STATUS AND EFFECTIVENESS OF PCPNDT ACT IN RAJASTHAN

PRAYATN
Struggle for a Dawn of Change

Status and Effectiveness of

PRE-CONCEPTION

AND

PRE-NATAL DIAGNOSTIC TECHNIQUES

(PROHIBITION OF SEX SELECTION)
(PC-PNDT) ACT IN RAJASTHAN

A RESEARCH REPORT

SUPPORT AGENCIES

USAID | INDIA

AUTHORS

PUNAM SAH
E.M.RADHAKRISHNAN

The following people contributed in preparation of this report:

Core Research Team :

Punam Sah, E.M.Radhakrishnan, Vijay Kumar Vadhyar, Susrita Roy, Yogesh Jain

Feild Investigators :

Dr. Suresh Kumar Mishra, Santosh Kumar Kushwaha, Sunil Jaiman, Kaluram Sharma, Rajendra Kumar Sharma, Mukut Bihari Meena, Mansingh Meena, Santosh Kumar Shrivastav, Mukesh Sharma, Keshav Kumar Agarwal, Balkrishna Sharma, Manoj Garg

Field Monitoring Support :

Vijay Kumar, Hakim Manjhi, S.R. Tanwar, Manish Singh, Rakesh Sharma

Data Analyst :

Kshitij Sharma

Data Processors :

Pinki Tanwar
Ghanshyam Verma

Publication :

Book Cover Design - Ridhima Khandelwal, Monica Jain
Book Design - Vimal Kumar Jain
Printed by : Shri Shyam Printers, Jaipur Tel. : 0141-2360609, (M) 9829747472

This publication was made possible through support provided by IFES and USAID under the terms of Agreement No. 386-A-00-03-00164. The opinions expressed herein are those of the authors and do not necessarily reflect the views of Prayatn, IFES and U.S. Agency for International Development.

FOREWORD

The circumstance is alarming decline in sex ratio and the rampant practice of female feticide. PRAYATN strives to reverse the phenomena of sporadic and feeble responses and facilitate an effective scrutiny of the system to the situation. The study has explored and revealed on the issue in-depth and wide across the state and called for transformative engaging in fieldwork reflections, policy framing and activism. There is a definite need emerged to think out of the box and to review, restructure and rejuvenate systems. The study attempts to offer insights for all involved in making a difference.

PRAYATN would like to acknowledge the assistance of many people who were involved in putting together a volume of this nature. Having been involved in the issues of female foeticide and female infanticide in the State, this study brings to us a new experience in the functioning of the Administration in its effort on curbing these issues through legislation. It has also helped us in consolidating our field perspectives to the extent that the issue is tackled in a holistic manner.

First and foremost, we thank the entire State machinery dealing with the implementation of the PCPNDT Act. The Directorate of Family Welfare, Government of Rajasthan, needs special mention here. Special thanks are due to the registered clinics, the NGOs, civil society groups, metropolitan magistrates, elected representatives and members from other walks of life who have wholeheartedly cooperated and provided gainful insights to make the study a success.

Our sincere gratitude goes to the IFES Team in Jaipur and Delhi, and the USAID, for encouraging us to undertake this study and providing necessary financial support. Inputs provided by IFES on the study have been very useful to boost the academic excellence of the research team.

We profoundly thank the entire research team. They had a tough task to undertake such an intensive study with a vast geographical coverage in a period of six months. A report of this volume to have been finished speaks of their meticulous planning, well-coordinated teamwork and unparallel hard work. My congratulations to them!

Last, but not the least, I thank all those who have directly or indirectly helped us in conducting this study.

MALAY KUMAR
Chief Executive

PREFACE

The context of this study is the PCPNDT Act. This study projects the implementation of the Act by the structures provided for in the State of Rajasthan. The purpose of this report is to create a reference ground that will give clarity and guide intervention in fulfilling the purpose of the Act. The study is devoid of any leanings to any perspective. The attempt has been to give a picture of the implementation in Rajasthan, by the machinery provided for the purpose, 'as is'.

The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act (PCPNDT Act) (amended), was introduced to provide for the prohibition of sex selection, before or after conception, and for regulation of pre-natal diagnostic techniques and for the prevention of their misuse for sex determination leading to female foeticide. The Act provides for implementing machinery managed by the state. There is a gamut of interest groups/stakeholders who can impact its implementation. This study has ventured into the domain of other stakeholders, besides the given implementing machinery to project a broader perspective and deeper understanding of the issues involved in the implementation of the Act.

Originality is one of the chief features of this study. In the absence of any reference point for designing and developing the study, ingenuity and intuitiveness of the team were banked upon. Sex determination leading to female foeticide is an act wherein visibility of the crime is shrouded. Under such conditions, examining the effectiveness of the implementation of the Act and projecting it in visible terms is the impossible task that the research team involved has made possible through this study.

This study is being presented with the intention of guiding intervention to prevent misuse of techniques for sex determination and sex selection that lead to female foeticide. It has insights and recommendations that will help the present implementing machinery in the state to be effective, the bodies at the center to monitor with clarity, and civil society members and other stake holders working on or intending to work on the issue of female foeticide, to do so with clarity. The bottomline is to inspire and guide action.

Punam Sah
E. M. Radhakrishnan

CONTENTS

ABBREVIATIONS

AA	-	Appropriate Authority
AC	-	Advisory Committee
Addl. CM&HO	-	Additional Chief Medical and Health Officer
ANM	-	Auxiliary Nurse-Midwife
Asstt.	-	Assistant
AWW	-	Anganwadi Worker
CEHAT	-	Center for Enquiry into Health and Allied Themes
CM&HO	-	Chief Medical and Health Officer
CSB	-	Central Supervisory Board
CSMs	-	Civil Society Members
CSOs	-	Civil Society Organisations
CVB	-	Chorionic Villi Biopsy
DA	-	Daily Allowance
Deptt.	-	Department
Dy. CMHO	-	Deputy Chief Medical and Health Officer
FOGSI	-	Federation of Obstetrics and Gynaecological Society of India
IMA	-	Indian Medical Association
IPO	-	Information and Publicity Officer
IRA	-	Indian Radiologists Association
MASUM	-	Mahila Sarvangeen Utkarsh Mandal
MLA	-	Member of Legislative Assembly
MTP	-	Medical Termination of Pregnancy
NGOs	-	Non-government Organisations
OPD	-	Out Patient Department
PCPNDT Act	-	Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act.
PHC	-	Primary Health Centre
PIL	-	Public Interest Litigation
PNDT Act	-	Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act
PRIs	-	Panchayati Raj Institutions
Sr.	-	Senior
SSB	-	State Supervisory Board
TA	-	Travel Allowance

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

INTRODUCTION

Precision in diagnosis of ailments and medical complaints has been an objective that the medical community seeks to achieve excellence in. But advancements in the field of medical technology have been, on occasion, examined and debated on ethical premises and for misuse. Pre-conception and pre-natal diagnostic techniques have been similarly examined because female foeticides in India have been attributed to practices of sex selection and pre natal sex determination in favour of a male child. It is projected that the adverse child sex ratio in India is a result of this phenomena.

To provide for the prohibition of sex selection, before or after conception, and for regulation of pre-natal diagnostic techniques for the purpose of gynaecological or obstetrical or medical procedures/tests and for the prevention of their misuse for sex determination leading to female foeticide, the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act (PCPNDT Act), 1994 (amended), was introduced.

This report is a study of the Status and Effectiveness of Implementation of the PCPNDT Act in the State of Rajasthan.

BACKGROUND TO ACT

The history of the Act can be traced from 1974 when the All India Institute of Medical Science conducted a sample survey of amniocentesis to investigate foetal genetic conditions and 90% of the 11000 pregnant women enrolled as volunteers for research were found to be desirous of aborting the female foetuses on identification of their sex. In 1978, there was a ban on sex determinations in all government institutions. But private clinics kept on. Efforts on getting the medical profession to self regulate and follow professional ethics were not fruitful.

Intensified campaign through the 80s and early 90s led to the formation of legislation, the PNDT Act, 1994, which came into force on January 1, 1996. But the ineffectiveness of law and the unabated continuation of pre-natal sex determination and sex selective abortions alarmed health activists to take action and lobby for its proper enforcement. A public interest litigation was filed in the Supreme Court by Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai, and the Mahila Sarvangeen Utkarsh Mandal (MASUM), Pune, and Dr. Sabu George. Following the PIL the court summoned the Central and State Governments to present the status of implementation of the Act. Based on the orders/observations of the Supreme Court for activating the implementing machinery, an amended act, the 'Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act 1994 (PCPNDT)' was passed, and is in force from 14th February 2003.

With the amendment to the PNDT Act, pre-conception and pre-implantation procedures for sex selections

are banned in the country. Compulsory maintenance of written records by diagnostic centers/doctors offering pre-conception and pre-natal diagnostic services has been stipulated in it. Local authorities in the states and union territories, such as ministers, secretaries and heads of the health departments have also been given powers to ensure the enforcement of the Act.

LITERATURE REVIEW

'Sex Selection – Issues and Concerns' and 'Learning Across Borders – An Information Resource on Adverse Sex Ratio' (draft) were two sources that gave us a bird's eye view of the literature concerning our subject of study and related topics. But in these two and other literature we scanned/browsed, we did not come across any study dealing with the PCPNDT Act intensively/solitarily. An article by Ravindra R.P., a monograph authored by Dr. S.G. Kabra and a paper by Dr. Vibhuti Patel's were certainly helpful providing insights to the issue.

The study underreport had three major purposes. First, it aims to provide the implementers of the Act with the opportunity to examine their experiences and organise appropriate strategies, second, given the increased emphasis placed by the Judiciary on the Act, equip the implementers with required skills, and third, involving to a maximum extent, several stakeholders in the implementation process. The study also envisages a holistic approach to deal with the nuances of the System that may be playing deterrents to the effective disposal of the provisions of the Act.

OBJECTIVES OF THE STUDY

1. To study the status and effectiveness in implementation of PCPNDT Act in the State of Rajasthan in terms of district wise situation and to understand constraints at various levels in the implementation of the PCPNDT Act

2. To propose measures policy, administrative and judicial, and community interventions for the effective implementation of the Act to curb female foeticide.

3. To understand the general trend of child sex ratio as a result of female foeticide in Rajasthan.

METHODOLOGY

The design is exploratory beginning with literature review and desk research. The crucial concepts in the objectives were first defined and variables were determined. A detailed data collection plan was determined. The study being exploratory, the design for data analysis was finalized after data started coming in and the team could assess the feasibility of having information against the different variables. Representation of data through simple tools such as tables was planned for every chapter

Informants for this study fell in two categories - those who were directly responsible in some way to implement the Act (AAs, Members of ACs and Chief Judicial Magistrates) and those interest groups or opinion makers that had an influence in the implementation of this Act (Registered Clinics, Elected Representatives and Civil Society Organizations/NGOs). Sampling was designed according to the structure for implementation in the State of Rajasthan at three levels, state, district and sub-division. Purposeful

sampling was applied for informants outside the purview of the Act. All the 32 districts of the state were covered for the study. Both quantitative and qualitative techniques for data collection were used. Interview guides, structured questionnaire and structured field observations were used. The checked data was then analysed.

The uncooperative officials & clinic owners and poor record maintenance in government offices proved deterrent in accomplishing this geographically widespread study.

FINDINGS

STATUS

(a) Existence of structures

There is compliance to provision for existence of structure. All requisite bodies exist – State Supervisory Board (SSB), as well as, Appropriate Authorities (AA) and Advisory Committees (AC) at the state, district and sub-divisional level. But, 100% compliance can be attributed only to AAs.

SSB has the requisite 21-member composition. But it is not functioning since its constitution. Not a single meeting of the body has taken place ever since it was constituted. Generally the members lack knowledge about the entire process of the Act or the SSB. Inadequate non-government representation makes the body a unilateral one not being able to discern different perceptions and perspectives, which otherwise can be supportive to the functions of the body. The body is bereft of a geneticist whose role is crucial in the overall context of the implementation of the Act.

The AC at the state level complies with the membership and representation criteria. But reality is reflected by the fact that the Sr. Gynaecologist, who is the Chairperson of the AC, has expressed ignorance about her membership though she has assumed the post since January 2004. She has not attended any meetings of the committee.

The ACs at district and sub-division level do not fulfill on eight-member requirement. There are at least 27 persons representing geneticist on multiple committees. There are 56 such committees. Information and publicity officers are also on multiple committees. Since some members on the AC are completing their term and new committees are in the process of being constituted, the indicator of compliance cannot be commented on.

Confusions as to forming the advisory committees, whether to be nominated at state level or recommended by the AAs for sanctioning at state level were evident from the responses of the AAs at the district, and subdivision with that of the state AA. Also eventually, since, the appointment is done by the Government itself; there is ample opportunity for the officials to induct only those individuals/organisations who are in their 'good books'.

(b) Status of Systems

There are no reports from SSB to CSB. At district and sub division levels, periodicity of reporting is irregular. Contrastingly, reporting from the state AA to PNDT Director is regular.

AAs at all levels comply with maintenance of permanent record of expenditure. But with regards to any other records (minute books, records of applications of registration, records of renewal of registration and records of letters of intimation) the maintenance is poor.

Irregularities were found in meetings with ACs. At none of the three levels, meetings are conducted as per stipulation. Quorum requirement met through manipulation. Minute books are filled up without meeting and signatures from the members are obtained by sending the registers at their homes. At some places fudging of signatures has also been observed.

EFFECTIVENESS

Prohibitory actions – issuance of summons, issuance of search warrants, and punishment for prohibited advertising - are almost absent. Only two offences have been detected in the complete state and no case has been fined, convicted or reported to the medical council. Decoy operations are considered good but never practiced.

There is lack uniformity in determination of jurisdiction between CMHO and Dy. CMHO with respect to managing registrations of clinics and record keeping. Inspections of clinics by AAs are not being done regularly. Though record checking and checking of display board has come out to be most commonly done exercises by the AAs during inspection, investigators have found shortfalls in a lot of cases. Hence, regularity as well as quality of inspection is not up to the mark.

The effectiveness of the implementation machinery in delivering it preventive role is reflected by the fact that 39% of the AAs have admitted that they have not undertaken any awareness generation. Lack financial allocation for awareness programmes has been expressed by AAs as one of the reasons.

There is an absolute absence of result orientedness. This is marked by absence of monitoring indicators as well as targets (admitted by AAs themselves).

CONSTRAINTS

Excessive workload and low priority assigned to the implementation of the Act have been expressed as administrative constraints in delivery by some of the AAs.

Among the functional constraints expressed by AAs were- nexus between the clinics and the political leaders and top decision makers, excessive paperwork and lack knowledge on the legalities of the Act. Also, there is lack of role clarity among the role-holders. At some places, among the CMHOs, Addl. CMHOs and Dy. CMHOs, there is confusion about the jurisdiction of their areas assigned to them.

AC members on the other hand have expressed their preoccupations and poor awareness about the Act as their constraint. This goes as an advantage for the AA to function single-handedly and take centralized decisions. Non-considerate AAs has also been expressed as one of the constraints. NGOs on the other hand have expressed that the machinery lacks commitment.

The appointment of a person from the same fraternity as appropriate authority has been expressed as controversial by the AC members as well as magistrates.

CONCLUSIONS

PCPNDT Act has fallen prey to government apathy. Thanks to the active role of the Judiciary, that at least, AAs are in place though ineffective. ACs and SSB are a mere formality. And records are used to hide the reality instead of revealing the status.

It is not that the Act is difficult to implement in its right spirit in the State. Appropriate provisions are provided which, given a zealous mindset, can bring about desired results. What the government requires is a concern for the declining sex ratio and a desire for revamping the existing machinery involved in the implementation of the Act.

RECOMMENDATIONS

The SSB should pursue its role actively be it regular meeting and reviewing work done by AAs, or coordinating with CSB. It should develop a multidisciplinary knowledge pool and make use of it in improving effectiveness of implementation & monitoring along with helping in overcoming any technico-legal hurdles.

Trainings, workshops and exposure programmes of AAs should be organized so that they are better equipped in socio-legal aspects that affect their functioning. Attitude building workshops should also be organized for them to make them more sensitive and spirited. Result orientation has to be encouraged throughout.

Regularity of meeting of ACs should be strictly considered. Only interested persons who can give time should be inducted after their consent. All the AC members should be trained about the provisions of the Act and their own role as AC member.

The government should consider making AAs at all levels multi-membered. It should push conduction of decoy operations and order the law and order machinery to provide active support to the PCPNDT machinery whenever demanded. It should encourage independent assessment and social auditing of the work done by the AAs. Complain registering system should be simplified; particularly e-complaining should be developed.

NGOs/ CSOs/ PRIs can also play crucial role particularly in awareness generation about the Act and the issue, keeping eye on clinics and pregnant mothers and developing demonstration models.

★★★

CHAPTER 1

INTRODUCTION

Chapter 1
INTRODUCTION

Precision in diagnosis of ailments and medical complaints has been an objective that the medical community seeks to achieve excellence in. The spectrum of diagnostic techniques is getting wider to reach higher levels of early diagnosis. Reproductive technologies for diagnosis prior to birth and prior to conception have been the new breaking grounds in this regard. Advancements in the field of medical technology have been, on occasion, examined and debated on ethical premises and for misuse. Pre-conception and pre-natal diagnostic techniques have been similarly examined.

Pre-natal diagnostic techniques include gynaecological or obstetrical or medical procedures and tests of any pregnant woman. These are conducted to detect genetic and metabolic disorders, chromosomal and congenital abnormalities, haemoglobinopathies and sex linked diseases. Procedures include ultrasonography, foetoscopy and taking or removing samples of amniotic fluid, chorionic villi, blood or any tissue of any pregnant woman. These are sent to a genetic laboratory or clinic for diagnosing abovementioned disorders, diseases and abnormalities.

Pre-conception diagnosis is a step prior to pre-natal. The technique includes the same procedures and additionally involves taking samples of blood or any other tissue or fluid of a man or of a woman before or after conception, for being sent to a genetic laboratory or clinic for conducting any type of analysis before or after conception.

These techniques are also used for sex selection and pre-natal sex determination of foetus. "Sex Selection" is undertaken to ensure or increase the probability that an embryo will be of a particular sex. It includes any procedure, technique, test or administration or prescription or provision of anything for this purpose. Sex determination includes use of techniques for predicting the sex of an unborn child after conception (see text box for techniques).

Female foeticides in India have been attributed to practices of sex selection and pre natal sex determination in favour of a male child. It is projected that the adverse child sex ratio in India is a result of this phenomenon.

The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act (PCPNDT Act) was introduced to provide for the prohibition of sex selection, before or after conception, and for regulation of pre-natal diagnostic techniques for the purpose of gynaecological or obstetrical or medical procedures/tests and for the prevention of their misuse for sex determination leading to female foeticide.

This report is a study of the Status and Effectiveness of Implementation of the PCPNDT Act in the State of Rajasthan. This chapter is in three parts. In the first part, it will present the background to this Act, the problem statement, perspectives on this problem, distribution of the problem, and literature review. In the second part, the PCPNDT Act is introduced. In the lastart, the framework of the study is presented.

Text Box 1

TECHNIQUES FOR SEX SELECTION AND SEX DETERMINATION

Sex Selection

Ericsson Method: *This method involves the separation of X chromosome bearing sperms and Y chromosome bearing sperms through a filtration process. The ovum is then fertilized with a high concentration of the sperm bearing the desired chromosome.*

Pre-implantation Genetic Diagnosis (PGD): *This is a latest technology that has the potential to be used for sex selection. This technique involves removal of a few early divided cells from a test-tube embryo that are then tested directly by chromosomal analysis, and determines sex.*

Sex Determination

Amniocentesis: *It refers to the removal of about 15 cc of amniotic fluid from inside the amniotic sac covering the foetus through a long needle inserted into the abdomen. The amniotic fluid contains foetal cells that are then separated from the amniotic fluid. These cells are either directly observed or are allowed to multiply and taken for chromosomal analysis that determines the sex of the foetus. The former method is less reliable, but usually followed as it is a quicker method.*

Chorionic Villi Biopsy: *It involves the removal of the elongated cells (Villi) of the Chorion (tissue surrounding the foetus) through the cervix. This tissue is then tested for determination of the sex. This new biotechnology enables sex determination between 6th and 13th week hence abortion can be carried out in the first trimester itself. This method is 100% accurate with lesser pain than amniocentesis and only 3% to 5 % risk of bleeding.*

Sonography or Ultrasonics: *The technique uses inaudible sound waves to get a visual image of the foetus on a screen. The technique is normally applied to determine the foetal position or abnormalities. Sex is determined if external genital of a male foetus is seen on the screen.*

Source : Sex Selection and Law by Qudsiya Contractor in Sex Selection – Issues and Concerns, CEHAT

RESEARCH QUESTIONS

The focus of this study is the implementation of the PCPNDT Act. The purview of the Act is to prohibit sex pre selection and determination and regulate diagnostic techniques leading to female foeticide.

Female foeticide is an act in which the sexual identity of an unborn baby is indicated and the parent(s) choose to abort it. There are other social factors such as son preference, status of women in a patriarchal society and practice of dowry system that undeniably contribute to the act. And, at every stage in women's lives, there is a spectrum of violence that begins even before conception. Irrespective of all these views and projection, female foeticide is an act located entirely in the domain of the medical community.

It involves two sets of actions: a pregnant woman (whether or not of her own will) approaching a clinic/place/person offering services for sex determination or pre selection and, on her decision to eliminate the foetus (whether or not of her own free will) approaching a clinic/place/person offering services for abortion. If such services were unavailable, there would be no female foeticide. And, if parent(s) still wanted a choice, they would resort to infanticide that does not require medical intervention. Squarely the act of female foeticide is located in the domain of medical practitioners, qualified or not. The PCPNDT Act focuses on the first step of determination of sex or its pre selection. The second step of aborting the unborn child is covered by the MTP Act. This study examines the following questions in the context of the State of Rajasthan:

- ★ What is the status of implementation of the PCPNDT Act?
- ★ How effectively is it being implemented?
- ★ What steps can be applied to enhance effectiveness?

BACKGROUND TO THE PNDT ACT 1994 (THE PRINCIPAL ACT)

Amniocentesis was used in government institutions in India on an experimental basis to diagnose chromosomal abnormalities. In Delhi, the All India Institute of Medical Science conducted a sample survey of amniocentesis in 1974 to investigate foetal genetic conditions. They enrolled 11,000 pregnant women as volunteers for research. The main interest of volunteers was to know the sex of the child (Patel, 2005). It was found that 90% of volunteers were desirous of aborting the female foetuses on identification of their sex (CEHAT, 2003). In 1978, there was a ban on sex determinations in all government institutions. At the same time private clinics performing sex determination tests and procedures, started emerging and spreading all over northern and north-western India. The first clinic came up in Amritsar in 1979 (National Advocacy Strategy – Draft, 2002). Its advertisement of availability of sex determination tests activised the Press and women's groups to denounce the practice. In 1986, the Government of Maharashtra appointed a committee to examine the issues of sex determination tests and female foeticide. Dr. Sanjeev Kulkarni of the Foundation for Research in Community Health (FRCH) investigated prevalence of this test in Bombay and interviewed 42 gynaecologists. His findings ascertained use of amniocentesis for sex determination. In the following years this issue got highlighted by the print media through investigative reports (Patel, 2005).

In 1985, in Bombay, activists from women's health and people's science groups formed the Forum Against Sex Determination and Sex Pre-Selection (FASDSP). They launched a campaign with a view to preventing sex determination tests. Its objective was to focus on the broader issues of discrimination against girls in all sectors of Indian society and not pass a moral judgement on technology itself. The first challenge was to regulate the practice of sex determination without modifying the MTP Act. This meant formulating a separate legislation and hence the Maharashtra Regulation of Pre-Natal Diagnostic Techniques Act, 1988. Legal regulation in just one state was found ineffective in addressing concerns about sex determination. Besides, efforts on getting the medical profession to self regulate and follow professional ethics were not fruitful. Intensified campaign through the 80s and early 90s led to the formation of legislation, the PNDT Act, 1994, which came into force on January 1, 1996 (CEHAT, 2003).

The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (Amended)

The ineffectiveness of law and the unabated continuation of pre-natal sex determination and sex selective abortions alarmed health activists to take action and lobby for enforcement in the years after the PNDT Act came into force. In response, a public interest litigation (PIL) was filed in the Supreme Court questioning the constitutionality of the PNDT Act. It was filed by the Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai, and the Mahila Sarvangeen Utkarsh Mandal (MASUM), Pune, and Dr. Sabu George. The petitioners contended that techniques such as pre-natal genetic diagnosis (PGD) violated the Act, and sought from the Court directions to the Central and State Governments to implement the Act in full by appointing appropriate authorities and advisory committees at the state and district levels. The Court also directed the Central Government to ensure that the Central Supervisory Board (CSB) that was set up under the Act met every six months. "The Central Supervisory Board had not met regularly and did not review the implementation of the Act", the petitioners stated. The petitioners sought a ban on advertisements relating to all sex selection techniques before or during pregnancy. In response to the petition, the Court issued, on 4th May 2001, notices to the Central and State Governments and Union Territories to file replies and, among other things, to appoint appropriate authorities at district and sub district levels, including advisory committees. Directions stated that the list of members appointed should be published in the print and electronic media. Appropriate Authorities were further directed to send a quarterly report to the Central Supervisory Board. Public awareness against the practice of pre-natal sex determination was also to be created. The petition came up for hearing on April 30, 2002, when the Supreme Court directed State Governments to take further steps to enforce the law. And, the Secretary, Department of Family Welfare of the Central Government was directed to file an affidavit indicating the status of actions taken.

In another order dated 11th December 2001 the Court directed nine companies to supply information of the machines sold to various clinics in the last five years. Details of about 11,200 machines from all these companies were procured, and fed into a common database. Addresses received from the manufacturers were also sent to concerned States and UTs to launch prosecution against those bodies using ultrasound machines that had failed to get them registered under the Act. The Court in its order dated 9th January 2002 directed that ultrasound machines/scanners be sealed and seized if they were being used without registration. Three associations, viz., the Indian Medical Association (IMA), Indian Radiologists' Association (IRA) and the Federation of Obstetrics and Gynaecological Societies of India (FOGSI) were asked to furnish details of members using these machines.

Based on orders/observations of the Supreme Court for activating the implementing machinery, an amended act, the 'Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act 1994 (PCPNDT)' was passed, and is in force from 14th February 2003. With the amendment to the PNDT Act, pre-conception and pre-implantation procedures for sex selections are banned in the country. The amendment stipulates compulsory maintenance of written records by diagnostic centers/doctors offering pre-conception and pre-natal diagnostic services. Local authorities in the states and union territories, such as ministers, secretaries and heads of the health departments have also been given powers to ensure the enforcement of the Act.

LITERATURE REVIEW

In reviewing literature the team came across several studies, papers and articles on female foeticide, sex selection and sex determination. There appear a number of studies and articles on the sex ratio and the child sex ratio in particular. There are regional studies conducted in districts and states in India, examining local socio-economic factors and/or trends. But for a few, most studies examine these issues from a gender perspective.

'Sex Selection - Issues and Concerns' and 'Learning Across Borders - An Information Resource on Adverse Sex Ratio' (draft) were two sources that gave us a bird's eye view of the literature concerning our subject of study and related topics. The former is a collection of papers, articles and news reports. Published by CEHAT, the book chronicles the campaign on the issue and its involvement in the PIL and it examines sex selection in the present context. Most of the contributors are people, organisations and forums that have participated in the campaign against sex determination. The articles and reports cover issues of sex selection and sex determination, female foeticide, low sex ratio, the societal factors and regional dimensions. These have been published during the period 1988-2002. The latter is a draft compendium providing abstracts of research studies, research publications, journal articles and documenting campaigns and interventions on the issue in the country. Information on studies is on occasion incomplete in the compendium (perhaps because it is a draft). The subjects covered are broader and include female infanticide, child mortality, reproductive health of women, reproductive technologies, and violence against women, besides those mentioned above. A number of village studies and regional studies examining local societal factors having a bearing on female foeticide and sex ratio have been quoted. Here, studies examining son preference and other social factors are included. Studies reflecting ground realities are plenty. There are studies that document practices and perception of women, relatives and communities on sex selective abortion, son preference and sex determination. In the early 80s studies on the medical communities and their perceptions were also conducted.

In these two and other literature we scanned/browsed, we did not come across any study dealing with the PCPNDT Act intensively/solitarily. Renowned lawyer Ms. Indira Jaisingh has edited a 'Pre-Conception and Pre-Natal Diagnostic Techniques Act - A User's Guide to the Law'. This is a manual for aiding medical professionals and appropriate authorities to adhere to the provisions of the law stated in the Act. 'The Victimizing Discourse: Sex Determination Technologies and Policy' is an article published in the Economic and Political Weekly (Feb 17, 1996) by Dolly Arora. This paper discusses the inadequacies and loopholes in legislative response and recommends comprehensive review of state policies and programmes. The Act has undergone an amendment since the publication of the article. Versha Deshmukh, a prominent activist on this issue in Mahasrashtra, presented a paper 'On Implementation of PCPNDT Act' at the workshop on PCPNDT Act and Gender Issues in Gwalior in April 2005. The paper largely documents her experience of interventions, working with the authorities implementing the Act in Maharashtra, use of decoys and activism.

Some studies have examined related issues in the context of the PCPNDT Act. Ashish Bose and Mira Shiva conducted a study on Female Foeticide in three districts of Punjab, Haryana and Himachal Pradesh. The study examined census data, perception surveys and household opinion surveys to examine causes for female foeticide. Their findings among other things mention poor awareness of the PNDT Act among the

masses. They have made recommendations for implementation of the Act. A Study of Ultrasound Centres in Maharashtra by Sanjeevanee Mulay and R. Nagarajan, in January 2005 attempted to establish correlation between sex ratio at birth linked to son preference through pre-natal discrimination using ultrasound techniques. In the context of the PCPNDT Act, it examined sonography practitioners/centers against the requisites in the Act for their registration and legal operation and found gaps in implementation of the Act.

Ground realities have been examined by various studies, correlations and linkages have been drawn between sex ratio and female foeticide, son preference and such other factors, comments have been made on reproductive techniques and their misuse for sex determination and sex selection. But we did not find a single study that examines the implementation of the PCPNDT Act. This Act makes provisions that have a direct bearing on regulating the use of the reproductive technologies under scrutiny.

This study gained insights from following studies/reports:

An article by Ravindra R.P., 'Techniques of Femicide: Foetal Sex Determination and Sex Preselection' helped understand technical aspects in sex determination. We relied heavily on Dr. Vibhuti Patel's paper titled, 'Sex Selection and Pre-Birth Elimination of Girl Child' for a comprehensive overview of the events preceding the campaign leading to the framing of the PNDT Act and the gender perspective on the issue of sex determination.

Abortion: 'Laws and Outlaws' is a monograph authored by Dr. S.G. Kabra, a physician, law graduate and academician. It examines socio-economic and medico legal dimensions of abortions; and deals with the issues of sex ratio and female foetal loss in a straight, direct, informative and comprehensive way. The study stands out in terms of the depth of understanding and clarity it provides on medical and legal dimensions. The study takes a view very different from those popularly held by feminist writers and others who base the issue of female foeticide and child sex ratio on gender disparity in the population. This study segregates assumptions from actions, places every issue in the medical, legal context. It has analysed studies linking female foeticide to declining sex ratio and has made a case of how the issue has been distorted. This study has provided comprehensive and clear understanding of issues. Although the study delves into abortion and the MTP Act and just makes a reference to PNDT Act, the report gave this study clarity and a viewpoint to consider that is contrary to the dominant gender perspective.

★★★

CHAPTER 2

METHODOLOGY

Chapter 2
METHODOLOGY

Originality is one of the chief features of this study. In the absence of any reference point for designing and developing the study, ingenuity and intuitiveness of the team were banked upon. The chapter on methodology deals with aspects pertaining to design and layout for the different stages of the study. These are shared explicitly and generously, with the intention of providing the background for the chapters that follow.

2.1. DESIGN OF THE STUDY

The study examines the status and effectiveness of the implementation of the PCPNDT Act, and answers questions on what structures and systems exist and how they function. It also answers what constraints are faced in its implementation. The nature of research questions indicated is an exploratory design.

2.2. PLAN FOR THE STUDY

Review of literature and desk research were undertaken first. The text of the Act was thoroughly read. Secondary information, largely from government sources were collected and screened for preliminary understanding of its implementation in Rajasthan and for understanding the different stakeholders within and outside the structure of the provisions of the Act. Broadly, these determined the key informants and a sample was drawn out.

The crucial concepts in the objectives were first defined and variables were determined for each. These concepts and variables were the pivot points, with which a framework, sources of information, the tools for data collection, analysis and representation of data, and chapterisation were planned. A completely original plan for the study was developed meticulously with a short timeframe as a crucial consideration. Next, a detailed data collection plan was determined. The study being exploratory, the design for data analysis was finalized after data started coming in and the team could assess the feasibility of having reliable information against the different variables. Representation of data through simple tools such as tables was planned for every chapter.

2.3. DEFINITIONS OF CRUCIAL CONCEPTS

1. Status of implementation of the Act

The Act and the Rules provide the operational mechanism to implement the Act. We define these as the structures and systems for implementation of the Act. The structure entails the State Supervisory Board (SSB), the Appropriate Authorities (AAs) and the members of the Advisory Committees (ACs).

The status examines existence of structures and compliance to provisions pertaining to the structures and systems was looked upon as a preliminary condition to assessing effectiveness.

2. **Effectiveness in implementation of the Act**

In this study, effectiveness implies causing specific measurable results that deliver on the intended purpose of the Act. Accordingly, it probes into acts of prohibition, regulation and prevention. Detailed notes of the provisions in the Act and Rules were made against the three aspects. This enabled in developing quantitative measures to assess performance of the implementing machinery (structure).

3. **State of Rajasthan**

32 districts and 105 subdivisions.

4. **Constraints**

Administrative and legal constraints were examined. Administrative implies structural; and functional constraints. Structural are those attributed to the operational provisions in the Act involving different bodies for implementation. Functional imply constraints faced in delivering the roles and responsibilities.

Legal constraints imply the inadequate provisions in the Act that hamper implementation. Besides, loopholes in the Act that impact the implementation are examined.

2.4. INFORMANTS AND SAMPLING

Informants for this study were divided in two categories. One, who were directly responsible in some way to implement the Act. These were officials or persons that have a mention in the Act and Rules, with functions or responsibilities assigned to them or those given any kind of directives.

1. Appropriate Authorities
2. Members of Advisory Committees
3. Chief Judicial Magistrates

The second category comprised interest groups or opinion makers that had an influence in the implementation of this Act.

1. Registered Clinics
2. Elected Representatives
3. Civil Society Organizations and NGOs

The general population, as a category, that avails services for sex determination was eliminated on two grounds: the short time frame of the study and the availability of ample reports projecting public experiences and perceptions on this issue.

Sampling was designed according to the structure for implementation in the State of Rajasthan; at three levels, state, district and sub-division. At all levels, the sample proposed for AAs comprised the total population of 140. The total population for AC was 1096. This was a big figure to accomplish in the given timeframe. At the district and sub-division levels, proposed sampling for the AC comprised 25-30% of total members. Accordingly, three members per district and two members per sub-division was the pattern adopted, with a guideline to interview at least one expert from medical, legal and social background, in each district.

For the three bodies at the state level, samples proposed were more than 50% of total population. Only about 35% of the proposed sample could be covered. The chairpersons for all the three structures were interviewed.

Purposeful sampling was applied for informants outside the purview of the Act. Four registered clinics per district were selected in such a way that two were from the district headquarters and two were from different sub-divisions, so as to get a better understanding about their practices. Three NGOs per district were chosen, one from the district headquarters and two from sub-divisions. Among the elected representatives, the *zila pramukh* from each district, in some cases the municipality chairperson, and two Panchayat Samiti representatives were interviewed. Thirty-two Chief Judicial Magistrates, one per district were proposed in the sample. The study proposed a total sample size of 795 and the team accomplished 98.5% (783) (See tables 2.4.a and 2.4.b).

TABLE 2.4.a. SAMPLES AT STATE LEVEL

No.	Category	Proposed	Accom-plished	Not responded	Remarks
1	State Supervisory Body (SSB)	15	5	1	Key officials except vice-chairper son covered
2	Appropriate Authority	3	1	1	Chairperson covered
3	Advisory Committee	6	3	-	-do-
4	Judiciary	3	-	-	Attempts did not materialize
5	Bar Council Members	4	-	-	-do-
6	Rajasthan Medical Council Members	4	1	-	Chairperson covered
7	Private Medical Practitioners' Association	4	-	-	Attempts did not materialize
8	Chairperson, State Women's Commission	1	-	1	Lack of time expressed
9	Ex-director, FW & and the first Appropriate Authority of the state (2001)	1	-	-	Attempts did not materialize
10	Representatives of Women's Organisations	4	4	-	-
11	Lawyers of Global Rights Network	8	5	-	-
	TOTAL	**53**	**19**	**3**	

TABLE 2.4.b. SAMPLES AT DISTRICT AND SUB-DIVISION LEVELS

No.	Category	Proposed	Accom-plished	Remarks
1	Appropriate Authority - District	32	31	One CMHO could not be interviewed as he was on leave.
2	Appropriate Authority -Sub-division	105	98	a. Jaipur District has reduced its sub-divisions from 7 to 5. Thus total sub-divisions are now 103. b. Two positions remain vacant c. Not interviewed - 3
5	Advisory Committee Members - District	96	93	-
6	Advisory Committee Members – Sub-division	210	206	-
7	Registered Clinics 128	142	-	
8	Judicial/Metropolitan Magistrates	32	22	a. Seven could not spare time due to work pressure. b. Three refused to give interview.
9	Elected Representatives	96	97	-
10	Civil Society Members	96	94	-
	TOTAL	**795**	**783**	

2.5. DATA COLLECTION

On examining the Act and Rules and the objectives of the study, a list of subjects and questions were made that needed to be answered. These were segregated into close-ended or open-ended questions. Source(s) of information were identified for each. Accordingly they were incorporated into structured questionnaires and guides. The tools, techniques and plan for data collection were developed by the research team.

Techniques and tools

The study combined quantitative and qualitative techniques for data collection. Chief concepts in the objectives were defined and indicators were developed for each of them. The tools for data collection were designed based on this.

Three types of tools for data collection were used, viz.,

1. Interview guides;
2. Structured questionnaire; and
3. Structured field observations.

Tools for the structure

Basic questions assessing status and effectiveness of the implementing machinery were framed. One questionnaire and two interview guides were developed from these for the category belonging to the

structure. On the basis of variations in functions and responsibilities, the interview guides were edited for respondents at different levels among the SSB, AAs and ACs and 8 interview guides were developed. While the questionnaire had only quantitative responses, the interview guides had quantitative and qualitative responses.

The Judicial/Metropolitan magistrates were asked for records of cases to assess effectiveness of the Act and for their views on certain judicial aspects.

Tools for the stakeholders

For the stakeholders, some common questions were retained to document the perceptions and views of a cross section. The Indian Medical Council Act and the State Women's Policy were examined to phrase questions probing into their respective roles.

For the registered clinics, as an important interest group, an intensive interview guide was developed. It comprised open and close-ended questions and elements of structured field observation. The object of this tool was to corroborate the responses of the implementing structures on aspects of effectiveness. There were 7 interview guides developed for 6 groups in the category of stakeholders.

Thus, depending on the objective of interviewing a particular respondent and their role, elements of qualitative and quantitative data and structured observation were incorporated.

The plan

A placement agency specializing in providing human resources to research institutes was contacted for field investigators. The eligibility criterion was an experience of 3-5 years in data collection. Since this study demanded eliciting response from government officials and political leaders, the investigators were also expected to have experience in interacting with such people and use interview guide to gather information. After screening their resumes and interviews, a team of 12 investigators was selected.

The investigators were intensively trained in the provisions of the Act, the administration of tools and skills in interviewing for five days. After pre testing the tools, another day of orientation followed to address bottlenecks and revise the tools. The team was then divided into four sub-groups to cover seven divisions. Out of these three sub-groups covered two divisions each while one group covered one division, which was the largest among all. When the investigators went into the field for data collection they were thoroughly familiar with the requirements of the Act. The investigators used both questionnaires and interview guides to collect information. A team of four senior professionals was assigned the task of supervising and monitoring the teams. The monitoring team visited all the districts during data collection and back-checked the schedules to ensure accurate data. Each team member also had to maintain a daily diary. After completion of one district each team recorded the number of interviews conducted and also cited reasons wherever the interviews fell short of the proposed number. The state level officials were interviewed by research officer.

2.6. TECHNIQUES OF ANALYSIS

It was ensured that the questionnaires were internally consistent. A basic tabulation plan was developed. The filled in questionnaires were checked for errors in skip patterns and other inconsistencies that came in

during the field data collection. Responses to different items were compiled together in order to get general idea as to what types of responses have been elicited. The same were then distributed into different categories and unique codes were assigned to every category of the responses.

After this, the computerized data entry package was created using the database application MS Access and training was conducted for data entry clerks to train them for data entry. Data from filled questionnaires were keyed in to the software application.

In the next step, cleaning of the data entered into the computer was done so as to eliminate any error, which might have crept in due to incorrect entries at the time of data entry operation, for example the dataset was checked for responses to those items which are linked to responses to other items in some way so that there is no discrepancy between the two. A few questionnaires and interview guides were randomly selected and re-entered by different person to verify the information entered by the data entry clerks. As the last step in processing, the dataset was exported to SPSS format to make it ready to be used for analysis and generation of tabulations. After the tables were ready for data interpretation, cross tabulation was examined to once again check for inconsistencies, which were sorted out and corrections were made in the final exhibits.

2.7. CONSTRAINTS AND LIMITATIONS

The research team faced several challenges – first and foremost being the strict time frame given. To finish such a comprehensive study within a short period of six months was a task that demanded meticulous planning, organizing and efficient and well-coordinated team work. This challenge was met by extended working hours and stretching out to adverse situations. The team was one in being uncompromising on the quality of the study and unreasonable in delivering within the timeframe committed to.

Instances of schedules getting changed due to last minute cancellation of interviews by interviewees were a handicap. This has adversely affected the sampling size at the state level. Many of the interviewees were found to be fresh in their respective roles and had no idea about the PCPNDT implementation. Also, there was a tendency of diverting the research team to the State Appropriate Authority by other top officials. These two factors proved deterrents to discern different perceptions on the Act and responses on its implementation.

At the field level, the team had to face some uncooperative officials and clinics that either behaved rudely or criticized the Act as another waste of legislative piece. Getting data from such people was cumbersome.

Overall data collection process was tedious because of the poor record keeping and maintenance at the district and subdivision levels. On some occasions, interviews had to be held with supporting staff of the AAs. The team also faced confusion about AAs' jurisdiction at the district and subdivision levels. Records provided thus had to be double-checked with the state level machinery. In instances where there was no reliable source to corroborate such data, it was decided to eliminate those aspects of the study, rather than present unreliable data. Some valuable aspects of the study were lost in this process.

The questionnaires were open-ended, and invited enormous qualifying data from the field. These had to be systematically processed and organized, task of which was both time consuming and challenging. In the

process, the team could not incorporate some verbatim responses as qualitative data for elucidating some of viewpoints and observations of the respondents. This gap is clearly visible in the presentation of the chapter on constraints.

2.8. TIME FRAME

The time frame for the study was six months, effective 20th June 2005. The first two months were utilized for literature review. After a thorough study of the Act and Rules were done, the plan for the study was developed in August. Data collection was undertaken between September and October. Report writing and data analysis was initiated simultaneously.

2.9. THE REPORT

This report is structured along the lines of the objectives of the study. Chapter 3 examines the status of implementation of the Act in terms of the structure and systems for implementation provided therein. Chapter 4 presents the effectiveness in its implementation mainly in terms of prohibition and regulation. Chapter 5 compiles the various constraints experienced by the implementers and those viewed by the stakeholders. Chapter 6 summarizes the findings. And, Chapter 7 provides conclusions and recommendations. References, data collection tools, list of respondents, additional tables and documents are attached as annexes at the end of the report.

★★★

CHAPTER 3

STATUS OF IMPLEMENTATION

Chapter 3

STATUS OF IMPLEMENTATION

The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 - PNDT Act - provides for constituting a central supervisory board to exercise the powers and perform the functions conferred under chapter IV. Chapter V of the Act provides for appointing one or more appropriate authorities for the whole or part of the state for the purposes of the Act, having regard to the intensity of the problem of pre-natal sex determination leading to female foeticide. And, it also provides for constituting an advisory committee for each appropriate authority.

The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act (amended) - PCPNDT Act - further provides for constituting a supervisory board in each state and union territory (Chapter IV, Section 16A). It also provides for appointment of a multi-member, state or union territory appropriate authority (Chapter V, Section 17) based on the same pattern presented above.

Although the PNDT Act 1994, (now known as the Principal Act), was enforced in the whole country from 1st of January, 1996 the Government of Rajasthan appointed these implementing structures only after the Supreme Court issuing an Order to the State to implement the Act forthwith.

In compliance with the Supreme Court Order, the Government of Rajasthan promulgated several orders appointing single-member appropriate authority (AA) and eight-member advisory committee (AC) for each AA at the sub-division, district and state level. Appointments of these structures had to be filed by the government through an affidavit as directed by the Supreme Court then. Sequences of these events are:

★ The Supreme Court Order dated 4th May 2001 directs the State Government to appoint, by notification, fully empowered appropriate authority and advisory committee at district and sub-division levels and report to the Court on or before 30th July 2001.

★ The State Government, by notification, appoints 32 CMHOs as district appropriate authorities and 105 sub-division appropriate authorities (32 Additional CMHOs from the Department of Family Welfare and 73 Deputy CMHOs from the Department of Health) covering the entire State on 16th June 2001. Similarly, it appoints eight-member advisory committees in these districts and sub-divisions on 16th June 2001.

★ The Government also appoints a single-member appropriate authority (Director, Family Welfare) at the State level on 25th July 2001. The same day it appoints the eight-member advisory committee at the State level.

While the government was able to appoint its own officers as appropriate authorities quickly it was unable to put in place the advisory committees within the stipulated period. The affidavit submitted to the Supreme Court thus did not include the advisory committees. This non-compliance was brought to the notice of the

government by the Court on 19th September 2001 and it was given directions to do the needful within six weeks or face consequences. The government structured these committees by identifying required expertise from medical and social work background. Accordingly, names of these persons on the committees at district and sub-division levels were declared on 7th January 2002 and 17th January 2002 respectively. Such a process was however carried out at the state level on 19th January 2003.

In response to the enforcement of the amended Act (PCPNDT Act), effective 14th February, 2003 the State Government constituted a State Supervisory Board (SSB) and changed the single-member body of Appropriate Authority at the State level into a multi-member body of three members on 1st July, 2003. However, nomination of members to both these structures took place on 25th July 2003. (Source: Government of Rajasthan orders)

This chapter projects the status of implementation of these structures and systems vis-à-vis the PCPNDT Act and PNDT Rules, 1996 in the State of Rajasthan. In the structures, it examines the constitution, representation, and membership. It also examines the compliance with the provisions, and the practices applied by the government to fulfil the requirements of the Act.

3.1. STATUS OF STRUCTURES

The Act is required to be implemented through effective coordination between the State and the Center. At the Central level, there exists one overseeing body called the Central Supervisory Board (CSB) and a coordinating department for PNDT implementation under the Ministry of Health and Family Welfare. While the CSB functions chiefly as an advisory body to the Government of India, the PNDT department coordinates and directs the concerned authorities of the State Governments to implement the Act effectively.

In Rajasthan the State Government has constituted a three-tier structure, viz., the State Supervisory Board (SSB), a State Appropriate Authority (multi-member body) and single-member body of Appropriate Authorities at the district and sub-division levels. It has also constituted the eight-member body of Advisory Committees at each of these levels.

Structure for implementation of the PCPNDT Act

At the Central level, the CSB and the PNDT department are responsible to implement the Supreme Court directions and the Act in full spirit throughout the country. In the State the existing structures are expected to implement this spirit in coordination with the Center. Accordingly, the Government of Rajasthan has the state supervisory board to supervise and oversee the implementation process, the appropriate authorities to exercise their powers through direct implementation, and the advisory committees to facilitate and guide the appropriate authorities in their overall activities in respective areas.

The status of these structures and the existing situation at each level are analyzed in the following pages:

The Central Supervisory Board (CSB)

The CSB being a policy making body, the Act makes provision for inclusion of government officials, specialists as well as representatives of welfare organizations in this board.

Constitution : Chapter IV, Section 7 of the Act provides for constituting this board comprised of 24 members. This was already suggested in the Principal Act, and is in force from 1st January 1996.

Exhibit 1. STRUCTURE OF THE CSB

Composition	Position
1. Government of India Representation	
Minister in-charge, Health or Family Welfare	Chairperson, ex-officio
Secretary, Deptt. of Family Welfare	Vice-chairperson, ex-officio
2 Representatives from Ministries:	
Deptt. of Women & Child Development	Member, ex-officio
Deptt. of Legal Affairs or Deptt. of Legislative Affairs	Member, ex-officio
Deptt. of Indian System of Medicine & Homeopathy	Member, ex-officio
Director General of Health Services	Member, ex-officio
3. Appointees by the Government of India (2 each from the following categories)	
Eminent medical geneticists	Members
Eminent gynaecologist & obstetrician or expert stri-roga or prasuti-tantra	Members
Eminent paediatricians	Members
Eminent social scientists	Members
Representatives of women welfare organisations	Members
4. Nominations from the Parliament	
Two women MPs from the House of People.	Members
One woman MP from the Council of States.	Member
5. State/Union Territory Representation (Appointed by the Government of India on recommendations of the State/Union Territory – rotational basis)	
Two members from the States (Alphabetical and reverse alphabetical order)	Members
Two members from the Union Territories (Alphabetical & reverse alphabetical order)	Members
5. Administrative appointment by the Government of India	
One officer with the rank of Joint Secretary or above from the Deptt. of Family Welfare	Member-secretary, ex-officio

Source: PNDT Act, 1994

The above is presented here to introduce this body at the Centre as it ensures proper implementation of the Act in the State. It is provided for reference only, and is outside the scope of this study for analysis.

The State Supervisory Board (SSB)

The SSB being the most important structure in the State the Act makes provision for inclusion of various role holders and expertise, and make it a large multi-member body.

Constitution : Chapter IV, Section 16A of the amended Act provides for constituting SSBs in each State and Union Territory. In Rajasthan there exists the SSB comprised of 21 members. The constitution of the board is as follows:

Exhibit 2. STRUCTURE OF THE SSB

Composition	Position
1. **Government of Rajasthan Representation**	
Minister in-charge, Health and Family Welfare	Chairperson, ex-officio
Secretary, Deptt. Of Health and Family Welfare	Vice-chairperson, ex-officio
Secretaries or Commissioners or their representatives:	
Deptt. of Women & Child Development	Member, ex-officio
Deptt. of Social Welfare	Member, ex-officio
Deptt. of Indian System of Medicine & Homeopathy	Member, ex-officio
Deptt. of Law	Member, ex-officio
Director of Health and Family Welfare or Indian System of Medicine & Homeopathy	Member, ex-officio
2. Nominations by the State Assembly	
Three Women MLAs	Members
3. Appointees by the State Government (Two each from the following categories)	Members
Eminent social scientists and legal experts	Members
Eminent women activists from NGOs or otherwise	Members
Eminent gynaecologists and obstetricians or experts of ***stri-roga*** or ***prasuti tantra***	Members
Eminent paediatricians or medical geneticists	Members
Eminent radiologists or sonologists	Members
4. Administrative Appointment by the State Government	
One officer with the rank of Joint Director in charge of family welfare	Member-secretary, ex-officio

Source: PCPNDT Act, 1994 (amended)

The Appropriate Authority (AA)

State level

Constitution: Chapter 5, Section 17, provides for one or more AA for the whole or part of the State. This provision existed in the PNDT Act 1994. This provision was amended later and provides for multi-member AA in the State.

Exhibit 3. STRUCTURE OF THE STATE AA

Composition	Position
1. State Government Representation	
An officer of or above the rank of the Joint Director of Health and Family Welfare	Chairperson
2. NGO Appointee	
An eminent woman activist representing women's organization	Member
3. Legal Appointee	
An officer of Law Department of the State or the Union Territory concerned	Member

Source: PCPNDT Act, 1994 (amended)

The AA at the state heads all the AAs at the district level and subdivisions. Thus the role of state AA encompasses supervision and monitoring of the subordinates, with little or no direct involvement in execution of functions of AA provided in the Act. However this body, especially the chairperson is instrumental in framing relevant instructions for the other AAs in district and subdivisions. The state AA also liaisons with allied institutions like State Women Commission (SWC), Rajasthan Medical Council (RMC) and similar bodies to ensure effective implementation.

District & sub-division

Constitution : The Act also provides that the State Government appoints its officials such as chief medical officer or civil surgeons at the district level. In Rajasthan these appointments have been conferred upon Chief Medical Health Officers (CMHOs) and Additional CMHOs/Deputy CMHOs at the district and sub-division respectively.

The Advisory Committee (AC)

Constitution : Chapter V, Section 17 again provides for constituting one advisory committee at state, district and sub-division levels. This provision had also existed in the PNDT Act 1994.

Exhibit 4. STRUCTURE OF THE ADVISORY COMMITTEE

Composition	Position
1. Medical Expertise (Three experts from the following areas)	
Gynaecologists	Members
Obstetricians	
Pediatricians	
Geneticists	
2. Legal Expertise	
One legal expert	Member
3. Communications Expertise	
One information and publicity officer of the Govt.	Member
4. Social Work Expertise	
Two eminent social workers	Members
One representative from women's organisation	Member

Source: PCPNDT Act, 1994 (amended)

* *The appropriate authority attends the AC meetings, and provides all logistics and secretarial assistance to the AC.*

** *The chairperson of the AC will be appointed by the State Government.*

3.1.1. EXISTENCE OF STRUCTURES

A. Structure

Information on existence of structures was collected from government records and through field investigation. Government of Rajasthan notifications project that there are three bodies at the state level and one AA for each of the 32 districts and 105 sub-divisions. There is one AC for each AA. This data shows 100% compliance at all levels.

The research team, during field investigation, found that there was 100% compliance vis-à-vis the AAs at the state, district and sub-division levels. However, with respect to the SSB and Advisory Committees, some discrepancies were found.

The SSB has not had a single meeting of the body ever since it was constituted. According to a top government official, meetings are not taking place due to pre-occupations of the members. The NGO representative on the body said that she had been requesting the concerned authority to hold meetings, but in vain. The research team found that generally members lack knowledge about the provisions of the Act or the role of SSB. Discussions with other selected members of the SSB revealed that they were not well acquainted with their roles on the board. Some stated this upfront. In the interviews some members expressed deep concerns about the declining sex ratio and female foeticide. The vice chairperson and the member-secretary of the board expressed the importance of the Act and felt it quite comprehensive.

The Chairperson of the board expressed that the political will of the State Government was strong to tackle the issue of sex determination tests. He said that his department is very serious about the problem and will resort to rigorous punishment on erring officials. When asked to substantiate this statement with activities carried out, he elaborated on the government schemes and subsidies for education of the girl child in the state. Educating girls according to him was the main remedy. There was general agreement that a body such as the SSB could play a pivotal role in the overall context of the implementation of the Act. But, they were silent on the basic tenets and principles of the board. It appeared that the sole responsibility of the implementation of the Act was of the State Appropriate Authority.

The SSB as a structure exists in Rajasthan. On closely examining these qualitative responses and the fact that none of the functions assigned to it have been undertaken, it is thus concluded that compliance to provision for structure is missing in essence.

The situation is peculiar with respect to the ACs. The Act provides for an eight-member advisory committee, comprising of a gynaecologist, a paediatrician, a geneticist, three social workers (one being a representative of women's organisation), a legal expert and an Information and Publicity Officer of the State Government. They are expected to advise the appropriate authority on medical, social and legal aspects. The positions of gynaecologists and paediatricians and information and publicity officers are government positions and hence permanent. Geneticist, three social workers and legal experts are nominated by the government for a period of three years by a notification. At the state level, the government has made the legal expert as its own ex-officio, making this position permanent unlike the district/sub-division levels.

According to sources in the government, having such experts in all the districts and sub-divisions of the state was not possible. To fulfill the Supreme Court directive, advisory committees were constituted with eight members each. It is to be noted here that the ACs at the district and sub-division levels were appointed on 16 June 2001 and members nominated on 25th July 2001 at the state level. On 7th January 2002, district level nominations of members from outside the government machinery took place. Similarly, on 17th January 2002 in the sub-divisions, and 19th January 2003 at the state level. If one goes by the Advisory Committee rules 1996, sub-rule (3), the term of nominated members from outside was over by January 2005. State Advisory Committee has been appointed on 19 January 2003 and it continues. According to field level information, the government seems to have asked the AAs to recommend names of prospective members to nominate them on new committees in the month of May and June 2005. Nevertheless, there are no new committees formed officially.

Among the AAs, the confusion about forming the advisory committees was seen at the district and subdivisions. Some AAs were under the impression that names of the members are finalized at the state level and they are being sent to the authorities at the district and subdivision. The state AA was of the opinion that nominations for the post of social workers, geneticist and legal expert are to be recommended by the AAs, which are sent to the Secretariat for finalization. From the responses of AAs at the district and sub-division levels, we have found three prevailing conditions, viz.,

1. Where old committees continued functioning.

2. Where nominated names of members that were recommended have been construed as constituted by the AAs without any official approval. These are referred to as new committees and have started functioning.

3. There are no committees functioning as of now since there is no clarity on the status of the AC.

Table 3.1.a. POSITIONING OF THE ADVISORY COMMITTEES (BASE: OCTOBER 2005)

Levels	Old committee	New committee	Absence of committee	No response	Total
District	23	7	0	1	31
Sub-division	75	16	3	4	98
Total	**98**	**23**	**3**	**5**	**129**

In 98 bodies, old committees are operating, in 23 bodies there are new committees and in three cases no committees exist and five of them gave no response. However no such confusions at the state level, since the term of the AC will be over in July 2006.

To sum, there exists 100% compliance at all 3 levels in terms of existence of structure if one goes by the government records. In essence complete compliance can be attributed only to the AAs and AC at state level.

B. Membership

Each body interviewed was asked for its composition. This was supplemented with data from the government records. The SSB has a 21-member body. The AA at the state has a three-member body and the rest are comprised of one-member AAs. With respect to the requisite eight members on ACs, we have found discrepancies in the government records, and between government records and field investigation.

The government records show every body having requisite number of members and therefore 100% compliance among the bodies for fulfilling the membership criteria.

While analyzing government records we came across records of AC members representing the position of Geneticist on multiple committees. Ideally, the state should have one geneticist per advisory committee, i.e. 137 Geneticists. These records show 46 members in effect as members representing on this position. Nineteen such members are on one committee each. The rest 27 are on more than one committee. These 27 names appear repeatedly on different committees. Table 3.1.b. gives a break up of these 27 members against the number of committees they represent.

Table 3.1.b. MULTIPLIED REPRESENTATION OF GENETICISTS (base: October 2005)

Memberrship on number of committees	2	3	4	5	6	7	8	9	10	11
Number of members representing geneticists	5	8	5	2	2	2	1	0	1	1

Source: Government Notifications dated 7th and 17th January 2002

Similar is the case of information and publicity officers (IPOs), who hold positions at the district level. There are no IPOs at sub-division level. The IPO or his representative is supposed to be a member of AC at district and sub-division. First, every district is supposed to have only one post of IPO. Two, there is paucity of IPO in the government structure and the chances of their representative to be the member of the AC and attend the sub-divisional meetings seem to be dim.

While interviewing a senior gynaecologist, who is the chairperson of the state advisory committee on her role, she expressed ignorance about her membership on the committee. She has assumed the post of sr. gynaecologist, since January 2004, but as of now has not attended any meetings of the committee. She said that her predecessor may have been aware of such a role. This response is quoted to throw light on the aspect of compliance to provision of membership in existence and in essence.

C. REPRESENTATION

The State Supervisory Board

Representation of members on the SSB is determined so as to derive their expertise for implementation of the Act. Table 4, annex 4 describes the representation for each member on the board. In this section we examine the compliance of representation.

With respect to representation of social workers, it is doubtful. The Act has a provision to include two women social workers from the NGO community. The government has appointed only one-woman representative from an NGO and the other appointment has gone to a Reader from the Political Science department of the Rajasthan University. The latter being identified as an NGO or an activist, does not comply with the provision. Hence, of the two women activists from the NGO community, only one is appropriately represented.

On the face of it there is compliance. On close examination of the composition of members, it is found that majority of the members identified are directly from government departments and other institutions supported by the government. Also, the body is bereft of a geneticist whose role is crucial in the overall context of the implementation of the Act.

The Appropriate Authority

Appropriate Authorities are the empowered CMHOs, Additional CMHOs/ Deputy CMHOs at two levels (districts and sub-divisions) who should be performing the most important role in the implementation structure. At the state level, the Director, Department of Health and Family Welfare, was appointed as the AA in the beginning. With the amendment of the Act, this single member body was replaced by a three-member body comprising of a social worker from a woman's organisation and a legal officer of the government, under the chairpersonship of the Director, Department of Family Welfare. In examining the compliance to representation in this regard, the team observed that this requirement is complied with at the district and sub-division levels. But in the state level the composition does not strictly adhere to the criteria mentioned in the Act. For example the provisions of introducing a woman representative from a women's organisation, in the multi-member AA intended to make it more efficient. However, the member nominated for the said post hails from the Indian Red Cross Society, which is not a women's organisation. To clarify this doubt the research team sought an interview with her and also sent a letter, but the response wasn't forthcoming.

The Advisory Committee

The representation of experts on the AC was assessed primarily through field investigation and supplemented with analysis of government records. AAs were asked for the list of members in their respective ACs. Table 3.1.c. depicts data collected from the AAs at the state, 31 districts and 98 sub-divisions. There should be as many experts as per the provision. But in reality there is no compliance.

Table 3.1.c. COMPLIANCE OF REPRESENTATION: ADVISORY COMMITTEE (base: October 2005)

Esperts	State	District	Sub-division
Sr. Gynaecologist/Obstetrician	1	12	31
Sr. Child Specialist	1	12	29
Medical Geneticist	0	29	73
Legal Expert	1	26	75
Officer – Deptt. of Information & Publicity	1	2	8
Social worker representing women's organisation	1	27	84
Social Worker	1	27	87
Social worker	1	25	79

The research team found that gynecologists and paediatricians on advisory committees were largely drawn from a centrally sponsored Post-Partum programme. This programme was discontinued in 2004 and these posts fell vacant. These positions have not been filled thereafter. Along with the information and publicity officers, these two experts have the least representation. Social Workers and legal experts appear to be the only experts fairly well represented on the ACs.

It was reported that in Rajasthan there are no medical geneticists. The government took a decision to nominate pathologists in place of geneticists. According to the member secretary on the SSB, a part of the curriculum of pathologists includes the subject, 'Pre-conception and pre-natal chromosomal studies'. Table 3.1.d. presents data from government records of the number of people occupying the post of medical geneticist in terms of their qualifications or positions held in the government. The post of geneticist in the state AC also goes to a doctor from the Pathology Department, SMS Hospital.

It appears a sensible decision on part of the administration to have this post filled up by those closest in their ability to fill the post of geneticist. On examining the profile of members occupying this post, the team is unconvinced about the ability of a microbiologist, surgeon, and officials from diverse government departments and diverse professional backgrounds such as jurists and lecturers in biology to be able to fulfill the requirement of a geneticist.

Table: 3.1.d. SUBSTITUTES FOR GENETICIST (base: October 2005)

Qualifications /Posts	Persons
Pathologist	26
Microbiologist	1
Surgeon	1
Medical Officer, P.H.C.	5
Medical Officer, Blood Bank	1
Medical Officer, T.B. Hospital	1
Medical Officer, Principal Medical Officer's Office	1
Medical Officer, B. Hospital	1
Medical Officer, (MD), Govt. Hospital	1
Anatomist	3
Medical Jurist	1
College Lecturers (Biology)	4
Total	**46**

Source: Niramaya, Health and Family Welfare Magazine, Volume 39 published by IEC Bureau; Medical, Health and Family Welfare Directorate, Rajasthan, Jaipur.

3. 2. STATUS OF SYSTEMS

Along with provisions in the Act and Rules, systems for implementation of the Act are being directed by the State AA through official memoranda from time to time. They are being sent directly to all the appropriate authorities individually. The directives include necessity of reporting on time, conducting AC meetings, surprise visits to clinics and punitive measures to be applied on clinics, which tend to violate the Act and Rules. The research team collected data/records from the three-tier AA and analysed them. The findings are presented below:

3.2.1. SYSTEMS OF REPORTING AT STATE, DISTRICT AND SUB-DIVISION LEVEL

Under Section 16 A in the PCPNDT Act, there is a mention of sending 'consolidated reports' of various activities undertaken in the State to the Central Supervisory Board and the Central Government.

The research team collected data/records from the offices of the AA at all levels. The records from office of State AA indicate that they have been sending quarterly reports to the PNDT Director since January 2001. The team collected these quarterly reports from January 2001 till September 2005 and found that every quarterly report had been sent. The AAs at the district and sub-division were asked about the frequency at which they send their reports. Their response, however, was not verified against documents. Table 3.2.a. assesses regularity in reporting at these three levels.

Table 3.2.a. REGULARITY IN REPORTING (base: October 2005)

Quarterly reports	Regularity
SSB to CSB	0
State AA to PNDT Director	1
AA District to AA State	23
AA sub-division to AA district	70

There has been no reporting from SSB to CSB, ever since the SSB was constituted. The State AA sends its reports to the PNDT Director. The State AA has been sending quarterly reports regularly since January 2001. This implies that every quarterly report has been sent to the Center. They, however, have not adhered to the requirement of following the proposed dates for sending reports. The figures at the district, 23 (74%) and sub-division levels, 70 (71%) indicate that the periodicity of reporting is irregular at these levels.

3.2.2. SYSTEM OF RECORD KEEPING

The assessment of compliance to record keeping is based on responses from AAs at the three levels. The research team sought to verify the records at all levels. At the state, the team procured minutes of two meetings from the four conducted. For the rest, the documents were verified from some AAs. The table represents the responses of the respondents. The field observations about record keeping are elaborated underneath.

Table 3.2.b. COMPLIANCE OF RECORD KEEPING (base: October 2005)

Records	State	District	Sub-division
Maintaining minute books	1	24	68
Permanent record of applications for grant of registration	-	25	63
Permanent record of application for renewal (Form H)	-	24	53
Permanent record of letters of intimation	-	23	49
Permanent record of expenditure	1	31	98

The state AA has reported of maintaining minute books for each of its 4 meetings with the state advisory committee. It is 77% (24) and 69% (68) at the district and sub-division levels. AAs at all levels maintain permanent record of expenditure. For the other records, the compliance of AA at district level is between 74% (23) - 81% (25) and it is between 50% (49) - 64% (63) at the sub-divisions. Accounts were maintained at all levels. Between the district and sub-divisions, the former have a better record.

3.2.3. SYSTEM OF COORDINATION WITH THE ADVISORY COMMITTEE

Regularity of meetings of AA with the Advisory Committee

The Act provides that duration between two meetings should not exceed 60 days. The rules state the quorum comprises of 4 members.

The research team enquired for the dates for the last 6 meetings with the AA and AC at the district and sub-division levels. Irrespective of the regularity, the team asked them for the quorum in each of the 6 meetings. 31 AAs at the district and 98 at the sub-division levels and 93 AC members in the district and 206 in the sub-divisions were interviewed. The compliance to the requirement for regular meetings was derived from their responses.

Table 3.2.c. REGULARITY OF MEETINGS BETWEEN AA AND AC (base: October 2005)

Structures	Regularity reported by AA	Regularity reported by AC
State AA	0	-
Dist AA	7 / 31	14 /93
Sub-division - AA	19/98	39/206

The state has had four meetings since its constitution. As far as regularity, the response of the AA was in the negative. The AC on the other hand, was unable to provide any data. Seven AAs (23%) at the district levels and 19 (19%) at sub-division level have complied with the requirement for meetings. The advisory committees in the same districts and sub-divisions reported only 15% and 19% respectively. The responses of the AAs and ACs in the sub-divisions match. There is a slight difference in the responses between district AA and ACs. Regularity in meetings is between 15-31% among the districts and sub-divisions, which is not an encouraging record and, they are absent at the state level.

The AAs were asked to provide dates for the last six meetings and the number of members attending them. The total number of meetings for which more than four members were present was tabulated and the percentage was derived from the total number of meetings. From this the per cent compliance to quorum was arrived at.

Table 3.2.d. COMPLIANCE TO QUORUM (base: October 2005)

Structures	State AA	District AA	Sub-division AA
Quorum maintained in meetings	**4/4**	**70/91**	**152/213**

The figures are impressive although there is 100% compliance only at state level. At the district and sub-division levels, it is above 70% of times. Although the attendance taken during the meetings reflect that a quorum is always maintained, but one of the members of the state AC reported that he was not aware of the meetings, nor the meetings took any decision.

Elucidating on the practices of meetings with the AAs, some AC members had the following responses:

- ★ Many members do not come for meetings, as they are not interested or not motivated.
- ★ For getting formalities completed, like four members are needed to grant registration to a clinic. When applications are to be considered for registration, no deliberations take place. The minute books are written and signatures are obtained from the member concerned from their home/office.
- ★ Forty-three public prosecutors said that they had never attended the meetings of AC because the court timings clashed.

Some AAs complained about social workers on the committees who were political leaders, whom the former could not fully trust with their intentions or their time commitments. In the case of members on multiple committees we question the feasibility of their capacity to deliver on their responsibilities. In effect, most of the quorums are quorums on paper.

FINDINGS

Status of Structures

There exists 100 % compliance among all three requisite bodies, the SSB, AA and AC in terms of existence of structure if one goes by the government records. In essence complete compliance can be attributed only to the AAs and the AC at state level.

The State Supervisory Board (SSB)

SSB has the requisite 21-member composition.

It is not functioning since its constitution.

The body is bereft of a geneticist whose role is crucial in the overall context of the implementation of the Act.

Of the two women activists from the NGO community, only one is appropriately represented.

The Appropriate Authority

There is compliance among the AAs with respect to the requisite structure and members.

Representation is also complied with but only at the district and subdivision levels. At the state level, among the three-member body, the provision for 'a woman representative from a woman's organisation' is not complied with.

The Advisory Committee

The status of this structure is dismal.

At the time of the study, the advisory committees at the district and sub-division levels were in a state of limbo.

There is not a single geneticist represented.

Those filling in for this post are only 27 when the requirement is for 137.

The profiles of those occupying the post of geneticists seem unlikely to contribute to the role.

There is a general paucity of experts, especially the gynaecologists, paediatricians, those representing on the post of geneticists and information and publicity officers.

Those representing geneticists and the information and publicity officers are on multiple committees.

Status of Systems

Reporting :

Reporting from State to Centre is regular from state AA to PNDT Director. There are no reports from SSB to CSB.

At district and sub-division levels, periodicity of reporting is irregular and between 71-74%.

Record keeping :

AAs at all levels comply with maintaining permanent record of expenditure.

Minute books are maintained with 100% compliance only at state level. For the rest it is between 69-77%.

Other permanent records pertaining to applications for registration and letter of intimation, the compliance is between 74-81% at district level and 50-64% at sub-division.

The district level AAs have a better record of record keeping as against the sub-division AA.

Coordination with Advisory Committee:

Coordination between AA and AC in terms of regular meetings as per provisions, across all three levels is irregular. There was also discrepancy in the records given by AAs and those by ACs in terms of compliance for regular meetings.

The record of compliance to quorums is very impressive in figures, but experiences of AC members that they have shared with the team leave scope for doubt in this regard.

Systems of reporting and record keeping were found weaker at the sub-division level.

ANALYSIS

The structure provides the base for the implementation of the Act. In Rajasthan, in the government records the structure seems full, complete and in place. In essence and on being a bit liberal, compliance to structure exists only for the AAs. Although, the AA is the main body responsible for implementation of the Act, but the SSB and the ACs have crucial roles too.

The SSB is the most important structure in the State. It comprises members who bring in expertise pertaining to law, medicine, social intervention, administration and public representation. This body can thus guide implementation, monitor it from various perspectives and influence policy when required. When such a body is defunct, the implications on implementation are manifold.

Firstly, the link with the CSB at the center is not made, which is a crucial policy making body. Two, the AA, operates in isolation and without guidance and supervision. The elected representatives in the SSB play a crucial role in taking the Act to the people and generating public awareness about it, representing the case of the common man for better implementation and influencing policy. When the SSB is defunct, implementation of the Act becomes weak and incomplete.

There is one AC assigned per AA. The composition of the AC is such that expertise and support is available to the AA on all aspects of prohibition, regulation and prevention. For instance, paucity of IPOs has a direct bearing on prevention of sex determination through public awareness programmes. The AC works closely with the AA where the action is happening. It is designed to be a complete team. But as seen above, coordination between the two bodies is weak.

The systems help manage the structure and keep it in existence. Functions are performed through the systems. None of the systems examined in this study are fully complied with.

There is no compliance either for the structure or the systems provided for in the Act. From the findings above, it is clear that the structure is incomplete and therefore weak. It is bound to happen then that the systems will also be weak. The effectiveness of implementation of the Act can be a forgone conclusion. However, irrespective of the status of structure, the next chapter examines the status of effectiveness on independent parameters.

★★★

CHAPTER 4

EFFECTIVENESS

Chapter 4

EFFECTIVENESS

Effectiveness implies causing the specific measurable results that deliver on the intended purpose of the Act. Primarily the Act provides for:

1. **Prohibition** of sex selection, before or after conception.
2. **Regulation** of pre-natal diagnostic techniques for:
   - ★ the purpose of detecting genetic abnormalities;
   - ★ certain congenital malformations;
   - ★ sex linked disorders;
   - ★ for the prevention of the misuse of such techniques for the purpose of sex determination; and
   - ★ leading to female foeticide and for matters connected therewith or incidental thereto.

Accordingly, this chapter probes into acts of prohibition, regulation and prevention. Additionally, it also examines result orientedness among the bodies responsible for implementation of the Act. This chapter first presents the provisions for prohibition, regulation and prevention. It then examines indicators for effectiveness with respect to each of these.

The research team studied the provisions for prohibition and regulation in the Act and Rules and incorporated them in the tools for investigation. The object was to examine the deliverance of roles and functions of AA and AC in a quantifiable manner. The Act assigns functions and power to state AA for acts of prohibition and regulation. It provides for constitution of AA for whole or part of the state. Given the constitution of state AA in Rajasthan, these functions are in effect performed by the AAs at the district and sub-division levels. The respective ACs support them in the deliverance of their functions. Since implementation of the Act actually happens at the district and sub-division levels, the responses are at these levels. Most of the responses in terms of effectiveness are from the district and sub-division levels. Documents and records at the state level were also procured for data analysis.

Besides the implementers, this chapter contains responses from the registered clinics and judicial and metropolitan magistrates. Registered clinics are where effectiveness gets projected; 142 of them were interviewed for verifying the prescribed parameters of effectiveness. In terms of effectiveness, 22 judicial and metropolitan magistrates were interviewed for records of any cases or legal proceedings that have been initiated under this Act.

4.1. PROHIBITION

Prohibition qualifies the acting upon misuse of pre conception and pre natal diagnostic techniques for determination of sex of foetus leading to female foeticide. It also acts upon all sorts of publicity in this area and for punishment for violation.

4.1.1. Issuance of Summons

The AA has the power to summon any person possessing any information relating to violation of the provisions of the Act.

4.1.2. Issuance of search warrants

The AA has the power to issue search warrant for any place suspected to be indulging in sex selection techniques or pre-natal sex determination. The Act empowers the authority or any officer authorized thereof in this behalf may, subject to such rules as may be prescribed, enter and search at all reasonable times with such assistance, if any, as such authority or officer considers necessary, such genetic counselling center, genetic laboratory or genetic clinic and examine any record, register, document, book, pamphlet, advertisement or any other material object found therein and seize the same if such authority or officer has reason to believe that it may furnish evidence of the commission of an offence punishable under this Act **(Section 30).**

The provisions of the Code of Criminal Procedure, 1973 (2 of 1974) relating to searches and seizures shall, so far as may be, apply to every search or seizure made under this Act **(Section 30(2)).**

As per the Act, any person suspected of having any object on his person may also be searched, but the primary pre-requisite for conducting a search is the presence of at least two independent and respectable witnesses of the locality. If no such persons are available or willing to be witness to the search, then two such persons of another locality should be present. In case the search is conducted on a woman it should be done by a female officer. The selection of the witness is on the AA or the officer duly authorized to conduct the search. The witnesses selected should be unprejudiced and uninterested as the object of the section is to ensure fair dealing and a feeling of confidence and security amongst public. Later the witnesses may be summoned by court to appear as witnesses.

4.1.3. Provisions for punishments for prohibited advertising

Issuing or causing to issue, or publishing or distributing any advertisement regarding facilities of pre-natal determination of sex by any person, organisation, genetic counselling center, genetic laboratory or genetic clinic at any place and in any form is prohibited **(Section 22 (1) & (2)).**

Contravention of these provisions is punishable with imprisonment for a term, of up to three years and with fine which may extend to ten thousand rupees **(Section 22(3)).**

The Rules cite following process to be followed for issuing summons, search warrant and illegal advertisement.

The process starts with collection of information against the accused. The nature of the evidence that needs to be collected in order to make out a case under the Act varies depending upon the nature of violation. For example, in case of illegal advertisement, the evidence will be mostly documents which include paper cutting of the advertisement and names of people involved in publishing it, the letterheads, reports etc. Other means of collecting evidence are referral slips, laboratory results, microscopy pictures, records and

forms. Oral evidences and decoy witnesses are also important sources of evidence. Once evidence is collected it has to be submitted before the magistrate and the above-mentioned actions are taken as per the judgement.

The team examined the status of prohibition in the districts and sub-divisions in terms of summons issued, search warrants issued and punishments for publicity. The results are zero in each of the cases. These have been reported by AAs. There has been one case of publicity that has been reported under penal action in the next section.

4.1.4. Action against Offences

Contravention of any of the provisions of this Act or rules is punishable with imprisonment for a term of up to 3 years and fine extending up to Rs. 10000 and, on conviction, with imprisonment extending up to 5 years and fine up to Rs. 50000.

Besides, the Act also states that the name of the registered medical practitioner shall be reported by the AA to the State Medical Council concerned for taking necessary action including suspension of registration, removal of his name from the register of the council for a period or permanently.

Husband and relatives of the pregnant woman who undergoes a pre-natal diagnostic technique are presumed to have compelled the woman to undergo the pre-natal diagnostic technique unless the contrary is proved; and liable for abetment of offence **(Section 23 (3) 40)** and punishable for the offence **(Section 23 (3) 41)**. If the contrary is proved, the woman can also be likewise punished.

If any person contravenes any provision of the Act of the Rules made under there for which no penalty has been specified, he will be liable to be punished with imprisonment extending to three months; or fine of up to Rs. 1000.

Any offence punishable under this Act can be tried only in a court of Metropolitan Magistrate or a First Class Judicial Magistrate **(Section 28).**

Also no Court shall take cognizance of an offence under this Act except on two conditions:

1. a complaint made by the appropriate authority or any officer authorized in this behalf or,

2. a person who has given notice of not less than (15 days) in the prescribed manner, to the appropriate authority of the alleged offence and his intention to approach the court.

   The tables beneath gives a status of penal action in terms of show cause notices issued and in terms of penalties imposed across the state. These are based on the records given by the AAs in the districts and sub-divisions.

Table: 4.1.a. PENAL ACTION AND PENALTIES – DISTRICT (base: October 2005)

Centers	Show cause notice	Cancellation of registration	Suspension of registration	Fined	Convicted by court	Reported to medical council
Genetic counselling center	0	0	0	0	0	0
Genetic clinic	2	0	0	0	0	0
Genetic laboratory	0	0	0	0	0	0
Gynaecologist	0	0	0	0	0	0
Others	0	0	1	0	0	0
Total	**2**	**0**	**1**	**0**	**0**	**0**

Table: 4.1.b. PENAL ACTION AND PENALTIES – SUB-DIVISION (base: October 2005)

Centers	Show cause notice	Cancellation of registration	Suspension of registration	Fined	Convicted by court	Reported to medical council
Genetic counselling center	0	0	0	0	0	0
Genetic clinic	1	0	0	0	0	0
Genetic laboratory	0	0	0	0	0	0
Gynaecologist	1	0	0	0	0	0
Others	0	1	0	0	0	0
Total	**2**	**1**	**0**	**0**	**0**	**0**

Others in these tables were found to be ultrasonography centers, maternity clinics. In the state, four show cause notices had been issued to clinics and to a gynaecologist. Of these, in two cases they were issued for improper maintenance of records and in two cases sonography machines registered in one place were regularly brought to another place and used. After issuance of notice the moving of machines was stopped. One registration was cancelled for advertising availability of sex determination tests in the clinic. At the time of data collection, the case was still under consideration.

There is one case of suspension of registration for improper maintenance of records. On taking up this case, the offender approached the AA at the state and used personal contacts in higher offices to influence the decision. This registration was restored in 45 days and the clinic is operating in the same district as before. No case has been fined, convicted or reported to the medical council.

The status of offences detected against clinics, laboratories and other professionals is projected in table 4.1.c.

Table : 4.1.c. OFFENCES AGAINST CLINICS (base: October 2005)

Level	Genetic counselling center	Genetic clinic	Genetic laboratory	Gynaecologist	Other Centers (Sonography Centers, Hospitals)
District	0	0	0	0	1*
Sub-division	0	0	0	0	1**
Total	**0**	**0**	**0**	**0**	**2**

* *Sonography Clinic*

** *Diagnostic Centre*

In the two cases, registrations were cancelled for advertisement implying sex determination tests in the clinic and one for improper maintenance of records and not displaying the board.

Every offence under this Act has been considered Cognizable (Cog), Non-Bailable (NB) and Non-Compoundable (NC) **(Section 27).** The research team interviewed 22 metropolitan magistrates and judicial magistrates and collected information of cases filed and verdicts passed. In every case the response was zero.

As for public complaints it was found that there were no complaints registered with the AAs.

4.2. REGULATION

Regulation in this context applies to the misuse of prenatal diagnostic techniques for purpose of pre- natal sex determination leading to female foeticide and matters connected therewith.

4.2.1. Regulation of clinics

Registration, deregistration, cancellation or suspension of registration

Application for Registration

(Under **Section 18(3)**)

Every genetic counselling center, genetic laboratory or genetic clinic engaged, partly or exclusively, in counselling or conducting pre-natal diagnostic techniques is required to apply for registration.

Certification of Registration

(Under **Section 19**)

For registration under the Act, every application is made to the appropriate authority in a prescribed form with the prescribed fee. **Section 18 (2) {@ use of fee}** The AA grants or rejects an application for registration. The authority holds an inquiry, checks for compliance with requirements, regards the advice of advisory committee before granting a certificate of registration. On not being satisfied, the applicant is

given an opportunity to be heard, regards the advice of the AC and on being satisfied about non-compliance, the application is rejected. These certificates have to be renewed in the prescribed period with the prescribed fees.

Cancellation or Suspension of registration

(Under **Section 20**)

The appropriate authority may, suo moto, or on complaint, issue a show cause notice to the genetic counselling center, genetic laboratory or genetic clinic, why its registration should not be suspended or cancelled on stating the reasons in the notice.

If, after giving a reasonable opportunity of being heard and having regard to the advice of the advisory committee, if the appropriate authority is satisfied that there has been a breach of the provisions of this Act or the rules, it may, without prejudice to any criminal action that it may take against such center, laboratory or clinic, suspend its registration for a period or cancel its registration.

Irrespective of the above, if the appropriate authority is, of the opinion that it is necessary or expedient to do so in the public interest, it may suspend the registration of any genetic counselling center, genetic laboratory or genetic clinic without issuing any show cause notice.

A registered clinic comes under scrutiny once the application or renewal for registration has been rejected by the appropriate authority or advisory committee or by both. It can also be scrutinized, in case the appropriate authority receives any complaints about a clinic. Under such conditions, the AA has the power to issue a 'show cause' notice to the respective clinic. The reasons for every such notice should be mentioned in the notice itself. Thereafter the clinic must be given an opportunity to defend itself against the charges. In case of rejected clinics, the applicant should be informed about the reasons for rejection in written. This should be communicated to the applicant within 90 days from the date of the receipt of the registration.

During field investigation, the AAs were asked for data on the following aspects of registration :

1. Number of applications for registration received;
2. Number of diagnostic centers registered;
3. Number of applications rejected;
4. Number of applicants informed about status of registration;
5. Number of centers operating without clearing registration.

The team could not collect complete information in this regard. Nineteen AAs were unable to provide information. In three cases due to unavailability of clerks, data could not be made available. No uniformity in determination of jurisdiction between CMHO and Dy. CMHO with respect to managing registrations of clinics and record keeping was a third reason. Eight AAs reported these tasks were under the sole purview of the CMHO, while three AAs stated that this task was assigned to additional or deputy CMHOs. The research team was doubtful about accuracy of data in this regard, as cases of dual responses and overlapping data were noticed in certain places. Rectification was not undertaken due to paucity of time. Hence field data with respect to regulation of clinics is not presented here. Data from government records show the total

registration to be 1045 (June 30 2005). The method is to calculate them cumulatively every quarter from the quarterly reports the AAs send to state AA.

Some observations from the field data indicate that the highest number of registrations is in the category of 'others'. These include diagnostic centers, radiography centers, sonography clinics or centers and general clinics. Although registration of clinics is a crucial aspect of regulation, we are unable to comment much due to lack of supporting data.

INSPECTIONS

The rules in the Act **(Section 6 (4))** refer to enquiry and inspection at the premises of genetic counselling center, genetic laboratory or genetic clinic, ultrasound clinic or imaging center. Once a month inspections are required to be undertaken by the AA accompanied by the AC members to check if the clinics are maintaining their records properly. The clinics are required to maintain these records for a period of two years.

On inspection, the AA is to ensure that all records, charts, forms, reports, display boards, consent letters and all other documents required to be maintained under the Act, are preserved in proper order. The records will also include any criminal or other proceedings against the clinic if they are not disposed off. These records will be made available to the AA or the designated authority on demand, by the clinics. The clinics will provide reasonable facilities for inspection visits of the AA.

In understanding the effectiveness of the implementers vis-à-vis inspections the research team undertook the in-depth exploration in the following:

1. Records of the frequency of their inspections were probed with 129 AAs in a close-ended question. (Table 4.2.a.) The response categories were:
   - ★ monthly - once a month, bi-monthly - once in two months, quarterly – once in three months, half yearly
   - ★ once in six months, yearly – once a year, irregular – no pattern, never, not aware – of frequency of inspection, no response).
2. In the same vicinity, 142 registered clinics were asked about the frequency of inspections in the same manner as AAs. (Table 4.2.b.).
3. Inquired with the registered clinics further on:
   - ★ Activities undertaken by AA during inspection (table 4.2.c.),
   - ★ Shortcomings reported to them during inspections (Table 4.2.d.),
   - ★ Registered clinics acting upon the shortcomings (Table 4.2.e.).
4. Registered clinics were queried for status of maintenance of records (table 4.2.f.), then asked in detail if they maintained all the requisite records. After recording their responses, their records were further explored. Tables 4.2.h. and 4.2.i. bring out the differences.

Table 4.2.a. FREQUENCY OF INSPECTION UNDERTAKEN BY AA (base: October 2005)

Levels	Frequency of inspection								
	Monthly	Bimonthly	Quarterly	Half yearly	Annually	Irregularly	Never	Not aware	No Response
District (n=31)	5 (16 %)	3 (10%)	5 (16%)	3 (10%)	1 (3%)	6 (19%)	7 (23 %)	0 (0%)	1 (3%)
Sub-division (n=98)	17 (17%)	7 (7%)	18 (18%)	7 (7%)	3 (3%)	13 (13%)	25 (26%)	6 (6%)	2 (2%)
Total (n=129)	22 (17%)	10 (8%)	23 (18%)	10 (8%)	4 (3%)	19 (15%)	32 (25%)	6 (5%)	3 (2%)

Table 4.2.b. FREQUENCY OF INSPECTION AS REPORTED BY REGISTERED CLINIC (base: October 2005)

Levels	Frequency of inspection (IN %)							
	Monthly	Bimonthly	Quarterly	Half yearly	Annually	Irregularly	Never	No Response
District (n=67)	2 (3 %)	1 (1%)	9 (13%)	8 (12%)	4 (6%)	26 (39%)	15 (22 %)	0 (3%)
Sub-division (n=75)	1 (1%)	4 (5%)	13 (17%)	5 (7%)	5 (7%)	34 (45%)	13 (17%)	0 (0%)
Total (n=142)	3 (2%)	5 (4%)	22 (15%)	13 (9%)	9 (6%)	60 (42%)	28 (20%)	2 (1%)

Among the AAs, the highest response 32 (25%) for single category is for "never", implying that they have not undertaken any inspections. Of these 32 AAs who reported no inspection at all, two have categorically stated that no sex determination tests are carried out in their area, so they don't carry out inspections. Ten AAs said that no registered clinics exist in their area, thus no inspections are conducted. Two Dy. CMHOs said they were handled by the CMHO and two CMHOs said they were handled by the Dy. and Addl. CMHOs. Ten respondents had been newly appointed, within the last three months and had not undertaken any inspections. Two said there were time constraints, three gave no reasons and one was not aware if any inspections had been undertaken. There were six AAs who were not aware that they are expected to inspect the clinics. Three gave no response. Twenty-eight registered clinics reported never having been inspected.

Among 142, 112 registered clinics inspected, irrespective of frequency, were asked if they were given prior information of inspections. The following table gives their response.

Table 4.2.c. PRIOR INFORMATION OF INSPECTIONS (base: October 2005)

	District (n=50)	Sub-division (n=62)	Total (n=112)
Prior information of inspections	0	4	4

From among 112 registered clinics, which were being inspected irrespective of frequency, four (4%) reported that they got prior intimation of inspections. All these respondents were from sub- divisions.

To test the effectiveness of inspections conducted by AAs, three of the prescribed activities to be carried out during inspections were selected for analysis; record maintenance, display of the boards at the clinics and having a copy of the Act at the clinic (display of sign-board with "Sex determination tests is against the Law" written on it on a prominent place in the clinic is mandatory).

The same 112 registered clinics were asked about the activities the AA undertook during inspections. Their open-ended responses were categorized and are tabulated in the table beneath. Table 4.2.g. lists the shortcomings indicated to the clinics during inspections

Table 4.2.d. MODE OF INSPECTIONS AS REPORTED BY CLINICS (base: October 2005)

Multiple responses

Activities	District (n=50)	Sub-division (n=62)
Checking records	44 (88%)	55 (89%)
Checking display board	16 (32%)	24(39%)
Inspection of sonography room	4 (8%)	16 (26%)
None	4 (8%)	4 (6%)

Twenty-two of the 112 clinics stated their shortcomings were pointed out during inspections. Their responses are listed beneath.

Table 4.2.e. FINDINGS OF INSPECTIONS (as reported by clinics) (base: October 2005)

Multiple response

Shortcomings	District (n=10)	Sub-division (n=12)
Improper maintenance of records	10 (100%)	8 (67%)
Shortcomings related with display boards	2 (20%)	4 (33%)

Note: Responses from 22 clinics out of the 112 respondents who stated that shortcomings were pointed out by the AA during inspection.

Table 4.2.e. indicates that during inspections, over 88% of the registered clinics, reported that records were checked. Between 30-40% reported that display boards were checked. About 8% at the district level and 26 % at the sub-division level reported inspection of the sonography room. None (6-8%) was a response from those who said that no activities were undertaken during inspections. Quoting one of them, "Inspection is a formality". In table 4.2.f. we see that of 22 clinics, 18 did not maintain proper records and 6 did not comply with the requirement of display boards. The following table shows that 11 out of 22 took steps to correct them and another 11 did not take any corrective action.

Table 4.2.f. FOLLOW-UP ACTION BY CLINICS (base: October 2005)

Corrective action	District (n=10)	Sub-division (n=12)
Prescribed action taken	7 (70%)	4 (33%)
Action not taken	3 (30%)	8 (67%)

This section deals with maintenance of records. Maintaining records is essential for regulation and an inherent part of the inspections that the AAs have to undertake. Text Box 2 below lists some of the records that ought to be inspected.

Text Box 2

Records to be maintained by Registered Clinics

Register

To keep a record of names and addresses of pregnant women and their husbands/fathers, who were subjected to prenatal diagnostic tests.

Form D

This form is meant for the genetic counselling centre, which specifies details of the patient being referred to a clinic which include their identification, weeks of pregnancy, history of genetic/medical diseases, diseases of previous children and procedure advised for test. It also indicates details of the doctor who has advised a clinical test.

Form E

This form is meant for genetic laboratory which specifies details of the patient being referred to a clinic which include their identification, weeks of pregnancy, history of genetic/medical diseases and diseases of previous children. It also mentions the sample taken, the laboratory test carried out with date and results of diagnosis.

Form F

This form is meant for genetic clinic, which specifies details of the patient being referred to a clinic, which include their identification, weeks of pregnancy, basis for diagnosis, and diseases of previous children. It mentions the procedures that have been followed for diagnosis and the laboratory tests recommended. The record also includes the need for MTP and in case of MTP was advised the data for MTP and signing of the consent form.

Consent Form

It is an undertaking given by the patient who desires to opt for prenatal diagnostic tests.

Source: The Handbook on PNDT Act, 1994 – Department of Family Welfare, Government of India.

Strict vigilance combined with inspection of records can effectively create an atmosphere that will deter offenders. Inspection of these records alone can also send out a message to offenders that they are being watched. The research team undertook to physically examine if this aspect of regulation was carried out effectively. A strategically devised plan was laid out that the field investigators carried out. The registered clinics were generally asked if they maintained records and their responses were recorded. Their assertions are presented in table 4.2.g.

Table 4.2.g. RECORD MAINTENANCE BY CLINICS (base: October 2005)

Levels	District	Sub-division	Total
Maintaining records	60/67 (90%)	66/75 (88%)	126/142 (89%)

The following tables, 4.2.h. and 4.2.i. deal with responses of registered clinics to adherence to maintenance of these records at district and sub-division levels. These are coupled with observations of the research team at the same levels. The tables list all forms prescribed under the rules that a clinic on registering undertakes to maintain. The responses of clinics are in four categories, viz.,.

1. Yes - those maintaining records
2. No – those not maintaining the records
3. Don't know – the respondent does not know if they are maintaining the records
4. Not Aware – the respondent is not aware of the requirement to maintain the particular record.

Alongside are observations of the investigators in the same parameters.

Eighty nine percent (126/142) registered clinics said that they maintained records. On checking records by the investigators, the highest adherence was for registers, 79% in the districts and 66% in the sub-divisions. Their initial response to adherence for those records was above 90% at both levels.

Table 4.2.j. RECORD MAINTENANCE BY CLINICS AS PER RULES – DISTRICT (base: October 2005)

Clinics maintaining the record (n=67)	Response of clinics				Investigators' Observations			
	Yes	No	Don't know	Not Aware	Yes	No	Not Known	Not Aware
Register	63 (94%)	3 (4%)	0 (0%)	1 (1%)	53 (79%)	9 (13%)	3 (4%)	2 (3%)
Form D	13 (19%)	40 (60%)	12 (18%)	2 (3%)	9 (13%)	44 (66%)	10 (15%)	4 (6%)
Form E	11 (16%)	42 (63%)	12 (18%)	2 (3%)	7 (10%)	45 (67%)	11 (16%)	4 (6%)
Form F	30 (45%)	24 (36%)	11 (16%)	2 (3%)	25 (37%)	28 (42%)	10 (15%)	4 (6%)
Case record (Card/OPD record)	49 (73%)	16 (24%)	1 (1%)	1 (1%)	35 (52%)	24 (36%)	6 (9%)	2 (3%)
Consent forms	51 (76%)	14 (21%)	1 (1%)	1 (1%)	32 (48%)	24 (36%)	9 (13%)	2 (3%)
Sonography plates/slides	17 (25%)	45 (67%)	3 (4%)	2 (3%)	8 (12%)	45 (67%)	10 (15%)	4 (6%)
Doctor's recommendation and letters	26 (39%)	33 (49%)	4 (6%)	4 (6%)	14 (21%)	39 (58%)	9 (13%)	5 (7%)

Table 4.2.k. RECORD MAINTENANCE BY CLINICS AS PER RULES – SUB-DIVISION (base: October 2005)

Clinics maintaining the record (n=67)	Response of clinics				Investigators' Observations			
	Yes	No	Don't know	Not Aware	Yes	No	Not Known	Not Aware
Register	70 (93%)	3 (4%)	0 (0%)	2 (3%)	50 (66%)	8 (11%)	10 (13%)	7 (9%)
Form D	17 (23%)	43 (57%)	13 (17%)	2 (3%)	7 (9%)	45 (60%)	15 (20%)	8 (11%)
Form E	16 (22%)	39 (51%)	18 (24%)	2 (3%)	8 (11%)	43 (57%)	16 (22%)	8 (11%)
Form F	33 (44%)	25 (33%)	15 (20%)	2 (3%)	24 (32%)	30 (40%)	13 (17%)	8 (11%)
Case record (Card/OPD record)	61 (81%)	12 (16%)	0 (0%)	2 (3%)	38 (51%)	22 (29%)	8 (11%)	7 (9%)
Consent forms	52 (69%)	18 (24%)	3 (4%)	2 (3%)	37 (49%)	22 (29%)	9 (12%)	7 (9%)
Sonography plates/slides	28 (37%)	44 (59%)	1 (1%)	2 (3%)	11 (15%)	47 (62%)	10 (13%)	7 (9%)
Doctor's recommendation and letters	28 (37%)	43 (57%)	2 (3%)	2 (3%)	19 (25%)	41 (55%)	8 (11%)	7 (9%)

Consent forms, which should be signed by each and every pregnant woman undergoing ultra sonography was reportedly maintained in 76% in districts and 69% in sub-divisions by the clinics. Observations of investigators in this regard found 48% and 49% of clinics at both district and sub-divisional levels respectively actually maintaining them. Doctor's recommendations and letters as reported by the clinics were 39% and 37% at district and sub-divisions respectively. On observation copies of doctors' recommendations could be found in 21% of the clinics at the district and 25% at the sub-divisional level. Almost 2/3rds of the clinics did not maintain sonography plates/slides. There is not a single record in the list where one can find adherence reported and actual adherence matching completely.

Display of Board

Every clinic has to display board stating 'sex determination tests are illegal' legibly and prominently in their clinics. The investigators observed in each of the 142 clinics if this requirement was adhered to. Where the boards were not visible the respondents were asked about them.

Table 4.2.j. GENERAL DISPLAY OF BOARDS (base : October 2005)

Level	Board displayed	Board not displayed
District (n=67)	58 (87%)	9 (13%)
Sub-division (n=75)	67 (89%)	8 (11%)
Total (n=142)	125 (88%)	17 (12%)

Out of the 142 Clinics, 125 (88%) said they had displayed the boards as per the norms and 17 (12%) said they do not have the board, as they were ignorant about this requisite.

Table 4.2.k. SPECIFIC DISPLAY OF BOARDS (base : October 2005)

Level	Legible and displayed prominently	Not displayed prominently
District (n=58)	47 (81%)	11 (19%)
Sub-division (n=67)	56 (84%)	11 (16%)
Total (n=125)	103 (82%)	22 (18%)

As per the observations of the research team, out of the 125 clinics displaying boards only 103 (82%) had displayed the board prominently. The other 22 (18%) were not fulfilling the requirement that they undertook to adhere to while registering. With respect to display of boards as such there are 39/142 defaulters.

The Act prescribes having a copy of the PCPNDT ACT in the Registered Clinic.

Table 4.2.l. AVAILABILITY OF THE ACT AT THE CLINICS (base: October 2005)

Levels	Yes	No	No Response
District (n=67)	28 (42%)	30 (45%)	9 (13%)
Sub-division (n=75)	40 (53%)	29 (39%)	6 (8%)
Total (n=142)	68 (48%)	59 (42%)	15 (11%)

Table 4.2.m. Awareness of the clinics about the code of conduct (base: October 2005)

Levels	Yes	No	No Response
District (n=67)	39 (58%)	28 (42%)	0 (0%)
Sub-division (n=75)	47 (63%)	24 (32%)	4 (5%)
Total (n=142)	86 (61%)	52 (37%)	4 (3%)

Sixty-eight (48%) clinics had a copy of the Act in their clinics and 61% were aware of the code of conduct.

Below is a record of defaulting clinics with respect to record maintenance at the district and sub-division levels. For data from tables 4.2.j. and 4.2.k. for every record, 'yes' response from investigators' observations was deducted from 'n'. This figure is presented against relevant records in table 4.2.n.

The Act empowers the AA to issue show cause notice to the genetic clinics, counselling centers etc in case they are not abiding by the provisions of the Act. The AA can also, with consultation of the AC members, cancel or suspend the registration of these clinics. Faulty maintenance of records, non-adherence to prominent display of board, no copy of the Act etc can also lead to such a step. According to the table above, there are a total of 857 offences. The accurate number of offending clinics has not been estimated in this report. Considering that these could be cases of multiple offences by clinics, as per the table at least 127 clinics have committed minimum one offence. These 127 clinics could have been at least issued show cause notices. Out of our sample of 142 clinics, thus, the team found at least 89% offenders against whom some penal action could have been carried out.

Table 4.2.n. DEFAULTERS OF RECORD MAINTENANCE (base: October 2005)

Offence	District	Sub-divisions	Total
Register not maintained	14 (21%)	25 (33%)	39 (27%)
Form D not maintained	58 (87%)	68 (91%)	126 (89%)
Form E not maintained	60 (90%)	67 (89%)	127 (89%)
Form F not maintained	42 (63%)	51 (68%)	93 (65%)
Case record (Card/OPD record) not maintained	32 (48%)	37 (49%)	69 (49%)
Consent forms not maintained	35 (52%)	38 (51%)	73 (51%)
Sonography plates/slides not maintained	59 (88%)	64 (85%)	123 (87%)
Doctor's recommendation and letters not maintained	53 (79%)	56 (75%)	109 (77%)
Board not displayed properly	20 (30%)	19 (25%)	39 (27%)
No Act at hand	30 (45%)	29 (39%)	59 (42%)

4.3. PREVENTION

Section 16 A provides that it is a function of SSB to create public awareness against the practice of sex selection or pre-natal determination of sex. Similarly it is also identified as a function of the AA under Section 17(4f). It was reported that in 2001 the state had incurred an expenditure of approximately 50 lakhs on developing IEC materials, after that there has been no budget allocated for IEC or any other awareness generating activities.

Table: 4.3.a. PUBLIC AWARENESS PROGRAMMES CONDUCTED BY THE AAs (base: October 2005)

Multiple responses

Types of awareness activities	Districts (n=31)	Sub-division (n=98)
Mass Publicity (Posters, Banners, Hoardings, Pamphlets)	6 (19%)	14 (14%)
Mass Education (Workshops, Meetings, Exhibitions, Papers, T.V./ Radio Programmes)	12 (39%)	45 (46%)
Mass Mobilization (Street Plays, Rallies etc.)	1 (3%)	5 (5%)
No Activities	12 (39%)	37 (39%)
Not Aware	1 (3%)	6 (6%)
No Response	1 (3%)	1 (1%)

At the district and sub-division levels, 20 AAs reported having undertaken mass publicity activity and 57 AAs reported mass education programmes. Almost half (58), reported no activities or unawareness about this role or gave no response to the question. The State AA however was of the opinion that the IEC department is responsible for printing material to generate awareness. He also mentioned that the workshop for doctors is organized by the IEC department. However he feels that such programme for private doctors is also necessary. He also expressed the lack of financial allocations to carry out such programmes on a regular basis.

4.4. RESULT-ORIENTEDNESS

Result-orientedness implies an approach to work that is deliberate, systematic and output oriented. There is no reference to this in the Act. However, in chapter V, while mentioning the provision for appointment of one or more appropriate authorities for the whole or part of the State for the purposes of the Act, it further says, "having regard to the intensity of the problem of prenatal sex determination leading to female foeticide". The term "intensity of the problem..." in our analysis is the only reference towards any quantifiable assessment of the problem of female foeticide. We derive an implied direction for the AAs to work towards.

Result-orientedness is an indicator for effectiveness. It implies an assessment of the situation at hand, goal setting to address it and indicators to monitor progress. The research team explored if there was orientation towards this either on a personal or collective level.

The team enquired from the respondents if any monitoring indicators existed. Every respondent in the structure was asked if any targets were set. Table 4.4.a. presents the responses of AAs and AC members. Table 4.4.b explores if any target setting was undertaken by them.

4.4.1. Existence of monitoring indicators

Table: 4.4. a. MONITORING INDICATORS (base: October 2005)

Structures		Responses			
		Existing	Non-existing	Not aware	NR
State	AA (N=1)	1 (100%)	0 (0%)	0 (0%)	0 (0%)
	AC (N =3)	1 (33%)	0 (0%)	2 (67%)	0 (0%)
District	AA (N=31)	8 (26%)	8 (26%)	13 (42%)	2 (6%)
	AC (N=93)	0 (0%)	24 (26%)	60 (65%)	9 (10%)
Sub-division	AA (N=98)	19 (19%)	20 (20%)	54 (55%)	5 (5%)
	AC (N=206)	0 (0%)	51 (25%)	142 (69%)	13 (6%)
Total	432	29 (7%)	103 (25%)	269 (62%)	29 (7%)

Of all the AAs and the AC members who responded that monitoring indicators existed, only the AA (state) stated that gender ratio and knowledge of the Act were two indicators. None of the others could qualify their statement.

4.4.2. Setting of targets

Table 4.4.b. TARGET SETTING (base: October 2005)

Structures		Responses			
		Existing	Non-existing	Not aware	No Response
State	AA (N=1)	0 (0%)	1 (100%)	0 (0%)	0 (0%)
	AC (N=3)	0 (0%)	3 (100%)	0 (0%)	0 (0%)
District	AA (N=31)	0 (0%)	29 (94%)	1 (3%)	1 (3%)
	AC (N=93)	0 (0%)	33 (35%)	53 (57%)	7 (8%)
Subdivision	AA (N=98)	0 (0%)	78 (80%)	15 (15%)	5 (5%)
	AC (N=206)	0 (0%)	76 (37%)	119 (58%)	11 (5%)

Most of the AAs admitted to no target setting.

FINDINGS

Prohibition

- ★ No summons or search warrants have been issued.
- ★ No punishments for prohibited advertising have been dealt.
- ★ Six show cause notices have been issued to clinic, laboratories and to a gynaecologist.

- ★ Two registrations were cancelled.
- ★ One suspension of registration.
- ★ Zero cases filed in the court.
- ★ No complaints received by AA against diagnostic centers from the public.
- ★ No complaints received by AA against diagnostic centers from expectant mothers for being forced to undergo sex determination tests.
- ★ No complaints registered in the court by AA.
- ★ No complaints registered in the court by a person or social organisation after having given notice for 15 days to AA.

Regulation

- ★ Total number of registered clinics in Rajasthan is 1045 by end of June 2005 (state records).
- ★ AAs are non-compliant on fulfilling on undertaking monthly inspections
- ★ Twelve AAs have never conducted inspections and three are not aware that this is a function they need to perform.
- ★ Clinics have exaggerated adherence to record maintenance. Field observations found a wide gap between their responses and actual records.
- ★ Records and practices, crucial to regulation of the Act are not maintained as required. E.g. consent forms, doctor's recommendations and letter, sonography plates/slides and display boards.
- ★ Based on the findings vis-à-vis regulation, 857 offences identified, 127 registered clinics can be punished for at least one offence. This is 89% of the sample.
- ★ Seventeen said that they were ignorant about the requirement for displaying boards.
- ★ Only 49% had a copy of the act and 61% aware of code of conduct.

Prevention

- ★ Out of 129 AAs, almost half (58) did not carry out any activities for public awareness.
- ★ There has been no budget allocation for IEC after 2001.

Result-orientedness

There is absence of result-orientedness - no monitoring indicators and no target setting. 29 out of 432 respondents who were AAs and AC members affirmed existence of monitoring indicators, but failed to qualify their statement.

Effectiveness

There are 1045 registered clinics as per the state records. Prohibitory action has been taken against 9 registered clinics since the implementation of the Act. As such the percentage of offenders from a population of 1045 is 0.86%. Of the 142 registered clinics the research team investigated, 857 offences were identified. At least 127 registered clinics had committed at least one offence. The rate of offenders as per the sample of 142 was found to be 89%. If this is projected onto the total population, there could be approximately 930 registered clinics in Rajasthan that can be booked under the PCPNDT Act.

CHAPTER 5

CONSTRAINTS

Chapter 5
CONSTRAINTS

This chapter deals with the constraints that are faced by the implementing authorities of the Act in their day-to-day functions. It therefore involves role-holders like appropriate authority and advisory committee from within, and the Judiciary and civil society members from outside.

5.1. ADMINISTRATIVE

Administration refers to disposing of the day-to-day affairs effectively and with desired results. Thus it includes both structural and functional aspects. When the implementers face constraints to deliver their roles and responsibilities it affects the smooth administration of the Act.

5.1.1. Structural Gaps: Provision vis-à-vis Structure

Structure refers to positioning of role holders who are expected to be delivering their duties and responsibilities with due importance provided to the implementation of the Act. Structure under study includes all the AAs (Director FW and CMHOs) and Additional CMHOs and Deputy CMHOs at sub-divisions.

Table 5.1.a. GAPS IN ADMINISTRATIVE STRUCTURE IDENTIFIED BY AA (base: October 2005)

Multiple Responses

Gaps	State(n=1) (n=1)	District (n=31)	Sub-division (n=98)
Excessive workload*	1	4 (13%)	7 (7%)
Low priority**	-	2 (6%)	5 (5%)
No shortcoming	-	20 (64%)	69 (70%)

* *Excessive workload refers to AA's involvement in various capacities vis-à-vis the medical and health department of the government.*

** *Low priority refers to lackadaisical approach to the implementation of the Act*

The personnel that comprise the AA are drawn from the departments of health and family welfare. There are other programmes under these departments that are entrusted to the AAs. Yet, only 12 respondents considered this as an obstacle and experienced excessive workload coming in the way of delivering their duties. About 5-6% of them stated that as a programme it was accorded low priority. It

was also felt that this is not a national/state health programme and hence doesn't deserve much attention. From the overall observations the research team also felt that there was no pressure applied by the policy makers, bureaucrats et Al to make the Act more effective. Irrespective, the majority of respondents (64-70%) expressed that there were no shortcomings in the structure that came in the way of its implementation.

5.1.2.i: Functional constraints

Functional constraints are those deterrents faced by the AA and AC members while delivering the functions assigned to them.

Table 5.1.b. FUNCTIONAL CONSTRAINTS FACED BY AA (base: October 2005)

Multiple Responses

Functional Gaps	District	Sub-division
Political and professional pressure	5 (16 %)	15 (15 %)
Lack of role clarity	1 (3 %)	9 (9 %)
Excessive paper work	2 (6 %)	—
No constraints	17(55 %)	54 (55%)

More than half the respondents said that there were no constraints in delivering their functions as AAs. About 15% stated that the nexus between the clinics and the political leaders and higher officials proved to be a hurdle in implementing the Act. A case mentioned in the previous chapter of a registered clinic that was booked under the Act, managed to revoke its suspension by influencing the top most official in the PCPNDT implementing structure, is an illustration of this point. Not all respondents shared such cases elaborately. Professional pressure was described in terms of the fact that the implementing structure and the groups that needed to be regulated belonged to the same fraternity of medical professionals. This proved to come in the way of taking stringent action against the registered clinics. Some of them (10) expressed that lack knowledge on the legalities of the Act and their role therein was a constraint. Besides, at some places, there was confusion among the CMHOs, Addl. CMHOs and Dy. CMHOs about the jurisdiction of their areas assigned to them.

As regards record keeping, the AAs are not able to do justice to this area. Two of them expressed that the paperwork is enormous and cumbersome to manage. Added to this is the shortage of clerical staff. The state AA also expressed that there was a problem in proper record keeping in the districts and subdivisions.

Table 5.1.c. FUNCTIONAL CONSTRAINTS FACED BY AC MEMBERS (base: October 2005)

Multiple Responses

Functional Gaps	District (N=93)	Sub-division (n=206)
Lack of role clarity	15 (16 %)	32 (15 %)
Time constraints	14 (15 %)	9 (4 %)
Discretionary power with AA	15 (16 %)	21 (10 %)
No constraints	51 (55 %)	140 (68%)

Between 55-68% of AC members reported no constraints. Less than 15% of the present members were unable to honour their commitment due to preoccupations. About 15 % of the respondents in this category did not know what role they should be playing in the AC. Further, they had not received any training to enable them to perform their roles in the AC.

5.1.2.ii: Training

The government has, till date, organized only one training for the AAs. AAs appointed after this training have not yet developed clarity on their role.

Table 5.1.d. TRAINING ATTENDED BY AA ON PCPNDT (base: October, 2005)

Structure	Trained	Untrained	No Response
State (N=1)	1 (100%)	-	-
District (n=31)	19 (61%)	10 (32%)	2 (7 %)
Sub-division (n=98)	46 (47%)	51(52%)	1 (1%)

5.2. LEGAL CONSTRAINTS

The Act provides that no AA should be charged for taking action against the registered clinics unless it is done with malicious intention. The following data projects that actions taken by the AAs are generally not challenged in courts. Hence, the AAs do not face any constraints in this regard.

Table 5.2. LEGAL SUITS AGAINST AA (base: October 2005)

Structure	Legal suit	No legal suit	No Response
State	0 (0%)	0 (0%)	0 (0%)
District (n=31)	0 (0%)	29 (94%)	2 (6%)
Sub-division (n=98)	0 (0%)	97 (99 %)	1(1%)

5.3. LOOPHOLES IN THE ACT

The loopholes in the Act are defined here as expressions in the Act lacking clarity or providing scope for circumvention by the offenders. Responses in this regard were sought from AAs and AC members.

Table 5.3.a. LOOPHOLES IN THE ACT AS REPORTED BY AA (base: October 2005)

Nature	State	District	Sub-division
Lack of security	-	-	2 (2%)
Not yet faced	-	2 (7 %)	2 (2%)
No shortcomings		19 (31%)	65 (66%)

Nature	State	District (N=93)	Sub-division (N=206)
Lack of powers	-	39 (42%)	73 (35%)
Enforcers (regulators) and offenders are from the same professional fraternity	-	9 (10%)	20 (10%)
No loopholes	-	46 (49%)	113 (55%)

A majority of the respondents among both the sets of respondents said that there were no loopholes. Two AAs expressed that they needed protection or security while undertaking activities pertaining to registered clinics. Among AC members, over 1/3rd felt that they lacked adequate powers and the scope for their role should be expanded. This was expressed in the context that since they played an advisory role, their interventions were not taken seriously.

Table 5.4.a. CONSTRAINTS EXPRESSED BY NGOs (base: October 2005)

Constraints	State	District (N=47)	Sub-division (N=47)
Provision of Act lack clarity	-	2 (4%)	3 (6%)
Act has not been publicized well	2	22 (47%)	24(51%)
Implementation machinery lacks commitment/conviction	1	38 (81%)	44 (94%)
None		5 (11 %)	4 (8 %)

Although the NGOs have mentioned that provisions in the Act lack clarity, they were unable to qualify their statements with any corroborative evidence. The team found that most NGOs, even those actively working on these issues were not clear or adequately informed about the provisions of the Act. The team found one medical professional, Dr. Kabra, playing an activist role who was well versed with the provisions of the Act and other Acts having a bearing on the issue of female foeticide. He was of the view that the PCPNDT Act cannot curb the occurrence of female foeticide. According to him, proper implementation of the MTP Act was sufficient to address the issue.

About 50% of the respondents said that the Act had not been publicized well. NGOs also opined that the implementation machinery lacks commitment. AAs do not have the will to implement the Act.

5.5. CONSTRAINTS EXPRESSED BY JUDICIAL MAGISTRATES/METROPOLITAN MAGISTRATES

86% of the Judicial Magistrates/Metropolitan Magistrates interviewed opined that there are no shortcomings in the Act. It is only the implementation part that is lacking. Others held the view that the appointment of a person from the same fraternity as appropriate authority is controversial. Some also believed that police should also be involved.

On the involvement of the police, though there were divergent views among a cross section of the respondents. Some felt involvement of police would expand the scope for corruption. Some felt it would provide the necessary security while bringing the offenders to book.

FINDINGS

Administrative constraints

- ★ Between 64-70% AAs said they did not find any shortcomings in the administrative structure.
- ★ 55% AAs expressed that they did not experience any functional constraints. About 15% experienced political and professional pressures in the performance of their functions and another 10 % felt they needed role clarity.
- ★ Among the AC members, between 55-68% stated that there were no functional constraints, 15% needed role clarity.
- ★ Almost half the AAs had not received training on the PCPNDT Act.

Legal constraints

- ★ None of the AAs has faced any legal suits while delivering their duties.

Loopholes in the Act

- ★ Majority of responses among the AAs and AC members said that there were no loopholes.
- ★ Over 1/3rd AC members expressed lack of power as a loophole.
- ★ 10% expressed that the enforcers and offenders belonging to the same professional fraternity was a loophole.

Judicial magistrates and NGOs opined that the implementation of the Act was lacking.

★★★

CHAPTER 6

FINDINGS & ANALYSIS

Chapter 6

FINDINGS & ANALYSIS

FINDINGS

Status of Structures

There exists 100 % compliance among all three requisite bodies, the SSB, AA and AC in terms of existence of structure if one goes by the government records. In essence complete compliance can be attributed only to the AAs and the AC at state level.

State Supervisory Board

- ★ SSB has the requisite 21-member composition.
- ★ It is not functioning since its constitution.
- ★ The body is bereft of a geneticist whose role is crucial in the overall context of the implementation of the Act.
- ★ Of the two women activists from the NGO community, only one is appropriately represented.

Appropriate Authority

- ★ There is compliance among the AAs with respect to the requisite structure and members.
- ★ Representation is also complied with but only at the district and sub-division levels. At the state level, among the three-member body, the provision for 'a woman representative from a woman's organisation' is not complied with.

Advisory Committee

- ★ The status of this structure is dismal.
- ★ At the time of the study, the advisory committees at the district and sub-division levels were in a state of limbo.
- ★ There is not a single geneticist represented.
- ★ The profiles of those occupying the post of geneticists seem unlikely to contribute to the role.
- ★ There is a general paucity of experts, especially the gynaecologists, paediatricians, those representing on the post of geneticists and information and publicity officers.
- ★ Those representing geneticists and the information and publicity officers are on multiple committees.

STATUS OF SYSTEMS

Reporting

- ★ Reporting from state to centre is regular from state AA to PNDT Director. There are no reports from SSB to CSB.
- ★ At district and sub-division levels, periodicity of reporting is irregular and between 71-74%.

Record keeping

- ★ AAs at all levels comply to maintaining permanent record of expenditure.
- ★ Minute books are maintained with 100% compliance only at state level. For the rest it is between 69-77%.
- ★ Other permanent records pertaining to applications for registration and letters of intimation, the compliance is between 74 to 81% at district level and 50-64% at sub-division.
- ★ The district level AAs have a better record of record keeping as against the sub-division AA.

Coordination with Advisory Committee

- ★ Coordination between AA and AC in terms of regular meetings as per provisions, across all three levels is poor. There was also discrepancy in the records given by AAs and those by ACs in terms of compliance for regular meetings.
- ★ The record of compliance to quorums is very impressive in figures, but experiences of AC members that they have shared with the team leave scope for doubt in this regard.
- ★ Systems of reporting and record keeping were found weaker at the sub-division level.

Prohibition

- ★ No summons or search warrants have been issued.
- ★ No punishments for prohibited advertising have been dealt.
- ★ Six show cause notices have been issued to clinic, laboratories and to a gynaecologist.
- ★ Two registrations were cancelled.
- ★ One suspension of registration.
- ★ Zero cases filed in the court.
- ★ No complaints received by AA against diagnostic centers from the public.
- ★ No complaints received by AA against diagnostic centers from expectant mothers for being forced to undergo sex determination tests.
- ★ No complaints registered in the court by AA.
- ★ No complaints registered in the court by a person or social organisation after having given notice for 15 days to AA.

Regulation

- ★ Total number of registered clinics in Rajasthan is 1045.
- ★ AAs are non compliant on fulfilling on undertaking monthly inspections.
- ★ Twelve AAs have never conducted inspections and three are not aware that this is a function they need to perform.
- ★ Clinics have exaggerated adherence to record maintenance. Field observations found a wide gap between their responses and actual records.
- ★ Records and practices crucial to regulation of the Act are not maintained as required. E.g. consent forms, doctor's recommendations and letter, Sonography plates/slides and display boards.
- ★ Based on the findings vis-à-vis regulation, 857 offences identified, 127 registered clinics can be punished for at least one offence. This is 89% of the sample.
- ★ Seventeen said that they were ignorant about the requirement for displaying boards.
- ★ Only 49% had a copy of the act and 61% aware of code of conduct.

Prevention

- ★ Out of 129 AAs, almost half (58) did not carry out any activities for public awareness.
- ★ There has been no budget allocation for IEC after 2001.

Result-orientedness

- ★ There is absence of result-orientedness - no monitoring indicators and no target setting.
- ★ 29 out of 432 respondents who were AAs and AC members affirmed existence of monitoring indicators, but failed to qualify their statement.

Effectiveness

There are 1045 registered clinics as per the state records. Prohibitory action has been taken against 9 registered clinics since the implementation of the Act. Accordingly, the percentage of offenders from a population of 1045 is 0.86%. Of the 142 registered clinics the research team investigated, 857 offences were identified with respect to record maintenance alone. At least 127 registered clinics had committed minimum one offence. The percentage of offenders as per the sample of 142 was found to be 89%. If this is projected onto the total population, there could be approximately 930 registered clinics in Rajasthan that can be booked under the PCPNDT Act.

Administrative Constraints

- ★ Between 64-70% AAs said they did not find any shortcomings in the administrative structure.
- ★ 55% AAs expressed that they did not experience any functional constraints. About 15% experienced political and professional pressures in the performance of their functions and another 10 % felt they needed role clarity.

- ★ Among AC members, between 55-68% stated that there were no functional constraints, 15% needed role clarity.
- ★ Almost half the AAs had not received training on the PCPNDT Act.

Legal Constraints

None of the AAs has faced any legal suits while delivering their duties.

Loopholes in the Act

- ★ Majority of responses among the AAs and AC members said that there were no loopholes.
- ★ Over 1/3rd AC members expressed lack of power as a loophole.
- ★ 10% expressed that the enforcers and offenders belonging to the same professional fraternity was a loophole.

Judicial magistrates and NGOs opined that the implementation of the Act was lacking.

ANALYSIS

The structure provides the base for the implementation of the Act. In Rajasthan, in the government records the structure seems full, complete and in place. In essence and on being a bit liberal, compliance to structure exists only for the AAs. Although, the AA is the main body responsible for implementation of the Act, but the SSB and the ACs have crucial roles too.

The SSB is the most important structure in the State. It comprises members who bring in expertise pertaining to law, medicine, social intervention, administration and public representation. This body can thus guide implementation, monitor it from various perspectives and influence policy when required. When such a body is defunct, the implications on implementation are manifold.

Firstly, the link with the CSB at the center is not made, which is a crucial policy making body. Two, the AA operates in isolation and without guidance and supervision. The elected representatives in the SSB play a crucial role in taking the Act to the people and generating public awareness about it. Also, representing the case of the common man for better implementation and influencing policy. When the SSB is defunct, implementation of the Act becomes weak and incomplete. This is reflected in the findings on effectiveness.

There is one AC assigned per AA. The composition of the AC is such that expertise and support is available to the AA on all aspects of prohibition, regulation and prevention. For instance, paucity of IPOs has a direct bearing on prevention of sex determination through public awareness programmes. That the prevention is weak is well reflected in the chapter on effectiveness. The AC works closely with the AA where the action is happening. It is designed to be a complete team. But, as seen above, coordination between the two bodies is weak and the two bodies do not have confidence in one another.

The systems help manage the structure and keep it in existence. Functions are performed through the systems. None of the systems examined in this study is fully complied with.

There is no compliance either for the structure or the systems provided for in the Act. From the findings above, it is clear that the structure is incomplete and therefore weak. It is bound to happen then that the systems will also be weak. The effectiveness of implementation of the Act can be a forgone conclusion.

However, irrespective of the status of structure, the status of effectiveness was examined on independent parameters.

The AAs have been given important and substantial powers for prohibition and regulation. The Act and Rules are comprehensive and seem to have taken into consideration various forms of violations and has accordingly empowered the AAs. Given that the nature of offence (misuse of diagnostic techniques for determination of sex leading to female foeticide) is difficult to detect, strict vigilance is a must.

The Act and Rules provide for strict vigilance through inspections of registered clinics and decoy operations. Given that decoy operations require more efforts, inspections are the least the authorities can do. As the findings suggest, even inspections are a weak area in the implementation of the Act in Rajasthan. Weak regulation has a direct bearing on prohibition. The study has established this weak link very clearly. AAs did not comply with the requirement of monthly inspections. Twelve AAs had never conducted an inspection and three were unaware of undertaking this function. The results of such lapses are visible in the records of the state in terms of prohibition. Since the implementation of the Act in the state, nine offenders have been booked so far, whereas the research team found 857 offences and at least 127 offenders only under lapses in record maintenance. An approximate figure of 930 (89%) out of 1045 registered clinics is projected as possible offenders in Rajasthan. The violation of the Act cannot be detected. But these figures give us a glimpse of the free ground available to offenders to perpetrate the crime. They have enough reasons to operate fearlessly.

Creating public awareness for prevention has been assigned to SSB and AA. SSB is dysfunctional in the state. Only half of AAs have engaged in some form of mass awareness programmes. There is no budget allocation for public awareness. That the Act is not well publicized has been observed by respondents from NGOs.

There are no monitoring indicators in place and no target setting within which the structure operates. Twenty-nine AAs and AC members affirmed the existence of monitoring indicators. Only one could qualify his statement. This sends out a strong message about the implementing structure's alertness about its own functioning.

In terms of effectiveness in implementation then, prohibition, regulation and prevention all three aspects that the structure should work on are weak.

Among AAs and AC members, majority of the responses were in 'no constraints' category. This implies two things; one, the implementing body is not in action and therefore they do not face constraints, two, there are no hurdles in implementation. The first observation holds more ground given the findings of chapters 3 and 4 and given the remarks of the judicial magistrates and NGOs in chapter 5 on the implementation being poor.

Conversely, if the majority of the AAs and AC members state that they do not experience any constraints, then why is the status of structure and effectiveness so weak?

A third possibility is that among the AAs and AC members, there are a committed few and the constraints expressed by them are real constraints that do not weigh quantitatively in terms of responses, but could be actually impacting the performance of those with a will to implement. In this scenario three issues need to be closely examined. One, political and professional pressure. Two, enforcers and offenders are from the same professional fraternity and three lack, of role clarity. ★★★

CHAPTER 7

CONCLUSIONS & RECOMMENDATIONS

Chapter 7

CONCLUSIONS & RECOMMENDATIONS

The Pre-Natal Diagnostic Techniques (PNDT) Act, 1994 was implemented in the country in January, 1996. This was enacted with a view to curb the female foeticides taking place throughout. Experience has shown that this Act did not contribute much to curb the female foeticide issue because of several factors, including government apathy. Later, the Union Government had to modify this Act, with amendments, and it was rechristened as the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994. Again, this was reintroduced in the country in February 2003 for implementation. However, it is to be noted here that this Act came into being only because of the intervention from the Supreme Court.

Consequent upon the directives of the Supreme Court, the Government of Rajasthan met almost all the requirements of the Act in constituting implementing structures and committees along with appointing officers and other individuals on various roles. Having done this process, the government was able to fulfill the directives of the Court.

Three years over, the findings on the implementation of this Act in the state are not very encouraging. The status of structure is weak. The structure for implementation is not in place and systems are impaired. The three bodies, SSB, AA and ACs exist but are not fully functional. Basically the Act in the state is handled by the Appropriate Authorities (AA) only. Other structures like the State Supervisory Board (SSB) and the three-tier Advisory Committees (ACs) do not perform their role as to the expectations of the Act. Each of these structures has important functions but they are hardly delivered or respected. For example, the SSB remains on paper with a 21-member body and the ACs are far from playing their role. Some are unaware of their role. The chairperson of the AC at the state level was unaware that she held such a position. It is still an area of doubt whether the members inducted into these bodies are having a thorough adaptation to the Act. The Act's expectations on these structures are that they play constructive role in order to strengthen the functions of the AAs. It is disheartening to note that they remain passive in the whole process. In such a scenario, the Act has found its way to be handled only by the AAs without much contribution from outside. As a result, it has become an exclusive mechanism at the hands of only the medical fraternity, i.e., the enforcers (medical officers) and the enforced (the clinics). The findings of the study are a testimony to this situation.

The SSB needs to come alive and ACs need to be constituted. There is no compliance to the systems for implementation. Implementation of the Act is bound to be ineffective. There could be several external factors that could have a bearing on effectiveness, but they can be authentically identified only when the Act is authentically implemented. Till the provisions of the Act are not on the ground, every other concern is peripheral.

STRUCTURE AND SYSTEMS

As a first step, the structure for implementation has to be strengthened. For the systems to operate efficiently, firstly the structure concerned has to be well aware of their role and functions. Training of members on all the three bodies to orient them on the functions they are expected to perform and the systems of reporting, meeting, coordination and record keeping that they are expected to follow is strongly recommended. The SSB has to play a proactive role in monitoring these systems.

The State Supervisory Board (SSB)

The SSB is supposed to be delivering the following functions:

(a) creating public awareness against the practice of pre-conception sex selection and pre-natal determination of sex of foetus leading to female foeticide in the state;

(b) reviewing the activities of the appropriate authorities and recommending appropriate action against them;

(c) monitoring the implementation of provisions of the Act and the rules and making suitable recommendations relating thereto to the CSB;

(d) sending such consolidated reports as may be prescribed in respect of the various activities undertaken in the state under the Act to the board (read again CSB) and the central government (PNDT department); and

(e) Any other functions as may be prescribed under the Act.

The SSB ought to align itself to perform these functions. An internal assessment of its representation can be undertaken and gaps can be filled in. A layout of its plans to fulfil on these functions could be sent out to the CSB and the PNDT department at the center. Accordingly, budgetary allocations for public awareness activities can be laid out. Specific recommendations include:

★ The board should honour the provision of the Act for meetings (once in four months), and take stock of the situation vis-à-vis the implementation of the Act;

★ Review of work done by the AAs should be followed by introducing corrective measures, wherever required. Besides, a system of obtaining "action-taken reports" from the AAs may be introduced;

★ As per the Act, it is the role of the board to coordinate with the Central Supervisory Board. This is essential because it will provide wider scope for sharing experiences and suitable recommendations to strengthen the Act. It will also help to plug loopholes in the Act because of which several crimes are going unnoticed, or the enforcers are handicapped;

★ The board may make it possible to work closely with the State Women Commission and Rajasthan Medical Council and such other bodies to develop a perspective on the issue of child sex ratio. Generating such a perspective will help the board to plan appropriate strategies to tackle the issue;

- ★ The board has a scope for expansion. It may expand by co-opting members (1/3rd of the total strength) and increase its strength. Co-option may be done by selecting representatives from civil society organisations working on women, specifically on their social issues;

- ★ The board is expected to be a knowledge pool with various experts to deal with the situation of declining child sex ratio and the application of the Act to curb the menace of sex identification practices. It may therefore maintain a "considered view" that its members are able to facilitate and direct the process of implementation of the Act;

- ★ Having a knowledge pool at hand, it is possible for the board to constitute various task forces or committees like (a) monitoring committee to ensure the mode of application of the Act; (b) technical committee to help overcome technical/legal hurdles faced by the enforcers; (c) implementation committee to ensure efficiency and effectiveness of the implementing structures; and (d) liaison committee to deal with the civil society members, other states, the PNDT department and the Central Supervisory Board.

The Appropriate Authorities (AAs)

At the state level the appropriate authority is made of a three-member body in accordance with the Act, which suggests " one or more appropriate authorities for the whole or part of the state for the purposes of this Act having regard to the intensity of the problem of pre-natal sex determination leading to female foeticide". Apparently this provision is made to have a participatory approach (government and the civil society) in tackling problems of female foeticide. In the state this body is composed of, apart from the director of family welfare, the chairperson of Indian Red Cross Society and a legal officer from the government.

Even after the state appropriate authority was made into a three-member body it remains as good as a single body run by the State Director of Family Welfare because the rest of the members are not found active in the body. In such a situation the spirit of state appropriate authority being a multi-member body contributing to the Act is diminishing. The state AA also needs to revise the representation of its members.

The role of state appropriate authority is found more in the administrative matters rather than guiding and monitoring the work at the lower levels. It is observed that the state AA promptly circulates any decision and/or instructions received from the PNDT department at the central level. Nonetheless, there are no findings on follow-up being done, or action taken reports demanded from the district and sub-divisions. Generally these instructions are not receiving due importance from the lower level AAs. The study has also found that the performance of AAs at the sub-division levels have been found to be less effective in almost all variables examined. This needs to be further probed for reasons and their capacities need to be strengthened.

At the district/sub-division level, the appropriate authorities are the chief and deputy chief medical officers respectively. The AAs at these levels are single bodies that, if desired, can be made as multi-member bodies on par with the state level. The AAs are the most important functionaries in implementing the Act. Any lapse on their part can easily defeat the purpose and seriousness of the Act. Unfortunately this is the case in

the state. The Act, according to our findings, is one more "routine job" in the already burdened administration. Against this backdrop are these enforcers with a demotivated mindset and indifference towards the issue of female foeticide in the state, and they remain lackadaisical. It is just one part of the scene. Added to this is their lack of knowledge on the legalities and technicalities of the Act that are essential components for enforcement. Their inability to comprehend the language used in the Act is another problem.

A look at the functions of the AAs (presented below) will underline the importance and powers that they hold in the implementation of the Act. Their functions are:

(a) to grant, suspend or cancel registration of a genetic counseling center, genetic laboratory or genetic clinic;

(b) to enforce standards prescribed for the genetic counseling center, genetic laboratory or genetic clinic;

(c) to investigate complaints of breach of the provisions of this Act or the rules made there under and take immediate action;

(d) to seek and consider the advice of the Advisory Committee, constituted under sub-section (5), on application of registration and on complaints for suspension or cancellation of registration;

(e) to take appropriate legal action against the use of any sex selection techniques by any person at any place, suo moto or brought to its notice and also to initiate independent investigations in such matter;

(f) to create public awareness against the practice of sex selection or pre-natal determination of sex;

(g) to supervise the implementation of the provisions of the Act and the Rules; and

(h) to recommend to the Board and State Boards modifications required in the rules in accordance with changes in technology or social conditions;

(i) to take action on the recommendations of the Advisory Committee made after investigation of complaint for suspension or cancellation of registration

These functions are also supported with specific powers. With this the AAs, if desired, can implement the Act in the proper direction and curb the menace of sex tests and female foeticide in the state. It is also to be noted that the AAs enjoy a quasi-judicial power and do not require running from pillar to post for taking decisions at their level. The powers given to the AAs are:

(a) summoning of any person who is in possession of any information relating to violation of the provisions of the Act or the Rules made there under;

(b) production of any document or material object relating to clause (a);

(c) issuing search warrant for any place suspected to be indulging in sex selection techniques or pre-natal sex determination; and

(d) any other matter which may be prescribed.

Specific recommendations for effective functioning of the AAs:

The AAs need to be well equipped to enforce the Act in its right spirit. It is observed that they require to be capacitated in their functions. Following programmes may be conducted for the AAs to enable them implement the Act effectively.

- ★ Training in the legal aspects of the Act, and awareness building on exercising powers vested in them to deal with clinics;
- ★ Creating sensitivity on the issue context and the role expected of them in the Act to curb the practice of female foeticide;
- ★ Training in social marketing techniques to create public awareness on the Act and its legal implications on the citizens and clinics when they violate the Act;
- ★ Workshops on rapport building exercise with civil society organizations and allied groups with a view to create group convergence for assistance;
- ★ Workshops on communication skills in order to hold public meetings/ rallies to publicize the Act;
- ★ Workshops on record maintenance and documentation skills; their systematic reporting to higher levels;
- ★ Exposure programmes to develop similar skills performed by vigilance inspectors; and
- ★ Workshops on motivational skills and attitudinal changes to deal with grievances and complaints;
- ★ Simplifying record keeping through managing them electronically is a possibility that could be looked into. This will also bring in transparency into the system.

The Advisory Committees (ACs)

If one goes by the spirit under which the ACs are placed in the implementation of the Act, it is beyond doubt that they have to perform as "watch-dogs" in their respective jurisdictions and facilitate the AAs in enforcing the Act with desired results. Thus, the ACs also have a definite and constructive role to see that the enforcement is taking place in the right direction. In addition, the ACs are the only conduits through which the government is able to establish interface with the civil society and ensure public participation in the enforcement of the Act.

Whether it is the spirit, value or purpose, the government has adopted its own ways to appoint members on the ACs for implementation. A major chunk of appointees are from the government departments or from its controlled institutions who are already preoccupied with their own duties and responsibilities. Under such circumstances their motivation and commitment towards another "task" in the ACs is doubtful. In our interview with many of these appointees it was clear that they did not hold any importance to their fresh task. They are not aware of the Act and do not hold any interest to fulfill their role in the ACs. Some of them even do not know of their names appearing in the list of appointees.

Appointment of members from the social work sector on the ACs is not done in a systematic manner. It is found that neither a principle is applied nor a criterion developed for this purpose. Majority of the

appointees are unable to meet the important pre-requisite of the Act ; that they should be able to spare time for the ACs. Many of them have reported that they were already engaged with their own activities or profession, and the timings fixed for any meetings (if convened) generally clash with their own priorities. At the same time, those who attend such meetings feel that their suggestions are not getting due importance from the appropriate authorities. All these indicate that the exercise carried out by the government in appointing members on the ACs was in a loose manner.

The above scenario does not provide any credence to the present ACs and their envisaged role, and the government has to be diligent while constituting these committees. The ACs should have people who are able to provide time, offer guidance and support to the AAs in the implementation of the Act. Also, they are expected to play a proactive role and simultaneously help and guide the AAs in their duties and responsibilities. Their active role in the overall implementation, therefore, cannot be overemphasized.

New ACs are in the making. It is an opportune time to give it appropriate consideration. Feedback from the former members and AAs can be obtained to re-examine membership and representation. Absence of geneticists in the state and paucity of other experts should be thoroughly examined and reviewed. Paucity of information and publicity officers and paucity of public awareness programmes is not a coincidence. IPOs play a crucial role in public awareness and alternatives have to be found to fulfill this requirement. There is scope to include members from outside the government bodies, such as media groups could be involved. The SSB could facilitate these processes under guidance from the CSB.

Specific Recommendations for constituting the Advisory Committees (ACs):

By virtue of the ACs' role in the implementation, the government needs to place serious efforts to rejuvenate these committees to implement the Act effectively in the state. The following recommendations may be taken into consideration while constituting these committees:

- ★ Government need not place its own expertise on the ACs as the Act does not specify this norm. It can explore other options for selecting concerned expertise from independent institutions and bodies in the state. This step will ensure effective public participation in the implementation;

- ★ Representation from the social work field should be made through a process of screening on the knowledge, interest and in-built ideology on the issue of child sex ratio. It is not necessary that all the social workers or NGOs hold these qualities. People working on women's issues, very necessarily on gender issues and mass mobilization, should find a place of priority in the ACs;

- ★ Regularity of the AC meetings needs to be ensured as per the provision of the Act. The appropriate authorities have to be made accountable to the ACs in implementing the Act in their jurisdictions;

- ★ All the appointed members need to be given an orientation on the applicability of the Act, their role clarity and responsibility;

- ★ The AC members should be able to accompany the appropriate authority while visiting the clinics. They should adhere to the rules prescribed for such visits and ensure that the AAs give priority to visit the clinic as per rules;

ANNEXURE-1

REFERENCES

REFERENCES

Annexure 1

1. Edwards J and Franklin S et al (1999) *Technologies of Procreation: Kinship in the Age of Assisted Conception*, London: Routledge.
2. IFES, India, *Learning Across Borders* - A Compendium of Information Resources (Draft) on Adverse Sex Ratio, compiled by Divya R. Tiwari and Ruchika Negi.
3. Centre for Enquiry into Health & Allied Themes (CEHAT)-2003- *Sex Selection Issues & Concerns*: A compilation of articles.
4. *Ending the Practices Changing the Mindset*, Draft Strategic Paper, National Advocacy Strategy, June 2002.
5. *Sex Selective Abortion and Fertility Decline*: Report of case of Haryana and Punjab, UNFPA, 2001.
6. Lal S, Vashisht B.M, Punia M.S, *Down With Low Child Sex Ratio*, Indian Journal of Community Medicine, Vol. XXVII, No.1, January - March 2002.
7. Santhya K.G and Verma S, *Induced Abortion: The Current Scenario in India*, RHF: WHO South-East Asia Region, Volume 8, Number 2, 2004.
8. *A Ban on Sex Selection,* Anonymous.
9. Bahuguna, Nitin Jugran, *Does Delhi Want Girls?* Women's Feature Service, December 19, 2004.
10. Kabra, S.G (Dr), *Abortion: Laws and Outlaws*, Indian Institute of Health Management Research (IIHMR), Jaipur.
11. Malik R, 'Negative Choice', A paper submitted in Abortion Assessment Project, August 2000.
12. Mulay, S and Nagarajan R, *A study on Ultrasound Centres in Maharashtra*, Population and Research Centre, Gokhale Institute of Politics and Economics, Pune, January 2005.
13. Patel Vibhuti (Dr), *Political Economy of Missing Girls*, paper presented at Workshop on Missing Girls in India: Sciences, Gender Relations, and the Political Economy of Emotions, at Department of Sociology, Delhi School of Economics, University of Delhi, 30-31 October 2003.
14. Patel Vibhuti (Dr), *Sex Selection & Pre-Birth Elimination of Girl Child,* paper presented at 'Regional meeting for Gender focal points and selected national participation in SAWA' on Culture, Gender and Human Rights, organized by UNFPA in Kathmandu, Nepal, 26-30 June, 2005.

15. Sharma C and Jain D, *Technology and its Impact on Female Foeticide in India*, May 2005.

16. Sharma D, *Bringing Female Foeticide on National Agenda*, Press Information Bureau, July 13, 2001.

17. Tendulkar Vijay and Setalvaad Teesta*, Where are our girls?*, Citizen for Justice and Peace (CJP), June 10, 2005

18. *Darkness at Noon - Female Foeticide in India*, Project Report on Declining Child Sex Ratio and Gender Balance, Voluntary Health Association of India, August 2003.

19. *Achieving Equality: Addressing Sex Selection,* Interactive Session on Female Foeticide conducted by United Nations Population Fund, National Commission for Women and Center for Social Research, on July 18, 2005 at New Delhi.

20. *Sex Selection In India: Issues and Approaches*, Roundtable (17 & 18th February, 2005), Hivos India Regional Office, Bangalore.

21. Government of Rajasthan, Registrar of Birth and Death, Annual Report 2000-2003.

22. Government of India, Census of India, 2001.

23. Government of India, Medical Termination of Pregnancy Act, 1971.

24. Government of India, Pre-Natal Diagnostic Techniques (Regulation and prevention of Misuse) Act, 1994.

25. Government of India, Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, (Amended).

26. Government of India, Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Rules, 1996.

27. Government of India, Department of Family Welfare, *Handbook on PNDT Act, 1994*, October 2002.

28. Government of Rajasthan, Department of Women and Child Development, Rajasthan State Commission for Women Act, 1999.

29. Government of Rajasthan, Department of Women and Child Development, State Women Policy, 1997, (pages 32-34).

30. Agarwal Gopinath, *Garv path-uchit ya anuchit: Faisla apka*, Gitapress, Gorakhpur.

31. *Mujhe Bacaho- Mera Kya Kasur*? Gitapress, Gorakhpur (Hindi).

32. *Mujrim Kaun*?, Madhya Pradesh Voluntary Health Association, Indore, September 2001 (Hindi).

33. *Rajasthan me ghatata linganupat: ek bara samajik anarth*, Prayas, Rajasthan (Hindi).

34. Deccan Herald, "*No Convictions for Sex Selective Abortions in the last 9 years, admits Indian Health Minister",* May 05, 2005.

35. Deccan Herald, *Serious Crime*, April 29, 2004.

36. Frontline, *An Act on Paper*, Volume 18, Issue 12, June 9-22, 2001.

37. Frontline, Menon Parvathi and Roy Chowdhury Srobona, *Dubious Choice*, Volume 18-Issue 26, December 22, 2001 - January 04, 2002.

38. Tribune News Services, "*Low Sex Ratio: Elite Equally Responsible",* New Delhi, February 16, 2004.

39. Health Care Management Express, *"Gynaecologist complain harassment under PNDT Act"*, Health Management Bureau, Mumbai, dated July1-15, 2003.

Sites Visited:

40. http://www.india-seminar.com/2003/532/532%20leela%20visaria.htm

41. http://www.unfpa.org/ culture/case_studies/india_study.htm

42. http://www.studentbmj.com/issues/03/10/life/384.php

43. http://lists.econ.ytah.edu/pipermail/marxism/2004-November/015861.html

44. http://www.centerdigitalgov.com/international/story.php?docid=94065

45. http://www.datamationfoundation.org

ANNEXURE-2

SET OF QUESTIONNAIRES

ANNEXURE- 2

SET OF QUESTIONNAIRES

SSB - CH

Study on the Status and Effectiveness of the PCPNDT Act in the State of Rajasthan

Interview Guide

State Supervisory Board – Chairperson

Respondent

Name:

Designation:

Duration in office:

Trained in PCPNDT Act: (Yes/No):

Address:

Telephone:

Name of the Investigator:

Signature:

1. **How many meetings have been held by your committee during the last year and at what intervals?**

2. Please give the details of these meetings:

Date	No. of members attending the meeting	Agenda of the meeting (in brief)

3. What is the role that this board plays in making the PCPNDT Act more effective?

4. What is the political will of the Government to make the implementation strong?

5. What measures are needed to implement the Act effectively in the State?

6. What are your views on female foeticide?

7. How will the public awareness activities take place in absence of special budget allocated for this purpose?

8. How can the implementation process be monitored, when the act is invisible?

9. Both CMHO and Doctor conducting the test are from the same fraternity. Do you think it is an obstacle to monitoring?

10. What future plans have the board envisaged to expedite the implementation process?

Investigator's Comments:

SSB - VC

Study on the Status and Effectiveness of the PCPNDT Act in the State of Rajasthan

Interview Guide

State Supervisory Board – Vice-chairperson

Respondent

Name:

Designation:

Address:

Telepone:

Name of the Investigator:

Signature:

1. **How many meetings have been held by your committee during the last year and at what intervals?**

2. **Please give the details of these meetings:**

Date	No. of members attending the meeting	Agenda of the meeting (in brief)

3. **How does the Board gauge the status and effectiveness of the implementation of the Act?**

4. **Do you have any indicators that are regularly monitored?**

5. **Has the board set any targets to achieve?**

6. **Does the Board find loopholes in the Act that restrain the effectiveness of its own functioning?**

7. **Does the board find gaps in the administrative structure that hinder in making the Act effective?**

8. **Have there been any recent orders passed by the Central Government to make the Act more effective? What have they been?**

9. **Have there been recommendations made to the Central Supervisory Board for introducing rules or orders to strengthen the Act?**

10. **How does the Central PNDT Department deal with the State through SSB/through state AA?**

11. **If the PNDT Department of the Centre is dealing with the State AA, what is the reporting system followed to inform the SSB?**

12. **Are you satisfied with the implementation of the Act in the State? Are there any problem areas?**

13. **What are your suggestions on improving the implementation of this Act?**

14. **Has the state been recommending any suggestions to the CSB/PNDT Department to improve the implementation of PCPNDT Act?**

15. **What measures are needed to implement the Act effectively?**

Investigator's Comments:

SSB-SW

Study on the Status and Effectiveness of The PCPNDT Act in The State of Rajasthan

Interview Guide

State Supervisory Board – Member from Social Work

Respondent

Name:

Designation:

Duration of service in the board:
(Since when)

Address:

Telephone:

Name of the Investigator:

Signature:

1. **How was your nomination processed and who informed you of your nomination to the Board?**

2. **How many meetings of the SSB have you attended since your nomination?**

3. **What are the main agenda, business transacted etc in the SSB meetings?**

4. **How do you attend the meetings? On your own expenses or through TA/DA provisions?**

5. **What sort of suggestions have you been keeping with the SSB meetings?**

6. **How do you view the effectiveness of the SSB in the implementation process of PCPNDT Act in the State?**

7. **Do the SSB meetings enjoy the full quorum of members? If not what category of members usually attend the meetings?**

8. **As a social activist on women's issues what were your efforts on the effective implementation of the Act in the State?**

9. **Are you able to logically relate your field perspectives and issues (child sex ratio and female foeticide) in the SSB meetings?**

10. **Do you share these perspectives and issues at other avenues/opportunities with the government other than the SSB meetings?**

11. **What are your views on the current situation on sex determination tests and subsequent female foeticide?**

12. **In your opinion, how serious is this issue in the State and what steps need to be taken to curb the recurrence of the sex determination tests?**

13. **Do you find any lacunae and constraints in the implementation of PCPNDT Act in the State? Can you describe them?**

14. **Do you think that the SSB is quite active in overseeing the entire process of PCPNDT Act in the State?**

15. **Does the SSB of the State working in tandem with the Central Supervisory Board in regard to the effective implementation of the Act?**

16. **As a member of the SSB, do you share any responsibility (individual) in overseeing and reviewing the process of implementation of PCPNDT Act in the State?**

17. **You are in the SSB in the capacity of a representative from a women's organization. What, according to you, should be the specific role of such organizations and also collective efforts with others in order to strictly enforce the Act and curb the female foeticide in the State?**

18. **Is PCPNDT Act enough to absolutely eliminate the sex determination tests in the State? Any other local Acts or Orders necessary to deal with the recurrences (in spite of the PCPNDT Act) of the misuse of the techniques?**

19. **What are your considered views about the status and effectiveness of PCPNDT Act in the State?**

20. **Do you think that the downward trend of child sex ratio can be tackled by the government alone? Any suggestions?**

Investigator's Comments:

AA - ST

Study on the Status and Effectiveness of the PCPNDT Act in the State of Rajasthan

Interview Guide

Appropriate Authority - State

Respondent

Name:

Designation:

Duration of serving:

Trained in PCPNDT Act: (Yes/No):

Address:

Telephone:

Name of the Investigator:

Signature:

1. **Is the AA in this state a single/multimember body? Give membership details**

S. No.	Members	Name	Yes/No
1	Chairperson		
2	Officer of Law Deptt. of State		
3	Woman representing women's organization		

2. **Is the state AC composed of following experts?**

S. No.	Members	Name	Yes/ No
1	Sr. Gynaecologist/Obstetrician		
2	Sr. Paediatrician		
3	Medical Geneticist		
4	Legal Expert		
5	Officer – Deptt. of Information & Publicity		
6	Social Worker – Women's Organization		
7	Social Worker		
8	Social Worker		
9	Any other (please give details)		

3. **How many meetings have been conducted of your Advisory Committee during the last year and at what intervals?**

   a. Intervals:

   i. Every month .....
   ii. Every two months .....
   iii. More than two months .....

   b. Please give details of the last 6 meetings:

Details	1	2	3	4	5	6
Dates of meetings						
No. of members attended						

(Please start from the last meeting)

4. **Are there any vacancies at present in your Advisory Committee? Please give details:**

S. No.	Designation	Vacancy	Since when is it lying vacant?
1	Sr. Gynaecologist/Obstetrician		
2	Sr. Paediatrician		
3	Medical Geneticist		
4	Legal Expert		
5	Officer – Deptt. of Information & Publicity		
6	Social Worker – Women's Organization		
7	Social Worker		
8	Social Worker		
9	Any other (please give details)		

5. **What is the practice adopted in the case of non-availability of members prescribed under the Act for the Advisory Committee at the three levels?**

6. **What is the system of record keeping and reporting followed?**

   a. Maintaining minutes book Yes / No

   b. What records are maintained at the state level?

   c. At what interval are reports brought out?

   d. Whom do you report to?

7. **Please provide information regarding PCPNDT implementation expenses**

   a) Which are the main heads for expenditure budgeted?

   b) Details of Income & Expenditure:

Budget details	**2003-04**	**2004-05**
Annual Budget Allocation		
Expenditure		
Balance		

   c) How are the funds actually spent? (Under which heads do you record most expenditure?)

   d) What is the system for fund allocation to the district and sub-divisional levels?

      1. Fund requirements
      2. Funds disbursal
      3. Regularity
      4. Transparency
      5. Accountability

8. **What is the system of coordination with the SSB?**

9. **What is the system of coordination with the State Advisory committee?**

10. **What practices are adopted for organizing meetings?**

    1. Advance notice period
    2. Place of meeting
    3. Provision for TA/DA, lodging and boarding

11. **What is the system of coordination (communication) with other appropriate authorities at district level?**

12. **What is the system of coordination (communication) with other appropriate authorities at sub-division level?**

13. **Which other organizations, associations or commissions does the authority coordinate with to strengthen the implementation of the Act?**

    1. SWC
    2. RMC
    3. Judiciary
    4. Legislature
    5. Other medical bodies

14. **Public awareness programmes conducted on this Act:**

    i. What types of awareness activities are undertaken?

    ii. Which media is used?

    iii. Which agencies are involved?

    iv. Is there a budget allocation for this purpose?

    v. Is it sufficient or not?

    vi. In the last year (April 2004 – March 2005) how much amount was spent?

    vii. What was the unspent balance?

15. **In terms of prohibition what is the role of AA?**

16. **In terms of regulation what is the role of AA?**

17. **How does the State AA monitor the functions of the district and sub-division levels?**

    - Prohibitory

    - Regulatory

    - Coordination with Advisory Committee

18. **When does AA state intervene in prohibitory and regulatory activities undertaken by the AA at the subordinate levels?**

19. **How does the authority gauge the status and effectiveness of the implementation of the Act?**
    - Do you have any indicators that are regularly monitored?

    - Has the authority set any targets to achieve?

20. **Does the authority find loopholes in the Act that restrain the effectiveness of its own functioning?**

21. **Does the authority find gaps in the administrative structure that hinder in making the Act effective?**

22. **Does the authority find interference from other administrative machinery due to lack of clarity and clashes in authority?**

23. **Has there been any legal suit or prosecution or legal proceeding been initiated on any of your members?**

24. **Are there any other constraints that hinder the deliverance of your responsibilities?**

25. **What has been the contribution of this authority in strengthening effectiveness of the Act?**

26. **What are the orders passed by the authority to make the Act more effective?**

27. **Have there been recommendations made to the State Supervisory board for introducing rules or orders to strengthen the Act?**

28. **What measures are needed to implement the Act effectively?**

Investigator's Comments:

AA-ST

Study on the Status and Effectiveness of the PCPNDT Act in the State of Rajasthan

Interview Guide

State Appropriate Authority – Member (Social Work)

Respondent

Position Held:

Duration of Serving:
(Since when)

Address:

Telephone:

Name of the Investigator:

Signature:

1. **Please provide details and the background on which you have been selected to serve on the State Appropriate Authority (SAA) as a Member**

2. **How many meetings of the SAA have you attended so far? Where are these meetings usually held?**

3. **What are the main agenda and business transacted in such meetings?**

4. **How do you attend these meetings? On your own expenses or any TA/DA provided?**

5. How do you feel that you are able to perform a pro-active role in regard to making the Act more effective in the State? Are your suggestions receiving due importance and follow up actions taken?

6. What sort of suggestions have you been putting forward in the meetings?

7. As a member on a very important structure in the PCPNDT Act in the State, please comment on the overall practices of the Act, including the constraints, if any

8. How are the meetings organized? At short notices or by giving due time of notice as per the norms?

9. Are you aware of the budget allocation etc for PCPNDT implementation process? (Please give details from 2003 onwards)

10. Are the meetings conducted with full quorum? Have you been regularly attending the meetings?

11. Do the meetings keep minutes of the deliberations? Do you receive copies of these minutes?

12. In your opinion, how efficient and effective is the State Appropriate Authority (as a multi-member body) in dealing with the PCPNDT Act in the State?

13. What are your suggestions if there are deficiencies in the above area?

14. Please comment on the steep decline of sex ratio in the State. What are the root causes, problems and issues?

15. **As a woman social worker/activist how do you visualize this scenario? What steps need to be taken by the Government?**

16. **Do you think that the implementation of PCPNDT Act is taking place in the State with desired results? Do you find any lacunae, constraints, etc, which hamper the effectiveness of this Act?**

17. **Please share your ideas and perceptions on the Act and required interventions to strictly prohibit the sex determination tests in the State**

Investigator's Comments:

AC- ST

Study on the Status and Effectiveness of The PCPNDT Act in The State of Rajasthan

Interview Guide

Advisory Committee - State

Respondent

Name:

Designation:

Period of membership:

Address:

Telephone:

Name of the Investigator:

Signature:

1. **How many meetings have been held by your committee during the last year and at what intervals?**
   - i. Monthly …….
   - ii. Bimonthly …….
   - iii. More than two months …….

2. **What were the main agenda in these meetings?**

3. **What are your functions as a member of the Advisory Committee?**

   a. Do you/other members accompany the appropriate authority for inspection of registered clinics?

   b. At what intervals?

c. Do you discuss registration, applications for registration, suspension, renewals, etc in the AC meetings?

d. What are your observations?

4. **What system of communication is maintained for coordination with the appropriate authorities at various levels?**

   a. Written communication
   b. Meetings
   c. Record Keeping
   d. Reporting
   e. Financial Allocations
   f. Any other (Please give details)

7. **What are the indicators for the effective implementation of this Act?**

   a. For regular monitoring
   b. For regular facilitation to appropriate authority
   c. For Goal Achievement

8. **What constraints do you experience in carrying out your role?**

9. **Are there any loopholes in the Act that influence the work of the committee?**

10. **What measures can be taken to make the Act more effective?**

Special section for Gynaecologist/Obstetrician/Paediatrician/Medical Geneticist

1. **What is the reaction of the medical fraternity on this Act?**

2. **How far the Code of Conduct has been practiced?**

3. Usually the sex determination tests are done secretly. How can they be monitored effectively?
4. What techniques have been adopted for exposing misuse of ultrasound machines and genetic techniques for sex determination?

5. What measures are needed to bring transparency in the use of medical techniques so that their abuse can be tracked?

Special section for Social Workers

1. What are the reactions of the community on this Act?

2. Usually the sex determination tests are done secretly. How can they be monitored effectively?

3. What methods have been adopted for exposing the offences?

4. What initiatives are required at community level for effective implementation of this Act?

5. What measures are needed to bring transparency in the techniques so that their abuse can be stopped?

Special section for Legal Experts

1. What are the reactions of legal community on this Act?

2. Do you think if MTP Act is misused, it can cover up for the offences under PCPNDT Act?

3. What legal steps should be taken against a guilty, to act as deterrent to others?

Investigator's Comment's:

RMC-ST

Study on the Status and Effectiveness of The PCPNDT Act in The State of Rajasthan

Interview Guide

Rajasthan Medical Council

Respondent

Name:

Designation:

Address:

Telephone:

Name of the Investigator:

Signature:

1. **What is the level of awareness among the medical practitioners about the PCPNDT Act?**

2. **What is the role of RMC in effective implementation of the Act?**

3. **What activities has the RMC undertaken to educate its members about the Act?**

4. **Can you estimate the extent of sex determination tests being carried out in Rajasthan?**

5. **Can you give an estimate of sex selection tests being carried out in Rajasthan?**

6. **Can you give an estimate of female foeticides in Rajasthan?**

7. **Do you see sex determination leading to female foeticide as a violation of human rights? Is it an unethical act?**
8. **How many physicians are engaged in such unethical acts in Rajasthan?**

9. **How does the RMC regulate professional misconduct and unethical act in this regard?**

10. **Have there been any enquiries initiated against an erring practitioner in this regard?**

11. **Have there been any punishments awarded or disciplinary actions undertaken against any practitioner?**

12. **Have there been any criminal proceedings initiated on any medical practitioner for professional misconduct in this regard?**

13. **Is the council actively involved with the state authorities to implement the Act? How does this happen?**

14. **Every applicant in the medical profession makes a declaration to maintain the utmost respect for human life from the time of conception. In view of practices of sex selection and sex determination leading to female foeticide and as the head of a body that regulates ethics among the medical professionals, what is your comment on this?**

15. **The regulatory body under the PCPNDT Act and the offending groups belong to the medical fraternity. What are your views on this?**

16. **What can the RMC do to make the PCPNDT implementation more effective in the context of its regulations and code of conduct?**

Investigator's Comments:

SWC-ST

Study on the Status and Effectiveness of The PCPNDT Act in The State of Rajasthan

Interview Guide

State Women Commission

Respondent

Name:

Designation:

Address:

Telephone:

Name of the Investigator:

Signature:

1. **What is the role of State Women Commission in the implementation of the PCPNDT Act at the central and state levels?**
    a. Monitoring
    b. Implementation
    c. Educating
    d. Powers equivalent to Civil court
    e. How does it link up with the Central SWC?
2. **How has the SWC been involved in the implementation of the Act in Rajasthan?**
    a. With the state administration
    b. With the state legislature
    c. With the state judiciary
    d. At what levels – district/sub-division

3. **How does the State Women's Policy help in making the implementation of the PCPNDT Act more effective?**

4. **What are your observations on the sex ratio in Rajasthan?**

5. **What are your observations on the female foeticide scenario in Rajasthan?**

6. **Please give your views about the PCPNDT Act.**

    a. Is the Act designed to meet its purpose of prohibition and regulation?

    b. Are the structures created relevant and effective in meeting the purpose?

    c. Are the systems for communicating, coordinating, monitoring and reporting sufficient and substantial?

7. **What have been your experiences of the authorities associated with this Act, in terms of:**

    a. Their understanding of the Act

    b. Their understanding of role

    c. Their preparedness to perform role

    d. Their ability to perform role

    e. Their inclination to implement the Act

8. **What is the level of public awareness about this Act?**

9. **Are there any loopholes in the PCPNDT Act?**

10. **Which are the common lapses in the implementation of the Act?**

11. **To what extent are the MTP Act and the PCPNDT Act, well aligned to meet the purpose of the latter and where do you see clash of interests?**
12. **To what extent does the Act address the issue of declining sex ratio and female foeticide? (given that many sex determination tests are a hoax – how can one attribute declining sex ratio to abortions carried out post test)**

13. **The offences under this act cannot be easily detected. What can be done to make the crime visible?**

14. **What indicators do you suggest to monitor the effectiveness of this Act? How does one ensure the Act is meeting its purpose?**

15. **What do you suggest to strengthen the provisions in the Act?**

16. **What do you suggest to strengthen the implementation of this Act?**

17. **What additional interventions are needed to address the issue of declining sex ratio and female foeticide?**

18. **How can the medical community be made accountable and their practices transparent? (given that the regulatory body and the offenders are from the same fraternity)**

19. **What has your organisation done to address these concerns?**

20. **What measures do you suggest?**

    a. At the policy level
    b. At the administrative level
    c. At the judicial level
    d. At the community level
    e. Among the medical fraternity

Investigator's Comments:

CSM- ST

Study on the Status and Effectiveness of The PCPNDT Act in The State of Rajasthan

Interview Guide

Civil Society Members (State)

Respondent

Name:

Designation:

Name of Organisation:

Address:

Telephone:

Name of the Investigator:

Signature:

1. **Please give a brief account on the working of your organisation - its objectives, programmes and geographical area**

2. **What are your observations on the sex ratio scenario in Rajasthan?**

3. **What is the mindset of people in Rajasthan about pre-conception and pre-natal sex selection?**

4. **How prevalent are sex selection techniques in Rajasthan?**

    a. In which regions are these most prevalent?

    b. Who are the people largely seeking sex selection techniques? (explore socio-economic groups, specific communities)

5. **Please give your views about the PCPNDT Act**

a. Is the Act designed to meet its purpose of prohibition and regulation?

b. Are the structures created relevant and effective in meeting the purpose?

c. Are the systems for communicating, coordinating, monitoring and reporting sufficient and substantial?

6. What have been your experiences of the authorities associated with this Act, in terms of

a. Their understanding of the Act

b. Their understanding of role

c. Their preparedness to perform role

d. Their ability to perform role

e. Their inclination to implement the Act

7. What is the level of public awareness about this Act?

8. Are there any loopholes in the PCPNDT Act?

9. Which are the common lapses in the implementation of the Act?

10. To what extent are the MTP Act and the PCPNDT Act, well aligned to meet the purpose of the latter and where do you see clash of interests?

11. To what extent does the Act address the issue of declining sex ratio and female foeticide? (given that many sex determination tests are a hoax – how can one attribute declining sex ratio to abortions carried out post test)

12. The offences under this act cannot be easily detected. What can be done to make the crime visible?

13. **What indicators do you suggest to monitor the effectiveness of this Act? How does one ensure the Act is meeting its purpose?**

14. **What do you suggest to strengthen the provisions in the Act?**

15. **What do you suggest to strengthen the implementation of this Act?'**

16. **What additional interventions are needed to address the issue of declining sex ratio and female foeticide?**

17. **How can the medical community be made accountable and their practices transparent? (given that the regulatory body and the offenders are from the same fraternity)**

18. **What has your organisation undertaken to address these concerns?**

19. **What measures do you suggest?**

    a. At the policy level

    b. At the administrative level

    c. At the judicial level

    d. At the community level

    e. Among the medical fraternity

Investigator's Comments:

AA-D/SD

Study on the Status and Effectiveness of The PCPNDT Act in The State of Rajasthan

Questionnaire

Appropriate Authority – District /Sub-division

Respondent

Name:

Designation:

Duration in office:

Trained in PCPNDT Act: (Yes/No):

Address:

Telephone:

Name of the Investigator:

Signature:

1. **Is the AA in your district single or multimember?**

S. No.	Members	Name	Yes/No
1	Chairperson		
2	Officer of Law Deptt. of State		
3	Woman representing women's organization		

2. **Formation of Adviory Committee**
   a. **How is the Advisory Committee constituted in your district?**

S.No.	Members	Name	Yes/No
1	Sr. Gynaecologist/Obstetrician		
2	Sr. Paediatrician		
3	Medical Geneticist		
4	Legal Expert		
5	Officer – Deptt. of Information & Publicity		
6	Social Worker – Women's Organization		
7	Social Worker		
8	Social Worker		
9	Any other (please give details)		

b. **Is the existing AC old or new?**

3. **Since 2003, how many summons have been issued by your office to persons violating the provisions of the Act?**

4. **Since 2003, how many search warrants have been issued by your office to persons suspected of indulging in sex selection and related techniques?**

5. **Since 2003, how many persons have been punished for giving publicity on the availability of sex selection tests?**

6. **Applications for registration received in your area since 2003:**

Code	**Pre-natal Diagnostic Centers**	**Nos.**
G.1.	Genetic Counselling Center	
G.2.	Genetic Clinic	
G.3.	Genetic Laboratory	
G.4.	Gynaecologist	
G.5	Any Other	

7. **Number of clinics registered in your area since 2003:**

Code	**Pre-natal Diagnostic Centres**	**Nos.**
G.1.	Genetic Counselling Center	
G.2.	Genetic Clinic	
G.3.	Genetic Laboratory	
G.4.	Gynaecologist	
G.5	Any Other	

8. Number of applications rejected since 2003:

Code	Pre natal Diagnostic Centers	Nos.
G.1.	Genetic Counselling Center	
G.2.	Genetic Clinic	
G.3.	Genetic Laboratory	
G.4.	Gynaecologist	
G.5	Any Other	

9. Number of clinics informed of the status of the registration in your area

Code	Pre-natal Diagnostic Centers	Nos.
G.1.	Genetic Counselling Center	
G.2.	Genetic Clinic	
G.3.	Genetic Laboratory	
G.4.	Gynaecologist	
G.5	Any Other	

10. Do you have any knowledge about clinics operating without registration in your area?

11. Number of offences detected

Code	Pre-natal Diagnostic Centers	Nos.
G.1.	Genetic Counselling Center	
G.2.	Genetic Clinic	
G.3.	Genetic Laboratory	
G.4.	Gynaecologist	
G.5	Any Other	

12. What are the penalties on the following for breach of provisions in the Act?

Code	Pre-natal Diagnostic Centers	Show cause notices	Cancellation of registration	Suspension of registration	Fined	Convicted by Court	Reported to Medical Council
G.1	Genetic Counselling Center						
G.2	Genetic Clinic						
G.3	Genetic Laboratory						
G.4	Gynaecologist						
G.5	Any Other						

13. Number of complaints received from the public against diagnostic centers

14. Number of expectant mothers who have registered complaints for being forced to undergo sex detection tests and/or abortions of female foetus

Investigator's Comments:

AA-D / SD

Study on the Status and Effectiveness of the PCPNDT Act in the State of Rajasthan

Interview Guide

Appropriate Authority – District /Sub-division

Respondent

Name:

Designation:

Duration in office:

Trained in PCPNDT Act: (Yes/No):

Address:

Telephone:

Name of the Investigator:

Signature:

1. **How many meetings have been conducted by your Advisory Committee during the last year and at what intervals?**

   a. Intervals:
      iv. Every month ……..
      v. Every two months ……..
      vi. More than two months ……..
      vii. Never happened ……..

   b. Please give details of the last 6 meetings:

Details	**1**	**2**	**3**	**4**	**5**	**6**
Dates of meetings						
No. of members attended						

(Please start from the last meeting)

2. **Are there any vacancies existing in your Advisory Committee? Please give details:**

Designation	Vacancy	Since when is it lying vacant?
Geneticist		
Legal expert		
Social worker (female)		
Social worker		
Social worker		
Any Other		

3. What is the practice adopted in the case of non-availability of members prescribed under the Act for the Advisory Committee?

4. What is the system of record keeping and reporting followed?

a. Maintaining minutes book — Yes / No
b. Reports brought out at regular interval — Yes / No
c. Do you have permanent record of the clinics
   i. Applications for the grant of certificate of registration — Yes / No
   ii. Applications for renewal of certificate of registration as specified in form H — Yes / No
   iii. Letters of intimation of every change of employee place, address and equipment installed — Yes / No

5. **Please provide information regarding PCPNDT implementation expenses:**

a. Which are the main heads for expenditure?

b. Details of Income & Expenditure:

Budget details	2003-04	2004-05
Annual Budget Allocation		
Expenditure		
Balance		

6. Public awareness programmes conducted on this Act:

a) What types of awareness activities are undertaken?

b) Which media is used?

c) Which agencies are involved?

d) Is there a budget allocation for this purpose?

e) Is it sufficient or not?

f) In the last year (April 2004 – March 2005) how much amount was spent?

g) What was the unspent balance?

7. Frequency of inspections undertaken on registered clinics:

a) Monthly ……
b) Quarterly ……
c) Half-yearly ……
d) Annually ……
e) Never ……

8. Do the Advisory Committee members accompany these inspections? Please give details

9. What are the different organizations, associations or commissions with which the appropriate authorities coordinate in order to implement the Act effectively?

10. How do you review the status and effectiveness of the implementation of the Act?

a. Monitoring indicators developed (If yes, please list out)

b. Targets set to achieve (Please give details)

11. **Does the authority find loopholes in the Act that restrain the effectiveness of its own functioning?**

12. **Does the authority find gaps and difficulties in the administrative structure that hinder in making the Act effective?**

13. **Are there any other constraints that hinder the deliverance of your responsibilities?**

14. **Have there been any orders passed by the State Appropriate Authority to make the Act more effective?**

    a. Type of orders?

    b. Which of these have been found useful in increasing the effectiveness?

15. **Has there been any legal suit or prosecution or legal proceedings against you in the context of PCPNDT implementation?**

16. **What have been your efforts on strengthening the effectiveness of the Act?**

17. **Have you made any recommendations to the State Appropriate Authority/State Supervisory Board for introducing new rules or orders to strengthen the Act? If yes, please give details.**

18. **What new measures are needed to make the implementation of the Act effectively?**

<u>Investigator's comments:</u>

AC-D / SD /

Study on the Status and Effectiveness of the PCPNDT Act in the State of Rajasthan

Interview Guide

Advisory Committee - District/Sub-division

Respondent

Name:

Designation:

Duration of serving:

Educational/Professional Qualification:

Address:

Telephone:

Name of the Investigator:

Signature:

1. **How many meetings have been held by your committee during the last year and at what intervals?**
   - ii. Monthly …….
   - iii. Bimonthly …….
   - iv. More that two months …….
   - v. Never …….

2. **What were the main agenda in these meetings?**

3. **How does the committee undertake public awareness programmes about this Act?**

   vi. Activities undertaken:

   vii. Media used:

viii. Involvement of outside agencies:

ix. Budget allocation for this purpose

x. Sufficient/Insufficient

xi. Amount spent during the last year (April 2004 - March 2005)

xii. Unspent balance

4. What are your functions as a member of the Advisory Committee?

a. Do you accompany the appropriate authority for inspection of registered clinics? If yes what are your observations?

b. At what intervals?

c. Do you discuss registration, applications for registration, suspension, renewals, etc?

5. What system of communication is maintained for coordination with the appropriate authorities at various levels?

a. Written communication

b. Meetings

c. Reporting

d. Any other (Please give details)

6. What are the indicators for the effective implementation of this Act?

a. For regular monitoring:

b. For Goal achievement:

c. For regular facilitation to Appropriate Authority

7. Have you made any recommendations to strengthen this Act?

8. **What constraints do you experience in carrying out your role?**

9. **Are there any loopholes in the Act that influence the work of the committee?**

10. **What measures can be taken to make the Act more effective?**

Special section for Gynaecologist/Obstetrician/Paediatrician/Medical Geneticist

1. **What is the reaction of the medical fraternity on this Act?**

2. **How far the Code of Conduct has been practiced?**

3. **Usually the sex determination tests are done secretly. How can they be monitored effectively?**

4. **What techniques have been adopted for exposing the sex determination practices?**

5. **What measures are needed to bring transparency in the use of medical techniques so that their abuse can be tracked?**

Special section for Social Workers

1. **What are the reactions of your community on this Act?**

2. **Usually the sex determination tests are done secretly. How can they be monitored effectively?**

3. **What methods have been adopted for exposing the offences?**

4. **What measures are needed to bring transparency in the techniques so that their abuse can be stopped?**

5. **What initiatives are required at community level for effective implementation of this Act?**

Special section for Legal Experts

1. **What are the reactions of your community on this Act?**

2. **What legal steps should be taken against a guilty, to act as deterrent to others?**

3. **Do you find any area of overlap between the PCPNDT and the MTP Act? If yes, please elaborate.**

Investigator's Comments

RC/ D/SD

Study on the Status and Effectiveness of The PCPNDT Act in The State of Rajasthan

Interview Guide

Registered Clinics

Name of Respondent:
(Owner/Employee)

Name of the Clinic:

Address:

Telephone:

Year of Registration:

List of Employees:

S. No.	Name	Educational Qualifications

Name of the Investigator:

Signature:

1. **What are your views about the declining sex ratio?**

2. **Is your clinic being inspected by the appropriate authority regularly? If yes, how frequently?**

   a) Do they inform you or your clinic in advance?

   b) What activities do they undertake while inspecting?

   c) Please give your comments on their behaviour during the inspection

3. **Were any shortcomings reported against you during the inspection? If yes, what were those shortcomings and what was the action taken in relation to those shortcomings? What was the outcome of those actions?**

4. **Have you read the PCPNDT Act?** Yes / No
   a. Have you understood it? Yes / No
   b. Do you have a copy of the Act in your clinic? Yes / No

5. **Do you know about the Code of Conduct applicable on the clinics?**

6. **On an average how many expectant mothers visit your clinic every month for**
   a. Sex tests ----------
   b. Pregnancy related diagnosis ----------
   c. Other diseases ----------

7. **Do you maintain their case records? (give details)**

   a. **Do you maintain the following records?**

S. No.	Record Name	Response Yes/No/Don't know	Investigator's Observation Yes/No/Did not understand
1	Register (With the name of the woman, name of her father/husband, date of consultation, etc.)		
2	Form D		
3	Form E		
4	Form F		
5	Case record (Card/OPD record)		
6	Forms of consent		
7	Sonography plates/slides		
8	Doctor's recommendation and letters		
Pertaining to abortion			
9	Form I		
10	Form II		
11	Form III (Admission register)		
12	Form C		

   b. **For how many years have you been maintaining these records?**

8. **Do you have any information on clinics undertaking sex determination tests illegally?**

a) i. Clinic

ii. Mobile clinics

b) Can you give us their names, addresses and telephone numbers?

9. **Check if there is a display board in the clinic stating, "Sex determination tests are illegal"** ***(for investigator's observation only).***

Investigator's Comments:

ZP/Pr – D/BL

Study on the Status and Effectiveness of the PCPNDT Act in the State of Rajasthan

Interview Guide

Zilla Pramukh (Elected Representative - District) / Pradhan (Elected Representative - Block)

Respondent

Name:

Designation:

Duration of service:

Address:

Tel:

Name of the Investigator:

Signature:

1. **Do you know about the sex ratio in your District/Block? (In 0-6 age group how many are boys and girls?)**

2. **What do you think about the PCPNDT Act?**

3. **What is the mindset of people about sex tests in your area?**

4. **Are there any pre-conception and pre-natal sex selection facilities available in your area?**

5. **How many such clinics are there in your area?**

6. **How do you get information about them? Is there any sort of advertisement regarding sex tests in your district/block?**

7. **Do people go for sex tests in your district/block? On an average, how many such tests are conducted every month?**

8. **Are there any efforts happening on PCPNDT implementation in your district/block?**

    a. Any specific work on this Act?

    b. Are clinics being raided?

9. **Is there any discussion on this taking place in the Zilla Parishad meetings?**

10. **What do you think should be the methods adopted for the following areas:**

    a. For stopping the tests

    b. For publicity on the act

    c. For generating public awareness

    d. For stopping the female foeticide

    e. For curbing the declining sex ratio

Investigator's Comments:

CSM- D/BL

Study on the Status and Effectiveness of the PCPNDT Act in the State of Rajasthan

Interview Guide

Civil Society Members (District/Sub-division)

Respondent

Name:

Designation:

Duration of serving:

Address:

Telephone:

Name of the Investigator:

Signature:

1. **Please give a brief account on the working of your organisation - its objectives, programmes and geographical area**

2. **What are your observations on declining sex ratio in your geographical area?**

3. **What is the scale of intensity of sex selection tests & sex determination in your area?**

4. **What is the mindset of people in your area about pre-conception and pre-natal sex selection?**

5. **What are the facilities for pre-conception and pre-natal sex selection tests available in your area? If yes, please answer the following:**

   a) On an average how many such diagnoses are carried out every month?
   b) Do you know where they are carried out?

c) Can you give us their names and addresses?

d) After identifying the sex of the foetus how is the abortion carried out?

e) What kinds of people are involved in it?

6. What are your views about the PCPNDT Act?

7. In the context of declining sex ratio, please elucidate the initiatives undertaken by your organisation:

a. Towards spreading public awareness about the issue

b. In relation to the legalities of the Act

c. Any other related issues

8. What more do you want to do in this matter?

9. Do you know about any other organization that works for the same cause?

10. Is this Act potent enough to curb female foeticide and adverse sex ratio?

11. What are the lacunae and what steps are needed to be undertaken?

Investigator's Comments:

MM/JM/ D

Study on the Status and Effectiveness of The PCPNDT Act in The State of Rajasthan

Interview Guide

Metropolitan Magistrate/Judicial Magistrate – District

Respondent:

Name:

Designation:

Duration in office:

Address:

Telephone:

Name of the Investigator:

Signature:

1. Since 2003, how many complaints have been filed in your Court by the following?

S. No.	Complainant	No. of cases
1.	Appropriate Authority	
2.	Any person or social organisation after having given notice 15 days to AA	
3.	Any other	

2. How many cases have been filed since 2003 for the following and what was the outcome?

S. No.	Offenders	No. of Cases filed			Verdict		
		Cog.	NB	Comp.	Pending	Convicted	Acquitted
1	Manufacturers, suppliers, retailer of Ultrasound Machine, Imaging Machine or scanners selling to unregistered persons/bodies						
2	Genetic counseling centers, laboratories and clinics.						
3	Medical Practitioners						
4	Husbands/Relatives imposing/ encouraging sex selection and sex determination tests.						
5	Others						

Cog – Cognizable, NB – Non bailable, Comp – Compoundable

3. **Members of the medical fraternity are offenders as well as regulators of this Act – Do you see any conflict of interests?**

4. **There is an opinion among legal experts that PCPNDT Act should be read along with the MTP Act 1971– Your comments please?**

5. **Sex selection and sex determination are crimes that are not very visible – detecting offenders is therefore difficult - how can the visibility of this crime be made transparent?**

6. **What can be done to make these diagnostic techniques more transparent?**

7. **Do you think that this law is potent enough to put a check on female foeticide and adverse sex ratio?**

   Are there any shortcomings?

   What steps should be undertaken?

Investigator's comments:

ANNEXURE-3

LIST OF RESPONDENTS

ANNEXURE 3

LIST OF RESPONDENTS

Appropriate Authorities

- State

Respondent	Position held	Designation
Dr. S.P. Yadav	Chairperson	Director, Family Welfare

- District/Sub-division

S.No.	Division	District	Sub-division	Respondent	Designation
1	Jaipur	Jaipur	-	Dr. Dilip Kimitkar	CMHO
2	„	„	Jaipur 1st	Dr. R.S. Chippi	Dy. CMHO
3	„	„	Jaipur East	Dr. Ramesh Chandra Sharma	Dy. CMHO
4	„	„	Jaipur South	Dr. Hetendra Singh	Dy. CMHO
5	„	„	Sambhar	Dr. Ashok Shondwal	Dy. CMHO
6	„	„	Kothputli	Dr. Ratanlal Meena	Dy. CMHO
7	„	Alwar	-	Dr. Dinesh Singh Gurang	CMHO
8	„	„	Alwar	Dr. Indu Gupta	Dy. CMHO
9	„	„	Tijara	Dr. Vinod Jain	Dy. CMHO
10	„	„	Kishangarh Bas	Dr. Babulal	Dy. CMHO
11	„	„	Behroad	Dr. Balvant Singh	Dy. CMHO
12	„	„	Rajgarh	Dr. Charangeet Singh	Dy. CMHO
13	„	„	Laxmangarh	Dr. Meghraj Singh	Dy. CMHO
14	„	Jhunjhunu	-	Dr. R. P. Singh	CMHO
15	„	„	Jhunjhunu	Dr. Vidyasagar	Addl. CMHO
16	„	„	Navalgarh	Dr. Sitaram Jhajhdia	Dy. CMHO
17	„	„	Khetadi	Dr. Vidyadhar	Dy. CMHO
18	„	Sikar	-	Dr. Atul Kumar	CMHO
19	„	„	Sikar	Dr. Ashok Mehria	Dy. CMHO
20	„	„	Neem ka thana	Dr. P. R. Jef	Dy. CMHO
21	„	„	Fatehpur	Dr. Champalal Sharma	Dy. CMHO
22	„	Dausa	-	Dr. P. C. Santhiya	CMHO

S.No.	Division	District	Sub-division	Respondent	Designation
23	„	„	Dausa	Dr. Satish Kandelwal	Dy. CMHO
24	„	„	Bandikui	Dr. O. P. Bairwa	Dy. CMHO
25	Ajmer	Ajmer	-	Dr. V. K. Mathur	CMHO
26	„		Ajmer	Dr. Ramdin Meena	Addl. CMHO
27	„	„	Beawar	Dr. C.l. Parihar	Dy. CMHO
28	„	„	Kishangarh	Dr. Akhilesh Narayan Mathur	Dy. CMHO
29	„	„	Kekadi	Dr. Pratap Singh Rawat	Dy. CMHO
30	„	Bhilwara	-	Dr. Ramanand Gupta	CMHO
31	„	„	Bhilwara	Dr. Chandrasekhar Sharma	Addl CMHO
32	„	„	Gangapur	Dr. Sohma Saxena	Dy. CMHO
33	„	„	Shahpura	Dr. Gyan Maheshwari	Dy. CMHO
34	„	„	Mandalgarh	Dr. Devilal Chippa	Dy. CMHO
35	„	„	Gulabpura	Dr. Ambalal Kalal	Dy. CMHO
36	„	Nagaur	-	Dr. B.l. Sohan	CMHO
37	„	„	Nagaur	Dr. Chaman Jain	Addl. CMHO
38	„	„	Deedwana	Dr. Mahesh Jha	Dy. CMHO
39	„	„	Parabatsar	Dr. S. K. Vijayvargi	Dy. CMHO
40	„	„	Merata City	Dr. S. P. Bohara	Dy. CMHO
41	„	Tonk	-	Dr. G. L. Rajoria	CMHO
42	„	„	Tonk	Dr. Alaknanda	Addl. CMHO
43	„	„	Malpura	Dr. J. S. Sisodia	Dy. CMHO
44	Jodhpur	Jodhpur	-	Dr. K. C. Madani	CMHO
45	„	„	Jodhpur	Dr. Vijay Kumar Purohit	Addl. CMHO
46	„	„	Pipad City	Dr. C. P. Gupta	Dy. CMHO
47	„	„	Phalaudi	Dr. Banvarlal Doyal	Dy. CMHO
48	„	Pali	-	Dr. Ramesh Mathur	CMHO
49	„	„	Pali	Dr. Jogaram	Dy. CMHO
50	„	„	Jaitaran	Dr. Madhu Rateswar	Dy. CMHO
51	„	„	Sojat	Dr. Sushil kumar Sharma	Dy. CMHO
52	„	„	Bali	Dr. Sanjeev Tank	Dy. CMHO
53	„	Jaisalmer	Jaisalmer	Dr. B.l. Bunkar	Dy. CMHO
54	„	„	Pokhran	Dr. Shantilal Purohit	Dy. CMHO
55	„	Sirohi	-	Dr. Mahaveer Singh Krishniya	CMHO
56	„	„	Sirohi	Dr. Dalchand Punsal	Dy. CMHO

S.No.	Division	District	Sub-division	Respondent	Designation
57	„	„	Abu Road	Dr. Sushil kumar Parmar	Dy. CMHO
58	„	Barmer	-	Dr. Yogeshwar Dayal Srivastav	CMHO
59	„	„	Barmer	Dr. Hari Singh Yadav	Dy. CMHO
60	„	„	Balotara	Dr. Ganpat Singh Rathore	Dy. CMHO
61	„	„	Gudamalani	Dr. Hemraj Soni	Dy. CMHO
62	„	Jalore	-	Dr. Hanshraj Sukhadia	CMHO
63	„	„	Jalore	Dr. Govindram Tanwar	Dy. CMHO
64	„	„	Bhinmal	Dr. Kansingh Chauhan	Dy. CMHO
65	„	„	Sanchor	Dr. Kamalkant Verma	Dy. CMHO

Members of Advisory Committees

- State

S.No.	Name of the Respondent	Position in the Committee	Representation
1	Dr. Adarsh Bhargav	Chairperson	HOD, Department of Obstetrics and Gynaecology, SMS Hospital
2	Prakash Chandra Dave	Legal Expert	Deputy LR, Department of Medical Health
3	Ratna Harish	Social Worker	Social Worker

- District and Sub-division

S.No.	District	Sub-division	Name of Respondent	Representation
1	Jaipur		Shri Rajani Tyagi	Woman social worker
2	„		Shri Pawan Kumar Jain	Social worker
3	„	Jaipur	Shri Dinesh Tripathi	Social worker
4	„	„	Smt. Shankuntala Devi Jain	Woman social worker
5	„	„	Dr. A. A. Pathan	Paediatrician
6	„	„	Smt. Suman Sharma	Woman social worker
7	„	„	Smt. Punam Chandra Bhandari	Asstt. Public Prosecutor
8	„	„	Shri Harish Punjabi	Pathologist
9	„	„	Shri Rajmal Punjabi	Social worker
10	„	Sambhar	Smt. Teeja Devi	Woman social worker

S.No.	District	Sub-division	Name of Respondent	Representation
11	„	„	Shri Maan Singh Bhagaud	Asstt. Public Prosecutor
12	„	Amer	Shri Mahesh Chandra	Social worker
13	„	„	Smt. Vimala Saini	Woman social worker
14	„	Kothputli	Smt. Manjeet Kaur	Woman social worker
15	**„**	**„**	Shri Pradeep Kumar Bhatnagar	Asstt. Public Prosecutor
16	Alwar		Shri Rajkumar Bhutodiya	Social worker
17	„		Dr. Premlata Sharma	Gynaecologist
18	„	Alwar	Dr. H. S. Mathur	Pathologist
19	„	„	Smt. Saroj Kansal	Woman social worker
20	„	„	Dr. R. K. Sharma	Paediatrician
21	„	Tizara	Shri Harish Yadav	Block Health Supervisor
22	„	„	Dr. S. V. Zareda	Gynaecologist
23	„	Kishangarh Bas	Shri Bane Singh Naruka	Social worker
24	„	„	Shri Rajendra Singhal	Social worker
25	„	Behror	Shri Bhavani Singh Yadav	Social worker
26	„	„	Shri Shiv Shankar Gupta	Social worker
27	„	Rajgarh	Shrikaant Joshi	Social worker
28	„	„	Smt. Neeraj Sharma	Woman social worker
29	„	Laxmangarh	Shri Om Prakash Sharma	Social worker
30	„	„	Shri Prakash Chandra Sharma	Legal expert
31	Jhunjhunu	Jhunjhunu	Shri Ramavtar Soni	Asstt. Public Prosecutor
32	”	„	Dr. S. D. Chobdar	Social worker
33	”	„	Shri Gilu Ram Ji Modi	Social worker
34	”	„	Dr. Mukul Araya	Gynaecologist
35	”	”	Shri Kailash Darji	Social worker
36	”	Navalgarh	Dr. Vijay Kumar Dalela	Paediatrician
37	”	”	Sh. Ranveer Singh	Legal expert
38	”	Khetadi	Dr. Anuradha	Gynaecologist
39	”	”	Dr. B. D. Sharma	Paediatrician
40	Sikar	-	Shri Harphool Singh	Asstt. Public Prosecutor
41	”	-	Dr. Surendra Singh Chauhan	Pathologist

S.No.	District	Sub-division	Name of Respondent	Representation
42	”	-	Dr. V. K. Khanna	Social worker
43	”	Sikar	Shri Chiman Singh Dhaka	Legal expert
44	”	”	Dr. Sarla Kabra	Paediatrician
45	”	Neem Ka Thana	Dr. R. P. Yadav	Paediatrician
46	”	”	Shri Ashok Agrawal`	Social worker
47	”	Fatehpur	Dr. Nirmala Khichad	Gynaecologist
48	”	”	Dr. Narottam Bilkhiwaal	Paediatrician
49	Dausa		Shri Someshwar Prashad Garg	Asst. Public Prosecutor
50	”		Sh. Satya Narayan Dhokiya	Social worker
51	Dausa	Dausa	Sh. Bhagwaan Sahay	Social worker
52	”	„	Dr. Harimohan Gupta	Paediatrician
53	”	„	Ram Avtar Choudhary	Social worker
54	”	”	Dr Rajkumari Bajaj	Pathologist
55	”	Bandikui	Sh. Kailash Tambi	Social worker
56	”	”	Sh. Sushil Kumar Gurjar	Asstt. Public Prosecutor
57	Ajmer	-	Smt. Shagufta Khan	Woman social worker
58	”	Beawar	Dr. Manohar Gurnami	Sr. Paediatrician
59	”	„	Dr. Maya Gurnami	Gynaecologist
60	”	„	Tikam Chandra Lodha	Social worker
61	”	”	Puspanjali Pareek	Social worker
62	”	Ajmer	Santosh Rawat	Social worker
63	”	”	Sagar Mal Koushik	Social worker
64	”	Beawar	Tikam Chandra Lodha	Social worker
65	”	”	Puspanjali Pareek	Social worker
66	”	Kishangarh	Atul Kumar	Social worker
67	”	”	Dr. Harish Chadra Labhoriya	Paediatrician
68	”	Kekadi	Dr. Savita Morya	Paediatrician
69	”	”	Dr. Karuna Soni	Sr. Pathologist
70	Bhilwara		Shushil Kumar Gandhi	Social worker
71	”		Dr. Vijaylaxmi Sharma	Sr. Gynaecologist
72	”		Manju Pokhrana	Woman social worker
73	”		Jabbar Singh	Social worker
74	”	Bhilwara	Arun Kumar Vyas	Ex Asst. Public Prosecutor
75	Bhilwara	Bhilwara	Pratibha Mehta	Woman social worker

S.No.	District	Sub-division	Name of Respondent	Representation
76	„	Gangapur	Jatan Bai Somani	Woman social worker
78	”	”	Govardhan Lal Mogra	Social worker
79	”	Shahpura	Dinesh JI Savarnkar	Social worker
80	”	”	Durga Lal Rajoriya	Asstt. Public Prosecutor
81	”	Mandalgarh	Geeta Tripathi	Woman social worker
82	”	”	Dr. Vinod Kumar Gupta	Junior Gynaecologist
83	”	Gulabpura	Dr. L. L. Sighavi	Social worker
84	”	”	Ramcharan Sharma	BHS
85	”	”	Ratan Singh Mehta	Social worker
86	Nagaur		Dr. S.S. Mathur	Junior Pathologist
87	”		Bhanvar Lal Ji Tanwar	Social worker
88	”		Dr. S. S. Mathur	Junior Pathologist
89	”	Nagaur	Ramkanya Manihar	Woman social worker
90	”	”	Dr. B. L. Bhutada	Social worker
91	”	”	Dr. S. S. Mathur	Junior Pathologist
92	”	Deedwana	Omprakash Ji Modi	Social worker
93	”	Parvatsar	Shyam Sunder Chouhan	Social worker
94	”	”	Anda Ram Chouyal	Social worker
95	”	Merata City	Babu Mantri	Social worker
96	”	”	Doulat Ram Mirgha	Asstt. Public Prosecutor
97	Tonk		Dr. J. C. Gahlot	Ex PMO
98	„	Tonk	Manoj Tiwari	Social worker
99	”	”	Dr. S. N. Jat	Paediatrician
100	”	Devli	Giriraj Ji Agarwal	Public prosecutor
101	”	”	Rajesh Rajvanshi	Social worker
102	”	Malpura	Santosh Kothayari	Social worker
103	”	”	Dr. J. S. Sisodiya	Dy. CMHO
104	”	”	Manohar Singh Tak	Social worker
105	Jodhpur		Dr. R. N. Singh	Social worker
106	”		Indu Kumar Avasthi	Social worker
107	”	Jodhpur	Shailash Tantrik	Social worker
108	”	”	Govindi Panwar	Women social worker
109	”	Pepad City	Chandrasekar vyas	Women social worker
110	”	”	Laxmi Devi Tak	Women social worker

S.No.	District	Sub-division	Name of Respondent	Representation
111	”	Phalodi	Devki Sharma	Women social worker
112	”	”	Om Ji Joshi	Social worker
113	Pali		Dr. Dinesh Kumar Jain	Pathologist
114	”		Meena Kalla	Women social worker
115	”		Kanmal Doshi	Social worker
116	”	Pali	K. M. Sharma	Social worker
117	”	”	Narendra Singh Purohit	Social worker
118	”	Jaitaran	Hardev Gujar	Social worker
119	”	”	Sushila Vyas	Social worker
120	”	Sojat Road	Prakash Kachawaha	Social worker
121	Pali	Sojat City	Paras Bhandari	Social worker
122	”	Bali	Ayub Ali	Social worker
123	”	”	Sh. Shivlal Parihar	Legal expert
124	Jaisalmer		Sh. Jalibh Singh Lodha	Legal expert
125	”		L. N. Mehta	Social worker
126	”		Rameshvari Purohit	Women social worker
127	”	Jaisalmer	Damodar Bairwa	Public prosecutor
128	”	”	Dindayal Bhatiya	Social worker
129	”	Pokhran	Urmila Purohit	Social worker
130	”	”	Baldev Joshi	Social worker
131	Sirohi		Dr. Sohanlal Patwi	Social worker
132	”		Dr. Vinod Taran Jain	Social worker
133	”	Pindwada	Sandhya Choudhary	Women social worker
134	Sirohi	Sirohi	Vimal Sindhi	Social worker
135	”	”	Kailash Singh Devada	Legal expert
136	”	Abu road	Dr. S. D. S. Mehta	Gynaecologist
137	”	”	Devendra Joshi	Social worker
138	Barmer		Shanti Mangal	Women social worker
139	”		Sh. Dhanraj Joshi	Social worker
140	”		Sh. China Ram Choudhary	Asstt. Public Prosecutor
141	”	Sivana	Sh. Rajshree Vyas	Asstt. Public Prosecutor
142	”	Badmer	Sh. Sushil Mehta	Social worker
143	„	Balotara	Mahamandleshvar Nirmaldas Maharaj	Social worker
144	”	”	Sh. Champa Lal Banothiya	Social worker

S.No.	District	Sub-division	Name of Respondent	Representation
145	”	Gudhamalani	Rana Bhavani Singh	Social worker
146	”	”	Himmat Ram	Social worker
147	Jalore		Pushplata Bansal	Women social worker
148	”		Shantilal Sharma	Social worker
149	”		Devi Singh Charan	Public Prosecutor
150	”	Jalore	Mohan Parashar	Social worker
151	”	”	Shamim Khokhar	Social worker
152	”	Bheenmal	Jaydeep Singh	Social worker
153	”	”	Pawan Kumar	Social worker
154	”	Sanchore	Bacchraj Jain	Social worker
155	”	”	Bhagvan Ram	Lecturer
156	Kota		Prashanna Bhandari	Women social worker
157	”		Mohan Lal Dhanavat	Public prosecutor
158	”		Kapurchandra Singhal	Social worker
159	”	Kota	Dr. Navneet Bagla	Paediatrician
160	”		Dr. Ranjana Gupta	Gynaecologist
161	”	Ramganj Mandi	Dr. Krishan Murari Meena	Paediatrician
162	”	”	Vandana Shreevastav	Asstt. Public Prosecutor
163	Baran		Mahesh Chandra Tyagi	Asstt. Public Prosecutor
164	Baran		Suresh Takkar	Social worker
165	”		Dr. Lajpat Ram	Social worker
166	”	Baran	Yashwant Maratha	Social worker
167	”	”	Nirmala maru	Women social worker
168	”	”	Shivkumar Goyal	Social worker
169	”	Chabda	Chiranji Lal	Public Prosecutor
170	”	”	Himmat Singh	Social worker
171	”	Shahbad	Prakash Choudhary	Social worker
172	”	”	Badan Singh	Social worker
173	Jhalawar		Dheeraj Singh Jhala	Social worker
174	”		Vijay Jain	Social worker
175	”	Jhalawar	Vibha Jain	Women social worker
176	”	Aklera	Rajendra Kumar Jain	Social worker
177	”	”	Gajanand Mangal	Social worker
178	”	Bhavani Mandi	Vittan Lal Acholiya	Social worker

S.No.	District	Sub-division	Name of Respondent	Representation
179	”	”	Kanchan Rathi	Women social worker
180	”	”	Chandalal Jain	Social worker
181	Bundi		Mahesh Patodi	Social worker & Vice President of Rotary Club
182	”		Shiv Prashad Meena	Social worker
183	”		Ram Araya	Asst. Public Prosecutor I
184	”		Manju Sharma	Women social worker
185	”	Bundi	Rekha Sharma	Women social worker
186	Bundi	Bundi	Mahesh Bahediya	Social worker
187	”	Nainwa	Rukmani Devi Meena	Woman social worker
188	”	”	Mahaveer Prashad Modika	Social worker
189	Bikaner		Rukmani Devi Soni	Women social worker
190	”		Arvind Ojha	Social worker
191	”		Ramdev Gahlot	Asstt. Public Prosecutor
192	”	Bikaner	Kapil Goud	Social worker
193	”	”	Rajat Baijal	Social worker
194	”	”	Ram Kishor Tripathi	Social worker
195	”	”	Amar Singh Chouhan`	P.R.O. of Information center office
196	”	Khajuwala	Dr. Jugal Kishor Chabada	Sr. Gynaecologist
197	”	”	Pradeep Yadav	Social worker
198	Sriganganagar		Fardeen Khan	Public relation Officer
199	”		Murlidhar Upadhyay	Asst. Public Prosecutor
200	”		Dr. P. C. Acharya	Social worker
201	”	Sriganganagar	Pratap Singh Shekhawat	Social worker
202	”	Anoopgarh	Kishan Lal Chipa	Asstt. Public Prosecutor
203	”	Suratgarh	Dr. Smt. Naresh Chough	Gynaecologist
204	”	”	Dr. Inder Chudh	Gynaecologist
205	”	Karanpur	Dr. Rajesh Arora	Paediatrician
206	”	”	Hajari Lal Muthreja	Social worker
207	”	Karanpur	Dr. Veena Arora	Gynaecologist
208	”	Raisingh Nagar	Dr. Naresh Makad	Paediatrician
209	”	”	Madan Singh Charan	Asstt. Public Prosecutor
210	Hanumangarh		Renu Soudhi	Social worker
211	”	`	Kunj Bihari Maharshi	Social worker

S.No.	District	Sub-division	Name of Respondent	Representation
212	”		Naval Kishor Sharma	Asstt. Public Prosecutor
213	”	Hanumangarh	Bhism JI Koushik	Social worker
214	”	Hanumangarh	Hemlata Joshi	Women social worker
215	”	”	Dr. Jagveer Singh	Paediatrician
216	”	Sangriya	Manohar Lal Garg	Asst. Public Prosecutor
217	”	”	Dr. N. K. Garg	MOIC –CHC-Sangriya PMO-M.D.
218	”	Nohar	Brahmanand Agrawal	Social worker
219	”	”	Dr. B. L. Nehra	CHC Nohar (MD – Medicines)
220	Churu		Dr. Ibrahim Chipa	PMO Churu
221	”		Santosh Masum	Women social worker
222	”		Hukum Chandra Lohiya	Social worker
223	”		Prem Singh Dhaka	Asstt. Public Prosecutor
224	”	Churu	Jaysingh Puniya	Social worker
225	”	”	Mo. Shabbir	Asst. Public Prosecutor
226	”	Ratangarh	Balkrishan Goswami	Social worker
227	”	”	Supyar Charan	Women social worker
228	”	Rajgarh	Brijmohan Sharma	Asst. Public Prosecutor
229	”	”	Dr. Mohanlal Meena	Paediatrician
230	Bharatpur		Shalo Hembram	Women social worker
231	”		Suresh Pandey	Asst. Public Prosecutor
232	”	Deeg	Krishna Gandhi	Women social worker
233	”		Sitaram	Social worker executive director –Lupin
244	”	Deeg	Naresh Goyal	Social worker
245	”	Kama	Murari Lal Sharma	Asst. Public Prosecutor
246	”	”	Subhashchandra Jain	Social worker
247	”	Bayana	Usha Agarwal	Women social worker
248	”	”	Dharam Priy Sharma	Asst. Public Prosecutor
249	Dhaulpur		Naresh Kumar Sharma	Public Prosecutor
250	”		Dr. Vijay Singh	Paediatrician
251	”		Dr. M. P. Agarwal	Pathologist (MD)
252	”	Dhaulpur	Dr. Anil Bansal	Gynaecologist
253	”	Badi	Jawaharlal Mangal	Public Prosecutor
254	”	”	Dr. Suresh Mangal	Paediatrician

S.No.	District	Sub-division	Name of Respondent	Representation
255	Karauli		Dr. Umesh Kumar Sharma	Pathologist
256	”		Nagendra Vyas	Asst Public Prosecutor
257	”		Ramswarup Sharma	Social worker
258	”	Karauli	Mukesh Chturvedi	Social worker
259	”	”	Ramveer Singh	Social worker
260	”	Hindaun City	Tikaram Rajora	Social worker
261	Sawai Madhopur		Dr. Mirja Batra	Gynaecologist
262	”		Chandrakala Sharma	Women social worker
263	Sawai Madhopur		Bajranlal Jat	Public Prosecutor
264	”	Gangapur City	Bhagchandra Jain	Asstt. Public Prosecutor
265	”	”	Lalluram Parashar	Social worker
266	Udaipur		Chandmal Shankhla	Public Prosecutor
267	”		Dr. Usharani Sharma	Sr. Gynaecologist
268	”		Pramodani Bakshi	Women social worker
269	”		Dr. Lalit Jain	Anatomist
270	”		Dr. Vimlesh Mathur	Social worker
271	”	Udaipur	Hamidan Banu	Public Prosecutor
272	”	Salumber	Kanahyalal Bhimavat	Social worker
273	”	”	Dr. Smt. Nandu Dangi	Social worker
274	”	Jhadol	Sh. Mangilal Purohit	Social worker
275	”	Vallabh Nagar	Madan Chouradiya	Social worker
276	”	”	Sushila Nimadiya	Women social worker
277	Dungarpur		Vinod Dhoshi	Social worker
278	”		Dr. Rakesh Verma	MBBS
279	”	Dungarpur	Rajesh Kumar Saxena	Public Prosecutor
280	”	Sangwada	Kanta Gahlot	Women social worker
281	”	”	Marak Dhoshi	Social worker
282	”	”	Dr. R. P. Bhatnagar	Jr. Surgeon
283	Banswara		Dr. Harish Sharma	Skin & Gynaecologist
284	”		Sariya Khan	Woman social worker
285	”		Kishan Kant Upadhay	Social worker
286	”	Banswara	Pannalal Nagar	Social worker
287	”	”	Suresh Trivedi	Asstt. Public Prosecutor

S.No.	District	Sub-division	Name of Respondent	Representation
288	”	Kushalgarh	Dr. Rajendra Ujjaniya	M.D. Pathologist
289	”	”	Hanshmukh Bhai Seth	Social worker
290		”	Kamala Seth	Social worker
291	Rajsamand		Dr. V. Pagariya	Senior Medical Officer
292	”		Shakuntala Pamecha	Women Social worker
293	”		Sujan Singh	Public Prosecutor
294	”	Rajsamand	Dr. V. Pagariya	SMO – Retired & Owner of Pagariya nursing home
295	”	Nathdwara	Rajesh Marvadi	Social worker
296	”	”	Dr. Rekha Sharma	Social worker
297	”	Bheem	Dr. Shaitan Singh	Paediatrician
298	”	”	Krishna Kumari Khatri	Woman social worker
299	Nimbaheda		Manohar Virani	Social worker
300	Chittaurgarh	Chittaurgarh	Savitri Devi Swarnkar	Women social worker
301	”	`”	Md. Yusuf	Social worker
302	”	”	Satyanarayan Baldeva	Social worker
303	”	Kapasan	Dinesh Chasta	Social worker
304	Chittaurgarh	Kapasan	Ramlal Choudhry	Asstt. Public Prosecutor
305	”	Nimbaheda	Surendra Sethiya	Asstt. Public Prosecutor
306	”	”	Dr. K. Ashif	Pathologist
307	”	Badi Sadadi	Archana Kahaliya	Women social worker
308	”	”	Abha Mahatma Jain	Women social worker
309	”	”	Dr. Sayyad Hisamuddin Sanjeri	Paediatrician
310	”	Pratapgarh	Bula Ojha	Women social worker
311	”	”	Yashwant Gupta	Ex-Public Prosecutor
312	”	Begun	Chanchlata Surana	Women social worker

District Elected Representatives

S.No.	Division/Sub-division	Name of Respondent
1	Jaipur	Ramgopal Gurjar
2	Alwar	Sh. Niwas Meena
3	Jhunjhunu	Sh. Vijay Pal Singh
4	Sikar	Smt. Malli Devi Gujar

S.No.	Division/Sub-division	Name of Respondent
5	Dausa	Kamri Devi
6	Ajmer	Smt. Sarita Gena
7	Gangapur (Bhilwara)	Sh. Goverdhan Mogra
8	Nagaur	Smt. Vindu Choudhry
9	Niwai (Tonk)	Sh. Ramkaran Gujar
10	Jodhpur	Smt. Anita Choudhry
11	Pali	Ms. Mamata Meghwal
12	Jaisalmer	Abdulla Fakir
13	Sirohi	Annaram Borana
14	Barmer	Smt. Madan Kour
15	Jalore	Smt. Manju Meghwal
16	Kota	Kamala Meena
17	Baran	Smt. Sarika Singh Chouhan
18	Jhalawar	Smt. Neetu Sharma
19	Bundi	Mahaveer Prashad Meena
20	Sriganganagar	Sh. Shyam Dhariwal
21	Hanumangarh	Sh. Rajendra Makkasar
22	Rajgarh (Churu)	Smt. Kamala Karcha
23	Hindauncity (Karauli)	Sh. Bharosi Lal
24	Sawai Madhopur	Sh. Prahlad Madhuriya
25	Dungarpur	Sh. Tarachandra Bhagora
26	Baswada	Sh. Mahendra Singh Malviya
27	Rajsamand	Sh. Narendra Singh Solanki
28	Kothputli (Jaipur)	Sharmila Arya
29	Kishangarh Bas	Sh. Hemraj Bhdana
30	Rajgarh (Alwar)	Smt. Kailashi Devi
31	Navalgarh (Jhunjhunu)	Shiv Narayan Sura
32	Khetadi (Jhunjhunu)	Smt. Chandrakala
33	Neem Ka Thana (Sikar)	Sh. Parmanand Yadav
34	Fatehpur (Sikar)	Smt. Jyana Devi
35	Dausa	Sh. Krishan Lal Bairwa
36	Bandikui (Dausa)	Sh. Brijmohan Gujar
37	Jawaja (Ajmer)	Sh. Prabhu Singh Panwar
38	Kekadi (Ajmer)	Smt. Rinku Kewar Rathore
39	Shahpura (Bhilwara)	Sh. Chotu Lal Bheel

S.No.	Division/Sub-division	Name of Respondent
40	Shahpura (Bhilwara)	Sh. Gopal Gujar
41	Mandalgarh (Bhilwara)	Smt. Radha Devi c/o Sh. Sharvan Balai
42	Kyusar (Nagaur)	Smt. Kavrai Methiya
43	Parvatsar	Sh. Nand Kishor Chouhan
44	Kashipura (Tonk)	Smt. Sugna Meena
45	Devli (Tonk)	Sh. Narayan Singh Solanki
46	Malpura	Sh. Gopal Gurjar
47	Pipadcity (Jodhpur)	Sh. Devi Singh Choudhry
48	Faloadi (Jodhpur)	Sh. Bhavani Singh Rathore
49	Pali	Smt. Indu Meena
50	Sojatcity (Pali)	Smt. Akta Jain
51	Jaisalmer	Kamal Kanwar
52	Majdoorpada (Jaisalmer)	Abdul Rahman Vakil
53	Sirohi	Sh. Lumbaram Vakil
54	Abu Road	Sh. Angadram JI
55	Balotara (Barmer)	Sh. Nainaram Choudhry
56	Dhorimana (Barmer)	Ms. Surendra Kumari (M.A. L.L.B.)
57	Jalore	Smt. Raju Sankhla
58	Bhinmal	Sh. Raju Meena
59	Ladand (Kota)	Anuradha Meena
60	Etava (Kota)	Vijay Shankar Nagar
61	Chavada (Baran)	Sh. Mansingh
62	Kishangarh (Baran)	Sh. Ramesh Faiji
63	Jhalawar	Sh. Shyam Patidar
64	Bhavanimandi (Jhalawar)	Sh. Ramlal Gurjar
65	Hindoli (Bundi)	Sharda Verma
66	Bundi	Pushplata Sain
67	Nainwa (Bundi)	Ramesh Chandra Nagar
68	Bikaner	Sh. Tulshi Ram Mude
69	Anupgarh (Sriganganagar)	Sh. Pawan Kumar Duggal
70	Suratgarh (Sriganganagar)	Smt. Sushila Devi
71	Karanpur	Sh. Om Solanki
72	Raisingh Nagar	Sh. Harjinder Singh Varad
73	Churu	Sh. Harlal Sharan
74	Ratangarh (Churu)	Sh. Harlal Singh Dukiya

S.No.	Division/Sub-division	Name of Respondent
75	Rajgarh	Smt. Nirmala Singh
76	Pakka Saharana	Sh. Dayaram Jakhad
77	Nohar (Hanumangarh)	Smt. Urmila Vijadniya
78	Deeg (Bharatpur)	Smt. Chandravati Faijdar
79	Kama (Bharatpur)	Sh. Nasru Khan
80	Bayana	Smt. Devi Singh
81	Badi (Dhaulpur)	Dhaniram Gurjar
82	Karauli	Smt. Keshanti Devi
83	Hindon (Karauli)	Smt. Shakuntala Devi
84	Sawai Madhopur	Sh. Jagdish Meena
85	Badgaon (Udaipur)	Sh. Onkar Chouhan
86	Jhadol (Udaipur)	Sh. Shankar Lal Kharadi
87	Vallabh Nagar (Udaipur)	Sh. Mohanlal Menariya
88	Dungarpur	Manjula Devi Roth
89	Sagwada	Smt. Asha Didond
90	Banswara	Smt. Sunita
91	Kushalgarh (Banswara)	Smt. Kanta Garsiya
92	Rajsamand	Sh. Ganesh Lal Bheel
93	Khamnor (Rajsamand)	Sh. Rameswar Khatik
94	Bheem	Sh. Mangu Singh Rawat
95	Kapasan (Chittaurgarh)	Smt. Kamala Devi Lohar
96	Badi Sadadi	Sh. Shambhu Lal Menariya
97	Pratapgarh	Sh. Gena Ram Meena

Metropolitan Magistrate/Judicial Magistrate

S.No.	District	Name	Post
1	Alwar	Sh. Chatra Ram Ji	District Judge, Alwar
2	Jhunjhunu	Sh. Ramesh Kumar Sharma	Chief Judicial Magistrate, Jhunjhunu
3	Sikar	Sh. Kamal Raj Sindhule	District Judge, Sikar
4	Tonk	Sh. C. P. Shrimal	Chief Judicial Magistrate, Tonk
5	Jaisalmer	Sh. N. K. Jain	District Judge, Jaisalmer
6	Sirohi	Sh. Chunni Lal Khatree	Additional District Judge, Sirohi
7	Barmer	Sh. Harendra Singh	Chief Judicial Magistrate, Barmer
8	Jalore	Sh. Harish Chandra Lohar	Chief Judicial Magistrate, Jalore
9	Kota	Atul Kumar Chatarji	Upper District Judge, Kota

S.No.	District	Name	Post
10	Jhalawar	Sh. G. S. Chauhan	Chief Judicial Magistrate, Jhalawar
11	Bundi	Sh. Atul Kumar Jain	District Judge, Bundi
12	Bikaner	Sh. Jhabar Mal Jat	Chief Judicial Magistrate, Bikaner
13	Sriganganagar	Sh. Satya Narayan Vyas	Chief Judicial Magistrate, Sriganganagar
14	Hanumangarh	Sh. Ravindra Kumar	Chief Judicial Magistrate, Hanumangarh
15	Churu	Sh. Girish Sharma	Chief Judicial Magistrate, Churu
16	Bharatpur	Satyajeet Rai	Chief Judicial Magistrate, Bharatpur
17	Karauli	Sh. Bhala Ram Parmar	Chief Judicial Magistrate, Karauli
18	Sawai Madhopur	Smt. Indu Pareek	Additional Chief Judicial Magistrate, Sawai Madhopur
19	Dungarpur	Sh. Rajendra Kumar Sharma	District Judge, Dungarpur
20	Dungarpur	Sh. Atul Kumar Saxena	Civil Judge (Sr. Div.) Cum Chief Judicial Magistrate, Dungarpur
21	Banswara	Sh. H. L. Dhanwal	District Judge, Banswara
22	Baran	Sh. Ayub Khan	Chief Judicial Magistrate, Baran

NGOs/CSOs

- State

S. No.	Name of the Respondent	Post	Name of NGO and Location
1	Dr. Kumkum Srivastav	Executive Director	VIHAAN, Jaipur
2	Dr. S.G.Kabra	Faculty member	Indian Institute of Health Management & Research, Jaipur
3	Dr. Pritam Pal	-----	Jaipur
4	Dr. Narendra Gupta	Executive Director	Prayas, Chittaurgarh, Jaipur

- District and Sub-division

S. No.	Name	Post	Name of NGO
1	Sh. Laxman Sharma	Research Officer	Indian Institute of Health Management & Research, Jaipur
2	Sukpal Singh Choudhry	President	Social Welfare Charitable Trust, Jaipur
3	Lalit Bhardwaj	Secretary	Sarojani Naydu & Mahila VikasSansthan, Jaipur
4	Sunil Kumar Sharma	Secretary	Takniki Prasikshan & Jan Jagrukta Kendra, Alwar
5	Dr. Rachi Arya	Secretary	Pragatisheel Mahila Samiti
6	Chetan Sharma	Field Supervisor	Rajgarh, Alwar

S. No.	Name	Post	Name of NGO
7	Rajesh Agarwal	Sub. Secretary	Jhunjhunu
8	Manisha Choudhary	Member	”
9	Rajan Choudhary	Secretary	”
10	Rakesh Kumar Mishra	Vice-President	Sikar
11	Pyare Lal Ji	Director	Ranoli Sikar
12	Krishan Kumar Yadav	Secretary	Samajik Chetana and Shodh Samiti, Neem Ka Thana Sikar
13	Satynarayan	President	Lines Club Samiti, Dousa
14	Deepak Gupta	Block Co-ordinator	Mata Shree, Gomati Devi Samooh, Dausa
15	Virendra Kumar Sharma	”	Lok Vijay Shiksha Sansthan, Bandikui, Dausa
16	Sagarmal Koushik	Executive Secretary	Rajasthan, Mahila Kalyan Mandal, Ajmer
17	Ramesh Chandra Heda	President	Jai Ambe Seva Samiti, Ajmer
18	Sagupta Khan	Secretary	Garib Nawaj Mahila Awas Bal Kalyan Samiti, Ajmer
19	Tara Devi	Secretary	Bal & Mahila Chetana Samiti, Bhilwara
20	Kailash Chandra Somani	President	Jan Kalyan Sansthan, Bhilwara
21	Komal Saini	Co-ordinator	Prayas Seva Sansthan, Shahpura (Bhilwara)
22	Mohan Lal	Co-ordintor	Urmal Khejari Sansthan, Jayal, Nagaur
23	B. L. Bhutara	President	Bharat Vikas Parishad, Nagaur
24	Shivji Ram Yadav	Secretary	Shiv Shiksha Samiti, Ranoli, Tonk
25	Rishindra Tripathi	Co-ordinator	Tonk
26	Liyakat Ali	Member	J.P. Vikas Sanstha, Tonk
27	Rajendra Tater	Secretary	Thar Voluntary Health Society, Jodhpur
28	Dr. Govindi Pawar	Active Director	Jagruk Mahila Vikas Samiti, Jodhpur
29	Indu Kumar Awasthi	Ex- Director	Manav Kalyan Sansthan, Jodhpur
30	O. P. Gahlot	President	Sidharth Vikas Sansthan, Himmat Nagar
31	Vijay Kumar Sharma	Ex-Director	Koshal Vijay Kala Kendra, Pali
32	Hitendra Vaishva	President	Navjyoti Vikas Sansthan Lunawa, Bali, Pali
33	Gopikishan Joshi	Secretary	Jaisalmer
34	Suman	Mahila-Sandarbh Incharge	Urmal Marushthal Vikas Samiti, Pokhran
35	Ashutosh Patani	Director	Sirohi
36	Kamala Panjwani	Director	Arawali Seva Samiti, Abu Road, Sirohi
37	Purushouttam Acharya	Secretary	Jila Mahila Jagriti, Barmer
38	Mumtaj Ben	President	Mahila Mandal, Barmer

S. No.	Name	Post	Name of NGO
39	Mrag Raj Jain	President	Shyor Sanstha, Barmer
40	Gayatree Acharya	Teacher	Mahila Shikshan Vihar, Jalore
41	Sumer Singh	Co-ordinator	Water Shod Consultant Organization, Bhinmal, Jalore
42	Dr. Varun Sharma	Ex- Director	Research Institute of Planeny Development, Narsana, Bhinmal
43	Koshal Kumar Meena	Project Co-ordinator	Haroti Adim Janjati Vikas Samiti, Kota
44	Shyam Kishor Agarwal	Chair Person	International Environment Science Samiti. Kota
45	Narendra Kumar Tiwari	President	Sramik Kalyan, Training Sansthan, Kota
46	Anurag	Community Co-worker (Samudaek Sahkrata)	Council for Social Development, Baran
47	Sh. Prakash Choudhry	Director	Baran
48	Nitin Vijay	District Project Co- ordinator	IIRD Baran
49	Manoj Kumar Shukla	Office Manager	IIRD Jhalawar
50	Bhawana Khanna	Teacher	Mahila Shikshan Vihar, Jhalawar
51	Vinod Joshi	Secretary	Jan Jagran Samiti, Bundi
52	Shalini Vijay	President	Grah Udhyog Sanstha, Bundi
53	Arvind Ojha	Secretary	Urmul Trust, Bikaner
54	Dinesh Pandey	President	Yuva Bharati Sansthan, Bikaner
55	Mukesh Sharma	Advisor	Shanti Maytri Mission Sansthan, Bikaner
56	Amit Khan	Secretary	Sriganganagar
57	Dr. P.V. Acharya	Chief Executive	Seth Bihari P. G. College Ganga Nagar
58	Hajari Lal Muthariya	President	Manav Seva Bharti Samiti, Srikaranpur, Sriganganagar
59	Dr. Naresh Makkar	Vice-President	Lines Club, Raisingh Nagar, Sriganganagar
60	Bheesm Koushik	Co-ordinator	Seva Viklang Samiti, Hanumangarh
61	Hari Singh	Chief Executive	Eklavya Seva Ashram Sansthan, Hanumangarh
62	Brahmanand Agarwal	President	Garbhsth Shishu Shikshan Samiti, Nohar, Hanumangarh
63	R. S. Shekhawat	Secretary	Lions Club, Churu
64	Sunita Rajpal	Micro Entetrises Experts	Shikshit Rajghar Kendra Prabandhak Samiti, Churu
65	Poonam Chandra	Agriculture Experts (DPIP)	Nawyuwak Madal Sansthan, Churu
66	Mahendra Singh Ji	Adminstrative	Mittal Foundation, Rajgarh

S. No.	Name	Post	Name of NGO
		Officer	
67	Sita Ram Ji	Executive Director	Lupin Bharatpur
68	Raman Lal Sharma	Management Officer	Jeevan Lok Nirwan Sansthan, Bharatpur
69	Hari Om Bindal	President	Sh. Mitra Mandal Samiti, Bayana, Bharatpur
70	Rajkumar Sharma	Field Assistant	Jan Shikshan Sansthan, Dhaulpur
71	Banwari Lal Rawat	Civil Engineer	E.RDS - Dhaulpur
72	Ashok Tiwari	Chief Executive Officer	Manglam Seva Samiti, Baseri, Dhaulpur
73	Braj Mohan Sharma	Secretary	Rajeev Gandhi Saryodaya Vikas Sansthan, Hindon, Karoli
74	Mahesh Kumar Upadhyay	Incharge	Indra Gandhi Shikshan Prashikshan Sansthan, Karauli
75	Mukesh Chaturvedi	Co-ordinator	EKAD Bhorugram Sanstha, Karauli
76	Rajeev Singh	President	Veena Memorial Seva Society, Karauli
77	Bharat Lal Khatana	President	Sri Deo Narayan Shikshan Sansthan Sanchalan Samiti, Gangapur City, Sawai Madhopur
78	Smt. Neeta Singh	Secretary	Mahila Seva Samiti, Sawai Madhopur
79	Smt. Chandra Kala Sharma	Secretary	Matra Shakti Sansthan, Sawai Madhopur
80	Ramesh Paliwal	Administrative Officer	ASTHA –Udaipur
81	Mangilal Agarwal	Acitve Director	Ankur Sansthan, Jharol, Udaipur
82	Kumril Agarwal	Research Associates	ARTH –Udaipur
83	Mahbooj Khan	Director	SECURA Society for Environment and Community applicant in Rajasthan, Dungarpur
84	Manoj Kumar Mishra	Out Reach Worker	Dungarpur
85	Kanta Gahlot	President	Bangar Mahila Jan Jagriti Sansthan, Sangwada, Dungarpur
86	Awdesh Gahlot	Secretary	Bangar Vikas Sansthan, Banswara
87	Bhupendenra Nath Purohit	Director	New Institute of Rural Affairs Society, Banswara
88	Jayesh Johshi	Secretary	Banswara
89	Shakuntala Pamecha	Co-ordinator	ASKITHA- Rajsamand
90	Sangram Singh	Co-ordinator	Rural Development & Technical Education, Society Rajsamand
91	Dinesh Ji Joshi	Director	ANBHUTI-CRA –Chittaurgarh

Global Rights Network

S.No.	Name	Profession
1	Atul Rastogi	Advocate
2	Vibhor Rastogi	Advocate
3	Naemuddin Aqil	Advocate
4	Payel Srivastav	Advocate
5.	Ashutosh Kumar	Advocate

Additional Respondents

S.No.	Name	Profession
1	Dr. S. P. Mathur	Lecturer In Business Management, M. L. B. College, Bhilwara
2	Smt. Asha Mathur	Joint Sec. UNESCO (Ex), Bhilwara
3	Mr. Shantanu Chakraborty	Distt. Programme Manager (DPM-RCH) Rajsamand
4	Ms. Shreena Rangnathan	DPM-RCH-Udaipur
5	Smt. Tara	Director, Bal & Mahila Chetana Samiti, Bhilwara
6	Sh. Ramesh Adhinani	Lecturer, Govt. Sr. Sec. School, Bigod, Bhilwara
7	Smt. Hemlata	Prog. Officer, Parivar Seva Sansthan, Bhilwara
8	Sh. Kailash Chandra Somani	President, Sankalp Seva Santhan, Bhilwara

ANNEXURE-4

LIST OF TABLES

ANNEXURE-4
LIST OF TABLES

PRAYATN

Struggle for a Dawn of Change

Administrative Office :

68/262, Pratap Nagar, Sanganer, Jaipur, (Raj.)
Phone : 0141-2792919, 2794239
E-mail : prayatnraj@gmail.com, prayatnraj@yahoo.com
Web : www.prayatn.org