS was providing Home Based Post Natal Care training, resulting in some overlap .

We understand that UNOPS has always viewed its role as being much larger than a Local Fund Agent and set up a state office from start of NIPI. They view a local office as essential to their role in planning and facilitating the effective progression of NIPI interventions in the state.

It was commented that the NIPI-UNOPS structure has worked well, as NIPI offered UNOPS the flexibility to fund incentive payments to Yashodas and ASHAs, which may not have been possible under the UNICEF arrangements.

Efficacy of the State Coordination Committee

The State Coordination Committee is used as a forum for discussing implementation plans (e.g. how and when planned trainings should be conducted) and reporting on NIPI interventions. The participation of the State Principal Secretary, Health in the State Coordination Committee was noted as very useful in terms of high level political support.

However, whether decisions are taken by consensus was questioned, especially given the Indian context wherein hierarchy affects the interactions in meetings. It was noted that the focus of the committee meetings has been on the NIPI-UNOPS interventions, with minimal discussion on the UNICEF activities funded through NIPI and the state-wide NIPI funding and implementation. In addition, consultees were not aware of how decisions taken at the State Coordination Committee meetings influence national level discussions/ decisions at the Joint Steering Committee and Programme Management Group meetings and requested greater clarity in this process.

4.3 Implementation/ processes

We provide a summary of our review of the process implementation of the Yashoda and Home Based Post Natal Care interventions in Rajasthan.

4.3.1 Yashoda

With the introduction of the Janani Suraksha Yojana intervention under the NRHM, wherein mothers and ASHAs are incentivised for institutional and/ or assisted home deliveries, the number of deliveries at the District Hospitals and Community Health Centres in Rajasthan has increased significantly from around 27% to 69%. This in turn presents a new challenge of providing quality services to mothers and newborns,[80] in support of which the Yashoda intervention was introduced in the three District Hospitals of Alwar, Dausa and Bharatpur from July 2008 to be implemented by NIPI-UNOPS. We understand that NIPI subsequently scaled up the intervention in all districts in Rajasthan, following which the state government is funding this intervention since April 2012 through the state budget. However, whether the Yashoda

[80] National Rural Health Mission, State Health Society (NRHM), Rajasthan, Directorate of Medical Health and Family Welfare., State Programme Implementation Plan, 2011-12.

intervention will be included in the NRHM state Programme Implementation Plan is still under debate, since it has not yet been incorporated under NRHM.

Following are some key points to on the description and process mapping (including recruitment, training, supervision, implementation and payment structure) of the Yashoda intervention, and our judgement of what has worked well and less well under the intervention.

Description and process mapping

- **Recruitment.** We understand that the Yashodas were recruited in response to an advertisement in the newspaper, after which they were interviewed and selected on the basis of certain qualification criteria (e.g. minimum education level of the 8th standard). Consultations with Yashodas suggest that most of them have applied out of interest – for some, it was an opportunity to get out of the house and engage in some work, and for others, it was a key source of household income. We were also informed at the District Hospitals and Community Health Centres in both the districts we visited that the attrition rate of Yashodas has been very low as mentioned).
- **Training.** The Yashodas were given three days of intensive training before the start of the programme. Feedback from them suggests that the training has been very beneficial, in that it helped in imparting the relevant skills and knowledge, and provided them with the confidence and ability to deliver their duties effectively. However, the number of refresher training sessions conducted for Yashodas has varied – while in Dausa, Yashodas at the District Hospital were trained twice in three years, in Alwar, Yashodas have been trained four to five times since the start of the programme. In general, both the Yashodas and hospital staff noted that it would be beneficial to provide Yashoda refresher training on an annual basis.
- **Supervisory support.** It was originally envisaged to place a Child Health Coordinator at the District Hospital for daily supervision, coordination of responsibilities and other administrative tasks. We understand that a Yashoda coordinator/ supervisor was recruited at the health facilities, however this position has now been removed after the end of NIPI funding. The Yashodas are now supervised by a mix of senior nurses, Lady Health Visitors[81], and other administrative staff at the health facilities. For example:
    - Yashodas at the District Hospital in Alwar are supervised by an administrative worker (discussions with the worker suggested that he is already overburdened with other hospital administrative tasks, and not interested in supervising the Yashodas without additional financial payments);
    - in some Community Health Centres in Dausa, Yashodas are supervised by Lady Health Visitors and Auxiliary Nurse Midwives; and
    - there is no supervisor for the Yashodas at the District Hospital in Dausa.
- **Implementation.** The Yashodas work in three shifts (8am - 2pm, 2 - 8pm, and 8pm - 8am) in health facilities, with a delivery load of more than 150 mothers per month. All

[81] Lady Health Visitor is a female health assistant. She is also called a public health nurse. Her responsibilities include improving the skills of Auxiliary Nurse Midwives, supervising their work, assigning specific tasks to them.

Yashodas are required to fill a register on each delivery to record information like initiation of breastfeeding, number of days stayed in the hospital, weight and sex of the baby, amongst others. They have a uniform so they can be easily detected in the wards in case the mothers need any help or have any questions.

- **Payment structure.** While the Yashodas were earlier paid INR100 (US$ 2) per delivery, their salary has now been capped at INR3500 (US$ 70) per month for parity with the salaries of the trained nurses/ Auxiliary Nurse Midwives.[82]

Experience under the Yashoda intervention

The Yashoda intervention has generally been viewed positively by all stakeholders, including the medical officers and nurses, and is considered beneficial in filling a critical gap of providing support for mothers and newborns. Our interaction with the Yashodas suggests that they perform their tasks effectively – e.g. comforting pregnant women on arrival, providing emotional support in the labour room, counselling mothers on the care of newborn including initiation of breastfeeding and immunisation, and counselling mothers and family members on the importance of giving equal attention to the boy and girl child.

Mothers also commented that they trust the Yashodas, and seek their support in case of any problems – however, it was not very clear if the mothers have interacted sufficiently with the Yashodas to have a well-informed view. There was a mixed response from the beneficiaries in the hospitals we visited, in terms of their interactions with the Yashoda and the information provided by her, with some mothers claiming not to have engaged with them during their entire stay in the hospital.[83] [84]

Below, we present the data provided to us by UNOPS up to December 2012 for the three NIPI District Hospital. While the data shows visible improvements under four key indicators that Yashodas support, there is no defined baseline for these results, which cannot be attributed to NIPI alone.[85]

- Weighing of newborn - 100%.
- Early initiation of breastfeeding (< 1 hour after child birth) which was 42% (District Level Household Facility Survey-3 (2007-08)) and 53% (Annual Health Survey 2010-11) is now around 85% where Yashodas are deployed.
- Zero dose polio and BCG vaccination was around 70-75% before deployment of Yashodas and is now reported as over 94.7%.
- More than 24 hours stay of mothers (99.6%) – In most cases, mothers have stayed in hospitals for longer than 48 hours, however, this has not been possible in cases where

[82] With an increase in institutional deliveries, the Yashodas were getting paid between INR4,000-7,000 (US$ 80-140) per month, which was more than the compensation paid to the trained and skilled Auxiliary Nurse Midwives. Also, Yashodas at different health facilities were paid varying amounts depending on the number of deliveries. Thus, it was decided to standardise and cap their salary at INR3,500 (US$ 70) to keep it below that of the trained Auxiliary Nurse Midwives.

[83] This might be a function of a very large number of mothers at the hospitals, making it difficult for the Yashodas to devote enough time to each. A number of the mothers that we met with were illiterate and hesitant to speak in front of their family members.

[84] While the quality of care at the health facilities was quite poor (e.g. no sheets on beds, overcrowding of wards with family members/ attendants of the mother), mothers were not able to comment on this. This might be on account of their reticence to complain or a lack of awareness, in that the mothers usually are of a low socio-economic background, and may not be aware of the quality of services provided at the institutional level.

[85] Government of Rajasthan, Directorate of Medical Health and FW Services, Rajasthan Swasthya Bhawan, Jaipur., Norway India Partnership Initiative (NIPI) and National Rural Health Mission (NRHM), Status of Report of NIPI Interventions (up to December 2012), 2013.

there is a shortage of wards (e.g. in Community Health Centres with a small number of beds).

While the Yashoda intervention has been largely viewed as effective, some key issues were raised as follows:

- *Delays in receiving payments*. Yashodas raised that there have been delays in receiving payments ranging from a few days to 2-3 months. Further, when NRHM funding replaced NIPI, there was a considerable delay of a few months in the payments to Yashodas.
- *Insufficient salaries*. This amount earned by Yashodas was noted as insufficient, given their high workload. Further, while all other hospital staff get annual increments, Yashodas' salaries have remained constant despite the increased workload.
- *High workload/ low Yashoda to mother ratio*. We understand the each Yashoda was originally envisaged to look after 4-5 mothers. However, this has varied substantially across District Hospitals and Community Health Centres, where in some places, the Yashodas are catering to as many as 30-40 mothers at a time.[86]
- *Engaging in other activities*. While the role of Yashodas is meant to be restricted to the maternity wards, in some cases, they have been engaged in other activities to support the hospital staff, which has further increased their workload. For example, Yashodas at the District Hospital in Alwar help with booking tickets for hospital staff, distributing medicines to mothers, amongst others. Further, in Alwar, four Yashodas have been deployed to support the Sick Newborn Care Unit staff in nursing and counselling mothers. Also, in some cases, Yashodas are made to support nurses in the labour rooms (despite their lack of formal training for the same).
- *Adjustments in the health system*. Initially, the Yashodas had some difficulty in adjusting to their role within the health systems, being a new cadre of unskilled workers amongst other hospital staff. However, these issues have declined over time.
- *Issues faced in counselling*. In many cases, mother's attendants do not let the Yashodas do their counselling properly, since the attendants are always present in the maternity wards and often interrupt the Yashodas, making it difficult for them to communicate effectively with the mothers.
- *Lack of space in hospitals*. In some hospitals, the Yashodas are not provided their own designated space/ room , which is very inconvenient, given that they are working at the health facilities at all times.

4.3.2 Home Based Post Natal Care

Rajasthan has a difficult terrain and a large number of outreach areas where referral of neonates is a challenge. Neonatal and perinatal deaths are very high in Rajasthan (neonatal deaths were around 41 per 1,000 live births, which is high vis-a-vis the national average of 34 per 1000 live births in 2009).[87] Thus, the introduction of Home Based Post Natal Care in the state was

[86] For example, there are 7-8 Yashodas for managing 40-50 deliveries per month in the district hospital in Dausa; 7-8 Yashodas for 50-60 deliveries at one Community Health Centre in Dausa; and 24 Yashodas for 40-50 deliveries per month in the district hospital in Alwar)

[87] Statistics Division, Ministry of Health and Family Welfare (2011)., Family Welfare Statistics in India, 2011.

required to improve the follow up and care of the mother and the newborn. This intervention was initiated in the three NIPI districts in 2009.

Following are some key points to on the description and process mapping (including, training, supervision, implementation and payment structure), and our judgement of what has worked well and less well under the intervention.

Description and process mapping

- **Training**. ASHAs are provided with two days of induction training and five days of Home Based Post Natal Care training. The 2+5 days training module developed by NIPI was viewed as very useful by all stakeholders, including the ASHAs. The ASHAs were trained on several aspects including on how to: fill the post natal care card, physically examine the baby (e.g. checking weight and temperature), and identify danger signs in the newborn. While the training provided to the ASHAs worked well, consultations suggest that the majority of them perform their duties effectively, while the others - who are illiterate, elderly or selected on the basis of political connections - do not perform well. The State Institute of Health and Family Welfare, Jaipur has been hired as the external technical agency for maintaining the quality of training at the district and block level.
- **Supervision.** The ASHAs fill a yellow post natal care card on each home visit, which is also signed by mothers/ family attendants to confirm their visit. After completion of the six visits, the card is deposited with the Auxiliary Nurse Midwives/ supervisor at a nearby health facility, based on which the ASHAs are paid. The ASHAs are accompanied by the Auxiliary Nurse Midwives/ supervisors at times to ensure that they are performing their duties effectively. On average, 2-3 post natal care cards get rejected due to mistakes made by the ASHAs. However, some government stakeholders (e.g. in Alwar) were doubtful if the ASHAs have in practice been able to identify the danger signs in babies, which suggests the need for more supportive supervision of the ASHAs during the home visits.
- **Implementation.** ASHAs are provided with a kit which includes a weighing scale and thermometer to physically examine the baby. In case of any danger signs, the ASHAs refer the newborn to a nearby health facility, and sometimes accompany the mothers to the facilities.
- **Payment structure.** Under th**e** Janani Suraksha Yojana scheme**,** ASHAs were paid INR100 (US$ 2) for post natal care work, which was increased to INR200 (US$ 4) under NIPI Home Based Post Natal Care. Now, under NRHM, ASHAs are getting a total package of INR600 (US$ 12) comprising INR100 (US$ 2) for ANC; INR100 (US$ 2) for institutional deliveries; and INR350 (US$ 7) for child health (which includes payments for post natal care).

Experience under the Home Based Post Natal Care intervention

Consultations with health workers at the Community Health Centres/ Primary Health Centres highlight that the Home Based Post Natal Care intervention has improved child health, with more newborns being brought to these Health facilities for treatment. This may be on account of

the ASHAs identifying any danger signs in the baby at an early stage; and motivating (and at times, accompanying) mothers to take their children to the health facilities. NIPI is introducing the Home Based Post Natal Care+ intervention in Phase II, under which the ASHAs will visit the mothers for up to a period of one year after the birth of her baby.

There was a mix of responses from the beneficiaries in terms of the quality of services provided by the ASHAs - some noted that the ASHA's post natal care visits were very helpful, a few commented that she did not visit; and some others did not recollect well enough or did not understand the value of her visits.

In our view, the main value add of this intervention has been increasing the emphasis on post natal care. The intervention is also results focussed, in that it introduced the post natal care card as an effective follow-up mechanism.[88] In addition, stakeholders noted that NIPI went beyond training, and actually implemented post natal care in the focus districts.[89] Through the intervention, NIPI has also focused on supportive supervision, which was not adequately emphasised previously.

Some key issues were raised are as follows:

- *Ineffective incentive system*. While the ASHAs value the incentives given to them, very often they are not aware of the amounts due to them. Therefore, they cannot ascertain if they are indeed receiving their dues (i.e. in case there is any corruption or delays in the payment process).
- *Insufficient payment*. Some ASHAs felt that they are not earning enough– one ASHA covers a population of 1,000, which implies that they take care of 30-40 households on average, and around about 30-40 babies a year. The ASHAs do not feel overburdened with their work as such, and are willing to work and earn more.
- *Delays in payment*. Money is credited to the bank accounts of the ASHAs. However, delays in payments have varied from 2-3 months to as long as 1.5 years, and this has reduced the ASHAs' motivation to work. ASHAs also expressed the need for getting regular monthly compensation, rather than ad hoc payments.
- *Issues faced during home visits*. ASHAs have usually belonged to a representative class in the society (i.e. in terms of economic status, religious preferences) and hence are able to interact well with the villagers. However, feedback from ASHAs suggests that very often mothers do not let them engage with their babies (e.g. mothers do not let ASHAs weigh the baby due to 'evil eye superstitions'), with the result that they have at times filled the post natal care card based on information provided by family members (without examining the baby). However, this appears to have improved over time with the mothers now being more receptive to and familiar with the ASHAs.

[88] However, in many cases, the yellow post natal care card is not available to the ASHAs, so they use photocopies.

[89] Stakeholders cited the example of Integrated Management of Neonatal and Childhood Illness programme wherein the focus had only been on training. There was also no follow up and supervision after the training, and the training was also more prolonged, in that it took 3-4 years to cover the state. NIPI, through this intervention on the other hand, completed the entire training in only a few months.

4.3.3 Other NIPI interventions

Some additional points on other NIPI interventions in Rajasthan include:

- While the techno managerial support is viewed as beneficial, some HR and techno managerial support positions created by NIPI have not been sustained/ retained under NRHM. For example, the position of Yashoda supervisor/ coordinator and Block Child Health Managers created by NIPI no longer exists. This could be due to the Government being risk averse to hiring additional HR in states on a permanent basis, given that most of the workers are contractual.
- While we have not examined the referral Shishu Raksha fund in detail, this has not been taken forward by the Government, as there was some uncertainty as to whether the ASHAs would hand over the money to the mothers.
- The well baby clinics started by NIPI in the three districts are being funded by the state government, but not being scaled up across the state (in the face of other priorities).

In addition to the descriptions of the Yashoda and Home Based Post Natal Care interventions, the box below presents some key points on the Sick Newborn Care Unit intervention in Rajasthan.

Box 11.1: Experience with Sick New Born Care Units in Rajasthan

NIPI has set up three Sick Newborn Care Units in each of three focus districts and the evaluation team has had the opportunity to examine the units in Dausa and Alwar. The unit in Alwar was set up in 2009, comprises 26 beds, and functions very well. It is being considered as a model unit and a training hub for doctors and hospital staff, but faces the following issues:

- *Lack of HR*. Initially, two paediatricians were hired by NIPI for managing the unit on a contractual basis, but now the unit is run by on-call doctors, with no dedicated doctors available at the unit round the clock. Attrition rates amongst public sector doctors and nurses are generally high given the more lucrative options in the private sector. In addition, consultees expressed the need for more laboratory technicians and a guard to secure the unit.
- *Absence of a strong link with the stabilising units at the Community Health Centres*. Given that stabilising units are the first port of call for the sick newborns, these units at the Community Health Centres (and lower levels) need to function well. This will help in reducing load of the units at the District Hospitals. There are nine stabilisation units that feed into the main Sick Newborn Care Unit in Alwar, but only three are functional.
- *Gender discrepancies*. Consultees noted that male babies are more frequently brought to the units as compared to females, especially from outside the hospital. Based on preliminary analysis of unit data available to us by UNOPS for the three NIPI districts, mortality rates at the units seems to be higher for the female newborn, than for the male newborns.
- *Lack of a strong referral system*: NIPI will initiate Sick Newborn Care Unit+ in Phase II, wherein ASHAs visit the discharged babies to ensure they are healthy. However, doctors in the unit at Alwar suggest that the ASHAs have not effectively reported back to them on the follow up visits and the health of newborns.
- *Over-crowding*. The unit in Alwar had two newborns on one bed in many cases. The unit in charge suggested that the occupancy rate in the unit is usually more than 100%, given that people from nearby districts (including Dausa) tend to bring their babies to the unit in Alwar.

In contrast, the unit in Dausa was set up in 2010 but was shut down initially for six months and is now going to be closed down again due to malfunctioning equipment (e.g. no air conditioners) and lack of doctors.

In general, all stakeholders commented that the Sick Newborn Care Units has been beneficial in reducing neonatal mortality, and particularly benefitted premature babies and babies with hypothermia.

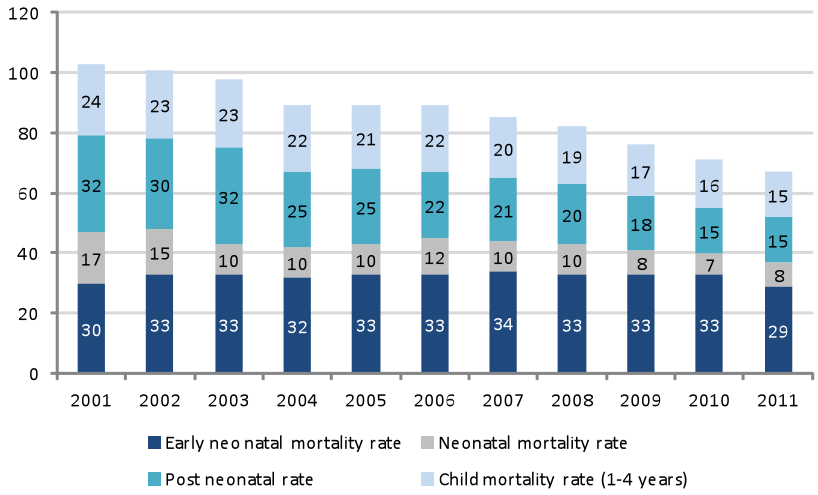
4.4 Results

The main value add of NIPI in Rajasthan, as perceived by several stakeholders, is that it has brought forward the neonatal health agenda by 4-5 years, and provided momentum to the

improvement of newborn health. Prior to NIPI, there was no intervention focussed on newborn health in the state.

As seen in the graph below, neonatal mortality was constant in Rajasthan over 2001-08, after which it started declining. While we have studied these figures in detail, consultations suggest that this decline can be (in large measure) attributed to NIPI interventions focussing on newborn care.

Figure A11.2: Neo-natal and child mortality trends in Rajasthan



Source: Statistics Registration System (SRS), 2001-10 data.

Consultations with stakeholders suggest that NIPI support has been catalytic and strategic, in initiating new interventions (e.g. Yashodas), and accelerating existing activities (e.g. implementing the Home Based Post Natal Care concept). While the main activities supported by NIPI may have existed in some form or the other under NRHM, NIPI gave a boost to this thinking, and facilitated the faster implementation of existing activities. For example, through the Home Based Post Natal Care intervention, NIPI took forward and scaled up the concept of post natal care in a systematic manner, and developed a comprehensive training module. NIPI has also promoted the continuum of care by creating a better link between the ASHAs and Yashodas, and the community/ home and facility.[90]

5. Summary findings

In summary, NIPI interventions in Rajasthan have provided momentum to the agenda of newborn health in the state, and have accelerated the implementation of some existing interventions in the state (e.g. Home Based Post Natal Care). While, NIPI interventions in the state are generally aligned with NRHM systems, the need for greater alignment at the district level was suggested by some stakeholders, by for example, adopting a state/ systems wide approach (so as to reduce pressure on other districts/ aspects of the health system).

[90] For example, the ASHAs bring the mothers to the health facilities, where they are looked after by the Yashodas. Once the mothers return home, the ASHAs follow up with them under the Home Based Post Natal Care model to ensure that the mother and newborn are healthy.

While the State Coordination Committee has served as an effective mechanism to review progress of NIPI interventions, a more synergistic approach is needed to facilitate coordination among the implementing partners in the state, to avoid duplication of efforts, and resulting inefficiencies.

Our assessment of the experience and key issues of the Yashoda and Home Based Post Natal Care interventions in the state suggests that both interventions have worked well, and are viewed as beneficial by stakeholders, including government officials and hospital staff. In particular, the Yashoda intervention has helped in filling in the critical gap of providing quality care and support to the mothers at the health facilities. The Home Based Post Natal Care intervention has supported a reduction in neonatal deaths in the state by virtue of providing an effective follow up mechanism for early identification of danger signs in newborns. However, certain issues were raised by consultees under both interventions, which might have impacted their effectiveness (e.g. delays in receiving payments by ASHAs and Yashodas; difficulty in engaging with mothers at health facilities and also during home visits; insufficient payments for ASHAs and Yashodas which has reduced their motivation to deliver their duties effectively, amongst others).

In addition, the Sick Newborn Care Units have been useful to reduce neonatal mortality in the state (e.g. the unit in Alwar is used as a model unit and hub for training of doctors and other hospital staff).

List of consultations

Table A11.3: List of consultations

Organisation	Name of consultee and designation
NIPI implementing partners	Dr Anil Agarwal, Health Specialist, UNICEF
	Dr S.P Yadav, Senior State Programme Officer, UNOPS
	Dr Pradeep Chaudhary, Programme Officer, UNOPS
State level representatives	Ms Gayatri Rathore, Mission Director, NRHM
	Dr A N Mathur, Project Director, Child Health, NRHM
	Mr Vijay Rajpurohit, Accountant
	Ms Poonam Shrivastava, State Yashoda Coordinator
State Institute of Health and Family Welfare , Jaipur	Dr Vishal Singh, Acting Registrar & Associate Professor
District and block level stakeholders	Mr Imran Khan, District Public Health Nurse Manager, District Hospital, Dausa
	Beena Badure, Lady Health Visitor , Dausa
	Dr Murlidhar Sharma (doctor at the Lavan Primary Health Centre), Dausa
	Dr M.C Gupta, Ex-in Charge, Sick Newborn Care Unit and Resource Person, distirct hospital, Alwar
	Dr Kanwar Singh, Sick Newborn Care Unit In-Charge, distirct hospital, Alwar
	Mr S M Islma Naqvi, District Public Health Nurse Manager, Chief Medical health Officer, distirct hospital, Alwar
	Mr Ashok Saini, Block Child Health Manager, distirct hospital, Alwar
	Ms Sharda, Head Nurse, Sick Newborn Care Unit, distirct hospital, Alwar
	Dr RK Meena, Chief Medical Health Officer, District Hospital, Alwar
Yashodas	We consulted with 7 Yashodas at the District Hospital in Dausa, Community Health Centre in Lalsot, and the District Hospital in Alwar.
ASHAs	We consulted with 6 ASHAs at the Community Health Centre in Lalsot and Chansen viallge in Dausa
Beneficiaries	We consulted with approximately one dozen beneficiaries

ANNEX 12: PROGRESS ON PREVIOUS REVIEW RECOMMENDATIONS

As noted in Section 5.4 of the main report, we have reviewed the progress made by NIPI in implementing the recommendations made by the: (i) Mid-term review (2010); and (ii) Evaluability study of the Partnership Initiatives Norwegian Support to Achieve Millennium Development Goals 4 & 5, February 2011[91]. The table below presents a summary of the key recommendations as well as our understanding of the progress made and steps taken by NIPI against these recommendations, based on the consultations for this evaluation. We provide a summary rating on CEPA's assessment of progress in the last column on a four-point scale: 'implemented', 'partially implemented' and 'not implemented'.

A number of issues have been covered in other sections of the report and only a summary discussion is provided here.

Table A12.1: Key recommendations and progress made[92]

Focus area	Key recommendations	Progress to date	CEPA's rating
Vision and strategy	*Mid-term review* • Develop a comprehensive programme document with clearly defined goals, purpose, objectives, indicators and targets by partners. • Clearly define ownership, duties, and responsibilities of the Partnership. • Create a balance between catalytic and implementing/ scaling-up of NIPI objectives.	• There have been no further developments at the programme level in terms of defining the role, objective, outputs and targets of the initiative. An M&E strategy for 2010-13 was developed but not implemented. • Regarding scaling up of interventions, the Joint Steering Committee strongly advised the partners to restrict their interventions to those with the potential for scalability and sustainability under NRHM; and for the prioritisation of interventions to be done in consultations with the state health societies. However, our assessment is that there has not been a systematic approach towards intervention selection.	Not implemented

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

[92] The Story of NIPI from Conceptualising to Pilot Testing in 13 Districts, to Scale up of Newborn and Child Health Interventions to Preparing for Second Phase, NIPI.

Focus area	Key recommendations	Progress to date	CEPA's rating
Management and governance	*Mid-term review* • Define goal and purpose of NIPI and associated bodies. • Assess mechanisms to support effective coordination and communication between NIPI agencies. • Separate the NIPI Secretariat and Local Fund Agent functions. • Strengthen the NIPI Secretariat roles with strong leadership with risk management capability. • Appoint a gender advisor in the NIPI Secretariat. • Reduce active role involvement of the Embassy in programme implementation and coordination of operations research. • Reconsider the structure of Joint Steering Committee where NIPI fund recipients (WHO and UNICEF) are also members.	The following steps were taken following the recommendations of the Mid-Term Review: • Re-organisation of the UNOPS role under NIPI with a clearer separation of the NIPI Secretariat function and Local Fund Agent. The coordination function (to be played by the Secretariat) has however not worked very well throughout Phase I. • NIPI Secretariat was strengthened with the appointment of a Director and M&E advisor. • A Gender Advisor was recruited and placed in the NIPI Secretariat. In a NIPI retreat held in December 2010, it was agreed by all partners that gender, as a cross cutting issue, will be reflected in all the interventions and operational research studies. • To the extent that we are aware, no further steps were taken to define the goals and structure of the NIPI governance bodies.	Partially implemented
Financial management	*Mid-Term Review* • Assess transaction costs of UNOPS in relation to the technical administration value of the NIPI Secretariat and the UNOPS Local Fund Agent function. • Assess level of flexibility of funding to WHO and UNICEF and bring out clarity on use of these funds between agencies and Government of India. • Analyse fiduciary risks in all states as a follow up to the study in Bihar with the aim of increasing State Health Societies' capacity for more effective implementation and improved financial management and accountability.	To the extent that we are aware, no focused action has been taken with regards to these recommendations. • A key issue with NIPI Phase I has been the lack of clarity on the use of funds by WHO and UNICEF. • We are not aware of any follow up to the study in Bihar for management of any fiduciary risks and improved financial management and accountability.	Not implemented
Areas of improvement in technical interventions	*Mid-Term Review* • Develop communication strategy for NIPI with a focus on disseminating lessons from schemes by using the body of experience in states more proactively. Effective dissemination	• Efforts have not made to raise awareness and document and disseminate results of NIPI Phase I. • We are not aware of any efforts made to promote	Not implemented

Focus area	Key recommendations	Progress to date	CEPA's rating
	of evidence to decision makers (NIPI and other stakeholders) to raise the profile of available evidence base in maternal and child health • Promote engagement with the private sector in areas where there are service deficiencies. • Develop robust link to the NRHM in the states where this is not established.	engagement with the private sector.	
Monitoring and evaluation	*Mid-Term Review* • Develop an overall strategy for monitoring, evaluation and applied research in NIPI, including a core set of indicators, and systems and procedures for collection data/ information. • Employ an M&E officer with relevant experience from a large Non-Governmental Organisation/ consultancy group to support the Secretariat. *Evaluability study* • Develop clear logic models to aid M&E of the Partnership Initiatives . • Recognise and address issues surrounding attribution – in particular, the Partnership Initiative document should account for the larger donor landscape in the country and the specific role of the Initiative in this context. • Adhere to internationally accepted standards for monitoring MDGs 4 and 5 – i.e. using the three internationally agreed MDG indicators of (i) proportion of infants immunised against measles; (ii) proportion of births attended by skilled health personnel; and (iii) Anti Natal Care coverage. • Need to revisit and refine M&E plans following their initial development in the project documentation. • For NIPI in particular, the study recommended: (i) use of available data sources to assess whether NIPI targets were achieved and whether statistically significant change occurred in specific outcome measures over time; and (ii) specific targeted interventions should be evaluated for their effect on	A comprehensive M&E strategy and its implementation were not achieved in NIPI Phase I (although as noted above, an M&E officer was recruited within the NIPI Secretariat).	Not implemented

Focus area	Key recommendations	Progress to date	CEPA's rating
	desired outcomes.		
Research	• Develop a view on the role of research in the organisation, and a research strategy will be needed if NIPI is extended. • Reducing the active involvement of the Embassy in programme implementation and coordination of operations Research.	• The Embassy handed over the responsibility for operations research to the Secretariat. • Operational Research Committee and Sub-Committee established to identify key research areas, and approve studies. • The NIPI Secretariat initiated two studies under operational research: o Prognosis, Exploratory Research for Identification of Determinants of Neonatal Health; and o Rapid Assessment of Yashodas, 2012	Partially implemented

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3A.02 Évaluation du programme ACOPAMUn programme du BIT sur l'« Appui associatif et coopératif auxInitiatives de Développement à la Base » en Afrique del'Ouest de 1978 à 1999
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4.09 Study Report: Norwegian Environmental Action Plan
5.09 Evaluation: Evaluation of Norwegian Support to Peacebuilding in Haiti 1998–2008
6.09 Evaluation: Evaluation of the Humanitarian Mine Action Activities of Norwegian People's Aid
7.09 Evaluation: Evaluation of the Norwegian Programme for Development, Research and Education (NUFU) and of Norad's Programme for Master Studies (NOMA)
1.10 Evaluation: Evaluation of the Norwegian Centre for Democracy Support 2002–2009
2.10 Synthesis Study: Support to Legislatures
3.10 Synthesis Main Report: Evaluation of Norwegian Business-related Assistance
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6.10 Study: Evaluation of Norwegian Business-related Assistance Uganda Case Study
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