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Title of study
An antidote to the missing girl child- the PC&PNDT Act

Dr. Kalapatapu Ravikiran Sharma, Assistant Professor- health communication, Indian Institute of Health and Family Welfare (IIHFW), Vengalrao Nagar, Hyderabad- 500038.

Co-author's name with official address

Prof. Shankar Das, Professor & Chairperson- Centre for Health Policy, Planning & Management, School of Health System Studies, Tata Institute of Social Sciences (TISS), Deonar, Mumbai- 400088.

Abstract

Introduction

The pre-conception & pre-natal diagnostic techniques (PC&PNDT) act is critically linked with the child sex ratio as its sound implementation inevitably leads to an improved child sex ratio. A secondary analysis of the census 2011 indicates that the entire north India has four bridegrooms compared to a single bride. If the same scenario should not be reenacted elsewhere in India, it is the PC&PNDT act that holds the key. Hence, Indian Institute of Health & Family Welfare (IIHFW), a state apex training centre in department of health, medical & family welfare with the state government in Hyderabad, has undertaken an extensive as well as an intensive capacity-building exercise on PC&PNDTA.

Purpose

Furnish a case study on IIHFWs experience, insights & initiatives with regard to the PC&PNDTA capacity-building.

Methodology

This is a qualitative case study and is based on the author's collection of capacity-building data as a team member in the PC&PNDTA capacity-building team at the institute dealt with exclusively.

Results

The PC&PNDTA capacity-building does not comprise dissemination alone but actually starts with dissemination. Societal change is a complex phenomenon and multi-phased, starting with awareness and running sequentially through education, sensitisation, participation, contribution, empowerment to culminate in transformation. Both demand-centric and supply-centric stakeholders have to be positively engaged in a continuous endeavour to inject gender equity into the mainstream of societal consciousness.

Conclusion

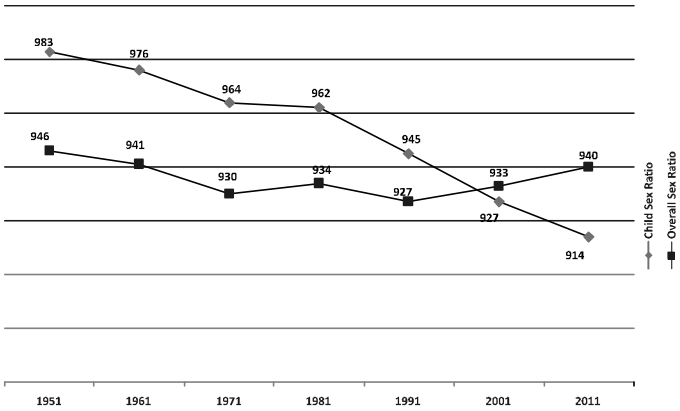
The PC&PNDTA is a cog in the wheel of the national save the girl child campaign. The need of the hour is to disseminate the PC&PNDTA in a mission mode across the nation.

An antidote to the missing girl child- the PC&PNDT Act

Introduction

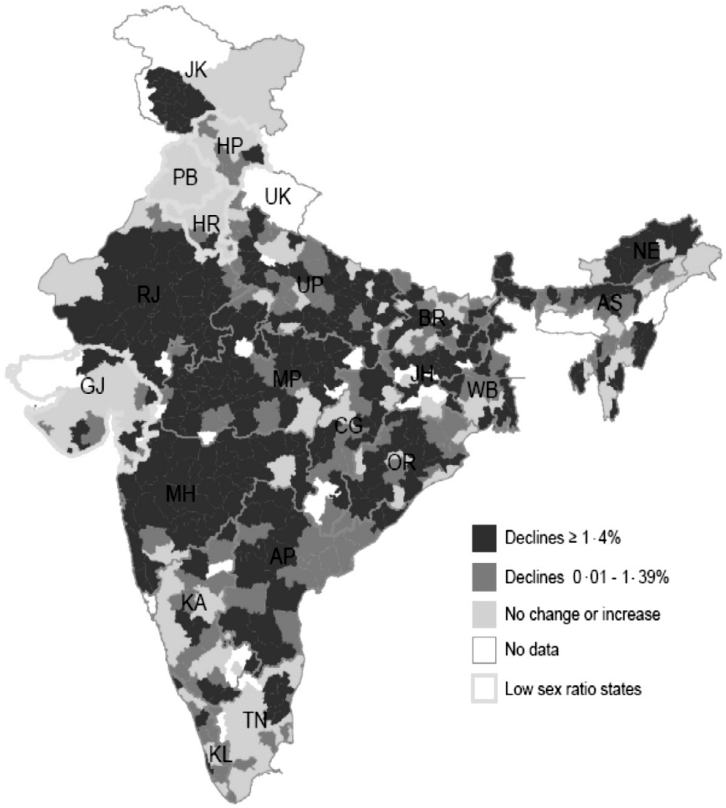
According to a report by the United Nations Children's Fund (UNICEF), up to 50 million girls and women are missing from India's population. In most countries in the world, there are approximately 105 female births for every 100 males. The proportion of females in India remained low over the past 12 decades and the sex ratio continued to decline roughly by 1 percent every decennial.

Trends of change in sex ratio in India



40 women for every 1000 men in the overall population as compared to the previous census in 2001 (933), the child sex ratio in the 0-6 years age band has revealed that there is a decline in sex ratio by 13 points from 927 in 2001 to 914 in 2011.

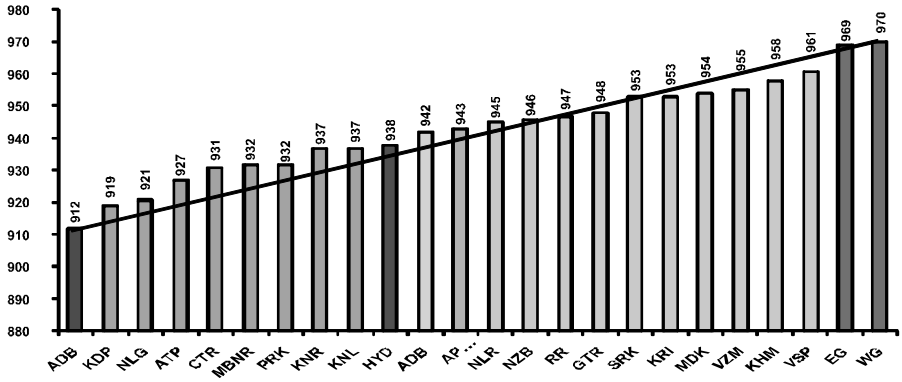
District-level changes in child sex ratio at ages 0-6, between 2001 to 2011



Source: Lancet, M

The situation in Telangana & Andhra Pradesh is thought relatively better as compared to national scenario, yet still needs attention. In undivided Andhra Pradesh, the overall sex ratio though has improved by 14 points during the decade 2001-2011 from 978 to 992 while the child sex ratio during the same period fell down by 18 points from 961 to 943.

Child (0-6 years) sex ratio of undivided Andhra Pradesh- 2011 census



There is broad agreement in the scholarly literature that India's low sex ratios are a stark indicator of the inferior position that women still occupy in Indian society. The remarkable Report of the Committee on the Status of Women in India concluded that "an increase in the neglect of female lives as an expendable asset" is "the only reasonable explanation for the declining sex ratio observed to persist over several decades" (Committee on the Status of Women in India 1975: 373). Scholars have suggested that the inferior economic position of women & the payment of dowry have been cited as the causes leading to selective abortion of female foetuses whose gender had been determined by amniocentesis and female infanticide (Kundu and Sahu 1991; Raju and Premi 1992). However, this anti-female bias is by no means limited to poor families. Much of the discrimination is to do with cultural beliefs and social norms. These norms themselves must be challenged if this practice is to stop. According to UNICEF, the problem is worsening as scientific methods of detecting the sex of a baby and of performing abortions is improving. These methods are becoming increasingly available in rural areas of India, fuelling fears that the trend towards the abortion of female foetuses is on the increase. A few estimations by experts reveal that there are nearly one million missing female births per year in India.

The consequences of skewed sex ratio are likely to have adverse repercussions in future. Already in certain parts of India among a few ethnic communities, a demand for brides has emerged. Sociologists have warned the planners that if right measures are not taken immediately, there is a likely rise in crime associated to gender and threat to safety of the social order. The women-concerned groups are also distressed as this skewed sex-ratio would not add any advantage to the position of women, rather would force women to face a double-edged discrimination and ultimately hamper the empowerment of fairer-sex and overall development of the society.

All these concerns have lead to an emergence of law in the country against sex- selective abortions. In order to check female foeticide, the Pre-natal Diagnostic Technique (Regulation and Prevention of Misuse) Act, 1994 was enacted and brought into operation from 1st January,

1996. The Act prohibits determination and disclosure of the sex of foetus. It also prohibits any advertisements relating to pre-natal determination of sex and prescribes punishment for its contravention. The person who contravenes the provisions of this Act is punishable with imprisonment and fine. However, during the course of implementation of the said Act, certain inadequacies and practical difficulties in working of the Act came to the notice of the Government of India. One such problem is a result of further advances in scientific research which led to development of advanced techniques that could select the sex of a foetus prior to conception. This led to re-look at the whole issue from a larger perspective and the Supreme Court took a note of all these developments in its various orders. As a result after detailed deliberations, the PNDT Act and Rules have been amended with effect from 14th February, 2003. The focus is to ban the use of sex-selection techniques before or after conception as well as misuse of pre-natal diagnostic techniques for sex selective abortions and to regulate such techniques. It is now called as Pre-Conception & Pre- Natal Diagnostic Technique Act (PC&PNDT).

Essence of PC&PNDT Act

The pre-conception and pre-natal diagnostics techniques (PC&PNDT) act is one of the most significant medico-legal acts that needs to be strictly complied with by any medical doctor who is handling any equipment that is capable of detecting the gender of the foetus. This act is particularly meant for obstetricians & gynaecologists, radiologists and sonologists. The act has a simple but stern bottom line. It is that the scanning of a pregnant woman can be done if any genuine medical indicator as specified in the act justifies the conduct of the scanning. But at the end of it, the gender of the foetus must not be disclosed at any cost and under any circumstances.

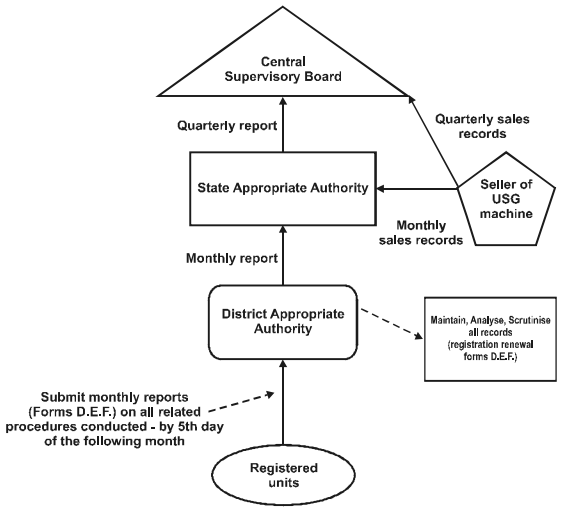
There are five kinds of healthcare centres that need to be registered under the act. These are genetic clinic inclusive of mobile genetic clinic, ultrasound scanning centre/imaging centre, ART clinic, genetic lab & genetic counselling centre. The strict compliance with this act has three dimensions to meet, namely registration, documentation and operational requirements. The registration process is user friendly and has three crucial documents to be submitted to the district appropriate authority under the act. These are:

a. A filled up form A in duplicate along with prescribed documentary evidence,

b. A demand draft favouring the DMHO and worth Rs. 3000/- or Rs.4000/-,

c. A legal notarised affidavit.

The documentation process emphasises equally on records compilation with special focus on form F and referral slip, and the monthly act compliance report submission as illustrated below.



There are key operational requirements for every registered healthcare centre in terms of infrastructure, facilities, & qualifications-cum-training of key operating medical personnel.

Every offence under this act is treated gravely as cognisable, non-bailable and non-compoundable. The major offences are:

a) Non- registration,

b) Conduct of PC & PNDT without any specific medical indication,

c) Determination of sex of the foetus,

d) Indicative communication of sex of the foetus,

e) Advertisement,

f) Non-maintenance / improper maintenance of records.

The punishment for these offences is in the forms of imprisonment, penalty imposition and suspension/ cancellation of medical license. The ultimate purpose of this act to ensure a balanced child sex ratio in the society & thereby avoid several harmful consequences like acute shortage of brides, purchase of lower class brides, wife-sharing, polyandry & high prevalence of social crimes against women. This act should above all be treated as a powerful female empowerment tool.

Major suggestions from public & private doctors throughout the state for implementation of the PC & PNDT Act

- The District Collector needs to accord high priority to the act implementation.
- The district-level advisory committee should become proactive Constant raids on the private scanning centres are an essential first step.
- The sub-district authorities must themselves reach out to the stakeholders and counsel them thoroughly.
- The sub-district authorities must together review implementation progress and share their own experiences. .
- Each sub-district authority must conduct a quarterly review meet with all the registered healthcare centre representatives and impart detailed feedback apart from listening to genuine grievances.
- Each sub-district authority must inform the private doctors in advance about the deficiencies and encourage them to comply well with the act instead of adopting punitive action straightaway.
- The private doctors need to be taught first-hand how to properly fill up the forms right from form A to form G.
- Grassroots NGOs must be involved in public awareness dissemination.
- The mass media must spearhead the campaign against female foeticides.
- The public healthcare centres should first apply for certificate of registration, wherever scanners are utilized.
- The local politicians should also put in their bit.
- A gentle caution must first be sounded out to the violators before adopting punitive action.
- A benefit of doubt must be permitted to the violators, wherever possible.
- Even public healthcare centres utilising PNDT must register themselves under the act.
- The mother NGOs as well as grassroots CBOs must be formally entrusted with duties and responsibilities with regard to the act implementation in order to save time and energy of the sub-district authorities.
- The conditions spelt out for PNDT use need to be diluted.
- Medical Council of India must ask medical colleges to offer a short-term certificate course in sonology in order to generate trained sinologists.

- Experience must be preferred over qualification when it comes to authorising competent doctors to conduct scanning.
- v The bare act copies must be distributed to all the registered as well as unregistered healthcare centres for wider dissemination of the act.

Major challenges faced by the authorities & practitioners while implementing the act

- Lack of time on the part of the authorities due to several more pressing matters
- Lack of guidance from the authorities to the practitioners
- Pressures from patients and their kith & kin on the practitioners to disclose the gender of the foetus
- Cumbersome documentation involved for practitioners
- Political pulls & pressures to shield the act violators
- No signal from the authorities about interest in implementation of the act.
- Day-to-day record-keeping is highly time-consuming.
- The doctors and their support staff have to sometimes bow to certain obligations.
- The ultrasound scanning business has developed itself into an industry, leading to entrenchment of vested interests.
- The act is itself seen as redundant by some stakeholders.
- Many practitioners opine that the act is just another excuse to extract money from gullible private hospitals and clinics in the name of non-implementation of the act.
- The authorities are perceived to be acting in an arbitrary manner while searching, seizing and fining the violators.
- The authorities are themselves confused about some intricate points.
- The authorities lack clerical assistance in their search, seizure and seal procedures.
- Some guidelines contained in the act appear to be too broad or vague.
- The act is ambiguous over certain matters of implementation
- The act was not implemented for many years and hence it would take some time to familiarize themselves with various aspects of the act
- Many doctors do not have a thorough knowledge about the indicators that permit the utilisation of PNDT.
- The authorities were critical about the attempts of private doctors to escape in the name of ignorance of the act.

Major issues as pointed out by different stakeholders

- A separate room should be earmarked for scanning.
- A workshop has to be conducted on the act at sub-district level.
- Most PHC medical officers do not submit compliance reports by the 5th of each month.
- The registered doctors meant to do scanning often do not do the actual scanning.
- It is mostly ultrasonologists who do the actual scanning.
- Many DMHOs do not supply a separate register for ante-natal scanning.
- Underreporting is the prevailing norm.
- Scanners should be made available in almost all rural and tribal PHCs.
- The gender of the foetus is often orally intimated by the violator.
- There is considerable confusion regarding the purpose and its mention in ante-natal scanning.

- Many pregnant ladies refer to non- MBBS practitioners or quacks in villages.
- No formal training is available in ultrasonology or embryology.
- Many loopholes & contradictions are being noticed in the act.
- If ASHA, ANM and AWW are utilised well and the three act in unison, then the act awareness can be well generated with fruitful results.
- The act has not offered clear-cut definitions about genetic clinics, genetic labs, image centres, etc.
- Most PHC medical officers are vaguely aware about the act.
- Documentation requirements are highly burdensome.
- Too much emphasis is laid on paperwork by the act.
- Violations of the act can be easily done even while documenting well.
- Until and unless public mindset is changed, the act will not serve its purpose.
- Most medical doctors are highly cynical about the act as it is perceived to be unfriendly to them.
- The spirit should be more important than the letter with regard to implementation of the act.
- The educated are often guiltier when it comes to foeticides and infanticides.
- The ultrasonologists need training on the act, in fact much more badly than the gynaecologists.
- The average medical doctor's awareness about assisted reproductive technologies (ART) is low.
- Decoy witnesses are not utilised by the appropriate authorities.
- Even basic record-keeping is not done by a huge majority of private hospitals.
- The average medical doctor is not interested in the act as s/he has rarely heard about penalties being imposed upon violators.
- So many new diagnostic techniques have entered the market; as a result of which amniocentesis is no longer a popular choice.
- Some family members actually welcome news of an impending arrival of a female baby, hence such people can be informed the gender of the foetus in advance by the doctors.
- The gender of the foetus has to be identified by the gynaecologist in the case of a suspected sex-related disorder.
- Doctors who personally know the patients tend to secretly disclose the gender of the foetus.
- The junior and senior assistants in the department who are involved in implementation of the act must be trained well.
- The violating clinics must be first furnished with a formal warning by the appropriate authority so that a chance is extended to the violators to make amends.
- The essence of the act must be disseminated at the sub-district level through a simple Telugu pamphlet.
- The district-appropriate authority must conduct a monthly review meet of the act implementation in the concerned district in order to discuss hurdles and issues apart from learning about latest progress from the sub-district appropriate authorities.
- The act is not clear about various medico-legal complications that may arise while implementing the act.

- In corporate hospitals equipped with many scanners, surveillance of their proper utilisation is a daunting prospect.
- Since the public healthcare centres are themselves not implementing even the basics of the act, the appropriate authorities lack the moral power to punish errant private healthcare centres.
- Many government doctors assume that the public healthcare centres are exempted from the purview of the act.
- Many appropriate authorities are not able to appreciate the direct link between sound implementation of the act and improvement in the overall sex ratio/child sex ratio.
- Many DMHOs do not themselves know who the sub-district appropriate authorities are.
- All the sub-district appropriate authorities must undergo refresher training on the act in order to be updated with the latest developments.
- Child welfare NGOs must be engaged in monitoring and dissemination in order to reach the wider community.
- A formal short-term training course must be offered in ultrasonology to interested medical doctors at medical colleges or healthcare training centres.
- Instead of running fleeting scrolls on basic provisions of the act in Telugu satellite channels, exclusive television and radio programs must be developed to generate public awareness about the act.
- State-level and district-level awards must be instituted to reward sound implementation of the act along the lines of the family planning awards.
- Some sub-district authorities are keen to implement the act well but simply lack time to conduct raids, collect evidence and chase courts.
- The act is not clear about whether non-allopathic doctors are eligible to conduct ante-natal scanning.
- Most radiologists are visiting consultants in hospitals and nursing homes and are hence not interested to keep records and do documentation in connection with the act.
- Most private healthcare centres do not follow the size specifications concerning the scanning rooms.
- As long as the patients demand for disclosure of the foetus gender, there will be keenness on the part of the healthcare centres to generate business from this demand.
- The sentiment that son is the bearer of the family flag is the major culprit behind foeticides.
- Dowry is one social evil that fuels disinterest in the birth of the female baby.
- The paediatrician must collaborate with the gynaecologist to counsel mothers and encourage them to feel good about female babies so that they are not desperate for the birth of male babies in their second or subsequent pregnancies.
- The sub-district appropriate authorities must also be exclusively trained in pre-natal diagnostic techniques so that they can better detect violations.
- The will power of the district collector matters a lot for the act to be implemented on a war footing.
- The bare act is couched in legal jargon and creates more confusion than clarity.
- It is much easier to maintain computer records than manual records for the healthcare centres.
- The private doctors perceive this act to be another nuisance to them and one that entails a huge waste of time, money and energy.

- Fear of law is a greater deterrent than self-motivation due to limited resources at the disposal of most healthcare centres.
- If the district-appropriate authority shows a good example, the sub-district appropriate authorities will take the cue and themselves be more alert and dutiful.
- The act has not dealt comprehensively with the scope for misuse on the ART front.
- The appropriate authorities should first deal with cases involving non-registration as these are countless.
- Strict action against any kind of violation would send a stern message that laws are meant to be followed.

Reasons for insufficient progress in implementation of provisions of the PC & PNDT Act & rules

- Insufficient man power and other resources
- Lack of sensitisation of implementing authorities
- Lack of cooperation from public
- Lack of inspection & monitoring of district level authorities
- The main problem in implementing the PC&PNDT Act is that almost all those involved in bringing the doctors to book are doctors themselves, and when doctors sit on a regulatory body over doctors, they forget their first basic clause of medical ethics i.e., exposure of unethical doctors.
- The doctors consider infanticide, sex selection and foeticide as low risk-high profit business.
- Money made per case is not much and those involved do many cases per year to make real big money.

Proposed solution

- The solution would not lie only in awareness and other campaigns but a systematic campaign to book the guilty.
- Proof in form of audits. Record is obligatory under the Act.
- Inspection of these records.
- Severe punishments to the doctors.
- The whole business of low risk with high profit needs to be inverted and made as a high risk business.

Recommendations for effective implementation of the legal provisions

- The very first requirement is that the appropriate authorities and the advisory committees throughout the country should be made aware of the provisions of the Act as well as the Rules. A copy of the judgment by the Supreme Court in CEHAT & Ors should also be provided to them. The lack of information about the relevant provisions of law and their powers coupled with duties is one of the reasons of non-implementation.
- Periodic meetings of the appropriate authorities and advisory committees, as provided in the Act & Rules and their monitoring by the state and centre supervisory boards is a must. The decisions taken in these meetings should be made public. The National Commission for Women may also ask for these reports for its independent assessment.
- Under the provisions of the Act as well as the Rules (Rule 3-A), the appropriate authority can have particulars about the total number of machines & equipments, which have potentiality to detect sex of the child in the state/UT along with names of the users of this facility. A state/UT-wise inventory should be available to the people. Further, a national inventory should be prepared for public information under Rule 17(3). Any new equipment/machine added can thus be easily identified.
- There is a total control on the clinics/labs/centres, which are registered (by virtue of

section 4(2), disclosure by Form A, maintenance of record under Form F, cancellation of registration under section 20), and the appropriate authority can take immediate action if there is any violation.

- If the registered centres/clinics maintain records as required by the Act and such records are inspected by the appropriate authority regularly, it will be possible to control the unwanted application of ultrasonography/ other techniques of detecting sex of the foetus. Neither the centres/clinics/laboratories are maintaining these records nor are these inspected by the appropriate authorities. The urgent requirement, therefore, is that the maintenance of keeping records be implemented vigorously and if those centres/ clinics/labs fail to maintain records, their registration should be suspended in addition to the criminal action.
- Under the Act, violation of the provisions is punishable with imprisonment and fine, whereas under Rule 11(2), if the appropriate authority seizes any ultrasound machine or other equipment capable of detecting sex of foetus, which is used by an organisation not registered under the Act, the machine of the organisation is released only on payment of penalty equal to 5 times the registration fee and on such organisation giving an undertaking that it will not indulge in detection of sex of foetus or selection of sex before and after conception. The Rule takes away the rigour of the punishment provisions under the Act. It permits a clinic/laboratory to run without registration, thus indulge in violation of the provisions of the Act but it can be let off merely on payment of fine and undertaking. This rule is required to be deleted/amended. Otherwise, it will be misused by those who are indulging in heinous practice of sex determination of foetus.
- Along with awareness in the society, strict implementation of the legal provisions and its close monitoring is an urgent requirement to curb the growing menace of female foeticide.

Recommendations for strengthening the laws

- There should be provision for separate registration of sonography/imaging techniques and gynaecological techniques. The applicant should have a choice to register for one or more specific gynaecological techniques.
- All powers of AA should be clubbed together under Sec. 17 A of the Act.
- Sec. 30 (1) and 30(2) which deals with search and seizure, with the provisions of CrPC, 1973, needs to be included under Sec. 17 A to get a comprehensive view of the powers of AA.
- Sec. 31 "any officer authorised in this behalf" to perform all tasks of an AA related to search and seizure. The officer also enjoys protection of action taken in good faith and powers under CrPC. (Sec. 30(2)).
- Qualifications of such a person, conditions under which such a power may be delegated by the AA, are not specified in the Act or Rules.
- Form of intimation to the AA and exact mechanism to be followed in case of-
  - Non-working sonography machine
  - Exchange or disposal of obsolete machine
  - Change of ownership
- The role of police in the implementation of this Act needs further elaboration.
- Moreover, in the absence of police intervention, the complaint filed by AA against an erring institution is regarded as a private complaint, thus denying the state support

and sanction to the action taken by the AA as a state functionary.

Purpose of IIHFWs capacity-building engagement in PC&PNDTA

- To sensitise the concerned state and district authorities, officials and concerned groups regarding the need for strict enforcement of the PC & PNDT act from a gender perspective
- To enhance their knowledge on the process of registration of various centres and maintenance of records under the act
- To acquaint them with the common violations being frequently detected
- To enlighten them with the latest act amendments and updated operational guidelines provided by the state government
- To enable them to adopt various administrative measures and enforce punitive measures towards effective implementation of the act
- Sharing of effective dissemination initiatives & classic conviction cases
- Learn from experiential exchange between participants as well as facilitators about practiced and proposed dissemination, administrative and enforcement strategies related to sound implementation of the PC&PNDT Act.

Role of Indian Institute of Health & Family Welfare

The PC&PNDT Act team members of Indian Institute of Health & Family welfare, Hyderabad, mentor all the capacity building activities. It involves facilitation, coaching, and hosting of workshops & dissemination activities. The IIHFW PC&PNDTA team has also proposed to be the lead investigating team for all state-wide research and evaluation initiatives. The following table furnishes info on the capacity building exercises that IIHFW has adopted with regard to PC&PNDTA.

Capacity-building exercises

A. Preparation and development of training courseware for the benefit of multi-level concerned authorities (state, district, sub-district); official monitors (committee members & nodal officers); enforcement authorities (judiciary & police); and supporting implementation staff (health & other departmental partners).

B. Departmental & inter-sectoral convergence capacity building comprising state-level sensitisation workshops, district level inter-sectoral convergence workshops & grass-root level inter-sectoral convergence workshops for the benefit of the following stakeholders:

- Multi member SAA
- State level monitoring & inspection committee
- State supervisory body
- State advisory committee
- State level office bearers of APMC, IMA, APNA, IRIA, FOGSI, FPAI, etc.
- SPHOs: Conveners of Sub-DAA
- District advisory committee
- Sub-district advisory committee
- Multi-member DAA
- Multi-member sub-DAA
- Hospital superintendents
- Teaching doctors & students
- Faculty & students from degree nursing colleges, GNM training schools, & ANM training schools
- PHC medical officers
- Members of ZPP, MPP, MPDOs, Maarpu cluster convergence members
- Community health functionaries/ANMs / ASHAs /AWWs /SERP VO members/ SHG members/ Grass-root NGO reps

C. Proposed PC&PNDTA research and evaluation initiatives by IIHFW

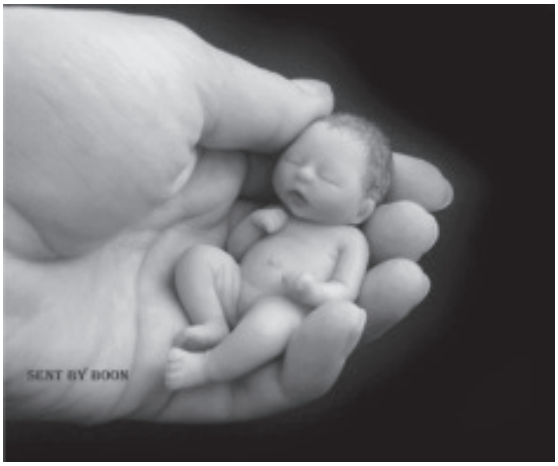
Serial #	Nature of initiative	Purpose
1	Research training workshops	To evolve concepts & indicators; develop research tools with a policy influencing perspective to save the girl child
2	Evaluation of PC&PNDT act implementation in Andhra Pradesh	Undertake an impact assessment of the administrative, dissemination and enforcement measures under the PC & PNDT act
3	Baseline survey on PC&PNDT act implementation indicators, gender equity indicators and community sensitisation indicators	Undertake an interview schedule based survey to know the existing situation with regard to gender equity and practice of PC&PNDT act rules, directives and guidelines
4	Action research in selected microcosm	Undertake action-research initiatives in some selected communities
5	Mid-term survey on PC&PNDT act implementation indicators, gender equity indicators and community sensitisation indicators	Undertake an interview schedule based survey to know the existing situation with regard to gender equity and practice of PC&PNDT act rules, directives and guidelines, and do a comparative analysis of the indices between baseline and mid-term surveys
6	Mid-term qualitative research assessment on social & behavioural change indicators with regard to PC&PNDT act	Discern and unravel the evolving experiences of implementers: administrators, enforcers & capacity-builders.Explore the resistance, gradual behavioural change & compliance with PC&PNDT Act norms among pregnant women and her kith & kin
7	End-line survey on PC&PNDT act implementation indicators, gender equity indicators and community sensitisation indicators	Undertake an interview schedule based survey to know the existing situation with regard to gender equity and practice of PC&PNDT act rules, directives and guidelines, and do a longitudinal analysis of the indices between baseline, mid-term and end line surveys
8	Cases on PC&PNDT act implementation success stories, systemic failures, and reflective conviction cases	Develop an extensive and intensive portfolio of case studies, cases and caselets in order to provide a repository of cases for the perusal and reference of law makers, policy makers, decision makers and front-line personnel
9	Dissemination of evaluation & research outcomes	Sharing of findings & insights gained from the evolving studies and analysis with intersectoral partners engaged in PC&PNDT act implementation

Conclusion

A positive supportive environment for women is required if one has to tackle the problem of female foeticide. The issue of decline in sex ratio of women cannot be addressed unless there is an improvement in the implementation of the laws for women. We also need to enhance the status of women, support women in employment and education. The efforts in this direction, therefore, need to be continuous and dynamic to facilitate better implementation of the law and to provide an effective solution to the problem of female foeticide.

The emerging social evils of wife sharing (adoption by wife of husband's unmarried brothers as co-husbands), bridal purchase (purchase of bride from poor & lower middle class families for varying sums) & androgamy (co-existence of wife with two or more husbands from different families) across north India where a recent independent survey has pointed out the alarming ratio of one bride to four bridegrooms, serves as a stark reminder of the gloomy future that awaits the wider society, be it forced bachelorhood for bridegrooms or sexual crimes against women.

The PC&PNDT Act has the best potential to raise our normal & child sex ratios encompassing mandal, district, state and national levels & inject gender equity. Both the Prime Minister of India & the Telangana State Chief Minister have publicly announced gender equity as a top priority on their implementation agenda. So this act needs to be catapulted into the national mainstream consciousness in the coming months. The options before us are loud and clear:



Do you want to kill her? Or sacrifice her? Or protect her!

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