



Title: Community Based Response to Adverse Sex Ratio in district Alwar Rajasthan

Background

The census data from 2001 revealed a concerning decline in the sex ratio in India, particularly in the age group of 0-6 years, dropping from 945 females per 1000 males in 1991 to 927 in 2001. This imbalance was particularly evident in states like Punjab, Haryana, Rajasthan, Gujarat, and Maharashtra. The data indicated an increasing trend in the relative mortality of girls after birth and gender imbalance in most states. Rajasthan, despite an overall improvement in sex ratio, experienced a continuous decline in the 0-6 age group from 954 in 1981 to 909 in 2001.

Sex ratio imbalance is seen as a result of both higher mortality rates for girls after birth and an increase in sex-selective abortions, reflecting underlying socio-economic and cultural practices. To address this issue, the Dignity of Girl Child (DGC) Program supported research and interventions in Rajasthan, impacting government administration, Community Based Organizations (CBOs), and mobilizing communities to enhance the dignity of girls in the state. Organizations were supported to strengthen grassroots and official responses against sex selection through sensitization and training on implementing the PC PNDT Act (Pre-Conception and Pre-Natal Diagnostics Technique Act).

Project objectives and Goals

- Increase awareness about declining sex ratio and female foeticide
- Increase awareness about PNC/PDT act
- Involve youth and Community Groups in addressing female foeticide
- Increase the capacity of community-based health care providers to address the adverse sex ratio using entry points while delivering health care for behavioural change

Project implementation:

SWACH Foundation Panchkula, supported by IFES, implemented a project from January 2006 to April 2008 to address the issue of adverse sex ratio in Alwar district, Rajasthan. The project was implemented in 175 villages across two community development blocks (Kot Kasim and Majri Kalan). The study focused on promoting gender equality, reducing sex selection, and improving access to healthcare services for women and girls. The project collaborated with various health care providers, community-based organizations, and government departments to ensure sustainability and community involvement.

During the preparatory phase, agreements were made with district and block health authorities, ICDS, and education departments. The key activities included conducting the baseline surveys, training of the project staff, with the involvement of Sahyogins (frontline health workers).

In the first phase of the project, 25 villages were selected for implementation. During the first two rounds of training, village panchayats were approached and briefed about the project objectives and apprised of their role in addressing the problem of adverse sex ratio.

Monitoring tools were developed during the first two months of the project implementation. These were tested and field staff was trained to report the findings of monitoring once every month. Feedback was provided to the staff on a regular basis when interaction was organized by SWACH as a part of training and capacity development of the field staff. Throughout the project, the stress was on monitoring for quality services and promotional activities through supportive supervision and check lists developed by SWACH consultants helped to guide the staff in the project villages to provide supportive supervision and link it to follow up training to address the performance problems of the staff and health volunteers.

The project utilized a systematic approach to scale up interventions and best practices. Community-based resource groups were formed, but challenges were encountered in sustaining their interest and involvement. Monitoring tools



and supportive supervision ensured the quality of services and promotional activities. The project successfully contributed to increasing institutional deliveries and promoting gender equality in the targeted communities.

Training of healthcare providers:

The healthcare providers were trained by monthly one-day sessions instead of three-day sessions due to time constraints and shortage of staff. The training material was designed for low-literate providers and focused on incremental skill acquisition, hands-on practice, and motivation. The training material was short and well-illustrated.

The training was instrumental in improving performance and establishing a connection between training and work. It also facilitated the development of facilitators' skills. Project staff from SWACH, healthcare providers, and village volunteers from Alwar district, India, were involved in the training. Training covered topics like adverse sex ratio, determinants of respect for women and girls, skills and motivation enhancement. The PNC/PDT act, dangers of adverse sex ratio, and induced abortion were emphasized. Strengthening of vital registration systems and using contacts for pregnancy, natal, and postnatal care were stressed upon. The importance of continuing female education, employment, family planning, immunization, anaemia control, and adolescent health were also covered. Brief hand outs were given to each participant at the end of each training session to encourage them to read the material whenever the need arises.

Table- Total number of participants trained

Category	Estimated number in project area	No. of training sessions	Proportion attendance achieved as compared to the targeted number	Number of providers contacted by staff as follow up to reinforce training
Female multipurpose health worker	30	6	55%	402
Anganwadi workers	150	34	88%	1034
Sahyogins	120	18	80%	380
TBAs	150	41	85%	982
Saathins		5	90%	189
Village doctors (RMPs)	120	32	60%	689

The average attendance was 20 participants in each training session. The attendance of Anganwadi workers, Sahyogins, Saathins and TBAs was high. The small proportion of absenteeism was related to illness or personal work. The attendance of ANMs was lower in case of other assignments while RMPs attendance was lower than that expected because of possible conflict with their loss in business as a result of participation in the training.

Distribution of materials: Health care providers and centers were supplied with materials like monitoring cards, weighing balances, delivery kits, and folic acid tablets as part of capacity development. Pregnant women reporting in the first trimester were provided with folic acid tablets, and iron and folic acid tablets were distributed during the second trimester according to the national program. SWACH staff ensured timely procurement and distribution of these tablets during antenatal services.

Table- The total amounts of materials supplied during the project.

Item distributed	Target audience	Number supplied
Menstrual card	Women in reproductive age	10000
Maternal child linked card	ANMs, AWWs, Dais and some	9500



	PMPS	
Newborn weighing scales	Dais	267
Clean disposable delivery kits	Dais	3500
Folic acid tablets	Women in first trimester of pregnancy	3000 courses to be used for one month

Distribution of literature: Access to knowledge was increased through distribution of relevant literature like the Dai Prashikshan Guide, TBA guide, modules on maternal and child health, common questions on breastfeeding, pamphlets on reducing sex discrimination and other educational messages to the TBAs, community-based volunteers including panchayat members, ANMs, AWWs, Sahyogins, and teachers.

Orientation of community-based groups was done during one-day orientation meetings in which discussion on four themes was done. In addition to the formal orientation, the field staff visited the villages and established contact with the community members and reinforced the messages and also motivated the people.

The information material was distributed widely in the community development blocks at the village libraries, educational institutions, community-based resource groups, temple libraries and entertainment groups.

Additionally, a large number of interactive special events like debate competitions, slogan writing competitions and poster competitions were organised in schools in Kot Kasim and Majri Kalan. The topics for the competitions included the following:

- The education of girls is necessary
- Girls should be employed outside the home
- Abortions are dangerous and sex selection is illegal for the provider and tile cluant
- Birth and death registration should be compulsory

Table: coverage of the special events in schools

Activities in the school	Number of schools	Number of participants
Slogan competitions	3	230
Debates	13	1079
Essay competitions	50	2339
Poster competitions	89	3036

Production and use of banners: A total of 249 banners with slogans were displayed at various sites including panchayats, anganwadi centres, village water tanks, piyaos, yoga camps, sewing centres etc. campaign through banners became very popular, and was scaled up.

Advocacy through local media: To spread awareness and reach a large audience at a low cost, the 'SWACH' project used two strategies:

- Key messages were embedded in audio cassettes used by temples during morning and evening prayer times. Priests were informed about the message's importance and agreed to include three slogans, excluding the one on abortion.



- The message on abortion and sex selection was included in video cassettes used by cable operators. Popular programs on the cable network were selected, and three cable networks embedded the four slogans in the tickers. This approach ensured a large reach among villagers.

Registration and reporting of births: SWACH field staff discussed the importance of vital registration and recording of vital events with PHC, CHC staff, supervisors of ANMs and AWWs, TBAs, MPs, and village panchayats during training programs. The field staff reviewed records and provided feedback during monthly monitoring and review processes. Village panchayats and CHCs were responsible for recording vital events. Village panchayats accepted reports from healthcare providers and participated well in birth registration. There was improvement in the registration of abortions. However, village panchayats did not participate adequately in recording stillbirths and deaths despite the efforts of healthcare workers. Initially, healthcare workers did not record stillbirths and deaths, but involvement improved through persuasion.

Births recorded	Village panchayats 2005	Village panchayats 2006	Health care providers (reported by SWACH field staff-2006)
Males	1176	1337	1416
Females	749	908	1013
Total	1925	2245	2429

There was an increase in the number of births recorded by village panchayats in 2006 as compared to 2005. The information on births reported by the health care providers was 9% higher than found in the records of village panchayats.

Baseline and end line surveys were conducted to assess the situation before and after awareness generation activities, training, and other inputs in two community development blocks. The surveys utilized a prepared questionnaire and survey guide, with questions carefully selected to elicit reliable responses. Detailed explanations for each question were provided to guide surveyors during training and ensure consistent and reliable responses.

A survey training guide was prepared, and training sessions were conducted for master trainers, supervisors, and surveyors. Logistics for the survey were finalized, and a plan to validate the survey's findings was developed. The training materials were revised after field testing, and four supervisors with experience in conducting surveys were selected. After two days of training, the materials were revised again based on field tests and then printed.

A visit was made to community health centers in Kot Kasim and Majri Kalan to decide on the training venue and logistics arrangements. Agreement was obtained from medical officers, and notional maps of blocks with villages were prepared. The survey work was planned in 30 village clusters, selected based on proportionate population sampling from a list of villages in the two blocks. It was agreed that 60 households would be included in each cluster, targeting a total of 1800 households. Non-participation or locked households would be counted for calculating participation proportion, but surveyors would consider a cluster complete only with 60 surveyed households.

Households were selected by rotating a pencil at a village's central location and then proceeding leftward, investigating every household until reaching the 60th one. If the village was too small to have 60 households, surveyors would move to the next village and start the process again.

Surveyors were chosen from local residents, preferably graduates with experience and conveyance, and were informed about the survey by PHC staff. Twelve male surveyors were selected from among 22 shortlisted candidates.

Surveyors and supervisors received a 2-day training, followed by hands-on experience. 11 surveyors were trained for baseline survey, 12 for end line survey, each covering 3 villages in 6 days with assistance from local guides.

During the survey, some surveyors faced difficulties and received support from supervisors. Feedback was provided daily to rectify mistakes. Two surveyors initially struggled but improved with support. Problems were identified, and surveyors were encouraged to solve them independently. A backlog occurred due to a local festival but was cleared



through additional work. Challenges included contacting respondents amidst farming activities and infrequent bus services, leading to logistic difficulties. Supervisors faced challenges in reaching villages due to unfamiliarity with the area.

Key highlights of the survey:

Household size and number of children 0-5 years were similar in baseline and endline surveys. More males were enumerated than females in the age group of 0-14 years, comparable numbers in 15-49 years, and more females than males aged 50 years and above.

Cleanliness of the child: The number of children who were clean at the endline survey was higher than the number in the base line survey. The families were more aware of the importance of cleanliness of the child and this was evident during the end line survey.

Immunization rates among children improved from baseline to endline, with a higher proportion of girls being fully immunized compared to boys. Despite this progress, a significant number of children remained incompletely immunized. Health workers should prioritize completing immunization schedules and reducing missed opportunities through better planning and programming.

Children taken to anganwadi centre for growth monitoring and nutrition supplementation: More children, both male and female, were taken to Anganwadi centers during the end line survey compared to the baseline survey. A greater proportion of children, especially female children, attended Anganwadi centers for more than one week in the end line survey.

Illness during the preceding one month: Higher illness was reported during the baseline survey. The illnesses reported in male children was higher than in females. This may be related to a greater sensitivity and family concern for symptoms of illness amongst the males. The gender difference in illness reporting reduced during the endline survey, suggesting increased awareness of female well-being.

Prompt treatment of illness: Treatment in a large proportion of women was initiated after more than 2 days of illness than males in the baseline and endline survey.

Expenditure on sick children: Expenditure exceeding Rs. 100 was comparable for sick male and female children at baseline survey, but declined for females at endline. Female children had lower illness recognition, delayed treatment, and lower treatment expenditure compared to male children at both baseline and endline.

Reporting of pregnancy: reporting of pregnancy during first trimester was below 5% is low due to health workers' avoidance of registering women until the end of the first trimester, common first-trimester abortions, and lack of awareness. The proportion of women reporting pregnancy and first-trimester pregnancy was comparable in baseline and endline surveys, validating the information gathered. Prospective review identified 19% of pregnant women in the first trimester, demonstrating the impact of efforts made by SWACH staff and healthcare providers.

Antenatal care: The proportion of pregnant women receiving antenatal care increased in a very impressive manner as shown by a substantial increase in the women who got antenatal care in the end line survey. There was also an increase in the antenatal care starting in the first trimester of pregnancy, thereby indicating increased awareness in the community. Moreover, there was a decline in the proportion of women receiving antenatal care care from TBAs and from private doctors while there was a very impressive increase in the proportion seeking antenatal care from the ANMs, doctors or LHV's when end line survey was done.

Possession of the home-based records also increased in the endline survey, indicating an improvement in the antenatal care.

Reporting of births: The reporting of births was comparable during the baseline and endline surveys. Reporting of total births and live births was higher for males than females.



Abortions: The number of abortions declined during the end line survey as compared to base line survey. There was a decline in the proportion of second trimester abortions in the endline survey as compared to the baseline. There was some decline in the proportion of induced abortions in the endline survey as compared to the baseline.

The reporting of abortions was almost negligible during the baseline but there was an impressive increase in the reporting in the end line survey, demonstrating that the community was more open and transparent about reporting this event.

Reporting of infant deaths: The registration of deaths improved in the end line survey. The registration of males was very high while the registration of female death was lower. The total number of infant deaths were comparable during the baseline and endline surveys. None of these deaths had been registered with the authorities. The numbers of deaths amongst males and female children were too small to draw any valid conclusions.

Phase III of the project:

Between January 2007 and April 2008, funding for the project on promoting women's and girls' rights and addressing female foeticide in Alwar, India, was reduced.

As a result, the ongoing training programs and outreach activities had to be discontinued. Irrespective of the challenges encountered, the project team consolidated their experiences and disseminated the key messages across the district.

The project aimed to:

- increase awareness about the declining sex ratio and female foeticide,
- increase awareness about PNCPDT ACT
- involve youth and community groups in addressing female foeticide
- increase the capacity of community-based health care providers in addressing sex ratio using entry points while delivering health care for behavioral change.

To achieve these objectives, meetings with leaders and influential persons, were planned in community block in the district.

In these meetings, resource persons identified from SWACH (field workers and supervisors) prominent persons from Kot Kasim and Majri Kalan blocks from health, education, WCD departments, Panchayats and Sanl/ Pujaris who had contributed to the work relating to sex selection and women's empowerment to share their experiences and successes in promoting respect for females and reducing sex selection.

Topics such as the importance of girls' education, female employment, compulsory registration of pregnancies and births, the dangers of abortion, and the PCPNDT Act were discussed in these meetings.

Orientation material prepared by SWACH was provided to the resource persons and the participants. Adequate numbers of copies were provided to the participants to be able to distribute them in the community after the meeting. A report was prepared for each meeting highlighting the achievements.