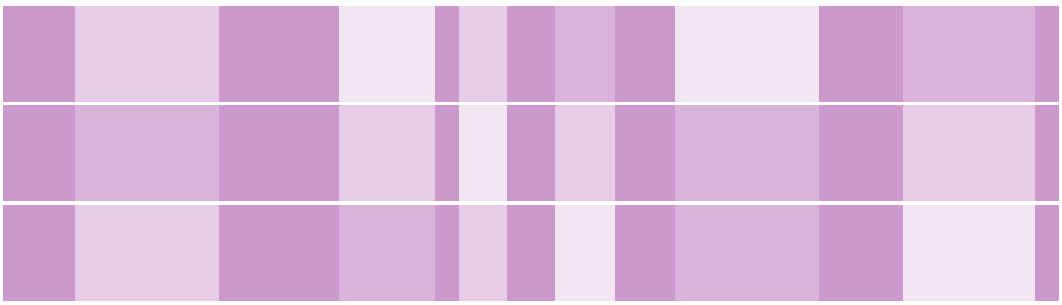

Reflections On
The Campaign Against Sex Selection
And
Exploring Ways Forward

Reflections on the Campaign Against Sex Selection and Exploring Ways Forward

This report is an outcome of an assessment commissioned by UNFPA, New Delhi, on the alarming state of the declining child sex ratio in India, advocacy efforts made to address it and future strategies for the campaign as a whole.

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Reflections On
The Campaign Against Sex Selection
And
Exploring Ways Forward

A Study Report

Study Conducted by
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&
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Commissioned By
United Nations Population Fund (UNFPA), New Delhi

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Centre for Youth Development and Activities (CYDA) is a Pune based voluntary organisation registered in 1999. CYDA aims at creating an enabling enviornment in society to build systems and channels, programs and policies so that young people meet their needs and realise their aspirations. Over the years CYDA has been able to create a niche in its work with young people through need-based programs in the areas of health, education, governance, livelihood and disaster management. CYDA has adopted a rights-based approach in its work in partnership with both national and international organizations such as UNICEF, ActionAid, SwissAid, and National Foundation for India and also collaborate with corporate bodies such as Zensar Foundation, Forbes Marshall and others.

Acknowledgements

The declining child sex ratio in India is so alarming that if the present trend continues it is going to result in a demographic and social disaster. Hence, hidden though it often is, this is an issue which ought to be of concern to every citizen of India.

Since its inception, the focus of the Centre for Youth Development and Activities (CYDA) has been to build among the youth a human rights perspective with a gender focus. Therefore this study on the issue of the "Missing Girls" in our country fitted in very well with our priorities, and we gladly chose to get involved in it in order to learn from the rich experiences that such a study would bring in its wake.

As an organisation working with young people, we at CYDA felt that a study on the issue of "Missing Girls" would contribute various perspectives and enrich our work by helping us understand the different naunces of the issue prevalent in society. The picture we get from these reflections is that sex selection is not a single problem in itself but is part of a larger social menace involving overall gender issues and male dominance in society.

The designing of the study was in itself a learning for CYDA as we had to find a way to reach valid conclusions without necessarily using a random sampling method. Through this process CYDA has improved in its understanding of how to study social issues which will stand it in good stead as it continues working on these kinds of issues with the youth.

This study would however not have been possible without being commissioned by UNFPA – an organisation that has given a lot of priority to this issue and has contributed towards creating a significant public discourse on it. The support we received at various phases of this study from UNFPA through Ena Singh now Acting Representative, UNFPA, Dhanashri Brahme, Programme Officer (Gender and Community), Beulah Isaac, Secretary, and the whole team of UNFPA was inspiring and valuable.

As we bring out this report, I, along with the team, express profound thankfulness to all those individuals and institutions, government officials and non-governmental organisations, district collectors and appropriate authorities, doctors and doctors' associations, communication experts and lawyers, advocacy specialists, religious and community leaders and each and every community group or individual we have met and interviewed (and whose names have been detailed in Annexure II) for their continuous encouragment and unconditional support throughout the study period. It is clear that this work would have been impossible if they did not spend their precious time to share with us their valuable inputs.

We are also really grateful to various individuals and organsiations who helped us significantly by facilitating our visits and interviews in all the 9 states we visited. We take this opportunity to thank all of them for helping and supporting CYDA to study and compile what we consider an important contribution to the efforts being made all around the country on this issue. We are also extremely grateful to Sanjeevanee Mulay, R. Nagarajan and Kiran Moghe who provided professional inputs in the initial stage of this study. We are also grateful to Sunita Vahi for reading through the manuscript during its final stage.

Finally, the support provided by every staff member of CYDA in supporting the entire exercise and providing continuous help during the field research, workshops and consultations held over the last six months throughout India is beyond thanks.

Mathew Mattam
CEO, CYDA

Introduction of the members of the study team

Mr. Josantony Joseph, Lead Consultant for this study, is a social activist who is Advisor (Maharashtra) to the Commissioner appointed by the Supreme Court of India in response to a PIL on the Right to Food. He is also on the board of the National Centre for Advocacy Studies, Pune and Creative Handicrafts, (a women's cooperative) Mumbai. He has worked as a trainer, human resource advisor and evaluator with non-profit organisations in the Indian sub-continent, Europe, Far East and North America. He has a number of articles to his credit and is also the author of a number of books including "FOOD" (Trocaire, Ireland, 1999) which focuses on ethical issues connected with food security in the context of globalisation today, and "AN ENQUIRY INTO ETHICAL DILEMMAS IN SOCIAL WORK" (College of Social Work, Mumbai).

Ms. Sofy Mathew, Coordinator of this study, completed her Masters in Economics and began her career with Consumer International in 1996. Later she joined as Academic Coordinator with the Symbiosis Institute of Mass Communication, Pune as well as the International School of Business and Media, Pune. She has been coordinating media training and documentary production in CYDA.

Dr. Kavita Siradhna, research associate for this study, is a social worker by profession who has been working in the development sector for close to a decade. She has worked on various social concerns and women related issues. She has worked closely with civil society and government initiatives on allied issues with a special interest in project designing, management of developmental projects / programs and capacity building on gender related issues.

Ms. Rohini Patkar, field research associate for this study, is a social development professional working in the field of violence against women, feminist research and reproductive health rights. She has been associated with Jagori, a feminist activist organization based in Delhi. She has Master's degrees in social work and in psychology. She is currently working as Coordinator with the India office of Ipas (Delhi), an international organization working on women's reproductive health, abortion rights and sexual well-being.

Ms. Vidya Kulkarni, field research associate for this study, is an independent journalist and photographer. She has been involved in the women's movement in Maharashtra for over the last two decades. Using her professional skills in writing and photography, she has been involved in documenting key interventions and initiatives in the state to promote women's rights. These include various reports on women's political participation and the status of women in the unorganised sector. She has prepared photo-exhibitions on women's issues and has presented them before a cross-section of groups in various parts of the state. She has also written extensively in mainstream newspapers on contemporary concerns of women.

E.M Radhakrishnan, who had earlier directed a research study for Prayatna on the implementation of the PC-PNDT Act in Rajasthan, also participated in this project as an adjunct team member and provided need-based inputs.

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Executive Summary

Introduction

Over the last two decades and more, ongoing efforts have been made by a number of actors to reverse the trend of a declining Child Sex Ratio (CSR) in India. Planned advocacy efforts on this issue of 'missing girls' are considered to have started in Maharashtra in the early 80s, leading to initial successes in the enactment of an Act in that state in 1988, and subsequently by the passing of the PNDT Act (Pre-Natal Diagnostics Techniques Act) at the Centre in 1994. Despite these successes, comparisons of the data offered in the 2001 Census of India with that collected a decade earlier indicated starkly that the downward dip in male-female ratios continued unabated in most parts of the country. In 2003, as a result of a PIL on the issue, the Act was amended to become the PC-PNDT Act (Pre-Conception and Pre-Natal Diagnostics Techniques Act).

In the light of the 2001 census findings, the United Nations Population Fund (UNFPA), decided to get involved in the campaign on this issue of 'missing girls', – an issue which was accepted as one of its priority areas of work. By 2006, however, UNFPA felt the need to commission a study to take stock of its own initiatives and those of others to develop a roadmap that would guide its future advocacy efforts on this issue within the larger campaign. UNFPA also felt it would be better to get this study conducted by a team that had an understanding of social advocacy and social campaigns, and was at the same time not too closely linked to this campaign, in order to get an independent or 'outside' view. Accordingly, Mr. Josantony Joseph, Lead Consultant (Executive Board Member of the National Centre for Advocacy Studies) in collaboration with the Centre for Youth Development and Activities (CYDA), Pune, were commissioned by UNFPA to carry out a rapid assessment in the second half of 2005.

The objectives of the study were as follows:

a) To map the gamut of reasons why despite all the advocacy and other efforts by various actors on the issue, the CSR in the country continues to be dismal;
b) To review the efforts of various stakeholders on the issue;
c) To explore ways forward and suggest guidelines for future strategies to the campaign as a whole, and to UNFPA in particular.

The report presented here is accordingly divided into three parts that correspond to each of the above three objectives. Thus
Part 1: LOOKING BACK, maps the reasons for continued decline in the child sex ratio;
Part 2: LOOKING BACK to LOOK FORWARD, reviews the efforts made so far; and
Part 3: LOOKING FORWARD explores the future strategies for the campaign as a whole.

1 See Annexure # I

Keeping in mind the understanding that the study was not meant to be a formal research study, nor an evaluation of any particular organization or effort, the team created its own process, using insights from the Case Study and Delphi approaches[1], to carry out the study in 9 states[2]. The process was validated by a wide variety of activists involved in this campaign, who at various points during the duration of the study acknowledged the validity of the insights and strategies offered in the report and considered that they could indeed guide UNFPA in particular, and the campaign as a whole, to work more effectively on this issue of 'missing girls'. In particular these stakeholders often articulated the view in several ways that the process of the study and the report functioned to bring together a wide variety of perspectives and efforts on this issue, and hence was of immense value to individuals or groups committed to working on it.

An Overview of the Findings

As mentioned above, **Part 1** of this report, **LOOKING BACK**, focuses on mapping the reasons for the continued decline of the CSR in the country. It explores the failure to reverse the CSR by identifying reasons that could be related (a) to the knowledge and attitudes of various stakeholders across these 9 states, (b) to the Act and its implementation and (c) finally to the various methods used in the campaign by the various stakeholders.

At a **knowledge** level it was clear that there is widespread knowledge among the relevant groups (those in the reproductive age and the medical community) regarding where sex determination services are available in their own neighbourhoods/localities, even though those entrusted with implementing the Act don't seem to have this information. With regard to the illegality of sex determination, this is more widely known among the medical community and the implementers, though not enough among the community in general. As far as the knowledge of other aspects of the PC-PNDT Act goes, there seems to be a lack of sufficient knowledge among all groups including the implementers and the legal community (both judges and lawyers). As far as awareness of the declining number of girls is concerned, many are aware that in general there are fewer girls in the country, but very few are willing to admit that it is also present in their own communities. Hence, except in a few states/districts where it has been highlighted by the government or the media, the awareness that sex selection is a matter of grave concern is not widespread.

At the **attitudinal** level, it would seem that while abortion in itself is disapproved of, sex selective eliminations of the girl child (SSE) seem acceptable and justified. This seems to be because son-preference attitudes and the patriarchal mindset are so ingrained in large sections of our society, that these seem to help in overcoming most people's reluctance to go in for SSEs. In addition, the financial costs expected to be incurred in the education and marriage of girls, the growth of affluence and urbanization, and even concern for the

2 i.e. Delhi, Haryana, Gujarat, Punjab, Maharashtra, Himachal Pradesh, Rajasthan, Tamil Nadu, and Karnataka

future well-being of the girl in a world where she would face many forms of oppression, have been the main reasons why people seem to prefer not to have a girl child. This is compounded by the attitude among a small but significant percentage of the medical community, which see a very lucrative business opportunity in offering sex determination services. As far as the implementers go (all of whom are currently from the medical community), the attitude seems to be one of helplessness or silent abetment because of a conflict of interest. Thus they seem to either feel they do not have the power or the resources to effectively implement the Act, and/or they find it difficult to take action against colleagues from their own profession. Finally, limited political will is also seen as a significant reason to explain the lack of effective implementation of the Act.

In the second section of this Part 1, the report delineates other reasons related to the **PC-PNDT Act and other policies** of the Government that make the implementation of the Act difficult. With regard to the Act itself, the report points out the need for clarification in terms of interpretation of specific sections, while some sections seem to offer loopholes for a person with a malafide intention to be able to break the law with impunity. Thus the lack of clarity among many as to who can be legally authorised to operate an ultrasound machine or the fact that there is no limit on the number of clinics for which a single ultrasound operator can be authorised, or the silence regarding whether non-pregnancy related ultrasound tests are to be recorded on the F-forms, all open up possibilities for misinterpretation. Secondly, the overlaps between legal abortion under MTP Act and the use of technology for sex selective abortions punishable under PC-PNDT Act, along with a push for small/2 child families, to contribute significantly to the failure of this PC-PNDT Act. Thirdly, various stakeholders have highlighted certain aspects of the Implementation and Monitoring process, which contribute towards making it difficult to implement the Act successfully. These reasons include the difficulties that arise from appointing doctors as Appropriate Authorities as the position is a quasi-judicial one and very few doctors would have an understanding of the technical nuances of law or the fact that most AAs claim that they have too few resources to pay due attention to the implementation of this Act while handling multiple portfolios.

In the third section of this Part 1, reasons for the lack of sufficient success in reversing the CSR that are based on the **efforts made by individuals and groups** working on this issue are highlighted. These include reasons related to the various communication strategies adopted by different groups, the difficulties of undertaking sting/decoy operations, and the weaknesses of community-based initiatives. For instance several stakeholders pointed out that the communication material being used to highlight the issue often carries contradictory and ambiguous messages, that the spots/messages on the electronic media are few and far between, or that the efforts are often product rather than process based. With regard to the sting and decoy operation since there is no court mandated process on how to conduct these, the efforts made and the results obtained

may sometimes fail to stand the scrutiny in courts on various technical grounds. As far as community-based efforts are concerned the patriarchal mind-set and gender-biased messaging of some of the community leaders spearheading community-based campaigns on this issue may lead to such campaigns being detrimental to the cause of women and gender equality in the long run.

Part 2 of this report, **LOOKING BACK to LOOK FORWARD** explores the various efforts made by different stakeholders to reduce the 'demand' for such SD services, to prevent the 'supply' of these SD services, and to ensure the implementation of the Act. These efforts are first described and then their strengths and limitations highlighted as they were expressed by different stakeholders around the country and analysed by the study team.

The methods used to **reduce the demand** for such services have been described as non-interactive methods (e.g. posters), interactive methods (e.g. workshops) and direct action methods (e.g. sting/decoy operations). Their respective strengths and limitations have then been analysed. For example, the IEC products that have been created are very often not professionally made or not disseminated enough, and hence have little value in changing mindsets. It is also the case that the communication efforts have remained at the awareness level and are not able to motivate the general public to act. The report also points out that efforts at communication on this issue are sometimes made without taking into account the environment in which these messages have to find a place – either because they are not local specific or they are lost in an environment of other media broadcasts (like soaps/serials) that foster gender inequity.

With regard to the efforts to **prevent the supply side**, the inability to co-opt a sufficient number of the medical community members to join in this campaign and the general perception that violating this law goes unchecked making sex determination a low-risk business with high monetary returns, are some of the significant reasons why these efforts have not been successful enough.

As far as the efforts to press for **effective implementation** are concerned, the lack of accountability of the State and its officers, and the lack of political will seem to be some of the major reasons why the law is not being implemented effectively.

Part 3 of this report, **LOOKING FORWARD**, explores the way forward for the campaign as a whole. It points out that this campaign must be understood within a **larger context** or environment of gender inequity, privatisation of health care, increasing consumerism and individualism, and that it would be futile to try and work on this issue in isolation from other efforts by social activists who are working on these issues.

The report suggests that the **central strategy** for a more effective campaign on this issue is to find a way to create a synergy among the different activist groups and individuals (government and non-government) who are committed to this issue, so that they can build on and learn from each other's work – a mutual learning process that is currently lacking in the campaign.

The report also proposes strategies that could be carried out in order to get on board various kinds of stakeholders (e.g. phone and web-based helplines, keeping track of various legal efforts being made around the country, and improving strategies for communication by bringing together experts from different fields). In addition the report proposes strategies at the level of implementation to make the State and its officers more accountable, and at the level of the medical community to get them actively involved in the campaign. However, the report also makes it clear that without getting local communities involved it would not be possible to change the scenario significantly, since whatever the efforts to improve Act implementation, technology will always run ahead, and it is only local communities that can effectively change the practices within their own groups. Finally the report suggests that efforts need to be made both in clarifying certain aspects of the Act as well as to make advocacy efforts to influence the government at a policy level if there must be significant success in a campaign that wishes to work on this issue of 'missing girls'. In this context the need to work at building a strong political will is particularly highlighted.

In conclusion, the report suggests that it is only if this issue is seen as a national emergency or national disaster, and the campaign is willing to take on board everyone who is concerned about this issue, whatever their own particular ideologies (on abortion, on gender issues or on anything else), only then can this campaign hope to succeed. The report suggests that though this may seem inappropriate because such an approach focuses on the short term goal of saving the girl child and less on the long term goal of gender justice or women's rights, and therefore may seem like winning the battle and losing the war – there is no option left to us today. For the battle to save the girl child must be won, lest there be no more girl children left for us to think of winning the war for gender justice.

List of Abbreviations

AA	Appropriate Authority (including both DAA i.e. District Appropriate Authority and SAA i.e. State Appropriate Authority)
AIDWA	All India Democratic Women's Association
ANC	Ante Natal Care
ANM	Auxiliary Nurse and Midwife
AWAG	Ahmedabad Women's Action Group
BAMS	Bachelor in Ayurvedic Medicine
BGVS	Bhartiya Gyan Vigyan Samity
BHMS	Bachelor in Homeopathic Medicine
CAPED	Campaign Against Pre-Birth Elimination of Daughters
CAPF	Campaign Against Pre-Birth Elimination of females
CASSA	Campaign Against Sex-Selective Abortion
CBO	Community Based Organization
CDMO	Chief District Medical Officer
CMHO	Chief Medical and Health Officer
CEHAT	Centre for Enquiry into Health and Allied Themes
CFAR	Centre for Advocacy and Research
CHETNA	Centre for Health, Education Training and Nutrition Awareness
CMO	Chief Medical Officer
CrPC	Criminal Procedure Code
CSR	Child Sex-Ratio
CWDS	Centre for Women Development Studies
CYDA	Centre for Youth Development and Activities
DAVP	Directorate of Advertising and Visual Publicity
DC	District Collector
DHO	District Health Officer
DM	District Magistrate
FASD	Forum Against Sex-Determination
FASDSP	Forum Against Sex Determination and Sex Pre-Selection
FAQ	Frequently Asked Questions
FGD	Focus Group discussion
FIR	First Information Report
FOGSI	Federation of Obstetrics & Gynaecologist Societies of India
GOI	Government of India
GR	Government Resolution
H.P.	Himachal Pradesh
HRLN	Human Rights Law Network
ICDS	Integrated Child Development Scheme
ICMR	Indian Council of Medical Research
IEC	Information, Education and Communication
IFES	International Federation of Election Systems
IMA	Indian Medical Association
IPC	Indian Penal Code
IRIA	Indian Radiologist and Imaging Association

ISR	Ideal Sex Ratio
MO	Medical Officer
MASUM	Mahila Sarvangin Uttkarsh Mandal
MCI	Medical Council of India
MLA	Member of Legislative Assembly
MOHFW	Ministry of Health and Family Welfare
MOYAS	Ministry of Youth Affairs & Sports
MSCW	Maharashtra State Commission for Women
MTP	Medical Termination of Pregnancy
NCERT	National Council for Educational Research and Training
NCW	National Commission for Women
NGO	Non-Governmental Organization
NHRC	National Human Rights Commission
NIIT	National Institute of InformationTechnology
NRT	New Reproductive Technologies
NRHM	National Rural Health Mission
NSS	National Service Scheme
NYKS	Nehru Yuvak Kendra Sangathan
PC-PNDT	Pre-Conception and Pre-Natal Diagnostic Technique
PBEF	Pre-Birth Elimination of Females
PFI	Population Foundation of India
PHA	People's Health Assembly
PP	Public Prosecutor
PRI	Panchayati Raj Institutions
PSBT	Public Services Broadcasting Trust
RCH	Reproductive and Child Health Programme
R&D	Research and Development
RMP	Registered Medical Practitioner
RTI	Right to Information
RUWA	Rajasthan University Women's Association
SC	Supreme Court
SD	Sex Determination
SDM	Sub-Divisional Magistrate
SHG	Self Help Group
SHO	Station House Officer
SIRD	Society for Integrated Rural Development
SRB	Sex Ratio at Birth
SSE	Sex Selective Elimination (understood as the elimination of female foetuses)
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHAP	Voluntary Health Association of Punjab
VHN	Village Health Nurse
VLHW	Village Level Health Worker
WCD	Women and Child Development
WHO	World Health Organization

Reflections On The Campaign Against Sex Selection And Exploring Ways Forward

1 Introduction

Over the last two decades and more, there has been an ongoing campaign in which a significant number of actors have made a number of advocacy and other efforts to respond to the alarming Child Sex Ratio (CSR)[1] in the country. Planned advocacy efforts on this issue are considered to have started in Maharashtra in the early 80's and had significant successes in the enactment of an Act in that state in 1988, and subsequently by the passing of another Act at the Centre in 1994. Despite these successes, comparisons of the data offered in the 2001 Census of India with that collected from those of a decade earlier indicated starkly that the downward trend of fewer girls continued unabated in most parts of the country.

In 2003, a study conducted by T.K. Roy (Indian Institute of Population studies) and Rutherford (Population and Health Studies, East-West Centre, Honolulu, Hawaii)[2] indicated that the Sex Ratio at Birth (SRB)[3] in all parts of the country, except the south, were still higher than what should naturally occur (*normal SRB is considered to be 1.05*), and that this higher SRB was found more among the higher socio-economic classes. This was a finding, which was in harmony with the concerns expressed about the CSR in the country – though it must be clarified that CSR and SRB being different indicators imply different conclusions. In India, the former (i.e. CSR) indicates the possibility of both infanticide and foeticide, while the latter (i.e. SRB) indicates only foeticide.

The study also indicated that though the Ideal Sex Ratio (ISR), which is calculated as the desired or ideal number of sons to the ideal number of daughters, has been steadily declining in all parts of the country, they are still far above 'normal'. This would indicate that it would take a significant amount of time before son-preference is completely

1 CSR or Child Sex Ratio, defined in India as the number of girls to every 1000 boys in the 0 to 6 years age group.

2 Robert D. Rutherford and T.K. Roy "Factors affecting Sex-Selective Abortion in India and 17 Major States" National Family Health Survey Subject Reports Number 21,January 2003; International Institute for Population Sciences, Mumbai, India and East-West Center on Population Honolulu, Hawaii, U.S.A

3 SRB or Sex Ratio at Birth, which unlike the CSR indicates the number of boys per hundred girls.

neutralised. More importantly, since some states like Uttar Pradesh, Bihar and Rajasthan, show high son preference but only slightly higher than normal SRBs, the study opined that there was a high likelihood of a significant increase in the elimination of girls (before and/or after birth) occurring in these states in the foreseeable future, once the access to new technologies (like ultrasound) became easy and more affordable. And the reality is that not only are these old technologies reaching to doorsteps at much more affordable rates than before, but even newer technologies that could help in sex determination before birth and even before conception, are either already introduced or sought to be introduced into the country.

In the light of this alarming scenario, and galvanised particularly by the 2001 census data, the United Nations Population Fund (UNFPA) too decided to get involved in this campaign. After much discussion and study of the issue during the first couple of years after the census, UNFPA began to organise and fund certain efforts in a more organised manner, primarily from 2004 onwards. These efforts were also in the form of exploratory attempts and covered a wide range of actors. However, despite all the efforts by many groups active on this issue (including UNFPA) and the amendments that were brought into the Act in 2003 as a result of a Public Interest Litigation (PIL) filed by various activists, the fact was that the child sex ratio continued to decline in most parts of the country. In 2005, by which time UNFPA, India, had declared that this issue was one of its prime concerns, UNFPA felt the need to commission a study to take stock of its own initiatives and to develop a roadmap that would guide its future advocacy efforts in the light of larger campaign and efforts of other stakeholders on the issue. UNFPA also felt it would be better to get this study done by a team that had an understanding of social advocacy and social campaigns, and was at the same time not closely linked to this issue, in order to get an independent or 'outside' view of the campaign. Accordingly, Mr. Josantony Joseph, Lead Consultant, (Executive Board Member of the National Centre for Advocacy Studies), in collaboration with the Centre for Youth Development and Activities, (CYDA) Pune, was commissioned by UNFPA to conduct this study, and requested to complete it over a period of around four months.

The objectives of the study were as follows:

1. Mapping the gamut of reasons why despite all the advocacy & other efforts by various actors on the issue, the child sex-ratio in the country continues to be dismal;
2. Reviewing the efforts of various stakeholders on the issue and reflecting on the strengths and limitations of such efforts;
3. Exploring ways forward and suggesting guidelines for future strategies to the campaign as a whole, and to UNFPA in particular.

It was clearly understood that the study was not meant to be a formal research study, nor an evaluation of the work of any particular organization or effort. It was meant to be a study that would look at UNFPA's efforts within the context of the other work carried out by a wide variety of actors involved in this campaign. Keeping in mind these contours, the study team created their own process[4] (which used insights from the case-study approach and the Delphi method) in order to arrive at what it considers are valid insights and strategies that could guide UNFPA's work (and that of the campaign as a whole) in the near future.

In the light of this process decided upon by the team, a decision was made (in consultation with UNFPA, Delhi) to concentrate on nine states spread out over three clusters. In the North, these included the states of Himachal Pradesh, Haryana, Punjab and Delhi; in the West they included Maharashtra, Gujarat and Rajasthan, and in the South the two selected were Karnataka and Tamil Nadu. With the help of UNFPA and through a snowballing method[5], the team got in touch with various stakeholders – both those 'converted' to the importance of this issue, and the 'non-converted' – in these states, focussing broadly on these four categories:

i) Communities (including individuals and groups)
ii) Enablers (those who have actively worked on this issue at various levels)
iii) Medical Service providers
iv) Implementers (those entrusted with the implementation of the Act)

While the methodology used did NOT demand that the study team visit all the important 'actors' who are working on this issue, the fact is that the team did manage to visit or interact with quite a significant number of these actors (sometimes more than once) over the duration of the study (see Annexure II).

The final report includes four sections as below:

1. **LOOKING BACK – Mapping the Reasons for Continued Decline in CSR**: In this section of the report the team has collated and categorised the various reasons (enumerated by the respondents) as to why the CSR continues to decline in the country despite the efforts by so many. The reasons have been categorised under three sections : i) Reasons related to stakeholder Knowledge and Attitudes ii) Reasons related to the Act/Law and other Policies, and iii) Reasons related to Individual/Group Efforts on the issue.

4 Annexure # I explains the Methodology in greater detail, and explains the similarities between the methodology used in the study, to the Case Study and the Delphi approaches referred to over here.

5 'Snowballing' sampling is a process of selecting samples based on the snowball effect, i.e. one case gives a reference to another, and the second to still another and so on and so forth.

2. **LOOKING BACK to LOOK FORWARD – Interventions, Experiences and Lessons learnt in addressing CSR decline**: This section of the report consists of a description followed by an analysis (by the team) of the strengths and limitations of the several efforts put in by various entities over the past many years. This analysis helps to identify the lessons that would need to be kept in mind for the future.

3. **LOOKING FORWARD – Suggestions for Future Strategies for the Campaign**: This section of the report consists of specific guidelines or suggested strategies that the study team proposes for the future, for the campaign as a whole.

4. **UNFPA Strategies**: This section of the report (which is meant only for UNFPA, and therefore not included in the disseminated printed report) includes an assessment of past UNFPA efforts as well as suggestions on future strategies for UNFPA.

The various annexures offer a variety of supplemental documents that contribute towards rounding out the report.

It is the earnest hope of the study team that the entire report will contribute towards helping the campaign, and UNFPA in particular, to move forward in a more strategic way in future.

Part 1

LOOKING BACK

Mapping the Reasons for the Continued Decline in the Child Sex Ratio

2 Part 1
Looking Back
Mapping the Reasons for the Continued Decline in the Child Sex Ratio

2.1 Introduction

This compilation of perceptions/reasons offered by various stakeholders has been presented below under the following three major sections:

a Reasons related to stakeholder Knowledge and Attitudes: This section includes reasons connected with both the knowledge and attitudes of all four categories of stakeholders mentioned in the introduction above. However, some of the reasons expressed or identified by the 'implementers' have been included in the next section (i.e. Reasons related to the Act/Law and other Policies, under the sub-section, 'Implementation and Monitoring Structures') in order to avoid duplication;

b Reasons related to the Act/Law and other Policies: This section includes all those reasons that are perceived to be rooted in the PC-PNDT Act itself, in the Implementation and Monitoring structures, and the difficulties that arise because of the influence of other Acts and policies of the government;

c Reasons related to Individual/Group Efforts on the Issue: In this section the team has included reasons offered by various stakeholders on the limitations of various kinds of efforts carried out as part of the overall campaign on this issue. This itself has been divided into 'communication strategies', 'community-based initiatives' and 'sting and decoy operations'. Difficulties arising from the monitoring operations of the various implementers have, however, been included in 'b' above in order to avoid duplication.

2.2
Reasons Related to Stakeholder Knowledge and Attitudes

Knowledge & Attitudes

From a people-centred advocacy perspective[1], it is important to sketch the 'knowledge and attitude scenario" in order to understand why the CSR continues to decline. Furthermore, it is only by articulating, and honestly acknowledging the current knowledge and attitude scenario regarding this issue among various sections of the population, that campaign strategies can be designed to effectively change the 'demand' for sex determination services.

1 Please see Annexure # 1 under the sub-title "What is Advocacy".

2.2.1 At The Level of Knowledge

i) Knowledge of the Skewed Sex Ratio

The overall impression gained during the interaction with various stakeholders is that clearly there is knowledge among a large proportion of the population that there are fewer girls than boys in the country. Whether this included the majority or not could not however be gauged, because it was also clear that there were also a significant number of ordinary citizens who are not aware that the numbers of girls are significantly less. Thus for example a teacher-trainee group in Pune indicated that they had heard of this problem of the declining number of girls, but never thought it was happening in Maharashtra as well. In villages near Dholpur (in Rajasthan) and Jalgoan (in Maharashtra) the rural women were quite unaware of the differences in the number, and in fact commented quite casually that 'Hamare gav me tho ladkiya jada hai' (i.e. in our village there are more girls).

Even among those who are aware of the fewer number of girls, there are very few who are aware of the actual CSR figures within the country, their state or their own community. Thus, for example, interviews with youth studying in a college in Delhi revealed that very few of the students (just 10 to 15% of those interviewed) were aware of the actual sex ratio, though they had a general idea that the number of girls was declining. Similarly a nagar sevak met in Maharashtra was not even aware of the problem in his own district where the ratio is a shocking 800/1000, - a figure which had been released as a news item a few days prior to the team's visit.

It may, however, be further clarified that in some states like Punjab, Haryana, Rajasthan and Gujarat, owing perhaps to the wide publicity the issue has received in the media, there seems to be a greater awareness amongst a significant proportion of the population that there is such a skewed sex ratio in their own state. The Gujarat government, for instance, has taken up this issue in an official way through its Dikri Bachao Campaign, and has galvanized many sections of the government machinery to work to redress the situation. In other states like Maharashtra (despite the fact that it is in this state that the first such Act was enacted), Tamil Nadu, Delhi, Himachal Pradesh and Karnataka, today this awareness is restricted to certain communities and is not widespread among the general population.

Moreover the issue has not featured significantly in the various question hours in various Legislative Assemblies in the country, though there have been two calling attention motions on this issue, and a few questions at various times in Parliament.

ii) Awareness that it is an Issue of Concern

Even among those who were aware of the skewed sex-ratio, a large proportion does not see it as a matter of serious concern. Thus a group of political and community leaders in one of the areas/blocks of Ahmednagar district in Maharashtra, where the present child sex ratio is 800/1000 seemed somewhat aware of the skewed child sex ratio, but apparently did not consider it a matter of concern, nor were they thinking about the future social consequences of this trend.

While there are some among the general population, medical community and among implementers who consider it a serious issue, the large number of those who are really concerned are to be found among the enablers. However, in general, it may also be stated that there is no denial of the seriousness of the issue, among those community/states where the consequences of the declining sex-ratio in terms of fewer girls available for marriage has been felt. For instance, according to an activist interviewed in Gujarat, a particular Patel community is now all geared up to tackle the problem, since the number of girls have dropped so much that they have to 'buy brides' from other communities/ castes. According to this activist these 'affected' communities have started doing internal surveys. It further stated that there are 40% less Patel girls than boys in 0-10 age group in Morbi district in Rajkot. In Upela in the same district the deficit is 35%. In Unjha block (district Mehsana, Gujarat) a campaign worker openly admitted: 'We were simply not aware of the severity of the problem till the ratio dropped down to 742/1000.[2] We were shocked when these figures were brought to our notice. Earlier the sex selection tests were being openly done and we even passed on the information in informal meetings. It was never considered a big issue till we faced the consequences.'

In other places though they may be aware of the differential child sex ratio the community members seem to be ignorant regarding the severity of it. A Maheshwari community leader in Jalgoan was of the opinion that the numbers of the boys and girls have never been exactly equal, but by blowing it up an issue had been artificially 'created'. Often enough even within those states where this issue is acknowledged as one of serious concern, there is often a denial within communities that their own community members are practicing Sex Selective Eliminations (SSE),[3] and certainly a refusal to accept that this practice is the reason behind this unbalanced sex-ratio in their own communities. During the study, the team members spent time interacting with the leaders and members of certain communities (most of whom were by and large economically prosperous and

2 "Sex- ratio in the state of Gujarat', a Health and Family Welfare Dept., Govt. of Gujarat publication undated

3 SSE or Sex Selective Elimination. This has been generally taken to refer to the process by which the sex of the foetus is first determined followed by the elimination or abortion of female foetuses. Strictly speaking, however, the term could also apply to the elimination or abortion even of male foetuses.

educated) amongst whom the declining sex ratio and sex-selection is particularly a problem. These included the Leva Patil community in Maharashtra, and the Khandelwal and Jain communities in Rajasthan. Most of these interactions revealed a tacit denial through claims that in 'our community we don't have a serious problem', even though they would also admit they have started taking girls in marriage from 'other' places. Alternatively, statistics pointing out the declining sex ratio in these communities were generally met with defensive comments such as "The number of girls is going down in all parts of the country. Same trend can be found in our community." (Member of the Khandelwal community).This kind of denial of the existence of the problem by the community members was also seen amongst the Gaunder/Karuba (belonging to the MBC or Most Backward Class category) in Kathir Narashimhapuram village in Theni District of Tamil Nadu. The community members interacted with were all aware that clinics indulge in sex determination tests - but not in their community according to them. They also agreed that there were more male children in their community but they did not attribute this to foeticide and/or infanticide.

iii) Perception regarding the sections of the population among whom such sex selection practices are more rampant

There was a general perception that such a declining sex ratio and elimination of female foetuses is prevalent mostly among the poor and the uneducated. Thus people in state capitals or urbanised centres like Delhi, Mumbai, Chandigarh, Pune, and Shimla generally expressed the view that the sex ratio is bad in rural areas in Punjab and Haryana, but were not aware that the problem also existed in their own cities and among the affluent. Thus for example a group of young college students studying in the University of Delhi, despite being part of an awareness campaign on the issue, thought that such practices were mostly to be found among poor people especially those who would not have the money to bring up their daughters

Educated people interviewed invariably linked the problem with poverty and backwardness. Therefore they would consider adequate financial incentives as the solution to this problem. Thus for instance a doctor-cum-political leader in Jalgaon (Maharashtra) suggested that the government should give an attractive incentive to parents who give birth to daughters. As he said: "Give 5 lakhs each to such families and the trend would reverse in five years". There is thus a tacit denial by the affluent class of themselves as being part of the problem.

When the statistics regarding these urban and affluent centres/groups were shared with these groups, they responded with the reasoning that if true this was probably because rich people could undertake tests whereas the poor could not. Some of them also suggested that since the poor and uneducated either do not know about sex determination tests, or cannot afford them, they continue to have children till they have a son.

A number of studies/publications/articles have shown that in actual fact, though people relate the problem with poverty, prosperity happens to be one of the factors influencing the problem. The Gokhale Institute in Pune has shown in its study[4] of the issue in Maharashtra that collusion of son preference, easy accessibility of the technology and affluence leads to a skewed sex ratio. Similarly, Unjha block in Mehasana district, which has the lowest sex ratio in Gujarat state (742/1000), is also the richest block in the state.

There are, of course, a small but significant number of people who are aware that the practice is prevalent among the rich and educated in rural as well as urban parts. A doctor from a village in Rajasthan said that the testing is more by these sections of the society as they have the required information and money to access them easily. In Punjab and Haryana, where absolute poverty is difficult to find, people acknowledged that sometimes among poor people one could find two daughters, but it was impossible to find a similar situation among the rich.

iv) Awareness of the illegality of sex determination

In Punjab and Haryana, because of the publicity the issue has received, it appears that a significantly higher proportion of the population is aware that sex determination is illegal. But in other states though awareness exists among some sections that sex determination is illegal[5], this legal awareness is not common among the majority of the population.

Thus in Delhi, where SSEs are quite common, a large number of those interviewed seemed to be generally unsure as to whether there is any question of legality involved with this practice. In other places, even among the medical service providers (aside from the doctors), certain groups like health workers were quite vague about the legality issue. A similar lack of legal awareness was also found among young students, including law students, in a number of places in major cities like Mumbai, Pune and Delhi. Even in Punjab where the concern over the declining number of girls is clear and a lot of people are clearly against female foeticide, the reason for their opposition is not necessarily because they are aware it is illegal, but more because of the social consequences of such a practice.

However, among those who have had an experience of pregnancy, there exists significant awareness that sex-determination is illegal. Many narrated incidents where the doctor had refused to convey to them the sex of the child because, 'aajkal is par bandi hai' (i.e. because nowadays this is not allowed). On the other hand, even they did not know much about other provisions, or about the punishments specified in the Act.

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4 A study of Ultrasound centres in Maharashtra done by Sanjeevanee Mulay and R. Nagarajan of Population Research Centre, Gokhale Institute of Politics and Economics, Pune in 2005.

5 The provision stipulating that asking for the sex of one's unborn child or giving such information is illegal according to the PC-PNDT Act is not known to many.

Furthermore, because the sex of the unborn child is communicated with a word, a gesture, or even with the colour of ink used, and since there is no complainant (as both the pregnant woman and the doctor collude in violating this Act) there is an opinion expressed by some of the interviewees that there are very few cases around the country which are registered specifically for indulging in sex determination. The few that have been registered for this have resulted from the various 'sting' operations. Most of the cases under this Act have been for failure to maintain or submit records. However Haryana apparently has the maximum number of complaints lodged not just for lack of registration of ultrasound machines[6], but for 'sex determination'. This could be because the knowledge of the illegality of sex determination tests is quite extensive in this state, and/or because of the effectiveness of the work of some committed implementers or enablers.

Finally, and significantly, a large number of educated persons would seem to consider it an unwanted intrusion into their personal lives to criminalise their wanting to know the sex of their unborn child. After all, most believe that it is a common (and acceptable) practice to ask the sex of the foetus, and it seems it is equally common for the doctor to communicate it as well.

v) Knowledge of the possibility of Sex determination before birth and of where to get these 'services'

There is knowledge among large sections of the general population that today the sex of one's child can be identified before birth. Furthermore knowledge as to where exactly these services are available, and which doctors would be willing to offer these services is also known to a large percentage of the population who have experienced or are experiencing pregnancy, and this is even more true among the educated class. The majority of the women (in the urban areas visited) were aware of the availability of sex-determination tests. The collusion between awareness, accessibility and affordability of technology that makes sex-determination and sex-selection possible is perhaps obvious, and has been further confirmed by the study done by the Gokhale Institute in Maharashtra that has been referred to earlier. A doctor in Jaipur commented: "A middle/upper class family having a first girl child is quite likely to go for ultrasound test in the second pregnancy. A poor family may do so in their third or fourth pregnancy."

However the rural–urban divide with regard to information/awareness and access to technology was clearly visible. The study indicated that in some rural areas while women were absolutely ignorant about the issue some of the men (who happened to move more often out of the home) were found to be having some knowledge about the imbalance in the ratio and the work of clinics and doctors in promoting sex-selection. Consequently, in

6 The PC-PNDT Act insists on the registration of ultra-sound machines, which can be used for sex determination, and according to the Act this lack of registration in itself constitutes a violation of the Act.

a tribal village (Badi) in Nimbada Block in Chittorgarh District of Rajasthan certain sections of the village expressed the fear that urbanization would affect their village as regards this issue and that their youngsters would fall prey to this "style" very soon. They indicated that as the educational level goes up among their youngsters they also tend to adopt certain lifestyles followed by city dwellers.

The access to information, means and technology and the impact of the pro-sex determination perspective of the urban educated economically well-off sections of the population has reportedly influenced some of the migrant populations of rural India. PRAYAS an NGO working in five panchayats comprising of eighteen villages in Chotisadri block (Rajasthan) and implementing a project sponsored by Indian Council of Medical Research (ICMR) that is involved in creating awareness among people about health issues, has reportedly witnessed the spread of this kind of awareness among the tribal belt. A social worker intervening in this area had this to say: "It is being increasingly felt that the issue of female foeticide is entering into the village settings dominated by tribals. Although in the programme area where we work there exist no ultrasound labs, our tribal youth are seen indulging in sex selective practices by going to the cities." There are also indications that in rural and tribal areas where the technology for sex-determination is not locally accessible the people seek the help of quacks and dais who prescribe herbs/ medicine claiming to change the sex of the child. Speaking of the practices of the people, a social worker in the area remarked: "People also use traditional herbs and other medicine to have a male child or to change the sex of the foetus from female to male".

The in-roads that technology has made into the semi-urban/rural areas has resulted in an increasing number of people in these areas going in for sex-selection. In Akluj grampanchayat (Solapur, Maharashtra), which is a well developed semi-urban area with a total population of 40,000, there are many unqualified people using portable machines and travelling to interior villages to offer these services. This is a doorstep facility, which charges very nominal fees.

The accessibility of technology has, (according to an organisation known as the Rural Rehabilitation Centre in Tamil Nadu) led certain communities like the Kallar community in Madurai, who were traditionally practicing female infanticide, to gradually shift to sex determination tests and sex-selected abortions.

Conversations with urban working women of the upper class in Jalgoan (Maharashtra) and Ahmedabad (Gujarat) revealed how sex determination has become a common practice now. Couples who have a first daughter invariably get the test done, either on their own or after friends/relatives suggest it.

In other words, whether they are aware or not of the illegality of the practice, the relevant population certainly has knowledge that such services are available, and also know where to get these services.

Interestingly, the claim of the Appropriate Authorities (AAs) in many districts that they do not have resources to implement the Act (with the implication that this is so because there are so many doctors to monitor in a district), seems a bit shallow considering that the main doctors/clinics who/which offer these illegal services are well known to all. In one district in Punjab, the AA was able to identify which are the doctors who indulge in these practices purely by monitoring the clinics to which women who already had daughters and no sons went to when they became pregnant again. But even aside from such monitoring, the knowledge as to where these tests are offered is clearly accessible to all who have any desire to find out. And since such doctors/clinics constitute a low percentage of medical practitioners, monitoring these fewer numbers is much more possible if there is the will to do so.

vi) Sources of Knowledge

The sources for this limited knowledge regarding the illegality of SD, as referred to in the previous points, are primarily the media (newspaper articles, TV spots, etc), the boards/notices put up in ultrasound clinics regarding this matter, the fact that government hospitals do not offer these 'services', the knowledge that is spread by word of mouth, and the efforts of various 'enablers'. Of course it is clear that those who are campaigning against such practices would not be spreading knowledge about where these services are provided.

As far as TV coverage is concerned, people in many states indicated that according to them it is primarily the Doordarshan channel (a free-to-air channel) that is the most common source of such information. However, it was also stated that since Doordarshan is watched less than the other channels, (particularly by the affluent who can afford cable, dishtv, etc) their exposure on the electronic media to this issue was far less. However, there are some channels (besides Doordarshan) and radio stations where off-and-on such issues are beamed, particularly if it happens to be a news item and sometimes this leads to a feature story as a spin-off. Thus in Delhi and Chandigarh, people have also heard of it through FM radio stations like the Mirchi channel.

In general, however, a significant percentage of the relevant population get information regarding where such SD services are available through the active connivance of the medical community including the doctors, health workers, ANM etc. even though the medical community claims that it is not they who encourage the use of these practices. In a study made by Sahiyar in Vadodara, Gujarat, the in-depth interviews of seventy women revealed that almost four out of ten received the information that sex determination was

possible from the doctors themselves. It may be noted here that though many doctors in many places generally justified their practice by claiming that they are only offering a service that people ask for, this study and many other interviews conducted by the study team suggest that a significant percentage of women come to know about it from doctors themselves. Health workers in other places have acknowledged that they themselves inform women who come for antenatal care.

vii) Lack of Knowledge of Other Aspects of the Law and related policies

There was significant lack of knowledge among all the categories interviewed regarding

a) what is actually included in the law;
b) the enforcement machinery within the Act (such as whom to complain to, what are the requirements etc);
c) what were the implementation processes to be followed when making a complaint or enforcing the law;
d) Knowledge of other schemes for the girl child, which were meant to off-set the discrimination against the girl-child.

This is true not only among people in general, but among law students, lawyers and judges, and even among some of the implementers and enablers themselves.

The low level of awareness about the Act even within the legal community is quite evident. A senior member of the Bar Association in Jaipur had not heard of the Pre-conception and Pre-natal diagnostic techniques (PC-PNDT) Act per se, though he had a general knowledge about the illegality question. Some of the lawyers interviewed in other places defended this knowledge gap by saying that because there exist several acts and laws in the country, it would be natural for many members of the legal community to develop their own expertise only when they deal with any cases pertaining to such acts/laws. Another High Court lawyer in Gujarat perceived sex detection as 'a wrong practice', but was not sure whether it is 'illegal' or not. The lawyer said, 'I know there is a law for abortion, and that abortion is legal under certain conditions. I am not sure whether or not abortion of the female foetus also comes under that.'

Among the general population too there was a significant amount of legal ignorance. Thus, for example, a journalist in Sinnar, who seemed very much against sex-selection shared his personal experience. "My first child was a son, however my wife underwent the sex determination test in the second pregnancy as we wanted a daughter…." The same legal ignorance seems to exist even among community groups who were themselves working on the issue. This was particularly surprising since in one case, a community group in Rajasthan had actively participated in a protest rally against the concerned AA, but the group was not aware of the legal procedures to launch a complaint.

Even amongst the enablers there are some working on the issue who lack adequate knowledge of the Act. This is not to say that there isn't any positive result from their work, but only that their efforts are bogged down in lack of knowledge of the technicalities of the Act and the implementation or monitoring procedures. The various mini-consultations organised during the second part of the study proved this conclusively, with even lawyers involved in working on this issue having different interpretations and levels of knowledge about this Act. For example, most of those that were met were unaware that according to a particular interpretation of the Act, there was no necessity that the States should appoint a doctor as the District Appropriate Authority (DAA)[7].

Similarly, there are many cases where First Information Reports (FIRs) have been filed with the police or under sections of the Indian Penal Code (IPC). While some activists feel that filing of FIRs lengthens the processing of complaints, others have used the investigative ability of the police by filing FIR and strengthened the case. However, in such cases too the primary action must be taken by the AA or by any other person after 15 days notice has been given to the AA. Thus the Act does not require FIRs but these may be effectively used to seek help of the police according to some activists.

Thus it appears that large numbers of even those involved with the implementation of this Act are not clear regarding the Law. Some of those interviewed opined that this lack of awareness about the law was one of the important reasons why so far there have been such a miniscule number of convictions under the Act. This was also acknowledged by some of the implementers who commented: "No amount of amendment can make the law perfect, unless it is used thoroughly. Only once we have started using it, would we know what changes should be there. The judges also do not know about it because there are not enough cases on it".

Several of the AAs the team interacted with suggested that since they themselves came from a medical background they had little understanding of the law and the police procedures to be followed in preparing a case under the Act. Consequently, in the absence of any police support or legal consultation on a regular basis to support the AA in the implementation processes, it was very difficult for them to implement the Act or to monitor compliance. Consequently some expressed the need for police help in pressing charges against defaulting clinics. One senior implementer in Rajasthan commented: "Many problems arise among my officers as they are unable to comprehend the law as expected by the government. Special modules for training and helping them through a technical

7 Section 17 (2) of the PC-PNDT Act states that "the state Govt. shall appoint, by notification in the Official Gazette, one or more Appropriate Authorities for the whole or part of the State for the purposes of this Act having regard to the intensity of the problem of pre-natal sex determination leading to female foeticide". This clause does not specify that the DAA should be a doctor.

cell are my priority." An administrative officer in a PC-PNDT cell in one of the states visited was of the opinion that apart from legal enforcement there is need for legal training for all AAs, a massive awareness campaign and setting up technical resource cells at state and district levels. He pointed out that very often AAs have little knowledge of the Criminal Procedure Code (CrPC), Evidence Act, Medical Termination of Pregnancy (MTP) Act etc. – all of which impinge on the implementation of the PC-PNDT Act. According to some lawyers, this lack of awareness has sometimes led to a way of dealing with cases in blatant contravention of fundamental rights or basic principles of natural justice and has often led to the cases being quashed on 'technical' grounds.

There also seems to be a lack of knowledge among the AAs with regard to their own powers and responsibilities. On the day of the team's visit to meet the AA of a particular district in Maharashtra, there was an article in a local newspaper – Lokmat – about the issue. The article highlighted the negative consequences of such practices but in the process the article made this service known to many people by giving details of the website where they could avail of these services. The AA knew about the article. When asked whether he (AA) was going to take any action against the paper, he was not sure whether taking such action would fit within the purview of his powers.

Additionally, since there is no publicity regarding the names and addresses and contact details of the members of the various Advisory Boards, or with regard to whom a complaint should be addressed, many felt it was very difficult for anybody to file a complaint.

Finally, since many are not aware of the various schemes and rules of the government that can be taken advantage of by girls/women, the value of these other schemes to offset the 'financial cost' (see section on Attitudes) in having a girl child and thus to create a mindset change among the general population is minimal.

In short then the lack of awareness about the law and government policies amongst all sections of the population, including those working directly on the issue, has been clearly evident in many states.

viii) Knowledge regarding the Legality of Abortion

While large numbers of women do not seem too clear about whether abortion is legal or illegal, there are others who think it is legal under any circumstance. A general perception among those who have heard about the MTP Act is the mistaken belief that the Act legalises all abortions. The medical community in general does not seem to make any effort to clarify this misconception. This was experienced in all the States visited

Thus for example, according to information collected by an activist in Pune, despite the MTP Act being promulgated in 1971, only 17-30% people are aware that abortion is legal

under certain conditions. This has also been the general feedback received from various 'enablers' during this study. On the other hand conversations with many of the groups the team met seemed to reveal that many casually mentioned that they believed that abortion has been made legal in India, without ever mentioning that it is legal only under certain conditions.

Doctors seem to know the conditions under which abortion has been made legal as is perhaps evidenced by the perception that 70% to 80% of all abortions are under the category of 'failed contraceptive methods' according to many activist doctors and enablers that the team met in various parts of the country.

2.2.2 At The Level Of Attitudes

i) Women's attitude to Abortion in general

In general a large number of women, including educated ones and young women, felt uncomfortable about abortion. Though it is legal under certain conditions, most women do not see it as a matter of legal or human rights. Most people seem to see abortion as clearly the killing of life (a life that has to be given the same status as a human being) and therefore as ethically wrong. A study conducted in Punjab indicated that 72% of the women interviewed "considered abortion a sin, as it is murder and a rejection of God's will."[8]

It is perceived that most religious groups also seem to see abortion as 'maha-paap' (i.e. a great sin). However, where there is danger to the life of a woman, or in the case of rape, or where there is a congenital defect in the foetus, many would seem to be willing to accept abortion as necessary. For instance, at the UNFPA supported workshop (2005) with religious leaders it was clear that most religious leaders were against abortion as they saw it as a moral crime despite its legality. However, more pointed discussions with members of various religious communities during one of the mini-consultations conducted by the study team, indicated that in the case of rape, danger and congenital defects, many religions might accept abortion. None would, however, accept abortion as a right on the grounds of failure of contraception.

ii) Women's attitudes with regard to SSEs

Despite this general feeling regarding abortion per se, many women seem to go in 'willingly' for SSEs. In a large number of cases, it is argued by enablers that this willingness could be rooted in the woman's cultural conditioning within a patriarchal environment with a strong son-preference.

8 Manmeet Kaur 'Female foeticide – A Sociological Perspective'. The Journal of Family Welfare, 39(1) P.40-43, March 1993.

'The women should be made more aware. It is they only who insist to have a son', said a group of professors in one of the colleges in Mehasana district in Gujarat. This was a common point made by many men. Some (both men and women) suggested that women too aspire to have sons, as the family values the woman more only if she 'produces' a male heir to carry on the family name. Additionally some doctors who cater to the upper classes expressed the opinion that among the economically and higher educated women, the choice to have an abortion is clearly the woman's as she is quite independent.

As against this there were quite a few who were of the opinion that the woman is under considerable pressure to undergo SSEs and it is important to understand the wider social and cultural reasons/motivations influencing people who practice it. "Mothers-in-law and husbands pressurize us to have sons, and we cannot even turn to our own family members because they are also under pressure," was the comment of women participants in a group discussion in Khichdipur, West Delhi.

What is undisputed, however, is that there are definitely a large number of cases where women are opting for sex selection under intense family pressure. Intense victimization of women was evident in remarks such as "life is very difficult for women, it is painful when they have to kill their own daughters, but still they have to do it." Apparently this intense social pressure, and the deep-seated internalisation of traditional values, beliefs and attitudes that perpetuate discrimination against the girl child, influence women in going in for sex-selection.

The team came across much anecdotal evidence subscribing to this claim. For instance, one of the members of the Khandelwal community (Rajasthan) shared that "the wedded couples resort to such practices under pressure from the elders in the family." Generally the women feel they cannot assert themselves despite having higher education and influence in the society (like holding senior posts in social and political institutions) and "they resign themselves to their fate as prescribed from time immemorial." This also raises questions about the effectiveness of education alone in changing mind-sets and as a strategy for empowering women to take greater control of their lives - or at least raises questions regarding the kind of education being provided.

iii) Attitude of 'husbands and in-laws' to Sex Selective Elimination of Girls (SSEs)

Among the families (husbands and in-laws) in general there doesn't seem to be any hesitation to avail of abortion services in order to have a male child. Some of the women we met in the field study complained about the pressure from their families. It seemed to imply that their mothers-in-law and husbands were so influenced by the son-preference mentality that they did not have difficulty in pushing the women into sex selective elimination of girls.

A significant section of the population that the team contacted expressed the view that SSEs were done secretly. No one boasts of sex selective elimination of girls, as they do so in the case of dowry – and yet both are illegal. This would seem to indicate that it is not the illegality of the act that troubles them, but the attitude regarding the 'wrongness' of abortion per se. Despite this there appears to be a growing acceptance of the phenomenon of SSEs especially amongst the socio-economically higher classes that view SD technology as a helpful method to have a baby of the desired sex. Tests are commonly done in the second pregnancy when the first child is a female. The growing societal pressure on couples with daughters to undergo sex-selection is perhaps evident from remarks such as "Oh! You did not do the test? You are educated and you should know this? How did you let yourself in to have the second daughter?''

The prevalence of sex-selective elimination of girls also appears to be influenced by religious affiliation. The families which belong to religious communities that ban abortions are generally against availing these practices. Thus, SSEs are less common amongst those followers of religions like Islam and Christianity which have clear and strong teachings against abortion. This is borne out by national statistics with Christians having the highest CSR, followed by Muslims. The team's visit to Mewat in Haryana, which has a predominantly Muslim population, revealed that it has a better sex ratio than the neighboring areas, – one that is almost at par with the national average. This is often attributed to Mewat's large Muslim population. Many in this community also agreed that because of their religion, women also do not have the freedom to go for an abortion. A Catholic bishop expressed surprise that there could be a campaign to prevent SSEs or gender discrimination, when the same campaigners would want to fight for the right to abortion.

However, as these same statistics on CSR for religious groups indicate, SSEs are also taking place in such communities, though admittedly at a lower rate. Further it was remarked, at the mini-consultation with religious representatives organised during this study, that sometimes religious edicts issued by the heads of a religious group did not seem to have as much of an effect on those who belonged to the higher socio-economic classes in that religious grouping. The Akhal Takht's hukumnama against sex selective elimination of girls was cited as an example to show that despite this, the CSR within the economically prosperous Sikh community which is the lowest in the country. Similarly another very rich community, the Jains, also show the second lowest CSR in the country as per the 2001 census report.

iv) Attitude of the Medical Community to Abortion and SSEs

Among the medical community too there does not generally seem to be much of a hesitation to offer or recommend abortion services, unless the medical service provider belongs to a religious group that condemns abortion (e.g. as in Catholic hospitals). Doctors feel more

comfortable and confident of offering MTP services, for two main reasons: (i) they can always indicate contraception failure as the reason, and (ii) for reasons of confidentiality the MTP records are not public documents and cannot be scrutinized by just about any one. Furthermore, for many medical service providers (not just doctors, but everybody right down to the ward boy or ayah) abortion appears to be a lucrative proposition and so it is easily recommended. One of the District AAs from Maharashtra pointed it out succinctly: "MTP is bread and butter for the doctors."

Many doctors consider the provision of legal and safe abortion as essential in our country and defend the Act, particularly from the point of view of offering a fail-safe 'family planning' measure - a view that may have prevailed at the time of legalising abortion through the MTP Act. According to the study team, this mindset is reflected in the provisions of the MTP Act that allows abortion for failure of contraceptive methods, and that such failure constituted grounds to establish sufficient mental agony for the woman.

Some doctors speak of helping the woman who comes to them for SSEs as they are aware that the woman would be hounded by her family if she gave birth to another daughter. Additionally, as one of the doctors met in Maharashtra indicated, the mindset of most doctors and nurses is also patriarchal, and they themselves do not find that there is anything wrong in son-preferential behaviour. For both these reasons, doctors generally do not hesitate to reveal the sex of the unborn child, subsequently do not counsel their clients not to proceed with an SSE and easily provide the service if they can do so without any danger to themselves. A doctor couple openly admitted that though they are at present strongly against SSEs, earlier they had shared a different opinion. 'Earlier we thought it is all right to do the test for the third or fourth pregnancy, because, we thought it would save the woman from repeated pregnancies to give birth to a son. Therefore we thought the test was okay in those cases. But now we think a complete ban is a right measure. Society is bound to face problems due to adverse sex ratio. One should accept the newborn baby, whatever the sex.'

Still another reason why some medical service providers support 'abortion' is their belief that it is an important right for women as it is the only reproductive right they can exercise without the consent of their husbands. This view was shared by many of the woman activists with whom the team interacted during the study. Therefore too, while many enablers did not want to use the term abortion in any pejorative context (therefore not even to use the phrase Sex Selective Abortion), there were others who were willing to critically examine the MTP Act only on condition that it could and would be done without violating a woman's right to abortion.

v) Reasons why a girl is not wanted

a) Financial cost

There is a perception among a large proportion of the population that people are inclined towards availing of sex determination services primarily because of the 'financial cost' of having a girl child – i.e. because of dowry, paying for her education, community customs that put a financial burden on the family etc. In general this perception, conjoined with the attitude that is common in India that the girl is "paraya dhan" (i.e. another's wealth), creates a mind set that all such expenses on the girl child are considered 'wasteful' *('watering somebody else's garden')*.

Thus 'mahangai' or cost of living was one of the reasons most commonly cited by people all over the nine states on 'why' sex-selection is practiced. Not only is a girl child considered costly from the point of view of dowry, but also her education and other expenses are seen as water down the drain as far as 'returns' are concerned. Therefore, many suggested that when the cost of living goes up the willingness to have girls decreases. Thus, for example, amongst certain communities like the Thever community of Usilampatti Taluka and Chellampatti Block of Tamil Nadu, a homogeneous community best known for its strong "macho" culture and uncompromising retention of certain age-old customs, there are signs of female infanticide practices giving way to female foeticide practices that correlates with the increasing access to technology and prevalence of the two-child norm. They are generally small and marginal farmers with an average landholding of one to two acres. The community members expressed that the girl child had turned out to be a burden in the family due to various social and economic reasons. For example parents found it difficult to nurture girl children in the context of the fact that any family function related to the girl child (e.g. her ears being pierced for earrings, attaining puberty, and most importantly her marriage) all invited huge expenses as the people vied with each other to do such things elaborately in order to gain 'status and recognition from society'. For example, the dowry amounts depended on the background of the bridegroom, so that a girl would have to be provided with a minimum 400-500 gms of gold if she was to marry a government servant. This was in addition to other expenses incurred to honour guests and giving the bride a large set of household articles, etc. All these efforts are spurred on by the concomitant fear of being ridiculed by others in case the above requirements are not carried out with élan, and therefore parents feel they must go to any extent in order to arrange the necessary finance even if it means pauperising themselves in the bargain. Obviously then those who were living in straitened circumstances in these communities, found it extremely difficult to cope with these customary practices and therefore resorted to practicing female infanticide and more recently female foeticide. A girl child, according to the group, is a 'curse' because of these unwanted social and customary practices. Similarly, in the context of a discussion with the members of the Peramalai Kallar (Most Backward Class category) community in Pinnathevanpatti village, Theni (5 km from

Theni district headquarters), in Tamil Nadu, the participants expressed their inability to look after the girl child owing to societal pressure and limited economic resources. The village is situated in a catchment area of a nearby dam and is prone to floods during the rainy season. "I hate the girl child' said one of the participants, with a lot of emotion, because she could not foresee any good future for them.

It appears that the proportion of girls has reportedly gone down considerably in areas/ communities where dowry transactions are heavy – for instance amongst the Jain and Khandelwal communities in Rajasthan. One of the doctors interviewed in Vadodara, Gujarat, indicated that the practice of dowry is a lifelong burden for a girl's parents. According to him, in his community, the girl's parents and brothers are supposed to provide her almost each and everything that the family requires even after the wedding, and that even educated families follow such customs.

Contrary to this, in Lakhanpal village in Punjab as per the survey conducted by Panchayat Federation (a local NGO), the village showed a CSR of 1400 girls to 1000 boys and the village panchayat has been awarded for improving the sex ratio in the village[9]. However, one activist remarked that one of the reasons for the increasing proportion of girls in that village is that it is primarily an SC village and amongst them the girls are seen as contributing to the family since their childhood.

In recent times there is also a fear that with property laws being amended a girl could take away a share of the family wealth when she gets married. A High court lawyer in Gujarat opined that the family wealth must always stay within the family and that this was possible only if a son was born. Some of the enablers present at the 'Looking Back' workshop (11th and 12th September 2006) felt that there is a need to look at the actual impact of bestowing the right to property on women. In a predominantly patrilineal society where 'men' are considered as the natural custodians of the family property, a daughter with property rights would mean an additional risk to such a patrilineal way of organising society since she could claim her share of the property after marriage. Whether this popular perception about the property rights for women makes girls more undesirable and has any bearing on the SSE of girls is an aspect that needs to be further explored. A worker in a Primary Health Center (PHC) in Jaipur commented: ''It is the sons who say they have exclusive claim to their father's property. I wanted to share my property equally among my three daughters and two sons. But my sons opposed it saying that I could give my daughters whatever I wanted to give at the time of their marriages." On the other hand other respondents felt there was need to do away with the custom of dowry and instead promote the notion of property rights for women. 'Do not give dowry to your daughter,

9 A news item in BBC News 16:22 GMT 17:22, U.K., Asit Jolly, "Punjab village bucks foeticide trend" 17 th May, 06.

give her the property right', is a slogan that an ordinary citizen in Rajasthan suggested should be popularized.

b) Patriarchal attitude and son preference

The whole patriarchal attitude which devalues women (for religious, financial and other reasons) tends to foster a very strong son-preference. The religious rituals, for instance, foster the importance of a son over a daughter, and shape societal attitudes in favour of the son. This attitude was pertinently expressed by a compounder working in a PHC in Chaksu block in Jaipur. "People adopt a son (dattak putra) from among their own relatives if they do not have any. This custom of dattak putra is quite discriminatory to girls. It must be abolished," he said. According to some other respondents, "Customs like dowry and beliefs like moksha prapti (attainment of salvation when the son does the last rites) not only makes a male child important, but also devalues the female child. The girl child thus happens to be an unwanted one."

The importance of societal dictates in shaping the 'anti-girl' perspective also emerged throughout the various interactions. Several people said that the religious heads themselves foster this. Thus though it has been argued that in Vedic times even women could do the necessary funeral rituals for their parents, it is still the common perception that a son is needed. The son is still perceived in religious discourse as 'Pu-Tar'; which means 'woh narakse tarega' (the one who will save from hell) and the one who enables the father to attain moksha.

Similarly community customs that put financial burdens on the family of the girl/woman right from childhood and which often enough continue even after marriage, ensure that the status of women remains low. Some of the reasons cited by women/mothers to participate in the killing of the girl child or foetus were: "The mother/woman gets greater dignity in the family when she gives birth to a male child" or "A son is considered important as they provide old age security to parents." All these reflect the reality that sex-selection is actually a fall-out of the overall low status of women in the society. Therefore several people were of the opinion that female foeticide would not stop as long as other manifestations of gender violence continued in society For instance although sex determination is considered to be legally wrong and abortion is considered a 'paap' yet son preference is so ingrained in people's (including women's) mindsets that the son preference can overcome the difficulties raised by the former two aspects. Thus the intent of the law is not in sync with the mindset found among a large proportion of the population.

The role of a patriarchal mind-set and the importance of having a male-child in a patrilineal society coupled with the overall low position of women is thus clearly considered as one of the primary motivating factors driving 'people' to practise sex-selection. Comments such as "nowadays people want to have two sons and one daughter" corroborate this

mindset. Some shared that this has become a set pattern in rural area, especially among rich and educated people. "Poor people give birth to more children for want of a son. Everyone wants to have a son." That this thinking is deep rooted can be seen from the mindset of the Thever community where having a male child in a family is considered as owning a "Sinha-kutty" (i.e. a lion-cub). Thus the preference for a male child as compared to a female child is obvious. The community explained that whether one is rich or poor, the place enjoyed by a male could not be questioned or discussed openly due to various superstitions and cultures practiced by people. All this may have led to the practice of female infanticide that was common in some parts of Tamil Nadu especially among poverty-stricken families, leading to social acceptance of the practice of not having female children. Today, the district administration would claim that female infanticide is satisfactorily under control, though one cannot say this categorically as isolated incidents are still reported. However, what is clear is that in its stead, the trend of female foeticide is purported to be on the increase due to easy access to technology and corrupt medical practitioners. It is also argued that if female foeticide is not affordable to a family or is prevented legally, then the age-old practice of female infanticide would probably be revived.

On the other hand, among the matrilineal societies there is a feeling that it is the women who will take care of them in their old age. For instance, in the case of the secluded tribal community known as Malaiwar Makkal (i.e. children of the hills) visited in Kathirvelpuram village, in Theni District, Tamil Nadu there is reportedly a child sex ratio, which is slightly in favour of women. This community follows the matriarchal culture where girls remain at home even after marriage. The parents, especially mothers, strongly felt that only girls could provide them security in their old age and hence there was no question of infanticide or foeticide in their own community.

Even among patriarchal communities, despite the increasing realization that girls seem to take better care of their parents in their old age and that boys are difficult to control, there seems to be a strong son preference. This ties in with the findings of Roy and Rutherford which speaks of declining ISR rates all around the country and yet the rate still being quite high.

c) Concern for the girl child

Many women (particularly in places where they were aware of their own oppression) expressed the opinion that since the girl child had nothing to look forward to except suffering, it was better that she was not born. Similarly many women also seemed to indicate that in today's world girls were increasingly in danger of being physically abused and violated and therefore it was better not to have a girl. These concerns were also expressed by other members of society. Some doctors who were interviewed justified SSEs by claiming that "by providing this 'service' we save the girls from sufferings in their future life."

There were many who referred to the stigma attached to women being single and the tremendous pressure that resulted in women necessarily having to be married somehow to anybody or at any cost – which of course also led to much suffering for the girl/young woman. "The mother/woman doesn't want to give birth to a child who would have to suffer what she herself has suffered" "The women suffer a lot and feel that their daughters would also meet with the same fate." These were some of the comments of a group of woman met in Khichdipur in West Delhi. Similar feelings were expressed by the women in Bhadgoan village in Jalgaon District, Maharashtra. Referring to the overall low status of women in their own community, women from the Thevar community in Tamil Nadu felt that their (girls') arrival in this crude society was not appreciated and even if she (the girl child) survived how could she have a better life within the context of the existing oppressions meted out to her by society, especially by the men folk. Many enablers suggested that this apparent helplessness deriving from the internalised oppression and discrimination experienced by women, needs to be targeted in order to change their mindset.

Their urban counterparts expressed concern of safety and security of their daughters. "A girl is a responsibility", expressed an educated urban woman. "The parents worry about her security and have to think of seemingly small matters to ensure her security. For instance, if you have a daughter, you cannot employ a male servant, you feel insecure to leave her alone at home."

The rural women near Dholpur in Rajasthan also expressed the need to ensure security and respect for women to improve their status within the society. One of them said, 'Jab ladki choti hoti hai to koi dhyan nahi deta, lekin badi ho jati hai to jadahi dhyan dete hai.' (when girls are small they are grossly neglected; but when they grow up many restrictions are imposed on them.) In Punjab some additional reasons were given, namely the historical reason of being a border state where protection of girls was an added source of worry.

d) Growth of "affluence and urbanisation"

It was suggested by some of the enablers the team met with, that the growth of affluence and urbanisation within the context of globalisation, fosters competition and looking after one's self as the primary responsibility if one wanted to succeed in life. This is perhaps leading to a situation where the girl child is undervalued significantly because she is not a good "investment". In this context, some of those interviewed were of the opinion that this undervaluing of the girl child was more of an urban phenomenon and could be attributed to the general erosion of 'values' and a growing commercial attitude of working couples. Many such working couples have very individualistic and commercial views towards life and would make use of Sex Determination (SD) tests for various reasons. Interactions with several women in and around Gurgaon district in Haryana indicated that an overwhelming majority of the women were aware of the methods of

sex-selection. Furthermore, since the people had become very rich in this part of the country (as their proximity to the industrial town of Gurgaon meant that property rates had skyrocketed) there was a fear that the property would go to the son-in- law, when the girl gets married and therefore it is perhaps not a good investment to have a girl.

Many of the participants at the various mini-consultations organised, or those interviewed individually, specifically identified the increasing commercialisation of society that was beginning to control all human interactions, and even human relationships. In the context of globalisation that fosters a consumerist and market economy there has been a general erosion of 'other-centred' values. In such a scenario monetary considerations appear to condition a lot of people's choices and seem to tie in with the growing greed of society, which is also reflected in the medical community. Added to this is the deification of the notion of 'individual choice' in a society that also exhibits strong male preference. All this would 'naturally' lead new technology (currently in the form of ultrasonography) being used to encourage the successive SSE of girls.

vi) Attitudes regarding implications of lower number of Girls

Even among those who accept that the child sex ratio in the country is a problem, the primary concern was expressed in ideas that seemed to exhibit a functional or utilitarian approach to the value of women (e.g. there will be no women to marry or to bear children), and not one that highlighted their intrinsic value.

The perception that the general population has with regard to the implications of a declining sex ratio is again insightful and reflects the gender stereotypes and patriarchal mind-set that most people subscribe to. On being asked 'why' a declining sex-ratio could be a problem, most of those who did perceive it as a problem said that there would be no girls left for the boys to marry, or to give birth to future generations. The issue is not looked at as one of equality or the girl child's right to live but from the functionalist point of view – namely that girls are needed to fulfil certain functions in society. This was the most common perception expressed in almost all the places visited.

Thus with regard to the perceived effects on the social fabric when the number of girls decline drastically, the most common ones enumerated were as follows:

a) For most people, the primary negative effect is that there would not be enough girls to marry (hence a lot of their practical responses are geared towards smoothening out problems of boys finding girls for marriage)
b) A few opined that it would make life less secure for girls everywhere, and more boys would get involved in acts of sexual abuse and harassment of girls etc. A few pointed out the increasing danger for girls and women to travel alone in the evenings/nights even in the capital city of India, Delhi.

c) Some however felt that the dowry system would decline, since there would be fewer girls than boys. However, another opinion often expressed was that in such a situation the dowry system would only be replaced by the outright buying and selling of women leading to their even greater devaluation and commodification

vii) Who should be punished? Pregnant Woman or Family of the Woman or Doctors?

It was commonly felt that the woman should not be the focus of pressure, as they themselves are mostly victims. However, in a few cases there has been a strategy implemented where the pregnant women are closely monitored and thus pressure is brought on them or on the clinics that service such SSE practices. A significant number of participants during the 'Looking Back'[10] workshop expressed the need to work both on the demand and supply side of the problem. However, while working on the demand side they felt that although it might be acceptable to focus on the families, it was not a good strategy to focus on the pregnant women. They felt that the latter was undesirable owing to its negative effects on ante-natal care (e.g. the women sometimes do not get registered with the government health centres till the fourth month or later, for fear of being monitored), and also because this kind of pregnancy-watch was not feasible in the private sector, rural and remote areas, as well as in the economically backward states.

Those who argued against targeting the women critique those efforts which focus on monitoring pregnancies and not on monitoring doctors. A critique of this kind of approach identified the following problems with such an approach: (a) Women have started concealing their pregnancies till the 4th month by which time they can find out the sex of the unborn child and abort without getting caught by the watchful eyes of the administration. As a result they do not access medical help even when needed during these crucial first months. (b) There is an increase in those who resort to quacks and non-trained medical personnel for termination of unwanted pregnancies with obvious effects on the health of the mother (c) The reproductive rights of women are being compromised by such an approach of monitoring the women, especially as there seems to be no distinction made between the right to abortion under the MTP act, and the illegal practice of SSEs. Thus even those who go in for an MTP under legitimate reasons are being hounded. (d) There is also the fear raised that a strict control of female foeticide could lead to an increase in female infanticide and abandonment of female children.

On the other hand those who have used this approach of monitoring the pregnant women, have shown that it is possible using this approach to both control SSEs and even the

10 Please see Annexure I for details on the 'Looking Back' workshops conducted in Sep,06 in the process of the study.

medical community which has since become extremely wary of getting involved in activities that go against the law as expressed in the PC-PNDT Act. It is also argued that since sex determination is communicated in such a secretive manner, and the abortion which follows is usually done in an unrelated clinic, there is no other practical way to really prevent it unless there is a monitoring of the pregnancies in a district. In response to the objection that the woman is already victimised and this makes her even more the brunt of the law, it is suggested that while the monitoring is done of the pregnancies, the legal action, if any, can be taken against the families rather than the woman. And if women are waiting till the fourth month before seeking medical care for their pregnancies, then it could perhaps be argued that they are in favour of SSEs and need to be held equally responsible. It is further argued that ultimately it is a question of finding the most effective way of preventing this hidden mass-scale genocide that is taking place, and this must be done in a way that is practical rather than worry about victimisation. They further argue that it must not be forgotten that it is the girl child (the female foetus) who is the most victimised and it is a lesser evil to bring pressure on women and their families than to allow the indiscriminate killing of the girl child. Finally, problems arising out of the infringement of the rights of the woman under the MTP Act need to be sorted out so that a woman's right under the clauses of this Act can be safeguarded.

Generally, however, attitudes regarding who was most culpable oscillated between those who blamed the medical service providers, and those who laid the primary blame on the families (mother-in-law and husband) of the woman. It was generally felt that the woman who requests an SSE is under tremendous pressure from her family and society and in this sense is a "victim" herself. The role of negotiation with mothers-in-law and husbands was recognized as playing a critical role while addressing the issue in letting the girl child to be born. Many of them felt that the "mothers-in-law and the husbands" should be punished for pressurizing the woman to undergo the tests. The doctors should also be punished "because if they do not do it, the woman cannot do it herself." This was the response among the general population right across all states visited.

Among the medical community, of course, there were many who said that the doctor should not be made the scapegoat. According to them there was too much emphasis on doctors and on 'catching' them, as they are viewed as the main culprits behind this problem. Such people argued that the medical community is only catering to people's needs. Therefore there should be severe punishment for people who request such services. As it is, people opting for it outnumber the doctors offering this service. A person related to the medical service community had this to say: "Doctors are not as responsible as the people who go for it. Doctors do not approach the patients. It is the other way round. If nobody visits the doctors they will have to close down their service. However, people demand it. The person approaching doctors should be considered equally guilty and must be punished. However, the woman should not be punished. Her husband pressurizes her

and he should be punished". Another opined: "There is no use punishing a doctor. The people should be punished. If they do not go to the doctor, how will he do the tests?" A cross-section of people particularly from the medical community who were met in Rajasthan expressed this viewpoint: "Firstly, the family should be punished. They have masterminded the 'murder'." Some sections amongst the doctors held that the people are primarily responsible for the problem. They opined, "The people are aware of this technology and it is also easily available to them. It is the people who insist upon knowing the sex of the foetus and are quite adamant about it."

A significant section of the people in the 'medical service provider' category including the health workers felt that it is the woman and not so much the doctor that should be blamed for sex-determination. This is reflected in comments such as 'ismein hamari kya zimmedari hai? Do paise to sab kamana chahte hain?' (i.e. what is our responsibility in this? Everybody desires to earn a little) – commented a health worker in Khichripur village in Delhi who claimed to be referring women for such services to the doctors in the neighbourhood.

A doctor in a government hospital in Rajasthan commented: "Only a few doctors are offering services for SSE. Doctors in general cannot be blamed. They are aware of the law and fear to get involved in illegal practices. The women, who go for such check ups, should stop going. Then only the situation will change. Most doctors do a fair practice. However, they are also part of the same materialistic society and want to make money" The blame-game of passing the responsibility to the customer was evident despite their tacit acceptance of the fact that the doctors are engaging in it purely out of greed motivated by their desire for making money.

This kind of perception of holding the 'community'/'buyers' going in for these kind of services as responsible for the problem rather than focusing on the 'medical service providers' was also seen among several AAs.

On the other hand a significant proportion of the general population felt that it was important to focus on the medical service providers (doctors in particular) as the main "culprits" behind the problem. Many, felt that the doctors are in this only for the money and therefore it is their greed that encourages and fosters sex determination and sex selective elimination of girls. For instance, a study conducted in Gujarat in 1999-2000 by Sahiyar found that almost 37% women confirmed that they got information regarding sex determination possibilities from doctors themselves. This seems to indicate that the doctors themselves advise patients to use the tests and they are not just catering to the demand. A calculation of the economics of this practice (ultrasound checking and subsequent abortion of the female foetus) seems to indicate that it is a huge business. One prominent doctor in Delhi interviewed by the team estimated this to be a 500 crore-

rupee business annually.). A study published in the The Lancet Report[11] claims that 0.5 million female foetuses are aborted annually in India. Thus there is reportedly a lot of big money at stake, which doctors will not give up easily. Therefore there are many who felt the doctor is the primary criminal and the one on whom the pressure ought to be brought.

There were those who felt that the doctors have been the focus under the Act as they are the agency engaged in sex-determination, whereas the health workers have so far not been targeted by any sustained and significant efforts. Yet these health workers are critical links in the chain that encourages and facilitates the use of Sex Determination and SSE services. And therefore many suggested that it might be important to also focus on this entire chain, right from the ward boy to the doctor.

Almost all the enablers visited felt that the doctors should be punished. 'They are guilty. If they practice ethically, the problem would not arise', they remarked. Most felt the focus should be on the doctor and sex selection and not on women and abortion.

In actual fact, some of the Medical Associations are gradually beginning to openly admit that the doctors are indeed prime culprits in this nefarious practice. They are willing to admit that as many as 10% or more of the doctors are indulging in these practices. And they are willing to concede that 'catching doctors' would help to bring down the prevalence of such practices significantly.

Stressing the need for doctors to play a more socially responsible role, one doctor from Dholpur, Rajasthan stressed the need, and said "Doctors can play a crucial role in dissuading people from opting for sex selection. Earlier some people used to approach me to know about the service. Since I refused there and then, now nobody comes asking for these services. They (doctors) can also offer counselling whenever a patient comes to them requesting a sex determination test. From my experience I can say that people are compelled to rethink their decision once you talk to them."

viii) Why is the implementation of the Act so difficult?

A number of reasons were proposed by different stakeholders;

a) Conflict of interest

Among those who knew about the Act, there were many among the community, as well as among the enablers and implementers who believed that there was an inherent conflict of interest that would make implementation of the Act very difficult. It was argued that doctors are the ones appointed to monitor and enforce the implementation of the Act

11 The Lancet, Volume 367, Number 9506, 21 January 2006. A study of the "Low male-to-female sex ratio of children born in India: a national survey of 1.1 million Indian households" by Prabhat Jha, Rajesh Kumar, Priya Vasa, Neeraj Dhingra, Deva Thiruchelvam, Rahim Moineddin.

(the Appropriate Authorities at District or State) and the ones who break the law are also doctors. Consequently, their 'loyalty' to their co-professionals makes it difficult for these authorities to take action. In general, it is the experience in India that doctors are rarely willing to speak up as witnesses against their own colleagues.

Among those in the medical community who do acknowledge this conflict of interest, there is a claim that only a miniscule percentage of doctors actually offer sex determination services. Furthermore, they claim that many of those who offer such services are not qualified or are those practicing alternative medicines. Many of the participants particularly the enablers present at the 'Looking Back' validation workshop however did not agree with the above statement that 'only a miniscule percentage of doctors actually offer sex determination services'. They felt that the actual percentage of doctors providing such services was drastically more than these figures. This was later confirmed by other doctors in the medical associations that are taking up this matter.

The participants in the 'Looking BACK' workshop felt that the reason for inadequate implementation lay not only in the 'conflict of interest', but also in the lack of a mechanism to ensure strict accountability of AAs. Several expressed the need to make the AAs accountable for his/her area of jurisdiction and having appropriate mechanisms to enforce such accountability.

b) Attitude of Sympathy

There was an attitude of sympathy among many for the woman who is harassed by her family because she does not have a son. In this context there were some who felt the same sympathy and gratitude to the doctors, as they felt that the latter were only fulfilling a need of the woman. Hence there is a general unwillingness to enforce the Act in a large proportion of the general population, as they too share the 'son-preference' mind-set.

The interviews indicated that the health workers serve as an important link between the customer and the doctors and in some instances the health workers consider it as part of their duty to help women looking for facilities to undergo sex-selective elimination in their neighbourhood. "These days people do not want too many children, and hence they are going in for repeated abortions. Many a time when they find that they are going to have girls, they go in for abortions as they already have too many children. They do not do it at the dispensary, I have often taken them for jaanch (finding out the sex of the child) to private clinics," was the comment of a health worker in Khichripur, Delhi. This 'sympathetic' attitude was reflected in many places.

However, many of the enablers present during the 'Looking Back' workshop did not accept the 'sympathy' factor as expressed by the medical community as a valid reason for

indulging in the 'practice' but on the contrary felt that it was predominantly their greed for money and pure commercial attitude that motivated them to indulge in such illegal practice.

c) Natural Desire and Right to know the sex of one's unborn child

Many felt that it was a natural desire, and even a person's right, to know the sex of his/ her child. Moreover, the entire matter was also perceived as a personal issue and NOT one in which the state or community should interfere. Thus for instance, women interviewed in many parts of the country, especially the educated and young, mentioned that women should be able to freely know what is the sex of the child. Thus some sections felt that it should be a matter of right for the women to know the sex of the child as they claimed was possible in some of the western countries. While they may not countenance the female foeticide that follows on such sex determination, they seemed to feel that these two issues are quite separate and sex determination per se was not a problem or something that could be perceived as criminal.

Also interlinked with the issue of sex-determination is the whole issue of 'reproductive rights' and 'right to information' which is often used especially by the educated, urban woman as a defence to justify her right to know the sex of the child. Thus, ethically they do not have a problem with sex-selection and this seems to indicate that a future market for the business is already being created.

Thus, a large proportion of the population does not have any ethical difficulty in finding out or helping others find out the sex of their unborn child. Consequently, they are not convinced of the need to criminalize sex determination services although they could simultaneously be concerned about the issue of 'missing girls'.

d) Attitude of Privacy with regard to availing of these services

While the statistics clearly show that a large number of people avail of such sex determination services and subsequent elimination of the female foetuses, the study team realised during the interactions with various community members in the 9 states visited, that very few acknowledge having undergone sex selective elimination of girl themselves. While this could be attributed to their knowledge of the law, this seems unlikely, since many who go in for abortion think that having an abortion is legal (under any circumstance) and a significant percentage of those who avail of sex determination tests do not know that it is illegal.

During the entire study there were very few who admitted that they or a relative of theirs actually underwent an SSE because the foetus was found to be a girl. In fact in most cases there was first a denial, with leaders of communities insisting (until they were brought

face to face with the relevant data) that this kind of practice was not prevalent in their own communities.

Furthermore, though dowry is illegal, people do not seem to have any difficulty in admitting or even boasting about the amount of dowry they were able to command for their sons or themselves. Consequently, this refusal to acknowledge having undergone SSEs may mean that though there is social pressure and even approval towards having a son, there may be a strong social taboo about abortion as a means to ensure this.

e) Desire for a Small & 'Balanced' Family

There was also an attitude that a small family (two-child family) was important for health, financial and career-related reasons. This attitude has spread throughout the country, and could be seen as a success of the Government's population campaign. Added to this is the commonly held belief that a balanced family would normally mean having one boy and one girl. This is probably also encouraged unconsciously by some of the family planning communication material which mostly shows a small family with one boy and one girl.

The small family norm along with the technology for sex-selection has indeed led to a skewing of the child sex ratio against the girls. This was implicit in comments heard from people. "The number of children people have these days is less, which is why the number of girls is also less." "These days people do not want too many children, and hence they are going in for repeated abortions." "Many a time when they find that it's a girl, they go for abortions as they already have too many children."

f) Foeticide as compared to Infanticide

In communities where female infanticide was taking place, female foeticide is seen as less gruesome and less revolting than killing a living girl child. This was particularly noticed in the interactions with groups in Tamil Nadu where female infanticide used to take place to a much greater extent earlier. But it was also a kind of mindset that came up in other interviews/interactions with civil society during the study. In fact it was pointed out that while infanticide was confined to a few communities spread out in a few places in the country, the practice of foeticide was found in all sorts of communities all over India, and one of the important reasons given was that the killing of the foetus did not evoke the same revulsion that infanticide does.

g) Scepticism about the efficacy of the Law

There was generally an attitude of scepticism among members of the general population with regard to the LAW being able to bring about change - especially as it is a 'crime' in which the victim is killed, and both the living witnesses are hand-in-glove, even as according to the law they themselves are the criminals. There is also the perception that the law has not succeeded much in catching any doctors despite the many 'stings', and that nothing

much will happen. There have been only 300 plus cases in all of India with hardly two convictions.[12]

Several individuals that the team met stressed the limited role that the law could play in addressing the issue as they felt it was more of a social problem, which could be effectively countered by bringing about attitudinal and behavioural change amongst the population.

The crass commercial attitude and 'business-like' nature of the operations and inefficacy of the law in curbing the menace was clearly evident from remarks made by people such as "I know that there is a ban on finding out the sex of the child, and they are not doing it anymore at the government clinics and hospitals. However some doctors charge more money saying that it is illegal and they can be caught, and sometimes they also threaten the woman for money saying that he can put her in jail. It is still happening, actually more, what is the use of the act?"

However, almost all the enablers are positive that proper implementation of the law is definitely one of the primary ways (sometimes the only way) by which this trend of SSEs of the girl child can be reversed. Many of them felt that changing social mindsets is a long drawn out task and that one could not wait for that to happen if one must bring about change in the short term. There was a smaller percentage among the enablers who, however, were of the opinion that focussing on the law alone cannot effectively bring about the change required.

h) Power of the Doctors' lobby

There was also an attitude that the doctors' lobby is so very powerful and rich, that it would be very difficult to go against them. Furthermore, in many places the doctors as a class are among the richest and most respected community group and also a group that the general population is dependent on. Therefore it has a lot of power to defend their practice. According to one enabler in Delhi, the doctor lobby is very strong both economically and politically and unless the government takes the implementation seriously enough, it cannot be tackled. Another enabler in Maharashtra commented, "There is tremendous political pressure from the doctor lobby, which is highly organized, and rich which makes it difficult for even willing authorities to function properly".

This was further compounded by the almost universal perception that doctors would never stand up against each other, even if their colleagues broke the law.

Many expressed the view that since the main motivation for the doctors is money there was no hope that the doctors would work for the implementation of the Act. If at all there

12 A report on the PC-PNDT Act by Symbiosis Society Law college legal Aid & Literacy cell in Aug,06 and newspaper clipping.

was a way of making the breaking of the law a high-risk option for them, then and then only would they tend to obey the law.

i) Corruption in Government

There was also an attitude that there is so much of corruption in the administrative machinery of the Government that this has led increasingly to a general attitude that money can buy anything. This is also influencing people to break the law with impunity because they believe that with money/political influence they can get out of any trouble, and knowing the sex of their unborn child, even if technically illegal, would also be one of the legal hassles that money/political influence can help them find a way out of.

Some doctors expressed the feeling that pressure in the form of allurement/coercion through bribes and/or political interference, could entice or force doctors to resort to sex determination tests. Many of them of course reported that they resist these pressures, but also commented that in the prevailing scenario it was difficult to gauge the extent to which it was possible for any one to resist the attraction of money, power and a relationship with an existing political power, as well as the prospect of losing customers.

One doctor shared the experience that high officials (police officials and bureaucrats) had approached her for sex-determination and allied services for some of their female relatives. She commented that obviously then the chances of people like these being willing to implement the Act strictly was unlikely.

The team came across cases where the AA would allegedly inform the identified doctor in advance before an inspection took place. In another district the Advisory Body refused to allow the AA to take further action demanded by the Act (i.e. to take the case to court). In still another case the State Supervisory Board overturned the action taken at the District level allegedly on the basis of extrinsic reasons. These were only a few of the many examples that were reported to the team.

j) Impossibility of Proper Monitoring

There is also the attitude among the doctors that in any case the AAs cannot and will not check the F forms[13] and other forms submitted, as the authorities do not have the will or the resources to check them. Furthermore there is also a belief that the forms can be easily fudged, and so overall there is little chance of the law being properly monitored.

This of course is further confirmed by the undisputed fact that very few have been convicted over the past twelve years of the existence of this Act, and the fact that a recent

13 As per the Rule 9(4) of the PC-PNDT Act the record to be maintained by every Genetic Clinic, in respect of each man or woman subjected to any pre-natal diagnostic procedure/technique/test shall be specified in Form F.

study by those enablers who have managed to analyse these F forms has shown that they are either not filled properly or fraudulently filled – and yet no one has either known about it, or done anything about it.

Furthermore, since the judges too are allegedly not too conversant with the law, it has been reported that seized machines have been unsealed because the judge believed that non-maintenance of records or inaccuracy in records were not serious enough crimes to punish the doctor from continuing with his/her livelihood. This has further emboldened doctors who indulge in such practices since they are further confirmed in their belief that such an Act cannot be properly implemented or monitored.

k) Lack of political will

There is a general feeling that there is a lack of political will to implement the Act, and hence nothing can really be done. Thus, it is claimed that many States have failed to issue the necessary Government Resolutions (GRs), to appoint AAs and other authorities, by notification at district and sub-district levels. It has also been shared by many that politicians also interfere in the implementation of the law by bringing pressure on the concerned authorities to ensure that the doctors are not punished.

The team has also come across many examples of significant political intervention that prevent the implementation of the Law. For example, it has been reported that even the Inspection Committee[14] have had to sometimes return from an inspection visit because the political establishment in the district visited sided with the violating doctors. In other cases the District Advisory Committee or the State Appropriate Authority(SAA) has been highly influenced by political pressure and has refused to allow action to be taken against doctors who violate the law. The lack of political will is also seen in the very lack of power experienced by those in the Central Supervisory Board at the Centre, to enforce the law at the State or District levels despite the power given to it in the Act[15].

"While implementing the PC-PNDT Act the problem of unregistered clinics who are reportedly practising sex determination and sex-selective abortions in Tamil Nadu cannot be addressed due to several reasons including political and bureaucratic patronage enjoyed by them", said a senior medical officer in Tamil Nadu.

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14 The National Inspection and Monitoring Committee is a governmental committee constituted at the Centre to take stock of the ground realities by field visits to the problem States. The Committee visits vulnerable States/districts and submit the report to the Central Supervisory Board (CSB) and the concerned State authorities.

15 Article 16, clause (v) states that CSR shall oversee the performance of various bodies constituted under the Act and take appropriate steps to ensure its proper and effective implementation.

Some also felt that the problem of there not being enough impact on the ground is also partly attributable to the fact that the priority of the government differs from time to time. These priorities could change from polio to HIV/AIDS to malaria to TB etc. So work done in one field falls apart since it is not carried out systematically and consistently over a long enough period of time.

Lack of proper records because of lack of proper registration of births doesn't allow constant and frequent monitoring of the SRB. Consequently it becomes a valid national issue only when the Census takes place - as happened with the 2001 census results, and for a brief period thereafter some political will is generated.

Some also felt that the issue has not been highlighted as an issue of national concern, which is why not enough attention and resources have been allocated to fight it on a war footing.

l) Beliefs about Ultrasound

There is a belief that the ultrasound technique helps the doctor to know conclusively the sex of the child – though a doctor from Maharashtra stated that chances of incorrect prediction are almost 93% in the first trimester of pregnancy. Thus this erroneous belief encourages people to go in voluntarily for the test.

Furthermore, despite a conviction among some senior gynaecologists that ultrasound tests are being indiscriminately and overused in ante-natal care, the use of these tests has become so ubiquitous with such a large number of doctors convinced of its absolute need, that the Law can only speak of regulating the use of these machines. And since in attempting to regulate it, the Act allows such tests to be conducted under specific conditions (23 different reasons are listed in the F form mandated by the Rules under the PC-PNDT Act), there is little that can be done to prevent its use for sex selection while the doctor uses the machine for a legally approved purpose.

ix) Attitudes of Doctors

a) Contrary effects of sting operations

While doctors clearly fear being sent to jail or publicly being branded as criminals and therefore seem to be quite affected by sting operations, there are others among the medical community who are also using the publicity generated by various sting operations and the many public awareness-building exercises, as an excuse to increase their charges for such services. This they do by pointing out the dangers they have to face by doing an illegal act for the sake of the customer. For instance, as per the information given to the study team during the field visits, abortion charges in some parts of Punjab have gone up to Rs.15,000/- to 20,000/- (which includes charges for sex determination). In districts

like Nawashahar where there is strict monitoring, the rates have gone up much higher as compared to what they were two years back.

b) Commercialisation & Privatization of medical services

There are a number of 'market-driven' factors that also contribute to the lack of implementation of the Act. For one, the introduction of management seats for medical colleges which result in huge amounts being spent on gaining admission, and the increasing cost of sophisticated machines that seem more and more necessary for medical practice today, are all seen as 'investments' on which a profitable return is expected and socially condoned. Secondly, the Act itself allows the separation between the owner and the medical practitioner, and further endorses the profit motive because the only reason a non-medical person would invest in such a machine would be to use it to make profit, and not to offer a medical service to the community. Thirdly the current political trend towards privatization of health care further fosters this commercial attitude. Fourthly the increasing number of sonography machines being sold often means that a doctor has to offer additional services in order to attract clients, and this particular business of offering sex determination services is estimated as being particularly profitable. All this of course leads to the increasing commercialization of the profession and contributes significantly to the difficulties in implementing the Act.

There are growing indications of commercialisation of the practice of sex selection in the existing health care system. Thus in many cases the monetary incentive helps to cement the collusion between various medical and para-medical functionaries operating at various levels including the grass-root level health functionaries like the ANMs, Dais, the doctors, and the clinics. "In the village, block level doctors and other health staff help people by giving information regarding the clinics which offer SD" – acknowledged a doctor from Jaipur. "SD means easy money to them. The doctors will not properly advice their patients. Rather they will see how their business will flourish. Most clinics and hospitals give commissions to rural doctors and nurses for sending them cases. They do everything possible to encourage people to come to their clinics." said another doctor in another part of Rajasthan. The doctors in the public health care system do not themselves do such tests or abortions, but they send cases to private clinics in the city and get huge commissions. This was the view expressed by a nurse working in a rural health Centre run in a village near Jaipur.

The general population also appeared to be aware of this collusion. A young person in a discussion held with a focus group in Jaipur said, "There are also ANMs and other health workers who act as conduits for information, and motivate women to go for such sex determination tests and in turn earn commissions." Other comments such, as "The people working in the official and unofficial health system are all hand in glove with each other. Thus, not only the midwives (dais) of the village, but also the lower rung staff in the

government health system, such as nurses, ward boys, sweepers get a commission from doctors and they divert people to such practices." were commonly heard.

'Private doctors take advantage of peoples' ignorance concerning health problems. Normally one sonography per trimester is enough to monitor the proper growth of the foetus. However, radiologists do it in every check-up during pregnancy. Thus a total of ten to twelve tests are done unnecessarily to get business', said an ANM in Maharashtra.

Another senior activist in Jaipur remarked: Ye to unka kamane khane ka dhanda ho gaya hai (i.e. this has become their business and way to earn money)" Another doctor in Maharashtra estimated that the income earned through SD related services runs into crores annually.

c) Decline in Medical Ethics

It was also suggested by many that the ethical grounding of today's medical practice has been completely undermined and the medical profession has been completely commercialised as explained above. There is an acceptance even among the medical community about the commercial and unethical practices some of their colleagues are indulging in. This was evident from remarks such as "They do it for easy money and also to recover investment made in the machines. Advanced machines cost Rs. 6 lakhs and more. We normally charge Rs. 250 for routine sonography tests. SD tests are costly and doctors charge Rs. 1500/- to 2000/- for that." Or "There is a competition due to availability of more machines. Doctors resort to illegal practice (by doing SD), as their investment will not be recovered from fair practice. After the test, if the foetus is female they get a case for abortion and if it is a male they get a case for delivery. Thus offering this service increases their business." This was particularly the perception of senior doctors in addition to many outside the medical community. No wonder the area in Jalgoan where most clinics and private hospitals are located is referred to as 'Doctor Bazaar'.

d) Perception of the Act as a means to Harass Doctors

There is an attitude among doctors that the ACT is meant to harass doctors, either through what they consider the painful and complicated paperwork that needs to be carried out, and/or because doctors cannot be expected to know all the intricacies of the law and hence could very well fall foul of it without intending to.

Some doctors also accepted that they were unaware of the nitty-gritty of the Act. Others felt that the filling out of the F forms and the maintenance of other documentation/ records as required under the PC-PNDT Act were all very cumbersome. The President of one of the state chapters of the Indian Medical Association (IMA) stated: "The forms to be filled under the Act are too many and complicated. The procedure for maintaining records and reporting to appropriate authorities needs to be simplified. The doctors really

do not have time to fill in the forms, which are not at all read by anyone." One of the doctors met in Pune, Maharashtra said, "The reason for non-acceptance by doctors in general is their perception that the amount of paperwork that they have to fulfil is not possible within the time of their practice, and also their fear of the harassment they tend to suffer in part due to their lack of understanding and knowledge of the Act."

On the other hand, certain other sections, even among the doctor community, expressed their belief that it was not difficult to fill up the 'F' forms. "It is very easy to fill the form. It is primarily a clerical job and I asked my assistant to do it." However, they also remarked that it is very easy to manipulate the records especially as one doctor remarked: "I doubt whether anyone reads this forms. I have not heard of any action taken against doctors who present fudged reports." A number of doctors corroborated with the view that though the forms are not difficult to fill-up they could also be easily fudged if one wanted to and thus disguise the real purpose and number of ultrasound tests. In that sense they did not see much value in it. In any case many doctors felt that there was need to orient and build the capacity of doctors to fill out these forms and fulfil the documentary requirements." Despite these differences in opinion most of the doctors felt that even if they did send the F forms no one would have the time to read and check them, and the reporting is mere paper work which did not serve any real purpose.

There was also confusion among doctors (and the enablers too) as to whether the F forms themselves had to be submitted every month, or only a consolidated report.

The fact that it is not the machine but the clinic or vehicle, which is registered, raises piquant situations, which doctors find strange. Thus if a patient who cannot be moved needs to have an ultrasound taken, technically the person has either to be placed in a mobile vehicle (which would of course not be possible) or taken to a registered clinic (in case the place where the patient is currently registered does not have this registration) which of course is also not possible. Failure to do either of the above, and to invite an ultrasound technician/doctor from another clinic to come and conduct the test where the patient is, would allegedly technically make the doctor liable to prosecution.

In Chennai, a diabetes specialty clinic was booked for using a non-registered ultrasound machine. It was only when CEHAT brought the case before the Supreme Court and the diabetes centre claimed that the Act was only applicable to genetic counselling centres, genetic clinics and genetic laboratories and the principle of natural justice had therefore been violated by the raid and seizure of the machine, that the court ordered all ultrasound clinics to seek registration.

Some radiologists have argued that terming all ultrasound scanning as a pre-natal diagnostic procedure was wrong, as there are other reasons (not included in the 23 different reasons

listed in the Act) why an ultrasound test would need to be used. The IMA has apparently requested that a distinction be made between ultrasound clinics and Genetic Clinics/ Genetic Laboratories. Some doctors even allege that this lacuna in the PC-PNDT Act – which fails to understand these facts – are being exploited by the authorities to harass them.

To add to the chaos, there are different rules in different States regarding procedures to be followed and these too are used to harass them unnecessarily, according to some doctors. Thus, while Haryana stipulates that the board indicating that "disclosure of the sex of foetus is prohibited" should be of 3 feet by 2 feet in dimension with the lettering in white on blue paint, in Punjab it should be 2 feet by 6 feet. In these two states boards are required to be installed outside the premises, while in Madhya Pradesh they are to be placed near the ultrasound machine[16].

Furthermore, unlike in the case of renewal of registration where if the AA does not renew it within 90 days the registration is considered as renewed[17], there is no such provision with regard to the first registration.[18] Since, furthermore, there is no penalty for the AA if he/she does not complete the registration within 90 days, there are those who say there is clear scope for corruption since a registration can be delayed for unknown reasons. Some doctors claim such corruption is already a factor in getting the first registration.

Some doctors expressed that many other professional groups are not being taken into confidence while implementing the Act (eg. FOGSI, IRIA etc). The authorities simply concentrate on pure administrative aspects like whether the clinics have filled the form and whether there are any mistakes in the form etc. and do not look into the issues of implementation.

All these kinds of rules make a number of doctors feel that the Act considers the doctors 'guilty unless proved innocent' and hence can be easily used and is used as a means to harass them.

However contrary to this perception some doctors interviewed in Tamil Nadu reported that the government officials who visit their clinics for inspection and monitoring purposes, do not apply any highhandedness or harass the doctors for non-pertinent issues. It is also reported that the clinics are helped by the authorities to maintain their responsibilities according to the provisions of the Act.

16 Article by Gaurav Vivek Bhatnagar entitled 'Stringent Rules' The Hindu, 30th June 2002.
17 Rule 8 sub-clause 6.
18 Rule 6, sub-clause 5 indicates that it needs to be completed within 90 days but does not have a similar clause like Rule 8, sub-clause 6 which would ensure that there is no unnecessary delay.

Some of the participants particularly amongst the enablers present at the 'Looking Back' workshop felt that PC-PNDT Act was a simple Act and that the perception of the Act as a mean to harass doctors is ill-founded. In fact they suggested that it was in the interest of the doctors that they maintain proper records, as it would protect them. Additionally they pointed out that in any case as part of their medical practice doctors do have to maintain a variety of other even more detailed records and hence not maintaining these particular records on the grounds of too much work is not justifiable.

x) Attitudes of Appropriate Authorities (AAs) and Related Bodies

a) Outside their competence

Many AAs have commented that they feel that fulfilling a policing function is not what they have been trained for, or have the capacity for, or interest in. In any case it is their perception that they have so many other responsibilities that they cannot do justice to the Act. The AAs often feel they do not have enough expertise, especially legal expertise, or time to do this work, nor does s/he have enough decision-making power according to the Act. Thus, for example, they are not experts in recording evidence. As a result they sometimes find themselves unable to handle legal matters. For instance, a member of the district advisory committee in Maharashtra shared the experience of a decoy operation they had planned which had not succeeded . "We are not legal experts and also fear that if any gaps remain in recording evidence it will weaken the case. It's not our job." As a result the same member expressed a feeling of incompetence to handle the responsibilities and suggested that there should be an independent machinery for law enforcement.

Some of them also expressed the view that as health officials, implementation of the PC-PNDT was just one part of their already substantial work-portfolio and therefore keeping female foeticide and PC-PNDT implementation as a priority was not always possible.

The participants particularly the enablers in the 'Looking Back' workshop however did not agree that the lack of time or finances as cited by the AAs were legitimate reasons for their lack of adequate implementation of the Act. These participants believed that the Act provided the AAs with enough independent decision-making power. However they did agree that lack of knowledge about the Act in particular and the law per se was an important limitation that needed to be addressed through capacity-building of AAs.

b) Futility of implementing the Act purely by force

According to many of the AAs, the Act cannot be implemented purely by external enforcement, but must be primarily grounded in the voluntary efforts of the people and the medical community. Thus some of the AAs perceived society as primarily responsible for the problem of the declining sex ratio. This again gives an insight into the attitude of enforcers under the Act. Some of the comments different AAs made were as follows:

"Not that doctors are not to be blamed for it, they are like you know under the law, but mostly I think it is the people, mothers-in-law and women who go in for these kind of things." "The Act is good and we are making every effort to take it to people and doctors. However, practice of sex selection cannot be fully checked in absence of voluntary compliance." On the other hand, a few AAs believe that the post of the AA can be used effectively, if those appointed are proactive enough.

Many AAs also believe that they are unable to do what they have to do because of interference by those (particularly politicians or corrupt officials) who are in authority above them.

c) Attitude towards the issue

The mindset and not-so-positive attitude of many of the AAs towards the issue appears to be part of the problem. In general there seems to be a lack of conviction about the objectives of the Act itself among the AAs. In a number of places where the AAs are not particularly proactive, a committed district authority would have to galvanise, (and even browbeat) them into taking action.

In one of the states where an order of the District AA was rescinded by the State Authority, the reason allegedly given was that none of the actions of the concerned clinics constituted a gross irregularity, whereas the Act does not make any distinction between gross or less gross irregularities.

The mind-set of some of the AAs was also reflected in comments like "… since there are more girls in Kerala does it mean "male foeticide" is happening there?" indicating that at least in some cases the AAs do not appear to recognize SSE as a genuine problem.

Some other members of the implementing community also appeared very skeptical in terms of what the sex ratio indicated. They felt that there has been no systematic study on the 'biological fertility rate' for women in their own communities. For instance in Punjab, they argued, for years people have been saying 'Jaton ke munde zyada hote hain' (Jats have more sons). They felt that this might even be true. Thus they felt the need for UNFPA or some other agency to actually do a study in Punjab and Haryana to find out what is the fertility rate, whether there are actually more number of boys being conceived than girls, and there is not as much foeticide as is being perceived.

Furthermore, with regard to the importance being given to the number as reflected in the statistics they felt that the registration data may not be accurate, as in a number of families the birth of a boy is registered in both paternal and maternal homes, whereas this does not happen with the girl. Hence there are always more boys counted than girls. This they

believed actually accounted for a 10% increase in the number of boys at any given point of time.

Some implementers, on the other hand felt that it was important to approach the whole issue not as a social issue, but as a criminal one. If one could catch some doctors and put them behind bars, it would control the matter because of the fear that it would raise in others. This reflects the attitude prevailing amongst certain sections of implementers and even many enablers who perceive strict enforcement of the law as the only effective means of overcoming the problem.

It was also felt by some that the PC-PNDT Act and their own roles have not been thoroughly internalized by the enforcers, and this is one of the important reasons behind the inadequate implementation of the Act on the ground. Furthermore, some perceived that one of the crucial reasons for the failure of the implementation of the PC-PNDT Act is that the implementers themselves are not convinced about the 'validity' of the Act. "The Act is not fully functional, people are interpreting it in their own ways and taking advantage of the loopholes in it. What is interesting is that doctors know more about how to bypass the law than our AAs. Hence our AAs cannot implement it strongly," commented one AA.

d) Lack of resources to implement the Act

Many AAs complained of lack of resources (human, financial and time) that prevented them from seriously pursuing the implementation of the Act. The National Commission for Women (NCW) (as quoted in a newspaper article entitled "NCW condemns 2-child norm', The Tribune, 8th August 05, Chandigarh) has also suggested that low priority was being accorded by most states to female foeticide and infanticide, adding that the implementing bodies and other resources put in place for the implementation of the Act were inadequate to implement existing laws that were enacted in order to prevent this grave social evil.

e) Perception of Members of the Advisory Committees

Many of the members of advisory committees interviewed felt that either they were not really able to contribute or that the rules were so cumbersome/complicated that it was difficult to do any real monitoring. They also commented that they often wasted their time, since the meetings were quite unorganised or convened at very irregular intervals. Furthermore some commented that at such meetings only administrative matters were discussed (e.g. passing registration applications), while implementation, inspection and monitoring aspects were rarely discussed or planned. But in some places for various reasons (especially when there is significant collaboration with, and support from other district authorities) the committees seem to work.

In any case the team concluded that unless an environment of support, motivation and accountability is created, it is unlikely that either the AAs or the Advisory Committees will really act. Thus in some cases it was only after the media had highlighted the issue, that the AAs or the Advisory Committees started functioning.

xi) Attitudes of Enablers

The attitudes of the enablers also appear to be problematic in some cases as they tend to under-cut each other's work, questioning each other's integrity, methods, etc. Furthermore, due to a lack of sharing of experiences amongst themselves, every entity (NGO, individual activists etc.) seems to have to learn everything on their own. This is particularly true about decoy and sting operations. For instance one of the enablers the team met in Maharashtra shared this; "There was an attempt to do a decoy case against a doctor in our district by an outside organisation which did not take any local organization into confidence either before or after the decoy operation. Had we been taken into confidence we would have been in a better position to assist in the process and follow-up. There should be exchange of experiences and expertise among people working on these issues."

An activist also commented that the NGO sector is mostly driven by the agenda of funding agencies and has lost its credibility because of an often hidden and apparently unstated desire to gain credit.

On the other hand, while meeting with many enablers at various times during the study, it was soon apparent that they found great value in meeting and hearing the views and experiences of others who were working on this issue. By implication it was clear that this kind of sharing had been missing for quite some time, and there is a real unspoken need for the same.

xii) Cross-purposes of Government policies and piece-meal execution

The perception among many is that the various policies of the Government of India sometimes work against the implementation of this Act. The section of this report on MTP and Population Policy of the Government expands on this point.[19]

For instance some felt that given the state of legal enforcement as well as preoccupations of the state, implementing authorities and other organizations that emphasize population limitation, no concerted and genuine effort to address the root causes of sex determination and the ensuing tilted sex ratio is taking place. Therefore they felt that the proportion of girls would continue to decline further.

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19 Under Part 1: Reasons related to the Act/Law and other Policies

Many were of the opinion that the declining sex-ratio is a manifestation of the wider problem of gender equality and therefore one cannot view the problem in isolation. As articulated by an activist in Maharashtra, "The problem of declining sex ratio of girls is a symptom of a wider problem, which is gender inequality. It is a manifestation of discrimination against women. Addressing this root cause requires strict implementation of all the laws and policies/programmes meant to protect women's rights. This entails strict enforcement of the prohibitions against child marriage, polygamy/polyandry, and dowry as well as enforcement of the policies and programmes to promote the girl's education, women's property rights and so on. Thus the government should take concrete measures to bring in structural changes in favour of women."

xiii) Sensitivity of Judges and Public Prosecutors

Many activists expressed the view that there is a lack of sensitivity among judges as well as a significant lack of knowledge of this Act within the legal community in general.

One of the lawyers practicing in the family court in Pune was of the opinion that "it is the lack of awareness and sensitivity of criminal lawyers and judges who handle these cases which create problems in the effective implementation of the Act. A criminal court focuses on available evidence, which has to be 'beyond reasonable doubt' whereas in civil matters it is required only 'to the satisfaction of the court'. It is difficult to get the former level of proof in sex selection cases." Thus the mindset of lawyers and judges affect the proceedings. This, according to them, is further confirmed in the few cases in one state High Court which reversed the closure of certain clinics. Activists have remarked that the judges often do not look at the PC-PNDT Act cases with a sympathetic perspective nor have they been able to see such cases as a way to create jurisprudence on this serious issue, as perhaps was seen among judges dealing with the Right to Food campaign.

According to activists, in some of these cases the judges tended to read this Act in the light of the Indian Penal Code (IPC) and released machines that were sealed, on grounds that the failure to maintain records, for instance, was not serious enough, whereas a better application of the specific clauses of this Act might have led to a different appraisal of the case.

There was almost a consensus amongst the participants during the 'Looking Back' workshop that the lack of sensitivity and knowledge about the Act among the legal community in general were indeed important lacunae that were adversely affecting the implementation aspect and needed to be accorded top priority in any future strategies.

2.3
Reasons Related to the Act/Law and Other Policies

2.3.1 At The Level of the PC-PNDT Act

In exploring the views of various stakeholders regarding the PC-PNDT Act per se, the team received two kinds of responses.

i) Unqualified positive response

On the one hand there were many who responded saying that the Act was a very good piece of legislation, or that the Act has "enough to be effective" if implemented properly. Reasons given by various stakeholders for their positive evaluation of the Act included the following:

a) The act gives enough powers to all the appropriate authorities – state, region, district and sub-district;
b) Because of this power, the concerned appropriate authority need not take any permission to implement the act unlike the usual practice in the government machinery
c) The act is not to be implemented by the government alone; it expects active involvement of civil society members and other professional experts;
d) This is the only act, which recognizes the appropriate authority as having quasi-judicial powers. Many of these powers if applied as per the norms cannot be challenged by other law and order machinery.
e) At the same time the act provides democratic space for the targeted constituency, which protects their right to go to a court of law if they are harassed by the appropriate authority.
f) The act envisages quick actions and follow-up results, as regulating the clinics is the prerogative of the local appropriate authority as and when h/she desires to act.

Thus some of the AAs commented that they felt very positive about the Act. As one AA in Haryana remarked: "I think, and I have shown time and again, that it is an excellent piece of legislation, where the authorities can really make a difference if they want. There is no role of the police and it is a very good thing- only it needs strict vigilance, and strong implementation. As part of the AA machinery for the implementation of the law, I started strict vigilance on the doubtful doctors. I used to undertake surprise as well as planned visits to clinics, register machines, and sealed some as well as planned decoy cases."

This was a view that was reiterated by many enabler groups and individuals.

ii) Good, but could be improved

On the other hand there were those who remarked that while the Act was generally a good piece of legislation, it did have areas where there was need for greater clarity, and it did have some loopholes, which could be easily taken advantage of. Others remarked that while the current Act was good, it could be improved in some small ways that would make it even more effective. Some of the reasons for this latter position that were put forward by various stakeholders included the following:

a) Fulfilling the strict requirements of Evidence

It is very difficult to really produce evidence sufficient to fulfil the standards set by the Evidence Act, CrPC, IPC, – at least as far as this crime of disclosing the sex of the unborn child is concerned, since it is a crime that can be committed by a word or a 'sign' and there is no physical proof of the same. Some activists pointed out that throughout the country, members of the medical community who indulged in such practices had devised several ingenious methods for communicating the sex of the foetus so that the law could not book them. "While many of the sonologists pass the message verbally, in other cases the sex of the foetus is conveyed to the pregnant woman or her family by drawing a leaf (girl) or a flower (boy), or asking for a laddoo (boy) or barfi (girl), or by using a specific colour of ink for writing," says an advocate who had pursued a research project on female foeticide at Bangalore. She pointed out that booking cases against doctors for sex determination rarely happens because of lack of evidence. Most of the cases are filed with respect to non-registration of ultrasound machines or failure in keeping records, and not for offering sex determination services per se".

However some of the participants present during the 'Looking Back' workshop felt that corroborative evidence could be helpful in the form of medical and social audits and that the Evidence Act is particularly important in the context of decoy and sting operations.

b) Procedural lapses

Some of those the team met felt that procedural lapses could occur easily in collecting the data, and when submitting the complaint, charge sheet, etc, - which when taken to court tend not to stand judicial scrutiny. This happens because the Act has to be read in conjunction with other Acts mentioned above and the filing of charges has to keep those in mind. Some of the ways these lapses could occur are:

- Not following the principles of natural justice (e.g. not giving advance notice to the accused, not giving him/her a copy of the charges etc)
- There are contradictory clauses in the PC-PNDT Act, which could be used to challenge sudden action by the AA in confiscating machines etc. Thus for example, in Section 20 subsection (1) the Act speaks of giving notice first, and subsection (2) speaks of giving an opportunity to be heard, while subsection

(3) says the AA need not follow the previous two sub-sections in a situation of public interest.[20] As the question of public interest is open to interpretation, action taken under this sub-clause may seem to go against the principles of natural justice, and it may so happen that the courts may dismiss it, as has allegedly happened in some High Court verdicts.

During the field visits the team came across instances where cases were apparently dismissed on grounds of not being in consonance with the principles of natural justice. However during the 'Looking Back' workshop some of the enablers shared their experiences wherein similar cases met with success despite the fact that action was taken in such cases without notice as stated in Section 20(3) above. They also felt that this clause stressed that if it is in the public interest it requires the AA to take immediate action, and therefore grants sufficient power within the Act to do so without giving any show cause notice as required under 20(1) and 20(2). Consequently they would argue that such action would not go against the principles of natural justice, since it was a question of saving a life or lives.

Despite the PNDT Act being in existence since 1994, cases are being booked under the IPC. For instance a case of female foeticide from Fatehgarh Sahib district in Punjab saw the accused charged under Section 312[21] and 120[22] of the Indian Penal Code, 1860. The provisions of the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 have not been invoked; despite the fact that Section 312 hardly had any relevance after the passage of the MTP Act (1971) and was rarely invoked. An advocate with the Punjab and Haryana High Court, said that the import and intent of the PC-PNDT Act was to prevent the misuse of foetal sex determination, and instead of focussing on the agency that conducted the test, the health department was focusing on foeticide itself. "When women get targeted, the focus gets blunted," she said. The involvement of the police only contributes to corruption, since the persons running the ultrasound centres get prior information and either wind up operations or run away from the scene. In fact, the police need not enter the picture at all, since the PC-PNDT Act provides for an 'Appropriate Authority' to implement the law. Faulty interpretation of the law adds to

20 Sub section(3) of Section 20 states that 'Notwithstanding anything contained in sub-sections(1) and (2), if the AA is of the opinion that it is necessary or expedient so to do in public interest, it may, for reasons to be recorded in writing,suspend the registration of any Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic without issuing any such notice referred in sub-section(1).

21 Under Section 312, whoever voluntarily causes a woman with a child to miscarry, shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both. Source 'Add special clause to check foeticide', Tribune News Service Sangrur, April 20,2003.

22 Section 120 pertains to concealing a design to commit an offence and this is punishable with imprisonment.

biased implementation. For instance, registering a case under the archaic Section 312 of the Indian Penal Code of 1860 (though it has been superseded by the Medical Termination of Pregnancy Act, 1971, which legalizes abortion under certain conditions) shifts the focus from sex-determination, which is the crime, to abortion which could be legal.

Under the Act since the pregnant woman is generally presumed to be not guilty unless proved otherwise, the only criminal is the doctor and the family - and the latter can easily claim that it was done independently by the woman since abortion does not require the husband's concurrence. Furthermore, it is unlikely that women will stand witness against their families.

c) Regarding who is considered 'trained'

There seems to be a weakness in the Act with regard to the clause concerning WHO should be considered trained. Most activists too are under the impression that only a Registered Medical Practitioner who is properly trained is permitted to operate the ultrasound machine. However the Act envisages that even a BSc degree holder or a person who has completed a medical laboratory course and who has been trained can legally be allowed to operate the machine. Since there is no fixed criteria in the Act as to who can offer such training, according to one interpretation of the Act[23] it would seem any sonologist or radiologist etc could train somebody and certify that that person is trained. Thus, according to this interpretation one need not be a Registered Medical Practitoner (RMP) to be allowed to operate such a machine. This of course opens the door to much malpractice. Others interviewed felt that this 'weakness' did NOT exist in the Act. There is perhaps need to study this matter at great depth to see whether indeed there is a loophole in this part of the law.

d) Restrictions on Sellers

With reference to the limitation on the manufacturer/seller of the machine having to ensure that the registration is already received before selling the machine to a customer, the actual practice seems to be that in some cases the 'sellers' are engaging in the malpractice of selling the machine based on an affidavit by the customer that his/her registration is under way. Some sections felt that since affidavits are easy to procure and do not need to actually reflect the truth this is a practice, which is in violation of the law, and such machines can be seized. A further problem arises in the case of those machines that are registered with mobile clinics, since there is no jurisdiction apparently specified within which they can offer their services, and so it is not clear which AA would have jurisdiction and responsibility to take action. Sellers also claim that the question of which

23 Section 3(2)(ii) states that a laboratory technician, having a B.Sc. degree in Biological Sciences or a degree or diploma in a medical laboratory course with at least one year experience in conducting appropriate pre-natal diagnostic techniques, tests or procedures may operate an ultrasound machine legally.

AA needs to be informed (whether the one in the district where the seller is located, or the one in the district where the buyer is located) is also not clear.

e) Profit-making Companies or Medical Service Providers?

Some legal professionals felt that the Act by its very language seems to indicate that such centres which offer ultrasound services are assumed to be centres that are set up primarily for profit, and the service offered is the means to make this profit. This is seen in a number of subtle ways:

- The Act refers to such centres as 'companies' and not as medical facilities
- The Act allows anybody, even non-medical personnel to set up such centres and buy such machines, so long as they have trained persons to operate them.

Both these clauses taken together imply that the Act sees ultrasound centres as a profit making enterprise, or else why would anybody who is not a doctor want to set up such a company?

According to some the Act also envisages that the primary registration is of the clinic or vehicle, though it does include a section that demands the listing of the machines in use in such a clinic or vehicle. Does this encourage the 'profit-making company' aspect, for in effect this means that once a unit has a registration it can multiply the number of machines it uses and thus is open for unlimited profit (keeping in mind the statistics that show this is a very profitable business), so long as it keeps the AA informed.

f) Distinction between Owner and Technician

The distinction envisaged in the Act between the owner of the company, and the technician or medical person actually using the machine, also creates confusion in the minds of the AAs who are not well versed with the Act with regard to the question of who should be charged (in case of a failure to comply with the provisions of the Act).

In effect this means that if a clinic is found to be violating provisions of the Act, the owner can terminate the services of a particular technician and continue to run his/her clinic IF he/she can prove that a sex determination test was done without his/her knowledge.

This confusion is apparently present even within the judiciary. Thus, in a case in Tamil Nadu the AA framed the charges only against the doctor concerned, whereas the stipulation in Section 26[24] indicates that the owner too must be charged. Subsequently,

24 Section 26 of the PC-PNDT Act states that where any offence, punishable under this Act has been committed by a company, every person who, at the time the offence was committed was in charge of, and responsible to, the company for the conduct of the business of the company as well as the company, shall be deemed to be guilty of the offence and shall be liable to be proceeded against and punished accordingly.

the judge, instead of adding the owner's name to the charge sheet, allegedly dismissed the case on the ground that since the registration was in the name of someone other than the doctor, no case could be made against the doctor.

Furthermore, the same registered user of the machine (the sonologist or the trained technician) is often found to be recorded as the official technician for far more clinics than what s/he can physically visit in a day. And yet the records would show that that this registered technician has actually conducted tests in all those clinics on the very same day, even if the number of cases in a day is unbelievably high. In effect then it would seem that the registered technician only signs the forms, whereas the tests are actually conducted by somebody else including those others who are not considered qualified to use ultrasound machines under this Act. While this is clearly against the law, it is this distinction between owner and technician which assists the owner to get around the law.

g) Minimal Penalty

Under Rule 11, the penalty that can be imposed on a clinic for not getting itself registered under the Act and still using the machine is only five times the registration fee (i.e. Rs. 3000 registration fee x 5 = Rs. 15000). This never acts as a deterrent because it is a very minimal amount considering the high profit margin in such services.

There was also an opinion expressed at multiple levels that the penalties indicated in the Act to be levied on doctors who indulge in such malpractices are not harsh enough and hence it is seen as a non-high risk crime – particularly as according to the Act, the question of imprisonment is discretionary and can be even for just one day. Furthermore the fine imposed for the first offence is only Rs.10,000 which is not a strong enough deterrent in the context of the fact that the machine itself costs around two lakhs, and just one test (in some districts) could help the doctor recover that amount.

h) Discrimination against Medical Practitioners of other alternative schools of medicine

Under the Act only those medical personnel trained in allopathic medicine (and certain laboratory technicians) are allowed to use these machines, whereas those trained in other alternative medical therapies are not allowed to use it. This seems discriminatory. It also means that these doctors from other schools of medicine only need to get a 'certificate' from a 'friendly' sonologist or radiologist to continue to use the machine. Participants during the 'Looking Back' workshop clarified that under the PC-PNDT Act a Registered Medical Practitioner is one who possesses any recognised medical qualifications under the Indian Medical Council Act, 1956 (102 of 1956) and as such medical practitioners of alternative schools are in fact not recognised as medical practitioner under this

Act.[25] Consequently they are legally not allowed to operate the 'machine' under the PC-PNDT. As for the patients/civil society who obviously do not know about this fine distinction in the Act, there is no difference among these various doctors and so there is little awareness of any violation of law ocurring.

Furthermore, though medical practitioners from alternate schools of medicine are not allowed to use the ultrasound machines, the Director of Indian systems of Medicine is a member of the State Board to regulate the implementation of this Act.

In effect then, some felt that this restriction is only discriminatory, but is of little if any use in ensuring that the machines are not misused.

There are others who would argue that medical community outside the allopathic group should definitely be kept out of this and so should NOT be allowed to offer ultrasound related services under any category as this would only open up the gates to a larger group of persons who could misuse the machines. This of course raises the question as to whether this is a ploy (often used by allopathic practitioners around the world) to keep out competition from other alternative therapy doctors, rather than a genuinely useful clause to prevent misuse.

According to one AA in one of the districts in Maharashtra, almost 25% machine owners in his district are BAMS or BHMS doctors, who are legally not qualified to operate the machine. They appoint qualified technicians to officially operate the machine, but in fact mostly use the machines themselves.

i) Dependence on Maintenance of Records

Aside from the civil-society-inspired way of ensuring implementation of the Act through sting/decoy operations, almost the entire 'success' of the implementation of the Act depends on the maintenance of the records and the monitoring of the same sometimes through sudden inspections. However, according to an interview with one of those engaged in working towards auditing such records, it took a civil society group almost a year to get these records even after the decision was made at a very high political level to allow them to be 'audited' by an outside party. Subsequently, the initial findings of this audit indicated that the vast majority of F forms are incomplete, or fraudulent in the details submitted. However, it must be remembered that this finding was possible only because doctors/clinics did not expect to be monitored. If such monitoring was perceived by them to be something that would be regularly done, all it would mean is that those who wished to

25 As per section 2(m) of the Act ''registered medical practitioner'' means a medical practitioner who possesses any recognised medical qualification as defined in clause (h) of section 2 of the Indian Medical Council Act, 1956 (102 of 1956), and whose name has been entered in a State Medical Register.

circumvent the law would take greater care to fill them out with fraudulent but believable data, and in this they would probably be supported by the clients who come to them for SD services.

Since sting/decoy operations to catch a doctor/clinic in the act are fraught with many practical and legal difficulties (see 2.3.1(ii)b above under procedural lapses), the burden is on the 'record monitoring'. Yet according to some activists, this record monitoring is not a very effective method for the following reasons put forward by various interviewees during the study:

- The records on the F form for instance can easily be 'fudged', especially as in such cases there is almost inevitably a collusion between the client and the doctor. After all the Act itself envisages the legal use of ultrasound for 23 different reasons.[26] It is therefore very easy for a doctor who wishes to keep on the technical right side of the law (not the spirit, of course) to indicate that the reason for the use of ultrasound was one of all those many reasons.
- The Act also envisages that while all imaging centres do have to register themselves, it is not clear whether each such centre has to keep records of any test which is not pre-conception or pregnancy-related as prescribed under the Rules. This is obviously a loophole that can be easily taken advantage of.[27]
- There is nothing in the Act that ensures that the AA checks these submitted records and is accountable for doing so, and would be penalised if s/he does not do this. In actual fact the experience in MOST places is that the AA does not have the time, the inclination, or the human resources to do such monitoring or checking of the records – a fact known by almost all doctors and clinics.

Consequently very few doctors/clinics are in any way pressurised by these requirements. In fact, recent experience suggests that it is only when particular civil society groups demanded this monitoring and checking that a particular assignment was taken on to study these forms in a limited area. All this means that there is little accountability demanded of the AA and weakens the possibility of properly implementing the Act.

There is also a difference of opinion among 'enablers' as to whether these records that are to be maintained by doctors are 'public' documents or not. One interpretation is that these are records that can only be accessed by the AA or somebody authorised by the AA, which of course would mean that the 'public' does not have an intrinsic right to these

26 Refer to Rule 9(4) of the PC-PNDT Act. The F form indicated in this Rule lists out the 23 legally acceptable reasons why ultrasound tests can be conducted during ante-natal care.

27 Rule 9(8) of the Act states that Every Genetic Counselling centre,Genetic Laboratory,Genetic Clinic,Ultrasound Clinic and Imaging Centre shall send a complete report in respect of all pre-conception or pregnancy-related procedures/techniques/tests conducted by them in respect of each month by 5th day of the following month to the concerned Appropriate Authority

documents, while another interpretation among other enablers is that these are public documents that anybody could access.

Many of the participants in the 'Looking Back' workshop particularly from amongst the enablers did not believe that record monitoring was fraught with difficulties as expressed by the AAs. They felt that the maintenance of records for monitoring purposes was actually possible. They also felt that if there were such records, a medical and social audit could be used to ensure the accountability of doctors and clinics, since even if the doctors tried to fudge the records, they would inevitably be caught by a careful audit.

j) Declaration by Woman and Doctor

The condition in the Act that the woman and the doctor must sign a declaration saying that they will not be doing the test for the sake of sex determination is, according to some, a meaningless piece of legislation (akin to people self-certifying that they are not carrying weapons or arms when they are entering a government building in Delhi). In this case, since there is clearly collusion between the client and the doctor, it is not clear what use it offers to further the implementation of the Act. On the contrary it only makes the offering of the services more lucrative for the doctor, who can raise his/her fees for such services by pointing out that s/he is doing an illegal act out of concern for the client. This has actually happened in some parts of the country where prices have gone up to Rs. 10,000/- or more on this very ground, namely that it is an illegal act.

However some of the enablers in the 'Looking Back' workshop did not agree that these declarations served no purpose, and on the contrary believed that in case a doctor or the women is caught in violation of the 'Act' these declarations could be used against them as important evidence in a court of law. Moreover, in the case of a doctor who genuinely wishes to implement this Act, such self-affidavits are useful in that they bring to the notice of the pregnant woman that such a request (to know the sex of one's unborn child) is against the law.

k) Inspection of Premises

Before registration is granted the AA is expected to personally inspect the premises to be registered. However, the Act demands that such inspection 'shall be carried out only after due notice is given to the applicant by the Appropriate Authority'.[28] It has been pointed out by some activists that this clause would mean that the unit can 'prepare' itself before the inspection, as has been found to be done in medical colleges where inspection of their facilities is required before the college is affiliated to a university. The experience of such prior notice to some medical colleges is that such advance notice defeats the very purpose

28 Rule # 6: 4 states that an enquiry under sub-rule(1),including the inspection at the premises of the Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic, shall, be carried out only after due notice is given to the applicant by the AA.

of such an inspection, if the inspection is meant to check on the suitability of the unit to offer such services.

Similarly the clause that a 15-day notice has to be given to the Appropriate Authority[29] before independent action can be taken by a civil society group/individual against a clinic/ doctor (alleged to be violating the law) is perceived by some activists as another self-defeating clause. This is so perceived because if there is a collusion of interest between the AA and the offending doctor/clinic, such notice could allow the violator to prepare adequately and clear out incriminating evidence.

l) Lack of Accountability of the AAs

Though the Act envisages that registration or rejection of registration has to be completed within 90 days[30], there is no provision for any penalty to be imposed on the AA if s/he fails to do so or fails to respond with a reason for not issuing a registration within such a period. Nor is there any automatic approval (as there is with the "renewal of registration" application) if the certificate is not given in time. This seems to open up the possibility of corruption on the part of the registering authorities. In actual fact, experiences collected in the field indicate that such corruption does exist and certain amounts have to be paid to get such registration certificates while getting the clinic registered in the first instance..

In general too there is no accountability demanded of the AA in the implementation of this Act (e.g. checking the records), and hence it is the experience of many activists that often enough these authorities do not take this role too seriously. Specific penalties for non-functioning of AAs do not exist in the Act, though there is a clause that allows the Central Supervisory Board to take action whenever the implementation is not effective enough.[31]

m) Conflict of Interest

Though many of the monitoring provisions of the Act do not demand medical knowledge for them to be carried out (e.g. checking whether the registration has been done, checking whether the forms like the F form have been filled in properly etc.) there is a preponderance of doctors in the Advisory Committees and Supervisory Boards at all levels, with the State and District AAs always being doctors too. This obviously leads to a conflict of interest, which is compounded by the unwritten rule followed by a large majority of doctors of never testifying against a professional colleague.

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29 Section 28 1 (b) states that no court shall take cognizance of an offence under this Act except on a complaint made by a person who has given notice of not less than fifteen days in the manner prescribed to the AA, of the alleged offence and of his intention to make a complaint to the court.

30 Rule # 6: 5

31 Section 16: (v)

The fact that medical knowledge is not necessary to check whether clinics are fulfilling the requirements of the Act is clearly seen in all the sting and decoy operations conducted by non-medical persons around the country (operations conducted by NGOs, lawyers, district collectors etc) and the fact that handbooks on the provisions of the Act can and have been brought out by non-medical personnel. Similarly the audit of the F forms in Delhi is currently being carried out by civil society members.

In actual fact whenever any of the 'charges' have failed in the courts, they have 'failed' on 'legal grounds' and not on 'medical grounds' It would therefore seem that a legal expert or an expert in criminal investigations could very well function as the Appropriate Authority. Moreover the Act itself envisages the possibility of a non-medical person being appointed as the District Appropriate Authority though all states have appointed doctors to perform this role.

n) Process of lodging a complaint

According to some activists, Section 27 of the Act is quite sweeping and seems to allow an ordinary complaint to be lodged, but this is undermined by Section 28 which outlines the limits to the complaints that can be taken cognisance of by the court. According to this latter section, the court has to take cognisance only if the complaint has been filed by the AA, or in cases where the AA has failed to act despite being given 15 days notice. Considering that AAs are also doctors and that there is a conflict of interest possible (as mentioned earlier) the chances are that such notice periods could end up with the targeted doctor or clinic being informed in advance of such a case being filed and would thus enable him/her to take preventive action.

Thus there appears to be a general lack of clarity and a sense of ambiguity in the Act with regard to provisions regarding the making of a complaint, and hence these are being interpreted differently by various 'actors'. For instance there is confusion with regard to the role and involvement of the police in the enforcement of the PC-PNDT Act (e.g. is there need for an FIR to be lodged with the police by the AA, or is it a possible option?)

o) Appeal under the Act

During its various interactions during the study, the team was told that the Act does not have any reference to any higher level of APPEAL if the State Appropriate Authority (SAA) makes a 'wrong' decision[32].

However, it was pointed out in one of the workshops conducted during this study, that that though it is not mentioned in the Rules, the State Government itself can always be appealed to in case the State Appropriate Authority functioned inappropriately. Others

32 Rule # 19

remarked, however, that often enough the same person would normally function both as the State Appropriate Authority and also the State Appellate Authority – which of course defeats the very purpose of any appeal since the one being appealed against is also the one who is judging the appeal.

The only option left of taking the case to the court would involve accusing the very same State Appropriate Authority under whom the District Authority has to work, and therefore is not likely to be attempted. In such a situation, the only other option is to lodge a PIL through some other organisation or individual.

p) Lack of Pressure on the Manufacturers

The campaign as a whole has not focused much on the manufacturers, though they do play a significant role in the spread of the machines that are being misused for sex determination procedures. This is another area where the lack of pressure by the government or the campaign, and confusions (real or imagined) about interpretations of the law regarding prior registration before selling a machine, have all contributed to there being a gap between the count of the number of machines sold and the number of machines registered.

q) Other clarifications required regarding the Law

There is also confusion amongst activists and legal experts regarding whether a complaint made under this Act is a 'state' complaint or a 'private' complaint, and the implications of both. Because the violation is non-compoundable, and/or because the case is brought up by the AA in his/her official capacity some are of the opinion that it is always a 'state' complaint, while others point out that since the police are not involved it is a 'private' complaint. The study team was informed that in fact such a case is always listed in the name of the individual AA against the offending clinic/doctor and never listed as the "state against…". This has implications for whether a public prosecutor MUST argue the case, or whether NGOs and others who push for such cases can hire a private lawyer without getting a no-objection certificate by the PP. The courts' decisions in different parts of the country have not been uniform on this issue as to who can represent the complainant.

Some lawyers and others have pointed out that there is need for better definitions and clarity in the Act with regard to terms like genetic clinics, and greater clarity on specific clauses like the one on who can be considered trained to operate the machine (as mentioned above), or on whether the doctors/clinics have to submit the F forms or only a consolidated report indicating the details, and whether there is any specific format for such a consolidated report etc.

Others have pointed out the need to make linkages between the PC-PNDT, the MTP and the IPC provisions in order to iron out the discrepancies between them.

There seems to be need for clarification whether the AA has the authority to suspend the registration and thus prevent use of the machine even if the court releases the machine and prevents sealing of the clinic. If such a power exists, it has never been resorted to.

Some legal experts also feel that the release of machines by some courts and appellate appropriate authorities on the grounds that failure to maintain records is in itself not a gross dereliction of duty seems to call for clarification on those clauses in the Act which seem to consider this as serious enough to take action.

There seems to be a general non-compliance in most states with regard to the setting up of multi-member State Appropriate Authorities, and there seems to be no action taken to penalise the State Governments for failure to do so. Is this because of a lack of clarity in the law or due to a lack of understanding of the law? Is there also a lack of clarity in the mind of the Central Supervisory Board (CSB) with regard to Section 16 (v) which indicates that it is the duty of the CSB "to oversee the performance of various bodies constituted under the Act and take appropriate steps to ensure its proper and effective implementation".

2.3.2 Relationship Between MTP And SSEs

The question of abortion or the medical termination of pregnancy (MTP) is a troublesome one and there are different positions among the stakeholders interviewed.

On the one hand some perceive the MTP Act as a liberal Act since it is one of the few that acknowledges the rights of a woman, – the right over her own body, the right of a woman over her own fertility, and one of the few rights that a woman can exercise without the concurrence of her husband. Hence it is perceived as a right that must not be given up.

On the other hand, others contend that since the sex of the unborn foetus can be generally determined by an ultrasound test after the 12th week of pregnancy, and the MTP Act allows legal abortions under certain conditions for a much longer period, there is the clear possibility that the MTP Act opens the door to SSEs. Furthermore, the Act specifically mentions that in the case of any pregnancy that occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such an unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman. Consequently the Act legalises any abortion done on this ground of failure of contraception. All this means that the Act opens up the very real possibility that SSEs will be carried out but that

they could be indicated in the records as having been done on this ground of failure of contraception. This is further confirmed by the claim of activists that an overwhelmingly large percentage of abortions in the country take place under this very clause of the Act,

Secondly there is a conscious effort being made by those who do not want to touch the MTP Act while discussing the PC-PNDT Act, to ensure that the terminology of 'foeticide' is not used, as that would raise emotional and ethical doubts regarding the right to abortion. Such groups therefore insist that the language used should only be that of discrimination against women/girls. On the other hand others believe that such a semantic difference does not take away from the fact that it is indeed a question of killing a foetus, though of course what makes it worse is that the female foetus is being systematically eliminated. Hence the latter feel that it is necessary to continue to use this terminology of foeticide, if one must create an emotional response against SSEs. The latter group argue that it is self-defeating not to use the natural aversion to killing the child in one's womb when appealing to the general public to oppose such practices.

Thirdly, there is confusion in the minds of people regarding MTP since those who have heard about the legality are often under the impression that it has been made legal in all cases. Thus, since knowing the sex of one's unborn child is seen as a normal desire, and going in for an abortion is seen as having been made legal, the result is that the entire process is not seen as particularly evil or criminal. This obviously has adverse implications for any campaign against sex selective elimination of girls.

i) The comments made by doctors across many states on this issue highlight these various points mentioned above:

- "The government by legalizing abortions has given a license to perform sex selective abortions."
- "At present MTP Act does have a bearing in allowing abortions during the fourth and fifth months. The MTP Act needs to be amended to reduce the period for legal abortions to six to eight weeks from the present sanction of twenty weeks, which would prevent people from knowing the sex of their child, and then go in for SSEs. Moreover there are simple and cheap methods that can be used to ensure contraception and these should be used instead of MTP. These methods should be made widely known"
- "Nowadays everybody is doing abortions. The clinics are not properly regulated. MTP should be strictly implemented. There must be a record of the number of abortions and the pregnancy period in which they were carried out. These records must be regularly scrutinized. The Chief Medical and Health Officer (CMHO) should have all updated records with him. There should be a check on abortions done after three months." Others have however stressed that the MTP records

MUST be kept confidential or they would impinge on the woman's right to privacy and could be misused by authorities to target women in many ways.

- 'No woman on her own would ever want to abort her child.'
- 'Women or couples often do not see or comprehend the distinction between abortion per se and elimination of foetus on the basis of its sex. (Health Watch, 2004)
- "MTP is letting people abort their girl child in a legal way."
- "Yes, the government has given us the MTP and now it is being used to kill the girls"
- "MTP gives social sanction to foeticide, but it should be given only within a given period of time during which sex determination is not possible. The time period during which MTP is allowed should be reduced to only twelve weeks."
- "The purpose of MTP is altogether different. It aims to curb unsafe and illegal abortions. 60% MTP s takes place within twelve weeks of pregnancy. We have asked District AAs to monitor records of clinics who also have MTP facility and also track records of abortions conducted after twelve weeks."
- "The PC-PNDT Act is not effectively implemented due to MTP. Since abortion is liberalized, sex selective abortions can be easily done anywhere. The MTP Act should be amended and the provision of failure of contraception should be removed. Simultaneously more thrust needs to be given on awareness of contraceptive devices and their accessibility."
- "At present doctors do MTP, even if they know that the patient has done the SD test before coming to them for abortion. Some restriction can be brought at this level".
- "Definitely the MTP Act is very liberal and if one wants then one can misuse the provisions provided under this act. And these days people are misusing this to a great extent, both the medical professional and the parents – one is doing it and the other is getting the sex determination test done. All these have contributed to the decline in the ratio of the girl child".
- "Bring an amendment in the MTP Act of 1971. Pregnancy termination should not be allowed after twelve weeks. Under the present Act, it is allowed up to 20 weeks of gestation. Pregnancy termination after twelve weeks should be allowed only if the life of the mother is in danger or the foetus has congenital malformations. Second trimester termination of pregnancy is still being carried out mostly in private sector. Over ninety per cent of terminations for limitation of family size are done before twelve weeks and the safest period is six to eight weeks of gestation and diagnosis can be made by use of ultrasound and pregnancy kits. Barring a few countries, the abortion law is liberalized, and in many of those countries it is allowed only up to twelve weeks. Most of pregnancy terminations (ten per cent in second trimester) are for female foeticide in the country.

- Some have claimed that most of the MTPs take place in the first trimester and therefore it is not being misused. Others have challenged this saying that the doctors purposely put the date of gestation to fall within the first trimester period in order to get around the law that demands a second medical opinion in the second trimester. Still others claim that the large number of second trimester MTPs are being shown as 'failure of contraception' and that this is indicative of a trend towards female foeticide.
- The clinics having both the facilities, sonography and MTP, should be regulated. They should not be allowed to do MTPs beyond ten weeks. However, others have said that today's advanced machines claim to detect the sex of the foetus by the 10th week of pregnancy, and that technology would continue to run ahead to make it easier and easier to find out the sex of one's unborn child.
- "In order to get patients for abortions they misinform people and tell that theirs is a female foetus". The abortions after tenth week in such clinics must be regulated and done with the permission of the civil surgeon.
- Some activists remarked that "the family welfare department views MTP as a family planning tool, therefore they do not want to touch MTP. Furthermore, doctors are making money through it; therefore they also do not want to touch the Act."
- During the 'Looking Back' workshop some of the participants also agreed that the MTP and PC-PNDT Acts should be taken together and not separately. Some felt that despite the MTP Act most of the abortions were taking place illegally. Non-registration of clinics under the MTP Act and lack of coordination between the various officials in-charge of looking after the PC-PNDT and MTP were cited as some of the reasons, which open the door for abuse of MTP for SSE. A need to critically review the MTP Act to check misuse of it for carrying out SSEs, while maintaining the women's right to safe abortion was also highlighted.

ii) Still another position was that of those who were against touching the MTP Act in any form as they felt that this would reflect an anti-abortionist stand and they did not believe in limiting the women's right to safe abortion under any circumstance.

- "There should not be any confusion between the two Acts. The 'act' of knowing/ selecting the sex of the foetus is itself illegal. PC-PNDT is a prohibitive Act, whereas MTP is an aid to doctors and women."
- "The intent and purpose of both the acts is different and there should be little confusion on it."
- One activist claimed that "even before ultra-sound became easily available, statistics show that the greater proportion of abortions were done around the sixteenth week, and therefore it cannot be said that those abortions that are done later are for sex selection. The reason why this was done later (and this he claimed is true even today) was that it took time for the woman to 'negotiate' the matter with her family."

- "The campaigns that are promoting safe abortions are being threatened by anti-sex determination campaign."
- "International Human Rights bodies (e.g. Amnesty International) allegedly do not want to touch the practice of sex selective eliminations, even though it is apparently practiced in around eighty countries, as it would impinge on what they see as a woman's intrinsic human right to abortion."

In general then, it can be said that this confusion about MTP, and this disagreement among activists with regard to how to deal with the MTP Act and the right to abortion for a woman, have led to a lack of focus in advocating on such issues among people, and hence has implications for communication efforts that seek to change behaviours of people.

2.3.3
Relationship between Two-Child Norm and SSEs

In a society

a) with a marked preference for a male child, and
b) one in which a girl child is perceived as undesirable for the various reasons mentioned earlier in this report, and
c) one in which there is easy access of technology, the two-child and/or small family norm has further aggravated the problem of sex-selective elimination of female foetuses.. As a result, it has been noted by many stakeholders interviewed that the population policy of the government and the coercive implementation strategy sometimes employed (including systems of incentives and disincentives) has encouraged families to go in for sex-selected abortions or non-registration/non-reporting of the girl child.

The National Commission for Women (NCW) has criticized the two-child norm introduced by some states for controlling population, saying that the policy was actually aggravating the social evil of female foeticide. Furthermore, disincentives like exclusion of people having more than two children (as happened in the PRI institutions in some states) were in turn working against the implementation of the PC-PNDT Act, which was enacted to combat the declining child sex ratio in the country.

One of the recommendations of an All India conference[33] on implementation of the PC-PNDT Act was that disincentives and other coercive measures to ensure small families must be dropped from all population policies and measures at Central and State Levels.

33 All India Conference on implementation of PC-PNDT Act organised by National Commission for Women in Delhi on 11th Aug,05

Furthermore, the team was informed that in judging whether a particular village panchayat is to be commended for fulfilling its population targets, a number of elements are used as the criteria, but it is significant that the child sex ratio in the village/district is not included as a criterion to judge a panchayat's success.

On the other hand the impact of the two-child norm followed by some state Governments and its impact on sex-selection was not accepted by some community members interviewed in Haryana who said that these have hardly any validity as the birth records can be easily manipulated.

However, in general, the impact of the population policy in a patriarchal society with strong preference for a male child almost always works against the interest of women and further pushes down the chances of a girl child. This has also been adequately demonstrated through the Chinese experience.

Various stakeholders and sections of the population have highlighted the linkage between family planning policies, and declining child sex ratio as reflected below:

i) "People have been opting for sex selection for quite long, even when the technology was not well advanced like ultrasound machines." Referring to research in genetics one of the doctors interviewed said, "Sex selection technology was viewed and studied hoping it would complement family planning measures by reducing the number of births. Scientists thought that since people give birth to number of children for the want of a son, a technology for sex determination would help trim the size of the family. This assumption was short sighted and is clearly proved by the skewed child sex ratio that is a reality today."

ii) 'Rural people do not know about this (sex determination), therefore they keep having children for the want of sons. That is why there are more girls among the uneducated and poor and there is an adverse child sex ratio among those who are educated and have the financial means and access.'

The relationship in the eyes of the people between the sustained advocacy of a family planning campaign fostering a two-child family norm with legislation prohibiting the conduct of sex determination tests and SSEs was also expressed in this manner: "As in most parts of India, two sons constitute the cut-off point for accepting sterilization. The people seem to be quite puzzled that while the government wants a small family norm to be practised, it yet opposes the conduct of these tests and subsequent abortions".

Among those interviewed by team members in the many states, the fact that people attributed SSEs to family planning and the two child norm reflected in comments like:

i) 'Sarkar hi kahta hai ki chota parivar ho, phir to ladkiyan kam hi hogi na!' *(The government is promoting small family size; therefore the number of girls will definitely*

go down, wouldn't it?) "The families with more than two children are denied some benefits." These comments indicate that in the minds of the people, the notions of small family and a balanced family lead to a pro sex-selection stance.

ii) "The family planning two-child slogan which has often been depicted in its earlier posters as showing one boy and one girl has not been paralleled with an equally strong campaign for the value of the girl child or for anti-patriarchal norms. All this coupled with the lack of health facilities for maternal and child care and unscrupulous medical practices and ethics is responsible for the decreasing number of girls in the country".

iii) "By restricting the number of children to two there is an increased desire for the first child to be a son and hence people are availing the test from the first conception itself. It is also the case that the two-child message and the consequent desire to have a small family is now growing among the villagers which is resulting in SSEs amongst the rural population as well."

iv) "With the two-child norm the chances are more that the girls are born as an accident and the boys by planning. If an effective technology is easily available people are bound to use it to have sons. When the families are large, chance of girls being born are more. When the family size is restricted, the number of girls for sure goes down."

v) "The educated and middle-upper class people nowadays prefer to have only a single child. As sons are given more importance they are likely to go for a test or take a second chance in case the first child happens to be a girl."

Some argue that the two child norm does not have such a direct impact, for in rural areas people can produce false documents to fit in the criteria. As one government official interviewed said, "A local government official in a village in Haryana has three children, but in his official declaration he has mentioned only two. The Talathi office handles the election process and he has got the required certificate from there. So he is a father of two children according to the Talathi office and father of three as per our records. No one bothers to verify these gaps even if they know the reality."

2.3.4
At the Level of the Implementation and Monitoring Structure

i) Conflict of Interest

The most obvious one is the one raised repeatedly all over the country, namely that there is a clear conflict of interest as the ones meant to implement and monitor belong to the same medical community as the ones against whom such action is to be taken. As a result the commitment of the AAs at all levels towards enforcing or implementing the Act is considered by many enablers to be doubtful in many places in the country. Some of the

AAs themselves acknowledge this problem, though they would stress that this cannot and should not be generalised as applying to all AAs

Some AAs expressed the view that there is a collusion of interest between the doctors and the people. As one of them commented, "The phenomenon is continuing only because there is collusion between the doctors, the implementers of the PC-PNDT Act and the people. The doctors' lobby in this country is very powerful and very rich, and they are making a large amount of money through sex selection. This is the primary reason why they are not interested in implementation of the PC-PNDT Act. The doctors are a big mafia in the country who are responsible for the mass genocide that is happening in this country".

A district collector said "Monitoring clinics and even confiscating or sealing them was an important step but only the first step. It is not enough to really deal with the issue. The law has rules for three elements, the place, the person and the machine and all three can be checked. The best implementation is only possible through the community, since doctors rarely if ever speak up or implicate other doctors. The AAs too are doctors and so are those sitting at the State Supervisory Board. They are thus judges as well as 'beneficiaries' and so there is a clear conflict of interest".

Certain other interviewees opined that people say it should not be in the hands of the doctors, but they do not provide an alternative. They questioned who else could have the technical knowledge to be able to implement such an act. Interestingly among the AAs some of them agreed that they did find it difficult to take action against the erring doctors as they belong to the same medical fraternity. Some felt that the District collector should be made the AA whereas other felt that the Sub-Divisional Magistrate (SDM) would be more appropriate as the DM or DC has other important issues at hand and will not be able to give it adequate priority. In general, however, it was conceded that it was important that the AA should be a government official.

In some states the District collectors and enablers are actively involved in the implementation of PC-PNDT. A member of a District coordination committee in Tamil Nadu which was constituted in 2006, shared that so far only one part of the Act pertaining to compulsory registration of the clinics operating in the area has been effectively implemented. This is because an over all preparedness of the government machinery has taken place only from December 2005 with the help of another body known as District Coordination committee headed by the collector.

In another place a government servant who is not a doctor has been appointed as project officer for the local PC-PNDT cell and works with the Collector and the District AA. In effect then he fulfils the role of the AA.

ii) Role, Powers, Responsibilities and Rights

With regard to the role, powers, responsibilities and rights of the AAs, some of the views expressed by a number of those interviewed seemed to offer other explanations as to why the Act could not be implemented effectively.

There was a general feeling that the knowledge of the AAs with regard to the Act and its implementation and their own roles, responsibilities and powers is very limited

The perception of many 'authorities' is that they do not have too much power to enforce the Act. The team was informed by the PC-PNDT division that because of the federal structure of the nation and the fact that Health is a State subject, and Family Welfae a concurrent subject, even senior PC-PNDT officials feel that they do not have enough power to take action against erring Appropriate authorities at the District or State level. For example, they believe that they do not have the power to summon a particular Appropriate Authority if they are not functioning well and/or to call them to account.

Some AAs also indicated that they are not too clear as to the geographical area that comes under their jurisdiction, and don't have enough accurate information regarding the clinics which fall within their areas of jurisdiction.

The DC in a particular district who managed to get a doctor behind bars for twelve days, reportedly could not eventually get him convicted partly owing to an inadequate knowledge of the law. Instead of going through the AA as the law demands the case was handled by the police. It is reported that in 21 of the many sting operations that Sahara channel had conducted in Rajasthan, apparently the same route was followed, as a result of which it is likely that these may be dismissed when they are heard in court.

In another case in Himachal Pradesh another procedural lapse happened in filing a complaint against a doctor and a woman who had indulged in sex selection. Here again the AA wrongly briefed the police about the Act that the woman also has an equal role in what had happened, and so she could not be protected, whereas the law considers her innocent unless proved guilty.

There are funds available in terms of the amount generated by way of registration fees/ renewal of registrations at the level of the AA. However there is relatively less clarity in terms of whether this money can be used for meeting the expenses related to the PC-PNDT work. Some other AAs expressed the view that though the money that comes from the registration is distributed between the state and the district, the disbursement to the district is not activated in a timely manner and hence funds are often not available. Many also requested that there should be clear guidelines on how the AA will be supported and protected when they file cases against members of the medical community.

Most of the AAs opined that there is a need for them to be legally oriented. Small mistakes in implementation can weaken the legal process. In recent hearings some of the doctors were released on minor technical gaps. For instance, the law says that the witness should be independent and therefore taking a government servant from one's own office would compromise the case – a detail which the concerned AA in one of the states was not aware of at the time of inspection. Some also said that though the Government has offered a "legal consultant" to AAs, this provision has not been adequately operationalized.

Some sections amongst lawyers also felt that the lack of knowledge amongst the AAs has often led some of them to handle the cases in contravention of the general law of the land. "They completely flout even the principle of natural justice such that the case gets dismissed in the court." Examples of these failures include not giving the doctor a copy of the complaint, or not giving the doctor a chance to call their lawyer.

Some sections felt that there is a significant level of confusion as far as the legal implementation is concerned, as the AA has no idea about how to implement it, while doctors are able to get expensive lawyers to find out flaws in the processes followed. The Public Prosecutors, in many cases, do not have complete knowledge of this particular law and they often do not know the section under which a particular evidence needs to be submitted or a particular charge needs to be framed. The first thing that they often do is to go ahead and file an FIR, while the court is often compelled to quash the FIR if there is no complaint by the AA or the AA has not been given adequate notice as per the Act. So such exercises do not lead to any significant legal remedy.

There are many procedural mistakes committed during search and seizure operations, including for example the absence of two independent witnesses, failure to issue a showcase notice etc. In one of the states, the panchnama was not done and the machine was sealed. The doctor went to the court and said that it was his right to earn a livelihood under his right to life, and the judge lifted the sealing on the machine. Activists pointed out that many AAs are unaware under what section they can seal, while Public Prosecutors may not often know that there has been an amendment in the Act, as per the information provided to the team.

The Appropriate Authorities are thus not well versed and equipped to handle the technical aspects of the law of evidence. Therefore although they can carry out a raid and seal a clinic when it comes to booking the erring doctor under the law they at times find themselves incompetent to collect the relevant evidence and make a foolproof case keeping in mind the technical nuances of the law. These grey areas in the legal knowledge of the implementers have also affected the implementation of the Act.

This was evident from a case filed on a clinic in Karnataka where a particular diagnostic centre was found to be involved in conducting sex determination tests. Subsequently, one of the Supervisory board members and the then appropriate authority sealed the clinic and filed a case against it. The case was filed in the local metropolitan court but as it was taking too much time, the clinic approached the high court and the high court in turn did not take cognizance of the case because it was not charged against the owner who was the registered owner, and the registration certificate did not carry the location of the clinic.

In the well-known Sahara sting operation in Rajasthan the channel telecasted interviews with 64 doctors recorded with a spy camera during April and June 06. Allegedly, due to the pressure from civil society as a result of this expose, the State Appropriate Authority was compelled to take action. However, the lack of clarity on the necessary steps to be taken by the appropriate authorities has delayed the action and wasted the tempo built up by the sting operations.

According to some activists and especially AAs, the Act is highly bureaucratic and so even after making great efforts, doctors are set free by courts on technical grounds. According to them, many in the judiciary are not very conversant with the Act itself, and/or how it is related to other Acts which may impinge on the implementation of this one. Moreover, it is alleged that many of them seem to personally condone sex determination as they themselves come from a patriarchal mindset.

iii) Inadequate Resources

The resources (time, human and financial) available with the AAs is, according to many of them, not adequate for such a huge task of monitoring the implementation of this Act.

At the level of the State PC-PNDT implementing cell some officials opined that although they have sufficient funds to carry out their tasks, they did not have enough staff to meet the work demands of the cell. They expressed the need to appoint junior level staff.

“The percentage of regular quarterly inspection is far below the expectation. Its average is 42% and in some parts inspection frequency is as low as 20% and there is an urgent need for improvement in this area. The lack of provision of funds/staff for executing duties assigned to the AA impedes effective implementation of the Act. Visits are not done regularly. Further, the AA does not have any staff for inspection; no mobility support and above all most of them are not interested in the issue” a perception shared by AA.

The District CMO identified as the appropriate Authority under the PC-PNDT Act is already overburdened with other concerns as an official of the state government dept.

and the implementation of the provisions of the Act are an 'add-on" to his already existing work portfolio. Other commitments and paucity of time perhaps does not allow sufficient time to do justice to the implementation of the Act. This was a view expressed by many AA's

As informed by an official in Gujarat, 'At times we receive 200 forms per month from one doctor. The forms pile up and we cannot make any use of them for lack of human resources and adequate infrastructure to do the job.' On being asked about a recent initiative to involve health workers to follow-up ANC cases to know the status of pregnancy he added that this system works very well in rural areas as one health worker covers a limited population. However, he continued, 'this is an impossible task in urban areas where we have only two health workers for one lakh population. They just cannot complete the task."

iv) The Advisory Committees

Many advisory bodies in the states visited by the team are practically defunct, while among the ones, which are technically 'alive', the roles, responsibilities and facilities available to them are not clear even to many of the well-meaning ones among them. Hence in actual fact most advisory committees rarely function effectively, except when there is sudden publicity as when a sting or decoy operation is conducted.

The monitoring undertaken through advisory committees, according to many of the enablers, is not stringent enough. They feel that most often the members are not chosen independently and hence are not the ones who are involved or even committed to the issue.

On the other hand, some of the members on these committees interviewed in various states commented that they themselves do not feel that they have much scope of monitoring as all they do at such meetings, when and if they are called, often at short notice, is to go through the applications for registration.

Almost all the implementers, particularly members of the Advisory Committees agreed that they undertake inspection and visits only when they get time, and not regularly. They also expressed the logistical difficulties they faced like getting a vehicle, or the travel allowance approved etc.

Enablers also expressed the view that because AAs lack sufficient legal grounding in the PC-PNDT Act or other related Acts like the Evidence Act, the inspection visits are not being used effectively as important tools for monitoring. They are often unaware of all the records that they need to check, how to record these visits, and subsequent actions to

be taken. "Persons selected to be on the Advisory Bodies are not necessarily the best persons to be on these bodies – either because they are very senior and don't have the time, or because they are not really interested or committed to the issue etc. Sometimes the NGOs or women's representatives are also like this."

Several of the committee members shared that during the meetings the only thing they seemed to be doing was to check the applications for registration of clinics and machines– something that could be checked by administrative staff and for which one did not need such senior people. When they suggested to the AA that they should make visits, the organizing of the visits (getting everybody's free dates) and the logistics (e.g. getting a vehicle) etc takes so much time, that one has to plan many months in advance and eventually that also means that many things could come up in between and the visit gets cancelled. Moreover, such long term planning also means that there can be no 'quick' response to any incident or issue related to such practices.

An advisory committee member met in one of the districts in Maharashtra opined: "The selection of members on the Committee itself appears to be faulty. People are selected who are senior most or already very busy and cannot or will not give time for this". She suggested that people who are selected or invited should be first given information as to what the work entails and only if they are willing should they be included.

Another one of those interviewed mentioned that the committee members are sometimes themselves corrupt. An example was given during one of the interviews of one of the committee members in a particular district being himself caught in a decoy deployed by an NGO in Maharashtra. It was also felt that some of the members of the advisory board do not really know:

a) What their tasks are (e.g. just administrative work or record review and inspections?)
b) What their rights are (e.g. they did not know that they could claim TA and DA for their meetings) and
c) What their powers are (can they take action, or ensure that the Appropriate Authority performs as per the Act)

It was generally felt that the authorities do not have an informed team (advisory committee) who is motivated to take action as it is alleged that they do not involve people who are informed and motivated.

One of the AA a team member met in Himachal Pradesh shared that in many districts the advisory committees have not been formed. Further they alleged that often enough people are appointed on the committees who will not ask too many questions.

Some opined that the experience of working on an advisory committee was not very encouraging. The meetings are organized at a very short notice – sometimes with a notice of just two hours before the meeting.

An NGO based in Rajasthan, whose representative is a member of the district advisory committee, felt that the status of implementation is poor. The meetings were irregular and the participation of the members was almost nil.

Some of the other members of other District Advisory Committees, expressed their unhappiness about the functioning of the committee for the following different reasons enumerated by members of various Advisory Committees:

- The committee is chaired by the appropriate authorities of the districts reportedly in some places (again this is not within the provisions of the act)[34] and hence he/she retains control which is not very helpful for the independent functioning of the committee"
- Organizing the meeting at short notice instead of being given seven clear days notice to members in normal course.[35]
- The committee does not discuss the issue nor is it aware of its role within the PC-PNDT Act of advising the appropriate authority to implement the act effectively.
- Many mentioned that no allowances are provided for attending the meeting and many are not aware if it exists. The impression among the members of many of these advisory committees is that the PC-PNDT implementation does not have any financial provision made for it either by the Centre or by the state.

However on the contrary where the appropriate authority and the advisory committee were able to function beyond the minimal bureaucratic requirements (i.e. beyond the function of clearing the applications for registration etc) and expand the scope of its work to take up general issues by linking this issue with other public programs, they were able to function more effectively. This has particularly been seen in those districts where DCs have taken a personal interest in implementing the Act.

It has also been remarked by some enablers and advisory committee members that often enough there are more doctors in such committee and they often stand together on matters that conflict with the interest of their professional colleagues, whereas the NGOs/women

34 Section 17(5) of the PC-PNDT Act states that the Central Government or the State Government, as the case may be, shall constitute an Advisory Committee for each Appropriate Authority to aid and advise the Appropriate Authority in the discharge of its functions, and shall appoint one of the members of the Advisory Committee to be its Chairman.

35 Rule 5(1) of the Advisory Committee Rules states that at least seven days' clear days' notice of all meetings of the Advisory Committee shall be given to each member, but an urgent meeting may be called by the Chairman at three clear days' notice.

representatives are less in numbers and therefore are unable to press for action to be taken against doctors.

v) Need for Official Mandating by Government

As per the law, there is need for the Appropriate Authorities and advisory bodies to be officially mandated by a special notification, but according to some of those interviewed, this has not been done by all States in all cases, and even then this is mostly because of pressure from activists. This of course makes it impossible for these bodies to function legally.

There was a major problem concerning the notification of appropriate authorities in the government gazettes. Till recently not all of them were notified – a situation which created problems in subsequent legal proceedings and hindered the implementation of the Act.

vi) Maintenance of records

Many doctors expressed the view that that they have to do too much paper work to maintain the various records that they have to keep under the Act. Consequently even the ones who would like to comply with the law claim that it is difficult for private doctors to submit all this paper work on time and regularly.

At the same time they feel it is a fruitless exercise since most of them believe that the AAs are most probably never going to read these submissions and it is just unnecessary paper work. Therefore, there are those who say that these records can be easily filled in with fraudulent data since there is no one to check these and in any case the doctors can always claim that they received the wrong information from the client if there was a check. Even among the enablers there are those who agree that the records can be easily manipulated.

The implementers, particularly the AAs, feel that it is not possible for them to scrutinize all the records with the limited staff and time resources at their command. On the other hand, some implementers, particularly the district collectors who have been proactive on the issue, have used precisely these records, particularly the F forms as an important tool for monitoring of medical professionals. Such kinds of medical audit were explored in Delhi and Hyderabad among other places.

vii) Difficulties in the Monitoring Processes

In general there was a feeling that the monitoring process was not an easy process. Furthermore there is no 'single window' (for people, implementers or even the medical community) where information about the Act or its implementation or where to complain etc is easily available. As one member from an advisory committee in one of the districts in Maharashtra noted: "There is no 'central' place where members of the advisory board,

doctors or the public could call to get information about the Act and its implementation etc. which is crucial" Some lawyers opined: "The police are not treating complaints as seriously as an FIR, and they do not arrest the doctors. By the time the complaint is filed and summons are sent, they get enough time to either run away or apply for an anticipatory bail."

The members of the National Support and Monitoring cell are, however, positive about their own role, believing that they can and do contribute to a better implementation of the act and do offer guidance to the AAs in the process. But there is a view expressed by some that since the tenure of the committee and its members is very minimal, it is difficult to bring about any real change in things in such a short span of time.

viii) Focus of Monitoring

In most cases the focus of monitoring has been the doctors, though there are significant examples where the focus of monitoring is the pregnant woman through involving the local government systems. However, several enablers and women's groups perceive this latter approach as anti-women and as mechanisms devised to instil fear among the people. Many of the participants in the 'Looking Back' workshop also expressed their reservations on the strategy of monitoring the pregnant women. In this context, some enablers also pointed out to a trend whereby pregnant women are hiding their pregnancy, thereby bypassing the monitoring system, as well as the health benefits that such health system offers. Some enablers have also pointed out that such monitoring is only possible for rural and poor women, who are the ones who access the government health system.

However despite this criticism at several places, the ANMs and the health workers at the community level have been involved in checking such instances from happening through monitoring and follow-up of pregnancies as demonstrated by the Tamil Nadu experience where the state government strategy of involving the Village Health Nurse (VHN) in surveillance and monitoring of all pregnancies and reporting any suspected cases to the appropriate authorities have reportedly shown some results. Panchayat level health committees under the direction of district coordination committee, have been formed to take care of female infanticide and foeticide problems in the state. Under this system a record of the birth of girls, pregnant mothers, and the abortions taking place are kept at the community level. The Tamil Nadu experience has shown that the government per se cannot tackle the problem but the community also needs to be brought in to help the government in the act. The village health nurse reports any attempts to the collector's office where there is a cell created to deal with such problems. Action against people is taken instantaneously and this has brought about some scare among people in the remote areas. As one such health worker commented: "Usually women come for check up and registration in the first or second month. But this month I met four women who came for registration in their fourth month. The first child of all four is a daughter. They did not

register their pregnancy till they did the SD test and were sure that they have a male child. I asked them where they had got the test done, and subsequently have sent the report to the Medical Officer. We have been told to send such reports, with the names of the clinic, as and when we come across them"

However, a nurse in a sub-Centre in a village in Maharashtra confirms that in her area the law is clearly not implemented. Being nurses we only try to convince people. We can neither force them against tests nor do we know what action is taken on the basis of information and reports we send to our superiors.

As far as monitoring goes, the general impression is that the AAs do very little of monitoring, except when 'pushed' by external forces (e.g. activists, a much publicised sting operation etc). On the other hand some doctors have also commended the positive role of the Appropriate Authorities in helping them to fulfil their responsibilities under the act (e.g. offering them support/guidance in fulfilling their documentation responsibilities).

ix) Pressure from above

Many implementers shared the experience that there are political pressures brought on AAs that make it difficult for them to take action, since many politicians are involved with the 'owners' of the companies (as the Act terms these clinics) where these services are offered.

Some doctors/collectors working towards enforcing the Act expressed the difficulty they faced from their peers, superiors and society in general as they are definitely in a minority if they dare to go against the system and powerful vested interests while performing their duties of enforcing the law

It has also been expressed by some enablers that the moment the focus of monitoring shifts to doctors, political and financial powers enter the picture and begin to play a role in influencing the outcome. This often makes monitoring both professionally and personally very difficult for the AAs.

However there were certain other sections that believed that the state authorities themselves, like the AAs, at district and State levels are in league with the clinics and doctors, and it is they who instigate such pressure from 'above'.

"It's a nexus between politicians and doctors," said a senior member of the Bengal Obstetrician and Gynaecologists Society. "Politicians shield the offending clinics." Another

lawyer activist of a well-known NGO agrees that there's no conviction because no doctor wants to speak out against another doctor[36].

There are many who insist that the blame cannot be laid only at the door of the medical community as there are clear indications of a wider systemic failure wherein politicians and ministers and people at the helm of affairs are perhaps not sincerely interested in getting the Act implemented. Instances of pressures from such quarters in case of legal action against the erring doctor were frequently cited during the various interviews.

An AA shared that in case of legal action against a doctor in one of the districts in Maharashtra, there was pressure from a local elected representative not to take action.

A former state appropriate authority said "My entire life has been given to the cause, I have faced grudges from ex colleagues, colleagues and everyone else. My pension was stopped; false cases were filed against me, and what not. I have been spending my own resources to work on the issue. Still there is a lot of antagonism that I face".

At the level of the PC-PNDT cell at the centre, there seems to be a belief among those in that central cell that they do not have too much power to take a specific AA in a district to task if s/he joins hands with the doctor concerned. He cannot call him and ask for explanation. He can only call them for a specific meeting when all the other AAs of a particular area are called.

x) Alternative system of monitoring needs to be explored

Some of the PC-PNDT officials at different levels have suggested that there is need to create an alternative system for monitoring, if the domination by medical professionals is a significant hindrance. They also believe that although enablers complain about this they themselves have not been able to come up with a viable alternative.

Some enablers have suggested that the women's commission or the NGOs should be given the charge, while the implementing authorities are unsure of their expertise to handle this task. There has also been a suggestion that the District Collector should be made the Appropriate Authority based on the understanding that the position of the District Collector as the administrative head of the district makes it easier for him or her to handle the political pressure and wield more power on the monitoring mechanisms

36 As quoted in a newspaper article by Prasun Chaudhari 'The PC-PNDT Act needs to have more teeth: Banning sex determination test is not enough', The Telegraph, 29th June, 2005

than the present structure. Others have said that the District Collector already has too much on his/her shoulders and therefore it could perhaps be given to the SDM. In any case it was felt that these would have a better understanding of the requirements of the courts and be able to fulfil them when inspecting or monitoring those who break the law

It has also been observed both by the implementers and the enablers that the involvement of local community and health system workers like the anganwadi workers and ANMs contributes to the efficiency of monitoring. The strategy of involving the local dais/ANM/ anganwadi worker in monitoring pregnancies to prevent cases of SSE from happening has been successfully adopted in certain parts of Punjab. On the other hand, there is also an opinion among the people and some enablers that there is a nexus between the doctors and these health workers that contributes towards fostering sex determination and sex selective elimination of females. Furthermore, although the experience of those using this strategy in the rural areas has reported to have had positive results in some places, others have reported the difficulty of introducing a similar system in the urban areas. "We do not have a similar efficient system at the urban level. We have only two health workers for one lakh population in the urban areas. They are unable to meet this task.', stated one of the government officials from Gujarat.

Some medical professionals also suggest that professional organizations like FOGSI etc are not being taken into confidence while monitoring. They felt that the AAs place too much focus on purely administrative aspects of the monitoring, and not on implementing the law in spirit.

Since monitoring cannot be effective enough UNLESS the community or people get actively involved, there is need to find ways to make it easy for them to be involved. Right now there is fear of the courts and the long-drawn out procedures, which positively prevent people from complaining or taking any step to counter SSEs. Also the process of complaining is so cumbersome and complicated that people do not understand it and are therefore unable to do anything even if they feel slightly inclined to do so.

In Punjab the district collector in a particular district through his initiative has been able to bring about a reversal of SRB. The multi-pronged strategy followed by him involves working closely with all the NGOs in the district who were working on separate issues (they continue to do the same, but on this they are a federation), the government system as well as the people. This is considered one of the reasons why the system works. The strategy works by creating a hesitation in the minds of the people so that they think twice before going in for sex selection. They now know that it is illegal, and they can be caught. The underlying idea is that there is no point in catching a doctor after the 'act'; hence this initiative aims at stopping people from doing it, and in this sense is proclaimed to be preventive in nature. This tactic has made these services expensive and inaccessible to

the masses. The strategy does not focus on the doctors but attempts to control such behaviour by pointing out the negative consequences of such actions. There have been objections raised against this approach. It is alleged that even when there are genuine cases of MTP (e.g. when the child had to be aborted because of some abnormality,) this committee would defame them.

The Gujarat state Health Department has recently launched a monitoring mechanism with the active involvement of the community. Each Grampanchayat publicly displays the number of male-female births in their area every month. This brings the local situation to public notice. 'First let them understand the situation in their own village. If they understand the problem in local context, they would also understand how widespread it is', opined one official from Gujarat.

Some of the groups working in rural Rajasthan have adopted a strategy of community rejection, which means community members would not do the tests and also keep a vigil on other members.

2.4
Reasons Related to Individual/Group Efforts on the Issue

2.4.1 Communication Strategies

Like with many other well-meaning laws in India (dowry, sati, child marriage, etc.), it is commonly accepted that unless there is a social mindset change among the general public and particularly among those who indulge in these practices, no law can really be implemented. This has generally been accepted by almost all enablers involved in this issue.

Communication strategies and materials play an important role in this effort to change people and bring about behavioural change. The following are some of the reasons articulated by various interviewees during this study as to why the communication strategies used so far have perhaps not been effective enough.

i) Lack of clarity in the message

One of the problems suggested for the lack of success in this campaign of SSEs, is the 'pulling in different directions' of the enablers. This is particularly seen in the field of communication reflected in often contradictory messages being transmitted on the issue. For instance in several places the communication material such as posters being used depict an anti-abortionist message and in some places such messages are also being sent out in public discourses. As a result of the confused or contradictory messages in this

campaign, it was suggested that the effectiveness of the campaign against SSEs is significantly compromised.

ii) Geared for information, not action/commitment

It was the perception gained by the study team during the field research that many of the communication strategies adopted by different groups focus almost primarily on awareness or information building, and do not seem to make any attempt to move towards behavioural change. It is suggested that communication strategies that do not work as catalysts in 'convincing' people from all categories that "WE" can do something are largely ineffective, because the normal tendency is to say that this is an age-old problem, and it will take years or decades to change the situation.

Similarly the workshops organized for capacity building which just give information do not help at all in bringing about any behavioural change, even if there is technically an 'action plan' at the end.

iii) Not adapted to different target groups

It was suggested by many that the communication strategies and materials prepared by different groups are generic and are not community and local specific. This kind of focus is necessary for various specific groups. There is no point in developing/creating common communication materials targeted at all and which then affect no one significantly.

As one of those interviewed remarked with regard to much of the IEC material, '*gaon ki bhasha mein nahin hai.*' (i.e. it is not in the local language). The fact that often the local language or terminology of the targeted group was not used in such communication efforts was also highlighted by some of those interviewed as one of the reasons for failure in communication effectiveness. Others also pointed to the limited efficacy and outreach of posters amongst the illiterate. For instance a health worker in Delhi shared that women who come to the health centre and cannot even read what is written in their own referral slip could hardly be expected to read the posters that give information on this issue.

It was also pointed out that most of the communication material was targeted at the pregnant women and girls, and not at the decision-makers in the family (like husbands, mothers-in-law etc). Allied to this was the lacuna in the lack of materials targeted at adolescent boys who would in many cases be the future decision-makers.

Finally most of the material prepared seems to be targeted at the 'converted', or the 'neutrals', not the non-converted. Many of those interviewed indicated that the posters or other promotional material would not change the mind-set of those who are already using/offering such services that lead to sex selective abortions. In this direction several

suggested the importance of working with the various 'conduits' that lead the patient to the clinic offering sex selective services.

The team met community health workers and nurses, who felt they were helping women who would suffer if they didn't help them find a doctor who could offer them sex selective abortions. As one health worker commented : "It is important to get members of the medical community to stop sympathising with those who offer these services for sex selective abortions and to help them perceive such doctors and clinics as social criminals" A compounder working in a PHC in Rajasthan echoed similar sentiments. He shared his perception that while they were indeed displaying the publicity material being received from the government departments on the issue at their centre, the same had little impact in spreading the intended message as very few of those visiting such centres could read. Therefore it was felt that it would perhaps be more effective to use mass media such as television to spread the message in rural areas, which have a predominantly illiterate population.

iv) Mistaken Stress on Products, not on Process

It was suggested that communication strategies that intend to bring about behaviour change and not just awareness must be not just product-based but also process-based. This applies to all sorts of communication material, whether they are posters, workshops, street plays, or any other. In all of these the process, not just the final product, is important, and the movement from awareness to commitment to action is possible only if the process is stressed. In a product-based communication strategy the process is only one-way, and this cannot lead to behaviour change or action.

Thus it would make little sense to prepare a street play or a poster and then just send it to other groups to be put up or displayed in different places, if the people who use them are not involved in creating them in some way.

Again, once the target feels motivated or made aware, some further communication strategy must be included in order to help the target group find a way to channelise this motivation. Without this second part any communication strategy is incomplete and ineffective and remains product-based.

v) Struggle between "being effective" and being "politically correct"

While being politically correct has its value, the point has been made that sometimes the language of the 'target' group has to be used first before explaining (once the 'connection' is established) why such in-correct language should not be used. Of course if one can be both politically correct and effective then such a process should be used.

According to some the struggle between those who have decided not to speak of 'abortion' because then it becomes a pro or anti abortion debate, and those who believe it must be spoken about because abortion may in fact be an issue on which people are confused – why abortion is right sometimes and why it is not at other times – has ended up with the campaign's communication efforts suffering.

Similarly it may be the case that a particular group, which intends to campaign on this issue may feel that using the support of religious leaders, may be adding to superstition or because they would allegedly be against all abortion, while others believe that since religious symbols and leaders do have power over people's minds in India today they must be included in such a campaign.

Thus communication efforts to most effectively communicate with the larger community struggle under this dilemma as to whether to concentrate on being effective or politically correct.

This struggle between being politically correct or effective is also reflected in the IEC material. Whereas a lot of IEC material on the issue is patriarchal and patronizing in that it motivates people to save girls in order to have wives and mothers (a utilitarian function), activists disagree on the value of using such material which may have a greater impact than other material which might be more politically correct.

vi) Lack of a Common logo

It was suggested that one of the weaknesses of the communication strategies being used for this issue is the lack of a commonly accepted logo that is universally recognised, like there was for the family planning campaign, as such logos have a tremendous recall value.

This was also evident among most community members with whom the study team interacted who had not seen such posters or if they had there was reportedly little recall. A common logo that is universally recognised therefore has the power to remind people right away regarding the basic message of any such material.

vii) Need for much greater Volumes

It was felt that this is crucial to the success of this campaign and is sorely lacking. For instance those interviewed could hardly recall advertisements or spots on this issue. There is obviously need to air such products at prime time and to significantly increase their frequency. These TV and radio advertisements are particularly crucial for those who are not literate. One of the possible reasons for the success of the family planning campaign has been its extensive 'volume' and a successful common logo.

Furthermore, even the ones that are shown on the electronic media give only limited information. Thus in the electronic media there are infrequent commercial slots which only publicize that the act of killing a girl child is punishable, but gives little other information unlike advertisements aired for instance by the Consumer Guidance Department of the Government, (today known as infotisments) which give enough significant information that allow consumers to take action.

viii) Inability to 'grab attention'

According to many of those interviewed especially the communication experts, a lot of the communication material used is very ineffective from the point of view of "grabbing attention'.

Many of the posters created by different groups (government departments and enabler groups) are often perceived as too technical, with too many words, with many unnecessary visuals (like the pictures of the ministers etc), and in any case mostly meant only for the literate. Thus a health worker in Rajasthan expressed this view: "Posters are useless; we just use them to decorate the walls of our PHC."

Many of the other kinds of material are also perceived as very dry and unattractive, and do not use different media (broadcast and narrowcast) to suit different locales. Hence the reach is very minimal.

ix) Contradictory messages being transmitted on the issue

Different stakeholders are running several separate awareness campaigns on the issues. A review of these campaigns indicates that the messages being propagated by different campaigns are sometimes contradictory, or even incorrect, or biased against women etc.

For instance in Gujarat an awareness campaign is being run in a local college in a district which is one of the worst affected districts in the state. This issue was referred to as a problem of foeticide in general (Bhrunhatya), instead of female foeticide. The posters and the other material being used also reflected this confusion. Many posters presented the foetus being killed. There were some posters depicting the woman as the killer. Thus the understanding of MTP and the right to legal abortion is perhaps not clear even in the minds of some of those involved in the campaign on the issue.

In certain areas, for instance in one of the blocks of Gujarat with the lowest child sex ratio of 742 girls in the state as per 2001 census report, the local political leaders along with community leaders are spearheading an awareness campaign on the issue. This campaign in its public discourses is making use of a depiction of abortion that is taken from 'Silent Scream', an anti-abortionist film from the pro-life campaign in the USA.

It is admittedly rather difficult for many to grasp the distinction between abortion as a legal right in India and SSEs as a crime. Therefore the issue of right to abortion is forgotten in such ground level campaigns and the messages invariably are anti-abortionist.

Similarly a number of spots prepared even by other groups often spoke of the need for girls/women as being grounded in the fact that otherwise there would be no brides in the future and no mothers to nurture the children. While this may be true, such messages further perpetuate the idea that the woman's value is primarily based on her 'use' to society and to males. Many activists who believe that the root cause of this violence against the unborn girl child is found in patriarchy, believe that such messages are extremely counterproductive.

x) Lack of Knowledge of Incentive schemes

If the general public does not know of the incentive schemes and the special provisions introduced to support the girl child, there is little hope that such schemes will have the desired effect or contributing towards preventing female foeticide. The communication strategies perhaps have not taken this sufficiently into account and have not focussed on spreading awareness of these.

For instance there are numerous schemes in Tamil Nadu These schemes include special deposits in the name of the girl child under certain conditions, financial assistance for adolescent girls, financial assistance for unmarried girls, marriage assistance schemes, free supply of sewing machines, schemes for socio-economic upliftment of women, etc. Many of these are not known and not included in campaign activities on this issue.

Also some especially amongst the enablers and the community felt that these schemes were not easily accessible and were in any case targeted at the BPL families, whereas studies show that it is the affluent classes who are practicing SSE in larger numbers.

Moreover some of these schemes (like the marriage related schemes) themselves foster the stereotype of the woman as one who needs to marry in order to avoid stigma in society.

xi) Role of Media

Most of the media coverage is event based, focusing mostly on numbers. While this has to a certain extent helped in making the issue public, it has often been limited only to that. Furthermore whenever there is a high profile event connected with this issue, the media does cover it, but as these are meant primarily for a particular kind of target group, its reach is limited. Other target groups would require completely different media.

It must also be remembered that communication strategies are significantly affected by the other messages that people are being bombarded with and therefore cannot be seen in isolation from the whole media environment. This has apparently not been taken sufficiently into account. Thus other messages being beamed by the media (e.g. ostentatious marriages which would imply huge dowries, son preference serials, etc) all undercut these very few messages that are put out by the media in favour of the girl child.

Some of the participants in the communication workshop also focused on the need for media–friendly stories on the issue that could then be appropriately highlighted. They also pointed out that some of the advertisements made for this issue were not properly planned and thought out. Thus, for example, with regard to the advertisement spots prepared by some groups on this issue, it was pointed that often these are of a long duration (e.g. one minute duration) and were therefore reportedly refused by the channels. It was therefore felt that such spots should be planned in such a way as to require less air time, which would make it easier to find channels willing to air these at prime time. In the absence of such planning, the exercise of creating such spots becomes a loss of precious resources.

xii) Capacities of NGOs/CBOs/Activists

Some enablers during the 'Looking Back' validation workshop also opined that NGOs mostly work with the poor and consequently may not even have the capacities/strategies to work with the middle-class and the affluent who are the ones mainly practicing SSE. In this context it was also mentioned that the mandate of the NGOs as commonly perceived by the general public also reiterates the need for the NGOs to work with the poor alone.

2.4.2 Sting & Decoy Operations

i) Decoy operations by NGOs - a Last resort

There is a section of enablers who believe that decoy operations should be the last resort; while others seem to feel that these should be used more often.

The former, which included many AAs and some enablers, felt that there were several other ways in which doctors and clinics could be monitored and these could be explored without focussing so much on decoy operations. Moreover, heavy dependence on decoy operations was felt to be problematic, both because it seems to be s specialized kind of effort and requires resources (financial, personnel, time, legal etc) which may not be available with enablers. Additionally many also felt that such efforts should be the primary responsibility of the State and not of civil society.

ii) Methodology of Decoy operations

There is significant confusion as to how to do a decoy among both AAs and enablers. While quite a few AAs showed interest in using this mechanism, as the other monitoring mechanisms are not applied, they also strongly expressed the view that they do not have the legal and technical expertise to carry this out. Among enablers each one does it on their own (at times ignoring the appropriate authorities) and there is little shared learning.

Some NGOs/individuals are sceptical about the effectiveness of such strategies being used in isolation in order to bring about any convictions against the erring doctors exposed through such operations. Though the implementers claim that decoy operations help to exert pressure on the doctors, the experiences of organizations that have attempted decoys are quite frustrating. An example was given of a recent decoy incident conducted in a major city in Maharashtra, where the case against a government. doctor, who indulged in sex determination during official working hours is in complete jeopardy. The reason given is that it was only after the case was filed in the court that the activist organization came to know that the necessary gazette notification appointing the AA had not been issued by the state. This, according to them, showed the lack of commitment on the part of the government and implementers, in the absence of which any decoy operation will eventually fail in delivering any punitive action against the erring doctor.

Some NGOs also felt that by encouraging them to do decoy operations the government is shirking its own responsibility to enforce the law.

Some amongst the enablers also viewed the provision of providing a monetary incentive to NGOs to conduct decoy (for instance Rs. 15,000/- being paid by the Maharashtra Government). as one of the means by which the government was trying to throw the responsibility of legal enforcement upon civil society organisations.

iii) Role of Police

There are various views about including police in the monitoring process. Many 'implementers' and some enablers believe that while going for raids, the police should accompany them; whereas many other enablers felt that the involvement of the police would only have negative effects.

Some of the AAs the team members met in Maharashtra expressed the need to involve the police in decoy operations, for evidence collection or panchnama as the AAs lack knowledge of law-related processes.

Others amongst the enablers particularly, felt that the police should not be involved as it would lead to corruption and unnecessary delays in legal processes. According to them,

the police need not enter the picture at all, since the PC-PNDT Act provides for an 'Appropriate Authority' to implement the law.

iv) Lack of trust between Enablers and Implementers

One of the reasons for the failure of the monitoring processes, especially decoy operations etc is that there is often much mistrust between the enablers and the implementers.

"The enablers tend to mistrust the integrity of the AAs", is a remark that was heard from one AA. In general, this was also the experience the team as it met many enablers and AAs during the study.

This mistrust further adds to the problem as according to the Act, nothing really can be done without taking the AAs into account and/or informing them, - and yet enablers have been heard to remark that if they do so then advance information would be given to the targeted clinic or medical service providers.

v) Importance of Publicity

There was a view expressed that decoy operations per se may not be so effective but it is the publicity, (media or otherwise) that make them more effective. However, some sections amongst the appropriate authorities feel that the enablers overdo their efforts on involving the print and electronic media in order to earn publicity for themselves and not so much for the issue.

Sting-Decoy operations have had an impact on doctors, as well as on some implementers and even on people, particularly when they are accompanied by publicity. These operations have made the doctors more careful and fearful, implementers have been forced to take action, and people have realised that sex determination is illegal. However, it has also meant that the price of these services have gone up significantly.

One of the indirect outcomes of the media publicity generated on the issue as a result of one of the sting operations in Rajasthan was the reported revival of the defunct advisory committee.

Some sections of the doctors the team members met in Rajasthan were of the opinion that on the one hand the PC-PNDT Act has instilled a feeling of fear amongst the doctors. On the other hand the doctors have capitalized on this opportunity by hiking the cost of sex determination tests allegedly to cover their risks. It was reported to the study team during its field visit to Rajasthan that after the sting operation the cost of SD had gone up from Rs. 2,000/- to Rs. 10,000/-.

Some of the doctors met in Rajasthan after the Sahara TV sting operation shared that, "what the doctors fear most is losing their dignity" One of them also shared that "I have heard that one doctor has closed his ultrasound clinic after action was taken against two clinics. Though he was doing a fair practice, he feared that he might also get caught due to some minor gaps in his records." This also shows that a stringent action against the doctors indulging in illegal acts exerts a pressure on the entire medical community and sting operations do sometimes act as a deterrent and exert great psychological pressure on those practicing it.

vi) Credibility of Sting/Decoy operations

The credibility of sting operations depends on many factors, all of which are not carefully taken into account at times. For example the witnesses should be perceived to be independent and not too closely linked to the group/enablers who are organising the operation.

Again, when political pressure leads to raids, when the independence of the witness is questionable, or when the motive of the individual/organisation conducting the sting-decoy operation can be challenged, the credibility of the entire effort is called into question when the case comes to court.

Thus, sting operations and raids done with a motive of sensationalism and harassment do not help the cause. Some officials opined that unnecessary raids motivated to gain publicity do not serve any material purpose in contributing to the campaign on this issue.

An advocate from Maharashtra who has done several decoy cases shared that the problem they have faced is with regard to witnesses. Under the Evidence Act in case of substantial corroborative evidence there is no restriction on the same witness appearing in more than one case in the same court. However the organization in such decoy cases only has their own employees as witnesses. This could be questioned by the court, which may perhaps view the credibility of such witnesses with scepticism.

vii) Legal Viability of Sting/Decoy operations

The legal viability of sting operations is not too clear. As of now there is no court mandated methodology of conducting such operations, so everyone is doing it in their own way.

There also appears to be a confusion in the minds of the implementers as to who is authorized to conduct decoy/sting operations,. One of the officials at the Block level shared the view that he was not clear whether he had the authority to conduct decoy operation and thought that he perhaps needed to take permission from the District AA.

The implementers who want to initiate action against the erring doctors and want to enforce the law find it difficult to do so in the absence of any clarity/awareness about the law. One of the collectors the team met in Madhya Pradesh shared the opinion that due to the inadequate knowledge on the details of the PC-PNDT, the help of an advocate of the SC, was taken in planning raids against some of the erring clinics. The revenue officers and others who conducted the raids did not know much about the act or the issue, and therefore a checklist of various elements that they needed to check was given to them before the raids.

The team members were informed that there were instances where the court had quashed certain charges for want of acceptable evidence and the lack of proper framing of the charges (i.e. for not including the details of the clinics, their locations, names of defaulting owner or employee etc).

viii) Sensitivity of the Judges

Finally a lot of the success of the outcome of sting-decoy operations is dependent on the sensitivity and knowledge of the judges. As referred to in Section X (xiii), according to many enablers, the lack of knowledge of the special features of this Act often creates problems in the successful pursuit of the cases that are filed under this Act.

2.4.3 Community-Based Initiatives

i) Need to get the community involved

Many of those interviewed were of the opinion that attitudinal change could be brought about primarily by community and/or religious leaders, and intra-community efforts, and there should be less of a dependence on external forces. Also as some enablers articulated the view that while strong implementation is necessary, things are incomplete if the community does not support the cause. This was also reflected in the strategy followed in Nawashahr of targeting the women and the families with the help of the community members who are encouraged to join the Upkar committee. Among others the International Federation of Election Systems (IFES) together with Rajasthan University Women's Association (RUWA) have been working with communities to change social mind-sets, and towards this end a pilot project has been initiated that focuses on communities where the practice of sex selection is prevalent. It is presently working with six local communities (Maheshwari, Jat, Rajput, Brahmin, Jain and Sikh) in Jaipur city.

The project involves interacting with the opinion leaders of the identified communities followed up with another interaction workshop, 8-10 weeks later with the same group to share experiences on action taken, constraints encountered and lessons learnt. A total of

12 workshops had been conducted as part of this project during the period September 05 to February 06.

Certain NGOs are also working with women SHGs as collectives and mobilizing them to act as pressure groups and keep vigil on instances of female foeticide happening around them. One such group is called Jago Sakhi Sanghatan – a network of women's group in Dholpur, Rajasthan. The strategy adopted is one of 'community rejection', which means communities will refuse to use this technology and also keep a vigil to ensure that this technology is not used in their own neighbourhoods. This women's group is actively involved in various activities that address the issue. There were no clinics in or around their own village, though there were a few clinics in Dholpur, which is located a few kilometres away. They knew the clinics as they had participated in campaigns against them.

The team's visits and interactions with certain women groups in Theni and Madurai Districts of Tamil Nadu revealed that here too many of the women's self help groups promoted by the enablers are playing an important role in building awareness on the issue of female infanticide and foeticide among the masses, especially among women. It is also noteworthy that these groups are working in tandem with the state's district coordination committees and their affiliates at the grassroots level. However these efforts only involve women and apparently do not venture to address the wider issue of patriarchal mindsets that are ingrained in the men and families in general.

ii) Patriarchal & other unhelpful attitudes of Community leaders

While many feel that the community must be actively involved, there are activists who think that depending on the community is a slippery slope, primarily because of the conventional/stereotypical attitudes of leaders of these communities towards women. At the same time, though they were not too sure of the kind of leaders of these communities, some of the enablers expressed the need to work with such proactive community leaders and not just criticize them. Some enablers and community members expressed doubts concerning the effectiveness of appeals made by these leaders. Though most suggested the need to involve these leaders, they were equally doubtful how far people would follow such exhortations. There were certainly many hesitations expressed regarding the 'use' of religious leaders particularly as it was felt that they would generally be against abortion per se.

iii) Communities who experience Consequences

Communities who are feeling the severe consequences of the declining number of girls, (such as having fewer girls of marriageable age), have begun to take initiatives on their own to address the issue.

The problem is more critical among communities where dowry demands are high. In Jalgoan, Maharashtra, the problem of an adverse sex ratio is seen among Leva Patil, Marwadi, Mali and Sonar communities, which are generally rich communities In the Leva Patil community the prevalence of female foeticide has resulted in a shortage of girls available for marriage within the community, and has led to inter-caste marriages. In the Leva Patil community, marriage expenses are very heavy. The gold is measured in kgs and tolas! Therefore, generally, marriages are fixed in community gatherings organized for this purpose.

As one of those who works with the Jain community mentioned : "The Jain community provides a platform for marriageable girls and boys and their families in their community to come together and know each other. These functions are organized to facilitate marriage proposals within the community. In one of such functions, there were 700 boys to 105 girls."

Amongst the Khandelwal community in Rajasthan which originally belongs to the Vaishya sect from Sikar district, the association takes care of its community members in terms of helping poor families to overcome sudden problems and issues like education of children (even to go abroad and study), old age homes, community marriages etc. This community like the Jain community also takes the initiative to perform collective marriages. At such community forums proposals are discussed and finalized among the respective families and marriages are performed collectively. There are registration charges for each side and the community provides wedding gifts to the newly wedded couples.

Some community leaders also shared with the team members the information that in Gujarat, the collective marriage forum is being utilized in some parts to raise understanding on the issue of the missing girls or the declining sex-ratio. The newly wed couples take an oath that they would not undertake SD tests.

The team was also informed that there are two sub-groups among the Patels in Gujarat: Kadva and Leva, who are supposed to be the descendents of Lord Ram's sons Kusha and Lava respectively. Till very recently they kept their identities very much distinct and did not accept inter-group marriages. Now with the backdrop the declining number of girls, they had organized a big ceremony in Surat recently, where the two decided to come together. In this ceremony called as 'Mahaladdu Sammelan' many community members gathered and decided to 'permit' marriages between Kadva and Leva community members. This message was then spread to all community members by sending everybody some prasad with the message.

iv) Reasons identified by Community/Political leaders regarding what action should be taken

Many community/political leaders expressed the view that the provision of substantial monetary incentives for parents with girl children would significantly help the campaign. This they felt would help in motivating parents to give birth to daughters. Thus they related the problem to one of poverty, and were convinced that poor people would change if they were offered adequate financial incentives. Thus many of these think that monetary provisions, like bonds, educational scholarships to girls etc., would dissuade parents against SD. It is too early to judge the effectiveness of these approaches since currently the statistics show that the problem is more acute among the higher socio-economic classes who might not be so amenable to financial incentives.

An activist in Gujarat shared with the team member the news that as per newspaper reports, there was a scheme announced by the Patel community which gave partial educational support to the second girl child and full educational support to the third girl child. The Patels, according to him, are giving material incentives to parents who give birth to a second daughter and even higher incentives for the birth of the third daughter in a family. They seem to be making this effort to increase number of girls within their family under the guise of educational support.

The "Girl Child Protection Scheme" was launched in 2001 in the state of Tamil Nadu after prodding efforts made by various activist and community groups. Under the scheme, an initial deposit of Rs.22, 000/- is made in the name of the girl child with the Tamil Nadu Power Finance Corporation by the government for families with a lone girl child and no other children and either of the parents sterilized, A minimum of Rs.150/- from the interest accruing from this deposit will take care of the education of the girl child from the Ist standard to the Xth standard. The terminal benefit from the deposit with accrued interest will be released to the girl at the end of 20 years to enable her to pursue her higher education or to defray her marriage expenses. In case of families with two girl children and no male child where either of the parents have undergone sterilization, an initial deposit of Rs.15, 200/- is made for each[37].

On September 25, 2002, the Haryana Government launched a scheme "Devi Rupak" for the welfare of women & the girl child, wherein an incentive of Rs. 500/- per month for a period 20 years will be given to the couples who opts for sterilization after the birth of their first child if it is a female child[38].

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37 'Social Welfare and Nutritious Meal Programme Department Policy Note-2005-06 Demand No.43 Chapter-2 'Women and Child Welfare')

38 Paper on 'Status of Implementation of PNDT Act in Haryana' from official state govt. site) http://haryanahealth.nic.in/ADDITIONALDOCS/PNDT.DOC

The ”Ladli” campaign (using the name popularised by Population First) has also been taken up by the state Government of Haryana under the name “Ladli Social Security Pension Scheme”. As a result, the state government claims that the sex ratio of 819 girls per 1000 males in the 0-6 age group has now improved to 823 girls per 1,000 males, according to the statistics of 2005. Under the “Ladli” scheme, parents having a second girl child are given financial assistance of Rs.5, 000/- per year up to five years of the birth of the girl. The amount is invested in savings schemes and a matured amount of nearly Rs. 87, 000/- would be paid to the girl when she attains 18 years of age. Buoyed by the success of the scheme, the state government has set a target of making the benefits of the scheme reach 85,000 girls in the next five years.[39]

The state Government of Punjab has announced cash incentives to panchayats for improving the village sex ratio. It has also announced handsome incentives for decoys and informers to check the problem – though as was said earlier this may create a problem in courts if it is perceived as ‘tutoring the witness’.

The issue has become part of the political agenda in the state of Gujarat after the current CM launched the ‘Beti Bachao Aandolan’ on March 5, 2006, in conjunction with Women’s Day. Subsequently, political leaders are creating awareness in their own constituencies by organizing small meetings and public gatherings on this issue. The awareness programmes, however, focus only on women, and leave aside the family members/ husbands, doctors and implementers.

Dharmapuri District of Tamil Nadu, one of the worst affected by female infanticide, has been able make a turnaround of sorts. The reason for the breakthrough is reported to be the result of a multi-pronged approach wherein on the one hand coercive action by the authority concerned involves playing on the fear of people by booking cases against those practicing SD. Such efforts have acted as a deterrent. On the other hand the state authorities have also initiated welfare measures to safeguard the girl child including providing families with IRDP loans, Indira Vikas Patra for Rs. 1,500/-, priority in starting rural enterprises, promoting all women ration shops and so on.[40]

v) Highlighting the positive in the girl child

Many community members have also expressed the need to promote the girl child and highlight achievements of the girls, as a way to create a positive environment for girls.

The initiatives led by the communities or political leaders focus only on the issue of the declining number of girls. Consequently, there is a criticism/concern expressed that they

39 ‘Ladli’ improves sex ratio: Haryana”, Deccan Chronicle, Chennai Edition , 31st July,06

40 As cited in a newspaper article by D. Sivarajan ‘Female infanticide a cause for concern’, The Hindu 15th May, 2000.

will not address the root causes of the problem (gender issues) and the campaign will get over once the marriage market is settled, i.e. the number of girls is increased.

vi) Efforts by the Medical Community

The medical community in some places, either stung by the constant criticism of doctors as the lynchpins in the breaking of this law, or out of a concern for the issue itself, has taken on itself to initiate campaigns to prevent their colleagues from indulging in such practices. It is too early to see how successful these efforts have been.

Thus the IMA in Maharashtra supported by UNFPA, Mumbai, has started a series of workshops to sensitise its own constituency.

Sometimes individual doctors have set up their own efforts to galvanise their own colleagues to work against such practices being carried out by their colleagues

vii) Involving Religious Leaders

With regard to the involvement of religious leaders in the campaign on the issue there were differences of opinion. While some felt there was value in involving them owing to their mass appeal, others felt that it was more important to focus on the content of the message of these religious leaders. Concern was expressed over their anti-abortionist stand, which might make them advocate pro-life choices, which was considered by some as being out of line with the intent of the SSE campaign.

2.5
Conclusion

The next section of this report **LOOKING BACK TO LOOK FORWARD Interventions, Experiences and Lessons learnt in addressing CSR decline,** serves as a kind of bridge to the concluding part which suggests particular strategies for the future. In the next part the study team shares their understanding of the various efforts made by different actors to deal with this issue of 'missing girls' and then draws out certain lessons that could help guide future efforts.

Part 2

LOOKING BACK to LOOK FORWARD

Interventions, Experiences and Lessons learnt in addressing CSR decline

3 Part 2
Looking Back to Look Forward
Interventions, Experiences and Lessons learnt in addressing CSR decline

3.1 Introduction

Having explored the reasons put forward by different stakeholders with regard to their understanding of WHY the CSR in India continues to decline despite the efforts by so many activists and groups over the past two decades[1], it is important to also look at the kinds of efforts made by various such individuals and groups around the country over these past years. This will help to nuance and guide any efforts to prepare future strategies for the campaign as a whole, as well as for UNFPA in particular.

In general these efforts can be said to be divided into three categories:

a) **Efforts to influence the 'demand' side** – or in other words, efforts to influence those who seek out such sex determination services;

b) **Efforts to influence or control the 'supply' side** – or in other words efforts to motivate and ensure that the medical community (doctors, nurses, ANMs, dais, and other ancillary workers in medical establishments) does not indulge in such practices; and

c) **Efforts to influence and ensure that the State**[2] (and its representatives) are sensitised and pressurised into fulfilling their role of ensuring the implementation of the Act.

Furthermore, these efforts can be said to have been carried out by

i) **Enablers**: These would include efforts made by individuals, and organisations (e.g. NGOs, Community Based Organisations (CBOs), individual doctors, doctors' associations, and others) who have taken up this issue in an active manner

ii) **Communities**: This would include efforts made by communities themselves when some of them (especially the leaders) have become sensitised to the issue and have begun to experience the consequences of the declining sex ratio. Sometimes

1 The efforts in Maharashtra are said to have begun in 1985 leading to the "Maharashtra Regulation of Pre-natal Diagnostic Techniques Act, 1988".

2 The term STATE is being used in a very technical sense as distinct from the term "Government'. The State includes the legislature, the judiciary and the executive. The Legislature includes all elected members at ALL levels right up to the panchayat. The Executive includes both the political (i.e. the current Cabinets at Centre and states), and the administrative executive (i.e. the bureaucracy at all levels). The Judiciary includes all officially appointed dispute settling mechanisms from the Supreme Court to consumer courts etc. For differences between the STATE and the GOVERNMENT, please see Annexure I.

the communities do this in conjunction with the enablers or in conjunction with officers of the State, and sometimes on their own.

iii) **State and its representatives**: This would include efforts made by Appropriate Authorities (AAs), other government representatives like District Collectors, efforts made by Government DAVP departments, as well as schemes put out by various state governments to support efforts to reverse the trend of a declining CSR.

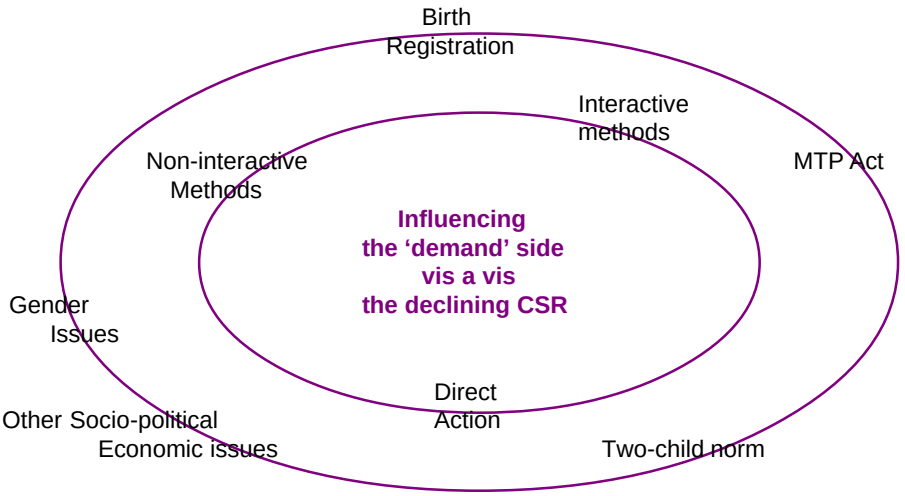
All these efforts can be said to together make up the 'campaign' on this issue. The following section will therefore describe and reflect on the strengths and limitations of some of the efforts made by these three different kinds of entities under these various categories.

3.2
Efforts to influence the 'demand' side – or in other words efforts to influence those who seek out such sex determination services

While there are significantly different perceptions among the various activists or influencers regarding the effectiveness and validity of such efforts[3], the fact is that a large number of those who would consider themselves as being active on this issue, have actually spent a considerable portion of their resources - human, financial, and time resources – on efforts to influence the 'demand' side. A listing of all those from whom such data has been collected (either through personal interviews or interactions, or through secondary sources) have been listed in Annexure II & III, while a brief description of the efforts of some of them is included in Annexure IV.

Many of these efforts cannot be categorised very clearly, but they do include efforts that are focused primarily on **awareness building** (using a whole slew of methods ranging from non-interactive to interactive types) as well as those that focus on catalysing people into taking **direct action**. While awareness building leads into direct action at times, it is also the case that sometimes direct action leads to both non-interactive and interactive awareness building. In addition there are other efforts, which do not directly attempt to influence the 'demand' side, but yet are significant in that they affect it indirectly. These include efforts to work against gender inequity in general, efforts to fight any coercive population restriction attempts, efforts to encourage birth registration etc. All these efforts can be diagrammatically represented as follows:

3 There are enablers who would argue that such efforts to work on changing the 'demand' are a waste of energy and resources if the immediate need is to reverse the continuous decline of the child sex ratio - and that most of the resources should be focussed on 'catching' the doctors.



Non-interactive methods are those efforts (often they are posters, films, short advertisement films, pamphlets, stickers, etc) that work only one-way, i.e. in giving information or making an emotional appeal to those who function as the audience. Interactive methods are those that attempt to get the 'audience' to respond to the stimuli offered, and which use such responses to guide or direct the ensuing process of awareness building or direct action. These would include workshops, melas (i.e. fairs), street plays, public meetings, rallies, competitions, interactions with school and college youth and other groups, exhibitions, cultural and religious festivals, etc. Non-interactive methods can be used in an interactive manner too, depending on how they are being used by a facilitator or resource person.

Efforts to catalyse people into taking direct action would include efforts that go beyond awareness building, and involve some form of action taken by individuals/groups/communities/state to influence the 'demand' side on this matter. These would include efforts that would lead to the setting up of village monitoring groups, participating in sting/decoy operations, etc.

These various efforts/methods are described below:

i) Posters, Hoardings, Print Advertisements and short advertisement films aired on the electronic media

Most of the efforts by government agencies to spread awareness on this issue can be categorised as non-interactive methods. This would include the work often done by the DAVP departments at the Centre and State which produce much IEC material on this

issue - i.e. primarily posters which are distributed to government-run health centres and other places, hoardings which are put up at various sites, and short duration spots/ advertisements/films which are aired on the electronic and mass media. Non-governmental enablers[4] too have felt the need to use these kinds of materials as well as pamphlets, postcards, and other kinds of handouts (e.g. caps, religious cards[5]) Almost every enabler group has some sort of such non-interactive material, though the quality of such material varies significantly.

Another kind of non-interactive method is one that flows out of adherence to the law, namely the signboard (indicating that sex determination is illegal) that is mandatory in every clinic that has an ultrasound machine. For many of the general public that the study team interacted with, this was the only source of knowledge with regard to the PC-PNDT Act. It has also been reported that some companies selling ultra sound machines are also including a similar 'warning' on each of their machines.

ii) Reports, Research Studies and other Print Material

These can also be considered non-interactive methods to build awareness and push for action both among the general public and the medical community.

Thus, for example many years ago, even prior to the Maharashtra Act, a report by Ravindra R.P. entitled 'The Scarcer Half' was published by CEHAT in 1986[6], and served as a catalyst to break the silence on the issue. More recently, the Lancet's[7] publication of a study which discussed the issue of "prenatal sex determination and selective abortion" accounting for around half-a-million girls going 'missing' yearly is an example. Similarly the Gokhale Institute of Politics and Economics, Pune has published a study of ultra sound clinics in Maharashtra[8] which clearly shows that knowledge, financial resources and access are three factors which when they come together enhance the possibility of sex determination techniques and SSEs being practised. Similarly Sahiyar's brief study in Gujarat[9] showed that a large number of people get to know of the technology for sex determination by being educated about it by medical professionals as well as the fact that

4 E.g. VHAI, Vimochana, PRAYAS, ActionAid, etc

5 For e.g. Population First printed "Ganapati' cards which had a picture of the Elephant God on one side and a message regarding this issue on the other.

6 Ravindra R.P. 'The Scarcer Half' a report on amniocentesis and other Sex-determination techniques,sex-selection and new reproductive technologies, Ed. And Revised by John D'Souza,Teesta Setalvad and Anjum Rajabali; Counterfact No.9 CED Health feature Jan,86

7 A study on 'Low male-to-female sex ratio of children born in India – a survey of 1.1 million households' published in the reputed British Medical Journal The Lancet, Volume 367, Number 9506, 21 January 2006

8 A study by Sanjeevanee Mulay & R. Nagarajan 'Ultrasound Sonography Centres in Maharashtra' Population Research Centre,Gokhale Institute of Politics and Economics, Pune, 2005

9 'Declining Sex ratio in Guajarat: Campaign against sex Determination and Sex Pre-selection' Dr.Trupti Shah

many medical professionals accepted and even defended SD on various grounds. Or again, Ashish Bose and Mira Shiva conducted a study on Female Foeticide[10] in three districts of Punjab, Haryana and Himachal Pradesh. It examined census data perception surveys and household opinion surveys to examine causes for female foeticide.

Besides these studies, there have been a number of specific articles on this issue which have also served as awareness raising tools during the course of this campaign. These include "Sex Selection – Issues and Concerns"[11] by CEHAT which is a collection of papers and articles and news reports (1988-02), and chronicles the campaign on the issue as it led up to the first PIL; and Dr. Vibhuti Patel's paper titled "Sex Selection and Pre-Birth Elimination of Girl Child"[12] which also provides a comprehensive overview of events preceding the campaign leading to the framing of the PNDT Act, 1994 and focuses on the gender perspective on the issue of sex determination.

At times a survey has sometimes been used to both create awareness and to push to action. Thus a group of rural youth who had been identified by an NGO, SWATI, for conscientisation on this issue were asked to go around their own neighbourhoods to find out how many of the last born children in those families were males and how many females. Through such a simple survey method the youth were sensitised to the fact that the issue was very much one that affected their own community/neighbourhood.

iii) Village Displays

Wall posters though apparently a non-interactive method, are usually the result of direct action taken by a conscientised group that wishes to do something to check sex selection practices in their own community. Hence the creation of wall posters could be considered an example of direct action for those who create them, and a non-interactive method vis a vis the others in a village. Similarly the order by the Health Commissioner of Gujarat to publicly display the monthly statistics with regard to the number of male and female births in the local area is another non-interactive method that has apparently kept the issue alive in many minds.

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10 'Darkness at Noon- female foeticide in India' a study by Ashish Bose and Mira Shiva assisted by Anjali Garg and Sharbati Sen on declining sex ratio and Gender Balance with special reference to Punjab,Haryana an Himachal Pradesh, 2003

11 'Sex Selection – Issues and Concerns – A compilation of writings' compiled by Qudsiya Contractor,Sumita Menon, Ravi Duggal; Centre for Enquiry into Health and Allied Themes(CEHAT), Mumbai/Pune

12 Paper entitled 'Sex selection and Pre-Birth Elimination of Girl Child' presented by Vibhuti Patel during the 49th UN convention on status of women at U.N. Headquarters, New York held between 28th feb-11th March,05

iv) Influencing 'high profile' groups

Efforts to influence and create awareness among specific high profile groups that are perceived to both belong to the primary target group (i.e. the high socio-economic classes who are clearly seen to indulge in such practices) and who also have an influence on the social norms and behaviours of the rest of society, can also be included in this category of non-interactive methods. Often this is done by using the good offices of celebrities. Some examples of such efforts include FOGSI's spot with Amitabh Bachchan, UNFPA's use of brand ambassadors like Shabana Azmi and Lara Dutta, high profile campaigns with a public launch and public hoardings (e.g. Laadli Campaign in Mumbai), public functions (IIT-Mumbai alumni meet), workshops and interactions with specific high profile groups like the ITA (Indian television Academy).

v) Workshops & Small Group Discussions

As far as interactive methods are concerned, workshops and small group meetings are perhaps the most commonly used methods resorted to by various enabling groups or individuals. Such workshops provide a platform to actively engage the participants in reflecting on the issue through the judicious use of films, interactive exercises, experience sharing by resource persons, etc. Sometimes these workshops are also built around the enhancing of a skill, (UNFPA's support to HT PACE theatre workshops in Delhi schools) or around a particular profession (media workshops for journalists by both UNFPA and PLAN).

vi) Interactions with Youth

In addition, there are those interactive efforts that involve the participants in the creation of some 'product' that creates awareness even as it motivates the participant into concrete action or commitment. These latter include the creation of street plays and competitions of various kinds (photography, essay writing, debates, short film making etc). These efforts have been practised with great success particularly when working with youth groups. (e.g. the Laadli campaign in Mumbai, the SUTRA inspired work in Himachal Pradesh), as they feed into the youth's appetite to learn by doing. There have been other kinds of efforts to motivate and enthuse the youth to work on this issue. In Navashahr, Punjab, college going students in the district are regularly invited to the DC's office everyday between 11 and 11.30 a.m. Around forty students, predominantly girls, generally participate in such meetings which are used to sensitise them to this and other issues and they are encouraged to become members of the UPKAR Coordination Committee. The Committee also offers Rs. 100/- to students who identify pregnant mothers who have not been registered in villages, and inform the authorities accordingly.

vii) Celebration of special 'days'

Another innovative approach is the effort to create a special day (e.g. Ballika Janmotsava celebrations as practiced in Satara and Belgaum) that celebrates the birth and life of the

girl child and/or brings together mothers who have had daughters. On such occasions a series of events are organised to raise awareness through interactive sessions with members of the public.

viii) Use of Electronic and Mass Media

Other efforts to use mainstream media can also be considered as examples of some of the non-interactive methods being utilised. Thus Madhab Panda with the support of PLAN India has produced a serial, Atmaja that has been built around this issue. Mathrubhoomi in Hindi and Karuthamma in Tamil are films that used the declining number of girls as the central theme of the storyline. The ongoing collaboration between UNFPA and Rabbi Shergill to include a pop song on this issue in his latest album is another example of such an effort.

Though normally non-interactive, such electronic efforts can and are sometimes effectively used in an interactive manner. Thus the serial Atmaja was used by some community groups which were facilitated to reflect on the episodes. Another very innovative interactive method is the use of community radio that has been used by one group (ARAVIS in Delhi) in helping the targeted community to reflect on social issues. As far as data collected during this study goes, apparently this method has not been used by any group on this issue of 'missing girls', but ARAVIS' experience would seem to indicate that it offers much promise as a methodology.

Additionally, there have been websites that have offered information and support in various ways. Two websites that have been brought to the notice of the study team are www.onlinevolunteers.org/india/sexselection and Datamation's website.[13] The latter has functioned in both non-interactive and interactive ways. On the non-interactive front such a website has tried to be a resource to those seeking knowledge on this issue, by offering information about the law, and about various community-based initiatives of the Foundation. On the interactive front, the website offers a forum to interact with others on the issue, as well as the option of making complaints online – complaints about any entity (doctor, hospital, clinic etc) which has offered such a service. The option of making a complaint is also offered by the phone hotline service that has been started in both Navashahr in Punjab and in some parts of Tamil Nadu.

ix) 'Pressurising' methods

There are certain methods that skirt the borderline between non-interactive and interactive means as well as move into direct action. Thus public meetings and exhibitions are sometimes conducted in such a way that the 'audience' only listens or watches, but can rarely respond to the speakers or the exhibited material. However, this need not be the

13 www.indiafemalefoeticide.org

case, and there are those who have used these means in an extremely interactive manner which often lead to direct action. Thus the use of rallies and public demonstrations including dharnas and other non-violent methods of pressurising those indulging in such practices are used frequently by conscientised groups (e.g. a rally organised by AIDWA in one of the 'worst hit' districts of Maharashtra). Others (like BGVS in Himachal Pradesh & the Laadli campaign in Mumbai) have used religious festivals in a creative manner by organising street plays on such occasions, or distributing 'religious cards' to devotees. Prabhat Pheris ('processions at dawn') as have been organised by ARAVIS, and processions that wind through a town/city/village are also used not only to bring about awareness but also to demonstrate the social unacceptability of such sex selective behaviour and thus bring pressure on all those involved to think again before indulging in such practices.

At times an elected legislator (as in Gujarat) or a Government officer (like a District Collector) has also taken up the onus of spreading awareness on this issue in his/her own constituency or area of jurisdiction. In such cases he/she has motivated his/her own cadres or officers and other organisations (e.g. the Jaycees in Unjha block in Mehsana district in Gujarat, or UPKAR in Navashahr, Punjab) to carry the message throughout the selected area or constituency. Some of these efforts also fall into the non-interactive category, when for instance it has meant the organising of a rally where speeches are given and films are shown. However, sometimes these may turn into a direct action mode when such rallies end up with people taking an oath or agreeing to form some sort of pressure group to oppose the aborting of the female foetus. Generally, such efforts have given the issue a high degree of visibility in the media, particularly in the area being targeted.

Certain communities have used their own techniques to bring social pressure on those within their own community who indulge in such practices. In Navashahr, 'shoka sabha(s)' or public mournings are organised by enabler groups in conjunction with the community members in front of the house where an SSE is reported to have occurred[14]. This is one community method of showing social disapproval of those who go in for SSEs. Still another effort is the practice of 'community rejection' by which activist members of the community openly express their rejection or disapproval of those who indulge in such sex selective elimination practices (e.g. community groups under the banner of Jago Sakhi Sangathan in the work area of Prayatna and Action Aid in Dholpur, Rajasthan and in Morena, Madhya Pradesh). Similarly there is the practice of motivated women in a community 'keeping community vigil' (organised by Datamation in Khichdipur, Delhi) and filing cases against erring doctors and clinics – all this resulting in ripple effects on the entire community. The VHAP in Punjab has been able to mobilise and set up village level inspection/vigilance committees in two districts in Haryana and Punjab. These functions

14 Critics of such efforts claim that sometimes the report may be mistaken and unnecessary pressure or embarrassment is brought to bear on a particular woman.

in ways similar to the other village-based groups mentioned above, and in addition organise Jan Sunvayis or public hearings. State health officials, nodal and village level officials and PRI members are also invited to such hearings. In general, the typical mandate of these kinds of village groups/committees includes some or all of the following:

- to meet regularly, once a month to review the conditions
- to work with the ANMs and village level health workers (VLHWs) to keep a watch on what is happening at the village level
- to hold meetings with the villagers and sensitize them on the issue of valuing the girl child
- to interact regularly with the district AA to report to them about a particular clinic which may be flouting the rules, so that action can be taken against them
- to encourage ante natal care and registration of the pregnant women and registration of pregnant women and new born children in the village
- to track the numbers in their own village

In some places the already existing community-based groupings like the mahila mandals/ self help groups (SHGs) and gram panchayats have also been utilised effectively in influencing the communities (e.g. SUTRA has done this in certain parts of Himachal Pradesh through their intensive campaigns in Baijnath and Lambagaion of Kangra and Gagret Blocks of Una district). These SHGs/Mandals in HP, for instance, have also been involved in creating pressure on the state authorities by sending petitions/memorandums to press for the removal of the two-child norm that had recently been used to remove elected members from the panchayats.

The Dikri Bachao campaign of the Gujarat government is still another kind of direct action effort to influence the community that has been spearheaded by political leaders in their respective constituencies. After the launch of this campaign in March 2005, the political leaders, from state to local governance level, organised public programmes in their constituencies.

Similarly certain caste communities have become aware of the issue for various reasons, and have decided to take action (e.g. the team was informed that a Jat Community in a particular area in Haryana had started the practice of ostracising members who indulge in sex selective practices).

x) Interactions with Religious Leaders

Advocacy efforts to attempt to influence religious heads, and through them to influence their own religious communities, has been another example of direct action. This has led to a number of religious heads exhorting their followers not to practice sex selective techniques (e.g. Art of Living) or formally condemning anybody who indulges in such practices (e.g. Akhal Takht).

xi) Sting/Decoy operations

Sting/decoy operations and the publicity that is generated as a result, though primarily geared towards 'catching' the medical community members involved in such practices, (and hence will be explored at length in that section), also has a salutary effect on the 'demand' side.

xii) Monitoring pregnancies

The efforts made by various government officials like the 'pregnancy watch' of Navashahr and the 'clinic' watch of Kaithal are examples of direct action initiated by government officials that are used to pressurise the respective community members NOT to indulge in such behaviour. In the case of Navashahr, the effort was made to ensure that all pregnant women were tracked, while in Kaithal the attempt was to identify those clinics which women who already have one or two daughters frequent, and then to find ways of monitoring the activities in such clinics.

xiii) Incentive Schemes

Incentive schemes set up by various governmental and non-governmental groups are also geared towards arresting the practice of SSEs.

Thus the reimbursement for expenses incurred or the 'reward' offered to those who expose those medical units that indulge in such practices, (e.g. the Rs. 15000 offered by the Government of Maharashtra, or the Rs. 100 offered in Navashahr, Punjab, etc) are examples of incentives offered directly in connection with the implementation of this Act.

On an indirect note, a number of states and union territories (e.g. Tamil Nadu, Andhra Pradesh, Pondicherry, Haryana, Punjab, Gujarat,) and even the Centre have a number of financial support schemes for those with girl children[15]. Thus there are schemes that offer free education, scholarships, interest-free loans (to be self-reliant) and reservation in jobs and educational institutes, and other such affirmative actions that have been put in place with the aim of making the girl child more desirable. In fact there are some schemes which try to support the family of the girl child at the time of marriage, by taking care of the marriage expenses or offering something in lieu of a dowry.

The Cradle scheme in Tamil Nadu, while not exactly an incentive scheme, does offer the unwanted girl child a home rather than death, and therefore can perhaps also be considered as an 'incentive' to prevent SSEs.

Even community groups (caste communities like Khandelwal or Patels) attempt to influence their own community members by offering financial incentives in various forms

15 Refer Annexure V

(gifts at the time of marriage, taking over marriage expenses, bonds and other instruments that mature as the girl grows older, scholarships etc)

xiv) Networking

Another form of direct action is the effort to network with various stakeholders (both government and non-governmental) and to get them to function in a coordinated manner on this issue e.g. in Kaithal in Punjab, in Gujarat, in Tamil Nadu, in Sangamner in Maharashtra etc.). In all these cases government functionaries have collaborated with civil society groups to jointly fight this menace of SSEs.

In many of these cases, wherever the government has got involved, the networking has tended to include (in rural areas) the ANMs, government officers, as well as Anganwadi and other health workers. Sometimes such networking has been helped by NGOs also working along with these government efforts (e.g CHETNA in Gujarat). Very often these efforts include some or all of the following tactics: ensuring and keeping track of birth registrations, keeping track of the pregnant women and sometimes using them to identify those clinics/doctors which indulge in such sex determination and sex selective eliminations and keeping track of abortions. In Tamil Nadu, for instance, this has worked through the Panchayat level health committee that works in tandem with the District Coordination Committee, the concerned AA, and the District Collector's office.

3.3
Reflections (Strengths and Limitations) on the various efforts made to influence the 'demand' side

i) Volume and Intensity

As far as the effectiveness or impact of various non-interactive efforts described above is concerned, it would seem that this is directly proportionate to the 'volume' and 'intensity' of these efforts to create awareness on the issue. Unfortunately, except in places where a 'movement' has been created, (by a local MLA or Government official, or an NGO/CBO etc.), in most cases such non-interactive efforts suffer significantly on both these aspects. Even when there is the availability of much printed non-interactive IEC material (e.g. posters), it has been reported to the team that often such material prepared by government departments often remain piled up and unused as the concerned department or officers have been unable or unwilling to do much to disseminate them. Theoretically, and in general such non-interactive methods have the advantage of being able to reach out to much larger numbers than interactive methods. However the latter have the advantage of being able to offer a more nuanced perspective on the issue and therefore greater clarity in messaging.

ii) Quality

The quality of these IEC materials is also another reason for the lack of effectivity of these efforts. Very often they do not grab attention, they are literacy dependent, they are often filled with data rather than communicating a simple message in a stark manner, they are sometimes more focussed on highlighting a political leader/party in power than the issue, and they often use clichéd language. From a communication point of view, many of the efforts are not very professionally done and hence the overall quality is often very dismal.[16] Wherever a professional body of communicators has been involved, the quality of the material created is much better, but in general the material is often of a sub-standard quality which has little appeal in itself to bring about awareness or change. What makes these efforts even more ineffective is that much of this material is targeted at the converted, and does little to affect the neutral or the non-converted who clearly comprise the vast majority of our national population. Another reason why such material was found to be ineffective was the fact that it was often not culture specific.

iii) Confusing or Inappropriate messages

For various reasons including because sometimes the 'creators' themselves have a mind-set that goes against the nuances of the PC-PNDT and MTP Acts, it is often the case that through such IEC material many 'inappropriate' or confusing messages are also conveyed.

Thus, for instance, in most cases the appeal is more often based on either the need for more girls to satisfy the marital requirements of men, or to give birth to children, and only sometimes are these messages based on the intrinsic value of the girl child in herself. For example, in a TV spot which was prepared by a particular medical association, the script given to the celebrity seems to clearly indicate that the value of women is found in the need for brides.

Alternatively the message focuses on the heinousness of the crime of killing a foetus, and thus seems to indicate that all abortions are equally criminal or morally reprehensible. Thus in most IEC material, the SSE of girls was being referred to as a problem of foeticide (*Bhrunhatya*), instead of female foeticide, and many posters showed the foetus being killed with some depicting the woman/mother as the killer.

Again one set of messages in some IEC material focussed on 'protecting' the girl child (as opposed to 'empowering' the girl child), which has raised mixed reactions among activists working on this issue, some of whom have supported this approach while others have questioned whether such an approach fosters a patriarchal mind set. It is also clear that except for the material created by a few NGOs/CBOs, very little or none of this material focuses on gender issues, and hence there is little or no effort to focus on the need to

16 Both, the communication experts as well as other 'test' groups who were shown some of the IEC material collected were clearly of this opinion.

bring about a change in gender injustices – injustices which clearly constitute one of the root causes of this alarming situation.

Thus one of the big challenges is how to effectively address the issue of SSE against girls in public campaigns without overlooking the need to find the right nuance in such messaging. This is made even more difficult by the apparent fact that material that makes an emotional appeal to women not to kill the child (any child) in one's womb, or to the community to change their practices lest they do not get brides in the future, are usually quite effective in the short term. Again, it seems very difficult for many women (based on the many interviewed by the team over the course of the study) to grasp the distinction between abortion as a right under certain circumstances, and sex-selective abortions as a crime. Interestingly even some doctors could not perceive this distinction with some assuming that all abortions were legal. In general then it becomes very confusing and challenging to effectively communicate an anti-SSE message.

iv) Celebrities

Although inviting high profile public figures and popular TV/Media personalities during awareness building campaigns is a good idea (as they are great crowd-pullers) care needs to be taken to ensure that having them does not dilute the focus by shifting the attention away from the core issue, as has reportedly happened on some occasions. On the other hand having such celebrities come forward to endorse such campaigns gives the message far greater reach and hence cannot and should not be easily discounted.

v) Work with Youth

Interactive efforts with youth have been particularly fruitful in leading to some direct action – often initiated by the youth themselves under guidance from an enabling group. The youth who have been animated are often eager to take some action immediately and wherever such opportunities have been opened out for them, they have eagerly participated. For example, some of the youth who have been effectively informed on the issue have themselves become animators who run workshops, or have worked to motivate their own families and those within their own circle of influence, to raise awareness and to push for action among these groups.

With regard to strategies while communicating with the youth it was suggested the efforts should focus on building skills on how to deal with the patriarchal and family traditions that foster gender discrimination that often leads to SSEs. Ignoring these underlying realities have in the past weakened the entire effort of some groups.

vi) Selection of Participants

Wherever and whenever interactive methods are used, the selection of the participants is itself a crucial issue and directly related to the possibility of success of such efforts. Thus

work with an already motivated SHG group (e.g. SUTRA's work) would be more effective than a workshop with doctors that is squeezed in to a larger workshop that was meant to upgrade their own clinical knowledge. Again a group brought together by the leaders of the community itself (e.g. RUWA's work) would have greater impact than one which congregates primarily because of the work of an 'outside' individual/group. Or once again, a group brought together by somebody who has significant clout (e.g. a senior Government officer like a district collector, or by an elected official at the State or National level, or a popular professor in a college or any other person who commands great respect in a community) would be more likely to lead to concrete action, than a group of participants who come together primarily because they 'have' to be there.

vii) Use of audio-visual Aids

The effectivity of audio-visual media is directly dependent on HOW it is used – whether in a non-interactive or interactive manner. Thus, just showing the film 'The Silent Scream'[17] may lead to an emotional outpouring of self-blame among women, but may also lead to a tendency to shift the onus of the entire problem onto the shoulders of the women who are themselves victims of the entire social system. It may also lead to a confusion in the minds of the audience with regard to the law in the country regarding abortion. On the other hand, the efforts by some community groups to use the input received from the mass media (TV, film, radio etc) to initiate discussions among themselves under the guidance of a facilitator/resource person can lead to significant attitudinal change, and equally importantly, a more nuanced understanding of the issue.

viii) Importance of Process

The 'export' of material created by one group through one or more of these interactive efforts (e.g. a street play) to another group which has not gone through a similar process in the creation of the material/play tends to transform a powerful interactive tool into a less effective non-interactive one. The latter group then just sees the material/play as a product which they present without really 'experiencing' its power within themselves – and as a result the 'product' has even less power to influence the audiences who watch this 'exported' version. Of course the public exhibition of such material (through putting up such plays at street corners, or displaying competition posters at public exhibitions etc) are very important and have their own value in that such material bring with them a 'passion' that a mass-produced poster or other IEC material cannot bring. This is even more effective when the 'creators' of the product are themselves present to share with the viewers their own reflections or explanations of their own product. However, it needs to be remembered that the primary value of such material is the effect it has on those who were involved in its creation and only secondarily on others who see the end-product.

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17 A pro-life film produced in the USA and used in the Dikri Bachao campaign of the Gujarat government

ix) Importance of Disaggregated Data

The use of relevant data, specific to the community or group which is being interacted with, is a very effective way of creating awareness and pushing the community/group to action. This is particularly so since it has been the experience of a large number of enablers that most communities begin in a state of 'denial'. This would therefore mean that a system has to be set up by which disaggregated data regarding a specific community's SRB and CSR[18] can be retrieved for use by enablers who work with that particular community. Currently those who try to get such data first try to see whether it can be extrapolated from government/census figures, and if not, then a limited-survey method has been used by a number of enablers. Others have suggested using a tie-up with those involved in the polio campaign by including an extra 'column' asking for the sex of the children being surveyed. In any case, till systems are put in place to ensure that such current data is available, there are those who would suggest using the Integrated Child Development Scheme (ICDS)/Anganwadi records though of course this would only apply to the lower socio-economic classes and so would not be that accurate. This latter approach has also been suggested by other enablers as a useful way of keeping track of local data without waiting for the next census. In any case, the census data cannot give the SRBs except for the year prior to the census data collection. What is clear however is that there is a great need to find a simple way of collecting such data on a continuous basis rather than wait for the next census.

x) Involving Community Members

Involving community members themselves as animators in such efforts leads to greater acceptance and more long-term/sustainable action to change the practices of a community. This has been demonstrated significantly by those communities (Patel, Maheshwari, Sikh and Rajput communities) where after an initial conscientisation by 'outside' elements, the community leaders or volunteers have themselves taken up the issue within their own community.

The advantage of direct action taken by communities to solve the problem among themselves is that they do not look for resources outside the group but raise such resources themselves. Moreover, they can bring a lot of community pressure on their own members – social pressure that seems to work far more effectively than any legal pressure can. Their own efforts also open up new creative alternatives that would not be possible if the effort did not come from within the community (e.g. the inter-marriages of the Kadva and Leva communities among the Patel community which had been unacceptable earlier). Thirdly, since many of these community efforts also include efforts to sponsor the

18 There are experts/demographers who would suggest that the CSR data is never very 'clean' for various reasons (e.g. people don't tend to acknowledge their female children to the census takers!) while others would also question the SRB data (people register the son at both paternal and maternal homes, but not the daughter!).

education of girls, there is the added advantage that such education will empower their girls in ways that would have benefits in the long-run. Finally since these communities are normally primarily motivated into taking action because of the difficulties in finding suitable brides for their sons, such efforts are often meant to lessen the financial burden that is placed on the girl's parents at the time of marriage (e.g. Vaishya Khandelwal community in Rajasthan) However, by arranging to give a 'dowry' to girl at the time of marriage to reduce the burden on the parents, the practice also seems to accept and even foster the inevitability of dowry.

In short then, it is clear that if an issue (like the declining CSR) is highlighted by the community members themselves, it will be met by a far greater receptivity and acceptance from within the community. Such a strategy leads to the creation of a sense of ownership of the issue and leads to concomitant action by the community. It is also quite clear that those communities that have an overseeing body with an elected governing body offer an already existing platform that can be effectively utilized to spread anti-SSE messages. These bodies exercise a powerful hold on the community, and wield considerable authority in setting norms and mores, which are generally followed by the members of the particular community. In any case if there must be sustainability at every level in taking forward such a campaign, it is important to create community ownership through participative planning and community implementation.

However, experience has shown that sometimes not enough care has been taken to ensure that such animators are carefully oriented in order to ensure that the nuances of the issue are properly understood and communicated. Consequently, the eventual or long term outcome of such efforts could turn out to be more detrimental to the status of the women in that community, even if it may have worked towards limiting or lessening the specific sex selective practices that were prevalent in that particular community. As a result of the patriarchal mindsets being left unchanged, the onus of solving the problem is laid on the woman's shoulder, and the nuances of the messages conveyed are often inappropriate or wrong. Another negative fall-out of such community specific efforts is that pressures are being brought on the marriageable girls in such communities (e.g. among a particular Maheshwari community group in Maharashtra). Such pressures tend to force the girls to marry from within their own community even though they (i.e. the girls) may consider boys within their own communities as unsuitable for themselves (because of the boys' relative lack of education or other such reasons). The Var Vadhu melas organised by a particular community to encourage intra-community marriages are also used as occasions to foster traditional patriarchy dictated roles for the women and thus actually work against gender justice.

In short then, it must be remembered that the perception of communities on the issue can be over-simplistic. Thus though there could be a realisation of the urgency to do

something to offset the skewed ratio existing within their own communities, there is often little understanding or effort at addressing the underlying causes of the 'anti-female' syndrome prevailing in their own communities. Therefore while the volunteerism and the community spirit of the community leaders spearheading such efforts should be tapped into, the danger is that the content and messages (women are needed for marriage, abortion is always a great sin etc.) of such campaigns may do more harm than good to the 'cause' in the long run.

Keeping all this in mind, it would seem that engaging sympathetically with such communities on a continuous and frequent basis will allow campaigners on this issue not only to remain updated, but also to keep refining their approach to such groups. This would be a much more productive approach than just refusing to interact or engage with them only because they have not reached the same level of gender awareness or equity as the enablers themselves.

xi) Use of Electronic Media

The use of the electronic media like the community radio, a website or a phone hotline is one that offers much promise. Unfortunately these are not being used enough and in most places are not even available (e.g. a phone hotline). Furthermore, it must be remembered that optimal use of all these methods involves a significant amount of prior and concomitant work on the ground. Thus the attempt to make it easy for people to complain online or on the phone would have value only if the complaints are followed up carefully and consistently and the complainant is informed in some way of the action taken. Unfortunately this has not happened in the case of the web-based complaint service of Datamation, and the status of such complaints is not only unknown to the administrators of the website but also to the PC-PNDT head office in Delhi to which the complaints were forwarded. As far as the community radio method is concerned, ARAVIS' work with this medium has conclusively demonstrated that there is a significant amount of preparatory and follow-up work that needs to be carried out at the ground level for it to bring about change. On the other hand apparently the hotlines set up in some places (e.g. in Tamil Nadu, or the hotline set up in Navashahr) have proved to be of significant help in saving many girl children and preventing the indiscriminate destruction of female foetuses.

xii) Campaigns

All the awareness raising methods when done systematically have usually led to some sort of direct action campaign, which is then carried on over a longer period of time. However, what must be remembered is that the intensity and sustainability of such campaigns depend on a number of factors but primarily on the support it can generate from within the community and from government officials/departments. Those who have initiated such campaigns without creating such a support base (even if they are government

officers themselves, and certainly if they are enablers) often have had to face much opposition and even personal threats and assaults.

Sometimes an enabler may choose to either initiate or feed into such efforts of others – even if such efforts are initiated by a political party, – with the hope that such an involvement would allow the enabling group to influence or 'guide' the effort that is being made, and thus 'push' it beyond any individual political agenda. Other enablers have shied away from such collaboration with political parties or government officers for ideological reasons. These reasons could include a fear that collaboration on this particular issue might signal to the public an acceptance by the NGO/CBO of other unacceptable aspects of that particular political party's agenda on other issues, or because there is disagreement with the approach of the particular government official or political party (e.g. is it denouncing abortion per se, is it focussing on women rather than on the doctors etc.).

Another and crucial kind of support is that which must be planned for in any campaign. This is the significant amount of support that must be offered to those who choose to take the first steps towards such change (through counselling services, phone helplines, support groups like those popularised by Alcoholics Anonymous etc) for without such support, even 'converted' ones would find it difficult to take action according to their new belief system.

In any case it is clear that the support that such campaigns can generate is an important factor that influences the impact and outcome of individual efforts. And the reality is that such sustainability in part is dependent on availability of funds and to what extent the campaign is able to create support bases within the community to carry it forward. Hence strategising for such local support (social and financial) becomes an essential element for the success of any such campaign. Those that are able to effectively involve different agencies and stakeholders, forge alliances, build networks and coalitions and work at multiple levels and fronts at the same time have a far greater impact and outreach.

xiii) Public Participation in Campaigns

The experiences of other social campaigns in the country seem to indicate that there is a greater possibility of success, if they can create spaces for public participation and don't remain confined to the 'sensitised' groups. In every campaign (particularly campaigns on social issues) the largest numbers of people are the 'fence-sitters' and it is they who can eventually make or break a campaign. Hence there is need for any campaign to plan specifically for this; such that every member of a usually apathetic public society will find it easy to do his/her little bit in a way that he/she sees some results. For example, a phone hotline would be an extremely effective way of inviting public participation on condition that it is easily accessible (e.g. the Childline 1098 service is a toll free number that can be

accessed from any public phone) and if the 'complainant' can see that action is taken when they make that minimal call - for instance that the doctor being complained about, or the family indulging in such practices are being 'visited' by an activist group or some other action is taken within the next few days from the time of the complaint.

xiv) Involving Doctors and AAs

Campaigns also have greater success if they are open to seeing there are nuanced positions even among the so-called opposition, and then use the 'divide and conquer' strategy to weaken it. Thus, any attempt to criminalise all doctors, or question the integrity of all AAs etc, are from a strategy point of view a self-defeating approach. It would therefore be necessary for any effective strategy on this issue to see how it can make inroads into the ranks of doctors and AAs, and to use the strengths of the well-meaning ones to work on this issue.

xv) The Target

The focus or target of direct action in this campaign has often been a matter of ideological disagreement among those who wish to work against sex selective practices. Pregnant women are clearly the most visible target, and efforts to focus on them has had significant success, but has led to other 'side-effects' that are of deep concern. Thus in the Navashahr experience, while the success of the effort in bringing down the prevalence of the practice of SSEs is clear to any independent observer[19], the criticism has been that it targets the already victimised woman since it can only be used against those women who use government ante-natal services, and therefore can bring little pressure on the higher socio-economic class who do not go to such government facilities for such care. Furthermore, because the woman is already a victim in such homes, this strict watch has led to the unfortunate outcome that women who are most pressurised to have sons are refusing to seek ante-natal care till the fourth month by when they can know the sex of the foetus and can abort quietly if necessary. In the case of Kaithal there has been an effort to use the 'pregnancy watch' in a way that identifies the clinics where such sex determination and sex selective eliminations are taking place. However, in all these cases, the effort does seem to necessitate going 'through' the pregnant woman and in that sense, to some degree at least focuses on the woman.

It would seem that if the goal is to bring about an immediate drop in the practice of using such services, this approach makes strategic sense. However, there are a whole group of

19 The sex ratio in district Nawashahr as per census 2001 was 808.The survey conducted by the Child Development Department indicated that child sex ratio had come down to 774 in March,2005 indicating a loss of another 34 girls per 1000 in just a span of four years. As compared to this, the result of the continuous efforts organised by the Navashahr DC, is that the sex ratio in 77 villages out of the 475 in the district have crossed 900 and in some cases have even reached 1000. (A Report on Awareness Campaign and Enforcement – Measures taken to control female foeticide in District Nawashahr- Nawashahr Model ,undated document).

enablers who ideologically disagree with this approach however successful it may be in improving the CSR or the SRB. These latter would rather focus on either the service providers (the medical community, particularly the doctors,) or the implementers (i.e. the AAs and judiciary).[20]

xvi) Gender Aspects

The problem of the declining sex ratio is a manifestation of the deep-rooted structural problems including patriarchy and gender inequality that are clearly present in our society. Although most agree to the long-term objective of addressing these gender imbalances and working towards improving the status of women, believing that this will ultimately affect the practice of SSE of girls, the fact is that most direct action efforts are in the form of 'quick-fixes' to achieve the immediate concern of increasing the number of girls. This is particularly true of direct actions taken by 'caste communities' and even elected leaders who are not able to or willing to consider the nuances of the issue, perhaps because they themselves subscribe to many patriarchal beliefs. In a sense this is a classic example of the 'blaming-the-victim' syndrome, which leads to an expectation that the victim take on the burden of solving the problem (e.g. "rape" can be minimised or lessened if women would dress modestly, and are careful not to go out alone etc). Thus the women who are pressurised to have sons for various reasons by society are made to believe that they are morally reprehensible human beings who instead of saving the child in their womb as a good mother should, are themselves the murderers of their children. While this approach certainly has a strong emotional appeal and can therefore contribute in the short run towards lessening such practices, it lets the real perpetrators (the families, the doctors etc) off the hook and loads the victim-woman with one more burden. Therefore it is crucial that any future strategy must consciously include initiatives that help the 'targets' to reflect on this gender question, and cannot be just an 'also-ran' in the campaign.

xvii) Current social trends

There are other newer social currents or trends that significantly affect this issue of the declining number of girls and which many campaigners perhaps do not sufficiently take on board. Thus the increasing trend towards individual choice on every matter, the significant jump in consumerism, the use of technology to control the basic elements of human life, the trend towards privatisation of health care, etc are all trends that increasingly lead our society to see human beings as a commodity rather than as a human being with intrinsic rights. Particularly when working with the higher socio-economic classes, these issues must be kept in mind when preparing strategies to influence them.

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20 These latter approaches will be discussed in the subsequent sections on efforts to influence the 'supply side' and the 'State'

xviii) Working with higher socio-economic classes

It has also been noted by a few enablers that many of these direct actions organised or inspired by NGOs/CBOs etc are usually geared towards those members of the community who belong to the lower socio-economic classes. NGOs/CBOs in general are perhaps more skilled or capacitated to find ways to bring pressure and influence on such groups, whereas the statistics seem to indicate that the problem is more prevalent in the higher socio-economic groups where people go to private doctors. Hence while the non-interactive ways of awareness building are being targeted at all groups including the higher socio-economic groups, very little direct action is being taken that is targeted at them. Furthermore when UNFPA and PLAN invest a significant amount of their resources in targeting this higher socio-economic class, such efforts have been generally questioned by NGOs/CBOs as a waste of financial resources. It was suggested by many that UNFPA and other donor agencies must focus less on high profile media campaigns and channel their funds to small scale local level efforts targeted for specific periods of time at specific communities and geographically local groups.

In this context it has been pointed out by some that most of the incentive schemes, while welcome from the point of view of giving the girl child a head start in an unequal patriarchal world, would inevitably not have value enough for those families from the higher socio-economic classes to be able to influence and change their sex determination practices[21]. Thus while such schemes perhaps help to prevent those who have financial difficulty from falling into the net of those who indulge in such practices, it is unlikely to have much effect on the declining CSR and SRB among those socio-economic classes who are currently the prime practitioners.

The study team therefore believes that learning to work with these higher socio-economic classes on this issue is crucial to the success of this campaign.

xix) Engaging Religious Leaders

Influencing the 'demand' side through religious leaders is a contentious strategy for a number of reasons. There are those who believe that making common cause with such leaders would imply an acceptance of other 'beliefs and practices' fostered by them – those which may be perceived as superstitious or furthering gender inequity. Secondly there is conviction among many enablers that religious leaders would not be willing to make a distinction between abortions done for different reasons, and would tend to condemn all abortions – a position that is perceived as harmful to women. Some enablers have also questioned whether in fact the religious leaders do have any influence over

21 Even with the lower socio-economic groups, the schemes may not have that much of an impact, because though they may offer suitable incentives, there is a feeling that emerged during the study that many did not know about these schemes, and others felt that there was difficulty in accessing such schemes.

those of the higher socio-economic classes in what are considered 'personal or private' aspects of their lives. An example of the last named concern is highlighted by some Sikhs with whom the team interacted with during the study and who claimed that the 'hukumnama' of the Akhal Takht against sex determination practices and abortions, has not had much of an impact on higher socio-economic class Sikhs.

In exploring this dilemma, the study seemed to throw up the conclusion that it may be important to realise that religious leaders and religious groups themselves often have a nuanced position on abortion. In fact during the study the team heard from various religious people that many of their own traditions would accept abortion as the 'lesser evil' in some of the special circumstances listed in the MTP Act – namely in the cases of rape, danger to the woman's life and serious congenital defect in the unborn foetus. Similarly, the belief that religions necessarily foster superstitious beliefs and practices is a stereotype that is easily accepted when all religious leaders are lumped together as one. In actual fact there are significant differences of opinion on these and other issues even among religious leaders themselves, and it would be wise to avoid over-generalizations. What is perhaps called for is the need to carefully 'check out' or explore the stances of different religious leaders and choose to ally with those specific ones who are willing to take on board the concerns mentioned above. In short a fundamentalistic approach is equally unacceptable whether it comes from the side of religion or even from the non-religious community.

xx) Importance of Legal Awareness

It has been implied earlier that any campaign that focuses all its efforts on implementing the law will not be able to sustain itself. Similarly any campaign that focuses on this issue as a social issue alone, and does not aim to sensitize the community to the criminality of those who indulge in such practices, may also tend to suffer a bit in its ability to bring about change. This is so because when an issue is viewed purely as a social issue there is relatively greater tolerance towards the 'defaulter' as the cause of the action is viewed as embedded in a social structure which is beyond the control of an individual. Hence while it is crucial to bring about social mind-set change, the criminality of the action should not be ignored or downplayed. Furthermore, creating legal awareness will significantly increase the capacities of the targeted audiences to effectively interface with the law. Thus while the social mind-set change efforts focus on helping people make 'informed' choices, building awareness on the criminality aspect aims at deterring people from going in for such services. Thus the strategy of keeping a vigorous vigil and monitoring potential defaulters is necessary if one must bring the issue of SSE out of the 'private' into the 'public' domain. A large percentage of those interviewed were unable to see how what they considered a personal choice about the sex of their child (which they considered a normal desire) could be considered a public issue. Thus bringing this 'private' issue into the public domain is even more difficult than the efforts of other campaigners to bring

the issue of domestic violence into the public sphere. Hence this is a necessary step for the success of any campaign on this issue, and particularly important for a campaign which needs to target the independent women (and families) of a higher socio-economic class who tend to consider the issue as falling within their right to autonomous decision making and the reproductive rights of a woman.

Finally there is need to design workshops (e.g. for Appropriate Authorities, doctors etc) in a way that leads to change in the perception of their own roles from being those who provide a clinical service to those who are change agents, or to change their approach from that of fulfilling a curative role, to engaging in a transforming effort. Legal awareness could also contribute to this change of perception.

3.4

Efforts to influence or control the 'supply' side – or in other words efforts to motivate and ensure that the medical community (i.e. doctors, nurses, ANMs, dais, and other ancillary workers in medical establishments) does not indulge in such practices;

It is the perception of a number of enablers and some committed government officials that in the short run the most important and effective method to reverse the declining trend of CSR and SRB is to focus on the 'supply' side. It is argued that since such sex selective discrimination and elimination can not take place without the active connivance of the medical community, the immediate short term goal must be focussed on the group of medical personnel who service this demand.

The efforts to influence medical service providers can be put under two broad categories as below;

i) Efforts made to 'catch' doctors/clinics allegedly violating PC-PNDT Act.
ii) Efforts made to sensitize doctors as well as to establish monitoring mechanisms.

i) Efforts to 'catch' members of the medical community who violate the Act

Towards this end the most common (and perhaps the only) two methods used so far are the audit or inspection of records and clinics, and the use of Decoy/Sting operations.

The Act allows the AA to make surprise visits[22]. In the few districts where this provision has been used, and machines confiscated or clinics sealed, the follow-up has not been very successful. In some cases the courts have reversed such actions (e.g. the High Court in Gujarat) or the sealing authority has omitted to take the next logical step of taking the case to court as is necessary (e.g. Shivpuri), or the higher authority in the State has reversed the decision on various grounds (e.g. Madhya Pradesh). In the last named case

22 Rule # 12 of the PC-PNDT Act

the reversal has been challenged through a PIL in the High Court of the State and the matter is awaiting a decision by the Court.

As far as the audit of records is concerned, the fact is that very few of the records around the country are being inspected or monitored by the concerned authorities (i.e. AAs). Wherever such checking has been done, the results have been very enlightening. Such audits have shown clearly that many doctors/clinics often do not submit the records, or submit inadequately/inaccurately filled records. (e.g. the efforts of the National support and Monitoring cell, or the efforts made by various government officials in Hyderabad, Andhra Pradesh, in Kaithal and other parts of Haryana, etc.) Sometimes action is taken purely on the basis of such records (or the lack of them) and sometimes a scrutiny of the records have given the implementing officer the data necessary to conduct surprise visits or to organise decoy operations.

In addition to this kind of audit of records, many individuals and groups attempted to control the supply side by conducting sting or decoy operations. A sting operation is a sudden inspection of a clinic that is based on prior reliable information that indicates that there is regular and clear evidence of violation of the Act by a clinic/doctor. A decoy operation is similar in its objective but includes the use of a decoy, usually a pregnant woman, who pretends to ask for sex determination or sex selective elimination services with the attempt to record on tape the entire interaction between her and the doctor, and with the possibility of other witnesses also being present. These operations have been conducted around the country by a wide variety of actors including social activists, government officials including AA's, and the media.

All these efforts, if successful, lead to one or more of the following results: the confiscation of the ultrasound machine, the sealing of the clinic, and the filing of a case in court.

Besides affecting the doctors 'caught' in such operations, it is very often the media coverage that multiplies the effect of such an operation in ways that include a direct pressure on other doctors. In addition such publicity has allegedly helped to activate defunct Advisory or Supervisory bodies, (as happened in Rajasthan after the Sahara Channel sting operation), encourages enabler groups and eventually has an effect on the 'demand'. However, in some cases such efforts have also offered an opportunity to the medical provider who decides to continue as before, but now chooses to raise his/her charges for continuing to offer such sex determination services 'at great risk to himself/herself'.

A number of such sting/decoy operations have been carried out around the country, and many of them have subsequently ended up in court. Unfortunately the convictions (as yet) are few and far between. This unfortunate situation sometimes lead to the negative outcome that other offending doctors/medical service providers begin to feel that the law

cannot do anything to them, and this emboldens them even further. Additionally, since most enabler groups or individuals who conduct these operations have apparently not shared their successful or failed experiences with many others, there is little of accumulated learning that could have helped to sharpen future efforts by those who would like to take action using such methods. Thus while various individuals or groups have pointed out to the study team members various mistakes or weaknesses made by themselves or others, the fact is that attempts to collect current data on all such cases around the country have so far faced great difficulties both when it was done by the PC-PNDT cell in Delhi as well as by CEHAT. As a result, as of today, there is no consolidated and constantly updated source of information on these court cases and the efforts made.

ii) Efforts made to sensitize doctors as well as to establish monitoring mechanisms

a) IMA and MCI

In 1998, the Indian Medical Association (IMA) initiated a conscientisation drive against SSEs[23] and openly admitted that doctors were and are indulging in these practices. The MCI publicly offered the assurance that any complaint received by it would be promptly dealt with by its ethical committee.

Having broken away from a passive attitude, the IMA and the MCI claimed that they were determined to join hands to enforce the code of medical ethics that was often bypassed for the sake of lucrative practices, and initiate strict disciplinary proceedings against 'errant doctors'[24]. Subsequently a letter was despatched from the Hon. General Secretary of the IMA to all branches on this issue. The MCI also publicly offered the assurance that any complaint received by it would be promptly dealt with by its ethical committee. The IMA too insists that it is ready to report on erring doctors and push for `justified punishment'.

However, for many doctors this open acknowledgement meant that the role that they expected of the IMA, namely to speak up for the doctor community, was seriously compromised and that a social issue had been reduced to the diagnostic use of the ultra-sound machine. Furthermore, many of the doctors claimed that it was only the quacks and a very miniscule proportion of qualified professional doctors who were offering SSE services. Further, some doctors argued that since foeticide is a criminal offence, it would be the responsibility of the government to take action against erring doctors, and the IMA could not do anything about it. As a result of these kinds of antagonistic 'responses' from some of its members, the IMA did not move forward very much on this issue for a

23 An article entitled 'Increasing menace of female foeticide' by Sharda Jain, 14th March 2005
24 An article entitled 'Female Foeticide' by Madhu Gurang, 1998

number of years. However, subsequently the IMA and even the MCI have become somewhat more active on this issue.

Subsequently, the Indian Medical Association, Punjab chapter, set up a high-powered vigilance committee to check sex-determination tests and female foeticide in the state[25]. The newly formed committee was empowered to check all ultrasound centres on its own and report any discrepancies to the IMA with the understanding that based on its findings action would be taken against any erring doctor. Accordingly the IMA Punjab has already made a "test complaint" to the MCI against four doctors who are alleged to have violated the PC-PNDT Act. Similarly, the Haryana[26] unit of the Indian Medical Association is actively trying to generate awareness against female foeticide. In 2006, the IMA Maharashtra, initiated a campaign – 'Girl Child, Nation's Pride', and with UNFPA's support organized workshops in those districts in the state where the sex ratio is below 900. The idea was to make the medical community aware of the adverse social implications of sex determination and the subsequent termination of female foetuses. In addition the workshops are also meant to convey a strong message that the IMA will condemn and not support those doctors who indulge in sex determination and sex selective eliminations. Apart from these general sensitization workshops, attempts are being made to personally meet those doctors who are offering these services and to counsel them to refrain from it. In the case of those doctors who, despite repeated counselling and warnings, continue to engage in the criminal practice of the SSE of girls, the IMA Maharashtra is also considering taking legal action such as filing cases against individual doctors and debarring such doctors from membership in the state IMA. This campaign of the IMA, Maharashtra, has been summarised in four catch-words (in Hindi): BAAT (awareness building), MULAKAAT (individual counselling), LAAT (taking action) and HAVALAT (putting in jail).

The IMA at the National level also organized a meeting of the religious leaders from across the country to create public awareness to evolve an effective strategy for preventing female foeticide in June, 2001 in New Delhi[27].

b) FOGSI

The Federation of Obstetric and Gynaecological Societies of India passed a resolution against the practice of prenatal sex determination tests and also against the medical termination of pregnancy that takes place because of the sex of the foetus. FOGSI has also prepared IEC material, particularly video spots involving media celebrities. In actual

25 An article – IMA panel to check female foeticide – cited in official website of Punjab State Government

26 An article entitled 'Education can help curb female foeticide', Tribune News Service, 4th January 2002, Chandigarh

27 A newspaper article by Soma Basu entitled 'IMA plans religious leaders meet to fight female foeticide', The Hindu, 22nd June 2001

practice, however, beyond expressing their commitment, not much has been done for various reasons including the claim that the evidence is often not conclusive.

c) IRIA

The Indian Radiology and Imaging Association has suggested that the PC-PNDT Act is not adequate enough with regard to the question of who should be considered trained to legitimately use an ultrasound machine. Consequently, the IRIA appealed to the Supreme Court to look into this lacuna. The Court directed the government to study the clause and a committee was appointed for this purpose.

d) The Medico Friends' Circle

It is yet another forum of doctors which publicly acknowledges SD practices as inherently patriarchal and unjust. In their efforts they claim that whether or not it is negatively impacting the sex ratio is immaterial and such misuse of technology is against medical ethics. MFC has made its position clear time and again at various forums that they it has part of, including the pioneering campaign against sex selection in Maharashtra in the eighties.

e) Doctors Against Sex Determination

It is another group which had worked to create awareness during the run-up to the enactment of the Maharashtra Act, though it is now not very active.

f) Efforts by Individual Doctors

The study team also came across many doctors (e.g. in Delhi, Maharashtra, Gujarat, Karnataka, Haryana, Punjab, Andhra Pradesh etc) who in their individual capacities or in collaboration with various organizations or local branches of the IMA are taking concrete steps to tackle the problem. These efforts include conducting workshops, meeting and counselling individual doctors who are 'known' to be offering such services, and working with other enablers to catch those who violate the Act. Workshops have also been organised by doctors for medical college staff, non-teaching staff, medical students, anganwadi workers and even government officials. In some cases, some doctors have published articles, or prepared power point presentations which they use to spread awareness on this issue especially on the responsibility of the medical community in this regard.

There are a large number of other kinds of efforts in which individual doctors are involved. Sometimes this has involved the setting up of a PC-PNDT action committee which consists of members from different specialisations i.e. a radiologist, a sonologist, a gynaecologist a paediatrician, a general practitioner and a pathologist (e.g. Yavatmal). The committee is supposed to initiate action against the doctors practicing SSE and create a moral pressure on such doctors not to indulge in the SSE of girls. In another case a doctor has started a 'Female Foeticide protection and Counselling Centre'. In Belgaum another doctor assisted

in a sting operation to catch three doctors who were offering such services. Unfortunately though the machines were first seized they were later returned and the accused doctors continue to offer such services.

According to some of these activist doctors, such attempts on their part have led them to feel isolated among their peers and colleagues, and they have also suffered economically besides being threatened physically. These doctors (as well as others) refer to the 'doctors' lobby as being very powerful and interconnected and hence that there is great difficulty in punishing doctors in this regard, especially as some claim it is a highly lucrative business. They also consider that the government machinery is totally unwilling to take action against criminal doctors, and that often the district advisory committees are often filled with apathetic or hypocritical members (sometimes the very doctors who offer these services) and therefore they hardly ever deliver justice.

g) Other Groups

Other enabler groups have also consciously tried to work to sensitise doctors to the issue. CEHAT in Maharashtra, and CHETNA in Gujarat for instance, and many other groups have organised workshops that were specially focussed for all those who could have a say in influencing the general public in this regard, including doctors, anganwadi workers etc. Furthermore many of these organisations have also published informative material in English and the local/State language that is used extensively by many other groups.

As part of their strategy, organisations like Tathapi and MASUM (the latter being one of the three litigants in the PIL of 2001) which worked primarily on women's health issues, have focussed on regularization of the private sector in the health sector.

The Maharashtra State Family Welfare Bureau chalked out a sensitization programmes for third and fourth year MBBS students in association with NGOs. The programmes were carried out in thirty seven medical colleges, both governmental and private. This attempt was to make would-be doctors aware of the issue and the law. The Bureau has also suggested to the Government that the PC-PNDT Act should be incorporated as one of the subjects in the medical syllabus.

In a number of districts efforts have been made to rope in Anganwadi workers, ANMs and others who interact with women who are in the reproductive age group, to try and identify doctors and clinics which indulge in such practices as well as to counsel women against going in for such services.

'Direct mailings' have also played a role in building awareness. Thus PLAN International facilitated and funded the sending of letters signed by the Health Secretary (together with a poster) to 1.60 lakh doctors registered in the country, informing them of the Act.

3.5
Reflections (Strengths and Limitations) on the various efforts made to influence the 'supply' side

i) Working through the Medical Associations/Councils

It is perhaps true that in many cases the medical community or its associations have chosen to back the accused doctor or clinic in a mistaken show of loyalty or perhaps in order to cover their own failures lest they too be caught in a similar way in the future. Furthermore there is the constant refrain among a majority of the medical community that there is a very miniscule percentage of doctors who indulge in such practices and bring disrepute to the profession. Hence there are some enablers who doubt the genuineness of such efforts by medical associations and even of some of the doctors who are involved in these campaigns, on the grounds that such groups are not willing to actually penalise the members of their own community.

Yet, it would seem that no campaign on this issue can ever function successfully purely through the use of legal means and without the support of the medical community itself. Therefore without trying to fruitlessly answer the question whether such efforts are genuine or not, it is absolutely essential that the attempt to rope in the medical associations must continue and efforts made to continuously push the frontiers of what they are willing to do, so that they are gradually pressurised to move from BAAT and MULAKAT to LAAT and HAVALAT.

Of course it must be remembered that in actual fact only the Medical Councils have the legal right to take action in de-registering doctors, while the other doctors' organizations do not have such legal power. The medical associations can only expel a member but not debar from practicing. Despite this, even while efforts must definitely be made to influence the Councils to take whatever action they can take, the role of the other medical associations (e.g. IMA, FOGSI, IRIA etc.) in bringing moral and social pressure on doctors should not be underestimated.

Hence it would be important for significant advocacy work to be done with the Medical Councils in every State and the Centre, as well as with medical associations like the IMA, FOGSI etc, in order to get them to come on board and work with enablers and committed AAs in weeding out the black sheep among the medical community. Refusing to do this, or assuming that there is no point in making such efforts is to lose a very significant tool that could be used to bring pressure on culpable doctors or at least to isolate those who violate the law. Aside from the courts, these bodies can bring pressure on such doctors who violate the law, as associations can expel members, and Councils can de-register such doctors as has been done in Punjab.

ii) Workshops to sensitise the Medical Community

It is also not easy to judge immediately how effective the workshops organised by different groups (like the IMA, Maharashtra, or by enabler groups) are in changing the practice and mindsets of doctors.

On the other hand a study of the content of the workshop material used by one of the core team members conducting the workshops for IMA, Maharashtra, indicate that there are nuances (like the position on abortion, or a gender perspective etc.) which ought to be of serious concern, and such groups must be helped to refine their presentations.

iii) Sting/Decoy operations

An important fall out of sting or decoy operations in some cases is seen in the publicity these operations can generate in the media. When such operations are coordinated with the media, this kind of a crack down on the 'supply' side creates a fear in the minds of the service providers (at least those in the vicinity of the sting operation, e.g. in the same district) and contributes towards making SSE a high risk activity for all those involved in this 'business'. Of course as mentioned earlier, this has led to the doctors capitalizing on the risk factor and raising the costs for ultrasound tests. While this in itself may also lead to a decrease in easy accessibility to such SD and SSEs, it also raises the possibility of non-trained personnel offering these services surreptitiously.

In this regard it may also be mentioned that there is a need to network among the various enablers and AAs around the country in order to collect information on the current status of such sting/decoy operations and the subsequent cases filed (remembering to keep updating such information). This would be necessary in order to analyse what has gone wrong and what has been done well. Such information needs to be circulated to all those interested in working on such a campaign.

Furthermore since there is, as yet, no court-mandated guideline on how to conduct these operations, there are serious questions that can and are being raised on the legal validity and integrity of such operations. In any case it is interesting to note that the Supreme Court has recently taken up the question of how sting/decoy operations run by TV and news channels should be regulated. Such a ruling by the Supreme Court (SC) would of course have implications for sting/decoy operations conducted in the furtherance of implementation of the PC-PNDT Act. The questions regarding the credibility of the witnesses, and the intention of the ones who carry out such operations, have been questioned not only by the medical community but also by some of the enablers and the appropriate authorities. Thus, the relatively recent offer by some States, for instance, to pay a certain stipulated amount to those NGOs/CBOs who carry out such operations has been questioned by some among the legal community saying that it could be construed as 'tutoring the witness' and hence would destroy the credibility of such operations. Others

have responded saying that such payments are (in the case of Maharashtra at least) purely reimbursements for expenses incurred and not a reward or payment for conducting such an operation. Another issue that has created technical problems in the follow up to such operations is that some groups after conducting such operations have failed to go through the respective AAs, which is what the law demands.

Such operations are also an expensive measure requiring hidden cameras and other recording equipment that all NGOs may not be able to underwrite. Moreover, while there are some enablers who insist that the use of the sting/decoy operations are the most effective tool to be currently used in this campaign, there were many other enablers who felt that doing such sting/decoy operations could only be taken up as a once-in-a-while activity by the enablers, and that it was primarily the government authorities who were responsible for such operations and who had the legal and other resources to be able to do these successfully. Hence many of them felt that this could not be taken up in a major way by the enabler community.

iv) Difficulties in 'court'

Since the police are not involved in the sting/decoy operations referred to earlier, or in filing the case that results from the auditing of the records, the team was informed by various lawyer activists that all such cases are considered 'private' complaints when they come before the courts. This leads to other complications and confusions which create other problems for the successful follow-up to such attempts. For example, with regard to who represents the complainant in court, there is a significant confusion as to whether the State PP must necessarily represent the complainant, or whether the complainant is free to retain his/her own lawyer without a no-objection-certificate by the Public Prosecutor. In fact in one court the complainant did take his own lawyer with the knowledge of the court, which some enabler lawyers claim is not legally permissible. Secondly the fact that it is a private complaint would mean, according to some AAs, that there is a great and unnecessary difficulty placed on the complaining AA who must continue in his/her personal capacity and on his/her personal expense and time to attend the case till it is duly completed – even after he/she has left the post and is even retired. Obviously, considering the slow pace of our courts, many AAs would naturally not want to be saddled with this for years.

Similarly there are other aspects regarding the implementation of the law or understanding of the law, which have created problems for the successful conviction of the doctors in various courts across the country.

v) Working with other members of the Medical Community

Those activists who focus on ensuring the implementation of the law tend to focus predominantly on the medical doctors and clinics. However, experience has shown that while cracking down on the supply side there is great strategic importance in working

with conduits like the other health functionaries including the ANM, Aanganwadi workers, health workers, and even peons in government hospitals.

vi) Need for a multi-pronged approach

In the light of the allegation that there is often a collusion of vested interests between the authorities appointed to implement the act and the offending doctors, there is obviously need for a multi-pronged approach – social pressure, sensitising of judges and lawyers, empowering of committed AAs, doctors, associations and medical councils – all of which must together work to make the entire situation a high risk one for doctors, as compared to the situation today where it is a source of easy money and low risk.

3.6

Efforts to influence and ensure that the State (and its representatives) are sensitised and pressurised into fulfilling their role of ensuring the implementation of the Act.

i) Elected Bodies/Individuals

There has been a growing realisation that there is very little that can be achieved on this or any other issue unless there is a political will to address it head-on. Therefore some organizations have felt the need to make efforts to generate the personal interest of ministers/legislators and other decision-making authorities to bring about pressure for stringent enforcement and implementation of the PC-PNDT Act.

One of the most potent examples of the strategic importance of lobbying with the government was visible in the efforts of the Forum Against Sex-determination and Sex Pre-selection (FASDSP) in the run-up to the enactment of the Act in Maharashtra. Concerned individuals from diverse backgrounds - the women's movement, human rights, health etc - came together and formed the FASDSP, on April 8, 1986. The campaign focussed on questioning the entire gamut of reproductive technologies from SD to Sex Pre-Selection to surrogacy and cloning, and raised sex-selection as an issue of societal concern, one that ought to be of concern both to men and women. Apart from street programmes like dharnas and demonstrations, a successful awareness campaign was carried out by putting up counter-advertisements in local trains, organising a parent–daughter yatra, orchestrating a signature campaign and letters to the Prime Minister etc. A 'Nari Jeevan Sangharsh Yatra', depicting women's struggle for life and livelihood throughout their life cycle was one such notable programme. Through these efforts the campaign not only reached out to people of all sections in society, but forced the State Government to take note of the issue. Additionally, a series of efforts such as direct interaction with the Secretary, Public Health, moving a private member's bill in the assembly and forcing a detailed discussion over it, a survey of SD Clinics, the appointment

of an Expert Committee etc., ultimately resulted in the enactment of the Maharashtra Regulation of Pre-natal Diagnostic Techniques Act 1988.

The initiative of FASDSP differed from earlier and less successful efforts in that it attempted to tackle the problem more broadly and at multiple levels. Thus, the question of sex determination and sex pre-selection was seen as an integral part of the oppression of and the discrimination against women, as a misuse of science and technology against people in general and women in particular, and finally as a human rights' issue. The strategy was to enact a new law regulating diagnostic techniques without demanding a total ban. The work of FASDSP stimulated concerted action in many parts of India particularly in the states of Goa, Gujarat and Orissa. FASDSP as an issue based campaign group performed a versatile role: researching, disseminating information and ideas, lobbying, having protest actions, helping in drafting legislation and coordinating and networking. The campaign acted as a catalyst to spin-off groups in other parts of the country (e.g. Forum against Sex Determination (FASD), Gujarat Voluntary Health Association (GVHA), Gram Gujarat and Baailancho Saad in Goa). Several such attempts by like-minded groups all over India resulted in the enactment of the Central Act in 1994.

In the recent past, (after the amendments in 2003) this aspect of influencing legislators has involved meeting and trying to influence individual legislators at the highest level (e.g. the Chief Minister Shiela Dixit in Delhi, the Health Minister in Gujarat etc) in order to ensure cooperation from the appropriate authorities as well as to generate a greater willingness to go that extra mile to implement the law. It has also included meeting with legislators in groups through sensitisation workshops planned especially for them.

In order to influence such persons, some organisations have made efforts to collect data relevant to the particular legislator(s) being approached in order to create the necessary legitimate ground for the campaigners to question the genuineness of the government's implementation of the Act within a particular constituency. Thus for instance, CAPED in Delhi, and Sahiyar in Gujarat have conducted studies like surveying various ultrasound clinics to prove that the provisions of the PC-PNDT Act were not being implemented before meeting with concerned legislators. In PFI conducted workshops the parliamentarians were given data from their own districts to get them sensitized to the issue.

Organizations like UNFPA, and PLAN have organized workshops and conferences with legislators to get them interested in the issue, with the hope that following such workshops at least some of them would take action for the better implementation of the act in their own areas of jurisdiction (along with other strategies that they might want to use). In Gujarat, CHETNA's efforts in this direction have been partially responsible for the Dikri Bachao campaign of the Gujarat Government.

Various activist groups have also managed to work with various legislators to bring up various questions during the question hour in Parliament over these many years. A calling-attention motion on this issue was also introduced once over the past two years, and a second calling attention motion was brought up in November 2006.

ii) Administrative Bureaucracy

Another area of intervention for strengthening the implementation of the Act has been to work with the AA's, who have been mandated to enforce the law under the PC-PNDT Act.

While working with AAs in strengthening implementation, the efforts have been primarily directed at addressing their lack of technical competence to implement the law, through technical capacity building programmes (e.g. CHETNA, CEHAT, Sahiyar, UNFPA). Similarly, with the help of IFES and USAID, the organisation called CFAR has designed a practical training module, which can be used to conduct such training programmes with AAs and those working on the implementation of the Act.

Within the PC-PNDT there is a definite space for participation by civil society under the mechanism for advisory committees that are mandated to support the AA in the implementation of the Act. Many NGOs have felt the need to claim their space within such committees and believe that by playing a proactive role as members they will be able to strengthen implementation. For instance Vimochana in Karnataka has its representatives working as members of the advisory and monitoring committees at the state and district levels. Other NGOs work on building the capacity of civil society organizations to enable them to claim their space in the implementation process (CFAR in Rajasthan).

Either as a result of these workshops or sensitisation efforts or because of their own commitment, a number of AAs have been working on the issue. As a result some AAs at both the state and district levels have used their appointments to take significant action to implement the Act. These included getting the support of other dedicated officers of their own departments, media persons, NGO representatives, police personnel, civil society groups etc. These various groups have helped such AAs to collect intelligence on this issue and conduct raids to curb illegal activities. Sometimes efforts were also made to get these raids telecast live, in an effort to deter any further unscrupulous acts and create awareness among the masses regarding this menace. In Haryana, and under the directions issued by the SC, such a task force completed a survey of all ultrasound machines and seized forty seven machines. The pressure brought to bear on the District Appropriate Authorities in this regard and the conduct of decoy operations have resulted in 22 prosecution complaints. The first three court cases coming under the purview of this Act were filed in Faridabad district and were the first of their kind in the country. Similarly

in a particular district in Maharashtra, the AA encouraged an activist lawyer and other civil society groups to take action in identifying and 'catching' errant doctors/clinics.

The National Inspection and Monitoring Committee of the PC-PNDT divison at the Centre also conducts monitoring visits every 6 months and covers 8 states in a year. Based on intelligence received, this committee officially visits the clinics identified through such information, and when found necessary even seals the clinics. However, in some places the politically connected doctors' lobby was able to prevent the committee from carrying out its task. Additionally, the National Support and Monitoring Cell (which is a non-government cell appointed in consultation with the Government) also makes its own visits and submits its reports to the PC-PNDT division. However, there are indications that at times even the police of a particular area have been known to refuse to cooperate in accompanying and protecting them when they visit clinics of 'powerful and well-connected' doctors.

A number of district collectors have taken a keen interest in a stringent implementation of the Act. This has happened either because they have attended a particular sensitisation workshop, or because of their own awareness of the situation in their own districts. However, they have followed a variety of approaches. In Hyderabad, efforts were made to sensitise doctors through workshops, and then the district authorities proceeded to engage in an analysis of the F forms to identify and catch the erring doctors in the district. The doctors were mainly booked under the non-compliance of the records requirement of the Act, but this did act as a deterrent. The sex ratio subsequently showed an improvement in the district. In Nawashahar, Punjab, the district authorities used the tracking and follow-up of pregnancies to enforce the Act. However, doctors have been booked, mostly on the basis of non-reporting, faulty reporting, and not meeting other requirements under the Act. Large-scale awareness campaigns and mass media have also been used in Nawashahar.

In Shivpuri, Madhya Pradesh, the district authorities managed, with the help of activists and lawyers to work with the local AA and seal all four clinics practicing such activities in the district. Unfortunately, the State AA reversed the ruling and the matter could not be taken to court. In Morena, Madhya Pradesh, the district authorities relied on data and experiences of community-based organisations to gauge the magnitude of the problem. The district administration decided to undertake a village-wise mapping of the CSR between 0-5 years in Anganwadi Centres in the district, by devising a detailed strategy for the same. Simultaneously other steps were initiated, such as discussions with members of the medical community and a medical audit of F forms. Four licenses were suspended with immediate effect under this section and finally seven registrations were cancelled. Incidentally the DC also attempted to persuade the medical community not to indulge in this heinous crime, but observing no change in the attitude of erring doctors, he had to

take legal recourse. The data obtained from these centres was computerized for further medical audit. The action against these centres became an effective tool in creating awareness regarding the Act among different stakeholders and building an environment on the issue within the community at large. Before this data could be used to further identify 'hot spots' and making area specific or community specific strategies, the Collector was transferred. Meanwhile, on June 2005, all the seven clinics against which action had been taken, filed appeals with the State Appropriate Authority. The SAA while admitting that these centres did not maintain proper records observed that it did not amount to gross irregularity to cancel the registrations and used this ruling to quash the order of the District AA to revoke the seven licenses.

As Health is a State subject, the PC-PNDT division at the centre would experience certain limitations in interacting with their counterparts in the states on this issue. The team was informed that in order to overcome this difficulty, the PC-PNDT Act has been placed under the purview of Family Welfare, which is a concurrent subject. The division organises monitoring visits every 6 months, constantly makes requests for information to be sent in by every State (very often not complied with[28]), and convenes the Central Supervisory Body meetings every 6 months. Their work is made even more difficult since according to information received, it would seem that not all the States have constituted the State Appropriate Authority, nor have those who have done so fulfilled the Act-mandated rule of appointing a multi-member committee as the SAA as envisaged in the Act.[29]

The division also seems to believe it is lacking significantly in human and material resources and that this significantly affects the effectivity of its work. However members of the division do attend seminars on the issue with different groups (legislators, doctors etc.) and contribute their knowledge and expertise at such opportunities. Finally, the division informed the team that the National Rural Health Mission (NRHM) has now taken centre stage, and the States have been asked to include this issue (PC-PNDT work) in the Project Implementation Plan they have to submit under the NRHM. Some states have complied with this, while others have included it under the earlier submitted Reproductive and Child Health-2 (RCH2) plans.

In most places the Advisory Bodies that are expected to monitor and assist the AAs in the implementation of the Act are either defunct or dormant for various reasons including what has been termed by some as the faulty selection of Advisory Board members. It was often alleged by activists that sometimes these bodies include the very people who are

28 One of the reasons given for such non-compliance is the fact that in a hierarchical bureaucracy, very few of the SAAs would feel obliged to respond to a lower ranking officer's (even if he is at the centre) request for information.

29 Section 17(3) of the PC-PNDT Act it shall be the duty of the State or the Union territory concerned to constitute a multi-member State or Union territory level Appropriate Authority.

indulging in these practices, or those selected often do not have the time or commitment to invest in this issue. In some places the members would like to work but do not get the necessary support or lack the necessary capacity (e.g. knowledge of their duties and rights, or lack of financial and material resources) to be able to carry out their work.

In the light of all of the above, (e.g. the fact that most AAs both at District and State levels are failing to fulfil their role as implementers of this Act), several NGOs are now forming monitoring committees in order to track this issue. NGOs and District Collectors have made district and village level committees (e.g. CHETNA, Vimochana, UPKAR) involving the local and state health workers, NGO members, ANMs, Anganwadi workers, elected representatives at the local level etc.

iii) Judiciary

Public Interest Litigations have, for some time now, been frequently used by civil society groups to get the court to clarify and/or take action to ensure that failure on the part of the legislature or the bureaucracy does not mean that the law remains toothless. Since the passage of the central PNDT Act in 1994, two PILs have been filed at the level of the Supreme Court. The first landmark PIL filed in 2001, apart from demanding a stringent implementation of the Act also demanded an increase in the ambit of the Act to include the various new pre-conception diagnostic techniques that could be used for sex-selection under the revised PC-PNDT Act. The result of the PIL was ultimately a whole new set of amendments and greater teeth to the implementation process that took effect in 2003. The second PIL is the one recently filed by the Voluntary Health Association of Punjab which seeks a stronger implementation of the act. In this context, in order not to have a piecemeal kind of legislation by the Court, a number of groups (including some NGO groups, the PC-PNDT division and its Central Supervisory Body and others) are working on collating and articulating specific amendments that could be submitted to the court.

A PIL has also been filed in Madhya Pradesh by an activist group to challenge the validity of the State Appropriate Authority's reversal of the action taken by the local district AA in Morena.

Similarly a number of cases have been filed in various courts around the country as a follow-up to a sting/decoy operation, or the failure of clinics to fulfil the provisions of the law in different ways. Unfortunately there is as yet no comprehensive listing of such cases, and their current status, with anybody in the country.

In addition, a number of information-giving, and sensitisation workshops for Judges and lawyers have been organised by different groups (e.g. HRLN), and funded by PLAN and others.

iv) Campaigns and Networks to Strengthen Implementation

In addition to efforts targeted specifically at the Legislature, the Bureaucracy and the Judiciary, there have been several networks of civil society organisations, individuals and institutions drawn from diverse fields which have tried to bring pressure on the State as a whole. Some examples are given below.

The Campaign Against Sex-Selective Abortions (CASSA) – a movement of non-governmental and women's organizations, human rights groups, lawyers, educationists, academicians, media persons and activists led by the Madurai-based Society for Integrated Rural Development has, since December 1998, been seeking to prevail upon the Appropriate Authority to regulate the setting up and functioning of scan centres. CASSA is campaigning for compulsory registration and monitoring of all hospitals, genetic clinics, laboratories and counselling centres, where such pre-natal techniques are carried out, and for monitoring the prohibition of sex selection and initiating action against violators. Through monitoring the enforcement of PC-PNDT Act and the MTP Act in the state and its proactive role in the Advisory Committees at the District level, it is making efforts at strengthening implementation of the Act. CASSA has filed several petitions against violations under PC-PNDT Act which are pending before the department for necessary action.

In Delhi a group of academicians, professionals and volunteers dedicated to the cause of protecting the rights of the girl child and women formed a Campaign Against Pre Birth Elimination of Females. The campaign sought to create a movement involving students and teachers to increase awareness about this issue by networking with like-minded individuals, organisations and institutions. The Campaign is also involved in advocacy efforts with the government and was part of the group that mobilized a 'March to Parliament' in 2002 urging immediate passage of the PC-PNDT Amendment Bill.

The Peoples' Health Assembly (PHA) initiative, a global initiative which is very active in India through over 1200 peoples' organisation and NGOs in eighteen different states, took a decision to take up sex-selection and sex-determination as a major campaign issue. It launched this campaign after a national meeting on this issue held in Rohtak, Haryana in April, 2001.

The Maharashtra State Commission for Women (MSCW) has taken on an active role in pressurizing the state government from within, to set up the appropriate machinery for the implementation of the Act as well as to build awareness on the issue. The MSCW has constituted a vigilance committee, authorized by the government to monitor and investigate laboratories and clinics, for any evidence of malpractice.

3.7
Reflections (Strengths and Limitations) on the various efforts made to influence the State:

i) Getting the AAs to Implement the Act

As has been mentioned clearly in Part 1 – Looking Back, there are three primary reasons that have been cited by various interviewees to explain the apparent failure of the AAs to act. These are (in order of importance): (i) a clear conflict of interest leading to lack of a political will in implementing the Act, (ii) a lack of legal competence to be able to follow all the requirements necessary for their actions to stand scrutiny in a court of law, and finally (iii) lack of human and other resources to help them in their work. In addition, the PC-PNDT division at the centre has apparently not demonstrated or exercised much power to enforce the Act in the states. Activists point out that there is a clause in the Act that allows the Central Supervisory Board (to which the PC-PNDT division reports) to 'oversee the performance of various bodies constituted under the Act and take appropriate steps to ensure its proper and effective implementation'[30]. Under this clause, it was suggested, proactive authorities at the centre could take action. All these are aspects that can be dealt with if there is the necessary will and support. For example, as mentioned earlier, according to one interpretation of the Act, there is no need for the CMO of any district, or even a doctor of any kind, to be made the district AA[31]. Similarly, capacity building for legal competence is something that can be offered through workshops and other aids. And lack of resources is something that can be remedied through assistance from NGOs (through an offer of personnel to be attached) and donor agencies (with funds to hire such help). As for the proactive role that could be taken up by the PC-PNDT division in monitoring and holding States accountable, this is a matter that can be discussed and solutions found.

ii) Conflict of Interest

There is also the fact that since the AAs are currently all from the medical community (though, as mentioned earlier, the law does NOT appear to demand this as being necessary at the district level) there seems to be a clear conflict of interest since most often than not they are not willing to take up cases against their own colleagues in the same profession. Therefore the provision in the law which by implication allows non-medical professionals to function as District AAs should be fully utilised. Furthermore, as far as the State AAs are concerned, though the law indicates that it must be a multi-member body of which only one needs to be a person from the medical profession, the fact is that in most if not all states the State AA comprises only one person who is inevitably a doctor. Consequently

30 Article 16, clause (v) states that CSB will oversee the performance of various bodies constituted under the act and take appropriate steps to ensure its proper and effective implementation.

31 Article 17, Clause 3 (b) states that AA when appointed for any part of the state or union territory shall be of such other rank as the state govt. or central govt. may deem fit.

besides this being an infringement of the law, for which no State has been held accountable as yet,. the fact is that the same conflict of interest could come into play when there is any appeal to such state appropriate authorities. This is another area where the law needs to be invoked in order to ensure that States follow the necessary guidelines included in the law.

iii) National Rural Health Mission (NRHM): It would seem that the movement to include activities towards implementation of the PC-PNDT Act under the NRHM could serve to dilute the necessary focus on the issue of 'missing girls'. However, this is not necessarily the case, as on the other hand the NRHM opens up the possibility of interlocking this issue with other social issues covered under it, even as it opens up the possibility of a larger basket of funds that could be availed of.

Another area of concern is that the NRHM is primarily geared towards the lower socio-economic groups in the rural areas whereas the statistics show that it is the higher socio-economic groups that engage more in these practices. On the other hand, since NRHM has an urban element in its overall plan, there may be possibilities of overcoming this difficulty at least with regard to those who are poor and can yet avail of such services because of their urban residential status.

It seems that this new development can serve this campaign through efforts made to monitor this issue of the missing girls as a part of NRHM review processes.

iv) Influencing the Elected Representatives

Although it appears to be a good idea to lobby with MLAs, MPs and even Chief Ministers to elicit their commitment to work for this cause, it seems that in general this has worked only for a little time and gradually the interest wanes. This could also mean that there is no strategic plan on the part of those who are making these attempts to ensure that the issue remains 'alive' in the minds of these elected representatives. This could also be the result of ideological and other struggles within the NGO coalition involved. Thus for example in some states/districts some activists are not willing to work with local government because of their disagreement with other state policies of a particular ruling party. In short then, while this route of influencing the elected bodies and members is very important, it is one that must be planned carefully several steps in advance, (almost like the advertising campaign of a major brand), and not planned just one step at a time.

v) Lack of Clarity in the Law

It is also clear that the lack of clarity even among the enablers/activists and the government functionaries regarding many aspects of the Act and the attendant Rules makes it very difficult to enforce the Act effectively. What is even more disconcerting is that this lack of

clarity about the Act is present even amongst those of the legal community who are engaged in working on this law. A listing of some of the disagreements raised at different fora during this study is included in Part 1 – Looking Back.

vi) Need for Amendments

There is also a clear need expressed by many that there is need for various amendments to be brought into the Act. While some activists say that the Act has not been implemented enough and there needs to be more field experience of implementing the Act before talking about amendments, the Central Supervisory Body as well as other NGO/activist groups have acknowledged that the Act is deficient in some ways and needs to be looked at again., particularly in the context of the current PIL filed by VHAP. However, even these agree that while pushing for amendments within the existing law may be an answer in the long run, there is need in the short run to make an honest attempt to make the existing law work.

vii) Use of PILs

It must be remembered that though PILs are necessary in order to fine-tune the law and to get the added weight of the backing of the judiciary, they do not necessarily get translated into effective actions on the ground, unless there is a group which makes conscious efforts to ensure its implementation at the grassroots level. PILs can also be used to question or hold accountable the district and state governments on non-compliance, and could be increasingly considered by activists as a tool to bring pressure on the bureaucracy which is expected to implement the Act.

viii) Auditing of Records

The auditing of the records that are to be maintained by every clinic seems to be an effective way of monitoring the various clinics. However, it involves a huge investment in time and personnel, which is apparently not forthcoming from the State. Consequently, the penalties attendant on failure to submit records accurately and on time, has very little deterrent effect on offending doctors/clinics. Additionally, wherever non-governmental groups have offered to help in such monitoring or auditing of records, there has often been great difficulty in gaining access to these records until some high level political influence is used. Therefore, such monitoring or auditing has been possible only in those places where an activist group has found its own resources, or where the local District Collector or AA has chosen to invest government resources in carrying it out. It is the claim of those who have been involved in auditing these records that skilled auditing of such records gives enough evidence to nail most doctors who are offering such services. It would be important therefore to influence government authorities at higher levels to issue the necessary State GRs that would make such records more easily available to those who really want to implement the Act.

ix) Creating a Supportive Environment

The few district collectors or individual State or District Appropriate Authorities who have taken a personal interest in the issue have also demonstrated through their work that where there is a will the law can be implemented in significant ways. On the other hand unless these kinds of initiatives are developed in a way that they are not centred around one person, such efforts cannot be sustained. The limitations of working against a popular practice is that those that dare to do so unfortunately make more enemies than friends. Those whose interests are being undermined by such efforts get together to sabotage and derail such initiatives. The inadvertent fallout of such initiatives by a handful of committed officers is that the officers who follow them in those districts find it difficult to continue the work of their predecessors (even if they want to) because of the apathy and animosity created among vested interests by the work of their predecessors. On the other hand, those who are able to effectively involve different agencies and stakeholders, forge alliances, build networks and coalitions and work at multiple levels and fronts at the same time, have a far greater impact and outreach, and it becomes difficult for vested interests to interfere in or impede their work.

Hence, it would be important for such individual committed government activists to be capacitated (because some of them may not see the need for this, or may not even have the skills to build such an environment of support) and supported in building up civil society and government support. Unfortunately wherever such a person has gone 'solo' s/he has had to face a very painful and uphill journey, and the effort fizzles out when s/he is transferred or retires.

Furthermore, it can be generalised that all these efforts can only bear fruit if there is a committed enabler or government official (AA, DC, etc.) who is willing to invest time and resources to pursue a very unrewarding and even potentially dangerous path of going against what is clearly a very lucrative business. Since such commitment cannot be found easily, it would be important to find ways to offer material, financial and human support to those who do demonstrate such commitment, and not leave them to fight their battles alone.

x) Monitoring Committees

The monitoring and vigilance committees seem to be somewhat effective, though a more careful and comparative impact study of the various models used in different districts or states would help to draw lessons and improve their functioning. Thus the Gujarat state sponsored model is different from the Tamil Nadu model, while the model used by one NGO/CBO group differs significantly from that of other such groups.

xi) Networking

Campaigns and networking require constant nurturing in order to keep them going. Thus, while many campaigns have begun with a bang, there are many which die out with a whimper. This has also been the case with many campaigns started in particular districts on this issue. Partially this is also because many activist groups realise that they cannot be one-issue organisations as they have to keep current with issues that are immediately affecting the communities they work with. As has been mentioned earlier with regard to influencing the elected representatives of the people, this is often primarily because campaigns are rarely if ever planned also for the long term, but tend to be focussed on the short term.

xii) Sensitising the Legal Community

At present, the information collected from the various enabler groups around the country indicate that out of around 300 cases, only a handful of cases (around two)[32] have reached a conclusion where the doctor or clinic was penalised for contravening the law. In many cases allegedly the judge has thrown out the case on technical grounds – either because apparently the judge him/herself was mistaken about the law or because there were technical irregularities in the case. All this only highlights a need expressed by many of those involved in this campaign, namely that there is an urgent need to have efforts focussed on sensitising judges and the legal profession (including law students, PPs etc) to the intricacies and nuances of this law.

xiii) Role of the Different Bodies appointed to Implement the Act

While a National Support and Monitoring cell has been set up at Delhi to help the PC-PNDT office monitor the implementation of the Act around the country, it would seem that this body is currently in a state of transition and future plans are uncertain. Similarly though the Act does seem to open up the possibility of monitoring by the Central Supervisory Board and the National Inspection and Monitoring Committee's visits, the fact is that the PC-PNDT office itself often experiences a certain inability to hold accountable those AAs who fail to carry out their responsibilities. As a result there is little monitoring of the work done by the various District AAs or State AAs and no action apparently can taken against them if they fail to implement the law vigorously. All this has led to a very lax implementation of the law. It would therefore be very important to clarify for the monitoring authorities at the central level the degree to which they can take action and to motivate and support them in carrying out this important role without fear of any kind.

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32 A report on the PC-PNDT Act by Symbiosis Society Law College Legal Aid & Literacy cell, Aug,06 and newspaper clipping.

3.8
Conclusion of Part 2

The descriptions of the various efforts made by different actors may not be exhaustive of all that is happening in the country, but includes all that the study team came across through its interactions with various primary sources and through its perusal of secondary sources. What is important, however, is not so much whether every single effort has been chronicled, but whether the campaign members are learning from their own and each other's efforts. The lack of such mutual learning (as mentioned in the earlier part of this report) is one of the weaknesses of this campaign, partially because of the distrust or ideological or other differences between various potential allies who are all claiming to work on this issue. The reflections offered in this part of the report are therefore an attempt to help those involved in this campaign at various levels to reflect on their own efforts and use the lessons learnt to plan more effectively for the future. The next section of this report offers specific suggestions with regard to the different kinds of strategies that the study team considers crucial to any successful campaign on this issue.

Part 3

LOOKING FORWARD

Suggestions for Future Strategies for the Campaign

4 Part 3
Looking Forward
Suggestions for Future Strategies for the Campaign

4.1 Introduction

In the light of the two earlier parts of this report-, this part suggests how the campaign can move forward. These are not suggestions that are specific to UNFPA but to the campaign as a whole.[1] Many of these future strategies suggested here are grounded in suggestions that were discussed and debated at the various interviews, workshops and mini-consultations that formed part of this study.[2]

Furthermore, this report does not intend to spell out a strategic plan[3] for the campaign as a whole, but only to highlight certain strategies/tactics that the study team would consider essential to any future successful strategic plan.

Thirdly, since the specific brief of this study is to come up with a way forward on this issue of 'missing girls' the report has limited itself to strategies/tactics that directly impinge on this issue. And yet inevitably such a campaign would be intricately affected by a number of other issues. Therefore, before making any specific suggestions, it is important to highlight some elements of the larger context within which the campaign on this issue must be strategised:

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1 The specific suggestions to UNFPA do not form part of this published report.

2 The various interviews, workshops and mini-consultations that formed part of the study are annexed at Annexure II.

3 The terms STRATEGY(ies) (or TACTICS) and STRATEGIC PLAN (or PLANNING) are often understood differently by different persons/groups in the developmental field. Hence it is important that the specific meaning of these terms is clarified for the purposes of this report. In this report these terms are understood as follows: **Strategies/Tactics** are understood as synonyms for elements/aspects that must be part of a larger strategic plan. A **Strategic Plan** is therefore a larger entity that encompasses the former and guides the specific flow of the campaign. To use the analogy of the country strategising to win gold in hockey at the Olympics, a strategic plan would include all that planning demands, including time-lines, priorities, responsibilities, etc. However, such a strategic plan would necessarily need to employ certain **strategies/tactics** like ensuring for instance that vested interests play no role in controlling the selection of players to represent the country, or ensuring that adequate athletic gear of specific quality be made available to the players, that adequate funds are made available for their training, that modern technological aids are made accessible to the team selected etc. Obviously these are not the only meanings that can be given to these terms, (i.e. strategic plans and strategies) but they are the meanings of these terms when they are used in this report.

4.2
The Larger Context

While the strategies/tactics outlined in this section focus only on ways to work on this issue of the 'missing girls' – as that is what falls within the purview of the commissioned study – this report would like to state unequivocally that any strategy to work on this issue must inevitably take into account the many other issues that social advocates struggle with in India.[4] These other efforts would include for instance the campaigns against dowry & domestic violence, or the trafficking of women, or the campaigns on child rights, HIV/AIDS, and of course gender equity.

In addition there are certain politico-scientific-socio-economic currents that clearly impinge on this issue. These include (among others)

a) the movement towards privatisation of health care;
b) the unbelievable medical and technological advances in predicting, controlling and modifying the basic building blocks of human life;
c) the increasing social trend towards individualism and personal choice;
d) the social acceptance of calculating the financial implications of all interactions including human relationships;[5] and
e) a mentality where 'having more' (encouraged by an environment that fosters unbridled consumerism) is often equated with increased self-worth.

It can easily be seen how these trends could lead to a situation where it becomes socially acceptable (especially among the higher socio-economic classes among whom these sex selective practices are more rampant) to see all children as entities whose value is to be judged purely from an economic and/or personal advantage point of view[6], and to feel that it is one's right to tailor-make the gender composition of one's own family according to one's own personal choice.

It is within this larger context that this campaign to save the girl child must be run, and hence it is crucial for the success of any such campaign to network and ally with those working on these other issues. Within this context, it must be stated here that the most obvious tie-in for this issue is the entire movement towards gender justice in the country. This is extremely crucial since it is clear that sex determination practices find

4 In fact many of the enablers who attended the 'Enabler mini-consultation' organised during the study, made it clear that their own organisations could not, and would not want to, be one-issue organisations as they see many of these issues as intimately correlated. The same consideration would also apply to the State agencies that have to deal with a wide variety of concerns and responsibilities.

5 e.g. the increasing use of pre-nuptial financial arrangements

6 e.g. the increasing number of DINK (double income no kids) couples, one-child couples and very rarely more than two-child couples among the higher socio-economic classes in India

their roots in the patriarchal mindset that controls an overwhelming majority of our population.

Secondly, it is the position of this study team that any campaign on this issue cannot afford to tackle it from only one angle i.e. by focussing only on the supply side, or only the demand side or only the implementation side. While it is obvious that any particular enabling group/individual, any state agency, or any donor agency must necessarily work from the area of its own strength, the campaign as a whole can succeed only if there are adequate efforts being made at all three levels. This demands that each agency that chooses to be part of this campaign must be able to honestly explore its own strengths and limitations, as well as the opportunities and threats that present themselves to it – and in the light of this honest analysis choose where it can best plug into the overall campaign. This will ensure that these various agencies and individuals will be able to push in the same direction, even if they may not always walk together. However, it is clearly not within the brief of this study team to tell each of the many activist groups or stakeholders that the team has interacted with over the course of this study what each should be doing. All that the team can do in this report is to suggest the various strategies/tactics that it considers necessary for the overall success of such a campaign.

This study team also clearly takes the stand that demonising any one group in its entirety – whether it is the medical profession, the government officers/AAs, or patriarchal community groups, or religious leaders etc. – would be ultimately self-defeating from the campaign point of view. This also implies that there should be greater coordination and cooperation among the enabler groups and individuals – something that has been significantly lacking according to many enablers themselves. This is particularly necessary taking into account the significant ideological, attitudinal, knowledge, and even strategic differences that have surfaced among the activists working on this issue. Some of these differences are briefly highlighted below:

a) There are those who insist that focusing on 'stopping the supply' must take precedence over all other efforts, because changing the mind-sets of the people, or lessening the 'demand' is not going to happen in the near future. This, of course, has many practical implications as for example the debate on whether it is worthwhile to spend 'tons of money' on costly celebrity-based high profile media campaigns ostensibly to change people's thinking, thus taking away resources from the more directly focused efforts to conduct sting/decoy operations which also require significant funding.
b) Similarly there are those who believe that it is naïve to believe that medical associations and councils would make any genuine attempt to punish members of their own community, and therefore funds or efforts spent on such attempts would be mostly exercises in futility. Thus, any attempt to counsel doctors or to

appeal to their social responsibility to stop such practices is, according to some activists a waste of energy.

c) With regard to abortion and the MTP Act, there are also strong disagreements. There are those who wish to speak of respect for all life, while there are those who point out that such a 'pro-life' approach would mean that the effort by some groups to get abortion recognised as a right for women in all circumstances would be undermined. It is in this context that some are even against using the Hindi term for foeticide (bhrunhatya) in the communication material, because denouncing it is seen as denouncing all abortions, while there are others who say that there is no real option to this term. Similarly, there are those who do not want to have anything to do with re-visiting the MTP Act, while there are others who believe that modifying the MTP Act is a necessity, because it is this Act (with its permission to have an abortion on the simple ground of failure of contraception and its confidentiality of records) that can be misused to carry out Sex Selective Eliminations of female foetuses.

d) The strategy of using the good offices of religious leaders has also created a divide on two grounds. There are those who oppose their inclusion on the grounds of their own belief that religious leaders would be against all abortions (though this might not necessarily be true) and/or on the grounds that allying with them would also imply an acceptance of other allegedly superstitious practices that these religious leaders might be otherwise fostering.

e) Another area of disagreement is with regard to whether implementation efforts should be focussed on monitoring pregnant women or not, and on the other hand whether the Act should allow women also to be considered guilty in certain circumstances[7]. With regard to the former, there is a strong belief among some that methods like a 'pregnancy watch' in order to monitor the entire situation is to victimise the women even more, while others claim that in actual fact this is the only practical way of monitoring the situation. With regard to the latter, it has been pointed out that since it is the higher socio-economic classes who are currently the main group that avails of these services, there could very well be many women among these who personally and freely choose to abort the female foetus. Yet, currently according to the Act, the woman is mostly considered innocent unless proved guilty. This allows even a woman going for sex selective abortion of her own free will to go scot-free under the law. Consequently some groups are against this kind of a clause in the Act.

f) There is also a difference of opinion on what is the 'minimum ideology' that each member of the campaign must subscribe to, in order to work together on this issue. There are those who believe that this minimum must include the acceptance of abortion as a right for women in all circumstances, or not

7 The PC-PNDT Act presumes the women to be innocent unless proved guilty

allowing women to be monitored as a means to the end of reversing the CSR decline, etc. while others believe that this is asking for too much and would tend to alienate a large number of groups who could and must be brought into the campaign.

g) There is also a strong disagreement among those interested in implementing the Act with regard to the role the police should or should not play in the implementation of the Act. Similarly, there are differences of opinion on whether a medical officer should continue to be the AA of the district or whether another senior government officer like the District Collector should take over this role. Some of the reservations on the inclusion of the police expressed by those opposing it were with regard to the doubtful efficacy of a generally patriarchal, politically controlled and a seemingly corrupt police force in implementing the PC-PNDT Act. On the other hand, those who ask for such inclusion do so on the grounds (a)-that the police/District Collector are much better capacitated to deal with the intricacies of the law in conducting search and seizure operations, (b) that having a medical officer as the AA is to have a situation where there is a clear conflict of interest, and (c) the fact that a case investigated and brought to the court by the police would ensure that it becomes a State complaint rather than a private one.

h) There are also differences of opinion among those who believe that the campaign should focus on implementing the law as it stands currently, rather than frittering away its energy in trying to bring about amendments to the Act. Those who believe that we need to focus on implementing the Act believe that the law already has enough teeth but has perhaps really not been implemented properly as yet. There are of course others who disagree with this position and believe that while efforts should continue to implement the law as it is, this can and should go on simultaneously with other efforts to improve the Act. This difference of opinion is expressed in many ways as for example in the fact that there are activists interviewed who expressed concern that a new PIL has been brought into the Supreme Court without taking on board the opinion of other campaigners on the advisability of doing this. Others believe that such a premature running to the Court might lead to piecemeal pronouncements by the court which do not take into account all the different positions on the issue, and therefore would not be comprehensive enough.

The arguments for and against each of the positions mentioned above are quite strong in their own contexts. Unfortunately this has resulted in campaigners on the issue ending up with attitudes that tend to downplay and undermine the work of those who function from a different ideological position than their own. It is the opinion of this study team that an overly puritan or fundamentalist approach will not help to work towards the goal of changing the CSR in the country in the near future.

In the light of the larger context explained above, the study team offers the following strategies as crucial elements contributing towards a successful strategic plan for the campaign as a whole. These have been presented in what the team would consider the order of importance and/or urgency:

A) Central Strategy

B) Particular Strategies for the Campaign

- **a) Strategies at Multiple Levels**
  - **i) Challenging Gender Stereotypes & Revisiting Affirmative Actions to Encourage the Girl Child**
  - **ii) Helpline for Complaints**
  - **iii) Keeping Track**
  - **iv) Drawing in Other Actors/Influencers**
  - **v) Strategies for Communication**
- **b) Strategies at the Level of Implementation**
- **c) Strategies at the level of the Medical Community**
- **d) Strategies at the level of the Community**
  - **i) Working with/through Community Leaders/Groups**
  - **ii) Focus on Working with Youth**
- **e) Strategies at the level of The 'Law'**
- **f) Policy Level Advocacy**

4.3
Central Strategy

Keeping the above-mentioned introductory comments in mind, it would seem that the most essential strategy would be to find a way for the various activists who wish to work on this issue to find a more coherent way of working together. Therefore there is need to work towards the creation of a body of representative stakeholders which can work towards synergising a National Campaign on this issue, rather than frittering away much energy and resources on separate and sometimes mutually antagonizing efforts.

Earlier efforts were made to come together through a non-structured "partnership group" that was initially chaired by the then Health & Family Welfare Secretary of the Government of India and facilitated by a core group constituted from among the ad hoc members of this group. However, whether such a partnership group is revived or not, it would be important to initiate a National Resource Group/cell, preferably supported by a secretariat, that would fulfil the functions enumerated below. It is true that there are already a number of entities that are supposed to provide some elements of coordination (e.g. PC-PNDT

Cell and the Central Supervisory Body, the National Inspection and Monitoring Committee at the Centre as well as the National Support and Monitoring Cell (which is a non-government cell appointed in consultation with the Government) the State Supervisory Boards, etc. Unfortunately, however, these have not able to bring about a significant change in the ground situation because members on these boards are either perceived as not committed enough, or do not have enough 'power' to take action, or ultimately because there is, according to activists, no political will at the Centre and State levels.

And yet, what is clear is that this need to link up with others was expressed repeatedly by the vast majority of those with whom the study team interacted during the past few months, and many really appreciated the linking up that was made possible through the many workshops that were organised by the team as part of this study. In this context, looking back at the rich experience of the study team in interacting with a wide variety of stakeholders, it may be that through this process one possible option of how to flesh out this coming together has in fact already been initiated. Through these various meetings organised by the study team, various stakeholders were able to find a platform where they could listen to each other, without the 'hub' playing any controlling role. In short then, whatever the validity of the findings of this report, the process the team followed seemed to have opened up arteries of communication that had been somehow clogged. This process could be used as a starting point to initiate such a National Resource group/ cell.

Furthermore, the Resource Group/Cell being proposed is not meant only to monitor, but also to offer resources to those working on this campaign. Later, as such a group evolves, it may perhaps be able to also function as a kind of pressure group on behalf of the entire campaign. In any case such a body of representative stakeholders would be effective if it can fulfil the following necessary functions (among others):

a) Ideological Leadership: Such a group would need to find a way through the various ideological dilemmas that surface from differences outlined earlier, and to find ways to encourage campaigners on this issue to keep in touch with, cooperate and coordinate with each other.

In this context many activists have insisted that there must be some minimal common ideological ground if people have to work together on this campaign. However, looking at the variety of contradictory approaches (some of which have been listed above), and keeping in mind the examples of other successful coalitions, it seems that a judgement on what should be the minimum will depend directly on whether one considers the current CSR figures as indicative of an urgent national emergency (like the Tsunami) or a serious social problem that needs to be solved urgently. What this means in effect is that if one considers that the ratio of boys to girls in the country is already a national disaster or fast becoming one,

then perhaps the only realistic common element that ought to be expected may be the commitment to reverse the current trend of increasing sex selective elimination of female foetuses[8]. This would allow a variety of 'actors' who subscribe to different positions (on abortion, on terminology, on the methods to be used, and who may even have different positions on gender issues, etc) to all participate in this campaign. If, however, this issue is seen as a serious social problem and not as a situation that needs an immediate reversal, then of course the minimal commitment or ideology demanded for cooperation between different groups would be of a higher level and must include a commitment to gender equity.

b) Legal Support: Such a resource group would also need to offer legal support and a comprehensive perspective if and when the issue is taken up in the courts anywhere in the country (e.g. the current PIL initiated by VHAP) so that the concerned activists are given the necessary information to bolster their case, and to ensure that if any amendment(s) is/are to be introduced (e.g. by the Supreme Court, or the Parliament) they are not done piecemeal and/or based on the ideology of just one or other group, but in a more comprehensive manner. This would also mean that this group would consider it part of their responsibility to ensure that there is a continuous track of the status of different court cases and sting/decoy operations in the country, and offer guidance and information as requested by any group interested in conducting such operations.

c) Networking & Capacity Building: Such a group would also need to network between various resources available among different groups in the country in order to be able to connect people to the right sources when they need support or guidance – e.g. communication strategies or techniques, legal knowledge, implementation queries, etc. Such networking would also help to prevent duplication of efforts (for example in the production of IEC material) and to ensure that the 'right' messages are conveyed. Furthermore, such a group needs to be able to offer resources for capacity building and sensitisation of all kinds of stakeholders, including the medical community, government officials, communities who want to begin their own initiatives, enablers and activists, media and communication groups, judges, public prosecutors etc - not necessarily from its own resources, but at least by offering to liaise between different groups.

d) Constant Updating of data on CSR/SRB: This group should also be able to organise through various governmental and non-governmental agencies a constant

8 It is pertinent to note that the minimum demanded of various constituents who were involved in the anti-emergency movement in the country was apparently just the desire/goal to defeat the person who introduced the Emergency. Thus the campaign was led by a Gandhian, and was supported by the LEFT as well as those who became the backbone of the Hindutva (Rightist) movement today. Of course the example of the Emergency is also a warning that once a minimal goal is achieved the chances are that the campaign will fold up and the internal contradictions will emerge and destroy the coalition. But that does not take away from the fact that the initial goal was achieved.

updating of current CSRs and SRBs in each district in the country. Such a constant updating would be useful not only in keeping track of, or monitoring the success or failure in implementation mechanisms, (and thus can be used to demand accountability from the State), but also would offer significant data to help mould the Communication Strategies that need to be set up at national, state and local levels.

It is also being suggested that similar State Resource Groups could and ought to be set up, at least in those states that currently exhibit very low CSRs, as well as those states where the CSR is likely to drop significantly because of high son-preference scores[9].

Thus these national and/or state resource groups would primarily function to **guide or facilitate** such a national campaign, but without having any **controlling** role. Such a group would have to consist of five to (a maximum of) ten persons who not only represent different perspectives, but are also willing to **truly listen to,** and **work with** those who come from different ideologies.

4.4
Particular Strategies for the Campaign

4.4.1 Strategies at Multiple Levels

i) Challenging Gender Stereotypes and Revisiting Affirmative Action to Encourage the Girl Child

As mentioned earlier working on overcoming/challenging gender stereotypes is directly connected with this issue of the declining CSR in the country. Therefore a conscious and strategic attempt should be made to rope in all those who are working on this theme of gender justice, to get them to include this issue in all their efforts – on the obvious ground that this is the most horrendous physical example of the inequities of a gender-biased society in which we live. This also means that efforts must be made by activists on this issue to include in their own monitoring efforts, the monitoring of those who give and take dowry in violation of the Dowry Prohibition Act, or who violate other pro-women laws of the country. This kind of tying in one's own work on this issue with other's working on allied issues should be an essential part of the strategy to work on the issue of the declining CSR in the country.

9 cf NFHS study by Roy (Indian Institute of Population Studies) and Rutherford(Population and Health Studies at the East-West Center in Honolulu, Hawaii) in 2003 on implications of high son preference and SRB figures in UP and Bihar.

Other incentive based schemes introduced by the government (centre and states) or non-governmental bodies have also been meant to fight the second-class status of the girl child in our country. However, a distinction must be made between those schemes which foster patriarchy (e.g. schemes which take care of the dowry of the girl, or help to fund her marriage expenses), and those which are geared towards helping the girl child develop to her fullest potential (e.g. scholarships for education). While it is obvious that the latter types of incentives must be aggressively fostered because they work more directly towards gender justice (and can be accessed even by those of the higher socio-economic classes), it is not necessary that the former type of incentives be discarded completely. Rather they can be used with discretion, and with the right kinds of modification. Thus for example, incentive programmes like 'Mangal Sutra' and 'Kuwarbai nu Mameru' which clearly support a patriarchal ideology can be re-named and the designated amounts given to the girl when she becomes a major to give her the opportunity to live a life of dignity and independence, rather than tying it up to a gift given at the time of marriage.

There is still another area where some form of preferential treatment for the girl child could also be explored. This would include special insurance schemes geared to non-employed women (apparently currently only 12% of LIC policies are for women) and/or offering preferences to women for employment or government schemes (like Public Distribution System shops) etc.

However, it must also be remembered, that most of these schemes are geared for the individual girl-child or family, and hence there is need for incentives or programmes to be planned for communities as a whole. Very little has been done on this level and some of the current efforts (like ballika janmotsvas, awards to panchayat where the SRB evens out, the creation of zero-violence zones[10], etc.) have to be upscaled and even more creative ways to recognise a community that has successfully worked on this issue need to be introduced.

On the disincentive side, the 'naming and shaming' of individuals, villages and communities in a public way (as has been done in some of the districts that the team has come to know about) can also function in a powerful way to get an entire community to take action to reverse a lopsided SRB rate and thus challenge gender inequity.

ii) Helpline for Lodging Complaints

In today's environment where increasingly the ordinary citizen is looking for a way to make his/her voice heard, it is clear that any effective instrument that makes it easy for this to happen will be increasingly used. In the case of this issue, the fact is that the large majority of civil society members either do not know about this Act, or even if they do

10 Swati, Gujarat, initiated such zones in some of the areas where it works.

have some awareness, they are clearly at a loss as to how to make a complaint or do something that would make a difference.

It is in this context that a toll-free hotline would play a significant role in enhancing the monitoring necessary for this Act to be truly implemented. The proposal put before the government by PLAN International[11] around 2 years ago (as has been explained to the study team) would seem to fulfil many of the necessary conditions of such a hotline and is worth exploring and implementing. Another option is to have a hotline similar to the CHILDLINE service (Toll free tel. no. 1098), which is serviced by teams of volunteers and/or NGO representatives around the clock. The advantage of this latter approach is that the caller would be able to interact with a person (which is far more satisfying) and the service could also offer information to those who desire it. However, as in the case of CHILDLINE, such a service would then have to take responsibility to follow up on every such call in its designated area, in order to ensure that action is taken. Whatever the modality of such a helpline, and though it may take time for the use of such a helpline to build up, it is believed that with adequate publicity members of the public who wants to get involved will find it relatively easy to do so through such a facility.

The internet based complaint mechanism is also a useful option though of course it would be limited to those who have access to such services, and hence cannot take the place of the ubiquitous phone services that have transformed the connectivity of the country in the past decade. However, since those who belong to the upper middle and higher socio-economic classes would more likely have access to the net, and since they currently comprise the largest group indulging in SD, this is a worthwhile option to expand and explore further.

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11 The proposal was based on a software that allows any complaint call received to be automatically categorized and then sent on to specific recipients without any human involvement. In the case of this issue of the 'missing girls' it is suggested that these recipients should optimally include (i) the central body invested with the responsibility of monitoring the issue, (ii) the local district and State authorities in whose area the 'infringement' took place and who are expected to take action, and (iii) finally any authorized non-government or community group which is willing to monitor action taken on such complaints in their local areas. In order for this to work, the government (and not a private body) must necessarily launch this hotline (though funding for such a service could come from a consortium of donors), so that any complaint received on this service would be considered an official complaint and the time and date of the complaint would be recorded and accepted as official. Such a service would create an accountability system, particularly as the local community that would also receive the complaint simultaneously would be able to follow up and use local pressure, the media, as well as the RTI act, to ensure that action is being taken on the complaint. Interestingly, since it is a software that can categorize calls, it would also be able to service complaints on any 'social' Act in the country (e.g. Dowry Prohibition Act, Domestic Violence Act, Rape, Sexual Harassment, Child Marriages etc) and hence would have multiple uses. Such a plan would have to be studied in order to iron out any potential glitches or misuse.

In either way such a phone and/or web-based hotline would offer the opportunity to transform a large number of 'passive' citizenry into 'active' ones, and create a far more effective means of monitoring and bringing pressure on those who violate the Act. However, it is very clear that any such helpline or website to lodge complaints would prove to be effective only if the grievances are followed up to their logical end, and so it must involve the local citizenry as a necessary element in its follow-up monitoring system. Extensive publicity for these services is also a sine qua non for the success of such an instrument.

iii) Keeping Track

In a world where information & knowledge truly has the power to change societies, keeping updated on a number of aspects related to this issue, and circulating the information and lessons learnt is crucial to the success of any campaign. This has been brought up repeatedly and in many ways by a number of stakeholders throughout the study. Here are some of the areas where this needs to be done either by the 'central group' (referred to in the Central Strategy section above), or by individual civil society groups.

a) Keeping track of all the legal efforts on this issue (successes, failures and ongoing attempts) going on all over the county is one of the areas that many consider very significant. This would help in a number of ways including the following: (1) activists involved with a particular case can be helped by the legal expertise/ advice of other activists around the country; (2) other activists can learn from the successes and failures of these various cases and can thus be helped to plan better for their own cases; (3) pressure can be brought by other activists at various levels e.g. by creating a high profile for such cases in the media, by asking to be included as 'co-petitioners' etc.

b) Similarly, in order to monitor the situation on the ground, a constant updating of the local SRB and/or CSR is crucial. A national strategy must explore the best means to do this and ensure that it is put in place at the earliest. This information must be carefully collected, collated and shared in an on-going manner with all activists that work on this issue. It can and should also be communicated regularly to all AAs around the country and thus used as part of an on-going advocacy campaign to influence both the Centre and the State, and to demand accountability of local officials.

c) Keeping track of pregnancies (not just in rural areas and in government-controlled clinics) is another obvious way of furthering the campaign – both because it tends to pre-empt the use of such illegal services as the medical community may offer, and also because it can help to identify the doctors and clinics where such illegal practices are rampant. The fact that it tends to focus on the woman who is already victimised is of course a matter of deep concern, but the fact remains that it is the most practical way of keeping track of the practice of SSE. Various efforts are being made by various activists to minimise the harassment of the woman by

trying to use such tracking only in order to offer leads in identifying the concerned medical service provider who offers these services on a regular basis. These alternative approaches must be explored, but it would be strategically self-defeating to completely ignore this obvious route to monitoring the issue. Since all doctors (even private ones) do keep records of all their patients, this is a tracking that can be done for all pregnancies, not just with those who come to government hospitals/clinics or in the rural areas. Like with the auditing of documents, such tracking of where women who have one or more daughters go to for various pregnancy-related services can establish patterns that can easily help to identify the most flagrantly criminal clinics/medical service providers.

d) Keeping track of complaints made in a way that is easily accessible to all, particularly to the local community where the violation is alleged to have occurred, is another important area where information can be used powerfully. Unfortunately this is not happening in any systematic manner at the moment, and in general there is apparently a deep reluctance or apathy at the district and state levels to ensure that such data is made available – perhaps because it would lead to much greater accountability. Hence the campaign must explore how the RTI Act can be effectively used to ensure that such a track is kept and complaints followed up on.

e) Keeping track of the consolidated records that each clinic must compulsorily hand over by the fifth of the following month is an absolutely essential element in furthering the implementation of this Act. While this of course needs to be done by the government agencies or officers appointed for the task, it would be very important to encourage civil society groups in each district to be included in keeping track of these, and thus function as community watch groups.

iv) Drawing in Other Actors/Influencers

One of the biggest weaknesses of this campaign, aside from the fact that there is a lack of coordinated work among those involved in this campaign, is the fact that out of the thousands of NGOs in the country, and even among the large number which consider working on gender issues as integral to their work, there are relatively very few who have taken up this issue of the 'missing girl child'. Even internationally, though this issue of sex selective elimination of girls has already become a serious issue in a very large number of countries, a number of important human rights watch groups/organisations are not willing to take it up[12]. Therefore, this issue suffers from the fact that while those who practice sex selective determination are obviously not interested in allowing the issue to gain much exposure, even those who should normally have been functioning as

12 Unofficially the reasons given by some activists for this absence in other Human Rights campaigns have been the fear that the highlighting of this issue would have an adverse impact on the right to abortion.

allies in this campaign to save the 'missing girls' are also shying away from speaking up. Furthermore, for these and other reasons, there is also difficulty in accessing funds for this campaign. Moreover, oftentimes when funds are made available for a particular effort, they are not sustained for the necessary period to allow the campaign/effort to take off.

Whatever the reasons for this in the past, it is clearly a necessary strategy for the future that a large number of other actors/influencers must be drawn into this campaign in some degree or other, and more funds on a long-term basis need to be brought into the campaign.

Among these various other groups that could be brought on board, those working on gender issues are natural allies to this campaign, and hence specific efforts must be made to reach out to include them. But there are many other groups that can be easily drawn into the campaign because of their focus on an allied issue (e.g. those which focus on Child Rights). Furthermore such inclusion can and must be expanded to specifically include panchayat bodies, which combine within themselves some of the qualities of civil society groups (in their closeness to the people) and governmental bodies (because of their elected status).

Religious leaders/groups are another set of players whom some groups have attempted to draw into the campaign. The 'value' of involving religious actors in such a campaign is clearly a contentious one and the reasons for this have been explained earlier in this report. Consequently what has been said earlier in this report needs to be reiterated here. First of all it may be important to realise that religious leaders and religious groups themselves often have a nuanced position on abortion. In fact many of them would accept abortion as the 'lesser evil' in some of the special circumstances listed in the MTP Act – namely in the cases of rape, danger to the woman's life and serious congenital defect in the unborn foetus. Similarly, the belief that religions necessarily foster superstitious beliefs and practices is a stereotype that is easily accepted when all religious leaders are lumped together as one. In actual fact there are significant differences of opinion on these and other issues even among religious leaders themselves, and it would be wise to avoid over-generalizations.

In the light of the above, and the understanding of this study team that religious leaders and religious communities definitely have 'some' influence over people's behaviours on a variety of issues, it would be a self-defeating strategy to forego the assistance that such groups/individuals could bring to the table. At the same time it would be important to carefully 'check out' or explore the stances of different religious leaders rather than making stereotypical generalisations. Subsequently the campaign can choose to ally with those specific religious leaders who are willing to take on board the concerns mentioned above.

Moreover, such explorations must not be done only at the macro level (e.g. all-India or State level), but also at the local level, since it must be remembered that individual leaders of local religious congregations may have different positions on these issues and may offer collaboration in different ways.

The campaign also needs to look beyond normal socially inclined non-governmental bodies, and include those who are not traditionally included in any such social campaigns. For example, this could include influencing community marriage bureaus and shaadi websites, popular web-based discussion platforms like ORKUT, shopping malls, etc and try to use their platforms to spread the messages of this campaign.

Of course in this context of drawing in other actors/influencers, a clear strategic decision has to be made (as mentioned earlier) regarding whether the issue of missing girls needs to be tackled on an emergency basis, or whether this is to be seen as a serious social issue. This decision is crucial as it will significantly influence the openness of the campaign to include various 'partners' into this effort.

v) Strategies for Communication

There is no doubt that the Media has a major role to play in such a campaign for many reasons including the following: changing societal attitudes towards the girl, bringing pressure on authorities, ensuring that the guilty do not get off free because of their status or influence etc.

The strategic question, however, is how best to engage with this media in the light of the realities of today in order to further the aims of the campaign. Obviously, too the strategies to be utilised would have to be different for different kinds of media, and not all groups/ individuals can interact successfully with all kinds of media.

a) At the Macro level

As far as the broadcast mass media is concerned, it seems to be clear that there is no possibility of a social campaign like this being able to compete with the level of financial investment that a campaign for a major consumer brand can bring to the table. Consequently, efforts to influence this kind of media has to be focussed on infiltrating electronic and print media rather than on trying to create new products (e.g. advertisements, serials, films, articles etc.) that would compete with those who have far more financial resources to flood the media. For example this would mean in effect that advocacy efforts in this regard have to be focussed on convincing major stakeholders (celebrities, script writers, directors, advertising agencies, etc..) to keep this social issue in mind when producing their own media products, so that they are willing to infiltrate

their own products with thoughtful and challenging references to this issue[13]. These intrusions into a regular 'storyline' would thus serve to 'co-opt' the broadcast media leading to the far more effective 'hidden persuasion' methods that would keep the issue constantly and subtly in the mind and thus more powerfully affect societal attitudes and practices.

However, the current efforts to do this 'convincing' of media managers through inputs at high profile meetings/workshops may not be the most effective way of going about such an infiltration process – though one cannot deny that such efforts also have some role to play as one of the means used to raise awareness of the issue. Personalized contacts may be a much more effective way of going about this kind of influencing. Furthermore, it must be remembered that such infiltration must not only take place at the mainline and English/Hindi media outlets, but also at the local language ones.

Furthermore on a national level there is no doubt that like the easily recognisable logos of the population campaign, or the HIV/AIDS campaign, there is need for this campaign too to introduce some nationally recognised 'tools' (whether it be a logo, and/or a theme tune, and/or a new practice/celebration like a 'sanrakshan band'[14] etc.) to be created and popularised so that there is constant and easy recall of this issue at all times and in all places. In this context it is the opinion of the study team that the government's present strategy to include the efforts towards the implementation of the PC-PNDT Act under the NRHM campaign, could tend to downplay the importance of this issue in the communication material prepared by the Government Departments at both the Centre and the States, and hence may tend to dilute this issue. However, this may not necessarily be the case and advocacy efforts to ensure that this kind of dilution does not occur would be important.

b) At the Mezzo and Micro levels

It seems to be clear to this study team that communication efforts to change personal practices are more effective when they are local or community specific. Consequently it would be more strategic to ensure that the major channelling of resources must be towards those working at the mezzo and micro levels.

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13 For e.g. L'Oreal's "I'm worth it" can be easily modified to speak of the 'girl child being worth it'. This would be called in-program messaging. There are many advertisements today which show the man and the woman, for instance, in non-traditional roles and thus work subtly to question the gender stereotypes of traditional society. Thus while the advertisement is for a consumer product, the in-program messaging questions gender stereotypes.

14 These were all suggestions that emerged at the mini-consultation with Communication experts that took place during the study. The 'sanrakshan band' is an idea that was proposed at this meeting and built around the celebration of raksha bandan but focused on 'protecting all girl children' not just one's own sister.

Furthermore, while support to produce non-interactive IEC material at these mezzo and micro levels is absolutely necessary, it would also be strategic to spend a greater portion of resources to support those who are involved in working with interactive material as it is the latter which more effectively change attitudes and behaviours. This would mean, for instance, that support of narrowcast media (street-plays, puppet shows, local theatre etc) would need to be given far greater support than has hitherto been offered by funding agencies.

Additionally, since the skills and capacities to produce such material and to disseminate them effectively are uneven across different groups/individuals in the country, it would be strategically important:

- To ensure effective coordination and mutual support between different players involved in these efforts: This will help to improve the quality of the material being created and also improve dissemination. For example, bringing the government departments and NGOs involved in producing such material together with communication experts from the advertising/media field would be a significant contribution to the entire campaign. In such a bringing together, communication experts who would be drawn into this network would bring their expertise honed by their own advertising media and other campaigns[15], while the government departments and the NGOs would contribute their own in-depth understanding of the issue so that the nuances are properly understood. Similarly, while government departments may have larger financial resources to produce such material, the civil society groups may have more of an outreach at the grassroots level to ensure that the material is effectively disseminated.
- To set up an effective feedback mechanism that would help individual 'producers' of such material to reflect on their own material in order to nuance the messages communicated: Additionally, in order to ensure the accuracy of the messages conveyed, it would be helpful to prepare and circulate a list of possible messages (in different languages) to be used by all those who wish to create posters and/or other non-interactive IEC material on this issue. This would help to overcome some of the difficulties and problems associated with the variety of messages being spread today including questions of terminology. For example, such a listing could ensure that some of the common enough reasons given for not having a girl (for example that a daughter cannot perform the last rites, or that daughters

15 Thus for instance the anti-smoking campaign apparently got a great fillip when it changed its messaging from 'smoking is injurious to the smoker's health' to the far more effective "smoking is injurious to the non-smoker's health" leading to the current practice of cutting down drastically on the places that people can smoke. The relevance of the lessons learnt from that experience, for instance, to a campaign on the issue of the 'missing girl child' is probably quite obvious – namely that the campaign probably needs to focus not on those who are indulging in SD practices, but on how such trends/practices will devastatingly affect those who are not indulging in such practices.

cannot look after their aged parents because they are 'paraya dhan' etc.) are adequately countered in this potential list of messages. Again, the dilemma as to whether such messages should focus on the criminality and/or immorality of such activities could also be addressed. It would also have separate types of messages depending on the targets being addressed and would therefore ensure that the right targets were being addressed.

- To advocate the need for greater inter-ministerial cooperation and coordination in government-produced material: Thus most earlier population posters would show a family in which there was always one boy and one girl, thus subtly further strengthening the belief that a balanced family necessarily involved having a boy and a girl. Similarly a transport department poster may rarely if ever show women as 'drivers'. In short, then, those producing IEC material for other Ministries could be made aware of the subtle nuances in their own material and be encouraged to bring about change. Additionally, some of the women friendly laws could be highlighted in IEC material produced for the relevant Ministries. (e.g. laws regarding the daughter's equal right to property, or the rule indicating that the woman does not need to give her husband/father's name in filling out government/ bank forms, or that the woman can keep her maiden name and does not have to take her husband's name, or the discount on registration fees on property if the woman is a joint/sole owner etc.). This kind of inter-ministerial cooperation would be of great value in creating an environment that attacks this problem/ issue from many fronts.

4.4.2 Strategies at the Level of the Implementation

While a significant portion of the resources of various groups has been focussed on the 'supply' and even on the 'demand' side, it seems apparent to the study team that not enough attention has been focussed on the implementation side, and on holding the State and its representatives accountable for the drop in SRB in each specific constituency. The concept that is gradually gaining ground today in other parts of government, that the concerned officer would be held personally accountable for failures to achieve a particular target in his/her area of control, should also begin to be applied to officers responsible for the satisfactory implementation of this Act at the Central, State and District levels. Strategically this would first involve clarifying the roles and powers of the various officers at different levels. The second step would be then to hold them accountable for carrying out the roles assigned to them, with **external verifiable indicators** (e.g. change in SRB figures) being used to evaluate their work.

There is also a significant problem being faced in the selection and functioning of Advisory Committees at various levels. The present functioning of these bodies is far from

satisfactory either because of the political nature or conflict of interest among the members of these bodies[16] or because of the lack of time or commitment to this issue on the part of its members, or because of the lack of resources made available to them, or the number of roadblocks placed in their effective functioning by the AAs or other powerful interests in the concerned district. Therefore, demanding accountability of these committees would be an important strategic move, though clearly this needs to be thought through very carefully, so that those who are truly committed do not suffer because of the failures of the others on these Committees.

There is a huge need for capacity building of all those involved in the implementation of this campaign. The need for capacity building and sensitisation efforts with the legal community is spelt out in the section on strategies at the Level of the Law (see # 5 below). Here it would be important to highlight the huge importance that must be given to the capacity building and sensitisation of the Appropriate Authorities, who, often enough, are not only ignorant of the intricacies of this Act, but are not even aware of their roles, responsibilities and powers. Furthermore they are often quite unaware of the requirements of functioning in a quasi-judicial capacity. Finally motivating them to see the importance of this issue and their crucial role in implementing the law is also extremely necessary, - as they generally tend to give less importance to this issue on various grounds (for example, that this is a private matter and not a social issue, or that this is a matter for which their own training has not given them the necessary legal expertise etc.).

4.4.3 Strategies at the Level of the Medical Community

As mentioned earlier, it is crucial to the success of this campaign to make concerted efforts to co-opt the medical community into working against sex determination and sex selective elimination practices. This can be done in a number of ways but would necessarily also include working with the Medical associations and the Medical Councils at the Centre as well as in the States. It must specifically be remembered that the above efforts must be geared not only to the doctors, but also to the entire medical community who are involved in and/or aware of these sex selection practices. This would mean working with Nurses (individually and through their associations), ANMs, hospital/clinic support staff, midwives, and even anganwadi workers and other 'middlemen' who generally function as crucial links in connecting the 'demand' to the 'supply'.

16 For example, the entire Advisory Committee in a particular district in Haryana unanimously asked the DAA not to take the doctors/clinics to court (though the law demands that) and asked him to go back on his earlier decision to seal and confiscate the machines - on the grounds that the clinics had only failed to keep records which the Committee considered a not very serious offence. This stand was taken though the Law specifically states that lack of proper maintenance of records is considered serious enough to take action against the clinics/doctors involved.

Simultaneously, efforts must continue to be made (by enablers outside the medical community, as well as by Medical associations) to ensure that the offering of these services becomes an extremely high-risk affair for doctors. These groups could severally choose to work on one or more of the four different tracks that have been pithily outlined in the campaign of the IMA, Maharashtra,

a) BAAT (awareness and sensitisation of the medical community and the medical associations/councils)
b) MULAKAAT (counselling and warnings to individual doctors who are violating the act)
c) LAAT (Willingness to initiate punitive action by complaining to the appropriate authorities and medical bodies about those who fail to change their ways, and/or to use various methods like sting/decoy operations and audit of records to 'catch' them in their criminal acts) and
d) HAVALAAT (Refusal to support any doctor caught in violating the Act, willingness to deregister and/or otherwise penalise him/her through actions taken by the Councils and Associations, as well as to publicly name and shame such doctors and medical personnel)

As far as the BAAT stage is concerned, it is strategically important that doctors and medical associations focus on animating and sensitising the medical community itself, and not waste their energy or resources on trying to do this with the rest of society (e.g. youth, women's groups etc.) as there are many others who can work with the latter.

As far as the LAAT stage is concerned, while the use of sting/decoy operations and audit of records would need to continue to be used, the 'public naming and shaming' (in a way that is legally permissible[17]) would also be an effective tool to be used. It is clear that a doctor's reputation in society is crucial to his/her self-esteem, and any harm to that is far more effective than any financial penalty.

Strategically, and specifically, all this would mean empowering/funding specific non-medical enabler groups in as many districts as possible to monitor and coordinate with the medical community (associations/councils etc) in carrying out the above activities. Such non-medical groups should be able to work in an intensive and sustained manner with this community after articulating clearly measurable short term and long term goals. In this context such groups could push the Councils to enforce their own professional ethics and conduct rules. Such groups could also lobby with the state in introducing the study of this and other social Acts into the curriculum in medical schools (e.g. Domestic

17 Thus, for example, a news item informing the public that a particular doctor has been caught for violating the act and the case is in court and could lead to the following penalties etc would stay within the legal confines of news reporting, and yet publicly name and shame the doctor in some small way. Subsequent updates on the case would keep the doctor on the defensive

Violence Act, PC-PNDT Act, etc), as well as work towards improving the quality and methodology of teaching medical ethics.

In addition to the above there are certain aspects about the law, which need to be re-visited. Some of the legal difficulties that have surfaced during this study are given in Part 1 of this report under the (Reasons related to the Act/Law and other Policies) section. However some of those that are of particular importance to the medical community include the following:

- The fact that a single radiologist or trained person is legally allowed to be the 'official' technician to as many clinics (and machines) as s/he wants, only means that it would not be physically possible for him/her to actually work the machine in so many places. In effect then this means that s/he has allowed the 'umbrella' of his/her name to allow owners of the clinics or other technicians to use the machine illegally.
- The allied question of who is to be considered trained is also a grey area easily open to misuse as has been explained in Part 2. This is something which reportedly the IRIA itself has brought up and which many others have similarly pointed out.
- The questions regarding ownership of the clinics and whether non-medical personnel should be allowed to open such clinics have been discussed earlier in this report. The concern is that this distinction between owner and user leads to a situation where the clinic is opened primarily to make money, and therefore fosters the breaking of the law in order to make profit[18].

There would also be no harm in finding out, as some interviewees have suggested, whether technological solutions can also be used to ensure the maintenance of records and their easy scrutiny. Thus, if all ultra-sound machines could be installed with built-in software that automatically records any use of the machine, and this programme is 'protected' so that no one could unlock it and erase records, then there would be an easier way of auditing the records and an easier way of ensuring submission of records. Apparently the newer machines may already have this capability of automatically recording all uses of the machine, but they do not necessarily 'save' it unless the operator wishes to save it. It might also help to try this technological solution in a couple of places on a pilot basis, before a judgement can be made on its practicability.

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18 From all over the study team received clear indications that the majority of clinics are owned by non-medical personnel who do not see themselves as bound by any ethical considerations of the medical profession and who have invested in these clinics purely to make money. Thus in Karnataka over 65% of these clinics are owned by these non-medical persons (As quoted in a newspaper article entitled 'PNDT Act Implementation in State unsatisfactory' by Nagesh Prabhu, The Hindu, 20th July, 2005, Bangalore, Karnataka

It may also be noted that (aside from a few interactions) there have been no significant efforts to target the machine manufacturers or retailers and this is a grave lacuna in the campaign. In fact the recent practice of selling new machines with an exchange offer, leaves open the possibility that the older 'exchanged' machines are not recorded and then sold illegally to other clinics or individuals without registration. The older exchanged machines can be officially shown as discarded and hence the sale of such machines remains underground.

Finally, however, it must be remembered that technologies to identify the sex of the child will continue to run ahead of any attempt to regulate it, and therefore it would be strategic for a policy advocacy that gets the government to commit itself to ensuring that any technology that could be used for sex determination should be specifically evaluated keeping the possibility of misuse before it is legally permitted for use in the country[19].

4.4.4 Strategies at the Level of the Community

i) Working with/through Community Leaders/Groups

While there are certain obvious difficulties, it is clear that the most effective way of influencing the 'demand' is to work through local community groups – whether they be SHGs, the local Panchayat, caste or linguistic community groups or in the case of youth with their own local groups. A local group can be defined as a group to which an individual feels a sense of belonging. It is this sense of belonging that allows the groups to have a greater influence over the individual in aspects of his/her life that willy-nilly are considered private and personal.

The problems with working through such groups (spelt out in Part 1) must be acknowledged and ways to overcome them should be specifically strategised for. This would and could include (i) identifying suitable leaders in each such local group who can be motivated and who can effectively function as local spokespersons; (ii) sensitising and building the capacities of these leaders so that they can be gradually nudged to perceive the issue in (what the campaign would consider) the right perspective; (iii) continue to relate with them on an ongoing basis in order to both influence their further steps in this regard, as well as to offer them the necessary support from outside the group (e.g. from the local administrative machinery) to enforce the law.

This would mean that civil society groups and other activists should focus on working through communities and their own leaders, rather than as 'outsiders' who work directly with the community.

19 cf section on Policy Advocacy (3.03.6)

Local Communities who are already experiencing the consequences that arise from the declining number of girls, (e.g. unavailability of girls for marriage) will perhaps be more attuned to take action to stop SSEs. With other groups, the first step would be to convince them of the urgency of the matter and for this disaggregated data specific to their own community would be an important tool. Consequently, methods must be found to get such data before beginning such work with the latter type of groups. Involving the community itself in collecting such data would have many obvious advantages, including the fact that it will probably be more accurate, and has an immediate effect on the community members who conduct such surveys.

Apart from community leaders, even political leaders and the administrative bureaucracy can also be more easily motivated to take action to curb the practice of SSEs in those constituencies where the sex ratio is significantly skewed. It must however be remembered that while such persons can bring to the issue many more resources from the government side, they can also tend to move the campaign in directions that serve other political agendas. Hence, while trying to influence such persons in order to bring them on board for this campaign, one must not only gauge his/her willingness to be part of this campaign, and his/her own level of acceptance within that constituency, but also judge his/her track record to ensure that he/she does not move the campaign in directions that would be far more harmful for women in the long run.

ii) Focus on Working With Youth

It is clear that the campaign must focus on those who are currently in their reproductive prime, as well as those who would soon join these ranks. This would mean that the entire campaign must focus primarily on the 15 to 35 age group, the age group that the UN categorizes as youth.

However since statistics show that a large percentage of our youth are not found in our junior and senior colleges, any campaign that intends to target the youth in this age bracket, must take this factor into account, and strategise accordingly. For instance, it is estimated that that only 10% of our youth of college-going-age actually attend college[20]. On the other hand since this practice of SSEs is more prevalent among the higher socio-economic classes, it is likely that among these classes a higher percentage of youth do attend school & college. Keeping both these factors in mind, it may be said that while the education sector can be a strong partner in such efforts, it is clearly not strategic to allocate a huge percentage of the resources available only to work with this section of youth who are attending school or college.

20 Estimate given by youth workers and organisations including CYDA

The methods used to target the youth must take on board some of the obvious and successfully tested methods of working with youth in general. These include the Socratic approach of evoking learning, and using interactive methods that lead to involvement, commitment & action. The aim is always to lead the youth to an internalisation of the issue that goes beyond just an intellectual understanding. In all of these the process, and not just the final product, is important.

It is also clear that this issue is not a 'women's' issue and hence must not be targeted only or primarily at women or female youth, as has been the case in many activities organised by different stakeholders around the country. In fact it has been repeatedly pointed out to the study team that the real decision-makers in a family are the men, and therefore animating the women alone is not only less useful, but also strategically mistaken. This must particularly be kept in mind when working with youth, and therefore any such efforts must equally be directed to the males as well as to the females. Unfortunately in many such programmes the males are present only in token numbers as compared to the women.

Among the student population, there are two sets of students that need to be particularly targeted in such efforts – those who are preparing to work in the medical profession (doctors, nurses, para-professionals etc) and those who are studying law. This would necessarily include advocating that this Act, and a study on it, be introduced into the respective curricula. In addition it would be important to offer capacity building so that this issue/theme can be taught in interactive and interesting ways in order to get these youth to reflect on the issue. It must be remembered that the skills to teach this issue in an enlightening way is as important as including the topic in the various curricula. Financially supporting a group of trainers to assist the government in exploring and suggesting how this Act and Ethics could be taught more effectively would be an example of a tactic that could be part of such a strategy.

4.4.5 Strategies at the Level of the 'Law'

It became very clear during the study that with regard to the knowledge of the details of the PC-PNDT Act and its Rules, there is a significant lack of knowledge among many, as well as a certain degree of confusion or difference of opinion even among those who are very active in trying to enforce the law.

Additionally, while there are quite a few who believe that the law does need amendments, there are others who believe that strategically it is better not to try and amend the law at the present stage. According to the latter, the law has not really been implemented enough, and it is only in trying to implement it more often and in various contexts that it

would be possible to see more clearly and completely where the difficulties are and a more comprehensive set of amendments can be suggested to the legislature and/or the Court.

From a strategic point of view then it is clear that it is first of all essential that a common understanding on the law needs to be built up among activists, AAs, the central PC-PNDT cell and other stakeholders who are committed to this issue. The mini-consultations that the study team had organised with different homogenous groups could function as a pattern for the kind of meetings that ought to be convened on clarifying the law. This could be followed up by commissioning a set of lawyers who are involved with this issue (from different organisations and a variety of perspectives) to sit together and come up with detailed answers to the questions that have emerged from various groups/individuals who have worked on this issue, as well as to collate the best kind of amendments that need to be introduced either now or later. This needs to be done urgently for the reasons offered in the next paragraph.

Since the VHAP has already set in motion a new PIL in the Supreme Court, the question of whether it is strategic to introduce a PIL at this stage (or not) is somewhat academic. Consequently, it would be important to use this above-mentioned commission of lawyers and their findings to support and guide the VHAP in the effort that it has undertaken. This is particularly urgent, since the Central Supervisory Board is already considering certain amendments (based on suggestions received from individuals and groups) and it would be important that the Board does not present its recommendations to the Court until the above exercise is satisfactorily carried out.

In the light of the fact that the knowledge of the law is allegedly limited even among the judiciary at different levels and public prosecutors in various states, the above referred conjoint study must be followed up by sensitisation and orientation sessions with these pivotal members of the legal community. It has been brought to the notice of this study team that a request has already been made to one funding agency for such sessions to be conducted in the Judicial Academies in 14 different states. This is a wonderful opportunity and is the kind of request that would need to be acceded to with alacrity. Similar opportunities should be explored with other groups (e.g. with Public Prosecutors) which have a significant bearing on the successful completion of such cases. Moreover such an opportunity should not end up being a one-off session, but should be followed up with subsequent mailings (e.g. net-based mailings or in the form of a regular printed newsletter, or through already existing widely circulated legal update journals) and/or other forms of interaction. Through these an effort must be made to continue to keep the relationship going and to continuously update the judges and PPs on the case law around this Act in different parts of the country. Such mailings from a 'known' source would ensure that even if a particular decision is unfavourable, there would be the option of giving the

judges a commentary on the decision in a way that would encourage them to think about such judgements and about this Act in particular.

Another important strategy would be to advocate for fast track courts to take care of many of the gender and child-related Acts (PC-PNDT, Dowry Prohibition Act, Domestic Violence Act, Rape, Sexual Harassment, Child Marriages etc). Besides being a valuable addition to the arsenal that would be available to campaigners on this issue, such an effort would also be strategic in that it would create links and common cause with campaigners on these other issues and thus strengthen the campaign as a whole. However, the fact that past experience has shown that fast track courts can themselves become overburdened and then function at the same speed as other courts must be kept in mind in planning this strategy.

It must also be remembered that despite the fact that often enough there is confusion and differences in interpretation on a number of crucial areas, it is also true that there are certain aspects/areas in which action can already be taken in accordance with those aspects of the law that no one disputes. Thus, for example, (according to the study team and others met during the various mini-consultations) the law is clear that the district AA can be anybody appointed by the State, and does not have to be a doctor. In matters like this where the law is clear and there is no ambiguity, it would be strategically important for the campaign to carefully discuss and decide whether it would like to first push for different options to be tried in different states and districts, before coming to a conclusion as to who are the best kinds of candidates for such a quasi-judicial post (e.g. which government officers or non-governmental persons). In this context exploring other set-ups (e.g. Juvenile Justice Act and Child Protection Laws, Consumer Movement etc) might throw some light on what would be the best approach.

As far as the enforcement of the law is concerned it has been made clear in the earlier part of this report that the two major methodologies that have been used to 'catch' violators in the medical community have been: the use of sting/decoy operations, and the audit of records. With regard to each of these methods there is a strategic action that needs to be taken urgently.

- With regard to **sting/decoy operations**, the Supreme Court has recently declared that it would be studying the various sting/decoy operations conducted by news channels and offering its own guidelines/reflections on them. In such a context, it would be strategic for campaigners on this issue of missing girls, to find a way to interact with the Court and share with it their own experiences in conducting such operations. This is essential in order to ensure that the Court has a holistic picture of these operations (for e.g. that they are not all being conducted just for higher TRPs as the court may tend to think if it focuses only on the news channel operations, or that with reference to the PC-PNDT law, such operations will

have a completely different relationship with the police as compared to any other law that is being breached). Furthermore it would help the campaign very much if the Court itself mandates the guidelines/principles/methodology to be followed (e.g. with reference to 'rewards', to selection of witnesses, or complainants), because then it would offer clear guidelines both to activists and to judges in using these operations to enforce the law. In this context it would also be very important for campaigners on this issue to get involved in articulating and creating the 'rules' that are currently being studied in order to set up a Witness Protection Programme/Act in the country, as this would have a direct bearing on the witnesses/decoys who are providing assistance in such operations.

- With regard to the **audit of records** there is an urgent need for those who have expertise in this field to interact with judges to explore the legal value of such audits and perhaps to get some guidance from the judges as to how to improve the carrying out of these audits in order that they may be considered acceptable evidence in court. Interacting with the judges would also have the additional invaluable benefit of educating the judges themselves to the evidence-value of such audits. Having carried out this exercise, it would then be strategically important to bring out a handbook and/or conduct training sessions for those interested in the issue (especially 'enablers' and committed 'implementers') in order to empower them to be able to carry out such audits in their own areas in a more effective and systematic manner so that they are accepted by the courts as sufficient evidence to prove the violation of the law.

4.4.6 Policy Level Advocacy

There are certain areas in which there is need for policy advocacy. Some of these are explained below:

A glance at some relevant findings regarding abortions in India are revealing. India's second trimester abortion rate is thought to be among the highest in the world, estimated annual number of induced abortion varied nationwide from 0.6 to 6.7 million (Chhabra and Nuna; 1994)[21]. Studies show that women undergoing sex selective abortion are the groups most likely to attempt second trimester abortions (Johnston; 2002)[22] Non-registration of clinics under the MTP Act and lack of coordination between the officials looking after the PC-PNDT and MTP also leave the door open for the use of MTP provisions to furtively carry out SSEs The findings of these studies clearly indicate the

21 Cited in Dr. Sharad Iyengar 'Current status of abortion in India', ARTH source hhtp://www.indianngos.com/issue/women/foeticide/dr_iyengar.htm

22 H.B. Johnson, 'Abortion practices in India: A review of Literature', Mumbai CEHAT and Health Watch, May, 2002.

need to re-look at MTP within the context of its bearing on the issue of SSE of girls despite the concern of some that this would unnecessarily create problems to women having a right to abortion in certain circumstances.

Similarly there is no doubt that the population policy of the government and its various attempts over the years to enforce and later to encourage the small family norm (even if through incentives or disincentives) is another area that must be reviewed in the light of its clear relationship with the practice of sex selective elimination. In fact an ALL INDIA CONFERENCE on Implementation of the PC-PNDT Act held in August, 2005 organised by National Commission for Women clearly resolved that "disincentives and other coercive measures to ensure small family norms must be dropped from all population policies and measures at Central and State Levels".

The whole issue regarding SSEs also needs to be looked at within the broader context of the population policies with specific reference to New Reproductive Technologies (NRTs) that are flooding the world today and for which increasingly a foothold is being sought in India. As no technology is value-neutral, and choices to allow (or not allow) these technologies into India are never made in a vacuum, it is important to be vigilant about power relations determined by race, age, class and gender while examining implications of NRT on different stakeholder groups. Philosophical and medical details of NRT need public debate without an iron wall of secrecy, in all Indian languages, as NRT is penetrating even into those areas where it is difficult to get even safe drinking water or food.[23] It is very clear that these NRTs will have significant implications for the child sex ratio and the SRB in India.

It is also important to review the actual functioning of the various schemes offered by different state governments (Annexure V) in order to judge whether they are actually achieving their objectives, and/or whether the funds are being used only by a few who know about these schemes. Towards this end it will help significantly if the government would be pushed to release the status reports on each of these schemes every quarter/ half year in order to understand the impact of these schemes.

The recent move by the Government of India to move the implementation of this Act into the NRHM 'family' is another area where policy advocacy needs to be done urgently in order to expand the opportunities to integrate this issue among other interventions of the Ministry(e.g. training of ASHAs, ANMs and in the publication of maternal health related material). If this is not taken up urgently there is a distinct possibility that this issue can easily be lost under the larger umbrella of NRHM since many of the health related schemes would be clubbed together and so monitoring of this issue could get less attention. Those

23 A paper entitled 'A cultural Deficit' by Dr. Vibhuti Patel, August 2003

working on this campaign could advocate strategically, there could be additional funds and human resources for monitoring this issue since the basket of funds is larger[24].

Another area for policy advocacy would be to try and get this issue clubbed with other efforts by the Government. Thus the polio eradication campaign which involves volunteers in collecting data on the children in a family below a certain age would be an easy place to collect the sex of each such child and thus automatically give the government an updated status on the CSR. Similarly clubbing this issue with the ICDS programme and other such Government programmes would be very useful.

What must also be remembered is that a lot of the success of all the above mentioned strategies is directly affected by the level of political will in the country - whether at the Central or state levels. A strong political will can do wonders as has been shown in Gujarat, in parts of Punjab and in other places. Hence creating such a political will must be an underlying strategy in all the efforts of this campaign.

In this context it might be an important advocacy goal to try and bring about horizontal linkages between the various social Acts in the country, so that for example the new domestic violence Act is sought to be linked to the PC-PNDT Act as very often women are forced by families to go in for sex selective elimination services, and so can be construed to involve mental torture. Thus working on the political front is obviously crucial to the success of this campaign.

3.04
Conclusion

The above suggestions for future strategies are obviously not meant to be carried out by any one particular group or individual. They are offered here as crucial and necessary elements that would need to be taken on board by the different campaign activists, with the hope that the central coordinating 'group/centre' referred to in the section entitled CENTRAL STRATEGY would be able to have an overview that would help to identify which particular strategies are being left out and then identify and encourage specific groups or individuals to address them.

24 The recent guideline from the Centre to the States to include this programme under their plans for NRHM was reportedly actually not complied with by a number of states as they have included it under the RCH2 programme. This is only an indication of the kind of control (or lack of it) that central departments have over the States on these issues, especially as Health is a state subject.

ANNEXURES

Annexure I

Methodology
&
Theoretical Background

This annexure has three parts, which are as follows:

1. **Approach and Methodology of the Study**
2. **The "Ends and Means" Ethical Dilemma**
3. **Understanding ADVOCACY**

1. Approach and Methodology of the Study

In 2005, UNFPA - India, felt the need to commission a study to take stock of its own initiatives and develop a roadmap that would guide its future advocacy efforts in the area of sex selection. For strategic reasons UNFPA felt it would be better to get this study done by a team that had an understanding of advocacy and campaigns and was as yet not closely linked to this issue, in order to get an independent or 'outside' view of the campaign. Accordingly Mr. Josantony Joseph (Lead Consultant, Executive Board Member of National Centre for Advocacy Studies) and the Centre for Youth Development and Activities, (CYDA) Pune, were commissioned to do this study over a period of around 4 months. CYDA, in turn, took on board four full-time research associates two of whom had already been involved with the issue in some way or other.

The objectives of the study were as follows:

1. Understanding the gamut of reasons why despite all the advocacy & other efforts by various actors on the issue, the child sex-ratio in the country continues to be dismal;
2. Reviewing the efforts of various stakeholders on the issue and reflecting on the strengths and limitations of such efforts;
3. Exploring ways forward and suggesting guidelines for future strategies to UNFPA.

It was clearly understood that the study was not meant to be a formal research study, nor an evaluation of the work of any particular organization or effort. It was meant to be a study that would look at UNFPA's efforts within the context of the other work carried out by a wide variety of actors involved in this campaign, in order to arrive at what would hopefully be valid insights and strategies that could guide UNFPA's work (and that of the campaign as a whole) in the near future.

In the light of the above, a decision was made (in consultation with UNFPA, Delhi) to concentrate on 9 states spread out over 3 clusters. In the North, these included the states of Himachal Pradesh, Haryana, Punjab and Delhi; in the West they included Maharashtra, Gujarat and Rajasthan, and in the South the two selected were Karnataka and Tamil Nadu. With the

help of UNFPA and through a snowballing method[1], the team got in touch with various stakeholders – both those 'converted' to the importance of this issue, and the 'non-converted' – in these states, focussing broadly on these four categories:

i) Communities (including individuals and groups)
ii) Enablers (those who have actively worked on this issue at various levels)
iii) Medical Service providers
iv) Implementers (those entrusted with the implementation of the Act)

It was also clear to the study team and to UNFPA that within the context of a short duration of approximately four months (including preparation, field visits and writing of report etc) there was no possibility of interacting with ALL the 'actors' in the 9 different states that the team was asked to visit. Secondly, since the project had been assigned by the UNFPA, there was no authority given to the study team to demand documents or cooperation from any of the other 'actors' who have been significantly involved in this campaign.

Keeping in mind these contours, the study team created their own process which used insights from the case-study approach and the Delphi method. These 'connections' are explained below.

a) An Approach that is Analogous to the Case Study Approach:

First of all, keeping in mind the limitations of time, the study team decided to follow a 'case-study' kind of approach – an approach that does not demand a quantitative kind of sampling of a large population/universe, in order to arrive at a scientific generalization.

"Case studies… are generalizable to theoretical propositions and not to populations or universes."[2] What this means in effect is that the "the investigator's goal is to expand and generalize theories (analytical generalization) and not to enumerate frequencies (statistical generalization)"[3] Thus, a case study approach uses the study of a few cases to check the validity of a theory that the researcher already has, and if the cases studied validate the theory, then it is scientifically legitimate to consider the theory as a valid explanation of a particular phenomenon. The case study approach therefore allows the researcher to check in a scientifically reliable way whether the reasons given in explanation of why a particular project or programme is effective or not, are valid. This is known as 'analytical generalization' and is distinct from the statistical generalization method that most people are familiar with. "In statistical generalization an inference is made about a population (or universe) on the basis of empirical data collected about a sample.[4] However, in analytic generalization "a previously developed theory is used as a template with which to compare the empirical results of the case study. If two or more cases are shown to support the same theory, replication may be claimed".[5] Therefore this approach is extremely useful for studies of social projects where very often a scientifically selected sample may not always be possible.

1 "Snowballing" sampling is a process of selecting samples based on the snowball effect, i.e. one case gives a reference to another, and the second to still another and so on and so forth.
2 "Case Study Research – Design and Methods" Yin, Robert K. pg. 21, SAGE Publications, Revised Edition1991.
3 Ibid, p. 21
4 ibid, p.38
5 ibid, p.38

Keeping in mind this approach, the study team first explored the campaign with an initial set of stakeholders/actors ('cases') under the four categories of respondents mentioned above, by asking them what they thought were the reasons why the campaign has worked or not worked so far. These reasons ('theories') were then collated and presented to a further group of significant stakeholders/actors at a workshop held in Pune on Sept. 11 & 12, 2006. The outcome of the workshop was that the participants at that workshop generally confirmed (with a few modifications) the outlining of the reasons why this campaign had generally not taken off over the past few years despite the significant work that had indeed been done. These reasons (or 'theories') are presented in Part 1 of this report that is entitled, LOOKING BACK.

Next, using this 'theory' as to why this campaign was still lagging behind, the study team then interacted with an additional set of actors through various mini-consultations (see Annexure # II for list of participants in these various mini-consultations) to further analyse the campaign, and explore their ideas as to how this campaign could be taken further. There were also other individual interactions that were organised/conducted in this second stage.

Finally, the study team put all this 'data' together and in order to learn lessons for the future, analysed the strengths and limitations of the efforts made so far. This was put together in Part 2 of this report entitled, LOOKING BACK to LOOK FORWARD. In the light of these two earlier parts, the team then put forward a list of strategies that it felt in its considered opinion were crucial for a future successful campaign on this issue. This was put together in the Part 3 of this report entitled, LOOKING FORWARD.

Keeping in mind the similarities of the process followed with the 'case study approach' that was utilised, the study team believes that there is validity in the findings presented in this report, even though the selection of the cases were not based on a quantitative sampling method, based on references, newspaper reports, well-known campaigners, or through a 'snowballing'sampling process.

b) An Approach that is Analogous to the DELPHI Approach:

The DELPHI method of study is a method used in those situations where a completely scientific method is not possible.

The Delphi method uses a panel of selected 'experts' who are selected for a reason, i.e. they may hold knowledge or opinion or a view on a particular topic. The person/team coordinating the Delphi method finds a way to ensure that the responses of such a panel are collected, then collates/synthesizes them, and then checks it out once more with the same panel and/or with others who are selected for similar reasons. Thus through this back and forth process of collecting views and getting it validated or checked with others who could be considered 'experts' on the subject, the coordinator(s) of the process can come to a very accurate idea of the matter to be studied or evaluated. After several rounds the process is complete and the coordinator(s) can come to final conclusions that are most likely to be valid to the phenomenon being studied.

This process has many similarities to the process employed by the study team. Before setting off on the inquiry and in the process of deciding on what needs to be done and

how most effectively it could be achieved, the research team had first dealt with the question of:

- What kind of group communication process is desirable in order to explore the problem at hand?
- Who are the people with expertise on the problem and where are they located?
- What are the alternative techniques available and what results can reasonably be expected from their application?

In working out these questions the study team decided to begin with identifying the various stakeholders and 'experts'[6] working directly on the issue or other related issues (e.g. gender equity) that directy impinge on the phenomenon of sex selective elimination of females. The purpose was to access and interact with those who are closely connected and thus may have significant knowledge, opinions or views on the issue. These 'experts' included

i) **Enablers**: including individuals, and organisations (e.g. NGOs, CBOs, individual doctors, government officials and others)
ii) **Communities**: i.e. communities proactive in addressing the issue
iii) **State and its representatives**: Members and representatives under the implementation structures of PC-PNDT including the AAs, advisory committees, central & state supervisory boards, other government representatives like District Collectors etc. who were involved in implementing the Act.

The underlying tenet behind the excerise was to garner the views of well-informed individuals, calling on their insights and experience, to guide the inquiry on the question of what plagues the present campaign and what needs to be done in the near future to strengthen it.

The process involved interacting with this group of stakeholders and sharing the findings of the preceding rounds with the 'actors' so that the participants could, in the light of what is being said by others, reflect/review their own opinions on certain questions that were being posed with regard to certain critical aspects of the campaign. Through these discussions and the sharing of the findings of preceding interactions with the actors, and then taking these to the subsequent interactions, an attempt was made to explore the thesis-antithesis on the facets of the issue to ultimately arrive at some sort of synthesis of ideas.

The application of the Delphi process in the context of the present inquiry enhanced the creative exploration of ideas and fostered the collation of suitable information to aid decision-making.

Sample

The study was conducted in the nine states of Delhi, Haryana, Himachal Pradesh, Punjab, Gujarat, Maharashtra, Rajasthan, Tamil Nadu, and Karnataka. The rationale behind selecting these states was to get a good mix of different regions facing the problem and also to include states where there may have been breakthroughs (for instance in certain districts of Tamil Nadu and Punjab). However wherever possible efforts made outside these nine states were also included and special efforts were made to interact with these or to collect data about their work. Thus for instance the efforts of various District Collectors like Dr. Manohar

6 i.e. those who had been working on the issue for some time and therefore had clear opinions on the issue and how best to deal with it.

Agnani and Dr. M. Geetha in Madhya Pradesh and Mr. Arvind Kumar in Hyderabad, Andhra Pradesh were also explored.

In the second phase of the study, the team organized a series of mini-consultations on this issue with a variety of groups of 'homogenous' stakeholders at different venues in India. These included a group of medical service providers, lawyers, communications experts, enablers, religious leaders, etc[7]. In addition, the team made it a point to interview a number of UNFPA staff, some government officials, and other significant individuals who could not be met in the first round of interactions, and/or from among those earlier interacted with but from whom further information was needed.

A list of individuals/organisations accessed by the study team in all these states is appended at Annexure # II.

Data Collection

In order to ensure a commonality of data collected, the team prepared a series of themes around which information and views were to be elicited. These were generally followed and modified further as the process was underway.

In addition the process of data collection (in the form of opinion/views) from experts and 'actors' working on the issue in the second phase of the study, involved sharing of findings (the different viewpoints and opinions) from previous meetings and exploring future strategies in a group discussion or individual interview format.

Sources of Data

Both primary and secondary sources of data were used. The primary sources included the data emanating from the field during the visits and meetings with different 'actors' in the course of interacting with them during the study.

The secondary sources of data included articles, studies, and both published and unpublished material including those accessed through the Internet. The secondary sources accessed often provided leads to other significant 'actors'/'players' and efforts associated with the campaign, and this in addition also formed a part of the concomitant effort to also create a resource base of significant material already existing on the issue.

The study team during the field visits also accessed IEC material on the issue, which was in the form of posters, films, audio-visual aids, etc. An annotated list of such IEC material is appended at Annexure # III b.

Most importantly, throughout the process there were numerous group and individual discussions among the team members that helped them struggle with and make sense of the various 'data' that was flowing in throughout the process. All these helped to create the current report.

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7 Please refer to Annexure # II for a complete list of participants and groups.

Report

The report is presented in three parts. The first part of the report, i.e. the 'LOOKING BACK', focuses on the various reasons as perceived and shared by the various stakeholders on the question of 'why' despite all the efforts the sex ratio in the country continues to be dismal. This was presented at the first workshop organized in Pune on Sept. 11 & 12, 2006, and the comments and views expressed by the participants were reflected on by the study team and incorporated as found necessary in the text of that report.

The Part 2, i.e. the LOOKING BACK to LOOK FORWARD deals with the efforts done so far by various 'actors' in addressing the issue and analyzing the strengths and limitations of the efforts made from the point of view of learning lessons for the future. In the light of this review of strategies, Part 3, LOOKING FORWARD enunciates the strategies for the future for the campaign as a whole.

The entire report was presented at the second workshop organized in Delhi on Nov. 30 & Dec. 1, 2006, for validation and the comments and views expressed by the participants have been incorporated appropriately in this final report.

A separate workshop for UNFPA staff took place on Dec. 6 & 7, 2006, for presentation of the complete report and also to present and discuss specific strategies for UNFPA in the light of this study. This report is an internal document of UNFPA and has not been included in this report. However, the strategies specific to UNFPA are drawn from the general strategies presented in this report by taking into account the UNFPA niche in the whole universe of the actors of the campaign.

2. The "Ends and Means" Ethical Dilemma

Very often during the study the ideological differences that surfaced among the different 'actors' raised ethical dilemmas that can be generally termed "ends and means" ethical dilemmas. For instance, is it ok to monitor women's pregnancies in order to end the pernicious practice of sex selective eliminations even though the woman is often the victim herself. Or is it ok to join with those whose political agenda is seriously unethical, but whose help would be very helpful in working towards elimination of SSEs etc. The following extended quote from a book, "An Enquiry into Ethical Dilemmas in Social Work'[8] edited by the lead consultant to this study responds to this concern:

> "It is in this context that one comes to the study of ETHICS which can be defined as the study of the principles of how to choose 'rightly' when different values clash. In other words the science/study of ethics comes into practice when human beings have to choose between competing values.
>
> In this context, it is suggested here, that no human being (however 'evil') chooses evil for the sake of the evil. An example might illustrate this better – Suppose in a situation of a communal riot in India, a mob is chasing a member of a different religious group in order

8 "An Enquiry into Ethical Dilemmas in Social Work" edited Joseph, J & Fernandes, G, Research Unit, College of Social Work, Mumbai, 2006, pg 28-30

to kill him/her. In an attempt to escape from the mob, the fleeing person hides in a place that certain bystander knows about. If then the mob comes to the bystander and asks him/her where the person is hiding, few would deny that it would be ethical for the bystander to 'tell a lie' and deny knowledge or even guide the mob in the wrong direction. But is the person who responds with a lie, really choosing between honesty or dishonesty? Isn't it more likely that s/he is being forced to choose between two values, i.e. honesty and love of neighbour (i.e. saving a person's life). Alternatively, this could also be seen as the choosing of the lesser of two evils, i.e. dishonesty or lack of love of neighbour. Similarly, a robber or a murderer who carries out an act that society considers cruel or evil, is always doing it for some 'good' that s/he hopes to gain by that act. We might disagree with whether that choice was indeed the ethical choice, but for the robber or murderer there is a 'good' that seems to be attainable by doing such an act – a 'good' like increased wealth for oneself, or taking revenge for some earlier done to him/her or some other reason that s/he perceives as a 'good' for him/her.

Thus, though a value (e.g. honesty) and its opposite/corresponding dis-value (e.g. dishonesty) are two sides of the SAME coin, in all situations, a person (whether that person is considered good or bad) is always choosing between TWO different coins (e.g. between honesty and love of neighbour) and not between two sides of the SAME coin. So it is not a choice between honesty and dishonesty, (i.e. two sides of the same value coin) but between the greater of two values (honesty and love for neighbour) or the lesser of two evils (dishonesty and hate of neighbour). And unfortunately our human finitude/ limitations demand that we can choose only one.

This insight that all ethical choices are between two values or dis-values (i.e. choosing the greater good or the lesser evil) helps to overcome the oft-faced dilemma between whether 'the ends justify the means' or not. What this clarification is saying is that it is not a question of 'ends justifying the means' but a question of choosing between two different ends or two different means – both of which espouse different values. This is a crucially different way of perceiving such ends-means dilemmas, because what it is saying in effect is that a good end can never justify an evil means, but one good could override another good only when one **has** to choose and **can** choose only one of the two.

Therefore, in such situations where human beings are faced with a dilemma, ETHICS offers a series of rules or guidelines, which can help us to choose rightly between two such values or goods, - and such 'right choosing' is called ethical. IN real life, it seems that there is certain unwillingness, or perhaps an inability, to grapple with ethical dilemmas in a way that is not ultimately controlled by **convenience to self** or our own **cultural upbringing**…

In that sense ETHICS is a philosophical science, based on rational thinking, with the ultimate aim of helping us choose between values. It offers us guidelines on when it would be right or not right to give up on certain values in favour of other values. These guidelines are themselves based on the principle that in order to live a VALUE-based life, one must not normally give up ANY value, when choosing a course of action. But it is also realistic in that it accepts that often we HAVE to choose between two or more values (because of the limitedness of our human situation where we cannot choose everything), and where even 'not choosing' is, at times, itself a choice for one or other value."

Applying the above reflections to the current study, it is clear that there is no question of justifying a method that some claim victimises women even further (e.g. the pregnancy watch) on the basis of some "end", but rather a question of 'weighing' the two 'ends or needs involved': (i) the need not to victimise women even further, and (ii) the need to protect the unborn girl child from being aborted. Similarly the question of abortion rights for women (another ideological divide among the 'actors' working on this issue) has to be seen as the choosing between the rights of women over their bodies, and the rights of a human foetus's right to life. In all such cases it is not an 'ends and means' dilemma, but a dilemma as to how to choose between two 'ends'. Ethics is all about HOW one chooses validly between two or more ends.

3. Understanding ADVOCACY

As Advocacy means different things to different people, it is important to explain the understanding that underlies the term when it is used in this report[9].

The history of Social work is the history of the attempt by social workers/activists to find the best way to work for the underprivileged and the disadvantaged. In trying to respond to the deprivations faced by so many individuals and groups, social workers and those involved in the helping professions in general, have come to realize that while working for sustainable and wide-ranging change, it is important to engage with those structures that can be called by the generic name: the STATE. This "State" refers to those institutions set up in human societies to 'order' the interactions between human beings living in that particular society. There are, of course, significant differences between those states which gain their legitimacy from the people (democratically elected States), and those that gain their legitimacy from the use of power wielded by a few (dictatorships, oligarchies etc).

Advocacy functions within the context of a **democratic State**, where the raison d'etre of the State is to serve its members by ensuring their basic rights – whether economic, social, cultural, civil or political. Consequently, many groups engaged in working for the amelioration of the plight of the deprived, have realized that engaging this democratic STATE is an essential element in any effort to bring about sustainable and wide-ranging change. There are a number of reasons why social advocates have come to this conclusion. These include the following:

a) **Primary responsibility**: It is after all the responsibility of this State to be working full-time to ensure 'freedom from want' and 'freedom from fear' for each of those who live within the geographical boundaries where it exercises its mandate. This it can do by enacting policies and laws that enshrine such freedoms even as it allocates resources to ensure that these freedoms are actually enjoyed by its people. This is primarily the responsibility of the Legislature.

b) **Resources**: Compared to the resources available with individuals and groups in civil society, the State has at its disposal not only an immensely larger resource base, but also the authority to ensure that sections of its citizenry do not take undue advantage of other more deprived sections, and that these common resources are effectively used to ensure the basic rights enumerated above. This is primarily the role of the Executive (both political and administrative).

9 The ensuring explanation of advocacy has been adapted from some of the manuals on Advocacy that have been prepared by Mr. Josantony Joseph

c) **Sustainability**: Sustainability of any effort to improve the lot of the deprived can only be maintained if the State decides to translate this desire into policy and law, so that its implementation is not based on the goodwill of individuals who may be in power at the moment, but is an obligation on all individuals and organs of the state. There must therefore be an organ of the State set up to ensure & monitor that this is happening, and which can penalise those who work against these policies and laws. This is primarily the role of the Judiciary.

Therefore, engaging with this State in order (a) to ensure that it enacts the necessary policies/ laws and introduces changes when necessary, as well as (b) to ensure and monitor the proper implementation of these laws, is what **ADVOCACY** in general is all about.

There are, of course, many groups that function to help the marginalized, but refuse to accept the legitimacy of the current State within whose geographical boundaries they live. This would include for example, the Naxalites in India, the LTTE in Sri Lanka, and till recently the Maoists in Nepal. Therefore, their efforts are not considered as Advocacy efforts in the meaning of the term that is accepted here. Advocacy efforts are different, in that though advocacy groups may be geared to overthrowing/changing the current Government that is not the same as working to overthrow the State itself. The difference is that such advocacy efforts use the 'spaces' available within the State's structure (e.g. elections) to change the Government. Hence, **governments**, as long as they are in power, **are the official face of the State, but they are not identical with the State.** Advocacy is therefore an effort to engage and influence the State, using the 'spaces' available within the structure of the State, but without attempting to overthrow the State completely.

Of course this kind of engagement with the State could be undertaken by all sorts of groups, not just by those working for deprived or marginalised groups, – and therefore advocacy work is not limited to such groups. In actual fact, business groups (e.g. Chambers of Commerce), religious groups, and all sorts of groups in Civil Society, do attempt to influence the state – and their efforts could rightly be called Advocacy.

Is a good Communication Strategy or the spreading of Information on a particular issue (e.g. a campaign on safe sex) also to be called Advocacy? It would seem that the spread of Information, Education and Communication through IEC material or through the Media are not by themselves an advocacy effort. While all these are often essential elements in an Advocacy campaign, they are not necessarily advocacy efforts. Thus, to use an example from the work done on HIV/AIDS, one would have to say that the social marketing of condoms or getting people to practice safe sex is not advocacy per se. Similarly using the media to inform the public or others of the kind of work that is being done by an organisation on HIV/AIDS, or on any other issue, is more a public relations campaign and not necessarily advocacy. Thus the Communication Strategy of an Organisation or Group is not Advocacy in itself.

On the other hand no Advocacy effort can succeed without an effective Communication strategy. Since Advocacy is all about influencing the State and civil society in general, it is all about persuasive communication. This is why in today's world there is a huge importance given in Advocacy efforts to using the Media at all levels:

- Broadcast (i.e. Print, Electronic, Internet etc.) and
- Narrowcast (local media like puppets, street plays etc.)

Hence many public advocacy practitioners use the term Media Advocacy, which is to be understood as trying to influence the media in ways that makes use of the powerful reach of the media to influence the State (by swaying public opinion on whose votes and goodwill, the government in power is always dependent). In some ways, then the Media is seen as the fourth arm/estate[10] of the State, as distinct from the other three arms, Legislature, Executive and Judiciary) because of the tremendous power it has to influence the making, implementation and monitoring of policies and laws.

People-Centred Advocacy takes this process one step further in two ways. First of all it stresses that the power to influence the State in all its organs must lie with the marginalised/deprived people themselves. It stresses that engaging with the State in this manner should not remain the prerogative or skill of those who work FOR the deprived/marginalised, as that would continue to keep these deprived sections dependent – albeit on an apparently more benevolent 'master' namely the advocacy group/NGO that is trying to help them. Secondly, people-centred advocacy also includes in such advocacy efforts the attempt to change the mind-set and practices among the deprived themselves – those mind-sets and practices that make change more difficult. For experience has shown that despite bringing about suitable laws and schemes through effective negotiation with the State (e.g. laws prohibiting SATI and Dowry and Sex selection procedures) these do not really have much effect if the people themselves continue to feel obligated or culturally impelled to continue those practices that go against these laws. Therefore changing mind-sets among the marginalised or deprived is an essential element of people-centred advocacy.

Finally **Public Advocacy** includes those advocacy efforts (whether done in a people-centred way or not) that focus on influencing or challenging the State on matters that affect the basic human rights of any individual or group, and therefore works on issues that are in principle important to the public.

Process of Advocacy: In understanding the process of advocacy, the distinction between Strategies and Strategic Plans[11] must also be reiterated over here so that it is clear what this report is attempting to offer. Furthermore, it must be clarified that the ways of doing advocacy (the 'HOW to' part) vary from situation to situation, and there is no single way by which this is done. It may include some or all of the following: a) building personal relationships with decision makers at different levels (from the Minister right up to the peon in a government office), b) communication strategies at the macro, mezzo and micro levels, c) pressurising methods that range from dharnas to vote bank politics, d) identifying and pressing the right 'buttons' that would influence particular decision-makers, e) taking advantage of sudden political/socio/economic events that may suddenly occur and which offer unforeseen opportunities or threats to one's advocacy efforts etc. Therefore, too, advocacy strategies can never be set in stone, but must be flexible enough to adapt to changing circumstances. In all cases an effective advocate realises that change takes place only when the decision-maker(s) find some 'value/advantage' in acceding to the change and it is very rare that they do this purely because s/he thinks it is the right thing to do.

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10 The term the "Fourth Estate" comes from the French Revolution, though at that time it may not have referred to the press. But when Thomas Carlyle used the term he clearly meant the Press as the fourth Estate that sits in the Reporters' Gallery as distinct from the three that sat in Parliament.

11 See footnote – iii in Part 3 – Looking Forward – Suggestions for Future Strategies for the Campaign.

Policy Advocacy: Thirdly as far as policy advocacy is concerned, there are broadly two types of such advocacy – one to change or modify a policy/Act/law, and the other to ensure the implementation of an already existing policy/Act/law. Furthermore, the target for these two different categories can be quite different and advocacy strategies for each target would change accordingly.

Annexure II

Primary Sources of Data

A) Meetings and interviews done during the field visits to various states

Pilot Visit done in the State of Maharashtra between 11th-15th July 2006

1. Visit to Sinnar, Maharashtra - interaction with three groups (one was a mixed group having both male and female members and the other two groups were exclusively groups of men and women) drawn from local communities
2. Visit to Nashik, Maharashtra – interaction with the managing body of an orphanage (girls from this center were being taken by families of certain communities for marriage purposes), Interviewed Mr. Anil Mahajan, Leva Patil community leader.
3. Visit to Sangamner, Maharashtra. Interacted with a group of women belonging to Maheshwari community.
4. Group discussion with Teachers trainees in Pune –14 participants
5. Group discussion with CYDA Youth volunteers in Pune - 12 participants
6. Interviewed Mr. Doiphode, Pune Circle Appropriate Authority, Pune.
7. Interviewed Mr. Marulkar, District Appropriate Authority, Satara, Pune.
8. Interviewed Dr. Ramesh Bhosale, Gynaecologist at Sassoon Hospital, Pune.
9. Interviewed Dr. Madhuri Abhyankar, Social Worker from SOFOSH (Society of Friend's of Sassoon Hospital) and a member of the District Advisory Committee, Pune.
10. Interviewed Adv. Varsha Deshpande, Dalit Mahila Forum, and a member of the District Advisory Committee, Satara.

Apart from the names noted down in this annexure, people who helped us the process of study also include; Deepti Raut, Nashik, Suneel Pote, Sinnar, Keerti, Pune, Students of Symbiosis Law College, Pune, Students of Pune University Law College, Pune, Meena Bag, Bhadgoan, Jalgoan, Shalan Shelake, Sangamner, Adwaita Marathe, Ahmedabad, Sushrita Roy, Jaipur and Sheoji Tanwar, Jaipur

State: DELHI
Visited between 17th-22nd July 2006

Community

1. A Discussion with a group of 16 women in the age - group of 21-36 years in Khichdipur, West Delhi.
2. A discussion with a group of 21 first year college students in Miranda House College, University of Delhi.
3. Interaction with a group of women in Trilokpuri colony, Delhi.

Medical Service Providers

1. Interview with an Urban Health worker in Govt. dispensary, Khichdipur, Delhi
2. Interview with Dr. Mrs. R.M. Sonali Gowri, New Delhi.
3. Interview with Dr. Mrs. Sonali Majumdar, MBBS, Family Physician, New Delhi.

4. Interview with Dr. Mrs. Soroj Lekha, General Physician, New Delhi
5. Interview with Dr. Mrs. Dolly Bagaii, Family Physician, New Delhi

Implementers

1. Interview with Dr Ratan Chand, Director, PC-PNDT Cell, Ministry of Health and Family Welfare, N.Delhi
2. Interview with Dr R.N. Kalita, Appropraite Authority, New Delhi
3. Interview with Dr R. S. Dahiya, Retd. Appropriate Authority

Enablers

1. Interview with Ms. Vijaya Nidadavolu, Population Council
2. Interview with Mr. Rizwan, Centre for Advocacy and Research
3. Interview with Dr. Sabu George, N. Delhi
4. Interview with Ms Sarita Sharma, Datamation Foundation, New Delhi
5. Telephonic interview with Ms Indira, SNS Foundation, Gurgaon
6. Interview with Dr Archana, Sehgal Foundation, Gurgaon
7. Interview with Ms Ruhani Kaur, Photojournalist, Indian Express
8. Interview with Girija Vyas, Chairperson, National Commission of Women, New Delhi

State: GUJARAT
Visited between 17th -22nd August 2006

Community

1. Interacted with a group of upper class women in Ahmedabad.
2. Interacted with a group of volunteers in Unjha, Mehsana District who coordinated awareness campaign on the issue.
3. Interacted with a group of professors running an awareness campaign on the issue in the Fine Arts college of Mehsana District.

Medical Service Providers

1. Interviewed Dr. Smita Paradkar, Gynaecologist in Vadodara

Implementers

1. Interviewed Ms. Ila Pathak, President, Ahmedabad Women's Action Group (AWAG), and a member of the State Appellate Authority
2. Interviewed Mr. Manubhai Patel, Block Information, Education and Communication (IEC) Officer, Mehasana
3. Telephonic interview with Dr. M.S. Ranawat, State Consultant PC-PNDT Cell, Gandhi Nagar, Gujarat.
4. Interviewed Ms. Mamta and Ms. Minisha, of Olakh an NGO in Vadodara that was earlier a member of the district advisory committee and continues to work on the issue.

Enablers

1. Interviewed Ms. Trupti Shah, Founder of Sahiyar Stree Sanghtan, in Vadodara working for awareness building and conducting community based research on the issue.

2. Interacted with Prof. Ashok Chaterjee, a development communication expert, Ahmedabad
3. Interacted with Mr. Rajeev Tiwari, State Representative, UNFPA, Gujarat
4. Visited CHETNA and interviewed Ms. Ila Vakharia, Senior Member of CHETNA and Ms. Bhoomika involved in organizing state level campaign on the issue.

State: HARYANA
Visited between 23rd-30th July 2006

Community

1. Interacted with a group of women in Janakpur village of Mewat District.
2. Interacted with a women SHG in Kurukshetra District, Haryana
3. A Group discussion with students of Kurukshetra University.
4. Interview with a teacher in Kurukshetra University
5. A group Discussion with women in Daulatabad village in Gurgaon.
6. Interacted with a group of women in Jahajgarh, Haryana
7. Interacted with a group of women in Jhajjar District.

Medical Service Providers

1. Interviewed Dr. Mrs Bindu Garg, private practitioner, Gurgaon
2. Interviewed Dr. M. Mahajan, private practitioner, Gurgaon
3. Interviewed Dr. Joseph, Private Practitioner, Gurgaon
4. Interviewed Dr. P. Surendranath, Private Practitioner, Panipat
5. Interviewed Dr. P.K. Goel, Gurgaon
6. Interviewed Dr. Nisha, Faridabad
7. Interviewed Dr. Satish Makijha, Gynaecologist, Faridabad, Haryana.

Implementers

1. Interviewed Dr B.S. Dahiya, retired Chief District Medical Officer (CDMO) and Ex-SAA, Haryana
2. Interviewed Mr. R.C. Aggarwal, Civil Surgeon, AA, Haryana State
3. Interviewed Dr. Rameshwar Chander, State AA, UT, Chandigarh
4. Interviewed Dr. Neelkanth Sharma, Director General Health,Haryana
5. Interviewed Dr. Sushma Madan, general, health services, Panchkula, Haryana
6. Interviewed Dr. Rekha Mehra, AA Gurgaon
7. Telephonic interview with Magistrate Jagjeet Singh

State: HIMACHAL PRADESH
Visited between 10th-15th August 2006

Community

1. Interacted with a group of female students of St Beads college, Shimla
2. Interviewed a teacher in a local school in Mandi.
3. Conversation with a group of upper class women

Medical Service Providers

1. Interviewed Dr. Suhani Kaur, Shimla
2. Interviewed Dr. Kushal, a Homeopathic doctor in Mandi
3. Interviewed Dr. Khosa, in Hamirpur
4. Interviewed Mr. Kamal, working as ANM in a local Health center in Hamirpur
5. Interviewed Ms. Sarita, working as a health worker in Mandi.

Implementers

1. Interviewed Dr. R N Mahanto, Director (Family Welfare, Directorate of Health Services, Govt of HP), AA ,Shimla
2. Interviewed Mr. Ashish Sharma, Station House Officer (SHO), Mandi
3. Interviewed Mr. Anita Verma, MLA, Hamirpur constituency
4. Telephonic interview with Ms. Pratima Malhotra, Lawyer, Human Rights Law Network (HRLN), Shimla
5. Interviewed Mr. Jitender Rana, Lawyer, HRLN

State: KARNATAKA
Visited between 21st -23rd August 2006

Community

1. Interacted with a group of women members of a self help group promoted by St. Thomas Mission Society, Santhome, Engineering college Rd, Mandia.

Implementers

1. Interviewed Dr. H.L. Krishna Gowda, District Health Officer (DHO), AA, Mandia District.
2. Interviewed Mr. H.C. Choudayya BHEO (Assisting the Appropriate Authority), Mandia District.
3. Interviewed Dr. Kamini Rao, Member of the State Supervisory Board as well as a member of Federation of Obstetrics and Gynecological Societies of India (FOGSI).
4. Interviewed Dr. Shivaram, DHO, AA, Bangalore Urban, Karnataka
5. Interviewed Dr. Manorama Thomas, Chairperson, AA Bangalore District

Enablers

1. Interviewed Ms. Donna Fernandes, VIMOCHANA, an NGO working on the issue at Bangalore, Karnataka
2. Interviewed Dr. Archana Mehandale, Consultant, National Law School, Bangalore

State: MADHYA PRADESH
visited between 8th-9th August 2006

1. Interviewed Dr. Manohar Agnani, District Collector, Shivpuri, Madhya Pradesh
2. Interviewed Dr. M. Geetha, District Collector, Datia, Madhya Pradesh.

State: MAHARASHTRA
Visited between 8th-10th and 12th-14th August 2006

Community

1. Interacted with a group of Political/Community leaders in Sangamner Block of Ahmednagar District
2. Interacted with a Self Help Group of women mobilized by Shivprerna Bahu Uddeshian Sansthan in Bhadgoan village in Jalgaon District.
3. Interviewed Mr. Satish Charkha, Member of Akhil Bhartiya Maheshwari Sabha.

Medical Service Providers

1. Interviewed Ms. Ashalata Awsak a Nurse in Neemgaon village sub-center in Sangamner Block, Ahmednagar District.
2. Interviewed Dr. Shailaja Gadgil, Sangamner, Ahmednagar District.
3. Interviewed Dr. Vandana Gandhi, Gynaecologist and a member of the team working on sensitizing the IMA doctors on the issue, Akluj in Solapur District
4. Interviewed Dr. Ulhas Patil, a Gynaecologist and a political leader in Jalgaon.
5. Interviewed Dr. Kaduskar, Jalgaon.
6. Interacted with a group of BHMS Students in Bharti Vidyapeeth Deemed University, Pune

Implementers

1. Interviewed Adv. Vrushali Vaidya, practicing lawyer, Family Court, Pune
2. Interviewed Dr. S. B. Chavan, State Appropriate Authority in Pune office.
3. Interviewed Dr. Dilip Siddhapure, Block level AA, Akluj, Solapur District.
4. Interviewed Dr. Kavita Sonatakke, District Advisory Committee member, Jalgoan

Enablers

1. Interviewed Manisha Gupte, Founder Member of MASUM, and a member of the Medico Friends Circle, Pune
2. Interviewed Audrey Fernandes, Founder Member of TATHAPI and Member of District Advisory Committee, Pune
3. Interviewed Shalan Shelke, activist in Sangamner
4. Interviewed Dr. Sharada from Population First in Mumbai.
5. Interviewed Adv. Kamayani Bali Mahabal of Center for Health Enquiry and Allied Themes (CEHAT), Mumbai
6. Interviewed Adv. Varsha Deshpande, Dalit Mahila Forum, Satara
7. Interviewed Ms.Vasanti Dighe, Jalgaon District Mahila Mahasangh, Jalgaon.

State: PUNJAB
Visited between 4th-10th August 2006

Community

1. Interacted with a group of women in Kudalhora village, Chandigarh
2. Interacted with a group of SHG member women in Lakhanpal village, Jalandhar District

3. Interacted with elected representatives of various local panchayats Fatehgarh Sahab District

Implementers

1. Interviewed Adv. Veena Sharma, Advocate and Member of the Inspection and Monitoring Committee.
2. Interviewed Mr. Krishan Kumar, District Collector, Nawashahar, Punjab.
3. Interviewed Mr. D.S. Singhal, AA, Chandigarh
4. Interviewed Dr. V.K. Goel, Nodal Officer, Health Department, Govt. of Punjab, Punjab

Enablers

1. Interviewed Mr. V.S. Sharma, Voluntary Health Association of Punjab (VHAP), Chandigarh.
2. Interviewed Mr. Manmohan Sharma, Activist and Secretary, VHAP

State: RAJASTHAN
Visited between 19th-26th July 2006

Community

1. Interaction with a group of young students from Rajasthan University, Jaipur
2. Interviewed Mr. S. Tambi, President Khandelwal Vaishya Community Association, Jaipur
3. Interaction with a Rural women's group mobilized by Action Aid and a local NGO PRAYTNA under the 'Jago Sakhi Sanghatan' campaign in Natthaka Pura village Rajewadi Block, Dholpur District, Rajasthan
4. Interaction with a rural women's group in Dagarpur village Rajewadi Block, Dholpur District, Rajasthan.
5. Interaction with a rural men's group in Dagarpur village Rajewadi Block, Dholpur District, Rajasthan.
6. Interaction with a rural women's group, Shivdaspura village, Chaksu Block, Jaipur District.
7. Interaction with a mixed group in a tribal setting in Badi village, Nimbada Block, Chittorgarh District

Medical Service Providers

1. Interviewed Dr. Y.C. Yadav, President of the Jaipur Medical Association, Jaipur.
2. Interviewed Dr. Chitra Bansal, Gynaecologist, Dholpur
3. Interviewed Dr. Umesh Sharma, Shivdaspura village Chaksu Block, Jaipur District.
4. Interviewed Mr. Premchand Goswami, Compounder in PHC in Padampura village
5. Interviewed Ms. Jyoti Mathur, ANM in Shivdaspura Health center Chaksu Block, Jaipur District.
6. Interviewed Dr. S. Shitoot, Practising Gynaecologist, Jaipur Hospital

Implementers

1. Interviewed Mr. Patani, Administrative office, State PC-PNDT Cell, Jaipur
2. Interviewed Ms. Ladkumari Jain, Member, State Advisory Board and President Rajasthan University Women's Association (RUWA)

3. Interviewed Mr. Karani Ola, President, Bar Association, Jaipur High Court
4. Interviewed Mr. Dharamveer Tolia, Advocate, Jaipur High Court.
5. Interviewed Mr. Rajendra Soni, Sr. Advocate, Constitutional Provisions, Jaipur High Court
6. Interviewed Ms. Shubhra Singh, Director General National Rural Health Mission (NRHM) and Secretary, Family Welfare, Govt. of Rajasthan.

Enablers

1. Interviewed representative of Centre for Health Equity, Jaipur
2. Met Dr Narendra Gupta, Secretary, Prayas, Chittorgarh, and interacted with Mangilalji Meena, Prayas Field Coordinator, Chotisadri, Chittorgarh and two of his assistants.
3. Interviewed Ms. Jaswin Ahluwalia, Programme Manager, International Federation of Election System (IFES), Jaipur
4. Interviewed Ms. Vijayalaxmi, State Programme Officer, Action Aid, Rajasthan.

State: TAMIL NADU
Visited between 14th-19th August 2006

Community

1. A Group Discussion with housewives belonging to the Thevar community (Piramala Kallar) – Most Backward Class in Chellampattin Block, Tamil Nadu
2. A Group Discussion with members of Permalai community (8 members) of Pinnathevanpatti village, Theni (5 km from Theni districts head quarter)
3. A Group Discussion with 25 participants in Kathirvelpuram village, on the Western Ghat, Theni District
4. A Group Discussion with members of Kathir Narashimhapuram village, District Theni
5. A Group Discussion with members belonging to the gaunder/Karuba (Most Backward Class) community.

Medical Service Providers

1. Interview with Dr. K. Bose, Madurai Medical College, Madurai, Tamil Nadu.
2. Interview with Dr. S. Aisa, Theni, Tamil Nadu

Implementers

1. Interview with Ms. P. Phavalam, SIRD, Madurai and a member of the District Advisory Committee, Madurai district.
2. Interview with Dr. S. Balasubramanyam, Deputy Director Health Services, District Theni, Tamil Nadu.
3. Interview with Sr. Anastasia, member of the District Advisory Committee, Theni District, Tamil Nadu.
4. Interview with Dr. Soundrarajan, Deputy Director, Medical Services, Salem District, Tamil Nadu.

Enablers

1. Visited Rural Rehabilitation Centre, Court Main Road, Usilampatti Taluka, and Madurai
2. Visited Society for Integrated Rural Development (SIRD) Madurai

3. Interacted with M. Valarmathi, Kiruba Foundation, Theni
4. Interacted with M. Seerami, Snegam Welfare Association Trust, Theni
5. Interacted with N. Pandeeswari, Mass Guild, Theni
6. Interacted with Nagendran, Angel Home of Women Trust, Theni
7. Interacted with P. Savitree, MMSSS, Theni
8. Interacted with V. Gunasekaran, RASI Society, Theni
9. Interacted with S.M. Jaffer Sadiq, WASA Trust, Theni
10. Interacted with G. Venketeshan, Theni
11. Interacted with Village Reconstruction and Development Project, Salem
12. Interview with Mr. Jeeva, CASSA, Madurai.

B) Participants in the 'LOOKING BACK' Workshop held on 11-12th Sep, 2006 in Pune

1. A. Farook, Senior Advocacy Officer, UNFPA, New Delhi
2. Dr. A. L. Sharada, Population First, Mumbai
3. Anjali Londhe, CYDA
4. Anuja Gulati, UNFPA, Maharashtra
5. Dr. B.S. Dahiya, Former Director, Health Services and Ex – SAA, Haryana
6. Dr. Devendra Shirole, Vice President, Indian Medical Association, Maharashtra
7. Dhanashri Brahme, Programme Officer, UNFPA, New Delhi
8. Donna Fernandez, Vimochana, Bangalore
9. E. M. Radhakrishnan, Research Associate, CYDA
10. Ena Singh, Assistant Indian Representative, UNFPA, New Delhi
11. Jitendra Jain, Unjha, Gujarat
12. Josantony Joseph, Lead Consultant, UNFPA/CYDA
13. Dr. Kavita Siradhna, Research Associate, CYDA
14. Dr. M. Geetha, District Collector, Datia, MP
15. Dr. M.S. Ranawat, State Consultant, PCPNDT Cell, Gujarat
16. Dr. Madhuri Abhyankar, District Advisory Committee member, Pune
17. Manmohan Sharma, Secretary, Voluntary Health Association of Punjab, Chandigarh
18. Dr. Manohar Agnani, District Collector, Shivpuri, MP
19. Dr. Manorama Thomas, Chairperson, Advisory Committee, Bangalore
20. Mathew Mattam, CEO, CYDA
21. Dr. Meeta Singh, Representative, IFES, Jaipur
22. Minaxi Shukla, CHETNA, Gujarat
23. Dr. Mira Sadgopal, Medico Friends Circle and Tathapi, Pune
24. Dr. Nalini Abraham, Country Advisor, Health, Plan International, New Delhi
25. Dr. Narendra Gupta, Prayas, Chittorgarh, Rajasthan
26. Dr. P.R. Deo, UNFPA, Maharashtra
27. Dr. Parag Biniwale, FOGSI, Pune
28. Prem Kumar Prince, CYDA
29. Priyanka Sharma, CYDA
30. Dr. Ramesh Bhosle, Gynaecologist, Sassoon Hospital, Pune
31. Dr. Ratan Chand, National Head, PNDT cell, New Delhi
32. Rohini Patkar, Research Associate, CYDA
33. Dr. S.C. Mathur, Director, State Institute of Health and Family Welfare, Rajasthan

34. Sangeeta Mansharamani, Assistant Advocacy Officer, UNFPA, New Delhi
35. Dr. Sanjeevanee Mulay, Research Dept, Gokhale Institute of Politics and Economics, Pune
36. Sofy Mathew, Coordinator, UNFPA Study, CYDA
37. Subhash Mendhapurkar, Founder Director, SUTRA, HP
38. Dr. Vaijayanthi Patwardhan, President, Indian Medical Association, Pune Chapter
39. Dr. Vandana Gandhi, Obstetrician and Gynaecologist, Akluj, Maharashtra
40. Veena Sharma, Human Rights Law Network, Chandigarh
41. Vidya Kulkarni, Research Associate, CYDA, Pune
42. Dr. Y.H. Doiphode, Deputy Director of Health, Pune

C) Participants in the Consultations with homogeneous groups

1. Consultation with Advocacy Experts held On 21st September, 06 at ISI, New Delhi

1. Amitabh Behar, NCAS, Pune
2. Archana Sinha, Indian Social Institute
3. Farah, CAPF (Campaign Against Pre Birth Elimination of Females)
4. A. Farook, Sr. Advocacy Officer, UNFPA
5. Gouri Chowdhary, Action India
6. Hemlata Kansotia, Snehbandhan Society, Delhi
7. Jojo Thomas, Desh, Delhi
8. Josantony Joseph, Lead Consultant, UNFPA/CYDA
9. Mahesh- (Working with Swami Agnivesh)
10. Mathew Mattam, CEO, CYDA, Pune
11. Poonam (CAPF-Campaign Against Pre Birth Elimination of Females), Delhi
12. Prem, Sanjha Manch
13. Rajneesh Sharan (Japanese Government consortium in India)
14. Rizwan Parwez, Centre for Advocacy and Research (CFAR)
15. Rohini Patkar, Research Associate, CYDA
16. Shramana, Centre for Advocacy and Research (CFAR)

2. Consultation with Communication Experts held On 6th October, 06 At Nirmala Niketan, Mumbai

1. Anuja Gulati from UNFPA, Maharashtra
2. S.V. Sista, Population First, Mumbai
3. A. Farook, Sr. Advocacy Officer, UNFPA, Delhi
4. Gaurav Singh, Grey World Wide
5. Gauri Dakne, Law and Kenneth
6. Josantony Joseph, Lead Consultant UNFPA/CYDA
7. Kirron Kher, film actor and Ambassador of Laadli campaign
8. Madhab Panda, Director of Aatmaja serial, N. Delhi
9. Mathew Mattam, CEO, CYDA
10. Mohammad Khan, Bates India Pvt. Ltd.
11. Dr. Prakash Deo, UNFPA
12. Mrinalika Joseph, Communication professional
13. Priyanka Sharma, Photograper, Writer and Designer
14. Ramesh Narayan, Canco Advertising Pvt.

15. Ritu Chawla, Webek TV Days
16. Sanovar, Grey World Wide
17. A.L. Sharada Population First
18. Sushma Ahuja, Script writer
19. Vidya Kulkarni, Research Associate, CYDA
20. Viji Varghese, UNFPA Maharashtra
21. Vinod Nair, Clea Public Relations

3. Consultation with Lawyers held on 7th October, 06 at New Delhi

1. Asha Singh, Praytna, Rajasthan
2. Asmita Basu, Lawyer's Collective, Delhi
3. Dhanashri Brahme, UNFPA, New Delhi
4. Josantony Joseph, Lead Consultant, UNFPA/CYDA
5. Kavita Srivastava, PUCL, Rajasthan
6. Adv. Kamayani Bali Mahabal, CEHAT, Mumbai
7. Rohini Patkar, Research Associate, CYDA
8. Adv. Shruti Pandey, HRLN, New Delhi
9. Adv. Varsha Deshpande, Dalit Mahila Forum, Satara, Maharashtra
10. Adv. Veena Kumari Sharma, HRLN, Chandigarh
11. Vijay Hiremath, HRLN, Mumbai

4. Consultation with Religious and Community leaders held on 9th October, 06 at YMCA, Pune

1. A. Farook, UNFPA, New Delhi
2. Anees Chisti, Educator, Writer, Islamic Scholar, Pune
3. Ashok Patel, Representative, Patel Community and Politician, Gujarat
4. Sister Divya, Representative. St. Ursuline, Pune
5. Edison Samraj, Representative, Inter-religious and International Federation for World Peace, also represented, Christian protestant group, Pune
6. J.D. Chaudhary, Representative, Chaudhary community, Gujarat
7. Josantony Joseph, Lead Consultant, UNFPA/CYDA
8. Brni. Karuna Chaitanya, Chinmaya Mission, Pune
9. Kavita Siradhna, Research Associate, CYDA
10. Kuldip Kaur, Representative, Sikh Community, Jaipur
11. Prof. Lalita Salkar, Chinmaya Mission, Pune
12. Pusha Baid, Representative, Akhil Bhartiya Thera Panti Mahila Mandal, Jain Community, Jaipur
13. Sudha Deshpande, Chinmaya Mission, Pune
14. Sofy Mathew, Coordinator, UNFPA Study, CYDA
15. Vidya Kulkarni , Research Associate, CYDA
16. Yuvraj Shah, President, Adinath Society, Jain Community, Pune

5. Consultation with Medical Community held on 15th October, 06 at Hotel Coronet, Pune

1. Dr. Anand Phadke, Medico Friend Circle, Pune
2. Dr. Anil Laddad, Nagpur, Maharashtra
3. Dr. Ashok Adhao, IMA President, Maharashtra
4. Dr. Girish Kavathekar, Solapur, Maharashtra

5. Josantony Joseph, Lead Consultant UNFPA/CYDA
6. Dr. Kavita Sirdhana, Research Associate, CYDA
7. Dr. Krishna Parate, Nagpur, Maharashtra
8. Dr. Prakash Deo, UNFPA Maharashtra
9. Dr. Puneet Bedi, Delhi
10. Dr. Sanjay Gupte, FOGSI, Pune
11. Dr. Sudha Rathi, Yavatmal, Maharashtra
12. Dr. D.K. Shirole, IMA, Vice President, Maharashtra
13. Dr. Sanjay Despande, Nagpur, Maharashtra
14. S.V. Sista, Population First, Mumbai, Maharashtra
15. Dr. Vandana Gandhi, Akulj, Maharashtra
16. Vidya Kulkarni, Research Associate, CYDA
17. Dr. Vivek Billampelly, General Practioners Association (GPA), Pune
18. Dr. Yeshwant Despande, Nagpur, Maharashtra

6. Consultation with Enablers held on 17th October, 06 at Vimochana, Bangalore

1. Anshumala Gupta, Bhartiya Gyan Vighyan Samiti, (BGVS), Himachal Pradesh
2. Divya, Vimochana, Banglore
3. Donna Fernandez, Vimochana, Banglore
4. Ila Vakharia, CHETNA, Ahmedabad
5. Josantony Joseph, Lead Consultant UNFPA/CYDA
6. Kiran Moghe, AIDWA, Maharashtra
7. Ladkumari Jain, Rajasthan University Women's Association (RUWA), Jaipur
8. Medha, Vimochana, Banglore
9. Poonam Kathuria, SWATI and Saurashtra Kachha Network on Violence against Women
10. Ravindra R.P., Activist, Maharashtra
11. Dr. Sabu George, New Delhi
12. Sofy Mathew, Coordinator, UNFPA Study, CYDA
13. Trupti Shah, Sahiyar, Vadodra, Gujarat
14. Vidya Kulkarni, Research Associate, CYDA

D) Participants in the workshop 'Reflections on the campaign against sex selection and exploring ways forward' workshop held on 30th November – 1st December, 2006 in New Delhi

1. Dr. A.L. Sharada, Population First, Mumbai
2. Adv. Apurva Rastogi, HRLN, New Delhi
3. Dr. Ashok Adhao, President, IMA, Maharashtra
4. Biplab. K. Paul, Lokvikas, Gujarat
5. Dhanashri Brahme, Programme Officer, UNFPA, New Delhi
6. Donna Fernandez, Vimochana, Bangalore
7. E.M. Radhakrishnan, Research Associate, CYDA
8. Ena Singh, Assistant Representative, UNFPA, New Delhi
9. Farook Ambalapurathe, Sr. Advocacy Officer, UNFPA, New Delhi
10. Ifat Hamid, NHSRC, New Delhi

11. Ila Vakharia, CHETNA, Ahmedabad
12. James Mathew, PC-PNDT cell, New Delhi
13. Josantony Joseph, Lead Consultant, UNFPA/CYDA
14. M. Jeeva, CASSA, Madurai, Tamil Nadu
15. Dr. Kavita Sirdhana, Research Associate, CYDA
16. Dr. Lad Kumari Jain, Rajasthan University Women's Association, Jaipur
17. Dr. Manohar Agnani, District Collector, Shivpuri, MP
18. Dr. Nalini Abraham, Plan International, New Delhi
19. Ms. Nandita Mishra, DWCD, New Delhi
20. Mr. Sadhu Ram Kusla, PNDT Cell, Bhatinda
21. Adv. Sanjay Parikh, New Delhi
22. Dr. Sharda Jain, Chairperson IMA Women's Wing, New Delhi
23. Shweta Bhonsle, CYDA, Pune
24. Sushma Rath, Under Secretary Min. of Health and Family Welfare, New Delhi
25. Dr. Vibhuti Patel, SNDT Women's University, Mumbai
26. Vidya Kulkarni, Research Associate, CYDA

E) List of Individuals Met

1. Dhanashri Brahme, Programme Officer, (Gender and Community), UNFPA, New Delhi
2. Dr. Dinesh Agarwal - Technical Advisor, RCH, UNFPA, New Delhi
3. Ena Singh, Assistant Representative, UNFPA, New Delhi
4. Farook Ambalapurathe, Senior Advocacy Officer, UNFPA, New Delhi
5. Geeta Narayan UNFPA Associate, UNFPA, New Delhi
6. Dr. K.M. Satyanarayana, Technical Advisor, UNFPA, New Delhi.
7. Nalini Abraham, Country Advisor, Health, Plan International, New Delhi
8. Dr. Patanjali Dev Nayar, Technical Advisor Adolescent and Youth, UNFPA, New Delhi
9. Dr. Prakash Deo, UNFPA, Maharashtra
10. S.V. Sista, Population First, Mumbai
11. Dr. Sabu George, New Delhi
12. Sangeetha Mansharamani, Junior Advocacy Officer, UNFPA, New Delhi
13. Dr. Satvir Choudhary, CMO, Kaithal, Haryana
14. Shachi Grover, UNFPA, New Delhi
15. Dr. Sharda Jain, Chairperson, Women's wing, IMA, New Delhi
16. Sharareh Amirkhalili, UNFPA Representative, New Delhi
17. Venkatesh Srinivasan, Asst. Representative, UNFPA, New Delhi
18. Representative of PRIA, New Delhi

Annexure III

Secondary Sources of Data

a) Annotated list of Reports, Research Studies, Books And Press Clippings
b) Annotated list of Posters on the issue
c) Annotated list of films

a) Annotated List Reports, Research Studies, Books And Press Clippings

1. ***'Missing Girls – Mapping the Adverse Child Sex Ratio in India'*** Published by UNFPA, Nov 2003 – This twenty pages booklet captures the decline in the number of girls as compared to boys in India. It presents maps of various states marking districtwise child sex ratio, which highlight deterioration of the ratio across the country over last decade.
2. Copies of the Bare Acts
    - The Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 with 1996 amendment
    - Handbook on PNDT Act, 1994
3. UNFPA 'Annual Project Report - Programme for support to the Department of Family Welfare Ministry of Health and Family Welfare, Government of India – ***Advocacy and Communication*** (UNFPA executed Activities-IND/03/P15) Jan2005-Dec2005. The Advocacy Project in UNFPA's Sixth Country Programme (CP6), IND/03/P15 (Programme for Support to the Department of Family Welfare: Advocacy and Communication) in which Advocacy was one of the core programme priority, was initiated in Oct,-03 and is to cover the period to Dec,07. The document describes the advocacy efforts made by UNFPA against sex-selection in 2005.
4. UNFPA document entitled '***Sex Selection in India- Ending the Practice of Pre-Birth Elimination of Females-Changing the Mindset – A National Advocacy Strategy***'-June, 2005. The document building up on the existing advocacy and communication activities provides a National Advocacy Strategy (NAS) in the form of an umbrella framework within which those wanting to work on the issue of sex-selective elimination could plan and implement its activities and initiatives. The purpose of NAS is to provide a common national framework to ensure that advocacy and behavior change interventions, undertaken by and with different groups are synergistic, coordinated and non-contradictory.
5. Report on the consultation on ***'Monitoring of PC-PNDT Act – Towards a National Campaign Against Sex Selection'*** by CEHAT Oct 2005 – The consultation was organized with an objective to review the status of implementation of the Act and review the advocacy material on the issue and to form a network of NGOs to work collectively towards monitoring and implementation of the Act. The report includes proceeding as well as presentations of participants from various states and useful statistical data.
6. A compilation of writings ***'Sex Selection: Issues and Concerns'*** compiled by Qudsiya Contractor, Sumita Menon and Ravi Duggal of CEHAT is collection of papers, articles

and news reports on the issue. The purpose of this publication is to bring together various points of view and voices that have shaped the sex selection debate to date. The three sections of the publication – Sex Selection and the Campaign, Role of the State and the Law and Social Impact of Sex Selection Practice - significantly put forth crucial aspects of the issue.

7. A document titled ***'Learnings Across Borders – An Information Resource on Adverse Sex Ratio'***, prepared by IFES is a compendium providing abstract of research studies, research publications, journals, articles and documenting campaigns and interventions on the issue in the country. Information of studies is on occasions in incomplete in the compendium (perhaps because it is a draft). The subjects covered are broader and include female infanticide, child mortality, and reproductive health of women, reproductive technologies and violence against women, besides those mentioned above. A number of village studies and regional studies examining local social factors having a bearing of female foeticide and sex ratio have been quoted. Compendium seems to be an in-house publication of the organisation.
8. An Information Booklet titled '***Sensitization of Doctors on Declining Child Sex-Ratio' and A Press Kit*** published by IMA Maharashtra State Branch with support form UNFPA State office. Apart from giving the picture of grim situation and social causes behind skewed sex ratio, the booklet also appeals the doctors to play their role in tackling the problem. The last section provides concrete guidelines for action for them in taking proactive steps to curb sex selective practices. The press kit presents IMA – Maharashtra; views and plan of action.
9. A report on the State level Advocacy workshop with members of legislative assembly, Gujarat on ***'Sex –Selection and Pre-Birth Elimination of females'*** organized by CHETNA in collaboration with Plan and Population Foundation of India, Nov 3rd, 2004
10. A report on the State level Advocacy workshop with corporate /industry leaders on ***'Sex –Selection and Pre-Birth Elimination of females'*** organized by CHETNA in collaboration with Plan and Population Foundation of India, in Gujarat Oct 1st, 2004
11. Training Module in Hindi on '***Sex Determination and Sex-Selection-Legal aspects'*** by Center for Advocacy and Research, New Delhi 2006 – The module gives an overview of the past efforts leading to amendment of the PNDT Act and comprehensive legal perspective on the issue of declining sex ratio to all willing to take direct action or to initiate advocacy on the issue.
12. The Report of Project on ***'Campaign Against Pre-birth Elimination of Female'*** by ARAVIS, December 2005 – The report outlines the efforts made by the organisation in six districts of Delhi to sensitize people on the issues to female foeticide. The project, supported by Population Foundation of India worked with slum dwellers and youth to initiate a concerted campaign to tackle the problem.
13. The Report ***'Female Foeticide in India'*** of the state level consultation in Chennai on December 2-3, 1998 by Society for Integrated Rural Development (SIRD), Madurai – The report includes enriching deliberations of the consultation which brought together ethical medical practitioners, government officials, activists, trade unionists, human rights groups, media and donors and women's studies scholars to consider the increasing practice of sex selective abortions in TN. The formation of the TN coalition – Campaign Against Sex Selective Abortion (CASSA) – was an immediate outcome of this consultation.

14. The Report of the national consultation on ***'Medico-Legal Issues related to Female Foeticide'*** organized by the Center for Child and the Law, National Law School of India University, Bangalore with the support from UNICEF, New Delhi on September 24, 1999 – The consultation sought to foster an inter-disciplinary interaction between the medical professionals and social scientists and social activists with an objective of understanding the areas where law on female foeticide needs to be reformed or strengthened through better implementation.
15. A handbook of guidelines ***'Pre-Birth Elimination of Females'*** prepared by CAPF (Campaign Against Pre-Birth Elimination of Females) supported by CWDS (Center for Women's Development Studies) – The handbook discusses the various aspects of the issue and is a useful educational tool on the issue for health personnel as well as policy makers, researchers and development workers.
16. ***'Pre-Conception and Pre-Natal Diagnostic Techniques Act – A User's Guide to the Law'***, edited by Indira Jaisingh is a manual for aiding medical professionals and appropriate authorities to adhere to the provisions of the law stated in the Act.

Research Studies

1. A case-study on ***'Pre-natal sex selection'*** UNFPA India October 2005. It is a case study of UNFPA efforts and its engagement with the issue of sex-selective elimination of girls. The document highlights some of its efforts, experiences, dilemmas and learnings in a reflective and experience-sharing mode and provides important pointers and much 'food for thought' for those grappling with the issue themselves.
2. A study report titled ***'The Scarcer Half'*** by Ravindra R. P. on amniocentesis and other Sex-determination techniques, Sex preselection and new reproductive technologies, January 1986.
3. **'Analysis of trends in Sex Ratio at Birth of Hospitalised Deliveries in the State of Delhi'** conducted by Joe Verghese, Vijay Aruldas and Panniyammakal Jeemon July,05 on behalf of Christian Medical Association of India, Delhi. This study is an attempt to identify the emerging pattern of sex ratio at birth of hospitalized deliveries in the state of Delhi and various demographic and socio-economic factors affecting it based on certain hospital data.
4. A report **'Patterns and Variation in the Sex Ratio at Birth in the Republic of Korea'** by Dudley L. Poston, Jr. Julie Juan Wu, Han Gon Kim Texas A&M University College Station, Texas Yeungnam University, Taegu, South Korea
5. Report of the roundtable on **"Sex Selection in India: Issues and Approaches"** HIVOS India Regional office
6. A study report ***'Attitudes regarding female foeticide in Himachal Pradesh'*** by SUTRA in 2003. This study carried out in selected areas on of Sirmaur and Solan districts is based on 219 personal interviews to examine their perceptions and attitudes regarding female foeticide. The study reveals reasonably high degree of information among people regarding the process of SD and the law and also highlights what they feel needs to be done to tackle the problem
7. A Study Report on **'A study of Ultrasound Sonography Centers in Maharashtra'**, by Sanjeevanee Mulay and R. Nagarajan, Population Research Center, Gokhale Institute of Politics and Economics, Pune Jan, 2005 – The report covers distribution, types and qualification of the owners and operators of sonography centers in

Maharahstra and impact of these centers on the CSR based on visits to 372 clinics in the state. The study highlights strong correlation between availability of sonography centers and decline in CSR during 1991-2001.

8. A Study Report entitled **'Darkness at Noon – Female Foeticide in India'-** by Ashish Bose and Mira Shiva assisted by Anjali Garg and Shrabanti Sen, Voluntary Health Association of India – 15th August 2003 – The report is based on in-depth investigation of the grassroots situation of declining CSR taken up in three worst affected districts of Kangra, Fatehgarh Sahib and Kurukshetra in States of HP, Punjab and Haryana respectively. The study concludes that female foetcide is the result of an unholy alliance between the traditional preference for sons and modern medical technology and therefore recommends frontal attack on all the players and stakeholders through a concerted action involving the Government, NGOs, civil society and concerned individuals.
9. A Report on '***Awareness Campaign and Enforcement Measures taken to control female foeticide in District Nawanshahr on the Nawanshahr Model'*** – The report in detail outlines salient features of the broad ranging efforts initiated by the District Collector Krishan Kumar. These efforts include developing an active infrastructure such as forum of NGOs, block level committees, mobilizing youth and health workers and to take up tasks such as recording pregnancies, medical audit of scanning centers, organizing awareness rallies, mourning against SSAs by the society and other such efforts.
10. Report entitled '***Nawashahr Model: An Exploration'*** by Iram Ghufran of VHAP
11. A study entitled ***'Factors affecting Sex-Selective Abortion in India and 17 Major States'*** by Robert D. Rutherford and T.K.Roy Jan, 2003 – This report examines the effects of demographic and socioeconomic factors on the prevalence of sex-selective abortion in India and 17 major states. Because reliable statistics on sex selective abortion do not exist, the analysis employs the sex ratio at births as an indirect indicator of sex selective abortion.
12. A Study Report on '***Declining Sex-Ratio in Gujarat; Campaign against Sex-Determination and Sex Pre-selection'*** by Dr. Trupti Shah,Sahiyar Stree Sanghtan, Vadodara, Gujarat. The study was primarily carried out to understand the extent and methodology of the spread of SD in 2000. It was based on in-depth interviews with 70 women and interactions with medial professionals and appropriate authority. The study reveals that people opting for one child are most likely to use SD even during their first pregnancy. The women also reported having gained knowledge of this facility from doctors.
13. A feasibility study report titled ***'Images and Icons: Harnessing the power of Mass Media to promote Gender Equity and reduce practices of Sex Selection'*** by Farah Naqvi for BBC World Service Trust, September 2006. The study done in Delhi, Haryana, Punjab and Rajathan examines the prevailing knowledge levels and attitudes related to sex selection together with an analysis of mass media consumption patterns and puts forth how mass media can be used as an effective vehicle to promote gender equality and reduce sex selection.

Books

1. Dr. Manohar Agnani's book ***'Missing Girls'*** is published by Books for Change in 2006. Dr. Agnani started working on the issue of sex selection in his capacity as a DC in Morena, MP. The book presents first hand account of his experiences and perceptions on the issue and suggests ways to tackle the problem. (bfchindi@yahoo.co.in)
2. Anvesha's '***Betiyon ka Katleam'*** in Hindi is published by Books for Change, 2006. The book gives comprehensive view of the problem if declining number of girls with statistics and underlying causes. This well illustrated book provides succinct answers to frequently raised questions concerning the issue. Anvesha is a women's rights activist in Jaipur and is actively involved in the campaign against sex selection. (bfchindi@yahoo.co.in)
3. Book entitled ***'Juni Vishamata Nave Tantradnyan'*** in Marathi is published jointly by CEHAT and MASUM in October 2005. The book gives an overview of the campaign against SSEs and perspective on issues within. The book includes FAQs for AAs, doctors and general public concerned on the issue. (cehat@vsnl.com)
4. Booklet entitled ***'Enabling Legal Activism on the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994'*** compiled and edited by Veena Kumari published by Voluntary Health Association of Punjab – The booklet proves useful handbook for activists, lawyers, medical practitioners, AAs and others as it gives introduction to the law in a simplified manner and also attempts to clarify myths surrounding the issue of sex selection. The booklet also carries formats of complaints that can be made to the AA and also by AA before the court of law. (vhapunjab@rediffmail.com)

Newspaper Articles

1. Article entitled ***'Child Sex Ratio paints a pretty sad picture'*** The Times of India, Mumbai dt.13 Sep, 04
2. News paper clipping '***Patel offer bonds to couples with two girls'*** by Radha Sharma/ TNN
3. Article entitled ***'Haryana parents give girl child a bad name'*** by Sukhbir Siwach/ TNN
4. Article entitled ***'State govt. served notices on sonography machine seizure'*** The Times of India, Ahmedabad dt. 14 June 06
5. Article entitled ***'Stung By TV stings, doctors resolve to fight female foeticide'*** Daily Excelsior, Jammu dt.1st May, 06
6. Article entitled ***'Open seals from Sonography clinics: HC to govt.'*** published in The Times of India Ahmedabad dt. 21st June 05
7. Article entitled ***'The PC-PNDT Act needs to have more teeth: Banning sex determination test is not enough'*** The Telegraph, 29th June 2005
8. Article entitled ***'Sting Operations to Nab docs involved in female foeticides'*** published in The Hitavada, Nagpur on June 5th 2006
9. An article entitled **'Five Foetuses found in garbage dumb'** Times of India 4th June, 06

10. Article entitled **' Sex selection treatment costly affair'** The Times of India Dt 5th June, 06
11. Article entitled ***'Made in America: Its a boy for Indian couples'*** Times of India
12. A newspaper article entitled ***'Abortion Victim Takes Her Mother To Court'*** Chennai Deccan Chronicle, Chennai, Bureau dt. 5th July, 06,
13. Article entitled ' **Sex Ratio improves in Sirsa'** National Herald , Delhi Bureau dt.1st July, 06,
14. Article entitled ***'DCW to monitor pre-natal tests'*** Asian Age, N. Delhi dt.3rd July 06
15. Article entitled ***'They didn't doctor with naturee-Gynaecs fight perception of' enemies of girl child'*** by Rasha Sharma, The Times of India, Ahmedabad, TNN dt.1st July, 06
16. An Article entitled ***'Haryana records improved sex ratio***' The Hindu, N. Delhi, Bureau dt.5th July, 06
17. Article entitled ***'Worried Sikhs want to end to foeticide'*** by Asit Jolly Indian Express dt. 5th Feb, 06
18. Article entitled ***'Shabana campaigns against female foeticide'*** Indian Express dt.6th Feb,06
19. Article entitled ***'Govt. proposes amendments in law to curb foeticide'*** TNN
20. Article entitled '***Doctors responsible for decline in child sex ratio'*** Indian Medical Association; UN body decides to tackle issue.' The Indian express Pune dt.13 July,06
21. Article entitled '***Laadli' improves sex ratio: Haryana'*** published in Deccan Chronicle Chennai edition dt.31st July,06.
22. Article entitled ***'5 cr female foetuses terminated last year***' The Tribune, N. Delhi , Bureau dt. 31st July,06
23. Article entitled ***'All skewed up in Gurgaon***' by Payal Saxena, The Times of India, N. Delhi dt.31st July,06
24. Article entitled '***Shiela expresses concern over declining sex ratio - Govt. to curb evil practices like female foeticide'*** The Hindu, N. Delhi, Bureau dt.9th Aug, 06
25. Article entitled ***'Punjab village mourns unborn girls***' The Times of India dt. 23 rd Feb, 06
26. Article entitled ***'PNDT Act: Campaign planned to educate MBBS students.'*** Indian Express 2nd Feb, 06
27. Article entitled ***' More literate people abort female fetuses'*** by Anjou Giri in TOI dt. 27th Nov, 05
28. Article entitled '***Radiologist of govt. hospital caught conducting sex test'***, Indian Express dt. 5th Jan '06
29. Article entitled ***'Pregnant decoy delivers doctor to justice'*** Indian Express dt. 5th Jan, 06
30. Article entitled ***'Back in Business'*** 1st Sep,05
31. An article entitled ***'Incredible Cruelty of foeticide'*** by Sanjay Pendse The Times of India dt.19th Jan,06
32. An article entitled ***'Glimmer of hope in Madhya Pradesh'*** by Hemangini Gupta — IBN
33. Article entitled ***'Unwanted even before birth'*** by Nilanjan Bose & Hamanini Gupta — CNN-IBN
34. Article entitled ***'Cradle of controversy'*** by Rohini Mohan — CNN-IBN
35. 'An article entitled '***Babies killed, Brides bought'*** by Ripashree Nanda — CNN-IBN

36. An article entitled ***'Son temple of Punjab'*** by Nilanjana Bose — CNN-IBN
37. An article entitled ***'Fighting female infanticide'*** by Mythily Sivaram — the Hindu
38. An article entitled ***'Punjab village bucks foeticide trend'*** by Asit Jolly — BBC news Lakhanpal, village Punjab state Wednesday, 17 May 2006, 16:22 GMT 17:22 UK Wednesday, 19 March, 2003, 14:56 GMT
39. An article entitled ***'Abandoned baby boy reverses trend'*** by Sampath Kumar 19 March, 2003, 14:56 GMT BBC correspondent in Madras
40. An article entitled '***India's unwanted girls'***, Jyotsna Singh BBC Tuesday, 11 July, 2000, 15:55 GMT 16:55 UK
41. An article entitled ***'Dead before they are even born',*** The Hindu, Sun June 30, 2002
42. An article entitled '***Cell to check female foeticide on the cards',*** the Hindu, Aug 12,2005
43. An article entitled '***Implementation of PNDT Act better in north, says expert'***, The Hindu, Karnataka, Bangalore Saturday, Jul 23, 2005
44. An article entitled ***'Stringent Rules'*** by Gaurav Vivek Bhatnagar, The Hindu June 30, 2002
45. An article entitled ***'PNDT Act implementation in State unsatisfactory'*** Nagesh Prabhu, The Hindu, 20th July 2005, Bangalore, Karnataka
46. An article entitled ***'Foetuses in Aligarh Pond'*** by Pradip Saxena Hindustan Times, N. Delhi dt.22nd Aug, 06
47. An article entitled ***'Unborn daughters'*** by Prem Kumar Jansatta, N.Delhi dt.19th Aug, 06
48. An article entitled ***'Orders to cancel doctor license for foeticide'*** by Sushma Verma Hindustan, N. Delhi dt.22nd Aug,06
49. An article entitled ***'Female fetuses recovered in Aligarh'*** The Pioneer, N. Delhi PTI dt.22nd Aug,06
50. An article entitled '***Notice to centre, States on female foeticide Declining sex ratio will have serious repercussions'*** Dainink Jagran, N. Delhi, Bureau dt.19th Aug, 06
51. An article entitled ***'Law to prevent female foeticide has failed'*** The Times of India, N. Delhi, TNN dt.19th Aug,06
52. An article entitled ***'SC efforts to curb female foeticide wasted, says PIL'*** Times of India, Ahmedabad, Times News Network dt.19th Aug, 06
53. An article entitled ***'Patran foeticide tip of Iceberg'*** by Gur Kirpal Singh Ashok Times of India dt.20th Aug, 06
54. ***'The Victimizing Discourse: Sex Determination Technologies and Policy'*** is an article published in the Economic and Political Weekly (Feb 17, 1996) by Dolly Arora discusses the inadequacies and loopholes in legislative response, and recommends comprehensive review of state policies and programmes.

Articles Downloaded from the Internet

1. Article entitled '***Fighting Female Infanticide'*** by Mythily Sivaraman on The Hindu Online
2. Article entitled '***Preventive Measures for Elimination of Female Foeticide'*** by B.R. Siwal deputy Director, NIPCCD, Delhi
3. Article entitled ***'The Paradox of Modernity'*** by Marie Nilsson.
4. Article entitled '***Death before Birth'*** by Lalitha Sridhar www.islamonline.net

5. Article entitled '***Open Debate on Women's Rights'*** by Louisa Winkler; China Daily 7/20/2005)
6. Article entitled ***'Turning to faith to find the missing daughters'*** by Rasheeda Bhagat
7. Article entitled ***'Innovations in Tamil Nadu'*** by Leela Visaria, International Institute of Population Sciences1995 National Family Health Survey
8. Article entitled '***Female Foeticide – A sociological Perspective'*** by Manmeet Kaur, March 1993
9. An article entitled ***'Social Welfare and Nutritious Meal Programme Department'*** – A Policy Note
10. Article entitled '***Female Infanticide a Cause for Concern'*** by D. Sivarajan, The Hindu, 5th May, 2000
11. Article entitled '***Female Infanticide in Tamil Nadu, India: From Recognition Back to Denial?'*** by Dr. Sabu M. George
12. Article entitled '***Female Infanticide: Philosophy, Perspective, Concern of SIRD'*** by M. Jeeva, Gandhimanthi and Phavalam, July –Sept 98.
13. Article entitled ***'Technology and its impact on female foeticide in India'*** by Mr. Chetan Sharma and Divya Jain Source: govt. technology, i4d online
14. Article entitled '***Findings of the medical Journal Lancet'*** CNN/IBN
15. Article entitled '***Turning to faith to find the missing daughter'*** - A study of girl discrimination in urban Punjab, India by Marie Nisson by Rasheeda Bhagat
16. Article entitled '***Crisis of masculinity in Haryana - the unmarried, the unemployed and the aged*** 'by Prem Chowdhry
17. Article entitled '***UNICEF endorses multi-faith campaign against female foeticide'*** by UNICEF representative to India by Mr. Cecilio Adorna
18. Article entitled ***'Sex selective abortion and infanticide'*** from wikipedia, the free encyclopedia
19. Article entitled ***'Gujarat dangerous prosperity'*** by www.datamationfoundation.org
20. Article entitled ***'Missing female births in India'*** published on line, 9th January 2006 www.thelancet.com
21. Article entitled ***'Advocacy workshop on pre birth sex selective elimination of female foetus'*** by Datamation Foundation
22. Article entitled ***'Working together for Health'*** Centre for health education training nutrition awareness (CHETNA)
23. An article entitled ***'National legal advocacy campaign against sex selection and pre birth elimination of females'*** by IHC, CAPF
24. An article entitled ***'The Campaign Against Sex Determination Tests. In: The Struggle Against Violence'*** Ravindra R. P. Edited by Chhaya Datar. Shree Pub. Calcutta. 1993
25. An article entitled ***'Gender Differentials in Female Mortality Killer Mothers'*** by M.H. Ahsan
26. An article entitled ***'The missing girls'*** by Leela Visaria, The Hindu, 2002
27. An Article entitled ***'MTP Act-1971'*** by Kriti Dwivedi, National Law Institute University Bangalore
28. Report on ***'Implementation of PNDT Act – 1994 in Haryana'***
29. A Report of the Interactive Session on Female Foeticide ***'Achieving Equality: Addressing Sex Selection'*** (In Commemoration of World Population Day) an event organized by the National Commission for Women, United Nations Population Fund and Centre for Social Research, 18th July 2005

30. A Report on the ***'All India Conference on Implementation of the PC-PNDT Act'*** convened at Vigyan Bhawan, New Delhi on 11th August, 2005, by the National Commission for Women.
31. A Report on the ***'Implementation of Pre-conception & Pre-Natal Diagnostic Techniques (Prohibition Of Sex Selection) Act 1994 in Delhi'*** Issued In Public Interest by chairperson, State appropriate authority cum-director family welfare, Govt. of Delhi
32. An article entitled ***'Gender Issues – An Act on paper'*** by T.K. Rajalakshmi Volume 18 – Issue 12, Jun. 09-22, 2001,The Frontline
33. An article entitled ***'Gender Issues – Sex Selection and questions of law'*** Volume 17 – Issue 21, Oct. 14-27, 2000, The Frontline
34. An article entitled ***'Declining sex ratio – a matter of concern'*** by Roopa Bakshi, Outlook 1st August 2006
35. An article entitled ***'Female foeticide'*** by Madhu Gurang, 1998.

b) Review of the IEC Material – Posters

Communication material in its various forms has remained one of the prominent efforts in the range of efforts being done to tackle the problem of sex determination and declining number of girls. Both the State and the non-State actors have devoted quite a significant portion of their resources towards production and usage of such communication material. The field researchers of this study have collected as much material as possible during their field visits to various states. This material is primarily in the forms of posters, handouts, brouchers and audio-visual films or spots. The team scanned through 47 posters in various languages, to understand their content. And also attempted to use some of these posters in interactive exercises during our field visits to get a sense of audience response. The following review of posters is based on these two attempts. *The list of posters with basic essential details is given at the end of this review.*

Target audience – Major proportions of posters are targeting the community and are focusing basically on the social awareness. While addressing community at large the posters do not seem to have any specific audience in mind, such as rural/urban or youth, pregnant women etc. It can be inferred that they are generally appealing to men and women from reproductive age group. Most posters are not tailor-made keeping in mind specific audience.

In reviewing the 47 posters we came across only a single poster directly aiming at the medical community and stressing importance of ethical medical practice. Rest as mentioned earlier are generally targeted towards women and men.

Message – Thematically the sample posters can be broadly categorized in two types; poster directly talking about the issue of female foeticide and posters focusing on gender justice and social status of girls. Out of the sample of 48 posters, Twenty-six posters focused on directly conveying the message against sex selection. In the remaining 18 posters the problem of declining number of girls is put in the context of wider gender and human rights issues. 11 posters stressed on valuing girl child, 7 were on gender issues such as women's health, role of male chromosomes in sex determination etc. and one highlighted the right of a girl child to live.

The messages primarily covers illegality of the act, why the girls are needed and the consequences of the declining number of girls. Most messages make an emotional appeal by highlighting value of girl child or posing question about 'missing girls' or appealing against sex selection. This emotional appeal is portrayed through subtle imagery in some of the posters, such as flower symbolizing the girl child About eight posters have used violent imagery, such as use of weapons killing foetus, splashes of blood, a fist squashing the foetus, abandoned foetus etc. What type of depiction is effective depends on whom the message is addressed to. While the subtle types of messages and imagery seem to appeal to positive emotions like love, care and concern, the violent types shock the viewer by bringing out gruesomeness of the act. In our test group responses we received for and against comments on both these types. For instance, some perceived depiction of weapons in the posters as unrealistic and thought it needs to be replaced by medical instruments. Posters having violent kind of imagery were said to be effective in stressing gravity of the problem or urgency of the issue. Whereas subtle kind of imagery such as use of flower/bud or male – female symbols is not comprehended by people who are not exposed to such symbolic depiction.

Major proportions of posters are information based and therefore in effect are literacy dependent. Many of the posters are useful to generate discussion and not convey clear message by themselves. Thus their usage as a non-interactive medium is very limited and helps to the extent of giving visibility to the issue.

Many of the information-based posters tell about illegality of the act and possible punishment. Out of the total sample of 8 posters highlighting the legal provisions six were stressing on the provision of punishment to doctors and only 2 have explicit mention of the provision of punishment to parents and relatives. The posters published by the government seem to have less thrust on imparting legal information. Only one of the total 11 posters gave information on the law. It implies that the government material views it more as a social issue than a criminal one. Most of the posters published by state governments (see the list below) either highlight social consequences or value for girl child. There is comparatively less thrust on creating legal awareness.

The moral appeal or information on legal and clinical aspect in effect do not fully cover the complexity of the issue of SSEs, which involves diverse interest groups and value settings. Many posters fail to give sense of urgency to the issue. This in effect means that they do not engage non-converted and fail to make the audience to take notice of the message and think about it.

Our interactive session with the test group revealed that posters with visuals drawn from everyday life situations, such as father with girl child from Laadli campaign, are more appealing to viewers as these can be easily identified with. The idea of 'Vanishing girls' is being used very often in the posters. However, the statistical facts per se, do not seem to make much impact on the test group. Unless the consequences of declining number of girls, specific to the particular target group, are realized. For example – not getting bride for marriage, her abilities or caring nature to parents etc. seems to work with the respective audiences. Though these messages clearly reflect utilitarian value of women they seem to give people a sense of their possible loss and therefore have an immediate effect.

A striking gap is that none of the IEC material is looking at the issue in the context of right of abortion. This is reflected in messages as well imagery. Very often the messages tend to be anti-abortionist if there is not clear understanding of the legal right to abortion and legal prohibition for sex selective abortion.

The terminology used in posters is technical / clinical and not very people friendly. For example, the terms like sex selective abortion or stree bhroonhatya are often used in defining the problem, which common people may not easily comprehend. Therefore these need to be simplified.

Annotated List of Sample Posters collected during Field Visit

No.	Language	Description	Published by
1	English (three posters)	This series of three posters imparts information on the PC-PNDT Act and Rules as amended upto 2002 with powers of enforcement authorities and rights of women	Campaign Against Sex Selective Abortion (CASSA), 11, Kamala 2nd Street, Chinna Chokkikulam, Madurai 625002, Tamil Nadu Ph: 0452-2530486/ 2524762 sirdmdu@hotmail.com
2	Tamil (two posters)	The posters in local language highlight women's contribution to society and her productive role.	
3	Hindi (six posters)	The set of six posters together are directed towards information dissemination as well as attitudinal change. Two posters primarily convey illegality and provision of punishment for SD and SSA. Of the remaining four, one directly hits the prevalent attitude towards girls; that she is a burden and therefore unwanted. Two other posters give scientific information that male chromosome decides the sex of the foetus and therefore it is incorrect to blame a woman for giving birth to a female child. One poster is addressing men to give respect to their wives and love and attention to their children. The posters touch upon almost all concerning areas fuelling the problem of SSEs.	Voluntary Health Association of India Tong Swasthya Bhavan, 40 Kutub Institutional Area, New Delhi 110016 Ph: 011-6518071, 6515018 vhai@vsnl.com
4	Hindi	This highly informative poster appeals both to doctors and general public- Stop killing the female in fetuses! It explicitly mention that the parents and close relatives are also guilty under the law.	State Resource Cell of Population and Development Studies, Shimla, Himachal Pradesh

No.	Language	Description	Published by
5	Hindi	The poster appeals to 'Denounce Feticide' and thus appeals to stop all abortions.	Shri Jain Shwetambar Terapanth Mahila Mandal, Jaipur, Rajasthan
6	English	This attractively designed poster has clear message that Sex Selective Abortion is unethical, illegal and inhuman. It also stresses the right of the girl child to live.	Vimochana – Forum for Women's Rights No. 33/1-9, Thyagaraj Layout, Jai Bharat Nagar, Bangalore 600033 Ph:080-5486934 awhrci@vsnl.com
7	Gujarati	This poster states the fact of 'missing girls' converting the census statistics in simple numbers people would understand. It explains how families, doctors and the state are responsible for this over 4 lakh missing girls in Gujarat.	Sahiyar (with Socio-Legal Information Center, Mumbai) G-3, Shivanjali Estate, Navjeevan, Aajva Road, Vadodara
8	English	The poster shows the doctor refusing to to do SD. The poster significantly brings out the need of ethical practice from the medical community in order to effectively curtail the practice of SD.	Center for Enquiry into Health and Allied Themes (CEHAT) Survey no. 2804 & 2805, Aram Society Road, Vakola, Santacruz (East), Mumbai 400055. Ph. 022-26673571 cehat@vsnl.com
9	Hindi (eight)	The set of attractively designed eight posters is published as part of 'Laadli', a campaign on the issue in Mumbai, urge for love, care and equal treatment/ status for girls. The visuals of common people in some of the posters makes viewer identify with them.	Population First Shetty House, 3rd Floor, 101 Mahatma Gandhi Road, Mumbai 400 001, Ph: 022-22626672 info@populationfirst.org
10	English	The headline of the poster says – Endangered; India's vanishing girl child. The poster gives comprehensive information at a glance by describing nature of problem, consequences and the act. It also lists possible actions that can be taken by individuals and organisations.	Human Rights Law Network Ph: 011-24374501/ 24376922 hrlndel@vsnl.net/ wji.delhi@hrln.org www.hrln.org

No.	Language	Description	Published by
11	Hindi (two)	The poster highlights significant role girls' play in the lives of parents and appeals to break silence concerning their disappearance. The other poster expresses the aspiration of the female fetus to take birth and see the world. The poster has a collage of news items highlighting the problem of declining number of girls.	Action Aid B-20, Khandela House, Shiv Marg, Bani Park, Jaipur 302016
12	Gujarati	Poster announcing 'Matruvanadana Yatra' as part of Dikri Bachao Abhiyan launched by the CM in the state. The poster highlights the consequences of declining number of girls on women and men. It will make women's life insecure and will make men more criminal.	Khetiwadi Utpanna Bajar Samiti, Visnagar, Mehsana
13	Hindi (three)	Set of three posters with sketches/photos of foetus killing. Direct hitting visuals showing the gruesomeness of the act of SD.	Center for Health Equity and Prayas 22, Suraj Nagar (east), Civil Lines, Jaipur Ph: 0141-2220421
14	Hindi/ Gujarati	Poster states fact that more than 4 lakh girl children are missing only in Gujarat! And appeals the viewers to thinks for its causes.	Olakh 24, Jalaram Park, opp. Lal Bahadur Shastry School, Harni Road, Vadodara 390006, Gujarat Ph: 0265-2486487/ 2466037 olakh@satyam.net.in
15	English/ Gujarati	Poster emphazises value of girl child through a beautiful visual of playful girl child	
16	Kannada	The poster highlights need for equal treatment and opportunity for the girl child.	——
17	English/ Hindi	The poster appeals that eliminate discrimination not women. Highlights girls positively.	CAPF (Campaign Against Pre-Birth Elimination of Females) Resource Centre, 28-B, DDA Flats, Shahpur Jat, Khel Gaon Marg, Delhi 49, Ph: 55162322 capf.nirali@gmail.com
18	Hindi	The poster conveys value of women and highlights various roles they perform in society and their potential contribute. The poster also has an appeal by CM that Female foeticide is a sin.	IEC Bureau, Rajasthan

No.	Language	Description	Published by
19	Gujarati (Six posters)	Emotional appeal that stop abortions and save mothers. The message is clearly anti-abortionist and stresses utilitarian value of women	IEC bureau and Health and Family Welfare dept. Govt of Gujarat
20	Marathi (three posters)	One of the posters highlights possible consequences declining number of girls. What will men miss; a bride and a sister, if women's number goes down.	IEC Bureau, Maharashtra
21	Marathi	Poster exhibition highlights rich history of Maharashtra and women's contribution towards development of the state. It states the issue on this backdrop and appeals views to think about it.	All India Democratic Women's Association (AIDWA), 121, V P House, Rafi Marg, New Delhi 110 001 Tel: 011-23710476 aidwa@rediffmail.com

c) Annotated List Of Sample Films Collected During Field Visit

1. A docudrama on female foeticide by PFI and Plan India – ***Simatata Kanya Ka Astitva*** – Hindi – 25 minutes
   The film is a mix of fiction and factual information. The first part of the film shows an aged father, with his wife, feeling ill and is waiting for his son to come and take him to the doctor. However the daughter comes for their help instead. The consequent part is a conversation with a Gynaecologist, one lawyer and a psychiatrist on PNDT, on the role of doctors and what are the mentalities associated with female foeticide. This highlights the role of family physician in counseling the family not to go to sex determination.

2. **Films by Population First**,
   a. ***Laadli, a Girl Child campaign by Population First*** – It is one minute 56 seconds spot in English made by Sunita Rao. The film conveys that girls are adorable and valuable with a montage of small girls and good sound track. The film ends with an impact "And to think that I prayed for a boy".
   b. Four minutes fifty five seconds spot in English made by ***Laadli*** campaign shows declining number of girls at national as well as Mumbai level. It highlights women's productive role and contribution to the society is made to introduce the Laadali campaign in Mumbai.

3. ***'Bitiya ne Janam Liya'*** a 5 minute film made by Tanuja Chandra in Hindi made for Health and Family Welfare Department of India.
   The film shows story of a girl from affluent family who has been neglected from her childhood by her father who was expecting a son. Finally the daughter gets his recognition when she achieves a medal in her school/ college. This emotionally appealing film has famous actresses Waheeda Rehmaan and Miss India Diya Mirza playing lead roles.

4. ***'Ladkahi hoga'*** 12 minutes animation film in Hindi is one among the *Meena* series produced by UNICEF
   This is one of the films in a series of animation films made on value of girl and their rights. Protagonist Meena takes the messages of gender equality, education for the girl child to people. This particular episode is an attempt to bring about the son preference in the community. It does not touch the sex determination and pre birth elimination of females. It shows a pregnant woman and her family desiring for a son and being upset when she has a daughter. It is through Meena that they realize the importance of girl child and what all girls can do (in this particular case, she helps the father in law start his tractor).

5. ***'Vo Anchahi Pari'*** a 21 minutes film in Hindi film presented by Kishenchand Chellaram College directed by Ruchit Shah and Ankit Khandelwal
   The first half of the film shows story of middle class a family. The daughter-in-law is pressurized by the mother-in-law to bear a male child. However, she does not succumb to the pressure and asserts that she would give birth to the female child. (despite having two previous daughters). The second part of the film has eminent women professionals from academics, media and police force, expressing their views on gender equality, sex selection and particularly appeal the young generation against sex selection.

6. An **untitled 2 minute spot in English** made by Hayden Francis shows the fetus, at its various stages of growth, talking to the viewer about its aspiration to come to this world and seek love and care. However, it is terminated when parents come to know the sex of the foetus. The film has effective visuals and script conveying the message against sex selection.

7. ***'Agony of a girl child',*** a 55 seconds spot by Kaashvi Nair tells don't murder the girl child

8. ***'Let me Live'*** a one-minute spot made by Mangesh Joshi for CYDA highlights value of girl child and her right to live

9. A film entitled ***'A Fine Imbalance'*** by CEHAT is 12 minutes duration in English
   The film, through interviews with activists and doctors, gives an overview of the issue of sex selection and pre birth elimination of females. It mentions some national statistics, graphs, and explains the patriarchal reasons and consequences of declining child sex ratio in the country. The film also mentions about the PNDT act and about the later amendments and how it came to be PC-PNDT act.

10. Audio-visuals By **UNFPA**
    a. Five CDs by UNFPA, containing proceeding of the workshop for religious leaders held on 8/11/05
    b. Communication Dossier I – This includes links to crucial information and events on the issue.
    c. Communication Dossier II – Includes news stories broadcasted on various news channels.

i. News story on BBC in Punjab made immediately after the first conviction of doctor under PC-PNDT. Highlights widespread practice of female foeticide through interviews of women and Aanganwadi workers.

ii. CNN-IBN story in Panipat, Haryana covers custom of 'bartering girls' in Rode community. The girls are married in a home from where her family can get girl for their son. News reveals that this custom is under threat due to lesser number of girls and families are opting to 'buy' girls from outside community. The story concludes that young girls are in demand, but at the expense of their dignity, which is being bought and sold in the market of marriage.

iii. Channel 7 story in Hindi from Punjab informs about website pregnancystore.com, which is used as a channel by many affluent class women for sex determination. The site offers a service called baby gender mender, popularly as *jantar mantar kit*, which is being used by upper class educated women having access to net.

iv. DD News – Talk show in Hindi broadcasts interview of Arvind Kumar, Ex-DC of Hydrabad who has taken stringent action against illegal practices of clinics in the city.

v. DD News – in their programme on Delhi Round Up broadcasts special event on the eve of women's day where CM Sheila Dixit gave oath to women. The women expressed their commitment saying that they would not go for testing at this launching event of Beti Bachao campaign in the city.

vi. India TV – News covers a birthday celebration with a difference. A popular comedian Jassi celebrated his birthday by giving public message to honor girl child and women.

vii. CNN IBN story on the vanishing girls mainly covers skewed sex ratio in Delhi and highlights rampant illegal use of ultrasound as its primary cause.

viii. Sahara Samay – Story from Varanasi of a novel marriage where brides brought barat to the grooms' home. This initiative by a local doctor is to challenge conventional practice of groom taking barat to bride and seeks to establish gender equality.

ix. Sahara Samay – Story covering the launching event of the campaign 'Beti' against female foeticide Anu Ranjan of Indian Television Academy

x. CNN-IBN – story from Shivpuri, MP covering the status of sex selective practices in the area. It was done after the seal on some of the clinics was revoked by the state appropriate authority

xi. Zee News – Story of launch of Beti Bachao Abhiyan by Chief Minister, Gujarat

xii. Zee News – Story from Punjab of a novel programme, which was organized to salute spirit of womanhood. New born girl children and their mothers were felicitated on this occasion by local leaders.

11. ***'The Condemned'*** a 90 seconds audio-visual spot by FOGSI (Federation of Obstetric and Gynecological Societies of India.

FOGSI, with a purpose to empowering women with health, has produced a series of audio-visual spots by appealing to eminent actors and directors to contribute towards the cause. One of the spot is on female foeticide. The film begins with '*god bharai*' event in a family. When suddenly the woman imagines the child is her hand falls down because it is a girl and dies. It concludes with a message by well-known actor Amitabh Bachchan who

talks about value of the girl. And also stresses utilitarian value of girls saying, '*Betiyan nahi hongi to bahu kahan se ayengi?*' very convincingly, again portraying the.

12. ***'Atmajaa'*** – This serial written and directed by Madhab. N. Panda and supported by Plan India in Hindi is broadcasted on DD.
    Atmajaa, which means born from the soul is a woman-oriented maga tele-serial. The baseline being on female foeticide and its root causes, the serial attempts to explode myths that daughters are a liability. The story revolves around a young woman, Mamta, who is forced to undergo sex determination test in her seventh month of pregnancy by her husband and mother-in-law Mamta runs away to save her second child and to search for her first daughter. As she goes through her fight and her search she comes across various people with an interesting mix of lifestyles and opinions. And each episode explodes the different issued of female foeticide; such as property rights for women, reproductive rights, dowry, dignity of girl child, gender discrimination etc. Contact – Eleanora Images – madhab17@rediffmail .com, Plan India – india.co@plan-international.org

13. The untitled spots produced in public interest by **Indian Television Academy (ITA),** 35 seconds duration each in English. This film has celebrities like well know director, actor and actresses upholding value of the girl child.

14. 'Matrubhoomi – A nation without women', is a feature film directed by Manish Jha is released in 2003-2004.
    The film is a violent representation of a future world without women. The background articles about the film state that the young director was inspired to do a film on sex selective practices when he came across news of a village in Gujarat where no girl is born for years. The director takes a leap into imaginative world where there are hardly any women, as all females were either killed in the womb or after the birth. Through a storyline of even more dehumanized and patriarchal 'men's world' the film stresses that lesser numbers in no ways is going to uplift the status of women, rather would lead to greater control upon and violence against them.

15. *'Hasina'**, a Film by Kannada filmmaker Girish Kasarvalli on barbaric discrimination against female fetuses in India.

16. '***Karuthamma***'* meaning Black Mother, a film by the well-known Tamil filmmaker Bharathiraaja in 1994, is a film in Tamil on female infanticide.

* From secondary sources – Newspaper clippings

Annexure IV

Efforts by Enablers

This is clearly not an exhaustive list – neither exhaustive of all the organisations or individuals working on this issue in the nine states visited, nor of all their work. However, it is based on the information that the study team was able to collate through the four months of its study and includes all those the team interacted with - often with varying degrees of intensity. Hence the 'description' given is based on the data the study team was able to collect and does not pretend to describe adequately everything a group/ individual may have done or is involved with on this issue.

ACTIONAID
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Jaipur-302016, Rajasthan
Phone: 0141-2207502/2207683
Email: vijayaj@actionaidindia.org
Website: www.actionaid.org
Contact Person: Vijayalaxmi

Action Aid is working with rural communities in Rajasthan state on the issue of sex selection. It has mobilized women's Self Help Groups and Mahila Mandals to work on the issue. The groups that have been sensitized are now adopting the strategy of community rejection by making other community members aware and motivating them not to go in for sex selection. This also includes keeping vigil on the community members to curb the practice of sex selection in their village/community. Partnering with a Jaipur based NGO, Praytna, the programmes are aimed at developing and capacitating community groups and networking with other like minded partners in the state.

ACTION INDIA
5/27A, Jangpura-B
New Delhi
Phone: 011-24374785, 24327470
Email: actionindia@vsnl.com
Contact Person: Gouri Chowdhary

Action India is working in Delhi for 30 years. It has been working directly with the communities. One of their key initiatives at the grass roots was the formation of Sabla Sanghs and the Mahila Panchayat Network around Delhi in affiliation with the Delhi Commission for Women. Action India works with a feminist perspective on gender based violence and is at present coordinating the National Secretariat on implementation the PWDV Act 2005. (Protection of Women from Domestic Violence) At the community level the organization is

working on the issue of sex selection within the overall context of gender equality and son preference. This includes working with newly married couples, taking up cases of violence against women and highlighting the value of the girl child through celebrating the birth of girls. Action India has initiated a campaign to save the girl child by involving children, youth and women taking the message to the public by organising events and rallies to highlight the issue of declining Child Sex Ratio and importance of implementing the PCPNDT Law .The members of the organisation were also on the District Advisory Committee in East Delhi. In 2005 Action India initiated a joint forum called CAPED (Citizens Againsts Pre-birth Elimination of Daughters) and were actively involved in monitoring the working of the Appropriate Authority in Delhi, with the focus on the audit of the F Forms maintained in order to check the misuse of Ultrasound by the medical community. Action India undertook a study of 3000 women in the Najafgarh Area in 2004 on declining CSR to understand women's perceptions on family planning, abortion rights, contraception and women's control over their body and decision making in the family. In 2005 Action India in collaboration with NMML (Nehru Memorial and Museum Library) brought together intellectual and activist from across the country to better understand the development paradigm and impact of reproductive technology in a globalized world and the question of son preference and the inability to curb the growing misuse of sex detection and sex selective abortion.

AHMEDABAD WOMEN'S ACTION GROUP (AWAG)
Hindu Arogya Bhuvan,
Near Highway Char Rasta,
Dist. Patan, Radhanpur-385340
Gujarat
Phone: 02746-277870
Contact Person: Ila Pathak

AWAG has been active on this issue since 1989, when like-minded organizations started a campaign to highlight the problem of sex selection and to demand a law at the state level. The issue was vastly debated and the medical community was very much against any legal regulation for SD. Since then the organization has been active at various levels. At present AWAG is involved in awareness building and the implementation process of the Act. Ila Pathak, founder of the organisation, is the NGO representative on the State Appropriate Authority, which is a three-member body at the state level to take decisions on the appeals made under the PC-PNDT Act.

ALL INDIA DEMOCRATIC WOMEN'S ASSOCIATION (AIDWA)
E-5, ENSA Hutments, Mahapalika Marg
Mumbai - 400001
Phone: 022-56286823
Email: aidwa@rediffmail.com
Contact Person: Kiran Moghe

AIDWA looks at the issue of sex selection as a ramification of the wider issue of gender inequality. AIDWA has therefore been attacking dowry, raising the question of ostentatious marriages and the issue of bride purchase, which is a further devaluation of women.

AIDWA also has a media-monitoring group that looks into the portrayal of women in the media.

AIDWA organized an awareness campaign on the issue in five districts of Maharashtra which had the worst sex ratios in 2005. It organized public gatherings & rallies throughout the belt, with the result that its activists got charged and planned a decoy operation in Pune. This led the group to get involved in the nitty-gritties of the Act.

ARAVALI VIKAS SANGATHAN (ARAVIS)
Plot No.36-41,
Udyog Kunj,
Village- Alipur,P.O.Ghamroj,
Gurgaon, Haryana
Phone: 9810131578
Email: aravisvikas893@hotmail.com
Website: www.aravisindia.org
Contact Person: Gayatri Paul

ARAVIS, with support from PFI, initiated an awareness programme on female foeticide and gender issues by mobilizing youth in six districts of Delhi. The intended outcomes of the project were sensitisation of the target population on the issues relating to female foeticide, girl child, gender issues and empowerment in an interactive manner.

ARVIND KUMAR
District Collector,
Hyderabad district,
Nampally, Hyderabad-500001, AP
Phone: 040-23202833

Hyderabad district collector Arvind Kumar has made efforts to implement PCPNDT Act as a means to keep check on clinics. He first conducted a sensitization workshop in October '04. Only 124 out of the total 389 scan center operators turned up. He collected information on Form F between Sept-Nov '04. Only 245 centres submitted records to the district medical health officer.

After scrutinising these records action notices were issued to 361 ultrasound centres for non-compliance with the Act. Licences of 91 centres were cancelled. Some 83 machines were seized from them and 71 released after an undertaking and fine. Three suppliers were prosecuted for supplying machines to clinics with no registration licenses.

The collector has also been instrumental in starting a campaign against female foeticide. It is a rule for every scan clinic in Hyderabad to display a poster showing that sex selection and determination is a crime. Kumar has even written a manual on understanding and implementing the PNDT Act. (Based on article published in The Outlook, February 2006)

DR. ASAVARI SANT
Belgaum
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In Feb 2003, based on the information in the local newspaper on doctors indulging in sex selection, Parivartan, local group, decided to organise a two-days workshop for its activists. Dr. Sabu George (CWDS), Sanjay Parikh (Supreme Court lawyer) and Dr. Sanjay Nagral (Medical Ethics) briefed the activists and consequently a campaign titled - Bring Forth the Girl Child – was launched. Subsequently a series of three workshops were organized for IMA members, medical students, and also for Anganwadi workers and Govt officials (with district administration).

The organisation also carried out several awareness sessions for mahila mandals, both in rural and urban areas with local NGOs And also organized essay and elocution competitions On March 8, 2005 a rally with 1000 women was held on the streets of Belgaum demanding to stop female feticide and bring forth the girl child. Balika janmotsav were held to stress the need to welcome the birth of a girl. Around the same time a painting exhibition was held on the issue and a pamphlet giving information about Belgaum scenario and PCPNDT was brought out.

DR. B.S. DAHIYA
4611 Sector-23-A
Gurgaon, Haryana
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Email: dghsdahiyabs@yahoo.co.in

Dr. B.S. Dahiya, who has been working on the issue since 1980s, was the Director General Health Services, Haryana and also worked as the State Appropriate Authority. Under his chairmanship a task force was constituted consisting of dedicated officers of the department. This task force worked with the help of local health officers, media persons, NGOs and police.

Many ultrasound machines were seized by the state task force, sealed and the license suspended. The respective District Appropriate Authorities undertook further investigations and legal processes. It created a very good impact in the areas and is expected to prove detrimental to the unscrupulous elements.

Dr. Dahiya believes that strong implementation of the law is the only thing that will work . The very first conviction under PC-PNDT is also an outcome of rigorous groundwork and follow-up by Dr. Dahiya.

Dr. Dahiya developed a strategy to work on the issue primary focusing on strict vigilance. He scrutinized and studied F forms to identify the defaulters. On the basis of this base line information he undertook planned as well as surprise visits to clinics , did several decoy cases and filed cases in the court.

BHARTIYA GYAN VIGHYAN SAMITI (BGVS)
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EngineGhar,Sanjauli,
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Phone: 0177-2620540
Email: anshumala@yahoo.com
Contact Person: Anshumala Gupta

Post 2001 census BGVS, HP decided to work on the issue in Shimla. Initially it got involved in creating general awareness by distributing pamphlets & other information material. The members of the organisation also held meetings with the religious and political leaders on the issue.BGVS also wanted to do something against doctors on a significant basis. For that it prepared a strongly worded appeal and visited about 52 clinics in Shimla urging doctors to take stand on this issue. In order to keep momentum of the work BGVS involved 28 organizations to work collectively on this issue.

During the Navratri festival in 2006, BGVS organised a campaign around the local religious/ cultural practice of 'girl worship' that takes place during this festival. On the Dasshera day, the campaign ended the 9-day programme with Ravan-dahan (burning effigy of Ravan). The event gained wide publicity. The major gain of this 'culture' campaign was that gender issues were able to reach widely across the various communities. One direct result of all this pressure on the medical community was an immediate meeting of the Shimla Medical Association to discuss the issue of sex selection.

CAMPAIGN AGAINST SEX-SELECTIVE ABORTIONS (CASSA)
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Contact Person: P. Phavalam/M. Jeeva

The Campaign Against Sex-Selective Abortions (CASSA)- a movement of non-governmental and women's organizations, human rights groups, lawyers, educationalists, academicians, media persons and activists led by the Madurai-based Society for Integrated Rural Development has, since December 1998, been working towards stopping the usage of sex selective technologies and techniques in medical practices and implementing a multi-pronged strategy for preventing and halting the declining child sex-ratio. The campaign since its inception has been seeking to prevail upon the Appropriate Authority to regulate the setting up and functioning of scan centers.

CASSA locates the Campaign Against Sex Selective Abortion in the overall struggle for social change towards empowerment of women and protection of children's rights, and strongly believes that this campaign should have its own agenda and programmes and formulate specific strategies to eliminate this gender violence.

CASSA and its member organisations have representation in the Advisory Committees at the District -level. CASSA has filed several petitions against violations under PC-PNDT Act which are pending before the department for necessary action. CASSA periodically collects data on vital statistics from PHCs and reviews the trend and accordingly submit memorandum to the Government for necessary action. CASSA has periodically involved in advocacy and lobbying with political parties and members of legislative assembly and parliament for legislative and policy changes with regard to PC-PNDT Act, Girl Child Protection Scheme and Cradle Baby Scheme. CASSA has also brought out educational materials, posters and resource manuals for VHNs, Adolescent Girls, Panchayat Presidents, Media and Doctors.

CENTER FOR ADVOCACY AND RESEARCH (CFAR)
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New Delhi-110019
Telefax: 011-26292787, 26229631, 26430133, 41600905
Email: cfarasam@ndf.vsnl.net.in
Website: www.cfaronline.org
Contact Person: Ms. Akhila Sivadas

With the PIL Case on the non-implementation of the PNDT Act filed in the Supreme Court by 2000, CFAR initiated the process of advocating with the media and strengthening evidence based reporting on the issue of sex selection and sex determination. Since then, we have conducted seven major media sensitization workshops, addressed a cross section of media practitioners from national, regional, English, language, print and electronic media. We have reached out to over 250 journalists many of whom are working in States with adverse sex ratio.

While the process of media sensitization was going on, Registrar General and Census Commissioner, Government of India was processing the data on sex ratio and updating the evidence. The workshops helped us to do “real time” dissemination of the data, build very effective partnerships and collaborations with many civil society organizations as well as committed officials and sustain the campaign on the media.

With the closure of the PIL in 2004, CFAR felt the need to strengthen the response on the ground, enable Appropriate Authorities and civil society organizations to implement the law with adequate know-how and commitment. In the last two years, we have been collaborating with many grassroots organizations and implementing authorities in different districts and regions of Rajasthan to strengthen their capacity to consistently enforce and implement the different provisions of the PCPNDT Act, in particular those simple clauses that create timely checks and balances against the misuse of technology.

CENTRE FOR WOMEN'S DEVELOPMENT STUDIES (CWDS)
25 Bhai Vir Singh Marg (Gole Market)
New Delhi-110 001
Phone: + 91-11-23345530 or + 91-11-2336 5541
E-mail: cwds@vsnl.com, cwds@cwds.org, cwdsorg@eth.net, cwdslib@vsnl.net
Contact Person: Mary John

The Centre for Women Development Studies, CWDS founded in 1980, has tried to build and expand the theoretical and empirical base on gender issues and combine research concerns with action and advocacy. CWDS was also instrumental in spearheading the campaign against pre-birth elimination of females (CAPF) on the issue of female foeticide in Delhi.

CENTRE FOR ENQUIRY INTO HEALTH AND ALLIED THEMES (CEHAT)
Survey no. 2804 & 2805, Aaram Society Road,
Vakola, Santacruz (East),
Mumbai.
Phone: (022) 26673154/26673571
Email: cehat@vsnl.com, Website: www.cehat.org
Contact Person: Adv. Kamayani Bali Mahabal

Some of the trustees of CEHAT have been actively involved in initiating the State level Campaign against SD, which led to the formation of Maharashtra State level Act against Sex Determination. The organization was also an important partner (with MASUM and Dr. Sabu George) in filing the PIL in 2000 for non-implementation of the Act. CEHAT is primarily involved in Advocacy and awareness with various stakeholders. They are working with the education department, Aanganwadi workers, Doctors' associations and so on for awareness and implementation. They have filed cases and are networking with various organisations on the issue. The organization has published awareness-building material in English, Hindi and Marathi, which includes FAQs, posters, books and films. They are planning to publish a table calendar for the doctors with messages against SD and role of doctors in addressing the issue. They are also attempting to collect data on all cases filed in India under this Act and to analyse them in order to help activists to understand the best way to handle these cases.

CENTRE FOR HEALTH EDUCATION TRAINING AND NUTRITION AWARENESS (CHETNA)
Samvaad, Heritage Conference Centre,
3010,Desai Ni Pole, Khadia
Ahmedabad-380001, Gujarat
Phone: 079-22111405
E mail: chetna@icenet.net
Website: www.chetnaindia.org
Contact Person: Ila Vakharia

CHETNA has been spearheading the campaign against sex determination in Gujarat with a network of NGOs. Their work in this area includes a wide ranging of activities, such as base line and perception studies, focussed campaigns, capacity and perspective building of NGOs,

sensitisation of political leaders, community leaders and corporate/industrials and advocacy. They have launched a campaign titled 'Valuing the Girl Child' and have come out with useful information and communication material on the issue. The organization has initiated awareness programmes in collaboration with the govt. The organization has also given four media fellowships to enhance media coverage on the issue. CHETNA has made the issue of declining sex ratio central to its efforts in Gujarat and has also attempted to link it with health advocacy throughout India.

CHETNA, initiated an intensive campaign, reaching out to 1,20,000 people (including women, youth groups, milk cooperatives, schools and colleges) of 180 villages in five blocks of Mehsana and Sabarkantha Districts of Gujarat State to address the survival issues of the girl child in the year 2005-06. CHETNA and its partners are also involved in district level advisory committees. CHETNA is also part of the District Monitoring and Inspection Committee formed to support the implementation of the PC-PNDT Act in the state.

As a result of the organisation's efforts community leaders got motivated to initiate various activities. The sarpanchs of some villages have pledged to take up the issue during the gram sabhas so that the message is conveyed to all villagers. More than 20,000 people took oath that they would not to resort to sex selection practices.

DALIT MAHILA FORUM
109/1 Sai Colony, Shahu Nagar,
Kodholi Satara District,
Maharashtra-415001
Phone: 02162-221031
Contact Person: Adv. Varsha Deshpande

The organization is based in Satara and primarily works on women's issues through awareness, mobilization and legal aid. The organization has initiated a number of decoy cases. In fact, Satara district has the maximum number of decoy cases in the country. After having exposed a number of doctors, the organisation feels the need to emphasize on streamlining legal processes to ensure convictions. Adv. Deshpande feels there is lack of sensitivity and understanding among lawyers and judges and therefore there is a need to appoint a special prosecutor who is sensitive towards the issue. With the support of the State Family Welfare Bureau, the organization has organized workshops in 36 medical colleges to sensitise the medical community on the issue. The medical students later contact the organization and are willing to support the cause.

Apart from decoy cases, Adv. Deshpande and her organisation are also actively involved in creating public awareness on the issue. For example, they initiated 'Balika Janmotsav' (Programme celebrating the birth of girl child).

DATAMATION FOUNDATION
'Vimal Shree'
B-12, Swasthya Vihar, Vikas Marg,
New Delhi 110092
Phone: 01122512161/2216682
Email: response@ datamationfoundation.org
Website: www.datamationfoundation.org
Contact Person: Chetan Sharma

Datamation Foundation is a community-based organization working with students and teachers to build their capacity on the issue through information technology. The chief functionary of the organization Chetan Sharma is an IT expert and he has designed and set up the website (with financial support from Plan International) called www.indiafemalefoeticide.org. He believes that those who make the most crucial decisions as far as curbing the practice of foeticide is concerned are those who access this technology most and are what he calls 'well-wired people'. At the same time there is also a realization that people who access this technology are also those who are educated and resourceful, and could be potential or present users of the Internet. The website offers information about the law, and about various community-based initiatives of the Foundation. It also offers a section whereby users can lodge complaints about any person they know of who would have accessed the service, any doctor or any service centre like a hospital or clinic. The website is made popular at the community locations where Datamation works. It also trains students and teachers on how to use the website. The portal has been launched at some other places also (like in the office of the Campaign Against Female Foeticide, at Shahpur Jat, New Delhi).

Datamation has also done some decoy operations with the community women they work with. They also report about these directly to the Director PNDT.

DESH
House No 1334, K Block, Jahangirpuri
New Delhi 110033
Contact Person: Jojo Thomas

One of its programs was a forty days' campaign on the issue. It identified peer educators and trained them on the issue and encouraged them to take some collective action. A street play group was formed and it performed in the community. It also took out a community newspaper on the issue to which young people and adolescents from the community were encouraged to contribute.

FEDERATION OF OBSTETRIC & GYNECOLOGICAL SOCIETIES OF INDIA (FOGSI)
Kwality House Above Chinese Room Kemp's corner
Mumbai-400026
Phone: 022-23802684, 23803965
Email: durushah@hotmail.com
Contact Person: Dr. Duru Shah

In January 2004, the Federation of Obstetric & Gynaecological Societies of India (FOGSI) condemned prenatal sex determination and passed the following consensus statement: "FOGSI strongly condemns the practice of pre-natal sex determination and female foeticide and all the discrimination against women. FOGSI shall contribute with all its resources to bring an end to such an abhorrent practice, a great social tragedy in India." FOGSI sent a circular to all its 18,000 members requesting them to refrain from any activity that leads to female foeticide and to comply with the PC-PNDT Act. FOGSI has made audio-visual spots on women's health issues, including SSEs.

HUMAN RIGHTS LAW NETWORK (HRLN)
65, Masjid Road, Jangpura,
New Delhi-110014
Phone: 011-24324501,24316922
Email: hrlndel@vsnl.net
Contact Person: Shruti Pandey

The Human Rights Law Network (HRLN) is a collective of lawyers and social activists dedicated to the use of the legal system to advance human rights. HRLN provides pro bono legal services, conducts public interest litigation, engages in advocacy, conducts legal awareness programmes, investigates violations, publishes 'know your rights' materials, and is participating in the campaign on the issue of sex selection. It has also been involved in workshops for the legal community specifically on the issue of sex selection and PC-PNDT.

INTERNATIONAL FEDERATION OF ELECTION SYSTEMS (IFES)
E-24, Durga Marg, Banipark, Jaipur,
Rajasthan
Phone: 0141 - 2704806
Email: msingh@ifes.org
Website: www.ifes.org
Contact Person: Dr. Meeta Singh

IFES has initiated several measures to address the issue under its programme titled - Dignity of the Girl Child. These include; A compendium of efforts addressing the issue of declining sex ratio and sex selective abortions, primarily to understand what works and what does not, Support for the sensitisation workshops with 6 communities in Jaipur that were conducted by RUWA. IFES is also partnering with three NGOs in 6 districts of Rajasthan state who are working through community groups to build a 'community watch'. Towards this end community groups, Aanganwadi workers etc are being capacitated to carry forward this work

without much external support. IFES has prepared a legal manual for doctors and lawyers and also commissioned a study on the status of implementation of the PCPNDT Act in Rajasthan.

INDIAN MEDICAL ASSOCIATION (IMA)
IMA House,
Indraprastha Marg
New Delhi
Phone: 011-23370009, 23378819
Email: sharda.lifecare@gmail.com
Contact person: Dr. Sharda Jain

The Indian Medical Association formally recognized that doctors are indulging in SSEs and officially condemned this practice at the National workshop held in August 1998 in New Delhi. Subsequently a letter was despatched from Hon. General Secretary to all branches on this issue.

IMA along with the National Commission for Women and UNICEF have launched a campaign against gender discrimination and female foeticide. The Indian Medical Association organized a meeting of the religious leaders from across the country to create public awareness to evolve an effective strategy for preventing female foeticide in June 2001 in New Delhi**.**

INDIAN MEDICAL ASSOCIATION (IMA), MAHARASHTRA
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Concerned with the decline sex ratio Indian Medical Association, Maharashtra initiated campaign - 'Girl Child, Nation's Pride', in 2006. IMA with UNFPA is organizing 12 workshops in 10 districts across the state where sex ratio is below 900. The IMA President Dr. Ashok Adhao got concerned when he came face-to-face with the statistics of sex ratios in Maharashtra. He is of the opinion that the doctors are mainly responsible for the declining child sex ratio in India. Because doctors are not counseling couples against sex detection either for the want of money or out of ignorance that doctors are adding to the problem. Therefore IMA is planning workshops to sensitize doctors. They are also organizing public programmes for general awareness. The workshops will be organized in 12 districts. The idea is to make realize the doctor community the adverse social implications of sex determination and consequent termination of female foetuses.

KRISHAN KUMAR
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A multi level multi focused community level campaign spearheaded by the local District collector is going on in Nawashahr, Punjab since May 2005. The system works through anganwadi workers, ANMs, govt. officers (who have been allocated ten villages each), a computerized database of all the pregnant women (3-5 month pregnancy only) is maintained through these health service providers.

Further the reports of all scanning centers are computerized and audited. Subsequently necessary disciplinary action is taken against the scanning centers that indulge in mal-practice or do not comply with the rules. Additionally efforts are also made to actively involve various departments in the Govt. in this endeavour.

In order to strengthen and encourage civil society participation a federation called UPKAR Coordination Society of all the NGOs in the district has been constituted and registered. The Deputy Commissioner is the ex-officio chief Patron of the Federation. There are 35 NGO members of the Federation and each of them has been assigned particular area of their choice to work. A large number of awareness programmes have been undertaken by the DC and by the Upkaar committee. Members of Upkaar, when they come to know of a sex selection that has happened somewhere, organize public mourning at their place. Awareness programmes including mass poster sticking, rallies, demonstrations, meetings and workshops have been organized at a very large scale. Village panchayats exhibiting change of behaviour with respect to this practice are also honoured.

Dr. M. GEETHA
Additional commissioner,
Gwalior and Chambal Division,
Gwalior
Madhya Pradesh
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Dr. M. Geetha, in her posting at Shivpuri (MP) as the district collector, was motivated by a workshop at which Dr. Sabu George and other committed activists spoke on different aspects of the issue. Post workshop she decided to take action against clinics in her area. Eventually she was motivated to focus on the 4 clinics in Shivpuri. She also managed to earn support from the then appropriate authority and involved him authorizing the raids. She relied primarily on her team of revenue officers and others to conduct the raids. Since they did not know much about the act or the issue, she first gave them an orientation and also prepared a checklist to enable them to carry out the raid. The CMHO confiscated the machines. Dr. Geetha faced a strong reaction from the doctor lobby and even local media, who supported them, and had to bear with resistance to her action. The raids were effective, however she was transferred soon after that. Some time later the State supervisory body reversed the order.

MAHILA SARVANGEEN UTKARSH MANDAL (MASUM)
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Contact Person: Manisha Gupte

Manisha Gupte is one of the pioneers in the campaign against sex selective abortion started in 80s in Maharashtra. As a result of this campaign the PNDT Act was made, first in Maharashtra in 1987 and later at the National level in 1994. MASUM together with CEHAT and Dr. Sabu George launched a PIL in 1999 demanding strict enforcement and specific amendments, which went in their favour in 2001. As a result the new amended PC-PNDT Act was passed in 2003.

MASUM primarily works on women's health issues and has remained involved in action-based research on women's right to abortion. It is involved in carrying out community-based work in Saswad block in Pune district and organises awareness and training related work; in collaboration with various organizations in the state as well as national and international level.

DR. MANOHAR AGNANI
District Collector
Shivpuri, Madhya Pradesh
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Dr. Manohar Agnani was posted as District Collector in Morena, MP in October 2004. The district has traditional reputation of a male dominant society practicing female infanticide. With the advent of ultrasound technique the practice of female infanticide has been replaced by female foeticide. The district administration, under leadership of Dr. Agnani, made sincere efforts to tackle the issue. Dr. Agnani involved community-based organizations and also did mapping of the sex ratio between 0-5 years in Aanganwadi centers. Simultaneously he initiated other steps; such as discussion with medical community and medical audit of F forms. After initial scrutiny of the records the Appropriate Authority, the Chief Medical and Health Officer (CMHO) issued show cause notices to five clinics. Four licenses were suspended with immediate effect under this section and finally seven registrations were cancelled. Meanwhile in June 2005 all the 7 clinics against which action was taken filed appeals with the State Appropriate Authority. The SAA while admitting that these centers did not maintain proper records observed that it did not amount to gross irregularity to cancel the registrations. The State Appropriate Authority quashed the order of the DAA and revoked the seven licenses. The cause of the concern in this case was that, those who were appointed at the helm of the affairs were not properly sensitized to this situation. Therefore this order of State Appellate Authority was challenged by two NGOs working in Morena on this issue by filing a Public Interest Litigation (PIL) in the High Court of MP at Gwalior bench. The matter is under *sub judice.* Based on his active engagement with the issue Dr. Agnani has written a book – Missing Girls – which includes his experience in Morena as well as provides a holistic perspective on this issue. The book was published by 'Books for Change' (bfchindi@yahoo.co.in) in 2006.

MEDICO FRIENDS CIRCLE
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Contact Person: Dr. Anant Phadke

It is a nationwide group of socially conscious doctors and health workers, who believe that establishing pro-people health systems would ensure accessibility of health services to all. It was started in 1974 with an objective to establish a comprehensive public health system and encourage active community participation in planning and carrying out preventive measures. It is actively working towards evolving an objective and rational approach to a health care system that can cater to the needs of a vast majority of the Indian populace. It communicates its experiences and information through its bulletins and other publications.

NARAYANBHAI PATEL
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Dist-Mehsana, Gujarat

Unjha (district-Mehsana) with a total population of about 60-70000 has the lowest child sex ratio (742 girls) in the state of Gujarat as per 2001 census report. The local MLA Narayanbhai Patel decided to take up a campaign against female feticide in his constituency of Unjha after he participated in a workshop organized by CHETNA for political leaders.

The campaign responsibility was entrusted upon the youth members of JAYCEES club in Unjha and the campaign was launched with a massive public programme organized on 5th January, 2005.Almost 15000 women participated in the programme and took the oath against SD. Shri Narayanbhai and his team of Jaycees has been successful in leading the campaign that has far reaching impact on the society. The fruits of the campaign can be seen from the fact that prebirth sex determination has almost stopped in the area, and the doctors have also co-operated. The main aim of the campaign has been to educate the village women, which has received excellent support from all walks of life. The campaign is still continuing through various programme in the area.

NARI SAHAYA SAMITI
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Contact Person: Vasanti Dighe

It initiated awareness campaign with local mahila mandals on the issue. There are several community based Mahila Mandals in Jalgoan city. All mandals have come together to form a federation - Zilla Mahila Mahasangh. The federation has taken up awareness campaign against female foeticide. First they organized a competition and invited entries for skits, songs (in traditional form) and slogans. Many women and youth participated in this competition followed by a public programme for prize distribution, where this issue was highlighted in a big way.

Recently they organized a poster competition. The federation is also planning to organize a rally with this communication material in select block of the districts. And is also trying to work with Rotary Club for in organising interactive workshops for its members.

NATIONAL COMMISSION FOR WOMEN
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First conference with Chairpersons of State Women Commissions was held on 28-29th March, 2003. During the conference there were discussions on issues like child marriage, foeticides, dowry, PC-PNDT Act and domestic violence.

The All India Conference of State Secretaries-Health, WCD and DGPs on the implementation of PC-PNDT Act (11th August, 2005) at Vigyan Bhavan, New Delhi.

OLAKH
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Gujarat
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Contact Person: Mamta

It is a feminist, documentation, resource and counselling centre based in Vadodara, Gujarat. It is involved in bringing out IEC material on the issue and creating awareness through publishing articles, essays and other interactive programmes. The organization is primarily working on violence against women and looks at the issue of sex selection as the worst form of violence against women.

PATEL COMMUNITY, GUJARAT
Gujarat

The Patel community has started an incentive scheme supporting partial educational support to the second girl child and full educational support to the third girl child (as per the news). The Patel's are giving material incentives to parents who give birth to a second daughter and even higher incentives for the birth of the third daughter in a family

The paucity of girls for marriage from within the community has lead to change in marriage rituals and norms. There are two cults in Patel's; Kadva and Leuva, supposed to be ancestors of lord Ram's sons Kusha and Lava respectively. Till very recently they kept their identities very much distinct and did not accept inter-cult marriages. Now on the backdrop the declining number of girls, they had organized a big ceremony in Surat recently, where the two decided to come together. In this ceremony called as 'Mahaladdu Sammelan' many community members

gathered and decided to have marriage between Kadva and Leuva. This message was spread to all community members by sending Prasad with the message.

PLAN International, INDIA
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Contact Person: Dr. Nalini Abraham

Plan works closely with communities to encourage the role of women in Indian society by upholding gender concerns such as literacy, employment, and mortality. Plan India has made concrete efforts in order to put female foeticide on the public agenda. The low status of females results in the common practice of sex-selective abortion (female feoticide), and the deliberate neglect of the education and health of the girls and women.

Plan International has also taken up the issue of sex selective eliminations in a big way and has funded many and various efforts in this regard. These included efforts with the media, with government officials, legal community and of course with enablers of various kinds including research studies.

Plan International also supports other allied efforts like the campaign for Universal Birth Registration, Campaigns/efforts on Gender issues etc. The Datamation Foundation website that provides information on the issue and on which complaints can also be lodged was also funded by Plan.

Plan International also works in close collaboration with the Population Foundation of India

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Contact Person: Vijaya Nidadavolu

An international, non-profit organization that conducts research on three fronts: biomedical, social science, and public health to help change the way people think about problems related to reproductive health and population growth. It has not specifically worked in the field of sex determination and sex selection, but intensively on abortion and its access to women in India and elsewhere. It has undertaken an intensive analysis of the available material on abortion and PNDT in Rajasthan. The study indicated an absence of informational materials on safe abortion in both public and private medical sectors in the study district.

POPULATION FIRST
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Population First is a communications based initiative that embraces the government objective of achieving population stabilization by the year 2045. Working to support the government's programmes, Population First builds the communication foundations for partnership between government, civil society, the corporate sector and the media, creating a common ground for the sharing views and perspectives that will help lead change in society. Population First's Laadli -Mumbai's Girl Child Campaign, is a comprehensive communications campaign combined with action programme to address the issue of the falling 0-6 sex ratio of Mumbai. Laadli addresses the core social values that promote sex selection and male preference in society by building public opinion and promoting community participation. The campaign adopts a four-pronged strategy of:

1 Increasing the visibility of the issue and creating awareness
2 Building commitment of people to stop the practice
3 Providing community support and vigilance to sustain the change
4 Promoting a positive image of the girl child.

Laadli works in close collaboration with the media. Promoting gender sensitive reporting on development issues in the media, working towards developing media guidelines to project a positive image of the girl child, and tracking the portrayal of the girl child in the mainstream media are integral to the media campaign.

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The Population Foundation of India was established in l970 and has been at the forefront of the Non Governmental efforts towards rights based, gender sensitive approach for population stabilization and Human development.

PFI has worked extensively in collaboration with a number of organisations on the campaign to prevent sex selective elimination of girls. These associations have included extensive work with UNFPA, the Ministry of Health and Family Welfare, GOI, Plan International as well as various other enabler groups/individuals.

PRAYAS AND CENTRE FOR HEALTH EQUITY

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Center for Health Equity
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Contact Person: Dr. Narendra Gupta & Mr. Tej Ram

The Center for Health Equity located in Jaipur is the advocacy unit of Prayas, Chittorgarh. Although CHE is a new entity but its interventions are planned based on the experiences of Prayas.

Prayas has done a series of activities with various stakeholders including policy makers, community, government officials and other partner NGOs. They have published dossiers and posters on the issue of declining sex ratio and sex selective abortion. At present CHE is actively involved in the statewide campaign against female foeticide, while Prayas is also working directly
with people to change their mindset about daughters.

Both at state and local levels, Prayas has conducted workshops/meetings, march and public meetings with community leaders, elected representative both of Panchayat and state legislatures. It has written papers and entered in policy dialogue with appropriate agencies. It has also organized workshops with media and representatives of trade and industry.

PRAYTNA

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Praytna with support from IFES conducted a research on the status of implementation of PC-PNDT Act in the state of Rajasthan. Praytna with support from Action-aid Rajasthan is also sensitizing women SHGs/mahila mandals in Dholpur district on the issue of sex selection and mobilizing them to advocate for community rejection of such discriminatory practices against girls.

RAJASTHAN UNIVERSITY WOMEN'S ASSOCIATION (RUWA)
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Jaipur 302015, Rajasthan
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The issue of SSEs has remained quite high on RUWA's agenda since 1992. RUWA believes working with various communities to bring about social change is equally important as ensuring strict implementation of the PC-PNDT Act. Initially RUWA started dialogue with medical community and approached doctors in the local Medical College. In 2005 RUWA, with support from IFES, organised six community focused workshops in Jaipur with Maheshwari, Jat, Rajput, Brahmin, Jain and Sikh for awareness building. The follow-up ensured that community members get engaged in extending awareness in their respective communities. RUWA is also working to sensitise youth and doctors on the issue in order to curtail demand and supply of the services respectively.

RUWA is networking with local organizations on issue-based campaigns. After recent Sahara Sting operation in 2006 the organizations working on the issue got together under the banner – Ling Janch Kanyan Bhroon Hatya Virodhi Abhiyan (Campaign Against SSEs of females).

RURAL REHABILITATION CENTRE
Court Main Road,
Usilampatti Taluka,
Madurai
Tamil Nadu

The organization is working in 30 villages under Usilampatti Taluka and Chellampatti Block. With a homogeneous community known as "Piramalai Kallar", generally known as the "Thever Community", best known for its strong "macho" culture and uncompromising on certain old age customs. The focus group of the organisation belongs to the MBCs (Most Backward Class) a classification introduced by the TN government. They are generally small and marginal farmers with an average landholding of one to two acres of land. Their livelihood depends on cultivation of these lands and engaging themselves as agricultural labourers with other rich farmers and taking up sundry jobs elsewhere.

The organization is working with women since 12 years by organizing them into 25 mahila groups comprised of 20 members each. Their inputs include adult education, economic empowerment and welfare of girl child. They have been successful in curbing the practice of female infanticide from the area by improving the living standards of people and linking various government welfare schemes planned for girl children.

Dr. SABU GEORGE
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Dr. Sabu George has been a campaigner on this issue since many years. Together with CEHAT and MASUM he was one of the litigants in the PIL in 2001, which led to various amendments in the Act. Since then he has been advising, motivating and guiding many other activists on the intricacies of this issue, and continues to be involved in various sting/decoy operations, and various court cases that flow out of these.

SAHIYAR
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Sahiyar is active on the issue since 1986. They were part of state level campaign against Sex Selection. The organisation has conducted a study by interviewing 30 clinics in 1987 in Vadodara to get a feedback to frame the issue in strengthening the campaign. The organization did another study in 1999, taking in-depth interviews of 70 women, of which 20 had undergone SD tests.

The various awareness-building efforts made by the organisation on the issue include sensitisation of medical students and dialogue with communities through cultural festivals. Sahiyar is an active partner on national level network on the issue.

DR. SATVIR CHOUDHARY
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Kaithal,
Haryana
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Dr. Satvir Choudhary has been involved with PC-PNDT work for the past 3 years since he joined as CMO in Karnal. He has also worked in Kurukshetra and Hisar before his present posting in Kaithal, Haryana.

The CMO has focussed the efforts at the demand as well as supply side. The pregnancy of the vulnerable mothers (the pregnancy of 10-20 weeks, and of those women who had two/ one daughters are categorised as the 'vulnerable mothers') is monitored through ANMs, VLHWs and MOs. Simultaneously surveillance of the ultrasound clinics is being carried out. There are 16 clinics in the district. The scrutiny of records takes into account the proportion of self-referral, the proportion of referral from outside the district and also the phone numbers and incomplete addresses. On the basis of this scrutiny Dr. Chaudhary has taken legal action against clinics indulging in sex determination.

SHAKTI VAHINI
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Shakti Vahini is running a campaign against Female Foeticide in the states of Haryana, Punjab & Delhi. The organisation has organised a meeting of stakeholders in Faridabad, in which officials from various Govt. agencies and Non Govt agencies participated. Awareness programmes are also carried out across the states. The organisation has organised training programmes at various levels, such as for sensitising Aanganwadi Workers on the issue and a state level training programmes with a view to build effective advocacy efforts on the issue. As part of the efforts Zilla Panchayats are also sensitised and activated against Female Foeticide in Haryana. The organisation is carrying out a study on the Ramifications of Female Foeticide.

SOCIETY FOR INTEGRATED RURAL DEVELOPMENT (SIRD)
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SIRD is implementing Comprehensive Rural Development program with a focus on women's empowerment. It has also addressed the infanticide issue in the area and that is how they have initiated the Campaign Against Sex Selective Abortions (CASSA). This campaign is a State level Campaign constituted by Social Action Groups, Women's Unions, Human Rights Groups, Advocates, Educationists, Researchers and Professionals from various fields for the purpose of stopping sex selection medical practices and preventing the declining child sex ratio in Tamil Nadu. The group considers sex determination tests as a basic human rights violation and a violation of the rights enshrined in the constitution, convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). However the group believes that the right to abortion must remain as an essential right of women. And women must have right to decide as well as control over their bodies and sexuality. Presently SIRD is the Secretariat of the Campaign. The geographical work area is Usilampatti Taluka of Madurai District.

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SUTRA has been involved in a street level campaign to create awareness on the issue. The Nukkad Natak concentrated in Baijnath and Lambagaion of Kangra and Gagret Block of Una district. A total of 116 Plays were staged. The Local CDPOs helped in organization of this campaign. During this campaign, the organisation realized the gendered perception of front line health workers and their complete lack of awareness regarding the implications of SSEs. Halla Bolo Campaign is paying dividends. SUTRA also supported PFI to organize a workshop for members of HP State Legislative Assembly.

SUTRA was also actively lobbying for the withdrawal of the two-child norm imposed on PRI representatives in HP SUTRA initiated action through sending petitions / memorandums from Gram Panchayats, Gram Sabhas, SHGs and Mahila Mandals for removal of 2-child norm. The continuous efforts of SUTRA succeeded in 2005 when the HP government took back the policy.

SUTRA has initiated monitoring of sex ratio at birth in 24 Gram Panchayats where it has Mahila Mandals, SHGs. Every six month the birth registration is checked at Gram Panchayat and discussed at Gram sabha if there is significant change. It has put up signboards in number of Gram panchayat offices giving sex ratio at birth for last 5 years to generate interest of common citizens in the issue.

SWATI
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SWATI - Society for Women's Training Initiative works for the socio economic empowerment of women in Gujarat. SWATI has played a catalytic role in bringing together organisations working in Saurashtra Kutch region, under the nomenclature of Saurashtra Kachchh Network on Violence Against women. The network's key initiatives include campaigns, research and advocacy on the issue of Violence against Women. The network has prioritized the issue of pre natal sex selective abortion as part of their work on violence against women.

The efforts at the state level include working with the government to suggest effective awareness creation, community monitoring and functioning of the PNDT committees

including the role of the AA. At District level, the network partners are working with community groups and Panchayats, students in the medical colleges and are also actively involved with the PC-PNDT committees.

TATHAPI
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Tathapi is working on gender and health issues. The organization has organized programmes for general awareness as well as conducted capacity building training for NGOs to monitor implementation of PCPNDT Act. It was part of a joint decoy operation done in Pune against two doctors. The organization has also helped organizations in deploying decoy cases. Audry Fernandez from Tathapi Trust is also member of Pune District Advisory Committee constituted under PC-PNDT.

THE LAWYERS COLLECTIVE WOMEN'S RIGHTS INITIATIVE
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Contact Person: Adv. Indira Jaisingh

The Lawyers Collective Women's Rights Initiative (LCWRI) is a group of lawyers, law students and legal activities committed to use of law as an effective instrument for empowering and changing the status of women in India. Since its inception in 1998, it has been actively engaged with the entire legal regime of addressing the rights of women in law. Towards this, the LCWRI has over the recent past initiated, undertaken and participated in extensive research, advocacy, law reform, legal aid, documentation and publication work on gender based discrimination, justice and law. Indira Jai Singh has prepared a users guidebook on PCPNDT Act.

Dr. Vandana Gandhi
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Taluka-Malshiras, Akluj,
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Dr. Gandhi is a practicing Gynaecologist from Akluj and is working to create awareness against SD for almost last 14 years. She got concerned due to the rampant use of ultrasound by other doctors in her area and started awareness programmes with the help of posters and handouts developed by her. So far she has reached out to people from all sections of society through her programmes. Recently she has got associated with IMA, who has initiated

campaign – Female Child, Nation's Pride. Dr. Gandhi is a member of a 5-member team formed by IMA for sensitization of medical practitioners. This team has been organizing workshops with doctors since 1st July 06.

Dr. Gandhi has written a booklet in 1998 titled 'Sonography Curse Or Boon?' to make general public aware about the technology. She has written in awareness building articles in mainstream newspapers and received awards for her social contribution.

VOLUNTARY HEALTH ASSOCIATION OF INDIA, PUNJAB (VHAP)
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Contact Person: Manmohan Sharma

It is one of the main organisations working on the issue in Punjab. There are not too many NGOs in Punjab as it does not have too much of a history of movements and social organizations. The organization believes that the decline in sex ratio is historic, and there has been very strong implementation of the two-child norm in the state. VHAP is involved with advocacy on the Act with the govt. Initially it worked in the districts that had the worst sex ratio, meeting officials and activating vigilance committees. Now it has identified the villages with the worst sex ratio and is working with the ANMs and Anganwadi Workers to form village level vigilance committees and involved in sensitizing the communities on the issue. It has also been making IEC material on the issue. Recently, VHAP has also filed a PIL demanding effective implementation of the PC-PNDT Act.

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Vimochana got concerned with the dramatic drop in sex ratio from 976 in 1961 to 945 in 1991 and 927 in 2001. The movement to girl child's right to live was initiated in 2001, through which it is sought to contextualize the understanding of the issue in relation to violence against women. The specific concern for Vimochana is with the misuse of new reproductive technologies by the unethical practices of sections of the medical profession that is directly contributing to this genocide. Vimochana, is now operating from both within the government machinery and outside. They have got into several committees including the recently constituted "Inspection and Monitoring Committee" at the state level. It has been working in Mandya district since June 2004 at different levels; both with communities as well as against doctors. One of the innovative forms of protest adopted by the organisation is Women in Black - women wearing black stand outside the clinics in protest.

Annexure V

Schemes for the Girl Child and Efforts by The State

BALIKA SAMRUDHI YOJANA

Government of India has launched a new scheme w.f. 15/8/97 for the development of girl child under which cash assistance of Rs.500/- is provided to mothers for nutrition on giving birth to girl child. Women should belong to BPL family and this benefit will be restricted to two girls children.

An additional benefit is provided as scholarships to the girl child when she starts schooling varying from Rs.300 to Rs.1000 from Class I-X. The benefit is limited to two girls per family.

TAMIL NADU

- **"Cradle Baby Scheme"** launched by the State Govt. of Tamil Nadu where female infanticide was rampant. The families can abandon unwanted female infants in cradles provided for that purpose in govt. primary health centers rather than kill them. Under the scheme, cradles are placed at Hospitals, Primary Health Centers, Orphanages and Childrens' Homes. Full-fledged reception centers have been set up at Madurai, Theni, Salem, Dindigul and Dharmapuri districts. *(A sum of Rs.6.81 lakhs has been provided for the year 2005-06 for this scheme)*

- The **"Girl Child Protection Scheme"** was launched in 2001 in the state of Tamil Nadu. Under the scheme, families with a lone girl child and no other children and either of the parents sterilized, an initial deposit of Rs.22, 000/- is made in the name of the girl child with Tamil Nadu Power Finance Corporation by the govt. A minimum of Rs.150/- from the interest accruing form this deposit will take care of the education of the girl child form Class I-X. The terminal benefit from the deposit with accrued interest will be released to girl at the end of 20 years to enable her to pursue higher education or to defray her marriage expenses. In case of families with two girl children and no male child where either of the parents have undergone sterilization, an initial deposit of Rs.15, 200/- (A *sum of Rs. 50 crores has been provided for the year 2005-06 for this scheme.)*

  The "Girl Child Protection Scheme" according to Dr. Ramasubbu, State Appropriate Authority, Director of Medical and Rural Health Services is ill-conceived as is clear from the eligibility criteria, which stipulates among other things that one of the parents of the child concerned should have undergone sterilisation that the family should have only one or two daughters and no sons; and that the beneficiary child should be less than three at the time of enrolment in the scheme.

- In Dharmapuri District of Tamil Nadu one of the worst affected by female infanticide has also been able make a turnaround of sorts. The reason for the breakthrough is

reported to be the result of multi-pronged approach wherein the one hand coercive action by the authority of playing on the fear by booking cases against people practicing it has acted as a deterrent. On the other hand the state authorities have also initiated welfare measures to safeguard girl child including providing families with IRDP loans, Indra Vikas Patra for Rs.1, 500/- priority in starting rural enterprises, promoting all women ration shops and so on.

ANDHRA PRADESH

The girl protection scheme has three components – an insurance cover of Rs.1 lakh in the name of the girl child in the age group of 3-20; an annual payment of Rs.1200/- towards the education of the girl for four years from Class IX and risk (death and accident) cover for parents in the BPL group. (**Business line Internet Edition Apr 19, 2005).** In case of two girl children policies of Rs. 30, 000/- each would be presented.

The Bhagyalakshmi scheme for the girl child (**in Karnataka**) aimed at fighting female foeticide and infanticide will be administered by LIC. Rs.234 crores has been set aside for the scheme for the year 2006.Under the scheme the Govt. will deposit Rs.10000 for every girl child born after Apr1, 2006 in a family living below poverty line. (**The Hindu Wed Apr. 26, 2006)**

Projected Maturity value in Rs.

	At 8%	**At 6%**
First Child		
Basic	35,915	25,267
Scholarship	4,800	4800
Total	40,715	30,067
Second Child		
Basic	39,960	28,543
Scholarship	4,800	4,800
Total	44,760	33,343

The tie up with LIC is first of its kind in the country. LIC has customized the scheme to offer long term pooled and earmarked accounts for educational scholarships for the girls, without any additional cost. The insurance benefit are considerable: low cost subsidized insurance through **Janashree Bima Yojana** which also covers the earning parent from the time the girl child is registered. An insurance amount of Rs.20, 000/- payable in case of death of the earning parent. The financial support for the scholarship is in the form of scholarship amount of Rs.100 per month paid quarterly for four months from Class ix to Class 12. The health benefits have the scope to cover critical illnesses affecting heart kidneys, physical disablement owing to any accident after the child reaches a certain age,

In **Pondicheery** the Union Territory Administration has evolved a scheme to generate awareness among parent about having girl children and also to raise the status of such children in families and a financial assistance of Rs.15, 000 will be given to the family having only one girl child born on or after Apri1, 2005 in the from of a fixed deposit. Incentive to parent of girl child having accepted family planning scheme will be entitled to deposit of Rs.15, 000 in fixed deposit in a bank or in a suitable post office saving

scheme. Where family has 2 girl children Rs.7, 500 would be deposited in the name of each of the child and maturity value of the deposit would be given to each of the girl child or the two children on their attaining 18 years of age. The mother would be the guardian of the minor child's account. **(The Hindu Nov.25, 2005)**

HARYANA

- "Laadli" campaign by the state Govt. of Haryana "Laadli Social Security Pension Scheme"

- **Bhiwani Haryana – Apni Beti Apna Dhan** – Under this scheme launched with effect from 1/20/94. Rs.500/- are given to the mother for her nutrition and recoupment within 15 days of giving birth to the girl child and Rs.2500/- are invested in saving scheme in the name of the girl child for a period of 18 years. The mature amount of Rs.25, 000/- is given after attaining the age of 18 years. Against a target of 3456 beneficiaries to be covered during 2000-01, 3557 mothers been provided the benefit upto March, 2001

PUNJAB

- The state Govt. of Punjab has announced cash incentives to panchayats for improving the village sex ratio. Rs. 2 lakh for 800 and above and Rs. 3 lakh for 900 and above. It has also announced handsome incentives for decoys and informers to check the problem.

- The Punjab government has roped in actor-activist Shabana Azmi to wage a renewed war against the menace. Shabana Azmi would be heading the state-level consultative committee entrusted with the task of educating people and spreading the message of female power in Punjab, which is credited with one of the poorest sex ratios in the country.

GUJARAT

- The Govt. of Gujarat has initiated effort to create awareness about the declining sex ratio through public display of number of male-female births in the area each month at the various Gram Panchayats. This initiative is launched by the Health Commissioner of Gujarat for creating awareness on the issue.

- The Gujarat Govt. started the 'Beti Bachchao Abhiyan' on 5th March 06, on the occasion of the Women's day. The issue has become part of political agenda in the state and the political leaders are creating awareness in their constituencies by organizing small meetings and public gatherings.

SOME REFLECTIONS ON THE SCHEMES FOR THE GIRL CHILD

- The benefits linked to adoption of family planning and only upto a maximum of two girl children.

- Benefits for only BPL families and in this sense little value for APL families who are actually practicing sex selection.

- Difficulty in accessibility.

- Limited coverage.