

**GENDER-BIASED SEX SELECTION
AND UNBALANCED SEX RATIOS
AT BIRTH IN SOUTH ASIA:
CASE STUDIES OF THE SITUATION
AND PROMISING APPROACHES
TO RESTORE BALANCE**

Population Council
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Table of Contents

	List of Tables	v
	List of Figures	vii
	Acknowledgements	ix
	Executive Summary	xi
Chapter 1	Introduction	1
Chapter 2	Factors underlying unbalanced sex ratios	16
Chapter 3	Exposure to communication, advocacy and community mobilisation programmes	36
Chapter 4	What works to reduce gender-biased sex selection: Perspectives on law enforcement	42
Chapter 5	What works to reduce gender-biased sex selection: Programmes to enhance the status of the girl child in Bangladesh, India and Nepal	52
Chapter 6	Gender-biased sex selection in Karachi, Pakistan: Provider perspectives on factors influencing the emergence of an unbalanced sex ratio at birth and recommendations for the way forward	63
Chapter 7	Factors underlying differences in the sex ratio at birth in Comilla and Rangpur, Bangladesh, and recommendations for the way forward	67
Chapter 8	Factors underlying differences in the sex ratio at birth in Kaski and Tanahun, Nepal, and recommendations for the way forward	71
Chapter 9	Factors underlying the improvement in the sex ratio at birth in settings with very adverse sex ratios, Haryana, India, and recommendations for the way forward	75
	References	80
Annexure 1:	Bangladesh: A summary of programmes and interventions to empower women and girls	85
Annexure 2:	Pakistan: A summary of available policies, programmes and interventions on empowerment of women and girls	87
Annexure 3a:	India: Initiatives to ensure that the PCPNDT Act is implemented	89
Annexure 3b:	India: Advocacy, communication initiatives and community mobilisation efforts to ensure effective implementation of the PCPNDT Act and promote gender equality	90
Annexure 3c:	India: Selected central and state government schemes for increasing the value of the girl child and counter disadvantages faced by girls	94
Annexure 4:	Nepal: A summary of programmes and interventions to build gender equality and counter gender-biased sex selection	99
	Authors	101
	List of Investigators	102

List of Tables

Table 1.1:	Sociodemographic profile of selected study districts and Bangladesh	3
Table 1.2:	Sociodemographic profile of Karachi, Pakistan, 2012–13	4
Table 1.3:	Sociodemographic profile of selected study districts and Haryana State, India	5
Table 1.4:	Sociodemographic profile of selected study districts and Nepal	5
Table 1.5:	Legal environment related to sex selection and abortion in Bangladesh, Pakistan, India and Nepal	8
Table 1.6:	Coverage of the study: Survey participants in Bangladesh, India and Nepal	10
Table 1.7:	Coverage of the study: Key informants, Bangladesh, Pakistan, India and Nepal	11
Table 1.8:	Selected sociodemographic characteristics of women who participated in the survey by district, according to residence, Bangladesh, India and Nepal	14
Table 2.1:	Family size preferences and actual family size	17
Table 2.2:	Attitudes about son preference	19
Table 2.3:	Disclosure of the sex of the foetus by parity and sex of the previous child	22
Table 2.4:	Experience of induced abortion and reasons for abortion	23
Table 2.5:	Attitudes about gender-biased sex selection	24
Table 3.1:	Awareness of laws relating to disclosure of the sex of the foetus	37
Table 4.1:	Perceptions about the extent of adherence to the law and law enforcement	43
Table 4.2:	Perceptions about different aspects of law enforcement and effectiveness of the law	44
Table 5.1:	Exposure to microcredit programmes, Bangladesh	55
Table 5.2:	Perceptions about and enrollment in the Female Secondary School Stipend Programme for girls, Bangladesh	56
Table 5.3:	Awareness and perceptions about and enrollment in conditional cash transfer (CCT) schemes for girls, Haryana, India	57

List of Figures

Figure 1.1:	Sex ratio at birth and among children in Bangladesh, and Comilla and Rangpur districts, 2010–2013	6
Figure 1.2:	Sex ratio at birth in Pakistan and Major Urban Sindh, 2010–2013	6
Figure 1.3:	Sex ratios at birth and among children in India, Haryana State, and Sonipat and Kurukshetra districts, 2010–2013	7
Figure 1.4:	Child sex ratio in Nepal, and Kaski and Tanahun districts, 2010–2013	7
Figure 2.1:	Among women who had two living children, indicators of son preference, according to residence, Bangladesh, India and Nepal	18
Figure 2.2:	Percentage of women reporting experiences of undergoing ultrasonography during pregnancy, disclosure of the sex of the foetus, and acquaintance with others who had sought disclosure of the sex of the foetus, according to residence, Bangladesh, India and Nepal	21
Figure 3.1:	Percentage of women reporting exposure to messages advocating equal treatment of boys and girls, and discouraging gender-biased sex selection, according to residence, Bangladesh, India and Nepal	37
Figure 3.2:	Percentage of women reporting exposure to various messages advocating equal treatment of boys and girls, and discouraging gender-biased sex selection by source of information, according to residence, Bangladesh, India and Nepal	39
Figure 5.1:	Percentage of women reporting awareness of, and percentage of women with an eligible daughter reporting use of educational entitlements for girls, Bangladesh, India and Nepal	54
Figure 5.2:	Percentage of women reporting awareness of scholarship schemes for girls, Bangladesh, India and Nepal, and percentage of women with an eligible daughter reporting use of scholarship schemes, India and Nepal	54

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Executive Summary

Sex ratios at birth in South Asia vary considerably. While the sex ratio at birth in Bangladesh and Pakistan, thus far, has been normal at country level (103 and 102.5 males per 100 females, respectively), Nepal is showing signs of disturbed sex ratios at birth, with a sex ratio of 106 males per 100 females, and the situation in India is particularly adverse, with a sex ratio at birth of 110 males per 100 females. In all of these countries, however, preconditions for a deterioration of the sex ratio at birth are evident. Preferences are expressed for small families, patriarchal social norms persist and societies tend to be gender-stratified with strong preferences for at least one son, and prenatal diagnostic techniques are widely available and used to monitor foetal development. Indeed, all four countries have long been characterised by wide gender disparities and a strong preference for sons, often manifested in terms of the greater investment in the health, nutrition and education of sons over daughters.

There are, however, within-country differences in sex ratios at birth and among children, including in Bangladesh and Pakistan, where overall sex ratios at birth remain normal. In Bangladesh, for example, skewed sex ratios at birth are observed in eastern/central regions and normal ones in the neighbouring western region (National Institute of Population Research and Training (NIPORT), Mitra and Associates and ICF International, 2013). In Pakistan, too, there are some settings in which adverse sex ratios at birth are evident; for example, Sindh has a higher than normal sex ratio at birth (National Institute of Population Studies and ICF International, 2013) and there is concern that adverse sex ratios at birth are also visible in some urban pockets. In Nepal, where skewed sex ratios at birth are evident at the national level, sub-national differences with unbalanced sex ratios have been observed in some districts in the Terai and hill regions but not in others in the same region (Central Bureau of Statistics, 2012). In India, which has had a far longer history of skewed sex ratios at birth, statewide differences are wide, ranging for example, from 103.5 in Kerala to above 118 males per 100 females in some states in the northwest, by 2002–04. Also notable in districts with particularly adverse sex ratios at birth and among children in the early 2000s, is evidence of improvements in the sex ratio at birth by 2011 in some districts but not in others in the same region (Office of the Registrar General, India, 2013).

Contextual differences must be noted. For example, while India and Nepal legally prohibit the disclosure of the sex of the foetus to guard against subsequent termination of pregnancies carrying a female foetus, Bangladesh and Pakistan have no such restrictions. Laws relating to termination of pregnancies, in general, also differ from relatively restricted in Pakistan to permitted under a host of reasons in India and Nepal, and permitted as menstrual regulation up to 10 weeks of gestation and somewhat restricted thereafter in Bangladesh. Also differing across countries have been programme responses to adverse sex ratios at birth and among children. As observed in the successful example of South Korea, it was a combination of enforcement of laws prohibiting gender-biased sex selection, the provision of educational entitlements and cash transfers for girls, and a strong community mobilisation programme intended to change norms about son preference and raise awareness about the law and the prohibition of gender-biased sex selection that was responsible for the rapid normalisation of the sex ratio at birth (Guilmoto, 2011). Of the four countries, it is in India where this multi-pronged response has been most concentrated—through the implementation of laws, as well as through programmes intended to build gender equity and raise the value of the girl child by way of educational entitlements and conditional cash transfers, and efforts to raise awareness and mobilise communities to both change norms related to son preference, and understand the dimensions of the law prohibiting disclosure of the sex of the foetus and subsequent termination of pregnancies carrying a female foetus. In the other three countries, the emphasis has been on efforts to build gender equity and raise the value of girls, through a diverse set of educational entitlements, conditional cash transfers and employment opportunities; in these settings efforts to reduce gender-biased sex selection, more specifically, are not present.

These widely differing scenarios raise different research questions for each setting. With support from UKAid, the Population Council's Bangladesh, India and Pakistan offices, and the Centre for Research, Environment, Health and Population Activities (CREHPA), Nepal, led by the Council's India office, undertook case studies that aimed to shed light on the issue of gender-biased sex selection in these countries and make evidence-based recommendations for actions that hold promise for responding to adverse sex ratios at birth in these settings. Given the wide contextual differences described above, a single research question across all four countries was not possible, and as such, the specific objectives of the studies differed across countries: (a) In Bangladesh, the objective was to explore programme and sociocultural factors underlying district-level differences in the sex ratio at birth, by comparing the

situation in one district (Comilla) with a high sex ratio at birth with that in a district (Rangpur) with a normal sex ratio at birth; (b) in Pakistan, where evidence is extremely sparse and signs of imbalance in the sex ratio at birth very recent, to explore provider perspectives about the practice of gender-biased sex selection in urban pockets of Karachi; (c) in India, to compare, in two settings of Haryana, a state with extremely adverse sex ratios at birth and among children, the programme and sociocultural factors underlying improvements in the sex ratio at birth in one district (Kurukshetra) from very adverse to somewhat less adverse levels in the 2001–2011 period, with a district (Sonipat) in which the sex ratio at birth remained stagnant over the decade; and (d) In Nepal, the objective was to explore programme and sociocultural factors underlying district-level differences in the sex ratios among children, by comparing the situation in one district with a high child sex ratio (Kaski) with a second reporting a normal sex ratio (Tanahun). We note that as district-level data on sex ratios at birth are unavailable in Nepal, and as the child sex ratio i.e., the sex ratio of the population aged 0–4 years reflects, to a considerable extent, the sex ratio at birth, we used the child sex ratio as our indicator to identify districts with low and high sex ratios at birth. Hence, in this report, we identify Kaski as the district with an adverse sex ratio at birth, and Tanahun as the district with a normal child sex ratio at birth.

The study adopted a mixed method approach. In Bangladesh, India and Nepal, it included a survey of 1,000 or more married women with at least two children, one of whom was aged 0–5 years. In these countries, it also included key informant interviews with health care providers and programme implementers from the public and NGO sectors. In Pakistan, where skewed sex ratios are not really observed, and evidence is sparse, only one component—key informant interviews with health care providers—was fielded. All four components were implemented in Bangladesh, Nepal and India. A common set of instruments was used; however, as noted above, certain issues that were not relevant in a particular country were omitted. The survey explored, from the perspective of women, family size desires, the strength of son preference, and the extent of disclosure of the sex of the foetus and termination of pregnancies carrying a female foetus; it also explored women’s knowledge of the law, exposure to messages relating to raising the value of the girl child, in general, and addressing gender-biased sex selection, in particular. Where possible, primary research also explored the extent to which three types of programmatic interventions—law enforcement; communication, advocacy and community mobilisation efforts, and the provision of educational entitlements and conditional cash transfer programmes for girls—were implemented in each district, and the extent to which these interventions may have contributed to the different levels of sex ratios at birth in contrasting districts of each country.

Findings from Bangladesh and Pakistan where disclosure of the sex of the foetus is not legally restricted

Bangladesh: Comilla and Rangpur were selected for the case study based on their high and normal sex ratios at birth that is, 117 and 105 males per 100 females, respectively. Findings highlight that although all three preconditions for skewing of sex ratios prevail in both districts, both use of ultrasonography, in general, and disclosure of the sex of the foetus, in particular, were more widespread in Comilla than Rangpur, with 65 percent of women from Comilla compared to 51 percent from Rangpur, having been informed about the sex of their foetus; however, termination of a pregnancy carrying a female foetus was reported by just one woman (out of 1,037), and women strongly opposed gender-biased pregnancy termination. Even so, son preference was evident in both districts, although more so in Comilla (the district with an adverse sex ratio at birth) than Rangpur (the district with a balanced sex ratio at birth). For example, the intention to have additional children was clearly related to the sex of living children among women in Comilla where women who had more sons than daughters were more likely than those from Rangpur to report wanting no more children. Moreover, women in Comilla were also more likely to report disclosure of the sex of the foetus than were those in Rangpur, and such disclosure appeared to be contingent on the sex of the previous child. In Comilla, women at parity 2 whose first child was a daughter were more likely to have been informed about the sex of the second child than were women whose first child was a son. Furthermore, women’s use of contraception was strongly associated with the sex composition of living children; in Comilla, women who had two sons were 50 percent more likely to have been practising contraception than those who had two daughters while in Rangpur, they were 17 percent more likely to have done so.

Factors underlying differences in sex ratios at birth between the two districts were explored. Differences in the implementation of laws and programmes were typically moderate. For example, with regard to educational entitlements and conditional cash transfer programmes, notably school stipends for girls, differences were mild

although access to these programmes was more likely to be reported by women from Rangpur than Comilla. Programme implementers were, moreover, optimistic that stipends, microfinance and employment opportunities in the apparel industry played a powerful role in changing attitudes about girls and raising their status, but were sceptical about whether these programmes could change preferences for sons over daughters. With regard to communication, advocacy and community mobilisation programmes, programme implementers from both public and NGO sectors confirmed that programmes focusing on gender-biased sex selection or sex-selective abortion are not implemented in the study districts or, more generally, in the country. However, they acknowledged that programmes that focus on non-discrimination against daughters are widely implemented, and while these take place in both districts, findings indicate that they are more prevalent in Comilla than Rangpur, confirming perhaps, that these programmes were more likely to be carried out in districts with high levels of gender discrimination. Finally, with regard to the implementation of laws, even though there is no law prohibiting the disclosure of the sex of the foetus, key informants, mainly health care providers from both districts, acknowledged that laws relating to abortion are poorly enforced and monitored, and that programmes do not exist that inform health care providers about the misuse of technology for gender-biased sex selection. Roughly, 40 per cent of women—particularly those in Comilla—expressed a need, moreover, for a law on gender-biased sex selection, suggesting perhaps, that the practice is not entirely absent in the district.

Overall, districtwise differences in programme implementation were mild, and findings suggest that while the potential does indeed exist for gender-biased sex selection and the termination of pregnancies carrying a female foetus, differences in sex ratios at birth in Comilla and Rangpur may also be attributed to different family-building strategies. The authors note that women from Comilla, the district with the adverse sex ratio at birth, compared to those from Rangpur, the district where it was normal, were more likely to base their childbearing strategies on the number of sons they had, in that they were more likely to stop childbearing as soon as they had their desired number of sons; in Rangpur, in contrast, childbearing was more likely to stop when the desired family size was achieved. The authors suggest that differential ‘stopping’ strategies (for family size limitation) may play a role in accounting for the differences between the two districts, but note that the potential exists, particularly in Comilla, for following the disclosure of the sex of the foetus with the termination of pregnancies carrying a female foetus, especially in view of the fact that violation of the abortion law relating to the termination of pregnancies beyond the prescribed gestation period is rarely punished.

Pakistan: Major Urban Sindh, in which Karachi is located, reports a sex ratio at birth of 107.5 compared to 102.5 males per 100 females in Pakistan as a whole. Our case study focused on understanding the perspectives of 15 experienced health care providers, selected to represent the array of providers offering women’s reproductive health services in the city, about the incipient increase in the sex ratio at birth in Karachi. Findings highlight that providers, ranging from mid-level providers to obstetrician-gynaecologists, were largely unaware of the emergence of an unbalanced sex ratio at birth in Karachi. Nevertheless, they confirmed that preconditions for skewing of sex ratios did indeed prevail in Karachi. For example, they acknowledged the persistence of son preference and observed that women who had sons were better treated than those who had only daughters, and emphasised the existence of a huge demand for the disclosure of the sex of the foetus, albeit largely for reasons that excluded gender-biased sex selection. Indeed, they emphasised that disclosure of the sex of the foetus was not against the law, but admitted that while abortion is legally restricted, laws are poorly enforced. Even so, most providers believed that sex-selective abortions were unlikely to be performed, because disclosure of the sex of the foetus via ultrasonography takes place only at 16–18 weeks and even though law enforcement is lacking, abortions at 16–18 weeks are almost impossible to obtain. At the same time, however, at least one of 15 providers was familiar with the practice of sex-selective abortion, and several reported that they were aware of providers and facilities that refused to reveal the sex of the foetus, suggesting again that the practice does take place. The authors conclude that there is indeed potential for increased resort to pregnancy termination following disclosure of a female foetus.

Findings from India and Nepal where disclosure of the sex of the foetus is legally restricted

Haryana, India: India has had a much longer history of skewed sex ratios at birth, a law that strongly prohibits gender-biased sex selection, and a more diverse set of interventions intended to restore balance in the sex ratio at birth. Although Haryana remains one of the worst affected states, over the decade 2001 to 2011, modest but noticeable improvements have taken place in the sex ratio at birth in some districts, such as Kurukshetra

(from 128.5 to 122.3), but not in others, such as Sonipat (from 124.2 to 124.1). Findings highlight that the small family norm is widespread, as is son preference; disclosure of the sex of the foetus, possibly under-reported, was acknowledged by small proportions of women, with more women experiencing their third pregnancy from Sonipat so reporting than their counterparts from Kurukshetra (6% versus 2%), and more women from Sonipat than Kurukshetra reporting that they or someone they knew had been told the sex of their foetus (23% versus 16%). While just 3–4 percent of women from both districts who had undergone an abortion reported that they had done so for sex-selective reasons, key informants, mainly health care providers and NGO programme implementers, from the two districts estimated that between one and fifty percent of pregnant women were likely to have done so.

In order to explore factors likely to have contributed to the improvement in the sex ratio at birth in Kurukshetra, we explored the extent to which differences emerged in terms of the spread of educational entitlements and conditional cash transfers for girls; implementation and awareness of the law on disclosure of the sex of the foetus and sex-selective abortion, and implementation of and exposure to communication, advocacy and community mobilisation activities. As far as educational entitlements and conditional cash transfers are concerned, similar proportions of women reported accessing school-related entitlements and enrolling their daughters in the *Ladli* Scheme, a conditional cash transfer scheme for girls. As in the case of the other three countries, however, programme implementers from public and NGO sectors from both districts, warned that while such schemes and educational entitlements would contribute to increased educational attainment and delayed marriage among girls, it may not, at least in the near future, affect son preference or gender-biased sex selection. With regard to the implementation of the PCPNDT Act also, interdistrict differences were not observed; relatively few women had heard about doctors being prosecuted or clinics closed (41–42%) or had heard about raids (21–26%) taking place in their district. Key informants from all three categories and from both districts not only described such measures taken to implement the Act as inspections and raids, maintenance of detailed records of women and tracking of pregnant women, prosecution of violators, suspension of licences, sealing of equipment and facilities, and imposition of fines, but also described such challenges as the absence of prosecution, in fact, of women and families who, in seeking disclosure of foetal sex, violated the Act just as did service providers (reported by health care providers and a few public sector programme implementers); excessive paperwork and harassment of honest providers (reported by health care providers); poorly-trained law enforcement officials, and the undue burden placed on state and district health authorities to implement the Act (reported by public sector programme implementers), and interference by political leaders and other influential individuals to protect certain providers (reported by all three categories of key informants, but mainly public sector and NGO programme implementers).

Interdistrict differences were more pronounced in the case of communication, advocacy and community mobilisation. More women from Kurukshetra than Sonipat were aware of the Act, although similar and large proportions had been exposed to messages about the prohibition of the disclosure of the sex of the foetus and about raising the status of girls. Notably, far more women from Kurukshetra than Sonipat had been exposed to interpersonal communication, for example, counselling by a frontline health worker (31% versus 23%) and discourses by religious leaders discouraging gender-biased sex selection (20% versus 14%). Moreover, interviews with public sector programme implementers revealed the far greater involvement of the public sector in communication, advocacy and community mobilisation activities in Kurukshetra than in Sonipat. Indeed, in Kurukshetra, public sector programme implementers held weekly *Night Halt* or *Open Durbar* programmes at village level, and made monthly visits to schools and colleges where oath-taking ceremonies were undertaken to build commitment among students and teachers about gender equity and desisting from gender-biased sex selection.

In addition, some key informants, raised two additional factors they believed accounted for differences between the two districts: Sonipat's greater proximity to Delhi and Uttar Pradesh, where, they believed gender-biased sex selection was more freely available than in Haryana, reported mainly by health care providers and public sector programme officials, and the dominant caste composition of the two districts, with a concentration of more gender inequalitarian castes in Sonipat than Kurukshetra, reported by a few public sector programme implementers. We emphasise that both of these factors reflect the perceptions of certain key informants, and others have dispelled these opinions, noting for example that mere geographic distance cannot inhibit a determined woman from accessing services, and that there is a danger in stereotyping castes as gender inequalitarian.

Nepal: Kaski and Tanahun districts were selected for the case study based on their differing child sex ratios (114 and 102 males per 100 females, respectively, and identified in this report as districts with a skewed and normal sex ratio at birth, respectively). Findings highlight that son preference is widespread, and, perhaps most revealing,

that disclosure of the sex of the foetus was reported by more than one in four women who had given birth in the five years preceding the survey, despite laws prohibiting such disclosure. Districtwise differences in both indicators were evident: the importance of at least one son was far more likely to be articulated by women from Kaski, the district with a skewed sex ratio at birth than Tanahun, the comparison district, and more women from Kaski than Tanahun (37% versus 27%) reported that they had been told the sex of their foetus. Besides, proportions reporting being so informed, increased systematically with parity, and in Kaski, in particular, disclosure was greater if the previous child was female than if it were male. Finally, far more women from Kaski than Tanahun reported that they themselves or someone they knew had experienced a sex-selective abortion (31% versus 15%).

In order to explore factors underlying districtwise differences in these practices, researchers explored the extent to which differences emerged in terms of the spread of educational entitlements and cash transfers for girls; access to communication, advocacy and community mobilisation efforts, and implementation and awareness of the law on disclosure of the sex of the foetus and sex-selective abortion, as well as certain sociocultural factors that set each district apart. Findings suggest that school-based entitlements, including scholarships were accessed in both districts but significantly more so in Tanahun than Kaski (37% versus 25% of women with eligible daughters); as in Bangladesh, programme implementers noted that while educational entitlements played a powerful role in empowering girls and reducing child marriage, they were unlikely to affect the desire for at least one son among parents. As far as the implementation of laws was concerned, programme implementers were more likely than health care providers to report awareness of law enforcement activities; findings suggest that the law was rarely enforced, neither inspections nor raids had taken place anywhere, and corruption was observed in both districts. Even so, programme implementers from Tanahun were somewhat more likely than those in Kaski to report that district public health staff played an active role in law enforcement and monitoring of facilities. Finally, communication, advocacy and community mobilisation activities focusing on raising the value of girls, were prevalent in both districts, and while differences were largely narrow, women from Kaski were more likely to have been exposed to media messages, and those from Tanahun to interpersonal communication delivered by frontline health workers, NGO programmes and religious leaders.

In short, while differences between the two districts were relatively mild, laws appeared to be better implemented, educational entitlements for girls better utilised, and exposure to interpersonal communication was more evident in Tanahun than Kaski. At the same time, the role of structural factors cannot be ignored. For example, key informants raised such issues as differences in prevailing caste compositions, with those in Kaski maintaining a stronger preference for sons than those in Tanahun; some also highlighted that the stronger son preference displayed by women from Kaski was linked to parents' aspirations for upward mobility, notably via the employment of sons in the British Army. Most evident were differences in such structural factors as poverty levels; the availability of ultrasonography facilities, equipment and trained personnel, and distances to available facilities, with Tanahun far more disadvantaged on all of these factors than Kaski. These findings clearly point to the potential for the spread of gender-biased sex selection, once services are more easily and cheaply available.

Lessons learned and the way forward

The findings of our studies are by no means conclusive, but provide a range of insights into both the potential for change in sex ratios at birth and among children on the one hand, and what works to improve these ratios, on the other.

For one, our findings have stressed that disclosure of the sex of the foetus does take place in all four countries. The practice appears to have little effect at present on the subsequent termination of pregnancies carrying a female foetus in Bangladesh and Pakistan, where disclosure of foetal sex is not against the law. While fewer women in India and Nepal, where it is prohibited by law, reported such disclosure, the practice was revealed by considerably more women in Nepal where it has become prevalent, particularly in the district in which the sex ratio at birth is unbalanced (Kaski), but also in the district in which the sex ratio at birth is currently unaffected (Tanahun), suggesting that no district of Nepal is immune from the risk of a worsening of sex ratios at birth, and reflecting, perhaps, the effect of the concerted efforts made in Haryana to halt the practice, and the relatively limited priority accorded to the skewing of sex ratios at birth in Nepal.

Second, findings from Bangladesh, Nepal and even Pakistan, highlight that the potential for greater resort to gender-biased sex selection and sex-selective abortion does exist, given persistent son preference and poor implementation of laws intended to prevent such practices. Indeed, as likely in Nepal, it may be structural

factors—poverty, lack of access to diagnostic facilities—that have impeded access to gender-biased sex selection in districts in which sex ratios are currently balanced, rather than specific efforts to ensure that the practice is not undertaken. As such, with the proliferation of diagnostic centres and better-trained providers, the likelihood of the practice of disclosure of the sex of the foetus and subsequent sex-selective abortion may increase even in poorer districts, as witnessed historically in Haryana and other parts of India, unless balancing measures are put in place.

With regard to what works, findings have shown that the full array of interventions—implementation of laws, provision of educational entitlements and conditional cash transfers for girls, and communication, advocacy and community mobilisation efforts to change gender inequalitarian norms and discourage gender-biased sex selection—was implemented only in Haryana. Even so, some commonalities were observed. For example, key informants (largely programme implementers) expressed a belief that while educational entitlements (Nepal) and both educational entitlements and conditional cash transfer programmes (Bangladesh and India; conditional cash transfer programmes are not implemented in Nepal) for girls were effective in enhancing girls' access to education and delaying their marriage, they were unlikely to influence the willingness of parents to have a (higher order) daughter or an only-daughter family in the short run, although their longer term impact should not be discounted. Findings from Nepal and Haryana, India, have also indicated the huge challenges that prevail in implementing their respective laws prohibiting disclosure of foetal sex.

Perhaps the most promising programme-related finding, observed consistently in both Haryana, India, and Nepal, is the importance of communication, advocacy and community mobilisation efforts. Evidence from Nepal highlights the role of interpersonal communication delivered by frontline health workers, NGO programmes and religious leaders that focused on raising the status of girls. From Haryana, India, the evidence is even stronger: interpersonal communication by frontline health workers, exposure to discourses by religious leaders, regular efforts made by public sector programme implementers to connect with communities at the village level as also with schools and colleges, on a regular basis, to change gendered norms and attitudes and raise awareness about the law, clearly distinguished the district in which improvement in the sex ratio at birth was observed from the one in which no such change was evident. Our findings, thus, offer tentative support to the conclusion that while educational entitlements for girls and implementation of the law are important, concerted efforts towards communication, advocacy and community mobilisation are essential to transform gender norms and discourage gender-biased sex selection.

Chapter 1

Introduction

Rationale

South Asia has long been characterised by wide gender disparities and a strong preference for sons, often manifested in terms of the greater investment in the health, nutrition and education of sons over daughters. In several settings, these gender disparities have resulted in a skewing of population and child sex ratios, typically the number of males per 100 females. Since the 1980s, however, the increasing availability of prenatal diagnostic technologies has facilitated an increase in the occurrence of gender-biased sex selection. As a result, sex ratios at birth have become skewed, far beyond the normal ratio of 105 male births per 100 female births. The sex ratio at birth in Bangladesh and Pakistan, thus far, has been normal at country level (103 and 102.5 males per 100 females, respectively), but has become slightly skewed in some settings (National Institute of Population Research and Training (NIPORT), Mitra and Associates and ICF International, 2013, and National Institute of Population Studies and ICF International, 2013, respectively). Nepal is showing signs of disturbed sex ratios at birth at sub-national level, with a sex ratio at birth of 106 males per 100 females (Central Bureau of Statistics, 2012). The situation in India is, however, particularly adverse. India's sex ratio at birth today, stands at 110 male births per 100 female births (or 908 female births per 1,000 male births, the indicator more typically used in the country) (Office of the Registrar General, India, 2013).

In all four of these South Asian countries, moreover, preconditions for a deterioration of the sex ratio at birth are evident (Guilmoto, 2011): preferences are expressed for small families, patriarchal social norms persist and societies tend to be gender-stratified with strong preferences for at least one son, and prenatal diagnostic techniques are widely available and used to monitor foetal development. However, some critical differences are evident: for example, while India and Nepal legally prohibit the disclosure of the sex of the foetus to guard against subsequent termination of pregnancies carrying a female foetus, Bangladesh and Pakistan have no such restrictions. Laws relating to termination of pregnancies, in general, also differ from relatively restricted in Pakistan to permitted under a host of conditions in India and Nepal, and permitted as menstrual regulation up to 10 weeks of gestation, and somewhat restricted thereafter, in Bangladesh.

Patterns of within-country sex ratios at birth also differ across the four countries, including in Bangladesh and Pakistan, where overall sex ratios at birth remain normal. In Bangladesh, for example, skewed sex ratios at birth are observed in eastern/central regions and normal ones in the neighbouring western region (National Institute of Population Research and Training (NIPORT), Mitra and Associates and ICF International, 2013). In Pakistan, too, there are some settings in which adverse sex ratios at birth are evident; for example, Sindh has a higher than normal sex ratio at birth (National Institute of Population Studies and ICF International, 2013) and there is concern that adverse sex ratios at birth are also evident in some urban pockets. In Nepal, where skewed sex ratios at birth are not yet noticeable at the national level, sub-national differences, that is, at district level, are observed particularly in some districts in the Terai and hill regions (Central Bureau of Statistics, 2012). In India, which has had a far longer history of skewed sex ratios at birth, statewide differences are wide, ranging for example, from 103.5 in Kerala to above 118 males per 100 females in some states in the northwest, by 2002–04. Also notable in districts with particularly adverse sex ratios at birth and among children in the early 2000s, is evidence of improvements in the sex ratio at birth by 2011 in some districts of this region but not in others (Office of the Registrar General, India, 2013).

Programme responses to adverse sex ratios at birth and among children also differ across countries. As observed in the successful example of South Korea, it was a combination of enforcement of laws prohibiting gender-biased sex selection, the provision of educational entitlements and cash transfers for girls, and a strong community mobilisation programme intended to change norms about son preference and raise awareness about the law and the prohibition of gender-biased sex selection that was responsible for the rapid normalisation of the sex ratio at birth (Kim, 2013). Of the four countries, it is in India where this multi-pronged response has been most concentrated—through the implementation of laws, as well as through programmes intended to build gender equity and raise the value of the girl child through educational entitlements and cash transfers, and efforts to raise awareness and mobilise communities

to both change norms related to son preference and understand the dimensions of the law prohibiting disclosure of the sex of the foetus and subsequent termination of pregnancies carrying a female foetus. In the other three countries, the emphasis has been on efforts to build gender equity and raise the value of girls through a diverse set of educational entitlements, cash transfers and employment opportunities; in these settings, efforts to reduce gender-biased sex selection, more specifically, are not present.

These widely differing scenarios raise different research questions for each setting. For example, what accounts for the districtwise differences in the sex ratio at birth and among children in some districts of Bangladesh and Nepal, respectively, but not in neighbouring districts? Why are skewed sex ratios at birth appearing in some large urban pockets in Pakistan, in which the sex ratio is, overall, balanced? What accounted for the improvement in the very adverse sex ratio at birth in some districts in north-western India relative to the continued adverse ratios in neighbouring districts? Our limited knowledge of the answers to these questions poses a key challenge to our understanding of promising approaches to halting or reversing trends in adverse sex ratios at birth in the region, and informs the design of effective programme strategies.

Recognising these gaps in understanding, and with support from UKAid, the Population Council's Bangladesh, India and Pakistan offices, and the Centre for Research, Environment, Health and Population Activities (CREHPA), Nepal, led by the Council's India office, undertook research that aimed to shed light on the issue of gender-biased sex selection in these countries and make evidence-based recommendations that hold promise for responding to adverse sex ratios at birth in these settings. The project was implemented in two phases: an initial phase in which researchers reviewed and synthesised the available evidence on the situation and available programmes to counter gender-biased sex selection, and identified key research topics; and a more recent primary research phase in which researchers conducted case studies that explored key emerging questions in each setting. Specific aims of the primary research component emerged from each country's synthesis of its own situation; a single research question across all four countries was not possible, given the wide differences in context described above. As such, specific objectives differed across countries:

- In Bangladesh, the objective was to explore programme and sociocultural factors underlying district-level differences in the sex ratio at birth, by comparing the situation in one district with a high sex ratio at birth (Comilla) with that of a district with a normal sex ratio at birth (Rangpur).
- In Pakistan, where evidence is extremely sparse, to explore provider perspectives about the practice of gender-biased sex selection in urban pockets of Karachi.
- In India, to compare, in two settings of Haryana, a state with extremely adverse sex ratios at birth and among children, the programme and sociocultural factors underlying improvements in the sex ratio at birth in one district (Kurukshetra) from very adverse to somewhat less adverse levels in the 2001–2011 period, with a district in which the sex ratio at birth remained stagnant over the decade (Sonipat).
- In Nepal, the objective was to explore programme and sociocultural factors underlying district-level differences in the sex ratio at birth and the child sex ratio, by comparing the situation in one district with a high child sex ratio (Kaski) with a second reporting a normal sex ratio (Tanahun). We note that as data on sex ratios at birth are unavailable in Nepal, and as the child sex ratio i.e., the sex ratio of the population aged 0–4 years reflects, to a considerable extent, the sex ratio at birth, we used the child sex ratio as our indicator to identify districts with low and high sex ratios at birth. Hence, in this report, we identify Kaski as the district with an adverse sex ratio at birth, and Tanahun as the district with a normal sex ratio at birth.

Where possible, primary research has explored the extent to which three types of programmatic interventions—law enforcement; communication, advocacy and community mobilisation efforts, and the provision of educational entitlements and conditional cash transfer programmes for girls—have been implemented in each district, and the extent to which these interventions may have contributed to the different levels of sex ratios at birth in the comparison districts of each country.

This report synthesises and summarises the findings of the primary research conducted in each country; individual country reports present country-specific findings in greater detail (Jejeebhoy et al., 2015, Talukder et al., 2015, Puri and Tamang, 2015 and Sathar et al., 2015). Given these differences in the legal environment, in this report, we have ordered our discussion to focus first on the situation in settings in which disclosure is legally permitted (Bangladesh and Pakistan) and subsequently on those in which it is legally prohibited (India and Nepal).

Project settings

In Bangladesh, the two districts were purposively selected to represent one district in which ratios at birth/among children are skewed, namely Comilla, where the sex ratio at birth is 117 and among children is 112 males per 100 females, and a second district that is sociodemographically similar to the first, but in which these ratios are normal, namely Rangpur, where the sex ratio at birth is 105 and among children is 104 males per 100 females.

In Pakistan, the city of Karachi, capital of Sindh province, was selected as urban Sindh has a slightly skewed sex ratio at birth of 107.5 males per 100 females, and is more advanced in its fertility transition than the rest of the country.

In India, two districts from the state of Haryana were purposively selected, in which particularly adverse sex ratios at birth and among children in 2001 (124–129 and 127–130 males per 100 females, respectively) had been observed, one of which—Kurukshehra—experienced some improvement by 2011 (a sex ratio at birth of 122.3, and among children of 122.2 males per 100 females in 2011), and a second district—Sonipat—sociodemographically similar to the first, which continued to display highly unbalanced ratios (a sex ratio at birth of 124.1 and among children of 125.3 males per 100 females, in 2011).

In Nepal, the two purposively selected districts were Kaski with a child sex ratio of 113.9 males per 100 females aged 0–4, representing the district with a skewed sex ratio, and Tanahun, with a child sex ratio of 102 males per 100 females, representing the district with a normal sex ratio, and identified in this report as districts with a skewed and normal sex ratio at birth, respectively.

The case studies were conducted in both rural and urban areas of the selected districts. This report, however, integrates and encapsulates the findings of the combined sample of the district; individual country reports present findings, including rural-urban differences, in greater detail.

Sociodemographic profiles of study settings

We provide below available district-level data from each case study site, acknowledging that in some settings, district-level data are not available for all indicators.

In Bangladesh, Comilla district is one of 16 districts in the eastern region of the country, while Rangpur is one of the 26 districts in the western region; Table 1.1 presents the sociodemographic profile of these two settings of the case study along with the national profile (Bangladesh). Population sizes differed, and ranged, according to the 2011 Census, from 5,387,288 in Comilla, to 2,881,086 in Rangpur. Even so, the urban area of Comilla is much smaller than that of Rangpur: while Comilla town contains a population of 168,378, spread over an area of 12 square

Table 1.1: Sociodemographic profile of selected study districts and Bangladesh

Indicator	Bangladesh	Comilla	Rangpur
Population (2011)	149,772,364	5,387,288	2,881,086
Number of sub-districts	492	16	8
Number of unions (lowest level administrative unit with an approximate population of 30,000)	4,501	184	84
Number of villages	87,310	3,687	1,519
Population in urban areas	42,725,450	168,378	251,699
Number of women in the reproductive ages	36,960,144	1,340,514	755,024
Population density (per km ²)	1,015	1,700	1,200
Female literacy (%)	49.4	59	51
Male literacy (%)	54.1	63	57
Households with access to piped water (%)	8.1	4.6	<1
Contraceptive Acceptance Rate (CAR)*	80.0	76.5	77.1
Total Fertility Rate (2011)**	2.3	2.4	2.1

Source: Bangladesh Bureau of Statistics, 2011; *Ministry of Health and Family Welfare, Bangladesh, 2014; **(National Institute of Population Research and Training (NIPORT), Mitra and Associates and ICF International, 2013.

kilometres and 18 wards, divided into 46 *mahallas*, the urban area of Rangpur contains a population of 251,699, residing in an area of 43 square kilometres, divided into 33 wards and 203 *mahallas*. Density thus ranged from a high of 1,700 per square kilometre in Comilla to a low of 1,200 in Rangpur. Literacy rates were somewhat higher in Comilla than Rangpur, and gender differences were mild in both districts (59–63% in Comilla, 51–57% in Rangpur). Availability of piped water is very limited in both settings (0–5%) (Bangladesh Bureau of Statistics, 2011). Of relevance to our case study, each district contains one public university and several medical colleges.

In Pakistan, Karachi was selected for the case study. Karachi is a major metropolis, the capital of Sindh province, and has an estimated population of about 15 million. It comprises 19 townships and six districts. As seen in Table 1.2, which depicts the sociodemographic profile of Karachi, the fertility rate of Major Urban Sindh* is 2.6, a rate much lower than the national average, and the contraceptive prevalence rate is 45 percent. About 40 percent of women have a secondary or higher education, almost all homes have electricity, and about 90 percent have piped water at home. Probably the best of service delivery settings in Pakistan, it was relatively easy to find a range of female health care providers.

Table 1.2: Sociodemographic profile of Karachi, Pakistan, 2012–13

Indicator	
Urban population (%)	96.3
Average household size	5.2
Net Enrollment Rate (Primary) (%)	
Total	62
Male	61
Female	61
Net Enrollment Rate (Middle) (%)	
Overall	25
Male	21
Female	28
Net Enrollment Rate (High) (%)	
Overall	15
Male	13
Female	17
Literacy—Population 10 years and older (%)	
Overall	82
Male	77
Female	86
Households with tap water as source of drinking (%)	86
Households using a flush toilet (%)	97
Households with electricity (%)	98
Current use of contraception, female (any method)*	45.4
Current use of contraception, female (modern method)*	33.4
Total Fertility rate (TFR)—Major Urban Sindh*	2.6

Source: Pakistan Bureau of Statistics, 2013; (Pakistan Social and Living Standards Measurement Survey, 2012–13); *National Institute of Population Studies, Pakistan, and ICF International, 2013.

* Estimates for Major Urban Sindh are cited from the *Pakistan Social and Living Standards Measurement Survey*, National Bureau of Statistics, 2013, and *Pakistan Demographic and Health survey (PDHS)*, National Institute of Population Studies, Pakistan, and ICF International, 2013. These estimates are closest to those available for Karachi; PDHS estimates are representative only of provincial and urban/rural areas and not districts.

In India, selection criteria were somewhat different from those used for the selection of districts in Bangladesh and Nepal. In India, the objective was to compare two districts with particularly adverse sex ratios at birth and among children in 2001, one of which experienced some improvement by 2011 and a second in which ratios remained highly unbalanced. Hence, we purposively selected districts that (a) belong to the same state and have largely similar sociocultural characteristics (percentage residing in urban areas, percentage of females who are literate, percentage of the population from socially excluded castes, percentage of the population that is Hindu, and percentage of the working population engaged in cultivation); (b) had similarly adverse sex ratios at birth and among children in 2001 (approximately 125 males per 100 females or worse); and (c) differed on the basis of ratios in 2011, with one district (Kurukshehra) showing some improvement (at least 5–6 points) and the other (Sonipat) showing hardly any change. Table 1.2 presents the sociodemographic profile of the selected study sites and Haryana State, India. As evident from Table 1.2, the two districts are roughly similar in terms of available sociocultural characteristics and, by and large, resemble state averages on these indicators. For example, 29 percent and 31 per cent of the population of Kurukshehra and Sonipat, respectively, live in urban areas compared to 35 percent in Haryana as a whole (Office of the Registrar General, India, 2011). Sonipat and Kurukshehra (with a population of nearly 1.5 and 1 million, respectively), comprise, respectively, six percent and four percent of Haryana’s total population. The female literacy rate was 67 percent in Haryana as a whole, and 71 percent and 69 percent, respectively, in Sonipat and Kurukshehra. Proportions belonging to socially excluded castes, and proportions of the working populations classified as cultivators were also similar.

Table 1.3: Sociodemographic profile of selected study districts and Haryana State, India

Indicator	Haryana	Sonipat	Kurukshehra
Population (2011) ^a	25,351,462	1,450,001	964,655
Population in urban areas ^a (%)	34.8	31.2	29.0
Female literacy ^a	65.9	69.8	68.8
Population belonging to scheduled castes ^a (%)	20.2	18.6	22.3
Population that is Hindu ^c (%)	87.1	94.0	79.7
Working population engaged in cultivation ^b (%)	27.8	27.2	20.5
Total Fertility Rate ^d (2011)	2.7	2.7	2.3

Note: ^aOffice of Registrar General and Census Commissioner, India, n.d.; ^bOffice of Registrar General and Census Commissioner, India, 2004; ^cCalculated from district-level microdata of District Level Household Survey (International Institute for Population Sciences, 2010); ^dGuilmoto and Rajan, 2013.

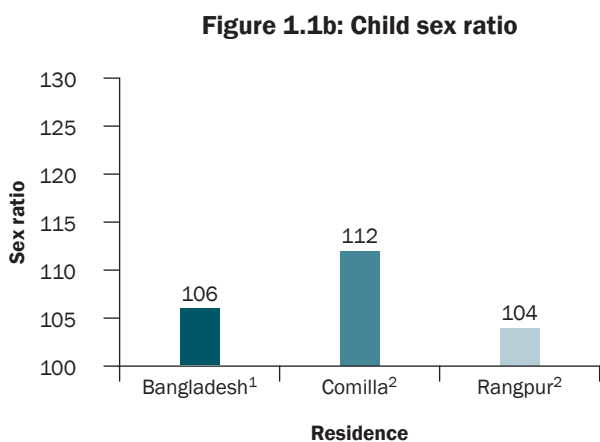
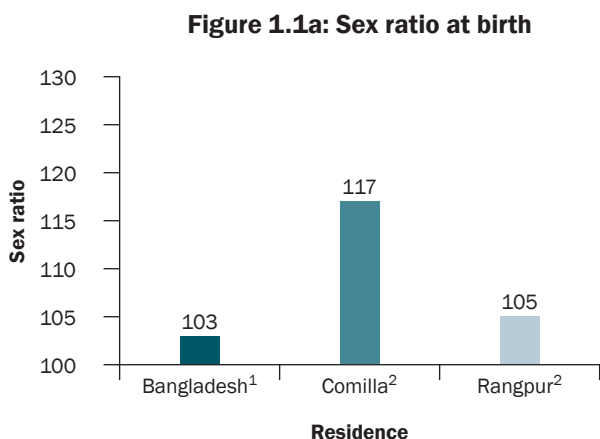
In Nepal, Kaski district covers an area of 2,017 square kilometres with a population of 492,098 in 2011, and Tanahun covers an area of 1,546 square kilometres, containing a population of 322,288; Table 1.3 presents the sociodemographic profile of the two study districts and that of the country as a whole. Kaski district has two municipalities and 43 Village Development Committees, while Tanahun has one municipality and 46 Village Development Committees. The Human Development Index ranged from 0.576 in Kaski to 0.506 in Tanahun in 2013. Ethnic profiles were largely similar, with major ethnic groups comprising Brahmins, Gurungs, Chhetris and Magars in both districts, and additionally, Newars in Tanahun.

Table 1.4: Sociodemographic profile of selected study districts and Nepal

Indicator	Nepal	Kaski	Tanahun
Population (2011)	26,494,504	492,098	322,288
Number of municipalities (2011)	58	2	1
Number of Village Development Committees	3,915	43	46
Human Development Index (HDI) (2013)	138	0.576	0.506
Major ethnic groups	Chhetri, Brahmin, Magar, Tharu and Tamang	Brahmins, Gurungs, Chhetris, Magars	Brahmins, Gurungs, Chhetris, Magars and Newars
Total Fertility Rate (2011)	2.6	NA	NA

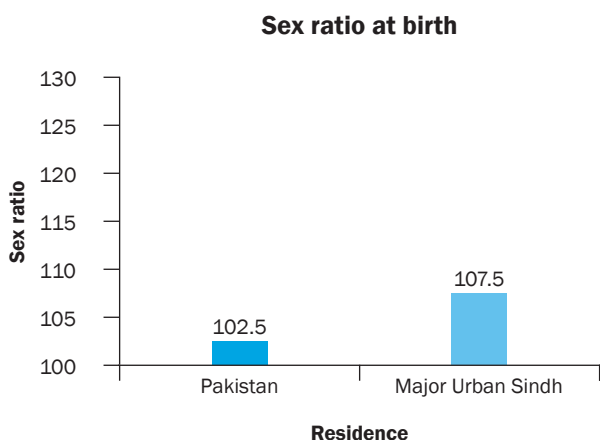
Source: Central Bureau of Statistics, Nepal, 2012; Government of Nepal (National Planning Commission) and UNDP, 2014.

Figure 1.1: Sex ratio at birth and among children in Bangladesh, and Comilla and Rangpur districts, 2010–2013



Source: ¹National Institute of Population Research and Training (NIPORT), Mitra and Associates and ICF International, 2013; ²UNICEF, 2011.

Figure 1.2: Sex ratio at birth in Pakistan and Major Urban Sindh, 2010–2013



Source: National Institute of Population Studies, Pakistan, and ICF International, 2013.

Sociocultural and legal context

Study settings in all four countries are characterised by patriarchal norms, limited female agency and a strong preference for sons. At the same time, as seen in Tables 1.1 to 1.4, fertility levels fall within a narrow band (the total fertility rate ranged from 2.1 to 2.7) and the small family norm is fairly well established in all four settings.

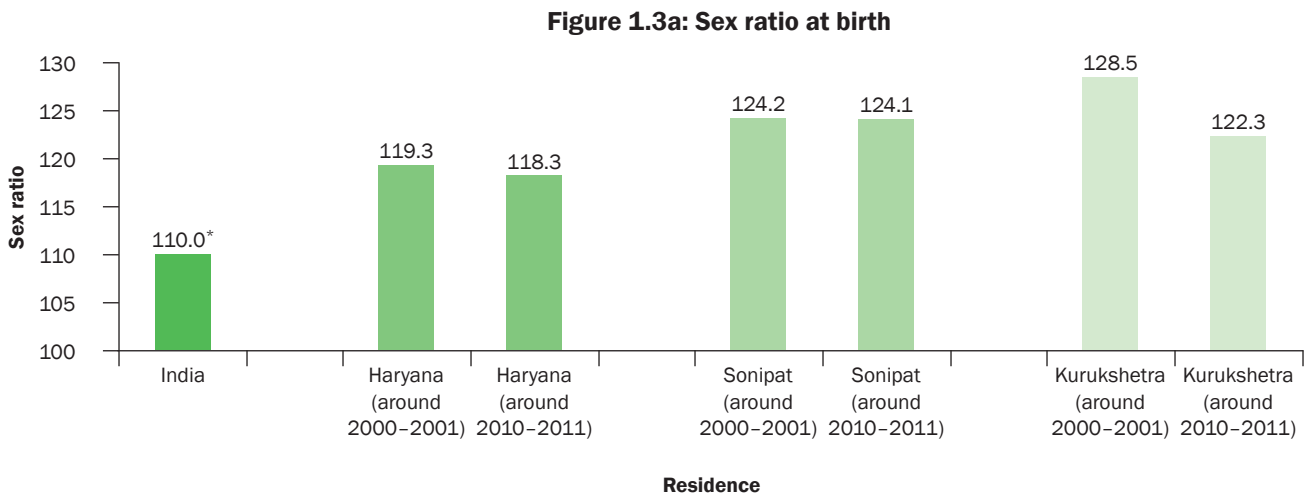
Differences are, however, substantial in the areas of sex ratios at birth and among children. As compared with a ‘normal’ sex ratio at birth of around 105 males per 100 females, the sex ratio at birth and indeed, among children, varied considerably over the selected districts in Bangladesh, Pakistan, India and Nepal as evident from Figure 1.1a (Bangladesh), Figure 1.2 (Pakistan) and Figure 1.3a (India); in Nepal (Figure 1.4), the child sex ratio, which, as mentioned earlier, is used as our indicator of the sex ratio at birth, showed a similar pattern. At country level, India has had a longer history of skewed sex ratios at birth than the other countries; its ratios remain particularly skewed (109–110), especially in its north-western states; for example, it was 118–119 males per 100 females in Haryana (Figure 1.3a). The child sex ratio showed signs of distortion in Nepal (106 males per 100 females) (Figure 1.4), but the sex ratio at birth was fairly balanced in Bangladesh and Pakistan—103 males per 100 females in both settings (Figures 1.1a and 1.2, respectively), although there was considerable within-country variation. Child sex ratios showed similar variation (Figures 1.1b, 1.3b and 1.4).

Given our district selection criteria, wide differences were observed in Bangladesh and Nepal, in the sex ratios at birth and among children; indeed, there was an approximately 8–12 point difference in the sex ratios at birth and among children (Bangladesh; Figures 1.1a and 1.1b, respectively) and among children (Nepal; Figure 1.4) between districts with high and normal ratios. In Pakistan, the sex ratio at birth in Major Urban Sindh was five points higher than the sex ratio at birth recorded for the country as a whole (Figure 1.2). In Haryana, India, while sex ratios remained unchanged in Sonipat between the early and late 2000s, they declined by 6–8 points in Kurukshetra over the same period; however, in 2011, there was just a two to three point difference in the sex ratios at birth and among children (Figures 1.3a and 1.3b, respectively).

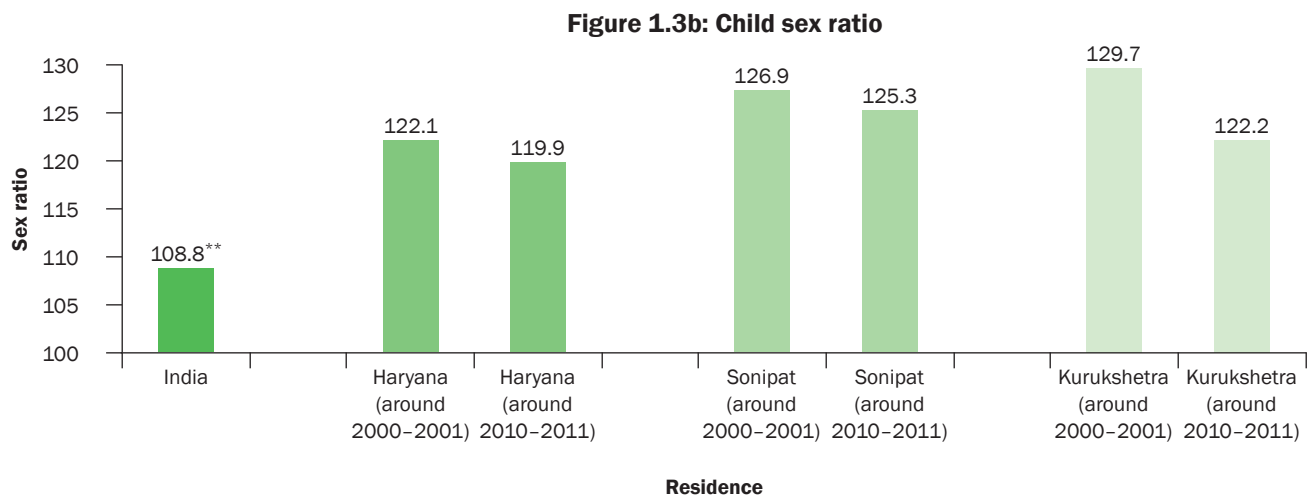
Differences were also evident with regard to the law, as summarised in Table 5.1.

With regard to disclosure of the sex of the foetus and women’s right to abortion, however, the four countries diverge considerably as shown in Table 1.5 which summarises the legal situation in these countries in respect of sex selection and abortion. For example, with regard to disclosure of the sex of the foetus:

Figure 1.3: Sex ratios at birth and among children in India, Haryana State, and Sonipat and Kurukshetra districts, 2010–2013



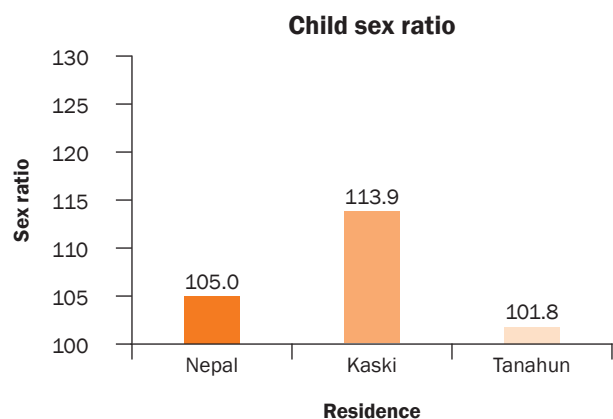
Source: Office of the Registrar General, India, 2013; *908 female births/1,000 male births.



Source: Office of the Registrar General of India, 2011; **919 female births/1,000 male births.

- There are no laws in Bangladesh and Pakistan that prohibit health care providers from disclosing the sex of the foetus to pregnant women.
- Although Nepal does not have a separate law regarding the use of preconception and prenatal diagnostic techniques to disclose the sex of the foetus, the abortion law contains a clause that restricts the use of technology or any means to determine the sex of a foetus for the purpose of sex-selective abortion, and punishes both those who disclose the sex of the foetus and those to whom it is disclosed.
- It is only in India that there is a special law, the Pre-Conception and Prenatal Diagnostic Techniques Act (PCPNDT) that prohibits disclosure of the sex of the foetus using any technique (including preconception)

Figure 1.4: Child sex ratio in Nepal, and Kaski and Tanahun districts, 2010–2013



Source: Central Bureau of Statistics, Nepal, 2012.

and permits law enforcement authorities to inspect and raid facilities, seal equipment and facilities, withdraw the licences of facilities and providers found to have violated the law, and prosecute and punish both those who disclose the sex of the foetus and those who seek disclosure.

Laws governing access to abortion in the four countries also vary (Table 1.5). For example:

- In Bangladesh, menstrual regulation (by vacuum aspiration, conducted to bring on menstruation and not as a method of pregnancy termination) is legally permitted within eight weeks of the last menstrual period by a paramedic and up to 10 weeks by a physician (Government of the People’s Republic of Bangladesh, 1979; 1980); beyond 10 weeks of gestation, abortion is legally permitted only to save the life of the mother.
- In Pakistan, abortion is permitted to save the life of the mother or in order to provide “necessary treatment”.
- India’s Medical Termination of Pregnancy Act permits abortion for a range of social and physical reasons, including contraceptive failure, mental and physical health of the mother, foetal complications and rape; termination of a pregnancy carrying a female foetus is, however, not permitted. Abortions are permitted up to 20 weeks of pregnancy and at any time during pregnancy to save a woman’s life, but must have the consent of two service providers if the pregnancy is more than 12 weeks.
- In Nepal, the amendment in the Country code (*Muluki Ain*), permits abortion up to 12 weeks of pregnancy on request, up to 18 weeks in the case of rape and incest, and at any time during pregnancy to save a woman’s life, if the physical and mental health of the mother is affected and in case of a foetal abnormality.

Table 1.5: Legal environment related to sex selection and abortion in Bangladesh, Pakistan, India and Nepal

Country	Law regarding sex-selective abortion	Legality of abortion
Bangladesh	No law	Restrictive abortion legislation. Since 1976, the Bangladesh National Population Policy attempted to legalise and liberalise the law on abortion within 10 weeks of gestation on vast medical and social grounds. ¹
Pakistan	No separate law	Abortion is permitted only to save the life of the mother and in order to provide “necessary treatment”. ²
India	Yes. Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act (the PNDT Act) implemented in 1996. The Act was amended in 2003 to both emphasise the “prohibition” of sex selection and to widen its scope to include preconception techniques. It was renamed the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) or PCPNDT Act. ³	Legal The Medical Termination of Pregnancy (MTP) Act of 1971 and the 2002 amendments to the Act. Pregnancies of up to 20 weeks may be terminated legally. ^{4,5}
Nepal	No separate law regarding preconception and prenatal diagnostic techniques but the 11th Amendment of <i>Muluki Ain</i> (Country Code) in 2002, which liberalised the old restrictive law on abortion, has a clause—Number 28A—which restricts the use of technology or any means to determine the sex of the foetus for the purpose of sex-selective abortion. ⁶	Legalised abortion in 2002. Induced abortion now permitted up to 12 weeks, and up to 18 weeks in cases of rape and incest. ⁶

¹Bangladesh Penal Code, 1860; ²Pakistan Penal Code, 1860; ³Ministry of Health and Family Welfare (MOHFW), 2003; ⁴Government of India, 1971; ⁵Government of India, 2003; ⁶Ministry of Health and Population, 2002.

Country-level efforts to address gender inequities and gender-biased sex selection also differ. As seen in Appendix Tables 1–4, the thrust of programme efforts are most wide-ranging in India, with other countries focused largely on reversing gender inequities and raising the status of the girl child.

Study design

As the earlier discussion has suggested, India has a longer history of adverse sex ratios at birth than have Bangladesh, Nepal and Pakistan, where adverse sex ratios have just started to emerge. As a result, a wider set of programmes—communication, advocacy and community mobilisation activities, law enforcement mechanisms, and educational entitlement programmes for girls specifically intended to stem gender-biased sex selection—has been in operation in India than in the other countries. Our design was therefore flexible, and researchers modified or omitted issues that were not relevant in their settings.

The case study adopted a mixed method approach, and included a survey of married women with at least two children, one of whom was aged 0–5 years; key informant interviews with health care providers, key informant interviews with public sector programme implementers and key informant interviews with NGO programme implementers. All four components of the study were implemented in Bangladesh, Nepal and India; however, as noted above, questions on certain issues that were not relevant in a particular country were not asked. In Pakistan, moreover, where skewed sex ratios are not really observed, and evidence is sparse, only one component—key informant interviews with health care providers—was fielded.

Survey of women with children aged up to five years: The study was conducted in rural and urban areas of the two selected districts of Bangladesh, India and Nepal, and focused on a total of 10 primary sampling units or PSUs (villages) in rural areas, and 10 primary sampling units (wards) in urban areas in each district. A retrospective study design was employed in which married women with at least two children, the youngest of whom was born in the preceding five years were interviewed.

Key informant interviews with health care providers: In all four countries, and in each selected district, a range of health care providers from the public and private sectors—obstetricians and gynaecologists, radiologists and others engaged in conducting ultrasound and other prenatal diagnostic techniques, and nurses and female paramedical health workers (Bangladesh)—were interviewed in depth in order to obtain their perspectives on the prevalence of gender-biased sex selection in their district.

Key informant interviews with public sector programme implementers/managers in government positions and from the NGO sector: Key informant interviews were also held with programme implementers/managers in the public and NGO sectors of the selected districts in Bangladesh, India and Nepal, and at central level (Bangladesh) and state level (India), more generally. Key informants included, from the public sector, those district authorities responsible for implementing the law, raising awareness, and, in Bangladesh and India, administering various educational entitlement and conditional cash transfer schemes in each district. They included, for example, staff responsible for administering the law (Nepal and India), those implementing programmes for women and girls, as well as various conditional cash transfer programmes and other educational entitlements for girls, and those working on community mobilisation activities to challenge traditional gender norms, son preference and gender-biased sex selection.

Also interviewed were programme implementers of NGOs in Bangladesh, India and Nepal, who were in charge of executing interventions relating to raising the status of women and girls, in general, and stopping gender-biased sex selection in particular, as well as those responsible for administering various educational entitlements and conditional cash transfer programmes for girls in the study districts.

Study samples and coverage

Samples for all three components of the case study were drawn from women and key informants residing in or responsible for delivering services in the selected study settings. Details are provided in Table 1.6.

Survey of women with at least two children, one of whom was aged 0–5 years: Our study design called for a sample of 1,000 (500 per district, 250 each from rural and urban areas) currently married women with two children, one of whom was aged 0–5 years. This number included inflation to take into account refusal to participate in the survey, which, together, we assumed to be 10 percent.

Ten villages and ten urban wards were selected in each district based on probability proportional to size (PPS) to represent the district at large. In each selected primary sampling unit (PSU), a household listing exercise was conducted that listed on average, 250 households in a village/urban ward; from this list, about 25–30 women were randomly selected for the interview. Details are provided in Table 1.6 and suggest high response rates. All women were interviewed in their home.

Table 1.6: Coverage of the study: Survey participants in Bangladesh, India and Nepal

Country and districts	Number of married women with at least two children, one of whom was aged 0–5 years		Response rate (%)
	Identified	Interviewed	
Bangladesh			
Total	1,100	1,037	94.3
Comilla	550	517	94.0
Rangpur	550	520	94.6
India			
Total	1,217	1,101	90.5
Sonipat	614	546	88.9
Kurukshetra	603	555	92.0
Nepal			
Total	1,064	1,000	94.0
Kaski	517	500	96.7
Tanahun	547	500	91.4

In the qualitative component of the study, as described in Table 1.7, we held interviews with a total of 44 key informants from the three groups in Bangladesh, 50 in India, and 29 in Nepal; in Pakistan, 15 health care providers were interviewed.

Key informant interviews with health care providers: In each site, reproductive health service providers, including nurses, female paramedics (in Bangladesh), Auxiliary Nurse Midwives (ANMs, in India), medical officers and obstetricians/gynaecologists, and those providing ultrasound and prenatal diagnostic services (technicians, radiologists) were identified. From amongst the health care providers thus identified, respondents for key informant interviews were selected purposively, ensuring that the array of provider types was included, and that those serving the villages and wards in which our survey was conducted were adequately represented. Key informant interviews were held with a total of 32 purposively selected health care providers from Bangladesh, 23 from India, 12 from Nepal, and 15 from Pakistan (Table 1.7).

Key informant interviews with programme implementers/managers in government positions: In Bangladesh, India and Nepal, in addition, we interviewed programme managers from various government sectors as relevant to each country. In Bangladesh, we interviewed a total of seven key informants selected purposively from among those identified to be responsible for the implementation of programmes for girls and women’s development programmes at district and national levels. District officials from India included those responsible for implementing the PCPNDT Act, those responsible for administering programmes for girls, and those working in the health and, women and child development sectors at the community level to change gender-biased norms and practices; in total, we conducted key informant interviews with 15 such programme implementers/managers selected purposively from amongst the programme implementers identified. In Nepal, district officials who were responsible for implementing programmes for girls and women, or engaged in health, education and development activities were similarly identified, and as above, from amongst those identified, 11 were selected purposively for key informant interviews. In all cases, care was taken to ensure that those implementing different programmes were included, and that those serving the villages and wards in which our survey was conducted were adequately represented.

Key informant interviews with programme implementers/managers of NGOs: We also sought to interview representatives of NGOs working on raising the status of women and girls or, more directly, on preventing gender-biased sex selection and the termination of pregnancies carrying a female foetus. A total of five, 12 and six such NGO programme implementers/managers were interviewed, respectively, from Bangladesh, India and Nepal, using the same selection criteria as described above for public sector programme implementers.

Table 1.7: Coverage of the study: Key informants, Bangladesh, Pakistan, India and Nepal

Key informants	Bangladesh ¹	Pakistan ²	India ³	Nepal ⁴
Health care providers	32	15	23	12
Public sector programme implementers/managers	7	-	15	11
NGO programme implementers/managers	5	-	12	6
Total	44	15	50	29

¹Bangladesh: Health care providers include obstetrician-gynaecologists; radiologists; mid-level providers, namely nurses, female paramedics (family welfare visitors), and those conducting ultrasound and other prenatal diagnostic techniques, menstrual regulation procedures and abortions; public sector programme implementers include district administrators responsible for implementing health and family planning programmes, and programmes for women and girls, including educational entitlements and conditional cash transfer schemes; NGO programme implementers include those working with NGOs engaged in local and national level communication, advocacy and community mobilisation programmes.

²Pakistan: Health care providers include general physicians, obstetrician-gynaecologists, radiologists and Lady Health Visitors (LHVs)/nurses.

³India: Health care providers include general physicians/MBBS doctors, obstetrician-gynaecologists, radiologists, nurses and Auxiliary Nurse Midwives; public sector programme implementers include all those interviewed from the Health Department, those serving in the judiciary and so on; we have clubbed these under law enforcement so as not to reveal identities: PO/CDPO (Programme Officer, Child Development Project Officer), ICDS (Integrated Child Development Services), and functionaries of the Integrated Child Protection Scheme (ICPS) and Department of Women and Child Development, implementing various programmes for women and girls; NGO programme implementers include those working with NGOs engaged in programmes for gender-biased sex selection issues, including raising the status of women and girls.

⁴Nepal: Health care providers include obstetrician-gynaecologists, radiologists and other abortion providers; public sector programme implementers include women's development officers, public health nurses, district education officers, and district police officers responsible for implementing various programmes for women and girls and enforcement of the law; I/NGO programme implementers include I/NGO representatives from I/NGOs working on/supporting programmes to raise the status of women and girls, abortion services and to prevent gender-biased sex selection.

Study instruments

A structured instrument was used to collect data from currently married women with two or more children, one of whom was aged 0–5 years. Key informant interview guidelines were used to interview health care providers and programme implementers/managers. A core of similar questions was posed in all countries; however, some questions (for example, law enforcement details) were not relevant in all countries, and others (relating to educational entitlements and/or conditional cash transfer programmes) that were specific to a particular setting were adapted or supplemented.

The survey questionnaire was designed to gather background information of the women as well as their birth and contraceptive histories, pregnancy loss and induced abortions in each birth interval, the wantedness of each birth and the use of ultrasound. Birth histories were ascertained, including the wantedness of each pregnancy, histories of terminations or pregnancy loss, and contraception between two births, use of ultrasound during pregnancy, and whether the sex of the foetus had been disclosed. Questions relating to whether the sex of the foetus was ever disclosed were asked for each pregnancy resulting in a live birth, as well as through a direct question about any experience of disclosure, and, at the end of the interview, an opportunity to respond anonymously, by ticking or crossing a card, placing the card in an envelope, sealing it and returning it to the interviewer. Direct questions about the experience of sex-selective abortions were also posed. A range of questions sought to assess preferences about family size and composition, attitudes relating to son preference or daughter aversion, and their gender role attitudes. Aside from these, a series of questions probed women's awareness of laws prohibiting disclosure of the sex of the foetus and attitudes about the effectiveness of the law (India and Nepal); their exposure to advocacy and community mobilisation efforts intended to change attitudes about sons and daughters, in general, and about the acceptability of gender-biased sex selection in particular; and awareness about programmes intended to raise the status of girls, and in Bangladesh and India, the extent to which daughters were enrolled in any conditional cash transfer programme.

Guidelines for key informant interviews with health care providers comprised a few introductory questions that established the respondent's background and the broad thematic areas to be covered. The topics covered included perceptions about the demand and supply side factors underlying the practice of gender-biased sex selection. We explored provider perspectives on gender-biased sex selection; perceptions about the antenatal care of pregnant women and routine use of prenatal tests; the extent of misuse of technology; provider-client interaction, including counselling and client attitudes and demands for information about the sex of the foetus and subsequent termination of pregnancies carrying a female foetus; provider attitudes about disclosing the sex of the foetus and/or knowingly conducting a sex-selective abortion; provider interaction with authorities with regard to probes into violations of the law and perceptions/experiences of monitoring of providers by authorities, as well as provider perspectives about the factors underlying (a) district-level differences in the sex ratio at birth in Bangladesh and Nepal; (b) the improved situation in Kurukshetra versus the persisting adverse situation in Sonipat, in Haryana, India; and (c) the more elevated sex ratio at birth in Karachi than in Pakistan as a whole. Key informants also offered their perceptions about the challenges inhibiting improvements in the sex ratio at birth, and their recommendations for strengthening action at community and provider or programme levels.

Guidelines for key informant interviews with programme implementers/managers from public and NGO sectors covered many issues that were identical to those included in the key informant interview guide for health care providers. Interviews with these key informants focused, as appropriate, on their own areas of experience—conducting community mobilisation activities, raising awareness of and sensitising communities to gender equality, programmes for girls' and women's development, the legality of abortion, implementing the law including conducting raids and dealing with law enforcement (India), and implementing programmes to raise the status of girls, including, in Bangladesh and India, managing educational entitlement and/or conditional cash transfer programmes for girls. Interviews also explored their perspectives about the implementation of laws, their views about the extent to which the practice of disclosing the sex of the foetus and terminating pregnancies carrying a female foetus persists in their district, and reasons for the differences in trends (India) in and levels of (Bangladesh and Nepal) the sex ratio at birth in the two districts under study in each country. The key informants were also probed in respect of their views about the extent to which educational entitlement and cash transfer programmes intended to empower girls, raise awareness and change behaviours had been successful in affecting parental preferences for sons and practices relating to gender-biased sex selection.

Study instruments were prepared in English, translated into country languages, and pre-tested. Key informant interviews were taped, transcribed and translated into English.

Data collection

Data collection for all three components of the case studies was conducted simultaneously and took place from September to December 2014.

Interviewers in each country underwent three to six days of training that comprised a combination of classroom sessions, mock interviews and field practice in rural and urban areas. Training focused on interviewing methods, the details of the questionnaire and research ethics including issues of confidentiality and privacy. Each team comprised one field editor who was responsible for field editing, back-checks and quality control of interviews; and one supervisor, responsible for the overall management of fieldwork and team-related logistics, as well as assisting in field editing and back-checking.

Principal investigators made frequent visits to monitor and supervise data collection operations. Each team filled quality control sheets regularly, giving the team, the coordinator and principal investigators a quick view of the quality of ongoing fieldwork. These quality control sheets were designed to provide information on response rates in each PSU covered, and track reporting of sensitive issues and interviewer performance.

Ethical considerations

We recognised that in both the survey and key informant interviews, serious ethical concerns could arise. First and foremost, we recognised that women may fear adverse repercussions if they disclosed experiences of gender-biased sex selection (India and Nepal), the experience of abortion (Pakistan), second-trimester abortion (Bangladesh) or sex-selective abortion. To allay these fears, we assured all respondents that all the data gathered were entirely

anonymous, that interviewers would not share their responses with anyone, including their family members, the authorities, or health care providers, and that names would never be recorded on the questionnaire. The following strategies were adopted, moreover, to maintain privacy and confidentiality.

The interviewers underwent extensive training in ethical issues. Emphasis was laid on explaining the content of the questionnaire, the respondent's right to refuse to participate or answer any question, and informed consent. At the same time, we trained interviewers on how to ask sensitive questions—regarding disclosure of the sex of the foetus, the experience of sex-selective abortion—in empathetic and non-judgemental ways, and emphasised the importance of offering to refer those in need to appropriate nearby organisations. Third, before entering a PSU, teams were instructed to apprise community leaders of the study and seek their support for its implementation in the community. This step ensured that community support was forthcoming and enabled team members to build rapport within the community easily. We note that despite the sensitive nature of the questions, not a single PSU refused permission to our teams on the grounds of study content.

Every effort was made to maintain privacy in the course of the interview. To ensure that interviews were not overheard by family members or others, interviewers conducted the interview in a separate room in the home, asked questions in whispers, or re-scheduled the interview so as to enable full confidentiality to the interview. Interviewers were permitted to skip to relatively non-sensitive sections in case the interview was observed by others. Each team was trained to assign one interviewer to conduct parallel discussion sessions with bystanders interested in listening to the interview, thereby providing privacy to the interview. Interviewers were instructed that if privacy could not be ensured, the interview must be terminated without asking sensitive questions. Notwithstanding these efforts, we acknowledge that some women who had been informed about the sex of their foetus or had terminated a pregnancy carrying a female foetus may not have reported these events accurately during the interview.

All the questionnaires were anonymous and names were never recorded on them. In order to preserve the confidentiality of the respondent, signing the consent form was optional; however, the interviewer was required to sign that she or he had explained the content of the consent form to the respondent. Consent forms were detached and stored separately from the questionnaires.

Finally, we also recognised the need for responding appropriately to requests from respondents for help or information related to harassment because they did not have a son, or because they had refused to undergo gender-biased sex selection or an abortion, or, in contrast, relating to their eligibility for, access to or difficulties in accessing the benefits of educational entitlement programmes for girls, and, in India, also conditional cash transfer programmes. Our field staff members were trained and equipped to refer such requests to local NGOs or concerned government authorities in the selected districts as appropriate.

Data management and analysis

Data management and analysis was undertaken at country level. All completed survey questionnaires were edited, both in the field and in each country team's office for omissions and consistency. Responses to open-ended questions were scrutinised and common responses were provided codes. Data were entered twice by different entry operators to minimise entry problems. The raw data were validated and cleaned to remove possible inconsistencies. The analysis of data was carried out using SPSS 18.0 or STATA 13.0. In each district, the sample was weighted to adjust for oversampling in urban areas and non-response rates.

For textual data, a coding scheme was developed. Coded blocks of text related to specific themes, for example, perceptions about the disclosure of the sex of the foetus in each district; about the extent to which the law was implemented and typical practices employed to enforce laws; about attitudes relating to whether laws and programmes, respectively, would affect gender-biased sex selection; the array of reasons offered for differences between the experiences of the two selected districts of Bangladesh, India and Nepal, and the situation in Karachi in particular; and recommendations for community-level and programme- or provider-level action.

Sociodemographic characteristics of women

Background characteristics of women in the two districts of each country are presented in Table 1.8. While inter-country differences were observed on several indicators (for example, religion and caste distributions, education, indicators of women's agency) more important for purposes of this study were intra-country differentials.

Districtwise differences differed by country: In Bangladesh, for example, there was a greater concentration of Muslims in Comilla than in Rangpur; in India and Nepal, the concentration of general castes was greater in Sonipat than in Kurukshetra in Haryana, India, and in Kaski compared to Tanahun in Nepal. Educational attainment levels also differed in each country, with those in the district in which the sex ratio at birth was particularly unbalanced exhibiting higher levels of attainment than the other district. Likewise, by and large, women's agency was more evident in the district with a more unbalanced sex ratio at birth than in the comparison district.

Table 1.8: Selected sociodemographic characteristics of women who participated in the survey by district, according to residence, Bangladesh, India and Nepal

Sociodemographic characteristics	Bangladesh		Haryana, India		Nepal	
	Comilla (N=517)	Rangpur (N=520)	Sonipat (N=546)	Kurukshetra (N=555)	Kaski (N=500)	Tanahun (N=500)
Age (years)						
18-19	1.0	0.8	0.9	0.2	1.0	0.6
20-24	20.7	23.5	21.8	21.8	18.2	22.0
25-29	43.7	44.0	45.9	41.8	41.2	36.8
30-34	24.8	23.1	23.9	29.5	27.8	25.6
35 and over	9.8	8.7	7.5	6.7	11.8	15.0
Mean age in years	28.0	27.9	27.9	28.1	28.6	28.8
Religion				***		
Hindu	4.1	9.2	96.1	93.7	85.0	89.6
Muslim	95.9	90.8	3.1	1.3	3.4	0.6
Others (Christian, Sikh, Buddhist or Jain)	—	—	0.7	5.0	11.6 [†]	9.8 ^{††}
Caste/ethnicity				***		
SC/ST ^a (India)/Dalit, disadvantaged indigenous group (Nepal)	—	—	24.8	22.5	38.4	50.8
OBC (India)/Religious minority, disadvantaged non-Dalit Terai caste group and relatively advantaged indigenous group (Nepal)	—	—	28.3	41.1	18.2	21.2
General/Upper Caste groups (Nepal)	—	—	47.0	36.4	43.4	28.0
Years of schooling				***	***	
None	9.9	25.6	9.7	17.8	12.0	20.2
1-7	37.9	42.9	26.6	36.0	35.2	45.0
8-11	39.2	27.1	30.6	22.3	38.8	27.6
12 and above	13.0	4.4	33.2	23.8	14.0	7.2
Median years of schooling completed	8	5	9	7	8	6
Standard of living index ^b [mean, range 6 to 48]	23.7	19.0 ^{***}	33.8	32.3	24.6	20.9

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Table 1.8: (Cont'd)

Sociodemographic characteristics	Bangladesh		Haryana, India		Nepal	
	Comilla (N=517)	Rangpur (N=520)	Sonipat (N=546)	Kurukshetra (N=555)	Kaski (N=500)	Tanahun (N=500)
Wage work status						
Engaged in any paid work in last 12 months	6.8	19.2***	23.6	24.1	34.6	23.8***
Women's agency						
Decision making: Makes independent decisions on at least one of the following: how to spend money, to which school to send children, and facility in which she delivered	48.2	24.8***	57.7	58.3	51.4	51.6
Freedom of movement: is allowed to go unescorted to all three of the following: a meeting/programme, to visit a relative outside the <i>tola/mohalla</i> , to a show or <i>mela</i>	57.8	31.2***	52.0	58.4*	80.2	70.0***
Self-efficacy: never finds it difficult to express opinions to her husband on working outside the home, going out unescorted, or education and care of children	63.2	86.3***	90.2	93.8*	79.4	71.6***

Note: * and *** indicate that differences between the two districts of each country are significant at $p < .05$ and $p < 0.001$, respectively; † includes 9.8 percent Buddhists from Kaski; †† includes 7.4 percent Buddhists from Tanahun; SC = Scheduled Castes; ST = Scheduled Tribes; OBC = Other Backward Castes. ^aIncludes one woman in Kurukshetra and two women in Sonipat who belonged to Scheduled Tribes; ^bThe standard of living index was created from data on ownership of land, property and consumer goods, and ranged from 0 to 50.

Structure of this report

This report synthesises key findings from detailed reports of each of the four country case studies. As unbalanced sex ratios at birth and among children have been observed for a longer period of time and addressed more extensively than in other countries, we note that in several sections of the report, the situation in India is described in greater detail than is the situation in the other three countries. Although the survey covered both rural and urban areas of each district, this regional report focuses on the combined district-level situation (findings relating to rural-urban differences have been presented in individual country reports).

This regional synthesis contains a total of eight main sections apart from this introductory chapter. Chapter 2 focuses on factors underlying unbalanced sex ratios from survey data drawn from the two selected districts of Bangladesh, India and Nepal, and from textual data drawn from key informants from all four countries. Chapters 3, 4 and 5 discuss findings from both the survey and the key informant interviews with regard, respectively, to advocacy, communication and community mobilisation programmes; law enforcement experiences, and educational entitlements and conditional cash transfer programmes intended to enhance the status of the girl child. Chapters 6, 7, 8 and 9 present country-specific perspectives integrating the findings of earlier chapters and presenting additional insights from interviews with key informants about factors underlying differences in the sex ratio at birth across the two selected districts of Bangladesh, India and Nepal, and in Karachi as compared to other parts of Pakistan; these chapters also offer recommendations for further action.

Chapter 2

Factors underlying unbalanced sex ratios

This chapter has highlighted that two of the three preconditions for gender-biased sex selection identified by Guilimoto (2011), namely small family size preferences, and strong patriarchal norms and preferences for sons, remain widespread in both study districts of Bangladesh, India and Nepal. Most women in both districts of all three countries had, on average, 2.5–2.7 children ever born, and most wanted just two children (82–90%). While interdistrict variation was not observed in Bangladesh or Nepal, in Haryana, India, on balance, it appeared that women from Kurukshetra, the district in which improvements in the sex ratio at birth had been observed, displayed a stronger preference for sons than did their counterparts from Sonipat, the district in which sex ratios at birth remained highly adverse.

Disclosure of the sex of the foetus was widespread in Bangladesh and Nepal, in spite of legal restrictions in Nepal but not in Bangladesh. In both countries, significantly more women from districts in which sex ratios were unbalanced than from districts with balanced sex ratios had been informed about the sex of their foetus (65% versus 51% in Bangladesh; 39% versus 26% in Nepal) or were acquainted with someone who had been so informed. In Haryana, India, in contrast, far fewer women, overall, reported that they had been told the sex of their foetus—just eight percent in both districts—than in Bangladesh or Nepal, but a considerably larger percentage of women from Sonipat than Kurukshetra admitted acquaintance with someone who had been so informed, and among women with three pregnancies, more women from Sonipat than Kurukshetra reported disclosure of the sex of the foetus.

Overall, six to eight percent of women in Bangladesh, nine to ten percent in Haryana, India, and 10–13 percent in Nepal had experienced one or more induced abortions. In Bangladesh, just one woman in the entire sample reported a sex-selective abortion; in Nepal, about one in eight women who had undergone an abortion from each of the two study districts so reported; and in Haryana, India, just two to four percent from the two study districts so reported. Inferences drawn from reasons given by women for undergoing abortion suggest, however, that women in India and Nepal may have under-reported sex selection as a reason for their abortion.

Key informant perspectives on disclosure of the sex of the foetus and extent of sex-selective abortion differed by country context. In Bangladesh and Pakistan, disclosure of the sex of the foetus was widespread, yet sex-selective abortion was perceived as very rare. Even so, narratives suggest that the practice may not be as rare as it appears (for example, some health care providers in Bangladesh refused to reveal the sex of the foetus to women who already have a daughter; a health care provider in Karachi, Pakistan, placed a signboard outside her facility, indicating that the facility did not disclose the sex of the foetus). In India and Nepal, key informants, irrespective of category, acknowledged that the misuse of technologies—both disclosure of the sex of the foetus and termination of pregnancies carrying a female foetus—persisted. Indeed, in both districts of Nepal, key informants suggested that the demand for disclosure of foetal sex had increased in recent years, while in Haryana, India, the consensus was that it had declined. Key informants from both districts of each country agreed, moreover, that information about the sex of the foetus was clandestinely conveyed, and linked to provider greed. In Haryana, India, interdistrict disparities in disclosure of the sex of the foetus and sex-selective abortions were not observed; health care providers and NGO programme implementers from both districts suggested that between one/two in ten and five in ten abortions were likely to be for sex-selective reasons. In Nepal, in contrast, key informants suggested that both sex selection practices were far more likely to prevail in Kaski, the district with an unbalanced sex ratio at birth, than in Tanahun, the district with a normal sex ratio at birth.

Imbalances in the sex ratio at birth are attributed to the convergence of three interlinked factors, namely fertility decline and small family size preferences, the persistence of patriarchal norms, inequalitarian gender roles and consequent son preference, and technological advances, notably, access to prenatal diagnostic technologies, that permit the detection of the sex of the foetus, followed by the termination of pregnancies carrying a female foetus (Guilimoto, 2011). This chapter explores the extent to which each of these three preconditions characterises study

districts in each country. Districtwise sex ratios of children ever born and surviving as gleaned from our survey are not provided in this report because the sample is too small to provide reliable estimates of sex ratios, and because it was restricted to a subgroup of women who had two or more children, the youngest of whom was born in the five years preceding the survey.

A. Perspectives of women

In this section we explore the responses of women from Bangladesh, Haryana, India and Nepal, to questions on family size preferences, son preference, and access to prenatal diagnostic technology and subsequent termination of pregnancies carrying a female foetus. We also explore their attitudes about having a son on the one hand, and the acceptability of gender-biased sex selection, on the other.

Small family size preferences

Small family size norms are widely espoused by women in all three country settings. As seen in Table 2.1, in each of the six study districts, more than four in five women reported a preference for two children. Most women had two or three children ever born, with a remarkably similar average of 2.5–2.7 across the six districts. Moreover, the large majority (81–93% across all countries) wanted no more children, reiterating the strength with which the two-child norm was held among women in all six districts under study, with little interdistrict variation in each country.

Table 2.1: Family size preferences and actual family size

Percentage of women reporting a preference for two children, mean number of children ever born, and percentage of women desiring no more children, according to residence, Bangladesh, India and Nepal

Family size preference	Bangladesh		Haryana, India		Nepal	
	Comilla	Rangpur	Sonipat	Kurukshetra	Kaski	Tanahun
Women who considered two children ideal	84.1	89.5	81.7	85.8	86.4	83.6
Children ever born (mean)	2.6	2.5	2.6	2.6	2.5	2.7
Women not desiring additional children ¹	81.4	87.3	89.1	89	93	92.6
Number of women	517	520	546	555	500	500

Note: ¹Sterilised women are assumed to want no more children.

Son preference

A second precondition for skewed sex ratios at birth is the extent of son preference expressed by women and their families. We measured the extent of son preference in several ways. First, using a direct question posed to assess the number of sons and daughters a woman considered ideal, we calculated the proportion of women who did not express a preference for sons over daughters when asked about their ideal number of sons and daughters. A second indicator of son preference was the extent to which a woman's desire to continue childbearing depended on the sex composition of her living children. In order to measure this, we compared, among women who had two living children, the proportion of women with two sons wanting no more children with the proportion of women with two daughters wanting no more children. Clearly, if there were no preference for sons over daughters, the ratio of these two proportions would be 1.0, and the higher the value of the ratio, the stronger is the son preference. Finally, since we know that son preference affects the family planning behaviour of couples, we examined the extent to which a woman's use of contraception was associated with the sex composition of her living children. A simple indicator was constructed to measure this—we compared, among those who had two living children, the proportion of women with two sons currently using contraception with the proportion of women with two daughters currently using contraception. As above, if there were no preference for the sex of children, the ratio of these two quantities would be 1.0, and the higher the value of the ratio, the stronger is the son preference.

Figure 2.1 presents the indicators of son preference in the study districts of Bangladesh, Haryana, India and Nepal. Findings suggest that son preference, as measured by these three indicators, was strong in both districts of each country. On the first of the three indicators, the ideal sex composition of children, differences were muted (Figure 2.1a). For example, in India, only one in five women who had two or more living children did not express a preference for a particular sex, and percentages were similar in both districts. In Bangladesh and Nepal, even fewer women (Bangladesh: 7–10%; Nepal: 7–15%) were indifferent about the sex of their children.

Our second indicator affirms a strong preference for sons in India, and a somewhat weaker preference for sons over daughters in Bangladesh and Nepal. In all three countries, more women who had two sons compared to those who had two daughters reported that they wanted no more children (Figure 2.1b). Now, interdistrict differences were apparent in India; where the ratio of those who had two sons versus those who had two daughters, expressing a desire for no more children was significantly greater in Kurukshetra (3.0) than in Sonipat (1.8). In Bangladesh and Nepal, however, ratios were similar across districts.

Contraceptive practice was closely linked with the number of sons women had in India and Nepal, and less so in Bangladesh. In India, women who had two sons were 40–60 percent more likely to have been practising contraception at the time of the interview than those who had two daughters. In Nepal, they were 10–20 percent more likely to have done so (Figure 2.1c). Districtwise differences were wide in both India and Nepal; however, while in Nepal, the son preference ratio was significantly higher in the district with an unbalanced sex ratio at birth (Kaski) than in the district with a normal sex ratio at birth (Tanahun), in India, it was the district that showed an improvement in its sex ratio at birth that displayed a higher son preference ratio (Kurukshetra). In Bangladesh, districtwise differences were not significant.

Figure 2.1: Among women who had two living children, indicators of son preference, according to residence, Bangladesh, India and Nepal

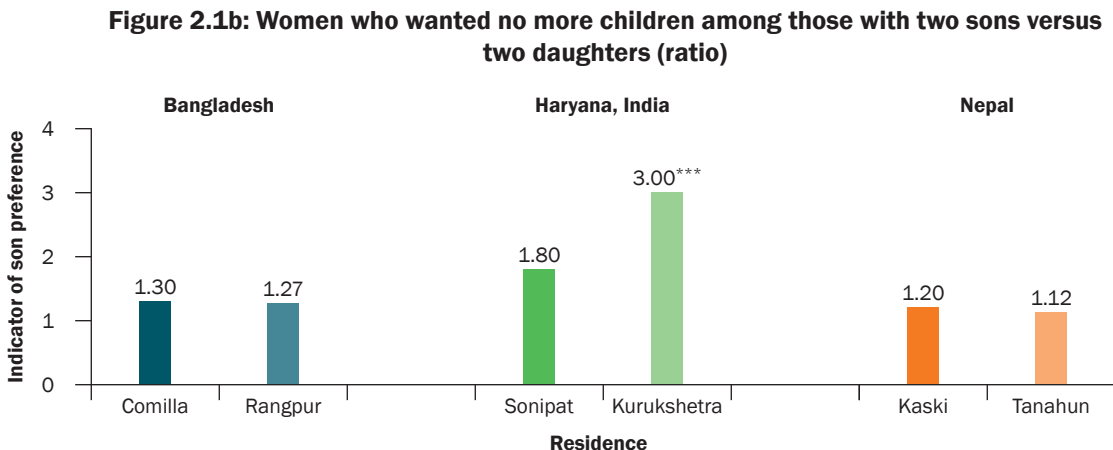
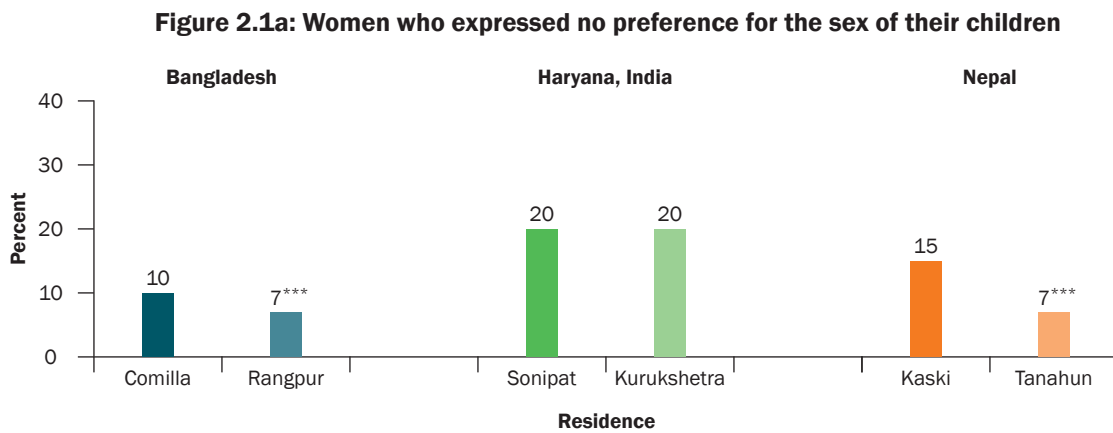
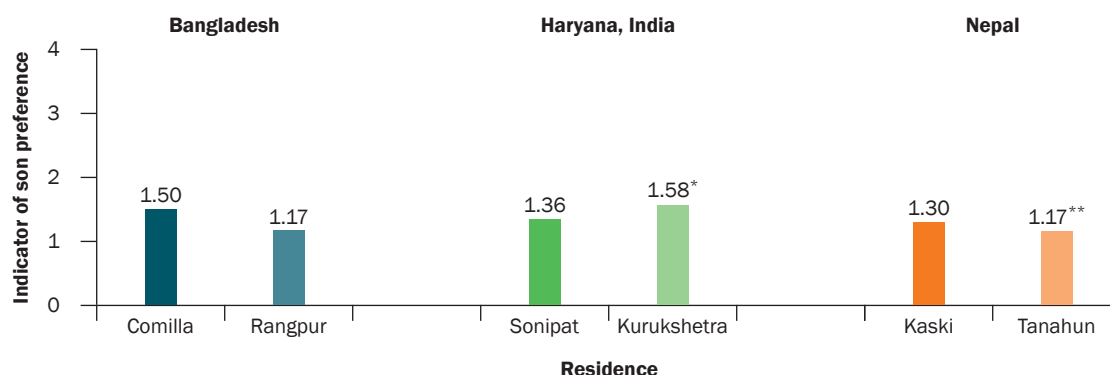


Figure 2.1c: Women currently using contraception among those with two sons versus two daughters (ratio)



Note: *, ** and *** indicate that differences between the two districts of each country are significant at $p < .05$, $p < .01$ and $p < 0.001$, respectively.

Finally, we assessed women's attitudes about having sons and daughters, and again, it is clear from the findings presented in Table 2.2 that son preference was prevalent in all three countries. Indeed, considerable proportions of women in Bangladesh, India and Nepal believed that a son is essential to continue the family line (81–88% in Bangladesh; 66–69% in Haryana, India; 63–72% in Nepal), that having a son determines a woman's status in her family (73–84% in Bangladesh; 42–49% in Haryana, India; 27–34% in Nepal), and that a family without a son gets less respect in society than other families (31–48% in Bangladesh; 32–38% in Haryana, India; 11–15% in Nepal). Fewer, considerable percentages of women also agreed that a woman with just daughters is unfortunate (11–28% in Bangladesh; 16–17% in Haryana, India; 9% in Nepal). Interdistrict differences varied across the three countries. They were negligible in India. In Bangladesh, those from Rangpur, the district with a normal sex ratio at birth, revealed a significantly stronger son preference on three of the four indicators of attitude, and a weaker one in the fourth. In Nepal, those from Kaski, the district with an unbalanced sex ratio at birth, revealed a significantly stronger son preference on two of the four indicators.

Table 2.2: Attitudes about son preference

Percentage of women reporting various attitudes relating to son preference, according to residence, Bangladesh, India and Nepal

Attitude about son preference	Bangladesh		Haryana, India		Nepal	
	Comilla	Rangpur	Sonipat ¹	Kurukshetra ¹	Kaski	Tanahun
Women who agreed that:						
it is important to have sons because only they can continue the family line	81.0	88.3***	65.8	68.9	71.6	63.2**
it is important to have sons because having a son determines a woman's status	73.3	84.2***	48.9	41.9	34.4	27.4*
if a family does not have a son, it gets less respect in society	30.9	48.3***	31.7	38.4	11.4	15.0
a women with only daughters is unfortunate	28.2	11.0***	16.3	16.5	8.6	9.4
women are forced to continue having children until a son is born	55.5	68.3***	84.2	87.4	84.8	69.8***
Number of women	517	520	546	555	500	500

Note: *, ** and *** indicate that differences between the two districts of each country are significant at $p < .05$, $p < .01$ and $p < 0.001$, respectively. ¹The remaining percentages of women either disagreed or were uncertain.

We also inquired about whether women, in general, are forced to continue having children until a son is born, and women's own experiences of pressure to bear a son. As evident from Table 2.2, large majorities of women in all three countries acknowledged that women are pressurised to continue childbearing until they have a son; more women from the district with a normal sex ratio than an unbalanced sex ratio at birth in Bangladesh (68% versus 56%), more women from the district with an unbalanced than a normal sex ratio at birth in Nepal (85% versus 70%), and 84–87% of women from both districts of Haryana, India, acknowledged so.

In Nepal, almost one-third of women from Kaski (31%), and almost one-sixth of those from Tanahun (15%) reported that they had faced such pressure. In Bangladesh and India, in contrast, very few women so admitted—four percent in both districts of Bangladesh and three percent in both districts of India reported so (not shown in the table).

Access to technology enabling disclosure of the sex of the foetus

The third precondition for skewed sex ratios at birth is the use of technologies to detect the sex of the foetus and selectively terminate pregnancies carrying a female foetus. The most commonly used method of detecting the sex of the foetus in study settings is ultrasonography, used by large proportions of women for monitoring the growth and development of the foetus. While disclosure of the sex of the foetus is not legally permitted in India and Nepal, there are no restrictions placed on such disclosure in Bangladesh. Despite the restrictions in India and Nepal, however, many providers do disclose such information to women and families, resulting in the subsequent abortion of female foetuses.

In this section, we explore women's access to technologies enabling disclosure of the sex of the foetus, the extent of termination of pregnancies carrying female foetuses and attitudes concerning the acceptability of gender-biased sex selection.

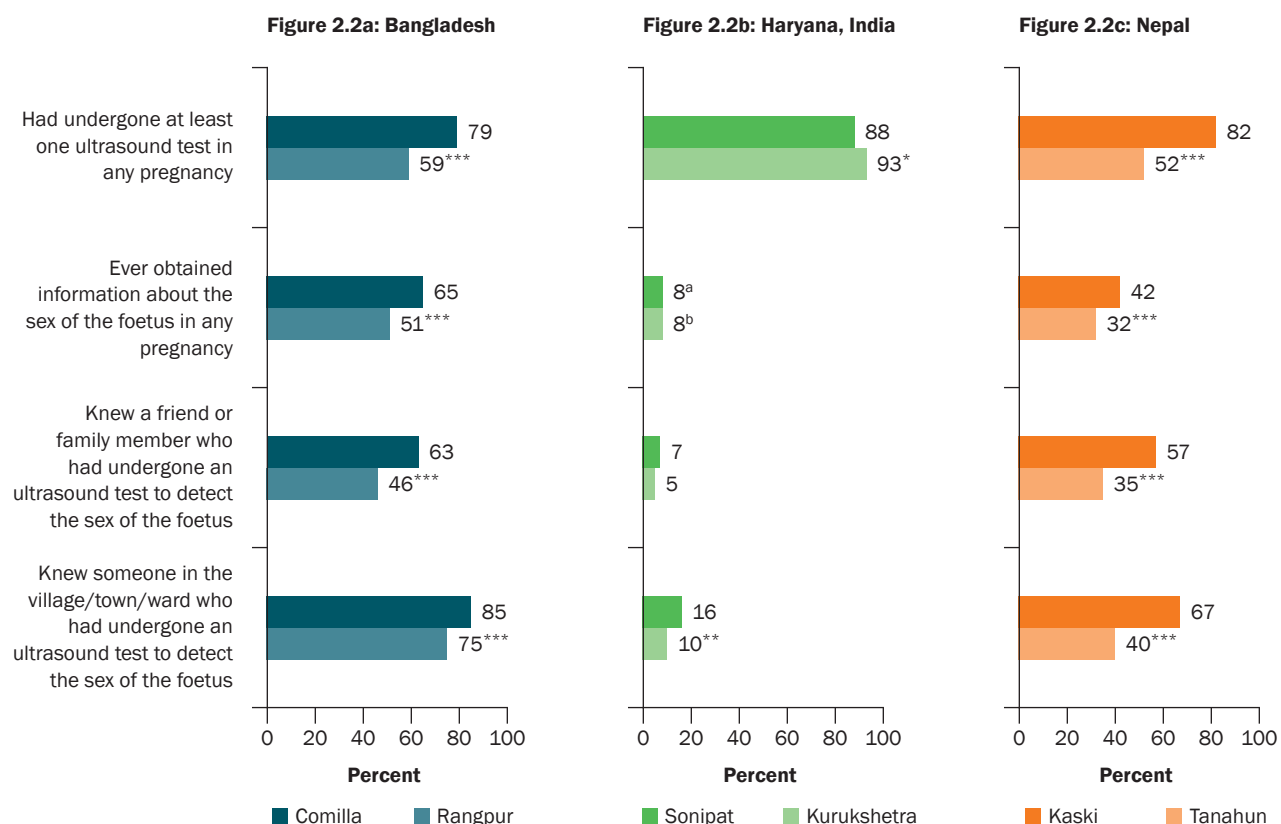
Experience of seeking disclosure of the sex of the foetus: Several questions were posed to assess the extent to which women reported disclosure of the sex of the foetus during any of their pregnancies. For one, for each pregnancy, our survey asked women whether ultrasound testing had been undertaken, and specifically, whether the doctor had disclosed to them the sex of the foetus. Second, a direct and general question was posed that asked whether the respondent had ever received information about the sex of the foetus. Third, for those reporting an abortion, we asked the reason, including for sex selection. And finally, recognising that women may be unwilling or uncomfortable about revealing in a direct face-to-face situation that they had obtained information on the sex of the foetus, we also asked the question indirectly, in an anonymous (but linked) format. For this, at the end of the interview, women were handed a card and were asked to mark a tick if the sex of the foetus had been disclosed to them after ultrasound or any other prenatal diagnostic test during any of their pregnancies, and a cross if not. They were also told to place the card in an envelope provided by the interviewer, seal it, and return it to the interviewer. The interviewer did not observe this part of the interview but informed the respondent that only Council staff in Dhaka and Delhi, and CREHPA staff in Kathmandu would be able to link the response on the card with other responses made in the main body of the interview. In addition, we also inquired about the respondent's acquaintance with a friend or relative, and with someone in the community (her village, town or ward), who had received information on the sex of their foetus.

Findings presented in Figures 2.2a and 2.2c suggest a similar situation in Bangladesh and Nepal, respectively, in spite of the fact that disclosure of the sex of the foetus is legally restricted in Nepal but not in Bangladesh. In districts of both countries, ultrasonography was widely used to monitor the growth and development of the foetus. Significantly more women from the districts in which sex ratios at birth were unbalanced had undergone ultrasonography than had those in districts with balanced sex ratios (in Bangladesh, 79% in Comilla versus 59% in Rangpur; in Nepal, 82% in Kaski versus 52% in Tanahun). At the same time, considerable proportions of women reported that they had been informed about the sex of their foetus—again, significantly more women in districts with unbalanced than normal sex ratios at birth. For example, in Bangladesh, 65 percent of women from Comilla compared to 51 percent of those from Rangpur, had been told the sex of their foetus; in Nepal, 42 percent of women from Kaski compared to 32 percent of those from Tanahun so reported. Likewise, significantly more women from Comilla than Rangpur, and from Kaski than Tanahun, reported acquaintance with a family member or friend, as well as with someone in their community, who had been informed about the sex of their foetus.

In Haryana, India, in contrast, the situation was quite different (Figure 2.2b). For one, ultrasonography had been experienced by about nine in ten women from both districts, but significantly more in Kurukshetra, the district that

had experienced improvements in its sex ratio at birth, than in Sonipat, the district in which the sex ratio at birth had remained stagnant (93% versus 88%). Although the law prohibits disclosure of the sex of the foetus, eight percent of women in both Sonipat and Kurukshetra admitted that they had been told the sex of their foetus. Women were clearly more willing to admit that they knew someone (a relative, friend or acquaintance in their village, town or ward) who had undergone gender-biased sex selection than they were to admit their own experience. Indeed, familiarity with gender-biased sex selection through acquaintance with a relative or friend, or with someone in the community to whom the sex of the foetus had been revealed, suggests that the practice was more common in Sonipat than in Kurukshetra (16% versus 10%).

Figure 2.2: Percentage of women reporting experiences of undergoing ultrasonography during pregnancy, disclosure of the sex of the foetus, and acquaintance with others who had sought disclosure of the sex of the foetus, according to residence, Bangladesh, India and Nepal



Note: *, ** and *** indicate that differences between the two districts of each country are significant at $p < .05$, $p < .01$ and $p < 0.001$, respectively; ^a and ^b indicate the percentage of women—8.4 and 7.7—in Sonipat and Kurukshetra, respectively, who ever obtained information about the sex of their foetus in any pregnancy.

A parity-wise assessment, presented in Table 2.3, highlights that, as expected, because disclosure of the sex of the foetus is not legally restricted in Bangladesh, considerably more women in Bangladesh than India or Nepal acknowledged that they knew the sex of their foetus. Moreover, as others have shown, there is a fairly systematic increase by parity in percentages of women reporting disclosure of the sex of the foetus. The association was particularly strong in Bangladesh and Nepal, where, at each parity, those in the district characterised by an unbalanced sex ratio at birth (Comilla and Kaski, respectively) were more likely to report disclosure of the sex of the foetus than were those in the comparison districts (Rangpur and Tanahun, respectively). Also notable are findings from Nepal suggesting that in Kaski, percentages informed about the sex of their foetus tended to be much higher if the previous child was a daughter than if it was a son; in Tanahun, corresponding differences were milder. In Bangladesh, a similar pattern was observed among women at parity 2.

Table 2.3 also shows that in Haryana, India, percentages of women reporting disclosure were similar in both districts at parities 1 and 2, but at parity 3, women from Sonipat, the district in which sex ratios remained unchanged, were significantly more likely than their counterparts in Kurukshetra, the district that displayed an improved sex ratio at birth, to have been informed about the sex of their foetus—six percent versus two percent (and at parities 4 and above, eight percent versus four percent, not shown in the table). A look at percentages of women at each parity who had been informed about the sex of their foetus, according to the sex of the previous child does not reveal a consistent picture; the only exception was among women at parity 3 from Sonipat, among whom, the proportion who reported the experience of disclosure was greater (6.7%) if the previous child was a daughter than a son (4.1%). Overall, at parity 3, while 6.7 percent of women from Sonipat whose second child was a daughter reported that they had been told the sex of the foetus, just 1.7 percent of those from Kurukshetra so reported. We note that disclosures were likely to be under-reported in Haryana, given the widespread publicity across both districts about the PCPNDT Act. Even so, findings suggest that the practice was prevalent in both districts.

Table 2.3: Disclosure of the sex of the foetus by parity and sex of the previous child

Percentage of women by personal experiences of disclosure of the sex of the foetus by parity and sex of the previous child, according to residence, Bangladesh, India and Nepal

Sex-selection practices	Bangladesh		Haryana, India		Nepal	
	Comilla	Rangpur	Sonipat	Kurukshetra	Kaski	Tanahun
Doctor disclosed the sex of the foetus by children ever born and sex of the previous child (Number of women)						
Parity 1	33.8 (517)	22.9*** (520)	1.6 (546)	1.6 (555)	10.6* (500)	6.6 (500)
Parity 2	43.7 (517)	35.6** (520)	2.6 (546)	2.9 (555)	24.0*** (500)	15.4 (500)
1st child—son	37.5 (248)	37.1 (240)	3.7 (257)	3.2 (221)	19.2*** (234)	14.4 (216)
1st child—daughter	49.4 (269)	34.3*** (280)	1.6 (289)	2.7 (334)	28.2*** (266)	16.2 (284)
Parity 3	47.7 (260)	30.7 (218)	5.7 (199)	1.9* (207)	29.2 (154)	18.7 (198)
2nd child—son	52.1 (121)	29.2*** (106)	4.1 (75)	2.3 (67)	19.0 (58)	13.4 (67)
2nd child—daughter	43.9 (139)	32.1 (112)	6.7 (124)	1.7* (140)	35.4 (96)	21.4 (131)

Note: *, ** and *** indicate that differences between the two districts of each country are significant at $p < .05$, $p < .01$ and $p < 0.001$, respectively.

Resort to abortion following disclosure of a female foetus: In a separate section from the one on pregnancy histories and disclosure of the sex of the foetus, our survey explored women’s abortion-related experiences. Findings presented in Table 2.4, suggest that overall, 6–8 percent of women in Bangladesh, 9–10 percent in Haryana, India, and 10–13 percent in Nepal had experienced one or more induced abortions.

Termination of a pregnancy carrying a female foetus was reported by varying percentages of women across study sites (Table 2.4). In Bangladesh, where the law does not forbid disclosure of the sex of the foetus, just one woman in the entire sample reported a sex-selective abortion. In Nepal, where the law does forbid disclosure, about one in eight women from each of the two districts reported a sex-selective abortion; and in Haryana, India, where the law is most strictly enforced, two to four percent from the two study districts so reported (not shown in the table). We note,

however, that in response to a general question about whether they or anyone they knew had experienced a sex-selective abortion, more women so disclosed from each setting; while interdistrict differences (3% versus 4%) were negligible in Bangladesh and India, they were wide in Nepal, with significantly more women from Kaski than Tanahun reporting so (31% versus 16%).

Reported reasons for abortion in India and Nepal raised questions about the likely under-reporting of abortion for sex-selection reasons. Indeed, reported reasons for abortion, also presented in Table 2.4, were somewhat different in India and Nepal than in Bangladesh and Nepal, and those suggested in the literature. In fact, most studies conducted in India and elsewhere suggest that key reasons for abortion relate to mistimed or unwanted pregnancy and to a lesser extent, concerns about the health of the mother (see, for example, Santhya and Verma, 2004). This pattern was indeed observed in Bangladesh and Nepal, but not in Haryana, India, where far more women reported medical reasons including doctors' recommendation, mothers' health concerns and foetal complications for their abortion (54–59%) than mistimed and unwanted pregnancy (13–17% and 23–28%, respectively). It is possible that some of the women from Haryana, India, who gave medical reasons may, in fact, have been masking sex-selective motives for their abortion. Reported reasons for abortion in Nepal raised similar questions. For example, contraceptive failure was considerably more likely to have been reported as a reason for abortion in Kaski than in Tanahun (16% versus 2%).

Table 2.4: Experience of induced abortion and reasons for abortion

Percentage of women reporting induced abortion and sex-selective abortion, and percentage of women who underwent an induced abortion by reasons for abortion, according to residence, Bangladesh, India and Nepal

Experience of induced abortion with reasons	Bangladesh		Haryana, India		Nepal	
	Comilla	Rangpur	Sonipat	Kurukshetra	Kaski	Tanahun
Experience of an induced abortion	6.0	8.3	10.1	9.1	13.4	9.6
Number of women	517	520	546	555	500	500
Reasons for abortion¹						
Did not want another child at that time/last child was too young	58.1	67.4	12.9	16.5	70.1	52.1
Did not want another child at all	16.1	16.3	27.5	23.2	47.8	64.6
Husband did not want another child	9.7	27.9	4.6	4.2	1.5	12.5
Was too young/old to have a child	3.2	4.7	0.0	3.1	0.0	6.3
Contraceptive failure	16.1	7.0	0.0	0.0	16.4	2.1
Medical reasons (doctor advised, concerns about mother's health, foetal complications)	6.5	2.3	58.5	53.5	9.0	8.3
Foetus was female	0.0	2.3	2.2	3.9	13.4	12.5
Number of women who had ever undergone an induced abortion	31	43	60	49	67	48
Women who had ever undergone a sex-selective abortion—combined (self, friend, relative and/or acquaintance)	4.1	2.7	3.8	2.9	31.4	16.0***
Number of women	517	520	546	555	500	500

Note: *** indicates that the difference between the two districts of the country is significant at $p < 0.001$; ¹Columns totals may not be equal to 100% due to multiple responses.

In order to assess, in a more indirect way, the practice of sex-selective abortion in Haryana, India, we explored the extent to which women who reported that they had been informed about the sex of the foetus in any pregnancy also reported at least one abortion. Findings (not presented in table) show that of the 38 and 42 women from Kurukshetra and Sonipat, respectively, who reported disclosure of the sex of the foetus either in the face-to-face or anonymous format, 25 percent of those from Kurukshetra (nine women) and 28 percent of those from Sonipat (12 women) had ever had an induced abortion. Given the likelihood of termination of pregnancies following the disclosure of a female foetus, we argue that a large proportion, if not all, of these terminations were indeed sex selective, again supporting our contention that the experience of sex-selective abortion was likely under-reported.

Attitudes toward disclosure of the sex of the foetus: In order to understand women’s attitudes about gender-biased sex selection, we asked women whether they agreed with three statements related to the acceptability of disclosure of the sex of the foetus and termination of pregnancies carrying a female foetus. Findings are presented in Table 2.5. Notwithstanding the likelihood that many women provided socially desirable responses, findings highlight that substantial percentages of women in all three countries favoured the disclosure of the sex of the foetus. In Bangladesh, for example, as many as 90 percent in Rangpur, the district with a normal sex ratio at birth, compared to significantly fewer (37%) in Comilla, the district with an unbalanced sex ratio at birth, believed there is nothing wrong about seeking disclosure of the sex of the foetus; however, hardly any women (0–2%) approved of sex-selective abortion. In Nepal too, the majority of women in both districts—more in Kaski (76%) than Tanahun (69%)—believed there is nothing wrong in seeking disclosure of the sex of the foetus; considerably fewer women approved of sex-selective abortion, now significantly more in Tanahun, the district with a balanced sex ratio at birth than Kaski, the district with a skewed sex ratio at birth (40% versus 25%).

Far fewer women from Haryana (17–20%) believed that disclosure of the sex of the foetus was acceptable, and almost as many (13–14%) expressed the view that women with two or more daughters were better off terminating a pregnancy carrying a female foetus than bringing up many daughters (Table 2.5).

Table 2.5: Attitudes about gender-biased sex selection

Percentage of women reporting various attitudes toward gender-biased sex selection, according to residence, Bangladesh, India and Nepal

Attitude towards sex selection	Bangladesh		Haryana, India		Nepal	
	Comilla	Rangpur	Sonipat ¹	Kurukshetra ¹	Kaski	Tanahun
Women who agreed that:						
there is nothing wrong about seeking services to know the sex of the foetus	37.1	89.8***	20.0	16.5	75.6	69.2*
abortion of a female foetus is OK if the family already has daughters	1.5	0.2*	4.7	3.4	16.8	15.0*
it is better for a woman with two or more daughters to have a test and abort a female foetus than bring up many daughters	0.6	2.3*	13.7	12.8	24.8	40.4***
Number of women	517	520	546	555	500	500

Note: * and *** indicate that differences between the two districts of the country are significant at $p < .05$ and $p < .001$, respectively; ¹Remaining % of women either disagreeing or uncertain.

B. Perspectives of key informants on factors underlying unbalanced sex ratios at birth

Key informant interviews with health care providers, and programme implementers/managers from the public and NGO sectors from the study sites in all four countries, covered many of the same issues that were addressed in the course of the survey with married women. The topics covered their perspectives on two of the three broad factors identified as key determinants of unbalanced sex ratios, namely persistent son preference and access to sex-selection technology. The issues raised by each country differed somewhat. For example the Bangladesh and Pakistan case studies did not address implementation of laws relating to the disclosure of the sex of the foetus; the questions focused on violation of laws prohibiting abortion or second-trimester abortion and the termination of pregnancies carrying a female foetus. Also, misuse of technology, in India and Nepal, focused on both the disclosure of the sex of the foetus and termination of pregnancies carrying a female foetus.

Persistence of son preference

Almost all key informants from all three categories, irrespective of district and country, acknowledged the persistence of son preference. They reiterated the well-known motivations expressed in previous studies for preferring sons: their support in old age, for performing the last rites of their parents, their ability to tend to the family property, and their role in carrying forward the family name. On the other hand, daughters were perceived to require large dowries, leave the home once married and provide little support to their parents; some mentioned that couples were deterred from wanting daughters because they feared for the safety of girls, and, in India, because of inheritance laws, feared that married daughters would claim property rights and thereby divide family property. For example:

Son preference happens for social, financial and religious reasons. The existing laws in our country allow nephews to inherit some of a couple's property if couples do not have a son. Daughters do not get the right of ownership of all parental properties and moneys. Daughters are not the heirs or the ones who continue the family line. That's why people prefer sons. Sometimes, the mother-in-law expects sons from her children and creates pressure. [Male, sonologist, aged 49, Comilla, Bangladesh]

I met a woman who already had four to five children, and was over 40 years old, but wanted to become pregnant to have a son. She wanted a son in the expectation that he would be the main source of income to the family in future. I also know from experience that a woman who is tortured by her husband and mother-in-law starts to cry when she hears that she is going to have a daughter. The truth is she fears that her daughter will be tortured in the same way. [Female, obstetrician-gynaecologist, aged 48, Comilla, Bangladesh]

Everyone craves for a son. Sons can work, they can earn. A daughter can earn too, but not like a son. Besides, a daughter's income will go to her husband, not to her parents. Moreover, sons are the successors in a family, not daughters. [Female, mid-level provider, aged 41, Comilla, Bangladesh]

Earlier, every family had 9–10 children. So, the number of sons and daughters wasn't something people would think about. But this is the 21st century. People want a small family. Two children are enough for them. Among these two children, if both are boys, people think it's good. If one is a boy and the other is a girl, that's good too. But when both are girls, parents have regrets. Even if they don't say it, they want a boy..... I think, in every district of Bangladesh, people become overjoyed when a son is born. It really doesn't matter whether they have one or ten male children. This reaction is normal because when a woman has a son she feels secure. Financial support is not as important as security. I know from my working experience that a man, whether he is a son, a father, a husband, a brother or even a boyfriend, is like a security blanket. The safety and security individuals feel because of a male presence can be of different types. Parents think their son will look after them and support them in their old age. This is financial security. On the other hand, a sister thinks, even after her marriage, her brother will be concerned about her happiness, her well-being. If any trouble comes, he will be at her side. This is social security. [Female, public sector programme implementer, aged 58, Comilla, Bangladesh]

In our country, parents become dependent on their children in their old age. And it's hard to depend on daughters since they go to their husband's house after marriage. So, naturally, people want sons to depend

on. Another thing is, people need a son to keep their properties and money in their own family. It's hard for people to give away their hard-earned money and properties to someone outside their family (the daughter, following her marriage). [Female, NGO programme implementer, aged 58, Dhaka, Bangladesh]

Everyone wants a son. It gives a woman social status. [Female, gynaecologist, aged 58, Karachi, Pakistan]

Son preference persists in Haryana. It is mainly to conserve family property in the long run. No man wants to entrust his properties to a daughter as they think that she will not remain with them in future whereas a son is conventionally considered as the heir of the family. [Male, law enforcement officer, aged 57, Sonipat, Haryana, India]

As you know, our country has always had a male-dominated society. We have always depended on males. If there are no sons in our family, we feel insecure, we fear who will take all the responsibilities of the family in the future. Having a son provides a family respect in the society, continues the family surname. These are the reasons why we value sons over daughters. [Male, health care provider, aged 52, Kaski, Nepal]

This is due to the society and tradition here in Nepal where people have the mentality that a daughter goes off after marrying and will not be in touch after marriage. Whereas for sons, there is a belief that they stay attached until they grow old and look after their parents. This is our culture and we cannot blame them, it is the fault of our culture. [Male, health care provider, aged 40, Tanahun, Nepal]

Many key informants described the jubilation that surrounds the birth of a son versus the grief that surrounds the birth of a daughter; several also suggested that women who gave birth to daughters were treated with less respect than were those who gave birth to sons. For example:

...After delivery, a woman becomes very happy when we tell her that she gave birth to a son. Women become unhappy when they come to know that they gave birth to a daughter. We see such disappointment among women who give birth to a daughter if she already has one or two daughters. When a woman who already has a girl child gives birth to a girl again, she suffers from depression after delivery and it becomes very hard to manage her. Most of the time, they cry. [Female, obstetrician-gynaecologist, aged 45, Comilla, Bangladesh]

Nowadays, people are much more aware. They generally don't discriminate between a son and a daughter. Even so, the birth of a son brings a different level of happiness in a family. The husband and in-laws become more pleased with the woman. I know from my experience of delivering babies, that in-laws, the husband and the woman herself become happier when a son is born. They bring sweets to celebrate. They do not become upset when it is a girl, but they are not as happy either. [Female, mid-level provider, aged 52, Comilla, Bangladesh]

When a mother gives birth to a son, her importance in the family increases. On the other hand, when it is a girl, sometimes her husband and her mother-in-law inflict mental and physical suffering on her. [Female, mid-level provider, aged 52, Rangpur, Bangladesh]

People have their personal reasons for son preference. Earlier, people reacted to the birth of a daughter. I have many bitter experiences about son preference. One time a parent left her own child in the hospital just because it was a girl. Another time, a man from a neighboring district came to me and said that after eight years of trying, his wife had given birth to a son. He ordered 100 kg of sweets to celebrate this occasion. Even the boxes of sweets were custom-made with his son's photo and name on top. [Female, NGO programme implementer, aged 62, Dhaka, Bangladesh]

She is given respect after the delivery of the son by the family and the community. [Female, gynaecologist, aged 58, Karachi, Pakistan]

People react differently at the birth of a boy or a girl. When they get the news of a third or fourth baby boy, they are happy, but if it is a girl, then they become sad. I have seen two to three cases going into depression and postpartum haemorrhage. [Female, Lady Health Visitor, aged 36, Karachi, Pakistan]

A woman came to me for a check-up and an ultrasound. She already had three daughters and now again she was carrying a female child. On hearing this, she started crying and said (to me) not to inform her

in-laws about it because they would be angry and mistreat her. [Female, gynaecologist, aged 58, Karachi, Pakistan]

People do behave differently (to the birth of sons and daughters). After the birth of a son everybody gets happy, they distribute sweets; congratulate one another, whereas after the birth of a daughter they get depressed, though they also accept their daughter but still somewhere in their mind they stay depressed! ...After the birth of a son, sweets are distributed among the hospital staff, and they are given presents along with some money as gifts, but after the birth of daughter no such activities are carried out. [Female, obstetrician-gynaecologist, aged 60, Sonipat, Haryana, India]

More attention is given to a son's mother; she has more value and more respect is given to her whereas a daughter's mother faces such behaviour as if she has committed some serious crime by giving birth to a daughter; she is cursed every time. [Male, NGO programme implementer, aged 52, Sonipat, Haryana, India]

Here in our Kaski district, two sisters-in-law delivered at the same time. The elder one gave birth to a daughter and the younger one delivered a son. The elder one gets leftover rice and water mixed with milk, but, at the same time, the younger one gets fresh food, and good and pure milk; also, she gets extra care from the family. [Female, public sector programme implementer, aged 42, Kaski, Nepal]

Even so, many key informants from all four countries believed that the situation was changing, with young, urban and better-educated couples displaying no son preference, and increasing numbers stopping childbearing after one or two daughters. Many cautioned, however that change is slow, with rural and less-educated families still preferring sons, and the older generation still pressurising young couples to have a son. For example:

People do have a preference for sons, but it is decreasing. Educated people do not have such preference. People who are less educated and do not have any financial support prefer sons. I asked women who had four to five children the reasons for having many children. Almost all of them had daughters only and had many children in the hope of a son. [Male, general physician, aged 52, Comilla, Bangladesh]

Things are changing. People do not prefer sons as before. Earlier, people would distribute sweets when a son was born, but now people distribute sweets to celebrate the birth of a daughter even. Now, people realise that a daughter is better than a son in many ways. Daughters look after parents, earn for them and will live with parents as long as they let her. Even after her marriage, a daughter takes care of her parents as much as she can. Besides, people nowadays, do not want more than two to three children. People do not think much about the sex of their children. [Male, public sector programme implementer, aged 50, Comilla, Bangladesh]

Son preference is decreasing day by day. Only families, who have three to four daughters are desperate to have a son. [Female, mid-level provider, aged 41, Comilla, Bangladesh]

I think parents, nowadays, do not have any preference. People are much more educated now. They are more aware. Long ago, people hoped their daughter-in-law would take care of them, so they wanted a son. But now it is not the reality. Nowadays, the daughter takes care of parents, not the daughter-in-law. [Female, mid-level provider, aged 57, Comilla, Bangladesh]

Things are changing. Women are now more independent and educated and prefer a healthy child instead of a son. [Female, mid-level provider, aged 47, Comilla, Bangladesh]

... Because of lack of education, people of our country are yet to develop the value that teaches them that sons and daughters are equal. But people are now beginning to understand that if they educate daughters, they can become like a son. [Female, mid-level provider, aged 40, Comilla, Bangladesh]

Women always take extra care of the males in the family, be it son or husband. It's a practice among women in our country. Women give their earnings to their husbands. But the situation is changing now. Women are more aware, now-a-days, and take care of themselves too. They know, in order to take care of others, it is important to take care of themselves. But in rural areas, women still give preference to their sons. In-laws love their son, but do not take care of their daughter-in-law. So, in rural areas, where the light of education hasn't reached expected levels, and where women are not empowered and do not have financial independence, the male continues to receive extra care. In urban areas, people do not do this anymore. [Female, public sector programme implementer, aged 58, Comilla, Bangladesh]

Whenever I deliver a male child, the parents spend a good amount of money as tips to hospital staff. Good thing is this kind of son preference is decreasing. People are more educated now. Young couples do not have son preference. [Female, obstetrician-gynaecologist, aged 51, Rangpur, Bangladesh]

Minds have changed now and I have not seen much preference for a son. [Female, sonologist, age 70, Karachi, Pakistan]

I don't agree with the statement that there is son preference. I have noticed that mothers want at least one daughter as they are very close to their mothers, while in our society now, sons are less caring. [Female, general physician, aged 48, Karachi, Pakistan]

Yes, with education and in urban areas, it is less, but it is still there in rural areas; earlier 100 percent wanted boys, now it may be down to 70–80 percent. The young are less concerned about having sons but have to obey the older generation. [Female, general physician/MBBS, aged 40, Sonipat, Haryana, India]

I see a change. I know some who are happy with one daughter and are not planning a second child. Now, educated people don't discriminate; young couples don't, but still the elders of the family try to influence their thinking. [Female, ANM, aged 42, Kurukshetra, Haryana, India]

Recently, I heard the news that women are participating in funeral processions and that last death rituals are performed by daughters. This kind of practice is being developed. There is a change in thinking now. I have encountered many couples who are interested in having girls. Boys usually move away from the family—sometimes abroad; so, parents prefer girls than boys. People think that the daughter will love them more than the son. [Male, health care provider, aged 59, Kaski, Nepal]

Son preference has been weakening in this district. These days, at least educated families and urban people don't care about it (whether son or daughter). They don't care much about the sex of children. Around 60–70 percent in rural areas and 10–15 percent or 20 percent (in urban areas) still have son preference but the trend has decreased. I feel it is due to education.... they have started thinking that a son and a daughter are equal. They become proud of what their children (daughter/s) have done and it follows when you see other people's daughters. [Male, health care provider, aged 40, Tanahun, Nepal]

Misuse of technology

Most key informants from the study districts of all four countries were familiar, either through their own interactions or those of their colleagues and/or the communities they served, with women and families seeking disclosure of the sex of the foetus; all agreed that abortions of female foetuses did occur, although, because abortions themselves are so restricted in Bangladesh (beyond 10 weeks) and Pakistan, the practice was perceived to be rare in these two settings. In India, some key informants suggested that these practices no longer existed but had taken place till a few years ago. Given the different contexts prevailing in each country, we discuss misuse of technology countrywise.

Disclosure of the sex of the foetus in settings where disclosure is not prohibited legally: Bangladesh and Pakistan

Bangladesh

Key informants across all categories agreed that disclosure of the sex of the foetus was widespread, that pregnant women regularly sought disclosure, and most obstetrician-gynaecologists and radiologists informed their patients about the sex of the foetus. In a few instances, they suggested that when approached, several health care providers dissuaded pregnant women and their families from insisting on knowing the sex of the foetus, emphasising that such information was not important for childbirth, and preferring instead, to counsel them about care during pregnancy, clearly suggesting concerns about women opting for the abortion of an unwanted female foetus. However, all key informants admitted that if families insisted, health care providers did inform them of the sex of the foetus. For example:

Actually, people do ultrasonograms mainly to know the sex of the foetus. Service providers who do not disclose the sex of the foetus lose clients. Once, a couple came to me for an ultrasonogram. When I did not disclose the sex of the foetus, the couple became very upset. And they went to another clinic and had the

ultrasonogram performed there, and got information about the sex of the foetus. [Male, radiologist, aged 36, Dhaka, Bangladesh]

When a client comes for an ultrasonogram, we ask her about the sex of her first child. If she says her first born is a girl, and if we see she is going to have a girl again, then we don't tell her about the sex of the foetus. We say it's not clear if it's a boy or a girl. [Male, radiologist, aged 34, Rangpur, Bangladesh]

...People really don't think much about the sex of the foetus when it comes to their first child. But during the second pregnancy, women go through an ultrasonogram. Even people in the rural areas know about this. When people find out they are not going to get a son, they become upset. As a result, the pregnant mother has to endure different types of physical and mental torture, but they do not go through abortion; not usually. In fact, urban people who are rich and educated are more likely to have an abortion; but even they do it to keep their family small, not because of the sex of the child. [Female, public sector programme implementer, aged 58, Comilla, Bangladesh]

When patients ask about the sex of the foetus, service providers usually tell them. But that doesn't mean all providers reveal the sex of the foetus or provide it willingly. In the case of the first child, almost all service providers reveal the sex of the foetus. Many people get upset when they hear the news of a girl child, but they do not undergo abortion. [Male, NGO programme implementer, aged 33, Rangpur, Bangladesh]

No differences were discerned between narratives relating to the situation in the two districts.

Pakistan

As in Bangladesh, the majority of health care providers reported that most women and their families asked about the sex of the baby, and this was the case across all socioeconomic groups and among educated as well as uneducated people. Indeed, most health care providers suggested that more than 80 percent of their clients sought disclosure of the sex of the foetus, and most of the remaining health care providers agreed that more than half their clients did so. Correspondingly, they agreed that 70–80 percent of health care providers would inform women or their families about the sex of the baby, while the remaining agreed that more than one-half would do so.

Health care providers also agreed that the demand for disclosure of the sex of the foetus had increased. They gave a number of reasons for this, including that people were increasingly aware of prenatal diagnostic techniques that reveal the sex of the foetus, that more facilities had become available, that birth preparedness had become a norm in society and prenatal diagnostic techniques were perceived as an essential component of preparing for birth, and that families wish to prepare for the baby with names, clothes and so on. Notably, not a single health care provider suggested that the desire to know the sex of the foetus was associated with any intention of aborting a female foetus.

Even so, several gynaecologists expressed discomfort about revealing the sex of the foetus. Some indicated that in both public and private tertiary care hospitals, there is a general policy that the sex of the foetus should not be disclosed to families. Two health care providers reported that they were acquainted with providers who refuse to disclose the sex of the foetus, arguing that this is against their code of ethics and religious beliefs. One key informant who had her own clinic reported that she has posted a notice at the entrance of the facility indicating that the facility would not disclose the sex of the foetus to clients. Clearly, these examples suggest that several health care providers did recognise the link between disclosure and sex-selective abortion, and, as in Bangladesh, many made efforts to counsel those carrying a female foetus against aborting it. For example:

We inform them if they ask, but we counsel them against termination if they intend to do so. [Female, nurse, aged 22, Karachi, Pakistan]

I don't think there is any harm in telling the sex (of the foetus). Now, there is so much modernisation that we cannot hide it. If the gynaecologist refuses to disclose the sex, then the sonologist will tell them. [Female, gynaecologist, aged 60, Karachi, Pakistan]

Most of the educated people come with full knowledge taken from the internet and if we don't tell them, they argue. [Female, general physician, aged 50, Karachi, Pakistan]

Most health care providers agreed, moreover, that the demand for foetal sex disclosure was more prevalent in Karachi than elsewhere in the country, particularly in rural areas.

Disclosure of the sex of the foetus in settings where disclosure is legally prohibited: India and Nepal

India

Most key informants, irrespective of district and informant category, agreed that women continued to seek information on the sex of the foetus during regular ultrasound examinations. Almost all health care providers acknowledged that in their district, requests for disclosure of the sex of the foetus continued to be made, and most of them suggested that irrespective of the counselling they provided, many women did go on to access services, either from unscrupulous providers in their own districts, or from neighbouring districts and states. Public sector programme implementers engaged in implementing the PCPNDT Act, were unanimous that the practice of disclosing the sex of the foetus is continuing in their district, performed by not only unqualified providers, but far more frequently, by unscrupulous doctors, including those in the public sector. NGO programme implementers concurred with this view, and, like their counterparts in the public sector, suggested that those who were unable to access services for disclosure within their district simply crossed state borders and obtained the service elsewhere. For example:

Yes, people ask, but we explain that disclosure is not allowed. For an ultrasound test, there is lot of paperwork that they have to complete, and they have to sign this statement saying that they are not getting the ultrasound test done to know the sex of the foetus.... In a day, if I see 50 patients then one or two patients ask this. [Male, general physician/MBBS doctor, aged 38, Sonipat, Haryana, India]

When it is established that certain doctors do it and others don't, then women who want to know (the sex of the foetus) just go to those doctors. And they do not come to (doctors like) us. It doesn't happen here. And if they do come here, they would return knowing our answer and would not visit again. The number of providers doing that (disclosure of foetal sex) here is very small; perhaps, someone may come and ask, otherwise they don't come. I think 20–40 percent of people might be doing it; those who are with their first child would usually not want to know. If they have daughters already, then they may want to find out. These women are fewer in villages; it is mostly educated women, like those from Sikh families or Jat communities..... (Nevertheless), people who want to do it (sex-selection test) can still do it. I have a couple of patients who had got it done outside, from Uttar Pradesh (the neighbouring state); there was one who did not get an abortion done, she told me she had conceived a daughter but she did not get the abortion done and her pregnancy is continuing. There are many who come till three or three and a half months (of pregnancy) and then they disappear; they stop coming, I don't know where they go but the assumption is that they have got the baby aborted..... Of all the patients I have had, two told me (about it); one did the test but not an abortion, and one got it aborted and even she got it done outside (in the neighbouring state)—she did not tell me where; she came to me because she was bleeding after the abortion, this happened two to three months ago. [Female, obstetrician-gynaecologist, aged 50, Kurukshetra, Haryana, India]

Often people from the health department are involved in sex-selection (tests). They easily manage to carry out multiple ultrasounds and are paid a small commission. It is a big nexus; health workers themselves inform the local people where to go and how to get the procedure; identifying these people (workers) is another challenge. Recently, we had a case of a dai (traditional birth attendant) who was caught in Jajjar with a diary containing a record of 500 sex-selective abortions; there were five court cases based on that. These things (sex-selective abortions) do not happen only in rural areas, educated people also do this, so do the rich. But, facilities are more easily available in urban than rural areas, and people there are richer too. [Female, law enforcement officer, aged 52, Panchkula, Haryana, India]

Literate and rich people are the ones who demand these (illegal) services more because in villages many are not even aware about the fact that there is a machine through which they can detect the sex of the foetus; moreover, it is not possible for the poor to invest so much and obtain these services..... According to my knowledge, in Sonipat there are about 100–125 doctors who have ultrasound machines but only some of them are involved in providing these services, and the government is very well acquainted with those who are involved and who are not involved in this work. Apart from this, Sonipat shares its border with Delhi and Uttar Pradesh, therefore, people easily avail of these services from those places. I would like to state an example from my family itself. One of my uncles already had three daughters and he wanted at least one son. So, the next time his wife got pregnant, he got her ultrasonography done and came to know that she

is again pregnant with a girl. Subsequently, after we persuaded him, he did not get the child aborted and his wife gave birth to her daughter. [Male, NGO programme implementer, aged 46, Sonipat, Haryana, India]

Most key informants revealed the clandestine ways in which the sex of the foetus is revealed to women and their family: invoking gods versus goddesses (*Jai Sri Krishna* for a boy and *Jai Ma Durga* for a girl; gifting the couple a calendar with a photo of Lord Ganesh for a boy and a female goddess for a girl), conveying emotions of happiness and grief (*'happiness is coming, get sweets'* for a boy or *'the family will become burdensome'* for a girl) or through colours (pointing to something blue for a boy and pink for a girl). For example:

They (health care providers) reveal it openly because often, people are uneducated and may not understand a secret code. I once accompanied a pregnant woman who had gone for an ultrasound to Ambala and the doctor openly informed her that the foetus is female, but the test took place clandestinely and they asked her to take a different route to leave the nursing home. [Female, Staff Nurse, aged 27, Kurukshetra, Haryana, India]

Maybe, nobody gives such information now and, even if one or two doctors do so, they do it secretly because everybody is afraid of the consequences. I think the doctors give such information very astutely; what I mean is that while conversing with the patient, they ensure that there is no evidence (that such information has been given). I mean to say that no written prescription or no document is given (to the woman or her family). [Female, law enforcement officer, aged 66, Sonipat, Haryana, India]

Nothing takes place in the open because the doctors are also scared of the consequences and by this way (being secretive), everybody saves themselves. Either the compounder or other staff members of such doctors are involved in this work so that nobody doubts the doctor and he/she is protected from any problem. Lady doctors have Sisters (nurses) and male doctors have compounders, and it is these workers only who give all the information to the families.Once, I went to a health centre with someone, where somebody said, "Bhaiya, check karwaliya, khushi anewali hai" (we have checked, there is good news). Therefore, it was apparent that it's a boy. At times, mothers request the doctor to tell them if it is a boy or a girl and the doctor tells them to be happy and not to worry because it's good news; then the woman knows that she is going to give birth to a boy. [Male, NGO programme implementer, aged 31, Sonipat, Haryana, India]

As the above narratives suggest, there was little interdistrict difference in the assessments of the key informants in respect of the extent to which the disclosure of the sex of the foetus continued to take place in their district.

Nepal

More than in India, almost all health care providers in the two districts of Nepal reported that pregnant women continued to seek information about the sex of the foetus. They suggested that requests for disclosure were made by women, irrespective of caste/ethnicity, religion and economic status. At the same time, a few health care providers, particularly those from Tanahun, suggested that women belonging to untouchable caste groups, at one extreme, and higher caste groups on the other, were more likely than those from other castes to seek information about the sex of the foetus. They also acknowledged that some health care providers do indeed disclose the sex of the foetus, and do so to women who are in their second trimester (18–30 weeks). Several health care providers suggested that they do not disclose the sex of the foetus until after the woman has completed six months of pregnancy, so that women would not have the option to seek an abortion if the foetus was female. They suggested that pressure from the client, easy access to services, weak enforcement of the law, and unscrupulous providers accounted for the prevalence of the practice, even though illegal. For example:

No difference by ethnic background. Whether they are from high classes or low classes, they all ask about the sex of their foetus. But what I have noticed is that Mongolian people generally don't have any problem about giving birth to either a son or a daughter because they don't have a male-dominated culture. Mostly these demands take place among Brahmin and Chhetri castes; Hindus generally ask about the sex of the foetus. [Male, health care provider, aged 52, Kaski, Nepal]

We have to provide services to more than 70 patients every day. Almost all the women and the visitors (their escorts) ask us to disclose the sex of the foetus. We should not and can't show our anger at these requests.

So, we tell them the sex of the foetus at a later period of their pregnancy, say, after 20 weeks. [Male, health care provider, aged 39, Kaski, Nepal]

Yes, most women ask me to disclose the sex of their foetus; they offer more money for that. Usually, women who are 26–27 weeks pregnant come for antenatal checkups and then they do an ultrasound. Once a woman who was told the sex of her foetus went on to have an abortion at 26–27 weeks of pregnancy; so, after that (happened), I don't tell them. [Male, health care provider, aged 37, Tanahun, Nepal]

Providers disclose the sex of the foetus to women for different reasons. Of course, the most common reason is clients' pressure. Service-seekers pressurise us to disclose the sex of the foetus. The next reason is our value. People trust us only when we can satisfy them. If we did not disclose, they would not trust us. A third reason many be related to the income of service providers. When they disclose the sex of the foetus, they get good money. The other reason is that there is unhealthy competition among providers in the market; they have to satisfy their clients to remain in the competition, so, they disclose it. [Male, health care provider, aged 27, Tanahun, Nepal]

As in India, key informants in Nepal, notably NGO programme implementers, suggested that service providers disclosed the sex of the foetus to women clandestinely. They suggested that while some service providers openly disclose the sex of the foetus to women, others did so in writing or by drawing a picture to inform their clients, for example:

At first, providers won't disclose the sex of the foetus. They might send women to the counter (to their administrative assistant) where she might have to bargain (about the fee) with them. I think they might ask the woman to pay additional money for the disclosure. Then, the doctor might reveal the sex verbally only if the woman commits to them that she will not leak out the fact that the doctor has told her the sex of the foetus. I don't think such practices exist in government facilities. It is only in private service centres. [Male, NGO programme implementer, aged 31, Tanahun, Nepal]

One of my relatives is a radiologist. I know his way of disclosing the sex (of the foetus). He draws a sign to refer to the sex of the foetus. He draws '♀' to denote female and '♂' to denote male in each report. But if a woman does not understand the sign, he would not reveal it verbally. [Male, NGO programme implementer, aged 35, Kaski, Nepal]

Most health care providers also agreed that the demand for disclosure of the sex of the foetus had increased in recent years, and attributed this increase to easier access to technology, and the persistence of a patriarchal culture and the traditional desire for sons.

The demand for disclosure has increased. Ten years ago, there wasn't a single centre in Tanahun. But now, there are a number of service centres and service providers and this has encouraged the general public to seek disclosure, and the demand for disclosure of the sex of the foetus has increased in recent years. [Male, health care provider, aged 27, Tanahun, Nepal]

As a consequence of our patriarchal society, the demand for disclosure of the sex of the foetus has increased. People believe that having a son is important for the family's honour in society, that a son can earn for the family, and that a son is necessary for continuing the family line. [Male, health care provider, aged 52, Kaski, Nepal]

Unlike in India, interdistrict differences were acknowledged. Key informants, mainly health care providers, suggested differences in the availability of services and trained providers across the two districts, with a greater concentration in Kaski than Tanahun, and, as a result, more women from Kaski than Tanahun accessed services, a finding confirmed by our survey findings reported earlier. For example:

There is no sex determination (testing) here (Tanahun). Women have to go to Pokhara (Kaski) where they do the ultrasound after the 13th week of pregnancy and if they have any doubt, they repeat it two weeks later. I have heard that they go to Pokhara (Kaski), or Bharatpur (Chitwan), for this service. They identify the sex of the foetus there and if it is a female child, they also abort it there. [Male, health care provider, aged 40, Tanahun, Nepal]

I think it is not difficult for women to select the sex of the foetus in Kaski. There are various centres there to provide this service with ultrasonography and a large number of radiologists too. Women have more

options to select from in terms of services; so, if one centre refuses, they can get the service in another.
[Male, health care provider, aged 52, Kaski, Nepal]

Persistence of sex-selective abortion

Key informants from all four countries, irrespective of category, acknowledged that sex-selective abortion takes place in their country and in study districts. In Bangladesh and Pakistan, the incidence of sex-selective abortion was, however, described as very rare; in India and Nepal, far more prevalent.

Sex-selective abortions in settings where abortion is legally restricted

Bangladesh

Health care providers were probed about the extent to which abortion beyond 10 weeks took place in their district, and the extent to which sex-selective abortion comprised the motive for abortion. All key informants were aware of the law surrounding abortion in Bangladesh. At the same time, about one-half of all health care providers noted that violation of the abortion law does occur. Indeed, they estimated that up to 20 percent of pregnancy terminations occurring in study districts were illegal, that is, conducted among women who were more than 10 weeks pregnant and for reasons not permissible under the law. Even so, health care providers from both districts were unanimous in their conviction that the practice of sex-selective abortion was extremely rare. A few service providers from the two study districts mentioned that a negligible proportion of the abortions occurring in these districts were sex selective. For example:

...There was an incident... I heard about an abortion of a 5-month-old girl foetus. A pregnant woman whose foetus was nearly five months old came to me to know the sex of the foetus. She came to me with an ultrasonogram report to know what the report said, whether it was a boy or a girl. I knew her, so I told her it's a girl foetus. Later, I heard that she underwent an abortion. She came to me again later to discuss the matter. [Male, radiologist, age 49, Comilla, Bangladesh]

Similarly, although most programme implementers agreed that the practice of sex-selective abortion was extremely rare, a few did acknowledge its potential. For example:

Sex-selective abortion is very rare in our country. Financially, physically, socially, and morally—from every aspect—it is not acceptable to the people of rural areas in the country. Besides, our technology is not that developed yet. [Male, NGO programme implementer, aged 33, Rangpur, Bangladesh]

... If the technology to know the sex of the foetus within 10 weeks of pregnancy were available in our country, the number of sex-selective abortions would increase. [Female, public sector programme implementer, aged 62, Dhaka, Bangladesh]

Even though many people get upset when they learn they are going to have a daughter, they do not have an abortion. Sex-selective abortion is very uncommon in our country. And this is because of our lack of technology and because the process is costly. [Female, public sector programme implementer, age 38, Rangpur, Bangladesh]

Pakistan

Health care providers were probed about whether clients continued or terminated pregnancies upon finding out that the foetus was female. The majority of providers interviewed were unaware of the exact provisions of the law, and the extent to which it permits abortion under certain conditions. In the opinion of these health care providers, about 60–70 percent of abortions are illegal. However, even they said that no one terminates a pregnancy because the foetus is female. Almost one-half of all health care providers noted that the sex of the foetus could not be determined until about 18–20 weeks of pregnancy through ultrasound technology, and that other techniques that detect the sex of the foetus earlier in pregnancy are not available in the country. These providers argued that it was difficult to access an abortion at such a late stage of pregnancy, and, as a result, it was rarely attempted. For example:

I have not heard about termination of a pregnancy in Pakistan just because the foetus is female. [Female, general physician, aged 48, Karachi, Pakistan]

None, in my opinion, terminates a pregnancy because the baby is female; usually, they terminate the pregnancy due to contraceptive failure. [Female, gynaecologist, aged 52, Karachi, Pakistan]

Usually, we do not know about the outcomes of pregnancy; they may be discussing with their doctor or gynaecologist. [Female, radiologist/sonologist, aged 70, Karachi, Pakistan]

Till three months (of pregnancy), the sex (of the foetus) cannot be determined, and then it becomes too late for an abortion. One woman wanted to know earlier, but it is not possible. [Female, nurse, aged 42, Karachi, Pakistan]

One health care provider, however, suggested that despite the difficulties, sex-selective abortions do take place, while rarely, because of family pressure, and fears about treatment from family members following the birth of a daughter. This provider estimated that 10–20 percent of illegally conducted abortions were because of sex selection:

One woman came from Baluchistan secretly, (hiding her coming) from her husband, to abort her female foetus because the husband was absolutely against having a girl child. [Female, Lady Health Visitor, aged 36, Karachi, Pakistan]

Sex-selective abortion in settings in which abortion is legally permitted: India and Nepal

In both India and Nepal, second-trimester abortions are legally permitted under certain conditions, up to 20 weeks in India and up to 18 weeks in Nepal. While abortions are legally permitted under a host of conditions, sex-selective abortion is strictly forbidden under the law in both countries. Nevertheless, in both settings, all three categories of key informants confirmed that the practice continues to take place.

India

All key informants—though fewer public sector programme implementers than health care providers and NGO programme implementers—acknowledged that sex-selective abortion of female foetuses took place in their districts. Indeed, health care providers estimated that anywhere between one in ten and five in ten abortions taking place among women in their districts were sex selective. Many, especially medical officers, suggested that it was largely ‘unqualified’ persons—ASHAs (Accredited Social Health Activists), dais, ANMs, Ayurveds (BAMS) and nurses—who were the key violators. Several key informants, including most NGO programme implementers, perceived that women who underwent sex-selective abortion were pressurised to undergo the procedure by their husband and family members. For example:

One to two of ten abortions may be sex selective..... In villages, there are dais or even ANMs who are retired and know the job more or less; even they do it. [Female, obstetrician-gynaecologist, aged 50, Kurukshetra, Haryana, India]

Five of ten abortions are illegal and all these are for sex selection. [Female, obstetrician-gynaecologist, aged 40, Sonipat, Haryana, India]

One to two of ten (abortions) must be illegal, and all for sex selection. I admit there are still one or two centres providing these (illegal) services; maybe they have fixed some time for abortions when the raid team cannot catch them or they get information about raids in advance. [Female, ANM, aged 42, Sonipat, Haryana, India]

Once we had information of such an activity and conducted a raid. We found a woman with money who was getting ready for an operation. People generally perform such procedures at night or on holidays. [Male, law enforcement officer, aged 57, Sonipat, Haryana, India]

I think out of 100 pregnant women who get to know that they are pregnant with a girl child, 15 to 20 terminate their pregnancy. [Female, NGO programme implementer, aged 73, Sonipat, Haryana, India]

Most key informants, and all health care providers, agreed that once informed that the foetus is female, most women—either of their own will, or, more likely, under family pressure—find a way of terminating their pregnancy, and that neither counselling nor fear of apprehension can deter these women. For example:

See, this is the mentality of the public. Those who already have a daughter do not want to go ahead with the pregnancy and try and get it aborted. We refuse outright, but there are people who do (sex-selective)

abortions and those who want to do it can get it done anywhere. If it is not possible in their own state, they get it done somewhere else. [Female, general physician/MBBS doctor, aged 57, Kurukshetra, Haryana, India]

The one (woman) who has already decided that she does not want a girl would do anything to get an abortion, whatever may be the expense or distance. Sometimes, we can convince women and change their mind, but just one or two percent of women may be like this. Women who already have two to three daughters and now want a son, will go for these services. [Female, ANM, aged 50, Sonipat, Haryana, India]

Health care providers unanimously agreed that abortion providers who conducted sex-selective abortions were aware of the reason for the abortion, for example:

They know everything and only after having this information, they provide such services, and the reason is money. Sex-selective abortion is carried out in the second trimester and no doctor would provide such a service without knowing the reason. [Female, obstetrician-gynaecologist, aged 34, Sonipat, Haryana, India]

There are a lot of times when patients try to hoodwink me—they tell us that they have two children, a son and a daughter; they tell us they don't want a third child—but they are lying. As, mostly, this happens after three months (of pregnancy), we know that they have been told the sex of the foetus and we send them back..... The ones (service providers) who do it (sex-selective abortion) in the second trimester would know. [Female, obstetrician-gynaecologist, aged 50, Kurukshetra, Haryana, India]

Nepal

Almost all key informants—health care providers and programme implementers from both districts—perceived that women who undergo ultrasonography to detect the sex of their foetus and are told that they are carrying a female foetus will resort to sex-selective abortion, irrespective of cost. However, key informants from Tanahun suggested that because facilities were not as easily available in Tanahun, sex-selective abortions may be undertaken less frequently in Tanahun than in Kaski; for example:

We don't have a centre for second-trimester abortion in Tanahun district. If a woman wants to abort a female foetus after disclosure of the sex of the foetus, she has to go to Gandaki Zonal Hospital (Kaski). So, because access to a service centre is difficult, women in this district continue their pregnancy regardless of the sex (of the foetus) (Tanahun). [Male, health care provider, aged 38, Tanahun, Nepal]

I have an example of sex selection. One of my friends had a good professional status. She had two daughters. During her third pregnancy, her family threatened to send her away from her home if she delivered another daughter. So, she did a USG (ultrasonogram) to select the sex of the foetus. She came to know that it was a son. So, she continued the pregnancy. But, if we generalise from this kind of situation, it is clear that female foetuses are aborted. [Female, NGO programme implementer, aged 31, Tanahun, Nepal]

When women or their family come to know that the sex of the foetus is female, they abort it. In Kaski, people go to a private hospital for sex-selective abortion even though they have to pay a higher fee and the facility may not have been approved for second-trimester abortion. [Female, public sector programme implementer, aged 46, Kaski, Nepal]

Chapter 3

Exposure to communication, advocacy and community mobilisation programmes

This chapter has highlighted, from women's perspectives, their awareness of the law on gender-biased sex selection in India and Nepal, and, in these countries as well as in Bangladesh, their exposure to various communication, advocacy and community mobilisation activities intended to change attitudes about son preference and gender discrimination, and discourage practices of sex determination and sex-selective abortion. It has also explored the perceptions of key informants in the three countries with regard to these behaviour change efforts in their district. Although communication, advocacy and community mobilisation activities were conducted in all three countries, the extent to which they focused on raising the value of daughters or reducing gender-biased sex selection varied. Interdistrict differences were not evident in either Bangladesh or Nepal. Indeed, in these study sites, it appeared that women in the district with an adverse sex ratio at birth were as likely as or more likely than their counterparts in the district with a normal sex ratio at birth to have been exposed to communication, advocacy and community mobilisation activities. Key informants from all categories, in both countries, confirmed that specific programmes to address gender-biased sex selection were not implemented, and those intended to challenge gender norms were implemented in conjunction with educational entitlement and conditional cash transfer programmes (as appropriate) for girls, or empowerment programmes for women.

In Haryana, India, not only were communication, advocacy and community mobilisation activities more extensively implemented in general, but interdistrict disparities were evident. Programmes did indeed appear to have been stronger and more wide-ranging in Kurukshetra district which displayed some improvement in the sex ratio at birth than in Sonipat district where it remained unchanged. For example, more women from Kurukshetra than Sonipat were aware of the PCPNDT Act; so too, one-on-one counselling by frontline health workers and efforts by religious leaders appeared to be significantly more likely to be reported by women in Kurukshetra than in Sonipat. Likewise, although more NGO activities were conducted in Sonipat than in Kurukshetra, Kurukshetra reported a strong commitment to community mobilisation on the part of the district administration, including regular interaction with village communities on the one hand, and with students and teachers, on the other.

Communication, advocacy and community mobilisation programmes hold promise for changing patriarchal norms and son preference in general, and more specifically, in reducing the practice of gender-biased sex selection. These have included programmes aimed at reducing discrimination against girls and fostering a more equal environment for sons and daughters, and those directly focused on discouraging gender-biased sex selection and the termination of pregnancies carrying a female foetus. They include programmes conducted by non-governmental organisations, the public sector, the media, as well as the efforts of influential individuals.

In this section, we explore the extent of women's awareness of the law on gender-biased sex selection (Haryana, India, and Nepal), and in Bangladesh, Haryana, India and Nepal, of behaviour change communication messages delivered through the media; by doctors, nurses and frontline health workers, as well as religious leaders and NGO programme implementers, challenging gender norms and advocating equal treatment of sons and daughters, as well as, in India and Nepal, providing information about laws on gender-biased sex selection. We also explore the perceptions of key informants in the three countries about communication, advocacy and community mobilisation programmes in their district. Specifically, we explore the extent to which districts with more normal sex ratios at birth/improvements over time in their sex ratios at birth revealed greater awareness of the law (India and Nepal) and more access to communication, advocacy and community mobilisation activities than those with unbalanced or stagnating sex ratios.

A. Perspectives of women

Findings are suggestive and vary across countries. For example, with regard to awareness of the law, as summarised in Table 3.1, patterns differ across the two countries, India and Nepal, where disclosure of the sex of the foetus is legally prohibited. In Nepal, there is no evidence that awareness about the law was greater in Tanahun (the district with a normal sex ratio at birth) than Kaski (the district with an unbalanced sex ratio at birth). In contrast, in Haryana, India, findings do lend support to our hypothesis, in that women in Kurukshetra, the district in which the sex ratio at birth improved over time, did indeed reveal greater awareness about the law on gender-biased sex selection than those in Sonipat district in which no such change had occurred.

Table 3.1: Awareness of laws relating to disclosure of the sex of the foetus

Percentage of women reporting awareness of the law on sex selection, and that those providing and those seeking services for disclosure of the sex of the foetus can be prosecuted, according to residence, India and Nepal

Awareness of the law	Haryana, India		Nepal	
	Sonipat	Kurukshetra	Kaski	Tanahun
There is a law on sex selection	86.4	95.7***	43.0	35.2*
A person seeking disclosure of sex of the foetus can be jailed	83.0	92.6***	27.4	26.4
A service provider/doctor/person conducting an ultrasound can be jailed if he/she discloses the sex of the foetus	84.0	94.3***	26.6	22.0
Number of women	546	555	500	500

Note: * and *** indicate that differences between the two districts of the country are significant at $p < 0.05$ and $p < 0.001$, respectively.

Likewise, as evident from Figure 3.1, interdistrict disparities in Bangladesh and Nepal lend no support to the argument that those residing in districts with normal sex ratios at birth (Rangpur and Tanahun, respectively) had more exposure to communication, advocacy and community mobilisation activities promoting equal treatment of boys and girls (Figure 3.1a), and discouraging gender-biased sex selection (Figure 3.1b) than did those from districts with skewed sex ratios at birth (Comilla and Kaski, respectively). Again, in Haryana, India, the situation differs; while almost all women from both districts had been exposed to messages advocating equal treatment of sons and daughters (Figure 3.1a), women from Kurukshetra, where the sex ratio at birth had improved over time, were significantly more likely than those from Sonipat, where it had remained stagnant, to report exposure to messages relating to gender-biased sex selection (Figure 3.1b).

Figure 3.1: Percentage of women reporting exposure to messages advocating equal treatment of boys and girls, and discouraging gender-biased sex selection, according to residence, Bangladesh, India and Nepal

Figure 3.1a: Exposure to messages advocating equal treatment of boys and girls

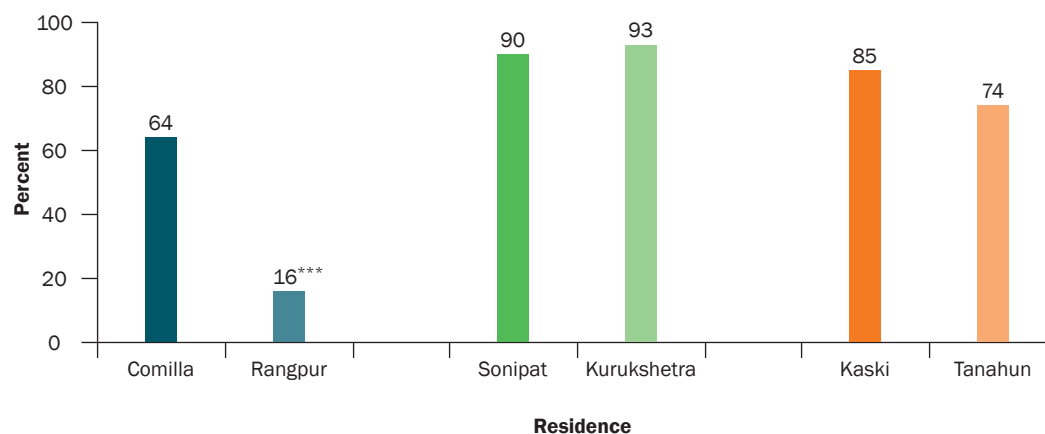
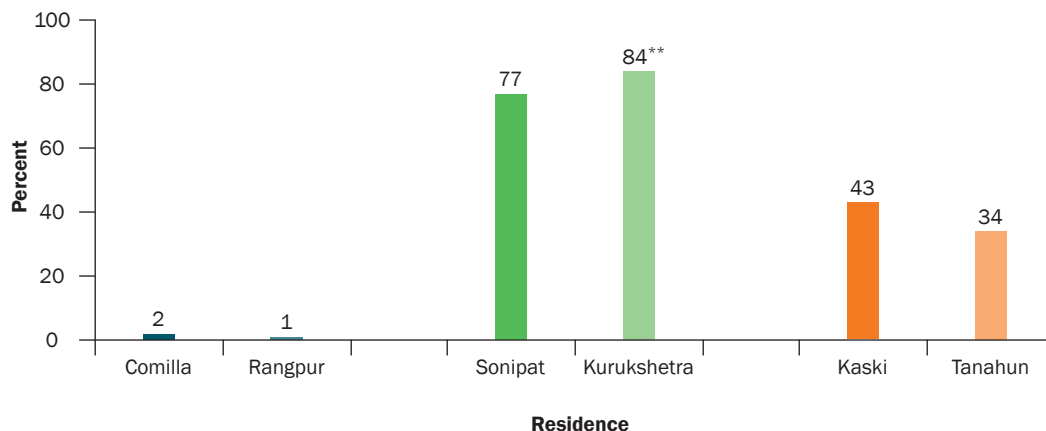


Figure 3.1b: Exposure to messages discouraging gender-biased sex selection



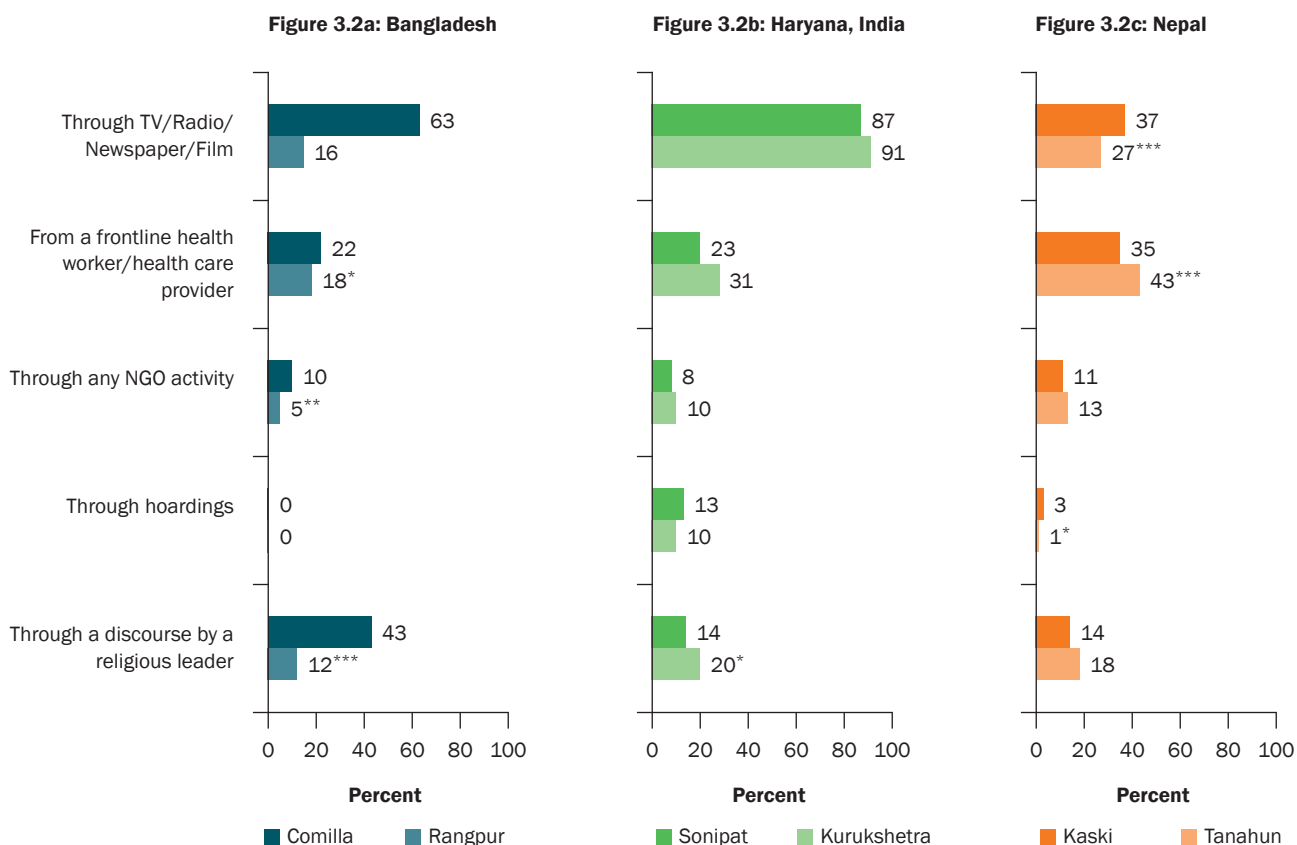
Note: ** and *** indicate that differences between the two districts of the country are significant at $p < .01$ and $p < 0.001$, respectively.

Women in all the study districts of Bangladesh, India and Nepal reported a variety of sources from which they had received messages advocating equal treatment of boys and girls and/or discouraging gender-biased sex selection. Findings, presented in Figure 3.2, suggest that while country-specific patterns varied, the media were the leading source of information in most districts. Again, there was no evidence from Bangladesh or Nepal that more women in districts with normal than unbalanced sex ratios at birth had received messages from various sources. Indeed, it appeared that these districts were less exposed than districts with adverse sex ratios to communication, advocacy or community mobilisation efforts delivered by the media, or from a frontline worker, health care provider, or religious leader.

- In Bangladesh, women from Comilla, the district with an adverse sex ratio at birth, were significantly more likely than those from Rangpur, the district with a normal sex ratio at birth, to have been exposed to messages or programmes challenging traditional gender norms relating to sons versus daughters (Figure 3.2a). Overall, women from Comilla were four times more likely than those from Rangpur to report exposure to advertisements, and almost all those exposed to such messages reported the mass media (television/radio/newspapers/films) as the primary source of such information. In contrast, hardly any women had been exposed to messages about gender-biased sex selection or termination of pregnancies carrying a female foetus, or seen a signboard notifying that a particular facility does not provide sex-selection tests; this is not surprising given our earlier findings about the limited prevalence of gender-biased sex selection and subsequent abortion of the female foetus (not shown in the figure). Women from Comilla were also significantly more likely than those from Rangpur to report exposure to messages delivered by religious leaders (43% versus 12%), NGOs (10% versus 5%), or health workers (22% versus 18%) advocating equal treatment of daughters and sons (Figure 3.2a).
- Findings from Haryana, India, were mixed (Figure 3.2b). About nine in ten women from both districts had been exposed to messages about equal treatment of sons and daughters, son preference and gender-biased sex selection from the media; even so, more women from Kurukshetra, the district displaying improvements in its sex ratio at birth, than Sonipat reported having heard media messages specifically discouraging gender-biased sex selection or termination of pregnancies carrying a female foetus (75% versus 69%, not shown in the figure), and to have received such messages as girls' right to be born (46% versus 34%, not shown in the figure). While few women had been exposed to messages through hoardings (10–13%), considerably more—60–65 percent of women—from both districts reported having seen a signboard in a health facility notifying that it did not offer sex-selection tests; this is not unexpected as ultrasound services are routinely accessed by pregnant women to monitor the growth and development of the foetus, and such facilities are bound by law to display a notice that the facility does not provide services for determining the sex of the foetus. Figure 3.2b further suggests that women from Kurukshetra were more likely to have been exposed to counselling from a frontline health worker or health care provider (31% versus 23%), as well as to discourses from religious leaders (20% versus 14%).

- In Nepal, too, as in Bangladesh, women from the district with an adverse sex ratio at birth (Kaski) were significantly more likely to report exposure to the media (37% versus 27%) and to hoardings (3% versus 1%), significantly less likely to report exposure to messages from health care providers (35% versus 43%), and about as likely as those from the district with a normal sex ratio at birth (Tanahun) to report exposure to messages delivered by NGOs (11–13%) and religious leaders (14–18%) (Figure 3.2c). Further, although seeking disclosure of the sex of foetus for sex-selective abortion is legally restricted as in India, just 12–15 percent of women from both districts had seen a signboard announcing that a particular facility does not perform sex determination tests.

Figure 3.2: Percentage of women reporting exposure to various messages advocating equal treatment of boys and girls, and discouraging gender-biased sex selection by source of information, according to residence, Bangladesh, India and Nepal



Note: *, ** and *** indicate that differences between the two districts of each country are significant at $p < .05$, $p < .01$ and $p < 0.001$, respectively.

B. Perspectives of key informants

Perspectives of key informants from the three countries about advocacy, communication and community mobilisation activities largely corroborated the situation suggested by women’s responses.

Advocacy, communication and community mobilisation in settings where abortion is legally restricted

Bangladesh

Programme implementers from public as well as NGO sectors in Bangladesh suggested that there are hardly any advocacy or community mobilisation efforts in their country aimed at discouraging gender-biased sex selection or the termination of pregnancies carrying a female foetus; while familiar with programmes to raise the status of the girl child, they suggested that such activities were delivered through entitlement programmes for girls rather than through advocacy and community mobilisation.

Advocacy, communication and community mobilisation in settings where abortion is legally permitted

India

In India, key informants (largely programme implementers from the public and NGO sectors) not only described a wide range of communication, advocacy, and community mobilisation activities, but also suggested that these activities were more imaginatively and extensively implemented in Kurukshetra than in Sonipat. For example, key informants from both districts described activities aimed at challenging patriarchal gender norms and discrimination against girls, as well as those specifically targeted at informing communities about the PCPNDT Act and dissuading pregnant women from seeking disclosure of the sex of the foetus or terminating pregnancies carrying a female foetus. They described programmes that were implemented by a range of players, including those from the public sector and the Health Department, as well as lawyers, magistrates and judges, and, at least in Sonipat, several NGOs. Key informants from both settings reported that programmes in their district targeted an array of audiences, including students and teachers, communities more generally, as well as frontline health workers and facility-based health care providers; and ranged from one-on-one interactions between frontline workers and women, to community meetings held by frontline health workers and those directly responsible for enforcing the PCPNDT Act to sensitise communities, as well as students and teachers in schools and colleges. NGOs described conducting mass weddings and public pledges not to practice gender-biased sex selection. Several also discussed the meetings and sensitisation programmes held by the district health authorities for various categories of health care providers to discuss issues related to gender-biased sex selection and sex-selective abortion.

Key informants from Sonipat described such activities as follows:

We organise workshops, seminars in collaboration with NGOs to increase awareness. We also organise rallies, wall painting sessions and poster competitions to change the mindset of people..... Awareness campaigns etc are very useful in bringing change in the attitudes of people. People participate in these activities and attend meetings..... There is a scheme called Beti Bachao Beti Padhao Abhiyan (Save the Daughter, Educate the Daughter Campaign) which operates at the district and block levels. They have fixed a target of an annual 10-point increase in the sex ratio... [Female, PO/CDPO, ICDS, aged 52, Sonipat, Haryana, India]

We work to spread awareness about having a girl child. We provide vocational training to girls so that they become independent through their own earnings. We also teach them sewing. Other than this, we organise programmes to send a message to people that they should not differentiate between a son and a daughter, that both are the same (equal); that they should not kill a foetus after sex determination—such activities are wrong. We teach these things to community members..... On the issue of sex determination, we work on spreading awareness among people. [Male, NGO programme implementer, aged 49, Sonipat, Haryana, India]

Our organisation implements several programmes to raise awareness about sex selection and also arranges mass marriages so that parents don't consider daughters to be a liability. In mass marriage ceremonies, there are 5,000–7,000 people who take a pledge never to seek sex selection. [Male, NGO programme implementer, aged 62, Sonipat, Haryana, India]

While activities intended to raise awareness and challenge traditional attitudes were described by key informants, mainly public sector programme implementers in both districts, some important differences were observed. In comparison to key informants from Sonipat, those from Kurukshetra described innovative advocacy and community mobilisation schemes in which district officials played a key role. For one, school- and college-based programmes conducted by high-level health sector officials were discussed; these programmes offered senior officials an opportunity to interact with students and teachers, and more specifically, to sensitise students and obtain pledges from teachers to desist from gender-biased sex selection and gender discriminatory practices, for example:

I think IEC (information, education and communication) programmes have some influence at community level and result in change. Here, schools and colleges are the main target groups.... There are also different awareness-raising programmes which even involve school teachers and students. Every first Tuesday, we have oath ceremonies in schools and colleges..... [Male, law enforcement officer, aged 52, Kurukshetra, Haryana, India]

The DC (Deputy Commissioner) and Civil Surgeon also visit schools and colleges to inform students about such affairs on the second Tuesday of each month. [Female, PO/CDPO, ICDS, aged 50, Kurukshetra, Haryana, India]

Second, key informants also described a programme known as the *Night Halt* or *Open Durbar* programme. In this programme, public sector officials (the Chief Medical Officer, Medical Officers, and/or the District Magistrate and the District Attorney) and other staff members from the Health and ICDS Departments, visit villages in the district on a weekly or bi-monthly basis, interact with village communities and make efforts to change patriarchal mindsets and raise awareness about various laws and programmes, including the PCPNDT Act. Such *Open Durbars* also offered an opportunity to community members to present their concerns to district officials. For example:

The former DC conducted a village-to-village awareness campaign for people and for health providers. He organised meetings and training programmes and has sensitised people to a great extent. The current DC is also working hard in this regard and organising Night Halts and Open Durbars to make people aware of various schemes related to reducing sex selection. Night Halts take place twice a month after 5 pm when all government health officers are present, and take an oath to offer dedicated services and discuss issues relating to sex selection in their division. [Female, PO/CDPO, ICDS, aged 50, Kurukshetra, Haryana, India]

There is also a programme called 'Night Halt programme' where officials spend a night in a particular village and try to increase awareness among the locals through discussion and documentaries. [Male, law enforcement officer, aged 52, Kurukshetra, Haryana, India]

Recently, our DC organised a special Night Halt programme where a lecture was delivered by a swami (religious leader) to ensure that more people understand the evils of sex selection and that it is against the law. Beti Bachao Beti Padhao is another campaign which aims to increase people's awareness of the issue. Meetings are held to raise awareness..... [Female, PO/CDPO, ICDS, aged 52, Kurukshetra, Haryana, India]

Nepal

In contrast, in Nepal, about one-half of the key informants who were interviewed from both districts suggested that there were programmes in their district that aimed at increasing public awareness about the importance of enhancing the value of women and girls, and a few mentioned programmes for girls that aimed at building awareness of health matters and gender-based violence. They suggested that these programmes had indeed contributed to raising awareness and changing attitudes toward women and girls. Even so, key informants suggested that specific programmes intended to raise awareness about gender-biased sex selection or equal treatment of sons and daughters were rare. For example:

We don't have any specific programmes to raise the value of girls and women. Such issues are covered under other programmes as cross-cutting issues. The issues of gender, abortion, and raising the value of girls might be included as part of other programmes. But I don't know of any programme targeted to raising girls' or women's value. [Male, NGO programme implementer, aged 35, Kaski]

Chapter 4

What works to reduce gender-biased sex selection: Perspectives on law enforcement

This chapter has highlighted, from the perspectives of women interviewed in the survey in India and Nepal, their experience with regard to the implementation of the law in their district (relating to disclosure of the sex of the foetus and women's legal right to abortion/sex-selective abortion), and their attitudes about the punishment to be meted out to health care providers and women or families who violate the law. It also explores, from the perspectives of key informants from all four countries, their experiences with the implementation of laws and the extent to which they believe law enforcement has been effective, and their insights into the outstanding challenges.

Relatively few women in Haryana, India, and Nepal were aware of raids on a facility or the prosecution of a doctor consequent to enforcement of the law. In India, somewhat more women from Kurukshetra than Sonapat had heard about raids taking place in their district (26% versus 21%), but about as many in both districts had heard about a doctor or facility being prosecuted (41–42%). In Nepal, hardly any women were aware of both types of incidents, irrespective of district (3–7%). Attitudes were also probed and suggest that 92–94 percent of women from the two districts of Haryana, India, and 62–68 percent from the two districts of Nepal, believed that health care providers who disclose the sex of the foetus as well as those seeking disclosure should be prosecuted. In both countries, many believed that or were undecided about whether the law should permit women who have two or more daughters to detect the sex of their foetus and terminate the pregnancy if the foetus is female: among women with two or more daughters, one-third in the two districts of Haryana, India, and Tanahun, Nepal, and as many as one-half in Kaski, Nepal, the district with an unbalanced sex ratio at birth, believed so. Finally, women in both settings expressed scepticism about whether the practice would diminish because of raids and other law enforcement measures.

In Bangladesh and Pakistan, where disclosure of the sex of the foetus is not legally prohibited, but abortion is legally restricted (beyond 10 weeks in Bangladesh), key informants (health care providers) discussed the extent to which abortion laws were enforced and sex-selective abortions took place. Key informants from both districts of Bangladesh suggested that services beyond the legal limit did take place in their district, and that violations of the law did occur. In both countries, moreover, key informants agreed that abortion laws were inadequately enforced, and most key informants reported that they had not heard of action being taken against any provider for performing an illegal abortion.

In India and Nepal, where disclosure of the sex of the foetus and sex-selective abortions are prohibited, key informants also reiterated that violations of the law do take place. Key informants from India, irrespective of category, described a host of actions undertaken to enforce the law, ranging from inspections and raids to seizing of equipment and sealing of facilities, to prosecution of providers violating the law. Also mentioned were efforts, for example, to encourage frontline workers to monitor pregnant women, offer incentives for reporting of violations, and establish systems for anonymous reporting of offences. Challenges were also noted: harassment of law-abiding providers; singling out health care providers but not women and families for prosecution; limited capacity of law enforcement authorities in collecting evidence and preparing cases for prosecution, and the exclusion of civil society representation among those entrusted with law enforcement. Also mentioned was corruption within the system, with political interference or interference from powerful individuals and the ability of certain providers to pay off the raiding team or avoid prosecution, often hampering the ability of the authorities to enforce the law. Districtwise differences were mild. In Nepal, in contrast, most key informants agreed that there were no mechanisms in place to enforce the law, and that supervision and monitoring did not take place. While districtwise differences were mild, programme implementers from both public and NGO sectors from Kaski were more likely than those in Tanahun to express this view. As in India, in Nepal too, several challenges were noted: difficulties in collecting evidence, lack of accountability, limited collaboration and coordination between departments responsible for enforcing the law, and financial constraints.

As mentioned earlier, the situation with regard to laws relating to disclosure of the sex of the foetus, women’s legal right to abortion and to sex-selective abortion differ between the four countries. In Bangladesh and Pakistan, disclosure of the sex of the foetus is not prohibited; in contrast, such disclosure is illegal in Nepal and India. In Nepal, a clause to this effect forms part of the abortion law. In India, gender-biased sex selection is covered under a special Act, namely the PCPNDT Act that empowers law enforcement authorities to monitor facilities and take action against providers found to have disclosed the sex of the foetus. Abortion laws also vary: in Bangladesh, the law permits abortions (Menstrual Regulation or MR) up to 10 weeks of gestation, and later abortions under specific conditions only. In Pakistan, the law is very restrictive, with abortion permitted only to save the mother’s life or for vaguely defined “necessary treatment.” In India, abortion is permitted under a host of conditions up to 20 weeks, and in Nepal, while abortion up to 12 weeks is available for a number of reasons, second-trimester abortion is permitted up to 18 weeks only, in cases of rape or incest. In both India and Nepal, however, sex-selective abortions are prohibited under the law.

Given these different situations, women’s perspectives on law enforcement and the extent to which laws were violated, were obtained only in India and Nepal where both disclosure of the sex of the foetus and sex-selective abortion are against the law. Specifically, among women, we explored perceptions about the effectiveness of the law and its ability to act as a deterrent to disclosure, and attitudes about whether the law should be relaxed in certain circumstances. Key informants from all four countries discussed law enforcement and the extent to which laws are being violated. In Bangladesh and Pakistan, the focus of key informant interviews was on country abortion laws; in India and Nepal, on laws prohibiting the disclosure of the sex of the foetus as well as about sex-selective abortion.

A. Perspectives of women, India and Nepal

In order to understand women’s perspectives about the law, we explored their perceptions about whether the law is appropriately enforced in their district, and their attitudes about whether gender-biased sex selection should be permitted under certain conditions.

In order to explore women’s perceptions about adherence to the law, we asked whether they had heard about a doctor being prosecuted or a clinic being closed for providing sex determination services or revealing the sex of the foetus, and whether they had heard about raids being conducted on some doctors in their district because they were providing information about the sex of the foetus. Findings presented in Table 4.1 suggest that awareness of incidents in which action had been taken to enforce the law was far from universal in both countries. For example, 41–42 percent of women from the two districts of Haryana, India, had heard about a doctor being prosecuted or a clinic being closed for disclosing the sex of the foetus to women or their family, and just 21–26 percent had heard about a raid conducted on a doctor in their district. In contrast, hardly any women—just seven percent—of those from the two districts of Nepal—had heard about a doctor being prosecuted, and three to six percent had heard about raids on doctors. Interdistrict differences were mild in both countries.

Table 4.1: Perceptions about the extent of adherence to the law and law enforcement

Percentage of women reporting that doctors continue to violate the law, and that raids and punishment of violators have taken place in their district according to residence, India and Nepal

Awareness of violations and law enforcement	Haryana, India		Nepal	
	Sonipat	Kurukshetra	Kaski	Tanahun
Heard about a doctor being prosecuted or a clinic being closed for providing sex determination services or revealing the sex of the foetus	41.2	42.4	6.8	7.4
Heard about raids conducted on some doctors in her district because they were providing information about the sex of the foetus	20.9	25.9	6.2	3.4*
Number of women	546	555	500	500

Note: * indicates that the difference between the two districts is significant at $p < .05$.

In order to assess women’s attitudes about the enforcement of the law, the survey posed a range of statements to women and inquired whether they agreed with each of these statements. Findings, presented in Table 4.2, are mixed. In Haryana, India, almost all women (93–94%) agreed that both those who seek disclosure of and those who disclose the sex of the foetus should be punished. In Nepal, relatively fewer women so believed (66–68% and 62–63%, respectively).

In both countries, particularly in Nepal, there was considerable sympathy for women with two or more daughters (Table 4.2). For example, just two-thirds (64–65%) of women in Haryana, India, maintained that the law should not be relaxed for couples with two or more daughters and no son. In Nepal, even fewer—50 percent of those from Kaski and 34 percent of those from Tanahun—believed that the law should not be relaxed for such couples. Finally, attitudes about whether the enforcement of the law would result in fewer women seeking disclosure were, by and large, sceptical. Just 25–30 percent of women from Haryana, India, and 22–23 percent of those from Nepal believed that fear of the law would discourage women and their families from engaging in these practices.

On the whole, interdistrict disparities in attitudes were narrow.

Table 4.2: Perceptions about different aspects of law enforcement and effectiveness of the law
Percentage of women reporting opinions on law enforcement and whether strict enforcement would reduce gender-biased sex selection and disclosure of the sex of the foetus, according to residence, India and Nepal

Views on law enforcement and its impact	Haryana, India		Nepal	
	Sonipat	Kurukshetra	Kaski	Tanahun
Think that people who ask for the sex of the foetus should be punished	92.5	93.3	68.2	65.8
Think that health care providers who disclose the sex of the foetus should be punished	92.9	93.6	61.9	62.5
Disagree with the statement that the law should allow sex selection if a couple has two or more daughters and no son	64.4	65.0	49.8	34.4***
Think that people will stop asking doctors to reveal the sex of the foetus because of raids	30.5	24.8*	21.6	23.0
Number of women	546	555	500	500

Note: * and *** indicate that differences between the two districts of each country are significant at $p < .05$ and $p < 0.001$, respectively.

B. Perspectives of key informants

The legal context in each country necessitated that a different set of questions be posed to key informants from each of the four countries. Key informants from Bangladesh and Pakistan were asked questions about the implementation of abortion laws in study settings; those from India and Nepal focused on the implementation and violation of laws relating to disclosure of the sex of the foetus and termination of pregnancies carrying a female foetus.

Settings in which disclosure of the sex of the foetus is not prohibited

Bangladesh and Pakistan

Given the fact that disclosure of the sex of the foetus is not legally prohibited in Bangladesh and Pakistan, and that neither country permits abortion in a range of conditions or beyond early gestation periods, only a brief set of questions on law enforcement were fielded in Bangladesh and Pakistan, and these focused on the implementation of the abortion law, in general.

Bangladesh

Key informant interviews explored perceptions about the extent to which the abortion law is enforced for pregnancy termination after 10 weeks of gestation. Mostly, it was health care providers who shed light on issues related to the

enforcement of the abortion law. All of these key informants from both study districts expressed a lack of awareness about how the abortion law is enforced, but suggested that law enforcement efforts were not stringent. They could not describe any district-based monitoring system for illegal abortions in their respective district. For example:

Service recipients do not know whether abortion is legal or illegal. But providers know the law related to abortion. Even if patients give consent, providers are held accountable for violating the abortion law..... In some cases, the authority turns a blind eye to it. [Female, obstetrician-gynaecologist, aged 45, Comilla, Bangladesh]

The authority turns a blind eye to it (violation of the abortion law). There is no district-level monitoring system for monitoring violations of abortion laws. [Female, radiologist, aged 32, Rangpur, Bangladesh]

Key informants (health care providers) reiterated that notwithstanding the restrictive law, services for abortion beyond the legal limit of ten weeks are easily available. More health care providers from Comilla (the district with an unbalanced sex ratio at birth) than Rangpur (the district with a normal sex ratio at birth) reported that violations of the law did take place. One-half of them, moreover, had no idea about whether service providers are punished for conducting illegal abortions and few had heard about complaints being lodged or a service provider being prosecuted for conducting a sex-selective abortion in their district. Indeed, responses of only three of the 32 health care providers (all from Comilla district) indicated awareness of an incident in which a service provider was punished for conducting an illegal abortion, and not a single key informant was aware that a provider's licence could be revoked for conducting an illegal abortion. For example:

...Women resort to abortion for illegitimate pregnancies..... I heard that an unmarried woman with a 7-month pregnancy died after abortion. And the service provider who did the procedure was jailed. [Female, radiologist, aged 55, Comilla, Bangladesh]

I have not seen any case in which a professional license was revoked because of sex-selective abortion. [Female, radiologist, aged 32, Rangpur, Bangladesh]

Pakistan

As in the case of Bangladesh, key informants from Karachi, all health care providers, suggested that the abortion law was not adequately enforced. They suggested, for example, that there is no specific authority responsible for enforcing the abortion law, that there were no NGOs or advocates working to enforce the law, that there was no monitoring mechanism, and ultimately, that as a result, no action had ever been taken against a service provider for performing an illegal abortion. Indeed, the majority of these key informants held the view that the authorities turn a blind eye to this issue, and that both service providers and communities, more generally, are unconcerned about the law. For example:

The authorities completely turn a blind eye as there are some NGOs working in collaboration with the government and performing abortions. [Female, gynaecologist, aged 56, Karachi, Pakistan]

There are no law enforcement agencies (to monitor or check illegal abortions). I have not heard of any doctor going to jail for doing an abortion, nor about any woman who was sent to jail for having an abortion. [Female, radiologist/sonologist, aged 70, Karachi, Pakistan]

I remember a case of (a woman who died of) multi-organ failure due to complications in an induced abortion, but no litigation was undertaken. [Female, general physician, aged 50, Karachi, Pakistan]

Settings in which disclosure of the sex of the foetus is legally prohibited

India and Nepal

All key informants were probed about their experiences with regard to the implementation of laws prohibiting disclosure of the sex of the foetus, and termination of pregnancies carrying a female foetus, and their perceptions about the effectiveness of law enforcement.

India

Key informants from all three categories and across both districts were well versed with the ways in which laws were implemented in their district. Health care providers reported that they were required to display information in all facilities that disclosure of the sex of the foetus is not provided, that their facilities were regularly inspected, that occasional raids were conducted, that periodic meetings were held for health care providers, and that voluminous documentation was required for all women seeking ultrasound services, including, for example, maintaining records of Form F containing extensive personal details of all women undergoing an ultrasound test, for tracking purposes. Health care providers and NGO programme implementers were familiar with inspections and raids, but rarely with sting operations conducted on diagnostic clinics and facilities providing pregnancy and abortion-related services. For example:

Here, inspection and raids are conducted intermittently. There is a team under the CMO (Chief Medical Officer) which conducts this task. Without prior information, they visit any centre and check all its records to find out whether everything is functioning properly or not, or whether there has been any foul play or not. They also interact with the patients present at that time in the clinic or nursing home and try to gather information from them. We are also ordered to keep the records of the patients, their identity proof, photographs, mobile number and Form F, which all who come for an ultrasound must fill. We follow this rule. [Female, obstetrician-gynaecologist, aged 60, Sonipat, Haryana, India]

First of all, there is a form filled under the patient's name..... a record is prepared regarding this (ultrasound test) along with photo ID proof, and only after this form is filled is the ultrasound done. (Not even) the patient's escort/attendant etc—no one is allowed in the room where this is done. In addition to this, the CMO conducts inspections, they (CMO's team) come every two months or so. And prosecution does happen, mostly in case of radiologists, from what I've seen. [Female, radiologist, aged 35, Kurukshetra, Haryana, India]

The law is well enforced in Kurukshetra. There is a team, which conducts inspections and raids on a regular basis. The health workers are also watchful about pregnant women and take care of their (pregnancy-related) details through a tracking system in both rural and urban areas. Suspension of the (doctor's) license, seizing of machines, and sealing of the nursing home are some steps taken if caught during the inspection or raids..... Raids take place every four to six months. In the past five years, there were two cases of doctors who were caught doing such sex-selective operations..... The doctor is prosecuted and fined if found guilty. [Female, ANM, aged 42, Kurukshetra, Haryana, India]

In Sonipat, all authorised doctors and radiologists are made to swear, by placing their hand on the Bhagavad Gita (ancient Hindu scripture), in front of the District Collector, that they would never perform sex determination tests of the foetus and sex-selective abortions! [Female, obstetrician-gynaecologist, aged 60, Sonipat, Haryana, India]

Raids do not happen frequently—once in a year or six months. I don't know who is doing these raids, I read about them from the newspapers..... I have heard that in some places an official went in the disguise of a customer. The doctor was caught but I did not hear that any legal action was taken against him, just that his licence was cancelled..... The (Appropriate) Authority has never included NGOs (in the team) during raids or inspections. I think NGOs should be included in raids and inspections so we can see what is going on..... [Male, NGO programme implementer, aged 49, Sonipat, Haryana, India]

Public sector programme implementers were engaged in some way in activities intended to enforce the PCPNDT Act. They described the Appropriate Authority responsible for implementing the PCPNDT Act as a three-member committee headed by the Civil Surgeon and comprising membership from amongst lawyers as well as senior district officials from the Integrated Child Development Services (ICDS) Department. The Authority in both districts was described as conducting regular inspections and raids, seizing equipment, sealing facilities, suspending licences, and preparing cases for court. Several programme implementers from both study districts and the state, described their reliance on frontline workers (ASHAs, ANMs and AWWs or Anganwadi Workers) to track pregnant women, especially those with one or two daughters and no sons, and report any cases that appeared suspicious to them. Also discussed were meetings of the District Advisory Committee (DAC) intended to guide the Appropriate Authority (AA) in respect of implementation issues; and of the District Task Force, headed by the district magistrate and

including representatives from the Appropriate Authority and NGOs, and mandated to make decisions about raids and prosecutions. They also discussed the regular meetings called by the Civil Surgeon for various categories of health care providers to review findings from inspections and raids, and monitor progress made by the Appropriate Authority; at these meetings health care providers are informed about their role in implementing the PCPNDT Act, the kinds of infringements that are considered violations, and the progress made in terms of raids and convictions. For example:

I have done at least 15 inspections in the last three months..... Recently, there was a case of conviction where the accused was punished with three years' imprisonment; there are 10 or 12 more such cases in the district that have still not been convicted. Cases have to be cleared in six months time..... I definitely think the AA is functioning better than before. (Inspection) teams are performing more efficiently and action is taken much more swiftly than before. [Male, law enforcement officer, aged 57, Sonipat, Haryana, India]

Last year, we conducted six raids, and this year three so far. There are many cases going on right now, two are in the high court. We try our best to carry out our legal responsibilities in the district. The result is manifested through the increasing figure of the sex ratio (at birth), which went up from 771 in 2001 to 890 in 2013..... [Male, law enforcement officer, aged 52, Kurukshetra, Haryana, India]

We go for regular inspections of ultrasound centres and conduct raids if there has been a complaint. We seal centres if they violate the (PCPNDT) Act and suspend the accused immediately. There are three members in the DAA: the District Attorney, Project Officer (ICDS) and the Civil Surgeon as chairman. The District Task Force, the DAC and the DAA are the three different entities who work on the (implementation of the) Act. The DAA passes orders to us for sealing, raids or suspension. In general, there are problems regarding filling of forms and often it is found that someone who is not an authorised operator has taken charge of the ultrasound machine. ... Sometimes, people inform us. Once or twice, we have tried to perform a sting operation. Once, we sent one of our employees as a pregnant woman to a clinic to pursue (track) a sex-selection test. She had her phone on and also a camera. We went inside as soon as the radiologist started the operation and caught him red-handed. He was punished with three months suspension..... We also arrange audits to keep a constant watch on pregnant women of the area. If we have any information about a woman undergoing an ultrasound test, we call and inquire about the child. We then go for inspection if anything seems wrong. But we don't get any reports about sex selection from ASHAs and AWWs..... Meetings of the District Task Force are held regularly to maintain coordination between the different departments and discuss the status of the sex ratio, implementation of the Act etc. The DC, SP (Superintendent of Police), SDM (sub-divisional magistrate), district education-in-charge and even college principals are members of the Task Force. [Male, law enforcement officer, aged 52, Kurukshetra, Haryana, India]

A few public sector programme implementers and health care providers suggested other activities undertaken to help enforce the PCPNDT Act: public oath-taking by medical practitioners, use of an anonymous toll free number, and incentives for those who report violations to the authorities. For example:

If we come across any news about female foeticide in our catchment area, we ask our Anganwadi Workers to pay special attention to pregnant women. We keep an eye on them to track whether they have had an ultrasound examination and if the baby was born. We also ask our workers to pay special attention to those women who already have one or two daughters, as once a girl is born, the tendency is not to encourage the birth of another girl child. [Female, PO/CDPO, ICDS, aged 36, Sonipat, Haryana, India]

We are also trying to promote the toll free number 102 for registering complaints under the PNDT Act regarding unqualified operators, unregistered centres, centres involved in sex selection etc.... ANMs, ASHAs and AWWs act as informants. General surgeons and NGOs also report to us. [Male, law enforcement officer, aged 57, Sonipat, Haryana, India]

One new thing that has been recently introduced is if somebody provides information about any incident of sex selection and sex-selective abortion in the district, then he/she will be rewarded Rs 51,000, with a promise that their identity would not be revealed in public. [Female, ANM, aged 48, Sonipat, Haryana, India]

The Health Department has announced rewards for workers who bring in this kind of information, but Anganwadi Workers are hesitant to speak out, as, after all, they are locals and are afraid of repercussions

from the community. We train our Anganwadi Workers to keep a special watch on those who get pregnant for the second time and to be alert about any sex-selection practices in the area..... we keep our workers updated about raids and ask them to be watchful about sex ratios. In this way the workers can inform us about various incidents and help us to take suitable action. [Female, PO/CDPO, ICDS, aged 57, Sonipat, Haryana, India]

All three categories of key informants perceived a number of challenges that inhibit the effectiveness of the PCPNDT Act. Two were particularly noteworthy. Several health care providers, in particular, spoke about the fact that only health care providers and not women and their family faced legal action. Moreover, most key informants recognised that interference from influential individuals in the district and state had, on occasion, inhibited the effective implementation of the Act. For example:

Only doctors and radiologists who are caught are prosecuted. But I have never heard that strict action is taken against the woman who takes services although she is equally guilty. Those who are pressurising her to do this (seek disclosure of foetal sex and/or abort a female foetus) should also be caught; but, it has never happened. [Female, ANM, aged 48, Sonipat, Haryana, India]

The (PCPNDT) Act says that the ones getting it (sex determination test and/or sex-selective abortion) done and the one doing it are both criminals, but our society is just anti-doctor; the woman is not at fault and she is left alone (not penalised). [Female, radiologist, aged 40, Kurukshetra, Haryana, India]

No, till today, no woman has been accused or punished. According to the (PCPNDT) Act, women or families who commit sex-selective tests are also responsible and should be punished, but they escape by saying that they just came to see the doctor for treatment. I mean to say that they put the entire blame on the doctor! [Female, law enforcement officer, aged 66, Sonipat, Haryana, India]

A number of health care providers expressed scepticism about the gaps in the implementation of the PCPNDT Act. Several suggested that law-abiding providers were harassed in many ways: they were held up on irrelevant issues, the paperwork demands on them were excessive, and they were not permitted to practise except during prescribed hours:

At times, we face difficulty; for example, a particular time is specified for us to carry out ultrasound tests. Now, if a serious patient comes after the (specified) time, we are deterred from conducting ultrasound tests, and if the patient needs the test urgently, then we have to take permission from the CMO, fill out paperwork, all of which requires a lot of time. Then, what should we do, should we attend to the serious patient or fulfil the paperwork requirements? Like this, there are other loopholes, which should be taken care of. Otherwise, everything is fine. [Female, obstetrician-gynaecologist, aged 60, Sonipat, Haryana, India]

There are people who come and check our records etc. But everyone knows about us, that here, nothing (illegal) happens. They come and inspect the machines that are lying here; if there are patients being treated, they check with them to see what is going on. And then they check my records and registers..... And these nonsensical PNDT rules that they have in place..... not wearing coats, why a copy of the Act is not properly displayed..... [Male, general physician/MBBS doctor, aged 59, Kurukshetra, Haryana, India]

Several key informants from all three categories, raised concerns about corruption in the system, suggesting that many facilities that are sealed reopen, and doctors whose licences are withdrawn return to practise within a few months because of pressure from politicians and others in power. For example:

Once, we raided two doctor-turned-politicians and experienced a lot of problems during law enforcement..... [Male, law enforcement officer, aged 57 Sonipat, Haryana, India]

Definitely there are leakages and foul play. You also must know how much corruption exists nowadays. And in the Health Department, it is no less. The health personnel are much involved in corruption. Doctors, nurses, everybody is involved. Sometimes, even if someone is caught red-handed, no action is taken against him because of political interference. The vigilance team is pressurised and proceedings are not carried out. Money and politics are part of the corruption, and the accused is released. Because connections are used, the law enforcing authorities—even if they want to—fail to take any action against the accused. [Female, law enforcement officer, aged 66, Sonipat, Haryana, India]

It can also happen that our Civil Surgeons get embroiled in a political matter; it could happen sometimes that you caught a doctor or someone else for wrongdoing (violating the Act) but then pressure is exerted on you from higher up the ladder. You would get calls for the person to be released. [Male, general physician/ MBBS doctor, aged 59, Kurukshetra, Haryana, India]

The convicted are mainly doctors and are often acquitted as they can easily pay off the law officials..... Government officials do not take cases of sex selection seriously even if taken to court. This is why in the last few years, we have kept our own legal advisors; when a case is in court, we appoint them on a contractual basis. [Male, law enforcement officer, aged 52, Kurukshetra, Haryana, India]

The biggest problem is that before any action is taken, there are orders from above for the release of the doctor. So, the authorities are helpless and this is the biggest challenge here. People who are well off, easily escape from these laws. So, nothing is exposed—only because of money and status—and the guilty are not punished. [Male, NGO programme implementer, aged 41, Sonipat, Haryana, India]

There are some who even get caught and cases are prepared against them but because they have political acquaintances, they create pressure and take advantage of some loophole in the legal system and get exempted from the charges! I am talking about both radiologists and gynaecologists. At times, the (Appropriate) Authority is also pressurised to let go the guilty because some doctors know persons in powerful positions. So, before carrying out proceedings against them the (Appropriate) Authority is called up and asked to spare the person (Ve mera aadmi hai uspar karwahi mat karna) and thus the authority fails to take any action against the accused. [Male, NGO programme implementer, aged 46, Sonipat, Haryana, India]

Public sector programme implementers also voiced concerns about the limited power and inadequate training of members of the Appropriate Authority, lack of community support for the law, overburdened staff and frequent transfers of district officials. For example:

The AA, who oversees the execution of raids, does not provide proper technical documentation. Its members are not aware of what information is needed, how to conduct raids effectively and how to document evidence technically. Therefore, what we get is half-processed documentation of cases. Once, I got a case in which a raid had been conducted of a female gynaecologist who had aborted a female foetus. Even though the female foetus was recovered, the case was not presented properly and there was no technical documentation..... In the case of the woman who had aborted a female foetus, the witness changed her statement, and the lady doctor said, 'How can you prove that the foetus was of the woman in question?' The AA does not have the training to collect evidence. No legal training is provided to the AA, and its members are not aware of medical practices..... Sonipat is surrounded by Uttar Pradesh (UP) on one side and Delhi on the other. Thus, women go to Narela and UP to do sex detection tests and get (sex-selective) abortions. This way, the matter automatically goes out of our jurisdiction..... the AA had once lodged a complaint against a doctor because he had portable ultrasound machines that were not registered. Later, when he was brought to court, he said that the higher health authorities had given him registration. [Female, law enforcement officer, aged 35, Sonipat, Haryana, India]

Other than that, as we are not proficient in legal affairs, errors take place from our side too. Though we know that any contravention of the PCPNDT Act under Section 23 is punishable, the court demands many other supporting documents to prove the case even when they are not required. For example, it demands witnesses to prove the offence even when there are reports and documents duly signed by that person. Our lawyers are also not sincere and, as a result, cases often go in favour of the convict. The Act, therefore, cannot be implemented the way it should be unless there are lawyers who are specialised in it..... [Male, law enforcement officer, aged 57 Sonipat, Haryana, India]

People are overburdened with work in our department. A single person has to deal with many issues and, as a result, does not do justice to the work. Civil Surgeons are loaded with too many administrative responsibilities and are unable to go for regular inspections. Frequent transfers and change of responsibilities are another problem..... even though we have suggested a separate authority to be in charge of PCPNDT (work), this has not materialised due to a shortage of doctors and programme officers..... Incidents of political interference take place; this is where all our efforts go in vain and our morale drops..... The DAA

holds meetings irregularly because of its busy schedules. Until today, only one DAC meeting was conducted during 2014–15; it shows lack of interest of the administration..... [Female, law enforcement officer, aged 52, Panchkula, Haryana, India]

A number of NGO programme implementers highlighted, in addition, the exclusion of NGOs from raids and inspections as a key challenge. A few suggested that it was not effective to have just doctors monitoring the activities of other doctors. For example:

The (Appropriate) Authority has never included NGOs during raids or inspections. I think NGOs should be included in raids and inspections so we can see what is going on.... [Male, NGO programme implementer, aged 49, Sonipat, Haryana, India]

If NGOs are involved then I don't think any muddle will exist. Up till now, only doctors have been designated to keep vigilance over other doctors; therefore, who knows what is happening between them? Chances are that the inspection team informs the doctor before conducting a raid in any nursing home and as such, the raid is just a formality. Therefore, I think that people like us, who work for social benefit, should be given training and included in the inspection team to bring transparency in the work. [Male, NGO programme implementer, age 52, Sonipat, Haryana, India]

Nepal

Key informants were mixed about the extent to which there were mechanisms in place to monitor violations of the abortion law with regard to the practice of disclosure of the sex of the foetus and sex-selective abortion. Among the 11 health care providers who were interviewed, all except one perceived that there were no mechanisms in place to enforce the law; most acknowledged that more supervision and monitoring of health facilities and diagnostics centres were necessary in order to ensure that providers adhere to the existing law. Programme implementers, both from the public and NGO sectors, were more likely than health care providers to report awareness of law enforcement activities; even so, while those from Kaski, the district with a skewed sex ratio at birth, suggested that monitoring mechanisms in Kaski were weak, several from Tanahun, the comparison district, suggested that their district public health office played an active role in enforcing the law. For example:

There isn't a good monitoring and supervision system in place to control sex-selective abortions. If there were such a mechanism, the demand for sex selection would not have increased. The practice would certainly have declined. People are willing to do anything when they want to know the sex of the foetus. Since there is no strong and transparent law in our country, it has made the practice grow. [Male, health care provider, aged 52, Kaski, Nepal]

There is a law and service providers are aware about it but it is not enforced in this district. If it was enforced, we would not have an unbalanced sex ratio at birth. Providers are greedy for money... people are ready to do everything to earn money, that's why we are having this problem. [Female, public programme implementer, aged 32, Kaski, Nepal]

Monitoring and supervision are carried out by the district health office in this district. We conduct such monitoring when we feel the need. We also monitor the types of infrastructure and equipment that providers are using in their facility as these help us to determine what services they are providing. We monitor both government and private facilities. We ask if they are using ultra-sonogram equipment and if they use it, we use an indirect channel to know whether they use the technology for sex selection. [Female, health care provider, aged 25, Tanahun, Nepal]

Most key informants agreed that laws against sex-selective abortion were not effectively enforced. While districtwise differences were mild, we note that more programme implementers in Tanahun than Kaski expressed this view. Key informants noted a number of challenges underlying the limited measures taken to regulate sex selection: difficulties in collecting strong enough evidence with which to prosecute violations, lack of accountability, limited collaboration and coordination between concerned departments responsible for enforcing the law, and financial constraints. As such, hardly any key informants had heard about raids, and not a single key informant had heard about prosecutions. For example:

No. I have not heard about any case of raids or punishment in this district. It is not only in this district, I have not heard of a case throughout the country. [Male, health care provider, aged 38, Tanahun, Nepal]

There is no system to enforce the law and punish the violators. If there were strong mechanisms to monitor and control such activities, the demand for sex selection would not have increased. [Male, health care provider, aged 52, Kaski, Nepal]

The most important thing is that there is no strong law in our country. Moreover, the existing law is not practical and not enforced either. The authorities should take action to enforce the law. Due to the weakness among the authorities responsible for enforcing the law, violators are beyond the control of law. [Male, NGO programme implementer, aged 32, Tanahun, Nepal]

It is very difficult to find evidence when the law is violated. It is not possible to get proof that the abortion was done after sex selection. Even if a violation is reported to the authorities, doctors can do everything so that the decision goes in their favour. Decisions are influenced by their business, profession and status. That's why the law is not enforced effectively over here. [Male, NGO programme implementer, aged 35, Kaski, Nepal]

I have heard from some pregnant women that they knew the sex of their foetus. How would they know if radiologists did not disclose the sex of the foetus? I'd like to repeat that there is law in our country, but it is not enforced in practice. Since the issue of sex selection is a very private matter, the law can't control it. In addition, it is not possible to get written evidence to prosecute. This makes it difficult for law enforcement. [Female, public programme implementer, aged 46, Kaski, Nepal]

Chapter 5

What works to reduce gender-biased sex selection: Programmes to enhance the status of the girl child in Bangladesh, India and Nepal

This chapter has highlighted, from women's perspectives, their awareness of the availability of various educational entitlements for girls in Bangladesh, India and Nepal, and, in Bangladesh and India, of conditional cash transfer programmes for girls and the extent to which their own daughters had availed of these benefits. It has also probed the perceptions of key informants about such programmes and schemes, focusing on their awareness of educational entitlement and cash transfer programmes for girls, and their perceptions about the effectiveness of such programmes, in general, as well as in terms of changing deeply-rooted son preference.

Most women were aware of the various educational entitlements offered to girls in their country, such as, for example, free textbooks and school uniforms, free bicycles, and/or scholarships. Indeed, well over 80 percent of women were aware of scholarship programmes for girls. Interdistrict differences varied. In Nepal, significantly more women from the district with a normal sex ratio at birth than the district with an unbalanced sex ratio at birth reported such awareness (90% versus 82%). In India, interdistrict differences were not observed (95–97%). Far fewer women from each country who had an eligible daughter reported that their daughter had availed of these benefits. In both settings, more women from districts in which the sex ratio at birth was normal (Nepal) or had improved (India) than the comparison district reported that their daughter had availed of a scholarship (37% versus 24% in India; 37% versus 25% in Nepal). In Bangladesh, moreover, significantly more women from the district with a normal than an unbalanced sex ratio at birth reported accessing microcredit programmes (Rangpur, 51% versus Comilla, 43%). Conditional cash transfer programmes are implemented in Bangladesh and India, and more than 80 percent of surveyed women from both countries were aware of these programmes. In Bangladesh, while more women from Comilla, the district with an unbalanced sex ratio at birth, than Rangpur, the district with a normal sex ratio at birth, reported such awareness (98% versus 94%), more women from Rangpur than Comilla had availed of the scheme (89% versus 73%). In India, in contrast, among women with a daughter eligible for the *Ladli* Scheme, two-thirds (64–66%) of women from Kurukshetra and Sonipat alike reported that their daughters were enrolled in the Scheme, with little interdistrict variation.

Key informants—health care providers (India), and programme implementers from government and NGO sectors in all three countries (Bangladesh, India and Nepal)—were familiar with various educational entitlements and cash transfer schemes (Bangladesh and India) for which girls are eligible. In India, several public sector and NGO programme implementers described their own role in assisting families to comply with the complex documentation requirements for enrollment in the scheme, and several NGO programme implementers described their own efforts in facilitating girls' schooling, and arranging group marriages to assist parents in defraying the cost of their daughter's wedding.

Most key informants from all three countries believed that educational entitlements and conditional cash transfer schemes (Bangladesh and India) for girls were successful in ensuring that parents treated sons and daughters equally, educated their daughters, delayed their daughter's marriage and invested resources in them (India). In India, moreover, many women, especially those in Sonipat, cautioned that conditional cash transfer schemes were not reaching their intended target group because the paperwork required to enroll into these schemes was daunting for many parents, and because of corruption within the system, including the presence of middlemen. In contrast, few key informants from all three groups and in all three countries believed that educational entitlements (all countries) and conditional cash transfer schemes (Bangladesh and India) could be successful in reducing son preference (Bangladesh and India) or practices relating to gender-biased sex selection (India). In short, while key informants agreed that such educational entitlements and schemes could be successful in changing people's perceptions of daughters as liabilities and burdens, they were sceptical about the role of these benefits in affecting preferences for at least one son, or promoting adherence to laws about the disclosure of the sex of the foetus and sex-selective abortion in India and Nepal. Interdistrict differences in all three countries were negligible.

Our case studies indicated that programmes and schemes that focus on raising the status of the girl child and empowering women are implemented by the public and NGO sectors in all countries. Entitlements for girls vary from country to country: they may include the provision of such school-related benefits as free textbooks and school uniforms, bicycles and scholarships, as well as conditional cash transfer programmes. While Bangladesh, India and Nepal provide educational entitlements for girls, Bangladesh and India additionally provide conditional cash transfer programmes (conditional cash transfer programmes do not exist in Nepal).

Bangladesh has a long history of conditional cash transfer programmes in the education sector. The Female Secondary School Stipend Programme (FSSP) is a leading example of a programme intended to deploy cash transfers to girls to increase their enrollment, completion and regular attendance in secondary school, as also to delay their marriage till after age 18. In India, similarly, Haryana has a long history of implementing such programmes. In these programmes, cash transfers are deposited in the name of the girl (or her parents) when certain conditions (immunisation, school enrollment, secondary school completion etc.) are met. Many believe that these educational entitlements and cash transfers hold promise for reducing the practice of gender-biased sex selection (India) by enabling parents to defray the costs of rearing daughters and discouraging parents from perceiving daughters as burdens. Other than educational entitlements for girls and conditional cash transfer programmes, the Bangladesh component of the study also explored women's access to microcredit programmes and opportunities for girls in the apparel industry, and the extent to which these income-earning opportunities have changed community perceptions about the value of girls.

Our survey and our key informant interviews probed women's awareness and experiences of these educational entitlements and conditional cash transfer schemes, as well as perceptions about the reach and effectiveness of these programmes and schemes, and their usefulness in reducing son preference and gender-biased sex selection practices. We note that the Pakistan study, which focused only on the perspectives of health care providers, did not address this issue. In this chapter, we explore the perspectives of women and key informants on these issues only from the remaining three countries, namely Bangladesh, India and Nepal.

A. Perspectives of women

Our survey explored women's awareness and use of various educational entitlements for girls. As mentioned above, these include free textbooks, school uniforms, bicycles (Haryana, India) and scholarships. In Bangladesh and India (but not in Nepal), they also include conditional cash transfer programmes that provide girls cash awards at the achievement of various milestones ranging from adherence to immunisation schedules to school completion (India) to enrolment in primary school to minimum attendance and maintenance of a minimum academic proficiency (Bangladesh) and delaying marriage beyond age 18 (both countries).

With regard to educational entitlements for girls, the survey inquired whether women were aware of these entitlements and whether their daughter had received any of them. Findings are presented in Figure 5.1, and show that almost all women in both districts of Bangladesh and Haryana, India, and the majority of those in the study districts of Nepal had heard about free textbooks/uniforms for girls (96–98%, 98–100%, 75–81%, respectively). However, as Figure 5.1 also shows, far fewer women with eligible daughters (aged 6 and above) reported that their daughters had received these benefits. Indeed, in Haryana, India, just 38–43 percent and 38–40 percent of women, respectively, reported that their daughter had received free textbooks and school uniforms. In Bangladesh and Nepal similarly, relatively small proportions of women with eligible daughters (38–47% and 27–31%, respectively) reported that their daughter had received free textbooks.

As in the case of educational entitlements, the large majority of women in all three countries were aware of scholarship schemes for girls (Figure 5.1). While interdistrict differences were narrow in Haryana, India (95–97%), in Nepal, women from the district with a normal sex ratio at birth, displayed significantly more awareness of these schemes than did women in the district with an unbalanced sex ratio at birth (90% in Tanahun versus 82% in Kaski). With regard to access to scholarships, presented in Figure 5.2, in both India and Nepal, more women in districts with an improved/a normal sex ratio at birth than those in comparison districts reported that one or more of their daughters (aged 6 and above) had received a scholarship (in Haryana, India: 37% in Kurukshetra versus 24% in Sonipat, and in Nepal: 37% in Tanahun versus 25% in Kaski). In contrast, in Bangladesh, awareness of such schemes was significantly greater among women from the district with an unbalanced sex ratio at birth than among

Figure 5.1: Percentage of women reporting awareness of, and percentage of women with an eligible daughter reporting use of educational entitlements for girls, Bangladesh, India and Nepal

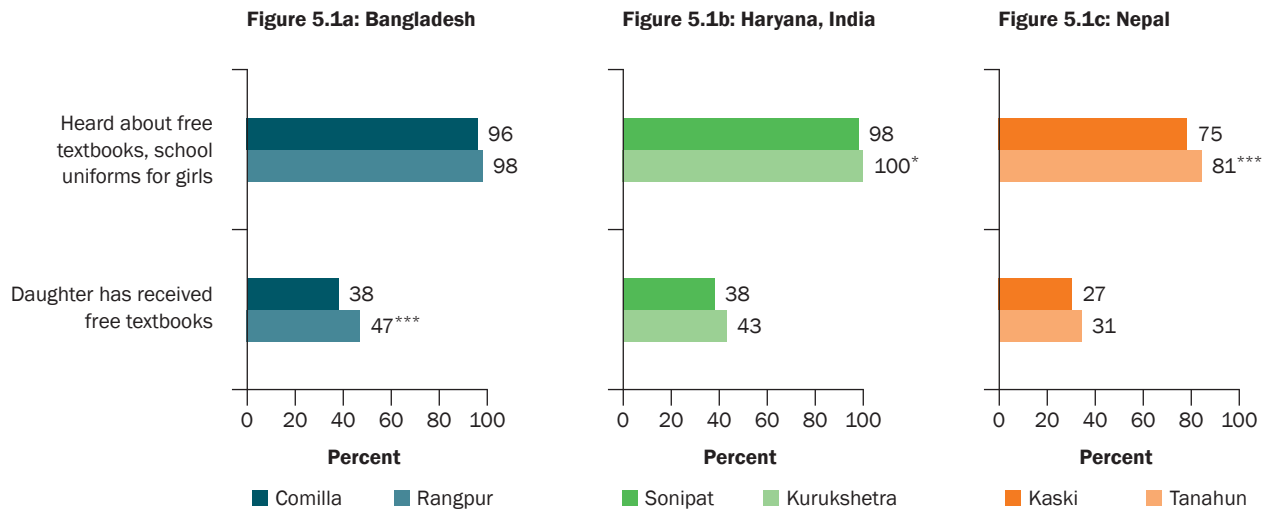
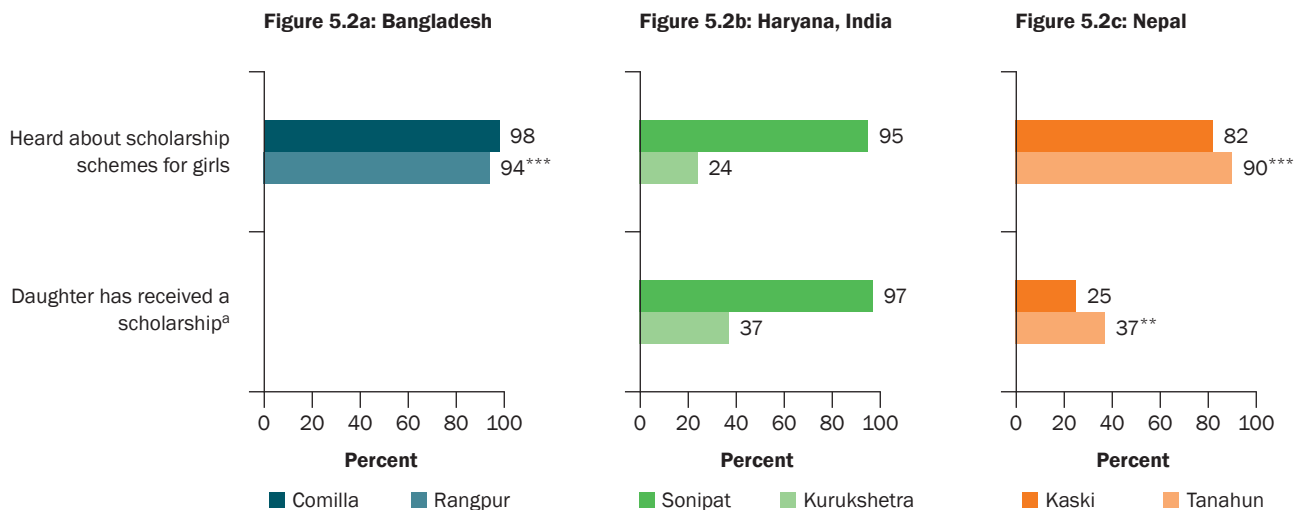


Figure 5.2: Percentage of women reporting awareness of scholarship schemes for girls, Bangladesh, India and Nepal, and percentage of women with an eligible daughter reporting use of scholarship schemes, India and Nepal



Note: *, ** and *** indicate that differences between the two districts of each country are significant at $p < .01$, $p < .05$ and $p < 0.001$, respectively.
^a Scholarship use in Bangladesh refers to the Female Secondary School Stipend Programme, a conditional cash transfer programme, and is discussed separately below.

those from the district with a balanced sex ratio at birth (98% in Comilla versus 94% in Rangpur); scholarships in Bangladesh refer specifically to the Female Secondary School Stipend Programme,¹ a conditional cash transfer programme, and are discussed separately below.

¹ The Female Secondary School Stipend Programme (FSSP) was launched by the Government of Bangladesh in 1994 to increase enrollment and retention of girls in secondary schools, and delay marriage and childbearing. This programme offers a stipend and a tuition subsidy to each girl attending secondary school, provided that she attends at least 75 percent of school days, maintains a minimum level of measured academic proficiency, and remains unmarried until age 18. The tuition part of the stipend is paid directly to the school and the rest of the stipend is directly deposited in two annual instalments into the savings account held by the student in a commercial bank (Khandker et al., 2003; Asadullah and Chaudhury, 2006).

The bicycle scheme, another measure which is implemented in Haryana, India, to promote secondary school education among girls, was also known to the majority of women, with significantly more women from Kurukshetra, the district with the improved sex ratio at birth, than Sonipat, the district with the unchanged sex ratio at birth, reporting so (81% versus 61%). Since the scheme is open only for girls entering secondary school, we restricted the sample for this indicator to women with a daughter aged 13 and above. Given our eligibility criteria, few women were thus eligible; however, findings suggest that very few eligible women reported that their daughter had received a free bicycle (2–4%, not shown in table).

In Nepal, women discussed the extent to which educational entitlements may have affected the life of girls. Findings from the survey suggest that while few women were aware of specific schemes for Dalits (11–13%, not shown in the figure), considerable proportions agreed that scholarship schemes helped parents defray the costs of rearing a daughter and allowed girls to complete their education. Districtwise differences were mixed: while more women from Kaski, the district with an unbalanced sex ratio at birth, than Tanahun, the district with a normal sex ratio at birth, agreed that such schemes helped defray the costs of rearing a daughter (46% versus 36%), more women from Tanahun than Kaski believed that scholarship programmes enabled girls to complete their education (28% versus 19%, not shown in the figure).

In Bangladesh, women were also asked about their awareness of and access to microcredit programmes, and their perceptions about whether access to microcredit reduced discrimination against women. Findings, presented in Table 5.1, show that awareness of microcredit programmes was fairly universal in both districts (99%); while significantly more women from Rangpur, the district with a balanced sex ratio at birth, than Comilla, the district with an unbalanced sex ratio at birth, had received microcredit (51% versus 43%), women from Rangpur were less likely than those from Comilla to believe that access to microcredit has an empowering effect on women.

Table 5.1: Exposure to microcredit programmes, Bangladesh

Percentage of women reporting awareness of and access to microcredit programmes and its effect on discrimination against women, Bangladesh

Exposure to microcredit programmes	Bangladesh	
	Comilla	Rangpur
Aware of microcredit programmes	98.6	99.2
Ever received microcredit	42.7	50.7*
Perceive that microcredit reduces discrimination against women	83.2	51.7***
Number of women	517	520

Note: * and *** indicate that differences between the two districts are significant at $p < 0.05$ and $p < 0.001$, respectively.

Conditional cash transfer programmes are not implemented in Nepal; hence women’s perspectives on these programmes were probed only in the Bangladesh and India case studies.

In Bangladesh, the Female Secondary School Stipend Programme, referred here as the Stipend Programme, was the only conditional cash transfer programme about which we probed. As shown in Table 5.2, significantly more women from Comilla, the district with an unbalanced sex ratio at birth, than Rangpur, the district with a normal sex ratio at birth, reported awareness of this conditional cash transfer or Stipend Programme (98% versus 94%). Likewise, significantly more women from Comilla than Rangpur agreed that the Stipend Programme had reduced discrimination against girls (92% versus 38%). Access to this programme was, moreover, widespread: 73 percent of women in Comilla and 89 percent of those in Rangpur who had a secondary school-aged daughter reported that their daughter had availed of it. Women whose daughters had enrolled for the Stipend Programme noted a number of benefits of the programme, such as, for example, enabling girls to save money (13–24%) or pay for private coaching (54–61%), and easing the financial burden on parents (22–23%).

Table 5.2: Perceptions about and enrollment in the Female Secondary School Stipend Programme^a for girls, Bangladesh

Percentage of women reporting awareness, utilisation and perceived benefits of the Female Secondary School Stipend Programme, Bangladesh

Awareness, utilisation and perceived benefits of the Stipend Programme	Bangladesh	
	Comilla	Rangpur
Heard about the Stipend Programme	98.3	93.8***
Number of women	517	520
Agree that the Stipend Programme reduces discrimination against girls	91.7	38.1***
Number of women	508	488
Eligible daughter has received a stipend	73.2	89.3
Number of women with a secondary school-aged daughter	41	28
Perceived benefits of the Stipend Programme		
The girl can save money	23.9	12.9
Helps the girl to pay her tuition fees	54.3	61.3
Provides support for girl's parents	21.7	22.6
Number of women whose daughter was enrolled in the Stipend Programme	30	25

Note: *** indicates that the difference between the two districts is significant at $p < 0.001$. ^aScholarship use in Bangladesh refers to the Female Secondary School Stipend Programme in Bangladesh is discussed as a conditional cash transfer programme.

A number of conditional cash transfer programmes for girls exist that are well known in Haryana.² The eligibility criteria and benefits of these schemes differ—for example, some are only available to parents from socially excluded castes and tribes, those from poor households, those who have been sterilised, or those with a second daughter. The survey inquired about women's awareness of any programme that offered cash transfers for girls, irrespective of whether they were aware of its name, and if so, whether their daughter was enrolled in it. As evident from Panel A of Table 5.3, conditional cash transfer programmes were well known; indeed, about four in five women reported awareness of such schemes (81%). Among all the schemes, the *Ladli* Scheme was best known, with more than three-quarters of women (77%) reporting awareness and recalling its name. Interdistrict differences were insignificant. We note that the *Ladli* Scheme is available only to families with a second daughter, and women who had two or more daughters reported even greater levels of awareness of this scheme—89 and 92 percent of women from Sonipat and Kurukshetra, respectively (not shown in the table). Many fewer were familiar with the *Apni Beti Apna Dhan* Scheme, now significantly more of those from Sonipat (23%) which recorded an unchanged sex ratio at birth, than Kurukshetra (16%), where the sex ratio at birth had improved somewhat. Of women aware of these schemes, specific awareness of the scheme in terms of eligibility criteria, documents required to enroll a girl into the scheme, the age at which the bond in the name of the girl matures, or the amount that a girl may receive on its maturity was limited (not shown in the table). Most women acknowledged the benefits of conditional cash transfer schemes (Table 5.3, Panel B); while the vast majority of women (95%) suggested that these schemes were useful, most perceived them as support for parents and not daughters who were the registered beneficiaries of the scheme. For example, 59 percent of women from Sonipat and 39 percent of those from Kurukshetra reported that the schemes were useful in defraying the costs of raising a daughter; 42 percent and 61 percent, respectively, that it helped in arranging a daughter's marriage, and 24–28 percent suggested that it helped parents, more generally. Relatively few women suggested that the schemes would enable girls to save money (29% from Sonipat and 22% from Kurukshetra).

² Key programmes available in the state were the *Apni Beti Apna Dhan* Scheme (discontinued from the birth cohort of 1999) and the *Ladli* Scheme. The *Apni Beti Apna Dhan* Scheme is a longstanding scheme implemented in Haryana, which offered payments for girls at birth and on the achievement of various milestones (varying from birth registration to delayed marriage). The *Ladli* Scheme is more recent and ongoing. It is open to all couples who have a second daughter, irrespective of their caste and economic status, and provides cash transfers in girls' accounts for five years on the achievement of various milestones (immunisation, school enrollment to delayed marriage), and a bond in the name of the girl that matures when she attains the age of 18, provided that she remains unmarried (Department of Women and Child Development, Government of Haryana, n.d.).

Table 5.3: Awareness and perceptions about and enrollment in conditional cash transfer (CCT) schemes for girls, Haryana, India

Percentage of women reporting awareness and perceptions about CCT schemes for girls, and enrollment of daughters in the *Ladli* Scheme, Haryana, India

Awareness and perceived benefits of and enrollment in CCT schemes	Haryana, India	
	Sonipat	Kurukshetra
A. Awareness of CCT schemes		
Heard of at least one scheme	81.0	80.7
<i>Ladli</i> Scheme	77.3	77.4
<i>Balika Samriddhi Yojana</i>	5.1	2.0*
<i>Apni Beti Apna Dhan</i> Scheme	22.5	16.1*
Other schemes	5.0	4.1
Number of women	546	555
B. Perceived benefits of CCT schemes		
Give girls some savings	29.2	21.5*
Help defray costs of raising a girl child	59.0	39.4***
Help parents	23.6	27.7
Help arrange girls' marriage	42.4	61.4***
Number of women who had heard about a CCT programme	444	439
C. Enrollment in the <i>Ladli</i> Scheme		
Daughter currently enrolled	63.8	66.1
Intend to enroll daughter in future	25.3	24.0
Do not intend to enroll daughter in future	10.9	9.9
Number of eligible women (with at least two daughters)	152	178
D. Intended use of CCT amount		
For daughter's higher education	49.8	32.9*
For daughter's marriage	69.0	66.0
For giving dowry	23.9	43.3**
For household expenses	2.5	1.8
Number of women whose daughter is enrolled in any CCT scheme	90	116

Note: *, ** and *** indicate that differences between the two districts are significant at $p < .05$, $p < .01$ and $p < 0.001$, respectively,

The *Ladli* Scheme was the main conditional cash transfer scheme that was accessed by women. Hence, we focus on enrollment in this scheme only. Table 5.3, Panel C, indicates that among women with two or more daughters, about two-thirds of those from both districts had enrolled their daughter in the *Ladli* Scheme (64–66%) and about one-quarter of all women reported that they intended to enroll their daughter in this scheme (24–25%). We also asked women whose daughters had been registered under a conditional cash transfer scheme about how they intended to use the money due to their daughter from the scheme. While leading responses related to arranging for the daughter's marriage, a considerable proportion of women also intended to use the money on their daughter's higher education (Table 5.3, Panel D). Interdistrict differences were evident. While two-thirds of women from both districts reported that they intended to use the money for their daughter's marriage (66–69%), more women from Kurukshetra than Sonipat specifically indicated that they would use it for their daughter's dowry (43% versus 24%), and significantly fewer women from Kurukshetra than Sonipat intended to use the benefits for the further education of their daughter (33% versus 50%).

Perspectives of key informants

Key informants in all three countries were probed about the extent to which they perceived entitlement programmes and conditional cash transfer programmes for girls, as appropriate in each setting, to affect attitudes about having daughters. In Bangladesh, in addition, they were probed about microcredit programmes for women and job opportunities for girls and young women in the apparel industry. It was largely public and NGO programme implementers as shown in Table 5.3 who had direct experience in implementing these programmes, and on whose narratives we rely to shed light on the links between educational entitlement programmes for girls and their likely effect on sex ratios at birth.

Settings in which disclosure of the sex of the foetus is not prohibited

Bangladesh

The study sought the perspectives of public and NGO programme implementers (at both national and district levels) regarding the impact of the Female Secondary School Stipend Programme, female employment in the apparel industry and women's access to microcredit, on improving the situation of girls and young women in the community. The key informants agreed that these schemes were well-known at the community level, and that many girls and young women had taken advantage of them.

Both categories of programme implementers also agreed that girls were more likely to remain in school and attend school regularly because of the Stipend Programme, and suggested that this programme had not only resulted in more girls completing a secondary education, but also in fewer girls marrying in childhood, and a change in community attitudes toward child marriage. For example:

...The Secondary School Stipend Programme has brought a very positive change in our society. Before this programme was introduced, girls went to primary school only, and after that they waited for two to three years at home until they got married. But now, they spend two to three years in secondary school and learn as much as they can. Attending secondary level education has a great effect on girls. They are more grown up at this stage, so they remember what they learn. [Female, NGO programme implementer, aged 45, Dhaka, Bangladesh]

Programmes, such as the Secondary School Stipend Scheme, have a huge impact on girls' education. Parents are sending their daughters to school regularly and girls continue their education even after primary school. In addition, through different training programmes, girls are learning new skills and getting a job and earning for their family. Their value in the family is increasing. It's also having an impact on son preference. People, today, do not have the same son preference as before. [Male, public sector programme implementer, aged 31, Rangpur, Bangladesh]

...Most families take the Stipend Programme positively. We try to encourage them not to marry off their daughters at an early age. Even so, the rate of early marriage in rural areas is alarming. These programmes do not have much impact on people who have a strong son preference. People still prefer sons over daughters. But the good thing is, people do give their daughters more importance now and the social value of girls has definitely increased. [Male, NGO programme implementer, aged 33, Rangpur, Bangladesh]

Programme implementers were not convinced, however, that the importance of daughters or the desire for a daughter had increased because of such stipend programmes. For example:

...I don't think the Stipend Programme has been successful in playing its intended role. Parents send their daughters to school just for the money, not for education. Very often, daughters from poor families work as a housemaid and go to school at a specific time only to receive the stipend. [Female, public sector programme implementer, aged 58, Comilla, Bangladesh]

Programmes for girls' education definitely have an impact on people. The presence of girls in schools is much greater now than (the presence of) boys. Women have reached a new level in the society. Things are changing rapidly. People are much more aware now. It is not clear whether these changes are having an impact on son preference. I think empowering girls will decrease son preference to a point, but it is

not possible to erase son preference completely. [Male, public sector programme implementer, aged 46, Comilla, Bangladesh]

The Secondary School Stipend Programme has brought a very positive change in our society. Because of this stipend, parents send their daughters to school much more than before. But it has not stopped early marriage. Lack of social security and the demand for young girls in the marriage market are the main reasons behind early marriage. But people's mentality is changing. They value their daughters more. Still, they prefer sons, but do not despair if they have a daughter. [Female, public sector programme implementer, aged 38, Rangpur, Bangladesh]

Most key informants did not note any flaws in the functioning of the Stipend Programme. However, one district programme implementer mentioned inadequacies in the supply side. For example:

.. The government is giving extra importance to the Stipend Programme since very few girls in rural areas continue their education after finishing primary school. But although 20 percent of our teachers' posts are allocated for women, sadly, it's hard to get even these 20 percent female teachers. Most husbands do not permit married girls to have a job. And many married girls who are financially stable do not want to have a professional career. As a result, we are hugely lacking when it comes to female teachers. We have a huge number of students and to educate them, we need many teachers. Women need to participate in our higher education system as teachers, so that more girls are encouraged to continue for secondary education and made to feel comfortable while learning their lessons. [Male, public sector programme implementer, aged 46, Comilla, Bangladesh]

A few programme implementers considered the Stipend Programme useful in changing attitudes about girls; but not a single key informant believed that the programme had brought about changes in the demand for sons or daughters or that it would play a role in deterring women from undergoing sex-selection tests and subsequent abortion of a female foetus.

Programme implementers from both public and NGO sectors were generally positive about the impact of microcredit programmes and of female employment in the apparel industry on son preference. They perceived, for example, that employment opportunities for young women in the apparel industry had succeeded in raising the value and importance of daughters in the family, and changing parents' views about the ability of daughters to support their parents economically. They suggested that working in the apparel industry had both enhanced the autonomy of young women and raised parents' perceptions of daughters as sources of economic support. For example:

...Girls who work in RMG (ready-made garment) factories are independent in most cases. Their families generally do not display a preference for sons. But that does not mean people want daughters and think that when they grow up, they will work in garment factories and support their family. People do not have that kind of aspiration for daughters. They don't like the fact that working in a garment factory means that a girl lives in the city, away from her family, and away from the protection and control of her parents. Also, it's difficult for parents to marry off girls who work in the apparel industry. [Female, NGO programme implementer, aged 45, Dhaka, Bangladesh]

The majority of programme implementers from both public and NGO sectors also suggested a relationship between access to microcredit and the increased importance of daughters in the family. At the same time, they acknowledged that it did not have a strong impact on son preference. For example:

In my experience, microcredit does not have any impact on son preference. Taking microcredit does not make one empowered. Some women are involved in productive activities with their husbands and use microcredit. In most cases, women act a medium to bring the loan home. Their husbands use it for business or other purposes. [Female, NGO programme implementer, aged 45, Dhaka, Bangladesh]

In short, key informants responsible for implementing programmes in both public and NGO sectors maintained that educational entitlements for girls, notably the Female Secondary School Stipend Programme, as well as employment opportunities for young women and microcredit facilities for women may change parents' perceptions about the value of their daughters, but may not affect their desire for at least one son.

Settings in which the disclosure of the sex of the foetus is legally prohibited

India

All key informants were asked about their awareness and perceptions of the usefulness of programmes and schemes intended to raise the value of girls. Again, health care providers were less likely to report detailed awareness of these programmes and schemes than were public and NGO sector programme implementers. Even so, all key informants had heard about schemes intended to raise the value of girls. Several public and NGO sector programme implementers were, moreover, managing or implementing school-related entitlement and/or conditional cash transfer schemes. For example, several public sector programme implementers reported a role in raising awareness of schemes, and assisting families in completing the paperwork to apply for these schemes. Several NGO programme implementers reported that NGOs provided educational benefits, including scholarships to girls, conducted mass marriages to help defray marriage-related costs, and helped parents avail of government programmes, including the *Ladli Scheme*. For example:

In addition, girls are also given books, uniforms, (school) bags and bicycles free of cost from the government. [Female, PO/CDPO, ICDS, aged 52; Sonipat, Haryana, India]

For girls, the government has started the Ladli Yojana, Asha Yojana etc. Apart from this, many steps have been taken to make education easily accessible for them, and ensure that financial help is available at the time of their marriage. Their school uniform, fees, books and cycle for daily transportation etc. are given free of cost by the government. The Ladli Yojana is run for girls from every caste and religion; however, the Asha Yojana is run only for those girls belonging to BPL (below poverty line) and Scheduled Caste/Tribe categories. I have seen that those who are really poor and needy do not have BPL cards whereas rich people have them and they also take all the benefits the card provides! Under the Ladli Scheme, the government fills a bond of Rs. 5,000 every year for five years, which becomes nearly Rs. 1 lakh when the girl turns 18, or at the time of her marriage. [Female, law enforcement officer, aged 66, Sonipat, Haryana, India]

Yes, starting from 2005, I think today there are more such programmes than ever before to raise the value of girls in the society. Other than the Ladli Scheme, the Social Welfare Department also organizes 'Ladli Suraksha Pension Yojana', 'Kannyadan Yojana' etc. [Female, PO/CDPO, ICDS, aged 52, Kurukshetra, Haryana, India]

We provide various government schemes to encourage the birth of a daughter; for example, the Ladli Scheme which, at the birth of a second daughter, gives Rs. 5,000 for five consecutive years, and KSY (Kishori Shakti Yojana) that aims to improve girls' health, provides them with nutritional supplements, and raises awareness among them. We arrange 'Best Mother' awards for those who have two daughters and at the Block level, we give awards to girls who come 1st, 2nd and 3rd in the State Board Exams. We also organise Sports Meets for girls in our district to encourage girls' participation in sports. In addition, the WDC (Women's Development Corporation) provides loans for higher education, and gives a five percent subsidy on the interest. [Female, PO/CDPO, ICDS, aged 50, Kurukshetra, Haryana, India]

To stop sex determination, we have started arranging community marriages. We organise mass marriages so that parents do not feel that daughters are a big responsibility that is very difficult to fulfill. Once, I organised a community marriage of eleven couples. Aside from this, we work on providing information about government schemes, which are specifically for girls, such as the Ladli Yojana and many others... And helping people access them, as the implementation part of these schemes is weak, the process of registering is very long, and to get the facilities of these schemes, parents have to engage with it continuously. [Male, NGO programme implementer, aged 46, Sonipat, Haryana, India]

The delivery of conditional cash transfer schemes and the challenges associated with their implementation were also discussed. While some described how they assisted parents in registering for schemes and avoiding registration bottlenecks, several public sector and NGO programme implementers admitted that tedious registration procedures deterred many couples from even submitting an application for registration in the scheme, and the presence of middlemen and so on, gave rise to corruption within the system and reduced the cash transfers effectively received by the girl. For example, those delivering the ICDS programme noted that programme workers were tasked with helping parents to process their applications. For example:

There has been an increase in the number of beneficiaries, and it's very easy to enroll girls in the programmes. Our Anganwadi Workers help people to fill up the form and submit the documents, that is, the birth and domicile certificates that are needed. It is a streamlined procedure and people don't even need to go to the concerned office. [Female, PO/CDPO, ICDS, aged 50, Kurukshetra, Haryana, India]

However the implementation of this (Ladli) Scheme is poor because some do not get the forms while others are unaware of the Scheme. The same situation exists with the Social Welfare Board (Samaj Kalyan Board). If we don't pay attention, then the authorities of that organisation swallow up the money reserved for scholarships and the Ladli Scheme, and people's needs are not addressed. Many people do not have even the slightest idea about the amount they will receive and when they will receive it. They are scared off when they enquire about such things. As a result, in all, the total benefits of the scheme do not go to the beneficiary, only five percent (does). All the work is done on paper, and the remaining 95 percent of the money is scraped off by the authorities. This is the reason why this scheme has proved ineffective in changing the mindset of the people towards their daughters..... We and members of some NGOs help people to enroll in these schemes..... There are numerous schemes run by the government and new schemes are also being introduced, but the problem is with their improper implementation and that's why the desired impact is not experienced. [Female, law enforcement officer, aged 66, Sonipat, Haryana, India]

There are education schemes and girls get free education till senior secondary school; even their books, uniforms and transport are free. There is a scheme called Ladli in this district where the government takes care of girls' upbringing and at the time of their marriage they get Rs 1,100 or 5,100. This is a very well-known scheme. But again, it happens that influential people help their own. Even today, caste and religion are important. If the village head belongs to a higher caste, then only higher caste people will benefit from these schemes. I think these schemes are only on paper and their benefits do not reach the individual. Those who are influential get benefits but those who are weak do not. [Male, NGO programme implementer, age 41, Sonipat, Haryana, India]

Key informants who implemented programmes in the public and NGO sectors were, however, mixed about the benefits of these schemes. Some suggested that they were successful in changing parents' perceptions about girls as liabilities and burdens, encouraging parents to immunise and educate their daughters, and helping poor parents to defray the costs of their daughter's education and marriage. At the same time, they argued that these schemes may be useful for the poor and poorly educated, but not for better off families who hold strong preferences for sons. While different opinions were expressed, on balance, they believed that while cash transfers helped, they could not change norms about having a son or deter son-less couples away from gender-biased sex selection. These key informants argued that money was not the critical factor in determining whether to opt for gender-biased sex selection. For example:

Yes, they (conditional cash transfer schemes) are useful for girls. They have changed attitudes toward girls and improved their status in society. [Female, PO/CDPO, ICDS, aged 52, Sonipat, Haryana, India]

Definitely the Ladli Scheme and other such schemes have made a change in the attitudes of people, especially the poor, about girls' status in society. People feel less burdened because of the money they receive from these schemes (Ladli/conditional cash transfer schemes), and thus less worried about the marriage and education of their daughters. The programmes are well implemented in Kurukshetra and every eligible family receives benefits. We have not done a study to examine the change in attitude, but I feel changes are taking place in people's perceptions about daughters, about disclosure of sex, and sex-selective abortion..... There has been an increase in the number of beneficiaries, and it's very easy to enrol in the programmes. [Female, PO/CDPO, ICDS, aged 50, Kurukshetra, Haryana, India]

Schemes are secondary; if you are educated, you allow a girl to be born, but if you are not giving birth to them, what good will these schemes do? Education is more important than schemes; education is free up to senior secondary school level, and girls get free transport, scholarships. Other than this, there is the Ladli Scheme going on here for girls; they get benefits. I only know they get some economic help but I don't know how much. I don't know whether the benefits are reaching the really needy. Those who get benefits are happy. They think they are at least getting some help from the government, so it helps in improving girls' education. Parents already want to marry their daughter late, not because of these schemes. [Male, NGO programme implementer, aged 39, Sonipat, Haryana, India]

I do not think that because of these yojanas (schemes), parents are less likely to want a son. But one good thing is that earlier daughters were thought of as a burden for their family; this mentality is gradually changing—but not because of these schemes, rather because of education and awareness..... [Male, NGO programme implementer, aged 46, Sonipat, Haryana, India]

In short, key informants acknowledged the plethora of educational entitlements and conditional cash transfer schemes that were implemented in both districts. They agreed that as a result of these educational entitlements and cash transfers, parents were less likely to perceive daughters as burdens, and more likely to educate them and delay their marriage; however, several key informants cautioned that educational entitlements and cash transfer programmes may not reduce parents' demand for at least one son. Interdistrict differences were not observed.

Nepal

Nepal implements few programmes intended to raise the status of women and girls. These include reservations for women in various fields and skill development programmes for women. A number of programmes are implemented, including in study districts, that focus on girls, including scholarships for girls, discussed earlier, as well as programmes aimed at making schools girl-friendly (distribution of sanitary pads, separate toilets for girls, etc.) and adolescent girls development programmes that build girls' vocational skills, address their health needs and raise awareness about violence against women and girls. Key informants were asked about their perceptions about how families view these programmes and the effect they may have on preferences for sons and daughters.

Key informants implementing public sector and NGO programmes in both districts suggested that communities in their district had indeed benefitted from these programmes. They maintained, moreover, that these programmes had multiple effects: raising girls' and women's awareness, enabling girls to complete their education, reducing the incidence of child marriage, and empowering women. For example:

We visit different schools to explore and support girl students who may be facing difficulties in pursuing their education. We ask them about their school and family environment. And we hold discussions with girls, parents and teachers to solve their problems. We do this regularly, every three months. It is a part of the girl-friendly programme. [Female, NGO programme implementer, aged 31, Tanahun, Nepal]

Though not highly remarkable, some changes have taken place because of these programmes. When a girl from a poor family gets a scholarship, she can continue her education. Such support from the government is important for the general public. [Female, public sector programme implementer, aged 46, Kaski, Nepal]

Nowadays, women have started to raise their voice against child marriage. The idea that a girl must have a certain level of education and employment opportunities before she marries is becoming more common. These are the changes made by such programmes. [Female, public sector programme implementer, aged 50, Tanahun, Nepal]

In short, while key informants agreed that these programmes had improved the status and wellbeing of girls, not a single key informant suggested that access to these programmes would reduce parents' demand for at least one son.

Chapter 6

Gender-biased sex selection in Karachi, Pakistan: Provider perspectives on factors influencing the emergence of an unbalanced sex ratio at birth and recommendations for the way forward

The chapter has highlighted, from the perspectives of experienced health care providers, the factors leading to the onset of skewed sex ratios in Karachi while those in the country remain balanced, and their recommendations to restore balance and prevent the emergence of skewing in other parts of the country. The extremely limited availability of early foetal sex-detection technology and the conviction expressed by experienced health care providers who constituted our key informants in this case study, that clients do not seek sex-selective abortion suggest that this practice is uncommon in Karachi. Health care providers noted, however, that while abortions do take place, they are almost entirely undertaken as a means of spacing or limiting births, but not for sex selection. This view corroborates the findings of a recent study that estimates that 2.2 million abortions were performed in 2012 in Pakistan, the abortion rate doubling over a decade, and a large number of women seeking services for the treatment of post-abortion complications (Sathar et al., 2014).

Key informants acknowledged their own lack of knowledge regarding the provisions of the abortion law, emphasised that most health professionals were similarly unaware of the law, and observed that there was virtually no enforcement of the law. These responses underscore that there are no effective legal barriers to check sex-selective abortions in Karachi, if they are, in fact, attempted. Additionally, son preference retains a strong hold, particularly in more patriarchal communities and the lower socioeconomic classes, while the demand for and trends in foetal sex disclosure are rising steadily in all classes and groups. While it may safely be inferred from this study that there is no observable trend of gender-biased sex selection in general health facilities, further investigation focused specifically on abortion service providers and their clients is required for more conclusive evidence regarding the incidence of this practice in Pakistan, and factors underlying the emerging imbalance in child sex ratios in Karachi.

In short, in view of findings of persistent gender inequalities and strong son preference, together with relatively easy access to induced abortion, the potential to resort to gender-biased sex selection and termination of pregnancies carrying a female foetus does exist in Karachi. There is a need for more research to explore strategies that stem the emerging imbalance in sex ratios at birth, and ensure that sex-selection practices do not spread to other parts of the country.

In Pakistan, while disclosure of the sex of the foetus is not legally restricted, abortion is legally restricted and permitted only to save the life of the woman or under other serious conditions. While Pakistan continues to record normal sex ratios at birth and among children, unbalanced sex ratios have begun to emerge in Karachi. The objective of this case study conducted in Karachi, Pakistan, was to better understand the situation from the perspectives of experienced health care providers. The study thus comprised key informant interviews with 15 health care providers from Karachi working in the field of reproductive health.

The health care providers who were interviewed were largely unaware of the emergence of skewed sex ratios at birth, and the more unbalanced child sex ratios in Karachi than in other parts of the country, and could not assign reasons for this imbalance. All were emphatic, however, that the imbalance could not be attributed to sex-selective abortion, and one provider expressed the perception that even if this were the case, gender differences in survival rates would restore balance. For example:

I don't agree that there is any imbalance in the ratio of boys to girls in Karachi. Anyhow, even if it is so, it is not based on sex-selective abortion, and may be due to some other issue. The next PDHS (Population and Demographic Health Survey) will surely confirm this. [Female, gynaecologist, aged 70, Karachi, Pakistan]

I think the sex ratio will come to normal because female survival is more than male (survival), so it will naturally become normal and if the quality of our neonatal units improves, the ratio will become normal. [Female, sonologist, aged 70, Karachi, Pakistan]

Nevertheless, the key informants acknowledged that all three preconditions for distortion of sex ratios at birth prevailed in Karachi. For example, they were unanimous about the persistence of son preference, even in Karachi, and observed that women with sons were more secure and better treated in their family than son-less women. They also acknowledged the spread of the small family norm among couples in Karachi, and the increasing use of prenatal diagnostic techniques—mostly ultrasonography.

Key informants, however, emphasised that despite the prevalence of these preconditions, sex-selective abortions were rare. Moreover, because disclosure of the sex of the foetus is not prohibited legally in Pakistan, they observed that there is a huge demand for foetal sex disclosure among pregnant women and their families, overwhelmingly in order to prepare for the birth, and this demand extends across all socioeconomic classes and education levels. Indeed, they were unanimous that in Karachi, interest in knowing the sex of the foetus had increased over the last ten years as communities became more aware of and accessed diagnostic services. About one-half of the health care providers we interviewed also believed that the practice of foetal sex disclosure was more common in Karachi than in other areas due to the more widespread availability and accessibility of facilities. Besides, there was greater public awareness in Karachi than elsewhere in the country. The majority of these key informants reported that health care providers typically do reveal the sex of the foetus to clients. Only in rare cases did providers refuse to do so, for example, on ethical or religious grounds, or in some teaching hospitals where disclosure is prohibited, perhaps because of a greater level of consciousness about the potential for sex-selective abortion.

In general, key informants suggested that although health care providers, by and large, were aware that there is a law concerning abortion in Pakistan, most—estimated at between 50 percent and 80 percent—were unfamiliar with its precise provisions, including the specific circumstances in which abortion may legally be performed. Key informants were also aware that abortions take place, but few knew about the practices adopted either by clients to access an abortion or by those who conducted illegal abortions. They were unanimous in their opinion that the abortion law is not at all enforced in Karachi, and that the authorities turn a blind eye to the practice. They suggested that there is no monitoring mechanism at all and no action has ever been taken against a provider for performing an illegal abortion. Indeed, the majority of the key informants suggested that more than one-half of the abortions conducted in Karachi are probably illegal; however, those who were well-informed about the provisions of the law, held that only one-tenth of abortions conducted in the city are illegal, and that the remaining were conducted for reasons permitted under the law. We note that, on the whole, many service providers are unaware of the exact provisions of the law. A few key informants discussed the ways in which women accessed illegal abortions: two suggested that only mid-level providers perform these procedures, a third indicated that misoprostol was increasingly being used to terminate a pregnancy, and one described “setups” in slum areas of Karachi where abortions of unwanted pregnancies are carried out.

Even so, while key informants freely admitted to the occurrence of illegal abortions, 14 out of the 15 health care providers we interviewed denied that such abortions are conducted for sex selection. They gave two reasons for this perception. First, they suggested that interest in knowing the sex of the foetus was related to preparing for the birth of the baby, and discounted any link between disclosure of the sex of the foetus and intentions to abort a female foetus. Second, they also noted that ultrasound technology, the technology most widely available, does not detect sex until 16–18 weeks into the pregnancy, at which stage abortion is difficult to access. They believed, moreover, that most service providers would not favour sex-selective abortion. There was, however, one exception: one provider had encountered a woman seeking a sex-selective abortion and suggested that in rare cases, the practice did indeed exist. In general, provider attitudes strongly condemned the practice of sex-selective abortion, and most discouraged abortion, unless the pregnancy was life-threatening.

In summary, provider (key informant) perspectives suggest that gender-biased sex selection and sex-selective abortion, while rare, are not entirely absent in Karachi. The preconditions for these practices exist: son preference persists, the small family norm is prevalent, and the practice of disclosing the sex of the foetus, while discouraged by some, is widespread.

Recommendations by health care providers

The health care providers we interviewed (key informants), made a number of recommendations regarding ways of restoring balance in the sex ratio at birth in Karachi and preventing it, more generally, from becoming skewed in the future, suggesting their concern about the threat of a growing number of sex-selective abortions in the city. Recommendations largely focused on sensitising service providers, by and large, and changing deeply-rooted preferences for sons. Several key informants expressed scepticism, however, about the ability of programmes to change deeply ingrained preferences for sons.

Place restrictions on the disclosure of the sex of the foetus

Health care providers, during the course of interviews, conveyed mixed opinions about whether restrictions should be placed on the disclosure of the sex of the foetus. Ten of the 15 key informants expressed the view that given the potential for sex-selective abortion in Pakistan, laws should be instituted to restrict disclosure, monitoring mechanisms set up to ensure adherence, and strict action taken against violators. Others suggested that women had a right to know the sex of their foetus, and since there was no link between disclosure and sex-selective abortion, the mere disclosure of the sex of the foetus was not in itself a negative practice and should not be prohibited. Another health care provider suggested that instead of a law, the issue of disclosure should be discussed widely in public forums and in the media in order to raise awareness and change attitudes at the community level. For example:

I don't think there should be any law. I am not against disclosing the sex (of the foetus)—it is the patient's right to know; but it is their (subsequent) behaviour that makes us avoid disclosure. Unless and until there are wrong intentions in asking the sex (of the foetus), there is no harm in telling. [Female, gynaecologist, aged 58, Karachi, Pakistan]

Sensitise health care providers about unbalanced sex ratios and providers' role in preventing the distortion of sex ratios at birth

All 15 health care providers we interviewed (key informants) acknowledged that sensitisation programmes had not been implemented for health care providers anywhere in the country. They perceived that such programmes were needed in order to raise provider awareness about possible links between disclosure of the sex of the foetus and sex-selective abortion, skewed sex ratios and their implications, as well as the service provider's own role in preventing distortion of sex ratios at birth in the city. Ten of the 15 key informants recommended such training programmes, and highlighted the need to improve provider understanding of the value of girls and the dangers of sex-selective abortion, to enhance their counselling skills to respond to women seeking sex-selective abortion, and sensitise them to religious rulings about the value and importance of daughters/girls in Islam. Key informants also suggested several mechanisms: for example, for senior doctors to conduct programmes for junior doctors and other health care providers, and for workshops and other forums to be organised at which service providers would be given an opportunity to discuss the pros and cons of disclosing the sex of the foetus.

Training should be imparted to health care providers to clarify their own understanding regarding the value of the girl child and hazards of sex-selective abortion, and how to counsel women about the importance of girls. [Female, general physician, aged 54, Karachi, Pakistan]

I am not aware of any programmes for sensitising the providers about the problem of sex-selective abortion; whatever few things I know is through attending conferences. [Female, radiologist, aged 42, Karachi, Pakistan]

There are no programmes at all to sensitise us about this issue, although there is a need. [Female, LHV aged 36, Karachi, Pakistan]

Involve men in efforts to reduce son preference

The majority of health care providers (11 of 15 key informants) suggested that efforts were needed to change parental perceptions of sons versus daughters, and called for a greater emphasis on changing patriarchal norms. Several of them emphasised that men should be counselled about gender equality and encouraged to support

women's empowerment as a religious obligation; one provider specified, in addition, that such programmes should convey that husbands are "responsible" for the sex of the baby, and women should not be blamed for it. For example:

Educate men to empower women because our religion also supports women's empowerment. [Female, general physician, aged 70, Karachi, Pakistan]

Empower women, educate girls

Several health care providers (key informants) emphasised the need to educate girls and empower women in order to change preferences for sons over daughters. Some argued for free education of girls. For example:

If we educate girls and solve problems associated with girls by taking care of their dowry, insecurity and problems of in-laws, son preference will decline. [Female, gynaecologist, aged 52, Karachi, Pakistan]

Yes, if women are empowered, with the passage of time and by understanding that females take more care of their parents, are more helpful and can do as much work as men can do. [Female, general physician, aged 48, Karachi, Pakistan].

Educate girls and involve women in income generating activities so they won't be dependent on others. [Female, nurse, aged 42, Karachi, Pakistan]

Engage influential opinion leaders to address son preference

Health care providers (key informants) suggested the involvement of influential opinion leaders in changing attitudes about sons and daughters, in advocating for a balanced sex ratio, and in raising community awareness about the dangers of sex-selective abortion. They recommended, for example, that influential individuals appear in media discussions and morning talk-shows, and that messages relating to female empowerment and the dangers of sex-selective abortion be widely publicised in the media. They also recommended the engagement of religious leaders/scholars in elucidating the Islamic view of sex-selective abortion according to the Quran and Sunnah, suggesting that communities were likely to respond to messages from religious leaders about equal treatment of sons and daughters and the dangers of sex-selective abortion. Several key informants also called for the training of social workers and frontline health workers and engaging them in raising community awareness and counselling individual couples about the value of girls and women, and the dangers of sex-selective abortion.

Chapter 7

Factors underlying differences in the sex ratio at birth in Comilla and Rangpur, Bangladesh, and recommendations for the way forward

This chapter has emphasised, from the perspectives of women and key informants, factors that have likely influenced the skewing of sex ratios in the eastern region of Bangladesh as compared to the western region, and offered recommendations to ensure balanced sex ratios. Women in both districts selected for the case study of Bangladesh, namely Comilla and Rangpur, exhibited a strong preference for a two-child family. The practice of disclosing the sex of the foetus is widespread in both study districts but the practice of sex-selective abortion was almost entirely absent, and women strongly opposed gender-biased pregnancy termination. Even so, son preference was evident in both districts, although more so in Comilla, the district with an adverse sex ratio at birth, than Rangpur, the district with a normal sex ratio at birth. The intention to have additional children was related to the sex composition of living children among women in Comilla. Women from Comilla who had more sons than daughters were more likely than those from Rangpur to report wanting no more children. Moreover, women's use of contraception was strongly associated with the sex composition of living children. In Comilla, women who had two sons were 50 percent more likely to have been practising contraception than those who had two daughters while in Rangpur, they were 17 percent more likely to have done so. Thus, women from Comilla were more likely to base their childbearing strategies on the number of sons they had than were those from Rangpur. Women from Rangpur, in contrast, were more likely to stop childbearing when they reached their desired family size, with less regard for the sex composition of their children.

Our case study observed that gender equality programmes, such as, stipends for girls, microfinance opportunities and employment opportunities in the apparel industry played a powerful role in changing attitudes about girls; nevertheless, the consensus among key informants was that these programmes were unlikely to change parents' preferences for sons over daughters. Key informants also highlighted the absence of any mechanisms that monitor the reasons for abortions beyond ten weeks of gestation. As disclosure of the sex of the foetus is not restricted legally and violations of the law prohibiting the termination of pregnancy beyond a prescribed gestation period are barely punished, potential does exist for increased use of gender-biased sex selection in settings such as Comilla that are characterised by strong son preference. The country needs to formulate policies/laws forbidding the use of technology for sex selection and ensuring strict enforcement of the abortion law in order to prevent gender-biased pregnancy termination. At the same time, it is necessary to strengthen gender equality initiatives, such as increasing opportunities for subsidised education for girls and for paid employment for women, so that parents value girls as highly as sons.

Bangladesh is characterised by an east-west divide in sex ratios at birth and among children. While the western region shows normal sex ratios at birth and among children, the eastern region displays unbalanced sex ratios. While disclosure of the sex of the foetus is not legally restricted in the country, abortion beyond ten weeks is legally restricted, and permitted only under certain conditions.

The objective of the Bangladesh case study was to identify likely factors underlying the skewed sex ratio at birth in the eastern region of the country, represented by Comilla, as compared with the normal sex ratio at birth observed in the western region, represented by Rangpur. The case study comprised a household survey among married women aged 18–49 years who had at least two living children, the youngest of whom was aged 0–5, and key informant interviews with health care providers and programme implementers. Findings have highlighted that in both districts, the preconditions for skewing of sex ratios do indeed prevail: the small family norm is widespread, gender norms continue to be hierarchical and son preference remains strong, particularly in rural areas, and prenatal diagnostic

techniques are used by large proportions of women to both assess the development of the foetus and know the sex of the foetus. In this chapter, we explore the extent to which low fertility, preference for sons and access to sex-selection technology has affected differences in the sex ratio at birth in these two districts with contrasting sex ratios.

Both districts exhibited a strong culture of low fertility, that is, the two-child norm. Women in Rangpur were more likely than those in Comilla to have just two children (62% versus 47%); in contrast, they were less likely than those from Comilla to have three children (25% versus 41%). High parity women and their husbands do not seem to be content to have only sons or only daughters, and a strong preference for children of both sexes is evident.

Even so, son preference was evident in both districts; more so in Comilla than Rangpur. The intention to have additional children was, for example, clearly related to the sex of living children among women in Comilla. Indeed, there was some suggestion that women from Comilla who had more sons than daughters were more likely than their counterparts in Rangpur to report wanting no more children. In Comilla, the desire for gender-balance in the number of children to have was stronger when couples had only daughters. For example, preference for a son as the third child is almost universal among women who had two daughters (90–99%) while a less intense preference for daughters as the third child was expressed by women who had two sons (76–92%).

Moreover, women in Comilla were more likely to report disclosure of the sex of the foetus than were those in Rangpur, and such disclosure appeared to be contingent on the sex of the previous child. In Comilla, women at parity 2 whose first child was a daughter were more likely to have been informed about the sex of the second child than were those whose first child was a son. Associations were modest in Rangpur. Furthermore, women's use of contraception was strongly associated with the sex composition of their living children. In Comilla, women who had two sons were 50 percent more likely to have been practising contraception than those who had two daughters while in Rangpur, they were 17 percent more likely to have done so. These findings suggest that women from Comilla were more likely to base their childbearing strategies on the number of sons they had than were those from Rangpur.

Despite large proportions of women reporting that they had been told the sex of their foetus, hardly any women, irrespective of district, favoured the termination of a female foetus (less than 2%). Findings highlight, moreover, that termination of pregnancies carrying a female foetus was almost entirely absent as revealed from both the household survey and discussions with key informants. Indeed, only one case of gender-biased sex selection was noted in the survey of 1,037 women. While eight percent of women reported an abortion, almost all these abortions took place in the first trimester of pregnancy, when detection of the sex of the foetus is not possible through ultrasonography, and the leading reason for pregnancy termination was for limiting family size.

Our investigation suggests no discernible differences between women in the two districts in terms of sex-selective abortion, almost entirely absent in both districts; however, there is a suggestion that women in Comilla were more likely than those in Rangpur to continue childbearing until they had a son, and less likely to stop childbearing at low parities, irrespective of the sex composition of their children. In Rangpur, a normal sex ratio coexisted with higher rates of pregnancy termination as a means of ensuring small family size, and without seeking disclosure of the sex of the foetus.

Findings have shed light on factors that may have resulted in these differences and in the greater acceptability of daughters in Rangpur than in Comilla.

Although women in Comilla were more likely than those from Rangpur to suggest that the Female Secondary School Stipend Programme played a role in reducing discrimination against girls (92% versus 38%), significantly more women from Rangpur than Comilla reported that their daughter had received a stipend (89% versus 73%). Programme implementers from both public and NGO sectors highlighted that stipends, microfinance opportunities and employment opportunities in the apparel industry played a powerful role in changing attitudes about girls. For example, the Stipend Programme was observed to have played a key role in delaying the age at marriage of girls, being one of the key conditions for receiving a cash stipend. Access to microcredit was perceived to have reduced discrimination against women and changed perceptions about the importance of daughters. Likewise, girls' access to the apparel industry—more widespread in Rangpur than Comilla—was perceived to have raised the status of girls in families and changed perceptions about the role of daughters in providing economic support to their family. Nevertheless, key informants—mainly public sector and NGO programme implementers—from both districts were

sceptical about the ability of these programmes to change parents' preferences for sons over daughters. Indeed, not a single programme implementer believed that the Stipend Programme had brought about changes in the demand for sons and daughters.

Findings suggest that programmes that specifically promote awareness of gender-biased sex selection (or termination of pregnancies carrying a female foetus) do not exist in the country. Exposure to advocacy and community mobilisation programmes related, rather, to non-discrimination against daughters, and these programmes took place in both Rangpur and Comilla. However, it was women in Comilla who were more likely than those in Rangpur to have been exposed to these programmes; more women from Comilla than Rangpur were also more likely to have been exposed to messages about equal treatment of sons and daughters delivered by religious leaders and health care providers. These findings run counter to our hypothesis that advocacy and community mobilisation efforts may have been more intensively administered in settings with normal sex ratios, and suggest perhaps that programmes relating to non-discrimination against daughters were more likely to focus on districts displaying higher levels of discrimination than other districts.

With regard to the awareness and enforcement of laws concerning abortion, we note that in Bangladesh, disclosure of the sex of the foetus is not restricted legally, and abortion (menstrual regulation or MR) is permitted only up to ten weeks of gestation, and later only under specific conditions. Findings suggest that women did not typically perceive a need for a law to prevent gender-biased sex selection; even so, more women in Comilla than Rangpur perceived this need (39% versus 13%). Health care providers did, however, perceive that the abortion law is not strongly enforced; they suggested that abortions beyond ten weeks of gestation did take place, and that there was no system whereby abortions were monitored at district level. They also noted that there have been no programmes that attempt to raise awareness about gender-biased sex selection among service providers. Perceptions of key informants concurred with reports of women that sex-selective abortions are extremely rare.

The way forward

Women in both study districts exhibited a strong culture of low fertility, that is, a strong preference for a two-child family. The practice of disclosing the sex of the foetus is widespread in both study districts but the practice of sex-selective abortion was almost entirely absent, and women strongly opposed gender-biased pregnancy termination. Despite these similarities, findings suggest a stronger desire for a male child in Comilla than in Rangpur. As such, women in Comilla were more likely than those in Rangpur to continue childbearing until a family with at least one son was achieved. Women in Rangpur, in contrast, adhered more strongly to the small family norm, adopting contraception and/or resorting to abortion to prevent higher-order births, irrespective of the sex composition of their children.

Caution should be exercised in interpreting the findings from our survey, as the size of the sample of women interviewed (1,037 respondents) was not adequate to reach a conclusion. Future studies are needed that work with a larger sample so that findings on differentials across characteristics can be generalised.

Given that sex-selection technology exists, and given that access to second-trimester abortions is not difficult to obtain as the violation of the law related to terminating pregnancies beyond the prescribed gestation period is rarely punished, potential does exist, particularly in Comilla, to resort to gender-biased sex selection and termination of pregnancies carrying a female foetus. There is a need, therefore, to explore strategies to avoid such a scenario.

Several recommendations emerge from this case study that have relevance for efforts to ensure a balanced sex ratio at birth. Indeed, given that gender-biased sex selection is not a serious concern at present, measures are needed that challenge traditional gender norms and strongly held preferences for sons over daughters:

- **Expand programmes intended to enhance the autonomy of women and girls:** It is critical to increase the autonomy of women and girls, by increasing opportunities for subsidised education for girls and paid employment for women; our findings have suggested that perceptions about the value of girls can change when communities observe girls providing economic support to their family and take on the economic roles traditionally conferred only to sons. While such changes may not affect parents' desire for a son in the short run, there is some suggestion that they will erode strong preferences for a son in the longer term.

- ***Provide safety nets to protect poor rural women:*** At the same time, safety net programmes for poor women in rural areas can be a useful instrument for reducing son preference, since poverty remains a key driver for son preference in the rural setting. Such programmes will not only provide much needed support to poor women in the short term, but may also change attitudes about reliance on sons for old age support in the longer term.
- ***Track the extent to which disclosure of the sex of the foetus is followed by gender-biased sex-selective abortion:*** In addition, there is a need for the government to track the extent to which disclosure of the sex of the foetus, currently legally permitted in the country, is followed by sex-selective abortion, and prepare, if necessary, to formulate policies/laws forbidding the use of technology for gender-biased sex selection.
- ***Step up communications, advocacy and community mobilisation efforts intended to challenge traditional gender norms:*** It is essential that outreach and other programmes are implemented that attempt to break down traditional norms about sons versus daughters, while at the same time, focusing on parents to promote equal opportunities for daughters and sons, and enhance awareness about and encourage parents to access available programmes and entitlements for their daughters.

Chapter 8

Factors underlying differences in the sex ratio at birth in Kaski and Tanahun, Nepal, and recommendations for the way forward

This chapter has highlighted from women's perspectives, the sociocultural and programme factors underlying differences in the sex ratio at birth between the study districts—Kaski, the district with an unbalanced sex ratio at birth, and Tanahun, the district with a normal sex ratio at birth, and recommendations based on the insights gained from the findings. Despite the fact that the two districts are geographically contiguous and share many similar characteristics, our comparison of Kaski and Tanahun draws attention to a few important factors likely to have influenced the sex ratio in Kaski as compared to that in Tanahun, one of which, in particular, reflects differences in programme initiatives to challenge gender norms and prevent the practice of gender-biased sex selection. First and foremost, were differences in women's access to ultrasonography and disclosure of the sex of the foetus. Our case study showed that significantly more women in Kaski than in Tanahun, underwent ultrasonography to monitor foetal development and screening for abnormalities of the foetus (82% versus 52%). Although disclosure of the sex of the foetus was not uncommon in both districts, a larger proportion of women from Kaski than from Tanahun reported disclosure (39% versus 26%). All key informants, irrespective of category explained this difference by highlighting that access to ultrasound facilities and to service providers who are qualified and willing to disclose the sex of the foetus, was far more difficult for women in Tanahun than for those in Kaski. In addition, women in Kaski demonstrated a greater inclination to undergo induced abortion following sex determination than did those from Tanahun. A second key difference related to the pressure to bear sons—again, women from Kaski were significantly more likely than those in Tanahun to report that they had been pressurised by family members to continue childbearing until they bore a son (31% versus 15%).

The third key factor is programme-related and lies in women's exposure to communication, advocacy and community mobilisation activities. Our findings indicate that the implementation of community-based awareness and advocacy programmes on gender equality reached more women in Tanahun than in Kaski. Even so, differences were not observed in the narratives of key informants: although key informants of all categories concurred that these programmes had contributed to raising awareness and changing attitudes toward women and girls, their narratives did not indicate any interdistrict differences.

Overall, findings suggest that in the absence of direct interventions in respect of gender-biased sex selection, there is a possibility of a worsening situation in Nepal with regard to the sex ratio at birth as access to prenatal diagnostic techniques proliferates to districts beyond Kaski. With regard to programme initiatives that hold promise, we may draw inferences from interdistrict differences, about the likely effectiveness of communication, advocacy and community mobilisation efforts in the shorter term. In the longer term, what is required are programmes that aim to empower girls, promote gender equality and improve the overall situation of girls. Programmes must focus on keeping girls in school and ensuring that they complete a secondary education, providing girl-friendly education to encourage school retention, and expanding the reach of the universal scholarship scheme for girls. Other efforts adopted in neighbouring countries, including conditional cash transfer schemes that provide benefits to parents when their daughter achieves immunisation, education and other milestones, and remains unmarried till the age of 18, may also hold promise.

Districtwise differences in sex ratios are evident in Nepal. The objective of the Nepal case study was to identify likely factors underlying the skewed sex ratios in some districts of the country, represented by Kaski, as compared with normal sex ratios observed in other districts, represented by Tanahun. As mentioned in Chapter 1, in the absence of district-level data on sex ratios at birth in Nepal, and as the child sex ratio (0–4 years) reflects, to a considerable

extent, the sex ratio at birth, the child sex ratio has been used as our indicator to identify districts with low and high sex ratios at birth; in this report, Kaski and Tanahun, respectively, represent the district with an unbalanced and normal sex ratio at birth. These districts are contiguous and have similar sociocultural characteristics. The study comprised a household survey among married women aged 18–49 years who had at least two living children, the youngest of whom was aged 0–5, and key informant interviews with district-level health care providers and programme implementers from both public and NGO sectors.

Findings have highlighted that in both districts, the preconditions for skewing of sex ratios do indeed prevail. The small family norm is widespread with the overwhelming majority of women desiring just two children. Gender norms continue to be hierarchical and son preference remains strong. Prenatal diagnostic techniques are used by large proportions of women to both assess the development of the foetus and know the sex of the foetus. In this chapter, we explore the extent to which low fertility, preference for sons and access to sex-selection technology has affected differences in the sex ratio at birth in these two contrasting districts, and the factors likely to have influenced these differences.

Perceived value of sons

There is a general belief in Nepalese society that sons determine the status of the family and the status of women, and provide security to parents in old age. Although son preference was articulated in our study by women in both districts, interdistrict differences did emerge. Women in Kaski, the district with an unbalanced sex ratio at birth, were significantly more likely than those in Tanahun, the comparison district with a balanced sex ratio at birth, to express attitudes that suggested the importance of having at least one son. For example, a comparison of women who had two sons versus those who had two daughters suggested that percentages of women in Kaski wanting no more children and practising contraception was greater among women who had two sons than among those who had two daughters; differences were negligible among women in Tanahun. Likewise, women in Kaski were significantly more likely than those in Tanahun to perceive that sons are important in order to continue the family line (72% versus 63%) and to secure a woman's status in her family (34% versus 27%).

Disclosure of the sex of the foetus and sex-selective abortion

Despite the fact that disclosure of the sex of the foetus is legally restricted in Nepal, considerable proportions of women reported that they or someone they knew had been told the sex of their foetus. Interdistrict differences were significant and consistent: significantly more women from Kaski, the district with an unbalanced sex ratio at birth, than Tanahun, the comparison district, had themselves been told the sex of their foetus (39% versus 26%), had a friend or relative who had been told the sex of their foetus (57% versus 35%) or knew someone in their community who had been given this information (67% versus 40%). In line with survey results, key informants—mainly health care providers—confirmed that women in Tanahun were less likely than those in Kaski to access ultrasonography, in general, and to seek disclosure of the sex of their foetus, in particular. They also suggested that as a result of the greater demand for sex determination in Kaski, doctors and service providers in Kaski were more likely than those in Tanahun to disclose the sex of the foetus to pregnant women.

Somewhat more women in Kaski than Tanahun also reported that they had experienced an abortion (13% versus 10%). Although similar proportions of women from both districts who had experienced an abortion reported that their abortion had been conducted for the purpose of sex selection (13%), there was a wide difference when compared with the proportions of women reporting familiarity with a person (self, family member, friend or acquaintance) who had undergone a sex-selective abortion, with women from Kaski significantly more likely than those from Tanahun to report such familiarity (31% versus 15%).

Access to health facilities providing prenatal diagnostic tests

Survey data have confirmed that significantly more women in Kaski than Tanahun underwent ultrasonography to monitor foetal development and screen for foetal abnormalities (82% versus 52%). Almost all key informants, across all categories, explained this difference by highlighting that access to ultrasound facilities and to providers willing to disclose the sex of the foetus was far more difficult for women in Tanahun, where the sex ratio at birth is normal, than for those in Kaski district in which it is unbalanced. Several obstacles were discussed. First, key informants suggested that there are fewer health facilities that offer prenatal diagnostic services in Tanahun than in Kaski; indeed, Tanahun district has fewer hospitals and private clinics and no radiologists. As such, access to

ultrasonography is limited in the district, and women desiring ultrasonography services must travel long distances to Pokhara (urban Kaski) or Bharatpur (Chitwan District).

A second and related reason was the perception of key informants—mainly health care providers—that there were fewer specialised health care providers in Tanahun than Kaski, and that, as a result, even if facilities were available, providers were unwilling to disclose the sex of the foetus to women. Lack of specialised training in carrying out ultrasonography among health care providers in Tanahun was also identified as a reason for poor access to services. Indeed, one doctor in Tanahun acknowledged this difference thus:

I am not a radiologist. I cannot accurately detect the sex of the foetus. Therefore, I don't say anything regarding the sex of the foetus to my clients. [Male, health care provider, age 38, Tanahun, Nepal]

Third, access was also perceived to be effectively restricted in Tanahun, relative to Kaski, for economic reasons. All key informants, irrespective of category, explained that women in Tanahun were economically worse off than those in Kaski and, hence, did not have the purchasing power required to obtain ultrasonography services, in general, or information about the sex of the foetus, in particular. They argued that many poor women from Tanahun would find it difficult to meet the costs of disclosure of the sex of the foetus, including travel costs to nearby districts and the fees demanded by health care providers engaged in revealing the sex of the foetus. In contrast, women in Kaski were described as economically better off and more able to afford ultrasound services.

Pressure to bear a son

Women from Kaski were also significantly more likely than those in Tanahun to report that they had been pressurised by family members to continue childbearing until they bore a son (31% versus 15%). Key informants—mainly health care providers—suggested several reasons for this. Some believed that there was a concentration of certain castes in Kaski, but not in Tanahun, among whom a son was considered essential, and among whom the pressure to bear a son was particularly strong. In contrast, a few key informants suggested that one of the main ethnic groups in Tanahun, the Magar, accords equal value to daughters and sons, and as such, in this community, sex-selective abortion is rare.

Others reported that many parents in Kaski but not Tanahun perceived opportunities for sons in the British army (Gurkhas) and aspired for sons so that they may join the British army where salaries are attractive and prospects for emigration, even for parents, to the UK exist. Traditionally, these youth are recruited from amongst selected ethnic/caste groups including the Gurung community (one of the main inhabitants of Kaski district); Kaski also houses the British Gurkha Recruitment Camp. These opportunities and aspirations are not evident among parents in Tanahun, thereby making parents in Tanahun more indifferent to having a son versus a daughter.

Exposure to advocacy and community mobilisation activities

Although more women in Kaski district where the sex ratio at birth is unbalanced, than in Tanahun where it is balanced, had been exposed to messages from the media on non-discrimination of daughters and saving the girl child, those in Tanahun were more likely to have been exposed to interpersonal communication delivered by health care providers and female community health volunteers (FCHVs), and slightly more likely to have been exposed to NGO programmes and discourses by religious leaders on these issues. We infer from these findings that the implementation of community-based awareness and advocacy programmes on gender equality reached more women in Tanahun than Kaski. Interdistrict differences were, however, not observed in the narratives of key informants; although key informants—largely public sector programme implementers—concurred that these programmes had contributed to raising awareness and changing attitudes toward women and girls.

Law enforcement

All key informants, irrespective of category, and from both districts agreed that the law was rarely enforced and monitoring mechanisms were weak. They suggested that neither raids nor prosecutions took place in their districts or anywhere else in the country, and pointed to corruption within the system and the ability of powerful providers to avoid prosecution as key reasons impeding law enforcement. However, key informants from Tanahun, the district with a normal sex ratio at birth, appeared somewhat more likely than those from Kaski, the comparison district, to report that their district public health office played an active role in enforcing the law, monitoring facilities and equipment, and confronting violators.

Access of girls to educational entitlement programmes

In Nepal, girls are eligible for free uniforms and textbooks, as well as scholarships. The Girls' Scholarship Programme (GSP), introduced four years ago by the government, provides scholarships for girls in government and community-managed schools up to Grade 8; these scholarships cover their full tuition fees and provide amounts to cover uniforms, stationery or any other expenses deemed appropriate by the School Management Committee (SMC). On balance, more women in Tanahun than in Kaski, had heard about these educational entitlements, and more women reported that their daughter had availed of a scholarship (27% versus 18%). Key informants, notably programme implementers from the public and NGO sectors, also described these programmes and agreed that they had succeeded in raising awareness levels among girls, enabled girls to complete their education, reduced the incidence of child marriage and so on, but had not affected parents' desire for at least one son.

Recommendations

Findings suggest that differences in the sex ratio at birth in Kaski, the district with an unbalanced sex ratio at birth, and Tanahun, where it is normal, likely reflect, on balance, such structural factors as greater purchasing power, better access to facilities, and a more deeply ingrained son preference in Kaski than in Tanahun, rather than programmatic influences such as advocacy and community mobilisation measures, law enforcement or provision of educational entitlements for girls. In the absence of direct interventions to prevent gender-biased sex selection, there is a distinct possibility of a worsening of the situation in Kaski and a shift towards unbalanced sex ratios in Tanahun. Several recommendations emerge:

- **Implement policies/programmes to empower girls:** There is a need to implement national policies and programmes that aim to empower girls, promote gender equality and improve the overall situation of girls. Promising approaches and programmes may include, for example, a greater focus on keeping girls in school by providing girl-friendly education, by ensuring that girls complete a secondary education, and by expanding the reach of the universal scholarship scheme for girls. Other efforts adopted in neighbouring countries, including conditional cash transfer schemes that provide benefits to parents when their daughter achieves immunisation, education and other milestones, and remains unmarried till the age of 18, may also hold promise.
- **Intensify advocacy and community mobilisation efforts:** A stronger focus is needed on advocacy, public dialogue and community mobilisation to inform communities about the law, and to change attitudes about the acceptability of prenatal sex determination and sex-selective abortion. More direct and focused messages are needed, through the media, through frontline health workers and other interpersonal mechanisms, as well as through discourses by religious leaders and other influential individuals. These opportunities must convey the value of the girl child, in general, as well as the ethics of prenatal sex determination and discriminatory selective abortion, and the long-term social consequences of unbalanced sex ratios.
- **Counter family pressure on women to bear a son:** Findings have confirmed that many women face family pressure to continue childbearing until they have a son. These findings call for advocacy programmes aimed at sensitising husbands, mothers-in-law and other family members about the value of daughters and the illegality and long-term consequences of gender-biased sex determination and sex-selective abortions.
- **Increase awareness of and adherence to the law:** More efforts are needed to raise awareness of and encourage adherence to the law, including stronger monitoring mechanisms for regulating the misuse of ultrasonography and involving communities in the monitoring and surveillance of clinics that are suspected to have violated the law by either disclosing the sex of the foetus or offering sex-selective second-trimester abortions.
- **Equip health care providers with comprehensive information about gender-biased sex selection and related issues:** Findings have suggested that health care providers themselves need to be oriented and sensitised about gender-biased sex selection practices prevalent in their districts. Health care providers at all levels, from frontline workers to specialists, need gender sensitisation as well as training about the law and the penalties for violating it. They must also be informed about the long-term demographic and social consequences of sex-selective abortion.
- **Evaluate programmes promoting equality for girls:** Finally, research is needed that assesses the effect of various programmes on promoting gender equality and improvement of the status of the girl child in the society, and provides direction for designing more effective programmes.

Chapter 9

Factors underlying the improvement in the sex ratio at birth in settings with very adverse sex ratios, Haryana, India, and recommendations for the way forward

This chapter has highlighted, from the perspectives and experiences of women and key informants, the differences in sex-selection practices and factors underlying the improvement in the sex ratio at birth in Kurukshetra district as against that in the comparison district, Sonipat, in which it remained unchanged; and proposed recommendations for action to promote and sustain a gender-equal environment and ensure balanced sex ratios. While noticeable changes in the sex ratios at birth and among children have taken place over the 2001–2011 decade in some districts of Haryana, including Kurukshetra, changes were modest in these districts and were not observed in others, such as Sonipat. Our case study comparing the situation in Sonipat and Kurukshetra has highlighted a few differences in the actions taken to challenge gender norms and halt the practice of gender-biased sex selection, but we acknowledge that observed differences have, by and large, been narrow and inconsistent across the two districts. What is very clear is that law enforcement by itself, while necessary, is not sufficient to bring about changes in the demand for gender-biased sex selection and termination of pregnancies carrying a female foetus. At the same time, educational entitlements and cash transfer programmes for girls are perceived as improving the status of girls already born but unlikely to affect son preference and access to gender-biased sex selection. The most significant difference between Sonipat and Kurukshetra lay in the area of communication, advocacy and community mobilisation. Significantly more women in Kurukshetra than Sonipat reported that they had been counselled by frontline health workers about gender equal socialisation and gender-biased sex selection, and had been exposed to discourses by religious leaders and other influential individuals; notably, in Kurukshetra, significant efforts were also made by district administration officials through regular interactions with village communities, as well as regular visits to schools and colleges to change attitudes and practices. Findings highlight that communities must be informed and mobilised, examples must be made of successful and caring daughters, and programmes must be implemented that emphasise the value of girls and women and make equal treatment of sons and daughters an accepted norm.

India has had a far longer history of adverse sex ratios at birth and among children than Bangladesh, Pakistan and Nepal, the three other countries in this study. As a result, India's sex ratios today are much more adverse than in these countries, and far more attention has been paid to implementing actions intended to change norms, enforce the law, and change perceptions of daughters as economic burdens in India than in the other three countries. Sex ratios at birth have been particularly adverse in the north-western states of India, including Haryana, but over the 2001–2011 decade, improvements have been observed in some districts of Haryana. The objective of this case study was to explore what worked to improve the situation in some districts, represented by Kurukshetra, relative to other districts in which ratios stagnated, represented by Sonipat. By comparing the perceptions and experiences of women and stakeholders in the two districts, the intention is to point toward practices that hold promise for restoring balance.

Before addressing these questions, we note that although Kurukshetra recorded some improvements in its sex ratios at birth and among children over the decade 2001 to 2011, both districts continued to have unbalanced sex ratios in 2011. As such, our findings, drawing on both survey results and key informant interviews, confirm that all three preconditions for unbalanced sex ratios at birth were prevalent in both districts. Small family size norms were pervasive, son preference remained deeply entrenched, and the misuse of technology to disclose the sex of the foetus was prevalent. Mild differences were indeed observed, with son preference more likely to be observed

in Kurukshetra than Sonipat, but disclosure of the sex of the foetus somewhat more likely to be reported, notably among those with more than two children, in Sonipat.

What worked?

Three key programmatic interventions have typically been implemented to address unbalanced sex ratios at birth, namely communication, advocacy and community mobilisation efforts; activities intended to enforce the Act, and the provision of educational entitlements and conditional cash transfers to girls. All three programmatic interventions were implemented in Sonipat and Kurukshetra. Drawing together the perspectives and experiences of women and key informants about each of these areas of intervention, we explore the likely factors that set Kurukshetra apart from Sonipat, and likely account for the improvement in Kurukshetra's sex ratio at birth. The conclusions drawn from this analysis are illustrative.

Findings suggest that of the three broad areas of intervention, no districtwise differences could be discerned in two areas. The extent of enforcement of the PCPNDT Act was indeed similar in both districts. While more women from Kurukshetra than Sonipat had heard about raids taking place in their district, those in Sonipat were more optimistic when asked whether the practice would diminish because of these actions; and large minorities in both districts believed that or were undecided about whether the law should permit women who have two or more daughters to know the sex of their foetus and terminate a pregnancy carrying a female foetus. Key informants from both districts, likewise, described a similar set of activities employed to enforce the Act: regular inspections of facilities; periodic update meetings with health care providers; raids, sealing of equipment and closing of facilities, and prosecution of and imposition of fines on violators. Moreover, before conducting ultrasonography on a pregnant woman seeking a prenatal diagnostic test, doctors are required to register her personal details, including her photograph and contact information. In addition, frontline health workers are expected to track all pregnant women from the time their pregnancy is identified to its outcome, and to pay special attention to those with one or two daughters. Finally, monetary incentives are provided to community members and frontline health workers who identify those violating the law. Both women and key informants recognised that service providers were warned about impending raids, and that political interference or interference from powerful individuals often hampered the ability of the authorities to enforce the law; also mentioned was corruption and the ability of certain health care providers to pay off the raiding teams or avoid prosecution. Several key informants also pointed out that law enforcement activities rarely addressed women and families who sought disclosure, concentrating rather on health care providers alone. In addition, some key informants, particularly public and NGO programme implementers, noted that those implementing the law—for example those conducting raids and building cases for prosecution—were insufficiently trained in law enforcement and the collection of evidence and, as a result, many court cases could not be pursued. Finally, a number of NGO programme implementers criticised law enforcement activities for excluding NGO representatives, arguing that this exclusion inhibited the effectiveness of law enforcement teams.

Perspectives of women and key informants about the reach and effectiveness of educational entitlements (textbooks, school uniforms, bicycles, scholarships) and conditional cash transfers to girls were also similar across the two districts. Large numbers of women and key informants, particularly public and NGO programme implementers, were aware of the educational entitlements and at least one conditional cash transfer programme, the *Ladli* Scheme offered to girls; while more women from Kurukshetra than Sonipat had availed of educational entitlements, large and similar percentages of women from both districts with an eligible daughter had registered for the *Ladli* Scheme. Key informants from both districts had similar views about the effectiveness of educational entitlements and conditional cash transfer schemes for girls. They agreed that the schemes could be successful in changing perceptions of daughters as liabilities and burdens, but were sceptical about their role in affecting the desire for at least one son and therefore, adherence to the PCPNDT Act. Key informants from Kurukshetra and those representing the state were, however, somewhat less sceptical than were those from Sonipat.

It is in the area of communication, advocacy and community mobilisation that districtwise differences were pronounced and these efforts appeared to have been stronger and more wide-ranging in Kurukshetra than in Sonipat. While exposure to television serials espousing gender equality and/or gender-biased sex selection was reported by similar percentages of women from the two districts, other measures—counselling by frontline health workers and efforts by religious leaders—appeared to be significantly more likely to be reported by women in Kurukshetra than in Sonipat. Likewise, although more NGO activities were conducted in Sonipat than in Kurukshetra,

the latter reported a strong commitment to community mobilisation on the part of the district administration. In particular, the *Night Halt* or *Open Durbar* programme enabled district officials, including senior officials, to interact on a regular basis with village communities and make efforts to change patriarchal mindsets and raise awareness about various laws and programmes including the PCPNDT Act; it also offered an opportunity to community members to present their concerns to district officials. Also described by key informants in Kurukshetra were programmes conducted by district officials in schools and colleges; these programmes offered senior officials an opportunity to interact with students and teachers, and more specifically, to sensitise students and obtain pledges from teachers to desist from gender-biased sex selection.

Key informants, mainly programme implementers from the public and NGO sectors, offered their own perspectives about the factors underlying the improvement in the sex ratio at birth in Kurukshetra versus its stagnation in Sonipat. While they suggested a common set of factors, districtwise differences were apparent. Key reasons cited by those in Sonipat included Sonipat's proximity, relative to that of Kurukshetra, to Delhi and Uttar Pradesh where, they believed, access to services disclosing the sex of the foetus and providing sex-selective abortion are readily available. A few public sector programme implementers attributed the stagnation in the sex ratio at birth in Sonipat to its caste composition, and specifically, the predominance of Jats, among whom they described son preference to be particularly strong. Relatively fewer key informants from Sonipat attributed the difference to better implementation of the PCPNDT Act or greater community awareness in Kurukshetra than in Sonipat.

In contrast, the leading reasons key informants from Kurukshetra cited were the better implementation of the PCPNDT Act in Kurukshetra and greater awareness at community level in Kurukshetra relative to Sonipat. Very few agreed with their counterparts in Sonipat that Sonipat's greater proximity to Delhi and Uttar Pradesh or the predominance of particular castes in Sonipat compared to Kurukshetra accounted for its lack of improvement.

The way forward

Several lessons can be drawn from the insights offered in this study that may be relevant for the implementation of programmes intended to ensure balanced sex ratios and break down traditional patriarchal norms and preferences for sons, in general, and misuse of technology to obtain information about the sex of the foetus and terminate pregnancies carrying a female foetus, in particular. As observed above, the key difference between the experiences of Kurukshetra and Sonipat appeared to lie in the greater emphasis in the former on communication, advocacy and community mobilisation, and our recommendations focus on these. We also include more general recommendations on enforcement of the PCPNDT Act, and on educational entitlements and cash transfer programmes for girls that were evident needs in both districts.

Place greater emphasis on communication, advocacy and community mobilisation to change patriarchal norms and enhance understanding of the PCPNDT Act

While often considered intractable, programmes must continue to challenge existing gender-biased norms relating to the value of the girl child and the need for at least one son. Findings have shown that a reliance on law enforcement alone has not succeeded in reversing the sex ratio at birth, and emphasis must be placed on other promising practices as well. Programmes are needed that convey, for example, what was evident in our findings—that young couples hold more gender egalitarian norms, but fall prey to pressures from the older generation to ensure having a son that disturbing proportions of women hold attitudes suggesting that sons are essential to further the family line, that sons ensure their mother's status and security in the marital home, that girls are a drain on the household's resources—and these perceptions need to be countered convincingly. Actions may include, for example, the inclusion in programmes of positive deviant families whose daughters have been successful and/or support their parents even after marriage; special attention paid to the older generation about adhering to their children's right to decide on the number and sex composition of their children; and engaging the next generation, namely those in schools and colleges, in espousing gender equality in their own life.

There exist a number of laws that have a direct bearing on raising the status of women and girls, including those relating to the right to education, the minimum age at marriage, the prohibition of dowry payments, equal inheritance rights and protection from domestic and sexual violence. These laws are poorly understood at community level and efforts to address patriarchal norms must encompass efforts to raise awareness of these rights of women and girls.

Communication, advocacy and community mobilisation activities also need to raise indepth awareness about the PCPNDT Act; for example, the extent to which providers and women and families seeking disclosure of the sex of the foetus may be penalised. We note, however, that simple awareness of the existence of the Act, as well as of the legal consequences for doctors and women for violating the Act, was fairly universal in both districts and no longer needs to be stressed in programmes. What is needed is attention to conveying the unacceptability of violation of the Act and building an appreciation of the longer-term social consequences of such violations in terms of the availability of brides, in particular. Engaging influential individuals, notably religious leaders, in conveying these ideas and obtaining pledges at the community level about desisting from such practices appear to be measures that have had some success in these districts.

Support more engagement of senior public sector officials in communication, advocacy and community mobilisation

The *Night Halt* or *Open Durbar* programmes described by key informants from Kurukshetra have apparently had success in linking senior public sector officials responsible for implementing the PCPNDT Act with communities. Those in authority play the role of change agents and their community-level visits enabled greater visibility of the Act, and greater credibility to the messages conveyed. The functioning and effect of this programme need to be better understood, but efforts to link respected opinion makers in positions of authority with community members likely enables community members to express their perspectives, while at the same time, to gain exposure to the perspectives of credible and respected health care providers and lawyers on the Act and on challenging traditional norms.

Review and strengthen the PCPNDT Act enforcement structure

A number of key informants who implemented public sector programmes highlighted that fool-proof cases are dismissed at the time of trial because evidence has been inadequately collected or is unavailable; others pointed out that those responsible for implementing the Act tend to have multiple responsibilities and are unable to devote sufficient time to Act enforcement. A key recommendation, thus, is to build the capacity of those responsible for implementing the Act in collecting evidence and preparing a case for trial. Also needed, given that these health care providers and law enforcement authorities are part of the same patriarchal society from which women seeking disclosure of the sex of the foetus belong, and may well empathise with women seeking a son, are efforts to sensitise health care providers—ranging from doctors to frontline health workers and from judges to lawyers—about the gender, legal, ethical and rights dimensions of the Act.

At the same time, the structure and responsibilities of officials responsible for administering the Act need to be reviewed, and the need for supplementing the human resources of the Appropriate Authority, and ensuring that the staff responsible for implementing the Act are not overburdened with other responsibilities assessed.

Both women and key informants representing all three categories, expressed scepticism about the ability of the Act to stem the practice of gender-biased sex selection. They argued that greedy providers would find a way of disclosing the sex of the foetus, that some health care providers used their influence and resources to squash a case, and that political interference in the operations of the authorities inhibited many cases of violations from reaching the courts. Corruption within the system was described as rampant. Efforts are needed to curb these practices; for example, the anonymous whistle-blowing opportunities or reporting of incidents in which pressure is brought to bear on law enforcement authorities may need to be explored.

We note that many key informants across all three categories, advocated harsher enforcement methods—for example, monitoring of all pregnant women, especially those with a daughter; installing equipment that enables the authorities to monitor what goes on between a provider and a client, more sting operations and other efforts to catch unscrupulous providers red-handed. Such practices have the potential to infringe on clients' right to confidentiality. At the same time, they are far from fool-proof—key informants have noted that women who intend to undergo gender-biased sex selection withhold information about their pregnancies from frontline health workers, and health care providers will find innovative ways of ensuring that discussions about disclosure take place through middlemen, and outside of the facility.

Forge closer public-private partnerships

The NGO sector, while conducting programmes intended to challenge patriarchal norms on the one hand, and providing educational entitlements and support to families with daughters on the other, has been a relatively overlooked resource at the district level. Public-private partnerships may be beneficial in a number of ways. For example, NGO representatives may be included in visits made by the authorities to raise awareness and challenge traditional attitudes at the community level. By virtue of their sustained relationship with communities, NGOs would be able to support the government in designing programmes, as well as in informing communities about available educational entitlements, implementing programmes intended to affect behaviour change, and undertaking follow-up action to reinforce messages and new ideas. Likewise, including NGOs in the enforcement of the Act, for example, in conducting raids and enforcing the Act, may enable them to serve as a watchdog with regard to political interference or pay-offs from health care providers.

Make efforts to resolve the challenges expressed by the medical community in complying with the requirements of the PCPNDT Act

Most health care providers supported the PCPNDT Act, and acknowledged that the practice of disclosing the sex of the foetus and terminating pregnancies carrying a female foetus had declined. Even so, several of these key informants complained about cumbersome reporting requirements, undue harassment over small violations such as failure to report a change of address or irregularities in filling forms, and interference in day-to-day activities. Many argued that although the law suggested that women who have been informed about the sex of their foetus, or their family members, are also guilty of violating the Act, rarely has action been taken against them. Finally, many also argued that efforts should be directed at reducing the demand for services rather than harassing or penalising honest doctors. Indeed, several expressed resentment about the enforcement of the Act and the implications this had on their practice. Dialogue is needed between law enforcement authorities and health care providers that explores the challenges faced by the medical fraternity, and makes efforts to resolve the challenges expressed by the medical community in complying with the requirements of the Act.

The role of conditional cash transfer programmes and educational entitlements for girls needs to be better understood

A considerable proportion of eligible women did indeed make use of educational entitlements and conditional cash transfer programmes for their daughters. Key informants, programme implementers from both public and NGO sectors, in particular, agreed, however, that availing of these schemes is likely to raise the value of the girl child, enhance her access to education, and delay her marriage, but will not influence the demand for a son or deter families from seeking disclosure of the sex of the foetus. Yet, evidence also suggests that bottlenecks in the application process and demands for payments to complete it, inhibit eligible parents from successfully enrolling their daughters into conditional cash transfer schemes; eligibility criteria are also stringent—for example the *Ladli* Scheme is open only to second and not first daughters, and others are available only for the poor and those from socially excluded castes and tribes. Evaluations are needed that assess the reach, acceptability and longer-term effects of these programmes and schemes on girls' educational and marriage outcomes.

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Annexure 1: Bangladesh: A summary of programmes and interventions to empower women and girls

Programme/Intervention	Objective/s	Activities	Effectiveness	Source
The Female Secondary School Stipend Programme (FSSP)	<ul style="list-style-type: none"> To incentivise families to increase girls' secondary school enrollment and completion; to delay their daughter's marriage 	<ul style="list-style-type: none"> Providing stipends to girls in Classes 6-10 in all upazilas Eligibility criteria: rural; attends 75% of school days; attains minimum academic proficiency (45%); remains unmarried Stipend covers full tuition and related costs (books, supplies etc) Amount increases with class Tuition part paid directly to the school; remaining stipend deposited in two instalments annually into the girl's savings account Implementing curriculum reform, developing instructional materials and making other improvements in school quality 	<ul style="list-style-type: none"> Not rigorously evaluated for its impact on delaying marriage or changing parental preferences for girls versus boys 	Khandker, Pitt and Fuwa, 2003; Mahmud 2003; Asadullah and Chaudhury, 2006; 2009
Microfinance Programmes	To empower women	<ul style="list-style-type: none"> Providing microfinance opportunities for women 	<ul style="list-style-type: none"> Direct association between microfinance and women's empowerment e.g., female microcredit recipients were more successful in increasing women's non-land assets and children's education than male recipients. 	Pitt and Khandker, 1998; Naved, Newby and Amin, 2001; Ahmed and Boulid, 2004; Hossain and Tisdell, 2005; KFW, 2006; World Bank, 2007; Khosla, 2009; Islam and Dogra, 2011;
Employment in Apparel Industry	To enhance women's employment	<ul style="list-style-type: none"> The industry employs over three million people and women constitute the largest part of the workforce. The industry, which is highly labour-intensive, does not demand a highly educated labour force. 	<ul style="list-style-type: none"> Group lending and peer borrowers deter domestic violence and provide a way for women to save by keeping money away from their husbands 	and Mahmud, 2013
Government service quota for women	To enhance women's employment	<ul style="list-style-type: none"> Reserving 10% quota for women (in addition to merit) in all government ministries, directorates and autonomous bodies; 15% quota in non-gazetted posts in addition to merit, and 60% of primary school teacher posts 	<ul style="list-style-type: none"> Offers easy access to credit for the poorest of the poor and helps create self-employment for about 20 million women, particularly from the countryside Opportunities created for women to work outside the home for wages Rural households send girls to work in cities- important geographic mobility for the rural female labor force Nearly 3-3.5 million people, mainly women employed in cities Patriarchal structure weakened Women's participation in labor force is higher than ever before; their participation rate is higher than in other South Asian economies 	

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Programme/Intervention	Objective/s	Activities	Effectiveness	Source
Media Programmes on Government-owned TV channel and radio; FM radio and community radio	<ul style="list-style-type: none"> To empower women 	<ul style="list-style-type: none"> 30 minute programmes daily on TV Radio broadcasts: 5h 30m programmes for women Social drama, <i>Meena</i>, intended to change discrimination against daughters 	<ul style="list-style-type: none"> Edutainment programmes effective 	Government of Bangladesh, 2010
CSR efforts by large commercial entities	<ul style="list-style-type: none"> To raise awareness of gender issues 	<ul style="list-style-type: none"> Undertaking various outreach and mass media efforts 		
National Population Policy	<ul style="list-style-type: none"> To promote the two-child norm 	<ul style="list-style-type: none"> Disseminating the message: "Not more than two children; one is better" 	<ul style="list-style-type: none"> Fertility desires of women exposed to media messages fell by 11% 	Khatun, 2011; Rabbi, 2012;
NGO engagement	<ul style="list-style-type: none"> To empower women 	<ul style="list-style-type: none"> Developing and implementing programmes in rural areas 	<ul style="list-style-type: none"> NGO-supported programmes improved women's agency 	Hossain and Tisdell, 2005; KFW, 2006; World Bank, 2007; Huq, Kabeer and Mahmud, 2012; Kabeer, Huq and Mahmud, 2013

Annexure 2: Pakistan: A summary of available policies, programmes and interventions on empowerment of women and girls

Programme/Intervention	Objective/s	Activities	Effectiveness	Source
The Benazir Income Support Programme	<ul style="list-style-type: none"> To alleviate poverty 	<ul style="list-style-type: none"> Offering non-conditional cash transfers to low-income families and women 5.5 million families targeted for cash assistance amounting to Rs. 70 billion (2012–13), aiming to provide aid to 18% of population i.e., 40% of the population below the poverty line Providing identity cards to women under this programme; 30 million identity cards provided so far Providing beneficiaries in Coastal Sindh with livelihood training, productive asset transfers, consumption support, savings plans and healthcare under a 24-month programme Beneficiaries receive a monthly stipend of Rs. 1,000 for the first year to stabilise consumption Households choose an asset and begin livelihood training (embroidery, fishing, raising livestock etc) Beneficiaries encouraged to save money and Lady Health Workers work in some areas to provide health services to participating households 	<ul style="list-style-type: none"> Initiated in October 2008 	Benazir Income Support Program, 2008
Ultra Poor Graduation Pilot Programme				Goldberg and Saloman, 2011
Gender-targeted Conditional Cash Transfer Enrollment Programme	<ul style="list-style-type: none"> To enhance girls' education 	<ul style="list-style-type: none"> Offering cash transfers 	<ul style="list-style-type: none"> Increase in the enrollment of girls in Classes 6 to 8 	Hasan, 2010
Stipend Programme for Secondary School Girls of Khyber Pakhtunkhwa	<ul style="list-style-type: none"> To enhance school enrollment of girls 	<ul style="list-style-type: none"> Conditional cash transfer programme offering stipends to secondary school girls 	<ul style="list-style-type: none"> 93% of households availed of stipends; 35% girls estimated to drop out of school if the stipend money was not available 	Ahmed and Zeshan, 2014

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Programme/Intervention	Objective/s	Activities	Effectiveness	Source
Punjab Female School Stipend Programme (FSSP)	<ul style="list-style-type: none"> To promote girls' school enrollment, retention and completion 	<ul style="list-style-type: none"> Covering girls in targeted districts having lowest literacy rates; by 2007, 245,000 girls were enrolled in the programme in middle school alone. 	<ul style="list-style-type: none"> Four years into the programme, adolescent girls in stipend districts were more likely to progress through and complete middle school, and work less. Evidence suggests that girls who participated in the programme would delay marriage by more than a year and have fewer births by the age of 19. Girls living in urban centres, in poorer households and with more educated parents appear to be impacted the most by FSSP 	IEG, 2011
Tawana Project	<ul style="list-style-type: none"> To improve girls' education and nutrition 	<ul style="list-style-type: none"> Creating a 'safe environment for women to take collective decisions' 	<ul style="list-style-type: none"> Significant reduction in wasted, underweight and stunted young girls and an increase in school enrollment. 	Badruddin et al., 2008

Annexure 3a: India: Initiatives to ensure that the PCPNDT Act is implemented

Programme/Intervention	Objective	Mechanism/s	Effectiveness	Source
Tracking down of all diagnostic clinics and issuing notices to those that did not comply with the PCPNDT Act; cancelling the licences, seizing machines, etc	To monitor the use of ultrasonography machines	<ul style="list-style-type: none"> Tracking down all centres violating reporting requirements of the PCPNDT Act 	<ul style="list-style-type: none"> Not specified, but positive results observed in Hyderabad 	<ul style="list-style-type: none"> Gupta, n.d. Association for Social Audit, Research & Development Initiatives, 2010
Active Tracker	To monitor the use of all ultrasonography machines	<ul style="list-style-type: none"> Device attached to all ultrasonography machines, tracks ultrasounds performed on pregnant women and links to reporting in Form 'F' 	<ul style="list-style-type: none"> Mixed 	<ul style="list-style-type: none"> Magnum Opus, n.d. UN Women, 2014
Sting or decoy operations	To apprehend violators of the PCPNDT Act red-handed	<ul style="list-style-type: none"> Surprise inspection of a facility Mystery client visits 	<ul style="list-style-type: none"> Anecdotal evidence of success in terms of demonstration that the PCPNDT Act can be enforced, raising awareness about legal processes etc Unintended effect on limiting women's legal right to safe abortion 	<ul style="list-style-type: none"> Public Health Foundation of India, 2010 Ganatra, 2008 Ipas, 2013
Save the Girl Child Campaign/ <i>Beti Bachao Andolan</i>	To promote the implementation of the PCPNDT Act	<ul style="list-style-type: none"> Identifying violations of the PCPNDT Act; detailed audits of Form 'F' Maintaining records at state level of all ultrasonography machines Preparing annual state and district plans to monitor the implementation of the PCPNDT Act 	<ul style="list-style-type: none"> Not available, but use of Anganwadi Workers and ASHAs to track pregnancies and MTPs has been recognised for its potential in violating women's rights 	<ul style="list-style-type: none"> Ministry of Health and Family Welfare, n.d.
State-specific interventions under the Save the Girl Child Campaign incentivising the provision of confirmed information about violations of the PCPNDT Act, eg., <i>Mukhvir Yojana, Rajasthan</i>	To expand sources through which violations of the PCPNDT Act are reported	<ul style="list-style-type: none"> Providing a toll free number to report violations of the PCPNDT Act, registration and other issues Maintaining records of village-, <i>Panchayat</i>- and district-level pregnancies, MTPs and birth registration; <i>Anganwadi</i> Workers and ASHAs tasked with tracking these events Offering awards of Rs. 50,000 and Rs. 25,000, respectively, for anonymous reporting of any instance of disclosure of the sex of the foetus and of unregistered ultrasonography machines, if confirmed 	<ul style="list-style-type: none"> Not available 	<ul style="list-style-type: none"> Forum against Sex Selection, 2012. Department of Medical, Health and Family Welfare, Government of Rajasthan, n.d.

Annexure 3b: India: Advocacy, communication initiatives and community mobilisation efforts to ensure effective implementation of the PCPNDT Act and promote gender equality

Programme/Intervention	Objective/s	Activities	Effectiveness	Source
State and national government	<ul style="list-style-type: none"> To raise awareness of the PCPNDT Act To change gender-biased attitudes 	<ul style="list-style-type: none"> Using posters and hoardings, television advertising Producing television serials that convey the value of daughters 	<ul style="list-style-type: none"> Television serials on sex selection are less popular than those continuing to portray women in traditional ways Serials inadvertently confuse communities about women's right to safe abortion 	<ul style="list-style-type: none"> Naqvi, 2006 Joseph and Center for Youth Development and Activities, 2007 Bracken and Nidadavolu, 2005
Save the Girl Child Campaign/ <i>Beti Bachao Andolan</i>	<ul style="list-style-type: none"> To promote the effective implementation of the PCPNDT Act: build capacity of implementers; change gender-unequal attitudes; raise community awareness 	<ul style="list-style-type: none"> Capacity building of advocates, the judiciary, medical associations and professionals, District Appropriate Authorities and others Launching youth campaigns Organising awareness- building and sensitisation programmes in schools and colleges Involving communities in monitoring implementation of the PCPNDT Act Engaging frontline health workers (AWWs, ASHAs etc) and locally elected officials (PRI members) in monitoring the implementation of the PCPNDT Act Conducting IEC, signature and media (electronic and press) campaigns, e-campaigns (on Yahoo and Facebook), television spots and advertisements in the print media and on FM radio, public rallies and so on; preparing and distributing IEC materials in various languages Implementing programmes and schemes for girls, including, at district level through PRIs 	<ul style="list-style-type: none"> Not available 	<ul style="list-style-type: none"> Ministry of Health and Family Welfare, n.d.

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Programme/Intervention	Objective/s	Activities	Effectiveness	Source
Satara district, Maharashtra	<ul style="list-style-type: none"> To change community attitudes about girls 	<ul style="list-style-type: none"> Organising public functions to change the name of girls named <i>Nakoshi</i> in a drive to mobilise communities about gender-equal treatment 	<ul style="list-style-type: none"> Not available 	Byatnal, 2011
Mission Hazaar, Sonipat, Panipat, Rohtak, Jhajjar, Haryana	<ul style="list-style-type: none"> Multimedia campaigns to recognise the value of girls and women and change the culture that perpetuates gender-biased sex selection 	<ul style="list-style-type: none"> Community mobilisation by organising fairs that involve students, frontline health workers and communities at large 	<ul style="list-style-type: none"> Not available 	Breakthrough, n.d.
Women Power Connect, "Support to community mobilisation and a people-driven response in preventing sex selection and arresting child sex ratio decline"	<ul style="list-style-type: none"> To raise awareness about the PCPNDT Act To change gender-biased attitudes towards girls and towards sex selection To mobilise communities to counter gender-biased sex selection To build the capacity of implementers of the PCPNDT Act 	<ul style="list-style-type: none"> Addressing diverse constituencies (local bodies, women's and youth groups) Holding face-to-face discussions, rallies, puppet shows and other culturally acceptable media. Forming community watch groups responsible for coordinating/ implementing activities Focusing on young people and youth organisations Forging partnerships with religious leaders Publicly pledging support, e.g., felicitating persons who have voluntarily adopted contraception after one or more daughters Honouring girls at male-focused festivals Sensitising PRI representatives Conducting capacity- building programmes of health care providers (ASHAs, Anganwadi Workers, medical staff) Strengthening <i>Save the Girl Child</i> Committees 	<ul style="list-style-type: none"> Process documentation available 	<ul style="list-style-type: none"> Women Power Connect, 2013; 2013a

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Programme/Intervention	Objective/s	Activities	Effectiveness	Source
Mahila Lok Aayog, Sangli, Maharashtra	<ul style="list-style-type: none"> To ensure that the government is vigilant in implementing the PCPNDT Act 	<ul style="list-style-type: none"> Putting pressure on the state government to implement the PCPNDT Act 	<ul style="list-style-type: none"> Not available 	<ul style="list-style-type: none"> Kulithe, 2013
The Campaign for Gender Equality and Safe Abortion (the <i>Pratigya</i> campaign)	<ul style="list-style-type: none"> To address the conflation between gender- biased sex selection and legal abortion To guarantee women's right to safe abortion services within the context of a declining sex ratio 	<ul style="list-style-type: none"> Developing public messages on legal abortion and gender equality Clarifying the Acts (Medical Termination of Pregnancy Act; Pre-Conception and Pre-Natal Diagnostic Techniques Act; and Drugs and Cosmetics Act) Expanding allies among development groups Taking steps towards the legalisation of first trimester medical abortion into public health facilities 	<ul style="list-style-type: none"> Recently launched 	<ul style="list-style-type: none"> Ipas, 2013
Because I Am a Girl Campaign	<ul style="list-style-type: none"> To address gender equality, girls' empowerment and rights 	<ul style="list-style-type: none"> Retaining girls in schools and ensuring completion of secondary school education Conducting vocational training for girls Preparing and disseminating annually, the <i>State of the Girl Child</i> report 	<ul style="list-style-type: none"> Not available 	<ul style="list-style-type: none"> Plan India, 2013
Let Girls Be Born Campaign	<ul style="list-style-type: none"> To engage multiple stakeholders in raising issues relating to girls 	<ul style="list-style-type: none"> Launching interventions with adolescents and youth, including college-level seminars and campaigns in Delhi colleges Engaging in interventions relating to the PCPNDT Act with service providers Celebrating the UN Girl Child Day, including a rally of 1500 students in Bihar 	<ul style="list-style-type: none"> Not available 	<ul style="list-style-type: none"> Plan India, 2013

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Programme/Intervention	Objective/s	Activities	Effectiveness	Source
Girls Count	<ul style="list-style-type: none"> To arrest the skewed sex ratio To address patriarchy 	<ul style="list-style-type: none"> Publishing reports, including <i>Civil Society's Charter of Demands to India's Political Parties on the Declining Child Sex Ratio</i>; <i>PCPNDT-Civil Society Report Card on Current Structure and Status of Statutory Mechanisms Constituted under the PCPNDT Act</i> Conducting activities to challenge patriarchy, implement the PCPNDT Act, build coalitions 	<ul style="list-style-type: none"> Recently launched 	<ul style="list-style-type: none"> Girls Count, 2014
Campaign against Pre-birth Elimination of Females (CAPF)	<ul style="list-style-type: none"> To generate awareness about the PCPNDT Act and gender equality amongst the academic community, and through the actions of this community, initiate voluntarism amongst young people to promote these issues 	<ul style="list-style-type: none"> Organising advocacy, awareness-raising and community mobilisation activities, including rallies, protest marches, creative programmes for awareness generation and encouragement of voluntarism among youth 	<ul style="list-style-type: none"> Not available 	<ul style="list-style-type: none"> Academics Stand Against Poverty, n.d.
Akal Takht	<ul style="list-style-type: none"> To reverse the skewed child sex ratio among Sikhs 	<ul style="list-style-type: none"> Issuing a directive indicating that gender-biased sex selection violates the tenets of the religion and that violators would be excommunicated 	<ul style="list-style-type: none"> Not available 	<ul style="list-style-type: none"> <i>The Tribune</i>, online edition, April 19, 2001, Chandigarh, India
Indian Medical Association (IMA), Doctors for Daughters	<ul style="list-style-type: none"> To sensitise doctors about their role in desisting from gender-biased sex selection 	<ul style="list-style-type: none"> Passing a resolution by the IMA, condemning gender-biased sex selection Conducting sensitisation campaigns for doctors Establishing cells to monitor ultrasonography practices of its members Publishing materials such as FAQs to support doctors with answers to questions, and information pamphlets highlighting doctors' responsibilities 	<ul style="list-style-type: none"> Not available 	<ul style="list-style-type: none"> Indian Medical Association, Doctors for Daughters, 2006 Indian Medical Association, Doctors for Daughters n.d., a Indian Medical Association, Doctors for Daughters, n.d., b Indian Medical Association, Doctors for Daughters n.d., c UNFPA, 2013

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Annexure 3c: India: Selected central and state government schemes for increasing the value of the girl child and counter disadvantages faced by girls^{1.2}

Name of scheme, location and year of initiation	Objective/s	Eligibility criteria	Benefits	Mechanism/s	Source
<i>Balika Samridhi Yojana</i> (MOWCD, GOI); nationwide (1997)	<ul style="list-style-type: none"> To change gender unequal attitudes To promote girls' education To delay the marriage of girls To provide economic opportunities to girls 	<ul style="list-style-type: none"> Girl is born on 15.8.1997 or later Girl's family is BPL-certified Scheme open for up to two girls per family 	<ul style="list-style-type: none"> Birth registration: transfer of Rs. 500 Immunisation: to be reported, but no transfers made Sliding annual cash transfer or scholarship for each year of school reached (from Rs. 300 in Classes 1-3 to Rs. 1,000 in Classes 9-10) Withdrawal of matured amount when the girl turns 18 years of age and is unmarried 	<ul style="list-style-type: none"> Money deposited in an account opened in the girl's name in a bank/post office Gram Panchayat, municipality or other local body is responsible for applications under this scheme 	<ul style="list-style-type: none"> Ministry of Women and Child Development, n.d.
<i>Dhanalakshmi Scheme</i> (MOWCD, GOI); selected blocks of Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Odisha, Punjab and Uttar Pradesh (2008)	<ul style="list-style-type: none"> To stop sex-selection practices To change gender-biased attitudes To promote girls' education To delay the marriage of girls 	<ul style="list-style-type: none"> Girl is born on 19.11.2008 or later Birth of the girl is registered Open to all socioeconomic groups Girl resides in the selected blocks 	<ul style="list-style-type: none"> Registration: Rs. 5,000 deposited in the account of the girl's family (preferably mother) Immunisation: Rs. 200 for every stage, Rs. 250 on completion of all immunisations Education: Rs. 1,000 on enrolment; Rs. 500 per year for each class attended up to Class 5 Rs. 750 for every class attended in Classes 6-8 Rs. 1500 on enrolment in secondary school Additional incentives for Classes 9-12 are provided by the Ministry of Human Resource Development (under a different scheme) Marriage: Rs. 1 on remaining unmarried up to age 18 	<ul style="list-style-type: none"> Cash transfers to the family (preferably mother) on fulfilling certain conditions after opening a bank account Insurance maturity cover of Rs. 1 lakh is provided at birth in the girl's name For other transfers, the state government is to authorise the bank or post office through standing instructions to register and transfer cash benefits to the beneficiary on production of verification certificates/documents from the authorities specified for the purpose 	<ul style="list-style-type: none"> Sekher, 2010 Ministry of Women and Child Development, 2011 Planning Commission, n.d.

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Name of scheme, location and year of initiation	Objective/s	Eligibility criteria	Benefits	Mechanism/s	Source
National Scheme of Incentives to Girls for Secondary Education (MOHRD, GOI); nationwide (2008)	<ul style="list-style-type: none"> To reduce school discontinuation To ensure secondary schooling 	<ul style="list-style-type: none"> Girl is unmarried and below age 16 on joining Class 9 Girl has passed Class 8 from KGBV, irrespective of caste SC/ST, disadvantaged Girl is studying in government, government-aided or local body managed schools 	<ul style="list-style-type: none"> Registration: Rs. 3,000 deposited in the girl's bank/post office account 	<ul style="list-style-type: none"> Money deposited in the account opened in the girl's name The period of deposit is up to the girl's attainment of age 18 	<ul style="list-style-type: none"> Ministry of Human Resource Development, n.d.
Free Bicycle Distribution Scheme; Bihar, Madhya Pradesh; other states (2004 onwards)	<ul style="list-style-type: none"> To continue education after the primary level 	<ul style="list-style-type: none"> Rural (girls and boys) who go to a school in a village other their own because a school is not available in their village Girl/Boy is studying in Classes 6-8; 9-10; Originally for girls from SC/ST and BPL, restrictions later removed; boys also included 	<ul style="list-style-type: none"> Free bicycle for the girl/boy Cash transfer of Rs. 2,000 and Rs. 2,400, respectively, to girls/boys in Classes 6 and 9, respectively, or to parents 	<ul style="list-style-type: none"> Account payee cheques made out to beneficiaries through government schools in which the beneficiary is enrolled 	<ul style="list-style-type: none"> Department of Education, Government of Bihar, n.d. Madhya Pradesh Education Portal, n.d.
Mahila Samakhyia Scheme	<ul style="list-style-type: none"> To provide a space for women to meet, raise women's awareness and expose them to new ideas, including about their rights and the right of their daughter to be educated; strengthen women's empowerment 	<ul style="list-style-type: none"> Rural out-of-school girls and women 	<ul style="list-style-type: none"> Provides a safe space for rural women's empowerment Participation in various programmes and awareness campaigns Raises awareness of women's rights, new ideas, builds women's self-confidence 	<ul style="list-style-type: none"> Group formation and activities 	<ul style="list-style-type: none"> Ministry of Human Resource Development (MOHRD), 2008

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Name of scheme, location and year of initiation	Objective/s	Eligibility criteria	Benefits	Mechanism/s	Source
Apni Beti Apna Dhan Scheme; Haryana (1994)	<ul style="list-style-type: none"> To enhance the value of daughters To delay the marriage of girls To improve the sex ratio at birth 	<ul style="list-style-type: none"> Girl is from SC/ST/OBC family Girl's family is BPL-certified Scheme open up to 3rd birth order Girl is born between 1.10.1994 and 31.12.1998 Girl's family is domiciled in Haryana 	<ul style="list-style-type: none"> Registration incentive of Rs. 500 Bond in the name of the girl Rs. 25,000 at age 18 if unmarried 	<ul style="list-style-type: none"> A bond in the girl's name to be encashed when she turns 18, if unmarried 	<ul style="list-style-type: none"> Nanda, 2012 Das Gupta et al., 2008
Ladli Lakshmi Yojana; Madhya Pradesh (2007)	<ul style="list-style-type: none"> To change attitudes towards girls To discourage child marriage To ensure education of girls To improve the status of women who undergo repeated pregnancy in order to have a son To promote family planning 	<ul style="list-style-type: none"> Girl's parents should have adopted family planning after two surviving children Girl is registered at the Anganwadi Centre Girl's parents are poor (do not pay income tax) 	<ul style="list-style-type: none"> Savings certificates of Rs. 6,000 in girl's name each year till the amount reaches Rs. 30,000 Sliding annual cash transfer on reaching each of various milestones in school (Class 6: Rs. 2,000; Class 9: Rs. 4,000; Class 11: Rs. 7,500; Rs. 200 per month in Classes 11 and 12) Lump sum of Rs. 1,00,000 on reaching age 18, if unmarried 	<ul style="list-style-type: none"> A Savings Certificate in girl's name to be encashed only at age 18, if unmarried (The state allocated Rs. 2,760,000,000 in 2007-2008; Rs. 240,000,000 in 2010-2011; beneficiaries ranged from 214,134 to 40,854) 	<ul style="list-style-type: none"> Department of Women and Child Development, Government of Madhya Pradesh, n.d.
Ladli Scheme; Haryana 2005	<ul style="list-style-type: none"> To improve the sex ratio at birth and combat sex selection 	<ul style="list-style-type: none"> Second daughter born on or after 20.8.2005 Birth of girl is registered No caste or poverty restriction Girl's family is domiciled in Haryana 	<ul style="list-style-type: none"> Rs. 5,000 per year at birth and for five years thereafter in the form of Kissan Vikas Patra in the name of second daughter through mother/father/guardian; and the matured amount of approximately Rs. 86,927 	<ul style="list-style-type: none"> Investment in Kisan Vikas Patra (KVP) in joint names of girl and mother (preferably) 	<ul style="list-style-type: none"> Department of Women and Child Development, Government of Haryana, n.d. Sekher, 2010

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Name of scheme, location and year of initiation	Objective/s	Eligibility criteria	Benefits	Mechanism/s	Source
Ladli Scheme; Delhi (2008)	<ul style="list-style-type: none"> To enhance the status of girls in the family and society To promote girls' education, to make them self-reliant and economically secure To protect girls from discrimination and deprivation 	<ul style="list-style-type: none"> Girl is born on or after 1.1.2008 Girl's family is domiciled in Delhi for at least three years Annual income of couple/parents <=Rs. 1,00,000 	<ul style="list-style-type: none"> Periodic payments transferred into girl's account, redeemable with interest on reaching age 18, if she has passed Class 10 as a regular student and is unmarried Birth: if in an institution in Delhi; Rs. 11,000; if in an institution elsewhere: Rs. 10,000 Enrolment in Classes 1,6,9,10,12: Rs. 5,000 each 	<ul style="list-style-type: none"> Fixed deposit in girl's name through SBI Life Insurance Company and State Bank of India (SBI) 	<ul style="list-style-type: none"> Department of Women and Child Development, Government of NCT of Delhi, n.d. Sekher, 2010
Balri Rakshak Yojana; Punjab (2005)	<ul style="list-style-type: none"> To promote gender equality and correct the distortion in the sex ratio at birth To stabilise the population by motivating couples to have two girl children To reduce the infant mortality rate by reducing the number of higher order births 	<ul style="list-style-type: none"> Family is non tax- paying Couple aged less than 45 (husband)/40 (wife) with one or two girls Wife is covered under the Scheme regardless of her age at marriage Youngest child is less than 5 years at registration Birth of the child is registered Wife or husband should have adopted a terminal method of contraception 	<ul style="list-style-type: none"> Rs. 500 per month for one girl and Rs. 700 per month for two girls, to be redeemed at age 18 	<ul style="list-style-type: none"> Eligible couple must open a joint account in a bank/post office The Civil Surgeon of the district is responsible for disbursing monthly funds, assuming that all eligibility criteria have been satisfied, including the adoption of a terminal contraceptive method by either parent 	<ul style="list-style-type: none"> Department of Health and Family Welfare, Government of Punjab, n.d. Sekher, 2010
Indira Gandhi Balika Suraksha Yojana; Himachal Pradesh (2007)	<ul style="list-style-type: none"> To reverse the declining sex ratio To sensitise communities about issues related to the sex ratio at birth To encourage the small family norm To raise the value of girls 	<ul style="list-style-type: none"> Wife or husband should have adopted sterilisation after one or two daughters and no son. 	<ul style="list-style-type: none"> Rs. 25,000 for one daughter, Rs. 20,000 for second daughter, to be redeemed at age 18 or at marriage 	<ul style="list-style-type: none"> Interest-bearing deposit in girl's name 	<ul style="list-style-type: none"> Directorate of Women and Child Development, Government of Himachal Pradesh, n.d. Sekher, 2010

Name of scheme, location and year of initiation	Objective/s	Eligibility criteria	Benefits	Mechanism/s	Source
Betl Hai Anmol Scheme; Himachal Pradesh; introduced in place of BSY (2010)	<ul style="list-style-type: none"> To change negative family and community attitudes towards girls and their mother To improve enrolment and retention of girls in school To delay the marriage of girls To support girls in undertaking income-generating activities To empower girls 	<ul style="list-style-type: none"> Couple is domicile of Himachal Pradesh Family is BPL-certified Couple has up to two daughters 	<ul style="list-style-type: none"> On registration: Rs. 5,100 Sliding scholarship amounts per year: Classes 1-3: Rs. 300; Class 4: Rs. 500; Class 5: Rs. 600; Classes 6-7: Rs. 700; Class 8: Rs. 800, Classes 9-10: Rs. 1000; Classes 11-12; Rs. 1,500 	<ul style="list-style-type: none"> Postbirth grant deposited in an interest-bearing account opened in the girl's name and which can be withdrawn when she turns 18 	<ul style="list-style-type: none"> Directorate of Women and Child Development, Government of Himachal Pradesh, n.d. Sekher, 2010

¹Impact not evaluated thus far; evaluation of the impact of the Apni Beti Apna Dhan programme by the International Center for Research on Women (ICRW) is ongoing; evaluation of the Dhanalakshmi Scheme is being conducted by the International Institute for Population Sciences (IIPS) and UNFPA to understand its impact at the household level, including on changing parental perceptions of having daughters. Implementation challenges have been described in Sekher, 2010.

MOWCD, GOI=Ministry of Women and Child Development, Government of India. MOHRD, GOI=Ministry of Human Resource Development, Government of India. BSY=Balika Samridhi Yojana. BPL=Below Poverty Line. KGBV=Kasturba Gandhi Balika Vidyalaya. SC=Scheduled Caste. ST=Scheduled Tribe.

Annexure 4: Nepal: A summary of programmes and interventions to build gender equality and counter gender-biased sex selection

Programme/Intervention	Objective/s	Activities	Effectiveness	Source
Initiatives to ensure that the law is implemented				
Various efforts to raise awareness of the law	<ul style="list-style-type: none"> To enhance adherence to the law 	<ul style="list-style-type: none"> Orienting radiologists and medical technicians about the law Organising awareness raising campaigns against sex selection by NGOs and the mass media 	<ul style="list-style-type: none"> No prosecutions made thus far 	Nepal Medical Association, 2014 and NESOG, 2013
Initiatives intended to build gender equality				
Year Against Gender-Based Violence (GBV) 2010	<ul style="list-style-type: none"> To reduce violence against women 	<ul style="list-style-type: none"> A Multisectoral Action Plan has been formulated The GBV unit is housed in the Prime Minister's Office 	Not available	Government of Nepal, 2009
Gender Equality Act 2006	<ul style="list-style-type: none"> To eliminate violence against women To eliminate gender discrimination, and promote gender equality To empower women 	<ul style="list-style-type: none"> Various programmes, details not available 	Not available	Nepal Law Commission, 2013
2007 Amendment to Civil Service Act	<ul style="list-style-type: none"> To reserve 44% of vacant posts in the Civil Service for excluded groups; 33% for women 	Reservations	Not available	Government of Nepal, 2007
Advocacy, communication initiatives and community mobilisation				
Various initiatives of the National Society of Obstetricians and Gynaecologists (NESOG), Nepal	<ul style="list-style-type: none"> To address gender-biased sex selection and promote gender equality 	<ul style="list-style-type: none"> Putting up posters on gender-biased sex selection in hospitals and clinics Screening a story-based educational film aimed at ending gender-biased sex selection Organising the awareness programme 'ANURODH' and talk programmes on social effects of gender-biased sex selection 	Not available	NESOG, 2013
Daily broadcast of videos by Nepal Peace Fund and Nepal Television	<ul style="list-style-type: none"> To address gender-biased sex selection 	<ul style="list-style-type: none"> Broadcasting short videos (20 seconds) daily on "no gender preference during childbirth" 	Not available	Nepal Television, (observations of principal investigators)

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Programme/Intervention	Objective/s	Activities	Effectiveness	Source
Various programmes by Kantipur Television and FM Radio Stations	<ul style="list-style-type: none"> To address gender-biased sex selection 	<ul style="list-style-type: none"> Broadcasting talk shows on gender-biased sex selection and related issues by experts Airing jingles on FM radio 	Not available	Kantipur Television, 2014
Daughter Project of Centre for Awareness Promotion (CAP)	<ul style="list-style-type: none"> To counter cultural preferences for sons 	<ul style="list-style-type: none"> Implementing awareness-raising programmes on gender equality Holding counselling sessions for mothers and pregnant women Conducting theatre programmes on the value of the girl-child Including youth to spread messages about gender equality Organising festivals/rituals traditionally favouring boys, to honour girls 	Not available	Centre for Awareness Promotion, 2010
Enable Project of CREHPA	<ul style="list-style-type: none"> To promote safe abortions To conduct awareness and advocacy programmes on safe abortion 	<ul style="list-style-type: none"> Providing information about the illegality of sex determination and sex-selective abortion 	Not available	CREHPA, 2002

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