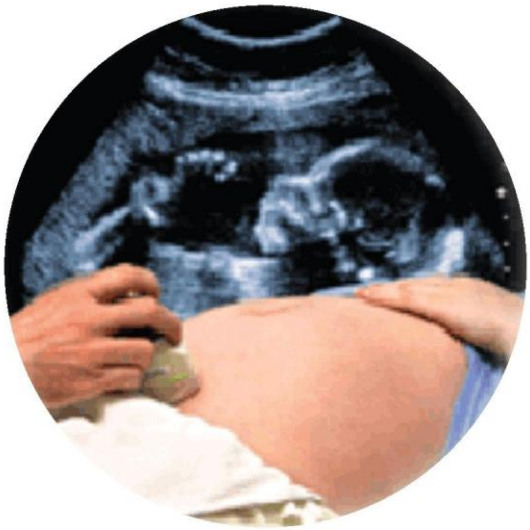
Report of

Evaluation Study of the Functioning of District Advisory Committee (DAC) and Corporation Advisory Committee (CAC) Established in Maharashtra under PCPNDT Act. 2003



Conducted by

Pravara Institute of Medical Sciences

Deemed University, Loni

Under the aegis of

State Health Systems Resource Centre (SHSRC),

Govt. of Maharashtra Pune

Supported by

UNFPA, Maharashtra, India

Dec. 2012

Report of

Evaluation Study of the Functioning of District Advisory Committee (DAC) and Corporation Advisory Committee (CAC) Established in Maharashtra under PCPNDT Act 2003

Conducted by

Pravara Institute of Medical Sciences – Deemed University, Loni

Under the aegis of

State Health Systems Resource Centre (SHSRC),
Govt. of Maharshtra, Pune

Supported by

UNFPA, Maharashtra, India

Dec. 2012

Report of

Evaluation Study of the Functioning of District Advisory Committee (DAC) and Corporation Advisory Committee (CAC) Established in Maharashtra Under PCPNDT Act 2003

Research Team

Principal Investigator

Prof. K.V. Somasundaram,
Director, Centre for Social Medicine, PIMS-DU, Loni

Co-Investigators

Dr. V.B. Bangal,
Prof. of Obstetrics & Gynecology, Rural Medical College, Loni
Dr. S.S. Jogdand,
Asso. Prof, Community Medicine, Rural Medical College, Loni

Under the Guidance of

Dr. Uddhao H Gawande,
Executive Director, SHSRC, Pune, Govt. of Maharashtra
Dr. A.P Khade,
Consultant PCPNDT Program, State Family Welfare Bureau, Maharashtra
Ms. Mukta Gadgil,
Senior Consultant, SHSRC, Pune, Govt. of Maharashtra
and
Dr. Daya Krishan Mangal,
State Program Coordinator, UNFPA, Maharashtra, India
Ms. Anuja Gulati,
Program Coordinator, UNFPA, Maharashtra, India

Dec. 2012

Evaluation Study of the Functioning of District Advisory Committee (DAC) and Corporation Advisory Committee (CAC) Established in Maharashtra Under PCPNDT Act 2003

Field Research Team

Dr. V.B. Bangal,
Prof. of Obstetrics & Gynecology, Rural Medical College, Loni

Dr. S.S. Jogdand,
Asso. Prof, Community Medicine, Rural Medical College, Loni

Dr. K.D. Chavan,
Prof. of Forensic Medicine & Toxicology, Rural Medical College

Dr. R.S. Bangal,
Prof. of Forensic Medicine & Toxicology, Rural Medical College

Dr.P.A. Giri,
Asso. Professor of Community Medicine, Rural Medical College

Dr. Sushil Kachewar,
Asso. Professor of Radio-diagnosis, Rural Medical College

Report of
Evaluation Study of the Functioning of District Advisory Committee (DAC) and Corporation Advisory Committee (CSC) Established in Maharashtra Under PCPNDT Act 2003

CONTENTS

PREFACE

Sex ratio is an important social indicator to measure the degree of equality between males and females in a society at a given point of time. Skewed sex ratio towards one gender largely reflects the underlying socio-economic and cultural patterns of a society in different ways. Progressive decline in the sex ratio (in favour of males) at national and state (Maharashtra) level has been a matter of concern for many decades.

The decline in national child (0-6 years) sex ratio from 927 to 914 girls and state child sex ratio from 913 to 883 girls per 1000 boys compared to 2001 and 2011 census - lowest since Independence, does not go well with the health and developmental workers as this could lead to serious socio-cultural problems. Declining sex ratio is a complex phenomenon which is an outcome of several factors at play that needs to be urgently responded with highest sensitivity using all possible means and resources at hand. A rise in sex determination tests and sex-selective abortions in the state had been the cause of sharp decline in sex ratio.

For effective implementation of the PCPNDT Act government of Maharashtra has constituted District Appropriate Authority and District Advisory Committee throughout the state. In order to further improve the functioning of these committees, the State Health Systems Resource Centre (SHSRC) of government of Maharashtra with the support of United Nations Population Fund (UNFPA) has undertaken a state level study on the evaluation of functioning of the DACs and DAAs established under PCPNDT Act 2003.

The Pravara Institute of Medical Sciences - Deemed University, Loni, which is one of the Technical Consultants enrolled with SHSRC, Pune , has been assigned the job of conducting this State level Evaluation Study in November 2012. I congratulate the Research Team headed by the Director, Centre for Social Medicine of PIMS-Deemed University for their professional and meticulous job which clearly brought to the fore some important points, for consideration of State for strengthening the implementation of PCPNDT Act.

Dr. Daya Krishan Mangal,
State Program Coordinator,
UNFPA, Mumbai, Maharashtra

Dr. Uddhao H. Gawande,
Executive Director,
State Health Systems Resource Center, Pune

ACKNOWLEDGEMENTS

At the outset, Pravara Institute of Medical Sciences (PIMS) - Deemed University, Loni would like to thank State Health Systems Resource Centre (SHSRC), Pune and United Nations Population Fund (UNFPA), Maharashtra, Mumbai for giving the opportunity to conduct the Study on a vital and highly sensitive issue. We specially thank and appreciate the valuable guidance and inputs provided by Dr. Satish Pawar, Director - NRHM, Dr. Uddhao H Gawande, Executive Director, Dr. Motiram Kamble, Asst. Director, and Ms. Mukta Gadgil, Senior Consultant of SHSRC, Pune, Dr. A.P Khade, Consultant PCPNDT Program, State Family Welfare Bureau, Maharashtra, and Dr. Daya Krishan Mangal, State Program Coordinator, UNFPA Maharashtra State Office and Ms. Anuja Gulati, Program Officer, UNFPA-Maharashtra, Mumbai while designing & implementing the research study.

Our special thanks to all the District and Corporation Appropriate Authorities (DAAs) and Chairman and Members of DACs of Beed, Bhandara, Jalgaon, Kolhapur, Parbhani, and Thane, and & CACs of Akola, Aurangabad, Bhiwandi, Dhule and Pune, who actively participated in the study by cooperating with the research team of PIMS-Deemed University. We would also like to acknowledge with much appreciation the assistance & cooperation provided by the staff of the offices of DAA/CAA of the selected districts under study.

Last but not the least, I am extremely thankful to Shri Rajendra E. Vikhe Patil, Chief Executive Officer, PIMS-DU and Dr. Sashank D. Dalvi, Vice Chancellor, PIMS-DU for their stimulating suggestions and encouragement to conduct and coordinate the study.

Prof. K.V. Somasundaram,
Principal Investigator of the Study
Director, Centre for Social Medicine,
Pravara Institute of Medical Sciences – Deemed University, Loni

ABBREVIATIONS

AA **:** Appropriate Authority

AC **:** Advisory Committee

CAA **:** Corporation Appropriate Authority

CAC **:** Corporation Advisory Committee

CS **:** Civil Surgeon

DAA **:** District Appropriate Authority

DAC **:** District Advisory Committee

DHO **:** District Health Officer

JMFC : Judicial Magistrate First Class

MS **:** Medical Superintendent

MOH : Medical Officer – Health

MTP : Medical Termination of Pregnancy

NGO : Non-governmental Organization

PIMS-DU **:** Pravara Institute of Medical Sciences–Deemed University

PP **:** Public Prosecutor

PCPNDT **:** Pre-conception & Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act in 2003

PNDT : Pre-natal Diagnostic Techniques Act 1994

SAA **:** State Appropriate Authority

SHSRC : State Health System Resource Centre

ToR : Terms of Reference

UNFPA **:** United Nations Population Fund

USG **:** Ultra Sonography

CHAPTER 1
INTRODUCTION

1.1 Background of the Study

Millions of women in India have been missing through illegal sex selection practices using various pre-conception and pre-natal diagnostic techniques. It is estimated that India is missing about 50 million women over past two decades. The word 'missing' was coined by Dr. Amartya Sen to refer to the number of women that should have been in India's population, according to the normal male/female ratio.

Skewed sex ratio has emerged to be one of the biggest threats to contemporary civilization. The rising imbalance has been attributed to increased crime against women, trafficking, sexual assault, and polygamy. Sex selection is a nefarious crime; perpetrators belong to the educated class, most likely they don't see it as a crime. The increasing demand for sex selection has led to commercialization & misuse of technology. Clinics providing sex determination tests are growing rapidly and widely. Sex selection facility is now available in places that do not even have potable water.

The practice of sex selection has been a critical influencer of skewed sex ratios. It has, therefore, been sought to be legally regulated or termed illegal in some countries of the world, and India is one of them. There is little doubt that strong socio-cultural and religious biases and a preference for sons in some communities have shaped societal attitudes in favor of the son. In many parts of India, community customs such as the practice of dowry are perceived as a financial burden on the bride's family during and after marriage. Women bearing male children are treated with respect in the community and a son is considered as a security for old age. That son preference is a common, widespread social characteristic is not new. But the last few decades have witnessed the unfolding of a disturbing, and now alarming trend – to give son preference that tiny, sleek, technological nudge through the misuse of prenatal diagnostic technologies. From mid 1980s, this technological breakthrough became an opportunity in waiting, for people who wanted to escape from giving birth to a baby girl and for the industry and medical professionals for improving their business by support this sinister idea. **(1)**

Government and its several partners, civil society, and a plethora of organizations responded to this trend by first acknowledging that prenatal diagnostic technologies – a vital pillar of women‘s sexual and reproductive health and rights–needed some watching, because sex selection was fast catching up, surely as a serious fallout of the low status of women in society over the years. The first legal response from the Government of India came in the form of the Pre-natal Diagnostic Techniques Act (PNDT) in 1994, and the same was further amended into the Pre-Conception and Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) (PCPNDT) Act in 2003 as a powerful legal instrument to foster positive change in this modern sociological trend.

1.2 Rationale of the Study

In Maharashtra, government has assigned powers of AAs to many administrative heads including non-medical agencies like revenue and municipal corporation authorities besides medical authority. For effective implementation of the Act, under section 17 (5), there is a provision to constitute an Advisory Committee for each AA in the discharge of its functions. Consequently, Govt. of Maharashtra issued notification, whereby constituted 33 District Advisory Committees (DACs) and 23 Corporation Advisory Committees (CACs). Despite the fact that DACs & CACs are constituted these committees are not performing the expected role, as is evident by meagre number of effective actions initiated under PCPNDT Act. Hence, a need was felt to evaluate the functioning of District Appropriate Authority (DAA) & District Advisory Committees (DAC) constituted under PCPNDT Act. It is believed that the observations and recommendation of such evaluation study will certainly be helpful in bringing the improvement in functioning of DACs and in-turn effective implementation of the PCPNDT Act at District level.

As part of an evaluation of implementation of this crucial social legislation, the Maharashtra State Health System Resource Centre (SHSRC) with support from United Nations Population Fund (UNFPA) has commissioned an evaluation study to assess the functioning of District Advisory Committees (DAC) formulated under the PCPNDT Act. The study was conducted in 5 randomly selected corporations and 6 districts of Maharashtra.

The study has been carried out through Pravara Institute of Medical Sciences–Deemed University (PIMS-DU), Loni - one of the consultant organizations, empanelled on SHSRC, Pune. The PIMS–DU, Loni–is an academic, research and service delivery organization specialized in medical and public health, located in Ahmednagar district of Maharashtra.

This statewide study aimed to understand the complete gamut of functioning of the district/corporation advisory committee (DAC/CAC), functioning of district appropriate authorities (DAA), record keeping, supervision on imaging centers, problems faced by appropriate authorities, awareness generation activities carried out in the selected districts/corporations and identify bottlenecks in the implementation of the Act, with the idea that remedial measures to make the law more effective, may be found through an in-depth understanding of these bottlenecks and impediments. Specifically, the evaluation was done with following key objectives:

1.3 Aims & Objectives

1.3.1 Aims

1. To review the constitution and functioning of the District/Corporation Advisory Committee (DAC/CAC) as per the provisions of the Act.
2. To appraise the performance of the District and Corporation Appropriate Authority (DAA/CAA) in relation to functions & powers delegated through the Act

1.3.2 Objectives:

1. To assess the formation of DAC/CAC as per the provisions of the Act
2. To assess the regularity of meetings held, attendance of members (quorum) and quality of the issues discussed at DAC/CAC
3. To find out whether the powers vested on the DAC/CAC are exercised optimally and correctly
4. To review various actions taken by DAA/DAC for effective implementation of the act.
5. To review the status of registrations, renewal, suspension, cancellations of the Genetic Clinics/Imaging Centres,
6. To find out difficulties faced by the DAA & DAC/CAC
7. To review the actions taken to create public awareness generation against practice of sex selection/sex determination
8. To suggest recommendations for improvement in the functioning of DAA /CAA and DAC/CAC

CHAPTER 2
SCOPE & METHODOLOGY OF THE STUDY

2.1 Scope of Study Subject:

2.1.1 Terms of Reference (ToR)

As per the Terms of Reference (ToR) prescribed by SHSRC, Pune and signed by PIMS-Deemed University as "Technical Consultant" for undertaking the study, the following activities have been successfully carried out by the Research Team of PIMS, Loni, within the time period prescribed by SHSRC, Pune.

1. Preparation of study proposal with study design, study tools for data collection and detailed budget as per the approved norms.
2. Orientation/training of field investigators on the study research methodology and on the data collection tools
3. Collection of data with due supervision on the data collection activity
4. Data entry and cleaning
5. Data analysis and report writing

2.1.2 Scope of the Study within the Framework of PCPNDT Act 2003

The Scope of the study has been defined keeping the constitution, functions and responsibilities of DAA/CAA and DAC/CAC under PCPNDT Act 2003, as per the details given below:

The Constitution, Functions and Responsibilities of DAA/CAA and DAC/CAC under the PCPNDT Act 2003: According to Section 17 (5) of the Act the respective State Government, shall constitute District Advisory Committees (DAC) to aid and advice District Appropriate Authority (DAA) in the discharge of its functions. {The broad functions of the DAA are i) implement the Act at District level, ii) register clinics, iii) inspect clinics, iv) investigate complaints, and v) file court complaints). The Advisory Committee shall be headed by the Chairperson, one of its own members. Section 17 (6) of the Act states that the Advisory Committee shall consist of:

a) Three medical experts from amongst gynaecologists, obstetricians, paediatricians, and medial geneticists;

b) One legal expert;

c) One officer to represent the department dealing with information and publicity of the District concerned,

d) Three eminent social workers of whom at least one shall be from amongst representatives of women's organizations

The DAC may meet as and when it thinks fit or at the request of the DAA for consideration of any application for registration or any compliant for suspension or cancellation of registration and to give advice thereon.

2.2 Study Period:

The duration of the study was two months (8 weeks) - 1st November to 31st December 2012, which includes preparatory phase, pilot study, training of investigators, data collection, analysis, presentation of preliminary findings and submission of first draft of the report.

2.3 Sampling methodology & Sample Size:

The task of evaluation of functioning of DACs, CACs & DAA, CAA established under PCPNDT Act was carried out in Maharashtra state by following the research and sampling methodology explained below.

Population & Sample

There are a total of 56 such Committees (33 District-level and 23 Corporation-level) functioning in the State of Maharashtra forms the Sampling Frame. A 20% sample size was arrived by adopting Stratified Random Sampling (SRS) at both district level and corporation level. Firstly, all districts and corporations of Maharashtra state were stratified as per the administrative circles and thus following districts and corporations were selected from each of the Administrative Circle. Thus in all 11 DACs - 6 District level and 5 Corporation-level were selected for the study.

The six districts selected randomly for conducting the study include (1) Thane, (2) Jalgaon, (3) Kolhapur, (4) Parbhani, (5) Beed, and (6) Bhandara

The Five Corporations Selected for conducting the study include (1) Bhiwandi, (2) Aurangabad, (3) Akola, (4) Pune and (5) Dhule

Primary Sampling Units and Size of Sample

The study participants (primary sampling units) included **were** the DAA, CAA and the Chairperson and One Member from each category of DAC and CAC from the 11 selected districts and municipal corporations. A total of 83 individuals were interviewed including 11 AAs, 72 members of DAC and CAC including Chairman (Refer Tables given below for details).

Serial no.	Category of Respondents	No. of Respondents	Tools Used
1	Appropriate Authority (AA)	11	IDI
1	Chairperson & Member of Advisory Committee	72	IDI
	Total	83	IDI

The distribution of the category wise (medical, legal, social work, public relations) members of the DACs and CACs interviewed was as follows:

Serial no.	Category	No. of Respondents	Percent
1	Medical professionals	38	52.78
2	Legal professionals	10	13.89
3	Social organization professionals	18	25.00
4	Public Relations Professionals	06	08.33
	Total	72	100.00

2.4 Study Tools and Analysis:

Keeping in mind the objectives of the evaluation study, detailed and uniform information, about the functioning of DAA & DAC/CAC was gathered in a pre-designed study format **(in-depth interview schedule**) addressing various designated authorities.

1. In-depth Interview (IDI) Schedule addressed to DAA/CAA who is responsible for overall implementation of the Act **(Annexure 1)**

2. In-depth Interview (IDD) Schedule addressed to the Chairman of the DAC/CAC (**Annexure 2**)

3. In-depth Interview Schedule addressing the Member of the DAC/CAC **(Annexure 3)**

Data **have** been recorded in the Interview Schedules and transformed into excel formats for detailed analysis. The Evaluation team has also checked all available relevant records & registers of DAA and DAC Offices. The evaluation teams have also made an attempt to visit some of the imaging centres, where USG machines have been sealed on various grounds .to understand the problems and procedures being followed.

2.5. Pre-testing of Tools & Training to Research Team

Pre-testing of data collection tools and research methodology was undertaken at Ahmednagar district, before launching the main study in the selected districts and corporations of Maharashtra. Orientation training on the scope of study, its design and data collection tools and methods for the field investigators was conducted before placing them for data collection through quantitative and qualitative methods by Principal Investigator & Co-investigators of the study.

2.6 Ethical Concerns Addressed:

In view of the sensitive nature of the study, necessary steps were taken to address the ethical issues related to the study. Written consent was obtained from all the respondents after explaining to them the relevance and purpose of the study. Oral consent was taken from the respective Chairman/Members of the Advisory Committee to review/verify the registers/records in the office of DAC/CAC. Complete confidentiality was assured and maintained during the course of study.

CHAPTER 3
OBSERVATIONS AND KEY FINDINGS

3.1 District/Corporation Advisory Committees (DACs/CACs)

3.1.1 Constitution of DAC/CAC:

Completeness (appointment of all members), Composition (as per fixed category), Procedure of Nomination/Appointment, Standing/Quality of the members nominated /appointed, Renewal of appointments, and Continuation of the Committee members:

DAC/CAC has been constituted in all six districts and five corporations under study (Table 1). All districts except one (Bhandara), have nominated members from all categories (medical, legal, social work, public relations etc) as per the norms.

Table 1
Status of Districts/Corporations with regard to Constitution of Advisory Committee (AC)

	No. of Districts (N = 6)	% Districts constituted ACs	No. of Corp. (N = 5)	% Corporations constituted ACs
AC Constituted	6	100	5	100

The members on AC were nominated by the AA as per his/her discretion. It was informed that the members were selected as per their credibility and background. There was no specific procedure or any specific criteria followed for selection of the members. There has not been any planned orientation programme or induction training of the selected members provided by AA.

In 3 districts (Thane, Kolhapur, Jalgaon) and 1 corporation (Pune) same members were continuing from the inception of the programme. In other 2 districts and 5 corporations surveyed, the AC members were changed as per the provisions of the Act.

3.1.2 Functions of DAC/CAC

A) Regularity of meetings (frequency), Procedure followed for convening meetings (notice of meetings with Agenda, Circulation of the minutes of the meetings to the members, exclusive/combined with other meetings

The AC meetings were held as envisaged (once in two months) in 73% of the districts/corporations (83% Districts & 60% Corporations) under study **(Table 2).** Three out of eleven districts/corporations (Bhandara, Bhivandi and Dhule), the AC meetings were not held as envisaged.

Table 2
Regularity of the AC Meetings Held

Meetings per year as envisaged	Held		Not Held	
	Number	Percent	Number	Percent
Districts (N=6)	5	83.3	1	16.7
Corporations (N=5)	3	60.0	2	40.0
Total (N=11)	8	73.0	3	27.0

An advance notice of the meeting of AC with agenda was prepared and circulated in 83% districts and 80% corporations. **(Table3).**

Table 3
Process followed in convening AC Meetings

Process of AC meetings	**Done as envisaged**		**Not done as envisaged**	
	Districts (%)	**Corporations (%)**	**Districts (%)**	**Corporations (%)**
Notice is sent well in advance	5 (83.3%)	4 (80%)	1 (16.7%)	1 (20%)
Agenda is made & circulated	5 (83.3%)	4 (80%)	1 (16.7%)	1 (20%)
Exclusive Meeting for AC organized	4 (67%)	5 (100%)	2 (33%)	0 (00%)

B) Chairperson of the meetings, Quorum of the meetings; Maintenance of minutes of meetings,

The Chairperson or in his/her absence, the senior member of AC was chairing the meetings in 60% of districts and 80% of corporations. In two districts (Kolhapur & Bhandara) and one corporation (Bhivandi), however the AA himself/herself was chairing the meetings **(Table 4). This is not as per the intent of the Act.**

On verification of the **records** of the AC meetings, it was observed that the percentage of attendance of members varies from 60% to 100%, with an average of 80 percent. The minutes of the meetings were read in the subsequent meetings. AAs invariably attended the DAC/CAC meetings.

Table 4
Person who chaired AC meetings

	No. of Districts (N = 6)	% Districts	No. of Corporations (N = 5)	% Corporations
Chairman of AC	4	60	4	80
AA him/herself	2	40	1	20

Based on the views expressed by the members of AC, the level of cooperation received from AA to AC could be graded as excellent in 3 places – 28% (2 districts, 1 corporation), good in 2 places – 18% (2 districts, 0 corporations) and Fair in 6 places – 54% (2 districts, 4 corporations) **(Table 5).**

Table 5
Level of cooperation received from AA to the AC

Cooperation received by AA	Excellent	Good	Fair	Poor
Districts (N=6)	2	2	2	0
Corporations (N=5)	1	0	4	0
Total	3	2	6	0

In more than 80% (9 out of 11) of districts/corporations, the AC members expressed their satisfaction about the conduct of the meetings including opportunity provided to voice their opinions freely. In less than 20% districts/corporations, the AC members expressed their dis-satisfaction about the authoritative manner of conducting meetings by AA.

In all the 6 districts and 5 corporations surveyed, it was found that the minutes of the AC meetings were maintained. Of course, in 2 districts (Thane and Kolhapur) a combined meeting register was maintained, while in all other districts/corporations a separate register was maintained. However, the quality of maintenance of the minutes varied from district to district and corporation to corporation. In all, 63% cases (50% districts & 80% corporations) the minutes were "well kept", in 18% of the cases they were "kept" and in the remaining 18% cases the minutes were "not well kept" **(Table 6).** Overall the corporations were keeping the minutes better than that of the districts.

Table 6
Maintenance of Minutes of AC meetings Held

Meetings	Well Kept		Kept		Not Well Kept	
	Number	Percent	Number	Percent	Number	Percent
Districts (N=6)	3	50	2	33	1	17
Corporations (N=5)	4	80	0	00	1	20
Total (N=11)	7	63	2	18	2	18

C) Quality of AC Meetings: **Issues discussed, Participation of members in the deliberations of the meetings**

The common points that were discussed in the meetings were related to new applications for registrations/renewals, rejection of applications in 100% districts and 80% corporations (**Table 7**).

Table 7
Issued discussed in the AC Meetings Held

Issues discussed in AC meeting	**Done as envisaged**		**Not done as envisaged**	
	Districts (%)	**Corporations (%)**	**Districts (%)**	**Corporations (%)**
New applications	6 (100%)	4 (80%)	0 (0%)	1 (20%)
Renewal applications	6 (100%)	4 (80%)	0 (0%)	1 (20%)
Rejections	6 (100%)	4 (80%)	0 (0%)	1 (20%)

Some of the Members of DAC & CAC (40% of Thane, 50% of Kolhapur, 100% of Bhandara, 70% of Bhivandi corporation, 100% of Dhule Corp.,) were not aware about State Appropriate Authority, their location and contact details.

The level of participation of members in the discussion and quality of discussion mainly depended on the professional and educational background, knowledge about the subject and the sensitivity of individual member towards the issue. Overall, women members and members from legal background were more active than other members.

D) Performance of functioning of AC

The performance of functioning of AC was assessed based on the following activities carried out in the districts/corporations **(Table 8).**

Table 8-Activity based Performance of functioning of AC

Activities Carried out	Districts		Corporation	
	Yes No. & %	No No. & %	Yes No. & %	No No. & %
Decoy operations	2 (33.4%)	4 (66.6%)	3 (60%)	2 (40%)
Pending cases	6 (100%)	0 (0%)	4 (80%)	1 (20%)
Disciplinary action initiated	5 (83.3%)	1 (16.7%)	5 (100%)	0 (0%)
Awareness activities conducted a) For AC members b) For general public	4 (66.6%) 4 (66.6%)	2 (33.4%) 2 (33.4%)	3 (60%) 3 (60%)	2 (40%) 2 (40%)
Machines sealed	5 (83.3%)	1 (16.7%)	5 (100%)	0 (0%)
Maharashtra Medical Council is informed of defaulters	2 (33.4%)	4 (66.6%)	0 (0%)	5 (100%)
Licenses suspended/cancelled by MMC	2 (33.4%)	4 (66.6%)	0 (0%)	5 (100%)

One in every three districts surveyed, the DACs are conducting decoy operations. Of course the rate of conducting decoy operations is much more (60%) in Corporation areas. While all the districts surveyed have filed cases and are pending in the court of law, only 80% of Corporations have filed cases. While 5 out of 6 DACs had a record of disciplinary action initiated and sealing machines, it has been done in all the 5 CACs surveyed. Only 2 out of 6 DACs and not a single CAC had informed Maharashtra Medical Council (MMC) about the defaulters of the PCPNDT Act. The MMC has initiated action by suspending the License of the Doctors, in the two districts whose DACs have sent information to them, in all other cases the MMC did not initiate any action, may due to lack of information from DACs/CACs.

Nearly 2/3rd of the DACs and CACs have conducted some awareness activities for general public and AC members about the PCPNDT Act.

E) Management of ACs: *Payment of TA/DA for the outside members of the meeting, Display of names of AC members, training of members*

Nearly 67% of districts and 100% corporations opened a separate Bank Account, for depositing the registration/renewal fee, in the name of PCPNDT Act. However, no AA has operated this account for making any financial transactions for conducting awareness activities, payment of TA/DA to the members attending the meetings etc as envisaged in the Rules, 1996 **(Table 9).**

Table 9
Management of Advisory Committees (ACs)

Management of AC	Districts		Corporations		Total	
	No.	%	No.	%	No.	%
Funds Utilized from PCPNDT Account for awareness activities	0	00.0	1	20	1	9
TA/DA of AC members	0	00.0	1	20	1	9
AC members names displayed	2	33.4	2	40	4	36
Trg. of AC members held						
a) On the role/responsibility	4	66.6	2	40	6	54
b) On the Act	0	00.0	0	00	0	00

In 4 out of 11 districts/corporations, the members of the DAC were displayed. In 6 out of 11 districts/corporations, training has been organized through internal resources for the DAC members on the roles and responsibilities. At some places, it was reported that DAC/CAC members were not given TA/DA for attending meetings and for clerical staff for attending court calls or work related to PCPNDT act,

3.1.3 Knowledge & Awareness of Members of DAC/CAC

The study revealed that the overall knowledge levels of non-medical members of AC on the PCPNDT Act was poor in 46% and an equal number of members **had** fair and good (27%) **knowledge respectively** (Table 10). Nearly half of the non-medical members were unaware about the exact provisions under the PCPNDT Act.

Table 10
Knowledge of AC members on PCPNDT Act

Knowledge level	Excellent	Good	Fair	Poor
Of Non-medical members of AC on ACT	0	3	3	5
Of AC member on Issues	0	2	3	6

The non-medical members of AC, especially at District level, had neither read the PC PNDT Act, nor did they have copy of the Act in a language they understand. The knowledge level of the members from Corporation was better than the members at District level. This could be directly attributed to their higher educational qualification and better access to the print media in urban areas as compared to their rural counterparts. The members of Corporation were relatively well educated/qualified and were holding some important position in one or the other organization.

A further probe on the knowledge levels of all members combined (medical and non-medical and District and Corporation) on various provisions & procedures of the Act has revealed that nearly 3/4th of the members were aware about filing court complaints (75%), conducting sting operations (78%), collecting evidence (82%), conducting search/seizure operations (78%) etc (Table 11).

Table 11

Knowledge of DAC/CAC members on various procedure of the Act

Serial No.	Aware of Procedures under Act	Yes (%)	No (%)
1	Filing court complaints	54 (75.00)	18 (25.00)
2	Conducting sting/decoy operations	56 (77.78)	16 (22.22)
3	Collecting evidence	59 (81.94)	13 (18.06)
4	Conducting search/seizure operations	56 (77.78)	16 (22.22)
5	Steps undertaken to implement Act	42 (58.33)	30 (41.67)

A study of the awareness levels of AC members about information on USG centres reveals that only 57% members had the correct information and 60% had correct information about the number of applications received by AC for registration.

Table 12
Knowledge of DAC/CAC members on USG Centres in their jurisdiction

Serial No.	Information about area	Know	Don't know
1	Number of USG centres in area	41 (56.94%)	31 (43.06%)
2	Average number of annual applications	43 (59.72%)	29 (40.28%)

3.1.4 Contribution of Members of AC

Members from (i) legal background, (ii) women organizations and (iii) district information office had positively contributed in the effective implementation of the programme. **Contribution of the members, who are with social & influential background from the economically backward districts, is not very encouraging.** Only 50% of the members of AC had actively participated in various campaigns against sex selective practices, organized by district administration. Same members also participated in conducting the sting operations. Active members kept the pressure on district administration for effective implementation of the programme.

3.2. District/Corporation Appropriate Authority

3.2.1. Constitution of DAA/CAA:

The designated person on the post of DAA/CAA was available in all the districts and corporation areas visited. It was mostly a District Civil Surgeon (CS) in the district and Medical Officer-Health (MOH) or his subordinate in the Corporation area. The team could meet all eleven DAA/CAA during their visit.

3.2.2. Functions of DAA/CAA:

The DAA/CAA were mostly concerned about implementation of the Act but were facing difficulties and constraints .The appropriate authorities were involved in scheduling the DAC/CAC meetings at regular intervals. In 20% Districts/Corporations visited, the meetings were not held for six to eight months due to absence/non appointment/vacancy of post of health authority. The appropriate authorities were keeping check on the records related to PCPNDT, except H register. It was not checked or signed by any appropriate authority.

Half of the corporation and district appropriate authorities had definite plan of supervision of imaging centres, whereas remaining half did not pay sufficient attention towards vigilance on imaging centres. At two places (20%) DAA/CAA had designated them as Chairman of DAC/CAC. They were authoritative in conducting the DAC/CAC meetings and clubbed the meetings with other general meetings. Three districts/corporations (30%) authorities were silent about taking any disciplinary action against sinologist/USG owners and more than half had not performed any sting operation in their district. Cancellation/suspension of MMC registration was seen in 20% of districts/corporations.

3.2.3. Knowledge and awareness of DAA/CAA:

Majority (72%) of the AAs had satisfactory knowledge about the PCPNDT Act and its provisions (Table 13). All DAA/CAA had gathered the knowledge of the Act through the meetings/ trainings/discussions/PCPNDT booklets and through departmental circulars.

Table 13

Level of Knowledge of AAs

	Level of Knowledge		Total
	Sufficient	Not sufficient	
District AA	4	2	6
Corporation AA	4	1	5
Total	8	3	11

3.2.4. Contribution of DAA/CAA:

During DAC/CAC meetings, DAA/CAA contributed through their technical knowledge of the Act. They provided the updated information to the members about the imaging centres, court cases and their present status. They also educated the DAC/CAC members about the information, instructions received from state appropriate authority and the state government.

They took disciplinary action against defaulters by serving notices and filing cases on various grounds. They tried to arrange a decoy case for attempt of sting operations. They called advisory committee meetings. Special/ emergency meetings/task force meetings/ meetings with district collector and held discussion during periodic meetings of medical officers of RH /corporation. For increasing public awareness, they involved district information officer for media coverage on centres sealed, sting operations performed. DAA/CAA tried to involve NGOs in identifying doctors involved in sex determination and illegal termination of pregnancies. Special drives of inspection were conducted by DAA/CAA.

3.2.5. Constraints of DAA/CAA:

While implementing the Act, various constraints and difficulties were faced by DAA/CAA. They were unable to spare sufficient time for the sensitive issue and were feeling pressure from higher authorities. They were of the opinion of appointing a separate officer as appropriate authority. They felt political pressure while taking disciplinary action against defaulters.

They expressed need for additional manpower and logistic support for supervision of imaging centres. Over 50% DAA/CAAs felt that they need technical assistance in legal matters. All DAA/CAA faced the difficulty in arranging decoy case for conducting sting operation.

3.3. Status and functioning of genetic clinics and imaging centres

It was observed that 30% imaging centres were closed down in last two years in the districts / corporations for various reasons like non availability of radiologist, fear of disciplinary action, too much of paper work, surprise visit of government officials, fear of legal action on flimsy ground of incomplete paper work etc. The trend was in favour of closure of centre than opening of a new centre.

It was reflected through reduction in new applications received by DAA/CAA. The records related to PCPNDT were checked. It was observed that in general the records were maintained but not updated and complete. The maintenance of H register was incomplete in all the districts and corporations visited.

It was maintained but incomplete and not updated. The record was not reviewed by appropriate authority. The regularity of monthly reporting from centres to district /corporation and from there to the state was satisfactory. The data received from the centres was not analyzed at the district level and thus there was gross mismatch of figures in 30% districts/corporations. The Renewal of imaging centres was done as per the norms and as per revised fees structure. Advisory committee was consulted before new registration/renewal. In 3 out of 11 districts/corporations, there was no definite record of number and location of functioning USG machines in the district/corporation. In one district, one unregistered USG machine was found. This machine was under repair for some time and later remained functional, but unregistered.

Imaging centres were mostly following the norms regarding display of certificates of registration, boards, F forms and record keeping in general. The centres which were closed down on request of the owners were visited for the status of the ultra-sonography machines. There have been different ways of temporary sealing of these machines. Some were appropriate and others were not. Similar observations were there regarding sealing of machines on legal ground.

3.4. Linkages of implementation of PCPNDT Act with MTP Act & RCH Schemes

One senior member of CAC expressed that some of the government medical colleges have either restricted or stopped performing second trimester medical termination of pregnancies (MTPs) for no obvious reasons. There has been unnecessary fear factor among gynaecologists regarding provision of MTP services to their regular clients. This has compromised women's right to safe abortion services provided under MTP Act. Needy women are unwillingly choosing the abortion services provided by the untrained persons (Quacks). **(18)**

This is likely to result in rising infective morbidity and mortality in abortion seekers at untrained hands. Presently, corporation authorities do not have any administrative control on MTP centres in their jurisdiction. This has affected tracking of quacks and un-authorized MTP centres performing illegal MTPs.

Non availability of medical pills (MTP Pill) for induction of early abortion has affected the MTP services. The medical drug stores and the stockists are not willing to keep these drugs due to stringent actions and norms for over the counter purchase and sell of these drugs. This is resulting in more number of surgical evacuations and the complications there of. These issues can be sorted out by handing over the control of MTP centres of corporation area to MOH for effective implementation of both Acts and by taking steps to remove the fear factor among medical practitioners to prevent negative effect on RCH services provided by private nursing homes. It was felt that there is need for interstate co- ordination to track the cases and the doctors involved in sex determination activity and subsequent MTPs in border districts.

CHAPTER 4

SUMMARY & CONCLUSION

4.1 Summary

Declining number of girls in the population is a matter of great concern .The population census data indicate that the child sex ratio is adverse for girls and this could lead to serious socio cultural problems and population imbalances in the country. One of the reasons attributed to the lesser number of girls in the age group of 0-6 years is the practice of sex selection. In order to check this evil practice, PC PNDT Act, 1994 is being implemented in the country and so also in Maharashtra state. For the implementation of the Act, the government has appointed different stake holders including the appropriate authorities in every district and corporation. The district and corporation advisory committee have been formulated as per the provisions of the Act. The members of the committee are expected to advice the DAA/CAA regarding critical issues arising out of implementation of the Act.

Considering the critical role and the responsibility of DAC and CAC in effective implementation of the Act, government of Maharashtra decided to review the functioning of DAC/CAC and DAA/CAA This state-wide study aimed to understand the complete gamut of functioning of the district/corporation advisory committee (DAC/CAC), functioning of district appropriate authorities (DAA), record keeping, supervision on imaging centres, problems faced by appropriate authorities, awareness generation activities carried out in the selected districts/corporations and identify bottlenecks in the implementation of the Act, with the idea that remedial measures to make the law more effective, may be found through an in-depth understanding of these bottlenecks and impediments.

The Scope of the study has been confined to the constitution, functions and responsibilities prescribed for DAA/CAA and DAC/CAC under PCPNDT Act 2003. The study duration was of two months from the date of commencement. The study period was 1st November to 31st December 2012. The task of evaluation of functioning of district advisory committees (DACs) established under PCPNDT Act was carried out in 6 districts and 5 corporations in Maharashtra state. A 20% sample size was arrived by adopting Stratified Random Sampling (SRS) at both district level and corporation level. The six districts selected randomly for conducting the study include (1) Thane, (2) Jalgaon, (3) Kolhapur, (4) Parbhani, (5) Beed, and (6) Bhandara The Five Corporations Selected for conducting the study include (1) Bhiwandi, (2) Aurangabad, (3) Akola, (4) Pune, (5) Dhule. The study participants included were the DAA, CAA and the Chairperson and One Member from each category of DAC and CAC from the 11 selected districts and municipal corporations. A total of 83 individuals were interviewed including 11 DAA/CAAs and 72 members of DAC/CAC including Chairman. Detailed and uniform information, about the functioning of DAA & DAC/CAC was gathered in a pre-designed, pre-tested study format **(in-depth interview schedule**) addressing various designated authorities. Three field evaluation teams were constituted comprising of two senior faculty members in each team, for collecting the field level data through in-depth interviews in the 6 districts and 5 corporations. In view of the sensitive nature of the study, all essential steps were taken-up to address the ethical concerns related to the study.

It was observed that DAC/CAC has been constituted in all six districts and five corporations under study. All districts except one, have nominated members from all categories (medical, legal, social work, public relations etc) as per the norms. There was no specific procedure or any specific criteria followed for selection of the members. There was no any planned orientation programme or induction training of the selected members, which reflected in their knowledge about the provisions of the Act, as nearly 50% members were unaware of the same. Majority of the members were unaware about their role and responsibilities. It was felt that, more than half of the members presently on the committees were not proactive and were not useful/ resourceful for the effective implementation of the programmes.

In 75% of the Districts and Corporations under study, the DAC/CAC meetings were held almost once in two months. On an average 70 to 80 percent of the members attended the meetings. The meetings were chaired by a senior member of the committee at most of the places. In three districts/corporations, this norm was not followed and the meetings were chaired by either DAA or CAA. DAA and CAA invariably attended the DAC/CAC meetings. In nine out of 11 districts/corporations, members were satisfactory about the conduct of the meetings including expressing their views freely. The common points that were discussed in the meetings were related to new registration /renewal or closure of the imaging centres, the court cases filed, pending and the follow up action taken. The quality of discussion mainly depended on the type of members, their educational background, their knowledge about the subject and the sensitivity of individual member towards the issue. Overall, women members and members from legal background were more active than other members. The members were unaware about the separate PCPNDT account in all districts and corporations.

The designated person on the post of DAA/CAA was available in all the districts and corporation areas visited. It was mostly a District Civil Surgeon (CS) in the district and Medical Officer-Health (MoH) or his subordinate in the Corporation area. The team could meet all eleven DAA/CAA during their visit. The DAA/CAA were mostly concerned about implementation of the Act but were facing difficulties and constraints .The appropriate authorities were involved in scheduling the DAC/CAC meetings at regular intervals. The appropriate authorities were keeping check on the records related to PCPNDT, except H register. Half of the corporation and district appropriate authorities had definite plan of supervision of imaging centres, whereas half number did not pay sufficient attention towards vigilance on imaging centres. Three districts/corporations (30%) authorities were silent about taking any disciplinary action against doctors and more than half had not performed any sting operation in their district. Overall knowledge level of all appropriate authorities regarding PC PNDT Act was satisfactory. During DAC/CAC meetings, DAA/CAA contributed through their technical knowledge of the Act. They provided the updated information to the members about the imaging centres, court cases and their present status.

DAA/CAA educated the DAC/CAC members through the information, instructions received from state appropriate authority and the state government. While implementing the Act, various constraints and difficulties were faced by DAA/CAA.

The DAAs/CAAs were unable to spare sufficient time for the sensitive issue and were feeling pressure from higher authorities. They expressed need for additional manpower and logistic support for supervision of imaging centres. Over 50% DAA/CAAs felt that they need technical assistance in legal matters. All DAA/CAA faced the difficulty in arranging decoy case for conducting sting operation.

It was observed that 30% imaging centres were closed down in last two years in the districts / corporations for various reasons like non availability of radiologist, fear of disciplinary action, too much of paper work, surprise visit of government officials, fear of legal action on flimsy ground of incomplete paper work etc. The trend was in favour of closure of centre than opening of a new centre. The data received from the centres was not analyzed at the district level and thus there was gross mismatch of figures in 30% districts/corporations. Imaging centres were mostly following the norms regarding display of certificates of registration, boards, F forms and record keeping in general.

It was observed that there has been unnecessary fear factor among gynaecologists regarding provision of MTP services to their regular clients. This has compromised women's right to safe abortion services provided under MTP Act. MTP related issues in corporation area can be sorted out by handing over the control of MTP centres to MOH for effective implementation of both Acts and by taking steps to remove the fear factor among medical practitioners to prevent negative effect on RCH services provided by private nursing homes. It was felt that there is need for interstate co-ordination to track the cases and the doctors involved in sex determination activity and subsequent MTPS in border districts.

There is an urgent need for reconstitution of DACs/CACs of the State with inclusion of individuals who are sensitive, proactive & having adequate knowledge with clean image & reputation as Chairman and Members of each category prescribed as per the Act.

It would be useful to conduct training of DAA/ DAC, MO PC-PNDT, district level legal advisor, advocates of JMFC court regarding provisions under PC- PNDT Act, in regards to the correct procedure of seize and seal operation, sting operation, filing of court cases, collecting the evidence and follow up of the cases till the final result.

It is suggested to establish interstate co-ordination among state level officers to track the cases and doctors involved in sex determination activity and subsequent termination of pregnancy in bordering districts. Every district should have definite plan of supervision of imaging centres in their jurisdiction. DAA/CAA must remain vigilant and should find out the defaulters. All efforts must be made to conduct sting operation on strong suspicion/definite information from reliable sources. The District/Corporation level advocacy and awareness efforts should include sensitization programs for political leaders, NGOs, religious leaders, members of medical professional bodies (FOGSI, IMA etc) regarding the need for strict implementation of the Act.

4.2 Conclusion

Disturbing figures of sex ratio in the state of Maharashtra provoked/stimulated state government to review the functioning of DAC/CAC and the DAA/CAA constituted under PCPNDT Act 2003. Although the advisory committee is formed in all the districts, they are not functioning proactively and as such the expected results are not satisfactory. It is necessary to take steps so as to make the committees vibrant. Some objective guidelines for selection of Chairman and Members of Advisory Committee and the induction and refresher training will sensitize & motivate the members and help improve the quality of output of the committees.

The DAA/CAA need to be more sensitive towards the issue and should improve their supervision over the imaging centres. Training of members of DAC/CAC and DAA/CAA and other key persons handling court matters related to PC PNDT will go long way in improving the functioning at the district/corporation level. It is essential that women's right to safe abortion is not adversely affected in any way during strict implementation of PCPNDT Act**.**

CHAPTER 5
RECOMMENDATIONS

1. Conduct induction training programme for all members (medical and non-medical) of AC regarding (i) issues of gender equity & equality, problems of sex selective abortions, (ii) PCPNDT Act and its scope and provisions, (iii) role, responsibilities of AA & AC.

2. Conduct training of all AAs, Chairperson AC, MO PCPNDT, district legal advisor, Asst. public prosecutor to cover provisions of PCPNDT Act, correct procedure of seize and seal operation, proper conduction of sting operation, proper filing of court cases, collection of proper evidence and follow up of cases till the final verdict.

3. Induct DHO/MHO or his/her nominee (RCH Officer) into DAC/CAC for better co-ordination and effective implementation of the Act between medical services & public health departments at all levels (Taluka & Village). Active involvement of Public Health Department at all levels (THO, MO PHC, ASHA) will provide a broad based and mass movement implementation strategy.

4. Strengthen the office of PCPNDT Nodal Officer and made him/her accountable for the effective implementation of the Act in the district/corporation by having definite plan of personal supervision/vigilance visits of all imaging centres (ultrasonography /genetic counselling etc) maintenance of registers, conduct sting operations in their jurisdiction periodically with the help of members of AC. The monthly plan should be communicated to AA and Chairman of DAC/CAC. The AA should oversee once in every month the outcome of the vigilance/decoy operations.

5. An appropriate mechanism should be developed to see that the State AA should get a summary/gist of DAC/CAC meetings and views of AC members periodically.

6. Suitable instructions through written circulars be issued from State AA to all DAAs & CAAs not to chair the DACs/CACs and unduly influence the proceedings of the meetings of DACs/CACs, utilize the District/Corporations level PCPNDT funds as per the laid down provisions in the Act (especially pay the TA/DA to the members of AC, spend on supervision/vigilance/decoy operations etc).

7. Establish interstate co-ordination among state level officers to track the cases and doctors involved in sex determination activity and subsequent termination of pregnancy in bordering districts.

8. Instruct the AAs to reconstitute the ACs wherever necessary, by nominating Chairman and Members of each category as prescribed in the Act, who are gender sensitive, proactive & having clean image/reputation, established track record, adequate experience in dealing/working in women's development issues.

9. Appropriate mechanism should be put in place to handover the administrative control of MTP centres of corporation area to MOH for effective implementation of PCPNDT & MTP Acts.

10. Appropriate steps should be initiated at State and District level to remove the fear factor among gynaecologists /sonologists/USG owners and other medical practitioners on the steps being taken by the vigilance/monitoring teams, decoy & other operations as part of implementation of the act so as to prevent its negative effect on **access to** MTP services provided by **public and private providers.**

• Address for Correspondence •

The Executive Director,
State Health Systems Resource Centre
NRHM, Government of Maharashtra
Arogya Bhavan, Parivartan Building
1st Floor, Yerawada, Pune - 411 006
Phone No. 020-2661210, Fax - 020-26615505
Email - shsrc.gom@gmail.com

The Director,
Centre for Social Medicine
Pravara Institute of Medical Sciences, Deemed University,
Loni,Tal- Rahata, Dist- Ahmednagar, (Maharashtra) India
Phone No-02422-271391, 271478,
Fax - +91-2422-273442
E-mail – csm@pmtpims.org, Homepage – http://www.pravara.com