EVALUATION OF THE UNFPA NINTH COUNTRY PROGRAMME
OF ASSISTANCE TO THE GOVERNMENT OF INDIA
CP9 (2018-2022)

Final Report

May 10, 2022

India Country Map

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Disclaimer: This is a product of the independent evaluation by the above team and the content, analysis and recommendations of this report do not necessarily reflect the views of the United Nations Population Fund (UNFPA), its Executive Committee or Member States. The report is not professionally edited.

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Abbreviations and Acronyms

ABR	Adolescent Birth Rate		MMR	Maternal Mortality Ratio
ANC	Antenatal care		MOHFW	Ministry of Health and Family Welfare
ANM	Auxiliary Nurse Midwife			
APRO	Asia-Pacific Regional Office of UNFPA		MOSPI	Ministry of Statistics and Programme Implementation
ASHA	Accredited Social Health Activist			
ASRH	Adolescent Sexual and Reproductive Health		MP	Madhya Pradesh
AWP	Annual Work Plan		MTR	Mid-term Review
A/Y	Adolescent and Youth		NCD	Non-communicable Disease
AFHC	Adolescent Friendly Health Clinic		NCERT	National Council of Education, Research and Training
AYSRH	Adolescent and Youth Sexual and Reproductive Health		NFHS	National Family Health Survey
BBBP	Beti Bachao Beti Padhao		NGO	Non-governmental Organization
			NITI Aayog	National Institute for Transforming India
CEDAW	Convention on the Elimination of Discrimination Against Women		ODA	Official Development Assistance
CHC	Community Health Centre		OECD	Organization for Economic Co-operation and Development
CO	Country Office			
COAR	Country Office Annual Report		OSSC	One-Stop Service Centre
CP	Country Programme		PCPNDT	Pre-Conception and Pre-Natal Diagnostic Technique
CP8	The Eighth Country Programme			
CPD	Country Programme Document		PGIMER	Post Graduate Institute of Medical Education and Research
CPE	Country Programme Evaluation			
CPR	Contraceptive Prevalence Rate		PLHIV	People Living with HIV
CSE	Comprehensive Sexuality Education		PMSMA	Pradhan Mantri Surakshit Matriya Abhiyan
CSO	Civil Society Organization			
DAC	Development Assistance Committee of the OECD		PSEA	Prevention of Sexual Exploitation and Abuse
DV	Domestic Violence		PO	Programme Officer
DOWCD	Department of Women and Child Development		PD	Population Dynamics
			PRI	Panchayati Raj Institution
ELA	Expected Level of Achievement		PWD	Persons with Disabilities
EmOC	Emergency Obstetric Care		RG	Results Group
ET	Evaluation Team		RRF	Results and Resources Framework
EU	European Union		RBM	Results-based Management
FGD	Focus Group Discussion		RH	Reproductive Health
FHC	Family Health Center		RKSK	Rashtriya Kishore Shiksha Karyakram (National Adolescent Health Programme)
FP	Family Planning			
FW	Family Welfare			
GBV	Gender-based Violence		RMNCH+A	Reproductive, Maternal, Newborn and Child Health + Adolescents
GE	Gender Equality			
GH	General Hospital		SC	Schedule Cast
HIV	Human Immunodeficiency Virus		SDG	Sustainable Development Goals
HMIS	Health Management Information System		SGBV	Sexual and Gender-based Violence
			SISS	Social Indicator Sample Survey
HR	Human Resources		SHG	Self Help Groups
HWC	Health and Wellncess Centre		SHP	Schedule Health Programme
IASC	Inter-Agency Standing Committee		SIRD	State Institute of Rural Development
ICPD	International Conference on Population and Development		SOGIE	Sexual Orientation, Gender Identity & Expression
IDA	International Development Association		SP	Strategic Plan
IECM	Information Education Communication Material		SPR	Standard Progress Report
			SRH	Sexual and Reproductive Health

IIPS	International institute of Population Studies	SSTC	South-South and Triangular Cooperation
ILO	International Labour Organization	SRS	Sample Registration System
INC	Indian Nursing Council	ST	Schedule Tribe
INGO	International Non-governmental Organization	STI	Sexually Transmitted Infection
LMIS	Logistics Management Information System	SY	Strategic Year
		TA	Technical Assistance
LNOB	Leaving No One Behind	TISS	Tata Institute of Social Sciences
LSBHE	Life Skills-based Health Education	TL	Team Leader
LSE	Life Skills Education	TOR	Terms of Reference
MDT	Multidisciplinary Team	TWG	Technical Working Group
MDG	Millennium Development Goal	UBRAF	United Budget, Results and Accountability Framework
MIC	Middle Income Countries	UNCT	United Nations Country Team
MISP	Minimum Initial Services Package	UNDAF	United Nations Development Assistance Framework
		UNDP	United Nations Development Programme
		UNEG	United Nations Evaluation Group
		UNICEF	United Nations Children's Fund
		UNFPA	United Nations Population Fund
		UPR	Universal Periodic Review
		VAWG	Violence Against Women and Girls
		WHO	World Health Organization
		WP	Work Plan

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Acknowledgement

Box 1. Structure of the India Country Programme Evaluation (CPE) Report

This report comprises an executive summary, six chapters, and annexes and follows the structure recommended in the evaluation handbook by the UNFPA Independent Evaluation Office.

Chapter 1, the **Introduction,** provides the background to the evaluation, objectives and scope, the methodology used, and the evaluation process including the limitations encountered. The **second chapter** describes India country context, and the development challenges it faces in the UNFPA mandated areas. The **third chapter** refers to the response of the UN system and then leads on to the specific response of UNFPA through its country programme to the national challenges faced by the country in the areas of sexual and reproductive health and rights, Adolescent and youth, gender equality and women's empowerment, including GBV/DV. The **fourth chapter** presents the findings for each of the evaluation question specified in the evaluation matrix (which is annexed); the **fifth chapter** discusses conclusions, and the **sixth chapter** concludes with strategic and programmatic level recommendations based on the conclusions.

As listed above, Part 1 Annexes 1-6 contain the obligatory documents for CPE (terms of Reference, list of persons met, stakeholders map, list of documents consulted, evaluation matrix and data collection tools). Part 2 Annexes A-E provide additional reference documents and are compiled as CPE Part2. Due to the CPE page limit, useful details are not included in the main report and additional information which may be beneficial to the Country Office (CO) and other interested readers could be found in these annexes. The titles of these annexes are mentioned under Part 1 and Part 2 Annexes above.

TABLE 1: KEY FACTS

Indicator		Source of information
Geographical Location	The Indian peninsula is separated from mainland Asia by the Himalayas and is surrounded by the Bay of Bengal in the east, the Arabian Sea in the west, and the Indian Ocean to the south.Afghanistan and Pakistan to the north-west; China, Bhutan and Nepal to the north; Myanmar to the east; and Bangladesh to the east of West Bengal. Source: Official website, Govt of India -https://www.india.gov.in/my-government	
Land Area	32,87,263 sq. km	https://www.india.gov.in/india-glance/profile
People		
Population	13,63,006	Population Projection, 2011-2036, National Commission on Population, MOHFW, July 2020
Urban Population	5,13,456	
Total Fertility Rate	2.2	SRS, 2018
Type of government	India is a "Sovereign, Socialist, Secular, Democratic Republic" with a parliamentary system of government.The Constitution provides for a Parliamentary form of government which is federal in structure with certain unitary features. Source: Official website, Govt of India -https://www.india.gov.in/my-government	
% of seats held by women in national parliament	14.36% (Lok Sabha[1]) 10.33% (Rajya Sabha[2]) 44.37% (Panchayati Raj Institutions)[3]	MOSPI, 2021[4]
Currency	Indian Rupee (INR)	
GDP per capita (2019)	2011.75 (US$)	https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=IN
GDP Growth rates (2019-20)	3%	MOSPI, 2021
Social indicators		
Human Development Index (2020) Rank (2020)	0.645 131 of 189 countries	HDR 2020[5]
Gender Inequality Index (2020) Rank (2020)	0.488 122 of 162 countries	HDR 2020
Global Gender Gap Index (2020)	0.625	World Economic Forum, 2021[6],

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[1] The Lok Sabha refers to the lower house of the Indian Parliament.

[2] The Rajya Sabha refers to the upper house of the Indian Parliament.

[3] Panchayati Raj Institutions is a system of rural local self-governance in India.

[4] Ministry of Statistics and Programme Implementation (MOSPI), 2021 Sustainable Development Goals, National Indicator Framework, Progress Report, 2021, MOSPI, Government of India, New Delhi

[5] United Nations Development Programme, 2020, Human Development Report, The next Frontier: Human Development and the Anthropocene, The UNDP, New York

[6] World Economic Forum, 2021, Global Gender Gap Report, Insight Report, March 2021, WEF, Switzerland

	140 of 156 countries	
Gender Parity in Tertiary Education (GPI) (2018-2019)	1.00	MOSPI, 2021
Adult Literacy Rate (15+ years) (2011)	69.3% (total)) 59.3% (female) 78.8% (male)	Census, 2011
Sex ratio at Birth (2016-2018)	899 females per 1000 males at birth	SRS, 2018 Census, 2011
Child sex ratio (0-6 years)	918 females per 1000 males in the age group 0-6 years	Census, 2011
Poverty Rate - Proportion of population living below the National Poverty Line (2011-12)	21.9%	MOSPI, 2021
Unemployment Rate (2018-2019)	5.8%	MOSPI, 2021
Health expenditure (%of GDP)	1.6	Economic Survey 2020
Life Expectancy at Birth (2014-2018)	Women- 70-7 Men - 68.2	Sample Registration System (SRS) Based Abridged Life Tables
Maternal Mortality Ratio (per 100,000 live births) (2018)	113	SRS (2016-2018)
Under-5 Mortality (per 1000 live births) (2018)	34.3	SRS, 2018
Neonatal Mortality Rate (per 1000 live births) (2018)	22	SRS, 2018
% of births attended by skilled health personnel	89.4 %)	NFHS-5 (2019-2021)

% of pregnant women received Antenatal Care 4+ ANC	58.1 %	NFHS -5 (2019-21)
Percent of births delivered by C-section (2015-2016)	21.5%	NFHS-5 (2019-21)
Adolescent birth rate (15-19 years)	12.2	SRS, 2018
Teenage pregnancy and motherhood	6.8%	NFHS -5 (2019-21)
Contraceptive Prevalence Rate modern methods	56.5 %	NFHS -5 (2019-21)
Unmet need for family planning	9.4 %	NFHS -5 (2019-21)
% of people living with HIV, 15-49 years old	0.22 %	National AIDS Control Organization (NACO) 2019
Ever married women 15-49 years who have experienced spousal violence (2015-16)	31.1%	NFHS-4 (2015-2016)
Ever married women 15-49 years who have experienced spousal violence during pregnancy (2015-2016)	3.9	NFHS-4 (2015-2016)
Women aged 15-24 married before 18 years (2015-2016(	26.8%	NFHS-4 (2015-2016)

Executive summary

Background:

In line with the United Nations Population Fund (UNFPA) evaluation policy, country programme evaluation (CPE) of the ninth cycle of Programme (CP9) of Assistance to the Government of India (2018-2022) was conducted by an external, independent team of evaluators. Managed by the Country Office (CO) in close collaboration with the Regional Monitoring and Evaluation Adviser in the UNFPA Asia and the Pacific Regional Office (APRO) and with oversight from the UNFPA Evaluation Office (EO), the CPE followed UNFPA CP evaluation guidelines, UN Evaluation Group (UNEG) ethical standards.

Key purpose of the CPE is to (i) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making; and (iii) contribute key lessons learned to the existing knowledge based on how to accelerate the implementation of the Programme of Action of the 1994 International Conference on Population and Development (ICPD). The overall objectives of this CPE are to provide the key stakeholders (see below the intended audience) with an independent assessment of CP9 (2018-2022) to broaden the evidence base to inform the design of the next programme cycle (CP10) and to contribute to the UN Sustainable Development Cooperation Framework (UNSDCF-2018-2022) evaluation and the design of the new UNSDCF.

The main audience and primary users of the evaluation are the decision makers and programme managers in CO, UNFPA APRO and UNFPA Headquarter divisions (HQ), Executive Board, CP9 Government counterparts, other national partners, donors, development partners, UNRCO and relevant UN Agencies, civil society organizations and academia.

The scope of the evaluation is to cover all activities planned and/or implemented during the period 2018-September 2021, under three outcome areas, Sexual and Reproductive Health and Rights (SRHR), Youth and Gender, and Population Dynamics (PD) at the national as well as state level in four focused states (Bihar, Madhya Pradesh (MP), Odisha and Rajasthan) as well as other states where specific interventions have been implemented. The evaluation covered cross-cutting issues such as disability inclusion, human rights and gender equality, coordination, monitoring and evaluation, resource mobilization, partnerships, communication and SRH and Gender-based Violence (GBV) prevention services during the humanitarian contexts. While assessing the intended effects, CPE identified potential unintended effects of the CP.

Methodology and Process:

CPE examined seven evaluation questioned employing OECD/DAC evaluation criteria of Relevance, Coherence, Effectiveness, Efficiency and Sustainability. UNFPA specific evaluation criterion Coordination and Added value come under Coherence criteria and assessed UNFPA's contribution to the existing coordination mechanisms and strategic positioning in the country with a focus on UNCT Coordination and UNFPA's comparative advantage in the development agenda within the development community and national partners in responding to national needs.

Using a theory-based approach ET developed key assumptions and indicators to measure the expected achievements. Evaluation matrix was developed upon identifying the sources and tools for data collection. CP9 supported at national level and in four states (Bihar, Odisha, Madya Pradesh (MP) and Rajasthan) covering 15 districts. In addition to these 15, UNFPA had standalone interventions in three states. From the fifteen districts in the four states that are assisted by UNFPA in CP9, a purposive sample of four districts (Rayagada, Udaipur, Sheikhpura, and Chattarpur) were chosen based on a few selection criteria. If an intervention under the three outcome areas was not implemented in the selected district, the adjoining

district was visited to cover that particular intervention in addition to the district selected in each state. The standalone interventions that are in other states were also included in the sample.

Data Collection, both primary and secondary, that based on the type of evaluation questions and indicators selected for assumptions, was via face-to-face interviews and group discussions using semi-structured interview questions, focus group discussions, observations, and document review. Data sources were selected from the stakeholder map, represented by the national to block level, government, private as well as UN agency representation, academia, CSOs and NGOs. The sample size was adequate given the purposive stratification to cover different types of beneficiaries, which increased the precision of conclusions reached. A purposive sample of stakeholders were chosen for data collection, allowing a mix of stakeholders at different levels to represent the type of data to reflect multiple views to fully assess the CP9 interventions including human rights and gender dimensions. A total of 924 (290 males and 634 females) were interviewed where the most being group discussions and group interviews.

Data analysis was mainly descriptive and content analysis and descriptive analysis was used to interpret quantitative data, in particular data emerging from programme annual reports, studies and reports, and financial data. Content analysis of documents, interviews, group discussions and focus groups notes, was done to identify emerging common trends, themes, and patterns for each key evaluation question, in the analyses. The evaluation triangulated data sources, data types, and data collection methods.

Main Findings and Conclusions:

CP9 delivered its work programme, in the development and humanitarian settings, focusing on sexual and reproductive health and rights, empowerment of women and young people, especially adolescent girls, and by strengthening the evidence base with data and population expertise, aiming to achieve the three transformative results in the coming strategic plan cycles leading up to 2030.

Keeping in line with the government priorities, UNFPA mandate, and addressing the needs of the vulnerable and marginalized populations, UNFPA maintained its programme relevance aligning CP9 workplans with the principles of the 2030 Agenda for Sustainable Development and the three transformative results. However, there is more room for improvement in disability inclusion as well as identifying and addressing the needs of the yet unreached populations such as persons based on sexual orientation, their gender identity, and expression (SOGIE).

Despite COVID19 context where most CO staff had been affected directly or indirectly (whose dependents had been affected) by the pandemic and the staff realignment taking place at the same time, the overall implementation rate had been satisfactory, achieving CP9 planned results.

With significant contributions to SRH/HIV integration of the United Budget, Results and Accountability Framework (UBRAF) project in Gujarat, UNFPA contribution to joint UN response to COVID-19 pandemic has been commendable, including preventing/addressing GBV (through media and strengthening services at one stop centres) in the context of COVID-19. UNFPA's contribution to FP2020 and FP2030 development in promoting focus on young people and rights issues is well recognized. Ministry of Health and family Welfare (MOHFW), while recognizing UNFPA's contributions, feels that stronger policy and technical support is needed in this area.

UNFPA has demonstrated its added value to the national reproductive, maternal, newborn, child and adolescents (RMNCH+A) programme by bringing to the foreground rights perspectives, particularly in the context of FP and maternal health service delivery, leveraging National Health Mission (NHM) funds in three of its focus states (MP, Odisha and Rajasthan). Aligned well with national RMNCH+A programme, CP 9 responded to new priorities and needs by reprogramming its resources to support MOHFW's midwifery initiative as well as to support the continuation of RMNCH services during the COVID-19 pandemic. UNFPA's support to MOHW midwifery initiative and its collaboration with INC has opened avenues for major national

contribution in maternal health and reduction on maternal mortality. It also contributes to overcoming the shortages in human resources for SRH.

During CP 9, investments have been made to integrate ICPD POA's rights-based approaches to FP through contributions to expanding the choice of spacing methods while monitoring quality and rights. However, more needs to be done in this area.

Considering that there was no inclusion of emergency preparedness under CP9, the COVID-19 support as part of the Joint UN initiatives is commendable. In response to floods and cyclones, provision of dignity kits was in place and only in the state of Odisha, Minimum Initial Services Package (MISP) was rolled out as it is an integral part of the state's preparedness plans. The reservations of GOI in involving UN and developmental partners in emergency relief measures, it may not be possible to influence the national level but possible to influence the state level strategies with regard to emergency response and preparedness.

Despite the recognition of the value of integrated package in contributing to universal access to SRH services, the degree of investment and quality of implementation of the integrated package need rethinking for achieving desired results. There is uneven implementation and focus of it (contents and geographical coverage) across the four states with Odisha and Rajasthan implementing majority of the RMNCH+A components, while the major focus in MP has been on activities related to young people, mostly school-based and community-based programmes and to some extent on FP. Bihar's activities related to FP were initiated late. While this variation may be based on a management decision, at the national or state level, the decision may have to be re-assessed in support of achieving transformative results. Two major services missing in the integrated package are health sector response to GBV and adolescent SRH services.

Working with youth, at national and state level, for both in school and community-based programme has shown promising results with strong demonstration pilots in reaching marginalised youth leading to increased awareness, creating a cadre of peer educators, and development of a range of knowledge products. Long gaps and irregular communication with MoHFW have led to missed opportunities to come up with innovations in engagement beyond life-skills education (LSE). UNFPA played a proactive role in evidence-based advocacy with MoHFW at the beginning of CP9 leading to recognition for its contribution to the National Adolescent Health Programme (RKSK programme) and proactive role in the national adolescent working group in the national ministry. However, although significant contributions have been made to RKSK programme at national and state levels in MP, Odisha and Rajasthan, the degree of support for adolescent friendly clinics (AFHCs) is less. Currently these clinics' outreach to adolescents is limited due to the location of the clinic, quality of services and contents.

Mixed progress on gender-discrimination, harmful practices and gender mainstreaming was observed. In-spite of not having a separate output on gender equality and a cross cutting gender strategy, CP9 has strengthened policies and capacities of state government, implementing partners (IPs), Panchayati Raj Institutions (PRIs) and one stop centres to address gender discrimination, child marriage and GBV during normal times and during COVID-19. Although gender mainstreaming in adolescents/youth empowerment has been effective, in SRH and PD this has been constrained by the fact that the gender strategy was linked to youth, and not SRH or PD. In keeping with gender aspects at UNSDCF, there is no collaborative agreement (informal) at state level. Partnerships with national institutes on gender and minority rights (e.g., Jamia, Mannu) and media groups have been sound, with need for strengthening partnership organisations on women, young people with disabilities and transgenders.

As for PD, its thematic group was able to link emerging population issues-urbanization and migration, to the intervention arm of the UNFPA India operations (that works through other thematic groups) through the socially inclusive smart city initiatives and it's work on ageing during COVID times (for which it got the Mahatma Award). In documenting a template for socially inclusive smart city (and other states have shown interest in replicating it), it had a direct effect on policy. PD performed well in its traditional (and critical in the current architecture of operations) role as the data skeleton for operation of other thematic groups. It

provided important support for initiatives-RKSK, LSE among others, through its engagement with data systems like the Logistics Management Information System (LMIS), Health Management Informatioon System (HMIS) and data sets like the Natonal Family Health Survey (NFHS-Demography Health Survey -DHS, for India).

Resources invested by UNFPA has had a leveraging effect with Joint programmes enabling expansion of interventions with the same available HR. However, UNFPA contribution could have been strengthened had there been more synergetic approach, between thematic areas at CO level and specifically in downstream work. The support for state level and district level consultants both in priority and aspirational districts has given UNFPA increased mileage at the state level and district level in improving quality of services and to a certain extent ensuring rights. However, the sustainability of this approach is a concern. Uneven implementation of priority interventions of RH in focus states and districts raises issues with regard to efficient use of resources.

While partnerships seem to vary at state level, CP9 has made sound partnerships with UN agencies, and these agencies perceived FP, maternal health, life skills, gender-based sex selection (GBSS), child marriage and gender statistics to be UNFPA strengths. In keeping with gender aspects at UNSDCF, there is no collaborative agreement (at state level. Partnerships with national institutes on gender and minority rights and media groups have been sound, with need for strengthening partnership organisations on women, young people with disabilities and transgenders.

Strategic and Programmatic Recommendations

UNFPA's strength is mainly in the provision of technical assistance at the national as well as state level. Strengthen UNFPA's technical assistance and visibility in national programming on youth empowerment through advocacy and increased evidence from impact of programs with enhanced multi sectoral programmes for adolescents and young people particularly in strengthening access to SRH services, support to quality data and evidence base for policy and planning purposes. While maintaining the role of coordination, advocacy and operating through strategic partnerships, identify key high impact interventions with links to achieving the three transformative results.

State-level focus to be continued with key interventions, especially the successful ones that are directly contributing to three transformative results. CP10 to focus more on FP (rights-based FP), SRH (increasing access to sexual and reproductive health and reproductive rights); adolescent and youth sexual reproductive health (AYSRH), and Health sector response to GBV as high priority. Continue with ongoing initiatives to reduce maternal mortality and morbidity through continued support to the implementation of the roadmap for development of cadre of Nurse Practitioners in Midwifery, support for quality assurance of maternal care and evidence-based interventions and capacity building in MISP to be included in all four states.

Mainstream gender and disability (starting from programme design and planning stage) and include a separate output on gender and social inclusion, covering its efforts to address gender discrimination (as relevant to the UNFPA mandate) and mainstream gender in SRH, adolescent and youth empowerment and population dynamics. Provide support for strengthening continuum of care approach by integrating and strengthening selected priority SRH services. Such interventions promote reproductive rights.

Overall, across all thematic areas, strengthen technical capacity of UNFPA for enhancing technical assistance to the government and other development partners. UNFPA has several interventions that include social norm changes (behavior changes, attitude changes among service providers as well as service receivers

(Duty-bearers and Rights-holders). Therefore, change measurement instruments and expertise to be included in all programmes where it is applicable and capacity development to be given importance.

Capacity building activities of data collectors and data managers be strengthened further to create Data Literacy. UNFPA to establish a clearer path from research to policy in medium run, especially ones that have a larger regional focus, and in focus states, on topics of demographic dividend (especially for young) and migration, ageing and urbanization.

Ex-ante evaluation (CP10 design related): While the above are for 2023, this recommendation is to be accomplished during CP9 before implementing CP10, for assessing its evaluability. Development of theory of change (TOC) as well as Theory of Action/TOA, are of high priority. The knowledge base that is already established could provide the basis for developing the TOC and the TOAs. A combination of interventions (multi-sectoral) can be employed for better results. Conduct a scoping exercise (informal) to see what other development partners are implementing in the same thematic area or contributing to the same objectives as UNFPA, for enhancing coherence /external synergy.

Chapter 1: Introduction

Country programme evaluation (CPE) of the ninth cycle of Programme of Assistance to the Government of India (2018-2022) was conducted as part of its 2021 work plan (WP). In line with the UNFPA evaluation policy, UNFPA Evaluation Handbook "How to Design and Conduct a Country Programme Evaluation", and norms, and ethical standards United Nations Evaluation Group (UNEG), this CPE was conducted by an external and independent team of evaluators. Managed by the Country Office (CO) in close collaboration with the Regional Monitoring and Evaluation Adviser, UNFPA Asia and the Pacific Regional Office (APRO) and with oversight from the UNFPA Headquarters Evaluation Office (EO), the purpose and overall objectives of the CPE are stated below. The evaluation consists of five phases and the details are presented later in this Chapter.

1.1 Purpose and Objectives of the Country Programme Evaluation

The CPE serves the following three main purposes, as outlined in the 2019 UNFPA Evaluation Policy: (i) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making; and (iii) contribute key lessons learned to the existing knowledge based on how to accelerate the implementation of the Programme of Action of the 1994 ICPD.

As per the Evaluation Policy, it is proposed to undertake a final evaluation of the country programme to assesses its achievements, factors that facilitated or hindered achievements and to compile lessons learned in respect of each of the programme components and thematic areas. More specifically, the evaluation assesses the programme's relevance, coherence, effectiveness, efficiency and sustainability, identify lessons learned and make recommendations for future directions for UNFPA in India. It also contributes to the evaluation of the UNSDF in India (2018-2022).

The overall **objectives** of this CPE are:
   i. To provide the India country office, national stakeholders and rights-holders, UNFPA APRO, UNFPA Headquarters, as well as a wider audience with an independent assessment of the CP9 2018-2022.
   ii. To broaden the evidence base to inform the design of the next programme cycle (CP10).

The main <u>audience</u> and primary users of the evaluation are the decision makers and programme managers in CO, UNFPA APRO and UNFPA Headquarter divisions (HQ), Executive Board, CP9 Government counterparts, other national partners, donors, development partners, UNRCO and relevant UN Agencies (UNAIDS, UNDP, UNICEF, UN Women, WHO, etc.), civil society organizations and academia. For transparency and accountability purposes, CPE report will be communicated to all stakeholders.

Specific Objectives

The specific objectives of the CPE are to assess:

1. its relevance, effectiveness, coherence, efficiency, and sustainability and make recommendations for future work for UNFPA.
2. the extent to which the implementation framework (Partnership Strategy; capacity building, quality support and assurance, Execution/Implementation arrangements; Cash Transfer Modalities; and Monitoring & Evaluation) enabled or hindered achievement of the results chain;
3. how UNFPA has strategically positioned itself within the UNCT, broader development community; and national partners with a view to adding value to the country development results; and
4. to draw key lessons from past and current cooperation, reflect on what worked well and what didn't and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programme, which will be submitted to UNFPA's Executive Board for consideration in 2022; and
5. To contribute to the UNSDCF evaluation and the design of the new UNSDCF.

1.2 Scope of the Evaluation

The scope of the evaluation, as per the TOR, was to cover all activities planned and/or implemented during the period 2018-June 2021, under three outcome areas at the national and state level in UNFPA's priority four focused states Bihar, Madhya Pradesh (MP), Odisha and Rajasthan. However, the team, upon consultation with CO decided to extend the coverage until field data collection was completed in September 2021. Besides the assessment of the intended effects of the country programme, the evaluation also aimed at identifying potential unintended effects. In addition, it covered cross-cutting issues, such as disability inclusion, human rights and gender equality, and transversal functions, such as coordination, monitoring and evaluation, resource mobilization, partnerships, communication and Sexual and Reproductive Health (SRH) and Gender-based Violence (GBV) prevention services during the humanitarian contexts. Standalone interventions implemented in Punjab, Gujarat and Uttar Pradesh were also included.

Methodology and Process

Evaluation criteria and evaluation questions: CPE evaluated the programme outcome areas using OECD/DAC evaluation criteria of **Relevance, Coherence, Effectiveness, Efficiency and Sustainability**. UNFPA specific evaluation criterion Coordination and Added value come under Coherence and assess UNFPA's contribution to the existing coordination mechanisms and strategic positioning in the country with a focus on UNCT Coordination and UNFPA's comparative advantage in the development agenda within the development community and national partners in responding to national needs. Evaluation team (hereafter referred to as ET) assessed how UNFPA has been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to achieve planned results, ensure ownership and the sustainability of effects.

FIGURE 1: EVALUATION CRITERIA FOR THE CPE
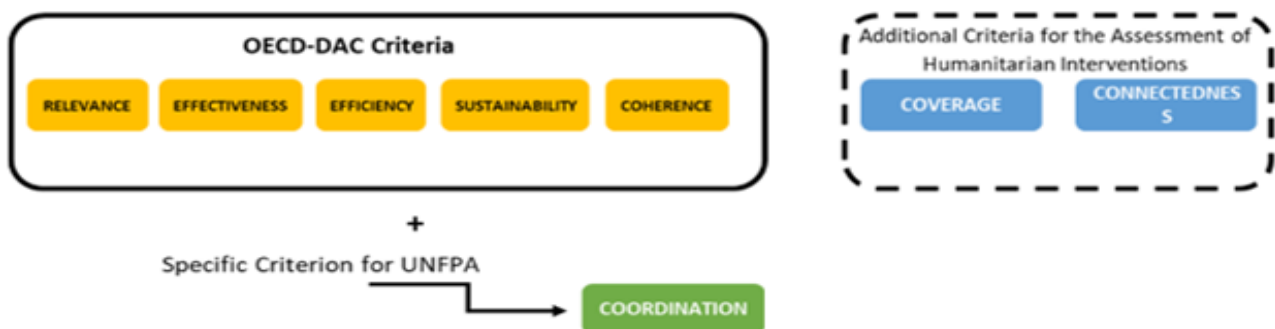
Source: Handbook UNFPA Evaluation Guidelines (2019 version) – modified by CPE team to add Coherence

The additional criteria on Coverage and Connectedness are discussed, where applicable, in relation to humanitarian programming including the response to recent pandemic and are embedded across the evaluation questions as appropriate. All evaluation questions (EQs) and the sub-questions proposed in the TOR and by ERG were covered.

While the country was in a grave situation due to COVID- 19 a few months before the data collection phase in September (2021), there was no major limitation for the national team to travel to the states where UNFPA supported work was implemented to conduct the evaluation. As such, the interviews took place face-to-face where feasible, adhering to safety measures, in addition to the virtual interviews and meetings.

Upon selection of the EQs, ET attended to desk review of key documents and specific details were clarified by CO staff members. ET prepared evaluation design matrices (Annex 5) covering all evaluation questions with assumptions, indicators, and data sources and data collection methods. Stakeholder map (Annex 3) was prepared upon identifying the sources for interviews, discussions, and feedback. The methods for data collection and analysis were determined by the type of evaluation questions formulated to test the assumptions. Following are the questions specific to the above evaluation criteria. While these were the questions proposed in the TOR, ET did a minor change by merging the two questions under the Relevance criteria into one while keeping the content same, as it was deemed more appropriate. In addition to the key evaluation questions stated below, CPE drew

lessons learned, what worked and what did not, factors that facilitated or hindered in achieving planned results, and what the unintended consequences are in the implementation processes.

TABLE 2: THE EVALUATION CRITERIA AND CORRESPONDING EVALUATION QUESTIONS

Evaluation Criteria and Evaluation Questions	

Relevance	**EQ1**-: To what extent are the objectives of the programme
	  (i) adapted to the needs of the population (including needs of the most vulnerable groups), including in the humanitarian and COVID-19 contexts,
	  (ii) aligned with government priorities,
	  (iii) in line with the 2030 Agenda, ICPD Programme of Action, and UNFPA Strategic Plan 2018-2022, and
	  (iv) respond to changes in national needs and priorities caused by major political changes and other contextual changes (such as humanitarian included above)?

Coherence	**EQ2**. To what extent the interventions are coherent with programmes and interventions of the government, development partners, including the UN agencies, having similar objectives? **EQ3** What are the main comparative strengths of UNFPA in India, how are these perceived by state level (priority states), national and international stakeholders including NGOs?

Effectiveness	**EQ4-** To what extent have the interventions supported by UNFPA delivered outputs and contributed to the achievement of the outcomes of the country programme(in development and humanitarian contexts):
	  i) to increase the access of adolescent and young persons *(in particular adolescent girls/young women)* to life skilled based adolescent education programme and quality sexual and reproductive health services in India,
	  ii) to improve access to and utilization of high quality SRHR services in development and humanitarian contexts, including for the most vulnerable groups,
	  iii) to improve national *and relevant state* responses to gender-biased sex selection and gender-based violence, *early marriage and other harmful practices* and
	  iv) to increase availability and use of data on emerging population issues at national and sub-national levels?
	EQ5. To what extent has UNFPA successfully integrated human rights, gender perspectives and disability inclusion in the design, implementation and monitoring of the country programme?

Efficiency	**EQ6.** To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools, approaches and partnerships, including South-South Triangular Copperation (SSTC), to pursue the achievement of the outcomes defined in the UNFPA country programme and in its response to humanitarian crisis (including COVID19 response)
Sustaina bility	**EQ7:** To what extent has UNFPA been able to support implementing partners, rights-holders (notably, women, adolescents and youth) and rights-based approaches in developing capacities and establishing mechanisms to ensure the durability of effects?

Taking into consideration the tasks of the evaluation as well as time and budget constraints, a non-experimental design was used to answer the evaluation questions. This type of design was relevant given that most of the key evaluation questions and sub-questions were descriptive and normative in nature. Experimental and quasi-experimental designs cannot be applied in this case, as they require creating a control group and this was not taken into consideration by the programme at design stage. It would have been possible to apply a quasi-experimental design by comparing with a non-intervention area with UNFPA intervention area; however, these methods are time-consuming and costly. Furthermore, there are other donors and IPs operating in most other provinces and to find an area or a population without any intervention would have been difficult and there could be contamination due to that.

The Evaluation utilized a theory-based approach. The Theory of Change (ToC) reflects the conceptual and programmatic approach taken by UNFPA over the period under evaluation including the most important implicit assumptions underlying the change pathway (Part 2- Annex E). The evaluation team l reconstructed the theory of change (ToC) of UNFPA support in India for the period under evaluation from UNFPA planning documents and represented it in a diagram during the evaluation design phase. The reconstructed ToC was used during the field and data collection phase. The analysis of the theory of change served as the basis for the ET to assess how relevant, effective, efficient and sustainable the support provided by the UNFPA India CO was in CP9.

Evaluability Assessment and Reconstruction of the programme logic: The team reviewed the TOC to understand the logical linkages and the objectives behind the interventions. CO made detailed presentations of State Work Programme   as well as the thematic Work Programmes for the ET to understand CP9. Each presentation was about three hours long, going into details of the work program clarifying the links from strategic intervention to outputs and in turn to outcomes. All sessions ended with a Q&A session. This provided the team with an in-depth understanding of the programme prior to field visits to reconstruct the TOC. CO M&E team described the targets per indicator for the delivery of each Output. Due to the pandemic, the reliability and validity of the underlying assumptions made at the time of country programme formulation may not be holding as originally anticipated. As a result, heavy reliance of evaluations on pre-pandemic information/evidence may not produce meaningful insights to inform the design of new Country Programme Documents and programmes. Hence, the evaluation team examined results frameworks and retrofitted the theories of change to take stock of the changing context and country realities due to pandemic as well as emerging programme needs during CP9 implementation. Reconstructed TOC was validated by CO staff during the CPE team presentations. The reconstructed TOC, per output, is attached in the Part 2 Annex E.

Brief overview of the project areas:

 In CP9, in addition to the support to the GoI at the national level, four states (Bihar, MP, Odisha and Rajasthan) were identified by the Government as a priority for UNFPA assistance. Within each of these states, two to three high-priority districts were identified for concerted action by UNFPA based on a vulnerability mapping exercise. The variables below had been used by UNFPA to construct a vulnerability Index to decide priority districts at the CP design stage. The focus of the programme is to support national efforts in achieving universal access to sexual and reproductive health and reproductive rights, including family planning, and to promote gender equality and rights. UNFPA prioritizes its attention on the most vulnerable and marginalized young women and girls by concentrating on focus states.

GOI made a request to UNFPA to include 15 out of the 115 districts identified as backward (called Aspirational Districts) for development (table showing these districts are in the part 2-Annex C on Sampling). Some of these districts overlapped with the priority districts already identified by UNFPA for CP9 support. There was some overlap as well and as such, the selected areas contained some Aspiration districts for UNFPA support, however, these were not targeted for interventions as heavily as UNFPA Priority Districts identified by the vulnerability survey. In addition to the aspirational districts, UNFPA has standalone interventions in several states such as Gujarat, Uttar Pradesh and Punjab[7].

Selection of the Sample

Based on a purposive sampling method, site selection for the CPE depended on the in-depth knowledge gained by related documents, vulnerability surveys, discussions with POs, ERG and the strategic direction that was presented by the country office staff. In addition, as explained below, ET   applied certain criteria for selecting the geographic locations for field visits.

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[7] in addition to aspirational districts' - there are projects in UP and Gujarat- large scale school based programmes (e.g. with national government and state government school systems) which cuts across districts and states. Example - under youth integrating LSE in vocational training in Usha Sewing Schools - this project is not limited to aspirational districts or unfpa focus districts. Similar for LSE integration in national school systems and state wise programmes with state board school - they cut across various districts.

Selection of sites for field visit:

Of the UNFPA supported 15 districts in the four states, Bihar, MP, Rajasthan and Odisha, ET decided to focus on four (4) districts based on selection criteria as explained below. Districts were chosen so that one district was "poor" at least in one of these five dimensions:

1. Spacing Methods of FP by women 15-49
2. % of women 20-24 married before the age of 18
3. Child Sex Ratio (males100/females)
4. Proportion of 10-14 year girls out of school
5. % Scheduled cast (SC) Scheduled tribes (ST)

While the final districts in CP9 where UNFPA operated were chosen based on recommendation of GoI (NITI Ayog), the focus on these variables is sound as each of them represents a dimension relevant to Sexual Reproductive Health, Youth and Adolescents and Gender. Further, for each indicator, districts were grouped into quartiles based on their relative performance-quartile 1 consisted of the worst 4 districts for an indicator where as quartile 4 the best four. The following was the final choice for selecting the sample districts for field visits.

1. Rayagada in Odisha is among the worst 4 performing districts in terms of out of school girls and is a district in the first quartile in terms of the percentage of population that is SC/ST
2. Udaipur in Rajasthan is in the worst 4 districts in terms of Spacing methods adoption
3. Sheikhpura in Bihar had to be chosen as it is the only district in Bihar where there is UNFPA implementation. It does poorly in the proportion of women (20-24) who are married before the age of 18. It is the worst half of districts on this indicator.
4. Chattarpur in MP had to be chosen as it is the only district in MP where there is UNFPA implementation. It performs poorly on the basis of CSR (but in the worst half), though it does even worse on marriage before 18.

The four districts satisfy the criteria on being poor in different dimensions. But this sample also yielded some additional nice variations, as a byproduct (see Part 2 Annex C Table for details).

While all UNFPA supported districts covered under CP9 were included in the evaluation using available secondary data and reports based on the above criteria, the team selected these four districts mentioned above for primary data collection for the evaluation. Only in one case, when the thematic interventions were not implemented (e.g youth, gender), in the selected district, the adjoining districts which had similar background characteristics where the interventions were implemented were visited by the thematic expert in order to cover that intervention outputs and outcomes. As a result, Dhenkenal Sawi Madhopur and Bhubaneshwar and Patna slums were visted. The decision on face to face (or virtual) primary data collection methods depended on the situation that prevailed at the field stage. Where credible secondary data were available, the team made use of them to triangulate and strengthen the evidence base. UNFPA had already completed an MTR and several thematic evaluations; therefore, the team made use of the findings of those evaluations without duplicating the efforts. In addition to the districts indicated in the Part 2 Annex C, UNFPA has standalone interventions in several states such as Gujarat, Maharashtra and Punjab and where relevant virtual interviews took place to collect data. Questions were directed to close the gaps as well as for validation of the findings. When the physical visits to the field sites were not possible, wherever feasible, interviews were held remotely.

Potential/possible biases of missing some populations with unique characteristics were mitigated by information gathered via secondary sources and interviewing sources that were familiar with these projects and populations. In some cases, missing populations, for example people with disabilities, reflected the biases which are noted in our findings elsewhere in the report.

Data Sources, Collection and Analysis

The data sources, collection and analysis methods were designed around the assumptions and indicators proposed in the evaluation matrix, considering the most effective ways to collect and analyze the needed information to answer EQs in the given country and programmes' context and limited timeframe.

Data Sources: Based on the selected evaluation questions and the theory of change model, the sources of data were both secondary and primary. The type of data was based on a mix of quantitative and qualitative, derived from multiple sources.

Primary data sources included IPs, government officials, UNFPA CO and state level staff, other UN agencies and donors at the national level, and IPs and beneficiaries at sub-national levels-states, districts and blocks as needed and time permitted. Primary data collection was through face to face and online (phone, zoom and skype) semi-structured interviews, focus group discussions or unstructured interviews, and direct observation during field site visits as appropriate. Secondary data were collected through desk reviews that included CP-related documentation, relevant national policies, strategies and action plans, national data sets and statistics, evaluation and review reports, and monitoring reports (quarterly reports, project-specific reports, annual reports, and field mission reports) submitted by IPs and UNFPA staff. Administration of an on-line survey, although was planned, was not required as the country situation regards to COVID-19 did not pose any restriction to gather data face to face. ET attempted to collect disaggregated data to be able to triangulate evidence across all dimensions: age, sex, geography. Due to limited outreach of programs to the disabled, CPE could not meet with people with disability. However, the lens of disability was adopted by asking questions around disability (e.g. whether women with disability use labour rooms, and ease of access etc.). Further, NGOs working with persons with disabilities (hearing, sight, motor impairments) were met by the evaluation team in one state and such instances- were mentioned where relevant, in the evaluation. The groups included for interviews were the vulnerable and marginalized groups like women from SCs, STs, minorities, those in remote areas and urban low-income settlements. Data collected were mostly qualitative and this type of design was also most relevant in the context of present CPE, given that the majority of the evaluation sub-questions were descriptive and normative in nature. As such, within the CPE timeframe, primary data gathered were mainly qualitative in nature and are descriptive while secondary data provided insights to the larger context.

Data Collection Methods:

The national team consisted of an experienced team that needed minimal guidance by the International Team Leader (TL). During the field phase, when conducting primary data collection, ET was led remotely, full scale by the TL. ET had regular virtual meetings and reviewed the work through setting up a timetable and ensuring that instructions were provided timely. As for the data collection, team used a hybrid model, virtual as well as face to face meetings. TL was able to lead virtual interviews via zoom, skype and telephone depending on the appropriateness and feasibility for the interviewee, to validate or to go in-depth on any information. At the data analysis and initial reporting phases, TL was in-country, working in-person with the CPE team and CO staff.

Based on the evaluation questions and the source, tools were prepared and used for data collection. The rationale for selecting these tools depended on the type of question to answer, stakeholder and the interventions. Tools were structured to gather the information based on the key questions as per the assumptions as well as the sources indicated in the evaluatin matrix. The main method was face-to-face interviews and group discussions using the semi-structured questions. Observation method was used in combination when functioning facility bases were visited. Using the programme knowledge and further discussion with CO staff, a purposive sample was drawn from the stakeholder map (Part 1 Annex3) to reflect all CP9 interventions and input. Programme beneficiaries were selected based on the availability, given the Covid19 environment. The respondents (e.g., implementing partners, civil society, programme participants, donors, representatives of vulnerable and marginalized groups etc.) were given the opportunity to discuss freely about the programme and to propose what works for them to make the programme better in their own context. ET included a wide range of stakeholders to reflect multiple views to fully assess the human rights and gender dimensions. Where the situation and skilled resources were limited in conducting FGDs, an unstructured or open-ended interview was conducted on pre-identified topic/s. Data Collection Tools are attached (Part 1 Annex 6).

Data Analysis:

The Evaluation matrix provided a guiding structure for data analysis for all components of the evaluation and the evaluation questions determined the method of data analysis. The team used descriptive analysis to identify and understand the contexts in which the programme has evolved, and to describe the types of interventions and other characteristics of the programme. This heavily depended on the availability of secondary data and time to collect primary data. Descriptive analysis was used to interpret quantitative data, in particular data emerging from programme annual reports, studies and reports, financial and NFHSdata.

Content analysis of documents, interviews, group discussions and focus groups notes, was done to identify emerging common trends, themes and patterns for each key evaluation question.. The emerging issues and trends provided a basis for preliminary observations and evaluation findings. Given the nature of the key data collection method in this CPE, major data analysis was mostly limited to content analysis to interpret qualitative data with some quantitative analysis using secondary data. List of documents consulted are attached (Part 1 Annex 4). Conclusions and recommendations show evidence of consistency and dependability in data, findings, judgments and lessons learned appropriately reflecting the quality of the methodology, procedures, and analysis used to collect and interpret data. As described earlier, the questions, data collection and analysis ensured that gender concerns and human rights-based approach were integrated. These are explained at each stage.

The evaluation triangulated data sources, data types, and data collection methods. ET assessed the extent of consultation of beneficiaries (including the representatives of the most vulnerable and marginalized groups) and partners during design the CP and during implementation and assessed how UNFPA has been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to achieve planned results. Upon reconstructing the logical pathway (reconstructed TOC, ref Part 2 Annex E) and understanding the results chain, ET developed assumptions and identified the indicators to assess them. A contributory analysis was done, using triangulated evidence to see to what extent CP9 contributed to the outputs and in turn outcomes; whether or not the programme made a difference and whether or not CP9 added value to the planned development results. These are explained in each section under chapter four on findings.

Special consideration was made, where feasible, to include and reflect the lens of boys, girls, men and women, and those belonging to marginalized groups (GBV survivors, youth, SCs, STs, minorities, disabled, those in conflict areas, slum dwellers etc. as specified by the CO staff and IPs) in evaluating CP9 design and implementation. The triangulation of data collection minimized the weaknesses of one method, offset by the strengths of another, enhancing the validity of the data.

Data Quality and Validation Mechanisms: Data quality was maintained by triangulating the data sources and methods of collection and analysis. Validation of preliminary findings, by key stakeholders, enhanced the quality of data collected ensuring absence of factual errors or errors of interpretation and no missing evidence that could materially change the findings. ET held regular discussions (via zoom) to monitor progress and clarify any pending issues. ET had follow-up discussions with CO programme staff to assure that the data (secondary) used in the evaluation are from valid sources and the reported limitations were taken into consideration when using the secondary data. Preliminary findings were discussed with all staff followed up by thematic presentations including detailed discussions with relevant CO programme staff and ERG members to validate the findings. The draft report is shared with CO staff, ERG members and selected stakeholders for their comments and feedback.
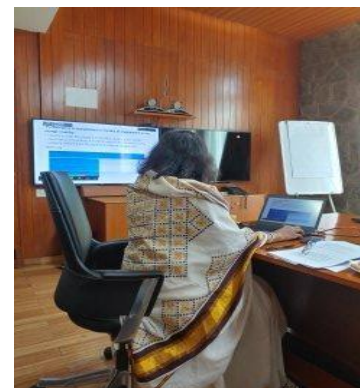
PRELIMINARY FINDINGS FOR VALIDATION

Retrospective and Prospective Analysis and the Evaluation Criteria: The evaluation team assessed the extent to which results have been sustainable, and in cases where expected results have already been generated, the team assessed the prospects for sustainability, i.e., the likelihood that the effects of UNFPA interventions will continue once the funding comes to an end. Questions were formulated to elicit this information; however, this was based on respondents' perceptions. Where interventions have been in effect for over several cycles (maturity), actual effects were observed. Previous evaluation findings and programme documents, CO

monitoring and performance data, and field observations were combined with interview data to substantiate ET findings. Relevance and Efficiency evaluation criteria were assessed mainly by reviewing the related policy and strategy documents, financial documents and face-to-face interviews with relevant stakeholders.

Stakeholder Participation: An inclusive approach, involving a broad range of partners and stakeholders, was followed. The evaluation team did a stakeholder mapping in order to identify both UNFPA direct and indirect partners (i.e. partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic areas in the national context). The stakeholders included representatives from the Government, civil-society organizations, academics, the private sector, UN organizations, other multilateral organizations, bilateral donors, and the beneficiaries of the programme. Key stakeholders were involved in several vital stages of the evaluation providing input to the design of the evaluation, validating the findings, and contributing to the future recommendations.

FIGURE 2: APPROACH TO STAKEHOLDER SELECTION
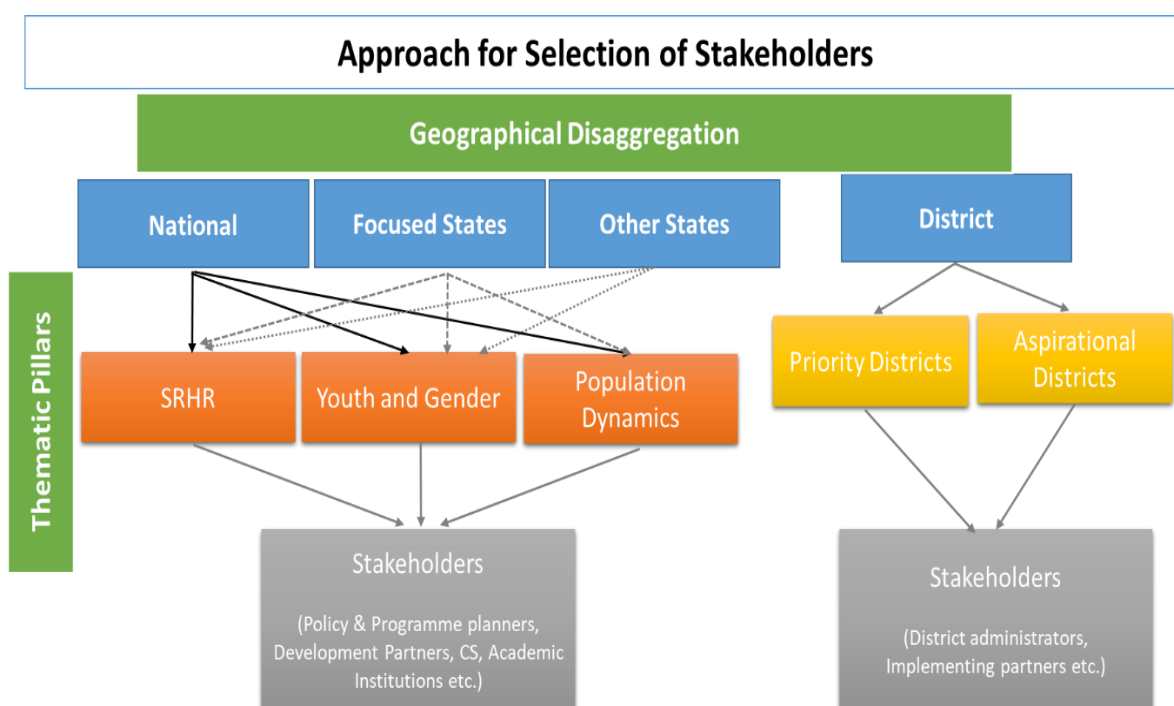
The sample size was adequate given the purposive stratification to cover different types of beneficiaries, which increased the precision of conclusions reached. While we employed the statistical idea of stratification, in an exercise such as CPE, sample size has limited meaning and to strengthen the validity, the team triangulated different points of views which is more important. (See Part 1 Annex 2 for the list of persons interviewed).

Based on desk review and discussions with CO staff, the evaluators developed the stakeholder map (Part1 Annex 3). These stakeholders are purposively selected through clearly defined criteria and as representative as possible, recognizing that it will not be possible to obtain a statistically representative sample. An inclusive approach, involving a broad range of partners and stakeholders, was followed. The evaluation team performed the stakeholder mapping exercise in order to identify both UNFPA direct and indirect partners (i.e. partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic area in the national context). These stakeholders included representatives from the Government, civil-society organizations, the private-sector, UN organizations, other multilateral organizations, bilateral donors, and most importantly, representatives of the beneficiaries of the programme -including marginalized and disabled groups or those representing these groups, as feasible.

Respondents and Representing Institutions	Male	Female	Total
UNFPA National and State Level	16	15	31
Other UN Agencies, RCO, Other Development Partners	3	15	18
National Government Level	7	5	12
National NGOs, Professional Councils	4	9	13
State Government Level	29	18	42
State Level Institutions	2	18	20
State Level Consultants	15	4	19
District Government Level	43	55	98
District Consultants	26	6	32
NGOs, CSO, Research Institutions, IPs	66	106	172
Adolescents and Young Representatives (in the community)	39	160	199
Specialists Working with Adolescents with Disabilities	1	4	5
Students (Adolescents in School)	27	96	123
Women's Groups and PRIs	10	69	79
Any Other (Teacher, School Management, Media)	2	54	56
Total	290	634	924

Detailed list of persons interviewed in Annex 2

Ethics and Maintaining the Quality of Evaluation: Ensuring the protection of respondents' rights, an informed consent was sought before all interviews were made. In residential schools where students under 18 years were gengaged, school principal gave the permission as they are authorized to do so. For the day school students, the school contacted the parents to obtain their consent prior to the interviews. The data collected were confidentially kept, with no identifiers. Where written consent was not applicable or feasible, verbal agreement was sought. UNFPA CO informed the respondents about the evaluation purpose and the rights and confidentiality of those participating in the evaluation and it was voluntary participation by those agreed to provide feedback.. The team followed UNEG guidelines and standards, as well as UNFPA's Handbook on "How to Design and Conduct a Country Programme Evaluation at UNFPA" in carrying out the CPE to ensure its quality.

ET followed a no harm principle; meeting national and sub-national level key stakeholders face-to-face was not a problem as there were no major restrictions, despite the COVID19 context. All planned meetings were kept based on stakeholders selected. Although the team hoped to meet non-beneficiaries of UNFPA interventions, it was not possible, but it did not affect the planned evaluation as this was something in addition that ET hoped to do if it was possible.

Limitations and Mitigation Measures: Sample is a purposive one and not a representative sample thus we cannot generalize the findings. Limited time duration in field sites, probable socially desirable responses, inadequate number of meetings with non-beneficiaries and PWDs, may have been some limitations. The time available and the logistical feasibility given the situation on the ground were not very conducive for conducting methodologically sound FGDs.

One area that COVID 19 situation affected was the inability to meet school children as the schools were closed and partial restrictions due COVID 19, it was hard to meet residential school children, including those with disability. Data collection online was also not an option as there was no way to obtain their email addresses. Due to COVID 19 restrictions and travel difficulties, interviewing people with disabilities was difficult. To mitigate this, NGOs representing people with disabilities were met to obtain data, but those were a very small number, and the findings cannot be generalized to a larger population. Questions were posed to midwifes on whether women with disability came to access institutional delivery and to IPs whether girls and boys with disability accessed life skill programs. However, they did not come to meetings with ET. Moreover, UNFPA disability inclusion was intensified only in 2020 and disaggregated data on populations with disabilities (PWDs) was limited.

TL REMOTE PARTICIPATION IN DATA COLLECTION WHILE A TEAM-MEMBER IS ON-SITE

Triangulation of different data sources and data collection methods and TL participating online most of the time regardless of the difference in time zone,CPE mitigated the limitations caused by the pandemic. The Selection of interventions was covered across the four States to understand the full spread of work CP9 had implemented. The four national consultants divided the interview visits based on their expertise to cover more ground and when feasible combined visits were made to achieve maximum out of the visits. Several rounds of meeting with CO and State staff helped clarify CP9 work programme and its implementation.

For obtaining feedback from school children, ET was able to meet representatives of peer educators, who are more active and knowledgeable adolescents. During the field trips ET met groups of adolescents who received services, but their experiences may not have fully illustrated the situation of the target groups. To minimize the effects of these gaps, we had detailed discussions with POs and the IPs who were in-charge of those programmes. ET conducted several small group discussions in multiple locations in the area to elicit required information. TL attended, virtually, most meetings and field visits and was able to work as a team. Towards the latter part of the evaluation TL joined the team in-country to continue with face to face interviews at the national level and virtual interviews at state-level.

CPE EVALUATION TEAM MEETING AT CO

Process Overview

The evaluation unfolded in five phases. Of the CPE five phases i) preparation, ii) design, iii) field, iv) reporting, and v) management response, dissemination and follow up, the preparatory phase was completed by the CO. The Design Phase included desk review of key documents; stakeholder mapping; analysis of the programme/intervention logic and reconstruction of the TOC, finalization of the evaluation questions, development of data collection and analysis strategy, and a plan for field phase; preparation of the evaluation matrix and presentation of the design report to the ERG and CO. ET met with UNFPA CO programme teams to go over the outputs and expected results in detail to agree on the indicators to be used and the list of key stakeholders for interviews. Upon approval of the design report by CO, APRO and ERG[8] data collection tools were refined, and field work started.

The Implementation Phase/Data collection and Analysis Phase: After the Design Phase, the team-initiated data collection in the selected states and districts.

Reporting Phase: Upon completion of preliminary analysis of data and the debriefing session, the first draft report is shared for review by CO staff, ERG, APRO and Evaluation Manager for feedback. The final draft, updated upon taking the feedback into consideration, will be shared with the national stakeholders and CO staff for validation. Revision will be made to fill the gaps, if any, and the finalization of the CPE report will be done based on the stakeholder feedback.

Preparation of the Management Response and the Dissemination of the final recommendations will be the CO responsibility. The CPE findings and recommendations will inform the development of CP10. The final report and evaluation quality assessment (EQA) will be posted in the UNFPA evaluation database and the country office will have the results and recommendations uploaded in their website.

Integration of Gender Equality and Human Rights Approach in the evaluation: GE and HR approach were integrated in the design, evaluation questions, selection of interview participants, in the overall evaluation methodology and analyses as well as in the conclusions and recommendations. GEWE is considered cross-cutting in CP9 and the team attempted to answer all the evaluation questions with a reflection on gender and HR concerns, while findings under Effectiveness provide detailed information of the CP9 GE strategic outcome.

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[8] *List of ERG members and their TOR included as an annex to the main TOR provided by the country office.*

Chapter 2: Country Context

India, a lower middle-income country with over 1.36 billion people[9], has been one of the fastest growing economies of the world. Remarkable economic growth of 6 to 8 percent annually in the past decade has led to an increase of GDP per capita income from US$ 1040.31.8 in 2005 to US$ 1410.42 in 2011[10]. As per Census 2011, 364 million people in India, or almost one-third of the country's population, are young people aged 10-24 years and contributing 34% to the GDP[11]. While economic growth has been unprecedented, levels of inequality and social exclusion remain significant. Disasters such as tropical cyclone, floods, earthquake, tsnaumi, drought, landslides, glacial lake outburst flood and cold wave are not uncommon and have an adverse effect on human development and economic growth[12].

The country is committed to universal health coverage for all its citizens; however, the allocation for health as a proportion of Gross Domestic Product (GDP) is 1.5 percent[13] one of the lowest in the world and is way below the 2.5% targeted for 2025 in the National Health Policy. On an average, about Rs. 5,357 in rural India and Rs. 13,292 in urban India were spent as out-of-pocket medical expenditure for hospital Childbirth. In Government/public hospitals, on an average, about Rs. 1,410 (about Rs. 1,305 in rural and Rs. 1,874 in urban areas) and in private hospitals about Rs. 21,231 (about Rs. 18,501 in rural and Rs. 25,096 in urban areas) were spent[14].

The proportion of pregnant women who have received four antenatal care visits has increased to 58.1% (2019-2020) probably due to greater push for increased coverage and quality of antenatal care through new schemes such as Pradhan Mantri Surakshit Matriya Abhiyan (PMSMA)[15]. Institutional deliveries have increased to 88.6% (2019-2020) and the deliveries by skilled birth attendants have increased to 89.4% percent (2019-2020), mainly due to the cash transfer schemes (*Janani Surakha Yojana* (JSY) and *Janani Shishu Suraksha Karyakram (JSSK).* Despite increase in maternal health indicators, the maternal mortality ratio (MMR) is still high at 113 per 100,000 live births (2016-18) (17% decrease from 2014-16)[16], with huge variations within and between states. Four out of ten maternal deaths occur among women aged 15-24 years. The official data on abortions in India is under-reported as many of the abortions are performed outside the public health system due to poor access as well as for reasons of privacy[17].

The estimated adult (15–49 years) HIV prevalence was about 0.22 percent in 2019 (declining trend)[18]. The push for anti-retroviral treatment (ART) has contributed substantially to the declining trend. The prevalence among pregnant women is 0.29 percent, though low, is higher compared to other countries in the region. It is estimated that approximately 20,000 pregnant women would require ART[19]. The prevalence of sexually transmitted infections (STI) as reported in NFHS-4 (2015-16) is 2.5 percent among women 15-49 years compared to 1.2 percent among men in the same age group[20].

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[16] UNFPA India. PSA, 2021

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[19] UNFPA India. PSA 2021.

[20] MOHFW. NFHS 4 (2015-16). IIPS Mumbai, 2017 (as quoted in UNFPA PSA 2021).

States with low fertility have the most skewed sex ratio. The sex ratio at birth is gender biased at 923 females per 1000 males as of 2011 which has declined from 935 in 2001[21]. The SRS 2016-2018 estimates that sex ratio at birth for India had declined further to gender biased at 899 in 2016-2018.

India is committed to end all forms of marginalization and discrimination against women. However, women remain the target for a range of gender-based violence- in public spaces and within homes. There are wide variations in social and human development indicators in geographical regions with states showing vast disparities in certain areas and populations (more details under the Development Challenges section). The government has requested several UN and other development agencies to develop districts that are lagging behind and in addition to these UNFPA has identified four states (Bihar, Madya Pradesh, Odisha, and Rajasthan) for development. Not limiting to these four states, there are other interventions located in several geographic areas which are also under the UNFPA development strategies. The section under Chapter 3, UNFPA's response through country programme, provides details about the states to which UNFPA provides sub-national level support as well as response to humanitarian related issues.

2.1 Development Challenges and National Strategies

2.1.1 Development Challenges

This section presents country's development challenges that are closely related to the UNFPA mandate.

The Ministry of Health and Family Welfare (MoHFW) intends to increase the public expenditure dedicated to health care, from 1.3 to 2.5 percent of the gross domestic product including to ensure provision of universal access to high quality health including reproductive health and family planning (RH/FP) services. However, challenges persist, like a lack of human resources, sub-optimal infrastructure, fragmented information systems, and limited managerial and technical capacity in the health sector, coupled with the effect of pandemic.

*Sexual and Reproductive Health and Rights (**SRHR**)*

While the institutional births have increased, (11.2% (2019-20) of women still deliver at home (mostly with unskilled providers, among rural and poor)[22]. Most of the maternal deaths are due to preventable causes. Inequity in access to Emergency Obstetric and Neonatal Care (EmoNC), poor quality of care, etc. are major factors that contribute to the continuing high maternal mortality, stillbirths and neonatal mortality.

While the prevalence of modern methods has increased, female sterilization is still the predominant method of contraception. The unmet needs have decreased due to increase in total contraceptive prevalence rate (CPR)which is 10 points higher than prevalence of modern methods of contraception[23]. The method mix of family planning use is skewed towards women with negligible coverage of male methods. A major issue that is plaguing India's family program is denial of informed choice and poor-quality services[24]. Socio-cultural barriers such as promotion of family planning methods among newly married or unmarried continues to affect the program. The national FP policies promote rights -based FP nevertheless, the provision of provider incentives for certain methods such as injectable, post-partum IUCD and sterilization run the risk of coercion of women to accept methods without informed choice and violation of rights.

By extrapolating WHO estimates of infertility in India, approximately 13-19 million couples are likely to be infertile in India. Major concerns are access to treatment, cost of treatment, ethical and legal aspects of treatments such as assisted reproductive technology. A commonly ignored SRH problem in women is cervical

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[21] Kumar Sanjay and K.M. Satyanarayana, 2012, Decadal Trends in District Level Estimates of Implied Sex Ratio at Birth, Demography India, 41, No1 and 1, 1-30

[22] MOHFW. NFHS 2015-2016. IIPS, Mumbai 2017.

[23] MOHFW. NFHS 4 and NFHS 5 data.

[24] UNFPA India. Studies on quality of post-partum IUCD insertion in two states 2016-17 and UNFPA and PSS. Quality assurance in rolling out of new contraceptives 2018-19

cancer. According to the global estimates for India, the incidence of cancer cervix is 18.7 per age-specific rate per 100,000 and mortality is 11.7 per age-specific rate per 100,000.[25] Only 30 percent of women aged 31-49 had screening done[26].

Heterosexual transmission is the predominant mode of transmission of HIV and STIs in India. The trends and transmission patterns of the epidemic follows the Asian Epidemic Model[27]. The low-risk women get infected by their spouses/partners who are clients of high-risk behavior groups such as sex workers, men who have sex with men, intravenous drug users, etc. It is clear that besides biological susceptibility, a greater role is played in transmission of HIV and STIs by prevailing gender inequalities, economic dependence, socio-cultural factors, intimate partner violence, lack of knowledge and empowerment to negotiate preventive behaviours, poor access to SRHR services, etc.

Youth and Adolescents

India ranks 133rd out of 183 countries in the 2016 Global Youth Development Index (YDI)[28]. There is increasing recognition of the need to invest in the health and development of young people, in order to harness the benefits of this demographic dividend. India's youth face several development challenges, including access to education, gainful employment, gender inequality, child marriage, youth- friendly health services and adolescent pregnancy[29]. Higher prevalence of NEET (not in education, employment and training) among young women in India could be due to the continuing high rates of early marriage and adolescent livebirths, which disrupts education, autonomy and in turn restricts prospects for employment[30]. There is a large, unfulfilled demand for access to contraceptive services and counselling and marked disparities in the unmet needs for contraception by age, rural residence, wealth quintiles, education and social class. The young people aged 15-24 face risks of early and unwanted pregnancy and other aspects related to their sexual and reproductive health. The adolescents and youth are particularly vulnerable to STIs and HIV/AIDS where stigma, and lack of knowledge about access to suitable and safe treatment continue to be key barriers [31]. Negative attitude of providers towards young people, low use of youth friendly services and current negative perception about youth friendly services remains a concern. The lives of girls and young women continue to be affected by poor access to improved sanitation and by low levels of knowledge to safely manage menstruation. Sensitivity around issues related to youth sexuality and sexual behaviours remains a barrier in designing and delivering comprehensive sexuality education initiatives in the country particularly within school-based initiatives. Outreach to more marginalized young people (especially early school dropouts, married adolescent girls) remains a concern.

Gender Equality and Women's Empowerment (GEWE)

India scores 0.488 on the Gender Inequality Index and ranks 122 of 162 countries as of 2020[32]. As discussed in Chapter 2, gender biased sex selection is prevalent in large parts of India, reflecting son preference and gender-discrimination. Underpinning this preference are expenses on dowry/marriage of daughters, patrilocal marriage systems, belief that lineage is through sons and sons look after parents, and norm that sons should do the funeral rites.[33] As per SRS 2016-2018, under five mortality rate is slightly higher for girls (37) than boys (36), and this

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[25] WHO. Globocon 2020

[26] MOHFW. NFHS-4 (2015-16). IIPS Mumbai, 2017 (as quoted in UNFPA PSA 2021)

[27] NACO. National strategic plan for HIV/AIDS and STI 2017-24, December 2017. MOHFW

[28] Global Youth Development Index 2016. Commonwealth Secretariat Youth Division. https://www.thecommonwealth-healthhub.net/global-youth-development-index-ydi

[29] UNFPA. Population Situation Analysis (PSA). UNFPA 2021

[30] UNFPA. Population Situation Analysis (PSA). UNFPA 2021

[31] UNFPA. Population Situation Analysis (PSA). UNFPA 2021

[32] United Nations Development Programme, 2020, Human Development Report, The next Frontier: Human Development and the Anthropocene, The UNDP, New York

[33] Kulkarni, 2020, Sex Ratio at Birth in India, Recent Trends and Patterns, UNFPA, New Delhi

gap is more in urban areas (27 for females vs 24 for males) than rural areas (41 for female's vs 40 for males)[34], reflecting neglect of the girl child. Female genital mutilation exists in a minority community in India[35]. Girl child sexual abuse (up to 18 years) is not uncommon and is higher than that of boys. As per National Crime Records Bureau as many as 21,605 child rapes were recorded in 2018, of which 21,401 cases were of girls [36]. Daughters of migrants (often SCs and STs), girls with disability in streets, girls in temporary shelters and children of sex workers are particularly vulnerable to sexual abuse[37]. Adolescent girls from marginalised communities are at times pulled out of school to look after siblings or for child marriage (higher amongst girls than boys), which has been discussed earlier. Forced marriage, honour killing and trafficking of girls for marriage are also issues, though data is not available[38]. Anaemia is higher amongst adolescent girls than boys, as well as low body mass index as per NFHS-5. 77.3% of young women use hygienic methods of protection[39] during their menstrual period as of 2019-21 (NFHS 5). Though gender parity in education is improving, the labour force participation of young women is lower than young men, as well as decision making, mobility and asset ownership[40]. Domestic work and child/elderly care is seen as women's responsibility. As per NFHS-5 only 25.4% of women who worked in the last 12 months were paid in cash, 43.3% owned land or house alone or jointly, and only 54% had a mobile phone they themselves could use. Women's independent decision making on health remains a concern. Twenty nine percent women aged 18-49 years report facing spousal violence in 2019-21 (NFHS-5).

The presence of 44% women in local government in rural areas in 2018[41], several women's self-help groups and federations, village health water and sanitation committees, patient welfare committees, social audits, maternal death audits etc. is an opportunity to strengthen gender equality towards SRHR[42]. There have been efforts at integrating gender equality in training to health providers. Yet gender biases persist in providing services such as denial of abortion and contraceptive services to unmarried women, forcing contraceptive service after delivery, verbally abusing women/girl patients, not being sensitive that a woman may be facing a health issue because of GBV or not maintaining confidentiality[43]. Yet another challenge in gender mainstreaming is that front line health workers are mainly women (Accredited Social Health Activist (ASHA) and village health nurses) and male front line workers are few to reach to men and adolescent boys[44].

Population Dynamics

India is the second most populated country in the world and with a projected annual growth rate of 1 percent, is slated to reach 1.52 billion in 2036. This throws up enormous development challenges. While there is an overall decline in fertility rate over time, the pace varies with some states still showing above replacement fertility rate.

Ageing and an increase in the share of older persons in the population poses a major challenge. By 2050, one out of every fifth person in India will be 60 years and above and this age-group will be the fastest growing sector of

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[34] Office of the Registrar General and Census Commissioner, Sample Registration System, Statistical Report, 2018, Ministry of Home Affairs, Government of India, New Delhi.
[35] United Nations, 2017, India Common Country Assessment, 2017, UNCT, New Delhi
[36] India Today, 2020, 109 children sexually abused every day in India in 2018: NCRB, January 12, 2020, UPDATED: January 16, 2020.
[37] United Nations, 2017, India Common Country Assessment, 2017, UNCT, New Delhi
[38] United Nations, 2017, India Common Country Assessment, 2017, UNCT, New Delhi
[39] The NFHS-5 considers locally prepared napkins, sanitary napkins, tampons, and menstrual cups to be hygienic methods of protection (International Institute of Population Studies and Ministry of Health and Family Welfare. 2021)
[40] Kaur et al, n.d. Changing Parental Attitudes and Shifting Value of Daughters Findings from four qualitative studies, UNFPA, New Delhi
[41] Social Statistics Division, 2020, Women and Men in India (A statistical compilation of gender related indicators in India) 2019, Social Statistics Division, Ministry of Statistics and Planning and Implementation, New Delhi.
[42] Social Statistics Division. "Women and Men in India (A statistical compilation of gender-related indicators in India) 2019." 21st Issue, Social Statistics Division, National Statistics Division, Ministry of Statistics and Programme Implementation, Government of India
[43] Nair, M.R and Ravindran, T.KS, 2012, Gender in the HLEG Report, Economic and Political Weekly, Vol. 47, Issue No. 08, 25 Feb, 2012
[44] Saha, 2017, Why India needs more male health workers to tackle the maternal health crisis, Hindustan Times, March 22, 2017

the age pyramid[45]. This ageing may be accompanied by a rise in disabilities[46] and may disproportionately affect women, since women in India are more likely to outlive men. Thus, ageing poses new challenges to a nation that is used to focusing on the young.

Figure 3 : Population Pyramids – India (2011 & 2036)

Changing Age-structure India: 2011 and 2036
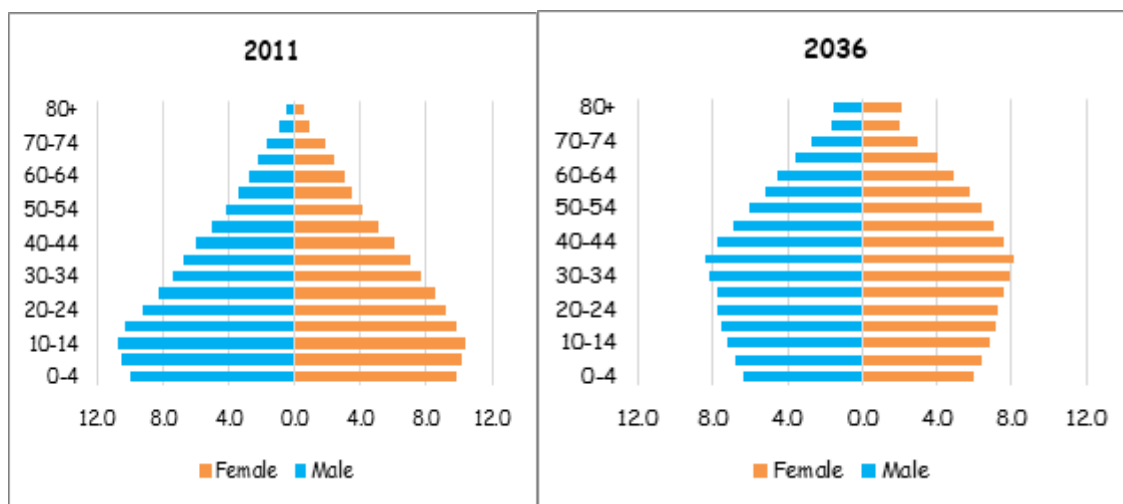
Source: **Source***: Population projections for India and states 2011 – 2036. Report of the technical group on population projections (Government of India, 2019).*

The demographic dividend that is driven by the working age group is critical to India's future- with service driven growth, this will be intertwined with the growth of urbanization with rural -urban migration (including interstate migration) playing an important part. The process of urbanization has tended to increase inequality-between the skilled and the unskilled. [47] It has been argued that official statistics undercount internal migrants[48]. Even with this underestimate, rural to urban migration forms 24 percent of the increase of urban population between 2001 and 2011. A whopping 35.2 percent of urban India was estimated to live in slums in 2018[49]. Therefore, sustainable equitable growth of both rural and urban spaces and the households that live in those spaces is a development challenge that India faces.

Emerging Issues COVID-19: Challenges in development

The COVID-19, a global pandemic and one of history's greatest public health disasters stuck the country. India witnessed rapid rise in cases and the government announced nationwide lock-down in March 2020, which continued nearly 68 days, after which slowly, the nation re-opened in a gradual manner. However, the active cases continued to increase around until around September 2020. As of April 7, 2021, a total of 12.8 million confirmed cases have been reported. More importantly, the country witnessed a second peak around April/May 2021, with more than 100,000 reported cases daily. During lockdowns, initially there were disruption on health services, as the health system was focusing mainly on the case management, however, slowly, SRHR services were resumed. UNFPA advocated with the Ministry of Health and Family Welfare and provided technical support

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45 UNFPA India (2011) Demographics of Population Ageing in India, UNFPA India New Delhi
46 UNFPA India (2011) Disability among elderly in India 2011, UNFPA NewDelhi
47 Jayanthakumaran K et al,(2019); "Introduction" in Jayanthakumaran, Verma, Wan & Wilson (Eds) Internal Migration, Urbanization, and Poverty in Asia: Dynamics and Interrelationships, ADB, Springer Open.
48 Nayyar G and Kim KY, (2018) India's Internal Labor Migration Paradox The Statistical and the Real World Bank Policy Research Working Paper 8356 February 2018
49 https://data.worldbank.org/indicator/EN.POP.SLUM.UR.ZS?locations=IN

in issuance of guidelines to consider reproductive health services and contraception as essential health care. In addition, UNFPA oriented officials of the one-stop centres, counsellors and helpline staff to address GBV services during the pandemic. As mentioned above, during the lockdown, initially there were disruption of essential health services due to supply side and demand side factors and the focus was mainly on the case management.

2.1.2 National Strategies

The National Health Mission (NHM) envisages universal access to equitable, affordable and quality health care services to all citizens through systems and institutions that are accountable and responsive to people's needs[50]. It has three important components- health system strengthening: reproductive, maternal, newborn, child and adolescent health (RMNCAH) and control of communicable and non-communicable diseases. The National Urban Health Mission (NUHM) is under the NHM[51]. The Government has launched many flagship programmes and one is the 'Transformation of Aspirational Districts' Programme (ADP) that aims to transform 117 backward districts with poor development parameters.

To improve universal access to health, the Ayushman Bharat programme was launched in 2018 and 150,000 Health and Wellness Centres (HWCs) in it seeks to provide comprehensive primary health care along with Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) to provide insurance coverage to poor and vulnerable families. Both the schemes include maternal health, family planning as well as adolescent health. It also includes coverage of services for screening and management of cervical cancer. Government of India has launched a population-based prevention, screening, and control programmes for cancers of the cervix and the breast for the first time.

Sexual and Reproductive Health and Rights (SRHR)

Under the family planning program, Mission Parivar Vikas (MPV) was introduced in 146 high fertility districts with TFR of 3 and above in 2016. Expansion of the basket of methods for spacing (such as the introduction of injectable in the public sector and promotion of centchroman (once-a-week pill) was introduced in 2016/17.

Under maternal health, several schemes were implemented to improve the access to institutional deliveries and antenatal care with a focus on poor and marginalized populations such as the JSY and JSSK schemes (initiated in 2011). The Dakshatha programme was initiated in 2015 to build skills for quality improvement at delivery points and is continuing. The LaQshya program was initiated in 2017 to improved quality of care in labour room and maternity operation theatres in public health facilities. Surakshit Matritva Aashwasan (SUMAN) launched in 2019 provides assured, dignified, respectful and quality health care at no cost and zero tolerance for denial of services for every mother and newborn visiting the public health facilities. The PMSMA, focusing on access, quality and coverage of antenatal care was initiated in 2016. The midwifery initiative was launched in 2018 through a cadre of Nurse Practitioners in Midwifery who are capable of providing compassionate women-centred, reproductive, maternal and newborn health care services. Revised guidelines on comprehensive abortion care have been introduced and the MTP act has been revised to enable wider access to safe abortion services as well as extension of duration of pregnancy when abortions can be legally performed. Another important policy decision was universal screening of pregnant women for HIV and STIs.

Youth and Adolescents

Youth in India continues to be a national priority[52]. Policies prioritise enabling youth, the need for quality education, healthy individuals, equal access to skills development as key pillars for full participation of youth and building gender sensitivity among students.[53] [54] Key national programmes and schemes reiterate the national response such as the RKSK program responding to needs of young people (10-19 years) married and unmarried

50 MOHFW. Annual report 2019-2020.
51 MOHFW. A strategic approach to reproductive, maternal, newborn and adolescent health (RMNCAH +A) in India. 2013
52 National Youth Policy 2014. Minustry of Youth and Sports Affairs Government of India.2014.
53 Three-year (2017-20) action plan, National Institution for Transforming India (NITI) Aayog.
54 National Education Policy 2020. Ministry of Human Resource and Development. Government of India. 2020.
https://www.education.gov.in/sites/upload_files/mhrd/files/NEP_Final_English_0.pdf

in communities and schools in a phased manner in 214 out of 709 districts across the country through youth friendly services (YFSs). It is one of the first youth centric public health programme that squarely recognizes the importance of responding to mental health concerns of young people. The school health component of Ayushman Bharat[55] is a joint programme between the Ministries of Education and Health targeted at upper primary and secondary levels of schooling (ages 11-17) and is being implemented in 191 districts in Phase one 1. This initiative will strengthen and harmonize existing programs such as RKSK, Weekly Iron and Folic Acid Supplementation (WIFS), deworming, Menstrual Hygiene Management (MHM) and linkages with Rashtriya Bal Swasthya Karyakram (RBSK) mobile health teams).[56]

Gender Equality and Women's Empowerment

The National Policy for Women, 2016[57] prioritizes among others, a life cycle approach to women's health, enhancing male involvement in contraception, transforming discriminatory attitudes through community involvement, eliminating all forms of violence against women and girls, and forming alternative dispute redressal systems like Nari Adalats (women's courts). Key legislations related to gender equality include the Preconception and Prenatal Diagnostic Act, 1994 (PCPNDT Act), the Protection of Women from Domestic Violence Act (2005), the Child Marriage Prohibition Act 2006, the Sexual Harassment of Women at Work Place (Prevention, Prohibition and Redressal) Act, 2013. At times, young adults who enter into relations/marriage by choice are booked under the CMA, as well as the Protection of Children from Sexual Offences Act, 2012. The Rights of Persons with disability Act, 2016 refers to ensuring access of women with disability to SRH health, while the Transgender Persons (Protection of Rights) Act (2019) emphasizes non-discrimination and access to sex reassignment surgery and hormonal therapy.

There are also a variety of schemes related to gender equality and women's empowerment. Beti Bachao, Beti Padhao (BBBP) is a national initiative to address the issue of the declining child sex ratio (CSR). The scheme for Adolescent Girls (SAG) focuses on out of school adolescent girls in the age group of 11-14 years, which aims to motivate these girls to rejoin the school system and empower them. One stop crisis centres under the Sakhi Scheme aid to provide integrated support and assistance under one roof to women and girls below 18 years irrespective of caste, class, education, marital state and culture, affected by violence in private or public spaces. The National Rural Livelihood Mission commenced in 2011 focuses on strengthening women's skills and livelihoods through women's collectives/self help groups and federations.

Population Dynamics

To deal with inequality in urban spaces, there is a move towards skilling urban labour. The National Urban Livelihood mission fosters self-employment and is targeted to the urban poor. To alleviate problems of housing, the Pradhan Mantri Awaas Yojana (PMAY) targets housing for all-in targeting particularly the urban poor-these include those living in slums. Migrants form an important part of this group. The support for the old is still muted with the old, widowed and disabled getting transfers as a part of the National Social Assistance Scheme. More recently, Atal Pension Yojana is a contributory pension scheme, benefits of which yield to those in unorganized sector, when they turn 60.

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55 Operational Guidelines, Ayushman Bharat: Comprehensive Primary Health Care through Health and Wellness Centres. National Health Systems Resource Centre (NHSRC), Ministry of Health and Family Welfare (MoHFW), Government of India. 2018. https://ab-hwc.nhp.gov.in/document/6, https://pmjay.gov.in/
56 Building Blocks of a Vibrant Nation – Investing in Adolescents in India. Submitted by Adolescent Health Working Group, Adolescent Health Division. Ministry of Health and Family Welfare. Government of India.2018.
57 Ministry of Women and Child Development National Policy for Empowerment of Women. 2016.

2.2 The Role of External Assistance

India is among top ten recipients of gross Official Development Assistance (ODA) and in 2018 it was USD million 5,699.5 and USD million 6,012.8 for the year 2019.[58] During the CP9 period, figures are currently available only for 2018 to 2019. Out of the top ten donors, Japan has the highest contribution, averaging USD million 2,466 in 2018 and 2019. Other key donors in these years, in the order of the amount contributed, had been International Development Association (IDA), Germany, France, EU Institutions, UK, Global Fund etc.(see Figure 4 below). Bilateral ODA by sector shows that expenditure on social sectors have been fairly small (Education 4%, Health and Population 2%, other social infrastructure 8% whereas on economic infrastructure stands at 74%).

According to the World Bank figures[59], net ODA received as a percent of central government expense shows a decline, for example it was about 0 .77% in 2017 and the expenditure as a percentage has been 0.58% in 2018, showing a downward trend. However, more recent figures are not available for comparison at the moment.

FIGURE 4 : ODA FOR INDIA USD MILLION (2018-2019 AVERAGE)

Source: https://www.oecd.org/dac/financing-sustainable-development/development-finance-data/aid-at-a-glance.htm

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[58] OECD-DACAidataglance (www.oecd.org/dac)
[59] https//data.worldbank.org/indicator/DT.ODA.ALLD.CD
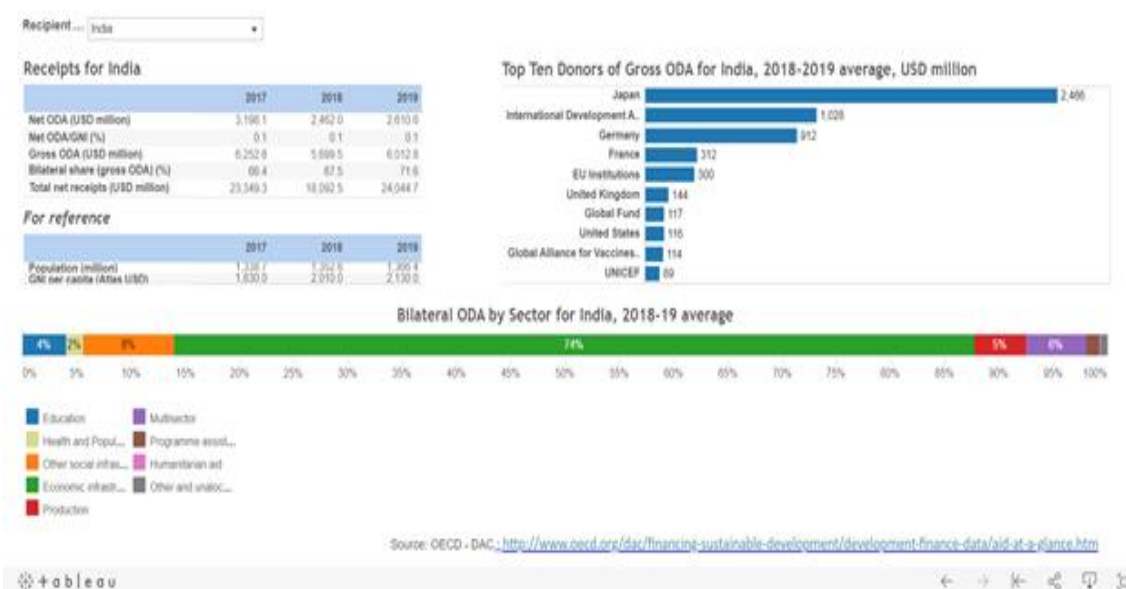
Chapter 3: UNFPA Response and Programme Strategies

3.1 UNFPA Strategic Response

Guided by the global corporate strategy set out in the UNFPA strategic plan, the 2018–2021 Strategic Plan (SP) covers the first of three UNFPA strategic plans leading to 2030. It describes the transformative results that will contribute to the achievement of the SDGs. The 2030 Agenda for Sustainable Development provides an opportunity to promote these transformative results and to implement the Programme of Action of the International Conference on Population and Development (ICPD POA). By aligning the strategic plan to the SDGs, most directly to Goal 3 (Ensure healthy lives and promote well-being for all at all ages); Goal 5 (Achieve gender equality and empower all women and girls); Goal 10 (Reduce income inequality within and among countries); Goal 16 (Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels); and Goal 17 (Strengthen the means of implementation and revitalize the global partnership for sustainable development), UNFPA plays a unique role addressing developmental issues with an emphasis on sexual and reproductive health (SRH), reproductive rights (RR), and gender equality (GE) within the context of ICPD POA and SDGs, particularly SDGs 3 and 5.

SP 2018-2021 reaffirmed the strategic direction represented by the "bull's eye." UNFPA, globally, works around three transformative and people-centred results in the period leading up to 2030: (a) an end to preventable maternal deaths; (b) an end to the unmet need for family planning; and (c) an end to gender-based violence and all harmful practices. This is planned to be implemented through: UNFPA "bull's eye" as shown below, for three consecutive strategic plan cycles. The implementation process will be enabled by evidence and population expertise, with a special focus on empowerment of women and young people, especially adolescent girls, both in humanitarian and development settings.

FIGURE 5: STRATEGIC DIRECTION OF UNFPA, THE "BULL'S EYE"
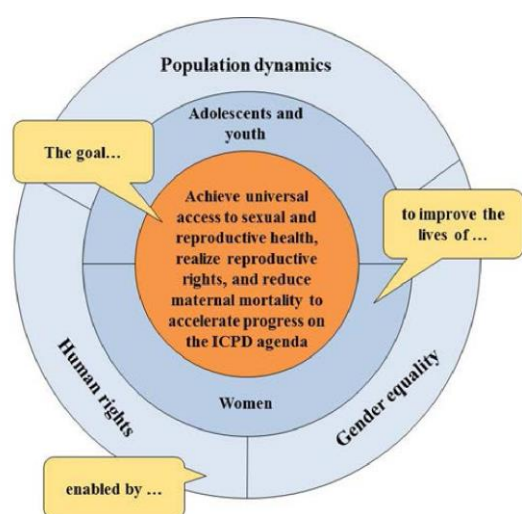
The bull's eye, the overarching goal to achieve universal access to sexual and reproductive health and reproductive rights (SRHR), has brought clarity and focus to the work of UNFPA. SRH and rights (SRHR) are essential for advancing the SDGs in all UNFPA contexts of operation. UNFPA has taken steps to integrate it into the theory of change, the modes of engagement and the integrated results and resources framework (RRF)[60].

UNFPA uses its strategic plan to mobilize and align its institutional strategies to the 2030 Agenda, and, throughout the period of its three strategic plans, the organization will monitor the 17 UNFPA-prioritized SDG indicators. To achieve the three transformative results, the strategic plan emphasizes the need for strengthened

partnerships and innovation.

While SP 2014-2017 covered the transition from MDGs to SDGs, SP 2018-2021 is the first cycle of the three SPs leading to 2030 where the achievement of the "three zeros[61]" (transformative results) are planned.

UNFPA's Global Gender Strategy 2018-2021 (Gender Equality Strategy 2018-2021) adopts a two-pronged approach to operationalize gender and rights aspects of its results framework. The first is to mainstream gender, and the second is to have dedicated outcomes for gender equality and reproductive rights (UNFPA, 2019). Priority

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[60] UNFPA Strategy Plan (SP) 2018-2021

[61]Three zeros are to: (a) end the unmet need for family planning; (b) end preventable maternal deaths; and (c) end gender-based violence and harmful practices, including child marriage by 2030.

areas for actions to promote gender equality include strengthening legal, policy and accountability frameworks to gender equality and reproductive rights, strengthening civil society and community action against discriminatory practices and norms against women and girls (including working with men and boys), strengthening multi sectoral approaches to prevent and address GBV, strengthening response to eliminate harmful practices affecting women and girls, and strengthen capacities to develop gender responsive data, statistics, and use it for SDG monitoring (as relevant to UNFPA mandate), advocacy and dialogues.

"My Body, My Life, My World!", UNFPA's new global strategy on adolescents and youth, supports the implementation of Youth 2030. It puts young people at the centre of and embraces all adolescents (aged 10 to 19) and youth (aged 15 to 24). It is integral to UNFPA's efforts to achieve three transformative results by 2030 through leadership and innovation of young people for young people, in development, in humanitarian action and in sustaining peace. The strategy prioritizes every young person to have the knowledge and power to make informed choices about their bodies and lives, using sound evidence in designing comprehensive strategies to deliver rights and choices and shared leadership and shared responsibility through government and non-government agencies including youth led and youth serving organisations. The strategy recognizes heterogeneity of youth needs and reaffirms sexuality as a positive dimension of personality.

UNFPA has paid special attention to the humanitarian programming, therefore, the UNFPA Global Response Plan is fully aligned to and part of the UN Secretary General's three-step plan to respond to the devastating socio-economic impacts of COVID-19. UNFPA's plan complements the WHO COVID-19 Strategic Preparedness and Response Plan. At the global and regional levels, UNFPA is part of the coordinated UN response under the Inter- Agency Standing Committee (IASC) COVID- 19 Global Humanitarian Response Plan.

The section below discusses the programme specific to UNFPA India.

3.2 UNFPA Response through the Country Programme

3.2.1 Brief Description of Previous Cycle Strategy, Goals and Achievements

Implemented at the national level and in five states (four CP9 states and Maharashtra), UNFPA CP8 (2013-2017) spanned across two SP cycles, 2010 to 2013 and SP 2014-2017 and was planned within the context of India's commitments to the Millennium Development Goals (MDGs) and other international commitments related to UNFPA CP8 thematic areas. The latter part of CP8 took into account the new global agreements on SDGs. CP8 strategy was on policy advocacy, knowledge management and capacity development, specifically to strengthen health systems to provide high-quality sexual and reproductive health services, including family planning services, with a focus on vulnerable and marginalized populations; strengthen capacity of state and non-state entities to promote gender equality, with an emphasis on reversing son preference, empowerment of adolescent girls, and women's and girls' rights in RH/FP and Population Dynamics programmes; and to strengthen national capacity to incorporate population dynamics in relevant national and sub-national plans and programmes, with a focus on gender and social inclusion.

CP8 had made crucial contributions to major national and state programmes: the Adolescence Education and Health Programmes, Youth Policy (Odisha) and Girl Child Policy (Rajasthan). The Government had scaled up state-level pilot initiatives, such as the Logistics Management Information System and Life Skills Education in tribal schools (Odisha). Programming for A/Y had been a major comparative strength, and UNFPA's greatest asset and source of added value is its ability to mobilize high quality technical assistance (TA) and expertise for national priorities. UNFPA has made significant contributions to design and implementation of large national and state adolescent health and life-skills programmes. In RH/FP, although there have been achievements, the limited scope of support had led to loss of leadership in FP and maternal health, within the context of ICPD frameworks. UNFPA helped to strengthen the health system by improving the availability and quality of services in underserved areas, with a focus on vulnerable populations and young people, through support for the development of the RMNCH+A strategy of the MOHFW. UNFPA support also laid the foundation for policy

changes in contraceptive social marketing (CSM) through a nationwide assessment and enabled the family planning (FP) programme to procure depot medroxy progesterone acetate (DMPA), thus expanding the basket of contraceptive methods. CP8 contribution to GBSS initiatives during CP8 has been effective and significant, and is now in a phase of experimentation, with initial steps to develop sustainable capacity development systems. The PD programme had made strong contributions to progress on GBSS, ageing, and social inclusion in Odisha, but overall underinvestment had led to mixed results and missed opportunities for enhancing results across all themes in CP8, especially in the planned focus on social inclusion.

3.2.2 Current UNFPA Country Programme

Given the middle-income country status of India, UNFPA supports the consolidation of earlier achievements as well as 'upstream' policy development, advocacy and Knowledge Management in line with the strategic focus of UNFPA's interventions.

The ninth cycle of assistance, 2018-2022, builds on the CP8 achievements and national priorities articulated in the Three-Year Action Agenda, 2017-18 to 2019-20 of NITI Aayog and is partially guided by the priorities identified in the United Nations Sustainable Development Framework (UNSDF 2018 – 2022), based on consultations with the Government and civil society. Furthermore, the UNFPA supported programme is based on national ICPD and SDG-related goals and priorities. The UNFPA Country Programme (CP) contributes to selected results of the UNSDF and in turn to national priorities according to UNFPA's comparative advantage in the country, building on past support and achievements.

The focus of the programme is to support national efforts in achieving universal access to sexual and reproductive health and reproductive rights, including family planning, and to promote gender equality and rights of adolescent girls and young women. UNFPA prioritizes its attention on the most vulnerable and marginalized young women and girls by concentrating in four states (Bihar, MP, Odisha and Rajasthan) identified by the Government as a priority for United Nations assistance. Within each of these states, UNFPA selected two to three high-priority districts for CP9, based on a vulnerability mapping exercise during CP design stage. Government of India later suggested that UNFPA include some of the aspirational districts identified by GoI. Thus, the final list of 15 districts reflected some districts that UNFPA had identified and some that NITI-Aayog had designated as aspirational, For more details see table illustrated in Part 2 Annex C on sampling.

FIGURE 6: MAP ILLUSTRATING THE CP9 INTERVENTION SITES

State-level presence supports the engagement of state governments in rolling out and implementing policies and plans at local levels with the aim of testing and scaling up interventions. UNFPA provides technical support to national schemes to implement innovative models for life skills and empowerment of young women and adolescent girls, especially from scheduled castes, tribes, minority communities and slums in the high-priority districts. CP9 envisages that results and evidence from these interventions will be leveraged to influence positive shifts in national policies, plans and programmes. Geographical coverage showing focused as well as other States supported by UNFPA with programmes and interventions are depicted in the map. However, in addition to the four focus states, there are other states (Punjab and Gujarat) receiving UNFPA development assistance. The map shows only key areas of support and there are other sites (which are not marked) with isolated development interventions supported by UNFPA which will be discussed later in the findings section.

At the national level, UNFPA provides upstream policy advice and technical support to flagship Government programmes on health, young people and girls' empowerment, including identifying and addressing bottlenecks in their implementation. With the above programming context, three Country Programme Outputs have been formulated, which in turn fall under and contribute to four outcomes of the UNFPA Strategic Plan, as follows:

TABLE 4: CP9 OUTCOMES AND OUTPUTS

Outcome	Outputs
Sexual and reproductive health (Strategic Plan Outcome 1) Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence.	1. Increased national and subnational capacity to provide accessible, high-quality, rights-based and integrated sexual and reproductive health services.
Youth and Gender (Strategic Plan Outcome 2 and 3)SP Outcome 2: Every adolescent & youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health & reproductive rights, in all contexts. Outcome 3: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings	CP9 Output 2 contributes to SP Outcomes 2 (based on CO feedback). GE cuts across all three outputs. 2: Strengthened capacities of Government and civil society to empower adolescents, especially young women and girls, with knowledge, life skills and assets so as to exercise agency
Population dynamics (Strategic Plan Outcome 4) Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development.	3. Strengthened national capacities to include population dynamics in sustainable development planning efforts and in rights-based policies and programmes at national and state levels.

For each of the outputs, an operational plan along with types of intervention proposed to be pursued, had been developed at the beginning of the CP-9 implementation. The operational plan served as the basis to assess the progress of implementation of various activities by the mid of the programme cycle. However, it also considers the emerging priorities due to changing context with the introduction of new policies and programmes by the Central Governments and requests made by the state governments.

Theory of Change (TOC): The country office provided the TOC based on the outputs and outcomes shown above. For each of the outputs, CO provided an operational plan along with types of intervention that was developed at the beginning of the CP-9 implementation. The operational plan served as the basis to assess the current programme and through discussions with CO staff and document review provided background for updating/reconstructing the existing TOC considering the emerging priorities due to changing context with the introduction of new policies and programmes by the Central Governments and requests made by the state governments as well as response to COVID19. While the TOC was developed at the time of programme design

stage, there had been several changes as well as emerging issues such as COVID19 which changed the operational strategies as well as interventions; and as such, these were not reflected in the TOC presented to the team for evaluation. Reconstructed TOC diagrams are presented in Part 2 Annex E and was reconstructed based on the current programme in consuotation with programme staff. Under the findings (for eg., Finding # 2) TOC is discussed in connection with CP9 results.

SRHR output contributes to SP SRHR outcome 1. Three main strategies were identified in the CPD and CPAP. The CPE modified Theory of Change (TOC) identifies four strategies. Strategy 1 focuses on enhancing capacities of the health systems at the national level and identified states for providing high quality family planning services. Strategy 2, which is new and added in the context of MoHFW's focus on midwifery on strengthening quality of maternal care including support for midwifery, Strategy 3 focuses on contribution to an enabling environment by promoting reproductive rights and quality of FP/RH services including in disasters. Strategy 4 focuses on advocacy for improved access of young people to SRH services and information.

Under youth and gender component, the youth outcome is related to SP outcome 2: Every adolescent and youth, in particular adolescent girls, and young women, is empowered to have access to sexual and reproductive health and reproductive rights in all contexts. The CO output 2 is on strengthened capacities of government and civil society to empower adolescents, in particular young women and girls with knowledge, life skills and assets to exercise agency. There are four key strategies in the reconstructed ToC which is the same as in the previous one. However, within each strategy key focus areas have been added based on the CP9 interventions. Strategy 3 and 4 are shared with interventions related to gender. Strategy 1 focuses on integrating and institutionalizing life skills-based education in formal and non-formal school systems. Within this institutionalizing LSE, integrating a gender transformative based curriculum and strengthening access to SRHR services for adolescents and youth have been added. Strategy 2 is facilitating integration of LSE in vocational training and livelihood programs. Strategy 3 is to support multistakeholder sectoral interventions to empower young women and girls particularly the marginalised and vulnerable within which focus areas of demonstrating innovative pilots and strengthening access to SRHR services for adolescents and youth has been added to existing focus areas. Strategy 4 to undertake upstream policy advocacy to address harmful practice and empower girls within amplifying youth voices and engagement with youth led organisations has been added.

Although there was no separate output to support SP outcome 3, the interventions related to Gender were included under the CP outputs 1,2 and 3. Interventions related to CP output 1 are inclusion of integrated approaches to delivery of SRH/health services including to survivors of GBV, Integration of gender and rights into quality of training of service providers on maternal health and contraception, Integration of gender and rights into SRH services for youth, Engaging with PRIs on preventing and addressing GBV, Engaging with media prevention/addressing GBV and sharing of work during COVID-19 response; Strengthening rights based perspective into ART/Surrogacy bill. Interventions related to gender mainstreaming/specific interventions related to output 2 are integration of gender transformative approaches in AE curriculum in school systems, promotion of linkages between adolescent girls and vocational training programme to promote economic empowerment, promotion of adolescent/ youth groups and child protection committees to monitor and reduce harmful practices against girls/young women, strengthening of capacities of national and state government/other stakeholders for implementation and monitoring of policies/laws to address GBSS/child marriage, integration of gender and rights into debates on adolescent and youth sexuality, consent and age at marriage, integration of gender in menstrual hygiene management strategies Interventions related to gender integration in output 3 include Gender and Rights based Inputs into ICPD+25 process and Strengthening NFHS-5 questions on decision making on gender and sexuality and strengthening analysis of NFHS 4 data on gender based asset ownership.

Key operational strategies under the output 3, Population Dynamics are to a) Support with data and evidence building, specifically program support to UNFPA thematic areas, support with data and evidence building during COVID, b) Capacity building on gathering and using population data by engaging and mentoring young faculty members to undertake research and support institutions and researchers working with population data; building capacity of National and Subnational (states and districts) government officials; capacity building to enhance census operations and to collect SDG indicators in UNFPA mandated themes; sensitizing Parliamentarians and government officials to the need for data and evidence based policy and Advocacy on emerging population issues by raising awareness of policy makers, government officials and society about emerging population issues, data and evidence building, support resource mobilization, and disaggregated data on SDGs for policy and programmes.

3.2.3 The Country Programme Financial Structure

Given the middle-income country status of India, UNFPA supports the consolidation of earlier achievements as well as 'upstream' policy development, advocacy, and Knowledge Management in line with the strategic focus of UNFPA's interventions ((CPD) 2018-2022, July 2017).

TABLE 5: OVERVIEW OF THE BUDGET (ALLOCATION INDICATIVE) FOR THE PROGRAMMATIC AREAS OF CP9: 2018-2020 (USD) INDICATIVE FIGURES

SP Outcome areas		RR	OR	Total
Outcome 1	SRHR	9.0	9.5	18.5
Outcome 2 & 3	Youth and Gender	10.0	9.0	19.5
Outcome 4	PD	2.5	1.0	3.5
PCA		1.5	0	1.5
Total		23.0	20.0	43.0

The overall indicative budget for CP-9 is $ 43.0 million, out of this, $ 23.0 million are from regular resources and $ 20.0 million are to be mobilized through co-financing modalities. Tables 5 & 6 provide indicative budget information during CPD approval, as per CPD 2018-2022 and actual budget and expenditure details of the UNFPA programme in India by year and thematic areas. The budget includes both from regular sources as well as those mobilized by the country office.

TABLE 6: OVERVIEW OF THE BUDGET ACTUAL ALLOCATION AND EXPENDITURE (ALL FIGURES IN USD MILLIONS)

Thematic Area	2018		2019		2020		2021 * (TENTATIVE)	
	BUDGET	EXPENDITURE	BUDGET	EXPENDITURE	BUDGET	EXPENDITURE	BUDGET	EXPENDITURE Until SEPTEMBER 2021
Sexual and Reproductive Health	2.76	2.42	2.76	2.60	4.24	4.16	3.72	3.13
Adolescents & Youth	3.25	2.74	3.68	3.21	2.40	2.17	4.24	2.26
Gender	0.65	0.57	0.48	0.35	0.82	0.67	1.18	0.67
Population Dynamics	0.75	0.61	0.62	0.54	0.86	0.83	0.79	0.45
Programme and Coordination Assistance	0.28	0.27	0.28	0.26	0.24	0.23	0.50	0.40
Advocacy and Communication					0.17	0.17	0.02	0.02
Total	**7.69**	**6.61**	**7.82**	**6.96**	**8.73**	**8.23**	**10.45**	**6.93**

The implementation rate per thematic and geographic aeras are presented in figures 7 and 8 below.

Implementation Rate by Theme and Year, 2018- 2021
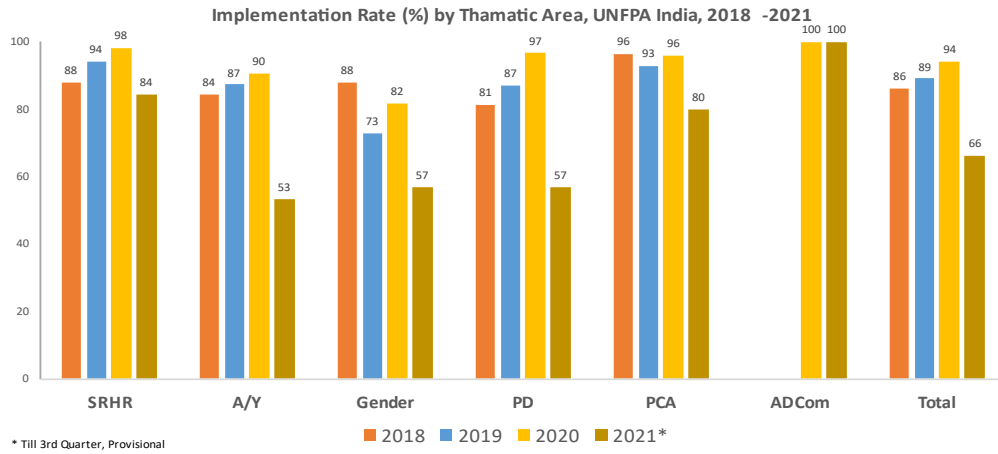
Implementation Rate (%) by Thamatic Area, UNFPA India, 2018 -2021

* Till 3rd Quarter, Provisional

Implementation Rate by Geography and Year, 2018- 2021

Implementation Rate by Geography UNFPA India, 2018 -2021

* Till 3rd Quarter, Provisional
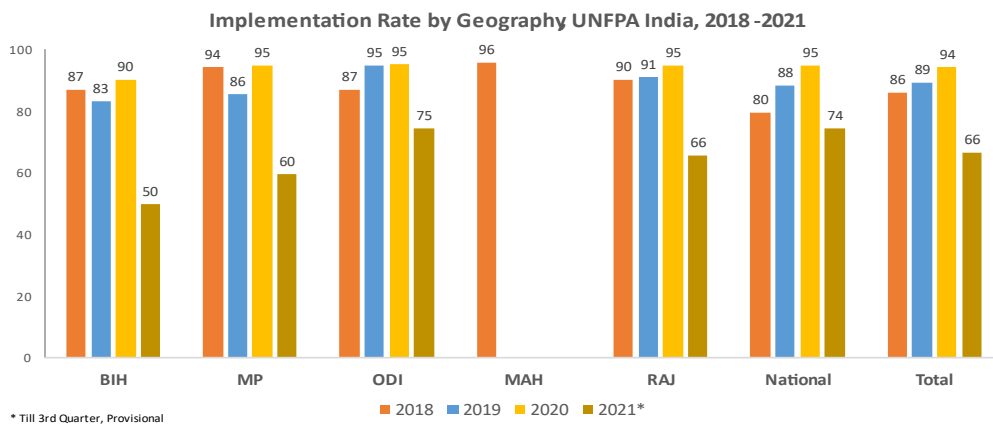
Chapter 4: Findings - Answers to the Evaluation Questions

This chapter provides the answers to the main evaluation questions. Key assumptions that were made (refer to Evaluation Matrix-Annex) at design stage are assessed using findings from triangulated data sources.[62]

4.1 Answer to Evaluation Questions on Relevance

Relevance brings into focus the correspondence between the objectives and support strategies of the CP, on the one hand, and population needs (with a specific attention given to the needs of the most vulnerable and marginalized), government priorities, and UNFPA global policies and strategies on the other. In particular, it will look into the extent to which the objectives of the UNFPA CP correspond to population needs at country level and were aligned throughout the programme period with government priorities, with strategies of UNFPA and UNDAF/UNSDCF.

Relevance: Evaluation question 1(EQ1):

To what extent are the objectives of the programme

- (I) *adapted to the needs of adolescents, youth, disabled, and women in the population (including needs of the most vulnerable groups), including in the humanitarian and COVID-19 contexts,*
- (II) *aligned with government priorities,*
- (III) *in line with the 2030 Agenda, ICPD Program of Action, and UNFPA Strategic Plan 2018-2022; and*
- (iv) *to what extent has the country office been able to respond to changes in national needs and priorities caused by major political and other contextual changes (such as COVID19 & humanitarian situation which are embedded in first part of the question) discussed above)?*

CP9 has three (3) outputs under four SP outcomes. Due to the commonalities across all 3 outputs, the Relevance criterion is discussed together for all three outputs

Summary of findings

UNFPA CP 9 is aligned with national program priorities and strategies related to programmes under SRHR, GE, PD, as well as health and education such as Ayushman Bharat, RKSK program and National Education Policy, National Women's Policy, Beti Bachao Beti Padao and advocated for inclusion of peer led approaches in youth empowerment programs. Under its support to RMNCH+A component of NHM of MOHFW, UNFPA specifically supports programmes under its mandate (FP, maternal health and adolescents SRH); thus, contributes to UNFPA's transformative goal on reducing unmet needs of contraception in three focus states and with the support for midwifery, to the transformative goal on reducing preventable maternal mortality.

CP9 design and implementation addressed needs of vulnerable and marginalized youth (SC, ST, minority, slum dwellers and youth in conflict regions) and provided platforms for youth to directly advocate for their needs and concerns as related to SRHR. CP9 leveraged digital technologies, audio-visual and edutainment measures to ensure continuity of engagement with young people, countering stigma and discrimination and addressing youth mental health concerns (through helpline) during Covid -19.

Strength of interventions varies across states Interventions with minorities were particularly strong in Bihar, with conflict affected and persons with disabilities/PWDs (piloting stage) in Odisha, and the other groups in all states. The focus on transgender people and their needs could be strengthened. CP9 support is partly aligned with the UNFPA global gender equality strategy 2018-22, SDG 5.2-5.3, as well as India UNSDF 2018-22 (UNFPA, 2019, GoI and UN, 2018). Though corporate gender equality strategy suggests dedicated outputs for gender equality, this was included with youth in CPD and CPAP 2018-2022 (UNFPA, 2017a, 207b) with some integration across all outputs.

Covering the humanitarian context that includes flooding, cyclones, and COVID-19, *as* per its global mandate, UNFPA's response during humanitarian crisis focused on provision of services for pregnant women, women of reproductive years and adolescents to reduce mortality and morbidity among them. Supplies of dignity kits to

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[62] Findings based on KI interviews including CO programme staff, group and focused interviews, observations, document review and general participants' interview and secondary data analyses.. Only when quotes are used the source is mentioned, otherwise, the findings come from a combination of various sources as stated.

women and girls is a significant contribution. During COVID-19 the focus on continuation of SRH services including for adolescents (details provided under the effectiveness section. Gender equality is largely integrated into the design of humanitarian and COVID- 19 response, with its commitment to implementation of Minimum Initial Services Package (MISP) in RH as well as strengthening one stop crisis centers to address GBV.

Finding #1: (Relevance specific to development setting): Needs of the vulnerable and marginalized groups[63] were identified and taken into account in both design and implementation stages and were meaningfully involved in CP9 planning and implementation. CO has been able to adequately and appropriately respond to the new opportunities and threats that occurred in the national context.

Overall, UNFPA maintained the programme relevance, keeping in line with govt priorities, UNFPA mandate, and the beneficiary needs in all key thematic areas. CP9 design and the interventions planned under the outcome areas (SRHR, Youth & Gender, and PD) are found to be highly relevant to the national priorities, the National strategies), State needs, UNFPA mandate, ICPD POA, 2030 Agenda, and the needs of the beneficiaries. CP9 is aligned with government policies and legislation on gender, youth and SRH issues. However, due to a CO management decision, specific output on gender equality and gender mainstreaming are not included in the design, although it is integrated across other thematic areas and the related work is carried out. The alignment with corporate Gender strategy 2018-21 could have been more strengthened.

UNFPA support is aligned with UNFPA Strategic Plan 2018-2021 principles (leaving no one behind and reaching the furthest behind), transformative goals, and business model. Program design and implementation reflect the needs of marginalized and vulnerable adolescents including adolescent girls, youth and women (evidence: baseline, need assessments, situation analysis, thematic assessments on gender).[64] A national position paper had been conducted prior to program intervention such as for integration of LSE in the state board school systems, community- based programs for reaching out of school adolescents.

UNFPA's response during humanitarian crisis (floods and cyclones and COVID-19) focused on provision of MISP for pregnant women, women of reproductive years and adolescents to reduce mortality and morbidity among them. Supplies of dignity kits to women and girls has been a useful and timely contribution. During COVID-19, the focus on continuation of SRH services including for adolescents are provided under the effectiveness section. Gender equality is largely integrated into the design of humanitarian and COVID- 19 response, with its commitment to implementation of MISP for RH.

Innovative programs initiated for reaching marginalized adolescents and youth such as tribal youth in conflict regions and adolescents with disabilities in Odisha, rural adolescent girls and boys In Bundelkhand region of MP and tribal regions of Rajasthan, and Muslim adolescents and dalit youth in Bihar. Overall, marginalised girls/women-SC/ST/Minorities reached, but less focus on people with disabilities and transgender. Disability inclusion became part of the workplan in 2020 and too early to assess the outputs. While the investments are made in states and districts focusing on geographical areas with vulnerable populations (girls and women focus including in humanitarian crisis) disaggregated information is available-except in Odisha where PVTG data is likely. UNFPA responded to national priorities and new challenges, as mentioned below:

Digital platforms were used, as explained below to try and ensure continuity of learning and capacity development during lockdown period and young people were actively involved in Covid 19 related

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[63] women, adolescents and youth, people with disabilities, scheduled castes/tribes, sexual/gender diversities
[64] Mehrotra, Firoza, n.d., Thematic Assessment of UNFPA India's Country Programme 8: Gender Biased Sex selection and gender mainstreaming, UNFPA, New Delhi

awareness generation and supported local government addressing vaccine hesitancy. Digital platforms also challenged gender norms during Covid, like breaking silence on GBV and sharing of domestic/care work.

UNFPA advocacy resulted in integration of Life Skills Education (LSE) into the 'Alternate Learning and Mentoring Programme - E-Suvidya' launched by the Tribal Welfare Department in Odisha, with over 4,500 teachers trained; and UNFPA developed a mobile application "COVID SANGRAMEE 20-20 CHALLENGE" for the Government of Odisha to reach young people with correct information and messages on COVID-19. Response to national priorities and new challenges: Based on interview feedback and CO input, UNFPA has successfully delivered its programming even in the COVID times, opening youth helplines, investing in relevant and yet emerging programmatic priorities such as counselling on GBV and MHM. About 43,000 peer educators trained, who in turn engaged over 1.5 million adolescents and youths to create awareness on COVID-19 and to counter stigma and discrimination.

Investing in midwifery and support through the Joint UN responses for COVID-19 preparedness assessments and mitigation activities reflect CO's ability to respond to changing needs and priorities. CO has well responded to threats like COVID-19 and threats to adolescent sexuality by supporting civil society groups to push retaining of present age at marriage[65] (however, post CPE scope the issue has been again reopened[66]). Opportunities have also emerged during CP9, and CP9 has responded to these partially. For example, CO has given inputs into surrogacy Bill[67] (UNFPA. 2020), calling for regulation rather than banning of surrogacy. It has played an important role in bringing state government upto-date with legal proposals, like DoHFW, Rajasthan and Maharashtra on the ART bill,[68] covering rights of clients as well as the fact that it cannot contravene provisions under PCPNDT (UNFPA, n.d.) CO has supported the MoHFW in drafting ICPD+25 report[69] (UNFPA, 2018). On the other hand, CO response to Transgender Protection of Rights Act (2019) and the Rights of Persons with Disabilities Act, 2016,, could have been stronger like responding to SRH services, revisions to medical curriculum and access to universal health insurance as stipulated in these two Acts (Ministry of Law and Justice, 2016, 2019). The Rajasthan UNFPA state office did however advocate inclusion of transgender issues in the State Women's Policy and as part of the curriculum on life skills education in MP.[70]

CO has responded well towards strengthening school health component of the national government flagship program Ayushman Bharat through the various programs integrating life skills education in national and state school systems and in coordination between the health and education departments. However, there is greater scope for UNFPA interventions towards strengthening adolescent health issues in the HWCs under the same government program.

Finding # 2: *Alignment of ToC to achieve results planned based on above relevant factors: Operational strategies of CP9 are results-based, gender mainstreamed and reflected in the program's (CP9) Theory of Change. However, some gaps were observed.*

Overall TOC is aligned with UNDAF and results framework. However key areas related to youth, for e.g. strengthening linkages to youth friendly SRH services, strengthening access to/linkages to entrepreneurship

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[65] Discussion with gender team, UNFPA and Partners for Law and Development
[66] December, 2021, The Union Cabinet cleared increasing the age of marriage of girls from 18 to 21 years (Vishwanath, 2021)
[67] UNFPA, 2020, The Surrogacy (Regulation) Bill, 2019- analysis and recommended changes, UNFPA, New Delhi.
[68] UNFPA, 2020, Assisted Reproductive Technology (Regulation) Bill, 2020, Orientation for Department of Health, Rajasthan February 12, 2020, UNFPA, Jaipur/New Delhi.
[69] UNFPA, 2018, 6th Asia Pacific Population Conference Midterm Review Background Material for Country Report, UNFPA, New Delhi

[70] UNFPA, 2019, Copy of content matrix (of life skills education), UNFPA, Indore.

for young people and demonstrating innovative community-based interventions for reaching marginalized and vulnerable youth are not mentioned in the ToC.

Operational strategies are well reflected in CP 9's theory of change; with the maternal health component being added later. The linkages with gender concerns are not well reflected. The TOC has been reconstructed to include quality maternity care and to highlight health sector response to GBV and adolescent RH clinic services under components related to reproductive rights and adolescent SRH. While cervical cancer contributes to mortality (as mentioned under the country context), CP9 did not have an intervention related to cervical cancer screening.

Gender equality is integrated into output/ TOC on youth and gender but could be better integrated in TOC in SRH and PD[71],[72],[73]. The output of TOC on youth and gender refers to strengthened capacity of government and civil society to empower adolescents, girls and young women with life skills, knowledge, and assets. The strategies refer to multisectoral interventions to empower young women and girls, and upstream work to address harmful practices and empower girls[74]. Terms such as rights, reproductive rights, multi sectoral and integrated are used in the TOCs but could benefit if definitions are included.

A human rights approach is partially reflected in the TOCs, in the sense that strengthening rights-based services is mentioned in the TOCs on SRH (as an output), but the emphasis on strengthening rights holders is mainly limited to adolescents and youth. The term rights-based services are not used in the TOC on Youth and Gender or Population Dynamics. The focus on strengthening rights perspective amongst adolescents/youth is implicit and strong in the life-skill training, but it is mainly where women and girl friendly panchayats are being piloted the rights of women as a right holder is being strengthened Accountability institutions and mechanisms are not mentioned in the TOC (Youth and gender)- other than forming youth organizations- but in reality, in some places child protection committees, school management committees, scorecards, and maternal death audits have been strengthened (in addition to women and girl friendly PRI which monitor implementation of schemes and access to legislation on Gender equality).

ToC lacked inclusion of sustaining and institutionalizing the gains made in integrating LSE in school systems which has been possible within the school systems at the national level and in state government school systems. UNFPA has made significant achievements in integrating gender sensitive approaches in training curriculum which was not included in the ToC. The ToC also lacked focus on linkages of youth programs to youth friendly SRH services. All these missing linkages have been included in the reconstructed ToC.

4.2 Answer to Evaluation Questions on Coherence

Coherence EQ2. To what extent the interventions are coherent with program and interventions of the government, development partners, including the UN agencies, having similar objectives?

Coherence EQ3. What are the main comparative strengths of UNFPA in India, how are these perceived by state (priority states) national and international stakeholders including NGOs?

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[71] UNFPA, n.d. (a), Theory of Change for Outcome 1 on Sexual and Reproductive Health

[72] UNFPA, n.d. (b), Theory of Change for Outcome 2 on Youth and Gender

[73] UNFPA. N.d. (c), Theory of Change for Outcome 3 on Population and Development

[74] UNFPA,n.d Operational Framework: Youth and Gender, UNFPA, New Delhi

Coherence assesses the dimensions of internal coherence and external coherence: how well or not, different actions work together by various partners (external) and within thematic and state units (internal). **Internal coherence** addresses the synergies and interlinkages between the intervention and other interventions carried out in CP9 within UNFPA, adhering to the norms and standards and the **external coherence** considers the consistency of the intervention with other actors' interventions in the same context. External synergy includes complementarity, harmonisation and co-ordination with other partners, and the extent to which the intervention is adding value while avoiding duplication of effort. ***The following discussion is related to both evaluation questions as some responses are common and overlap.***

Summary Findings:

UNFPA partnering at national level with MOHFW and other national institutes, on GBV, PCPNDT, child marriage, age of consent and marriage, SDGs, NFHS and participating in national taskforce on BBBP   added value in incorporation of rights-based approaches in the provision of services and monitoring.

In general, the national and state offices have aligned their workplans to contribute to the CP RRF though the degree of alignment varies between states. Shared output coordination and collaboration between youth and gender teams contributed significantly to gender and GBV prevention component's integration in resource materials for adolescents and young people.

Annual Work Plans (AWPs) are developed at the state level and at the national level under each thematic area and coordinated well between the country office thematic teams and state office teams and UNFPA was able to deliver the workplans without duplicating efforts in cross-cutting themes such as gender and youth by the responsible teams.   However, there is lack of overall national overview and review of progress across states during the AWP development process. The national and state offices are to contribute to the RRF indicators; however, the implementation of SRHR and GEWE interventions is uneven with limited cross thematic reviews, responses, and limited regular meetings on progress.

Overall, the coordination role played by UNFPA within UNCT is well recognized, respected and appreciated by the UN agencies that provided responses. UNFPA has been the Chair or co- Chair of Youth and Gender group of UN and is working closely with UNICEF on Pillar 3 – ending child marriage and Beti Bachao Beti Padao and civic engagement and youth innovations. Several UN Agencies have come together during the COVID19 pandemic time to prevent and address GBV, with UNFPA taking the lead on health and data /Emergency Context – performing a very responsive and strong coordination role being the focal point on addressing and including Prevention of Sexual Exploitation and Abuse (PSEA) and disability within human rights perspective. Information sharing and collaboration of ideas take place at joint meetings, however, sometimes the implementation later taken on bilaterally with the government.

UNFPA's leadership in technical areas as well in partnership is well recognized in joint UN initiatives and partnership with development agencies. UNFPA's state and district presence is considered a strength by other agencies; however, partners also feel that there is scope for improving UNFPA's focus on SRH. Though MOHFW considers UNFPA as its main partner for SRH, some officials feel that the organization needs to bring value through technical and policy support. MOHFW appreciates UNFPA's leadership in the health sector response to GBV. UNFPA's comparative advantage in terms of incorporating rights-based approaches in the provision and monitoring of support to Aspirational districts, HWCs and MPV districts programme and quality assurance of maternal health services and midwifery initiative have added value to the country programme.

Covers Synergy aspects (External and Internal)

Finding # 3: *(related to external synergy) UNFPA added value by partnering with other development agencies (government, non-government, UN) working towards same objective (same end results) without duplicating efforts (and resources)) in the development as well as humanitarian context.*

As a member of executive as well as coordination committee of FP 2020 which is a coordinated effort of several UN agencies, UNFPA has played an important role in FP2020 committee activities to bring focus on FP services for young people, promoting rights-based approaches and accountability and continues to contribute to the same areas under FP 2030[75]. Under the midwifery initiative, the support to Indian Nursing Council (INC) (the regulatory body for nursing and midwifery) for quality assurance of the training of key trainers and regulations, adds great value in addition to its support for developing the midwifery programme in selected states[76].

CO added value by partnering at national level with MoHFW and training institutes for health providers on GBV, MoSPI on SDGs, IIPS on NFHS-5 data[77]. CO took part in the national task force on BBBP in 2019-2021, providing insights from its experience in the four states, and arranging for exposure to international platforms to speak on programs to address son preference and discriminatory practices. It also collaborated with MoHFW on implementation of PCPNDT implementation. UNFPA added value by incorporating rights-based approaches in the provision and monitoring of support to Aspirational districts, HWCs and MPV districts programme and quality assurance of maternal health services.

CP9 partnership with the Indian Institute of Population Studies (IIPS) was on analysis of raw data on women's asset ownership, new question on decision making on sexuality (gap in 5.6.1) and supported use of MHM data in NFHS for planning by government[78]. Partnerships with the department of Women and Child Development (DoWCD) and local government were stronger at state levels in Rajasthan[79][80], Odisha[81],[82],[83] and MP[84], adding value to departments' initiatives on child marriage, MHM, sex selection/ son preference, GBV and marriage registration (Odisha). In Bihar, the collaboration with DoWCD was at a nascent stage, and includes inputs into Women's Policy and strengthening one stop centers.[85] In Odisha and Rajasthan, UNFPA is represented in committees of DoWCD on Scheme for Adolescent girls, BBBP and Women and girl friendly Panchayats[86]. In MP, UNFPA is collaborating with Department of Panchayati Raj and State Institute of Rural Development to strengthen capacity of Panchayati Raj Institutions (PRIs) to prevent and address GBV.

UNFPA is the lead partner in implementation of the national program on empowerment of adolescents i.e., the RKSK program in its priority states and is part of the national task force in the Adolescent Health Division of MoHFW an played important role in convening then group and providing visibility to peer led approaches through evidence building. Under the school health program UNFPA is part of the national resource group through which it created a cadre of 1800 master trainers across the country who will be training teachers and developed an e-course for teachers. Previous CP efforts in supporting the National Council of Educational Reserch and Training (NCERT) in developing as a resource centre on adolescent education including LSE resulted in NCERT institutionalizing LSE in current school health curriculum of Government of India. In CP9 UNFPA supported NCERT in development of resource materials aligned to international guidance on CSE including audio-visual job aids

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[75] UNFPA reports and feedback from MOHFW

[76] Work plan with INC has a specific focus on quality of training

[77] UNFPA, 2021, CP9 Population Dynamics, Presentation to CPE team, June 21, 2021.

[78] Discussion with PD team, UNFPA

[79] Department of Women and Child Development, 2021, Rajasthan State Women's Policy, DoWCD, Government of Rajasthan, Jaipur. This document refers to important contribution of UNFPA in acknowledgement

[80] Department of Women and Child Development, 2018, Operational Guidelines MHM-2018, DoWCD, Government of Rajasthan, Jaipur.

[81] UNFPA, 2019, Simplified Process for Universal Registration of Marriage (PPT), UNFPA, Bhubaneshwar/New Delhi

[82] Department of Women and Child Development and Mission Shakti, 2020, #Odisha for Women, Government of Odisha, Bhubaneshwar

[83] Department of Women and Child Development and Mission Shakti, UNFPA and UNICEF 2019, State Action Plan to end Child Marriage in Odisha 2019-2024, DoWCD and Mission shakti, Bhubaneshwar.

[84] UNFPA, 2021, UNFPA operations in Madhya Pradesh, UNFPA, Bhopal/New Delhi. This presentation refers to placing of Adolescent and Gender consultant with the DoWCD for strengthen schemes in this sphere.

[85] UNFPA, 2021, Proposal for Partnership between Women and Child Development Corporation Bihar and UNFPA for promoting Gender Equality and Women's Empowerment, UNFPA, Patna

[86] Discussion of Evaluation Team with personnel from o, Odisha on 15th September, 2021 and 21st September, 2021 in Rajasthan

and helped create the Virtual Resource Center in NCERT (aeparc.org). At the state level strategic partnership with state government departments has led to UNFPA being part of the state government core team for implementation of respective government program e.g. RKSK in MP and Rajasthan, School Health Program in all four priority states.

Finding # 4*: (Internal synergy) UNFPA thematic and state team coordinated well among themselves without duplicating efforts and resources and integrated cross-cutting themes such as gender and youth by the responsible teams (within CO and State units) while implementing programmes under development and humanitarian contexts. However, there is more room for better coordination.*

In general, the national and state offices have aligned their workplans to contribute to the CP RRF[87] though the degree of alignment varies between states. In Odisha and Rajasthan, the workplans are well aligned. The degree of alignment is lower in MP, as the focus is on one district and the support to state level is limited (except for FP). In Bihar, the support is limited to one district and within that selected population coverage (Muslims and Dalits). Some of the rationale for the unevenness for the implementation is provided in the CO briefing note[88]. Some evidence points to limited coordination between the CO and State level with some instances where state priorities are not given due consideration and support (E.g. FP LMIS, maternal health). Supportive role of CO could have been more (e.g. sharing experiences from other regions or countries). In responding to COVID-19 pandemic, the CO and state offices coordinated well. Integration of cross-cutting themes is not optimal (specific responses under the Efficiency criteria).

Based on field data and documented evidence, shared output coordination and collaboration between youth and gender teams contributed significantly to gender and GBV prevention components integration in resource materials for adolescents and young people. For example, discussions with UNFPA Madhya Pradesh team and visits to the field in Madhya Pradesh indicate that comics and posters integrating gender equality, GBV and life skills were prepared, which were then modified and used in other states as well. PD and M&E have also provided necessary support in providing data for program decision making, facilitating evidence generation such as implementation research, end line assessment etc. of youth programs. However, there is room for better coordination between youth and communications division particularly the need for increased involvement of the communications team in state level communications resource materials and knowledge product development, its dissemination and providing a platform for visibility of state level brands developed under youth interventions such as 'UMANG' which was originally the name of one of the community based youth interventions which was later on adopted by the state government of MP as the brand name across many other youth interventions in the state.

 Finding # 5*: Within the division of labour, UNFPA CO has actively contributed to UNCT working groups, results group, and joint initiatives, ensuring synergy and maximizing and optimizing results, both in development and humanitarian contexts*

Under the SRHR thematic area, the CO has contributed to UNCT working groups through the following. Under United Budget, Results and Accountability Framework (UBRAF) as the lead agency for SRH and HIV integration, facilitated implementation of community component and primary health care component as well as promoted collaboration between National Health Mission (NHM) and State AIDS Control Societies at state and district level. During the response to COVID -19 pandemic, contributed in planning and implementation of the joint UN response at national and state level in areas such as health sector response to GBV, but the collaboration has not been satisfactory because of the attitudes of the partners. At the state level, coordination has been stronger in Odisha and Rajasthan, especially about support for aspirational districts as found from the discussions with UN agencies during state visits. Concerns were raised about UNCT not meeting regularly on common thematic focus areas and jointly pushing for policy dialogue, particularly on rights-based approaches. Another concern was lack of collective follow-up on some joint efforts. As part of the One UN effort information sharing happened across

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[87] CP RRF and State Programme Presentations
[88] UNFPA briefing note on selection of districts and interventions.

UN agencies and collaboration ideas are shared in joint meetings however follow-up is often taken on bilaterally by each agency. UNFPA is also a member of the NITI Ayog task force on youth and has been contributing to the discussions in the group.

UNFPA has been contributing to Results Group (RG) 7, on gender equality and adolescents/youth empowerment has a strong presence as co-chair in RG 7 through planning, reporting, working on indicators, and coordinating the group for past two to three years. UNFPA will continue to lead the subgroup on youth. UNFPA advocated for youth as key focus and it became a priority outcome. However, concerns were shared regarding youth indicators being spread across various results groups thereby making it difficult to track progress.

UNFPA works closely with UNICEF on RG3 i.e., on civic engagement and youth innovations. As part of this collaborative work UNFPA has seconded a UNV on youth innovations to UNICEF. Both agencies have been involved in developing a common framework for youth innovations in a more systematic way. Under civic engagement the joint work involves supporting NYKS and NSS (both large scale youth volunteering platforms). As part of this one joint event was undertaken where young people spoke directly about their concerns and needs. This was the first time that ten organizations come together. For the future, both agencies have agreed to work together on the capacity development Mission of Government of India specifically on developing guiding principles for civic engagement.

UNFPA and UNICEF have collaborated on ending child marriage, as part of the global UN strategy and in Odisha and Rajasthan on supporting the DoWCD on ending the same[89] . The two agencies worked jointly to implement the Gender Transformative Accelerator (GTA) tool to assess progress on ending child marriage in India[90]. At a strategic level, UNFPA along with other UN agencies pushed for a separate Gender and Youth outcome in UNSDCF 2018-2022. It was chair/co chair in the gender and youth task force of UNCT during CP9. UNFPA is part of the Working Group on GBV during COVID-19, taking the lead on health and evidence generation[91].

UNV values partnership with UNFPA and the handholding and mentoring role played by UNFPA and strongly believes in continuing the partnership and inclusion of element of volunteerism in the next country program.

 Coordination on help lines and online counselling on gender-based violence between UNFPA and other agencies and between UN and other agencies have been very good during COVID 19 pandemic times as well as floods in Bihar, 2021 and duing Cyclone Fani in Odisha, 2019[92] . The state team presentations indicate that they coordinated with government to strengthen availability of hygiene kits during floods and cyclone. Similarly, the government officials met from Sheikpura and Sawai Madhapur appreciated support for ensuring FP supplies and safe delivery during COVID.

Findings # 6. With a well established relationship with the government of India and other development partners for over several country programmes, UNFPA offers unique contributions and builds on its comparative advantage in SRHR, gender equality, social inclusion, rights, and data to UNSDCF and joint UN initiatives, and has demonstrated specific technical contribution to the country's development agenda. UNFPA focus on SRHR could be strengthened further.

UNFPA's technical leadership and partnership in establishing collaboration between NHM and State AIDS Society, government and NGOs working with marginalized groups such as sex workers for SRH and HIV integration (under the UBRAF) and advocacy for rights-based approaches in service delivery are recognized as its comparative strengths. UNFPA's state and district level presence is also considered an advantage by UN partners, particularly during humanitarian crisis and in the recent pandemic. However, there is consensus among UN agencies that UNFPA's focus on SRH can be improved[93]. As perceived by other UN agencies, provision of evidence-base data,

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89 Discussions of Evaluation Team with UNICEF at national level and in Rajasthan and Odisha.
90 UNFPA and UNICEF, 2021, Gender Transformative Accelerator: India Country Report, UNFPA/UNICEF, New York/India
91 UNCT, Joint Work Plan on Responding to GBV, UNCT, India
92 State team presentation to evaluation team and discussions with representative of UNICEF, Rajasthan and Odisha
93 Information on UNFPA's unique contributions is obtained from stakeholder feedback, see also reference 67

quality research, and data analytical strengths were among the top skills that UNFPA possessed. Bringing the UN agencies together contributing to the UN coordination mechanism (eg kick off of PSEA), UNFPA has been commended, unanimously, by other agencies.

While MOHFW recognizes UNFPA as a key organization for SRHR, some officials felt that the organization could do better in bringing much value in terms of technical expertise and policy support. UNFPA is recognized for its contributions in health sector response to GBV GBV at national level, though the gains are yet to reach priority districts[94]. It is recognised, by state NHM officials particularly Family Welfare (FW) programme officials and by district administration, for its contribution to Aspirational Districts through UNFPA supported consultants[95]. UNFPA is well recognized at the national and state level for its work with young people particularly with adolescents on the issue of SRH and LSE. UNFPA technical assistance on respectful delivery care and rights-based FP are valued by partners. However, there is need for continued engagement with national level partners. Some of the NGO IPs believed adolescent empowerment programs of UNFPA should be for the long term to ensure that those adolescents particularly girls who have begun raising their voice and emerging as youth leaders are mentored for further development.

Perceptions of comparative advantage of UNFPA in general is the global pool of quality technical assistance that UNFPA is able to mobilize and draw from for the CP as well as at national level needs as appropriate. UNFPA also held a longstanding leadership role in the field of SRH and PD. Now with new players in the field of SRH[96] the niche UNFPA had may not stay the same unless adequate technical resources are allocated and rights- based approaches to maternal health, FP programme and joint programmes are promoted on the ground. On PD, UNFPA still has a strong comparative advantage, however UNFPA may not have given adequate support and attention to what UNFPA can offer in this field, either due to limited staffing or funds. On gender, there is a mixed experience on the ground. On gender equality component, UNFPA comparative advantage was observed to be in the area of PCPNDT implementation (national level), ending child marriage, gender integrated life skills, addressing GBV and gender discrimination (the last four at national or/and state levels[97]). Online capacity building on gender responsive counseling and gender statistics, as well as responsiveness to gender issues identified by the government were seen as strengths. On the other hand, stakeholders related to gender did not see rights integration in SRH as a niche area, as well as work with transgender persons, persons living with disabilities and sex workers. Although the opportunity of GBV integration in training of medical professional was mentioned as a strength by a key informant, the scale of UNFPA's operation was considered limited. While UNFPA is perceived to be a leader in integrating life skills-based education within school systems, its community-based programs reaching marginalized and vulnerable youth are not widely known.

4.3 Answer to Evaluation Questions on Effectiveness

Evaluation Question 4: *To what extent have the interventions supported by UNFPA delivered outputs and contributed to the achievement of the outcomes of the country programme in (both) development as well as humanitarian context?*

i) *to increase the access of adolescent and young persons (adolescent girls/young women to life skilled based adolescent education programme and quality sexual and reproductive health services in India,*

ii) *to improve access to and utilization of high quality SRHR services including for the most vulnerable groups,*

iii) *to improve national (and relevant state responses) to gender-biased sex selection and gender-based violence, early marriage and other harmful practices and*

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[94] The state level presentations by UNFPA staff to the evaluation team (Bihar, Odisha, Madhya Pradesh, Rajasthan) in 2021. Meetings of the evaluation team with staff of one stop centers in Jaipur, Rajasthan (21st September, 2021) and Bhubaneshwar, Odisha (17th September, 2021) also just that medical officers are yet to receive training on protocols on handling GBV survivors.

[95] The information from MOHFW and state officials is obtained from stakeholder feedback

[96] Field observations and discussions with field level staff

[97] Filed interview data, document review

Evaluation question 5:

To what extent has UNFPA successfully integrated human rights, gender perspectives and disability inclusion in the design, implementation and monitoring of the country programme?

Findings under Effectiveness (EQ4 and EQ 5) are reported separately under each Output area.

SRHR Output: Increased national and subnational capacity to provide accessible, high-quality, rights-based and integrated sexual and reproductive health services.

SRHR Effectiveness: Answers to EQ 4 and 5 (Output1)

Summary of findings (Output 1)

UNFPA's technical assistance and programme support at national and state level in the focus states have contributed to expanding spacing methods and institutionalization of rights-based approaches in FP service. Support to national CSM, support for operationalization of FP LMIS is Odisha and Rajasthan, efforts at introducing alternate indicators to monitor FP programme, etc. have policy implications. However, there are gaps in the rights-based approaches to introduction of Antara and sterilization and also the gaps related to monitoring of the FP programme and continuation of provider incentives. The above initiatives have the potential to contribute to increasing (CPR) and reducing unmet needs.

The support for institutionalization of quality assurance initiatives such as LaQshya, supported by district consultants in Odisha and Rajasthan and state level support for maternal health is significant. The reprogramming of CO budget to support the MOHFW's midwifery initiative and support to INC is strategic. The above activities have the potential to contribute to reducing MMR. The reorganization of funding to INC during the COVID pandemic to support capacity building of midwifery trainers was innovative.

The support to Aspirational districts in addition to priority districts in implementation of RMNCAH programmes has provided opportunities to further promote quality and rights-based approaches to FP and maternal health including in the HWCs and to implement more elements of RMNCAH programme. The district consultants have played a major role in the support.

The support for implementation of AFHCs has been significant through operationalization of AFHCs with trained counsellors and medical officers and availability of client educational materials.The support for mitigation of impact of COVID 19 pandemic at national and focus state level were significant. In Bihar and Odisha, during natural calamities, support for distribution of dignity kits have been provided. In Odisha, MISP was implemented as part of the state response.

Several innovations were introduced at state level for improving coverage, quality, and effectiveness of programmes. Significant contributions to digital health interventions have been made at state level prior to and during COVID -19 pandemic and are appreciated by key stakeholders.

Overall, UNFPA with minimal funds supported qualitative implementation of the national RMNCAH programme, leveraging NHM resources and gaining recognition for its significant contribution, in Odisha and Rajasthan. At the state level, the posting of consultants has earned a place at the policy table and opportunities to innovate. However, there are gaps that need to be remedied for sustained changes and impact.

Finding # 7: UNFPA's technical assistance and programmatic inputs at the national and state level have contributed to national priority of reducing unmet needs in family planning through a wider choice of spacing methods, informed choice, quality services and equity with a focus on young people, particularly from underdeveloped geographical areas.

The above finding is aligned to country programme strategy 1.1 on support provision and availability of contraceptives and contributes to the outcome indicator on reducing unmet needs. Based on the recommendations of CP 8, CP 9 has focused on the promotion of rights-based FP.

The following points relate to three focus states (except Bihar where support for implementation of FP programmes started recently as explained under finding 4 on internal synergy). The activities listed below contribute mainly to the achievement of the RRF indicator related to CPR of modern methods among 15-29 years and the two signature indicators (sub-indicators) related to stock-outs of commodities and couple-years of protection (Part 2 Annex A). An additional signature indicator specifically focuses on improving the quality of PPIUCD and sterilization services. The preliminary state NFHS 5 2019-20 reports (key facts table and Part 2 Annex B1 SRHR 2)show an increase in overall modern methods use in the country and in focus states (age-disaggregated data is not available). The increase in focus states cannot be attributed to UNFPA inputs alone as the coverage is limited to few districts in the focus states; however, with regard to injectable - *Antara*, UNFPA could take credit as the sole agency that made investments in introducing this method. Stockouts of contraceptives have been reduced in focus states due to the support to FP LMIS (Part 2 Annex A). The couple years of protection values are not available. A major problem with the estimation is that the list of methods included does not include long acting methods. As mentioned under country context, targets, poor quality of services and violation of client rights has been the bane of India's FP programme. Specifically, the inputs related to improving the quality of PP IUCD services and sterilization services have contributed to improved adherence to the guidelines (Part 2 Annex A). The other activities listed below contribute to further access and quality of services. The development of alternate mechanisms to monitor the FP programme has the potential for major policy changes, provided the indicators are robust to capture quality and results. Due to COVID-19 pandemic, activities initiated in 2019 could be evaluated to assess progress and coverage. The Health Management Information System (HMIS) at state level had a setback as the officers responsible were deputed to COVID surveillance; hence it was also difficult to get updated information from the focus states.

In support of MOHFW's commitment to broaden spacing methods and to enable achievement of increased use of RRF indicator on use of modern contraceptives, UNFPA took the lead in supporting MOHFW to roll out *Antara* through procurement, and development of quality assurance tools such as guidelines, checklists and client educational materials[98] including state level support for quality assurance through follow up and mentoring. Despite the investments in quality assurance in introducing the *Antara*, the discontinuation rates are high due to poor quality of counselling (initial and follow up), *as reported by state officials- an area where UNFPA could have provided more support[99]*. The support for MOHFW's CSM programme assessments has led to policy dialogues involving MOHFW and *Niti Ayog.* The tripartite pilot initiative for strengthening the quality of FP services provided by pharmacists involving a private social marketing organization with support from a corporate agency showed promising results but was not continued due to administrative decision (35,000 chemists reached)[100].

As referred to earlier under progress of signature indicators, strengthening the quality assurance of PPIUCD and sterilization services including consent for the procedure has been a major contribution of UNFPA at state and district levels[101]. Monitoring consent for PP IUCD and sterilization has been institutionalized in UNFPA-supported priority and Aspirational districts and is part of the monitoring dashboard at state level and CO level (Consent is part of the quality assurance checklist). UNFPA's advocacy has led to expanded use of checklists and consent forms in the implementation of national programmes such as MPV and in fixed day services in focus states as was during field visits. *However, a major omission from rights perspectives is the lack of follow up counselling and services for clients of sterilization, who had complications/ the procedure failed which UNFPA could have supported.* A good practice noticed was the booklet for each client of sterilization which includes checklists, consent forms and provider notes which enables quality monitoring.

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[98] Support for procurement was provided in the early months of introduction (started end of CP 8)
[99] State officials and facility staff reported that a significant proportion of women discontinued after first and second injection.. Data for focus states is not available.
[100] UNFPA Annual Report 2020
[101] PGIMER Chandigarh: Study on PP IUCD services in Mahatashtra and Rajasthan 2016-17. The study was supported by UNFPA and based on the study, improved checklists have been developed.

Implementation of the MOHFW's revised version of FP LMIS is being supported extensively in the three states and stock level situation is being monitored at all levels; the process of reaching the software to Auxiliary Nurse Midwives (ANMs) and ASHAs is underway, best coverage is in Rajasthan. The contribution of UNFPA in strengthening FP LMIS system in focus states has certainly contributed to reducing the number of stock-outs (Part 2 Annex A), however, there are stockouts of *Antara* due to stockout at national level.

A significant contribution is Innovations in monitoring of the FW programme in Odisha and Rajasthan: Though at the national level, Expected Level of Achievement (ELA) of coverage, is not recommended or used, the state departments of FW use the same to allocate targets to districts. In Rajasthan, support has been provided with inputs from CO (M&E) to develop alternate means of estimating ELAs that are linked to actual needs and is much appreciated by the state department. Another significant contribution to quality monitoring of the programme is the development of alternate indicators for monitoring the performance of FP programme (outcome of a high-level consultation involving MOHFW, state officials, development partners and civil society forums). Odisha and Rajasthan have implemented the changed monitoring format and uses the same for ranking performance of districts[102,103,104]. While it is a worthwhile initiative, *the inclusion of incentives for ASHAs and lack of inclusion of qualitative indicators is a concern.* No evaluations have been done as the above indicators were introduced just before the pandemic.

Monetary incentives to <u>providers</u> of *Antara* were introduced for promotional purposes but is being continued; incentives for providers of PP IUCD and sterilization continues with all incentives being double in MPV districts. Provision of incentives increases the risk of promoting a particular method over client's choice and has marginal effect on achieving fertility targets; it is contrary to MOHFW's commitment at ICPD@25 in Nairobi[105,106]. Despite the support to FP programmes over the years at national and state level, UNFPA has had limited success in influencing the provider incentives and will need strong evidence and advocacy to change the practice.

All the focus states have dedicated consultants for FP whose technical support to FW programme is significant, more so in Rajasthan, due to UNFPA's role as the coordinating agency for RMNCH+A programme. Significant contributions have been made to streamlining the listing of eligible couples and users of FP methods to <u>enable identification those needing services</u> and <u>follow up,</u> thus contributing to efficiency of fixed day services and follow up (as reported by state officials) [107].UNFPA supported the development of a comprehensive road map for FW programme in MP. Contributions of district consultants through monitoring of quality and rights during provision of services especially during special programmes when large number of clients are served are commendable. The consultants took remedial actions wth regard to quality and rights and coverage through the district health systems [108].

The support for innovative technologies or programming in focus states have contributed to improving efficiency of the FP programme as well as promotion of FP. The innovations included the use of digital technology in tracking eligible couples and users and creating of e-platfroms for learning. Promotional activities for FP include

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[102] UNFPA. Monitoring of Family Planning Programme: Exploring Alternatives: Outcome of 30th September 2019 Meeting and Next Steps.

[103] UNFPA. Expanded indicator for monitoring of family planning programme in Odisha 2020.

[104] UNFPA. Expanded indicator for monitoring of family planning programme in Rajasthan 2020-21.

[105] UNFPA. ICPD Programme of Action, 1994- ICPD PoA clearly states that provision of incentives is counter-productive and has marginal effect on reducing fertility. It also states that demographic targets imposed on providers for recruitment of clients is not acceptable.

[106] MOHFW: India Statement on ICPD@25: Accelerating the Promise. 12-14 November, Nairobi, Kenya

[107] Madhya Pradesh: FP Management Information System (MIS) is a web-based application that is computer and mobile phone linked. The software is fed into computer tablets at subcenter level and interfaces with the subcenter application of MOHFW called ANMol. In Rajasthan, the existing software such as the pregnancy and child tracking system has been modified to track eligible couples and users. In Odisha, a computer software tracking system for eligible couples and users has been used.

[108] Consultants' reports, discussions with district consultants during state visits

observation of special days in Odisha which led to improved access to integrated SRH services especially FP[109], involvement of men and young people and interface between community-based workers and the health system. The lists of innovations and promotional activities are mentioned in Part 2 Annex B 1 SRHR 2. The innovations were introduced just before the pandemic except in Bihar. Some of the innovations are state-wide; most have the potential to improve access and quality. No assessments have been done. Details of the above paragraphs are provided in Part 2 Annex B 1 SRHR 2.

Finding #8*: UNFPA's technical assistance and programmatic inputs at national and state level have contributed to **improving quality maternal health through support to national midwifery programme.***

There is no RRF indicator directly related to maternal health as it was not a focus area in the beginning of the CP as explained earlier under findings 2 and section 3.2.2 on country programme. However, some of the advisories and guidelines related to RRF indicator 1 covers selected aspects of maternal health (see Part 2 Annex A)[110]. Though maternal health was not a focus area in the beginning of the country programme, — the activities listed below contribute to improving the quality of maternal health services and potential reduction in MMR (outcome indicator), particularly the support to midwifery initiative. However, it is too early to comment on the impact of the midwifery initiative as the full scale of activities could not be implemented due to the COVID pandemic.

Though not much support was provided in the beginning of the CP for maternal health at the national level, through the priority and Aspirational district consultants, support has been provided for strengthening the national quality assurance programmes such as *LaQshya* certification (provided when quality standards are met in labour room and operation theatre) as well as to state and district level quality assurance initiatives. Another significant contribution is the promotion of respectful maternity care and improvements noted in facilities as a result of the monitoring and mentoring support by district consultants. During facility visits, there was evidence of improved quality of labour rooms and promotion of respectful maternity care. The above support is limited to Odisha and Rajasthan for reasons provided under finding 4 on internal coherence.

Support for monitoring maternal health services in Rajasthan is extensive due to UNFPA's role as the coordinating agency for RMNCAH. The posting of a dedicated expert on maternal health has contributed to state-wide monitoring of maternal health indicators, maternal mortality estimations and reviews and remedial actions including mentoring of providers. Maternal mortality reviews are part of the monitoring activities in Aspirational Districts and remedial actions are taken. However, these need further review and improvement[111]. (illustrative examples of monitoring are provided in Part 2 Annex B 1 SRHR 2). Some of the innovations or inputs, supported by UNFPA merit consideration as 'lessons learnt' include real-time monitoring of delivery practices, creating delivery points at subcenter level to promote access to institutional deliveries and establishment of maternity waiting homes in tribal areas for easy transfer to instituions for delivery. The data presented by state offices and feedback from district consultants indicate improved access and utilization of services[112]. Details are provided in Part 2 Annex B 1 SRHR 2.

Support to the national midwifery programme was through two streams. (i) Technical assistance for capacity building of two National Midwifery Training Institutes (NMTIs) through systematic needs assessments and remedial measures using NHM funds and (ii) support to INC for orientation of the master trainers of NMTIs and quality assurance of the training of the trainers and their accreditation. Quality assurance of training of trainers is critical for developing competencies of trainees and provision of quality services. The support to INC also facilitated the buying-in of key stakeholders, responsible at the state level for training (see Part 2 Annex B 1 SRHR 2. for the list). The interventions have long term policy and health systems implications. Due to stalling of

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[109] Family welfare days observed on Village Health and Nutrition Days (VHNDs) for promotion of spacing methods especially newer contraceptives as well as facilitation of access of young couples to FP (Odisha) (case study on the success of the programme developed for the two priority districts) Source: PREM, Odisha: Annual reports for the UNFPA assisted districts.

[110] List of guidelines supplied by CO and discussions at CO and state level.

[111] Rajasthan state office presentations, presentations by maternal health consultant and discussions with state level experts with district health officials, district consultants, reports of maternal health state officer and state consultants and feedback from State Maternal Health Officer

[112] State reports of Odisha and Rajasthan, field visit observations, feedback from district level officials and consultant of Jaisalmer

activities during the pandemic, funding with INC was strategically reallocated to support strengthening of midwifery trainers nation-wide including from the private sector. Technical assistance provided by CO for designing the course as per international standards and for developing e-modules are significant and has wider impact[113].

Finding # 9: *UNFPA's technical assistance and programmatic inputs at national and state level have contributed to **promoting rights-based, integrated, quality SRH services at state level and in priority districts with special focus on vulnerable groups. However, some gaps were noted as described below.***

The RRF indicator related is percentage of health facilities that deliver integrated sexual and reproductive health services which shows an increase (Part 2 Annex A and B1 SRHR 2). The main rationale behind the integration was to support convergence of components of RMNCH+A programme at the district level; however, the selection of interventions and unevenness of investments (example safe abortions, RTI/STI management) —are concerns[114,115,116]. Opportunities for incorporating lessons learned from the ongoing efforts SRH/HIV integration (UBRAF) or state level efforts for screening for STIs are missed. *A major omission is horizontal linkages between services across the continuum of care which is a critical element of quality of services and an efficient use of human resources.*

UNFPA's decision to support Aspirational districts, leveraging NHM funds, is strategic as it provides an opportunity to extend its evidence-based and rights-based approaches to FP and maternal health services including in HWCs and gain recognition. As pointed out under findings 7 and 8, the aspirational districts consultants supported by UNFPA, promoted —the quality and rights-based approaches and monitored its implementation. The– evidence of the same was found during field visits (diffusion of good practices into a wider geographical areas). It also provides opportunities for monitoring some of the critical services not included in the UNFPA priority districts[117]. The district consultants play a significant role in monitoring and facilitating actions. The consultants regularly report on the state dashboard and CO dashboard. The implementing partners (Odisha and Rajasthan) play a critical role in monitoring the consultants, analyzing the data and facilitating actions[118].

The other activities listed below specifically refer to investments in activities to promote integrated SRHR approaches.

Health sector response to GBV, though recognized as an intervention in the CP operational strategy[119], the activity was not implemented due to a management decision, even in Odisha that had a strong intervention under CP 8[120,121]. As a result of past collaboration with MOHFW, UNFPA is considered as the lead agency for GBV and the CO gender unit has responded to a request for developing a reference module which comprehensively covers various aspects of GBV including rights of women to care and is currently being converted to an e-training

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[113] INC reports, Review of e-modules, discussions with CO team and INC

[114] The integrated service package constitutes availability of 5 contraceptive methods, safe delivery services, prevention of unsafe abortion services and RTI/STI management at community health centres, sub-district and district level facilities.

[115] With regard to prevention of unsafe abortion, the investments are limited to monitoring by district consultants on availability of services in PHCs and above, facilitating the availability of services through training and supplies and in post abortion FP counselling and services. With regard to RTI/STI services, the contributions are less clear.

[116] UNFPA. MyM and E dashboard

[117] Some of the services and activities included in Aspirational districts are maternal death reviews, cervical cancer, adolescent health services, ANC, syphilis screening, the STI screening and referrals during VHNDs, etc.

[118] The implementing partner in Odisha is (People's Rural Education Movement (PREM) and in Rajasthan it is Centre for Community Economics and Development Consultants' Society (CECOEDECON).

[119] Although it appears in the TOC, it is not included in the CPAP.

[120] Priority areas identified under the CP operational strategy 3: Technical assistance to plan, implement and review FP/MH policies, strategic plans and guidelines at national and state levels, strengthen quality assurance for rights-based FP services, advocating for fulfilment of SRH and reproductive rights in the context of FP 2020 and RMNCH+A strategy, advocating for strengthening *health sector response to gender-based violence* and advocacy for mainstreaming MISP in emergency response.

[121] Discussion with CO and state office staff

manual[122]. *The training module needs to be well-integrated into the various SRH services and will require inputs from the SRHR unit.* Additional efforts to integrate GBV as part of medical education and midwifery and nursing education (as explained elsewhere) are noteworthy; however, the efforts *need continued collaboration between the SRHR unit and gender unit.*

Pursuing its agenda of promotion of rights-based approaches and respectful maternity care, UNFPA collaborated with a a renowned post graduate medical institute - PGIMER, Chandigarh to inculcate the approaches in medical education in 11 medical colleges[123]. The expected outputs could not be achieved due to the pandemic.

A set of five e-modules and a e-learning course on integrated services (FP, maternal health, safe abortions and reproductive rights) were developed by SRHR unit. The modules were used for midwifery teachers' training by INC and training health service providers in Odisha. The e-course is open to the public now and it was reported that the number of course participants is steadily increasing (116 participants August -November 2021). UNFPA East and Southern Africa Regional Office (ESARO) has expressed interest in using the modules which has the potential to be a good practice in SSTC[124].

Finding # 10: *UNFPA's technical assistance and programmatic inputs at national and state level have contributed to **improving access of adolescents and young people to SRH services and information, especially girls from vulnerable sections such as SC/ST and remote areas including those with disabilities and from priority districts, through policies and programmes.***

The RRF indicator related to this strategy is related to adolescents receiving RH information/services enabled by the health systems and numbers of clinical providers responsible for RH services in public facilities who have received training on youth friendly SRH. According to Part B Annex A on progress of indicators, almost 50% of the targets for reaching information and services to adolescents and almost two-thirds of the target for achieving the number of providers trained have been achieved. Major efforts have been made during the COVID pandemic to continue with the capacity building efforts through digital platforms. However, there are major gaps in the delivery of information and services as described below. The data presented does not include Bihar for reasons explained under finding 4. As evident from the discussions under the effectiveness section on youth, the focus of the interventions has been on girls from SC/ST and remote areas and in Odisha there has been focus on sharing SRH information to adolescents with disability (ref:finding #14).

UNFPA is recognized for its role in implementation of the adolescent sexual and reproductive health (ASRH) programme and its role in RKSK programme in the past CPs and in this CP. At the national level, UNFPA is the lead agency for the development of training materials and capacity building of medical officers and recently for the development of e-manuals and digital training [125]. UNFPA's main contributions at the state level are related to development of training materials (later converted to e-modules during the pandemic), capacity building of counsellors and medical officers, operationalizing the youth friendly clinics(leveraging NHM funds) and demand creation for the use of the services. Recognizing the need to improve access of adolescents and young people to facilities closer to them (currently services are located at Community Health Centre (CHC) level and above), user-friendly materials for ASHAs and Medical Officers have been developed by CO. Training of service providers using the materials have been done in one district in MP and two districts in Odisha. It is too early to comment on its effectiveness and reach of the above interventions. Impressions gained from discussions with health service providers is that access to services and information is a major issue[126]. Disaggregated data on 15-19 is not easily available which is a major gap in planning and monitoring services. The referral pathways between various

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[122] Feedbackfrom MOHFW, CO gender team, review of the module
[123] Report of PGIMER, Chandigarh. The medical educators were oriented on evidence-based intrapartum guidelines and rights-based approaches to FP, GBV and ASRH services and have initiated training of final year medical students and interns. The proportion covered is difficult to estimate as the total number of medical educators and students is not provided.
[124] Review of e-modules, discussion with CO staff and report of Odisha
[125] Discussions with MOHFW and state officials in Rajasthan, CO ASRH focal point, review of materials for medical officers
[126] Discussions with service providers

community based and school-based adolescent services is clear. UNFPA's contribution is maximum in the state of MP, followed by Rajasthan and Odisha.

Finding # 11: *UNFPA's technical assistance and programmatic inputs at national and state level have contributed to:* **continuity of RMNCAH services during COVID-19 pandemic at national level and focus state level and introduction of MISP into preparedness plans.**

CO has been able to respond adequately to mitigate the indirect impact of COVID-19 on RMNCAH and ageing populations at national level along with UN partners and others and state level through needs assessment and planning and provision of supplies and equipment as described under the section on Coherence and is a subject for case study on coordinated UN approaches. The district consultants played a critical role in the assessments. The support provided at focus state level was appreciated by state health officials. The national data showed decrease in coverage of various RMNCAH services in 2020, which gradually improved in 2021(also referred to under country context) [127]. As pointed out under earlier sections under this output, UNFPA contributed substantially to development of service guidelines and training materials at national and state level and contributed to national training efforts through INC and national medical institutions (details provided under Part 2 Annex B,). A significant contribution was the gender unit's collaboration in topic such as GBV. The above have contributed to the process of restoring disruption of services (though difficult to quantify). In collaboration with Plan International, support for old age homes was provided (included under the thematic area on PD). During natural calamities in Odisha and Bihar dignity kits were provided to women and girls and additionally, dignity kits and contraceptives were provided during floods in Kerala[128] (Data provided in Part 2 Annex B 1 SRHR 2). In Odisha, MISP is incorporated into the state disaster plans (sustained actions from previous CP investments in the state). There is no evidence of capacity building for inclusion of MISP in emergency preparedness or response plans of other focus states (Investments were made in the last CPs in collaboration with National Disaster Agency for inclusion of MISP)[129]. A major enabler was the communications support provided by CO.

Facilitating factors under Output 1

UNFPA's past contributions and good standing and India's commitment to ICPD programme of action is a major facilitating factor. The presence of UNFPA at the state level and district level and their support to implementing RMNCAH programme is another factor. In Rajasthan, as the coordinating agency for RMNCAH has been able to provide more support. UNFPA's ability to reprogramme its budget and raise resources within the country (though there are donor restrictions) are other factors[130].

Hindering factors under Output 1:

Majority of the hindering factors are related to inadequate opportunities for dialogue between CO and State offices and lack of recognition of state priorities. This also has impacted the continuity of some of the flagship programmes at the state level (FP LMIS) or areas where leadership was provided (such as Health sector response to GBV in Odisha, capacity building for MISP, etc.). Inadequate focus on higher level policy objectives and focused investments lead to missed opportunities. Lack of full utilization of existing data from districts and states available at the M&E portal and information to improve programming is another hindering factor. Factors related to administration are included under hindering factors that affected efficiency[131].

Youth and Gender Effectiveness: Answers to EQ 4 and 5 for Output 2

CP Output 2: Strengthened capacities of Government and civil society to empower adolescents, especially young women and girls, with knowledge, life skills and assets so as to exercise agency

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[127]Data Source: Analysis of HMIS report available at https://hmis.nhp.gov.in/#!/standardReports. State specific data for 20-21 is not accessible.

[128] UNFPA Annual Report 2020

[129] Information gathered from discussions with CO and state office staff.

[130] Feedback obtained during meetings with MOHFW, state health officials, partners, etc. Ability to reprogramme budget is referred to under findings on relevance, effectiveness, etc.

[131] Findings related to coherence, effectiveness of SRHR contributions and efficiency cover most of the indering factors.

Summary of findings

Progress on two of three outputs under youth and gender are on track as of 2021, and likely to be reached by 2022. Two of the output indicators pertain to youth, and one on gender.

As per the RRF indicator progress report, UNFPA leadership, advocacy, and technical assistance led to integration and institutionalization of rights based gender transformative LSE curriculum as a scholastic subject at upper primary and secondary levels in 11 school systems as compared to a target of seven (RRF 6, Part 2 Annex A). Total of 4.2 million adolescents have been reached as of 2021 against a target of 6.1 million by 2022 (RRF 7) primarily due to closure of schools and restrictions in community level group engagement ue to the pandemic. Sex or socially disaggregated data on adolescents reach is not available.

UNFPA's all key outputs under youth and gender are on track. Building on the gains made in CP7 & CP8 UNFPA's leadership and technical assistance achieved integration and institutionalization of rights based gender transformative LSE curriculum in 11 school systems against a target of 7. This includes national government schools, state government school systems in four focus states and special schools for adolescents from scheduled tribes, minority communities and adolescents with disabilities. LSE integration in vocational insittutions has been intiated in one focus state which requires further strengthening. Total of 4.2 million adolescents have been reached against a target of 6.1 million (RRF 7) primarily due to closure of schools and restrictions in community level group engagement due to the pandemic. However, disaggregated data on adolescents in not available. UNFPA two models of peer led community based adolescent empowerment programme i.e. NGO led and government system led is recognized by the national government and has been institutionalized in two focus states. Innovative demonstration pilots offer scope for future learnings on reaching marginalized and vulnerable youth in diverse settings cutting across the humanitarian development nexus.

Building on the gains made in CP7 & CP8 in strengthening government school systems capacities in integrating LSE, in CP9 the LSE program achieved high level of ownership and is fully owned and institutionalized in three national school systems and the state governments wherein implementation funds are provided by the respective governments. Community-based programs had led to empowerment of youth, particularly girls, in creating a cadre of youth leaders with increased knowledge, confidence, and decision making on delaying marriage and menstrual health and hygiene management. Innovative demonstration pilots offer scope for future learnings on reaching marginalized and vulnerable youth in diverse settings cutting across the humanitarian development nexus.

The gender equality related output of CP9 has been largely achieved (RRF 5). Three of the targeted four states are implementing policies and programmes for empowerment of girls and women as of 2021, and a memorandum of understanding underway in the fourth with the DoWCD as of 2021. In terms of outcomes related to gender equality and empowerment of women and girls, progress is reported by stakeholders on reducing child marriage (one of the outcome indicators), enhancing girls' enrolment and reducing gender-based violence, but outcomes are not consistent on GBSS (related to the outcome indicato of CSR). Further the gains cannot be attributed entirely to CP9 or UNFPA. Other than in a few pockets (for example work with women sanitary workers in Patna), gender gaps in the economic sphere persist amongst youth, though bridging the gender inequality index is included in CP9 as an outcome indicator.

Rights of adolescents and young people from SCs, STs, Muslims, slum dwellers/ migrants and people in remote areas have been well promoted in the four states, as planned. Work on gender and, masculinities is strong in MP, integrated with life skill education. CP9 has supervised e-counselling on GBV during COVID-19. However, it has not adequately promoted protocols on management of sexual violence laid out in MISP in RH. Gender sensitivity is reflected in PD interventions at national level and support to programming at state level (Odisha), with scope for better contribution of PD to programming on gender/ gender mainstreaming, based on correlation analysis using NFHS data (e.g on relationship between ownership of assets, and decision making and GBV). CP9 has also contributed to data on SDG 5.6.1 and 5.62. Institutionalization of gender training (like in MP the SIRD or the National Judicial Academy) is an area for strengthening along the lines of what has been

done in the area of life skills education. UNFPA has used media effectively for challenging (also regulating) gender discriminatory practices and norms with greater scope to tailor it to contexts.

Finding # 12: *UNFPA technical assistance at the national and state level has led to **strengthened government capacities in institutionalizing and integrating LSE in formal and non-formal school systems at national and state levels at primary and secondary level.***

Integrating LSE in national school systems.

LSE has been institutionalised and sustained with government funding during CP9 in all three government national school systems of KVS[132], NVS[133] and NIOS[134] involving total of approximately 5000 schools across the country. It is integrated in school academic timetable, transacted in classroom settings by trained nodal teachers, is part of regular school monitoring system and fully funded by the respective school systems[135]. However disaggregated data by school systems is not available.

Discussions with representatives from NCERT and the school systems revealed that UNFPA's support was instrumental in institutionalizing LSE in the national school systems and is a valued technical partner for NCERT. The reasons given were UNFPA's comparative advantage of ensuring quality technical assistance on gender, sexual and reproductive health and rights; ensuring alignment of the national curriculum with national government priorities in health and education; UNFPA's long history of investment in integrating LSE in school systems. However, representatives from the national school systems mentioned during discussions with them that UNFPA's communication with their respective national school systems has been weak during CP9 which could have been maintained to ensure strengthened monitoring of the program and identifying new areas of partnership. While an assessment of the programme was undertaken before CP9, future assessment of the programme in the next country cycle will have to be undertaken after schools return to normalcy to determine student satisfaction and teachers' acceptability and comfort in transacting full gamut of topics including SRH. For more see (Part 2 Annex B-Youth/Eval.Matrix.13.1.1).

Integration of LSE in state school systems

UNFPA technical assistance has resulted in institutionalisation of LSE in eight state government school systems. These are state government schools in Rajasthan, Madhya Pradesh, Odisha, Bihar, Delhi and in Tribal Residential Schools and Special schools for adolescents with disabilities of Government of Odisha and Madarsas[136] in Bihar. However, implementation of schedule health programme (SHP) varies across states since the pandemic delayed further implementation of the program which will be restarted after state board schools reopen.[137] While SHP is being implemented in MP from 2018, its implementation has begun recently in Rajasthan, Odisha and Bihar by the respective state governments. [138] Discussion with NCERT and supported by UNFPA progress reports highlighted that efforts at supporting SHP at the national level led to the government approving UNFPA's lead role in ensuring rollout of the SHP program in select states including in all UNFPA priority states. For additional details please refer to Part 2 Annex B/youthEM13.1.2.

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[132] https://kvsangathan.info/kvs-kendriya-vidyalaya-sangathan/

[133] https://cbseitms.nic.in/

[134] https://www.nios.ac.in/about-us/

[135] Mapping of Youth Interventions, UNFPA, New Delhi 2021.

136 Madarsa is a minority educational institution formed under Article 29 & 30 of Constitution of India for promoting Urdu education across the country, to extend help and all support to the students of muslim community and weaker sections of the society with special emphasis on girls education. Education in Madarsa's are managed by the Madarsa Education Board which is an autonomous body. Teaching in Madarsa's combine Islamic teachings and modern academic curriculum at par with the school boards.

137 Discussion with state teams in UNFPA priority states.

138 UNFPA state programme brief 2021, Rajasthan, Odisha, Bihar.

A cross sectional quantitative and qualitative study of the first phase of the programme[139] in MP (known as Umang) indicates that Umang has to a significant extent institutionalized processes for capacity development, transaction of sessions and monitoring within schools. The report states that students do articulate that the sessions have helped them in many ways, such as building their ability to relate to peers, discuss topics and build their self-confidence. The report also states that UNFPA's innovative approach of mentoring of trained nodal teachers provided onsite support to teachers for quality improvement in delivering sessions. School monitoring data mentioned in the report shows that the mobile app developed by UNFPA is used by the state/district education officials to monitor progress at school level.In Chhattarpur district in MP interaction with teachers and

UMANG: ADOLESCENT HELPLINE

students in a co-ed high school who had returned to school a few days prior to the CPE team field visit shared that they were looking forward to their life skills sessions being initiated again once classroom teaching was regularized. The school principal highlighted the need for increased access to counselling services for students and proposed use of available video conferencing facilities in schools to increase interaction of students to orientation sessions by counselors from local AFHCs. The Chief Minister of MP appreciated the Umang program in a public meeting on 8 March 2021[140] and emphasized empowering girls and need for developing curriculum for boys with focus on positive masculinity. The state government has agreed to widely disseminate the ten boy's centric posters developed by UNFPA addressing gender discrimination through social media, print media and printed on the back cover page of textbooks used in government schools.[141]

Finding # 13. *Gender mainstreaming in adolescent empowerment has been strong, and youth empowerment could be strengthened.*

As per the CP9 Report Progress and Data Sources of RRF and Signature Indicators[142] seven school systems are implementing gender-transformative and rights-based life skill education, fully achieving the RRF output, (Target 6). In states where a scheme for adolescent girls is being implemented (like Advika in Odisha and SAG in Rajasthan and MP), residential school life skill curriculum (in Odisha), and adapted school health programme in Bihar (through Madarsas[143]), it was observed that the life skill curriculum included concept of gender and socialisation process, addressing gender discrimination in food, education and health, prevention and consequence of child marriage, good touch bad touch, violence against girls and women (including cyber ones), menstrual taboos and legislation like the Child Marriage Prohibition Act and *Protection of Children from Sexual Offences (*POCSO) Act 2012. Girls and boys who had dropped out were encouraged to re-enrol in schools in the case of SAG. See quotes at the end of Finding # 13.

There were some state/location specific innovations on gender-transformative life skill education In Bhubaneshwar Smart City; self-defence was also covered, which was much appreciated by the girls and parents. In MP, the issue of construction of masculinity and the challenges it poses for gender discrimination and boys' well-being was also included and is being replicated through the state[144]. Further issues of gender orientation were also covered from 10th class onwards in Madhya Pradesh[145]. In Bihar, the Madrasa curriculum covered girls'/ women's rights within Islam, including in Nikah Nama[146]. A missed opportunity is to integrate good practices from all systems, and foster space for adolescent/ young women's holistic empowerment.

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139 Implementation Research for LSE Phase 1 in Madhya Pradesh. Report. UNFPA 2019.

140 IBC24 TV channel video clip 8 March 2021, Bhopal, Madhya Pradesh.

[141] Government Order 2021, Education Department, Government of Madhya Pradesh.

142 UNFPA, 2021, UNFPA CP-9 Progress and Data Sources of RRF and Signature Indicators, UNFPA, New Delhi.

[143] 'Madrasa' is the Arabic word for any educational institution. In this brief, 'madrasa' refers to any institution of education, especially primary or secondary education imparting Islamic religious education

[144] UNFPA, 2021, Briefing on UNFPA operations in Madhya Pradesh, UNFPA , New Delhi

[145] UNFPA, n.d, Copy of content Matrix (Madhya Pradesh)

[146]UNFPA, 2021, Innovating, Testing and Upscaling (Presentation to the evaluation team by Bihar team), 27, September, 2021

During FGDs of the evaluation team with adolescent girls in Dhenkenal district, Odisha, Sawai Madhopur in Rajasthan, Nalanda in Bihar, slums of Patna and Bhubaneshwar, in Bihar the girls' recall of content varied with duration of the programme (better when three years, whether it was face to face or online (better face to face) and better when the programme had a separate cadre of women staff than making use of already overworked cadres of anganwadi workers. The girls confirmed gains like reduction in child marriage and increase in girls' enrolment. Occasionally, they reported cases of domestic violence against mothers to higher officials for action. MHM practices were shared with mothers and sisters. The FGDs and other methods used in the same sites reveals attitudes of the girls were progressive on non-gender discrimination in food, health and education, rights of women with young children to work, need to break the silence on gender-based violence, on the assertion that marrying the perpetrator in cases of rape was not a solution and that elected women cannot be represented by men in PRIs. Their attitude was, in fact, more progressive than front-line workers, adult women in SHGs and men in PRIs. The progressive attitudes, according to respondents in FGDs, were due to CP9 supported life skills, and also to viewing progressive TV channels, influence of self-help groups and exposure of peer leaders to other states and countries (who shared on return) However, as confirmed by the assessment of Samridhdhi in MP, confusion remains on menstrual taboos[147] (ICRA Analytics Limited, n.d.).

Whether women can work when they had young children and dowry vs property rights were areas of debate in the FGDs with women and aodlescnet girls in Odisha,Rajasthan and Bihar. A constraint, mentioned during discussions with officials involved in the Madarsa programme in Nalanda[148], was the low percentage of women teachers (and high percentage of girl students), and difficulties faced by male teachers in facilitating discussions around puberty and changes in body with adolescent girls.

FGD *WITH A GROUP OF WOMEN*

The issue of absence of both male and female staff applied to AFHCs too. Male counsellors attached to AFHCs in Rajasthan[149] stated that they drew support from untrained ANMs, while female counsellors stated that they drew support from their male colleagues from other AFHCs. Nevertheless, the CP 9 doumentation on case studies in Rajasthan suggests huge potential for AFHCs to addressing issues of gender discrimination, dominant masculinity, GBV, and mental health[150]. A constraint mentioned by the Counsellors was that majority of health providers were not sensitised to provide adolescent-friendly health services. As yet, in all districts and states visited, there was no e-platform (WhatsApp, e-group) for alumni of adolescent life skills program to sustain the momentum after completing the course. Adolescents could also be represented in core groups initiated in such interventions.

"We keep condoms and female contraceptive methods in AFHCs.Adolescent boys and male youth ask for the same, and married young women, but rarely adolescent girls or unmarried girls. Norms are hard to break, especially if the counselor is of the opposite sex" (AFHC counsellors in e-FGD, Rajasthan)

"In Madhya Pradesh, issues of challenging dominant masculinities and challenges facing transgender people have been looked at as part of the curriculum. The comics developed by UNFPA are effective and now being used in other statesas well"(Officials DWCD, Madhya Pradesh).

Finding # 14. *UNFPA technical assistance at the national and state level has led to innovative LSE demonstration programmes implemented in reaching vulnerable and marginalized adolescents based on caste, minorities, geography and disability status with education and SRH services in UNFPA priority states.*

In Bihar, UNFPA has successfully piloted a first of its kind initiative in the country to contextualize LSE within the Madarsa education system without compromising its core elements. Beginning as a pilot in 494 Madarsas in two

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[147] ICRA Analytics Limited, n.d., End-line Evaluation of Samridhdhi – Action for Adolescent Girls Project in Madhya Pradesh, ICRA Analytics Limited
[148] Discussion of Evaluation Team in Madrasa, Nalanda on 5th)ctober, 2021
[149] Met online by the Evaluation Team on 24th September, 2021
[150] Joshi, Aparna & Babre, Tanuja & Sharma, Ayesha. (2021). Colours of Light: A Compilation of Transformative Life Experiences of Adolescents from Rajasthan through RKSK programme.

districts of Bihar, the program is now at scale involving 904 Madarsas, including curriculum for secondary level and committed government funding to upscale the initiative in all the 2000 Madarsas in Bihar reaching 1 million adolescents and strengthening Madarsa's as Regional Resource Centers.[151] UNFPA has been entrusted with implementation of the programme by the Madarsa Education Board of Bihar.[152] Discussions with state government stakeholders and technical resource partners revealed that the program was successful in ensuring Madarsa willingness, developing curriculum in the context of Islamic theology, mainstreaming gender in the Islamic curriculum, bringing pedagogical improvement through increased teacher student interaction (including co-curricula activities), and providing structured capacity building opportunity of Madarsa teachers. (details Part 2 Annex B Youth/EM.13.2.1 to 13.2.5)

"This was the first time that all of us teachers in this Madarsa have undergone such a training. We were never exposed to such interactive and participatory training." Madarsa teacher, Bihar.

Using the Madarsa open ground for life skills based group activities was completely new for me. We don't play in the Madarsa". Girl Student, secondary level, Madarsa Bihar.

In Odisha UNFPA's long term partnership with the Scheduled Caste and Scheduled Tribe Research and Training Institute (SCSTRTI) had helped build on efforts made in CP7 at empowerment of vulnerable tribal adolescents in residential schools under SCSTRTI in Odisha through an innovative convergence program of life skills in 1150 middle and secondary schools, promoting safety and wellbeing and improving access to anaemia screening facilities. Key achievements of the program were teachers transacting weekly life skills sessions on fixed days as part of school timetable, introduction of peer led approach in high schools to complement the classroom sessions; range of resource materials including a multimedia package and comics series; and intiating service provision through roll out of anaemia screening program in five intervention districts resulting in increased anaemia screening and establishment of inter sectoral convergence.[153] Mental health concerns were addressed in the program through 3000 hostels matrons trained on adolescent counseling and mental health who are providing first line counselling in the residential schools (details Part2 Annex B-youth EM13.2.7)

In Odisha interaction with school management and girl students of class 9 and 10 who returned to school in one residential school for girls revealed that LSE has had a positive impact in increasing students' knowledge about growing up processes namely on changes during adolescents, menstrual hygiene management (MHM), RTI & STI, consequences of early marriage & teenage pregnancy and different forms of sexual abuse and its prevention. Students also shared that the sessions increased their confidence in asking questions about their personal issues regarding menstruation, RTI and seeking health services. As one 19-year-old girl student mentioned – *"life skill issues are part of our life. We need to talk about it. Life skills have taught me how to live life confidently."* Another girl student while at home during Covid lockdown acted against eve teasing in her village by complaining to her local panchayat member.

In Rajasthan the state government has invited UNFPA to provide technical assistance in integrating LSE in all government residential schools for girls (known as Kasturba Gandhu Balika Vidyalaya – KGBV) from primarily tribal, marginalized and remote rural backgrounds. The MOU has been signed with the state government with implementation beginning in 2022.[154]

Integration of LSE in Special Schools for Adolescents with Disabilities in Odisha

UNFPA is piloting an innovative program (named Samarthya) in partnership with the Department of Social Security and Empowerment of Persons with Disabilities (SSEPD), Government of Odisha and Kalinga Institute of Social Sciences (KISS) in integrating age-appropriate correct information related to LSE issues for 10 – 19-year-old adolescents with disabilities in all 162 special schools in Odisha. Led by an advisory group of eminent experts working on issues of disability in India, the initiative seeks to build capacity of matrons, teachers, parents, care

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[151] Annual Progress Report 2020, UNFPA.
[152] Agreement between Bihar State Madarsa Education Board and UNFPA, 4 March 2020.
[153] Health, Nutrition and Well Being of Adolescents in Tribal residential Schools in Odisha. Programme Assessment Report, UNFPA, 2020.
[154] UNFPA Rajasthan Programme Brief, 2021

givers. Implementation has been delayed due to school closure for the pandemic. Currently the baseline survey design is being finalized. A booklet on Sexuality and Reproductive Health of Adolescents with Intellectual Disability (AwID) has been developed as part of this initiative in consultation with experts, government stakeholders and representatives of special schools and adolescents with different types of disabilities. It includes topics such as core life skills and its application; reproductive health, sexual health, reproductive rights including rights and responsibilities of parents and guardians, safety and wellbeing, legislations and entitlements among others. UNFPA has supported development of a facilitator's module on sexual and reproductive health for training adolescents with disabilities.[155] Representatives from the SSEPD department, Government of Odisha was appreciative of UNFPA addressing the needs of one of the most vulnerable youth groups in the state. Learnings from this initiative will inform future programing on disability inclusion by UNFPA and developing a future institutional strategy on disability inclusion for UNFPA in India which will be initiated by CO in 2022.

Finding # 15: *Partnerships initiated for integrating LSE in vocational training institutions*

As per the RRF indicator progress report, two strategic partnerships have been initiated out of three towards integrating LSE in vocational training institutions. One is with the Industrial Training Institutes (ITI), Government of MP and secondly a corporate partnership with Usha India Ltd for integrating LSE in their sewing school (Usha Silai Schools) curriculum. Overall there has been mixed results in integrating LSE in vocational training with the efforts being limited to the ITIs and the Usha sewing schools with no engagement with sector skill councils in India.

The Life Skill Education based Jeevan Tarang programme was introduced in 130 government run it is in 2018 as part of collaboration between Directorate of Skill Development, Government of MP and UNFPA [156] . Implementation research[157] results showed that there is a need to evolve a different strategy since the employability skill trainers are on contractual basis for a short period in the ITIs and are not very effective in conducting the LSE sessions. There was a a greater need to involve and build capacities of the permanent cadre of various trade specific teacher/trainers in the programme. Based on discussions with the state government, Indore Zone was selected as the pilot using a more intensive approach in 46 ITIs of 8 districts in Indore Zone. Discussions with the leadership of the ITIs reflected high level of ownership of the programme by the ITI management. However, they shared that the challenges remained since there is limited capacity of trade teachers in these institutes in transacting LSE, particularly on SRH topics thereby requiring intensive capacity development of the trade teachers.

Another effort is a corporate partnership with Usha India Ltd that led to integration of LSE in sewing school training curriculum which is being implemented in 200 sewing schools reaching 4000 girls and women in all four UNFPA priority states. [158] Discussion with Usha management team highlighted the need for strengthening capacities of the sewing teacher, ensuring mentoring and monitoring by the NGOs who manage and operate the Usha sewing centres. The management also shared the need for outreach and advocacy with sector skills council - for accreditation by the nationally recognized sector skills council and integration of LSE within a particular trade system. There is a need to rethink UNFPA niche and value addition in the vocational training institutions beyond integration of LSE towards a more holistic program on implementing a gender transformative approach (including addressing GBV issues) for empowering women and girls.

Finding # 16: *UNFPA has ensured youth responsive multisectoral programming at national level and in priority states particularly for reaching marginalized adolescents and youth (rural and urban)*

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[155] Samarthya Project Progress Report, UNFPA 2021.
[156] UNFPA Programme Brief, Madhya Pradesh 2021

[157] Implementation Research for LSE Phase 1 in MP. Report. UNFPA 2019.
[158] Usha Silai School Progress Report, 2021.

UNFPA is providing significant support to the state governments in priority states in piloting innovative approaches in reaching marginalized and vulnerable youth in diverse community settings. While the programmes have led to empowerment of adolescents, there is a need to ensure that the momentum is sustained, most marginalised adolescents and youth are included, and part of all the activities and older adolescents who are no longer part of the programme are engaged as mentors.

In Rajasthan and MP UNFPA provided technical assistance in strengthening implementation of the RKSK programme.[159] Total of 416 AFHCs have been strengthened in both states and close to 30,000 Saathiyas (peer leaders) have been empowered. The programme adopted an NGO led mentoring process in MP and a government health worker led mentoring system in Rajasthan. An assessment of the community-based component of RKSK showed that the peer-led community focused program is innovative and can potentially have far reaching effects on health promotion and on enabling adolescents to achieve their potential.[160] The report of the above assessment provides a safe social space for adolescents; it conveys useful health promoting information and focuses on changing hierarchical gender role attitudes, and, at the same time, offers a channel through which to link adolescents to health services and Adolescent Friendly Health Clinics. Mental health concerns were included in the program design where 22 topics of RKSK were developed into e-learning modules which was used for training of counselors in Rajasthan and MP. Discussions with the national health ministry revealed high level of appreciation of UNFPA's efforts in providing evidence based results in strengthening implementation of the RKSK programme and keenness to utilize the e-learning resource for training counselors in other states. Responses from interviews with government stakeholders at the national level and in the state government health department in MP showed that UNFPA support was critical in strengthening existing program guidelines, incorporating use of mobile App based processes for real time program monitoring and ensuring convergence meetings between different government departments at the state and district level for program review.

*INTERVIEW AT AN **AFHC***

Endline assessment of the programme in MP showed that adolescent girls perceived that the programme developed/enhanced their decision-making abilities, self-belief, and ability to convince others.161 By the end of the program, they learnt to identify the wrong and say NO, speak out for their rights and dream big and try to achieve that. In endline evaluation, 95% girls knew that India has a fixed legal minimum age for marriage as compared to awareness in 82% girls in the baseline. The overall knowledge on menstruation improved with only 26% girls faced problems during menstruation at the endline as compared to 45% at the baseline. However, certain myths and misconceptions such as women should not visit the temple during menstruation persisted among girls. The endline evaluation also states that parents reported tha the programme made their girls more confident and vocal, more knowledgeable on health, nutrition and personal hygiene, encouraged them to participate in activities outside home, made them able to take decisions. The assessment identified, use of media to engage community members and adolescent such as popular cinema/TV spots etc. as a successful strategys. The program also engaged adolescent girls in manufacturing and social marketing of sanitary pads.[162] However, the evaluation revealed poor lack of awareness about youth friendly services. Note on lessons from the effort mentions that such social marketing efforts require development of proper business model and training of adolescents and women in marketing and communication skills, availability to credit facilities and a strong supply chain system along with revenue collection mechanism to avoid losses.

"We are the Saathiya Brigade. We are a large team of boys and girls in our village. It is because of the programme that I know so much and I am not confident in talking to government officers and people in my village. It is because

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[159] Programme Brief Rajasthan and MP, UNFPA 2021.

[160] Towards a better understanding of the community-based component of the RKSK programme: Findings from a pilot study in 12 villages from Madhya Pradesh, Tamil Nadu and Uttarakhand. RKSK subgroup on peer-led approaches, UNFPA 2020

[161] Endline Evaluation of Samridhhi, Action for Adolescent Girls Project in Madhya Pradesh.

[162] Sanitary Napkin Manufacturing Unit – Note on Lessons Learnt, UNFPA 2021

of our good work that the district administration took our help in undertaking house visits to motivate people for vaccinations during the Covid lockdown.” Saathiya peer leader, female, Chhattarpur district, MP.

The district administration representatives, during meetings with them, acknowledged the contribution of the Saathiya peer leaders in supporting awareness and mobilization for vaccination. The administration also recognized and acknowledged in public meetings the contribution of exceptional peer leaders for their efforts.

UNFPA has piloted engaging young people in civic engagement. Under the project Uday In Odisha UNFPA is providing TA to the state government in a youth leadership initiative in conflict affected areas of Odisha through which it reached 279,000 young people in three conflict affected districts.[163] Virtual interaction with Uday project youth change makers from Rayagada district revealed that their awareness on SRH issues and civic engagement had increased.

“Initiatives such as those under Project Uday gives us the opportunity to think about alternative and positive ways in which I can be support my community.” Change maker – male, Rayagada, Project Uday.

Another youth leadership program in Uttar Pradesh through seven NGOs in seven districts led to youth taking up close to 100 social action projects. These programs offer opportunity for learnings to be replicated for youth engagement in peace building efforts and needs to be assessment to determine the impact on youth leadership and empowerment.

Finding # 17: *Country office has been able to address AY needs during humanitarian situations:*

In 2020, when the pandemic struck and all the schools were closed, innovative initiatives were undertaken in different formats to ensure program implementation and continuity of learning.

In MP, as part of the Umang school program a set of 20 animation videos in 2D format on health, nutrition, life skills developed and shared with group of students on weekly basis across the state using the digital learning platform - DigiLEP.[164] Data from the digital platform show that more than 1 million YouTube View and 260,000 students provided positive feedback so far. Average about 98% of students have remarked ‘Liked’ on the sessions clearly indicating their satisfaction and interest in the online series. Teachers have also shared that the sessions are very useful, and many have remarked these as most relevant considering the negative psychological effects of a lockdown situation. Additionally, 20 videos for class 9 and 15 videos for class 10 were created and telecast as one-hour episodes every Sunday from 12:00 pm to 01:00 pm by the government television channel Doordarshan in MP with the aim of reaching out to students who did not have access to a smartphone and the internet. The responses received are highly encouraging. As of now close to 300,000 positive feedback have been received from students so far.

In Odisha the SCSTRTI undertook a range of activities to strengthen response to COVID19. Key achievements were working closely with Odisha State Disaster Management Agency (OSDMA) for training of volunteers on COVID safety and Management. 2500 volunteers from NSS, NYKS and Scouts and Guides were trained; 4500 teachers, 9900 SMC/PTA members, 254 ANMs,1600 Headmasters and 2400 Matrons were trained through online platform on life skills. UNFPA successfully advocated for integration of life skills education the SCSTRTI Government of Odishas state wide initiative during COVID-19 pandemic named “Alternate Learning and Mentorship Programme - ALMP”.[165] Under this initiative, around 4500 teachers were empaneled to visit around 22,000 tribal villages to provide alternative education and mentoring support to students to continue learnings in these villages. The trained teachers visited their assigned villages twice a week to to interact with students and provide onsite-mentoring support for health and wellbeing of students. Besides, organizing sessions on scholastic subjects, mentoring teachers have been asked to transact LSE and keep a close vigil on issues such as child marriage, teenage pregnancy, psychosocial wellbeing, adolescent health, gender sensitivity and prevent dropout when the schools reopen. While this is a worthwhile initiative, currently no systematic assessment has

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[163] Project Uday progress report. UNFPA 2021
[164] Programme Brief Madhya Pradesh, UNFPA 2021.
[165] Note on Alternate Learning and Mentorship Programme, SCSTRTI, Government of Odisha.

been undertaken to link the output of this to the changes contributing to lowering child marriage, teenage pregnancy etc.

Findings # 18: *CP 9 has been effective in addressing child marriage, drop out of adolescent girls from school, gender-based violence at community but the performance addressing gender biased sex selection has been mixed.*

There are three CP9 indicators pertain to GEWE[166]. Against a target of all four states implementing policies and programmes for empowerment of girls and women, in three policies and programmes for empowerment of girls are reported by CO as being implemented[167]. Another indicator is the **n**umber of interventions for strengthening PCPNDT Act implementation at national and priority state levels.   Five types of interventions were envisaged (advocacy, capacity building, IEC, guidelines, compilation of SC directives) and the target was that 75% of these types of interventions would be carried out in four states and at national level. This target is reported by CO to have been fully achieved. A third indiciator states that "75% of proportion of priority districts in UNFPA supported states implementing multi-sectoral interventions to empower girls and address harmful practices". The report on Progress and Data sources observes that against this target in 66% of districts multi-sectoral interventions are being rolled out at the time of evaluation. Part 2 Annex B on Gender Equality gives the nature of gender related interventions carried out in four priority states and nationally related to these three indicators. It can be seen that that progress stated in RRF and signature interventions by Country Office is higher than evidence in the Annex EM Gender Equality compiled through discussion of evaluation team with gender team, visits to the three states and presentation by state teams.

At an outcome level on RRF 5, gains on gender equality are visible in some issues, but not all. FGDs with women, adolescent girls, young women and elected leaders in Dhenkanal and Bhubaneshwar in Odisha, Sawai Madhapur in Rajasthan and Sheikpura and Patna in Bihar (MP was not visited by the gender consultant and virtual discussions at community level were difficult) suggest that child marriage and domestic/public violence have reduced through CP9 supported awareness generation, gender-training of PRI members, safety audits by women and PRIs, and monitoring by core groups in Panchayats (using WhatsApp in Odisha). While the re-enrolment of dropped-out girls and boys in schools was also reported by the above stakeholders and School head masters inRajasthan (till COVID-19), the same FGDs suggest that demand for dowry continues to be high, which is one amongst the factors leading to mixed performance on gender-biased sex selection. This was also evident in secondary data. In both Dhenkanal and Sawai Madhapur, sex selection was reported to be prevalent in FGDs, and by media reports.[168] Yet another concern is that young women, reported during FGDs, having to discontinue work/ education post marriage due to gender norms, and lack of care infrastructure. Vocational skills and livelihood strengthening of young women are not a programmatic thrust area in CPAP, and this is an area to be look into in the future.

Looking beyond micro level, at national and state level data from NFHS 4 and NFHS 5, improvement is seen nationally in all the indicators (listed in Part 2 Annex B on Gender Equality) between 2015-16 and 2019-21: sex ratio at Birth, ending early marriage, ending intimate partner violence and use of menstrual hygiene products. At the level of the four states, improvements are seen in all indicators other than sex ratio at birth (SRB). While SRB improved in MP and Rajasthan, Bihar and Odisha have seen declines, and Rajasthan's SRB is still precarious at 891 against a global norm of 954. In Odisha, Low fund utilization of budget under BBBP scheme by government is said to have contributed to less awareness on adverse consequences of gender biased sex selection[169]. In Bihar, the reasons for decline are not clear. Child marriage has reduced overall and, in all states, but remains high in Bihar, where UNFPA has invested the least. Use of menstrual hygiene products has improved in all priority states, but is least in Bihar and MP, and maximum improvement is seen in Rajasthan, where the government provided free napkins for both adolescent girls and adult women. UNFPA has contributed to the implementation of the

[166] UNFPA, 2021, UNFPA CP-9 Progress and Data Sources of RRF and Signature Indicators, UNFPA, New Delhi.
[167] UNFPA, 2021, UNFPA CP-9 Progress and Data Sources of RRF and Signature Indicators, UNFPA, New Delhi
[168] Indian Express, 2021, 5th February, Fund use low in Odisha despite declining sex ratio
[169] Indian Express, 2021, 5th February, Fund use low in Odisha despite declining sex ratio

MHM policy in Rajasthan[170], by being in the State level coordination committee. Intimate partner violence has reduced in all priority states but remains high in Bihar. See caselet below for an example of strategy adopted. Again, all improvements cannot be attributed to UNFPA alone.

"Domestic violence has always been high in the village and in Dhenkanal district. During COVID-19, it has increased with every body staying at home, and difficulty in meeting the needs of family members. Violence against women increased. Hence those of us-mainly lenaders- in SHGs with WhatsApp formed an e group. Anybody facing violence could call or message us, and we would visit them and take action immediately. One of us had taken loan for purchase of auto rickshaw (three-wheeler), and we used this for visits. The auto was driven by a male relative, but this came in handy to handle the men if the situation became difficult. We have handled several cases like this. Now the government is thinking of replicating third model" (feedback from SHG leaders, Dhenkanal, Odisha).

"For two-three years we have been part of the Scheme for Adolescent group. We have been trained on different legislation and schemes to protect girls, children and women. Parents of one of our classmates of 16 years were planning to get her married as a good proposal had come. She did not want to do so, and knew it was illegal. We peer leaders of the programme informed the Saathin (front line worker from the DoWCD) who got in touch with the parents and informed them the negative consequence to the girl and that they would have to report the matter to child help line and police, if they did not change the plan. The girl is continuing to study as she wishes!" (Adolescent group, Sawai Madhopur, Rajasthan).

Whether UNFPA's work on capacity building of Appropriate Authorities in 22 states (including MP) and Union Territories and with Judicial Authorities in 9 states (including MP) and its presence in the steering committee of MWCD on schemes that address son preference and media and civil society campaigns contributed to the slight improvement in national SRB is a question with no definite answer. Authorities in one of these states observed that along with capacity building the rate of conviction of violators under the Act was low, and that implementation of other legislation that have a bearing on implementation on son preference needs to be strengthened,[171]

Finding # 19. CP9 has used a variety of media strategies to challenge discriminatory social norms and practices on gender, and promote positive ones during normal and COVID-19 times, but not so much during flood Bihar and Odisha Cyclone. Limited access of adolesnet girls/women to smart phone and limited internet connectivity have been constraints.

Several innovative initiatives have been launched to address gender discrimination and GBV during normal and COVID-19 setting, and not much in disaster situations[172] The DWCD in Rajasthan, which upon a missed call to the number 7733959595. gives 15-minute entertaining messages on gender equality and life skills[173]; the alliance to create an Android app called Bandhan Tod, meaning "Break Your Shackles", that enables girls in Bihar to quickly and confidentially reach out to a network of civil society organizations when in distress[174], the mascot Tiki Mausi is used by DWCD and Mission Shakti in Odisha to communicate messages on GEWE. This mascot and its communication messages were ideas supported by UNICEF and UNFPA[175]. "Yeh Kahani badalni hai" is a

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[170] Name of UNFPA is mentioned in the State level coordination committee of MHM guideline of Rajasthan for monitoring. DoWCD, 2018, Operational Guidelines for Menstrual Hygiene Scheme for Girls and Women in Rajasthan

[171] Included one UNFPA Consultant and one Advocate.

[172] See https://india.unfpa.org/en/videos

[173] UNFPA News 10th October 2021, Mobile Phone Edutainment helps prevent Child Marriage, https://india.unfpa.org/en/news/mobile-phone-edutainment-helps-prevent-child-marriage.

[174] Asokan, Akshaya, 2018, Young girls in Bihar are using this app to fight child marriage and dowry abuse, edexlive ,24th January, 2018.

[175] Report Wire, January, 28, 2022, National Girl Child Day: Odisha Govt's Initiative For Safer Society For Girls & Women – ODISHA BYTES

https://www.reportwire.in/national-girl-child-day-odisha-govts-initiative-for-safer-society-for-girls-women-odisha-bytes/

campaign which uses youth to bring about changes in gender attitudes and norms in Rajasthan and UP[176]. In MP, Saathiya cinema is used by UNFPA partners to discuss issues like child marriage, reproductive rights, gender-based violence, etc. The comics on life skills evolved with support from UNFPA have been used elsewhere, too. In Bihar, "Raatri Chaupal"(night discussions), "Saas bahu Sammelans" (mother in law and daughter in in law meetings), "Purush Sammelans" (men's meetings), "Nari Sammelans" (women's meetings), etc., are used by partners, with the CMO of SheikPura requesting expansion of these initiatives[177]. *See quote below. National and Urdu print media have been reached through partners of UNFPA on gender equality.[178]* UNFPA has worked with the Ladli campaign to strengthen capacity on gender sensitive reporting (including on transgender issues), media regulation, and rewarding gender-sensitive reporting. During COVID-19, UNFPA along with Ladli, Whistling Woods International and, Screen Writer's Association as promoted "e-lockdown diaries" which placed issues of child marriage, gender-based violence and shared care on the agenda. Systematic assessment of the outcome of use of digital platforms for gender equality have not been carried out. FGDs at village level with women and adolescent girls in Bihar, Odisha and Rajasthan, suggest that smart phone ownership of women and adolescent girls and internet connectivity was limited. On the other hand, the face-to-face campaigns, screening of movies, and visual materials (flip charts, posters) were appreciated by women, girls and men met.

" Ask UNFPA to increase number of villages covered through Ratri Chaupals, Purush Sammelans and Nari Sammelans after Covid -19 reduces. The offtake of maternal and contraceptive services (by married couples and male youth) improved. We use the flip charts on maternal health, family planning and GBV during pregnancy developed by your partner and UNFPA in own training eslsewhere too"(Chief Medical officer, Sheikpura)

Finding # 20: *Gender mainstreaming in SRH better on FP and maternal health and for married couples than for full range of ICPD and for adolescents and transgender persons. Training on addressing GBV at national level yet to percolate to district levels in four states.*

The report "Progress and Data Sources of RRF and Signature Indicators[179]" suggests that in six of nine (66%) districts, the capacity of duty bearers in rendering rights based SRH had been strengthened as of 2020, against a target of seven in nine districts (75%) by 2022. According to the UNFPA, 87.6% of facilities in Gavjapati, Rayagada, Udaipur, Sawai Madhopur, Jaisalmer and Chattarpur were taking women's consent before PPIUCD insertion in 2020, against a target of 75% by 2022. Service providers met in the CHC Sawai Madhapur reported following "respectful care" (consent, privacy, confidentiality and birth companion); as women came to the labour room in advanced stages of labour, clients could not always be informed of their rights to standards on "respectful labour". Women belonging to Scheduled Castes (10 women) in a slum of Patna when asked about quality of service, reported that they were provided respectful delivery care (no caste names, no shouting) in government health facilities, but half reported delivering now in private sector as public delivery services which were available in the area in health sub centers were now available in bigger public facilities located further. Large surveys of client perception of how far delivery services delivered are respectful is not available. The same CO report notes that 32% of healthcare facilities deliver integrated sexual reproductive health services (contraception, prevention of abortion, safe delivery, RTI/STI) in UNFPA focus districts in 2020, exceeding the target of 25% by 2022 However, this could not be triangulated. Discussion of gender consultant with 16 service providers in one CHC, one health and wellness center and one district hospital in Sawai Madhopur, Rajasthan one district hospital in Sheikpura in Bihar suggests that the rights-based SRH services promoted under CP9 were mainly related to FP and delivery care, with abortion being available only for married women, and younger women if they came with parents or through the police. Modern methods of contraception focused mainly on women (with male sterilisations being low in number), and according to providers met in Sawai Madhopur, women had to compulsorily adopt a method before leaving the labour ward, which does not seem rights based. On the other

[176] Khullar, Priyanka, 2020, Together with Communities, Changing the Narrative, ActionAid India, Wednesday, 30th September 2020

In https://www.actionaidindia.org/story/together-communities-changing-narrative/

[177]UNFPA, 2021, Innovating, Testing and Upscaling (Presentation to the evaluation team by Bihar team), 27, September, 2021

[178] UNFPA, 2021, Gender and Rights, Ending Gender based Violence and All Harmful practices, Meeting with the CPE team, June 22, 2021

[179] UNFPA, 2021, UNFPA CP-9 Progress and Data Sources of RRF and Signature Indicators, UNFPA, New Delhi.

hand, the nurses in CHC reported providing services to women with disabilities (motor, sight, hearing) and sex workers. So far, no transgender person had come for SRH services other than for HIV consultations (however, provision of SRH services to transgender persons was not part of CP9 design).

The report "Progress and Data Sources of RRF and Signature Indicators[180] indicates that against a target of 700,000 adolescents accessing reproductive health information by 2022, only 420000 have been reached in the four states as of 2021, one of the state's reasons was limited outreach during COVID-19. In Rajasthan, according to two AFHCs visited/e-visited by the gender consultant the unmarried adolescent girls found it difficult to access contraceptive services through regular FP booths attached to the CHCs and district hospitals. The pictures on the walls of a family planning booth which was observed by ET in Rajasthan[181] were of married (abled bodied) couples accessing contraception. The barriers seem to be both at supply and demand sides, with only 48% of providers in these four states having received training in youth friendly SRH, against a target of 75% as per the same report cited above. There is an opportunity to strengthen male involvement through HWCs, which include a Community Health Officer who could be a male (was a male in the centre met in Sawai Madhopur, Rajasthan). They could also promote male involvement in women's health as well as uptake of vasectomy where appropriate. ANM in HWC Rajasthan mentioned that they (manually) examined women for breast cancer, this could not be ascertained with clients. She was confident of screening for cervical cancer screening if trained. At the national level, the Country Programme has engaged with MoHFW on strengthening health sector capacity to address GBV. As mentioned under finding 9 (SRHR), CO has developed a reference manual for GBV which has been used for training of health professionals. However, the training had not percolated to health providers linked with one stop centres and AFHCs, and this was not planned in CP9 at state level systematically[182].

*"We greatly benefitted from online training on counseling on GBV during COVID-19. Not only we got trained but also protection officers, police and members of free legal aid centers. The value addition is the guidelines on dealing with cases of domestic marriage and different kinds of counseling (individual, couple, family, group). However we are constrained by varying sensitivity of medical officers as they have not been trained" (*One stop centers in Bhubaneshwar and Sawai Madhopur).

Finding # 21: Gender mainstreaming in population dynamics has been stronger at national level and in Odisha, and could be strengthened in other states. There is a need to strengthen institutionalization of gender in population dynamics within national institutions, so that they do not remain as one off initiative.

The report "Progress and Data Sources of RRF and Signature Indicators[183] includes a target of 6 technical papers and policy briefs to be developed on emerging population issues against which 16 technical papers/briefs have been prepared. These cover gender specific ones on sex selection and sex ratio, harmful practices on girl child, adolescent girls' empowerment, value of the girl child and child marriage (Kaur and Kapoor, 2019, Neetha and Abhraham, 2019, UNFPA, 2021). The PD unit and the gender unit in CO worked together to help the MoHFW draft the ICPD+25 report for the Nairobi summit. Meetings with UNICEF and UN Women indicate that these reports are valued and used by other UN agencies. The Evaluation team opines that state level research on gender was not as strong other than in Odisha. In Odisha, it supported the state office and DWCD to prepare a state profile of women and girls[184]. It also supported DWCD in Odisha on using SDG 5 statistics to rank districts, as well as to estimate the number of adolescent girls for MHM programmes[185]. Additionally, in MP, UNFPA and the National Health Mission consultant collaborated to rank blocks according to sex ratio at birth[186].

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[180] UNFPA, 2021, UNFPA CP-9 Progress and Data Sources of RRF and Signature Indicators, UNFPA, New Delhi.
[181] Visit of gender consultant to CHC in Chaut Ka Barwar, Sawai Madhopur, 21st September, 2021
[182] Reflected in the presentation of the MP team to the Evaluation Mission (but could not be validated), and not the other states. (UNFPA, 2021, Briefing on UNFPA operations in Madhya Pradesh, UNFPA , New Delhi)
[183] UNFPA, 2021, UNFPA CP-9 Progress and Data Sources of RRF and Signature Indicators, UNFPA, New Delhi.
[184] Department of Women and Child Development and UNFPA, 2020, #Odisha for Women, DoWCD, Government of Odisha, Bhubaneshwar.
[185] UNFPA, 2021, CP9 Population Dynamics, Presentation to CPE Team, June 21,2021
[186] Discussion of Evaluation Team with PCPNDNT focal person, Department of Health, Madhya Pradesh on 11tht November, 2021

Another RRF output indicator is "Proportion of Sustainable Development Goal indicators in the areas of UNFPA mandate that have disaggregated data available for monitoring". UNFPA 2021 report notes that that against a target of 90%, on 75% indicators disaggregated data is available for monitoring. How much of this achievement is due to UNFPA, due to other agencies and government itself is not clear. This includes strengthening question under NFHS on gender and decision making on sexuality (5.6.1), organizing a workshop on gender statistics for the National Statistical Systems Training Academy (NSSTA)[187] and strengthening Census data on sex ratio at birth an opportunity is to strengthen trend analysis on SDGs 5.6.1 and 5.6.2 nationally and in priority states, as well as analysis of how other gender indicators (e.g., asset ownership influence, domestic violence) influence 5.6.1 and 5.6.2. Data on violence against adolescent girls is another gap in the country.

FEMALE SANITARY WORKES

Five FGDs by ET in Bhubaneshwar and Patna with women, adolescent girls and boys suggest that smart city i nitiatives, classified as a PD initiative in CP9, have reduced GBV and early marriage, challenged stereotypes involving young women and SCs (Patna), and strengthened accountability of municipal government to marginalized. However, issues of youth employment and safe migration have not been addressed.

"*We were sanitary workers on daily wages, and some involved in manual scavenging[188] earlier, in Patna. We were not allowed in some of the tea shops*

as the task we did was considered polluting. We earned only Rs 100 a day then. Patna Municipal Corporation, UNFPA and Diksha Foundation "upskilled us". We have been trained in driving a vehicle and desludging operations We now earn Rs 350 a day. We now command respect, as we do what men do and better with no cigarette breaks! The sanitation federation, which we are part of, owns these vehicles". (Women in desludging operations, Patna, 3rd October, 2021)

Facilitating factors (with regard to addressing gender discrimination, GBV and gender mainstreaming):

The facilitating factors behind what was achieved on gender discrimination/GBV are the following: The presence of several legislation and national schemes to end gender discrimination, competence and support from gender team at CO level, State Programme officers' commitment to and capacity on gender equality, UNFPA's presence in adequate number of districts, presence of competent gender consultants at state level, and level of coordination of other UN agencies (notably UNICEF). The presence of a State Coordinator from a minority community aided work with the Department of Minority Affairs in one of the states. At the national level, the fact that UNFPA is housed in MoHFW aided work on PCPNDT as it is in charge of implementation, though the results were mixed. The presence of a separate cadre of front-line staff with DoWCD in some states and long history of local governance aided implementation of multi sectoral work at the grass roots through implementing partners. The larger priority of politicians also made a difference. For example, in one state the ruling party wanted to work with men and boys on masculinity, in another women's empowerment was a concern, with a quota of 50% in local governance.

Gender mainstreaming in SRH was better when state coordinators combined medical, public health and gender backgrounds.

Hindering factors (with regard to addressing gender discrimination, GBV and gender mainstreaming):

The hindering factors (apart from being the reverse of facilitating factors), include the sudden outbreak of epidemic, which constrained implementation, in particular work with medical doctors on addressing GBV. They were busy with work related to COVID prevention. Further, face to face support was not possible by

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[187] UNFPA, 2021, CP9 Population Dynamics, Presentation to CPE Team, June 21,2021
[188] *Manual scavenging* refers to the unsafe and manual removal of raw (fresh and untreated) human excreta from buckets or other containers that are used as toilets

the gender team at country office. The Gender budget of CP9 was limited, and this was a constraint. Gender mainstreaming was constrained by positioning gender unit under "gender and youth", lack of access to checklist to screen work plans and varying gender capacity of other teams

Effectiveness: Population and Dynamics

EQ 4 and 5 under Effectiveness - The extent to which the interventions supported to increase availability and use of disaggregated data on emerging population issues at national and sub-national levels

CP Output 3: Strengthened national capacities to include population dynamics in sustainable development planning efforts and in rights-based policies and programmes at national and state levels.

Summary of findings (Output 3):

UNFPA undertook many worthwhile enterprises in strengthening national and sub-national capacities to collect and monitor ICPD and SDG indicators, with increasing disaggregation (especially sex/gender and diversity) and, by and large, succeeded in this role. It also succeeded in capacity building activities to use disaggregate data for policy making but such activities were one-off- there was no larger strategic plan to increase capacity across all focus states. UNFPA created knowledge through academic studies, but there was no larger medium run vision on how such research would be taken to policy and it lacked regional focus. It achieved greater success through documentation of successful interventions like the Smart City Initiatives. The Smart city initiatives in Bhubaneswar and Patna represent the biggest success in the theme of population dynamics where interventions were blended in well with ICPD topics of urbanization and migration. Further the interventions for the older persons during Covid highlighted and spoke to issues related to ageing -another important demographic issue. These interventions also reflected a desire to partake in interventions on the such demographic issues that population dynamics has been raising at the national level through its knowledge creation. The population dynamics group continued in its traditional role as the data and evidence provider to other thematic groups of UNFPA. However, there were differing views on optimal weights of the different roles, and some incoherence on this part remained through most of CP-9. Overall, UNFPA was able to perform adequately on it's various designated outputs of generating disaggregate indicators and creating knowledge on issues of population dynamics to meet the overall outcome of stregthening the national capacity at various levels of governace.

CP9 population dynamics (PD) programme had a four-pronged strategy to increase national capacity for planning at the national and state level. First (*Strategy 1 – for reference see Annex E (part2 Annex PD TOC attached)*), it sought to strengthen the national capacity for collecting data (see TOC: B.3.), and for use of such data at the national and sub-national level (TOC: B.2.). It did so by engaging with large data systems and more directly with large surveys-where possible, encompassing aspects of gender mainstreaming. It also sought to provide its technical expertise, advocating in some instances new methods to arrive at disaggregated indicators (TOC: B.4.). Second, it interacted with the academic community- bringing new evidence to the fore through eminent scholars (TOC: C.1.) and began, though in a limited way, to enable young researchers to work in areas of UNFPA interest (TOC: B.1.). Such evidence, as well as that generated internally was subsequently disseminated in conferences, workshops and through blogs, media writings, workshops and meetings and was aimed at sensitizing the public and policymakers (TOC: B.5.; C.3.)- (*Strategy 2*). Third, it provided support for other thematic pillars: by analyses of relevant data, which in some instances laid the groundwork for policy advocacy (TOC: A.1.) and helped in mobilizing resources for interventions (TOC: C.4.)- (*Strategy 3*). Fourth, it raised awareness of key and emerging issues of population-demographic dividend, urbanization, ageing, migration for policy makers (TOC: C.3) and provided convergence between key areas of population dynamics-urbanization in particular, and interventions relevant to SRH, youth and gender (TOC: C.2.) - (*Strategy 4*). The CPE team identified significant positive results from the PD programme, as described below. It also identified missed opportunities, some of which can be redressed by a follow up-these are highlighted at the end of the section.

These findings are based on information collected in response to assumptions laid out in the evaluation matrix. These are provided in Annexure, which also contains references to sources of information. Due to the page limit,

the details are in Part 2 Annex B on PD, and at the end of each finding, section numbers of the evaluation matrix (EM) are mentioned and can be referenced for information on evidence.

Finding # 22: *UNFPA undertook many worthwhile enterprises in strengthening national and sub-national capacities to collect and monitor ICPD and SDG indicators, with increasing disaggregation (sex/gender, disability and diversity) and, by and large, succeeded in this role. It also achieved some success in capacity building activities to use disaggregate data for policy making.*

UNFPA took important aspects in increasing capacity of collecting, monitoring and using data, especially for the ICPD and SDG indicators through the following steps:

Technical Advice on Indicators: UNFPA influenced all large data systems with varying degrees to collect SDG indicators as well as to affect its disaggregation; as a consequence, India provides 75% of the priority SDG indicators (the total number of indicators includes the disaggregates by Age, Sex, State, Districts, Social Group).[189] Ministry of Statistics and Programme Implementation (MOSPI) officials recognizes the contribution of UNFPA for technical advice regarding SDG indicators, for example-nominating UNFPA to the Health and Gender sub-committee and the Data for Development Forum-groups that focused on SDG indicators and its disaggregation. Often it clarified issues, for ministries and statistical division, on SDG/ICPD indicators-the appropriate customization of questions to the Indian context or issues of sorting out the correct data source.[190] This is continued success for its traditional role on indicators it is custodian of. [For more see Part 2- Annex B on PD EM 1.1]

Mobilizing Surveys to Measure: Given UNFPA's nodal ministry is the MoHFW, its largest role is through the National Family Health Surveys (DHS for India). This is a large survey and getting questions included in the survey to calculate SDG indicators is a fairly competitive process. The Population Dynamics group (PD) had considerable success in retaining and adding questions in the latest NFHS (for example for SDG indicators 5.2.2 and 5.6.1).[191] This is seen as a success internally as well as by other stakeholder-including those in key academic bodies.[192] [see Part 2 Annex B on PD, Eval. Matrix 1.1]

Improving Quality of Data: UNFPA contributed positively in measures to improve the quality of data collection. There is a general recognition in India data systems that quality of data needs to improve and some of this can be achieved through modernization of training techniques and collection tools. UNFPA engaged in this worthwhile endeavor with Office of Registrar General of India (ORGI) (as a part of pan-UN initiative) for census data (creating e-manuals for census enumerators and coordinating the combined UN initiative)[193] and with the National Statistical Systems Training Academy (NSSTA), the training wing of MOSPI, for improving the quality of enumerators.[194] [For more see Part 2 Annex B on PD, EM 1.1]

Disaggregated Indicators: UNFPA took a small but important step in supporting imputation based disaggregate statistics. Traditionally, PD's role in obtaining disaggregate data deals with influencing surveys like NFHS and for suggesting appropriate data sources. While it played its usual part in that (see findings above), it responded to this need by advocating a relatively sophisticated imputation method-small area estimation to MOSPI.[195][196] Small

[189] UNFPA (2021): Progress of RRF and Signature Indicators-CP9, Accessed at https://sites.google.com/unfpa.org/india-mymne/mydashboard/tracking-key- indicators.

[190] UNFPA (2020), "Sex Ratio at Birth in India: Recent Trends and Patterns' 2020", New Delhi

[191] Source: Key members on technical commitees on the National Family Health Survey.

[192] Interview of academics working on demography (see under interview list).

[193] UNFPA: Census Support Documents 2019; Minutes of meetings ORGI 2019; E- Modules 2020; Interview with key ORGI official

[194] UNFPA (2021), "Outline of Certification Course for Survey Investigator: Module for Health and Nutrition Surveys", Internal Draft.

[195] UNFPA (2019), Small Area Estimation Workshop: Hands-on Session: Key Steps, October 2019, Presentation

[196] MOSPI (2020 & 2021), Meetings of the Committee to bridge the data gaps for Sustainable Development Goals (SDGs) indicators through Small Area Estimation techniques, Minutes.

area indicators-for example, district level level indicators are important because in a large country like India with great heterogeneity, high level planning (national level/state level) needs to be reinforced with district level planning and monitoring. This is an important innovation, in its early stages (such methods have been standardized for poverty but not for issue in the domain of UNFPA), and there has been some success in getting MOSPI to agree to experiment with such techniques. This is important step forward for UNFPA since this is a relatively sophisticated approach and it's technical contribution will speak to its core area-bringing in technical expertise. [For more see Part 2 Annex B on PD, EM 1.2]

Capacity to use Data: The general consensus among those advocating data usage (MOSPI, academics, UNFPA staff) is that officials, especially at the sub-national level, do not know how to use data or are not always aware of "facts" based on data. UNFPA conducted a training program to build capacities of state, district and block level health officials and data managers in Rajasthan on use of Health Management Information Systems (HMIS) data and this seemed to have great success, according to its beneficiaries (this was a repeat of similar success in Bihar in an earlier CP). This project spoke to the problem of "data illiteracy"-a problem highlighted by national level officials in the use of disaggregate data for sub-national planning.[197] From all relevant sources (trainers, trainees, state office, country office), there was an acknowledgement that this was a meaningful way to increase capacity. [For more see Part 2 Annex B on PD, EM 2.1]

Findings # 23: UNFPA was successful in fostering knowledge creation through its commissioned work and documentation of successful interventions.

Knowledge creation: UNFPA continued to be able to reach out to eminent researchers on issues related to ageing, migration, urbanization and demographic dividend. This is important as a majority of them felt that raising knowledge on such issues was critical to creating the environment for policy (or policy change) in India. It continued to have success, though sporadically, in affecting policy (the work on child marriage in Odisha being noteworthy). Workshops and National dialogues were well attended and some of them led to key technical input (for example-the National policy for senior citizens).[198] [199]The public outreach of PD through blogs, social media posts, articles in newspapers, was deemed as satisfactory, according to sources in academia. [For more see Part 2 Annex B on PD, EM 2.3]

Documentation as a path to policy influence: In addition to academic endeavors, in this CP, UNFPA achieved some policy traction through process documentation of a key intervention it undertook in the area of socially inclusive cities-the Bhubaneswar Smart City Initiative.[200] Typically, to influence policy, UNFPA has sought to provide evidence on interventions and lobbied to incorporate emerging issues into policy. Making Smart cities socially inclusive was a newer concept, with more uncertainty on what exactly to do. One of the key outputs from UNFPA's involvement in this endeavour was to document the entire process of how to make smart cities socially inclusive, in practice. This formed a potential template for future implementation by various governments (for example state governments) and got traction in policy circles. This also reflected a vision for UNFPA to how to take the agenda of population dynamics like urbanization, migration more directly into concrete policies. [For more see Part 2 Annex B on PD, EM 2.3 and EM 2.5]

Findings # 24: The thematic groups of SRH and Youth and Gender were ably supported by Population Dynamics group in data and evidence support.

Support to Other Thematic Pillars: The Population Dynamics (PD) group played its traditional role of providing data support to other thematic groups of UNFPA. A large part of PD work was, in fact, in generating evidence to support other thematic areas. These were more hands on at the national level (every other thematic group spoke positively about the support PD provided) and seemed to be more advisory in nature at the state level. This had,

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[197] Key government functionary in MOSPI
[198] UNFPA (2020), "National Dialogue on Population & Development", Concept Note.
[199] UNFPA (2019), "National Action Plan for Senior Citizens" Final Draft.
[200] See documents of BSCL-UNFPA in document review

perhaps, more to do with the capacity of the national office which relied on PD for data and evidence (according to sources in Country Office), whereas the capacity to work with data was higher through state consultants in Rajasthan and MP and through the UNFPA state staff in Bihar and Odisha (state presentations and field visit observations). Such instances included many requests for data, help with implementation research of Life Skills Education project and RKSK, on child marriage[201], on analysis of HMIS and LMIS to monitor projects, and on SDG indicators for advocacy.[202] Majority of the recipients of support (other thematic groups, state program officers, consultants) pointed to one key resource person in the country office as the primary driver of the support. [For more see Part 2 Annex B on PD, EM2.5]

Findings # 25: There was Convergence between key areas of population dynamics and interventions relevant to SRH, youth and gender

Population Dynamics Group in Intervention Mode: In the past, PD has largely provided evidence on support to other thematic pillars of UNFPA. There was a feeling among some key functionaries that population dynamics should play more active role in interventions on topics of demographic dividend, urbanization and ageing, which are key demographic issues. In the past this has been a challenge due to overlap of its key themes with areas under the purview of other UN agencies. In CP-9, UNFPA was able to intervene in emerging areas of population dynamics-in particular on urbanization (with small components of ageing and migration)-through the Smart City Initiatives in Bhubaneswar and Patna [203], and on ageing through interventions during COVID [204]. While interventions were finally delivered through other thematic groups (as activities in their area), there was some active thinking-at least at the stage of conception- (as indicated from documents of smart city initiative, interviews with key PD personnel who planned these activities) on how these interventions fit into issues like social inclusion in urban spaces, issues of migrants in Slums, safety for women in cities of India. [For more see Part 2 Annex B on PD, EM 2.5]

Gender and PD Strategies:

Engagement with Gender Issues: As mentioned above, UNFPA influenced gender in data sytems by the inclusion of questions in the NFHS that had to with SDG indicators 5.6.1 and 5.6.2 that have directly to do with issues of gender (e.g.,un-met need for contraception, intimate partner violence). It also played a key role providing evidence on child marriage that influences state level action plan (Odisha). In addition, its work on Sex Ratio of Birth was cited by NITI Aayog as the basis on which it tracks GBSS in it's SDG dashboard. There were many fora at the national level where it provided resource people that addresses issues of gender (Health and Gender Sub Comitttee, NSSTA) as well as the state level.[205] An important step in this direction was the Smart City initiatives in Bhubasneswar-which sought to inform women on safe spaces as well as in Patna where initiatives were taken to address gender vulnerabilities in migration, to promote gender friendly slum development and to extend health and urban infrastructure services to female sanitation workers. [see Part 2 Annex B on PD, EM 3.1]

Findings # 26: Mixed Results/Missed Opportunities:

Moving Beyond NFHS: While UNFPA's engagement with national data systems is expectedly focused on health and gender (it's priority areas), there is a need to engage more with the National Sample Survey Organization (NSSO) that collects data in India regarding issue of population dynamics (ICPD)-migration, urbanization and on specialized surveys on sub-populations that are small in number and whose indicators are hard to calculate with

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[201] Source: Internal assessments on Social Marketing of contraceptives and free supply of contraceptives (FP), monitoring framework of FP programs, analytical support on SRHR data, HMIS data analysis, Analysis of NFHS data on unmet need for Odisha, estimation of missing girls, evidence on women policy in Odisha and Rajasthan, SAG and Menstrual Hygiene Management, analysis of NHFH-4 on MHM
[202] UNFPA (2020), "Sustainable Development Goals and gender equality, Orientation of Planning Officers Planning and Convergence Department, Government of Odisha", Presentation
[203] See documents of BSCL-UNFPA in document review;
[204] UNFPA (2020), "Elder Care in India: Responses during COVID", Presentation Slides.
[205] UNFPA (2020), "Gender Statistics: Feb 2020", NSSTA Presentation

other data sources. Such an opportunity was missed, for example, with UNFPA absence in the special NSSO survey on disabled people. [For more see Part 2 Annex B on PD, EM 1.1]

Ownership of Imputed Indicators: The step from creating imputation-based indicators to their use in policy work is a crucial one and a possibility of the lack of "ownership" was cited by many officials[206] on why they have some hesitance in investing more in it. UNFPA does not still have a concrete plan on how it will create this ownership. [For more see Part 2 Annex B on PD, EM 1.2]

South-South Cooperation: The Indian census activities could do with many upgradations and learnings from census operations of other southern countries (some of which UNFPA interacts with globally). UNFPA was not able to strategize on this. [For more see Part 2 Annex B on PD, EM 1.3]

Capacity Building UNFPA capacity building initiative reflects both its success and failure. The general consensus among those advocating data usage (MOSPI, academics, UNFPA staff) is that officials, especially at the sub-national level, do not know how to use data or are not always aware of "facts" based on data. UNFPA missed out on pursuing capacity building on data usage as a strategic activity, in-spite of the historical fact that it was equally successful in such an endeavor in Bihar during CP-8. The discontinuation of the Rajasthan training program reflected unclear thinking on how to take such training forward-the lack of an evaluation framework in the long run plagued the program. It was also not clear why such attempts were not made in other priority states. This also reflected a general problem in how "capacity building to use data" activities were visualized within UNFPA-a lot of it depended on individual initiative of program officials in states and while there was a general appreciation of the need to build capacity for data at the country office level, there was no strategy across priority states to initiate such an activity. Such idiosyncracies can also been seen in state level trainings-training was initiated when it was demanded (Odisha), but there was no larger strategic plan to increase capacity across all states. [For more see Part 2 Annex B on PD, EM 2.1]

Lack of Transparency: While there is good research produced due to PD activities, the outreach to young researchers is limited. This is especially so for state level institutions. The process of giving support to researchers was network based (ostensibly to guard quality of those being supported-perhaps, a valid concern); however, this could also be viewed as a non-transparent procedure for the larger community interested in being supported. [For more see Part 2 Annex B on PD, EM 2.2]

Paper to Policy: On the whole, the quality of papers produced were good, but there did not seem to be a strategic plan on how to influence policy makers-even in the medium run, through particular specific areas within broad themes. While there were sporadic successes (mentioned in the findings), there was no strategy on paper to policy transformation. In addition, what was especially missing was a regional focus in any of the commissioned research, which was a missed opportunity, since there could have been synergies with the on-the-field presence in the priority districts and states. [For more see Part 2 Annex B on PD, EM 2.3]

Lateral Outreach: Apart from collaborations on census issues (mentioned above), there was no evidence that UNFPA raised the capacity of other UN agencies or NGOs. [For more see Annexure EM2.4]

Gender: There are gender modules as a part of routine training but NSSTA views these as a "routine" activity delivered by a knowledgeable "resource" person.[207] This is a missed opportunity as gender sensitization is more than gender statistics and a more intervention mode with NSSTA could have been attempted. [For more see Part 2 Annex B on PD,EM3.1]

Facilitating Factors

1. Some state government departments, in particular in Odisha and Rajasthan, took pro-active interest in capacity building, evidence and data usage activities, and UNFPA was able to respond these demands

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[206] Key officials in MOSPI
[207] UNFPA (2020), "Gender Statistics: Feb 2020", NSSTA

adequateley While this is itself a product of years of networking activities of UNFPA state officers, such a stand facilitated the success that UNFPA achieved in capacity building.

Hindering Factors

1. Within the PD thematic areas, there seems to have been a difference of opinion on the relative weight to be put on different activities. Some members of the PD (including senior management), sought to de-emphasize the traditional role of support to other thematics areas and extend PD activities more towards other areas of population dynamics- especially to the "intervention mode", whereas others felt that the competency of PD was largely in providing solid evidence base and research. It is not clear whether this led to any perceptible difference in outputs-however, there were noticeable gaps in both the strands- Smart city initiatives lacked a solid data driven evaluation framework (a core strength of PD), whereas some state consultants reported that they could have done more at the state level with help on data issues. [For more see Part 2 Annex B on PD,EM 2.5]

2, Tangential Drift: PD resources are low. They were, at times, asked to partake in activities that took up their time (eg., working with Bhutan, Adolescent Investment Case Study). While it is not possible to causally attribute missed opportunities directly to these activities, given the shortage of staff and the number of activities (as expressed by the PD staff), it is possible that this is was an unnecessary diversion of scarce resources. [For more see Part 2 Annex B on PD, EM 2.3 and EM 1.3]

4.4 Answers to Evaluation Questions on Efficiency

Evaluation question 6: To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools, approaches and partnerships, including SSTC, to pursue the achievement of the outcomes defined in the UNFPA country programme and in its response to humanitarian crisis (including COVID 19 response

Summary Findings
Based on the interview feedback and the documental evidence, CO has been able to manage the programme well and has achieved most of the planned results despite limited financial and human resources. Several additional responsibilities are also absorbed within the existing human resources (HR). Resources invested by UNFPA have had a leveraging effect (triggered provision of resources from other development partners) and joint programming enabled expanding interventions with the same available HR. UNFPA's state level presence, consultants for support to the programme at state level and the significant support by district consultants in priority and aspirational districts have contributed to successful implementation of the activities.

UNFPA has made good use of its gender team in COs and IPs and its gender consultants at state level. The gender and youth strategy has supported gender integration in youth interventions more than gender mainstreaming in SRH and PD. The gender team responded well to addressing unanticipated issues like gender discrimination during COVID-19. According to the gender team, it was constrained by lack of a guideline/framework for reviewing work plans from gender lens. The evaluation mission perceives the limited budget allocated to gender issues (and hence few Ips) , gender being unevenly integrated into job descriptions, absence of state gender persons and of state-level gender strategies.

Finding # 27: CP9 has sufficient financial and human resources including relevant and adequate technical expertise to implement interventions to achieve planned results under all outputs, including development and humanitarian parts.

At the time of the evaluation staff realignment was just completed and several new staff were on board.There is no post of humanitarian officer under the current office structure (also last CP); additional responsibility is given to programme officers and currently the Deputy Representative has the overall responsibility. The rationale is that there is not enough workload to create a separate post as in India, unlike other countries, the role of the UN and development partners is limited as the GOI takes the lead and follows its response plans. Even during the COVID-19 crisis, the support is limited. The CP does not include interventions /activities for emergency

response; however, support for dignity kits were provided during the cyclone in Bihar and Odisha through implementing partners. In Odisha, MISP was rolled out as part of the state response as a result of investments in the past[208].

CP9 has appreciably leveraged its two-member gender team at country level, though it has no gender staff at state level (which it proposes to rectify). The strategy of placing gender consultants in DWCD in priority states and PCPNDT consultants in the DoHFW in Maharashtra at state level has been efficient but is vulnerable to turnover unless their career growth is planned for. Further, the number of staff at both national and state levels is inadequate vis-a-vis the dual task of addressing discrimination/ GBV and gender mainstreaming. The proposed new HR realignment seeks to rectify the gap[209]. Combining Youth and Gender into one unit is problematic, as gender needs to be mainstreamed into all three—youth empowerment, SRH and PD; gender discriminatory practices and GBV need to be addressed. The gender unit at national level is perceived by other staff at national and state levels as well as other UN agencies to have good expertise on gender discriminatory practices and gender integration in life skills, with positioning to be able to influence at national level. However, it was observed that they did not have adequate time to go to the field. Capacities of non-gender programme staff on gender mainstreaming was seen as varying, with some having the required sensitivity and others feeling that working with women and girls is the same as gender mainstreaming. A review of two job descriptions revealed that the one pertaining to PD was well integrated, but not the one on M and E coordinator (UNFPA, n.d e, f).

It appears, from interviews, documents and observation, that the SRHR staff have the right skills to be accountable to achieve the planned results; however, the skills in UNFPA focus areas during humanitarian crisis such as introducing MISP, data collection tools, etc. appear to be less. A concern expressed is the shifting of programme assistants, attached to specific thematic units at the CO. The programme assistants are the repository of knowledge on various activities, implementing partners, etc., which results in loss of efficiency and also an opportunity for the staff to further gain expertise in the area.

Expenditure/ Budget allocation to gender during 2018-20 was second least. Of the cumulative financial expenditure (2018-20) (all fund sources) of 10.15 million US dollars for IP, the least was to PD at 1.06, followed by gender at 1.14, and the maximum was for youth at 4.81 and SRH at 3.17. The total expenditure on TA was higher, but the pattern on expenditure on gender remained the same. The trend on gender budget was similar to trend on expenditure, with percent of expenditure to budget on gender being least in 2019 (UNFPA, n.d.). Of the IPs supported under gender, a majority had prior expertise and experience on addressing gender inequality. Some, like PREM, Odisha, were supported by a gender consultant by UNFPA as a strategy to strengthen capacity. However, the shift to large partners who at times contracted to new small partners poses problems when the relationship between the two sours, affecting work on the ground. Capacities of partners on MIS need strengthening, with partners focusing mainly on gender outputs rather than on outcomes.

Finding # 28: *UNFPA state and country offices aligned the work plans and implemented the CP major strategies as per CPD and CPAP to achieve the RRF using a combination of tools to achieve the appropriate outcomes in a timely manner. Some gaps were also observed.*

As noted elsewhere in the report, the state and CO workplans are generally aligned to achieve the RRF. State offices also focus on state priorities and takes into consideration partners working in the same geographical areas. The latter consideration is reported as one of the justifications for uneven implementation of SRHR interventions especially in MP and Bihar. It appears that leadership opportunities in some of the thematic areas such as FP Logistics Management Information System (FP LMIS), maternal health, etc. were missed due to

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[208] CO Organogram, India emergency preparedness and response plan

[209] Presently, the CO has one full time staff and one consultant in the youth and gender unit, supported by National Consultant Programme Management. The new organogram envisages a full time Program Analyst-Gender to assist the Programme Manager. As of now, there are no gender staff posted in state offices, though the new organogram (2021) proposes a Youth and Gender position in each state office (UNFPA, 2021).

delayed and often non-collaborative decision making by the administration. The role of CO in providing technical leadership and support to state offices often did not match the expectations. Lack of cross thematic reviews and responses, and lack of regular meetings on progress were concerns. The above findings could be related to the vacancy of senior management post for prolonged periods.

The coherence between RRF indicators and interventions and universe of implementation are concerns. There are also concerns whether the construct of the indicators is results-based as they don't adhere to the SMART criteria.

India is classified as an orange country, under UNFPA's business model of Strategic Programme 2017-2021. The findings under the expected mode of engagement related to SRHR are as follows. Contributions to capacity building of state and district health departments especially in building systems such as the FP LMIS and quality assurance systems is good. The partnership with Government, UN and developmental partners is good. It was disappointing to note that no active support for SSTC has been made. From the review of the programmes, there are potential areas that can be further developed for SSTC (this is also a priority of GoI). In the areas of knowledge management, it was observed that the documentation of innovations and successful interventions was poor. Several successful lessons can be obtained, for example on demogaphic dividend (SWEDD/Africa, Health Leadership Governance Programme, HLGP, Philippines). Though there were specific areas that would have merited from implementation research (especially the gaps in service delivery), not much has been done except in the case of youth. Potential areas for policy dialogue are identified under the effectiveness section, however these have to progress to policy dialogue and policy changes.

The gender and youth strategy and work plans on gender are aligned with Output 2, and RRF 1 and 4, pertaining to gender equity. They outline interventions to address gender discrimination and gender mainstreaming in life skills, though there is less on gender mainstreaming in SRH and PD (UNFPA, n.d.). The extent of gender mainstreaming in work plans under PD and SRH varied with IP and theme of collaboration[210]. The gender team vets work plans, which come to them from the PD and SRH unit, but stated they would benefit out of a guideline or framework. The gender team is housed in youth and gender unit, it works closely with the youth unit, and the youth and gender work plans are classified into youth, gender and youth and Gender. As of now, there are no official "Gender and SRH" combined work plans (like youth and gender work plans). However, some multisectoral work plans address/ seek to address some social determinants of SRH, adolescent access to SRH services, and gender-based discriminatory practices (mentioned in CPD, 2018-22).

Finding # 29: *UNFPA has flexibility to reallocate its budget to respond to government priorities that were not identified at the time of the CP9 design and responding to COVID-19*

CO has adequate flexibility to reallocate the budget as noted above and evident from revision of budget to support the midwifery initiative as well as the support to COVID-19 response.

Another concern in efficiency is how speedily/ flexibly UNFPA responded to emerging issues. The CP responded flexibly and appropriately to gender issues arising out of COVID-19, and responded partly to floods in in Odisha and Bihar (with dignity and sanitary kits). However, it has not adequately taken into account recent legislation like the Rights of Persons with Disabilities Act, 2016, and the Transgender Protection of Rights Act, 2019. There is only one partnership (KISS in Odisha) that focuses on the persons with disabilities, and mainly on life skills of adolescents with disabilities.

 During the CP9, several digital efforts have been efficiently used to further gender equity and rights. A few examples include Naubat Baja (based on missed call, with a return edutainment) and Tikki Mausi mascot

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[210] For example, the work plan partnering with PGIMER includes building capacity of health professionals on respectful family planning and delivery care, while the work plan with Population Health International on strengthening capacities of pharmacies in five states does not refer to gender issues Similarly, the work plan with IIHMR, Rajasthan (D partner) on strengthening evidence-based planning does not refer to gender considerations, while the work plans on Smart City, Patna, refers to empowerment of women Safai Karmachari youth, and using them to press for safety, working with dignity, and claiming entitlements (UNFPA, 2019).

(messages on WhatsApp and television on gender, SRH and life skills through the mascot). Further, during COVID-19, help lines and online platforms were used to raise awareness on GBV, sexual abuse and the need for sharing work. Capacities of one stop centre staff were strengthened through online training on counselling and guidelines on how to address cases pertaining to domestic violence. Digital efforts under SRHR during COVID19 is discussed under SRHR section.

Finding # 30.The implementing partners (IPs) selected for various interventions have adequate expertise and experiences to implement interventions assigned to them.

The IPs are selected as per UNFPA guidelines and meets the criteria for expertise. The state level implementing partners in Odisha and Rajasthan for RMNCAH programme have contributed significantly. The IP in Odisha has provided effective technical support while the IP in Bihar has brought several innovations as described under effectiveness section. The IPs selected by UNFPA for its support to the SRH and HIV integration component of UBRAF (three partners were recruited, the latest being India HIV/AIDS Alliance) are highly skilled in capacity building of community-based organizations and working with sex workers. The current IP has skills in advocating to the government as well as good understanding of the functioning of the health systems[211]. There are concerns about dropping partners without proper justification or evaluation. IP contribution is mentioned under finding 9 and also under coherence and synergy.

Finding # 31. UNFPA established partnerships with UN and other donor agencies to harness best possible results on mandates of CP9 including gender issues, assuming technical leadership in gender equality and adolescent issues.

This is discussed under Coherence section and referred to in the Effectiveness sections, UNFPA has established technical leadership for SRH/HIV integration under the UBRAF project in Gujarat as well as in FP2020.

Finding # 32: UNFPA has been able to <u>sustain</u> learning efforts and provision of training through digital platforms during the COVID-19 pandemic in a timely manner and mitigate its effects

Digital health interventions have been effectively used by CO and state offices, even prior to the onset of the pandemic, but much more so during the pandemic, as evident from the effectiveness section. The effectiveness section provides the description of the e-modules developed by CO. During the pandemic, these modules were used for various training programmes for state offices, significantly in the training of midwifery tutors through INC form all over India. Contributions to the e-learning programme for management of SRH activities during COVID in collaboration with AIIMS and PGIMER also had an all India coverage. In MP first e-learning platform was created with UNFPA support, originally created for building capacity for provision of injectables and now being used for other types of training. The digital support for FP services during the pandemic in Rajasthan is much appreciated by the MOHFW and considered a good practice by National Health Systems Resource Centre. Odisha used the i-SRHR package of modules for training district level during the pandemic and continues to use the same. The digital training of master trainers of medical officers under the RKSK programme- materials and conducting the training- has been another significant contribution.

Facilitating factors (for efficiency)

Overall, the presence of consultants at state level (as pointed out under effectiveness section), dedicated UNFPA staff and rapport established at state institutional mechanism contributed to successful implementation of the activities in priority and aspirational districts. In Rajasthan, the RMNCAH coordinating agency role has helped to provide greater support and visibility. Scattered interventions beyond the focus states impact the results in focus states and national level and reduces the efficiency of already limited resources, both HR and financial..

Hindering factors (for efficiency)

Few of the factors are covered under the hindering factors related to lack of collaborative decision making have been covered under effectiveness of SRHR interventions. In addition to budget constraints, lengthy procedures in contracting have also contributed to missing opportunities for hiring top level technical assistance. Arbitrary

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[211] Reports of IPs in Odisha and Rajasthan, HIV/AIDS alliance, work plans

decisions to drop implementing partners (not based on evaluations of performance) have led to loss of momentum and continuity. Contextual changes such as interrupted leadership -leadership changed several times with changes in programme priorities; COVID19 pandemic and staff realignment creating uncertainty impacting the staff focus on results achievement.

4.5 Answers to Evaluation Questions on Sustainability

Evaluation Question) 7: **To what extent has UNFPA been able to support implementing partners and rights-holders (notably, women, adolescents, and youth) in developing capacities and establishing mechanisms to ensure the durability of effects?**

Summary of findings:
Sustainability of efforts at preventing/ addressing discriminatory practices may vary with how far capacities had been strengthened not just at national and state levels, but also district and sub-district levels; with how far gender sensitive accountability structures have been promoted at grassroots levels; and with how far institutionalisation in training institutes at national and state levels has progressed. Partners are scaling up good practices across and within states (with and without support of UNFPA). For IPs which are NGOs, sustainable spaces have been created to engage with state governments, and their knowledge and skills on gender has been strengthened through partnering with UNFPA. Sustainability is linked to promoting a rights-based approach. UNFPA has tried to build the capacity of rights holders to make claims on government, but greater attention is required on group-formation and strengthening. Efforts at strengthening gender capacity of duty bearers have been good, but fragmented.
The support for state level and district level consultants both in priority and aspirational districts has given UNFPA increased mileage at the state level and district level in improving quality of services and to a certain extent ensuring rights. However, the sustainability of this approach is a concern.

Finding # 33: *ICPD POA's rights-based approaches to FP commitments at Cairo and Nairobi have been well integrated into the programme, but needs more inputs as explained below.*

As indicated under the effectiveness section, significant inputs have been provided to influence the FP programme towards rights-based approaches especially at the state level. The continuation of the use of the checklists and consent forms for FP services point to potential of sustainability of efforts. The efforts in developing alternate indicators is a step in the right direction, but requires more work on indicators and advocacy to states (finding 7) and has the potential to be sustained. As mentioned under finding 7, with regard to provider incentives, the use of alternate means of rewarding the providers have not been fully explored. MOHFW is committed to ICPD POA and has further expressed its commitment at ICPD @ 25, however the continuation of ELAs and provider incentives do not support the commitments.

Finding # 34 *UNFPA strengthened the mechanisms to enhance accountability to SRHR (including GBV, child marriage, GBSS, discriminatory practices) at national, priority states and districts level reproductive health services/systems, including COVID response.*

As indicated under the effectiveness section, support for improving accountability such as monitoring the use of consent forms for PP IUCD and sterilization clients and client exit interviews and quality assurance processes monitored for certification of labour rooms and operation theatres, contribute to accountability. However, the lack of supportive care to cases of sterilization failures, high discontinuation rates of *Antara,* pointers to gaps in accountability.

MHRD/National Council for Educational Research and Training (NCERT) and Adolescent Health Division of MoHFW have demonstrated accountability to integrate life skills based Adolescent Education in school systems

Responses from UNFPA staff and government stakeholders including NCERT revealed that the adolescent program is sustained by NCERT. NCERT provided technical assistance to the national and state schools system (through state SCERTs) from its own funds. Reporting is part of the regular school monitoring system.

Finding # 35: *Gains made and learnings from community based programmes for adolescents and youth are adopted/consolidated in national programs*

UNFPA provided actionable recommendations to MoHFW on addressing health and wellbeing of adolescents as convenor of the Adolescent Health Working Group of MoHFW. UNFPA showcased evidence in support of peer lead approaches through two national studies on enhancing efficacy of peer-led approaches and strengthening institutional capacities to implement RKSK. MoHFW has requested UNFPA to undertake an assessment of the NGO and government system led approaches for peer led efforts and suggest recommendations to the national government. This provides an opportunity for future advocacy. In addition, there is need for sustained communication and engagement as a TA partner to the government.

Government of India has initiated to update the National Youth Policy. UNFPA in partnership with United Nations Volunteers (UNV), ensured that concerns of young people and potential solutions were clearly articulated towards shaping the new policy. UNFPA was instrumental in ensuring youth consultations involving 200 young people from across India including representation from most disadvantaged backgrounds (Scheduled Caste/ Tribes, LGBTQ, religious minorities and with disabilities).

Finding # 36*: Systems have been put in place for sustainability and scaling up of gender equality and women's empowerment and gender mainstreaming interventions, and for promoting accountability; with scope for strengthening through instiutionalisation, greater budget allocation and community accountability structures*

As per the government officials met and the evidence from documents, the interventions in CP9 on strengthening policies, action plans, monitoring systems and capacities of states government on child marriage, BBBP, MHM and PCPNDT (in some states) will have impact beyond the CP9. In Rajasthan, Odisha and MP, the sustainability may be higher, as there has been engagement in districts and block capacity building in priority districts and beyond (UNFPA being a member of state level convergence task force on BBBP), and in MP, through investment in SIRD to strengthen capacity of PRI to work on these issues. The staff of the one stop centre in Odisha (MP not met) and Rajasthan expressed that training of staff of one stop centres on counselling survivors of gender-based violence by TISS during COVID-19 needs to continue longer to lead to sustainable improvement in capacities on gender aware counselling and must be supported by more guidelines and training of medical, police and legal officers. Further, there is staff turnover, and new staff inducted have to be trianed for sustainability.

Sustainability of gender and rights-based work also hinges on the continuation of implementing partners, sub-contracted implementing partners and staff/consultants. In Patna, a new implementing partner had been recruited, as the previous one was unacceptable to the government. The work with women sanitary workers to get them to move to mechanised, safe and better work, while impressive, will take a few years to stabilise and be scaled up. In Odisha, the partnership between the implementing partner and the sub-contracted local NGO in Dhenkenal had soured. Frequent transfers of government officials also hamper sustainability.

Through the women- and girl-friendly panchayats, the accountability of PRIs to empowerment of women and girls is getting strengthened, but this is at the nascent stage. In Odisha, where there is a tie-up with Mission Shakti (promotes women's SHGs) and the culture is less patriarchal, accountability to end child marriage, gender-based violence, reenroll dropout girls in school/ open education is strong. The state government is scaling up this UNFPA pilot initiative to the entire state. The gender budget within PRI, in Orissa, has been used to strengthen accountability to GBV (strengthening existing shelter home under Mission Shakti in one PRI), but the budget itself is limited.

There is a need for integration on GBV response in both in-service and preservice training. The efforts to promote rights-based family planning and maternal health services, according to staff nurses met, are likely to continue if infrastructure matches the need for privacy and if all those who work in labour wards (both boys and girls) are aware of "rights-based approaches" and the need for respectful care. Unless legislation is changed with regard to POSCO, pregnant adolescent girls cannot be provided with privacy and confidential contraceptive services. However, apart from Lakshya certification and scorecards for RMNCH+A, community accountability

mechanisms to gender and rights in SRH remain weak, like strengthening VHNSC and monitoring of rights-based community charters on SRH.

There is some evidence of scaling up of community-based interventions of implementing partners to state level. In Odisha, for example, the gender integrated activities, like skill training of SCSTRTI, is being replicated in other states wherein tribals speak the same dialect. The women- and girl-friendly PRI has been upscaled into state level in Rajasthan, and the effort to strengthen gender-transformative life skill training in madrasa education boards in a few districts of Bihar has been scaled up to the entire state. The women-and girl-friendly initiative with Patna Municipal Corporation has been scaled up to 80 slums in Patna City. In MP, the government is replicating work with men and boys on gender through the state. The TISS training on counselling for people from RKSK counsellors has been scaled up to training counsellors in other institutions, like one stop centres, in MP, Odisha and Rajasthan.

4.6 Other Concerns

4.6.1 Unintended Effects

In general, the investments in digital health interventions served as useful tools during service disruption due to COVID 19 pandemic. The expanded use of the e-learning platform created for capacity bilding of providers for the programme related to implementation of *Antara* programme was unintended and expanded the scope and reach of the platform. The reprogramming of funding to INC has provided an opportunity to orient tutors of nursing colleges across the country in evidence-based practices and rights-based approaches, implications of GBV for SRHR and its management, etc.

The inclusiveness of the entire evaluation process became a learning experience for the new and old staff equally. For the old staff, who had been with the country and state offices for a long time, the interaction with the evaluators as well as with several others within the State itself, brought a new experience, one about the evaluation process, two, about their own programme, three, how one does an evaluation. Most of the UNFPA staff got a good understanding about the entire programme as staff due to time pressure, focus only on their programme and not fully aware of other areas of work. CPE process provided enough time to look back at one's own work in the context of the overall programme. The new staff as well as those who moved to other roles and/or new locations (after HR realignment) benefitted from the presentations (by CO and State staff as well as CPE team) and received detailed briefings on the current (CP9) programme.

4.6.2 Good Practices and Lessons Learned

The following are the potential areas for consideration as good practices. None of the following have been evaluated to assess the effectiveness or cost-benefit.

- At the operational level, the role of district level consultants is effective as seen under discussions on effectiveness and efficiency. Their contributions are also appreciated by the district administrators. The district and state level consultants are involved in developing Programme implementation Plans and provides opportunities for including UNFPA agenda. UNFPA as a coordinating agency for RMNCAH is a good practice as it provides many opportunities to influence policy and programmes including at the national level by sharing experiences. Opportunities to hire dedicated thematic consultants further strengthens the value of such collaboration.
- The creation of a dashboard for monitoring the district level services is a great intervention. Such dashboards are created at the state level, managed by the IPs as well as state consultants. While it appears to be well utilized at the state level and corrective actions are taken, the same cannot be said about the CO. The M&E officer does analysis but the involvement of the programme officers is doubtful.
- Collaborating with an institution such as INC opens the opportunities to influence other areas of SRH and introduce generally neglected components of service delivery such as rights of clients and advance knowledge in evidence-based practices that will improve the safety of services. The opportunity to improve the knowledge of midwifery tutors of nursing institutions was utilized well.

- Women and girl friendly PRIs to bring about convergence in strategies to address GBV and discriminatory practices through partnership between implementing partners, PRIs, women's SHGs (engaged in economic programs). These are being piloted in all four states where CP9 is operational, and scaled up state wide in one after seeing success in reduction of drop out, reducing child marriage and addressing gender-based violence. See Annex EM Gender Equality.

- Tailor making approach to reach particular groups such as adolescents with disabilities, adolescent (girls mainly) from minority groups and with youth in conflict prone areas. Looking beyond the approach of integrating LSE in the curriculum to ensure linkages to SRH services, addressing mental health concerns and promoting social action on SRH by young people.

- Partnering with rights-based groups to advocate on sensitive SRHR/gender issues like ending FGM, debating age at consent, pros and cons of enhancing age at marriage. While these efforts are yet to bear results, the fact that debates are being held on these issues can be considered a good practice.

- At a policy level, UNFPA supported DoWCD, Rajasthan to formulate a State Women's Policy, with its steering role being acknowledged in the foreword. The Policy covers strategic priorities of UNFPA, and two unique features are its emphasis on working with men and boys and addressing health and other issues facing transgender persons. See Annex EM Gender Equality.

- As described under partnership, the SRH/HIV integration SRH and HIV integration at facility and community level. UNFPA contributions recognized for its technical leadership, ability to work with community-based organizations, identification of implementing partners and ability to advocate for rights-based approaches. This intervention has been written up as a best practice and shared with APRO. The collaboration is a good practice in terms of use of the most appropriate IP, facilitating collaboration between two vertical programmes – AIDS prevention and control and NHM (RMNCAH component) and two institutions - State AIDS Control Society and Department of Health and counterparts at the district level. In addition, promoting opportunistic integration of services (for example, screening for syphilis in ANC, provision of FP services in STI clinics, etc. as well as partnership in sharing information and supplies (condoms indented through NHM) between ASHAs and facilitators of sex workers' organizations at community level, thus destigmatizing sex work. However, in-depth reviews are needed before counting as a good practice.

- Exploring non-health routes for improving access to RH commodities while ensuring accuracy of information about the products through the pharmacists/ chemists in rural and urban areas is an intervention that has the potential to be considered a good practice but needs to be evaluated. The reach of chemists is extensive in rural and urban areas and in rural areas, often the only source of medicines or contraceptives. The project inputs focus on improving the knowledge about the products including side effects to enable the chemists to inform the clients accurately which enables to improve their credibility to provide safe services to clients. Because of anonymity, young people use such facilities more compared to health facilities.

- The support to MOHFW for evaluating the contraceptive social marketing programme and buy-in on the recommendations (twice in 2015 and 2019) has provided opportunities to influence and strengthen a programme that was not functioning well. This is a good practice and more such opportunities need to be identified.

- Improving access to delivery points through innovations as in the case of developing sub-centres as delivery points in Jaisalmer district in Rajasthan has enabled to increase institutional deliveries. Collaboration with communities and using traditional folk media to promote the use of the facilities has further facilitated the use of the delivery points. The support for operationalization maternity waiting homes in Odisha is another good practice. While provided technical assistance; NHM and tribal welfare funds were used to strengthen the development of the waiting homes, transportation and advocacy to PVTG community leaders. This has enabled women from PVTG communities to use institutions for deliveries which has the potential to reduce maternal mortality.

- Some of the positive lessons learned from the list of good practices are appointment of district consultants, coordinating role for Women's Policy at state level, RMNCAH at state level, SRH/HIV integration, but need in-depth reviews to include them as lessons learned. See Annex Gender Equality for lessons from the Rajasthan State Women's Policy, 2021.

Chapter 5: Conclusions

1. ***Overall, UNFPA maintained the programme relevance keeping in line with the government priorities, UNFPA mandate, and the beneficiary needs.*** UNFPA CP9 work is aligned with the principles of the 2030Agenda for Sustainable Development and UNFPA's three transformative results. UNFPA enhanced UN's collective contribution to national development (significant contribution to UNSDCF via working groups, results groups (RGs), and bringing UN agencies together onboard on common themes (e.g.PSEA, Gender Equality, Disability, COVID19-GBV response etc.,). Partnerships established at the national as well as state-level have been a factor in accomplishing development results. While CP9 covered a lot of ground, it could have been more focused to achieve high impact and more sustainable results *(Origin: Findings # 1, 2, 3, 4, 5 under Relevance and Coherence (Effectiveness, in general)).*

2. **Vulnerable populations are included in the design and programme implementation and their needs are addressed. However, there is more room for improvement in disability inclusion.** CP9 promoted girl and woman-friendly panchayats and strengthened convergence of all programmes related to women and girls, for example as observed in Rajasthan. Strong outreach to women from SCs (including former manual scavengers), STs (including primitive tribes), Muslims, and migrants. In one of the four states (Odisha), the life skill training manual has been adapted to the needs of the persons with disabilities (sight, hearing and motor); CP 9 has focused on vulnerable populations through its choice of focus states and districts including the Aspirational districts. Focus on disability was limited, maybe because the emphasis began only recently in 2020 *(Origin: Findings # 1, 6, 10, 12, 13,14, 16 under Relevance, Coherence, and Effectiveness).*

3. ***UNFPA has added value and provided leadership in UN joint programmes as well in partnership with development partners. Contributions to SRH/HIV integration of the UBRAF project in Gujarat is significant and is recognized by UN partners. Similarly, contributions to joint UN response to COVID-19 pandemic has been significant, including on preventing/addressing GBV (through media and strengthening services at one stop centres) in the context of COVID-19.*** UNFPA's contribution to FP2020 and FP2030 development in promoting focus on young people and rights issues is recognized. MOHFW, while recognizing UNFPA's contributions, feels stronger policy and technical support is needed in this area *(Origin: Findings # 3,4,5, 6,9, 10, 11 under Coherence, and Effectiveness).*

4. ***UNFPA has demonstrated its added value to the national RMNCH+A programme by bringing to the foreground rights perspectives, particularly in the context of FP and maternal health service delivery, leveraging National Health Mission (NHM) funds in three of its focus states (MP, Odisha and Rajasthan).*** This was achieved through the development and implementation of quality and rights-based tools at national and state level. The district level support, particularly Aspirational district support, has provided opportunities to promote UNFPA's agenda while gaining recognition by the state and district level administration and greater visibility to UNFPA in *NITI Ayog,* a policy think tank, planning and programming and monitoring body for developmental goals. The support has provided opportunity to be involved at the national level, beyond MOHFW. UNFPA's support to INC is another example of value-addition for promoting rights perspective *(Origin: Findings # 7,8,9 under Effectiveness).*

5. ***CP 9 responded to new priorities and needs by reprogramming its resources to support MOHFW's midwifery initiative as well as to support the continuation of RMNCAH services during the COVID-19 pandemic.*** Though CP9 did not have focus on maternal health, the UNFPA state offices supported maternal health activities through support to districts. The addition of support to midwifery has brought focus at national level to maternal health *(Origin: Finding # 1, 2 TOC, 8, 11 under Relevance and Effectiveness).*

6. ***Despite the recognition of the value of integrated packages in contributing to universal access to SRH services, the support for its implementation in focus districts is limited to Odisha and Rajasthan.*** Even in these states, the current support for integrated services including its contents, degree of investment and quality of implementation need rethinking for achieving any results. For example, cervical cancer which is a major contributor to mortality among women is missing. Besides the uneven implementation of the integrated package contents (specifically abortions and RTI/STI) and geographical coverage, the focus of the programme varies in the four states. Odisha and Rajasthan implementing majority of the RMNCH+A components, while the major focus in MP has been on activities related to young people, mostly school-based and community-based programmes and to some extent on FP. Bihar's activities related to FP were

initiated late. A major reason for these differences between activities in states and activities between state and district levels is probably related to decisions by CO administration Two major services missing in the integrated packages are health sector response to GBV and adolescent SRH services. At the national level, UNFPA is considered the lead agency for both services. The integration lacks horizontal integration across the continuum of RH care. Further, outreach of SRH services to adolescents is limited *(Origin: Findings # 4,6, 9 under Coherence and Effectiveness (also development challenges under SRH).*

7. *During CP 9, investments have been made to integrate ICPD POA's rights-based approaches to FP through contributions to expanding the choice of spacing methods while monitoring quality and rights.* Notable are UNFPA's support to introduction of *Antara*, efforts to institutionalize quality and rights perspectives into PP IUCD and sterilization services. The support for operationalization of FP LMIS leading to reduced stock-outs (except in the case of *Antara* which is a procurement issue), inputs to change the ELA estimations in Odisha and Rajasthan and use of alternate indicators to monitor the program and support to CSM and support to state departments are significant. However, the monitoring of the programme needs more inputs and advocacy. The issue of provider incentives needs to be reviewed to improve accountability of the system. The investment in medical education to incorporate rights-based approaches has a long-term potential; however, the cost-effectiveness of such interventions needs to be assessed *(Origin: Findings # 7, 9 under Effectiveness).*

8. *UNFPA's support to MOHW midwifery initiative and its collaboration with INC has opened avenues for major national contribution in maternal health and reduction on maternal mortality. It also contributes to overcoming the shortages in human resources for SRH.* The support to INC, expands UNFPA's scope to influence quality assurance of training of the midwifery cadre. However, with the delay in activities due the pandemic, review of progress with regard to midwifery initiative needs urgent attention. The support for national initiatives to promote evidence-based and respectful maternity care at district level and focused support at state level are significant. However, much more needs to be done in terms of expanding quality assurance to lower-level facilities and improving access to skilled care, strengthening MDSR, promoting some of the good practices *(Origin: Finding # 8 under Effectiveness).*

9. *Though significant contributions have been made to RKSK programme at national and state levels in MP, Odisha and Rajasthan, the degree of support for AFHCs is less*. Currently the AFHCs outreach is limited due to the location of the clinic, quality of services and contents. The acknowledgement of UNFPA's role in building capacity of counsellors and medical officers is not optimized to improve and expand the AFHCs. The opportunity to converge the investments in school-based and community-based efforts to promote use of services and policy dialogue and change has been missed. The efforts to include RKSK under the *Ayushman Bharat* scheme are strategic *(Origin: Findings # 10 under Effectiveness).*

10. *Gender mainstreaming in adolescents/youth empowerment has been effective (with room for strengthening in employment and age group of 19-24 years), while gender mainstreaming in SRH and PD has been constrained by the fact that the gender strategy was linked to youth and not SRH or PD.* It does not encompass a full range of ICPD commitments, access to health insurance, and working towards SDG 5.6.1 (decision making) and 5.6.2. Accountability structures to gender and SRHR need strengthening. Overall, the CO gender mainstreaming interventions is partially in sync with the UNFPA Gender Strategy 2018-22 *(Origin: Findings # 13 under Effectiveness).*

11. *Working with youth, at national and state level, for both in school and community-based program has shown promising results as observed and evident by strong demonstration pilots in reaching marginalised youth leading to increased awareness, creating a cadre of peer educators, and a development of a range of knowledge products* including topics on SRH, mental health, comics etc. In addition, State level TA in roll out of various programs such as school health program, RKSK, SAG with promising initiation in adolescent with disabilities, youth in conflict areas, although in a nascent stage, are achievements during CP9. Strong relationship with government departments, UNFPA TA, and contribution of UNFPA supported consultants are added values to the programme *(Origin: Findings # 14,15,16, 35under Effectiveness and Sustainability).*

12. *Long gaps and irregular communication with MoHFW have led to missed opportunities to come up with innovations in engagement beyond LSE. UNFPA played a proactive role in evidence based advocacy with MoHFW at the beginning of CP9 leading to recognition for its contribution to the national RKSK programme and proactive role in the national adolescent working group in the national ministry.* However, subsequent engagement with MoHFW has been irregular leading to missed opportunities at the national level in flagship programmes such as Ayushman Bharat and rethinking helping adolescent girls to make the transition to

empowered young women, socially, economically and politically. As of now there is no earmarked strategy *(Origin: Findings # 15 under Effectiveness).*

13. ***Considering that there was no inclusion of emergency preparedness under CP9, the COVID-19 support as part of the Joint UN initiatives is commendable.*** While the provision of dignity kits in response to floods and cyclones is impressive, only in the state of Odisha MISP was rolled out as it is an integral part of the state's preparedness plans. Given the reservations of GOI in involving UN and developmental partners in emergency relief measures, it may not be possible to influence the national level but possible to influence the state level strategies with regard to emergency response and preparedness. The response to COVID-19 pandemic as part of joint UN response and capacity building through national institutions and INC is impressive *(Origin: Findings # 5, 11, 17, 27, 29 under Coherence, Effectiveness and Efficiency).*

14. ***The Population Dynamics thematic group was able to link emerging population issues-urbanization and migration, to the intervention arm of the UNFPA India operations (that works through other thematic groups) through the socially inclusive smart city initiatives and its work on the older persons during COVID times*** (for which it got the Mahatma Award). In documenting a template for socially inclusive smart city (and other states have shown interest in replicating it), it had a direct effect on policy. The action orientated outreach of these activities could have been even more effective had there been more clarity among key personnel about the relative weights of the various roles of PD-how much research/advocacy to undertake for "higher" level policy action, how much to be data facilitators to other thematic groups and how much to be involved in initiatives like Smart city initiatives. A possible convergence between research and intervention orientation was missed as very little research on PD issues was in fact in sync with UNFPA deeper engagement in focus states and priority districts. There were other successes in influencing policy in focus states-for example, in influencing the Child Marriage action plan in Odisha, but these were sporadic *(Origin: Findings # 24,26,27under Effectiveness).*

15. ***PD performed well in its traditional (and critical in the current architecture of operations) role as the data skeleton for operation of other thematic areas.*** It provided important support for initiatives-RKSK, LSE among others, through its engagement with data systems like the LMIS, HMIS and data sets like the NFHS (DHS for India). It helped on advocacy and measurement related to issues in gender. However, the PD engagement seemed to focus on a resource person model-with a key member as a go-to person, both for internal CO members as well as for key national bodies *(Origin: Finding # 24 under Effectiveness).*

16. ***UNFPA CO lacked clarity on the activities of Population Dynamics thematic areas.*** The current architecture of Country office operations means Population Dynamics thematic area is tasked with providing the data skeleton for all activities with CO. But another view that emerged within PD was to push, more directly, interventions on demographic issues (for example smart city initiatives to address urbanization), in contrast to just creating knowledge and policy advocacy at the national level. PD is a small thematic group: both tasks were hard to do. Further, PD was not clear about its capacity building activities; part of the problem was in how "capacity building to use data" activities were visualized within UNFPA. A lot of it depended on individual initiative of program officials in states and while there was a general appreciation of the need to build capacity for data at the country office level, there was no strategy across priority states to initiate such an activity. Such idiosyncrasies can also been seen in state level trainings-training was initiated when it was demanded (Odisha), but there was no larger strategic plan to increase capacity across all states *(Origin: Finding # 26 under Effectiveness).*

17. ***Given the COVID19 context where the majority of CO staff had been affected directly and others whose dependents had been affected by the pandemic, and despite the fact that the staff realignment taking place at the same time, the implementation rate (IR) overall had been satisfactory***, with the year 2020 reflecting IR over 90%! Although CP9 may have had about two to two and half years in full for the entire CP9 implementation, most of the CP9 work plan was accomplished in addition to the emerging tasks amidst the response to the pandemic *(Origin: Finding # 27, 28 under Efficiency, Tables 7& 8 Finance data).*

18. ***Resources invested by UNFPA have had a leveraging effect (triggered provision of resources from other development partners (e.g. APPI, REC). Joint programming enabled expanding interventions with the same available HR. However, UNFPA contribution could have been strengthened had there been more synergetic approach***, between thematic areas at CO level and specifically in downstream work. Missed opportunities to save human and financial resources have been observed. Efficiency in selection of implementing partners and discontinuation of their services are concerns. Administrative and operational issues have been the main hindering factors to efficient implementation of the CP. Use of digital health innovations, particularly during

the COVID pandemic, has been significant at CO level and state level and is an efficient use of resources. Uneven implementation of priority interventions of RH in focus states and districts raises issues with regard to efficient use of resources. Another area of concern is scattered interventions beyond the focus states. This impacts the results in focus states and national level and reduces the efficiency of already limited resources. UNFPA missed opportunities to benefit from as well as contribute to SSTC *(Origin: Finding # 4, 7, 8, 9, 28, 29, 30, 32 Effectiveness and Efficiency).*

19. **The support for state level and district level consultants both in priority and aspirational districts has given UNFPA increased mileage at the state level and district level in improving quality of services and to a certain extent ensuring rights. However, the sustainability of this approach is a concern.** In some instances, multi sectoral interventions and integrated districts have not included elements of all three SRH, youth, Gender and PD, and these terms have to be thought through systematically *(Origin: Finding # 9 under Effectiveness).*

20. **The coherence between RRF indicators and interventions and universe of implementation are concerns**. There are also concerns whether the construct of the indicators is results-based. A few gaps identified in the TOC may have led to this *(Origin: Finding 28 (Efficiency) and across thematic areas as seen in TOC).*

21. **M&E dashboards are a great innovation and provide real-time data for monitoring some of the RRF indicators, but its regular monitoring by programme officers and the interpretation of results on the basis of the differences in investments in various elements of the package are concerns.** Investments in capacity development at various levels across CP9 programme was found to be high but has limited monitoring data to measure outcomes, especially related to behaviour change. While it is not easy to measure institutional changes and individual behavior changes, there is an absence of tools to measure these within the CP9 system. Capacity building strategies which have included institutionalization (like in judicial academy) have worked better than one off capacity building *(Origin: Finding # 9 under Effectiveness).*

22. **CP9 has made sound partnerships with UN agencies, with FP, maternal health, life skills, GBSS, child marriage and gender statistics perceived as strengths**. Partnerships seem to vary at state level. In keeping with gender aspects at UNSDF, there is no collaborative agreement (informal) at state level. Partnerships with national institutes on gender (like CWDS, PLD) and minority rights (e.g., Jamia, Mannu) and media groups have been sound, with need for strengthening partnership organisations on women, young people with disabilities and transgender persons *(Origin: Findings # 30,31 Efficiency)*.

23. **Mixed progress on gender-discrimination, harmful practices and gender mainstreaming: In-spite of not having a separate output on gender equality and a cross cutting gender strategy, the CP9 has strengthened policies and capacities of state government, IPs, PRIs and one stop centres to address gender discrimination, child marriage and GBV during normal times and during COVID-19.** However, allocating a separate output with targets and making each thematic area responsible in achieving them could be useful. CP9 has contributed to reduction in these forms of discrimination/GBV in all priority states, other than on GBSS and proposed age at marriage wherein progress is uneven. In absolute terms gender indicators have shown poor progress in one of the UNFPA priority states *(Origin: Findings # 18, 19, 20 and in general across Relevance, Coherence, Effectiveness and Sustainability).*

Chapter 6: Recommendations

Note: The report includes 11 recommendations of which one is design related and to be implemented (if agreed) within CP9 cycle when CP10 is being planned and developed. Five recommendations are identified as strategic and five as programmatic indicating if they are of high, medium or low priority. Unless it is specified, all action plans are the responsibility of UNFPA CO (implementation in collaboration with GOI, other national and international development partners and selected UN agencies as agreed by CO and relevant to the mandate). At the time of these recommendations are made, ET had no indication about the budget allocation for CP10.

*Recommendation 1 is **related to Design of CP10 and to be carried out during CP9 final year/2022***

Recommendation 1: Linked to all conclusions in general, and specific to # 1, 2,12,16,18, 19,20.
(High Priority) Ex-ante evaluation (Design related): Development of TOC (and Theory of Action/TOA): and assessing the evaluability of the programme (before implementation).

The knowledge base that is already established could provide the basis for developing the TOC and the TOAs. A combination of interventions (multi-sectoral) can be employed for better results. Conduct a scoping exercise (informal) to see what other development partners are implementing in the same thematic area or contributing to the same objectives as UNFPA.

For CP10 new initiatives, conduct *evaluability assessment (ex-ante evaluations)* at the onset of the programme for each-planned Output, assessing the availability of data for measuring progress (with in-built M&E system, monitoring tools for assessing quality improvement; improving on programme design related issues based on identified programme gaps/needs, develop clear and detailed intervention logic model with risk assumptions and mitigation plans included). Prioritize UNFPA input with explicit sustainability strategies (exit strategies) in the work plan.

Action Plan:
   a) Formulate integrated indicators (if joint programmes and/or integrated programmes) that are agreed on upfront based on the mandate and expertise of the Agency with clearly defined roles and responsibilities. A clear and detailed theory of change (TOC) to be included where a *contribution analysis* can be conducted. Map out the specific expertise that each Agency contributes to the results chain, finally measuring the integrated indicator.
   b) TOC to be done in *collaboration with UNFPA staff (CO and State) together with relevant IPs* to have a clear understanding of the context, objectives, expected results of interventions as well as to increase IPs' ownership.
   c) CP10 could be more focused on integrated programming approach across all development programme components
   d) Accompany with theories of change that encompass the entire results chain, ensuring adequate skills and capacity of staff that participate in the formulation of the results framework.
   e) A separate gender outcome on ending discriminatory practices/GBV and gender mainstreaming in SRH, Youth empowerment, and PD is necessary.
   f) Mainstreaming of humanitarian response within all key programme components (SRH, ASRH, GE and PD) (at least SRH and GE to begin with).
   g) To make the program evaluable (in the future CO needs a good monitoring system, with measurable indicators (SMART and gender-sensitive indicators) ensuring that data will be available to measure the progress (either qualitatively and/or quantitatively; primary or secondary data). If data is not available assess whether collecting data is an option or not (if not available with any other sources). Indicator selection to be based on cost-benefit of obtaining the data (disaggregated data to be used as much as possible).

h) With "leaving no one behind" including Disability and SOGIE (all sexual orientation, gender identity and gender expression) mainstreaming as key part of CP10, disaggregated data will become an important part of evaluability. Limited data on most vulnerable population groups.

i) To make it clearer and easier to monitor and evaluate the results, link all planned interventions to the three zeros (ending the unmet need for family planning; ending preventable maternal deaths; and ending gender-based violence and all harmful practices, as the key objectives of CP10). Develop the results pathway contributing to the three zeros. Theory of Change to emphasize the operational strategies that include interventions with SMART indicators that are gender transformative – that requires data to be already available or will be made available. (UNFPA staff capacity to use data to monitor and report results to be increased).

j) Social Norm Change and Measurement: UNFPA has several interventions that include norm changes (behavior changes, attitude changes among service providers as well as service receivers (Duty- bearers and Rights-holders). Unless there is an effort to address both at the same time, realization of desired results can delay/vary. (UNFPA HQ shared a good document on Social Norm change a few years ago).

k) While continuing to empower youth, identify the social norms and the behavior change that needs to be addressed to achieve desired outcomes. Given the lack of measurement of behaviour change, develop indicators for behavior change measurement to monitor progress. For an effective Measurement of change behavior, the interventions should be based on systematic barrier analysis embedded in context-specific social norms, cultural beliefs and practices.

6.1 Strategic Recommendations

Recommendation 2: Linked to conclusion # 1,3,8,11,12,18,19,22

(High priority) Coordination, Advocacy Role and Strategic Partnerships: UNFPA to operate through strategic partnerships as the key mode of engagement.

Action Plan:
a) <u>Continue to strengthen</u> the relevant strategic partnerships with key government and non-government and private agencies (multi-stakeholder partnerships). Given the high priority and focus at state level development & programming needs, UNFPA to maintain its leadership and strengthen its strategic engagement with a broader network of public and private stakeholders, both at national and state level (assist with strategy and policy development).

b) Reinstate UNFPA supported consultants in relevant ministries at the National Level. These consultants can be the conduit through which UNFPA can have ready access to the ministries while establishing UNFPA's presence. UNFPA to support the established institutions to scale up the successful interventions. Maintain the current consultant positions at State and District level.

c) Building on experience, maximize comparative advantage and resources available, explore joint programming with other UN agencies if it adds value mutually, and specifically to UNFPA planned programmes. This to be finalized upon availability of shared resources, mutual agreement, and on added value. To address "Leaving no one behind" plan joint programmes with clear responsibilities – optimizing comparative advantage of each partner.

d) South-South and Triangular Cooperation: CP10 to focus on SSTC -APRO can provide good examples as well as CO to identify which interventions/experience can be shared with others). Start with potential areas identified under findings (for example, FP LMIS, integration of SRH and HIV services, e-modules)

e) Other UNFPA country experience partnering with faith-based organizations and with religious and traditional leaders, SWEDD (Africa demographic dividend, Health Leadership and Governance Programme (HLGP) are some examples that UNFPA can benefit from)

Recommendation 3. Linked to conclusion # 1,4,5,6,9,11,13,14,18,19,22 (in general linked across all)

(**High priority**) **State-level Focus**: **Continue focus on State-level with key interventions**, especially the successful ones (as described in the CPE presentations) that are directly contributing to <u>three zeros.</u>

a) Identify key successful interventions, assess the effects and costs of these innovative strategies, and select those that are feasible and appropriate for scale up and/ or replication in other states.

b) State level coordination (somewhat similar to UNSDCF coordination mechanism), assess what interagency can bring to the state development framework. Review State Strategy papers CO/state staff had developed for CP9 to see what was followed and what was not feasible and prepare a clear strategy taking into account what other development partners have to offer in achieving the same objectives as UNFPA's.

c) Long-term (not limiting to one CP cycle, if possible) interventions to be planned in a more focused manner at State level to have a high impact.

d) Inter and Intra-State level Lessons learned: Create more opportunities to learn from good practices and replicate where possible, with due consideration to socio-cultural and other contexts. UNFPA to have a follow up mechanism, with the initiatives that are being complete successfully, to ensure sustainability and document the success stories.

e) Greater alignment of CO and state level work plans and monitored throughout the CP cycle.

Recommendation 4: Linked to conclusion # 3,4,5,7,8,

(High priority) CP 10 to focus more on rights-based approaches to FP and skilled care at delivery by creating a foundation/base for stronger, evidence-based advocacy and policy dialogue on rights-based approaches to reduce unmet needs and maternal mortality, based on India's commitment at ICPD@25. Achieving the 2030 Agenda for Sustainable Development is only 8 years away and CP10 to sharp focus on achieving the targets set for the two of three transformative results.

Action Plan: (The action plans listed below create the evidence base for the strategic recommendation).

a) Create evidence for advocating for rights-based approaches through a deep-dive analysis of the FP programme that covers all aspects of the current policy, programme strategies including incentives for promotion of methods, quality assurance that includes informed choice, current monitoring of FP performance (including new approaches introduced in focus states), health system elements, FP LMIS, community perceptions, social marketing, private sector, etc. using quantitative and qualitative methodologies. Access of young people and those with disability should be paid attention.

b) In collaboration with INC, create evidence for need, supply and demand for skilled care. This action is critical as the availability of a health workforce of adequate size and skill mix is critical to the attainment of universal health coverage and health related targets of SDGs and build resilience of the health system, vital for survival and well-being of women and newborn. Expand the support to INC for QA of midwifery education, accreditation and regulation while continuing to support the two NMTIs.

Recommendation 5: Linked to conclusion # 3,4,8,9,16

(Medium priority) Strengthen the technical capacity of UNFPA (across all thematic areas based on priorities in the workplan) for CP10: CP10 resource envelope may further be reduced and the strategy for UNFPA engagement would be to maintain a *high level advocacy role as UNFPA's strength is in the technical assistance,* in strategy and policy development.

Action Plan:
a) Strengthen the technical capacity of UNFPA CO and/or link required expertise from UNFPA global pool of experts, to maintain high quality and brand reputation of UNFPA.

b) Increase investments in capacity development at various levels across CP9 programme.

Recommendation 6: Linked to conclusion # 6

(*Medium priority) CP 10 should renew focus on GBV as a life-threatening and human rights' issue focusing on health sector response (management, access to health services, including referral pathways from community-based initiatives). Such investments are critical for achieving SDGs 3 &5 and for achieving transformative results.*

Action plan:

a) In collaboration with focus state health officials, conduct a situational analysis of the current management of GBV from a service delivery readiness and health system lens.

b) Health care providers to address GBV to ensure life-saving care for women and girls and other at-risk groups (The perspectives of health providers, ability to include GBV as a part of differential diagnosis in women presenting with RH problems to health institutions, etc. are important).

c) Review various health system drivers such as policy mandates, coordination across various levels and across sectors, readiness of facilities, etc.

These will provide adequate evidence to pinpoint the gaps in the system.

6.2 Programmatic Recommendations:

Recommendation 7: Linked to conclusion # 4, 5,6, 8,10,

(Medium priority) CP 10 should provide support for strengthening continuum of care approach by integrating and strengthening selected priority SRH services.

Action plan: (three key areas)

a) **Technical assistance**
   - The current support to INC should be continued and expanded for quality assurance of education and regulation of midwifery cadre.
   - Technical assistance and capacity building for strengthening MOHFW's initiatives on maternal death and surveillance in focus states should be provided (could be a collaborative effort with WHO and UNICEF).
   - Support for strengthening screening for cervical cancer and treatment of pre-cancerous lesions to prevent cervical cancer should be initiated. This will involve advocacy to NHM to include screening and treatment of pre-cancerous lesions as part of RH services. Suggest gather evidence on the prevalence of cervical cancer in focus states, followed by a development of a strategy for pilot programmes in districts (as reports of HWCs and Aspirational districts include information on cervical cancer- HWCs in Aspirational districts could be an appropriate site) (maybe in collaboration with WHO).
   - Support to MOHFW and for fast tracking implementation of health sector response to GBV as an integral part of SRH services should be provided building on the support provided by the gender unit with greater involvement of SRH unit. At the state level, efforts should be built on the initiatives supported by UNFPA in the past.
   - Support for building capacity in all the focus states in MISP (including preventing and addressing sexual violence/GBV) and its inclusion in preparedness and response plans should be initiated as a priority as with global warming more natural calamities and pandemics are frequent and every state is vulnerable.
   - Support for expanding access to comprehensive abortion care, paying special attention to counselling, consent and post-abortion FP.
   - Support for estimating RH sub-account should be provided in focus states to track expenditure on RH and FP to enable strategic planning at focus state level (using national health accounts methodology and in collaboration with APRO health economist

b) **Support assessment, evaluation, implementation research**
   - Evaluation of the qualitative aspects of FP LMIS intervention should be undertaken and promoted as an area for SSTC.
   - In-depth reviews/implementation research of the various innovations and strategic interventions at state level for improving quality and access of maternal health should be undertaken with a plan to identify lessons learned and knowledge products and shared with other states.
   - Implementation research on evidence-based ANC, innovations such as digitized intrapartum monitoring, maternity waiting home and others etc. should be considered for identifying best practices.

- In-depth review of current strategy and implementation of AFHCs in the focus states (and 1-2 other states) should be undertaken covering access and utilization (married and unmarried), quality, various models of service delivery, perceptions of providers and beneficiaries, referral pathways between various RKSK programme elements, linkages with single interventions such as distribution of iron and folic acid, etc. This review could contribute to changes in policies and has the potential for consideration as an area for SSTC.
- Assessment of the SRH/HIV integration under the UBRAF project in Gujarat should be done and the lessons learned should be shared with NACO and MOHFW to develop a road map for strengthening integration and improved access of key populations to SRH services (contributes to constellation of services, quality of services and rights of clients).
- As support to the M&E capacity building, initiate pilot programme on creating a cadre of young graduates. For example, Young Emerging Evaluators (YEEs) and empowering them on the youth, ASRH, gender initiatives and use of data for planning, based on the mode of the on-going YEE programme supported by APEA (Asia Pacific Evaluation Association) and APRO.

c) *Support for Innovations*
- Innovative strategies to track contraceptive use based on evaluations of the current efforts in various states, use of Ayush doctors (non-allopathic) to improve access based on the experience in Uttar Pradesh, social marketing strategies to improve access of young people, etc. should be promoted.
- Possibilities of introducing pre-conception care at selected AFHCs as a pilot initiative should be explored as it has implications for life course events. The concept will need to be further developed between family welfare, maternal health and adolescent health departments.

Recommendation 8: Linked to conclusion # 9,10,11,12,21

(High Priority) Strengthen UNFPA's technical assistance and visibility in national programming on youth empowerment through advocacy and increased evidence from impact of programs with enhanced multi sectoral programmes for adolescents and young people particularly in strengthening access to SRH services.

Action Plan:

a) Promote youth leadership and voice of marginalised youth in policy advocacy through increase collaboration with youth led organisations/coalitions.

b) Initiate engagement on disability beyond LSE integration to develop a disability inclusion strategy for UNFPA in the next country program.

c) Link with other UN agencies to strengthen young women's social, economic and political empowerment, like employment, contesting PRI election, attending Gram Sabhas, negotiating marriage, reproductive rights etc.

d) CO to be a catalyst in speeding up the implementation of comprehensive sexuality education (CSE) programme and gender sensitive programming approach as a platform to change deep-rooted social norms related to gender relations (joint programme/with UNICEF and any other relevant partners).

Recommendation 9: Linked to conclusion # 14, 15,16,19

(High priority) UNFPA to establish a clearer path from research to policy in medium run, especially ones that have a larger regional focus, especially in focus states, on topics of demographic dividend-(especially for young) and migration, ageing and urbanization.

Action Plan:

a) Use commissioned research collaborations with other UN agencies on topics of shared interest and domain such as - Migration, Youth (in relation to demographic dividend), Urbanization

b) More regional focus, especially in focus states, on topics of demographic dividend-(especially for young) and migration, ageing and urbanization

Recommendation 10: Linked to conclusion # 10, 16,18,19,20

(**Medium Priority**) **Capacity building activities of data collectors and data managers be strengthened further to create Data Literacy** and the capacity to generate and use disaggregate data be strengthened. Data collection and usage are recognized as critical needs in India-especially among those that need to use them for policy. UNFPA has successful models to address these and over time, this can be a signature product of UNFPA.

Action Plan:

a) UNFPA should enhance capacity to generate credible disaggregated and intersectional data
b) UNFPA should attempt to increase ownership of disaggregates and revalidation of data
   - Capacity Building Activities of data collectors and managers to be strengthened further to create Data Literacy and can be a signature product of UNFPA
   - Capacity to generate credible disaggregate data must be enhanced but by increasing ownership of disaggregates and revalidation of data
c) UNFPA should support training on small-area estimation of demographic indicators, in partnership with government, academic institutions, and civil society that will institutionalize the updating of small-area estimates of demographic indicators and provide future technical assistance at sub-national levels on appropriate use and interpretation of demographic indicators for policy and planning.

Recommendation 11: Linked to conclusion # 6,10,23

(**Medium Priority**) CP-10 to include a <u>separate output</u> on gender equality keeping in line with Global Strategy 2018-2022, covering its efforts to address gender discrimination, harmful practices and GBV and <u>mainstreaming gender</u> as a cross cutting issue.

a) The output should be supported by an independent gender/gender mainstreaming strategy cutting across all thematic areas of focus, with checklist (see Annex Gender Equality for suggestions), targets and indicators to monitor, staff capacity building strategies, and budgets/expenditure.
b) CP10's efforts to gender mainstream in SRH may strengthen women's decision making on SRHR, government capacity on reproductive cancer, provision of SRH services to adolescents, transgender persons and persons with disabilities (in addition to existing focus on SCs, STs, minority groups, migrants and conflict affected groups). CP 10's gender mainstreaming in PD efforts may focus on strengthening national and state capacity to monitor SDG (5.1-5.3, 5.6.1 and 5.6.2) and analyses trends and patterns.
c) At state level, gender specialists or focal persons within UNFPA team may be vested with responsibility for looking into gender mainstreaming, in addition to address gender discrimination/ GBV.
d) CP-10 may pay attention to emerging gender issues like young women's economic and political rights, while continuing to promote consensus on age of consent for sexual relations and age at marriage. Alliance with civil society to advocate on these issues may be forged.
e) CP 10 may strengthen state capacity to address son preference in priority districts, and redressal mechanisms related to gender discrimination/ GBV. State capacity to address the gender-based violence arising out of decline in sex ratio may also be strengthened.
f) Synergy may be strengthened with relevant UN agencies, Women's Development Corporations/Livelihood Missions, and research and training institutions on these issues at national and priority state levels, with focused attention on those states lagging behind on relevant gender indicators.
g) Best practices from CP9 on gender equality may be documented and placed before the relevant departments.
h) In keeping with global gender strategy 2018-2022, the thrust on working with men and boys on masculinities, through a human rights-based approach, and strengthening accountability could be strengthened (through using CEDAW and, Universal Progress Reviews in addition to SDG and ICPD).