Summary & Conclusion:

Despite the natural biological endowments, the existing evidence, reiterated time and again, in defiance to all the efforts has led to decrease in sex ratio in general and child sex ratio in particular. There is sufficient evidence that the developments in technology which were expected to facilitate the healthy outcome of the physiological process have been regularly abused under one or the other pretext.

There are legislations with content and context well laid out but the societal pressures and the economic forces driving the profession, at times for easy money; has made a mockery of them.

Under this pretext the State Institute of Health and Family Welfare undertook a study in October 2008 for assessment of sex ratio (0-6 years) in five districts of the state, the selection criteria being the increase or decrease in sex ratio between the two census periods.

With 2850 respondents from community, private clinics, PHCs, CHCs along with the health care workers at these institutions and the appropriate authorities at state and district level were questioned on different issues.

The state level appropriate authorities were relatively better when it came to the implementation mechanism, the penal provisions under the Act the damages that misuse of the technique has done in already distorted sex ratio.

Somehow at district and block levels, the understanding on the said issues needs impassivity particularly so when it comes to regular monitoring registered centers and booking the defaulters in a full proof manner the only comforting observation is that state, district or block, all the authorities have shared their concern with decreasing sex ratio particularly the number of girl children but then it appears that every body's concern stands as no one's responsibility, evident enough through the data triangulated from different sources.

Out of the total number of children in 2850 households there were 2432 male children and 2276 female in the age group 0-6 years giving a child sex ratio of 935 per 1000 male children; which is well above the state average but then the averages always hide the disparities and the realities get lost in the vortex of numbers.

In the study households women who were pregnant at the time of survey, 36% of them had an expectation for a male child while 17% wanted a female child (as the break up of number of children they already had before this pregnancy was not recorded, the interpretation is a little difficult but the

observations from all other respondents and various reasons accorded for son preference it appears that these women must have had desired number of male children prior to this pregnancy).

The other shocking observation is that 26% of the pregnant women have themselves gone for USG for sex determination without a medical advice. This reinforces that it is the elite and educated who are making a palpable dent in the girl child sex ratio (While income and education do increase the use of PCPNDT, its misuse is governed more by cultural factors and sex composition of children already born. (Bhat and Zavier, 2005).

Multiple reasons were offered by the respondents from the community for preference given to son, son needed for maintaining family tree, being the commonest excuse (69%). In the preceding six years a total of 2763 women had been pregnant, one or more times resulting in 4566 live births.

The awareness of PCPNDT Act and the penal provisions apart from the fact that sex detection is illegal is fairly large in both the sexes from urban and rural areas but the associated findings reflect that despite the knowledge practices have not changed and the girl child remains neglected. The social consequence of distorted sex ratio is a matter of concern among the community respondents but their translation into action has not been there.

The health workers keep a good track of the entire pregnancy period and are well versed with the conditions for referral, still a high maternal mortality ratio and this is where we failed to justify the responses of health workers.

Pregnant women do contact and ask for sex detection centers but are counseled and advised not to go for it as legally it is a crime. With 26% of women (self motivated) going for USG for sex detection it appears that some other forces are working in the society exploiting the inherent psyche where the male is the preferred sex; defy the efforts of workers from the system.

The community, the health workers and the medical officers collectively hold the society and pregnant women herself for abusing the PCPNDT and are aware that distorted sex ratio leads to polyandry, increase in crimes in general and sexual crimes in particular, but the deep rooted values have been hard to hit.

The need for putting PCPNDT Act in place, the knowledge about the appropriate authority is well known to health workers and all of them singled out the need for media and the NGOs to make concerted efforts in increasing the awareness levels and work with community putting the girl child at the same pedestal, if not higher.

There is a strong need emerging out of the study that the pregnant women and the family needs to be counseled for not going for sex detection and accepting the girl child.

Medical officers in general and those who are operating the USG centers be it in private or public sector are in knowledge of the statutory requirements to operate such a center. Majority of them are aware of the requirements to be fulfilled, penal provisions under the Act and the conditions under which a pregnant women can be subjected to USG, but for the poor enforcement keep on flouting these obligations like registration of machines with the appropriate authority and display of signage indicating 'sex determination is illegal'.

The record keeping and filling of form 'F' is another grey area particularly in the public sector institutions where only 7.7% of the pregnant women get the form 'F' filled before going for USG in contrast to the private sector where almost 92% comply with this requirement. Similarly, there is an utter disregard for the holding time of records, government institutions keeping the record in 5.8% of the cases for four years and above.

Recommendations:

In view of the observations, a set of recommendations are being made as follows:

1. District based sensitization workshops should be organized in consultation with local NGOs and influencer groups.
2. A dialogue with USG machine manufacturers should be started for manufacturing machines that are temper proof where all records of sonography are preserved and cannot be deleted.
3. All unregistered centers should be identified, brought under registration and asked to comply with the statutory requirements of PCPNDT.
4. Professional bodies like IMA, FOGSI (local branches), registered societies of private practitioners should be taken into confidence and asked to create a peer pressure among the defaulting few.
5. The defaulter should be booked with full proof charge sheets and exemplary actions be executed.
6. Possibility of putting a premium on the birth of a girl child (incentives, recognition) be explored.
7. Government institutions operating USG machines should be made more accountable towards record keeping and reporting.
8. Regular meetings of appropriate authority and advisory committee to be ensured at district and block levels.
9. All births be registered under the relevant Act.
10. Health staff to be made accountable for tracking all pregnancies and their outcomes.
11. Self motivated pregnant women should not be entertained for sex selective procedures, come what may.
12. The assessment studies be done at a more frequent interval covering all the districts in the state.