COUNTRY PROGRAMME EVALUATION

INDIA

Eɪɢʜᴛʜ PROGRAMME CYCLE (2013-17)

Evaluation Report

December 2016

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Abbreviations and Acronyms

AAG	Action for Adolescent Girls
AEP	Adolescent Education Programme
AFHS	Adolescent Friendly Health Services
ANM	Auxiliary Nurse Midwife
ART	Assisted Reproductive Technology
ASHA	Accredited Social Health Activist
ASRH	Adolescent Sexual Reproductive Health
AWP	Annual Work Plan
BBBP	Beti Bachao Beti Padhao
BKPAI	Building Knowledge Base on Ageing in India
BMGF	Bill and Melinda Gates Foundation
CBO	Community Based Organisation

CCM	Country Coordination Mechanism
CIDA	Canadian International Development Agency
COE	Centre of Excellence
CP	Country Programme
CP8	Country Programme 8
CPAP	Country Programme Action Plan
CPE	Country Programme Evaluation
CRS	Civil Registration System
CRTC	Census Resources Training Center
CSM	Contraceptive Social Marketing
CSR	Child Sex Ratio
DFID	Department for International Development,
DMPA	Depot Medroxyprogesterone Acetate
DOHFW	Directorates of Health and Family Welfare
DP	Development Partners
EAG	Empowered Action Group
FP	Family Planning
FSW	Female Sex Workers
GBSS	Gender Biased Sex Selection
GBV	Gender Based Violence
GPS	Global Programming System
HDI	Human Development Index
HPD	High Priority District
ICPD	International Conference on Population and Development
ICRW	International Center for Research on Women
ICT	Information and communications technology
IIPS	International Institute for Population Sciences
IMR	Infant Mortality Ratio
INC	Indian Nursing Council
ISR	Internal Strategic Review
JSY	Janani Suraksha Yojana
LASI	Longitudinal Ageing Study In India
LSE	Life Skills Education
M&E	Monitoring & Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MH	Maternal Health
MHRD	Ministry of Human Resource Development
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio

MoHFW	Ministry of Health and Family Welfare
MoHRD	Ministry Of Human Resource Development
MoSJE	Ministry of Social Justice and Empowerment
MOU	Memoranda of Understanding
MoYAS	Ministry of Youth and Sports
MWCD	Ministry of Women and Child Development
NACO	National AIDS Control Organisation
NCERT	National Council of Educational Research and Training
NDMA	National Disaster Management Agency
NFHS	National Family Health Survey
NGO	Non Governmental Organisation
NHM	National Health Mission
NIOS	National Institute of Open Schooling
NISD	National Institute of Social Defense
NPOP	National Policy on Older Persons
NRHM	National Rural Health Mission
NYKS	Nehru Yuva Kendra Sangathan
ORGI	Office of Registrar General and Census Commissioner
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
PD	Population Dynamics
PDS	Population and Development Strategy
PE	Peer Educators
PIP	Programme Implementation Plan
PMO	Prime Minister's Office
POA	Programme of Action
QA	Quality Assurance
RCH	Reproductive Child Health
RH	Reproductive health
RKSK	Rashtriya Kishor Swasthya Karyakram
RMSA	Rashtriya Madhyamik Shiksha Abhiyan
RRF	Results and Resource Framework
RTI	Reproductive Tract Infection
SC	Scheduled Caste
SDG	Sustainable Development Goal
SIR	Strategic Internal Review
SOCA	Senior Officials Committee on Ageing
SRB	Sex Ratio at Birth
SRH	Sexual and Reproductive Health
SRS	Sample Registration System
SSD	Scheduled Tribes and Scheduled Castes Development

ST	Scheduled Tribe
STI	Sexually Transmitted Infections
TA	Technical Assistance
TFR	Total Fertility Rate
TISS	Tata Institute of Social Sciences
TORs	Terms of References
UHC	Universal Health Coverage
UNDAF	United Nations Development Action Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Populations Fund
WHO	World Health Organization

MAP OF INDIA

KEY FACTS: INDIA

Facts and Figures		Source
Geography		
Geographical location	India is a vast South Asian country with diverse terrain – from Himalayan peaks to Indian Ocean coastline – and history dating back 5 millennia. It is the <u>seventh-largest country in the world</u> in terms of land area.	https://en.wikipedia.org/wiki/Geography_of_India
Land mass	3,287,263 square kilometers. The country is surrounded by Pakistan in the west, China, Nepal and Bhutan in the north, Bangladesh and Myanmar in the east and Sri Lanka in the south.	
Population		
Population	1,210,854,977. India is the 2nd most populated country in the world	Census of India, 2011
Annual exponential growth rate	1.64%	
Population Density (Population per sq. km.)	382	
Urbanization	31.1%	
Sex Ratio	943 females per 1000 males	
Child Sex Ratio (0-6 years)	918 females per 1000 males	
Sex Ratio at Birth (2011-13)	909 females per 1000 males	Sample Registration System (SRS) Statistical Report, ORGI
Government		
Type of government	Democratic republic	
Seats held by women in National parliament	11%	http://parliamentofindia.nic.in/
Economy		
GDP per capita (current US$) – 2015	1,581.6	http://data.worldbank.org/indicator/NY.GDP.PCAP.CD
GDP per capita growth (annual %)	6.3	http://data.worldbank.org/indicator/NY.GDP.PCAP.KD.ZG
Population below poverty line (%) (2011-12)[1]	21.9	http://planningcommission.gov.in/news/pre_pov2307.pdf
Social Indicators		

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[1]Since 2005, the Indian Government adopted the Tendulkar Methodology to estimate poverty levels, which moved away from calorie anchor to a basket of goods and used rural, urban and regional minimum expenditure per capita necessary to survive.

HDI (2014)	0.609 Rank 130	http://hdr.undp.org/sites/default/files/hdr_2015_statistical_annex.pdf
Gender Inequality Index (2014)	0.563 Rank 130	http://hdr.undp.org/sites/default/files/hdr_2015_statistical_annex.pdf
Adult literacy (% aged 15 and above)	Persons: 69.3 Males: 78.9 Females: 59.3	Census of India, 2011
Gross enrolment ratio in higher secondary classes (IX-XII, 14-18 years) 2013-14	Persons: 52.2 Males: 52.7 Females: 51.5	http://mospi.nic.in/mospi_new/upload/man_and_women/chapter%203.pdf
Health and FP		
Total Fertility Rate (2013)	2.3	Sample Registration System Statistical Report, 2013, ORGI
Life expectancy at birth (2009-13)	67.5	Sample Registration System, ORGI
Infant Mortality Rate (IMR) (2014)	39	Sample Registration System, ORGI, 2016
Under-5 mortality (per 1000 live births)	49	Sample Registration System Statistical Report, 2013, ORGI
Maternal mortality (deaths of women per 100000 live births), 2011-13	167	Sample Registration System, ORGI, 2015
Health expenditure % of GDP, (public and private), 2014[2]	4.7	http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS
Births attended by skilled health personnel (%), 2013	74.4	Sample Registration System Statistical Report, 2013, ORGI
Adolescent Fertility Rate (births per 1000 women aged 15-19)	28.1	Sample Registration System Statistical Report, 2013, ORGI
Contraceptive Prevalence Rate	48.5	NHFS-3 (2005-06)
Unmet need for family Planning	12.8	NHFS-3 (2005-06)

1.1   **[2]**Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities and emergency and designated for health but does not include provision of water and sanitation.

EXECUTIVE SUMMARY

This report presents the results of the final evaluation of the United Nations Populations Fund (UNFPA) Eighth Country Programme (CP-8) of Assistance to the Government of India (2013–2017). The present evaluation focused on activities planned and/or implemented during the period 2013–2016, and was also designed to generate inputs that could inform the planning process for CP-9.

UNFPA initially committed US$60 million of core resources over the five years of CP-8. In addition, US$ 1.68 million was made available through other sources of funding. The breakdown was as follows:

- Youth out of school: $13.75 million
- Youth in school: $11.25 million
- Family planning: $15.5 million
- Gender equality: $9 million
- Population dynamics: $9 million
- Programme coordination assistance (PCA): $1.5 million

Scope and Methodology of Evaluation

United Nations Populations Fund (UNFPA) India commissioned the Country Programme Evaluation (CPE) to conduct an independent assessment of programme achievements and compile the lessons learnt to inform the development of the next programming cycle. The evaluation covered programmatic implementation in all five UNFPA intervention states, namely Bihar, Madhya Pradesh, Maharashtra, Odisha and Rajasthan. The four thematic areas covered are adolescents and youth (A/Y), reproductive health and family planning (RH/FP), gender and gender biased sex selection (GBSS), and population dynamics (PD). Gender mainstreaming was analysed across all thematic areas.

The evaluation examined 10 strategic questions based on the OECD–DAC evaluation criteria of effectiveness, relevance, efficiency, and sustainability; two additional evaluation criteria, coordination and added value, were also included to analyse strategic positioning. The evaluation team designed additional learning and visioning questions in response to the Terms of Reference objective: "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 cycle."

The main CPE data sources were (i) documentation provided by UNFPA and key informants on CP-8 as well as national or state programmes and policies; (ii) semi-structured individual and group interviews with key informants, with a system to analyse notes; (iii) four in-depth thematic assessments carried out the month before the CPE; (iv) field visits to programmes in the five states; (v) dialogue with UNFPA country and state staff. A case-study method was employed to examine highly successful initiatives to develop a theory of change.

The two weeks of data collection by the CPE team was mainly complementary to the site visits and stakeholder interviews of the thematic assessments, which covered a broad range of sites and stakeholders, with intensive investigation into the major programmes supported. Given the size and complexity of the India programme, the thematic assessments were essential to enable the CPE team to examine critical learning questions and strategic positioning. Methods to triangulate data included review of documents from different sources and purposive stakeholder sampling to represent varying perspectives. Findings were validated with UNFPA staff, who provided additional data as needed, and

with the Evaluation Review Group of the national government and development partners.

Limitations of the CPE included insufficient time to fully assimilate the main CP-8 documentation and thematic assessments, the lack of state-level strategic plans, and insufficient data on the activities in the technical assistance budget and knowledge management. These limitations were mitigated by additional document review after country office meetings, dialogue with state office staff, and learning questions on technical assistance through use of consultants and on knowledge management.

Conclusions and Recommendations

Strategic Conclusions and Recommendations

Conclusion #1: *The lack of state-level strategic plans reduces the relevance, effectiveness, efficiency, and evaluability of UNFPA's programmes.* The lack of state-level strategic plans and objectives limited the CPE team's ability to evaluate the relevance and effectiveness of each state programme. This poses a threat to relevance given the unique context in each state, and is a contributor to inefficiencies in the approval process for state-level activities.

Recommendation #1: *Develop state-level strategic plans as part of planning for CP-9.* Sound state-level strategic planning would analyse the context, and develop a result framework and strategies based on state and UNFPA priorities.

Conclusion #2: *Multi-faceted initiatives on specific ICPD-related issues that employed the full range of UNFPA's expertise, and were continued over two to three country programmes achieved the highest sustainable outcomes.* Effective long-term theory of change is based on the following principles—continuity, systemic comprehensive approach to modes of engagement, and sustainable managerial and technical systems. Sustainable outcomes for testing pilot programmes depend on adequate evaluation. Deployment of UNFPA's technical

strengths across themes by breaking out of silos is a key principle. Gender equality objectives are fully integrated in A/Y programming, but the level of gender mainstreaming is mixed in the RH/FP and PD areas and at the state level. Attention to GBV has been sporadic. CP-8 lost leadership and focus on the SRH bull's eye in the UNFPA strategic direction due partly to lack of investment in staffing but also to failures to mainstream SRH issues in the other thematic programmes.

Recommendation #2: *Develop or continue focused initiatives following principles that maximize the long-term impact of UNFPA programmes, including cross-thematic approaches and improved mainstreaming of gender and the UNFPA SRH "bull's eye" in all thematic areas.* The principles of continuity and sustainable managerial and technical systems demand a 10-15 planning time frame for new or emerging issues. In areas with sustainable systems in place, such as midwifery and PD, initiatives addressing specific capacity gaps could have more limited objectives and shorter planning time frames. Cross-thematic approaches are recommended for major initiatives, with special attention to mainstreaming a focus on the UNFPA SRH bull's eye, not just in RH/FP, to **s**trengthening gender mainstreaming in PD and RH/FP, and to increasing attention to GBV across themes.

Conclusion #3: *UNFPA's greatest asset and source of added value is its ability to mobilize high quality technical assistance and expertise for national priorities.* UNFPA's comparative advantage depends on this ability to respond with quality evidence to guide policies and programmes, technical assistance, and capacity-building. UNFPA's use of consultants with high levels of expertise has had outstanding results in several cases. Judicious use of technical assistance funds has been essential to enable UNFPA to mobilize expertise in a timely and efficient fashion for national priorities.

Recommendation #3: *Strengthen all human resource functions that improve UNFPA's ability to*

mobilize high quality expertise.* These functions include hiring and professional development of country and state office programme staff, and consultant vetting and supervision.

Conclusion #4: *Addressing two gaps in UNFPA monitoring and evaluation systems would enhance effectiveness, relevance, efficiency, and sustainability.* First, the need for more investment in process evaluation (including implementation research) was detected in some pilot programmes, and in new government programmes that are rolling out at scale to the states. Second, the lack of programmatic MIS on the use of technical assistance budgets reduced the evaluability of CP-8, especially in the case of knowledge management activities.

Recommendation #4: *Strengthen M&E systems through increased investment in process evaluation and improved programmatic tracking of technical assistance activities.* Strengthened evaluation of national programmes and pilots would maximize the value of CP investments. The evidence on effective implementation strategies, and on initial results, helps consolidate government commitment to the programme, and ensure that capacity building tools for roll-out to new areas reflect the best evidence on how to implement the programme. Improved evaluability of technical assistance activities would strengthen planning for efficiency and effectiveness.

Conclusion #5: *Effective strategies and technical expertise developed in one state have maximum impact when also used for capacity-building in other states and at national level.* GBSS, RHCS, and A/Y programme experiences illustrate the potential for cost-effective South–South strategies within India that share learning and capacity-building resources from start-up trials and larger programmes in one or more states. Many stakeholders identified the opportunity and need for cross-state learning on programme strategies, modes of implementation, and tested educational and training tools.

Recommendation #5: *Increase investment in learning exchanges among states in the priority initiatives.* Expert technical networks and close partnerships with governments and leading NGOs constitute UNFPA's most important assets. Building on these assets, UNFPA is positioned to create "learning hubs" and communities of practice coordinated by different UNFPA offices to address the South–South learning needs and opportunities within India.

Programmatic Conclusions & Recommendations

Conclusion #6: *Programming for A/Y is a major comparative strength of UNFPA, and UNFPA has made significant contributions to design and implementation of large national and state adolescent health and life-skills programmes.* These results were made possible through close partnerships with government counterparts and experienced national or state NGOs. Technical assistance in A/Y programming is highly valued by government officials. Government prioritization on the use of information and communications technologies (ICT) for capacity development and education presents an opportunity in CP-9 for alignment with government priorities and increasing SRH content in A/Y programmes. Concerns in A/Y revolve around questions of sustainability, inadequacy of process evaluation, inaccessibility of certain sub-groups of young people, and weak SRH content.

Recommendation #6: *Build on the strengths and achievements of the adolescent and youth area through planning for sustainability, process evaluations, cross-thematic approaches, and experiments with use of interactive ICT platforms to increase access to SRH information and counselling for young people.* The two major national A/Y programmes—RKSK in communities and AEP in the schools—are rolling out to the states, as is the BBBP

programme that counters GBSS and promotes empowerment of adolescent girls. Support to create sustainable training and mentoring systems at state, district and sub-district level is recommended. Cost-effective process evaluations are also recommended, including tests of the effectiveness of interactive ICT platforms in increasing young people's access to SRH knowledge and counselling, and of innovative strategies to increase usage of adolescent friendly health services. A/Y programming would benefit from: (1) a cross-thematic strategy for adolescent girls' empowerment, (2) experimentation with pilots to prevent child marriage; (3) efforts to reach married girls and other hard-to-reach populations, and (4) greater attention to the issue of GBV.

Conclusion #7: *Although there are achievements in RH/FP, the limited scope of support led to loss of leadership in FP and maternal health, within the context of ICPD frameworks.* Some UNFPA support has helped to strengthen the health system in terms of improving the availability and quality of services in underserved areas, with a focus on vulnerable populations and young people. Specific instances of evidence-based policy and advocacy at national and state levels contributed to improved quality, with some sustainable interventions. The web-based RH Commodity Logistics Management Information System (RHC LMIS) in Odisha led to fewer stock-outs and is being considered for replication. Overall, however, UNFPA lost leadership and strategic focus in FP and maternal health. Partly resulting from lengthy lapses in hiring RH/FP staff during CP-8, strategic gaps include: 1) lack of support for maternal health in four focus states; 2) insufficient advocacy to promote the principles of ICPD in the national FP programme through the FP2020 mechanism, and 3) failure to advocate for inclusion of FP as a central element of the country's Universal Health Care (UHC) initiatives.

Recommendation #7: *Regain UNFPA's leadership in FP with renewed focus on reproductive rights, and strengthen maternal health programmes with a focus on midwifery capacities.* Given India's recommitment to ICPD, UNFPA should support the MOHFW to reorient the FP 2020 action plans within the framework of reproductive rights, and to include FP as a central component of UHC. This framework would strengthen the emphasis on voluntary and informed choice, eliminate provider incentives to meet targets for long-acting methods and sterilization, and focus on addressing unmet needs for the full range of FP and condom services, supplies and information. There is an opportunity to collaborate with the Indian Nursing Council (INC) to implement a robust midwifery framework to strengthen human resources for maternal healthcare.

Conclusion #8: *UNFPA contributions to GBSS initiatives have been effective and significant, and are now in a phase of experimentation, with initial steps to develop sustainable capacity development systems.* GBSS initiatives in UNFPA and in India have started to address the structural and cultural drivers of this issue. The BBBP umbrella can be used to evaluate variations in implementing the programme, and showcase effective practices that reduce son preference in work with girls, schools, women elected representatives, panchayats, young men and boys. UNFPA has also made major contributions to the design and initial implementation of systems to build capacity in the health system to implement the PCPNDT Act. Drawing on lessons from these experiences, developing sustainable technical and management systems was noted as a need, and the next step.

Recommendation #8: *Continue to give priority to GBSS initiatives.* BBBP campaigns and other pilot programmes to deal with drivers of GBSS are learning opportunities to identify the most effective

strategies to counter the drivers of son preference. In addition, sustainable training and supervision systems in MOHFW to implement PCPNDT need to be put in place, with planning and benchmarks for gradual withdrawal of UNFPA support.

Conclusion #9: *The PD programme made strong contributions to progress on GBSS, ageing, and social inclusion in Odisha, but overall underinvestment led to mixed results and missed opportunities for enhancing results across all themes in CP-8, especially in the planned focus on social inclusion.* CP-8 has made strong contributions in the areas of GBSS, ageing data analysis, and to initiatives on social inclusion in Odisha. UNFPA has a strong comparative advantage and leadership role in the work on ageing. Partnerships with the Ministry of Social Justice and Empowerment (MSJ&E) and other partners have strong potential to build national capacity to benefit the ageing population.

A major missed opportunity is lack of follow-up of CP-7 training on use of census and demographic data for sub-district analysis, an essential skill to promote social inclusion and to improve allocation of resources to the most vulnerable populations. Two opportunities were identified to revive this initiative. In addition, some key gender issues were not focused on. The plan to work with the Census Commissioner to establish a South-South training centre is stalled, but strategies to overcome barriers were identified

Recommendation #9: *Deploy PD expertise in all programmes to strengthen promotion of social inclusion and provide population analysis for policy and programme design.* It is recommended to strengthen the focus on social inclusion by reviving the CP-7 initiatives to build capacity in vulnerability mapping and district/sub-district data analysis. Such initiatives would build the capacity of top bureaucracy in the states and key district and municipal officers, especially those in charge of planning for vulnerable population groups, in the use of census and other demographic data for small area planning. It is recommended to consolidate the work on ageing through the release of the *Longitudinal Ageing Study in India* (LASI) and *India Ageing* Reports, and continuing to work through the MSJ&E for advocacy and policy formulation, especially to nurture the revival of the National Institute of Social Defence (NISD). Re-engagement with the Census Commissioner to establish and operationalize the planned Census Resource Training Centre (CRTC) as a South-South collaboration is also suggested.

1. INTRODUCTION

United Nations Populations Fund (UNFPA) India commissioned an independent assessment of its Eighth Country programme's (2013-2017) with the purpose of "assessing the achievements of the programme, factors that facilitated or hindered achievements and to compile lessons learned in respect of each of the programme components and thematic areas."[3]

This report presents the findings of the evaluation team on four thematic areas (reproductive health and family planning, adolescents and youth, gender, and population dynamics) anchored in the strategic questions put together based on the OECD–DAC evaluation criteria.[4] The report follows the guidelines of the UNFPA Evaluation Handbook 2013 in design and structure.[5] Chapter 1 outlines the purpose, objectives, scope of the evaluation and the methodology and process adopted to conduct the evaluation. Chapter 2 describes India's present scenario, with a focus on the four thematic areas. Chapter 3 lays out UNFPA's global agenda and explains how the country programme (and budget) aligns itself to this agenda. Chapter 4 presents the main findings structured into the evaluation questions and finally Chapter 5 describes the conclusions and the strategic and programmatic recommendations drawn from each of the conclusions.

1.1 Objectives of the Country Programme Evaluation

The specific objectives of the evaluation are:
- to provide an independent assessment of the progress of the programme towards achieving country programme outputs set forth in the results framework of the country programme;
- to assess 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;
- to provide an analysis of how UNFPA has positioned itself within the development community; and national partners with a view to adding value to the country development results; and
- 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 cycle.

1.2 Scope of the evaluation

While the scope of the evaluation is to assess the progress of the Eighth Country Programme (CP-8) that is planned between 2013 and 2017, the present evaluation focused on activities planned and/or implemented during the period 2013–2016. The CPE assessed the progress and achievements of the four thematic areas along with UNFPA's strategic positioning, vision and learning outcomes in the present programme cycle. The evaluation covered programmatic implementation in all five UNFPA intervention states, namely Bihar, Madhya Pradesh, Maharashtra, Odisha and Rajasthan.

1.3 Methodology and process

Evaluation Process
The evaluation process for the present country programme was conducted across five phases— preparatory, design, field, reporting and dissemination. The process flow is depicted in Figure 1.1 which lists the activities

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[3] Terms of Reference for the Evaluation of UNFPA's Eighth Country Programme in India (2013–2017). See Annex 1.
[4] The evaluation standards for development aid, established in 1991 by the Development Assistance Committee (DAC) has five criteria to evaluate development interventions - relevance, effectiveness, efficiency, impact, and sustainability.
[5] https://www.unfpa.org/sites/default/files/admin-resource/Evaluation%20Handbook.pdf

undertaken within each phase and the corresponding milestone or deliverable that was achieved at the end of each. Figure 1.2 represents the timelines for the evaluation process.

Figure 1.1: The Eighth Country Programme Evaluation Process

Phase	Activities	Deliverable
Preparatory Phase	- drafting terms of references for Thematic Assessments and Country Programme Evaluation - Undertaking of Thematic Assessments in four UNFPA intervention areas - Preparing a gateway to UNFPA documents on Google drive - Selection and recruitment of the external evaluation team - Constitution of an Evaluation Reference Group (ERG) - Preparation of a preliminary stakeholder list	**TORs and Thematic Assessment Reports**
Design Phase	- Review of documents - Initial briefing by UNFPA staff to the evaluation team regarding programme and strategies and detailed mapping of stakeholders - First ERG Meeting (5 July, 2016) - Finalization of evaluation questions and preparation of evaluation matrix outlining indicators and methodology for each question - Preparation of a design report	**Design Report**
Field Phase	- Data collection tools and formats along with select stakeholders finalized - National level stakeholders interviews completed - A two-week in country mission to different UNFPA states completed - Data collection done through semi-structured stakeholder interviews and discussions with programme staff	**Presentation for UNFPA Staff de-brief meeting**
Reporting Phase	- analysis and coding of data - Validation meeting with programme staff by thematic area - De-briefing meeting with UNFPA national and state level staff - Second ERG Meeting (28 July, 2016) - Presentation to government counterparts on preliminary findings and recommendations - Production of final report	**Final report**
Dissemination Phase	- Quality Review of final report - Publishing and dissemination of evaluation report - Management Response to the recommendations from the evaluation report - Follow up on the recommendations from the report (one year later)	

Figure 1.2: Timeline of the Eighth Country Programme Evaluation

Evaluation Timelines

Evaluation questions

The Terms of Reference of the CPE (Annex 1) outlined the initial evaluation questions corresponding to the four evaluation criteria—relevance, effectiveness, efficiency and sustainability.[6] Apart from these, the evaluation as per the UNFPA Handbook also focused on Added Value as an evaluability criteria.[7] Cross-cutting issues of vulnerability, gender mainstreaming, resource mobilization, corporate social responsibility and south–south collaborations were also addressed in the data collection through complementary review of documents, purposive sampling of interviewees and interactions with development partners and UN agencies. A team member also conducted inquiries on potential resource mobilization at the request of the country office (provided as Annex 11).

The evaluation questions were reviewed and refined in the design phase after a thorough scrutiny of documents; discussions with UNFPA staff and feedback from the first Evaluation Reference Group (ERG) meeting on 5 July 2016 (refer to Annex 2). The final questions that guided the evaluation are given below:

EQ1: To what extent have the interventions supported by UNFPA helped to develop and improve youth-friendly policies and programmes that increase the access of young people (10–24 years) to quality life skills-based education programmes and comprehensive health services, including sexual and reproductive health?

EQ2: To what extent have the interventions supported by UNFPA in the field of reproductive health and rights contributed to improved availability and quality of sexual and reproductive health services, especially family planning services and humanitarian response?

EQ3: In what ways has UNFPA supported gender equality and to what extent has it contributed to: (i) improved responses to gender biased sex selection and (ii) gender mainstreaming across the programming area?

EQ4: To what extent have the interventions supported by UNFPA in the field of population and development contributed to an increased availability and use of data on emerging population issues at national and subnational levels?

EQ5: To what extent are the objectives of the Eighth Country Programme in India, as well as its geographic focus, (i) adapted to the needs of the population (including needs of vulnerable groups), (ii) aligned with government priorities (iii) as well as with policies and strategies of UNFPA?

EQ6: To what extent are the strategies reflecting a sound theory of change grounded in the national and state context to contribute to outcomes and outputs?

EQ7: 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?

EQ8: To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of structure, functions and approaches to pursue the achievement of the results defined in the UNFPA country programme?

EQ9: To what extent have the partnerships established by UNFPA promoted the national and state ownership of supported interventions, programmes and policies?

EQ10: What are the main comparative advantage of UNFPA in India and to what extent does UNFPA maximize development results by coordinating effectively with UN and other international and national stakeholders for potential synergies and south-south collaboration?

The correspondence between evaluation question and evaluation criteria is given in Figure 1.3.

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[6]DAC Criteria for Evaluating Development AssistanceFactsheet, OECD, http://www.oecd.org/dac/evaluation/49756382.pdf accessed on 5 August 2016

[7] Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA, UNFPA Evaluation Office, October 2013.

Figure 1.3: Mapping evaluation questions according to evaluation criteria

EQs	Relevance	Effectiveness	Efficiency	Sustainability	Added Value
EQ1		●			
EQ2		●			
EQ3		●			
EQ4		●			
EQ5	●				
EQ6	●			●	
EQ7	●				
EQ8			●		
EQ9				●	
EQ10		●			●

Strategic learning and visioning questions

Further based on the fourth UNFPA evaluation objective which was "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 cycle"; the evaluation team designed additional questions under two broad criteria of Learning and Strategic Visioning. While the data collection process was guided, in most part, by the first ten evaluation questions, the team used the first 'learning' questions to assess UNFPA's capacity development, pilot projects, policy advocacy strategies and knowledge management programmes, while arriving at strategic 'visioning' inputs through the second set of questions that informed the next programme cycle. The detailed learning and strategic visioning questions are provided in annex 6.

Evaluation methodology

Thematic Assessments: With the objective of conducting independent and in-depth review of progress under each thematic area during 2013–2016 and assess results and lessons learnt to inform the CPE; thematic assessments on: (i) young people's sexual and reproductive health and sexuality education,(ii) reproductive health and family planning, (iii) gender biased sex selection and gender mainstreaming, and (iv) population and development, were conducted by consultants prior to the CPE during 5 May 2016–28 June 2016. The final assessment reports were made available to the evaluation team, and a bilateral sharing of interview notes and data was also facilitated without the involvement of UNFPA to maintain strict ethical considerations of the evaluation process. The CPE benefited from the extensive data and analysis of the backward looking assessments, and could hence delve deeper into a more focused forward-looking evaluation process.

Data collection: After an initial immersion into the UNFPA India country programme through country office presentations (1 July 2016) and thematic assessment de-briefs (4 July 2016), the evaluation team extensively researched programme documents and finalized the field visit plans. Some of the major data collection methods are highlighted below:

1. Document review: A detailed list of documents "Gateway to UNFPA" was uploaded on Google drive which served as an important source of qualitative data. The team was able to review the CPAP, annual reports, programme review reports, thematic assessment reports, the Monitoring and Evaluation Report on the CPAP Results and Resources Framework (RRF) indicators, and 7[th]country programme evaluation report and management response, among others. Other documents, such as the Strategic Internal Review, were used to address specific evaluation questions, and are mentioned in the evaluation matrix (Annex 7). A third set of documents, including some selected annual work plans (AWPs), was reviewed to ensure that stakeholder interviews yield as much new information and insight as possible. In the design phase, document review (4 July 2016–7 July 2016) was accompanied by in-depth discussions with UNFPA programme staff (3 and 5 July 2016) in order to gain sufficient overview of the programme. A list of documents is provided as Annex 3.
2. Semi-structured personal interviews: Prior to the launch of the field phase, the evaluation team designed interview guides and formats to conduct semi-structured personal interviews which were a significant source of data both from national as well as state counterparts. In order to gather maximum information within a limited time, the evaluator determined the primary purpose of each interview by reviewing the checklist based on the Evaluation Matrix. Most interviews lasted 60–90 minutes. The interviews began with general questions, and proceeded to specific questions relevant to each stakeholder. The interview guide and the template for analysis of interviews are attached as Annex 9.
3. Group interviews: At all stages of the evaluation, semi-structured group interviews were conducted with external stakeholders, including counsellors, consultants, and government or NGO programme staff at state level to respond to a variety of evaluation questions. A detailed list of persons interviewed is provided as Annex 4.
4. Field visits: The evaluation team visited all five UNFPA states during the field phase between 11 July 2016 and 20 July 2016 to collect data. Semi-structured interviews along with observation of programme events, focus group discussions and group interviews were conducted. States were selected for field visits based on their potential to provide inputs for future programming (forward-looking). The data gathered during field work was expected to supplement the backward-looking findings of the thematic assessments. The CPE team members also interviewed key national stakeholders, either prior to state visits or while transiting from one state to other via the headquarters.

Data analysis: To the extent possible, each stakeholder interview was based on the interview guide and format. However, given the handwritten interview notes and the imperative of analysing the data under severe time constraint, the consultants were tasked with the exercise of matching relevant portions of the interview transcripts with the corresponding evaluation question on the matrix. A group exercise compiled the relevant findings pertaining to each evaluation question in a spreadsheet. In August 2016, the team members deepened the analysis by consulting some additional documentary sources in order to write the final report.

Data validation mechanisms: Two methods were used for triangulation and data validation. Documentary review of AWPs, progress reports, minutes of review meetings, policy briefs, research studies and other publications substantiated and strengthened data collection and analysis. The thematic assessments reports also complemented the primary data collected by the CPE consultants. Meetings with programme staff, technical support staff and consultants at national and state levels; debrief to the UNFPA thematic clusters and state offices on 21 July 2016 to gather initial impressions on significant factual errors and a feedback session from the national government and development partners meeting (second ERG) on the 26 July 2016 (refer to Annex 2) have been used to support data validation and refine and strengthen findings.

Selection of the sample of stakeholders: A stakeholder list was created for the thematic assessments through a participatory exercise based on the significance of the partnership and the level of investment and relevance of a

particular programme. This stakeholder list was shared with the CPE team flagging those who had already met the thematic assessors as well as those recommended by the country office.

Since the evaluation was designed to be complementary to the thematic assessments, CPE consultants prioritized those stakeholders who had either not met the thematic consultants or could provide additional information to support the thematic findings. In the latter case, the evaluators examined the interview notes of the thematic assessors and focused more on added value, strategic learning and visioning questions. A small number of high-level stakeholders were chosen to address cross-cutting issues of resource mobilization, corporate social responsibility and south–south collaboration.

Table 1.1 provides the number of semi-structured individual interviews and group interviews that were undertaken during the evaluation process with national and state ministries and lead government agencies, implementing partners, UN agencies and development partners, institutions, civil society, consultants and beneficiaries. For complete list of persons interviewed refer to Annex 4.

Table 1.1: Individual interviews and group interviews

Type of stakeholder	Adolescents and youth	Reproductive health and family planning	GBSS and gender mainstreaming	Population dynamics	
Interviewee details for semi-structured personal interviews					**Numbers**
National government agencies	3	3	3	5	14
State government departments	4	9	3	10	26
Implementing Partners	4	4	7	2	17
UN Agencies and DPs	5	5			10
Institutions			1	4	5
Civil Society/NGOs	4	3	2	1	10
Consultants			2		2
Total of personal interviews					**84**
Group interviews					**Numbers**
State Agencies			2		2
Institutions			1		1
Consultants		2			3
Beneficiaries			1		1
Total of group interviews					**7**
GRAND TOTAL					**91**

Limitations

1. The week allotted for gaining an overview understanding of the program and designing the CPE was insufficient, given the length of the detailed background documents. Given the size and complexity of the India country programme, it would be useful in the future to maintain a two-phase model beginning with thematic assessments for in-depth data collection and allocation of some days for immersion for CPE team before the in-person meetings and the design stage while ensuring that the thematic assessments are available during that month. However, the thematic proved extremely useful in improving the quality and rigour of the CPE.

2. The Ministry of Health and Family Welfare (MOHFW), the nodal ministry for UNFPA, did not participate in the initial ERG, and the timing of planned site visits made it impossible to have a one-on-one dialogue. As a result there were no inputs from the ministry to the CPE team at the design stage. However, CPE members

conducted individual interviews with several MOHFW officials, and their participation in the final ERG meeting was active and supportive.

3. The lack of state-level strategic plans and objectives limited the CPE team's ability to evaluate the relevance and effectiveness of each state programme, which in turn made it difficult to analyse trends in state-level programming overall. UNFPA provided the team with maps Identifying the national and pilot programmes being implemented in each state, but the strategic reasoning behind the presence or absence of a national programme or attention to a particular output in each state was only revealed through interviews with the UNFPA cluster or state office staff.

4. It was impossible to assess thoroughly and systematically the efficiency and effectiveness of use of the technical assistance (TA) budget, since the activities are not entered into the UNFPA GPS system, and there are so many different TA-supported activities each year. This limitation was partially addressed at the design stage. Based on initial conversations with UNFPA programme staff on their priorities for learning lessons from the CPE, the team designed a learning question and collected considerable data on the effectiveness of use of long-term consultants, and was able to form judgments on some activities and publications that were supported through the TA budget.

5. Similarly, it proved difficult to evaluate the effectiveness and relevance of knowledge management strategies. Initially, the CPE team intended to inquire systematically about the use of the publications produced in CP-8, posing this as a strategic learning question, but it was impossible to get a complete list, much less conduct a systematic review. Some are produced under AWPs by implementing partners, and many others by UNFPA using the programme TA budget. The indicators in the CPAP RRF related to knowledge management are framed as the number of research reports and publications produced, so that there is no monitoring system in place to record how they are disseminated, and much less any indications of use and influence. However, both the thematic assessments and the CPE were able to evaluate the utility of certain high-profile publications.

While many positive aspects of the country office monitoring and evaluation (M&E) system facilitated the CPE, limitations of the study linked to the evaluability analysis remained (see Annex 8 for evaluability assessment framework). The detailed comments on the country office M&E system are included under EQ8 in Chapter Four on Efficiency.

2   COUNTRY CONTEXT: THE EIGHTH COUNTRY PROGRAMME OF UNFPA INDIA

2.1   Country context

Economic and Social Context

India is the seventh-largest country in the world and second most populous country (with over 1.2 billion people). The country at present is a federal republic governed under a parliamentary system consisting of 29 states and 7 union territories. The country is classified as an emerging industrialized country, one of the G-20 major economies, a member of BRICS and a developing economy with an average annual growth rate of approximately 7 percent[8] over the last decade. The long-term growth prospects of the Indian economy are positive due to its young population.

According to International Monetary Fund World Economic Outlook (April-2015), India is at 145th position in terms of GDP (nominal) per capita due to its huge population size.[9]   As per data from the World Bank,[10] the annual per capita income in 2015 is US$1,581 (current), which is one-seventh the world average around $10,880.India's GDP measured in terms of purchasing power parity (PPP), ranks the country as the third largest in the world.[11]

While the agricultural sector is the largest employer in India's economy; the service sector is the fastest growing contributing to 57 percent of GDP in 2012–13. India has become a major exporter of IT services, BPO services, and software services with $167.0 billion worth of service exports in 2013–14. The IT industry continues to be the largest private sector employer in India.[12] India also reported a $600 billion retail market in 2015 and supported one of the fastest growing e-commerce markets in the world.[13]

Though economic growth in the last two decades has been moderate to high, this growth has not translated to commensurate reduction in inequality and social exclusion. Approximately 22 percent of the Indian population lives below the poverty line with states such as Bihar (33.7 percent), Odisha (32.5 percent), and Madhya Pradesh (31.6 percent) reporting figures way above the national average.[14] Social exclusion of Scheduled Castes (SCs), Scheduled Tribes (STs), minorities and workers in the informal sector is particularly high as are poverty levels of SCs and STs who account for about one-fourth of India's population.

India is ranked 130[th]amongst 146 countries in the UNDP Human Development Index 2014.[15] The literacy rate in India for those aged 15 years and above is 69.3 percent (78.9 percent for men and 59.3 percent for women) with considerable state wise variations.[16] While literacy and educational attainments have shown incremental increase over time, along with narrowing of the gender gap, it still holds that merely 31 percent men and 15 percent women above the age of 20 years in India have completed high school education[17]and gender disparities persist even amongst the young. With strong political will to ensure the right to education of children through the Right to Education Act 2009, school retention and literacy rates may be expected to improve further creating the opportunity to extend sexual and reproductive health (SRH) information through the educational system.

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[8]Press note on Annual National Income, Ministry of Statistics and Programme Implementation, GOI, 2016
[9]http://www.imf.org/external/pubs/ft/weo/2015/01/pdf/text.pdf
[10]http://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=IN
[11]World Development Indicators, The World Bank, 2015
[12]https://www.linkedin.com/pulse/indian-service-sector-industry-india-168-billion
[13]https://en.wikipedia.org/wiki/Economy_of_India
[14] Press Note on Poverty Estimates, 2011-12, Planning Commission, GOI, July, 2013
[15]http://hdr.undp.org/sites/default/files/hdr_2015_statistical_annex.pdf
[16] Census of India 2011, Office of the Registrar General and Census Commissioner, Ministry of Home Affairs, GOI
[17] Census of India 2011, Office of the Registrar General and Census Commissioner, Ministry of Home Affairs, Government of India

Keeping in mind the inequities and growth requirements the present government has initiated several flagship programmes including *Beti Bachao Beti Padhao* (BBBP: Save the girl child and educate her)to ensure survival, protection and empowerment of the girl child; the Skill India Mission to make India the "human resource capital" of the world; the Make in India initiative designed to increase the "ease of doing business" in India and facilitate investment, foster innovation, enhance skill development, protect intellectual property and build best-in-class manufacturing infrastructure for making India a global manufacturing hub; the Digital India Programme aimed at empowering the nation digitally and making government services available to citizens electronically; and the Smart City Mission to make 100 Indian cities citizen friendly and sustainable. Besides the schemes on social security and infrastructure improvement, there are health sector missions and programmes such as the National Health Mission (NHM), Reproductive Maternal Newborn and Child Health + Adolescents (RMNCH+A) and the *Rashtriya Kishore Swasthya Karyakram* (RKSK) which is the national programme for adolescent health.

Population dynamics

Though the annual population growth rate in India has reduced from 2.2 percent in the 1980s (Census of India 1991) to 1.6 percent in2000–2010(Census of India 2011) to 1.43 per cent in 2014 (Sample Registration System, SRS 2016), India's population is rapidly heading towards being the largest in the world, overtaking China's total population, which is at 1.4billion, as early as 2022, under all the medium variant assumptions of fertility projected by the United Nations Population Division.[18]

Interstate differences in the population growth are vast, varying from a mere 0.47 percent in Kerala to 2.24 percent in Bihar. The total fertility rate (TFR) declined from 3.6 children per women in 1981 to 2.3 children per women in 2013. Most states have reached replacement level except the large northern states of Bihar, Uttar Pradesh, Rajasthan and Madhya Pradesh, where TFRs continue to be high. India has therefore, a relatively young population and the base of the population pyramid still large.

Figure 2.1: Population Pyramid- India 2011
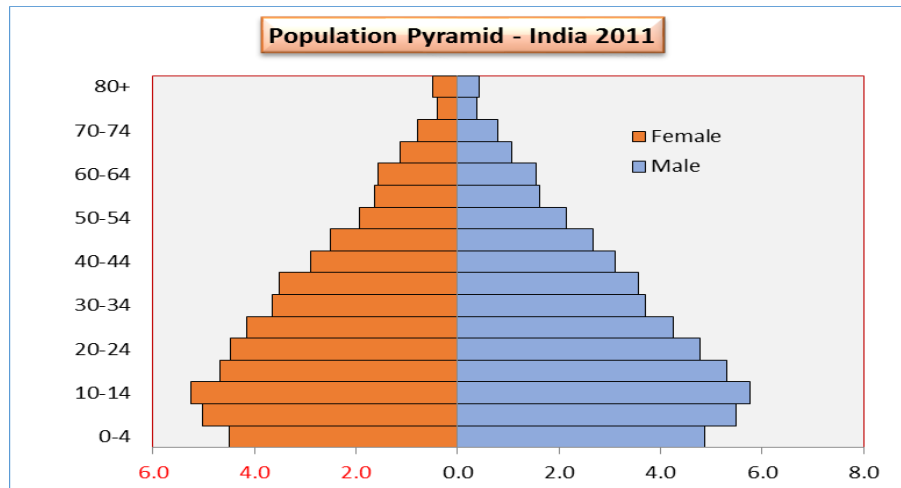
Source: Census of India, ORGI, 2011

According to Census of India 2011, 365 million people in the country (30.1 percent of the population) are aged 10–24 years, 253 million are adolescents aged 10–19 years, and 232 million are youth aged 15–24 years. Compared to earlier generations, the situation of young people in India has undoubtedly improved: they are healthier and better educated and gender disparities in child mortality, school enrolment, and educational attainment have narrowed. Nonetheless, vulnerabilities persist and obstacles remain that inhibit young people

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[18]World Population Prospects: The 2015 Revision, Population Division, United Nations

from making informed life choices, limit young women's exercise of agency, and compromise young people's health, notably in the SRH arena. Recognizing the importance of harnessing the demographic dividend of India's "youth bulge" the Ministry of Youth Affairs and Sports (MOYAS) has recently revised the youth policy, to support the implementation of a youth agenda in India.

Despite its relatively young population, India is witnessing a rapid demographic transition where ageing population is emerging as an area of concern. As per Census of India (2011) there are 104 million persons aged 60 years and above constituting 8.6 percent of the total population which will be more than double by 2030. Older persons, particularly women, are likely to be vulnerable with breaking down of joint family systems, income insecurity, illiteracy, age-related morbidity and physical and economic dependency, Socio-economic security and access to affordable health care and services must lie at the core of India's response to the ageing population.

It has also been estimated that by 2030, the urban population will double to over 600 million people;[19] causing densification of towns, sprouting of peri-urban settlements and slums around larger towns and cities. Adolescents and young people, more often males moving to seek employment, would form the core group of migrants living in slums. Substantive proportions of them may be working in the unorganized sector and exposed to several risks that compromise their education, health and well-being.

Reproductive health and rights

Investments in health over the years have contributed to improving life expectancy with 69.3 years for females and 65.8 years for males.[20] There have been significant improvements in maternal and child health indicators with maternal mortality ratio (MMR) decline from 301 per 100,000 live births in 2001–2003 to 167 by 2011–2013 (and yet India accounted for 19 percent of all global maternal deaths) (RMNCH+A Strategic Approach, MOHFW, 2013). The same is true for the infant mortality rate (IMR), which declined from 66 per 1000 live birth in 2001 to 39 in 2014. The inter-state variation of MMR ranges from 61 per 100,000 live births in Kerala to 300 in Assam, 285 in Uttar Pradesh, 244 in Rajasthan, 221 in Madhya Pradesh, 208 in Bihar and 222 in Odisha. The conditional cash transfer under *Janani Suraksha Yojana* (JSY) scheme has resulted in a surge in institutional deliveries, registering an increase from 40.7 percent in 2005–2006 to 74 percent in 2013. Four out of 10 maternal deaths occur amongst women aged 15–24. Young women from SC or ST communities or Muslim minorities are at greater risk.

Although the practice of child marriage is declining considerably, it is still deeply rooted in India. During 0–4 years prior to the Census 2011, 37.6 million females got married, out of which 6.5 million females reported their age to be less than 18 years of age at the time of marriage. This translates to about 17 percent of all females married during the period which is a substantial reduction from 32 percent reported in Census 2001. Percentage of girls marrying below age 18 years has been highest in Rajasthan in 2011 at 32 percent which decreased from 52 percent a decade ago. Childbearing follows close on the heels of marriage. For example, 30 percent of ever married girls aged 15–19 years were already mothers in 2011 and adolescent girls aged 15–19 years accounted for 6 percent of maternal deaths during 2011–2013 (Office of the Registrar General and Census Commissioner, 2015b).

Started in 1952, India's family planning programme was one of the first in the world to be made part of the development planning process. The use of modern methods of contraception among married women in the age group of 15–49 years has increased from 37 percent to 49 percent during the period 1992–93 to 2005–06, suggesting an increase of about 1 percent per year.[21] However the contraceptive prevalence rates are much lower among the young, poor, less educated, Muslims and those belonging to SCs and STs and also in certain states like Assam, Bihar and Uttar Pradesh. Unmet need for contraception is substantial and it is estimated that if unwanted births had been eliminated, the TFR would have dropped to below replacement levels (2.1 births per women) by

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[19] Census of India, 2011

[20] ibid

[21] All data in this paragraph is sourced from the National Family Health Survey (NFHS-3), 2005–6

2005–2006. As of 2005–2006, about 13 percent of currently married women (aged 15-49 years) had an unmet need for contraception, which was very high among adolescent married women (15–19 years) at 27 percent. Interstate variation in unmet need is high with Bihar (23 percent) and Rajasthan (15 percent) being the high focus states for UNFPA. Female sterilization still constitutes about 80 percent of all modern contraceptive methods adopted.

India is a priority country for the Family Planning 2020 (FP 2020) initiative as well as UNSG's global strategy. Fifteen commitments are included in Government of India's Vision FP 2020 document, ranging from a central focus on universal health coverage (UHC) to increased resource allocations, 48 million new family planning users (40 percent of the global target) through expanding method choice, with a focus on spacing methods, quality of services, and voluntary informed choice.[22] The FP 2020 commitments have resulted in state-specific plans for achieving the FP 2020 goals, predominantly focusing on female sterilization.

The Ministry of Health and Family Welfare (MoHFW) has taken several initiatives during last few years including expanding methods by adding injectable Depo-Medroxy Progesterone Acetate (DMPA), Progestin Only Pill (POP) and Centchromanto the basket of choices. The *Jansankhya Sthirta Kosh* (JSK) under the National Population Stabilization Fund has developed a scheme for strengthening public–private partnerships (PPP) by forging collaborative initiatives between private providers and state health departments in provision of services to reduce the mutual distrust between district officials and accredited providers. Initial results on having an interface agency in Uttar Pradesh are encouraging.

The National Rural Health Mission, re-named National Health Mission (NHM) focuses on strengthening health infrastructure, human resources and quality. To further boost improvements in maternal and child health and family planning, a strategy for Reproductive, Maternal, New-born and Child Health + Adolescent (RMNCH+A) was developed in 2013 that focuses on the continuum of care across the reproductive age, with special focus on young, vulnerable and marginalized populations. The Urban Health Mission is consistently expanding coverage in the largest urban areas, especially in the urban slums, with plans to spread its reach to smaller cities at the next stage.

Following a Call to Action summit held in February 2013 and within its commitment to focus on vulnerable and marginalized populations, the Ministry of Health and Family Welfare, identified 184 High Priority Districts (HPDs) for the intensification of service delivery interventions across the country.

The latest round of HIV estimates in the country reveals that in 2015, 0.26 percent of 15–49-year-olds were living with HIV (interstate variations ranged from 0.22 percent to 0.32 percent). Reproductive tract infections including sexually transmitted infections (RTIs including STIs) are recognized as a public health problem with an estimated 30 million episodes of STI/RTI occurring every year.[23] The prevention, control and management of RTIs/STIs is well-recognized for controlling the spread of HIV/AIDS in the country as well as to reduce reproductive morbidity among the sexually active population.
Although the total health care expenditure in India, both public and private is around 4.7 percent of the GDP, public expenditure is only about 27 percent. However the Twelfth Five Year Plan seeks to nearly double the public expenditure from 1.3 percent to 2.5 percent to ensure universal access to quality health services.[24]

Gender equality

India ranked 130thamongst 146 countries on the UNDP gender inequality index in 2014, with data confirming that women have limited control over economic resources, freedom of movement and decision making authority, thus restricting their ability to make strategic life choices. Despite economic progress, gender discrimination in various

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[22] http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2015/04/Indias-Vision-FP2020.pdf
[23] Annual Report of NACO, 2015
[24] 12th Five Year Plan (2012–17), Social Sector, Volume III, Planning Commission, GOI

forms continues in India. One of the most fundamental expressions of gender inequality in India is the preference for sons over daughters. Gender discrimination is manifested in health care, family planning practices, feeding practices for girls, and more recently, in the practice of pre-conception and pre-natal gender-biased sex selection (GBSS).

A complex web of socio-economic and cultural factors results in discrimination against girls. Patriarchal mind-sets, rapid decline in fertility, desire for small family with sons lead to the misuse of technology resulting in GBSS.[25]

Figure 2.2: Trends in overall population sex ratio and child sex ratio

Trends in Overall Sex Ratio and Child Sex Ratio
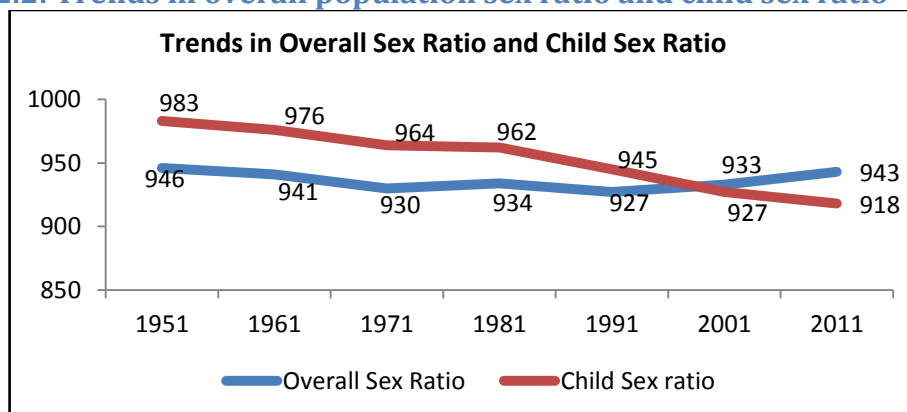
Source: Census of India, 1951 – 2011, ORGI

As evident in figure 2.2, the child sex ratio (0-6 years) dropped to 918 in 2011 from 927 a decade ago, the lowest since independence.

The sex ratio at birth (SRB) has been observed to be lower in the more affluent states of Punjab (832), Haryana (848) and Maharashtra (895) and in states characterized by gender stratified social systems such as Rajasthan (877) and Uttar Pradesh (870). The phenomenon was more urban in the last census, but has now diffused to rural and tribal areas as well.[26]

Sex ratio at birth (SRB) defined as the number of girls born for every 1000 boys born, is a more accurate indicator of gender–biased sex selection. The annual trend in Sex Ratio at birth from Sample Registration System (based on three years moving average) indicates that it declined progressively during the first half of the decade 2000-2010, when it was below 892 girls per 100 boys, dropping as low as 880 in 2003-2005, thereafter improving steadily and reaching 909 in 2011-13.

UNFPA has estimated the number of missing girls computed from the difference between numbers of girls actually born compared to the number that should have been born if the SRB was normal. Analysis shows that while the number of missing girls per year peaked at 700,000 in 2004; there has been a declining trend in the missing girls, which in 2012 were estimated to be 290,000.[27] Government of India passed the Pre-Natal Diagnostic Techniques (PNDT) Act in 1994 renamed as Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act 2003.

India has also committed to end all forms of marginalization and discrimination against women in line with the Convention to End all forms of Discrimination against Women (CEDAW). Though domestic violence was recognized as a criminal offence in India in 1983, after a decade-long process of consultations and revisions, a comprehensive domestic violence law, known as the Protection of Women from Domestic Violence Act 2005, took effect in 2006. According to the National Crime Report Bureau (NCRB) 2012, the proportion of crimes committed against women

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[25] Lest More Girls Go Missing – Initiative of UNFPA India to address gender-biased sex selection. May 2013
[26] The data presented in the above paragraph is sourced from various rounds of Census of India.
[27] How many girls are missing at birth? Trends in sex ratios at birth (2001-12) UNFPA sourced from Sample Registration System 2001-12

has increased from 8.9 percent in 2008 to 9.4 percent during 2012. Every hour, 2.84 cases of rape are reported in the country.[28] Gender based violence (GBV) received a great deal of attention in India after the infamous 16 Dec 2012 rape case of *Nirbhaya*. The Ministry of Health and Family Welfare has developed "Guidelines and protocols: Medico legal care for survivors and victims of sexual violence" in 2014 as a result of it.[29]

Disaster

India is one of the most disaster-prone countries in the world with 60 percent of the country prone to earthquakes and 70 percent to floods. The intensity and frequency of natural disasters have increased in last decade, often leaving a large number of vulnerable people in need of aid and assistance. Although health services are being provided to the disaster affected communities, reproductive health and GBV issues are often not addressed adequately and appropriately. The Government of India enacted the Disaster Management Act in 2005 and setup the National Disaster Management Authority (NDMA), to spearhead and implement a holistic and integrated approach to disaster management in India.

2.2   The role of external assistance

There are many external donor agencies supporting the Government of India in UNFPA's priority areas of work including United Nations Children's Fund (UNICEF), United Nations Entity for Gender Equality and the Empowerment of Women (UN WOMEN), World Health Organization (WHO), United Nations Educational, Scientific and Cultural Organization (UNESCO), bilateral agencies United States Agency for International Development (USAID), Department of International Development (United Kingdom) (DFID), Canadian International Development Agency (CIDA), and foundations McArthur, Packard and the Bill and Melinda Gates Foundation (BMGF). In Bihar and Uttar Pradesh, BMGF has been providing large external support. There are new donor agencies entering India which provide support for adolescent education programmes in the country, especially focused on education of adolescent girls. Given the scale of financial investments by some of the development partners, UNFPA's niche lies in technical support as well as its sustained supportive role for implementing the Indian Government's priority programmes.

Net official development assistance and official aid received in India is shown in Table 2.1.

Table 2.1: Net Official Development Assistance to India, 2011–2014

Year	US$ (Current)
2011	2,811,780,000
2012	3,245,190,000
2013	1,667,240,000
2014	2,983,560,000

Source: http://data.worldbank.org/indicator/DT.ODA.ALLD.CD

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[28]National Crime Records Bureau (2005 and 2012) Ministry Of Home Affairs, http://www.ncrb.nic.in, Accessed 25 August 2013.

[29] http://uphealth.up.nic.in/med-order-14-15/med2/sexual-vil.pdf

3   UN AND UNFPA RESPONSE AND PROGRAMME STRATEGIES

3.1   UN and UNFPA response

The UNFPA Eighth Country Programme Action Plan (CPAP-8) is aligned to national policies and priorities through the United Nations Development Action Framework (UNDAF)[30] 2013–2017 and to the global development agenda through the UNFPA Strategic Plan 2014–2017.[31] The linkages between UNFPA CPAP outputs and the national and global development strategies and outcomes are presented in Annex 10. International commitments made by the Indian government are aligned to UNFPA's mandate to implement the International Conference on Population and Development (ICPD) Programme of Action (PoA), 1994, which affirms the principles of reproductive and sexual health, reproductive rights, women's empowerment, and sustainable development. The CP-8 was also planned within the context of India's commitments to the Millennium Development Goals (MDGs), as well other international commitments related to the thematic areas. The remainder of the CP8 and plans for the CP-9 will take into account the new global agreements on the Sustainable Development Goals (SDGs).

3.2   Evaluation Findings of UNFPA's Seventh Country Programme

The Seventh UNFPA Country Programme (2008–2012) (CP-7) was evaluated in 2011 and the main findings and lessons learned are provided under each thematic intervention areas:

Adolescent and Youth - Three broad interventions were made: first was to provide life skills education to adolescents in state school boards; second, significant contribution to reach out-of-school adolescents was made through the Teen Club programme of the *Nehru Yuva Kendra Sangathan* (NYKS); and finally, UNFPA funded three village level ASRH programmes in Madhya Pradesh and one in Bihar to change RH behaviour. The evaluation exercise revealed increase in knowledge and attitudinal change in students covered through the AEP training programme, however pointed out the lack of expected attitudinal changes from such initiative. Apart from these, UNFPA provided technical assistance to the Government of Maharashtra to set up clinics in select districts to provide adolescent friendly health services (AFHS) through primary health facilities. The evaluation of CP-7 revealed that the access and quality of services through these clinics were quite limited and the intervention did not have much success.

Reproductive Health and Family Planning - UNFPA significantly contributed towards achieving goals under the Reproductive and Child Health Programme Phase II (RCH-II) and National AIDS Control Programme Phase III (NACP-III) through capacity building support, quality assurance programmes and communitization of the National Rural Health Mission (NRHM). The evaluation acknowledged the UNFPA's contributions to: (a) improvements in the quality and reach of family planning and maternal health services; (b) increase in institutional delivery rate; and (c) reduction in maternal mortality. However, the evaluation of CP-7 identified the need to revitalize the stagnant family planning programme in India by working for improved conceptualization strategies to meet the needs of the community through quality family planning services.

Gender-Biased Sex Selection - The desired output for the overall gender component of CP-7 was to improve the child sex ratio (CSR) by at least five points, which were 927 per 1000 males at baseline (Census of India 2001). Another intended result from interventions under this programme area was to address the skewed sex ratio at birth through advocacy and action. In this regard, the evaluation mentioned that UNFPA's efforts to strengthen the implementation of the Pre-Conception and Pre-Natal Diagnostic Techniques (*PCPNDT*) *Act, 1994* through

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[30] India UNDAF, "United Nations Development Framework 2013-2017", http://www.in.one.un.org/img/uploads/India_UNDAF%202013-17_9Jul2012.pdf

[31] UNFPA Strategic Plan 2014-2017, United Nations Population Fund, http://www.unfpa.org/sites/default/files/resource-pdf/Strategic%20Plan%2C%202014-2017.pdf

training and orientation of the judiciary, mobilization of medical professionals and mobilization of civil society were very significant in raising public awareness on the issue, however did not led to any change in the trend.

Population Dynamics - The overall outcome for the Population and Development Strategy (PDS) component of CP-7 was to build capacity for integrating population dynamics into national policies and programmes through developing national and sub-national plans and using disaggregated data in planning and monitoring and commissioning of policy studies on the emerging issue of ageing. The findings from the evaluation reveal significant contributions in capacity building for decentralized planning at district level (implemented in 35 districts) for senior officials of various government departments and development of a sub-national estimation methodology for tracking developmental indicators and district level population projections for eight selected states of India (2006–2016).

Based on these findings, the evaluation recommended: (a) scaling up the AEP in state board schools and make Life-Skills education more sustainable through pre-service teacher training; (b) focus on the need for high quality RH services, particularly birth-spacing methods for young people; (c) continue attention to sex selection issues and (d) continue giving priority to working with planners to strengthen district level decentralized development planning and attention in the generation and use of population data for development planning, including data on ageing.

3.3   The Eighth Country Programme Action Plan (2013–2017)

UNFPA's goal is to achieve universal access to sexual and reproductive health (SRH), realize reproductive rights and reduce maternal mortality to accelerate progress on the ICPD agenda, focusing on adolescents and youth and women. The goal cannot be achieved without attention to human rights, population dynamics and gender equality. Population data helps to identify gaps in services, inequalities, vulnerable populations and progress on outcomes. Achieving the goal will directly contribute to the ICPD target of universal access including family planning and to reducing maternal mortality.

Figure 3.1: The Bull's eye—UNFPA Strategic Plan 2014–2017
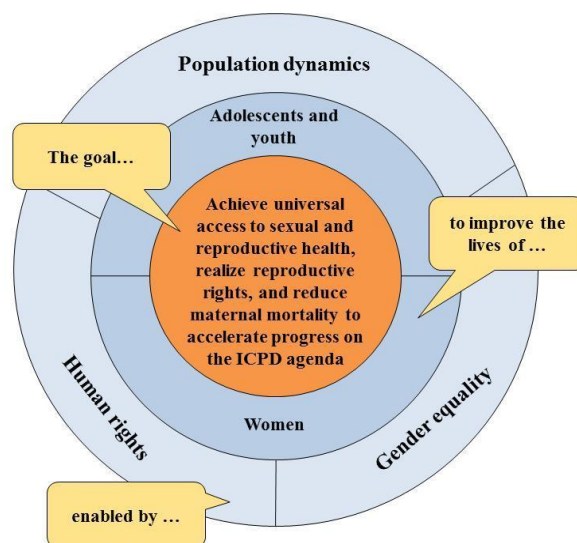
Nationally, the CPAP-8 was prepared in close consultation with the government and other stakeholders. In addition, a population needs assessment was conducted to synthesize available evidence within the country on

to the current situation and progress made in improving the health and population situation and highlighting gaps and priority areas for future action.[32]

As recommended by the CP-7 evaluation and discussions with the Indian government, UNFPA continues to work in these five states as they are lagging behind on key development indicators in the areas of population and health, they have a large absolute number of poor and present the greatest potential for work on emerging issues such as gender equality and addressing GBSS (Figure 3.2). UNFPA programme reaches out to adolescent girls and boys in the age group of 10–19 years and women in the reproductive age group particularly from the marginalized sections of society.

Figure 3.2 UNFPA supported states in India

3.4 Reconstructing the CPAP-8 Intervention Logic

The intervention as implemented in the CP-8 was somewhat different from the original CPAP-8 outputs. Therefore, the CPE team proposes a reconstructed intervention logic wherein the articulation of outputs and strategies corresponds more closely to CP-8 activities. The rationale for reconstruction is further explained under each thematic area where the intervention logic has been revised.

Adolescent and youth

Original Intervention logic

CPAP Output 1: Young people, especially the marginalized (scheduled castes, tribes and minorities), have acquired gender sensitive knowledge on sexual and reproductive health and services.
CPAP Output 2: Adolescents have access to gender sensitive, life skills based sexual and reproductive health education in schools.

These two outputs contribute to the **UNFPA Strategic Plan Outcome 2**: "Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health services."

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[32]Jejeebhoy et al (2011) 'Health and population in India: An assessment of the current situation and future needs' UNFPA publication

Rationale for reconstruction of intervention logic

Jeejeebhoy (2016)[33] made two valid comments on the A/Y intervention logic. First, calling programmes under Output 1 "out-of-school" programmes is misleading. They are actually community-based, and in practice serve both in-school and out-of-school young people. However, these programmes have made special effort in their choice of geographies to reach the most vulnerable young people who are out of school. Second, Strategy 1 under Output 1 on "mainstreaming the agenda of adolescents and young people in national policies and programmes" is actually a major output in itself, labelled "support for youth-friendly policy and programme development and implementation."

The CPE made additional observations, concluding that the intervention logic of A/Y activities of the CP-8 was somewhat different from the CPAP-8 outputs and strategies.

- CP-8 in practice has been better aligned with the UNFPA strategic outcome than the wording of Output #1 would indicate. The output aims for increase in knowledge (including knowledge of services), but UNFPA has made major financial and technical investments in the National Adolescent Health Programme (or the RKSK), which aims for increased availability of comprehensive "adolescent-friendly health services (AFHS)" that include physical and mental health as well as SRH. Although RKSK is still in initial phases of implementation, customized state plans have been developed in six states, and UNFPA is actively engaged in assisting roll-out in four of the UNFPA states. Results on increased availability of AFHS will be documented by the programme's MIS systems by the end of CP-8.
- Output 1 is labelled in all Country Office systems as focusing on out-of-school youth. However, as Jejeebjoy commented, the community-based programmes supported under this output reached young people both in- and out-of-school, as does RKSK.
- The focus on SRH in the original wording of both outputs is aligned with the UNFPA "bulls eye," but in practice, cultural and political barriers mandate that any SRH content—particularly in official written curricular or training materials—is played down. This is especially true in the case of the second output, where the main focus is on "life skills education".

Reconstructed intervention logic

For these reasons, the CPE suggests revised and simplified intervention logic, with fewer strategies, and articulation that corresponds more closely to the CP-8 in practice.

Output 1: Young people in communities and schools, especially the most vulnerable and marginalized (for example, scheduled castes and tribes (SC/ST), other minorities, early school dropouts, and married girls), have increased gender-sensitive knowledge and life skills to protect their sexual and reproductive health.

Strategy 1: Provide evidence-based technical assistance to support the design and roll-out of national adolescent and youth (A/Y) programmes that promote comprehensive health, including sexual and reproductive health, and gender-sensitive life skills.

The interventions under this strategy provide technical support to MoHFW to roll out RKSK, including experiments with ICT outreach like the *Saathiya* mobile based application. At the state level, technical support helped to formulate the Odisha State Youth Policy and the Commitment to End Child Marriage in Rajasthan. Through the NYKS programme 1860 teen clubs were rolled out in five states of UNFPA and more than 7000 peer educators were trained for active citizenship and leadership roles for the youth.

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[33] Shireen Jeejeebhoy, (2016) 'Young People's Sexual and Reproductive Health and Sexuality Education', Thematic Assessment of UNFPA India's Country Programme-8. Unpublished report

Strategy 2: Test community-based approaches to promote the health and development of the most marginalized and vulnerable young people (especially adolescent girls) and disseminate effective strategies and tools.

Community based approaches such as the Action for Adolescent Girls (AAG) among tribal adolescent girls in Rajasthan and Odisha; the LEHAR project with marginalized communities in Bihar and Barwani focusing on married girls in Madhya Pradesh were set up to reach vulnerable adolescent youth with SRH information.

Strategy 3: Increase the availability of gender-sensitive, quality life skills education programmes and counselling in schools to promote adolescent health.

At the national level, the adolescence education programme (AEP) has been implemented through the National Council of Educational Research and Training (NCERT) in two formal national school systems, the *Kendriya Vidyalaya Sangathan* (1,120 schools) and the *Navodaya Vidyalaya Samiti* (595 schools). In the states, SRH education was scaled up to nine districts in Bihar and residential tribal schools in Odisha, life skills programme for adolescent girls in hostels in Madhya Pradesh under the *Rashtriya Madhyamik Shiksha Abhiyan* (RMSA) was supported and counselling services for in-school youth on mental health implemented in Delhi schools.

Reproductive health and family planning

Original Intervention logic

The UNFPA **CPAP Output 3**—Health systems are strengthened to provide high-quality sexual and reproductive health services, including family planning services, with a focus on vulnerable and marginalized populations— contributes to **UNFPA Strategic Plan Outcome 1** which is "increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access."

Rationale for reconstruction of intervention logic

In the CPAP-8, Strategies 1–3 were initially identified and a Strategy 4 "Responding to emerging RH issues" was added later. The CPE team felt that there was no added benefit of enunciating a fourth strategy, since the interventions listed under the strategy were either already included under one of the three strategies or had the potential to be included. For example, mainstreaming MISP in national response to emergencies from natural calamities was an intervention under Strategy 2. Research on assisted reproductive technology (ART) and commercial surrogacy as well as data collection on hysterectomy and female genital mutilation provides evidence for policy and programme changes for protecting reproductive rights, hence are more relevant under Strategy 1.

Reconstructed intervention logic
The rearticulated strategies are listed below:

Strategy 1: Strengthening policy and programme design to improve quality of services based on promotion of reproductive rights and gender mainstreaming.
The interventions under this strategy included development of the RMNCH+A strategy and its design. Leadership role was played in the creation of FP2020 Country Coordination Mechanism (CCM). Research studies and evaluations included an assessment of contraceptives social marketing, study on artificial reproductive technologies (ART), prevalence of female genital mutilation (FGM) and collection of data on hysterectomy through NFHS-IV.

Strategy 2: Enhancement of health care delivery systems for improving coverage and quality of RH services.

Under this strategy the RMNCH+A was rolled out in the high priority districts of UNFPA focus states (lead development partner in Rajasthan). Support was provided for developing and implementing the Reproductive Health Commodities Logistics Management Information System (RHC LMIS) in Odisha and Rajasthan. Pre-service

midwifery training was strengthened in Rajasthan. A Quality Assurance (QA) system was provided in Maharashtra and health sector response to sexual GBV was strengthened. In addition, support was provided for capacity building in mainstreaming MISP in disaster preparedness and response plans.

Strategy 3: Support for alternate service delivery models to address underserved young people.

UNFPA supported capacity building of Accredited Social Health Activists (ASHAs) for community based distribution of contraceptives in Odisha; and reduce adolescent fertility and increasing age at marriage through health system interventions in Barwani district of Madhya Pradesh. Studies were supported to identify needs of SC/ST and Muslim populations in Bihar.

Gender Biased Sex Selection and Gender Mainstreaming

Original intervention logic

UNFPA CPAP **Output 4**, "Strengthened capacity of state and non-state entities to reverse son preference", linked to the **Strategic Plan Outcome 3** "advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth" is addressed by improving the sex ratio at birth and reducing maternal mortality rate in the country.

Rationale for reconstruction of the intervention logic

The original CPAP output and the three strategies were reconstructed. The original output does not reflect the additional work done on gender equality and cross cluster work on empowering adolescent girls and child marriage during CP-8, hence the reconstruction of the output is given below:

Reconstructed intervention logic and strategies

Revised Output: Strengthened 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 family planning/reproductive health (FP/RH) and population dynamics (PD) programmes.

Further, the CPE team identified conceptual overlaps between strategies 1 and 3, hence the analysis of results on son preference is organized as one strategy and the work on GBSS as another. Therefore the reconstructed strategies are:

Strategy 2: Strengthen implementation of the PCPNDT Act

Capacity building of judiciary in Maharashtra and technical assistance to MoHFW and health departments were supported in order to strengthen the implementation of PCPNDT Act in states like Bihar, Madhya Pradesh and Odisha.

Strategy 1 and 3: Countering the drivers of son preference

a. *Civil society and media advocacy to address cultural biases that fuel son preference and gender inequalities* – including gender-based violence- Partnerships have been promoted through civil society coalitions (Girls Count, Population First, Breakthrough); media engagement (Laadli Media and Advertising Awards for Gender Sensitivity) and within the UN system on issues of gender biased sex selection and child marriage.
b. *testing community-based interventions that enhance the value of girls, to inform the design of effective policy and program solutions*- Corresponding to the global programme on ending child marriage since 2015, UNFPA India, had certain key initiatives aligned to the theory of change such as supporting states like Rajasthan, Madhya Pradesh and Bihar in the roll-out of the Beti Bachao Beti Padhao (BBBP) program of the government.
c. *Research on the drivers of son preference to inform policy*- Several studies were commissioned under this strategy such as the "Financial Incentives for Girls—what works"; "Masculinity, Intimate Partner Violence and

Son Preference in India"; and "How many girls are missing at birth in India? Trends in Sex Ratio at Birth (2001–12)".

Gender Mainstreaming in key areas of UNFPA work

Most A/Y programmes and curricula were planned with strong attention to gender in mind, and incorporate the goal of adolescent girls' empowerment. Collaboration between the gender and PD clusters included mapping of child sex ratio (CSR) across states and districts for the Ministry of Women & Child Development's BBBP programme to enable targeted interventions. Gender mainstreaming projects in the FP/RH area included integrating gender in medical education, Guidelines and Protocols for Medico-legal Care for Survivors/Victims of Sexual Assault, and projects to protect women's reproductive rights.

Population dynamics

UNFPA CPAP Output 5, "Strengthened national capacity to incorporate population dynamics in relevant national and sub-national plans and programmes, with a focus on gender and social inclusion" is linked to **Strategic Plan Outcome 4** "strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality" to promote forward looking development strategies, policies and programmes for sustainable development. Under this output cross-cutting thematic areas including demographic trends, sexual and reproductive health (SRH) (including family planning), adolescent's awareness and gender equality are to be addressed through improved data analysis.

Strategy 1: Research to build policy evidence

Under this strategy UNFPA provided support to large scale data systems such as NFHS IV and LASI. A strategic policy paper on "Population and Sustainable Development" was prepared for the Prime Minister's office and financial support provided to the India Exclusion Report.

Strategy 2: Positioning ageing in development agenda

Several thematic and working papers were published to build knowledge base on population ageing. A Senior Officials Committee on Ageing was set up among government personnel for policy advocacy on ageing issues.

Strategy 3: Capacity building of institutions and human resources

On the request of the nodal Ministry, a management study was undertaken of the National Institute of Social Defence (NISD) to make it a centre of excellence on Ageing (NISD). Support was provided to TISS as CoE on Adolescent and Youth to build significant strategies and policy advocacy. District level training on use of data was conducted in 30 districts of Odisha. Training on data use resulted in Tribal Sub Plans (Odisha) and Scheduled Caste Sub Plan for Minorities and *Maha Dalits* (Bihar).

The Figure 3.4 outlines the reconstructed logical effects of the interventions outlining each thematic area by strategy and activities (provided at the end of this chapter).

3.5 The financial structure of CP-8

UNFPA initially committed US$60 million of core resources over the five years of UNFPA's Eighth Country Programme of Assistance in India (2013–2017). The breakdown was as follows:

a. Youth out of school: US$13.75 million
b. Youth in school: US$11.25 million
c. Family planning: US$15.5 million
d. Gender equality: US$9 million

e. Population dynamics: US$9 million
f. Programme coordination assistance (PCA): US$1.5 million

The largest share of the budget (42 percent) is earmarked for the youth programme (both out-of-school and in-school interventions), followed by family planning (26 percent) (Figure 3.4). Gender equality and population dynamics programmes received 15 percent each of the total budget under CP-8. In addition, US$ 1.68 million was made available through other sources of funding which included Department for International Development, UK (DFID), United Nations Fund (UNF) and Canadian International Development Agency (CIDA). An Atlas of Budget for CP-8 has been given as annex-5.

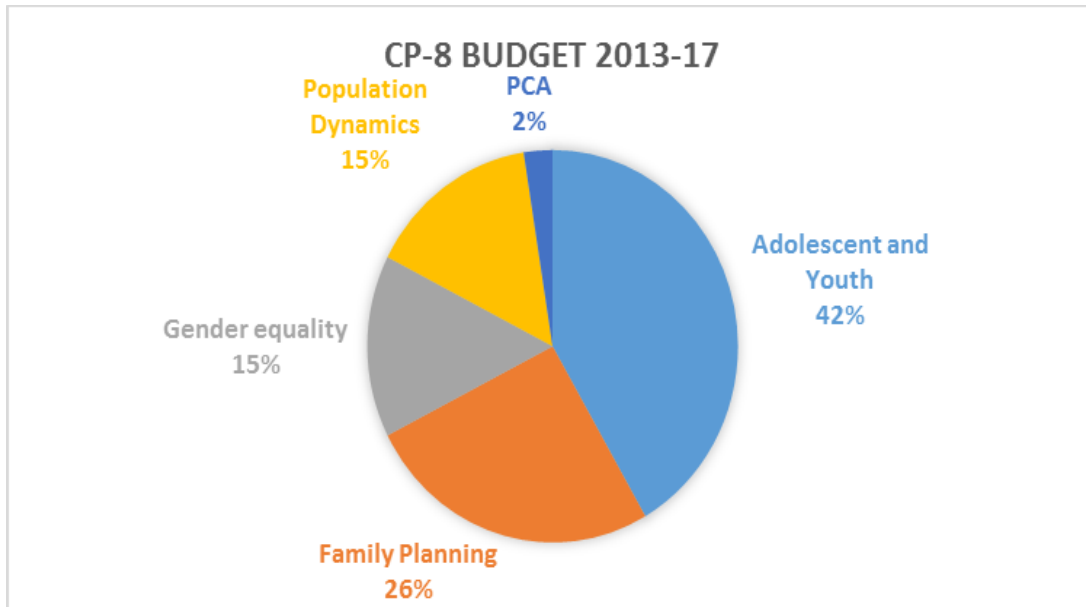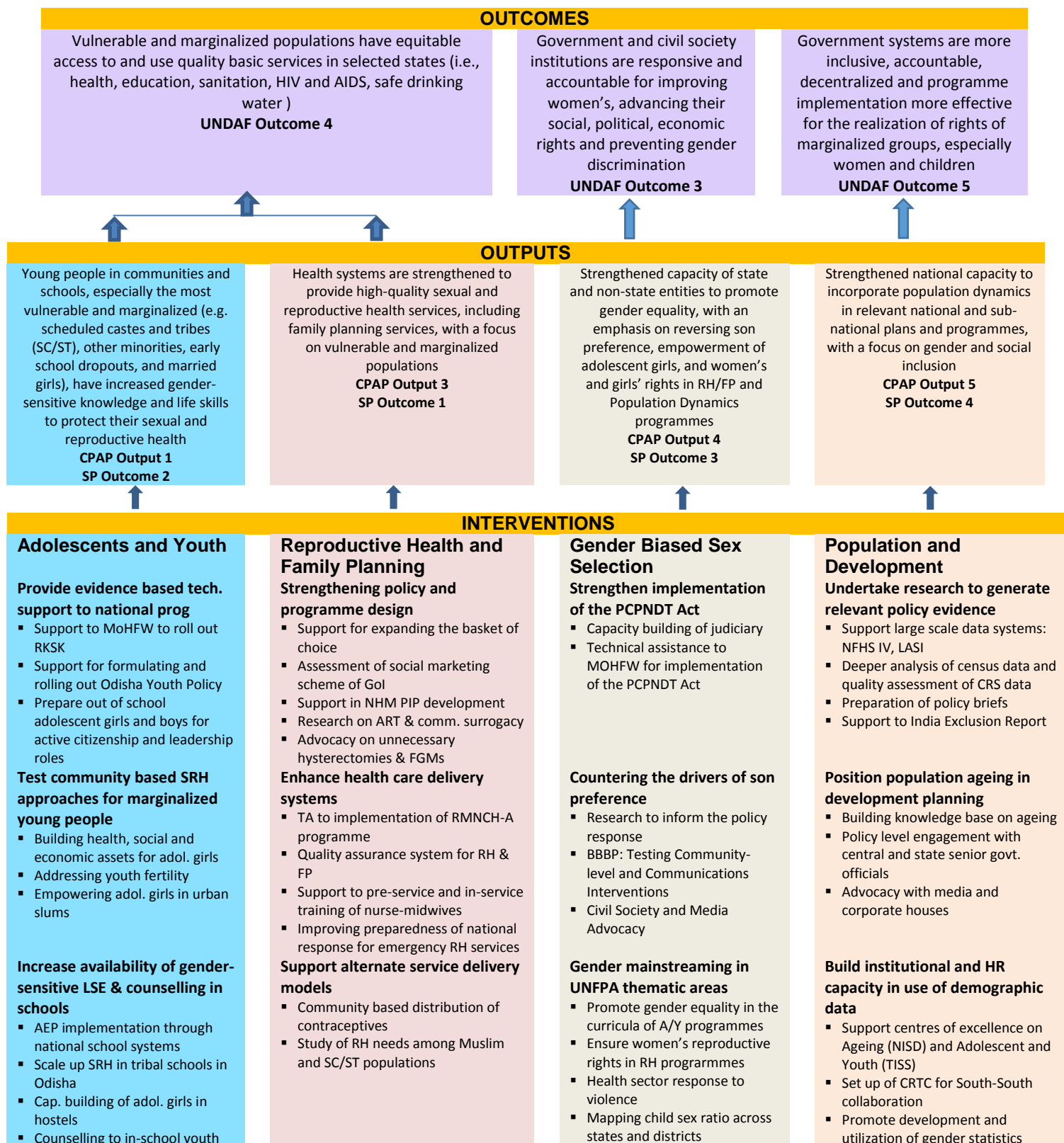**Figure 3.3: CP-8 Budget by thematic area**

Figure 3.4: Reconstructed logical effects of intervention

OUTCOMES

Vulnerable and marginalized populations have equitable access to and use quality basic services in selected states (i.e., health, education, sanitation, HIV and AIDS, safe drinking water) **UNDAF Outcome 4**	Government and civil society institutions are responsive and accountable for improving women's, advancing their social, political, economic rights and preventing gender discrimination **UNDAF Outcome 3**	Government systems are more inclusive, accountable, decentralized and programme implementation more effective for the realization of rights of marginalized groups, especially women and children **UNDAF Outcome 5**

OUTPUTS

Young people in communities and schools, especially the most vulnerable and marginalized (e.g. scheduled castes and tribes (SC/ST), other minorities, early school dropouts, and married girls), have increased gender-sensitive knowledge and life skills to protect their sexual and reproductive health **CPAP Output 1** **SP Outcome 2**	Health systems are strengthened to provide high-quality sexual and reproductive health services, including family planning services, with a focus on vulnerable and marginalized populations **CPAP Output 3** **SP Outcome 1**	Strengthened 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 **CPAP Output 4** **SP Outcome 3**	Strengthened national capacity to incorporate population dynamics in relevant national and sub-national plans and programmes, with a focus on gender and social inclusion **CPAP Output 5** **SP Outcome 4**

INTERVENTIONS

Adolescents and Youth	**Reproductive Health and Family Planning**	**Gender Biased Sex Selection**	**Population and Development**
Provide evidence based tech. support to national prog ▪ Support to MoHFW to roll out RKSK ▪ Support for formulating and rolling out Odisha Youth Policy ▪ Prepare out of school adolescent girls and boys for active citizenship and leadership roles **Test community based SRH approaches for marginalized young people** ▪ Building health, social and economic assets for adol. girls ▪ Addressing youth fertility ▪ Empowering adol. girls in urban slums **Increase availability of gender-sensitive LSE & counselling in schools** ▪ AEP implementation through national school systems ▪ Scale up SRH in tribal schools in Odisha ▪ Cap. building of adol. girls in hostels ▪ Counselling to in-school youth	**Strengthening policy and programme design** ▪ Support for expanding the basket of choice ▪ Assessment of social marketing scheme of GoI ▪ Support in NHM PIP development ▪ Research on ART & comm. surrogacy ▪ Advocacy on unnecessary hysterectomies & FGMs **Enhance health care delivery systems** ▪ TA to implementation of RMNCH-A programme ▪ Quality assurance system for RH & FP ▪ Support to pre-service and in-service training of nurse-midwives ▪ Improving preparedness of national response for emergency RH services **Support alternate service delivery models** ▪ Community based distribution of contraceptives ▪ Study of RH needs among Muslim and SC/ST populations	**Strengthen implementation of the PCPNDT Act** ▪ Capacity building of judiciary ▪ Technical assistance to MOHFW for implementation of the PCPNDT Act **Countering the drivers of son preference** ▪ Research to inform the policy response ▪ BBBP: Testing Community-level and Communications Interventions ▪ Civil Society and Media Advocacy **Gender mainstreaming in UNFPA thematic areas** ▪ Promote gender equality in the curricula of A/Y programmes ▪ Ensure women's reproductive rights in RH programrmes ▪ Health sector response to violence ▪ Mapping child sex ratio across states and districts	**Undertake research to generate relevant policy evidence** ▪ Support large scale data systems: NFHS IV, LASI ▪ Deeper analysis of census data and quality assessment of CRS data ▪ Preparation of policy briefs ▪ Support to India Exclusion Report **Position population ageing in development planning** ▪ Building knowledge base on ageing ▪ Policy level engagement with central and state senior govt. officials ▪ Advocacy with media and corporate houses **Build institutional and HR capacity in use of demographic data** ▪ Support centres of excellence on Ageing (NISD) and Adolescent and Youth (TISS) ▪ Set up of CRTC for South-South collaboration ▪ Promote development and utilization of gender statistics

4 FINDINGS - ANSWERS TO THE EVALUATION QUESTIONS[34]

4.1 Effectiveness in the Adolescence and Youth Programmatic Area

EQ1: To what extent have the interventions supported by UNFPA helped to develop and improve youth-friendly policies and programs that increase the access of young people (ages 10-24) to quality life skills-based education programmes and comprehensive health services, including sexual and reproductive health?

Summary

UNFPA advocacy and technical support contributed to a high level of national ownership and significant results in three evidence-based national and state programmes: the Adolescent Education Programme (AEP) in schools, the adolescent health programme of the MoHFW (RKSK), and the Youth Policy in Odisha. UNFPA also support contributed to scale-up in two state-level pilot programmes. A 4th major community-based program (Teen Clubs) was discontinued in CP8.

UNFPA is a recognized leader on adolescence and youth policies and programmes, especially on SRH and gender issues. UNFPA's technical contributions are highly regarded, and resulted in evidence-based participatory pedagogical and training methods, comprehensive approaches to young people's health and development, and a high level of integration of gender issues in all programmes. The CPE identified concerns, including the need for investment in process evaluation, cultural and political barriers to inclusion of SRH content, difficulties reaching early school drop-outs and married girls, and risk of lack of sustainability in some programmes.

The CPE designed a simplified intervention logic that corresponds more closely with the CP-8 in practice.[35]

REVISED INTERVENTION LOGIC

OUTPUT: Young people in communities and schools, especially the most vulnerable and marginalized—including scheduled castes and tribes (SC/ST), other minorities, early school dropouts, and married girls—have increased gender-sensitive knowledge and life skills to protect their sexual and reproductive health.

Strategies

1. Provide evidence-based technical assistance to support the design and roll-out of national adolescent and youth programmes that promote comprehensive health, including sexual and reproductive health, and gender-sensitive life skills.
2. Increase the availability of gender-sensitive, quality life skills education programmes and counselling in schools to promote adolescent health.
3. Test approaches to promote the health and development of the most marginalized and vulnerable young people—especially adolescent girls—and disseminate effective strategies and tools.

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[34] More detailed evidence that supports these findings is in the Evaluation Matrix, Annex 7.
[35] See explanation in Chapter Three.

Overview of Results

UNFPA made crucial contributions to national ownership and quality of A/Y policies and programmes in CP8[36], employing comprehensive strategies and a sound theory of change[37] that built on continuous support and partnerships with health, education, and women's empowerment official sectors over several country programmes. All "orange country" modes of engagement have been employed in synergistic ways, and all thematic areas contributed significantly to the programming, with a fusion in practice of gender and A/Y objectives when programmes focused on adolescent girls.

- UNFPA support has contributed to ***significant advances in the quality of evidence-based national and state policies and programmes*** promoting the health and development of young people.
    - o UNFPA's technical contributions resulted in evidence-based participatory pedagogical and training methods, comprehensive approaches to young people's health and development, and good integration of gender issues in all programmes.
- CP8 A/Y programmes achieved a ***high level of national ownership and institutionalization*** for the main programmes supported[38]: the Adolescent Education Programme (AEP) in schools of the MHRD, the adolescent health programme (RKSK) of the MoHFW, and the Odisha State Youth Policy. The quality of UNFPA technical support is highly regarded by officials and other stakeholders. Results were enabled by embedding this support – from staff, consultants, and implementing partners – within large-scale government programmes, accompanying each phase in the programme's development with policy dialogue, knowledge products, and technical assistance for implementation. In addition to these major A/Y public programmes, two pilot programmes – the Barwani project in Madhya Pradesh and a life-skills education programme in tribal schools in Odisha – are being scaled up by state governments.
- Through geographical targeting, CP-8 programmes were partially successful in ***increasing representation of the most vulnerable and marginalized young people***. The Barwani project in Madhya Pradesh is the only example in CP8 of a pilot that succeeded in reaching married girls.

Findings on Major A/Y Programmes

Rashtriya Kishor Swasthya Karyakram (RKSK):[39] Responding to a strong recommendation from the CP-7 evaluation to improve existing adolescent sexual and reproductive health (ASRH) service models, UNFPA sought advice from international experts, commissioned ASRH research at the state level, and worked closely with MOHFW to design a more comprehensive and evidence-based ASRH programme.[40] The highly praised programme design ushers in a paradigm shift in adolescent health for the Indian health system, focusing less on supply-side medical services and more on prevention strategies with community outreach and adolescent-friendly communications. RKSK community-based health promotion aims for convergence with the ministries of education, youth and sports, and women and child development, and focuses holistically on nutrition, sexual and

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[36] The crucial role of this contribution and the evidence-based nature of the programme and policy design was confirmed by numerous high-level officials and partner organizations in both the thematic assessment and the CPE.

[37] Full discussion is in EQ6.

[38] The findings by strategy on additional programmes are included in Annex 7.

[39] Sources of data are CPE and thematic assessment interviews with RKSK consultants and lead government officials in Delhi, Bihar, Rajashtan, and MP, where Jejeebhoy & CPE team member visited an AFHC clinic. There is no information from Odisha, and Maharashtra RKSK consultants are supported by UNICEF.

[40] See Jejeebhoy 2016, pp 21-24 for a full description of the programme design, with observations about strengths and concerns.

reproductive health, non-communicable diseases, substance misuse, injuries and violence (including gender based violence GBV), and mental health. During the CPE visits, the programme was in the process of hiring and/or training dedicated counsellors in health centres, and 4 million peer educators to connect young people to the health system, mentored by frontline village-based health workers (ASHA).

In these initial stages, UNFPA staff and consultants provide intensive technical assistance for the roll-out of the programme. RKSK is almost fully implemented in Madhya Pradesh (MP), where UNFPA has concentrated efforts, viewing the state as the main locus for learning how best to implement the programme. Unfortunately, given the large-scale roll-out of RKSK, this learning is occurring simultaneously with design and rollout of the programme in other states. The Rajasthan and Bihar state offices provide technical assistance through consultants to design implementation plans and roll out the RKSK programme in HPDs, but such activities in Odisha are comparatively limited.

It is too early to report RKSK results in expected outcomes such as increased use of adolescent-friendly health services, but stakeholders – especially in MoHFW – commend the introduction of mobile app *Saathiya (*peer educators) [41] in MP; initial reports on its reach are impressive.

Adolescent Education Programme (AEP)

The AEP is run through National Council of Educational Research and Training (NCERT) in the Ministry of Human Resources Development (MOHRD), who recognize UNFPA's significant and "essential" technical contribution to programme and curriculum design and to roll-out to the states. The thematic assessment validated the strong incorporation of gender issues in the curricula. Although SRH content is minimal, it is improved as compared to the previous life skills curriculum. The potential reach of the programme is massive; NCERT aims to implement the programme in a phased manner throughout the country. AEP has been implemented in two formal national school systems (*Kendriya Vidyalaya Sangathan* with 1120 schools and *Navodaya Vidyalaya Samiti* with 595 schools across the country) and the National Institute of Open Schooling (NIOS).[42] All but eight states are implementing some aspect of the programme.[43]

India's new national Education Policy is still in draft form, with state consultations taking place. The latest public draft verifies that the policy mandates integration of the Adolescent Education Programme into the curriculum of schools and into pre- and in-service training programmes of secondary school teachers.[44] The statement of principles promotes girls' and women's empowerment, but reproductive or sexual health issues are not mentioned in the draft.

Long-standing work with on SRH and gender education within the school system is a comparative strength for UNFPA; with the exception of UNICEF and UNESCO, few other development partners work on these issues within the public school system at a national level or state level. UNFPA's technical assistance is viewed by education

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[41] Saathiya are share technically accurate information on adolescent issues with their peers. This mobile application helps the Saathiya provide information and advice sought by other adolescents. Any adolescent can download this application on his/her mobile phone or computer to receive information directly.

[42] The NIOS provides primary, secondary, and technical education for older learners through distance courses

[43] State education boards are autonomous, and they are not required to implement the programme. Among UNFPA states, Bihar and Odisha boards have done so.

[44] Some Inputs for Draft National Education Policy 2016. See p 18.
http://mhrd.gov.in/sites/upload_files/mhrd/files/nep/Inputs_Draft_NEP_2016.pdf

officials as crucial in making additional scale up possible, and creating sustainable training, supervision, and M&E systems during roll-out of the AEP. Education officials are especially interested in having UNFPA bring innovative internationally-tested models to adapt in India, especially those involving new ICT platforms.

The agenda of gradually integrating culturally sensitive gender and SRH issues faces many barriers, and it is pressing that in-school adolescents receive the information and skills they need to protect their health and development. Several stakeholders pointed out that as the AEP is extended to the 10–14 years age group, integration of these issues will need more creativity and nuanced emphasis.

Odisha Youth Policy 2013[45]

Odisha's 2013 Youth Policy emphasizes youth development in nine key areas, including education and life skills, skill development training and employment, health and wellbeing, citizenship, and gender justice. UNFPA played a key role in supporting the consultations that shaped the policy, and achieved broad participation, including more than 150,000 youth, grassroots level community members, programme managers, and policy makers. Inputs were received through letters, village level meetings, women's group meetings, outreach to socially excluded youth, and social media. Drawing on this input, UNFPA supported the government in preparing the policy, and now contributes to its implementation through placement of a Technical Support Unit in the Department of Sports and Youth Services to coordinate the programme, with financing shared 50:50 with the state. The second current major contribution is UNFPA's support for implementing the Youth Policy's flagship programme, namely the Active Citizenship Programme, which has evolved from a UNFPA-supported programme in a few secondary schools to a government scheme in 2015-16, with budgets allotted for its expansion to all government and private educational institutions in the state. However, as in the two other major A/Y programmes, SRH content is minimal.

Commitment and Action Plan to End Child Marriage in Rajasthan

This initiative was announced in July 2016 and is still at the planning stage. However, there is potential for significant impact given the number of development partners involved,[46] and statements demonstrating high levels of commitment by the Department of Women and Child Development, the State Health Society, and Canadian International Development Agency (CIDA). The four-member consultant support team within DWCD is led by a UNFPA consultant, with three others supported by UNICEF.

Pilot programmes[47]

Most of the pilot programmes supported in CP8 do not yet have final evaluation evidence; the thematic assessment noted the need for improved evaluations in some of them. Two successful examples stand out. UNFPA's initial partnership with Odisha government's Department of Scheduled Tribes and Scheduled Castes Development (SSD) and a local NGO to provide life skills education in residential tribal schools is an example of successful institutionalization of a pilot programme; the state is extending it into all remaining districts.[48] Another example is the Barwani project in Madhya Pradesh, which succeeded in reaching married girls and their families.

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[45] This write-up is based on the thematic A/Y assessment, Jejeebhoy 2016.

[46] According to a billboard at the launch, stakeholders include UNFPA and UNICEF as leads, as along with Save the Children, Actionaid, Plan International, International Center for Research on Women (ICRW), and FXB (François-Xavier Bagnoud) India Suraksha.

[47] These projects correspond to Strategy #3 in the revised intervention logic: Test effective approaches to reach the most marginalized and vulnerable young people —especially adolescent girls, and disseminate effective practices." The main source is the thematic assessment, Jejeebhoy 2016, pp. 34–41. CPE team members did not visit any of these projects.

[48] Additional information on this example is in Chapter 4, EQ 6 on Theory of Change.

The project had mixed evaluation evidence of effectiveness, but this was sufficient for the Madhya Pradesh government to incorporate the model into RKSK in 11 high priority districts.

Concerns and Challenges

- **Need for increased investment in process evaluation:** Three newly designed government programmes (including BBBP) are rolled out at scale without testing of state-level variations in strategies, and some smaller-scale pilot programmes are not being evaluated adequately to determine whether they are worthy of scale-up. Increased investment in process evaluation – including implementation research – would allow these programmes to identify and disseminate the most effective strategies quickly, lessening the risk of inefficiency and ineffectiveness.

- **Cultural and political barriers to inclusion of SRH content in curricula and educational materials for young people:** Key SRH content on contraception and/or sexual health is minimal in the major national A/Y programmes, although UNFPA staff pointed out instances in which dialogue led to more inclusion of SRH content. Strategies being tested to address this concern include: 1) participatory and interactive strategies that do not rely on written curricula, such as the Question Box in AEP and Adolescent Health Days in RKSK; 2) development and use of ICT educational and training materials, and interactive platforms.

- **Challenges in reaching early school drop-outs[49] and married girls, and the most vulnerable young people**: Both large and small community-based programmes found that "when enrolment is open to any interested adolescent, the most vulnerable get excluded."[50] On the other hand, programmes that recruit only certain categories of marginalized young people run a risk of not recruiting enough participants in time for activities to start as per schedule. CP-8 experience suggests that married girls are the hardest to reach amongst the most vulnerable and marginalized young people, and that outreach to their families was inadequate in all but one programme.

- **Sustainability:**[51] Concerns about the sustainability in the CP-8 A/Y programmes – especially in peer education and pilot community-based programmes with comprehensive strategies – were related to resistance to adopting or scaling up programmes that might increase fixed operational budgets when assumed by the states.

- **Low usage of youth-friendly health services** is a challenge globally and in India in A/Y programmes, and suggests the need to do rigorous testing of the innovative outreach and service provision strategies in RKSK. Low usage of CP-8 pilot programmes deploying school-based mental health counsellors suggests the need to rethink these strategies.

In summary, due to development of a sound comprehensive strategy and the high level of expertise of staff and consultants working on A/Y, **UNFPA is a recognized leader in this field, especially on SRH and gender issues**. This clear comparative advantage can be built on in CP-9, using the strengths of the programme to promote evidence-based programming in India, and addressing strategic gaps to improve results.

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[49] As opposed to "out of school youth," the category used in the CPAP.

[50] Jejeebhoy, 2016

[51] These sustainability concerns are discussed in detail in EQ#9 on sustainability.

4.2 Effectiveness in the Reproductive Health and Family Planning

EQ2: To what extent have the interventions supported by UNFPA in the field of reproductive health and rights contributed to improved availability and quality of sexual and reproductive health services, especially family planning services and humanitarian response?

Summary

UNFPA made noteworthy contributions: 1) in supporting the development of the Reproductive Maternal Newborn Child and Adolescent Health (RMNCH+A) strategy of the MOHFW; 2) laying the foundation for policy changes in contraceptive social marketing (CSM) through a nationwide assessment of the same; 3) the development of policy guidance on the implementation of the PCPNDT Act, 1994 without jeopardizing access to safe and legal abortions (abortion is legal in India); and protocols for the health sector response to sexual violence.

A significant support to the family planning (FP) programme is the procurement of depot medroxy progesterone acetate (DMPA) to enable the MOHFW to expand the basket of contraceptive methods. UNFPA also helped to constitute the FP 2020 Country Coordination Mechanism (CCM). However, UNFPA's support for rights-based FP and maternal health decreased significantly in India, giving rise to three significant strategic gaps**:** lack of appropriate attention to advocacy and policy dialogue on reproductive rights issues in the national FP programme, and to inclusion of FP in Universal Health Coverage; and lack of investment in maternal health in all but one state.

UNFPA-supported research on the misuse of reproductive health (RH) procedures led to progress towards protection of reproductive rights. UNFP supported advocacy and capacity-building that contributed to incorporation of the Minimum Initial Service Package (MISP) through with the National Disaster Management Agency (NDMA).

CP-8 Output 3: Health systems are strengthened to provide high-quality SRH services, including FP services, with a focus on vulnerable and marginalized populations.

The CPE has identified significant results, as well as concerns and strategic gaps, within the RH and FP programme, which are outlined below.

Strategy 1: Strengthen policy and programme design to improve quality of services based on promotion of reproductive rights and gender mainstreaming

Results

- An assessment of the **Contraceptive Social Marketing (CSM)** programme of India identified several areas for improvement followed by support for the implementation of recommendations related to pricing and packaging of socially marketed products.
- Assistance in the procurement and introduction of depot medroxy progesterone acetate (DMPA) contributes to the **expansion of the basket of FP choices**. The UNFPA guidance note for provision and services includes input from women's NGOs and promotes respect for reproductive rights at the policy and programme level.

- **Gender-biased sex-selection (GBSS):** policy guidance to avoid jeopardizing access to safe and legal abortions in its support for the implementation of the Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994 (PCPNDT Act) is being used by MOHFW and in states implementing the Act.**.**
- **Development of protocols on health sector response to sexual violence**. Responding to the increased official concern on sexual violence, UNFPA built on WHO guidelines to provide technical assistance to the Hospitals' Division of MOHFW for developing guidelines and protocols for medico-legal care of survivors of sexual violence. UNFPA state offices in Odisha and Maharashtra supported health departments in implementing the protocols, with capacity-building to provide care to survivors in these states and Madhya Pradesh.
- **Reproductive Rights:** Support for advocacy and evidence-based research on the misuse of RH procedures has resulted in greater political support and progress towards changes in policies and laws.
  - UNFPA supported advocacy in Odisha that led to policy changes that improved the quality of sterilization services and eliminated the camps as a service mode.
  - UNFPA supported gathering evidence and advocacy on unethical medical practices related to assisted reproductive technologies (ART), commercial surrogacy, hysterectomy and female genital mutilation (FGM). Work on ART led to the inclusion of rights, health and safety concerns related to surrogacy in the draft ART and Surrogacy Bill.
- **Family Planning:** Leadership in establishing a Country Coordination Mechanism (CCM) for FP2020, with MOHFW as chair and UNFPA and USAID as co-chairs, and the roll out of FP 2020 in Odisha and Rajasthan.
- Several CP-8 RH/FP interventions have a high potential for impact, but results could not be verified in field visits. One promising example is support for the development of **national guidelines on maternal health;**[52] if followed widely, these should contribute to improving care and reducing maternal morbidity.

Concerns and Strategic Gaps

The CPE identified significant missed opportunities which, if acted upon, could have made sustainable contributions to rights-based family planning and maternal health. Understaffing seems to have been an important factor in the following strategic gaps and in some missed opportunities; the country office had no full-time national RH/FP programme officer during most of CP-8.

- **The key strategic gap in UNFPA's work on FP is the failure to focus full attention and investment in promoting the gender and rights principles of the ICPD.** The FP 2020 vision document emphasizes spacing methods and informed choice, and the Government of India reiterated its commitment to the ICPD Programme of Action in 2014.[53] However, in reality the FP programme focuses on achieving targets for sterilization and post-partum intra-uterine contraceptive device (IUCD) insertion at the state level[54] , and includes incentives to providers for achieving targets. This system raises significant risks of violations of reproductive rights, and UNFPA failed to advocate strongly on the issue.

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[52]Guidelines supported include use of routine ultrasound in pregnancy, maternal near miss review, engaging general surgeons for C-sections and screening for hepatitis b and syphilis during pregnancy

[53]The Government of India recommitted to ICPD PoA at ICPD at 20 conference. Due to UNFPA's high level advocacy, MOHFW adopted a "target free approach" after ICPD 1994.

[54]Interviews with state FP officers

- o **FP2020:** As a co-chair of the FP 2020 CCM and a respected partner of the MOHFW, UNFPA's role in facilitating regular engagement between the two has not been optimal, resulting in another missed opportunity to engage in the required advocacy.
- **The second strategic gap is that appropriate attention has not been paid to address the absence of FP as a central element of the country's Universal Health Coverage (UHC) initiatives.** Support for developing the design and contents of the RH package was planned within the CPAP, but did not progress much. Family planning is a missing component under the current beneficiary package, even though inclusion of FP in UHC is an action point in the FP 2020 vision document.
- **The third strategic gap is insufficient investment in maternal health, specifically midwifery.** India's high maternal mortality makes it a focus country in the UNSG's "Every Woman and Every Child" initiative, and UNFPA was and is well-positioned to have a positive impact due to its global leadership and comparative advantage in midwifery. However, due to a management decision, in CP-8 UNFPA under-invested in maternal health in all focus states, except Rajasthan.
- **The fourth strategic gap in CP-8 is failure to build on promising models (**developed in CP7) **of private–public partnership (PPP) for FP services**. These have potential to expand access to contraception, especially for young people.

Strategy 2: Enhance health care delivery systems for improving quality and coverage of RH services
Strategy 3: Support alternate service delivery models to address underserved young people

This section summarizes findings of both Strategies 2 and 3, as the interventions overlap, and covers strategies related to availability and quality of reproductive health services, reproductive health commodity supplies (RHCS), gender based violence (GBV) and mainstreaming SRH needs in humanitarian settings. Only the most significant results and concerns are noted, with details of other results, activities, and footnotes in Annex 7. Initiatives in Strategy 3 are discussed mainly in EQ#1 on A/Y programmes.

Results
- UNFPA made a major contribution through **development and rollout of the national flagship programme, Reproductive Maternal Newborn Child and Adolescent Health (RMNCH+A), at the national and state levels.** Evidence of sustainable results from UNFPA support are in three areas— developing a *quality assurance (QA) system*, promoting *adolescent sexual and reproductive health* (ASRH), and *increased availability and quality of SRH services* in the high priority districts (HPD) of four empowered action group (EAG) states.
- The web-based **RH Commodity Logistics Management Information System (RHC LMIS) in Odisha** led to fewer stock-outs, and is being considered for replication at state and national level.
- Integration of the **Minimum Initial Service Package (MISP)** through advocacy with the National Disaster Management Agency (NDMA), and through capacity-building led to the use of MISP beyond UNFPA's focus states and its incorporation into disaster preparedness and response in Maharashtra and Odisha.
- Capacity-building **support to community-based organizations (CBOs) of female sex workers (FSW)** in partnership with the National AIDS Control Organization (NACO) enabled them to advocate for and demand access to treatment and the right to livelihood. This initiative is now supported by NACO, with interest from other countries showing potential for South-South Collaboration.

Concerns

- **Ineffective use of consultants:** The main support for FP is provided by consultants who assist to develop FP 2020 action plans and budgets at the state and district levels. They monitor quality indicators related to FP, particularly on sterilization. While their contributions are recognized, their effectiveness in improving the quality of services is limited because they lack technical and data management capabilities to intervene when gaps are identified. They have not been effective in advocating for rights-based approaches, or for greater gender mainstreaming.
    - Technical experts have been more effective than district-level consultants in improving quality, for instance, in the monitoring of sterilization services in Rajasthan and the annual monitoring by a third party through medical colleges in Odisha.
- **Need for increased attention to reproductive health commodity supplies (RHCS) in three states.** Opportunities were missed to replicate the successful RHC LMIS of Odisha in other focus states, particularly Bihar, where follow up on the expression of interest was missed. A key opportunity was missed at the national level to explore possibilities of including contraceptives during the roll out of *E-Aushadi* (MOHFW's supply management system).
- **Lack of attention to all forms of gender-based violence (GBV):** UNFPA has collaborated effectively with WHO India to support the strengthening and expansion of the health sector's response to sexual gender based violence (SGBV), but with that exception, attention has been minimal to GBV in general, in spite of a recommendation of the CP-7 evaluation to build on promising initial programmes to mainstream gender issues and address GBV in the health care system.
- **Outstanding issues in mainstreaming SRH in disaster response**: Although SRH is better mainstreamed in two states in disaster response due to UNFPA support, several outstanding issues were noted; MISP and SRH were left out of the recently published Disaster Management Plan of 2016, which is not aligned with the national guidelines for FP and maternal health.
- To build **midwifery capacities**, the Rajasthan state office strengthened five ANM and two GNM training schools in the Udaipur division. The end-line assessment showed improvements in capacity and capability; however, no follow-up support has been provided since 2015.

4.3 Effectiveness in the Gender Biased Sex Selection and Gender Mainstreaming

> **EQ3: In what ways has UNFPA supported gender equality and to what extent has it contributed to: (i) improved responses to gender biased sex selection (ii) gender mainstreaming across the programming area?**

Summary
GBSS Strategies
UNFPA contributions to strengthened national capacity to address GBSS have been significant. CP8 has supported research to inform the policy response as well as experimentation with community-based strategies and mass communications in partnership with NGOs and media outlets. UNFPA has made major contributions to the design and initial implementation of the PCPNDT Act. Building on these experiences, assistance to MoHFW to create sustainable technical and management systems to enforce the Act would be the final stage.

> Working at the community level under the BBBP umbrella with the MWCD to counter the drivers of son preference is in the beginning stages; it is too early to make judgments on effectiveness.
>
> **Gender Mainstreaming**
>
> Gender in A/Y programs has been integrated well in the programme design and curricular materials, but seems to be receiving varying emphasis across states. In RH/FP, gender has been integrated emphasizing women's rights issues in new reproductive technologies and to protect reproductive rights to safe legal abortion in the implementation of the PCPNDT Act. Attention to gender and reproductive rights needs to be strengthened in FP/RH programmes. The PD area engaged effectively on GBSS issues, with high-profile and influential studies as well as data analysis to inform planning in the BBBP program. However, the area focused little on gender analysis on important socio- demographic and economic parameters affecting women and development, child marriage, and single/ divorced women and widows.

Revised output:[55] Strengthened 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 FP/RH and Population Dynamics programmes.

UNFPA's work towards gender equality includes initiatives both at the upstream policy level and through downstream community processes and media campaigns to transform discriminatory attitudes, behaviours and practices. UNFPA also supports evidence building initiatives to provide input to policies and programmes. The gender programme strategies have two main programmatic focuses: (i) Gender-biased sex selection (GBSS) and (ii) Gender mainstreaming across other UNFPA programme areas.

Strategies to Counter Gender Biased Sex Selection (GBSS)

UNFPA contributions to strengthened national capacity to address GBSS have been significant and span the previous four country programmes. The strategies in the previous country programme have contributed to full government commitment to eliminating GBSS, and in CP8, UNFPA achieved significant results in close partnership with national and state nodal ministries. Analysis of results is organized into the two main programmatic focuses.[56]

➢ **Strengthen implementation of the PCPNDT Act** to cut off the supply of GBSS services (Strategy #2);
➢ **Countering the drivers of son preference** on the demand side (Strategies #1 and #3)
    a. *Mass communications advocacy* to address cultural biases that fuel son preference and gender inequalities – including gender-based violence
    b. *Research on the drivers of son preference to inform policy* and programme design
    c. *Testing community-based interventions* that enhance the value of girls, to inform the design of effective policy and program solutions.

Results and Concerns
Strategy 2: Strengthen capacity of state and non-state actors to implement the PCPNDT Act

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[55] See explanation in Chapter Three.
[56] There is some conceptual overlap in strategies #1 and #3 in CP8. *Strategy 1: Improve policy response to reverse son preference; Strategy 2: Strengthen capacity of state and non-state actors to implement the PCPNDT Act; Strategy 3: Promote partnership building among state and non-state actors to reverse son preference*

There is widespread acknowledgement among stakeholders in national and state government, media outlets, and civil society partners of UNFPA's significant contribution to placing GBSS on the policy agenda, as well as the quality of CP-8 assistance in implementing the PCPNDT at the national and state levels. Knowledge products and training have contributed to increased identification, tracking, prosecution and conviction of offenders especially by the Maharashtra state office. Currently, UNFPA strategy focuses on technical assistance – generally supplied by embedded consultants – to monitoring and enforcement mechanisms at the state level, especially for judiciary and health ministry bodies.

- *Maharashtra and Odisha have attained high levels of institutionalization* with a state officer for Act implementation, review of action on complaints, active district committees, online complaint system (especially in Maharashtra) and regular video-conferencing updates by key officials.
  - o Work on GBSS in Bihar restarted only a year ago, and has achieved full commitment from the State Health Society; health officer training is underway.
- *Judicial advances:* Two UNFPA-supported judicial training products are considered useful training tools by state judicial academies. Training of judiciary at all levels is leading to active engagement with the Act, with significant convictions and de-registration of erring doctors.
- *Protection of reproductive rights:* Training and communications materials avoid criminalizing women seeking abortion as per the law. UNFPA research and advocacy on an invasive ultrasonography tracking technology (Silent Observer Active Tracker' to monitor and record all ultrasonographies done on pregnant women) led to reversal of MOHFW plans to implement this technology.

No major concerns emerged, but it was noted that the next phase in building state capacity of state actors would be support to achieve sustainable staff-led training, mentoring, and management systems.

Countering the drivers of son preference: Strategies #1 and #3

CP8 strategies to counter the drivers of son preference are multi-faceted, including research, community-based strategies, and mass communications. The CP-8 is supporting MOHFW as well as state Departments of Health and Family Welfare (DOHFWs) in the five UNFPA states to promote an effective policy and legal response to end discrimination against the girl child.

Recognizing that factors such as dowry, asset ownership, gender-based violence, and old age security contribute to gender discrimination and the "unwantedness" of girls, UNFPA supports district level approaches in the five focus states, mainly through a new Ministry of Women and Child Development (MWCD) scheme to enhance the value of girls in families and communities: *Beti Bachao, Beti Padao* (BBBP - *Save and Educate the Girl Child).*

- **Research to infordm the policy response:** Demographic research through the PD thematic area has enabled programmes to target districts with highest levels of GBSS. UNFPA-supported research on the drivers of son preference and declining sex ratios has informed national programmes – most notably BBBP and state policies for the Girl Child (Rajasthan) and for Girls and Women (Odisha). UNFPA contributed to other schemes and policies by providing evidence on the efforts of other schemes and programmes to address GBSS. [57] UNFPA also conducted a useful review of the effectiveness and impact of government policies, schemes and

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[57]"Comprehensive Actions to Address Gender-biased Sex Selection and Declining Child Sex Ratio". Note submitted to Ministry of WCD, 24 October 2014.

programmes that provide financial incentives to raise the value of the girl child,[58] resulting in policy measures to ensure that such schemes promote girls' education, and do not have the perverse effect of facilitating child marriage.

- o UNFPA is strengthening South–South cooperation by facilitating exchange of research findings and expertise, and linkages with global and regional research on GBSS.

- **BBBP: Testing Community-level and Communications Interventions:** CP-8 has focused strongly on work under the BBBP umbrella with MWCD and with NGOs to counter the drivers of son preference. It is too early to make judgments on effectiveness, and the strategy is decentralized and varied. In order to contribute effectively to an improved policy response, evaluation of variations in implementing the program should be supported to identify and then showcase effective practices in work with girls, families, schools, women elected representatives, Panchayats, and young men and boys.

- **Civil Society and Media Advocacy:** Civil society implementing partners of UNFPA, at the national level and in the states, are well grounded in grassroots work, capacity building or media advocacy.

- o Support to Girls Count, a civil society coalition of 400 NGOs, works across many states to strengthening government accountability in implementing the PCPNDT Act and challenge discriminatory gender norms and structures that lie at the roots of son preference.

- o Population First has increased the outreach to regional and vernacular media, and improved the quality and sensitivity of reporting on GBSS. Significant impact of these efforts on public discourse has been documented.

Gender Mainstreaming in key areas of UNFPA work

Capacity to track the level of gender mainstreaming is only partially operational in UNFPA M&E systems, but all members of the CPE team collected data on this topic.

Adolescent/Youth Programmes: Gender issues in A/Y programs have been very well integrated in all programme designs and training materials or curricula, as verified by a systematic review in the thematic assessment. The curricula used in national programmes – AEP, RKSK, Teen Clubs – all strongly promote gender equality, as do the curricula in most of the pilot A/Y programmes such as the LSE content in Odisha tribal schools. The CPE review, however, found that content related to GBV should be reinforced. The pilot A/Y community-based programmes are exemplary by holding empowerment of adolescent girls as their main goal. Another pilot implement an approach led by rural men and boys in Maharashtra to reach out to others to counter GBSS, child marriage, and discrimination against daughters, but CPE found no evidence of results. However, gender mainstreaming in A/Y programming varies in its emphasis across states.

RH/FP Programmes: Gender mainstreaming results leading to future opportunities include: 1) Support to partners on women's rights issues in new reproductive technologies informed legislation; 2) the Odisha study on the two-child norm as a requirement in local elections and welfare schemes is helping to counter this policy: 3) protection of reproductive rights to safe legal abortion in the implementation of the PCPNDT Act. However,

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[58] IIPS & UNFPA (2015) Conditional Cash Transfers for Girls in India: Assessment of Girl Child Promotion Scheme from Beneficiary Perspective (unpublished); and UNFPA (2015) 'Financial Incentives for Girls – What works?' Policy brief, http://india.unfpa.org/sites/asiapacific/files/pub-pdf/UNFPA_PolicyBrief_07-04-20166pm.pdf

attention to gender and reproductive rights needs to be strengthened in the RH/FP central focus on reproductive rights advocacy and health systems strengthening.

PD Programmes: The PD area engaged effectively on GBSS issues, with high-profile and influential studies as well as data analysis to inform planning in the BBBP program, and in the five states. UNFPA's and ICRW research on masculinity, son preference and intimate partner violence in five states examined the linkage between attitudes and behaviour associated with masculinity and the practice of son preference.[59] Other gender-related activities include collaboration with a UN and NGO partner on gender statistics, and incipient work on women and aging. However, the area focused very little on gender analysis on important socio- demographic and economic parameters affecting women and development, child marriage, and single/ divorced women and widows.

GBV: Promising initiatives to develop responses to all forms of gender-based violence (GBV) in the public health system were carried out in CP-6 and CP-7, but were discontinued in CP-8, except for effective work on the health sector's response to sexual violence. Findings suggest that results in CP9 would be enhanced by a higher level of involvement in work on all forms of GBV across all thematic areas and settings (research, medical education, health sector and work place). The CPE documented the need for better quality of GBV data in India. This is an opportunity for PD experts to play an important role in generating evidence on prevalence of and factors in all forms of GBV.

4.4   Effectiveness in Population Dynamics Programmatic Area

EQ4: To what extent have the interventions supported by UNFPA in the field of population and development contributed to an increased availability and use of data on emerging population issues at national and sub-national levels?

Summary
CP8 has made strong contributions to progress on GBSS, ageing data analysis and social inclusion in the state of Odisha. UNFPA's leadership role is well recognized and valued in the work on ageing. However, overall the area suffered from underinvestment leading to mixed results in some initiatives and missed opportunities. Barring Odisha, no other state office appears to have directly engaged in PD activities. Given that the output is explicit in its aim to focus on gender and social inclusion, CP8 contributions to this aim were disappointing. The CP8 gave high priority to establishing a census training centre as an opportunity for S-S collaboration. However, for a variety of reasons, this initiative has not yet been successful, and the opportunity is close to being lost.

Output 5: Strengthened national capacity to incorporate population dynamics in relevant national and sub-national plans and programmes, with a focus on gender and social inclusion

CP-8 aimed to focus on areas constrained by data gaps related to young people, family planning, gender-biased sex selection (GBSS), needs of the most vulnerable population groups, and ageing. CP-8 also planned to strengthen the civil registration system to improve the accuracy of vital data, and establish a census resource and training centre to undertake South–South collaboration.

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[59] ICRW and UNFPA (2015), State Specific Policy Briefs on 'Masculinity, Intimate Partner Violence and Son Preference in India'. http://india.unfpa.org/publications?title=Masculinity&field_thematic_area_tid=All&field_publication_date_value%5Bvalue%5D%5Byear%5D=

The CPE identified significant positive results from the PD programme, described below. The CPE also identified opportunities to follow up on the mixed results in some initiatives and missed opportunities that are highlighted at the end of the section.

Results

Strategy 1: Undertake policy and programmatic research studies to generate relevant policy evidence
Strong contributions to progress on GBSS: Analysis of the census data and publications on the skewed sex ratio at birth at national and state level brought GBSS into policy focus for the government. The research has been used in several advocacy instances, and has been particularly useful in building political will and capacity for implementation of the PCPNDT Act as well as in planning BBBP interventions, by enabling the targeting of high-priority districts with highly skewed sex-at-birth ratios.

Use of data to enhance social inclusion for the vulnerable populations in Odisha: The Odisha state office maintained a strong focus on social exclusion in its PD activities as vulnerable and marginalized population constitutes well over 50 percent of the state population. UNFPA Odisha partnered with state government to publish "Assessment of Tribal Sub-Plan and Scheduled Caste Sub-Plan Programme Implementation In Odisha" in 2015. The study has led directly into building institutional capacity for social inclusion through use of the study and its tools to monitor progress in several departments engaged in welfare schemes for marginalized and vulnerable populations, and to invest the necessary budgetary and human resources to implement the schemes.

Concept paper on the demographic dividend for the Prime Minister's Office: UNFPA country office was asked recently to prepare a concept paper on, "Leveraging Population Dynamics: Way Forward for Poverty Reduction and Sustainable Development in India", for the perusal of the Prime Minister's Office (PMO). This is an acknowledgement of UNFPA's expertise in the area of population dynamics. Describing the theory and status of, "Demographic Transition, leading to the Demographic Dividend", and presenting India's growth story pegged on age, gender and location (geography) at national and sub-national level, this paper draws attention of the government to issues related to urbanization, migration, youthfulness and ageing structure of the population, the skewed sex structure, child marriages and the low female work participation rates.

Strategy 2: Position population ageing in the development planning process
UNFPA's leadership role is well recognized and valued in the work on ageing. CP-7 and CP-8 implemented a four-track strategy: 1) building knowledge database on ageing in India; 2) creating a supportive political and socio-cultural environment through advocacy and communications (to develop a more positive image of ageing and elderly persons as opposed to seeing them as dependent and burdensome); 3) capacity development for three key autonomous institutions to function as the professional and technical arms of government ministries that shoulder responsibilities for mitigating old age vulnerabilities and promoting well-being of the elderly;[60] 4) policy level engagement at national and state levels to improve convergence and implementation issues across relevant agencies and departments. Interventions corresponding to the 2nd track are still in the exploratory phase.

The CPE identified positive results and opportunities to follow up on them.

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[60] These are: National Institute of Social Defense, Ministry of Social Justice and Empowerment, National Institute of Rural Development, Ministry of Rural Development, and the National Institute of Health and Family Welfare, Ministry of Health and Family Welfare.

- *Longitudinal Ageing Survey in India (LASI):* With International Institute of Population Sciences (IIPS), Mumbai UNFPA supported the design of LASI – the most exhaustive survey on ageing ever conducted in India, which also includes the pre-ageing group of 45–59 years. It covers morbidity pattern for non-communicable and communicable disease as well, and other measures of health and well-being. This survey will be conducted every two years for the next 25 years.
- *National Institute of Social Defense:* UNFPA and the Ministry of Social Justice and Empowerment (MOSJE) implemented a capacity development management study, which was used to develop a plan to revitalise the National Institute of Social Defense (NISD) as a Center of Excellence on ageing and elderly population. The CPE identified this first step as a key opportunity to build national capacity in this field. Implementation of the plan would make the NISD more autonomous, with appropriate systems and processes, staff capacity and other organizational development improvements.
- *Odisha Ageing Report:* [61] In 2014, the Odisha state office disseminated this report, leading to a comprehensive change in the programmes for elderly in Odisha.
- *Improved convergence of government agencies:* UNFPA co-chairs regular meetings of the Senior Officials Committee on Ageing (SOCA) to synergize all government efforts, in response to earlier assessments on the poor implementation of the National Policy on Older Persons (NPOP) due to poor coordination and lack of synergy across the 18 central ministries involved and the five that were primarily accountable.

Strategy 3: Build institutional and human resource capacity in use of demographic data
- **Support to Centres of Excellence (COE) for data analysis and research:** Six partnerships with COEs were judged to be effective, leading to research studies, publications, training manuals, capacity development, and knowledge products,[62] including joint work on the National Family Health Survey IV (NFHS IV), LASI, evaluation of the Civil Registration System in seven states, the India Youth Portal, and preparation of development plans based on demographic and socio-economic analysis for the Smart City Mission. An important opportunity was identified to improve maternal deaths registration under the civil registration system.
  - *National Family Health Survey IV (NFHS IV)* : UNFPA is on the Technical Committee of NFHS, playing an important role in question formulation, methodology, training, and analysis and data dissemination. UNFPA and partners flagged women's health concerns and successfully advocated for the inclusions of three questions on hysterectomy, and inclusion of a question on land/property ownership by women
- **Strengthened data systems in health care delivery in Bihar:** In partnership with the Indian Institute of Health Management Research (IIHMR), CP-7 supported strengthening of the Health Management Information Systems (HMIS) in Bihar. CP8 transferred knowledge and skills to state and regional M&E cells to steer, guide and monitor the HMIS work, with plans to follow up at the district and sub-district levels. An evaluation study completed in 2014 reported that the system was functioning well, with substantial improvements in timeliness, completeness and correctness of HMIS portal data. For example, 27 out of 38 districts did not have any validation errors as on December 2013 and improvements in indicators such as antenatal care coverage

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[61] http://india.unfpa.org/publications/status-elderly-odisha-2011
[62] As documented in Chapter 3 on limitations of the CPE, and in EQ#7 on M&E systems, systematic evidence of results (use and influence) from knowledge products supported in CP8 was not available.

were observed. However, UNFPA did not continue this project, and CPE findings raised concerns about sustainability due to lack of staff for training, mentoring, monitoring and evaluation systems.

Mixed Results or Missed Opportunities

- **The Census Commissioner and the Census Research and Training Centre:** The CPAP8 gave high priority to work with the Census Commissioner to establish a census training centre as an opportunity for South-South collaboration, with potential benefits both to India and to countries seeking census expertise. However, for a variety of reasons, this initiative has not yet been successful, and the opportunity is close to being lost. The CPE identified a possible strategy to pursue.
- **Missed opportunities for social inclusion results:**
  - The lack of follow-up of CP7 manuals and training on sub-district analysis of small area data from the census and other demographic and socio-economic data sources was a lost opportunity to build national capacity to promote social inclusion across the range of ICPD goals. However, there are opportunities to revive this relevant initiative with state planning departments and state directorates of economics and planning to provide much-needed training.
  - The India Exclusion Report has not yielded desired results; there is no evidence of dissemination to relevant stake holders nor input into policies or programmes for any state.
- **Demographic dividend**: CP8 could have built on the analyses in the Demographic Dividend paper to conduct state-level demographic dividend studies. Several major Indian states have large population size, considerable socio-economic and cultural diversity and states in the northeast especially do not have the capacity to analyse the policy implications of key population dynamics related to youth development and ageing.

4.5 Relevance of Country Programme-8

EQ5: To what extent are the objectives of the Eighth Country Programme in India, as well as its geographic focus, (i) adapted to the needs of the population (including needs of vulnerable groups), (ii) aligned with government priorities (iii) as well as with policies and strategies of UNFPA?

Summary

Adaptation to the needs of the population: Most UNFPA programming is highly relevant to the identified needs, and served vulnerable population groups. Population research informed CP-8 planning, with appropriate targeting of districts with most vulnerable populations in A/Y, GBSS, and FP programmes and PD support to Odisha social inclusion policies and to addressing the needs of the elderly. However, A/Y programmes are challenged in reaching married girls, and early school dropouts. The RH/FP programme did not invest in maternal health in states with high need.

Alignment with global and UNFPA policies: The CPAP framework is well aligned with global and UNFPA policies, however, loss of alignment with the SRH "bullseye" in UNFPA's strategic plan in practice was noted in two programmes in particular. The findings on the RH/FP programme revealed loss of relevance and leadership on issues of maternal health and reproductive rights. In the A/Y programme, the level of inclusion of adequate SRH content in national and state-level program curricula is minor, although improving, due to political and cultural barriers.

> <u>Alignment with the Government of India:</u> Strong aligned long-term partnerships with national and state government entities are a hallmark of UNFPA's strategies. In the case of emerging issues that are not yet government priorities, the GBSS case study showed a progression over several country programmes from research and advocacy initially, to the present close alignment between UNFPA and government partners and national ownership of programmes. UNFPA's mandate to lead implementation of ICPD principles of reproductive rights and women's empowerment should and often does lead UNFPA to engage in advocacy/policy dialogue on sensitive issues where government approaches or priorities are not aligned with these principles, with the ultimate goal of strong alignment.
>
> The lack of state-level strategic planning emerged as a key threat to UNFPA's relevance.

Adaptation to the needs of the population, especially vulnerable groups

Most UNFPA programming is highly relevant to population needs, and appropriately targets programmes for vulnerable population groups in alignment with the Government of India through its focus on Empowered Action Group (EAG) [63] **states and High Priority Districts (HPDs)** [64] **within them.** A thorough identification of needs informed CPAP-8, relying on the evaluation findings of CP-7, an extensive situation analysis conducted by Shireen Jejeebhoy et al,[65] and state level situation analyses. Among many positive examples of CP-8 relevance to national needs and highly vulnerable groups are the following: maternal health programmes and midwifery training in Rajasthan, programmes addressing HIV risks with sex worker organizations, use of census data on vulnerable populations to target program geographies in the adolescent/ youth and GBSS programmes, PD initiatives on aging, and use of PD data for planning for vulnerable populations in Odisha.

Four relevance concerns related to social inclusion of vulnerable populations were discussed in the thematic EQs (1-4) and are listed below:

1) *Adolescent/youth programmes* were unable to reach married girls with the exception of one pilot programme, and had difficulties targeting early school dropouts.
2) *The RH/FP programme* did not invest in strengthening maternal health programmes in four states with high need, even though the CP-7 evaluation and pre-CP-8 situation analyses identified maternal health as a relevant focus area.
3) *RH/FP programme advocacy* failed to address the structures in the national FP programme that do not comply with ICPD agreements and FP2020 quality standards.
4) *Agency-wide M&E systems are lacking to capture whether most vulnerable were reached.* Systems to document results for these populations are only at the project level.
5) *The PD programme* discontinued CP7 initiatives to build capacity in sub-district and district analysis of small areas, which would enable improved programming for vulnerable populations.

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[63] Eight socio-economically backward states are referred to as EAG states. Four of the five UNFPA states are EAG states. Maharashtra is the exception.

[64] To ensure equitable health care, the bottom 25% of the districts in every State, based on composite health index have been identified as HPDs. All conflict-affected districts and districts with majority tribal population whose composite health index is below 50% are also categorized as HPDs.

[65]Jejeebhoy, S, Kulkarni, et al., Health and Population in India: An assessment of the current situation and future needs. The final publication was not available until after CP8 approval.

Alignment with global and UNFPA policies

The CPAP framework is well aligned with global policies, including ICPD, FP2020, and the key global policy that was made final later during CP-8: the 2030 Agenda for Sustainable Development. The CPAP is also well-aligned with the UNFPA Strategic Plan, including the use of middle-income "orange country" modes of engagement.

In practice, however, *loss of alignment with the SRH "bullseye" in UNFPA's strategic plan* was noted in analysis of CP-8 implementation and results, mainly in the RH/FP programme:

- *Maternal health:* UNFPA is the global lead on midwifery, and maternal health is a main element in the SRH bullseye. Investment in maternal health at the national level and in all focus states except for Rajasthan has been minimal or missing -- a failure of relevance in addressing population needs, and of alignment with UNFPA and global policies.
- *Family planning:* The government family planning programme contravenes ICPD principles of reproductive rights by using targets linked to provider incentives, mainly for long-acting and/or permanent methods. Global evidence and experience in India confirms that this approach poses high risks for undue pressure on providers, who in turn pressure clients. The country office did not take advantage of UNFPA's position as co-chair of FP2020 to provide leadership in advocacy and technical support for the national and state FP programmes to work within a rights-based framework of unmet needs and give priority to voluntary informed choice,
- *A/Y programme*: the level of inclusion of SRH in official curricula improved in CP8, but is still minor, due to political and cultural barriers to the inclusion of adequate SRH content.

Alignment with the Government of India

UNFPA's programmes are strongly aligned with the Government of India. Strong long-term partnerships with national and state government entities are a hallmark of UNFPA's strategies in all thematic areas, and a major source of added value. UNFPA's main strategy of providing technical assistance within the platform of national schemes to support implementation and roll-out to states is highly appreciated by government counterparts. Several such partnerships have led to outcome-level results, i.e. national ownership of ICPD-related policies and programmes. In A/y programmes, the high level of investment of UNFPA in this thematic area is aligned well with UNFPA and Government of India priorities. Other positive examples of alignment include CP-8 support to the Reproductive, Maternal, Newborn, Child and Adolescent (RMNCH+A) Health programme of the MoHFW, UNFPA serving as co-chair of FP 2020, and support for GBSS programming.

On the other hand, 100% alignment with government priorities is not a prerequisite for relevance when culturally sensitive issues cause controversies, or when attention to key issues is in the incipient stage. In one of the most successful cases of outcome-level results in CP-8, UNFPA began work in previous CPs on gender-biased sex selection (GBSS) before it was a priority for the government. Through presentation of research evidence, convincing policy arguments, and high-level technical support, UNFPA contributed to the government's current strong commitment to combat GBSS, with UNFPA's full support.

Cross-cutting relevance concerns

Two cross-cutting relevance concerns were identified.

1) *Lack of state-level strategic planning:* The state offices completed situation analyses in preparation for CP-8 planning, but these were not used to produce state-focused plans and results frameworks. This gap poses the

risk of lack of relevance, because the political, economic, and socio-cultural context of each state is unique, and in the federal system, state governments enjoy considerable autonomy.

    a. At the state level, failures in relevance were noted in Bihar, which has the lowest contraceptive prevalence rate among the five UNFPA focus states, with more than a third of the population living below the poverty line. In this high-need state, the country office under-invested, and state office programme positions went unfilled for a long time.

2) *UNFPA middle-income "orange" country strategies*: States in India show wide disparities in socio-economic indicators and capacities of the health system; socio-economically backward states such as Bihar and Odisha correspond more closely to "red country" profiles in UNFPA's strategic plan. This mismatch has led to tensions with government partners at the state level, when the highest priority needs of the state—specially to expand staffing coverage -- do not correspond well with UNFPA strategies.

4.6 Relevance and Effectiveness: Evidence of Sound Theories of Change

EQ 6: To what extent are the strategies reflecting a sound theory of change grounded in the national and state context to contribute to outcomes and outputs?

Summary

The CPE used a case study method to understand the theory of change (TOC) in the UNFPA programmes with the strongest results. The GBSS and A/Y programmes have common characteristics that illustrate an effective long-term theory of change: continuity for at least two-three country programme cycles ; a systemic comprehensive use of all "orange country" modes of engagement; use of high quality technical support and policy-relevant research to contribute to policy/programme design and implementation; testing demand-side prevention approaches in the field; and deployment of all UNFPA's technical strengths by breaking down UNFPA thematic silos. The CPE also analysed the TOC in support for community-based pilot programmes.

The CPE used a case study method to understand the theory of change (TOC) in UNFPA initiatives that have had the strongest and most verifiable results. The GBSS and A/Y programmes illustrate an effective long-term theory of change (TOC) when UNFPA works on issues that are not yet fully institutionalized as a government priority, with the following common characteristics:

- **Continuity:** they traverse at least two-three cycles of country programmes until national ownership is achieved.

- **Systemic comprehensive approach to modes of engagement**: A systemic approach is evident in the mature phases of these initiatives, in which policy-relevant research, policy and programme design, capacity building for quality implementation, and testing approaches in the field, all reinforce each other and often occur simultaneously.

- **Countering the drivers of discrimination:** Changing policy and legislation is a necessary, but not sufficient, intervention to eliminate deeply rooted harmful practices such as child marriage and GBSS. When these policies or laws are being implemented, structural and socio-cultural barriers impede progress unless they are countered through "demand-side" programmes, which often lack evidence of effective prevention strategies.

These pilot programmes require investment in evaluation in order to generate evidence on effective strategies.

- **Deployment of all UNFPA's technical strengths:** Numerous examples were identified of how breaking down the thematic silos within UNFPA enhances results. In the case of GBSS, for example, important contributions to the results came from the clusters of PD and RH/FP. The PD cluster made the initial key contributions by building capacity to analyse and report data on declining sex ratio at birth, while at a later stage, RH/FP contributed guidelines for enforcement of the PCPNDT Act to safeguard women's access to legal, safe abortion, and expertise in the workings of the health system. Currently, UNFPA support to the BBBP programme uses PD data to help identify high priority districts, and combines GBSS and A/Y expertise, since empowerment of adolescent girls is a key focus in BBBP.

The findings illustrate how UNFPA India's **systemic comprehensive approach to modes of engagement** complement and reinforce each other:

- **Policy-relevant research and knowledge management in response to advocacy needs**: Generating and disseminating information to respond to policy advocacy needs occurred at every stage in the life cycle of these initiatives. GBSS work illustrates this synergy. Initially, knowledge outputs based on demographic studies on child sex ratio and district level analysis of "missing girls" were effectively used to amplify civil society voices and draw the attention of the state to the declining sex ratio. Most recently, UNFPA-supported research on conditional cash transfer schemes to encourage valuation of the girl child contributed to redesigning the schemes.
- **Contribution to National or State Policy & Programme Design:** UNFPA technical contributions during the design of policies and programmes produced significant results in all thematic areas, increasing effectiveness through use of evidence. For example, national and state A/Y teams shaped the development and implementation of the national adolescent health strategy (RKSK), the adolescent education programme (AEP), and the BBBP programme of Ministry of Women & Child Development. State offices contributed to evidence-based state policies: the Odisha State Policies for Youth (2013) and Women and Girls (2014), and the Rajasthan Commitment to End Child Marriage.
  - **Facilitating programme implementation through High Quality Technical Support:** UNFPA's value added through provision of high quality technical support was verified by multiple stakeholders. [66]
  - **Demand-side communications and knowledge management:** UNFPA supports engagement with public and community audiences to promote society-wide changes in harmful or discriminatory norms, beliefs and practices. GBSS and Y/A programmes employ two approaches: 1) mass communication strategies to focus on SRH and gender issues; and 2) testing community-level pilot programmes that promote the desired changes. In the latter approach, to achieve the ultimate objectives of strengthening programmes and policies, feedback learning loops must be created, requiring adequate investment in evaluation, as illustrated in the Figure below.

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[66] See full discussion in EQ#7 on Efficiency and use of consultants and in EQ#9 on Comparative Advantage.

Figure 4.1 Programme Strategy
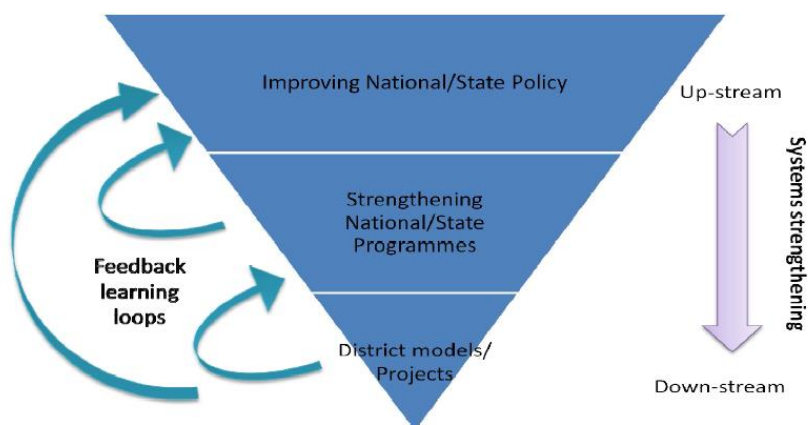
Without such evaluation to test new approaches for effectiveness, community-based pilot projects amount to scattered small projects with no collective impact. The CPE identified several needs for increased investment in evaluation of community-based pilot programmes and newly designed but large-scale government programmes to enable continual improvement of policies and programmes.

Pathways to sustainability and government ownership

The path to sustainable scale-up and institutionalization of such community pilots is often indirect and fraught with obstacles. The pathways seem to be more direct and promising when under the umbrella of large government programmes. The pathway of engagement on the A/Y Life Skills Education (LSE) in Odisha is illustrated in figure 4.2 below as a successful example of how pilot programme strategies can progress to full institutionalization, moving up from one level to another, with strong government partnership and UNFPA technical assistance and policy advocacy. UNFPA's engagement in the Odisha Youth Policy and the policy on Women and Girls facilitated political support for scale-up of the pilot. The engagement of the state education office increased through several stages, starting with partnering with a non-state institute (Kalinga Institute of Social Sciences) to develop and perfect the LSE content. After training of teachers, the LSE programme was introduced in a few districts in 2012. At this point in the maturity of this programme, there is excellent national ownership. The curriculum was gradually scaled into government residential schools with teachers trained and all study material made available by the Department of Scheduled Caste & Scheduled Tribe Development, Government of Odisha. Currently, the LSE programme covers 169,012 students (boys, 39 percent and girls, 61 percent). UNFPA provides minimal technical assistance and has retained a mentoring status with the Government of Odisha, which is bringing the programme to scale and has made financial allocations.

Figure 4.2: Life Skills based SRH Education[67]
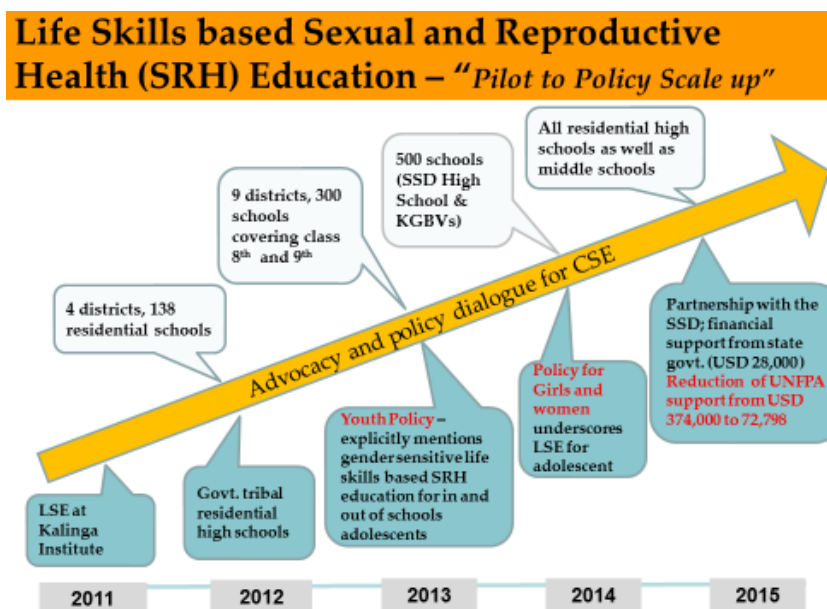
Theory of change in the RH/FP and PD programmes

A major difference in the theory of change for the RH/FP and PD programmes is that for the most part national and state government programmes are well institutionalized, with full financial and political support. Therefore, UNFPA support and the accompanying theory of change mainly focuses on systems strengthening – improving quality, or integrating new issues or services into training or service systems that are already sustainable.

Pilot programmes in RH/FP are rare because decades of global investment in research and evaluation on RH/FP programmes has created a substantial body of evidence for programme design. Hence, most of the interventions supported through the RMNCH+A programme are proven interventions with impact. This contrasts with the situation in the A/Y and gender portfolios, where global evidence for prevention and behaviour change programmes is weaker and hence, testing community-level approaches to promote adolescent SRH or to prevent GBSS or child marriage can add value.

On the other hand, addressing threats to reproductive rights in these systems, or testing any innovation to improve quality in sustainable RH/FP programmes, would follow the theory of change for pilot programmes illustrated earlier in Figure 4.2. One such example of potential areas of RH/FP support for pilot programming in CP-9 could be strengthening health sector and community response to gender based violence (GBV).

As in the RH/FP portfolio, PD usually does not engage in testing pilot interventions, but there are numerous examples in CP-8 where the PD research and analysis was an indispensable input to design such interventions. In the early stages of work on emerging issues, PD plays a key leadership role in research and analysis to identify trends and patterns that inform new policies, with the most outstanding example in CP-8 being the work on ageing.

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[67] SSD refers to SC & ST Development, Minorities and Backward Classes Welfare Department, Govt of Odisha . Source: State Presentation by the State Program Coordinator, Dr. Deepa Prasad, Odisha, UNFPA, July 2016

4.7 Relevance: Response to National, Political and Contextual Changes

EQ 7: 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 change?

Summary

CP-8 responded in a timely fashion to unexpected opportunities in the national context with the introduction of new policies and programmes of the National Democratic Alliance (NDA) government elected in 2014, such as *Beti Bachao Beti Padhao* (BBBP - Save and Educate the Girl Child), which counters GBSS and promotes girls' empowerment, and the Smart City Mission. UNFPA responded effectively to the aftermath of a widely publicized sexual assault case in 2012 to advance integration of SGBV[68] into health services. Other examples of relevant UNFPA responses include a concept paper on the Demographic Dividend for the Prime Minister's Office, the addition of questions on hysterectomy and gender in the National Family Health Survey, and the Commitment to End Child Marriage in Rajasthan. Skills India is a government program that could pose an opportunity for youth programming in CP9. However, the findings in the Population Dynamics and Reproductive Health/Family Planning themes contain examples of significant missed opportunities.

The CPE identified several examples[69] during CP8 in which the CO responded in a timely fashion to unexpected national opportunities that arose from new government schemes, or from events that created increased political will in favour of UNFPA objectives.

- **Beti Bachao Beti Padhao (BBBP) -** UNFPA seized an opportunity to support of the roll-out of this new government schemes in three states. National and state offices of Women and Child Development (MWCD) are promoting this scheme to ensure survival, protection and empowerment of the girl child[70].
- **Sexual violence and the health sector:** UNFPA responded effectively to opportunities to advance integration of SGBV into health services in the wake of a sexual assault case (*Nirbhaya*) in December 2012 that caused widespread outrage and nationwide protests.
- **Smart City Mission:** UNFPA missed the chance to engage in determining proposal selection criteria in the planning stages, so that citizen services such as health and education could receive greater emphasis. However, in 2016 UNFPA devoted staff resources and engaged a partner to provide small area population data to inform planning in the cities that won the competition.
- **Sustainable Development Goals (SDG):** In 2016, UNFPA devoted PD staff resources to enable tracking of progress on the SDGs in India.
- A **concept paper on the Demographic Dividend** was produced for the Prime Minister's Office, in response to increasing interest in Demographic Dividend analyses for planning.
- **The Commitment to End Child Marriage in Rajasthan**: The UNFPA consultant to MWCD and the UNFPA state office noted the potential for convergence on combatting child marriage among several government and development partners and led efforts to promote a joint commitment.

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[68] Sexual gender based violence
[69] Those listed below and additional instances can be found in the discussion on effectiveness, EQ#1-4.
[70] Described in EQ#3

- **NFHS IV:** UNFPA responded to increasing rates of hysterectomies and caesarean operations as an area of concern in India through sustained policy dialogue on the Technical Advisory Committee on NFHS IV, and succeeded in adding pertinent questions on hysterectomy and women's property rights.

Initial CPE data collection produced long lists of "missed opportunities." However, it would not have been strategic for UNFPA to pursue all of them. Given incomplete evidence on the human and financial resource constraints governing past decisions, the CPE team analysed missed opportunities that seemed most significant in terms of potential added value. Full discussion of these strategic gaps is in EQ#1-4.[71]

4.8 Efficiency of the Country Programme

EQ8: To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of structure, functions and approaches to pursue the achievement of the results defined in the UNFPA country programme?

Summary

Continuity in programmes, staffing, and implementation facilitated effective use of resources, while lack of continuity in programmes before reaching the stage of sustainable training and mentoring systems and full national ownership greatly lowered the return on previous programme investments in two notable cases. Lack of continuity in staffing led to loss of efficiency, effectiveness, and relevance, especially in the FP/RH area and in the state of Bihar. Implementation delays caused inefficiencies through weaker results and additional unnecessary expenses.

Highly qualified consultants are an effective use of UNFPA's resources, especially when embedded at higher levels in major government ministries and programmes, with outstanding examples in the A/Y and GBSS programming. Examples from FP programmes at state level illustrate that less qualified consultants who mainly fill staffing gaps are not an effective use of resources.

Findings on the evaluability and M&E systems of UNFPA reveals certain strengths which include: tracking of implementation, AWPs, and budgets; systems to track the CPAP indicators and response to CP7 evaluation recommendations; base- and end-line evaluations for several national or pilot programmes; and regular programme meetings to reflect on progress and adjust strategies. The main areas of concern are the need for more investment in process evaluation and for state-level strategic planning to enable evaluation of state-level relevance and results.

On execution and implementation arrangements, thematic silos led to inefficiencies caused by arbitrary classification of activities that are relevant to more than one thematic cluster. In terms of planning and utilization of budgets, the integration of technical assistance (TA) activities into the program tracking system would enable UNFPA to evaluate the relevance and effectiveness of these activities, and optimize the use of these funds in strategic planning. Findings on Direct Resource Mobilization show lapses in planning for adequate human resources to this end for CP-8, causing failure to meet funding targets; a firm plan is yet to be developed.

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[71] RH/FP lapses are described in EQs #2 and #5, and for PD in EQ#4. There were very few missed opportunities noted in the Gender and A/Y programmes.

The evaluation team focused on issues named in the 2ⁿᵈ evaluation objective in the TOR,[72] with two additional topics added in the design discussions: efficient and effective use of consultants in capacity-building, and the capacity for efficient humanitarian response.

The CPE framed the following overarching efficiency question, in recognition of the link between efficiency and other OECD evaluation criteria in the analysis of "good use" of resources. ***How did the allocation of human, financial, and technical resources facilitate results, or pose a barrier to results?*** Hence, these findings are based mainly on CPE analysis of factors that are within UNFPA's control leading to results – or lack of results -- regarding effectiveness, relevance, and sustainability.

Continuity as an Efficiency Principle

An important crosscutting principle emerged from the findings:

Continuity in programme priorities is key to the achievement of the outcome-level result of national ownership, and is essential in capacity development processes. Programmes or initiatives that had been continued over two or more country programmes were found to make the best use of UNFPA resources by allowing enough time for a process that results in national ownership. Stakeholders also pointed that the continuity of UNFPA's commitments to topics and to partnerships is a source of value added.   Lack of continuity in long-standing programmes that had not reached the final stage of national ownership resulted in failure to achieve the potential return on investment from the programme. The most significant examples of the negative consequences of lack of continuity were the NYKS Teen Club program, the HMIS system in Bihar, the CP7 initiative to build capacity in use of census and other demographic data for sub-district analysis, and the CP7 activities to introduce GBV care into the health system.

The findings on sustainability led to a conclusion related to continuity in capacity development processes:

Support to establish sustainable training and mentoring systems is essential to achieving the potential long-term results of capacity development investments, and is often a necessary last stage in exit strategies. Conceived as final stage in achieving national ownership, this type of support is well-suited to UNFPA's niche and technical strengths. Both accomplishments and concerns in multiple CP-8 examples confirmed that creating and institutionalizing capacity building systems is a major investment, and a long-term process. One implementing partner who had successfully done so remarked: "Don't cut corners if you want capacities to be sustainable." Initial training of trainers who are staff in government programmes needs to be intensive and accompanied with mentoring, and so on down the line to state, district and sub-district level.

Both successes and failures to achieve the required continuity in CP8 demonstrated the importance of a ten-to-fifteen-year planning perspective in capacity building strategies for major government programmes, especially when the baseline capacity is low. The four premature exit examples cited above illustrated how, without sustainable capacity development systems, staff turnover and/or withdrawal of external funding gradually lead to the demise of a programme, and/or erosion in quality of implementation and effectiveness.

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[72] "To assess the extent to which the implementation framework (partnership strategy; capacity building, execution & implementation arrangements; cash transfer modalities; and monitoring & evaluation) enabled or hindered achievement of the results chain." Quality support and assurance was on the original list in Objective Two, but given the limited time period for CPE data collection, this topic was dropped from the priorities for data collection.

Other findings on the role of continuity in efficiency included:

- **Continuity in staffing** contributed to the effectiveness of UNFPA strategies on GBSS and young people, while staffing gaps led to loss of strategic focus, leadership and effectiveness, especially in the FP/RH theme and in the state of Bihar. The costs of designing and starting up a new, more coherent thematic or state programme, and rebuilding lapsed relationships with government partners, could have been avoided with more timely and strategic hiring decisions.
- **Continuity in implementation:** Data from NYKS, RKSK, and AEP illustrated how delays in implementation schedules led to weaker results, and to additional unnecessary expenses. Delays in approval of AWPs led uncertainties about the future, loss of staff, & unbudgeted hiring and training expenses. Training needed to be repeated when too much time elapsed between training and implementation of the program, which is a concern in RKSK.

Capacity Development: use of consultants for technical assistance.
Two main conclusions arise from the CPE findings:

1) *Highly qualified consultants are an effective and efficient use of UNFPA's resources, especially when embedded at higher levels in major government ministries and programmes*. In general, CPE analysis concluded that A/Y, gender, and ageing consultants (mostly experienced social scientists) have been effective in all modes of engagement, most recently in programme planning, design of capacity building materials and curricula, and advocacy/policy dialogue. Maternal health consultants (mostly specialist doctors) have been effective in capacity building and quality assurance. The most effective consultants engage in policy dialogue, design programmes with Ministry colleagues on an equal footing, and act in close coordination with country office or state office programme managers. They strengthen UNFPA's partnerships with government entities; ministry stakeholders point out that they fill a key capacity gap because the human resources package is not competitive enough to hire or retain staff with the level of expertise that they need to ensure high quality design, planning, and coordination of new initiatives. The CPE team heard from several government stakeholders that UNFPA funds are less important than the expertise that UNFPA offers them, much of which comes through consultants. Recently, Government of India issued regulations restricting the use of long-term consultants supported by development partners. In a few cases in MoHFW, UNFPA consultants have been rehired as Ministry staff – a positive indicator of the Ministry's recognition that this level of technical capacity is necessary for effective programming.[73]

2) *Less qualified consultants who mainly serve to fill staffing gaps are not an effective use of UNFPA resources.* Most examples of ineffective use of consultants were those working at district or sub-district levels in state FP programmes. The official objective of FP consultant support was to build capacity of government counterparts; however, the consultants mainly acted in a staff capacity, ranging from being an assistant to being a monitor in the field. A majority do not have the skills for the positions they hold and their capability to analyse findings independently and take action is unclear.

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[73] This was a recent development, with notice of such rehiring emerging during the CPE visit in July 2016. The situation was fluid at the time of the visit, and it seemed possible that most UNFPA consultants would not be affected.

Evaluability and the UNFPA Country Office Monitoring and Evaluation Systems

Strengths of the UNFPA Monitoring and Evaluation (M&E) Systems include: 1) tracking of implementation, Annual Work Plans, and programme and technical assistance budgets & expenditures; 2) tracking CPAP indicators and responses to evaluation of CP7; 3) base- and end-line evaluations built into several national or pilot programmes; 4) regular programme meetings to reflect on progress and adjust strategies.

The four main areas of concern reduce the evaluability of the UNFPA programme.

1) **The lack of integration of activities supported by the technical assistance budget into the programmatic MIS tracking systems:** Technical assistance (TA) activities are a third crucial pillar in achieving CP outputs, complementing UNFPA staff-led national and state activities and the work of implementing partners. All consultants are hired with these funds. In many cases, an MOU with an implementing partner would be the less efficient, costlier, and less timely way to move a programme strategy forward, especially when quick responses to advocacy opportunities are called for. The 2016 programme TA budgets range from 58 percent of the total programme budget for the RH/FP output to around 25 percent for GBSS and PD outputs. Integration of TA activities into the UNFPA programme database would enable UNFPA to evaluate systematically the relevance and effectiveness of these activities, and optimize the use of these funds through strategic planning.

2) **The lack of results-based indicators** was the most common evaluability concern in the CPAP Resources and Results Framework (RRF), [74] especially in the Gender, RH, and PD outputs, where indicators often count the number of programmes, studies, initiatives, or organizations, without a means to determine results. Knowledge management strategies were especially prone to lack of results-based measures, with indicators framed as the number of research reports and publications produced, and no monitoring system in place to record how these were used or whether they had influence.

3) **The need for more investment in process evaluation**, including implementation research, especially in new large-scale government programmes and in pilot programmes testing new strategies. This need was detected in the analysis of the A/Y programme (EQ#1), the BBBP programme (EQ#3), and the theory of change for pilot programmes (EQ#6). The large national programmes supported by UNFPA – RKSK, AEP, and BBBP – are being piloted or started up simultaneously in two or more states at scale. The state strategies for implementation vary, and none of these variations are adequately tested. For these as well as several A/Y pilot programmes where evaluation gaps were detected, implementation research would enable on-the-spot learning on which variations in implementation work best, and enable evidence-based guidance to inform capacity development for further scale up. Such research/evaluation should include implementation measures, such as numbers of people reached or trained, and short-term results measures, such as increases in usage of adolescent friendly health clinics (AFHC) in RKSK.

4) **Lack of evaluability of relevance and results in state programmes** due to the absence of state-level strategic plans, as discussed in EQ#5.

Execution and Implementation arrangements

- **Thematic silos:** Two thematic assessments (Gender and A/Y) and the internal strategic review (ISR) brought up inefficiencies caused by arbitrary classification of activities that are relevant to more than one thematic

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[74] See Annex 8: Evaluability of the CP8 Resources and Results Framework, for full analysis.

cluster. CPE analysis of effective theories of changes (EQ#6) also led to the conclusion that the most cost-effective use of resources deploys all UNFPA's technical strengths on a given issue.

- **Country office/State office arrangements:** Inefficiencies in these arrangements were identified as an operational concern. Inefficiencies in approval processes that allow state offices to respond to unexpected opportunities were partially addressed in 2016 for expenditures under $5,000. The development of state strategic plans and results frameworks should facilitate streamlining of subsequent approvals for Annual Work Plans and technical assistance budget use.

- **Partnership arrangements:** Partners interviewed rated these arrangements highly, especially regarding the horizontal and collaborative nature of their relationship with UNFPA. No issues related to efficiency or cash transfer modalities were raised, except for the inefficiencies caused by having Annual Work Plans, which significantly raise the administrative burden both for UNFPA and partners, and can cause delays in implementation, leading to a suggestion to pursue two-year work plans whenever possible.

Capacity to respond efficiently to humanitarian response

In Maharashtra and Odisha, the two states where district and state disaster plans mainstreamed MISP, the state offices should be able to respond efficiently.

Resource Mobilization

A CPE team member investigated results in resource mobilization, since the target of raising $10 million from non-regular resources was set in the CPAP (See Annex 11 for the full report). Efforts in generating the funds through Direct Resource Mobilization have been made, but most of the work is in nascent stage or exploratory in nature and a firm plan and action pathway is yet to be developed. UNFPA was remiss in its financial and operational planning for CP8 when a separate unit for Resource Mobilization was not created.

4.9 Sustainability

EQ9: To what extent have the partnerships established by UNFPA promoted the national and state ownership of supported interventions, programmes and policies?

Summary

UNFPA's strategies are well-designed to achieve national and state ownership by working within and under the umbrella of government programs. Although there are sustainability concerns in some major programmes, overall the CP8 made important contributions to UNFPA outcomes, i.e. results that rise to a higher level than the CPAP outputs through institutionalization of national and state programmes, with four major examples in A/Y programmes, and another related to GBSS.   At the state level, UNFPA advocacy and technical assistance contributed to inclusion of several UNFPA-supported programmes in a state annual budget.

Concerns regarding sustainability include need for more investment in sustainable capacity development in gender and A/Y programmes, and resistance by states to implementation of programs that are nationally funded if they create new staff positions in state services. Resource-intensive pilot programmes face sustainability barriers when they use personnel outside the existing public programmes and infrastructure. Lack of implementation research & process evaluation could jeopardize sustainability if there is not enough evidence of effectiveness to feed into implementation guidance for scale up based on lessons learned.

UNFPA made significant contributions to increased political and financial sustainability in national and state gender and adolescence/youth programmes. In CP-8, UNFPA contributed to institutionalization of GBSS-related programmes and policies in two ministries, to new gender and youth policies in Odisha and Rajasthan, and to increased support for the Adolescence Education Programme (AEP) and RKSK at the national and state level. Given the inclusion of adolescent education in the new draft Education policy, the future seems promising for the financial sustainability of the AEP. In several examples, UNFPA advocacy and technical assistance contributed to support for UNFPA-supported programmes in the state annual budget (PIP).

The CPE analysis focused on four sustainability categories and their corresponding goals. When these goals are reached, a programme or policy can be said to enjoy national ownership:

1. Political sustainability – Broad spectrum support from key decision-makers such that a programme is likely to continue when new governments are elected.
2. Technical sustainability – Programme staff have the required technical expertise, and sustainable systems of capacity building, supervision/mentoring, planning/evaluation cycles are in place, so that the effectiveness and technical quality of the programme is maintained and continues to improve.
3. Managerial sustainability: Management systems are in place to administer the programme efficiently.
4. Financial sustainability: The programme is fully integrated into core budgets, which are complemented if necessary by revenue generation systems and a healthy mix of other revenue sources.

The main programme strategies in CP8 demonstrate effective practices to achieve national and state ownership of supported interventions. Although there are sustainability concerns in some major programmes, overall the CP8 made important contributions to institutionalization of programmes at the national or state level. Once a UNFPA core issue becomes high priority in the national or a state government, UNFPA's strategies promote institutionalization by working within and under the umbrella of government programmes.

The elements of sustainability are interdependent. For example, the history of programming in adolescent/youth SRH in UNFPA in India and globally – both of which span decades – illustrates the close link between political and financial sustainability. Life skills and SRH education in Indian schools suffered a controversy in the 2000s that caused several states to ban and dismantle the program. UNFPA's mission includes other focus areas that are culturally sensitive – promotion of reproductive rights, and gender equality and equity. Since other competing government priorities are less apt to arouse controversy, programming in these areas is particularly vulnerable to loss of political, and subsequently budgetary, support, affecting all other aspects of sustainability. To maintain sustainability in any culturally sensitive area, especially in A/Y programmes integrating SRH issues, the country programme must pay continuous attention to advocacy, communications and policy dialogue.

One test of sustainability is whether programs survive changes in government leadership with budgetary and infrastructure support. The UNFPA thematic areas that meet this test include family planning, maternal health, and population dynamics data collection and analysis. These programs enjoy stable political and financial support in India, with technical and managerial systems in place (although varying in coverage and quality) at the national and state level. However, past controversies in the Indian family planning programme illustrate how reproductive rights violations could threaten its sustainability.

Programme areas where the level of sustainability is high and technical and managerial systems are in place demand different types of strategies and contributions than other areas such as GBSS, adolescent girls'

empowerment, adolescent health, and ageing, where the political and financial commitments are more recent and therefore unstable, and managerial and technical sustainability is not yet in place. In general, CP8 programme strategies have appropriately reflected this distinction, with FP/RH and PD support (except for work on ageing) focused on specific needs in technical or managerial areas in an institutionalized national program; these programmes have numerous examples of sustainable results in CP8.

Gender and A/Y programmes must have a long-term sustainability strategy with the following elements: for political and financial sustainability --sustained promotion of political commitments and financial support through advocacy, communications and research; for technical and managerial sustainability -- technical assistance for policy and programme design, followed by planning and technical support to roll out new national programmes to the states, learning effective practices by testing variations in implementation, and finally, establishing sustainable capacity development and managerial systems. To counter GBSS, UNFPA strategies employed all these elements over three country programmes and contributed to the current high level of political, legal, and financial commitments by the national and UNFPA focus state governments. In CP8, UNFPA staff, partners, and consultants are engaged in work on technical and managerial sustainability: the development of systems for enforcement of the PCPNDT Act, and technical support to large-scale initiatives such as BBBP to reduce daughter aversion/son preference.

The main sustainability concerns in CP-8 were:
- The ultimate need to **develop sustainable technical and managerial systems at all levels** was the most frequently cited sustainability concern in the Gender and A/Y programmes, especially regarding the potential for government ownership of resource-intensive pilot programmes.
- **Resistance by states to implementation of nationally funded programs** if they create new staff positions in state services. This concern arose in the findings on the RKSK programme, which aims to add counsellors in adolescent-friendly health clinics.
- **Resource-intensive pilot programmes face sustainability barriers when they employ personnel outside the existing public programmes and infrastructur**e. Stakeholders were more optimistic when new programmes build capacity with existing staff and infrastructure, but noted that the initial capacity-building investment in these cases often needs to be more intensive than when hiring personnel from outside the system.
- **Inadequate implementation research & process evaluation** may jeopardize sustainability. Evaluations provide evidence of effectiveness, which facilitates political sustainability, as illustrated by two pilot A/Y programmes with evaluation evidence of short-term results, which were adopted by state governments.

Principles to Improve Sustainability

Based on analysis of successes and concerns in CP8, the following principles to enhance sustainability are suggested:

- Analyse the four components of sustainability in major initiatives to plan for achieving institutionalization.
- Create the capacity to implement pilot programmes or innovations within existing public systems and personnel, whenever possible.
- Make long-term plans over two-three country programmes, including gradual exit strategies, with assistance in building sustainable technical and managerial systems as the final stage.

4.10 Comparative advantage and added value

EQ10: What are the main comparative advantages of UNFPA in India and to what extent does UNFPA maximize development results by coordinating effectively with UN and other international and national stakeholders for potential synergies and south-south collaboration?

Summary

Comparative Advantage

Through continuous investment over several country programmes, UNFPA has achieved strong stakeholder recognition and comparative advantage on GBSS, health and development of adolescents/youth (including SRH), and ageing. UNFPA's ability to draw on networks of trusted experts and partner organizations in all thematic areas to fill national and state governments' need for research, technical assistance, or capacity-building has been a source of added value. UNFPA still has comparative advantage and strong recognition for its technical strengths and unique niche in family planning (FP), maternal health, and population dynamics (PD). However, under-investment in staffing in CP8 led to the loss of a leadership role in FP and maternal health, and to low visibility of its work in PD, except for its leadership role in the field of ageing and support for social inclusion data in Odisha.

Coordination with UN and other Development Partners

Examples of collaboration with UN agencies in CP8 include the UNCT task force on youth, collaboration with WHO in ageing and GBV guidelines, and with UNICEF to end child marriage in Rajasthan. Since planning for the next UNDAF coincides with UNFPA planning for CP9, other major opportunities for convergence and synergy could arise. CPE identified opportunities to collaborate more closely with UNICEF on empowerment of adolescent girls, AEP in the schools, and child marriage.

Few other development partnerships in CP8 were identified, except for an opportunity to collaborate with USAID and other development partners through UNFPA's role as co-chair of FP2020. The new Corporate Social Responsibility legislation has expanded the possibilities for public-private partnerships, as well as for non-core support for UNFPA programmes, but resource mobilization efforts are still in exploratory phases.

Potential for South-South Collaboration

The CPE identified the greatest potential for south-south collaboration as among states in India, with numerous examples in the thematic reviews of positive results from technical support from one state to another. CP-8 plans to establish a South-South Census Resource Training Centre encountered several barriers, and is not yet a reality. Other areas identified as having potential for Indian institutions to promote learning exchanges and provide South-South technical assistance are GBSS, adolescent/youth programmes, and commodity supplies (RHCS).

Comparative advantage of UNFPA in India

UNFPA's comparative advantages are strongest in the areas of greatest and most continuous investment over several country programmes, enabling the agency to establish productive working relationships with government partners, and play a leadership role amongst other national and international partners. The programme areas most recognized by stakeholders are GBSS, gender-sensitive adolescent/youth health (including sexual and reproductive health), and ageing.

Government stakeholders affirmed almost unanimously that UNFPA's strong partnerships with government are founded on two elements: provision of highly valued relevant expertise and skills, and the continuity of this relationship over decades. First, UNFPA's greatest asset and source of added value is the expertise and legitimacy of its management and programme staff, as well as staff's ability to draw on networks of trusted experts and expert organizations in all thematic areas to fill government partners' need for research, technical assistance, or capacity-building. Second, government and civil society partners stressed the importance of trust: knowing that UNFPA's contributions to their priorities will not come and go with donor fads.

UNFPA's leading role in advancing attention to GBSS in India is widely recognized. In CP-8, the agency is leading in the next steps to reduce son preference and implement the PCPNDT Act in a way that respects reproductive rights. It should be possible, given UNFPA's years of experience and strong expertise on GBSS, to explore opportunities for South–South cooperation on this issue across other Asian countries that also experience skewed sex ratios at birth, and in ages 1–5 years.

Likewise, regarding SRH of young people, UNFPA is widely acknowledged by government stakeholders as the lead development partner focusing on young people's SRH in the health sector, and one of the lead partners in adolescent health in the education sector. Ironically, UNFPA's comparative advantage arises from the challenges of working in this field. Strategies to increase young people's access to quality SRH education in schools and to youth-friendly health services encounter many political and socio-cultural barriers and setbacks, and thus require holistic and long-term approaches such as UNFPA's. In contrast, such A/Y approaches are not the priority or the forte of the major international RH/FP partners in India.

UNFPA is considered a dependable and enabling development partner in reproductive health, particularly in FP, by the government at the national and state levels. Central and state health officials (in the five UNFPA states) stated that they would like UNFPA to play more of a leadership role. UNFPA is considered the "go to" agency for reproductive health/contraceptive supplies (RHCS) because of its global role in quality assured procurement. Although UNFPA still has recognition for its technical strengths and global leadership in family planning and maternal health (MH), UNFPA leadership and relevance was lost in CP8 in for reasons described in earlier EQs: 1) letting key Programme Officer positions go unoccupied for long periods in the country office and in Bihar; 2) ineffective use of FP consultants; 3) a management decision to work in MH and midwifery only in Rajasthan; and 4) failure to exercise leadership and conduct advocacy through its FP2020 co-chair role to support ICPD principles of women's empowerment and reproductive rights.

UNFPA has a longstanding leadership role and unique niche amongst UN partners in population dynamics (PD), including censuses and other demographic research, such as socio-demographics studies on GBSS and adolescents/youth, or small area analysis. Most recently, UNFPA has gained a leadership role and strong comparative advantage in the field of ageing. CP8 supported research, knowledge products, and a UNFPA convening role to inform policy and programmes that address the needs and vulnerabilities of the elderly population. In other PD strategies, however, under-investment in staffing in CP8 also led to the loss of the planned strategic focus on gender (except for GBSS) and social inclusion (except for work in Odisha), and to low visibility of other activities.

The CPE was tasked with investigating UNFPA's comparative advantage in the state of Bihar, which has a significance presence of major FP development partners, and where UNFPA lost leadership due to gaps in staffing.

Comparative advantage was found in GBSS, in UNFPA's expertise in working with adolescents and youth on RH/FP, in the State Office initiatives to reach the most vulnerable and marginalized populations, and in RH commodity security. Other development partners confirmed UNFPA's advantage due to its partnership with the MoHFW, posing an opportunity for UNFPA to take leadership in FP2020 coordination and promote integration of ICPD frameworks in the state family planning program.

Coordination with UN and other Development Partners

The 34 UN agencies active in India, of which 28 are resident, have a long trajectory in the country, and around 4,500 employees, with a major proportion of these employed in a joint WHO/UNICEF programme. Types of coordination range from dividing up responsibilities by district or role to avoid overlap (such as the UNFPA–UNICEF–WHO coordination in RKSK) to jointly planned and implemented strategies, which are more likely to maximize development results. Joint UN initiatives are more prevalent at the national level, since only UNICEF has a staff presence at state level – including only Bihar and Rajasthan among the UNFPA focus states. The CPE identified opportunities to collaborate more closely with UNICEF on empowerment of adolescent girls, the Adolescent Education Programme in the schools, and child marriage.

Examples of collaboration in CP-8 include joint initiatives on GBSS, UNFPA leadership of the UNCT Task Force on Youth, collaboration with WHO in the working group on ageing and on GBV guidelines, creation of a gender statistics platform with UN Women, and a UNFPA-UNICEF team supported by the Canadian International Development Agency (CIDA) to coordinate efforts for the Commitment to End Child Marriage in Rajasthan. In FP/RH, however, UNFPA missed the opportunity in CP-8 to collaborate with WHO, UNICEF, World Bank and UNAIDS under the H4+ partnership to promote UNSG's Every Woman, Every Child Initiative, due to the reduced focus on maternal health under the CP-8.[75]

Few examples were found of joint initiatives with other development partners, but opportunities were identified, including collaboration with USAID and other partners in the FP2020 mechanism. The new Corporate Social Responsibility legislation has expanded the possibilities for public-private partnerships and non-core support for UNFPA programmes, but planned resource mobilization efforts are still in exploratory.[76]

Potential for South-South Collaboration

The CPE identified the greatest potential for south-south collaboration among states in India, with numerous examples of positive results from South-south exchanges and technical assistance in the thematic reviews. For example, UNFPA-supported experts and partners from states with advanced work on GBSS, especially Maharashtra, have served as trainers and consultants in states with less capacity. The main South-South objective in the CPAP was the creation of a Census Resource Training Centre (CTRC); however, this effort encountered several barriers, and is not yet a reality. Other potential South-South areas in which Indian institutions have considerable expertise to share learning and provide technical assistance outside the country were: GBSS, adolescent/youth programmes, and commodity supplies (RHCS).

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[75] The H4+ partnership comprises six United Nations agencies: UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank as the lead technical partners for the implementation of the Secretary-General of the United Nations (UNSG) Global Strategy for Women's and Children's Health.
[76] Annex 11 provides a report of findings on resource mobilization, with a brief discussion of these findings in EQ8 on Efficiency.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Strategic conclusions and recommendations

The evaluators set the following strategic learning questions:

- Given the country context, based on the work undertaken in the Eighth Country Programme (CP-8) and the emerging UNFPA funding scenario to India, what strategic areas and interventions, mode of engagements and geographies should UNFPA pursue in CP-9?
- Given the emerging scenario and requirements, what institutional arrangements could be considered?

The findings on these questions point to five major conclusions at the strategic level, with accompanying recommendations, and then a conclusion and recommendation for each thematic area.

Conclusion #1

The lack of state-level strategic plans reduces the relevance, effectiveness, efficiency and evaluability of UNFPA's programmes

The lack of state-level strategic plans and objectives limited the CPE team's ability to evaluate the relevance and effectiveness of each state programme, which in turn has made it difficult to analyse trends in state-level programming overall. The process to produce an overview for the CPE team of which national or pilot programmes are implemented in each state was labour-intensive because systems to do so were not in place. Due to the lack of state-level plans, the strategic reasoning behind the presence or absence of a national programme or attention to a CP-8 output in each state was not evident.

The political, economic and socio-cultural context of each state is unique, with much autonomy in the health and education systems, so the lack of state-level strategic plans and objectives poses a threat to relevance. Relevance concerns were evident in the CPE visit to Bihar, a state with the highest level of need on several ICPD indicators. A long lapse in staffing the office led to UNFPA's loss of presence and leadership, and several missed opportunities to contribute to CP-8 results.

Finally, inefficiencies were reported in the approval process for state-level activities [EQ#8]. A key requirement for relevance in the policy/advocacy "orange country" mode of engagement is that UNFPA must be able to respond agilely to dynamic policy environments at national and state levels. Relevance is threatened when there are administrative barriers to seizing windows of opportunity, or to responding to threats. Defining state-specific medium-term objectives along with strategies in CP-9 should facilitate the approval for unplanned activity if it clearly contributes to these objectives.

➢ **Origin: EQ#5 and #8**

Recommendation #1

Develop state-level strategic plans as part of planning for CP-9

Sound state-level strategic planning would analyse the context, and develop a result framework and strategies based on the most promising opportunities to contribute to UNFPA outcomes and related state priorities; this should increase the relevance and effectiveness of UNFPA in CP-9. When policies and programmes are designed at the national level, a process of roll-out to states begins, often with the requirement for advocacy for state buy-in. With state-level strategic plans, a more bottom-up process could test an initiative or strategy in the state, which if successful, could have a positive influence in other states, or on national policies and programmes. Examples of impact from both top-down and bottom-up approaches are described in this report.

  ➢ **Priority: HIGH**

Operational implications:

- The profile of state programme staff should be suitable to lead or conduct situation analyses, engage in strategic planning, and conduct advocacy and policy dialogue in the state. For this reason, they should have adequate induction training in all UNFPA's major programme areas, to enable them to highlight these strengths to partners and detect needs in these areas.

- Two programme staff per state office can only guide and accompany a certain number of initiatives well. Furthermore, the main areas of expertise of the two state office staff will not always match the requirements of initiatives identified as high priority in a state strategic plan. The strategic plan must include the required human and financial resources to respond to these opportunities for high-level results in each state. In particular, population dynamics (PD) expertise is under-represented in the state offices; PD experts would help the programmes engage in vulnerability mapping. Recommendation #5 for the creation of UNFPA learning hubs should facilitate state strategic plans.

  o Bihar: Findings on UNFPA comparative advantage in Bihar led to a recommendation that two expert consultants be attached or implementing partners be identified to work closely with the state office in family planning (FP), and in PD to conduct sub-district analysis of vulnerable populations and sex ratios at birth as well as sex ratios in under-5 child mortality.

Conclusion #2

Multi-faceted initiatives on specific ICPD-related issues that employed the full range of UNFPA's expertise, and were continued over two to three country programmes achieved the highest sustainable outcomes.

The CPE used a case study approach to identify the main characteristics of initiatives that had demonstrably high impact, using CP-6–8 initiatives on gender biased sex selection (GBSS) as an emblematic example, but also examining initiatives in adolescent and youth (A/Y) and reproductive health and family planning (RH/FP). The theory of change (TOC) described under EQ#6 is based on examination of these experiences, which illustrate systemic, continuous and comprehensive approaches. The programme design principles to maximize the potential for impact that emerged from case study analysis include the following:

- **Continuity:** A key finding of the CPE is that continuity in long-term relationships with government institutions is a major comparative advantage of UNFPA. (E#10) The most significant UNFPA contributions, progressing from initial research and advocacy on an emerging issue to full national ownership in addressing the issue,

have been made possible by sustained investments over a 10- to 15-year time span. The loss of policy/advocacy leadership in FP and the lack of follow-up to capacity development in the use of district/sub-level data for planning in CP-7, were the most mentioned negative examples of how leadership, strategic focus, and the potential impact of previous CP investments are lost when programmes are discontinued prematurely, or when there are significant lapses in hiring key programme staff.

- **Comprehensive systemic approaches:** Non-siloed approaches in focused initiatives that deploy all UNFPA's technical strengths and employ all "orange country" modes of engagement to address systemic barriers to progress have been the most effective and sustainable.
- **Sustainable managerial and technical systems:** Findings on sustainability revealed the key role of these systems in ensuring that the initial investments in major initiatives have lasting results. Without these systems, quality degrades, implementation may become sporadic, and programmes or systems risk termination. The main examples of UNFPA contributions to such systems are from the RH/FP and PD thematic areas.

The theory of change in community pilot programmes emerged from CPE findings (EQ#6), and a bottom-up feedback loop is described that illustrates the key role of evaluation so that investments in these programmes result in improvement in policies and programmes. Two positive examples from GBSS in Maharashtra and Life Skills Education in Odisha demonstrate progression from the pilot phase to government ownership. Analysis of some pilot A/Y programmes gave rise to concerns on sustainability and adequacy of evaluation. The findings on the A/Y programme lead to the conclusion that testing pilot interventions under the umbrella of large government programmes and using existing infrastructure and personnel facilitates sustainability.

Employing the full range of UNFPA's thematic expertise emerged as a principle through examining successes in initiatives that did so, as well as consequences of weak thematic mainstreaming. The history of the GBSS initiative over three country programmes illustrates how breaking out of thematic silos creates a whole that is greater than the sum of the parts. The GBSS initiative shows consistent, effective use of PD data for advocacy, policy dialogue, and strategic communications to raise awareness of the issue with a variety of audiences. The issue was mainstreamed within A/Y programming, and RH expertise was used to safeguard reproductive rights in the guidelines for the implementation of the PCPNDT Act. Finally, the initiative has used networks of partners and experts across thematic areas to employ all modes of engagement -- including experimental pilot strategies -- to address the drivers of son preference.

Progress on gender mainstreaming is mixed, especially in the RH/FP and PD areas and at the state level. Gender mainstreaming is at a high level in A/Y programme design and most curricula, but seems to be receiving varying emphasis across states. Except for building health systems response for survivors of sexual violence, attention to gender-based violence (GBV) in CP8 has been minimal, failing to build on promising initiatives from CP7. Since GBV is highly relevant to all ICPD issues as a key barrier to women's and girls' empowerment and their sexual and reproductive health, results in CP-9 would be enhanced by strengthening work on GBV across all settings (research, medical education, health sector and work place). PD expertise could play an important role in generating evidence on prevalence of and factors behind all forms of GBV in India.

CP-8 lost leadership and focus on the SRH bull's eye in the UNFPA strategic direction due to lack of investment in staffing and lack of mainstreaming SRH issues. These findings are discussed mainly in EQ#2 on the RH/FP

programme, but the focus on SRH in other thematic areas was also weak. The work on GBSS protected reproductive rights in guidelines and advocacy, but major gender programmes such as BBBP have little SRH focus. Due to strong political and cultural barriers, the SRH focus in most A/Y programmes was minimal. The PD programme lost significant opportunities to contribute to improved maternal health data, although some UNFPA partner institutions have strong expertise in this area.

> **Origin: EQ#1-4, EQ#6,**

Recommendation #2

Develop or continue focused initiatives according to principles that maximize the long-term impact of UNFPA programmes, including cross-thematic approaches and improved mainstreaming of gender and the UNFPA SRH "bull's eye" in all thematic areas.

On any emerging issue, to ensure that the initiatives follow the TOC principles that maximize long term impact, the investment required would be substantive. Therefore, too many initiatives cannot be pursued at the same time. The TOC principles point to the importance of planning for a 10–15-year period when taking up any new initiative, and/or deciding whether to continue current ones that are relatively new, especially when initial capacity to address an issue is low. In a reduced budget scenario, such plans might entail discontinuing less effective strategies to focus on the most promising ones. Even when planning for the long-term, identifying the benchmarks for an exit strategy is important, concluding with the final phase of developing sustainable management and technical capacity.

The theory of change does not mean that UNFPA always has to start from zero. In UNFPA thematic areas that are more mature, with more national investment and systems in place, such as midwifery, there are opportunities for significant contributions to outcomes by focusing on improvements or innovations within sustainable systems. In these cases, the principles of comprehensive cross-thematic approaches, and continuity until institutionalization is achieved would still apply, but the initiatives could have more limited objectives and shorter planning time frames.

The CPE identified UNFPA's comparative advantage in programmes to empower adolescent girls, with a recently increased focus on reduction in the incidence of child marriage. CP-8 adolescent girls' projects illustrate the benefits of cross-thematic approaches. However, the high interest of current and new development partners in adolescent girls has created a "crowded field". Given this scenario, a convening role along with government ministries and UNICEF might open the best opportunity to add value, with the Commitment to End Child Marriage in Rajasthan as an incipient example in CP-8.

Efforts to strengthen gender mainstreaming should focus especially on quality assurance systems in RH/FP programmes, follow-up on research and policy dialogue on the two-child norm in Odisha, and in PD programmes on ageing, urbanization and smart cities. Mainstreaming a focus on issues of gender-based violence (GBV) is recommended for all thematic areas; it is a key driver of gender inequalities and inequities, and a barrier to achievement of SRH and A/Y outcomes. Programmes addressing GBV could focus both on prevention in communities amongst both males and females, and on integrated health and justice systems serving women and girls who are experiencing GBV. PD has an important role to play in generating data to inform GBV policies and programmes.

➤ **Priority: HIGH**

Operational implications:

- Country/state office Cross-thematic Working Groups would be needed on major initiatives to coordinate efforts.

- Initiatives to empower adolescent girls and improve their SRH (including but not limited to a focus on child marriage) should integrate all UNFPA expertise, and build on opportunities for convergence in the Government of India and UN agencies.

- In planning for CP-9, the four components of sustainability need to be analysed in major programme initiatives to maximize the chances of achieving institutionalization and sustained results. This could be one criterion for setting priorities.

- Consideration should be given on efficient means to track cross-thematic strategies in general, and progress in mainstreaming SRH issues.

- Capacity to track the level of gender mainstreaming is only partially operational in UNFPA M&E systems. The CPE team suggested adjustments to current guidance on gender scoring criteria, and scores should be added to standard programme MIS reports.

Conclusion #3

UNFPA's greatest asset and source of added value is its ability to mobilize high quality technical assistance (TA) and expertise for national priorities

Analysis of the data on comparative advantage and on the value added of UNFPA's TA yielded this clear conclusion. UNFPA's comparative advantage in all thematic areas depends on its ability to respond to national and state needs (especially those of government partners) for high quality research and evidence to guide policies and programmes, TA and capacity-building, whether on a specific topic or within a programme. When UNFPA staff, implementing partners, and/or TA consultants with proven high-level expertise were chosen, the results were often outstanding. Judicious use of TA funds has been an essential CP strategy to mobilize expertise in a timely and efficient fashion for national priorities.

Findings show that the value that UNFPA adds to the achievement of national priorities depends on the ability to mobilize the required expertise, first that of its management and programme staff, and then, that of UNFPA's networks of trusted experts and partners in the thematic areas. Lapses in hiring key staff were a major factor in loss of leadership and effectiveness. Hiring consultants who were not fully qualified led to lower results in the FP thematic area.

➤ **Origin: EQ#1-4, #8 & #10**

Recommendation #3

Strengthen all human resource functions that improve UNFPA's ability to mobilize high quality expertise

These functions include hiring and professional development of country and state office programme staff, and consultant vetting and supervision. Findings show that timeliness in hiring country office and state office staff (especially those in lead programme roles) is especially important.

  ➢ **Priority: HIGH**

Operational implications:

- Consider whether and how staffing and hiring structures might need to adjust to strengthen these functions.

Conclusion #4

Addressing two gaps in UNFPA monitoring and evaluation (M&E) systems would enhance effectiveness, relevance, efficiency and sustainability.

The two gaps noted are the following:
1. The need for more investment in process evaluation (including implementation research) in some pilot programmes, and in new government programmes that are rolling out at scale to the states.
2. The lack of programmatic MIS on the use of technical assistance budgets, which reduced the evaluability of CP-8, especially in the case of knowledge management activities.

Process evaluation (which includes implementation research) is a crucial component of the intervention logic for pilot or innovative programmes, so that they serve the purpose of testing a model to see if it is effective [See EQ#6]. The learning from testing can be used at higher levels for policy and programme design. Evidence on initial results of two pilot programmes helped to consolidate government commitment to the programmes in CP-8. However, some pilots in CP-8 have inadequate investment in evaluation to fulfil this purpose. In addition, large national programmes such as the *Rashtriya Kishore Swasthya Karyakram* (RKSK), Adolescent Education Programme (AEP),[77] and *Beti Bachao Beti Padhao* (BBBP) are being rolled out at scale at a state or district level without adequate testing of the intervention models to determine the most efficient and effective ways to implement them. In particular, there is enormous variation and experimentation under the BBBP umbrella. RKSK is being implemented at scale in four states, with one of the states intended to be a learning laboratory for the other states. Strengthened evaluation of these initial phases of the programme, and exchanges to learn from these tests, is needed to identify and then disseminate effective strategies that address the specific challenges posed in each of these national programmes.

As pointed out in Conclusion #3, high quality TA expertise is a major source of added value and comparative advantage for UNFPA, and therefore, the TA budget is a key enabler of results for both country and state office teams. These funds are an invaluable strategic resource because they provide the CP with the capacity to adapt to changing political environments, to respond to requests from government partners, and to complement the activities of implementing partners. The CPE noted numerous examples in which TA activities increased the relevance, effectiveness, and efficiency of CP strategies. However, although the use of the TA funds is adequately tracked financially, programmatic tracking is piecemeal, making it impossible for the CPE team to evaluate systematically the effectiveness and efficiency in use of these funds. Through focused data collection, the CPE

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[77] Although AEP is more mature and has some evaluation evidence, the role and effectiveness of certain innovations such as the Question Box will remain unknown without further study.

team was to reach conclusions about certain TA components, such as the use of consultants, and high-profile meetings or publications.

> **Origin: EQ#1-4, #6 & #10**

Recommendation #4

Strengthen M&E systems through increased investment in process evaluation and improved programmatic tracking of technical assistance activities.

Strengthened evaluation in national programmes and pilots would maximize the value of CP investments. Evaluation evidence on effective implementation strategies ensure that capacity building materials and tools for roll-out to new areas reflect the best evidence on how to implement the programmes, and evidence on initial results helps to consolidate support for a promising programme model.

TA activities should be more fully integrated into the country office M&E systems so that they are clearly linked to outputs and orange country modes of engagement, and so that results can be tracked. In the short term, the lack of an overview of the effectiveness of TA activities should be addressed in preparation for CP-9 planning, and subsequently established as a sustainable system within the existing M&E tracking systems. Given decreases in core UNFPA funding, CP-9 planners must understand which types of TA expenditures were effective and should be continued, and which could be decreased without significant loss of added value. The CPE findings only partially address this need. The permanent solution to remedying these concerns should a) be efficient; b) not compromise the ability of programme officers, especially in state offices, to use TA budgets to implement multi-faceted strategies and respond agilely to the opportunities to add value in the national or state environment.

> **Priority: HIGH**

Operational implications:

- Consider whether a full-time M&E staff person with expertise in both quantitative and qualitative methods and experience in process evaluation is needed to meet this recommendation. Complementary actions include developing a network of qualified evaluation consultants to meet specific needs, and including M&E costs in implementing partner budgets as needed.
- Re-design of the existing M&E databases to integrate TA activities may take some time. An exercise to evaluate the results from CP-8 TA activities might be needed to plan use of TA funds in CP-9.

Conclusion #5

Effective strategies and technical expertise developed in one state have maximum impact when also used for capacity-building in other states and at national level.

Great potential exists to employ South–South (S–S) strategies within India by taking advantage of the vast pool of expertise within the country. GBSS, reproductive health commodity security (RHCS), and A/Y programme experiences illustrate the potential for cost-effective S–S strategies within India that share learning and capacity-building resources in one or more states. For example, technical expertise in GBSS in Maharashtra -- acquired over several years of programming -- was employed effectively to build capacity in other UNFPA states and beyond. Stakeholders at all levels identified the need for cross-state learning on effective programme strategies, modes of implementation, and tested educational and training tools. Cross-state learning would be particularly

valuable for the large multi-state programmes in A/Y and gender, where there are variations in the strategy within each state and between states such as BBBP, RKSK, Action for Adolescent Girls (AAG), and AEP.

➢ **Origin: EQ#8 and #10**

Recommendation #5
Increase investment in learning exchanges among states in the priority initiatives.

Technical skills, subject area expertise, and close partnerships with governments and leading NGOs constitute UNFPA's most important assets.   Building on these assets, UNFPA is positioned to create "learning hubs" and communities of practice coordinated by different UNFPA offices to address the S–S learning needs and opportunities within India.   The "learning hubs" option would build on specific strengths and areas of expertise in the country office and state offices, and promote cross-state and national/state capacity-building, learning exchanges and communities of practice. As a knowledge management strategy, the main outcomes of such hubs would be increased use of learning and evidence from experience, leading to improved effectiveness overall of the UNFPA-supported programmes.   Other outcomes could include improved visibility and legitimacy for UNFPA and main partners as thought leaders on a particular topic (facilitating policy/advocacy); and greater dissemination and discussion of effective strategies and tools (capacity-building). In the long run, the learning hubs could facilitate resource mobilization by providing expert advice and skills, and open up opportunities for S–S cooperation with other countries.

The recommendation is that the learning hubs be considered seriously in the planning for CP-9, and that whatever form they take, operational structures and consultant hiring plans be adapted so that the learning hub coordinators have a manageable workload.

➢ **Priority: MEDIUM**

5.2 Programmatic conclusions and recommendations in thematic areas

Adolescents and Youth

Conclusion #6
Programming for A/Y is a major comparative strength of UNFPA, and UNFPA has made significant contributions to design and implementation of large national and state adolescent health and life-skills programmes.

Programming for A/Y is a major comparative strength of UNFPA, and it is especially strategic to build on the CP-8 accomplishments in schools (AEP), in RKSK, and in the Youth Policy in Odisha. These contributions were made possible through close partnerships with government counterparts and with experienced national or state-level NGOs, led by expert cluster members and state programme officers who engaged and worked closely with highly qualified consultants. UNFPA's TA in A/Y programming—whether through staff, consultants, or implementing partners—is highly valued by government officials for its multi-faceted nature, with staff, consultants, and partners engaging as needed in policy dialogue, programme design, and planning and coordination for implementation at the state level.

Most of the community-based pilot programmes to reach the most vulnerable adolescent girls are promising, but it is too early to evaluate results. Both pilot programmes and the three major programmes are evidence-based in their design, and take a holistic approach to young people's health and development, with the caveat that some strategies such as peer education and youth-friendly health services models would need to address concerns on these models arising from international evidence.

Empowerment of adolescent girls: The thematic assessment, the Internal Strategic Review (ISR), and the findings of the CPE all identified a high level of gender mainstreaming and promotion of positive changes in gender norms in these programmes. Furthermore, empowerment of adolescent girls is one of the primary objectives of UNFPA's work under the umbrella of the government's BBBP scheme. Elimination of thematic silos in programming to empower adolescent girls could be enhanced by the expertise in the RH/FP and PD areas.

A major opportunity for alignment and innovation: The Ministry of Human Resources Development (MOHRD) and MOHFW place high priority on the use of ICT for capacity development systems, giving young people (students or peer educators) as well as adults (teachers, counsellors, health providers, etc.) access to standardized and high quality content through virtual channels. The use of smart phones, social media platforms, and ICT in general is predicted to expand in the future to ever broader segments of the population; although at present adolescent girls in particular do not have good access, especially in rural areas. MOHRD views these platforms as a promising strategy for delivering life skills, gender and SRH content – and possibly counselling -- to young people.

Sustainability is a major concern. Clinic- and peer education-based adolescent-friendly SRH (ASRH) strategies need adequate investment in personnel and training/mentoring systems to be effective, but these systems are not always in place when states assume ownership of these programmes.   Both clinic-based counsellors (whether in RKSK or in mental health pilots) and peer educators demand substantial initial investment in training, supervision, and mentoring systems, and then continuing investment at a lower level for two reasons: 1) the sensitive socio-cultural barriers related to gender and SRH, and 2) inevitable turnover, especially in the case of peer educators.

CPE evidence suggests that when pilot community-based programmes rely on additional personnel rather than building capacity in existing human resources in government programmes, the pilots are less likely to be scaled-up in their current form. The addition of nationally-funded counsellor positions in any youth programme, especially RKSK, raises concerns in state governments about assuming the costs of these positions in the future, since national funding tends to phase out, as in the case of the SABLA programme started under the previous government.

Other concerns to be addressed included: 1) difficulties in reaching married girls, one of the most vulnerable groups in the A/Y population, as well as challenges in reaching early school dropouts; 2) the limited SRH content in training and education curricula; 3) the need for more investment in process evaluation (discussed in previous conclusion); and 4) weak initial results from mental health pilot programmes.

  ➢ **Origin: EQ#1**

Recommendation #6

Build on the strengths and achievements of the adolescent and youth area through planning for sustainability, process evaluations, cross-thematic approaches, and experiments with use of interactive ICT platforms to increase young people's access to SRH information and counseling.

The following options to strengthen the programme by building on strengths and addressing concerns should be considered in planning for CP-9:

- Empower adolescent girls by addressing issues of child marriage, GBV & SRH through a cross-thematic initiative that draws on all of UNFPA's technical strengths and leadership advantages.
  - o Identify opportunities to play a convening role with UN and government partners in a convergence strategy, given the high interest of other development partners.
  - o Strengthen focus on adolescent girls in other major PD & RH CP-9 initiatives once they are decided.
- Learn from innovative strategies to reach married girls. Analyse more closely the experience in the Barwani project to reach married girls, and consider additional experimentation with this or similar strategies under the RKSK programme.
- Experiment with strategies to increase the SRH focus in school-based and community programmes: Experiment with interactive ICT platforms, long-distance learning and training modules with expanded SRH content, and participatory components of AEP that enable individualized questions and answers. Expand outreach to families and community leaders on SRH issues to reduce cultural and political barriers to this focus. Other opportunities include testing of other possible service models, such as public–private partnerships and social franchising.
- GBV: Assess whether there is a need and opportunity to make a significant contribution to the integration of GBV prevention and care as a component of empowerment of adolescent girls, as well as in the other major A/Y programmes.
- Sustainability: Focus on design and roll-out of sustainable training and mentoring systems at state, district and sub-district level. If they could be sustainable, one option for national and S–S capacity building would be establishment of training centres in adolescent life skills, SRH and youth leadership.
- Reaching other vulnerable and marginalized young people: Experiment with ways to reach other underserved groups of young people, including youth in urban slums if CP-9 focuses on urban initiatives, and early school leavers in community or workplace programmes.
- Mental health pilot programmes: Consider ending this strategy. Weak initial results suggest the need to rethink how to address mental health issues.

  ➢ **Priority: HIGH**

Reproductive Health and Family Planning

Conclusion: #7

Although there are achievements in RH/FP, the limited scope of support 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

Reproductive Maternal Newborn Child and Adolescent Health (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. The web-based RH Commodity Logistics Management Information System (RHC LMIS) in Odisha led to fewer stock-outs and is being considered for replication, and protocols were developed for the health sector response to sexual violence. The institutionalization of efforts to mainstream SRH in disaster preparedness and response has been moderately successful.

Key strategic gaps result partly from lengthy staffing gaps for RH/FP during CP-8. These gaps include:

1) lack of support for strengthening maternal health and midwifery programmes in four focus states with high levels of maternal mortality; 2) failure to advocate for inclusion of FP as a central element of the country's Universal Health Care (UHC) initiatives; and 3) insufficient advocacy to promote the reproductive rights principles of ICPD in the national FP programme through the FP2020 mechanism; UNFPA is recognized as a lead agency globally and in India, and is co-chair of the FP 2020 Country Coordination Mechanism (CCM). However, its support for FP for the achievement of the country's FP 2020 vision and quality principles has been less than optimal, particularly in integrating a strong rights-based ICPD framework. UNFPA has not sustained past successes in advocacy for the implementation of rights-based family planning. It has also been unable to provide evidence on the negative implications of the current strategies at state levels that focus on provider/institutional targets and incentives for long-acting FP methods and sterilization.

> **Origin: EQ#2**

Recommendation #7

Regain UNFPA's leadership in FP with a renewed focus on reproductive rights, and strengthen maternal health programmes with a focus on midwifery capacities.

Given India's recommitment to the ICPD Plan of Action, its population policy and its own articulation of FP as a basic human right, UNFPA should build on its credibility to help the MOHFW reorient the implementation of the FP 2020 action plans within the framework of reproductive rights. This framework would strengthen the emphasis on voluntary and informed choice, and focus on addressing unmet needs for services, supplies and information. Such support will contribute to the achievement of India's twin goal of FP 2020—meet the unfulfilled needs of 48 million people and sustain support for 100 million, build on the FP 2020 vision and contribute to the development of a strategy to reduce the unmet needs, moving from the rhetoric of reproductive rights to practical implementation, with due regard for voluntary and informed choice.

To achieve the above, UNFPA should advocate with and support MOHFW to refocus the FP programme, and inclusion of FP as a central component of Universal Health Coverage (UHC). Possible strategies to promote rights-based approaches to FP could generate or share evidence on critical issues in programme quality, such as the fallacy and risks of promoting numerical targets along with provider incentives, the higher long-term effectiveness of providing a full basket of methods with full voluntary informed choice and building capacity in small-area data analysis to strengthen availability and quality in geographical areas where need is greatest.

Considering India's high rate of maternal mortality and the country's commitment to Sustainable Development Goals (SDGs) and the "Every Woman, Every Child" initiative of the Secretary-General of the United Nations (UNSG), UNFPA, building on its comparative advantage of global leadership in midwifery, has an opportunity to provide a high level of TA to the Indian Nursing Council (INC) for the implementation of a robust midwifery framework. This should include standards of education, supervision, practice, etc. which will help to strengthen human resources for maternal healthcare. The development of such a plan will require support for an analysis of the existing human resources, gaps in production and utilization, and future needs. Innovative ways of meeting the needs for advanced skills in emergency obstetric care are also needed. To monitor the impact of the interventions, the provision of support for strengthening systems to ensure completeness and coverage of maternal mortality and morbidity data will be of critical importance.

> **Priority: HIGH**

GBSS and Gender Mainstreaming

Conclusion #8

UNFPA contributions to GBSS initiatives have been effective and significant, and are now in a phase of experimentation, with initial steps to develop sustainable capacity development systems.

GBSS initiatives in UNFPA and in India recognize that it is imperative to address the structural and cultural drivers of this harmful practice, and thus to address gender inequality more broadly, yet in a focused way. UNFPA has achieved its most significant results when working in close partnership with government programmes. In the case of GBSS, the BBBP umbrella can be effectively used by evaluating variations in implementing the programme, to identify and then showcase effective practices in work with girls, schools, women elected representatives, panchayats, young men and boys, that reduce son preference. These initiatives must be carefully studied for drawing important lessons on community dynamics, pathways to strengthen community mobilizers on behalf of girls, building sustainable support structures and a new cultural social capital that nurtures gender equity.

UNFPA made major contributions to design and initial implementation of systems to build capacity in the health system to implement the PCPNDT Act. Drawing on lessons from these experiences, developing sustainable technical and management systems was noted as a need, and the next step.

> **Origin: EQ#3**

Recommendation #8

Continue to give priority to GBSS Initiatives

UNFPA should stay on course with the current initiatives on GBSS in partnership with major government programmes. Continuing the GBSS initiatives in CP-9 offers an opportunity to build on the strong successes to produce sustainable results in reducing son preference, with input from all thematic areas of expertise, and employing all orange-country modes of engagement.

Recognizing that campaigns and schemes to address drivers of GBSS are experiments that pose learning opportunities, strong process evaluations would enable UNFPA and partners to identify the most effective strategies to address structural and behavioural drivers of son preference. In addition, sustainable training and

supervision systems in MOHFW to implement PCPNDT Act still need to be put in place, with planning and benchmarks for gradual withdrawal of UNFPA support.

Population Dynamics

Conclusion #9

The PD programme made strong contributions to progress on GBSS, ageing, and social inclusion in Odisha, but overall underinvestment led to mixed results and missed opportunities for enhancing results across all themes in CP-8, especially in the planned focus on social inclusion.

CP-8 has made strong contributions in GBSS, but several key gender issues were not focused on. The lack of follow-up of CP-7 training on use of census and other demographic data for sub-district analysis was a lost opportunity to build national capacity to promote social inclusion and to improve allocation of resources to the most vulnerable populations.

UNFPA has a strong comparative advantage and leadership role in the work on ageing. Partnerships with the Ministry of Social Justice and Empowerment (MSJ&E) and other UN and development have strong potential to build national capacity to benefit the ageing population.

The plan to work with the Census Commissioner to establish a South-South training centre is stalled, but strategies to overcome barriers were identified. The Centre would have potential benefits to India as well as countries seeking census expertise.

➢ **Origin: EQ#4**

Recommendation #9

Deploy PD expertise in all programmes to strengthen promotion of social inclusion and provide population analysis for policy and programme design.

It is recommended to strengthen the focus on social inclusion by reviving the CP-7 initiatives to build capacity in vulnerability mapping and district/sub-district data analysis. Such initiatives would build the capacity of top bureaucracy in the states and key district and municipal officers, especially those in charge of planning for vulnerable population groups, in the use of census and other demographic data for small area planning. Two opportunities were identified to build capacity among government officials in these decentralized planning skills.

These decentralized planning capacities are equally relevant to all UNFPA initiatives, including: 1) the Smart Cities Mission, especially for the vulnerable population groups such as migrants and slum dwellers; 2) programmes to empower adolescent girls, and especially to reach girls in child marriage; 3) identifying FP/RH needs and gender discrimination among the most marginalized and vulnerable population groups, such as SC/ST, where these populations are concentrated in small areas.

It is recommended to consolidate the work on ageing through the release of the *Longitudinal Ageing Study in India* (LASI) and *India Ageing* Reports. Based on this new evidence—while building on existing evidence and analysis from the UNFPA initiative on Building Knowledge Base on Population Ageing in India (BKPAI)—continue to work

through the MSJ&E for advocacy and policy formulation, especially to nurture the revival of the National Institute of Social Defence (NISD).

As a medium priority, the CPE recommends engagement with the Census Commissioner to establish and operationalize the planned Census Resource Training Centre (CRTC) as a South-South collaboration. UNFPA could rework its strategy of engaging with the new incumbent Census Commissioner and Registrar General of India (CCI/RGI) in establishing the CRTC. The new CCI expects UNFPA to assist in strengthening of the civil registration system and its linkage with the National Population Register (NPR). UNFPA may wish to and respond to this need and in the bargain establish the CRTC with the assistance of CCI.

> **Priority: HIGH**