GENDER NORMS AND THE WELLBEING OF WOMEN AND GIRLS IN INDIA: A REVIEW

Shireen J Jejeebhoy

(A report prepared for the United Nations Population Fund)

Gender Norms and the Wellbeing of Women and Girls in India: A Review

Published in 2024

Published by:
United Nations Population Fund (UNFPA)
55 Lodi Estate, New Delhi 110003, India
Tel: +91-11-4632333
E-mail: india.office@unfpa.org

Affiliation
Shireen J Jejeebhoy, Director, Aksha Centre for Equity and Wellbeing, Mumbai; and Distinguished Visiting Faculty, International Institute for Population Sciences, Mumbai, India

Acknowledgements
I am grateful to Sanjay Kumar and Shobhana Boyle, UNFPA, for valuable comments on earlier drafts, and to Shagun Singh for her careful and patient editing of the report.

Contents

01 Introduction

There is growing acknowledgement that economic growth is not sufficient to close wide gender gaps persisting in many countries including India; rather, socio-cultural features, and in particular prevailing social norms about gender, may be equally important in narrowing gaps (see, for example, Jayachandran, 2015; Kabeer and Natali, 2013; Rao Gupta et al., 2019; Bingenheimer, 2019). Indeed, many would agree that gender equality, particularly in education and employment, is far more likely to contribute to economic growth, in comparison to economic growth contributing to gender equality (in terms of health, well-being and rights) (Kabeer and Natali, 2013). At the same time, it is evident that the inability of the health sector to show progress on a range of sexual and reproductive health and rights (SRHR) outcomes underscores the considerable role that gender inequalities and norms play in determining these outcomes (Rao Gupta et al., 2019). These deeply rooted inequalities have impeded progress in various areas in the lives of women and girls, including education, employment, and the realisation of rights.

Social norms have been defined as unwritten rules that determine what is appropriate and acceptable behaviour in any society (Cislaghi and Heise, 2018). Comprising descriptive norms that reflect what others typically do and injunctive norms that define what is deemed acceptable, these norms are reinforced through a combination of sanctions and rewards, encompassing structural, material, social, and individual factors (Costenbader et al., 2019; Heise and Manji, 2016; The Social Norms Learning Collaborative, 2021). Although social norms may differ by socio-cultural setting, several meta-norms have been identified consistently across multiple sectors. These include gender norms, or notions of masculinity and femininity that dictate appropriate roles and rights for men and women, as well as norms defining the authority or power of a particular group over others exercised through the use of strategies of control and violence in relationships and interactions. Social status norms confer or deny respect to certain individuals; privacy norms define what personal information may be shared with others; and protection norms encourage protection from a range of deleterious outcomes (The Social Norms Learning Collaborative, 2021). These meta-norms may vary across cultures and may shift with time, depending on the prevailing strength of patriarchy and the pace of social development in a particular setting.

Key among social norms are those relating to gender ideology. Gender norms comprise commonly accepted social or cultural rules that specify male and female roles and acceptable behaviours, and more generally define male-female power relations (The Social Norms Learning Collaborative, 2021). Particularly in patriarchal contexts such as the one prevalent in India, social and economic life is typically governed by a host of norms that discriminate against women and girls.

Gender norms inhibit women from asserting their rights, exercising agency, and making choices about various aspects of their lives, spanning from marriage and childbearing to freedom of expression and movement. Additionally, these norms

restrict their ability to seize opportunities, including those in education, training, and employment. Indeed, social norms on sexual and reproductive health and socio-economic outcomes are almost always gender norms. Therefore, this paper uses the term 'gender norms' to specifically address these societal standards. In this paper, the term gender norms will be employed in discussions of all discriminatory social norms that are based on notions of masculinity and femininity or reflect male-female power relations.

Gender norms in India have long been skewed in the favour of men, resulting in substantial disadvantages for women and girls. From birth, girls face discrimination and inequality, which limit their agency and opportunities, undermine their health and well-being, and perpetuate poverty and exclusion. However, gender norms are not static. We are interested in understanding the contours of discriminatory norms and identifying pathways through which they may be modified.

Several global indexes that measure gender equality among nations have consistently ranked India low on gender equality, highlighting persistent challenge in attaining gender parity. For example, the Gender Development Index profiles gender inequalities across three key human development indicators -- life expectancy at birth[1], years of schooling expected and attained, and income. It then groups countries according to their cumulative scores. India with a value of 0.84 falls into countries of low equality (United Nations Development Programme (UNDP), 2022). Similarly, UNDP's Women's Empowerment Index[2], which measures women's ability to make choices and leverage opportunities, and the Global Gender Parity Index, that measures the status of women compared to men in terms of key human development indicators both highlight India's sub-optimal performance in terms of female empowerment and gender parity (UNDP and United Nations Entity for Gender Equality and the Empowerment of Women (UN Women, 2023). Also available is the Gender Social Norms Index (GSNI)[3], capturing beliefs relating to gender equality in capabilities and rights over four key dimensions—political, educational, economic and physical integrity. The findings suggest that in India, 99 percent of men and women hold at least one (of 7) gender biases and 86 per cent hold two; moreover, in the area of physical integrity, biases are expressed by as many as 92 percent (UNDP, 2023). These indexes reinforce the need to understand the persistence of biased gender norms and articulate promising practices that may drive change towards achieving gender equality and empowering all women and girls.

1. *GDI measures gender inequalities in the attainment of three basic dimensions of human development: health, measured by female and male life expectancy at birth; education, measured by female and male expected years of schooling for children and female and male mean years of schooling for adults ages 25 years and older; and command over economic resources, measured by female and male estimated earned income (United Nations Development Programme (UNDP, 2022).*
2. *The Women's Empowerment Index is a composite measure covering five dimensions of female empowerment, namely life and good health (two indicators); education, skill-building and knowledge (two indicators); labour and financial inclusion (two indicators); participation in decision-making (three indicators); and freedom from violence (one indicator). A WEI value close to 1 indicates higher empowerment across the five dimensions, and a value close to 0 indicates lower empowerment; India's score is 0.520, placing it among the low achieving countries. The Global Gender Parity Index measures the relative achievements between women and men in four dimensions: life and good health (one indicator); education, skill-building and knowledge (two indicators); labour and financial inclusion (two indicators); and participation in decision-making (three indicators). A GGPI value below 1 means that, on average, women perform worse than men across the four dimensions, and a value above 1 indicates that women perform better than men. India scores 0.560, again placing it among countries with low gender parity.*
3. *The GSNI is calculated using data from the World Values Survey (WVS). It focuses on four dimensions, each characterised by one or two indicators of biases against women: political (women having the same rights as men is essential for democracy, men make better political leaders than women); educational (university is more important for men than women); economic (men should have more right to a job than women; men make better business executives than women; and physical integrity (proxy for intimate partner violence; proxy for reproductive rights).*

02 Objectives

This evidence review will comprehensively synthesise the available evidence concerning social and cultural norms that adversely affect the lives of women and girls in India thereby inhibiting the pace of improvements in their health and wellbeing. In addition, it aims to describe promising practices to overturn these unbalanced norms, as observed in a number of initiatives undertaken globally and in India to accelerate the pace of reductions in the Three Transformative Goals identified by the United Nations Population Fund (UNFPA) (2022-25): ending unmet need for family planning, ending preventable maternal deaths; and ending gender-based violence and harmful practices, such as child marriage and gender biased sex selection, key goals in UNFPA's Strategic Plan, 2022-2025 (UNFPA, 2022).

More specifically, the objectives are:

1. To synthesise the available evidence relating to the ways in which gender norms adversely affect the lives of women and girls in India, including the ways in which they compromise the pace of reductions in unmet need for family planning, in preventable maternal deaths, and in gender-based violence and harmful practices (key goals in UNFPA's Strategic Plan, 2022-2025) and in female agency more generally.
2. To describe promising practices to overturn these unbalanced norms, as observed in a number of initiatives undertaken in India (or other Low and Middle Income Countries (LMIC)) to accelerate norm change in key areas relating to sexual and reproductive health and rights.
3. To briefly highlight gaps in what we know about gender norms and effects on the lives of women and girls in India, and in data needed to measure norms and their effects on the lives of women and girls in these key areas.

03 Synthesis Methodology

This synthesis consolidates evidence from several sources–published, unpublished, reports and so on -- covering the period from the late 1990s to the present. The primary focus is on prevailing norms in India; however, the review incorporates conceptual frameworks, as well as scoping and systematic reviews of evidence, that are broadly relevant. In addition, the review also includes formative research insights and discussions on promising strategies for modifying norms and attitudes.

The search strategy focused on India, employing key terms including social norms, gender norms, and gender attitudes, and outcomes such as education, labour force participation, early, child and forced marriage, agency/autonomy, health seeking and so on. In addition, reports of key international organisations (United Nations Children's Fund (UNICEF), UNFPA, UN Women), non-governmental organisations (NGOs), international NGOs (INGOs), and

academic institutions were consulted as appropriate, such as the International Institute for Population Sciences (IIPS), the Population Council, the International Center for Research on Women (ICRW), the Advancing Learning and Innovation on Gender Norms (ALIGN) network, UNFPA colleagues and others.

This, however, is not a systematic or scoping review. No specific criteria for eligibility or relevance in selecting articles were adopted. A wide net was cast, in terms of methodologies and study designs employed in selected articles. This included strong formative studies, evaluations of interventions, as well as quasi-experimental designs, panel designs, and randomised trials.

04 Conceptual Framework

In patriarchal societies, as in India, kinship systems have traditionally been authoritarian, hierarchical and gendered, with the patriarch exercising control over the socio-economic life of the kin group in ways that reinforce inequities. Within this, gender systems provide the foundation for the roles of women and men, with norms ensuring that power, authority and control rest with men and subordinate women (Harper et al., 2020). Power is exercised over every aspect of life and is perpetuated throughout the life cycle. Norms of masculinity and femininity reflect male superiority and female subordination. They also dictate attributes and behaviours that are considered acceptable for men and women.

Patriarchal kinship systems in India enforce gender inequities through hierarchical norms, perpetuated by socialization and institutions, though development is slowly shifting these power dynamics.

Frameworks employed in the study of norms have typically adhered to the ecological framework and recognise that norms operate at multiple levels (Pulerwitz et al., 2019; Institute for Reproductive Health, 2017; Cislaghi and Heise, 2019; 2019a; Heise, Greene et al., 2019). For example, Cislaghi and Heise (2019) identify four core features in the gender norms discourse. They agree that these norms are transmitted in the process of socialisation, learned in childhood from parents and peers, and reinforced through social institutions such as family, school, workplace, religion and the media. Inequitable gender norms reflect and perpetuate inequitable power relations that are often disadvantageous to women and are embedded in and reproduced through institutions. At the macro-level, policies and regulations, decision-making processes and biases in how institutions function are a reflection of a given gender system and reinforce gender norms at national and community levels. Finally, gender norms are perpetuated through social interaction, as individuals conform to or reject prevailing notions of masculinity and femininity.

One framework (also known as the 'Flower for Sustained Health' model) identifies four domains of influence (institutional, material, social and individual) underlying social change. The individual domain includes age, sex, religion, caste, as well as knowledge, attitudes, beliefs, self-efficacy, skills and aspirations. The social domain includes factors at the family, peer and community levels, such as social support and networks, and exposure to role models and positive deviants, for example. The material or resource domain in this framework includes resources, such as money, land or services, and the institutional domain includes the formal system of rules and regulations (laws, policies or religious rules).

Other terms have also been employed to reflect these domains: agency or individual level and collective attributes, such as knowledge, attitudes, skills, assets and access to services; relations with others, such as expectations, negotiation dynamics embedded within families, communities, groups and organisations; and structural level factors, namely the informal and formal institutional rules that govern individual, collective and institutional practices (Hillenbrand et al., 2015).

The Overseas Development Institute (ODI) and UNFPA guidance note uses a similar framing of the ecological framework model, depicted in the form of concentric circles. The outermost concentric circle illustrates the broader political and social context, policies and laws, as well as mass media influences. At the mesa-level one can find the quality, accessibility and availability of services, the workplace environment, the school environment, the health system and those delivering services. At the community level, norms are conveyed through the affiliations with which one identifies – the village or neighbourhood, neighbours, religious leaders and extended family for example. Exerting more immediate influence on the individual is the family, notably parents, partners and couple relations. The innermost concentric circle represents the individual level, reflecting how the larger context influences individual norms and attitudes, and how the individual either adheres to or rejects the overarching normative structure (ODI and UNFPA, 2022).

The concept of intersectionality, namely, crosscutting forms of advantage and disadvantage (poverty levels, caste, religion etc as well as gender) is also important here. Intersectionality defines which groups are most disadvantaged and which groups wield the most power.

Each domain interacts with others, shaping behaviour. For instance, gender roles and power dynamics may be influenced by intersections between individual, social, material, and structural domains (Cislaghi and Heise, 2019). The concept of intersectionality, namely, crosscutting forms of advantage and disadvantage (poverty levels, caste, religion etc as well as gender) is also important here. Intersectionality defines which groups are most disadvantaged and which groups wield the most power (Heise, Greene et al., 2019).

Norms change at different paces and gender systems dominated by ideas of purity and shame are slowest to shift. They keep women and girls out of the workplace and school and give them a limited voice in making decisions or making choices. Where the chastity of women and girls is synonymous with family honour, fear of censure, gossip or violence can ensure that norm change proceeds slowly at best. Both women and men uphold these unequal norms, but with development, cracks in traditional power hierarchies are becoming visible (Harper et al., 2020).

05 Norms and Influence on Sexual and Reproductive Health and Rights outcomes

Gender norms have both direct and indirect influences. Directly, norms associated with a specific behaviour affect that particular behaviour (For example, a norm that suggests women should remain within the home affects women's freedom of movement). Indirectly, norms specific to other behaviours influence the behavioural outcome of interest (for example, norms dictating that family honour must be carefully guarded, indirectly influencing girls' age of marriage, entry into higher education or the labour force). Using the ODI and UNFPA framework, this section outlines the evidence on gender norms and their influence on the agency of women and girls, and sexual and reproductive health outcomes.

5.1 Institutional domain

The institutional domain includes the political and social context, the broader and formal rules–laws, policies or religious rules that govern the roles and lives of women and men–as well as mass media influences (ODI and UNFPA, 2022). For example, institutional structures and political instability may condition the ways in which available entitlements and services are accessed by women and men. Poverty and inequality compromise people's knowledge of their entitlements, affect their ability to claim these, reinforce subordinate positions for women and girls, and enhance reliance on children (sons) as sources of support. Laws governing social life (for example, right to education, inheritance laws, employment protection), are likely to affect resources for empowerment and female agency, and condition the ways in which sexual and reproductive outcomes are affected. Several studies highlight the ways in which religion–Islam, Christianity, Hinduism–inhibit the exercise of choice, including in reproductive life.

Laws, policies and programmes can both transform norms and improve health, for example, not only influence change in the behaviour they intend to address but also, more indirectly, others that reflect norm change. A review of laws and policies that made primary education compulsory and that provided maternity and paternal leave to women found that these changes not only improved enrolment and utilisation of benefits, but also improved women's and children's health and even women's decision-making agency, thereby reaffirming the need for a multisectoral and multilevel approach (Heymann et al., 2019).

Laws, policies and programmes can both transform norms and improve health, for example, not only influence change in the behaviour they intend to address but also, more indirectly, others that reflect norm change.

India has enacted many laws and policies intended to mitigate adverse outcomes of gender norms that disadvantage women and girls. Inheritance laws have been modified to enable women to inherit family property (Hindu Succession Act, 2005). The Prohibition of Child Marriage Act 2006 (PCMA) applies severe penalties on families and all those with knowledge of child marriage taking place among girls under 18 and boys under 21. Dowry is legally prohibited (Dowry Prohibition Act, 1961). The right to safe abortion has been guaranteed through the Medical Termination of Pregnancy (MTP Act, 1971) and the practice of pre-natal sex determination and selective abortion of female foetuses has been legally sanctioned through the Pre-Conception and Pre-Natal Diagnostic Technique Act (PCPNDT, 1994).

Further, The Right to Education Act (2009) guarantees free and compulsory education to all children up to Class 8. Violence against women and girls is expressly prohibited through laws on violence in the home (Protection of Women from Domestic Violence Act (2005), sexual violence against minors (The Protection of Children from Sexual Offences (POCSO) 2012) and harassment and violence in the workplace (Protection of Women from Sexual Harassment Act, 2013).

While laws have been enacted, what is lacking is implementation. Moreover, the effect laws can have on gender power imbalances has been limited by the persistence of traditional gender norms and the resulting lack of awareness among women about their legal rights, limited skills or support to navigate the system to seek help, and reluctance to invoke the law for fear of backlash from families and communities. Hence for example, despite laws on women's inheritance and property ownership rights, not only do women lack awareness of these laws and the rights but societal norms and attitudes further deter women from demanding or accessing their rights for fear of losing natal family support (Deininger et al., 2010, Roy, 2011, Mookerjee, 2019, Heath and Tan, 2020). Likewise, while 23 percent of Indian women aged 20-24 married as children, and domestic violence is experienced by more than one quarter of married women, just a few of these cases (1,000 and 140,000, respectively) have taken legal recourse (National Crime Records Bureau, 2023). While recent bills propose more stringent laws on rape, marital rape is still not an offence and forced sex within marriage continues to be considered a man's right.

The effect laws can have on gender power imbalances has been limited by the persistence of traditional gender norms and the resulting lack of awareness among women about their legal rights, limited skills or support to navigate the system to seek help, and reluctance to invoke the law for fear of backlash from families and communities.

Political representation of women remains poor at national level and varies at state level. In the current Lok Sabha and Rajya Sabha, just 14 percent and 11 percent, respectively, of seats are held by women (78/543) In contrast, women are well represented at the local level due to the enforcement of the 73rd amendment of the Indian Constitution 1992 (although it came into force only in 1994). Under this amendment, one-third of seats in Panchayati Raj Institutions (PRI) are reserved for women and in 20 states, this proportion has been increased to 50 percent. However, female PRI members have had to grapple with patriarchal norms that question their ability to make sound decisions or assume leadership roles. Additionally, they contend with the dominance of male members in the panchayat who may disregard their voices (Singh, 2018).

The media can also demonstrate positive role models and thereby contribute to changing gender norms. Unfortunately, thus far, the depiction of women in the media has remained traditional. One review highlights that topics such as adverse sex ratios, rape, workplace sexual harassment, dowry-related crimes domestic violence molestation, 'eve-teasing' and honour killings are at best superficially addressed. Rather, the media continues to portray women as subservient and conforming to stereotypes, and actively sensationalises violence and commodifies women. Women who are described as defying traditional norms tend to be characterised negatively, suggesting that the media continues to uphold gender norms (Mishra, 2015). Women are, moreover, under-represented in Indian newsrooms; a recent report reviewing gender disparities across print, digital and broadcast media concludes that irrespective of the medium, men dominate newsrooms.

For example, across newspapers, three in four articles are authored by men. On TV shows, only one in five panellists across prime-time debates in the English category, and one in ten of those in the Hindi category were woman. Half of all debates included only male panellists. Women were far more likely to be represented in human interest and culture and entertainment discussions, and least likely to be represented in discussions about defence, the economy or politics (UN Women, 2019). Social media are also used to perpetuate gender inequalities. A recent study exploring the content of some 30 million tweets posted on Twitter from India during 2018-2021, showed that two percent of these tweets included some form of misogynistic content, most including sexist abuses and sexual objectification, demeaning women and shaming them for their presumed sexual activity (Dehingia et al., 2023).

5.2 Material or resource domain

This domain encompasses the availability of services and transport, infrastructure, and assets, including land and other property, and more generally, the quality, accessibility and availability of services. It includes the workplace environment, the school environment and the health system (ODI and UNFPA, 2022). Evidence from India suggests that despite the expanded availability of schools, health facilities and employment opportunities, services and infrastructure disadvantage women and girls in several ways. For example, the absence of toilets, or toilets for girls can deter girls and women from attending schools and skilling establishments, or accessing the workplace (Adukia, 2017; Gius and Subramanian, 2015). While public transport facilities are available, adverse experience and fears of male harassment inhibit girls from continuing their education outside their home village (Jejeebhoy and Kumar, 2021) thus likely impeding women from taking on employment that requires commuting. At the workplace discrimination may extend to wage disparities and gendered hiring practices.

With regard to access to schools, there is evidence of active or more passive discrimination against girls – teacher attention disproportionately rests with boys, textbooks display stereotypical roles for women and men, and in more subtle ways, teachers may convey that education for girls is unnecessary or that girls are not as intelligent as boys in certain (notably STEM) areas. Teachers lack the skills to use sensitive teaching methods, and are poorly sensitised about, for example, girls' hesitation of speaking in front of boys or male teachers (see Advancing Learning and Innovation on Gender Norms (ALIGN), 2019, for global evidence). Teacher bias and negative stereotypes regarding the limited value of education for girls as well as their limited learning capacity leads teachers to make little effort to engage girls or adapt the classroom teaching in consonance to their learning needs. A school-based study in Bihar showed that classroom dynamics, particularly non-discriminatory treatment by teachers and their expression of gender egalitarian attitudes positively influenced gender role attitudes and awareness of health matters among secondary-school going girls and boys. It also influenced their academic performance (Santhya et al., 2015). Moreover, significant proportions of teachers conform to norms about the need to keep the young ignorant of sexual and reproductive matters, expressing discomfort about imparting sexuality education in the classroom (Nair et al., 2012).

A school-based study in Bihar showed that classroom dynamics, particularly non-discriminatory treatment by teachers and their expression of gender egalitarian attitudes positively influenced gender role attitudes and awareness of health matters among secondary school going girls and boys.

Health systems also have the potential for changing norms by demonstrating patient-centred and respectful services. A review of gender norms and quality care in the health system notes, however, that health systems reinforce patients' traditional gender roles and inequalities. In many countries, women have less authority as health workers than men and are themselves undervalued compared to their male counterparts within health systems. Gender parity in the physician workforce is disproportionate and the paucity of female doctors in the workforce can compromise care seeking among women (Rao Gupta et al., 2019; Hay et al., 2019). Frontline workers, overwhelmingly female, are accorded little prestige and remain poorly compensated. And finally, community mobilisation of women has received very little attention, although self-help groups have achieved remarkable success in enabling better quality interactions between women and health care providers, thus increasing confidence of women in demanding quality services (Hay et al., 2019).

Disrespectful and judgemental health care provider attitudes can inhibit care seeking, with poor quality care and abuse disproportionately experienced by poor and marginalised women, often young women.

Disrespectful and judgemental health care provider attitudes can inhibit care seeking (Rao Gupta et al., 2019), with poor quality care and abuse disproportionately experienced by poor and marginalised women, often young women. Norms denying women the right to participate in health-related decisions can also inhibit care-seeking. Persisting beliefs that women must acquiesce to health care providers as final decision-makers, and the adherence of healthcare providers to traditional gender norms may result, for example, in lack of respectful provider-client interaction, including during delivery (Ansari and Yeravdekar, 2020), brushing off incidents of domestic violence (Jejeebhoy et al. 2017), or shaming unmarried women and girls who seek sexual and reproductive health services (Santhya et al., 2014). Unnecessary harassment of women and girls who seek abortion services through demands for partner or parental consent or making post-abortion contraception a condition for abortion can inhibit safe abortion services (Stillman et al., 2014). Many providers themselves report discomfort in serving the contraceptive or information needs of unmarried girls (Shukla et al., 2022).

5.3 Social Level: Community and family

Community norms regard men as the protector and breadwinner. They are perceived to be intelligent, physically tough, demonstrating sexual prowess, and bearing the right to wield authority and control over women and girls. They are also seen as critical to carry forward the family line and inherit property, as worthy of investment from an early age (feeding, education, training, health care) and at liberty to explore the outside world. Women and girls, in contrast, are considered to be powerless, inferior, weak, helpless, innocent and submissive. They hold no authority (except perhaps the mother-in-law over the daughter-in-law) and must be obedient to their husbands and fathers. The impression is that they are incapable of navigating the outside world without male protection, and therefore their role is confined to the domestic sphere and to reproduction. Failure to produce a child, notably a boy, can severely affect women's security in the marital home.

Norms are reinforced by the community with which one identifies, such as, for example, the village or neighbourhood, neighbours, religious leaders and extended family. *Izzat* or family reputation or honour is sustained at this level and fears of the consequences of transgression ensure conformity with these norms. At community level, consequences of transgression include gossip, ostracism, and even injury and death. Khap panchayats, an extreme example of how communities defend traditional norms, will judge and punish the transgressors and their families, exerting pressure on families and relatives to 'eliminate' the transgressing individual or couple, and on other community members to ostracise their families (Kaur, 2010). Perceived consequences of deviating from community norms result in tight controls on women and girls, as evident from the narrative of the mother of an adolescent girl in Rajasthan:

> ***If she goes [lives]away, [for college/work] and some accident or gadbad [bad incident] happens, like the girl runs away with a boy, or gets murdered, kidnapped, raped, then what? We should not send girls from our family out. Times are not good. You can't send them out alone. You hear nowadays that they run away. So one feels a bit scared. We can't send her…. If a girl goes off with someone and gets married, we will have to hold our heads in shame. Our society will never stop passing comments. I would be afraid of that. In our area, if a girl runs off with a boy (galatkaam), she won't be allowed back home…***
>
> - Jejeebhoy and Kumar, 2021

From a young age, children are socialised to imbibe these norms, to absorb messages and instructions about gender inequality and who has power over whom, what the differences are in how boys and girls, men and women, should behave and who deserves the larger share of family resources (Kagesten et al., 2016). The family in India is a powerful instrument through which traditional unequal gender norms are sustained and norms of masculinity and femininity assign separate and unequal roles to men and women. As reflected in the global literature, gender stereotypes become established early in life, and adherence to gender norms become deeply entrenched (Weber et al., 2019).

From childhood and early adolescence, boys and girls are aware of gender norms. Boys are socialised to be strong and authoritative, to display physical prowess and power and shun feminine or weak behaviour. They are given freedom to make choices and aspire for careers. Traditional masculinity also assigns to men and boys the role of protector, responsible not only for meeting the economic needs of the household, but also for the safety of its women and children, etc. Given their greater freedom, boys transition earlier to a greater reliance on peer influences and interaction and away from the influence of parents and teachers. Notions of masculinity, moreover, encourage boys and young men to exhibit sexual prowess and experience, and other risky practices, such as substance abuse that can hurt boys' physical and psychological well-being, resulting in risky sex and infection, violence and coercion in sexual relations (Joint United Nations Programme on HIV/AIDS, UNAIDS, 2023).

Girls in contrast are brought up to believe they are inferior and must be subservient to boys. They are taught that their exercise of voice, their freedom of movement, and their exposure to the outside world must be restricted. They are considered to be someone else's property (*paraya dhun*), a drain on the natal family economy, unable to contribute economically to the natal family home or provide for parents in old age, and payments of dowry and large wedding-related expenses are perceived to further drain the family's resources.

Opposition to educating girls or delaying their marriage has weakened, and new and positive role models of women and girls in professional careers and non-traditional roles are no longer rare, yet sexuality-related norms and norms relating to female 'purity' remain untended.

Even before birth, norms are at work. Gender-biased, sex-selective abortions that disproportionately disadvantage girls are being carried out, leading to skewed sex ratios at birth. Puberty marks a tightening of controls on girls, as opposed to the loosening of those on boys. Concerns about upholding family *izzat* and associations with female sexuality (and even social mixing with boys) results in parents tightening controls on daughters, keeping them under close supervision and restricting their freedom to make choices, their mobility, as well as their aspirations for their futures – schooling, employment and marriage for example. Interaction between males and females is curtailed, and deviation by women and girls from demure behaviour, family-arranged marriage, virginity before marriage, faithfulness and acquiescence to sex within marriage largely define loss of family honour. Parents ensure that girls are supervised or chaperoned as far as possible, fear of romantic liaisons of daughters are a key motivator of early and family arranged marriage.

Parents believe, moreover, that girls must be kept ignorant of sexual matters; many themselves are embarrassed to discuss physical maturation with their daughters, fearing that information will lead daughters to engage in pre-marital sex (Jejeebhoy and Santhya, 2015).

Gendered behaviour thus emerges even among siblings: within the home, girls remain subservient to their brothers, bringing food to them, washing clothes, and acquiescing to their brothers' judgement on the clothes they wear and the friends with whom they mix (Jejeebhoy et al. 2017). With socioeconomic development some norms are weakening. Opposition to educating girls or delaying their marriage has weakened, and new and positive role models of women and girls in professional careers and non-traditional roles are no longer rare, yet sexuality-related norms and norms relating to female 'purity' remain undented.

Family honour or *izzat* is further dependent on privacy. The patriarch ensures that family discord, including marital strife, does not become public on the one hand, and the family unit is discouraged from intervening in other families' strife on the other – thereby denying women of a support network.

5.4 Individual Level

The individual domain shapes the ways that the larger contextual factors described above influence individual norms and attitudes, and the individual's own adherence to the wider normative structure (ODI and UNFPA, 2022). Conforming to these norms significantly impacts multiple domains of the lives of both women and girls, including their sexual and reproductive health throughout the lifecycle. Notably, women and girls from poor economic backgrounds are particularly disadvantaged.

5.4.1 Attitudes

Norms translate into individual attitudes about what is an acceptable practice for males and females, and are imbibed through the institutional, resource, and social-levels described earlier. Attitudes tend to be based on perceptions of what is 'normal' in one's setting, even among individuals whose personal views may differ. There is a sense that one's own judgements cannot defy local norms, as the consequences of violating these norms would far outweigh the benefits of any expression of individual belief (Heise and Cislaghi, 2016). Perceptions about the views of others and institutions in the society would inhibit women and men from acting on their changed attitudes (Harper et al., 2020). Sexual norms, in particular, are so strongly held that even those who have no objections to adopting new behaviours are culturally restrained from violating traditional norms. Women and girls themselves, as well as others in their environments–parents, brothers, community members, teachers and healthcare providers for example–uphold and reinforce these norms.

Attitudes tend to be based on perceptions of what is 'normal' in one's setting, even among individuals whose personal views may differ.

UNDP's Gender Social Norms Index (GSNI) quantifies biases against women, capturing people's attitudes on women's roles along four key dimensions: political, educational, economic and physical integrity. What is evident from this index is the persistence of inegalitarian gender attitudes espoused by females and males across the world, and particularly in India. While globally, at least one gender bias is held by 87-90 percent of men and women, it is held by virtually all men and women in India (99-100%). The composite gender inequality index ranges from 0.155 in very high human development countries to 0.577 in low human development countries, and 0.487 in developing countries in general and 0.490 in India. India ranks 122nd of 170 countries in this index highlighting the pervasiveness of inegalitarian attitudes in the country (UNDP, 2023).

Table 1 Gender Inequality Index

	India			World		
	Total	Female	Male	Total	Female	Male
Political	68.9	62.0	74.0	61.2	57.3	65.1
Educational	38.5	34.9	41.2	28.1	24.9	31.2
Economic	75.1	67.9	80.4	59.6	54.5	64.7
Physical integrity	92.4	92.4	92.4	74.7	73.4	76.2
At least one bias	99.2	98.9	99.5	88.7	87.4	90.2
At least two biases	86.3	80.7	90.0	70.7	66.5	75.0
Gender Inequality Index	0.490			0.465		
Rank among 170 countries	122			NA		

Source: *UNDP. 2023. Breaking down gender biases: Shifting social norms towards gender equality. UNDP, New York.*
Political: 2 indicators, women have the same rights as men; men make better political leaders than women
Education: 1 indicator, university is more important for men than for women
Economic: 2 indicators, men should have more right to a job than women; men make better business executives than women
Physical integrity: 2 indicators, proxy for intimate partner violence; proxy for reproductive rights
Gender Inequality Index: a composite measure reflecting inequality in achievement between women and men in three dimensions: reproductive health, empowerment and the labour market.

Using Demographic and Health Survey (DHS) data across almost 30 countries (mostly African), one study developed an index comprising agreement with four statements reflecting men's gender role attitudes and found that only in some six countries did men express gender egalitarian attitudes on all four indicators (acceptability of a woman asking her husband/partner to use a condom if he has an STI; abhorrence of perpetration of violence on a wife/partner for any reason; belief that contraception should be jointly determined by women and men; and denial of the attitude that a women who use contraception may be promiscuous) (Starrs et al., 2018).

Evidence from India corroborates the persistence of traditional attitudes. For example, in the National Family Health Survey, just 56 percent of men and 55 percent of women expressed attitudes rejecting men's right to perpetrate wife-beating in any situation. Among men, moreover, 83 percent agreed that a woman is justified in refusing to have sex with her husband if she believes that he has a sexually transmitted disease, 77 percent if she knows that her husband has sex with other women, and 75 percent if she is tired or not in the mood. Just two-thirds agreed in all three situations (International Institute of Population Sciences (IIPS) and (ICF), 2021).

A six-state study exploring adherence to masculinity norms observed that rigid masculinity, defined as weak adherence to egalitarian attitudes and strong adherence to men's role in controlling women, was expressed by two in five men; at the same time, equitable norms were espoused by another two in five. Rigid masculinity varied statewise, from a high of 64 percent in Uttar Pradesh to a low of 23-25 percent in Maharashtra and Rajasthan. It was more likely to be espoused, moreover, by lesser educated and rural men, or those facing economic stress, and was closely linked with son preference and the perpetration of intimate partner violence. Notably, rigid masculinity was more likely to be expressed by those in the youth ages (18-24) than in older ages, highlighting the intergenerational perpetuation of masculinity norms. Women corroborated their experience of male control on behaviour and were considerably less likely than men to express inegalitarian gender role attitudes on several matters. (Nanda et al., 2014).

More evidence comes from three state-representative surveys of adolescents in Bihar, Uttar Pradesh and Jharkhand that explored gender role attitudes among the young (see for example, Santhya et al., 2017a; Santhya et al., 2017b; Jejeebhoy et al., 2019). Findings confirm that attitudes are gendered. For example, considerable proportions of the young condone intimate partner violence, believe decision making about household expenses should rest with the man, and reject a girl's right to express voice in marriage related decisions (Table 2). While differences are narrow, girls appear less likely than boys to hold inegalitarian attitudes, suggesting that boys may be slower in adopting new notions of masculinity and femininity and in holding attitudes that concede power to women and girls.

Table 2 Gender role attitudes among the young, Bihar, Uttar Pradesh and Jharkhand

	Bihar[a]	Uttar Pradesh[b]	Jharkhand[c]
Girls should be allowed to decide when they want to marry			
Boys aged 15-19	53.1	64.7	61.5
Girls aged 15-19	61.1	72.4	79.4
Married girls aged 15-19	57.8	63.9	82.3
Not necessary that father/husband should alone/mainly decide about household spending			
Boys aged 15-19	70.7	82.6	76.5
Girls aged 15-19	87.3	88.5	85.6
Married girls aged 15-19	84.3	89.5	84.7
It is wrong for a man to beat his wife if she doesn't listen to him			
Boys aged 15-19	75.8	82.4	72.6
Girls aged 15-19	79.4	87.9	71.5
Married girls aged 15-19	73.7	76.3	64.7

Source:
a Santhya, Acharya, Pandey, Singh, Rampal, Zavier, Gupta. 2017a.
b Santhya, Acharya, Pandey, Gupta, Rampal, Singh, Zavier. 2017b.
c Jejeebhoy, Raushan, Gupta, Bhattacharya. 2019; in this survey, the age group extends to 21.

With regard to boy-girl mixing and sexual relations, adolescents' attitudes suggest adherence among considerable proportions to traditional norms about social mixing -- almost one-quarter of boys (23-24%), and two fifths of girls (37-40% of the unmarried, 43-44% of the married) believed, for example, that it is wrong for a girl to have male friends (Santhya et al., 2017a; Santhya et al., 2017b). Parents, teachers and care-providers conform to these views, with considerable proportions of parents unwilling to discuss sexual matters with their daughter for fear that they will "go astray" (Jejeebhoy and Santhya, 2014),

Other studies have also confirmed gendered attitudes. For example, in a pre-intervention investigation of a structural and social norms intervention intended to reduce school drop-out and child marriage among socially excluded girls in Karnataka, boys typically did value girls' education, wished to marry an educated girl, supported their sisters' career aspirations and rejected the practice of child marriage for girls. However, on some issues, notions of masculinity and adherence to existing gender hierarchies prevailed. For example, boys described the benefits of girls' education not in terms of empowering girls but rather in terms of better marriage prospects for girls.

Even so, many maintained that while education was important, any blemish on the girl's character, even communication with a boy, could justifiably invite teasing, and would affect the girl's marriageability and soil her family's reputation (Pujar et al., 2023).

Gendered attitudes are expressed even among young adolescents. A study of boys and girls aged 11-13 in poor disadvantaged urban communities in Delhi and Shanghai highlighted that while patterns were similar in both settings, transmission of unequal gender norms was far more stringent in Delhi. In both settings, however, rules about dress and demeanour, including how to behave, extent of freedom of movement, access to education and career expectations were evident already in early adolescence. Opposite-sex interaction was met with violence, especially for girls. While fathers and mothers played a similar role, fathers' more distant interaction with adolescents meant their influence was more muted than that of mothers (Basu et al., 2017).

5.4.2 Aspirations and agency

Patriarchal gender norms and gendered socialisation patterns restrict freedom to make life choices among women and girls, restrict their mobility, household decision-making or engagement with males, and ensure that they play a submissive role in the family. Educational trajectories, careers and indeed, lifestyles are bound by gender norms relating to what is acceptable and what is appropriate to maintain family izzat. Aspirations for the future are compromised and the majority of women and girls are expected to and assume traditional roles. Parents and even brothers enforce these norms (see, for example, Hebert et al., 2020).

Just 71 percent of women make basic decisions concerning their own lives, and this percentage is as low as 51 percent among those aged 15-19. Freedom of movement is similarly curtailed, with just 42 percent of all women reporting freedom to visit selected places; again, the mobility of those aged 15-19 is particularly constrained (26%). Control over resources by way of a bank account is far from universal, with 79 percent of all women and 68 percent of the youngest cohort reporting a bank account that they themselves operate (Table 3). While corresponding indicators are not available for men on all indicators, what is available confirms that far more men have decision-making agency than women (85% of all men, and 70% of those aged 15-19) (IIPS and ICF, 2022).

Table 3 Agency of women, India, NFHS5

	Age 15-19	Age 20-24	All age 15-49
Decision making: Participation in decisions about own health care, major household purchases, and visits to own family	51.0	63.3	71.0
Freedom of movement: Mobility to go to the market, a health facility and outside home village/urban community unescorted	26.1	33.8	42.3
Access to money: Owns and operates a bank account or savings account	68.1	76.1	78.6

Source: *IIPS and ICF, 2022*

Ownership of assets among women aged 15-49 is also limited. While just 42 percent of women own a house, 60 percent of men do so. Women's property ownership is a strong factor enhancing women's agency, specifically in terms of reducing their risk of marital violence (Panda and Agarwal, 2005).

The aspirations of adolescent girls about their own lives – how much to study, what careers to pursue, when and whom to marry, sexual life, childbearing, health seeking, making small and large purchases – are also curtailed by family norms. With regard to education, the state representative surveys of adolescents in Bihar and Uttar Pradesh found that while 68 percent and 74-77 percent of unmarried boys and unmarried girls in Bihar and Uttar Pradesh aspired to gain a college education, just 60-64 percent and 59-62 percent, respectively, of those aged 18-19 had even completed Class 10 (Santhya et al., 2017b). The sparse evidence available suggests that aspirations for careers conform by and large to traditional expectations. For example, in a small study in rural Rajasthan that sought to understand the career aspirations of girls' and the aspirations of parents' for her career, most aspired for female-dominated careers that would be available in the vicinity of their future marital home, or careers did not involve much mixing with men (teachers, beauticians, anganwadi workers and so on). Very few girls believed that careers in the service industry or factory work were acceptable careers for them, and even fewer mothers believed so. Reasons for the lack of acceptability almost always centred around family honour and female sexuality. Fears of girls mixing with men/boys while commuting or at their place of work, of sexual harassment while outside the village, and of community disapproval or gossip were almost always highlighted (Jejeebhoy and Kumar, 2021).

The extent to which parents and families are ready to let go of traditional norms of masculinity and femininity plays an important role in shaping girls' aspirations and agency. There is evidence that parent-child communication on school performance, friendship, and personal issues in adolescence may help delay marriage and girls' engagement in choice of partner. A longitudinal study that followed unmarried girls aged 15-19 in 2015-16 to 2018-19 in Bihar and Uttar Pradesh found that parent-child communication on school performance and personal matters was positively associated with delayed marriage, and discussion on school performance was positively related also with joint parent-girl decision-making with regard to the choice of husband. These findings stress the need to develop interventions that focus on fostering trust and communication between parents and adolescents (Paul et al., 2023).

5.4.3 Feeding/eating practices and health-related outcomes

Feeding and eating practices are also the result of unequal gender norms with intra-household food allocation typically favouring men and boys. Beliefs about men's role requiring strength and nourishment are perceived to entitle them to the lion's share of available food. Women and girls, perceived to be self-sacrificing and submissive result in women eating last as well as least. Women's limited agency and control over resources further limits their ability to purchase nutritious food for the family or seek care; men are the primary breadwinners for the family but may not invest in iron-rich food for the household (Sedlander et al., 2021). Pregnancy among poorly nourished women, and girls physically unprepared for pregnancy may deplete their already compromised supply of micronutrients. Low birth weight, severely malnourished infants, stunting, wasting and underweight children, perpetuate the cycle of malnutrition.

Intra-household feeding norms have contributed to the significant gender disparities observed in anaemia – the NFHS5 reports for example, that 57 percent of women, compared to 25 percent of men, are anaemic (IIPS and ICF, 2022). Even among adolescents, huge disparities have been observed in levels of moderate and severe anaemia, ranging from nine percent among boys to 20 percent among girls in Bihar and Uttar Pradesh (and 24% and 42% respectively for overall anaemia).

5.4.4 Education

Secondary and higher education exposes adolescents to new ideas, diverse peer networks, and improved communication and negotiation skills, empowering them with the self-esteem and confidence to challenge inequitable norms. Change, however, depends on whether the environment is supportive. Unfortunately, the environment is not always encouraging in India.

Secondary and higher education exposes adolescents to new ideas, diverse peer networks, and improved communication and negotiation skills, empowering them with the self-esteem and confidence to challenge inequitable norms. Change, however, depends on whether the environment is supportive.

Gender norms influence the priority that parents place on their sons' education as compared to their daughters'. Education is valued for boys for its better career prospects and the prestige and old age support this brings; education for girls is valued for its role in attracting a better marriage, and by fewer parents, for its career opportunities for girls. Yet parents fear that educated daughters will require payment of a larger dowry, may be more difficult to control than others, and may be more at risk of violating pre-marital chastity norms. While gender disparities in school and college enrolment, previously observed, have narrowed considerably, and even disappeared in some settings, intersections between gender norms and poverty and social disadvantage can still deny certain groups access to education (see, for example, John, 2018).

Even so, as seen earlier, fewer girls than boys have opportunities to attend college, and girls who are enrolled in higher education are more likely to undertake correspondence courses and attend facilities close to home, and less likely to opt for a STEM course (Jejeebhoy and Kumar, 2021).

Fewer girls than boys attend higher quality schools attracting larger fees, receive after-school private coaching, or have access to digital devices for online classes; more school-going girls are expected to also contribute to household chores, offering less time potentially to do homework.

School-going girls may be more likely to face negative teacher attitudes, and receive less attention from teachers than boys (Santhya et al., 2015). Outcomes of gendered investment in education is evident from findings of state-wide surveys of adolescents that show that while learning outcomes are poor for both girls and boys, wide gender discrepancies persist, with more boys than girls displaying numeracy skills (Das and Singhal, 2023).

5.4.5 Skilling and labour force participation

Adherence to traditional gender norms also restricts girls' and women's ability to participate in the workforce, access skilling opportunities or pursue a career. Norms not only limit the earning potential and economic independence of women and girls, but also reinforce the idea that women's place is in the home, that work is inconsistent with their care responsibilities, that women cannot contribute to the household economy and that they must remain dependent on men. Time-use studies demonstrate that domestic responsibilities continue to fall entirely on women, with men reluctant to relinquish their perceived entitlement to refrain from housework responsibilities. Norms about the primacy of family honour also raise fears about loss of reputation if women workers mix or develop relations with men in the workplace or while commuting to the workplace, or face violence while using public transport. As a result, occupational preferences are typically gendered. Girls and young women opt for training opportunities close to home, and for skills that will enable "acceptable" careers, and boys and young men opt for skills that have real market opportunities (see, for example, Santhya et al., 2017a; Santhya et al., 2017b; Jejeebhoy and Kumar, 2021).

Norms not only limit the earning potential and economic independence of women and girls, but also reinforce the idea that women's place is in the home, that work is inconsistent with their care responsibilities.

Constraints on female participation in skill training and market related occupations include an interplay of norms and structural factors that contribute to the wide gender gaps in skill training and job placement. These vary from limited physical access to training facilities due to distance and lack of transportation, to harassment in public transportation, absence of functional toilets and female trainers in training institutions, lack of digital literacy and difficulty with tech-based registration, gender stereotyping in the choice of occupations offered to young women, and marriage as precipitating dropout. At the same time, structural obstacles such as, employer unwillingness to invest in women's safety and fears about women's irregularity in the workplace as a result of the demands of family and motherhood can also deter women's work (Ernst &Young commissioned by Ministry of Micro, Small & Medium Enterprises, MSDME, 2019). Women working in male dominated sectors, and even their husbands often face serious disapproval, gossip and so on for violating norms. Moreover, shocks and crises such as the Covid pandemic have reinforced gender stereotypical roles and reduced employment opportunities for women. During the Covid crisis, for example, women and especially young women were most likely to drop out of the labour force, and least likely to re-enter it (Abraham et al., 2021).

Gender norms and preference for a non-working wife can also influence the marital preferences of men (Afridi et al., 2023). A study conducted on an online marriage platform noted associations between gender norms, partner preferences, and women's employment. Employed women were 15 percent less likely to receive interest from male suitors than women who were not working, and women working in masculine occupations (in which men are also engaged) were less likely to elicit interest from men than those in 'feminine' occupations (dominated by women, such as teachers etc) (Afridi et al., 2023).

Wide gender disparities persist in labour force participation. For example, the Periodic Labour Force Survey shows that female labour force participation is amongst the lowest in the world in India. Just 37 percent of all women aged 15 years or more and 25 percent of young women (15-29) (compared to 79% and 64%, respectively, of men) are engaged in the labour force and there are no signs of these percentages increasing (Ministry of Statistics and Programme Implementation, 2023). Gender disparities in percentages of youth aged 15-24 not education, employment, or training (NEET), moreover, varied significantly. For young men, the NEET rate stood at 11 percent, whereas among young women in the same age range, it surged to 42 percent (International Labour Organisation (ILO), 2023). A sub-national survey (12 states) of students enrolled in Industrial Training Institutes (ITI) found that females comprised a mere 21 percent of the student body and were concentrated largely in non-engineering trades. Obstacles to female enrolment and choice of programme were both infrastructural (lack of transportation, harassment, lack of toilet facilities, limited career guidance, counselling and soft skill training) and normative (reluctance of parents to permit girls to attend institutions, gender stereotyping in the skills encouraged by faculty, withdrawal from training because of marriage and/or the dual burden of training and household responsibilities, and the unwillingness of families to invest in training fees for girls, Ernst and Young LLP, 2020).

5.4.6 Digital Divide: access to media including digital technology

Fewer women and girls than men and boys own mobile phones or access social media, denying them both information and peer networks

In terms of media access, women and girls exhibit a notable presence in television viewership. However, their access to print media and digital technology remains restricted (IIPS and ICF, 2022). Fewer women and girls than men and boys own mobile phones or access social media, denying them both information and peer networks. For example, although 93 percent of households possess a mobile phone, just 54 percent of women in India own one (IIPS and ICF, 2021). Hierarchical gender norms severely curtail the access of girls to digital technology and exacerbate the digital divide between boys and girls. Fears are expressed that access to mobile phones leads girls astray, offers them opportunities to engage in relations with boys, and so forth. In Bihar and Uttar Pradesh, for example, among adolescents aged 15-19, just 7-9 percent of unmarried girls and 33-37 percent of married girls owned mobile phones, compared to 55-57 percent of unmarried boys.

Furthermore, there is a notable contrast in social media usage, with only 7-12 percent of unmarried girls and 4-7 percent of married girls accessing social media, compared to 39-42 percent of boys (Santhya et al., 2017a; Santhya et al., 2017b). While there is evidence that young people are exposed to misinformation and negative sexual images through various kinds of media, further analysis of the state-representative surveys in Bihar and Uttar Pradesh highlights the positive effect of digital access, and reveals an encouraging association between access to social media and knowledge of sex and contraception (Saha et al., 2022).

5.4.7 Growing up and entry into sexual life

Sexuality related taboos persist. For example, menstruation is stigmatised, women and girls are often perceived as impure and unclean during this natural process. Many women and girls are isolated, excluded from family activities, forbidden from entering the kitchen or engaging in specific tasks like preparing pickles and papad (Jejeebhoy et al., 2019; McGammon et al., 2020; Chandra Mouli and Patel, 2017). Menarche marks the end of childhood for many girls, and new behaviours are initiated–it is no longer appropriate for them to play outdoors, their behaviour must be demure and they must moderate how they express themselves (Santhya and Jejeebhoy, 2015; McGammon et al., 2020).

Sexuality related norms inhibit open discussion of sexual and reproductive matters. Parents are embarrassed about discussing physical maturation or preparing their daughters for menstruation (Jejeebhoy and Santhya, 2015). As a result, adolescents are rarely informed about menstruation and lack opportunities to discuss or understand the links of menstruation and pregnancy. Many girls experience shock when menstruation first occurs. In school, girls may face teasing and ridicule if their skirts are stained, and many avoid school during their periods. Girls are shy to disclose menstruation related health problems, compromising healthcare seeking (Gundi and Subramanyam, 2019). Boys have little or no awareness of menstruation. A mixed-method study of boys and girls, and adult key informants in Nashik district confirmed that boys were typically excluded from any discussion of menstruation, perpetuating gendered attitudes about menstrual health. Girls from families that adhered to stigmatising women and girls during menstruation tended to have poorer menstrual health, thus perpetuating health inequalities from an early age (Bhan et al., 2020).

Girls from families that adhered to stigmatising women and girls during menstruation tended to have poorer menstrual health, thus perpetuating health inequalities from an early age

Entry into sexual life in India takes place largely within the context of marriage; although child marriage has significantly reduced (IIPS and ICF, 2021). Child, early and arranged marriage is considered part of the cultural fabric and critical to a person's group identity and acceptance in a community. The practice continues because the majority accepts traditional norms, believe that others practice it, and fears that deviation will attract community sanctions. Norms relating to parental responsibilities, for example, entitle parents–patriarchs–to fix a suitable marriage for their daughter. Marrying a daughter is perceived to be a religious obligation of parents, and a decision that the girl should simply obey (Greene and Stiefvater, 2019; Karve, 1965). Early marriage is seen as a means of preserving the sexual purity of girls; and securing a family's honour or izzat. Child brides are preferred, because they are more malleable and more likely to be virgins. Well-educated girls, on the contrary, may attract larger dowries, making it more challenging to find a suitable match. (see, for example, Hebert, Bansal, Lee, Yan, 2020). Fears of threats to young women's 'purity' before marriage results in girls

being closely guarded, with limits placed on their mobility, social interactions and access to education (see, for example, Basu et al., 2017). These norms are so strongly held that even parents who understand the importance of delaying marriage for their daughters argue thus:

> ***"Everyone knows that getting married at an early age is bad. But even then, everyone does it…People are scared to violate this custom…. They will be despised by the community."***
>
> - Santhya et al., 2006

These marriage related norms have also cemented the practice of marriage without consent, and without the girl–and sometimes the boy–playing a role in marriage related decision-making. Even today, over one-third of married girls have never been consulted in the decision regarding their husband-to-be, about two in five were consulted, fewer than ten percent make the decision on their own, and more than two-thirds met their husband for the very first time at the wedding ceremony (Allendorf and Pandian, 2016). That large proportions meet their husband for the first time at the wedding raises questions about whether young women who reported their involvement in selecting their husbands were given an opportunity to make an informed decision. Some may have provided consent on the basis of a photographs or information about the family background, without an opportunity to become acquainted with the future husband without a chaperone present (Jejeebhoy and Kumar, 2022).

Child marriage and marriage without consent have clear consequences for girls' married lives. Although those who marry in childhood are likely from more disadvantaged sub-populations than others, child marriage diminishes the likelihood of school completion and access to skilled employment, accelerates the process of childbearing, and likely compromises girls' agency in married life including in decisions relating to health care seeking, pregnancy and contraception. Likewise, marriage without meaningful consent can affect the quality of married life, and compromise young women's agency and voice in the marital home (Jejeebhoy and Raushan, 2022), and even exacerbate experience of depressive symptoms after marriage (Zahra et al., 2021).

In addition, dowry prevalence is associated with increased poor self-rated health among women, reinforcing perhaps the link between the payment of dowry and women's powerlessness and subordinate status in the marital home (Stroope et al., 2020). Signs of change have, however, been documented. In the study in Haryana and Maharashtra discussed earlier, many parents feared separation and divorce of their daughters and thus tried to ensure, as much as possible, compatibility between the couple (John, 2018).

While pre-marital sex, or even the formation of a romantic relationships among girls is deeply feared, stigmatised and censured, pre-marital sex among boys is tolerated. A sub-national study of youth in India in 2006-07 observed, for example, that just four percent of young women and 15 percent of young men had engaged in pre-marital sexual relations (IIPS and Population Council, 2010); more recently, state-representative surveys in Bihar and Uttar Pradesh in 2015-16 reported similar percentages: 14-17 percent among boys, six percent of unmarried girls, and 6-10 percent of married girls aged 15-19 (Santhya et al., 2017a; Santhya et al., 2017b). Parents, teachers and care-providers conform to these views, with considerable proportions of parents unwilling to discuss sexual matters with their daughter for fear that they will "go astray" (Jejeebhoy and Santhya, 2015).

5.4.8 Maternal health and health care

Although fertility at ages below 20 has fallen considerably over time (from 42% in 2005-06 to 23% in 2019-21, IIPS and ICF, 2021), fertility is highly prized, signifying both a man's virility and a woman's ability to discharge a key responsibility. Infertility is deeply dreaded, and viewed as the women's failure to discharge a key duty, and precipitates gossip, violence, even divorce or taking on a second wife. Once married, pregnancy is expected to follow swiftly and even newly married girls and young women – and even their husbands–who desire to delay pregnancy, fear violating these norms and being labelled infertile (see for example, Barua and Kurz, 2001).

Infertility is deeply dreaded, and viewed as the women's failure to discharge a key duty, and precipitates gossip, violence, even divorce or taking on a second wife.

Even though fertility is prized, pregnancy is considered a 'normal' event and unworthy of special care. As recently as 2019-2021, 11 percent of women in India had delivered their last baby outside of a facility, 41 percent had received fewer than the recommended four antenatal care visits, and 16 percent received no postpartum care. While studies are relatively sparse, what is available does suggest that gender norms likely contribute to the less than universal pregnancy related care prevailing in the country. In Madhya Pradesh, for example, women experiencing inegalitarian relations with family elders, or with their husband were less likely to access antenatal care and deliver in a health facility (Allendorf, 2010). Reluctance to seek pregnancy-related care from a male provider may also inhibit care-seeking; a district level study notes that those districts with a female doctor were significantly more likely than others to report skilled birth attendance and postpartum care (Bhan et al., 2020). Mistreatment and disrespectful and abusive maternity care of women during childbirth may also inhibit facility-level delivery. A systematic review suggests that this is particularly so among poorly educated women, those expressing limited agency and those from poorer households (Jungari et al., 2021).

At the individual level, embarrassment and feelings of shame may inhibit women from even voicing problems or their need to seek care, preventing timely or any care at all. Gender power differences mean moreover that women are denied decision-making power about care seeking, and lack the physical mobility and control over money to ensure good sexual and reproductive health for themselves. At family level, initiative to ensure care for women may not be taken, and families may be less likely to support women when they are ill as compared to other family members. This lack of support can extend even to pregnancy-related and post-partum care (see, for example, Barua and Kurz, 2001). At facility level, provision of services may be affected – access to appropriate care can be limited, and women may experience judgemental provider attitudes.

5.4.9 Contraception and unmet need for family planning

As of today, 67 percent of married women aged 15-49 practise contraception, with 56 percent opting for modern methods. Notably, 82 percent of modern method users are female. However, there remains a notable unmet need for contraception, with 9 percent of all married women and 17-18 percent of those aged 15-24 lacking access to contraception despite a desire to limit or delay childbearing (IIPS and ICF, 2021). For example, one study conducted in six Indian states among women aged 15-24 who were married for five or fewer years, confirms considerable demand for contraception to postpone first pregnancy (51 percent), but very limited practice of contraception (10%), concentrated among the more advantaged women (educated, aware of family planning methods and exposed to sexuality education before marriage, participated in marriage-related decision making). Women who reported feeling pressure to prove their fertility were less likely to have practised contraception (Jejeebhoy et al., 2014). Moreover, a strong preference for a male child means that if the first birth is a female, contraception may not be practised to delay the second, resulting in short birth intervals that take a toll on women's, and especially adolescents' health and raise chances of poor birth outcomes.

Spousal discussion about contraception is likewise inhibited by norms associating sexual matters with shame and embarrassment. Moreover, women's limited power in marital life results in many women never discussing with their husband whether to practise contraception, which method to use, or indeed, preferred number and timing of pregnancies. Contraceptive decision-making rests with the husband in many cases, thus the husband's disapproval is a leading reason underlying lack of contraception among married girls with unmet need (33% in Uttar Pradesh, 20% in Bihar, Santhya et al., 2017b; Santhya et al., 2017). Judgemental provider attitudes, moreover, can discourage contraception among the unmarried; a study in which mystery clients enacted an unmarried girl aged 17 seeking oral contraceptives reported judgemental provider attitudes:

> ***He (The doctor) told me that it is wrong to engage in sex before marriage. He said that I could take the emergency contraceptive pill (ECP) after sex, but it is dangerous, that is, it can cause more bleeding and difficulty in conceiving (in future). He said that he cannot give me oral pills because of their side effects…. And my life will be ruined if my partner refuses to marry me (if I become pregnant)***
>
> - (Santhya et al., 2014).

5.4.10 Son preference, daughter aversion, gender biased sex selection and skewed sex ratios at birth

Although the small family size norm has proliferated through India, the preference for sons has not diminished substantially. For example, nationally, sixty-five percent of currently married women aged 15-49 with two living daughters and no sons want no more children, compared with 91 percent with two sons and no daughters. The pattern is similar for men (66% versus 90%) (IIPS and ICF, 2022). A more in-depth study in Haryana and Maharashtra found that while most people want one son and one daughter, daughter aversion or reluctance to have a daughter-only family is widespread, especially in Haryana (John, 2018). Those with just daughters appeared resigned to their fate, or continue childbearing; in these cases, it is evident that more girls are born than are desired, with likely adverse consequences for their education and marriage. There was, however, some breakdown of the norm rejecting support from a daughter, with many alluding to the caring daughter and wayward son who would not live up to expectations of a son, suggesting cracks are appearing in the intergenerational contract that assumed that reliance on sons for parents in old age would persist:

> ***Daughters are better than boys. … boys are more burdensome because we would have to construct a house for him and he might still throw us out when we are old***
>
> (John, 2018).

While a two-child norm has been widely imbibed, the importance of having at least one son has not abated, but has become adapted to suit the proliferation of the two-child norm. Historically, the son preference norm would be manifested in post-birth disparities in feeding and health care patterns that raised the mortality of daughters as compared to sons and resulted in unbalanced child sex ratios in favour of boys over girls. Since the 1980s, families have adopted new ways of ensuring the birth of at least one son. With the increasing availability of prenatal diagnostic techniques, post-birth discrimination has been replaced by pre-natal gender-biased sex selection, and skewed sex ratios at birth – most recent estimates suggest that the sex ratio at birth is 923 female births per 1,000 male births or ~108 male births per 100 female births (UNFPA, 2020), far beyond the normal ratio of 952 female births per 1,000 male births (or 105 male births per 100 female births).

These distortions in the sex ratio at birth are attributed to the convergence of three interlinked factors, namely, the persistence of patriarchal norms and inegalitarian gender roles and consequent strong son preference, fertility decline and declining family size preferences, and technological advances that permit the detection of the sex of the foetus (Guilmoto, 2011). Although the PCPNDT Act criminalises the disclosure of the sex of the foetus, there is evidence of the persistence of discrete ways in which providers do convey this information to families (Jejeebhoy, Basu, Acharya, Zavier, 2015). Surveys have confirmed wide awareness of the PCPNDT Act, a reluctance among women to admit that anyone in their neighbourhood or they themselves have undergone a sex-selective abortion; although in several instances, family composition hints of a general preference for sons and an avoidance of families with just daughters (John, 2018).

5.4.11 Unintended pregnancy, abortion care

Gender norms play a role in abortion-seeking women resorting to unregistered providers. Premarital sex and pregnancy are highly stigmatised at family, community and system levels and can have huge social costs for unmarried girls and young women (Makleff et al., 2019). Among the unmarried, norms relating to the importance of pre-marital virginity result in girls not only hiding their sexual relationships, but also their pregnancies from family members. Many unmarried women who become pregnant lack awareness about the link between menstruation and pregnancy resulting in a delay in seeking termination. Once they recognise that they are pregnant, many are unaware of where or from whom to seek help. They lack partner or family support, prioritise confidentiality in choosing the facility for abortion services, opt for a faraway facility, make at least one unsuccessful previous attempt to abort, and delay seeking services (Jejeebhoy et al., 2010). Even among women who are married, pro-fertility norms and related perceptions of stigmatisation may result in clandestine terminations or medication abortion that is purchased directly from chemists and other unauthorised sources (Makleff et al., 2019). Fear of community disapproval, judgemental attitudes and negative behavioural reactions, including ostracism, gossip, loss of honour to the family, can adversely affect women's and girls' abortion practices, delaying the decision to undergo abortion, affecting the timing of abortion, or driving abortion-seekers to a less safe provider or facility.

Many unmarried women who become pregnant lack awareness about the link between menstruation and pregnancy resulting in a delay in seeking termination. Once they recognise that they are pregnant, many are unaware of where or from whom to seek help.

Providers adhere to traditional norms, and may be unwilling to offer services or offer judgemental treatment to the marginalised – young, unmarried, poor, for example (Sjostrom et al., 2014). They may demand written consent from the husband or guardians (Jejeebhoy et al., 2010) and even deny abortion services to those unable or unwilling to provide consent (Shekhar et al., 2020). A mystery client study in Madhya Pradesh found that pharmacists were more likely to provide correct and comprehensive information relating to medication abortion to men than women seeking to purchase supplies without a prescription; they were least likely to offer information to unmarried young women, reflecting their own biases and discomfort about conveying information relating to sexual matters (Percher et al., 2021).

5.4.12 Violence within and outside the home

Gender power imbalances also justify men's entitlement to perpetrate violence on their wives and partners. Both women and men accept marital violence as a husband's right (44-45%) and believe it is acceptable for a host of reasons, including going out without permission, disobeying the husband's orders or disrespecting him or his parents or refusing sex. Norms of masculinity dictate that women may not refuse their husband's sexual demands, that engaging in marital sex is a man's right and that women have no say in the matter (Ravindran and Balasubranian, 2004). In a qualitative study conducted in Bihar, many women concurred about the acceptability of wife-beating:

> ***If the wife does not obey her husband, he will get angry and it will lead to hitting. She should be beaten because the husband hits his wife only when she makes a mistake such as not obeying (his instructions) or not giving him food etc on time; and, sometimes, there are certain situations in which a husband has to beat his wife. If I am living with my parents and my wife abuses my mother, and I slap her twice or thrice for doing so, there is nothing wrong in it…… it doesn't matter if they (husbands) slap them (their wife) once or twice….if they (wives) have done any mistake then they (their husband) can slap them…. it is the husband's right to slap her (the wife) if she has made a mistake.***
>
> (Jejeebhoy et al., 2013).

Violence perpetrated by the husband or partner is experienced by more than one-quarter (29%) of women and controlling behaviour by almost half (46%). Forced sex is also prevalent, with six percent of women reporting the experience (IIPS and ICF, 2021). Most women who have suffered marital/intimate partner violence (77%) neither seek help nor disclose the incident to anyone (IIPS and ICF, 2021). This silence about the violence they have experienced reflects deeply entrenched gender norms, including a widespread belief that they deserve the violence because it was their transgression that resulted in that outcome. This is further enabled by the widespread belief that personal matters should not be disclosed to others. As a result, women do not reveal their experiences even to family or friends and only a small minority seek help from a formal provider (healthcare provider, helpline, police or members of the judiciary).

Outside the home too, norms surrounding masculinity condone sexual harassment, teasing and even violence on women and girls who venture out in public without a suitable escort, and are perceived to have defied traditional gender norms about women's freedom of movement. In a qualitative study of adolescents in Lucknow, for example, girls documented their experiences of unwanted sexual touch while using public transport, or verbal harassment and teasing in school (Hebert et al., 2020). In rural Rajasthan, parents refused to allow their daughters to travel by public transport for fear of harassment, preferring to purchase a scooter for daughters attending college (Jejeebhoy and Kumar, 2021).

In Delhi, over the course of their lives, almost all young women (92%) had experienced at least one form of harassment – mostly verbal but also unwanted touch, stalking and flashing. More than half of young men reported perpetrating harassment and violence on women and girls in public places, mostly verbal harassment and obscene gestures, but also unwanted touch, stalking, flashing and assault. Many justified their action arguing that their victims had provoked them by their dress etc, or just by being out unescorted. While more than three in four young men had witnessed an incident of harassment or violence in a public place, few took action, believing the incident was 'none of their business' (UN Women and ICRW, 2013).

06 Backlash and Stigma

Non-conformity and transgression of gender norms can trigger harmful sanctions (Weber et al., 2019). Any expression of agency is perceived as a violation of traditional norms and repercussions are significant–for example, expediting an early marriage among girls, loss of reputation or ostracism of families (Naved et al., 2022). Women and girls may hesitate to seek contraception or abortion without parental or husband's consent, leading to many adopting contraception clandestinely. At the same time, the unmarried may hesitate to seek facility services for fear that they will be recognised and face community censure and backlash. There is, moreover, ample evidence of backlash by normative forces against young couples opting for a cross-cultural relationship or marriage (*love-jihad*).

Unfortunately, in India, research on backlash against expressions of agency is sparse. One recent study of more than 100 youth serving organisations suggests that 85 percent of responding organisations were familiar with at least one incident of backlash against girls who displayed agency or defied traditional gender norms. Half recounted incidents in which a girl was refused permission to participate in outdoor sports for fear of adverse reactions from the community or likely teasing from boys. More than half reported familiarity with an incident in which a girl was beaten or denied food for refusing to marry against her will or for making attempts to gain livelihood skills or pursue a career. More than half were aware of a girl who had experienced sexual harassment on her way to school and was subsequently withdrawn from school by her parents who feared loss of family honour. About half were familiar with an incident in which a girl was forced to discontinue her education because she was friendly with a boy. Organisations themselves experienced backlash for conducting programmes aimed to empower girls – a third were forced to modify programme content (eg. drop modules on sensitive topics such as sexual health or child marriage) and more than half were denied entry into communities, or their field level programme implementers had faced threats, verbal abuse and even physical violence for implementing empowerment programs (Dasra, 2020).

07 Strategies to Transform Gender Norms

Gender norm interventions and strategies are intended to enable communities to challenge existing norms and arrive at gender transformative change. Normative change interventions are, in practice sparse, and what is available tends to focus on individual behaviours and narrowing gender power gaps at individual level rather than broader community or system level inequality.

Several multi-country systematic, scoping and evidence reviews have been undertaken that assimilate available evidence from various interventions that have shown promise in modifying gender norms. For example, a systematic review of 71 interventions addressing violence against women and sexual and reproductive health observed that 55 reported statistically significant or mixed outcomes; promising interventions aimed to change participant attitudes and awareness of gender stereotypes or norms, strengthening peer engagement, developing agents of change, using role models, and co-designing interventions with participants or target populations (Stewart et al., 2021). A global systematic review from 59 programme evaluations that focused on the health and wellbeing of children, adolescents, and young adults found that successful programmes most frequently focused on improving the individual power of the beneficiaries, rather than working on broader systems of inequality. While 45 evaluations showed significant improvements in health-related and gender-related indicators, only 10 showed evidence of, or potential for, broader norm change and these worked with sectors beyond health, included multiple stakeholders, implemented diversified strategies, and fostered critical awareness and participation among affected community members (Levy et al., 2020). Also, a scoping review found positive effects of norm change interventions (mostly directed at girls and young women) on delaying marriage and/or childbearing in over half of the studies reviewed; authors caution that attribution of effects to normative change components is difficult to establish (Santhya, Dayal, Jena, Rampal, 2021).

Key promising interventions, for example, keeping girls in school, cash transfers, life skills education, community mobilisation and so on, have been shown to have effects on multiple outcomes. Among those conducted in India, many showed mixed findings – for instance, not all displayed positive effects on agency, and not all measures of agency were positively affected in the same study. Moreover, almost all programmes have been multi-component, making it difficult to disentangle the unique effects of gender norm components. Finally, questions remain about the quality of intervention delivery, duration of the intervention, fidelity and regularity of exposure.

7.1 Ensuring schooling for all

A quality and accessible education system is fundamental for transforming patriarchal gender norms. Education exposes girls to the outside world of new ideas and rapidly changing opportunities, supporting them to challenge patriarchal norms and adopt new practices, including with regard to sexual and reproductive outcomes.

7.1.1 Encouraging quality secondary/higher education

A secondary or post-secondary education has multiple positive outcomes – exposure to new knowledge and ideas, expanded social networks, as well as communication, negotiation and market skills, and good health practices. The better educated are also more likely to hold egalitarian gender norms, express agency, participate in marriage related decisions, be aware of their rights and entitlements, and have the livelihood skills to access paid work opportunities. Certainly, there is considerable evidence demonstrating the effect of education on reproductive health outcomes, including contraception, pregnancy care, and access to services (see IIPS and ICF, 2021; Jejeebhoy and Santhya, 2023). However, simple exposure is not sufficient. Proactive efforts are required to ensure that girls are not only enrolled, but also attend school regularly, that they find curricula interesting and useful. Parent-level norms also need to be transformed, so that their concerns about the relevance of education for girls are abated, and they are sensitised to support higher education for their daughters. Infrastructure lacunae must also be addressed – ensuring physical accessibility to schools and safety in public transportation, making toilets available for girls, addressing gender biases of teachers, or providing supplementary coaching to disadvantaged students. Classroom interaction cannot be gendered and stereotyped, curricula and teaching materials must be responsive to the unique needs of girls and career counselling that equips young people with a direction and the self-confidence to aspire for and take advantage of new opportunities must be made available (Advancing Learning and Innovation on Gender Norms (ALIGN), 2019; Harris et al., 2023).

The better educated are also more likely to hold egalitarian gender norms, express agency, participate in marriage related decisions, be aware of their rights and entitlements, and have the livelihood skills to access paid work opportunities.

A modelling exercise evaluating interventions to reduce child marriage in India estimated the costs and benefits of investing in two types of interventions. Both included measures to keep girls in school. First, education interventions, were those essentially supply-side interventions that aimed to make education more attractive (closer, more girl-friendly schools with better-trained teachers). Second, child marriage interventions included those that provided conditional, non-cash incentives to delay marriage and life skills programmes to empower girls to remain unmarried and remain longer at school. Both types of interventions succeeded in delivering large benefits not only in improved productivity for every year of additional schooling, but also in the opportunity to find higher paid jobs in the formal sector. However, child marriage interventions delivered a higher benefit-cost ratio (21.0) than the education interventions (13.1), partly due to the relatively high costs of education interventions (Rasmussen et al., 2021).

7.1.2 Sensitisation and orientation of school curricula and teachers

Promising practices that have succeeded in changing stereotypes and biases include: (a) building teacher knowledge and skills on issues of gender, equality, disability, creating inclusive classrooms etc; (b) positive discipline approaches without resort to corporal punishment; (c) community dialogue on the value of education; and (d) inclusion of comprehensive sexuality education in the school curriculum and building teacher capacity to impart it without hesitation and embarrassment (see, for example, The Social Norms Learning Collaborative. 2021).

In some settings in India, confidential or anonymous reporting chains have been established that enable girls to report an impending child marriage or any other violation of their rights to teachers or frontline health workers in complete confidence, who in turn convey such information to law enforcement officials. However, there is little evidence about the extent to which these innovative interventions have actually had success in changing community attitudes or halting a child marriage (Nirantar. Trust, 2015). More indirect support for the role of teachers comes from evidence that teachers in settings with low prevalence of marriage were more likely than others to have been engaged in monitoring children likely to drop out of school in order to marry (Santhya, 2019).

7.2 Encouraging female labour force participation

While sparse, a few interventions conducted in India have succeeded in enabling the entry of women and girls in the labour force, and thereby denting norms about women's inability to contribute to the household economy, and allay concerns about women interacting with men in the workplace and potentially risking the *izzat* of their families.

Interventions in India have aimed to both build employability skills in school settings, and increase employment opportunities for young women. For example, an intervention among girls in Classes 9 and 11 from low-income communities in New Delhi, that aimed to build girls' self-efficacy and ability to identify, plan and realise their future personal and professional goals, succeeded in enhancing girls self-efficacy and employability, aspirations for future careers and planning towards preparing themselves for these careers (Nanda et al., 2017). Others were more directly linked to employment and related outcomes. In a randomised intervention implemented in selected rural areas over a three-year period, one project connected women – mostly younger and unmarried women – with experienced recruiters and through them raised awareness of and access to new and non-traditional employment opportunities in the Business Process Outsourcing (BPO) industry. Agents were engaged in informing and mentoring girls and young women aged 18-24 from relatively remote rural areas to access labour market opportunities in the BPO sector. Exposure to this intervention resulted in an increase of almost five percentage points in employment in the BPO sector. Aspirations for a career prior to marriage were 12 percentage points higher than in the control villages. Girls aged 5-15 in villages that received the intervention were 3 to 5 percentage points more likely to be in school than were those in control areas.

Adolescents in the intervention villages were more likely to enrol in computer or English language courses, less likely to get married (five percentage points), and more likely to express a desire for fewer children than those who were in the control sites. Authors argue that building awareness of the returns to human capital and the opportunities available to educated young women are strong demand-side factors weakening traditional norms about careers for girls and prompting parents to invest in girls' education (Jensen, 2012; Oster and Millet, 2010).

7.3 Providing role models

Exposure to women who have rejected stereotypical images...can change the status of expected behaviour so that conforming to traditional gender norms is no longer valued.

Exposure to women who have rejected stereotypical images – girls who defy traditional norms and speak up in class; girls and young women who receive higher education, a career woman, a female politician, a family who has delayed their daughter's marriage – can change the status of expected behaviour so that conforming to traditional gender norms is no longer valued. While evidence overall on the effect of different role models, there exists strong evidence from the political arena in India (Castilla, 2018; Beauman et al., 2012). For example, following one or more election cycles post the enactment of the 73rd and 74th Amendments to the Indian Constitution that established Panchayati Raj institutions, a household survey (2011-2012) sought to estimate the effect on child marriage in settings with and without a female Pradhan. Women who married after being exposed to female Pradhans were significantly less likely to have experienced child marriage, and more likely to have delayed marriage and cohabitation (Castilla, 2018). Shifts also took place in attitudes and aspirations for girls; for example, mothers' aspirations for daughters' education, as well as the girls' own aspirations regarding marriage and career underwent a significant shift, as did the girls' schooling outcomes. Effects on the aspirations and schooling outcomes of sons however, remained unchanged. Men were more likely to hold positive attitudes about women in leadership roles. There is evidence moreover of the success of female panchayat members in organising communities, encouraging women to exercise voice and ensuring that panchayat resources are used in women-friendly ways (Zahir, 2018). These studies have confirmed that exposure to women in leadership positions can precipitate changes in gender norms and even behaviour at community and household levels (Beaman et al., 2012).

The media– both traditional and increasingly social and new media–- have tremendous potential to establish new role models and thereby dent gender norms.

The media– both traditional and increasingly social and new media–- have tremendous potential to establish new role models and thereby dent gender norms. For example, an assessment of the first season of the Population Foundation of India's trans-media series (Mein Kuch Bhi Kar Sakti Hoon (I, A Woman, Can Achieve Anything) suggests that among those exposed to the series, gender role attitudes did become more egalitarian, and knowledge about sexual and reproductive health matters improved (Population Foundation of India, nd). Social media platforms and digital campaigns, increasingly used to connect with communities, may also be useful ways of communicating messages relating to new norms and behaviours in a way that is accessible to and resonates with communities. Unfortunately, in India, rigorous evaluations of media interventions are not currently available.

7.4 Offering conditional and unconditional cash transfers

Conditional and unconditional cash and other transfers have been found to have a profound effect on changing norms and practices, for example, in keeping girls in school reducing child marriage, enhancing institutional delivery, and presumably, though indirectly, their agency (Patton et al., 2016; Harris et al., 2023).

7.4.1 Keeping girls in school

In the South Asia region, for example, a monthly secondary school stipend programme in Bangladesh succeeded in increasing years of schooling significantly (Hahn et al., 2018). In Pakistan, likewise, a conditional cash transfer programme succeeded in raising middle school completion of girls substantially (Alam et al., 2011). In India, such initiatives exist but have not been rigorously evaluated. At state level, the Kanyashree Prakalpa scheme in West Bengal offers a state-wide conditional cash transfer programme to promote secondary school and college enrolment of girls. An assessment of this programme observed some increase in percentages of girls aged 13-18 attending school or college, and in displaying aspirations for a college education and a career (limitations of the study design make it difficult to attribute these findings to the programme; Pratichi Institute, 2017; KADENCE, 2018). Non-cash transfers, such as the bicycle programme for secondary school girls in Bihar and other states have also been found to improve schooling outcomes. In Bihar, for example, the programme not only resulted in improved school attendance and completion, but also raised aspirations for further education etc (Muralidharan and Prakash, 2013; Mitra and Moene, 2017).

Non-cash transfers, such as the bicycle programme for secondary school girls in Bihar and other states have also been found to improve schooling outcomes.

7.4.2 Reducing child marriage

Several global systematic and scoping reviews have observed that interventions that supported girls' school attendance and retention through cash or in-kind transfers showed significant effects on delaying marriage. For example, Malhotra and Elnakib (2021) identified 34 high-quality evaluations of interventions focused on three overarching themes—empowerment, conditional or unconditional cash or kind transfers, and livelihood skilling and career opportunities. What stood out were interventions that supported girls' school attendance and retention through cash or in-kind transfers (significant in 8 out of 11 studies). Substantial effects were also observed in studies of the few (3) interventions offering skilling and career opportunities. In contrast, multi-component interventions that aimed to empower girls through multiple pathways were not as successful as single-component interventions in preventing child marriage (just 3 out of 11 studies showed positive effects). Another set of scoping reviews covered evaluations of programme interventions carried out in sub-Saharan Africa and South Asia, namely, those related to education (notably cash and non-cash transfers), life skills education, technical and vocational education and training (TVET), livelihoods, and social norms. Here too, education-related interventions, particularly the provision of conditional cash transfers or subsidies, were highly effective in delaying marriage in most of the studies reviewed (Gundi et al., 2021). Although exposure to life skills education showed limited effects on delaying marriage and childbearing, programmes whose curricula emphasised gender, rights, and child marriage matters did, more often, have a significant effect than others (Santhya, Jejeebhoy, Jena, Gundi, Dayal, 2021). In contrast, the effects of vocational training and livelihoods strategies tended to be weak and inconclusive (Jejeebhoy et al., 2021). An earlier global review (Chae and Ngo, 2017) of 22 evaluations of interventions

focused on: empowerment (14 interventions); changing social norms at the community level (6 interventions); schooling incentives, through strategies like covering fees, uniforms, and tutoring costs (7 interventions); and economic approaches or cash transfers, conditional or unconditional, and mainly for schooling (10 interventions) arrived at somewhat different findings. It concluded that child marriage interventions were most often successful in those using empowerment approaches (8 out of 14 interventions) and least often successful amongst those using economic approaches (3 out of 10 interventions).

In India, there exists one long-term conditional cash transfer scheme that aimed specifically to delay girls' marriage. Under this programme, parents of girls could avail bonds of Rs. 2500 within three months of the child's birth. This bond then could be redeemed when the girl turned 18 without being married. This intervention succeeded in increasing secondary school completion (class 12) by 12 percentage points and increased aspirations for higher education by 19 points, but participation had no effect on delaying marriage age (Nanda et al., 2016).

7.4.3 Improving pregnancy-related outcomes

India's Janani Suraksha Yojana (JSY) programme, one of the largest conditional cash transfer programmes in the world, aims to increase access to safe pregnancy and delivery services, thereby reducing maternal and neonatal mortality and morbidity. JSY and several successor programmes provide financial incentives to pregnant women to encourage institutional delivery, as well as to ASHAs for facilitating these institutional deliveries. Various evaluations of the programme have found significant positive effects with regard to antenatal care, institutional delivery and skilled birth attendance; less consistent effects were observed with regard to reducing perinatal and neonatal mortality, and maternal mortality effects were not observed (Lim et al., 2010; Ng et al., 2014). Several additional, perhaps unintended effects–- contraception, early initiation of breastfeeding and postnatal check-up were also observed among JSY beneficiaries compared to non-JSY beneficiaries (Sen et al., 2020). Even after controlling for social and economic inequalities, JSY beneficiaries in low performing states were 12 percent more likely to use contraception, eight percent more likely to initiate breastfeeding within one hour of delivery and six percent more likely to obtain postpartum check-ups than their counterparts in high performing states. While direct evidence is not available, these findings do suggest that the JSY programme weakened traditional norms considering pregnancy and delivery a "normal" event unworthy of special care.

7.5 Offering gender transformative education in formal and informal settings

There have been a variety of gender transformative education programmes offered to young people and adults to both raise awareness of sexual and reproductive health and rights matters, as well as build agency and new norms of masculinity and femininity. The majority have addressed the young.

7.5.1 Comprehensive sexuality education in school settings and effect on enhancing agency

Comprehensive sexuality education has been identified as among the most consistent and important determinants of good health practices among adolescents and youth, as well as of young people's agency and ability to exercise sexual and reproductive rights (Patton et al., 2016). Such exposure enables young people to question restrictive gender norms and power dynamics and overcome the stigma and shame that exists around sexuality. It also improves access to information and care on SRHR matters (Harris et al., 2023). Ideally, such education encompasses critical thinking, communication and negotiation, development of voice and self-confidence, as well as correct information on growing up, on sexual and reproductive health, financial literacy, skill building and career guidance as well as an understanding of rights. A comprehensive review of evaluations of 22 interventions offering sexuality and HIV education concluded that those that addressed gender or power were five times as likely to be effective (lower rates of Sexually Transmitted Infection or unintended pregnancy) as those that did not (Haberland, 2015).

Comprehensive sexuality education enables young people to question restrictive gender norms and power dynamics and overcome the stigma and shame that exists around sexuality.

In India, there have been several models of life skills education programmes delivered at state level. For example, the Ayushman Bharat school health programme aims to deliver an age-graded curriculum to school-going students that exposes them to many of the above concepts. While its curriculum focuses on building awareness of adolescent and child health, and includes sections on gender relations and sexual and reproductive health, the curriculum shies away, even among older adolescents, from explaining how pregnancy occurs or how contraception works (National Council of Education, Research and Training (NCERT, 2019)). Unfortunately, neither the spread of its delivery nor the effects on young people have thus far been analysed. State governments in Bihar and Jharkhand have also undertaken school-based Adolescence Education programmes for students in Classes 9 and 11. Overall, none of these school-based sexuality education models at national or state levels have been rigorously evaluated, and little is known about the comprehensiveness of content, the reach of the programme or its effect and acceptability to students, teachers and other stakeholders.

Such education encompasses critical thinking, communication and negotiation, development of voice and self-confidence, as well as correct information on growing up, on sexual and reproductive health, financial literacy, skill building and career guidance.

There are however rigorous evaluations at the sub-state level. One intervention in Haryana that lasted two years and was delivered at classroom level among girls and boys succeeded in making attitudes more supportive of gender equality and behaviour more gender-equal, effects were also observed two years following the conclusion of the intervention (Dhar et al., 2022). Another intervention, delivered to students of secondary schools of Bihar (SEHER project) found that interventions delivered by a lay counsellor, compared with the usual government-run Adolescence Education Programme, showed large effects on improving school climate and at individual level, improving student attitudes towards gender equity and knowledge of reproductive and sexual health, as well as improving health-related outcomes including depressive symptoms, bullying and violence (Shinde et al., 2020; Shinde et al., 2018).

A comprehensive school-based programme in Jharkhand (also Vietnam and Bangladesh, the Gender Equity Movement in Schools) offered a classroom-based gender transformative programme to adolescent girls and boys aged 12-14 years to promote gender equality and change perceptions of boys' right to perpetrate violence. It also aimed to foster equitable attitudes related to gender and violence among students, strengthen their understanding and skills to resolve conflicts without violence; and create a safe school culture that supported egalitarian and nonviolent attitudes and behaviours. Its activities included teacher training and support, school and community campaigns, meetings with those in authority, as well as classroom sessions. Classroom sessions were delivered jointly to boys and girls, with the exception of sensitive topics that were conducted in single-sex groups. Compared to base-line findings, results at the conclusion of the programme confirmed that attitudes of girls and boys in schools exposed to the programme became more equitable than those in comparison schools. For example, they were more likely to abhor violence, to express comfort in communicating and interacting with peers, including those of the opposite sex, as well as teachers. However, despite more gender egalitarian attitudes, perpetration of violence had not reduced. Despite teacher training, teachers were not uniformly comfortable imparting the programme, several faced resistance from other teachers as well as parents, and many were unable to give students confidence to exercise voice–- suggesting that changing adolescent norms and behaviours may face less pushback than changing those of adults (Achyut et al., 2016; Achyut et al., 2017).

Mixed findings were also observed in an evaluation of a similar Gender Equity Movement in Schools (GEMS) programme, implemented in Mumbai at classroom level by way of group education activities. This programme succeeded in engaging adolescents to not only understand body changes and sexual and reproductive health matters, but also to challenge traditional gender norms that may affect sexual and reproductive health in the future. Attitude shifts were evident, especially among girls, but were more significant among those who started with moderately equitable attitudes than those who started with highly unequal attitudes. Attitudes relating to men's entitlement to perpetrate violence on women were just weakly affected by exposure to the intervention, although there were increases in girls' confidence about complaining about someone who is threatening them, and in boys' expression of intent to intervene in case of violence against a girl (Achyut et al., 2015).

7.5.2 Gender transformative life skills education in non-formal settings and effects on agency and SRHR awareness and attitudes

There have also been interventions implemented in out-of-school settings in LMICs that have been evaluated, and their findings are mixed. For example, an assessment of 21 projects supported by the Girls' Education Challenge Fund reported that interventions that worked directly with girls and boys through the formation of groups and safe space opportunities were successful in changing perceptions about girls' potential; so too were the availability of mentors and role models, and the engagement of community leaders. Some norms however, notably those relating to early marriage and housework, were not changed (Advancing Learning and Innovation on Gender Norms (ALIGN) network, 2019). A systematic review of 13 studies evaluating various

programmes in India observed an increase in SRH knowledge (body changes, menstruation, infections (RTI, STI, HIV), contraception and availability of services) in the majority (9). However, the review cautions that only three studies observed a shift toward more egalitarian gender role attitudes and away from inequitable norms relating to masculinity, control over women and girls, men's right to perpetrate violence on women for example. Behaviour change was observed in four studies, and changes included new aspirations, increased agency, better communication skills and even a decrease in perpetration of violence among males (Siddiqui et al., 2020).

Several interventions have been carried out in India, and assessments of these have also yielded mixed or inconsistent findings. One, in Rajasthan, comprised weekly group education activities and sports sessions with girls over a 14-month period, as well as interactions every three weeks, between girls and the wider community on issues arising during the education activities. Significant positive effects were observed with regard to schooling, age at marriage and mental health; however, effects on measures of agency and gender role attitudes were milder (Andrew et al., 2019). This was followed by a three-armed cluster randomised controlled trial in Rajasthan that established girls' groups along with sports sessions for one arm, and these, together with actions seeking to sensitise the broader community and its leaders and break down norms and sanctions in another. Girls in both arms were significantly better off than those in the control group at the endline in terms of education and marriage outcomes, but mental health outcomes (symptoms of anxiety and depression) were significantly improved only in the group exposed to community activities. Authors conclude that the community focus succeeded in not only changing community norms but also reducing the sanctions girls faced for deviating from traditional norms (Andrew et al., 2022). Also in Rajasthan, an RCT of a group-based life skills education curriculum for girls aged 12-17 found that participation significantly reduced the probability of older girls being married or engaged at the endline; this programme did not, surprisingly, find significant effects on girls' agency or gender role attitudes (Andrew et al., 2019).

The Disha project, implemented in villages of Bihar and Jharkhand combined life skills education imparted by trained peer educators for boys and girls, married and unmarried, aged 14-24, supplemented by vocational training in traditional skills for girls. Findings were mixed. While married girls' agency (freedom of movement, spousal communication, self-efficacy) was significantly affected by programme participation, agency of unmarried girls (to communicate marriage preferences with their parents) was not (Kanesathasan et al., 2008).

Yet another intervention, conducted in Karnataka, offered a bundle of interventions for socially disadvantaged girls aged 13-16: a safe space for girls, along with life skills education, academic coaching, boys' gender sensitisation and sports groups at the individual level, as well as community and school level outreach, and structural changes to make schools girl sensitive, and sensitisation of local government representatives about replicable actions. Findings generally found no significant effects on schooling or safe sex behaviours, although some increase was observed in age at marriage among those aged 15-19 (Prakash et al., 2019).

7.5.3 Gender transformative life skills programmes for married young women and effects on agency and SRHR outcomes

Gender norms may prevent married young women from participating in interventions open to all young women irrespective of marital status. A few interventions have focused exclusively on married adolescent and young women. The First-time Parents Project was implemented in two rural settings in West Bengal and Gujarat, among young women who were newly-married, pregnant for the first time, and postpartum first-time mothers. It also held activities for their husbands, mothers and mothers-in-law, health care providers and the wider community. The intervention comprised the provision of information, health care service adjustments and group formation as a means of empowering young women. Using a quasi-experimental research design to evaluate the effects of the intervention, researchers found that the intervention had a significant, positive net effect on most indicators reflecting married young women's agency, social support networks, partner communication and knowledge of sexual and reproductive health. It also had a positive net effect on reproductive health practices such as use of contraceptives to delay the first birth, comprehensive antenatal care, delivery preparations, routine postpartum check-ups and breastfeeding practices. However, the net effect of exposure to the intervention was mixed with regard to indicators related to gender role attitudes and attitudes towards domestic violence (Santhya et al., 2008).

7.6 Empowering women and girls through community mobilisation

Group-based programmes have been implemented among self-help and other women's groups, with activities largely focused on community conversations, strengthening local gatekeepers as change agents, and even, in some cases, offering economic empowerment activities. Studies have noted that interventions promoting group cohesiveness and solidarity can enable women and girls to challenge existing norms and exercise voice in matters relating to them (Harris et al., 2023). Several interventions have employed community mobilisation strategies to address sexual and reproductive health matters.

7.6.1 Pregnancy related care

Studies have concluded that mobilisation efforts, and particularly participation in women's groups can change behaviour relating to pregnancy related practices and care. Typically, interventions have taken advantage of existing safe space forums (eg Self Help Groups) or have created new collectives of women. Evidence confirms that community mobilisation through women's groups improves birth outcomes, builds awareness of health promoting practices and enables a recognition of the role of discrimination, power imbalances and marginalisation in hampering care seeking. Mobilisation also strengthens community capacity to solve problems relating to care seeking and health practices, build social networks and enhance collective action, and through these, empower women.

For example, an evidence review of interventions that addressed gender dynamics in low- or middle-income countries, several based in India, identified a total of 23 interventions, 22 of which addressed reproductive and maternal and child health practices (e.g., birth spacing, antenatal care, breastfeeding). Findings suggested that the focus on gender dynamics played a strong indirect role in improving outcomes by enhancing women's and couple's ability to make and act on decisions that benefit their own, their children's and, in some cases, their community's health. Mixed findings were observed with regard to effects of engaging men (Kraft et al., 2014).

A mixed-methods systematic review of 99 studies (some of moderate quality) conducted in India explored the role of wome"s groups in affecting the health of women and children (under 5) and the enablers and barriers to achieving positive outcomes. On balance, the studies included in the review confirm that health interventions with women's groups can improve perinatal practices, neonatal survival, immunisation rates and women's and children's dietary diversity, and help control vector-borne diseases. Evidence of positive effects was strongest for community mobilisation interventions that built communities' capabilities and went beyond sharing information, notably by engaging whole communities and with sufficient intensity. Barriers included limited time or focus on health, outcomes not relevant to group members and health system constraints (Desai et al., 2020).

Perhaps the best known and most successful such intervention to improve maternal and new-born health outcomes has been the Ekjut intervention implemented among groups of women in Jharkhand and Odisha, who were overwhelmingly tribal and rural. Using participatory learning approaches, the intervention focused on building knowledge, skills and 'critical consciousness' among marginalised groups of women, with special efforts made to include the newly pregnant; local women from the community were trained as facilitators. Community involvement beyond the groups was also included. A rigorous evaluation of the Ekjut cluster-randomised controlled trial across 244 women's groups in 18 intervention clusters (2005-2008) demonstrated a 45 percent reduction in neonatal mortality in the last two years of the intervention, largely driven by improvements in safe practices for home deliveries. Maternal depression, also measured, did not decline significantly, although there was a considerable reduction in moderate depression by year 3. Authors concluded that the intervention's impact was influenced by the fact that it was perceived as acceptable, employed a participatory approach to the development of knowledge, skills and 'critical consciousness,' involved the wider community from which groups were drawn, focused on marginalised communities, actively sought the engagement of newly pregnant women, and covered a wide geography. Findings also showed that effects were most prominent among the most marginalised (Rath et al., 2010; Houweling et al. 2013; Tripathy et al., 2010).

Ekjut utilised participatory learning approaches, focused on building knowledge, skills and 'critical consciousness' among marginalised groups of women, with special efforts made to include the newly pregnant; local women from the community were trained as facilitators.

More support emerges from three studies conducted in Uttar Pradesh. In one, a qualitative study that aimed to retrospectively understand maternal and newborn health care-seeking behaviour among families who had reported an incident of maternal death or newborn illness or death, observed that households with one or more SHG members were significantly more likely than other households to report positive outcomes in terms of rejection of deep-rooted cultural beliefs (for example that haemorrhage is normal, or that newly delivered women and their infants should not leave the home) and prompter care seeking (Aruldas et al., 2017). The second, implemented among a large number of SHGs focused on discussion of maternal and newborn health issues in SHG meetings on the one hand, and community outreach activities on the other. The intervention was evaluated using a quasi-experimental design, and findings suggested significant improvements in several pregnancy and newborn care practices, particularly among the most-marginalised women, in intervention sites compared to those in comparison sites (Hazra et al., 2019). The third offered an eight-session behaviour change model among women's self-help groups (SHGs) with the intention of promoting healthy practices among the most disadvantaged, and more specifically to raise awareness, change attitudes, and promote positive behaviours in the areas of pregnancy related practices and care. Using a pre-post quasi experimental evaluation design, the study found that women from intervention SHGs were considerably more likely to have had an institutional delivery, practised skin-to-skin care, delayed bathing for three or more days, adopted timely initiation and exclusive breastfeeding, provided age-appropriate immunisation and practised contraception. They were also more likely to seek the support of SHG members for antenatal care and postpartum help. Authors suggest that structured participatory communication can have positive effects on pregnancy related best practices (Saggurti et al., 2018).

7.6.2 Contraception

Married adolescent and young women are known to have higher levels of unmet need than older women (17-18% vs. 9%, IIPS and ICF, 2021), largely a consequence of norms dictating that women must prove their fertility as soon as possible following marriage. The PRACHAR intervention, implemented among the young (up to age 24) in rural Bihar, sought to break this norm; its objective was to promote contraception, educate the young about reproductive health matters, and change norms about early pregnancies. Using the ecological framework discussed earlier, the intervention adopted a community-wide approach, although the primary focus was youth. At individual youth level, activities were calibrated to life stage–- unmarried, newlywed, or mothers of one child, and also their husbands, and centred around individual sessions and counselling, couple level activities, home visits and small-group meetings that conveyed key messages and behaviour change communication. At parent-level, group meetings were held; at system level, the project encouraged connections between the young and available public sector services; and at wider all-community level, more light-touch activities were implemented (drama, wall paintings etc). The evaluation confirmed that not only had the intervention succeeded in significantly improving reproductive health knowledge and dispelling misconceptions but also in delaying the first and second births, increasing contraception and building a generally more supportive environment (Daniel et al., 2008).

The PRACHAR intervention, implemented among the young (up to age 24) in rural Bihar, sought to break this norm; its objective was to promote contraception, educate the young about reproductive health matters, and change norms about early pregnancies.

A synthesis of evidence from multiple PRACHAR studies concluded that the original NGO-led comprehensive model, with close NGO engagement, increased contraceptive use among married young couples, and succeeded in changing outcomes, many of which were sustained 4–8 years after the end of the intervention. The synthesis cautioned that the subsequent upscaled, less intensive, public-private model (government-NGO) of PRACHAR implementation reached greater scale than the original NGO-led model, but was less successful in generating programme effects or sustained change (Subramanian et al., 2018).

Another intervention focused on providing literate and illiterate rural women in Jharkhand information about contraceptive methods, couple communication and decision making related to family planning and women's reproductive rights over a three-year period, via street theatre, puppet shows and other culturally relevant forms of information dissemination. Anganwadi workers were trained to offer family planning information and services in ways that took into consideration gender power dynamics. Findings suggest that attitudes about women's power in contraceptive decision making, control over money earned and decisions on visits to relatives and friends vis-à-vis their husbands' power became more egalitarian and unmet need for contraception declined (León et al., 2014).

Findings suggest that attitudes about women's power in contraceptive decision making, control over money earned and decisions on visits to relatives and friends vis-à-vis their husbands' power became more egalitarian and unmet need for contraception declined.

The importance of ensuring that health care providers counsel women to arrive at their own decisions has been acknowledged but poorly studied in India. A global systematic review of 63 publications explored the comparative effectiveness of two different counselling strategies for modern contraception on contraceptive behaviour and satisfaction, one that supported women to arrive at their own decisions with regard to contraception, including postpartum contraceptive use, and a second, in which providers made decisions about appropriate methods to promote – effects were observed in the first but not second strategy (Cavallaro et al., 2020).

7.6.3 Child marriage

Community-level interventions to prevent child marriage are rare in India. One exception is a cluster randomised trial evaluating a multi-arm intervention implemented over a seven-year period (2012-2019) in locations in Bihar and Jharkhand. Several models (in various combinations) were implemented: mass media campaigns through TV etc that exposed communities to tailored messages on rights; training and sensitisation of various community leaders; and community mobilisation comprising various local level events. The evaluation showed that compared to the control sites, the arm in which all interventions were implemented showed significant impact not only on delaying marriage, but also on raising school enrolment of girls and fostering more egalitarian gender role attitudes, particularly towards girls' education and mobility, and less so with regard to marriage and girls' work (Raghunathan et al., 2021).

7.6.4 Gender biased sex selection

Strategies to reverse gender biased sex selection and sex selective abortion have operated on multiple levels. At a structural level, legal measures are available: the 1994 PCPNDT Act prohibits health facilities and health care providers from disclosing the sex of the foetus. At system level, a second strategy is the provision of entitlements including enrolment in conditional cash transfer schemes for girls. At community level, a third is behaviour change activities conducted by community leaders and those in positions of authority to more directly influence norm change.

Research on what works is sparse. One mixed method study that compared two districts of Haryana, in which improvement in sex ratios at birth had and had not been observed, explored the extent to which differences emerged in terms of the spread of educational entitlements and conditional cash transfers for girls, implementation and awareness of the PCPNDT Act on disclosure of the sex of the foetus, and implementation of and exposure to communication, advocacy and community mobilisation activities. As far as educational entitlements and conditional cash transfers are concerned, access to school-related entitlements and enrolment in conditional cash transfer schemes for girls was similar in both settings, but women were sceptical about whether these would dent strongly held norms about investing in sons or gender-biased sex selection. Implementation of the PCPNDT Act has been weak in general, and inter-district differences in knowledge of the law were not observed. Large minorities of women and key informants in each district justified the validity of the law; however, they believed that, or were undecided about whether women with two or more daughters should be permitted to know the sex of the foetus and terminate a pregnancy carrying a female foetus. Many were, moreover, aware of the ease with which disclosure could be procured, the deliberate disregard of violations by law enforcement authorities and other impediments to successful implementation of the law. It was in the case of communication, advocacy and community mobilisation initiatives that inter-district differences were pronounced. Compared to the district exhibiting no change, the district displaying improvements in sex ratios at birth was marked by sustained interactive sensitisation and advocacy programmes by a range of players – counselling by frontline workers, discourses by religious leaders and interactions with public sector programme implementers in schools, colleges and the community (Jejeebhoy et al., 2014).

7.6.5 Gender based and intimate partner violence

A systematic review of 20 evaluations of programmes in LMIC concluded that both economic, including microfinance and cash transfers, and social, including participatory learning, community mobilisation and multimedia approaches, as well as combinations of economic and social reduced violence and controlling behaviours can reduce violence and controlling behaviours. At the same time, they improved economic well-being, enhanced relationship quality, promoted empowerment, generated new help-seeking practices and collective action, reduced social acceptability of IPV, and encouraged the expression of more egalitarian gender norms. However, these promising associations were not uniform across studies, or, within studies, across all outcomes measured (Bourey et al., 2015). Another evidence review in LMIC, covering a broad range of intervention models, and many forms of

violence (partner and non-partner, as well as female genital mutilation, and child marriage) concludes that of the few evaluations available, many point to the positive effects of group training for women and men, community mobilisation interventions, and livelihood and training interventions for women. Effective programmes were participatory, and engaged multiple stakeholders, with content focused on forging equitable gender relationships, questioning the acceptability of violence, and encouraging greater communication and equitable decision making among family members (Ellsberg et al., 2015).

In India, a meta-analysis and systematic review of 10 community-based intimate partner violence interventions provides insights into what works to reduce IPV. Intervention duration ranged from one month to five years. Multiple groups were addressed–- young people, women, men, couples, and sex workers, and interventions were conducted in group sessions at both community- and classroom-levels. Content typically varied but focused on the provision of information and counselling, communication and negotiation skills, and knowledge about sexual and reproductive health. Findings showed that participation in community-based IPV interventions produced a significant reduction in attitudes condoning IPV against women, as well as actual experience of IPV and in particular, physical and emotional violence (Mittal et al., 2023).

Within India, there have been several interventions, with varying effects. For example, an intervention aimed at reducing the experience of marital violence while enhancing women's agency, financial literacy, and access to social support was delivered to members of self-help groups (SHGs) in rural Bihar. Activities comprised gender transformative group learning sessions delivered fortnightly to SHG members and delivered monthly to husbands of SHG members along with interactive voice response system (IVRS) messages delivered through their phones. The gender transformative group learning curriculum for SHG members focused on empowering them economically as well as exposing them to topics relating to gender discrimination, notions of masculinity, and the acceptability of violence against women and girls. The curriculum for husbands focused more exclusively on issues related to notions of masculinity and violence against women. Efforts were also made to link SHG members with livelihood training opportunities and access to credit. A range of community events was also conducted. An RCT conducted to explore effects found that a significantly larger proportion of SHG members in intervention than control arms expressed egalitarian gender role attitudes, rejected the notion that men had the right to exercise control over their wife, and reported improved agency (decision-making, freedom of movement, financial literacy, control over economic resources). With regard to the experience of violence, findings were mixed. Compared with women in the control arm, SHG members in the intervention arm reported significantly lower levels of physical violence perpetrated by their husband in the six months preceding the interview, but this effect weakened once associations were adjusted for covariates. Effects on sexual violence were not observed, and intervention participants reported significantly higher levels of emotional violence perpetrated by their husband in the six months preceding the endline interview, suggesting possible backlash (Jejeebhoy, Santhya, Acharya, Zavier et al. 2017).

Another project, also in rural Bihar, trained frontline health workers to incorporate a screening and counselling component into their regular home-based interactions with women aged up to 39 years who were pregnant or had a 0-5 year-old child. Counselling related to women's rights, the unacceptability of marital violence, the need to share experiences with neighbours, friends and family, and services available for women in distress. A pre- post- follow-up of women residing in study communities found that although help-seeking was limited, a larger proportion of women had shared their experiences of violence with family and friends or had sought services from formal sources at endline than at baseline. Findings suggest that counselling on violence related matters and screening for violence could well be incorporated into the regular activities of frontline workers (Jejeebhoy, Santhya, Singh, Zavier et al. 2017).

Yet another community-level intervention was aimed at empowering locally elected representatives (PRI members) in rural Bihar to act as change agents to promote egalitarian gender norms among men and women in their communities, make efforts to reduce violence against women and girls, and alcohol abuse in their communities. Activities implemented in this seven-month intervention included sensitisation and capacity building of PRI members to conduct community-level awareness raising sessions on topics such as ending gender discrimination, violence against women and girls, domestic violence and alcohol abuse. Findings suggest that PRI members' intervention in cases of alcohol misuse and violence had increased, and alcohol abuse among men in the intervention arm had declined, however, neither gender role attitudes, nor attitudes about the acceptability of VAWG, nor men's controlling behaviours and perpetration and women's experience of violence within marriage were affected by exposure to the intervention (Jejeebhoy, Zavier, Santhya, Acharya et al. 2017).

7.7 Engaging men and boys in acceptable formats

Norm change interventions that engage men and boys cannot simply replicate those that are observed to be successful among women and girls. Rather, content and formats must be specifically designed to appeal to men and boys. Promising interventions are described below, largely focused on boys and young men.

7.7.1 Changing notions of power and masculinity

Programmes offering gender transformative life skills education have demonstrated positive effects in changing attitudes and behaviours among boys. A systematic review of 29 studies, mostly from high income countries but including one from India, found that mentoring approaches demonstrate promise for improving soft skills and social assets and reducing violence perpetration, but evidence was mixed with regard to gender norm transformation, reproductive health, and substance use (Plourde, Thomas and Nanda, 2020). A WHO assessment of interventions with adult men related to SRHR matters found important effects on men's attitudes and behaviours, mostly these worked with individuals, groups and communities to change norms about what it means to be men, cultivate new notions of masculinity and femininity and raise awareness of reproductive health matters (Starrs et al., 2018).

There are several examples of successful gender transformative programmes for boys and men in India. The *Yari-Dosti* programme implemented a specially designed curriculum among young men (aged 18-29) in a low-income metropolitan area of Mumbai over a six-month period. The intervention covered issues relating to gender, sexuality and masculinity and its effect on individual attitudes. Findings showed a significant decrease in support for inequitable gender norms (measured using the GEM scale) and sexual harassment of girls and women (Verma et al., 2007). Another study assessing the effect of a one-year pilot project in Rajasthan implemented among groups of boys (14-17) and young men (18-25) succeeded in promoting individual and community-level changes in knowledge and attitudes related to gender, sexuality and violence, but behaviour change was limited (Freudberg et al., 2018).

Several interventions that have combined gender-transformative life skills education with sports-coaching have been particularly effective and acceptable among boys and young men. One such intervention that aimed to transform boys' attitudes and beliefs regarding gender inequality, was implemented among boys through school-based training along with sports opportunities. Findings suggest that the intervention did cause some shifts in boys' reflections on their behaviours, and efforts to modify behaviours, including taking action to change the behaviours of others to prevent teasing or gossiping about girls; yet traditional notions of masculinity persisted. For example, boys continued to perceive themselves as protectors of girls' honour. Primary decision-making power remained with parents and other adult gate-keepers, thwarting even boys' ability to challenge harmful norms that deny women and girls their rights (Pujar et al., 2023).

The *Do Kadam* project implemented such a programme among boys aged 13-21 who were members of youth clubs in the highly gender stratified setting of rural Bihar. It aimed to promote positive masculinities, team spirit, a sense of fair play, and more specifically, an abhorrence of violence, as well as actions such as intervening in violent incidents they observed, and reducing their own perpetration of violence. The intervention was delivered over 42 weekly sessions spread over 18 months, with one hour each week devoted to the gender transformative life skills education component overseen by a team of core trainers and one hour to cricket-coaching overseen by coaches. Findings of a cluster randomised controlled trial with panel surveys suggest that the intervention succeeded in changing notions of masculinity, attitudes about men's controlling behaviours over women/girls, and about men's right to perpetrate violence on a woman/girl, and perceptions about peer reactions to young men acting in gender equitable ways. There was strong evidence also that the intervention was effective in making boys take action, that is, intervene in incidents of teasing and other forms of verbal abuse (eg. spreading sexual rumours), or perpetration of unwanted touch on a woman or girl; however, behaviour change in the perpetration of violence was just modestly observed (Santhya et al., 2019; Jejeebhoy, Acharya, Pandey, Santhya et al., 2017). Another study using the same data set compared effects on younger and older boys, and concluded that gender transformative programmes may be more effective in changing traditional attitudes and practices among boys in early compared with late adolescence (Gupta and Santhya, 2020). In a third study, participants

of this intervention were followed up five years after the completion of the original trial to explore the long-term effects of this programme. The follow-up concluded that the intervention succeeded in sustaining gender equitable attitudes and notions of positive masculinity, attitudes rejecting men's controlling behaviours, and reducing perpetration of intimate partner violence even five years following the conclusion of the original intervention (Santhya and Zavier, 2022).

Two other programmes combined education with sports training. In one, among boys aged 10-17, school-based cricket coaches and community-based mentors were trained and tasked with raising awareness about abusive and disrespectful behaviour, promoting gender-equitable, non-violent attitudes, and empowering boys to exercise their voice to intervene when witnessing violence or harassment. Compared to boys in comparison areas, attitudes became significantly more gender egalitarian and perpetration of abusive behaviour (harassment or violence) declined significantly among boys exposed to the intervention; bystander intervention however was not much affected (Das et al., 2012).

7.7.2 Engaging men in improving sexual and reproductive health

A review of 58 evaluations of programmes with men and boys in sexual and reproductive health confirmed that well-designed programmes that incorporate a gender-transformative approach and promote gender-equitable relationships between men and women were associated with positive changes in behaviours and attitudes. Specifically, positive outcomes were observed with regard to maternal, newborn and child health; men's interaction with their children; perpetration of violence against women; questioning of violence perpetrated by other men; and health-seeking behaviour (Barker et al., 2010).

Well-designed programmes that incorporate a gender-transformative approach and promote gender-equitable relationships between men and women were associated with positive changes in behaviours and attitudes.

With regard to maternal and newborn health interventions engaging men, a systematic review of 13 studies in low- and middle-income countries including five from India suggested that interventions typically encompassed enhancing male participation in facility-based counselling, or home-based one-on-one or group or community level information sessions. Findings suggested that these interventions were associated with improved azntenatal care, skilled birth attendance, facility birth, postpartum care, birth and complications preparedness, and maternal nutrition, although their effect on mortality, morbidity and breastfeeding was less clear. Male engagement also improved their support for women and increased couple communication and joint decision-making (Tokhi et al, 2018).

Within India, a study implemented among men in Uttar Pradesh worked through a network of change-agents working on reducing gender-based violence; findings confirm that gender role and violence-related attitudes both among those conducting outreach and men in the community in general became significantly more egalitarian compared to those residing in control areas, but violent behaviour was not modified (Das et al., 2012).

The CHARM and CHARM2 cluster randomised controlled trials focused on counselling couples about reproductive health and building equitable marital relations, and explored effects on contraceptive outcomes and female agency in contraceptive choices. The CHARM intervention, delivered over three-sessions and focused on family planning and gender equity, was delivered by male health care providers to married men. It found that men exposed to the intervention were significantly more likely than men in the control group to hold equitable attitudes toward household decision-making in a shorter term (9 month) follow-up but this difference was not sustained in the longer (18 month) term (Fleming et al., 2018). A sustained effect was not observed with regard to women's perceptions that they had an equal right as husbands to decide on which contraceptive method to use, or their perception that they could use a contraceptive even if their husband did not consent (Raj et al., 2022). CHARM2 comprised five provider-delivered sessions, two delivered separately to husbands and wives, one joint, spanning a four-month period. The findings were uneven. Modern contraceptive use increased significantly nine months post-intervention, but differences were not evident at 18 months; some indicators of agency and couple communication increased significantly at both 9 and 18 months. Moreover, there was no significant difference in pregnancy over the period, although among those who reported wanting no more children at baseline, marginally fewer from the intervention reported an unintended pregnancy by endline (Fleming et al., 2018). Findings highlight that short interventions may not be appropriate for sustained gender norm change among men.

08 Measures, Data and Gaps

Given the recognition that gender norms play an important role in holding back the pace of development, not only interventions that facilitate norm change, but also sound measures and measurement tools to assess change are urgently needed. More work is imperative to improve how we measure gender norms (Costenbader et al., 2019; Greene and Stiefvater, 2019). Much of what is known, in India and elsewhere, comes from surveys and focuses on individual level perspectives. Surveys probe individual attitudes – often not culturally comparable across settings. In India, the National Family Health Survey (NFHS) is the sole nationwide data collection initiative that furnishes information on attitudes related to gender; it also provides comparable data from each state. Questions posed to assess attitudes across India are identical to those posed globally, allowing for placing them against those reported across and beyond the region, as well as across India, and at the same time allowing for tracking changes in attitudes over time at national and state levels. There have been other sub-national or smaller survey exercises that also explore attitudes and these need to be assessed for improvements in arriving at a core set of appropriate attitudes applicable in the Indian setting (for example, the UDAYA surveys, the Do Kadam programme evaluations, the GEM scale applied in rural India).

More work is needed to assess whether these attitude measures are sufficient, or need to be supplemented by others that are more culturally relevant – for example, relating to parent-child interaction, girls' role in marriage-related decisions, schooling experiences, school to work transitions or careers, marital relations, issues surrounding safety in domestic and non-domestic settings, men's right to dominate women, and so on. Historically, the focus of measures relating to attitudes has been on women. Although more recently, DHS/NFHS and other surveys have included men, more research is needed to explore if, aside from a core set of common attitudes, additional gender-specific attitudes may need to be devised. Future research must be undertaken among both women and men, girls and boys in which males and females are equally represented, across age groups and are asked the same unbiased attitudinal and behavioural questions to enable gender-comparative research.

Attitudes of key gatekeepers – parents, community leaders, teachers, health care workers, religious leaders, elected officials – also need to be probed. Thus far, what we know about gatekeepers has come largely from the perspective of primary survey respondents or intervention target groups. Questions remain about the extent to which gatekeeper norms are loosening.

Norms themselves (as opposed to attitudes) are rarely measured in surveys and more attention is needed to identify how to include these in data gathering exercises (Heise and Cislaghi, 2016). Surveys may wish to incorporate and test questions that measure expressions of community level norms ("in my community, people would talk if I go out for work…."- or "men in my community would call me my wife's slave if I don't beat her"-type questions). When compared against corresponding personal attitudes, such questions may give an idea of the dissonance that may exist between norms and attitudes.

Understanding norms will require more attention to obtaining in-depth insights and perhaps what is needed is the inclusion of vignettes in surveys, as well as more qualitative and mixed method studies to allow for a deeper analysis of gender norms and their varied influences. For example, much needed is research that explores gendered pathways to health, and rights achievement, and these can best be probed through mixed method and longitudinal data gathering exercises. Such methodologies can provide rich evidence of factors facilitating and obstructing the acceptance of equitable forms of masculinity and femininity, and the ways in which these pathways affect sexual and reproductive outcomes (Weber et al., 2019).

09 Summary and Concluding Reflections

Gender norms have a profound impact on the lives of women and girls, limiting their opportunities, undermining their health and well-being, and perpetuating poverty and social exclusion. The report of the Guttmacher-Lancet Commission on sexual and reproductive health and rights for all concludes that the most crucial reforms to enhance sexual and reproductive health and rights are those "that promote gender equality and give women greater control over their own bodies and lives" (Starrs et al., 2018). While gender norms are pervasive, they are not static and evidence confirms that they are resisted and redefined in many instances. This review has outlined the ways in which gender norms adversely influence the lives of women and girls in India, including their sexual and reproductive health and rights.

The review also outlines the seven best or promising practices that challenge existing gender norms, promote more equitable ones, and empower women and girls to take control of their own lives, in multiple domains of sexual and reproductive health and rights. Of course, gender equality in secondary and higher education is central; it affects norm change at individual as well as family and community levels, builds agency and aspirations, and gives girls a springboard into skilling and careers. Women's paid work and exposure to formal sector employment not only give women control over money, but open up new opportunities for women and break down norms that perceive women as economic burdens. Role models, whether in the community or political life, also dent traditional norms about the capability of women and girls. For example, girls exposed to skilling and placement in new careers have been found to not only enhance their own agency, but also that of others in their community. Political participation and women's political voice and representation are found to enable other women to demand their rights and open up new career options for young women.

More specific interventions have also succeeded in transforming gender norms and affecting behaviours. Offering conditional and unconditional cash and non-cash transfers for changing a number of practices ranging from keeping girls in school to enhancing institutional delivery has potential to change gender norms while improving schooling outcomes, delaying marriage, and increasing access to institutional delivery. Also, gender transformational education in formal and non-formal settings not only promotes egalitarian norms, but also enhances agency and the adoption of health promoting practices. Evidence with regard to comprehensive sexuality education in school settings is strong and consistent, whereas for life skills or adolescence education programmes in out of school settings, effects have been more variable. Empowering women through community mobilisation promotes women's self-confidence to upturn traditional norms, build female solidarity and peer networks and promote economic empowerment. For example, through participation in self-help groups, women take on leadership roles in their community, adopt health promoting practices and timely decision-making regarding care-seeking.

Offering conditional and unconditional cash and non-cash transfers for changing a number of practices ranging from keeping girls in school to enhancing institutional delivery has potential to change gender norms....

Limitations are evident. While recognising that gender norm change is affected by multiple levels of the ecological framework, and community wide change is needed, along with individual level change, in practice, interventions focus on changing individual behaviours and narrowing gender power gaps at individual and relationship levels. At the same time, interventions have often been multi-component and it can be difficult to disentangle the unique contributions of gender norm components. Moreover, while we acknowledge that norm change is a gradual process, most evaluations are short term, and findings may not show significant change at the conclusion of the intervention. And only a few studies have followed intervention participants to explore whether positive norms observed at the conclusion of an intervention are sustained at a later point in time.

Also, for too long, programmes to change norms and behaviours have focused solely on women (and less so, girls). Increasingly, this has been viewed as a short-sighted strategy, and the importance of engaging men and boys has been universally acknowledged. However, programming for men and boys has not always been creative or responsive to their interests and sensitivities and not necessarily those appealing to women and girls. Another group that has power to transform norms and outcomes are service providers and gatekeepers including families and community leaders. While their power is well understood and many

interventions have included teacher and health care provider training, this training has remained a secondary activity, effects have not been rigorously assessed and where assessed, the focus has been on post-training knowledge, attitudes and practices of service providers rather than the impact on their own and their clients' knowledge, attitudes and practices.

Likewise, interventions have included interaction with parents and families, and community members and leaders as secondary target groups, and neglect to measure effects directly among them. Given the role that these groups play in upholding traditional patriarchal norms, interventions must assess the kinds of activities and messages that foster among them new notions of masculinity and femininity and enable them to foster these among family and community members. Communities may exact a heavy burden –- violence, social ostracism, gossip, loss of izzat–- on women and girls who defy traditional norms, and engaging and changing norms and attitudes among communities and gate-keepers may minimise these penalties, and encourage the adoption of egalitarian practices.

Meaningful change occurs when institutions, communities, and individuals collectively embrace new expectations, fostering momentum for non-traditional behaviour.

Finally, although adherence to patriarchal gender norms is recognised as an important factor slowing down the pace of economic change, data gaps persist. Surveys must expand the range of attitudes currently probed to include well-tested, culturally-relevant measures of attitudes. Attitudes must be probed not only among women, but also men, adolescents, and the range of secondary target groups whose perspectives are so critical to preserving or changing overall gender norms. Data must be gathered that assess the persistence of norms at community level and whether these are loosening, individual attitudes and whether they reflect or deviate from existing norms, and evaluations of what works to change norms and affect sexual and reproductive health and rights outcomes. Quantitative measures of norms and attitudes need to be supplemented by qualitative data that provide insight into trajectories through which norms change, and/or backlash persists.

This review has synthesised what is known about gender norms in India. Changing these patriarchal gender norms can be a slow process. Despite evolving individual attitudes, societal expectations and fear of backlash and loss of reputation impede action. Meaningful change occurs when institutions, communities, and individuals collectively embrace new expectations, fostering momentum for non-traditional behaviour. Accelerating change necessitates the adoption of effective practices outlined in the review, emphasising the urgency of investment in their implementation in India.

09 References

Abraham, R., Basole, A., & Kesar, S. (2021). Tracking Employment Trajectories during the Covid-19 Pandemic: Evidence from Indian Panel Data. Centre for Sustainable Employment Working Paper 35. Bengaluru, Azim Premji University

Achyut, P., Bhatla, N., Verma, R. (2015). Questioning gender norms to promote sexual reproductive health among early adolescents: Evidence from a school program in Mumbai, India. In YK Djamba & SR Kimuna (Eds.). Gender based violence: Perspectives from Africa, the Middle East, and India. Springer International Publishing, Switzerland, DOI 10, 1007/978-3-319-16670-4_9.

Achyut, P, Bhatla N., Kumar U., Verma H., Bhattacharya S., Singh, G., Verma, R. (2017). Changing Course: Implementation and Evaluation of the Gender Equity Movement in Schools (GEMS) program in specific sites –Vietnam, India and Bangladesh. New Delhi: International Center for Research on Women.

Achyut P., Bhatla N., Verma H., Uttamacharya, Singh G., Bhattacharya S. and Verma R. (2016). Towards gender equality: The GEMS journey thus far. New Delhi, International Center for Research on Women.

Adukia, A. (2017). Sanitation and education. American Economic Journal: Applied Economics, 9(2), 23-59. Available at: http://www.jstor.org/stable/26156194

Advancing Learning and Innovation on Gender Norms (ALIGN). (2019). Learning about norm change in girls' education in low- and middle-income contexts: Lessons from the Girls' Education Challenge (GEC) Fund. London, Overseas Development Institute.

Afridi, F., Arora, A., Dhar, D., & Mahajan, K. (2023). Women's work, social norms and the marriage market. IZA Discussion Paper No. 15948, Available at SSRN: https://ssrn.com/abstract=4361917 or http://dx.doi.org/10.2139/ssrn.4361917

Allendorf, K. (2010). The quality of family relationships and use of maternal health-care services in India. Studies in Family Planning, 41(4), 263–276. http://www.jstor.org/stable/27896276

Allendorf, K. & Pandian, R. K. (2016). The decline of arranged marriage? Marital change and continuity in India. Population and Development Review, 42(3), 435–64.

Andrew, A., Gautam, A., Krutikova, S., Smarrelli, G., & Verma, H. (2019). Can Life Skills Interventions Help Girls Who Have Little Say? Evidence from a Field Experiment in India. Accessed on 5 March 2021 at https://www.semanticscholar.org/paper/Can-Life-Skills-Interventions-Help-Girls-Who-Have-a-Andrew-Gautam/d9cfda2f2c49cd7018a4c397a822f5e0f4b16a05

Andrew, A., Krutikova, S., Smarrelli, G., Verma, H. (2022). Gender norms, violence and adolescent girls' trajectories: evidence from a field experiment in India, IFS Working Papers W22/41, Institute for Fiscal Studies.

Ansari H, Yeravdekar R. (2020). Respectful maternity care during childbirth in India: A systematic review and meta-analysis. Journal of Postgraduate Medicine, 66,3, 133-140 (July-September). doi: 10.4103/jpgm.JPGM_648_19. PMID: 32675449; PMCID: PMC7542060.

Aruldas K, Kant A, & Mohanan PS. (2017). Care-seeking behaviors for maternal and newborn illnesses among self-help group households in Uttar Pradesh, India. Journal of Health and Population Nutrition, 21,36(Suppl 1), 49 (December). doi: 10.1186/s41043-017-0121-1. PMID: 29297413; PMCID: PMC5764050.

Barker G, Ricardo C, Nascimento M, Olukoya A, Santos C. (2010). Questioning gender norms with men to improve health outcomes: evidence of impact. Glob Public Health, 5,5, 539-53. Doi: 10.1080/17441690902942464. PMID: 19513910.

Barua, A., K. Kurz. 2001. Reproductive health-seeking by married adolescent girls in Maharashtra, India. Reproductive Health Matters, 9, 17, 53-62, ISSN 0968-8080.

Basu S, Zuo, X. Lou, C., Acharya, R., & Lundgren, R. (2017). Learning to be gendered: Gender socialization in early adolescence among urban poor in Delhi, India, and Shanghai, China. Journal of Adolescent Health. 61, 4S, S24-S29 (October). doi: 10.1016/j.jadohealth.2017.03.012. PMID: 28915988.

Beaman L, Duflo E, Pande R, Topalova P. (2012). Female leadership raises aspirations and educational attainment for girls: A policy experiment in India. Science, 3,335(6068):582-6 (Feb). doi: 10.1126/science.1212382. Epub 2012 Jan 12. PMID: 22245740; PMCID: PMC3394179.

Bhan N, McDougal L, Singh A, Atmavilas Y, Raj A. (2020). Access to women physicians and uptake of reproductive, maternal and child health services in India. EClinicalMedicine, 5,20 (Mar),100309. doi: 10.1016/j.eclinm.2020.100309. PMID: 32300752; PMCID: PMC7152807.

Bingenheimer JB. 2019. Veering from a narrow path: The second decade of social norms research. Journal of Adolescent Health, 64, 4S, S1-S3 (April). doi: 10.1016/j.jadohealth.2019.01.012. Epub 2019 Mar 20. PMID: 30914161; PMCID: PMC6426718.

Deininger, C, Williams W, Bernstein EE, Stephenson R. (2015). Systematic review of structural interventions for intimate partner violence in low- and middle-income countries: organizing evidence for prevention. BMC Public Health, 23,15, 1165 (Nov). doi: 10.1186/s12889-015-2460-4. PMID: 26597715; PMCID: PMC4657265.

Castilla, C. 2018. Political role models and child marriage in India. Review of Development Economics. 22. 10.1111/rode.12513.

Cavallaro FL, Benova, L., Owolabi, OO, & Ali, M. (2020). A systematic review of the effectiveness of counselling strategies for modern contraceptive methods: what works and what doesn't? BMJ Sexual and Reproductive Health, 46, 254–269. doi: 10.1136/bmjsrh-2019-200377. Epub 2019 Dec 11. PMID: 31826883; PMCID: PMC7569400.

Chae, S. & Ngo, T. (2017). The global state of evidence on interventions to prevent child marriage. GIRL Center Research Brief, 1. New York: Population Council.

Chandra-Mouli, V. & Patel, SV. (2017). Mapping the knowledge and understanding of menarche, menstrual hygiene and menstrual health among adolescent girls in low- and middle-income countries. Reproductive Health, 14, 1.

Cislaghi B & Heise L. (2019a). Using social norms theory for health promotion in low-income countries. Health Promotion International. 1,34(3), 616-623 (June). doi: 10.1093/heapro/day017. Erratum in: Health Promot Int. 2019 Oct 1;34(5):1069. PMID: 29579194; PMCID: PMC6662293.

Cislaghi B, & Heise L. (2019). Gender norms and social norms: differences, similarities and why they matter in prevention science. Sociology of Health and Illness, 42,2, 407-422 (February). doi: 10.1111/1467-9566.13008. Epub 2019 Dec 13. PMID: 31833073; PMCID: PMC7028109.

Cislaghi, B. & Heise, L. (2018). Theory and practice of social norms interventions: eight common pitfalls. Global Health, 14, 83. https://doi.org/10.1186/s12992-018-0398-x

Collumbien, M., Mishra, M. & Blackmore, C. (2011). Youth friendly services in two rural districts of West Bengal and Jharkhand, India: Definite progress, a long way to go. Reproductive Health Matters, 19,37, 174-183, DOI: 10.1016/S0968-8080(11)37557-X

Costenbader, E; Cislaghi, B; Clark, CJ; Hinson, L; Lenzi, R; Mc-Carraher, DR; McLarnon-Silk, C; Pulerwitz, J; Shaw, B & Stefanik, L. (2019). Social norms measurement: Catching up with programs and moving the field forward. Journal of Adolescent Health, 64,4, S4-S6. ISSN 1054-139X DOI: https://doi.org/10.1016/j.jadohealth.2019.01.001

Daniel EE, Masilamani R. & Rahman M. (2008). The effect of community-based reproductive health communication interventions on contraceptive use among young married couples in Bihar, India. International Family Planning Perspectives, 34, 4, 189-97 (Dec). doi: 10.1363/ifpp.34.189.08. PMID: 19201679.

Das, U. & Singhal & K. (2023). Solving it correctly: Prevalence and persistence of gender gap in basic mathematics in rural India. International Journal of Educational Development, 96, 102703, ISSN 0738-0593, https://doi.org/10.1016/j.ijedudev.2022.102703.

Das M., Ghosh, S., Miller, E., O'Conner B., Verma, R. (2012). Engaging Coaches and Athletes in Fostering Gender Equity: Findings from the Parivartan Program in Mumbai, India. New Delhi: ICRW & Futures Without Violence

Das, A., Mogford, E., Singh, SK., Barbhuiya, RA, Chandra, S & Wahl, R. (2012). Reviewing responsibilities and renewing relationships: an intervention with men on violence against women in India, Culture, Health and Sexuality, 14:6,659-675, DOI: 10.1080/13691058.2012.677477.

Dasra. (2020). Lost in lockdown: chronicling the impact of Covid-19 on India's adolescents. Mumbai, Dasra.

Dehingia N, McAuley J, McDougal L, Reed E, Silverman JG, Urada L, et al. (2023). Violence against women on Twitter in India: Testing a taxonomy for online misogyny and measuring its prevalence during COVID-19. PLoS ONE, 18,10, e0292121. https://doi.org/10.1371/journal.pone.0292121

Desai S, Misra M, Das A, Singh, RJ, Sehgal, M., Gram, L., Kumar, N. & Prost, A. (2020). Community interventions with women's groups to improve women's and children's health in India: a mixed-methods systematic review of effects, enablers and barriers. BMJ Global Health 5:e003304, doi:10.1136/bmjgh-2020-003304

Dhar, Diva, Tarun Jain, and Seema Jayachandran. (2022). Reshaping adolescents' gender attitudes: Evidence from a school-based experiment in India. American Economic Review, 112,3, 899-927. DOI: 10.1257/aer.20201112

Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, Coll-Seck AM, Grover A, Laski L, Roa M, Sathar ZA, Say L, Serour GI, Singh S, Stenberg K, Temmerman M, Biddlecom A, Popinchalk A, Summers C, Ashford LS. (2018). Accelerate progress-sexual and reproductive health and rights for all: Report of the Guttmacher-Lancet Commission. Lancet, 30,391(10140), 2642-2692 (June). Doi: 10.1016/S0140-6736(18)30293-9. Epub 2018 May 9. PMID: 29753597.

Ernst & Young LLP. (2020). Gender study to identify constraints on female participation in skills training and labor market in India. Kolkata, Ernst and Young LLP

Fleming PJ, Silverman J, Ghule M, Ritter J., Battala M, Velhal G, Nair S, Dasgupta A, Donta B, Saggurti N, Raj A. (2018). Can a gender equity and family planning intervention for men change their gender ideology? Results from the CHARM intervention in rural India. Studies in Family Planning, 49,1, 41-56, March. doi: 10.1111/sifp.12047. Epub 2018 Feb 14. PMID: 29441577; PMCID: PMC6469641.

Freudberg, H., Contractor, S, Das, A., Kemp, CG., Nevin, PE., Phadiyal, A., Lal, J. & Rao, D. (2018). Process and impact evaluation of a community gender equality intervention with young men in Rajasthan, India, Culture, Health and Sexuality, 20, 11, 1214-1229, DOI: 10.1080/13691058.2018.1424351

Gius, M. & Subramanian, R. (2015). The relationship between inadequate sanitation facilities and the economic well-being of women in India. Journal of Economics and Development Studies, 3,10.15640/jeds.v3n1a2.

Government of India, Ministry of Statistics and Programme Implementation. (2023). Annual Report: Periodic Labour Force Survey (PLFS) 2022 – 2023 (JULY 2022 - JUNE 2023), New Delhi, Ministry of Statistics and Programme Implementation.

Greene, ME. & Stiefvater, E. (2019). Social and gender norms and child marriage: A reflection on issues, evidence and areas of inquiry in the field. ALIGN: London

Guilmoto, C.Z. (2011). Sex Imbalances at Birth: Trends, Consequences, and Policy Implications. Accessed at http://www.unfpa.org/sites/default/files/resource-pdf/Guilmoto_Revised_presentation_Hanoi_Oct2011.pdf.

Gupta AK & Santhya KG. (2020). Promoting gender egalitarian norms and practices among boys in rural India: The relative effect of intervening in early and late adolescence. Journal of Adolescent Health, 66,2, 157-165 (February). doi: 10.1016/j.jadohealth.2019.03.007. Epub 2019 Jun 18. PMID: 31227386.

Gundi M & Subramanyam, MA. 2019. Menstrual health communication among Indian adolescents: A mixed-methods study. PLoS One. 17,14-10:e0223923), (Oct). doi: 10.1371/journal.pone.0223923. PMID: 31622407; PMCID: PMC6797238.

Gundi, M., Santhya, KG, & Rampal, S. (2021). Educational interventions and transition to work roles, marriage and motherhood among adolescents and young women in South Asia and sub-Saharan Africa: Findings from an evidence synthesis. Technical Brief. New Delhi: Population Council Consulting Pvt. Ltd.

Haberland, NA. (2015). The case for addressing gender and power in sexuality and HIV education: A comprehensive review of evaluation studies. International Perspectives on Sexual and Reproductive Health, 41,1, 31-42 (March), doi: 10.1363/4103115. PMID: 25856235.

Hahn, Y., Islam, A., Nuzhat, K., Smyth, R., & Yang, H. S. (2018). Education, marriage, and fertility: Long-term evidence from a female stipend program in Bangladesh. Economic Development and Cultural Change, 66,2, 383-415. https://doi.org/10.1086/694930

Harper, C, Marcus, R., George, R., D'Angelo, S. and Samman, E. (2020) Gender, power and progress: How norms change. London: ALIGN/ ODI (www.alignplatform. org/gender-power-progress)

Hay K, McDougal L, Percival V, Henry S, Klugman J, Wurie H, Raven J, Shabalala F, Fielding-Miller R, Dey A, Dehingia N, Morgan R, Atmavilas Y, Saggurti N, Yore J, Blokhina E, Huque R, Barasa E, Bhan N, Kharel C, Silverman JG, Raj A. & Gender Equality, Norms, and Health Steering Committee. (2019). Disrupting gender norms in health systems: Making the case for change. Lancet, 22, 393(10190): 2535-2549 (June). doi: 10.1016/S0140-6736(19)30648-8. Epub 2019 May 30. PMID: 31155270; PMCID: PMC7233290.

Hazra, A., Atmavilas, Y., Hay, K., Saggurti, N., Verma, RK., Ahmad, J., Kumar, S., Mohanan, PS, Mavalankar, D. & Irani, L. (2019). Effects of health behaviour change intervention through women's self-help groups on maternal and newborn health practices and related inequalities in rural India: A quasi-experimental study. EClinicalMedicine, 20,18, 100198 (November). doi: 10.1016/j.eclinm.2019.10.011. PMID: 31993574; PMCID: PMC6978187.

Hebert, LE., Bansal, S., Lee, S., Yan S., Akinola, M, Rhyne, M., Menendez, A. & Gilliam, M. (2020). Understanding young women's experiences of gender inequality in Lucknow, Uttar Pradesh through story circles. International Journal of Adolescence and Youth, 25,1, 1-11, DOI: 10.1080/02673843.2019.1568888

Heath, R. & Tan, X., (2020). Intrahousehold bargaining, female autonomy, and labor supply: Theory and evidence from India. Journal of the European Economic Association, 18,4 (August), 1928–1968, https://doi.org/10.1093/jeea/jvz026

Heise L, Greene ME, Opper N, Stavropoulou M, Harper C, Nascimento M, Zewdie D. & Gender Equality, Norms, and Health Steering Committee. (2019). Gender inequality and restrictive gender norms: Framing the challenges to health. Lancet. 15, 393 (10189), 2440-2454 (June). doi: 10.1016/S0140-6736(19)30652-X. Epub 2019 May 30. PMID: 31155275.

Heise, L. & Cislaghi, B. (2016). Measuring Gender-related Social Norms. Technical Report. LSHTM, London.

Heise, L. & Manji K. (2016). Social norms. GSDRC Professional Development Reading Pack 31. Birmingham, UK, University of Birmingham. (https://www.gov.uk/research-for-development-outputs/social-norms-gsdrc-professionaldevelopment-reading-pack-no-31).

Heymann J, Levy JK, Bose B, Ríos-Salas V, Mekonen Y, Swaminathan H, Omidakhsh N, Gadoth A, Huh K, Greene ME, Darmstadt GL. (2019). Gender equality, norms and Health Steering Committee. Improving health with programmatic, legal, and policy approaches to reduce gender inequality and change restrictive gender norms. Lancet, 22;393(10190):2522-2534 (June). doi: 10.1016/S0140-6736(19)30656-7. Epub 2019 May 30. PMID: 31155271.

Heymann, J., Levy, JK., Bose, B., Ríos-Salas, V., Mekonen, Y., Swaminathan, H., Omidakhsh, N., Gadoth, A., Huh, K., Greene, ME., Darmstadt, G L., & Gender Equality, Norms and Health Steering Committee. (2019). Improving health with programmatic, legal, and policy approaches to reduce gender inequality and change restrictive gender norms. Lancet, 22, 393(10190) (June), 2522–2534. doi: 10.1016/S0140-6736(19)30656-7. Epub 2019 May 30. PMID: 31155271. https://doi.org/10.1016/S0140-6736(19)30656-7

Hillenbrand, E., Karim, N., Mohanraj, P., Wu, D. (2015). Measuring gender-transformative change: A review of literature and promising practices. CARE, USA.

Houweling TA, Tripathy P, Nair N, Rath S, Rath S, Gope R, Sinha R, Looman CW, Costello A, Prost A. (2013). The equity impact of participatory women's groups to reduce neonatal mortality in India: secondary analysis of a cluster-randomised trial. Int J Epidemiology. 42,2 (April), 520-32. doi: 10.1093/ije/dyt012. Epub 2013 Mar 18. PMID: 23509239; PMCID: PMC3619953.

Institute for Reproductive Health. 2017. The Flower for Sustained Health: An integrated socio-ecological framework for normative influence and change: A Working Paper. Learning Collaborative to Advance Normative Change. Washington, D.C.: Georgetown University.

International Institute for Population Sciences (IIPS) & ICF. (2021). National Family Health Survey (NFHS-5), 2019-21: India, Volume I. Mumbai: IIPS.

International Institute for Population Sciences (IIPS) & Population Council. (2010). Youth in India: Situation and Needs 2006-2007. Mumbai: IIPS.

International Labour Organisation. (2023). ILOStat Data Resources: Statistics on Youth, accessed on 3.11.2023 at https://www.ilo.org/shinyapps/bulkexplorer28/?lang=en&id=EIP_NEET_SEX_EDU_RT_A

Jayachandra, S. (2015). The roots of gender inequality in developing countries. Ann. Review of Economics, 7, 63-88

Jayachandra, S. (2021). Social Norms as a Barrier to Women's Employment in Developing Countries. IMF Economic Review, accessed at https://doi.org/10.1057/s41308-021-00140-w

Jejeebhoy, SJ. & Santhya, KG. (2023). Sexual and reproductive health and rights in the ESCAP region. Report prepared for the Seventh Asian and Pacific Population Conference, organised by United Nations ESCAP, Bangkok

Jejeebhoy SJ & Raushan MR. (2022). Marriage without meaningful consent and compromised agency in married life: Evidence from married girls in Jharkhand, India. Journal of Adolescent Health, 70 (3S), S78-S85. doi: 10.1016/j.jadohealth.2021.07.005. PMID: 35184837.

Jejeebhoy, SJ. & Kumar, AKS. (2021). What prevents adolescent girls from transitioning from school to work in India? Insights from an exploratory study in Rajasthan. Indian Journal of Human Development, 15(1), 30-48. https://doi.org/10.1177/0973703021998993

Jejeebhoy, SJ., Raushan, MR., Gupta, S. & Bhattacharya, S. (2019). The Situation of Adolescents in Jharkhand: Findings from the DASRA State-wide Survey. Mumbai: DASRA.

Jejeebhoy, SJ. & Santhya, KG. (2015). Parent-Child Communication and Sexual and Reproductive Health Matters. In AK. Shiva Kumar, P. Rustagi & R. Subrahmanian (Eds.). India's Children Essays on Social Policy. New Delhi, Oxford University Press.

Jejeebhoy, SJ., R. Acharya, S. Basu & AJF. Zavier. (2015). Addressing gender-biased sex selection in Haryana, India: Promising approaches. New Delhi: Population Council.

Jejeebhoy SJ, Santhya KG, Zavier AJF. (2014). Demand for contraception to delay first pregnancy among young married women in India. Studies in Family Planning, 45, 2, 183-201 (June). doi: 10.1111/j.1728-4465.2014.00384.x. PMID: 24931075.

Jejeebhoy, SJ., KG. Santhya & S. Sabarwal. (2013). Gender-based violence: A qualitative exploration of norms, experiences and positive deviance. Technical report. New Delhi: Population Council.

Jejeebhoy SJ, Kalyanwala S, Zavier AJ, Kumar R. & Jha N. (2010). Experience seeking abortion among unmarried young women in Bihar and Jharkhand, India: delays and disadvantages. Reproductive Health Matters, 18, 35, 163-74. doi: 10.1016/S0968-8080(10)35504-2. PMID: 20541095.

Jensen, R. (2012). Do labor market opportunities affect young women's work and family decisions? Experimental evidence from India. Quarterly Journal of Economics, 127, 2, 753-792.

John, M. (2018). The political and social economy of sex selection: Exploring family development linkages. New Delhi, UNFPA.

Jungari, S., Sharma, B. & Wagh, D. (2021). Beyond maternal mortality: A systematic review of evidences on mistreatment and disrespect during childbirth in health facilities in India. Trauma, Violence, & Abuse, 22,4, 739-751. https://doi.org/10.1177/1524838019881719

Kabeer, N. & L. Natali. (2013). Gender equality and economic growth: Is there a win-win? IDS Working Paper 417, Brighton, Institute of Development Studies.

KADENCE KP. (nd.). Rapid Assessment of Kanyashree Prakalpa 2016-17: Report. KADENCE KP, Unpublished.

Kågesten A, Gibbs S, Blum RW, Moreau C, Chandra-Mouli V, Herbert A. & Amin A. (2016). Understanding factors that shape gender attitudes in early adolescence globally: A mixed-methods systematic review. PLoS One. 24, 11, 6 (June):e0157805. doi: 10.1371/journal.pone.0157805. PMID: 27341206; PMCID: PMC4920358.

Kanesathasan, A., Cardinal, LJ. Pearson, E., Das Gupta, S., Mukherjee, S. & Malhotra, A. (2008). Catalyzing change: Improving youth sexual and reproductive health through DISHA, an integrated program in India. Washington, DC: International Center for Research on Women.

Karve, I. (1965). Kinship Organization in India. Bombay: Asia Publishing House.

Kaur R. (2010). Khap panchayats, sex ratio and female agency. Economic & Political Weekly, 45, 23, 14–16

Kraft JM, Wilkins KG, Morales GJ, Widyono M. & Middlestadt SE. (2014). An evidence review of gender-integrated interventions in reproductive and maternal-child health. Journal of Health Communication,19 Suppl 1(sup1), 122-41. doi: 10.1080/10810730.2014.918216. PMID: 25207450; PMCID: PMC420588

León, F.R., Lundgren, R., Sinai, I., Sinha, R. & Jennings, V. (2014). Increasing literate and illiterate women's met need for contraception via empowerment: a quasi-experiment in rural India. Reproductive Health 11, 74. https://doi.org/10.1186/1742-4755-11-74

Levy JK, Darmstadt GL, Ashby C, Quandt M, Halsey E, Nagar A. & Greene ME. (2020). Characteristics of successful programmes targeting gender inequality and restrictive gender norms for the health and wellbeing of children, adolescents, and young adults: a systematic review. Lancet Global Health, 8, 2, e225-e236 (February). doi: 10.1016/S2214-109X(19)30495-4. Epub 2019 Dec 23. PMID: 31879212; PMCID: PMC7025324.

Lim SS, Dandona L, Hoisington JA, James SL, Hogan MC. & Gakidou E. (2010). India's Janani Suraksha Yojana, a conditional cash transfer programme to increase births in health facilities: an impact evaluation. Lancet. 5, 375(9730), 2009-23 (June). Doi: 10.1016/S0140-6736(10)60744-1. PMID: 20569841.

Makleff S, Wilkins R, Wachsmann H, Gupta D, Wachira M, Bunde W, Radhakrishnan U, Cislaghi B. & Baum SE. (2019). Exploring stigma and social norms in women's abortion experiences and their expectations of care. Sexual and Reproductive Health Matters, 27, 3, 1661753 (Nov). doi: 10.1080/26410397.2019.1661753. PMID: 31551027; PMCID: PMC7887901.

Malhotra, A. & Elnakib. S. (2021). 20 years of the evidence base on what works to prevent child marriage: A systematic review. Journal of Adolescent Health, 68, 5, 847–62.

McCammon E, Bansal S, Hebert LE, Yan S, Menendez A, Gilliam M. (2020). Exploring young women's menstruation-related challenges in Uttar Pradesh, India, using the socio-ecological framework. Sexual and reproductive health matters, 28, 1 (Dec), 1749342. doi: 10.1080/26410397.2020.1749342. PMID: 32308152; PMCID: PMC7175471.

Ministry of Statistics and Programme Implementation (MOSPI). (2023). Period Labour Force Survey 2022-2023. New Delhi: MOSPI.

Mishra, D. (2015). Portrayal of women in media. Journal of Higher Education and Research Society: A Refereed International, 3, 2, October

Mitra, S and Moene, K. (2017). Wheels of power: Long-term effects of targeting girls with in-kind transfers. London: International Growth Centre.

Mittal M, Paden McCormick A, Palit M, Trabold N. & Spencer C. (2023). A meta-analysis and systematic review of community-based intimate partner violence interventions in India. International Journal of Environmental Research in Public Health, 27, 20, 7, 5277. doi: 10.3390/ijerph20075277. PMID: 37047893; PMCID: PMC10093839.

Mookerjee, S. (2019). Gender-neutral inheritance laws, family structure, and women's status in India. The World Bank Economic Review, 33, 498–515.

Muralidharan, K. & Prakash, N. (2013). Cycling to school: increasing secondary school enrollment for girls in India. NBER Working Paper, 19305.

Mwaikambo, L., Speizer, IS., Schurmann, A., Morgan, G. & Fikree, F. (2011). What works in family planning interventions: A systematic review. Studies in Family Planning, 42, 2, 67-82 (June), doi: 10.1111/j.1728-4465.2011.00267.x. PMID: 21834409; PMCID: PMC3761067.

Nair MK, Leena ML, Paul MK, Pillai HV, Babu G, Russell PS, Thankachi Y. (2012). Attitude of parents and teachers towards adolescent reproductive and sexual health education. Indian Journal of Pediatrics, 79, Suppl 1, S60-63. doi: 10.1007/s12098-011-0436-7. Epub 2011 May 26. PMID: 21614606.

Nanda P., Gautam, A., Verma, R., Khanna, A., Khan, N., Brahme, D., Boyle, S. & Kumar S. (2014). Study on masculinity, intimate partner violence and son preference in India. New Delhi, International Center for Research on Women.

Nanda, P., Datta, N., Pradhan, E. Das, P. & S. & Lamba, S. (2016). Making change with cash? Impact of a conditional cash transfer program on age of marriage in India. Washington, D.C.: International Center for Research on Women (ICRW).

Nanda, P., Gautam, A., Das, P., Vyas, A., Guhathakurta, A., & Datta, N. (2017). Shaping futures. planning ahead for girls' empowerment and employability: An evaluation study of a school-based girls' gender integrated skills program in Delhi, India. New Delhi, Delhi: International Center for Research on Women.

National Council of Education, Research and Training (NCERT). (2019). Training and resource material: Health and wellness of school going children (under the aegis of School Health Programme of Ayushman Bharat). New Delhi: NCERT

National Crimes Records Bureau, Ministry of Home Affairs. (2023). Crime in India 2022, Statistics. Vol 1. New Delhi, National Crime Records Bureau (Ministry of Home Affairs), accessed on 7.2.2024 at https://ncrb.gov.in/uploads/nationalcrimerecordsbureau/custom/1701607577CrimeinIndia2022Book1.pdf

Ng M, Misra A, Diwan V, Agnani M, Levin-Rector A, De Costa A. (2014). An assessment of the impact of the JSY cash transfer program on maternal mortality reduction in Madhya Pradesh, India. Global Health Action, 3,7, 24939. doi: 10.3402/gha.v7.24939. PMID: 25476929; PMCID: PMC4256523.

Naved RT, Kalra S, Talukder A, Laterra A, Nunna TT, Parvin K, Al Mamun M. (2022). An exploration of social norms that restrict girls' sexuality and facilitate child marriage in Bangladesh to inform policies and programs. Journal of Adolescent Health,70, (3S), S17-S21 (March). Doi: 10.1016/j.jadohealth.2021.12.002. PMID: 35184825; PMCID: PMC8916528.

Nirantar Trust. (2015). Early and child marriage in India: A landscape analysis. New Delhi, Nirantar Trust.

Oster, E. & Millet, B. (2010). Do Call Centers Promote School Enrollment? Evidence from India. University of Chicago and NBER, unpublished report.

ODI & UNFPA. (2022). Guidance note: Integrating the gender and social norms output into country programme documents. New York, ODI and UNFPA.

Panda, P. & Aggarwal, B. (2005). Marital violence, human development and women's property status in India. World Development, 33, 823-850, 10.1016/j.worlddev.2005.01.009.

Patton, GC., Sawyer, SM., Santelli, JS., Ross, DA., Afifi, R., Allen, NB., Arora, M., Azzopardi, P., Baldwin, W., Bonell, C. & Kakuma, R. (2016). Our future: A Lancet commission on adolescent health and wellbeing. The Lancet, 387, 10036, 2423–78.

Paul P, Closson K. & Raj A. (2023). Is parental engagement associated with subsequent delayed marriage and marital choices of adolescent girls? Evidence from the Understanding the Lives of Adolescents and Young Adults (UDAYA) survey in Uttar Pradesh and Bihar, India. SSM Population Health, 5, 24 (Oct), 101523. doi: 10.1016/j.ssmph.2023.101523. PMID: 37860704; PMCID: PMC10583165.

Percher J, Saxena M, Srivastava A. & Diamond-Smith N. (2021). Differential treatment in the provision of medication abortion at pharmacies in Uttar Pradesh, India. AJOG Global Reports. 30,1, 4, 100025 (Sept), doi: 10.1016/j.xagr.2021.100025. PMID: 36277455; PMCID: PMC9563544.

Plourde KF, Thomas R, Nanda G. (2020). Boys mentoring, gender norms, and reproductive health-potential for transformation. Journal of Adolescent Health, 67, 4, 479-494 (October). doi: 10.1016/j.jadohealth.2020.06.013. Epub 2020 Aug 1. PMID: 32753346.

Population Foundation of India. (Nd.). Main Kuch Bhi LKar Sakti Hoon. New Delhi, Population Foundation of India.

Prakash R, Beattie TS, Javalkar P, Bhattacharjee P, Ramanaik S, Thalinja R, Murthy S, Davey C, Gafos M, Blanchard J, Watts C, Collumbien M, Moses S, Heise L, Isac S. (2019). The Samata intervention to increase secondary school completion and reduce child marriage among adolescent girls: Results from a cluster-randomised control trial in India. Journal of Global Health, 9, 1 (June), 010430. doi: 10.7189/jogh.09.010430. PMID: 31448111; PMCID: PMC6684866.

Pratichi Institute. (2017). Assessment of Kanyashree Prakalpa. Kolkata, Pratichi Institute.

Pujar A, Howard-Merrill L, Cislaghi B, Lokamanya K, Prakash R, Javalkar P, Raghavendra T, Beattie T, Isac S, Gafos M, Heise L, Bhattacharjee P, Ramanaik S. & Collumbien M. (2023). Boys' perspectives on girls' marriage and school dropout: a qualitative study revisiting a structural intervention in Southern India. Culture Health and Sexuality, 7, 1-16 (Aug). doi: 10.1080/13691058.2023.2241525.

Pulerwitz, Judith, Robert Blum, Beniamino Cislaghi, Elizabeth Costenbader, Caroline Harper, Lori Heise, Anjalee Kohli, and Rebecka Lundgren. (2019). Proposing a conceptual framework to address social norms that influence adolescent sexual and reproductive health. Journal of Adolescent Health, 64, S7eS9

Raghunathan N., L. Sushant, S. Mankad. (2021). Can media campaigns change attitudes and spark actions to reduce early child marriage? Impact evaluation of Breakthrough's early marriage campaign in Jharkhand and Bihar states of India, Report to the International Initiative for Impact Evaluation, New Delhi.

Raj A, Ghule M, Johns NE, Battala M, Begum S, Dixit A, Vaida F, Saggurti N, Silverman JG, Averbach S. (2022). Evaluation of a gender synchronized family planning intervention for married couples in rural India: The CHARM2 cluster randomized control trial. EClinicalMedicine, 5;45 (March):101334. doi: 10.1016/j.eclinm.2022.101334. PMID: 35274093; PMCID: PMC8902598.

Rasmussen, B., Maharaj, N., Karan, A., Symons, J., Selvaraj, S., Kumar, R., Kumnick, M. & Sheehan, P. (2021). Evaluating interventions to reduce child marriage in India. Journal of Global Health Reports, 5. 10.29392/001c.23619.

Rath S, Nair N, Tripathy PK, Barnett S, Rath S, Mahapatra R, Gope R, Bajpai A, Sinha R, Costello A, Prost A. (2010). Explaining the impact of a women's group led community mobilisation intervention on maternal and newborn health outcomes: the Ekjut trial process evaluation. BMC International Health and Human Rights. 22, 10, 25. doi: 10.1186/1472-698X-10-25. PMID: 20969787; PMCID: PMC2987759.

Rao Gupta G, Oomman N, Grown C, Conn K, Hawkes S, Shawar YR, Shiffman J, Buse K, Mehra R, Bah CA, Heise L, Greene ME, Weber AM, Heymann J, Hay K, Raj A, Henry S, Klugman J., Darmstadt GL. & Gender Equality, Norms, and Health Steering Committee. (2019). Gender equality and gender norms: framing the opportunities for health. Lancet 22, 393, 10190, 2550-2562 (June). doi: 10.1016/S0140-6736(19)30651-8. Epub 2019 May 30. PMID: 31155276.

Ravindran, TKS. & Balasubramanian, P. (2004). "Yes" to Abortion but "No" to Sexual Rights: The Paradoxical Reality of Married Women in Rural Tamil Nadu, India. Reproductive Health Matters, 12, 23, 88–99. http://www.jstor.org/stable/3775975

Roy, Sanchari. 2011. Empowering Women: Inheritance Rights and Female Education in India. University of Warwick, Working Paper Series, No.46 (revised).

Roy, S. (2011). Empowering women : inheritance rights and female education in India. Working Paper. Coventry, UK: Department of Economics, University of Warwick. CAGE Online Working Paper Series, 2011, 46, http://www2.warwick.ac.uk/fac/soc/economics/resear...

Saggurti N, Atmavilas Y, Porwal A, Schooley J, Das R, Kande N, Irani L, Hay K. (2018). Effect of health intervention integration within women's self-help groups on collectivization and healthy practices around reproductive, maternal, neonatal and child health in rural India. PLoS One, 13, 8 (Aug 23), e0202562. doi: 10.1371/journal.pone.0202562. PMID: 30138397; PMCID: PMC6107172.

Saha R, Paul P, Yaya S, Banke-Thomas A. (2022). Association between exposure to social media and knowledge of sexual and reproductive health among adolescent girls: Evidence from the UDAYA survey in Bihar and Uttar Pradesh, India. Reproductive Health, 19, 1, 178 (Aug 17),. doi: 10.1186/s12978-022-01487-7. PMID: 35978427; PMCID: PMC9382779.

Santhya KG & Zavier AJF. (2022). Long-term impact of exposure to a gender-transformative program among young men: Findings from a longitudinal study in Bihar, India. Journal of Adolescent Health, 70, 4, 634-642 (April). Doi: 10.1016/j.jadohealth.2021.10.041. Epub 2021 Dec 21. PMID: 34952780.

Santhya, KG., Dayal, R., Jena, Z., & Rampal, S. (2021). Social norms interventions and transition to work roles, marriage and motherhood among adolescents and young women in South Asia and sub-Saharan Africa: Findings from an evidence synthesis. Technical Brief. New Delhi: Population Council Consulting Pvt Ltd.

Santhya, KG., Jejeebhoy, SJ, Jena, Z., Gundi, M. & Dayal, R. (2021). Exposure to life skills education and transition to work roles, marriage and motherhood among adolescent girls and young women: Findings from a rapid review of evidence from South Asia and sub-Saharan Africa. Technical Brief. New Delhi: Population Council Consulting Pvt Ltd.

Santhya. KG, Jejeebhoy, SJ, Acharya, R., Pandey, N., Gogoi, A., Joshi, M., Singh, SK., Saxena, K. & Ojha, SK. (2019). Transforming the attitudes of young men about gender roles and the acceptability of violence against women, Bihar. Culture, Health and Sexuality, 21. 12, 1409–1424 https://doi.org/10.1080/13691058.2019.1568574

Santhya, KG. (2019). Perceptions of young adolescent girls on marriage. Research Brief, New Delhi: Population Council.

Santhya, KG., Acharya, R., Pandey, N., Singh, SK, Rampal, S., Zavier, AJF. & Gupta, AK. (2017a). Understanding the lives of adolescents and young adults (UDAYA) in Bihar, India. New Delhi: Population Council.

Santhya, KG., Acharya, R., Pandey, N., Gupta, AK., Rampal, S., Singh, SK. & Zavier, AJF. (2017b). Understanding the lives of adolescents and young adults (UDAYA) in Uttar Pradesh, India. New Delhi: Population Council.

Santhya, KG., Zavier, AJF. & Jejeebhoy, SJ. (2015). School quality and its association with agency and academic achievements in girls and boys in secondary schools: Evidence from Bihar, India, International Journal of Educational Development, Volume 41, pp. 35-46, ISSN 0738-0593, https://doi.org/10.1016/j.ijedudev.2014.12.002.

Santhya, K. G., R. Prakash, S. J. Jejeebhoy and S. K. Singh. (2014). Accessing adolescent friendly health clinics in India: The perspectives of adolescents and youth. New Delhi: Population Council.

Santhya, KG., Haberland, N., Das, A., Lakhani, A., Ram, F., Sinha, RK. & Mohanty, SK. (2008). Empowering married young women and improving their sexual and reproductive health: Effects of the First-Time Parents Project. New Delhi, India: Population Council.

Santhya, KG., Haberland, N. & Singh, AK. (2006). 'She knew only when the garland was put around her neck': Findings from an exploratory study on early marriage in Rajasthan. New Delhi: Population Council.

Sedlander E, Talegawkar S, Ganjoo R, Ladwa C, DiPietro L, Aluc A. & Rimal RN. (2021). How gender norms affect anemia in select villages in rural Odisha, India: A qualitative study. Nutrition, 86:111159 (June). doi: 10.1016/j.nut.2021.111159. Epub 2021 Jan 24. PMID: 33636419; PMCID: PMC8209141.

Sen S, Chatterjee S, Khan PK, Mohanty SK. (2020). Unintended effects of Janani Suraksha Yojana on maternal care in India. SSM Population Health, 11 (June 25), 100619. doi: 10.1016/j.ssmph.2020.100619. PMID: 32642548; PMCID: PMC7334609.

Shekhar C, Sundaram A, Alagarajan M, Pradhan MR, Sahoo H. (2020). Providing quality abortion care: Findings from a study of six states in India. Sexual and Reproductive Healthcare, 24 (June):100497. doi: 10.1016/j.srhc.2020.100497. Epub 2020 Jan 30. PMID: 32036281, ISSN 1877-5756, https://doi.org/10.1016/j.srhc.2020.100497.(https://www.sciencedirect.com/science/article/pii/S1877575619302228)
.

Shinde S, Weiss HA, Khandeparkar P, Pereira B, Sharma A, Gupta R, Ross DA, Patton G, Patel V. (2020). A multicomponent secondary school health promotion intervention and adolescent health: An extension of the SEHER cluster randomised controlled trial in Bihar, India. PLoS Med, 11, 17, 2 (Feb), e1003021. doi: 10.1371/journal.pmed.1003021. PMID: 32045409; PMCID: PMC7012396.

Shinde, S., Weiss, HA., Varghese, B., Khandeparkar, P., Pereira, B., Sharma, A., Gupta, R., Ross, DA., Patton, G., & Patel, V. (2018). Promoting school climate and health outcomes with the SEHER multi-component secondary school intervention in Bihar, India: A cluster-randomised controlled trial. The Lancet, 392, 10163, 2465–2477. https://doi.org/10.1016/S0140-6736(18)31615-5

Shukla A, Kumar A, Mozumdar A, Acharya R, Aruldas K, & Saggurti N. (2022). Restrictions on contraceptive services for unmarried youth: a qualitative study of providers' beliefs and attitudes in India. Sexual and Reproductive Health Matters.30, 1, 2141965 (Dec). doi: 10.1080/26410397.2022.2141965. PMID: 36416064; PMCID: PMC9704070.

Siddiqui M, Kataria I, Watson K, Chandra-Mouli V. (2020). A systematic review of the evidence on peer education programmes for promoting the sexual and reproductive health of young people in India. Sexual and Reproductive Health Matters, 28, 1, 1741494. doi: 10.1080/26410397.2020.1741494. PMID: 32372723; PMCID: PMC7887991.

Singh, MK. (2018). Gender and women empowerment approaches: Interventions through PRIs and CSOs in Northern India. Women's Studies International Forum, 71, 63-67, https://www.sciencedirect.com/science/article/pii/S0277539518300839

Sjostrom, S., B. Essen, B. Syden, F., Gemzell-Danellsson, K. & Klingberg-Allvin, M. (2014). Medical students' attitudes and perceptions on abortion: A cross- sectional study among medical interns in Maharashtra, India. Contraception, 90, 10.1016/j.contraception.2014.02.005, 42-46.

Stewart R, Wright B, Smith L, Roberts S. & Russell N. (2021). Gendered stereotypes and norms: A systematic review of interventions designed to shift attitudes and behaviour. Heliyon. 13;7, 4, e06660 (April). doi: 10.1016/j.heliyon.2021.e06660. PMID: 33912699; PMCID: PMC8066375.

Stillman, M., Frost, JJ, Singh, S., Moore, AM. & Kalyanwala, S. (2014). Abortion in India: A Literature Review. New York, Guttmacher Institute.

Stroope S, Kroeger RA. & Fan J. (2021). Gender contexts, dowry and women's health in India: A national multilevel longitudinal analysis. Journal of Biosocial Science, 53, 4 (June), 508-521. doi: 10.1017/S0021932020000334. Epub Aug 10. PMID: 32772940.

Subramanian L, Simon C, Daniel EE. (2018). Increasing contraceptive use among young married couples in Bihar, India: Evidence from a decade of implementation of the PRACHAR Project. Global Health: Science and Practice, 29, 6, 2, 330-344, (June). doi: 10.9745/GHSP-D-17-00440. Erratum in:. 2018 Oct 4;6(3):617. PMID: 29959273; PMCID: PMC6024625.

The Social Norms Learning Collaborative. (2021). Social norms atlas: Understanding global social norms and related concepts. Washington, D.C., Institute for Reproductive Health, Georgetown University.

Tokhi M, Comrie-Thomson L, Davis J., Portela A, Chersich M. & Luchters S. (2018). Involving men to improve maternal and newborn health: A systematic review of the effectiveness of interventions. PLoS One, 25, 13, 1, e0191620 (January), doi: 10.1371/journal.pone.0191620. PMID: 29370258; PMCID: PMC5784936.

Tripathy P, Nair N, Barnett S, Mahapatra R, Borghi J, Rath S, Rath S, Gope R, Mahto D, Sinha R, Lakshminarayana R, Patel V, Pagel C, Prost A. & Costello A. (2010). Effect of a participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: A cluster-randomised controlled trial. Lancet, 3, 375, 9721, 1182-92 (April). doi: 10.1016/S0140-6736(09)62042-0. Epub 2010 Mar 6. PMID: 20207411.

UNAIDS. 2023. The path that ends AIDS: UNAIDS Global AIDS Update 2023. Geneva, Joint United Nations Programme on HIV/AIDS.
United Nations Population Fund. (2020). Sex Ratio at Birth in India: Recent Trends and Patterns. New Delhi, UNFPA.

United Nations Population Fund. (2022). Strategic Plan 2022-2025. New York, UNFPA.

United Nations Development Programme (UNDP). (2022). Human Development Report 2021/2022: Uncertain times, unsettled lives -- shaping our future in a transforming world. New York, UNDP.

United Nations Development Programme (UNDP), United Nations Entity for Gender Equality & the Empowerment of Women (UN Women). (2023). The paths to equal: Twin indices on women's empowerment and gender equality. New York, UNDP.

United Nations Development Programme (UNDP). (2023). 2023 Gender social norms index--Breaking down gender biases, shifting social norms towards gender equality. New York, The Human Development Report Office (HDRO), United Nations Development Programme (UNDP).

UNWomen, (2019). Gender inequality in Indian media: A preliminary analysis. New Delhi, UNWomen.

UNWomen and ICRW. (2013). Safe cities free from violence against women and girls: Baseline findings from the Safe City Delhi Programme, Delhi, ICRW.

Verma, RK., Pulerwitz, J., Mahendra, VS.,, Khandekar, S., Singh, AK., Das, SS., Mehra, S., Nura, A. & Barker, G. (2008)."Promoting gender equity as a strategy to reduce HIV risk and gender-based violence among young men in India. Horizons Final Report. Washington, DC: Population Council.

Weber AM, Cislaghi B, Meausoone V, Abdalla S, Mejía-Guevara I, Loftus P, Hallgren E, Seff I, Stark L, Victora CG, Buffarini R, Barros AJD, Domingue BW, Bhushan D, Gupta R, Nagata JM, Shakya HB, Richter LM, Norris SA, Ngo TD, Chae S, Haberland N, McCarthy K, Cullen MR., Darmstadt GL & Gender Equality, Norms and Health Steering Committee. (2019). Gender norms and health: insights from global survey data. Lancet. 393, 10189, 2455-2468 (Jun 15),doi: 10.1016/S0140-6736(19)30765-2. Epub 2019 May 30. PMID: 31155273.

Zahra, F., Austrian, K., Gandhi, M., Psaki, S. & Ngo, T. (2021). Drivers of marriage and health outcomes among adolescent girls and young women: Evidence from sub-Saharan Africa and South Asia. Journal of Adolescent Health, 69, (6S), S31-S38. doi: 10.1016/j.jadohealth.2021.09.014. PMID: 34809897.

Zahir, F. (2018). How a silent revolution in rural Bihar is empowering women to be agents of change. World Bank Blogs, accessed at https://blogs.worldbank.org/governance/how-silent-revolution-rural-bihar-empowering-women-be-agents-change

United Nations Population Fund - India
55, Lodi Estate, New Delhi - 110003
Phone: 011-46532333 | **Email:** india.office@unfpa.org

Visit our website: india.unfpa.org | **Follow us on : @UNFPAIndia**