



Recognizing Connectedness

The Practice of Feminist Evaluation

RAJIB NANDI
RATNA M. SUDARSHAN

ZUBAAN ACADEMIC



ZUBAAN

128 B Shahpur Jat, 1st Floor

New Delhi 110049

Email: contact@zubaanbooks.com

Website: www.zubaanbooks.com

First published by Zubaan Publishers Pvt. Ltd 2021

© This collection Zubaan Publishers Pvt. Ltd. 2021

© Individual essays with the authors 2021

All rights reserved.

ISBN: 978 93 90514 39 7 (paperback)

ISBN: 978 93 90514 44 1 (ebook)

Zubaan is an independent feminist publishing house based in New Delhi with a strong academic and general list. It was set up as an imprint of India's first feminist publishing house, Kali for Women, and carries forward Kali's tradition of publishing world quality books to high editorial and publishing standards. Zubaan means tongue, voice, language, speech in Hindustani. Zubaan publishes in the areas of the humanities, social sciences, fiction, general non-fiction, as well as books for children and young adults under its Young Zubaan imprint.

Ebook conversion by Digiultrabooks Pvt. Ltd

Contents

Introduction

Ratna M. Sudarshan and Rajib Nandi

1 Girls' Agency in 'Delaying Marriage': A Gender, Caste and Sexuality Perspective

Aditi Arur

2 Evaluating Policies and Programmes that Address Sexual Harassment: A Feminist Deconstruction Framework for the Indian Context

Anukriti Dixit and Navdeep Mathur

3 Dilemmas of Being a Padhulikhi Ladki: A Study of Girls' Education in Eastern India

Manika Bora

4 Impact Evaluation of Women's Collectives: Applying a Gender Lens

Niti Saxena

5 Evaluation Methods to Uncover Gender Related Perspectives Post-ICPD: An Analysis

Neetu Purohit and Nutan Prabha Jain

6 Power Shifts: Lessons from Evaluating a Programme that Engages Young Men

Sonal Zaveri

7 Falling out of Pocket: Insights from Gendered Health Research of a Publicly Funded Health Insurance Programme in Tamil Nadu

Rajalakshmi RamPrakash and Lakshmi Lingam

8 Beyond Safety: Understanding Open Defecation Programmes through a Feminist Lens

Mahima Taneja and Anjali Krishan

Notes on Contributors

Evaluation Methods to Uncover Gender Related Perspectives Post ICPD

*An Analysis**

NEETU PUROHIT and NUTAN PRAPHA JAIN

Introduction

The International Conference on Population and Development (ICPD) took place in Cairo in 1994. It brought together the subjects of population and development into a complementarity. Up until then, development advocates had favoured the idea that development was the best contraceptive and had promoted it as a necessary precondition to sustained fertility decline whereas proponents of population asserted that family planning services had to be implemented to meet the high demand for fertility control, which they believed existed. The ICPD took giant strides toward resolving this conflict by placing the population problem squarely within the development context and emphasizing individual needs instead of demographic targets. (Pachauri 1999). The ICPD located people's rights at the heart of development. It affirmed sexual and reproductive health as a fundamental human right and emphasized that empowering women and girls is the key to ensuring the well-being of individuals, families, nations and the world. The advancement of the human rights perspective on reproductive health with gender roles in development was a major step forward for the population debate at the time.

The ICPD Programme of Action provided a comprehensive plan for promoting gender equality and empowering women. Chapter IV of the ICPD Programme of Action titled, 'Gender Equality, Equity and Empowerment of Women', outlines a wide range of actions that governments, the private sector, international organizations and non-governmental organizations should take to promote gender equality, equity and women's empowerment. The areas for action include, among others, women's participation in political life, education, fulfilment of women's rights, enabling women to earn, eliminating violence against women, including female genital mutilation, eliminating discrimination against women in the workplace and in international organizations, facilitating women's ability to combine work with child rearing, enforcing national laws and international conventions concerned with women's rights, ensuring women's property rights and legal rights to inheritance, providing infrastructure and other investments that will lessen women's domestic burdens, and strengthening women's civil society groups (Program of Action, ICPD 1994).

Some sections in a number of chapters of the ICPD document (chapters IV, VI, VII, VIII, IX and X) specifically deal with issues of gender in health and the well-being of people. In addition to the actions identified in Chapter IV, the Programme of Action outlines numerous areas where a special focus on the needs of women and girls is required. Examples include improving women's status as part of the actions to address population growth (Chapter VI); meeting the special needs of young women as part of promoting the well-being of children and youth (Chapter VI); paying special attention to the needs of elderly women (Chapter VI); ensuring that reproductive health care systems meet the needs of women (Chapter VII); recognizing women's physical and socioeconomic vulnerability to sexually transmitted diseases, including HIV/AIDS, and giving special attention to women and girls in programmes designed to prevent the spread of these diseases (Chapter VII); supporting women's role as primary custodians of

family health (Chapter VIII); promoting breast feeding and ensuring safe motherhood (Chapter VIII); offering special protection to displaced women (Chapter IX); eliminating discriminatory practices against women migrants and specifically protecting women who migrate as family members from abuse or denial of their human rights (Chapter X); and providing particular support to refugee women (Chapter X).

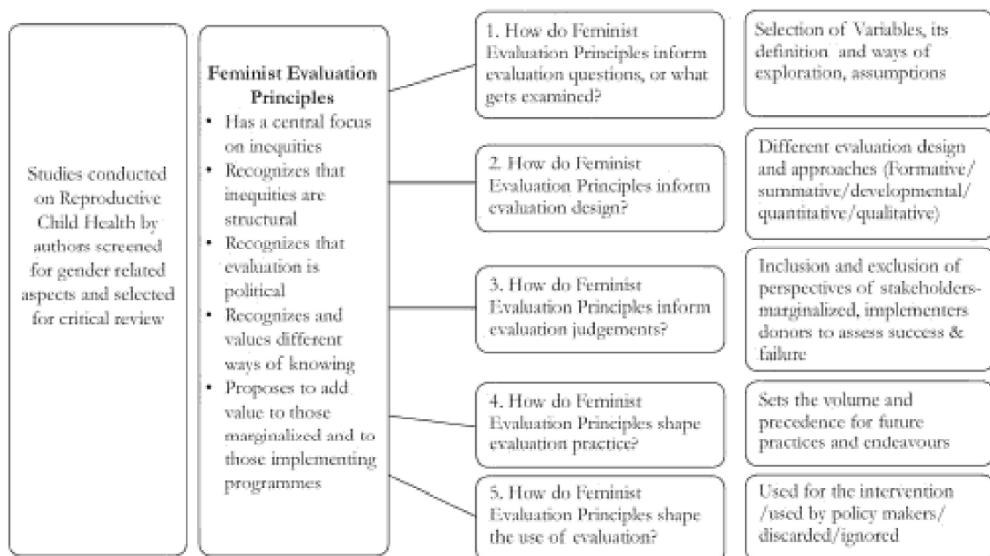
In line with the ICPD Programme of Action, governments of various countries set out an ambitious agenda to deliver inclusive, equitable and sustainable global development. This agenda has guided policy and helped secure advances in equality and empowerment for women, global health and life expectancy, as well as education for girls. After the ICPD, India too approached the issue of population stabilization from the perspective of reproductive rights and health and launched the Reproductive and Child Health (RCH) programme. It was also explicitly acknowledged that a conducive environment for a small family norm can be created by ensuring gender equality, empowering women and improving their status through education.

Several public and private development agencies conceived and conducted evaluation studies and surveys to assess various aspects of gender related to reproductive health as covered in different chapters in the Programme of Action of ICPD.

Conceptual Framework

Feminist evaluation does not provide a framework or advocate a precise approach; rather, feminist evaluation is often defined as a way of thinking about evaluation. (Podems 2010; Beardsley & Hughes Miller 2002; Hirsch & Keller 1990; Hughes 2002; McRobbie 1982). Figure 1 shows the conceptual framework used for writing this essay. The Feminist Evaluation Principles and five questions corresponding to the stages in the evaluation process appeared in an article (Hay 2012a) and these form the base of this essay. The evaluation studies selected for the review were critically analysed according to this evaluation framework and how it changed pre and post ICPD.

Figure 1: Feminist Evaluation Principles and Five Questions by Issues



Feminist Evaluation Principles and the Five Questions

Since Feminist Evaluation Principles have a central focus on inequities in society and recognize that inequities are structural and also that evaluation is often a political activity, the concept accepts and values different ways of uncovering reality and in the process proposes to add value to the marginalized

and to those implementing programmes. It is against this backdrop that evaluations are expected to change in terms of:

1. Inclusion of variables which get examined, the definitions of variables, testing of assumptions, explorations and queries.
2. Feminist evaluation is not one design or one set of methods, but a lens or a standpoint that influences the choices made in design and methods. A rigorous feminist evaluation would be one that would use the range of methods that best match the variables to be measured/questions around the type of change the policy or programme is addressing. Individual methods per se are not 'feminist' or non-feminist; their suitability (and rigour) in any given evaluation is a function of their ability to generate valid and reliable data that speaks to the nature and change around the inequity the programme is attempting to address. Thus it leads to the use of different research designs and approaches, qualitative or quantitative or both.
3. Figuring out whether something works or not often entails first articulating what 'working' - or success - might actually look like. The concept of feminist principles does this. Based on the above principles, feminist evaluation defines and identifies whether policies, programmes, projects, or organizations are successful or not.
4. Unlike positivist approaches, feminist evaluation starts with the idea that knowledge is constructed and shaped and the principle of evaluation should add value to those who are marginalized as well as to those who are actively part of gender and development work; all of these ideas come out as reflections and learnings and set the pattern for future endeavours.
5. A frequently raised challenge in feminist evaluation is the evaluator's responsibility to act on their findings. These pathways are sought and taken by evaluators with an understanding of the nature of evaluations as political and negotiated. Sometimes the evaluation findings become instrumental for bigger change-programmes or implementation, at others they may lead to policy change but all too often, they remain limited to reports and are discarded.

Using the evaluation framework (Figure 1), this essay traces the changes in evaluation queries on gender issues in reproductive and child health and identifies the probable reasons for such changes. The authors conducted a number of evaluation studies and surveys over a period of two and half decades which attempted to explore gender along with health issues. In their experience of conducting the studies, the authors witnessed change in the terms and terminologies, questions, the mode of asking questions, the interpretation and use of evaluation findings. Along with the evaluation studies conducted by them, National Family Health Surveys were also considered to tap the change.

The experience of conducting these studies led to cumulative capacity-building too for the authors and they attempted to bring their increased knowledge on gender related aspects to bear on subsequent evaluations. In this, they were in line with literature that states that space for reflection by the evaluator is also necessary (Khanna 2012); they also introspected on their own biases and fears in designing, interpreting, and presenting their findings. This essay, which is perhaps reflective of the journey of many others who have worked in gender and reproductive health, is based on the authors' experiences.

Objectives, Methodology, Results

This essay is based on a review of the evaluation studies conducted in the domain of reproductive and child health (RCH) with reference to gender aspects. Owing to high morbidity and mortality attached to its poor status, RCH was given the highest priority by the health system, though international pressure in improving the services cannot be denied.

A total of 25 studies conducted by the authors for reproductive and child health for different public and private agencies were selected initially for consideration. After preliminary scanning with regard to gender aspects, 18 studies were included in which some changes post ICPD could be identified for inclusion. The authors took into account National Family Health Survey (NFHS) findings of all four rounds to substantiate and address the objectives of this essay. NFHS is the most prestigious survey, equivalent to the Demographic Health Survey (DHS) conducted across countries and it has some consistency as four rounds of NFHS have been conducted so far in a period of 25 years. In many cases, it sets the precedent and is used as reference and guide by those working in RCH. Most national and international agencies quote it and even borrow the questions included in it for their own evaluation studies and surveys.

Though it is a survey, it works as an evaluation for all the schemes and programmes being implemented as it is an assessment of status with respect to knowledge, acceptability and utilization of reproductive and child services by the community.

A review of the evaluation studies conducted by the authors over two decades helped in identifying the reproductive and child health issues and concepts related to gender and feminist theories. For identifying the probable reasons for the specific wording and subsequent change, the concurrence of experts to the emerged aspects was taken into account. Principles of feminist evaluation (Hay 2012) were considered for deliberation and discussion using the Delphi technique for collating different perspectives.

Table 1 (Annexure 1) shows all the studies which were considered for inclusion in the review to meet the proposed objectives. The studies were screened for questions related to gender and feminist orientation in RCH, education, and development. Those that fulfilled the criteria were selected. In addition, NFHS 1-4 were also included as they become a reference point for almost all studies/evaluations done in reproductive and child health.

For addressing the objectives, a comparison was done by categorizing the studies into three groups of an eight-year period each. For the year 1994, when ICPD was held, only NFHS 1 has been kept and it has been subsequently compared with other rounds of NFHS conducted in different periods in the last 25 years. Other than these, from 1994 to 2002, two studies have been considered; from 2002-2010, five studies and from 2010-2018, nine studies have been considered and compared. The distribution of identified studies itself is an indication that as the years progressed, the gender issue was increasingly incorporated and that is why the authors could identify more such studies in later periods.

Perspectives, Terms and Issues in Evaluation Studies of Reproductive and Child Health post ICPD

Inclusion and Revision in Theoretical Perspectives

Among many contributions of the ICPD, the attention paid to sexual and reproductive health and to population planning was intended to enable women to manage their own fertility safely and effectively by conceiving when they wanted to, terminating unwanted pregnancies, and carrying wanted pregnancies to term; to have a healthy and pleasurable sexual life free of disease, violence, disability, fear, and unnecessary pain or death associated with sexuality and reproduction; and bear and raise healthy children when and as desired. This was, indeed a great move towards acknowledging the role of gender in development.

Before the Cairo conference, reproductive health was synonymous to family planning and maternal care. While under family planning, the biggest concern was the unmet need for contraception, under maternal care, it was ante-natal care, women's age at childbirth and post-partum care. Owing to high infant mortality, childcare was an important issue, but the focus was limited to breast feeding promotion, nutrition, immunization, growth monitoring, and care during sickness. Post ICPD, the focus expanded from family planning to a more comprehensive programme of integrating population and health activities that would help individuals meet their reproductive health needs. It emphasized improvement in women's equality in education, health and economic opportunities and also involved men as equal partners in meeting the goal of responsible parenthood. In addition to a shift to a rights-based approach, there was a shift away from macro concerns at the population level for reduction in its growth for achievements of stabilization to micro concerns at the individual level for improvement in well-being (Alongkone Phengsavanh 2011).

Another major introduction was the definition of reproductive health. Building on the World Health Organization's (WHO) approach to defining health, the ICPD Programme of Action defined reproductive health in broad and holistic terms as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the

right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. Further, it also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases (WHO 2008).

In view of the above definition, a paradigm shift was needed for operationalizing reproductive health programmes. In the context of India, a change in focus from a population control approach of reducing numbers to a client-based approach of addressing the reproductive health needs of individuals, couples and families, was needed. Hence, the scope of population policies which had thus far been mainly concerned with fertility reduction was expanded to include an emphasis on reproductive health, reproductive rights and gender equity. To achieve these, two major challenges had to be addressed. First, it was necessary to create an understanding of the paradigm shift, that is, a reconceptualization of the population problem by all stakeholders - from a focus in the past on achieving method-specific contraceptive targets, often using coercive means, to providing client-centered, quality services. And second, redesigning service delivery programmes to effectively address the reproductive and sexual health needs of people, based on community needs assessment.

RCH approaches were initiated to translate the promises made at Cairo into policy and programme actions in India in October 1997. The change signalled major reform as the existing target-oriented approach had done considerable harm to the objective of population stabilization and it was felt that a needs-oriented approach was a better option. The virtual stagnation in India's population growth during the Census periods between 1971-81 and 1981-91 (average annual growth rate hovering around 2.2 per cent) was perceived by many as a failure of India's family planning programme, urgently requiring stringent measures. The centralized planning and target-oriented family planning approach had not worked partly because it allowed little innovation or flexibility (Planning Commission 1992). The approach pursued thus far did not stabilize population; the quality of health care services suffered and the health and contraceptive needs of couples remained unmet. However, the measures taken post-ICPD were much lauded. All state population policies recognized that after the ICPD, India approached the issue of population stabilization from the perspective of reproductive rights and health and launched the RCH programme. The states also explicitly acknowledged in their policy documents that a conducive environment for a small family norm could be created by ensuring gender equality, empowering women and improving their status through education (Visaria et al. 2006).

As far as the experiential learning of the authors is concerned in this transition period, the most important was the emergence and application of various theoretical perspectives in the health field to accomplish the objectives of ICPD. While some could be implemented in full breadth, others were modified to gain acceptance.

One aspect is about reproductive health itself which includes sexual health too. Culturally, talking about sex is a taboo issue in India. The sexuality aspect in reproductive health got support from many HIV/AIDS related studies. These studies focused on safe sex and hence many issues, neglected thus far, got integrated into the evaluation studies and the relevant information could be collected. While the implementing agencies were still successful in interacting with adults and couples on safe sexual health, this theoretical perspective met with resistance and couldn't be incorporated in the desired manner into the schools for adolescents. The importance of sex education notwithstanding, it remained neglected with no takers, neither parents nor teachers. As a result, sex education was partially incorporated under family life education to ensure parental acceptance and schools and the subject remains neglected even now.

A review of studies post ICPD shows that after this conference, research was not limited to family planning and maternal and child health. Subjects such as adolescent reproductive and sexual health, women's right to health, abortion, infertility, reproductive tract infections, sexually transmitted diseases, child marriage, sex ratio and child sex ratio, gender-based violence, and gender mainstreaming were also included.

Integration and Modification of Issues in Evaluation Studies: What Gets Examined?

Post ICPD, many new terms acquired currency in different research and evaluation studies that were conducted in reproductive and child health. The scope of research studies/surveys and evaluation studies broadened in many ways as it assimilated aspects that had thus far been neglected or just touched upon by the agencies.

NFHS 1 was conducted in 1992-93, just before the ICPD conference and the subsequent NFHS 2, NFHS 3 and NFHS 4 were conducted in 1998-99, 2005-06 and 2015-16 respectively. The comparison shows the changes which occurred after NFHS 1 and could be attributed to the occurrence of ICPD. NFHS 1 is a reference point for pre ICPD.

Firstly, the very first question of marital status was changed post ICPD and in subsequent NFHSs. In NFHS 1, the response categories included currently married, separated, widowed, divorced and never married. Henceforth, the categories included currently married, married but *gauna* not performed, separated, deserted, divorced, widowed and never married. The shift was probably to give scope for the other categories of women who too have their reproductive needs. While all the response categories introduced after NFHS 2 were retained till the last NFHS 4, the important shift occurred after the first two NFHSs. From NFHS 3 onwards questions on reproductive and child health were added for women who were never married too.

It was encouraging to note that many issues that were missing in NFHS 1 were integrated in NFHS 2. For example, questions were asked on health worker visits in the last 12 months and the different issues which were discussed, as well as the time of the last visit. The woman respondent was also asked who visited her the last time and what type of services she received and importantly, about both the length and quality of the interaction. These questions tell us about the inclusion of an important component, the *quality* of care, and not simply care itself which was the focus in earlier surveys. In previous surveys the sections were on reproduction and contraception and only the care received for family planning methods was rated, in the later surveys, the focus of the evaluation became holistic in line with the new definitions of reproductive health.

This shift in thinking is in line with the ICPD which specifically focused on population concerns within a human rights framework—creating a key shift in the population debate at that time. It succeeded in replacing a macroeconomic perspective on population policy and focused instead on a woman's need to receive appropriate reproductive and sexual health care (within a functioning health system) and to control the timing of her pregnancies.

Similarly, the pregnancy and breastfeeding section in NFHS 1 was given a new name: 'antenatal, natal and post-natal care' in NFHS 2. In addition to the questions which were in NFHS 1, others were added relating to whether all the required check-ups were performed during ANC (Q 411, NFHS 2) and the desired advice was given to women who availed of the service (Q 412, NFHS 2). While the question relating to the place of delivery was posed to women in NFHS 1, in NFHS 2, the options of place of delivery were increased (Q420, NFHS 2) and women were further probed about why they did not take the help of health professionals (Q424). NFHS 1 limited itself to the place of delivery but from NFHS 2 onwards, the reasons for domiciliary delivery (Q 42, NFHS 2) were also investigated. Similarly, in NFHS 1, the inquiry is only for post-delivery complications but from NFHS 2 onwards, the inquiry relates to the entire post-natal period.

Finally, as far as use of contraceptive/family planning methods is concerned, NFHS 1 included questions about contraceptive methods, the problems, if any, faced with the current method, the quality of care for sterilization and follow-up. From NFHS 2 onwards, the respondent was asked if she had discussed the problems with anyone and if so, who that person was. The response categories included health and service providers in addition to husband and friends and relatives. This inclusion probably further expanded the accountability part in addition to the quality of care as highlighted in the ICPD document.

From NFHS 2 onwards, the response categories on the question on non-use of contraception were also further categorized into fertility-related reasons, opposition to use, lack of knowledge and method-related reasons (Q 357, NFHS 2). This question was important as it helped identify the most pressing reasons, which in turn could help make evidence-based strategies for promoting family planning methods.

Questions are also being raised on what contraceptives are available in the market. The fact that these are mostly for women in a way pressurizes them to use them. Men do not feel the pressure particularly for spacing methods as there are no pills or injections available for men. This is in line with feminist evaluation principles, particularly the fourth and fifth principles (stated above), which show that women are being marginalized as compared to men. The politics is such that the external market scenario is content with making men a part of reproductive health just by encouraging spousal communication and increasing sensitivity. The desirable thing would be the availability of long-lasting contraceptives in the market for men too so that women alone are not required to bear the responsibility of contraception. The evaluation studies reinforce the responsibility of women by repeatedly putting the same question on regularity and continuity of family planning methods – despite some health hazards – to them. The evaluation studies never ask women if they would want men to take the responsibility of contraception. Expecting women to be taking drugs for an act in which men are equal partners defeats gender and feminist principles. This situation continues to this day.

In view of the change in subsequent years in the way survey evaluations posed questions, from NFHS 3 onwards, separate sections were added on marriage and cohabitation, contacts with health personnel, children's nutrition, women's nutrition, utilization of ICDS services, sexual life and household relations. This exemplifies the need to ask different questions in changing situations. This need was recognized as ICPD included these things in its document and India, as a signatory to this document, was required to consider them.

In addition to NFHS 3, NFHS 4 also included one important aspect: the use of threat to force sexual acts. This comes under the category of household relations (Q 1107, NFHS 4). An option in the form of brother/step brother was added as a response category in the question asked to those who were forced to have sexual intercourse or any other sexual act. (Q1127, NFHS 4). This inclusion reflects what is happening in society today.

Jealousy and anger are two very different emotions and do not necessarily result in similar behavioural reactions; different approaches are required to understand them. With respect to questions on violence, women were asked if their partner had acted violently as a result of anger or jealousy. The blunder of putting them together (Q 1105, NFHS 4) was committed because of a lack of in-depth understanding of the issue. It is crucial that the evaluation team is sensitive to issues of gender and social relations, and is competent to capture them. The defense might be that the violence which ensues and the number of women facing violence is important; this is perhaps logical but not in alignment with feminist evaluation principles. According to our understanding, the very act of recording this information is an attempt to not only understand the situation and probable reasons for it but also to do something to correct it. If the scenario is not understood correctly, the strategy that results will also be faulty. Both in the literature and culture, these two emotions have been accepted as different and therefore need to be recorded separately.

As per the ICPD document, special efforts were also to be made to emphasize men's shared responsibility and active involvement in responsible parenthood and sexual and reproductive behaviour. While in NFHS 1, men were not included in the survey, from NFHS 2 onwards, there was a separate survey tool for men. This was in line with the ICPD document. It was observed that questions such as whether the father was present in any of the ante-natal check ups (NFHS 2, Q 416) were integrated after ICPD.

In the questionnaire for men, in NFHS 3, the section on marriage and sexual life was modified, by the time of NFHS 4, to marriage and co-habitation. This again is an example of both the assimilation of the definition of RH in the ICPD (where the partner is important) and also a reflection of societal norms where the concept of a live-in partner is increasingly being accepted.

While differences between men and women are being recognized, the inclusion and exclusion of certain aspects is also indicative of gender-biased or gender-neutral norms. The NFHS 4 questionnaire for men and women has been taken to comment about the current/most recent scenario. Unwanted pregnancies are an important area. Interestingly, while women are asked whether their last pregnancy was something they wanted or whether they would have preferred to wait, (NFHS 3, Q405), it has not been felt necessary to question men about this and thus a question pertaining to this is missing from the men's survey. This is a necessary question to put to men, for in a patriarchal society, it is mostly men who are the decision-makers. Further, a question relating only to whether the pregnancy was wanted or not is an incomplete one for the pregnancy/child may well be wanted but it is necessary to know by whom –

behavioural aspects, questions were asked by narrating small situations and small counting problems to tap their decision-making power, financial literacy, banking ability. (Baseline Survey of Adolescent Girls' Initiative (AGI) in Selected Blocks of Udaipur District, Rajasthan 2014)

The biggest lacuna in evaluation studies on the reproductive health of adolescents could be in terms of a gender bias which did not give as much importance to adolescent boys as it did to adolescent girls. While it is clear that the status of boys is relatively better than that of girls, it is also important to understand that in reproductive health, the support system of boys is equally bad or rather poorer than that of girls.

How Were Issues Explored and with Whom?

The following sections attempt to represent the importance of the mode of queries, their effect on consequent interpretations and the changes which followed owing to increased sensitivity and understanding of gender issues. This is based on the observations of the authors who conducted the studies.

A project was implemented on 'Women's Health, Rights and Empowerment' (1997-2002), to build the capacities of NGOs on concepts such as reproductive health, sexual health, reproductive rights, sexual rights, and women's empowerment. CBOs were involved for collecting and tracking quantitative data on select indicators of women's health, rights and empowerment according to their education, occupation, marital status, caste etc. What was not realized was that women are not a homogenous group and need to be understood in their situational context. What is recognized now – that similar educational attainment by women may not be associated with the similar reproductive patterns as it varies by gender relations between partners, family members, and even by social and gender norms – could not be recognized at that point in time. Capacity was thought to be built by following the 'giving mode', the 'teaching mode', the approach was to spoon-feed women about what works rather than learn from them. Despite the realization that social inequities are a reality, the principles of feminist evaluation could not be appreciated and a conventional approach was followed for capacity building. Instead of quantitative methods, qualitative ones better capture the nuances of gender power relations and the ways in which they govern women's reproductive health and would have truly built the capacity of NGOs. Literature too states that role plays and focus group discussions (FGDs) work well in evaluations which intend to excavate barriers at family, community and school levels (Ramachandran 2012).

A study entitled 'Women Right to Life and Health' was conducted in 2002 in the middle group of eight years. The rights perspective was given considerable importance and to realize it, efforts were made to enable the meeting of technology, management and a rights-based approach for safe motherhood. The study covered three districts of Rajasthan and the funding agency worked to ensure the reach of technology via adequate infrastructure and supplies. To facilitate the bringing in of attitudinal change among the medical staff, the management concept of Appreciative Inquiry was used. Before this time, the approach was akin to the welfare mode so services were provided for the welfare of the people. In this study the basis was an integration of rights, management and technology and how it can improve health services for women. The discourse focused on the ensuring of reproductive health services as rights of women rather than as a favour which was something emphasized in the ICPD conference too. This realization led to keeping of women/clients as a central focus. The study also investigated the reasons behind inequities and paid attention to listening to women through the use of qualitative methods. The attempt was to help the medical staff appreciate every person who was responsible for providing services, to become accountable and to provide services not as a favour but as a right of the clients/women. The initiative could show positive changes which were reflected in improved maternal health in the districts where interventions were made.

A different study entitled 'Building Local Leadership in Reproductive Health with a focus on the convergence of Panchayati Raj Institutions and Self Help Groups', (2004-2005), emphasized capacity building for women who had managed to secure a political position through reservations but could not become empowered. This was a time when '*Sarpanch Pati*' (husband of the sarpanch) became a popular term and it began to be understood that the inequities could not be so easily addressed as they were structural. This could be viewed as a study which attempted to consider a few feminist evaluation principles and showed capacity-building as an important tool to add value to the marginalized and those expected to implement programmes, in other words women SHG members and women PRIs.

The role of funding agencies is important in deciding both the scope and specificities of evaluation studies. In a project entitled 'Gender Elements Mainstreamed in State and District Health Plans and Program Interventions' (2009-10), the DLOs/ BLOs (District/Block Level Officers) were interviewed on their perspectives on health needs and health complaints and community representation by type and proportion in men, women, adolescents and children. Further, seeking their views on the provision of contraceptive and abortion services for unmarried adolescents, sexual violence faced by men and women (rape, injuries, forced masturbation, anal intercourse, oral sex, etc.) could be possible as the funding agency was specifically interested in gender issues and wanted to investigate health issues from the gender perspective. This would not have been possible had the agency not been sensitized to the subject. Thus, for once, we saw a clear mainstreaming of gender in all plans.

In this study, once the material had been collated and interpreted, it became clear that there was a lack of knowledge among key officials, the agency was informed of it. As a result, a capacity-building training was held to orient health care providers and managers on gender mainstreaming. In view of the feminist principles, this was one example where the evaluation results were put to good use.

In the same vein, Pragma, a qualitative study on multi-sectoral gendered approaches to improve family planning and reproductive health, was conducted in 2010-2011. The idea was to gather evidence about the extent to which the PRACHAR project, which focused on gender-sensitive approaches to behaviour change communication for reproductive health, and referring to vocational educational sectors, enabled decision-making to delay marriage among adolescents. The uniqueness of this study was that gender operations were looked at retrospectively for the project already completed as the agency realized that they had missed capturing gender in their previous study and through this one they wished to collect information on three major domains: changing trends about men's and women's roles; education and work; and marriage. Since a qualitative approach was used, one of the important stakeholders who played a role in early marriage was identified. Usually, attempts are made to sensitize parents to prevent early marriages: this study identified the role of the maternal uncle as instrumental in the early marriages of nieces. Customarily, maternal uncles conduct some key rituals and ceremonies (e.g. the ritual called *Bhaat*, whereby the maternal uncle of the girl provides gifts in cash and kind to his sister and her in-laws as well as the groom's family). Since this custom-laden responsibility involves financial implications, it pushes maternal side to prefer arranging early marriages. The sooner the uncle is free of this responsibility, the more attention he can give to his own children.

The next year (2011-12), the authors conducted an evaluation on birth registration, 'Counting the Girl Child: Base-line and end-line survey ensuring rights to the girl child through birth registration in rural and urban areas.' The evaluation addressed the issue of low birth registration of girls as the birth certificate was being advocated as a tool for child protection (prevention of child marriage and trafficking). In civil registration and vital system (CRVS), birth registration was used to calculate the number of births registered by sex out of the total births that had taken place. It always revealed a lower birth registration level for girls because a fewer number of girls were born. The learning in the previous project on mainstreaming gender helped the authors to develop relevant denominators to capture a more accurate picture. A gender-sensitive approach for data analysis allowed the birth registration rate to be calculated using different denominators for boys and girls such as the number of girls registered out of number of female births.

In a study on 'Reaching out to Youth in Secondary Schools in Bihar with Information and Skills for Improved Health and Well Being: A Baseline Survey, 2009-2010 (AEP)', it was noticed that the response categories (Q 18, AEP) were not exhaustive and restricted the responses which could be given. For example, the question, 'who do you talk to?' listed certain personal and sensitive things, the response options were limited to mother, father, siblings/friends and teacher. There was no place to record anyone other than these people and also if the listed issue was not discussed with anyone, there was no place to record that. This is again a reflection of bias on the part of both the funder and the implementing agency.

Similarly questions about permission to go the market/shops or to a friend's place or to a nearby village will depend on many factors. A study was conducted on improving reproductive and sexual health using the quantitative approach. It was realized that a single quantitative question will not do justice until the reasons – real or perceived – that lie behind responses are also recorded. ('Improving reproductive and sexual health of young people by increasing the age at marriage in India, Nepal and Bangladesh 2012-2013'). A qualitative method is a better option to collect this information as has been

found in another study ('Baseline Study for Strengthening the Implementation of the *Beti Bachao Beti Padhao* Programme in Four Districts of Rajasthan 2015'). This study showed that the reasons for not giving permission to women to go out have more to do with safety concerns rather than control which a quantitative study focusing only on affirmative and non-affirmative responses without reasons can not provide. Thus, quantitative studies sometimes unintentionally present findings which are not reflective of the actual situation.

In the study, 'Developing Competency Frameworks for Mainstreaming Gender Responsive Healthcare Services, 2014-2015', the focus was on providing sexual and reproductive health services to adolescents. The effort was to identify if health providers are gender-sensitive towards adolescents' needs, and if they render gender-sensitive services. In this reference, all the government guidelines were reviewed from gender responsive perspectives. Further, various agencies conducted training programmes for different aspects of gender but there was no clarity or consensus on the specific knowledge which should be imparted. It was an important study as it tried to develop a competency framework

It can therefore be stated that because of internalized gender bias in the minds of researchers and implementers, the questions for evaluations are framed in such a way that the information they elicit presents only a partial picture, which in turn further reinforces existing biases. Many intervention strategies are built on this faulty ground.

Impact of Evaluation Studies in Shaping Evaluation Practice and Use

Some evaluation studies conducted over the years were successful in setting precedence in gender domains while others were unable to do this. Some were instrumental in making corrections and modifications while in others, inconsistencies were not recognized. Similar things could be said for the utilization of the results of the study. Although these evaluation results are almost always used by the agency that commissions the work, their use also depends on many other factors – policy or programmes, or donors. Change at the societal level also has a role to play and sometimes the results are influenced by the enthusiasm of the evaluation team or investigator.

For instance, an omission with the tools developed as a means of query of interest with respect to the informed consent form was observed in NFHS 4 and many similar evaluation studies. When seeking informed consent, the respondent is assured of his/her right to refuse or withdraw in between or not to respond to any question which she/he does not want to. If he/she refuses right at the beginning the investigator can simply record the response and close the interview. However, if the respondent wishes to not answer any particular question or wishes to withdraw in-between, the tool has no place to record this response (neither the refusal to respond to a particular question nor withdrawal in between). This makes the informed consent not only a pseudo choice but also puts undue pressure on the implementing agency to fill the tool which is fake or discard it when some part of the tool was filled genuinely and correctly. This is a concern which was not taken up despite being used in many evaluation studies and surveys.

Policy and Programme Driven

Political willingness plays an important role and mostly, the policies and programmes being promoted by the system get weightage. Since feminist evaluation principles do not get operationalized in the perspective of policies, the evaluation studies too are limited in this aspect.

Looking back at her experience with education evaluation, Ramachandran (2012) observes that it is crucial that evaluators go beyond statistics on 'girls' enrolment'. It is important to capture how many girls finish schooling as well. In other words, indicators have to be gender-specific and long-term impact oriented. It is crucial that the evaluation team is sensitive to issues of gender and social relations, and competent to capture them. The above point gets substantiated through many studies conducted by the authors. The *Beti Bachao Beti Padhao* (BBBP) programme provides an illustration of this. BBBP focuses on girls' safety and girls' education and all efforts are being made by the education department to keep girls in school. This concern led to a decision to distribute cycles to deserving girl students and to provide travel vouchers to other students to avail free rides upto school. However, the data that was collected only showed the number of cycles distributed; it should instead have been collected on the proportion of girls using cycles to come to school, that is, both practical and strategic gender needs should be taken into account. The reality is that most girls do not use cycles, and these are then taken

away to be used by men of the family. Since this did not become apparent, the education department has now decided to distribute scooters (scootys) to the girls and very likely this initiative will also see a similar fate. The important question to ask is: did the provision of cycles result in girls remaining at school, which was, after all, the primary purpose of giving these to them.

The decision to provide cycles or scooters also indicates that the results of evaluations do not get the attention they deserve or that it is superficial attention: the primary reason, cited by about one third of the adolescents, for girls dropping out of schools is parents who force them to leave. Less than 10 per cent of the schools reported that the reason for dropping out was because of the distance to the school (BBBP 2015). Even if we believe that the decision of the education department is well-intentioned and they want to retain girls in schools, it is important to remember that it is the parents whose decisions matter more, not what the school wants. In qualitative discussions, parents reported that safety concerns and the inability to find a matrimonial match for more educated girls and the consequent increase in dowry all pushed them to discontinue the education of girls. As a matter of fact, the parents' decision is influenced by social norms. Further, the parents who cited safety concerns did not see cycles or travel vouchers as an appropriate measure, rather they wanted an arrangement for the girls to be picked up and dropped from village to school and back. Such aspects are not touched upon in evaluation studies and therefore they do not get the attention they deserve.

Unfortunately, quantitative methods, which are primarily used are data-based and they can only capture whether the cycles or scooters were given or not. In a qualitative study, however, we can go beyond the surface facts and understand other factors such as parents' concerns about safety.

Donor Driven

An evaluation study is rarely questioned for its limitations in conceptualization and interpretation; by the time it reaches the table, it has won the approval of most of the stakeholders who matter. For example, if a concept presented to the funders secures the funding, that is indicative of the acceptance and approval of the suggested approach. Once approval has been secured, this becomes a ground for defending the concept with other ethical or quality assurance committees even on valid suggestions for revisions. The point is the very first approval becomes a protective shield against any suggested changes and is projected as scientific and ethical. Once the evaluation is completed, it sets an example for others to follow on the pretext that it has the approval and acceptance of the wider development community.

Jandhyala (2012) observed how the focus of the Mahila Samakhya programme, implemented by a quasi-government organization, was reduced over the years from the empowerment of women/girls to girls' education (reflecting donor and national priorities). Murthy (2012) argues that issues of power mediate evaluations. These play out in relations between the evaluation team and the community, amongst evaluation team members, between evaluation teams and the implementing agency and finally between evaluation teams and donors. The power which could have been used to integrate feminist evaluation principles therefore gets compromised.

Often, the mode of enquiry and the way questions are framed jeopardizes the richness of the information in evaluation studies. This happens because the funding agency wants particular questions asked and in particular ways. The result is that even when the evaluation is conducted, it doesn't add much to existing knowledge and cannot therefore be utilized. A very common example is attitude related questions which need to be asked in the form of statements using the Likert scale but are asked in the form of questions and the principles of the Likert scale are flouted.

Some of the evaluations use a multi-centric approach and are even multi-country. In this situation, the investigating tools are mostly common to all sites or all countries and this compromises cultural and contextual aspects as donors want to keep the questions similar for all sites. For example, from NFHS 3 onwards, never married women were asked questions on reproduction and childbirth and questions on marital status came later. To the extent that pre-marital sexual relations are a reality and the needs of such couples are also to be considered, the inquiry appears fine but the very purpose is defeated as the implementing agency is not comfortable in asking such questions and they fear retaliation from the community so the end result is that such questions are asked somewhat apologetically and hence the likelihood of getting the correct response goes down.

Issues of ensuring privacy and safety, compensating for women's time and women/men giving the 'right' answers are concerns at the community level. Race, gender, caste, religion, work culture etc.,

could come into play in team dynamics. Implementing agencies may be anxious about the results, and may be defensive. Involving them in evaluation, yet maintaining objectivity, is important. Donors may at times want to hear 'what they want' or have preset agendas (like discontinuing funding). Khanna (2012) observes the importance of putting oneself in the shoes of the implementing agency. She argues that evaluation should leave implementing organizations in a better place than when the evaluation started and help the implementers reflect on their potential for transforming themselves and the community. At the same time, they should not sweep issues under the carpet.

Society Driven

Social reception to any change is gradual and the change can be said to be fully accepted when it becomes commonplace. More than feminist principles, it is society which plays a role in the way evaluation studies are designed and implemented. Some questions are included or changed because of societal norms. For instance, due to live-in relationships, in the section on the men tool of the NFHS 4 a question was asked about partners who are not necessarily into marital relationships. However, women who were not currently married were not asked if they were into live-in relationships or not.

Similarly, in one of the studies entitled 'Utilization of Emergency Contraceptive Pills (ECP) among Rural and Urban Women of Rajasthan: A Study of Psycho-social Determinants' (2012), the decision to include unmarried women for the use of ECP was society-driven. There was speculation and discussions in health and academic forums that ECP was being used by single women who are not engaged in regular sex. This prompted the authors to include them as respondents.

Methodologically, colleges were meant to be the study sites, but because of the nature of the subject, the authorities did not give permission for fear that it would harm the reputation of colleges, despite the fact that they had been assured privacy and confidentiality. This led to a change in methodology and instead of qualitative discussions, a semi-structured tool was used and the respondents were contacted at popular food joints. The result was that information that could have been detailed and deep remained cursory and superficial and did not meet the standards of scientific rigour.

A very important implication of the use of ECP instead of the barrier method is on STI and HIV/AIDS which unfortunately could not be highlighted in the desired manner as the planned evaluation method could not be used.

Investigator Driven

Some studies reflect the gender bias of the implementing agency. Institute of Social Studies Trust (ISST) found evidence of this while evaluating a voice messaging programme for rural communities in two states, Punjab and Rajasthan. The implementing agency had tied up with a multinational mobile service provider to market a special SIM with a free value-added service targeted at the agricultural community which provided five pre-recorded voice messages to its subscribers on general agriculture, animal husbandry, climate, market rates, health, education, government schemes etc. The goal of the project was to create an empowered rural community through the provision of timely information and regular feedback from the actual users on the quality, timeliness, usefulness and impact of the information provided as compared to other sources of information, and how to improve the service. After discussing with the implementing agency, the ISST team perceived a gender bias in the understanding of the implementing agency which believed that mobile phones were only used by men (in rural India), which is why the programme primarily targeted men. Moreover, they believed that agriculture is a male domain and women do not play much role in decision-making related to it. The ISST evaluation that used a feminist lens found that women had been deliberately excluded from the target group. (Nandi 2013)

The authors observed something similar in one of their own evaluation studies. They realized that their gender bias/gender blindness played a role in the way the study was conducted. In a study on the psycho-social determinants behind the utilization of the Emergency Contraceptive Pill (ECP 2012), at the time of designing the study and developing the questions for respondents, it was perceived that women would be using ECP and that too because of method failure or unprotected sex. However, later it emerged that ECP has an important component attached to it, which is ease of use. Therefore, it is also used as a regular contraceptive and male partners can be instrumental in promoting its use to avoid using external barriers like condoms. The investigating team thought of ECP as a step towards