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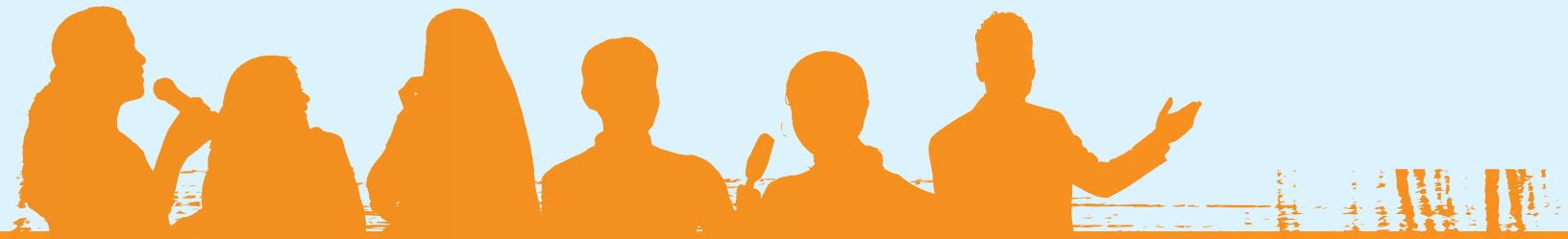
R4i REVIEW

RESEARCH FOR IMPACT



INSIDE

ROUND II MEETING, DECEMBER 2023

Table of Contents

Foreword

This document provides an overview of the Research for Impact (R4I) meetings initiated by the United Nations Population Fund (UNFPA) as a strategy to deepen understanding of ongoing research and ensure its relevance and effectiveness. The purpose of these meetings is to not only benefit from existing expertise but also to foster a community of practice around critical issues.

UNFPA aims to use the R4I meetings as a platform to periodically assess the direction of research, ensure that crucial issues are being addressed and incorporate insights from allies and partners. These meetings are envisioned as forums where new data and analysis converge to generate fresh evidence, shape thinking, guide program interventions and serve as a foundation for policy advocacy.

The document highlights that two R4I review meetings have already been conducted in May and December 2023 in New Delhi. With 2024 marking the 30th anniversary of the International Conference on Population and Development and the 50th anniversary of UNFPA in India, the year holds particular significance for the organization. UNFPA aims not only to reflect on the past achievements but also to envision India's trajectory over the next 50 years and ensure the protection of rights and choices of all citizens.

The outcomes of the R4I Review Meeting Round II are deemed crucial for a diverse range of stakeholders, including UNFPA's funding partners eager to engage with new research areas, as well as government bodies, including state governments, seeking implementable solutions to India's developmental challenges.

Overall, the document underscores UNFPA's commitment to fostering collaboration, generating actionable research and addressing pressing issues facing India's development sector through the R4I meetings.

Andrea Wojnar
UNFPA Representative for India
Country Director for Bhutan





Summary

The R4I Review Meeting held in December 2023 at New Delhi opened with a detailed and comprehensive discussion on the economic and demographic trends in India with a special focus on health, education and gender. It then deliberated on studies related to family planning and contraception; reflected on new research tools and frameworks; and explored the underpinnings of child marriage, impact of climate change on exacerbating vulnerabilities, the value of women's unpaid work, etc. By disseminating its research work, UNFPA aimed to generate new evidence, inform policy and promote actionable research for the future.

India's Population Dynamics: Progress, Challenges and Opportunities

With rising income, reduction in poverty, digitalization, financial inclusion, health, education and women's participation, India has been an exemplar economy in recent decades. However,

Sidebar 1: Policy Briefs Launched during R4I Round II Review Meeting

- India's Population Growth and Policy Implications (https://india.unfpa.org/sites/default/files/pub-pdf/brief1_-_indias_population_growth_and_policy_implications.pdf)
- The Sexual and Reproductive Health Status of Young People in India (https://india.unfpa.org/en/publications/sexual-reproductive-health-status-young-people-india)
- Men's Participation in Family Planning and Reproductive Health (https://india.unfpa.org/en/publications/mens-participation-family-planning-reproductive-health)

alongside these great strides are also certain concerns—income inequality, hunger and malnutrition, disparities in health and education indicators by region and strata, interstate and intrastate variations in development, ramifications of rapid urbanization, challenges related to environmental sustainability, etc.

Providing quality universal public health and education and clearing the way for greater gender parity can accelerate India's economic and social progress. Significant concerns include the prevalence of gender-based violence (GBV), lack of women's agency in marriage and family planning, SRH of adolescent girls and young women and the lack of community connect on these issues.

India needs transformational, structural and social change to pave the way for sustainable development that will create a more equitable and just society. There is a need to develop an appropriate research and evidence strategy. Given India's diversity, there is perhaps a need for a greater number of smaller surveys to customize research to more local contexts and generate evidence for focused policy and better targeted action at the district and state level.

This is the moment for India to harness its resources, navigate through complex global challenges and seize opportunities to profoundly shape its trajectory, and make not just its own future but also that of the world more secure and sustainable.

Family Planning and Contraception

While India's TFR has declined from 2.2 to 2.0 between NFHS-4 (2015–2016) and NFHS-5 (2019–2021) and the use of modern contraceptives has increased from 47.8% to 56.5% among couples in the same period, wide disparities across states and different population groups persist. While men dominate decision-making on contraception, they are uninvolved in issues of SRH and the onus of birth control and family planning is placed squarely on the women. These challenges were examined from three perspectives:

- What are the determinants of the uptake of reversible contraceptive methods in Bihar, Madhya Pradesh and Rajasthan?
- What are the barriers to family planning among adolescents and young adults in Bihar?
- How can men's participation in family planning and reproductive health be improved?

Uptake of Reversible Contraception in Bihar, Madhya Pradesh and Rajasthan

The study indicated that although overall contraceptive awareness is high, non-utilization is also high with most respondents reporting "infrequent sex" as the primary cause. It concluded that female sterilization was the overwhelming choice for limiting family size and there is a clear unmet need for contraception and family planning services in the study states.

Lack of female autonomy, lack of partner involvement, costs, lack of awareness and, hence, apprehensions about use, son preference, religious beliefs, lack of privacy and poor engagement and involvement of service providers, family pressure, etc. were some of the factors preventing adoption of reversible contraceptive methods. Service providers often neglected client-specific needs and preferences for contraceptives or made a poor assessment of medical history. Clients also reported instances of biased counselling or the provider pushing for specific contraceptive methods.

Recommendations from the study included awareness generation; catalysing behaviour change through health workers and community; delivering comprehensive counselling; strengthening supply chain management in contraceptive products; collaborating with private sector and non-government organizations; etc.

Access to Family Planning Among Adolescents and Young Adults in Bihar

Unintended childbirth in young ages poses global health challenges, escalating maternal and newborn risks. Despite a notable increase in modern Contraceptive Prevalence Rate (mCPR) from 23% (2015–2016) to 44% (2019–2020) in Bihar, gaps persist, especially among adolescents. The study (in collaboration with AN Sinha Institute of Social Sciences, Patna) found that only 7.6% of 15–19-year-olds use contraception with a 5.3% unmet need for spacing. Among adolescents, non-use of contraception is primarily attributed to child preference (76.5%), lack of knowledge (26.4%), husband's migration (25.9%), and denial of his consent (18.3%). Social stigma prevents discussion about family planning methods with their mothers or peers among adolescent girls. About 42% of married respondents have never discussed this "taboo" subject even with their husbands. Most have never heard of YUVA Clinics, 91% respondents have had no interaction with health workers and a mere 27% of the married respondents have received couple-counselling at health facilities.

The study attributed the gap between family planning awareness and utilization to myths, low education, gender preference, and socio-cultural beliefs. Network analysis of focus group discussions (FGDs) reveals persistent patriarchal barriers to family planning: low women's agency, limited husband involvement, family objections, male child preference, and fear of side effects. Lack of counselling by health workers (24.7%), unavailability of preferred method (13.5%), financial limitations and poor quality (10.6%) are the main reasons for non-use of spacing methods.

Providers also face challenges such as delays in recruitment, insufficient training for grassroots health workers, limited contraceptive options and a cumbersome stock maintenance process.

The study considered prioritizing reproductive health as fundamental to the well-being of women and girls and ensuring a continuous investment into supporting each new cohort of young couples. Recommendations included enhancing knowledge of SRH and rights among adolescent girls through intensive information, education and communication (IEC) strategies by engaging the husband and mother-in-law and involving men in family planning. Sensitizing and training health workers, ensuring privacy and delivering customized counselling and positively influencing adolescents and young adults were also suggested. Using digital media to reduce barriers, gender discriminatory and regressive social norms and repositioning family planning as "not just birth control" were also highlighted.

Men's Participation in Family Planning and Reproductive Health

The Population Foundation of India conducted a study to analyse the NFHS-5 (2019-21) data on men's participation in family planning and reproductive health and developed a policy brief for promoting strategies to support and increase men's participation.

In the study, 35% of male respondents stated that contraception is women's business, 40% of those with 3 or more daughters but no son desired more children while 80% of those with at least one son did not want more children (indicating son preference). Men were hesitant to discuss contraception with female health workers and sought out

unreliable sources instead, feeding misconceptions about contraceptive methods. For instance, male sterilization is believed widely to lead to impotence (indicating end of sex life) and weakness (with adverse effects on work life). Lack of access to information on SRH and well-being through school or out-of-school programmes creates unhealthy and misinformed behaviours in their marital life as adults that propagate patriarchy, misplaced sense of masculinity and diminished involvement of men in family planning.

Inequitable gender role attitudes among adolescents can be transformed through long-term multi-stakeholder gender sensitization programmes designed to include families, teachers and social influencers to create a supportive environment for boys. Promoting strategies that prioritize men as beneficiaries of the family planning programme, focusing on SRH, re-energizing the family planning programme to promote male sterilization, redefining family planning beyond mPCRs in social conversations and catalysing consensual decision-making on such matters were recommended. Therefore, investing in Social and Behavioural Change Communication (SBCC) interventions, formulating policies to mainstream gender sensitization of young boys and promoting comprehensive sex education in schools covering SRH and life skills are crucial to transformational social change.

Implementation, Research and Operational Frameworks of Gender Interventions

Assessment of Services of One-Stop Centres and Coordination with the Health Sector

One-Stop Centres (OSCs) have been established by Government of India to facilitate immediate, emergency and non-emergency access to medical, legal, psychological and counselling support under one roof to survivors of GBV. For a coordinated response from the health facilities and the OSCs, UNFPA proposed a baseline in four states, Bihar, Madhya Pradesh, Odisha and Rajasthan. The study aimed to assess GBV response services; use an intersectional lens to understand their response to the needs of persons with disabilities (PWDs); and develop an adapted version of the GBV Quality Assurance Tool for internal assessments to be applied for continuous quality improvement and policy-making.

Initial findings from Madhya Pradesh and Rajasthan indicate that the 24x7 OSCs get no walk-ins or referrals from health facilities, but only those referred to by the police. It was also found that unless the survivor mentions it, health personnel do not probe for GBV, even in instances of doubt. Bhopal was the only OSC that was undertaking outreach and had a defined system for coordination with health facilities. Other OSCs, even if housed within a health facility, had no coordination system. Bhopal and Jaipur OSCs were relatively more PWD-friendly.

Tackling of Social Norms through Panchayati Raj Institutions

In the 10th Country Program, UNFPA aims to intensify and scale up its ongoing work on strengthening Panchayati Raj Institutions (PRIs) to help loosen the grip of informal and exclusionary practices on the lived experience of women and girls in India. The proposed intervention that will support the panchayat's role and action for tackling discriminatory norms and enhancing the value of women and girls are built on five pillars. Strengthening systems by creating Gender Cells at State Institute for Rural Development and Panchayati Raj (SIRDPR) and building capacities of PRIs is the first. Community action in the form of organizing Mahila Sabhas, transacting life skills with adolescents, undertaking safety audits, linking women and girls to vocational skills and establishing model panchayats is the next. The third is creation of knowledge products that include developing markers of women and girl-friendly panchayats, documentation of

good practices and a Standard Operating Procedure (SOP) for elected representatives for addressing GBV. Advocacy through actionable policy recommendations and state and district level consultations and workshops and development of a measurement and evaluation framework to measure changes in discriminatory social norms over two–three years are the other two.

In collaboration with the MoPR, UNFPA has already conducted training programs for PRI officials on the documentation of good practices related to integrating gender into Gram Panchayat Development Plan, and also developed an operational framework for PRIs for the same. These will provide guidance on improving women's and girls' education, employment and empowerment and engagement of men and boys to create an enabling environment at the village level. Starting with a district each in Rajasthan and Madhya Pradesh, it is expanding to all Indian states with UNFPA presence.

Proposed Areas of Research

Going forward, three areas of research are proposed to be studied, two of which are related to child marriage and one on the economic valuation of unpaid work by women.

Building an Investment Case towards Eradicating Child Marriage from Bihar

"India is home to the largest number of child brides in the world: 223 million—a third of the global total."[1] Indian states of Uttar Pradesh, Bihar, West Bengal, Maharashtra and Madhya Pradesh together account for over half of such unions of girls (and women) before they turned 18. Bihar reports the highest total fertility rate (TFR) of 3.0 across all states (~1.7 in West Bengal). An FGD and a stakeholder consultations workshop in Bihar informed a concept note to help Government of Bihar (GOB), planners, donors and other stakeholders in building a "comprehensive investment case towards eradicating child marriage from Bihar".

From a solutions perspective, child marriage in Bihar may be viewed as an outcome of the interplay of traditional and regressive (T&R) forces that uphold it, modern and progressive (M&P) forces that push back, and disasters (like floods or the pandemic) that precipitate it by exacerbating human insecurity. The concept note studied the T&R forces such as patriarchy, gender disparity, population, social groups, multidimensional poverty, social progress, school education, literacy, health, gender roles in family and society, land rights of women, industry and employment, urban development and migration and disasters in Bihar.

Eradication of child marriage from Bihar demands neutralizing the T&R forces and a strong fortification against them by systematically harnessing and organizing M&P forces. Multidimensional poverty at the intersection of caste, class, religion and gender strengthens T&R forces and prevents many of the M&P forces from working well. Broad areas of intervention include ensuring safe and quality schooling, strengthening the education-to-economy continuum (linking schooling/skilling to better jobs), organizing awareness campaigns, refocusing attention on health of adolescent girls, ensuring accountability of law enforcement and administration, etc. Designing interventions to dispel beliefs and weaken social structures that normalize child marriage, and conducting local trials and pilots before scaling up were also recommended.

[1] UNFPA–UNICEF (2021), UNFPA-UNICEF Global Programme to End Child Marriage, 2020 Country Profiles, India. https://www.unicef.org/media/111381/file/Child-marriage-country-profile-India-2021.pdf.

More studies are necessary to identify high-impact interventions before developing the investment case for Bihar. Such studies will also assimilate attendant hurdles, bottlenecks and gaps that are impeding progress towards the desired goals. It will include innovative, customized, targeted and prioritized interventions.

Implications of Climate Change on Child Marriage and GBV

The interaction between human behaviour and demographic factors and the environment is a two-way process with many studies dedicated to environmental impact and few exploring impact of climate change on child marriage and GBV in the Indian context. This study examines the interlinked domains of schooling, SRH, marriage, pregnancy, migration and GBV in the context of climate change. The study proposes to look at two packages of work. One, to develop a systems dynamics model on climate change and child marriage and GBV through consultations, literature review, secondary sources, build and test the model and identify drivers that are attributable to climate change. And, two, undertake case studies on how climate change-induced migration increases the risk of child marriage and GBV and research on potential policies, strategies and interventions.

Measuring the Economic Value of Women's Unpaid Work

Considering the declining female labour force participation rates in India, there is a need to value women's contribution to the economy. The proposed study will analyse India's first Time Use Survey 2019 data on paid and unpaid work of the Ministry of Statistics and Programme Implementation. This will build a case of advocacy around the economic contribution of women and its geographic, socioeconomic or task type-based variations.

There are two approaches for imputing value to unpaid work[2]—the **output approach** (number of meals, clothing washed and ironed, area of house cleaned, children taught, number of elderly persons given care to, etc.) and the **input approach** (measure time spent and then calculate opportunity cost or market replacement cost).

Challenges to the process of valuation include lack of wage data on occupation for valuation; appropriateness of valuation method and acceptability of valuation by national concerned practitioners.

Crosscutting Issues and Emerging Research Needs

Gender parity interacts with every other goal of sustainable development and the four states of India where UNFPA is present have much ground to cover on most of them. Consequently, issues discussed during the meeting touched upon some of the most crucial factors that will drive the desired demographic dividend for India. The review meeting touched upon the limitations of available data, shortcomings and gaps in the present interventions, exploring interventions that do not depend upon the schooling of adolescent girls, reimagining the IEC and BCC strategies to create effective knowledge and also made many specific suggestions related to the showcased studies.

[2] Outside the System of National Accounts (SNA) production boundary.





1

India's Population Dynamics: Progress, Challenges and Opportunities[3]

India has recorded considerable progress along several dimensions of human development—economic growth and rise in per capita income, poverty reduction, eradication of small pox and polio and increases in life expectancy, improvements in child survival and maternal mortality, schooling among both girls and boys, expansion in the reach of basic social services, electricity and drinking water, expansion in employment opportunities including an increase in the female labour force participation rates in India since 2017, reduction in fertility, and use of digital technology, digital platforms and technological innovations to enhance people's access to services. Looking ahead, India is projected to overtake Japan and become the world's third-largest economy by 2030, with gross domestic product of $7.3 trillion. Its annual per capita income might go up to $14,000 by 2050.

At the same time, despite India's several accomplishments, there are still considerable gaps in human development and large interstate variations. Levels of income remain low and inequality is high and deep rooted. Food insecurity remains widespread and deficiencies in health and

[3] To request for the presentation on "India's Population Dynamics: Progress, Challenges and Opportunities" please write to india.office@unfpa.org. For detailed discussion, please refer to Annexe 1.

nutrition persist. Learning attainments at school level are extremely low. Precariousness marks the lives of millions working in the informal sector, especially women. Freedoms and opportunities for women remain limited with gender discrimination crosscutting all aspects of human life. Women have inadequate access to sexual and reproductive health (SRH) services. Climate change is adversely affecting India's natural environment, population and economy.

Challenges related to climate and environment, conflicts and wars, inequalities in access to resources and social justice, crises in job markets, geopolitical rivalries, trade disputes and potential regional instabilities beleaguer not just India but the whole world. To sustain and flourish within this ecosystem in the future and bridge its development gaps, India needs to be able to provide free universal quality public health services, guarantee free and compulsory public education to children 6–14 years, increase female labour force participation rate, eliminate gender discrimination and expand freedoms and opportunities for women and deepen community connect, listen to the community, take on board what they want done and get them involved in administration, management and governance.

For advancing these development outcomes, investment priorities will need to be guided by regional population dynamics. Policies and initiatives related to nutrition, health, education and skilling should be systematically targeted at Bihar, Madhya Pradesh, Rajasthan and Jharkhand which provide the bulk of the labour force to the rest of the country. The southern states have to gear up to the needs of an aging society. Labour migration from populous states (mentioned above) to the south will increase as the south ages.

Interventions related to non-communicable diseases and geriatric care, as well as financial, institutional and social support to the elderly will need to go hand in hand with initiatives to support, skill and employ India's adolescent and youth population (below 25 years) to reap our demographic advantage. Health and well-being of adolescent girls and young women needs to remain in focus. Attention must be paid to the 90% of India's workforce that is in the informal sector. Challenges related to the rapid urbanization of India need to be adequately met.

To overcome these, India will need to get its principles, priorities, policies, prices, practices and politics right. Drawing upon Amartya Sen's capabilities approach, we may say that India has witnessed extraordinary expansion of physical infrastructure and economic growth, displayed in terms of overt affluence in big cities. There is perhaps genuine convergence in the space of commodities. The masses today have access to a range of affordable goods from instant noodles and shampoo to smartphones. But hiding behind is a poverty of capabilities and opportunities which is not receiving adequate attention.

Beyond economic growth and bringing total fertility rate (TFR) to replacement level, both of which India has achieved admirably, what India needs is transformational structural and

social change to address the issues that persist. For that, establishing community connects and understanding the deep cultural contexts at the local level is an imperative. Given India's diversity, there is perhaps a need for a greater number of smaller surveys to customize research to more local contexts and generate evidence for focused policy and better targeted action at the district and state level.

India is at a critical juncture in navigating its population dynamics to ensure a sustainable future. Addressing these challenges requires comprehensive strategies that prioritize equitable access to universal basic education and healthcare and expansion of economic opportunities, particularly for women. By leveraging its demographic dividend and fostering inclusive policies, India can harness the potential of its youthful population, paving the way for sustainable development and building a more equitable and just society. This is the moment for India to harness all its resources, navigate global challenges, and seize opportunities to profoundly shape its trajectory, and make not just its own future but also that of the world more secure and sustainable.





2 Family Planning and Contraception

While India's total fertility rate (TFR) has declined from 2.2 to 2.0 between National Family Health Survey Round 4 (NFHS-4) (2015–2016) and NFHS-5 (2019–2021) and the use of modern contraceptives has increased from 47.8% to 56.5% among couples in the same period, wide disparities across states and different population groups persist.[4] Unintended childbirth at young ages continues to pose health challenges, escalating maternal and newborn risks.

Despite government initiatives like Mission Parivar Vikas to expand contraceptive options, logistic management systems (to improve access) and awareness campaigns (to increase acceptance), female sterilization remains the preferred contraceptive method over others. The reasons for this preference and underutilization of reversible methods are unclear. Besides, while men dominate decision-making regarding family size and their partner's use of contraceptive methods in many traditionally patriarchal settings, the onus of birth control

[4] The NFHS is a large-scale multi-round survey conducted in a representative sample of households throughout India. While NFHS-1 (1992–1993), NFHS-2 (1998–1999), NFHS-3 (2004–2005), NFHS-4 (2015–2016) and NFHS-5 (2019–2021) have been completed, the NFHS-6 (2023–2024) study is underway. The NFHS provides state and national information for India on fertility, infant and child mortality, the practice of family planning, maternal and child health, reproductive health, nutrition, anaemia, utilization and quality of health and family planning services and has two goals: (a) essential data on health and family welfare to the Ministry of Health and Family Welfare and other agencies for policy and programme purposes and (b) information on important emerging health and family welfare issues.

and family planning is placed heavily on the shoulders of the women. By and large, male engagement is at best characterized by a lack of interest in matters related to reproductive health or, at worst, actually obstructive, impeding women's decision-making on contraception. Women sometimes point to their male partner's resistance to family planning as a significant barrier to uptake and continuation, resulting in decisions to use contraceptive methods covertly or not at all.

The challenges around family planning and contraception in India are thus examined from three perspectives in this section.

- Uptake of reversible contraceptive methods in three states (Bihar, Madhya Pradesh and Rajasthan)
- Barriers to family planning among adolescents and young adults in Bihar
- Men's participation in family planning and reproductive health

2.1 Uptake of reversible contraception in Bihar, Madhya Pradesh and Rajasthan[5]

2.1.1 Background

Existing literature highlights the influential role of community health workers, husbands and mothers-in-law in shaping contraceptive choices, but a comprehensive understanding of enablers and barriers to adopting reversible contraceptives methods is lacking. To address this gap, a study was conducted in Bihar, Madhya Pradesh and Rajasthan by the Department of Community Medicine and School of Public Health in collaboration with the Obstetrics and Gynaecology Department, Post Graduate Institute of Medical Education and Research, Chandigarh.

2.1.2 Objectives

- To identify determinants influencing the uptake of reversible contraceptives and reasons for discontinuation among women aged 15–49 years, including users, non-users and dropouts.
- To assess the quality of care of family planning services involved in the provision of reversible contraceptives.
- To explore and understand the perceptions and beliefs of users, key community influencers, family decision-makers (men and other family members), non-users and family planning service providers regarding reversible contraceptive methods.

2.1.3 Methodology

The study was undertaken from July to December 2022, employing a mixed-methods approach.

[5] To request for the presentation on "Uptake of reversible contraception in Bihar, Madhya Pradesh and Rajasthan" please write to india.office@unfpa.org.

- From across the three states, three districts with similar reversible contraceptive preference were chosen for the study—Gaya in Bihar, Jaisalmer in Rajasthan and Chhattarpur in Madhya Pradesh.
- Initial quantitative analysis used NFHS-5-unit level data to identify national and state-level determinants of reversible contraceptive uptake.
- Subsequently, qualitative research involved 84 interviews and 9 focus group discussions with stakeholders. Participants and respondents included individual users, family members, community stakeholders and service providers such as doctors, nurses, accredited social health activists and auxiliary nurse midwives.
- Additionally, nine mystery client interviews were undertaken to observe real-time interaction and provide insights into the quality of family planning services. Mystery clients emulated three scenarios—a newly married woman, a woman with one child and a woman with more than two children.

2.1.4 Key Quantitative Findings

Reversible contraceptive use increased nationally from 10.2% (NFHS-3) to 18.2% (NFHS-5). With notable spikes in use of such contraception in Bihar (4.5% to 9.5%), Madhya Pradesh (7.2% to 12.8%) and Rajasthan (9.5% to 19.5%), female sterilization also increased in Bihar (23.8% to 34.8%), Madhya Pradesh (44.3% to 51.9%) and Rajasthan (34.2% to 42.4%) from NFHS-3 to NFHS-5.

As per NFHS-5, the unmet need for family planning is 9.4%, with Bihar exhibiting the highest rate at 13.6%, followed by Madhya Pradesh (7.7%) and Rajasthan (7.6%). Notably, the highest unmet need is observed within the 15–24 years age group.

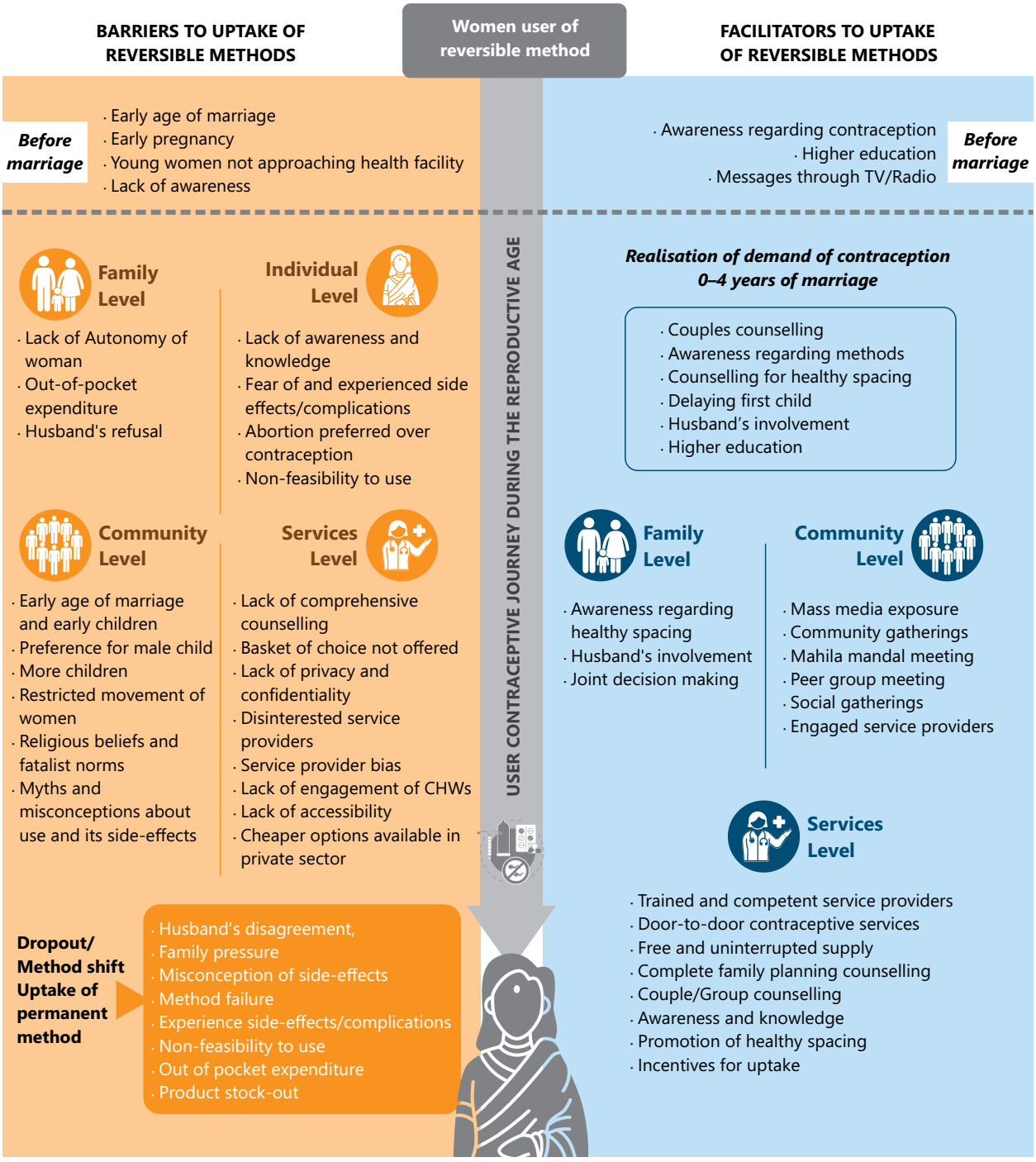
As per NFHS-5, the unmet need for family planning is 9.4%, with Bihar exhibiting the highest rate at 13.6%, followed by Madhya Pradesh (7.7%) and Rajasthan (7.6%).

While overall contraceptive awareness is high at 98.8%, awareness specifically regarding at least four reversible methods diminishes to 74.2%. Emergency contraceptive awareness is relatively low nationally (47.6%) and in Bihar (43.4%), Madhya Pradesh (49.4%) and Rajasthan (55.2%). Notably, women aged 15–19 years show particularly low awareness at the national level (30.5%).

The chances of using contraceptives is significantly higher among the women in the 25–35 years age group, with secondary level education, belonging to the richest wealth quintile, or those with longer duration of marriage and exposure to family planning messages compared to their counterparts.

Infrequent sexual activity is cited as the primary reason for non-use of contraception among women, comprising 30%–40% of cases. Additional factors include breastfeeding (13.5%), faith-based prohibitions (5.0%), concerns about side effects (6.9%) and partner opposition (0.4%).

Figure 2.1: Barriers to Uptake of Reversible Contraception Methods



A limitation of NFHS-5 data is that reasons for non-use of contraception (with a large proportion citing infrequent sex as the driving cause) have not really been unpacked as probing questions have not been asked. In states such as Bihar, Rajasthan and Madhya Pradesh, which experience high out-migration, a follow-up question, "last time the husband was at home was there any contraception used" could reveal real reasons for non-use of contraception. The question may have been introduced in NFHS-6.

2.1.5 Key Qualitative Findings

The study employed a life path approach to delineate the barriers and facilitators influencing contraceptive users. Figure 2.1 illustrates factors impacting the adoption, continuation and discontinuation of reversible contraceptive methods.

2.1.6 Quality of Family Planning Services: Mystery Client's Feedback

- Clients experienced an average 15-minute waiting time across three states, signifying reasonably prompt service. However, some reported insufficient greetings and instances of being asked to return another day, highlighting the need for improved patient engagement and communication.
- Hygiene standards were generally maintained at most healthcare facilities, ensuring a clean and safe environment for clients.
- Providers often neglected client-specific needs and preferences for contraceptives, with inconsistent assessment of medical eligibility based on medical history.
- Clients reported biased counselling, stating a provider tendency to promote specific contraceptive methods without presenting a range of options.
- Healthcare facilities often lacked sufficient auditory and visual privacy, potentially compromising the confidentiality of family planning discussions. Additionally, the unavailability of Information, Education and Communication (IEC) materials limited clients' access to essential information at these facilities.
- Mystery clients in Rajasthan generally reported positive interactions, while those in Bihar and Madhya Pradesh faced dismissive and unhelpful behaviour. Client satisfaction with counselling varied, with some expressing satisfaction despite limited information, while others remained dissatisfied due to incomplete information about family planning methods.

2.1.7 Recommendations

- Enhance awareness and strengthen social and behaviour change communication by frontline health worker education, equipping them with effective communication tools and leveraging innovative digital solutions.
- Address socio-cultural norms through community engagement, amplifying existing initiatives and leveraging civil society.

- Strengthen health systems by improving accessibility, capacity building of health workers, improving health worker outreach, enhancing family planning counselling, strengthening supply chain management and utilizing digital technologies.
- Provide policy guidance, including task sharing for non-medical personnel, collaboration with private sector and non-government organizations, introducing peri-coital contraceptives, promoting self-care, scaling up long-acting reversible contraceptive use and addressing humanitarian situations.
- Approach policy advocacy from the impact perspective to arrest dropout of the reversible contraceptive methods to better sustain the family planning effort.
- Encourage private sector participation in the family planning programme to increase sense of ownership and bridge the unmet contraception need and expand the basket of choices with regard to reversible methods in the context of spacing, which is quite high, particularly for youth and adolescents. Private players have to be truly engaged to take the focus away from sterilization to reversible contraceptives.

2.1.8 Gaps and Alternate Perspectives

- Besides the mystery client feedback, perhaps it might have helped improve the quality of future engagements if feedback had also been sought from the healthcare providers on how the interaction with the client could be improved.
- An adolescent was not included in the mystery clients but that might have been yielded useful information given the SRH concerns of adolescents and child brides.
- There is little scientific study on the traditional methods of contraception and their role in managing to keep India's population under control. Since traditional methods are widely prevalent, a better understanding of their pros and cons will help in improving appropriate awareness.
- The research needs to also look more closely at "switching" between methods as a phenomenon. Are those who are discontinuing one method migrating to another? If so, what are the common patterns? The study did ask respondents about all the methods they have ever used and the method currently in use but it does not specifically study patterns of switching to understand the causes and preferences.
- Deeper exploration is needed of the causes behind high female sterilization. Why do women prefer it to reversible methods? What are the driving factors and insecurities? Is the incentives-based model promoting sterilization or are the clients trying to avoid the side effects of other spacing methods?

2.2 Access to Family Planning among Adolescents and Young Adults in Bihar[6]

2.2.1 Rationale and Objectives

Unintended childbirth in young ages poses global health challenges, escalating maternal and newborn risks. Family planning is crucial to counter these issues. Bihar, India's third most populous state, reported a high TFR of 3.0 in 2019/20. With almost no improvement in child marriage, family planning methods are vital for replacement fertility and improved SRH. Despite a notable increase in modern Contraceptive Prevalence Rate (mCPR) from 23% (2015/16) to 44% (2019/20), gaps, especially among adolescents, persist. The UDAYA report highlights that only 9% of married adolescents in Bihar use spacing methods.[7] This underscores the need to investigate scalable family planning practices and address social norms and barriers. Given this, the study under discussion (undertaken in collaboration with AN Sinha Institute of Social Sciences, Patna) aimed to: (a) assess contraceptive behaviour among adolescents and young adults; (b) identify socio-cultural and institutional barriers to contraception usage; (c) explore challenges faced by family planning service providers and (d) suggest actionable mechanisms to scale up services, considering challenges and successful practices.

With almost no improvement in child marriage, family planning methods are vital for replacement fertility and improved SRH.

2.2.2 Sample Design and Sample Size

The study adopted multi-stage stratified sample design. A total of 1,142 women in the age group 15–29 years were interviewed (701 married and 401 unmarried) from 60 primary sampling units. Besides, 32 focus group discussions involving women, husbands, adolescent boys and girls and senior women, along with 60 key informant interviews featuring health workers, medical officers in charge and block community mobilizers were conducted to comprehensively grasp the demand and supply-side challenges in service delivery.

2.2.3 Key Survey Findings

Adolescent Health

- Findings indicate that approximately 74.1% of unmarried/adolescent respondents maintain menstrual hygiene by using sanitary pads. Notably, this percentage is comparatively low among less educated and marginalized groups.
- There is lack of awareness (94.6%) regarding YUVA clinics among adolescent girls. This can be attributed to limited interaction with health workers, as nearly 91% reported no engagement with them.

[6] To request for the presentation on "Access to Family Planning Among Adolescents and Young Adults in Bihar" please write to india.office@unfpa.org.

[7] Understanding the lives of Adolescents and Young Adults (UDAYA), implemented by Population Council from 2015 to 2020, provides crucial insights into the quality of adolescents' transitions to adulthood in India. https://www.projectudaya.in/about-udaya/.

- Education plays a vital role in raising awareness, with 60.3% of school-going individuals being aware of issues related to SRH and family planning methods compared to 28.1% of those not attending school.

Awareness and Effective Knowledge of Family Planning Methods

- As per study, 77.4% for married women and 77.9% for unmarried/adolescents are aware of family planning methods.
- For unmarried/adolescent girls, peer group (46%), family members (mother or sister 29%) or school/college (25%) serve as primary information sources. Similarly, married women rely on peers/neighbours (54.7%), mothers-in-law (72.8%) and husbands (64.2%).
- Health workers play a more significant role in creating family planning awareness among married women (39.2%) compared to unmarried/adolescent girls (8.8%).
- Study shows a notable gap between contraceptive awareness and effective knowledge. For intrauterine contraceptive devices/postpartum intrauterine devices, awareness is 57.2%, but effective knowledge is 34.6%. Similar gaps exist for injectables and oral contraceptive pills.

Current Users of Family Planning Methods and Their Preferences

- The prevalence of mCPR among currently married women in Bihar is 39.3%, which is comparable to 40.5% in NFHS-5, 2019–2021. Of these, 26.4% are using contraception to limit the family size while 12.9% are using it for spacing between children. Notably, only 7.6% of 15–19-year-olds use contraception, rising to 55.8% among 25–29-year-olds. Overall, 64.5% have ever used family planning methods.
- Non-utilization of contraception is higher in migrant households (62.9%) compared to non-migrant households (59%).
- Respondents expressed that if they had access to long-acting injectables they would not opt for sterilization once the desired family size is attained.

Unfulfilled Intentions[8] (in the last 12 month)

Unfulfilled intention rates are 5.1% for spacing methods and 3.6% for limiting methods in family planning. Notably, among those aged 15–19 years, unmet need for spacing at 5.3% is slightly higher than in the 25–29 years age group (4.4%).

2.2.4 Barriers to Using Family Planning Services

Socio-Cultural Norms

- The husband's migration (35.6%) and possible side effects of contraceptives (30.6%) are the main reasons for discontinuation of family planning methods in the last 12 months.

[8] Unfulfilled intention: Women who intended to use a spacing/limiting method to delay/avoid pregnancy but could not use it in the last 12 months.

- Most adolescents are reluctant to discuss family planning methods with their mothers/ elders or peer group due to associated social stigma of discussing a "taboo" subject. Most have never heard of YUVA Clinics and about 91% respondents have had no interaction with health workers.
- About 42% of married respondents have never discussed family planning methods even with their husbands; this is variously attributable to lack of knowledge, migration and husband's disinterest. And only 27% of the married respondents have received couple-counselling at health facilities.
- Among adolescents, non-use of contraception is primarily attributed to child preference (76.5%), lack of knowledge (26.4%), husband's migration (25.9%) and denial of his consent (18.3%).
- Network analysis of focus group discussions reveals persistent patriarchal barriers to family planning: low women's agency, limited husband involvement, family objections, male child preference and fear of side effects.

Challenges in Service Delivery

- Lack of counselling by health workers (24.7%), unavailability of preferred method (13.5%), financial limitations and poor quality (10.6%) are main reasons for non-use of spacing method.
- Key informant interviews reveal a gap between family planning awareness and utilization among married respondents, attributed to myths, low education, gender preference and socio-cultural beliefs.
- Providers also face challenges such as delays in recruitment, insufficient training, limited contraceptive options, cumbersome stock maintenance process and complexities of tackling norms related to son preference and early marriage and engaging with men on SRH issues.

Recommendations

- Enhance SRH and rights knowledge among adolescent girls as they represent the future generation of women who will bear children. Empowering them to make informed decisions about their menstrual and reproductive health through comprehensive education and active community engagement is essential.
- Implement intensive IEC strategies engaging key decision-makers like husband and mother-in-law, emphasizing family-centric approach, specifically involving male participation in family planning.
- Sensitize and train health workers to address adolescent needs, ensuring privacy and delivering customized counselling. Capacitate health workers particularly in terms of giving quality time for counselling in a youth- and gender-friendly way.

Empowering adolescent girls to make informed decisions about their menstrual and reproductive health through comprehensive education and active community engagement is essential.

- Examine the causes behind greater non-utilization of contraception among migrant households to understand if the issue lies in the lack of access to contraception when required or lack of couple communication, especially between younger adults when the husband returns home for a period. Mapping of the barriers to the key insights and issues will be helpful from that perspective.
- Strengthen the role of the digital media in reducing barriers, gender discriminations and regressive social norms to influence adolescents and young adults.
- Reposition, repackage and rebrand the family planning programme as "not just birth control". Keep at its core, the priority of reproductive health as fundamental to the well-being of women and girls. Treat it, not as a one-time investment but a continuous investment into supporting each new cohort of young couples.

2.3 Men's Participation in Family Planning and Reproductive Health[9]

2.3.1 Rationale/Objectives

The National Population Policy 2000, inspired by the 1994 International Conference on Population and Development, calls for greater emphasis on men's shared responsibility and active involvement in issues of SRH, including family planning, supporting contraceptive use, helping pregnant women stay healthy, arranging skilled care during delivery, avoiding delays in seeking care, helping after the baby is born and, finally, in being a responsible father.[10]

Evidence shows that addressing gender in family planning programmes—for instance, by engaging men—can improve programme outcomes and increase gender equality.[11, 12] While we continue working towards women's empowerment, it is also critical to educate men on reproductive health and family planning, so that they can be responsible partners, family members and friends and have an informed discussion with their partners and foster an enabling environment where decisions and responsibilities are shared equitably.

This calls for understanding the status of men's participation in family planning and reproductive health in the country and addressing the deeply entrenched gender norms and other social and cultural practices that act as barriers to engaging men in family planning. The Population Foundation of India conducted a study to analyse the NFHS-5 (2019–2021) data on men's participation in family planning and reproductive health and developed a

[9] To request for the presentation on "Men's Participation in Family Planning and Reproductive Health" please write to india.office@unfpa.org.

[10] United Nations Population Fund, Report on the International Conference on Population and Development, Cairo, 5–13 September 1994, (ICPD Programme of Action, UNFPA, New York, 1995).

[11] The truth about... men, boys and sex: Gender transformative policies and programmes, (International Planned Parenthood Federation, London, 2009).

[12] E. Rottach, S.R. Schuler, and K. Hardee, Gender Perspectives Improve Hhealth Outcomes: New Evidence, (Population Reference Bureau, Washington, D.C., 2009).

policy brief with an objective to build a policy narrative for promoting strategies to support and increase men's participation.

2.3.2 Key Research Findings

Male Participation in Family Planning

- Men's participation in family planning remains low in India. According to NFHS-5, (2019–2021), a very large share (76%) of married men remains non-users of contraception.
- As per NFHS-5, the contraceptives used by men (condom and male sterilization) have a share of approximately 17% of mCPR. The major responsibility of contraception among married couples falls on women (83%), of which female sterilization alone makes up 67%.
- Women's share in the method mix was higher than men's share across all states and Union Territories (UTs). Barring Chandigarh, Delhi (National Capital Region) and Uttarakhand, states with mCPRs close to or more than 50% reported much higher share of female than male methods. In 23 of 36 states and UTs, share of female methods is more than 85%. While six southern states and Puducherry (UT) figure among the top 15 states to adopt any mCPR, they are at the bottom of the list as far as adoption of male methods are concerned, indicating an incredibly high burden of family planning on the women. For instance, in Andhra Pradesh where 69.4% of women in union (15–49 years age group) report using some mCPR, 68.3% are sterilized.
- Of the male respondents, 35% stated that contraception is women's business, and they should not worry about it.
- As per NFHS-5, if men aged 15-49 years were given a chance to choose their family size, they would want to have an average of 2.1 children, similar to women in the same age group.

Sidebar 2: Male Participation in Sexual Health and Family Planning: Initiatives of Population Foundation of India

Population Foundation of India's (PFI's) Social and Behavioural Change Communication initiative "Mai Kuch Bhi Kar Sakthi Hoon" has sought to change mindsets and stereotypes around family planning, early marriage, early and repeated pregnancies, contraceptive use, domestic violence and sex selection, with the use of positive role models.

With about 58 million viewers (48% men) having watched season 1, the show had huge positive impact on the people. The independent evaluation of all three seasons showed that after watching the serial, women became more confident in communicating and negotiating with their partners on contraception and accepting family planning services.

The PFI has partnered with Men Against Rape and Discrimination (MARD), founded by Farhan Akhtar, to launch a digital campaign, 'Bas ab bahot ho gaya', to reach a large number of men to address cultural and social norms to combat gender-based violence and engage them in public discourses and actions on gender equality. The PFI also contributed a chapter on Male Engagement and Family Planning for Family Planning 2030, a document from the Government of India.a And finally, PFI has had sustained media engagement to create an informed discourse on male engagement in family planning and reproductive health.

[a] https://wordpress.fp2030.org/wp-content/uploads/2023/08/India_FP2030_Vision_Document.pdf.

- Son preference is clearly apparent with over 40% of men with no sons expressing desire for more children even when they already have 3 or more daughters. Whereas over 80% of men with at least one son state that they do not want to have more children.
- Currently-married men's knowledge of any modern method of contraception is universal. However, their knowledge of male sterilization is lower than that of female sterilization (88% versus 96%). NFHS-5 indicates that, of men, 88% know about pills and 70% know about injectable contraceptives.
- Men's information about contraceptives is also constrained by myths and misconceptions, which affect their participation in family planning as users. Male sterilization is believed by many to make men impotent or weak, thereby hampering their ability to work and continue their sexual life.[13, 14] This is despite the fact that male sterilization through non-scalpel vasectomy is a non-surgical, simpler and quicker procedure as compared to female sterilization.
- In the past few months, 62% of men encountered family planning messages through wall paintings or hoardings, and over half saw such messages on television.
- The percentage of men not exposed to family planning message was significantly higher for those who had less than five years of schooling or no schooling, those belonging to the Scheduled Tribes and those who were from the lowest wealth quintile.
- Research studies found that men often feel uncomfortable discussing contraception with female health workers, turning to unreliable sources like friends or local pharmacists for information.[15, 16]

Access of Adolescent Boys to Information and Services Related to Sexual and Reproductive Health

Men's information about contraceptives is also constrained by myths and misconceptions, which affect their participation in family planning as users.

- Family life education in schools, community outreach through frontline health workers and peer educators and counselling as well as health care at adolescent-friendly health centres are important programme components of the Rashtriya Kishor Swasthya Karyakram. However, the implementation of these components is found to have many gaps.
- A longitudinal study with youth and adolescents found that just 14% of older boys (aged 18 to 22 years) had ever received any family life education, and less than 10% had interacted with any frontline workers in the last one year.[17]

[13] R. Jacobstein and others, Down But Not Out: Vasectomy Is Faring Poorly Almost Everywhere—We Can Do Better To Make It A True Method Option. *Global Health: Science and Practice*, 11 (1): e2200369 (February 2023). https://doi.org/10.9745/GHSP-D-22-00369.

[14] K. Seth, S. Nanda, A. Sahay, R. Verma and P. Achyut, "It's on Him Too": Pathways to Engage Men in Family Planning—Evidence Review. (International Center for Research on Women, New Delhi, 2020).

[15] K. Seth and others (2020), Ibid.

[16] Family Planning: Whose Work Is It? Review of Male Engagement in India's Family Planning Policies. https://ipc2021.popconf.org/uploads/210487.

[17] Population Council of India, UDAYA – Understanding the lives of adolescents and young adults. (New Delhi, 2020)

- Lack of uniform access to information on sexual health and well-being at school or through out-of-school programmes creates an early gap in the knowledge of SRH among boys, and a missed opportunity in shaping healthy behaviours in their marital life as adults.

Social Norms and Men's Participation in Family Planning

- Patriarchal norms, perceptions of masculinity and men's perceived duty to continue the family lineage create pressure for early family-building after marriage, diminishing men's involvement in family planning. Unequal power dynamics and fragmented knowledge hinder informed decision-making for couples.
- As per NFHS-5, the use of any modern contraceptive by married men was half of the use by men currently not married (24% versus 50%). Probably social stigma of unintended pregnancy forces men to know about and use family planning methods when they are not married. However, what prevents them from using and participating when they get married, and what are the drivers of change in their beliefs and practices merits further research.
- As per NFHS-5, 32% of ever married women in the age-group of 18 to 49 years experienced any form of violence (physical and/or sexual and/or emotional) committed by their husband. This figure has remained unchanged between NFHS-4 and NFHS-5.

2.3.3 Policy Recommendations to Promote Male Engagement in Family Planning

- Promote strategies that prioritize men as beneficiaries of the family planning programme. Activities within Mission Parivar Vikas need to have components focusing on men, addressing their unique needs and preferences. The component within Mission Parivar Vikas that reaches out to young couples immediately after marriage needs to be strengthened so that the engagement of men with sexual and reproductive health can be secured early and firmly.
- Re-energize the family planning programme to promote male sterilization.
- Redefine family planning in social conversations to go beyond mPCRs to include traditional methods, SRH and the importance of consensual decision making by the couple on such issues.
- Make greater investments in Social and Behavioural Change Communication (SBCC) interventions to address social and systemic barriers to male engagement. Sustained SBCC campaigns can effectively be used to debunk misconceptions regarding SRH and family planning issues that are deeply embedded in social norms.
- Formulate policies to mainstream gender sensitization of young boys and promote comprehensive sexuality education in schools including SRH and life skills, pushing for transformational social change.

- Create a supportive environment for boys through long-term multi-stakeholder gender sensitization programmes, working with families, teachers and social influencers in the community. This is important because while inequitable gender role attitudes take shape in adolescence, they can be transformed if addressed effectively at an early age.
- Make greater investments to build in evaluation and impact assessment of male engagement interventions to generate evidence of their efficacy and enable replication at a larger scale.
- Document and disseminate information on good practices for male engagement in family planning.

2.3.4 Gaps and Alternate Perspectives

- What are the sources of SRH information for men? Are there male SRH information providers to cater to men?
- Are men and boys welcome to family planning counselling? Is it a case that the women get the counselling while the men take the decisions?
- Are SRH services related to sexually transmitted infections and HIV available to men? Do men and boys have adequate access to accurate information on these?
- Can programmatic interventions related to mPCR and SRH be suitably implemented at locations where men are present, such as their workplaces, trade unions, agricultural marts, etc.?

3 Implementation, Research and Operational Frameworks of Gender Interventions

3.1 Assessment of Services of One-Stop Centres and Coordination with the Health Sector[18]

3.1.1 Background

Gender-based violence (GBV) in India is a serious and widespread problem that affects millions of women and girls, as well as some men and boys, across the country. It is a significant public health issue affecting the physical, sexual, reproductive and mental health of the survivors and their household members. It has a distinct impact on different populations, like survivors with disabilities.

Apart from the police and the legal apparatus, the health system is often accessed first by the survivors. To support the fight against many forms of GBV, the Government of India has established One-Stop Centres (OSCs) in a phased manner since 2015. These centres facilitate

[18] To request for the presentation on "Assessment of Services of One-Stop Centres and Coordination with the Health Sector" please write to india.office@unfpa.org.

immediate, emergency and non-emergency access to a range of services for GBV survivors, including medical, legal, psychological and counselling support under one roof. The health facilities and the OSCs are expected to ensure a coordinated response. Given this context, UNFPA has proposed a baseline assessment of this coordination in its four focus states—Bihar, Madhya Pradesh, Odisha, and Rajasthan.

3.1.2 Objectives

- To assess GBV response services extended through health facilities and OSCs in four states.
- To understand how health facilities and OSCs are equipped to respond to the needs of persons with disabilities (PWDs) experiencing GBV.
- To develop an adapted version of the GBV Quality Assurance Tool that may be applied subsequently for conducting internal assessments by facility staff for continuous quality improvement.[19]
- To contribute to the formulation of state government policies.

3.1.3 Methodology

In each state, the assessment is proposed in three districts (three OSCs and three health facilities): (a) the state capital, (b) a district close to the state capital and (c) a remote location.

Table 3.1: Areas of Inquiry

Accessibility	Availability and appropriateness of services and pathways to providing support
	Facility and infrastructure readiness with regard to standards of accessibility
	Outreach
	Linkages between health facilities and One-Stop Centres (OSCs)
Quality	Health response at OSC—cognizance of legal and policy protocols on disability and GBV
	Survivor-centred clinical care and communication in OSC and health facility—understanding of roles and responsibilities in addressing GBV and gender perceptions and conscientization
	Handling of evidence and case information
	Training and quality improvement
	Identification of patients who have experienced intimate partner violence or sexual violence
	Issues and challenges in the provision of services and assessing risks and opportunities for improving response
Coordination	Referral system and follow-up of patients
	Reporting and information system

[19] The Gender-Based Violence Quality Assurance Tool (GBV QA Tool) is a resource for health providers, facility managers and programme planners to assess, improve and ensure the quality of post-GBV healthcare. It is closely aligned with World Health Organization, President's Emergency Plan for AIDS Relief and US Agency for International Development guidelines and technical considerations and can be used as a tool to initiate post-GBV care services, as well as to assess existing post-GBV care services. It was developed with the support and tools of many partner organizations and can be used by any partner or government to improve post-GBV care.

The idea is to gain a comprehensive understanding of how these facilities operate across locations. Before OSCs are scored and ranked based on footfall or efficiency of functioning, we have to acknowledge where they are located, how much investment they have received and what circumstances and constraints they are operating under. The key areas of inquiry adapted from the Jhpiego's GBV Quality Assurance Tool are presented in Table 3.1.[20]

The assessment is proposed at three levels. Table 3.2 outlines the levels and the methods of data collection.

Table 3.2: Levels and Methods of Data Collection

Levels	*Method*	*Respondents*	*Number proposed*
Policy level	Key Informant Interview (KII)	State officials of Health, Woman and Child Development Department, and UNFPA	12
System-level	KII	District officials of Health and Woman and Child Development Department	4
		Head of district hospital	12
	Facility assessment	One-Stop Centre (OSC)	12
		Health facilities	12
Service provider level	In-depth interviews	OSC staff including centre administrator, case worker, counsellor, para medical officer	48
		Health facility staff including medical officers across health facility, staff nurse/auxiliary nurse midwife	36
Total			136

3.1.4 Status

- A Technical Advisory Group of four external members was formed and the first meeting was held.
- Instruments for data collection were developed, and data was collected in Madhya Pradesh and Rajasthan.
- Permissions from the Governments of Bihar and Odisha for data collection are to be received.

3.1.5 Initial Findings from Madhya Pradesh and Rajasthan

- One-Stop Centres are open 24/7. However, cases are referred only by the police. There are no walk-ins or referrals from health facilities.

[20] https://www.jhpiego.org/wp-content/uploads/2022/03/Revised-2021-GBV-QA-Tool-CDC_FINAL.pdf.

- The health facilities in Bhopal and Jaipur are relatively more PWD-friendly. Sign language interpreters are called in case any language-based support is required.
- Except for the OSC in Bhopal, there appears to be no defined system for coordination between health facilities and OSCs in other districts. This is so even if the OSC is housed in a health facility.
- Unless the survivor mentions it, the health personnel do not appear to be probing or finding out about GBV, even in instances where there is doubt.
- Except for Bhopal, no outreach is done in other districts.
- The OSC staff is trained at the time of joining and retrained at 3–6-month intervals.

3.1.6 Gaps and Alternate Perspectives

- Causes underlying the absence of walk-ins should be explored. How approachable are the OSCs? Why are people not reaching out unless referred to by the police or the welfare committee?
- Is there stigma or fear of retaliation associated with an OSC visit? What is happening to the survivors once they complete their five-day stay at the OSC and return to the environment they came from? Can case studies be done to see who is coming in and who is not, how they are coping afterwards and what the patterns are?
- At the village level, the anganwadi centre is the nodal agency for women and child development and it should be the first port of call for instances of domestic violence. And yet, the centres are not capable of handling such cases. In general, cases of domestic violence are referred to the police and/or the health centre. Are the OSCs adequately connected with village level structures like the panchayat office, the anganwadi centre, the Mahila Sabha, etc.? How can a network of anganwadis be trained and organized around an OSC in a hub-and-spoke structure such that they may be oriented to dealing with GBV cases?
- Among population groups where the digital gender gap is wide, how are the women expected to report GBV?
- How would the study deal with a situation where survivors have rationalized domestic violence?
- How would the study deal with non-partner GBV within the family?
- Can the study include women survivors in the respondent group? It is not easy to do so. For instance, when the Population Council on-boarded frontline health workers to identify and screen women at risk of GBV and link them to redress facilities, it was found that the frontline workers have the same biases as everyone else.
- Many other United Nations Agencies are also working on OSCs issues and it would be good to share the findings and seek their inputs as well.

At the village level, the anganwadi centre is the nodal agency for women and child development and it should be the first port of call for instances of domestic violence. And yet, the centres are not capable of handling such cases.

- It may be useful to coordinate with child welfare committees and boards on child specific issues. For survivors below 18, referral mechanisms may be different for each medical, legal, social, or psychological need. Therefore, all these institutions need to be involved.
- Considering the current deployment of the Nirbhaya Fund and related output, an emphasis on greater efficacy in its utilization might help the cause of more desirable outcomes.

3.2 Tackling of Social Norms through Panchayati Raj Institutions[21]

3.2.1 Impact of Social Norms on Women and Girls

Women's ability to make decisions about reproductive health, contraceptive use and sexual relations is pivotal to gender equality and universal access to SRH and rights. Quite often, women are not able to exercise their autonomy and agency due to discriminatory social norms and harmful practices. Social norms are the informal, mostly unwritten rules and beliefs that dictate acceptable behaviours of members of a society. Such norms may vary from one community to another depending on cultural contexts. Norms provide an expected idea of how people should behave, and function and maintain order in the society. While certain norms may be beneficial for the society, those norms which discriminate by sex, age or caste are harmful to the attainment of the fullest potential of the members of the society.

The NFHS-5 showed improvements in many SRH, gender and women's empowerment-related indicators. However, harmful practices such as child marriage, sex-selective abortion, and violence against women continue. The evidence indicates that:

- One in three women (18–49 age group) reported experiencing physical or sexual violence (NFHS-5, 2019–2021)
- Sex ratio at birth continues to be low, with 907 girls being born for every 1,000 boys (Sample Registration System, 2018–2020)
- One in four girls continues to be married before age 18 (NFHS-5)

Concepts of family honour and the ideal conduct of a "good girl" that will uphold said honour are very strongly negotiated at the community level which surrounds the environment that girls are raised in. This translates to very severe restrictions on girls' mobility. It impacts their ability to avail opportunities for education, skill building and employment. Deep-rooted social and cultural norms prevent women from taking appropriate decisions by themselves. Discriminatory social and gender norms put individuals in vulnerable situations at even greater disadvantage. Women and girls are often most disadvantaged due to existing structural inequalities and the way gender norms promote and reinforce limited access to resources, information and services, and opportunities.

[21] To request for the presentation on "Tackling of Social Norms through Panchayati Raj Institutions" please write to india.office@unfpa.org.

3.2.2 The Intervention

In the 10th Country Programme, UNFPA focuses on community structures to help loosen the grip of informal and exclusionary practices on the lived experience of women and girls in India. Since rural local bodies work very closely at the community level, UNFPA has chosen to deepen its engagement with Panchayati Raj Institutions (PRIs) through strengthening institutions, community action, creating knowledge products, policy advocacy and the development of a measurement framework to tackle social norms.

UNFPA, in collaboration with the Ministry of Panchayati Raj (MOPR), has conducted training programmes for PRI officials on the documentation of good practices related to integrating gender into gram panchayat development plans. Towards this, UNFPA has developed an operational framework for PRIs to systematically work to drive change.

3.2.3 Operational framework to tackle social norms

The operational framework has been developed for pilot intervention at the programmatic and policy levels for various stakeholders to systematically and effectively address the challenges increasingly posed by negative social norms. The objective of the operational framework is to provide guidance for intervention strategies to improve women's and girls' access to Education, Employment, Empowerment and Engagement of men and boys to create an enabling environment (Annexe 2).

3.2.4 Measurement Framework to Tackle Social Norms

UNFPA is in the process of expanding PRI engagement to all states where it has a presence, starting with a district each in Rajasthan and Madhya Pradesh. It is also in the process of developing a measurement framework to tackle social norms which should make

Sidebar 3: Areas of UNFPA-PRI Engagement

Under the proposed intervention, UNFPA aims to intensify and scale up its ongoing work on strengthening Panchayat action for tackling discriminatory norms and enhancing the value of women and girls.

Addressing discriminatory social norms, GBV and Harmful Practices through Panchayat engagement

1. System strengthening
   - Creating Gender Cells at SIRDPR
   - Building capacities of Panchayati Raj Institutions
2. Community action
   - Organizing Mahila Sabhas
   - Transacting Life Skills with adolescents
   - Undertaking Safety Audits
   - Linking women and girls to Vocational Skills
   - Establishing model panchayats
3. Creation of knowledge products
   - Markers of Women and Girl Friendly Panchayats
   - Documentation of Good Practices
   - SOP for Elected Representatives for addressing GBV
4. Advocacy
   - Sharing Actionable Policy Recommendations with MoPR
   - Organizing State & District Level Consultations/ Workshops with stakeholders
5. Measurement framework to tackle social norms
   - Developing M&E framework to systematically and effectively measure changes in discriminatory social norms

GBV = Gender-Based Violence, M&E = Monitoring and Evaluation, MOPR = Ministry of Panchayati Raj, SIRDPR = State Institute for Rural Development and Panchayati Raj, SOP = Standard Operating Procedure.

it possible to measure change owed to UNFPA interventions at the community level over a period of two or three years. UNFPA is exploring a partnership with an international knowledge partner that has extensive research expertise on behaviour change.

3.2.5 Gaps and Alternate Perspectives

Unpacking Social Norms

- In identifying gender-adverse social norms, we must distinguish between social norms (attitude of the society) and the attitude of an individual. What is right behaviour is not just defined by what the society expects one to conform to but also one's personal attitude, approach and personality. Any intervention that aims to change social norms is also in effect trying to alter the behaviour and attitudes of individuals.
- Does everybody believe the same thing or is there a significant minority that sort of diverges from it? For instance, a behaviour study group researching in Bangladesh found that if young girls faced sexually harassed in a public bus, the rest of the passengers would not intervene. The girls would be forced to endure the harassment quietly. Approaching the police was not part of the social norm. Many complained that the helpline numbers for sexual harassment displayed on police posters were bogus. Since in 90% of the cases the bystanders were not intervening, is this a social norm or an individual attitude? How are these persons to be targeted?
- So it is important to answer clearly, who are the actors whom the intervention is trying to influence? How will their actions affect other actors in the ecosystem? Not being clear on this can lead to circularity of thinking and, in turn, to poor effectiveness of the intervention. The research needs to add greater conceptual rigour to the idea of defining and measuring social norms while drawing a distinction between the society and the individual actors.
- One could also take an outcome-oriented approach, such as, "ensuring secondary education of all girls" may be a desired outcome. Having identified it, one could focus on specific social norms that are coming in the way of achieving said outcome. For instance, in the example mentioned above where girls face harassment in buses, this is clearly a social milieu in which girls would be discouraged from going to the secondary school or tuitions using public transport. So working backwards from a desired outcome to factors hindering it can reveal underlying social norms and attitudes that need to be dispelled.
- Norms could be teased out in group discussions by observing responses to provocative statements like, "Beating your wife if she talks back is acceptable" or "Raghu doesn't beat his wife if she goes out without his permission, he is such a weakling; has no control over his woman."
- The free flowing qualitative interviews could be run through artificial intelligence software to analyse patterns and implicit norms that are not immediately obvious to the research

team. That way prejudices and preconceived notions of the researchers can also be filtered out and judgements about what is a harmful social norm and what is not can be avoided.

Adopting Action Research Approach

- It may be advisable to make initial interventions at Panchayat and self-help group levels, document the learnings and suitably revise the framework in a blended approach in action research mode.
- The same norm may manifest differently in different contexts. For example, the aspirations of "daughters only" families in Haryana are very different from the hopes and aspirations of similar families in Maharashtra. So strategies need to be contextualized to the people and the community that one is working with and not just the norm one is targeting.
- It may be possible to influence social norms through indirect deterrents. For instance, in one of its interventions, the Population Council of India distributed cards with helpline or health facility numbers to women at risk of GBV. The women respondents mentioned that while they have never actually called the helpline, in case their husband tries to hit them, they display the card and threaten to call. This stops him in his tracks.

Scope for Convergence with Other UNFPA Initiatives

UNFPA is already assisting the MOPR, Government of India (GOI) in its endeavours towards localizing the Sustainable Development Goals (SDGs) to achieve the 2030 development agenda. As per GOI's Expert Committee Report on Localizing SDGs through PRIs, nine themes have been adopted for local action on the SDGs. Theme 9 focuses on creating women-friendly panchayats and aims to localize SDG-5 for achieving gender equality and empowering all women and girls. Theme 3 focuses on child-friendly panchayats.

Under this initiative, UNFPA (in partnership with Institute of Rural Management, Anand) conducted a pilot with 50 gram panchayats with the SDG Theme 3 on child-friendly panchayats and interacted with Bal Sabhas and Mahila Sabhas to learn about the challenges. Baseline and endline data from these pilots may be able to inform the current study better.

Also, United Nations Children's Fund (UNICEF) and The Pacific Community are partnering on strengthening of data collection and data analysis to improve the lives of the most vulnerable children, women and PWDs across the Pacific islands and territories. The collection and dissemination of reliable data of children and women worldwide is vital to identify and plan for their needs and to inform policies. This is also an important resource to delve into for both data and perspectives on social norms.

Perspectives on Gender Sensitization of Village-Level Institutions

Physical representation of women in PRIs with women sarpanchs is not necessarily improving gender sensitization. These women leaders are supposed to operate within a highly oppressive patriarchal structure where they have to prove that they are effective leaders. In effect, they also become custodians of patriarchy.

Women sarpanchs are supposed to operate within a highly oppressive patriarchal structure where they have to prove that they are effective leaders. In effect, they also become custodians of patriarchy.

A more important institution in the PRI umbrella is the gram sabha. A vibrant gram sabha with active participation of women's collectives and youth's collective can ensure the democratic functioning, gender-sensitivity and accountability of the panchayats. Safety audits (when properly implemented and monitored) can lead to change in the gram panchayat development planning process. Funds allocated to gram panchayat development planning need to be linked to activities related to social justice. Panchayats are then compelled to widen their focus from mere construction works in the name of development to adequately performing their social justice function.





4 Proposed Areas of Research

Going forward, three areas of research are proposed to be studied, two of which are related to child marriage and one on the economic valuation of unpaid work by women.

4.1 Understanding the Underpinnings of Child Marriage

4.1.1 Introduction

Child marriage or the marriage of a young girl (sometimes less than 13 years old but more commonly 13–17 years of age) to an older adolescent boy, young adult male or grown man is prevalent in many communities, especially in Asia and Africa. For the child bride, strapped with onerous patri-local marital and childbearing–rearing responsibilities, the adverse personal, psycho-social and economic repercussions of marriage are many times more than for her husband. Worldwide, child marriage compromises health, education and development of one in five girls (UNICEF 2020) and is six times more prevalent among girls than boys (UNICEF, Press Release 2019).

This section examines the underpinnings of child marriage from two perspectives:

- Building an Investment Case towards Eradicating Child Marriage from Bihar: The state of Bihar is placed under the magnifying lens to see how child marriage works in the

state, what makes it endure and how an investment case may be made for specific action towards eradicating it.

- Examining the Implications of Climate Change on Child Marriage and GBV: Across 14 countries most at risk from climate change impact, UNFPA examines the impact of climate change on maternal mortality, intimate partner violence, adolescent birth rates and child marriage. Of these, climate change impact on child marriage and GBV are explored here.

4.1.2 Building an Investment Case towards Eradicating Child Marriage from Bihar[22]

"India is home to the largest number of child brides in the world: 223 million—a third of the global total."[23] Child marriage in India is governed by the Prohibition of Child Marriage Act, 2006. Its incidence is measured as the percentage of women in the 20–24-year cohort who, at the time of survey, report being married before the age of 18. The prevalence of child marriage declined significantly from 47% in 2005–2006 to 27% in the NFHS-4 (2015–2016), which further dropped to 23.3% in the NFHS-5 (2019–2021). However, there are significant interstate and intrastate variations.

States such as Himachal Pradesh (5%), Jammu and Kashmir (5%), Goa (6%), Kerala (6%) and Nagaland (6%) perform well. In contrast, Uttar Pradesh, Bihar, West Bengal, Maharashtra and Madhya Pradesh together account for over half of the Indian girls and women who were in a union before 18 years of age. Furthermore, Bihar reports the highest TFR of 3.0 across all states (as compared to ~1.7 in West Bengal).

Although the balance of gender roles is improving very gradually in rural Bihar, patriarchy is still going strong. While women do get elected to local bodies, on-ground empowerment of girls and women is a far cry. Land and property rights for women are rarely secured in practice. The administration and police are not always able to safeguard school/college-going girls from harassment or violence en route. Anecdotes abound of the police turning a blind eye to a child marriage in progress.

Wherever traditional patriarchal notions about women's purity, honour and safety have blended with entrenched social hierarchies and multidimensional poverty in the absence of economic (industrial/urban) growth opportunities, livelihood options and education, child marriage has remained a self-fulfilling prophecy. With many complex, inter-webbed and long-standing cultural and socio-economic underpinnings, child marriage is a "higher-order" practice, deeply embedded in the psyche of its practitioners, impossible to root out through a few isolated interventions.

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[22] To request for the presentation on "Building an Investment Case towards Eradicating Child Marriage from Bihar" please write to india.office@unfpa.org.

[23] United Nations Population Fund and United Nations Children's Fund, UNFPA-UNICEF Global Programme to End Child Marriage, 2020 Country Profiles, India (2021). https://www.unicef.org/media/111381/file/Child-marriage-country-profile-India-2021.pdf.

UNFPA Initiative and Progress

UNFPA and UNICEF are already collaborating to implement a project called "Global Programming to End Child Marriage" which is running in several countries including India. It focuses on the social dimensions of ending child marriage. As a natural twin, building an investment case for eradicating child marriage will work on economic dimensions in terms of benefit–cost ratio and the amount of resources expected to be required.

In this context, taking a lead in policy advocacy in child marriage eradication, UNFPA organized a focus group discussion in Choddargah, Sheikhpura, Bihar and a stakeholder consultations workshop in Patna during 8–11 September 2023. These consultations informed a concept note that was developed to help Government of Bihar (GOB), planners, donors and other interested stakeholders understand the stepwise approach to (and getting buy-in on) building a "comprehensive investment case towards eradicating child marriage from Bihar". Besides the consultations, the concept note was also preceded by a detailed background study that covered patriarchy, gender parity, population, social groups, multidimensional poverty, social progress, school education, literacy, health, gender roles in family and society, land rights of women, industry and employment, urban development and migration and disasters in Bihar.

The Proposed Investment Case

The investment case will build on the high-level pitch presented in the concept note to articulate the scope of each proposed intervention, envisaged timelines, resource requirement, output and outcomes to get the GOB and donors to go for the investment. For instance, a recent study based on the Child Marriage Optimal Interventions (CMOI) model estimated the costs and effectiveness of education and child marriage interventions in India. It yielded a benefit–cost ratio of 16.8 for all interventions, 21.0 for child marriage interventions alone and 13.1 for education intervention alone.[24]

For the investment case towards eradicating child marriage in Bihar, a similar exercise with interventions and their costs will need to be undertaken to take evidence-based investment decisions for education, child and other interventions. Further drill down to district- or block-level may also be required for better targeting and greater effectiveness of certain interventions, which will maximize the benefit–cost ratio.

More investigation and studies are necessary to gather evidence to identify high-impact interventions before developing the investment case. Such studies will also assimilate attendant hurdles, bottlenecks and gaps that are impeding progress towards the desired goals. It will include innovative, customized, targeted and prioritized interventions.

[24] B. Rasmussen and others, Evaluating interventions to reduce child marriage in India. *Journal of Global Health Reports*. 5:e2021044 (2021). https://www.joghr.org/article/23619-evaluating-interventions-to-reduce-child-marriage-in-india. | The Burnett Institute and the Victoria University are helping modify the CMOI to reflect the specific factors and determinants of child marriage at play in Bihar.

A Solutions Perspective

The spectrum of forces influencing child marriage in Bihar is so vastly spread across all aspects of human existence that it needs a systemic approach while also organizing the forces into more manageable groups. Arranging these into Traditional and Regressive (T&R) and Modern and Progressive (M&P) forces and chronology-agnostic disasters seemed like a simple and usable solutions perspective.

Though there was a steep drop in child marriage between NFHS-3 and NFHS-4, the pandemic led to some reversals that became visible in subsequent years. Stakeholder inputs suggest a reassertion of T&R forces post-pandemic, with the disaster impact pushing up child marriage given the aggravating socioeconomic circumstances of vulnerable groups. Schooling for adolescent girls has been de-prioritized by many such families. With reverse migration of workers from cities due to the pandemic and diminishing opportunities in cities, feudal and caste structures that were gradually loosening up seem to have regained grip, especially on the rural poor from backward castes. For instance, a stakeholder mentioned the case of a lower caste rape victim (and her family) reportedly being pushed by the panchayat to consider marriage with the rapist as a solution.

With reverse migration of workers from cities due to the pandemic and diminishing opportunities in cities, feudal and caste structures that were gradually loosening up seem to have regained grip, especially on the rural poor from backward castes.

Although the balance of gender roles is improving very gradually in rural Bihar, patriarchy is still the norm, and challenging it is met with stiff resistance. Culturally, it would seem that support for child marriage never really wavered in the psyche of the average family. While women do get elected as representatives in local governance, the shift in approach to administration and governance to create on-ground empowerment of girls and women has a long road ahead. Even in situations where women are empowered enough to be employed as frontline workers or self-help group leaders, time poverty is an extreme reality in patriarchal structures because the men and boys do not contribute to household chores. These are shouldered entirely by women (who may also be going out to work) and the daughters. These girls get pulled out of school to look after younger siblings and keep home on behalf of their mothers and are soon married off. Land and property rights for women are mostly limited to policy documents. Administration and police in the state are not always able to act as upholders of the law and protect school or college going adolescent girls from teasing, harassment and even violence en route. Stakeholders also mentioned cases where the police avoided taking action despite knowing that a child marriage was taking place.

Modern & Progressive (M&P) forces will need to be organized and systematically harnessed to build a strong fortification against and neutralize T&R forces. It is imperative to find solutions that will have at least some traction in influencing forces such as patriarchy, feudal structure, caste system, etc. A strong bulwark will also be necessary for the state to provide enough social security to a girl child in case of disasters.

Multidimensional Approach to Tackle Multiple Forces

With gender inequality being the central issue, intersectionality with caste and class (including socioeconomic) sharpens the intensity of the challenge in Bihar, as in other states with child marriage in India. Multidimensional poverty strengthens T&R forces and prevents many of the M&P forces from working well.

The chances that M&P forces can sweep over a poor, low-caste, remote village with TFR above 3.0 in a disaster-prone district of Bihar, and cure it of the scourge of child marriage are next to nil. Child marriage is a multidimensional problem and, therefore, it can only be effectively dealt with using a multidimensional approach. Even a single T&R force requires synchronized sustained effort to contain so that other foundational positive forces such as education can play their part.

For any setback such as a flood, pandemic or economic slowdown, families at high risk of child marriage must be focused upon for better targeting and adoption of effective safeguards and counter-measures.

Multidimensional interventions have to be planned in such a way that positive forces can be synchronized and synergized to overcome the T&R forces. For any setback such as a flood, pandemic, economic slowdown or any other, families at high risk of child marriage must be focused upon for better targeting and adoption of effective safeguards and counter-measures. To ensure that 10–18 year old girls (and boys) stay in school and out of marriage, it is important to influence members of their extended families, friends, neighbours and community leaders from where the pressure starts to build as soon as a girl attains puberty.

Towards Possible Solutions

From the work on the study and concept note so far, a range of large-scale data was found to support schooling as a lever to inform the investment case. The following interventions around schooling emerged from the stakeholder consultations:

- Ascertaining security, safety and basic services to facilitate schooling of girls;
- Focusing on boys to co-opt them in the long-term empowerment of girls and women;
- Ensuring delivery of teaching outcomes through rigorous oversight and review as well as innovation to overcome local hurdles;
- Introducing qualitative changes in school curriculum and evaluation mechanism for relevant and better outcomes by maintaining interest of students;
- Infusing innovative content that opens the minds on sticky issues such as patriarchy, feudalism, women's contribution to the economy, etc., in school curriculum; and
- Strengthening the entire education-to-economy continuum at village, block and district levels to build greater faith in the value of long-term investment in schooling of girls and boys.

Awareness about benefits of eradication of child marriage among parents, family and society and the negative effects of its continued practice and its illegality are also part of the wider education that is necessary in Bihar for behaviour change at a societal level.

Targeted interventions that compel the vulnerable families to focus on the health of the adolescent girl child as well as her nutrition, growth and physical and emotional well being can dissuade them from child marriage by creating an awareness-led social movement. Existing GOB programmes related to SRH of adolescent girls, education of all adolescents on SRH and other initiatives related to reproductive, maternal, newborn child plus adolescent health (RMNCH+A) could be dovetailed into the intervention. This will create a strong transformational change through awareness and action while also fulfilling GOB targets on health.

Law enforcement, administration and policy are clear areas for action by the executive and legislative arms of governance at the state level that need to become proactive and accountable for existing statutes. These not only cover the ones directly related to child marriage but also those that relate to crime against adolescent girls and women, dowry, atrocities against vulnerable groups and minorities, maintenance of peace, civic life, ensuring safety and security, etc.

Apart from child marriage-related direct interventions in schooling, education, health, law and order and basic services, innovative interventions (including conditional cash transfers and social protection) that effectively move the other identified levers such as social awareness and protection and skills and jobs also need to be initiated in coordination with direct ones. The objective for these interventions is to loosen the stranglehold of the anachronistic socioeconomic reasoning (anti-education, dowry cost-minimization, etc.) and structures (feudal, patriarchal, etc.) that tend to normalize child marriage in Bihar. Many of these are built around an archaic sociocultural core of beliefs, tradition and practices that can be systematically removed through modernization of thinking, society, education, health, economic opportunity, etc.

The number of interventions should be planned keeping administrative and implementing capacity in mind so that resources are not spread too thin to be effective. Some of the innovative interventions will have to be undertaken as local trials or pilots before scaling up.

4.1.3 Examining the Implications of Climate Change on Child Marriage and GBV[25]

Over time, demographic research has expanded its horizons in response to shifts in social structures and patterns driven by a wide range of factors, the most prominent one of which in recent times is climate change. Climate change impact on every aspect of life on earth will manifest in the next 20 years and humans are going to have to learn to live with it in some

[25] To request for the presentation entitled "Examining the Implications of Climate Change on Child Marriage and GBV" please write to india.office@unfpa.org.

Sidebar 4: Gopalpur Sea Beach, Ganjam District

Gopalpur Sea Beach in Ganjam district has been in the news recently due to repeated cyclones and disasters. A field study documented experiences as shared by the coastal community in terms of the past (1990 to 2005), present and future to understand how climate change impact was changing their lives.

In 1990–2005, people used manual boats to fish within a radius of 2 km from the coast. Although men did migrate for work for some part of the year, they would return to Gopalpur and their traditional occupation seasonally. Literacy levels, especially among girls, were low as compared to the present.

In present times, uncertainties have increased with coastal erosion, industrial pollution, advent of mechanized boats, and large-scale fish trade with the involvement of intermediaries. Fish haul by the local community has reduced drastically and poverty has induced entire families to resort to migration for months at a time in search of livelihoods. Out-migration for long periods has disrupted schooling and pushed adolescent girls as young as 14 into marriage.

And yet, Ganjam district was declared free of child marriage in 2021. Evidence from NFHS-6 may shed more light on the ground realities of Gopalpur.

form, like other anthropogenic transformations led by industrialization, urbanization and migration. **Just as human behaviour and demographic factors have impacted the environment, so also has the environment impacted society and demographic behaviour.**

Several studies have explored the drivers of child marriage in the past but none has ever attempted to look at the impact of climate change on these factors, life course transitions, trajectories and outcomes. The current study examines the linked domains of schooling, SRH, marriage and child marriage, pregnancy and parenthood, migration and GBV in the broader context of climate change impact. It proposes to understand the pathways by which climate change impact is impeding or rolling back progress previously made in child marriage and GBV reduction by aggravating factors that precipitate them.

Disasters that are more closely associated with child marriage, specifically from the international literature (mostly Bangladesh, not India), are droughts, floods, coastal erosion, the cyclones and high temperatures. While there are limitations to that current evidence base, environmental crises through loss of assets and opportunities for income generation and displacement of people from their homes increasing human insecurity, demonstrably worsen known drivers of child marriage, pushing families to marry their daughters off early.

The proposed study initially examined time series data on Podampet in Ganjam district, Odisha from 2005 to 2016, published by Utkal University. This showed that the shoreline which was 211 meters from the main city in 2005 was merely to 91 meters away in 2016. Recent conversations with local communities revealed their fear that their homes would soon be swallowed by the sea.

A rapid scan of literature suggests that climate change and child marriage and/or GBV is less explored/examined in Indian context. In view of this knowledge gap, the study proposes to look at two packages of work.

Package 1: Develop systems dynamics model on the intersectional issue of climate change and child marriage or GBV through:

- consultations with individuals /groups;
- rapid literature review;
- examine the existing secondary sources of data;
- build model through consultations, input data through Delphi method and existing information to identify the critical data gaps; and
- produce written output on the drivers of child marriage/GBV exacerbated due to climate change.

Package 2: Undertake case studies on how climate change affects people's mobility (since migration and climate change are strongly linked).

- Climate-induced migration and its role in increasing the risk for child marriage and GBV is an important area for discussion, not just for India but also globally.
- The research on potential policies, strategies and interventions to reduce child marriage and GBV in the context of climate change should be undertaken as well.

4.1.4 Gaps and Alternate Perspectives

Is it possible to arrive at direct calculations of increase in child marriage due to some proxy indicator which are affected by climate change? Taking any determinant of child marriage incidence, say reduction in assets, how can the climate change impact component of the reduction (direct effect) be isolated or separated out? Climate change impact may not always work through income or asset loss but other means. With a series of shocks, the community may have partially adapted overtime. So if it is possible to calculate, say, the reduction in fish haul/value/income owed to climate change, it should be possible to put an accurate number to the impact on child marriage. For example, to make a statement like, "50% reduction in fish haul per year led to 10% increase in incidence of child marriage between 1990 and 2005".

In such a calculation, it is important to differentiate the micro shock from the macro shock. Past studies may have focused on individual households but the overall impact on a community or an entire coastal belt may be very different. It is important to investigate how existing research can be used to measure the impact.

4.2 Measuring the Economic Value of Women's Unpaid Work[26]

4.2.1 Introduction

Given the context of declining female labour force participation rates in India and the need to acknowledge and value women's contribution to the society and economy, this study proposes to analyse data on paid and unpaid work generated by India's first Time Use Survey 2019 conducted by the Ministry of Statistics and Programme Implementation (MOSPI). It is a pertinent area of research to build a case of advocacy around the contribution of women (reaping the gender dividend) and understand how it varies across geographies, socioeconomic classes or across task types.

Women contribute to development not only through remunerated work but also through a great deal of unremunerated work.[27] The 1995 Fourth World Conference on Women through the Beijing Platform for Action (BPFA) called for the recognition and visibility of women's work, particularly in the unremunerated sector. This international plea was reinforced by the 1995 Human Development Report, which focused attention on women's contribution to the economic and social development of their own family, community and society.

The social and cultural constructs of gender are manifested in the differential nature of participation of women and men in the labour market (United Nations, 2000).[28] In general, women have to combine market work with family responsibilities. Consequently, they are often found in occupations that are different from those of men, usually in the less formal types of work and lower in status. Also, women proportionately spend more time in unpaid work than men.

Time-use data provides detailed information on how individuals spend their time, on a daily or weekly basis. They reveal the details of an individual's life with a combination of specificity and comprehensiveness not achieved in any other type of social survey. Thus, time-use data provide a more complete and better measurement of all labour inputs, both within the household and in the market. Time-use data pinpoint the unpaid work and amount of time women and men spend on both work and leisure activities, offering a key source of data to improve the analysis of gender issues. Policy decisions related to gender-friendly programme and resource priorities are better informed with data and statistics such as results of time-use studies.

4.2.2 Data Source

The National Statistical Office, under MoSPI in India, conducted the first Time Use Survey (TUS) during January–December 2019. The primary objective of the TUS is to measure

[26] To request for the presentation on "Measuring the Economic Value of Women's Unpaid Work" please write to india.office@unfpa.org.

[27] United Nations, The Beijing Declaration and Platform for Action (1996). https://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf.

[28] United Nations, The World's Women 2000: Trends and Statistics. *Social Statistics and Indicators Series K*, No. 16 (New York, 2000).

participation of men and women in paid and unpaid activities. In this survey, information on activity particulars was collected for each household member of age 6 years and above, with a reference period of 24 hours starting from 4:00 AM on the day before the date of interview to 4:00 AM on the day of the interview. The TUS is an important source of information on the time spent in unpaid care-giving activities, volunteer work and unpaid domestic service producing activities of the household members. It also provides information on time spent on learning, socializing, leisure activities, self-care activities, etc., by the household members. A total of 138,799 households were selected in the survey and information was collected from 445,299 persons above 6 years of age. The report provides estimates of indicators of time use in both rural and urban areas with different levels of disaggregation like gender, age, etc.

4.2.3 Key Data Highlights

The data indicates that the time women spend in unpaid domestic and care-giving services of family members is 17 times that of men. As a natural corollary, they spend much less time on paid employment, skill building and learning and leisure activities (Annexe Tables 3.1 and 3.2).

Related research indicates that the number of years that women spend living with young children has fallen sharply because the fertility has declined. Nonetheless, participation in the labour force by women has not increased commensurately. If women are having so many fewer children, what are they doing with their time? Where is it going? Is it going to higher quality human capital in the form of their children? Therefore, the dynamic relationship between fertility and employment of women, time invested in child-rearing, household chores and care giving are important areas of study.

4.2.4 Problems and Issues in Valuation

Some problems that might arise in the process of valuation are listed below.

- Lack of wage data on occupation for valuation: The valuation of unpaid work activities assumes a known wage rate for similar services rendered. Only then would unpaid work be priced according to compensation in paid employment.
- Appropriateness of valuation method: The various approaches assume conditions under which a method could be applied. For example, data is needed on the activities or occupation of the unpaid worker that will match with the occupation in the market including the compensation rate.

Sidebar 5: Approaches to Measure and Analyse Unpaid Work

Of the two approaches for imputing value to unpaid work,* the **output approach** requires data on the output of the unpaid work, such as the number of meals prepared, items of clothing washed and ironed, area of house cleaned, children taught, number of elderly persons given care, etc. The **input approach** based on time spent is more commonly used for the valuation of unpaid work for household production of domestic and personal services for own consumption. There are two general approaches used—opportunity cost and market replacement cost. The former is based on the potential wage rate that the person would be earning in the market. The latter is based on the market compensation of the worker, which is different for specialist and generalist roles.

* Outside the System of National Accounts (SNA) production boundary.

- Acceptability of valuation by national concerned practitioners: A key step in institutionalizing the valuation of unpaid work and its consequent consideration in the calculation of the gross domestic product is the recognition and acceptance of its significance in charting the actual growth of a country's economy. Care in the choice of the appropriate valuation approach in a country will help in resolving these issues, given an understanding of the importance of unpaid work to the further development of human capital resources.

4.2.5 Gaps and Alternate Perspectives

- Why does women's contribution through unpaid work need to be measured? Is it to demonstrate that even if unpaid, women are doing useful work? The counterpoint could be to emphasize on the urgent need to increase women's participation in paid work given its other consequences related to women's empowerment and agency instead of highlighting their unpaid contribution. UNFPA, therefore, needs to explore the bearing women's work, paid and unpaid, has on other aspects, such as, bargaining power. How does a women being in paid work impact her prospects in marriage negotiations? Does valuing her unpaid work have the same impact? Probably not.
- The technical problem that arises is that any research that imputes the value of women's unpaid care work by estimating the value of said work in the market ("from the outside") is assuming that women are working or not as a matter of choice. Indian markets are extremely exploitative to women and for many of these activities, the actual value is much more than what the wages reflect. Say, if the task of a homemaker cleaning her home is valued at Rs 1,000 per month because that is what a domestic helper would be paid for the same task, the model would not be accounting for the fact that the desperately poor domestic helper with little bargaining power may have accepted wages that are way below the productivity of this work. Or the researcher equally could take the stand that these wages were fair value and were attractive enough to have induced the women to come out of their households and take up these jobs. Now, depending on either stand, the researcher could either be overvaluing or undervaluing such work. Perhaps it would be better to go with ranges of estimates, take the minimum and the maximum, and taking a call on a reasonable middle value.
- How will self-employment be treated? There are many people who are self-employed in this country. The Periodic Labour Force Survey provides some idea of self-employed income, but it is much harder to calculate than wage labour which can be valued per time unit of work. Self-employment, on the other hand, has to be measured in terms of income, profit and business income ideas.
- It might be illuminating to look alongside at time-use data from 1997/98 that was collected in six states. Since then, women's labour force participation has more or less stayed the same but the portfolio of what she does as unpaid labour may have changed.

5 Crosscutting Issues and Emerging Research Needs

Gender parity interacts with every other goal for sustainable development and the four states of India where UNFPA is present have much ground to cover on most of them. Consequently, issues discussed during the meeting touched upon some of the most crucial factors that will drive the desired demographic dividend for India. Interventions for family planning, contraception, SRH among adolescents, comprehensive sex education, etc., have to necessarily navigate other aspects such as poverty, hunger, education, health, urbanization, environment, etc.

There are areas in family planning and contraception-related behaviour and attitude that the NFHS does not probe into or its study sample is too small for meaningful conclusions. In this context, more focus on smaller studies to unpack the NFHS data or get state-specific and district-specific evidence is desirable.

While evidence from research underscored shortcomings in present interventions, such as gaps in quality of family planning services or capacity of frontline health workers, more ideas on "then what" are needed. Need for action research to answer many "how to" questions were also highlighted during the meeting.

Since all adolescents are not school-going, a sizeable section may remain outside the purview of formal engagement (via curriculum) and peer interaction on taboo subjects such as SRH,

family planning, etc. There is a need to bypass the 100% school enrolment of adolescents precondition as such efforts for higher gross enrolment ratio will go beyond 2030. If a focused strategy to enhance individual, family and community awareness about SRH, family planning, etc., for non-school-going adolescents segment are developed, it is likely to yield better outcomes.

All the research showcased during the meeting also mentioned the overwhelming influence of social, economic and cultural norms, practices and traditions that often prevent IEC and SBCC strategies from building effective knowledge for the target community. This calls for more innovation and customization of such strategies as well as deeper capacity building for those delivering the interventions.

Specific suggestions such as non-inclusion of adolescents in the mystery client study on reversible contraceptive methods, shortcomings in facilities and processes and the predominance of female sterilization for contraceptives, which were highlighted during the review meeting, have been articulated along with the relevant discussion.

Annexe 1
India's Population Dynamics
Progress, Challenges and Opportunities[29]

What is Going Well: Highlights

Income

- From 1992 to 2021, India's gross domestic product (GDP) grew at an annual average rate of 6.8% and is slated to grow at 6.5%–7% in 2023/24.
- Real per capita income, which doubled over 40 years between 1950/51 to 1989/90, grew 2.5 times within the next 20 years, from 1991 to 2011.
- Given its extraordinary market size, India is among top 10 host economies for foreign direct investment (FDI) inflows. India's FDI inflow hit all-time high in 2021/22 despite setbacks caused by the war in Ukraine and the COVID-19 pandemic.

Poverty

- Income poverty declined at an increasingly rapid pace between 1993/94 (with 45.3% population living below the poverty line [BPL]) and 2011/12 (21.9%). During this period, 133 million people were lifted out of poverty. In the absence of more recent decadal Census data, the percentage of BPL persons may be extrapolated for 2021/22 to 6%–8%; this is however, inexact.
- According to the World Poverty Clock, 3% of India's population lives in extreme poverty on less than $1.90 a day.
- According to the Multidimensional Poverty Index (MPI),[30] India's multidimensional poverty halved between 2005/06 and 2015/16 with 271 million people moving out of poverty.
- According to NITI Aayog's MPI (including indicators related to maternal health and financial inclusion), 135 million people have moved out of poverty between 2015/16 and 2020/21.

Labour Force Participation of Women

- According to Periodic Labour Force Surveys, Female Labour Force Participation Rate (FLFPR) has prima facie increased from 23.3% of 15 years plus women in 2017/18 to 37% in 2022/23.
- Government of India ascribes this increase to its range of initiatives in girls' education, skill development, entrepreneurship facilitations, safety at workplace, etc.

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[29] For all data sources, please refer to the presentation entitled "India's Population Dynamics: Progress, Challenges and Opportunities". For the presentation, please write to india.office@unfpa.org.

[30] MPI is based on ten indicators across education, health and living standards.

- However, the increase we see is primarily owed to rise in rural FLPFR from 24.6% in 2017/18 to 41.5% in 2022/23. In contrast, urban FLPFR has increased only 5 percentage points over the same period. Had GOI's initiatives been at play, the increase ought to have been as dramatic or more in urban India as well.
- Whether increase in FLFPR indicates greater economic empowerment of rural women or greater felt livelihood insecurity is a matter of exploration.
- Besides, India's FLFPR does not compare well with global figures at all (more on that later).

Health

- Smallpox was eradicated from the country in 1977.
- India declared polio-free in 2014.
- The spread of HIV/AIDS has been contained.
- Life expectancy at birth: up from 49.7 years in 1970–1975 to 69.7 years in 2015–2019
- Sharp reduction in Maternal Mortality Ratio (MMR) from 327 per 100,000 live births in 1999–2001 to 97 in 2018–2020.
- Reduction in Under-5 Mortality Rate (U5MR) from 69 per 1,000 live births in 2008 to 28 in 2020

Education

- Literacy rate: 12% in 1947 to 73% in 2011
- Mean years of schooling: 2.8 years in 1990 to 6.5 years in 2019
- Gross Enrolment Rate (GER) of 103.4 in 2021/22 at the primary level
- The GER of the female child has been higher than that of male child at primary level.
- The adjusted net enrolment ratio has always been higher for female students at all levels of education over many years.

Digitalization

- Digital technology and digital platforms have ushered in a silent revolution.
- India's digital payment innovation has been a game changer.
- Many digital platforms have come up in health and education but whether these are enabling better lives and greater freedoms and choices is a matter to exploration.

Other dimensions

India is doing well on many other significant dimensions such as access to electricity and drinking water, share of institutional births, vaccination, fertility reduction, etc. Even if it is lagging behind targets on a few, it is getting there rapidly and approaching its vision of becoming a developed country by 2050.

With **particular focus on TFR,** it is worth noting that:

- India has reduced fertility without resorting to any coercive state policy like the "one child policy" of China, which has had deeply adverse sociological repercussions.

- Both rural and urban TFR for India are below 2.1.
- Almost 70% of India's population lives in states with a TFR<2.1.
- Improvements in income, educational levels of mothers and child survival rates have contributed to drop in TFR.
- All inter- and intrastate data indicates that fertility reduction is driven by socioeconomic factors and not religion. While Muslims have higher TFR than other religious groups, they are also overrepresented in terms of relative share in population among the poor. Steepest drop in TFR has also been reported among Muslims between 1992 and 2019.

What is Not Going so Well: Highlights

Income and Inequality

- India, with a per capita income of US$ 2,150, the lowest among the G20 nations, is a lower middle-income country.
- A vast majority of Indians earn very little. According to the World Inequality Database, if a person's monthly income is more than ₹25,000, they are earning more than 90% of India. So, it points to extraordinary inequality in the distribution of income.
- The rich are getting richer. Billionaires' fortunes increased almost 10 times between 2013 and 2023. Billionaires' total wealth was higher than the entire Union budget for the 2018/19.
- Millions of workers in the informal sector lead insecure and precarious lives.

Health

- Large inequalities are visible in health indicators across states. For example, MMR (2018–2020) ranges from 19 in Kerala to 195 in Assam. Similarly, U5MR (2018) ranges from 10 in Kerala to 56 in Madhya Pradesh. A state's U5MR reflects its performance in terms of family income, mother's education, livelihoods, the reach and efficacy of public health services, and access to safe drinking water and proper sanitation. One nation, one election, one ration, etc., cannot be realized with these extremely disturbing inequalities.
- Of India's children, 36% are stunted. Only 16 countries in the world report higher levels of stunting than India. This is owed at the outset to low birth weights reflective of intergenerational transfer of maternal malnutrition and anaemia. Birth weight of less than 2.5 kg was reported in 8% of births in 2019–2021 (with no improvement from 2015–2016). Of the women aged 15-49 years, 57% are anaemic. Only 13% of non-breastfeeding children aged 6-23 months are receiving adequate diet. Even for Kerala, which is India's best performing state in terms of health indicators, the figure is only 20%–22%.
- India has a large and increasing burden of non-communicable diseases such as diabetes, hypertension and cancer, cutting across socioeconomic classes. Public healthcare is woefully inadequate to cater to the needs of the nation given the sheer size of the affected population.

Hunger

- India is placed at 111th position among 125 countries on the Global Hunger Index (based on undernourishment, child stunting, wasting and mortality), below Nepal, Bangladesh, Pakistan and Sri Lanka.
- While the Government of India does not agree with the index, it still accepts that over 800 million Indian receive

subsidized food under the National Food Security Act. It says that 75% of rural population and 50% of urban population are entitled as a matter of right to subsidized food. The food subsidy programme has been extended for five more years.

Education

- Education is not only about enrolment rates, literacy rates and mean years of schooling.
- Consecutive Annual Status of Education Reports (ASER) have shown that levels of learning remain far behind the grade in which the student is purportedly studying.

Gender and Gender-Based Violence

- Discrimination against the girl child is apparent in the precipitous decline in child sex ratio from 960 girls per 1,000 boys in 1961 to 919 in 2011. Data demonstrates not just son preference but more pertinently, "daughter aversion".
- Gender discrimination persists in the informal labour market, with women facing stark wage disparities compared to men.
- According to NFHS-5, 45% women and 44% men in 15–49 years age group agree that a husband is justified in beating his wife for one or the other reason. In fact, across the whole range of possible reasons including disrespect to in-laws, neglect of household or children, arguing with husband, going out without permission, not cooking well or suspicion of adultery, the percentage of women justifying domestic violence consistently outstrips men in both NFHS-3 and NFHS-5. This is possibly because men are more wary of the law in this regard. But it is also the women championing the cause of patriarchy and power structures within the household.
- According to the *Youth in India* study of the Population Council of India in 2005, a large proportion of young male respondents agreed that women who dressed provocatively deserved to be teased.

Fertility, Unmet Contraception Needs and Women's Agency

- Educational level of the mother is a crucial determinant of fertility rate which drops from 2.82 at no schooling to 1.78 with 12+ years of mother's education. Interstate variation in female educational attainment is large with only 17% of women having completed 10+ years of education in Bihar (worst performer). Even the best performing state, Kerala, reported only 50% on this indicator in 2019–2021.
- Increase in use of modern contraceptives has been marginal between NFHS-3 and NFHS-5: 48.5% of currently married women (15–49 years) in 2005/06 to 58.5 in 2015/16.
- The onus of family planning is largely on women. Less than 1 in 10 men use condoms in India, while nearly 4 in 10 women undergo sterilization to avoid pregnancy, according to NFHS-5 (2019–2021).
- According to a study published in the Lancet, in 2015, there were nearly 16 million abortions in India annually (to be viewed against 24–25 million live births). The NFHS reports that almost half of all women (48%) in the reproductive age group have been through an abortion due to an unplanned pregnancy. An abortion is physically invasive, psychologically stressful and emotionally extremely disturbing, so this is worth noting and addressing.
- The problem is not one of awareness because according to NFHS, 99% of men and women know about some of the other modern method of contraception. And yet, irrespective of location (rural–urban), education (less than

5 years of schooling), state (Uttar Pradesh or Jharkhand), or religion (Hindu–Muslim), TFR is higher than "Wanted TFR". Women end up having more children that they want to due to a lack of agency over their bodies and fertility decisions.

- Survey after survey has shown that when asked questions regarding ideal family size, respondents have a tendency to say 1–2 children because (perhaps) that is what they imagine is the right thing to say. It may not be what they actually think or believe. This makes unmet needs for contraception very difficult to estimate. There is a need to invest into well-designed research for accurately measuring unmet contraception needs and understanding its causes and prevalence by geography and socioeconomic group.

Sexual and Reproductive Health of Adolescent Girls and Young Women

- Adolescents and young women have limited access to information regarding SRH.
- Societal stigma and cultural taboos surrounding topics like menstruation contraception and sexual health create (a) barriers to seeking information and services; and (b) contribute to misinformation, fear and reluctance to seek necessary care.
- Limited access to quality healthcare facilities, especially in rural areas, poses a challenge. This can result in inadequate prenatal care, limited availability of contraceptives and insufficient facilities for safe deliveries and postnatal care.
- Early marriage and teenage pregnancy not only poses health risks for young girls but also limits their educational opportunities and economic empowerment.
- Adolescent mental health is taking a nosedive. Depression, anxiety and stress are on the rise. The pressure to conform to societal expectations, limited support systems and lack of awareness contribute to this challenge.
- Participation of adolescent girls in decision making around marriage and family planning is extremely limited. According to the *Youth in India* study of the Population Council of India in 2005, 47% of young women were very scared or very unhappy on the day of their wedding. According to the UDAYA study,[31] as recently as

Sidebar 6: Findings from the UDAYA Study on the Prevalence of Early Marriage in Bihar

In the UDAYA study on the prevalence of early marriage in Bihar, of the 12,600 participants, 7,000 were youth with girls in the 14–24 years and boys in the 16–26 years age group.

The study indicated that if anything, regressive mind-set is becoming more deeply entrenched in Bihar instead of modernizing. When asked questions around the need to "control a girl's sexuality" most unmarried boys responded in the affirmative. Similar positive responses were drawn from married males on questions related to continued relevance and importance of patriarchal norms. For instance, many 16–18 year old boys felt that when they migrate to work in other states, they would like to have a wife to leave behind in the village to take care of household chores and look after their parents.

The study also found that about 50% of registered crimes against women in Bihar are cases of kidnapping and abduction of girls. In truth, in any instance that a girl goes against all odds to exercise her independent will to be with a partner of her choice, the parents immediately lodge a case of kidnapping and abduction against said partner.

Source: https://www.projectudaya.in/about-udaya/.

[31] https://www.projectudaya.in/about-udaya/.

2016, 77% of young women in Bihar and 57% in Uttar Pradesh met their husbands for the first time on the day of their wedding.

- This lack of autonomy of adolescent girls over marriage-related decisions reflects poorly on their husbands too, begging the question why these young men do not dig in and refuse to marry a girl less than 18 years old.
- There is a clear need to engage more deeply with the men and involve them in responsible decision making regarding marriage and family planning, thus pinning the onus of birth control more firmly on them. This may prove effective in better securing the reproductive and sexual rights of women.

Interstate Variations in Levels of Development

- Expansion of social opportunities goes hand in hand with the expansion of economic opportunities or economic growth.
- Kerala and Tamil Nadu, which are doing well in terms of economic performance per capita, also have better life expectancy, better child survival, lower fertility rates, better female literacy rates, higher percentage of women with 10+ years of schooling and extraordinarily low populations that are multi-dimensionally poor.
- But for states such as UP or Bihar to develop, the trade-off is not between investing into economic growth versus social development but rather a challenge of cracking the code for transformational social change.

Environment

- India's natural environment, population and economy are beginning to feel the intense pressures of climate change.

In a nutshell, therefore, India's rapid GDP growth, urban infrastructure, malls and highways are not translating to freedoms, rights and choices for women or any other vulnerable group for that matter.

Key Hurdles in India's Economic and Social Progress

Far from Providing 'Free' Universal Health Coverage

- No country in the world has achieved universal health coverage without the presence of a dominant public sector. Whereas in India, 93% of all hospitals, 64% of all beds and 80%–85% of all doctors are in the private sector treating two-thirds of all ailments.
- Private healthcare is extremely non-standardized with quacks at one end doling out allopathic drugs in the villages and high-end city hospitals at the other, over-testing, over-prescribing and overcharging hapless patients who have no reasonable recourse to quality public healthcare.
- Government of India spends only 1.5% of GDP on health (stagnant since 2001), lagging behind Brazil (8%), Thailand (3.9%) and even Sri Lanka (2.2%). Per capita annual health expenditure in purchasing power parity terms at $191 is way lower than even Bhutan at $496. As a result, out of pocket expenditure as a percentage of current health expenditure is as high as 51% as compared to only 9% in France.

No Surety of Free and Compulsory Education to Children 6–14 Years

- In India, 52% children are going to private schools as compared to advanced nations such as Singapore, Canada, the US and Germany where it is less than 10%. This is a big burden on a large majority of parents with extremely limited financial resources.

- Private schools do not necessarily offer quality education. On the contrary, ASER reports year after year that learning levels in both private and public schools are low and declining though learning levels are marginally higher in private than in public schools.
- Just like the unregulated private market in health, the unregulated private market in school education also flourishes due to stagnant public spending on education (3% of GDP since 2006). The Kothari Commission recommended as far back as 1968 that this should be raised to 6%, which India is far away from over 5 decades hence.

Low Female Labour Participation Rates Hampering Economic and Social Progress

- According to the World Bank, all countries with a FLFPR lower than India (37% according to GOI) are Islamic countries that impose severe restrictions on women at the workplace.
- Southeast Asian nations are doing far better than India—Cambodia (74%), Lao PDR (68%), Bhutan (65%) and Thailand (59%).
- A male–female LFPR gap of 42 percentage points in India is the highest in the world as of now.
- Women in India are also in low-paying work reflected in the fact that they contribute only 17% of the GDP as compared to China's 47% and global average of 37%.
- Why is India's FLFPR low? It is difficult to quantify and value unpaid family work. Unpaid domestic care responsibilities are huge; women just are not able to go out to work. Global average for women's time spent on unpaid domestic services is 277 minutes; Indian women spend 299 minutes on such tasks, compared to the 97 minutes spent by men.
- There are no jobs created for women close enough to their residence so that they can balance their care responsibilities with work-life.
- The prima facie increase in FLPLR from 23.3% of 15-plus women in 2017/18 to 37% in 2022/23 primarily owed to rise in rural FLPFR from 24.6% in 2017/18 to 41.5% in 2022/23.

Sidebar 7: Key Questions Raised in the Asia Pacific Population Conference (November 2023)

- Countries across Asia (including those with high fertility rates and a youth bulge) are all either experiencing or anticipating simultaneous challenges related to population aging and a large cohort of the aged. What can such countries learn from those that have already reached their stable ageing levels?
- How can aging within Asia be examined not just in terms of life expectancy and proportion of 60-plus or 80-plus population but also quality of life?
- What is the impact of population aging on the labour force? How can the shrinking of the labour force be tackled?
- What are the challenges related to internal and international migrations in Asia? How can Asia ensure stable and orderly and well protected migration?
- How can migration policies be used as a means to invite the best and the most appropriate individuals to contribute to the destination economy?
- How can conditions be created for migratory people to be able to contribute but also to return back?
- Why do socioeconomic degradation, violation of human rights, ageism and gender inequalities persist and aggravate in Asia with each passing decade? What has been the impact of climate change, disasters, conflicts, COVID19 pandemic and digital transformation on these issues?

- Much of this increase is attributable to rise in women in self-employment (particularly post-pandemic) rather than regular salaried wage employment or even casual wage labour. Most new entrants are engaged either in "own account enterprises" or as a "helper in household enterprises". Before COVID, 50% of women were self-employed. After COVID, this rose to 60%. This indicates the absence of wage/salaried employment opportunities.
- Women's share in person-days of work under Mahatma Gandhi National Rural Employment Guarantee Act (which is basically unskilled earth work at minimum wages) has gone up post pandemic from 53% to 58%. As wages under MGNREGA are lower than those paid for female casual wage labour in private markets, this indicates absence of alternative, more productive forms of employment.
- Therefore, the rise in FLFPR has more to do with rising financial distress in rural areas than expanding opportunities for skilled employment.

Sidebar 8: Summit of the Future (September 2024)

- The Summit is a high-level event, bringing world leaders together to forge a new international consensus on how we deliver a better present and safeguard the future. This once-in-a-generation opportunity serves as a moment to mend eroded trust and demonstrate that international cooperation can effectively tackle current challenges as well as those that have emerged in recent years or may yet be over the horizon.
- We already have the "what" in the form of many existing agreements and commitments, starting with the UN Charter and including the Universal Declaration of Human Rights, the 2030 Agenda, the Paris Agreement, the Addis Ababa Action Agenda and many others. The world is not likely to be able to achieve the Sustainable Development Goals by 2030. So what are we going to do differently?
- The Summit of the Future will look at the "how"—How do we cooperate better to deliver on the above aspiration and goals? How do we better meet the needs of the present while also preparing for the challenges of the future?

Constraints to Freedom and Opportunities of Girls and Women

Freedom and opportunities for girls and women at par with boys and men can not only improve socio-economic condition at the community level but also boost the GDP growth. In India there is an urgent need to ramp up policy and action to ensure greater gender parity in select indicators related to: life and good health; education, skill-building and knowledge; labour and financial inclusion; and participation in decision-making.[32]

Lack of Community Connect

In India, most policies and programmes in terms of both formulation as well as implementation are driven from the top. India has failed to get the community involved adequately in, for instance, the delivery of healthcare and school education. It is important to listen to the community, take on board what they want done and get them involved in the administration, management and governance of these institutions.

[32] United Nations Development Fund, Technical note: Twin indices on women's empowerment and gender equality (2023). https://hdr.undp.org/sites/default/files/publications/additional-files/2023-07/paths_equal_2023_tn.pdf.

Annexe 2
Operational Framework for Addressing Gender and Social Norms

Enhancing Value of Women and Girls

	Education	*Empowerment of women and girls*	*Employment*	*Engaging men and boys to tackle patriarchy*
Norms and beliefs	Role of women and girls is restricted to household and childbearing. Investment in girls' education has low returns.	Both men and women hold biased attitudes to gender roles. A large proportion justifying male power over women, male superiority and female submissiveness.	Traditional gender norms restrict girls' abilities to participate in the workforce, access skill-building opportunities and make career choices. Beliefs that constrain women's freedom of movement, perceptions regarding the compatibility of women's work and caregiving responsibilities, as well as safety concerns in the workplace and during commutes	Men as powerful, tough and sexually dominant, holding positions of authority exercise control and discipline over women Women as weak, innocent, obedient and submissive

	Education	*Empowerment of women and girls*	*Employment*	*Engaging men and boys to tackle patriarchy*
Strategy 1	Ensuring secondary and higher education, exposing adolescents to new ideas, diverse peer networks and improved negotiation skills to drive change and build self-esteem and self-confidence among girls	Working with parents and community influencers on decision-making about girl children—what to study, how much, which careers to pursue, sexuality, whom to marry, childbearing, health-seeking, autonomy in making purchases and freedom of mobility influence the degree of empowerment from adolescence to youth	Breaking gender stereotypes in skilling and career choices	Raising awareness about the adverse consequences of toxic masculinity*
Strategy 2	Working with parents and communities on the value of investing in girls	Providing spaces (sports, self-defence, group activities) for adolescent girls to voice their opinions and build networks so that they don't acquiesce to the opinions of others	Additional research on sharing of household chores and shifting of norms	Integrating comprehensive sexuality education and life skills education among boys at puberty
Strategy 3	Analysing and reducing gender disparities in school enrolment with a focus on the quality of schooling from the perspective of girl's access to digital devices, reducing time for girls in household chores, changing teachers' attitudes towards gender		Targeting youth especially between 15–24 years who are not in education, employment, or training (NEET) as they are the most deprived girls Enabling skill development, fostering confidence and empowerment	Early response to the incidence of sexual harassment and GBV has a significant deterring effect.

* Engagement with men and boys is extremely important for gender sensitization. For instance, Malvika Pandey interviewed 100 convicts in Tihar jail serving term for rape. The study revealed that a majority of them did not even know what consent meant.

Annexe 3
Time-Use Survey Data Highlights

Annexe Table 3.1: Percentage share of total time in different activities in a day per person, India, 2019

Description of the activity	*Rural*		*Urban*		*Combined*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
Employment and related activities	16.9	4.2	21.3	4.3	18.3	4.2
Production of goods for own final use	2.7	2.2	0.3	0.3	1.9	1.6
Unpaid domestic services for household members	1.9	17.2	1.5	16.1	1.7	16.9
Unpaid caregiving services for household members	0.8	2.6	0.7	2.5	0.8	2.6
Unpaid volunteer, trainee and other unpaid work	0.2	0.1	0.2	0.1	0.2	0.1
Learning	7.1	5.7	7.0	6.1	7.1	5.8
Socializing and communication, community participation and religious practice	9.6	8.8	8.7	8.8	9.3	8.8
Culture, leisure, mass-media and sports practices	9.7	9.0	10.9	11.7	10.1	9.8
Self-care and maintenance	51.2	50.3	49.4	50.0	50.6	50.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: Government of India, Time Use Survey in India, 2019 (National Statistical Office, Ministry of Statistics and Programme Implementation, Government of India, New Delhi, 2020).

Annexe Table 3.2: Percentage of persons in different age groups participating in the activities in a day, all-India, 2019

Description of the activity	*15–29 years*		*15–59 years*		*60 years and above*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
Employment and related activities	53.9	14.2	70.9	21.8	43.5	13.8
Production of goods for own final use	11	18.1	15.6	22.7	21.4	20.8
Unpaid domestic services for household members	24.2	85.8	28.9	92.3	34.7	78.3
Unpaid caregiving services for household members	11.5	39.8	16.2	32.8	11.1	17.1
Unpaid volunteer, trainee and other unpaid work	2.6	2.1	2.9	2.2	3.2	2
Learning	32.9	25.4	14.3	10.9	0.6	0.3
Socializing and communication, community, participation and religious practice	91.9	91.3	93.4	92.6	96.7	96.2
Culture, leisure, mass-media and sports practices	88.3	84.2	86.9	83.8	88	84.9
Self-care and maintenance	100	100	100	100	100	100

Note: The estimates have been calculated considering all the activities in a time slot.

Source: Government of India, Time Use Survey in India, 2019 (National Statistical Office, Ministry of Statistics and Programme Implementation, Government of India, New Delhi , 2020).

Agenda for R4I Review Meeting Round II

Time	*Sessions*
9:30–10:00	Registration
10:00–10:45	**Opening Session** **Welcome and setting the context** • Jaydeep Biswas, Chief, Policy and Partnerships, UNFPA • Sanjay Kumar, Population Dynamics, and Research Specialist, UNFPA **Opening remarks and update on APPC** • Andrea M. Wojnar, UNFPA India Representative & Country Director Bhutan
10:45–11:45	**Population and development, SRHR, gender, education, and demographic mega trends in India: progress, lessons learnt and way forward** • A.K. Shiva Kumar, Development Economist & Independent Consultant **Q&A**
11:45–12:00	Coffee/Tea
1200–13:30	**Research on Family Planning Based on Primary and Secondary Data** **Chair:** Dr. Deepa Prasad, Chief, Technical and Programme, UNFPA 1. **Determinants of the uptake of reversible contraceptive methods in three states (Bihar, Madhya Pradesh and Rajasthan)** • Dr. Madhu Gupta, Professor, PGIMER, Chandigarh / Dr. Saswati Das, Sexual Reproductive Health and Rights Specialist, UNFPA 2. **Barriers to Family Planning among Adolescents and Young Adults in Bihar (in collaboration with AN Sinha Institute of Social Sciences, Patna)** • Sandhya Mahapatra, Associate Professor, NCDS, Odisha 3. **Men's participation in Family Planning & Reproductive Health** • Alok Vajpeyi, Lead, Knowledge Management, Population Foundation of India (PFI) **Discussants** 1. Dr. Ajay Khera, Country Representative, EngenderHealth 2. Niranjan Saggurti, Country Director, Population Council **Q&A**
13:30–14:15	Lunch

Time	*Sessions*
14:15–15:45	**Implementation Research and Operational Framework of Gender Interventions** **Chair:** Shireen Jeejeebhoy, Director, Aksha Centre for Equity and Wellbeing **1. Framework and tool for the assessment of One-Stop Centres (OSCs)** • S. Ramanathan, Development Solutions **2. Investment Case Study to End Child Marriage in Bihar** • Sudipto Patra, Independent Consultant **3. Piloting a framework to tackle social norms through local governance (PRI)** • Shobhana Boyle / Sanjay Kumar / S. Kaushik, UNFPA **Discussants** 1. Hyun Hee Ban, Chief of Social Policy, UNICEF, India 2. Anamika Priyadarshini, Research Lead, C3 3. Yogesh Kumar, Director, SAMARTHAN **Q&A**
15:45–16:00	Coffee/Tea
16:00–17:00	**Emerging Population Issue and Climate Change** **Chair:** Dr. Sonalde Desai, Professor, National Council of Applied Economic Research (NCAER) **Co-chair:** Jaydeep Biswas, Chief, Policy and Partnerships, UNFPA **1. Implications of climate change on child marriage and GBV** • Niranjan Saggurti, Country Director, Population Council **2. Measuring the economic value of women's unpaid work (household work, caregiving) using time-use survey and PLFS data** • Sanjay Kumar, Population Dynamics and Research Specialist, UNFPA **Discussants** 1. Dr. Abhiroop Mukhopadhyay, Indian Statistical Institute, New Delhi 2. Oommen C. Kurian, Head of Health Initiative, Observer Research Foundation 3. A.K. Shiva Kumar, Development Economist & Independent Consultant **Q&A**
17:00–17:30	**Crosscutting Issues and Way Forward** • Sriram Haridass, Deputy Representative, UNFPA India **Vote of Thanks** • Shivendra Singh, Data Analyst, Population and Development, UNFPA

Participants for R4I Review Meeting Round II

Andrea Wojnar

Resident Representative for UNFPA India and the Country Director for Bhutan

Abhiroop Mukhopadhyay

Professor in the Economics and Planning unit, Indian Statistical Institute, Delhi

Ajay Khera

Country Representative at EngenderHealth

A.K. Shiva Kumar

Development economist and evaluator who works on issues related to human development including poverty, health, nutrition, basic education and the rights of women and children

Alok Bajpayee

Development professional, monitoring and evaluation specialist and researcher with progressive experience in evidence-based development

Anamika Priyadarshini

Lead-Research at Centre for Catalyzing Change

Deepa Prasad

Chief, Programmes and Technical Support, United Nations Population Fund, India

Hyun Hee Ban

Chief of Social Policy for UNICEF India

Jaydeep Biswas

Chief of Policy, Advocacy, and Partnerships, UNFPA

Kiranjit Kaur

Public health professional with extensive experience managing various projects related to reproductive health, engaging with medical college faculty, data analysis and managing project-related social media.

Neena Singla

Consultant Obstetrician and Gynaecologist

Niranjan Saggurti

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Gender and Human Rights Specialist at UNFPA India

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R4I REVIEW

RESEARCH FOR IMPACT

ROUND II MEETING, DECEMBER 2023

The mission of the United Nations Population Fund (UNFPA) is to deliver a world where every pregnancy is wanted, every birth is safe and every young person's potential is fulfilled ensuring rights and choices for all. UNFPA works towards achieving three transformative results that promise to change the world for every woman, man and young person by 2030:

- Ending preventable maternal deaths
- Ending unmet need for family planning
- Ending gender-based violence and harmful practices

The new country program (CP-10) of the UNFPA in India (2023–2027) envisions strengthening of data systems and promoting greater use of data and evidence to design and advocate for policies and programmes that impact the furthest left behind and hasten the pace of change required to achieve these three transformative results.

One of the core activities of UNFPA is to promote evidence-based decision-making and policy formulation in the areas of sexual and reproductive health, gender equality and population dynamics. To be able to do this demands a thorough understanding of political and policy processes in India which UNFPA seeks to gain through systematic and structured interactions with eminent scholars, academicians, and researchers from multidisciplinary fields through Research for Impact (R4I) Review Meetings, proposed to be organized bi-annually. This issue captures the highlights of the R4I Round II deliberations held in December 2023 in New Delhi.

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