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Evaluation Report
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UNFPA India Country Programme-7

2011

Evaluation conducted for
UNFPA Country Office, India
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List of Abbreviations

AA  Appropriate Authority
ACC  Apex Coordination Committee
AEP  Adolescence Education Programme
AGCA  Advisory Group on Community Action
AHD  Adolescent Health and Development Project
AIDS  Acquired Immune Deficiency Syndrome
ANM  Auxiliary Nurse Midwife
APRO  Asia Pacific Regional Office (UNFPA)
ARSH  Adolescent Reproductive and Sexual Health
ASHA  Accredited Social Health Activists
ATI  Apex Training Institute
AWP  Annual Work Plans
AWW  Anganwadi Worker
BEmOC  Basic Emergency Obstetric Care
CBOs  Community Based Organizations
CBSE  Central Board of Secondary Education
CEDPA  Centre for Development and Population Activities
CEmOC  Comprehensive Emergency Obstetric Care
CHC  Community Health Centre
CHSJ  Center for Health and Social Justice
COBSE  Council of Boards of Secondary Education
CP  Country Programme
CPAP  Country Programme Action Plan
CSR  Child Sex Ratio
DFID  Department for International Development
DLHS  District Level Household Survey
DP  Development Partners
DPIP  District Project Implementation Plan
DWCD  Department of Women and Child Development
EAG  Empowered Action Group
EmOC  Emergency Obstetric Care
FP  Family Planning
FRU  First Referral Unit
FSW  Female Sex Worker
GBV  Gender Based Violence
GMTF  Gender Master Trainer Facilitators
GOB  Government of Bihar
GOI  Government of India
GOMP  Government of Madhya Pradesh
GOM  Government of Maharashtra
HIV/AIDS  Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HMIS  Health Management Information System
ICPD PoA  International Conference on Population and Development Programme of Action
IHMP  Institute of Health Management Pachod
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<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>PHC</td>
<td>Primary Health Centre</td>
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<td>PHI</td>
<td>Public Health Institute</td>
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<td>PIL</td>
<td>Public Interest Litigation</td>
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<td>PIP</td>
<td>Project Implementation Plan</td>
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<td>PNDT</td>
<td>Pre-natal Diagnostic Technique</td>
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<td>PPP</td>
<td>Public Private Partnership</td>
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<td>PRI</td>
<td>Panchayati Raj Institutions</td>
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<td>PVC</td>
<td>Price Waterhouse Cooper</td>
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<td>QA</td>
<td>Quality Assurance</td>
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<td>RCH</td>
<td>Reproductive and Child Health</td>
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<td>RGNIYD</td>
<td>Rajiv Gandhi National Institute of Youth Development</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>RKS</td>
<td>Rogi Kalyan Samiti</td>
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<td>RRE</td>
<td>Red Ribbon Express</td>
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<td>RSACS</td>
<td>Rajasthan State AIDS Control Society</td>
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<td>RTI/STI</td>
<td>Reproductive Tract Infections/Sexually Transmitted Infections</td>
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<td>SCERT</td>
<td>State Council of Educational Research and Training</td>
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<td>SRB</td>
<td>Sex Ratio at Birth</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>SWAp</td>
<td>Sector Wide Approach</td>
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<td>TA</td>
<td>Technical Assistance</td>
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<td>TCG</td>
<td>Thematic Core Group</td>
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<td>THP</td>
<td>The Hunger Project</td>
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<td>TSU</td>
<td>Technical Support Unit</td>
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<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<td>UNDMT</td>
<td>United Nations Disaster Management Team</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>UNFPA</td>
<td>United Nation Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UP</td>
<td>Uttar Pradesh</td>
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<td>USG</td>
<td>Ultra Sonography</td>
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<td>VHSC</td>
<td>Village Health and Sanitation Committee</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WPC</td>
<td>Women Power Connect</td>
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<td>YFHS</td>
<td>Youth Friendly Health Services</td>
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Executive Summary

Part A: Introductory

Section I: Introduction

UNFPA’s Country Programme 7 (CP-7) defines the goals, outcomes and strategies that the Government of India (GOI) and UNFPA will jointly use to reach national goals in health and population, the Programme of Action of the International Conference on Population and Development (ICPD) and the Millennium Development Goals (MDGs).

The National Rural Health Mission (NRHM), launched in 2005, focuses on 18 Indian states with weak health infrastructure and poor health outcomes. The Reproductive and Child Health Project (RCH) II is incorporated into NRHM. Large financial resources have been devoted by the GOI to RCH, to improve access to quality health services, particularly for the poor and marginalized and to achieve reduced maternal and infant death and total fertility. Development assistance forms a mere 8% of the resources provided for RCH-II. However, government values the flexible technical assistance (TA) and programme implementation support of development assistance partners—particularly assistance that demonstrates how implementation can be made stronger and more effective at the state and district level in geographic areas that are lagging behind.

Responding to the great regional imbalances in India and the over 300 million that live in poverty despite India’s middle income status, development partners have focused assistance on districts and states where development lags behind.

UNFPA has provided sector wide support to the RCH-II project by pooling 28% of its CP 7 budget with funds of the GOI and other donors—UNFPA’s contribution works out to 0.48% of all funds dedicated to RCH-II. UNFPA also provides technical support for the programme. In the states of Maharashtra, Madhya Pradesh (MP), Rajasthan, Orissa and Bihar, where it has a presence, UNFPA provides policy and programme support to the state governments. In these states it also supports the implementation of a variety of pilots to assess their feasibility for replication and scale-up.

Overall, UNFPA development assistance to India is meant to achieve reduced regional disparities, social inclusion, gender equity, increased participation of women in local government, reduced gender based violence and discrimination against the girl child, a successful demographic transition with attention to emerging demographic issues, reduced maternal mortality and reduced transmission of the human immune-deficiency virus (HIV).
CP 7 has three broad components:

1. **Reproductive health (RH):** Where the outcomes desired are a reduction in maternal mortality, reduction in unmet need for contraception, reduction in adolescent fertility, and reduction in adult HIV prevalence.

2. **Gender:** This component seeks to mainstream gender in UNFPA’s RH programmes; advocate and act against gender based violence (GBV) and empower women. Moreover it seeks to reduce sex selection. The outcome desired is a reduced skew in the child sex ratio.

3. **Population and Development Strategy (PDS):** This component seeks to foster systematic use of data on population dynamics and trends to guide increased investments in decentralized development planning.

**Section II: Evaluation Scope, Purpose, Objectives, Key Questions**

UNFPA commissioned this evaluation to elicit achievements made in each of the programme components, understand effectiveness of mainstreaming cross-cutting themes such as gender and advocacy in programming, and examine lessons learned for incorporation into CP 8. The evaluation involved a desk review of key documents, field visits, and meetings with UNFPA staff, government and non-government counterparts at both national and state levels, development assistance partners and other UN agencies. A special consultative meeting on gender was also held in Delhi with UNFPA staff. The evaluation was not designed to include meetings with a representative cross section of final beneficiaries. Data has been gathered from meetings with these stakeholders. The evaluation has looked at inputs, processes and outputs that are visible at this time (CP-7 ends only in 2012). Data from surveys which will provide values of performance indicators as of the end of CP-7 are awaited. However, intermediate values of two indicators have been extracted from other sources. The evaluation team has assessed how UNFPA’s work serves needs in the country, fills gaps in RCH- II programme implementation, and what potential the various initiatives have for scale-up and sustainability. Challenges the programmes have encountered are also discussed, and suggestions made for strengthening. The report explains the challenges to measuring performance against the indicators given in the Results and Resource Framework of CP-7. The evaluation has been conducted in accordance with UNFPA evaluation guidelines- including ethical guidelines.
Part B: Programme Assessment – Findings, conclusions & recommendations

The evaluation report has looked at the many initiatives that make up CP 7- reproductive health including gender based violence and HIV/AIDS, adolescent sexual and reproductive health, sex selection, and population and development strategy. Though adolescent reproductive and sexual health is a part of the reproductive health component, because of the scope of this initiative, this report has discussed it in a separate section. The report also addresses issues of program geography, partnership strategies, and operational modalities.

Section III: Reproductive health component – excluding adolescents

CP-7 shares 4 indicators with RCH-II and the National AIDS Control Program (NACP) III: reduce total fertility rate, infant mortality rate, maternal mortality ratio, and adult HIV prevalence. UNFPA’s 5 states are home to 42% of India’s poor and four of them are amongst the 6 most backward states of the country. This ensures that UNFPA’s work addresses those who are most vulnerable.

UNFPA’s significant contributions towards achieving RCH II and NACP III goals are characterized by TA and capacity building support, quality assurance programmes, communitization of NRHM, gender mainstreaming efforts including efforts to reduce gender based violence, RH related advocacy, and promotion of safe sex behaviours among most vulnerable populations- female sex-workers and women. In addition, CP-7 envisioned mainstreaming RH and gender issues in recovery and rehabilitation responses for natural disasters and environmental challenges.

In CP-7, UNFPA has provided wide ranging **TA and capacity building support** to the National and State governments and has produced technical guidelines, operational manuals, protocols and tools that incorporate evidence based public health innovations that have not yet become standard clinical practice in India.

The **QA initiatives** that UNFPA has carried out in Rajasthan and Maharashtra are its most significant contribution. It is showing results in terms of improvement in the quality of facilities and services at the primary health care level. Both the Maharashtra and Rajasthan governments have begun to see quality as an essential element of the national programme and are committed to taking the effort forward with their own resources. A holistic model of QA would enable UNFPA to weave together all its priorities in RH- quality, adolescents, gender, gender based violence, and community needs assessment and engagement- into one coherent framework and programme.
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Recommendations

- Widen and deepen the quality assurance model to include gender sensitivity of providers, detection of gender based violence, convergence of HIV with RH, sensitivity to adolescents, and community needs assessment and engagement.

- Advocate at both the national and state levels to scale up QA programmes and for the addition of quality indicators in the HMIS.

UNFPA commissioned Price Waterhouse Cooper (PWC) to carry out a study and recommend robust processes for managing Public Private Partnership (PPP) so that access to family planning services can be improved. PWC has recommended that the government use a third party to procure services from the private sector. The PWC recommendations need to be reviewed and implemented.

Recommendation

- Advocate with government, fund and evaluate pilots of the PWC recommended PPP management model so that private sector participation in FP service delivery is promoted.

Interventions to address Gender Based Violence (GBV) have been undertaken in a health facility and also in the community. There is need to see if the programme has resulted in change in practices related to detection of violence and provision of support for survivors of violence. The synthesis of Indian evidence on the health and social consequences of marital violence\(^1\) commissioned by UNFPA could prove to be a strong advocacy tool for building sustained responses from within the health care system to gender based violence.

Recommendations

- Before the formulation of CP 8, UNFPA should carry out an evaluation of the gender work that it has done in support of the NRHM programme, and prepare a document that records the approaches it has used, the inputs it has provided, whether these have really been institutionalized and whether they have changed the gender sensitivity of the system. Have the gender aspects built into the PIPs been implemented? This evaluation, combined with documenting the gender work of UNFPA post NRHM, could be a good starting point for a fresh attempt to orienting government personnel and other stakeholders including civil society, to the pressing need to incorporate gender sensitivity into health services.

- UNFPA should continue to work to enhance the capacities of Panchayati Raj Institutions\(^2\) (PRI) members through organizations like PRIA and The Hunger Project and ensure that there are measurable indicators to assess the role of PRIs and their members in community based monitoring of key issues related to sex-selection, child marriage and maternal and child health.

In community settings in Rajasthan and Bihar, NGOs funded by UNFPA are working with elected local government leaders and women leaders, to motivate them to address violence

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1 Jejeebhoy et al (2010); “Health and social consequences of marital violence: A synthesis of Indian evidence”; UNFPA/Population Council
2 Panchayati Raj Institutions are structures of the system of local self government that has been in place in India since the early 1990s, but is not yet quite fully functional.
against women. Given the increasing importance of and devolution of powers to PRIs and the increased number of elected women representatives, it is important that PRIs take greater responsibility for community based monitoring of key issues of gender based violence and also on maternal and child health.

UNFPA’s *advocacy work* has chiefly focused upon advocating (successfully) with other development partners for the national government to drop the age and parity clauses that excluded young mothers below the age of 18, and those with more than 2 children, from being eligible for the *Janani Suraksha Yojana* (JSY) scheme. This advocacy effort was sustained through CP-7 to ensure that these clauses were not revived.

CP-7 had identified the need to revitalize the stagnant *family planning program* in India by working for improved conceptualization of strategies to service contraceptive needs of the community and to provide TA to ensure systemic planning for delivering quality family planning services. However, there have been a few issues on family planning that need stronger and more sustained advocacy. The most important of these is the need to reposition family planning as a tool for achieving good health and reduced mortality for mothers and infants, empowerment of girls and women through delayed marriages and spacing between births, family well being and poverty alleviation.

**Recommendation**
- Build strong advocacy strategy to reposition family planning, UNFPA should undertake a planned program of advocacy for repositioning family planning within the ICPD framework of informed choice and quality care with a much broader range of services rather than merely endorsing the overwhelming use of sterilization methods that some of the state governments seem to currently place emphasis on.

TA provided by UNFPA in the area of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) in Rajasthan, has been seen by the state authorities as comprehensive, material, problem solving, and supporting effective implementation of the AIDS programme. However the strategies to promote safe sex-behaviours among female sex-workers and women need careful review to ensure that these strategies do not stigmatize community based sex-workers. UNFPA has not yet comprehensively addressed the issue of RH and HIV/AIDS convergence as planned in CP-7. This is a niche that no agency has yet sought to fill.

**Recommendation**
- Begin to work on providing TA to the National AIDS Control Organization and its intervention programmes for other vulnerable groups on how to converge RH with HIV/AIDS interventions.

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3 A nationally sponsored scheme that offers financial incentives to encourage institutional delivery
The UNFPA country office has played a small but critical role in mainstreaming RH and gender issues within recovery and rehabilitation responses for natural disasters and environmental changes. The main thrust of the work is to engage with agencies such as the National Institute of Disaster Management (NIDM) and its Apex Training Institutes (ATIs) and provide technical support to integrate a minimum initial service package (MISP) for RH in disaster in the professional development course for managers of disaster relief programmes.

**Recommendation**
- Map vulnerabilities due to environmental challenges within its 5 states, identify geographic locations with recurring or constant environmental challenges, where continuing work could be done to mitigate effects on the RH of vulnerable segments of society and advocate with others to work to mitigate these conditions.

**Section IV: Adolescent Reproductive and Sexual Health (ARSH)**

Outcome 4 of CP-7’s RH component is “Adolescents and youth empowered with knowledge and life skills for improved reproductive and sexual health (in school and out-of-school).” Indicators relate to the integration of life skills education (LSE) into school education through curricular and co-curricular approaches; training of teachers in the life skills approach; increased accurate knowledge of HIV/AIDS, and increased application of life skills imparted to them. A third component of the programme for adolescents and youth is “Institutionalization of Adolescent and Youth Friendly Health Services”.

A variety of strategic interventions have been worked on.

**Life skills education for adolescents in school:** Material has been developed that meets the criteria of UNESCO’s International Guidelines for Sexuality Education. Formal feedback on the material and on the quality of nodal teachers training has rated those at 4 at the high end of a 5 point scale. Extensive coverage has been achieved of schools affiliated to the boards of secondary school education at the national level. Scores for knowledge and attitude change brought about by the training show modest gains, somewhat higher in knowledge than in attitude. Preliminary findings of a study to see if adolescents exposed to the programme have acquired life skills, show modest programme effects. Though the ultimate goal of UNFPA’s programme is to deliver adolescent LSE in the curricular format in schools, most programmes so far have been in the co-curricular format. Only three organizations have so far opted for the curricular approach. With the exception of Rajasthan, the programme has not yet been rolled out in the schools governed by the state boards of education in which the large majority of the neediest students study. If the benefits of the programme are to reach the large majority of Indian adolescents in school, it will have to be rolled out in the state board schools. In Rajasthan UNFPA is working with all the seven universities that provide pre-service teacher training to incorporate LSE in the teacher training curriculum. This will make LSE sustainable.
Recommendations:

- Scale up the adolescence education programme (AEP) in schools affiliated to state boards of education

- Make LSE more sustainable through pre-service teachers’ training programs

Initiatives for adolescents who are out-of-school: Six different approaches were to be used to reach adolescents out-of-school with reproductive and sexual health knowledge. Only three of these activities have so far been undertaken, of which the most significant is the Teen Club programme of the Nehru Yuva Kendra Sangathan (NYKS). UNFPA has also funded 3 village level ARSH programmes in MP and one in Bihar to change RH behaviour, and improve demand for and delivery of RH services to the villages. There have been some positive outcomes of these programmes.

An assessment of the 4000 Teen Clubs set up across the country under the UNFPA programme, showed that although the activity was primarily meant to reach out-of-school adolescents, 89% of Teen Club members were attending school. UNFPA has now decided to re-strategize the Teen Club initiative and from 2011 to implement it in only the 5 UNFPA priority states so as to avoid spreading the programme too thinly over the entire country, and also to develop alternative models.

Given that 65% of India’s 240 million adolescents aged 15 and above are not in school, reaching adolescents in out-of-school contexts has priority. Given the enormous number of adolescents to be reached, financial investment by government will be required, and advocacy to encourage this investment is essential. A programme that has to reach out-of-school adolescents to scale must have clear and limited objectives, have clear and pragmatically defined content in a brief capsule which can be delivered in a very short period in community settings. From out of its excellent life skills module for schools UNFPA could create a capsule which will focus on young people’s need to make healthy and responsible sexual and reproductive choices as they grow into marriage and adulthood. Both the community based models in MP and in Bihar, funded by UNFPA to change adolescent reproductive behaviour, offer proven alternatives to the Teen Club approach. UNFPA must invest in finding effective ways of reaching them by developing realistic content and methodology and testing alternative delivery mechanisms.

Recommendation:

- Prioritize the development and evaluation of practical approaches for reaching out-of-school youth, and advocate with government to invest financial resources in reaching out-of-school adolescents.

Institutionalizing Adolescent Friendly Health Services (AFHS): NRHM provides for the provision of adolescent friendly health services through primary health facilities. UNFPA provided the Government of Maharashtra with TA to set up such clinics in selected districts. An evaluation of the programme revealed that the access and quality of services through these clinics were quite limited and the intervention did not have much success.
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**Recommendation:**
- A stronger approach and demonstration pilot will offer concrete alternatives to many states of India, most of whom are struggling with understanding the purpose and modalities of the concept of YFHS and with how to implement it.

Section V: **Sex Selection**

The desired output for the overall gender component of CP-7 is the child sex ratio (CSR), which at baseline (2001 census) was 927 per 1000 males. This was to be improved by at least five points as measured by the 2011 census. The desired output for the sex selection programme is – to address through advocacy and action the skewed sex ratio at birth (SRB). Two indicators have been selected:

(i) Sex ratio at birth in the worst affected districts improved- for which the baseline was to be determined and a ten percentage point improvement was sought by end-line

(ii) The gender gap in under 5 mortality rate reduced at the national level. The baseline was 6.8 per 100 births in 2005 and this was to be brought down to below 5 in 2012

The CSR at the national level in the 2011 census is 914. It has deteriorated by 13 points compared to the 2001 value of 927. There has been similar deterioration in the states of Maharashtra, MP and Rajasthan. CP-7 has 2 more years to go and it seems unlikely that the targets set for reduction of CSR or SRB will be met within this timeframe. In the five UNFPA states too, the SRB has deteriorated since 2001. The evaluation team finds that the national level indicators that UNFPA chose to measure success were grossly unrealistic and overly ambitious. Other intermediate measures of outputs and processes which would enable measurement of UNFPA’s contribution to achieving CSR or SRB should have been used.

CP-7 interventions sought to strengthen implementation of the Pre-Conception and Pre-natal Diagnostics (PCPNDT) Act at the national and state level; mainstream the work in sex selection by integrating sex selection issues into ongoing programmes of various ministries; create through advocacy, an environment that would discourage, disapprove and act against sex selection; strengthen capacity of civil society to address this issue; and build a strong evidence base for advocacy by supporting research initiatives. The programme has experienced significant success.

Efforts to **strengthen implementation of the PCPNDT Act** through training and orientation of the judiciary; mobilization of medical professionals; mobilization of civil society to activate and participate in statutory bodies responsible for Act implementation, and to monitor ultrasonography (USG) clinics; have resulted in better case preparation, expeditious disposal of cases, improved functioning of statutory boards, higher rates of registration of USG clinics, and better compliance with the Act. Where only community awareness work was undertaken, compliance with the Act has not improved.

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4 Rajasthan decline from 909 to 883; MP decline from 932 to 912; Maharashtra decline from 913 to 883; Orissa 953 to 934.
5 Some of the worst off states, where UNFPA has contributed through workshops with medical communities, judiciary and religious leaders, have seen an improvement in the CSR as in Punjab, Haryana and Himachal Pradesh.
6 Interviews with key civil society organization stakeholders in Haryana
Community level work through networks of NGOs has brought about higher awareness of the issue of sex selection and awareness of the PCPNDT Act to the grass roots level and other specific positive outcomes. The work has challenges in that grass roots communicators need value clarification on abortion per se, the intersect between legal abortion and sex selective abortion, and on reproductive rights, so that their messaging to women and communities is clear, and their community level work does not end up stigmatizing legal abortion.

**Recommendation:**
- Community based work to change mindsets may not be the best use of UNFPA’s resources. However, the learning from the community level work should be documented and disseminated as a resource for others working on these issues, and to advocate for more community work to change social norms.

The media has been a key partner in advocacy initiatives. The many media initiatives are interesting and innovative, but the evaluation team did not perceive the existence of an overall synergistic strategy for communication and advocacy for the issue of sex selection.

**Recommendation:**
- Lay out a more forward looking and comprehensive communication strategy in the area of sex selection. Evidence based advocacy to shape public opinion must be a central objective of communication.

Several publications have been developed by UNFPA as the evidence base, and as tools for understanding and advocating on the issue of sex selection. There is a need for current and representative data on attitudes of men and women towards son preference and sex selection and on how social norms change or resist change.

**Recommendation:**
- Continue to build the evidence base for advocacy and action through new research in the area of son preference and sex selection.

The findings of Census 2011 show that work against sex selection is urgently and widely needed in India. The need of the hour is advocacy at the national level, to build equal value for daughters compared to sons. If UNFPA wishes to have national impact through its work on sex selection, it may need to consider playing the role of a catalyst for advocacy, using its position and influence to draw and hold together a strong group of influential, independent and resourceful partners at both the national and state levels, who will work together to advocate for allocation of resources and action on the issue of sex selection. Discussions with development partners including other UN agencies bear out the idea that in order to build partnerships and buy-in, it is important to reposition the work within a wider lens of discrimination.

**Recommendation:**
- Catalyze action and partnerships by bringing together a wide variety of agencies, to contribute to rapid change in a coherent manner, using a wider frame of gender discrimination.
Government commitment to Act implementation at both national and state levels remains weak.

Recommendation:
- Advocate for scale up and strengthening of Act implementation: work closely with the governments of Maharashtra and MP, civil society, legal and medical professional agencies to advocate at the national and state levels for greater government commitment to the issue of sex selection, and for more rigorous Act implementation.

Section VI: Population and Development Strategy

The overall outcome for the Population and Development Strategy (PDS) component of CP-7 is that capacity be built to integrate population dynamics into national policies and programmes. Two outcomes are desired, the first is that development plans at the national and sub national level build upon the findings of studies on emerging population issues, and the second is that plans and policies are linked to population and development realities, through use of disaggregated data in planning and monitoring.

The most significant programme inputs to achieve CP-7 objectives included capacity building for decentralized planning through the joint GOI-UN Convergence Programme; TA for strengthening the health management information system and the civil registration system for vital statistics; TA for the Census of 2011; support for developing the Bihar Population Policy; and the commissioning of policy studies on the emerging issue of aging.

Decentralized district planning: To facilitate the development of integrated district development plans through convergent action of various government departments and schemes at the district level, UNFPA organized capacity building training for both senior officials engaged in planning and programme management, and for statistical and planning officers. Both participant feedback and the request from the state governments for repeat workshops to be organized at the state level are evidence of relevance and effectiveness. UNFPA needs to review the content and methods of these training programs to include inputs on the cross cutting development issues of gender, rights and equity. The evaluation team finds that 20 out of 35 districts have prepared the integrated district plans using participatory and consultative processes, and the quality of the plans has improved. The monitoring of programmes has become more focused and systematic, and the plans are made on the basis of data, facts and evidence.

Recommendations:
- Continue to give priority to broadening the vision and perspectives of development planners to understand population and development linkages. The relationship of the key issues of gender, equity, and empowerment to development, must continue to receive priority in the India country programme. For sustained in-service capacity building of senior administrators, and programme and policy leaders, population and development courses should be integrated into the induction, orientation and training courses that are regularly conducted for government officials. Side by side, to widen the pool of population and development professionals in the country, UNFPA should support the development of Masters/Diploma/Certificate programme on population and development at appropriate educational institutions.
Continue to support decentralized and convergent district level development planning.

Other important contributions towards district planning are the development of a sub-national estimation methodology for tracking developmental indicators and district level population projections for eight selected states of India (2006 - 2016). The exercises of district level projections and sub-national estimation are likely to have positive impact on decentralized planning and programme monitoring UNFPA has worked strategically and systematically to help the districts to define the denominators that form the basis of the planning exercise.

The Health Management Information System (HMIS) is an essential input for monitoring the RCH-II programme. UNFPA supported the training of functionaries at the sub-district levels in Bihar and Maharashtra. The evaluation team finds that the HMIS does not include strong data quality checks and data triangulation. It does not measure any elements of quality of care, nor does it gather data disaggregated by markers of social disadvantage. These are necessary for assessing whether programmes are reaching the vulnerable with quality services. UNFPA should advocate for the inclusion of such data in HMIS.

There is a need for improvement in the use of vital registration data. Since coverage levels of the civil registration system are not high, there is a need to show how the most reliable estimates can be made from even imperfect levels of coverage. This would be an important contribution that UNFPA could make.

**Technical Assistance and Support for the conduct of Census, 2011:** UNFPA supported the Office of Registrar General of India (ORGI) in four specific areas: (a) digital mapping of census blocks in capital cities, (b) census training and publicity, (c) gender aspects of the census and (d) data dissemination. A ‘Census Training and Resource Centre’ has been proposed to be set up and UNFPA has commissioned a study to develop a road-map for the establishment of the Census Training and Resource Centre which is expected to be used for south-south collaborative activities.

**Emerging Population Issues:** Several emerging issues identified by CP-7 require study and analysis for advocacy. Progress so far has been made on the issue of aging. UNFPA commissioned eight secondary studies covering a range of issues relating to the elderly that have been peer reviewed and are to be published and disseminated to a wide audience of stakeholders including government. Three large scale primary studies have been initiated to study additional areas so that policy and programme advocacy can be better supported.

**Recommendations:**

- Use the results of Census 2011, to point emerging demographic trends and issues. Launch a concerted and continuing advocacy effort at many levels and for many audiences, to shape public opinion, create an environment, and generate pressure for government to respond with appropriate policies and programmes.
Executive Summary

- Census data should be further analyzed and built upon to deepen the understanding of emerging population issues like the youth bulge and the demographic dividend, migration and urbanization, population and environment, abortion and sex selection, and post-reproductive morbidities. These have not been substantially taken up during CP-7, and need to be taken up in CP-8.

In summary, the PDS work accomplished under CP-7 is varied, significant and relevant. The evaluation team found that considering the importance of PDS in the context of the global mandate of UNFPA, the expansive scope of this thematic area and the present and future needs of the country, the human and financial resources provided to this component of the UNFPA programme need enhancing so that it is better able to (a) engage in policy advocacy, (b) provide capacity building inputs on population-development dynamics, (c) ensure gender mainstreaming in population programs, and (c) establish essential linkages with resource persons and institutions that are inter-disciplinary. The evaluation team found that the budget allocation for PDS thematic area is quite low. During 2009 and 2010, it varied between 6% and 8% of the total funding for those years.

**Recommendation:**
- Strengthen the PDS thematic area group in UNFPA to enable it to more fully and effectively address the scope and complexity of this critical component of UNFPA’s portfolio.
Part C: Geography & Partnerships

Section VII: Programme Geography

The evaluation team has reviewed the appropriateness of the selection of states where UNFPA works. Criteria used are the ranking of states on key development indicators in the areas of population and health, absolute numbers of the poor, and potential for work on emerging issues. The evaluation team is of the view that UNFPA should remain in the states where it presently is. Discussions with officials in the GOI reveal they too are of the opinion that UNFPA should remain in the states where it currently is- these states are amongst the most under developed of India’s states, and require UNFPA support.

Recommendation:
- The evaluation team recommends that in CP-8 UNFPA continue to maintain offices in the 5 states where it is currently present.

UNFPA plays a mix of three meaningful roles: policy advocacy, TA, and programme implementation support. Given these, UNFPA’s current mix of national and state presence is well considered. However, to play the policy advocacy role effectively, especially on emerging issues, UNFPA may sometimes need to work in states other than the 5 in which it has regular programmes. It should be able to pursue work on key issues at the state level, even if that work falls outside the 5 states where it is pursuing state level programmes.

Recommendation:
- UNFPA should retain the flexibility it currently has to pursue policy, advocacy or selective work in some themes, particularly in emerging issues, outside of its 5 states. Such programmes could be managed out of Delhi or one of the five state offices depending on proximity, and technical skills of the staff in the state offices.

Section VIII: Partnership Strategies

The evaluation report discusses the partnerships that UNFPA has in-country with the government, other development partners in India, a range of academic, research and civil society organizations, and other UN agencies in India. Civil society organizations play a variety of roles in UNFPA’s programmes, contributing to research, providing TA and building capacity on behalf of UNFPA, implementing programmes and pilots for scale-up- particularly projects that are community based, and furthering UNFPA’s advocacy agenda by mobilizing civil society.

Harmonization and synergy between UN agencies in India is a concern of the UN. Efforts to harmonize at the national level are exerted by the UNDAF. However, at the state level, given that each UN agency follows different norms related to the delegation of authority and power to their state representatives, some UN agencies do not feel that they are able to adequately represent the agenda of their agencies.
Executive Summary

Recommendation:
- In the interest of ensuring that UNFPA’s interest and agenda is represented at par with those of other UN agencies, it is recommended that the UNFPA state representatives be given the same degree of flexibility and decentralized authority as representatives of other agencies have.

Section IX: **Operational Modalities**

The evaluation reports examines the three main modalities by which UNFPA operates in India: SWAp, annual work plans, and direct execution.

Recommendation:
- Among several issues including staffing, processing of annual work plans, and improving accountability for mainstreaming gender into UNFPA’s work, the most significant recommendation is related to the **SWAp**: Only if the Ministry of Health and Family Welfare (MOHFW), conscious of the limited resources of UNFPA, feels that a monetary contribution from UNFPA to the pool will help to underline a robust partnership between the two, then UNFPA should continue to contribute to the SWAp, albeit with a lesser contribution, as it is not the financial resources of UNFPA per se that matter to MOHFW.
UNFPA’s Country Programme 7 (CP-7) is a five-year framework defining mutual cooperation between the Government of India (GOI) and UNFPA covering the period 2008-2012. The CP was designed based on the Programme of Action of the International Conference on Population and Development (ICPD PoA) and the needs of the country as reflected in the national XIth Plan document. It was prepared in close consultation with the government and other stakeholders, and defines the goals, outcomes and strategies that the government and UNFPA have jointly subscribed to within agreed financial parameters. After CP-7 was approved by the GOI, the United Nations Development Assistance Framework (UNDAF), and UNFPA’s Strategic Plan (2008-2013), were approved. UNFPA India reworked the results framework of CP-7 to achieve alignment with both UNDAF and the Strategic Plan. CP-7 has been detailed in the Country Program Action Plan (CPAP).

The national health policy and programme environment in India has seen much change in the period between CP-6 and CP-7. The National Rural Health Mission (NRHM), launched in 2005, incorporated within itself the Reproductive and Child Health-II (RCH-II) project. NRHM focuses on 18 Indian states with weak health infrastructure and poor health outcomes. Large financial resources have been devoted to improving access to quality health services, particularly for the poor and marginalized. Donor assistance forms an insignificant proportion of resources that government has provided for NRHM. In this new environment, government values flexible technical assistance and programme implementation support that demonstrates how implementation can be made stronger and more effective at the state and district level, particularly in geographic areas that are lagging behind.

Recognizing that inspite of India’s middle income status, great disparities in regional development remain, and that over 300 million Indians still live in poverty, donors have shifted focus from the national to the state level, choosing to work in states that are lagging behind. The Department for International Development (DFID) of the United Kingdom has decided to focus all its funding on the three states of Madhya Pradesh (MP), Bihar and Orissa, with only policy interventions at the national level. The United States Agency for International Development (USAID) focuses on state level interventions in its programmatic priority areas, while continuing to provide policy and NRHM programme review inputs to the central government. UNFPA uses its presence at the national level, to support the implementation of national programs, advocate for issues and provide policy inputs. In addition, UNFPA uses its presence in 5 states to provide policy and programme guidance to the state governments in areas that are UNFPA programme priorities. It also funds and supports the implementation of pilots to assess their feasibility for replication and scale-up.

All multilateral and bilateral development assistance partners are members of the Development Partners Forum, where, along with the Ministry of Health and Family Welfare (MOHFW), they reach coordinated development assistance decisions based upon their individual strengths and mandates, and where they jointly review progress of the Reproductive and Child Health Project.
Part A: Introductory (Section I: Introduction)

II (RCH-II). The assistance provided by UNFPA and other UN agencies is guided by the UNDAF strategic framework.

Towards the end of 2010, the MOHFW sought the cooperation of its development partners in strengthening implementation of all health programmes in 265 districts across the country. These districts were identified as requiring "high focus" for development. Partners were allotted districts in their respective focus states, with the request that they be responsible for assisting government to coordinate all health programming in the districts. UNFPA was allotted 13 districts in 4 of its 5 states. Partners are fine tuning district strategies and plans, in consultation with state governments. Government would like partners to assist in programme implementation so that RCH objectives in the districts are met.

**Funds and implementation modalities of CP-7**

Midway through CP-6 UNFPA agreed to pool its resources with those of the GOI for its SWAp (sector wide approach) programme for RCH. Other donors who contributed to the pool were DFID, and the World Bank. In CP-7 UNFPA pooled 28% of its resources to the pool. Together the 3 donors contributed 8% to the pool, with 92% coming from government. UNFPA’s contribution to the pool was 6% of donor contributed funds, or 0.48% of the total pool. Following this decision, UNFPA’s development assistance to India changed from a project mode with direct execution to providing stronger policy and technical support at the national and state levels for RCH-II. UNFPA as a member of the Development Partners Forum, and as a pooling partner of the GOI, participated in key program formulation and review activities including the Joint Review Missions (JRM) of NRHM. This role transformation continued to be firmed up in CP-7 where, in addition to policy advocacy and need-based technical assistance, UNFPA used the un-pooled portion of its CP budget to provide implementation support in areas where new approaches needed to be proven or the government was experiencing implementation difficulties.

**Programme objectives**

UNFPA assistance was focused on addressing challenges in states that were lagging behind in development indicators- Bihar, MP, Rajasthan and Orissa, and also in Maharashtra, though it is not considered one of the laggard states. This assistance was to achieve:

- reduced regional disparities;
- social inclusion- particularly of the scheduled castes and tribes, and within them of women and girls;
- gender equity, increased participation of women in local government, a reduction of gender based violence including discrimination against the girl child;
- a successful demographic transition including reducing fertility in high fertility states, reducing high adolescent fertility, meeting unmet need for contraception, optimizing the opportunity of the demographic dividend by addressing the health and development needs of youth, and managing the issue of aging;
- reduced maternal mortality;
- Controlling the spread of human immunodeficiency virus (HIV) transmission with an emphasis on building capacity to scale up preventive interventions in the general and vulnerable population
Programme components

*CP 7 has three broad components:*

1. **Reproductive Health (RH)**

   The key outcome sought in this component is to improve the RH of the population, particularly of vulnerable and unreached groups such as scheduled castes and tribes and within them particularly women and girls. The measures of improved RH status are:

   - reduction in maternal mortality
   - reduced unmet need for contraception
   - reduced adolescent fertility and
   - reduced adult HIV prevalence

   Four subcomponent strategies are proposed to be used to address the vulnerable: first, enhance access and utilization of high quality RH services; second, promote safe sex behaviour; third, empower in and out of school adolescent and youth with life skills education (LSE); and fourth, mainstream RH and gender issues into recovery and rehabilitation response to natural disaster and environmental challenges.

2. **Gender**

   This component focuses on mainstreaming gender in UNFPA’s RH programs, advocates and acts to prevent gender based violence and to empower women. In CP-7, gender based violence and gender in general were mainstreamed into RH. The gender component focused on the area of sex selection. The measure of success in this component is a reduced skew in the female child sex ratio.

3. **Population and Development Strategy (PDS)**

   The component seeks to ensure systematic use of population dynamics to guide increased investments in gender equality, youth development, RH and HIV/AIDS for improved quality of life, sustainable development and poverty reduction. Key strategies used are enhancing the capacity of programme managers to use disaggregated data for integrated district planning, monitoring and policy dialogue; making data on key issues such as aging, urbanization, migration, abortion, maternal mortality and sex selection available when policy and programmes are made; assessing performance through data and evidence; broadening the vision of administrators on the linkages between population and development; strengthening the capacity of the Office of the Registrar General, India (ORGI) and Census Commissioner for conduct of the 2011 Census; and putting in place south south cooperation mechanisms to support knowledge transfer for understanding of population and development issues.

   Annex 1 is the Results & Resource Framework taken from the CP-7 document. It provides details of outcome and output indicators for each of the three key components of CP 7.
Section II: Evaluation Scope, Purpose, Objectives, Key Questions

UNFPA has commissioned this evaluation of CP-7. As a parallel exercise it has also commissioned a Population Needs Assessment. The findings of both these studies will be used to draw up a strategy for the next programme cycle-2013 to 2017.

2.1 The main aim of this evaluation is to elicit achievements made in each of the thematic areas as well as to understand effectiveness of mainstreaming cross-cutting themes such as gender and advocacy in programming. In addition, the evaluation from the perspective of the next cycle of the India programme is meant to be lesson-learning and forward looking. The scope of the evaluation therefore is to examine:

2.1.1 The financial, policy and technical assistance provided by UNFPA through the CP, in each of its thematic and cross-cutting areas of work in terms of:

i. Whether interventions are aligned with the current and future needs of the country and with the larger CP / UNDAF results and strategic framework;

ii. The extent to which UNFPA’s support has added value to national and state government programmes and priorities;

iii. The extent to which gender has been mainstreamed in UNFPA’s work, and the extent to which this has been accepted and adopted in Government or civil society actions.

iv. Whether adequate attention has been devoted to building capacities of Government and other partners, and the extent to which this has been achieved

2.1.2 Whether the geographic focus and spread of the programme is appropriate;

2.1.3 Whether partnership strategies have been appropriate;

2.1.4 The extent to which internal UN coordination has avoided duplication or built synergies

2.1.5 Whether the operational modalities of implementing the programme (SWAp pooling, annual work plans (AWPs) with partners, and direct execution) have been utilized effectively;

2.1.6 Whether UNFPA presence has been effectively used in policy advocacy, gap identification, programme design and implementation, and responding to the needs of state governments.
2.2 Methodology of Evaluation

This evaluation was conducted between February 2, and April 30, 2011. The Terms of Reference for the Evaluation Team are at Annex 2. The evaluation was conducted by a team of four consultants.

The evaluation process commenced with a meeting at UNFPA on February 2, 2011. At the meeting, senior management of UNFPA gave the consultants an overview of the concept of the evaluation, went over the steps in the process to be followed, reviewed key elements of UNFPA’s Evaluation Guidelines, and reviewed the relative roles of the consultants in the evaluation team. The relative role of the consultants is specified in Annex 3. The Advisor, Asia and Pacific Regional Office (APRO) participated in the meeting by conference call to provide guidance to the consultants on the UNFPA’s minimum requirements for a quality evaluation. Towards the end of the meeting, the consultants worked out a preliminary/draft schedule for the evaluation. The consultants developed an inception report laying out the methods that would be followed for the evaluation, and a list of areas to be investigated during evaluation visits and interviews. The inception report and timeline were provided to UNFPA on February 22, 2011. Comments received from both the Country Office and APRO were incorporated into the work done by the evaluation team.

In these initial discussions that the evaluation team had with UNFPA it was agreed that the evaluation would look at 4 of the 6 evaluation criteria- relevance, effectiveness, sustainability and management. Impact could not be evaluated at this midway stage of CP-7 because according to the CP-7 Results Framework, impact indicators will be measured by large national surveys only in 2012-2013. A study to establish efficiency would need to compare cost of inputs with value of outputs, and compare the resultant ratios with those of other similar programmes. Such an analysis would need more data than was available for CP-7 and was not possible within an evaluation such as this one.

The steps in data collection were:

- Desk review of key documents (Annex 4 provides a list of documents reviewed by the team)

- Meetings with concerned UNFPA staff and some project counterparts both in Delhi and in the states where UNFPA is present and has programmes. Between February and March, 2011 team members made visits to four of the five states where UNFPA has programmes and offices. The team was unable to visit Orissa, but the UNFPA Programme Coordinator in Orissa came to Delhi to meet and brief the evaluation team, as did one of the key implementing partners of UNFPA. Ms. Priya Nanda also visited sites in Haryana and Delhi where interventions to prevent sex selection were being implemented. Visits to the states began with a comprehensive and detailed briefing by UNFPA’s state team led by the State Programme Coordinator. The members of the evaluation team then met key counterparts in both government and non-governmental partner agencies to gain their perspectives about UNFPA’s role, achievements, and responsiveness to the requirements of states. The expectations and suggestions of counterparts related to UNFPA’s work in the present and future were also discussed. On return to Delhi from the states, members of the team continued to meet more UNFPA staff and government and non-governmental counterparts to gather data and share impressions gained from the visits to the states. The evaluation team
met donors - both those who had joined the RCH pooling arrangement, and those who had not. Annex 5 is a list of the persons met by the evaluation team.

- On April 21, 2011 the evaluation team facilitated a gender consultation meeting for all state and country office staff, to understand how gender was being mainstreamed into CP-7, and what direction the staff felt their work in gender mainstreaming should take in the future. Annex 6 is the agenda of this consultation and a presentation made by UNFPA staff outlining UNFPA’s work in gender over the years.

- Throughout the evaluation, members of the evaluation team coordinated closely with each other, to reach a common understanding and analysis of issues, of how to provide a unified picture of CP-7 achievements and issues.

- The team obtained and analyzed data on the annual work plans of the country office and the state offices, and the distribution of funds between SWAp, technical assistance, and projects implemented by the range of partners.

- The largest possible range of stakeholders had the opportunity to provide information on their involvement in CP 7, project their achievements, their concerns and further needs.

2.3 Ethical considerations

The evaluation team was brought together after ensuring that there were no conflicts of interest. All those who were interviewed by the evaluation team were assured of confidentiality. Where interviews were recorded for future reference, consent was obtained. Individuals interviewed were informed that their specific consent would be taken before anything that they said was quoted directly. Sensitive information gathered has been collated and generalized- it has not been used as a specific example or as a direct quote. The evaluation team has taken care to ensure that all information that is not in the public domain is kept confidential.

2.4 The structure of the evaluation report

- Part A of this report contains Sections I and II which broadly describe the programme being evaluated, and the aims and methods of the evaluation.

- Part B contains an assessment of the components of CP-7. This part contains Sections III to VI on programme components- RH including HIV/AIDS and RH in disaster response, adolescent reproductive and sexual health (ARSH), sex selection, and population and development. Each of these sections can more or less be read alone. They contain background, the results desired, findings, analysis, conclusions and recommendations. These sections discuss the purposes and broad approaches of programme components, substantiating and illustrating the discussion with specific examples. The sections assess and comment on the achievements of these programmes. Conclusions and recommendations related to a particular section are provided at the end of the section.
Part A: Introductory (Section II: Evaluation, Scope, Purpose, Objectives, Key Questions)

- Part C is made up of Sections VII to IX. Sections VII and VIII address the issues of geography and partnerships, including partnerships within the UN system. Section IX discusses the modalities of financial, administrative and human resources management in CP-7.

- Part D is conclusions, and

- Part E is made up of annexes that contain supporting information that has been used in writing the report. All annexes are referenced in the text of the report.

2.5 Challenges and limitations

The UNFPA programme is spread over 5 states of India, has many different small and large elements and components, and is complex. Mostly, UNFPA state programme coordinators in consultation with senior management and concerned programme officers, shape the projects that they are implementing based on features negotiated with the host government. Therefore, projects even on the same theme, for example on quality assurance, could differ from state to state, with different emphases and components. Studying and commenting upon such a wide ranging, complex programme in a coherent manner within a span of 35 days has been a huge challenge, and this is an evaluation of the programme as a whole. It is not a detailed evaluation of its component parts.

Several factors make it difficult to measure performance of CP-7 against the indicators specified in the Results and Resources Framework at Annex 1. In the two programme areas of improved access to RH services for the vulnerable, and safe sex behaviour of vulnerable groups, the indicators are national level impact indicators that measure the overall performance of the RCH-II and National AIDS Control Programme (NACP) III. They do not measure UNFPA’s contributions to these programmes. To this extent, the appropriateness of these indicators as measures of UNFPA programme performance is in question. It would have been advisable to select indicators that more directly reflect the outputs and outcomes of the inputs provided and processes used by UNFPA in the geographies where it operates. The MOHFW will be measuring achievements against the indicators of RCH-II and NACP-III in 2012-2013, using large household surveys such as the District Level Health Survey IV, and the National Family Health Survey IV. The Ministry is now planning these surveys. When the RCH-II and CP-7 results frameworks were developed, no periodic/intermediate benchmarks or proxy indicators were set up that could be used to measure progress toward achievement of desired results. The evaluation team found that UNICEF’s Coverage Evaluation Survey (2009) and the District Level Household and Facility Survey-3, provide the value of two of the indicators and these interim value have been added to the data on programme performance in Annex 1.

When the large surveys are done in 2012, attribution of results to UNFPA will be difficult. Achievements against these indicators would depend on the pace and effectiveness of RCH-II programme implementation by Government. Given the design of the RCH-II implementation mechanisms, donors contributing to the programme have little control over the pace of programme implementation.
Two components of CP-7, ARSH and PDS, have outputs or outcomes that can be directly related to UNFPA inputs and processes in the geographies where the programmes operate. Also, projects and programmes that are being directly supported by UNFPA in the 5 states do have input, process and output indicators specified. Some of these programmes are half way through their implementation period, others are just beginning. These projects will be evaluated towards the end of CP-7. At that time more complete performance data will be available.

The evaluation team relied largely on document review and discussions with UNFPA staff to understand the programme and its achievements. Meetings were held with key government counterparts, both at the national and the state level. Key staff of almost all NGOs engaged in implementing UNFPA supported projects, were met. Data gathered from government and NGO counterparts related to their overall understanding of program priorities, achievements and challenges. They were rarely able to share data related to outcomes. The methodology of the evaluation did not include meetings with a representative cross section of beneficiaries. The team did meet some beneficiaries during visits to the field, but data gathered from them could best be described as anecdotal.

This evaluation has looked at inputs, processes and such programme outputs as are evident as of now (programmes will be completed only in 2012). This information, as well as data gathered from stakeholders have been used to analyze and assess how UNFPA’s work serves needs in the country, and fills gaps in RCH-II programme implementation. It also helped to assess the potential of programmes for scale-up and sustainability. The evaluation discusses the challenges that the programmes has encountered, and makes suggestions for programme strengthening.

2.6 Key stakeholder involvement

The concept of the evaluation and the scope of work for the evaluation team were approved by the GOI. Besides this, the involvement of stakeholders in the evaluation has been mostly in the capacity of interviewees. While several categories of stakeholders have been met and their inputs taken, the evaluation was not designed such that the team could meet a representative cross section of final beneficiaries of programs at the community level, or providers who have been trained in the various UNFPA capacity building programmes. The scope of work of the evaluation did not suggest that this was necessary.

Once the evaluation findings are available, a series of consultative meetings are to be held at which the findings of the evaluation and a suggested strategy for CP-8 are to be shared with all key stakeholders including the government, development assistance partners, UN agencies, and other partners.

2.7 Gender considerations in the evaluation

The evaluation team was gender balanced; it ensured that it talked to key informants of both sexes to obtain a balanced view of programme perceptions; as the team studied the programme it attempted to observe the extent to which they were engendered. A special gender consultation was organized with UNFPA staff to understand fully the gender perspectives that underlay the programme and the extent to which UNFPA staff were aware of how programmes could be engendered.
Section III: Reproductive Health Component including Gender; HIV/AIDS; and RH in disaster response

3.1 Background

CP-7 of UNFPA is in consonance with the GOI’s RCH-II programme. RCH-II commenced from 1st April, 2005 within the overall umbrella of the NRHM (2005-2012). The main objective of RCH-II is to bring about a change in three critical health indicators: total fertility rate, infant mortality rate and maternal mortality ratio, for “realizing the outcomes envisioned in the Millennium Development Goals, the National Population Policy 2000, and the Tenth Plan Document, the National Health Policy 2002 and Vision 2020 India”. RCH-II adopted the sector wide approach (SWAp) which aimed to extend programme reach beyond reproductive and child health to the entire family welfare sector and emphasized the need for decentralization based on state and district level planning. The RCH-II strategy also envisaged pooled financing by development partners to “simplify and rationalize the process of accessing external assistance”.

A key component of CP-7 is the wide ranging RH component which includes adolescent sexual and RH, HIV/AIDS, and RH in disaster. The RH component aims to achieve the following outcomes:

3.2 Results Desired

Improved RH of the population, particularly of vulnerable and unreached groups such as scheduled castes and tribes and within them particularly women and girls, is to be assessed through the following indicators at the national level:

- Reduction in maternal mortality ratio from 301 per 100,000 live births in 2001-03 to less than 100 in 2012
- Reduction in unmet need for contraception: 80% of unmet need to be met.
- Reduction in adolescent fertility rate from 16.8% to 12% by 2012.
- Reduction in adult HIV prevalence from the 2005 level of 0.36

HIV related outcomes have been included within the overall RH portfolio because the regional/global division of labour matrix among UN agencies designates UNFPA as the lead agency for the prevention of HIV transmission in sex workers. Aspects of child health are excluded from CP-7 because that is UNICEF’s area of focus.

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7 Government of India, National Rural Health Mission; Reproductive and Child Health- Phase-II; 2006-2012; www.mohfw.nic.in/nrhm.htm
8 ibid
The outcome indicators in CP-7 are congruent with national goals but as emphasized in CP-7, the responsibility for implementing the RCH-II programme rests with the Government. The achievement of outcomes depends on the pace of RCH II programme implementation - over which UNFPA and other development partners have little or no control.

Compared to other components of CP-7, the RH component - both TA and non-TA has received a fairly substantial proportion of financial resources and adequate priority11.

Activities and interventions that received financial, technical and policy support sought to achieve the following RH outputs:

**Output 1:** Enhanced access and utilization of high quality RH services by vulnerable communities. This output also included gender mainstreaming through enhanced response to issues of gender based violence (GBV)

**Output 2:** Safe sex behaviours among vulnerable population groups (sex-workers and women)

**Output 3:** Empowerment of adolescents and youth with knowledge and life skills for improved reproductive and sexual health ((in-school and out of school)12 and

**Output 4:** Mainstreaming of RH and gender issues in recovery and rehabilitation responses for natural disasters and environmental challenges

The specific indicators against each of these outputs are listed in the Results and Resource Framework for India (2008-2012) included in the CP-7 document. Intermediate values of three indicators are available - the percentage of deliveries attended by a skilled birth attendant13 has increased substantially (in 2009) to 76.2% 14 from 48.8% at baseline (2005-06), against the target of 80%. The percentage of first referral units that are functional has increased from 30% at baseline to 52% in 200915 against a target of 100%. The number of districts that have established Quality Assurance Groups is 1616 in 2010 against a target of 20. However, for the large majority of indicators in the RH component, no progress data is available since data from the large scale household survey is still awaited.

The RH programme under CP-7 comprises a wide range of activities and interventions undertaken both at the country and the state level. Every activity has nuances and adds value to the total programme. Details of activities can be found in the annual work-plans, state and country annual reports and other documents listed in Annex 4. The following sections do not describe each and every activity undertaken by the country and state offices. Rather the section seeks to trace broad and significant patterns emerging out of the many activities and interventions undertaken, and presents an analysis of these activities keeping in mind the criteria

11 Of the total $ 65 million, $12.6 million went into SWAp, $10.28 million was budgeted for the RH component, $3.8 million each for the ARSH and sex-selection whereas PDS received $2.55 million.
12 Output 3 has been addressed separately under Adolescent Reproductive and Sexual Health programme.
13 Skilled births attendant include Doctor, ANM / Nurse / LHV
14 UNICEF Coverage Evaluation Survey 2009
15 District Level Health Survey 3, 2007-2008
16 UNFPA Progress reports
of their relevance, effectiveness and sustainability. Some specific activities or intervention are referred to when they typify or are illustrative of the patterns being discussed.

3.3 Strategic Interventions: Findings and Analysis

3.3.1 Output 1: Enhanced access and utilization of high quality RH services by vulnerable communities

From senior programme managers at UNFPA, and from a review of state and district project implementation plans (PIPs), it is seen that the definition of vulnerable population is drawn from the XIth Five Year Plan document which lays special emphasis on the health of marginalized groups like adolescent girls, women of all ages, children below the age of three, older persons, disabled, and primitive tribal groups\(^\text{17}\). The Plan also views gender as a cross-cutting theme across all planned schemes.

UNFPA’s RH interventions are located within the high focus or empowered action group (EAG) states\(^\text{18}\) (Maharashtra is an exception) that are home to 42% of India’s poor. The MOHFW has further identified 265 high focus districts in India that need special attention because they have weak public health indicators and poor health infrastructure. In October 2010, GOI allotted 13 of these high focus districts to UNFPA. These districts are located in 4 of UNFPA’s 5 states - Orissa, MP, Rajasthan and Bihar. Thus a major section of the population that benefits from CP-7 programmes is poor, marginalized and vulnerable.

Working directly with the national and state governments and other key civil society partner organizations, CP-7 supported the following broad sets of interventions/activities to achieve enhanced access to and utilization of high quality RH services by vulnerable communities:

1. Technical Assistance (TA) and capacity building for RH programmes
2. Quality Assurance
3. Communitization\(^\text{19}\)
4. Programmes to reduce vulnerability to GBV and
5. Advocacy for RH

UNFPA’s CP-7 program has envisaged mainstreaming gender in all RH activities. In the following sections, as and when appropriate, we will comment on gender mainstreaming within the RH programmes.

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\(^{17}\) Government of India; XI\(^{\text{th}}\) Five Year Plan-2007-12; Volume II-social Sector; paragraph 3.1.7; pp. 55-56

\(^{18}\) Government of India, National Rural Health Mission; Reproductive and Child Health- Phase-II; 2006-2012; [www.mohfw.nic.in/nrhm.htm](http://www.mohfw.nic.in/nrhm.htm)

\(^{19}\) “Communitization” is a word coined in RCH II/NRHM, which is shorthand for the process of community mobilization to build awareness, generate demand for services, prepare village plans, and use these plans to monitor service delivery and hold government accountable.
3.3.1.1 TA and Capacity Building for RH Programmes

a. Provision of consultants to government: Both at the national and state levels TA for RH largely comprise the provision of human resources or consultants to national and state governments. In a recent incident in Barwani district of MP, when a series of maternal deaths occurred in a public hospital, the first fact finding report was prepared by the UNFPA programme official seconded to the government. The report became the basis on which the state government took action. A detailed discussion on consultants provided under CP-7, and the pros and cons of these arrangements is presented in Section IX: Operational Modalities.

b. Continuing support to state governments from UNFPA state offices: During the field visits and discussions of the evaluation team with government officials at the national and state level, it became abundantly clear that UNFPA state programme coordinators and programme officers are regularly called upon to participate in and provide inputs at various state level technical and core group meetings and consultations such as on maternal health and family planning. It is not an exaggeration to say that in many states, UNFPA and its officials are seen as an extension of Government and are relied upon to represent the state on technical matters. UNFPA also helped the MOHFW to systematically assess all state PIPs.

c. Reviews, assessments, guidelines and manuals, tools: TA on RH has been provided on wide ranging issues both at the national and the state levels. At the national level as per programme needs articulated by government counterparts, UNFPA staff provided support to NRHM. Assessments and evaluations of various key national and state reproductive and sexual health programmes were undertaken. Joint Review Missions (JRM s) were facilitated by preparing tools and a manual on ‘what to do while in the field, JRM reports were prepared and mid-term reviews of RCH-II programmes participated in. Based on needs identified through these assessments, reviews and evaluations, UNFPA either took the lead on or played a critical role in producing a variety of technical guidelines, operational manuals, protocols and tools:

- Trainer’s handbooks, training guides and work - books for basic emergency obstetric care (BEmOC), pregnancy care and management of common obstetric complications, and practices of safe delivery and immediate newborn care.

- Guidelines on maternal health, skilled birth attendance, safe abortion, and (with WHO) the management of reproductive tract and sexually transmitted infections (RTI/STI)

- Operations manual for the district quality assurance programmes for RH services

Guidelines and material have been appreciated by the Ministry of Health & Family Welfare. They take into consideration the realities of resource poor health care settings and facilities, and offer pragmatic alternatives to protocols designed for non-resource poor settings. Protocols incorporate evidence based public health innovations that have not yet become standard clinical practice in India- magnesium sulphate for eclampsia, the use of uterotonics and active management of the third stage of labour for prevention of post partum haemorrhage, and kangaroo care to prevent hypothermia in newborns.
In keeping with its mandate to prevent the consequences of unsafe abortion, UNFPA contributed to the development of national guidelines for comprehensive abortion care and advocated for the adoption of the guidelines.

A list of all protocols, tools, guidelines, manuals and training modules produced during the CP-7 cycle is in Annex 7. Some of the tools and guidelines prepared prior to CP-7 continue to remain useful for current national programmes - for example contraceptive updates, the series of books for ASHAs, and the handbook on infertility management.

d. **Operationalization of First Referral Units (FRUs):** UNFPA consultants in the maternal health division of the MOHFW supported the operationalization of FRUs and 24 hour primary health centers (PHCs). The evaluation team views this TA as relevant and timely since it was provided in response to the recommendations of the JRM. The DLHS 3 of 2007-2008 shows that the percentage of FRUs made operational had increased from 30% at baseline (2005-2006) to 52% against the end-line target of 100%.

e. **Capacity building for maternal and new-born care:** A series of need based training programmes were undertaken to build capacity in key areas of RH such as EmOC, pregnancy care and management. Obstetricians and gynaecologists in medical colleges and at the district level were trained on evidence based delivery and new-born care practices. These programmes have been appreciated by both practitioners and the state governments. No pre and post test assessments have been conducted for these programmes. During its visits to the field, the evaluation team made attempts to assess if the training provided by UNFPA is being put into practice, but it was not possible to assess this effectively given the short time frame available to the team. However, reports from some beneficiaries that the team met in the field (auxiliary nurse midwives and Medical Officers), suggest that they were appreciative of the various trainings that they attended.

f. **Capacity building for family planning**

   **Contraceptive Updates:** In 2009, UNFPA funded the Indian Medical Association (IMA) to provide its members contraceptive updates. Approximately 4000 doctors received the updates. UNFPA prepared and distributed the instructional material on CD to the concerned IMA branches, and organized expert master trainers to train six to eight members of the IMA in each of the five states as trainers. These trainers in turn trained other members of the IMA. There is no data available on the outcomes of these training programmes.

   **No scalpel vasectomy:** Family planning in India has long been equated with female sterilization. While no-scalpel vasectomy offers a much more convenient alternative, it is a method for men. It is not a method that has been popular, though the technology has been around for close to two decades and was initially introduced and promoted in India with UNFPA support. UNFPA has supported efforts being made by the governments of Bihar and of Rajasthan to improve the provision of no-scalpel vasectomy (NSV) services. In Rajasthan, the government wishes to offer NSV services through special once-a-week clinics at all district hospitals and in selected FRUs. UNFPA is supporting the branding of these clinics, and is developing prototype communication material to promote the clinics and generate demand for NSV. This work is almost done and the Government will then use the prototypes to produce materials in the volumes that it needs. In Bihar there is a shortage of doctors who are trained to perform non-scalpel vasectomy. The government would like to undertake the
training of providers in all districts, by first training 1 trainer in each district. Commencing 2010, UNFPA helped the Government of Bihar in this effort by training 6 doctors as trainers. Of these, 4 have been designated to serve as trainers in 4 districts. The doctors will begin training others in the district in training camps. Currently, UNFPA is providing funds for demand side activities to generate sufficient case load for training the doctors in these 4 districts.

The work on NSV is particularly relevant since it helps to fill a significant gap in family planning services. Most stakeholders that the evaluation team spoke to perceived that this TA would contribute to increasing acceptance of NSV in the states.

Post partum contraception: Training on post partum and post abortion family planning was provided to professors from medical colleges and senior block and district programme managers of NRHM.

The demand for post partum and post abortion family planning, as for NSV, has always been sluggish. The needs, benefits and methods are poorly understood by the general public. Significant and consistent effort is required to motivate larger acceptance. Mere focus on provision of services is not going to result in greater acceptance of this method.

g. Enhancing access to FP/RH services: Government has recently begun to see public private partnership (PPP) as a potentially viable alternative for improving the availability of services within government RH program structures. UNFPA commissioned Price Waterhouse Cooper to carry out a study and recommend robust processes for managing PPP so that access to family planning services can be improved. PWC has recommended that the government use a third party to procure services from the private sector. For instance, an agency would be contracted by government and provided funds to make private sector services available as required by the public sector (for instance for holding sterilization camps, offering IUD services and so on). Under this arrangement, the contracted third party agency would be responsible for supervising the delivery of private sector services, ensuring the quality of the services, and making payments to the providers from funds provided by government. UNFPA staff informed the evaluation team that UNFPA is now negotiating with government to pilot the suggested arrangement in one or two UNFPA states, and has offered to support these pilots with start up funds. This is an important initiative and needs to be pursued. If successful, it would show the way for how government can use the private sector to extend access to services in other fields of health care as well.

Even before the PWC study, states like Bihar had already initiated action on expanding access to family planning services by accreditation of private providers so that they could be listed as part of a network of providers of essential RCH services. However, the state is facing difficulties with internal systems that do not allow for timely payment of subsidies to the accredited private providers. This problem is symptomatic of a wider systemic problem weak procurement and contracting systems for services and goods. Technical assistance inputs are needed to solve these problems and such assistance would have wider benefits across the health system, including in the procurement of drugs, consumables, and small & large equipment. UNFPA’s recent efforts to expose legislators in Bihar to the Tamil Nadu Medical Supplies Corporation, and the PWC proposal to develop a third party agency to procure and manage private sector services for the public sector, are both well considered.
h. **Formulation of project implementation plans (PIPs):** In order to facilitate the decentralized planning that is so central to RCH-II, both UNFPA country and state offices provided TA for the formulation of state and district PIPs and helped prepare the district health action plans which were then collated into state PIPs. Through this process UNFPA has been able to influence state and national RCH strategy and programmes. A review of the PIPs of Maharashtra and Rajasthan show that these states have incorporated QA into their PIPs. At the national level too, the revised operating manual for operationalizing and monitoring the immunization component of RCH-II provides guidance on the need to undertake QA interventions. The evaluation team observed that NRHM program managers at both district and block levels need training and capacity development in areas such as programme management, financial and human resource management, to be able to contribute fully to PIP formulations and the effective implementation of PIPs.

i. **Capacity building for assessment and evaluation of health programmes:** To strengthen national capacity to conduct regular assessments, evaluations and research studies for national health programmes, towards the end of CP-6 UNFPA supported the National Institute of Health and Family Welfare (NIHFW) to conduct a series of training programmes on research and evaluation for the faculty of medical colleges and government research institutions. In CP-7, the Center for Health and Social Justice (CHSJ) - an Indian NGO- and the University of Washington were supported to conduct similar programmes for the NGO sector. The idea of building institutional capacities on research and evaluation among both public sector health institutions and networks of NGOs has the potential to provide long term support to national and state programmes, provided the training programmes become institutionalized and thus sustainable. In the absence of any formal pre-post evaluation of these training programmes it is difficult to assess how effective the programmes were. Discussions of the evaluation team with various participants from both government and the NGO sector suggest that these training programmes were perceived as highly relevant and were appreciated by all the key stakeholders. As regards the future use of research capacity built, the evaluation team found that because NIHFW is funded by the national government as a training and capacity building institution for national health programmes, it is in a position to sustain this programme, and will also be able to mainstream this training into its regular calendar of training. However in the two years since NIHFW was supported for this activity, it has not included this training in its regular calendar of programmes. There is no evidence that NIHFW is committed to running these programmes on a long term basis. In the case of CHSJ it is clear that it will not be able to continue this programme on its own without funding. UNFPA should advocate with the government to develop a clear strategy for utilizing the public sector and NGO capacity that has been enhanced by UNFPA training. For instance government could routinely involve these institutions in carrying out such rapid assessments as are needed to monitor the quality of RH services. UNFPA should also plan to advocate for much greater engagement of NGOs/CBOs, public sector institutions, and other credible and independent research organizations/institutions, in providing feedback on maternal health and RH interventions implemented within the NRHM framework. Such organizations should also be involved in monitoring the extent to which evidence based practice is being used in public health institutions.
j. **Capacity building to mainstream gender into RH:** Important inputs on gender have been the checklist for assessing PIPs from the gender perspective, and the gender tool kit which is a guide that helps providers and programme managers to make services gender sensitive. In CP-7, an important capacity building input given by UNFPA to providers has been training in gender sensitivity. Providers need to go beyond the bio-medical symptoms of a client, to a holistic understanding which will enable more effective care and treatment. In addition to training on clinical issues, providers need gender and other inputs which will help them to achieve greater appreciation of social and cultural aspects.

One of the learnings discussed at the Gender Consultation workshop held with UNFPA staff in April, 2011 was that providers are not receptive to stand-alone gender sensitivity training. An alternative training approach is recommended - when technical training is designed and provided, no matter on what subject, training methodology and content must ensure that trainees are made aware of all gender and social issues that are related to the subject and that skills are developed in delivering holistic and gender sensitive care.

Over the years, UNFPA has done a great deal of work on gender. The fundamental belief underlying this body of work has been that women need to be treated more equally and with more dignity than they have been treated in the past. Therefore in a way, the term “gender sensitivity” has become synonymous with ‘sensitivity to the special needs of women”. This definition needs re-examination. In recent years there has been growing recognition of the existence and plight of sexual minorities in society. “Gender sensitivity” and gender mainstreaming now need to aim for equitable treatment for all genders, according to their differing needs.

In the CP-7 document, the work that will be undertaken on gender is quite clearly articulated. However, from the evaluations team’s visit to the state offices, and from the Gender Consultation Workshop held with all UNFPA country and state office staff in mid April, 2011 the evaluation team perceived that not all staff has a clear and sufficient understanding of the issue of gender and of how it should be integrated and mainstreamed into its work. Even those working in RH were not always clear about what the gender component of their work is and of how gender is being mainstreamed into RH. At times, personal conviction seemed to be lacking. Without clear shared understanding of the value of including gender in all that is done, and of how it is to be done, programme managers will miss opportunities for mainstreaming, and may not even be able to ensure appropriate attention to gender issues when programmes are being implemented. Concern for and inclusion of gender is the hallmark of quality services.

In Section X of this report - Operational Modalities- the evaluation team has discussed organizational arrangements which could be made to ensure that all programme staff, whether in the country or state offices, understand the issue of gender from the same perspective and know what each member of the staff needs to do to take UNFPA’s important gender agenda forward.

Overall, stakeholders at both the national and the state levels said that they found the TA and capacity building provided by UNFPA relevant and valuable. All the key stakeholders reiterated and underscored this, and singled out UNFPA TA for appreciation. TA has been particularly relevant and effective in the content areas of maternal health and EmOC, and in
the preparation and development of district PIPs. Government partners have felt that family planning related TA has, by and large, been relevant to current programme needs and has ensured the development of knowledge and skills of practitioners. Both at the national and the state levels there is a continuing need for TA in family planning and RH, and governments see a continuing need for UNFPA TA in these areas.

While government and other stakeholders have appreciated UNFPA TA, it was evident during field visits made by the evaluation team and during its discussions with community level functionaries such as ASHAs, auxiliary nurse midwives (ANMs) and Village Health and Sanitation Committee (VHSC) members, that there are several socio-economic barriers that prevent women from poor communities from seeking proper health care. They said that while the monetary incentives for institutional delivery drew poor women into the facilities at the time of delivery, it did not really ensure change in mother and child health practices. Women from poor communities do not seek regular antenatal or post natal check-ups. They are unable to give up daily wages for a visit to the clinic. They continue as before, doing what they think is appropriate within their circumstances. The evaluation team is of the view that UNFPA’s TA to the state governments and NRHM could have added more value by building the capacity of government and other structures to address the specific needs of marginalized populations and the socio-economic & socio-cultural barriers to their utilizing services.

3.3.1.2 Quality Assurance

Among the major intervention programs supported by CP-7, Quality Assurance (QA) is one that has responded to a much felt gap in quality of maternal health and family planning services. Pointing to this need the M & E framework of RCH-II says that quality assurance should be an integral part of service delivery. QA pilot projects in Karnataka and Maharashtra were implemented in CP-6, and in CP-7 were scaled-up in clusters of districts in Rajasthan and Maharashtra. It is expected that by 2012, the end of the CP-7 cycle, the UNFPA initiated QA approach would be scaled up to 20 districts of both states with funds from the respective state governments. As of today, 16 districts have been covered20.

The QA programme in Rajasthan typifies UNFPA’s approach to quality. The programme attempts to both assess and improve the quality of maternal health and family planning service delivery in the primary health system- at sub-centers, and at primary and community health centers (PHCs and CHCs). A set of tested checklists are used to assess quality of facilities. The program includes a series of capacity building programmes at various levels. The key implementing partner is PRAYAS, a local NGO which has a long standing presence in Rajasthan. The Government of Rajasthan provides overall guidance and also plays an oversight role. To ensure commitment at senior levels in the health system, the state government has appointed nodal QA officers. The district QA team is responsible for reviewing the quality of facilities and includes senior district officials. Periodic programme reviews are a way of monitoring the programme and also enable corrections and improvement. The state government sees the QA interventions in Rajasthan as successful and has made budgetary provision in the state PIP for 2011-2012 for implementing QA programmes in 50 blocks of 19 high focus

20 See Annex 1 for intermediate results against the indicator “Number of districts having QA groups established.”
districts. The eventual plan is to scale up to all blocks of the high focus districts, and then to scale up to all districts in the state.

In Maharashtra, the major implementing partner for QA is the Public Health Institute (PHI), Nagpur- a Government of Maharashtra (GOM) institution. The structure and approaches of the QA project in Maharashtra are similar to those described for Rajasthan. The only difference is that while in Rajasthan the project is confined to only four blocks in the selected districts, in Maharashtra the QA project has been implemented in all blocks of the 12 districts. The GOM has committed to scale up the programme by adding another 6 districts, taking the district total to 18 by 2012. PHI has completed all the training and capacity building required to implement this programme, and has included faculty of medical colleges and health programme managers in these training programmes. These participants from medical colleges are expected to become programme resource persons and trainers when the programme is up-scaled to other districts.

The QA programme is showing results in terms of improvement in the quality of facilities and services at the primary care level. Between October 2009 and July 2010, the 6 districts where implementation began in phase 1 of the project, have had a total of 3 rounds of quality assessments. The assessment shows that there has been impressive improvement in quality in these facilities. In the first round only 22.5% of CHCs, 4.5% of PHCs and 0.01% of sub centers qualified to be rated as category A facilities. At the end of round three, 67.5% of CHCs, 51.5% of PHCs and 64% of sub-centers were graded as category A facilities. The system of assessment of facilities has been understood and internalized by the staff of primary care facilities in the intervention areas. TA provided by UNFPA on QA, is relevant as it fits in well within the RCH-II M & E framework. It has effectively achieved the desired outputs. Programme processes have attempted to use capacity building approaches which will enable the effort to continue, and be replicated in more districts. As evidenced by the PIPs of Maharashtra and Rajasthan for the years 2010-2011, where quality assurance activities have been built into the programme plans of the states, the government has begun to see quality as an essential element of the national programme and is committed to taking the effort forward with its own resources. Even the GOI revised operating manual for preparation of state PIPs points out that QA must be an essential component of RCH II and immunization programmes.

A challenge to scale-up is going to be to ensure that the government allocates adequate resources and manpower to quality assurance programmes. UNFPA will need to work closely with the state governments to ensure that appropriate financial and human resource provisions are made in the PIPs. In fact, if the work of QA is to be scaled up in many more states, UNFPA needs to take advantage of the current interest of the government in quality assurance, and to leverage greater resource allocation at the national level for QA work in many more states. The second challenge is that if quality is to become an essential aspect of service delivery, the health management information system (HMIS) should report data against a few well chosen quality indicators, and the performance of the system against these indicators should be routinely reviewed and monitored. At present the HMIS does not include any indicators of quality.

There is a pressing need to improve the quality of services and care in India. This is a niche that UNFPA could fill and the work that it has done in Rajasthan and Maharashtra is a credible starting point. The value and relevance of the work of Quality Assurance could be increased by developing and implementing a more robust and comprehensive model of quality assurance than is presently being used. At the facility level, the model should aim for holistic quality of care
incorporating detection of gender based violence and support for survivors, gender sensitivity of providers, sensitivity to the special needs of adolescents and youth, and the provision of services based on community needs assessment. The present QA approach needs to be aligned with the overall quality of care framework in which community needs assessment and monitoring is an essential component. There is a clear need to bring together the experiences of both clinical and community programmes and rebuild the capacity of the health service delivery system to plan from the grass roots level, using community based eligible couple registers/health registers and building much greater and intensive interface between NGOs, communities, and government officials to bring in community monitoring of quality. In the current programme the linkages with the community are less than adequate. Such a holistic model of QA would enable UNFPA to weave together all its priorities in RH, quality, adolescents, gender, gender based violence, and communitization, into one coherent framework and programme.

At the present time, in Maharashtra, UNFPA is supporting a massive sensitization programme to train members of women’s self help groups to enable them to demand need based and quality health and RH services. However this work is not being done in the same districts where the QA programme is being implemented. In Rajasthan too, the Jan Mangal Couples, who were originally meant to be a community based distribution for contraception, are now being used to mobilize communities to demand quality services, but the work of community involvement in quality needs to be much more closely linked to the QA programme.

3.3.1.3 Communitization of NRHM

The work in Maharashtra and Rajasthan, to enable communities to demand need based and quality services, is an example of communitization.

Within the framework of NRHM, the communitization activities have in recent years, received major attention from government and development partners alike. The work of the Advisory Group on Community Action (AGCA) set up by the GOI is particularly relevant in this regard as it helped to develop strategies, methodologies and tools for community monitoring of NRHM. CP-7 too has responded with major efforts to pilot and scale-up communitization activities.

In MP and Orissa, communitization activities have aimed at strengthening the capacity of community based structures such as VHSCs, and Rogi Kalyan Samitis21 (RKS) to carry out decentralized planning, monitor the quality of maternal health services, and conduct social audits of maternal and neonatal deaths.

In MP, as part of the communitization process, the State Government, UNFPA and the MP Voluntary Health Association (MPVHA) jointly took up activities such as capacity building of VHSC members; establishment and functioning of village information centers; orientation of health care providers; issue based campaigns; community based monitoring and working with health care services; experience sharing meetings and workshops; and public dialogue sessions (Jan Sanwad). The MP Government has made district programme managers (DPMs) and block programme managers (BPM) of NRHM accountable for communitization processes and activities.

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21 Patient welfare committees formed at larger government health facilities
NRHM sees communitization as a means of strengthening the demand for RH services. In Orissa, working with Orissa Voluntary Health Association (OVHA) and My Heart, UNFPA worked in 50 villages each of 4 blocks of 2 districts, and supported training and orientation workshops for VHSC members and a community campaign on communitization. It helped to prepare village health plans. 50% of the villages prepared village health plans but though these plans were handed over to the state NRHM authorities, they were not incorporated into the district and state level plans. In Orissa the main objective of UNFPA’s communitization program was to develop process details for operationalizing the VHSC. The programme developed process details, resource material and training material. These were used and adapted by the Health Department for operationalizing VHSCs through the whole state.

Most stakeholders including NRHM officials, NGO partners and community members, found the communitization related activities highly relevant. The activities brought partners together on a common platform, helped build capacity on issues of community mobilization, and raised awareness on maternal health issues. The programme succeeded in developing village health plans and also in laying out processes for forming and activating non-existent or dormant VHSCs. However, it was not able to get the decentralized district planning process to take cognizance of and build upon the village planning process. Nor are the village plans being used to deliver and monitor health services. This is largely because currently ASHAs who are members of the VHSCs and can be important instrument to help prepare and monitor village health plans are incentivized only for the work that they do to mobilize women for institutional delivery, and to mobilize attendance at monthly village health and nutrition days. Our discussions with VHSC members and ASHAs clearly revealed this. The meagre resource of Rs. 10,000 allocated to VHSCs are spent largely in meeting the logistical and other infrastructural costs of sub-centers including rents and medicines required at the time of the child delivery as part of JSY. During the field visits of the evaluation team, it was evident that ASHAs and resources allocated to VHSCs are focused largely on meeting JSY objectives and not on other aspects of village health planning and service delivery at the community level. VHSCs need a lot of handholding to enable them to prepare tangible plans. It appears that while the village health plans developed pay attention to maternal health and family planning issues, they do not adequately deal with other aspects of village health and sanitation that are the responsibilities of the Gram Sabha.

The whole process of village planning and monitoring requires serious resources of time, and technical support. It is the impression of UNFPA staff that government does not have either the commitment or the resources to really make village health plans robust and to scale up these processes throughout states. This perception combined with other priorities has led to the work on communitization being placed on the back burner.

Communitization is an important component of NRHM programmes. The extremely relevant and significant activities supported by UNFPA to help implement the communitization process have to become part of a larger scheme where community empowerment and quality of services are integral and complementary components. UNFPA should support the evaluation of various communitization programmes - including but not limited to those supported by UNFPA - to assess their potential for providing sustainable, community led mechanisms that will hold government accountable for delivery of high quality health services. These communitization

22 The Gram Sabha is the general body of the village
models need to be studied to assess how best to strengthen VHSCs to prepare decentralized village health plans and how they can serve as a tool for monitoring service delivery - in a cost effective manner.

### 3.3.1.4 Interventions to address Gender Based Violence (GBV)

a. **UNFPA** has brought out a synthesis of Indian evidence on the health and social consequences of marital violence\(^{23}\). This document could prove to be a strong advocacy tool for building sustained responses from within the health care system to gender based violence.

b. **GBV in hospital and health institution settings:** In CP-6 UNFPA worked on detecting GBV in hospital and institutional settings in Rajasthan and Maharashtra. UNFPA has filled a much felt gap in health services by developing and testing screening tools to detect domestic violence cases in hospital settings. These tools allow tracking and follow up of cases of gender based violence.

In CP-7 this work was implemented in one New Delhi Municipal Corporation hospital in Delhi. Staff of the hospital including doctors, nurses and paramedics was trained to look for signs of violence when a woman comes for services, and to refer survivors to a counsellor. The tools for this programme need to be peer reviewed and validated before national advocacy can be undertaken to use them at scale. There is no information available on programme outcomes- on whether this training has had any impact on providers and whether they are now detecting and dealing with cases of gender based violence.

c. **GBV in community settings:** In Rajasthan and Bihar, UNFPA worked with PRIA and The Hunger Project respectively to sensitize members of Panchayati Raj Institutions (PRI) about the need to address violence against women including on the issues of dowry, sex-selection and child marriage. Pre-election voter’s campaigns in Rajasthan, and the work with women elected representatives in Bihar, have helped to generate wide discussion and visibility of these issues. In Rajasthan, work started in 2009. 10,000 women PRI candidate took an oath to fight violence against women. There has been no evaluation of this programme and there is no evidence of any other measurable outcomes of effectiveness of this intervention. Neither of the programmes have any indicators to measure whether PRIs are doing anything to prevent sex selection, child marriage or other manifestations of gender based violence. In Bihar, the intervention began in 2010 and the first report of progress is awaited.

Given the increasing importance of and devolution of powers to PRIs, and the increased number of elected women representatives, it is important that PRIs take greater responsibility for community based monitoring of key issues of gender based violence such as sex selection and child marriage, and also on maternal and child health.. UNFPA should continue to work with PRIA and THP to enhance the capacities of PRI members and ensure that there are measurable indicators to assess the role of PRIs and their members in community based monitoring of these key issues. If PRIs become responsible for taking cognizance of and acting against gender based violence, it would also help to challenge inequitable gender norms within community settings and ensure that women survivors receive community support.

\(^{23}\) Jejeebhoy et al (2010); “Health and social consequences of marital violence: A synthesis of Indian evidence”; UNFPA/Population Council
support. Community partners can also help to advocate with State Governments for setting up monitoring cells and for allocating resources to implement the Act.

d. **Operationalizing the Prevention of Domestic Violence Act**: In MP, jointly with Action Aid Association, UNFPA has worked on the operationalization of the Prevention of Domestic Violence Act (PWDA), 2005, in two districts. Due to the strong advocacy effort of this programme, a monitoring cell has been established in the District Collector’s Office to monitor the implementation of the Act. Training and awareness materials have been prepared to raise awareness and also to train auxiliary nurse midwives and ASHAs.

e. **Programme for men and boys in Maharashtra**: UNFPA is supporting CHSJ to implement a programme to engage with men and boys in 125 villages of 2 districts of rural Maharashtra, promote gender equality, reduce violence against women and achieve positive RH outcomes. WHO conducted a meta-analysis of programmes for men and boys\(^{24}\) that seek to reduce violence against women and concluded that there is no evidence to show that such stand alone programmes for men and boys eventually reduce violence. Programmes such as that undertaken by CHSJ therefore need to be rigorously evaluated for impact on reducing violence against women. Started in April 2010, the programme has an evaluation plan, and a baseline study has been conducted. Groups of men and boys have been formed in the 125 programme villages. Both the study and its evaluation are important because they have the potential for generating evidence on the extent to which such programmes help to mainstream gender in RH and in the achievement of UNFPA’s overall advocacy and programme goals of promoting gender equality and positive RH outcomes. Both the intervention design and the evaluation design need to be constructed in a manner that will generate evidence that will withstand scrutiny.

Most stakeholders perceived the UNFPA initiatives to institutionalize GBV in health care setting as something of a pilot that should be scaled up if found effective. These initiatives were seen as relevant, although it is difficult to assess the effectiveness as the programme as outcome data is not being collected.

### 3.3.1.5 RH Advocacy

UNFPA’s advocacy work has been low key and has chiefly focused upon:

a. **Advocacy against the 2 child norm**: Towards the end of CP-6, UNFPA, jointly with other development partners, led a particularly successful advocacy effort with the national government to drop the age and parity clauses that excluded young mothers below the age of 18, and those with more than 2 children, from being eligible for the Janani Suraksha Yojana (JSY) scheme\(^{25}\). The advocacy efforts were sustained through CP-7 to ensure that these clauses were not revived.

b. UNFPA advocated for adding a second auxiliary nurse midwife to the PHC so that the primary health care delivery system to rural communities could be strengthened. There is

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\(^{25}\) A scheme that offers financial incentives to encourage institutional delivery
also a need for male health workers in the primary health outreach service delivery system. When there is increased focus on male involvement in health, men in the community need counselling and education as much as women do. On issues such as family planning, RTI/STI, safe sexual behaviour, and violence against women, male voices at the community level are needed to advocate for change. The lack of men in the primary health outreach system is a debilitating gap and as long as the gap persists, women health workers will continue to target women, burdening them alone with the responsibility for change. The GOI is in the process of hiring nearly 53,000 male health workers in 235 high focus districts. Currently, job description of male health workers is limited to vertical disease control work. Their role needs re-definition. UNFPA should play a TA role in helping to define the role of this category of health worker and in preparing it through orientation and training to play its role productively.

c. **Revitalizing Family Planning:** CP-7 very accurately identified the need to revitalize the stagnant family planning program in India. The Country Program document expressed the need for improved conceptualization of strategies to service contraceptive needs of the community and to provide TA to ensure systemic planning for delivering quality family planning services. UNFPA intended to analyze past programme performance, unmet need and expected levels of achievements, and availability and deployment of skilled providers to provide an expanded package of contraceptive choices. It also planned to build capacities in the FP divisions at the national level and in selected states to routinely collect, analyze and utilize programme data for sound planning leading to improved performance. The work that UNFPA actually accomplished in the area of family planning has already been discussed in the paragraphs on TA and capacity building on page 18 of this report.

- **Advocacy issues in family planning:** There have been a few issues on family planning that need sustained and strong advocacy.

- **Repositioning family planning:** Perhaps the most important of these is the need to reposition family planning in India. There is a need to change service delivery and demand generation approaches from those that push sterilization for reasons of population control to those that recognize that men and women will benefit from deciding early in life when they want to begin child bearing, how much space they want between children, and how many children they want. Such family planning needs to be the centerpiece of a primary health and national development strategy that seeks to ensure good health and reduced mortality for mothers and infants, empowerment of women, family well being, and poverty alleviation. However, family planning has not yet been viewed from this perspective by policy makers and programmers. Strong advocacy is needed to build such perspectives at all levels of the health system. Given the youth bulge in demographic trends, and a growing body of evidence that shows the positive impact that delaying and spacing child bearing has on maternal health and infant mortality, it is clear that a family planning focus on youth, rather than on those who have attained their desired family size, will pay greater dividends in both improving maternal and child health and in stabilizing population growth. This evidence makes it necessary to “reposition family planning”. Recently, UNFPA has begun to support two adolescent family planning interventions in Bihar and MP promoting change in social norms that pressure young people into early child- bearing, and promoting the use of contraception for delaying the first child and spacing subsequent children. The results of these
programmes will need to be carefully measured and disseminated to ensure that the programmes can be used to support an advocacy agenda for repositioning family planning.

- **Advocating against the emphasis on single method family planning programmes:** The government health system is anxious about the high unmet need for contraception. There is a growing demand for contraception including for non clinical spacing methods, IUD, and sterilization. The health system has fallen behind on delivery. The response of programme managers is to focus on the numbers sterilized. Reminiscent of the days when the family planning programme was target driven, administrative attention and resources are now being focused on the number of men and women sterilized. As a result, the attention of the primary health system is diverted from routine provision of quality RCH and family planning services, to just conducting sterilization camps. The adverse effects of this approach are well known. The desire of the state health systems to provide family planning services is laudable. The problem is with the single method approach that they are choosing. It is imperative that UNFPA uses a farsighted, comprehensive and constructive advocacy programme to bring balance into the system. There is a need to gather, analyze and present national and international data that shows that it is possible to achieve high contraceptive coverage and consequent maternal and child health objectives through provision of services that deliver a basket of choices suitable for all age groups and parities. Advocacy on this potentially sensitive issue is needed urgently.

### 3.3.2 Output 2: Promoting safe sex behaviours among vulnerable population groups: Sex-workers and women

In accordance with the regional division of labour matrix among UN agencies, UNFPA is designated to play the lead role in the area of HIV prevention among sex-workers and their clients. Two specific indicators defined both by NACP III and by the United Nations General Assembly Special Session to review HIV/AIDS guide the activities under this HIV output:

- Percentage of female sex workers (FSWs) reached by targeted interventions –to increase from 45% in 2005 to 80% by 2012; and

- Percentage of female sex workers reporting use of condoms with their most recent client–no specific values have been assigned by the NACP III for this indicator.

Review of UNFPA’s HIV portfolio in India, field visits and discussions with programme personnel suggest that in CP-7, UNFPA has not been confined to the sex-worker and client themes, but has played a much wider role in HIV prevention. The following interventions were undertaken during CP-7:

- TA for HIV;

- Interventions among female sex-workers in Rajasthan, and MP, to promote female condoms and safe sex behaviors and
• Development of learning sites for the transfer of targeted interventions to community based organizations in Rajasthan;

In addition, UNFPA has tried to integrate content on HIV into its life skills programmes for youth. Jointly with UNICEF, UNFPA is a global lead agency responsible for working on the theme of preventing HIV among out of school youth.

3.3.2.1 TA for HIV

Within the framework of the NACP III, UNFPA has provided TA on a wide range of issues and activities to the National AIDS Control Organization (NACO), and in particular to the Rajasthan State AIDS Control Society (RSACS). Some of the areas of TA that were provided by the technical staff both at the country and the state offices include:

• Capacity strengthening of RSACS to up-scale targeted interventions. This included the establishment of a Technical Support Unit (TSU); facilitation of the Mid Term Review of NACP-III in Rajasthan, and support during the observance of World AIDS Day/Week.

• Concurrent evaluation of the Red Ribbon Express\textsuperscript{26};

• Joint review of the Gates Foundation funded Avahan programmes in Maharashtra in order to assess how AVAHAN funded target HIV prevention interventions for risk groups can be cost-effectively transferred to the state government

• Preparation of a user’s manual on best practices by Community Based Organizations (CBOs) on FSWs

• In 2005, UNFPA invested in the study on convergence between the service delivery approaches of HIV/AIDS and of RCH\textsuperscript{27}. It intended to provide TA to convert the key themes of this policy document into action. In the CP-7 document, convergence was rightly viewed from two angles: (a) integrating RH services into HIV AIDS services being provided to vulnerable groups such as sex workers, and (b) integrating HIV/AIDS services into RH service packages for the general population. Pilots were intended to demonstrate both approaches. UNFPA is currently funding two FSW projects in MP and Rajasthan. Neither has been used to demonstrate integration of RH into HIV services for vulnerable groups.

Of the many TA activities in HIV, the support provided in Rajasthan is significant. UNFPA has played a critical role in developing the action plan for HIV prevention in the state of Rajasthan, and has also facilitated the establishment of a Technical Support Unit (TSU) in RSACS to provide on-going technical expertise in the area of HIV prevention, through the placement of consultants and a team of professionals. Currently UNFPA is supporting 3 state level programme

\textsuperscript{26} The Red Ribbon Express is national campaign focusing on mainstreaming the issue of HIV through a railway train and is the world’s largest mass mobilization campaign on HIV/AIDS. A one year long journey of the trained covered over 27,000 kms and touched 180 district / halt stations along with outreach activities at the halting stations.

\textsuperscript{27} Convergence Between The National AIDS Control Programme (NACP) And The Department Of Health And Family Welfare (DOHFW), Dr. Rajani Ved, February 2005
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officers to help run the TSU and has hired two field staff. The Technical Support Unit (TSU) of RSACS is providing technical support to the State of Rajasthan to achieve maximum coverage and sustain quality of the implementation in HIV/AIDS prevention, care and treatment programmes. The TSU provides technical expertise to RSACS in the areas of evidence based strategic planning & management; targeted interventions for core & bridge populations; capacity building of civil societies & service providers; information education & communication/behaviour change communication; advocacy & enabling environment; public-private partnerships (PPP) & mainstreaming; and condom promotion.

The TSU team is a high calibre, technically competent team with solid previous experience of working on issues of HIV prevention. According to the RSACS chief, the UNFPA run TSU is the ‘eyes and ears of RSACS’.

According to RSACS, some valuable contributions of the TSU include playing a ‘problem solving’ role between NGOs and the community; providing support during planning phase and in strengthening the surveillance system. The TSU has also played a technical oversight role in supervising some UNFPA supported female sex-worker projects in Rajasthan.

Clearly the TSU has effectively played its routine role and ensured stronger implementation of NACP-III targeted interventions. Programme data has been systematically organized and is used for planning purposes. This important experience could inform and help refine the HMIS for HIV at the national level.

However, the evaluation team finds that UNFPA missed the opportunity presented by the NACP-III to work to bring about convergence between RH and HIV. Guidance on how this can be achieved is available from two studies, one commissioned by USAID in 200428, and one by UNFPA in 200529. Neither UNFPA nor others have as yet taken up the challenge of showing the way to convergence. As funding for HIV programmes shrink and NACP-IV begins to be designed, consideration of convergence is timely. NACO has expressed the need for TA in this area. Any work done in this area would be hugely innovative and would need to be carefully designed and documented. Maharashtra offers the ideal setting for this work which should be done in collaboration with the state government. Mumbai and Pune have large populations of brothel based sex workers and would be ideal locations for piloting sex worker interventions that integrate RH into HIV services. Similarly, a rural district could be used to demonstrate integration of HIV into RH. Maharashtra has a critical mass of expertise in both government and the NGO sector in HIV AIDS programming, and two of the largest donor programmes in HIV, funded by USAID and the Gates Foundation. UNFPA could draw all these partners into designing and implementing a significant programme that would be truly relevant and pioneering.

3.3.2.2 Interventions among female sex-workers to promote female condoms and safe sex behaviour in Rajasthan and MP.

28 An Exploration of Scope for Convergence of Services between National AIDS Control Programme (NACP) and Reproductive and Child Health (RCH) Programme, Policy Project, the Futures Group International, New Delhi, June 2004
29 Convergence Between The National AIDS Control Programme (NACP) And The Department Of Health And Family Welfare (DOHFW), Dr. Rajani Ved, February 2005
UNFPA has supported a couple of interventions to promote safe sex-behaviours among FSWs in Rajasthan and MP. Population Services International (PSI) implements the intervention in Rajasthan, promoting and testing the efficacy of female condoms among FSWs. In MP, Jeevan Jyoti Health Service Society, works in two districts to mobilize and build the capacity of FSWs to implement community led targeted interventions for HIV prevention. Jeevan Jyoti has set up drop-in-centers, distributes condoms and communication materials; and offers peer counselling and STI treatment services. Though both projects appear to be one-off and disconnected, since they address the same population, they are likely to have the potential to offer learning that would be useful for other sex worker interventions. It is not immediately clear how the State AIDS Control Societies propose to sustain these two activities and mainstream the uptake of female condoms and other prevention services provided by these projects when UNFPA support is withdrawn.

In the MP FSW project, some recent attempts have been made to extend RH services to FSWs. These include weekly clinics for FSWs to diagnose and treat RH problems and offer counselling services. However, it is our considered view that the FSW projects in MP and Rajasthan can even now be used to design and evaluate approaches to integrating SRH into HIV programs for sex worker.

3.3.2.3 Developing learning sites for the transference of targeted interventions to community based organizations in Rajasthan

With technical support from Ashodaya, an Indian NGO that runs a targeted intervention (TI) for FSWs in Rajasthan, UNFPA has implemented a mentorship programme under which a series of training programmes sought to build the capacity of sex workers to manage their own TI. The aim is to transfer the TI to the community. While no detailed work plan has as yet been submitted to the state office, Ashodaya plans to hold a series of workshops and training programmes for a few identified community based organizations of FSWs and hopes to handhold them till they are able to run their own TI programmes. As a part of this effort, a visioning workshop was also held for RSACS officials. There is certainly a need to evaluate this programme to assess the feasibility of the model and then to work out a sustainable way of ensuring capacity building of community based organizations (CBOs) formed by sex workers and other target groups.

Transferring the management of TI programmes to the community for which they are meant appears to offer a sustainable and stigma free solution to the provision of prevention and care services. The evaluation team recognizes that NACP-III strategy includes a major objective of building the capacity of CBO’s to implement TIs, and that this is the basis for supporting the ASHODYA intervention. However, it is also important to recognize that, the concept is fraught with challenges. In situations where sex-work is home-based and hidden- as is the case with a large majority of sex-workers- or where women covertly sell sex as a means of supplementing income, and do not define themselves as sex-workers - as in the Bedia and Nat tribes in Rajasthan- it is problematic to create artificial “community based” structures to take over and manage targeted interventions meant for them. Such a move would destroy the cover that the women so carefully create for themselves. Once the cover is destroyed, social stigma cannot be avoided. In the case of communities such as the Bedias and Nats, entire communities run the risk of being stigmatized.
This programme is just beginning. FSWs and NGO staff have just made one exposure visit to Mysore to study similar programmes, and it will be interesting to observe the results of this programme. If the ASHODYA model works, UNFPA should promote it to NACO for replication. Long term sustainability of programs such as Ashodaya would depend a lot on the availability of funds to NACO to run these interventions.

In our discussion with NACO we learned that it is glad of UNFPA’s support, particularly now as funds from the Global Fund for HIV/AIDS for India are shrinking, and the Gates Foundation is withdrawing support to the NACP. NACO views UNFPA positively for its technical strength in the areas of RH, population and youth. However the support NACO expects from UNFPA is not in the area of sex-work as there are several players (despite shrinking funds). Rather, NACO expects UNFPA to contribute to the issues of convergence and evaluation- as with the evaluation of the Red Ribbon Express.

In deciding on the role that UNFPA should play in HIV/AIDS, there is a need to balance several factors: that UNFPA’s core competence is in population and development, in RH, family planning, and youth; that though its core competence is not in HIV, yet its global mandate for HIV programmes gives it the role of being the lead player on sex work. UNFPA’s overall strategy to address HIV prevention needs to be carefully defined within these factors as well as with in-country expectations of it. Evaluation and convergence are certainly two key areas where UNFPA should play a role.

3.3.3 Output 3: Mainstreaming of RH and gender issues in recovery and rehabilitation responses for natural disasters and environmental challenges

The UNFPA country office has played a small but critical role in mainstreaming RH and gender issues within recovery and rehabilitation responses for natural disasters and environmental changes. It is understood that this has been done in keeping with the UNDAF commitment and also in line with UNFPA HQ role in natural disaster.

The CP 7 programme in India has largely focused on advocacy efforts to mainstream gender and RH into responses to natural disaster. This has been done working closely with the National Disaster Management Authority (NDMA), the Indian network of NGOs called SPHERE which works on issues of disaster management, and the Joint UN Disaster Management Technical Group (UNDMT),

Worldwide, UNFPA provides “Dignity Kits” as an immediate relief item to women and girls during a disaster and in the post disaster phase. “The dignity kits in India contain clothing for adolescent girls and women and other items like sanitary napkins and panties that promote maintenance of menstrual hygiene and provide basic dignity”.

UNFPA CP-7 also provides training to NGOs/CBOs to enable them to provide psychosocial counselling to the community.

Members of the UNDMT team agreed with the evaluation team that in India, the scale of disaster is too large, and the Government’s own system of response is well developed. Although the

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30 UNFPA; Brochure on Dignity Kit
evaluation team recognizes that UNFPA support in disaster relief has been vital in leveraging the larger pool of resources available within the government, there is very little that an agency like UNFPA can meaningfully do to actually provide direct relief.

Though there is lot of visibility of the dignity kits, it has received mixed reactions in terms of its uniform suitability across hugely diverse Indian cultural settings. UNFPA team members in the states have commented on the fact that some of the materials kept in the dignity kit- for example Salwar Kurta\textsuperscript{31} which is used largely in the north India-, were not suitable for women in the North East or in places like Leh. Also, they pointed out that ensuring timely and regular supply of a sufficient number of dignity kits to meet the large scale of disaster in India presented a major logistical challenge. Perhaps the dignity kit is not the best use of UNFPA’s technical role and resources. Government could be assisted to source it from elsewhere if needed.

In Maharashtra UNFPA provided technical support to integrate a minimum initial service package for RH in disaster in the professional development course for middle level managers. UNFPA has recently signed a memorandum of understanding with National Institute of Disaster Management (NIDM) to mainstream the gender and RH related training programmes in NIDM and the Apex Training Institutes (ATIs). This is a welcome move in the right direction and needs to be pursued to provide TA and assess its impact in the delivery of services.

At the present time, the only material available on how to incorporate RH and Gender issues into disaster response is in the form of power point presentations. Considerations of sustainability require that this content is included into all training programmes on disaster management and response so that the content is mainstreamed and institutionalized.

Apart from large disasters, there are smaller, more localized environmental challenges - for instance desertification and other forms of land degradation, floods and regular droughts - that go unnoticed since they are not large in magnitude. Yet these local environmental challenges impact men and women differentially. More often than not it is the women who bear the brunt of these challenges. Very often men go out in search of jobs and money and women are left behind with little or no support. A niche role for UNFPA could be within its 5 states to identify locations with recurring or constant environmental challenges, where continuing work could be done to mitigate the effects of challenges on the RH of vulnerable segments of society. For these areas, UNFPA could play a role in mapping RH and gender vulnerabilities, disseminate this information to governmental and non-governmental agencies, and advocate for them to work to mitigate these conditions.

3.4 Conclusions and recommendations

Some significant achievements of the RH program have been:

- Success at ensuring that Janani Suraksha Yojana entitlements are not limited to only women with two children or less.

- Development of a wide range of knowledge products for TA- guidelines, tools, protocols, and manuals including those on incorporating gender perspectives

\textsuperscript{31} Outer garments used by women in the northern India.
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- State ownership of the QA pilots in Maharashtra and Rajasthan, resulting from successful intermediate scale-up of the QA model, to district clusters in Maharashtra and Rajasthan. These two state government have now bought into the program and will invest their own funds for further scale up

- Major efforts in communitization in MP and Orissa

- Development and testing of tools for use within medical facilities to screen for gender based violence so that survivors can be followed up and supported

- An impressive TSU in RSACS offering comprehensive and much appreciated support to the State’s HIV programme

- MOU with the NIDM for integration of RH/gender issues in training programs on disaster response

3.4.1 TA and Capacity Building

Guidelines, manuals, protocols tools developed: The guidelines, protocols and training modules developed and used under the CP-7 and in previous cycles need to be disseminated and used widely, and integrated into regular pre-service, in-service and refresher training programmes for practitioners at all levels.

**Suggested Action:** UNFPA should evolve an advocacy strategy to review and promote both the training materials and the learning from various capacity building activities.

**Public Private Partnership for Improved Access to RH Services:** Public private partnership does offer a means of expanding the service delivery network for family planning and RH services provided the government has reliable systems for accrediting, using, and paying for services provided by the private sector to the poor and marginalized.

**Recommendation:** Advocate with government, fund and evaluate pilots of the PWC recommended PPP management model.

3.4.2 Quality Assurance

Improving the quality of services in the health system is a pressing area of need and requires consistent, high level attention and there are few agencies working systematically and comprehensively on this area. UNFPA has chosen to fill this niche. Advocacy for more NRHM resources to be dedicated to QA in the PIPs of the 5 UNFPA states would be a good starting point. UNFPA advocacy for inclusion of its QA model into these five states could be done in collaboration with the governments of Maharashtra and Rajasthan, who have tried out, and are themselves investing in scaling up the model. Simultaneously, through continued work in Maharashtra and Rajasthan, the QA model can be made more robust through the inclusion of some other key quality measures such as whether the facilities detect, track and follow-up cases
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of gender based violence; how gender sensitive and youth sensitive the systems and staff are; how HIV has been converged with RH; whether the facility uses community needs assessment data to tailor its services; and to what extent the community is involved in monitoring service delivery. A holistic quality of care strategy should help to bring both clinical and community components together to complement and build accountability on service delivery system on one hand and the community based structures like ASHA and VHSCs on the other. UNFPA should try and facilitate the process through evidence building, advocacy, networking and capacity building.

Recommendations:

- Advocate at the national level for greater resource allocation from NRHM/RCH for QA in the 5 UNFPA states, for establishing QA cells at the state level and QA teams in districts, and for financial resources for QA to be set aside in the PIPs.

- Widen the quality assurance model to include gender sensitivity of providers, detection of gender based violence, convergence of HIV with RH, sensitivity to adolescents, and community needs assessment and engagement.

Suggested Actions:

- Advocate for and fund wider use of technical guidelines, tools and protocols developed.

- Assess the current QA process for gender sensitivity - to what extent are tools currently measuring gender sensitivity, and have quality assurance activities actually led to gender sensitivity.

As a part of its quality agenda, UNFPA could advocate for independent, objective feedback to NRHM of program performance and quality, from agencies that have the capacity to conduct quality assessments and evaluations, and provide actionable feedback. Funds would need to be set aside in the NRHM budget for this role, evaluation agencies identified, and their capacities honed. Similarly, there is a need for continuous feedback to the health system on evidence based practices. This is an important aspect of using data for RH and development. Partnerships could be established with academic and research agencies to gather and provide this evidence to the health programme.

3.4.3 Communitization

Major efforts have been made in MP and Orissa. The capacity of VHSCs and RKSs has been strengthened for decentralized planning, monitoring the quality of RH service delivery, and social audit of maternal death. Public dialogue has been encouraged and village health plans made. Process details for operationalizing VHSCs have been documented. This is important work. However, over the rest of CP-7 this work should be brought to its logical conclusion. Plans should be subsumed into district and state PIPs, and be used to deliver or monitor services.

Communitization is not an end in itself. It should lead to community empowerment, to demanding for and receiving quality services.
There is a need to develop a strong model for successful communitization. A first step could be a study of various approaches that have been used to date, to identify what processes result in strong and comprehensive decentralized planning, and in holding government accountable for delivering to plan.

**Suggested Action:**
- Evaluate various communitization programmes and models to assess how best to strengthen VHSCs to prepare decentralized village health plans and how they can serve as a tool for monitoring service delivery.

### 3.4.4 Gender in RH

**Gender based violence:** Addressing gender based violence or violence against women within health care settings has been a major contribution of UNFPA. This work needs to be strengthened and strategized in a manner that results in institutionalization and scale up. Valid and reliable tools, widely disseminated and widely adopted, are a way of taking pilot interventions to scale, not directly through an investment of one’s own resources, but through the resources of those who begin to use the tools in their own programs.

**Suggested Action:**
- Carry out intensive policy advocacy with organizations like IMA and FOGSI to review and vet the screening tools that are to be used in health care settings to detect gender based violence. After review and evaluation, UNFPA should disseminate the tools widely for use.

UNFPA currently works with three powerful civil society groups on issues of gender based violence and sex selection- The Hunger Project, Women Power Connect, and PRIA. All UNFPA advocacy efforts in the area of gender based violence should include the strong voices of these partners. The current programs with PRIA and THP do not have any indicators to assess if PRIs are doing anything to prevent sex-selection or child marriage or to ensure that poor pregnant women seek appropriate maternal and child health care. UNFPA should continue to work with partners such as PRIA and THP to enhance the capacities of PRI members and ensure that there are measurable indicators to assess the role of PRIs and their members in community based monitoring of these issues.

**Recommendations:**
- UNFPA should continue to work to enhance the capacities of Panchayati Raj Institutions\(^\text{32}\) (PRI) members through organizations like PRIA and The Hunger Project and ensure that there are measurable indicators to assess the role of PRIs and their members in community based monitoring of key issues related to sex-selection, child marriage and maternal and child health.

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\(^{32}\) Panchayati Raj Institutions are structures of the system of local self government that has been in place in India since the early 1990s, but is not yet quite fully functional.
Involvement of men and boys: Gender strategy within RH should necessarily bring both men and boys and women and girls programmes together. Stand alone programmes like the one with boys in Maharashtra should be avoided.

**Recommendations:**

- Before the formulation of CP- 8, UNFPA should carry out an evaluation of the gender work that it has done in support of the NRHM Programme, and prepare a document that records the approaches it has used, the inputs it has provided, whether these have really been institutionalized and whether they have changed the gender sensitivity of the system. Have the gender aspects built into the PIPs been implemented? This evaluation, combined with documenting the gender work of UNFPA post NRHM, could be a good starting point for a fresh attempt to orienting government personnel and other stakeholders including civil society, to the pressing need to incorporate gender sensitivity into health services.

**Suggested Actions:**

- Stand alone gender programmes like the one working with men and boys in Maharashtra, need review to assess the extent to which they are helping to achieve UNFPA’s overall advocacy and programmatic goals- promoting gender equality and positive RH outcomes. UNFPA should have an institutional strategy to work with both men and women across all Programmes rather than working with men alone or women alone.

### 3.4.5 Advocacy

A priority area for UNFPA advocacy is the achievement of a shift in perspective from the emphasis on sterilization to that of serving the unmet need of those who also wish to delay and space child bearing. Given the youth bulge in India, a family planning focus on youth, rather than only on those who have attained their desired family size, is what will pay dividends in stabilizing population growth and also in achieving maternal health and infant mortality goals. There is a need to “reposition family planning” so that it is seen not as a population controller, but as a guardian of maternal and child health, of environment, of quality of life, and of family well being, and as an empowerer of women. Viewed from this perspective, family planning needs to be the centerpiece of a primary health and national development strategy. Family planning is not yet being viewed from this perspective by policy makers and programmers. Strong advocacy is needed to build these perspectives at all levels.

**Recommendation:** Build strong advocacy strategy to reposition family planning. UNFPA should undertake a planned program of advocacy for repositioning family planning within the ICPD framework of informed choice and quality care with a much broader range of services rather than merely endorsing the overwhelming use of sterilization methods that some of the state governments seem to currently place emphasis on.

### 3.4.6 HIV: Promoting Safe Sex Behaviour

In HIV programming in India, the field of targeted intervention for vulnerable populations is crowded with players who bring significant experience and large resources to the issue. UNFPA is the designated lead UN agency for working with sex workers for prevention and mitigation of
the effects of HIV on sex workers. However, the NACO does not expect UNFPA to play this role in India. There is one particular niche in HIV that UNFPA could meaningfully choose to fill— that of convergence of RH and HIV. Convergence has two aspects— (a) convergence of RH services into HIV prevention and services programs for high risk groups, and (b) convergence of HIV with RH services for the general population. UNFPA could develop its female sex worker projects in Rajasthan and MP, into pilots to demonstrate how RH can be integrated into targeted HIV interventions for female sex worker populations. Similar efforts could also be made within targeted interventions being implemented by other agencies, for other vulnerable populations. Simultaneously UNFPA should support pilots to demonstrate how HIV prevention and services can be incorporated into RH services for the general population— one or more of Maharashtra’s districts where HIV and STI prevalence in the general population is greater than 1% would be ideal for such pilots. Once proven these models can be advocated for and scaled up through NACO’s targeted intervention programmes, and through RCH-II.

**Recommendations:**
- Begin to work on providing TA to NACO and its intervention programs for other vulnerable groups on how to converge RH with RTI/STI/HIV interventions.

**Suggested Actions:**
- For the remainder of CP- 7, develop the two FSW programs in Rajasthan and MP into pilots to demonstrate how RH can be integrated into HIV prevention programmes for vulnerable populations.
- Work in one high prevalence district of Maharashtra to demonstrate how RTI/STI/HIV interventions can be integrated into RH services for the general population.

### 3.4.7 Mainstreaming RH and Gender into Disaster Response

UNFPA plays a small but critical role in the UNDMT. It has succeeded in signing an MOU with the National Institute of Disaster Management under which, it will contribute essential training content on how RH and gender need to be accounted for in response to disaster. Given the scale of disaster in India, and the very limited role that external agencies can play in a disaster situation in India, this strategic approach to engendering disaster response is well thought out, and should receive continued emphasis. Over the years, training inputs may be required, training material may need refreshing, and the training of civil society organizations that pitch in to help in national emergencies, may be appropriate roles for UNFPA to play. Given the logistics challenges of making the dignity kit available to all who need it in an emergency, it is advised that UNFPA discontinue the supply of dignity kits. It is also recommended that in all its 5 states, UNFPA map areas of chronic environmental challenge, the RH vulnerabilities present there, and advocate with Government and NGOs to respond appropriately. UNFPA may itself wish to take on a pilot project in one or two states.

**Recommendations:**
Mapping vulnerabilities due to environmental challenges: UNFPA could within its 5 states, identify geographic locations with recurring or constant environmental challenges, where continuing work could be done to mitigate the effects of challenges on the RH of vulnerable segments of society and advocate with others to work to mitigate these conditions.

Suggested Action:
- UNFPA should pursue the mainstreaming of gender and RH related training into disaster management programmes run by the NIDM and it’s Apex Training Institutes (ATIs).
Section IV: Adolescents and Youth

4.1. Background

UNFPA has since 2003 worked on the issues of young people in and out of school through partnerships with the Ministry of Human Resource Development (MOHRD) and the Ministry of Youth Affairs and Sports (MOYAS). The National Population Education Project (NPEP) was initiated as a UNFPA-Government partnership in 1980, with ‘Family Life Education’ as a focus, and in 1986, under the National Policy on Education, was recognized in all states as a thrust area in school education. Post ICPD, adolescent reproductive and sexual health (ARSH) was identified as an important focus area under the NPEP. After 2005, in the wake of controversy around sex education, and in tune with the recognition of ‘Adolescent Education’ in the school curriculum by the National Curriculum Framework (2005), the ARSH Programme was restructured as the Adolescent Education Programme (AEP) in school settings. As a continuation of these years of involvement that CP-7 envisaged empowering adolescents and youth both in and out-of-school with knowledge and life skills for better reproductive and sexual health. The “Adolescent Health and Development” (AHD) project was designed in line with the focus of the National Youth Policy for out-of-school adolescents this segment.

4.2. Results Desired

Adolescents and youth are a part of the RH component of the CP. Output 4 of the RH component is: “Adolescents and youth empowered with knowledge and life skills for improved reproductive and sexual health (in school and out-of-school).” The indicators for this output are:

- % of youth 15-24 with accurate knowledge of HIV/AIDS who recall 3 modes of transmission, 2 modes of prevention and who reject major misconceptions about HIV transmission- this is to be measured by NACO’s BSS at the end of NACP III though no end line value has been specified.

- Application of life skills by adolescent boys and girls- for which no base line is available and the end line value is 40% of boys and girls in intervention will demonstrate life skills. Measurement of achievements is to be through the administration of skill application tests.

- Integration of LSE in school curricula and extracurricular activities- LSE gaps have been identified by a baseline mapping exercise. At end line, LSE should be included in school curricula and extra-curricular activities.

- The number of teachers trained to impart knowledge and skills through LSE- no baseline or end-line values have been specified. However, for the purpose of monitoring and measuring teacher training, UNFPA has established a goal of training at least one teacher for every 150 secondary school students.
4.3. Strategic Interventions: Findings and Analysis

CP-7 pledged to continue supporting interventions and provide technical assistance to reach adolescents and youth through a range of partners with emphasis on “increasing access to knowledge and providing opportunities for acquiring life skills for both in-school and out-of-school adolescents”. The two main national supports were to be the MOHRD for adolescents/youth in school, and MOYAS for out-of-school youth. A third component of the programme for adolescents and youth is “Institutionalization of Adolescent and Youth Friendly Health Services”.

4.3.1. Programmes for adolescents in school

The Adolescence Education Program (AEP) aims to empower young people with accurate, age appropriate and culturally relevant information, promote healthy attitudes and develop skills to enable them to respond to real life situations effectively.

The conceptual framework guiding programme design and implementation has been updated in 2010, to recognize adolescents as a positive resource and focus on the transformational potential of education in a rights framework. The guiding principles of the program recommend that AEP should be participatory, process-oriented and non-judgmental, and that it should not be prescriptive, stigmatizing or fear inducing. AE should enable adolescents to understand and negotiate existing and constantly changing lived realities.

The updated training/resource materials address various topics of concern to adolescents including gender discrimination, sexuality, and HIV/AIDS.

The revised conceptual framework and the updated training and resource materials is a big step forward from the ‘abstinence only’ curricula that was the forced reality of AEP immediately after the turbulent political controversy that arose in 2005 around sex education in schools. As a result of consistent advocacy efforts by multiple stakeholders including civil society, academic and research institutions, UN agencies, educationists, and certain government departments and officials, program related resource materials were revised and updated. The National Council for Educational Research and Training (NCERT) revised the adolescent education curriculum to make it more comprehensive and responsive to the concerns of young people.

The training and resource materials currently used in the program are the outcome of a series of consultative workshops in which professionals from all concerned constituencies, including adolescents and teachers, contributed. In 2010, the revised resource materials were pre-tested with master trainers and teachers. Quantitative and qualitative feedbacks were taken on five criteria including content, understanding, transaction, learner participation, relevance and usefulness. The average score across the 5 criteria was ‘4’ on a scale of 1 through 5 with 1 being ‘unsatisfactory’ and 5 being ‘excellent.’

It is recognized that outcomes in terms of prevention of teenage pregnancy, RTIs/STIs and HIV are important for programs working to improve sexual health of young people. These issues have been addressed in the curriculum. Although, it may seem that there is less emphasis on these specific risk behaviours, the contours of the curriculum are determined by the reality that substantive proportions of unmarried adolescents in India are not sexually active either by choice
or due to social norms disapproving of premarital sex. Findings from the nationally representative youth survey conducted by Population Council and International Institute of Population Sciences in 2006-07 show that in the age group of 15-24, 12% unmarried males and 3% unmarried females reported pre-marital sex. In order to respond to young people’s concerns, the curriculum focuses on important non-health attributes that have a strong influence on health outcomes, for example the agency of young people, gender norms in the local context etc. The updated training and resource materials fulfill the 18 criteria cited as key characteristics of effective sexuality education programs as provided in UNESCO’s International Guidance on Sexuality Education of 2009.

4.3.1.1. Programmes using co-curricular approaches

a. The co-curricular approach: works through the three national school systems - Central Board of Secondary Education (CBSE), Navodaya Vidyalaya Samiti (NVS) and Kendriya Vidyalaya Sangathan (KVS). The program works on a cascade training approach that has created a pool of master trainers who orient nodal teachers who are entrusted with the responsibility of transacting life skills based education (16 hours module) to secondary school students through interactive methodologies. Nodal teachers are provided guidelines and materials to facilitate the transaction process. Advocacy sessions are organized with principals of participating schools and sensitization sessions are held with parents. By end 2010, at least two nodal teachers from 3500 CBSE schools, all the 919 KV schools, and all the 583 NVS schools have received orientation on adolescent education issues.

For better impact and quality, the programme has been consolidated in 5 UNFPA priority states (rather than 32 States), to achieve the goal of one trained teacher for every 150 secondary school students.

The programme conducts an annual assessment of the quality of the nodal teacher’s training. The assessments for the years 2008 and 2009 used 4 indicators: how completely was the content covered, have life skills been integrated, did trainees participate actively, and did the participants feel confident that they would be able to deliver the curriculum in a class room setting. On a scale of 1-5 where 1 is unsatisfactory and 5 is excellent, the average score across all the four indicators was 4, i.e., very good. These scores are statistically significant. Change in knowledge is higher than change in attitude which is understandable since attitudes are harder to change through training. Similar results are visible from the assessment of teacher training programs and sensitization programs held for principals.

A concurrent evaluation of the co-curricular component of AEP was conducted across 200 schools in 5 different states of the country in end 2010 and early 2011. Recognizing the fact that there is a lack of good instruments for assessing life skills, a consortium of experts from relevant disciplines was created to develop the assessment tools. The core group developed the draft tool kit that was validated by a larger group of experts and finalized after field test. Both quantitative and qualitative tools were used to assess adolescents’ knowledge, attitudes and abilities to apply life skills in the context of their health and well being. The data from the evaluation are still being analyzed but preliminary findings using an experimental and control design show modest programme effects. Findings show that 56% of the adolescents who have been exposed to the programme knew the correct definition of menstruation compared to 14% who have not been exposed to the programme. In comparison to 62% of
adolescents who did not have programme exposure, 70% who were exposed to the programme knew that green leafy vegetables should be included in the diet of anemia patients. Ninety percent of adolescents exposed to the programme had correct knowledge of minimum legal age at marriage in comparison to 81% who did not have programme exposure. Sixty seven percent of adolescents exposed to the programme knew that male condoms can prevent both HIV transmission and pregnancy compared to 58% who were not exposed to the programme. Similarly on attitudes to gender and response to sexual harassment, students exposed to the program had marginally higher scores than did students who were not exposed to the program.

b. **Orissa:** In the Kalinga Institute of Social Sciences (KISS) in Orissa, a different approach to life skills and adolescent education is being followed. Inputs are provided in both co-curricular and curricular formats and age appropriate content is provided in all classes starting from primary school. Institutional capacities are being enhanced for broadening the research base for AE and LSE (LSE). KISS has 12000 tribal students who are the direct beneficiaries of this program. The efforts of KISS in Orissa aim to upscale the intervention through ashram schools\(^{33}\) where tribal students from vulnerable areas will be benefitted. Effective linkage of KISS to NCERT and the State Council for Educational Research and Training have not so far been established.

c. **Bihar:** In 2010, UNFPA began to work with SCERT, Department of Human Resource Development, Government of Bihar, to reach out to young people in about 1000 secondary schools across 9 districts with information and skills for improved health and well-being. CEDPA is the lead technical agency appointed by UNFPA for providing technical assistance to SCERT, and for ensuring that the ability to address adolescent concerns is institutionalized in the government school system. CEDPA has created a pool of 100 master trainers. Two hundred teachers have been oriented to the program. This is the first pilot that uses the co-curricular approach in state government schools and will help to take the program to scale in Bihar. It is noteworthy that the costs of the project are being shared between the Government of Bihar and UNFPA, laying the ground for sustainability of the effort.

### 4.3.1.2. Curricular Approach

a. **The curricular approach:** The National Curriculum Framework (NCF)\(^{34}\), 2005 clearly outlines that rather than a stand-alone program the AEP should become an integral part of school education. At the present time, UNFPA’s work at the national level with MOHRD is largely co-curricular. The goal remains to mainstream adolescent education into the curriculum. NCERT has undertaken a content analysis exercise which shows that textbooks in different parts of the country have integrated adolescent education issues into various scholastic subjects. Efforts are underway for more comprehensive inclusion of adolescent concerns into the curriculum. The Council of Boards for School Education (COBSE) is involved in advocacy efforts with relevant stakeholders in selected state education boards in India, to integrate life skills into the curriculum.

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\(^{33}\) Ashram schools are residential schools for tribal boys and girls

\(^{34}\) A policy document to guide school education across the country
b. **National Institute of Open Schools (NIOS):** Curricular interventions also include ongoing UNFPA support for integration of life skills in the secondary curriculum of NIOS that enrolls approximately 400,000 learners each year. NIOS provides those who cannot enroll in regular secondary and senior secondary schools with the opportunity to learn on their own, attend contact classes to seek clarifications on items that they do not understand, and take qualifying examinations. Learning materials in NIOS must facilitate self learning and are popularly known as ‘teachers in print.’ NIOS officials have bought into the idea that life skills enhancement is a worthy initiative that would go a long way in improving the overall quality of their learning materials. In 2009, NIOS took an informed decision to undertake an innovative pilot to integrate life skills in selected lessons and subjects in its secondary curriculum.

In order to maximize the reach of the integrated lessons, the most popular subjects of Home Science, Social Science, Science, and Languages (Hindi and English) were identified for integration. Life skills woven into the curriculum include empathy, communication skills, and recognition that a large population could also be viewed as India’s most important asset and Life skills were woven into all the 15 model lessons without compromising the subject content. Consistent efforts were made to enhance capacities of subject coordinators, lesson writers and tutors (who provide clarifications to open learners). Several rounds of sensitization workshops were organized and this initiative will be further strengthened in the coming years. As yet, the integrated lessons have only been in limited circulation, but the feedback from all stakeholders has been very positive.

c. **Rajasthan:** In 2005, life skills focused adolescent education was introduced as a separate subject in the senior secondary curriculum across approximately 4500 government schools in the state of Rajasthan and the subject is now institutionalized within the government schools. The state government has bought into the programme completely but has not yet thought about investing its own resources into continuing the programme once UNFPA financial support for the programme ends. Sustaining the programme with Government’s own resources is critical.

d. **Life skills integration into pre-service teacher training:** Recognizing the importance of integrating life skills and adolescent concerns in the pre-service teacher training curricula, UNFPA’s Rajasthan state office has launched an ambitious project in partnership with all the seven universities in Rajasthan that provide pre-service teacher training. The curricula are under revision and it is expected that by 2013, teacher trainees will be trained in the integrated curriculum. This activity is very important to ensure long term effectiveness and sustainability of school based programmes.
4.3.1.3. Health Services for in-school adolescents

Given the gradually improving school continuation rates through middle and senior school in India; there is an enhanced focus on providing youth friendly health services in school settings. Mental health and counselling is being rightfully recognized as a vital component of school health services. However, there is very limited information on the feasibility of providing counselling services in school settings in India.

In order to address this gap, the services of a professional agency, Sangath were hired in 2009-2010 to build capacities of existing nurses in the Jawahar Navodaya schools from two regions in the country- Chandigarh and Pune- to provide first level youth friendly counselling services. In the pilot phase, 32 staff nurses in the Chandigarh region and 26 staff nurses in the Pune region were trained and approximately half of them received continuous telephonic supervision.

An assessment after one round of orientation and refresher training showed that 98% of the staff nurses agreed that the training was useful and 98% felt that it would help them in their work. Based on these findings, the 10 day orientation program followed by a three day refresher training programme and constant telephonic supervision have been extended to all the 5 UNFPA priority states. In these states, 4 orientation training programmes have been completed and 96 nurses have been trained from 4 of 5 regions. Although the importance of providing counselling services is well understood, more efforts need to be made to popularize these services and improve their uptake. At present, a trained staff nurse sees only one case per month. A qualitative assessment of the pilot phase conducted in 2010, shows that several systemic barriers need to be addressed so that improved counselling services can be provided and accessed by students in school settings.

4.3.2. Programmes for adolescents who are out-of-school

As envisaged in CP-7, these programmes were to focus on developing new structures or utilizing the potential of existing structures to reach rural out-of-school youth with adolescent reproductive and sexual health knowledge. A national level program with the Nehru Yuva Kendra Sangathan (NYKS) was to organize most rural youth into Teen Clubs. The Ministry of Youth Affairs was to be the key nodal ministry for reaching out of school youth. The Country Plan also included exploring opportunities for partnership with the National Service Scheme (NSS) and the Rajiv Gandhi National Institute of Youth Development (RGNIYD). The potential of the rural IT kiosks to reach youth was also to be explored. In Orissa, village based Balika Mandals (girls groups) were to be formed and linked to anganwadi centres. In Rajasthan they were to be reached through post literacy schemes.

4.3.2.1. Nehru Yuva Kendra Sangathan (NYKS) Teen Clubs

Starting in 2006, approximately one hundred thousand adolescent girls and boys were enrolled through 4000 teen clubs in 64 districts across 31 states. The enormous geographical spread of the initiative led to difficulty in monitoring and getting a good understanding of the quality of

35 Jawahar Navodaya Vidyalayas are residential government schools in rural areas that are mandated to have a para-medical staff available on the campus round the clock
program implementation. Hence, an independent assessment was conducted by UNFPA’s country office in the first quarter of 2010.

The assessment covered 120 teen clubs in 5 representative geographical regions of the country. It was found that though the programme was meant to serve out-of-school youth, only 11% of members were out of school youth. The rest were all in school. On an average, there were 122 male teen club members for every 100 female members. While lower participation rates of girls is understandable given the social norms that restrict participation of girls in activities outside school and home, work is needed to improve the enrolment and active participation of girls in these fora.

The 2010 assessment measured the knowledge of Teen Club members on some key adolescent RH issues. Unfortunately since no baseline was done for the teen club program in 2007, changes brought about by the program cannot be compared with what prevailed before the programme started. Findings of the National Youth Survey conducted by the Population Council of India and the International Institute of Population Sciences in 2006-2007, and of the National family Health Survey of 2005-2006 were examined. One measure that is not identical but is reasonably similar and could be compared is in the National Family Health Survey and is related to knowledge of HIV prevention. 52% of young people in the age group 15-24 reported that HIV/AIDS can be prevented by using condoms and limiting sexual intercourse to one uninfected partner. In the Teen Club Assessment, 80% of Teen Club members were aware that the major modes of HIV transmission were infected blood, unprotected sexual intercourse, and multiple sexual partners.

UNFPA has now decided to re-strategize the Teen Club initiative and from 2010 to implement it in only the 5 UNFPA priority states so as to avoid spreading the programme too thinly over the entire country.

UNFPA is now attempting to design alternative models to reach unmarried adolescents who are out of school. The objective remains to provide them with focused experiential learning on reproductive and sexual health issues in a gender-sensitive manner; information on education and skills building for better employability; and to improve access to youth friendly and gender sensitive services in the public and private sectors.

4.3.2.2. The Rajiv Gandhi National Institute for Youth Development (RGNIYD)

RHNIYD is being supported by UNFPA for its Masters Programme in Life Skills Development to create and nurture a pool of well-trained human resources equipped to respond to adolescent concerns. The programme commenced in 2008 when the first batch of 9 students was enrolled. The batch graduated in 2010, and 6 students have been placed. The second batch enrolled in 2010 has 33 students. A faculty of 6 are involved in teaching, extension work, and research.

At RGNIYD, the UNFPA Country Office also supports a community radio program that is being run by young people enabling them to articulate their concerns and also to find ways of addressing some of them. This initiative also builds awareness on various issues related to the health and well-being of young people. Officials in the Ministry of Youth Affairs informed the evaluation team that government considers this community radio programme a great success, and
would like such programmes to be replicated in other states. However the ability of the community radio program to reach and involve out-of-school youth has not yet been assessed.

4.3.2.3. The Samarthan programme in Sehore, MP

Since July 2008, Samarthan has implemented a pilot intervention in 205 villages in Sehore district of MP, to enhance life skills of young people. Each village has 3 groups, of adolescent boys, adolescent girls, and newly married couples. There are 615 youth groups in the 205 villages. Capacity building activities have been conducted for different groups and a trained cadre of 205 girls and 205 boys has been created to facilitate orientation of other youth groups in the villages on RH issues and concerns. The groups also take collective action to improve both demand and utilization of RH services. Youth groups help to monitor the availability/delivery of primary RH services to the poor and the marginalized in the village. As a result of consistent efforts of the youth groups, 213 out of the 245 anganwadi centers\(^{36}\) have begun to function regularly. VHSCs have been formed in all the 205 villages and 95\% of gram panchayats\(^{37}\) have started discussing reproductive and sexual health issues. Better menstrual hygiene practices, and higher demand for family planning consequent to counselling of all newly married couples, are reported. However, evidence from the field reveals that there is a need for UNFPA to do effective policy advocacy with government for recognition of the model and its scale-up.

4.3.2.4. Interventions for adolescent girls in Rajasthan

In four blocks of each of four districts in Rajasthan, support is being provided to an initiative that reaches approximately 20,000 out-of-school adolescent girls with the objective of empowering them with knowledge and life skills for improved reproductive and sexual health and to delay the age of marriage. Adolescent girls’ clubs have been established in these blocks and a village level animator holds weekly sessions to build awareness. The girls are connected to formal or non-formal education. The learning from this programme has fed into the development of the SABALA (empowered woman) programme that has been approved by the national government for implementation in selected districts across the country. The resource material developed under the UNFPA supported programme has been nationally disseminated to all the states where the SABALA programme is now being implemented.

4.3.2.5. Interventions for newlywed couples including married adolescents in Bihar and MP

RH and family planning interventions with these groups to change social norms of early childbearing, and to increase the adoption of contraception to delay first child and space subsequent children are underway in Bihar. A similar activity has also begun in MP.

All these programmes are approaches to reaching out-of-school youth with RH information and education and methods and results need to be watched carefully. Given that 65\% of India’s 240 million adolescents aged 15 and above are not in school, reaching adolescents in out-of-school contexts is vital. The evaluation team finds that there are three challenges to reaching out-of-school adolescent with effective health and development programmes. The first is to design

\(^{36}\) Government sponsored pre-school education and nutrition centers

\(^{37}\) Village self government councils
essential content in a manner that can be delivered completely and with consistency in community settings. The second is finding appropriate delivery systems that can achieve effective contact with out-of-school adolescents and youth. The third is to find delivery systems that can reach scale. Given the enormous number of adolescents to be reached, financial investment by government will be required, and advocacy to encourage this investment is essential. The use of voluntary peer educators poses challenges too. Training, retraining, motivating, supervising, and managing a field force of peer educators so that the programming that is desired is effectively implemented is even more challenging than managing a paid workforce because volunteers are hard to hold accountable. The life skills approach which desires to build skills and linkages for livelihood and careers is extremely ambitious. It involves much more than delivering specific RH information in a short capsule. There is no evidence that life skills programs have been successfully delivered by peer educators. A programme that has to reach out-of-school adolescents to scale must have clear and limited objectives, clearly and pragmatically defined content in a brief capsule which can be delivered in a very short period. UNFPA’s excellent life skills module for schools contain material that can be refocused for adolescents out of school, enabling them to make healthy and responsible sexual and reproductive choices as they grow into marriage and adulthood. Such a programme can be delivered as a one-time intensive capsule by NGO training teams visiting communities. The value and impact of this model has been demonstrated by Pathfinder International’s Prachar Project in Bihar. If India’s millions of out-of-school adolescents are to be reached several alternatives will have to be developed and tested.

4.3.3. Institutionalizing Adolescent Friendly Health Services

NRHM provides for the provision of adolescent friendly health services through the primary health facilities. Based on this, the government of Maharashtra has made provision in its PIP for opening adolescent friendly health clinics in its facilities. By the end of 2009, the government of Maharashtra initiated 73 adolescent friendly health clinics in 33 districts and a few municipal corporations. These clinics have been branded and named Maitri (friendship) clinics in consultation with experts and adolescents.

UNFPA support to this endeavour included conducting workshops to build the perspective of providers in the facilities where the adolescent clinics were located; orienting them on an implementation guide; and holding workshops for district officials of related departments such as the National Service Scheme, NYKS, Department of Youth Affairs and Sports, and Department of Education). Counselors appointed by GOM at all district hospitals, were trained on ARSH issues. GOM was supported in building the capacity of Mother NGOs and Field NGOs of the RCH project, to mobilize attendance at the clinics and to refer adolescents to them.

The GOM requested UNFPA to undertake an evaluation of the functioning of the Maitri clinics and to assess service environment, status of training of service providers and availability of information to adolescents with regard to ARSH services. The study revealed that around 61% of facilities had one medical officer (either a male or female) trained for provision of ARSH services; only 8% of the facilities had both medical officers trained. Only 30% of facilities had a trained paramedical staff for provision of ARSH services. Communication material on ARSH was available in only around 22% facilities. All but 4% of clinics had an appropriate waiting area with sitting arrangement. 75% facilities had a clean examination table. Contraceptive availability at the clinics was low, although most hospitals where clinics were functioning had sufficient
quantities of contraceptives and these were made available to adolescents as and when required. In the one year between 1st April 2010 and 31st March, 2011, 53137 adolescents (40% male and 60% female) accessed the services provided by 73 clinics. The scope of services included counselling for contraceptive choices, handling concerns related to menstruation and gender-based violence, improving life skills, providing antenatal services, and treatment of RTIs/STIs. Thus, the access and quality of services were quite limited and the intervention did not have much success.

The GOM has requested UNFPA to help it to devise a feasible alternative to the present NRHM concept of youth friendly services/clinics. Re-examination of the concept of youth friendly services as laid out in NRHM and RCH-II is definitely required. This is an important NRHM activity and a well thought out concept and demonstration pilot will offer concrete alternatives to many states of India, most of whom are struggling with understanding the purpose and modalities of the concept of YFS and with how to implement it.

4.3.4. Programmes/Projects not taken off

a. **Support to the MOYAS to undertake conduct of an adolescent survey for reliable data on adolescents:** After the detailed survey on adolescents/youth undertaken by IIPS and the Population Council, UNFPA did not pursue this matter.

b. **Harnessing IT Kiosks in rural areas:** UNFPA was to explore the possibilities for piggybacking on existing IT networks to reach rural youth with an essential package of life skills focused reproductive and sexual health information. Meetings have been held with ITC, IL&FS and state governments in this regard. Progress needs to be made in both in preparing the software modules to be hosted on the IT networks, and on getting permission to use the IT kiosks for this purpose. During the rest of CP-7, UNFPA will focus on preparing the standardized curriculum in software.

c. **Balika Mandals in Orissa:** A collaborative effort with the Department of Women and Child in Orissa was to pilot Balika Mandals in two districts of Navrangpur and Khurda. UNFPA developed prototype materials for training trainers/facilitators, field tested them and shared them with government but there has as yet been no comeback on this activity.

d. **Post-literacy centers in Rajasthan:** As GOI has revised the strategy for engagement of these literacy centers, this activity has not been pursued.

e. **National Service Scheme:** The collaboration with National Service Scheme for engaging college students to reach out to rural out-of-school adolescents has not taken off so far in CP-7. UNFPA is discussing a broad based intervention with the Institute of Health Management at Pachod in Maharashtra. Discussions are ongoing on how students from colleges that are based in urban locations can reach out to adolescents in disadvantaged urban areas located close to the colleges.
4.4. Conclusions

A significant achievement of the adolescent health program in CP-7 has been the development of a sound conceptual framework, with curricular and co-curricular training and resource material for use within the school system. UNFPA’s use of the LSE approach, wide consultation, and concern for quality, successfully overcame the challenges posed by the controversy that arose in 2005 around sexuality education. Government and other stakeholders acknowledge UNFPA’s important contribution to the field of AE through the development of material that adapted international technical guidance to the country’s cultural values, while successfully addressing the core concerns of young people in a gender, empowerment and rights perspective.

Except in Rajasthan, the co-curricular in–school programme has been initiated in schools controlled by the central government. These are the schools for the more privileged sections of Indian society, and form only a small proportion of the Indian school system. Only work through the state government run schools can reach the less privileged young people, and also reach scale. Advocacy efforts are being made for curricular integration in selected state education boards through COBSE. These are relevant initiatives, and have to be sustained through advocacy and technical assistance to NCERT, COBSE, SCERT and selected state governments.

Recommendation:
- UNFPA should stay with the initiatives it has taken through NCERT to introduce school based LSE initiatives. This work should now be scaled up to state board schools. The advocacy work already begun with COBSE needs to be hastened. UNFPA must advocate with the Government of Rajasthan to make budgetary allocation for this programme from the regular budget of the department of education, else the programme will die out when UNFPA funds cease. The successful work done with the 4500 Rajasthan State Board schools should be used to strengthen advocacy with other states for introduction of LSE into school programmes.

The quality of nodal teacher’s training programme as assessed during 2008-2010 has been found to be better at changing knowledge than in forming attitudes. Preliminary findings from a concurrent evaluation just completed show modest programme effects of LSE on the knowledge of students.

The approach being used at Kalinga Institute of Social Sciences, of drawing up a LSE programme that reaches children with age appropriate inputs from primary school onwards, rather than just in high school, is interesting, has potential and is challenging. This experiment needs to be watched closely and its quality and uniformity carefully guided and assessed.

Suggested Action::
- UNFPA needs to link KISS with NCERT which is working on developing the LSE curriculum. The two organizations are using different LSE approaches and a linkage between them would result in mutual learning, and the provision of technical backstopping from NCERT to KISS, and a continuing review of the KISS model by NCERT. KISS is influential in Orissa, and linking NCERT with it will also further the processes of taking LSE approaches into the schools affiliated to the Orissa State Board of Education.
Feedback from the NIOS’ limited use of UNFPA’s material as integrated into the NIOS curriculum in home science, social sciences, science and languages, is positive. NIOS is now working towards integration of life skills across all 150 lessons in science, social studies, and languages.

Pre-service teachers’ training, as has been initiated in Rajasthan, and is a relevant, effective and sustainable approach to giving teachers the skills that they need to work with adolescents on life skills, maximizing the chances of making future work in schools, whether co-curricular or curricular, successful.

Recommendation:
- Pre-service teachers’ training programs would make school based programs more cost effective and sustainable. The pre-service teacher training program beginning in Rajasthan needs careful guidance and management so that it demonstrates the way forward for pre-service training in other states.

To reach out-of-school adolescents is of the highest priority for adolescent programs. The independent assessment of Teen Clubs conducted in 2010, shows that the Teen Clubs model has not been effective in reaching out-of-school adolescents. The evaluation team concludes that the real challenge of the out-of-school programme is content and delivery system. What is needed is an essential package of RH inputs that can be provided in a time and cost efficient manner to the millions of adolescents who are out of school in rural and urban areas. Reaching so many adolescents in community settings requires investment and advocacy with government is essential so that the necessary financial commitments are made. Apart from the variants of the Teen Club model that UNFPA is now beginning to develop and test, other alternative approaches should also be developed. The pilot in Sehore district in M.P. being implemented by Samarthan is comprehensive in approach (adolescent boys and girls and the newly married group) and content (RH issues and has shown some positive health outcomes. The newly funded community based adolescent and youth family planning program approaches in Bihar and MP also offer alternative models that should be carefully evaluated for potential for scale-up. The Rajasthan model for out-of-school adolescent girls clubs has been a collaborative effort of the Rajasthan Government and UNFPA, and its programme learnings have been helpful in approval of a recent GOI ‘SABLA’ strategy now under operation in selected districts of a number of states.

Recommendations:
- UNFPA must invest in finding effective ways of reaching adolescents who are out of school by developing realistic content and methodology and testing alternative delivery mechanisms. In addition to the variants of the Teen Clubs that are being developed and tested by UNFPA to reach out-of-school adolescents, UNFPA should carefully examine other models that have been tried and tested, before it lays out its strategy for out-of-school adolescents for CP-8. UNFPA needs to advocate with government to invest financial resources for reaching out-of-school adolescents.
Stand-alone adolescent friendly health service clinics have not demonstrated much success in the government health systems since they were introduced in the late 1990s under the RCH-II Programme. Even the national strategy for adolescent health under the current RCH-II has not been able to suggest ways of making this system work. In Maharashtra, where UNFPA’s has provided sustained and substantial support to Government for setting up the Maitri clinics, the evaluation reveals very limited success in terms of access to and quality of services. Adolescent health clinics are an important RCH-II activity. A well thought out concept and demonstration pilot undertaken in collaboration with the State Government will offer concrete alternatives to many states of India, most of whom are struggling with understanding the purpose and modalities of the concept of YFS and with how to implement it.

Recommendation:
- UNFPA should help the government of Maharashtra to develop a feasible alternative to the present RCH-II concept of youth friendly services/clinics (YFS) within the primary health care system.
Section V: Sex Selection

5.1 Background

The gender component of UNFPA’s CP-7 addresses mainstreaming of gender in RH, and sex selection. The desired outcome for the gender component is to prevent gender based violence and empower women. The outcome indicator is the child sex ratio. Activities and interventions for strengthening the capacity of the health system to address gender based violence have already been discussed in Section III of this report, and Section VII discusses gender as a cross cutting theme across CP-7. This section is devoted to UNFPA’s work on the issue of sex selection.

The 2001 census results revealed that the child sex ratio had continued to decline in most states of the country. Committed to gender equality, and to correcting demographic and health imbalances, UNFPA began to work on the issue of sex selection. In 2001 UNFPA launched a campaign around “Missing Girls” to stimulate a wide response. A widely disseminated booklet on “Missing Girls” presented census data in a manner that made it easy to understand and absorb the facts.

A national stakeholder group meeting was convened by the MOHFW around 2001. After 2003, the convening role for this group went to civil society organizations like the Population Foundation of India (PFI) and Plan International. The group remained active for a few years and then petered out. When UNFPA began its program in a big way in CP-6 and 7, it took on the immense challenge of supporting the implementation of the PCPNDT Act and advocating against sex selection alone, with no partners to share the needed work and scale to achieve success.

In 2002-2003 at the request of the MOHFW, UNFPA trained state and district appropriate authorities (AAs) to build capacity for implementing the Pre Natal Diagnostic Technique (PNDT) Act.

Between 2004-2005, UNFPA’s sixth CP-6 made concerted efforts to reach out and create awareness of the sex selection issue amongst a wide variety of new audiences including faith leaders, the medical community, media, civil society, parliamentarians, celebrities, artists, corporate houses, advertisers and youth. The idea was to create a domino effect by reaching out to as many people as possible. Emerging evidence revealed that at that time, sex selection was not behaviour of the rural poor but an emerging urban middle class trend. However, UNFPA still needed to decide upon a systematic strategy for addressing sex selection.

The 2005-2006 period was characterized by evidence based advocacy, a desire to set strategic priorities and to scale up programmes. In 2006, UNFPA commissioned an extensive study that was conducted by the Center for Youth Development Activities (CYDA). The study observed that UNFPA’s efforts to campaign against sex selection and to encourage better Act enforcement had been sporadic. While there was awareness that sex selection was not legal, the PCPNDT Act was weakly enforced and its detailed knowledge was limited even amongst the medical community. Even where efforts were successful they were largely due to visionary individuals and were not enough to achieve the intensity and spread that could effect change on a large scale. The study also noted that the effectiveness of advocacy interventions “were directly proportional
to the volume or intensity” of awareness creation. The recommendations arising from the study were that UNFPA should work to strengthen Act implementation, and address the medical community, the judiciary, and civil society. It suggested that advocacy efforts instead of using a broad cast approach, be restricted to young people. Thus over the last few years of CP-6 UNFPA’s efforts focused on building awareness of the issue at all levels in society. UNFPA proceeded to shape its programme of work in sex selection along these lines.

5.2 Results Desired

The desired output for the overall gender component is the child sex ratio (CSR), which at baseline (2001 census) was 927 per 1000 males. This was to be improved by at least five points as measured by the 2011 census. The desired output for the sex selection programme is – to address through advocacy and action the skewed sex ratio at birth (SRB). Two indicators have been selected:

a. Sex ratio at birth in the worst affected districts improved- for which the baseline was to be determined and a ten percentage point improvement was sought by end-line

b. The gender gap in under 5 mortality rate reduced at the national level. The baseline was 6.8 per 100 births in 2005 and this was to be brought down to below 5 in 2012

The CSR at the national level in the 2011 census is 914. It has deteriorated by 13 points compared to the 2001 value of 927. There has been similar deterioration in the states of Maharashtra, MP and Rajasthan. CP-7 has 2 more years to go and it seems unlikely that the targets set for reduction of CSR or SRB will be met within this timeframe. In the five UNFPA states, the SRB too has deteriorated since 2001. If UNFPA’s work in sex selection is to be judged by the CSR and the SRB, then it has not succeeded. However, we believe that the national level indicators that UNFPA chose to measure success were grossly unrealistic and overly ambitious given the short, five year timeframe of CP-7, the long timeframes needed to make any significant change in long standing and deeply ingrained son preference in India, and the very limited resources that UNFPA has brought to bear on the issue. Even in its priority states UNFPA did not work with all stakeholder groups and in all districts. Also, its efforts needed to be complemented by the state’s efforts at Act implementation- which were uneven. While UNFPA could facilitate, advocate and build capacity, implementing the Act goes beyond the mandate of the UN.

On-the-ground assessment suggests that the programme has experienced significant success, but that the right measures of this success are intermediate measures of outputs and processes that will over the long term, help to achieve impact (increase in CSR or SRB). Such measures could be: the formation and effective functioning of statutory bodies charged with implementing the Act; the engagement of civil society partners in the watchdog role; the registration of ultrasoundography (USG) facilities and effective oversight of their functioning; the trends in cases registered and tried; the proportion of convictions, and so on. UNFPA programme staff also acknowledges the need to develop indicators other than CSR and SRB to capture successes on

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38 Rajasthan decline from 909 to 883; MP decline from 932 to 912; Maharashtra decline from 913 to 883; Orissa 953 to 934.
39 Some of the worse off states, where UNFPA has contributed through workshops with medical communities, judiciary and religious leaders, have seen an improvement in the CSR as in Punjab, Haryana and Himachal Pradesh.
the ground – not just to attribute it to UNFPA’s work but to enable recognition of the contribution of others such as the larger civil society actors that have worked with UNFPA to change attitudes and perceptions of people against sex selection.

5.3 Strategic Interventions- Findings and Analysis

Having successfully achieved magnification of the discourse and broad awareness of the Act during CP-6, CP-7 interventions were centered on:

a. Strengthened implementation of the PCPNDT Act at the national and state level;
b. Creating through advocacy, an environment that would discourage, disapprove and act against sex selection
c. Strengthened capacity for community based action on sex selection
d. Supporting research initiatives to build a strong evidence base for advocacy and
e. Mainstreaming the work in sex selection by integrating sex selection issues into ongoing programmes of various ministries;

5.3.1 Strengthened implementation of the PCPNDT Act at the national and state levels

A 2010 study commissioned by UNFPA in collaboration with the National Human Rights Commission (NHRC)\(^\text{40}\) reinforced the need for a prioritized plan of action to enhance the effectiveness of existing implementation structures and systems, and for pushing for reform in current practices of implementing authorities.

5.3.1.1 Collaboration with MOHFW

To strengthen the implementation of the Act, UNFPA works to ensure that statutory bodies charged with implementation of the Act have full membership, function effectively, and that their capacity to implement the Act is built. At the national level UNFPA has supported the establishment of a PCPNDT monitoring cell in the MOHFW.

In collaboration with the MOHFW and state governments, UNFPA has developed a PNDT complaint reporting software to encourage reporting of complaints. The innovation assists the AA at the district level to receive reports from anyone who is interested in the cause, to weed out malicious complaints, and to use relevant information for better act implementation. The software also makes the AA accountable for taking action on complaints received\(^\text{41}\). In 2010, the software was launched on the web. Data is not yet available on the extent of use of this site. However, counterparts in the Rajasthan government shared with the evaluation team their sense

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\(^{40}\) Implementation of the PCPNDT Act in India, perspectives and challenges, Public Health Foundation of India, 2010, unpublished

\(^{41}\) The software, housed on a state government’s website, will function as an online complaint facility, where anyone can register a complaint (or report their suspicion) related to sex selection/improper functioning of an ultrasound centre, hospital etc. The complaint, once reported, will be immediately sent to the concerned district and state level appropriate authorities (mandated under the PCPNDT law to take cognizance and act on it) to ensure prompt action and maintain the accountability of appropriate authorities. A copy of the complaint will also be sent to senior administrators in the state. The website will become operational for public after the completion of data security audit by National Informatics Centre (Annual report 2010) 61400.
of pride at having launched the site. After Rajasthan adopted the complaints website, three other states have requested TA for launching similar sites.

5.3.1.2 Intervention with the legal system and the judiciary

Work with the judiciary in Orissa, MP, Maharashtra and Rajasthan, is noteworthy. Judicial colloquia and a judicial academy are being supported to build awareness and a nuanced understanding at all levels of the judiciary, of the social and medical issues around sex selection. The object is to ensure that priority is given to cases registered, leniency discouraged, and punishment commensurate with the offence is dispensed. The Maharashtra State Legal Services Authority (MSLSA) in collaboration with the State Health Systems Research Center, and the State Appropriate Authority, has trained members of the judiciary in all 33 districts of the state on the Act. The Orissa State Legal Services Authority has achieved a similar feat in Orissa. In Maharashtra, the first conviction ever, happened in 2010 when a judge who attended a colloquium went back and reopened a case that he had heard in the past. The judicial academy in Maharashtra has prepared a compilation of case law which will become an important reference for other lawyers and judges. The Academy has also included the issue of sex selection and the PCPNDT Act in all its in-service and induction training programmes. The colloquia have resulted in violators not being given bail during judicial proceedings and in the reopening of one case under a full bench.

In Rajasthan, capacity building of legal professionals on the PCPNDT Act and other gender-related legislation was initiated through a partnership between the National Law University Jodhpur and the Department of Medical, Health and Family Welfare. Under this initiative, 30 young lawyers were trained over a period of two years.

The National Law University of India (NLUI) in MP has been involved in training lawyers and judicial members. It has created a pool of 50 young lawyers from 50 districts and equipped them with knowledge of the PCPNDT Act. These young lawyers will be placed with the district AAs to provide support in case filing and notification. The 2011 work plan in MP includes sensitization of the district and state bar councils, and capacity building of district prosecutors. Training of lawyers and public prosecutors builds awareness of how to prepare and present a strong case so as to minimize the chances of the case being set aside for lack of strong case documentation. Other desired outcomes are to increase case notification and expedite judgments.

The mechanism for sustainability is embedded in the design of this work. Training is done through existing professional bodies whose mandate it is to train and develop legal professionals and the judiciary. In MP and Maharashtra, it is now being proposed that the curriculum for law schools be re-examined to ensure that students get adequate exposure to the laws that relate to issues such as sex selection, and domestic violence. Most of UNFPA’s work on capacity building of lawyers and judiciary is seeded with an understanding that these opportunities will also lead to sustainability. Clearly institutionalizing gender and sex selection curriculum in law training is a step in that direction.

Capacity building of appropriate authorities, legal experts and of the judiciary has improved compliance with the Act.
The evidence is found in higher registration of ultra sound facilities, maintenance and timely submission of records and forms stipulated under the Act, and more complete information in the forms than was available before these interventions were undertaken. This is true in states like Rajasthan, Maharashtra and MP where UNFPA interventions have included direct work with the legal system and the judiciary. In Indore district, compliance by facilities has increased from 63% to 83% as a result of monitoring visits. In Haryana where direct work on Act enforcement was not done, but civil society partners were supported to do community awareness work, compliance with the Act has not improved42.

5.3.1.3 Act compliance, value clarification and advocacy with the medical community

UNFPA has rightly considered the medical community as the provider of services for sex selection. This community as a whole could play a critical role in ensuring ethical practices within the fraternity: educating them about the Act and ensuring compliance with the law; sensitizing them to the problem of sex selection; dissuading clients; and influencing mindset change in the larger community. In partnership with the professional medical associations including those of radiologists, and through the “Doctors for Daughters” initiative at the national level, doctors have been sensitized and have made professional resolutions to work against sex selection. In the last few years there have been state and district workshops with the IMA with the intent of creating a cadre of peer monitors and ambassadors who would be change agents within their community. Actions have included direct mailers to doctors to stop sex selection and to take action against violators. Previous work with the IMA at the national and state level included making of resolutions and taking of oaths to act against violators. Outside of the IMA the work with the medical community has spanned the Indian Association of Preventive and Social Medicine (IAPSM), the Indian Radiological and Imaging Association (IRIA), the Federation of Obstetricians and Gynaecologists of India (FOGSI), Surgeons performing non scalpel vasectomy, and the faculty and students of medical and nursing schools. The WHO India Office has prepared modules on the issue of sex selection from the rights and gender perspectives, for inclusion in undergraduate and postgraduate courses in medical colleges. The modules have been prepared after consultation with selected obstetricians and gynecologists and radiologists in 2009-10. A network of academic, research and community based activists were involved in the Campaign against Pre-Birth Elimination of Females (CAPF).

A tool-kit for doctors43 has been prepared to help them understand what the law says, and also to clarify values and change attitudes. The tool kit includes Frequently Asked Questions, a sample checklist to monitor compliance of ultra-sonography clinics (first used in Indore, see box), and briefs on the law for the medical community. The value clarification content in the kit has been prepared based on questions that some doctors ask, and responses that other doctors have given to knotty questions related to sex selection. Doctors who have undergone the first round of training are meant to identify others in the medical community who will enhance the reach of this initiative. A self learning CD on the Act is being developed as a training tool for doctors.

The nursing curriculum is being revised by the Maharashtra Nursing Council to include these issues in the basic training of nurses. Similarly UNFPA supported the capacity building of

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42 Interviews with key CSO stakeholders, Haryana
43 A toolkit to guide practitioners – Gender sensitivity and community responsiveness in healthcare, UNFPA, 2010, to be published
professors of medical colleges on sex selection and has proposed to the Maharashtra University of Health Sciences, that these issues be included as part of the curriculum for undergraduate and post graduate courses.

In Maharashtra, UNFPA provided support for training of nursing tutors on the issue of sex selection and the Act.

5.3.1.4 Strengthened role of civil society organizations in ensuring Act implementation

UNFPA has built capacity of state partners, to activate the implementation structures constituted by the Act. In MP for example 114 civil society members of district advisory boards were reoriented with updated knowledge and skills to review the functioning of the boards and their contribution to the implementation of the Act. Similar action has been taken in other states as well. In Orissa, a series of sensitization, orientation and capacity building processes were initiated involving key stakeholders such as the Indian Medical Association, NGOs, CBOs, health functionaries, and senior members of the judiciary. UNFPA supported the PC PNDT cell, and facilitated a mapping exercise of USG clinics. This map was later used to monitor the USG clinics. Civil society organizations are also oriented to monitor ultrasound clinics and ensure that they comply with the law.\textsuperscript{44}

In Maharashtra, UNFPA supported the training of 127 Mother NGOs and Field NGOs appointed under NRHM for effective implementation of the PCPNDT Act.

Where civil society partners serve on district advisory boards and monitor clinics, the AAs more responsively implement the Act\textsuperscript{45}. Functioning of the state and district supervisory boards and AAs has improved, with more regular meetings, at which transactions are more focused on the issue of Act implementation\textsuperscript{46}.

UNFPA is also supporting capacity building of elected representatives from urban areas of Maharashtra for advocacy and action on sex selection in collaboration with the All India Institute of Local self Government.

\textsuperscript{44} This stems from evidence that low sex ratios at birth are directly proportional to availability of USG facilities (Gokhale Institute Study, Pune).

\textsuperscript{45} Interviews with key stakeholder at the National PCPNDT Cell, MOHFW

\textsuperscript{46} Interviews with state programme coordinators and AWPs
5.3.2 Strengthening the capacity for community based action on sex selection

In CP-6, UNFPA supported the work of 5 large national NGOs on the issue of Sex Selection and had positive results. In CP-7, it decided that there was a need to increase the spread of this work by drawing many more NGOs into it. UNFPA therefore sought a national agency with a large network and demonstrated commitment to the issue. Women Power Connect (WPC) was such an agency. It was brought into UNFPA’s programme to involve its network of civil society member organizations in fostering community level advocacy and action on the issue of sex selection. The approach used by the network is to build the capacity of its members to undertake advocacy and action at the community level, using a common strategy and vision for community perspective building. The original vision included the formation of state resource groups and a national coordination mechanism that would find new opportunities for expanding this work and making it sustainable.

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**The Indore ‘Model’**

An interesting pilot intervention is underway in CP 7 where a triangulated, multi layered approach is being executed in Indore district, which had a CSR of 908 in 2001. It is a three pronged approach with strategies that are mutually reinforcing: 1. Work directly with the Appropriate Authority, Indore to implement the Act; 2. Build capacity of NGOs to play an advocacy role and monitor USG clinics to ensure compliance; 3. Simultaneously create awareness among key stakeholders on the issue.

MPVHA is the main partner. It has built the capacity of NGOs to advocate for vigilance and monitoring of ultra-sonography clinics. These NGOs have become members of the district advisory board. The capacity building of the district AA has also ensured regular meetings and better monitoring of USG centers. MPVHA has regular update meetings with key stakeholder from the medical community (IMA, IRRIA), members of the bar association, media, faith leaders and CSOs that further the agenda for larger awareness creation. As a result of fairly concentrated efforts there is now stricter action of the district AA against non compliant clinics or non registered clinics. Within a few years there is a belief that the pilot is self sustaining and moving forward, the role of MPVHA would be to monitor, review all training/advocacy material, and document the process.

MPVHA has converted these efforts to a checklist that offers a very good, comprehensive tool to conduct monitoring of clinics. About 15 members visit 5-7 clinics a month (2 hours per clinic). They revisit the same clinics a month later to see if concerns raised in the previous visit were addressed and if the clinic remains compliant. This is voluntary work where travel is reimbursed. The volunteers are social workers, doctors, legal experts and NGO members. In the last 3 years they have done 147 visits and 151 follow-up visits and been able both improve registration and compliance. Over 63 show-cause notices, 4 court cases, several suspensions of clinics and doctors and Rs 1,30,000 collected in penalties, are some of the indicators of successful Act implementation. The checklist developed by MPVHA has been incorporated into the orientation tool-kit that UNFPA has prepared for medical practitioners.

A more thorough evaluation would be needed to obtain a full picture of changes that have occurred as a result of this intervention.
WPC has brought into its fold 31 NGOs across 11 states. Through each of these NGOs, grassroots level civil society organizations have been trained and their capacity built to make communities act against sex selection. These civil society organizations mobilize influential women- anganwadi workers, auxiliary nurse midwives, teachers-self help groups, and panchayats- to create awareness of the adverse effects of sex selection. Community mobilization is done through sensitization, awareness generation, capacity building workshops and creation of communication materials. Resource groups formed within the community comprise those who show an interest in becoming change agents. The role of WPC is to ensure consistency and quality through capacity building workshops, to develop communication materials with the right messaging, and to screen and approve all material being used by civil society organizations for appropriateness and quality. Beyond this WPC has also formed state resource groups in 5 states.

The work with the WPC has brought a higher awareness of the issue of sex selection and awareness of the PCPNDT Act to the grass roots level. Specific positive outcomes reported by participating NGOs are that many members of the WPC network have become members of Districts AAs or District Advisory Committees. Two NGOs have joined State Supervisory Boards. Advocacy meetings have been held in 6 of the 11 states, bringing Government, CSOs, and media onto one platform. In Uttarakhand this has led to the reconstitution of the once defunct State Advisory Board, with the concerned implementing partner as its member. In many communities, the celebration of the birth of a girl child is now announced through celebratory ceremonies such as kanya lohri, thali bajao, and badhai patra which were once reserved for male children. This is considered by grassroots workers associated with WPC as a sign that communities are beginning to value the girl child.

While these are shifts in the right direction, field visits in Delhi and Haryana reveal some problem areas. It is very important to build perspectives of grass roots partners and communicators at all levels on the issue of sex selection so that they see sex selection within the larger rubric of discrimination. Though WPC has built the perspectives of project coordinators, these perspectives have not been appropriately transmitted down to grass roots workers and volunteers. UNFPA’s messaging on the issues of abortion and sex selection is clear and congruent, however, a nuanced understanding, and the ability to communicate these messages to the grass roots has not yet been developed in participating NGO’s and their communicators. The use of the cascade approach to communication training may be resulting in loss of clarity of the messages around sex selection and abortion. Moreover, some partners do not fully appreciate the fine line between pregnancy tracking for more effective prenatal care and birth registration and that done for monitoring sex selection. Based on findings from the field visits, the evaluator offers a note of caution - over emphasis on monitoring sex selection in pregnancies can easily create a more repressive environment with clandestine practices and unsafe or risky abortions. In order to communicate effectively on the issue, grass roots communicators need to understand the difference between legal and safe abortion, and sex selective abortion, so that their messaging to women and communities is clear, and their community level work does not end up stigmatizing legal abortion.

UNFPA chose to work with WPC because of its extensive reach, its capability and experience of lobbying with parliamentarians, and its commitment to working on sex selection as one of its

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47 Bihar, Gujarat, Uttarkhand, Maharashtra, Orissa, Uttar Pradesh, Delhi, Haryana, Rajasthan, Punjab, Himachal Pradesh
48 Celebratory family ceremonies traditionally performed at the birth of a boy.
four priority issues. If WPC’s skills in community level advocacy and communication were built, it would add a new dimension to its capability and role. The hope was that in each state there would be one key partner or platform for advocacy. The issue of sex selection demanded operation on a large scale. Notwithstanding the immense support that UNFPA has provided to WPC, especially in systematizing the selection criteria of the partners, training the NGO coordinators, and setting up their monitoring and process documentation systems, the overall success of WPC’s work is uneven. A recent evaluation of the WPC program notes that their skills in lobbying and leveraging with state networks and state level policy advocacy have not been effectively and uniformly applied to the work against sex selection in all states. Advocacy has been successful only where there has been a critical mass of partners working on the issue. Overall only about 50 % of the partners have performed moderately well. This is because capacity building for work at the community level requires intense and repeated training for value clarification, and adequate staff time and resources for capacity building and monitoring. The evaluation report notes that these have not been available consistently across all states.

5.3.3 Research initiatives to build a strong evidence base for advocacy

Several key publications have been developed by UNFPA that include FAQs on the PCPNDT Act for doctors, the public and implementing bodies. Findings from the very recent and comprehensive analysis of the implementation of the Act by NHRC through Public Health Foundation of India can be considered as a very useful resource and advocacy tool on strengthening the implementation of the Act. The Trends in Sex Ratio at Birth and Estimates of Girls Missing at Birth in India is a very useful brief to understand the various data sources and how to read the trends over time. This brief is also very important for researchers, media, district programme staff and policy makers alike to understand how to read the census data and its trends and the differences between various types of data sources. Other resources developed include:

- Trends in Child Sex Ratio at District Level: Maps from 2011 Census results 2011 unpublished


- A Review Of Literature And Annotated Bibliography On Declining Child Sex Ratio (0-6) In India, Udaya S. Mishra and T. R. Dilip, Centre for Development Studies, 2009

- Reflections On The Campaign Against Sex Selection And Exploring Ways Forward, a study report, Josantony Joseph, Centre for Youth Development and Activities (CYDA), 2007

- Estimation of Missing Girls at Birth and Juvenile Ages in India, Prof. P. M. Kulkarni, Centre for the study of Regional Development, School of Social Sciences, Jawahar Lal Nehru University, Delhi, 2007

A research study is in progress which scans the laws of the nations to identify those which may explicitly or implicitly be promoting son preference.
While research and documentation over the last decade is compelling and transformative, more research on social norms and attitudinal change is needed.

There is a critical need to strengthen evidence through systematic evaluation of UNFPA’s own programmes. There are very few interventions currently underway that address the issue of sex selection as systematically as UNFPA is doing in some of its states - for instance the Indore model and the WPC project. There is much to be learned from sharing the experience of WPC’s 31 NGO partners who have engaged in a common task and sought common outcomes, but have used their own approaches. What was the diversity of approaches and experiences? What has been the relative effectiveness of these approaches? Which are more sustainable? How can the approaches be strengthened?

There is a dearth of current and representative data on attitudes of men and women towards son preference and sex selection. There is much to be learnt from attitudinal studies for the questions around how social norms change or what makes certain norms resistant to change.

5.3.4 Support advocacy initiatives to create an environment that would discourage, disapprove and act against sex selection

Several audiences have been reached. Popular media such as song and artwork, posters, films, advertisements and news articles have lent their voice to the issue of sex selection.

UNFPA’s media partner, Population First has designed advocacy and promotional messaging for a young audience, and UNFPA’s own calendars and posters communicate for the issue. The media has been the key partner in advocacy initiatives:

a. In partnership with Population First, UNFPA has instituted the Ladli Media Awards for gender sensitivity. It is expected that these awards will influence media to break gender stereotypes in its treatment of women. From 2011, Population First will take ownership of this initiative and work towards long term sustainability of the awards through corporate sponsorships.

b. BBC radio serial, Life Gulmohur Style, in partnership with MacArthur and Packard on a range of issues including this one

c. In the Sapno Ko Chale Chune initiative in partnership with Jagran Pehel, the corporate social responsibility unit of Dainik Jagran (a national Hindi newspaper), young women from college interned with the Dainik Jagran newspaper in Bihar and were mentored by the district bureau chiefs of the newspaper. The programme seems to have had unprecedented success in a short time period. After the initial two years of UNFPA support, Jagran Pehel took ownership of the programme and has obtained support from new actors including the Department of Women and Child Development. This is an example of a multi stakeholder initiative successfully creating its own momentum beyond the support provided by UNFPA. Such successful models need to be made visible and promoted to different and newer constituencies. A note of caution: there is a need to monitor to ensure that after ownership of the programme changes hands, the original agenda and messaging related to fighting discrimination against the girl child, continues.
d. At the level of the states, there has been extensive media coverage on the issue of sex selection. Journalists have been trained and have then profiled the issue of sex selection in the English, Hindi and regional language press. While each of these media initiatives is interesting and innovative, the evaluation team did not perceive the existence of an overall synergistic strategy for communication and advocacy for the issue of sex selection.

5.3.5 Integrating the prevention of sex selection into on-going programmes/activities of various ministries

5.3.5.1 Ministry of Women and Child Development (MOWCD), Ministry of Youth Affairs and Sports (MOYAS), Ministry of Panchayati Raj (MOPR) and Ministry of Defence (MOD)

There have been joint activities undertaken with the Ministry of Women and Child Development (MOWCD), but they have been opportunistic rather than part of an overall plan made with the Ministry. MOWCD and UNFPA have held joint briefing meetings with the MOYAS, the Ministry of Panchayati Raj, and the Ministry of Defence in 2008. Sensitization workshops on the issue of sex selection have been conducted for members of the National Cadet Corps (NCC) at the state level, and the NCC is now taking this work forward as part of its regular programming, with its own resources. Over the next CP, should UNFPA desire to enlarge the treatment of the theme of sex selection to that of discrimination against the girl child, planned collaboration with MOWCD would be needed.

5.4 Conclusions and recommendations

The need of the hour is advocacy to build equal value for daughters compared to sons. This work is needed with immediacy and at scale. The findings of Census 2011 provide fresh impetus for urgently, systematically, and comprehensively taking this advocacy agenda to the national level so that it covers all States. UNFPA’s own resources are not large enough to bring about rapid and extensive change. If UNFPA wishes to have national impact through its work on sex selection, it may need to consider playing the role of a catalyst for advocacy, using its position and influence to draw and hold together a strong group of influential, independent and resourceful partners at both the national and state levels, who will work together to advocate for quick, high level attention and resources to the issue of sex selection.

UNFPA’s own experience has been that it is difficult to get a coalition organized around the issue of sex selection per se. Given the challenges and divisiveness on the issue of sex selection in the past, it is important to reposition the work within a wider lens of discrimination to build partnerships and buy in. Discussions with donors as well as with other UN Agencies reveal that while everyone is concerned about the issue of sex selection, they have not been able to articulate what they can do about it and how. They would like to seek a balance- working on sex selection within the broader framework of women’s rights in RH and violence against women. They lean towards sets of interventions that would have dual outcomes. Sex selection is part of the broader agenda of violence and discrimination against women. Difficult as it may be, allies are needed in this work, and must be found. If UNFPA does not find allies who can speak
strongly with one voice and work together to attain scale, there is no way any significant change can be brought about. Common perspectives will need to be built on the issue, and clarity reached on how the messaging on the PCPNDT Act and the Medical Termination of Pregnancy Act can be provided without compromising either. The timing is right and the need is felt by others who may have chosen adversarial positions earlier. The new Inter-agency Statement on Preventing Gender Biased Sex Selection of which UNFPA is a partner, is testimony to the fact that there is renewed interest in the positioning of this issue and this opportunity must be realized at the national level49.

**Recommendation**

- **Catalyze action and partnerships:** UNFPA should act as a catalyst and bring together a wide variety of agencies, to contribute to rapid change in a coherent manner, each playing a role that fits its interests and capacity, using a wider frame of gender discrimination. The opportunity should be used to reframe and renew relationships with key partners within and outside of the UN system, to reach out to new potential partners including corporate houses and national foundations that are showing an interest in investing in social causes, and to build common ground on this divisive issue.

UNFPA has a clear role in advocating with the Government for greater commitment on monitoring the PCPNDT Act. Broadening the lens and understanding other aspects of discrimination does not imply that successful efforts on strengthening Act implementation should not continue. There is clear success in the area of Act Implementation that needs to be scaled up especially through more committed efforts from the Government.

**Recommendation**

- **Advocate for scale up and strengthening of Act implementation:** UNFPA could work closely with the governments of Maharashtra and MP to advocate at the national and state levels for greater government commitment to the issue of sex selection, and for more rigorous Act implementation. State Governments and government agencies across the country need to adopt sex selection as their own agenda. UNFPA should urge agencies such as the Maharashtra State Legal Services Authority and the MP Voluntary Health Association to share with other states their experiences and the positive results that they have seen from the work that they are doing to stimulate thought and action for strengthening Act implementation.

However, UNFPA also needs to keep sight of the future. Technology changes fast and it is not unlikely that it will soon be possible to determine the sex of the foetus with home based techniques. It will then become harder and harder to get results from Act implementation. Working within the wider frame of discrimination would allow UNFPA to keep pace with these emerging trends so that its work does not merely shadow the growth of technology but in fact addresses the root causes of the problem while curtailing the demand and supply for existing and newer technology. Analysis of the different policies that address daughter discrimination triangulated with sex ratio at birth and other data on girl’s education, health and RH to understand nuanced patterns of son preference and daughter discrimination is critical. Such an analysis can influence work with media as well as community advocacy through grassroots and

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civil society actors. Choosing to focus on just sex selection at this point has the risk of missing critical pathways of discrimination that may, in the long run, affect sex ratio at birth. It also confines the work to Act implementation and advocacy around the issue of sex selection alone. Emerging data and research show that son preference, gender inequality, and patriarchal practices such as dowry co-exist with improved outcomes of delayed age of marriage and higher school education for girls. It is important to delve deeper and understand what factors are sustaining the ideology of son preference even in a rapidly changing social milieu where women are taking on iconic positions and roles in sports, media and governance. The role of men and masculinity thus need more attention in the work on sex selection.

**Recommendation:**
- Research such as the ongoing study on son preferring laws, is a step in the right direction and more needs to be done. New research could be commissioned to understand attitudes in the area of son preference and sex selection building the evidence base.

Changing social mindsets through advocacy and communication programmes is the ultimate ideal and long term goal of programming. To be successful, such communication needs to use of a broader frame of discrimination against daughters. UNFPA’s current advocacy strategies and community work do not make explicit the causes of daughter discrimination and son preference-cultural beliefs, dowry, practices of inheritance- which result in pre birth elimination of girls, There is an absence of a well planned and clearly articulated communication strategy with the central objective of shaping public opinion and changing mindsets so that girls are allowed to be born. This is a gap that needs filling.

**Recommendation:**
- UNFPA needs to lay out a more forward looking communication strategy in the area of sex selection with clearly defined objectives, audience segments, segment specific messages, media plans and budgets, integration of available research in development of messages, and an embedded evaluation plan. Evidence based advocacy to shape public opinion must be a central objective of communication.

Community level work through networks of NGOs has brought about higher awareness of the issue of sex selection and awareness of the PCPNDT Act to the grass roots level and other specific positive outcomes. The work has challenges in that grass roots communicators need value clarification on abortion per se, the intersect between legal abortion and sex selective abortion, and on reproductive rights, so that their messaging to women and communities is clear, and their community level work does not end up stigmatizing legal abortion.

**Recommendation:**
Community based work to change mindsets may not be the best use of UNFPA’s resources. However, the learning from the community level work should be documented and disseminated as a resource for others working on these issues, and to advocate for more community work to change social norms.

The findings of Census 2011 show that work against sex selection is urgently and widely needed in India. UNFPA has done pioneering work in this important area. The work on sex selection has not been easy and has generated some controversy. In all its work, UNFPA has maintained a
careful balance between disapproving sex selection and strengthening implementation of the
PCPNDT Act, while not stigmatizing legal abortion carried out under the medical termination of
pregnancy Act (1970) which helped cut down maternal death from unsafe abortion. Some civil
society organizations felt that UNFPA was not doing enough about sex selection, and others felt
that UNFPA was endangering hard won maternal health gains from the passage of the Medical
Termination of Pregnancy Act (1970). For these reasons, UNFPA has found it difficult to build
coilitions of influential partners for this programme and has had to work virtually alone. Despite
this, UNFPA has significant achievements to its credit in the area of sex selection.
Section VI: Population and Development Strategy

6.1. Background

The strategic plan of UNFPA 2008-2013, aimed to accelerate progress and national ownership of the ICPD Programme of Action (ICPD PoA) and drew up the following broad framework for its work in the area of Population and Development:

a. UNFPA will use its expertise in population data collection and analysis, and contribute to the Millennium Development Goals by supporting countries to incorporate population dynamics and its inter-linkages with gender equality, SRH and HIV/AIDS into public policies, poverty alleviation strategy and expenditure frameworks.

b. Given the sheer size of the youth population, the Fund will also advocate for strategic investments in young people’s health and development by highlighting potential benefits in terms of building human capital, capitalizing on the demographic dividend and breaking the inter-generational cycle of poverty.

c. UNFPA will continue technical and financial support- including advocacy and mobilization of resources- for the collection, analysis, utilization and dissemination of gender-disaggregated data.

d. One hundred and eleven countries will be supported to implement their national censuses as the foundation for development planning in the coming decades.

The directions proposed gel well in the Indian context, especially when the country’s development is still to reach the millions of underprivileged and there is still a long way to go for realization of the Millennium Development Goals (MDGs). The demographic transition along with the present level of social and economic development has presented India with several opportunities and newer developmental challenges. CP 7 therefore designed its Population and Development strategy keeping in view the ICPD-PoA and the present and future needs of the country as reflected in the 11th five year plan.

6.2. Results Desired

The overall outcome for the Population and Development Component of CP-7 is that capacity be built to integrate population dynamics into national policies and programmes. The Results and Resources Framework states two outcome indicators:

a. Results of studies on emerging population issues reflected in national/sub-national development plans

b. Plans and policies are linked to population and development realities, through use of disaggregated data in planning and monitoring
The output desired is social development planning that takes into consideration demographic transitions. Four revised indicators have been mentioned:

a. Number of UNDAF districts using disaggregated development data in planning and monitoring programmes

b. Research and policy studies undertaken and disseminated for policy dialogue

c. Data made available on emerging and priority demographic issues

d. Number of activities undertaken for building the capacity of the Census Organization to undertake the 2011 Census.

6.3. Strategic Interventions: Findings and Analysis

6.3.1. Joint GOI-UN Convergence Programme

UNDAF 2008-2012 articulated the vision, strategy and collective action of the UN system in India as “promoting social, economic, and political inclusion for the most disadvantaged, especially women and girls”, and set priorities and outcomes that were congruent with the 10th and 11th five year plans. UNDAF outcome 3 is about convergence among various departments and agencies at the district level to catalyze efforts to achieve the 11th plan targets related to the MDGs.

The GOI and UN agencies, jointly formulated the GOI-UN Convergence Programme to be implemented in 35 backward districts of the 7 UNDAF states. The objective of the programme was to facilitate the development of integrated district development plans through convergent action of various government departments and schemes at the district level. The Planning Commission at the national level, and planning departments at the state levels, were involved. Within the UN, UNICEF, UNDP and UNFPA came together to form a “thematic cluster” and work together with synergy on this programme. The objectives of the Convergence Programme were to:

- Improve participatory planning through the District Planning Committees
- Enable better understanding of budgets and resource flows at the district level
- Help address bottlenecks in implementation of flagship programmes and
- Support the strengthening of physical and financial monitoring systems for measurement of programme outcomes

A manual for preparation of district integrated plans has been developed by the Planning Commission. The manual summarizes district planning as the process of preparing an integrated plan for the local government taking into account the natural, human and financial resources available and covering sectoral activities and schemes assigned to the district level and below and those implemented through local governments in a state.

For the purpose of operationalization, the manual listed the following sequential steps:
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- Preparation of district, block and panchayat level vision documents
- Preparation of participatory plans involving Gram Sabha and from Village Panchayats to District Panchayats.
- Preparation of plans by Urban Local Bodies
- Consolidation of plans prepared by local bodies by District Planning Committees.

It lays emphasis on the preparation of a vision document for 10-15 years based on participatory assessment in 12 sectors of development.

Subsequent to the vision planning exercise, annual plans and Five Year Plans with quantitative targets and goals pertaining to the 12 sectors of development were proposed.

The division of work among the UN agencies was as follows: UNICEF and UNDP provided district facilitation support in the rollout and monitoring of the district integrated plans and strengthened capacity of human resources and institutions. UNDP in addition included change management principles and development of District Human Development Reports, as other priority areas of intervention. UNFPA support entailed enhancing the skills of officers at the district and state level in use of data for evidence-based planning and for monitoring development programmes.

With regard to the operational modalities of the Convergence Programme, UNDP supported the establishment of a Programme Management Unit (PMU) which provided technical support to the Planning Commission for the rollout of the Convergence Programme as well for other governance related activities of UNDP. The three participating UN agencies, along with the PMU, are expected to put together a joint annual work plan that is vetted both by the Planning Commission and the UN Resident Coordinator’s Office.

While reviewing and discussing the rollout of annual work plans, the evaluation team found that when one partner was not able to ensure synchronized initiation and progress of interdependent activities, it hampered the work of the others and caused delays in overall execution of the project. Inspite of these issues being discussed in coordination meetings, individual agencies continued to move ahead according to their own plans, adversely affecting other activities that were interdependent or complementary.

6.3.1.1. UNFPA’s contributions in the Convergence Programme

UNFPA developed sensitization and capacity building programmes for senior government officers and district statistical officers on the use of data for planning and monitoring development programmes. It also helped in developing a guide/manual for tracking development indicators at the sub-national level. Brief details of each of the areas are discussed below:
6.3.1.1.1. Training programme for senior officers

This was a two day sensitization programme for senior officials who are departmental heads, and district administrators engaged in planning and programme management.

India’s Eleventh Plan document sets out goals (many of which correspond with the MDGs), to be achieved by the end of the plan period (2007-12). The achievement of these goals requires proper planning and monitoring of programmes at the state, district and local levels. For this purpose, senior officers, departmental heads and district administrators need to know what data is available, how they can be used, and the challenges in their use. These capacity building workshops aimed to apprise participants about the importance of data and its utilization in planning and monitoring. Specifically, the programme dealt with data requirements, the different sources of data, their merits and demerits and how data are to be used and interpreted.

Four programmes were conducted between September and December 2009 and nearly 80 officials participated. Participants comprised senior state officials from the Planning Departments, District Collectors, Additional District Collectors and UN national and state officers. The programmes were conducted by the Institute for Social and Economic Change (ISEC), Bangalore, in its campus. Renowned experts, in-house faculty, and retired senior bureaucrats were invited to be the resource persons. A range of topics were covered - education, poverty, income, demography, health, gender budgeting, and the need for planning, monitoring and evaluation of development programmes. The sessions were participatory and there was discussion on survey-based and programme generated data systems. Further, there were panel discussions around monitoring and evaluation and of how, in the absence of denominators in reports, numerator based data could be used to make inferences about performance. The need for improving the routine government data-base was emphasized, and most of the experts were of the view that once programme managers start using routine data for monitoring the data-system is bound to improve.

Analysis of participants’ feedback provided during the evaluation session at the end of the training programme indicates that most participants found the content and structure of the programme useful. They said that senior experts had enabled them to understand both the uses and limitations of available data. The administrators admitted that before the training programme, they had been unaware of the extent of limitations of data. Participants rated the sessions on need for planning, demography, health, poverty and income as “excellent”. They said that they would be interested in refresher courses on district income and poverty and requested that similar programmes be conducted at the state level so that officers in the states could also benefit from these inputs.

This activity is well aligned with the global mandate and national objectives of the UN and is relevant to the needs of the country. Positive participant feedback and the request for repeat courses and refreshers confirm this. A shortcoming of the programmes was that while concepts and techniques around data collection and use for planning and monitoring were being emphasized, an important opportunity was missed of orienting senior administrators on the cross cutting issues of gender, rights and equity which are an important part of the ICPD PoA and also of national policies and strategies related to population and development.
6.3.1.1.2. Training programme for district planning and statistical officers:

The objective of this five-day programme is to enhance the capacity of district programme managers/statistical officers in use of data for planning and monitoring and to enable them to have a broad, holistic understanding of population and development and of their inter-linkages. The International Institute for Population Sciences (IIPS), Mumbai is the implementing agency and 21 training programmes are planned- three programmes of five days each, in each state. Nearly 400 district statistical officers and UN district teams located at the districts are expected to be imparted hands-on-training.

For the purpose of rolling out the training programmes, local partner agencies have been identified and assessed in Rajasthan, Orissa, MP, Chhattisgarh and Bihar. In UP an agency is yet to be identified. An agreement signed with these agencies by IIPS specifies that they will undertake the training of government functionaries and staff of other UN agencies engaged in the Convergence Programme, and that IIPS will strengthen the capacity of their faculty members to do this work. This approach will succeed not just in training state level officials but will also build sustainable capacity within the states to scale up the training programs to all the districts of the states.

The training modules were developed in the first quarter of 2010 for a six-day programme, but after pre-test in Rajasthan was modified and reorganized as a five-day programme. Programme content included a range of topics- sources of demographic data, merits and limitations of data, interpolation and extrapolation, population projections, education, poverty, water and sanitation, results-based management, and monitoring of development programmes. It emphasized the use of data and the development of practical skills in data analysis. However, the module did not cover the inter relationship between population dynamics and development, nor did it deal with the relationship of gender, rights and empowerment (as laid out in the ICPD PoA to development issues.

To date, 12 training programmes have been conducted in the five states of MP, Chhattisgarh, Rajasthan, Orissa and Jharkhand. In MP, Chhattisgarh and Orissa all scheduled programs have been completed. Nearly, 280 participants from different state/district development departments as well as UN recruited district officers have participated in the training programmes. The feedback received from participants, has been encouraging. They appreciated very much the hands-on practice that they were given in analyzing data from their own districts and states on the computer. A few of the participants expressed the opinion that teaching life-tables is not relevant. However they appreciated the content on interpolation and extrapolation, population projections, education, results based management, and monitoring of development programmes.

IIPS organized an expert group meeting to review participant feedback and to fine-tune, and make the module more practical and district specific through the use of district level administrative data sets wherever feasible. The committee concluded that it was essential to expose participants to the basics of life-tables and of software for working out district estimates. It was felt that for teaching indirect estimation of fertility through the reverse-survival method, teaching of life-table is essential. Hence, despite participants’ feedback, the training content on life-tables has been retained.
The training programmes in Rajasthan, Jharkhand, Bihar and UP will all be conducted and completed in 2011.

These programmes are made most relevant by reason of their timing—when India’s XIIth five year plan is under formulation, States with committed leadership have ensured that the programmes become replicable and sustainable. Jharkhand and Chhattisgarh on the contrary have not yet identified state-level agencies to conduct the programmes and sustain them in the future. A letter from the State Planning Board of Chhattisgarh to UNFPA explains that it will compensate for its inability to find a local training agency by nominating more officers for the training programmes so that they in turn can take the training forward in the future.

As regards the immediate impact of the training programme, the evaluation team finds that districts have started working on district plans. Minutes of the review meetings at state planning departments reveal that 20 of the 35 districts started preparing the integrated district plans within the stipulated time-frame. The quality of the plans has improved. The planning process has included consultations with the community, panchayati raj members at the village panchayat level, and with government development departments. Common elements of the programming have been discussed and additional budgetary provisions made for better synergy at the service delivery level (e.g. convergence between Health and Nutrition at the anganwadi level on village health days, immunization services at schools and anganwadi centers along with co-operation from the Accredited Social Health Activists). Earlier the “district plan” was merely a set of plans from individual departments, with no effort at convergence. In the process, district management has become pro-active in those districts where the District Collector (administrative leader of the district) is taking the lead. The monitoring of programmes has become more focused and systematic, and the plans are made on the basis of data, facts and evidence. Of late, it has been reported that a few districts are venturing into new areas such as afforestation, climate change, dry land farming and so on. There is now scope for further improvement of district plans and for use of data in developing these plans.

MP and Chhattisgarh have requested refresher training. Before refresher training is imparted, a need assessment exercise is underway with participants. Based on feedback received, the refresher programme would be developed and rolled out in these two states. This activity will be initiated by UNFPA’s MP Office during the current year and the local agency that conducted the initial rounds of training will carry out the refresher training as well.

One of the observations of the evaluation team is that skills within the government system for development planning are scarce. This reflects the situation in the country where the pool of development planners is small because there are few academic institutions that offer courses in development planning. Staff of government planning departments is not trained professionals in population and development. Also, staff turnover is high. For these reasons, despite the valuable training devised by UNFPA, one-time training is not going to be sufficient. Repeated rounds of training and continuous hand holding in the form on on-the-job training will be needed.
6.3.1.1.3. **Sub-National estimation methodology for tracking developmental indicators**

In India, the district is the administrative unit for planning of development programmes. Programme managers need to be able to measure the performance of the district on key development indicators, study intra-district variations, and decide upon how to devise and allocate development inputs. However, lack of data at the sub-national level and for small areas, has impeded planning, monitoring and accountability of development programmes at the district level. Also there is little expertise in estimation methodologies for sub-national and small area data, which is generally based on indirect estimation techniques. Building capacity and expertise in small area statistics, is a high priority task for India given the nation’s focus on district level planning and accountability for development.

A two-day workshop of experts on Methodologies for Sub-National Estimation was held at ISEC, Bangalore, and culminated in field based-studies in districts with both good and not-so-good data sets. Two districts in each of the two states of Karnataka and Rajasthan were visited by a team of experts. Data on different development indicators were collected, analyzed, tested for reliability and validated. A manual of amenable indicators was then prepared and vetted by an expert group. The draft manual was pre-tested in Orissa with statistical officers from the health department. Participants’ feedback has been addressed and the manual finalized. This manual is useful because it allows the quality of data to be examined before it is used for planning. The manual not only facilitates planning, it enables district officers to track amenable MDG outcome indicators related to demography, health and education, and district level process indicators of national flagship programs.

6.3.1.1.4. **District-Level Population Projections in Eight Selected States of India (2006 -16)**

Population Projections in the country are made by an expert group constituted by the Registrar General, India. Following the 2001 census, the expert group undertook a population projection exercise at the national and state levels. Realizing the importance of district-data in decentralized planning, UNFPA undertook a projection exercise for the UNDAF states and Maharashtra. The report of this exercise provides age and sex disaggregated district data on the basis of which district planners can develop realistic plans and also calculate the value of development indicators. The published report has been shared with all the UNDAF states and is being taught and used in the capacity building programme for district statistical officers. The MOHFW has reviewed the report and requested UNFPA to share a soft copy of the report which it is now using for planning purposes. The publication has been hosted on the website of the Ministry (http://nrhm-mis.nic.in/PublicPeriodicReports.aspx). In addition, MOHFW has written to UNFPA requesting it to undertake a similar exercise for all the states/districts in the country after the release of 2011 census data.

The exercises of district level projections and sub-national estimation are likely to have positive impact on decentralized planning and programme monitoring UNFPA has worked strategically and systematically to help the districts to define the denominators that form the basis of the planning exercise.
6.3.2. Essential data for health programme planning and monitoring- Health Management Information Systems and Vital Registration Systems

6.3.2.1. HMIS

The MOHFW in collaboration with the National Health Systems Resource Centre (NHSRC) has developed manuals and a web-based portal for operationalizing the Health Management Information Systems (HMIS). While NHSRC introduced the HMIS system at the state and district levels, it was difficult for them to train functionaries at the sub-district levels. Hence, states were requested to prepare their plans of action for capacity building of functionaries at the sub-district level and below. Given that UNFPA had presence in Bihar and Maharashtra, the states requested UNFPA to help to operationalize these plans. UNFPA engaged the Indian Institute of Health Management Research (IIHMR) and the International Institute of Population Sciences (IIPS) to carry out this work in Bihar and Maharashtra respectively. In Bihar, UNFPA support was extended to build capacity of all staff members at the level of the district and below, while in Maharashtra it was confined to the capacity building only of mid-level managers. Training modules that complemented NHSRC modules were developed, pre-tested and introduced in both the states in collaboration with the state units of NHSRC and the respective state governments and the state units of NHSRC. These modules can continue to be used as and when required to train additional staff in the future.

The training programmes in both Bihar and Maharashtra have been completed. In Bihar, besides HMIS training, UNFPA is also helping mid-level managers to analyze the quality of data and to use the data for monitoring and feedback. In Maharashtra the module focused more on the monitoring aspects of the programme. Discussions of the evaluation team with state governments and other agencies including NHSRC and Ministry of Health have revealed that HMIS reports in Bihar are now being prepared on time and the quality of data reported has improved, though in many districts, there is still scope for improvement. Supervisory staff that has been trained has started moving into the field to conduct review meetings. It appears that the states of Bihar and Maharashtra are seeing HMIS improvements as a result of the UNFPA capacity building inputs.

The evaluation team finds that the quality of training in HMIS has not been evaluated in depth and would be necessary before advocacy for replication and scale-up. Besides, the HMIS does not include strong data quality checks, and data triangulation, it does not measure any elements of quality of care, nor does in gather data disaggregated by markers of social disadvantage. Without these, it was not possible to train district and sub-district managers and supervisors and front line workers to analyze programme performance from the point of view of whether vulnerable sections of the population had access to services or were utilizing them.
6.3.2.2. The Civil Registration System and Vital Statistics

The civil registration system in India is implemented under a central law, namely, the Birth and Death Registration Act, with the overall supervision of and guidance from the Registrar-General, India (RGI). If the system functions well it provides vital statistics for small areas which can be the key data set for decentralized development and programme planning. In India the system has not yet taken firm root and system effectiveness, coverage and data reliability vary greatly across the country.

UNFPA undertook an important study of the civil registration system and vital statistics in the state of Rajasthan. The study provided estimates of the degree of coverage of the system, and the community’s awareness about and perception of the system. Lapses and deficiencies in the system were identified and the need for sustained building of public awareness was highlighted and shared with government counterparts. A consultant provided and placed by UNFPA within the Planning Department of the Government of Rajasthan has been continuously reviewing vital registration system data and providing regular feedback to the state government. The state government has accepted a few short-term recommendations from the study and will be implementing them in the XII Five-Year Plan cycle.

The study in Rajasthan could have benefited from consultation with and guidance from RGI and other stakeholders such as UNICEF.

Since UNFPA is engaged in building national capacity to gather and use data for decentralized development planning, the provision of TA for improving the utility of vital registration data and showing how the most reliable estimates can be made from data even though coverage levels are not high, would be an important contribution that UNFPA could make.

6.3.3. Technical Assistance and Support for the conduct of Census, 2011

The Census operations in India are carried out in two phases. The 2011 census included house-listing and housing census in the first phase, and population enumeration in the second. The United Nations (UN) agencies of UNICEF, UNIFEM, UNDP and UNFPA in India have been supporting the Office of Registrar General of India (ORGI) in four specific areas:

a. digital mapping of census blocks in capital cities,
b. census training and publicity,
c. gender aspects of the census and
d. data dissemination.

A joint UN-ORGI five-year work-plan was drawn up in 2008 wherein both the programmatic role to be played by each UN agency and the financial support to be provided by them to the census were well defined.

In the first phase of the census, UNFPA and UNICEF supported the digital mapping exercise, and in the second phase, UNFPA and UNICEF supported training and publicity activities for gender mainstreaming. Presently, UNFPA is supporting streamlining historical data series through e-archiving going back to 1931 at least, and data warehousing for the 2001 and 2011 censuses. This will enable disseminations of census data with historical comparison and context.
A study is also being undertaken to develop a road-map for establishment of Census Training and Resource Centre.

‘Digital mapping’ of all wards in 33 capital cities barring a few in the Kolkata Municipal Corporation was accomplished in 2010. The RGI and his staff informed the evaluation team that these digital maps were useful in carving out enumeration blocks and ensured better coverage during enumeration.

Enumerators were trained for effective conduct of the census. Training of enumerators was done using a cascade approach. Ninety national trainers trained 725 master trainer facilitators who in turn trained 54,000 master trainers who then trained 2.7 million enumerators all over India on the population enumeration schedule.

Though gender had been a prominent cross-cutting priority in the 2001 census, it had enumerated several villages/districts that had reported very few women, very low female literacy, and no female workers. Data related to female count, marital status, female headed households, female disability and female work-participation had continued to suffer from under count or under reporting. To ensure better data on these aspects in the 2011 census, it was decided that enumerator training would include a gender module that sensitized all 2.7 million enumerators in the country on the need to exercise care to ensure that data gathered on the above mentioned female issues was accurate, and on how such data should be collected.

The gender module was developed for all levels from national trainer to enumerator. The training guides integrate the seven categories of gender-specific issues through well laid out session-plans. To facilitate the sessions, appropriate teaching aids in the form of an e-module, role-plays, quizzes, flyers and data-posters were developed. A two-sided flyer in A4 size containing gender-data on one side and gender mainstreaming matrix on the other for 260 critical districts was printed by India Census office in local languages for all the 2.7 million enumerators across the country. The flyer was used as training material in the training programs.

Special training was given to the enumerators in “gender critical” rural and urban areas. Gender critical urban and rural areas were identified on the basis of three criteria emerging from the 2001 Census- overall sex ratio, female literacy, and female work participation. These three indicators reflect the status of women and additionally enable analysis at the lowest disaggregated level, i.e. the village. Thus, rural districts that scored low in the 2001 census in sex ratio (less than 900); female literacy (less than 30%) or female work participation (less than 20%) were identified. For urban areas - cities and towns- different cut-offs were used. Using this methodology, 260 out of 593 districts and urban areas across the country, were identified as gender critical.

 Enumerator training in these 260 districts was considered the key to ensuring completeness and accuracy of data concerning women and girls. For these districts, a pool of 260 specially trained gender master trainer facilitators (GMFTs) were put in place, and they trained the 1.2 million enumerators of these districts in the gender module. This was done to make sure that in the gender critical districts, the training of enumerators on gender issues did not suffer any dilution through the cascade training approach.

For reinforcing gender elements in the 260 gender critical districts, bi-lingual gender-data posters in A2 size (English and Hindi) were printed by UNFPA for use during training programmes and
as publicity material at training venues and government offices in the districts. During training of enumerators, the GMTFs discussed the district situation in 2001 census in terms of the indicators shown in the poster, and later emphasized the importance of completeness of data concerning women & girls. This was done through a 45 minute training capsule that focused on ensuring inclusion, better netting of different categories of women, and appropriate information on births of girls, female headed households, etc.

UNFPA worked closely with UNICEF and UN Women in the census project. A national alliance of NGOs was supported by UNICEF through a cost-sharing mechanism with UNFPA, for developing training outlines, session plans, teaching aids, and e-modules and for imparting training to the trainers, thus complementing the efforts of the Census Organization. Further, gender aspects were mainstreamed into training and publicity activities. A note on the processes of how gender is to be mainstreamed was put together by the gender working group led by UNFPA. The gender note is hosted on the website of Census India and can be accessed through the link:


For undertaking publicity activities, reputed advertising agencies were hired by UNDP and UNICEF for the first and second phases respectively. Communication strategy and media planning, designing and preparing publicity materials and creatives were all undertaken. Web-based publicity was used for the first time in Census 2011. Apart from generating awareness about the census, the publicity agenda focused on communicating specific gender messages and included women’s work, as one of its major themes.

**Dissemination of census data**

The dissemination of census data has been planned wherein IT based solutions like ‘Census Info India’ that is both CD and web-based, user-friendly software to run Primary Census Abstract (PCA), establishment of in-house data ware-housing and mining system, and e-archiving of earlier census data are on the anvil. Dissemination of the provisional results of the 2011 Census has just been initiated and UNICEF has provided the Census Info platform for disseminating data. These efforts are likely to result in expeditious and smooth dissemination of census data much earlier than in past censuses.

A ‘Census Training and Resource Centre’ has been proposed to be set up and UNFPA has commissioned a study to develop a road-map for the establishment of the Census Training and Resource Centre which is expected to be used for south-south collaborative activities.
6.3.4. Bihar Population and Development Policy formulation

UNFPA was requested by the Bihar Government to facilitate the process of developing a population and development policy and to help in its formulation. UNFPA developed a road-map of the formulation process which was ratified by the government. To take the initiative forward, sectoral reviews in the following areas were initiated:

a. Demographic trends and future scenario for attaining replacement level fertility;
b. Health, mortality and morbidity patterns and burden of diseases in Bihar;
c. Education status, current gaps and future requirements;
d. Employment scenario and livelihood options;
e. Development options for Bihar; and
f. Status of women in Bihar

All the sectoral reviews have been finalized after seeking feedback from government and civil society organizations in a one-day consultative workshop. The government is presently reviewing the papers and after once it concurs, the next steps in the policy formulation process will be initiated. The evaluation team finds that studies are yet to analyze the inter-sectoral linkages within a rights-based and gender sensitive framework.

6.3.5. Emerging Population Issues

UNFPA expects that emerging changes in the age and sex structure of the population in India, particularly the growing numbers of the elderly, combined with the migration of youth and families, will pose newer demographic and developmental challenges related to the life situation and care of the elderly. Therefore UNFPA has identified population aging as a priority area in its work in PDS. CP-7 proposed to pursue three dimensions of work in this emerging issue: (i) build a general knowledge base in the country through special research and programmatic studies, (ii) work with the government on policy and programme issues which will enhance the economic and social integration of the elderly to the mainstream of society, and (iii) build capacity of national institutions for more effective implementation of the government programme.

6.3.5.1. Build a knowledge base in the country through special research and programmatic studies

The knowledge base in regard to the elderly in terms of their demographic, social and economic conditions, health needs and their living arrangements particularly of single and widowed women is weak. Further, there have been few or no studies that have documented the awareness and use of entitlements by the elderly. Hence UNFPA commissioned eight secondary studies covering a range of elderly issues from demographic, socioeconomic and health aspects to government policies and programmes. These studies were conducted in partnership with the Institute of Social and Economic Change (ISEC) – Bangalore and the Institute of Economic Growth (IEG) – Delhi. The eight studies were on:
Part B: Assessment of Programme Components (Section VI: Population & Development Strategy)

a. Demography of the Indian elderly
b. Elderly workforce in India: labour market participation, wage differentials and their contribution to household income
c. Elderly health in India: dimensions, differentials and changes overtime
d. Family structure, living arrangements and the social dimensions of the elderly
e. Critical gaps in the implementation of integrated programme for older persons
f. Critical review of the national policy on aging
g. Synthesis of policies for the aged, of select Asian countries, and a study of the relevance of these policies in the Indian context
h. Studies on aging in India: A review

By the first quarter of 2011, these eight studies have been completed and peer-reviewed. They are to be published in a series of discussion papers, and are to be shared and disseminated to a wider audience of stakeholders and partners across the country including government.

In the second stage of the research, based on gaps identified by the secondary studies, three large scale primary studies have been initiated to fill the gaps because they would have bearing on the development of policies and programmes. The primary studies are being conducted by partner institutions and will examine (i) family composition, family dynamics and living arrangement of elderly persons across different socio-economic settings; (ii) health status of the elderly; and (iii) economic status of elderly, social protection and safety nets in the context of aging in India. These primary studies are being carried out in seven states of India with a relatively high proportion of elderly populations. Field data collection started in March, 2011 and is expected to be completed by August 2011.

A set of comprehensive primary study instruments have been prepared by the partner institutes in consultation with a technical advisory committee formed of senior researchers from within the institutes, experts in the field of population aging, and UNFPA.

The evaluation team finds that the process of developing the questionnaires and manuals was very systematic.

6.3.5.2. Work with the government on policy and programme issues to enhance integration of the elderly into the mainstream; and (iii) build capacity of national institutions for more effective implementation of the government programme:

UNFPA approached the Ministry of Social Justice and Empowerment (MOSJE), the nodal ministry concerned with the care of elderly in India. UNFPA proposed to support the Ministry by providing policy analysis, identifying programmatic gaps, and helping the Ministry to streamline its strategies for economic and social integration of the elderly into the mainstream of society. UNFPA also proposed to build the capacity of apex institution such as the National Institute of Social Defence; facilitate the formation of networks of NGOs and build their capacity to undertake national pilot interventions for the elderly. The MOSJE’s involvement has been restricted to engagement with UNFPA on a case-to-case basis and UNFPA could not therefore move ahead systematically with a comprehensive plan for this field of work. Consequently, UNFPA’s work in the field of aging is at the moment restricted to research and programmatic studies.
6.3.6. Supporting Professional Associations working in the field of Population and Development

In CP-7, UNFPA has provided technical and financial support to various professional bodies and associations for organizing workshops and conferences, The support provided professionals the opportunity to present recent research in the field of population and development, and promoted discussion and dialogue among scholars. These professional bodies and associations include Indian Association for the Study of Population (IASP), Indian Association for Social Sciences and Health (IASSH), Asian Population Association (APA), Centre for Gerontological Studies (CGS) and Indian National Science Academy (INSA). In addition, UNFPA provided IASP with one time financial assistance to revive its journal “Demography India”.

6.3.7. Other research and programme studies

UNFPA has from time to time undertaken other research and programme studies during CP-7. These studies include an assessment of Janani Suraksha Yojna\(^5\) (JSY), home-based pregnancy testing kits for MOHFW; and evaluation of the Red Ribbon Express for NACO; the prevalence of obstetric fistula; assessments of the adolescent education programme, and of the functioning of Teen Clubs; and trend analysis of sex ratio at birth based on data from census, and assessing impact of incentives on SRB.

The CPAP of CP-7 envisioned studies on important emerging population issues such as the ‘youth bulge and the demographic dividend’, migration and urbanization, population and environment, and post reproductive morbidity. Some papers on these issues have been presented at national and international conferences. However, more systematic and rigorous studies for policy advocacy are yet to be taken up.

6.4. Conclusions and recommendations

The interventions to improve decentralized and convergent development planning at the district level through use of data particularly those related to population dynamics, are fully aligned with the global mandate of the UN and relevant to the needs of the country. Activities were planned in a systematic way and interventions were rolled out through the UN-GOI Convergence Programme. Inspite of lack of synchronized action between the partners, UNFPA made efforts to take forward the intervention in discussion with other UN partners.

**Recommendation:**
- Continue to support decentralized and convergent district level development planning and add depth to the training content used so far by emphasizing how to gather, analyze, interpret and use data for the formulation of policies and programmes that address and safeguard the fundamental principles of rights, equity, and gender.

UNFPA’s training programs for senior administrators and planners/statistical officers at the state and district level on the use of data for planning and monitoring is a good first step in this capacity building process. Both participant feedback and the requests from the state governments

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\(^5\) A nationally sponsored scheme under which financial incentives are provided to families to encourage institutional delivery
for repeat workshops to be organized at the state level are evidence of relevance and effectiveness.

**Suggested Actions:**
- Since repeated rounds of training for capacity building will be needed in the foreseeable future, and since such training needs to be scaled-up, it is important to build institutional capacity in the states to design and conduct such programs. This would make the capacity building sustainable and cost effective. To enable all this, the state governments would need to allocate resources in their budgets for conducting these programmes on a continuing basis.

- For sustained in-service capacity building of senior administrators, and programme and policy leaders, population and development courses should be integrated into the induction, orientation and training courses that are regularly conducted for government officials.

There is a shortage of professionals trained in population and development studies particularly with a gender sensitive and rights based perspective. While in-service training approaches used by UNFPA are a valuable input for filling the gap, it may be worthwhile to support pre-service education to enlarge the pool of trained personnel in this field in India.

**Suggested Action:**
- UNFPA should support the development of Masters/Diploma/Certificate programme on population and development at appropriate educational institutions.

The strengthening of the capacity of administrators by broadening their vision on population and development inter-linkages as envisaged in CP is an important strategic initiative. This initiative is yet to take off. This intervention is very crucial to PDS in India along with sensitization and training on data use. It is a highly effective and sustainable tool of policy advocacy around the ICPD PoA and for the implementation of the National Population Policy.

**Recommendation:**
- Broadening the vision and perspectives of development planners to understand population and development linkages, and the relationship of the key issues of gender, equity, and empowerment to development, must continue to receive priority in the India CP.

The district population projection exercise was highly appreciated by all stakeholders. UNFPA has worked strategically and systematically to help the districts to define the denominators that form the basis of the planning exercise. That government put the projections on its website and is using it for planning purposes speaks for the relevance, effectiveness and quality of the work. The exercises of district level projections and sub-national estimation are likely to have positive impact on decentralized planning and programme monitoring.

**Suggested Action:**
- UNFPA should advocate for sustained use of the projections.
Part B: Assessment of Programme Components (Section VI: Population & Development Strategy)

Capacity building support provided for HMIS in Maharashtra and Bihar has begun to show results. However, the evaluation team finds that the quality of training in HMIS has not yet been evaluated in-depth. It is necessary to do so before carrying out advocacy with state governments for replication and scale up. One challenge with the HMIS is that it does not gather data disaggregated by sex and other markers of disadvantaged social status. It does not permit triangulation of data, and it does not have strong, in-built data quality checks. Nor does it report on any elements of quality of care. This makes it difficult to measure access to quality services for vulnerable sections of the population. Without such data from the HMIS district and sub-district managers, supervisors and front line workers will not be able to track health programme implementation on these critical aspects. Given the importance of vital statistics from the civil registration system for decentralized development planning, TA for both strengthening the system, and in how to use and make estimates from data when coverage rates are imperfect, are important contributions that UNFPA could make in India.

**Suggested Actions:**

- Proactively advocate with government for the inclusion of markers of disadvantaged social status in the HMIS.

- Provide TA inputs for strengthening both vital statistics from the civil registration system and HMIS data.

The evaluation team concludes that the support given by UN agencies (with UNFPA as the lead) for conduct of Census 2011 has been timely and extremely valuable. The unique role and niche of UNFPA in engendering the census has been well recognized. Moreover, the effective leadership provided by UNFPA on this joint initiative has been appreciated by its UN sister agencies and Government/ORGI. This joint programming approach is a model that could be replicated for joint UN programming in other areas of work. Most of the products developed by UN agencies are available on the census website. Furthermore UNFPA staff has reported to the evaluation team that the Ministry of Rural Development has sought technical support of the UN for the planning and execution of the Below Poverty Line Census to be conducted from July 2011, and that the UN agencies are supporting the conduct of a pilot for this Census.

With regard to the **population policy work in Bihar**, well-written sectoral papers have been prepared. However inter sectoral linkages are yet to be analyzed within a rights based and gender sensitive framework.

**Suggested Action:**

- In formulating the Bihar Population & Development policy, care needs to be taken to ensure that the resultant programme is rights-based and gender-sensitive. An advisory group of eminent population and development and gender professionals may be set up by UNFPA to advise on policy strategisation.
Reviewing the work done so far in the field of aging, the evaluation team finds that UNFPA has approached this emerging issue very systematically, starting with a comprehensive research agenda to establish a strong knowledge base that will serve as an effective tool for advocacy to address policy and programmatic gaps related to the elderly. It is disappointing that despite the best efforts of UNFPA, the MOSJE is not actively engaged. If UNFPA wishes to make headway on this emerging issue it will need to advocate to find alternative routes and mechanisms to get civil society organizations and the government to be engaged in the issue of aging, so that the elderly are included in the national development agenda.

**Suggested Action:**
- Begin advocacy for the issues of the elderly by disseminating the aging studies commissioned by UNFPA to important civil society organizations and government. In partnership with these organizations, work out collaborative and persistent policy advocacy approaches.

As the results of Census 2011 become available, there will be more data on several emerging issues including the youth bulge, the demographic dividend, aging, sex selection, migration, and urbanization. Development planning will need to be contextualized in the light of these developing trends. The need for advocacy to ensure contextualized planning will become even more apparent than it was in 2008 when CP-7 was formulated. The present advocacy approaches of UNFPA hinge on training and capacity building of senior managers in government. The evaluation team is of the view that higher level advocacy is needed such as the wide dissemination of a series of policy papers with a matching set of articles and reports designed to inform the public and generate a discussion on what needs to be done. A concerted and continuing advocacy effort at many levels and for many audiences, including parliamentarians, legislators, youth, the university system, policy think-tanks, the media, and the general public would help to shape public opinion, create an environment, and generate pressure for government action in these areas.

**Recommendation:**
- Further analyze and use the results of Census 2011, launch a concerted and continuing advocacy effort at many levels and for many audiences, to shape public opinion, create an environment, and generate pressure for government to develop policies and programs in the context of emerging demographic trends and issues. To enable this, preliminary research and studies on emerging population issues like the youth bulge and the demographic dividend, migration and urbanization, population and environment, abortion and sex selection, and post-reproductive morbidities which have not been substantially taken up during CP-7, need to be taken up in CP-8.

In summary, the PDS work accomplished under CP-7 is varied, significant and relevant. Considering the importance of PDS in the context of the global mandate of UNFPA, the expansive scope of this thematic area, the policy advocacy agenda, and the present and future needs of the country, there is a need to strengthen UNFPA’s human and financial resource allocation to this thematic area so that it acquires the capacity to engage in policy advocacy, provide capacity building inputs on population-development dynamics, ensure gender mainstreaming in UNFPA’s programs, and establish essential linkages with resource persons and institutions that are inter-disciplinary. The evaluation team found that the budget allocation for
PDS thematic area is quite low. During 2009 and 2010, it varied between 6 and 8% of the total funding for those years.

**Recommendation:**
- Strengthen the PDS thematic area group in UNFPA to enable it to more fully and effectively address the scope and complexity of this critical component of UNFPA’s portfolio.
Part C: Geography & Partnerships

Section VII: Programme Geography

The evaluation team has been asked to consider whether the geographic focus and spread of UNFPA’s programme is appropriate. In answering this question we considered the history behind UNFPA’s present location, the areas in India that need the greatest development inputs in the sector of health and population, the views of the GOI on where it believes UNFPA could play a significant role, the cost of maintaining state offices, as well as the intangible costs of exiting present locations and entering new ones.

In 1991, when CP-4 began, it was agreed that UNFPA would develop a state presence to support programme implementation in areas where development indicators were behind expectations. To cover such areas UNFPA set up offices in Kerala, Maharashtra, Gujarat, Rajasthan and Orissa. At this time Kerala was chosen not because its development indicators lagged behind the norm but because it had certain unique health issues and pockets of underdevelopment, like Mallapuram. It also offered the opportunity to roll out the comprehensive ICPD agenda in middle and well performing regions. Gujarat, despite an overall positive development picture, had some extremely backward districts and areas within it. In CP-6, Government requested UNFPA to develop a state presence in Bihar where considerable improvement was needed in RH and development indicators. UNFPA withdrew from Kerala and Gujarat, and entered Bihar. Even after it withdrew from Gujarat, UNFPA continued its engagement there by providing inputs to address issues related to sex selection, adolescent reproductive and sexual health and other needed interventions. This assistance was coordinated by the UNFPA office in New Delhi.

At the present time, UNFPA works in 5 states- Maharashtra, MP, Orissa, Rajasthan and Bihar. Last year, in continuation of its policy of guiding development partners to focus their assistance on less developed areas, the GOI allocated 265 districts requiring high focus for development, to various development partners. UNFPA was allotted 13 such districts within four of the five states where it is present.

There is questioning within UNFPA on whether or not it should continue in all the five states where it currently operates, and if changes are to be made, what those changes should be. Where UNFPA should be located depends very much on where the Government feels UNFPA’s presence would provide the greatest value and support to the national program in line with UNFPA’s own priorities.

In essence, UNFPA plays a mix of three meaningful roles: policy advocacy, technical assistance, and programme implementation support. Given these, UNFPA’s current mix of national and state presence is well considered. UNFPA’s presence at the national level is required for effective policy advocacy. Its strong technical resources at both national and state levels allow for sustained interaction and provision of competent technical assistance at both national and state levels. UNFPA’s field presence in selected states enables it to support and prove innovative pilot approaches, and to demonstrate effective programme implementation techniques. When such work is carefully chosen and executed, with outcomes evaluated and processes documented, it lends weight and credibility to UNFPA’s policy change and advocacy agenda. In every state
that the evaluation team visited, state government representatives said that local presence of UNFPA in their state was most helpful as it allowed UNFPA to be completely familiar with state context and scenario and to quickly respond to the technical assistance needs of the state based on a thorough understanding of the context.

The evaluation team discussed with the GOI the issue of which states UNFPA should work in. The GOI is of the view that it should remain in the states where it currently is. It agrees that the states that UNFPA is currently in, are amongst the most under developed of India’s states, and require UNFPA support.

Annex 8, compares the 28 states of India on 7 key development, health and population parameters- female literacy rate, child sex ratio, infant mortality rate, total fertility rate, contraceptive prevalence, unmet need for family planning and percentage of population living below the poverty line. Between them the 5 UNFPA states are home to 33 percent of India’s population and 42% of India’s poorest. In Annex.8 a composite indicator combining all 7 of these indicators has been used to rank the states, and the findings are that Orissa, MP, Bihar and Rajasthan are amongst the top 6 most underdeveloped states in the country. They are all high fertility states (TFR over 3.1 when the national average is 2.1), with high infant mortality. In these states, achievement of national and MDG goals related to population and maternal health lag behind the national average. These four states fall into the special category of states which, for development purposes, are monitored by an Empowered Action Group (EAG) set up by government. Amongst the poorest states in the country, they continue to offer a very appropriate setting for work in UNFPA’s areas of core competence- RH including family planning, and attention to youth. All these states need inputs to create demand for health and family planning services. Social norms still promote early marriage, and early and too frequent child bearing- contributing to exacerbating maternal and infant mortality and causing poor maternal and child health.

Maharashtra is an enigmatic mix of developing and underdeveloped. TFR has fallen below 2.1. The age at marriage remains low. The sex ratio has worsened since Census 2001. Maharashtra ranks 16 out of India’s 28 states, and it ranks 5th amongst the states with the most adverse child sex ratios. It is a huge state with 10% of India’s population and an equal proportion of India’s poor. The state has its own extensive areas of backwardness in Vidharbha and Marathwada, which compare with the most backward districts of MP, Bihar and Uttar Pradesh. If district disaggregated data were examined, there would be very large absolute numbers of people with poor health and population indicators. Next only to Tamil Nadu, Maharashtra is hugely urban, with 42% urban population and high levels of employment related migration from other states. It is a state where health service delivery systems are better organized, and where the state is ready and wanting to work on emerging issues such as aging, urban health and a more comprehensive primary health approach to women’s health – one that addresses issues beyond a woman’s reproductive years. Maharashtra has impressive experience in working on HIV prevention and control, and with its more developed health infrastructure, is exactly the right state in which to work on programmes that address quality of care; maternal health, family planning and age appropriate services for young people; and convergence of HIV and RH. It could be a very valuable proving ground for approaches that will be more widely needed in the future by states such as MP, Rajasthan and Bihar, once they have moved to the next rung in the ladder of social and human development.
There are advantages to staying on in the five states of Bihar, MP, Rajasthan, Orissa and Maharashtra. Four of these five states are UNDAF states. Effective relationships, trust and credibility have been built with the state governments. Entering a new state would require large initial investments of both time and money before results are visible. No clear advantages are apparent from such a move. Even if UNFPA decides not to work on emerging issues in CP-8, there is little reason to leave Maharashtra. The Marathwada and Vidarbha regions of eastern Maharashtra are in every way as backward as MP and Bihar. Approaches relevant for Bihar and MP are equally relevant in these two regions of Maharashtra. Even in the matter of sex selection, these five states offer ample opportunity for meaningful policy advocacy, TA and programme implementation support. The data from Census 2011 shows that the sex selection contagion is no longer a concentrated epidemic; it is slowly attaining the proportions of a more generalized epidemic touching states that once seemed unaffected.

Regarding whether UNFPA should spread out more extensively in India, the evaluation team feels that no purpose would be served by spreading out too thin. India is a huge country. Five states are a significant presence. Each additional state office costs a significant amount annually to staff and operate, not including programme resources. Even if UNFPA were to have more funds than it has at present, it might be well advised to allot more to each of the current 5 states than to add another.

Recommendations:
- In CP-8 UNFPA should continue to maintain offices in the 5 states where it is currently present.
- UNFPA should retain the flexibility to pursue policy, advocacy or selective work in some themes, particularly in emerging issues, outside of these 5 states. Such programmes could be managed out of Delhi or one of the five state offices depending on proximity, and technical skills of the staff in the state offices.
8.1. Government

UNFPA’s primary partner has been the government both at the national and the state levels. The partnership has many dimensions and is largely with the ministries and departments of Health and Family Welfare, Education, Youth Affairs and Sports, and Women and Child.

The nature of the partnership that UNFPA, indeed all donors, have with the GOI has changed significantly over the last decade. Donor assistance in the area of health now forms an insignificant proportion of resources that the government has provided for its flag ship programmes, including RCH-II (within NRHM) and NACP-III. Except for five bilateral donors including DFID, the European Union and USAID, most bilateral donors have been informed that they should provide their assistance to NGOs or the UN, instead of to the government. In this new environment, government values flexible technical assistance and programme implementation support that demonstrates how implementation can be made stronger and more effective at the state and district level, particularly in those that are lagging behind. Late last year the government allocated such districts to its various development partners, and sought their assistance in helping these districts to catch up with others on key national programme indicators.

As discussed in the introduction to this report, donors whose support the GOI continues to accept have shifted focus from the national to the state level, choosing to work in states that are lagging behind. UNFPA uses its presence at the national level, to support the implementation of national programs, advocate for issues and provide policy inputs. In addition, UNFPA uses it presence in 5 states to provide policy and programme guidance to the state governments in areas that are UNFPA programme priorities. The assistance provided by UNFPA and other UN agencies is guided by the UNDAF strategic framework.

The primary and most significant partnership that UNFPA has with government during CP-7 is the co-financing of the RCH-II programme through the SWAp mechanism. Over the life of CP-7, UNFPA will contribute 28% of its budget to this programme. UNFPA’s focus in the SWAp was to be on issues related to evidence based programming, quality of care, gender issues, and community orientation. UNFPA found that this partnership with the central government enabled it to participate in and contribute appropriately to the design, review, monitoring and assessment of RCH-II. UNFPA also provides funds for implementation of specific programmes by various departments and agencies of state governments -for instance the implementation of the school based adolescent life skills programme and the incorporation of the LSE programme into the B.Ed. curriculum in teacher training colleges through the Department of Education in Rajasthan. In the states, it also funds and supports the implementation of pilots to assess their feasibility for replication and scale-up.
8.2. Multilateral and Bilateral Donors

The Development Partners Forum at the national level brings together all bilateral and multilateral donors that provide development assistance to the RCH-II programme, and the government. Members of the forum include DFID, and the World Bank who along with UNFPA have contributed to the GOI’s SWAp and are called “pooling partners”. Other members such as UNICEF, USAID, and the European Union, who did not join the SWAp are called “non-pooling partners”. All partners discuss progress of the RCH-II programme, share information on each others’ programmes, and discuss issues of common interest. In the event of a request for assistance from the Ministry, the nature of assistance that each can provide is discussed and decided upon. Members from the Development Partners Forum pool their resource to contribute to Joint Review Missions, assessments, and the development of technical guidelines and tools needed by the government. All partners have found that this forum is a good platform for coordination, strategic planning, and programme review.

At the state level too there are Development Partner Forums that play a similar role to that played at the national level.

Of the bilateral partners, DFID has the greatest geographic overlap with UNFPA as it has programmes in Bihar, MP and Orissa. UNFPA too works in these states, and should seek a strategic partnership with DFID in common areas of interest- which would be policy dialogue on gender issues such as women’s sexual and RH and rights rather than sex selection alone, reduction in total fertility rate, and family planning for young women. UNFPA’s programmatic emphasis on family planning, maternal health and HIV AIDS is shared by USAID. The Development Partners Forum enables discussion for coordinated action.

8.3. Non-governmental organizations:

UNFPA has worked with academic, research and professional bodies, and with civil society organizations that play a variety of roles in the programme:

8.3.1. Research and academic agencies conduct studies, carry out assessments, and develop tools that become the basis for advocacy on key issues, for programme design, review and evaluation or for providing technical support or building the capacity of other UNFPA partners including state government organizations.

8.3.2. Professional bodies such as the Indian Medical Association (IMA) or the national and state federations of obstetricians and gynaecologists (FOGSI and its state chapters), or the Maharashtra State Legal Services Authority, set standards, provide and promote protocols, and carry out professional capacity building and orientation for, and advocacy with their members. For instance IMA educated doctors on the sex selection issue. The Maharashtra Judicial Academy has done critical work in educating and sensitizing the judiciary on the issue of sex selection.
8.3.3. Civil society organizations/NGOs: play three roles

a. Implement pilot interventions: Several civil society organizations are engaged in implementing innovative pilot projects to demonstrate new concepts. Once the projects prove the concept, the effort is to take the intervention to scale through the government. Jan Mangal is a model that has been adopted by government and has been taken to scale with government resources. The QA project too has now been taken over by government. Most of these projects are community based, addressing issues that require community outreach and mobilization. Several of these interventions are community based, and the civil society partnership is necessitated because the government own human resources and communication chain does not effectively reach communities with health education and primary health services.

b. Provide technical support to government programmes: Agencies such as CEDPA, PRAYAS, IIPS and IIHMR have provided technical and capacity building support for UNFPA programmes with government, such as HMIS strengthening in Bihar and Rajasthan.

c. Advocate on issues: Agencies like PRIA, THP, MPVHA have played an important role in strengthening the implementation of the PCPNDT Act, by monitoring the registration and compliance of ultra sound clinics with the Act, and by mobilizing civil society organizations to pay their legitimate role in making statutory boards and bodies.

UNFPA’s relationship with NGOs too has changed over the years. Before CP-7, UNFPA worked to gain the acceptance by government of civil society organizations/NGOs. In CP-7, the engagement with NGOs shifted to associating with them and having them play the variety of roles discussed above. In the past few years, there have been developments that are adverse to NGOs. Government has begun to use them as contractors, but there are few funds that enable NGOs to work on innovations, or to pursue other issues and priorities of significance to civil society. Donor funding for NGOs is drying up, and the few large international donors such as the Gates Foundation, fund very large programmes that are implemented by consortia of a few very large NGOs, mostly international NGOs. Unless support for civil society organizations is ensured, there will be a withering away of a small, vital set of players in the development sector. There has been a slow but steady growth of Indian donors that could be a source of support to Indian NGOs. However, it is at the moment unclear what the priorities of these donors are, and of whether they could be interested in funding reproductive health and family planning.

8.4. South south partnerships envisioned in CP-7

South south collaboration has happened on the issue of sex ratio decline, where UNFPA offices in China, Vietnam, Nepal, and the Caucuses came together to work with UNFPA’s Asia Regional Office and Head Quarters. India, Nigeria, Bhutan, Sudan and Afghanistan have had exchange visits designed to share Indian experience and expertise on Census operations. Work on south south collaboration to enable other Asian countries to learn from India’s expertise in census operations has not yet begun but is expected to begin shortly as soon as the Census Training Center is set by in Delhi.
8.5. Partnerships within the UN system- harmony, synergy and avoidance of duplication

A mid-term review of the UNDAF for the period 2008-2012 which was conducted recently by Rohini Nayyar and Ananya Ghosh Dastidar, has provided a very detailed analysis on the effectiveness and harmonization of UN Agencies at both the national and state level. This evaluation report of CP-7, does not therefore reinvestigating all issues in depth. It only offers a brief summary of the issues.

Harmonization at the national level

The development of the UNDAF was the first step in the harmonization of the work of the many UN agencies in India. Bi-monthly meetings of the UN Country Team (UNCT), comprising heads of agencies helps in harmonization. The UNCT shares information and encourages collaboration and joint programming between the agencies.

The process of harmonization is taken forward by selected member organizations who work on similar development issues, coming together to form Thematic Clusters. There are eleven thematic clusters, and UNFPA is a member of 5 thematic clusters: (a) the Joint UN Technical Assistance Group or JUNTA which works on HIV/AIDS; (b) Empowerment of Women and Gender Based Violence; (c) Health; (d) Convergence, and (e) the UN Disaster Management Team (UNDMT). The record of effectiveness of each of these thematic clusters is mixed. Some clusters have done better than others at harmonization and synergy of operations. Members of each cluster are meant to share information and resources, and explore ideas that can lead to effective capacity mapping and resource pooling for addressing their common agendas. The best example of this is the Gender Cluster. Each cluster prepares work plans annually, putting together information on those activities of each agency that contribute to the achievement of outputs related to the theme. A monitoring and evaluation matrix sets out indicators, baselines and targets with which to track progress that each agency is making towards achievement of UNDAF results related to the theme. Members of each cluster have the opportunity to work together to think about how to integrate cross-cutting issues such as gender, decentralization, capacity development, human rights based approaches, disaster risk reduction, results based management, and social inclusion into the work of their theme.

The joint program on the Census of UNFPA, UNICEF and UN Women was a success and details have been discussed in Section VI of this report, relating to PDS. Also in the same section, the work done by UNDP, UNICEF and UNFPA to improve district planning, including problems of harmonization have been discussed.

The evaluation team learned from conversations with some members of the Thematic Clusters, that the barriers to team work are the usual: distrust, a strongly developed sense of territoriality, and fears of loss of territory and of watering down of one’s own agenda.

Till 2007, UN agencies typically operated individually, with territories and budgets clearly demarcated. They developed their own work plans, independent of each other. Each agency independently pursued its policy, advocacy and programme agenda with host country governments. The thematic clusters formed in or after 2008, are still nascent. It is going to take a while for cluster members to be comfortable operating in clusters to build harmony and synergy between themselves.
At the state level

Attempts have been made to locate all UN agencies operating in a given state under one roof. This move has succeeded in Bihar, MP and Orissa, where UN agencies are co-located. This certainly makes it easier to build effective interpersonal relationships, share information and collaborate. Even when offices are not co-located, individuals who reach across their agencies to colleagues in other agencies, and develop effective communication with each other, are able to work together as in Maharashtra where UNFPA and UNICEF talk to each other regularly about their work and potential for doing some things together—such as the jointly hosted workshops on adolescents for the State Government.

In MP, the Department of Health has issued a circular identifying for each major thematic area of RCH/NRHM which UN agency will play the lead role and which will play a supporting role. This has helped to avoid duplication. In Orissa, a maternal and neo-natal health group, comprising UN agencies, bilateral donors, international NGOs working in the state, and the State Government, meet to share knowledge and learning from programmes. This has resulted in a harmonized response to the programme needs of the state.

At the state level, given that each UN agency follows different norms related to the delegation of authority and power to their state representatives, some UN agencies do not feel that they are able to adequately represent the agenda of their agencies. To ensure that UNFPA’s agenda receives equal attention as that of other UN agencies in the states it is suggested that the UNFPA state representative be given the same degree of delegated authority as the state representatives of other UN agencies are.

It is understood that the United Nations Country Team (UNCT) has decided that in the coming years, attempts will be made by UN agencies that work at the state level to work together in a few selected districts so that jointly they can cover more than they do separately and can multiply their impact. To be successful, interagency teams will need to be properly oriented and briefed, and systems for working together with coherence will need to be worked out.

8.6. Conclusions and recommendations

In the changing aid environment, UNFPA’s continued relevance and its ability to effectively play an advocacy role for innovation in RH/FP, and to guard the ICPD agenda of gender, will depend on its ability to maintain to collaborate with all its partners—national and state governments, other development assistance partners, civil society organizations, and other UN agencies. Its credibility with government can be maintained by continuing to deliver responsive TA at both the national and state levels, demonstrating effective programme implementation particularly in laggard districts and states, and strengthening government’s capacity to scale up successful pilots. A strong state presence will help the advocacy agenda as states operate in a fairly decentralized manner on health issues—including in implementation of nationally sponsored schemes such as RCH-II and NRHM. Developing strong collaborative relations with key development assistance partners such as USAID and DFID on issues of common interest such as gender discrimination, women’s empowerment, and family planning, will strengthen its advocacy voice. Strengthening NGO capacity for effective programme implementation and assisting them to find alternative and accessible sources of funding for NGOs will keep alive
civil society participation and voice in innovation and advocacy for critical issues. Specific recommendations for some of these issues are:

**Recommendations:**
- To ensure that UNFP’s interest and agenda is represented at par with those of other UN agencies, it is recommended that the UNFPA state representatives be given the same degree of flexibility and decentralized authority as representatives of other agencies are.

**Suggested Actions:**
- Since the pilot projects being implemented by NGOs are investments with eventual scale-up in mind, they need to be designed with sustainability kept in mind from the start, provision for evaluation, and technical support to ensure strong implementation and success. UNFPA staff at the national and state levels is continuously focused on providing support and assistance to government counterparts. However, because the lean UNFPA staff teams in the states are over-stretched, civil society organizations do not get the same inputs. Also, concurrent evaluation and documentation of such programmes is essential. Currently, these are areas of weakness in NGO programming.

- The issue of sustainability of programmes designed for scale-up through government needs to be considered and built into the projects from the project design stage itself. Realistic project timeframe should allow for: (a) demonstration of results, (b) fine tuning of methodologies for scale-up and replication, and (c) an additional, concluding period during which UNFPA should assist the implementing partner to budget for project activities within its own departmental budget, and provide support so that departmental staff learn exactly what needs to be done to implement, monitor and continuously review and strengthen the programme so that it remains as effective as possible. In this model, it is crucial that departmental staff is completely involved in key stages of project design, roll out and review, so that they acquire the skills to manage these programmes when UNFPA withdraws.

- UNFPA should explore and map emerging Indian sources of funding for social sector programming, from high net worth individuals, corporate and foundations; ascertain the geographic as well as subject areas for which funding is available, and how funding can be accessed. Advocacy with these funders for investment in reproductive health and family planning is needed, so that these emerging resources can be directed towards NGO to work for the RH/FP priorities of the country.
Section IX: Operational Modalities

During CP-7, UNFPA basically uses the following 3 kinds of modalities in the course of their work:

9.1. Contribution to the Government’s SWAp (sector wide approach programme) of RCH-II Programme using the Annual Work Plan (AWP) or project modality.

After a detailed analysis of the pros and cons, UNFPA took a considered decision in the middle of CP-7 to participate in GOI’s RCH-II programme by contributing to the government’s pool of resources. The RCH–II programme is presently funded by GOI to the extent of 92%, and by 3 donors to the extent of 8%. Of the donor pool, DFID contributes 52%, the World Bank 42% and UNFPA 6%. However, from April 2010, DFID is no longer a pooling partner. Though miniscule in the larger context of RCH, UNFPA’s contribution of US$ 18 million, to SWAp amounts to 28% of CP-7 funds. It appears that the decision to be part of the pool partners was a wise decision at the time it was taken and has stood UNFPA in good stead. UNFPA has been able to influence the design of the entire RCH programme including the RCH monitoring and evaluation strategy, while ensuring that gender and quality of clinical services were properly integrated. UNFPA was also able to input into the design of the Joint Review Missions. UNFPA support, especially technical and conceptual, has been well appreciated by the MOHFW. The question that now needs to be addressed is, should this arrangement continue in CP-8? Is it value for money and the best use of UNFPA’s resources? One of the big questions for CP-8 is – ‘to continue or not to continue contributing to the RCH SWAp’. The situation has no doubt changed since 2005 when UNFPA joined the RCH SWAp by contributing financially as well as technically to the pool. In the initial days of SWAp, there was a differentiation between ‘pooling’ partners who contributed to the pool and ‘non-pooling’ partners (like UNICEF and USAID) who contributed only with technical assistance. Pooling partners had greater access and opportunities to influence programmatic matters. Now however there is a ‘Development Partner’s Forum’ where all development partners have more or less equal standing. So, in today’s context, being a pooling partner does not matter much. Discontinuing financial support to SWAp will also mean more resources for UNFPA to programme in states and at the central level.

9.2. The Annual Work Plan (AWP) or project modality (other than for SWAp):

These can further be categorized as under:
- a. AWPs with central ministries like Ministry of Youth Affairs and Ministry of Human Resource Development.
- b. AWPs with national and state level institutions like IIPS, ICMR
- c. AWPs with NGOs and research organizations.

The process for finalizing AWPs has been streamlined in mid 2010 and has become more inclusive and robust. Three Thematic Core Groups (TCGs) have been formed for PDS, RH (including ARSH, HIV, disaster preparedness and Gender in RH) and Sex Selection. Staff of the country office and state offices has been spread out in these groups in such a way that each TCG gets the benefit of the perspectives of staff who are experts in other areas as well, and views from both the national and field levels. Funds for implementation are either released as advances or

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reimbursements, depending on the partner’s individual assessment and the kind of work involved. The funds release process has also recently been further streamlined to make releases quicker. Electronic transfer of funds to implementing partners has also been introduced. These recent developments have helped to make the operational modalities more efficient. However, it is felt that there is still room for speedier and more streamlined approvals, especially of ongoing AWPs. It was also felt that when projects are conceived of at the country office, there is need for substantive and consistent involvement of the state offices, especially because they are expected to follow up and monitor AWPs in their states. There have been instances when AWPs have been approved / extended and the state officers were unaware of the same.

9.3. Direct execution modality

a. UNFPA is also providing TA through its own country and state office staff. The TA being provided by UNFPA has been appreciated across the board – both by the centre and in the states where UNFPA has a presence. The state governments have also been quite satisfied with the responsiveness of UNFPA to their requests for things like quick reviews, assessments, workshops etc.

b. It responds to emerging issues and requests from Planning Commission, MOHFW, MWCD, state governments etc. for quick assessments, evaluations, studies, workshops, consultations etc.

c. In addition, UNFPA is at present, providing technical assistance by placing 67 consultants in national and state government departments- 13 persons in MOHFW, 5 in MOHRD and 49 persons in the 4 states of Bihar, Orissa, Rajasthan and MP. However, there are two sides to this coin. On the one hand there is definitely some value added by placing these persons in government set ups as they often do provide valuable technical inputs. On the other hand the cost of providing this technical assistance of 67 persons is quite high at US$ 1.3 million per annum, compared to their comparative advantage – often these persons are used for routine government work and to fill gaps in staffing.

9.4. Conclusions and recommendations

9.4.1. The SWAp modality

The decision of UNFPA to join RCH II as a pooling partner when it was initiated, in the middle of CP-7, was a wise decision at that time. Today the Development Partners Forum facilitates more or less equal access to all development partners, irrespective of their pooling or non-pooling status. Mindful that MOHFW is the nodal ministry for UNFPA, robust partnership with them is key. There appears to be a question mark on the very existence / continuation of this sector wide programme in its current pooling modality. While the RCH programme will definitely continue even after RCH-II, it may not be in the shape of a sector wide pooling programme. There are indications that the MOHFW, GOI may fund the RCH programme completely from its own funds.
Recommendation:
- UNFPA should continue to provide technical assistance to the RCH programme. In the event that RCH continues as a SWAp, involving pooling of funds, it is recommended that only if MOHFW, conscious of the limited resources of UNFPA, feels that a monetary contribution from UNFPA to the pool will help to underline solidarity and a robust partnership between the two, then UNFPA should continue to contribute to the SWAp, albeit with a lesser contribution, as it is not the financial resources of UNFPA per se that matter to MOHFW.

9.4.2. Processing Projects/Annual Work Plans

The process for finalizing AWPs has been streamlined in mid 2010 and has become more inclusive and robust. There is however still room for even more improvement.

Suggested Actions for new AWPs
- Presently a project proposal goes to the TCG twice in the 1st year and then once every year. Besides the TCG, the UNFPA Representative also looks at the proposal at each of these stages and gives the final approval. In the first year, a proposal first goes to TCG and UNFPA Representative as a Concept Note and secondly as an AWP for that particular year. This process often takes quite long and sometimes reopens issues that have already been decided upon. In order to ensure transparency, harmony, consistency and early clearances, it is recommended that there should be guidelines/check-lists about what aspects will be looked at/examined at each of these stages. At the concept stage itself, the proposal should be checked for consistency with UNFPA strategies and views and experiences from other states should also be invited.

- In the first year, instead of an AWP, there should be a project proposal outlining activities, outputs, outcomes and budgets for the entire project period – such an AWP should in fact be called a ‘Project Proposal’. The process for new AWPs should be started 5 to 6 months prior to the start of the project.

Suggested Actions for Thematic Core Groups
- The setting up of Thematic Core Groups for P&DS, RH and sex selection has been a welcome step and a good effort to get other perspectives into the formulation process. However, the TCG should work more as a team, doing peer review in a constructive way. This has not always been the case.

- The membership of the TCGs should be rotational so that all field staff get an opportunity and exposure as well as contribute. It would be even better if the TCG could be expanded to include as ‘ad hoc members’ state programme staff that have experience in the subject/aspect under consideration. This could be done via email or teleconference.
Suggested Action for on-going AWPs:

- Since ongoing AWPs have already been thoroughly examined and approved for a particular period at the time of the first approval, every subsequent year they should be ‘approved in routine’ (without opening up the AWP afresh) unless there has been any substantial change in the circumstances or the performance of the implementing partner (I.P.) has not been satisfactory. By ‘approved in routine’ is meant that the head of the TCG (either the Deputy Representative or the Assistant Representative) should decide if the AWP needs to go to the TCG or not. If there is a substantial change in the circumstances of the IP, or performance has not been satisfactory, only then should the AWP go the TCG. Or else after clearance by the head of the TCG (DR or AR), final approval of the UNFPA Representative should be obtained. These approvals should be given latest by the first week of January every year. Since 80 to 85% of AWPs are continuing/ongoing AWPs, this will affect a large number of AWPs.

Suggested Action for the Apex Coordination Committee (ACC)

- ACC chaired by the Secretary, MOHFW should meet by mid-December positively of the previous year so that progress can be reviewed and the Annual Plan of Operations for the coming year can be approved, leading to timely final approval of AWPs and release of funds to I.P.s. Delay in these processes results in a much shorter duration for actual implementation of project activities, slippages in achievements, low utilization of resources etc.

Suggested Actions for release of funds for AWPs and programme review:

- Presently funds are being released on a quarterly basis, using the FACE form. Electronic transfer of funds is also being encouraged. Inspite of all this, funds releases are delayed and programme delivery is affected. On a case to case basis, UNFPA could consider releasing funds six monthly or for 6 months at a time for the first 3 quarters, instead of quarterly as at present. Programme review should however be undertaken at least quarterly. Country office staff should be encouraged to undertake field monitoring visits to states more regularly.

- UNFPA HQ/APRO communicates budgets for the next year around October/November, so budgets can be entered into ATLAS in Nov/Dec. As soon as the ACC approves the program of action (POA) and AWPs (especially continuing AWPs) get clearance, funds can be released to IPs in January itself. This will hopefully help streamline the flow of funds.

9.4.3. Direct Execution modality

Considering the fact that policy advocacy and technical assistance are likely to be the key planks of CP-8, which should also look at emerging issues, it is essential that UNFPA has a team of highly competent professionals for each of their core areas, who will support each other and ensure continuity in the event of staff attrition. UNFPA presently provides a total of 67 consultants to the central and to 4 state governments. While governments do appreciate this assistance which often has proved useful, it is still debatable whether this is the best use of UNFPA resources.
Part C: Geography & Partnerships (Section IX: Operational Modalities)

**Suggested Action for delegation to State Coordinators:**
- Presently State Coordinators have powers to approve proposals/expenditure up to US$ 5,000 at a time. In view of the present costs in India, the short time frame within which requests from state governments need to be responded to, and considering the competency and level of the State Coordinators, this delegation could be increased to US$ 10,000 at a time. This will help state offices to respond in a time bound way to requests that fall within their mandate, which otherwise other agencies like UNICEF take over. The decentralization with regard to the categories and kinds of things covered by this delegation also needs to be reviewed, for instance, small printing and procurement jobs to be in tune with other development partners.

**Suggested Actions for Human Resources in the Country and State Offices:**
- It is suggested that a detailed needs assessment of the number, competencies & skill mix of the staff required, based on the content of CP-8 be conducted. Once this kind of profiling of staff is done, the existing staff can be re-skilled or appropriate staff can be put in place, as required.
- A team building exercise of all UNFPA country and state office staff (both professional and other) is highly recommended well before the start of CP -8.
- Especially in state offices, recourse should be taken to hiring UN volunteers and/or short term consultants. The establishment of a comprehensive roster of consultants for national and state levels needs to be constantly updated, in order to facilitate this.
- The question/dilemma which has engaged the attention of staff and management has been, should UNFPA staff themselves provide the T.A. or should consultants be hired for the same. Considering the technical competencies of a lot of the UNFPA staff and their reputation and value, it would be a pity not to use their skills and competencies. However care must be taken to see that they do not over stretch themselves, as often happens at present. Perhaps the answer lies in striking the correct balance between the two.
- There appears to be need for more sharing and learning amongst staff. It is suggested that a full staff meeting be held at least once in 6 months, where not only is progress monitored but where at least 50% of the time is spent on substantive issues, providing a platform for learning and sharing. Outside experts/ regional office could also be invited from time to time as necessary.

**Suggested Actions for Technical Assistance to Government through consultants:**
- Considering the present stage of development of the health sector in India, where health infrastructure is fairly well either in place or being provided for, the need of the hour seems to be adequate and appropriate human resources. Under these circumstances, it is essential for MOHFW to be adequately staffed with the appropriate skills and competencies. In order to facilitate this being done in a harmonized and planned manner, it is suggested that MOHFW commissions a competent independent agency to conduct an “organizational structure and staffing needs assessment”. Such a study will enable Government to determine what human resource gaps it would like supported by various development partners. This could also result in harmonization of contributions from all development partners who support this kind of TA. UNFPA should simultaneously get the development partners
together to jointly advocate for such an exercise. This will facilitate the identification of the number and profile of the staff required as well as the sources of the financial resources (government, which development partner etc) required for them. All this should be done well before the start of CP-8. Accordingly, in CP-8, UNFPA should support staff only according to this assessment. In order to bring in consistency in the recruitment process, all positions supported by development partners could be recruited by National Health Systems Resource Centre (NHSRC). Competencies and technical knowledge of these consultants should be upgraded from time to time by NHSRC in collaboration with other development partners. For this, a ‘training needs assessment’ should initially be carried out.

- In addition, Government may wish to obtain assistance with the task of building within government systems, the capacity to access, procure and utilize both Indian and international technical assistance. In doing this, the initial challenge is to get government to recognize that there will always be needs for TA, and that government must itself provide in its annual work-plans and budgets for the procurement of such technical assistance. Once this realization occurs, government departments may need capacity building in how to recognize and clearly define technical assistance requirements, how to scan for and identify appropriate and capable sources of technical assistance, how to lay down procedures and processes for procurement and payment of technical assistance, and how to monitor and evaluate the quality and effectiveness of TA received, so that services being paid for are actually delivered.

- Capacity building in procuring and using technical assistance is a cross cutting requirement across all departments of Government, and should be addressed by UNFPA in partnership with other UN agencies, multilateral and bi-lateral donors.

9.4.4. Accountability for programme congruence with UNFPA’s gender objectives and approaches

Since gender is a crucial cross cutting issue and needs to be mainstreamed in all the work that UNFPA does across thematic areas, it is suggested that a three pronged operational modality be adopted.

**Suggested Action:**

- Firstly all programme staff should be held responsible and accountable for ensuring that their programmes meet UNFPA’ gender objectives and are in consonance with the organization’s gender strategies and approaches. Secondly there should be a full time gender adviser/programme specialist who is exclusively responsible for providing timely insights, direction and guidance on the issue of how to ensure that UNFPA programmes address gender in the most relevant and effective ways. This individual would not be accountable for UNFPA programmes achieving results in the gender area. Rather she/he would be responsible for ensuring that the UNFPA team in country has a shared understanding on what gender means, of how it should be addressed in UNFPA’s programme, and for ensuring that there is a coherent gender strategy in place and effective gender tools available to support programme managers in ensuring that their programme attain gender objectives. The third prong is to have six monthly or annual gender workshops for all UNFPA country and state office programme staff to share and learn from each other, and strategize together.
could be clubbed with the six monthly full staff meetings. This is being suggested since
gender is a cross cutting issue that needs reinforcement from time to time.

9.4.5. The Organizational Development Group:
The country office has set up such a Group recently with a view to suggest how efficiency and
impact can be improved and systemic issues addressed. The group is also supposed to look at
internal processes and organizational environment.

Suggested Action:
- This Group should be activated to see how recommendations of the evaluation as well as
other issues can be operationalized.

9.4.6. Programme Component Managers
The CPAP 2008-2012 provides for Programme Component Managers (MOHFW, MOHRD,
MOYAS, NACO, RGI and State DHFW) for each component. They are expected to coordinate
and synergize interventions related to the component as well as monitor and review progress.
Unfortunately, this has not worked as expected.

Suggested Actions:
- Efforts should be made to make these arrangements function well and effectively, or to
identify suitable alternatives as leadership and ownership of government is a key factor for
success.

9.4.7. Monitoring & Evaluation
The CPAP also provides for two main instruments for monitoring and evaluation – the CPAP
Planning and Tracking Tool and the CPAP monitoring and evaluation calendar. AWPs are being
monitored by UNFPA.

Suggested Actions:
- These tools have been developed and should be used more effectively for programme review.

- Select, orient and use a team of two or three consultants to monitor and provide technical
assistance across states, to all projects that address the same theme- such as quality
assurance, or sex selection, or community mobilization for monitoring quality of services.
Orient consultants in the programme objectives, indicators, and strategic approaches, and in
how cross-cutting issues such as gender, advocacy and capacity building need to be
addressed within the theme.

- Organize cross-site learning between similar programmes in different locations, not just for
implementing partners but also for government counterparts to ensure that pilots remain in
government’s field of attention, ensuring interest and ultimate buy in to successful concepts.
The three modalities used to operationalise CP-7 described above have proved to be by and large appropriate, relevant and sustainable. Some recommendations have been given to make them more effective and efficient which will hopefully contribute to better delivery and even greater impact of UNFPA’s resources and efforts in CP-8.
Part D: Conclusion

UNFPA’s CP-7 was designed to help India reach the MDGs, and other national health and population goals articulated in the XIth Plan, using approaches true to the ICPD PoA. India’s new found middle income status, has changed its development assistance needs, from financial to technical support, particularly that which demonstrates how stronger programme implementation and innovative models can help India’s backward states and districts catch up with development in the rest of the country. UNFPA ’s CP-7 works towards these goals through contributing approximately a quarter of its funds to sector wide support, and using the rest for a programme of technical assistance and direct project implementation to help India’s backward states catch up. Four out of the 5 states where UNFPA works are amongst the six most backward states of the country, and it has now begun to strengthen programming in 13 of India’s 265 most backward “high focus” districts.

CP-7 has tried to be true to the UNDAF agenda of serving the most vulnerable. The 5 states where it works are where 42% of India’s 300 million people living below the poverty line. Besides this, the various components of the program seek to serve the most vulnerable- women, adolescents and sex workers.

RH: UNFPA coordinates with other development partners and the GOI to provide technical support to performance improvement processes such as review, monitoring and evaluation of key national programs in health- the NRHM, RCH-II, and NACP-III. Based on the findings of these reviews, technical support is provided to strengthen capacity of the service delivery system, and to improve the quality of services provided. These inputs include the standardization of clinical practices, as well as the introduction of newer practices in a variety of areas of RH. This is done through the development of protocols, tools and guidelines and through training and capacity building.

Four key areas of RH programming have received particular attention from UNFPA programmes- quality assurance, communitization, gender based violence, and gender sensitivity. All four are areas where health systems have noticeable gaps and where there is a need for the types of pilots and demonstration models that UNFPA is working on, to generate solutions capable of scale-up.

An area of need that was identified as important when CP-7 was designed was revitalization of the family planning programme. While work done in this area has been reported in the report, more is needed, especially advocacy and assistance to support the government to reposition family planning, particularly to address the issues of delaying and spacing, and family planning for youth. In the area of convergence of RH and HIV, work has not yet commenced.

UNFPA has been appreciated by both the national and the state governments for its responsiveness to the government. However, government programmes are supply driven and in the urgency of attending to government’s needs for TA and assistance, UNFPA programming has not paid adequate attention to the demand side of health issues- improving health seeking behaviour, demand generation, and increasing utilization of services, whether for family planning, or for other RH services, particularly of the most vulnerable. Currently, health
management information systems do not capture service delivery data by category of population, making it impossible to assess whether services are actually reaching those most in need. Advocacy is needed to correct this situation.

There is also a need to build more holistic approaches by weaving together the many strands of work in the RH component of CP-7. The work in quality assurance offers the opportunity to integrate almost all the present work in RH-adolescent services, community involvement, gender sensitivity, gender based violence, and a repositioned family planning service.

**ARSH:** The policy, technical and financial assistance provided by UNFPA through the interventions in CP-7 in the thematic area of “Adolescents and youth” & ARSH has been found to be relevant to and aligned with the current and future needs of India, as well as with the larger CP results and strategic framework. UNFPA support has certainly added value to the national and selected state government programmes and priorities. The extent of the value addition has been substantial in most of the key interventions of in-school LSE programme, but less in respect of out-of-school adolescent health and development programme and much less in the health services programme, as discussed and analysed earlier. UNFPA has devoted adequate attention to building capacities of the master trainers and facilitators in the few elite schools as well as NIOS, but more attention is needed to be paid, as it rolls out to more and more schools and more teachers, particularly in the states. Gender has been mainstreamed in the adolescent education programme, in the LSE curriculum, and it appears to have been accepted and adopted in Government and civil society action, as analyzed under the relevant interventions earlier. The UNFPA presence has definitely been used effectively in policy advocacy, gap identification, program design and implementation and responding to the needs of some state governments as discussed earlier. The recommendations made above suggest areas for strengthening and future directions.

**Sex Selection:** UNFPA’s programme has been successful in identifying a major gap in the area of sex selection- strengthened Act implementation, and through its work in Maharashtra, Rajasthan, Madhya Pradesh and Orissa, has shown how integrated interventions that address key segments- government, the legal profession, the medical profession, and civil society, result in stronger implementation of the law. Sustainability of work has been ensured in the design of programmes- implementing agencies such as the judicial academies, and law and medical universities have been capacitated and are incorporating interventions into their regular programmes of work. The work of changing mindsets is the longer term change that is needed if sex selection is to be eliminated. In this area, UNFPA’s strategies have been less successful, inspite of its work at the community level though a wide network of civil society organizations. The scale of this work in a country like India is vast and UNFPA’s resources alone cannot make a dent. If UNFPA wishes to have long term impact in this programmatic area, it will need to craft and successfully implement a strategy for bringing many more influential players and resources into this work.
Part D: Conclusion

**PDS:** PDS within the framework of the ICPD PoA and National Population Policy remains as valid and relevant today as it was during the earlier UNFPA CPs. post ICPD. Policy and strategy advocacy, as well as support for accelerated implementation of core programmes of population and development (including family planning with quality of care, gender equity, equality and women’s empowerment) within a rights-based and gender sensitive approach remains the niche and unique selling proposition of UNFPA in India. This over all role and function of UNFPA has been perceived by government and most of the UN system as well as by other development partners. There is a feeling that the effectiveness of this role has been diluted over the last few years. Indeed this is also the assessment of the evaluation team- as discussed in the evaluation of thematic areas in Section II of this report,

Renewed priority to and repositioning of family planning programmes has to be seen in the above context. Policy advocacy and programme implementation support from UNFPA has to be strategic, sustained and synergistic. It has to carve out a leadership role among the development partners and spur the government and civil society players to action. The synergistic framework of policy and programme implementation will have to be internalized by all stakeholders within the ICPD PoA, National Population Policy, and NRHM. The same is encapsulated below:

a. Contraception/family planning with a need based, client centered approach and quality of care indicators for priority monitoring

b. Planning and monitoring of family planning programme at the community (village/block) level, rather than targeted from above on purely demographic considerations

c. Family planning programme to be organically positioned within “comprehensive RH care” (for details see section III of this report on the RH component of the programme)

d. RH care (with family planning as a priority) to be positioned and administered within “comprehensive primary health care” being strengthened under the NRHM

e. The organically planned and administered programme to be positioned within appropriate social development approach with reproductive and sexual rights, gender equity and inclusiveness as cross-cutting in all programmes.

UNFPA needs to more proactively support the incorporation of population dynamics and its inter-linkages with gender equality, sexual and RH into public policies, poverty alleviation strategies and expenditure frameworks of government at central and state levels. This support may involve documentation of existing evidence, policy advocacy, and capacity building of administrators at various levels.

More proactive advocacy is needed for strategic investments in young people’s health and development by highlighting potential benefits in terms of

a. Building human capital
b. Capitalizing on demographic dividend and
c. Breaking the inter-generational cycle of poverty
The PDS work accomplished under CP-7 is varied, significant and relevant. Considering the importance of PDS in the context of the global mandate of UNFPA, the expansive scope of this thematic area, the policy advocacy agenda, and the present and future needs of the country, there is a need to strengthen UNFPA’s human and financial resource allocation to this thematic area so that it acquires the capacity to engage in policy advocacy, provide capacity building inputs on population-development dynamics, ensure gender mainstreaming in UNFPA’s programs, and establish essential linkages with resource persons and institutions that are inter-disciplinary. The evaluation team found that the budget allocation for PDS thematic area is quite low. During 2009 and 2010, it varied between 6 and 8% of the total funding for those years.

These initial years of CP-7 have been characterized by the commencement of very relevant programming designed for sustainability and scale-up. However more time is needed to strengthen these models, assess the extent of change that is being brought about by them, document processes, and assist government to scale up those models that are delivering results. Evaluation to assess outcomes needs strengthening. For instance in the area of gender based violence, and developing gender sensitivity in the health system, innovative things have been done, but no data is being collected to see if change is actually happening. The remaining years of CP-7 could be devoted to this, and the work continued in CP-8 to see real results, institutionalization and scale-up.
**Annex 1 - RESULTS & RESOURCE FRAMEWORK FOR INDIA (2008-2012)**

<table>
<thead>
<tr>
<th>Results</th>
<th>Indicators</th>
<th>Baseline (year)</th>
<th>Target (year)</th>
<th>Progress (Latest available year)</th>
<th>Means of Verification</th>
<th>Assumptions and Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPAP Outcome Reproductive Health</td>
<td>Reduced maternal mortality ratio</td>
<td>301 (01-03)</td>
<td>&lt;100 (2012)</td>
<td>212 (2007-09)</td>
<td>SRS Reports</td>
<td>UNFPA is part of the National RCH II SWAp and helps government at the national, state and below levels. The responsibilities of implementation rests with the government and the pace of implementation can have a bearing in achieving the indicators. The indicators proposed are in sync with the national goals.</td>
</tr>
<tr>
<td></td>
<td>Reduced unmet need for contraception</td>
<td>12.8 (05-06)</td>
<td>80% of need met</td>
<td>Large scale HH survey for latest year is awaited</td>
<td>NFHS National HH Surveys</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduced adolescence fertility rate</td>
<td>16.8%</td>
<td>12%</td>
<td>--- do ----</td>
<td>NFHS National HH Surveys</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduced adult HIV Prevalence</td>
<td>0.36 (05-06)</td>
<td>No value stated in NACP – III.</td>
<td>--- do ----</td>
<td>NACP III Reports and NFHS Survey</td>
<td></td>
</tr>
<tr>
<td>Results</td>
<td>Indicators</td>
<td>Baseline (year)</td>
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<tr>
<td>CP Outputs 1</td>
<td>Enhanced access and utilization of high quality reproductive health services by vulnerable communities</td>
<td>● Modern contraceptive prevalence rate among currently married women aged 15-49 years</td>
<td>48.5% (05-06)</td>
<td>59% (2012)</td>
<td>--- do ----</td>
<td>National level large HH surveys</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Percent of FRUs functional as per national guidelines</td>
<td>&lt;30% (2006)</td>
<td>100% (2012)</td>
<td>52.0</td>
<td>District level Household &amp; Facility Survey- (DLHS – 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Percentage of districts having operational plans for FRUs and 24 hr services</td>
<td>&lt;50% (2006)</td>
<td>100% (2012)</td>
<td>--</td>
<td>NRHM Service statistics/ facility surveys</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Number of districts having AQ groups established</td>
<td>7 (2006-07)</td>
<td>20 (2012)</td>
<td>16 (2010)</td>
<td>UNFPA Progress reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Number of institutional mechanisms responding to GBV (eg. GBV protocols being adopted by states in responding to GBV as an health issue)</td>
<td>Nil</td>
<td>1 state</td>
<td>--</td>
<td>Services</td>
</tr>
<tr>
<td>Results</td>
<td>Indicators</td>
<td>Baseline (year)</td>
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<tr>
<td>CP Output 2</td>
<td>Safe Sex Behaviour promoted amongst vulnerable population groups (sex workers and women)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>UNFPA will be supporting setting up of TSU in one state and will monitor its work to achieve the national goals specified in the NACP-III. Source of verification depends on frequency of BSS studies undertaken by NACO and other development partners.</td>
</tr>
<tr>
<td></td>
<td>• Percentage of female sex workers reached out by Targeted Interventions</td>
<td>45% (2005)</td>
<td>80% (2012)</td>
<td>Next round of BSS awaited</td>
<td>CMIS Reports of NACO BSS Reports of HRG</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Percentage of female sex workers reporting use of condoms with their most recent client (UNGASS(C(6)</td>
<td>Value yet to be published from the latest round of BSS</td>
<td>No end-line goal specified in NACP-III</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Results</td>
<td>Indicators</td>
<td>Baseline (year)</td>
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</tbody>
</table>
| CP Output 3 | Adolescents and youth empowered with knowledge and life skills for improved reproductive and sexual health (in school and out-of-school) | Percentage of youth (15-24 years) with accurate knowledge of HIV/AIDS (who recall 3 modes of transmission, 2 modes of prevention and who reject major misconceptions about HIV transmission (UNGASS (G) 10) or as an alternative using the same definition, NFHS-III can be used as well. | Boys: 36.1% (2005-06)  
Girls: 19.9% (2005-06)  
Comprehensive definition: Refer NFHS-3 India Report, page nos. 325-328 | No end-line goal specified in NACP-III | Next round of BSS/NFHS Reports awaited | BSS/NFHS Reports | Responsiveness of MoYAS, MHRD and their implementing partners in undertaking planning activities.  
Capacity of MoYAS improves. |
| | Application of Like Skills by adolescent boys and girls | Not available | 40% of adolescent boys and girls demonstrate life skills in intervention sites | --- | Skill application test to be administered in select intervention sites | |
| | Integration of life skills education in school curricula and extra-curricular activities | LSE gaps identified by mapping exercise | Inclusion of LSE in school curricula and extra-curricular activities | --- | Mapping Exercise Reports | |
## Results

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline (year)</th>
<th>Target (year)</th>
<th>Progress (Latest available year)</th>
<th>Means of Verification</th>
<th>Assumptions and Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP Output 4: Reproductive Health and Gender issues mainstreamed in recovery and rehabilitation response to natural disaster and environmental challenges</td>
<td>Percentage recovery and rehabilitation plans prepared reflecting RH and Gender perspectives</td>
<td>Not applicable</td>
<td>As and when prepared</td>
<td>Recovery and rehabilitation plan documents</td>
<td>---</td>
</tr>
</tbody>
</table>

- Not applicable
- As and when prepared
- ---
<table>
<thead>
<tr>
<th>Results</th>
<th>Indicators</th>
<th>Baseline (year)</th>
<th>Target (year)</th>
<th>Progress (Latest available year)</th>
<th>Means of Verification</th>
<th>Assumptions and Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPAP Outcome-Gender</strong></td>
<td>● Child Sex Ratio</td>
<td>927 females per 1,000 males (2001 Census)</td>
<td>Improved by at least five points</td>
<td>914 females per 1,000 males (2011 Census)</td>
<td>Census 2011 and SRS Annual Reports/Large-Scale Surveys</td>
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<tr>
<td><strong>CP Output 1</strong></td>
<td>● Skewed Sex Ratio at birth in worst affected districts improved</td>
<td>To be determined</td>
<td>Improved by at least 10 points</td>
<td>---</td>
<td>Special studies to be undertaken or if available thru AHS</td>
<td>No change in current practices of doctors</td>
</tr>
<tr>
<td>Results</td>
<td>Indicators</td>
<td>Baseline (year)</td>
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<tr>
<td>CPAP Outcome- Population and Development</td>
<td>● Policy actions initiated in one or two emerging areas</td>
<td>0</td>
<td>1(2009) 2(2010)</td>
<td>7 Secondary studies on Aging / 7 sectoral papers for Bihar Population &amp; Development policy initiated</td>
<td>Activity Reports and project report</td>
<td></td>
</tr>
<tr>
<td>Build Capacity to integrate population dynamics into national policies and programmes</td>
<td>● Plans and policies reflect population and development linkages by utilization of disaggregated data for planning and in monitoring</td>
<td>0</td>
<td>DPIPs/ Monitoring reports in intervention sites located in states of UNFPA presence</td>
<td>35 District PIPs</td>
<td>District Service Statistics and DPIPs in UNFPA states</td>
<td></td>
</tr>
<tr>
<td>Results</td>
<td>Indicators</td>
<td>Baseline (year)</td>
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<tr>
<td>CP Output 1</td>
<td>Social development planning is supported with special emphasis on demographic transition perspectives</td>
<td>NA</td>
<td>5 districts (2010)</td>
<td>35 Districts</td>
<td>District Service Statistics</td>
<td>Commitment of Collectors to the value and use of data at the district level</td>
</tr>
<tr>
<td></td>
<td>• X no. of districts adopting and using disaggregated data for planning, monitoring and policy dialogues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Information made available on policy issues of concern for policy dialogue and advocacy</td>
<td>Policy Research on a thematic area will be covered each year from 2009 onwards</td>
<td>One dissemination workshop each year</td>
<td>Report for JSY, Missing Girls and PTC assessment undertaken</td>
<td>Workshop and Policy Reports/ Briefs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Data available on emerging and priority issues and programme performance assessed</td>
<td>Will be identified and large-scale national surveys of AHS, NFHS etc. will be supported</td>
<td>Surveys include PDS issues</td>
<td>Primary studies on Aging initiated, Analysis of Census 2011 data on CSR initiated</td>
<td>Survey Reports and funding agreements and expenditure statements</td>
<td></td>
</tr>
<tr>
<td>Results</td>
<td>Indicators</td>
<td>Baseline (year)</td>
<td>Target (year)</td>
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<tr>
<td>• X no. of Institutions started imparting training on population and development</td>
<td>Nil</td>
<td></td>
<td>2</td>
<td>ISEC and IIPS + Regional institute (1 each in Rajasthan, MP and Orissa) imparted training</td>
<td>Agreement, Reports and Work-plan agreement</td>
<td></td>
</tr>
<tr>
<td>• Pre-census gender mainstreaming activities supported for 2011 census</td>
<td>Planned and supported upon request</td>
<td></td>
<td></td>
<td>Activity completed pre-census enumeration</td>
<td>Work-plan and agreements and documentation of media activities</td>
<td></td>
</tr>
<tr>
<td>• X no. of institutions supported in S-S collaboration</td>
<td>TBD</td>
<td></td>
<td></td>
<td>Just initiated, eg. Census Resource and Training Centre (CR&amp;TC)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex 2 - Terms of Reference for the Evaluation Team

**Evaluation of CP-7**

The main aim of CP-7 evaluation is to elicit achievements made in each of the thematic areas as well as to understand effectiveness of mainstreaming cross-cutting themes such as gender and advocacy in programming. In addition, the evaluation from the perspective of next cycle of the India Country Programme should be lesson-learning and forward looking. The scope of the evaluation therefore, is to provide answers and solutions to the following:

1. Examine the financial, policy and technical assistance provided by UNFPA though the Country Programme, in each of its thematic and cross-cutting areas of work in terms of:
   a. Whether interventions are aligned with the current and futuristic needs of the country; and with the larger CPAP / UNDAF results and strategic framework;
   b. Extent to which UNFPA’s support has added value to national and state government programmes and priorities;
   c. Extent to which gender has been mainstreamed in UNFPA’s work, and the extent to which this has been accepted and adopted in Government or civil society actions.
   d. Whether adequate attention has been devoted to building capacities of Government and other partners, and the extent to which this has been achieved
2. Whether the geographic focus and spread of the programme is appropriate;
3. Whether partnership strategies have been appropriate;
4. Extent to which internal UN coordination has avoided duplication or built synergies
5. Whether the operational modalities of implementing the programme (SWAp pooling, AWP with partners, and direct execution) have been utilized effectively;
6. Whether UNFPA presence has been effectively used in policy advocacy, gap identification, programme design and implementation, and responding to the needs of state governments.

The evaluation will be conducted by a team of 3 – 4 Consultants under the guidance of a Team Leader.

The Terms of Reference for the Evaluation Team is to undertake thorough investigation of the scope of evaluation as outlined above. The exercise will entail a review of the available documents; interactions with UNFPA staff members and key stakeholders; and undertaking field visits to validate and ratify the achievements. More specifically, the processes will include the following:

- Desk-review – see illustrative list of documents in **Table-1**
- Discussions with UNFPA staff – management, state office and national programme staff
- Discussions with key stakeholders – see illustrative list in **Table-1**
- Undertake field visits – see illustrative list in **Table-1**
- Debriefing of key findings with UNFPA
- Drafting of Evaluation Report and presentation to stakeholders and finalization of Evaluation Report
- Participate in stakeholders consultations for prioritizing intervention and preparation of strategy paper for UNFPA next cycle of country programme
**Tenure**
The tenure of this assignment will be around 30-35 working days during the period February to April 2011.

**Table – 1: Illustrative list of documents for review and field visit plan for Evaluation Team**

<table>
<thead>
<tr>
<th>1.</th>
<th><strong>Thematic areas of UNFPA Work</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Country Programme 7</td>
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<tr>
<td></td>
<td>SWAp including district facilitations</td>
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<td></td>
<td>RH supplementary activities to SWAp including gender in RH</td>
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<td></td>
<td>HIV</td>
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<td></td>
<td>Adolescent Reproductive and Sexual Health (ARSH)</td>
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<td></td>
<td>Sex Selection</td>
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<td></td>
<td>Population and Development</td>
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<td></td>
<td>Operations</td>
</tr>
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<td></td>
<td>Internal processes – Financial management, HR etc.</td>
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<td></td>
<td>AWP Management</td>
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</tbody>
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<table>
<thead>
<tr>
<th>2.</th>
<th><strong>Illustrative list of key documents for review</strong></th>
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<tbody>
<tr>
<td></td>
<td>Minutes of GOI Programme Review meetings and reports</td>
</tr>
<tr>
<td></td>
<td>JRM / CRM / MTR reports of GOI</td>
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<td></td>
<td>Country Office Annual Report (C OAR)</td>
</tr>
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<td>MTR Report</td>
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<tr>
<td></td>
<td>UNFPA Staff Meeting proceedings, especially meeting held at Bhopal</td>
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<td></td>
<td>UNFPA India Website</td>
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<td></td>
<td>Documents available through E-Archive –UNFPA India</td>
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<td></td>
<td>Summary report of Technical Assistance in each thematic area of work</td>
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<td></td>
<td>Project related key documents</td>
</tr>
<tr>
<td></td>
<td>One pager note per AWP</td>
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<td></td>
<td>AWP Quarterly reports</td>
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<td>Available evaluation reports</td>
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<tr>
<th>3.</th>
<th><strong>Field Visits to generate new evidences and validate achievements</strong></th>
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<tbody>
<tr>
<td></td>
<td>Visit to few states on sample basis</td>
</tr>
<tr>
<td></td>
<td>Undertaking field visit to understand specific project sites</td>
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<td></td>
<td>Interactions with key Government officials</td>
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<td></td>
<td>Interaction with Implementing partners and other development partners</td>
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</table>

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<tr>
<th>4.</th>
<th><strong>Discussions with key stakeholders</strong></th>
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<tbody>
<tr>
<td></td>
<td>Secretary, Health and Family Welfare, MOYAS, MOHRD</td>
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<tr>
<td></td>
<td>Additional and Joint Secretaries, MOHFW, MOYAS, MORD</td>
</tr>
<tr>
<td></td>
<td>Director General, NACO</td>
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<tr>
<td></td>
<td>Registrar General and Census Commissioner on UN Support</td>
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<tr>
<td></td>
<td>UNRC’s office, UNDP and UNICEF in regard to PDS-Convergence and Census support</td>
</tr>
<tr>
<td></td>
<td>State Secretaries from relevant ministries in a few states having UNFPA offices</td>
</tr>
<tr>
<td></td>
<td>Development Partners, NGO partners and IPs</td>
</tr>
</tbody>
</table>
Annex 3 – Relative roles of evaluation consultants

Responsibilities and Roles of Evaluation Team Members

1. **A. R. Nanda:** Studied the adolescent reproductive and sexual health program, and the work done under the population and development strategy theme.

2. **Firoza Mehrotra:** Studied operational modalities and related issues.

3. **Ravi Verma:** Studied the reproductive health program including gender based violence, integration of gender into emergency response, and HIV/AIDS, but excluding adolescent reproductive health.

4. **Priya Nanda:** Studied sex selection.

5. **Rekha Masilamani:** Served as the team leader and studied geographic focus, partnerships, synergy within the UN system, and cross cutting issues of gender and policy advocacy.
Annex 4 - List of Documents Reviewed

   1.3 End of CP6 Programme Evaluation
   1.4 Mid Term Review Report of UNFPA 7th Country Programme (2010)
   1.7 Minutes of the Apex Coordination Committee meetings, Briefing Note and Presentations – 2008, 2009, 2010
   1.8 Documents shared with GOI for the upcoming Apex Coordination Committee meeting to be held in Feb, 2011
   1.10 Report of the Team UNFPA Meeting, April 12 – 14, 2010 at Bhopal

   2.2 UNDAF Cluster Joint Programming Plan – 2009, 2010
   2.3 UNDAF Mid Term Review (2010)

3. **Thematic Area: Population and Development**
   3.1 Population and Development Strategy for UNFPA

   **UN Convergence Programme: Use of Data for Planning and Monitoring Development Programmes**
   3.2 District Level Population Projections in Eight Selected State of India : 2006 - 2016
   3.3 Resource Materials for Sensitization of Senior Officers in Use of Data for Planning and Monitoring
   3.4 Module for Training District Officers in Use of Data for Planning and Monitoring Development Programmes
   3.5 Manual for Estimating Development Indicators at Sub-national Level
   3.6 Progress Report on Convergence Programme

   **Census**
   3.7 MoU between UN agencies and ORGI
   3.8 Annual Work Plans (AWPs)-2009, 2010
   3.9 District Gender Data Prototype
   3.10 Process Note on Engendering Census activities
   3.11 Presentation on Joint UN Support to Census, 2011

   **Aging**
   3.12 Aging Concept Note
   3.13 Building knowledge base on Aging in India
      a. Discussion Papers on the basis of secondary data
   3.14 Presentations on Aging
      a. Living Arrangements of Elderly in India-Trends and Differentials
      b. Spatial Analysis of Aging in India-Programmatic Implications
Bihar Population and Development Policy
3.15 Bihar Population and Development Policy - Concept Note
3.16 Discussion Papers on Sectoral Reviews

Support to HMIS under NRHM-National and State
3.17 Analysis Framework of Critical indicators from HMIS
3.18 HMIS Training Modules for ANMs/LHVs

Articles/Reports/Presentations
3.19 Population Research and MDGs in India in Population, Gender and Health in India(ed) K.S. James et.al.
3.20 Concurrent Assessment of JSY in Selected States
3.21 Demographic Dividend in Southern States of India
3.22 Tracking Implementation of Health Programmes at Sub-national Levels through HMIS Data
3.23 A Study of Vital Registration System in Rajasthan – Report and Presentation

PDS
3.24 2011 Census kits and communication material received from Census Commissioner.

4. Thematic Area: Reproductive Health (including Gender and Disaster Management)
A. Reproductive Health Services

Swap based RCH2 Programme (Support for planning, participation and substantive inputs in the Aide Memoires)
4.1 Process Note on Transition from Project Mode under CP6 to a SWAp Environment
4.2 Participation in a SWAp based RCH II Programme : Initial Experiences of UNFPA, INDIA
4.3 Process Manual for 1st Joint Review Mission of RCH2
4.4 Aid Memoires (I – VII) and Mid Term Reviews
4.5 Reports for Common Review Missions of NRHM

District Planning (Facilitating Decentralised Planning)
4.6 District Health Action Plan Manual

Maternal Health (Capacity Building & Quality of Care):
Skilled Birth Attendant
4.7 Guidelines for Antenatal Care and Skilled Attendance at Birth by ANMs/LHVs/SNs
4.8 Guidelines for Operationalizing SBA Training in RCH II
4.9 Skilled Birth Attendance (SBA) - Trainers Guide for Conducting Trainers of Auxiliary Nurse Midwives Lady Health Visitor & Staff Nurses
4.10 Skilled Birth Attendance (SBA) – A Handbook for Auxiliary Nurse Midwives Lady Health Visitor & Staff Nurses
4.11 Guidelines for Accreditation of Private Health Facilities for Providing SBA Training – Reference Manual for Programme Managers on Accreditation Process
Basic EmOC/EmOC
4.12 Trainers Handbook for Training of Medical Officers in Pregnancy Care and Management of Common Obstetric Complications
4.13 Trainers Guide for Training of Medical Officers in Pregnancy Care and Management of Common Obstetric Complications
4.14 Workbook for Training of Medical Officers in Pregnancy Care and Management of Common Obstetric Complications
4.15 Recommendations of consultation for of Medical colleges faculty and District Hospitals staff on delivery and new born care Practices in Rajasthan
4.16 Checklist for labour room in Orissa

Safe Abortion
4.17 Comprehensive Abortion Care Guidelines

Family Planning (Access and Quality of Care): Standards & guidelines
4.18 Sterilization Standards (male and female)
4.19 Guidelines for Quality Assurance Committees
4.20 Standard Operating Procedures for Sterilization in Camps
4.21 Emergency Contraceptive Pills, IUDs
4.22 Post Partum Family Planning: A Manual for Service Providers
4.23 Contraceptive updates (Reading material and Guide for facilitators)

Adolescent Reproductive and Sexual Health (ARSH) - Strategy formulation and programme development
4.24 Assessment of Adolescent Reproductive and Sexual Health (ARSH) - Gujarat

Capacity Building for Rapid Assessment of Health Interventions: Medical Colleges (Through NIHFW)
4.25 RAHI Phase II (2008-09) NGOs (Through Centre for health and Social Justice)
4.26 Phase 1 (2009)
4.27 Phase 2 (2010-2011)
An edited book compiling the articles from the trainees.

Quality of Care in RCH
4.28 District Quality Assurance Programme for RH Services – An Operational Manual
4.29 Assessment of QA programme in Gujarat State

RTIs/STIs/HIV
4.30 Guidelines for prevention and management of RTIs/STIs in RCH2
4.31 Note on convergence between RCH2 and NACP-III

ASHAs
4.32 Book Number 1 – 4 for ASHAs
4.33 Guidelines for Supportive Supervision of ASHAs
4.34 Communication Kit for ASHAs-FP

Support for Mother NGO Scheme
4.35 Training of Trainers Manual for MNGOs
4.36 Rapid Assessment of MNGO Scheme
## B. Gender in RCH 2

### Gender Mainstreaming in RCH – II
- 4.37 Report on Mainstreaming Gender in RCH Training
- 4.38 Mainstreaming Gender within India’s RCH 2 programme (National PIP)
- 4.39 Mainstreaming Gender in RCH 2 programme – Guidelines for States
- 4.40 Note on Enhancing women’s role in addressing global humanitarian and health crisis J
- 4.41 Gender Sensitivity and community responsiveness in healthcare: Toolkit to guide practitioner
- 4.42 Gender Ready Reckoner (Gender Kunji)
- 4.43 Strategy Paper on Men as Supportive Partners in RCH: Moving from Intent to Action

### Gender Based Violence
- 4.44 Health and social consequences of martial violence: a synthesis of evidence from India – 2010 - A Report and power point presentation
- 4.45 Study on assessing various models of family counseling centres (FCCs) addressing Gender Based Violence (GBV) – Rajasthan
- 4.46 Family Counseling Centers in Madhya Pradesh - An Assessment
- 4.47 Concept Note for Protocols to Detect Gender Based Violence in Health Settings
- 4.48 GBV - Possibilities for interventions by Ministry of Health and Family Welfare, health service providers to facilitate implementation of Domestic Violence Act - Sept 2005
- 4.49 Information kit for Health Service Providers on Violence Against Women (Information booklet for medical officers, Facilitator’s Guide and Poster)
- 4.50 Report of the National Workshop on Violence Against Women: Health Sector Perspective (Resolution adopted at the National Workshop)

### Working with Community and PRI
- 4.51 Strengthening Gender Responses of Panchayats in Rajasthan – PRIA- Annual Report 2010
- 4.52 Awareness building on gender discrimination with a focus on RR and RH and Gender Justice – Hunger Project- Annual Report 2010
- 4.53 A note on the process of Jan Samvad to be held in Chhoti-Sadri block of Chittorgarh District on 30.09.03
- 4.54 Jan Samvad - Public Dialogue with Women On Gender and Health Management – Chittorgarh, Rajasthan - September 03

## C. Disaster Management and Humanitarian Response
- 4.56 NDMA Guidelines on psycho social counseling
- 4.57 Brochure on Dignity Kit
- 4.58 Presentations:
  a. AIUCK Second Workshop, Kobe, 2007
  b. First World Congress on Disaster management, Hyderabad, 2008
  c. Regional training of Trainers on MISP for RH in Crisis Setting, Bangkok, 2010
5. **Sex Selection**

*Annual Reports*

5.1 Annual Project Report – 2006-07
5.2 Annual Report: Advocacy – 2007
5.3 Annual Report: Advocacy – 2008
5.4 Annual Report: Sex Selection – 2009

*Advocacy*

5.5 Strategy Note on Sex Selection - 2007
5.6 Briefing Note on Sex Selection in India – 2007
5.7 A Guidance Note on Sex Selection and Abortion in India - March 07
5.8 Sex Selection Advocacy - An Action Framework - A Brief Report – 2005
5.9 Note on Sex Selection in India for Key Players – 2005
5.10 Presentation on -
   a. Advocacy strategy to address Sex Selection – September 2007
   b. Locating Pre-natal sex selection in reality – November 2005
   c. Issues of sex selection made at Regional planning meeting – February 2007
   d. Programme Priorities for Sex Selection in CP7
   e. Sex Selection Advocacy Initiatives- Involving new Partners - An action framework
5.11 Complexities & Challenges in Addressing Sex Selection in India: Key Points from brainstorming discussion – September 2010
5.12 Background presentation - Brainstorming Discussion on complexities & challenges in addressing SS in India - Sep 2010
5.13 Note on Gender and Sex Selection Intervention Framework (2010-2014)–April 2010
5.14 Sex Selection Programming & Advocacy - Summary of Planned and Ongoing Initiatives (2008-09)
5.15 Follow-up to State Review meeting-Action points on sex selection-Mumbai-May 2009
5.16 Sex selection Reflections on strategies, interventions and use of terminology - Session Note for State Review Meeting – 2009
5.17 Addressing sex selection - Strategy and Interventions for 2009
5.18 Sex Selection Programming & Advocacy: Summary of Initiatives and Interventions from 2002 and planned - ongoing initiatives for 2008 – 09
5.19 Field visit of the Director, APD, Mr. Sultan Aziz to Punjab in understanding initiatives undertaken to address sex selection. 22 - 23 February, 2007
5.20 To understand the initiatives taken by Dy. Commissioner Nawanshahr on the issue of SS-Nawanshahr and Chandigarh - Feb 2007

*Assessment and Research Reports*

5.21 Reflections on the campaign against sex selection and exploring ways forward – Recommended strategies for UNFPA
5.22 Assessment of the efforts to address sex selection – looking back-looking forward report- presentation of key findings
5.24 IMAGES AND ICONS: Harnessing the Power of Mass Media to Promote Gender Equality and Reduce Practices of Sex Selection-BBC study
5.25 Special Financial Incentive Schemes for Girl Child In India: A Review of Selected Schemes
Global / Regional
5.26 Interagency statement Preventing Sex Selection Statement – November 2010
5.27 Presentation on Communicating around Prenatal Sex Selection
5.28 Technical Consultation on Sex Selection - Workshop Overview and Way Forward - October 2008

Working with Medical Fraternity
5.29 Note on IMA Strategy for Addressing Pre-Natal Sex Selection - 2008
5.30 Annual Conference of Indian Association of Preventive and Social Medicine, Gujarat Chapter, 25-26 November 2005, Baroda: To make a presentation on sex selection and build linkages with IAPSM for the PSM network and faculty to actively address the issue in their day-to-day work
5.31 Regional Workshop towards development of State and District Action Plans, Dehradun - March-2008: To facilitate the Northern region workshop consisting of the IMA members from Punjab, Haryana, Chandigarh, Uttranchal, Delhi, Himachal Pradesh
5.32 Regional Workshop towards development of state/district action plans, Kolkata - March 2008
5.33 Sensitization workshop for Medical Colleges faculty of UP on prevention of female foeticide - March 2007
5.34 Mission Report & Presentation: To participate and present on sex selection at the 14th Annual Conference of IAPSM (Gujarat Chapter) organized by Kesar SAL Medical College and Research Institute, Ahmedabad - December 2006
5.35 Presentation made on sex selection to IMA - Sept ‘06

Media and Population Culture
5.36 Presentation made at Madhya Pradesh media workshop on abortion Vs sex selection - June 08
5.37 Song ‘BALLO’ by Punjabi singer, Rabbi Shergill focusing on the girl child
5.38 Song ‘Sun Zara’ by Suneeta Rao focusing on the girl child
5.39 Journalist Training Workshop, Bhubaneswar December 2005

Political Advocacy
5.41 Notes for parliamentarians/legislators on issue of Sex Selection – 2008
5.42 Note on Sex Selection and Two Child Norm - for Parliamentarians

Partnering with Judiciary
5.43 Presentation:
   d. Judicial colloquium on PCPNDT Act: Orissa – February 2010.ppt
5.44 Himachal Pradesh state level Judicial Colloquium on PCPNDT Act, Jan 2009 - Mission Report
5.45 Orissa State Level Judicial Colloquium on PCPNDT Act, Feb 2010-Mission Report
5.46 Maharashtra State Level Judicial Colloquium on PCPNDT Act - Dec 2007: To participate and present at the Judicial Colloquium on 9 December, 2007 and facilitate work with judiciary and Maharashtra State Legal Services Authority (MSLSA) - Mission Report

**Faith Based Organisation**

5.47 Presentation on sex selection during the Art of Living Workshop - September ’09

**Support to Civil Society / NGOs**

5.48 WPC Annual Report 2009, 2010
5.49 Presentation made on the issues of sex selection to Women Power Connect

**Collaborating with the Government**

5.50 Note on Sex Selection & women’s empowerment for Planning Commission - Sept 05
5.51 Locating prenatal sex selection in reality: Presentation made to MWCD convergence meeting – June 2007
5.52 Presentation made to Planning commission on issue of sex selection
5.53 Note on strengthening implementation of PC & PNDT Act - Possibilities for Appropriate Authorities
5.54 Note on Integrating the Issue of Sex Selection in the Work of MOHFW
5.55 UNFPA support to Maharashtra in CP7 - January 2008: To hold discussions with the Department of Health and potential implementing partners for finalizing UNFPA support to Maharashtra in CP7 and specifically in 2008 - Mission Report
5.56 Presentation on sex selection issues made to Punjab Governor, Feb 2007
5.57 Gender empowerment - sex selection - EC seminar 19.3.07
5.58 Presentation made on sex selection issues to LBSNAA - May 06
5.59 Sex Selection LBSNAA EMS 8 May 2006
5.60 Presentation on sex selection issues for NCC training programme - Mar 2008
5.61 Understanding gender and health issues: Their implications for girls and women : Presentation made to Bharat Scouts and Guide

**Gender-Population Dynamics**

5.62 Visit to: Mumbai, Maharashtra Dhanashri & Sathyanarayana : Finalization of contents and session-plans for census training enumerators and trainers
5.63 Note on Steps for Ensuring Gender Responsive Census – key points
5.64 Note on Gender Mainstreaming in Census of India - 2011
5.65 Sex Ratio at Birth in India and selected states.ppt
5.66 Booklet on Trends in Sex Ratio at Birth and Estimates of Girls Missing at Birth in India
5.67 Booklet on Missing Girls: Mapping the Adverse Child Sex Ratio in India
5.68 State-wise maps depicting the decline in child sex ratio
5.69 Frequently Asked Questions on Sex Selection – demystifying the legislation
5.70 Declining Child Sex Ratio (0-6 years) in India _ A Review of Literature and Annotated Bibliography
5.71 PCPNDT Act - Answers to Frequently Asked Questions A Handbook for Implementing bodies
5.72 PCPNDT Act - Answers to Frequently Asked Questions A Handbook for the Public
5.73 PCPNDT Act - Answers to Frequently Asked Questions A Handbook for Medical Professionals
5.74 Why do daughters go missing—Frequently asked questions on pre-natal sex selection in India
5.75 Trends in sex ratio at birth and estimates of girls missing at birth in India
5.76 Doctors’ Dilemmas—Questions doctors face in communicating about pre-natal sex selection
5.77 IMPLEMENTATION OF THE PCPNDT ACT IN INDIA: Perspectives and Challenges
5.78 CYDA report

**Thematic Area: Adolescent Reproductive and Sexual Health (ARSH)**

*Annual Reports*
5.79 Technical Assistance - Annual Work Plan – 2011
5.80 Overview of work in ARSH portfolio in 2010
5.81 Annual Plan of Operation – 2010
5.82 Annual Report – 2009

*Reaching Out to Adolescents in India: Lessons Learnt and Way Forward*
5.83 Strategy Note for Reaching Young People in Out of School Settings
5.84 Strategy Note for Reaching Young People in Institutional Settings: Envisioning the Future of Adolescence Education Program (AEP) 51: 2010 and Beyond
5.85 Presentations on:
   a. Addressing Youth Realities in UNFPA India Country Program 7
   b. Adolescence Education Program in India: Lessons Learnt
   c. Evolution of Adolescence Education Program in India: Lessons Learnt and Way Forward

*Documents related to Monitoring and Evaluation of ARSH Programs*
5.86 Evaluation Report of Functioning of Teen Clubs under Nehru Yuvak Kendra Sangathan
5.87 Presentations on Assessment of Nodal Teachers Training Programs Implemented Under the Adolescence Education Program in 2008
5.88 Instruments of AEP Assessment 2010-11
   a. AEP School Monitoring format
   b. FGD Guide for Students, including the pictures to initiate discussion among students on the program, especially to seek their opinions on gender issues
   c. In-depth Interview Guide for Principals
   d. In-Depth Interview Guide for Teachers
   e. Questionnaire for Students
   f. Questionnaire for Teachers

*Concept Notes and Training Materials*
5.89 Background Note on National Seminar on Life Skills Focused Adolescence Education, 2009
5.90 Adolescence Education Programme: Scheme of Content across different Stages of Schooling
5.91 Conceptual Framework: Adolescence Education Program, 2010

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51 Please note that the Adolescence Education Program is implemented in partnership with the Ministry of Human Resource Development for in-school adolescents
Co-curricular format
5.92 Adolescence Education Program: Training and Resource Materials
5.93 Presentation on Rationale for Materials Development

Curricular format
5.94 Concept Note: Integrating Life Skills in Secondary Curriculum of National Institute of Open Schooling (NIOS)
5.95 Presentation on Life Skills Integration: Concept, Rationale, and Characteristics of Effective Programming in the context of NIOS
5.96 Presentation on Life Skills Evaluation in the Sample Lessons of Secondary Curriculum of NIOS
5.97 Documents on adolescent health and life skills development prepared by Kalinga Institute of Social Sciences in Oidya and English

6 Communications
A. Gender & Sex Selection
Laadli Media Awards: Population First, with the support of UNFPA launched the UNFPA Laadli Media Awards for gender sensitivity and Laadli UNFPA National Creative Excellence Awards in 2007-08. Since then, every year, the Awards felicitate gender sensitivity in Journalism and Advertising – both print and electronic.

PCPNDT Online Reporting: The online reporting site allows people to report PCPNDT Act violations online. The website was launched in Rajasthan in July 2010, and until January 2011, over 60 reports had been registered online. The software enables Appropriate Authorities and health officials at the state and district levels to follow-up and report-back online on the action taken.
6.76 Link to the website for online reporting of PCPNDT Act violations
6.77 PCPNDT Online Reporting Site Users Manual

Self-learning CD to know more about PCPNDT Act: The CD asks the user a series of multiple answer questions in an interesting manner – making learning about the Act interesting & participatory. On successful completion of the test, the CD automatically generates a certificate that can be printed. The CD is being reviewed before being finalized.

Sapno Ko Chali Chooney
In early 2009, UNFPA India partnered with Jagran Pehel to launch Sapno Ko Chali Chooney in 21 colleges across the state of Bihar. Designed as a mentorship and empowerment programme, this initiative facilitated interactions of college girls, with journalists, women’s empowerment groups, and with each other. In 2011, the government and other organizations have come forward to fund the replication of the project in the rest of the state.

B. UNFPA Organisational Development
6.78 Bhopal Planning Meeting Agenda
6.79 Bhopal Programme Planning Meeting Visuals
6.80 Power of Positioning - First discussion on UNFPA positioning

C. Other work
6.81 RH Communication Development in Bhutan
6.82 Development Sector Photography Workshops
# Annex 5 – List of visits made & persons met

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Name &amp; Designation</th>
<th>Organization</th>
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<tbody>
<tr>
<td>1.</td>
<td>K. Chandramouli, Secretary, Health and Family Welfare</td>
<td>MOHFW</td>
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<td>2.</td>
<td>Aradhan Johri, Addl. Secretary</td>
<td>NACO</td>
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<td>3.</td>
<td>Anuradha Gupta, Jt. Secretary, (RCH)</td>
<td>MOHFW</td>
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<td>4.</td>
<td>P. K. Pradhan, Addl. Secy &amp; Mission Director, (NRHM)</td>
<td>MOHFW</td>
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<td>5.</td>
<td>Suresh K. Mohammed, Director (RCH &amp;DC)</td>
<td>MOHFW</td>
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<td>6.</td>
<td>Madhu Bala, Addl. DG (Statistics)</td>
<td>MOHFW</td>
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<td>7.</td>
<td>Pravin Srivastava, DDG, (Stat)</td>
<td>MOHFW</td>
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<td>8.</td>
<td>T. Sundararaman, Executive Director</td>
<td>NHSRC</td>
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<td>9.</td>
<td>S. Kunthia, Jt. Secretary</td>
<td>MOHRD</td>
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<td>10.</td>
<td>Sailesh, Jt. Secretary</td>
<td>MOYAS</td>
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<td>11.</td>
<td>Indu Patnaik</td>
<td>MLP Div, Planning Commission</td>
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<td>12.</td>
<td>Karin Hulshof, Representative</td>
<td>UNICEF</td>
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<td>13.</td>
<td>Anne F. Stenhammer, Regional Director</td>
<td>UN-WOMEN</td>
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<td>14.</td>
<td>Kerry Pelzman, Director (PHN)</td>
<td>USAID</td>
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<td>15.</td>
<td>Vikram Rajan, Sr. Health Specialist</td>
<td>The World Bank</td>
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<td>16.</td>
<td>Billy Stewart, Sr. Health Specialist</td>
<td>DFID</td>
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<td>17.</td>
<td>Saroj Yadav, Reader</td>
<td>NCERT</td>
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<td>18.</td>
<td>Abhijit Das, Director</td>
<td>CHSJ</td>
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<td>19.</td>
<td>P. M. Kulkarni, Prof.</td>
<td>JNU</td>
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<td>20.</td>
<td>K. S. James, Prof. &amp; Head (PRC)</td>
<td>ISEC</td>
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<td>21.</td>
<td>Moneer Alam, Prof.</td>
<td>IEC</td>
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<td>22.</td>
<td>Ladu Singh, Prof.</td>
<td>IIPS</td>
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<td>23.</td>
<td>Prasanta Kumar Routray, CEO</td>
<td>KISS</td>
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<td>24.</td>
<td>Sushanta Kumar Panda, Project Manager</td>
<td>KISS</td>
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<td>25.</td>
<td>Irfat Hamid, Consultant</td>
<td>MOHFW</td>
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<td>26.</td>
<td>Suraj Kumar, Head (Governance)</td>
<td>UN-WOMEN</td>
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<td>27.</td>
<td>Ruchi Pant, Prog. Analyst</td>
<td>UNDP</td>
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<td>28.</td>
<td>Marc Dervwwuw, Representative a.i.</td>
<td>UNFPA</td>
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<td>29.</td>
<td>Ena Singh, Asst. Representative</td>
<td>UNFPA</td>
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<td>30.</td>
<td>Venkatesh Srinivasan, Asst. Representative</td>
<td>UNFPA</td>
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<td>31.</td>
<td>Yogesh Bhatt, Operations Manager</td>
<td>UNFPA</td>
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<td>32.</td>
<td>Dinesh Agarwal, NPO (RH)</td>
<td>UNFPA</td>
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<td>33.</td>
<td>Dhanashri Brahme, NPO (Sex Selection)</td>
<td>UNFPA</td>
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<td>34.</td>
<td>Rajat Ray, NPO (Advocacy)</td>
<td>UNFPA</td>
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<td>35.</td>
<td>Jaya Jaya NPO (ARSH)</td>
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<td>36.</td>
<td>Geeta Narayan NPO (ARSH)</td>
<td>UNFPA</td>
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<td>37.</td>
<td>K. M. Sathyanarayana NPO (PDS)</td>
<td>UNFPA</td>
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<td>38.</td>
<td>Sanjay Kumar NPO (M&amp;E)</td>
<td>UNFPA</td>
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<td>39.</td>
<td>Sachi Grover, NPO (DM)</td>
<td>UNFPA</td>
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<td>40.</td>
<td>Pinky Sharma, Consultant (Gender)</td>
<td>UNFPA</td>
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<td>41.</td>
<td>Azza Omer, JPO</td>
<td>UNFPA</td>
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<td>42.</td>
<td>Nalini Srivastava, NPA</td>
<td>UNFPA</td>
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<td>43.</td>
<td>Sushil Choudhary, NPA</td>
<td>UNFPA</td>
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<td>44.</td>
<td>Hemand Dwedi, SPC, Orissa</td>
<td>UNFPA</td>
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<tr>
<td>45.</td>
<td>Savita, Programme Manager</td>
<td>WPC</td>
</tr>
</tbody>
</table>
### BIHAR

1. Sanjay Kumar, Secretary Health Cum Executive Director | State Health Society, Bihar
2. Ajay Kumar Sahi, State Family Planning Nodal Officer | State Health Society, Bihar
3. Arvind Kumar, State Data Analyst | State Health Society, Bihar
4. Yameen Mazumder, Chief Field Office, Bihar | UNICEF
5. Shailesh Kumar Singh, State Programme Officer | UNDP
6. Hasan Waris, Director | SCERT
7. Jaydeep Kar, State Programme Coordinator | CEFPA
8. Jaiwanti P. Dhaulata, Senior Consultant | ANSWERs
9. Thomas Jenifer Malardizhi, Project Officer | ANSWERs
10. Sujeet Kumar Verma, Prog. Associate | THP
11. Shahina Perween, Prog. Associate | THP
12. Shyama Prasad Chatterjee, Associate State Coordinator | IIHMR
13. Aftab Rahamani, Zonal Officer | IIHMR
14. Karuna Shanar, Zonal Officer | IIHMR
15. Ram Kishore Prasad Singh, General Secretary | Gramin Evam Nagar Vikas Parishad
16. Anju Sinha, Prog Coordinator | Gramin Evam Nagar Vikas Parishad
17. Yogendra Kumar Gautam, Secretary | Jan Jagran Sansthan
18. Uday Singh, Project Coordinator | Jan Jagran Sansthan
19. Swapan Dey, Prog Director | Nirdesh
20. Madhu Singh, Block Coordinator | Nirdesh
21. Nielshe Deshpande, State Prog. Coordinator | UNFPA
22. Vibhuvendra Singh Raghuyamshi, State Prog Officer | UNFPA

### MAHARASHTRA

1. Shomita Biswas, Member Secretary | Maharashtra State Commission for Women
2. Shanar Padhal, Dy. Secretary | Maharashtra State Commission for Women
3. Jayant Bantiya, Addl. Chief Secretary | Public Health Dept, Govt. of Maharashtra
4. Archana Patil, Jt. Director | Health Services
5. Gorakhnath Chinde, Jt. Director | Health Services
6. Prabir Das, Coordinator | PDC, Public Health Institution
7. Shalini Phansalkar Joshi, Jt. Director | Maharashtra Judicial Academy
8. Prakash Doke, Executive Director | SHSRC
9. Vikas Kharge, Mission Director, | NRHM
10. Satish Pawar, Jt. Director | NRHM
12. Ashok Chitale, State, QA Officer | State Family Welfare Bureau
13. Shambhu Sista, Executive Trustee | Population First
14. A.L. Sharad, Programme Director | Population First
15. D. K. Mangal, Statr Prog. Coordinator | UNFPA
16. Anuja Gulati, SPO | UNFPA
1. B. N. Sharma, Principal Secretary, Health  
Govt. of Rajasthan
2. D. B. Gupta, Principal Secretary, Planning  
Govt. of Rajasthan
3. Moti Lal Jain, Director, RCH  
Directorate of Medical Services, Govt. of Rajasthan
4. Pradeep Kumar Sarda, Project Director  
RSACS,
5. Hardayal Singh, In-charge  
PCPNDT Cell
6. Ritesh Tewari, Legal Advisor  
PCPNDT Cell
7. Vaidehi Agnihotri, Consultant, VHSC  
NRHM
8. S. D. Gupta, Director  
IHM
9. Narendra Gupta, Secretary  
PRAYAS
10. Mudit Mathur, Asst. Project Coordinator  
PRAYAS
11. Pradeep Kachawa, Asst. Project Coordinator  
PRAYAS
12. Kishan Tyagi, State Coordinator  
PRIYA
13. Ahmad Tahreem, Programme Officer  
PRIYA
14. Jaidev Balakrishnan, Dy. Regional Director  
Population Services International
15. Swati Saxena, R.M. Communication  
Population Services International
Population Services International
17. K. Jimreeves  
RSACS
18. Pavan Kumar Shetty, Team Leader, TSU  
RSACS
19. Reshma Azmi  
RSACS
20. Suraj Mal Raiger, Director  
Economic & Statistics, Govt. of Rajasthan
21. Manoj Kumar Raut, Demographer  
Economic & Statistics, Govt. of Rajasthan
22. Sanejeev Bhanawat, Prof.  
University of Rajasthan
23. Shubhra Singh, Director – Census and Jt. Secretary, GOI  
Census Dept
24. Kanchan Mathur, Prof.  
IDS
25. Nutan Jain, Asst. Prof.  
IHMR
26. Sarita Singh, Commissioner  
Women Empowerment
27. Rita Arora, Head, Dept of Education  
University of Rajasthan
28. Bhaskar A Sawant, Commissioner, Secondary Education & Project Director  
Life Skill Education Shiksha Sankul
29. Umakant Ojha, Principal  
IASE, Bikaner
Dept. of Education
31. Anita Shekhawat, Asst. Project Officer  
Dept. of Education
32. Samuel Mawunganiyte, State Chief  
UNICEF
33. Madhu Vijayvergia, District RCH Officer  
Dept. of Health, Ajmer
34. Pabhakar, MO  
Saradhana PHC, Ajmer
35. Salukshana Sharma, QA Coordinator  
PRAYAS, Ajmer
36. Kapil Mali, QA Coordinator  
PRAYAS, Ajmer
37. Sunil Thomas Jacob, State Prog. Coordinator  
UNFPA
38. Manita Jangid, State Prog. Officer  
UNFPA
<table>
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<tr>
<th>No.</th>
<th>Name and Designation</th>
<th>Organization/Institution</th>
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<tbody>
<tr>
<td>1.</td>
<td>Yogesh Kumar, Executive Director</td>
<td>Samarthan</td>
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<td>2.</td>
<td>Harish Verma</td>
<td>Samarthan</td>
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<td>Tapan Mohanty, Project Director</td>
<td>National Law University</td>
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<td>Swati Singh, Project Coordinator</td>
<td>National Law University</td>
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<td>5.</td>
<td>Palak Tiwari, Project Coordinator</td>
<td>Vanya</td>
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<td>Actionaid Association</td>
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<td>Kamar Fatima</td>
<td>Actionaid Association</td>
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<td>9.</td>
<td>Meera Singh</td>
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<td>P. Biswas</td>
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<td>11.</td>
<td>Gangan Gupta, Health Specialist</td>
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<td>Rajan Dubey, Sr. Prog. Officer</td>
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<td>13.</td>
<td>Priti Dave Sen, Team Leader,</td>
<td>MP-TAST</td>
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<td>Dyoti Benawri, State Prog. Officer</td>
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<td>Sandeep Kumar, Prog. Officer</td>
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<td>Amit Anand, State Prog. Officer</td>
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<td>Dorothy Rodrigues, OIC</td>
<td>WFP</td>
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<td>18.</td>
<td>Sayeed Fareeduuddin, Operations Manager</td>
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<td>Pratibha Sharma, State Prog. Officer</td>
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<td>Ajay Khare, Dy. Director,</td>
<td>Directorate of Health Services</td>
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<td>21.</td>
<td>Manohar Agnani, Mission Director</td>
<td>NRHM</td>
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<td>22.</td>
<td>Anand Shukla, Addl. Collector</td>
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<td>23.</td>
<td>Satish Joshi, Nodal Officer, PC&amp;PNDT Act</td>
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<td>24.</td>
<td>Mukesh Kumar Sinha, Executive Director,</td>
<td>MP-VHAI</td>
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<td>Ramesh Nagrath, Member,</td>
<td>IMA, Indore</td>
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<td>28.</td>
<td>Ishrat Ali, Religious Leader (Shahar Kai)</td>
<td>Indore</td>
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<td>29.</td>
<td>Manoj Joshi, Project Coordinator</td>
<td>MP-VHAI</td>
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<td>30.</td>
<td>Sudesh Jain, Religious Leader</td>
<td>Jain Muni, Indore</td>
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<td>31.</td>
<td>Sudhir Gokhale, Ex-Mmeber</td>
<td>District Advisory Committee, PC&amp;PNDT Act, Indore</td>
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<td>32.</td>
<td>P. Y. Pandey, Member</td>
<td>Monitoring Team, PC&amp;PNDT Act, Indore</td>
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<td>P. K. Bajaj, Member</td>
<td>Monitoring Team, PC&amp;PNDT Act, Indore</td>
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<td>34.</td>
<td>Sudhanshu Sekhar</td>
<td>MP-VHAI, Maheshwar</td>
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<td>B. S. Kaney, BMO</td>
<td>Maheshwar, Khargone</td>
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<td>36.</td>
<td>Rahul Jain, DPM</td>
<td>RCH/NRHM, Khargone</td>
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<tr>
<td>37.</td>
<td>Shalini Kapoor, Project Coordinator</td>
<td>MP-VHAI, Indore</td>
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<td>38.</td>
<td>P. R. Deo, State Prog. Coordinator</td>
<td>UNFPA</td>
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<td>39.</td>
<td>Tej Ram Jat, State Prog. Officer</td>
<td>UNFPA</td>
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</tbody>
</table>
Annex 6 – Agenda of Gender Consultation Workshop and presentation on UNFPA’s gender work

AGENDA FOR UNFPA’S GENDER CONSULTATION
21st April 2011

**Objectives:** To brainstorm and debate on what and how to, to integrate gender better into CP-8, based on an assessment on how gender has been mainstreamed into UNFPA’s work so far.

**Participants:** 1. All UNFPA Delhi and State offices programme staff
2. All members of the Evaluation team

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<thead>
<tr>
<th>Session</th>
<th>Time</th>
<th>Session</th>
<th>Speaker/Facilitator</th>
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<tbody>
<tr>
<td>1.</td>
<td>09:30-09:40</td>
<td>Introduction and background</td>
<td>Rekha Masilamani</td>
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<tr>
<td>2.</td>
<td>09:40-10:15</td>
<td>Overview of how UNFPA perceives ‘gender’ and key achievements</td>
<td>Ena Singh</td>
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<td>3.</td>
<td>10:15-10:45</td>
<td>Plenary session: Q.1: Any comments or additions to what was presented?</td>
<td>Ena Singh</td>
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<td>4.</td>
<td>10:45-11:00</td>
<td>TEA BREAK</td>
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<td>5.</td>
<td>11:00-12:00</td>
<td>Group Work in 4 Groups to discuss theme-wise Q 2: What is the most important gender thing you did? Group 1: RH/HIV/Disaster Group 2: ARSH Group 3: Population data and dynamics Group 4: Population Policies &amp; Reproductive Rights</td>
<td>A.R. Nanda and Rekha Masilamani</td>
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<td>Session</td>
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<td>7.</td>
<td>13:45-14:30</td>
<td>LUNCH</td>
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| 8.      | 14:30-16:00| Group Work in 4 Groups to discuss theme-wise  
**Q.4: What is the most important gender work that is needed to further integrate it in UNFPA’s RH/HIV/Disaster, ARSH, Population data and dynamics and Population Policies/RR work?**  
Group 1: Population data and dynamics  
Group 2: ARSH Population Policies & RR  
Group 3: RH/HIV/Disaster  
Group 4: ARSH | Firoza Mehrotra and Rekha Masilamani |
| 9.      | 16:00-16:15| TEA BREAK                                                               |                                             |
| 10.     | 16:15 –16:45| Session 8 continued                                                    | -do-                                       |
| 12.     | 16:45-17:15| How and where should the responsibility for implementation/mainstreaming gender be located | Rekha and Firoza                           |
| 13.     | 17:15-17:30| Summing up and Vote of Thanks                                          | Marc and Rekha                             |
UNFPA WORK ON GENDER MAINSTREAMING

21 April 2011

ORIGIN OF UNFPA WORK ON GENDER

Women’s RH situation

- FP camps very disrespectful to women

- Population programmes used targets & incentives to achieve macro objectives

- Population control in the process women’s bodies abused
**UNFPA response to emerging concerns**

**UNFPA Response**

- Quality of care
  - A woman’s (client’s) perspective
- Men to share the burden of FP
- And why only FP, why not other RH services

**Global ICPD deliberations**

**Pre-ICPD consultations in India**

**Swaminathan Committee recommendations**

<table>
<thead>
<tr>
<th>TIME PERIOD</th>
<th>WHAT</th>
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<tbody>
<tr>
<td>CP 3 (1988-1992)</td>
<td>- Recanalization and standards for sterilization</td>
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<td>- Counseling Training Project</td>
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<td>- SEARCH conference – Redefining population issues</td>
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<td></td>
<td>- 9 elements quality Framework – incl</td>
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<td>- Women’s participation in management</td>
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<td>- Protocols – RTI, Infertility, camps</td>
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<td>- Haryana Women’s Empowerment Project (till CP6)</td>
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<td>CP 5 (1998-2002)</td>
<td>- Population Policy in 5-6 states and formulation of NPP</td>
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<td>- Gender training for health staff – Sirmour workshop+ follow up</td>
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<td>- Support to Gender Issues Project</td>
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<td>- Gender Training for staff – 2 programmes</td>
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<td>- Gender Policy in Gujarat</td>
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<td>- Kerala IPD – GBV intervention + studies</td>
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<td>- Sex ratio work begins</td>
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</table>
### Categories of Gender Work

1. **Policy**
2. **Comprehensive & Quality RH Services**
3. **Mainstreaming in RH Planning**
4. **GBV – Policy, Research, Training & Health Sector Pilots**
5. **Women's Empowerment**
6. **Community Demand for Quality**
7. **Gender in PDS**
8. **ARSH**
### Time Period 1  Policy

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<tr>
<td></td>
<td>- Population Policies – 2 child; NHRC Colloquium; NCW; PRI study, Population Myths, Question Answer/Briefing kit</td>
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<td>- LBSNAA – Briefing on gender sensitive Population policies</td>
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<td>- Gender in Youth policy deliberations</td>
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<tr>
<td></td>
<td>- Bihar Population + Development Policy – chapter on women’s empowerment</td>
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<td>- Dipstick joint study on out of pocket expenses in Orissa</td>
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### Time Period 2  Comprehensive & Quality RH Services

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<td>- 9 element Q Framework – included women’s participation in management</td>
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<td>- Gender training for health staff – ANM/MOs – Himachal – 1 workshop in Mandi</td>
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### Time Period | 2 Comprehensive & Quality RH Services | Contd.. |
|----------------|---------------------------------|---------|
| **CP 6** (2003-2007) | - Gender Training of Health Staff  
  - Gender training of Ministry Officials (2)  
  - NIHFW – Revision of training modules  
  - SIHFW Faculty training @ NIHFW  
  - Instructions to states from MOHFW for RCH II training  
  - Facilitators guide for how to integrate in all health training & Gender Kunji - how to provide client-centered services  
  - Gender in ASHA training; SBA training for ANMs; integration in nursing curricula, contraceptive updates  
  - QOC through Panchayats -pilot in Bawal, Haryana  
  - Study on female condom use  
  - Study on Prolapse, FGM, Fistula  
  - ARSH services – piloting + testing + study | ❚ Gender Training of Health Staff  
  - LBSNAA for health administrators  
  - Gender training of Ministry Officials (2)  
  - NIHFW – Revision of training modules  
  - SIHFW Faculty training @ NIHFW  
  - Instructions to states from MOHFW for RCH II training  
  - Facilitators guide for how to integrate in all health training & Gender Kunji - how to provide client-centered services  
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  - QOC through Panchayats -pilot in Bawal, Haryana  
  - Study on female condom use  
  - Study on Prolapse, FGM, Fistula  
  - ARSH services – piloting + testing + study |
| **CP 7** (2008-2012) | - Gender training of service providers and Programme Managers - Raj, Orissa  
  - ARSH Services  
  - Programming on Female Condoms  
  - Empowering female sex workers – CBOs  
  - Dignity kits in emergency situations  
  - Capacity building for integrating RH + Gender in disaster management  
  - NGOs working on disaster oriented on RH and gender  
  - MISP training - Maharashtra  
  - Conceptualization & integration of ‘gender and equity cell’ within HFW | ❚ Gender training of service providers and Programme Managers - Raj, Orissa  
  - ARSH Services  
  - Programming on Female Condoms  
  - Empowering female sex workers – CBOs  
  - Dignity kits in emergency situations  
  - Capacity building for integrating RH + Gender in disaster management  
  - NGOs working on disaster oriented on RH and gender  
  - MISP training - Maharashtra  
  - Conceptualization & integration of ‘gender and equity cell’ within HFW |

### Time Period | 3 Mainstreaming in RH Planning |
|----------------|--------------------------------|
| **CP 6** (2003-2007) | - In RCH II – defined gender for government programmes – more female workers, demedicalization, cost for women; GBV; Gender training; security of women workers  
  - Guidelines for states on how to integrate gender in PIPs  
  - In some state PIPs – included gender – eg. GBV in Kerala  
  - Checklist for assessing PIPs at national level– used by most states for formulating PIP  
  - Allocation for labour rooms, provision of toilet – as a result of gender checklists  
  - Appreciation of gender elements by program mangers  
  - In RCH District Planning Manual – included gender & community  
  - Vishakha guidelines incorporated state PIP -MP  
  - JRMs – gender examined | ❚ In RCH II – defined gender for government programmes – more female workers, demedicalization, cost for women; GBV; Gender training; security of women workers  
  - Guidelines for states on how to integrate gender in PIPs  
  - In some state PIPs – included gender – eg. GBV in Kerala  
  - Checklist for assessing PIPs at national level– used by most states for formulating PIP  
  - Allocation for labour rooms, provision of toilet – as a result of gender checklists  
  - Appreciation of gender elements by program mangers  
  - In RCH District Planning Manual – included gender & community  
  - Vishakha guidelines incorporated state PIP -MP  
  - JRMs – gender examined |
| **CP 7** (2008-2012) | - Gender examined in RCH II Mid Term Assessment  
  - Gender Tool Kit – “How to” for service providers  
  - Gender consultant in MOHFW  
  - Gender and equity plan in Orissa PIP  
  - Appointment of female FP counsellor – MP, Bihar  
  - Yashodas appointed FP counsellor  
  - Tools and protocols for labour rooms, prescription audit, MCH coordinators of 30 districts oriented on assuring women’s rights in receiving care - Orissa | ❚ Gender examined in RCH II Mid Term Assessment  
  - Gender Tool Kit – “How to” for service providers  
  - Gender consultant in MOHFW  
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<th>4 GBV - Policy, Research, Training &amp; Health Sector Pilots</th>
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</table>
| CP 5 (1998-2002) | - FCCs in hospitals / Police station/NGOs-Help desks in Orissa – police training on addressing GBV  
- GBV incorporated in gender training of health worker  
- GBV part of “Support to Gender Issues” Project  
- Kerala IPD – GBV intervention + studies |
| CP 6 (2003-2007) | - IPD output 6 – GBV as a health issue – FCCs continued  
- “How to” address GBV in health sector–NCW & CHETNA Manual  
- Workshop & Resolution on GBV as health issue – NCW + MOHFW  
- ICRW status paper on violence against women in India  
- GBV module in NFHS 3  
- GBV incorporated in gender training of health workers (includes ASHAs, SBA etc.) |
| CP 7 (2008-2012) | - FCCs leverage into RCH II (minimally), GBV protocols, counselling trg ; to start counselling centres– mahila aayog  
- PRIs & to address GBV – Hunger, PRIA  
- Operationalizing DV Act in 2 districts in MP  
- Population Council paper on Physical & RH consequences of GBV  
- NDMC experiment on “how to” address GBV in a tertiary setting |

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<tr>
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<th>5 Women’s Empowerment</th>
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</table>
| CP 4 (1993-1997) | - Working Women’s Forum  
- Haryana Women’s Empowerment Project (till CP6) |
| CP 5 (1998-2002) | - SEWA project on RH  
- Support to Gender Issues – SGI Project (Includes GBV, Sex Selection, ARSH) |
| CP 7 (2008-2012) | - BBC series Radio drama – Life Gulmohar Style  
- Sapno ko chali Choone in Bihar Colleges  
- Male Involvement for improved RH & gender equality – Maharashtra  
- Gender cells in gujarat and raj  
- Trg of mngos and fngos on gender – Mhs and Orissa |
### 6 Community Demand for Quality

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Activities</th>
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</table>
| **CP 6** (2003-2007) | - Gathering of women panchayat members – rajasthan  
- Joint training AWW, ANMs and PRIs -Rajasthan  
- QOC Project with Panchayats – Bawal/ Haryana (module developed)  
- Jan Samwads – Women’s testimonies on QOC & RR – Raj SCW  
- Women’s groups to demand quality services–IPDs – Output 5  
- Health & gender issues in SIRD Training – PRIs + Faculty – MOPR Project – MP, Maharashtra, Rajasthan  
- Balika Mandalis – Adolescent girls empowerment project – Orissa  
- Kila – PRI training |
| **CP 7** (2008-2012) | - VHSCs work in Orissa & MP  
- Community level action for QA projects – Rajasthan + Maharashtra  
- Women PRIs oriented to address RH & gender – Hunger Project, Bihar  
- Pre Election Voter Awareness Campaign – gender as an election agenda – Rajasthan – PRIA  
- PRIs to address MH, DV & SS – PRIA – Rajasthan  
- Gender & Health integrated in SHG and Sathin-Sanjeevani Training modules – MAVIM, Maharashtra and Rajasthan |

### Gender in PDS

- Gender responsive budgeting – Rajasthan & Gujarat  
- Paper on SRB trends and missing girls’ estimates  
- Study on girl child incentives  
- Training on use of development data – emphasis also on gender data – ISEC/Convergence  
- Ageing studies – inclusion of elderly women  
- NFHS 3 – GBV module, DLHS, fistula

### ARSH

- Population Education -> LSE for Adolescents  
- Gender concerns integrated in all life skills education  
- 50% membership of girls in teen clubs  
- Peer volunteers 50% girls
<table>
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<th>TIME Period</th>
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Counseling Training Project  
Jan mangal (through to present)  
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| **CP 4** (1993-1997) | Research on alternatives to targets  
Pre ICPD Consultations  
Gender training for health staff – HP – 1 workshop  
Move away from Targets  
SEARCH conference – Redefining population issues  
9 elements quality Framework – incl Women’s participation in management  
Protocols – RTI, Infertility, camps  
Working Women’s Forum  
Haryana Women’s Empowerment Project (till CP6) |
How to address gender  
QOC in IPDs – based on 9 elements framework  
Gender training for health staff – Sirmour workshop+ follow up  
Support to Gender Issues Project  
Gender Training for staff – 2 programmes  
LBSNAA-Briefings on Population Policies & RR  
Strategy for male involvement in RH  
SEWA project on RH  
Participatory village workplans based on CNA  
Gender Policy in Gujarat  
Shift from population education to LSE for Adolescents  
Study on injectables  
Gender training of health service provider in IPDs-manuals; 2day training; 1 day integrated in RCH 1 Training  
CNA approach promoted  
FCCs in hospitals / Police station/NGOs-Help desks in Orissa  
GBV incorporated in gender training of health worker  
GBV part of “Support to Gender Issues” Project  
Kerala IPD – GBV intervention + studies  
Sex ratio work begins |
| **CP 6** (2003-2007) | IPDS intense focus – Zoutputs GBV + Community, FCC continued  
Women’s groups to demand quality services–IPDs – Output 5  
LBSNAA – Briefing on gender sensitive Population policies  
Population Policies – 2 child /SSA connect (includes ASHAs, SBA etc.)  
QOC through Panchayats pilot in Bawal/Haryana  
Jan Samwad  
In RCH 2 –gender defined for government  
GBV in NHFS – 3  
Facilitator’s guide for integration in all health training and Gender Kunji circulated by Ministry  
Gender training for health administrators & health staff @ LBSNAA  
SIHFW Faculty training @ NHFW  
Gender training of ministry officials (2)  
NIHFW-Revision of training modules  
Study on Prolapse, FGM, Fistula  
Instructions to states from MOHFW for RCH II training  
Gender in ASHA training; SBA training for ANMs; contraceptive updates  
Study on female condom use  
ARSH services – piloting + testing + study  
Guidelines for states in how to integrate gender in PIPs  
Gender included in some state PIPs eg. GBV in Kerala  
In RCH District Planning Manual – included gender & community  
JRM – gender examined  
GBV incorporated in gender training of health workers (includes ASHAs, SBA etc.)  
Health & gender issues in SIRD Training – PRIs + faculty  
Balika Mandalis – Orissa  
“How to” address GBV in health sector–NCW & CHETNA Manual  
Workshop & Resolution on GBV as health issue – NCW + MOHFW  
ICRW status paper on violence against women in India  
Gender in youth policy deliberations |
| **CP 7** (2008-2012) | Community – PRIs and SHGs; complementary aspect of QA project  
PIPs checklist, Gender Toolkit for how to; Mid Term of RCH  
Bihar Population, Development Policy – chapter on women’s empowerment  
ARSH Services  
Programming on Female Condoms  
Empowering female sex workers – CBOs  
Gender & Health integrated in SHG – Rajasthan & Maharashtra  
FCCs leverage into RCH II (minimally)  
Population Council paper on Physical & RH consequences of GBV  
NDMC experiment on “how to” address GBV in a tertiary setting  
PRIs & community to address GBV-Hunger, PRIA  
Dignity kits in emergency situations  
Gender consultant in MOHFW  
Operationalizing DV Act in 2 districts in MP  
BBC series Radio Drama– Life Gulmohar Style  
Sapno ko chahi Choon in Bihar Colleges  
Male Involvement for women’s empowerment  
VHSCs work in Orissa & MP  
QA projects – Rajasthan + Maharashtra  
Women PRIs– Bihar - Hunger Project  
Voter Awareness Campaign -Rajasthan  
PRIs to address MH, DV & SS –Rajasthan  
Capacity building for integrating RH + gender in disaster management |
Annex 7 - List of Protocols, Tools, Guidelines and Manuals produced during CP 7

Reproductive Health

Maternal Health, capacity building and quality of care
1. Guidelines for antenatal care and skilled attendance at birth by ANMs/LHVs/SNs, April 2010
2. Guidelines for operationalizing SBA training in RCH II, 2008
3. Skilled birth attendance (SBA)- trainers’ guide for conducting training of auxiliary nurse midwives, lady health visitors and staff nurses, 2010
4. Skilled birth attendance (SBA)- a handbook for auxiliary nurse midwives, lady health visitors and staff nurses, 2010
5. Guidelines for accreditation of private health facilities for providing SBA training-reference manual for programme managers on accreditation process, 2009
6. Trainer’s handbook for training of medical officers in pregnancy care and management of common obstetric complications, 2009
7. Trainer’s guide for training of medical officers in pregnancy care, management of common obstetric complications, 2009
8. Workbook for training of medical officers in pregnancy care and management of common obstetric complications, 2009
9. Recommendations of consultation for medical college faculty and district hospital staff on delivery and new born care practices in Rajasthan
10. Checklist for labour room in Orissa, 2010
11. Assessment of training of medical officers in Emergency Obstetric Care including caesarean under NRHM / RCH – II, 2010

Family Planning
12. Sterilization standards (male and female), 2006
15. Guidelines for administration of emergency contraceptive pills and IUDs, 2008
16. Post partum family planning: a manual for service providers
18. Defining Processes to Administer Public Private Partnership framework for Family Planning Services at State Level, 2010

Adolescent Reproductive and Sexual health- strategy formulation and program development
2. Assessment of adolescent reproductive and sexual health services- Maharashtra, 2010

Quality of Care in RCH
1. District quality assurance programme for RH services- an operational manual, 2006
2. Assessment of QA programme in Gujarat State, 2009

RTI/STI/HIV
1. Guidelines for prevention and management of RTIs/STIs in RCH 2, 2007
ASHAs
1. Reading Material for ASHA: Book No. 1, 2005
4. Reading Material for ASHA: Book No. 4—National Health Programmes, AYUSH & Management of Minor Ailments, 2006
6. Guidelines for supportive supervision of ASHAs, 2007
7. Communication kit for ASHAs- FP, 2010

Support for Mother NGO Scheme
1. Training of trainers manual for NMGOs, 2005

Advocacy
1. Gender tool kit, 2010
2. Notes for parliamentarians/legislators on issue of sex selection, 2008
5. Judicial colloquium on PCPNDT Act: Orissa, 2010

Collaborating with Govt
1. Sex selection LBSNAA EMS, 2006
2. Understanding gender and health issues, their implications for girls and women- presentation made to Bharat Scouts and Guides, 2006
3. NHRC full commission briefing on sex ratio at birth, 2010

HIV/AIDS
2. Fact Sheet of west, south, east and central and north zones, 2010 - 2011
3. Presentation on mapping sex workers among Bedia community in MP, 2011

Assessment research reports
1. Reflections on the campaign against sex selection and exploring ways forward- strategies recommended by UNFPA, 2007
2. Special financial incentive schemes for girl child in India- a review of selected schemes, 2011

Population and Development
1. District level population projections in eight selected states of India: 2006-2016, 2009
2. Process note on engendering Census activities, 2010
3. Analysis framework of critical indicators from HMIS, 2010
4. Concurrent assessment of JSY in selected states, 2009
5. Tracking implementation of health programmes at sub-national levels through HMIS data, Presentation made during IASP conference at Bhubaneswar, 2010
6. A study of vital registration system in Rajasthan- report and presentation, 2010

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Annex 8 - Methodology of Composite Ranking of the States on Seven Indicators

A composite rank of the states in India was computed based on the following seven indicators:

1. Female literacy rate, 2011
2. Child sex ratio (0 – 6 age population), 2011
3. Infant mortality rate, 2009
4. Total Fertility Rate, 2008
5. Use of modern methods of family planning, 2005-06
6. Unmet need for family planning, 2005-06
7. Percent of population below poverty line, 2004-05

The data source for the above indicators numbers 1 and 2 is Provisional Population Total of 2011 Census; indicators 3 and 4 are from Sample Registration System; number 4 and 5 are from National Family Health Survey – 3; and indicator number 7 is from Planning Commission.

To obtain a composite rank of each of the 28 states, firstly ranking was done on individual indicators and secondly, the ranks for each state were added to get the sum total of all ranks on seven indicators. For each indicator, states were ranked in such a way as to get the highest rank for the best performing state on that particular indicator. For example, Kerala gets highest rank of 28 on female literacy rate, while Goa gets the highest rank of 28 in terms of having the lowest infant mortality rate. Thus, the highest composite ranking score of a given state could be 196 (28 states x 7 indicators) and minimum could be 7. After getting the composite states, state with minimum composite ranks may be termed as backward and with highest composite ranks may be termed as most advanced.

The table below presents the share of each state in total and below poverty line population along with composite ranks on seven indicators.
## Percentage share of states in total and below poverty line population of India and ranking on seven indicators

<table>
<thead>
<tr>
<th>SL No</th>
<th>States</th>
<th>Total Population (000), 2011</th>
<th>Percentage of India's population</th>
<th>Percent of populatio n below poverty line, 2004-05</th>
<th>Number of persons below poverty line (000)</th>
<th>Percenta ge share of states to India's total below poverty line populati on</th>
<th>Composit e rank based on seven indicator s</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Jharkhand</td>
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