USAID New and Expanded Social and Economic Opportunities for Vulnerable Groups in India (IR-3)

DIGNITY OF THE GIRL CHILD (Female Feticide, Infanticide, General Neglect of the Girl Child)
Planning Levels - $2m

I. BACKGROUND:

I.I NATURE OF THE PROBLEM

The sex ratios at birth as well as sex selective mortality at younger ages are key indicators of gender discrimination. The child sex ratio (CSR) shows a clear and undisputed decline over the last three decades with the country undergoing a demographic transition that puts at serious risk its girl children. 70 districts in 16 states and Union territories recorded more than a 50 point decline in the CSR in the last one decade.

Child Sex Ratio, (No. of girl children per 1000 boy children, in 0-6 yrs age group)

YEAR	TOTAL	RURAL	URBAN
1981	962	963	931
1991	945	948	935
2001	927	934	903

Source: Census 2001

The decline is so wide spread that out of 28 states and seven Union Territories only four states [1]and one union territory showed a positive increase. The states that show the worst decline in the Child Sex ratio - Punjab, Haryana, Himachal Pradesh, Chandigarh, Gujarat and Delhi – are also among the most affluent regions of the country. Consequence – the Census of 2001 shows that India has a deficit of 35 million women as against a three million deficit recorded in the Census of 1901.

Though a block-wise breakup shows a much wider spread of the problem across the country, clearly the extent, depth and pervasiveness of the problem is greatest right now in the north and northwest parts of India. The ten districts with the most skewed CSRs fall in Punjab and Haryana region. Panjab represents the worst case with a state average of 793 with no district (19 districts in all) recording a ratio of more than 820. From 1991 to 2001 census ten districts record a drastic reduction in the CSR to less than 800 with Fateh Garh being the lowest at 754. Haryana is next with a state average of 820 and five districts recording a ratio of less than 800 and almost all districts (17 of 19) record a ratio of less than 850.

Incidentally, the 10 districts with the most equal CSRs are from hilly regions located in the Northeast and Northwest, quite inaccessible and inhabited by tribal populations. This could perhaps be because of the economic value of a woman in primarily tribal societies. In many of the hilly regions, local economies are steered and households managed by women as men are mostly away in cities. Most importantly in these parts of the country technology for sex selection is slow to reach. More studies need to be undertaken if any conclusive relationship needs to be established here.

[1] The states being Kerala, Sikkim, Tripura and Mizoram and the UT being Lakshwadeep

National Family Health Survey (NFHS) -2 (1998) results clearly show evidence of abortion of girls among second and third births to women who already have daughters but no sons. National level results from NFHS -1 (1992) do not show this pattern, indicating **a trend towards greater use of sex – selective abortion during the six years between the surveys.**[2]

The decline in sex ratios may be due to several factors such as neglect of female children leading to their higher mortality at young ages, female infanticide and female feticide[3]. High incidence of induced abortion and the sharp decline in the CSR in the last decade clearly point to the practice of female feticide. [4]

In most states, the decline first appears in the urban areas and can be attributed to accessibility of affordable modern technology in affluent cities and small towns. Of late sex determination test facilities are available in small towns and villages and anecdotal evidence reports about mobile vans traveling through villages. An analysis of NFHS 1 and NFHS 2 shows the trend that practice of sex selective abortion is spreading from India's cities and towns to rural areas.[5]

Already some anecdotal evidence is beginning to emerge regarding the consequences of such a trend. In Punjab and Haryana, the team has been informed about increasing practice of importing brides from other regions. These brides ("kudesan") are normally not accepted by the broader society and are treated more like concubines. They suffer higher rates of abandonment and their children are never fully accepted. In Rajasthan, we have been informed about increasing incidence of wife-sharing, one woman being married to several men, possibly brothers. It is also believed that there has been an increase in trafficking of women, in Punjab and Haryana. Shakti Vahini, an NGO based in Haryana reports that in 2003 they rescued 26 girls who were trafficked to Haryana for marriage.

I.II POLICY FRAMEWORK:

Amniocentesis, Chorionic Villus Sampling (CVS) and Ultrasound began to be used in India in early 1970s to detect fetal abnormalities. Within a decade though these tests were being used primarily for sex selection. The first concerted campaign against sex determination happened in Maharashtra led by the Forum Against Sex Determination and Sex Pre-selection (FASDSP) in 1985. **Government of Maharashtra was the first state to ban sex determination in 1988. In 1994 GoI passed the PNDT (Pre-natal diagnostic techniques (regulation and Prevention of Misuse) Act.** The Act came into force in 1996.

In 2000, NGOs filed a Public Interest Litigation (PIL) in the Supreme Court for non implementation of the Act and for bringing under the purview of the Act all possible emerging technologies that could be abused to eliminate the girl child. An interim judgment was delivered in May 2001 and the Act was finally amended on 14th February 2003. **Now the Act is renamed as**

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[2] Factors affecting Sex-selective Abortion in India; by Robert D Rutherford and T.K. Roy; NFHS survey Bulletin no. 17 January 2003;

[3] Female feticide or sex selective abortion refers to a practice where the female fetuses are selectively aborted after prenatal sex determination.

[4] Sex determination and female feticide – a status paper by Population Foundation of India and Plan, India;

[5] Factors affecting Sex-selective Abortion in India; by Robert D Rutherford and T.K. Roy; NFHS survey Bulletin no. 17 January 2003;

The Preconception and Prenatal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994. The Supreme Court has asked all states to explain the census results that show the high decline in CSRs and reprimanded them for poor implementation of the law. To date only one clinic has been closed under the purview of the Act (substantiate...and Source).

The legislation specifies that : only government-registered clinics or laboratories may employ prenatal diagnostic procedures that could be used to assess the sex of a fetus; no prenatal diagnostic procedures may be used unless there is a heightened possibility that the fetus suffers from a harmful condition or genetic disease and " no person conducting prenatal diagnostic procedures shall communicate to the pregnant woman concerned or her relatives the sex of the fetus by words, signs or any other manner."

The tenth five year plan stresses on elimination of all forms of gender discrimination so as to enable women "to enjoy not only dejure but also de-facto rights and fundamental freedom on par with men in all spheres, viz: political, economic, social, civil, cultural etc." It also calls for complete eradication of female feticide and female infanticide through effective enforcement of both the Indian Penal Code, 1860 and the PNDT Act, 1994. The Ministry for Health and Family Welfare has started a positive campaign for the girl child, using Sania Mirza, the teenage Wimbledon tennis champion, as its ambassador. Certain state governments and the Central government as well have come out with incentives for couples who have a second daughter, as in Haryana.

Population stabilization is a recognized public priority for the government. Certain states have introduced the two child norm policy and offer a series of incentives and disincentives – primarily debarring the person from holding a position in the panchayat. Since the last three decades if not before, health communication messages have aggressively promoted small family norms. The messages moved from the 1970 - 80s – "do ya teen bas" (two or three only) to the current long running "hum do, hamare do" (we two have two), with a quickly discarded "one is fun" in the middle. The visuals sometime change form happy family of one boy and one girl to two girls. Surveys have established that the small family norm has been accepted at a societal level. From an average five children per couple in 1971, the number has come down to three children by 1997[6].

Evidence of sex-selective abortion tends to be strongest in families that already have two children. This pattern reflects the fact that the total fertility rate for India is about three. Because a large proportion of families wish to stop childbearing after three children they are especially likely to have a strong gender preference for the third child[7]. Couples planning their families often eliminate the second girl child to stay with in the social boundaries of two-child norms.

[6] Compendium of India's fertility and mortality indicators; 1971-97 based on the Sample Registration system (SRS); Registrar General, India; New Delhi - 1999

[7] Factors affecting Sex-selective Abortion in India; by Robert D Rutherford and T.K. Roy; NFHS survey Bulletin no. 17 January 2003;

I.III KEY PLAYERS

There exists a core group at the national level set up by the GoI, though it is not very functional. A similar, and perhaps more active but still informal group of NGOs and activists exists (MORE DETAILs.....). The group is well attended by the various UN agencies. The UNFPA publication (get the name) release in October this year once again highlighted the severity of the problem in certain states. The issue has attracted considerable media coverage with both the national and the regional press reporting on it.

Some of the national and international NGOs that have already taken up this issue include, Center for Women and Social Development (CWSD), Population Foundation For India (PFI), National Foundation of India (NFI), Voluntary Health Association of India (VHAI), Plan International, ActionAid etc. Other organizations have focused on media advocacy (JAGORI), undertaking research (HEALTH WATCH) and filing PILs (CEHAT, MASOOM) etc. Some religious bodies have been active in denouncing such practices, notably the Akal Takht in Punjab, which issued a hukmnama in 2003.

It is true that today skewed child sex ratio is recognized as a problem. The response, however, has been scattered and ad-hoc, limited largely to highlighting the census figures at the national and in some measure at the states. No agency, government or otherwise has come up with comprehensive strategies to address the issue at all the levels, nor is there any support for promoting experimentation. Not enough is known about the multiple drivers that have lead to a skewed CSR and thus on possible strategies to address the issue. The development community itself has yet to acknowledge and frame the issue as a focal point within all other development interventions.

II CAUSES & CONSEQUENCES

II A Factors contributing to sex selective abortions

1. **Patriarchal social structures with their strong preference for sons** continue to be a wide spread cause. Sons are preferred for many reasons - maintaining the lineage, passing on of property, theoretically for looking after the parents when daughters are married off, performing last rites for parents so they can go to heaven and in more macho violent parts of society they are also important for maintaining the family "izzat" or the honor. Practices do not simply favor sons but disfavor daughters. Unequal treatment in property inheritance, unequal opportunities for education and employment, lack of appreciation of domestic work as "productive work" and therefore invisiblising women's' contribution to the economy are all related aspects encouraging a greater devaluation of the girl child.

   Dowry is perhaps is the single most negative social practice that devalues girls and gives the family an "economic rationale" to do away with them. Today, female feticide is practiced as almost a matter of fact thing, with little sense of criminality being associated with it.

2. **It is very important to note here that this is a continuum of discrimination and deprivation.** Sex selective killing can happen and does happen at various stages of life cycle. Beginning from preconception, to while pregnant, to after birth and then onward to general neglect leading to higher mortality and morbidity amongst girl children and further on in life to dowry deaths. The problem needs to be looked at within a framework of inequity and injustice. Else, addressing inequity at one point will only bring this out in uglier forms at other points in the lifecycle. For eg. As the design team was informed by one respondent, efforts at enforcing the PNDT Act in Punjab, have led to greater incidents of abandonment of the newborn baby girls, and sale of baby girls. (MORE DETAILS)

3. **The flip side of social and economic prosperity.** The states that show the highest levels of discrimination are also the most prosperous with high literacy rates, including Delhi. NFHS – 2 data analysis shows that women who are educated (at least middle school) and exposed to mass media and with a high standard of living, are probably more likely to use sex-selective abortion than other woman as they have better access to information and facilities and are also more likely to be in the habit of family planning. [8]

   This therefore is a reaffirmation of the belief that growth alone does not automatically translate itself into equity and justice for all. Economic growth in an essentially patriarchal society, where very little has been done to really change the position of women, has translated itself into people being able to access the services, now made easier by technology, that help them in having sons. In fact the technology was promoted in the first place with advertisements such as, "spend 500 and save 500,000"; meaning that spend Rs. 500 in sex selective test would save Rs. 500,000 that one would have to spend in marriage and dowry expenses.

4. **Lack of ethics in medical practice.** It can be argued that medical professionals operate within the same mindsets as the larger society. Hence many doctors see no harm in selecting the sex of one's child. The lack of ethics in medical practice, the commercialization of this profession and lack of professional oversight have all led to an indiscriminate use of technology and skills to abort female fetuses. The fact that these are motivated by greed rather than sympathy towards the potential mothers of daughters is reflected in the significantly higher prices charged for conducting sex selective elimination, citing legal risks, as against a simple medical termination of pregnancy. (AFFIRM) Indian Medical Association has been unable to hold any one of its members accountable. Instead, the Association has tended to get together and protect each other, functioning like a union focused on self interest rather than protecting the dignity of the medical practice itself.

5. **Weak implementation of existing law** The implementation machinery prescribed under the PNDT Act by way of setting up Appropriate Authority and Advisory committee though established in principle still needs to gear up. The law is easy to circumvent. Sex selective abortions are carried out entirely by private practioners[9]. Private laboratories

[8] Factors affecting Sex-selective Abortion in India; by Robert D Rutherford and T.K. Roy; NFHS survey Bulletin no. 17 January 2003;
[9] RCH II and gender- workshop organized by UNFPA.

and clinics are not monitored as closely as government facilities. Despite restrictions doctors continue to communicate the sex of the child to parents who want to know, often verbally. Closer monitoring and speedy action in case of violations is essential given the organized manner of functioning of different vested interests perpetuating this system. However there are also reports about a strong pressure from interested lobbies from a more liberal legislation. In Karnataka, there is a draft legislation pending approval of the Legislative Assembly, that permits sale of equipment to non-medical professionals.

6. **The corporate sector has ridden on societal attitudes.** The Corporate Sector has given a fillip to demand for such technologies by its marketing strategies and by providing cheap credit for purchase of equipment. As soon as one private practitioner owns an ultrasound machine, it increases pressure on the competition to buy the machine as well. Fierce competition then leads to cheaper rates for scans and easier accessibility for sex determination especially for those who would have not otherwise been able to afford it. GenSelect an American product, that facilitated preconception sex selection, was being aggressively promoted in India in October 2001. It had to be withdrawn following the Court Order in February 2003.

> **The Case of General Electric (GE*):***
> ***It is alleged that GE has indulged in indiscriminate and illegal sales of ultra sonic machines to users across the country. Reportedly, this has been one of the most lucrative, profit making business lines for the Company in India.*** *Examination of the lists of more than 5000 sales provided by GE-WIPRO following the court order revealed that most of the sales had been in North-west parts of the country, parts which show very high declines in CSR. Activists claim that GE has defaulted on its promise, made by Jack Welch in 1993, when the company was trying to enter Indian market, that their ultra sound machines will not be used for sex determination purposes.*

II B Consequences

Census 2001 brought home a startling and worrying scenario and focused attention on the northern states. As the following section reveals, given the deep rooted preference for sons and a patriarchical society across religious groups, across socio-economic classes, across states, there is a strong probability that the practice will pervade "poorer states" as well. **If no concerted efforts are made now, by the next Census of 2010 the CSR would become more skewed.**

1 **Potential spread of the practice.**[10] – Analysis of data from NFHS 1 and 2 indicates that though son preference is declining in almost all states and socio-economic groups, it is still more than the biological norm.[11] It must be mentioned here that the NFHS survey includes only women in the reproductive age group of 15 - 45 who are not necessarily the primary decision makers and thus the reduced "son preference" may not be representative of the mindset of the larger society. Also women with high socioeconomic

[10] Factors affecting Sex-selective Abortion in India; by Robert D Rutherford and T.K. Roy; NFHS survey Bulletin no. 17 January 2003;

[11] Decline in the ideal sex ratio, from 1.43 to 1.35 during the six years between NFHS1 and 2, the biological norm is 1.05

status are less likely to be explicit about their strong preference for sons even though it is this group that seems to be adopting sex-selective abortion. **Nevertheless, this stand alone difference between the desired and the biological ratio in itself implies that considerable potential exist for further increases in levels of sex-selective abortion in India.**

Sex selective abortions are somewhat innovative behavior that diffuses from higher to lower socio economic groups and **sex ratios at birth may increase further with development despite declining son preference.**

At risk states - The potential or the risk rather is greatest in states that currently have very strong son preference but which is not corroborated with the actual sex ratios at birth, indicating that not much sex selective abortion is currently taking place. **But once the technology is easily available, it could lead to indiscriminate and large scale killing of female fetuses. States that fit into this pattern are Uttar Pradesh, Rajasthan and Bihar.**

2 **Potential increase in crimes against women** – Female feticide further disempowers and devalues women and leads to a gender skew that can have serious implications on women's overall well being. It could lead to increase in abductions, rapes, and sexual abuse, bride-selling and forced polyandry. As per a report submitted to the Home Ministry[12] from the West Bengal state government at least 7000 young women were trafficked from impoverished areas of Bengal, Assam and Bangladesh to more prosperous Panjab and Haryana. Reports are already trickling in about how unemployed young men in Haryana are finding it difficult to get married. As the enforcement of the Act becomes a little stringent, Panjab reports abandonment of baby girls.

The threat of violence has serious effects on curtailing women's mobility and her access to schooling, employment or even entertainment. The increase in crimes would further fuel the macho attitudes of the male members to protect the honor of their families. and severely curtail not only their mobility but also women's decision making role within the family.

3 **Potential affects on women's physical and emotional health** – Repeated pregnancies and abortions, many times backroom abortions and many times at advanced stages of pregnancies, have a negative impact on a woman's health. Not to speak of the emotional trauma when a woman is forced into undergoing sex-selective abortions. While older women may be able to rationalize the decision, the effect on young girls growing up in an environment that blatantly and brazenly undervalues girls could be devastating in terms of low self esteem and perpetuating discrimination.

III KEY LEARNING GAPS

[12] The Gender Gap – A growing Cause for Concern – spurs trafficking in women; TRIPS TRIUMPH Cable 4 – Jan 2004; Internal USAID document

1. *Urgent need for grassroots action:* Though there have been important efforts made to highlight the issue of discrimination and sex determination, these remain mostly at the national levels. Even there, most of the attempts have been piecemeal, patchy and sporadic at best and there is no well-articulated comprehensive strategy to squarely address the deep-rooted discrimination against the girl child. The design team has as yet not come across a single comprehensive program of action at the grassroots level. **Yet, for a complex problem such as this, very little change can occur without reaching the households; without grassroots level commitment and action.** Discrimination and violence within the protective walls of family cannot be removed by putting in place effective laws alone. There is need for grassroots activism that will influence the mindsets and practices at individual, family and community levels. And the need to set up vigilance bodies that will encourage public accountability for those who abuse the law. A brief experience with NGOs monitoring in Mumbai after Maharashtra passed its law showed positive impact.

2. *Need for focused research to better understand the multiple and complex aspects of the problem:* There is urgent need to undertake research to better understand the problem and its dimensions. There is little documented research for example about the impact of declining girl child sex ratios on children – girls and boys, family structures and society. We need to know more about family decision making processes and dynamics in choosing to abort one or more female fetuses.

Some studies have been undertaken about the role of corporate sector as also the business cycle and links of the practice. Better understanding of the role of corporate giants such as GE that have aggravated the problem by supplying technology on easy terms, needs to be built. At the same time its important to understand the motivations, economic or otherwise, that lead medical professionals to promote and provide such services.

3. *Operationalising the Act and monitoring its implementation:* The PNDT Act has been passed, but its implementation, as is the case with most Acts, especially most Acts relating to women's' empowerment, remains challenging. In many states there are no established mechanisms to take action against doctors and medical professionals who would encourage sex determination. Some limited work has been done, largely by the individual initiative of committed bureaucrats. This needs to be supported, but also replicated through workable mechanisms. (ADD ABOUT IMPLEMENTATION MECHANISMS AS PROVIDED BY THE ACT.)

4. *Visibilising the Practice:* At all levels, panchayat, blocks, districts, state, nationally and internationally, the declining girl child ratios need to be looked at as a development challenge, and not just "social issue specific to women". It is important to engage with all stakeholders.....

II. PURPOSE

IR 3 promotes a learning lab approach. While there exists some knowledge about the current status of the problem, not enough is known about its causes, trends, linkages among vested interests or long terms consequences. In particular, there is no understanding of grassroots, community based interventions and strategies to work on this issue. No other donor has really committed a program or actual funds to the issue.

The Mission actively promotes human rights for women through its various programs, more so Women's legal Rights Initiative and SARI/Q. USAID's work on domestic violence was a pioneering effort in that it brought the issue out in the open and established the extent of the problem. Sex selective abortions represent a continuum of extreme violence against girls, perhaps the most vulnerable of them. Within the limited resources available, USAID's support to prevention of feticide will be significant in testing strategies, positioning feticide within the larger development agenda and creating a sense of urgency within selected states.

The overall goal for the proposed project is "To arrest the decline of the child sex ratios and enhance the dignity of the girl child." The next Census of 2010 should reflect an improved CSR.

The project objectives will include:

- Increased public awareness and understanding of the problem of feticide and Infanticide and dignity of girl child in selected states.
- Increased commitment by key stakeholders to address issues of infanticide/ feticide/ neglect of girl child in selected states..

The design for the proposed project is based on the available analysis that identifies existing learning gaps and thus suggests activities that could be developed. Key elements of the approach, that are mutually linked and enforce each other, are:

- *Supporting grassroots action to question attitudes and encourage implementation of the law, educate the public, government official, corporate sector and medical community.*
- *Helping bridge the knowledge gaps by undertaking focused research*
- *Raising awareness at national and local levels and creating a sense of urgency about the genocide*
- *Facilitating the implementation and monitoring the implementation of the PNDT Act, including any adverseconsequences.*

2 *Geographical focus* - Limited resources entail judicious selection of geographical areas. Following criteria could be used to narrow down on the states.

- The worse hit states where the girl child sex ratios have dropped far below the national average and thus the need for action is greatest. (Punjab and Haryana)
- Areas where the problem is not yet severe but trends exist which warrant interventions that could be more preventive in nature (Rajasthan, UP, Bihar)
- Government response and willingness to work on the issue
- Availability of grassroots civil society organizations and their ability to implement innovative programs that help build greater awareness and action on the issue.
- Existence of other USAID programs where there could be complementarities and thus better possibility of greater impact
- Opportunity to link up with other existing initiative at national levels and support advocacy and policy work by feeding in experiences from the ground.

Scenario	Areas of Focus
I, with funding levels at	Comprehensive effort in one or two of the states decided on

$2m	the basis of criteria above. Little effort at national level.
II, with increased funding of at least $1.5m; for a total of $3m	Expand into other states. Support more national level advocacy and awareness building.

3 **Overlaps and Linkages with other programs:** There are real complementarities between the proposed feticide program and WLRI. They work on related rights issues and they pursue the same kinds of interventions, (research, legal and policy advocacy, public education and awareness raising, changing legal and public section attitudes, knowledge and skills, NGO monitoring of law's enforcement.) WLRI also offers a management structure that IR 3 funded at only $2million could take advantage of. The proportion of funding that would need to go for actual management and overhead costs would be lower if this program is folded into the IFES CA rather than being bid separately. The one difficulty is that WLRI works primarily in Karnataka and Rajasthan. While Rajasthan is not one of the worst states in terms of the 0-6 years old sex ratio, it could well join this group of state for the next census, without action. Therefore at the $2 million funding level we would recommend interventions in Rajasthan and either Punjab or Haryana."

The SARI-Q program also offers interesting overlaps. The common concern is violence against women and there could be rich learning linkages in terms of effective interventions and impacts. SARI funding of pilots could support the integration of feticide into a set of wider concerns.

IV EXPECTED ACCOMPLISHMENTS

In either scenario, efforts will be made especially at grassroots level where it is most important to catalyze a response. At the same time district and state officials will also need to be targeted. Some of the expected accomplishments are shared below:

1 *Increased grassroots action:*

As explained above, action at the grassroots is perhaps the most critical aspect for influencing change. It will be important to therefore involve local bodies, panchayats, local medical community, women's' groups, self help groups, traditional and jati panchayats and any other existing civil society bodies to create public awareness and institute community based vigilance structures. Following accomplishments could be expected:

- *Increased grassroots activism against practices that devalue girl child.*
- *Increased monitoring of equipment, and clinics where services are provided through women's SHGs, panchayts, NGOs and other community watch groups.*
- *Increased awareness and participation of jati panchayats, religious bodies etc towards women's' empowerment and leadership*
- *Strengthened efforts at universal birth registration or other programs that work with youth, women etc, supporting linkages*
- *Increased Public Awareness through locally developed messages and public media*

2 *Bridging knowledge gaps, undertaking focused research:*

As this is a relatively speaking new area of intervention, it is important to undertake rigorous and focused research that will help develop a deeper insight into the problem and thus develop more effective responses. Some of the gaps are discussed in the section on Key Learning Gaps. In addition, more analysis to understand different trends as also greater

documentation of best practices and existing interventions even if they exist in small pockets, needs to be undertaken. The expected accomplishment from these interventions would be:

- *Enhanced understanding and knowledge about the problem which will enable more effective response*
- *Contributing to the larger understanding enabling a wider response from other players as well.*

3 ***Operationalising the Act and monitoring its implementation:***

It will be important to engage with the State Administration, Judiciary, Prosecutors, Women's' Commissions, Health Ministry, medical community and other political leaders and representatives to ensure the PNDT Act is implemented. Some work has been done in Haryana through its Directorate State Appropriate Authority. It would be useful to support similar initiatives in other states. Monitoring the sale of Ultrasound machines, sex determination clinics can be effectively undertaken at the community level, provided clear legal mechanisms for accountability are set up and known. Community monitoring and feedback can also help address the issue of policy level inconsistencies. Expected accomplishments from such interventions would include:

- *Better enforcement of the PNDT Act – with Judiciary, Women's' Commissions, health Ministry, MLAs, Lawyers groups and other stakeholders.*
- *Greater awareness of policy inconsistencies, especially in supporting the two child policy norm, and possibly better policy environment*

4 ***Increased awareness of the issue at State and Local levels:***

National and local level media campaigns, consultations and dialogues with powerful players – political, social and economic leaders, and supporting other NGOs, networks to advocate and work on this issue will help in creating the sense of urgency. Student and youth groups are important allies in this process and will need to be involved at local and national level campaigns. It is expected that these and similar interventions would lead to some of the following accomplishments:

- *Strengthened networks of civil society organizations/networks/alliances around the issue.*
- *Increased advocacy with medical associations and the rest of development community and other stakeholders (especially student and youth groups) to identify this as a development issue.*
- *Greater awareness among key stakeholders and the public that sex selective feticide is wrong.*

V Possible Pre Implementation activities:

1. A review of grassroots strategies being used already and an assessment of what appears to be working. (Agreed it is too early to yet undertake an impact kind of assessment as not enough has been done to merit that). Supporting national consultations to share experiences of different groups and people working on these issues.
2. Research the network of providers of sex selective abortion services (formal and informal) in order to get a better understanding of the chain and where it breaks and how etc.
3. Supporting the ethnographic research – into family decision making as undertaken by Action Aid in Dhaulpur, in Rajasthan.
4. Funding some parts of a media strategy including a TV soap opera series on feticide that is ready to be shown but lacks funding for airtime.

V DESIGN SCHEDULE AND ILLUSTRATIVE BUDGET

IV.I Indicative Budget:

Total $2m.
$1, 250,000 in Panjab and Haryana.
$750,000 in Rajasthan