SERIES IN FEMINIST EVALUATION-2

ENGENDERING META-EVALUATIONS: TOWARDS WOMEN'S EMPOWERMENT

Editors
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ABBREVIATIONS

ABL	Activity Based Learning
AFPRO	Action for Food Production
AIE	Alternative and Innovative Education
ASER	Annual Status of Education Report
ASHA	Accredited Social Health Activist
AWPB	Annual Work Plan and Budget
BC	Backward Caste
BCC	Behaviour Change Communication
BPL	Below Poverty Line
BRC	Block Resource Centre
CAL	Computer Aided Learning
CBGA	Centre for Budget and Gender Accountability
CBM	Community based monitoring
CCE	Continuous and Comprehensive Evaluation
CDA	Centre for Development Alternatives
CEB	Chief Executive Board
CHC	Community Health Centre
CIFE	Central Institute of Fisheries Education
CRC	Cluster Resource Centre
CRM	Common Review Mission

CRRID	Centre for Research in Rural and Industrial Development
CWSN	Children With Special Needs
DFID	Department for International Development
DH	District Hospital
DIET	District Institutes of Education and Training
DISE	District Information System of Education
DP	Development Partners
DPEP	District Primary Education Programme
DPMU	District Programme Management Unit
DWCD	Department for Women and Child Development
ECP	Emergency Contraceptive Pill
EdCIL	Educational Consultants India Limited
EFA	Education for All
EGS	Education Guarantee Scheme
EI	Education Initiatives
FGD	Focus Group Discussions
EMRI	Emergency Management and Research Institute
GE	Gender Equity
GER	Gross Enrollment Ratio
GOI	Government of India
GPI	Gender Parity Index
HH	Household
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Rights
HRH	Human Resources for Health
HSC	Health Subcentre
IAMR	Institute of Applied Manpower Research
ICDS	Integrated Child Development Scheme
ICT	Information Communication Technology

IDS	Institute of Development Studies
IDSP	Integrated Disease Surveillance Programme
IEC	Information, Education and Communication
IFA	Iron and Folic Acid
IIT	Indian Institute of Technology
IIM	Indian Institute of Management
IDRC	International Development Research Centre
ISWSD	Indian School of Women's Studies Development
IWRAW	International Women's Rights Action Watch
JRM	Joint Review Mission
JSSK	Janani ShishuSwasthyaKaryakram
KGBV	Kasturba Gandhi Balika Vidhalaya
LEP	Learning Enhancement Programme
MDGs	Millennium Development Goals
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MHRD	Ministry of Human Resource Development
MI	Monitoring Institutions
MOHFW	Ministry of Health and Family Welfare
NAS	National Achievement Survey
NCERT	National Council of Educational Research and Training
NCF	National Curriculum Framework
NDCP	National Disease Control Programme
NFIW	National Federation of Indian Women
NGOs	Non-Government Organisations
NHM	National Health Mission
NPEGEL	National Programme for Education of Girls at Elementary Level
NREGA	National Rural Employment Guarantee Act
NRHM	National Rural Health Mission
NSS	National Sample Survey
NSSO	National Sample Survey Organization

NUEPA	National University of Educational Planning & Administration
NUHM	National Urban Health Mission
OBC	Other Backward Classes
OCP	Oral Contraceptive Pill
OGs	Operational Guidelines
OOP	Out of Pocket Expenditure
OOSC	Out of School Children
PAB	Project Approval Board
PCPNDT	Pre-conception Prenatal Diagnostic Test
PHC	Primary Health Centre
PIN	Professional Institute Network
PPIUCD	Post-partum Intrauterine Contraceptive Device
PPP	Public Private Partnership
PRA	Participatory Rural Appraisal
PRI	Panchayati Raj Institution
PS	Primary School
PTR	Pupil Teacher Ratio
QAC	Quality Assurance Committees
RCH	Reproductive and Child Health
RKS	RogiKalyanSamiti
RTE	Right to Education
RTI	Reproductive Tract Infections
SC	Scheduled Caste
SCR	Student Classroom Ratio
SES	School Education Statistics
SGSY	Sampoorna Grameen Rozgar Yojana
SHG	Self-Help Group
SMC	School Management Committee
ST	Scheduled Tribe
STI	Sexual Tract Infections

SSA	Sarva Shiksha Abhiyan
STC	Special Training Centres
STPs	Standard Treatment Protocols
TLM	Teaching Learning Material
ToR	Terms of Reference
TSG	Technical Support Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPS	Upper Primary School
USAID	United States Agency for International Development
VER	Village Education Register
UNEG	United Nations Evaluation Group
VHNDs	Village Health and Nutrition Days
UNSWAP	United Nations Systems Wide Action Plan
WB	World Bank
WHH	Women-headed Household
WHO	World Health Organisation

PREFACE

Feminist evaluation, as an approach to evaluation that exposes and critically assesses gender and other sources of inequalities, is a new and emerging field in India. Over the last several years, responding to the increased attention given to evaluation in policy circles, there has been a concerted effort by social science researchers, evaluators, and funders to build the field of feminist evaluation (Hay, 2010). In August 2010, the Institute of Social Studies Trust (ISST) with support from the International Development Research Centre (IDRC), Canada, organised a workshop on Gender and Participatory Evaluation in New Delhi to reflect on the possible role of feminist evaluation in engendering policy and supporting changes that lead to gender equality along different dimensions. The workshop brought together a group of feminist/ gender responsive equality advocates who, as social science researchers, had carried out evaluations but had not had the opportunity to reflect on the role of these evaluations within their larger research agendas. This initial gathering, and the discussions it generated, led to the publication of a special issue on 'Evaluating Gender and Equity' in the *Indian Journal of Gender Studies* in June 2012, the first collation of articles to examine the field of gender responsive/feminist evaluation in India. Simultaneously, ISST, in conversation with IDRC and the Ford Foundation, developed a proposal with the aim of building the field of feminist evaluation through a focus on generating research on and building capacities in feminist evaluation. The project, 'Engendering Policy through Evaluation: Uncovering Exclusion, Challenging Inequities and Building Capacities', which began in October 2012, was a result of these concerted efforts.

From the start of the project, the purpose was to engage various stakeholders and build a network of development practitioners, evaluators, researchers, policy-makers and funders interested in the field of feminist evaluation. As part of this effort, ISST organised seven workshops over the period of the project where we brought a range of these actors together. These workshops proved to be fertile ground, generating rich discussions on the value and the contours of feminist evaluation in various domains such as education, sexual and reproductive health rights, and livelihoods. The diversity of perspectives brought to the table enriched the discussions, and enabled cross learning. Development practitioners provided insights on the

various dimensions of gendered inequalities in their respective fields, and reflected on their own experiences of evaluation as project implementers. Alongside, those with expertise on evaluation shared their own understandings of the values and ethics of feminist evaluation, as well as a range of approaches to evaluation. Funders too shared their interest in evaluation as a tool of accountability and learning. The workshops have allowed a structured interaction with policy-makers; they have also provided an avenue for sharing research on feminist evaluation that the project enabled through the provision of small grants.

This series of publications by ISST on feminist evaluation is a result of a sustained engagement by this network to generate and widely share information on the values, ethics, methods, tools and approaches of feminist evaluation in a range of domains. While all the four publications pay attention to the 'what' of feminist evaluation, two of the publications in particular focus on the 'how to' of feminist evaluation, to give insights into how one may conduct feminist evaluations.

This volume on engendering meta-evaluations is motivated by the recognition that in a large and diverse country programme outcomes can vary widely, and therefore that looking across a range of evaluations of the same programme in different contexts can offer valuable insights. These meta-evaluations do not have the primary intention of forming a judgement on the quality of project evaluations. They are focused rather more on different methods and frameworks that can help first, in drawing out the gendered outcomes of large national programmes in different contexts and second, in identifying any recurrent patterns that have implications for programme design. We are grateful to all the authors for the work they have done on these important questions and hope that the studies included here would stimulate more work in the area.

Special thanks are due to Katherine Hay (formerly with IDRC), Vanita Nayak Mukherjee (Programme Officer, Ford Foundation) and Navsharan Singh (Senior Programme Specialist, IDRC) for supporting this project. We would also like to extend a heartfelt thank you to the group of feminist researchers, evaluators and activists who have contributed in different ways to the project activities. Thanks are also due to the ISST research team, Rajib Nandi and Shiny Saha, and to Preeti Gill for her editorial assistance in pulling the series of publications together.

Ratna M. Sudarshan
Shraddha Chigateri
New Delhi, August 2015

INTRODUCTION

Engendering Meta-Evaluations: Towards Women's Empowerment

Ratna M. Sudarshan, Ranjani K. Murthy & Shraddha Chigateri

The term 'meta-evaluation', first used by Scriven in 1969, has been described by him as 'the conscience of evaluation, just as evaluation is the conscience of society' (Scriven 2009: viii). 'Meta-evaluation' refers to an 'evaluation of evaluations' or 'a procedure for describing an evaluation activity and judging it against a set of ideas concerning what constitutes good evaluation' (Stufflebeam, 1974). It can also refer to a synthesis of evaluations.

Meta-evaluations have had a place in development since the 1990s (Kemmis, 1997). At that time meta-evaluations attempted to assess whether the evaluations addressed the terms of reference and whether the quality of evaluations was good (Kemmis, 1997). The scope of meta-evaluations in development has widened since. Now the thrust of meta-evaluations ranges from assessment of the planning of the evaluations, concurrently evaluating implementation of multi-site evaluations, evaluating the evaluation process once it is over and drawing out programmatic or institutional lessons from similar evaluations (Kemmis, 1997, *Better Evaluation*, 2013, Hansen et al, 2008, Russ-Eft and Preskill, 2008). Meta-evaluations can be done with community members, external experts, and others through stakeholder meetings and peer reviews (*Better Evaluation*, 2013). Meta evaluations of meta-evaluations have emerged, which call for better standards and frameworks for meta-evaluations (Cooksy and Caracelli, 2009)

While there are several articles on meta-evaluation in development,very few reflect a gender and equality lens (Weigel, 2012). Individual UN and donor agencies have carried out a synthesis of their

evaluations from a gender lens. For example, the Evaluation Cooperation Group has carried out a synthesis of performance of, and lessons from, evaluations of select multi-lateral and bilateral aid agencies from a gender lens(International Fund for Agriculture Development, 2012). The focus was on analysis of evaluation frameworks and on evaluation outcomes. The United Nations Evaluation Group developed a UN System-wide Action Plan Evaluation Performance Indicator on Gender Equality and the Empowerment of Women (GEEW). This Evaluation Performance Indicator rates each evaluation and each parameter (e.g. evaluation criteria) from a GEEW lens and comes with an average meta-rating for all evaluations and 13 parameters, which are part of the framework (UN Evaluation Group, 2013). This methodology is used in one of the case studies in this volume, and will be illustrated in Chapter 1. Overall, it appears that attention to meta-evaluations with a gender equality and women's empowerment lens is recent, and centered on UN and donor agency programmes. Few have looked at meta-evaluations of government programmes.

This book bridges this gap in a small way. It presents four meta-evaluations of different flagship programmes of the Government of India. Flagship programmes are centrally designed and implemented through a set of projects in different parts of the country. Of the four programmes discussed here, one is targeted at poor, disadvantaged women in rural and urban India; two are intended for both men and women in rural India, and one is for all children of school going age in the country. Evaluations of the programmes commissioned by the government are conducted on a regular basis by research and evaluation organisations. Given that flagship programmes are implemented in a wide variety of situations and locations, one would expect to find variation in the outcomes. Through these evaluations, some information is available on area-wise differences and the overall performance of the programmes with focus on effectiveness of the implementation and an audit of resources. However, what gets less attention is the extent to which gender and equity issues are addressed by these evaluations, whether the programmes succeed in being gender-transformative, and whether there are recurring and gendered findings of such project evaluations. This collection of meta-evaluations is motivated by these latter questions.

Two of the papers included here perform a meta-evaluation on an available set of project evaluations (MGNREGA[1] and STEP[2]). The other two perform a meta-evaluation on Joint Review Mission (JRM) reports of the SSA[3] and RCH (Reproductive and Child Health programme) and

[1] Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) legally guarantees 100 days of employment per year for every rural household that seeks work, with a stipulation that 33 per cent of the workers should be women. Work is preferably to be provided within a distance of 5 kilometers, and if there are five or more women with children less than 6 years applying for work, one of them is to be assigned the task of looking after children (Ministry of Law and Justice, 2005).

the latter also analyses the Common Review Mission (CRM) reports of NRHM[4] It might be asked whether JRM reports can or should be seen as evaluations at all. Although the JRM process has not entirely displaced more conventional evaluations, yet increasingly for large and multi-donor funded programmes it is becoming the assessment method of choice. JRMs are periodic assessments of the performance of a programme against an agreed set of objectives, targets and performance indicators, which include the efficient management of resources. In most cases, the process involves national governments, representatives of funding and technical cooperation agencies, national and/or international consultants, and sometimes civil society organisations and NGOs. This process is at work in many countries in Africa (including Benin, Burkina Faso, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Mali, Mozambique, Niger, Rwanda, Tanzania, Uganda, Zambia); and Asia, including Cambodia, India, Nepal. In India, there have been Joint Reviews of the District Primary Education Programme (DPEP), and now a Government of India (GoI) review of Sarva Shiksha Abhiyan (SSA) takes place twice a year. SSA is supported by three donors – IDA, DFID and the European Commission, all of whom were donors to DPEP. The methodology of the SSA review appears to draw heavily on the experience of reviewing DPEP. Given that India is a federal country, the SSA review places a strong emphasis on district level planning and the performance of individual states. It is conceived as providing a regular opportunity to examine overall programme implementation, financial management and procurement arrangements, research needs, and assessment of external financing requirements. A framework for sample state level reviews is prepared and the areas on which recommendations should focus are agreed for each joint review (see Packer 2006). Despite its visibility and the resources allocated for the process, it is unclear what contribution to improved effectiveness or efficiency is actually made by the JRMs. According to Packer, 'remarkably little attention is paid to the recommendations of the previous review.' (Steve Packer 2006: 13). However, JRMs continue to provide an opportunity for civil society

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[2] Support for Training and Employment Programme (STEP) was launched in 1986 by the Department of Women and Child Development, as a Centrally Sponsored Programme. It aims to increase the self-reliance and autonomy of women by enhancing their productivity and enabling them to take up income generation activities. Women are mobilized into small groups, given training for skill upgradation, helped to access credit and given support services. The target group includes marginalised, assetless rural women and the urban poor(.http://www.wcd.nic.in/Revised%20schemeof%20STEP.pdf).

[3] SarvaShikshaAbhiyan (SSA) is Government of India's flagship programme for Universalization of Elementary Education in a time bound manner, as mandated by 86th amendment to the Constitution of India which makes free and compulsory education of children of 6-14 years age group, a fundamental right. (Ministry of Human Resource Development, n.d.).

[4] The National Rural Health Mission (NRHM) was launched by the Government of India in 2005, to provide accessible, affordable and quality healthcare to the rural population, especially vulnerable groups. Since 2013 it is a sub-mission of the National Health Mission along with the National Urban Health Mission (Ministry of Health and Family Welfare, n.d).

to engage in discussions on education and health programmes. Similarly,in the health sector, JRMs have been conducted on the RCH Programme from 2004 to 2009 and the CRMs (Common Review Missions for the NRHM) have been conducted every year since 2007. NGOs are required to be included on CRM teams, and INGOs on JRM teams. Ministry officials, public health experts, civil society members, development partners and consultants of the MoHFW are nominated to carry out a field-based review. There are thus, pragmatic reasons for drawing attention to the JRM/CRMreports, their priorities and processes, and applying a meta-evaluation approach to highlighting these.

Of the four studies included here, the meta-evaluation of MGNREGA adapts the UN System-wide Action Plan Evaluation Performance Indicator on Gender Equality and the Empowerment of Women (GEEW). To the three evaluation processes that the UNEG proposes for meta-evaluation namely, preparedness, methodology and report and use, it adds evaluation outcomes or impact. Fourteen criteria are adopted, and a rating system is used for scoring gender sensitivity of evaluation processes and criteria. The STEP meta-evaluation uses the OECD-DAC evaluation framework, – namely, the criteria of relevance, effectiveness, efficiency, sustainability and impact, for assessing each evaluation, and poses gender-transformative questions within each (OECD, n.d). The study uses a synthesis method to analyse the evaluations through the development of an evaluation matrix consisting of OECD-DAC criteria tailored to STEP, along with additional criteria of research process and utilization of the evaluations. The STEP meta-evaluation included interviews with government officials. The study of health programmes began by adopting the framework suggested by UNEG's 'Integrating Human Rights and Gender Equality in Evaluation' which emphasizes the need for a human rights perspective in identifying stakeholders, framing terms of reference, evaluation criteria questions and indicators, selecting team members, choosing methodology, writing reports etc (UNEG, 2011). It then went on to develop its own criteria as well as to offer additional insights. The education study develops its own framework to analyse JRM reports with a gender and equity lens. The education study examines how equity and gender are understood within the Joint Review Mission reports, whether the focus on equity integrated input, process or outputs/outcomes, whether teacher attitudes on gender and equity are assessed, the kind of equity and gender issues flagged by the report etc. The STEP, SSA and RCH/NRHM studies also included interviews with stakeholders and key informants, while the MGNREGA study was based on a review of evaluation reports and communication with few evaluation mission members. What are being presented in this book therefore are not standard meta-evaluations, with the exception of the study on MGNREGA, but rather a set of (meta)studies drawing upon available frameworks for evaluations, using different methods, and highlighting the implications of a feminist focus.

A question frequently asked is whether it is appropriate to assess programmes that are not designed with a clear gender and equity focus, from this lens; for example, the main motivation of the MGNREGA is, arguably, livelihood support. However while not explicitly stated in the text of the Act itself, the operational guidelines state that women/ Dalit empowerment is an objective of the programme. Some explicit provisions seek to respond to specific gender issues, such as women's greater responsibilities for care work. For example, the programme envisages crèche facilities at the worksites, requires that work be available within 5 km of place of residence and women be give preference at worksites closer to home, and so on. Our view is that such assessments offer an opportunity to provide constructive feedback, at two levels. One is at the level of the programme; a synthesis of project evaluations can offer feedback on the recurring design or implementation aspects that have gendered implications. The other level is the evaluation process; a feminist meta-evaluation framework can bring out whether individual evaluations have been sensitive to gender and equity concerns. One of the contributions of these studies is thus to offer some suggestions and guidelines on promoting substantive gender equality that could help in designing evaluations of these programmes in the future. To be useful in this way, details of questions asked in each study have been included in this volume.

Incorporating gender and equity in meta-evaluation

Each of the studies draws upon both a meta-evaluation framework and a specific understanding of gender and equity. The analysis of the MGNREGA has been framed with a substantive equality perspective. The substantive equality goal recognizes that purposeful interventions are needed to tackle unequal initial outcomes, rather than treating people unequally placed in a similar manner (Kapur, 1993). The analysis of STEP paid special attention to the understanding of the term 'women's empowerment' which is frequently used in describing women-focused programmes, to find that it had been interpreted rather narrowly by many evaluations. Specifically the level of women's participation and the possibility of generating additional income from assets created through the project, as compared to income at the start of the project,was equated with 'empowerment'. (Some evaluations use a control to assess whether the increase in income exceeds the increase that might have taken place without the intervention). The analysis of SSA focuses on how better 'equity' (same as substantive equality) can be incorporated into regular programme assessments. The analysis of NRHM has a 'gender equity and human rights perspective'. All the meta-evaluations viewed gender as interlocking with caste, class, religion, ethnicity, differential ability, age etc.

Though two studies, on MGNREGA and health, used gender-transformative meta-evaluation frameworks (the UN SWAP and UNEG frameworks)– a concern was that issues of equity

were not necessarily addressed. Hence the authors had to add questions. For example, did the evaluation team meet with Dalit women? Was there access to the programme for the most vulnerable, were benefits assessed in similar ways for all, and so on. The STEP evaluation had to tweak 'general' questions on relevance, effectiveness, efficiency, impact, sustainability etc .to what is relevant for marginalized women and the programme. While the meta-evaluation on education was extremely innovative, quantification posed difficulties. Thus each meta-evaluation framework has its strengths and weaknesses from a gender and equity lens, and there is no perfect answer.

Some Insights from the meta-evaluations

Under the MGNREGA Act, there is a legal guarantee of 100 days of employment per year for every rural household that seeks this work, with 33% of the work days generated reserved for women. Ranjani Murthy evaluated 22 evaluations of the flagship Mahatma Gandhi National Rural Employment Guarantee Scheme, which started in 2005. She used the UN-System Wide Approach to Evaluation (UN SWAP) to assess the evaluation preparation, its methodology, its report and its use. An additional question about the lessons from evaluation findings on substantive equality and women's empowerment was added. The gender and equity analysis focused on the evaluation team, the identification of stakeholders, the evaluation criteria, the evaluation approach, questions, methods, indicators, data analyses, data validation, management responses and dissemination. Findings on impact were also reviewed from a substantive equality and empowerment lens. Of the 22 MGNREGA evaluations reviewed, 64% 'approached requirements' and 36% 'met requirements' as per the modified UN SWAP Evaluation Indicator. None of the evaluations 'exceeded' or 'missed' requirements. The availability of gender-expertise within the team was identified as a key factor in the meta-score awarded to the evaluations.

Started in 1986, the Support for Training and Employment Programme (STEP) is managed by the Ministry of Women and Child Development, Government of India.[5] The programme has the objective of giving support to training for upgradation of skills to women, initially in eight traditional sectors of employment, Agriculture, Small Animal Husbandry, Dairying and Fisheries, Handlooms, Handicrafts, Khadi and Village Industries and Sericulture. Two more sectors were added later, Social Forestry and Waste Land Development. The programme expects that if women are mobilized into small groups (the programme is now implemented through women's self-help groups), training given for skills upgradation, along with support

[5] For more on the programme, see http://www.wcd.nic.in/stepnew.pdf

for acquiring productive assets, creation of backward and forward linkages, as well as awareness generation and gender sensitization, that this package of inputs would lead to sustainable self-employment (or occasionally wage employment). The target group consists of marginalized and assetless rural women and urban poor. Implicit in the programme description is the idea that a successful outcome would include higher incomes for the women participants as well as enhancing other dimensions of 'empowerment' such as their awareness of legal rights, confidence and self-esteem. The study by the ISST team reviews 20 evaluations of STEP.All these evaluations had been conducted during the Eleventh Five Year Plan period (2007-2011) and included evaluations conducted by different organisations in different sectors and states. In addition to reviewing the reports, other secondary data has been analysed and interviews had been conducted with some of the stakeholders, including both evaluating and implementing organisations. The OECD-DAC framework of relevance, effectiveness, efficiency, sustainability and impact has been used. To this, questions on methodology and utilization of evaluation findings were added. Among other insights, the study points out that care responsibilities and constraints on mobility can influence outcomes and need to be factored into assessments of design and outcomes. The study is an attempt at a formative meta-evaluation using a synthesis method, and with the purpose of using already completed evaluations to inform and strengthen future evaluations. An evaluation synthesis matrix has been prepared with the dual purpose of synthesing findings and of offering guidelines to future evaluations.

The Sarva Shiksha Abhiyan is the umbrella programme for elementary education. Vimala Ramachandran and Prerna Chatterjee review 17 SSA JRM reports and research studies commissioned under SSA from 2004 to early 2013, with the main purpose being to see whether and how gender and equity goals have been tracked and addressed in the JRM processes of SSA. Interviews were held with twelve selected key informants. The study looks at JRM processes in some detail, starting with the Terms of Reference for each JRM, which are agreed between MOHRD and the team members, and the checklists that are prepared for each goal. The different indicators used to assess enrollment, retention, quality etc. can be mapped against boys and girls from different social groups or vulnerabilities such as CWSN, so as to bring in all relevant details about the location and group specific experience of education. The analysis records the information that is usually presented in each JRM report, and the data sources that are referred to, and what is missing. It suggests overall that while SSA JRMs have flagged various issues from time to time, they have not sufficiently focused on the variations across geographic locations, by gender, socio-cultural profile and income, and makes some suggestions for what processes could add further value to the JRMs.

The NRHM acknowledges Right to Health as a fundamental right. The Mission is committed to equitable healthcare. Elimination of disparities in health between states, between districts and among various groups of the community is a primary focus. It includes provisions for ensuring equitable access, decentralised planning and implementation, and active involvement of the community in identifying its health needs and monitoring health systems. Unlike the NRHM document, the NHM clearly acknowledged gender as one of the factors responsible for disparities in access to healthcare and health outcomes. Its focus is not restricted to maternal and child survival services but to ensuring quality of life for women, children and adolescents. Both programmes embrace the equity approach. Human rights and, to some extent, a gender perspective are present in the designs of both programmes. Renu Khanna and Priya John have reviewed seven Common Review Mission Reports of the NRHM and eight Joint Review Mission Reports as well as the Mid Term Report of the RCH II. Three independent published reviews of NRHM are also included, and semi structured interviews conducted with nine Key Informants. They find the UNEG framework suitable for meta-evaluation of design and planning of health programmes. For meta-evaluation of implementation and results, the UNEG framework was not followed and instead a two stage process was followed. First, a set of questions was developed incorporating gender equity and human rights perspectives to be addressed to users and providers of health services, corresponding to the areas of concern of the programme. The evaluations were then graded according to whether these questions had been asked and how they were used to examine gender equity and human rights concerns.

Conclusion

Evaluation of official programmes has a long history. Along with the setting up of the Planning Commission in 1951, the Programme Evaluation Organisation was set up in 1952 as an independent office under general supervision of the Planning Commission.[6] Its initial mandate was evaluation of the Community Development programme. Over the years the PEO had evaluated many different schemes and programmes of the government. It had a three tier structure, with regional offices and field units. The PEO evaluated selected programmes. Additionally, evaluations have been outsourced to other organisations, mainly government funded research organisations, according to their area of expertise. In the last couple of decades, with liberalization, and the changing structure of the Indian economy, the nature of evaluation demand has also changed. More foreign funding has been allocated to flagship programmes,

[6] http://planningcommission.nic.in/reports/peoreport/peo/peoabout.htm [9.7.2015]

bringing in evaluations commissioned by foreign donors as well as the Indian government. The NGO sector has grown, both in its role as an 'intermediary' or implementing agency of government programmes, and as independent evaluators. The Independent Evaluation Office, announced in 2013, launched in 2014, but effectively closed in the same year, was intended to conduct independent evaluations on any programme `which has access to public funding or implicit or explicit guarantees from the Government` and to make its findings public.[7] With the closure of the Planning Commission and the opening of Niti Aayog in 2015, the evaluation function has not lost its importance although its organizational form is yet to take shape. Looking ahead, in an era of greater role for the market, private players and investments, and regulation rather than direct controls, building up stronger independent evaluation capacity across the country is likely to emerge as a priority. Meta-evaluations are one way of evaluating evaluations, and will in the coming years point to how to enhance evaluation quality and capacity. At the same time, gender and other inequities persist in India, in all realms of life. In this context, it is crucial to build evaluation capacity and quality from a gender and equity lens. With considerable amount of budget going into flagship programmes, transformative meta-evaluations of these programmes are a must. Some tools for such gender transformative meta-evaluation are presented in some detail in this book and it is hoped that this will stimulate more such analysis and the development of other such frameworks and tools.

Lessons may be drawn from such meta-evaluations for engendering policies and programmes (through the cycle). Ways of taking back findings to federations/trade unions of marginalized women and men, relevant ministries and gender resource centers are a must. Gender and equity are integral to all development goals but, we would argue, fail to be adequately captured without explicit effort.

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CHAPTER 1

Meta-Evaluation of MGNREGA* with a Gender Lens

Ranjani K. Murthy

1.0 Background

1.1 Mahatma Gandhi National Rural Employment Guarantee Act

The National Rural Employment Guarantee Act (NREGA) was a landmark legislation enacted in 2005 to "provide for the enhancement of the livelihood security of the households in rural areas of the country by providing at least one hundred days of wage employment in every financial year to every household whose adult members volunteer to do unskilled manual work" (Ministry of Law and Justice, 2005: 1). In 2009, the NREGA Act was renamed the Mahatma Gandhi NREGA or MGNREGA. The fourth edition of the Operational Guidelines outlines seven goals of MGNREGA which are broader than enhancement of livelihood security, one of which pertains to the empowerment of socially marginalised groups, including women. These goals are:

i) social protection for the most vulnerable people living in rural India by providing employment

ii) livelihood security for the poor through creation of durable assets, improved water security, soil conservation and enhanced land productivity

iii) strengthening drought proofing and flood management in rural India

iv) empowerment of the socially disadvantaged, especially women, Scheduled Castes (SCs) and Scheduled Tribes (STs), through the processes of a rights-based legislation

v) strengthening decentralised, participatory planning through convergence of various anti-poverty and livelihood initiatives

vi) deepening democracy at the grassroots by strengthening Panchayati Raj Institutions (PRIs)

* Mahatma Gandhi National Rural Employment Guarantee Act; also referred to as MNREGA.

vii) effecting greater transparency and accountability in governance

(Ministry of Rural Development, 2013)

There are distinct design features of MGNREGA that make it different from earlier wage-based national level employment generation programmes like the Sampoorna Grameen Rozgar Yojana (SGRY) or the National Food for Work Programme. By design, it is demand based, unlike the earlier ones which were supply driven. Hence, under MGNREGA there is a provision for unemployment allowance if employment is not provided within 15 days of application for work; there was no such provision in earlier schemes. Further, there is a guarantee of 100 days of employment at a minimum wage of Rs 60 per day (the minimum wages are to be upgraded periodically) (Nayak et al., n.d). The labour expenditure component under the programme is supposed to be larger than the material expense component (a 60:40 ratio), and no contractor or machinery is to be used. As per the MGNREGA, the government is supposed to provide medical support and compensation to the tune of half the wages for workers[1] who meet with accidents. It is also supposed to provide ex gratia compensation to the legal heirs if a worker dies or becomes disabled in the worksite to the tune of Rs 25,000 or such amount as notified by the central government (Ministry of Law and Justice, 2005; Ministry of Rural Development, 2013).

One gender-specific difference between MGNREGA and earlier national wage employment programmes is the provision that at least 33% of workers under MGNREGA should be women. Further, the Act provides for facilities like crèche at the worksite if there are five or more children under the age of six accompanying the women workers (however, this provision does not include men workers with children in the same age). This is apart from the legal stipulation of provision of drinking water, first aid and shade in the worksite. The 2005 MGNREGA Act asserts that the Equal Remuneration Act 1976 should be complied with, and there should be no gender discrimination with regard to work. Work is to be provided within a distance of 5 kilometres under the Act, a requirement that particularly benefits women. The Act also stipulates that not less than one-third of the non-official members[2] of the Central and District Employment Guarantee Council should be women (Ministry of Law and Justice, 2005). Circulars published in 2010 specified that trolleys should be provided for women who supply water at worksites; suggested linking crèches at worksites to the Integrated Child Development

[1] The Act does not specify whether half the wages are to be paid only for the duration of hospitalisation or for the duration of full recovery (Ministry of Law and Justice, 2005).

[2] Non official members includes members of Panchayati Raj Institutions and organisations of workers from marginalised groups (Ministry of Law and Justice, 2005).

Scheme (ICDS); and recommended that states should consider reserving 50% of posts of 'mates' for women (Ministry of Rural Development, 2010a, b). In 2012, a circular was issued to the effect that individual household toilets (in keeping with the total sanitation programme), school toilets and anganwadi[3] toilets could be built under the MGNREGA (Ministry of Rural Development, 2012). In 2013, a guideline was formulated stating that "as far as possible" individual bank/post office accounts should be opened for workers for transfer of wages (Ministry of Rural Development, 2013). A directive was issued in 2012 by the Minister of Rural Development to the Government of Maharashtra to identify, give job cards to and provide 100 days employment to widowed women, deserted women and destitute women who qualify as a household under the Act. It also suggested special works for pregnant women and lactating mothers that are closer to their house and require less effort. Another recommendation was to carry out special time and motion studies to formulate age, disability, gender and terrain/climate specific schedules of rates (Minister of Rural Development, 2012).

A caste/ethnic-specific difference from previous wage employment oriented programmes is the provision for strengthening irrigation facilities (later, land development was added) on land belonging to Scheduled Caste (SC), Scheduled Tribe (ST) households, land reform beneficiaries and beneficiaries of the Indira Awaz Programme[4] (Ministry of Law and Justice, 2005). There is 33% reservation for SCs, STs, Other Backward Castes (OBCs) and Muslims amongst the non-official members of the Central and State Employment Guarantee Councils (ibid, 2005). Further, the MGNREGA Act empowers the Gram Panchayat and the people, by requiring that 50% of the works are to be implemented by the Gram Panchayat. Regular social audits of employment and the works are to be conducted through the Gram Sabha. In addition, there is a grievance redress mechanism using which anybody can register a complaint at the block and district levels (Ministry of Rural Development, 2013).

1.2 The Professional Institutional Network and Evaluations of MGNREGA

There are two mechanisms for MGNREGA evaluation by the government. The first is through national level concurrent evaluations[5] spanning sixteen states and twenty districts, and the second is through studies carried out by members of the Professional Institute Network (PIN),

[3] Anganwadi centres come under the Integrated Child Development Scheme. The main objective of this scheme is to cater to the nutrition and education needs of children in the age group 3-6 years.

[4] Indira Awaz Yojana is a rural housing programme for the poor that provides for construction of new houses, up-gradation of existing houses and purchase of house sites by the landless (Ministry of Rural Development, n.da).

[5] Concurrent evaluations refer to evaluations that are carried out when a scheme, programme or project is ongoing (Business Dictionary, n.d)

typically covering a few states and districts. Both types of studies examine effectiveness of implementation and impact.

As of January 2014, only one Concurrent Evaluation of MGNREGA has been completed. As per the website of the Planning Commission this was undertaken by the Institute of Applied Manpower Research under the aegis of the Planning Commission (IAMR, 2008). The Ministry of Rural Development has initiated forty-one studies by PIN members as of January, 2014, of which twenty-one reports[6] (2006-2009) are available on the website (see Ministry of Rural Development, n.db). According to the government, the PIN is a network of institutions that includes the Indian Institutes of Management, the Indian Institutes of Technology, the National Institute of Rural Development, agriculture universities, the Administrative Staff College of India, think tanks, civil society organisations and other professional institutes (Ministry of Rural Development, n.dc). A few women's organisations and academic and research institutions with a social orientation have managed to find a place under the PIN umbrella, though two-thirds of the PIN organisations are management and technical institutes.

The objective of a Concurrent Evaluation, as spelt out in the Terms of Reference issued by the government, is to focus on key aspects of the MGNREGA, such as (i) livelihood security, (ii) generation of demand, (iii) issue of job cards, (iv) payment of wages through banks/post offices, (v) creation of assets, (vi) social audit, (vii) appointment of ombudsmen, (viii) role of panchayats, and (ix) creation of awareness through the Information, Education and Communication (IEC) (Ministry of Rural Development, n.dd:1). The scope of the PIN evaluations, as spelt out by the Ministry of Rural Development is to "identify practices, procedures, processes, factors that have contributed to good performance and the positive outcome and impact generated" and identify "practices and factors that have or will limit the optimal performance of the Scheme" (Ministry of Rural Development, n.de: p1). It is hoped that the PIN studies will strengthen the capacity of the districts to implement schemes under the MGNREGA and thereby strengthen its impact.

2.0 Objectives and Scope of the Meta-Evaluation

2.1 Objectives

The UN System Wide Approach Evaluation Performance Indicator[7] differentiates between three broad evaluation processes that should be considered in meta-evaluations: evaluation

[6] The 21 PIN studies covered between 1 to 4 states and 1 to 8 districts each.

[7] The UN SWAP builds on the gender-related norms and standards for evaluations developed in UN General Assembly resolution A/RES/59/250. These norms include the sensitivity of evaluators to issues of gender discrimination, sensitivity to cultural norms while carrying out evaluations, methodology for capturing issues of under-represented groups and their human rights, gender-balanced evaluation teams; whether the design and implementation address the key issues facing women and unaddressed groups (UNEG, 2005).

preparation, evaluation methodology, and evaluation report and use. Further, an assessment should be made into how far gender equality and women's empowerment is integrated into the three evaluation processes (United Nations Evaluation Group, 2013). A fourth evaluation process has been added, namely impact on gender and social equality aspects emerging from the evaluations.

Adapting the above framework, the objectives of the meta-evaluation of MGNREGA evaluations are to examine

- the extent to which preparatory processes adopted by the Concurrent Evaluation and PIN evaluations on MGNREGA were sensitive to issues of gender and social equality;
- the extent to which the evaluation methodology adopted by the Concurrent Evaluations and PIN studies on MGNREGA was amenable to capturing gender and social equality aspects;
- the extent to which the evaluation reports of the Concurrent Evaluations and PIN studies on MGNREGA pay attention to issues of gender and social equality; and,
- the lessons derived from the Concurrent Evaluations and PIN studies on the impact on MGNREGA on gender and social equality.

2.2 Definitions

The study shall use the term equality to refer to substantive equality, rather than formal equality. The concept of formal gender equality is premised on the principle of the sameness of women and men, and assumes that if women and men are given the same opportunity and are treated similarly (using male standards), equality will be achieved. It does not take into account the ways in which women are different from men (biologically and socially) and how they are disadvantaged because of these differences. The substantive equality approach recognises that women and men have to be treated differently, and that their disadvantages to begin with have to be addressed to achieve equality (Kapur, 1993; Facio, A. and Morgan, M.I, 2009). The same principle of substantive equality applies to equality based on caste, ethnicity, religion, ability and gender orientation.

Substantive equality can be achieved through a process of institutional changes in favour of women and marginalised groups—changes in norms, power and resources of institutions of household, community, markets and state (Kabeer and Murthy, 2000). Such changes require a process of empowerment of women and other marginalised groups, which Kabeer defines as expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them (Kabeer, 2001). Here, we shall see whether there has been

an expansion in the ability to make strategic choices at the individual (power to), collective (power with) and deep-rooted gender and social biases that a person held on to (power within) (Rowlands, 1998). We shall also see if there has been any change in the attitudes of men and powerful groups—has there been a process of conscientisation?

2.3 Scope

The scope of this meta-evaluation includes fourteen criterions under the headings evaluation preparation, evaluation methodology, evaluation report and use, and evaluation findings (see Figure 1).

Figure 1: The Scope of the MGNREGA meta-evaluation

Evaluation preparation	Evaluation methodology	Evaluation report and use	Evaluation findings
• Evaluability of gender and social equality and women's empowerment aspects • Gender and socially sensitive stakeholder identification process • Gender and social expertise of, and gender balance in, evaluation team	• Gender and socially sensitive evaluation criteria • Gender and socially sensitive evaluation. questions • Gender and socially sensitive evaluation approach • Gender and socially sensitive evaluation indicators • Gender and socially sensitive evaluation methods • Gender and socially sensitive data analysis	• Report mentions methodology, findings, conclusions and recommendations on gender and social equality • Findings are validated with women and men workers including marginalised • Government response is obtained on gender and social specific findings and recommendations • Findings are disseminated to women including marginalised/NGOs	• Findings on MNREGA's impact on gender and social equity from the Concurrent Evaluation and PIN studies

Source: Adapted from UNEG, 2005, 2013

Each of the 14 criterions for the meta-evaluation are explained further. Evaluability assessment (the first criterion) entails assessing whether an intervention is ready to be evaluated from a gender and social equality lens. For example, it may find that it is too early to assess whether

an intervention is promoting gender equality. Evaluability assessment also identifies data and information gaps, and tries to address them before the evaluation. For example, if most of the records are not sex/diversity disaggregated, an evaluator may ask for such data to be gathered before the evaluation. The stakeholder analysis (the second criterion) identifies the different stakeholders in an intervention and specifies whether, how and when they should be included in the evaluation process. It is important to identify both direct stakeholders (e.g., women and men workers) and indirect ones (e.g., non-workers and women's rights organisations). Assessing gender and social expertise and assessing gender balance of evaluation teams (the third criterion) are two different issues. Information on gender and social expertise can be gathered through interviewing the team members (not adopted in this meta-evaluation), by reviewing their evaluation reports, or by reviewing other publications from a gender and social equality lens. Gender balance refers to the sex composition of the team. However, the presence of a female evaluation team member does not automatically mean gender expertise exists within the team (adapted UNEG, 2005, 2013).

The term integration of gender and social equality into all the relevant evaluation criteria (the fourth criterion) is fairly self-explanatory, and this requirement can be assessed from the contents of the Terms of Reference as well as the evaluation report. Evaluation questions (the fifth criterion) help one assess whether gender and social equality concerns are integrated into the programme cycle. In the context of MGNREGA, questions on the gender/diversity sensitivity of design, planning, implementation and the results of MGNREGA, as well as on institutional arrangements are quite important. Indicators (the sixth criterion) for the evaluation of an intervention must ideally include gender and diversity specific information (e.g., percentage of land developed that is owned by Dalits and Dalit women). Inclusion of quantitative and qualitative indicators is important. Questions and indicators on gender and social equality can be best explored through an evaluation approach (seventh criterion) that uses mixed methods and, further, triangulates data.[8] Data collection across indicators is the next step. It is important to examine methods (eighth criterion) and ensure they are developed to collect gender and social equality related data, used in a gender-responsive manner, and follow ethical codes of conduct. At the data analysis stage (ninth criterion), a crucial question is whether any conclusions on gender and social equity and empowerment impact are backed by data/information (adapted UNEG, 2005, 2013).

[8] Triangulation is a method used by qualitative researchers to check and establish validity in their studies by analysing a research question from multiple perspectives. Any inconsistency should lead to a deeper probe and the giving of priority to perceptions of marginalised groups (Guion, et at., 2011).

The assessment of the report (tenth criterion) entails examining if the section on methodology and the findings on design, implementation and results reflect gender and social equality concerns and further, whether conclusions and recommendations are gender/diversity sensitive. Integration of gender and social equality into the validation process (eleventh criterion) entails taking back the findings and recommendations to women and marginalised communities, as well as to panchayat leaders from these groups. Yet another thrust area, once a draft report is ready, is to get the government to respond (seventh criterion) to the findings, conclusions and recommendations. Once the report is finalised, the findings have to be disseminated in accessible formats to a diverse group of stakeholders (including women's rights groups, women studies centres, women's federations and agriculture trade unions) who have an interest in or are affected by, gender and social equality issues (including women's groups, networks and individuals) (adapted UNEG, 2005, 2013).

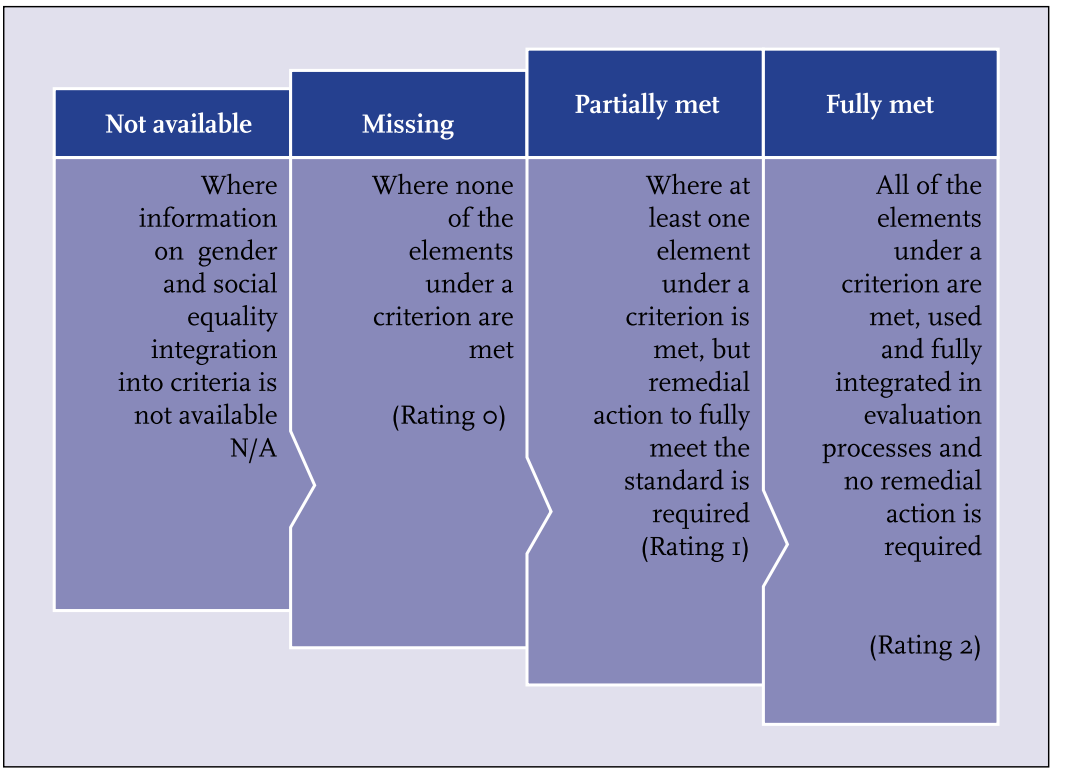
Finally, the question of whether there is progress towards gender and social equality arises. The 22 documents will be reviewed so as to assess whether women are benefitting equally from MGNREGA in terms of participation, access to work, equal wages, and income in their hands. The meta-evaluation would also explore the following questions: Are their sex/gender differentiated needs with respect to tools, nature of work, working-system, work timings and amenities taken care of? Are worksites free of sexual and caste-based harassment? Do women (and marginalised women) engage in planning, measuring (mates) monitoring and audits in equal measure? Are marginalised women involved equally in managing common property resources created/strengthened through the project? Amongst SCs/STs, are women's land prioritised for land development? Has women's bargaining power increased within household, community, markets and vis-a-vis government? Are attitudes changing on gender, marital status, caste, abilities, religion, gender orientation etc.? Are dalits, adivasis, minorities, single women, pregnant and lactating women, differently-abled women and transgender people benefitting to a fair extent?

2.4 Rating system

The report has adapted the rating system adopted by the UN System Wide Approach Evaluation Performance Indicator.[9] This entails assessing performance of each evaluation across each of the criterions using a four level rating system: Not applicable, Missing, Partially met and Fully met. As the MGNREGA can be assessed across all the 14 criterions listed in the scope,

[9] UNEG, 2013

Figure 2: Evaluation Report/Meta-Evaluation Rating System



Source: Adapted from UNEG 2013

the category "Not applicable" has been removed. Instead, "Not available" has been included in situations where information on gender and social equality integration into the criterion was not available. The four ratings, other than "Not available", are described in Figure 2 above.

Once each evaluation is assessed across the fourteen criterions, the score for each evaluation is calculated by computing the average (excluding the criterions where information was not available). The meta-score for all evaluations is calculated by averaging the meta-score for each evaluation. The meta-score for each criterion can also be calculated by averaging the scores of all evaluations on the criterion (excluding the criterions where information was not available). The calculation of evaluation score and meta-score is as follows:

- 0 – 0.50 points = Missing
- 0.51 – 1.25 = Approaches requirements

- 1.26 – 1.75 = Meets requirements
- >1.76= Exceeds requirements

(UNEG, 2013)

3.0 Findings

3.1 Evaluation preparation

Evaluability

The evaluability of gender and social equality integration as reflected in the 22 evaluation studies is rated as 1 on a scale of 0–2.

The Concurrent Evaluation of MGNREGA/S[10] was conducted in 2008, three years after the launch of the scheme in 2005. At that time, the gender and social equality scheme was amenable to evaluation. Seventeen of the 21 PIN studies were conducted in or after 2008, and thus, the gender and social equality aspects of a majority of the studies were evaluable.

The design of the MGNREGA is gender-sensitive in some respects, namely, 33% reservation for women, provision of equal wages, provision of work within a distance of 5 kms, provision of amenities like childcare and maternity allowance, etc. However, to name a few negatives, it has little to say in terms of,

- (till recently) on tools that are appropriate for women's height and weight;
- mechanisms that address sexual harassment at worksites;
- women's participation in social audits or village monitoring committees;
- transfer of land once developed to women; and,
- women's decision-making in management of community resources or
- percentage of women staff at all levels (recently it has been mentioned that 50% of mates should be women)

Thus, there are several gender and social equality aspects that were not considered during enactment of the legislation and framing guidelines, and hence, the extent to which these are examined will be determined by the gender expertise of the team.

Yet another question is: does adequate data exist on gender and social equality outputs/outcomes of MGNREGA, and is additional data required to make it evaluable? Data is available

[10] Some PIN studies have referred to evaluation of MGNREGA (Biradar et al., 2009) while others to MGNREGS (CRRID, 2009).

in the public domain on person-days of wage employment provided to women and men at national, state and district levels. The muster roll and employment register is supposed to give sex disaggregated data on the number of days worked and the amounts deposited in post offices or banks (Annexures 14 and 19, Ministry of Rural Development, 2013). The employment register maintained at the Gram Panchayat level is supposed to provide sex disaggregated data on whether unemployment allowance was paid.

On the other hand, the form to be maintained at Gram Panchayat on "Details of work" (each work separately) does not provide any details on the amenities available at the worksite (Annexure 1, Ministry of Rural Development, 2013). The Asset Register, while providing details on assets created and the extent of labour involved, does not specify who manages community assets and who owns private assets. The Complaints Register, to be maintained at the block and district levels, lists the complaints received and actions taken, but does not segregate complaints received from women and men workers or on the basis of other (marginal) identities.

Given these design and data gaps, for organisations conducting evaluations from a gender and social equality lens, a rating of "partially evaluable" seems appropriate.

Gender expertise and gender balance in the team

The gender balance and gender expertise in the team is rated 0.8 on a scale of 0–2, that is, "approaching requirements".

Women constituted only 25% of the Concurrent Evaluation team, which was led by a male. The gender expertise, as reflected in the content of the evaluation report (see following sections), is rated as approaching requirements. It is difficult to make out the caste, ethnicity or disability status of the team leaders and members from the names. None of the team members was a Muslim.

In the case of 7 out of 21 PIN studies, there was no information on the composition of the evaluation team. Women constituted only 28% of the evaluation team of the rest of the 14 PIN studies. On the positive side, a greater percentage of women assumed the role of team leader of PIN studies than members. Women led 40% of PIN studies on which data was available. As is to be expected, the percentage of women members in evaluations facilitated by women's organisations (14% of PIN studies) was higher at 65%, and needless to say, these studies were facilitated by women. None of the 14 PIN studies on which data was available was led by a Muslim.

As it was difficult to assess gender expertise in the evaluation team based on the names of the team leader and the members, (other than the few PIN studies, where prominent feminist economists were involved), the average score of the evaluation has been taken as a proxy

indicator of expertise. Six of the 21 PIN studies met minimum standards on integration of gender and social equality into evaluation (29%), while the rest were approaching requirements. None exceeded requirements. Needless to say, those PIN studies where feminist economists have been involved as leaders or advisers have scored higher. Further, not all evaluations (40%) led by women meet minimum standards.

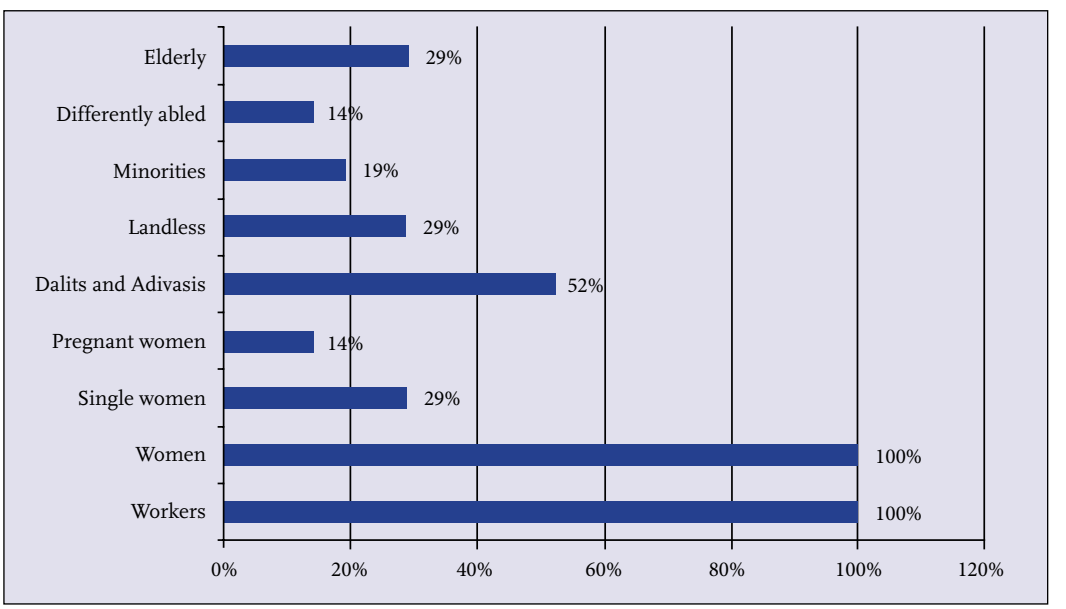
Gender and socially sensitive stakeholder identification process

The gender and social sensitiveness in stakeholder identification is rated 1.33 on a scale of 0–2, that is, "meets requirements".

The Concurrent Evaluation Team mainly met workers (including women workers, single women workers, workers from landless households and workers from Dalit and Adivasi communities) and national, state and district authorities.

The stakeholders met by the PIN studies included workers, women workers, workers from other marginalised communities/groups, PRI members, Gram Rozgar Sevaks, mates, Programme Officers and block level officials, District Programme Coordinators, other District officials, District Collectors, State Authorities and civil society actors. National/state/district level women's studies centres and women's rights groups were not seen as important stakeholders by a majority of the organisations involved in the evaluation.

Graph 1: Kind of workers who were met by PIN Evaluation Teams



The extent to which PIN studies perceived women, single women, pregnant women, people living with disability, Dalits/Adivasis, minorities, landless, and aged persons amongst workers to be important stakeholders in the evaluation (and provided at least some disaggregated data) varied widely. See Graph 1. None considered transgender persons as important stakeholders. Fourteen per cent of the 21 PIN studies met with non-workers/non–job card holders as indirect stakeholders to gather their perceptions on the MGNREGA and impact as well as assess the benefits they were getting from "public assets" (e.g. deepened water bodies).

3.2 Evaluation methodology

Evaluation criteria

Box 1 Objectives of Concurrent Evaluation:

> "The objectives of the study would be to focus on some key aspects of MGNREGA: (i) livelihood security, (ii) generation of demand, (iii) issue of job cards, (iv) payment of wages through banks/post offices, (v) creation of assets, (vi) social audit, (vii) appointment of ombudsmen, (viii) role of panchayats, and (ix) creation of awareness through IEC. Keeping in view the complexity of the process followed under MGNREGA, it would be better to evaluate only the essential and important processes. ….. Secondly, though the direct/indirect and the intended/unintended impact of MGNREGA are many, the impact evaluation should also focus on the 'livelihood security' of the beneficiaries- the primary objective of the Act".
>
> (Ministry of Rural Development, n.d(d): p1)

In the absence of clear-cut evaluation criteria, the objectives and scope spelt out by the Ministry of Rural Development for the Concurrent Evaluation and PIN studies have been reviewed from a gender and equality lens. Integration of gender and social equality concerns into evaluation objectives and scope is rated as 1 on a scale of 1 to 2, corresponding to "approaching requirements" as per the UN SWAP Evaluation Performance Indicator.

Box 1 summarises what the invitation to submit 'Expression of Interest' issued by the Ministry of Rural Development in the Concurrent Evaluation study of MGNREGA states. While the exact objectives would be evolved in consultation with the nodal officer, the above guidelines on the objectives of the Concurrent Evaluation are gender-blind; they refer to assessment of implementation of processes and outcomes in general terms like generation of demand, beneficiaries, assets, wages, awareness, social audit, etc., but do not state for whom or by whom.

With regard to the PIN studies, the guidelines state that the Professional Institutional Network organisation will undertake an impact assessment to identify, within districts and across states (but

not as many states as the Concurrent Evaluation), efficient management practices, procedures and processes; factors that have contributed to positive outcomes and impacts; and constraints that will limit performance. The thrust is on strengthening the capacity of the districts. It elaborates on 17 parameters for evaluation, of which two focus on women and one on Scheduled Castes, Scheduled Tribes, the disabled and those below the poverty line. These 2 parameters are given in Box 2.

Box 2: Gender and social equality parameters to be examined in PIN evaluations:

"The objectives of the study would be to focus on some key aspects of MGNREGA: (i) livelihood security, (ii) generation of demand, (iii) issue of job cards, (iv) payment of wages through banks/post offices, (v) creation of assets, (vi) social audit, (vii) appointment of ombudsmen, (viii) role of panchayats, and (ix) creation of awareness through IEC. Keeping in view the complexity of the process followed under MGNREGA, it would be better to evaluate only the essential and important processes. ….. Secondly, though the direct/indirect and the intended/unintended impact of MGNREGA are many, the impact evaluation should also focus on the 'livelihood security' of the beneficiaries- the primary objective of the Act".

(Ministry of Rural Development, n.d(d): p1)

While it is laudable that the guidelines for PIN studies include an assessment of women's empowerment and effectiveness in including women (and several of the marginalised groups) in the growth process, it is of concern that they indicate the progressive finding the evaluation findings should report. Yet another concern is that gender issues are not integrated into 15 other parameters that should be the focus of study/evaluation: assessment of livelihood security, income and wages, financial inclusion, creation of assets and convergence, agricultural productivity, regeneration of natural resources, environment services, stemming of migration, strengthening of PRIs, accountability, building social capital, impact in extremist districts, innovations and multiplier effects (Ministry of Rural Development, n.de). For details see Annexure 1. Further, an assessment of how far MGNREGA has benefitted minorities, women-headed households and transgender persons has not been called for.

Evaluation questions

Integration of gender and social equality concerns into evaluation questions evolved by the Concurrent Evaluation and PIN studies is rated 1.18 on a scale of 0 to 2, that is "approaching requirements" as per UN SWAP Evaluation Performance Indicator.

The Concurrent Evaluation of MGNREGA examines issues of implementation and impact. Evaluation questions focus on the following:

Implementation

1. Profile of household
2. Mechanism of job card registration
3. Issue of job card
4. Registration and application for work

Impact

1. Impact on work, wages, income and quality of life
2. Impact on out-migration

(IAMR, 2008)

The household profile within Concurrent Evaluation included questions around headship, community and income status, but other aspects of diversity like disability were not explored. Further, questions on gender-based division of labour, distribution of resources, decision-making and nutritional status are largely absent. Questions on access of women/women-headed households to work, equal wages and amenities are raised. But there are wider questions on impact on gender and social equality which have been omitted (see subsection on indicators). Questions on gender and social equality issues in design, institutional arrangements, monitoring (including social audit), and impact of MGNREGA could have been stronger (IAMR, 2008).

Table 1: Focus of questions and gender and social integration equality within these questions: PIN studies

Aspect	Number of PIN studies that included questions on aspect	% of PIN studies that included questions on aspect	Number of PIN studies that included gender and social equality questions	% of PIN studies that included gender and social equality questions
Design of MGNREGA	5	24%	5	24%
Planning	14	67%	5	24%
Context of Area	17	71%	5	24%
Implementation	21	100%	21	100%
Impact	21	100%	12	57%
Institutional	17	81%	3	14%

The twenty-one PIN studies focused on a broader range of questions than the Concurrent Evaluation. Table 1 gives details of the percentage of PIN organisations that raised questions on design, planning, implementation, results and institutional aspects.

From Table 1, it is apparent that questions related to gender and social equality were better integrated into questions on implementation of MGNREGA (percentage of work that went to women, access to equal wages and access to amenities at place of work) and least with regard to institutional aspects, with the level of integration on questions around impact, planning, design and context falling in between.

Evaluation approach and methodology

The approach and methodology make for the overarching framework of an evaluation that determines what methods are employed and how they are used.

The integration of gender and social equality concerns into the evaluation approach and methodology adopted in the Concurrent Evaluation and PIN evaluation studies is rated as 1.32 or "meeting requirements" as per the UN SWAP Evaluation Performance Indicator.

The Concurrent Evaluation covered 20 out of a total of 200 districts at that time. Care was taken to ensure that the 16 states selected represented all regions of the country,[11] with more weightage being given to the eastern region, where out-migration was high. The evaluation report notes that the state average of "man-days" and the number of job cards issued were first calculated (Institute of Applied Manpower Research, 2008, p3). Two districts from each state were selected, one above and one below the state average. From each district, two blocks were selected in consultation with the district and block officials concerned, and from each block, three Gram Panchayats were selected for the household survey. In every Gram Panchayat, 50 "beneficiaries" were selected on a random selection basis from the list of job card holders/ beneficiaries available with the GP office. Thus, 6000 "beneficiaries" located throughout the country were interviewed. The main gender and social aspect focused on in the evaluation is the participation of women, SCs, STs and BPL households (see next sub-section for indicators). The Concurrent Evaluation report does not state the use of qualitative methods for assessing gender and social equality dimensions of design, implementation or results of MGNREGA (Institute of Applied Manpower Research, 2008). The use of the term "beneficiary" denotes that the workers—women and men—are not seen as rights holders, and further, the term "man-days" is problematic. Methods of triangulation used on the findings from the survey are not outlined (Institute of Applied Manpower Research, 2008).

While three PIN studies focused on environmental issues and the environmental impact of MGNREGA, the other 18 PIN studies entailed a quantitative survey of workers (66%) or

[11] Two states from Northeast India were also covered.

worker households[12] (44%). The sampling procedure of two-thirds of the 18 PIN studies was similar to the Concurrent Evaluation—selection of districts, blocks and Gram Panchayats above and below average in terms of person-days of employment created per person registered, and random selection of workers within that. One study, however, chose districts where at least 40% of employment openings targeted women. Three studies gave preference to women workers while selecting workers for interview, and one additionally to workers who were Dalits and Adivasis, and one only interviewed women workers. That is, purposive sampling was used for selecting workers or worker households in four out of the 18 studies (22%). If the purpose is to explore in-depth the impact of participation in MGNREGA on gender and social equality, purposive sampling of districts, blocks, Gram Pachayats and workers (where a higher percentage of work has gone to women) may be better. If however the purpose is to examine the impact of MGNREGA on gender and social equality, random sampling is more appropriate.

The issue of pros and cons of "household" questionnaire and "worker" questionnaire merits debate. From a gender lens, the household questionnaire, even if randomly selected, can go hand in hand with interviews with men as heads of household, gathering their perceptions on the gender friendliness of the designs, women's participation in MGNREGA as planners and workers, and distribution of benefits through participation and assets that are created. The questionnaire for workers, on the other hand, leads to gathering of perceptions of women workers directly, and are more gender-sensitive. Questionnaires were also developed for other stakeholders (see the section on evaluation methods).

Quantitative surveys were combined with qualitative methods such as focus group discussions (FGDs), PRA methods and case studies in 62% of the PIN studies. The extent to which gender and social equity issues were integrated into these methods is discussed later. Adoption of mixed methods can help triangulate information from different sources. In addition, 24% of the PIN studies have checked records (muster rolls, employment registers, job cards, etc.) to triangulate findings.

Indicators

The attention to gender and social equality issues in indicators used in the Concurrent Evaluations and the PIN studies can be rated 1.23 in a scale of 1–2, representing "approaching requirements" as per the UN SWAP Evaluation Performance Indicator.

[12] One study interviewed job card holders, though all job card holders may not have been working.

Table 2: Gender and social equality indicators used in PIN studies

Percentage of PIN studies that focused on the indicators	Gender and social equality Indicators
< 20%	Design - Appropriateness of schedule of rates for women/pregnant women - Appropriateness of tools for the height and weight of women in different areas and MGNREGA works - Appropriateness of distance - Appropriateness of timing of work Context - Labour force participation of women and marginalised and wage rates in the area - Sex ratio of the population - Nutritional status of women and marginalised in the area - Presence of women workers in community organisations, if any Planning/monitoring - Percentage of members in vigilance & monitoring committees and workers' committees who are women and percentage of women occupying leadership positions - Percentage of Dalits, Adivasis, BPL and Muslim women who take part in and influence Gram Sabhas, VMCs and workers' committees Implementation - Percentage of poor women & men who applied for job cards; reason for non application - Percentage of women and men applicants who got job cards - Percentage of job cards issued in women's names - Percentage of women who demanded work, and without any compulsion from men - Percentage of women working acting as proxies for men - Percentage of women entering paid work for the first time - Percentage of men who refused to work because of equal wages - Percentage of women who see the schedule of rates as just - Percentage of women[13] who see the labour process as fair
	- Appropriateness of schedule of rates for women/ pregnant women - Percentage of single women and women from marginalised communities who report easy access to tools - Percentage of worksites where there is absence of girl child labour/child labour - Percentage of women who report absence of sexual harassment at the workplace - Percentage of mixed caste worksites - Percentage of Dalits, disabled, Muslims, etc., who report the absence of identity-based harassment at work place

[13] In particular, the proportion of single, differently-abled, pregnant and elderly women who see the labour process as fair.

	- Percentage of differently-abled and Muslims amongst the workers - Person days of work quantum that has gone to the differently-abled and Muslims - Percentage of individual works[14] on lands of SCs/STs/BPL households Impact - Percentage of women reporting control over income from the MGNREGA - Gender differences in use of MGNREGA income - Percentage of women and marginalised groups reporting increased access to water, food, health and sanitation - Percentage of women, in particular those from marginalised communities, reporting reduced indebtedness - Percentage reporting decline in migration of women and marginalised groups - Percentage reporting increased intra household decision-making - Percentage of women reporting increased decision-making at community level, especially in the case of marginalised groups - Percentage of women reporting greater mobility and self-confidence - Percentage of women reporting reduced violence against women Institutional - Percentage of mates who are women - Percentage of Gram Rozgar Sevaks who are women
20-40%	Design - Percentage of women who are happy with distance of work Planning - Percentage of women and men workers who attend and influence Gram Sabha meetings to select works and carry out social audits Implementation - Percentage of workers who are single women - Percentage of women who receive payments to their individual accounts for work done - Percentage of women reporting access to equal wages - Ease of access of single women, Dalits, Adivasis in accessing job cards and work
41–60%	-
61–80%	Implementation - Percentage of Dalits and Adivasis amongst workers - Person days of work that has gone to Dalits and Adivasis - Percentage of workers who report access to creche at the place of work
>80%	Implementation - Women's participation in the MGNREGA - Share of women in person days of employment created

[14] Examples of individual works include land development and construction of wells and toilets.

The gender and social equality indicators used in the Concurrent Evaluation include the percentage of workers that were women; the percentage of participating households that were women-headed; the percentage of employment opportunities created that was going to women; and the presence of a crèche in worksites. Indicators of participation of SCs, STs, OBCs and general categories in the scheme have also been included. That is, the gender and social equality indicators pertain mainly to access and not outcomes and impact. This oversight could have arisen because gender and social equality issues were not adequately integrated into the Terms of Reference.

The PIN studies have used a broader set of gender and social equality indicators. However, the number of PIN organisations that have focused on each indicator varies (see Table 2). The more complex issues (e.g., women workers' control over income, freedom from sexual harassment at worksite, equal access of Dalits to water at worksite) have only been used in 20% or less of the PIN studies.

The range of indicators used in the PIN studies is indeed impressive, though less than 20% of them have used the more complex indicators of gender and social equality. Inclusion/exclusion of transgender persons and women and men with communicable diseases could have been considered. Further, indicators of possible adverse consequences (apart from child labour in worksites) of participation in the MGNREGA could have been included, like impact on the health of anaemic women workers (estimated to be 56% amongst married women in the age group 15-49 years in 2005–06[15]) and the work loads of women workers. Women's control over common and private property resources that were developed under the MGNREGA is another indicator that could have been considered. Lastly, mobilisation of women as workers at the village and higher levels could have been another indicator used.

Data collection methods and tools

The attention to gender and social equality issues in the data collection methods and tools used in the Concurrent Evaluation and the PIN studies can be rated 1.23 in a scale of 1–2, reflecting "approaching requirements" as per the UN SWAP Evaluation Performance Indicator.

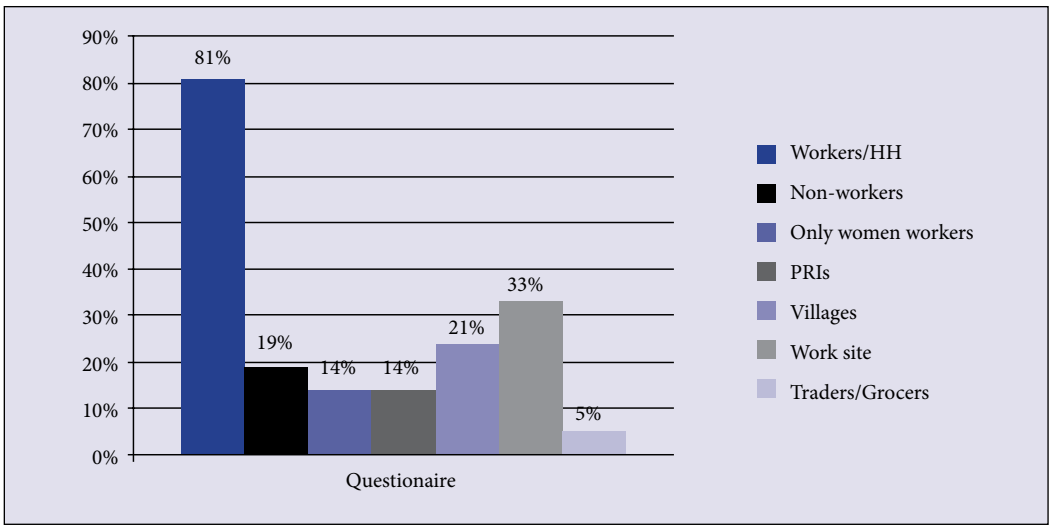
The primary data collection method adopted by the Concurrent Evaluation was a survey of the MGNREGA's "beneficiaries". There is no mention of any qualitative method being used in the report. A copy of the questionnaire used was not available.

The data collection methods adopted by most PIN studies included desk reviews of the performance of the MGNREGA in the states/districts and structured interviews with direct

[15] International Institute of Population Sciences, 2007.

stakeholders (workers, job card holders and participant households). In addition, some studies held structured/semi-structured interviews with indirect stakeholders, such as non-participants from the same village, PRI representatives, mates, Gram Rozgar Sevaks, shopkeepers and merchants in town, and relevant block and district level officials. Graph 2 gives details on the percentage of PIN studies that used questionnaires with different stakeholders.

Graph 2: Percentage of PIN studies that used questionnaires with different stakeholders



Some of the study reports attached the questionnaires used with workers/worker-households as annexures. They modified the government's model questionnaire. This report examines one questionnaire[16] for workers from a gender and social equality lens. The questions pertaining to gender and social equality dwelt on

- awareness of the 33% reservation for women in the MGNREGA;
- participation of women workers in Gram Sabhas;
- awareness of the minimum wages under the MGNREGA;
- whether the worker has an individual or joint bank/post office account (or no account);
- availability of child care facilities at the worksites;
- presence of women's SHGs in villages; and
- impact of women's participation in the MGNREGA on intra-household decision-making.

[16] The reviewed questionnaire was drafted by a non-women's organisation. The questionnaires by women's organisations were not available on the website.

The questionnaire also examines the headship profile of the household to which each worker belongs. While the questionnaire has raised several gender issues, there are several questions pertaining to the indicators listed in Table 2 that are not included. With respect to the other identities, the questionnaire examines the caste, religion, BPL, landholding and disability status of the worker. However, questions on forms of exclusion (for example, existence of caste or religion-based harassment at worksites, accessibility of worksites for the disabled, etc., whether transgender take part in MGNREGA) are not asked.

FGDs were adopted by 52% of the PIN organisations, mainly with workers, and at times, with elected representatives, non-workers, concerned officials and NGOs. Three PIN studies held separate focus group discussions with women and one held a separate discussion with Dalits and the landless. The guidelines for FGDs are not provided in the studies. Going by the reports, no separate FGD seems to have been held with differently-abled workers, Muslim workers or single and pregnant women workers.

Case studies of good practices on implementation of works and individual profiles of workers were documented in 29% of the PIN studies. Few case studies, however, documented practices that failed. Barring one PIN study by a women's organisation that documented case studies of experiences of eleven women workers with the MGNREGA (documenting women's improved access to employment, income, housing, water, mobility, markets, savings and jewels and consequent reduction in migration), the degree of attention to gender issues in the other case studies has varied.

Three PIN studies reported adopting participatory rural appraisal methods, but details were not provided by two; the third mentioned using a transect walk to help look at the environmental relevance of works. No details are provided on whether women took part in the transect walk and whether their perspectives were taken into account. Gender and socially aware participatory rural appraisal methods like gender and caste division of labour mapping, mapping of villages with locations of works, gender and caste based preferences of works mapping, and road maps of general and gender specific changes through the MGNREGA could have been used.

Apart from questions on methods, another question that arises is whether ethical principles were adopted. One study mentions that while conducting individual interviews with women workers, care was taken to meet them separately and keep power-holders away. As discussed earlier, three other studies mention that FGDs were conducted separately with women, and one mentions separate FGDs with the landless and Dalits. However, it is not clear whether ethical

principles such as confidentiality, appropriate timing and venue, same gender interviewer/facilitator and fostering of democratic participation in group discussions were adopted.

Data analysis

There are two questions regarding exploring integration of gender and social equality concerns in data analysis. First, were gender and social analysis techniques employed in the analysis of the data? Second, was special attention paid to data and information that specifically referred to gender and social equality issues (UNEG, 2013)?

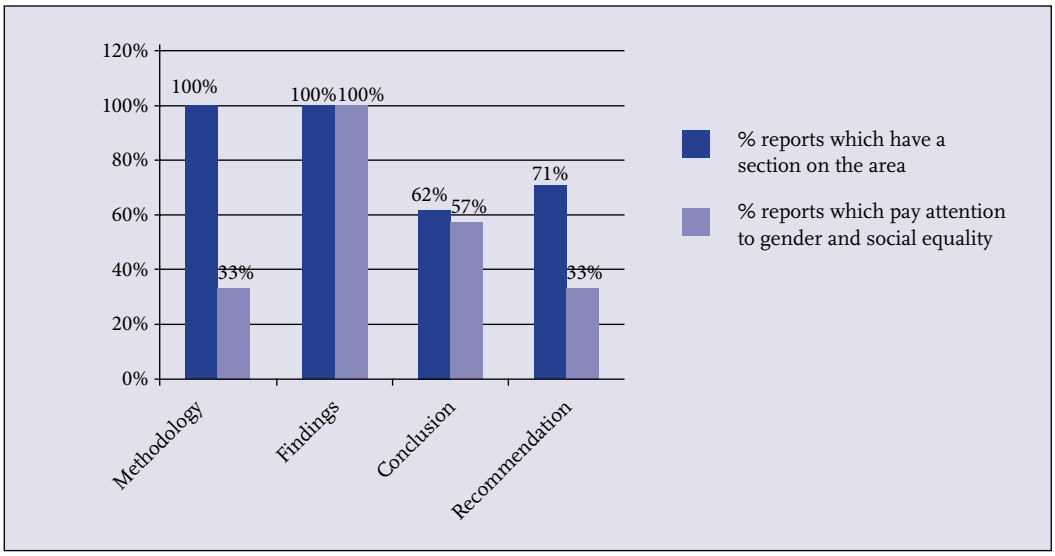
The integration of gender and social equality concerns within "data analysis" in both the Concurrent Evaluation and the PIN studies is rated 1.38 in a scale of 1 to 2, tallying with the "meeting requirements" classification as per the UN SWAP Evaluation Performance Indicator.

The Concurrent Evaluation does not use any gender and social analysis techniques for analysing the data. As discussed, slips such as use of the term "man-days" of employment are noted. However, it does note that there is wide variation in women's participation across the 20 districts and it was not possible to comment on whether the 33% employment quota for women had been met (IAMR, 2008).

Five of the 21 PIN studies (24%) had used gender analysis frameworks for assessing data emerging from a gender lens. Two examined the data to assess whether practical or strategic gender interests of women were addressed through their participation in the MGNREA. The same two PIN studies explored if "male/men" worker was the norm in the MGNREGA or whether the biologically and socially differentiated needs of "female/women" were addressed. In other words, they explored whether MGNREGA was promoting formal or substantive equality. One other PIN study sifted through data to assess whether women's work in the MGNREGA was "visible and paid" or "invisible and unpaid". A fourth study used the lens of whether women were able to develop an independent identity through their participation in the MGNREGA while sifting through the data. Finally, one study, while not using a conceptual framework, developed a gender equality and women's empowerment index based on indicators of person-days of employment going to women and of equality in wages. The framework of equal access and non-discrimination was used by those who looked at social equality issues within the MGNREGA.

While 24% of the PIN studies had used a gender and social analytical framework, 57% came to some conclusion on whether participation of women in the MGNREGA in the district studied was empowering for them. The indicators for women's empowerment were not clearly spelt

Graph 3: The attention to gender and social equality within sections of reports in Percentage: 21 PIN Studies



out in all cases. Two-thirds (of the 57%) appeared to be on track in arriving at the conclusion that while a beginning has been made, women are not as yet empowered.

3.3 Evaluation Report and Use

Evaluation report

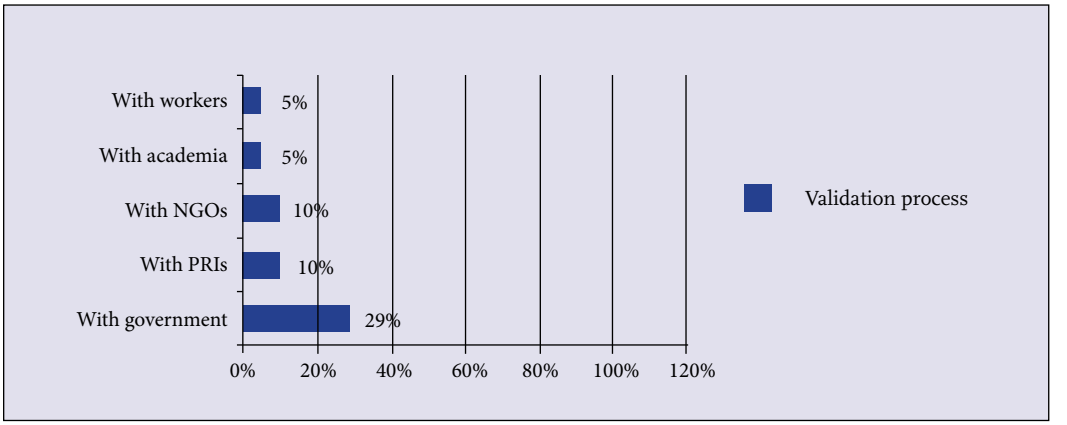
The integration of gender and social equality concerns in evaluation reports is rated 1.27 in a scale of 0–2, which falls in the "meeting requirements" category as per the UN SWAP Evaluation Performance Indicator.

The Concurrent Evaluation integrates gender and social equality into the section on findings, but not the evaluation methodology. There is no section on conclusions/inferences and recommendations in the report. Further, the gender and social equality findings pertain to implementation (percentage of households that used 33% reservation for women, reach to women-headed households, SCs, STs and access to crèche).

The attention to gender and social equality within reports produced by the PIN organisations is described in Graph 3.

On the positive side, all reports include some finding or the other related to gender and social equality, with a tilt towards reporting findings on women's employment, meeting of the stipulated 33% reservation for women, and access of women workers to gender-

Graph 4: Stakeholders with whom the PIN findings and recommendations were validated



intensified amenities[17] like crèche. Women's organisations have covered a wider range of issues (see Table 2 on indicators). However, only 33% of the reports make gender-specific recommendations, and 57% arrive at gender-specific conclusions. This is not surprising, as only 33% of the methodologies are gender-sensitive or reflect a social relations perspective. Further, a substantial 38% and 29% of the reports did not offer any conclusion (inferences) or recommendations.

Words like "man-days" were used in one-third of the PIN reports and the Concurrent Evaluation, and at times even when referring to women workers (women "man-days")!

Validation

The integration of gender and social equality concerns in validation of findings and recommendations rated 1.09 on a scale of 0–2, matching "approaching requirements" as per the UN SWAP Evaluation Performance Indicator.

The Concurrent Evaluation report does not refer to any validation process, though it acknowledges the research inputs from the Planning Commission.

An important question is whether the findings and recommendations of the evaluation of the MGNREGA were validated with women and marginalised workers, the Gram Sabhas, women SHG members/federations, agriculture trade unions from the area and women PRI members. Graph 4 provides some stark statistics, which point to the weak mechanisms to validate findings and recommendations with any workers, leave alone women workers, Dalit/Adivasi workers or workers from the minority or transgender groups.

[17] Amenities that both women and men need, but women require more due to the social construction of gender or biological differences.

The Concept and Background Note on PIN organisations recommends that once the findings are ready, discussions should be held with the state government (Ministry of Rural Development, n.d (e)). A majority of the reports do not confirm if a process of validation of findings and recommendations was followed at all. A few of the PIN organisations (29%) reported they had shared the findings and recommendations with the government.[18]

A few of the PIN organisations (10%) had taken back their findings and recommendations to PRIs and NGOs. There is no data on whether women PRI representatives and PRI representatives from marginalised communities were invited and whether NGOs working with these groups were invited for validation workshops. Only 5% of the PIN organisations reported inviting the workers themselves for the validation process. The report does not outline whether women workers and workers who were Dalits, Adivasis and from the minorities were invited. An innovative approach adopted by this PIN organisation was to hold a public hearing at the block level to which workers, PRI representatives, government officials and NGOs were invited. The findings were presented in this public hearing and solutions were debated. This strategy is highly commendable, but it is not clear whether gender and equity specific issues were raised and addressed.

Management response

The integration of gender and social equality concerns in management or government response is rated 0.67 on a scale of 0–2, reflecting "approaching requirements" as per the UN SWAP Evaluation Performance Indicator.

There is no information in the Concurrent Evaluation report on the response to the findings, conclusions and recommendations from the government.

Only one of the 21 PIN study reports included information on government responses to the findings—in particular, the problem areas that were identified (Biradar et al., 2009). None of the problems raised or commitments made by the government were gender or caste specific.[19] However, it raised the issue of non-recording of BPL status in the muster rolls, which was mandatory as per the MGNREGA guidelines, and the government agreed to rectify the error.

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[18] Mentioned in the report (Hirway and Singh, 2006, CBGA, 2006, Pankaj, 2008, Biradar et al., 2009, Centre for Sustainable Technologies, n.d) or through correspondence (communication between the Executive Director, AFPRO and the author on February 14, 2014 and communication between the Director, Indian Institute of Technology, Rural Technology and Business Incubator and the author on February 14, 2014).

[19] The problems pertained to poor awareness of workers about the period of validity of job cards, non- issuance of job cards to all registered households, lack of entries in a few job cards, delays in payment of wages, staff vacancies, etc. The government officials—the Deputy Collector and his team—agreed to address most problems, other than delays in payment which they stated was due to the lengthy central government procedures involved in the scheme.

Correspondence with three organisations that are part of the Professional Institute Network (a letter was sent to those whose email could be accessed, of whom three replied) suggests that the experience in terms of government response has varied. One PIN organisation reported that the state government issued a letter in the local language which went to to district, block and panchayat officials, sharing concerns raised in the report, such as inadequate crèches at worksites, low participation of women in Gram Sabhas and the need to use different measurement yardsticks for women workers. The other two PIN organisations stated that they were not aware of any action taken on their recommendations, general or gender/social equality specific.

Dissemination

Once the final report is ready, dissemination of evaluation findings and recommendations related to gender and social equality to relevant stakeholders is important. In the case of the MGNREGA, this may include women workers as well as women's rights groups, women panchayat leader networks, women's unions, women's federations, women's wings of political parties, women's studies centres, etc.

The rating on attention to gender and social equality issues in dissemination for both the PIN studies and Concurrent Evaluation is 1.05 on a scale of 1 to 2 for the reasons discussed below.

The guidelines from the Ministry of Rural Development on "Invitation for Expression of Interest in Concurrent Evaluation" include one line that indicates its dissemination strategy. It asks the evaluation agency to submit "100 hard copies of the final report and 5 compact disks" (Ministry of Rural Development, n.d (d)). The evaluating agency is thus not expected to play a role in disseminating findings to the stakeholders. The report outlining findings and recommendations from the Concurrent Evaluation is available on the webpage of the Planning Commission. However, a two-page policy brief is not available.

The concept note on PIN does not outline a dissemination strategy. In fact, it states the reverse (see Box 3) :

Box 3: Proprietary clause with regard to PIN Studies:

"All the data collected, findings and report from the Appraisal may not be shared or published without prior consent and authorization of the Ministry of Rural Development" (Ministry of Rural Development, n.de).

If one searches the website of the Department of Rural Development, Ministry of Rural Development, all the 21 PIN studies reviewed here are uploaded, as well as PowerPoint presentations of 7 of the 21 studies (33%). However, the reports and the PowerPoint presentations

are in English, and hence, are inaccessible to the community women, women panchayat leaders, women's unions, women's federations and several of the women's NGOs for whom it is most important. Further, net access and female adult literacy varies across states/districts, and hence, even translated versions may not be understood in all states/districts.

To explore whether it was posted in the relevant regional language by the Department of Rural Development, six states were chosen at random: Meghalaya, Uttar Pradesh, Jharkhand, West Bengal, Chhattisgarh and Andhra Pradesh. The webpages of these Departments of Rural Development were visited. The reports were not available, whether in the local language or in English. A similar search of six PIN organisations revealed that their reports—in English or in the relevant local language—were not present on their websites (two organisations did not have a website – AFPRO, n.da, Indian Institute of Management Bangalore, n.d, Indian Institute of Management Calcutta, n.d, Rajiv Gandhi Indian Institute of Management, n.d).

None of the reports mentioned that they had adopted any strategies to disseminate their findings and recommendations to the women "rights holders" through pictorial flyers, community radio, street plays and Gram Sabhas. Two PIN organisations out of three[20] mentioned that no budget was available for preparing appropriate materials and taking back the findings to women and men workers or to other non-governmental stakeholders.

3.4 Findings on MGNREGA's impact on gender and social equality

The impact on gender and social equality and women's empowerment can be rated 1.08 on a scale of 1 to 2, corresponding to "approaching requirements", as per the UN SWAP Evaluation Performance Indicator.

Gender equality and women's empowerment

The Concurrent Evaluation did not have a section on conclusions, but observes that it was too early to comment on the female employment potential of the MGNREGA.

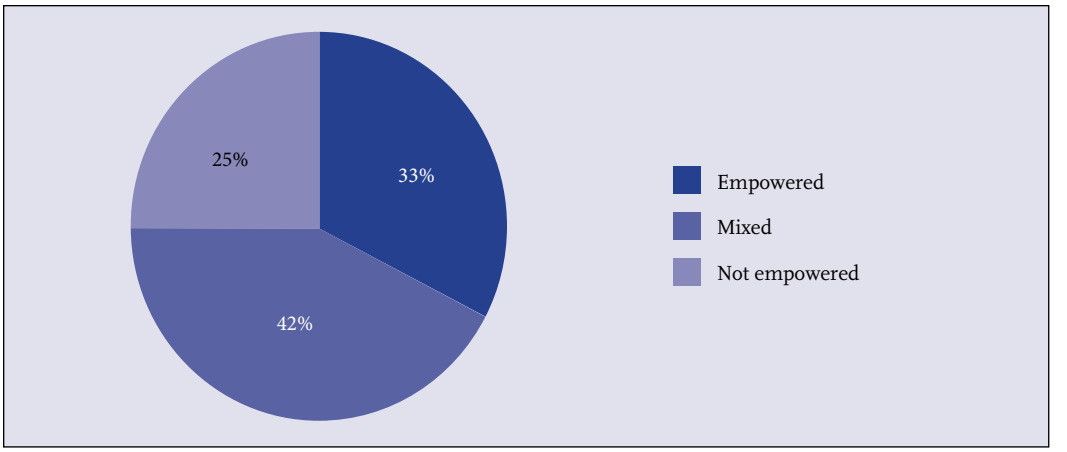
Of the PIN studies, 57% (12 out of 21) arrived at a conclusion on whether gender equality and women's empowerment were promoted through women's participation in the MGNREGA.[21] The conclusions on these 12 PIN studies are depicted in Graph 5.

The PIN studies point out that women's participation as workers ranged from 20–40% in West Bengal to 70–90% in Tamil Nadu, 2009,[22] and the share of women in person days of

[20] The author corresponded with the PIN organisations which had an email in the month of February, 2014. Of the 18 she got in touch with (two had carried out two studies each), three replied.

[21] Some studies commented on impact on gender equality and others on women's empowerment.

Graph 5: Assessment of impact on women's empowerment and gender equality by 12 PIN studies



employment created in a year ranged from 30.5% in Jharkhand and Bihar in 2008 to 46% in Gujarat in 2006.[22] Most studies had used either of the two indicators, while a few used both. The percentage of households that secured 100 days of employment in a year range from 0.24% to 0.30% in the case of districts studied in Gujarat and West Bengal in 2009 to 83% in Rajasthan in 2008.[23]

Forty-two per cent of the 12 PIN studies observed that women's participation in the MGNREGA had a mixed impact on gender equality and women's empowerment. Another 33% observed that women's participation in the MGNREGA had empowered them and fostered equality, and a quarter noted that women were neither treated equally (substantive lens) nor empowered through their participation in the MGNREGA.

Some of the PIN studies that noted little/mixed impact observed that while the provision for 33% reservation in employment had been made for women, the typical worker was assumed to be a "male/man", and productivity norms and amenities at work place were determined according to what men can do and what men want. This leads to women earning lower wages (CBGA, 2006). Bihar is noted to be an exception, having fixed around 15–18% lower norms for women when compared to men for soft, semi-hard and hard soil (Pankaj, 2008). ISWSD (2006) also expressed that productivity norms have to be different for women and men. This is so because malnutrition rates are higher for women often due to widespread gender discrimination.

[22] Rural Technology and Business Incubator, 2009, Indian Institute of Management, Calcutta, 2009
[23] Pankaj, 2008, Hirway and Singh, 2006

Further, multiple childbearing and work load has weakened many of them. Also, elderly women, pregnant women and women with disabilities have to have a lower productivity norm (Hirway and Singh, 2006). The greater absence of crèche[24] facilities than drinking water in most worksites, as noted by several studies,[25] also reflects the notion of a male worker unfettered by childcare responsibilities. The timings of work under the MGNREGA ranged from 8 to 10 hours, with no breaks to go home to feed/breastfeed the child(ren) and ensure their well-being; again, this reflects the notion of a "male/man" worker (Hirway and Singh, 2006).

Substantive equality implies that women, by themselves, are recognised as individuals. One study notes that women were asked to get the approval of their husbands before their applications for work were accepted (ISWSD, 2008). Yet another issue highlighted by the studies, pointing to mixed/little impact on gender equality and women's empowerment, is the "invisibility" of women's work in the MGNREGA. This invisibilisation takes several forms, such as control of men over the women's earnings, through payment of cash due to the women to men, payment of amounts due to the women into the bank/post office accounts of men or to the couples' joint accounts managed by men (Pankaj, 2008). Yet another form of invisibilisation is registering the men in the household as workers, but sending women to work in their place (CBGA, 2006). The payment for the women's work then goes to men. A third form occurs when the task that women and men do at worksites are different based on a gender division of labour, with digging and breaking (being done by men) being paid and lifting and throwing (the tasks done by women) being unpaid and subsumed under the men's work. When couples work in pairs, the payment in some sites has gone to the men (ISWSD, 2006). Yet another issue in the division of labour is that women are given the responsibility of fetching and supplying water. At times, the distance to the water source is too far, and they have to cater to many workers (ibid, 2006). There are no norms to address this situation. Recently trolleys have been introduced but this is not enough.[26]

However, most women workers in Tamil Nadu and Kerala reported receiving equal wages, as a majority of the workers were women and the rest were elderly men. An innovation found in some of the districts of Gujarat is the formation of "women only" gangs, with all payments going to the women (Hirway and Singh, 2006).

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[24] Joshi et al., 2008, and Datta et al., 2009

[25] Other than sample "households" covered in West Bengal, the 13 others on which information was available reported proportion of worksites with crèche to range from 0 to 26%. Interestingly, 96% of the households interviewed in West Bengal stated that crèches were available.

[26] Ministry of Rural Development, 2010a.

The percentage of workers who reported getting minimum wages ranged from 49 to 100% in Jalaun District of Uttar Pradesh (Joshi et al., 2008; IIM Lucknow, 2009). In Jalaun, coupons for the designated minimum wage value (Rs. 100 in 2009) are given at the end of every workday to the workers, and the designated bank is to provide cash in exchange for the coupons. What remains unclear is whether women are able to go to the bank. The payment is on the basis of daily wages and not on piece rates. In contrast, in one of the worksites in Gorakhpur District of the same state, women and men workers reported receiving 49% of the minimum wages (ISWSD, 2006). Twelve per cent of the surveyed panchayats in Hoshiarpur, Punjab, reported that women received equal wages as men, while a high 87.05% of the surveyed panchayats in Sirmaur, Himachal Pradesh, reported along the same lines (CRRID, 2009). Thus, there is a wide range in women's access to equal wages. One report noted that wage disparities may arise because men worked longer hours than women (Hirway and Singh, 2006). This could be due to the fact that unlike women, they did not have household responsibilities. Women met by the evaluation team in Orissa were worried that men may want to access work to a greater extent under the MGNREGA, and consequently, the women would lose out (ISWSD, 2006).

Yet there are places where women's participation in MGNREGA is more than that of men. Even in places where women's participation is more than men's, a study cautions, it is necessary to find "why" they are participating more. The study, covering parts of Andhra Pradesh and Karnataka, found that men felt it was beneath their dignity to work in a scheme where the wages were equal across genders (Sastry, 2007). Another study observed that husbands in parts of Tamil Nadu, where women's participation was higher, snatched their women's job cards and demanded money for alcohol before returning the cards (ISWSD, 2006). Substantive equality is far from achieved in such contexts. Coming to the consequences, the question remains whether men participate more, or at least equally, in house work and childcare in states where women's employment figures in MGNREGA schemes are higher than men's (examples of such states are Kerala and Tamil Nadu). Whether already anaemic women are being overworked and compensating by passing on their domestic chores to their children is a moot question. However, this question has not been raised in the PIN studies (though there is evidence in a few studies of single women pairing with their under-aged children to meet the requirement for couples to report to work) (CBGA, 2006; Datta et al., 2009).

Substantive equality demands a process of empowerment of women. The assumption in some studies that empowerment is a 'state' that is achieved at one point can be questioned. Further, the analytical/empirical validity of coming to the conclusion that women have become

"empowered" based on indicators of women's access to employment, paid work and public space can be questioned. Critiquing the analytical framework of household underpinning the MGNREGA in design (guaranteeing 100 days of employment per household) and implementation, other PIN studies that have pointed to non-empowerment of, or mixed impact on, single women[27] (de jure and de facto) who have been excluded from registration or had less access to employment under the MGNREGA (Hirway and Singh, 2006; CBGA, 2006; ISWSD, 2006; Sastry, 2007; ISWSD, 2008; Joshi et al., 2008). Absence of a male partner has been a constraint for women, some of who have been compelled to pull their children out of high school to work. Other excluded women were malnourished women, women in advanced stages of pregnancy and women with disabilities (Joshi et al., 2008; ISWSD, 2006; Hirway and Singh, 2006).

In spite of these constraints, women who have worked in the MGNREGA have reaped some gains at the individual or "power to" level. One-third of the 12 studies with a conclusion have noted that women's mobility has expanded and women's incomes have increased through their participation in the MGNREGA, and that they have invested their income in strengthening food security, health and education, as well as purchase of durable goods and (occasionally), livestock. Women have also used the income for redeeming assets that were pledged (NFIW, 2008; IIM Calcutta, 2009; Rural Technology and Business Incubator, 2009; Nayak et al., n.d). Migration of women workers in Rajasthan is reported to have reduced (Joshi et al., 2008). One study notes that child labour, male alcoholism and trafficking of girls and women has declined in parts of Gujarat and West Bengal (Datta et al., 2009). In contrast to studies in many other parts of India, single women are noted to have benefitted in Sikkim and Meghalaya, and the scheme has redeemed them from destitution in the event of divorce (Panda et al., 2009).

An aspect that is not probed is whether there is gender parity in intra-household distribution of increased food, health and education, whether assets created through women's income are considered theirs and whether assets redeemed first are women's. A few studies note that women workers have a greater say in household decision-making, but it is not clear over which aspects (expenditure, assets, political participation, reproduction or sexuality) (NFIW, 2008). Thus, at the individual level, women's participation in the paid work force was increasing (for some Upper Caste women for the first time) and women were more mobile, but how far they

[27] Widows, divorced, deserted, separated women, never married women, women living alone because of migrant husbands or women in male-headed households (in their marital village or natal village).

exercised (increased) control over their labour, wages/income, assets, reproduction or sexuality is to be seen. No women have been found functioning as Gram Rozgar Sevaks, but in some places, they were found as mates (varying from very low to 33%) and where present, they attracted women workers[28] (Joshi et al., 2008; IIM Lucknow, 2009).

At the collective level, one study observes that the very process of women working together on a worksite creates spaces to share information and learn from each other, in particular about health. Yet, another study notes that comradeship amongst women—cutting across castes—has increased, with women singing and gathering together in the morning while assembling for work. Cases of sexual harassment of women have been noted in worksites by two studies, while one has observed its absence (Sastry, 2007; NFIW, 2008; Joshi et al., 2008). Giving details, one study noted that the setting up of tents for shade led to men hanging around and passing comments about women workers in Rajasthan. Security had to be provided to the women (Joshi et al., 2008).

A consistent observation across several studies is the absence or presence of few women in Gram Sabha meetings where works are selected and social audits are supposed to take place (Singh et al., 2009; Rural Technology and Business Incubator, 2009; AFPRO, n.d; Hirway and Singh, 2006). Women were rarely found in vigilance and monitoring committees (where established) (Singh et al., 2009; NFIW, 2008). Neither are women involved in managing assets created. One study, which concentrated on workers' committees, however, observed that women and men were equally represented as office bearers (AFPRO, n.d). Thus, on the whole, it appears that women have little say in decision-making, including on selection of works. As a result, women's priorities, like strengthening the density of fuel-wood plants/trees, water bodies and ICDS centres got less priority than roads. But the hill regions may be exceptions. In hilly areas, women appear to exercise greater autonomy. In Meghalaya, it was observed that there were no panchayats, and hence, the scheme was implemented through alternative participatory structures in which 30% of the seats were held by women who exercised their power, which was not always the case in the plains (Panda et al., 2009).

None of the studies explored the process of women's empowerment at an attitudinal or "power-within" level. Questions like whether women's or men's (or community) values in terms of son preference, dowry, girl child marriage or inheritance were changing were not explored.

[28] None of the studies report the sex compositions of District Programme Officers, Programme Officers and Junior Engineers.

Social equality

Several of the PIN studies note the popularity of the MGNREGA amongst Dalits, Adivasis and the landless and the higher participation rates of these communities when compared to the others. Muslims are under-represented when compared to their ratio in the overall population, as per two studies. One study notes the higher participation of rural people in hilly areas when compared to the plains (Singh et al., 2009).

At the same time, 48% of the studies note some form of discrimination or the other against Dalits, Adivasis, the landless, the differently-abled and Muslims. The first kind of discrimination, which is hopefully corrected by now, is to start the scheme in the main village and not in habitats where Dalits reside. Another is the failure to provide tools to the landless, Dalit and Adivasi workers, a majority of who are too poor to buy them (ISWSD, 2008). In fact, there are instances where women from these communities in Gujarat were forced to sell their jewels to buy tools (Hirway and Singh, 2006). The practice of serving Dalits from a separate vessel has been observed in some of the worksites of Uttar Pradesh and Tamil Nadu (ISWSD, 2008), while two other organisations observed the formation of caste-specific work-groups in Rajasthan and Tamil Nadu (Rural Technology and Business Incubator, 2009; Joshi et al., 2008). The issue of whether amenities were better at the worksites of the Upper Castes was not studied. Since literacy is lower amongst the Dalits and Adivasis (and women amongst them), their level of awareness on MGNREGA was lower (NFIW, 2008).

Overall, while Dalits are well represented in the MGNREGA, in Upper Caste dominated areas they do not easily get employment in MGNREGA projects in parts of Rajasthan (Joshi et al., 2008). To strengthen the assets of Dalits and Adivasis, there is a provision for development of land and construction of wells through the MGNREGA. This provision was not fully exploited (Datta et al., 2009; Singh and Nauriyal, 2009). One reason was that wages for digging wells were fixed at lower rates than for construction of roads (as in Madhya Pradesh), due to which it was not prioritised in the Gram Sabhas (Centre for Science and Environment, 2008). Another reason was the reluctance of Jains and Caste Hindus to work on land belonging to Dalits (Joshi et al., 2008). Yet another issue is the higher degree of landlessness amongst rural Dalits (Singh and Nauriyal, 2008). In the context of rural landless Dalits and Adivasis, the provision of land development is of little use. On the other hand, one study noted that the lands of Upper Castes were being developed in parts of Andhra Pradesh using MGNREGA funds (Sastry, 2007). In contrast to these negative observations, one study notes that people of different castes in parts of Orissa were coming together for employment for the first time (Nayak et al., n.d).

Rajput, Brahmin and Jain women have started coming to work in MGNREGA schemes in Rajasthan, some entering paid work for the first time. They and their families consider it demeaning for women to work for private employers, while working in government sector public works is less demeaning (Joshi et al., 2008). However, working on land owned by SCs/STs/BPL is considered the equivalent of working for a private employer, and hence, is also demeaning. Over and above the Dalit/non-Dalit issue is the tendency of elected panchayat representatives to deny employment to the castes that voted against them (Joshi et al., 2008).

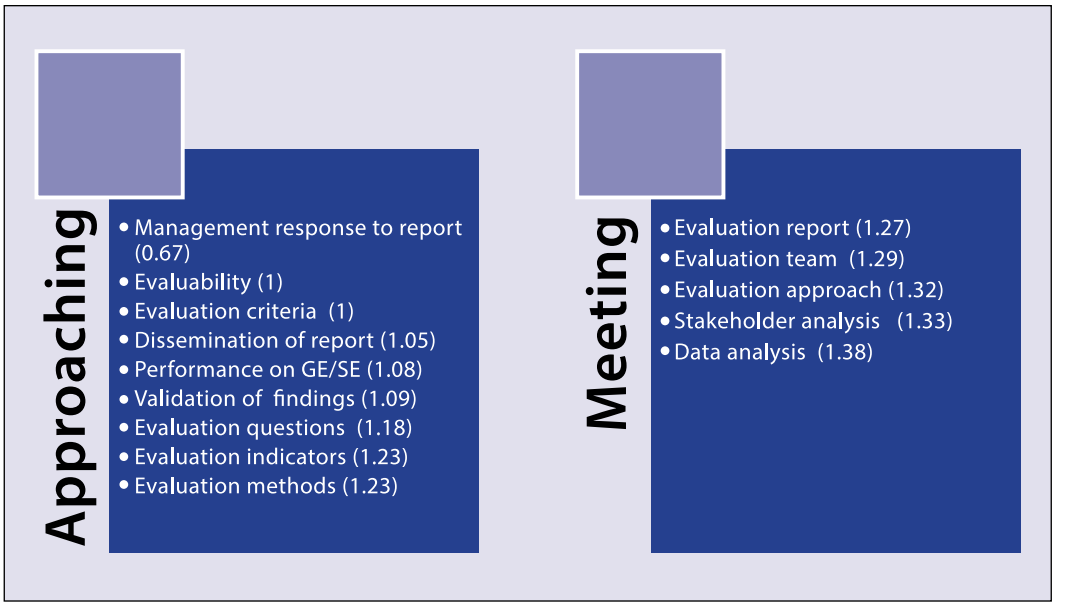
There is paucity of information on the experience of Muslims with the MGNREGA. One study in Bihar notes that they constitute 12% of the workers, as against their representation of 16.5% in the overall population in 2001 (Pankaj, 2008; Office of the Registrar General and Census Commissioner, n.d). Another study notes that Muslims in Uttarkhand were less aware of the MGNREGA than their Hindu counterparts, and their participation was lower (Singh and Nauriyal, 2009).

There is slightly more information on access of the differently-abled to the MGNREGA. One study, which covered Gram Panchayats in parts of Punjab, Haryana, and Himachal Pradesh, observed that the percentage of Gram Panchayats that made an effort to generate employment for the disabled averaged between 12.5% and 25% (Centre for Research in Rural and Industrial Development, 2009). Further, the nature of work given to the differently-abled is not appropriate. Three other studies also recorded the exclusion of the differently-abled from registration or employment, though numbers are not provided (ISWSD, 2006; Hirway and Singh, 2006; Sastry, 2007).

On the whole, the norm of "able-bodied man" underpins the MGNREGA. Though affirmative provisions are present to strengthen the assets of SCs/STs/BPL workers, institutional hierarchies and norms mediate their access to work; ability to overcome poverty and strengthen livelihood.

The Concurrent Evaluation did not include any recommendations (IAMR, 2008). Of the 21 PIN studies, 71% had a section on recommendations. Of those that had a recommendation section, 67% had gender/social equality specific recommendations to make, as summarised in Annexure 2. Several of the gender-specific government orders that were passed after 2009 address some of the recommendations, but there are several that are yet to be taken forward.

Figure 3: Performance of Evaluations across Criteria on a Scale of 0-2



4.0 CONCLUSIONS AND RECOMMENDATIONS

Of the 22 evaluations of MGNREGA reviewed, 64% 'approached requirements' and 36% 'met requirements' as per the UN SWAP Evaluation Indicator. None of the evaluations 'exceeded' or 'missed' requirements. The availability of gender-expertise within the team had a major role to play in determining the meta-score of the evaluations. Examining criterion wise, on 5 of the 14 evaluation criteria (36%), the evaluations[29] are 'approaching requirements' and on 9 of the 14 evaluation criteria (64%) the evaluations are meeting requirements. See Figure 3 for details. The meta-score of all the evaluations and all the criteria is 1.15 that is, 'approaching requirements'. Evaluations are thus 'gendered'/'socialised' spaces, and reflect gender and social hierarchies in society in the criteria, questions, approaches, indicators, methods, analysis, etc., they adopt. Figure 3 gives details on which criteria the evaluations approach or meet requirements.

The meta-scores on integration of gender and social equality within evaluation preparation and evaluation methodology are more or less the same at 1.21 and 1.22 respectively, while the score is lower, at 1.02, at the stage of evaluation report and use. The rating of impact of MGNREGA on gender and social equality is equally a matter for concern, at a low 1.08. While

[29] The 22 evaluations include one Concurrent Evaluation and 21 PIN studies.

Table 3: Recommendations to strengthen gender and social equality integration into evaluations

Shifts required	Recommendations
Moving from "approaching requirements" to "exceeding requirements"	
Management (0.67)	- The government may outline its response to gender and social equality (and other) findings/recommendations in the evaluation reports along with an action plan on when and how it will act on the recommendations. This note may be attached to the evaluation reports.
Evaluability (1)	- The government may improve the evaluability of the MGNREGA from a gender and equality lens by strengthening its design further through this lens.[30] - The government may review all records and monitoring systems from a gender and social diversity lens so that disaggregated data is available.
Criteria (1)	- The government, while framing the Terms of Reference for evaluations of the MGNREGA, may spell out the fact that gender and social equality is a cross-cutting issue, in addition to being one of the issues explored. - The TOR may give emphasis to addressing marginalities such as gender orientation, marital status, disability and religious minority status.
Dissemination (1.05)	- The government may provide for a budget to evaluation organisations to disseminate important findings and recommendations[31] to women and men workers, mass organisations and women's rights/studies centers. - Organisations involved in evaluation may convey the main findings, recommendations and government commitments to women workers through translated policy briefs,[32] pictorial flyers, community radio, street plays and Gram Sabhas.
Evaluation questions (1.18)	- The government may indicate in the Terms of Reference that evaluation questions should focus on the gender/social sensitivity of design, planning processes and institutional arrangements, as well as implementation and impact analyses. - A working group on gender and social equality[33] may be constituted to suggest questions that could be considered.

[30] See recommendations that follow the Table.

[31] Including on gender and social equality.

[32] The translated policy briefs could be uploaded on government websites as also those of the organisations that carried out the evaluations.

[33] There was a working group on specific needs of special category of workers in 2010 (Ministry of Rural Development, 2010b). The composition of the working group would need to be studied to examine expertise on substantive equality.

Validation of findings (1.09)	- The government may allocate a budget to the evaluation organisation to validate its findings and recommendations with women workers and workers from marginalised groups, elected representatives and mates/Gram Rozgar Sevaks. - Evaluation organisations may organise public hearings, workshops and role-plays for presenting their findings and recommendations to the stakeholders indicated, with a focus on the hamlets of marginalised.
Evaluation indicators (1.23)	- In consultation with the working group, the government may evolve indicators for evaluations that are gender and socially aware (building upon Table 2), and annex it to the Terms of Reference.
Evaluation methods (1.23)	- Taking the help of the proposed working group, the government may modify the model questionnaire for different stakeholders to take into account gender and socially aware questions and indicators. - The government may evolve guidelines on gender/socially aware participatory methods that could be used in evaluation of the MGNREGA. - Ethical and gender/socially aware principles that need to be adopted while using evaluation methods may be outlined in the Terms of Reference, taking the support of the working group.
Moving from "meeting" to "exceeding requirements"	
Evaluation report (1.27)	- The government may provide guidelines on evaluation reports emphasizing inclusion of sections on conclusion & recommendations and integration of gender and social equality issues into all sections.
Gender balance and expertise (1.29)	- The government may ensure that at least half of the organisations involved in evaluations of the MGNREGA have expertise on gender and social equality. - The government may issue a directive that organisations involved in evaluations may ensure that there is percentageate representation of women and marginalised communities in the evaluation team.
Evaluation approach (1.32)	- The terms of reference for evaluations of the MGNREGA may clearly specify that quantitative and qualitative gender and socially aware methods should be used and that the "worker" rather than the "household"[34] should be the unit of analysis. Workers may be selected randomly and comparison may be made with similar non-workers.
Stakeholder analysis (1.33)	- Government guidelines on stakeholders to be met by evaluation teams may include single women, minorities, transgender persons, pregnant and lactating women and people with disabilities, as well as women's federations and agricultural unions.
Data analysis (1.38)	-In consultation with the working group on gender and social equality, the government may evolve indicators of social empowerment through the MGNREGA; which may be annexed to the terms of reference given to organisations evaluating the MGNREGA.

[34] Other than for calculating the number of days of employment per household per year.

one of the aims of the MGNREGA is social empowerment of women workers and workers from the marginalised communities, it is perhaps only half-way there, with the empowerment impact being mediated by gender/social norms and power embedded within households, communities, work places and governments.

Some important recommendations to governments and evaluation organizations (PIN or Concurrent) to strengthen gender and social equality integration within evaluations of the MGNREGA are given in Table 3.

In discussing recommendations to strengthen[35] the impact of the MGNREGA on gender and social equality, it is crucial that the design, planning, implementation and institutional arrangements challenge biased institutional norms that come in the way of marginalised women's employment translating into gender and social equality or women's empowerment. The government needs to break the concept of household as the unit of intervention and issue job cards and work to individual women (ISWSD, 2006; UN Women, n.d). The government has in 2012 passed a directive to the states to issue job cards to women heading households, but not all categories of single women, like never-married or divorced women (Minister of Rural Development, 2012). This lapse may be looked into, as well as the invisibility of transgender persons within the MGNREGA. Guarantees may need to be applied at the individual level (they do not exist presently), and payments be made compulsorily to individual workers, as outlined in the 2012 government directive (Minister of Rural Development, 2012). Yet another issue that the government could consider is the transfer of private land that is developed through the MGNREGA from men to women (or joint ownership) as a precondition to deriving benefits. List of works under MGNREGA could also include construction of drinking water facilities, regeneration of commons for strengthening women's access to fuel and fodder and intra-village roads for improving access to basic facilities; works which would reduce women's unpaid work burden and free up their time for economic and political interventions.

At the worksite, the norm of a "male able-bodied worker" needs to change. In comparison to men, the productivity norms may be lesser for women, differently-abled, elderly women and pregnant women so that they can access minimum wages (Hirway and Singh, 2006; Joshi et al., 2008; UN Women, n.d). The central government has directed state governments to conduct a time and motion study to determine schedules of rates

[35] For the rating of gender and social equality impact to shift from "approaching requirements" to "exceeding requirements".

and works for women and the differently-abled. This could be extended to pregnant and lactating women (Minister of Rural Development, 2012; Ministry of Rural Development, 2010a). The government may consider making the working time for workers flexible so as to enable women workers to juggle their domestic responsibilities with paid work (Pankaj and Tanha, 2010). To make visible women's work, the government may pass an order that where women and men work in pairs, the women's work is accounted and paid for separately and not subsumed under the work of the men (ISWSD, 2006). All women's gangs may be promoted and women workers' organisations strengthened, to avoid such problems (UN Women, n.d). Exclusion of single women, differently-abled women and pregnant and lactating women from work gangs or pairs may be addressed by reducing the wages of the perpetrators.

Facilities at worksites need to take account of sex/gender differences beyond provision of crèches (less found in practice, and its provision needs monitoring). A suitable maternity (there is a provision in MGNREGA, Act, 20015) and paternity benefit scheme is essential to protect women workers (ISST, 2006). Given the high levels of anemia amongst women (generally much higher than in men), iron tablets may be distributed by the Department of Public Health to women workers (Murthy, Bernard et al 2010). Mobile toilets with water and sanitary materials with disposal facilities may be provided at the worksites. The government may put in place a system for dealing with sexual, caste or disability based harassment/discrimination at workplaces in consultation with the appropriate working group on gender and social equality. This applies both while working and resting in tents.

The implementation of the government order of 2010 reserving 50% of mate positions for women may be monitored by the government (Ministry of Rural Development, 2010b), while at the same time ensuring that the majority of them are from marginalised communities.[36] Apart from being of value by itself, women workers are reported to feel safer when working under women mates. Unions of (marginalised) women workers at the MGNREGA may be formed[37] and trained on the Act, gender equality legislation in India, best practices from within India on promoting gender and social equality through the MGNREGA, literacy skills and technical skills (like masonry, plumbing, tiling, etc.). Taking the help of organisations that work with men on gender and social equality, men workers may be sensitised to gender and social equality, as well as on the need for sharing domestic work and care of

[36] Caste women are not free of biases against Dalit women.
[37] Unionisation of women workers was the approach adopted by the Lok Samiti project (Patel et al., n.d).

children, the sick and the elderly, especially in areas where women's participation is high (ISST, 2007).

At the community level the norm is of "Caste men as decision-makers". To change this norm, the government must ensure that 50% of participants and decision-makers in the Gram Sabhas (wherein MGNREGA is discussed), village monitoring committees and workers' committees are women from marginalized communities. A separate meeting with women workers may be convened before the Gram Sabha to help them articulate their demands (ISWSD, 2006). Equal priority may be given to works that develop common property resources and works that develop land, houses and toilets of Dalits, Adivasis and BPL families. Cases of Caste-workers refusing to work on private or community lands of Dalits/Adivasis may be brought to the notice of government, 2009, and taken up for action under the SC/ST (Prevention of Atrocities) Act, 1989. This equally applies to funds being diverted to develop lands of caste Hindus. There should be convergence of MGNREGA with policies and schemes of Ministry of Social Justice and Empowerment for distribution of land to landless Dalits/Adivasis. Community assets created through the MGNREGA may be handed over to (marginalised) women's groups or SHGs, and they may be linked with the SGSY for credit for livelihood interventions like fisheries so that returns from assets created/developed through MGNREGA are maximum and equitably distributed (also see UN Women, n.d). Thus, convergence with Ministry of Women and Child Development is also crucial.

At the institutional level, there may be reservation and training for women for the posts of Gram Rozgar Sevaks, Programme Officers and Junior Engineers (Pankaj and Tanha, 2010). There is also a need for developing a gender and equality sensitive monitoring system (UN Women, n.d).

Lastly, the government may commission a study by organisations working with transgender people to explore the potential for providing employment to transgender persons through the MGNREGA and to identify the specific strategies required for this purpose. The same applies to Muslims.

To sum up, a "substantive equality" approach to design, planning processes, implementation and institutional arrangement is required to ensure that the good intentions of the MGNREGA on "social empowerment" of rural women and other marginalised groups are to be realised. This equally applies to evaluations that are commissioned to assess MGNREGA implementation and impact. Otherwise, the MGNREGA could be a platform for participation without empowerment of already malnourished and overworked women and the marginalised.

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Annexure 1

Suggested list of topics by Ministry of Development to be covered by evaluations:

Supplementing Employment and Livelihood Opportunities: The basic objective of the NREGA is to provide a fall- back employment source, when other employment alternatives are scarce or inadequate. By providing up to 100 days of employment, NREGA provides an additional source of income during lean seasons.

Economic and Social Women Empowerment through equal wages, greater work opportunities: The Act encourages participation for women and adds a dimension of equity to the process of growth. Narratives of workers indicate that the NREGA has not only proved to be an independent employment source for women, but has also given them a greater role in decision-making within the household.

Increase in Income and wages: Over the past three years, there has been an increase in minimum wages for agriculture labourers across the country, and the average wage per person day at the national level has increased from Rs. 65 in 2006 to Rs. 83 in 2008.

Inclusive Growth, particularly for disadvantaged groups– BPL/SC/ST/disabled: Experience has shown that it is the poorest of the poor and the most vulnerable groups who seek employment under the NREGA. The participation of SC and ST is 55%, with a nearly equal women's workforce participation. Thus, the NREGA is self-targeting in a way.

Financial Inclusion–Bringing the marginalized into the formal banking system: Under NREGA, around 5.7 crore (upto December 2008) bank and post office accounts have been opened. Feedback from districts points towards greater savings for the workers and greater transparency in wage disbursal, as well as an increased access to the formal banking system and facilities.

Creation of Durable and Productive assets and Effective Convergence practices: Through its emphasis on water conservation, the NREGA has not only proved to be an important scheme for

drought prone areas, but it has also created durable and productive assets for years to come. For instance, the ponds created under the NREGA are being used for pisciculture and the roads constructed have only increased access to markets.

Increase in Agricultural Productivity: Districts have noted a significant rise in water levels and agricultural productivity. The resultant increase in small and marginal farmers' income is also contributing to better input for farming.

Regeneration of natural resource base through plantation, afforestation, water conservation and other activities: The auxiliary objective of the Act is to strengthen natural resource management through works that address causes of chronic poverty like drought, deforestation and soil erosion, thus encouraging sustainable development.

Quantification of Environmental Services, Adaptation and Mitigation of the Effects of Climate Change: NREGA workers, through different permissible activities like water conservation and drought proofing, are rendering environmental services. These are also helping in adaptation to climate change. The impact of NREGA works on climate change and benefits like carbon credits that can be accrued to the rural people needs to be studied.

Stemming of Migration (at the level of the village, district and/or state): Reports have indicated that by providing employment on demand within 5 kms of the villages, the NREGA has aided in the stemming of rural–urban as well as inter-state migration.

Strengthening of Panchayati Raj Institutions: Under the Act, the shelf of projects has to be prepared by Gram Sabha. At least 50% of works have to be allotted to Gram Panchayats for execution. Panchayat Raj Institutions [PRIs] have a principal role in planning and implementation.

Ensuring transparency and accountability through information technology such as, for example, smart cards for wage disbursal.

Building social capital formation through awareness generation/ social mobilisation, social Audits.

Impact of the NREGA in leftist extremist districts such as Chhattisgarh, Jharkhand and Orissa

Other Multiplier effects of the NREGA: Apart from being a pathbreaking wage employment programme, the NREGA has become a transformative vehicle for empowering local communities to enhance their livelihood security and to renegotiate their rights with institutions of governance. Other multiplier effects include better village development through participatory planning and convergence practices.

Any innovation/best practice/case studies/beneficiary narratives: The design of the Act is encouraging the state governments and districts to evolve innovative solutions to the infrastructural or procedural constraints.

Annexure 2

GENDER AND SOCIAL EQUALITY SPECIFIC RECOMMENDATIONS FROM PIN STUDIES
Gender-specific recommendations from PIN studies

Area	Recommendation
Design	Individual job cards rather than household job cards Including lifting and throwing in schedule of rates Women's productivity norms to be set at 85% of norms for men Fix productivity norms for pregnant and lactating women at lower levels than workers, and give them lighter work[1] Single women should be given the choice of working on their own and not necessarily in pairs, and paid daily rates Create separate column for women and men in job cards for recording payments Individual bank accounts in women workers' names[2] Biometric system so that women are not forced to work as proxies for men Women fetching and giving water should cater, at the most, to 30 workers[3] Priority to development of land of single women and irrigation facilities therein Handing over of completed works to women's self-help groups for management and livelihood; access to microcredit under SGSY Training of youth—female and male—in social audit
Planning	Selection of works that reduce the work burden of women, like water harvesting structures, drought proofing and bio-fuel plantation Hold separate meetings of women before Gram Sabhas to articulate their priorities
Implementation	PRI staff to go house to house to assess demand for work for the year; this will help women who have multiple responsibilities Ensuring 100% coverage of single women interested in working under the MGNREGA Ensuring provision of creche at all worksites or in the villages with nutrition supplementation where required[4]
Institutional	33% reservation of the post of mates for women[5] 33% reservation of the post of Gram Rozgar Sevaks for women

[1] In 2010, the government passed an order urging states to consider providing pregnant and lactating women with works like nursery and horticulture development (Ministry of Rural Development, 2010a)

[2] The 2013 guidelines on the MGNREGA states that as far as possible, individual accounts should be opened for every worker (Ministry of Rural Development, 2013).

[3] In 2010, the government passed on order that states should provide trolleys at worksites within the 6% budget allocated for administrative expenses (Ministry of Rural Development, 2010a).

[4] In 2010, the government passed an order stating that crèches should be established in worksites (in keeping with the legislation) and nutritional supplementation for children may be provided in convergence with ICDS (Ministry of Rural Development, 2010a).

[5] In 2010, the government passed an order that state governments should "consider" reserving 50% of the posts of mates for women (Ministry of Rural Development, 2010b).

Source: Hirway and Singh, 2006; ISWSD, 2006; Sastry, 2007; Pankaj, 2008; Indian Institute of Management, Lucknow, 2009; Joshi et al., 2009; Singh and Nauriyal, 2009

Diversity-specific recommendations from PIN studies (other than gender)

Area	Recommendation
Design	- Allocate appropriate work for the differently-abled[6] - Revise schedule of rates so that the differently-abled can earn minimum wages - Biometric muster rolls so that no child is made to work as a proxy - Provision of tools as part of the MGNREGA - Guarantee hundred days per worker rather than per household - Mobile banking systems in remote and hilly areas - Have a long term plan of skill training for workers when potential for works using unskilled work is exhausted - Link elderly people with severe disability, or those suffering from illnesses with other social safety nets
Implementation	- Link the MGNREGA with adult literacy programmes so that the workers can check records and file a written application for work - Link with SGSY or bank loans so that the poorest with loans elsewhere can repay the loans and join the MGNREGA - Raise awareness amongst workers on all provisions of the MGNREGA, in particular on unemployment allowance and complaints registration - Raise awareness amongst Dalits and Adivasis on specific provisions for them under the MGNREGA - Create a system of demand estimation for workers belonging to different sections across months - Monitor completion and quality of works so that sustainable employment and livelihood development can be created - Release adequate funds on time
Institutional	- Strengthen awareness amongst institutions on objectives of MGNREGA on sustainable employment creation, livelihood strengthening and strengthening of natural resources - Fill vacancies of staff, in particular Junior Engineers and mates central to measurement of work - Train mates in measurement, as well as institutionalise a system of mates so that power is not vested in one person

[6] In 2010, the government passed an order to the effect that state governments should identify works that are friendly towards people with disability (Ministry of Rural Development, 2010b).

Source: Centre for Sustainable Technologies, n.d; Nayak et al., n.d; Rajiv Gandhi Indian Institute of Management, n.d; Biradar et al., 2009; CSE, 2008; ISWSD, 2008; Pankaj, 2008; CRRID, 2009; Panda et al., 2009

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CHAPTER 2

Learning from STEP Evaluations

Shraddha Chigateri, Tanisha Jugran, Rituu B. Nanda & Rajib Nandi

STEP Programme

The Support to Training and Employment Programme (STEP) for Women was launched in 1986 by the Central Government as one of the measures to empower women in the informal sector. It is a poverty alleviation programme that seeks to provide income generating activities to women from vulnerable groups to enable their economic empowerment.

STEP has the objective of extending training in new skills or the upgradation of existing skills to provide sustainable employment opportunities to women through a variety of action oriented projects. The scheme covers ten traditional sectors of employment namely, Agriculture, Small Animal Husbandry, Dairying, Fisheries, Handlooms, Handicrafts, Khadi and Village Industries, Sericulture, Social Forestry and Waste Land development.

Box: 1: Objectives of STEP

- To mobilize women in small viable groups and make facilities available through training, access to credit and other inputs.
- To provide training for skill generation and upgradation.
- To enable groups of women to take up employment cum income generation programmes on their own or access to wage employment.
- To provide support services for further improving employment conditions of women and for access to healthcare, literacy, legal literacy and other information.

The programme is implemented through Public Sector Organisations, District Rural Development Agencies, Federations, Cooperatives and Voluntary Organisation registered

under the Societies Registration Act, 1860 or under the corresponding State Acts. Recipients of financial assistance under STEP are required to be bodies, organisations or agencies working in rural areas, although their headquarters may be located in an urban area.

The target group to be covered under STEP includes marginalised, assetless rural women and the urban poor. This includes wage labourers, unpaid daily workers, female-headed households, migrant labourers, tribal and other dispossessed groups, with special focus on SC/ST households and families below the poverty line.

The present study is based on two objectives. First, to review completed evaluations of STEP, using a feminist framework, to see what the recurring themes are in evaluations of STEP projects, and what the implications are for programme design and implementation. Second, to develop a framework for evaluation that uses a gender and equity lens that could inform future evaluations.

The STEP scheme was started in 1986 and is one of the early efforts to strengthen skills of women in informal employment in selected sectors. In this context, lessons learnt from a programme like STEP that has been in place for over three decades are pertinent.

As part of this study, we have developed a framework to analyse the 20 sample evaluations given for the study by the National Mission for Empowerment of Women (NMEW). This study is conceived of as a formative evaluation and uses a synthesis method to analyse the implications for the evaluations of STEP as well as STEP programme design and implementation. The framework prepared for this study is based on the criteria for evaluations developed by the Development Assistance Committee (DAC) of the Organisation for Economic Cooperation and Development (OECD), along with additional criteria of research process and utilisation of evaluations.

Importantly, the study assesses what makes an evaluation a gender responsive evaluation which is reflected by the findings on the mobility and accessibility of women to institutions and resources, their participation in political and decision-making bodies, their economic and social empowerment, reduction in drudgery, increase in awareness and confidence levels, better communication skills, and access to health and sanitation facilities.

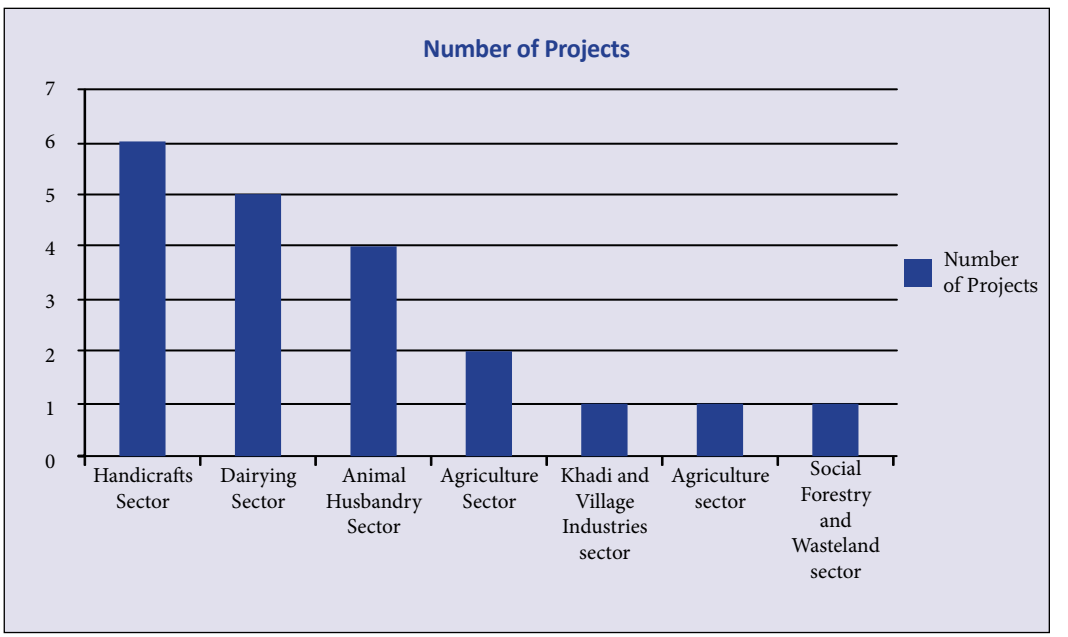
Based on the findings, the framework synthesizes the common constraints/weaknesses through the evaluations and evaluation approaches that have appeared to have worked well. It also throws light on what makes it a gender responsive framework.

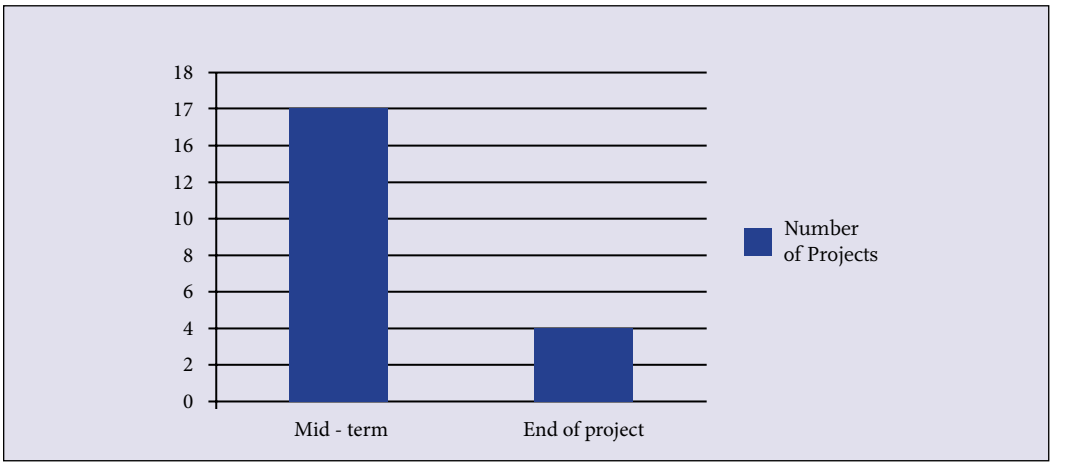
Methodology and Tools

The study is primarily based on an analysis of 20 STEP evaluation reports which were made available by the Ministry of Women and Child Development to the study team (a list of evaluation reports is available in Appendix III). The reports were picked up randomly from various sectors and states and done by different evaluating organizations. However, all of those reports were completed during the Eleventh Plan period (2007-2011).

Table: Sample of STEP Evaluation Reports

Type of traditional sector	Number of Projects
Handicrafts Sector	6
Dairying Sector	5
Animal Husbandry Sector	4
Agriculture Sector	2
Khadi and Village Industries sector	1
Aquaculture sector	1
Social Forestry and Wasteland sector	1
Total	20





In addition to the 20 STEP evaluation reports, the study also conducted in-depth interviews with evaluating organizations based in Karnataka, Madhya Pradesh, Uttar Pradesh, and West Bengal. Interviews were also conducted with the implementing organizations based in U.P, Karnataka and Kerala. Interviews were conducted with state Women Development Corporationsin Uttar Pradesh (a list of interviews is attached as Annexure II). The various implementing and evaluating organizations were chosen to get a broad geographical and sectoral spread. Semi structured open-ended questionnaires were formulated to conduct interviews with different stakeholders (Annexure V).

This study is conceived of as a formative meta-evaluation, viz., an evaluation to strengthen and improve future evaluations. The term meta-evaluation was first used in a paper by Michael Scriven in 1969 to assess the design used to evaluate educational products (Scriven, 1969; Stufflebeam, 1974). The term itself was coined by him 'somewhat earlier' to deal with the problem of comparability of several evaluations of housing projects commissioned by the Urban Institute (see Scriven 2011). Meta-evaluation is 'a systematic and formal evaluation of evaluations, evaluation systems or use of specific evaluation tools in order to guide planning / management of evaluations within organisations' (Olsen and O'Reilly, 2011:1). Further, a meta-evaluation can be used for ongoing evaluations (formative) or to report on the strengths and weaknesses of previous evaluations (summative) (Ibid). Although this study is based on already concluded evaluations, rather than being a summative and concluding exercise assessing the outcomes of these evaluations, this study is conceived of as a formative meta-evaluation to inform ongoing and future evaluations of STEP. The purpose is to use the evaluations already concluded to strengthen and improve future evaluations (see Scriven, 1967).

Box: 2: DAC Evaluation Criteria A

The OECD DAC criteria for evaluations lays down certain key questions to be addressed in evaluating programmes and projects under the different heads of Relevance, Effectiveness, Efficiency, Impact and Sustainability. These criteria were first laid out in the DAC Principles for Evaluation of Development Assistance and later defined in the Glossary of Key Terms in Evaluation and Results Based Management. The following further explains the criteria and provides some sample questions to illustrate how they may be used in practice:

Relevance

The extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor.

In evaluating the relevance of a programme or a project, it is useful to consider the following questions:

- To what extent are the objectives of the programme still valid?
- Are the activities and outputs of the programme consistent with the overall goal and the attainment of its objectives?
- Are the activities and outputs of the programme consistent with the intended impacts and effects?

Effectiveness

A measure of the extent to which an aid activity attains its objectives.

In evaluating the effectiveness of a programme or a project, it is useful to consider the following questions:

- To what extent were the objectives achieved/are likely to be achieved?
- What were the major factors influencing the achievement or non-achievement of the objectives?

Efficiency

Efficiency measures the outputs – qualitative and quantitative – in relation to the inputs. It is an economic term which signifies that the aid uses the least costly resources possible in order to achieve the desired results. This generally requires comparing alternative approaches to achieving the same outputs, to see whether the most efficient process has been adopted.

When evaluating the efficiency of a programme or a project, it is useful to consider the following questions:

- Were activities cost-efficient?
- Were objectives achieved on time?
- Was the programme or project implemented in the most efficient way compared to alternatives?

Impact

The positive and negative changes produced by a development intervention, directly or indirectly, intended or unintended. This involves the main impacts and effects resulting from the activity on the local social, economic, environmental and other development indicators. The examination should be concerned with both intended and unintended results and must also include the positive and negative impact of external factors, such as changes in terms of trade and financial conditions.

When evaluating the impact of a programme or a project, it is useful to consider the following questions:

- What has happened as a result of the programme or project?
- What real difference has the activity made to the beneficiaries?
- How many people have been affected?

Sustainability

Sustainability is concerned with measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn. Projects need to be environmentally as well as financially sustainable.

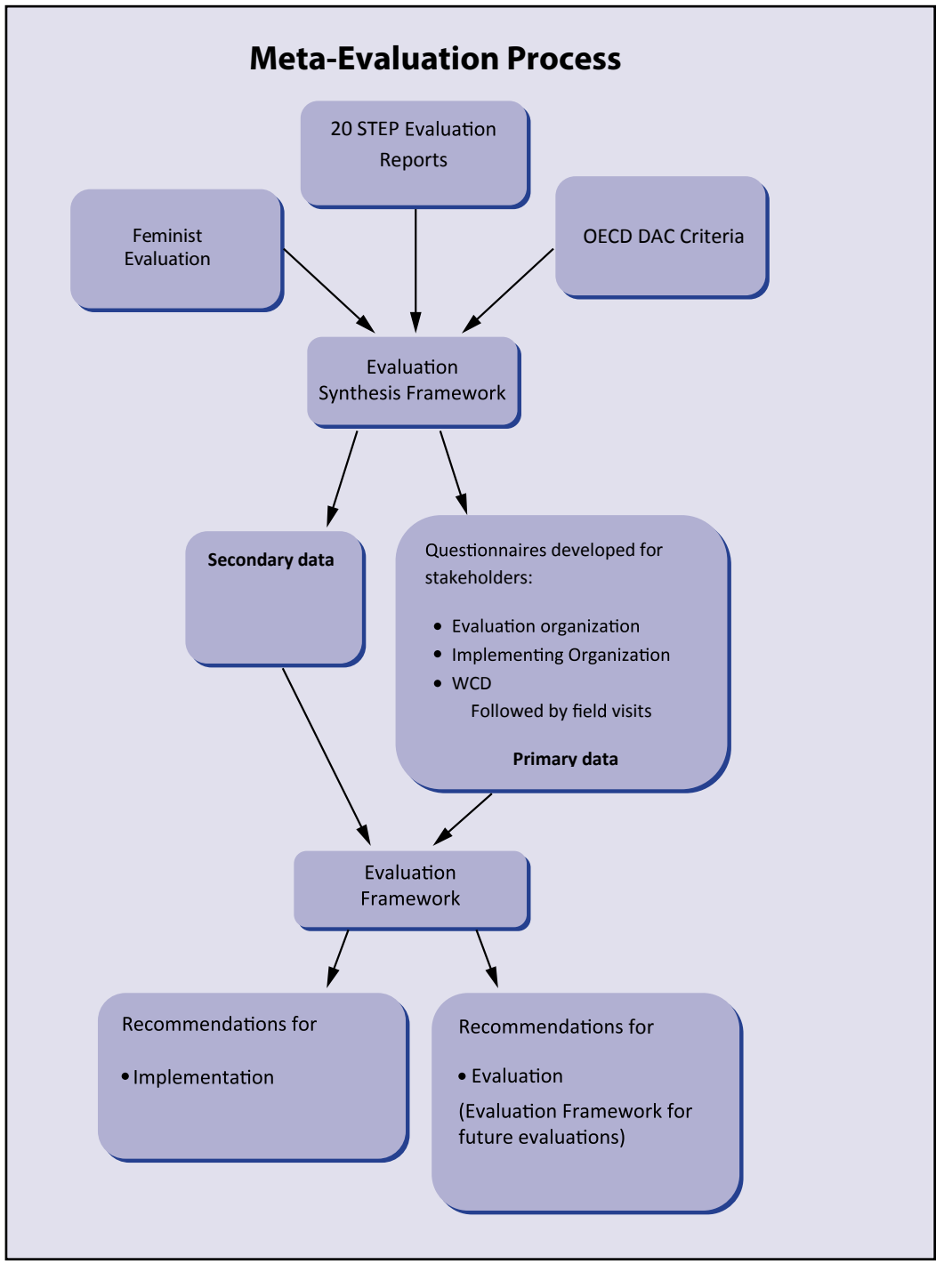
When evaluating the sustainability of a programme or a project, it is useful to consider the following questions:

- To what extent did the benefits of a programme or project continue after donor funding ceased?
- What were the major factors which influenced the achievement or non-achievement of sustainability of the programme or project?

Sources: The DAC Principles for the Evaluation of Development Assistance, OECD (1991), Glossary of Terms Used in Evaluation, in 'Methods and Procedures in Aid Evaluation', OECD (1986), and the Glossary of Evaluation and Results Based Management (RBM) Terms, OECD (2000).

Further, this study uses a synthesis approach, seeking to provide evidence by synthesizing information from the evaluation reports, on what works in the evaluations and why. This approach also allowed us to analyse implications for the implementation of STEP. In order to synthesize the evaluation reports, we developed an evaluation synthesis framework using the criteria for evaluations developed by the Development Assistance Committee (DAC) of the Organization for Economic Co-operation and Development (OECD).

The purpose of using DAC criteria for assessing the evaluation reports was to assess whether the evaluations themselves addressed issues raised by the DAC criteria, and if so, how they were dealt with by the evaluation reports. In order to also analyse the question of the research process of the evaluations, which are not necessarily covered by the DAC criteria, we also included in the evaluation synthesis framework specific questions on this. Along with this, the study also felt it necessary to examine the important subject of the utilization of the evaluations.


Meta-Evaluation Process
20 STEP Evaluation Reports
Feminist Evaluation
OECD DAC Criteria
Evaluation Synthesis Framework
Secondary data
Questionnaires developed for stakeholders:
• Evaluation organization
• Implementing Organization
• WCD
Followed by field visits
Primary data
Evaluation Framework
Recommendations for
• Implementation
Recommendations for
• Evaluation
(Evaluation Framework for future evaluations)

This broad evaluation framework which included DAC criteria, and questions on research process and utilisation of evaluations allowed us to systematically synthesise the reports, not to judge whether every criteria was addressed, but to get a sense of whether and also how evaluation reports addressed questions raised by the criteria. The evaluation framework was used as basic guideline for this study. Secondary sources of data were used in developing this framework and also to develop the questionnaire for the primary data.

Both secondary and primary data collected for the study were later synthesized and amalgamated for this meta-evaluation. The process of development of the evaluation framework was therefore an ongoing process which allowed us to iteratively develop the framework by adding to and changing the questions for evaluating STEP from a gender responsive lens. This process served the dual purpose of synthesizing our findings and producing a framework that could serve as a guideline for future evaluations.

Another important methodology of this study is the use of feminist principles in analyzing the gendered impact of STEP. The present study draws not only on evaluation theory but also on feminist evaluation principles (see Podems 2010, Hay 2010, Hay and Sudarshan 2012, Batliwala and Pitman 2010). 'Feminist evaluation' is a term used to describe an approach to evaluation that exposes and looks critically at gender and other sources of inequity. Feminist evaluation is grounded in the understanding that discrimination or inequality based on gender is systematic and structural, that evaluation is a political activity, that knowledge is a powerful resource that serves an explicit or implicit purpose, that knowledge and values are culturally, socially, and temporally contingent, and that there are multiple ways of knowing – some privileged over others (Sielbeck-Bowen, Brisolara, Seigart, Tischler, and Whitmore, 2002).

STEP aims to empower women by enabling them to take up employment cum income generation activities. It is based on the recognition of structural gendered inequalities in society. It is further based on an understanding that enabling women to be self-sufficient is a means of women's empowerment. Evaluating such a scheme requires a perspective that also recognizes structural gendered inequalities and that is sensitive to the complex processes of women's empowerment.

Feminist evaluation is an approach to evaluation that places emphasis on reflexivity, participatory and inclusive methods. This is also informed by an ethical sense in evaluation design, data collection and use and can be characterized by the following broad principles (Hay 2010):

- Feminist evaluation has a central focus on inequalities and recognises that discrimination or inequality based on gender is systemic and structural – this informs evaluation questions and evaluation design.
- Evaluation is a political activity; the contexts in which evaluation operates are politicized; and the personal experiences, perspectives and characteristics evaluators bring to evaluations lead to a particular political stance; this will impact judgments
- Knowledge is a powerful resource that should be a resource of and for the people who create, hold, and share it. Consequently, the evaluation or research process can lead to significant negative or positive effects on the people involved in the evaluation/research.
- There are multiple ways of knowing; it is important for evaluations to recognize and value different ways of knowing

Each of these principles has informed our own evaluation methodology, even as we sought an understanding of these in the evaluation studies that we analysed. For instance, the central focus on inequalities that informs feminist evaluation allowed for us to probe whether the evaluation assessed if the relevant beneficiaries were targeted. Further, a recognition that discrimination based on gender is systemic allowed us to probe whether the evaluations assessed the effectiveness of the projects in terms of the double burden that women face which enhances their time poverty, and their drudgery. Similarly, the cultural restrictions on mobility allowed us to assess whether the evaluations focused on accessibility to training spaces, production centres, markets for women.

As a result of the methodology we have employed, as well as the findings of our research, we have produced an evaluation framework (appended to this report), which we hope will serve as a useful guide for future gender responsive evaluations of STEP.

A Brief Overview of STEP: State, Sectors and Beneficiaries

Since STEP was launched in 1986, a total of 241 projects were approved by the ministry till March 2010. However, when one examines the number of projects approved in various sectors, it can be seen that most of the projects are concentrated in a few sectors. Among all the STEP projects approved till March 2010, 97 projects (40.25%) were in the dairy sector. The next big chunk after dairy is animal husbandry. A total of 47 animal husbandry projects (19.5%) were approved in this period. Around 16 per cent of the projects were in the domain of handicrafts trades during this period, whereas around eight per cent projects were in the handloom sector. The sectors, which did not find as much support from STEP in this period are agriculture

and social forestry (5%), khadi (3.7%), sericulture (3.3%), fisheries (2.5%) and wasteland development (1.2%). However, social forestry sector and wasteland land development sector became part of the traditional sectors only in 2009. See Annexure I for the detailed distribution of STEP projects across the states and the sectors.

Since its inception till 2010 STEP projects have provided training to more than 8 lakh and 30 thousand women across various sectors. However, among the trainees, almost 6 lakh women were trained in a single sector, that is dairy. The trainees in the dairy sector constitute around 72 per cent of the total trainees. Consequently, the dairy sector had the major share as far as the government grant is concerned. Till March 2010, the government released almost 200 crores of rupees for the dairy sector under STEP programme. The next two large sectors in terms of number of trainees are the animal husbandry sector (6.73 %) and the handicrafts sector (6.1%).

Table: Number of Trainees and total cost and release of grants across the sectors

Sector	No of Trainees	Total Cost (Rs. in lakhs)	Govt. Share (Rs. in lakhs)	Amount Released (Rs. in lakhs)	percentage of total cost released	percentage of government share released
Agriculture	19550	1511.55	1043.61	918.88	60.79	88.05
Animal Husbandry	55950	2920.26	2536.52	1662.78	56.94	65.55
Dairy	595590	30035.33	26060.94	19623.29	65.33	75.30
Fisheries	6740	552.79	495.67	346.82	62.74	69.97
Handicrafts	50701	3692.33	3074.15	2451.96	66.41	79.76
Handloom	45250	3155.12	3194.67	2708.01	85.83	84.77
Khadi	21500	1252.87	958.43	864.90	69.03	90.24
Sericulture	33000	2419.79	1863.37	1753.35	72.46	94.10
Vermicompost	2600	35.14	20.99	14.86	42.29	70.80
All Sectors	**830881**	**45575.18**	**39248.35**	**30344.85**	**66.58**	**77.31**

Under Dairy projects, a single project provided training to 6,140 women on average under the scheme. In terms of scale, the dairy projects are much larger than any other sectors. However, there are few instances, where a large group of women were provided training under the programme in other sectors.

If one looks at the government share in the project vis-à-vis the number of beneficiaries in the sector, it shows that economy of scale plays a dominant role. Data indicates that per person

expenditure in the sectors like handicrafts, handloom and sericulture is much higher than the dairy sector. As per our analysis, based on the data provided in the ministry's portal in current price, the actual expenditure of government per trainees in the dairy sector is roughly around Rs. 3300. Whereas the actual expenditure per trainee in handloom sector is Rs. 6000, for handicraft sector it is roughly around Rs. 4850 and in sericulture sector, it is around Rs. 5320.

Table: Percentage Distribution of Trainees by major trades, total cost, govt. share and amount released

Sector	Trainees	Total Cost	Government Share	Actual Released
Agriculture	2.35	3.32	2.66	3.03
Animal Husbandry	6.73	6.41	6.46	5.48
Dairy	71.68	65.90	66.40	64.67
Fisheries	0.81	1.21	1.26	1.14
Handicrafts	6.10	8.10	7.83	8.08
Handloom	5.45	6.92	8.14	8.92
Khadi	2.59	2.75	2.44	2.85
Sericulture	3.97	5.31	4.75	5.78
Vermicompost	0.31	0.08	0.05	0.05
All Sectors	**100.00**	**100.00**	**100.00**	**100.00**

Source: calculated on the basis of data provided by the web portal of Ministry of Women and Child Development, Govt. of India at http://wcd.nic.in/

From its inception, dairy projects have taken centrestage in the STEP programme launched by the Women and Child Development department. Along with dairy projects, a few other trades that have been granted STEP support across regions are animal husbandry, handicrafts and handloom trades. State milk federations have a longer history than STEP which meant that they already had a developed infrastructure in terms of technical inputs to the beneficiaries and also a well established marketing strategy. The state milk federations could also reach remote villages to form women's cooperatives. That might be one reason for diary projects taking centrestage in the entire STEP programme. However, it has also been found that the size of the projects under the dairy sectors are generally larger and this economy of scale could actually bring down the cost of training and marketing. Having said this, there is a need to bring forward some of the sectors which could be locally relevant in terms of geographical and social feasibility.

Findings of the Meta-Evaluation study

This chapter sets out the findings of the report based on a synthesis of the sample of evaluation reports combined with the information obtained from fieldwork. A key aspect as elucidated in the methodology section, is the gender responsive nature of the lens employed in the design of the evaluation framework for conducting this research, and in the conduct of the fieldwork. This has allowed us to locate the different approaches used by evaluating agencies (EAs) in evaluating STEP, in particular those that throw light on the gendered effects of STEP. Drawing on the approaches of the evaluating agencies, along with the OECD DAC criteria, the report locates the innovations in the approaches already employed by EAs as well as the gaps in the approaches that need to be filled for evaluations to more fully ascertain the gendered impacts of STEP.

This chapter also identifies, through a synthesis of the various evaluations, the recurring themes in the evaluations of STEP projects that identify both what has worked as well as the challenges faced in the implementation of STEP, and what lessons there may be for STEP programme design and implementation. Further it also locates the important dimensions of the framework and process through which STEP evaluations are conducted, as well as the utilization of STEP evaluations (and how this maybe better facilitated) based on field research with key stakeholders.

The chapter is structured as follows:

I. Criteria employed to evaluate STEP
II. Evaluation process
III. Utilization of evaluation findings, and
IV. Implications for STEP programme design and implementation

I. Criteria employed in evaluating STEP

STEP clearly aims the programme at marginalized, asset-less rural and urban poor women. This includes wage labourers, unpaid daily workers, female-headed households, migrant labourers, tribal and other dispossessed groups. with a special focus on SC/ST households, and families below the poverty line (see MWCD website). Usually in a meta-evaluation, an assessment of the criteria employed is made on the basis of an evaluation checklist (see Olsen and O'Reilly 2011). In this study, the evaluation checklist is based on the OECD-DAC criteria viz. relevance, effectiveness, efficiency, sustainability, and impact, along with the additional criteria of research process and utilisation of evaluations.

1. Relevance

In this section, the report examines the criteria of 'relevance' as one of the important ways of evaluating the implementation of STEP. This section locates the various approaches of the

evaluating agencies in identifying whether the implementation of STEP has been targeted at the right beneficiaries through both a gender responsive lens and the OECD DAC criteria. It also locates the process of selection of beneficiaries as an important component of properly targeting the right beneficiaries and also assessing the economic and geographical suitability of the project in order to study how relevant the intervention has been.

a. Economic and Geographical suitability of the project

The economic and geographical suitability of the project forms the basis of the start of any project, therefore how the evaluations address it is a question to be examined. The STEP programme expects at the project formulation stage that the implementing agency (IA) undertake an analysis of the sector to ascertain the socio-economic status and role of women in that sector (see MWCD website).

The majority of evaluations under study did not always assess the geographical and economic suitability together. Most evaluations however, assessed the economic viability of the projects. For example for most of the projects under dairy sector, the economic viability has been assessed by Evaluating Agencies (EAs) as there was already a set up in existence in the form of milk cooperatives, milk unions and federations. Similarly for the handicrafts sector projects, EAs locate the traditional activity of handicrafts in the states. In the few evaluations that did assess geographical suitability, this was done through assessing the advantages of infrastructure as well as forward and backward linkages (including availability of raw materials and labour). Similarly, another method of assessing geographical suitability that we found in our sample evaluations in the agricultural sector was to assess the suitability of soil and climate to grow the produce.

b. Relevance of beneficiaries selected

This is one of the most important components for assessing relevance, and all evaluations, bar two, assessed this in one way or the other. Where it was assessed, there was however, no consistency in the ways in which this was done. Most evaluations assessed whether the IAs identified 'poor women' as the target group. Many evaluations also examined whether SC/ST women were targeted by the IA. However, there were fewer evaluations that examined the reach of the IA amongst minority women and female-headed households.

The importance of assessing whether the intended beneficiaries of STEP were targeted is a fundamental aspect of the effective implementation of STEP. In order to properly assess this, the benchmark survey has to provide adequate information about the socio-economic profiles of the target group in order to assess whether the right beneficiaries were identified.

c. Process of selection of beneficiaries

Although most evaluations assess the relevance of the implementation of the projects based on who is identified as beneficiaries, not all evaluations assess the process of identification and selection. Where this was assessed, there were some interesting insights to be obtained. For instance, in some projects, village/district level council and committees were formed to select the beneficiaries. In one project, it was observed that the selection of beneficiaries was made by the IA with the help of elected representatives of village panchayats and in this instance no village level committee was formed for the selection of beneficiaries.

The majority of evaluations identified that the beneficiaries were selected by the IA alone after detailed door to door survey of the area and that they were also chosen through references from various sources like local leaders, other NGOs etc. In one of the projects, the evaluation found that the selection of beneficiaries was made by 9 partnering NGOs who had no financial stake in the project. In the case of dairy projects, possession of animals and willingness of the beneficiaries was found to be an important criteria, although this was not necessarily part of the STEP criteria. Similarly, for another project, selection of beneficiaries was also based on whether the beneficiary was an active member of SHG and whether she has a regular savings and a credit habit. In one of the handicrafts projects, beneficiaries were selected from those weavers who were ready to devote at least 26 days per month to weaving/handicrafts activities.

What is quite clear is that examining the process of selection of beneficiaries is an important component in any assessment of relevance.

Conclusion and Recommendation: That there is no common process of selection of beneficiaries comes out of the analysis. A more comprehensive approach or process may help in selection of right beneficiaries. Special attention should be paid to pre-project activities including the conduct of benchmark survey which is an essential pre-requisite for every project and helps in developing a data base for the assessment of the project performance over time. A meticulously conducted benchmark survey can generate valuable information on the women employed in the unorganized sector besides helping in identification of beneficiaries for the project.

2. Effectiveness

In this section, the report examines the criteria of 'effectiveness' as one of the important ways of evaluating the implementation of STEP. This section locates the various approaches of the evaluating agencies in identifying whether the implementation of STEP has been effective through both a gender responsive lens and the OECD DAC criteria. Since STEP has several

components for the delivery of the scheme, these components will be individually examined in this section to evaluate whether EAs have addressed these components and if so how, and whether there are any lessons to be learnt for a gender responsive approach to evaluating STEP.

STEP aims to make a significant impact on women in the traditional sector by doing the following: upgrading skills, mobilizing women in viable groups, arranging for productive assets, creating backward and forward linkages (including providing access to credit) and arranging for support services (see the details of the STEP scheme, MWCD website).

In order to assess whether and how EAs have evaluated each of these components, each of the components will be taken in turn.

a. Upgradation of skills through training

The upgradation of skills through training is at the heart of STEP, and this component has been evaluated by all EAs in one way or another. Some have examined the number of beneficiaries that have attended the training, the details of the training provided, as well as the expected outcomes of the trainings. In order to assess the gamut of issues that may arise in the upgradation of skills through training, this study breaks down the training component to ask whether the EAs addressed the following further questions. These are by no means exhaustive, and several of them are drawn from the evaluation reports. We will look at each to examine how and whether the EAs addressed the question, and also why it is important to address these in order to effectively evaluate the implementation of STEP.

(i) Was training provided on the technical skill training in the sector, skills of group formation, entrepreneurship marketing, and wider awareness of the beneficiaries' rights, particularly gender sensitization and awareness, legal literacy and conscientisation?

This question is crucial to evaluating whether the training adhered to the requirements of STEP. It allows for an EA to assess whether each and every component of the requisite training was given adequate attention by the IA in order to provide an effective base for achieving the objectives of STEP. It also allows for an assessment of which aspect of the training actually resulted in enhancement of skills. For instance in an evaluation conducted in the handlooms and handicrafts sector, the EA was able to identify the enhancement of skills amongst the women based on the components of training that were provided. Therefore, they identified the levels of skill enhancement amongst the women in terms of SHG formation, marketing, and article manufacturing. In a mushroom cultivation project on the other hand, the EA was able to assess that the training given on marketing was inadequate, which then provided insights into one of the challenges in achieving the goals of STEP for the project.

Breaking down the components of training and asking questions of the syllabus also puts in focus the important component of gender awareness and sensitization. As STEP aims to not only impart training for the upgradation of skills to enhance the income and employment opportunities of the beneficiaries, but also a package of services consisting of health check up, nutrition, non-formal education, legal literacy education, mobile crèches, gender sensitization and gender awareness, (see the details of the STEP scheme, MWCD website), the component of gender sensitization and awareness is a crucial one for the effective empowerment of women. In an evaluation of an animal husbandry project for instance, the EA was able to note the absence of the gender awareness and sensitization component. Moreover, examining the component of gender awareness and sensitization as an integral aspect of the training also allows for an examination of whether such training was effective and how one may assess the same.

While the effectiveness of the training component on skills enhancement, marketing, formation of SHGs etc., can be assessed by examining various other indicators (for instance, change in employment, increase in income, formation of SHGs etc.,), the component of gender awareness and sensitization, legal literacy, etc. require the use of other empowerment indicators, which are more difficult to attribute, but which are nonetheless crucial to assess. In the evaluation of a project on handicrafts for instance, the EA found it useful to address whether the project had increased the confidence level of the beneficiaries, their decision-making power and their control over resources in the family and in the community by creating effective leadership and social awareness among the beneficiaries Similarly, in an animal husbandry project, the EA also examined the participation of the women in public meetings, and even whether they were able to give suggestions to family members. An evaluation conducted in the handicraft sector also examined the percentage of girls sent to school as an indicator of the extent of impact of the gender awareness training.

In our interviews with one of the key stakeholder EAs, the importance of assessing whether the trainings were contextualized to the sector and catered specifically to the needs of the women was also emphasized. The argument made by the EA was that the trainings would not be effective otherwise, and that women would just remain recipients of STEP. In order to empower the women, the trainings had to be linked to their lives. Further, the trainings had to cater to the functional requirements of the women. It was recommended that the legal training not be limited to awareness of legal rights but should also address functional and transactional legal literacy in the particular context of the sector, for instance to know what happens in the case of non-repayment of loans, or to sectorally specific issues such as what happens if the milk produced is not safe.

Conclusion and Recommendation: All components of the training (including technical training on sector specific skills, SHG and cooperative formation, accessing credit, marketing, gender awareness and sensitization, legal literacy, etc.) have to be delineated and assessed for effectiveness. It also has to be assessed whether the training provided is context, sector and need specific. The important component of gender awareness and sensitization should be assessed through the use of indicators such as levels of confidence, mobility, decision-making and control over resources at the household level, and participation in public fora and politics.

(ii) Were the trainers properly trained?

This question allows the evaluation to evaluate the quality of the training provided. From the evaluations assessed, it is clear that satisfaction levels of the beneficiaries on the training obtained by them is based on the trainer's technical abilities as well as their ability to impart training on other non-technical areas too.

(iii) Was time spent on training adequate?

This question was not consistently asked by all EAs. When this question was asked by EAs, it provided several insights. In the handicrafts and handloom sector, for instance, it was noticed by the EA that a four month period of training to develop various skills was too short. Similarly, again in the handicrafts and handloom sector, it was felt by the EA that a period of three months was insufficient for women to learn the trade and successfully integrate themselves into the market. Again, in a project on mushroom cultivation, it was considered that a period of three months training was not sufficient and that a continuous training effort should be made in order to supervise women's efforts for 2-3 seasons.

(iv) Were raw materials provided by IA during training?

One of the important components of STEP is the provision of financial assistance to the IA for working capital and raw materials in a phased manner starting with 100% in the first year, lessening to 50% in the second year and 30% in the third year (see MWCD website). Backward and forward linkages are an integral part of effectively implementing STEP, and the provision of raw materials is an important component of the backward linkages. In this context, it is essential for the EA to assess and expand on whether this was provided during training, and whether there was continued assistance in the second two years of the project, as well as whether sustainability options were built into the implementation of the project. Although most evaluations examine

the question of whether raw materials were provided, there is no consistent information across the reports of whether there was continued assistance by the IA in this regard.

(v) Was time set for conducting training sensitive to the needs of women? In terms of season as well as time of day?

One of the important ways in which the implementation of STEP can be feminist is to be attentive to the needs of women. One of the consistent findings of feminist research has been the constraints of time, or the time poverty that women face given their role in social reproduction as well as the dual burden of responsibilities that they bear. This is particularly true of poor women who are the target beneficiaries of STEP. It is therefore important that the evaluations assess whether the trainings are provided to women at a time that is suitable to them, and that does not in fact increase their dual burden. While some of the evaluations have assessed the number of hours a day that the trainings are provided, none of the evaluations assess whether the trainings are provided at a time convenient to the women.

In our fieldwork with one of the implementing agencies, how IAs cater to the particular requirements of women was clearly brought out. The training hours for one of the projects were scheduled from 12 pm to 3 pm so that the beneficiaries could send their children to school in the morning and come back home by 3 pm to resume their household responsibilities. Lunch was also provided to the trainee women. There are other cultural constraints for IAs to overcome to engage women in STEP. For instance, again in our fieldwork, the women beneficiaries belonged to traditional families and many of them had never ventured out of home because of the *ghoonghat* system. The IAs had to slowly convince them through meetings about the benefits of engagement in STEP.

(vi) Were there crèche facilities at training site? Were the facilities used?

One of the important ways in which a programme is made gender responsive is to provide support for the childcare responsibilities that women disproportionately bear in our society. Recognizing this, STEP in its programme design and in the funding it provides has built in the component of nutrition and crèche facilities for dependent children. This is usually done through a convergence between various government departments (for more on this, see below). While this is important to assess separately, it is also important to assess in the effectiveness of the delivery of the training programme whether childcare facilities were provided during training as well. There are very few amongst the sample evaluation reports that assess the provision of childcare facilities, and where they are assessed, it is clear that they fulfill a felt need.

(vii) Is the training venue conveniently located for the women? If not, does the IA provide support for the mobility of women?

The question of the location of the training facility is another aspect that speaks of how gender sensitive the delivery of the project is. In the diary sector for instance, as one of the evaluations pointed out, the diary management training was field oriented which meant that some of the family members of the beneficiaries were not willing to send them for training. Similarly, the same evaluation pointed out that the lack of proximity of the training centre was a constraint, especially for members from different districts. However, in our interviews with one of the key stakeholder evaluating agencies, it was pointed out that this could be considered a positive aspect of the project as it enabled mobility, as our respondent put, 'for one month's training, a woman has to stay away from home as it is a residential programme'. Whatever the findings on the proximity or lack thereof, it is quite clear that asking the question provides insights on the processes of women's empowerment which would not be available otherwise.

Conclusion and Recommendation: Evaluations have to recognize the dual responsibilities that women shoulder and the time poverty that this entails. The location of the training centre, the provision of childcare at the training centre as well as the times at which training is provided are all important indicators of the gender responsive nature of the project implementation. Moreover, recognition of the cultural contexts of women allows for an evaluation of the constraints in the implementation of STEP.

(viii) How many women experienced an increase in their level of skills? And to what extent?

One of the key indicators of the success of the training programmes of each STEP project is an assessment of the enhancement of skills of the beneficiaries. This is a subject that most of the evaluations address, and it is an important indicator of the success of several of the above listed factors on which it is dependent. An assessment of the enhancement of skills by the beneficiaries also provides insights into the challenges faced in the implementation of STEP. So for instance in an agricultural project, while the beneficiaries were assessed to be satisfied with the training, it was also found that 30% of the saplings were not properly planted and maintained, indicating that more training was required by the beneficiaries.

b. Employment generation/occupational mobility

Employment generation is one of the core purposes of STEP, and this is an issue that most evaluations address, but which only a few address in depth. This is a key indicator of the success of the training and ancillary inputs. While most of the evaluations address the changes in employment through occupational mobility or through employment generation, the extent

of the changes, or the effects of the changes on their levels of work, or even whether their new employments are valued by themselves and their households are not assessed by all evaluations.

(i) Has there been a change in employment? If so, for how many women? If not, why not?

Many of the reports indicate that there has been employment generation/change of occupation as a result of the intervention. Only a few evaluations however, chart the extent of the change in occupation or generation of employment. This is important in order to assess the depth of the changes in employment. Moreover, it is also important to track why there has not been a change in employment. For instance in one of the mid-term evaluations of the agriculture sector, it was clearly indicated that there was no employment generation because the time span for producing yield was longer than when the evaluation was conducted in the project cycle. This was re-affirmed through our interviews with one of the key stakeholder IAs.

(ii) How many hours are spent on employment on average?

A few of the evaluations characterize the beneficiaries as housewives and 'not engaged in any economic activity'. Some of the evaluations recognize that the women were already working – in household activities. Some note a change from household work to the occupation in which they obtained training. It is unclear from these reports whether women continue to perform household work (burdening themselves some more with the new occupation, albeit with benefits).

As mentioned earlier, women are disproportionately involved in social reproduction, and the burdens on poor women are particularly heavy. It is important to recognize that most of the women (given their profiles) were already working- even though that work was largely unrecognized, unpaid and time-consuming. This recognition allows for a fuller evaluation of the effects of the new employments/changes in occupation on women. As one evaluation report put it, 'an attempt has been made to see whether [the sector] has brought economic empowerment to women and reduced their drudgery or at least not enhanced their workload'. Tracking the time spent on work (both paid and unpaid) is a good indicator of the quality of life enjoyed by the women.

One of the interesting ways of assessing time spent on work comes from an evaluation report on the handicraft sector. It tracks the number of hours devoted to production before, during and after the project. Prior to the project the largest percentage of women were the ones who spent no time on production. After the project, the largest percentage of women was the ones who spent less than 5 hours on production. What was interesting to note was that the percentage of women who spent more than 8 hours on production remained virtually unchanged both

prior to and after the project. While it is clear from this picture that more women were engaged in employment even if it was for only a few hours of the day, it could also be indicative of the constraints on women's time. In any case, tracking the time women spend on production across a time span is a useful means of assessing the effects of employment.

(iii)Is the employment valued by the women and the household?

An evaluation report in the animal husbandry sector profiles cases to assess the effectiveness of the intervention. It examines narratives of transformation in the life stories of the beneficiaries to indicate the ways in which the employment (and the income generated) is of value to the women and their households, including stories in which women are now the sole responsible earners of the household, taking care of the needs of their families. In another evaluation report one woman was able to leave a violent husband because of the security that the employment provided. Further, in one of the evaluation reports, the EA tracked a quantitative response to the question of whether there was a change in attitude among the family members regarding the work of women after the training, which solicited an above 47% positive response. Clearly, this is an important means of assessing the importance of the employment to the women and to the household, as well as the effectiveness of the STEP project.

Conclusion and Recommendation: Women are disproportionately involved in social reproduction, and the burden of work on poor women is particularly heavy. A recognition that women perform largely unrecognized, unpaid and time consuming work allows for a fuller evaluation of the effects of the new employments/changes in occupation on women. One of the ways in which to assess this is to examine the number of hours spent on paid and unpaid work by women.

(iv) Is there adequate space provided for production/work sheds/employment activities?

One of the features of STEP is to provide support for training cum production centres, as well as to give 50% assistance for the construction of individual work sheds and production centres not related with training. Having a space to work is an essential component of actualizing the employment generation potential of STEP. Most of the evaluations assessed whether such a space was provided or available for the women to carry on employment. It allows for an assessment of the effects as well as the constraints in the implementation of STEP. For instance, in one of the evaluations of the handicrafts and handloom sector, the EA pointed out that the majority of the beneficiaries complained about the lack of a common work shed. Similarly in a couple of the diary projects, the EAs identified that the beneficiaries limited

themselves to maintaining one animal only for the lack of space and manpower. In another of the diary projects, only 60% had adequate space to carry out activities and the remaining faced difficulties in storing the equipment and furniture.

All of these instances further highlight the importance of the EA assessing the adequacy and quality of the space provided.

c. Income generation

One of the major concerns of STEP is to raise the standard of living of the women and their families through the generation of additional income from the project's economic activities. This, it is expected, will enable the beneficiary women and their families to rise above the poverty line (see the MWCD website). Income generation therefore, is a key goal of the STEP programme, and all but one of the evaluations addressed this question. However, whether or not income has increased does not give an indication of the rate of increase or even whether such a rise adequately improved the standard of living of the women. While most evaluations mentioned the increase in the income levels of the beneficiaries, only a few actually examined the rate of increase. Furthermore, many evaluations did not also assess the value or the materiality of the income for the women as well as for their households, which is an important qualitative indicator of the effects of STEP.

(i) Has there been an increase in income for the women? If so, what was the rate of increase, and for how many women?

As mentioned earlier, it is insufficient to assess whether the women beneficiaries are receiving an income as a result of the employment generated by STEP. An evaluation of the increase in income has to also include the margins of the increase in the incomes of the women beneficiaries, as well as how many women experienced such increase, as these are better indicators of the effects of the project on the lives of women. Where the EAs did examine this, they were able to assess whether this increase was marginal or substantial, providing a glimpse into whether the income was a viable source of support for the women. Moreover, by assessing the numbers who experienced changes in income, the depth of the effect of the STEP intervention could also be assessed. For instance, in an evaluation conducted in the handicrafts and handloom sector, the majority of women had no income before the start of the project but as a result of the STEP intervention there was a huge jump in the number of women earnings up to Rs 1000. What was interesting to note was that there was also an increase in the number of women who earned between Rs 1000-2000, though this was not as substantial. However, significantly, nobody earned more than Rs 2000, which was the case prior to the intervention of STEP as well. This is a good indicator both of the positive effects as well

as the limits of the particular intervention. In any case, it is indicative of the importance of tracking the increases of incomes in order to ascertain the effectiveness of STEP projects.

(ii) Is the income valued/or of material significance to the women and the household?

If one of the aims of STEP is to lift women beneficiaries and their households out of poverty and to provide them with a better quality of life, then the materiality of the increase in the income, as well as the value of the income earned by women as perceived by themselves and their households is also important to assess. The narratives of the evaluation report on animal husbandry mentioned in the employment section (above) which indicated the transformatory power of the employment in the women's lives as well as the lives of their households are important to remember here. However, it is also important to know what the average incomes in the area are to analyse whether the increase in the rates of income of the women genuinely offer a better quality of life in comparison to others.

Conclusion and Recommendation: One of the most important indicators of the effectiveness of STEP is the increase in income of the women beneficiaries. However, in order to more fully grasp the effectiveness of STEP, the evaluations should also examine the rate of increase (whether this was marginal, significant, substantial), and for how many women.

d. Formation of collectives

One of the processes which STEP envisages as essential to providing and sustaining employment for women is the mobilization and organizing of women through collectives. To this end, STEP provides funding support to IAs for the formation of cooperative societies, producer/worker cooperatives leading to formal organizations. The idea of mobilizing women in collectives is to develop the group to thrive on a self-sustaining basis in the market place with minimal government support and intervention after the project period is over (see the MWCD website). All of the evaluations examine the formation of collectives through an a close study of the formation of Self Help Groups (SHGs). Some of the evaluations, particularly of the diary sector also evaluate collectivization through cooperatives. While many of the evaluations examine the numbers of SHGs/cooperatives and whether or not inter-lending has commenced, not all of them assess whether the SHGs/cooperatives continue to be active and whether they conduct economic activity beyond inter-lending. This is an important component of the sustainability of employment generation commenced by STEP programmes, and it needs to be evaluated, even if it is to assess the challenges of sustaining the effects of STEP.

(i) Were SHGs/cooperatives set up? If so, how many and of how many women?

Questioning whether SHGs/cooperatives were set up, as well as assessing how many were set up and of how many women throws up many interesting insights – from the evaluation synthesis, an insight that the diary sector is the most sophisticated in this regard with well developed self help groups in large numbers, as well as women's diary cooperatives. The SHG formation, or collectivization in other sectors such as fisheries, which did not have such a large target group, was not as robust.

The collectivization of women also provides insights into the processes of women's empowerment. As the evaluation of a diary sector project noted, women's bargaining power as a member of the society was enhanced and importantly it was also observed that their access and control over the resources of the household and community had strengthened.

(ii) How many SHGs/cooperatives are active and conduct economic activity?

Not all the evaluations examine how active the SHGs were or whether they conducted economic activity beyond inter-lending. In an evaluation of an animal husbandry project, it was observed that women from the same group were working together, in the house of a member, or in a common work shed. The group leader was maintaining a book where the records were being kept on the items such as amount of raw materials distributed to each member, work hours put in by each of them, the wage income due to them etc.; although savings had been started, there was no inter-lending yet or repayment of loans. Because of this, the group had difficulty in availing loans from banks to set up their own business. This is valuable information to assess the constraints in the implementation of STEP.

In the diary sector, for some of the long standing STEP projects, a different picture emerges of a well structured system of women's development cooperatives which are expected to operate as local business enterprises.

Conclusion and Recommendation: Collectivisation through SHGs and co-operatives is one of the key processes that STEP envisages for the programmes sustainability. It is not sufficient for evaluations to assess the numbers of SHGs and cooperatives, but to also assess whether they are active, and conduct economic activity beyond inter-lending.

e. Access to Credit/Bank linkages

Support for backward linkages, as mentioned earlier is an important component of the implementation of STEP. Of this, access to credit/bank linkages is an integral part. The IA is expected to help in tying up credit facilities after the project is over (see MWCD website).

In this context, asking whether the women have access to credit/bank linkages as most of the evaluations do is an important method of assessing the effectiveness of STEP. Asking this question yields useful insights, for instance, in the evaluation of a handicrafts and handlooms project, it was found that several SHGs had taken loans from the banks for raw materials and one had also managed to avail of a subsidy from the bank. Other projects of the handloom and handicrafts sector were not so successful, and in fact the women beneficiaries of these other projects could not access credit/bank linkages at all. Assessing the reasons why it is possible for some projects to assess credit linkages whereas it is not so easy for others requires evaluating agencies to provide more information on the processes involved in obtaining credit.

Robust cooperatives which have subsidized access to margin money through the milk unions in the diary sector provide glimpses of the functioning of well oiled and supported institutions which in turn seem to facilitate the access to credit/bank linkages. How and whether this can and should be replicated across sectors and in smaller projects is a difficult question to answer without more rigorous information.

f. Market linkages/Access to markets

Apart from the training to be provided by IAs on marketing, it is also expected that the IA help in ensuring proper marketing and tie-ups for marketing of the produce during the project period and help the groups of women under these projects to manage marketing activities once the project is over. The scheme expects the women's groups to not be wholly captive to government corporations for marketing their products in the interests of making the groups self-sustaining in the market place (see MWCD website). To this end, it is important for the evaluations to assess how women sell their products (from home, at the market, to the co-op, etc.) as well as whether they have adequate information on the marketing of their products (the effectiveness of their training on marketing management). Further, it is also important to assess whether the women are able to access markets if they are selling from home or to the co-op to properly assess the effectiveness as well as the sustainability of STEP interventions.

(i) Do the women sell their products from home, at the market or to the co-op?

While most of the evaluations address the questions of how the women sell their products, there are the odd evaluation reports that do not assess the same. Where this is assessed, we are able to get an interesting picture both of the differences between sectors as well as projects. For instance, in the larger diary sector projects, there was a ready market through the dairy cooperative societies and milk unions with a clearly delineated market route and robust wholesale distributor networks for milk products. Interestingly women also sold to private

traders. In the handlooms and handicrafts sector, in an evaluation of one of the projects, although the beneficiaries marketed their products individually (mostly), export linkages were also found. In the animal husbandry industry, most the evaluations note that women sold their products from home.

(ii) Are they informed of the markets for their products?

The question of the information that the beneficiaries had on the market for their products, yielded interesting insights. Particularly in the evaluations of the animal husbandry industry, where it seems from the sample, that marketing is largely done from the homes of the beneficiaries and that the women were largely unaware of the markets for their products.

Conclusion and Recommendation: In order to properly evaluate forward linkages, the evaluations must examine how the women sell their products, and whether they are informed of the markets for their products.

g. Support services

As mentioned earlier, STEP aims to not only impart training for the upgradation of skills to enhance the income and employment opportunities of the beneficiaries, but also a package of services consisting of health check, up, nutrition, non-formal education, legal literacy education, mobile crèches, gender sensitization and gender awareness, etc. (see the details of the STEP scheme, MWCD website). Most evaluations examine whether support services were offered by listing the camps and sessions attended by different numbers of women. However, this is not consistently examined by all evaluations and neither is there an in-depth examination of the effects of the training conducted on support services.

Moreover, there is an expectation on the part of the IA as well as the state departments to provide support services for health, nutrition, crèches, etc. From our fieldwork, it is quite clear that this convergence was negligible.

Assessing both the training in support services as well as the actual provision of support services is a key indicator of the successful implementation of STEP.

Conclusion and Recommendation: It is essential that the evaluations of STEP examine the provision of support services and particularly the issue of convergence seriously. For this, it is essential that evaluations are also based on interviews with key stakeholders and functionaries of STEP

h. Has IA been involved in every step of the above? If not, which of the above requires more IA involvement?

The question of IA involvement in all of the above components is important to assess the effectiveness of the implementation by the IA, as well as to identify where if at all the IA should target its attention.

i. Process of implementation of STEP

The process of implementation of STEP is another crucial component to be assessed in evaluations.

(i) Was there a process in place for effective monitoring and evaluation?

STEP requires that each project will have its own Management Information System and monitoring committee, which will regularly review the progress of the project on a regular basis, meeting as often as possible, but at least every three months. Furthermore, the Department of Women and Child Development is expected to hold regular Review Meetings on a half yearly basis to assess various elements of the programme. The scheme also envisages that a concurrent evaluation will be carried out through an independent agency. (See the details of the STEP scheme, MWCD website)

(ii) Was there convergence between different government bodies for effective implementation of STEP?

STEP aims to not only impart training for the upgradation of skills to enhance the income and employment opportunities of the beneficiaries, but also a range of services consisting of health check-up, nutrition, non-formal education, legal literacy education, mobile crèches, gender sensitization and gender awareness, etc.. The scheme mandates a convergence in the STEP areas through existing programmes of various other Ministries/Departments like Health, Education, Rural Development, Women and Child Development, CSWB, etc. (see the details of the STEP scheme, MWCD website).

Moreover, it is expected that the IA will be assisted by the state department involved in women's development to effectively co-ordinate and to draw upon resources of existing infrastructure and services under programmes like ICDS, DWCRA, Mahila Samkhya, IRDP, etc. (Ibid).

It is very important therefore that the question of whether there has been effective convergence between various ministries, departments at both central and state level forms a component of the evaluation of EAs. In order to effectively assess convergence it is important that EAs are able to meet more stakeholders rather than just the beneficiaries and IAs.

j. Were there any unintended outcomes of STEP?

Some of the more interesting insights that have come from feminist evaluation approaches have been the understanding that we get about the implications of policies, programmes and schemes when we are also attentive to the unintended outcomes of the same (Sudarshan and Sharma, 2012). While some of the evaluations mention this, it is not something that has been given serious attention by the evaluation reports. The identification in one of the evaluation reports of the reduction in consumption of milk by the women beneficiaries in the diary sector, as well as of her household (corroborated by fieldwork), is something that can be attributed to the unintended outcomes of STEP. While the meanings of these unintended outcomes are debatable viz. whether the women found more value in the money obtained for instance so that it is not necessarily perceived as a negative unintended outcome, what is interesting for our purposes is that examining the unintended outcomes provides valuable insights about the effects of STEP.

3. Efficiency

Efficiency in general describes the extent to which time, effort or cost is well used for the intended task or purpose. It is often used with the specific purpose of relaying the capability of a specific application of effort to produce a specific outcome effectively with a minimum amount or quantity of waste, expense, or unnecessary effort.

Most of the evaluations assess whether the project was completed on time. Interesting insights also come from evaluations that assess the reasons for delay or discontinuation when these occur. Many of the evaluations also assess efficiency in terms of whether the activities were cost efficient, that is, whether the funds were used effectively or not. This is usually done by an assessment of whether the spending was done in accordance with various heads.

a. Project completed on time?

Among 20 STEP evaluations studied here, 12 STEP evaluations reported that the projects were either completed on time or were on the right track at the time of the evaluation. However, another five projects were lagging behind; two were discontinued and for one project there was no information at all.

b. Cause of delays?

There are several reasons identified in the evaluation reports for the slow pace of activities or discontinuation of the project. Late disbursement of funds is one important issue with many implementing organizations. Based on our interviews with key stakeholders, it is clear that some

organizations are capable of using their own resources for timely completion of the projects. However, not all organizations are able to do this. At times the project activities come to a standstill due to late arrival of funds.

When the evaluations assess the reasons for delays, they provide interesting insights. For instance, the lack of technical assistance in an emergency could be a huge problem for the implementing organizations. Due to some unforeseen circumstances, which could be environmental, social or political, if a major damage happens to the project or to the stakeholders of the project, there should be a system of immediate attention to the situation. In one of the evaluations, the EA observed that a particular poultry project had to be closed by the IA when an epidemic broke out in the region. Mortality rate of the chicks was very high and a sizeable number had died during the first year after which the IA had stopped coming to the implementation area.

In another case implementation was slow due to blockade of the National Highways. Turmoil in the political or social environments could be a major hindrance in timely completion of the project. It has been observed that projects suffer due to changes in the external environments.

c. Were funds utilized effectively/activities cost efficient?

Most of the evaluations study cost efficiency as an assessment of whether the amount allocated under different uses has been fully utilized under the respective heads. They also assess whether the utilisation of funds for creation of assets, awareness/training programmes are found to be as per the norms or not. The majority of the evaluations have studied year wise cost of the project under different heads such as administration, establishment of co-operatives, skill upgradation training, raw material and equipment for training, infrastructure, raw material and equipment for production, marketing, support services etc., to see whether the set physical targets/financial targets have been achieved or not. Most of the evaluations report that the funds were utilized effectively by the implementing organizations. However, not many of the reports analyze this systematically or use some common indicators. It is essential that evaluations examine the efficient use of resources in a systematic manner. In one of the projects, as the evaluation was undertaken prior to stage of production, cost efficiency of the activities could not be fully judged. However the funds allocated were used by the IA effectively during the given period. In one of the handicrafts project, costs were reasonably close to the norms, however under the same project for the handloom sector due to increasing price of materials and high overheads the norms were not met a few times, and in another phase of the project, due to insufficient release of funds the divergence from the norms was substantial.

Appropriate technology developed keeping in view the skills and needs of local people also makes project cost efficient. If modern technology is introduced, there is a possibility that the right expertise and human resource is not available in the rural areas to use the technology as a result of which the technology is underutilized leading to inefficiency.

Conclusion and Recommendation: It is clear that in assessing efficiency, evaluations should also assess the reasons for the delays where they occur. This could offer insights for the better programme design of STEP. Further, what has to be kept in view in evaluating the efficiency of projects from a gender responsive lens is the purpose of STEP – to make women self-sufficient and empowered through training and employment. So, while time, effort and cost are important to assess whether the project was efficiently implemented, it is also important for the evaluations to keep in mind the purpose of STEP, and assess whether sufficient time, effort and cost were spent on the activities of STEP including training on rights awareness.

4. Impact

STEP envisages that a concurrent evaluation will assess the impact of two things: the sectoral impact of the STEP programme, and secondly the impact of each of the projects being implemented on the status of women beneficiaries. It envisages the progress of non-quantifiable inputs such as:

- Self-confidence in rural women to manage their own institutions
- Gradual change in the traditional system of social/family barrier to remain indoors
- Sense of responsibility for income generation
- Exposure/knowledge of essential needs of life, like child immunization, maternal and child healthcare, importance of nutritious food/clean drinking water, self hygiene and family planning, child spacing programme.
- Self motivation and mobilization to participate in different types of training programmes within the village/district/state and any other part of the country
- Demands/grievances for maternal healthcare, child immunization, child and adult education, activities relate to cottage industries, etc. (See MWCD website)

Most of the evaluation reports study the sectoral impact and the impact of the intervention on the economic, social and political status of the beneficiary under STEP programme through different indicators. However they all assess the change in income of the beneficiaries as a result of the intervention. In an evaluation of the handicraft sector for instance, it was observed that the income generated from the production is helping the beneficiaries to have a better quality of life. One of the beneficiaries mentioned that she could buy books for her kids, provide food to her family three times a day which was her dream before the intervention.

There were also other indicators employed to assess impact on the socio-economic contexts of the women, for example how ardous the labour was. Dairy activity, for example, has given the beneficiaries the opportunity to earn cash income that was found to be useful and the work was seen as less arduous than wage labour. For a few projects it was noticed that as a result of the intervention all the school going children are sent to school. Due to the awareness generated, the women have started sending their girl child to school which has motivated the other women also to join the programme. Another finding reveals that in one of the agriculture projects, migration in the villages reduced by 5% after the project implementation as revealed by the beneficiaries.

Overall, all the evaluations assess the impact of the intervention in terms of increase in income of the beneficiaries and whether there was skills upgradation of the beneficiaries.They also assess whether the programme gave the beneficiaries an exposure on all the aspects of decent social life such as health, education, bank facilities, facilities available to the women through various awareness programmes. Few evaluations have also assessed impact in terms of whether the participation of beneficiaries in decision-making forums has increased or not.

At the level of sectoral impact, it was observed in the diary sector, that activities undertaken by the NGO under STEP helped villages in getting doorstep veterinary services and building capacities in management of dairy animals. Steps for better market interventions helped the beneficiaries to earn better income for the milk produced showing profits in dairy farming. Another evaluation of the handicrafts project shows that there was a shift in the production of goods from traditional to innovative/modern products. About 31% beneficiaries in handloom sector and 36% beneficiaries in handicrafts sector increased their production level by more than 50%. Both handicrafts and handloom products saw an increase in product values. Export linkages were also seen. STEP intervention has transformed unskilled rural women folk to skilled (85%) and semi-skilled (15%).

Assessing the overall impact both on the sector as well as on the socio-economic contexts of the women continue to be important methods of assessing the overall impact of STEP.

5. Sustainability

STEP advocates an integrated package of inputs aimed at the overall development of women by enabling groups of women to take up employment-cum-income generation programmes of their own, or to access wage employment. The ultimate endeavour of each project under STEP is to develop the groups of women to thrive on a self-sustaining basis in the market place with minimal governmental support and intervention. (see STEP, MWCD website).

Sustainability in this sense is about the continued employment of women in the sectors in which they have been trained with minimal governmental support. A wider understanding of sustainability would include environmental sustainability along with economic sustainability.

While most of the evaluations look at sustainability from the lens of economic sustainability, viz., whether the activities of the scheme can continue without economic support, the evaluations do not examine the environmental sustainability of the projects. This is an important component as it is critical to ensure that there are no long term negative consequences of the intervention. It has to be noted that there is project to project variation and as an evaluating agency environmental sustainability of the project should be taken into consideration to determine whether the evaluation is environment friendly or not.

In assessing economic sustainability, evaluations also assess whether the trainings helped the SHGs and cooperatives formed to continue their existence even after the training support from IAs and other agencies ceased. They also assess the areas such as marketing linkages and credit linkages to assess the sustainability of the project after the support from IA and the government body ceases. Few of the evaluations have also addressed sustainability in terms of potential/high demand for the product in the area and the cost of investment.

Evaluations that examine sustainability provide insights into the major factors that influenced the non-achievement of the objectives of the programme. For instance, one of the evaluations found out that cooperatives were not formed and members of SHGs were not made self-sufficient in marketing and production Similarly, other evaluation reports have identified the absence of inter-lending amongst the group, as well as the absence of linkages with banks for credit support and with link agencies for implementation of support services like health check-up, mobile crèches etc., and also for market support.

Another evaluation found that after completion of training, the trainees faced the problem of adequate supply of raw materials and could barely utilize their skill in the absence of formation of SHGs and cooperatives.

Another important method of assessing sustainability is by analyzing whether there is any requirement for refresher training for the beneficiaries. Most evaluations do not address this question. Where it is addressed, the valuations yield interesting insights. One of the evaluation reports found for instance that 61% beneficiaries required refresher training.

Conclusion and Recommendation: It is important that evaluations address the question of sustainability from the point of view of both economic sustainability as well as environmental sustainability. It is clear that assessing backward and forward linkages, as well as the market for products in the region and the requirement of refresher training are some of the key means of assessing economic sustainability. Assessing environmental sustainability would also yield interesting insights into whether scaling up of some of the projects is environmentally viable. Importantly, an assessment of sustainability yields very important insights into the areas of focus for future STEP design and implementation.

II. The Evaluation Process

The scheme envisages that the mechanism of concurrent evaluation will be built into the scheme as a whole and will be carried out through an independent agency. In this section, we examine the evaluation process including the methodology and ethics of conducting evaluations and the coordination between the various governmental departments in the conduct of evaluations.

1. Process of conducting STEP evaluations

STEP evaluations are normally undertaken by independent organizations once in the middle of the project, i.e. concurrent or mid-term evaluation; and secondly upon the completion of the project that is end-line evaluation. The concurrent evaluations are undertaken to assess both sectoral impact and the impact of each of the projects being implemented on the status of women beneficiaries. A research or specialized organization with appropriate knowledge and experience in evaluating employment oriented programmes is selected for undertaking concurrent evaluation. This agency is supposed to be provided with all the baseline information as per the survey conducted by the IA prior to the implementation of the project. The EA devises the methodology on the basis of the TOR provided by MWCD. The EA is expected to survey 25% of the beneficiaries within a stipulated length of time, which is normally one month.

2. Methodology employed in conducting STEP evaluations

It is clear from a synthesis of the evaluations that apart from a questionnaire survey, which is canvassed among 25 per cent of the beneficiaries by nearly all EAs, most of the evaluating organizations also conduct FGDs and structured and semi-structured interviews to get a more holistic picture of the project. Some EAs also use participant observation methods, case studies and appraisal methods.

For the first step in evaluation, the evaluators with help from the IAs identify project stakeholders and their involvement at various levels. The evaluation synthesis indicates that

the surveys conducted by EAs are more often than not based on random samples, though one evaluation also used a purposive sample. Largely however, proportionate stratified sampling and random sampling in collection of primary data has been followed. Also, heterogeneous data is usually made into homogenous data through stratification to make it a representative sample and to avoid bias. One EA also noted that in order to make the sample representative, the sample was drawn from the list of beneficiaries/SHG members by location/distance of the village from the IA's training centre.

The evaluation synthesis also indicates that some evaluations do not have any information on the baseline surveys conducted by the IA prior to the implementation of the project.

a. Participation of stakeholders in evaluation

In order to fully understand the extent of stakeholder participation in the evaluations, we also probed this issue in our interviews with IAs and EAs. Four out of five EAs interviewed stated that they followed an overall participatory approach for various stakeholders. One evaluating agency elaborated that after listing of stakeholders their role in evaluation is ascertained. So, the extent of participation depends upon the role played by stakeholders. However, further questioning found that the degree of engagement was limited to interviews and FGDs. This was supported by implementing agencies which noted that involvement was limited to helping the evaluation agency in providing a list of beneficiaries and accompanying them for FGDs. One evaluating agency was also emphatic that participatory evaluations will not work in the Indian context because it is time consuming and will further complicate the evaluation process.

If one of the key precepts of feminist evaluation is also to recognize the power hierarchies in knowledge production (Hay 2010), then it is key that the voices of the women beneficiaries are properly heard and represented in evaluations. While FDGs, interviews, case studies are some key methods with which to incorporate the experiences and voices of the beneficiaries, it is also important that participation is valued by the EAs. Moreover, this participation cannot be limited to the women beneficiaries, and should include the IAs as well. In one evaluation, it was clear that the entire evaluation excluded the voices of the IA. Engaging all key stakeholders in the evaluation process is essential for the evaluation to be truly participatory.

b. Gender responsive lens in evaluation

STEP is specifically for women beneficiaries as the respondents of the evaluation are only women. However, this fact alone does not suffice to make the methodology gender responsive. In fact, the evaluation methodologies adopted by the evaluating agencies are not always and

consistently gender responsive. One of the evaluating agencies we met also suggested that since STEP is an exclusive programme for women, evaluating a STEP project makes the methodology gender responsive by default! This troubling approach to gender responsiveness was not seen across the board however. Both from the evaluation synthesis as well as our interviews with EAs, it is clear that there are some interesting gender responsive methodologies that have been used in a few of the evaluations, particularly in locating the time and mobility constraints of women. However, the overall picture is one of an inconsistent approach to gender responsiveness across evaluations, which this report has tried to point to. One of our findings is that there is definitely scope to make the evaluation methodologies more consistently gender responsive.

Conclusion and Recommendation: It is important to have the voices of women beneficiaries properly heard and represented in evaluations. It is also important that participatory modes are valued by EAs. Participation is one element of making the evaluation gender responsive. The gender responsive evaluation framework that is attached as an appendix will we hope provide further inputs into how future evaluations can be made more gender responsive.

3. Constraints in the Methodology and Evaluation Process

The field findings found the following constraints in the evaluation process:

a. Time given for and timing of evaluations

Although not all evaluating agencies found the time period stipulated for conducting evaluations a constraint, there were EAs who suggested that the time period for evaluation was a challenge, especially when sample size of beneficiaries to be met was large. The 25% beneficiary sample size stipulated by the Government of India can get particularly unwieldy when the number of beneficiaries of a project is 10,000. The stakeholders we interviewed had varying opinions on this. While some evaluating agencies said that the numbers were too large, from the perspective of one IA the requirement of 25% beneficiaries was considered good – as the larger sample size provided more robust information.

The time provided also posed a challenge when the evaluations were to be conducted in hilly terrains where access to different scattered villages was a challenge.

EAs also provided the insight that there were constraints not just in relation to the time given for evaluations, but the time at which the evaluation had to be conducted. On several occasions, the evaluation has to be done in the monsoon or post-monsoon season, which is not a good time to do field visits.

b. Funds for evaluating agencies

EAs also reflected on the differences between the funds allocated for different EAs to conduct evaluations. It was recommended by one EA that although the amount need not be uniform across EAs, there should be uniform criteria employed in the money paid for conducting evaluations. Further, that the release of funds for conducting evaluations should be done in a timely manner.

c. Baseline surveys

As mentioned previously, the EAs also did not always have access to reliable baseline surveys on which to base their understanding of the effectiveness of programmes.

Conclusions and Recommendations: There are several constraints that have been identified in the methodology and evaluation process. The time given for conducting evaluations as well as the timing at which the evaluation has to be conducted has to be context specific, taking into account distance, sample size as well as whether the evaluation is feasible at a specific time (dependent on seasons). Secondly, the EA has to be provided all the necessary documentation in relation to the project, particularly the baseline survey conducted by the IA prior to the implementation of the project. Further, the funds for the project as well as for evaluations have to be released in a timely fashion.

4. Ethics of conducting evaluations

The question of the ethics of conducting evaluations has been important to incorporate in our evaluation synthesis. Although we have found no irregularities in the conduct of evaluations, this is an issue that is not directly addressed in many of the evaluations.

III. Utilization of the Evaluation Findings

From our interviews with EAs and IAs, it is our understanding that generally, the EA compiles the draft report and presents it to the Ministry for inputs. Suggestions, corrections from the Ministry are taken into account and incorporated before submitting the final report. This report then gets fed back to the IA in terms of recommendations by the Ministry. The implementing agencies do not get the details of the evaluation report, and therefore they do not get a chance to respond to the findings of the evaluation. Moreover, the evaluating agencies also do not know what use the evaluations have been put to. However, the interviews revealed that although the implementation organizations do not know the full content of the evaluation reports, they do get verbal inputs from the evaluation team during the evaluation. Also the Central ministry gives recommendations

back to implementation organizations based on the evaluation report when the next installment of the project is released. The evaluating agencies get to know of this through implementation agencies.

Moreover, from our interviews, it also appears that Women Development Corporations are also not aware of the evaluation findings. Though they are involved in the selection of NGOs for projects they are not provided information on which NGO has got selected. It is when NGOs approach them for release of second installment of project funds or when there is a delay in the release of funds that they know about the project.

Further, and importantly from the perspective of feminist principles of evaluation, there is no system of feedback of the evaluation process to the women beneficiaries of the project.

There is, therefore, no system in place for conversations between the implementing agencies, the Ministries (at the state and central level), the evaluating agencies and the beneficiaries about the evaluation process and its utilization. From our meetings with both IA and EA, the one exercise that the Central Ministry held to bring the various stakeholders together (2010) was appreciated across the board as being useful to understand the process and utilization of evaluations as well as to have their voices heard on the same.

Conclusions and Recommendations: The basis of all evaluations are ultimately to be utilization focused, viz., to effectively intervene in the implementation of the project. It is key therefore that all stakeholders are involved more fully both in the process of the evaluation as well as the utilization of the evaluations. We would also recommend annual meetings organized by the Ministry for all stakeholders in STEP.

IV. Implications for the implementation of STEP

Since the method of meta-evaluation that we have adopted in this study is one of evaluation synthesis, we have also synthesized not just the commonalities between the evaluations in terms of the process of evaluation and what this means for the methods of conducting future evaluations, but also the commonalities and dissonances in findings between the various evaluations conducted. This has allowed us to locate several implications for the implementation of STEP.

1. Process of co-ordination between the Central MWCD, state MWCD and Women's Development Corporations

Based on interviews with key stakeholders, one of our key findings was that in some of the states, the links between the various functionaries of the State and Central Ministries were

not robust throughout the project period. While the State Women Development Corporations were responsible for vetting the projects, in practice, they did not remain involved beyond the process of selection. Some of the IAs interviewed talked of the need for closer links between the IAs and state functionaries, so that they could seek advice and support in the implementation of projects, as well as for convergence between ministries.

Conclusion and Recommendation: There needs to be a process where the activities and responsibilities of the various central and state ministries and the departments are coordinated which will result in the better implementation of STEP. This will also result in a better involvement of the Ministry throughout the project period and in the conduct of evaluations. Furthermore, the links between the IA and the various agencies of the state need to be strengthened so that the project can be more effectively implemented.

2. Delays in release of funds and in conducting concurrent evaluations

One of the key findings from the fieldwork was that some IAs experienced delay in the release of funds. Due to this delay in funding, especially for the smaller IAs, project activities were completely stopped. Bigger IAs managed to see through the financial crunch, but the smaller IAs experienced hardships in continuing the activities of the project.

Another finding based on conversations with IAs was that there was a delay in the conduct of concurrent evaluations, and in some instances the release of the next installment was linked with the release of funds. This meant that until the evaluations were conducted, the project cycle and activities were stalled, thereby causing disruptions in the implementation of the projects.

Conclusion and Recommendation: There should be timeliness in relation to the release of funds and in conducting evaluations. Late evaluations make both the implementation and the evaluation process less effective.

3. Selection of relevant beneficiaries

The findings of the report suggest that there are several diverse practices in the selection of relevant beneficiaries. Whilst this diversity is not problematic, it is more important that this process results in the targeting of the right beneficiaries. The evaluation reports indicate that more than 80% of the projects targeted "poor women", whereas very few projects targeted minority women and single women/widows/female-headed households.

Moreover, the field study reveals that the beneficiaries are from poor background, but not for all projects. In some projects, it was based on the geographical location of the project and the selected trade. The poorest sections sometimes do not prefer a trade which they are not aware of. In those cases the IA without looking into the relevant criteria selected the beneficiaries from the not-so-poor sections of the society.

Conclusion and Recommendation: It is important that the projects target the right beneficiaries, including in their target minority women, single women, widows and female-headed households.

4. Training Process

Majority of the evaluations do not give information on the duration of the training period. However, where this information is given, it is clear that a few of the evaluations reflect the need for an increase in the duration of training and a few others mention a refresher training course for the beneficiaries. In the project on cultivation of mushroom it was felt that for an activity like this 3 months training was not sufficient but a continuous training effort should be in place to supervise women's effort for 2-3 seasons. In one of the handicrafts project, it was seen that the duration of training of 4 months was too short to develop skills in various components of loom weaving and training needed to be enhanced to about 6 months to 1 year. In one of the piggery project it was found that 61% of the beneficiaries demanded refresher training.

Conclusion and Recommendation: For the effective implementation of STEP, it is key to ensure that the training is for the right period and that there are adequate processes in place to ensure refresher trainer for the beneficiaries where necessary.

5. Timing and Place of Delivery of Training

Most evaluations gave no information on whether the time set for conducting training was sensitive to the needs of women in terms of seasons as well as time of day. However, from our fieldwork it is clear that when the needs of women are taken into account (see section on effectiveness above), the trainings are bound to be more effective.

Most evaluations also give no information on whether the course venue was convenient for the women in terms of proximity. However, where such information is given, it is clear that the lack of proximity can be a constraint for the effective implementation of the training programme.

Further, the majority of the evaluations do not give information on whether crèche facilities were provided to the beneficiaries or not. Where this information is given, it is clear that they fulfill a felt need.

Conclusion and Recommendation: For the effective implementation of STEP, it is important to take into account women's needs, particularly those that flow from their double burden of work. The timing and place of delivery of training, as well as the provision of crèche facilities at the training site are important ways in which to ensure that women's needs are met during training, which in turn ensures a more effective implementation of STEP.

6. Training of Trainers

From the evaluation reports, it is clear that the satisfaction levels of the beneficiaries on the training obtained by them is based on the trainer's technical abilities as well as their ability to impart training in other non-technical areas, particularly on gender awareness. It is important that the issues of the training of trainers are taken seriously as the quality of the implementation of STEP is dependent on the quality of the training provided.

Conclusion and Recommendation: The training on both technical abilities and other non-technical areas, particularly gender awareness has to be taken on as an integral component of STEP implementation. Government training institutes such as NIPCCD should be tasked with the provision of gender awareness training.

7. Production Space

Most of the evalautions do not give the information on the availability of production space for the beneficiaries. However, where this is taken into account, a few mention the inadequacy of the production space for the beneficiaries and even the poor and congested conditions of the production space provided to the beneficiaries. In one of the projects on handicrafts for instance, majority of beneficiaries complained about the lack of common worksheds.

Conclusion and Recommendation: The effective implementation of STEP requires the provision of adequate production space by the IA.

8. Effectiveness of SHGs and Cooperatives

Formation and registration of SHGs and cooperatives are essential components of the STEP scheme. From our evaluation synthesis, it is clear that in many projects, the SHGs and cooperatives were formed routinely as a pre-requisite of the project. However, the operational

effectiveness of the SHGs and cooperatives was not consistent across the board. While some of the evaluations indicate the use of SHGs and cooperatives for regular savings and internal lending, in most instances, economic activities of these collectives did not extend to further economic activity such as the handling of production, claiming credit from banks, or the marketing of the products.

From the evaluation synthesis, it is also clear that the diary sector is the most sophisticated in this regard with well developed self help groups in large numbers, as well as women's diary cooperatives. This is especially true for some of the long standing STEP projects, where a well structured system of women's development cooperatives are expected to operate as local business enterprises.

Conclusion and Recommendation: The collectivization of women is a key component for the effective implementation of STEP, but more so for the sustainability of STEP without government support. This requires far more attention from the IAs particularly in ensuring that the activities of the collectives go beyond inter-lending.

An inclusive checklist of activities for SHGs would be the following: savings, inter-lending, handling of production, claiming credit from banks, and the marketing of the products.

9. Credit and Market Linkages

From a majority of STEP evaluations, it is clear that the key weaknesses in the implementation of STEP, and in particular the sustainability of STEP, are in the availability of backward and orward linkages. Access to credit and to markets, are key to the functioning and sustainability of STEP.

In the evaluation of a project on mushroom cultivation for instance, it was recommended that finding a link between the production centres and a wholesaler who could take bulk orders was key to the sustainability of the project. Furthermore, it was also found that without credit linkages, the ability to buy raw materials would be seriously hindered. In short, in the absence of credit linkages it was not possible to implement the income generating activity. This picture unfortunately is replicated across many of the projects across the sectors (barring a few exceptions).

The lessons from the few success stories (in some of the larger diary projects for instance) have to be learnt and modified to suit the contexts of other projects to deal with the twin issues of backward and forward linkages. In relation to credit linkages for instance, robust cooperatives which have subsidized access to margin money through the milk unions in the diary sector provide glimpses of the functioning of well oiled and supported institutions which in turn seem to facilitate the access to credit/bank linkages.

On the question of market linkages, again, in the larger diary sector projects, there was a ready market through the dairy cooperative societies and milk unions with a clearly delineated market route and robust wholesale distributor networks for milk products. Interestingly in this sector, women also sold to private traders. In the handlooms and handicrafts sector, in an evaluation of one of the projects, although the beneficiaries marketed their products individually (mostly), export linkages were also found. In the animal husbandry industry, most the evaluations note that women sold their products from home, that many of the women were not aware of the markets for their products.

How and whether the success stories, for instance in the diary sector can and should be replicated across sectors and in smaller projects is a difficult question to answer without more rigorous information.

Conclusion and Recommendations: Credit and market linkages are crucial for the effective implementation and sustainability of STEP. It is clear from the evaluation synthesis that this is an area of weakness for the future sustainability of the projects. Without more robust information, it is difficult to assess the reasons for the success of some interventions and the failure of others. However, this is an area that requires immediate attention for the future effectiveness of STEP.

10. Convergence between various Ministries

The delivery of support services is an integral part of STEP and in order to ensure this, the scheme expects a convergence between the various state and central ministries and departments. From the evaluations studied however, there is either no information on the convergence between the various ministries, and where this information is available, it is clear that convergence between ministries is poor. The few instances of successful convergence was in the case of the larger diary projects, which being well established are able to liaise better with various departments of the government. This finding was reiterated by our interviews with key stakeholders.

Conclusion and Recommendation: Convergence between ministries and departments is crucial for the effective implementation and sustainability of STEP. It is our finding that overall, there is a poor convergence between ministries and departments in the implementation of STEP. This is an area that requires attention.

11. Monitoring and Evaluation System

While STEP mandates a monitoring and evaluation system, the majority of the evaluations give no information on the existence of a monitoring and evaluation system in the IAs. Those

that do examine this issue mention that there is no monitoring and evaluation system in place at the IA. This is a key element in the effective implementation of STEP as it ensures accountability and learning on the part of all key stakeholders.

Conclusion and Recommendation: A robust M&E system ensures a regular process of accountability in the IA. It also allows for a process of learning for the IA. It is a key component of effective implementation of STEP, and all IAs should ensure that a system is in place for the same.

Conclusions and Recommendations

Using a meta-evaluation synthesis method supplemented by fieldwork to fill the gaps in understanding on research process while conducting evaluations, the utilizations of evaluations, the process of implementation of STEP, this report has identified certain findings on the implications for evaluations of STEP as well as for the programme design and implementation of STEP. Our conclusions and recommendations in this section are based on the findings of our secondary and primary research.

1. Conclusions and Recommendations for Evaluation of STEP

Relevance

- The benchmark survey has to provide adequate information about the socio-economic profiles of the target group in order to assess whether the right beneficiaries were identified.
- The EAs should clearly spell out the economic and geographic suitability for implementation of project in the area. Where this has been done (benchmark surveys) this should be made available for the evaluations.

Effectiveness

- All components of the training (including technical training on sector specific skills, SHG and cooperative formation, accessing credit, marketing, gender awareness and sensitization, legal literacy, etc.) have to be delineated and assessed for effectiveness.
- Training provided has to be assessed for context, sector and need.
- Gender awareness and sensitization should be assessed through the use of indicators such as levels of confidence, mobility, decision-making and control over resources at the household level, and participation in public fora and politics.

- Evaluations have to recognize the dual responsibilities that women shoulder and the time poverty that this entails. The location of the training centre, the provision of childcare at the training centre as well as the times at which training is provided are all important indicators of the gender responsive nature of the project implementation.
- A recognition that women perform largely unrecognized, unpaid and time-consuming work allows for a fuller evaluation of the effects of the new employments/changes in occupation on women. One of the ways in which to assess this is to examine the number of hours spent on paid and unpaid work by women.
- One of the most important indicators of the effectiveness of STEP is the increase in income of women beneficiaries. However, in order to more fully grasp the effectiveness of STEP, the evaluations should also examine the rate of increase of income (whether this was marginal, significant, substantial), and for how many women.
- Analyzing the collectivization of women should not be limited to an understanding of how many SHGs were formed and whether inter-lending had started. It should also include an analysis of how many active groups are involved, as well as the extent of the economic activity conducted by the groups.
- Apart from examining from where women sell their products (home, market, co-op), it is also essential for evaluations to examine the information that women have on market access as well as the hindrances to accessing the market that women face.
- It is essential that the evaluations of STEP examine the provision of support services and particularly the issue of convergence seriously. For this, it is necessary that evaluations are also based on interviews with key stakeholders and functionaries of STEP.

Efficiency

- It is clear that in assessing efficiency, evaluations should also assess the reasons for the delays where they occur. This could offer insights for the better programme design of STEP.
- Evaluations should also assess whether the project was efficiently implemented, it is also important for the evaluations to keep in mind the purpose of STEP, and assess whether sufficient time, effort and cost were spent on the activities of STEP including training on rights awareness.

Sustainability

- The evaluations should examine not just economic sustainability but also environmental sustainability to capture the long term effects of projects.

Process and Methodology of Conducting Evaluations

- The voices of women beneficiaries should be properly heard and represented in evaluations.
- There are several constraints that have been identified in the methodology and evaluation process. The time given for conducting evaluations as well as the timing at which the evaluation has to be conducted has to be context specific, taking into account distance, sample size as well as whether the evaluation is feasible at a specific time (dependent on seasons).
- The EA has to be provided all the necessary documentation in relation to the project, particularly the baseline survey conducted by the IA prior to the implementation of the project.
- The funds for the project as well as for evaluations have to be released in a timely fashion.

Utilization of STEP evaluations

- The bases of all evaluations are ultimately to be utilization focused, viz., to effectively intervene in the implementation of the project. It is key therefore that all stakeholders are involved more fully both in the process of the evaluation as well as the utilization of the evaluations. We would recommend annual meetings organized by the Ministry for all stakeholders in STEP.

2. Conclusions and Recommendations for the implementation of STEP

Process of co-ordination between the central MWCD, state MWCD and Women's Development Corporations

- There needs to be better co-ordination between the various state and central ministries and departments involved in the process of implementation of STEP. A system of regular communication between these bodies, where the activities and responsibilities of the various central and state ministries and the departments are more effectively coordinated will result in the better implementation of STEP.
- Better coordination will also result in better monitoring by the Ministry throughout the project period and in the conduct of evaluations.

Delay in the release of funds and in conducting concurrent evaluations

- There should be timeliness in relation to the release of funds and in conducting evaluations. Late evaluations make both the implementation and the evaluation process less effective.

Selection of relevant beneficiaries

- It is critical that the projects target the right beneficiaries, including in their target minority women, single women, widows and female-headed households.

Training process

- For the effective implementation of STEP, it is critical to ensure that the training is for an adequate period based on skills being imparted, and that refresher training for the beneficiaries is provided where necessary.

Timing and place of delivery of training

- Women's needs have to be taken into account particularly those that flow from their double burden of work. The timing and place of delivery of training, as well as the provision of crèche facilities at the training site are important ways in which to ensure that women's needs are met during training, which in turn ensures a more effective implementation of STEP. Each IA has to make this assessment based on local contexts before the training is provided.

Training of trainers

- The training on both technical abilities and other non-technical areas, particularly gender awareness has to be taken on as an integral component of STEP implementation. Government training institutes such as NIPCCD should be tasked with the provision of gender awareness training for trainers.

Production space

- The effective implementation of STEP requires the provision of adequate production space by the IA. This should form a key component in the monitoring of STEP.

Effectiveness of SHGs and cooperatives

- The collectivization of women is a key component for the effective implementation of STEP, but more so for the sustainability of STEP without government support. This requires far more attention from the IAs particularly in ensuring that the activities of the collectives go beyond inter-lending.
- An inclusive checklist of activities for SHGs would be the following: savings, inter-lending, handling of production, claiming credit from banks, and the marketing of the products

Credit and market linkages

- Credit and market linkages are crucial for the effective implementation and sustainability of STEP. It is clear from the evaluation synthesis that this is an area of weakness for the future sustainability of the projects. Without more robust information, it is difficult to assess the reasons for the success of some intervention and the failure of others. However, this is an area that requires immediate attention for the future effectiveness of STEP.

Convergence between various ministries and departments

- Convergence between ministries and departments is crucial for the effective implementation and sustainability of STEP. It is our finding that overall, there is a poor convergence between ministries and departments in the implementation of STEP. Lessons can be learned from the Samajik Suvidha Sangam – Mission Convergence in order to set up an adequate convergence system that IAs can approach to ensure the effective implementation of STEP.

Monitoring and evaluation system

- A robust M&E system ensures a regular process of accountability. It also allows for a process of learning for the IA. It is a key component of effective implementation of STEP, and all IAs should ensure that a system is in place for the same.

Gender responsiveness of EAs:

- The selection of EAs should be made through a more robust process of selection. Currently, the proposal submitted by EAs does not need to elucidate how the evaluation will proceed in a gender responsive manner. The process of selection of EAs should be made more robust and should include an assessment of how gender responsible the evaluation proposes to be.

Gender responsiveness of IAs:

- Gender awareness training is an important component of the effectiveness of STEP. It is critical that the IAs themselves are gender responsive in their overall implementation of STEP. An assessment of the gender responsiveness of IAs should form a critical component of the selection of IAs.

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Annexure 1

Table: STEP Grants: Distribution of Major Sectors by State (up to March 2010)

State	Agriculture & Soc. Forestry	Animal Husbandry	Dairy	Fisheries	Handicrafts	Handloom	Khadi	Sericulture	Wasteland Development	Total
Andhra	1	0	10	0	0	3	0	1	0	15
	8.33	0.00	10.3	0.00	0.00	15.00	0.00	12.50	0.00	6.22
Assam	0	5	0	0	1	7	0	0	0	13
	0.00	10.64	0.00	0.00	2.56	35.00	0.00	0.00	0.00	5.39
Arunachal	0	1	1	0	0	0	0	0	0	2
	0.00	2.13	1.03	0.00	0.00	0.00	0.00	0.00	0.00	0.83
Bihar	0	0	4	2	1	1	0	0	0	8
	0.00	0.00	4.12	33.33	2.56	5.00	0.00	0.00	0.00	3.32
Chattisgarh	0	0	2	0	0	0	0	0	0	2
	0.00	0.00	2.06	0.00	0.00	0.00	0.00	0.00	0.00	0.83
Delhi	0	0	0	0	1	0	0	0	0	1
	0.00	0.00	0.00	0.00	2.56	0.00	0.00	0.00	0.00	0.41
Gujarat	0	0	0	0	4	0	0	0	0	4
	0.00	0.00	0.00	0.00	10.26	0.00	0.00	0.00	0.00	1.66
Haryana	1	0	2	0	0	0	0	0	1	4
	8.33	0.00	2.06	0.00	0.00	0.00	0.00	0.00	33.33	1.66
Himachal	0	0	0	0	2	1	2	0	0	5
	0.00	0.00	0.00	0.00	5.13	5.00	22.22	0.00	0.00	2.07
J&K	2	0	0	0	0	0	0	0	0	2
	16.67	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.83
Karnataka	1	3	7	0	0	1	1	0	0	13
	8.33	6.38	7.22	0.00	0.00	5.00	11.11	0.00	0.00	5.39
Kerala	4	4	2	2	0	0	1	1	0	14
Maharastra	2	4	10	0	0	0	0	0	0	16
	16.67	8.51	10.31	0.00	0.00	0.00	0.00	0.00	0.00	6.64
M.P.	1	0	3	1	3	1	1	1	0	11
	8.33	0.00	3.09	16.67	7.69	5.00	11.11	12.50	0.00	4.56

State	Agriculture & Soc. Forestry	Animal Husbandry	Dairy	Fisheries	Handicrafts	Handloom	Khadi	Sericulture	Wasteland Development	Total
Manipur	0	13	0	0	2	2	1	0	0	18
	0.00	27.66	0.00	0.00	5.13	10.00	11.11	0.00	0.00	7.47
Meghalaya	0	0	0	0	0	1	0	0	0	1
	0.00	0.00	0.00	0.00	0.00	5.00	0.00	0.00	0.00	0.41
Mizoram	0	2	1	0	0	0	0	0	0	3
	0.00	4.26	1.03	0.00	0.00	0.00	0.00	0.00	0.00	1.24
Nagaland	0	7	2	0	0	2	0	1	0	12
	0.00	14.89	2.06	0.00	0.00	10.00	0.00	12.50	0.00	4.98
Odhisa	0	2	9	1	0	0	1	0	0	13
	0.00	4.26	9.28	16.67	0.00	0.00	11.11	0.00	0.00	5.39
Punjab	0	0	4	0	0	0	0	0	0	4
	0.00	0.00	4.12	0.00	0.00	0.00	0.00	0.00	0.00	1.66
Rajasthan	0	0	8	0	0	0	1	0	1	10
	0.00	0.00	8.25	0.00	0.00	0.00	11.11	0.00	33.33	4.15
Sikkim	0	1	0	0	0	0	0	0	0	1
	0.00	2.13	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.41
Tripura	0	1	0	0	0	1	0	2	0	4
	0.00	2.13	0.00	0.00	0.00	5.00	0.00	25.00	0.00	1.66
Tamil Nadu	0	2	1	0	0	0	1	0	0	4
	0.00	4.26	1.03	0.00	0.00	0.00	11.11	0.00	0.00	1.66
Uttar Pradesh	0	0	17	0	16	0	0	2	0	35
	0.00	0.00	17.53	0.00	41.03	0.00	0.00	25.00	0.00	14.52
Uttarakhand	0	1	8	0	4	0	0	0	1	14
	0.00	2.13	8.25	0.00	10.26	0.00	0.00	0.00	33.33	5.81
West Bengal	0	1	6	0	5	0	0	0	0	12
	0.00	2.13	6.19	0.00	12.82	0.00	0.00	0.00	0.00	4.98
Total	12	47	97	6	39	20	9	8	3	241
	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Source: calculated on the basis of data provided by the web portal of Ministry of Women and Child Development, Govt. of India at http://wcd.nic.in/

Annexure 2

Field Visits

Mr Kuldeep Singh ,NABCONS, Evaluating Organistion ,
Bhopal, Madhya Pradesh (7 March 2013)

Mr Jang Bahadur Singh ,Jansamaj Kalyan Gramodyog Vikas Seva Samiti, Implementing Agency,
Unnao, Uttar Pradesh (20 March 2013)

Aarti Srivastav, Joint Director, Women Welfare Department
Lucknow, Uttar Pradesh (20 March 2013)

Prof. Jaydev Majumdar, Mr. Mihir Pal, Mr. Sukhendu Basak, Ms. Apurba Bhattacharjee, Mr. S.K. Sinha Vidhaysagar School of Social Work, Evaluating Organisation,
Kolkata (7-8 March 2013)

Dr PC Das ,NABCONS
Bangalore, Karnataka (7th March 2013)

Dr MS Tara, Regional Director, and Dr Aneel Babu, Assistant Director National Institute of Public Cooperation and Child Development
Bangalore, Karnataka (7th March 2013)

Mr Vakil ur Rehman, Additional Director, STEP ,Karnataka Milk Federation
Bangalore, Karnataka (8th March 2013)

Mrs Deepty Sunil ,NABARD
Trivandrum, Kerala (11th March 2013)

Mr Rajashekharan, Project Co-ordinator; Ms G Vijayamma, President, Mr George Winsent, Principal Investigator, CN Memorial Vanitha Samajam
Pattanakalla, Trivandrum, Kerala (11th March 2013)

Annexure 3

20 Evaluation Reports

Implementation of STEP for Women By Rashtriya Seva Samithi- An Evaluation, by National Institute of Public Cooperation and Child Development, Southern Regional Centre,Bengaluru

Evaluation of STEP Project – Support to Haryana Nav Yuvak Kala Sangam, Haryana for Mushroom Cultivation by Institute of Social Studies Trust ,New Delhi

Mid-term Evaluation Study of STEP Implemented by Pragathi Seva Samithi – Prepared by NABCONS,Hyderabad

Mid-term Evaluation Study of STEP by NABCONS Mumbai

Impact Evaluation of STEP for Women in Badi and Papad Making-Implemented by Ojaswini Samdarshi Nyas-prepared by NABCONS, Bhopal

Evaluation of STEP Projects-Centre for Rural Development, Assam-Poultry Project – Prepared by Women's Study Research Centre, Guwahati University Impact Evaluation of STEP in Cultivation and Processing of Aromatic and Herbal Spices- Implemented by Gram Shilpi, Bhopal, report prepared for Ministry of Women and Child Development by NABCONS Bhopal

Report of Evaluation Study on Project on Vanilla Cultivation, Processing and Marketing (Sanctioned to CN Memorial Vanitha Samajam Thiruvananthapuram under STEP), prepared by NABCONS, Kerala

A Report on Impact Assessment Study of STEP Project of Rural Development Society of Thoubal District, Manipur. Study Commissioned by Ministry of Women and Child Development, Government of India. Presented by Vidyasagar School of Social Work (Vidyasagar University)

Handicraft Project Implemented by Malikpur Samaj Unnayan Samiti, District Howrah (West Bengal), submitted by NABCONS New Delhi

Evaluation of STEP Project Implemented by Jan Samaj Kalyan Gramodyog Vikas Seva Samiti, Unnao U.P. Report prepared by National Institute of Public Cooperation and Child Development Regional Centre , Lucknow

A Report on Impact Assessment Study of STEP Project of Tribal Weave of Dimpaur District, Nagaland. Study Commissioned by Ministry of Women and Child Development, Government of India. Presented by Vidyasagar School of Social Work (Vidyasagar University)

Implementation of STEP by Karnataka Milk Federation- an evaluation of Phase V. Prepared by National Institute of Public Cooperation and Child Development, Bangalore.

Evaluation of project under STEP scheme of Ministry of Women and Child Development, GOI-KMF, Bangalore–Dairy Trade (Phase VI). Prepared by Nabard Consultancy Services Private Limited, Bangalore

A report on Impact Assessment Study of STEP Project of Resource Centre for Social Welfare And Rural Development of Chandel District, Manipur. Report prepared by Vidyasagar School of Social Work (Vidyasagar University)

Evaluation Cum Impact Study of STEP Projects for Handloom and Handicrafts. Implemented by ARTFED, Guwahati. Report prepared by Indian Institute of Entrepreneurship (IIE),Guwahati

Evaluation Cum Impact Study of STEP Projects for Handloom and Handicraft. Implemented by Artfed. Prepared by Indian Institute of Entrepreneurship (IIE), Guwahati

Report on Evaluation of Aquaculture Training Project under STEP Implemented by Aspiration Achiever Society, Bhopal. Prepared by NABCONS Bhopal

Evaluation Study of STEP, implemented by All Manipur Young Volunteers Association Kongba Nandeibam Leikai, Kongba Singjamei Road, Imphal, West District. Prepared by NABCONS, Manipur

Evaluation of STEP project,Support to Sanidhya Samiti,Bhopal,Madhya Pradesh for Handicrafts by Institute of Social Studies Trust,New Delhi

Annexure 4

Evaluation Matrix/Meta-evaluation framework

The evaluation matrix that is attached is recommended as an information resource to be used at the stage of project design. Evaluations are put to best use at this stage of the project cycle as the project is then informed by the ways in which it will be assessed right from the start. Moreover, it provides a useful tool to monitor the progress of the project, assessing whether the project is on target to achieve its desired goals. Further, for a good quality evaluation to take place, it is important to ensure that the correct information is collected so that a robust evaluation is possible afterwards.

Importantly, the evaluation matrix is a gender responsive tool and incorporates several elements that keep the needs of women central to the process of evaluation.

Meta-evaluation Framework

Type	Information tag
Descriptive	Name of the report
Descriptive	Short title of the report
Descriptive	Year of Evaluation
Descriptive	Sector
Descriptive	Sub-sector
Descriptive	Evaluating organisation (EO)
Descriptive	Implementing organisation (IO)
Descriptive	Mid-Term or End of Project Evaluation
Descriptive	Duration of the Project
Descriptive	Total Project Cost
Relevance	Did the EO assess the following
Relevance	a) Economic and geographical suitability of the project
Relevance	b) Suitability of the IO to carry out the project
Relevance	c) How the beneficiaries were selected?
Relevance	d) Did the project target the intended beneficiaries?
Relevance	d) (i) poor women

Relevance	d) (ii) SC/ST women
Relevance	d) (iii) Minority women
Relevance	d) (iv) single women/widows/female headed households
Effectiveness	Total Number of Intended Beneficiaries
Effectiveness	Total Number of Actual Beneficiaries
Effectiveness	To what extent did the EO assess the achievement (likelihood of achievement) of objectives in terms of
Effectiveness	a) Skills upgradation
Effectiveness	a) (i) Was the course curriculum well structured?
Effectiveness	a (ii) Were the trainers properly trained?
Effectiveness	a (iii) Was time set for training adequate?
Effectiveness	a (iv) Were raw materials provided by IO during training?
Effectiveness	b) Course delivery
Effectiveness	b (i) Was the time set for conducting courses gender responsive? - in terms of seasons as well as time of day
Effectiveness	b (ii) Were there creche facilities at training site
Effectiveness	b (iii) Is the course venue convenient or beneficial to the women?- in terms of promoting mobility or convenience through proximity
Effectiveness	c) Income generation
Effectiveness	c) (i) Has there been an increase in income?
Effectiveness	c) (ii) Has there been an increase in the rate of income?
Effectiveness	c) (iii) Is the income valued and/or of material significance to the household?
Effectiveness	d) Employment generation
Effectiveness	d) (i) Has there been a change in employment?
Effectiveness	d) (ii) How many hours are spent at employment?
Effectiveness	d) (iii) Is the employment valued by the household?
Effectiveness	d) (iv) Is there adequate space for employment activities?
Effectiveness	e) Was there a SHG/Cooperative?
Effectiveness	e) (i) How many SHGs/Cooperatives are there?

Effectiveness	e) (ii) How many SHGs/Cooperatives are active?
Effectiveness	e) (iii) Do the SHGs/Cooperatives conduct economic activities?
Effectiveness	f) Did the beneficiaries have access to credit/bank linkages?
Effectiveness	g) Access to markets
Effectiveness	g) (i) Do women sell from their homes, market, co-op?
Effectiveness	g (ii) Are they informed of the markets in their products?
Effectiveness	g (iii) Are they able to access the markets to sell their products?
Effectiveness	h) Increase in awareness of their rights and gender sensitization
Effectiveness	i) Health Education
Effectiveness	j) Availability and use of crèches
Effectiveness	k) Other support services
Effectiveness	l) Has the IO been involved at every stage of the above?
Effectiveness	m) If not, which of the above requires more IO attention?
Effectiveness	n) Were there structures in place at the IO for effective implementation?
Effectiveness	o) Was there a process in place at IO for monitoring and evaluation?
Effectiveness	p) Was there convergence between different govt. bodies for implementation of support services?
Effectiveness	q) Were there any unexpected outcomes of the project?
Effectiveness	r) If so, what where they?
Efficiency	Did the EO assess the following
Efficiency	a) Was the project finished within the stipulated time, or is it on track to complete on time?
Efficiency	b) If not, was this because funds were not released on time?
Efficiency	c) What other reasons were there for not completing the project on time?
Efficiency	d) Were the funds for the project utilized effectively? Were activities cost efficient?
Impact	Did the EO assess the following
Impact	The impact the intervention had on the sector as a whole?

Impact	The impact the intervention had on the social, economic and political status of the beneficiaries
Sustainability	Did the EO assess the following
Sustainability	Will the benefits of the programme continue with minimal or no government support after the project period is over?
Sustainability	If so, what were the reasons?
Sustainability	Is there a requirement for refresher training?
Sustainability	Did the project take steps for environmental sustainability?
Sustainability	Were there any major factors which influenced the nonachievement of the objectives of the programme?
Sustainability	If so, what were they?
Research Process	Time given for evaluation
Research Process	Methodology employed by EO
Research Process	a) Survey
Research Process	b) Random/Purposive Sample
Research Process	c) Size of sample
Research Process	d) Interviews, structured, semi-structured
Research Process	e) FGD
Research Process	Was a baseline conducted by IO?
Research Process	Did any of the content of the evaluation raise ethical concerns
Research Process	Were the activities being delivered in accordance to local cultural norms?
Research Process	Was the confidentiality of the beneficiaries maintained while conducting interviews?
Research Process	Were the voices of marginalized groups and power imbalances considered in the analysis, conclusions and recommendations?
Research Process	Were the interviews held in presence of the implementing agency?
Research Process	Were the evaluation results shared with the intended users?

Annexure 5

Questions for the Implementing Organisations

Implementation of STEP

1. What is the process through which the IA was identified as the right organization to implement STEP? (Geographic/economic suitability, previous experience of IA)
2. What does the IA understand as the purpose of STEP?
3. What does the IA think of as effective/positive about its implementation of STEP? (in terms of outcomes- increase in income, employment generation? change in time use patterns?- how would/does the IA assess these changes?) Are these changes attributable to STEP? If yes, why so? If not, how could the other contexts be incorporated into STEP?
4. Was there any particular strategy/intervention that the IA identifies as particularly effective?
5. Were the positive outcomes sustainable in the long run? If yes, what makes it sustainable?
6. What difficulties/constraints did the IA face in implementing STEP?
7. Identification of beneficiaries, mobilisation of beneficiaries, providing training, setting up of SHGs/co-operatives, facilitating market linkages, convergence of govt agencies - health, education training etc
   - Were these constraints intensified because the beneficiaries were women? Were the constraints specific to women (were women able to attend the training in the midst of other domestic responsibilities? were there dropouts because of the double burden faced by women?
   - Were strategies put in place to deal with these constraints?
8. What would a successful STEP intervention look like? What recommendations does the IA have in improving STEP?

Evaluation of STEP

1. How involved was the IA in the process of the evaluation? (TOR to methodology to findings to use) Did they find that the evaluation was conducted in a participatory manner? Did the evaluation take into account the views of the beneficiaries, the implementing agency? If so, how?
2. What did they think was the reasons for the evaluation? (Accountability/ learning)
3. Has the DWCD acted on the recommendations of the IA? If so, what has the DWCD done?
4. Was the evaluation useful? If so, in what way was it useful?
5. Does the IA have any recommendations on how evaluations maybe better conducted in the future?

Questions for the evaluating organisation

Implementation of STEP

1. What is your assessment as an EA of the following based on the projects you have evaluated?:
   a. Relevance of STEP?
   - Are the right projects identified in the right conditions? Are the right beneficiaries identified? Is there a coherent theory of change? (context of STEP, of the project- the suitability of the projectgeographic/ economic suitability; the suitability of the IA)
   b. Effectiveness of STEP? How would you assess this? Do you use a gender responsive lens in your assessment? What specific criteria make it a gender responsive lens? criteria for assessment- adequate infrastructure? provision of relevant materials? the course curriculum (length, relevance, expertise)? changes in income, changes in employment patterns, changes in time use? effectiveness of wider training provided (health, education, rights)? backwardforward linkages- (SHGs, co-operatives, access to markets), convergence between ministries
   c. Efficiency of STEP- again, how would you assess this?
   d. Sustainability of STEP?- environmental, as well as changes in outcomes in the long term?
2. In your assessment, what makes STEP work? And what doesn't make it work?
3. Are there any unintended impacts that you have observed in STEP projects?
4. Do you have any recommendations about how to make STEP more effective? If so, what?

Evaluation of STEP:

1. What does the EA see as the purpose of the evaluation?
2. Were the IA and the beneficiaries included in the process of the evaluation? If so, to what extent?
3. What was the methodology employed by the EA, and why? (Participatory?)
4. What were the constraints faced by EA in conducting the evaluation?
5. Time given for evaluation, bounded TORs, availability of resource materials- baselines, monitoring reports?
6. What adjustments to the methodology did the EA make in light of constraints?
7. Was the evaluation conducted with a gendered lens? If so, what are the elements of this gendered lens?
8. Were the findings of the EA taken into account by the Ministry? Was there a follow up rocess?
9. What recommendations would the EA make for improving the quality of the evaluations? Would this make STEP more effective?

Questions for the State Women Corporation

Implementation of STEP

1. What is the criteria and the process for choosing NGO, and trade? (geographical, economic suitability of project)?
2. What is the role of the state/central ministry?
3. Are the funds, resources (raw materials, infrastructure) provided in a timely manner? How is this monitored, assessed?
4. How do you ensure the convergence between the various govt departments to make STEP effective?

Evaluation of STEP

1. What is the basis of the criteria stipulated in the evaluation? (time, TORs, including sample size, etc.)
2. Are the evaluation findings used? If so, how?
3. How could evaluations be made more effective?

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CHAPTER 3

Gender and Equity Issues under SSA*

Vimla Ramachandran & Prerna Goel Chatterjee

The backdrop

It is now widely acknowledged that India has made significant progress in the field of school education in the last sixty-six years. In 1951, Gross Enrollment Ratio (GER) was 42.6 (boys - 60.6, girls - 24.8) at primary level and the percentage of girls enrolled in primary schools was a mere 28.1%. We have come a long way since then. In 2011, GER was 116 (115.4 for boys and 116.7 for girls) at primary level (SES, 2007; GOI, 2012). Equally significant is that independent non-governmental sources also report that close to 96% of children between 6 to 11 years are enrolled in school (ASER, 2013) and that close to 95% of children can access a primary school within 1 km distance. Furthermore, since 2004, "pupil teacher ratios have fallen by nearly 20% (from 47.4 to 39.8); the fraction of schools with toilets and electricity has more than doubled (from 40% to 84% for toilets and 20% to 45% for electricity); the fraction of schools with functioning midday meal programme has nearly quadrupled (from 21% to 79%); and the overall index of school infrastructure has improved by 0.9 standard deviation (relative to the distribution of the school infrastructure index in 2003)" (Muralidharan, 2013). Likewise, the National Sample Survey (NSS), a periodic survey conducted by the Indian government also reveals a positive trend, "the overall proportion of 6-10 year olds not attending school has declined from around 28% in 1993-94 to around 8% in 2009-10. While the proportion of 6-10 year old boys declined from 23% to 7% during the same period, the decline has been most significant among girls – from 34% to 9% in a period of 15 years. The gender gap between boys and girls has declined from around 11% in 1993-94 to around 2% in 2009-10. Similarly, in the 11-13 years age group, the gender gaps in the proportion of children not attending was around 17 percentage points in 1993-94 which has now declined to around 2% in 2009-10" (Sankar, 2013 forthcoming).

* Sarva Shiksha Abhiyan

Yet, despite impressive gains in enrollment rates and formal access to school within walking distance, there is a sense of disquiet about what these figures actually mean. The last ten years have thrown up much evidence of poor learning outcomes across the country (Desai et all, 2010; ASER Reports, 2005 to 2013; Educational Initiatives, 2009; Probe Revisited, 2006; Bhattacharjea, Wadhwa & Banerji, 2011; Jhingran, 2011; Mukherji & Walton, 2012; Muralidharan, 2013). Contradictory information on prevalence of child labour and the real extent of children who are out of school adds to the prevailing scepticism about India's achievement. Daily press reports of domestic child labour (mainly girls), or bonded child workers (mainly boys) in shops and roadside eateries, small factories and sweat shops adds to this sense of scepticism. In addition, the inability of our education system to ensure that teachers actually attend school and teach for the prescribed time remains a huge challenge. In fact, the situation remains particularly bad for girls and children from socially disadvantaged communities who attend government schools. Hence, in order to understand how GOI has been tracking achievements of gender and equity goals in elementary education, this desk review was conceptualized with a particular focus on Sarva Shiksha Abhiyan (Universal Elementary Education).

Evolution of Sarva Shiksha Abhiyan

After independence, the Government of India initiated several policies to address various issues in the field of education. The National Policy of Education (1986) was an important turning point followed by the Jomtien declaration on 'Education for All' (EFA) in 1990.[1] During this period, the government collaborated with select international donors and launched a number of basic education projects in Uttar Pradesh, Bihar, Andhra Pradesh and Rajasthan. In 1994, the Government of India launched the District Primary Education Programme (DPEP – see Annexure 1) covering most states in India. After the Dakar declaration in 2000, the Government of India formulated a National Plan of Action for EFA, which was finalised in 2002. This was reviewed in 2005-06 and strategies were reformulated for the Eleventh Five-Year Plan in 2007 and Twelfth Five-Year Plan in 2011 (GOI, 2008).

In 2001, Sarva Shiksha Abhiyan (SSA) the flagship programme to achieve universal elementary education was launched with the following objectives (GOI, 2002):

i. All children in school, Education Guarantee Centre, Alternate School, 'to School' camp by 2003

ii. All children complete five years of primary schooling by 2007

[1] http://www.unesco.org/education/wef/en-conf/Jomtien%20Declaration%20eng.shtm

iii. All children complete eight years of schooling by 2010

iv. Focus on elementary education of satisfactory quality with emphasis on education for life

v. Bridge all gender and social category gaps at primary stage by 2007 and at elementary education level by 2010

vi. Universal retention by 2010.

The SSA programme is also funded by the government, along with significant contributions from the World Bank, DFID and the Delegation of the European Union. With the introduction of SSA, all smaller elementary education projects, state-specific initiatives and joint UN system projects were merged into SSA. By 2003, this programme emerged as the umbrella programme of the government in elementary education. In 2010, the Right to Free and Compulsory Education Act (RTE) 2009 came into effect. This legislation generated considerable momentum within the government and in civil society. Thirty-two States and Union Territories of India have incorporated the Act into the state legislative framework and have adopted the norms prepared by GOI. The SSA framework was harmonised with RTE and the government started bringing out an annual status of implementation of RTE.

Box 1: Evolution of JRM mechanism

Joint Review Mission emerged in 1994 in the District Primary Education Project of the Government of India. It was designed as a periodic evaluation mechanism in which the Development Partners (DPs) consisting of the World Bank, the European Commission, the UK Department for International Development (DFID), UNICEF and the Royal Government of the Netherlands nominated experts to review progress of DPEP, alongside an equal number of experts nominated by MHRD, GOI. This team would review progress made towards achieving the goals of DPEP by reviewing the data base of the programme (DISE and SES), research studies commissioned by the government and DPs, independent research studies done in the last one year and progress reports presented by GOI and the state governments. The JRM team was divided into eight state teams and each team would visit one of the eight states, wherein they would interact with the state government, visited couple of districts and held discussions with state level institutions.

In 2001, GOI decided to phase out DPEP and introduced the Sarva Shiksha Abhiyan (SSA). Initially the SSA programme was fully funded by GOI. However, by 2004 three DPs were invited to participate, namely the World Bank, DFID and Delegation of the European Union. In 2005, SSA adopted the JRM mechanism. Like the DPEP JRM, SSA JRM also included an equal number of nominees from both DPs and GOI. However, one significant change was introduced in the SSA JRM mechanism. SSA JRM is a six monthly exercise alternating between a field based review and a desk review of data and reports.

Since its first mission in 2005, 17 Joint Review Missions have been held till January 2013. SSA JRMs are held twice a year, in the months of January and July. In January, members of the mission visit select few states and in July, a desk review is undertaken. Each JRM consists of members from both GOI and DP and is alternatively led by one of them. For each JRM, the members decide Terms of Reference and a checklist is prepared, which basically includes a list of items, under each goal, that needs to be reviewed by the members.

At this point, it is important to note that SSA has various mechanisms for concurrent and periodic monitoring. A Project Approval Board (PAB) reviews progress and approves annual SSA plans that are presented by the state governments. This internal GOI mechanism serves as a tool for GOI to keep track of progress and also be apprised of problems and concerns at the state level. In addition, GOI has also nominated recognised research institutions in 28 states to monitor progress on the ground. The reports of the Monitoring Institutions (MI) are taken into consideration when annual work-plan and budget (AWPB) is approved. This is an internal GOI mechanism to get periodic feedback on the status of implementation of SSA. However, PAB and AWPB are not positioned as an 'evaluation process' and are essentially viewed as internal monitoring mechanisms of GOI. On the other hand, SSA JRM is regarded as an intense monitoring and evaluation mechanism. In fact, different government departments and independent organizations such as Centrally Sponsored Scheme for Teacher Education (CSSTE), Mahila Samakhya Programme of GOI, the Secondary Education Mission of the government (Rashtriya Madhyamik Shiksha Abhiyan) and Pratham have adapted the SSA JRM mechanism.

This desk review was conceptualized with the purpose of systematically scanning SSA JRM reports (from 2005 to 2013), research and case studies commissioned by SSA during the same period in order to understand how gender and equity goals have been tracked and addressed in JRM reports. As discussed in the preceding section, gender and equity (social, economic, location) have been taken together in this study. This is because gender relations are intermeshed with social and economic inequity and location exerts a strong influence on both (see Annexure 2 on Education and Equity). Another aim of this study is to track the recommendations made in each SSA JRM and action taken report based on these recommendations. Keeping this in mind, the main objectives of this study are as follows:

- How the gender and equity goals of SSA are monitored?
- Is the focus on input indicators, implementation processes and / or output indicators?
- To what extend have classroom practices, teaching-learning process and curriculum related issues been addressed from a gender and equity perspective?

- To what extent have issues related to teacher deployment, teacher attitude and practices, and teacher training been addressed from a gender and equity perspective?
- Has the everyday experience of schooling of children been taken into consideration?
- What gender related issues have been flagged in SSA JRM?
- In what ways does it addresses issues of caste/community based discrimination and inclusion/exclusion in various school activities and classroom processes?
- In what ways have abuse (physical, emotional, sexual) and corporal punishment been addressed in JRMs?

In addition to the above questions, the review process also looked at JRM processes that influence how gender and equity are tracked, namely:

a. On what basis states, to be visited, are selected;
b. What happens during the school visit; what is observed and not observed;
c. Who decides what data should be reviewed and how data from various sources are analysed and reviewed;
d. To what extent are studies commissioned by SSA and other independent research studies discussed;

The objective of this study was formulated to understand in what ways the JRM process has been able to assess whether SSA have been able to reach the equity objectives that were set in 2001 including introducing strategies specifically designed to improve the participation of the most disadvantaged in education. This inquiry is guided by the understanding that bridging gender and equity gaps is an overarching goal of SSA.

How the SSA JRM is organised

Since, SSA was primarily conceptualized by MHRD, a limited numbers of donor partners were invited to be on board by the government. In addition, the government is the main funding agency for SSA programme and financial contribution by donor partners is very small. As a result, the intensity of involvement of donor partners has been considerably less and in the last few years (especially since 2010), some donor partners have diversified their funding to include secondary education (Key Informant Interviews 2013).

Since the first SSA JRM in January 2005, seventeen Joint Review Missions have been held till January 2013. They are held twice a year, in the months of January and July. In January, members of the Mission visit select few states and in July, a desk review is undertaken. Each JRM consists of members from both GOI and DP and is alternatively led by one of them.

For each JRM, team members decide Terms of Reference and a checklist is prepared, which basically includes a list of items, under each goal, that needs to be reviewed by the members. Many key informants shared that the terms of reference and data/information sources to be used by the JRM team is primarily decided by MHRD, GOI.

Some of our key informant interviewees revealed that JRM is the only mechanism through which the India offices of donor partners convey information on progress made to their headquarters. Given that all donor partners actively participate in the JRM missions, alongside independent experts and GOI nominees, JRM reports are taken seriously. Donor agencies also believe that the JRM mechanism brings in some degree of rigour in periodic monitoring and evaluation processes. A significant amount of data and information is generated and this is carefully scrutinised by the JRM missions. Equally significant is that the JRM recommends in-depth research studies, some of which are commissioned by the government and some by the donor partners through the technical assistance fund, and findings of these studies are supposedly presented in the JRM. Several informants also feel that the SSA JRM is a good opportunity to highlight and showcase good initiatives and practices.

As already stated, January missions are field-based missions. The MHRD and the donor partners identify sets of states to be visited. Usually the JRM team visits at least two states from south of India, one state from the northeast, along with central Indian states like UP and Bihar and some states from the West and the North. In quantitative terms, there are eight states that get 80% of the SSA funding and therefore, these states are visited more frequently. Table 1.1 lists key states that have been visited more often during the field visits. One of the key informants from the government shared that states to be visited during field-visit are usually decided by the MHRD. Within each state, the districts to be visited are chosen by the state government. During field visits, state governments make a presentation to the team, which is followed by two days of school visits and two days of report writing. School visits are usually planned in advance. However, there have been instances wherein JRM teams have visited schools that have not been on the itinerary (for e.g. 2012 mission in Gujarat). During interviews, one informant shared that, "it is normally a planned exercise and since I have been a part of this, I can say that it is easier to say that you can go at random and go and visit any school. States are very open on that. But how do you do that? You have a very limited time, you don't know the geography of the area and so you have to be depended on the state. And also, the states know that certain district would be covered during a JRM, so they alert the whole district. It becomes almost impossible to venture out on your own because there is no time and it is a very tight schedule."

Table 1.1: States mostly covered in JRM field visits

States	JRM field visits	Number of times visited
Andhra Pradesh	3rd, 5th, 13th, 17th	4
Bihar	3rd, 5th, 7th, 9th, 11th, 13th	6
Chhattisgarh	3rd, 7th, 11th, 15th	4
Madhya Pradesh	1st, 5t^th, 9th, 11th, 13th	5
Maharashtra	1st, 7th, 13th, 17th	4
Rajasthan	3rd, 7th, 11th, 15th	4
Tamil Nadu	1st, 7th, 11th, 15th	4
Uttar Pradesh	1st, 3rd, 5th, 9th, 13th, 17th	6
West Bengal	1st, 3rd, 7th, 9th, 11th, 15th	6

Limitations of this study

There were a few of limitations to this study:

a. In the following sections, we have commented that findings of many research studies, commissioned by SSA and donor partners, were not shared in the JRM reports. This is partly due to the fact that there was no way to ascertain which research studies/documents were shared and discussed during JRM meetings. It could be possible that some of these studies were discussed during meetings but their findings were not included in the final national report.
b. Our findings are largely based on the national reports. During the review process, all state reports were not available to us. Consequently, our findings focus, to a great extent, on the 17 Aide Memoires.
c. Finally, we don't know to what extent recommendations made in JRM reports are received by different states and what measures have been undertaken by each state to bridge gender and equity gaps in schools. We were informed that several states take state level de-briefing meeting recommendations very seriously. This may or may not be reflected either in the national Action Taken Report or the national Aide Memoire.

Process of review

1. As a first step, all JRM reports (all 17 JRM Aide Memoire and all available state reports) were scanned. We then developed a matrix for meta-analysis and entered key information from the JRM reports (Table 1.2). This formed the base document for analysis. A summary of the meta-analysis done is given in Table 1b below (See Annexure 4 for analysis on access, learning & teaching).

2. We then reviewed various research studies commissioned by SSA and tried to ascertain how findings of these research studies were received in the JRM.
3. We also reviewed independent studies and surveys done on SSA or on elementary education in the last 10 years (from 2003 to 2013) in order to ascertain how the findings or insights gained from these studies were received in the JRM.
4. Finally, we conducted key informant interviews with people working in DPs and those who had participated in more than 4 JRMs. It is important to note that several members of the DPs and GOI did not agree to be interviewed. Only 12 current and past members agreed to

Table 1.2: What is discussed and what is missing in JRM reports

	All children	Gender (Boys/Girls)	Social group SC/ST/Muslim)	Location (Urban/Poor)	CWSN (general)	Children from migrant family	Urban poor
Enrolment	Discussed	Discussed	Discussed	Limited discussion	Discussed	Discussed but no data given	Discussed but no data given
OOSC	Discussed	Discussed	Discussed	Discussed	Limited discussion	Limited discussion	Limited discussion
Drop out rates	Discussed	Discussed	Limited discussion	No discussion	No discussion	No discussion	No discussion
Attendance	Discussed	Discussed	Discussed	No discussion	No discussion	No discussion	No discussion
Retention	Discussed	Discussed	Limited discussion	No discussion	Referred occasionally	Referred occasionally	Referred occasionally
Transition from PS to UPS	Discussed	Discussed	Limited discussion	No discussion	No discussion	No discussion	No discussion
Completion rates	Referred occasionally	No discussion	No discussion	No discussion	No discussion	No discussion	No discussion
Govt. vs private school	Discussed	No discussion	No discussion	No discussion	No discussion	No discussion	No discussion
Drinking water	Discussed	Discussed	No discussion	No discussion	No discussion	No discussion	No discussion
Toilet	Discussed	Discussed	No discussion	No discussion	Discussed	No discussion	No discussion
Ramp	No discussion	No discussion	No discussion	No discussion	Discussed	No discussion	No discussion
Learning levels	Discussed	No discussion	Limited discussion	No discussion	Mentioned once	No discussion	No discussion
Special training centers	Discussed	No discussion	Discussed	No discussion	No discussion	Discussed	Discussed
Bridge courses	Discussed	Discussed	Discussed	No discussion	No discussion	Discussed	Discussed
Residential schools	Discussed	Discussed	Discussed	No discussion	No discussion	Discussed	Discussed
PTR	Discussed	No discussion	No discussion	Limited discussion	Discussed	No discussion	No discussion
Multi-grade schools	Discussed	No discussion	No discussion	Limited discussion	No discussion	No discussion	No discussion
Single teacher schools	Discussed	No discussion	No discussion	Limited discussion	No discussion	No discussion	No discussion
Availability of teachers	Discussed	No discussion	No discussion	No discussion	No discussion	No discussion	No discussion
Types of teachers (regular/para)	Only overall data has been given						
Female teachers	Data on total no. of female teachers is given occasionally; Low female teacher ratio in remote, tribal areas has been discussed only a couple of times						
Teacher qualification	Discussed	No discussion	No discussion	No discussion	Referred occasionally	No discussion	No discussion

be interviewed on condition of anonymity. During the interviews, most of them specifically requested that they do not want to be quoted in the report.

Gender and equity in SSA JRM

Indicators used in SSA JRM reports

One of the main goals of SSA is to achieve universal elementary education by bridging gender and social disparities. To achieve this goal, the SSA programme has focused on various input based, process based and outcome-based indicators (Table 2.1). This section gives an overview of the indicators used in JRM reports to discuss various gender and equity related issues.

Table 2.1: Input, Process & Outcome based indicators

Input based indicators	Process based indicators	Outcome based indicators
Enrollment • Data is mainly disaggregated by gender, social group, CWSN, location (urban/ rural – sometimes), govt. vs. private school (occasionally) • Information on innovation strategies to improve enrollment **Attendance** • Data is mainly disaggregated by PS & UPS, grade (sometimes), state (sometimes). **Incentives, to increase enrollment** • Free textbooks • Free uniforms • Bicycles to girls • Aids and appliances to CWSNs • Mid Day Meals (occasionally discussed) **Interventions/programmes introduced for girls and marginalized groups** • KGBV & NPEGEL for girls; • EGS (now discontinued) & AIE centres for remote areas; • Residential schools for Tribals/Dalit; • Madrasas for Muslims; • Residential schools • Bridge courses and remedial classes • Special training centres • School infrastructure & civil works	**PTR** • Data is disaggregated by PS & UPS; districts (sometimes) **Pedagogy** • ABL methodology • TLM • CAL **Teacher effectiveness** • Teacher training • Training for special educators • Challenges of multi-grade classroom, single teacher schools • Time on task **Curriculum & textbooks** • Bi-lingual textbooks esp. in Urdu and tribal languages • Inclusion of gender issues in curriculum • Alignment of curriculum acc. to NCF framework **Classroom processes** • Inclusion/exclusion of students in both school and classrooms (occasional reference)	**OOSC – data is disaggregated by** • Gender • Social group • Migrants and urban poor (sometimes) • CWSN (occasionally) • Location (rural/urban) **Retention rate – data is disaggregated by** • Grade • Gender • Social group (occasionally) **Drop out rate - data is disaggregated by** • Grade • Gender • Social group (occasionally) **Transition rate - data is disaggregated by** • PS to UPS • Grade • Gender • Social group (occasionally) • **Completion rate** • Data is disaggregated by PS & UPS

• No. of schools & classrooms sanctioned & constructed • Toilet facilities (within it for girls and CWSN) • Drinking water facilities • Ramps for CWSN • Playground & boundary wall (occasionally) • Blackboard & libraries (sporadically) • Availability of land **Teacher recruitment – data is disaggregated by** • Gender (sometimes) • PS & UPS (occasionally) **School Management committee** • Structure of SMC **Finance** • Mainly on utilization of funds	**SMC** • Roles and responsibilities of SMC members **BRCs & CRCs** • Capacity building and training	**Learning levels** • Information sometimes includes learning levels by gender and social group

Data sources used by SSA JRM

While the number of indicators tracked in SSA JRM is fairly exhaustive, it is important to note that the JRM process relies mainly on data from District Information System of Education (DISE). Apart from DISE, some missions refer to Selected Educational Statistics/School Education Statistics (SES) of MHRD, GOI and National Sample Survey (NSS). During field visits, team members, sometimes, also look at the data generated by Village Education Register (VER).

1. DISE was initiated in 1994 (under DPEP) and it collects district-wise data on indicators such as – number of schools, student-classroom ratio (SCR), pupil-teacher ratio (PTR), enrollment at different levels and in all grades (this disaggregated by social group and gender), average repetition and drop-out rates, retention and completion rates, data on under-age and over-age children, number of single teacher schools, number of female teachers, data on school facilities such as drinking water, toilets, boundary wall etc. Most child-related and teacher-related data is disaggregated by social group, gender and rural/urban. However, some data (for example, data on CWSN or contract teachers) is not always disaggregated.

2. Select Educational Statistics (SES) or what is now known as School Education Statistics (SES) is an annual publication of Department of School Education and Literacy (DSE&L), MHRD. Data sent by the state governments is collated and presented under SES. This includes data on enrollment (numbers and enrollment rates), drop-out rates, number of schools and teachers,

PTR and Gender Parity Index (GPI), which is disaggregated by social group and gender.

3. All India School Educational Survey is conducted by NCERT. There have been eight surveys so far and the last survey was done in 2009. This survey collects data from recognized schools (government and private) and collects information on location, teacher deployment, infrastructure and facilities etc. Since this survey is conducted once in six or seven years, it is not always used in JRM reports. However, 7th and 8th surveys gave information on the time period just before the launch of SSA and after the launch. Hence, these surveys are usually referred in JRM reports.
4. Village Education Survey/Village Education Register is also maintained at the school level. This has location specific information on total number of school going children in the catchment area of the school and those enrolled in schools (all types, including residential schools, private schools). The data is maintained for every child and is available by age group, community and gender.
5. National Sample Survey Organization (NSSO) has been conducting nation-wide sample surveys on various socio-economic aspects since 1950. NSS, conducted by the Ministry of Statistics, collects data on various socio-economic aspects such as labour force participation, fertility, mortality, population growth, family planning, employment, education etc. Till date, there have been three rounds that have specifically covered education – 42nd round (1986-87), 52nd round (1995-96) and 64th round (2007-08). In the 64th round, data was collected on indicators such as literacy rate, distance of household from schools, enrollment and attendance rate, proportion of students getting free education and educational incentives, percentage of students never enrolled, and percentage of students who drop-out of the school system. In addition, there is always some data related to education in almost all rounds.

If we look at the above data sources, range and type of information that is collected by each source varies with each other. Nevertheless, data that is available today is tabulated and made available to the public in a short span of time. This is particularly true with DISE data. However, notwithstanding the impressive turn-around period and the fact that raw data has a lot more information, data on different indicators are not triangulated and tabulated with each other. Another significant factor that influences what data is used and how it is presented in JRM is the composition of the team and priority areas identified by the government. For example, if there is a JRM team member whose main focus is CWSN then, there is likelihood that the JRM report would use all available information on CWSN including data from various surveys and independent studies.

Indicators presented

Scanning seventeen JRM reports, we found that the following information is presented and discussed in most JRM reports. Each of these indicators has been discussed in detail in the following paragraphs.

Table 2.2: Information given under each indicator in JRM

Access	• Enrollment – class-wise as well as level-wise (primary, upper primary) disaggregated by social group and gender. • Survey findings on out-of-school children (OOSC); • Information on average dropout; retention; attendance and transition rates. • Opening of new schools and school infrastructure.
Learning process	• Student assessment carried out by NCERT; • Curriculum and textbook related information, • Purchase and use of TLM; • Pedagogy and classroom processes – for example activity based learning (ABL), child-centred pedagogies
Teachers and teaching	• Hiring of teachers – regular and contract (earlier para teachers); • Number of female teachers; • Pupil-teacher ratio (PTR); • Teacher attendance; • Teacher training; • Academic support system (BRC, CRC related)
Community	• Whether SMC and VECs have been constituted; • Structure of SMC and VEC; • Role of community, SMCs, VECs, and civil society;
Programme Management	• Convergence with different departments and NGOs for community mobilisation, enhancing school quality and providing school facilities; civil works and infrastructure
Finance	• Finance – allocations of GOI, • Allocation of state-government share, • Expenditure

Access

Providing universal access is one of the basic tenets of education. It is also widely acknowledged that a healthy discussion on access is possible when it moves beyond

the realm of enrollment and physical infrastructure and includes other dimensions of schooling experiences such as availability of teachers, quality of books, teaching-learning process and whether schools are functioning properly. However, as evident from Table 2.2, in JRM reports, discussion on access is limited to data on enrollment, out of school children (OOSC), drop-out rates, retention, attendance, transition from primary to upper primary school and school infrastructure. Within these, most information is presented according to national, state or district level data. Only occasionally, this data is further given for blocks and clusters. Furthermore, data is not always tabulated according to location, social group and gender. This means that even though disaggregated data on each indicator is available (for e.g. in DISE), it is not presented in a composite manner. Table 2.3 lists various issues that have been tracked and addressed under access in JRM reports and issues that have been left out from the discussion.

Table 2.3: How access related issues are tracked and presented in JRM

Indicator	Main observations made under JRM	What is missing from JRM discussion
Enrollment	• Increase in overall enrollment rates across gender and social groups; • Narrowing of gender gap in enrollment • Low enrollment rates in upper primary schools (UPS); • Decrease in enrollments in government schools • Enrollment data on CWSN, urban poor and children belonging to migrating families	• Discussion on local enrollment trends and differences between schools that are located in remote locations with those that are well connected • Juxtaposing enrollment data with attendance and drop-out rates to get a more realistic picture by location, social group, gender • Reasons for low enrollment rates in UPS and which children are not going to UPS? • Reasons for increase in enrollment in private schools? • Which children have more access to private schools and which children are going to govt. schools? • CWSN, among them the situation of children with different kinds of disabilities and who is left out • Which children are completing elementary education?
OOSC	• Overall rate of OOSC including girls, CWSN, and various social groups such as SC, ST, Muslims • Various strategies to target most vulnerable groups • Existing discrepancy in OOSC data, because there is no uniform definition of OOSC	• Location specific presentation of data on OOSC, especially with respect to areas that are remote, inaccessible or conflict prone; • Reasons for not being in school • No information on profile of students who are being admitted to Special Training Centres. • Challenges of urban poor, migrant children etc.

Drop-out	• Overall drop-out rates disaggregated by gender and social group • Drop-out rates are highest from grade 5 to grade 6 • No uniform definition of drop-out • Reasons for drop-out – poverty, domestic work, sibling care, migration	• Areas where drop-out rates are highest • In depth analysis of reasons for dropping out of schools including teachers' attitude towards students, unable to cope with failure etc. • Drop-out rates in government versus private schools • Linking drop-out rates with learning outcomes
Retention	• Overall retention rate; • Retention of girls, SC/ST and Muslim children remains low • Retention of students, especially in upper primary is a challenge • Growth of unrecognized private schools is making it difficult to determine actual retention rate;	• Reasons for low retention rate according to gender and social groups • Factors that facilitate or impede successful transition and retention
Attendance	• Overall attendance rate • Sporadic and persistence absenteeism • Reasons for absenteeism – migration, ill health, distance, discrimination, irrelevant teaching methods	• Detail discussion on reasons for absenteeism according to gender and social group, by location and seasonal issues such as monsoons • Reasons missing – inadequate facilities in schools, teacher shortage, overcrowded classrooms, household work, sibling care, child labour
Transition	• Transition rate from PS to UPS; • Main reason include non availability of UPS and socio-economic reasons, esp. for girls	• Reasons for low transition rate by location, social group, gender etc.
School infrastructure	• Access has been understood mainly from the point of view of physical access. • Emphasis on overall growth in school infrastructure • Functioning toilet for girls and CWSN continues to be a challenge • Ramps for CWSN	• Huge variations in school facilities in areas where there are high proportion of children from disadvantage-background • Quality of ramps, toilets and drinking water facilities • No. of schools complying with RTE norms

Enrollment

Almost all JRM reports refer to the achievements made since 1990. The 17th JRM (2013) cites that nearly 199 million children (DISE, 2012) are currently enrolled in schools. In addition, not only has there been an increase in the overall enrollment rates, but there has also been a

significant increase in the overall enrollment of girls, children from various social groups, and children from economically weaker sections of the society.

However, JRMs have also observed that enrollment rates in upper primary level are still low. Even though ratio of PS to UPS is 2.22 (DISE, 2011-12), there are huge inter-state and intra-state differences. While rural-urban disparities have been discussed, what is conspicuous by its absence is the analysis of enrollment in UPS by location within rural areas or urban settlements. For example, more than 57% primary schools and 56% upper primary schools in rural areas are located more than 10 km away from BRC (calculated from DISE 2011-12). If one were to do an analysis of enrollment rates in relatively remote areas and compare them with schools that are located less than 10 km distance from BRC, JRMs could have gained a greater insight into where UPS enrollment is very low. It is important to note that even though there is information on location of schools, this information is not leveraged to get a better understanding of how location related equity issues are played out when it comes to enrollment at upper primary level.

Similarly, most JRM reports have mentioned that enrollment rates at UPS are lower than enrollment rates at PS. It is a well documented fact that one of the main reasons for low enrollment rates at upper primary level is low completion rate in primary schools and even when children are able to formally complete primary school, transition to a new school remains a problem in small villages and habitations (Ramachandran, 2004; Jha and Jhingran, 2005). In addition, there is little discussion on children who are not able to complete primary school and children are able to complete PS but do not move to UPS. In fact, in their paper, Pritchett and Pande (2006) have argued that completion rates are low at primary level, and the percentage is particularly low for girls and children from economically weaker sections. There could be many reasons for this including household work, sibling care, illness, poor quality of school, migration, exclusion etc. According to Boissiere (2004), if parents consider the quality of schools to be poor or feel that their children are not learning, they may choose to not enrol them or in some cases, remove their children from the schooling system. Such reasons could have a direct impact on the completion rate and yet, JRM reports are largely silent on discussion on reasons for low completion rate.

Furthermore, over the past few years, there has been a steady drop in enrollment rates in government schools and a steady increase in enrollments in private aided and unaided schools. This phenomenon was first acknowledged in the 3rd JRM report (2006) and according to the 17th JRM (2013) report, government school enrollment has decreased

from 151m in 2007-08 to 147m in 2011-12, while private school enrollment has increased from 34m in 2007-08 to 52m in 2011-12. As a matter of fact, there has been an increase in private school enrollments even in backward districts (16th JRM, 2012). This phenomenon has a lot of implications.

- First, there is a prevalent assumption that private schools provide better quality education and have lower PTR, which presumably means greater attention to students by teachers (Goyal and Pandey, 2009).
- Second, significant numbers of poor parents are opting for private schools, despite high school fees (Goyal and Pandey, 2009; PROBE Revisited, 2006). Again, there is a belief that private schools are 'better' because teachers are more regular and that students have marginally higher learning levels in private schools (PROBE Revisited, 2006).
- Third, it is a common perception that children from well to do and usually Upper Caste families have more access to private schools, due to relatively high costs of private schools. Within this, boys will have more access to private school education than girls. According to PROBE (1999) and PROBE Revisited (2006), many parents are still unwilling to invest (in other words, send girls to fee paying private schools) in girls due to existing patriarchal beliefs in society.

All these three issues impact enrollment rates of girls and boys in government schools and yet, we didn't find any discussion of these factors in JRM reports.

Most JRM reports have noted that enrollment rates of girls have been steadily increasing in government schools. Admittedly, a significant increase has been largely due to various interventions and strategies that have been introduced, at both state and central level. However, could it be possible that increase in the percentage of girls' in government schools is due to the fact that more boys are enrolling in private schools? If such is indeed the case, this can create a serious gender imbalances in both private and government schools. Therefore, it is important to analyse data according to the demographic profile of students on the basis of gender, social group and location in both government and private schools in order to effectively compare enrollment rates in both government and private schools. In fact, some disaggregated information has been captured under DISE, but unfortunately, SSA JRM often refers to the overall data (see Box 2), which tends to mask a lot of gender and equity related issues. Consequently, we do not know who has access to private schools and who doesn't; what is the completion rate in PS and UPS according to gender and various social groups; and what is the profile of students who are attending schools that are located in remote areas (i.e. more than 10 km from BRC).

Box: 2: Excerpts from 17th JRM, Aide Memoire (2013)

3.14 According to DISE data for 2011-12, 199 million children are enrolled in elementary education and enrollment trends, as illustrated in Figure 3.2 below, show that this has been increasing steadily at upper primary level since 2005-06. As reported in the 16th JRM report (2012:18), there has been some stagnation at primary level since 2007-08, due possibly to a decline in the child population and the reduction in the number of over-age and under-age children attending primary schools. (p. 11)

3.15 Girls' enrollment levels are overall showing a positive trend, with girls sharing 45% or more of the total enrollment in all States, with an overall average of 48.56%. (p. 12)

4.1 The gender gap at primary level has reduced to 3.18 per cent in 2010-11, from 4.08 per cent in 2003-04. In the case of upper primary schools, the reduction is considerable: from 8.8 per cent in 2003-04, to 3.22 per cent in 2010-11. The retention rate of girls at primary level was 75.94% in 2011-12. The transition rate of girls at upper primary level has improved considerably: from 74.15% in 2003-04; to 87.32% in 2010-11. (p. 20)

Finally, discussion on groups such as CWSNs, urban poor and children belonging to migrant families is largely limited to enrollment data, which is highly inconclusive. Equally significant is that, apart from data on CWSN who have been identified and who have been enrolled into school, there is hardly any discussion on gender, social group and types of disabilities with respect to CWSN. For example, we don't know whether boys and girls get equal opportunity to attend regular schools, what happens to children with severe disabilities (mental, physical, neurological) and if there are any discriminatory practices observed against CWSNs. Other barriers include lack of adequate numbers of special educators available to all schools, teacher capacity to work with children with mental disability, facilities for home schooling for severely disabled children and cultural norms and stigma related to disabled children. In fact, there is consensus within the government that provisions for children with disabilities are clearly insufficient. According to 12th Plan Working Group Report (Oct 2011), "Neither the school system nor other institutional mechanisms are equipped or geared to address needs of mentally disabled children" (paragraph 21.8). As a result, in the 12th Plan approach paper, the Planning Commission of India has specifically called for the need to go beyond enrollment data to address the issue of access to schooling of CWSN.

In conclusion, while SSA JRMs have flagged various issues from time to time, they do not dwell into variations between states, districts, and blocks and within them equity issues related to gender, location, socio-cultural profile and income.

Out of school children (OOSC)

Information on OOSC forms an important indicator to assess progress towards reaching gender and equity goals of SSA. However, data on OOSC has been a contentious issue because the donors and government do not always agree on the number.[2]

The 16th JRM report (2012) refers to the Human Development Report (2011) to highlight that the number of OOSC students is highest in ST community among different social groups and highest in Muslim community among all religious groups. However, disaggregated data on OOSC according to location and gender within social group has been infrequently discussed in JRM reports. For example, by and large most discussion on OOSC in JRM is limited to interventions such as bridge courses, KGBV and NPEGEL and innovations such as free uniforms and bicycles. This is rather unfortunate because there is a lot of information in the public domain that analyses various reasons for children dropping out of school, including work burden of children in poverty (PROBE, 1999; Probe Revisited, 2006; SRI-IMRB, 2009; Sankar, 2007 and 2011). Children with disabilities make up a significant proportion of OOSC. According to the Planning Commission report (2011, paragraph 21.8), among total disabled children identified in 2005, 34.19% were out of school, and this proportion remained at 34.12% in 2009.

In fact, a main issue with OOSC is the huge discrepancy in data in different studies (SRI-IMRB, 2009; NSS 66th Round, 2009-10). As stated in the preceding paragraph, this is largely due to the fact that there is no agreed common definition of OOSC across states. Even though this issue has been raised since the 1st JRM report (2005) and has been highlighted subsequently in many JRMs, no concrete steps have been taken as yet to agree on a common definition. Given the wide variations across states and agencies in defining who is out of school, calculating the actual number of OOSC remains a daunting task.

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[2] Data on OOSC is collected by different agencies and it is not always possible to triangulate. Equally, the definition used for "out of school" children has not yet been standardised across different surveys. Currently, there are three data sources - (1) MHRD estimates OOSC on a yearly basis by conducting a detailed household child census. As per this data, at present (in 2012-13 academic year) there are around 3 million OOSC among 6-14 years old, well below the target of 5.1 million. (2) MHRD commissioned third party/independent household surveys every few years to measure the number of OOSC. The first such survey (2005) estimated that the number of OOSC was around 13.4 million. In 2009, second independent survey indicated that the number of OOSC had reduced to 8.1 million. The third independent household survey (2012-13) is still underway. (3) Independent National Sample Survey (NSS) data is carried out by the National Sample Survey Organization (NSSO). While data from the latest NSS round (2011-12) are not available, number of OOSC fell by 2.37 million annually between 2007-8 and 2009-10, and past trends would indicate that the OOSC would fall to around four million by 2011-12 – again exceeding project targets. In addition to these, independent surveys also estimate children in school. As per ASER (Pratham) surveys, around 4.3% of rural 6-14 years in India were out of school in 2008 while, in 2012 this proportion had come down to 3.5% (World Bank, 2013).

JRM reports have also highlighted various strategies that have been adopted to address the needs of OOSC which includes residential special training centres, non-residential special training centres, seasonal hostels for children from migrant families and home-based education for CWSN children. However, there is no discussion on the scale of such interventions (e.g. in how many states such programmes have been implemented?) or what has been their impact in reducing the numbers of OOSC. There is also little analysis on whether such interventions have been sustainable (for example, seasonal hostels for migrant communities). Under SSA, special training centres (STC) have been set up to provide academic support to OOSC so that they are able to enrol into age appropriate classes. However, there is no discussion in JRM reports on the profile of children who are being admitted into STCs and progress made by these students once they enter regular schools and most importantly, how many of them drop-out again and re-enrol in the STC year after year. Gender dimension of the issue of OOSC has also received little attention and this is particularly worrying because out-of-school girls tend to be invisible when they are engaged in domestic work.

In fact, the enormity of this issue has been succinctly captured in the Twelfth Plan by the Planning Commission (2011). According to the document, "Disadvantaged groups are worse off with the dropout rates for SCs and STs higher than the national average. Of particular concern is that some of the most educationally backward States (Uttar Pradesh [UP], Bihar, Madhya Pradesh [MP] and Jharkhand) have the lowest student attendance rates (below 60 per cent). While there has been a decline in the percentage of out-of-school children (OOSC) across gender and social categories, Muslim, scheduled caste (SC) and scheduled tribe (ST) children need greater and focused attention. The number of OOSC who are physically or mentally challenged remains a cause for concern. The proportion of disabled out-of-school children in 2005 was 34.19 per cent and remained unchanged at 34.12 per cent in 2009. It is important to note that the maximum numbers of OOSC are those with mental disabilities (48 per cent), followed by children with speech disabilities (37 per cent)" (paragraph 21.6, 21.7, 21.8). Additionally, many research studies have highlighted issues surrounding OOSC (IMRB, 2010; PROBE Revisited, 2006). Yet, apart from data and information on various interventions, there is hardly any follow-up discussion in JRM reports on measures that needs to be undertaken to address the issues of OOSC.

Drop-out

Similar to OOSC data, data on drop-out rates is also contentious in JRM reports (see Table 2.4). This is largely due to the fact that like OOSC, there is no common agreed definition on who is

considered as a drop-out and this issue has been repeatedly raised in JRM reports. According to the 16th JRM (2012), "One of the problems with the data collected at present by DISE is the lack of clarity and uniformity in defining what constitutes a dropped-out child" (p. 20). For example in Rajasthan, a child is considered a dropout if he/she remains absent for 45 days, while in Kerala, if a child is absent for two weeks, he/she is considered a drop-out (14th JRM, 2011). Hence, data on drop-out rates remains inconclusive in JRM reports.

Table 2.4: Drop-out rates by different data sources

Data Source	Annual Average Drop-out Rate: Primary %
Drop-out study	1.4
DISE	8.1
SES	7.1
OOSC Study	5.4

Source: Taken from Table 9, 10th JRM Report (2009)

Furthermore, reasons for drop-out are often referred as blanket issues without any in-depth analysis. To cite an example, the 10th JRM (2009) report states, "It is evident from the drop-out study that retention is first and foremost an equity issue with SC, ST, Muslim children and girls most at risk of drop-out. Based on the study the main causes of drop-out include: poverty; domestic work; sibling care; migration of the family; lack of interest; own illness; repeated failure; unsatisfactory teaching; unsuitable school location" (p. 27). However, there is no reflective analysis in any JRM reports on whether there is a pattern of drop-out rates according to locations, how drop-out rates are linked to learning outcomes, in what ways teacher behaviour is resulting in drop-outs and which children are more likely to drop-out due to teacher attitude, etc.

Likewise, we don't know the status of drop-out rates in remote areas or whether drop-out rates also consider students who have moved to private schools. Similarly, we know that drop-out rates are highest after grade 5 (Drop out study, SSA, 2009; 16th JRM, 2012). But we don't know which children are dropping out, whether there are more boys or girls, whether drop-out rates are higher in some locations and why are they dropping out. Finally, just like the case with STCs (discussed under OOSC), JRM reports are silent on the status of children who have been

enrolled into bridge courses. Most children who enter bridge courses are either OOSC or have dropped out of regular schools. But we don't know what happen to children after they re-enter regular schools, and whether they drop-out again? If yes, who are these children and why do they continue to drop-out of schools again and again?

Retention

Over the years, it has been noted that girls, especially older girls and children from SC, ST and Muslim groups have the lowest retention rate. There has also been a persistent challenge in retaining children, especially in upper primary level. According to 17th JRM (2013), retention rate at primary level is 75.94%, which means that around 24% of children enrolled in grade 1 have either dropped out or are repeating grades and have not reached grade V. However, from JRM reports, we don't know why these children are repeating grades or dropping out. Also, there is no information on whether some of these students have dropped out from the school system completely or they have joined private schools. In fact, in some JRM reports, it has been argued that due to insufficient clarity on reasons for drop-outs, it is difficult to suggest 'context specific strategies' (10th JRM, 2010) that would help in increasing retention rate. However, this point is debatable because some reasons have been cited in the 10th JRM report itself (see section on drop-outs). Similarly, there have been many studies including studies commissioned by SSA (2010a, 2010b) that have cited various reasons for dropouts and low enrollment.

Furthermore, in few JRM reports, it has been recommended (for e.g. 9th 2009; 12th JRM, 2010) that there is a need for focussed strategies for most vulnerable groups, SC/ST and Muslim children, older girls, CWSNs, children affected by migration and urban poor. In fact, in these reports, there have been discussions on ways to improve retention rate. For example, by specifically targeting most vulnerable children in districts where transition rate from primary to upper primary is less than state average (9th JRM) and by converging with National Rural Health Mission to address child health issues (12th JRM, 2010). Unfortunately, most of these recommendations are often repeated in JRM reports but in reality, there is not much evidence of what actions have been undertaken to improve retention rate.

Attendance

Along with low retention rates, low attendance rate in schools is another area that has been flagged many a time in JRM reports. In many JRM reports, it has been highlighted that student absenteeism is a huge issue, in both PS and UPS. In fact, in some reports (for e.g. 11th JRM,

2010; 16th JRM, 2012), it has been argued that the problem with attendance data lies in the fact that it is often recorded as an overall average rate, which does not reflect the real scenario. For example, many states are reporting more than 90% student attendance (6th JRM, 2007; 16th JRM, 2012). We also know, from 14th JRM report (2011), that low attendance rates have been recorded among children from disadvantaged groups. However, we don't know anything about locations where attendance is low, whether girls are more absent or boys, whether attendance varies according to social or occupational groups or if there are seasonal variations in attendance.

In order to understand the complexity of low attendance rates, it is important to analyse reasons for absence. This is because there are basically two main types of student absenteeism – (i) students who are enrolled in schools but do not attend schools at all (persistent absenteeism); and (ii) students are temporarily absent from schools (sporadic absenteeism). One way to analyse this difference, which has been often emphasized in JRM reports, is to disaggregate data on persistent and sporadic absenteeism by gender, social group, and by location. Also, this differentiation is important because strategies required for regular attendance would be different for students who are absent on a regular basis as compared to students who are absent sporadically (16th JRM, 2012). Since no such data is available, there isn't much evidence of strong recommendations on ways to tackle student absenteeism in JRM reports.

Nevertheless, some JRM reports (13th & 14th JRM, 2011) have mentioned reasons for absenteeism, namely migration, ill health, social distance, discrimination, irrelevant teaching methods etc. Apart from these reasons, there are other issues that have been discussed in other studies such as lack of adequate facilities in school; teacher shortage; overcrowded classrooms; household work and sibling care; and participation in agricultural and other income generating activities (World Bank 2004; SSA, 2009a; SSA 2009c). Equally significant is the prevalence of seasonal child labour, especially girls, in cotton seed farms (Jandhyala, 2011). Unfortunately, information or insights gained from these studies have not been taken on board in JRM reports.

School infrastructure

In most JRM reports, physical access has been explained with respect to providing adequate number of schools and classrooms, STCs and basic facilities such as drinking water, toilets and ramps. In the following paragraphs, each of these indicators has been discussed in detail.

[3] http://www.rtemaharashtra.org/index.php/rte-schools/88-norms-for-schools-and-school-facilities-quality

Schools and classrooms: According to many JRM reports, increase in access has been made possible through opening of primary and upper primary schools, alternative education centres, residential and non-residential bridge courses, residential hostels, provision of early childhood care and education. OOSC girls are being reached through KGBVs and till recently, children in remote habitations were reached through EGS/AIE (now discontinued) centres. In many areas, transport allowance is also being provided to children to help them reach the nearest school (17th JRM, 2013). However, JRM reports mainly highlight the overall growth with respect to school infrastructure and any discussion on regional differences in quality of access has been largely ignored. To illustrate, several studies (World Bank study, 2003a; PROBE Revisited, 2006) have presented evidence that there is a considerable difference in the quality of school infrastructure, especially in areas where there is a high proportion of SC/ST community. But we do not find this sort of analytical discussion in JRM reports.

Number of schools complying with RTE norms: Another area where JRM reports have failed to highlight a realistic picture is the number of schools that are complying with the physical infrastructure norms as stipulated under the RTE Act.[3] According to the 14th JRM report (2011), more than 70% government schools and more than 85% private schools are complying with at least 5 out of 9 physical facilities, as stipulated under the RTE Act. However, according to PAISA report (Accountability Initiative, 2012), only 15% government schools are complying with all norms. This is a huge difference and one could argue that the interpretation of RTE norms could have been different in both reports or maybe methodology adopted by both reports were different. Even then, this is a considerable difference and it cannot be ignored. In fact, many newspaper articles[4] have also highlighted the number of schools who are not complying with RTE norms. Yet, we don't find their reference in any JRM reports.

Drinking water: While most states have reported that schools are providing adequate drinking water (10th JRM, 2009; 12th JRM, 2010; 17th JRM, 2013), it remains to be seen whether this supply is regular and safe.

Toilets: A major challenge area, which has been acknowledged in most JRM reports, is the lack of adequate functioning toilets for girls and CWSN, especially in upper primary schools. At present, a toilet is considered functional if even one seat is working and even though, it has been recommended that definition of functioning of a toilet needs to be changed (12th

[4] http://articles.timesofindia.indiatimes.com/2013-07-22/mumbai/40726865_1_new-schools-space-crunch-rte-act
http://www.thehindubusinessline.com/industry-and-economy/education/rte-deadline-ends-many-schools-yet-to-implement-norms/article4569409.ece

JRM, 2010), not much progress has been made so far in this direction. Further, provision of facilities/infrastructure is not presented in relation to the number of students in each school. Therefore, a school with over 300 children may have one toilet for girls and one for boys. Can this be interpreted as having adequate toilet facilities?

Ramps: While many schools have constructed ramps for physically challenged students, their quality remains a challenge in many states. From JRM reports, it is unclear whether the approach to ramp is wheelchair friendly or is the ramp too steep, etc.

Special Training Centres: Under SSA programme, Special Training Centres (STC) have been started with the purpose of mainstreaming OOSC into formal school system and enabling children to be admitted into age appropriate classrooms. However, a major challenge that has been reported in many JRMs is that there is no common understanding regarding eligibility criterion of children enrolled in these centres. In some instances, for e.g. in Chhattisgarh, it was noted that younger children (4-6 year old), either orphaned or abandoned by families were included in STC (15th JRM, 2012). Additionally, a majority of these children need support even after they have been mainstreamed into regular schools. While this has been acknowledged in some reports (e.g. 15th JRM, 2012), no focused study has been commissioned by JRM on this issue.

With the implementation of RTE, it was discussed in the 12th JRM (2010) that the definition of access needs to move beyond the realm of physical infrastructure and should include other dimensions of school e.g. whether teaching-learning is happening in school, availability of teachers, availability of books and material and most importantly availability of a school that functions regularly. However, till early 2013, i.e. up until the 17th JRM report, discussion on physical infrastructure had not been integrated with issues related to quality and equity.

Learning and teaching

Along with improved access, equity and retention, quality of schooling experience is also closely linked with improved learning outcomes. As the 11th JRM (2010) succinctly states, "Universal enrollment, attendance, retention and inclusive education are necessary components to ensure equity in education, however, it is ultimately the quality of the schooling experience for the children, the classroom processes and activities and improvement of learning levels that are of essence in achieving education of equitable quality and moving towards the goals of Education for All" (para 3.70). While the statement holds true, ironically, in most JRM reports, approach to learning and teaching, as a main component of quality, has been extremely fragmented (see Table 2.5).

Table 2.5: Issues related to Learning and Teaching

Indicator	Main observations & concerns raised in JRM	What is missing from JRM discussion
Student assessment and learning outcomes	• Large scale evidence of rote learning • Increasing use of CCE as a continuous assessment tool. However, there is confusion regarding CCE itself and how it is being rolled out; • Learning levels are low, especially among disadvantaged groups (using NAS of NCERT) • Various learning interventions that have been implemented to increase learning levels	• Reasons for low learning levels • In what ways various interventions have increased learning levels of students • Learning levels of students in government versus private schools; • Analysis of learning levels by location and triangulating it with single teacher schools/two teacher schools, PTR etc. • Not acknowledging independent learning assessment surveys.
TLM, curriculum, textbooks	• Most states are changing their curriculum acc. to principles of NCF • Increasing use of bilingual languages in textbooks	• Not much discussion on the status of inclusion of gender and equity issues in curriculum • Are textbooks being delivered in time?
Classroom processes	• Innovations such as CAL, ABL, pictorial dictionary, mobile libraries etc. • Traditional methods of teaching largely employed by teachers	• What kinds of inclusion and exclusion practices are prevalent in schools and classrooms?
Recruitment of teachers	• No. of single teachers schools continue to remain high	• No information on location where most single teachers schools are situated • No information on composition and qualification of teachers • No data on special education teachers
Female teachers	• Steady increase in the number of female teachers over the years • Proportion of female teachers in educationally backward areas is not known	• Discussion surrounding gender discrimination of all kinds in hiring of regular and contract/para teachers • No discussion on deployment of female teachers, with respect to location or type of school; • Safety and other related issues of women teachers posted in remote or inaccessible areas
PTR	• Low PTR ratio, especially in remote & tribal areas; • High PTR in the most populous states where PTR could go to over 100 students per teacher	• There is no information on whether schools with high PTR have also high no. of contract teachers and/or are single teacher schools? • What is the composition of students in schools that have high PTR ratio?

Teacher training	• Data on no. of teachers who have been trained and yet to be trained • Extensive use of traditional methods in teacher training programmes • Poor content of training programmes • Lack of focus on equity and gender issues in training programmes	• Limited discussion on impact of training on teaching & learning process; • No discussion on the content of training programmes, how the needs of teachers are being ascertained and problems that are being faced by teachers in multi-grade classrooms
Attendance & accountability	• Insufficient time being spent on child-centric activities • Insufficient data on teacher accountability	• No analysis of whether the accountability and effectiveness of regular and para teachers are different / same

Learning outcomes

While there are general comments on the learning levels, data on learning levels of students has not been tracked systematically in the JRM reports. Additionally, even though most JRM reports (3rd JRM onwards, 2006) have commented on the low learning levels of students, reasons for low learning levels have not been addressed at all in any reports. There could be two possible reasons for this. Firstly, as mentioned above, a main limitation of JRM mechanism lies in its reluctance to refer to different sources of data. Often, only, data from NCERT's National Achievement Survey (NAS) is referred to in JRM reports for measuring learning levels of children and NAS does not capture reasons for low learning levels.

Secondly, as Pritchett and Pande (2006) have argued, there has been little documentation of learning levels in government schools in India. Whatever little government documentation is there, the results are hardly compared with other independent studies such as ASER. Consequently, even though some JRM reports (11th JRM, 2010; 16th JRM, 2012) have commented that learning levels of children from disadvantaged groups are low, there are no discussions on reasons for this, even though many studies (e.g. PROBE Revisited, 2006; Reardon, 2011) have discussed these reasons at length. In his paper, Reardon (2011) has argued that income of parents has a bearing on the achievement levels of a child. According to him, there is a substantial achievement gap between children from high and low-income group families. For example, well-to-do families are more likely to invest more in the education of their children, either through tuitions and/or by sending them to private schools. In addition to low income, factors such as social group, educational level of parents and gender of a child also influence the educational outcomes of a child. In fact, parents with low or no education level are less likely to help their child with schoolwork (PROBE Revisited, 2006). Additionally, many examples have

been given in PROBE Revisited (2006) to highlight that teachers often marginalize children from socially disadvantaged communities, which again has a negative influence on the learning outcomes of children. But we don't see such references in JRM reports.

JRM reports have also discussed various programmes and interventions that have been introduced under SSA to improve learning achievement levels such as Learning Enhancement Programme (LEP), on-site teacher training, teacher support/supervision through BRC/CRCs, quality monitoring tools, measurement of teachers' attendance and time on task. It has also been noted in many JRM reports that most states are providing remedial teaching and long-term bridge courses. But, what is not discussed are: (i) scale of these programmes; (ii) profile of students who are benefiting from these interventions; and (iii) what resources have been allocated for the implementation of such interventions. It also remains to be seen to what extent remedial teaching is addressing the fundamental issue of low learning levels among children.

Finally, up until 2010, learning outcomes were not discussed and it was not one of the 'must do' items in JRMs. However, in the 12th Five-Year Plan by Planning Commission (2012), there is a huge focus on learning outcomes. The report states that learning of children will be, "measured, monitored and reported independently at all levels of school education with a special focus on ensuring that all children master basic reading and numeracy skills by class 2 and skills of critical thinking, expression and problem solving by class 5" (Vol. II, p. 51). In line with the 12th Plan, the 17th JRM report (2013) has recommended that independent studies should be commissioned by the government to measure learning outcomes of students. Hopefully, in the near future, we will have more information to analyse learning outcomes of children from different locations, social groups, situations, disability and gender, along with strategies required to improve the learning outcomes of children.

Student Assessment

In most JRM reports, NCERT's NAS finding is accepted as the official data to evaluate students' learning levels. It captures data of students studying in government and government-aided schools and estimates are generated at both national and state level. In 2003, NAS data revealed that there was a distinct gender and rural gap in learning achievement. Unfortunately, this gap still persists. Furthermore, interpreting NAS data is a daunting task as the data given is highly technical and since, assessments done by other independent or non-governmental organizations are not tabled in JRM reports, discussion on student assessment in JRM reports remain biased.

Even though it was discussed in NCF (2005), it was only after the enactment of RTE in 2010, that Continuous and Comprehensive Evaluation (CCE) was introduced as a mechanism to assess

students' performance. The main purpose of CCE is to evaluate students' learning levels at various intervals and provide remedial measures to improve their performance.[5] At present, more than 20 states and UTs have introduced CCE in schools. However, there is lack of clarity with regard to implementation of CCE at various levels and this issue has been raised in many JRMs. For example, instead of focusing on continuous evaluation along with regular assessments, many states are focusing on semester and unit tests, which has increased the academic pressure on students (15th JRM, 2012). Similarly, many teachers have reported that CCE involves filling out many forms and this has only increased their administrative workload. They also feel that this format is not child friendly. Hence, it has been argued in JRM reports that more effort and training is required to explain the concept of CCE to both parents and teachers (17th JRM, 2013).

TLM, Curriculum, Textbooks

In order to increase enrollment rates, especially among girls and children from disadvantaged groups, many strategies were formulated. At present, all children under SSA are being provided free textbooks. However, along with free supply of textbooks, it has been mentioned in the 17th JRM report (2013) that it is also equally important that these textbooks are child-friendly and comprehensible to children.

In addition, JRM reports have mentioned that there is a need for revision in order to make them more inclusive. For example, after the DPEP programme, it took almost a decade before SSA commissioned another gender review of textbooks (done by TSG, EdCIL in 2012 and the draft has not yet been presented in the JRM). Further, no such review has taken place with respect to caste and community and hence, we don't know how specific communities are represented in textbooks (for example, tribal groups, Muslims etc.). Equally, the rich geographical diversity of India also does not find a place in textbooks.

As a matter of fact, all states are required to change their school curriculum and textbooks according to the principles of National Curriculum Framework (2005) and should include social issues such as "poverty, child labour, illiteracy, caste and class inequalities in rural and urban areas" (p. 52). While many states have aligned or are in the process of changing their curriculum, it is still a huge challenge for some states (15th JRM, 2012). Having said that, JRM reports are weak on highlighting some key examples that demonstrates in what ways gender and equity issues have been interlinked with the curriculum or in what ways gender and SC/ST stereotypes have been removed from the textbooks (World Bank study, 2004a).

[5] http://www.cbse.nic.in/cce/index.html

Recruitment of Teachers

A major part of student learning and achievement depends on the effectiveness of the teacher and one of the first steps to map this effectiveness is recruitment of teachers. According to RTE norms, there should be a minimum of two teachers in a school, which has 1-60 students. However, according to DISE (2011-2012), 11.47% primary schools in rural India are single teacher schools and in some states, these figures are more than 20%. In Arunachal Pradesh, for example percentage of single teacher primary schools is close to 60.35%, it is 21% in Assam, 31.34% in Rajasthan and 24.02% in Uttarakhand (Flash statistics, DISE, 2011-2012). Even though JRM reports have highlighted the challenges of single teacher schools and multi-grade classrooms, recommendations to tackle such issues are largely limited to the need to recruit more teachers. Further, there are hardly any discussions on areas/locations that are under-served. One report (12th JRM, 2012) does mentions the issue of teacher recruitment in under-served areas and makes a recommendation that states need to ensure that teachers should remain in such areas for at least a minimum period. However, not only do we not know what is the 'minimum' period or how many teachers are deployed in under-served areas, there is also no way of knowing how many of these teachers actually go to schools.

Moreover, if we look at the distribution of schools, about 71% single teacher schools are located more than 10 km from BRCs (Analysed from DISE, 2011-2012, see Annexure 3). Hence, it is possible to infer that not only are remote locations more likely to have single teacher schools, but also that schools in remote locations have poor facilities. In addition, there is no information on the composition and qualification of teachers who are being recruited in these schools. This is a huge equity challenge, which has been overlooked in JRM reports. Similarly, while most JRM reports have mentioned the total number of teachers that are recruited each year, it does not take into account disaggregated information on these teachers in terms of gender, social group and location (even though this information is available in DISE). In fact, the situation is worse when it comes to data on special education teachers. This is because there is no data on the number of special education teachers that have been recruited (even DISE does not collect data on special education teachers).

Female teachers

It is generally believed that female teachers can have a significant influence on girls' enrollment and retention in schools. The government's Education Commission reports (1965 onwards) have reiterated this belief. However, in JRM reports, recruitment of female teachers has been mainly discussed in the form of data and not from the perspective of their positive role in enrollment and retention of girls, especially older girls.

Currently, the total distribution of female teachers is 41.78% at primary level and 41% at elementary school level in rural areas (Analytical Report, NUEPA, 2011-2012). However, this percentage reduces drastically to 25.7% in Madhya Pradesh; 24.8% in Rajasthan, 25.7% in West Bengal and 20.4% in Tripura. Furthermore, when we look at schools that are located more than 10 km from BRC (Analysed from DISE, 2011-2012, see Annexure 3) percentage of women teachers is lower in remote locations. In fact, earlier JRMs have acknowledged that low female teacher ratio is a huge challenge in many areas, especially educationally backward and remote areas (5th JRM, 2007). But this discussion has not been followed up in later reports. In addition, we don't know whether female teachers are being discriminated against during the recruitment process and in what ways; and whether any safety measures have been put in place for female teachers, especially in remote areas.

Pupil Teacher Ratio

Another issue that has been repeatedly mentioned as a huge challenge is high PTR, especially in schools that are located in remote and tribal areas. Almost 40% primary schools and 30.58% upper primary schools in rural areas are struggling with adverse PTR ratio (NUEPA, 2011-2012). On the other hand, according to ASER data (2012), only 42.8% schools are meeting PTR norms, as set under RTE. Even though there is a discrepancy in both data sources, on several occasions, JRM reports have highlighted the issue of adverse PTR in several districts. They have also pointed out that even though the state average might be low, there are huge variations within districts and blocks. PTR situation is worse when it comes to children with special needs. According to the 11th JRM (2010), on an average, one special teacher educator is available for 60 severely disabled children. However, in none of the JRM reports is there any discussion on adverse PTR issue from the perspective of gender and equity. It is quite plausible that schools with high PTR are single teacher or multi-grade schools and are more likely to have children with low learning levels. Consequently, the issue of adverse PTR cannot be seen only in terms of numbers and location, but needs to take into account other issues such as hiring and training of teachers, time-on-task (discussed in the following section), school infrastructure etc.

Attendance and accountability

Even though many studies have been conducted to measure teacher effectiveness (Pritchett and Pande, 2006; SSA, 2010d), there is insufficient discussion on teachers' accountability in JRM reports. According to the Time-on-Task study that was undertaken in 2006-07 (SSA, 2010d), 80% of total teacher time is spent in classroom activities. On the other hand, in multi

grade classrooms, teachers usually focus on one grade and as a consequence, students from other grades spend nearly 65% of their time in non-academic activities. The study also revealed that more than 50% of total instructional time is spent on traditional teaching practices and only about 24% time is spent on child-centric activities. While the 8th JRM report (2008) does acknowledge the results of time-on-task study, it does not address some pertinent questions such as what is the difference between the accountability and effectiveness of regular and contract teachers (also referred to as para-teachers) and what are the learning levels of children, especially in multi-grade classrooms.

Absenteeism is another issue that has been found to be particularly common among regular teachers. For example, in their study, Pritchett and Pande (2006) have argued that even though primary school teachers in India are given better remuneration compared to some other countries, yet, absenteeism is highest among Indian primary school teachers. Similarly, other studies have found high attendance and engagement rate among contract teachers as compared to regular teachers, even though the former are paid poorly (Muralidharan and Sundaraman, 2008; Goyal and Pandey, 2009). Incidentally, in 2009, SSA commissioned a research study on para-teachers. Yet, we don't find many references to these studies or their findings in JRM reports.

Teacher training

Teachers are one of the main determinants of quality of education. Encouraging teachers to perform well is a complex process that not only involves teacher recruitment, but also includes good working environment, regular training and professional development, and adequate remuneration. In addition, as already discussed in preceding paragraphs, there are issues surrounding single teacher schools and multi-grade classrooms that needs to be addressed in order for teachers to perform well. All these issues are intertwined and have a huge impact on teachers' performance and motivation. Yet, as the 17th JRM (2013) acknowledges, discussion on teachers focuses mainly on the training aspect, which includes mapping total number of teachers who have been trained or are yet to be trained.

A major issue observed with teacher training, in JRM reports, is the didactic nature of the training process. Largely traditional methods are employed in training programmes and as pointed out in the 6th JRM (2007), there is a persistent use of lecture based training methods with little focus on participation, reflection and skill development. In most JRMs, it has also been observed that there is little evidence of critical evaluation of the impact of teacher training in classrooms. Based on these observations, repeated recommendations have been made in

JRM reports that there is a need to evaluate the impact of teacher training programmes in order to assess classroom process and student learning achievement (9th JRM, 2009). In fact, the 12th JRM (2010) had reported that a study on teacher effectiveness had been commissioned but the results of that study have not been discussed in subsequent JRM reports.

Another issue that has been frequently highlighted in JRM reports is the poor content of teacher training programmes. Even though most training programmes focus on areas such as CWSNs, RTE Act, use of TLMs, understanding of NCF, along with different subject matter, yet these areas are addressed separately. In addition, some reports have argued that despite a 28% increase in teacher training programmes, most teachers have not undergone any training on inclusive education (13th JRM, 2011). In fact, this is one area where the JRM has repeatedly argued that there is a need to revitalize programmes because they are increasingly becoming routinized (11th JRM, 2010). Some JRM reports have also suggested that training programmes need to go beyond the subject matter and focus more on gender and equity issues (6th JRM, 2007; 7th JRM, 2008; 8th JRM, 2008; 14th JRM, 2011), challenges of multi-grade classrooms (4th JRM, 2006) and leadership aspect (13th JRM, 2011). Unfortunately, even though these recommendations have been made regularly in JRM reports, very little progress has been made in this area. There is also little discussion on the role of DIET, BRC and CRC in the teacher training process, in particular, what is their role in assessing the training needs of teachers, provide on-site training or working with teachers on specific issues/concerns. Equally, orientation and training of CRC and BRC on gender, social equity, discrimination, inclusion-exclusion is yet to be taken on board.

Role of SMCs

Community participation and SMC involvement has been positioned as an important strategy to achieve equity goals of SSA. The belief is that by involving people, especially women and parents from disadvantaged groups, it would help bridge the gap between school and the community. Having said that, while JRMs have mentioned that women and parents from minority communities do not always participate actively in SMC meetings, the hard reality is that the JRM does not dwell into ways in which gender and equity issues influences how SMCs are constituted, how meetings are conducted and whether members are oriented and trained to function effectively.

Under the RTE Act, every government and government-aided school is required to constitute a School Management Committee (SMC). Members of SMC should include parents, head master, community members and a student. Further, 50% of its members should be female

and it should also have representation from SC, ST, and other minority communities. Since the beginning of the SSA JRM process, there has been a continuous focus on the role played by community and civil society in the functioning and monitoring of schools. According to JRM reports, SMC members in most states have a general idea about their roles and responsibilities, in particular, about school maintenance grants, budgets for additional classrooms, various grants for children, monitoring of MDM, etc. JRM reports have also focused on the role played by SMC members to improve functioning of school, enrolling OOSC, ensuring regular attendance of teachers, monitoring civil works and MDMs etc. However, there are some serious challenges that most SMC members have been facing.

Even though 50% positions in SMCs have been reserved for women, few women were found taking leadership positions (15th JRM, 2012). It has also been reported that most women and parents from minority communities don't participate actively in SMC meetings. According to a study (Singh, 2011) commissioned by SSA, a possible reason for such behaviour is that meetings are usually presided over by 'influential' members, who are often males. Similarly, in the 16th JRM (2012), it was reported that many members, especially those from disadvantaged communities, are often in awe of school authorities. Finally, it has also been reported that many SMC members often do not have information on how committees should be formed and what are the roles and responsibilities of SMC members (Pandey, Goyal, Sundararaman, 2011).

In order to help SMC members perform their roles effectively, many JRM reports have suggested that there is a requirement for intensive training. Along with information on functioning of SMC, training programmes also need to include issues of CWSNs, bullying, discrimination, corporal punishment, understanding RTE norms, how to monitor teacher effectiveness and learning levels of children etc. (various JRM reports). In fact, it has been argued that timely and relevant information could significantly increase the participation of SMC members, which in turn, could lead to increase in accountability of schools and teachers (Pandey, Goyal, Sundararaman, 2011). In a study by Pandey, Goyal, and Sundararaman (2011), it was found that the participation of community members increased significantly, after they ran an information campaign wherein they provided relevant information to various stakeholders. To cite an example, after a successful information campaign, engagement of SMC members in both Uttar Pradesh and Madhya Pradesh increased, leading to significant improvement in teacher effectiveness and functioning of school committees.

Finance

According to Jhingran and Sankar (2009), state governments are responsible for nearly 80% of all expenditures in the field of elementary education. However, most of this budget goes into

paying salaries and incurring other recurrent expenditures. Therefore, a prime focus of the SSA programme is to provide additional support to the state government so that they can meet respective elementary education needs in order to reduce educational disparities (Jhingran and Sankar, 2009). However, in almost all JRM reports, the section on finance mostly deals with money received by each state and expenditures made. There is not a lot of information on how this money is being spent on various innovations and strategies that are being implemented for children from disadvantaged groups. Further, there is not much information on the status of allocation of funds according to districts that are grappling with high PTR, high rate of OOSC, inadequate infrastructure facilities etc. In fact, Jhingran and Sankar (2009) have rightly argued in their paper that there needs to be a higher financial allocation to districts and blocks that are way behind in achieving universal elementary education.

Apart from the indicators that have been discussed above, on several occasions, JRM reports have also discussed various other indicators. They include innovations such as Computer Aided Learning (CAL) and Activity Based Learning (ABL); roles and responsibilities of BRCs and CRCs especially with regards to providing academic support to schools and teachers; and convergence with various NGOs and other departments for better provision of resources such as clean drinking water, benefits to CWSN etc. However, in this chapter, these aspects have not been discussed in detail because these indicators have not been looked at from a gender and equity point of view.

Summing up

"Despite many gains during the Eleventh Plan, education in India faces several challenges. The country's mean years of schooling at 5-12 years is well below the other emerging market economies. A matter of particular concern is the steep drop-out rate after the elementary level. The sharp drop-off in enrollment at the middle school level and the increasing enrollment gap from elementary to higher secondary suggests that the gains at the elementary level have not yet impacted the school sector as a whole. Disadvantaged groups are worse off with the dropout rates for SCs and STs higher than the national average... While enrollment levels at the elementary level are generally high, studies of student attendance show that there is considerable variation across states in the percentage of enrolled students who are attending school on any given day during the school year. Of particular concern is that some of the most educationally backward states (Uttar Pradesh [UP], Bihar, Madhya Pradesh [MP] and Jharkhand) have the lowest student attendance rates (below 60 per cent). There has been a substantial increase in the availability of teachers at elementary level during the past few years and if all the teacher posts sanctioned under both Sarva Shiksha Abhiyan (SSA)

> and state budgets are filled, the pupil–teacher ratio (PTR) at the national level will almost be 27:1. The challenge, however, lies in correcting the imbalance in teacher deployment. The number of schools that do not comply with the Right to Education (RTE) norms for the required PTR is fairly high. School-wise analysis based on District Information System for Education (DISE) 2009–10 indicates that 46 per cent of primary and 34 per cent of upper primary schools have poor PTRs. Another serious challenge is the presence of teachers without professional qualifications approved by the National Council of Teacher Education (NCTE), as is required under the RTE Act. There are about 8.1 lakh untrained teachers in the country with four states—Bihar, UP, Jharkhand and West Bengal—accounting for 72 per cent of them…" (Planning Commission, Government of India. 2011, paragraph 21.6, 21.7, 21.8)

This review process reveals that gender and equity related issues have been superficially tracked and addressed in JRM reports. The way in which data has been presented, the manner in which various research studies have been discussed (or not discussed), and lack of attention to detail indicates that most of the indicators, mentioned above, do not do justice to the SSA goal of bridging gender and social gaps. Input indicators like enrollment, number of schools, infrastructure, number of teachers etc. remain important indicators to measure progress towards achieving equity goals of SSA. However, not only these indicators but also other indicators such as retention or teacher recruitment have been discussed separately in JRM reports and not as a part of quality and equity continuum. Additionally, issues such as diversity in the classroom or social gap between teachers and children and issues of exclusion and discrimination are not integrated with an analysis on equity and quality. All these issues have been discussed in detail in the next section.

The JRM process

If one were to take a long view, there is no doubt that India has made significant progress in the field of education in the last 60 years. There has been a steady increase in the literacy rates of both males and females and there has been an overall increase in the enrollment of girls and children from SC, ST, OBC and other minority communities. Along with enrollment, impressive progress has also been made to decrease the number of OOSC and drop-outs, improve school infrastructure and facilities. Many schemes have been introduced to increase school enrollment and retention of students such as Mid-Day Meal scheme, free textbooks, uniforms and bi-cycles to students, bridge and remedial courses for OOSC, programmes like KGBVs and NPEGEL to increase enrollment among girls, and many more. More teachers are getting hired, new teaching methodologies are being adopted, and efforts are being made to increase the role of community and SMCs in the

overall management of schools. In this regard the SSA JRM reports have been quite successful in highlighting positive changes that have taken place under the SSA programme.

Yet, despite the progress, there are still persistent gaps in achieving the spirit of UEE i.e. every child in school and learning. This situation is particularly bad for girls and children from socially disadvantaged communities who attend government schools. Consequently, even though the JRM mechanism is valuable in providing periodic feedback to the government and donor partners, it has done little to enhance our understanding of how and under what circumstances do children not only attend school but learn. In the following paragraphs, two aspects have been discussed in detail – understanding of equity issues under SSA JRM and issues with the JRM mechanism. These two aspects are important because they illustrate why bridging gender and equity gaps still remains an elusive dream under SSA.

Understanding of equity issues under SSA JRM

The biggest drawback of the JRM mechanism is that location, social–economic situation, caste/community, gender and other dimensions of equity are not triangulated with educational indicators gathered in DISE. This is partly due to limited understanding and articulation of equity under SSA. Equity is mainly understood as creating "equal opportunity" under SSA (MHRD, 2010). The definition itself is inconclusive because it does not specify what 'equal opportunity' means. Does it mean that all children will have equal access to a physical school, that all children will be treated fairly and equally in classroom, that all children will have equal access to all resources and basic minimum facilities and most importantly, that all children will get an equal opportunity to learn? It remains unclear.

It has been long established that gender, social and economic status has a strong influence on the education level of a child (Table 3.1). A child is at a greater disadvantage if he/she is living in rural areas and belongs to a poor family. This situation becomes worse if a child is a girl and especially an older girl. However, the situation is not much better for boys. In specific situations and communities (like coastal communities engaged in fishing), boys may be at a greater disadvantage as they are summoned to accompany their fathers out to the sea. Similarly, in many cases, boys are sent on short-term bondage to pay off family loans (Ramachandran, 2004). All these conditions lower the chances of children getting good quality education.

Other factors such as caste, family income, parent's occupation, and education level of parents also contribute significantly towards educational inequalities (Ramachandran and Saihjee, 2002). Similarly, first generation learners are at a greater disadvantage because of limited support

Table 3.1: Different children, different chances

Rural/Urban	Less likelihood of rural children enrolling in pre-school and completing primary school
Income	Poor children have lower chances across location, gender, and caste. This includes children from urban slums.
SC	Lower chances than non SC/ST children for all measures including pre-school and regular school enrollment
ST	Even lower chances than SC
Gender	Disparities increase as girls grow older and affect completion and repetition rates
State	Children from northern and eastern states are less likely to enrol in pre-school, primary school and completion

Taken from World Bank (2004). Reaching out to the child: An integrated approach to child development. Report No. 29695 (p. 34).

in schoolwork at home. All these factors exert a significant influence on access, attendance, completion and learning achievement. Yet, JRM reports are weak in analysis when it comes to making connections between learning achievement and various socio-economic factors.

Likewise, discussion on CWSN, urban poor and children belonging to migrant families remains superficial. We know very little about this group or who constitutes this group. With respect to CWSN, JRM reports are largely restricted to the number of children that have been identified and enrolled in schools and various incentives that have been provided to them. JRM reports have also acknowledged that identification of children and training of special educators continues to remain a major challenging area. However, we don't know the gender and social group composition of CWSN, we don't know which children among CWSN have more access to schools, what are various inclusive practices in place for CWSN, and what is the attitude of teachers and other children towards CWSN.

Similarly, we know that children belonging to migrating families and urban poor are hardest to reach. However, beyond some state-specific initiatives that have been introduced to address the educational needs of this group, not much is known. Finally, there is absolutely no discussion on the issue of street children, children with HIV/AIDS, child labourers (full time, seasonal or part-time), children living in areas of conflict or children affected by war or natural disaster and those who have been victims of physical, mental and sexual abuse. A possible reason for limited discussion on this group could be due to the fact that there are no visible policies or guidelines in place under SSA. Equally, there is a hesitation to talk about the workload of

children, even those who are enrolled in schools but are frequently absent due to seasonal or after-school work.

Going further, access and quality intermeshes with equity, but again, these indicators have been addressed individually. Admittedly, it has been indicated in many reports that there is a need to link quality with equity, but so far, inputs on gender and equity remain isolated from other goals. A possible reason could be absence of concrete definition of "quality" under SSA framework. Consequently, broadly what we do know from SSA JRM reports includes:

- Data on enrollment, out of school children, retention, drop-out, attendance, transition and completion rate;
- Information on strategies and interventions that have been introduced for girls and children from disadvantaged backgrounds;
- Data on school infrastructure and facilities, e.g. toilet, ramps etc.;
- Total number of children being targeted through bridge courses and residential schools;
- Overall learning levels among children;
- Information on school curriculum and textbooks;
- Data on teachers who have been appointed, including total number of female teachers;
- Data on total number of teachers trained

However, there is no way of discerning:

- Who are learning, what are they learning and at what level they are;
- Who do not have access to upper primary schools and why;
- Reasons for low learning levels of children in different circumstances and different kinds of schools;
- What systems are in place to measure teacher accountability and teacher attitude / practices in the classroom;
- Composition and qualification of teachers in remote and tribal areas;
- Quality of school infrastructure and facilities in remote and tribal areas;
- How various discriminatory practices towards children and women teachers are being addressed by schools;
- What is the behaviour of teachers towards students from various social and economic background and CWSN; and
- Within all of the above, how gender relations, stereotypes and prejudices play out?

Issues and concerns

As mentioned in the beginning, SSA JRM mechanism was introduced to inform both GOI and DP about the progress being made under each SSA goal. The mission is held twice a year and consists of members from both GOI and DP. While the mechanism has brought a lot of issues to the forefront, there are some major flaws in the methodology that has resulted in lack of in-depth analysis of various indicators, which has already been discussed in preceding sections.

Field visits are a part of every alternate JRM and GOI, along with DP, identify states to be visited each year. Unfortunately, within states, it is up to each state to decide which districts and blocks will be visited. During the interview, some key informants had commented that due to time constraint, most school visits are a planned exercise. Further, mostly schools that are easily accessible by good roads are frequently visited. In some cases, districts are informed beforehand about the visits. Hence, observations made during school visits may not be a true representation of the reality.

Another weakness of the JRM mechanism is that it is mainly data driven. There is more emphasis on input indicators and implementation processes and outcomes do not receive adequate attention. Consequently, discussion on gender and equity is reduced to data on enrollment of boys and girls, closing the gap in enrollment and listing of quantitative achievements in special schemes for girls.

Thirdly, recommendations made by the JRM are not binding on the state governments. Over the last 8 years, some issues have been raised over and over again. For example, JRMs have repeatedly asked for a rigorous study on the impact of teacher training on teaching learning processes and ultimately learning outcomes of children. It has also been recommended that all data presented in JRM needs to be disaggregated by location, social group and within them, gender. Further, there has been a demand to expand the coverage of all private schools under DISE. These issues are yet to be tackled with the rigor and seriousness that they merit.

Equally significant is the fact that over the years JRM has recommended many in-depth studies such as a study on inclusion and exclusion in the classroom; a study on effectiveness of VEC (Village Education Committee) and SMC; a study on contract teachers etc. However, we were informed that even though most of these studies are presented in the mission, issues raised in these studies are often skimmed over after formal presentation. Consequently, we do not find any reference of these studies in JRM reports.

Finally, there is reluctance on the part of the JRM to look at data from different sources. GOI is comfortable with using DISE data and is also willing to look at data generated by NSSO (National Sample Survey Office). But, triangulation of information on socio-economic indicators and caste/community with education participation of children remains a challenge (Sankar, 2008). Despite the fact that DISE collects information on equity indicators such as location, there is no analysis of data on PTR, multi-grade classrooms and single teacher schools. Similarly, data generated by other independent reports such as ASER Surveys, EI studies on learning (2010), PAISA report (2012) are often ignored. Even studies that other government departments accept such as NCAER's HDI survey (Desai et all, 2010) or the Right to Food campaign studies on Mid-Day Meal[7] are not discussed during the JRM because they have not been 'officially sanctioned' (Key informant interviews, 2013).

Going forward

There is little doubt that exploring gender and social equity issues is not easy in a country like India. We perhaps know a lot more today than we did at the start of DPEP in 1994 and SSA in 2003. Going forward, the ultimate goal of SSA is not only to ensure that children enrol in school, but also that they learn regardless of their gender, ability, social identity and economic status. The key to learning lies with teachers and teaching learning processes. This is one issue that has been skirted in most JRM reports. There is a little discussion on how the system can make sure teachers attend school regularly and teach children with love and affection and not discriminate or exclude some children.

Equally, we are wary of taking on board remedial teaching and on-going supplementary support required by children from underprivileged families and communities. There is mounting evidence that more and more children are forced to attend private tuitions and that this adversely affects the education of the very poor and among them, girls. This is primarily because either parents do not have enough money to pay for tuitions or they would rather send boys for tuitions. There is also considerable evidence that suggests that teachers are pressurized to complete the syllabus regardless of whether children are learning or not. Research shows that in the absence of regular teaching-learning process or in a situation where a majority of children do not have basic language or mathematic skills, focused efforts are required to help these children to acquire basic skills (Muralidharan, 2013). For example, there is evidence that suggests that after-school learning programmes and focused early reading programmes can make a huge difference (Banerjee,

[7] http://www.righttofoodindia.org/mdm/mdm_surveys.html

Banerji, Duflo, Walton, 2012). Additionally, we need to work out ways by which teachers are motivated, maybe through incentives and disincentives, so that they ensure that every child in their classroom is learning. Along with that, there is also a need to clearly define "equity" and "quality" in order to create measureable goals to bridge gender and equity gaps.

Finally, in order to address equity and gender issues more seriously under JRM mechanism and to create a stronger monitoring and evaluation process, we feel that it is necessary to re-conceptualise the JRM process and re-work on the methodology. Keeping this in mind, we propose the following recommendations:

(a) The JRM process needs to triangulate information from different sources and on different dimensions of the schooling experience and move towards a more holistic understanding and appreciation of equity and quality. Being an independent mechanism the SSA JRM should go deeper into systemic issues that frame realisation of equity and quality goals of SSA. Given the overwhelming evidence from diverse sources, it is possible to initiate a culture of reflection.

(b) Research studies commissioned by SSA, as a follow-up to JRM, need to be taken more seriously and as evidence, that informs evaluation. Equally, many more agencies and institutions should be encouraged to conduct research across the country. Independent research is valuable and with some persuasion and reflection, it could be brought into the ambit of the JRM.

(c) Instead of a 6-monthly mission, an annual exercise for a longer duration could result in in-depth examination of various issues. It would give the team an opportunity to spend more time in a district, visit randomly selected schools and interact with teachers, parents and the community, and hence, get an insight into the real situation. It is equally important to involve people who are working directly with schools, teachers and communities (e.g. faculty from universities, educational researchers or NGOs) in the JRM process. It would provide greater insight into field realities.

(d) Finally, in order to create a more effective mechanism, rather than exploring all the issues, each JRM could agree on a theme. As for example, social equity can become a theme for a mission and various indicators such as access, learning, teaching, finance, programme management and role of community can be discussed under the aegis of the larger theme.

While acknowledging that large scale programmes are difficult to review, focusing on specific issues or questions in each JRM and also bringing together a larger team that could spend at

least two weeks in at least 10 to 12 states in each mission could enrich the process. In addition to that, India has a large and rich pool of researchers, practitioners and administrators and also people who are actively engaged in issues related to social equity and gender justice. Reaching across disciplines and involving people who can bring a feminist and an equity perspective to the table would enrich the whole process.

The overarching learning from this modest desk review is that systemic capacity and functioning need to be brought centre-stage for the provision of high quality elementary education for all children and in particular, to bridge gender and social gap in all dimensions of education.[8] Therefore, the JRM process needs to recognise the centrality of systemic reform and focus on core issues within the system. In conclusion, gender and equity are not supplementary goals of SSA; they are actually overarching goals. Unless this perspective is foregrounded we will not be able to achieve the goal of education for all.

[8] "The elementary education system in India is situated in the context of stark social inequities, a fact which needs to be appropriately recognized. At present, the hierarchical ordering of the system on the one hand, and the illegitimate exercise of power by privileged individuals through the informal system on the other, aligns the system to serve, rather than counter these inequities. To a great degree, systemic reform and a better functioning state-run education system will address the question of inequity, because the inadequacies of the system affect the poor the most. Children from better-off families move to private schools, or supplement schooling with tuition, and it is the poor who bear the brunt of the poor functioning of the system. If government schools improve, even poor children will be able to access good education, like their better-off counterparts... General improvement across the system is unlikely to be enough and the system will need to move towards countering social inequities in more specific ways. At present, a dual approach is visible across the system. On the one hand there are measures that counter inequities, such as midday meals, free textbooks, scholarships for SC/ST and other poor students etc. Such provisions are essential. A further reduction in household expenditure, i.e., a more complete provision in the form of notebooks and other teaching-learning material to poorer children would be an important aspect of equity. Better implementation of such programmes is also necessary... On the other hand however, these measures to counter inequity are negated by the fact that the quality of schools tends to build upon existing inequities by providing lesser quality schools to poorer children. This negates the student benefits provided. In fact, scholarships provided by a school that does not function well amounts to a general subsidy to the family and not an increase in educational opportunity. At the same time, the education of children from marginalized communities requires a greater degree of skill, and teachers teaching such communities need to be trained rigorously. Children from such communities may need more support in terms of teaching learning materials etc. Thus schools for children from marginalized communities may need more, and not less than average funding. This is in stark contrast to the present situation where the quality of the school tends to 'match' the socio-economic status of students, rather than ensuring that the social deprivations faced by these students are countered with their education. Sharma and Ramachandran. 2008.

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Annexure 1

The DPEP Programme

The District Primary Education Programme was initiated as a part of the larger Social Safety Net Credit Adjustment Loan under the Structural Adjustment Programme of the World Bank to India in 1991. Taking off from the policy guidelines in NPE 1986 and drawing upon the experiences of a range of primary education programmes, the DPEP Guidelines of 1994 stated that holistic planning and management is necessary to achieve universal primary education and that it 'should incorporate a gender perspective in all aspects of the planning and implementation process'. The guidelines recognises the importance of mainstreaming gender and making it an integral part of DPEP. It also recognizes the need for gender focus in tackling problems of access, retention and achievement levels and the importance of reaching out to children from most disadvantaged groups/communities. In this programme, educationally backward districts with female literacy below the national average were taken as the priority districts. Equally, the programme stressed education for socially disadvantaged groups. The goals set by DPEP were:

- Reduce differences in enrollment, dropout and learning achievements between gender and social groups to less than 5%;
- Reduce overall primary dropout rates for all students to less than 10%;
- Raise average achievement levels by at least 25% over measured baseline levels by ensuring achievement of basic literacy and numeracy competencies and a minimum of 40% achievement levels in other competencies for all primary school children; and
- Provide access for all children to primary schooling or its equivalent non-formal education.

These goals bring out the programme's intent to increase coverage of girls, improve their academic achievements and reduce gender disparities in respect to enrollment, retention and learning achievements. Essentially, DPEP adopted a two-pronged strategy to meet gender and social equity goals, namely:

a. Make the education system more responsive to the needs and constraints of girls and children from disadvantaged communities; and
b. Create community demand for girls' education and enabling conditions for greater participation.

In pursuance of these objectives, DPEP created monitoring systems and structures to track gender and equity issues. The information and monitoring system of DPEP consisted of the following:

- PMIS (Project Management Information System) to capture inputs such as teacher deployment, civil works, training, research completed, expenditure and reimbursement – thereby tracking both physical and financial information;
- DISE (District Information System for Education) to capture enrollment, teacher deployment, classroom and performance indicators like Gross Enrollment Ratio, Net Enrollment Ratio, repetition rates, student classroom ratio and pupil teacher ratio. The data was to be disaggregated by gender and SC/ST; and
- Bi-annual Joint Review Missions, research studies and, most recently, household surveys to estimate the number of out-of-school children to enable the government and donor partners to assess progress towards short-term, medium term and long-term development objectives.
- The DPEP MIS cell based in NIEPA developed the Index of Gender Equity and Index of Social Equity to track progress towards gender and social equity objectives and this continues to be a mandatory exercise in reporting on progress.

By 2001, DPEP was operational in 18 states and 271 districts after taking into account recent bifurcations and trifurcations in districts and the carving out of three new states.

Source: Vimala Ramachandran, 2004

Annexure 2

Equity and education

When India gained Independence in 1947 and during the formulation of the Indian Constitution, political leaders of that time debated the notion of equity and equality. Discussing the notion of equality, Jawaharlal Nehru said (in the Constituent Assembly on December 13, 1946),[9]

"...at this stage, it is surely desirable that we should give some indication to ourselves, to those who look to this Assembly, to those millions in this country who are looking up to us and to the world at large, as to what we may do, what we seek to achieve, wither we are going. And I wish this House, if I may say so respectfully, should consider this Resolution not in a spirit of narrow legal wording, but rather look at the spirit behind that Resolution. Words are magic things often enough, but even the magic of words sometimes cannot convey the magic of the human spirit and of a Nation's passion...[The Resolution] seeks very feebly to tell the world of what we have thought or dreamt of so long, and what we now hope to achieve in the near future..."

The "spirit" of equality referred to by Nehru and Ambedkar during the constitutional assembly debates involved going beyond the formal mechanisms like equality before the law or the right to vote and moved towards creating a level playing field for the most disempowered and disadvantaged in our society. Various forms of affirmative action, including the reservation policy of the government, seeks to correct centuries of discrimination through proactive means in education, employment, land allocation and other benefits that the State announces from time to time. Equally, the "spirit of equality" also includes adherence to the right against discrimination, which means that overt and subtle forms of exclusion in the forms of untouchability, abuse, derogatory comments and stereotypes are punishable under legal provision made to combat atrocities against historically disadvantaged groups.

Taking the "spirit of equality" as the guiding maxim, this study goes beyond formal notions of equality. The various dimensions of equality are:

- Social identity – belonging to specific disadvantaged groups like SC and ST (within them the Maha Dalit – being the excluded within the excluded), minority communities like Muslims and those who are disadvantaged because of following certain occupations (sex work, rag pickers) that alienate them / exclude them from active membership in civil society.

[9] http://www.indiankanoon.org/doc/548244/

- Gender – being a boy or girl could mean different things in different situations, communities and locations. Analysis of ASER data from 2006 to 2011 reveals that there is a consistent gap between percentage of boys and girls enrolled in private schools (all types, aided and unaided) with many more boys being sent by parents to fee-paying private schools (Bannerji and Wadwa, 2011).
- Location – where a particular group of people are situated determines what kind of access they have. For example, remote desert villages in Jaiselmer or in Ladakh; remote tribal habitations in Chhattisgarh or Jharkhand; areas prone to seasonal flooding along the banks of rivers like the Brahmaputra in Assam, areas that experience frequent conflict along international borders or in conflict prone zones within the country, new unrecognised urban slums that cater to new migrants and so on.
- Disability is yet another dimension that leads to differential access, differential treatment and in many situations total exclusion from educational processes.
- Poverty, migration and related economic issues remain one of the most important markers of inequality.
- Health and physical situation is another important axis of inequality. In recent years, the situation of families who are HIV positive has been highlighted. However, when we look at health related issues among children, some health conditions like scabies lead to exclusion of children in the classroom and on the playground. Equally, persistent hunger and malnutrition has now been recognised as an important marker of inequality and exclusion.
- Educational level of parents, siblings and other significant care-givers in the family.

All of the above intermesh with each other influencing not only formal access to schools but more importantly, how children are treated inside the school, their ability to participate actively in school activities, ability to learn in school and the kind of support they get or do not get at home and in their community (Bhattacherjea, Wadhwa, Banerji, 2011). Formal or physical access is just one dimension of equity. Many researchers (Balgopalan and Subrahmanian, 2003; Ramachandran, 2004; PROBE Revisited, 2006; Nambissan, 2009; Ramachandran and Naorem, 2012) have pointed out the persistence of differential behaviour of teachers and administrators towards children from specific social groups or economic status or gender.

Coming to grips with gender and social equity issues in education requires a framework that can capture heterogeneous gendered realities and multiple disadvantages. Gender is embedded within a complex social and institutional structure in India. Therefore, it is necessary to look at gender inequalities in education within the broader framework of social, economic and location

specific inequalities on the one hand and the prevailing school system on the other. A global study on girls education summarised the issues: "Already excluded because of their gender, many girls face multiple barriers, making it more difficult for them to enrol in and complete primary school and continue on to secondary school…reaching excluded girls generally means higher costs and alternative policies and strategies because their needs differ from those of the majority population" (Lewis and Lockheed, 2007, p. 19-20).

Feminist scholars and those working on social exclusion have tried to tease out the texture of exclusion by identifying the levels, the sources and also the forms of exclusion. While the government has provided schools in most areas, discrimination or non-inclusion takes different forms for people from different social groups/locations. The illustrative grid Table 4.1 attempts to capture the heterogeneous gendered and social realities that frame educational participation in India. Given the complex inter-relationship between the social and economic situation of children and the situation that is obtained in the school it is globally acknowledged that achieving equity goals in education requires work on several fronts at the same time. It could be said that this is an unrealistic expectation especially in a country where inter-departmental and inter-ministerial coordination is not easy. As a result, our ability to achieve gender and equity goals of an education programme cannot be one-dimensional.

Researchers working on inequality in different spheres of social and political life invariably comment on how education could help children overcome disadvantages that they inherit. Many contemporary research studies discuss "teacher indifference (towards) or outright discrimination (against children from minority groups) as well as school policies, such as the medium of instruction being the state language rather than tribal languages or Urdu (Nambissan and Sedwal, 2002; PROBE Team 1999). Increasing reliance of schools on parental input may be another means through which generational disadvantage may persist. Parents with similar educational and economic backgrounds may still differ in their interpersonal, cultural and social skills of transferring educational and income gains onto to their children. This difference could lie between first-generation parents (Dalits, Muslims, Adivasis) with high income and education levels and, say, high-caste Hindu parents, with a tradition of good quality education going back many generations in their families…" (Desai and Thorat, 2011) Furthermore the HDI survey done by NCAER points out that "educational discontinuation rates – at primary and upper primary levels is highest among ST, followed by SC and Muslims, then OBC and a huge drop in discontinuation rates when it comes to forward caste Hindu. These observations are consistent with the finding from international literature on comparative education (Raftery and Hout, 1993; Shavit and Blossfeld, 1993), which also notes

greater inequalities in education at early stages. Unfortunately, public policies, when it comes to addressing educational inequalities, tend to focus more on higher education instead of on early education, possibly because they are easier to address (Desai and Thorat, 2011).

While the education department may not be able to tackle poverty or migration or displacement or conflict, it could address the multitude of issues that enable a child to attend school, learn and emerge from it as a confident and happy child. This study tried to explore school level factors that could actively promote gender and social equity goals, namely:

1. Formal access to a functioning school, enrollment of all children in school;
2. Regular attendance of children, and efforts to ensure this;
3. Teachers present regularly and in stipulated numbers; and teaching. Here the question that begs attention is whether the teachers are focusing on completing the curriculum or are focused on children's learning.
4. Remedial/supplementary/focused support for children who need it, especially children who are not able to keep pace, long absentees and children who are not able to cope due to unfamiliarity with school language
5. Conducive school environment – infrastructure available and functioning (toilets, water), safe building and protection from extreme weather,
6. Access to books, stationary and other learning material; sports material available for use of all;
7. Children have proper clothes to wear (uniforms) to school, being extremely important for the very poor and, among them for girls;
8. Teacher friendly, positive attitude (non-discriminatory, no prejudices), child-friendly and has necessary training to perform her/his task as teacher;
9. Absence of all forms of violence and abuse (mental, physical, emotional, sexual);
10. Provision of mid-day meal of good quality, nutritious and served without any overt or subtle forms of discrimination/exclusion;
11. Regular (or continuous) assessment and feedback to children, monitoring their learning and support to children who need it (those whose mothers/care-giver is either not literate or has very basic literacy skills) or when needed; and
12. Textbooks and learning material free of gender and social/community biases.

The above inputs and processes, if delivered and monitored with care, would lead to meaningful access to education. The literature on education, for over fifty years now, underscores the

importance of both formal inputs in the form of buildings, books, teachers etc. but also the criticality of processes and the everyday experience of teaching and learning in a school and the family environment (including access to reading material). Unfortunately, many content and process issues are not easily amenable to standardised quantitative indicators. For example, ensuring an environment that is free of prejudice, discrimination and stereotyping children on the basis of gender, caste, community, disability or parental occupation is now accepted as being as important as the daily routine of teaching and learning. These issues have been discussed across the world and the rich global experience on de-segregation of schools and making the integrated schools genuinely inclusive and welcoming to all could help India meaningfully address these difficult issues.

Table 4.1: Heterogeneous gendered realities

School factors Socia factors	Formal acess to school/ enrolment	Regular attendance of children	teacher available and teaching; availability of women teachers	Conducive school environment, library, play ground, functioning toilets, safe drinking water	Access to books, stationer; free of gender/ social biases	Proper clothes to wear to school	Teacher attitude/ prejudice/ practices child friendly	Absence of abuse, punishment, harassment (physical, mental, emotional, sexual)	Mid-day Meal- nutritious and clean	Learning assessment, feedback, encouragement, remedial support when needed	Sport and extra curricular activities
Poverty											
Location: remote, mountains, desert, inaccessible											
Social identity/ community											
Gender											
Family occupation											
Educational level of family, especially mother or care giver											
Child labour - seasonal/periodic/ regular											
Migration - seasonal, distress											
Displacement- natural and man made											
Conflict											
Violence - at home, in school, in society											
Disability											
Health											

Annexure 3

Some indicators by location

Table 4.2: Schools with adverse PTR by distance from BRC

State/UT	Total Schools with adverse PTR	Schools with distance (Percentage)		
		Less than 5 Km.	Between 5 - 10 Km.	More than 10 Km.
A & N Islands	12	8.3	0.0	91.7
Andhra Pradesh	9120	27.0	34.7	38.3
Arunachal Pradesh	2150	13.8	14.4	71.9
Assam	20644	7.1	22.0	70.9
Bihar	58367	23.7	45.1	31.2
Chandigarh	43	90.7	7.0	2.3
Chhattisgarh	12424	8.2	11.9	80.0
D & N Haveli	189	3.7	17.5	78.8
Daman & Diu	29	20.7	41.4	37.9
Delhi	1270	33.0	44.3	22.8
Goa	364	7.7	29.4	62.9
Gujarat	7375	11.0	23.2	65.8
Haryana	4912	20.0	35.7	44.4
Himachal Pradesh	1407	5.1	9.5	85.4
Jammu & Kashmir	3197	14.2	32.0	53.8
Jharkhand	26175	13.0	32.5	54.5
Karnataka	8714	6.0	11.6	82.3
Kerala	270	18.5	27.0	54.4
Madhya Pradesh	61789	5.8	13.6	80.6
Maharashtra	12743	15.7	16.6	67.7
Manipur	494	9.1	21.1	69.8
Meghalaya	1021	10.7	15.8	73.6
Mizoram	232	7.8	4.3	87.9
Nagaland	305	11.8	9.8	78.4
Odisha	21213	10.5	22.9	66.7
Puducherry	13	15.4	23.1	61.5
Punjab	6317	16.7	33.1	50.2
Rajasthan	32840	6.1	11.0	82.9
Sikkim	44	15.9	22.7	61.4
Tamil Nadu	9008	15.2	30.8	54.0
Tripura	494	19.0	33.6	47.4
Uttar Pradesh	93823	17.7	37.0	45.4
Uttarakhand	6086	5.6	15.1	79.3
West Bengal	22480	27.1	38.9	33.9
Total	425564	14.4	28.1	57.5

Source: DISE 2011-12, tables prepared by MIS Unit, SSA TSG, EdCIL

Table 4.3: Single Classroom Schools by distance from BRC

State/UT	Total Schools	Schools with distance (Percentage)		
		Less than 5 Km.	Between 5 - 10 Km.	More than 10 Km.
A & N Islands	9	11.1	22.2	66.7
Andhra Pradesh	20423	21.3	36.1	42.6
Arunachal Pradesh	910	17.4	16.9	65.7
Assam	7277	6.9	22.5	70.6
Bihar	2237	27.5	43.0	29.5
Chhattisgarh	1227	5.6	10.5	83.9
D & N Haveli	17	0.0	11.8	88.2
Goa	223	8.1	25.1	66.8
Gujarat	685	8.2	15.5	76.4
Haryana	319	26.0	35.1	38.9
Himachal Pradesh	640	6.1	13.3	80.6
Jammu & Kashmir	3046	22.3	29.8	47.9
Jharkhand	350	17.4	35.1	47.4
Karnataka	2847	6.4	14.7	78.9
Kerala	73	21.9	21.9	56.2
Madhya Pradesh	4071	6.6	13.3	80.1
Maharashtra	3677	6.1	12.3	81.6
Manipur	51	3.9	15.7	80.4
Meghalaya	1231	7.2	16.9	75.9
Mizoram	14	0.0	0.0	100.0
Nagaland	29	44.8	10.3	44.8
Odisha	2932	9.9	20.0	70.1
Puducherry	14	42.9	35.7	21.4
Punjab	401	23.7	29.2	47.1
Rajasthan	1773	13.4	15.9	70.7
Sikkim	15	20.0	33.3	46.7
Tripura	137	10.9	25.5	63.5
Uttar Pradesh	1214	53.6	24.3	22.1
Uttarakhand	345	5.5	13.3	81.2
West Bengal	2529	27.3	36.3	36.5
Total	58716	16.1	26.5	57.4

Source: DISE 2011-12, tables prepared by MIS Unit, SSA TSG, EdCIL

Table 4.4: Schools with single Teacher by distance from BRC

State/UT	Total Schools with adverse PTR	Schools with distance (Percentage)		
		Less than 5 Km.	Between 5 - 10 Km.	More than 10 Km.
A & N Islands	10	10.0	0.0	90.0
Andhra Pradesh	5500	21.5	34.9	43.6
Arunachal Pradesh	1865	13.3	15.2	71.5
Assam	9219	4.5	18.0	77.5
Bihar	2500	26.1	40.8	33.1
Chhattisgarh	3195	10.3	7.1	82.7
D & N Haveli	70	0.0	8.6	91.4
Daman & Diu	2	0.0	50.0	50.0
Delhi	2	0.0	50.0	50.0
Goa	346	7.2	29.2	63.6
Gujarat	236	11.0	16.5	72.5
Haryana	389	16.7	36.5	46.8
Himachal Pradesh	927	2.7	7.7	89.6
Jammu & Kashmir	2160	14.3	30.2	55.5
Jharkhand	5356	10.9	28.8	60.3
Karnataka	4117	3.6	10.6	85.8
Kerala	58	10.3	13.8	75.9
Madhya Pradesh	19296	3.5	10.4	86.1
Maharashtra	1962	8.9	9.8	81.2
Manipur	349	7.2	17.8	75.1
Meghalaya	209	4.3	14.8	80.9
Mizoram	29	6.9	10.3	82.8
Nagaland	63	7.9	9.5	82.5
Odisha	4858	9.0	14.8	76.2
Punjab	1847	13.6	29.2	57.2
Rajasthan	15378	4.5	8.4	87.1
Sikkim	32	12.5	15.6	71.9
Tamil Nadu	1649	7.3	24.6	68.0
Tripura	63	15.9	30.2	54.0
Uttar Pradesh	14968	23.4	30.4	46.3
Uttarakhand	3846	3.7	10.3	86.1
West Bengal	1768	25.8	35.9	38.2
Total	102269	10.3	18.5	71.2

Source: DISE 2011-12, tables prepared by MIS Unit, SSA TSG, EdCIL

Table 4.5: Percentage of Female Teachers by distance from BRC

State/UT	Percentage of Female Teachers by distance from BRC			
	Overall % Female tchs.	Less than 5 km.	Between 5 and 10 km.	More than 10 km.
A & N Islands	56.3	62.1	57.0	50.2
Andhra Pradesh	41.0	49.3	38.0	33.7
Arunachal Pradesh	35.8	47.3	37.5	28.0
Assam	32.2	48.3	31.9	27.5
Bihar	40.8	45.2	39.7	38.2
Chandigarh	74.4	74.5	na	67.3
Chhattisgarh	32.4	54.0	38.9	27.7
D & N Haveli	54.0	72.7	75.6	33.0
Daman & Diu	66.5	66.9	68.5	63.5
Delhi	62.4	65.1	62.6	57.1
Goa	76.9	82.8	78.1	73.0
Gujarat	48.1	61.5	53.3	43.1
Haryana	41.4	59.0	40.8	35.6
Himachal Pradesh	36.0	53.9	44.3	30.3
Jammu & Kashmir	36.7	49.0	34.7	28.6
Jharkhand	26.1	41.4	26.5	20.8
Karnataka	48.0	66.1	56.6	41.9
Kerala	71.7	71.7	72.7	70.8
Lakshadweep	46.4	47.8	na	44.4
Madhya Pradesh	30.9	54.4	36.5	25.7
Maharashtra	39.0	57.0	47.6	32.0
Manipur	46.1	57.4	50.8	39.8
Meghalaya	50.2	61.1	55.7	46.5
Mizoram	40.9	53.6	44.9	34.3
Nagaland	38.8	52.0	46.3	30.7
Odisha	38.5	56.4	41.6	31.7
Puducherry	56.5	59.5	56.1	52.2
Punjab	58.1	69.1	58.5	52.7
Rajasthan	28.7	49.3	35.1	24.8
Sikkim	43.9	54.0	47.9	37.9
Tamil Nadu	68.5	77.1	70.0	64.1
Tripura	25.7	35.3	25.7	20.4
Uttar Pradesh	44.2	50.8	44.6	41.1
Uttarakhand	43.0	62.9	50.6	38.7
West Bengal	33.9	43.1	31.2	25.7
Total	40.5	52.1	42.5	34.6

Source: DISE 2011-12, tables prepared by MIS Unit, SSA TSG, EdCIL

Annexure 4

What is discussed and what is missing from JRM

Table 4.6: Illustrative example on access related indicators

Indicators	Gender (boys/ girls)	Social group (SC/ST/ Muslims)	Social groups (boys/girls)	Location (Rural/ Urban)	Location (Remote/ Hilly/Tribal)	CWSN (general)	CWSN (acc. to disabilities)	Children form migrant families	Urban Poor
Enrolment	Discussed	Discussed	Limited discussion	Limited discussion	Rarely discussed	Discussed	No discussion	Recognised as a challenging area; no data given	
Govt. vs private school enrolment	Overall discussion	No discussion	No discussion	Rarely discussed	No discussion	No discussion	No discussion	No discussion	No discussion
Attendance	Discussed	Discussed	No discussion	No discussion	No discussion	No discussion	No discussion	No discussion	No discussion
Absenteeism	Rarely discussed	Rarely discussed	No discussion	No discussion	No discussion	No discussion	No discussion	High absent rate; no data given	No discussion
Drop-out rate	Discussed	Limited discussion	Rarely discussed	No discussion	No discussion	No discussion	No discussion	No discussion	No discussion
OOSC	Discussed	Discussed	No discussion	Discussed	No discussion	Limited discussion	No discussion	Limited discussion	Limited discussion
Retention	Discussed	Limited discussion	No discussion	No discussion	No discussion	Rarely discussed	No discussion	Rarely discussed	Rarely discussed
Transition from PS to UPS	Discussed	Limited discussion	Limited discussion	No discussion	No discussion	No discussion	No discussion	No discussion	No discussion
Completion rate	Rarely discussion	No discussion	No discussion	No discussion	No discussion	No discussion	No discussion	No discussion	No discussion
Availability of school	Discussed including data on KGBV, NPLGEL	Discussed including data on EGS, AIE	Mainly data on KGBV, NPEGEL	No discussion	Mainly data on EGS, AIE	Bridge course; residential schools		Bridge course; residential schools	
Availability of PS within 1 km	Has not been discussed separately for any particular group			Limited discussion		Has not been discussed separately for any particular group			
Availability of UPS withing 3 km									
Drinking water facility	Discussed	No discussion	No discussion	No discussion	No discussion	No discussion	No discussion	No discussion	No discussion
Toilets	Discussed	No discussion	No discussion	No discussion	No discussion	Discussed	No discussion	No discussion	No discussion
Ramps	No discussion	No discussion	No discussion	No discussion	No discussion	Discussed	No discussion	No discussion	No discussion

Table 4.7: Illustrative example on learning and teaching related indicators

Indicators	All children	Gender (boys/ girls)	Social group (SC/ ST/Muslims)	Location	CWSN	Children from migrant families	Urban Poor
Learning levels	Discussed	No discussion	Limited discussion	No discussion	Mentioned only once	No discussion	No discussion
Availability of textbooks	Discussed	Discussed	Discussed	No discussion	No discussion	No discussion	No discussion
Incentives	Discussed	Discussed	Discussed	No discussion	Discussed	Limited discussion	Limited discussion
STC	Discussed	Not specifically according to gender or social group but under broader category of children from vulnerable groups		No discussion	No discussion	Discussed	Discussed
Bridge courses	Discussed	Discussed	Discussed	No discussion	No discussion	Discussed	Discussed
Residential schools	Discussed	Discussed	Discussed	No discussion	No discussion	Discussed	Discussed
FTR	PRT has been usually discussed in terms of PS and UPS and only occasionally, according to rural/urban						
Single teacher school	Discussed	No discussion	No discussion	Limited discussion	No discussion	No discussion	No discussion
Multi-grade classroom	Discussed	No discussion	No discussion	Limited discussion	No discussion	No discussion	No discussion
No. of teachers	Not discussed in relation to any particular group. Only overall data is given						
No. of female teachers	Overall data on female teachers is given occasionally Issue of low female teacher ration in remote & tribal areas has been discussed a few times.						
Teacher qualification	Discussed	No discussion	No discussion	No discussion	Limited discussion	No discussion	No discussion
Teacher training	Overall data on number of teachers trained and yet to be trained is given regularly. Discussion on issues of gender and equality as a part of training programme has been discussed often						
Attitude & behaviour of teachers	Not discussed at all						

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CHAPTER 4

Meta-Evaluation of NRHM and RCH II

Renu Khanna & Priya John

Introduction and Background

Introduction

The chapter looks at the study processes of the National Rural Health Mission (NRHM) and the Reproductive and Child Health Programmes (RCH) to understand whether and how gender, rights (social, economic, location) and equity related issues have been incorporated in the evaluation approaches employed by the Common Review Mission for NRHM and the Joint Review Mission for RCH. As the National Health Mission begins to be implemented, it is important that the reviews and evaluations of the NHM be informed by the lessons learnt from the meta-evaluation of the reviews of the earlier programmes. The main objectives of our evaluation are:

- To examine the extent to which gender, rights and social equity concerns are incorporated into the design and implementation of NRHM, RCH II and NHM.
- To examine the extent to which gender, rights and social equity concerns are incorporated into the design and implementation of monitoring and evaluations of the above programmes.

This review is a part of a series of feminist meta-evaluations of selected public programmes and policies in India.[1]

'Meta-evaluation' is defined as: an evaluation that aggregates findings from a series of evaluations. A meta-evaluation can also be an evaluation of an evaluation to assess the performance of the evaluators. It has been described as 'a procedure for describing an evaluation activity and

[1] Other meta-evaluations that have been done are on STEP, SSA, MGNREGA etc.

judging it against a set of ideas concerning what constitutes good evaluation'. (Stufflebeam 1974).

A feminist standpoint, used as a powerful foundation of inquiry, leads us to infuse the process of evaluations of policies, implementation plans and development projects with a feminist spirit wherein the assessment of the adopted approaches/strategies is undertaken with the ultimate aim to establish a gender-equitable and socially-just society. An evaluation, then, is an area of inquiry to unpack the ways and the extent to which a policy or plan renders itself to promoting gender-justice. Hay et al. paraphrase Sielbeck-Bowen et al. to claim that, '(A) Feminist evaluation is grounded in the understanding that discrimination or inequality based on gender is systemic and structural, that evaluation is a political activity, that knowledge is a powerful resource that serves an explicit or implicit purpose, that knowledge and values are culturally, socially and temporally contingent, and that there are multiple ways of knowing—some privileged over others.'(2012 p. 180).

A feminist project is intrinsically a project to achieve justice and equality. Human rights – right to equality, non discrimination among others – are embedded in the feminist worldview. This chapter examines all the available reports of these two evaluations to understand whether the specific health concerns and needs of different sexes or/and genders have been met through the programmes and whether the evaluations are geared to examine these concerns and needs appropriately. It also seeks to capture the progress of the programme in addressing women's holistic health needs and the way in which NRHM and RCH II has impacted the barriers to healthcare traditionally experienced by women and other marginalised sections of society.

The Reproductive and Child Health Programme and the National Rural Health Mission began as twin programmes complementing each other in their content although the NRHM was supposed to be overarching. We have included the National Health Mission also although it is a new programme and has not been evaluated yet. It is important to note the evolutionary nature of each of these programmes and that they build on lessons learnt from the earlier phases.

National Rural Health Mission (NRHM) 2005-12

The National Rural Health Mission launched in 2015 is one of the milestones in the history of Indian Public Health Services in order 'to bring about dramatic improvement in the health system and health status' of people especially in high focus states called the Empowered Action Group states. The NRHM Framework for Implementation – a guideline document – acknowledges the limitations of earlier health programmes as seen in continued morbidity

and mortality due to preventable diseases, pregnancy, childbirth related complications and malnutrition. The Mission acknowledges the critical role played by social determinants of health, their relationship with poverty and a degrading rural environment. It identifies the challenges facing the Indian public health system – one with the lowest health spending in the world, focus on curative rather than preventive healthcare, the epidemiological transition being experienced, to mention a few.

NRHM aims at the architectural restructuring of the public health system. It seeks to create a strong public healthcare delivery system through upgradation of existing healthcare facilities to meet the Indian Public Health Standards, improve quality of healthcare by investing in training, periodic reviews and monitoring of health services, a decentralised planning system, strengthening capacities of personnel involved in the planning processes at all levels, involvement of persons with technical skills (e.g. CA, MBA) into planning bodies for better planning and management, utilisation of all available resources through establishing partnerships with civil society organisations, public health experts, medical colleges and even private sector to enhance the reach of the health services as well as for generating demand.

The NRHM is also an umbrella under which all existing vertical health programmes were to converge e.g. tuberculosis control, leprosy elimination, blindness control, ICDS, malaria control etc., with multi-skilling of vertical programme staff as another strategy to ensure optimum utilisation of the available human resource. Convergence between various governmental departments that provide services related to various health issues (AYUSH, WCD, FWMCH) as well as those that deal with social determinants influencing health (e.g. road construction, water supply, sanitation) is another important focus area of NRHM. At the village level, the NRHM allows the untied funds to be utilised to deal with various factors affecting health of the residents (e.g. water supply/purification, sanitation etc.).

The NRHM Framework for Implementation has identified seven critical areas to achieve the main goals of the Mission. These are: Well functioning health facilities; • Quality and accountability in the delivery of health services; • Taking care of the needs of the poor and vulnerable sections of the society and their empowerment; • Prepare for health transition with appropriate health financing; • Pro-people public private partnership; • Convergence for effectiveness and efficiency. • Responsive health system meeting people's health needs.

As a measure of improving quality of care through the public health system, the NRHM focuses on capacity building of technical and administrative staff at all levels of healthcare delivery and management.

In addition to the strategies for strengthening the supply side, NRHM proposes strategies also for demand generation for public health services. Communitisation of health – a weakness in earlier programmes – is another area that the Mission seeks to amend through institutionalisation of community action. The NRHM expects the community – as represented by the elected representatives, and representatives of various vulnerable groups from within the community – to take leadership in health matters and to have ownership of the public healthcare delivery system. Other community based groups such as CBOs, women's groups etc., too are expected to play a role in health management at the community level. The NRHM has Village Health Sanitation Committees with representatives from community, local health worker (ANM) and PRIs that would play a key role in health planning which will then be reflected into district health plans. Appointment of village level ASHA as a liaison between the community and the public health system is another key strategy of the Mission. The Mission also expects the community to play a role in monitoring of public health delivery at each level – village, sub-centre, PHC, block and district.

Figure 1: Expected Outcomes of NRHM

The expected outcomes from the Mission as reflected in statistical data are:

- IMR reduced to 30/1000 live births by 2012.
- Maternal Mortality reduced to 100/100,000 live births by 2012.
- TFR reduced to 2.1 by 2012.
- Malaria Mortality Reduction Rate - 50% up to 2010, additional 10% by 2012.
- Kala Azar Mortality Reduction Rate - 100% by 2010 and sustaining elimination until 2012.
- Filaria/Microfilaria Reduction Rate - 70% by 2010, 80% by 2012 and elimination by 2015.
- Dengue Mortality Reduction Rate - 50% by 2010 and sustaining at that level until 2012.
- Cataract operations-increasing to 46 lakhs until 2012.
- Leprosy Prevalence Rate –reduce from 1.8 per 10,000 in 2005 to less that 1 per 10,000 thereafter.
- Tuberculosis DOTS series - maintain 85% cure rate through entire Mission Period and also sustain planned case detection rate.
- Upgrading all Community Health Centers to Indian Public Health Standards.
- Increase utilization of First Referral units from bed occupancy by referred cases of less than 20% to over 75%.
- Engaging 4,00,000 female Accredited Social Health Activists (ASHAs).

Source: NRHM Framework for Implementation

Figure 2: Timeline for NRHM Activities

	Activity	Phasing and timeline	Outcome Monitoring
1	Fully trained Accredited Social Health Activist (ASHA) for every 1000 population/large isolated habitations.	50% by 2007 100% by 2008	Quarterly Progress Report
2	Village Health and Sanitation Committee constituted in over 6 lakh villages and untied grants provided to them.	30% by 2007 100% by 2008	Quarterly Progress Report
3	2 ANM Sub Health Centres strengthened/ established to provide service guarantees as per IPHS, in 1,75000 places.	30% by 2007 60% by 2009 100% by 2010	Annual Facility Surveys. External assessments
4	30,000 PHCs strengthened/established with 3 Staff Nurses to provide service guarantees as per IPHS.	30% by 2007 60% by 2009 100% by 2010	Annual Facility Surveys. External assessments
5	6500 CHCs strengthened/established with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS.	30% by 2007 50% by 2009 100% by 2012	Annual Facility Surveys. External assessments.
6	1800 Taluka/ Sub Divisional Hospitals strengthened to provide quality health services.	30% by 2007 50% by 2010 100% by 2012	Annual Facility Surveys. External assessments.
7	600 District Hospitals strengthened to provide quality health services.	30% by 2007 60% by 2009 100% by 2012	Annual Facility Surveys. External assessments.
8	Rogi Kalyan Samitis/Hospital Development Committees established in all CHCs/Sub Divisional Hospitals/ District Hospitals.	50% by 2007 100% by 2009	Annual Facility Surveys. External assessments.
9	District Health Action Plan 2005-2012 prepared by each district of the country.	50% by 2007 100% by 2008	Appraisal process. External assessment.
10	Untied grants provided to each Village Health and Sanitation Committee, Sub Centre, PHC, CHC to promote local health action.	50% by 2007 100% by 2008	Independent assessments. Quarterly Progress reports.
11	Annual maintenance grant provided to every Sub Centre, PHC, CHC and one time support to RKSs at Sub Divisional/ District Hospitals.	50% by 2007 100% by 2008	Independent assessments. Quarterly Progress reports.
12	State and District Health Society established and fully functional with requisite management skills.	50% by 2007 100% by 2008	Independent assessments.
13	Systems of community monitoring put in place.	50% by 2007 100% by 2008	Independent assessments.
14	Procurement and logistics streamlined to ensure availability of drugs and medicines at Sub Centres/PHCs/ CHCs.	50% by 2007 100% by 2008	External assessments.

15	SHCs/PHCs/CHCs/Sub Divisional Hospitals/ District Hospitals fully equipped to develop intra health sector convergence, coordination and service guarantees for family welfare, vector borne disease programmes, TB. HOV/AIDS, etc.	30% by 2007 50% by 2008 70% by 2009 100% by 2012.	Annual Facility Surveys. Independent assessments.
16	District Health Plan reflects the convergence with wider determinants of health like drinking water, sanitation, women's empowerment, child development, adolescents, school education, female literacy, etc.	30% by 2007 60% by 2008 100% by 2009	Appraisal process. Independent assessments.
17	Facility and household surveys carried out in each and every district of the country.	50% by 2007 100% by 2008	Independent assessments.
18	Annual State and District specific Public Report on Health published	30% by 2008 60% by 2009 100% by 2010	Independent assessments.
19	Institution-wise assessment of performance against assured service guarantees carried out.	30% by 2008 60% by 2009 100% by 2010	Independent assessments.
20	Mobile Medical Units provided to each district of the country.	30% by 2007 60% by 2008 100% by 2009	Quarterly Progress Report.

Figures 1 and 2 provide two bases of measuring the progress and achievements of the NRHM. While Figure 1 contains the expected outcomes that could be measured through statistical data, Figure 2 is a timeline for major activities planned under NRHM, with some targets and methods of assessment. We would expect these to be part of the review and evaluation frameworks.

The Framework for Implementation states that a three way monitoring framework would be used – Community Monitoring of services, special studies by commissioned reviewers and monitoring through the HMIS. An elaborate description for Community Monitoring has been laid out in the Framework for Implementation. In addition, a system of Common Review Missions was specified.

Common Review Missions

A system called Common Review Mission was set up for periodic and regular evaluations of NRHM These reviews assess progress on key indicators and provide recommendations. Ministry officials, public health experts, civil society members, development partners and consultants of the MoHFW are nominated to carry out the review every year. Each year teams of 4-5 members make field visits in each of the selected states and each year reviews

are conducted in at least 15-17 states. These states are high focus states including states in the Northeast, as well as non high focus states. For details of the CRM teams and the states reviewed see Annexure 1.

Reproductive and Child Health Programme Phase II (RCH II) 2004-09

The RCH II was designed based on the lessons learnt from the implementation of RCH I. Its key priority was reduction of maternal mortality, infant mortality and overall fertility. Experience of RCH-I pointed out that there was an absence of a vision and policy guidelines in RCH I which led to unfocussed implementation. It was conceived of as a project and not as a programme with specified long-term outcomes. Financial flows impeded the progress of the activities. RCH I was centrally designed, there was limited involvement of the states and limited consultation with other stakeholders. RCH II therefore was a document which was finalised after wide discussions, based on 16 very important supporting documents (on Tribal Health, Urban Health, Adolescent Health, Gender, Equity and Access, Immunisation, BCC, PPPs and so on). RCH II planned to introduce several reforms and innovations – a streamlined drug procurement and distribution system, improving blood supplies in first referral units, introducing maternal and child death audits, district PIPs based on Community Needs Assessment, block and district level intersectoral coordination.

The RCH II was supported by development partners like the World Bank, USAID, UNICEF, UNFPA, WHO, DFID. It had four technical areas – Maternal Health, Child Health, Family Planning and Adolescent Health (Table 1) and three cross cutting issues – Gender and Social Equity, Behaviour Change Communication and Training. The PIP also details out Programme Management and Technical Assistance, Monitoring and Evaluation, Financial Management and Procurement as support functions.

Table 1: Thematic Areas and Lead Development Partners

Technical	Management	Cross Cutting
Maternal Health(UNFPA)	Programme Management &TA (WB)	Gender &Social Equity (DFID)
Child Health (UNICEF)	Monitoring & Evaluation (DFID)	Behaviour Change Communications (USAID)
Family Planning (USAID)	Financial Management (WB)	Training (WB)
Adolescent Reproductive and Sexual Health (WHO)	Procurement (WB)	

The goals of the programme were by 2010 to: have TFR reduced to 2.1, Maternal mortality ratio reduced to 100/100000 live births and Infant mortality rate reduced to less than 30/1000 live births, especially among the poorest. The process indicators to be used for ongoing monitoring were:

a. Percentage of ANMs positions filled
b. Percentage of districts having a full time programme manager for RCH II b. Administrative and financial powers delegated
c. Percentage of sampled state and district programme managers aware of their responsibilities
d. Percentage of sampled state and district programme managers whose performance was reviewed during the past six months
e. Percentage of districts not having one month stock of a. Measles vaccine b. OCP c. Gloves
f. Percentage of districts reporting quarterly financial performance in time
g. Percentage of district plans with specific activities to reach vulnerable communities
h. Percentage of sampled outreach sessions where guidelines for AD syringe use and safe disposal followed
i. Percentage of sampled FRUs following agreed IP and healthcare waste disposal procedures
j. Percentage of 24 hrs PHCs conducting minimum of 10 deliveries per month
k. Percentage of CHCs upgraded as FRUs offering 24 hr EmOC services
l. Percentage of sampled health facilities offering RTI/ STI services as per the agreed protocols
m. M & E Triangulation

Joint Review Missions

The RCH II programme was monitored through the Biannual Review Missions called Joint Review Mission. These multi-stakeholder review missions were led by the National Government with participation from state governments, and Development Partners. Eight biannual Joint Review Missions and a Mid Term Review were done.

The Joint Review Missions primarily focused on assessing the overall programme performance and implementation of the programme strategies/polices against the above mentioned indicators. These were focused on Institutional strengthening (Management and systems) and technical domains in terms of improving Service Delivery (access, availability, quality, affordability). Each JRM also tracked the actions against the earlier JRM recommendations.

During each JRM, teams visited a few states after studying their reports and state PIPs once they began to be written up. There was a national level review of all thematic and programme divisions as well as a review of all states, even those not visited. Each JRM had a Process Manual which laid out the scope and the methodology of the JRM, including the tools to be used during the field visits.

National Health Mission (NHM) 2012-17

A few years into the implementation of the NRHM, questions began to be asked 'what about the health of the urban poor? Did we not also need a National Urban Health Mission?' Several drafts and budgets of the NUHM were in circulation, but the NUHM was never formally launched. The National Health Mission subsequently was formulated to be implemented after NRHM and the 11th Plan period. The NHM thus encompasses two existing missions – the NRHM and NUHM. It retains the framework of implementation of NRHM drawn in 2006 which 'served it well' in the past and adds on to it. "It is both flexible and dynamic and is intended to guide states towards ensuring the achievement of universal access to healthcare through strengthening of health systems, institutions and capabilities." The NHM framework draws on several sources: the NRHM Framework for Implementation 2006, learnings from NRHM distilled through several evaluation studies, and experiences of practitioners and communities, the Chapter on Health in the 12th Five Year Plan and comments and suggestions from the Planning Commission, several ministers and state governments.

As with NRHM, it focuses on ensuring universal access to healthcare through strengthening of public health services and building capacities. The core concerns are the same as in NRHM. But the NHM is a forward looking programme and its commitment is towards sustaining the positive changes in the healthcare delivery system. It mentions strategies at community, and programme management level for this, e.g. creation of health management cadres creating effective institutions for programme management, providing incentives for improved performance and building high quality research and knowledge management structures and improved HMIS to provide disaggregated data for monitoring reach to marginalised groups. Synchronisation of goals of the NHM and 12th plan is also an indicator of greater commitment and more systematic approach towards the stated goal. The NHM (like NRHM) gives the flexibility to plan their strategies and implement state specific action plans.

The NHM is focussed on health systems strengthening. In addition to the historical oft repeated endeavours – decentralised health planning, strengthening facility based and outreach services, development of human resources, community processes including BCC and addressing social

determinants – the NHM Framework for Implementation specifies some new action areas. These are: developing District Health Knowledge Centres, Social Protection as a public health function, ensuring health services in Left Wing Extremist (LWE) areas in addition to tribal areas and for the urban poor, and implementing district pilot projects for Universal Health Care.

Monitoring and Evaluation of NHM

The Framework for Implementation mentions that there will be four approaches to monitoring and evaluation – data from large surveys like SRS, NSSO, DLHS, NFHS and so on, commissioning of special studies, a concurrent evaluation and end of the project impact evaluation, use of data from the HMIS, and finally, appraisal visits including the Common Review Missions. Despite its limitations, the framework mentions that the CRM reports are found to be frequently cited and that the CRM methodology would therefore be strengthened.

Methodology

In this section, the methodology used for in this evaluation is presented. The section covers rationale, objective and scope of the study along with definitions of key terms, frameworks used and the criteria developed for the purpose of the review.

Rationale, objectives and scope of the study

A feminist standpoint is predicated on women and their lived experiences as distinct from those of men. Furthermore, a standpoint is a position of political engagement emerging from this lived reality. To explain a feminist standpoint, Nancy Hartsock writes,

'Women's lives make available a particular and privileged vantage point on male supremacy, a vantage point which can ground a powerful critique of the phallocratic institutions and ideology which constitute the capitalist form of patriarchy…a feminist standpoint can allow us to understand patriarchal institutions and ideologies as perverse inversions of more humane relations.' (1983, p. 284)

Murthy questions whether gender sensitive evaluations and feminist evaluations differ (Murthy 2014) and concludes that 'gender-redistributive evaluations and socialist feminist evaluations are similar, while gender-neutral and gender-specific evaluations are not. Gender-redistributive/transformative evaluations examine how far the project/programme has contributed to changing power relations within institutions based on gender and other identities..... Like in the case of feminist evaluations, issues of power are placed at the center both on the ground, within the evaluation team, between the evaluation team and implementing agency and implementing agency and donor.'

Armed with this understanding of a feminist/gender evaluation, we embarked on a review of the two national health policies or programmes viz. the NRHM[2] (or NHM) and the RCH II.

The study seeks answers to following questions:

- How are different genders viewed in the NRHM/RCH II evaluations – as gender stereotypes or in gender transformative roles?
- Are the evaluations of NRHM/RCH II gender sensitive, gender neutral, gender specific or gender blind? Are the programmes themselves gender sensitive, gender neutral, gender specific or gender blind?
- How gender sensitive are the indicators used for evaluation? Do these indicators register violation or upholding of women's rights regarding health and healthcare?
- Which services show improvement (or deterioration) since the implementation of NRHM? Is the improvement uniform across the country? Do the evaluations capture these?
- Do the evaluations examine how the NRHM/RCH II has helped to address known barriers to access?
- What has NRHM/RCH II done to promote empowerment in terms of health rights of women and other invisible/neglected genders? Have the CRMs commented on this?

Interface of Feminism and Human Rights

Feminism's discomfort with the international covenants has been documented in the past by many (see Otto 2010, Byrnes 1992). For some feminists, the discomfort stems from a position that rights embedded in these instruments are ineffective in dismantling the structural and systemic basis of patriarchy and its misogynist manifestations. Yet, at the other end of the spectrum, we find that there has been an explicit acknowledgement among feminist activists that these international instruments are a useful and important means to bring about concrete change in the lives of women across the globe. So, we understand that feminism is oriented towards a revolution for social change through struggle and collective action while international rights conventions accord each individual the legal right to demand entitlements. Against this backdrop, as feminist evaluators, our foremost focus is justice and equality for women and vulnerable groups i.e. gender equity within which is subsumed social equity for all oppressed groups. The use of human rights framework is an instrumentalist approach to ensure that all

[2] The NRHM was launched by the UPA government in 2005 to address the health concerns of rural India. In 2013 the NHM was launched with the existing NRHM as a sub-mission along with the new NUHM.

fundamental, social, economic, political and cultural rights are covered. For the purpose of the study, the combined force of the twin goals viz. gender equity and fulfilment of human rights were invoked to address social justice concerns in the health policies. We therefore use 'human rights' as one of the main pivots of the review along with 'gender-equity'. (See the following section for definitions of the terms used in the review).

Definitions

Gender

For this review, we borrow UNEG's definition of gender which is as follows, 'Gender refers to the array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. Whereas biological sex is determined by genetic and anatomical characteristics, gender is an acquired identity that is learned, changes over time, and varies widely within and across cultures. Gender is relational and refers not simply to women or men but to the relationship between them.' (2014, p. xii)

In the context of health, we understand and define gender as men, women and people of the third gender with varying health needs and with varying power to relate with the health system. Special attention needs to be given for the removal of barriers to access healthcare for all the gender categories especially women and vulnerable groups. It is also important to bear in mind that women's health needs extend beyond reproductive health as mothers or potential mothers. A gender perspective also recognises intersectionalities including class, caste, marital status, disability, which can both enhance and harm health. An equitable health system is one that recognizes and caters to these intersectionalities – being fair to varying needs.

Equity

Each person has a fair opportunity to attain their full health potential, no one faces barriers that prevent him/her from achieving this potential if it can be avoided.

Equity in policy

A policy can be considered an equity policy if it –

- addresses barriers to individuals' attaining full health potential
- focuses on root causes of inequities in health
- is directed towards enabling people to adopt healthier lifestyles
- has a commitment towards decentralisation of power and decision-making

- encourages people's participation at each level of policy-making
- facilitates people's – especially vulnerable people's – involvement in identifying health needs and interventions most suited to them(Whitehead, 1992)

Human rights

Human rights are the legal rights/entitlements related to all aspects of life that are accorded to each individual/citizen through international legal instruments or national policies and programmes. These entitlements are geared towards ensuring equality and justice in society. Human rights work towards the protection of the poor, vulnerable and disadvantaged in society.

Framework used for Gender Equity and Human Rights Analysis

The study uses the framework provided by UNEG guidance document (UNEG, Integrating human rights and gender equality in evaluation – towards UNEG guidance, 2014) for examining the programme designs and the planning frameworks of NRHM, RCH, NHM and for the JRMs. Details are provided in Table 2 below. For the implementation and progress of the NRHM as captured through the CRMs, a new set of criteria had to be developed as described in subsequent sections.

Review of CRMs

In the review, the UNEG framework is used to discuss the design and planning aspects of the NRHM. The relevance, effectiveness, efficiency, sustainability and impact of the CRMs are closely examined through the UNEG framework. Some 'tailored evaluation questions' were either modified or omitted depending on the pertinence of the question to understanding the review mission. However, UNEG framework was not used for the analysis of the implementation and results of NRHM as reflected through the CRM reports. As the NRHM was launched in 2005, the Mission was implemented gradually and the pace of implementation differed in different states. The earlier CRM reports viz. first, second and third largely describe the process being put in place for implementation. Often the reports discussed the steps which would facilitate the later implementation of certain components of NRHM. With little reporting of actual implementation (reflecting the ground reality) in the beginning of the CRM process, we found the UNEG framework to be limiting and inappropriate for reviewing 'stated intentions', processes and/or enabling factors which would eventually aid implementation.

Moreover, there are no clear quantitative or qualitative indicators developed for the assessment of NRHM/NHM. The Framework of Implementation identifies expected outcomes for the Mission, and activities with certain timelines and how these would be monitored, but these do

Table 2: Framework used for analysing documents

Evaluation criteria	Assessing design and planning	Assessing implementation	Assessing results
	Do the reviews by CRM and JRM provide an answer to –		
Relevance	• Whether NRHM and RCH were formulated according to international agreements and national strategies to advance gender and social equity and to ensure rights of stakeholders? • Are NRHM and RCH developed to respond to needs and interests of all targeted stakeholder groups?	• Whether activities under NRHM and RCH operationalise a gender, social equity and rights based approach? • Did the activities under NRHM and RCH meet the needs and interests of all targeted stakeholders? • Did the activities address the underlying causes of inequality and discrimination?	• Do results of NRHM and RCH contribute towards realisation of international and national norms and strategies to advance gender and social equity and realisation of rights? • Do results of NRHM and RCH results respond to the needs of all stakeholders as identified at the design stage?
Effectiveness	• Are gender and social equity and rights related objectives clearly stated in the results framework of the NRHM and RCH documents including short term, medium term, long term objectives? • Is the responsibility for ensuring adherence to gender, rights and equity related objectives well-articulated in the monitoring and review framework and implementation plans? • Do NRHM and RCH have specific quantitative and qualitative indicators and baselines to measure progress on gender, rights and social equity related indicators?	• During implementation, were there systematic and appropriate efforts to include various groups of stakeholders, including those who are most likely to have their rights violated? • Did the intervention (NRHM and RCH) maximize the efforts to build the capacity of rights holders and duty bearers? • Was monitoring data collected and disaggregated according to relevant criteria (gender, age, location, income, religion, caste etc) • Was sufficient information collected on gender, rights and equity related indicators to show progress regarding these? • Was monitoring data shared adequately with stakeholders (duty bearers, rights holders, men, women etc)? • How was monitoring data on gender, rights and social equity used to improve the intervention (NRHM, RCH)?	• What are the main results of NRHM and RCH towards realisation of gender, rights and social equity ? • To what degree are these results distributed equitably across the targeted stakeholder groups? • Do results contribute towards changing attitudes and behaviours towards gender, rights and social equity? • Do these results contribute to reducing the underlying causes of inequality and discrimination? • Did the intervention (NRHM, RCH) contribute to the empowerment of rights holders to demand and duty bearers to fulfil gender, rights and social equity norms?

Efficiency	• Are there sufficient resources (financial, time, people) allocated to integrate gender rights and social equity and in the design, implementation, monitoring and evaluation of the intervention (NRHM, RCH)? • To what extent are HR & GE a priority in the overall intervention budget?	• Were the intervention resources used in an efficient way to address gender, rights and social equity in the implementation (e.g. participation of targeted stakeholders, collection of disaggregated data, etc.)? • Were there any constraints (e.g. political, practical, bureaucratic) to addressing gender, rights and social equity issues efficiently during implementation? What level of effort was made to overcome these challenges?	• Was the use of intervention resources to address gender, rights and social equity in line with the corresponding results achieved?
Sustainability	• Did the planning framework build on an existing institutional and organisational context that is conducive to the advancement of HR & GE? If not, did the intervention design address the institutional and organisational challenges to advancing the HR & GE agenda?	• Did the intervention (NRHM, RCH) activities aim at promoting sustainable changes in attitudes, behaviours and power relations between the different stakeholder groups? • How was monitoring data on gender, rights and social equity used to enhance sustainable change on these issues?	• To what extent do stakeholders have confidence that they will be able to build on the HR & GE changes promoted by the intervention? • To what degree did participating organizations change their policies or practices to improve realisation of gender, rights and social equity related objectives (e.g. new services, greater responsiveness, resource re-allocation, improved quality etc.)?
Impact	• Did the intervention envisage any specific impact on gender, rights and social equity? Is it clearly articulated in the results framework?	• How did the intervention activities relate to the intended long-term results on gender, rights and social equity? • Did the intervention monitoring systems capture progress towards long-term results on gender, rights and social equity? • Were there any positive or negative unintended effects on gender, rights and social equity identified during implementation? How were they addressed?	• Did the intervention clearly lead to the realization of targeted HR & GE norms for the stakeholders identified? • Were there any unintended results on gender, rights and social equity in the intervention? Were they positive or negative and in which ways did they affect the different stakeholders? • Did the intervention activities and results in HR & GE influence the work of other organizations and programmes?

Source: UNEG, Integrating human rights and gender equity in evaluation – towards UNEG guidance

not lend themselves to evaluations regarding gender equity and human rights. All the seven CRMs were carried out based on the Terms of Reference (ToRs) prepared for the review team members. The ToRs mainly enumerate thematic areas which needed to be examined in the course of the Review Missions. The reports of the CRMs were prepared using the thematic areas identified in the ToRs.

Development of an Appropriate Framework to assess Implementation and Results

As mentioned earlier the NRHM Framework for Implementation has identified seven critical areas to achieve the main goals of the mission. These critical areas are further subdivided into several components. This evaluation uses these critical areas as the basis for the assessment of processes and enabling factors reported by the CRMs. The CRM reports were scanned to cull out components of the seven critical areas of NRHM. Subsequently, the team developed gender equity and human rights criteria for each component of the critical area. The criteria emerged from an interface between the field realities of the public health system and the socio-economic conditions of vulnerable populations including women. The questions in the UNEG framework for assessing implementation and results for relevance, effectiveness, efficiency, sustainability and impact were used to develop the criteria for assessment. For each component, gender equity and human rights criteria were prepared for [i] users of services and [ii] healthcare providers. The CRMs reports were then scanned for the use of each of the HR and GE criterion in the assessment of the NRHM. Subsequently, in our review we recorded whether [i] the criterion is used in the review, [ii] how the criterion is used and lastly, [iii] if the criterion is used then, is the use of the criterion in the review of NRHM is furthering HR and advancing GE?

Overlapping criteria can be seen across components and target groups i.e. users and providers of healthcare. We have avoided repetitive discussions related to the overlapping criteria. The ToRs prepared for the second and the seventh CRM have also been included in the evaluation to capture the mandate and methodology of the reviews.

Review of JRMs

For the review of the JRMs, the Aide Memoires of each JRM were scrutinised against the questions in the UNEG framework (Table 2). The findings were then summarised.

In addition, we draw upon an unpublished review done by UNICEF (Guhathakurtha 2010). The purpose of the 2010 review was to assess and document the outcome of the first six Joint Review Missions and the Mid Term Review, in terms of implementation of the recommendations.

The assessment was meant to be used to identify the areas of the RCH-programme requiring focused attention during the 7th JRM.

The 2010 review examined the JRM state presentations, the national Aid-Memoires, and the Programme Implementation Plans (PIP) of the first six JRMs. Three colour code methods were used to map the recommendations according to the status of the actions against them.

Not met 

Partially met 

Already met 

The recommendations were reviewed for 11 Thematic Areas as outlined in Table 1. The Matrices were circulated to all the lead development partners (DPs) of the 11 Thematic Areas for discussion and finalization in consultation with the Nodal Programme Division of the Ministry of Health and Family Welfare.

In our review we are focusing only on the Thematic Areas of Gender and Social Equity and not the other ten Thematic Areas. We have extended the original 2010 Gender and Social Equity Matrix to include JRMs 7 and 8.

Review of published NRHM Evaluation Reports

In the course of our review we identified other evaluations of NRHM besides the CRM to understand whether GE and HR concerns are covered by NGOs, researchers and/or government departments. The criteria for selection of the studies were as follows:

a. The evaluation was conducted in the period 2005-2012 i.e. the seven year period when the mission was launched until the year it was proclaimed a sub-mission under the NRHM.
b. The evaluation is a national level study of the programme.
c. The evaluation is based largely on primary data with some aspects covered through secondary sources.
d. The study report is readily available in the public domain.
e. The evaluation was undertaken independently by a government agency, NGO, academic institution or researchers.

Three evaluation studies which met the above criteria were selected for the purpose of this review. A rapid assessment of these evaluation reports/papers was undertaken using the five main evaluation criteria delineated in the UNEG Framework. The studies were carefully

scanned to assess whether the studies were conducted with a view to reveal the relevance, effectiveness, efficiency, sustainability and impact of NRHM on GE and HR concerns. A more detailed assessment of the studies using the UNEG framework in its entirety along with the GE and HR criteria developed for the review of the CRM is desirable.

Semi-structured Interviews with Key Informants

Interviews were conducted with nine individuals who had either participated in CRMs, or were representatives of development partners engaged with GE and HR issues in health. Annexure 3 gives details of persons interviewed. Annexure 4 is a list of interview questions. All interviews were recorded and transcribed. Interviews took between 40 minutes and 90 minutes, most interviews were around an hour. Two interviews were over telephone and Skype and others were face-to-face. Responses were compiled according to themes and interview questions.

Limitations of the Evaluation

The UNEG framework was used for assessing the design and planning of NRHM but the review of implementation and results were assessed with Human Rights and Gender Equity criteria developed based on the 'tailored evaluation questions' in the framework. The limitation of the review is that due to time constraints the team was unable to develop an exhaustive list of HR and GE criteria and related quantitative and qualitative indicators to assess the CRMs.

Findings: NRHM/NHM and CRMs

The Findings section brings together our observations and analyses from four sources – 1. the NRHM and the CRMs, 2. the RCH II and the JRMs, 3. the findings from the Key Informant Interviews, and 4. the studies and evaluations reviewed .

The extent to which a Gender Equity and Human Rights perspective is incorporated in the design of the CRMs and the JRMs is dependent on the extent to which this perspective is incorporated in the designs of the programmes themselves. In the NRHM and RCH II sections, we first analyse the programme designs – NRHM and NHM Framework for Implementation and the RCH II Project Implementation Plan – from a GE and HR perspective. Then we go on to examining the Mandate and Methodology of the CRMs and JRMs and then the findings based on the UNEG and other guidelines.

Observations on the NRHM/NHM design from a gender equity and human rights perspective

To analyse the designs of the NRHM and the NHM, we used the definitions of gender, equity and human rights. Some of the questions that we were asking were:

- How are different genders viewed in the NRHM/ NHM? – As gender stereotypes or in gender transformative roles?
- Are the designs of the NRHM/ NHM gender sensitive, gender neutral, gender specific or gender blind?
- How do the NRHM/ NHM propose to address known barriers to access?
- How do NRHM/NHM propose to promote empowerment in terms of health rights of women and other invisible/neglected genders?

Based on Whitehead's definition of equity in policy, we also examined the extent to which NRHM and NHM have a commitment towards decentralisation of power and decision-making; whether they encourage people's participation at each level of policy-making; whether they facilitate people's – especially vulnerable people's – involvement in identifying health needs and interventions most suited to them. (Whitehead, 1992)

The NRHM acknowledges right to health as a fundamental right, and a broader definition of health as improved quality of life and not merely morbidity and mortality. The Mission's commitment to equitable healthcare is stated clearly and repeatedly throughout the Implementation Framework. Addressing disparities between states, between districts and among various groups of the community has been stated as the main focus area of the Mission. The broad features of the NRHM – efforts for ensuring equitable access to healthcare, decentralised planning and implementation, active involvement of community in identifying its health needs and monitoring the health systems, mechanisms for empowering community to fulfil their role, facilitating community involvement through amendments of Acts and an integrated monitoring review mechanism – point towards NRHM being an equity policy.

The concept of social equity and proposed strategies for achieving equitable quality healthcare is better articulated in the NHM implementation framework. The document defines high priority areas and groups; and spells out specific strategies for meeting specific needs of various marginalised groups such as those from remote areas, tribal populations, women, children, adolescents, elderly etc. The document stresses on ensuring 'continuum of care' and accessible and acceptable healthcare services (e.g. patient friendly adolescent clinics, patient friendly services to TB patients registered under the RNTCP etc.). Unlike the NRHM document, the NHM clearly acknowledges gender as one of the factors responsible for disparities in access to healthcare and health outcomes and proposes specific strategies for addressing gender disparities. It therefore has a broader focus regarding 'women's health needs'. Its focus is not restricted to maternal and child survival services but to ensuring

quality of life for women, children and adolescents. This understanding is also reflected in the goal of the Mission which includes building a broad based inclusive partnership, ensuring financial health of households in addition to universal access to healthcare and an accountable health system responsive to the community's health needs – which were mentioned even in the NRHM framework.

The NHM Implementation Framework reflects a better understanding of gender and intersectionalities as compared to the NRHM Implementation Framework. NHM recognises specific health and reproductive health needs of adolescents including need for access to contraceptives and prevention of STI/RTIs. Adolescent friendly health services are proposed under NHM at facility level. The BCC component of adolescent health is to include information on general health concerns such as anaemia as well as prevention of STIs/RTIs and contraception. It proposes convergence with programmes like Rashtriya Kishori Swasthya Karyakram and Sabla for better service delivery.

In terms of reproductive health needs of women, the NHM recognises the need for provision of safe abortion services. These would be provided through all 24x7 facilities and the Mission proposes to build capacities of the medical and paramedical staff regarding medical abortions. Recognition of gender based violence as an important factor affecting women's general, reproductive and mental health and committment towards providing services to women survivors of violence is another step towards addressing gendered aspect of health. NHM proposes linkages with other government departments for providing help to women suffering from gender based violence.

NHM proposes opportunities for skill upgradation for ASHA, ANM through bridge courses. Though primarily a step towards developing skill base, it can also be considered a step towards empowerment of women and greater participation of women in the formal healthcare delivery system.

The Mission also identifies declining sex ratio as a social problem and has proposed measures for ensuring health of the girl child. It proposes to deal with son preference at the community level through BCC and awareness generation by ASHA, using PCPNDT Act to control the medical professionals and schemes for welfare of the girl child.

Unlike the NRHM, the NHM mentions men in the context of reproductive health. However the focus appears to be limited in terms of contraception, it proposes prioritising male sterilisation.

The NHM recognises the importance of disaggregated data to monitor the reach of services to the marginalised populations and hopes to achieve this through digitised HMIS in the near future.

To summarise, the NRHM and the NHM are programmes that embrace the equity approach. Human rights and, to some extent, a gender perspective are present in the designs of both programmes, in NHM more than in NRHM.

Mandate and Methodology of CRM

In this section, we take a close look at ToRs prepared for the CRM teams, the schedule of the CRM teams in the field and the methods used for data collection during the review. We were able to collect only two ToRs viz. the second and the seventh CRMs, the others were not available in the public domain.

Team composition and states reviewed

The CRMs have been conducted every year since 2007. Ministry officials, public health experts, civil society members, development partners and consultants of the MoHFW are nominated to carry out the review. Each year a team of 4-5 members is formed to make field visits in the selected states. The reviews are conducted in at least 15-17 states. Every year the CRM is mandated to review high focus states including states in the Northeast as well as the non high focus states. For details of the CRM teams and the states reviewed see Annexure 1.

It is observed that feminist academics, activists and/or gender specialists do not necessarily find a place in the CRM team. There is no explicit understanding to include them in the review process. If some have found themselves selected as part of the team, it is purely incidental. The selection of representatives of civil society organisations perhaps indicates the inclusion of persons working on social justice and human rights. However, there is a large variety of organisations with a range of goals and objectives in the country. Not all of these organisations can be presumed to be human rights or social justice oriented. The selection of organisations should be such that adequate representation of persons with a Gender Equity and Human Rights perspective is ensured in the review teams.

Mandate of the CRMs and methods used

All the CRM reports have a section on the mandate/methodology followed in the course of the mission. The ToRs also clearly lay out how the review is to be conducted and what is to be reviewed by the teams. In terms of mandate, all the teams received detailed ToRs with NRHM core strategies or thematic areas to be reviewed along with related questions which needed to be answered in the final report. See Annexure 2 for tabulation of themes covered in each CRM. The themes common to all the CRMs are – improvements in service delivery, RCH services, National Disease Control Programmes, Human Resources for Health, community processes, knowledge

management, financial management and programme management. While most reports may cover issues like medicine and technology, procurement system and equity concerns, where these were not main themes to be reviewed in the ToR, the discussions are not so much in detail.

The second CRM ToR is vastly different from the seventh CRM ToR. The earlier ToR identifies themes for review along with some basic questions related to management of the Mission such as questions of quality of service, availability of resources or utilisation etc. The theme related to 'reaching difficult areas and vulnerable population' has a few questions related to access to health services for poor and vulnerable groups. None of the other recommended probes in any of the themes is related to HR and GE.

On the other hand, the ToR for the seventh CRM is more detailed in the themes for review and questions to be probed. Each theme is divided into separate components and questions/ criteria have been developed for each component. There are some questions which seek quantitative answers while others which are qualitative in essence. Like the second CRM ToR, most of the questions are programme management oriented. However, there are also probes related to equity concerns, efforts related to reaching the poor and vulnerable etc. At the same time, the probes are as gender-blind as those in the second CRM ToR. Importantly, one finds that a number of the probes are related to documentation or qualitative information of a component. There are probes related to best practices, for example, for Information Technology, documentation of steps taken for Community Based Monitoring, commentary on practices, electronic funds transfer system etc. In many ways, the last CRM ToR is far more equity oriented than the earlier one.

The reports of the CRMs are prepared based on the ToR provided to the team members. The ToR themes are taken as the main headings and the components are the subheadings in the reports. It follows that the more detailed the ToR is the more detailed the report is too.

The timeline and schedule in nearly all the CRMs is the same. The entire review is spread over roughly a month. On day one, the ToR is shared with the team at a joint meeting of all the state teams in Delhi. The fieldwork commences the next day at the selected state capital. The officials of the MOHFW including the Mission Director of the NRHM and the State Programme Officer present data and facts related to the functioning of the mission in the state. The state officials also identify two districts (one good performing and one bad performing) for the purpose of the review mission. On day three, one half of the CRM team goes to the 'good performing district' while the other goes to the 'bad performing district'. At the district, there

is a briefing by the district health officials regarding the district level progress and constraints in implementation. In the following 4-5 days, facility visits are conducted at the district, block and village level. The team interacts with community members, healthcare providers and other staff at the facilities. Community level VHSNC members and ASHAs are also interacted with for the review. At the facility, observations of wards and review of official documents/records are undertaken. Occasionally, night visits are also made to 24X7 facilities to document level of functioning of the same (see sixth CRM, 2012). After the district level visits, the team returns to the state capital to present their findings and recommendations to the officials. Finally, the reports are written up and shared with the MOHFW (compiled from the CRM reports).

In the review process, one finds that other than ToRs, there is no mention of tools used for the purpose of data collection during fieldwork. The observations, document reviews, facility examinations, state/district level review presentations, interactions with the providers and users etc., are undertaken without any tools to assist the processes. Checklists, interview schedules, discussion guides etc., if used in the review are not shared in the reports. The data or information, in the review, is not collected systematically and so, raises questions regarding the validity of the information provided in the reviews. Secondly, the entire fieldwork is completed in a matter of only six to seven days. Within this time period a state, two districts, blocks and villages are to be covered; the respondents range from healthcare providers to users of services to community members and health department officials. A week is a very short period to be able to capture field realities at all these levels. The state's selection of districts could be biased and misleading about the actual state of affairs. **Random selection of the two districts must be undertaken to assess actual progress and constraints in the state. The state officials should be consulted only after a few districts are selected based on reliable government (or non-government) secondary data.**

At this point, it is important to note that national programmes and schemes are difficult to review and assess owing to the sheer scale of the programme. Yet, reviews such as the CRM which are instituted within the programme should take measures to put in all possible checks and balances to ensure that the review is a meaningful exercise and at par with the scale of the programme itself.

Management or organisational theory appears to be at the heart of the ToRs and the actual assessments conducted by the reviewers. The reports of the CRMs indicate that for nearly all the critical areas of NRHM, the assessment places a heavy emphasis on management of each of the components. Human resource management, information management, management of facilities etc., form the crux of the review. This emphasis leaves little room for a feminist

evaluation rooted in ensuring gender equity and furtherance of human rights. Theoretically, feminism and management have hardly ever seen eye-to-eye, except now in the case of critical management studies which incorporates progressive theories in its understanding of organisations and management (Ashcroft, 2001; Bendl 2000). Feminists have critiqued classical management theories for their gender-blindness and overly masculine approach to management (Bendl 2000). Certain sections of the CRM evaluations as highlighted earlier are affected by this classical approach.

How do the CRMs look at Design and Planning issues in NRHM?

In this section, we use the UNEG framework (relevance, effectiveness, efficiency, sustainability and impact) to assess the extent to which the CRMs have reviewed the design and planning of NRHM and NHM from a gender-equity and human rights perspective.

The CRMs shed little light on the design of NHM vis-à-vis its relevance to gender equity and human rights, as per the UNEG framework. The Mission was formulated in line with the country's National Health Policy and with the expressed aim to meet the Millennium Development Goals. Both of these are geared toward promoting social justice and health access for all. Apart from the MDGs, other international norms and agreements have not been directly invoked in the NRHM or the NHM. On the other hand, national or local strategies did feature in the NHM design and planning. For instance, the PCPNDT Act is a national strategy to address sex determination and the declining sex ratio. From the fourth CRM onwards one finds that reporting on the status of the implementation of the PCPNDT Act was included in the reports.

The Health Mission was formulated according to the needs and interests of all targeted stakeholder groups. The CRMs have captured the different stakeholders and their needs by reporting on 'equity concerns', 'gender issues' and community interests. However, it is difficult to say how these needs were assessed.

1. Relevance

- Was the NRHM/NHM formulated according to international norms and agreements on HR & GE (e.g. CEDAW, UDHR, CRPD), and to national and local strategies to advance HR & GE?
- Was the NRHM/NHM formulated according to the needs and interests of all targeted stakeholder groups? How were these needs and interests assessed?
- Were HR & GE analyses conducted at the design stage? Did they offer good quality information on the underlying causes of human rights violations, inequality and discrimination to inform the NRHM/NHM?

It is difficult to ascertain whether HR and GE analyses were undertaken for the purpose of formulation of NHM/NRHM. There is neither any reporting of this nor of any data collected on inequality, discrimination or human rights violations in the public health system.

The NRHM has incorporated gender-equity and human rights objectives related to ensuring universal access, bringing about gender balance and focus on women's health. However, the objectives also include 'population stabilisation' which often takes a toll on women, their bodies and health with a heavy emphasis on measures such as female sterilisation.[3] In the expected outcomes of the NRHM, one finds that reduction in maternal mortality and engagement of ASHA per 1,000 population are a few women-oriented outcomes that have been included. The remaining are all morbidities or mortality related outcomes. The CRMs thus far have not assessed these outcomes of the NRHM. The Mission has detailed performance monitoring frameworks and implementation plans with specific responsibility regarding all objectives. At the time of the launch, specific activities were planned along with timelines and proposed methods to assess progress. Also, HR and GE related activities are few and far between. These include: selection of ASHAs, formation of VHSNCs and putting in place community monitoring mechanisms.

The CRMs have not reported in detail on the specific activities based on the timelines given in the Framework for Implementation. The Review Missions have reported on the effectiveness of the performance monitoring frameworks and the implementation plans such as the

2. Effectiveness

- Are HR & GE objectives clearly stated in the results framework, including short, medium and long-term objectives?
- Is the responsibility for ensuring adherence to HR & GE objectives well-articulated in the performance monitoring framework and implementation plans?
- Does the NHM have specific quantitative and qualitative indicators and baselines to measure progress on HR & GE?

[3] 'Population stabilisation' is an extension of the population control mindset which implemented coercive population policies which were rather violative of human rights. Although the language and terminology has now changed – from 'control' to 'stabilisation' – the Family Planning Programme on the ground continues to be implemented with ELAs (Expected Levels of Achievements) - read targets – and incentives which continue to violate human rights of the poorest sections of our society. The Family Planning Programme is also discriminatory – the burden of contraception continues to be on women, the focus is on terminal methods – mainly female sterilisation rather then promoting men's role in contraception and male methods.

performance indicators for ASHAs or the use of statutory audits (see seventh CRM 2013, sixth CRM 2012).

The Framework for Implementation does not clearly state the short, mid-term and long term objectives of the Mission. However, the document does mention that some of the suggested changes (e.g. formation of societies, appointment of appropriate staff at district health missions, amendments in Acts for providing space for community partnership in health planning and monitoring, filling up of vacancies etc.) are pre-requisites for the other strategies to work (these can be considered short term objectives). Most of these are related to structural strengthening of the health system and therefore aim at equitable access to healthcare.

The CRMs annually assess and report the financial and human resources available for NRHM. However, the adequacy of funds for different components is not clearly reported in the CRMs. None of the reviews thus far provide disaggregated and detailed information regarding resources available. Therefore, data regarding funds available for different components of the Mission, Human Resources in position and corresponding number of vacancies, investments made

3. Efficiency

- Are there sufficient resources (financial, time, people) allocated to integrate HR & GE in the design, implementation, monitoring and evaluation of the intervention?
- To what extent are HR & GE a priority in the overall intervention budget?
- What are the costs of not addressing HR & GE adequately from the design stage?

for training/skill building etc., are not available in the CRMs. The CRMs also fail to comment on the allocation especially for HR and GE related aspects in design and implementation or monitoring and evaluation of NRHM. The Mission seeks to reach the unreached and ensure health access to the poor and vulnerable. Some of the Mission's objectives, strategies and implementation plans express an intention to integrate HR and GE in the work to some extent. However, the evaluations undertaken by the CRM do not delve into this aspect to provide a clear picture. Hence, it is difficult to state, based on the CRM reports, about the prioritisation of HR and GE in the overall intervention budget. Finally, the reports do not address the consequences of not including HR and GE adequately in the Mission's design stage. However, the more recent CRMs keenly report on gender or equity related issues and highlight the exclusion of important women-centric laws/mechanisms/strategies in the reviewed states. For example, the fifth CRM pointed out that Vishakha guidelines for the protection of women against sexual harassment are not followed in any state other than Goa.

The NRHM was launched in 2005 to bring greater focus to rural India and the status of health services in villages. Equitable access to health services is undeniably at the heart of the Mission. The Mission sought to make 'architectural corrections' in the existing public health system in order to reach the last household in the last village. The entire system underwent an overhaul to effectively cater to the needs of different target populations viz. pregnant women, adolescents, poor and vulnerable. These structural changes and their effectiveness are captured in varying degrees by the seven CRMs undertaken so far. All the CRMs were mandated to shed light on improvements in construction/repair of physical infrastructure, range of services provided in facilities, financial management etc., in the reviewed states. While reviewing each of these, the recent CRMs have upheld the HR and GE agenda. For example, in the construction of physical infrastructure, the CRM teams have commented on the absence of segregated or appropriate wards, toilets and examination rooms for the different sexes (CRM 2013, CRM 2012, CRM 2011).

However, this review is of the implementation of the plan and not of the plan itself. The ASHA programme within the NRHM is a key strategy for communitisation of public health. The CRMs praise the implementation of the ASHA programme but seldom discuss its intrinsic design wherein the ASHA is an incentivised volunteer with a heavy workload and no regular compensation for carrying out her responsibilities. Similarly, the absence of planning for improved working conditions for the healthcare providers especially women is not discussed in the CRMs. Within the NRHM design, the examination of organisational and institutional challenges to achieving the HR and GE agenda is not prioritised by the CRM.

In terms of impact, the NRHM does not clearly identify any specific impact on HR and GE. In the Results framework (next section) as discussed in the subsection on 'effectiveness' the expected outcomes are related to reducing mortalities and morbidities along with improving access to health facilities at the community level. The quantitative mortality and morbidity related outcomes would be assessed based on statistical data (2005, p. 10). The Framework for Implementation does not clearly point out how the community level outcomes would be assessed. The potential unintended impact on different stakeholder groups was not identified in the NRHM. Importantly, the impacts and outcomes have so far not been assessed in the CRMs. The CRMs also fail to speak of specific impact on HR and GE in the course of their review of the NRHM.

4. Sustainability

- Did the planning framework build on an existing institutional and organisational context that is conducive to the advancement of HR & GE? If not, did the intervention design address the institutional and organisational challenges to advancing the HR & GE agenda?

5. Impact

- Did the intervention envisage any specific impact on HR &GE? Is it clearly articulated in the results framework?
- Did the intervention design consider how impact on HR& GE could be assessed at a later stage?
- To what extent were the potential unintended impacts on the various stakeholder groups identified during the design stage?

Implementation and Results

CRM

In this section, gender equity and human rights criteria developed for the purpose of this review are used to analyse the CRM process.

How do the CRMs look at Design and Planning issues in NRHM?

In conclusion, regarding the assessment of Design and Planning of the NRHM through the CRMs it is safe to say that the review missions have not examined the promotion of HR and GE in the design of the Mission. CRMs have largely concentrated on the implementation of the NRHM/NHM rather than implementation plans and design of the programme. The NRHM/NHM is an equity policy i.e. It is designed to address social inequities. The NHM is a well thought out gender sensitive policy unlike the NRHM which was largely gender blind.

1. Well-functioning health facilities

The presence of well-functioning facilities is indispensable for achieving the ultimate goal of ensuring health for all in the country. The NRHM builds every strategy on the assumption of the existence of facilities with [i] physical infrastructure [ii] mandated range of services [iii] human resources [iv]biomedical waste management and infection control [v] sanitation services [vi] drugs and equipment and [vii] diet provision. One of the main objectives of the CRM is to assess the status of each of the above enumerated components in health facilities in the review states. From time to time the review process neglects to consistently question whether gender-sensitivity and rights entitlements are incorporated in the components. To unpack this lapse further, we will review the CRM reports using a variety of gender-equity and human rights criteria relevant to each component of a critical area.

i. Physical Infrastructure

Different gender equity and human rights criteria relevant for the component of physical infrastructure under well-functioning facilities are given in Box 1.

In all the seven CRM reports, infrastructure gaps and the need for development therein, is discussed in detail. The NRHM upholds that appropriate and adequate health infrastructure is essential for regular and quality service provision. Basic physical infrastructure development is assessed as per the Indian Public Health Standards (IPHS) from the point of view of service provision and coverage. It is commendable that nearly all the reviews are oriented towards highlighting geographical access of different populations in the reviewed states. However, in CRMs the reasons for shortfall in infrastructure in different states are often not clearly pointed out. It is unclear whether the buildings/other infrastructure are constructed but not in use, under-construction and delayed or not sanctioned in the first place. In many states, one finds that sanctioned buildings are constructed over protracted periods of time, defeating the objective of setting up well-functioning facilities. In the seventh CRM, Arunachal Pradesh and Jharkhand are identified as the states with a slow pace of construction of sanctioned buildings. Apart from geographical access, the peculiar accessibility concerns of vulnerable groups such as women, children, marginalised communities must find space in the reviews.

Box 1. Construction/repair of physical infrastructure

Target groups	Gender-equity criteria	Human rights criteria
Users of services	• Adequate number and well-maintained wards with electricity and water supply for all sexes and age groups; separate wards for different sexes	• Availability of functioning facilities as per IPHS norms in all areas; including approach road, 24X7 water and electricity supply, adequate wards
	• Construction and availability of facilities as per the IPHS norms to ensure access for all	• Construction of accommodation facilities for those accompanying inpatients from hard-to-reach or distant villages
	• Adequate and appropriate examination area for women patients in all facilities/during VHND	
	• Adequate accommodation facilities for relatives of inpatients - especially for women	
Healthcare providers	• Appropriate and adequate accommodation facilities for women healthcare providers within or near the facility campus	• Adequate and context specific amenities to be provided to all healthcare providers irrespective of location of service
	• Overnight accommodation facilities for ASHA who accompany women and children to referral centres	

Based on the gender equity criteria in Box 1, lack of privacy of patients in the examination areas and wards is discussed by all CRM teams, although the details of the discussion in the reports vary considerably. In the initial reports viz. the first and second CRMs the reviewers have pointed to absence of curtains or screens in one or two reviewed states. The reviewers in CRMs since the third CRM in 2009 have been consistently stressing the need for curtains or screens in wards, examination area for ANC during VHNDs, screen around the examination table etc.

In the sixth CRM report, a section on 'gender and security' highlights the needs for privacy and security in facilities for the users of the services. Admission of men and women in the same ward is identified as a concern requiring immediate remedial action in all the CRMs, except for the first and the second report. Well maintained, segregated wards for men and women would go a long way in ensuring access to services for women. Additionally, the provision of healthcare services for persons of the third gender is equally in line with gender equity and human rights. None of the CRMs have thus far addressed this issue. The seventh CRM report of 2013, merely quotes a guiding principle of the NHM/NUHM which recognises the vulnerabilities of the transgender community in urban India and seeks to address these through affirmative action (p. 120). The CRM reviewers have neglected to assess the system's responsiveness to the third gender in rural as well as urban areas. In view of the Supreme Court judgement on the recognition of the third gender, this omission must be rectified at all costs. The Supreme Court directs that, 'Centre and State Governments should take proper measures to provide medical care to TGs (Third gender) in the hospitals and also provide them separate public toilets and other facilities.' (p. 104, 2014)

Accommodation facilities for those accompanying women inpatients or inpatients from hard-to-reach or distant areas are not considered in any of the CRMs over the last seven years. Facilities would be more women-friendly insofar as their kith and kin can escort them and once admitted, can attend to them. For patients from distant villages or hard to reach areas, accommodation facilities for kith and kin are essential to reduce high travel cost and time.

As mentioned in the previous section, a number of concerns of healthcare providers in public health facilities are missing in the CRMs. In Box 1, women healthcare providers need for accommodation in/near the facilities has been identified as a criterion. In the course of the CRMs, all except the first team, has dwelt to some extent on the issue of accommodation for the staff. Over the years the focus on accommodation in the review process has increased due to the emphasis on providing 24X7 services. The Fifth CRM (2011) recommends the following – 'Residential accommodation for service providers is emphasized yet again, with the

recommendation to prioritise those facilities where this is identified as the single most important, even if it is the only reason for not being able to operationalise a 24X7 services.' (p. 14).

In light of this strategy, one tends to question the appropriateness and quality of the residential accommodation provided to the staff. Although accommodation for staff has been discussed in varying degrees from the second CRM, one does not have disaggregated information regarding cadre-wise allotment, type of accommodation, location, amenities provided etc. This data is pivotal in understanding whether [a] gender, class or communal hierarchies are invalidated and [b] action is taken in the interest of the vulnerable and marginalised. Also, the fourth CRM reviewers state that 'liveable' staff accommodation in Kerala and Chandigarh are not in use (2010, p. 24). The reasons for this, however, are not shared. Conversely, reasons for unliveable or unavailable accommodation are usually not stated. The fifth CRM is exceptional in reporting the reasons for the use of unsuitable accommodation due to non-cooperation of the local PWD staff which has deferred the construction of new buildings in Nooh, Mewat in Haryana.

Similarly, although rooms for ASHAs accompanying women to the institutions is identified as a necessity in the fourth, fifth and seventh CRMs the factors working as a hindrance in ensuring this provision are not clearly stated in the reports.

ii. Range of services

Gender-equity and human rights criteria for range of services are given in Box 2.

All CRMs included an assessment of case load, utilization of outreach, outpatient and inpatient services at various levels of health, RCH II, National Disease Control Programme care delivery system as parameters for review. For the purpose of the present evaluation all these are taken as proxy indicators for the component of range of services in well-functioning facilities. Since these indicators also reflect on components such as quality of care (critical area of Quality and Accountability) and accessibility, these are considered together in this section. Though these indicators also provide information on acceptability of services, it is considered separately under user satisfaction. For the present study we interpret increased range of services as provision of services which were not provided before introduction of NRHM due to non-availability of resources, and provision of services which have been added to the assured services since introduction of NRHM.

Though the CRMs report on national disease control programmes and management of various communicable and non-communicable diseases, including endemic and epidemic vector borne

conditions; the focus remains on obstetric and immunization services. All the CRMS report in considerable details on various aspects of childbirth, contraception and immunization services.

Box 2. Range of services

Target groups	Gender-equity criteria	Human rights criteria
Users of services	• Health care services that respond to/ meet specific needs of different sexes in all age groups.	• Need based quality healthcare (accessible, affordable, acceptable) to all sections of the society.
	• Health services which facilitate users to overcome gender barriers to care for sexual, reproductive health related services as well as for various communicable and non-communicable diseases.	• Right to healthcare without any discrimination of the basis of social characteristics
	• Utilisation of gender specific healthcare services (as a proxy for range and access to services)	

The first CRM noted (and the sixth CRM reiterated) a phenomenal increase in number of institutional deliveries especially in states with weaker health systems and at district hospitals. This increase was attributed to introduction of JSY. Similarly outpatient and inpatient utilisation too showed increase, though disaggregated data were not available for the reviewers to examine. The first CRM noted the relationship between availability and commitment of staff especially Medical Officer and increase in utilization of services. This report did not comment on provision of additional services since the focus in the initial phase and in states with weaker health systems had been on strengthening obstetric and child health services.

Subsequent CRMs noted some improvement in range and/or quality of services and commented on need for and quality of wider range of sexual reproductive health services/ services beyond obstetric care in keeping with the RCH II framework. The second CRM noted increasing cases of incomplete abortion resulting probably from misuse of misoprostol by private practitioners and commented on slow expansion of safe abortion services. The third CRM commented on the narrow and limited focus on increasing institutional deliveries under RCH II and lack of data on safe abortions, STIs/RTIs, contraception. It reported on low utilization and poor quality of ANC and PNC. However, this CRM also noted improved quality of services for institutional deliveries, improved referral transport service for institutional delivery, effective use of VHND for improved outreach for better immunization coverage. The fourth CRM reported on management of maternal health related complications being

sub-optimal in public sector. Mismatch between (increased) demand for services and (non-availability of) resources was seen to adversely affect quality of care. The concern regarding limited range of reproductive health services provided through NRHM has been expressed in the fourth, fifth and sixth CRM reports.

Other components of women's health and men's health needs are not discussed in the report. For example, reduction in number of snake bite deaths because of 24x7 availability of healthcare providers and availability of anti-snake venom which are relevant for those who work in fields or populations staying in forests are not mentioned in the CRMs. All services reported on in the seven CRMs are mostly directly or indirectly related to obstetric care because of the priority assigned to development of institutional delivery related services under the NRHM and the RCH.

Though the narrow range of services provided under NRHM were about reproductive services specific to women, the CRMs noted gender insensitivity in these. The third CRM noted predominant focus of family planning services on female sterilization, decrease in IUDs and NSVs in some states primarily because of lack of skilled personnel for provision of these services, lack of EmOC services even at district hospitals in some states, inadequate hospital stay (less than half a day) despite institutional deliveries, changing role of Sub Centres from functioning as outpatient clinics with limited range of RCH services to primarily providing immunization and ANC .

Integration of services related to communicable, non-communicable diseases at PHC level is reflected only in involvement of ASHA as a DOT provider for TB patients and ASHA's involvement in generating awareness about malaria and other diseases. Sex disaggregated data on utilization of services for communicable and non-communicable diseases has not been reported on in the CRM reports. The CRM reports also do not reflect on significance of certain diseases/conditions for women/pregnant women; for example, none of the CRMs that mention efforts for malaria control report on incidence of malaria in pregnancy, or TB among women, iodine deficiency among women etc. Fifth CRM reports on initiative in Goa under which screening services for cervical and breast cancer, and gestational diabetes are provided.

The CRMs reported on increased utilization of referral transport services. However, less than 20% usage was noted to be for pregnancy/childbirth related referrals.

Equitable access to healthcare is reported only in the context of obstetric and childbirth related care in the CRMs. Certain observations made by the CRM such as increased utilization of

District Hospitals (DH) for institutional delivery, shifting preference towards CHCs and DH as delivery points (less than 10% SCs from some states conducted deliveries) etc., indicate services moving away from the people. Unless referral transport system is strengthened and universal, this trend is likely to put the most marginalized at a considerable disadvantage. Though the CRMs noted introduction of referral transport systems in all states the quality of services provided were found to be varied. The fifth CRM noted that referral transport system in most states was found to be effective in urban and peri-urban areas.

Introduction of mobile medical units was another intervention for reaching the services to remote and underserved areas. The first CRM reports on various models of mobile medical units adopted by or proposed by different states including helicopter service in Tripura to reach a group of particularly remote tribal hamlets which was found to be functional at the time of the CRM, boat clinics in Assam etc. Tamil Nadu tried out a concept of birth resorts in remote, hilly, tribal areas where pregnant women in the last month of pregnancy could move to a temporary home closer to a site that could offer institutional delivery. Tamil Nadu also introduced a scheme that provided free bus passes to pregnant women to enable them to attend three ANC visits. However, the CRM noted non-availability of bus services in some of the remote areas. According to the fifth CRM, the role of and services provided through the mobile medical units varied across the states.

A look at the gender equity and human rights criteria in Box 2, indicates that CRMs have progressively taken a keen look at the extent to which gender barriers are lifted and rights entitlements are secured through the range of services provided in facilities. For the CRMs to accomplish this task more effectively, data for relevant quantitative and qualitative indicators must be developed for the criteria. For instance, sex disaggregated data for communicable and non-communicable diseases by facility would throw light on overcoming gender barriers for healthcare for communicable and non-communicable diseases.

iii. Human resource availability

Box 3 presents the gender equity and human rights criteria for the component of human resource availability in well-functioning facilities.

a. Users of services

Ensuring adequate and appropriately skilled human resource – medical, paramedical and supportive – has been an important strategy of the NRHM. The availability of skilled and

trained staff for different levels of care in public health facilities is one of the main review parameters of the CRM. All the CRMs extensively comment on measures taken by various states to address the non-availability of appropriately skilled personnel. These measures include expanding the number of seats in nursing training institutions, re-openings /re-vitalisation of ANM and MPW training institutions, introduction of medical colleges in states with shortage of trained doctors, Public Private Partnership (PPP) initiatives for recruiting specialists, creating career progression paths for existing healthcare providers to fulfill requirement for higher skills. Measures taken for retention of existing healthcare providers are also discussed and include incentives for postings in remote, extremist affected areas.

As seen in Box 3, for the users of health services, the availability of skilled personnel is the main criteria from a gender and human rights perspective. In this context, the fifth CRM points to the limited success NRHM has had in addressing the needs of vulnerable populations. The report claims that the improvement in human resources for health has been disproportionate with 95% sub-centres functioning with only one ANM. The CRM team also found insufficient progress in availability of laboratory technicians in 2011. The sixth and seventh CRM reiterates the unmet need for specialists and nurses especially in areas where it is needed the most.

It is important to note that the seventh CRM shares that the causes for the unavailability of personnel are 'fund constraints, concerns about rational deployment and more component specific allocations of additional human resources.' (2013, p. 30) The factors resulting in the HR crunch must be identified in the course of CRMs.

Inadequate human resources especially at sub-centre and PHC level is likely to affect women more adversely than men since utilisation of primary level of services is predominantly for obstetric care. However, the CRMs do not report on these linkages between human resource shortages from a gendered perspective. In fact, they report an increased utilisation of obstetric care and immunization services which is a cause for concern considering the less than adequate number of healthcare personnel. The measures for addressing this shortfall of skilled healthcare providers, directly converts to women's better access to obstetric healthcare.

From the user's entitlement perspective related to human resource availability, the CRMs cover most of the areas of concern in their review process. The third CRM, importantly, brings attention to the poor supervision of healthcare personnel. The reviewers report that there are effectively no norms to 'monitor' the care provided or the 'individual performance' of the personnel (2009, p. 35). Moreover, the 'wide variability of the functioning of the staff across

centres' is highlighted in the report (ibid.). Generally, we find that the quality of healthcare providers is discussed in all the CRMs.

Box 3. Human resource availability

Target groups	Gender-equity criteria	Human rights criteria
Users of services	• Easy and timely access to skilled healthcare provider for preventive and promotive healthcare services	• Access to appropriate skilled healthcare provider irrespective of social characteristics of the user of health services and those of the healthcare providers
Healthcare providers	• Equal pay and benefits for all sexes working in the same cadre, regardless of type of employment i.e. contract or regular	• Appropriate training and skill building of all cadres
	• Enabling environment considering gendered needs of healthcare providers (accommodation, transport, social support for assertive health action etc.)	• Equal pay and benefits for equal work regardless of regular or contract employment
	• Equal opportunities for regular and updated training programmes, medical education for women and men working in the system	• Equality in opportunity of employment
	• Provision for setting up of Complaints Committees to deal with sexual harassment cases	• Equal distribution of work
	• Provision of adequate, fair, regular compensation to women workers in different cadres e.g. ASHAs	• Supportive supervision of different cadres to carry out their responsibilities
		• Accessible, affordable and quality medical education available to all interested with special focus on inclusion of vulnerable communities
		• Enabling work environment to carry out one's duties – training, amenities, security etc.
		• Availability of adequate numbers of appropriate cadre at each level of healthcare service

b. Healthcare providers

The CRM reports on healthcare providers from a gender and human rights perspective are relatively wanting in the issues covered and the details provided. In Box 3, issues and concerns of healthcare providers are identified through broad criteria. To root out gender based discrimination at the workplace, sex-disaggregated data related to number of personnel, type of work, location, compensation, benefits etc. should be collected and analysed. This is not done in the course of the CRMs. The fifth CRM reports that – 'The NRHM has also led to a major increase of employment for women especially in the most remote and underprivileged areas.'(2011, p.7)

This focus is laudable and must be furthered with relevant quantitative and qualitative data related to HRH. The gendered needs of personnel vis-à-vis accommodation, transport, amenities etc., are only implicitly dealt with in the CRMs. For instance, in the sixth CRM report the need for a positive workforce environment is mentioned. It is, however, unclear what a positive workforce environment implies and how it is experienced differently by men and women (or the third gender). The principle of 'equal pay for equal work' is evoked in all the CRM reports, excepting the first and the second, in the context of contractual and regular employment. This principle must be applied to all social signifiers and to contractual employees in a cadre. Opportunities for medical education and training are reviewed in most CRMs. Preferential admission for government personnel in training institutes and medical colleges is also reviewed and widely recommended across CRMs. Within this, the question of equal opportunity for the sexes and marginalised communities must be raised. The fourth CRM reports on the preferential admission for candidates from under-serviced areas in Tamil Nadu. Handling of sexual harassment cases at the workplace is mentioned only by the fifth CRM team which reports that the adherence to the Vishaka guidelines is seen only in Goa.

Another cause for concern for the personnel's well-being is the distribution of work and individual workload. None of the CRM reviews this area in any detail. Also, with regard to supportive supervision for different cadres, the last CRM recommends 'night stays' or 'working with the team' in facilities in hard to reach areas to understand the problems faced in both, service delivery and health seeking.

The introduction of the ASHA is one of the core strategies of NRHM and all CRMs report extensively regarding enrollment, training and performance of ASHA. All CRM reports state that ASHA is enthusiastic and vibrant, keen to absorb knowledge and to contribute more significantly. Fourth CRM onwards, the reviewers discuss the problems faced by ASHA in

discharging their duties e.g. problems in replenishment of drug kits, healthcare providers' response to ASHA's role in healthcare delivery, problems of coordination between AWW, ANM and ASHA. The fourth, fifth and sixth CRM reports have voiced concerns for creating career paths for ASHA. However, the impact of the appointment of ASHAs on the women and the village community they represent is not adequately documented. Only the third CRM reports on ASHA feeling empowered and commanding respect and confidence from the community. The CRMs also neglect to provide insights into the distribution of ASHAs in vulnerable communities. Based on the reports, the payment to ASHAs has improved over years. Some problems resulting from performance based payment of ASHA too are noted. The first CRM noted instances of delay and denial of payments to ASHA as well as conflicts between AWW, ANM and ASHA regarding JSY incentives. Subsequent CRMs report improved coordination between the cadres.

The payment of incentives for ASHAs is reviewed by all CRMs, however the data related to delay in payment, Direct Benefit Transfer, scheme-wise incentives received etc., are not collected and shared in the reports. The pros and cons of incentivised compensation vis-à-vis regular compensation should be reported on through discussions/interviews with ASHAs, an assessment of their workload and the incentives for each scheme or task. It is important to raise questions about equality and fairness regarding the chosen mode of compensating ASHAs for their work.

'The lack of sensitive and enlightened workforce management policies for contractual staff is even more apparent when it comes to non-clinical managerial staff including staff of programme management units, data entry and account staff, and staff of government training and technical support institutions. This leads to a revolving door effect, with constant, high attrition and inadequate replacement resulting in poor quality and performance.'(Sixth CRM 2012, p. 5)

'Gender sensitivity in service provision should be made part of quality management protocols and should be certified. This also includes training of service providers, instituting Vishaka guidelines and mandating district level committees to take action on sexual harassment.' (Fifth CRM 2011, p. 20-21)

iv. Drugs and Equipment: Logistics and supply chain management

The CRM reports show that revamping the procurement systems has been an important component and strategy of the NRHM for improving the quality of services. This section deals with availability of drugs, equipment, bloodbanks/storage and related challenges.

The first CRM did not report on these matters. All CRMs have noted an improvement in the supply of drugs. The second CRM reports improvement in supply of drugs and consumables in all states visited, however as a result of supply procedures which did not respond to the utilization, some facilities with higher patient loads experienced shortages. More commonly used drugs and consumables too were noted to be in short supply. The CRM noted non-availability of Manual Vacuum Aspiration (MVA) kits and patients being asked to purchase intra venous (IV) drip sets and sutures. States with stronger health systems were better off in terms of drug supply than those with weaker health systems where even district hospitals reported shortage of drugs. Utilisation of untied funds provided to the RKS for providing free medicines to patients below poverty line was noted as a positive development. Non-availability of Ayurvedic drugs is noted in the second, sixth and fifth CRM reports.

Box 4. Range of services

Target groups	Gender-equity criteria	Human rights criteria
Users of services	• Adequate supply of drugs and equipment required for specific health needs of all sexes and age groups	• All essential drugs available to all patients/users of services free of cost or at affordable prices

The fourth CRM reports comment on availability of drugs required for management of obstetric emergencies and their inclusion in the states' lists of emergency medicines. Availability of other drugs required for management of RTIs/STIs etc., are largely not reported on. All the CRMs report on the availability and supply of Iron Folic Acid tablets in the reviewed states. The availability of different contraceptives including Post Partum IUCD (PPIUCD), Emergency Contraceptive Pills (ECPs) and Oral Contraceptive Pills (OCPs) are reported from the reviewed states since the second CRM in varying degrees. The fifth, sixth and seventh CRM reports, highlight the role of the ASHA as an agent of social marketing of contraceptives. Documentation of the information provided regarding PPIUCD to women prior to the procedure is however missing. Additionally, informed consent of women with PPIUCD insertions is an indicator of absence of coercion, undue persuasion or any malpractice on the part of the system.

The seventh, sixth, fourth and third CRMs remark on the absence of committments by states regarding provision of free drugs for all/BPL households. The fourth CRM onwards, the reviewers have recorded in detail the high out-of-pocket (OOP) expenditure incurred by patients in public facilities owing to the cost of drugs and diagnostics. In the last CRM report there is a useful tabulation of OOP expenditure by patients on drugs, diagnostics, diet, transport, blood transfusion and consumables. The practice of 'outside prescription' or prescribing drugs to be purchased from

private pharmacies is also captured in the fourth and the sixth CRMs. The stock of drugs should be collected during CRMs as done in the fourth CRM. The problems with replenishment of ASHA drug kits are reported in the fourth and the fifth CRM. Also, the adequacy of blood banks and blood storage facilities in the states are closely examined by the reviewers in the last few CRMs.

v. Biomedical waste management and infection control

Box 5 provides gender equity and human related criteria for the component of biomedical waste management and infection control.

Box 5. Biomedical waste management and infection control

Target groups	Gender-equity criteria	Human rights criteria
Users of services	• Appropriate and adequate staff for waste management - no practice of compelling female relatives of patients to dispose biomedical waste	• All patients are protected from any form of infection that could be contracted within the facility. All users of services have the right to protection from infections in any public facility
		• Appropriate and safe measures are taken for disposal of biomedical waste and infection control.
Healthcare providers		• All providers are protected from any form of infection that could be contracted in a facility; All cadres are sensitised to the issue of waste management and assigned appropriate roles for the same

For the users of health services and the providers at facilities, infection control is imperative. In NRHM, biomedical waste management through proper segregation, management and disposal is mandated as per the Biomedical Waste (Management and Handling) Rules 1998/2011. All the CRMs have reported on bio-waste management. In the more recent CRMs viz. sixth and seventh it is reported that BMW is ensured through PPP and outsourcing. Concerns have been raised in nearly all the recent CRMs about the quality of BMW undertaken. In the last two CRMs, the reports state that segregation and waste disposal was not strictly followed. In the seventh CRM, the reviewers observe in their field visits that in some states there is inadequate display of protocols for infection control. The fifth CRM, highlights that overall in some states the compliance to the BWM rules were found to be inadequate. Regarding infection control, sterilisation of equipment and instruments is discussed only the fourth CRM report.

vi. Sanitation services in facilities

Hygiene and sanitation is a major component of well-functioning facilities in the NRHM. Except for the first CRM report, the others report on functional toilets in facilities of the reviewed state. Only the fifth CRM team speaks of separate toilets for men and women in the review states. The report points out that in some states common toilet facilities are available for all sexes. Toilet facilities for all the sexes and persons with disabilities would provide an indicator of equity across the board. Toilets in labour rooms are reviewed in the sixth and fourth CRM reports. Hygienic conditions in the wards, toilets and facilities in general are reviewed in most CRMs. Outsourcing of sanitation services is reported by the recent CRMs.

Box 6. Sanitation services in facilities

Target groups	Gender-equity and Human rights criteria
Users of services	• Adequate number of clean toilets at the facility with water and electricity supply – separate for men and women
Healthcare providers	• Adequate number of clean toilets at the facility for staff with water and electricity supply – separate for men and women

vii. Diet provision in facilities

Diet for pregnant women is to be provided under the JSSK free of charge. Diet is properly discussed from the fourth CRM onwards. Outsourcing of diet provision is uniformly reported by all CRMs from 2010 onwards. The last CRM reports that in Odisha local SHGs have been involved in diet provision. In some states, a flat rate is disbursed instead of food to pregnant women. It is important to conduct patient interviews to understand whether the food provided is satisfactory or the cash amount disbursed is adequate to meet the needs. In some areas, diet provision is seen in only district hospitals while in others, it is available till CHC level facilities (Fifth CRM, 2011).

With regard to diets, the need for a clear policy regarding free diet provision in public facilities is highlighted in the sixth CRM.

Box 7. Diet provision in facilities

Target groups	Gender-equity and Human rights criteria
Users of services	• Provision of timely, adequate and context specific diet to inpatients free of cost or at nominal rates
Healthcare providers	• Appropriate provision for relatives of inpatients to prepare food or purchase food at nominal rates

Quality and Accountability in delivery of health services

Since the inception of NRHM, quality of services and accountability of the public health machinery has been a key concern. The components of this area include – [i] Quality Assurance and Improvement Systems: formation and functioning of Quality Assurance Committees (QACs), [ii] Accountability, [iii] Quality data management of service provision, HR, infrastructure and institutional mechanisms at different levels,[iv] Availability and use of Standard Treatment Protocols and Operational Guidelines and [v] Quality of services – technical quality, acceptability.

How do the CRMs review 'well functioning health facilities' from a GE and HR perspective?
Lack of privacy of patients in the examination areas and wards is discussed by all CRM teams– since the third CRM the reports have been consistently stressing the need for curtains or screens in wards, examination area for ANC during VHNDs, screen around the examination table etc. Admission of men and women in the same ward is identified as a concern requiring immediate remedial action in most CRMs. The seventh CRM report of 2013 recognises the vulnerabilities of the transgender community in urban India and states the need to address these through affirmative action. However, none of the CRMs have thus far addressed this issue. Accommodation facilities for those accompanying women inpatients or inpatients from hard-to-reach or distant areas are not considered in any of the CRMs. The CRMs have dwelt to some extent on the issue of accommodation for the staff but have not asked for disaggregated information regarding cadre-wise allotment, type of accommodation, location, amenities provided. Although rooms for ASHAs accompanying women to the institutions is identified as a necessity in the fourth, fifth and seventh CRMs, why these are not ensured are not clearly stated in the reports.
Focus remains on obstetric and immunization services – all the CRMs report in considerable detail on various aspects of childbirth, contraception and immunization services. A few CRMs identified some abortion related issues – misuse of misoprostol by private practitioners, slow expansion of safe abortion services, lack of data on safe abortions. Concern regarding limited range of reproductive health services provided through NRHM has been expressed in the latter CRM reports. Though the narrow range of services provided under NRHM were about reproductive services specific to women, the CRMs noted gender insensitivity in these. Sex disaggregated data on utilization of services for communicable and non-communicable diseases has not been reported in the CRM reports. The CRMs that mention efforts for malaria control, do not report on incidence of malaria in pregnancy, or TB among women, iodine deficiency among women etc.
Equity measures for maternal health are reviewed and discussed in state reports – mobile medical units, helicopter services in Tripura, boat clinics in Assam, birth resorts in tribal, hilly areas of Tamil Nadu, free bus passes for pregnant women in Tamil Nadu.

The availability of skilled and trained staff for different levels of care in public health facilities is one of the main review parameters of the CRM.From the user's entitlement perspective related to human resource availability, the CRMs cover most of the areas of concern in their review process. The quality of healthcare providers is discussed in all the CRMs. However, the CRMs do not report on the linkages between human resource shortages from a gendered perspective. The CRM reports on healthcare providers from a gender and human rights perspective are relatively wanting in the issues covered and the details provided. The gendered needs of personnel vis-à-vis accommodation, transport, amenities etc., are only implicitly dealt with in the CRMs. It is unclear what a positive workforce environment implies and how it is experienced differently by men and women (or the third gender). Handling of sexual harassment cases at the workplace is mentioned only by the fifth CRM team. The payment of incentives for ASHAs is reviewed by all CRMs, however data related to delay in payments, scheme-wise incentives received etc., are not collected and shared in the reports.

The CRM reports show that revamping the procurement systems has been an important component and strategy of the NRHM for improving the quality of services. All CRMs have noted an improvement in the supply of drugs.The second CRM noted non-availability of MVA kits and patients being asked to purchase IV drip sets and sutures. All the CRMs report on the availability and supply of IFA tablets in the reviewed states. The availability of different contraceptives including PPIUCD, ECPs and OCPs are reported from the reviewed states since the second CRM in varying degrees. Utilisation of untied funds provided to the RKS for providing free medicines to patients below poverty line was noted as a positive development. The adequacy of blood banks and blood storage facilities in the states are closely examined by the reviewers in the last few CRMs.

Concerns have been raised in nearly all the recent CRMs about the quality of Biomedical Waste management. In the last two CRMs, the reports state that segregation and waste disposal was not strictly followed. In the seventh CRM, the reviewers observe in their field visits that in some states there is inadequate display of protocols for infection control.

Hygienic conditions in the wards, toilets and facilities in general are reviewed in most CRMs. Only the fifth CRM team speaks of separate toilets for men and women in the review states. It points out that in some states common toilet facilities are available for all sexes.

Diet for pregnant women is to be provided under the JSSK free of charge. Diet is properly discussed from the fourth CRM onwards.

i. Quality Assurance and Improvement Systems: formation and functioning of QACs

Box 8 presents a list of possible gender-equity and human rights related criteria for the first component of quality and accountability in delivery of health services.

In this evaluation, we examine the review of the formation and functioning of QACs by different CRM teams based on the gender-equity and human rights criteria provided in Box

8. The last CRM was critical of how the drive to achieve quality assurance is leading to setting up of QACs but little beyond this. The report states, 'Quality assurance appears to be limited largely on forming quality assurance committees. The new approach, with its emphasis on being able to measure and certify quality and close quality gaps in a time bound manner is yet to be rolled out in the states.' (2013, p. 8) The third CRM onwards, a review of the formation of QACs in facilities is included in all the reviews. Importantly, the functionality of the committees is questioned in all the CRMs as well. CRM reports point to subpar functioning of the committees owing to a lack of clarity on measurements of quality and disuse of the operational guidelines(seventh and sixth CRM).

Box 8. Formation and Functioning of QACs

Target groups	Gender-equity criteria	Human rights criteria
All	• Empanellment of women assessors in the QACs	• Use of operational guidelines and appropriate protocols to assess and maintain quality in all public health facilities

The composition of QACs is missing in all the CRMs conducted so far. It is important to review whether qualified women are empanelled as assessors in the states, as it is matter of equal opportunity to participate in the process. Additionally, the CRMs do not reflect on the number and level of committees and their units set up in each state. This is important from the point of view of capturing whether quality assurance is being ensured in all facilities in the state. Also, the composition of internal quality assurance units in each facility should be reviewed to ensure that representatives of each department and preferably, each cadre participate in the quality assurance process.

ii. Accountability

Box 9 presents the composite criteria for accountability measures relevant to users of services and healthcare providers of NHM.

The Mission has sought to put in place a variety of accountability measures to check the availability and quality of care provided in the facilities.

In the more recent CRMs, we find that there is a greater emphasis on examining the accountability measures of NHM and how they are operationalised in the states. All the CRMs, report on grievance redressal systems in varying degrees. It is largely unclear in the earlier CRMs whether the systems are put in place separately for users and providers. The fifth, sixth and seventh CRM report in some detail on the status of separate provider and patient

grievance redressal mechanisms. In the last CRM report it is shared that an NRHM helpline is launched but is currently not used by both providers and patients due to lack of awareness. The sixth CRM claims that in most states the peripheral employees do have a grievance redressal system. Grievance redressal mechanisms for ASHAs in Chhattisgarh, Assam, Sikkim and Arunachal Pradesh are highlighted in the sixth and the fifth CRM reports. The discussion on this accountability measure, however, is largely limited to its existence in the reviewed states in the reports. Details of functionality and reasons for lack of effectiveness are missing in the reports. It is important to review the grievance redressal mechanisms for different cadres of providers separately. In case there are no divisions in the redressal mechanism for different cadres, then it is important to review whether the concerns of peripheral staff including ASHAs are addressed. It is praiseworthy that in 2013, the CRM team in Himachal Pradesh found bilingual forms for users and provides these to register their complaints regarding the system and services.

Box 9. Accountability

Target groups	Gender-equity and Human rights criteria
Users of services	• Display of citizens' charter, complaint boxes in facilities
	• Display of assured services including drugs, diagnostics, emergency transport, referral structures, eligibility for and benefits under various schemes, user fees, utilization of user fees, RKS untied funds etc
	• Grievance redressal cells for patients and community with transparency about members and procedures involved; Timely reporting of action taken for complaints received
	• Community based monitoring of services provided and timely sharing of action taken for issues raised
Healthcare providers	• Periodic monitoring of data maintained at facility level
	• Grievance redressal cell for healthcare providers; Timely reporting of action taken for complaints received

Till the last i.e. seventh CRM, one finds negligible examination of the action taken to redress grievances. In the CRM conducted in 2012 i.e. the sixth report mentions briefly that in Assam no Action Taken Reports are formulated. Action taken for grievance redressal or based on community monitoring could throw some light on the effectiveness of the accountability measures. Their absence should be reviewed and reported with details related to complaints registered, date, directives issued for action, department or personnel responsible for action, causes for delay etc. Even if this form of tabulation throws up blank rows or columns, it is a

useful exercise from the point of view of documenting the accountability of the system to its users and employees.

The display of the Citizen Charter and signage regarding entitlements are reviewed by all the review team so far. The CRM teams should also report the extent to which their review finds the displays and signage effective. The inappropriate placement of signage and display of entitlement was discussed in the sixth CRM. An assessment of their placement should be carried out more consistently as part of the review along with testimonies of their usefulness by users of the services. The content of the displays need to be closely examined as seen in the last CRM report of 2013. The team reports that although there were displays of the JSSK entitlements for pregnant women in the field, those related to infants and newborns were missing.

iii. Availability and use of Standard Treatment Protocols and Operational Guidelines

Box 10 shows the gender and human rights related criteria for the component on 'Availability and Use of Standard Treatment Protocols and Operational Guidelines' (OGs).

Box 10. Availability and Use of STP and OGs

Target groups	Gender-equity and Human rights criteria
Users of services	• All treatments are provided strictly as per Standard Treatment Protocols or operational guidelines
Healthcare providers	• Training of healthcare providers in the use of STP and Operational Guidelines
	• Availability of STPs for all communicable and non-communicable diseases available at appropriate level of facility; Operational Guidelines related to different treatments or care procedures for all cadres

The NRHM provides Standard Treatment Guidelines for a variety of conditions and diseases. The guidelines were developed by the Armed Forces Medical College in collaboration with the Health Ministry and the WHO. STPs for infectious diseases, ophthalmology, non-communicable diseases, nutritional deficiency, obstetrics and gynaecology, psychiatry etc., are easily available. The protocols are expected to have been shared with all the states to ensure standard quality of care. Similarly, operational guidelines are available ranging from care for conditions/diseases to key areas of management within the public health system.

After scanning the seven CRM reports, we find that progressively over the years STPs are currently available in the states. However, their use in facilities is far from satisfactory. The last CRM's critique lies in the absence of mechanisms to ensure adherence to the STPs. The CRM reports uniformly do not provide information regarding which STPs are available and at

which level. In the sixth CRM report it is apparent that the adherence to STPs related to RCH is reviewed, but the availability and use of other STPs is not shared. Even though, there is a limited range of services provided in facilities (see section on well-functioning facilities), the availability of STPs and operational guidelines could be commented on. Similarly, there is little reportage on training of personnel on the said protocols or operational guidelines.

To protect the interests of the users of services, mechanisms to ensure the availability and adherence to the treatment protocols should be examined in future reviews. Without these mechanisms the STPs and other guidelines would be wholly ineffective in provision of quality care to the users of these services.

iv. Quality data management of service provision, Human Resources, infrastructure and institutional mechanisms at different levels

The box below presents select criteria for the assessment of the component of quality data management to bring about gender equity and the fulfilment of human rights.

Box 11. Quality data management

Target groups	Gender-equity criteria	Human rights criteria
All	• Maintenance, use and monitoring of disaggregated data of use of health services by all sexes at facilities	• Maintenance, use and monitoring of disaggregated data of use of health services by all communities
	• Data of morbidities and mortalities at the facilities for all ages and sexes	• Data of morbidities and mortalities at the facilities
		• Data related to different health institutions e.g. RKS, VHC etc.
Healthcare providers	• Data for different cadres – separately for men and women	

Over the years, the NRHM has completely revamped the data management system in order to maintain information related to every aspect of the public health system. The HMIS was fully established in 2009 as per the sixth CRM report. The CRMs affirm that the HMIS has greatly improved the management of data in all the states. However, the reviews also maintain that apart from improved feeding of data into the system, there is little progress in the actual use of the information collected at the state, district and sub-district level (see CRM 2013, CRM 2012, CRM 2011, CRM 2010). The latest CRM recognises improved quality of data and regular updation of data in the national portal. At the same time, the Seventh CRM team reports that states fail to use the data for planning, management and monitoring of health services.

Besides the HMIS, the IDSP is reviewed for data quality and management. In the all reviews, the teams report the need to analyse the data collected for local use (see CRM 2013, CRM 2012, CRM 2011, CRM 2010). Similar to the HMIS, the IDSP data too is well-managed but its benefit to the state is yet to be realised. In the context of the IDSP, the fifth CRM reports, 'Across the states the pattern is of complete non-use and non-response to disease reports. Often the data goes from facility to district IDSP officer who enters the data and transmits it up with no feedbacks to district, block or facility level officers. The general problem observed with the IDSP is that it sees itself as collecting data for transmission to a national repository – rather than using it for immediate and local public health action.' (CRM 2011, p. 140)

From the above discussion, one gathers that the reviews of data management in the public health system by the CRMs have been largely critical of the lack of analysis and use of the data maintained.

In this evaluation, based on the feminist criteria in Box 11 we point out some areas which are missing in the CRMs. The review of data management systems should be two-pronged. Firstly, it is important to review the data that is maintained and secondly, whether the data is used in planning, monitoring and decision-making within the state. Although the second type of assessment is undertaken by reviewers, one finds that the actual content is not reviewed in as much detail. A review of the information collected by the state is important in order to understand whether disaggregated data is available for different sexes and vulnerable communities. CRMs should report on whether disaggregated data of morbidities and mortality are available facility and area wise. Additionally, mechanisms to regularly monitor the data collected are not commented on in the CRMs. The lack of such a measure is mentioned in passing in the sixth CRM, however this lapse should to be highlighted in each reviewed state.

Addressing the Needs of Poor and Vulnerable

As a mission, the NHM is dedicated to reaching out to the poor and vulnerable by [i]addressing accessibility concerns, [ii] improving communication strategies and [iii] facilitating the participation of communities in planning, management and monitoring processes. These three form the main components of the critical area of 'Addressing the needs of poor and vulnerable'. In this section, we review the assessment by the CRMs of these components based on the criteria developed for gender-equity and fulfilment of human rights entitlements.

i. Accessibility of services

Box 12 presents the gender-equity and human rights criteria for accessibility of services for users of services and healthcare providers.

How do the CRMs review 'Quality and Accountability in Health Systems' from a GE and HR perspective?

The third CRM onwards, a review of the formation of QACs in facilities is included in all the reviews. The functionality of the committees is also questioned. The composition of QACs is missing in all the CRMs conducted so far. CRMs should look at whether qualified women and representatives of each department and each cadre are members of QACs.

In recent CRMs, there is a greater emphasis on examining the accountability measures of NRHM and how they are operationalised in the states. Recent CRMs report on the status of separate provider and patient grievance redressal mechanisms. Details of functionality and reasons for lack of effectiveness are missing in the reports. It is important to review whether the concerns of peripheral staff including ASHAs are addressed. Only in the last CRM report, there is an examination of the action taken to redress grievances. The display of the Citizen Charter and signage regarding entitlements, have been reviewed by all the review teams. However, the CRM teams should also report on the content and the effectiveness of the displays and signage.

Progressively over the years Standard Treatment Protocols are currently available in the states. However, their use in facilities is far from satisfactory. There is little reportage on training of personnel on the protocols. Mechanisms to ensure the availability and adherence to the treatment protocols should be examined in future reviews.

The CRMs maintain that apart from improved feeding of data into the system, there is little progress in the actual use of the information collected at the state, district and sub-district level. CRMs should report on whether disaggregated data of morbidities and mortality are available facility and area wise. The review of data management systems should be three-pronged – first, review the data that is maintained, second, assess whether the data is used in planning, monitoring and decision-making within the state, and third, review the mechanisms to regularly monitor the quality and type of data collected.

Over the years, public health researchers have attempted to define 'access' in its varied forms. Michelsen et al., for instance, understood access as 'economic and geographical distance' and 'socio-cultural and gender distance' in their study on access to quality healthcare for women in urban slums in Maharashtra (2011, p. 372). Carrillo et al. defined 'access barriers' in terms of [a] 'structural' barriers i.e. availability of services, [b] 'cognitive' barriers i.e. patients' beliefs and knowledge and [c] 'financial' barriers i.e. capacity to pay (2011, p. 555-6).Borrowing primarily from Michelsen et al., the gender-equity and human-rights criteria were developed in order to capture accessibility concerns other than geographical access. Cost, privacy, access free of prejudice etc. presented in Box 12 are identified as criteria to evaluate CRMs for gender sensitivity and an equity focus. Also, the following section on IEC/BCC strategies is relevant

to accessibility concerns as it addresses the 'cognitive barriers' identified by Carrillo et al. (ibid.).

Box 12. Accessibility of services

Target groups	Gender-equity criteria	Human rights criteria
All	• Adequate and assured referral services for men and women of all age groups	• Better accessibility for vulnerable groups e.g. workers who cannot access healthcare during the work day without losing wages through 24x7 availability of emergency services etc.
	• Easy access to safe abortion services in facilities for women from every social and economic strata without any discrimination or prejudice	• Healthcare facilities within reach of marginalised communities or in hard to reach areas along with outreach services in remote locations e.g. mobile medical units
	• Free of cost services, drugs, diagnostics and transport for men, women and third gender individuals from socially vulnerable communities	• Adequate referral services and assured referral transport for communities in hard to reach areas
	• Adequate privacy in outpatient departments, examining rooms, injection rooms and inpatient wards	• Presence of staff who speak the local language - to support inpatients and outpatients
Healthcare providers	• Transport and accommodation for ASHAs accompanying pregnant women to facilities	• Transport allowance or facilities for health providers posted in hard to reach or distant villages
	• Accommodation and transport allowance for ANMs	

It is, however, important to reiterate that any woman availing abortion services in public health facilities should not face prejudice or discrimination on account of her age, marital status or community. CRMs comment on the availability of the service or the lack thereof, but the experiences of women who have availed the services and those who were not reached or turned down need to find some space in the review process. Sensitisation of staff vis-à-vis provision of services such as MTP must be reviewed and reported on regularly by the CRMs.

Better accessibility for vulnerable groups is reported on in nearly all the CRMs. The reports are primarily related to the availability of referral transport services or selection and functioning of the ASHA or the VHSNC to ensure outreach in vulnerable areas. For instance, the sixth CRM team shared that due to 'inadequate community involvement' in the form of ASHA, the system in Delhi had failed in improving access for the poor and vulnerable (2012, p. 153). In the

report, the recommendations for vulnerable populations are related directly to the selection of ASHAs and the functioning of VHSNCs (p. 65). Community involvement is a necessary step towards addressing access related issues, however, the system's response to these concerns must not be overlooked. All the reports discuss the availability of emergency services in the context of pregnancy and childbirth. Often the emergency care in FRUs and the Emergency Response System are referred to while discussing the care available during emergencies. However, strategies for emergency care for vulnerable populations, for instance, in hard to reach areas are not reviewed in detail. The absence of such services should be reported on by CRMs. The provision of transport services during pregnancy apart, the emergency transport services available for other cases need to be reviewed and documented.

Accessibility of services is greatly influenced by the socio-cultural milieu of the area. Measures taken to improve access of vulnerable groups in line with their culture should be documented in the CRMs. For instance, none of the CRMs report on the language used by the health providers with their patients. The local language or dialect spoken in the area where a facility is based could be vastly different from that which the appointed doctors or nurses use. Use of the local language can play a major role in improving access of the poor and vulnerable in an area considerably. Other socio-cultural indicators and criteria related to health should be developed as part of the CRM to meet the objective of reaching the poorest and the most vulnerable communities.

ii. Effectiveness of IEC/BCC Strategy

Gender-equity and human rights criteria for IEC and BCC Strategy of facilities are presented in Box 13.

Box 13. IEC/BCC strategy

Target groups	Gender-equity criteria	Human rights criteria
Users of services	• Awareness generation regarding facilities and public health schemes specific to women	• Awareness generation regarding facilities and public health schemes for different sections of society e.g. Primitive Tribal Groups (PTGs), BPLs, Adolescents etc.
	• Through IEC/BCC creating awareness regarding gender stereotypes which affect access to health by men and women	• Preventive and promotive care addressing wider determinants of health

In this evaluation of CRMs one finds that, over the years, the review missions reported diligently on the use of IEC strategies in awareness generation regarding schemes and available services. In the seventh CRM report, there is a discussion on the innovative and context-specific strategies developed in Odisha and Jharkhand. The team identified the need

for capacity building for better implementation of IEC strategies in the other states. One of the observations regarding the strategies in the reviewed states was that there was a heavy emphasis on awareness generation regarding JSY and JSSK at the cost of other schemes and services. Also, the last CRM team raises an important point regarding the absence of impact assessment of the strategies used in all the states. Similarly, the CRMs previously identified the lack of IEC related to AYUSH, absence of State BCC cells, insufficient IEC materials and ill-equipped IEC staff as the problems with this component in the reviewed states (See CRM 2012, 2011, 2010, 2009).

The criteria for gender equity and human rights in Box 13 demand close examination of the content of IEC strategies. The review of IEC and BCC strategies at the national and state level need to clearly comment on [a] target population-wise which schemes and services are covered; [b] specific preventive and promotive care related strategies/materials developed and [c]material addressing gender and equity concerns. With regard to each of these points, the existence of relevant IEC material along with an assessment of the content of the materials used should be presented. In the Sixth CRM report, one finds a list of themes for which IEC/BCC material or strategies are developed or are in use. This listing should be adopted in future CRMs.

As of now, none of the CRMs report on IEC strategies addressing gender stereotypes or hierarchies in detail. The sixth CRM report shares that 'gender awareness' is included in the material developed in the reviewed states of 2012 (p. 57). However, a detailed documentation of relevant material should be a part of the review in order to assess whether the material is directed towards gender equity and/or educating the masses regarding their rights and entitlements.

iii. Increase community involvement and participation in planning, monitoring and implementing

In Box 14, the gender equity and human rights criteria used to assess the sensitivity to both in NRHM as reviewed in CRMs since 2007 are given.

In all the CRMs one finds that there is clear articulation of the ASHA and VHSNCs helming the community processes viz. planning, monitoring or implementation. The reports have discussed in varying degrees the functioning of ASHAs and VHSNCs to galvanise community processes. Yet, the 'horizontal accountability mechanisms' are inadequate in number according to the seventh CRM report (2013, p. 16). In our review, we find that the CRMs are mostly silent on the processes leading up to and the outcomes resulting from community participation in planning, monitoring and implementing. The sixth, fifth, fourth and third CRMs report on whether

community based monitoring is taking place or not. The sixth report states that CBM across states is 'sporadic and poorly sustained' (2012, p. 6). Although CBM is highly recommended in nearly all the CRMs, it is difficult to find much of a review of the processes in the reviewed state. A look at the recommendations in the last CRM, however, evinces the gender-sensitive and human rights oriented approach espoused by the CRM team in recommending that women and marginalised groups must find voice in the community processes.

Box 14. Community involvement and participation

Target groups	Gender-equity criteria	Human rights criteria
Users of services	• Women from all age groups (adolescent, reproductive age group, post-reproductive age group, elderly etc.) get an opportunity to participate in the community processes for planning and monitoring of health services at all levels	• Community based monitoring-involvement of community/PRI members in the planning and monitoring of facilities and services
	• Women are empowered to share their views and concerns about health services and influence health services to ensure specific needs of various age groups of men and women are met by the health services at all levels	• Representatives of all sexes and social groups including the socially, economically marginalized communities are empowered to participate in the community processes for planning and monitoring of health services at all levels
	• There is an enabling environment which facilitates women's active participation in the process of planning and monitoring of health services at all levels.	• There is an enabling environment which facilitates different community representatives' participation in the process of planning and monitoring of health services at all levels.

The CRMs do not comment on whether community women are empowered to share their views and influence health services to ensure that specific needs of various sections of the society are met by the health services at all levels (see Box 14 for gender-equity criteria). None of the CRMs document the composition of the community level groups involved in planning and monitoring. Additionally, steps taken for ensuring an enabling environment for community processes or lack thereof are missing in the reports. Future CRMs must develop process and outcome indicators to assess and document the above-mentioned criteria i.e. participation, empowerment and enabling environment vis-à-vis women and marginalised groups' involvement in community processes.

How do the CRMs address needs of the Vulnerable and Poor from a GE and HR perspective?

CRMs report diligently on the use of IEC strategies in awareness generation regarding schemes and available services. None of CRMs report on IEC strategies addressing gender stereotypes or hierarchies in detail. The criteria for gender equity and human rights listed in this section demand close examination of the content of IEC strategies. A detailed documentation of relevant material should be a part of the review in order to assess whether the material is directed towards gender equity and/or educating the masses regarding their rights and entitlements.

In all the CRMs one finds that there is clear articulation of the ASHA and VHSNCs helming the community processes. CRMs are mostly silent on the processes leading up to and the outcomes resulting from community participation in planning, monitoring and implementing. Although CBM is highly recommended in nearly all the CRMs, it is difficult to find much of a review of the processes in the reviewed state. The CRMs do not comment on whether community women are empowered to share their views and influence health services to ensure that specific needs of various sections of the society are met by the health services at all levels. None of the CRMs document the composition of the community level groups involved in planning and monitoring.

CRMs comment on the availability of abortion services or the lack thereof, but the experiences of women who have availed the services and those who were not reached or turned down need to find some space in the review process. Sensitisation of staff vis-à-vis provision of services such as MTP must be reviewed and reported on regularly. Strategies for emergency care for vulnerable populations in hard to reach areas are not reviewed in detail. None of the CRMs report on the language used by the health providers with their patients.

Public Private Partnerships

In the NRHM, the government seeks to improve the health system in the country through the partnerships with the private sector. Within this, NGOs and private firms/companies are the main stakeholders and partners. The engagement of the private sector mainly takes the shape of outsourcing or subcontracting of services. See Box 15 for some gender and human rights related criteria which are used subsequently to review the CRMs conducted till 2013.

Box 15. Outsourcing or subcontracted services

Target groups	Gender-equity criteria	Human rights criteria
Users of services	• All services are provided free of cost to pregnant women/socially vulnerable women	• Services are provided free of cost or at a nominal charge as agreed with the state
Healthcare providers	• Effort is made to involve women's groups/contractors in ancillary and supportive services	• No discrimination against members of marginalised or minority communities in subcontracting of services

In all the CRMs, services provided in PPP mode are reported on. The different modalities of PPP covered in the CRMs include healthcare provision through accredited private hospitals and NGOs, outsourcing or subcontracting of diagnostics, diet, maintenance of facilities, sanitation etc. and contracting private parties to run the EMRI or other local referral transport. Most of the recent review missions note that PPP for service provision has seen mixed results in the states. One of the success stories shared in the seventh report is the contracting of private vehicle owners in the 'Mamta Vaahan' scheme in Jharkhand. The sixth CRM claims that waste disposal has especially improved in states owing to outsourcing to private firms. The report states that OOP expenditure of JSSK patients has seen an increase due to service provision in the PPP mode. In Gujarat, to address human resource shortfall, paramedical staff are hired in the PPP mode.

In the CRM reports, the assessment of PPP is primarily centred on the quality of care or services provided. The reviews, however, provide little information regarding the modalities of the PPP, the processes involved and how and if, it is different/better than public provisioning. Different players in the PPP mode must be assessed differently. For example, a self help group (SHG) providing diet at the PHC/CHC level is vastly different from a private firm with a diet provision contract for block/district facilities. These entities operate differently in terms of team composition, work allocation, motivation, work ethics etc. It is, therefore, important from a gender and rights perspective to report on the functionality and viability of each of these for the public good. The process of subcontracting should be reviewed to ascertain that such partnerships are free from graft with a level playing field for all potential partners. Also, affirmative action to involve vulnerable groups in service provision needs to be highlighted and documented.

OOP expenditure on health services can have devastating results on the lives of the poor and vulnerable. Outsourcing and subcontracting to private players with a profit making motive could open up the possibilities of increased OOP expenditure. This must be tracked and regulated by the public health system. A review of increased OOP, such as the one undertaken by the seventh and sixth CRM teams, must be continued to track the PPP services in the states.

How do CRMs assess Public Private Partnerships from a GE and HR perspective?

The assessment of PPP is primarily centred on the quality of care or services provided. The reviews, however, provide little information regarding the modalities of the PPP, the processes involved and how and if, it is different/better than public provisioning. It is important from a gender and rights perspective to report on the functionality and viability of each PPP. Outsourcing and subcontracting to private players with a profit making motive could open up the possibilities of increased OOP expenditure. This must be tracked and regulated by the public health system.

Financial Management

The fruitful implementation of a central government programme depends largely on the funding made available to the states and their ability, in turn, to fulfil the set objectives of the programme. The financial management of the NRHM is a critical area of the Mission which entails [a] public health expenditure and [b] capacity of states to absorb the funds provided. In the following sub-sections, we look closely at these two components as discussed in the CRMs to see whether the reviews capture the gender and rights criteria of the same.

i. Public Health expenditure

In Box 16, the gender and human rights criteria for the public health expenditure component are given.

Box 16. Public Health Expenditure

Target groups	Gender-equity criteria	Human rights criteria
Users of services	• Adequate public health expenditure to improve women's health beyond RCH	• Adequate, timely public expenditure to provide health for all that is affordable and discrimination-free; social protection against the rising costs of healthcare
Healthcare providers	• Provision of adequate public funds to improve the working conditions of HR in public health facilities especially ANMs, nurses and ASHAs	• Provision of adequate public funds to improve the working conditions of HR in public health facilities.

There has been considerable improvement in the financial management of the NRHM. The sixth CRM, clearly states that the public share in the total health expenditure has increased from 19.1% in 2005 to 30.3% in 2009 (2012, p.7).The team goes on to note that despite this increase in total health expenditure, there is low allocation of funds in the public health system. The report claims that Rs. 1,75,000 crores was earmarked for NRHM for the period from 2005 to 2012. However, the actual allocation against the earmarked fund was Rs. 71,963 crores and of this, 98% is absorbed by the states (2012, p. 67). The report contends that the central problem of the public health system is the 'lack of government investment' (p. 7). As seen in Box 16, in the interest of the users of services, adequate and timely public expenditure is important to ensure health for all that is discrimination-free and affordable. Therefore, the CRMs should collect and present relevant state and national public health investment data to track the government's commitment to social protection for the poor and vulnerable against rising costs for healthcare in the country.

Additionally, the review of the component of public health expenditure during CRM must also reveal whether the funds are channelized to improve women's health beyond RCH (see Box 16).

As discussed in the previous sections, most CRMs studied the range of services provided in health facilities and deemed them limited to RCH related services. Reporting on programme-wise fund utilisation would provide evidence of public action to broadening the scope of health services to address other health issues of persons of all sexes and ages.

Fund utilisation break-up would also throw light on the extent to which investment is made towards ensuring conducive work environment for all heath care providers engaged in the public health system. At present, the CRMs do not report on the rate of public expenditure dedicated to improving amenities for the healthcare providers. At the same time, as discussed in the 'human resources availability' section, the reports comment on the state of HRH availability, accommodation, their training and other opportunities. The extent of public investment related to HRH is however not shared in the CRM reports.

ii. Capacity of states to absorb the funds provided

The criteria developed for gender and human rights are not vastly different from generic financial management as these are directly related to the capacity of states to absorb the funds provided. This component has been reviewed by the CRMs over the past seven years in varying degrees. The documentation of the changes in the Mission's management strategy is done progressively in each CRM report. Improvements in the accounting systems and recruitment of accounts-related HR are tracked from the second CRM. Adoption of electronic transfer is reviewed regularly in the CRMs. The fifth CRM also reports positively on the statutory audits adopted by the states. The team claims that transparency levels are improved considerably owing to the new audit system.

The reviews have also highlighted and commented widely on the bottlenecks in state expenditure. The 2013 review mission claimed that there were low utilisation levels owing to inadequate staff, underuse of e-transfer and lack of knowledge of the accounting processes among the staff (p. 14). Also, the team notes that the sanctioning of funds to states and districts is done haphazardly

Box 17. Capacity of states to absorb the funds

Target groups	Gender-equity and Human rights criteria
All	• Adequate trained staff for financial management
	• Funds are put to optimum use as per approved heads of budget
	• Bottlenecks to state expenditure under different heads are identified and removed
	• Percentage of fund utilised of the total budget

over the year which also leads to under-utilisation or irregular utilisation of funds. Poor training of HR is highlighted in the more recent CRMs viz. seventh, sixth and fifth reports. Need for streamlining the accounts, guidelines and structures are pointed out in the fourth and fifth CRM reports. The seventh CRM also identifies inflexibility in expenditure and delay in release of funds to the districts from the states as common bottlenecks in state's absorption of funds.

What we find missing in the CRMs are the actual figures of funds utilised under different heads and the percentage utilisation of total allocated funds. These figures for all the reviewed states along with national level data should be made available in the CRM reports. These figures are fundamental to understanding any state's capacity to absorb the funds – i.e. to what extent fund absorption has been possible in a year.

How do CRMs look at Financial Management from a GE and HR perspective?

CRMs do not report on proportion of public expenditure dedicated to improving amenities for the healthcare providers. Review of fund utilisation break-ups would indicate the extent to which investment is made towards ensuring conducive work environment for all heath care providers. Capacity of states to absorb the funds provided has been reviewed by the CRMs over the past seven years in varying degrees. The reviews have also highlighted and commented widely on the bottlenecks in state expenditure. What is missing in the CRMs are the actual figures of funds utilised under different heads and the percentage utilisation of total allocated funds. These figures for all the reviewed states along with national level data should be made available in the CRM reports.

CRMs should collect and present relevant state and national public health investment data to track the government's commitment to social protection for the poor and vulnerable against rising costs for healthcare in the country. Since most CRMs deemed the range of services provided in health facilities, as limited to RCH related services, the review of public health expenditure during CRMs must reveal whether the funds are channelized to improve women's health beyond RCH.

Convergence

One of the strategies of the NRHM which seeks to bring together different departments for a holistic approach towards health is inter-departmental coordination and convergence. In Box 18 the gender equity and human rights criteria is presented to review inter-departmental coordination and convergence.

The seven CRMs have discussed the area of convergence in their respective reports. In the more recent reports viz. the seventh, sixth, fifth and fourth CRMs, convergence with the Department of Women and Child Development (DWCD) for operationalising VHNDs are

Box 18. Inter-department coordination and convergence

Target groups	Gender-equity criteria	Human rights criteria
Users of services	• Inter-departmental convergence is gender-sensitive. All government programmes and schemes are free from prejudice against women and work towards their well-being.	• Adequate coordination with other department to ensure proper implementation of schemes and programmes
		• Inter-departmental convergence efforts are rights and entitlement oriented. All programmes and schemes are inclusive, non-discriminatory and work towards the well-being of all.

reviewed, although not in qualitative terms. There are overall reports of improvement in the implementation of the scheme while noting the below-par convergence achieved with the said department (seventh CRM 2013, sixth CRM 2012). The other programmes discussed within convergence are the School Health Programme and water and sanitation related programmes. On the whole, the CRMs point out that convergence is an important strategy however inter-sectoral convergence is currently operating at a suboptimal level.

How do CRMs view Convergence from a GE and HR perspective?

The CRMs comment on the adequacy of the convergence and coordination between departments. However, the reports thus far provide a limited qualitative understanding of the convergence and literally no analysis of the gender sensitivity of the schemes and programmes within the ambit of the intersectoral convergence undertaken.

A feminist evaluation demands that the inter-sectoral convergence is reviewed through a gender lens to assess how women-oriented and equity-bound all related schemes and programmes are. The CRMs do not review 'convergence' through this lens and are largely silent on entitlements or rights in other department's programmes and schemes.

Responsive Health System

A responsive health system is one which is reliable, consistent and constantly seeking feedback to improve its systems and structures to ensure patient and provider satisfaction. Box 19 shows the criteria for the assessment of a responsive health system.

Patient and provider satisfaction are discussed in some detail in the second CRM report wherein this component forms a subsection of the reporting on 'Quality of Care'. The report

states that there is high patient satisfaction owing to the considerable improvements in the public health system after the NRHM was launched in 2005. Providers expressed satisfaction with the system but with some reservations owing to increased workload, shortfall of HR and inadequate infrastructure. After the second CRM, patient satisfaction is mentioned only in the last CRM conducted in 2013. The report of the seventh CRM simply claims that patient satisfaction is not recorded in any state. No other details are provided of the same.

Box 19. Patient and Provider satisfaction

Target groups	Gender-equity criteria	Human rights criteria
Users of services	• Men and women from all age groups find all health services provided at all levels of healthcare delivery accessible, affordable and acceptable; they express satisfaction towards the health services received	• Members of vulnerable sections of the society including residents of geographically remote and difficult to reach areas, members of socially marginalized groups, religious and other social minorities, economically weaker sections of the society find all health services provided at all levels of healthcare delivery accessible, affordable and acceptable; they express satisfaction towards the health services received
Healthcare providers	• Providers express satisfaction about equal opportunities for entering the health workforce, for skills development for men and women, enabling conditions, fair and adequate compensation etc.	

As we review the CRMs from a gender and human rights perspective (see Box 19), we find that firstly most CRMs have neglected to assess patient and provider satisfaction within the public health system. Secondly, where this component is reported on, the methodology used is not clearly spelt out. A note on the methodology used would throw light on the respondent patients and providers – especially their gender, community and/or cadre in the case of providers. Thirdly, mechanisms built into the system for recording patient/provider satisfaction or lack thereof, is mostly not reported in the CRMs. On the other hand, CRMs thus far have not captured patient/provider satisfaction through interviews of patients and providers. Lastly, it is recommended that to be gender-equitable and free of discrimination CRM reports should document or assess patient satisfaction based on the demography of the area served by facilities. Special focus on the experiences of the poor and vulnerable vis-à-vis the public health system should be ensured.

How do the CRMs assess Responsive Health Systems from a GE and HR perspective?

Most CRMs have not assessed patient and provider satisfaction with the public health system. Where this component is reported on, the methodology used is not clearly spelt out. Further, mechanisms built into the system for recording patient/provider satisfaction or lack

thereof, is mostly not reported in the CRMs. CRM reports should document or assess patient satisfaction based on the demography of the area served by facilities. Special focus on the experiences of the poor and vulnerable vis-à-vis the public health system should be ensured.

Findings - RCH II and JRMs

Observations on the RCH II Design

The RCH II Project Implementation Plan (PIP), prepared over 2008-09, is quite a remarkable document from a gender and equity perspective. One reason for this may be that gender and health rights activists were engaged in drafting the Supporting Documents on Gender and Equity and Access. An understanding of intersectionalities and pathways to gender based inequalities in health, is evident in the following box:

Gender roles and unequal gender relations interact with other social and economic variables, to produce different and often inequitable patterns of exposure to health risk and differential access to and utilization of health information, care and services. These differences clearly impact on health outcomes.

The Vision statement of RCH II states that there should be 'no discrimination in access to essential quality health services. The poorest have the right to get value for money being spent by government or out of pocket.... Girl child has an equal right to health, emergency medical aid, and to live with human dignity.... The RCH programme efforts will consistently focus on the most vulnerable'. The Programme intention is stated as 'It would address access, equity, vulnerability and gender issues while taking into the demand side requirements'. Unreached populations such as adolescents, urban poor and tribal areas are specifically mentioned.

The document states 'the GoI is committed at policy level to reducing the gender bias in public health and family welfare programmes. The shift in policy and programme focus from family planning and fertility control to reproductive health must be completed. Family welfare and women's health must be promoted as a shared responsibility between men and women. Men and women should jointly decide on issues related to contraception, abortion, sexual health and sex education of children'.

While there is no explicit mention of the international agreements and conventions that India has ratified, the contents do reflect an understanding and appreciation of some of the international health rights' discourse. The national strategies that are quoted in the document are not those

that advance gender and social equity, they are strategies to do with population stabilisation – to meet the Unmet Need for Family Planning, bring down the Net Replacement Rate and so on.

Gender and Equity indicators are spelt out in the logframe as well as illustratively in the Mainstreaming Gender and Equity chapter. The Equity section also states some Maternal Health and Women's Health outcome indicators. These sets of indicators are good as an initial attempt to get healthcare providers and programme managers to begin thinking about gender equity indicators but, as will be analysed further in the Discussion section, quite inadequate from the perspective of comprehensive reproductive health services.

The Process Indicators against which the progress was to be reviewed during the JRMs, were largely focused on programme management aspects – around 25% of the Process Indicators could be said to be related to Gender and Equity.

The chapter on Gender and Equity contains a good analysis of the factors that influence women's access to healthcare. In addition to the economic, social and cultural factors, health system factors and mindsets and attitudes as barriers are also listed. It states that for RCH II to achieve its health outcomes, a deeper understanding of the care seeking behaviour of women across different age, ethnic, religious and income groups will be necessary. Recognising that health is a state subject, RCH II PIP states that 'Mainstreaming gender within the state's RCH II PIPs and Logframes will require fuller understanding and consideration of the different needs, identity and behaviour of women and men arising from their unequal social relations, and the awareness that as a result, a state's PIP can benefit women and men differently. State PIPs and Logframes must take into account the well being of women according to their own needs.'

RCH II is cognisant that much needs to be done 'for developing the skills, attitudes, and knowledge of staff designing state PIPs and Logframes, managers and health workers in gender specific methodological approaches and tools including gender specific needs analysis, monitoring and impact assessment.' At several places, the PIP becomes educational, spelling out for the readers in the states how to mainstream gender in the state PIPs. It specifies the need for establishing equity objectives with measurable indicators and benchmarks for the state PIPs.

For a state PIP to effectively mainstream gender, it must:

- Acknowledge gender as a key determinant of women's health, and actively involve women in planning, implementation and evaluation.

- Be an integral part of a broader equity strategy to reach the most vulnerable, marginalized and poorest groups.
- Not only about "clients" but also about providers and institutional environment in which the RCH programme is located;
- Not have a narrow focus on activities and service provision, but also address gender barriers to stimulating demand such as the attitudes and skills of providers and service planners and managers.
- Establish mechanisms to foster the participation of women in all aspects of planning, management, delivery and promotion of services.
- Address how to improve the responsiveness of the system so that it best meets the needs of the poor and of women.

In keeping with its educational nature the RCH II PIP lays out the strategies that the health service delivery system can adopt to overcome the social and cultural barriers that hinder women's access to health services.

While the chapter on Gender and Social Equity is excellent, a gender perspective is not sufficiently incorporated in the rest of the document. For example, the section on Human Resources does not talk about how the needs and issues of the army of women healthcare workers – ANMs, ASHAs – would be addressed. The MIS section does not state that sex disaggregated data would be generated.

Equity

The RCH II Equity objective is: "To reduce the health inequities both between geographical areas and between social groups, and to respond to the needs of vulnerable populations."

The target populations that need to be addressed in pursuit of health equity outcomes are extremely diverse. The combined picture of health disparity between population groups that emerges has gender, geographical, social, economic, age, and livelihood dimensions:

- Disparities between women and men.
- Disparities between scheduled tribes and non-tribal populations.
- Disparities between scheduled castes and other castes.
- Disparities according to religion, for example, Muslims having a higher unmet need for contraception.
- Disparities between socio-economic groups.

- State wise disparities particularly between the EAG and non-EAG states.
- Disparities between districts even in better performing states.
- Sub-district pockets of extreme deprivation.
- Disparity between urban and rural populations, with urban populations at the aggregate level achieving better health outcomes, but the urban poor having significantly poorer health outcomes.
- Disadvantage of unmarried adolescents having their RCH needs met.
- Disadvantage of the elderly having their reproductive health needs met.
- Certain livelihoods expose people to health risks and inhibit their capacity to access services, such as migrant workers, miners.

The RCH II PIP envisaged that concurrent equity monitoring at state and district level through the RCH Random Household Survey would provide evidence of equity trends. As recommended by the Planning Commission and the HDRs, it was planned that two district indices would be developed for each state; a disparity index based on RCH II outcomes, and a discrimination index based on RCH outputs and processes.

Mandate and Methodology of the JRMs

The RCH II Joint Review Missions (JRMs) in contrast to the NRHM (CRMs) had detailed Process Manuals. Each Aide Memoir has an annexure, the first one, which is the Process Manual for that JRM. The Manual lays out specifications of the Pre Mission preparatory tasks, what the Mission will comprise of, details of the field visits, checklists that would need to be used, formats for compilation of various data, suggested outline for state presentations and so on. The Process Manual also contains Terms of Reference for the Mission members.

The team for the State visits for JRMs generally consisted of between 6 to 7 persons: Government of India Officers (2 to 4), Government of India Consultants (1-3) and representatives from amongst Development Partners (1 to 2). As specified in Table 1, DFID was the development partner anchoring Gender and Social Equity aspects in RCH II and a representative from DFID would be part of one of the state teams.

The Pre Mission tasks included: completion of process indicators data sets by states, intensive programme performance reviews in high focus states through visits to states and regional meetings (e.g. Northeastern states as part of JRM 2). Pre Mission activities were adapted for each JRM – for example, for JRM 4 the teams were also required to review draft reports of the JSY and ASHA evaluation in six states.

The Mission meetings spread over 9 to 10 days consisted of a national level programme review of the progress on work plans of programme divisions as well as the review of the progress on work plans for all states and Union Territories. In some of the later JRMs the number of days were reduced (JRM 6 a total of 5 days). The schedules in the different TORs show that each state was required to present their report in one hour.

Each JRM ended with a Wrap Up session

The earlier JRMs had four day field visits in the states. The later JRMs increased the number of days to 5. In each state two districts were to be visited and in each, the facilities to be visited were 2 subcentres, 2 PHCs and 2 CHCs. In later JRMs, the facilities were increased – a District Hospital or/and a teaching hospital were added on in JRM 6 and beyond. In the 6th JRM Village Health and Nutrition Days were to be observed in each subcentre area. The later JRMs added on a state level consultation with MNGOs and FNGOs to get their perspectives on the implementation of the NRHM/RCH II.

The JRMs undertook to monitor the 13 process indicators specified in the National Project Implementation Plan. These are mentioned in an earlier section. Several of the indicators are relevant from the Gender and Social Equity point of view. For example, Access indicators include: number of PHCs upgraded to provide 24X7 services, percentage of functional subcentres, number of different categories of staff trained in Skilled Birth Attendance, IUD insertion, EmOC, NSV and so on. There are some regressive indicators like percentage of planned sterilization camps held. Adolescent Health indicators in JRM 2 were quite inadequate – proportion of ANC registrations for women below 19 years of age, rather than utilization of services by adolescents, or number/proportion of institutions offering comprehensive sexuality education and so on.

Structured checklists and tools were provided in each Process Manual. These included: topic guidelines and interview schedules for state level managers and state health society members, district managers and officers, women's group, facility observation checklists, record review checklist, monitoring and evaluation systems checklist, among others. In JRM 5, there were two additions: JSY Checklist, and Do's and Don'ts for PIP Planning for 2008-09.

Gender and Equity concerns were fairly well included in the indicators and checklists. For example in JRM 2 Process Manual, under Governance issues, the teams were directed to see how the states were prioritizing vulnerable groups. The State Health Society and the State Programme Management Unit's assessment checklist in a sub section on Convergence: Community, Gender and PRIs included the following question: How gender/rights/

vulnerable community groups needs are being addressed in the state? (States plans to have rights and gender mainstreaming including gender focal point and also thinking on reaching out to vulnerable groups such as SCs and STs, nomadic population). The FGD guideline for managers from state, districts and zones had the following issues: Planning for Vulnerable groups: 1. Plans for reaching out to inaccessible areas, 2. Current provisions for planning outreach sessions, 3. Adequacy of package of services, 4. Collaboration with ICDS and PRI in organizing service delivery for outreach sessions. The Records Review checklist (District) required that the visiting JRM team look at: Women from VG accessing services: Proportion of Clients from VGs for Immunisation, ANC, Institutional Deliveries, FP services. A Focus Group Discussion with women in reproductive age group – users – was part of the JRM team's mandate to find out about their knowledge (availability of services, entitlements, JSY), and opinions (about the ANM, regularity of services, attitudes of healthcare providers). The Observation of Facilities checklist included issues like: visual privacy in labour room, and in the OPD, separate, functional, clean toilets for men and women. In JRM 6 a checklist to assess Gender and Social Equity was included. (See Annexure 5). This checklist can be reviewed and adapted for assessment of health programmes in the future.

How did the JRMs look at Design and Planning of RCH II

In this section, we use the UNEG framework (relevance, effectiveness, efficiency, sustainability and impact) to assess the extent to which the JRMs have reviewed the design and planning of NHM/NRHM from a gender-equity and human rights perspective.

1. Relevance

- Was the RCH II formulated according to international norms and agreements on HR & GE (e.g. CEDAW, UDHR, CRPD), and to national and local strategies to advance HR & GE?
- Was the RCH II formulated according to the needs and interests of all targeted stakeholder groups? How were these needs and interests assessed?
- Were HR & GE analyses conducted at the design stage? Did they offer good quality information on the underlying causes of human rights violations, inequality and discrimination to inform the RCH II?

There is no mention of international agreements in RCH II Project Implementation Plan. The Vision statement is consistent with the National Population Policy (2000), Millennium Development goals, the Tenth Plan document, the National Health Policy 2002 and Vision 2020 India. It seeks to minimize the regional variations in the areas of Reproductive and Child

Health and Population Stabilization. There is a reference to 'no discrimination in access to essential quality health services... The poorest have the right to get value for money being spent by government or out of pocket.... Girl child has an equal right to health, emergency medical aid, and to live with human dignity... The RCH programme efforts will consistently focus on the most vulnerable.'

The national strategies that are mentioned are to do with population stabilisation rather to advance gender and social equity. Strategies focus on Unmet Need for Family Planning, reaching the Net Replacement Rate, and Population Stabilisation. The stated programme intention is that it would address access, equity, vulnerability and gender issues while taking into the demand side requirements. Amongst 'other focus' is mentioned targeting of services – define essential services for the poor, review physical and financial performance against such priorities, resources predominantly used to finance essential services that address the needs of the poor.

Thus there appears to be a mixed picture – a confusion between upholding a gender and equity perspective and meeting the historical population control/stabilisation agenda.

2. Effectiveness

- Are HR & GE objectives clearly stated in the results framework, including short, medium and long-term objectives?
- Is the responsibility for ensuring adherence to HR & GE objectives well articulated in the performance monitoring framework and implementation plans?
- Does the RCH II have specific quantitative and qualitative indicators and baselines to measure progress on HR & GE?

The design of RCH II does incorporate Gender and Equity in the results framework. There is consistency between the stated vision and the indicators and how they are disaggregated to provide information on the health status of disadvantaged and vulnerable groups. GoI's commitment at the policy level to reducing the gender bias in public health and family welfare programmes is clearly stated in the PIP.

There is awareness that it would be necessary to establish equity objectives with measurable indicators and benchmarks, identify priorities in state PIPs and Logframes.

'Mainstreaming gender within the state's RCH II PIPs and Logframes will require fuller understanding and consideration of the different needs, identity and behaviour of women and men arising from their unequal social relations, and the awareness that as a result, a state's

PIP can benefit women and men differently. State PIPs and Logframes must take into account the well being of women according to their own needs.'

The PIP recognises that 'despite unanimity on the need for incorporating the issue of gender in the health sector, much remains to be done. There is huge scope for developing the skills, attitudes, and knowledge of staff designing state PIPs and Logframes, managers and health workers in gender specific methodological approaches and tools including gender specific needs analysis, monitoring and impact assessment.'

3. Efficiency

- Are there sufficient resources (financial, time, people) allocated to integrate HR & GE in the design, implementation, monitoring and evaluation of the intervention?
- To what extent are HR & GE a priority in the overall intervention budget?
- What are the costs of not addressing HR & GE adequately from the design

Indicators are there both in the logframe and in the 'Mainstreaming Gender Concerns' chapter of the RCH II PIP. **National Indicators of Health Equity** are stated as follows:

Neo natal mortality

(i) reduction in the disparity between the NNMR of the lowest socio-economic group and others.

(ii) reduction in the disparity between the NNMR of scheduled tribes and other social groups.

(iii) reduction in the disparity between the NNMR of scheduled castes and other social groups.

Infant mortality

(i) reduction in the disparity between the IMR of the lowest socio-economic group and others.

(ii) reduction in the disparity between the IMR of scheduled tribes and other social groups.

(iii) reduction in the disparity between the IMR of scheduled castes and other social groups.

Child mortality

(i) reduction in the disparity between the under 5 mortality rate of the lowest socio-economic group and others.

(ii) reduction in the disparity between the under 5 mortality rate of scheduled tribes and other social groups.

(iii) reduction in the disparity between the under 5 mortality rate of scheduled castes and other social groups.

(iv) reduction in the disparity between under 5 mortality rate of girls and boys.

Maternal health

(i) reduction in the disparity between the proportion of pregnant women that receive full antenatal care in the lowest socio-economic group and others.

(ii) reduction in the disparity between the proportion of pregnant women that receive full antenatal care from scheduled tribes and other social groups.

(iii) reduction in the disparity between the proportion of pregnant women that receive full antenatal care in the 35+ age group to younger ages.

(iv) reduction in the disparity between the proportion of pregnant women receiving TT vaccinations from scheduled tribes and others.

(v) reduction in the disparity between the proportion of deliveries assisted by a trained attendant in the lowest socio-economic group and others.

(vi) reduction in the disparity between the proportion of deliveries assisted by a trained attendant for scheduled tribes and other social groups.

(vi) reduction in the disparity between the proportion of deliveries assisted by a trained attendant for scheduled castes and other social groups.

Women's Health

(i) reduction in levels of anemia among scheduled tribes.

(ii) reduction in levels of anemia among scheduled castes.

(iii) reduction in levels of anemia among the lowest socio-economic group.

(iv) reduction in levels of anemia among 15-19 year olds.

Geographical Inequity

(i) reduction in the difference between the above key health indicators in the EAG states compared to non-EAG states.

(ii) Accelerated improvement in health outcomes of the poorest performing 100 districts.

Urban Health

(i) reduction in the disparities between the health outcomes of the urban poor and the urban non-poor.

The sheer volume of background and supporting documents indicates that there were sufficient resources allocated to arrive at a rigorous and robust design of RCH II that mainstreamed a gender and equity perspective. The 6 monthly JRM reports also show that gender and equity were seriously assessed and monitored. Performance Based Financing, incentives for incorporating equity measures were employed.

The Financial Review sections of the JRM reports basically discuss the levels of expenditure in relation to funds available and the modalities of transfer to states and the time lags/delays.

The first JRM reported that only 17 % of the funds available were actually spent. The low level of expenditure was due to a combination of low level of expenditure incurred (as the funds were transferred only in the middle of the financial year) and expenditure incurred, but not yet reported. JRM 2 stated that the expenditure was 44% of the GOI releases. And JRM 4 noted that the expenditure on the programme had increased – it was 52 % of the approved. A large proportion of the expenditure in some states was primarily on account of JSY. The financial reviews also highlighted which states had better utilization and absorptive capacity. Generally the pattern was that the EAG states and the Northeast states showed better utilization than non-high focus states.

4. Sustainability

- Did the planning framework build on an existing institutional and organisational context that is conducive to the advancement of HR & GE? If not, did the intervention design address the institutional and organisational challenges to advancing the HR & GE agenda?

The RCH II PIP does not seem to contain any conscious mention of any particular existing institutional framework to advance HR and GE. However JRM 3 hints at sustainability when it states that 'There is a need to assess capacity strengthening requirements and to identify the most optimal method of embedding capacity e.g. in SHRC (State Health Resource Centre), SIHFW (State Institute of Health and Family Welfare), SPMU/DPMU. Programmes such as Norway-India Partnership Initiative (NIPI) will need to work within/ strengthen the existing structures and not set-up parallel structures'. Although HR and GE is not explicitly mentioned here we could read this as an 'opportunity' to embed HR and GE within the capacity building structures.

How did the JRMs look at the Implementation of Gender and Equity within RCH II?

In this section we use the UNEG tailored questions to assess whether the JRMs looked at the implementation of RCH II with a gender and equity lens. We use the questions as an indicative guideline, responding to the spirit of the question and the category rather than the literal meaning of the question.

1. Relevance

- Whether activities under RCH operationalise a gender, social equity and rights based approach?
- Did the activities under RCH meet the needs and interests of all targeted stakeholders?
- Did the activities address the underlying causes of inequality and discrimination?

The JRMs consistently assessed what the RCH II was doing to operationalise a GE and HR approach.

JRM 1 spoke about strengthening of the 24X7 FRUs for Emergency Obstetric Care, ASHAs,NSV (Non Scalpel Vasectomy) Camps, Skilled Birth Attendants (SBA) training. JRM 2 laments that disaggregated data is not available to help in planning, that access to services is limited to health camps and mobile outreach strategies rather than strengthening the subcentres and other holistic strategies. Similarly, JRM 6 talks about SBA guidelines and training modules being revised and the Village Health and Nutrition Days' (VHND) guidelines being revised by the Maternal Health Division to ensure a complete ANC package for clients in their villages. Both the SBA training and regular conduct of VHND are equity measures to ensure that those living in remote areas have access to good maternal health services.

JRM 6 also emphasized that during appraisal of PIP 2009-10, states were asked to focus on comprehensive abortion services (MVA, EVA, MA) up to FRU/CHC level and at least MVA at 24.7 PHCs; to plan and up-scale MTP services and to make a roadmap for training and certifying MTP providers. In addition states were advised to strengthen District level Committees for certification of private sector providers. Safe abortion is a critical gender issue and the JRM's focus on strengthening access to safe abortion is an equity and gender measure.

Causes of inequity were spelt out in the Supporting Document. Activities in the JRMs included assessing the District PIPs planning for reach to the vulnerable groups. JRM 1 stated that a Urban Health Resource Centre was being set up to guide a programme on health for the urban poor. JRM 2 and JRM 3 mentioned that activities for increasing access to vulnerable groups

2. Effectiveness

- During implementation, were there systematic and appropriate efforts to include various groups of stakeholders, including those who are most likely to have their rights violated?
- Did RCH II maximize the efforts to build the capacity of rights holders and duty bearers?
- Was monitoring data collected and disaggregated according to relevant criteria (gender, age, location, income, religion, caste etc)
- Was sufficient information collected on gender, rights and equity related indicators to show progress regarding these?
- Was monitoring data shared adequately with stakeholders (duty bearers, rights holders, men, women etc)?
- How was monitoring data on gender, rights and social equity used to improve RCHII?

were restricted to health camps and mobile units and not on upgrading the infrastructure with additional staff and increased resources.

The JRMs placed an emphasis on Maternal Death Reviews. JRM 3 stated that social audits of maternal deaths were required to analyse underlying causes. And then JRM 7 said that Maternal Death Reviews were being done but it was not clear whether the data was being systematically analysed.

JRM 3 under Areas of Concern about Child Health states that 'Equity and Gender concerns need to be considered with setting priorities. Gender differentials are very high.' (page 14)

The JRMs indicate that there was attention to many of the aspects listed in the box on Effectiveness.

In the section on Access and Equity (page 7) JRM 2 states that there is an inadequate understanding of the Equity aims of RCH II in the states, that there is little evidence that disaggregated SC/ST data was used to identify underserved communities or gaps in service provision. This JRM recommends that the SC/ST and women PRI members should be involved in developing the District Action Plans and serving on Village Health Committees and District Health Societies.JRM 3 raises a concern about the extent to which the poor are availing of the JSY (page 10).

In relation to capacity building of rights holders and duty bearers, the JRMs do discuss the various kinds of training that healthcare providers need to be given – SBA, nursing skills, gender training, anaesthesia, emergency obstetric care. JRM 2 and 3 state that there needs to be a MOHFW directive to include Gender Module in all RCH training. Capacity building of rights holders is mentioned indirectly in relation to the participation of SC/ST and PRI members in the VHSCs and district Health Societies.

Collection of disaggregated monitoring data was suggested in JRM 1 in the Disparities section – 'data needs to be disaggregated'. JRM 2 then notes that there were delays in disaggregation of data and that only Gujarat had disaggregated data. It reminded the states that the disaggregated data required for institutional deliveries and immunisation agreed upon for Performance Based Financing to begin from the second year of the programme was pending. JRM 4 states 'The broader concept of vulnerable people in the RCH II design is not well incorporated into state plans. Many states still equate vulnerable populations with tribal districts, and do not systematically address other causes of vulnerability to ill health or barriers to services'. JRM 4 also mentions that the focus on the urban poor – whose use of health services is sometimes as low as that of the rural poor – was quite weak (page 21).JRM 5 stated that disaggregated data for RCH indicators for SC/ST population was not available.

In response to the question 'Was sufficient information collected on gender, rights and equity related indicators to show progress regarding these?'it is safe to say that some data was being collected on these indicators and more could be collected. For example, JRM 2 states that there is a need to identify Performance Indicators for inclusiveness and non-discrimination at facilities. JRM 6 cites data provided by states on 24/7 PHCs, to show variable provision of services – which can be construed as a right to healthcare: Only 44% of PHCs meet all 3 essential criteria (management of normal deliveries, some common obstetric complications and essential newborn care). Referral transport arrangements are reported to be available in 66% of 24/7 PHCs. Only 39% FRUs meet all three criteria – C-sections, blood storage/ linkages with blood banks and newborn care services on 24/7 basis.

There is no mention in the JRM reports on sharing of the data with rights holders. While quantitative data is part of the JRMs, it is not always followed up with an assessment of the quality. For example in JRM 3 report it is mentioned that 1 million VHNDs were held, but there is no discussion on the quality of VHNDs. Or whether the VHNDs are succeeding in covering all vulnerable populations, what is the extent of exclusion, and so on. Or, again in JRM 3 report it is stated that JSY increased from 6 lakh beneficiaries to 21 lakh – without questioning the fundamental flaws in the JSY that result in violation of a women's right to quality maternal health services in overcrowded, under-resourced institutions.

3. Efficiency

- Were the intervention resources used in an efficient way to address gender, rights and social equity in the implementation (e.g. participation of targeted stakeholders, collection of disaggregated data, etc.)?
- Were there any constraints (e.g. political, practical, bureaucratic) to addressing gender, rights and social equity issues efficiently during implementation? What level of effort was made to overcome these challenges?

There are however some deviations from the above pattern – JRM 2 report states that 1700 FRUs were reported to be ready – but in effect there were very few with complete set of conditions to provide more than basic EmOC. Or, as in JRM 3 'Although 1858 FRUs are reported to be operationalised, in practice they are not according to GOI guidelines/norms'. JRM 4 noted – 'Services for spacing methods and information are extremely limited and stock outs of contraceptives were noted. Field visits found that providers were unfamiliar with the ten-year protection offered by IUD-380A. Knowledge levels were also poor on indications for emergency contraception, dosage schedules, post-partum contraception, and natural family

planning methods such as LAM and SDM. This situation creates missed opportunities to increase contraceptive use. Many states have not planned any Contraceptive Update training in their PIPs. Standard Operating Procedures (SOPs) for sterilisation services in camps are still to be prepared'. Field visits during the JRM found very little focus on planning ARSH interventions in the districts.

JRM 2 stated that acute shortages of RCH pharmaceuticals and supplies continued. And that acute shortage of staff was seen in field visits. Another issue highlighted by JRM 2 was that the prioritisation of the worst off districts for additional allocation of resources to match the needs reflected was yet to be addressed. A major concern was the lack of disaggregated performance data to show improved use of RCH services by the poorest and most vulnerable populations. JRM 3 expressed a concern about whether the JSY money is being used by the woman herself. JRM 4 stated that although the expenditure on the programme had increased, a large proportion of it was on account of the JSY payments. These are some glimpses of Efficiency related issues to do with gender, social equity and rights.

4. Sustainability

- Did the intervention (NRHM, RCH) activities aim at promoting sustainable changes in attitudes, behaviours and power relations between the different stakeholder groups?
- How was monitoring data on gender, rights and social equity used to enhance sustainable change on these issues?
- How did the intervention activities relate to the intended long-term results on gender, rights and social equity?
- Did the intervention monitoring systems capture progress towards long-term results on gender, rights and social equity?
- Were there any positive or negative unintended effects on gender, rights and social equity identified during implementation? How were they addressed?

Gender training which can effect changes in mindsets, can be considered to be an activity to bring about sustainable changes in attitudes, behaviours and power relations. JRM 4 noted that, 'States have trained trainers for gender mainstreaming, (42 master trainers were trained for 14 states in 2005, and 15 states/UTs have completed training of trainers). However, gender modules have yet to be incorporated into wider programme training. Recognising that the private sector is here to stay, JRM 4 also stated 'Pro-poor indicators for performance of private/non-state contractors are not routinely incorporated into contracts. A system for SC/ST and BPL

people to be routinely exempted from fees for private/outsourced services such as ambulance and X-rays still needs to be established'.

How did the JRMs assess the Results from a Gender and Equity Perspective?

In this section, we try to apply the UNEG framework to review how the JRMs assessed the Results in RCH II. It was difficult to apply this framework as the JRMs mainly report progress on several processes and not the actual result, although each JRM report does start off by mentioning the progress against the main NRHM/RCH goals of MMR, IMR and TFR. Thus, many of the questions appear irrelevant. We have tried to read the JRM reports through the lens of the adapted 'tailored questions'.

1. Relevance

- Do results of RCH contribute towards realisation of international and national norms and strategies to advance gender and social equity and realisation of rights?
- Do results of RCH respond to the needs of all stakeholders as identified at the design stage.

In response to the adapted 'tailored questions' from the UNEG framework, our observations on the contents of the JRM reports are as follows. JRM 1 noted that in UP the Gram Pradhans were trained on gender issues (contribution to advancing gender equity) while there was no progress on the tribal RCH plan (stakeholders identified in the design stage) or on the ASHAs.

2. Effectiveness

- What are the main results of RCH towards realisation of gender, rights and social equity?
- To what degree are these results distributed equitably across the targeted stakeholder groups?
- Do results contribute towards changing attitudes and behaviours towards gender, rights and social equity?
- Do these results contribute to reducing the underlying causes of inequality and discrimination?
- Did RCH contribute to the empowerment of rights holders to demand, and duty bearers to fulfil gender, rights and social equity norms?

3. Efficiency

- Was the use of intervention resources to address gender, rights and social equity in line with the corresponding results achieved?

The JRM 2 noted that the Unmet Need for contraceptives still remained. JRM 3 noted that maternal anaemia increased between the two NFHS in most states.

4. Sustainability

- To what extent do stakeholders have confidence that they will be able to build on the HR & GE changes promoted by the intervention?
- To what degree did participating organizations change their policies or practices to improve realisation of gender, rights and social equity related objectives (e.g. new services, greater responsiveness, resource re-allocation, improved quality etc.)?

5. Impact

- Did the intervention clearly lead to the realization of targeted HR & GE norms for the stakeholders identified?
- Were there any unintended results on gender, rights and social equity in the intervention? Were they positive or negative and in which ways did they affect the different stakeholders?
- Did the intervention activities and results in HR & GE influence the work of other organizations and programmes?

JRM 3 observed that there was a greater visibility of Emergency Contraceptives (ECs) and that states were demanding ECs and NSV kits. Another observation was that less than 10% of the SBA and EmOC training were completed.

As mentioned above, each JRM has reported on the key goals of NRHM and RCH – MMR, IMR and TFR. JRM 8 noted that there was no gender or social disaggregation of IMR, NMR data in JRM documents, although the UNICEF Coverage Evaluation Survey (2009-10) and DLHS 3 were attempting to disaggregate data. JRM 8 further noted that India's MMR at 212 (SRS 2007-09) had improved significantly from 254 (SRS 2004-06), IMR at 47 (SRS 2010) had improved from 50 (SRS2009), while TFR at 2.6 (SRS 2009) had improved from 3.0 (SRS 2003). According to JRM 8 report the number of states /UTs achieving the RCH II /NRHM goal1 for MMR, IMR and TFR were 2, 12 and 14 respectively. Kerala and Tamil Nadu had achieved all the three RCH/ NRHM goals. Off-take of selected services amongst SC, ST, lowest wealth quintile and EAG states was better than the national average:

- 12-23 months children fully immunized, overall increase (CES- 2009 over DLHS-2) is 15.2 percentage points where as for SC it is 17 percentage points, for lowest wealth quintile 16 percentage points and for EAG states 18.2 percentage points.

- Similarly percentage of eligible couples using modern contraceptive methods the overall increase (DLHS-3 over DLHS-2) is 1.4 percentage points, whereas for SC and ST it is 6 and 3 percentage points respectively.

Amongst the process indicators mentioned by JRM 8 were:

- More than 3000 adolescent friendly health clinics across District Hospitals, CHCs and PHCs are functional. 5527 Medical Officers and 16728 ANM/LHV/Counsellors have been trained on offering adolescent friendly health services across the country.
- There is encouraging movement towards making services more accessible to women and vulnerable groups particularly in hilly and difficult to reach areas. The state PIPs and annual budgets demonstrate a stronger focus on reaching vulnerable groups.
- Poor quality of ANC services during VHNDs is a concern. Surveys have also indicated that women generally tend to bypass VHNDs for ANC. The women are asked to go to higher facilities for lab examinations/ sonography/ HIV screening. In many states, the VHND does not provide comprehensive services, and remains restricted to immunization.

Examples of progress on processes reported by JRM 7 are:

- While the number of facilities (FRUs & 24x7 PHCs) reported to be operational by the states has gone up significantly, the JRM visits and subsequent discussions during the state reviews show that the number of facilities meeting critical criteria of functionality is still low. Availability of blood storage facilities along with specialists and/ or general duty doctors trained in EmOC and Life Saving Anaesthesia Skills (LSAS) continue to be major bottlenecks. State reviews showed that a number of MBBS doctors trained in LSAS and EmOC, as well as medical officers with postgraduate qualifications continue to be posted at PHCs and additional PHCs.
- Training of medical officers in Basic Obstetric Care/Management of Common Obstetric Complications (BEmOC) is a critical aspect of operationalising the 24x7 PHCs. While training of medical officers (MOs) has been initiated in some states, it needs focused attention to accelerate it so that there is at least one trained MO at 24x7 PHCs.

An unintended consequence mentioned in JRM 3 is that the focus on JSY took away from attention to Safe Deliveries. It went on to say that although institutional deliveries increased, because of capacity constraints, the quality of deliveries was a concern. JRM 3 recommended a sample check to ensure use of money by women. And also to check how many poor were using the scheme.

Mid Term Review (MTR) of RCH II – Gender and Social Equity Perspective

The MTR took place in towards the end of 2008. The Process Manual for the MTR provided detailed of Terms of Reference for the review of each Thematic Area including Gender and Social Equity. The overall purpose for the Gender and Social Equity theme was ..... to assess the progress made by the programme in providing RCH services to different social groups (SC, ST, minorities, Muslims, urban poor) and mainstreaming gender within the programme, to assess the impact of the programme in terms of reduced disparities in key outcomes, and to identify examples of improved service delivery and remaining challenges. (Page 32, Process Manual)

The specific objectives included:

- To review recent data to assess the status of and trends in health service usage and health outcomes by social group (as above), and gender.
- To assess progress made in implementing strategies for mainstreaming gender and social equity approaches within programme work-plans at all levels.
- To assess the capacity, building processes and human resource developments in the programme that support social and gender equity at national, state, and district levels.
- To assess progress in enhancing service delivery to women and men, as well as to vulnerable social groups.
- To review progress in use of performance bonuses for equity, and suggest appropriate additional or alternative approaches.
- To suggest an appropriate framework and tools to institutionalise in-depth reviews of social and gender equity in access and outcomes in the joint review missions.

A team of two experienced independent gender and health resource persons undertook the exercise, one of whom was the co-author of the Supporting Document. Two checklists (Checklist N – Tool for Assessing Social Group Equity and Gender Mainstreaming in RCH II and Checklist O – Basic Criteria to Assess Mainstreaming of Gender Issues in State Plans for RCH II) were provided in the Process Manual as guidelines. These checklists (Annexure 5) can serve as models and be refined for further reviews/evaluations of health programmes.

The recommendations of the MTR appear to have had some results in JRMs 6, 7 and 8. Some checklists were developed and used. The JRM reports became a little more in depth and nuanced. However, as the next section shows the Gender and Social Equity agenda as envisioned in the RCH II PIP and the MTR Report, largely remained neglected and unaddressed.

A Review of the JRM Recommendations to assess their Implementation

As mentioned in the Methodology section, we extended the UNICEF review to include JRMs 7 and 8. See Table 4. The process that was followed was:

- Under the Thematic Area, the recommendations have been categorized in terms of State and National;
- The list of recommendations (on the first column on the left hand side) indicates the JRM in which they were made. The colour pattern (on right hand side) reflects at what stage the corresponding actions were taken or not taken. As mentioned in the Methodology, red indicates recommendations not met, yellow partially met and green already met. Actions against some recommendations were not satisfactory. Therefore they have been marked yellow.

Table 4: Review of the JRM and MTR Reports for Implementation of Gender and Social Equity Recommendations

JRM Recommendations	JRM 1	JRM 2	JRM 3	JRM 4	JRM 5	MTR	JRM 6	JRM 7	JRM 8
Gender and Social Equity									
State level									
1. States to incorporate strategies/ actions to integrate gender and equity concerns in the State PIPs (MTR, JRM-6, JRM 8)		S 1							
2. Map (a) key indicators disaggregated by sex, SC/ST, District and Block to identify the most vulnerable & their specific requirements;(b)Health infrastructure and staff resources to identify gaps & disparities in service provision for vulnerable populations and strategies to address them (JRM 1)		S[4]2							
3. Identify & disseminate clear criteria for rational & fair resource allocation based on need by each state/district. (JRM 1)									
4. Accelerate efforts to gather reports and analyse disaggregated data on different populations (including SC/ ST) as well as backward districts/ blocks in order to identify patterns of vulnerability (shortages in human resources/functional facilities, location of facilities) and gaps in service provision and to begin payment of performance bonuses. (JRM 3-8)				S 4					

[4] N= National ; S= State specific recommendation

JRM Recommendations	JRM 1	JRM 2	JRM 3	JRM 4	JRM 5	MTR	JRM 6	JRM 7	JRM 8
5. Institutionalise capacity to integrate gender and social equity by (a) Designating a nodal person at state and district level; and (b)Identifying technical resource persons/ institutions that could provide support on an ongoing basis.(MTR, JRM-6, JRM 7, JRM 8)				S 5					
6. Include urban health & tribal health plans in the State PIP (JRM 1)									
7. Prioritise Blocks with high tribal and SC populations for establishing new ANM Training Institutions .(JRM 3)		???							
8. Ensure that ASHA is well linked to the SC and PHC, and fully supported by the health staff at those facilities (JRM 1)									
Total Recommendations met	2/ 7								
National level									
9. Recruitment of Gender and Equity consultant at MoHFW to help address gender and equity concerns (reiterated in MTR, JRM 6, JRM 8)						N 9			
10. Identify Performance indicators to measure the extent to which, government, NGO or PPs health facilities are inclusive and non-discriminatory to all patients (SC/ST, BPL women and girls). Disseminate among NGOs and PRI members to facilitate Community Monitoring and reporting. (JRM 3)				N 10					
11. Develop, test and include a gender module in IMNCI & training for AWWs in States with relatively high female child mortality (JRM3)				N11					
12. MoHFW& DPs should support efforts to evaluate, document and disseminate best practices within RCH II to identify and reach vulnerable population groups and mainstream gender.(JRM 4)									
13. National and regional workshops conducted to present the findings of documented best practices in urban health, tribal health and reaching vulnerable groups (JRM 3)							N --13		

JRM Recommendations	JRM 1	JRM 2	JRM 3	JRM 4	JRM 5	MTR	JRM 6	JRM 7	JRM 8
14. Use District Level Household Survey to be used as the source of disaggregated data for the purposes of awarding the performance bonus.(JRM 5) Finalisation of Equity Analysis of DLHS and NFHS data (JRM 6, JRM 7)								N 14	
15. Donor Coordination Division to coordinate the preparation of appropriate tools for looking at gender and equity issues (MTR)								N 15	
16. Prepare checklists to mainstream gender and social equity concerns in various technical areas, in monitoring of facilities at different levels, and in job responsibilities of personnel (MTR thematic report)									
17. Gender and Equity Toolkit to be disseminated (JRM 7, JRM 8)								N 17	
18. Gender and Equity Sensitisation and Training (GEST) – ongoing – at national and state levels. Integrating GEST with QA. Capacity building of SHRCs in GEST.									N18
19. Improvement of communication both among healthcare providers and between HCPs and women users.									N 19
20. Address the issue of PCPNDT Act reducing women's access to safe abortion services because of fear of providers even in registered MTP facilities.									N 20
21. Implement the recommendations of the report developed by the Task Force (2005) to advise the NRHM on "Strategies for Urban Health Care". (JRM 3)								N21	
22. High focus blocks and villages instead of high focus districts – planning and use of resources can then befine tuned.									N 22
Total Recommendations met	1/ 14								
Grand Total Score	3/ 14								

Other observations are:

Successes	
S 1	Overall, many states have initiated innovative strategies to improve access to care to the vulnerable population (tribal population and urban poor).Some examples include Orissa, Rajasthan and Gujarat who are mapping the distribution of health facilities in order to identify gaps in coverage; TN has made efforts to reduce inequities in the distribution of health staff; Rajasthan, MP & Haryana have used incentives to get ANMs and other workers to serve in rural areas.
N 8	Resource Directory of consultants to guide addressing gender/ equity concerns has been developed. The resource directory lists out resources/ institutions that could be available to states to provide technical assistance for addressing gender and social equity concerns/ issues in on-going and new interventions. Resources and programme data such as – In-depth social group analysis of DLHS and NFHS data, and a Tool Kit to integrate Gender & Community Responsiveness in the health programme are being finalized- with the DPs taking lead. They will be shared and further strategy of action to use the same is to be decided with MoHFW. The toolkit was never finally disseminated.
N 15	Checklist for Gender and Social Equity- The Donor Coordination Department with support from DPs circulated a checklist for Gender and Equity mainstreaming in the PIP process, at state and district level.
Areas requiring attention and reasons for slow /lack of progress	
	Many states have yet to systematically address causes of vulnerability to ill health or barriers to services among the vulnerable populations. Although social equity and gender mainstreaming is a key strategy in RCH II design, it is understood variably and is implemented as a set of dispersed activities.
S 4	Disaggregated data on RCH indicators for SC and ST populations has not been available, as a result of which the performance bonus for coverage of interventions among these populations has not been awarded. With the revised MIES format no longer reporting on disaggregated data, and national surveys being the main source to collect disaggregated data, there is little evidence that data is being analysed, disaggregated by SC/ST or used to identify/address underserved communities or gaps in service provision, mainly due to lack of capacity at all levels.
S 5	Recruitment of gender & equity specialist at MoHFW / State level is yet to be completed. List of resource organizations have been compiled.
N 9	The Gender Consultant at the National level is yet to be recruited
N 10	Is it covered under the Community Monitoring framework/Tool under NRHM ?
N 13	National/Regional workshops to sensitise/disseminate equity related analyses have yet to be organized by MoHFW

N 17	The NUHM is yet to be launched as its still pending approval from the Planning Commission. The focus on the urban poor which has been quite weak in the NRHM need to be strengthened.
	While some states are gathering disaggregated data and using it in planning, gender and equity concerns should be addressed in the future state PIPs and that innovations aimed at promoting gender and social equity needs to be properly evaluated and disseminated. For many underserved areas, stand-alone or stop-gap, short term strategies such as mobile clinics or periodic camps have been proposed to improve access to the vulnerable populations. A concerted attempt is needed to embed within an overarching and holistic long-term strategy defining service package, follow-up mechanisms and partner management.

- The recommendations became more focused with each JRM, making it more doable and measurable, and thus making it easier to hold the MoHFW/DPs accountable. This was especially so after the Mid-Term Review of RCH II.

While mapping the actions taken under Gender and Social Equity Thematic Area, it was observed that there are very few greens on the report card which means that very few recommendations have been satisfactorily implemented.

Table 5 shows that in comparison to other Thematic Areas least number of recommendations for the Gender and Social Equity theme have been met. UNEG Guidelines discuss some of the reasons for this kind of a pattern. There may be a lack of acceptance of the mandate to integrate a gender and rights perspective in the evaluations. Or there may a low level of understanding of what these approaches mean in theory and practice.

Table 5: Summary of the RCH JRM Recommendations met

	Recommendations			
RCH Thematic Areas	Already met	Not/partially met	Total	Percentage met
Maternal Health	13	7	20	65
Child Health	13	13	26	50
Family Planning	13	10	23	57
ARSH	5	2	7	71
BCC	4	7	11	36
Gender & Equity	3	11	14	21
Training	9	1	10	90

Programme Management	4	7	11	36
Financial Management	8	12	20	40
Monitoring & Evaluation	7	9	16	44
Procurement	6	11	17	35

Summary of RCH II and JRMs from a GE and HR Perspective

The RCH II design was based on lessons learnt from RCH I, and many consultations with wide stakeholder groups. Detailed supporting documents were drafted on Gender, Social Equity, Tribal Health, Adolescent Reproductive and Sexual Health and so on. The RCH II PIP incorporated many of the finer nuances on Gender and Social Equity from these supporting documents. Included were also various boxes and tables to facilitate easy understanding and application of Gender and Equity concepts. Mainstreaming a Gender and Equity perspective in the state PIPs was spelt out in many different ways. The vision spelt out in RCH II is slightly confused – the earlier agendas of population stabilisation bringing down Total Fertility Rates, sterilisation camps continue to dominate the discourse even as there is progressive SRHR language used.

The JRMs have detailed process manuals and checklists which include Gender and Equity concerns. After the Mid-Term Review in 2008 a checklist to assess Gender and Equity aspects was also included in the JRMs' process manual.

The Project Implementation Plan (PIP) includes some National Indicators for Health Equity but these are not referred to in any of the JRMs. The JRMs consistently look at process indicators like: commissioning of 24 X 7 PHCs, training of skilled Birth Attendants, training for Emergency Obstetric Care, use of disaggregated data as a basis for decentralised health planning, and so on. Incorporating a gender module in all training is mentioned in the later JRMs. Two other dimensions consistently reviewed are the Janani Suraksha Yojana and the Village Health and Nutrition Days – issues of quality related to these are raised in the later JRMs.

An unpublished UNICEF study showed that only 21% of the total recommendations made by all the JRMs for thematic area Gender and Social Equity were implemented – and this was the lowest. This indicates that there may be a low level of understanding of what these approaches mean in theory and practice.

While the JRMs brought up important gender issues likes afe abortions and implementation of the MTP Act, related recommendations were not satisfactorily implemented – access to safe abortion services continues to be an issue even today. JSY was pushed even while health facilities were unprepared to provide quality maternal health services – quality of ANC delivery care and PNC is an issue even today. Table 5 shows that although most recommendations for ARSH were implemented, the quality of the programme on the ground remains an issue till today.

The Mid-Term Review provided valuable Gender and Equity checklists and tools that can be reviewed and refined for further use.

Findings: Other NRHM Evaluations

As part of this review, we zeroed in on three evaluation studies of the NRHM conducted at a national level between 2005-2012 by NGOs, academics or government agencies other than those linked with the MOHFW. Based on the selection criteria (refer to section on Methodology) the studies identified were:

i. Nirupam Bajpai, Jeffrey D. Sachs and Ravindra H. Dholakia, (2009), Improving access, service delivery and efficiency of the public health system in rural India: Mid-term evaluation of the National Rural Health Mission, CGSD Working Paper No. 37 October 2009, Working Papers Series Center on Globalization and Sustainable Development. The Earth Institute at Columbia University

ii. Indian Institute of Population Studies (2011), Concurrent evaluation of National Rural Health Mission 2009, Fact Sheet States and Union Territories

iii. Programme Evaluation Organisation, Planning Commission, Government of India (2011) Evaluation Study of National Rural Health Mission (NRHM) in 7 States

In this section, we present the findings of our rapid assessment of these above mentioned studies using the main evaluation criteria of the UNEG framework. For the purpose of the review, the objectives along with the key findings of the studies have been reviewed using the evaluation criteria.

Mid Term Evaluation of NRHM by The Earth Institute, Columbia University 2009

The mid-term evaluation was conducted in 2009 as the MOHFW requested the International Advisory Panel for the NRHM to review the progress of the programme. The evaluation was led by the Centre for Globalisation and Sustainable Development, Earth Institute, Columbia University. The study was undertaken in selected districts of three of the programme's high-focus states viz. Madhya Pradesh, Uttar Pradesh and Rajasthan. Primary and secondary data was collected in the course of the review. Interviews were conducted of ASHAs, ANMs, members of VHSC/PRI/RKS, members of the DPMU, and PHC/CHC. The main objectives of the evaluation were:

- The role of the Accredited Social Health Activists: To what degree are ASHAs effectively utilized? How are they working with the Aanganwadi workers of the Integrated Child Development Service (ICDS) programme to achieve the key objectives of the NRHM?
- The role of the Panchayati Raj Institutions (PRIs) in managing local health facilities.
- The existing infrastructure and human resources at the Sub-Centers (SCs) and the Primary Health Centers (PHCs): Are they commensurate with the growing needs of the regions?

- The efforts to reduce the infant mortality rate (IMR) and maternal mortality rate (MMR): Is the NRHM effectively undertaking the necessary interventions to reduce IMR and MMR? And are major efforts in various settings, such as novel strategies for reducing neo natal and maternal deaths, impacting outcome rates?
- Are the necessary management structures in place to manage health services at the village, block and district levels?' (2009, p. 6)

From the objectives it is safe to say that the lack of GE and HR focus of the programme is reflected in this mid-term evaluation as well. There are neither expressly gender-orientated objectives nor those geared towards assessing NRHM's equity related strategies. Largely one finds that the evaluation captures the extent to which the implementation of the programme has progressed. Improvements in infrastructure, human resources, management structures etc. are crucial areas for evaluation in NRHM – yet, increase in numbers and qualitative improvements are inadequate indicators in the furtherance of HR and GE.

The main findings of the evaluation include changes in infrastructure, rate of antenatal checkups since the launch of the programme, HR shortfall in facilities, financial management including use of NRHM funds and public participation, among others. The team also present innovations in different states for the purpose of communication and management. Apart from the research methods used for the evaluation, this review is not vastly different from the CRMs in terms of its focus and intent. It also mirrors the CRM in its neglect of gender and HR concerns. The evaluation provides no disaggregated data regarding access to facilities or utilisation of services neither on gender grounds nor for vulnerable populations in the area. Equity concerns are seen to a minimal extent in the use of variables such as 'residences for doctors and nurses' and 'availability of seating for relatives near the bed'. However, apart from these two variables one finds little else on gender and HR concerns.

Using the UNEG framework's main evaluation criteria for the mid-term evaluation we find that in terms of 'relevance' the objectives and the main findings do not contribute in any way to the international norms or national strategies related to GE and HR. The only exception to this is the focus on the reduction of MMR which is envisaged in the MDGs. Regarding 'effectiveness', the mid-term evaluation does not have specific quantitative and qualitative indicators related to GE and HR. The indicators used are specifically related to infrastructure, HR availability, facility management etc. These are essential to assess the progress of the programme, however, insufficient in a feminist review seeking benefits for women and vulnerable populations. Financial management is discussed in the evaluation, however, again it lacks a gender lens which could provide information related to funds available for women's

health and addressing equity concerns. The team also does not reflect the sustainability of the programme in ensuring the rights of women, the poor and vulnerable. Moreover, the impact assessed in the evaluation is largely gender blind expect for the focus on reduction of MMR as mentioned earlier. The ASHA programme is studied in detail by the evaluation team but one finds that it is reviewed from an instrumentalist perspective i.e. to identify how the ASHAs can be used to achieve the NRHM goals. There is little discussion regarding their concerns regarding the payments or their empowerment. The evaluation provides details of ASHA's responsibilities and their performance so far. Disaggregated data regarding users of services and healthcare providers is also missing in the evaluation.

Concurrent evaluation of National Rural Health Mission 2011

The concurrent evaluation of NRHM was undertaken at the behest of the MoHFW to 'assess the reach of the NRHM at the facility levels and among the rural communities' (2011, p.2). The concurrent evaluation sought to gather evidence which could directly feed into the implementation of the programme across the country. The ToR for the evaluation clearly states that the goal of the study is to assess the progress of the critical areas of concerted action (2008). Many field level organisations and zonal agencies were contracted to undertake the study. The nodal agency at the national level was Indian Institute for Population Studies, Mumbai. The evaluation was carried out in 187 districts in 33 states and Union Territories. This was one of the largest evaluations of the programmes in terms of scale. For the purpose of the study in each district 1,200 heads of households and 1,200 currently married women (15-49 years) were covered. District hospitals, CHCs, PHCs and HSCs were the facilities covered. Some in-patients and out-patients were interviewed for the study.

It is laudable that the evaluation concentrates on access related issues in rural India vis-à-vis implementation of the programme. The methodology of the evaluation makes space for the voices of heads of households and equal number of women in reproductive age. Although the objectives do not expressly have any GE or HR focus, it can be said that the inclusion of users of services i.e. heads of households, Women in Reproductive Age (WRA), inpatients and outpatients as respondents lead one to consider this evaluation in a different light than the CRM. In this study as the specific objectives are not spelt out, we consider the main findings to understand the extent to which a gender perspective has been employed in the evaluation.

As stated at the outset, the inclusion of women respondents along with other stakeholders is a step towards presenting the voices of the users of the services. The household responses include data collected from SC, ST, OBC households. Many of the respondents were illiterate and BPL i.e. one-third and two-fifth, respectively. Access to health services for the respondent

households was gauged through the visit of the health worker in the past month and knowledge of any local health worker. The utilisation of government services by the households in comparison with private facilities is presented in the report. The women respondents were asked about pregnancy, assistance during delivery, awareness about diseases e.g. HIV/AIDS, family planning services, immunisation, breastfeeding etc. In the responses sections it is clear that the evaluation limited the inquiry to reproductive health and child health. The study did not seek to review the NRHM's success in reaching out to women for their holistic health. However, the evaluation does present data regarding the use and awareness of the Nishchay Pregnancy Test and MTP. From the health providers' point of view, some important concerns of ANMs and their welfare are highlighted in the concurrent evaluation. This includes the availability of transport for ANMs to carry out their duties and their training needs. Residential facilities, communication amenities and toilets in facilities are discussed in the report. Disaggregated data about the profile of the inpatients and outpatients interviewed for the study is provided. SC, ST and BPL percentages of the respondents is part of the report. However, gender based data is not provided. Also, their responses regarding their satisfaction with the services are not part of the evaluation.

As per the UNEG framework, the relevance of the concurrent evaluation in terms of GE and HR is not clearly stated. The evaluation, however, does make an effort to include more stakeholders in the evaluation. WRA, ASHAs, inpatients, outpatients are respondents in the evaluation. In comparison to the CRMs and the mid-term evaluation, the effectiveness of the NRHM is tested in this evaluation through the inclusion of a wide range of stakeholders. Disaggregated data of important indicators related to gender and human rights is unavailable in the evaluation report. Financial management for efficiency in the programme is captured to some extent, however, again without a gender and human rights perspective. The data collected in the course of the concurrent evaluation provides information regarding improved access to different populations. At the same time, specific demography-wise data of access is not made available. This is crucial for sustainabilityof the programme. The impact of the programme on different stakeholders needs to be more clearly captured than what we find in the study. At the same time, the concurrent evaluation takes steps in inclusion of a wide range of stakeholders of the NRHM. This array could be widened and their responses could be shared separately in order to shed light on the realities of different target populations.

Evaluation Study of National Rural Health Mission in Seven States 2011

This evaluation study was supported by the Planning Commission and undertaken by the Population Research Centre, Institute of Economic Growth. The study was conducted in seven

states viz. Tamil Nadu, UP, MP, Jharkhand, Odisha, Assam and Jammu and Kashmir. The evaluation was conducted with the objective of capturing the progress of the implementation of the NRHM in rural India. Utilisation of the services, adequacy, availability in the seven states was reviewed along with the role played by the ASHA and the ANM. Importantly, the study also seeks to document the constraints faced by the providers especially ASHAs. The evaluation has a fairly elaborate research design which includes facility surveys including interviews with providers and household surveys. The approach adopted to capture field realities and people's experiences is commendable. Surveys of DHs, CHCs, PHCs, HSCs and villages covered by the selected HSCs were conducted. Additionally, households with one pregnant woman, lactating woman, children in the age group of 1-5 years, one person with a chronic disease and a couple that has utilised any family planning method were selected. A total of 7400 households in 296 villages were part of the study. Providers and users of the services were the study respondents.

In the facility survey, financial mechanisms, physical infrastructure, range of services in the DHs, CHCs, PHCs and HSCs were captured. The functioning of ASHAs was a part of the evaluation. One of the variables related to the ASHA covered was whether they received travel allowance during their training programmes. Also, we find that the VHSC members' opinion was sought regarding the facilities in their area, the availability of accommodation for night stay, free medicines etc. This evaluation sheds some light on the community's perception of the public health services. In the household survey, we find that unlike any of the other evaluations including CRMs, this evaluation provides utilisation information based on background characteristics such as education, income, type of house etc. Utilisation of services related to ANC, delivery, PNC, family planning and chronic diseases is provided based on different background characteristics. This is very useful as the conclusions of the study highlight that younger and better educated women have better obstetric care-seeking behaviours whether in public or private facilities. Also, the evaluation claims on the basis of the data that educated couples show higher use of family planning methods. Finally and most importantly, the study shows that households with better facilities i.e. pucca houses, toilet facilities, drinking water supply etc., tend to have better health-seeking patterns than those households which do not have the above mentioned amenities. However, it is important to highlight that utilisation by gender, caste and tribe is not provided. Within a household, the power dynamics which leaves women at a disadvantage is not captured. Additionally, disaggregated data of utilisation by caste, tribe, religion is also missing in the analysis. With these, the evaluation would have been a more gender and human-rights oriented.

As per the UNEG framework, the evaluation does not seek to assess the relevance of the NRHM to address GE and HR concerns. None of the international norms or national strategies is included in the evaluation. Efficiency is understood from the point of view of financial mechanisms for the implementation of NRHM but not necessarily for furtherance of GE and HR. In terms of effectiveness, it must be acknowledged that different stakeholders have been included as respondents in the study. Both users and providers were interviewed to grasp the extent of accessibility and challenges therein. At the same time, as stated earlier, disaggregated data for gender, caste, tribe, religion is missing. Moreover, the focus with regard to women continues to be RCH services rather than a holistic approach to women's health. This affects both the sustainability and impact of the NRHM as seen through this evaluation. This myopic vision of health for women, as reflected in this evaluation and in NRHM (not NHM) undermines women's right to well-being and proper care and treatment.

Findings from Key Informant Interviews

Nine indepth interviews were conducted with Key Informants. Their responses are summarised below.

CRM Team Composition

The CRM teams comprise of government officers from the Ministry as well as from the states, consultants, Public Health academics and researchers and civil society representatives. Key informants felt that the teams are not well balanced in terms of expertise. An understanding of Gender Equity and Human Rights is generally very uneven among the team members. Consultants tend to be not too critical of what they see in the field – 'they are loyal to the king' (AS). There is a stereotyping of roles/allocation of portfolios – in the field, the civil society representatives are generally supposed to look at community processes. 'The team roles are designed such that it is difficult to get our perspective incorporated'.

> *'.....there were those in the team who were not even aware of the NRHM Implementation Framework.... They announce the CRM dates so late and invite people so late that the most suitable people, because of short notice, cannot make it into the teams.... academicians and those with research background should definitely be in the team'. (JV)*

'Selection of team leaders is deliberate' – team leader is a government officer and has his/her own interests that affects the quality of reports – there is a tendency to bend the report towards those interests.

Process of CRMS

Preparation

One key informant felt that very short notice is given to be part of the CRMs. At least three respondents felt that there is not much effort made to give critical or relevant data/information/ documents. Teams are dumped with an overwhelming volume of documents, many of them superficial – '.... were given a 2 GB pendrive full of many documents – the first CRM report, NRHM PIPs, National level frameworks, expenditure statements for previous years' (JV). Informants stated that there was not sufficient time to analyse the data before going out in the field.

There was a day long orientation meeting, which was 'not really enlightening'. It was a 'mammoth meeting' with many participants and very little consultative process. One key informant stated that civil society members may try and influence the process but with little success. Another said, 'There is no scope to contribute to the design of the CRMs/JRMs in terms of tools formulation or design of the review'. (PM). 'The process was quite questionable – we set out for the review with very little idea of exactly what to look into during the field visit' (JV). There is no systematic orientation given to what is meant by Gender Equity and Human Rights perspective.

> *As a (state) team there was very little time for planning. The NHSRC person had some idea – he gave some suggestions and we followed them. He was much better prepared maybe because of the experience of the earlier CRM. (JV)*
>
> *The orientations are hurried, done by uninterested government officers; those who have little to do with the programme are brought in to do the orientation. Preparation for the field visits are usually poor and non-specific, for example, the teams are not prepared (given directions) to look at state specific questions and issues.(PM)*

According to the key informants while they were given TORs, there were no tools that the CRMs could use. 'The indicators that the teams are supposed to look at in the field are not clear. The whole thing results in an impressionistic exercise' (PM). RP stated that in the first two years there were no checklists – after 2010 the Ministry evolved questions and formats to guide the teams.

Field Visits

One key respondent felt that the positive thing about the CRM is the multiple forums for dialogue. The CRM started with the secretary of the particular state giving a briefing and at the end of the process, questions were asked by the CRM team and the state officers had to

respond. After the state level briefing also wherever the teams went, they met people and asked questions.

The states generally tried to present a good picture. 'The state NRHM officers suggested where to go. They had selected the two districts earlier. We suggested that we don't want to be restricted. They had organised our visits.... From the equity perspective, I was interested in visiting the naxal affected areas, which did not happen...' (JV)

One key informant felt that CRMs were an exercise of power –as the CRM team landed there as 'people with power'. 'The bureaucracy saw us in a very 'different' way – as someone with a lot of power'. (JV)

There is no atmosphere, space to have meaningful explorations on gender and equity issues in the field – 'the officers are hovering around, respondents feel overwhelmed and overpowered' (AS). The CRMs do not have space for meetings with local CBOs, panchayat members.

> *The Reviews are too health system oriented, there is no scope for assessing community perspectives. This is how they are structured, the government is not really interested in community perspectives. Their focus is on reviewing the systems inputs that have been provided – is the PHC clean or not? (PM)*

Some CSO representatives in the teams were able to manoeuvre and go to different places/ facilities from those originally planned. And they found a difference between those that were in the original plan and the ones they managed to visit. Three respondents stated that they had to be extremely resourceful and creative to carve out those spaces by either sneaking away on their own, or by arranging small meetings with volunteers of the Jan Swasthya Abhiyan calling in villagers from the surrounding villages to talk to the visiting CRM team including the officials. Or by manoeuvring to get visits to innovative community health projects included in the field visit agenda. JV stated that the visit he was able to arrange changed the perceptions of the CRM team.

> *CRM team members are those who work at the national level, including the donor community. They are perceived as powerful – people going to inspect, verify..... People with a certain understanding of what should be public health... Because of perceptions of power, many times all views do not come in. During the visit I was able to arrange, the JSS team – who are powerful in their own right – challenged several aspects of NRHM. They gave information of what is actually happening in their area. The state officers could ask questions, which forced the CRM team to begin thinking differently (JV).*

Respondents felt that the field visits were too short and rushed.

> *The time is too tight, Mission mode 3 to 5 days – more so for the JRMs than the CRMs. The CRMs were made 7 days long in the field, but that also did not work – people left the teams early after 3 days, and went back (PM).*

At least three key informants raised many ethical issues. 'The teams went off on a pilgrimage at the state's expense. Convoy of 6-7 cars, entertainment of the CRM team by the higher officials – food of your choice, hotel...and then on the side they would visit 2-3 PHCs'. Others questioned within the short time available for field visits, should priority be given to visits to temples? Some respondents mentioned that they felt uncomfortable with all the hospitality and attention being lavished upon them.

Debriefing Meetings

The CRMs ended with a debriefing meeting which consisted of presentations by states – state after state made repetitive presentations. Some states were prepared, others came without preparation.

> *'.... the Health Secretary and others sit on the podium and about 200 people sit in the hall, there is no scope for any dialogue on issues. There is no serious engagement with any focus issues or themes'.*

Another point of view was that the national level debriefing process was very consultative in terms of identifying critical gaps. At least two respondents stated that the Mission Directors and Joint Secretaries took the debriefing reports seriously. The state teams took the message – there was peer pressure created when the CRM teams presented state reports – and the subsequent year's state PIPs were influenced by the CRM reports.

Final Report and Recommendations

Respondents felt what is finally included in the report – and how – is an issue – 'all the critical issues are pushed into the annexure and the reports are watered down'. (AS).....'the person who wrote the report had advantage and was able to manipulate the contents'. (JV)

JV felt that CRM reports are considered with seriousness – they are used in the development of the state PIP. When the state PIPs are presented in the national mission directorate, the CRM report is again a reference document. '....Commissioned evaluation reports may not be looked at the way the CRM reports are'.

About implementation of recommendations, respondents felt that although specific recommendations are made they are never taken seriously. One person stated that the previous CRM reports should be the baseline.

'The recommendations are given to the 'government' but who is the government? The officers in charge get transferred there is a turnover within the government, subsequent officers do not feel responsible to implement the recommendations. Same recommendations keep coming up in each review'. (PM)

Gender Equity and Human Rights

Respondents felt that the understanding of gender and health issues is very uneven amongst health systems representatives. There is also a disjunct between policy makers'/ health administrators' understanding of gender and the feminist evaluator's understanding. Health officers believe that since they are working on Reproductive Health, Maternal Health, Institutional Deliveries, Janani Suraksha Yojana – all to do with women – since they have created a huge group of ASHAs all over the country, they are working with a gender perspective. There is no understanding of the fact that one could do all this with a bureaucratic, managerial mindset that is quite gender blind.

There is a macro and micro understanding of gender and health. The fact that JSY and JSSK have been implemented to reduce expenditure on women's health, and therefore reduce feminisation of poverty, is a gender and equity measure. But it is not recognised by many policy-makers and programme managers, neither articulated as such. Implementation of the PCPNDT Act, analysis of the Child Sex ratio, making these part of the ASHAs' training – are all gender measures. Within the resource constraints there are attempts to make services women friendly. In the field, the staff are addressing the poorest of the poor. The emphasis is on reducing out of pocket expenses (OOPE)(RV).

One respondent also felt that the health system is blind to gender based violence. In district hospitals' registers, there are rapes listed every two or three months. They are treated like any other case, maybe with more police involvement. This respondent tried to get gender based violence as a health issue into the ASHAs' curriculum and she found that it was very difficult – there was tremendous resistance from all quarters.

It appears that programme managers feel Human Resources for Health, Infrastructure, OOPE, Universal Health Care are all bigger priorities than the 'soft' issue of gender. 'Programme managers fail to realise that they can address those issues more effectively by using a gender lens'(RV).

According to another respondent (AS), a gender perspective would mean that issues of the women staff – ASHAs, ANMs, Staff Nurses and other women healthcare providers – would be explored and addressed. TN narrated that while in MP, she saw that institutional deliveries had increased so much that the Obstetricians were exhausted. CRMs should build in space for

this kind of feedback. Also women users' experiences of receiving health services should be sought – privacy, availability of toilets, and so on.

> *'In the first CRM, during the visit to TN, we visited 24x7 PHCs late at night – 9.30 -10 pm. The nurses were sitting there, but there was no rest room or duty room for them to lie down, or have their food. There was no compound wall, even though the PHC was in a remote area. This raises security issues for young women'(TN).*

PM who was part of both the CRMs and the JRMs felt that what is required is a greater understanding of Gender and Equity. Only stating these as principles is not enough – suitable interventions have to be designed. He felt that the RCH II framework and logframe translated Gender and Equity into clear interventions. The problem was that these sections of the framework were never referred to in the course of the implementation.

> *'There was little-buy in by the government about Gender – either to mainstream it or to promote it as a vertical area of emphasis. ... There was a Gender Working Group in RCH II like other thematic groups. But it was dissolved with the end of RCH II. The last two JRMs focused on Gender and Equity – a group was convened to put together a tool but it was never translated into something concrete that the reviewers could use in the field... At best it could be found in aspects of Maternal Health Quality – eg privacy'. (PM)*

Similarly understanding of Equity is uneven. RP felt that equity is a focus in all CRMs – all the teams do look at how the needs of SC and ST populations are being met. The selection of districts is also by the criteria of 'well performing' and 'poorly performing'. Some CRM teams – or individuals within the teams – are particular about going to the Dalit areas in the village during field visits, about checking the composition of the VHNSCs to ensure that weaker sections are represented, about checking the JSY lists to see who is getting the benefit. But all this is very individual dependent. PM felt that health officers reduce equity to 'vulnerable population that was hard to reach'. With this understanding interventions are reduced to Mobile Units and not investing in functioning Sub Centres or more ANMs. He stated that there is no capacity in the states for context specific planning.

PM also felt that promoting transformatory gender and equity norms has to do with communication and there is very little investment in IEC/BCC programmes.

JRMs

Each Thematic Area in the RCH II had a focal person in the Ministry. Gender and Equity had no focal person. 'This Thematic Area fell on the lap of the Director, Donor Coordination, who had no gender expertise'. We were told that in RCH II there was an attempt to collect

disaggregated HMIS data – both on Social Equity and on Gender. The NRHM removed all this, and stated that a common format had to be followed. The rationale was that it would be very difficult for the grassroots workers to collect disaggregated data and compile it and transmit it up the hierarchy. The rationale given was that the NFHS and the AHS would collect disaggregated data.

Two respondents mentioned that the later JRMs – after the Mid Term Review – became more focussed. The JRM started focusing on which thematic area was lagging behind – e.g. Gender and Equity, Quality of Care.

> *'The 6th JRM was very different... more focused – for example, operationalising of FRUs, and the Village Health and Nutrition Days etc., were the focus' (EG).*

After the Mid-Term Review, a framework/checklist was developed to monitor Gender and Equity, in order to institutionalize these aspects. Also, UNFPA developed a Toolkit on Gender and Equity which was never formally released/launched.

> *'The probable reason that it was never accepted was because there was no ownership in the Ministry. There was no one in the Ministry to steer the agenda....The Process Manual for each JRM had several checklists. Gender and Social Equity questions were integrated into each section – including Procurement and Finance. The Process Manuals were very good documents. There was also a PIP Process Manual – to review and appraise the state PIPs. This Manual was given to the states to help them develop the state PIPs and this manual also had Gender and Equity perspective integrated.*
>
> *Despite all this, Gender and equity continued to be low priority for the governments. The reason for this low priority was that there was no dedicated person in charge of this agenda, who was accountable for showing results.*
>
> *The design of the JRMs was good. The strategies may be good. But if no one will implement these what is the point?'*

Women's Health Issues

A few respondents talked about specific women's health issues from a gender and rights perspective. One person said that CRMs also need to monitor and highlight the pressure created by the 'Expected Levels of Achievement'. IUCDs are being inserted without knowledge of women – there is an 80% insertion rate of PPIUCD which is too high.

> *'Eighty per cent insertion rate is considered an achievement by the government and not a violation..... State method mix is not taken into account – why in Orissa the uptake of OCPs*

is high while in Andhra Pradesh sterilisations are high? These kinds of questions are not discussed' (AP).

While speaking about the new RMNCH+A Strategy (launched in October 2013), she pointed out that a Gap Analysis exercise was done, however, Gender figured nowhere in this. There is no focus on young people's needs – the ASHAs are told to target only newly married couples! The application of the Equity concept in the area of contraceptive services, would identify who are the marginalised with respect to contraceptives – both younger and the older age groups are excluded from these services.

Another respondent raised the issue of safe abortions. She remarked that there is no monitoring focus on Medical Termination of Pregnancy (MTP). And there are several reasons for this namely, 1. The PCPNDT Act has had an adverse effect by creating fear amongst healthcare providers that they are violating the PCPNDT Act if they provide safe abortion services. 2. Dilation and Curretage as an MTP method is a way for providers to earn an income, they have no interest in Medical Abortion (MA) which does not afford the same income earning opportunities. 3. Since doctors are not present in PHCs, women are consuming MA pills, without supervision which can lead to incomplete abortions. This calls for empowering nurses to prescribe MA. This key respondent raised the issue that MTP indicators that are not monitored with the kind of seriousness accorded to Institutional deliveries and JSY disbursements.

MTP is not on any monitoring checklist – no one is required to enquire into how many facilities are providing MA. They are required to enquire into how many JSY beneficiaries have they reached – how much has JSY expenditure increased (TN).

These respondents emphasised that using a Gender and Rights framework would also highlight women's health issues which are neglected and where violations are routine.

Recommendations by the Key Informants

Developing a vision of Gender: What does a gendered vision mean in practical terms for the health system? A policy document needs to be created drawing upon the excellent ideas in the RCH II PIP and Supporting Document. There should be at least a 5 year commitment by the government to implement this vision systematically.

'We need to communicate the gender mainstreaming ideas in different ways to management at different levels – national, state, district – to explain gender in a different language – language that is more understandable and does not make them defensive. Translate the gender philosophy into concrete doable ideas – eg Sexual Harassment Committees, defining women friendly services etc..... Don't do 'gender sensitisation' programmes, these make them defensive'. (PM)

A gradually expanding pool of trainers should be created: Capacity building for gender and health should not be restricted to the ASHAs and ANMs – it should be done at all levels, along the continuum from the frontline to the highest level of healthcare provision – including medical colleges. Institutional responsibility and accountability needs to be created. There has to be a designated officer in the Ministry for the implementation. These aspects have to be part of the monitoring framework. Institutionalization is also required through the state health training institutes – Gender and Equity concepts should be integrated in their training curricula and all the training modules. There should be a dedicated team in the institutions for the implementation of this agenda.

Equity perspective: There is need to redefine Equity to go beyond geographical accessibility. Access to health services of the transgender community and persons with mental illness is an equity issue. Also the elderly and people living with disabilities – accessible toilets for them.

CRM should be designed to include equity: This would then define selection criteria of visit areas - geographical access, access of marginalized groups. The CRM should be designed to capture all this information – unless an equity focus is there, the information will not be collected. One way of doing this is by collecting information directly from the marginalised people/communities. During the field visits, direct interaction with the community would be helpful.

Composition of the team: There should be mixed teams, with members from diverse backgrounds and expertise. Larger number of civil society representatives should be included. There should be a gender specialist as well as civil society representatives from the state being visited. There should be a restriction on the number of state level representatives – they should not overshadow the external team. Frontline health workers and panchayat members should be part of the team. As far as possible include a gender and equity expert. But since there are not many of this breed around, checklists are important.

Time: There should be enough time for preparation before the field visit. Given that field travel is time consuming the field visits should be longer.

The Methodology and the Process of the reviews need to have GE and HR aspects integrated across all areas – expenditure, resource allocation, programme management, technical areas. The TOR should include separate component of Gender, Equity and Accountability processes. Every CRM should have a focus, for example, functioning of ASHAs, or Human Resources/ workforce related issues, CRMs should not spread themselves too thin. CRMs should look at the processes also and not just input and output indicators. This is particularly important because the NRHM is being implemented in the mission mode.

There should be a methodology workshop before the CRM to get all the team members on the same page. Before the field visit, data should be given to the teams, they should have time to study this and the field visit should be used to ask 'why'. Field visits should build on earlier explorations of issues. There should be scope for small groups of the CRM team members to move around the villages without officials, only with local guides. There should be space for interaction with frontline staff without officials. Triangulation of data/information should be promoted. There should be a meeting with civil society organizations at the beginning of the state visit.

Also multiple sources of data and mixed methods should be used. Variety of tools can be used – Most Significant Change, Appreciative Enquiry and so on. Small studies which can feed into the review process should be commissioned and shared with teams. There should be clear and specific recommendations with time frames. The Secretary should be present in the final wrap up session – to take ownership for the follow up agenda.

The Debriefing meeting should ask 'hard questions' – like in the UN system there should be Concluding Comments that have to be responded to. The gaps identified in the previous CRMs have to be addressed and reported upon. And if this does not happen, questions have to be asked.

'The lack of learning culture around evaluation has to be changed. Evaluation should be empowering and not punitive. It should be forward looking. The art of problem solving should be built into the process'. (AD)

Tools: There should also be a workshop on Gender and Rights to evolve a tool that the CRM teams can use during the field visits. The toolkit should be relatively simple, include a few key points – like women's access to toilets, issues of the women workers – transport, remuneration, harassment by mukhiyas etc.? The checklist that was developed for RCH II should be revisited.

> *'We need to come out with something very, very practical on what is gender and equity at the Block level, the District level... the UNFPA toolkit contains these practical examples. DFID had produced a toolkit to assess the environment of health facilities – it was pictorial with very little written word – something practical like that should be produced. The toolkit should cover the entire cycle – how to plan from a gender and equity perspective, how to implement, how to monitor and evaluate... there should be a Process Manual and Checklists which contain Gender and Equity aspects. Also for PIP formulation and the budgets'. (EG)*

Indicators: These should be specified for different levels. And the TORs should mention the indicators to be tracked very clearly. The indicators should not just be quantitative – for example, it is not enough to find out how many ASHAs have received how much training – it is also

necessary to check the quality of the training from ASHAs recall or skill levels. Indicators for Gender and Equity should include rights of women workers.

There is a lot of disaggregated data available, but how is it used in programme management both at the central government and the state government levels? There has to be a utilization focus. The Annual Health Surveys are generating disaggregated data, but there is no capacity to analyse and interpret it and use it in programme management.

Dilemmas and Ethics: Respondents talked about dilemmas – for example, CRMs are seen as an avenue for passing on 'secret information' – 'people want to come at night to provide you information. The dilemma is – should this information be used without specifying the source? Should the identity be revealed?'

Another key respondent felt that CRM members should be asked to give a written and signed declaration that they will not accept any gifts or material benefits. Strict action should be taken if there is any lapse.

In conclusion, the key respondents felt that the CRM process is very important from an Accountability perspective. They stressed that the CRM should not be seen only a research process – it should also be an Accountability creating measure. Power as an issue within the CRM structure should be recognised – it comes in the way of collecting authentic information. Power issues need to be addressed both through the composition of the team as well as the way the process is designed. The several rounds of debriefing and consultation present in the CRM process are mechanisms that function as accountability mechanisms as well as mechanisms to mitigate the power issues.

Summary of Findings, Lessons Learnt and Recommendations

Summary of Findings

We first looked at the design of the NRHM, RCH II and the NHM to assess how HR and GE perspectives were incorporated in the design itself. We then examined the CRM and JRM ToRs and methodologies to see whether an HR and GE perspective was adequately reflected in these. And we also reviewed all the CRM and JRM reports to see how far this perspective was present in these reports. Three independent published evaluations were also reviewed. Findings from Key Informant Interviews were also included in this chapter.

We tried to use the UNEG framework and soon realised that it does not lend itself easily to 'review of reviews' or meta-evaluations. Therefore, we developed HR and GE criteria based on the NRHM's seven critical areas which formed the foundation of most official reviews as well.

The main findings of our review were:

- The NRHM Framework for Implementation though strong on equity and rights, did not have a clearly spelt out position on gender concerns. Although it can be argued that gender issues are subsumed within the quest for equity in NRHM, we find this not to be the case on close examination of the activities and expected outcomes of the NRHM. The CRMs in turn did not have a clear mandate to review the implementation of the Mission from a gender angle. In the RCH II Programme Implementation Plan, there was a clear vision of how a gender and social equity perspective can be incorporated in the design of the programme. So, JRMs were mandated to look at these aspects and each JRM Aide Memoir (report) had a section on gender and social equity. With the launch of the NHM in 2013, there has been a considerable shift in the gender sensitivity of the policy. The NHM is a well-thought out gender sensitive policy unlike the NRHM which was largely gender blind.
- There are no clearly spelt out Gender Equity and Human Rights indicators in the NRHM, in the absence of which members of the CRM teams may use their own understanding of Gender Equity and Human Rights to point out gaps or achievements, as the case may be, in these areas. It must be noted that this understanding could vary from reviewer to reviewer.
- In the CRM process, besides the ToRs, there is no mention of tools used for data collection during fieldwork. Checklists, interview schedules, discussion guides etc., if used in the review are not shared in the reports. The observations, document reviews, facility examinations, state/district level review presentations, interactions with the providers and users etc., if undertaken without any tools or explicit frameworks to assist the processes raises questions regarding the quality of data collected in the review missions. The JRMs, on the other hand, used a detailed Process Manual which included adequately spelt out ToRs, several checklists and formats for HR and GE analysis. The Process Manual and the tools evolved over subsequent JRMs and especially, after the Mid-Term Review of RCH II. The Mid- Term Review had well spelt out ToRs, methodology and specific tools for assessing progress on gender and social equity – the MTR report thus has a good HR and GE analysis and substantive recommendations to strengthen these aspects of health programmes.
- The CRM reports show that several gender aspects are looked at but these are uneven and not systematic.
- The CRM reports have been consistently stressing the need for curtains or screens in wards, examination area for ANC during VHNDs, screen around the examination table etc. Admission of men and women in the same ward is identified as a concern requiring

immediate remedial action in most CRMs. The seventh CRM report of 2013 recognises the vulnerabilities of the transgender community in urban India and states the need to address these through affirmative action. However, the CRMs have so far not reviewed the extent to which their transgender health needs have been addressed. Accommodation facilities for those accompanying women inpatients or inpatients from hard-to-reach or distant areas are not considered in any of the CRMs. The CRMs have dwelled to some extent on the issue of accommodation for the staff but have not demanded disaggregated information regarding cadre-wise allotment, type of accommodation, location, amenities provided. Although accommodation for ASHAs accompanying women to the institutions is identified as a necessity in the fourth, fifth and seventh CRMs, the reasons for the unavailability of rooms are not clearly stated in the reports. Only the fifth CRM team speaks of separate toilets for men and women in the review.

- About 'range of services' the focus remains on obstetric and immunization services. A few CRMs identified some abortion related issues – misuse of misoprostol by private practitioners, slow expansion of safe abortion services, lack of data on safe abortions etc. Concern regarding limited range of reproductive health services provided through NRHM has been expressed in the latter CRM reports. CRMs comment on the availability of abortion services or the lack thereof, but the experiences of women who have availed the services and those who were not reached or turned down also need to find some space in the review process. Sex disaggregated data on utilization of services for communicable and non-communicable diseases have not been reported in the CRM reports. The CRMs that mention efforts for malaria control, do not report on the incidence of malaria in pregnancy, or TB among women, iodine deficiency among women etc.
- Strategies for emergency care for vulnerable populations in hard to reach areas are not reviewed in detail.
- The CRMs do not report on the linkages between human resource shortages from a gendered perspective. The gendered needs of personnel vis-à-vis accommodation, transport, amenities etc., are only implicitly dealt with in the CRMs. It is unclear what a positive workforce environment implies and how it is experienced differently by men and women (or the third gender). Handling of sexual harassment cases at the workplace is mentioned only by the fifth CRM team. The payment of incentives for ASHAs is reviewed by all CRMs, however data related to delay in payments, scheme-wise incentives received etc., are not collected and shared in the reports.
- All CRMs have noted an improvement in the supply of drugs. The second CRM noted non-availability of MVA kits and patients being asked to purchase IV drip sets and sutures. All

the CRMs report on the availability and supply of IFA tablets in the reviewed states. The availability of different contraceptives including PPIUCD, ECPs and OCPs are reported from the reviewed states since the second CRM in varying degrees. Utilisation of untied funds provided to the RKS for providing free medicines to patients below poverty line was noted as a positive development. The adequacy of blood banks and blood storage facilities in the states are closely examined by the reviewers in the last few CRMs.

- CRMs report diligently on the use of IEC strategies in awareness generation regarding schemes and available services. None of CRMs report on IEC strategies addressing gender stereotypes or hierarchies in any detail.
- The assessment of PPP is primarily centred on the quality of care or services provided. The reviews, however, provide little information regarding the modalities of the PPP, the processes involved and how and if, it is different/better than public provisioning. It is important from a gender and rights perspective to report on the functionality and viability of each PPP. Outsourcing and subcontracting to private players with a profit-making motive could open up the possibilities of increased OOP expenditure.
- The CRMs comment on the adequacy of the convergence and coordination between departments. However, the reports thus far provide a limited qualitative understanding of the convergence and literally no analysis of the gender sensitivity of the schemes and programmes within the ambit of the intersectoral convergence undertaken.
- Most CRMs have not assessed patient and provider satisfaction with the public health system. Where this component is reported on, the method used to collect this information is not clearly spelt out. Further, mechanisms built into the system for recording patient/provider satisfaction or lack thereof, is mostly not reported in the CRMs. CRM reports should document or assess patient satisfaction based on the demography of the area served by facilities. Special focus on the experiences of the poor and vulnerable vis-à-vis the public health system should be ensured.
- The Project Implementation Plan (PIP) of RCH II includes some National Indicators for Health Equity but these are not referred to in any of the JRMs. The JRMs consistently look at process indicators like: commissioning of 24 X 7 PHCs, training of skilled Birth Attendants, training for Emergency Obstetric Care, use of disaggregated data as a basis for decentralised health planning, and so on. Incorporating a gender module in all training is mentioned in the later JRMs. Two other dimensions consistently reviewed are the Janani Suraksha Yojana and the Village Health and Nutrition Days – issues of quality related to these are raised in the later JRMs.

- An unpublished UNICEF study showed that only 21% of the total recommendations made by all the JRMs for thematic area Gender and Social Equity were implemented – and this was the lowest.
- While the JRMs brought up important gender issues like safe abortions and implementation of the MTP Act, related recommendations were not satisfactorily implemented – access to safe abortion services continues to be an issue. JSY was pushed even while health facilities were unprepared to provide quality maternal health services – quality of ANC delivery care and PNC is an issue even today. Although most recommendations for ARSH were implemented, the quality of the programme on the ground is a matter of concern.
- The Mid-Term Review provided valuable Gender and Equity checklists and tools that can be reviewed and refined for further use.
- The review of three national level evaluations of NRHM conducted in the period 2005-2012 by NGOs and/or government departments shed light on a gender-blind approach to assessment of the progress of NRHM. The evaluations are mostly of the functioning of facilities, delivery of services, financial management, formation of Village Health Sanitation and Nutrition Committees, selection of ASHAs etc. Disaggregated data by gender and community are not provided in these evaluations. Gender Equity and Human Rights concerns are not included in these evaluations much like the CRMs.
- Data from the interviews with Key Informants strongly reinforced the findings from our desk review. Key Informants commented on the composition of the review team, the process of the fieldwork which did not lend itself to inclusiveness and participation, time constraints etc. They gave some good recommendations for further engendering health programme reviews.

Lessons Learnt

This Meta-evaluation looked at seven Common Review Mission Reports of the NRHM and eight Joint Review Mission Reports as well as the Mid-Term Report of the RCH II. Three independent published reviews of NRHM were also included. Semi-structured interviews were conducted with nine Key Informants.

Some lessons learnt through this meta-evaluation are:

1. The methodology of the reviews is dependent on the degree to which the programme designs and frameworks incorporate a Gender Equity and Human Rights perspective – for example, in the RCH II Programme Implementation Plan, there was a clear vision of how a gender and social equity perspective can be incorporated in the design of the programme,

JRMs were mandated to look at these aspects and each JRM Aide Memoir (report) had a section on gender and social equity. The MTR of RCH II had clearly spelt out ToR and Methodology to review the progress on Gender and Social equity and the MTR report on this thematic area, yielded several important lessons and recommendations. The NRHM Framework for Implementation though strong on equity and rights, did not have a clearly spelt out gender perspective. The CRMs therefore did not have a clear mandate to examine the implementation from a gender angle.

2. While doing a HR and GE review it is important that the review team members have an understanding of gender power relations vis-a-vis different health issues. For example while Maternal Health is a sex specific health issue and therefore can be construed as a 'gender agenda', unless the gender power dimensions in Maternal Health are understood – e.g. Who in the family decides what the pregnant woman's JSY money will be spent on? Or, Who can decide whether a woman can go for an MTP? – the analysis can be incomplete and limited. Another example is while assessing malaria prevention strategies, are the reviewers asking questions about whether there is special consideration for pregnant women? An understanding of gender and health should not be restricted to the superficial notion of 'gender= women'. Gender transformative strategies should be sought.
3. There are some necessary conditions for effective evaluations from a HR and GE perspective and some desirable conditions. From our analysis the necessary conditions appear to be: (i) an explicitly stated gender equity and human rights framework, with these concepts defined and indicators/parameters to be assessed, (ii) a well defined, clearly stated methodology with sample checklists, guidelines and other kinds of tools that can be used by anyone after a basic orientation. These could be compiled into a Manual for Review of Health Programmes from a HR and GE perspective. The desirable conditions are: (i) a balanced team composition which includes expertise in HR and GE, (ii) ensuring processes that recognise evaluations and reviews as opportunities for learning and growth and processes that are sensitive to power differentials in an evaluation situation and ensure power sharing rather than an exercise of 'power over' (iii) an orientation programme for the CRM teams based on the Manual mentioned above.
4. The UNEG framework is useful to the extent that it can provide a way of thinking about evaluations. It can be used as a basis for developing Gender Equity and Human Rights criteria based on what is given in the programme to be evaluated. It should be treated as a guideline that can be played around with, that can be adapted, and not as strait-jacket methodology.

5. There already exist a few good tools and guidelines (Annexure 5 in this report and the RCH II MTR ToR and Process Manual) that can be reviewed and refined to form a resource pack for HR and GE sensitive health programme evaluations.

6. There are some larger questions about the 'success' of such evaluations – even well designed and effectively conducted gender and rights' sensitive evaluations may not always lead to implementation of recommendations. This is because they are political in nature, threaten to dismantle existing power structures and are to do with transformation of mindsets. 'Champions' are required, both within and outside of the health system, to persevere and sustain action on these agendas. Newer and newer strategies may be required.

Recommendations of the Meta-evaluation

1. Developing a vision of Gender: A policy document needs to be created, which can be the basis for at least a 5 year commitment by the government to implement this vision systematically. It is recommended that Gender Equity and Human Rights criteria and related indicators should be developed for the health system as a whole along with users and providers of health services. This will require some measures to institutionalise Gender Equity and Human Rights as core values – someone at the national as well as state levels whose mandate is to mainstream a GE and HR perspective within the health system. This person should then be held accountable for time-bound action that will contribute to the aforementioned mainstreaming. A gradually expanding pool of trainers should be created.

2. Capacity building for gender and health: should be done at all levels, along the continuum from the frontline to the highest level of healthcare provision – including medical colleges. Institutionalization is also required through the state health training institutes – Gender and Equity concepts should be integrated in their training curricula and all the training modules. There should be a dedicated team in the institutions for the implementation of this agenda.

3. Equity perspective: There is need to redefine Equity to go beyond geographical accessibility. Access to health services of the transgender community, persons with mental illness, the elderly and people living with disabilities, is an equity issue.

4. CRM should be designed to include equity: defined selection criteria of visit areas - geographical access, access of marginalized groups, design should capture all equity related information. Including triangulating information by directly collecting it from the marginalised people/communities.

5. Composition of the review teams: There should be mixed teams, with members from diverse backgrounds and expertise. Larger number of civil society representatives should be included. There should be a gender specialist as well as civil society representatives from the state being visited. There should be a restriction on the number of state level representatives – they should not overshadow the external team. Frontline health workers and panchayat members should be part of the team. There should be inclusion of gender experts and feminist researchers in each CRM team.
6. The Methodology and the Process of the reviews need to have GE and HR aspects integrated across all areas: expenditure, resource allocation, programme management, technical areas. A Resource Manual as suggested above should be developed – this should include Gender, Equity and Accountability processes. In addition to input and output indicators, it should include Processes. The Manual should be used in a Methodology Workshop before the CRM to orient all the team members. The teams should also be oriented to the vision and values of the review as well as the ethical requirements.
7. Teams should be given relevant data before the field visit, so that they have time to study this and frame further questions for the field visit. Selection of districts to be reviewed should be done on the basis of secondary data. The selected districts could be finalised in consultation with the state, if need be during the state briefing.
8. There should be an improvement of processes to ensure participation and inclusion: space and time for free interaction with CBOs, CSOs, panchayat members, as well as non-users of services so as to elicit diverse perspectives. Small groups of the CRM team members should be able to move around the villages without officials. There should be space for interaction with frontline staff without officials. There should be a meeting with civil society organizations at the beginning of the state visit.
9. Multiple sources of data and mixed methods should be used: Tools like Most Significant Change, Appreciative Enquiry and so on are useful methods to neutralise power relations.
10. The Debriefing meeting and Wrap Up session should be serious reflection based on field visit observations: Questions should be asked and answered – like in the UN system there should be Concluding Comments that have to be responded to. The gaps identified in the previous CRMs should be reported upon and addressed.

National programmes and schemes are difficult to review and assess owing to the sheer scale of the programme. Yet, reviews such as the CRM which are instituted within the programme should take measures to put in all possible checks and balances to ensure that the review is a meaningful exercise and at par with the scale of the programme itself.

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Annexure 1

CRM review teams and states visits

S.no.	Year	No. of reviewers	Profile of reviewers	States reviewed
1	2007	52	30 ministry officials - centre/state, 3 former union health secretaries, remaining public health experts working on NRHM	Andhra Pradesh, Assam, Bihar, Chhattisgarh, Orissa, Madhya Pradesh, Gujarat, Jammu and Kashmir, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh and West Bengal
2	2008	67	Each team comprising State/ Centre ministry officials, 1 Public Health expert, 1 representative of Development Partners, 2 representatives of civil society	Assam, Bihar, Chhattisgarh,Orissa, Rajasthan, Tamil Nadu, Karnataka, Kerala, Madhya Pradesh, and Uttar Pradesh, Jharkhand, Maharashtra, Mizoram
3	2009	96	Each team comprising State/ Centre ministry officials, 1 Public Health expert, 1 representative of Development Partners, 2 representatives of civil society	Bihar, Chhattisgarh,Madhya Pradesh, Orissa, Rajasthan, Uttarakhand, Uttar Pradesh, Meghalaya, Sikkim, Jammu & Kashmir, Andhra Pradesh,Gujarat, Haryana, West Bengal, Andaman and Nicobar Islands, Dadra and Nagar Haveli, Daman and Diu.
4	2010	130	40 government officials, 25 public health experts from academic or technical supportunits, 20 from civil society, 15 representatives of development partners, 30 Ministry consultants	Arunachal Pradesh,Nagaland and Assam, Chhattisgarh,Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, Uttarakhand, Punjab, Tamil Nadu, Maharashtra and Kerala
5	2011	171	72 governmentofficers, 36 public health experts, including 11 from civil society, 22 from DevelopmentPartners, 41 were consultants with the MOHFW, served as research associates, representatives from other government departments	Bihar, Chhattisgarh,Himachal Pradesh, Jharkhand, Odisha, Rajasthan, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Jammu and Kashmir,Assam, Sikkim, Andhra Pradesh, Goa, Gujarat, Haryana, Karnataka
6	2012	171	43 governmentofficials, 42 public health experts, 17 from civil society, 18 representatives of development partners and 51 were consultants working in the Ministry.	Bihar, Chhattisgarh, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand, Uttar Pradesh, Assam, Manipur, Tripura, Delhi, Kerala, Punjab, Tamilnadu andWest Bengal
7	2013	197	Each team comprising 3-5 Government officials, 2 Public Health Experts, 1-2 representatives from Development Partners and 1-2 civil society representatives visited each State	Andhra Pradesh, Arunachal Pradesh, Bihar, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Karnataka, Maharashtra, Meghalaya, Nagaland, Odisha and Uttar Pradesh

Source: Compiled from CRM reports

Annexure 2

Themes reviewed in the CRMs

Themes	CRM 1	CRM 2	CRM 3	CRM 4	CRM 5	CRM 6	CRM 7
Improvements in Service Delivery	✓	✓	✓	✓	✓	✓	✓
Reproductive, Maternal, New born and Child Health Programmes	✓	✓	✓	✓	✓	✓	✓
Disease Control Programmes	✓	✓	✓	✓	✓	✓	✓
Human Resources for Health including Training	✓	✓	✓	✓	✓	✓	✓
Community Processes and Convergence Issues	✓	✓	✓	✓	✓	✓	✓
Information and Knowledge	✓	✓	✓	✓	✓	✓	✓
Financial Management	✓	✓	✓	✓	✓	✓	✓
Medicine and Technology	×	✓	×	×	×	×	✓
National Urban Health Mission	×	×	×	×	×	×	✓
Governance and Management	✓	✓	✓	✓	✓	✓	✓
Coverage of outreach services	×	✓	✓	✓	✓	✓	
Action on Social Determinants and Equity concerns and Promotive Health Care	✓	✓	✓	×	×	✓	×
Infrastructure development	×	✓	✓	✓	✓	×	×
Gender and PCPNDT Act	×	×		×	✓	×	×
Procurement system	×	×	✓	×	✓	×	×
Mainstreaming of AYUSH	×	×	×	×	✓	×	×
Assessment of case load handled by the Public Health system	×	✓	✓	×	×	×	×
Quality of services	×	✓	✓	×	×	×	×
NGO partnerships	✓	✓	✓	×	×	×	×

Source: Compiled from CRM reports

Annexure 3

List of Key Informants

Sr. No.	Name	State	Year
1	Dr A S	Madhya Pradesh	2007
		Maharashtra	2010
2	Dr A D	Uttarakhand	2009
		Assam	2010
3		Assam	2012
	Dr J V	Chhatisgarh	2008
4	Dr P M	Chhatisgarh	2008
		Meghalaya	2009
5	Dr T N	Bihar	2007
6	Dr. R P		
7	Dr. A P	Development Partner	
8	Dr. R V		
9	Ms E G	Development Partner	

Annexure 4

Key Informants Interview Guidelines

For CRM members

1. How many CRMs have you been part of and when?
2. How many JRMs have you been part of and when?
3. Can you tell me about the process of the CRM you were part of? Composition of the team? The preparation? During CRM what happened? Post CRM?
4. Similarly, can you tell me about the JRMs that you were part of? Composition of the team? The preparation? During JRM what happened? Post JRM?
5. What Gender and Equity Indicators did the CRM/JRM look at?
6. What data did the CRM/JRM consider? What were the sources of this data?
7. If you were part of more than one CRM/JRM did you notice any difference in methodology?
8. Can you comment on the implementation of recommendations?
9. What are your suggestions to make CRM/JRM, more Gender and Equity sensitive?
10. Any other comments?

For RP

1. You were in NHSRC and had a role in designing the CRM. Tell me about it.
2. What do you think were the strengths and weaknesses of the CRM design from a gender and equity perspective? How were these perspectives meant to be incorporated?
3. Were you yourself part of any CRMs? JRMs? If yes, which ones?
4. Process of CRMs? Composition of the team? The preparation? During CRM what happened? Post CRM?
5. Where can I find the TORs? Tools?
6. What Gender and equity Indicators did the CRM/JRM look at?
7. What data did the CRM/JRM consider? What were the sources of this data?
8. Can you comment on the implementation of recommendations?
9. What are your suggestions to make CRM/JRM, more Gender and Equity sensitive?
10. NHM document? Monitoring framework?
11. Who else do you think that I should interview?

For EG and AP - Development Partners

1. You are in a Development Partner organisation. What is your perspective on the CRMs and the JRMs?
2. Were you yourself part of any CRMs? JRMs? If yes, which ones?
3, What do you think were the strengths and weaknesses of the CRM design from a gender and equity perspective? How were these perspectives meant to be incorporated?
4. Process of CRMs? Composition of the team? The preparation? During CRM what happened? Post CRM?
5. Where can I find the TORs? Tools?
6. What Gender and Equity Indicators did the CRM/JRM look at?
7. What data did the CRM/JRM consider? What were the sources of this data?
8. Can you comment on the implementation of recommendations?
9. What are your suggestions to make CRM/JRM, more Gender and Equity sensitive?
10. Who else do you think that I should interview?

Annexure 5

JRM 6 - ANNEX 3.5

Checklist To measure equity and gender

Measuring Equity

Disaggregate D data

- Collect Sex disaggregated data for access to services, e.g. RTI/STI services
- Collect Social group disaggregated data in cluding SC, ST, Minorities and other locally vulnerable groups along with BPL for services and performance listed in list below

Performance during January to December 2008.

If possible compare with performance before it started functioning as fully operational 24X7 PHC (Review Records/Obtain Data). Also collect data across different social groups mentioned above.

	Total	%BPL
1. Number of deliveries in the facility • normal • assisted (Forceps delivery/Vacuum) • caesarean section		
2. Number of live Births		
3. Number of post natal visits (at facility and athomes by workers)		
4. Number of neonatal/infant deaths in the facility–get causes if possible		
5. Number of maternal deaths in the facility–get causes if possible		
6. Number of maternal cases given blood transfusion		
7. Number of MTPs • MVA • EVA • D&C		
8. Number of sterilizations • Male (conventional/NSV) • Female(Laparoscopic) • Female(Minilap)		
a. Number of FP Spacing Methods b. IUD insertions; c. OP cycles d. Condoms		
10. Number of cases of RTIs/STIs treated		
11. No of laboratory investigations		

Process

- VHND-Ask how access to remote, Dalit or Tribal population as is ensured
- Processes which undermines access and representation of socially marginalized groups to services at the level of services providers it can be related to minds ets, behaviour patterns, quality of services, timings, location, etc.

Gender and Community Responsive Checklists

There are four elements suggested here for assessment.

i. Gender and Community Responsive Checklist for 24x7 PHCs
ii. Gender and Community Responsive Checklist for FRUs
iii. Short interview with patients
iv. Essential Reproductive Health Services for women

Check List for 24X7 PHCs

Date _____ Name/ Address of Facility _____

Name of JRM team member _____

	Specifications	Yes/No
1.	Infrastructure and general supplies (Observe)	
	▸ Separate men and women toilet.	Yes No
	▸ Clean toilet with stored/running water.	Yes No
	▸ Signboard to indicate toilet etc.	Yes No
	Availability and use of screens/partition in the examination room to maintain privacy	Yes___ No___
	Display of ▸ Citizen's/Patient's chart outlining patient's rights ▸ Services available ▸ Rates charged for chargeable services, if any	Yes No Yes No Yes No
	Comfortable waiting space with seating arrangement and drinking water for ▸ OPD patients ▸ Women in labour/IPD patients waiting to be admitted	Yes___ No___ Yes___ No___
	Grievance redressal mechanism displayed with name of person to contact in case of complaint	Yes___ No___
	Labour Room (Observe a part from other technical aspects)	
	Additional women toilet attached to the labour room	Yes___ No___
	Sink with running water in labour room	Yes___ No___
	Clean Mackintosh and linen is provided for labour table	Yes___ No___

2.	Key Delivery Related Services for women	
	Vehicle available and used for transfer of women in maternal health emergency (see records)	Yes___ No___
	Delivered women are admitted for minimal 48 hrs post delivery (see records)	Yes___ No___
	Proportion of doctors and ANM strained in Skilled Birth Attendance out of total number posted there	Doctors:___ out of_____ Nurses: out of
3.	Safety and security of women staff (Observe and ask)	
	Separate toilets with water for female staff	Yes___ No___
	At least one Doctor has quarters on the premises and stationed at the facility	Yes___ No___
	At least one ANM has quarters on the premises and stationed at the facility	Yes___ No___

Check List for FRUs

Date _____ Name/ Address of Facility _____

Name of JRM team member _____

	Specifications	Yes/No
1.	Infrastructure and general supplies (Observe)	
	▸ Separate men and women stoilet. ▸ Clean toilet with stored/running water. ▸ Signboard to indicate toilet.	Yes No Yes No Yes No
	Availability and use of screens/partition in the examination room to maintain privacy	Yes___ No___
	Display of ▸ Citizen's/Patient's charter outlining patient's rights ▸ Services available ▸ Rates charged for chargeable services, if any	Yes No Yes No Yes No
	Comfortable waiting space with seating arrangement and drinking water for ▸ OPD patients ▸ Women in labour/IPD patients waiting to be admitted	Yes___ No___ Yes___ No___
	Grievance redressal mechanism displayed with name of person to contact in case of complaint	Yes___ No___
	Labour Room (Observe a part from other technical aspects)	
	Additional womens toilet attached to the labour room	Yes___ No___
	Sink with running water in labour room	Yes___ No___
	Clean Mackintosh and linen is provided for labour table	Yes___ No___

2.	Key Delivery Related Services for women	
	Vehicle available and used for transfer of women in maternal health emergency (see records)	Yes___ No___
	Delivered women are admitted for minimal 48 hrs post delivery (see records)	Yes___ No___
	Proportion of doctors and ANM strained in Skilled Birth Attendance out of total number posted there	Doctors:___ out of_____ Nurses: out of
3.	Safety and security of women staff (Observe and ask)	
	Separate toilets with water for female staff	Yes___ No___
	At least one Doctor has quarters on the premises and stationed at the facility	Yes___ No___
	At least one ANM has quarters on the premises and stationed at the facility	Yes___ No___
	If resident duty is by rotation, is there a room for the night duty doctor to stay?	Yes___ No___
	If resident duty is by rotation, is there a room for the night duty nurse to stay?	Yes___ No___
	Mechanisms operationalised to address harassment including sexual harassment at workplace ▸ Vishakha Guidelines Committee established to address sexual harassment ▸ Board in local language displaying name of person to address complaint ▸ Were there any complaints?	 Yes No Yes No Yes No
	Specifications	
	▸ How were they handled?	
4.	Use of untied funds	
	Were untied funds utilized in the last year to bridge any of the above gaps? (note)	
	Probe for reasons for any gaps (Funds, Lack of priority etc.)	

	Specifications	**Yes/No**
	▸ How were they handled?	
4.	**Use of untied funds**	
	Were untied funds utilized in the last year to bridge any of the above gaps? (note)	
	Probe for reasons for any gaps (Funds, Lack of priority etc)	

Patient/Exit Interviews

To the extent feasible, interview 2 or 3 patients at the facility/those leaving the facility. Ask about issues such as:

- In case of delivered women/women who had come for delivery ask how and in which vehicle they travelled to the facility
- Quality and promptness of services
- Infrastructure: Could they access clean to ilets? Did they get a bed promptly with clean linen? etc.
- Availability of in formation, drugs, any payments-formal/informal which had to be made to access services?
- Behaviour of service providers
- Knowledge of and Access to Grievance redressal

Essential Reproductive Health Services

1.	**Services**	First trimester safe abortion services available regularly Yes _____ No _____ Other _____	Family Planning services provided regularly at facility during PNC and regular OPD (not camp sterilizations) Yes _____ No _____ Other _____	RTI/STI services for women and men available on regular basis Yes _____ No _____ Other _____
2.	**Trained Doctor/ ANM available**	Yes _____ No _____ Other _____	Yes _____ No _____ Other _____	Yes _____ No _____ Other _____
3.	**Supplies**	For Medical Abortion, MVA, Equipment for D&C available as per guidelines (inspect) Yes _____ No _____ Other _____	OCPills, ECpills, Condoms, IUDs, sterilization supplies available as per guidelines (inspect) Yes _____ No _____ Other _____	Essential Anti biotics for RTI/STI available as per guidelines (inspect) Yes _____ No _____ Other _____
4.	**Laboratory services**	-	-	Yes _____ No _____ Other _____
5.	**Trained Laboratory Technician**	-	-	Yes _____ No _____ Other _____
6.	**Board announcing service in local language**	Yes _____ No _____ Other _____	Yes _____ No _____ Other _____	Yes _____ No _____ Other _____
	Other facilitieses sential from women "sperspective	Is Husband's consent essential for abortion? Yes _____ No _____	FP Counsellor/trained ANM stationed Yes _____ No _____ Other _____	Partner Management Practices followed Yes _____ No _____ Other _____

Mid Term Review – Process Manual

Checklist # N

Tool for Assessing Social Equity and Gender Mainstreaming in RCH II

Social Equity and Gender Objectives	Key Issues	Indicators
A. What are the actions undertaken by the States for provision and access to quality health services for women/ adolescent girls/ SC/ ST/Minorities (particularly Muslims) 1. Setting the social group and gender equity objectives 2. Service access and availability 3. Service Quality	1.1 Reduce gender and social group gaps in health outcomes. 2.1 Increase in the availability of women and Primary Health providers belonging to disadvantaged social groups such as SC/ST/Minorities (particularly Muslims) 2.2 Removing information and knowledge barriers that prevent women/ adolescent girls/socially disadvantage groups to seek or access health services behaviour 2.3 Improving progress in of performance bonus for equity 3.1. Moving technology and skills closer to socially disadvantage groups and women 3.2 Reducing economic barriers to increase SC/ ST/ Minority women and adolescent girls access to health services 3.3 Making services responsive and accountable to women/ adolescent girls and socially disadvantaged group's needs. 3.4 Service environment Client provider interaction 3.5 Informed decision-making	1.1.1 Vulnerable social groups identified and barrier to access health services analysed (both rural and urban) 1.1.2 Social group and gender equity indicators to measure change included in annual plans 1.1.3. Specific strategies to reach socially disadvantaged groups been evolved and implemented 1.1.4 States and districts reporting against gender and social group disaggregated indicators 2.1 % increase in number of SC/ST/ minority health workers; % increase in women doctors/ nurses/ ANM's in rural areas/ planned deployment of staff to maximize social acceptability/Gender needs of female staff addressed through ensuring safety and security measures, transfer/ posting norms; 2.2. Increase in socially relevant IEC material, social mobilization; and community education on issues of maternal and child health; 2.3. 1 Districts plans with specific activities to reach socially disadvantaged groups designed and being implemented. 2.3.2 DHAP data collection as per schedule. 3.1.1 Improve/ draw down quality health services/facilities (below the set norms) by SC/ ST/Minority population. Increase in functional health facilities and equipped sub-centres; Wider range of MCH, FP, safe abortion and RTI/STI services available; transport facilities Budget allocations to finance RCH services such as JSY (% of total budget); 3.1.2 Increase in trained and skilled ANMs and other health workers in remote and other areas with poor provision of health services (SC / ST villages, Tolas, Hamlets) particularly in the EAG states. 3.1.3 Resource allocation based on districts /areas/ social groups with poor health outcomes both within EAG states and otherwise

		3.1.4 G/E mapping of infrastructure and facilities in states and districts. 3.2.1 List schemes supported by the State to ensure Affordable services, flexible payment options, emergency transport and care; women centred health financing (micro-credit, health insurance) 3.2.2 Budget allocations for ARSH (attention to adolescent girls – married and out of school) and marginalized groups. 3.2.3 Policy on user charges, exception policy for SC/ST/ BPL users agreed and displayed 3.3.1 Check for the following at the services health centres: Ensuring privacy, confidentiality and basic amenities such as electricity, water, separate toilets for women; 3.4.1 Community education on client rights and community monitoring programmes supported 3.4.2 Representation and involvement of CSOs working with Women, SC, ST, Minorities in service planning and delivery process 3.5.1 Health services information displayed on PHC walls, Local Panchayats, in distant and remote hamlets/ villages of socially disadvantaged groups.
B. How have the social Gender equity issues been mainstreamed in RCH 2 Training Programmes 1 Gender Training Programmes (Stand alone)	1.1 GT being a priority 1.2 Trainings to address: Use of sex disaggregated data across different social group of health outcomes, gender across different social groups sensitive indicators, gender and social equity monitoring (to monitor that the services provided are gender and social group friendly as defined in service quality and access above), documentation and gender inputs in management and health communication and follow principles of organizing gender sensitive training programmes;	1.1.1 Budget allocations and expenditure reports; 1.2.1 .Content Analysis of the Training manuals and training reports 1.2.2 Gender training include other dimensions of social inequity and discriminations. 1.3.1 Trainers Pool with expertise in Gender, Social Inclusion and health issues. 1.3.2 Civil society perspectives included in trainings; Trainings organized to suit the requirements of female staff; ensured equal male and female participation 2.1.1 GBV Protocols developed to provide appropriate healthcare; Training provided on it 2.2.1 All national training and workshops related to RCH-II include content on vulnerability and social exclusion. 2.2.2 Topics of care of the girl child included (nutrition, healthcare, declining girl child ratio) in IMNCI and other trainings such as ASHA's

2. Gender and social equity mainstreaming in all health trainings	1. 3 Human Resources for conducting trainings And follow principles of organizing gender sensitive training programmes 2.1 Integration of GBV as a health issue 2.2 All Trainings/ Training Manuals include relevant gender and social issues 2.3 Capacity building of IEC staff on integrating gender and equity dimensions in BCC 2.4 Capacity within health delivery system to deliver services to socially disadvantage groups	2.3.1 Examples of gender and social group sensitive BCC material such as use of gender neutral language, social and cultural sensitive messages, messages to address men and women. 2.4.1 Capacity building of ANMsand health workers priorities in remote and areas with poor provision and health outcomes. 2.4.2 Training and sensitization of health providers (particularly paramedic/ nurses/ ANMs) on issues of stigma/ discrimination/ social exclusion.
C. How has the issue of sex selection been addressed in the programme areas of the State?	Creations of awareness among the officials on the issue Institutional Arrangements to address the issue specifically Integration of the issue in IEC/ BCC material Trainings: Integration of issue in all trainings Tracking of Data on disparity in sex ratio Research Integration in Medical and nursing curriculum	Number of events organized to create an understanding on the issue Operational PNDT cell Strategy development by the Department to address the issue Resources allocated for creation of specific material on the issue Training Manuals include the issue e.g. ASHA training modules, maternal health and child health training modules. Information system (such as HMIS) includes indicators on sex ratio e.g. indicators tracking birth order, sex-disaggregated data on infant mortality etc. Special studies and research collaborations for tracking regional disparities within state relating to sex ratio Identification and support to women facing pressures for sex selective abortions by health providers
d. How has GBV as a health issue been addressed?	Trainings Integrate issues of GBV Institutional mechanisms to address GBV as health issue IEC and BCC integrating the issue Support Programmes and Research	Health providers identifying and providing appropriate services to women facing violence Providing 'GBV as a health issue' service protocols for maternity, RTI, ARSH and other RH services; ensuring documentation of medico legal cases, providing appropriate referral services to women facing violence BCC strategy addressing GBV as health issue; Material produced to address men on issues of VAW NGOs' supported to work on GBV as a health perspective; Research studies supported

e. Other Innovations	1. Examples of innovations undertaken to address Gender issues in RCH 2. Examples of innovations under taken to address social group equity	1.1 Pilot projects addressing issues of Gender 2.1 Pilot projects addressing issues of social equity
f. Programme Management	1. Human Resources policy 2. Guidelines against Sexual Harassment (Vishakha judgement) 3. Ensuring Knowledge base	1.1 Addressing Staffing issues (e.g. improving female staff to female supervisor ratio) and Gender issues of health service providers 1.2 The recruitment criteria and priority appointments within underserved communities and areas 2.1 Committee to address Sexual Harassment cases established at various levels (block, district, State), number of cases registered, resolved; 3.1. Concerned Technical divisions such as MH, ARSH, FP, CH, M&E – capacity building on gender and social equity mainstreaming as ongoing initiative
Institutional Mechanisms	1. Institutional Mechanisms in place to address Gender equity issues in RCH II 2. Gender and social equity Budgeting	1.1 Gender Focal point in the Ministry/ Department PCPNDT Cell- budgetary allocations, activities and expenditure; Performance appraisal of providers reflects Gender-RCH priorities 2.1 Gender Budgeting capacity building; GB reporting 2.1.1 Criteria for allocation of budget include differences in health outcomes.
	3. Monitoring and Evaluation system relating to Gender and social equity in RCH II	3.1 Specific Gender indicators to track progress on Gender issues; MIS to track gender data; Budgetary allocation and expenditure on gender issues; Pilots and innovations addressing Gender issues 3.1.1 Social equity and access indicators included in the MIS

Generic questions for discussion with State/District/frontline functionaries:

- What kinds of indicators have been used to monitor the programme? Do they assess comprehensiveness of services? Is there, for example, a balanced emphasis on promoting available FP methods in providing a basket of options to the client?
- What is the process of integrating social equity issues into the planning, management, monitoring and programme accountability?
- What are the mechanisms for regular reporting of progress on integrating social and gender analysis and actions at the state, district and community level?

- Are there any proposed strategies and provisions in the state plan that address issues such as child sex ratio, age at marriage, involvement of men and inter-sectoral coordination?
- Are there planned mechanism for greater outreach and information dissemination to the community for greater awareness and utilization of services? For example, broadening the role of community based volunteers, displaying - rate charts (to know which services are at cost and which ones are free), facility timings, ANM outreach visit schedule, development of patient charters (the Rajasthan model – charters have been developed up to CHC level and charter for PHCs is in the pipeline).

Basic Criteria to assess mainstreaming of gender issues in state plans for RCH II

Gender needs of female staff addressed

- Responsibilities allocated for safety and security of ANMs and other female staff (committees formed, revamped, activated with mechanism for periodic monitoring of status on ground)
- Mechanism to rework transfer/posting norms towards greater availability of ANMs at sub-centres

Gender issues in institutional mechanisms

Staff

- Allocation for increase in the number of female staff per facility, esp. sub-centre
- Plan to improve the female staff to female supervisor ratio (including mobility of LHVs)
- Plan to rework sub-centre jurisdiction norms to represent coverage of given geographical area rather than population covered (geographical coverage for outreach activities made realistic and service access also improved)
- Gender focal point within the department of family welfare

Improving facilities (for improved access, outreach and coverage)

- Plan and budget allocation to ensure basic amenities at esp. at sub-centres such as electricity, water, toilets
- Budget allocations made for training, equipment and supplies for a wider range of services at primary level (complete antenatal and postnatal care, skilled attendance at birth, IMCI/IMNCI for neonates and children, preventing unsafe abortion, a wider range of reversible contraception, the management of RTIs and counselling for HIV prevention)
- Specifically, budget allocation for necessary equipment for improving access to services at the primary level – labour rooms, MVA equipment, speculums, light source, health cards

(ANC, checklists for copper-T insertions, partogarphs, etc.), blood storage, drugs for BEOC in PHCs/CHCs, along with drugs for IMCI treatment and RTI management

- Budget allocations for 24-hour PHCs and making sub-centres remain open always (alternatives for ANM home visits, leave vacancy of field posted ANMs, etc. explored)

Training

- Plan and budget allocation for integration of gender issues in training of service providers. To start with, specifically provision for orientation of managers and trainers on gender, economic inequity and rights, and on concrete ways to deal with them to improve access to service delivery

Gender issues and stakeholder involvement/decentralized planning

Health financing

- Provision and easy access to emergency transport funds (how much and where it is located –SHG, Panchayat, PHC)
- Provision for innovative health financing made in terms of voucher based subsidies to poor households, availability and ease of access to insurance coverage especially for maternal complications, MTP, infertility treatment, emergency obstetric care etc.
- Provision of funds to micro-credit groups to cover health needs specifically of women and children

Community interface for improved service delivery and utilisation

- Proposed PRI/SHG involvement in CNA for prioritizing community needs
- Proposed devolution of health funds (%) to Panchayats for health governance
- Proposed communication and networking through community and women's groups for improved RCH outcomes (e.g. health messages through SHGs- A.P. model, strengthening of Mahila Swasthya Sanghs, health action groups and community health dialogues – providing platforms for interface between providers and women and community)
- Provision of adolescent friendly health services (inclusion of adolescents boys/girls, married and unmarried, out-of-school and in-school for SRH education and service provision)

Innovation

- Provision for innovative approaches to making services client –centred (24 hour help counters at district hospitals for assisted referrals, helplines for emergency transport- Tamil Nadu approach, improving ANM/supervisor mobility, etc.)

Generic questions that need to be asked for ensuring an overall gender perspective in the state plans

- What kinds of indicators have been used to monitor the programme? Do they assess comprehensiveness of services? Is there, for example, a balanced emphasis on promoting available FP methods in providing a basket of options to the client?
- Are there any proposed strategies and provisions in the state plan that address issues such as child sex ratio, age at marriage, involvement of men and inter-sectoral coordination?
- Are there planned mechanism for greater outreach and information dissemination to the community for greater awareness and utilization of services? For example, broadening the role of community based volunteers, displaying rate charts (to know which services are at cost and which ones are free), facility timings, ANM outreach visit schedule, development of patient charters (the Rajasthan model – charters have been developed upto CHC level and charter for PHCs is in the pipeline).

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Contributors

Prerna Goel Chatterjee has worked extensively in the field of outdoor education and has conducted programmes on communications, team building and leadership with young adults. She has done her Masters in Education from LaTrobe University, Australia and is a Certified Coach from Coach for Life. She has worked with Prof. Vimala Ramachandran on various research projects. Along with that, she is also a faculty with the capacity building unit of ASER Centre, where she conducts workshops on Communications and Leadership.

Shraddha Chigateri works as a Research Fellow at the Institute of Social Studies Trust and leads the project on Engendering Policy through Evaluation. She completed her doctoral research on Dalit feminist politics in Bangalore in 2004 from the University of Warwick, UK after which she taught for a few years at the Universities of Warwick and Keele in the UK before joining ISST.

Priya John is a Senior Research Officer with the Centre for Enquiry into Health and Allied Themes (CEHAT). She has worked extensively on issues of access to health services for vulnerable and marginalised populations. In the past, she has undertaken research studies related to women's health in rural Jharkhand. She has a Masters in Gender and Development from the Institute of Development Studies, Sussex University and was awarded the Young Champion of Maternal Health Fellowship in 2013 by the Maternal Health Task Force at the Harvard School of Public Health.

Tanisha Jugran is a Research Associate with the Institute of Social Studies Trust, New Delhi since January 2013. She has a Masters in Economics and has worked on several Evaluation and Research projects on a variety of subjects including women's empowerment , childcare, youth and adolescent girls. She was part of an International Development Research Centre (IDRC) and Ford Foundation funded project on 'Engendering Policy through Evaluation' and was involved with the training component of the project, with a view to facilitating the development of the gender and evaluation resource pack. She was also part of an International Labour Organization (ILO) funded project on 'Development of a Self Assessment Tool for Domestic Workers on Decent Working Conditions using Community Life Competence Process(CLCP)' and worked on the preparation of the self-assessment tool and training module for facilitators on using the CLCP approach to develop a self -assessment tool for domestic workers.

Renu Khanna is a feminist women's health and rights activist. She is the founder of SAHAJ (Society for Health Alternatives) based in Vadodara. In 1992, along with others she started the

Women's Health Advocacy Cell in the WSRC, MS University, Vadodara which evolved into a vibrant interdisciplinary centre called WOHTRAC (Women's Health Training, Research and Advocacy Centre). She has been a part of Shodhini, a feminist women's network that authored *Touch Me Touch Me Not: Women, Plants and Healing* (Kali for Women). She has also coedited *Towards Comprehensive Women's Health Policies and Programmes*. She has been an Erasmus Mundus scholar and taught at KIT, Amsterdam and Queen Mary University, Edinburgh. She continues to a member of several pro-people's networks like Jan Swasthya Abhiyan, PUCL, Medico Friends Circle etc.

Ranjani K. Murthy is a researcher and consultant working on issues of gender, poverty and health. She has around two decades of experience in capacity building and evaluations from a gender and equality lens. She has facilitated evaluations on behalf of NGOs, government and UN agencies around gender, agriculture, micro-finance, disaster, adolescent girl empowerment, violence and maternal and child health. She has brought together gender-sensitive participatory evaluation methods that she has used, in a book titled, *Toolkit on Gender-sensitive Participatory Evaluation Methods* published by the Institute of Social Studies Trust (2015). In the past, she has facilitated national and international workshops on 'Socialist Feminist Theory of Change', 'Change Matrix' and 'Feminist Monitoring and Evaluation', and has co-authored a manual on *Institutionalizing gender within organisations and programmes* (2007) with Mercy Kappen (produced by Visthar). She is on the editorial board of the journal Gender and Development.

Rituu B. Nanda loves strength-based and participatory practices and has acquired experience in community development, monitoring and evaluation, knowledge management, and participatory action research. She is particularly interested in the aspect of learn in M&E. Her primary sector of work has been public health. Under the project "Engendering Policy through Evaluation" she facilitates the international online community of Practice-Gender and Evaluation http://gendereval.ning.com

Rajib Nandi is Research Fellow and Office-in-Charge at the Institute of Social Studies Trust, New Delhi. He has been working with the organization since 1998. Rajib has conducted a range of research and evaluations funded by the government, UN agencies and the other national and international donor agencies. His areas of interest include gender and development, livelihood issues of poor urban communities, youth development, ICTs, research and evaluation methodologies and programme evaluations.

Ratna M. Sudarshan is Former Director, Institute of Social Studies Trust, and a member of the Board of Trustees, ISST. As Director, she initiated ISST's work on feminist evaluation and remains associated with the project.

Vimala Ramachandran is the Director in Educational Resource Unit (now known as ERU Consultants Private Limited) – a unit created in 1998 as a network of researchers and practitioners working on education. From 2011 to mid-2015 she was a National Fellow and Professor of Teacher Management and Development in NUEPA. She has been engaged in research on elementary and secondary education focusing on gender and equity issues, teacher status and motivation and systemic barriers to realising the equity goals of national policies and programmes for elementary education, adult literacy and continuing education. She has also been engaged in researching educational needs of out of school youth – especially girls. She is based in Delhi.

Engendering Meta-Evaluations: Towards Women's Empowerment

This volume on engendering meta-evaluations is motivated by the recognition that in a large and diverse country programme outcomes can vary widely, and therefore that looking across a range of evaluations of the same programme in different contexts can offer valuable insights. These meta-evaluations do not have the primary intention of forming a judgement on the quality of project evaluations. They are focused rather more on different methods and frameworks that can help first, in drawing out the gendered outcomes of large national programmes in different contexts and second, in identifying any recurrent patterns that have implications for programme design.

This is the second in a set of publications by ISST on feminist evaluation seeking to share information on the values, ethics, methods, tools and approaches of feminist evaluation in a range of domains, and is an output of the project on 'Engendering Policy through Evaluation: Uncovering Exclusion, Challenging Inequities and Building Capacities' (2012-15) that has been supported by the IDRC, Canada and the Ford Foundation, New Delhi. The other publications in the series are a *Toolkit on Gender-Sensitive Participatory Evaluation Methods*, and an Evaluation Resource Pack for Training Purposes (forthcoming).

The Institute of Social Studies Trust (ISST) is a non-profit NGO, registered as a trust in New Delhi. Since 1980, ISST has been conducting research for social change with a focus on livelihood, work and well-being of vulnerable communities from a gender lens. Its scope of study includes macro-level policy research to micro level action research as well as evaluative research, in India and beyond. ISST aims to bridge the gap between research, action and policy with objectives of promoting social justice and equity for the underprivileged. (For more information, kindly visit the following links: http://www.isstindia.org/, http://www.feministevaluation.org/, and http://gendereval.ning.com/)