

Explaining challenges in policy implementation concerning sex-selective abortion in India

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Abstract

Sex-selective abortion is an issue that is related to abortion rights, severe gender discrimination and maternal healthcare. This issue occurs mostly in Asia, including in India which has the highest level of excess female child mortality, declining fertility rates and strong son preference. Although legislation and policy interventions regarding the issue exist, the impact has been little. To gain more understanding regarding this puzzle, this thesis will explore the policy implementation related factors that underlie the slow progress in reducing sex-selective abortion in the North of India, with the use of qualitative research methods. Given the role of NGOs and medical professionals, this thesis will pay particular attention to these actors.

The relevant theories that are needed to analyze and discuss the results are related to implementation and professionalism. The theories regarding implementation include the 'top-down approach', the 'bottom-up' approach and the theory of translation. By applying these theories to the situation in India, a more complete understanding and explanation of failure of implementation can be provided. How and why the implementation process exists in its current form can be explained as well. The theories related to professionalism address the behaviour, power and role of medical professionals. Through these theories, understanding and explanation regarding the role of medical professionals can be gained.

The data for this research have been collected through qualitative research methods. After conducting a literature study a topic list was set up. Based on this list, respondents from NGOs were interviewed. Also, additional documents, such as e-mails from respondents and articles of their interventions were analysed. During the analysis, the data has been divided into three subjects, i.e. the perception and way of dealing with the issue of NGOs, interventions with long term goals and interventions with short term goals. The theories of implementation and professionalism, provided further categorization when analysing the interventions.

In end it can be concluded that the current challenges in implementing policies concerning prevention of sex determination and sex-selective abortion in the North of India can be explained by taking into account the situational and cultural factors due to which the issue is very dynamic, diverse and complex. NGOs act against sex-selective abortion as they perceive the issue to be a growing problem. They implement long term strategies as they frame the issue to be a social and cultural problem, which needs to be solved by targeting the gender insensitive norms of society. The interventions targeting these cultural and social norms are being implemented using a bottom-up approach. In addition, they frame the issue as failure of implementation of legislation and the lack of medical ethics, which results in short term strategies targeting proper implementation of the law and the control of ultrasound machines. A top-down approach, where the government can be seen as the central decision-maker, can be recognized. Although the interventions are not set up from a translation perspective, within all interventions, elements of translation are recognized which explain the changes of behaviour of actors and changes within the interventions. Eventually, the concepts of professionalism and countervailing powers provide modest insight into the role of medical professionals, which contributes to the challenges regarding policy implementation to prevent sex-selective abortion in the North of India.

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1. Introduction

The third, fourth and fifth millennium development goal (MDG) defined by the United Nations include gender equality and women empowerment, child mortality and maternal healthcare (United Nations 2012). Even if there is progress in reaching the MDGs, there is a growing realization that not all of them will be reached by 2012 (UNDP 2010:7). Social attitudes and difficulties to reach vulnerable target groups, such as women, are some of the bottlenecks contributing to this failure (UNDP 2010:13).

A phenomena which is related to the three mentioned MDGs and the two bottlenecks is 'sex determination' and 'sex-selective abortion'. This occurs mostly in Asia, in countries such as China, India and Korea (Gupta et al. 2003). Of these countries, India has the highest level of excess female child mortality, declining fertility rates and strong son preference (Bandyopadhyay 2003:911). Practises of sex-selective abortion have led to unbalanced sex ratios which are male dominant, and to millions of girls missing in the past decades (Jha et. al. 2006:211). This issue is not only related to abortion rights, but also a case of severe gender discrimination (George 2006:607).

This gender inequity can be changed by well-designed policies and programmes (Parker & Sommer 2011:94). However, although legislation and policy interventions regarding this issue exist in India, the impact has been limited suggesting that the situation is unlikely to improve (Sudha & Rajan 1999, Ganatra, Hirve & Rao 2001, Arnodl, Kishor & Roy 2002, Hirve 2004, Miller 2001). India has a history of policy attention to sex determination and sex selection. However, implementation remains ineffective resulting in no convictions of medical professionals (Miller 2001:1089) and failure to prevent people from having sex determination tests (Arnold, Kishor & Roy 2002:783). Moreover, in the highly unregulated environment of India's health sector, in which healthcare providers operate, there is no control on services, costs and quality of care (NCMH 2005:43). Because of this, medical professionals, who play a key role in the decision-making of sex-selective abortion (Population Council 2004:58), benefit from great power.

This thesis will explore the factors shaping ineffective policy implementation in India as these are seen to underlie the slow progress in reducing sex-selective abortion. In doing so, I draw on legal data and use qualitative methods. The main question structuring the present thesis is as follows: 'How can we explain the current challenges in implementing policies concerning the prevention of sex determination and sex-selective abortion in the North of India?'

This first chapter will outline the research problem as follows. First, to understand the extent and significance of the problem, the first section will focus on the occurrence of sex-selective abortion in India, its effect on maternal health and the effect of unbalanced sex ratios. In the second section the current policy context of sex-selective abortion in India. In the third section the objective of the research and the related questions will be stated.

1.1 The extent and significance of sex-selective abortion in India

The problem of sex-selective abortion is highly related to son preference, which is found to be higher in Northern India than Southern India (Arnold, Kishor & Roy 2002; Miller 2001; Gupta et. al. 2003). This difference can be recognized in the prevalence of unbalanced sex-ratios, which is high in Haryana, Punjab, Delhi, Gujarat and Maharashtra (George 2006; Agrawal 2008). Also, parts of Rajasthan and Gujarat are experiencing a drastic decline in the juvenile sex-ratio in recent decades (Visaria 2005:4) due to high occurrence of female feticide (Arnold, Kishor & Roy 2002:764). This discrimination of sex accounts for about one-fifth of child mortality in India (Gupta et. al. 2003:158). Women who already have one or two female children are most likely to perform sex-selective abortion (Jha et. al. 2006:207). Nearly all of the shortage in number of girls, born as second or third child, are due to sex-selective abortion. Conservative assumptions conclude that sex-selective abortion accounts for 0.5 million missing female births yearly, leading to 10 million missing female births in the past two decades (Jha et. al. 2006:211). Between 1995 and 2001 this was estimated to be 4.5 million girls eliminated before birth (George 2006:607). Research indicates that of every 1000 fetuses aborted in India, 995 are female (Bandyopadhyay 2003:911). Although there is an estimation of the number of legal and illegal abortions, it is likely that the numbers of sex-selective abortions are considerably higher (Arnold, Kishor & Roy 2002:782).

These high numbers of sex-selective abortion can be seen as a public health issue as it contributes to high maternal mortality (Abrejo, Shaikh & Rizvi 2009:10). Sex-determination is done by the use of ultrasound tests. This technology, which is intended for diagnostic purposes and monitoring foetal and maternal health, is also used by couples to determine the sex of the foetus (Kishor & Gupta 2009:126). However, this way the sex-selective abortion takes place after 12 weeks of gestation. Second trimester abortion leads to unsafe health conditions for women which include risk of post-abortion complications (Ganatra, Hirve & Rao 2001:122), obstetric morbidity and infertility, and risking the life of women (Agrawal 2008:7-8). Besides these risks, structural aspects of the healthcare system lead to an increase in maternal health risks. India has the highest second trimester abortion rate in the world (Johnston 2002:20) which is primarily done by uncertified providers as conducting a second trimester abortion is legally more difficult (Johnston 2002:20). Performance of abortion by untrained doctors leads to even greater health risks for women.

The resulting imbalance of sex-ratios itself has an influence on society. Study shows that murder rates and male violence towards women correlate with highly masculine sex ratios (Parker & Sommer 2011:90). Unbalanced sex ratios do not only impact on the physical and mental health of females, but also on those of males whose survival may be impaired in their adult years because of violence, risky and unhealthy behaviour and premature mortality due to superior position and masculinity of social norms (Parker & Sommer 2011:90). Besides growth of violence and war, less political power of women due to fewer votes of women will presumably lead to a worsening of women's societal and political status (Goodkind 1999:58). The shortage of women leads to greater restriction and growing control over them. Increasing intensity of violence against women in all domains of life is evident for

this (Sudha & Rajan 1999:610). The correlation of imbalanced sex ratio with the frequency of violence in home and public area is an important argument, based on which balanced sex ratios can be seen as a local and global public good and a factor related to human rights (Miller 2001:1092). To sum up, balanced sex ratios are believed to lead to a better quality of life from a human rights and women's health perspective.

1.2 Current policy context concerning sex-selective abortion in India

As already stated, India has a history of policy attention to sex determination and sex selection, but implementation remains ineffective. In order to understand the current policy context, it is important to understand how this came into being. Therefore this section will address the history of sex-selection policies and the current policies of the Indian government. As NGOs actively try to tackle the issue of sex-selective abortion, attention will be paid to their current interventions. The different kinds of target areas for policy interventions will also be described, to show the dilemma of choosing a specific approach to solve the problem of sex-selective abortion.

1.2.1 The social movement in the 1980s

The start of action against sex-selective abortion came from society itself. During the popular movement for independence, the idea of gender equality was incorporated resulting gender equality firm establishment in civil discourse and women's movements as a major force of change. The gains however were not as large as achieved through state intervention in East Asia (Gupta et. al. 2003:178). Since the 1980s activist groups, such as the India's Forum against Sex Determination and Sex Pre-Selection, the Bombay Forum for Women's Health, and UNIFEM, an international group addressing new reproductive technologies in general, have tried to increase awareness of the problem and demanded legal and other reforms (Miller 2001:1090). In 1986, the Federation of Obstetric and Gynaecological Societies of India passed a resolution against prenatal sex determination and medical termination of pregnancy because of sex of the foetus. All members of the federation were asked to discourage female feticide as it is a 'crime against humanity' (Sheth 2006:186). The series of campaigns in the 1980s were very successful resulting in passing a range of new laws in order to protect women. These new laws were related to rape, dowry, domestic violence, prostitution and sex-determination tests of an unborn foetus. However, this success weakened the movement leading to failure to sustain action to ensure implementation. This resulted in most laws never being implemented and thus little real impact (Hardgrave & Kochanek 2000:215).

1.2.2 Current Policy of the Indian Government

Although policies to prevent sex-selective abortion have been initiated by the government, in some cases policies have not been implemented, such as the 1997 Government scheme to subsidize girl children in families identified as poor (Sudha & Rajan 1999:610). However, according to research the

government has a 'do nothing' attitude towards unsafe abortions, as these abortions help to keep the population growth down (Duggal & Ramachandran 2004:123).

Regarding policies at state level, different states have adopted other policies and programs. The state of Haryana, which has an extremely unbalanced sex ratio, implemented a scheme in 1994 that invests Rs 2.500 in the name of a newborn girl. When the girl reaches the age of 18, the investment becomes Rs 25.000. If the girl would get married before that age, the money would not be granted. This plan was restricted to families with an annual income below Rs 11.000 and with no more than two children (Miller 2001:1089). The state of Rajasthan had a similar plan, but this was linked with the girl's father or mother undergoing sterilization. These policies failed due to flaws in its design regarding its targeted group as sex selection is practiced among people who are non-poor and the intervention focused on poor people (Miller 2001:1089).

Besides government interventions regarding sex-selection, policies on different issues have had an impact on sex-selective abortion. Policies on population reduction, such as the one-child policy (Goodkind 1999:50), lead to more sex determination and sex selective abortion (Agrawal 2008:5; Ganatra, Hirve & Rao 2001:122). The Indian policy to prevent population growth is one of the most extensive family-planning programs in the world. It was designed to overcome the fatalistic belief in 'God's will' with its slogan "A small family is a happy family" (Hardgrave & Kochanek 2000:5). Having fewer children decreased the probability of having a son, leading to sex selection, which became more accepted due to this policy (Goodkind 1999:50). Also aspects such as modern thinking and economic reasons, especially in urban areas where having a large family leads to a large financial burden, contributes to the acceptance of smaller families. This shows that son preference is also linked to political economy, including population policy, and public acceptance of such discrimination (Goodkind 1999:51). These factors contribute to the insensitiveness of the public to government appeals which result in failure of sex-selective policies (Goodkind 1999:51).

1.2.3 Current NGOs interventions

Apart from the government, there are different NGOs which target the issue of sex determination and sex selection. Their current strategies have a large range, including 'long term strategies', such as consciousness raising, and 'confrontational strategies', such as reporting suspicious abortions to the police (Sudha & Rajan 1999:610). Unfortunately, examples of plans that have succeed are rare and the impact on demographic behaviour of these plans is small. The difficulties in success are related to the lack of perceiving sex-selective abortion as a serious social problem (Miller 2001:1090). This is the result of the lack of sincere opposition due to widespread acceptance of sex selective abortions, the fundamental belief that having a son is the right of every couple (Arnold, Kishor & Roy 2002:763) and the denial of the significant effect on the population in the form of unbalances sex ratios (Miller 2001:1090).

Despite the many difficulties, the NGO advocates strive for improvement of the situation. In relation to these attempts, UNFPA advocacy strategy suggests that to be able to tackle the problem, the history and mindset of the issue must be understood. Deeper understanding has led to the multi-pronged advocacy strategies of UNFPA that aim to tackle prevailing practice of sex-selection (Visaria

2005:14). Also, it must be recognized that long term consequences of sex selection will have a huge impact on the behaviour of people. The concern that investing in daughters is unproductive, will have to be addressed through advocacy, in the form of real-life stories of girls and women who have made their parents proud of them. There has to be consciousness raising in the parents about the value of daughters as well as the understanding of cultural factors that undervalue girls. Using popular media and publishing human stories, by means of visual media are effective ways of conducting media advocacy workshops / work (Visaria 2005:14). Although this is one way of tackling the problem, there are other recommendations made in scientific literature, which show that there are many areas that can be targeted to preventing sex-selective abortion. These recommendations will be addressed in the next section.

1.2.4 Dilemmas in choosing a target area

Sex-selective abortion is a complex issue, which results in many different recommendations for policy in scientific articles. Most of the recommendations are related to education, socio-cultural factors and organizational factors. In this section the recommendations will be depicted to give an overview of the diversity of policy areas. This way the dilemma of policy makers, who try to fight against the complex issue of sex-selective abortion, can be understood.

Education

Interventions related to education of women are controversial, because educated women are more likely to conduct sex-selective abortion (Sudha & Rajan 1999:593). Also, education will not change the conditions that improve the liability of daughters. Therefore, simply investing in education can actually lead to a reduction of girls (Miller 2001:1091). This shows that besides education, due to which girls have a chance to develop themselves, more interventions on different areas are needed to improve the situation.

Socio-cultural concerns

Concerning the prevention of sex-selective abortion, the restriction of technology that is used to determine sex is not enough (Sudha & Rajan 1999:611). The root cause of devaluation of Indian women must be addressed, otherwise all policies will just drive the practise of sex-selection underground where they will continue (Sudha & Rajan 1999:611). Understanding of gender power and aspects that lead to son preference are important for adequate policy interventions that will reduce the discrimination against women (Agrawal 2008:2). Also, social changes that aim at the increase of female autonomy and economic power are needed, which will increase the value of a girl child. Without these changes, any legal sanction will be difficult to enforce due to large acceptance of the practise (Ganatra, Hirve & Rao 2001:109). Eventually, these changes will lead to a reduction of son preference (Agrawal 2008:45).

Organization by medical professionals or government

As medical professionals are important actors, efforts should be made by the medical community itself, to regulate its members and incorporate the existing laws (Ganatra, Hirve & Rao 2001:123) and pay attention to medical ethics (George 2006:607). Education for professionals on ethics of sex determinations and the provisions of the PNDT Act is needed (Duggal & Ramachandran 2004:128). Also, training more providers and simplifying procedures is a way in which illegal abortions can be reduced (Hirve 2004:114). Besides the medical community, the government should also enforce regulations which prohibit sex determination (Bandyopadhyay 2003:925). In addition, all social and legal institutions that have an effect on son preference, such as inheritance, should be altered (Goodkind 1999:52).

The mentioned recommendations show that there are many factors that can be included to tackle the issue. While stating this, it is important to realise that no single policy will end the problem, and that multiple forms of policy are needed (Miller 2001:1091). In relation to these recommendations, it is not likely that the government will actively follow them, due to the 'do nothing' attitude towards the issue (Duggal & Ramachandran 2004:123). However, it seems that NGOs have the will to do something, regardless of the difficulties they face in implementing their interventions (Sudha & Rajan 1999:610; Miller 2001:1090). Therefore, to understand the difficulties of implementation, the experiences of NGO members that are active in the field of advocacy regarding prevent sex-selective abortion, can provide insight in the difficulties of implementing their interventions.

1.3 Objective and research questions

Objective

The central problem addressed in this thesis is the lack of progress in eliminating sex-selective abortion despite existing legislation and policy interventions. This thesis takes a closer look at policies regarding the issue of sex determination and sex-selective abortion. Given the strong involvement of NGOs in this field, particular attention will be paid to NGO policies and the obstacles they encounter in policy implementation. Also, attention will be paid to the role of medical professionals as they hold a strong position as providers of abortion. Because of the high occurrence of the problem in the North of India, this research will only focus on Northern states.

Main question

How can we explain the current challenges in implementing policies concerning the prevention of sex determination and sex-selective abortion in the North of India?

Sub questions

1. What situational and cultural factors need to be taken into consideration for policy making and implementation regarding the problem of sex-selective abortion?

2. How do advocacy initiatives (national and international NGOs) perceive of and deal with the problem?
3. What shape has the implementation of existing legislation and policy taken?
4. What is the role of medical professionals regarding the issue of sex-selective abortion?

In order to answer these questions, the following chapter will describe the theoretical framework in which theories related to policy implementation and the concept of professionalism will be addressed. In the third chapter an overview of the current situation of sex-selective abortion in India will be given, based on a literature review. This chapter will deal with the current legal and ethical framework and factors that influence the issue of sex-selective abortion. The fourth chapter will describe how this research has been conducted using qualitative research methods. In the fifth chapter the results will be analysed and discussed using the theoretical framework and the literature review. Eventually, the conclusions, limitations of this research and recommendations will be addressed in the last chapter.

2. Theoretical Framework

In this chapter, I will discuss relevant areas of scholarship, which make up the theoretical lens for the present analysis. The first section will address theories of policy implementation as the research problem is framed as a matter of policy implementation. Three approaches that can help understand and explain the challenges of policy implementation will be described. The second section will address the theory of professionalism that can help understand and explain the role of medical professionals, since they have a crucial role as providers of sex-selective abortion.

2.1 Policy implementation perspectives

The limited impact of legislation and policy interventions mentioned in the previous chapter, suggests that the implementation is not successful. In frequently used policy models, implementation is the fourth step of the so-called 'Policy Cycle' mentioned by Ramesh and Howlett (1995:13):

1. Agenda Setting
2. Policy Formulation
3. Decision-Making
4. Policy Implementation
5. Policy Evaluation

Here implementation relates to 'how government (or organisations) put policy into effect' (Ramesh & Howlett 1995:13). Buse, Mays & Walt (2005:120), describe implementation as the process of turning policy into practice and 'what happens between policy expectations and (perceived) policy results' (Buse, Mays & Walt 2005:121). The same authors call the difference between what was intended with the policy and the end result of it, the 'implementation gap'. In the case of preventing sex-selective abortion, the occurrence of the issue despite policy interventions and legislation, can be called an implementation gap. The existence of an implementation gap indicates that policy implementation is a process in which it cannot be assumed that implementation in practise will be as intended by decision makers, since other actors have to turn policy into action (Buse, Mays & Walt 2005:120). Regarding the issue of sex-selective abortion, it must be noted that actors such as NGOs, bureaucrats who have to put legislation into practise and medical professionals who are a powerful actor, influence the implementation process in such a way that an implementation gap can increase.

To reduce this implementation gap, different approaches, such as the 'top-down approach' and the 'bottom-up approach' provide methods and tools in order to achieve the goal of the policy. These two approaches, which will be discussed in the following sections, are very linear as they perceive implementation to be divided into steps. Because these steps are not always recognized in practise, this perspective cannot provide a full understanding and explanation for the implementation process. To resolve this limitation, the theory of translation, which deals with the uncertainties of reality, provides a more comprehensive perspective to understand and explain the implementation process. This theory will be discussed in section 2.1.3.

2.1.1 The 'top-down' approach

One of the many approaches to understand policy implementation is the 'top-down' approach. In this approach a clear division is made between policy formulation (a political process) and policy execution, which is a technical, administrative or managerial activity (Buse, Mays & Walt 2005:122). This approach includes a 'central decision-making' process, which can be related to the role of the Indian government that lays down policy and legislation upon citizens. The aim of the 'top-down' approach is to understand the 'gap' between the intentions of policy makers (at the top) and the execution in reality. From this perspective, this approach can be used to understand the gap between existing policy and legislation of the government and the failure of implementation.

In this approach policy needs to have a clear goal that is widely understood. Also, availability of necessary political, administrative, technical and financial resources, a sequence of command from the centre to the periphery, and a communication and control system are important factors that contribute to successful implementation. Buse, Mays & Walt (2005:123) argue that implementation failure is the result of a wrong adopted strategy. Regarding such a strategy Sabatier and Mazmanian (1979), who examined the conditions necessary for effective implementation from a top-down perspective, name six conditions for effective policy implementation, which are:

1. Clear and logically consistent objectives
2. Adequate causal theory
3. Implementation process structured to enhance compliance by implementers
4. Committed, skilful, implementing officials
5. Support from interest groups and legislature
6. No changes in socio-economic conditions that undermine political support or causal theory underlying the policy

The 'top-down' approach can, according to its proponents, provide useful guidance to policy makers in understanding why implementation succeeded or failed. However, when put into practise, the first objective is rarely met since policies mostly have unclear and inconsistent objectives (Buse, Mays & Walt 2005:123). The opponents of the 'top-down' approach declare that this approach is unrealistic in most situations and that it does not provide a good description of what happens in reality (Buse, Mays & Walt 2005:124). This should be taken into consideration when this approach is used to understand and explain policy implementation.

2.1.2 The 'bottom-up' approach

Another linear view of the implementation process, is the 'bottom-up' approach. Here the implementers play an important part in implementation which should be taken into account during policy making (Buse, Mays & Walt 2005:124). Implementers can change the way policy is implemented and can even redefine the objectives of the policy (Wildavsky 1979). Because health and social services depend on a lot of professionals, an interactive political process exists in which negation and conflict of interests occurs (Buse, Mays & Walt 2005:125). This approach therefore focuses on the goals, strategies, activities and interlinks of all actors related to the implementation

process. According to this approach, the relationship between centre and periphery influences policies. The way of control depends on factors such as funding (where do they come from and who controls them), legislation (defining responsibility of authorities) and ability of government to enforce rules (Buse, Mays & Walt 2005:125).

To reconcile the two linear approaches, Buse, Mays & Walt (2005:132) mention that they focus on two sets of variables. The 'top-down' approach focuses on 'the extent of government capacity' and the 'bottom-up' approach focuses on 'the complexity of the particular policy field'. By using both approaches, a more comprehensive approach to tackle the implementation gap is provided. However, as noted before, these approaches do not deal with uncertainties that occur in practise. Therefore, another theory is needed to make up for the limitation of these approaches in order to gain better understanding of the difficulties in implementation regarding policies concerning sex-selective abortion in India. Consequently, in the next section the theory of translation will be discussed.

2.1.3 Theory of translation vs. theory of diffusion

In order to understand the implementation process, the concept of translation focuses on how implementation comes into being, rather than the linear steps that should be followed to reduce the implementation gap. This concept is described by Latour (1988) who mentions the co-construction of a black box by all involved actors (Latour 1988:135). Although Latour talks about the process of how technologies are invented, in the context of this thesis, the black box can be the implementation process of legislation and policy. During this process both the black box (the implementation process) and the actors change. Also, it is not clear which actor actually is responsible for the construction of the black box as there are many who contribute to it (Latour 1988:136). Latour mentions that the strength of the weakest link decides how strong a chain is. Therefore, although the black box and its implementation might have good aspects, the weakest link can result in failure of acceptance or construction of the black box (Latour 1988:61). The search and relevance of allies, whose powers can be combined and used to regulate each other, contributes to this process of translation which ultimately decides the way the black box comes into being (Latour 1988:67).

In addition, McMaster et. al. (1997:67), describe the Actor-Network Theory (ANT) as part of the translation theory. Within the ANT a black box is created across time and space from chains of weaker to stronger associations of both human and non-human alliances (McMaster et. al. 1997:67). New allies strengthen the chain and contribute to the making of the black box. This way, the network lengthens across time and space. Enrolment to the network is being done by getting other actors interested through invention of new goals and groups. As the black box is created by the whole network, there is no sovereignty of control and development.

McMaster et. al. (1997:65) make a difference between two perspectives, i.e. the theory of translation and the theory of diffusion. The authors call the two theories counterpoints and explain the fundamental differences between the two theories. According to the authors, the theory of diffusion separates people (society) and things (technology), which implies that technology can exist

independent of humans and has a diffusion power of its own (McMaster et. al. 1997:72). Also, in contrast to what the ANT suggests, within the diffusion theory there is a need of 'geniuses' who invent the black box, whereas the ANT relies on many actors who contribute to the development of the black box (McMaster et. al. 1997:72). The 'top-down' and 'bottom-up' approach are part of the diffusion theory and focuses on the causes and effects of implementation, whereas the theory of translation is about how the implementation process comes into being using actor networks.

Although the concepts are not developed to analyse policy, it is being suggested that they offer opportunities to do so (Zuiderent-Jerak 2007). Also, while the theory of translation and diffusion contradict each other, they both provide a different view on the implementation process. By using both perspectives, the theory of translation helps to understand and explain how and why the implementation process exists in its current form (Zuiderent-Jerak 2007). This way, the linearity inherent to the other approaches can be overcome. The theory of diffusion focuses more on the implementation gap and can provide an understanding and explanation of failure of implementation. To gain a more comprehensive insight of the implementation process regarding prevention of sex-selective abortion in India, both perspectives will be used to analyse the results of this research.

2.2 Understanding and explaining the role of professionals

In the previous sections, I outlined ways of understanding implementation in order to explain the challenges of implementing policies concerning sex-selective abortion. As medical professionals are crucial actors, in this section I will provide theory to understand and explain their role and power. First I will discuss the literature on professionalism which addresses the behaviour, power and role of professionals. Attention will be paid to the concepts of Freidson (2001) and Light (2010). As these theories are not specifically focussed on the context of India, I will thereafter elaborate on the role and power of medical professionals regarding sex-selective abortion in India.

2.2.1 Concepts of professionalism

According to Freidson (2001:180), professionalism implies that professionals serve a greater value, which leads to great devotion in doing 'good work', rather than performing only for economic reward. Professionals are accountable for their actions and have total authority and control. This amount of power is needed as patients are often not in a position to determine what choices are best to be made. In the professional – patient relationship, which is based on trust, the professionals make health related decisions on behalf of the patient. However, this kind of pure professionalism does not exist in reality, which leads to abuse of power by professionals. This results in extreme high prices and low quality of care (Freidson 2001:184). According to Freidson, this behaviour is the result of consumerism, where private gain is the highest interest. This contradicts the value of 'dedication to the service', which is the base of professionalism in its pure form (Freidson 2001:188-189). To correct the behaviour of medical professionals, mechanisms of accountability and control are needed which will also protect the health and interests of patients (Freidson 2001:189).

Although the concepts of Freidson focuses more on the motives of professionals that support their behaviour, Light (2010:203) addresses professionalism from the perspective of the countervailing model in which he includes other actors. From this perspective, an imbalance of power of one actor group results in countervailing powers to assert themselves in order to find a new balance. Therefore if medical professionals abuse their power, other countervailing powers, such as government or civil society, use their powers to reach a new balance in which all parties are happy with their position. In this case other forces, such as managers and consumers, are not seen as contradictions, but are helpful to restore balance. In the context of healthcare, the government is often mentioned as a countervailing power to protect the rights of patients (Light 2010:204). The concept of countervailing powers has led to a paradigm change of professional autonomy (mentioned by Freidson) to professional accountability (Light 2010:207). Ironically, due to the characteristics of healthcare, such as information asymmetry, trust remains a silent ingredient which is needed to establish accountability (Light 2010:212).

Using the concepts of both authors, the behaviour, role and power of professionals can be addressed from different points. From the concept of Freidson, the behaviour of professionals can be explained by looking at their motives for action. To include the role of other actors, the concept of Light can provide insight in how these actors provide countervailing powers to restore a new balance. Because these theories are not specifically focussed on the context of India, an understanding of the current role of medical professionals regarding the issue of sex-selective abortion is needed to apply the theory. Based on scientific literature, an overview will be given next on the role of medical professionals.

2.2.2 Role of medical professionals regarding sex-selective abortion in India

As stated in the introduction, within the highly unregulated healthcare sector of India (NCMH 2005:43), the medical professionals have a lot of power as they play a key role in decision-making regarding sex-selection (Population Council 2004:58). Although a medical council exists, who is responsible for medical education, the recommendations of medical qualifications and the registration of medical doctors (MCI 2012), the issue of sex-selective abortion is not being advocated by them. Also, due to the strong position of medical professionals, they can make large economic profit from sex-selective abortion, as performing medical tests is extremely profitable for doctors in India. Based on a six-day workweek, a clinic can gross up to Rs 2.8 lakh¹ per month. Moreover, training doctors in the techniques has in itself become a lucrative business (Sudha & Rajan 1999:599). The business of aborting female foetuses before birth is worth at least \$100 million (George 2006:607).

In relation to gain economic profit, it has also occurred that clinics promote sex-selective methods. Billboards stating 'Invest Rs 500 now, save Rs 50.000 later' have been put up to persuade potential parents to abort female foetuses to save future costs on dowry (Abrejo, Shaikh & Rizvi 2009:14). These clinics state that the government should promote sex determination technologies to

¹ Lakh means 100.000

reduce population growth (George 2006:605). Moreover, the clinics claim that they do not understand why some Indians are ashamed that most Indians want to have boys, which is based on centuries old traditions which are not going to change quickly (George 2006:605).

Due to the regrettable but inescapable culture of son preference in Indian society, medical professionals see sex determination tests as a 'humane' service that they provide to couples that do not want any more daughters (Sudha & Rajan 1999:600). The professionals feel powerless to change this culture and claim that sex determination is needed to control the population arsenal (Sudha & Rajan 1999:600). Medical practitioners also argue that aborting a female is preferable because it prevents an unwanted daughter to a lifetime of neglect and abuse (Sudha & Rajan 1999:600). Not only professionals, but also the general public has these attitudes (Ravindra 1995). Ultimately, medical professionals do not hold themselves responsible for the extreme numbers of sex selective abortions (George 2006:607).

Although there are professional associations of medical practitioners that actively discourage the use of sex determination tests, these efforts are unlikely to be successful, because of the underlying conditions of son preference, the poor societal status of women and acceptance of the practice (Arnold, Kishor & Roy 2002:783).

From the concepts of Freidson, the behaviour of professionals would seem to be a result of growing consumerism. However, as mentioned before, the concept of Freidson is not specifically focused on the context of India, but is based on analysis of developed countries. As this difference in context can influence the results of the research, it should be taken into account when analysing the behaviour of medical professionals in India using the concepts of Freidson. In addition, from the concept of Light the current behaviour of medical professionals can be contributed to the lack of countervailing powers, such as government, NGOs and patients. Nevertheless, the behaviour and motives of the professionals can not merely be contributed to these notions, because the issue of sex-selective abortion is very complex due to contextual factors. Also, to understand the role of medical professionals regarding sex-selective abortion, more information is needed regarding their role in difficulties of implementing sex-selective abortion prevention policies.

This chapter addressed theories of implementation and concepts of professionalism that will be used to analyse and discuss the results. However, to understand the difficulties of implementation, it is important to understand the legal context, as the problem of sex-selective abortion is striking despite the existence of legislation. Also, as mentioned many times, the issue is very complex. Therefore some important cultural and socio-economic factors need to be understood. Based on a literature review, these factors will be described in the next chapter.

3 Contextual and situational factors of sex-selective abortion in India

The previous chapter provided a theoretical lens based on which the analysis of this research will be done. Nevertheless, the issue of sex-selective abortion is a complex issue as many contextual and situational aspects contribute to its existence. To better understand its complexity, I will describe the legal and ethical context of the issue in this chapter. Moreover, important cultural and socio-economic factors, such as son preference, women empowerment and the role of education, will be described thereafter.

3.1 Legal and ethical context

Research shows that more abortions are being done illegally than legally in India (Arnold, Kishor & Roy 2002:761). Unjustified reasons for abortion, inability to meet payment, and a lack of clinics with a permit to perform abortion result in illegal abortions (George 2006:606). Also, the risk of being caught at violating the law is very little (George 2006:606). To understand the legal and ethical context regarding sex-selective abortion, this section will give an overview of the applicable law. First abortion law will be explained, after which sex-determination related law will be discussed. Some international law will also be described. Finally, the related ethical complexity will be explored.

3.1.1 Abortion Law

Although abortion has been legalised for more than 30 years, the majority of women in India still lack access to safe abortion care (Hirve 2004:114). Problems include poor regulation of public and private sector, a public physician-only policy that excludes other providers and low registration of rural compared to urban clinics (Hirve 2004:114). There are also issues of poor awareness of law, unnecessary spousal consent requirements and contraceptive targets linked to abortion (Hirve 2004:114).

The Medical Termination of Pregnancy Act

The first step to legalize abortion was the appointment of the Shah Committee by the Government of India, who carried out a review of socio-cultural, legal and medical aspects of abortion and recommended legalisation in 1966. States saw the recommendation as a strategy of reducing population growth, but the Committee denied that this was its purpose. The term 'Medical Termination of Pregnancy (MTP)' was used to reduce opposition from socio-religious groups that were against the liberalisation of abortion law, which was passed by Parliament in 1971 (Act No. 34, 1971) (Hirve 2004:114).

The Act allows an unwanted pregnancy to be terminated up to 20 weeks of pregnancy and requires a second doctor's approval if the pregnancy is beyond 12 weeks (Hirve 2004:115). The pregnancy can only be aborted when certain conditions are met, such as risk to the life of the pregnant women, injury to her physical or mental health, contraceptive failure, rape or risk to the child

(Population Council 2004:11). Any hospital can perform abortion when required approval (for government hospitals) or certification (for private clinics) is obtained. Without approval or certification the abortion is illegal. The new MTP (Amendment) Act 2002 and amended Rules and Regulations 2003 reduce bureaucracy for approval and certification, decentralize regulation from State level to District Committees and provide punitive measures of imprisonment for individual providers and owners of facilities with no approval by Government (Hirve 2004:116).

Despite legislation the number of abortions reported to the government is declining (Hirve 2004:115). Data from beginning of the 1990s to recent years are highly speculative and range from 11 illegal abortions performed for every 2 legal abortions (Hirve 2004:115). Another criticism of legislation concerns the assumption that the public sector is accountable to the public (Hirve 2004:116). This assumption leads to lack of quality in the private sector, which is unregulated, less controlled and lacks the self-discipline to maintain quality standards that are specified in the law (Hirve 2004:116). The government, however, has the power to suspend or cancel licenses of offending private clinics or laboratories (Sudha & Rajan 1999:597).

There also is a large misconception about law among women and providers (Hirve 2004:116). According to the MTP, women need to have legal reasons for abortion, such as having tried to prevent the pregnancy, or change in circumstances which made the pregnancy unwanted. In practice it may be that the pregnancy was unwanted from the start, but to justify the abortion, women falsify the circumstances (Hirve 2004:117). Although abortion care is not denied to unmarried women, separated women or widows, the use of the term 'married' women in the law may be misunderstood as a denial of abortion to unmarried women. The unwritten requirement for a married woman to have consent of her husband, is the result of the low social status of women and their dependency on their husbands. This leads to a barrier for women to seek abortion (Hirve 2004:118).

In relation to the issue of sex-selective abortion, it can be noted that abortion in general is legal in India when certain conditions are met. When tackling the issue of sex-selective abortion, it must be taken into account that women have the right to abortion and this right should not be violated. Nevertheless, when conducting a sex-selective abortion, a sex determination test has to be done beforehand to determine if the foetus is a girl or not. Legislation on determining the sex of a foetus is therefore also applicable in the case of sex-selective abortion and will be described next.

3.1.2 Sex determination law

The Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act (PNDT Act) 1994, which was later amended by the Pre-Conception and Pre-Natal Sex Selection and Determination (Prohibition and Regulation) Act 2002, prohibits the misuse of diagnostic tests for the purpose of sex determination which may lead to abortion of female foetuses. Also prohibition of advertising for these tests, obligation to register the use of tests and prohibition of conducting tests to reveal sex of the foetus are included in the Act (Hirve 2004:118). Although these tests are only forbidden for government facilities and not private clinics, the ban of revealing the sex of the foetus is forbidden for all medical facilities (Sudha & Rajan 1999; Population Council 2004). Being caught at providing a sex

determination test results in a fine, imprisonment and suspension of medical practitioner's licence (Sheth 2006:185). Not all forms of sex selection are part of this Act. Sperm separation and the use of portable ultrasound machines are not being mentioned (Miller 2001:1089). The government, however, has expanded the laws to ban chromosome separation techniques used to increase probability of having a son (Arnold, Kishor & Roy 2002:783). Also other pre-conception and pre-implantation procedures for sex selection are a part of this new amendment (Population Council 2004:11).

Amendment proposal to the MTP

As result of a Public Interest Litigation suit filed in the Supreme Court by Dr. Sabu George and the NGOs CEHAT (Centre for Enquiry Into Health and Allied Themes) and MASUM (Banglar Manabadhikar Suraksha Mancha) in 2000 against the Government of India for failure to implement the PNDT Act, a policy review meeting discussed amending the MTP Act to prevent sex-selective abortion following sex determination (Hirve 2004:118). One of the suggestions was to only allow abortion up to 12 weeks, which will result in preventing sex-selective abortions following from sex determination by use of ultrasound technique. But, experts said that there was no need to amend the MTP Act, as implementation of the PNDT Act was required. Reporting women's identity would have been a violation of confidentiality and restricting abortions to 12 weeks of pregnancy would lead to illegal abortion for women seeking abortion after 12 weeks. Also, recording the sex of the aborted foetus would be unethical and would lead to suspicion of abortion for all other reasons, which would indirectly lead to obstacles to safe abortion access (Hirve 2004:118).

Practice of sex-selective abortion despite legislation

Despite the knowledge of its illegality, including among most women (Duggal & Ramachandran 2004:126), sex determination and sex-selective abortion are seen as common practice (Ganatra, Hirve & Rao 2001:122). Very little prosecution of law has led to numerous clinics providing sex-selective abortion (Bandyopadhyay 2003:922), especially in Gujarat, Haryana and Punjab (Arnold, Kishor & Roy 2002:782). Restriction of revealing the sex of the foetus has not lead to disappearance of the practice, but to continuation of it underground by providing information in code language, therefore not revealing the sex of the foetus explicitly (Visaria 2005:11). Also, as mentioned before, ineffective implementation of the law results in no convictions of medical professionals (Miller 2001:1089) and failure to prevent people from having sex determination tests (Arnold, Kishor & Roy 2002:783). In addition, because of fear to be criminalized, clinics stopped performing abortions, which led to reduction of safe, legal and affordable abortion (Visaria 2005:11). This indicates that due to failure to implement legislation regarding sex determination, the right for women to safe abortion is violated.

3.1.3 International law

Besides national law, there are some international laws that are applicable regarding the case of sex-selective abortion in India, as the country has committed itself to safeguarding human and reproductive rights which are stated in many international treaties and forums. In 1994 the United

Nations Conference on Population and Development in Cairo stated the elimination of all forms of discrimination against the girl child and the root causes of son preference, which result in harmful and unethical practices regarding female infanticide and prenatal sex selection (Goodkind 1999:49). The United Nation Population Fund (UNFPA) is guided by this Conference and by the Millennium Development Goals (UNFPA 2012).

India is also a part of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and has submitted its Initial Report in August 1998 (Committee on the Elimination of Discrimination against Women 2005). Implementation of the PNDT Act and its amendments is a way in which India is preserving the CEDAW. Creating awareness and formulating advocacy strategies in partnership with several stakeholders are ways in which India is trying to prevent sex selection. The monitoring and effective implementation of the Act has also been issued by the Supreme Court (Committee on the Elimination of Discrimination against Women 2005). However, the Committee on The Elimination of Discrimination against Women (2007) expressed its concern about continuing deterioration of the sex-ratio despite the PNDT Act. They also declare concerns of criminalization of women who are pressured in seeking sex-selective abortion as a result of the Act. In the end the committee mentions that the State party must ensure adequate mechanisms for effective implementation and monitoring of the PNDT Act, including safeguards to prevent criminalization of women. Based on statements of the Committee it can be said that India has an obligation which it does not fulfil due to failure of implementation of legislation. In the end it can be noted that not only national legislation, but also international legislation is not implemented as it should be. The existence of the necessary legal documents indicate that the act of sex-selective abortion is in many ways a violation of the law and that proper implementation is needed to end these violations. However, these violations are not always perceived as violations due to its ethical complexity, which will be depicted next.

3.1.4 Ethical complexity

Sex selective abortion has been almost universally condemned, referring to it with 'moral outrage' (Goodkind 1999:49). This discrimination has great ethical complexities regarding reproductive freedoms and human suffering. Prohibiting sex-selective abortion is claimed to be in interference with reproductive freedoms and maternal empowerment, two goals adopted at the Cairo conference.

Based on these rights, in 2005 at the Bombay High Court, a patient claimed that Article 21 of the Constitution of India (Right to Life), includes the right to sex selection. The Court dismissed the claim, stating that it did not make a case for violation of Article 21. The right to life could not be expanded in such a way that it meant that a person could have the liberty to determine sex of a child. 'The right to bring into existence a life in future with a choice to determine the sex of that life cannot in itself be a right' (George 2006:607). Based on this case it can be noted that maternal empowerment and reproductive freedom does not include the right to determine the sex of a child. This implies that the issue of sex-selective abortion is not a case of conflicting human rights.

Besides the discussion of conflicting rights, authors claim that the prohibition of sex-selective abortion may lead to more suffering due to shifting of the discrimination to the postnatal period in the

form of female infanticide (Goodkind 1999:49). This suggests that sex-selective abortion might be a substitute for postnatal discrimination. The children that are born as result from sex-selective abortion, are wanted. This will therefore lead to a decline of postnatal discrimination (Goodkind 1999:53). If this substitution takes place, prenatal sex testing could be defended by stating that it prevents worse suffering during the postnatal period. This argument of the author is merely theoretical and not supported with empirical evidence. Moreover, the defence of prenatal sex testing is in conflict with the statement of the Cairo document which states sex selection to be harmful and unethical (Goodkind 1999:55). Therefore, given these arguments, it will be difficult to ethically defend the act of sex-selective abortion.

In this section I described the legal and ethical context of sex-selective abortion in India, to provide a better understanding of the implementation problem. However, in addition there are some cultural and socio-economic aspects that contribute to the difficulties of implementation, which will be described in the next section.

3.2 Related cultural and socio-economic factors

As described before the implementation of legislation and policy are unlikely to be successful, due to underlying conditions of son preference, poor societal status of women and acceptance of the practice (Arnold, Kishor & Roy 2002:783). Literature also suggests that the underlying cultural notions should be targeted via policies to improve the situation. Because these factors are seen to be a major factor in the existence of sex-selective abortion, this section will elaborate on son preference, the status of women and some socio-economic factors that are related with the occurrence of the issue.

3.2.1 Reality and reasons for son preference

The under-representation of girls in birth and their over-representation in child deaths, shows that there is a strong son preference in India (Kishor & Gupta 2009:126). To ensure the birth of a son in the family can be done by sex-selection or by stopping to have children after a son is born. The unbalanced sex-ratios show that sex-selection is being conducted, as the ratio would have been normal when stopping would be the case (Arnold, Kishor & Roy 2002:780). This son preference is rooted in the male dominant culture, which refers to a male dominated economy, political and social environment and ideology. This includes male preferred employment, economic dependency of females, male leadership and decision making, the existence of the dowry system and ideas of female impurity and the perceived necessity of male control over females (Miller 2001:1086-1087).

This culture results in three major factors that underlie son preference in India (Agrawal 2008:3). First is the economic utility of sons, second, the socio-cultural utility of having a son, and third, the religious function of a son. The last two factors refer to the preference of a son who will continue the family name and blood line (Sheth 2006; Agrawal 2008) and, according to Hindu tradition, will kindle the funeral pyre (Agrawal 2008:3). The economic factor exists due to lack of a social security scheme in India and the realities of poverty. Sons are therefore preferred who will provide for

the family by bringing financial income and take care of parents in their old age. High dowry and low levels of female labour force participation strengthen the preference of a son (Agrawal 2008; Gupte Bandewar & Hemlata 1997; Sheth 2006; Gupta et. al. 2003). Some authors state that the need to pay high dowries is not an underlying cause of son preference in India, but it does add to the discouragement for raising girls and plays an important role in the treatment of daughters (Gupta et al 2003:170). The increasing size of the dowry leads to a financial disaster for a family, especially if the family has no son whose bride will bring in money that can be used for the daughters marriage (Miller 2001:1087). Eventually circumstances such as impoverishment increase the level of discrimination and strengthen the preference for a son (Gupta et al 2003:172).

This culture of male dominance and son preference is an important aspect of family formation in India and leads to more discrimination of females and higher risk of female infant death (Agrawal 2008:4). Having a daughter is only accepted when there is a son; otherwise, the daughter is unwanted. Also, when she remains unmarried, she is seen as a burden to her parents. In many cases women are unable to work and support their parents due to lack of education (Sheth 2006:185). These factors contribute to the decision making of a sex-selective abortion and the experience of women in this process.

Decision making and women's experience concerning undergoing a sex-selective abortion

Indian culture contains the concept of 'ever-married' women, who spend their lives in the service of their families. These women are dependent on their husbands (Agrawal 2008) who are themselves dependent on their parents. Although, it is the husband who determines the sex of the child, prejudice and dislike for women cause the family to make the women's life miserable, as she is held responsible for giving birth to a girl (Sheth 2006:185). This leads to pressure of having prenatal sex determination. Because of this culture, family members are likely to be involved in the decision of having a sex-selective abortion. According to research (Ganatra, Hirve & Rao 2001:115), women living in joint families, the mothers-in-law are more likely to know the woman's intention to undergo a sex selective abortion (96%) than of an abortion for other reasons (77%) (Ganatra, Hirve & Rao 2001:115). The same is true for fathers-in-law and sisters-in-law (Ganatra, Hirve & Rao 2001:115). There is, however, little research on decision-making, indicating that more research is needed (Population Council 2004:58).

Although the decision of undergoing a sex determination is often made by family, in many cases women themselves decide to do the test as a response to the intense pressure to produce male heirs. These women do not want to suffer the burden of frequent and repeated childbirths in order to fulfil their obligation of producing sons, which they feel they have to fulfil (Agrawal 2008:37). It also occurs that the demand for a sex determination test comes directly from family elders, often against wishes of the woman herself. The husband usually agrees or stays indifferent (Ganatra, Hirve & Rao 2001:115). Moreover, in some cases women do not know what the tests are for and have no saying in decision-making (Gupte, Bandewar & Hemlata 1997). Women feel helpless and say that their status in the family and sometimes the survival of their marriage depends on the ability to produce sons (Duggal & Ramachandran 2004:126). There is no social stigma associated with sex-selective abortion,

especially for mothers with many daughters. Women from Gujarat and Haryana reported that they were not comfortable with abortion, but because it was done for the sake of the family, they accepted it (Duggal & Ramachandran 2004:126). In the end, the son preference of women themselves is important as having a son defines the woman's identity (Population Council 2004:68). Without a son, women are very vulnerable. Having a son gives women power in the household (Gupta et al 2003:165).

3.2.2 Socio-economic factors

Assumptions exist that son preference, and therefore sex-selective abortion, can be reduced by modernizing factors such as education, urbanization and exposure to mass media (Agrawal 2008). These factors are however ambiguous in their relation with prevalence of sex-selective abortion, as some authors claim that these factors lead to higher prevalence of sex selection and other authors claim that these factors are needed to improve the situation of women in order to reduce sex selection. This makes the issue more complex, which results in the difficulty of choosing a target area for policy, as has been described in the introduction. This section will elaborate on the factors of urbanization, income and education as these are factors that are to be claim to reduce sex-selective abortion (Agrawal 2008), whereas other authors claim that these increase its occurrence.

Urbanization and economic growth have led to higher prevalence of sex selection, instead of a decrease, due to diminishing family size in combination with son preference (Miller 2001:1086; Visaria 2005:8). In urban areas, such as cities like Delhi and Mumbai, people are more likely to use technology to determine the sex of the foetus, also because they can afford the cost of the procedure (Visaria 2005:8). Due to the substantial spread of the so-called 'small family policies' and the higher costs of raising children in cities, the occurrence of abortion in urban areas is higher than in rural areas (Agrawal 2008:40). This also reflects in the fact that sex-ratios are more unfavourable to women in the economically prosperous states (Bandyopadhyay 2003:912).

Overall, the practise of sex-selective abortion happens in all socioeconomic groups (Population Council 2004:58), however, class seems to impact on decision-making (Johnston 2002:20). Higher income increases the likelihood of obtaining an abortion, because of better access to health services in general and abortion services in particular (Agrawal 2008; Ganatra, Hirve & Rao 2001). This results in higher evidence of sex selection in the highest wealth quintile than in other quintiles (Kishor & Gupta 2009:126). Women of lower socio-economic class obtain services from less trained, but more accessible and illegal providers, whereas women of higher socio-economic class access more safe facilities (Johnston 2002:20).

In addition, authors claim that lower literacy and education level of women affect the prevalence of sex-selective abortion (Bandyopadhyay 2003:912). However, research often shows that highly educated women, contrary to expectations, use tests for sex determination more than less educated women (Kishor & Gupta 2009:12; Miller 2001:1085; George 2006:604). Educated women are more informed about policies and programs regarding abortion services (Agrawal 2008:40) and have easier access to, and greater affordability of prenatal ultrasound tests (Jha et al. 2006:216).

Although education makes women more aware of health, studies show that these women are also more efficient in discriminating against their daughters. Educating women is therefore not enough to change the conditions that improve the liability of daughters (Sudha & Rajan 1999:593). Also, son preference of women is not being reduced by education due to their attachment to values that lead to the preference (Visaria 2005).

The factors mentioned above show that urbanization, higher income and education do not lead to reduction of sex-selective abortion, due to the underlying cultural notion of son preference. This shows that the issue of sex-selective abortion is complex as there are deep rooted cultural and many socio-economic factors that influence its existence. This complexity can be related to the difficulties that are experienced in implementation of policies.

In this chapter I described the legal context and related cultural and socio-economic factors in order to better understand the complexity of sex-selective abortion. However, in order to do an analysis of the current challenges in implementing policies concerning the prevention of sex determination and sex-selective abortion in the North of India, it is needed to gain more information about the actual challenges in practise. Because NGOs are actively trying to prevent sex-selective abortion with their interventions, the experiences of NGO members regarding difficulties in implementation can help to gain insight in the challenges of implementation. What research methods have been used to gain information about the experiences of NGO members how this information is analysed to arrive at the objective of this research, will be explained in the next chapter.

4. Research methods and design

In the previous chapters I explained the theories which will be used to analyse the failure of implementation and the role of medical professionals and the contextual and situational background of the issue of sex-selective abortion in India. In this chapter I will describe how the research has been conducted using qualitative methods. First an explanation will be given for the chosen methods. Thereafter the ways of data collection and data analysis will be described. The final section will address how validity and accountability have been safeguarded in this research.

4.1 Why qualitative research?

As the main question is explanatory, comprehensive study is needed to answer this question. Although some portrayal of the context has already been done by a literature review, qualitative research methods are needed to attain more information, as these methods are used to gain in-depth and comprehensive understanding of the research subject (Marsh & Stoker 2010:255), which is in this case the difficulties of implementation. Within qualitative research, it is very important to explain and understand human, social and political behaviour. Therefore, in-depth qualitative study includes taking interviews to obtain information about experiences of actors in a certain situation (Marsh & Stoker 2010:256). Consequently, data collection for this research has been done through interviews.

4.2 Conducting the interviews

Through interviews information has been gained about the experiences of the respondents regarding their interventions and the difficulties in implementation. Also, an understanding about the way they perceive the problem, and their opinions and attitudes towards the issue has been gained. The interviews for this research were conducted through telephone and Skype, because face-to-face interviews with the respondents in India were not achievable. The interviews were taken in the period of February and March 2012. The interviews were voice-recorded after asking approval of the respondent and notes were taken during the interviews.

Respondent choice

Regarding the issue of sex-selective abortion, there are many actors involved, including government, NGOs, medical professionals and patients. For this research, the choice has been made to interview members of national and international NGOs which are active in advocacy work concerning or deal with the issue of sex-selective abortion. As the subject is very sensitive, NGO members are more likely to talk about their experiences than government officials or the general public, because they actively deal with the issue. Also, while medical professionals have a prominent role regarding the issue, the choice has been made to exclude this important actor group as respondents. Because of the sensitivity of the subject, the medical professionals will be confronted with their own behaviour due to which the chance of cooperation is low and the risk of little description of experience is high. To

reconcile their exclusion, non practicing medical professionals, active within NGOs, have been interviewed. Because of their background, they can understand the position of medical professionals. Moreover, because of their role as activists, they can easily talk about the issue and reveal their experiences.

Respondent search and approach

All respondents were approached by using my own existing contacts in India, who are themselves active in NGOs targeting medical projects or medical ethics. Via these contacts, members of NGOs which are active on the field of preventing sex-selective abortion, were contacted. Also, contact details were looked up on the internet of NGOs and international organisations active in the field of sex-selective abortion in India. To all members an e-mail was sent with the request to cooperate with the research by giving an interview about their experience regarding implementation and execution of interventions in order to prevent sex-selective abortion. Although none of the approached members actively declined to be interviewed, a non response to the request has been experienced. It cannot be said if this non response was due to lack of interest of cooperation or due to technical reasons which could result in the member not receiving the email. In total 11 respondents, willing to cooperate in the research, were interviewed. All respondents had a different background, however, they were all confronted with difficulties regarding preventions of sex-selective abortion. More information about the different kinds of respondents can be found appendix 1. With all the respondents one interview was taken. In some cases, documents of interventions and other (scientific) articles were sent by the respondents for further information. Also, to some respondents an e-mail was sent after the interview with questions for more elaboration, to which they responded via e-mail. Because these supporting documents included experiences of the respondents, they were also used in the analysis.

Topic list

The interview was conducted based on a topic list, which means that some subjects were chosen beforehand. These subjects were chosen based on the literature review and the sub and main questions of the research. In line with the topic list, open ended questions were asked to invite the respondent to share her/his view and opinion (Creswell 2003:188). The topics discussed were:

- a) Experience and work of the respondent regarding sex determination and sex-selective abortion
- b) Cultural and structural causes (and effects) of the problem
- c) Current policies of the organization
- d) Experienced obstacles in policy implementation and their solutions
- e) The role and accountability of professionals

Sensitivity of issue

Taking interviews has the risk of receiving socially accepted answers (Creswell 2003:186). This risk is higher for this research as the subject is socially sensitive. Therefore, extra attention has been paid to avoid socially accepted answers and to improve the likelihood of cooperation. Such answers occur when respondents are confronted with behaviour of their own that is not socially accepted. This can

lead to lack of cooperation by the respondents. An effort to reduce these effects was made based on Lensveldt-Mulders (2003:61) in the following ways:

- a) A broad introduction of the aim of the research and contact details of iBMG (the institution for which the research is being done) were given in the first e-mail to gain the trust of the respondents.
- b) The respondents were assured that their privacy would be respected and that the information would not be used for other purposes nor in a way that would be harmful for the respondents.
- c) During the interview, the questions were formulated in such a way that the respondent would not be repulsed or condemned. The aim of the questions was to understand the respondents and not criticize their behaviour.
- d) The topic list was shown to others, such as supervisor, to contribute to improvement of formulation of questions.

4.3 Analysis and interpretation of data

Qualitative research is fundamentally interpretive (Creswell 2003:182). This is why personal interpretation can occur in the form of bias. To prevent this bias, importance was given to the social and cultural aspects of a society during the analysis. Bias has also been minimized by organizing information properly for analysis and interpretation. Six steps that give proper guiding in this process were used in this research (Creswell 2003:190-195).

During the first step all the data was read to get a general understanding of the issue. This included all written notes that were taken during interviews, which were documented and expanded thereafter. During documentation all recordings of the interviews were used to check if no information was missed and to be sure that everything was understood properly. The interviews were not transcribed in text form, which could be used as a secondary interpretation, because assumptions made by the transcriber can change the nature of the source (Schnur 1995). Also, mistakes in transcription and misinterpretation can lead to totally different conclusions (Easton et. al. 2000:706). Therefore the choice was made to use the recording and writing notes as primary sources for data.

The second step involved organization of the data per subject. The subjects were chosen after all data was read. Because the interventions could be divided in interventions with short term goals, and interventions with long term goals, these two subjects were firstly chosen. Not only the respondents, but also the literature uses these two categories of interventions, calling them 'long term strategies', such as consciousness raising and 'confrontational strategies', such as reporting suspicious abortion to the police (Sudha & Rajan 1999:610). Furthermore, as understanding of the perception of the NGOs contribute to the way they deal with the issue, this was also chosen to be a subject. As a result, the following three subjects were chosen; the perception and way of dealing with the issue of NGOs; short term interventions, i.e. prosecution of medical professionals and control of medical technology; and long term interventions targeting the mindset of people.

During the third step the data was categorized within the subject according to the theories described in the theoretical framework. However, the first subject did not contain any analysis of implementation failure and the role of medical professionals. Therefore this subject has only been described and not analysed using theory. Despite the lack of analysis, the description of this subject

has been included in the form of background information, because it provides a better understanding of how NGOs frame the issue and why they choose certain strategies. The other subjects were categorized using the three theories on implementation and the concepts of professionalism.

Through the fourth step, per category, quotes were chosen that give a description of the situation. In order to achieve this, all notes and recordings of the interviews were used again to search and for relevant quotes, after which they were put in writing.

During the fifth step, the data has been analysed and discussed by looking at the relations of the data with the theories and concepts. Per intervention, the difficulties of implementation have been explained by looking at how the implementation gap can be reduced using the top-down approach and the bottom-up approach. The difficulties in implementation and how the current implementation process came into being, has been explained using the translation theory. Also, per intervention, the role of professionals has been depicted and explained using the concepts of professionalism.

Throughout the last step the analysis and discussion have been interpreted to make conclusions in order to answer the research questions. In addition, questions and recommendations for further research have been formulated.

4.4 Safeguarding validity and reliability

Reliability is concerned with the influence of the observations by coincidence or inconsistency (Boeije 2008:145). This also means that when this research is repeated, it should lead to the same outcome. Reliability or generalizability does not have the same role as in quantitative research and plays a minor role in qualitative research (Creswell 2003:195). The steps that have been taken to assure reliability as far as possible were the use of multiple sources for the background information and literature review in order to prevent coincidence. Also, through the guidance of supervisor and two co-supervisors, who read the research proposal and draft of the thesis, an effort has been made to prevent inconsistency.

Validity is seen as the strength of qualitative research and is used to determine whether findings are accurate (Creswell 2003:195). Measuring what one actually wants to measure is very important here (Boeije 2008:145). The validity of this research has been safeguarded by deviating as minimum as possible from the research plan. Consequently, when searching for respondents, only NGOs who were actively trying to prevent sex-selective abortion and who had interventions with that specific target were approached with a request to cooperate in the research. Also, when looking for literature, asking interview questions, selecting data for analysis and interpreting the data, the aim of the research has always been kept insight. Moreover, using rich descriptions, in the form of quotes, and presenting discrepant information (Creswell 2003:196) has been applied to preserve validity.

In this chapter I portrayed what research methods have been chosen and how the research has been conducted using these methods. Also, a description has been given of how the analysis and discussion of the data has been done. The results of this analysis and discussion of data will be given in the next chapter.

5. Explaining implementation challenges in implementing advocate strategies on sex-selective abortion in India

In the previous chapter I described the research methods and analysis design. In this chapter, the results of the analysis and discussion will be depicted, based on which the challenges in implementation of policies regarding sex-selective abortion in the North of India can be understood and explained. The sections of this chapter are based on the subjects and categories that I described during the analysis steps in the previous chapter. The first section of this chapter will therefore focus on the perception of NGOs, i.e. how they frame the issue of sex-selective abortion and, as result of different kinds of framing, deal with the issue. The following sections will depict interventions that target the issue of sex-selective abortion. In the second and third section two long term strategies will be described, which are the 'Garima' project and the 'Kanya Lohri' project, both implemented in Rajasthan. I draw on these as exemplary cases as they aim to change underlying cultural and social norms in order to fight against the rapidly declining sex-ratios in the area (Garima Booklet, appendix 2 p. 4-6), which is the central aim of long term strategies. In the fourth and fifth section two short term strategies will be described, of which one has as aim to get medical professionals prosecuted and the second to control the use of ultrasound machines. I describe these interventions as the first depicts the central fight to get legislation implemented, which is the main target of short term strategies as it is the result of framing the issue as failure of implementing legislation. The second short term strategy has been chosen because it is a government initiative to control the misuse of ultrasound machines, which is the result of unethical medical behaviour, a way of framing that leads to short term strategies. Per intervention, the context, aim and working of the intervention will be portrayed. Thereafter, the way in which implementation has taken place and the challenges that have occurred, will be explained using the top-down, bottom-up and translation theory. Using the top-down and bottom-up approach, an explanation will be given of the way implementation has taken place and how the implementation gap can be explained. By applying the theory of translation, an explanation will be given of why the implementation process has taken its current shape. In the end, the role, power and behaviour of medical professionals will be explained using the concepts of professionalism.

5.1 Perception of NGOs and how they deal with the issue

To understand the choices of the NGOs in how they execute their interventions, it is important to understand their perception of the issue of sex-selective abortion. Therefore, this section will give a description of the findings regarding the perception of the issue. First, the experiences and perception of the respondents regarding the extent and effects of the issue will be described, in order to understand their motivation for action. Also, the factors that contribute to the growing extent of the issue will be depicted to understand their targets of interventions. Second, attention will be paid to the different ways the respondents frame the issue of sex-selective abortion and, as result, what kind of interventions they choose to tackle the issue.

5.1.1 Extent and effects of the issue – why is action needed?

The motivation to act against sex-selective abortion occurs when the issue is framed as a problem. In relation to this an activist (respondent 7), who has been fighting against the issue since the 1980s, states that the issue has not been perceived as a problem until recently. When talking about the issue as a growing national problem, the respondent (7) claims to be ridiculed and argues that “if we would have been taken seriously then, the problem could have been prevented”. The same activist claims that since the numbers of unbalanced sex-ratios have been published and the existence of the issue is undisputable, the awareness of the issue is rising.

Besides publication of the numbers of unbalanced sex-ratios, respondents also describe the effects of the lack of girls. A medical doctor who coordinates an IFES (International Foundation for Electoral Systems) project (respondent 1) describes the occurrence of ‘bride buying’ in Gujarat and cases where one girl gets married to multiple brothers of a family. Women are powerless in these situations. “People try to postpone the problem, they only feel it when they are at marriageable age” an activist (respondent 7) argues. These statements indicate that the issue of sex-selective abortion is being perceived as a problem and that immoral effects of the issue are being recognized.

The motivation for action is also related to the issue being perceived as a growing problem, as respondents experience the spread of areas where sex-selective abortion occurs. According to a researcher (respondent 9) there is no difference in occurrence of sex-selective abortion between urban and rural areas anymore. Although the literature claims that this difference exists (Miller 2001; Visaria 2005), the chief executive and secretary of the Urmul Foundation (respondent 2) argues that due to the existence of portable ultrasound machines, the technology is now available everywhere, leading to the disappearance of the difference between the areas.

Not only the growing availability of technology, but the growth of some other related factors are noted. A researcher active in a NGO in Rajasthan (respondent 9) explains that the problem of sex-selective abortion is now also happening in tribal areas, which is contrary to the reviewed literature (Agrawal 2008). The respondent (9) describes that this is due to the population policy of India that plays an important role in people’s perception of the ideal family size. The population policy is widely spread, even in these tribal areas, where there is no other government facility, such as birth and marriage registration. However, the slogan ‘a small family is a happy family’ is known by everyone. In combination with son preference, the wish of wanting to have a small family, results in sex-selective abortion, especially when a couple already has a daughter.

Although some respondents claim that the availability of technology and the spread of population policy has resulted in the growing extent of the issue, a program officer of UNFPA India (respondent 11) claims that the population policy does not affect the sex-selective abortion problem. The program officer states that “people already want small families due to economic change and urban migration. So the small family policy is not the cause”. The program officer argues that the cause of sex-selective abortion is the declining fertility rate which is a result of economic change and urban migration. People living in cities, do not want to have large families as making a living in the city

is more expensive. The program officer explains that this declining fertility rate in combination with son preference and the availability of technology leads to active discrimination of daughters.

In relation to economic change and the growing extent of the issue, the program officer (respondent 11) also states that underlying causes of sex-selective abortion, such as dowry and the low status of women, are spreading to areas where they did not occur before. The program officer calls this “the result of consumerism”, which is growing in India. This leads to weddings becoming more costly and dowry more pricy, due to which the economic burden of raising a daughter becomes higher. Hence, the program officer argues that the growing issue of sex-selective abortion can be contributed to effects of growing consumerism.

Although the definitions of causes for the extent of sex-selective abortion differs between the respondents, they all perceive the problem to be growing. However, the perception of the related factors, can lead to different ways of framing the issue. Respondents who are active in rural areas, perceive the issue to be related to the availability of technology and the social changes due to the population policy. This indicates that the issue is framed as ‘misuse of technology’ and ‘the result of social changes regarding family size’. However, other respondents claim that urbanization and consumerism are factors that contribute to the growing extent of the issue, due to which the issue can be framed as ‘the result of modernization’. Nevertheless, this is how the causes for growth of the issue is being framed. Although it provides an understanding of the kind of intervention strategies NGOs choose to tackle the issue, it is important to understand how the actual problem of sex-selective abortion is being framed. The next section will therefore focus on the way the issue is framed and what types of interventions NGOs choose as result.

5.1.2 Framing the issue and types of intervention

The ways in which the issue of sex-selective abortion is framed, results in different interventions. In relation to these different ways, an editor of the Indian Journal of Medical Ethics (respondent 4) claims that “in the long term the demand side can be reduced, in the short term the supply side can be reduced. The law only reduces supply, not demand. To change demand, you need to change social values”. This indicates that two kind of strategies, i.e. interventions with long term goals and short term goals, result from the ways of framing the issue and that both strategies are needed to tackle the problem.

The ways in which the issue is framed, can be divided in three categories which will be discussed in this section. First attention will be paid to the issue framed as a social and cultural problem, which includes gender insensitivity and the low status of women. Second, framing the issue as the failure of implementing legislation which relates to the lack of medical ethics in practice will be described. In the end, the thought of the issue being a human rights and health issue will be explained. Furthermore, attention will be paid to the kind of interventions which are perceived to be important in context of the different ways of framing the issue.

Social and cultural problem – gender insensitivity and low status of women

A program officer of UNFPA India (respondent 11) states that the issue of sex-selective abortion is a social and cultural problem, and not just a legal issue. The program officer argues that cultural and social factors define the way people think about the 'perfect family'. The availability of technology to help you create that family, results in sex-selective abortions. These cultural and social factors are closely related to gender insensitivity, the low status of women and son preference. A representative of UN Women India (respondent 10) explains that the problem is a gender issue which is rooted in the culture of the Indian society. The respondent also argues that due to these gender issues, ironically, sex-selection seems to be accepted, although there are many activists against abortion. Also, a program officer of UNFPA (respondent 11) argues that the problem is not religious, but social as dowry now occurs in places where there is no tradition of dowry. The program officer claims that the issue is the result of "social failure and not a failure of law" as the problem also occurs in places where women are economically independent and empowered. This statement implies that, in contradiction to other respondents, women empowerment is not the solution of the issue and that other strategies are needed to prevent sex-selective abortion. Also, the failure to implement the law, is being contributed to social aspects and not to governance or implementation failure, suggesting that the government and its legislation are not responsible for the occurrence of the issue. In relation to sex-selective abortion as a social problem, an editor of the Indian Journal of Medical Ethics (respondent 4) therefore argues that "a gender sensitive society is needed". This way of framing the issue indicates that respondents perceive the issue to be related to cultural and social norms. Therefore, in order to prevent sex-selective abortion, NGOs claim that the social and cultural mind-set of society must be changed. An activist (respondent 7) argues that "Social transformation is the ultimate solution". To achieve this transformation, the underlying values and thoughts that obstruct implementation of current legislation and policies are addressed through these interventions. This notion results in interventions with long term goals, as changing cultural and social norms cannot be accomplished in a short time period.

Regarding the interventions to change cultural and social norms, different NGOs focus on different aspects and target-groups. A representative of Un Women India (respondent 10) claims that a change can be achieved in combination with overall empowerment of women. Therefore, issues such as dowry should be targeted and adequate action should be taken for the safety and security of women. A medical doctor and coordinator of a IFES project (respondent 1) also argues that it is important to increase the value of a girl in society and the possibilities for girls to develop to their fullest capacity in order to empower women. However, this respondent stresses the need for education for girls, which is a large change for communities living in rural areas. Whereas, as mentioned before, in urban areas, modernization and consumerism are perceived to be targeted in order to change the norms of the community. Consequently, a program officer of UNFPA India (respondent 11) states that it is important to target the middle class, with the help of media, as the issue is related to the consumerism life style. This indicates that although the issue is overall framed to be related to underlying cultural and social norms, because of the different factors that influence these norms in different areas, the interventions also differ depending on the context.

Besides empowerment of women, a program officer UNFPA India (respondent 11) argues that the general community should accept equal responsibility and all actors should be involved in the process of gender sensitisation. The program officer declares that not only issues related to sex selection, but all policies should be made more gender sensitive. Also, the program officer also claims that in rural areas, the 'panchayat' (local government) should be targeted, as they are a powerful actor within the rural community. The notion that overall responsibility is needed, reflects in the effort of NGOs to include as many actors as possible in their interventions. As a representative UN Women India (respondent 10) argues that everyone at all levels, i.e. national, state and civil society, should be included even if the perspectives on the issue are different. Thus an overall approach is being perceived as an important factor to be able to change the underlying cultural and social norms of the whole society.

Although most respondents stress the need for women empowerment, the founder-member and chief functionary of 'Men Against Violence and Abuse' (MAVA) (respondent 6) claims that men should be targeted too as they are part of the problem, but also a part of the solution. The respondent argues that "it is the men who have to change, this is a major loophole!". The NGO MAVA therefore targets the attitude of men. The founder-member of MAVA explains that when asking young boys in the age of 18-19 years about their opinion of women, they find them too emotional, not practical and incapable of functioning in a business, especially not as a leader. The founder-member of MAVA claims that these young boys should realize the effect of declining sex-ratios, otherwise more trafficking and situations in which one girl marries multiple boys will occur. Therefore, the attitude that women are perceived as a burden and that abusing women is perceived as normal, should be targeted. In relation to this change of attitude, the respondent also mentions that not only men, but also women should be targeted as they too are the carrier of this paternalistic culture. Women should realize that abuse and low status of women and the preference of sons is not 'normal'. In order to achieve this, the paternalistic thinking in its whole should be targeted.

In order to achieve this goal, MAVA tries to change this paternalistic way of thinking by creating awareness through street plays and discussion forums after the play. Although the respondent of MAVA is aware of the issue of sex-selective abortion, the main aim of the interventions is not to reduce sex-selective abortions, but to change the overall mind-set which affects many other issues, such as women abuse and trafficking. Therefore, no further attention to their interventions will be paid in this thesis, as the aim of this research is to explain implementation challenges of policies that target sex-selective abortion. Nevertheless, the argument of the respondent that not targeting men specifically can be a loophole of interventions, can provide insight into why implementation of interventions that target the cultural and social norms of society is failing. Therefore the choice has been made to include this information in the research. Two interventions that focus on the cultural and social norms of society are the 'Garima' project and the 'Kanya Lohri' project, which will be described in sections 5.2 and 5.3.

Failure of implementing legislation and lack of medical ethics

The issue of sex-selective abortion is also being framed as a legal issue. Medical doctor and project manager of CFAR (Centre For Advocacy and Research) Rajasthan argues that mobilization of the community and political will is needed to effectively implement the law. This results in interventions that target the prosecution of medical professionals and encouragement of the government to control the use of ultrasound machines. The medical doctor and project manager of CFAR argues that interventions targeting the cultural and social norms of people are also important as it focuses on the underlying cause, but this will take years and there is no time to wait that long.

Also international organisations find themselves in a position where they can stimulate the government to implement the law properly. The program officer of UNFPA (respondent 11) states that in order to stop the problem from escalating, the law has to be implemented and information must be given to medical officers as in many cases they do not know the law.

Besides lack of knowledge of medical officers, respondents also perceive the issue as the result of lack of medical ethics. The editor of the IJME (respondent 4) states that the healthcare system appears to be completely commercialized and everything has become a business. "Medical professionals just want to make profit and medical ethics are not followed", the editor explains. As a result of the lack of ethics, implementation of legislation is more difficult. Therefore, in order to be able to implement legislation, the medical professionals are confronted with their actions. These kind of interventions have short term goals as prosecution of medical professionals can happen in a short time period. Exemplary cases of such interventions will be depicted in-depth in section 5.4 and 5.5.

Human rights and health issue

As mentioned in the introduction, human rights and health are closely related to sex-selective abortion. However, only international NGOs explicitly frame the issue as a human rights and health issue. A representative UN Women India (respondent 10) argues that the issue of sex-selective abortion cannot be seen in isolation and that it is a case of violence against the girl foetus and the mother. Although many respondents relate the issue to violence against women, they frame it as social failure and not as a human rights issue. Regarding the relation of sex-selective abortion with maternal health, only respondents with a medical background and respondents from international NGOs recognize this relation. This also reflects in the interventions of the NGOs, where there is little attention for human rights and maternal healthcare and more focus on changing the cultural and social norms and implementation of legislation.

In this section three ways of framing the issue of sex-selective abortion have been mentioned, which lead to different types of interventions, i.e. interventions with long term strategies and interventions with short term strategies. In the following sections, attention will be paid to two interventions with long term goals and two interventions with short term goals. To understand and explain the challenges of implementation, the theories of implementation provided in the theoretical framework will be used. Also, to understand the role of medical professionals regarding the different interventions, the concept of professionalism will be applied.

5.2 The 'Garima' project

As I mentioned in the previous section, the interventions of NGOs can be divided into interventions with long term goals and short term goals, which is a result of the different ways of framing the issue. This section and the next section will focus on interventions with long term goals. In this section, the 'Garima' project in Rajasthan will be portrayed, in order to understand the challenges in implementation of an intervention with a long term strategy. The project is an initiative of the Urmul foundation, which has been initiated by URMUL Dairy (Uttari Rajasthan Cooperative Milk Union Ltd.) in 1983 (URMUL 2012) and focuses on health, research and development. To understand the context of the intervention, first attention will be paid to the current context of the places where the intervention has been implemented. Secondly, a description will be given of the project. By using the top-down and bottom-up approach, an explanation will be given for the challenges that are experienced during implementation by the respondents. The aspects of this intervention which can be related to the theory of translation will be depicted thereafter. Although medical professionals do not have a prominent role in this intervention, their attitude towards the intervention, as experienced by the respondents, will be explained using the concept of professionalism.

The context of rural Rajasthan

In chapter 3.2, some cultural and socio-economic aspects have been described that affect the issue of sex-selective abortion. Besides the occurrence of son preference, there are other factors that need to be understood in order to understand the context of the 'Garima' project. The project takes place in the Thar Desert in India, which is located in Rajasthan. The project targets three districts, i.e. Hanumangarh, Ganganagar and Jaisalmer, of which the first two are located in a desert area. A member of the Urmul foundation (respondent 3) explains that the culture of the districts is male dominant with a 'Purdah system', which means that women do not have the right to talk to men. The status of women is very low and they have no right to profile their own opinion. The member (respondent 3) also explains that the status of women is so bad, that people even tender their animals when they fall sick, but give no attention to the health of women when she is sick. Her condition is not perceived as important, even not when she is pregnant. Also, the respondent (3) argues that ultimate goal of a girl is perceived to be marriage. Therefore no attention is paid to their education, as the need for girls' education is not understood.

The member of the Urmul foundation (respondent 3) also describes the reasons for son preference of the chosen areas of the intervention. As the society is based on agriculture, boys are preferred to work on the land. Moreover, regarding the tradition of dowry, this results in a high financial burden as it is very difficult to earn an income in these regions. Therefore, having a son secures income and having a daughter results in financial disaster. This corresponds to experiences of a representative of UN Women (respondent 10), who states that in India there is a saying that "bringing up daughters is like watering the neighbours' plants", which indicates that all investments will be gone to someone else when she is married off.

Furthermore, the member of the Urmul foundation (respondent 3) claims that the inheritance law has a huge effect on the behaviour of people. The respondent (3) explains that this law ensures

equal division of land of the parents between all their children. However, when a girl gets married, her part of the land will belong to her family in law. As people do not want to lose their financial guarantee, they do not want to have a daughter, as this will result in losing a part of their land. This policy therefore results in son preference and preferably a small family, as too many children will result in every child inheriting a very small portion of land.

As women themselves experience the difficulties of life in such a male dominant culture, they do not want such a life for their daughter. The member of the Urmul foundation (respondent 3) explains that many women therefore, 'voluntarily' choose to not have a daughter. This results in entire villages where no girls are born anymore. The respondent (3) describes a striking example of a village where after 100 years a girl was getting married. Before that, there were no girls born. This girl was saved by her grandfather, otherwise her mother would have killed her. As only aspects that are relevant to explaining the challenges in implementation will be depicted, additional information can be found in appendix 2, which contains a booklet of the 'Garima' project.

The 'Garima' project

As mentioned before, the 'Garima' project is an intervention of the Urmul foundation which is still running. The chief executive and secretary of Urmul foundation (respondent 2) explained that in 2001 the initiative rose that something had to be done against the rapid decline of sex-ratios. This led to the set up of the 'Garima' project during 2004 and 2005, with the aim to save the girl child. Through this project the community is reached using education and existing health services in order to raise awareness regarding the issue of sex selection and change cultural and social values that denigrate the status of women. As the 'Garima Booklet' (appendix 2) describes:

"The intervention works closely with personnel of existing local administrative structures, mechanisms and programs such as the Anganwadi workers (AWW), Auxiliary Nurse Midwives (ANMs), ASHA (Accredited Social Health Activist) Saathins, Traditional Birth Attendants (TBAs), members of the Panchayat (elected local governance bodies), school teachers, and the district administration to first sensitize and then motivate them into action, to initiate, adapt and sustain the fight" (Garima Booklet 2011:7).

The respondent (2) explains that these services have been chosen, because they have a continuous role in society. All the members of the services are motivated to create awareness among their patients, students and associates by talking to them about the earnestness of the situation and the role of daughters. In relation to this, the people were asked to visualize the next decade where there would be no brides, as there would be no girls. The chief executive and secretary of the foundation (respondent 2) argues that although it is not the right way to only see girls as brides, as this does not increase the value of having a daughter, it is necessary to make a start somewhere.

A member of the Urmul foundation (respondent 3) argues that targeting women via health services has a large advantage as they have a strong link with society and therefore know when a woman is pregnant. When an abortion has taken place, they can confront the parents and ask why the abortion has been conducted. However, the respondent (3) explains that it is very hard to prove if the reason of the abortion was sex selection. Therefore it is important to focus on the role of a girl in

society to prevent these abortions. To achieve this, the project includes activities such as the 'Kanya Vardan Pattra' (girl birth certificates), where certificates are being distributed in order to celebrate the birth of the girl. Besides such activities, the importance of including the 'panchayat' (local government), students and the use of media are stressed by the chief executive and secretary of the foundation (respondent 2). More elaboration regarding the role of these actors will be done when explaining the intervention from the top-down and bottom-up approach.

The 'Garima' project has now been running for over five years. The chief executive and secretary of the foundation (respondent 2) claims that three districts which the projects targets, have not shown any further fall in sex-ratios. The respondent (2) also explains that these villages were chosen because they had worse sex-ratios, but also had strong leadership. "Society needs models to form an example for others" the respondent (2) states and claims to believe that they have achieved to be such a model.

To understand and explain the challenges in implementation of this intervention, the difficulties explained by respondents will be explained using the top-down and bottom-up approach. Also, aspects which relate to the theory of translation will be depicted thereafter. Although medical professionals do not have a prominent role in this intervention, their attitude towards the intervention will be explained using the concept of professionalism.

Top-down perspective

The Urmul foundation is stated to be a community-driven organization which devises programmes which are finally handed over to communities (see appendix 2). Although this would imply a bottom-up approach, many top-down aspects are recognized in the set up of the intervention and the challenges the respondents experience.

First of all, the chief executive and secretary of Urmul foundation (respondent 2) claims that the success of the intervention can be contributed to strong leadership. The respondent (2) states that when the intervention started, initially there was resistance, but due to good leadership this gradually changed. The 'panchayat' had a newly elected 'sarpanch' (head of the local government) who was interested in making changes. With his help, the intervention was accepted and changes were able to be made. This corresponds to the literature which implies that support from interest groups (Sabatier and Mazmanian 1979) is needed to successfully implement an intervention. Within this intervention, large importance has been given to include the 'panchayat', students and media. The chief executive and secretary of Urmul foundation (respondent 2) also claimed that strong religious leaders should be included as well, as they have a large follower group and are opinion makers.

Regarding the challenges experienced by the respondents, a member of Urmul foundation (respondent 3) argues that it is very difficult to create a team of young and committed people. This lack in committed and skilful implementing officials (Sabatier and Mazmanian 1979) is experienced in the form of shortage of manpower and limitations of skill of the field staff. According to the respondent,

these limitations occur despite exhaustive training. However, in some cases the lack in skill of the staff is due to inadequate training and capacity building opportunities for the staff.

Another obstacle that is being experienced, is finding funding for projects, which can be seen as a lack of financial resources (Buse, Mays & Walt 2005:123). A member of the foundation (respondent 3) states that funding agencies want to see results of the projects they support. However, the projects have a long term goal and due to which the results cannot be seen within a short period. The respondent (3) argues that “you cannot change the community in a day. The process is slow and the changes come even slower”. According to the same respondent (3), funding agencies want to see quantitative evidence and when do not see quick changes, they decide to stop the funding. The respondent (3) claims that for the intervention this means that all their efforts “have gone back to zero as there is no follow up”. In relation to the funding problem, the chief executive and secretary of Urmul foundation (respondent 2) argues that it is not difficult to find funding as the problem is interrelated to domestic violence, which is perceived as a serious issue. However, it is difficult to keep the funding for a long time as most funding agencies provide only based on time-bound projects. This implies that there is no actual lack of funding, but lack to find agencies willing to provide funding for a long time.

Bottom-up perspective

As explained before, the Urmul foundation is stated to be a community-driven organization, which would imply a bottom-up approach regarding implementation of their interventions. Although many top-down approach elements have been recognized, a number of bottom-up approach elements can be named too.

To be able to successfully implement a community-driven intervention, it is important to get compliance of all actors, including medical professionals, skilled implementers and society. As the chief executive and secretary of Urmul foundation (respondent 2) explains that powerful actors that make opinion of society should be included. The difficulties in getting compliance from medical doctors (which will be elaborated in the end of this section), implementers and society, can be explained by the difference in the goals and strategies of the actors (Buse, Mays & Walt 2005:125). The importance of including all actors, is also explained by a representative of UN Women India (respondent 10) who claims that actors at all levels, i.e. national, state and civil society, should be included within an intervention to tackle sex-selective abortion, even if the perspectives on the issue are different. The representative explains that this is why the HIV/AIDS programs work and this approach could also work for sex selection.

Although leadership is being stressed from the top-down approach, the role of the media and students has been perceived as important by the chief executive and secretary of Urmul foundation (respondent 2). They are being perceived as strong actors that can change the opinion of people regarding raising a daughter and the importance of change of ‘mind-set’. A member of the Urmul foundation (respondent 3) explains that due to the regular reports in the media that showed the need for change, the intervention has been successful. This implies that not only strong leadership, but compliance of actors that have a strong influence of society, is needed to successfully implement the

intervention. The importance of the media has also been stressed by a program officer of UNFPA India (respondent 11) who claims that, in order to change the consumerism life style of the middle and upper class, the media can help change the way this life style is being framed. This opinion shows that the assumption exists that media is a strong actors that influenced the way society thinks.

Besides the importance to include all actors, the bottom-up approach states that the way of control also depends on funding, i.e. where does funding come from and who controls it (Buse, Mays & Walt 2005:125). As explained by the respondents (2,3), the funding agencies want to see change within a short time period. From the bottom-up approach, this implies a difference in goals of the foundation and the funding agencies and not a lack in funding as would be concluded from the top-down approach. From the bottom-up approach the differences of the actors results in both parties being unsatisfied with the cooperation. Therefore, other funding agencies with the same goal and willing to cooperate should be approached in order to implement the intervention successfully.

Within the 'Garima' project elements of both top-down and bottom-up approach can be recognized. As the project tries to include as many actors to successfully implement the intervention, a bottom-up approach can be recognized. The willingness of all actors can be seen as the main requirement for successful implementation. Also the difference in goals, which is the explanation of the bottom-up approach for the difficulties in funding, gives an explanation that better reflects the reality than the explanation of the top-down approach, as funding is not lacking. Nevertheless, the Urmul foundation itself has a top-down approach in organising the intervention, as the respondents (2,3) describe strong leadership and skilled team members as important tools for implementation. It therefore can be stated that, although the foundation has a top-down approach in working, they decided to implement the intervention, which targets the cultural and social norms of people, with a bottom-up approach. Within the 'Garima' project, translation aspects also provide an explanation to why the implementation process exists in its current way. This will be elaborated next.

Translation perspective

Since the translation theory deals with the development and implementation of technology, there is no clear way to determine what the 'black box' is within this intervention. To be able to apply the theory on the 'Garima' project, the choice has been made to entitle the black box as 'the underlying cultural and social norms', as these are the target of the intervention. From this perspective, it can be suggested that these cultural and social norms are co-constructed by all involved actors, with every actor having a different, yet significant influence on the process (Latour 1988 :135). Due to this co-construction, an Actor-Network can be recognized (McMaster et. al. 1997:67), which is created by getting all actors interested into creating awareness and new cultural and social norms. The influence of leaders, such as the 'panchayat', the role of media, students and even religious leaders are perceived to be able to influence, and therefore co-construct, the norms of society. This implies that more actors strengthen the chain (McMaster et. al. 1997:67) and contribute to the process of creating new cultural and social norms of society. Not only human allies, but also non-human factors

(McMaster et. al. 1997:67), such as the existence of cultural traditions and the difficulty to earn a living in the rural desert area of Rajasthan, contribute to the notions of society. Due to this co-construction (Latour 1988:136) and involvement of a large network (McMaster et. al. 1997:67), ambiguous and no sovereign responsibility regarding the construction of the black box, i.e. the cultural and social norms of society, can be noted. Therefore, it cannot be explicitly concluded that the NGO is responsible for the change of norms of the community. The role of actors eager to make a change, such as the newly elected 'sarpanch' (depicted within the top-down approach), also contributes to the change of cultural and social norms.

The translation aspects within the intervention are recognized by a member of the Urmul foundation (respondent 3) who states that "in the field, when working with and within the communities, there are certain limitations you cannot overcome despite best efforts and intentions. The workability has its dynamics that continuously restructures itself". This change of implementation, actors and context (Latour 1988:136) implies a translation perspective on implementation. The respondent (3) also stresses that "the heterogeneity of complex and varied cultures, even within communities, have to be dealt with". This implies that although the intervention can be implemented by the NGO, the way it will be implemented depends on all involved human actors and non-human factors (McMaster et. al. 1997:67), such as the cultural context. Therefore, many differences in the process of changing the cultural and social norms of people can be experienced, as both the human actors and non-human factors can differ per context.

Related to the difference in context are the reasons for sex-selective abortion, which differ in every case and context. Financial security, cultural traditions, growing consumerism and the overall status of women are all factors described before that contribute to the occurrence of sex-selective abortion. However, not all factors exist in the same form and extent in every area. As a member of the Urmul Foundation (respondent 3) states, that in the areas the 'Garima' project was launched, difficulty is experienced in implementation due to the low education levels of implementers and society. Whereas in urban areas, where the education level is higher, the challenges are different. This high variety in context contributes to the implementation process, which cannot be linear due to the complexity of the issue of sex-selective abortion.

As stated before, due to the complex environment, not only actors and context, but also the intervention changes. This change can also be seen within the 'Garima' project, where the intended cultural and social norms have been adjusted due to the large resistance of the community. The community can be seen as the weakest link (Latour 1988:61) as change of norms can only happen when society itself cooperates. In order to make some small changes, the chief executive and secretary of the foundation (respondent 2) stated that within the project, people are asked to visualise the future without brides, as there will be no girls. The respondent (2) also states that these norms are not the aim, because seeing girls only as brides does not contribute to the increase of the value of a daughter. However, due to the challenges in implementing new cultural and social norms that include overall empowerment of women and the notion that having a daughter is experienced positive, the change has been made into seeing girls as brides. This change implies that during the implementation

process, not only actors and context, but also the black box, i.e. the to be reached cultural and social norms, are changed too.

Based on the translation aspects, it can be stated that the 'Garima' project, which tries to change the cultural and social norms of the community, has to deal with uncertainties of society and the co-construction of the actors and their norms. This leads to changes of actors and even the black box, what was not taken into account. Although a bottom-up approach has been chosen by the NGO to implement the intervention, as willingness of all involved actors is perceived to be important to succeed, translation aspects should be taken into account to understand the dynamic process of changing the cultural and social norms that are deeply rooted in the culture of the society.

Role of medical professionals

During the implementation of the 'Garima' project, difficulties were experienced in including medical professionals, as stated by the chief executive and secretary of Urmul foundation (respondent 2). Eventually, no medical professionals cooperated within the project. The difficulties were related to the attitude of medical professionals towards the issue of sex-selective abortion.

In relation to this attitude, the chief executive and secretary of Urmul foundation (respondent 2) states that medical professionals have a business mentality which is very hard to change. The respondent (2) also claimed that "you can change people, but you cannot change doctors". This implies that changing the mindset of medical professionals is experienced to be more difficult than of the general society. From the concepts of Freidson, this behaviour is the result of consumerism, due to which medical professionals act for economic profit. The lack of actual professionalism results in unethical behaviour and lack of responsibility of the medical professionals. The power of the medical society is perceived to be too large to be able to make a difference. Therefore focus is set on the cultural and social norms of society instead of medical professionals. Since when there will be no demand, eventually the supply side will stop with the practise.

Not only their attitude, but a program officer of UNFPA India (respondent 11) claims that the difficulty is that the medical professionals are not accepting their responsibility. The same respondent (11) explains that change is coming, but very gradually, as there is little acceptance of the existence of the issue among medical professionals. The respondent (11) also claims that those professionals, who have accepted their responsibility, should become spokespersons and try to convince the entire medical community of taking responsibility, which suggests a translation approach. The program officer of UNFPA India (respondent 11), also explains that the medical council, who should make sure that doctors keep their ethics, ignore the problem and claim that the issue is not the responsibility of the doctors. The respondent (11), therefore, states that self-regulation is needed by the medical council. From the concepts of Light, self-regulation is not possible, as countervailing powers are needed to restore the balance in power and make sure that all actors take their responsibility. In an unregulated private healthcare, which is the case in India, there already is lack of countervailing power. Therefore, self-regulation is not feasible in such an environment where there is no system of

accountability. Although the lack of professionalism and countervailing powers help explain the behaviour of the medical professionals, more insight is needed regarding the motivations of the medical professionals' behaviour to better explain their current role regarding sex-selective abortion. As medical professionals have a more profound role regarding implementation of legislation, a more thoroughly description of their behaviour will be mentioned in section 5.4.

In this section the implementation process of the 'Garima' project has been depicted, which has as aim to target the cultural and social norms of communities in Rajasthan. The next section will also depict an intervention that targets the notions of the community in Rajasthan, by focussing on the development and education for girls.

5.3 Kanya Lohri project

The previous section focussed on an intervention with a long term goal. In this section, another intervention with a long term goal will be described, which focuses on the empowerment of women and their status in society. This initiative of a foundation called 'Dignity of the girl child' has been implemented in the Ganganagar district of Rajasthan and organised in cooperation with the Urmul foundation. To get an idea of what the intervention looks like, first a description will be given of the project. Thereafter, the challenges that have been experienced by the respondent, but also its approach, will be explained using the top-down and bottom-up approach. Thereafter attention will be paid to how translation aspects have led to the current situation of implementation of this intervention. As professionals do not have a prominent role in this intervention, no information about their role and behaviour can be mentioned. Therefore, no attention towards the role of professionals will be paid in this section.

Kanya Lohri project

The 'Kanya Lohri' project is an initiative of a foundation called "Dignity of the Girl Child" located in Rajasthan. This project was set up in cooperation with local businessmen and the chamber of commerce. The aim is to invest in the education of girls and celebrate the birth of a daughter. The coordinator of the project (respondent 1) stated that the birth of a girl is not celebrated, whereas the birth of a son is (during a festival called 'Lohri'). To change this, the idea of 'Kanya Lohri' came into being.

The initiative started in 2006 with including the community, administrators and every other group that was possible. In 2008 the 'Kanya Lohri' project started with the target to achieve free education for girls. In 2009 the girls received scholarships and in 2010 1 till 1.5 crore rupee was granted for scholarships. This trend continued in 2011 where, "to promote higher education among the women, the Chamber of Commerce (COC) in Sriganganagar has offered a Rs 1.37 crore package" (Tribune India 2011). In 2012 a total of 250 girls benefited from this project. This project has been very successful as WPC (Women Power Connect) (2010:7) recounts:

"The celebration was unique because almost all major educational institutions and professional colleges in the district came forward and gave scholarships to girl students amounting to more than 1 crore rupees. The process for selection included asking for applications depending on the interests of the girls prior to the actual selection and on this occasions, the names were declared publicly through draw of lots (wherever the applications were more than the seats offered). The atmosphere was so charged that by end of the function, other institutions which were not part of the donors also started announcing scholarships to deserving girl students. In all, about 40 girls got the awards and to make it fool proof, a monitoring committee was also formed to see that these girls actually get free education and institutions do honour their commitments" (WPC Connect 2010:7).

Through the project an effort is made to give daughters dignity and develop them as decision makers. The coordinator of the project (respondent 1) claims that in rural areas a difference can be made with education as majority of the girls is uneducated. The respondent argues that this lack of education

results in no empowerment and lack of knowledge about women's rights. However, the respondent (1) states that although education will not solve the problem, it will contribute to the raise of value of a girl child and the improvement of the status of women.

Because this intervention has been implemented with the help of the Urmul foundation and is also part of the 'Garima' project, some aspects of implementation process are the same. In this section, attention will be paid to the elements that are different from the 'Garima' project and are characteristic for the 'Kanya Lohri' project. First the intervention will be discussed using the top-down and bottom-up approach. Thereafter, some elements of translation will be mentioned.

Top-down approach

Just as the 'Garima' project, the "Kanya Lohri" project is a community driven project. However, as the way of organizing comes close to the 'Garima' project, some of the same top-down elements can be recognized. This includes the relevance of strong leadership and compliance of important actors, such as the 'panchayat'. Especially the later point is being stressed by the project coordinator (respondent 1) as an important factor to successfully implement the intervention. However, the top-down elements of lack of skilful implementing officials and the lack of funding, which are mentioned within the 'Garima' project, are not experienced by the project coordinator (respondent 1) of the 'Kanya Lohri' project. The reason for no lack of funding could be the result of the project being funded and set-up by IFES (International Foundation for Electoral Systems) which implies that the project does not need funding from outside.

Unlike the 'Garima' project, the 'Kanya Lohri' project includes the setting up of a monitoring committee to check whether the girls actually get their free education. This central way of controlling refers to a top-down approach (Buse, Mays & Walt 2005:123). The use of a control system can also be seen in the working of the 'panchayat'. As the project coordinator (respondent 1) describes, the 'panchayat' has been given the responsibility to warn and watch people and therefore fulfils the role of a central control system.

Bottom-up approach

Within the 'Kanya Lohri' project many bottom-up approach elements can be recognized as the coordinator of the project (respondent 1) claims that the cooperation of all important actors is needed in order to successfully implement the intervention. This central point is also recognized within the 'Garima' project, where compliance of all important actors, especially the media, is being stressed. Regarding the 'Kanya Lohri' project, the project coordinator (respondent 1) explains that the success of the intervention can be contributed to the large variety and numbers of actors, which all are willing to cooperate within the intervention. The willingness is so large, that other institutions who were not a part of the intervention, also made donations for the project. This shows that the interventions is very much community-driven, as initiatives come from society itself. Implementation is not done by laying down the project top-down, but is willing implemented by all actors. This shows that the project has been implemented bottom-up, but with inclusion of top-down tools to control its proper execution.

Translation theory

Complementary to the 'Garima' project, translation aspects can be recognized as many actors significantly contribute to the co-construction of the project (Latour 1988:153) and an Actor-Network is created, which is growing as many more actors show their interest in the intervention (McMaster et. al. 1997:67). The black box within this intervention can be called the 'status of women' which is the target of the project. Within this intervention, the influence of human and non-human alliances (McMaster et. al. 1997:67) can be recognized as actors and contextual factors influence the implementation of the intervention. In addition, another translation aspect can be recognized within the 'Kanya Lohri' project.

The coordinator of the project (respondent 1) states that the main obstacle when implementing the intervention is to change the mindset of people. The respondent (1) explains that "people ask you questions like 'why should we save them?', 'how do we raise them?', 'will you give dowry?' and 'will you be there?'" Also, as girls are becoming a financial risk due to more costly weddings and dowry, social denigration of sex-selection is happening quietly.

In relation to this social denigration of girls, which is deeply rooted within the culture of the society, translation aspects can be helpful to implement a new perception of girls. By using an existing concept of 'Lohri', which is used for boys, a change can be made gradually. As the concept of 'Lohri' already exists and is widely accepted, interest for a new notion can be created more easily using this concept in a new way. Because this new concept is well known, deeply rooted within the culture and accepted by many actors, interest of actors can be created easily. As large interest leads to growth and strength of the Actor-Network (McMaster et. al. 1997: 67), working with concepts that are already accepted and implemented, can improve likelihood to effectively form an Actor-Network to execute the intervention. This suggests that translation is important for interventions that target cultural and social ideas which underlie the issue of sex-selective abortion. Although implementing the intervention using a bottom-up approach can be important for the intervention to succeed, as this implies large support for change within society, translation is needed to create interest in changing the cultural and social norms which are co-constructed by the many involved actors.

In this section, attention has been paid to the implementation of the 'Kanya Lohri' project which targets the norms of society and focuses on women empowerment by striving for education for girls. The next section will depict an intervention with a short term goal, i.e. the implementation of legislation by which accountable medical professionals can be prosecuted and convicted.

5.4 Getting medical professionals executed

The previous sections focused on interventions with long term goals. The following two sections will depict interventions with short term goals. In this section, attention will be paid to actions of NGOs, who try to get medical professionals executed. First, a description will be given of how the NGOs act in order to get medical professionals prosecuted and executed. Thereafter, the challenges of implementation, which result in an implementation gap, will be depicted using the top-down and bottom-up approach. Also, some aspects of the current situation which can be explained by the translation theory will be explained. Because medical professionals play an important role within these interventions, their behaviour and role will be explained using the concepts of professionalism.

Actions of the NGOs

Chapter 3.1 described the current legal context, in which it has been explained that legislation regarding sex determination states that revealing the sex of the foetus by medical professionals is illegal. Regarding this law, a medical doctor and project manager of CFAR Rajasthan (respondent 5) states that attention to implementation of the PC PNDT Act came after 2006, due to growing attention to the issue of sex-selective abortion. Before that, the law existed only on paper with no prosecution and execution as result. The respondent (5) states that in order to get the law implemented, it is important to first get attention for the issue and secondly, to actively implement the law.

To enforce implementation of the law, the NGOs try to get medical professionals, who are guilty of revealing the sex of the foetus to parents, executed. As a representative UN Women India (respondent 10) explains, revealing the sex of the foetus is being done in 'ugly creative ways', due to which it is very difficult to catch the medical professionals. The coordinator of the IFES project (respondent 1) describes that medical professionals often do not reveal the sex of the foetus themselves. However, the information is passed on to someone else who informs the parents. The respondent (1) explains that "the news travels and comes to you via different channels, such as the riksha driver". This shows that the whole community is involved. Also, other implicit ways are used to inform the parents, such as pointing to the picture of a Goddess when the foetus is a girl. Due to these practices, it has become very difficult to catch medical professionals and to get them convicted.

In order to get medical professionals prosecuted, the NGOs try to catch them red handed while revealing the sex of a foetus to the parents. In order to achieve this, the NGOs ask pregnant women to volunteer. These women negotiate with the doctor to reveal the sex of the foetus. If the doctor agrees, the woman makes a statement that the doctor revealed the sex. The NGOs confront the doctors with this statement. In some cases the doctor accepts the mistake and promises to never do it again. However, in some cases, the confrontation leads to prosecution of the medical professional.

In order to explain the challenges in implementation of this intervention, the top-down and bottom-up approach will be used. Also, aspects which relate to the theory of translation will be depicted thereafter. As medical professionals have a prominent role within this intervention, attention will be paid to their role, behaviour and power using the concept of professionalism.

Top-down approach

As legislation is being implemented by the government, a top-down approach can be recognized. The NGOs also work within the top-down approach, as they try to get the existing law actively implemented. Therefore, many obstacles that explain the implementation gap, can be mentioned from the top-down approach.

Regarding the implementation of sex determination law, a representative of UN Women India (respondent 10) states that the difficulty in prosecution and conviction exists due to lack of clarity, which results in many complicated bureaucratic steps incorporated in the system. A program officer of UNFPA India (respondent 11) also states that the many complicated bureaucratic steps incorporated in the system are an obstacle in itself. The same respondent (11) explains that, besides the bureaucratic complexity, the difficulty in many cases is that there is no clear cut evidence to support the case. Although the respondents describe this obstacle, the intervention of the NGOs do not target the complexity of bureaucracy, but they target the difficulty in getting clear cut evidence with the help of volunteers. When doing so, they experience two kinds of obstacles.

A medical doctor and project manager of CFAR Rajasthan (respondent 5) explains that conviction of medical professionals does not happen because of no availability of a board or because there is no official form filled against the medical professional. The respondent (5) claims that in Rajasthan there were 250 cases filled against medical professionals with the help of civil society groups. However, none of them were caught as result of the two obstacles. This indicates that there is lack of political resources and a lack of committed implementing officials (Sabatier & Mazmanian 1979). Both obstacles have different causes, which can be related to lack of capacity and lack of administrative resources (Buse, Mays & Walt 2005:123) due to corruption.

Regarding the unavailability of a board, the medical doctor and project manager of CFAR Rajasthan (respondent 5) explains that every district should have a committee for gender issues, who is responsible to get attention for the sex determination law. The unavailability of a board is often the result of lack of capacity within the committees, which leads to overworked people. As there is little attention for sex-selective abortion, the issue has low priority. Because the overworked officials have to make choices, no attention is paid to sex determination law. The same respondent (5) also explains that in some cases, a committee for gender issues does not even exist. The respondent explains that this is the result of low priority of gender issues, due to which a committee for gender issues is not being perceived as important.

Regarding the lack of administrative resources, such as absence of a filled form against the medical professional, an editor of the Indian Journal for Medical Ethics (respondent 4) claims that the biggest obstacles are the officials who are the loopholes in the system. Due to their corrupt behaviour, it has become difficult to prosecute a doctor. The respondent (4) explains that the officials who have to prosecute the law get 'cuts' from medical professionals. This way, medical professionals can continue their illegal practises without any consequences. The behaviour of the officials and medical professionals suggest that there is lack of support from interest groups (Sabatier & Mazmanian 1979).

Besides the obstacles that are being experienced, the medical doctor and project manager of CFAR Rajasthan (respondent 5) explains that the lack of registration of medical technology results in

no control of the use of ultrasound machines. This makes implementation of the law more difficult, as the use of ultrasound machines plays an important part in sex determination. The respondent (5) claims that there are 43.000 registered centres. Nevertheless, how many unregistered centres exist is unknown. Concerning the registered centres, the same respondent (5) states that its registration and monitoring is the obligation of the same boards that handle the sex determination law. The respondent (5) claims that in cases where the boards exist, the government nominates 'yes men', which results in no adequate registration and monitoring of the ultrasound machines. Although the government tries to control its use with intervention such as the 'silent observer', which will be elaborated in the next section, in practice there are no adequate control and monitoring organs and systems leading to large possibility to misuse the ultrasound machines for sex determination.

As implementation of legislation and the control and monitoring of ultrasound machines is the obligation of the government, the inability of the government to enforce rules can be mentioned as a large obstacle from the top-down approach. The non-existence or unavailability of boards, corrupt officials and misuse of ultrasound machines, can all be seen as a result of lack of proper communication from the centre to the periphery and a lack of control systems (Buse, Mays & Walt 2005:123). All these factors lead to the implementation gap, which results in failure of proper implementation of legislation.

Bottom-up approach

As legislation is implemented top-down, not many bottom-up elements can be recognized within the interventions. The only link that can be made is the inclusion of volunteers from society, that are willing to work with the NGOs to get the medical professionals caught. The further process takes place within the existing legal framework.

Although the whole society is involved in the practice of revealing the sex of the foetus to the parents, the NGO did not include more actors within the interventions. Using a more bottom-up approach by getting more compliance from society itself, might be helpful in successfully implementing legislation. Also, by involving the officials into the implementation process, the chances of better implementation of legislation can be expanded. With their inclusion both government and officials will have the same goals, instead of their currently conflicting goals. Furthermore, getting compliance of the medical community itself, as they are a powerful actor, can make a difference. As these parties have not been included in the interventions by the NGOs, it cannot be said if inclusion of these parties actually will make a difference.

It can be clearly stated that the intervention has a top-down approach by which it tries to work within the current legal framework that has been implemented by the government as central decision-maker. As compliance of many actors is missing, a more bottom-up approach might help to successfully implement the legislation, although this cannot be concluded based on this research. To better understand the current shape of implementation, some translation elements can be recognized, which will be elaborated next.

Translation perspective

During the implementation process of legislation, it can be noted that the way of implementation has been co-constructed by all involved actors (Latour 1988:135), such as officials, medical professionals and society itself. Due to the existence of legislation, the act of sex determination has become illegal. As underlying cultural norms imply parents wanting to have a son, officials, medical professionals and other members of society construct other ways to fulfil the wishes of the parents. This puts officials and medical professionals in a position in which they can illegally make money. The legislation in combination with the cultural norms has led to corrupt practices, which was not the aim of sex determination law. The 'black box' (i.e. implementation of sex determination law) has therefore completely changed into only existence of the legislation on paper, with little execution in practice.

In relation to this little execution, it can be stated that there is no strong Actor-Network (McMaster et. al. 1997:67) that is willing and interested to contribute to and implement the sex determination law. This results in the lack of will to actively implement the law. As an editor of the Indian Journal of Medical Ethics (respondent 4) states "India is very good in making law and passing them, because they are ashamed of the problems. However, implementation is very difficult as there is no will to implement". This lack of will is the result of cultural norms of society (i.e. non-human factors), which is also embedded in the implementers, medical professionals and society (human actors). As there is no strong chain of human and non-human alliances (McMaster et. al. 1997:67), the implementation does not take place.

Moreover, the existence of legislation in combination with the cultural norms have led to change of behaviour of the actors, as revealing the sex of the foetus is now being done in 'ugly creative ways', in order to still achieve the sex determination under water. Not only parents, but medical professionals and members of society have changed their behaviour due to existence of this law. This implies that the actors have changed their behaviour (Latour 1988:136) to maintain cultural norms. Due to these changes, it has become difficult to implement the legislation, as finding proof against a medical professional has become a new challenge.

The co-construction of the legislation as a tool to earn money and the change of behaviour of many actors, suggests that the underlying cultural norms that cause these changes need to be addressed. Without taking the cultural context into account, implementation of legislation will always lead to changes in behaviour of actors in order to maintain cultural norms which are deeply rooted in society. Although the implementers use a top-down approach, these aspects which are recognized from a translation perspective, can provide more insight in how the implementation can lead to different results.

Role of professionals

As legislation on sex determination directly affects medical professionals, as supplier of sex-selective abortion, they have a prominent role regarding its implementation. The overall attitude of the medical community is being described by an editor of the Indian Journal of Medical Ethics (respondent 4), who states that they do not talk about the PC PNDT Act and have no intention of following it either. A

researcher (respondent 9) claims that the only way in which the medical professionals show support to the act, is through boards outside the medical clinics which state that 'revealing the gender of the foetus is illegal'. The medical council is also being held responsible, as a medical doctor and coordinator IFES project (respondent 1) explains that "a doctor was suspended by the medical council in Rajasthan, however this is just one of the many doctors who freely conduct illegal practises on a daily basis". This implies that the medical council mostly remains silent and does not take responsibility for the issue. In relation to responsibility, a medical doctor and project manager of CFAR Rajasthan (respondent 5) explains that no party wants to take responsibility for the problem as the government claims that it is a mindset issue and the medical professionals do not feel accountable for the problem.

Regarding the position of the medical professionals, the medical doctor and project manager of CFAR Rajasthan (respondent 5) claims that "Sex-selective abortion has become a 'million dollar business' where there is no fixed price. Everyone has to pay based upon their capacity". An editor of the Indian Journal of Medical Ethics (respondent 4) explains that the healthcare system appears completely commercialized and everything has become a business. However, a medical doctor and coordinator IFES project (respondent 1) argues that medical doctors are in a difficult position as women sometimes come and beg for a sex-selective abortion. The women claim that their in-laws will throw them out of the house if another girl will be born. Nonetheless, the respondent (1) also states that "on the other hand, they also make a lot of money out of it". This portrays the complex position of medical professionals, based on which in cannot be concluded that economical profit is the only motivation for them to provide a sex-selective abortion. Therefore it cannot be concluded that medical professionals behave merely based on consumerism, what could be suggested based on the concepts of Freidson. Although the fact that everyone has to pay based upon their capacity can be contributed to consumerism, because of the underlying cultural and social norms, medical professionals are in a position in which they can feel the need to provide the service of sex-selective abortion. In such cases it can be implied that the power and situation of patients is strong enough to motive the medical professional to conduct the abortion. This could suggest that the behaviour of medical professionals can be the result of a strong position of patients that provide countervailing power. However, this argument is very unlikely due to the the strong position of medical professionals in reality due to which many actors fail to provide countervailing power. The strong position of medical professionals will be portrayed next.

Besides the attitude and position of medical professionals, respondents experience the extent of the power of medical professionals in different ways. As officials receive 'cuts' from the medical professionals, this shows that medical professionals have financial resources which contributes to their power. In relation to their power, a medical doctor and project manager of CFAR Rajasthan (respondent 5) states that "it is not the court that is weak or the law, it's just that the medical doctors are much stronger". This statement suggests that the situation can not be contributed to the quality of the court or legislation, but that implementation of it is failing due to no control on the medical society. Although the power of medical professionals is recognized, the respondent (5) does not mention ways

in which the power of the medical community can be reduced, but tries to work around it. As their power is being experienced as very large, objectionable ways, such as educating medical professionals to reveal the sex of the foetus, are applied to help the court and law to do its work. During these practices, the respondent (5) also experiences the large extent of the power of medical professionals. The respondent (5) describes that when a doctor is caught, conviction is still very difficult as women, whose statements are the key of the case, are often threatened by doctors and even taken hostile or harassed by goons. Due to these practices, women are often not present in court to make a statement or they withdraw their statement, which leads to no conviction of the doctor. Because of this risk for volunteers, the respondent (5) experiences difficulties in getting women to cooperate. This large extent of the power of medical professionals, suggests that there is hardly any countervailing power which can lead to a balance of power between all actors. Although NGOs try to be a countervailing power, they experience difficulties within their interventions. As the awareness of the issue of sex-selective abortion is rising, civil society might provide countervailing powers in order to reduce the extent of power of medical professionals. Also, the government can be an actor to provide countervailing powers and demand accountability from the medical professionals. More on the position of the government will be elaborated in the next section.

In this section, the interventions of NGOs that try to get medical professionals prosecuted and convicted have been depicted. The next section will also depict an intervention with short term goals, which has been implemented by the government in order to control the misuse of ultrasound machines.

5.5 Controlling the use of ultrasound machines

In the previous section one intervention with short term goals was depicted. In this section, a closer look will be taken of an intervention implemented by the government in order to control the use of ultrasound machines. First the working and current situation of the intervention will be explained. Thereafter, the challenges of implementing will be explained using the top-down and bottom-up approach. Although this approach does not have many translation aspects, little attention will be paid to understand the current situation of the implementation process of the intervention. In the end, the power of medical professionals, which is an important aspect regarding this intervention, will be explained using the concept of professionalism.

The 'silent observer'

Regarding the controlling the use of ultrasound machines, it is the government that undertakes action. However, medical doctor and project manager of CFAR Rajasthan (respondent 5) explains that as member of a NGO they have an advising role regarding new and current interventions that are focused to prevent the misuse of ultrasound machines. A recent intervention of the government is the 'silent observer', which is a device that tracks the use of the ultrasound machine. As officials from the government explain:

“Silent Observer can be fitted into sonography machines to allow the authorities to monitor and record pre-natal ultrasound scans taken by doctors. It thus helps the authorities track down on doctors conducting gender tests, which result in selective abortions.

The project of the 'silent observer' was launched in 2009 and has been installed in hundreds of ultrasound machines across the Kolhapur district in Maharashtra (Matharu 2012). Also, Haryana has installed the device on an experimental basis and Punjab plans to implement the project. Madhya Pradesh and Rajasthan recently sent teams to Kolhapur to see the working of the project. Regarding this project, the district magistrate of Kolhapur explains:

“Through this, we are closely monitoring the doctors. If a doctor is caught disclosing the sex of the foetus, the images captured in Silent Observer can be presented as evidence in court” (Matharu 2012).

Although the device has been launched for 19 months, not a single doctor has been booked for disclosing the sex of the foetus in the district of Kolhapur, claims a lawyer and activist (Matharu 2012). Thus, sex-selective abortions are continuing despite the installation of the 'silent observer'. This implementation gap can be the result of difficulties in implementation. In order to understand and explain this failure in implementation, the top-down, bottom up and translation theory will be applied to the case. In the end, attention will be paid to the role of professionals using the concept of professionalism.

Top-down approach

Because the interventions has been implemented by the government as central decision-maker, this suggests that the interventions has been implemented top-down. From this approach, some

challenges can be recognized, which include the lack of the government to enforce rules, missing of a causal theory and the lack of technical resources and a good control system.

As already stated in the previous section, there are many ultrasound machines which are not registered. The non-existence of boards who have to control and register the machines and corrupt officials, which has been elaborated previously, can be seen as a result of the inability of enforcement by the government. Although the 'silent observer' is a way in which the government tries to control the misuse of ultrasound machines, in practice the intervention does not work.

The failure of the intervention can be contributed to the lack of adequate causal theory what results in no effective policy (Sabatier & Mazmanian 1979). This indicates to the inability of the machine to check whether the medical professional reveals the sex of the child to the parents or not. The machine only checks what the doctors is seeing, but not what he is saying. According to the law, seeing the sex of the foetus is not illegal, but revealing it to the parents is. As a medical doctor and project manager of CFAR Rajasthan (respondent 5) explains:

“Every medical doctor has to check the femur leg bone to see if the foetus is growing properly. Therefore the sex of the child will always be known by the doctor. This is something you cannot prevent”.

Also, a radiologist from Haryana states that the device cannot implicate doctors just for checking the sex of the foetus, as the doctor has to check the genitalia to ascertain if the baby is growing healthy (Matharu 2012). The radiologist argues that as per the PC PNDT Act, communicating the sex of the foetus to parents is criminal, but not viewing it. Based on these responses it can be implied that the machine does not tackle the actual issue of communicating the sex of the foetus to the parents.

Besides inability to solve the problem, the 'silent observer' has some technical and practical difficulties, which suggests the lack of technical resources and a good control system (Buse, Mays & Walt 2005:123). As a lawyer and activist states “the device is plugged in externally and can be turned off. This way, there will be no record of the tests conducted” (Matharu 2012). This implies that there is no proper control system. Also, a member of the CFAR explains that “this system can never work. Hundreds of ultrasounds are conducted each day. It is impossible to scan through the images stored in Silent Observer each day” (Matharu 2012). This impossibility suggests the lack of technical resources, which are needed to process the large amount of data produced by the 'silent observer'.

Bottom-up approach

As the intervention has been implemented by the government, not many bottom-up approach elements can be recognized as there is no mention of inclusion of other actors by the respondents. The only element which can be recognized, is the redefinition of the goals of policies by actors (Wildavsky 1979). The medical doctor and project manager of CFAR Rajasthan (respondent 5) claims that the 'silent observer' is a way for the government to earn money, as the every observer costs Rs. 28.500 and has to be bought by every medical centre that has an ultrasound machine. The respondent (5) claims that all the profit of the intervention will go to the government. In relation to this perception, the intervention is also being called “more hogwash than an answer” (Matharu 2012) and

“a money-making venture” (Matharu 2012). This perception correlates to the concepts of translation which will be elaborated next.

Theory of translation

Regarding the intervention of implementing the ‘silent observer’, the black box can be defined as the technology called the ‘silent observer’. Its development and implementation is therefore the main concern of all involved actors. From the concept of ANT, it can be stated that because of no sovereignty of control and development by one actor (McMaster et. al. 1997:67), the technology develops in a way in which the aim of the government, of controlling the misuse of ultrasound machines, is not being reached. Due to the lack of power of the government (human actors) and the existence of strong cultural and social norms which result in conducting sex-selective abortions (non-human factors), the aim of the ‘silent observer’ has changed into a way to earn money. This implies that not only the black box but also the actors changed (Latour 1988:136) and redefined the goal of the technology. However, as no government officials have been interviewed, it cannot be concluded for sure if the government actually redefined its own goals. The suggestion made by the respondent (5) is based on the perception (s)he has of the government. As a medical doctor and project manager of CFAR Rajasthan (respondent 5) explains, the government tries to solve the problem without dealing with the issue of responsibility of the medical professionals. According to the respondent (5), the medical community is so strong, that the government is not in a position to directly control them. The ‘silent observer’ is the result of an attempt of the government to control the use of ultrasound machines, without directly dealing with the behaviour of medical professionals. This implies that due to the strong position of medical professionals, who have no interest in implementing the ‘silent observer’, the government is not in a position to build a strong Actor-Network that can support their intervention. Based on this assumption it can be stated that the inability of the ‘silent observer’ to check whether the medical professional reveals the sex of the foetus or not, is the result of lack of an Actor-Network and not a technical or practical failure. More elaboration on the strong position of the medical community will be done next, while analysing the behaviour of medical professionals.

Not only the ‘silent observer’, but also the aim and use of ultrasound machines, a technology which can also be seen as a black box, has been redefined and co-constructed by the medical community and society. Due to the existence of son-preference (non-human factors) and the willingness of the medical community to fulfil the wishes of parents (human actors), an Actor-Network has been created due to which the machines are used to determine the sex of the foetus instead of checking its health and growth. However, although the use of ultrasound machines has been redefined by actors, Banerjee & Mohanty (2012:5) mention that “it will be wrong to solely associate the increasing availability of USG to the increase in sex-selective abortions”. They advocate the role of USG during pregnancy in order to improve maternal health outcomes across the country and try to get back to the original aim of ultrasound machines. This indicates that both aims of ultrasound machines exist (i.e. two Actor-Networks exist), which makes targeting the use of ultrasound for sex determination difficult, as the machine is also being used to improve maternal health. This double role of ultrasound machines results in the machine being a contributor but also a danger to

maternal health. This complexity should be taken into account when implementing interventions in order to monitor the use of ultrasound machines.

The double role of the use of ultrasound machines, contributes to the difficulties in constructing and implementing an intervention that can control its use. Although the government is responsible for such an intervention, which implies a top-down approach, the translation elements should be taken into account as the intervention is redefined in such a way that the target is not reached. The strong position of the medical community, which plays an important role in redefining the intervention, will be elaborated next.

Role of medical professionals

As described before, the medical doctor and project manager of CFAR Rajasthan (respondent 5) explains that the government tries to solve the problem without dealing with the issue of responsibility of the medical professionals. In relation to the position of the medical professionals, an editor of the Indian Journal of Medical Ethics (respondent 4) describes that “the medical community can purchase anything, they have people working for them in every field”. The respondent (4) also explains that the government is being supported by medical professionals. Therefore, they cannot act against the professionals without losing their support. In cases where the government wants to implement the law, the dominating medical community makes this very difficult. Due to their position, the medical professionals benefit from much power and are therefore not threatened by the government. About the role of the government, the medical doctor and project manager of CFAR Rajasthan (respondent 5) states that “the government has deliberately let it out of control. They cannot target the medical community, so they divert their focus on women by tracking their pregnancy instead of tracking doctors”. This implies that the government is perceived to be weak and therefore not in a position to act and provide countervailing power against the misuse of ultrasound machines. In order to solve this, the government could find other actors willing to cooperate, such as NGOs and civil society, in order to provide countervailing powers to restore the balance and reduce the extent of power of medical professionals.

In this section a second intervention with short term goals, which has been implemented by the government in order to control the misuse of ultrasound machines has been depicted. With this last intervention I conclude this chapter, in which I first analysed the perception and way of dealing with the issue of sex-selective abortion by NGOs. Thereafter, I analysed four interventions by using theories of implementation and the concept of professionalism. In the next chapter the conclusions will be described. Also, limitations of this study and recommendations for further research will be mentioned.

6. Conclusions and recommendations

The aim of this thesis was to explore the policy implementation related factors that underlie the slow progress in reducing sex-selective abortion in the North of India, using qualitative research methods. Given the strong involvement of NGOs in this field, particular attention has been paid to NGO policies and the obstacles they encounter in policy implementation. Importance has been given to the role of medical professionals as they hold a strong position as providers of abortion. The main question was 'How can we explain the current challenges in implementing policies concerning prevention of sex determination and sex-selective abortion in the North of India?' In order to answer this research question, this chapter will depict the conclusions of this thesis. In the first section, answers will be given to the sub and main questions. Thereafter some limitations of the study will be discussed. In the end some recommendations for further research will be made.

6.1 Conclusions

In order to answer the main question, four sub questions were formulated, which addressed situational and cultural factors, perception of NGOs, shape of implementation and the role of medical professionals. This section will first address these four sub questions. Based on those conclusions an answer will be given to the main question.

Situational and cultural factors

In order to understand the difficulties in implementation of policies and legislation regarding sex-selective abortion, it is important to keep in mind some situational and cultural factors. Regarding the legal context, it can be concluded that abortion is legal in India. However, sex determination and therefore sex-selective abortion is an illegal act. The legislation regarding sex determination includes the use of ultrasound machines, which is often used to determine the sex of the foetus. Also, internationally the act of sex-selective abortion is condemned. The relevant international laws are also applicable for India, due to which an obligation exists to prevent sex determination and sex-selective abortion.

Although legislation regarding the issue exists, due to underlying cultural factors, the practise has gone underground, which makes it hard to prevent its existence. These cultural factors include son preference and the low social status of women. In the North of India, sons are preferred as they are a financial security. Due to the male dominant culture, they are perceived to be the caretakers of the family. Socio-cultural factors and religious utility of a son also contribute to the existence of son preference. The low social status of women results in no decision-making power, also in the case of conducting a sex-selective abortion, economic dependency and low level of female labour force. Due to the existence of dowry, daughters are perceived as a financial burden, which can lead to financial disaster within families with low income. This research shows that in the context of rural Rajasthan, the inheritance policy in combination with the low social status of women also affects the occurrence of sex-selective abortion. Although this policy makes sure that the property of parents is equally

divided among the children, after marriage the property belonging to the daughter will be owned by her family in-law. Therefore, parents do not want to have a daughter and are urged to conduct sex determination.

Besides the cultural factors that can be seen as the underlying causes of sex-selective abortion, some socio-economic factors influence its occurrence. Urbanization and economic growth lead to more sex selection, as families living in cities want to have small families, but also want to have a son. The notion of wanting to have a small family, can be perceived as the result of India's population policy. The availability of technology, especially within higher classes, results in sex-selective abortion. Moreover, higher education levels of women results in more sex selection as these women are better informed about their possibilities. Based on this research it can be concluded that education of girls is perceived to make a difference in rural areas in order to empower them and provide them possibilities for further development. This shows that different strategies are needed in different areas, as their background is different. When designing an intervention that targets sex-selective abortion, the mentioned situational and cultural factors should be taken into account.

Perception of NGOs and how do they deal with the issue

In order to understand the way NGOs deal with the issue of sex-selective abortion, it is important to understand their perception of the issue. These different perceptions and framing of the issue, lead to different problem definitions and therefore, to different types of interventions. Based on this research it can be concluded that NGO members perceive the extent of the issue to be growing as there is no difference between urban and rural areas anymore. The growing extent is contributed to the wide spread of the population policy, availability of technology and growing occurrence of dowry. A difference can be seen in framing the issue between urban and rural areas, where in urban areas the extent is being contributed to growing consumerism, whereas in rural areas this is contributed to availability of technology and the population policy. Moreover, the effects of unbalanced sex ratios are experienced by respondents, in the form of bride buying and one girl marrying multiple brothers.

In order to tackle the issue, mainly two kinds of interventions are conducted. Long term strategies are applied by NGOs who frame the issue of sex-selective abortion as a social and cultural problem, related to gender insensitivity and the low status of women. These interventions target the cultural and social norms of society which causes sex-selective abortion and advocate the dignity of girls and women empowerment. Because changing these norms and notions of society happens slowly and takes time, the interventions are called long term strategies. Short term strategies are concerned with the failure of implantation of legislation and the lack of medical ethics. The interventions target the prosecution of guilty medical professionals and the control of ultrasound machines. As the results of these interventions can be seen within a short time period, they are called short term strategies. Another way of framing the issue of sex-selective abortion is as a human rights and health issue. Although some respondents mention maternal healthcare as being related to the issue, none of the interventions of the NGOs which were interviewed for this research, focussed on this matter. In the end it can be concluded that regarding the interventions, both long term and short term strategies are being perceived to be needed in order to tackle the issue of sex-selective abortion.

Shape of implementation

To be able to understand the shape of implementation, two interventions with long term goals and two interventions with short term goals were explored. The top-down approach (Buse, Mays & Walt 2005; Sabatier & Mazmanian 1979), bottom-up approach (Buse, Mays & Walt 2005; Wildavsky 1979) and theory of translation (Latour 1988; McMaster et. al. 1997), were used to analyse the strategies and implementation process of the four interventions. The top-down and bottom-up approach are part of the diffusion theory and focus on limiting an implementation gap, which occurs if implementation does not happen the way it was intended by the implementers. By applying the steps required for an adequate top-down approach and bottom-up approach to the chosen interventions, an analysis was made based on which it was concluded which approach was applied and how the challenges in implementation could be explained. To make up for the limitations of the both approaches, which have a very linear view, and to gain more insight in the implementation process, the interventions were also analysed using the theory of translation. From this perspective, attention was paid to how the implementation process came into being using the concepts of co-construction of a black box and the Actor-Network Theory. The aspects of the translation theory that were recognized within the interventions were analysed in order to gain more insight in the current state of implementation.

Based on the analysis it can be concluded that although the long term strategies imply a bottom-up approach, as the interventions are community-driven, some top-down approach aspects are recognized as well. Because the interventions target the cultural and social norms of the community, the willingness of all actors to cooperate within the intervention is perceived to be required for successful implementation. When this is not being achieved, the implementation fails. This results in the interventions being implemented bottom-up, with large attention for inclusion of as many actors as possible. However, within the foundation that implements the interventions, a top-down approach is recognized, as the intervention is being laid down from the top upon the implementers who have to work in the field. Also, ways of controlling proper implementation of the intervention is being done top-down by using a central control system. Nevertheless, a bottom-up approach is perceived to work best when implementing an intervention with long term goals. In addition, elements of the translation theory help explain the difficulties in implementation. As the interventions target the cultural and social norms of the community, it should be taken into account that the cultural notions they try to change are deeply rooted within the culture and is co-constructed by all involved actors. The dynamic and diverse context in combination with the uncertainties of society results in changes of actors' behaviour and even changes of the intervention. Therefore, a strong chain is needed of human and non-human factors to form an Actor-Network that is interested to make the change happen. Consequently it can be concluded that although a bottom-up approach might be perceived as best approach to implement the intervention, translation aspects should be taken into account to understand the dynamic process of changing society's cultural and social norms.

Concerning the short term strategies it can be noted that a top-down approach is clearly recognized as legislation of sex determination and control of ultrasound machines is the obligation of the government, who functions as central decision-maker. The NGOs work within the top-down

approach, as they try to get the existing laws actively implemented. The obstacles which are experienced during implementation, relate to aspects of the top-down approach, such as lack of the government to enforce rules. Limited bottom-up approach elements can be recognized as there is no mention of inclusion of other actors. Nevertheless, as compliance of officials and medical professionals is missing, a more bottom-up approach might help to successfully implement legislation. However, based on this research it cannot be concluded if change of approach will lead to better implementation. Aspects of translation are also recognized, due to which the change of behaviour of actors, the redefinition of the goal of legislation and a double role of ultrasound machines can be explained. The lack of will to implement legislation suggests that there is no strong Actor-Network who is interested in implementing the law. Also, the strong position of medical professionals leads to government not being in a position to form a strong Actor-Network against the misuse of ultrasound machines. Underlying cultural norms cause these changes, which suggests that without taking the cultural context into account, implementation of legislation will always lead to changes in behaviour of actors as they want to maintain their cultural norms. This also suggests that long term strategies are needed to tackle the causes of failure when implementing legislation.

Role of medical professionals

To understand and explain the role of medical professionals, the concept of professionalism (Freidson 2001; Light 2010) were used. The concept of professionalism implies that medical professionals serve a greater value and is therefore concerned with the motivations to act of medical professionals (Freidson 2001). Economic reward is perceived to be the result of consumerism that leads to lack of professionalism. In addition, the concept of countervailing powers (Light 2010) suggests that other powerful actors, such as the government or civil society, are needed to control abuse of power of medical professionals. Both concepts were used to address the behaviour and role of medical professionals in India.

Based on the analysis it can be noted that the attitude and power of medical professionals is related to their behaviour and role regarding sex-selective abortion. Because of the underlying cultural norms, medical professionals are in a position in which they feel the need to provide sex-selective abortions to demanding couples. However, the high financial benefits as result of their illegal practises, can be contributed to consumerism and lack of professionalism. Nevertheless, as the concept of professionalism (Freidson 2001) is based on analysis of developed contexts, its relevance for the context of India can be questioning. Therefore it cannot be concluded that the behaviour of the medical professionals is solely the result to consumerism.

The large extent of the power of medical professionals, suggests that there is hardly any countervailing power which can lead to a balance of power between all actors. Although NGOs and the government try function as a countervailing power, they are unable to reduce the extent of power of medical professionals. In order to solve this, other actors, such as civil society, can be approached to provide countervailing powers to reduce the extent of power of medical professionals. Nevertheless, although the lack of professionalism and countervailing powers help explain the behaviour of the

medical professionals, more insight is needed regarding the motivations of the medical professionals' behaviour to better explain their current role regarding sex-selective abortion.

Conclusion

In conclusion, the current challenges in implementing policies concerning prevention of sex determination and sex-selective abortion in the North of India can be explained by taking into account the situational and cultural factors due to which the issue is very dynamic, diverse and complex. NGOs act against sex-selective abortion as they perceive the issue to be a growing problem. They implement long term strategies as they frame the issue to be a social and cultural problem, which needs to be solved by targeting the gender insensitive norms of society. The interventions targeting these cultural and social norms are being implemented using a bottom-up approach. In addition, they frame the issue as failure of implementation of legislation and the lack of medical ethics, which results in short term strategies targeting proper implementation of the law and the control of ultrasound machines. A top-down approach, where the government can be seen as the central decision-maker, can be recognized. Although the interventions are not set up from a translation perspective, within all interventions, elements of translation are recognized which explain the changes of behaviour of actors and changes within the interventions. Eventually, the concepts of professionalism and countervailing powers provide modest insight into the role of medical professionals, which contributes to the challenges regarding policy implementation to prevent sex-selective abortion in the North of India.

6.2 Limitations of the study

This study has some limitations which should be taken into account when interpreting the conclusions of this research.

The first limitation is that among the respondents important actors, such as citizens, victims, government officials and practicing professionals were not included. Although it was not the aim of the research to include these actors, it should be taken into account that the results are from the perspectives of NGO members. This can give a one-sided view of the issue. To be able to reduce the effect, not only members of NGOs were interviewed, but also other respondents, such as an editor, researcher and members of international organs were included into the research. Although they were contacted via NGOs, as they are not actively involved in the interventions, they can give a less coloured view of the current situation of sex-selective abortion in India.

Most of the respondents were active in the rural areas of Rajasthan. Due to this the conclusions of this research cannot be applied to different areas of North of India where the context and culture is different.

In the end, it should be noted that the interviews were not taken in person. This may have the result that the reaction of the respondents are more difficult to put into context, as their non-verbal reactions were not observed during the interview. Therefore a personal interview could have led to a better understanding of the context. Additionally, not personally approaching the respondents led to a low number of interviews, as interviewing the members of the NGOs on location would have led to

more data and more interviews. An attempt to solve this has been made by including a literature review and additional documentation about the interventions.

6.3 Recommendations

Based on this study, some recommendations for further research are suggested in this section.

As mentioned in this study, many of the interventions regarding prevention of sex-selective abortion are relatively new. To gain a better understanding of what factors are important to keep in mind when designing an intervention, case studies of the new interventions can provide some insight. As these interventions are quite new and still running, the factors and their causality with the issue, obstacles in implementation and results can be followed closely.

Regarding the interventions that target the cultural and social norms and paternalistic culture, research is needed how men and women are carriers of this culture. A better understanding can lead to more insight in how an intervention can be constructed.

Besides knowing the factors that are crucial for people's mindset to change, a way can be found to measure the change that is coming slowly. Not only the numbers of sex-ratios, but other variables can be used to determine if a change is coming. These numbers can help foundations to get funding for their projects. In addition, this way of measuring can help to determine what factors lead to what kind of results.

Regarding the interventions, extra attention can be paid to the role of the media, which is mentioned by many respondents. Research is needed to show to what extent the media can effect society, and which parts of society are reached. If more information is available about the role of the media, a large difference can be made regarding the proper use of media.

Besides taking a closer look at interventions of NGOs, research targeting the overall functioning of the government can provide insight of the loopholes and ways to tackle these. The role of the government, the way officials work and other factors that are related to the legal context should be taken into account when conducting such a study. Also, more research on interventions such as the silent observer is needed to gain more insight into its existence and implementation.

In the end, an in-depth study targeting the behaviour, power and role of medical professionals can help to get insight in how the medical community can be held accountable in the context of India. Looking at different options that can be applied in the healthcare of India can help to improve the overall lack in controlling the medical community. This will not only affect the issue of sex-selective abortion, but will improve the quality of healthcare in India in general.

7. References

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Appendix 1 – Respondent list

Respondent 1 – Medical doctor and coordinator IFES (International Foundation for Electoral Systems) project ‘Dignity of the Girl Child’

Respondent 2 – Chief executive & Secretary at Urmul Foundation (Rajasthan)

Respondent 3 – Member responsible for documentation work regarding female feticide (Urmul Foundation Rajasthan)

Respondent 4 – Editor Indian Journal of Medical Ethics

Respondent 5 – Medical doctor and project manager of Centre For Advocacy and Research (CFAR Rajasthan)

Respondent 6 – Founder-member & Chief Functionary of MAVA (Men against Violence and Abuse located in Mumbai)

Respondent 7 – Activist sex-selective abortion who was part of the movement in the 1980s

Respondent 8 – National program officer of Ipas (NGO focusing on women’s health)

Respondent 9 – Researcher (PhD student) at Seva Mandir (Rajasthan)

Respondent 10 – Representative UN Women India (in charge of Development Fund)

Respondent 11 – Program officer UNFPA India (United Nation Population Fund)

Appendix 2 - Garima Booklet



garima
experiences and stories...

“

I'm not to be blamed for the state of my children or that of my wife.
Her parents should have known better than have her married
knowing she wasn't strong enough to give birth to healthy children.

”

Magga Ram from Dabla village, Jaisalmer. At 23, father of three children aged 4 years, 2 years and 5 months.

Preface

This Booklet is an endeavor to compile the stories and narratives of change and of those who have become this change.

It is an account of a five-year journey with its toil, interventions, outcomes and setbacks to safeguard the dignity of Girl Child. Collected and recounted here are experiences from the 'Project Garima' undertaken by URMUL Trust in Thar Desert in India.

This account is aimed to serve as an institutional memory and as a reference material for organizations and individuals working on similar issues of concern.



THAR, DEVELOPMENT AND WOMEN

Thar is a way of living. A challenging way. It tests people at every stance. Their zeal to live, progress and develop an inspiring way of living has been the signature of one of the most densely populated deserts in the world. A lot has changed, improved and progressed in decades after independence- incrementally after the 90's economic reforms. Beyond the visible progress arguably -what has changed? Mind-sets of the people, cultural mal -practices, structural frameworks and persisting poor governance still remain the driving issues for governments, organizations and individuals.

The dynamics complicate further, when the 'road of change' (a typical connotation of progress, development and a solution), connects the local communities with external influences - but negatively. Thus aggravating the traditional problems in a modern fervor. One example of this entire discourse is the gender based discrimination in the entire desert of Thar.

Sex based discrimination is one critical challenge that has remained untouched in Rajasthan. As a society it is still discriminating - physically, mentally or emotionally, on the basis of gender. Thus binding the women of sand in a life-long trap of being a women. Even today.

Amidst so many similar stories, Urmul Trust executed in 2006- project *Garima*, In a programmatic approach, this was a five year long initiative to understand gender exploitation better, and so, to address it more efficiently. Partnering with USAID, COUNTERPART and IFES, this initiative opened spaces in feudalistic and patriarchal social systems, which have in plenty- the above mentioned instances and so many similar stories. Female foeticide, infanticide, child abuse, lack of education, child marriages, and domestic violence- frame the realities of so many women here.

In past years these disparities and its resulting incidents have not just spread, but also manifested in numerous ways. This added to the traditional ill-practices, gives an immensely grim picture of the context in which project *Garima* was initiated in three districts - Hanumangarh, Ganganagar and Jaisalmer (also ranging in two sharply contrasting geographies of Rajasthan).

Historically arid- the adjoining districts of Hanumangarh and Ganganagar, saw almost a magical boom in farming (and subsequent industries) with the waters of Indus coming in through Indira Gandhi Canal in 1980s and 90s. This translated in alarming gender gaps

"He Killed Her. I Kept Her Hidden For 12 Years". Cried A Mother From Jaisalmer With Stoned Eyes.

and further complicating the discriminations. These paradigms eventually resulted in more sophisticated and formidable ways of women sufferings.

The canal and other developments, in their wake, brought along an attaché - land hoarding, drug mafia, systemic corruption, standard failures of public service delivery, and all this with a built-in exploitation surge against women.

The disparity in sex ratio has seen a rise as well. As land became more valuable, the 'sons' as torchbearers of the family rose to an inflated status and 'girls' now meant loss of irrigated land in dowry. Female subservience in forms of female foeticide, domestic violence and child marriages, have become a standard practice. The society has little projected realization of this dynamic shift that has come along with the much celebrated developments.



Moving westward to the expanse of Jaisalmer, the landscape changes from lush greens of canal to far stretched gold and browns of sand, the dialect shifts, livelihood alters from agriculture to animal husbandry- primarily sheep rearing; and in the context, the cultural mapping of the area changes – from the Punjab influence moves into a Rajput dominant socio-culture. The economic and

education indicators, in comparison to Ganganagar and Hanumangarh districts are much lower. The 'Ghunghat', and Purdah system, are an explicit assertion of women's status and a reiteration of male supremacy in this society, thus a rewind of hundred years on the time-line. According to 2001 census, Thar stands third among places with highest gender disparity (in the age bracket of 0-6 years).





PROJECT INTERVENTIONS

Consequently, the interventions called for innovations in approach and implementation strategy. The same reformatory processes were needed to be fortified but with different sensibilities and fine tuned for successful implementation.

When the project began, no one – neither the district nor the local Panchayats would pay attention to the factual details we had. The locals would not let us into their homes, making it very difficult to reach to them. The issues of female foeticide or anything approaching gender theme could not be addressed. We began to work in the sectors of health and education to initiate and establish our connections first and slowly once we gained

trust, issues were gradually brought up. The efforts in the last five years have helped us get a footing into the project villages.

The intervention works closely with personnel of existing local administrative structures, mechanisms and programs such as the Anganwadi workers (AWW), Auxiliary Nurse Midwives (ANMs), ASHA (Accredited Social Health Activist) Saathins, Traditional Birth Attendants (TBAs), members of the Panchayat (elected local governance bodies), school teachers, and the district administration to first sensitize and then motivate them into action, to initiate, adapt and sustain the fight.

Institutionalizing the Institutions

The interventions have been designed and developed over a period of 5 years, working with various personnel from the PRI, communities and other individual institutions, inventing and reinventing the processes.



Village Health and Sanitation Committees (VHSC) (Meetings and Trainings):

We work with various VHSCs formed at the village levels, instrumentalising these for the dissemination of information and awareness about the issues of sex selection, female foeticide and domestic violence. Urmul has been assigned with the responsibility of training VHSCs in Hanumangarh and Jaisalmer districts by the ministry of Health and Family Welfare, Rajasthan under National Rural Health Mission (NRHM).

We guide, train and equip VHSC members to strengthen the monitoring procedures and reform the health and sanitation of the village as well as information related to the issues. We work on raising awareness on the legal provisions for the issues. Along with VHSC members, we work towards taking actions that promote the overall status of the girl child such as celebrating the birth of girl

children, ensuring girls' enrolment and retention of girls in schools, promoting health care for girls and women, motivating Panchayats to honour new born baby girls and their parents, support girls performing last rites of parents, encourage couples to marry without dowry, recognize and honor couples who adopt permanent family planning methods after having one or two daughters; and counsel parents/families with daughters regarding value of the girl child. The VHSC meets each month on the decided MCHN day to discuss and to review.

CBR Groups

Community Based Response groups (CBRs) are formed to generate community feedback platform that can facilitate better planning and implementation at the local level, helping the village to become self-reliant. CBRs are formed one at every village with a population of 1000 or above. This group includes various members identified with certain skill sets, from the village by the coordinators. There are various groups in village like Kishori Prerna Manch, and Mahila Mandal that come together to form a mixed group. This helps avoid overlapping of efforts and ensures more streamlined and guided efforts.

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The Panchayats

“I forced two abortions on my wife in the early nineties – I regret it today. If it wasn't for the Ultrasound machines...” speaks the remorse of a father – as the Sarpanch of Pakki Saran, Hanumangarh, heworks hard to make people aware of the importance and pleasures of having daughters and motivates them to have children not more than 3 even when all three are daughters.

The Panchayats today are motivated and are taking initiatives at their levels. Most Panchayats, as an initial step, have warned all the Ultrasound Centres in the district, to inform them of any couple wanting to undergo sex selection tests, from their Panchayats. If 10 percent of birth certificates were issued when the project began, today 60 – 70% of certificates are issued. The Panchayats are making efforts at providing for better education and health facilities,

with women as their primary focus. They believe that the basic needs have to be met before the bigger issues, such



as child marriage and female foeticide, the traditional carry-forwards can be addressed. The Panchayats have begun adopting ideas that incorporate traditional customs of 'Thaali Bajaana' and innovations such as 'Kanya Janam Badhai Patra', at much behest. A greater acceptance has been received for those in the adjoining districts; the adoption rate has been slow in Jaisalmer.



Thaali Bajaana

Customarily, as a son is born to a family, the women of the house go beating a plate as an announcement of the joyous event. We began to beat the Thali (Plate) at the birth of a girl as well to establish equality. First it was started with individual families and then we began celebrating this at Panchayat levels. More than 30 Gram Panchayats and over 50 families have celebrated the birth of little girls by beating the thaali.

Kanya Badhai Patra

An innovation of the custom of thaali bajaana and the birth registration certificates is Kanya Janam Badhai Patra (congratulatory certificate at the birth of a girl child). This idea was first adopted at Dabli Qutub in 2009.

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Various Panchayats since (16 in Hanumangarh and 20 in Ganganagar) have adopted this idea of felicitating the parents with one or two daughters. The thought behind this is to deliver the message that birth of a child is ceremonial, be it of a girl or boy; to inspire, motivate, celebrate and raising the awareness about the importance of girls.

Community and Role Reversal

A significant change has been sighted in the communities. If only 25 percent of pregnant women registered themselves at the Anganwadis a few years back, the number has risen to 70 percent now.

Number of hospitalized deliveries has risen to 60 percent and 60 percent of women in the district avail Reproductive Health care and Family Planning measures. Such changes are indicative of the rising awareness levels amongst the locals. Individuals at their end have also begun taking considerable

measures to promote and motivate the number of girls in the society and are working towards improving their status.

Kanya Lohri, is one such initiative being taken at Ganganagar. The Ganganagar Chambers of Commerce has been partnering and supporting this since 2007.

It began with the idea of celebrating the Harvest Festival of Lohri in honour of girls, moving away from the tradition of honouring birth of boys in the family, at a community level. Scholarships for higher education are awarded to girls from families that have only one or two girls as children. In 2010, Rupees 1.93 crore worth scholarships were awarded to 101 girls in the district.

Students' participation

We have been working with the youth, extensively, to sensitize them towards the issues of Child Marriage, Domestic Violence and Female Foeticide and to inspire and motivate them into becoming ambassadors to the cause. Competitions like essay-writing, slogan-writing, painting have been used to provoke thought. We organized rallies with students from colleges and schools. They use slogans and placards to motivate as well as





spread the message. A group of self-motivated students from B.ED College, at Ganganagar, have pledged their support to the issues. They have scripted and performed a play “Betiko jeene ka haq do” (give daughters their right to live) at various occasions organized.

Referral Displays

All project villages have referrals displayed at all frequented public places. The referrals carry information and contact numbers of the authorities concerned with the issues. The information helps the locals inform the authorities of any happenings and they could take further action. It has proved useful because it helps them keep their anonymity.

Kala Jatha Programmes

Using traditional forms of entertainment – puppetry and storytelling – awareness drives across villages have been

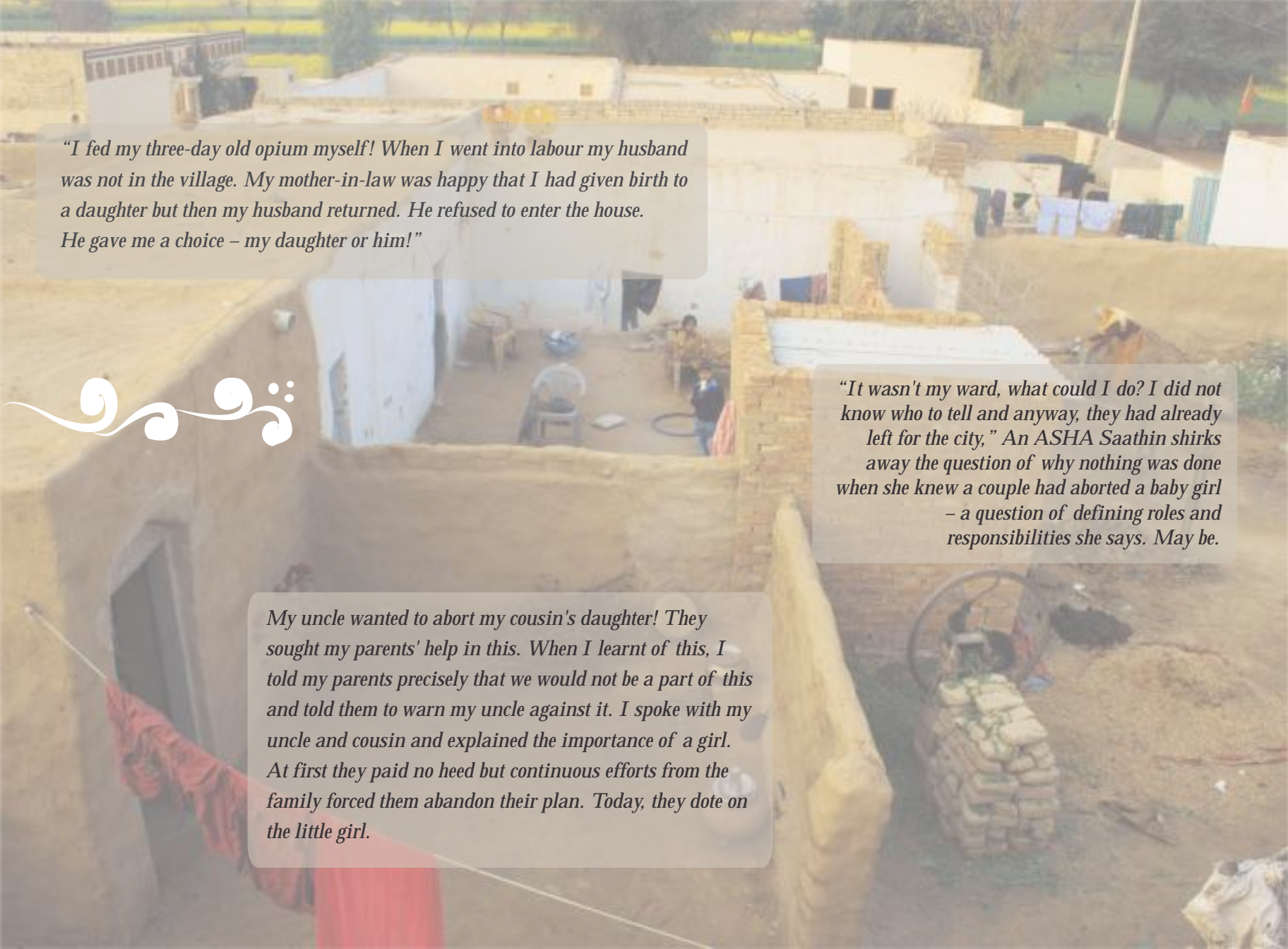
organized to extend the information and advice on the issues.

Media Workshops


Workshops with the media professionals have been conducted to help sensitize the media towards the issues of Female foeticide, domestic violence and child marriage. This has enabled extended support from the media in highlighting stories, endeavors and experiences in the field and otherwise.

Print Media

The print media has provided extensive support to the project by covering and highlighting the issues of concerns through reports, features and articles.



“I fed my three-day old opium myself! When I went into labour my husband was not in the village. My mother-in-law was happy that I had given birth to a daughter but then my husband returned. He refused to enter the house. He gave me a choice – my daughter or him!”



“It wasn't my ward, what could I do? I did not know who to tell and anyway, they had already left for the city,” An ASHA Saathin shirks away the question of why nothing was done when she knew a couple had aborted a baby girl – a question of defining roles and responsibilities she says. May be.

My uncle wanted to abort my cousin's daughter! They sought my parents' help in this. When I learnt of this, I told my parents precisely that we would not be a part of this and told them to warn my uncle against it. I spoke with my uncle and cousin and explained the importance of a girl. At first they paid no heed but continuous efforts from the family forced them abandon their plan. Today, they dote on the little girl.

Young Kalia refused to accept any dowry from his in-laws and even refused gifts from all other attendees at his wedding. His involvement in the Kishore Manch and regular CBR meetings, says he, motivated him into this and he has pledged to support to safeguard the honour and dignity of girl child and women.

A grieving mother she was until she found strength and support in the mixed group. Sapna had just lost her only 5year old and was very depressed. This friend began narrating her discussions and learning's from her VHSC meetings, and would tell Sapna of how girls like Puniya are doing their parents & state proud and how they are growingly a bigger support to parents. Discussions like these Sapna says, not only helped decide for herself but also voice it and convince her family of the importance of daughters. Today she is pleased and finds herself blessed to be a mother of two daughters.

I have pledged to save at least lives of a 100 girls in this village before I die. I have been working for this for the last 15 years. Today you see so many girls in this school, there was a time there was not one girl. We struggled to explain it to the village members the importance of a girl. But today the youth are more aware and few of them are standing up against the pressure.



“An honour; because you are my parents!”

85 little baby girls and their parents were congratulated and honoured at festivities organized by the Gram Panchayats of Doongarsingpura and Ganeshgarh, together. A crowd of 1500 was present to witness the distribution of Kanya Janam Badhai Patra to those parents, who had a daughter in the bygone year. The Zilla Pramuk, Zilla Pradhan and a few MLAs supported the endeavor.





A struggle continues...

A mother and a daughter fighting for their right to existence... An impending decision!

In the village of Kumaharawali Dhani, in the district of Hanumangarh, a mother strives to save and restore her daughter's rights. A fight where she finds herself strengthened by her sister (who incidentally is her co-sister as well). Veerpal and Manveer, two women of exemplary strength who walked out of their home wanting acceptance for Veerpal's daughter.

Veerpal's husband and mother-in-law forced her to undergo an ultrasound examination to determine the sex of her unborn child. When their fears came alive they were determined to terminate Veerpal's pregnancy. Veerpal put her foot down and decided she would give birth to the girl and she did. She was meted out with all sorts of atrocities, physical and mental. She was beat up black and blue and once, suffered hemorrhage for which she was hospitalized in Bikaner for a fortnight.

When the atrocities got unbearable Veerpal decided to walk out of home and fight for justice. Manveer walked out on the family as well in support of her sister and niece. The village Panchayat has tried to resolve the matter but in vain. The mother-daughter waits for justice to be meted out to them. They wish to find a place in a loving home. But will justice be received?

A historical wedding in 108 years:

Patriarchy strongly rooted - only male children were preferred, thus this saw the absence of girls for more than a century. For 108 years there were no marriages of daughters in Devada, a village in Jaisalmer.

A father, braved, took a stance and the first girl in a hundred years was born in the village. Grieved with loss of his only son to malaria, a year before his daughter was born, Mr. Inder Singh pledged that he would not let his child, be it a girl or boy, die. He stood against the village and raised his daughter providing all 4 children equal opportunities to grow. The daughter was educated till class 10 and was married with a pompous wedding as she turned sixteen.

Today he is a grandfather of a girl and six boys. Unfortunate however, is the fact that the mother of his granddaughter does not think very highly of his decision to let the girl survive. She explicitly says, "I'm having a third child only for a second son. Both my sisters-in-law have two sons each. If it weren't for my father-in-law I would not have let her live" pointing at the little toddler in front of her. Speaks the hurt and pain of being a woman in the feudalistic framework of society, or the hurt ego of a woman beaten at familial politics, is easier left to contemplation.





“I’m not to be blamed for the state of my children or that of my wife. Her parents should have known better than have her married knowing she wasn’t strong enough to give birth to healthy children.”

This is how a conversation unfolds with a father, who has his two children hospitalized for malnourishment. He is a father of 3 at 23, married for 5 years, to a woman who is all of 17 years today. The woman is weak and mal-nourished, and the children, for obvious reasons, are under-nourished.

Ashok, coordinator at Jaisalmer, Urmul trust, came to know of the pathetic situation and ran to the rescue. He and a few more people managed to get the two year old Nisha and five month old Prakash admitted to the government hospital, Jaisalmer, where they are currently under observation and are being treated. With no remorse, the father Magga Ram did not wish to have the two children admitted. He thought they would manage! The wife remains silent.

*As narrated to Mrs. Vimala, Project coordinator, Jaisalmer
(February, 2011)*

The way ahead...

The census 2011 indicates that the disparity in the sex ratio has reduced in the district of Ganganagar – a testimony to the efforts and their effects of last five years. As a significant start, this highlights the changing mentalities of communities and a hope for a better future for girls. Despite this, the situation is far from congratulatory and lacuna at sustenance in the initiatives is continuously felt. The sex ratio of Rajasthan has fallen from 909 to 883 causing for the rise in alarm.

Dignity of Girl Child Foundation is an attempt to address the newer facets of the gender based discrimination in Rajasthan. It has been established as an endeavour for affirmative action for girls, restoration of their value in the society, complete ban on sex determination tests and female foeticide. This initiative pivots at renewing and sustaining efforts to check the declining sex ratio in the state of Rajasthan.


The constant refurbishing of ideas, thoughts, zeal and enthusiasm will see the fight against sex selection and female foeticide through. These rejuvenated efforts will continuously strive to restore the lost spaces of girls in the society.



The Team

The tiny sprouts of change have been nurtured with undeterred zeal, passion and toil. Oscillating in time and space -from one village to another, from one mindset to another and from one story to another- our team has worked with much fervor and ardent determination. Hours turned into days and days into years, and even today each one of our team member works with the same enthusiasm they once started of with. Standing by each other in support, sharing ideas, innovating newer schemes and plans, drawing newer possibility, has been our greatest strength.

"We have no problems working with people. They are most cooperative once they realise and understand the alarm in the situation. Initially we do have to tackle a lot of apprehensions and misconceptions but slowly these give way. We don't really do anything but motivate people into seeing the true picture; rest just snowballs thereafter," says NishaChauhan. Adding to this, Vikram Singh highlights "The actual problems lie in the expectations of the funders and the field reality. The disparity is huge - each village is different, each case is different and therefore the way to tackle them would naturally be different. Time-bound and target orientated projects don't give us the space to work around each issue with utmost sincerity and care. However, we do understand the constraints on the funders' part and just try doing our possible best in each situation.



Mrs. Vimala reiterates the difference in the worlds of Jaisalmer and Ganganagar-Hanumangarh. “In jaisalmer,” she says, “we had to bargain our way through homes using health concerns as a shield. The purdah system forbade the women to talk to women outside of their community. It has been a real task to gain their trust and even greater a problem to raise the question of female infanticide and foeticide with the communities here. Today after five years the situation is slightly more promising but the pockets of traditional carry-forwards remain.”

We have seen five years of success stories interspersed with dejections and rejections, but each one of them only brought us closer to victory of our efforts. We understand how important it has been to even seed the rhetoric in people and this we believe has been our biggest victory. As a team, we had decided that even if we could get people to start talking and openly address the issues, it would slowly but definitely translate into a change. And this exactly what it seems now. Those questions are taking their space and are helping make a way for a solution. This has been our greatest motivator.



Urmul Trust

In the harsh and inhospitable regions of rural Rajasthan in the Thar Desert, URMUL Group of Organisations have been innovating models for inducing community-driven socio- developmental changes by devising programmes, strengthening them, sustaining and finally handing them over to communities.

Urmul's work is guided by the spirit and trust placed in people's capabilities to bring about the much needed social change with their own efforts. Most of the work is focused on vulnerable and marginalised sections of the society - Women and Children. Following the integrated development approaches, Urmul works on all the Millennium Development Goals. We adopt service delivery platforms, advocacy and lobbying tools for empowering the marginalised and vulnerable sections of society in over 1000 villages in this desert state of India- thematically working on Health, Education, Livelihood, Environment, Mother-Child care et al.

Food, Fodder and Water securities are major concerns including drought and disaster mitigation. Women's socio-economic empowerment, Capacity building, improving access to basic services, Education, Early Child Care & Development, and Child Right Issues are few concerns addressed. Urmul recognises and acknowledges the strength of youth and their role in development of any society and thus, collaborates with a network of over 5000 youth for their capacity building and driving them towards awareness and Rights-based development.



Urmul works across verticals ranging from Governments and INGOs to Panchayati raj Institutions, Self Help Groups and other Civil Society Organizations. Collaborating with over 300 gram panchayats in over 1000 villages in the Western Rajasthan directly. More than 30000 families have been beneficiaries of various programmes and have joined to form a network to carry forth the endeavours and reach out.

The Group has been working as an implementation agency for numerous state and central government programs including Shiksha Karmi, Lok Jumbish and Integrated Child Development Scheme. The Government of India has also identified URMUL Trust as mother NGO for implementing reproductive and child health projects in Western Rajasthan.

During these decades Urmul has developed a network of several committed voluntary agencies, consortiums and individuals in the region. The trust is also an executive member in several GO-NGO collaborations and Policy Planning Committees.

We had a celebration at the arrival of our daughter. The entire village and all are near and dear ones had been called to join in our joyous occasion. My wife and I were just happy to have a child after 10 years of our marriage and it couldn't matter if it were a boy or a girl. We feel so blessed to have her.

Mr. Bhati, Khatori village, Jaisalmer



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