"Not Girls, only Boys for us"-

The (in)effectiveness of Pre-Conception & Pre-Natal Diagnostic Technique (PC & PNDT) Act 1994 of Government in addressing the Declining Child Sex Ratio in India

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Disclaimer:

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- **Only few RTIs annexed as sample**

Abstract

Historically, the sex ratio in India shows a dis-favourable trend towards females. For last two decades, there is a slight upward gradient in the overall sex ratio of the population, but the persistently declining Child Sex ratio is a matter of concern, threatening a stable social set up in the country.

The surprising element remains that decline is unabated despite the fact that there is no dearth of policy interventions at Central and State level, aimed to tackle the 'son-preference-daughter aversion' culture through (a) punitive measures against foeticide and infanticide and (b) conditional cash transfer schemes for upbringing and promoting girl child. Additionally, many policies aimed to end gender discrimination, women empowerment etc. have also been launched in the country.

The most potent policy intervention at the level of Central Government is The Pre-conception and Pre-Natal Diagnostic Technique {PC & PNDT} Act (1994), which aims to regulate the use of Ultrasound technology and prohibit its misuse in sex determination, leading to sex selective abortions. This research paper critically examines the extent to which this flagship policy intervention by Government of India has succeeded to address the burning issue of declining child sex ratio. To investigate this, paper has assessed implementation & monitoring mechanism and the capacity issues of the Act. The role of centuries old socio-cultural norms in whatever results the Act has produced, is also analysed.

This paper has shown that it is a case of 'double whammy' where the ineffective implementation, near absent monitoring and visible capacity gaps in all dimensions further exacerbated by overall socio-cultural (& gender) norms have rendered in partial success of the intervention.

Keywords: Sex Ratio at Birth, Child Sex Ratio, Foeticide (sex selective abortions), Infanticide, Policy, Implementation, Monitoring, Capacity.

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Abbreviations

AA	Appropriate Authority
AC	Advisory Committee
ASHAs	Accredited Social Health Workers
AWWs	Anganwadi Workers
BBBP	Beti Bachao Beti Padao
BJP	Bhartiya Janta Party
CD	Capacity Development
CBO	Community Based Organisation
CGHR	Centre for Global Health Research
CJM	Chief Judicial Magistrate
CMO	Chief Medical Officer
Cr PC	Criminal Procedure Code
CSB	Central Supervisory Board
CSR	Child Sex Ratio
CYDA	Centre for Youth Development and Activities
DAA	District Appropriate Authority
DAC	District Advisory Committee
DC/DM	Deputy Commissioner/District Magistrate
DCSR	Declining Child Sex Ratio
DG	Director General
DIMC	District Inspection and Monitoring Committee
EUR	Erasmus University Rotterdam
FOGSI	Federation of Obstetrics & Gynaecologists Society of India
GC	Genetic Clinic
GCC	Genetic Counselling Centre
GL	Genetic Laboratory
GoI	Government of India
Govt.	Government
IMA	Indian Medical Association
IMR	Infant Mortality Rate
IPC	Indian Penal Code
IRIA	Indian Radiological and Imaging Association
ISS	International Institute of Social Studies, Hague
JM	Judicial Magistrate
MCI	Medical Council of India
MHA	Ministry of Home Affairs
MHRD	Ministry of Human Relation Development
MoH&FW	Ministry of Health and Family Welfare
MoL & J	Ministry of Law and Justice
MP	Member of Parliament
MTP	Medical Termination of Pregnancy
MWCD	Ministry of Women and Child Development
NCRB	National Crime Record Bureau

NCT	National Capital Territory
NCW	National Commission for Women
NGO	Non-Governmental Organisation
NHRC	National Human Rights Commission
NIMC	National Inspection and Monitoring Committee
NRHM	National Rural Health Mission
ORGI	Office of Registrar General of India
PC & PNDT	Pre-conception and Pre-Natal Diagnostic Technique
PHFI	Public Health Foundation if India
PIB	Press Information Bureau, Govt. of India
PIL	Public Interest Litigation
PM	Prime Minister
QPR	Quarterly Progress Report
RTI	Right to Information
SAA	State Appropriate Authority
SAC	State Advisory Committee
SC	Supreme Court of India
SH	Stakeholder
SIMC	State Inspection and Monitoring Committee
SRB	Sex Ratio at Birth
SSA	Sex Selective Abortions
SSB	State Supervisory Board
SWC	State Women Commission
U5MR	Under-5 Mortality Rate
UNFPA	United Nations Population Fund
UPA	United Progressive Alliance
USG	Ultrasonography

Chapter –I

1.1 Introduction:

India is the 2nd highest populated country on globe with 1210 million people i.e nearly 17 % of world population (Census of India: 2011). With present decadal increase of around 18 %, it will overtake China (having lower fertility rate) in few years**.** The irony is that amongst top 10 most populated countries, India has second worst sex ratio[1] at 940, just better than China(926) but much below than that of US (1025),Brazil (1042),Russian Federation (1167), Indonesia (988) , Japan(1055) etc (Census of India:2011).

There is plethora of literature on reasons of abysmal poor sex ratio in the region. Hesketh & Xing (2006:13271) say "The tradition of son preference has distorted the natural sex ratio in large parts of Asia and North Africa. This son-preference is manifest in sex-selective abortion and in discrimination in care practices for girls, both of which lead to higher female mortality. Differential gender mortality has been a documented problem for decades and led to reports in the early 1990s of 100 million 'missing women' across the developing world".

The issue, however, does not remain uncontested. Madan & Breuning (2014:426) quote Sharma et. al (2007) and Aravamudan G (2007) that "Prenatal sex selection was seen as a solution to a number of problems: it would fulfil the desire of families for a son, result in happier marriages, make the life of women easier; it would stop female infanticide; it would stop women repeatedly reproducing till they had a son and was seen as an important part of India's population control program."

1.2 Trends in Sex Ratio and Child Sex Ratio[2] (CSR) in India

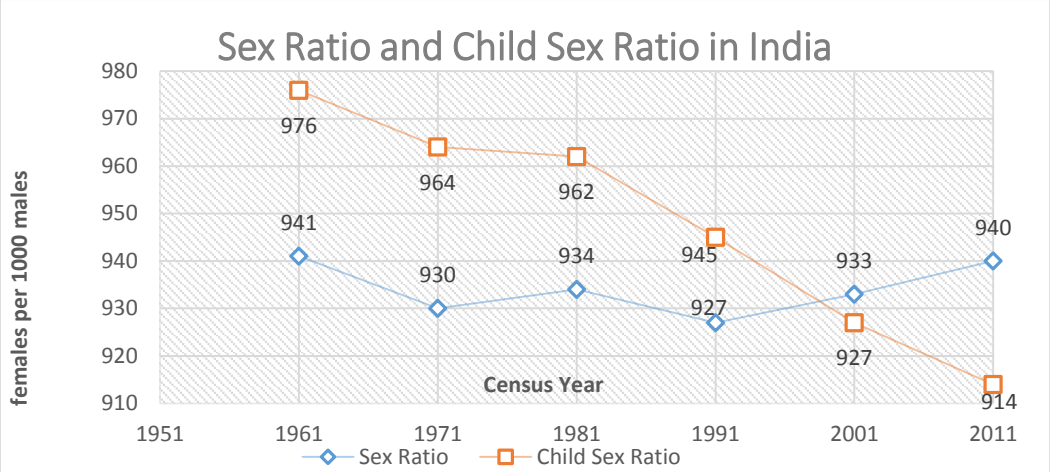
Sex ratio in India has been historically unfavourable to females. Though it is improving since past two decades (*Fig below*, Census of India: 2001, 2011), it is still on the poorer side in comparison to its neighbours {Pakistan(943), Bangladesh(978), Sri-Lanka(1034),Nepal (1014), Myanmar(1048)} with only China(926) , Afghanistan(931)and Bhutan(897) being worse.

Despite improved Sex Ratio, the persistently Declining Child Sex Ratio (DCSR) is cause of major concern (*Fig below refers*). CSR 2001 and 2011 data (Census of India: 2001, 2011) show that of the total 35[3] states/ Union Territories (UTs) it has declined in 27 States /UTs and the declining pattern is becoming prevalent even in those states which had been maintaining healthier child sex ratio (Eurasia Review:14 Apr 2011).

[1] Sex Ratio- Overall Population Sex Ratio- number of women per 1000 men

[2] Child Sex Ratio- Number of girls per 1000 boys in age group 0-6 years

[3] Telangana- the 29th state created in June 2014 is considered part of erstwhile whole Andhra Pradesh.



In Indian context, amongst various reasons of Declining CSR, foeticide and infanticide angle both contribute to systematic elimination of girl child. Various studies show that the 'son preference: daughter aversion' culture in Indian patriarchal social set up is mainly responsible for unabated fall in CSR.

1.3 Problem Statement:

Various studies have shown that in earlier times when sex selection techniques were not available, male centric regions were heavily into girl infanticide as shown by various studies. The situation became manifold acute when technology was introduced in 1975-80s which could help patriarchal society to choose the sex of child.

A repercussion of heavily skewed CSR has been that scarce women face increased incidences of violence, rape, trafficking and polyandry (Hundal: 2013). Cases of bride purchasing, polyandry, mismatched marriages have increased (Misra 2011:152). The number of rapes, kidnappings and abductions in India for the period 2006–2011 indicate an upward trend (Madan & Breuning 2014:428-429) as corroborated by National Crime Records Bureau (NCRB) and they also observed large incidences of trafficking of girls from the poorer eastern states to rich north-western states (with masculine CSR) and forced polyandry cases where woman is merely treated as 'son-producing machine'.

The surprising element is that decline in child sex ratio is unabated despite there is no dearth of Government Acts/Policies- i.e both under the 'Carrots' and the 'Sticks' categories. In addition to various punitive provision under Indian Penal code (IPC), we have Acts like Women infanticide Act, Pre-Conception & Pre-Natal Diagnostic Technique Act, Dowry Prohibition Act, Medical Termination of Pregnancy (MTP) Act, Domestic Violence Act etc. Also, there are numerous incentive schemes, again at National and State level, where conditional financial incentives[4] are given for upbringing and non-discriminating a girl child.

The PC & PNDT Act 1994 is the flagship Act of Central Government covering the pre-birth scenario to address the issue of DCSR in country. Though Act has been in operation for 19

[4] These are the Conditional Cash Transfer (CCT) Schemes- where at defined milestones, cash incentives are given.

years, the initial impression and evidence show that results are below satisfactory level and not all seems well with the manner in which the Act is implemented and monitored on ground.

1.4 Objective of Research:

Objective of this research is to investigate up to what extent the PC & PNDT Act has delivered on its goals/objectives, specifically focussing the implementation and monitoring mechanism and the capacity aspect of the Act and the role of socio-cultural determinants of problem.

1.5 Research Question:

To What Extent has the Central Government's PC & PNDT Act (1994) been (in)effective in Addressing the Persistent Declining Child Sex –Ratio(DCSR)?

Research Sub-Questions:

1 What are the trends, determinants and repercussions of the DCSR in India? Are there any specific reasons for a steep fall in CSR in 1980s?

2 What are the provisions of PC & PNDT Act of Central Government (the key intervention under the 'sticks' category – targeting pre-birth scenario) to address the DCSR?

3. How effective is the Act, in terms of the Implementation, Monitoring and Capacity aspect with a view to achieve the intended objectives?

4. To what extent has the Act succeeded or failed to arrest the persistent DCSR? Which issues are solved and left un-resolved, focusing the role played by socio-cultural context?

1.6 Research Methodology/Design/Approach:

The paper takes three pronged approach to delve deeper into the problem by taking up the policy study, literature review and secondary cum primary data analysis. In a systematic manner, the plan was to first appreciate the overall social, cultural and political context of the problem , then capturing the trends ,determinants and repercussions of the 'son preference – daughter aversion' culture.

Thereafter, I move on to policy study of the Act to appreciate its designing aspect. Then a detailed examination cum analysis of implementation and monitoring mechanisms of the Act along with evaluating the capacity aspect is taken up by correlating the secondary data (taken for 10 years period) and primary data (collected through raising RTI[5] queries to concerned government bodies) analysis with ultimate aim of looking as to how do the findings connect with the theoretical and conceptual framework considered in the research.

Sources of Data, Mode of Data Collection and Research Techniques:

I largely depend upon secondary data sources available in form of previous researches by individuals and organisations , media news items, various government publications & gazette notifications (specially for policy documents), minutes of meetings of workshops and seminar

[5] RTI-Right to Information

proceedings held by concerned government departments , performance appraisals by individuals and organisations etc. Mainly, the sources of empirical data collection were:

- Government of India (GoI) documents/websites like: The Census of India, National Crime Records Bureau (NCRB) {under Ministry of Home Affairs (MHA)}, Ministry of Women and Child Development (WCD) and Ministry of Health and Family Welfare (MoH&FW) – steering Ministry of PC& PNDT Act
- Academic literature from the sources like-International/National Journals, Economic and Political Weekly, ISS/EUR libraries, Other University/research institutions/organisations, On-line library and Search Engines like 'Google Scholar' and 'JStor' etc.

Secondary Data Analysis and analyzing the Primary data are the research techniques used herein

1.7 Relevance and Justification of the Research Topic:

India has been struggling with DCSR for decades and everyone acknowledges that situation has already reached emergency level. It is both relevant and justified to critically examine /acknowledge as to why a country where more goddesses than gods are worshipped; which is making notable and enviable economic progress; where health parameters and literacy among population have improved- for what reasons the decline in CSR is unabated that too when the potent PC & PNDT Act is in place for past 2 decades?

1.8 Risks, Ethical Challenges and Limitations in Carrying Out the Research:

Main source for the research is secondary data and no field visits are involved. Most of government owned websites do not display latest data in public domain. In some cases, data may be 3-5 years older and this, precisely is the weak link which can hinder useful research. I have tried to fill this gap by raising Right to Information (RTI) queries to concerned government authorities. Here too, many a times the information supplied is incomplete and queries are circumvented to avoid probing questions. Triangulation of data is resorted to by response collected through RTI queries

1.9 Structure of Research Paper

Chapter-II deals with main Theoretical and Analytical concepts to be used in research. **Chapter-III** covers the contextual details, trends, determinants and repercussions of DCSR in country. In C**hapter-IV**, features of PC & PNDT Act, fund provisioning and impact are discussed. **Chapter-V** covers the Analysis to see how this intervention is working in real setting in terms of implementation, monitoring and capacity and socio-cultural determinants of problem. Research findings through the secondary and primary data analysis are presented herein. **Chapter-VI** answers the Research Question and gives conclusions based on findings.

Chapter II

Theoretical and Conceptual Framework

2.0 **Background-**

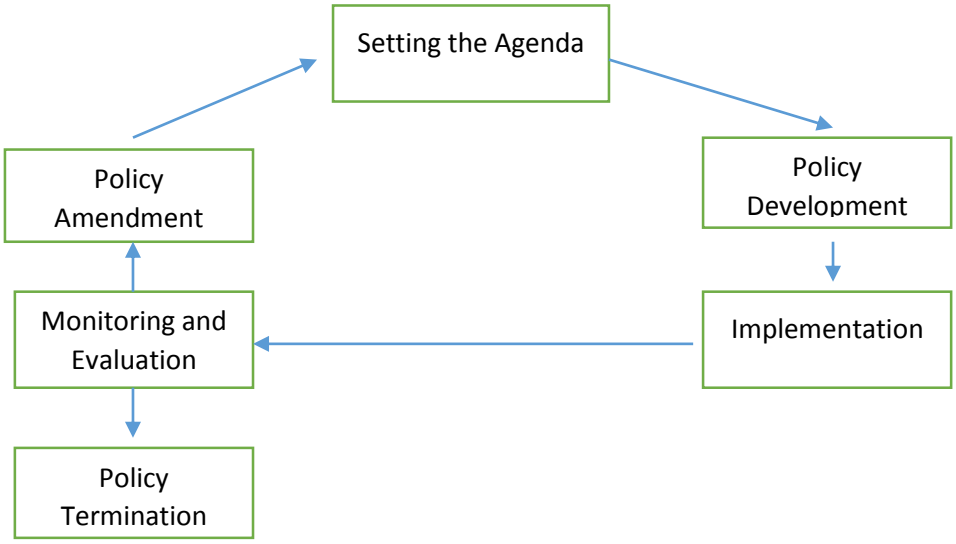
To critically analyse the effectiveness of The PC & PNDT Act 1994 i.e flagship state intervention of the National Government, aimed to regulate the use of technology (key factor assisting the patriarchal society to choose the sex of offspring) I investigate intrinsically interwoven concepts - policy implementation and monitoring mechanisms and the capacity aspect. The hypothesis that overarching socio-cultural (& gender) norms, political and economic context in which whole process takes place affect the output, outcome and impact at each step- is also put to test. Thus, study of the overall context (**Chapter III**) forms a pre-requisite before attempting meaningful assessment of intervention (**Chapter V**).

Below are the main concepts used in this paper :

2.1 Policy Implementation

Conventional way to describe policy process enlists four chronological stages namely- agenda-setting, policy development (policy formulation & decision making), implementation and monitoring cum evaluation (Jann & Wegrich 2007:45-55) (*fig below*). In present research, policy implementation and monitoring would be the key focus area for assessing the effectiveness of the selected intervention.

Factually, even the best designed policy does not guarantee that selected intervention is the best suited and will meet the aims/objectives when executed by institutions and organizations that are often part of the public sector. And it is here that the criticality of a suitable, efficient and effective implementation and monitoring aspect is acknowledged.



O'Toole (2000) in Jann & Wegrich (2007:51) defines Policy implementation as – "the gap between intentions and impact" or objectives and results or theory and practical, due to the very reason that the political and administrative action on real ground is not as perfect/ideal or controllable as assumed (Hogwood and Gunn:1984 quoted ibid). The Implementation processes require individual and concrete decisions, as well as compliance to the procedural

rules and regulations by implementing public agencies (UN FAO: undated). The implementation stage necessarily outlines as to which agency will be steering the programme, how and which agencies /organisations will execute it and what will be the resource allocation i.e on budget and personnel and also on how the decisions are carried out (Jann & Wegrich (2007:52).

The Implementation phase, where project plans are put into real action (Angelo State University) and the properly planned inputs (humans, process, funds etc) are mobilised (how much of these and with defined responsibility) "needs to be carried out in such a way that the project is completed within defined scope, quality, time & cost constraints"(MoUD[6] 2011:1-4). "A good policy-making process should produce policies which can be executed swiftly and successfully, which requires close involvement, during formulation, of the persons who actually have to implement a policy on the ground, [Darman, 1998]" (Aggarwal and Somanathan 2005:9). World Bank's experience shows that "success during implementation depends heavily on a sense of ownership by the borrower, adequate capacity in borrower institutions, and sustained interest from the task and project managers throughout the life of the project" (World Bank: 1996).

The critical factors in effective implementation are that implementation be planned well in advance(like preparing the infrastructure-creating implementing structures), coordinating with all agencies involved, training the managers) to avoid time and cost overrun and mis-utilisation of resources and most important being that " implementation agencies are to follow good practices in project management" (MoUD 2011:3-6).

2.2 Monitoring and Evaluation (M & E)

Projects/interventions aim to achieve long-term goals, but their objectives should be clear and specific, realistic in the timeframe and measurable for evaluation (World Bank: 1996).In any intervention, M & E bear key importance because- Monitoring is a tool to check progress against plans and the data generated by monitoring is used to evaluate the intervention. Monitoring is integral to evaluation and M & E together assess the outputs, outcomes and impacts generated through the intervention (International Platform on Sport & Development).

2.2.1 Monitoring

It provides information on progress achieved by the intervention through routinized and structured reports. It allows actors to "learn from experiences and to incorporate suitable amendments into policy and practice and provides a basis for questioning and testing assumptions .It provides vital inputs to take informed decisions on future of the initiative" including planning funds and resource allocation and influencing policy (International Platform on Sport & Development). Monitoring is a barometer used to assess how far are the outcomes from intended objectives, guides if some tweaking/mid-course correction(amendment) is required in design or inputs to improve the results and forces policy makers to critically examine root causes of shortfalls between the two(Gage and Dunn 2009, Frankel and Gage 2007 in UN Women: undated). Bamberger (World Bank: 1986) defines it as: "an internal project activity designed to provide constant feedback on the progress of a project, the problems it is facing, and the efficiency with which it is being implemented".

[6] MoUD- Ministry of Urban Development, Government of India

2.2.2 Evaluation

At **evaluation** stage, which is termed central to a rational policy process (Jann & Wegrich (2007:54), program is evaluated (among others, through monitoring and feedback mechanisms) Using Evaluations tool "one can draw conclusions about five main aspects of the Intervention: Relevance, Effectiveness, Efficiency, Impact and Sustainability" (International Platform on Sport & Development). Evaluation analysis provides insights into strengths and weaknesses of intervention thereby providing vital inputs influencing design of future interventions and sector specific strategy (World Bank: 1986).

M & E together provide constant feedback by tracking the implementation and outputs systematically and form the basis for modification of interventions to improve the implementation while it is an action. M & E also aims to measure the quality and efficiency of activities being conducted and ultimately assess effectiveness of programmes (World Bank: 1986, Gage and Dunn 2009 and Frankel and Gage 2007 in UN Women: undated). M & E help in identifying if the resources have been used efficiently in course of implementation or if allocation/re-allocation of same is required (Gage and Dunn 2009, Frankel and Gage 2007 in UN Women: undated).

2.2.3 A sound M & E Design

It starts with clear and measurable objectives for the intervention where a structured set of indicators is defined to measure outputs generated by the project and their impact on beneficiaries. It also encompasses ways and means (Institutional arrangements) for gathering, analyzing data required for indicators at reasonable cost and time. It finally aims to generate data for guiding investing in capacity building and also entails the Processes in which M&E findings will be fed back into decision making (World bank: 1996).

Quarterly progress reports, annual reviews, workshops and seminars to review the project progress, feedback studies, mid- term review and project appraisals are some of the tools deployed to assess M & E information regarding any intervention (World Bank: 1986). The standards of any M & E exercise depend on the quality, completeness, timeliness, integrity of field data collected for M & E indicators and thus, M&E designers should examine practices adopted, efficiency of record-keeping and reporting procedures to assess the capacity (and any need for capacity development) to generate data meeting above standards (World Bank: 1996).

2.3 Capacity

'Capacity' -is key to the success or failure of the intervention and resides at the level of individual, organisation, institution and society (UNDP 2008:5**).** Capacity is the degree to which individuals, groups, organisations and societies are able to "plan & perform functions to solve problems or achieve intended objectives in a sustainable manner (UNDP: 1997)" (Lusthaus et.al 1999:3**).** Capacity is also defined appropriately as the combination of people, institutions and practices that facilitates to realise developmental goals (World Bank: 1998).

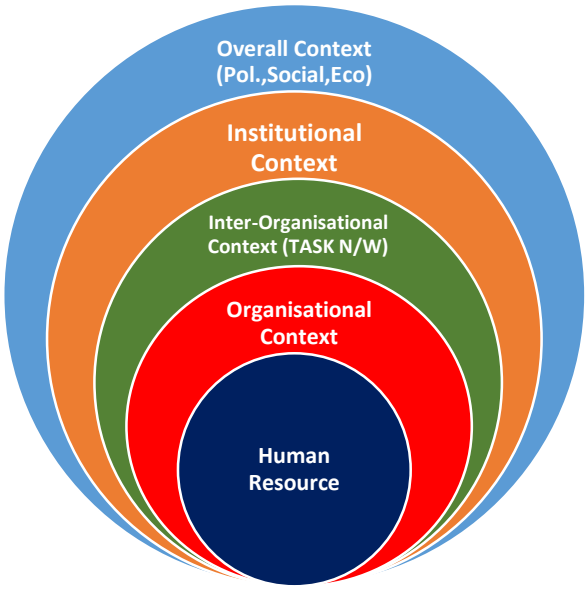
2.3.1 **Capacity Development (CD)**

'Capacity Development'- is both ways and means to achieve all of above, with transformation (of mind-set /attitude) being the main ingredient (UNDP 2009:5). CD focuses hand, head & heart & latter two (attitude and feelings) is where most of interventions miss their attention and limit to the simpler ones i.e training, education and skill development of human resource.

2.3.2 Five Dimensions of Capacity-

UNDP has recognised that 'capacity development' is a continuous, long drawn process wherein all stakeholders participate and is a much broader than merely the human resource development. CD also incorporates- organizational development (focussing management structures, processes and procedures, leadership) inter-organisational relationships (including with NGOs, Private sector etc) , institutional development (including the societal mind-set) and providing a sound Policy and legal framework (i.e making appropriate legal and regulatory changes to enable organizations, institutions to enhance their capacities) (UNDP 2009:5-13, World Bank 2005:7). Also, not to forget is that whole exercise is heavily influenced by " overall system, environment or context within which individuals, organizations and societies operate and interact (UNDP: 1998)" Lusthaus et.al (1999:3), Fukuda et al (2002) ,World bank (2005:8).

Grindle and Hildebrand (1995:441) concluded that designing interventions must cover broader variables including action environment in which all activities happen. They go on to show that (1995:445-447) that 5 dimensions promote or constrain performance of any capacity development exercise-



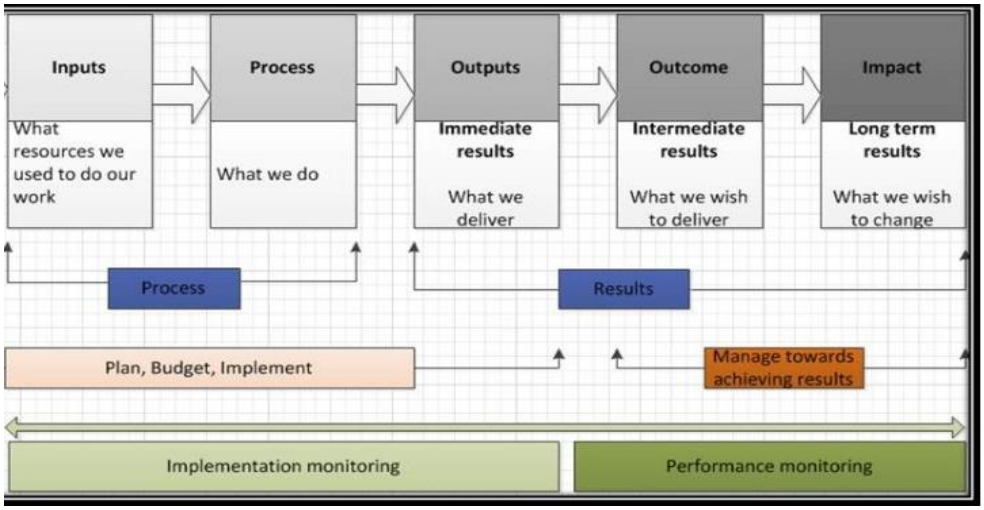
1. action environment - social (human resource profile , social and cultural norms including gender norms , informal structures), political (type of state, political stability, legitimacy) , economic (rate of economic growth),
2. institutional context of public sector (rules/procedures);
3. task network-set of organisations (including NGOs, private sector) involved in accomplishing tasks, how these communicate and coordinate;
4. organisation -building blocks of network –its structure, resources, processes, authority, and
5. the Human resource management i.e how the workforce is educated, trained, utilised and retained. This as the starting point.

Any capacity development effort must address all three levels: individual - improve existing knowledge and skills to grab fresh opportunities; institutional- instead of building new institutions, capacity development of existing be focussed; and societal- aim transforming for development (Fukuda et al 2002:9). These three being mutually interdependent, development becomes skewed and inefficient, if all are not pursued together (Fukuda et al 2002:10). 'Institutions' also cover the societal mind-set, deeply embedded behavioural patterns and practices (traditions, cultures, customs) which take decades to alter. CD, therefore, is a complex/multi-dimensional process wherein all these factors play key role to determine effectiveness of any such exercise (Fukuda et al: 2002).

Also, "CD is not a one-off intervention but an iterative process of design-application-learning-adjustment and it starts with capacity assessment i.e identifying what key capacities already exist and what additional capacities may be needed to reach objectives"(UNDP 2008:4-5). It

is to be borne in mind that "Capacity is an attribute of people, individual organizations, and groups of organizations i.e it is something internal to these units—not external. Therefore, CD is a change process internal to organizations and people and thus must be owned by them else it does not happen at all. External partners can just support CD processes but cannot 'do' or 'manage' CD of others and whether and how capacity develops may largely be determined by the 'demand-side' or external contextual factors" (Asian Development Bank 2008:6-7,2011:1).

Moving along results chain, CD framework presents "how the improvements that can be brought in people's lives (the impact level), are affected by changes in institutional performance, stability and adaptability (the outcome level), which in turn are affected by the products and services produced from programming actions (the output level)" (UNDP: 2010) where standard inputs are - human, financial and physical resources. It is important to see how the inputs (resources- human, capital) & activities (processes, procedures, programmes, strategies and plans) are to be aligned so that the output and outcome are both efficient and effective and make desired impact.



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2.4 Conceptual Framework-

I have used the capacity framework by Grindle and Hildebrand (1995:445-47) and tried to locate and assess the Act implementation and monitoring mechanisms within it. Taking the Central and state level bodies/organisations, one by one, the inter-organisation /task network operationalization and its efficiency and how and in what manner the overarching socio-cultural and political context affects the performance(output, outcome and impact) of the Act- all is seen within the realms of this framework.

The conceptual framework being tested is that- the output, outcome and impact of intervention not only greatly depend on the project implementation (structures, awareness and practices) and its regular and effective monitoring (& both have to interact) but is also affected by the capacity of the system (in all of its five dimensions) and the overall socio-cultural norms, economic and political context wherein all these activities occur.

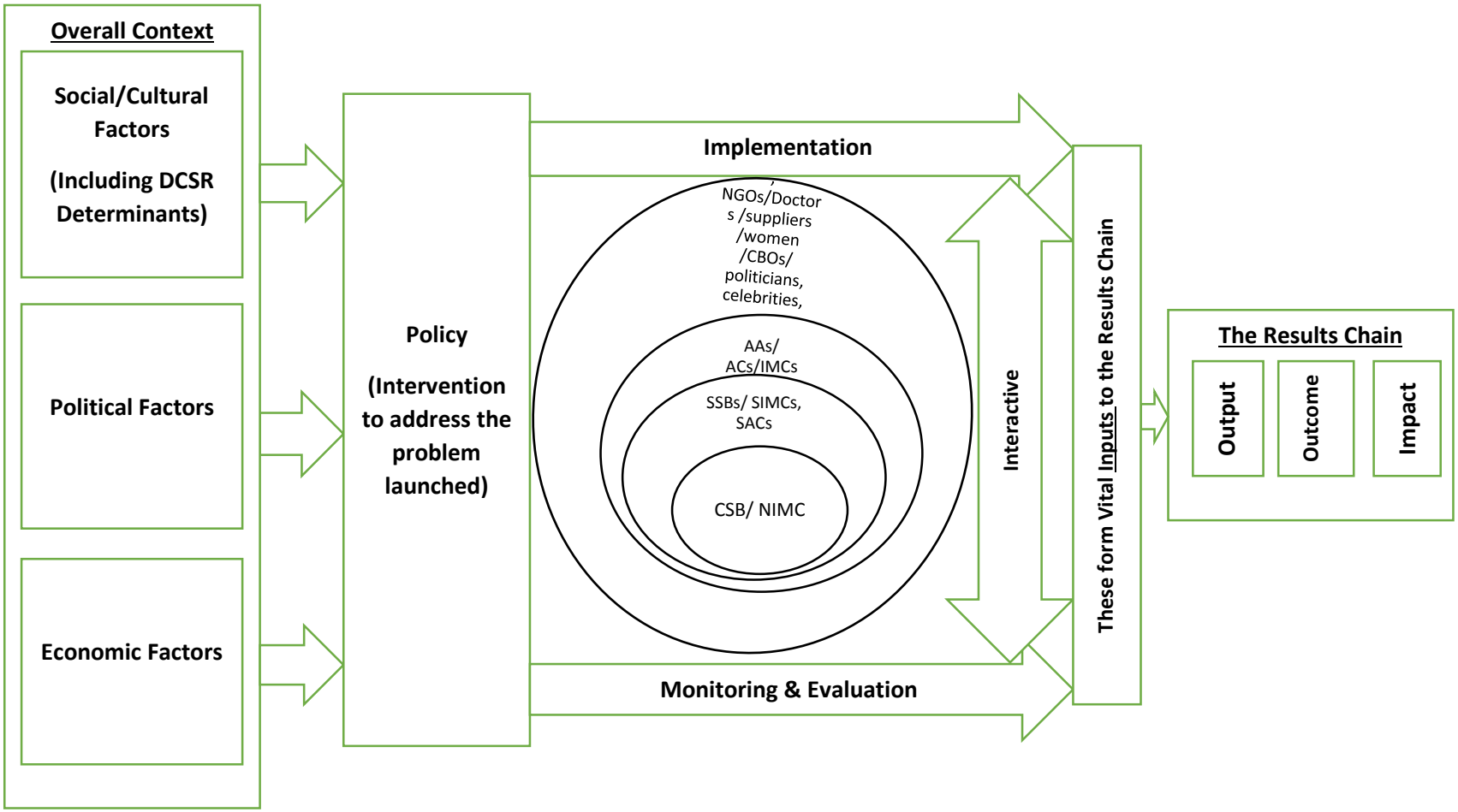


Fig 2.4 b- The Conceptual Framework-(Circles show Task Network in Implementation and Monitoring, heirarchically moving from inner to outer circle) (Outermost circle shows stakeholders outside Govt)

Chapter III

Administrative and Socio-Cultural Background to India's Child Sex Ratio

3.0 Background

Overall context defines the making of an issue as well as the intervention to address it and its output, outcome and impact. This chapter looks at:

(i) India specific details (type of society, political system, informal institutions and nature of policy making process),

(ii) Trends, the socio-cultural determinants and the repercussions of DCSR in India.

3.1 India

India, the largest democracy in the world (UN) is a federal republic consisting of 29[7] states and 7 union territories. There are 640 districts and 597608 villages in the country (Census of India: 2011). It is a representative democracy and Panchayati Raj system forms the foundation of administrative, political and (partial) financial decentralisation to Local Bodies. In rural set up it is a three- tiered, elected local government system from Village level (Gram Panchayat) to Block level (Panchayat Samiti) to District level (Zila Parishad). In urban setup, administration is either under Mahanagar Nigam (Municipal Corporation -In Metro cities) or Nagar Palika (Municipality- in Cities of more than 1,00,000 population) (elections.in).

3.1.1 Demography-

During 2001-2011, population grew by 17.64%, urbanization level rose from 27.81% to 31.16% & the literacy rate was 74.04% (females - 65.46% and males -82.14%) with rural-urban literacy gap narrowed down to 16.1 % from 21.2 % (Census:2011). India is predominantly a Hindu nation (80.5%) and Islam (13.4%), Christianity (2.3%), Sikhism (1.9%), Buddhism (0.8%), Jainism (0.4%) etc. are next in order (Wikipedia).

3.1.2 Politics-

A multi-party system, with six recognised national parties, including the Indian National Congress (considered "liberal") and the Bhartiya Janata Party (BJP- considered "conservative"), and 64 state parties exists in India (The Election Commission of India : 2015). Till 1980s, Congress formed all the governments, after which non-congress led coalition governments came to power. The 2004, 2009 governments were again coalition governments under UPA (United Progressive Alliance) with Congress being the largest party. "In 2014 general election, BJP became first political party since 1984 to win a simple majority" (The DNA India: 16 May 2014) with Narendra Modi as Prime Minister of India.

3.1.3 Society-

In the multilingual and multi-ethnic society defined by social hierarchy "Family values are still important in Indian culture and multi-generational patriarchal 'joint- family' system have been

[7] Telangana was formed as 29th state of India on June 2nd June 2014 by bifurcating Andhra Pradesh. For all data purposes, Telangana has been considered a part of erstwhile Andhra Pradesh.

the norm in India, though nuclear families are becoming common in urban areas" (Makar 2007:44-46 , Wikipedia). Marriage as an institution is considered a lifelong relationship & majority of weddings are 'arranged marriages' (Medora: 2003) with minimal divorce rate (Jones and Ramdas 2005:111). "Payment of dowry, although illegal, remains widespread across class lines" (The Telegraph: 2 Sept 2013).

3.1.4 Economy-

India claims to be world's one of the fastest-growing economies after kitting in 5.8% average annual GDP growth in past two decades (Nayak et al 2010: xxv). The women participation rate in workforce in India is quite low (compared with world average or even in the East Asian region) and has been steadily declining post 2000 and there exists an appreciable variance in wage rates compared with peer male group (IMF 2015:1-7).

3.1.5 Corruption-

In 2014, India ranks 85th amongst 175 countries in Corruption Perceptions Index (perceived levels of public sector corruption) which signs widespread bribery, lack of punishment for corruption and ineffectiveness of inter-institutional checks and balances (Transparency International: 2014). Independent studies on analysis of World Bank and IMF data show "Indian economy loses an estimated 60 trillion rupees ($1 trillion) each year from its formal sector and $2 trillion is the total amount Indians currently have stashed abroad illegally without paying taxes of around $600 billion" Bloomberg (9 Jun 2014). NDTV (20 Jun 2014) also put similar estimates.

3.1.6 Type of Democracy-

"Global Democracy Ranking defines 'Quality of Democracy' as combination of 'freedom & other characteristics of political system' & 'performance of the non-political dimensions' (wherein socio-economic gender equality is one of important attributes) places India at 70th position out of 112 nations" (Global Democracy Ranking:2014**)**. Studies show that People elect patrons not representatives as the evils of dependency, exploitation and inequality continue (Gupta 2004: 154 in Wit and Berner 2009: 934-935). Politicians, bureaucrats work in tandem, in this "patronage democracy (Chandra, 2007; Kitscheld and Wilkinson, 2007) where they have significant discretion in the implementation of laws allocating the jobs and services at state disposal" (Wit and Berner 2009:929). The logic of patronage also engulfs CBOs and NGOs also as they have to work in same system (Wit and Berner 2009:944).

3.1.7 Nature of Policy Making Process in India –

It is said that "India has been an under-performer mainly due to adopting wrong public policies and poorly implementing the right public policies" (Agarwal and Somanathan 2005:3). Literature shows that most of policies underperform because:

(i) Political considerations often derail policy-making process (Agarwal and Somanathan 2005:3, Mathur: 2013, Gupta: 2012);

(ii) with onset of coalition politics since 1989, policy making process began to serve the vote-bank agenda of alleys rather than public interest, with political strategists taking space from technocratic advisors and institutions of public accountability fading away (Mathur and Bjorkman 2009:159). As coalition partners grew, civil

servants started looking for opportunities for forging political loyalism for personal service benefits at cost of professional policy advice (Mathur and Bjorkman 2009:162). With politicisation of bureaucracy, role of civil servants also changed from instrument of change to obstacle to development, from professionalism to loyalty (Mathur and Bjorkman 2009:76-100);

(iii) not taking on-board the views of other important parties/wings affected by a decision (Agarwal and Somanathan 2005:6, Maheshwari 1987:346-351) leading to conflicts and contestations and poor implementation (Mathur:2013) which is often dictated by local politics (Maheshwari 1987: 346-351);

(iv) debate occurs after policy-making (and not before); endogenous factors to problem not considered (Agarwal and Somanathan2005:6);

(v) absence of systematic study and research further plagued by unreliable & incomplete data (Maheshwari 1987: 346-351) ;

(vi) excessive fragmentation in Thinking and Action ('blind men and the elephant' syndrome in policy-making); too often overlap between policy making and implementation; absence of non-governmental inputs and informed debate; policy decisions often made without adequate analysis of costs, benefits, trade-offs and consequences; mediocrity of in-house specialists and preferring 'generalists' (IAS) over 'specialists' (Agarwal and Somanathan 2005:12-15) .

(vii) The annual reviews (source of monitoring and evaluation) i.e mandatory component of a policy framework is usually missing in India as yearly data sets are generally almost impossible to get and whatever review is resorted to , is piecemeal and fragmented (National Social Watch Coalition, India 2006:42-43).

(viii) Frequent changing of bureaucrats/Cabinet Ministers adversely impact policy making process with newcomers looking at things from a new perspective (Mathur and Bjorkman (2009:74).

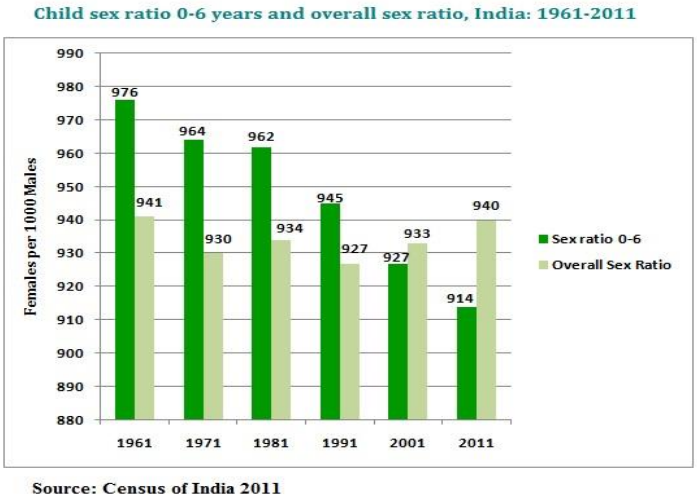
3.2 Trends of Sex Ratio and Child Sex Ratio (CSR) in India:

3.2.1 Historically, India has maintained a sex ratio where men outnumber women (Census of India: various years). Female Foeticide and infanticide, both are key components of Child sex ratio .Studies show that female infanticide was practised in many parts of country. It was reported in 1780s in many parts of Rajasthan, western shores of Gujrat (Saurashtra and Kutch) and in eastern UP (Tandon 1999: 46-57, Desai :1988 in Tandon and Sharma 2006:3). Post-independence, it was reported in entire belt from Madurai to Dindigul, Salem, Erode and North districts of Tamilnadu {Kumar (1992), George et al (1992), Srinivasan (1992) and Chunkath and Atherya (1997) ibid}, Bihar, Orissa, Maharashtra, Rajasthan (Tandon and Sharma 2006:4). John (2011:11) has also recorded similar observations. In a study on Madhya Pradesh, Premi and Raju (1996) (in Tandon and Sharma 2006:4) show that female infanticide was practised by Gujjars, Ahirs and Rajputs.

3.2.2 Steep Fall in CSR post 1980s:

Plethora of literature makes it clear that it was the medical technology that further ignited decline in child sex ratio. Rustagi (2006:6-7), Nandi and Deolalikar (2013:6) bring out that since its introduction in 1980s, the USG (ultrasonography) technology aimed to detect biological abnormalities in foetus was misused by way of sex determination and foeticide in a horrific manner by demanders (the Society) and providers (medical practitioners) both, for

mutual benefit. In patriarchal Indian society where sons are prized and daughters are devalued, it was sure that couples will choose the help of technology to abort female foetus only. George and Dahiya (1998:2197-98), Oomman and Ganatra (2002:184-185), Santhiya (2004:3), Sharma et al (2007:855), Khichi and Bir (2012:95-96) also say that problem got accelerated with introduction of USG in 1980s. (Graphic Source: http://iipsenvis.nic.in)



Hesketh and Xing (2006:13271-72 and 2011: 1374-77) pointed out that better female mortality rate achieved through improved health care, was offset by menace of female foeticide (SSA[8]) post introduction of non- invasive sex-determination facilitated by ultrasound technology in mid 1980s. Bhattacharya and Saxena (2015:4) also point towards clear evidence that increased SSA made available through sex detection tests after 1981 altered SRB[9] in Indian context and have quoted "Jha et all (2006) offered an estimate of around 10 million SSAs over the period 1986-2005 with similar estimates indicating high SSAs shown by Arnold et al (2002), Bhat and Xaviers(2007)". Renowned demographer Bose (2001: 3427-3429) coined term 'DEMARU' which stands for –**D**aughter **E**liminating **M**ale Aspiring **R**age for **U**ltrasound-says it all. (Graphic Source - driverlayer.com)

3.2.2.1 1980s onwards– High Profit Margins lead to Aggressive Advertisement and Widespread use of Technology

This was the time when advertisements on walls, in print media read like "Spend Rs 500 now and Save Rs 500000 later (on dowry)" The Oxonian Globalist (11 March 2013),Nayak (2014:50). Tandon and Sharma (2006:2) refer to a field study in Mumbai by Kulkarni (1986) as per which "84 % of Gynaecologists admitted to have performed such test for sex determination and majority of 'patients' were from middle and upper middle class who were only interested to know the sex of Foetus". Diaz (1988) (in Tandon and Sharma 2006:1) states that of the appx 16000 abortions done by a prominent abortion centre in Mumbai, 100 % were female foetuses. Gangrade (1988:63-70), Kishwar (1995:1) also report similar findings for Mumbai & Delhi highlighting that doctors were operating openly or in clandestine manner.

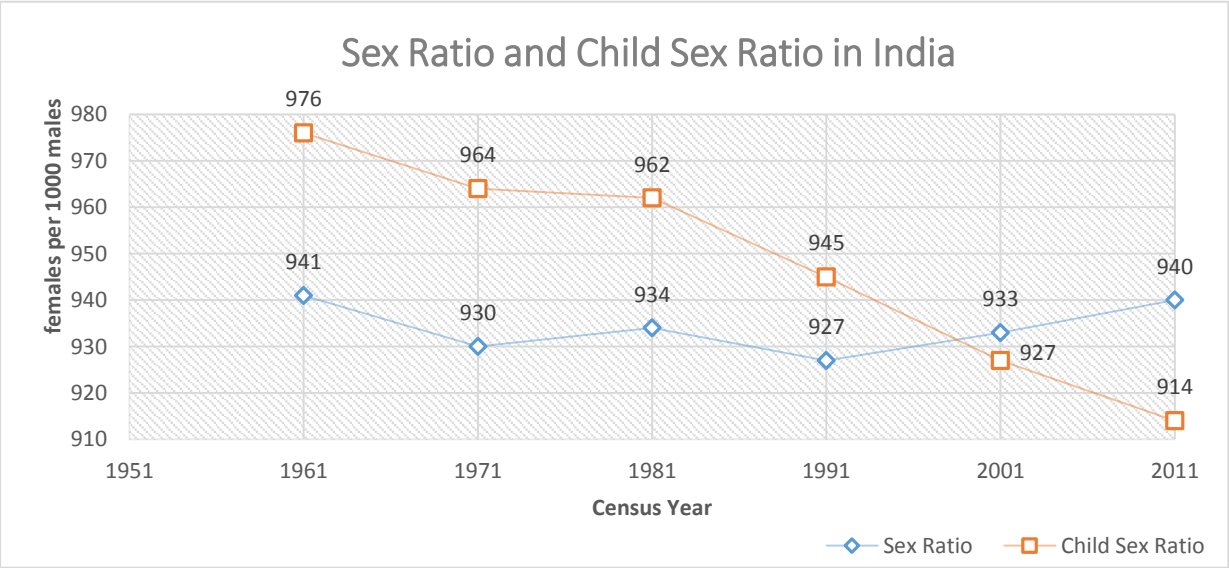
[8] SSA-Sex Selective Abortion
[9] SRB-Sex Ratio at Birth(female births per 1000 male births)

Kishwar (1995:2) brings out that misuse of USG technology continued even after PNDT Act was introduced in 1994 banning all such advertisements and misuse of PNDT techniques for sex determination and says that "the only difference the new law made was that huge hoardings that had earlier read 'Ladka Ya ladki jaanch karaiye' (Find out if it's a boy or a girl), were replaced by barely veiled messages such as 'Swasth ladka ya ladki?' (Healthy boy or girl?) Or 'Garbh mein bacchhe ki har prakar ki jankari' (Everything you want to know about the child in your womb)". Unisa et al (2003) from their study of Haryana and Tamil Nadu show that "abortion rate increased from 1971 to 2001 in both states with 33 % & 20 % of the studied women in Tamil Nadu and Haryana having undergone abortion in their reproductive life and concluded that out of total estimated induced abortions, 60 to 80 percent were due to sex selective abortion". Sharma et al (2007:855) say that USG Clinics with widespread reach and use by masses, started milking record profits. Singariya (2012:10) cites that a sting operation by a TV channel caught over 100 doctors in Rajasthan engaged in sex determination and SSAs. Tandon and Sharma say (ibid) that the techno doctors take advantage of anti-women bias and girl aversion culture and have reduced women to 'son- producing machines'.

Union Minister of Health, Government of India in his reply to Parliament also attributed easy availability of technology as catalyst in DCSR (MoH& FW: 2015). A **phenomenal rise of 33 times** is reported by government sources in ultrasound machines manufactured in country between 1988 -2003 (Saheli: 2006).

3.2.3 Last 2 decades Scenario-

Census data for 1991, 2001 and 2011 indicate that while overall Sex-ratio in India has shown slightly upward slope, child sex ratio (CSR) is declining continuously and is a cause of major concern. From 1981, 1991, 2001 till 2011, there is a fall of 17, 18 and 13 points in the CSR- which is alarming. (Graphic Source: Census Of India: various years)



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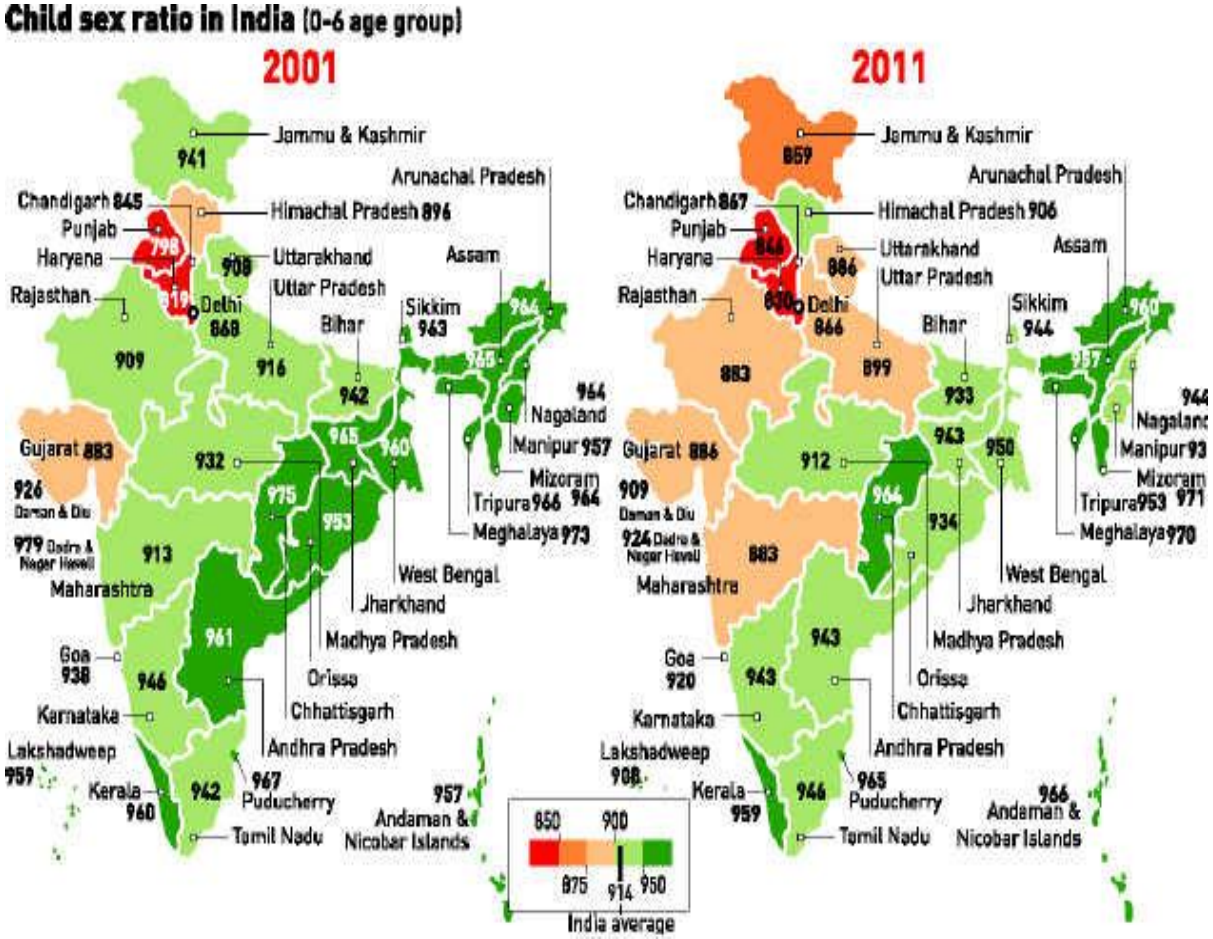
The map below shows the state-vise CSR change as per Census 2001 and 2011



The Table below shows the CSR change in 2001-2011

Overall sex ratio 2011 and Decadal change in child sex ratio (0-6 yrs) - Census 2011 and 2001

State/ UT Code	India/State/ Union Territory #	Child Sex Ratio (0-6 Years)		
		2011	2001	Change
	INDIA	**914**	**927**	**-13**
01	JAMMU & KASHMIR	859	941	**-82**
02	HIMACHAL PRADESH	906	896	**10**
03	PUNJAB	846	798	**48**
04	CHANDIGARH #	867	845	**22**
05	UTTARAKHAND	886	908	**-22**
06	HARYANA	830	819	**11**
07	NCT OF DELHI #	866	868	**-2**
08	RAJASTHAN	883	909	**-26**
09	UTTAR PRADESH	899	916	**-17**
10	BIHAR	933	942	**-9**
11	SIKKIM	944	963	**-19**
12	ARUNACHAL PRADESH	960	964	**-4**
13	NAGALAND	944	964	**-20**
14	MANIPUR	934	957	**-23**
15	MIZORAM	971	964	**7**
16	TRIPURA	953	966	**-13**
17	MEGHALAYA	970	973	**-3**
18	ASSAM	957	964	**-7**
19	WEST BENGAL	950	960	**-10**
20	JHARKHAND	943	965	**-22**
21	ORISSA	934	953	**-19**
22	CHHATTISGARH	964	975	**-11**
23	MADHYA PRADESH	912	932	**-20**
24	GUJARAT	886	883	**3**
25	DAMAN & DIU #	909	926	**-17**
26	DADRA & NAGAR HAVELI #	924	972	**-48**
27	MAHARASHTRA	883	913	**-30**
28	ANDHRA PRADESH	943	961	**-18**
29	KARNATAKA	943	946	**-3**
30	GOA	920	938	**-18**
31	LAKSHADWEEP #	908	959	**-51**
32	KERALA	959	960	**-1**
33	TAMIL NADU	946	942	**4**
34	PUDUCHERRY #	965	967	**-2**
35	A & N ISLANDS #	966	957	**9**

#: Union Territory

(Source:updteox.com)

3.2.4 Other Key Trends-

An exhaustive study of secondary sources covering following key trends at **Annexure 3A,** gives more insight into the problem magnitude. The gist is as below:

a) **Is it PAN India Syndrome**?- 2011 Census shows that barring 8 states, the CSR has declined in 27 states/UTs .The southern and Northern-Eastern states which used to maintain healthier CSR are also showing a downfall.
b) **Is it Urban or Rural (or both) phenomena**?- While the decline is in both settings, 2011 Census shows the fall in rural areas is 3 times steeper than those in urban areas.
c) **Does a North –South Divide Exist**?- North-western belt continues to hold stronger son preference culture (Nayak 2014:51-52), but the declining CSR is becoming prevalent in southern and estern belts too (Rustagi 2006:12-13)
d) **What is the social groups vise Pattern**?- While minority groups like Muslims are less prone to sex determination and SSAs { Bhattacharya and Saxena (2015:10), Varghese et al (2005:15)},Communities of Gujjars, Rajputs, Hindu Punjabis, Sikhs, Jains other Northern and Western belt communities are more involved in these unlawful practices Malhotra (2006: 152).
e) **Is SRB affected by Birth order and sex of Previous Child/children?** - SSAs become more prominent on 2nd or 3rd birth order in the family with previous child/children being girl/s {ORGI[10] (1998) ,(Varghese et al 2005:13), Jha et al (2006:211-218) ,George (2006:604) ,Perwez et al (2012:75-76)}
f) **Does Education and Economic Standard affect SRB?**- Finding show that sex selective abortions are more in well off areas/states{ORGI (1998), Retherford and Roy (2003:71-73), Sharma et al (2007:854). Mishra and Dilip (2003: 1-20), Srivastava and Sushma (undated) Chaturvedi (undated)} and also that with increase in literacy level, the practice becomes more prominent (Mishra and Dilip(2003:1-20), Nandi and Deolalikar (2013:22).

3.3 Determinants of Declining Child Sex Ratio (DCSR)

3.3.1 Background-

An old folk song in India:

Prabhuji mein teri binti karoon
Paivan Paroon bar bar |
Agle Janam Mohe Bitiya Na Dije
Narak Dije Chahe Dar...

Oh, God, I beg of you,
I touch your feet time and again,
Next birth don't give me a daughter,
Give me HELL instead... - ----

Taken from (Garg and Nath: 2008)

Three ratios determine overall sex ratio of population- Sex Ratio at Birth (SRB), differential Mortality rates for males/females and the plus / minus as a consequence of migration of masses. Studies bring out that in absence of any human resorted manipulations, SRB is fairly constant

(Hesketh and Xing (2006:13271). UN's Millennium Development Goals identify SRB as a robust indicator of gender equality and women empowerment {Kishore (2005:1-2) in Khichi and Bir (2012:96), Agnihotri (2000) in Rustagi (2006:10)}.

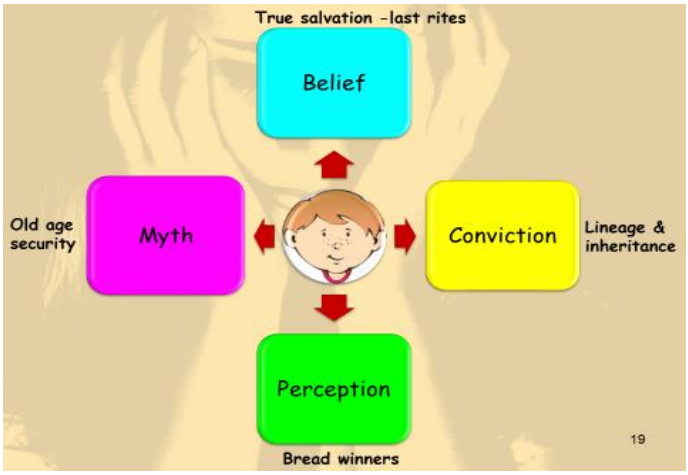
Findings by Hesketh and Xing (2006:13271-13275) show that female foeticide (i.e artificial killing of foetus by sex selective abortions) as well as female infanticide (death of baby girl within 1st year of birth by simply killing or due to discriminatory girl child care practices in terms of nutrients intake or access to health facilities or simply abandoning etc.) create distortions in nature determined sex ratio and lead to decline in CSR and consequently lower sex ratio of population. Lingam (1998) and Patel (1997) in Rustagi (2006:7), Miller (1991), Dreze and Sen (1995) in Singariya (2013:120) also point out similar findings. The differential gender mortality has been documented with reports of about 100 million missing women in India , China and North Africa alone by 1990s {Hesketh and Xing (2006), Bhattacharya and Saxena (2015),Perwez et al (2012:73) }.

Discussed next are the determinants of DCSR in Indian context:

3.3.2 '**Son-Preference: Daughter-Aversion' Culture-**

Various studies point towards existence of a multifactorial scenario linked with various socio-cultural, economic and religious factors in India behind DCSR. Khichi and Bir (2012:95-103) carried out a survey to assess what do the ASHAs[10] (who are the first level contact point for primary health issues with rural and semi -urban population for maternal and child health, reproduction & family planning matters) think about reasons attributing to DCSR. Their study brings out that these reasons manifest in the 'son-preference: daughter- aversion' culture {as also brought out by Hesketh and Xing (2006:13271-13275)} wherein Indian families' **desire for a son manifests in notions like-**

(i) He is supporter and provider for parents especially in old age
(ii) carries family name/lineage ('Kul Ka Deepak' in Hindi)
(iii) is must to perform last rites for attaining salvation
(iv) investing in sons' education and health means a productive act as wealth remains within family and males have better earning capacity



(*Graphic Source:* http://www.slideshare.net/amitjogdand/pcpndt-act?related=1)

[10] Accredited Social Health Activists – "Ministry of Health and Family Welfare (MoHFW) appointed trained female community health workers in every village and from village itself , **907918** in number as on 31 March 2015" (MoH & FW)

Nayak (2014:49-54), Tandon and Sharma (2006), Singariya (2012:8-19, 2013:119-127) also bring out similar findings. Union Minister of Health, Government of India in his reply to a parliament question also attributes these reasons for DCSR (MoH& FW:2015).

R**easons for not preferring a girl child**, as per Khichi and Bir (2012:95-103), Nayak (2014:49-54) are –

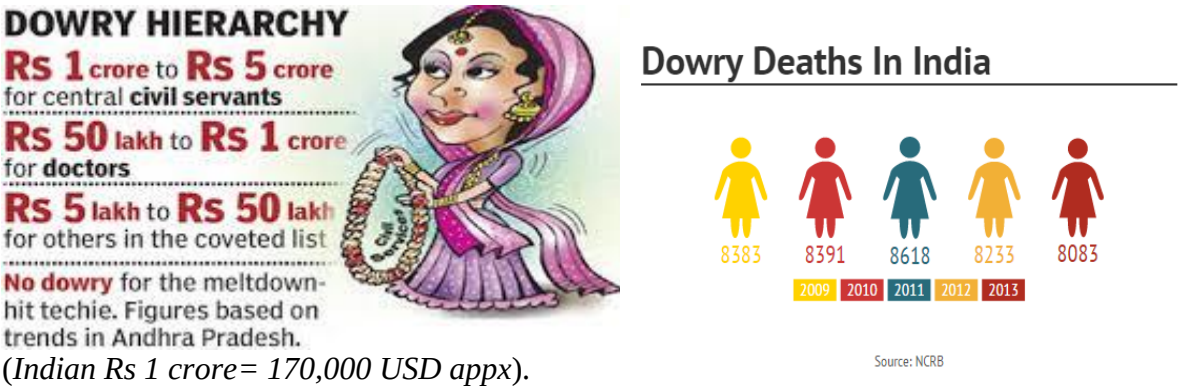
(i) **Dowry**[11] (a tradition in India, more pronounced in Northern states, where on marriage the bride's parents/family gives cash/gifts/property/gold/jewellery etc to groom's family)

(ii) the notion of girl being 'Praya Dhan'('someone else's property' or parallel English saying means 'watering neighbour's garden') as in India, Girl after marriage not only shifts to grooms place, adopts their surname but has almost minimal relation with her own parents)

(iii) Girl considered to be an economic burden/drain as investing in her education will bring no return and on contrary will mean more Dowry burden as groom will have to be better/equally qualified

(iv) more responsibility towards protecting a girl child coupled with fears that a girl may bring bad repute to the family honour due to ever increasing sexual offences (i.e danger to her chastity) in society, and

(v) failure of law and government machinery to implement laws and curb crime against women-.



(*Indian Rs 1 crore= 170,000 USD appx*).

(Graphic Source: https://encrypted-tbn1.gstatic.com and http://www.indiaspend.com)

In similar findings Shah and Taneja (1991), Rustagi (2006:8-9), Sadh and Kapoor (2012:19-21), Singariya (2013:126) ,Bhattacharya and Saxena (2015:1-23), (MoH& FW:2015) also show that these deep rooted cultural (& gender) norms play defining role in determining SRB and further that these factors are non-responsive towards enhanced women agency or increased labour force participation, overall economic development and modernisation. On dowry, two graphics, still relevant in present time, showing the current market rates for Dowry (though demanding dowry is prohibited in Law) and the reported dowry deaths (killing, burning of bride) indicate toothlessness of 'Dowry Prohibition Act' or other Penal provisions provided by law. Union Minister of Health, Government of India in his reply to a parliament question also attribute Dowry for the DCSR (MoH& FW:2015).

[11] Dowry stems from earlier concept of the 'Stree Dhan' (wealth belonging to bride) ,an act to provide some personal financial security to the girl at wedding time to meet any eventualities like the death of husband, or sickness in family or other financial catastrophes. It was supposed to be with the woman and even dowry law says that this is to be returned in case of divorce. However by mid-19th century, it took entirely a different shape of Dowry and first it was expected then demanded. (Sharma et al 2007: 856)

3.3.3 **Smaller Family Trend-**

Parwez et al (2002:73-77), Hesketh and Xing (2006:13272), Rustagi (2006:6-23), George (2006: 604), (MoH& FW: 2015) point out that smaller family norms heavily attributed towards SSAs with son preference taking more aggressive dimension than before.

3.3.4 **Urbanisation and rising Economic Pressures** –

Oomman and Ganatra (2002:184), George (2006:604) ,Bhattacharya and Saxena (2015:13) show that urbanisation and economic pressures led to poorer CSR. Easy access to USG clinics in urban centres is major factor leading towards female foeticide (Khichi and Bir 2012:95-103). Nandi and Deolalikar (2013: 22) say that increased women labour participation to handle rising economic pressures and living cost has a negative relation with CSR as the increased opportunity cost of child bearing has resulted in fall in total fertility rate (TFR)[12]. They also say that presence of doctor or midwife(more health care facilities available in urban areas) brings CSR down by 3-8 points as people now have the information and access to pre-natal sex determination technology{(Srivastava: 1998, Ganatra et al:2001, Deolalikar et al :2009) ibid:23}.

3.3.5 **Patriarchal Setup-**

One factor which cuts across diverse language, caste, religion, cultural customs and practices in Indian society is the- 'gender discrimination', which finds its roots in patriarchal social setup. Rustagi (2006:6-26), Nayak(2014:49-54)} say that factors like lower status assigned to women, undervaluation of women, centrality of reproductive roles of women dwarfing all other roles, intra-household inequalities in consumption, added to the aversion and disinterest in girl child in India. Rustagi continues (2006:6-7, 10, 12) that "patrilineal property transfers (no son in family means, property goes to sons of paternal uncles), ritualistic practices, patriarchal social structures all laid emphasis on male offspring. These aspects have strong influence even among propertied, well to do upper castes {noted as 'Prosperity effect' by Miller (1981), Agnihotri (2000)} which have spread over to other castes and communities over the time".

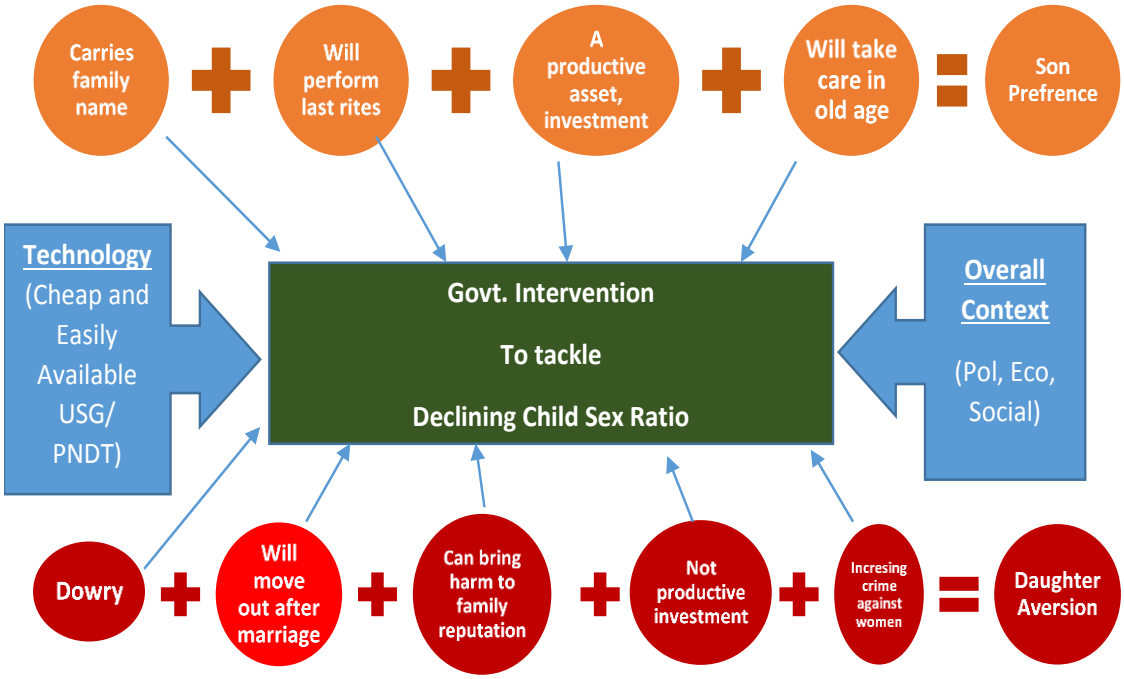
3.3.6 **Joint family Setting-**

Sadh and Kapoor(2012:20-21) add that the joint family[13] setup calls shots in dictating terms to newlyweds on the timing, number and composition (to necessarily have a male offspring). Innumerable Indian movies show a common dialogue by some elderly person to newlywed girl in family "Beti, mere marne se pehle pote ka muh dikha do (Oh dear, show us the face of male child before I die)". Srivastva (2001:7-12) in Tandon and Sharma (2006:7) also report that under pressure, coercion, threat of divorce/desertion and domination from husbands and family, women abort or kill their baby girls. The birth of male child is so essential in Hinduism (Sharma et al 2007:186), that society believes that woman's status rises if she gives birth to a male offspring (Nayak 2014:50-51).

[12] TFR- Total Fertility Rate- average number of live births by a women in her reproducing age i.e 16-45 years.
[13] Para 3.1.3 refers. An important institution in Indian context, comprising of parents, grandparents, uncles, aunts staying together.

3.4 The Big Picture

Above determinants of DCSR (shown graphically below) are acknowledged in reply to Parliament by MoH & FW Minister (MoH &FW: 2015).



3.5 Repercussions of Declining Child Sex Ratio

DCSR, has not only impacted the demographic composition but has led to other serious repercussions (details at **Annexure 3B**), like-

(i) **Rising Crimes Against Women** {Hesketh and Xing (2006:13271, 73) (2011:1374-77), Madan and Breuning (2014:429) Nayak (2014:51) Hudson and Boer (2004)

(ii)**Bride Purchasing, Trafficking and Polyandry cases going up** {Madan and Breuning (2014:429), Misra (2011:152), Khichi and Bir (2015:100-101)}

(iii)**Mental and Physical Agony to Women** due to repeated abortions resulting in increased mortality and morbidity (Madan and Breuning 2014:429), (Sharma et al 2007:858).

(iv)**Adverse impact on Economy** due to lesser participation by women-Singariya (2012:9), Chaturvedi (undated), IMF (2015:7).

3.6 Counter Arguments- In Support of Sex Determination /Sex Selective Abortions:

The issue, however, does not remain uncontested. Sharma et al (2007:856), Madan & Breuning (2014:426) show that Pre-natal sex-selection was advocated as solution to number of problems like-

"(i) It would fulfil desire of families for a son
(ii) Result in happier marriages (save marriages)
(iii) Make life of women easier

(iv) Help parents define ideal family
(v) Stop female infanticide
(vi) Stop women repeatedly reproducing till they had a son and
(vii) Seen as an important tool in India's population control program."

Oomman and Ganatra (2002:187) also bring out that with business proving too lucrative, medical professionals were propagating all such justification, Hesketh and Xing (2006:13274) link SSAs (made available by USG technology) as one of the factors contributing to better female mortality rate in China, India and South Korea. They (ibid) and Rustagi (2006:7-8) opine that SSA led lower birth rate was particularly beneficial for these countries trying for population control (i.e '**population argument'**?) and argue that scarcity of women would enhance their agency (including right to abortion, control over reproductive decisions) and their social status -ultimately leading to balanced sex ratio with people opting for girls lately (i.e '**demand-supply argument**'?)**.** Santhiya (2004:4), Oomman and Ganatra (2002:186), Nayak (2014:50) says that foeticide was considered easy alternative to female infanticide to avoid post-natal discrimination and lifelong humiliation and rejection to the prospective girl (i.e '**fatalistic argument'**?) and skyrocketing financial burden i.e dowry(i.e '**Burden argument'**?).

But question remains- do these reasons justify the way problem is dealt with?

I don't agree with these so called justifications and my Reflection is at **Annexure 3C.**

Chapter IV

Pre-Conception and Pre-Natal Diagnostic Technique (PC & PNDT) Act 1994 & its 2003 Amendment

4.0 Background-

With Medical Termination of Pregnancy (MTP) Act of 1971 legalising abortions in India and subsequent introduction of USG technology in 1975-80s, Sex Selective Abortions went through roof. **Chapter III** explained that technology provided an easy sex-detection assistance to people in strongly embedded patriarchal society which resorted to sex-selection, at pre-natal stage.

In 1988, Maharashtra passed a Law named "Maharashtra Regulation of Prenatal Diagnostic Technique Act 1988" to prevent sex determination tests. Later, on 20th September 1994 Government of India too brought out a similar act - The PNDT (Regulation and Prevention of Misuse) Act 1994 {(Sadh and Kapoor 2012:21-22)}, hereinafter referred to as 'Act'.

The Act came into force in 1996 on notification of rules in Government Gazzette. Need for its amendment in 2003 as **The Pre-conception & PNDT (Prohibition of Sex Selection) Act 1994**[14] arose post Supreme Court Directions in a Public Interest Litigation (PIL) in 2000 by CEHAT[15] and others on poor implementation of Act (already a case of policy failure?) and also on realizing the emerging technologies which facilitated choosing sex of foetus at pre - conception stage.

This chapter discusses the design details of PC & PNDT Act, fund allocation and utilisation, the stakeholders in the implementation process and finally a snapshot of impact achieved.

4.1 Objectives and Provisions of Act-

The Act aims at arresting falling Sex Ratio at Birth.

Objectives
Prohibition- of sex selection, before and after conception
Regulation- of PNDT for legitimate use only
Preventing- PNDT misuse for sex determination leading to female foeticide

• **Act Regulates by providing** –

(a) Use of Diagnostic Techniques(after registration only[16]) including use of ultrasound, scanners, imagers or any other technology capable of foetus sex determination to check - "Genetic & Metabolic disorders, Chromosomal abnormalities, Congenital malformations or Sex linked disorders"[17] and

[14] The Act (with amendments) is seen at http://www.ncpcr.gov.in/view_file.php?fid=434 and detailed one at http://highcourtchd.gov.in/hclscc/subpages/pdf_files/2.pdf

[15] CEHAT- "Centre for Enquiry into Health and Allied Themes) is the research centre of Anusandhan Trust- involved in research, training, service and advocacy on health and allied themes". (http://www.cehat.org/go/AboutCehat/Home)

[16] Section 3 of Act

[17] Section 4(2) of Act

(b) lays punitive measures to prevent PNDT misuse for Sex determination leading to female Foeticide[18].

- **Act Prohibits**

(i) Pre and post- conception sex selection / determination done on a woman or man,
(ii) Communicating Sex of foetus in any manner [19]
(iii) "Sale of ultrasound machines etc. to persons, laboratories, clinics, etc. not registered under the Act"[20].
(iv) Any advertisement on sex selection or determination in any manner[21] (Chapter I and II of Act) (Graphic source- http://www.slideshare.net/amitjogdand/pcpndt-act?related=1)

- **Act stipulates**

Medical conditions under which PNDT shall be used by only qualified person/s as stipulated under Act, with complete record keeping along with consent form signed only by the pregnant woman herself and with certificate of having explained the side and after effects to the patient (section 3 to 5 of Act).

4.2 Implementation Framework (Task Network)

- **Policy Making Body and its Functions**-

Central Supervisory Board (CSB), the top most policy making , reviewing and monitoring body under the act[22] , is constituted at the level of Cabinet Minister of MoH&FW, GoI with representative from MWCD, MoL&J, Indian system of Medicine and Homeopathy; DG Health Services Central Government; ten members (two each amongst—eminent medical geneticists, gynecologist and obstetrician , pediatricians, social scientists and representatives of women welfare organisations) ; three women Members of Parliament; four members to represent the States / UTs and the Joint Secretary Level Member Secretary"[23]. **CSB is to necessarily meet every 6 months[24] to render important functions like**:

(i) "Advise Central Government on policy matters relating to use of PNDT, sex selection techniques and against their misuse
(ii) to review and monitor implementation of Act and recommend changes in Act or its rules
(iii) to create public awareness against the practice of pre-conception sex selection and pre-natal determination of sex of foetus leading to female foeticide

[18] Section 6 of Act
[19] Section 5(2) of Act
[20] Section 3B of Act
[21] Section 22 of Act
[22] Section 16(i) (ii) of Act
[23] Section 7 of Act
[24] Section 9(1) of Act

(iv) to lay down code of conduct to be observed by persons working at all types of facilities using USG and PNDT;
(v) to oversee performance of various bodies constituted under Act and take appropriate steps to ensure its proper and effective implementation"[25]

• **Intermediate Supervisory Body[26]-**

At each state/UT level, State/UT Supervisory Boards (SSBs) which will meet every 4 months are constituted with similar structure and set of functions as CSB .It sends regular reports/ recommendations to central government

• **Main Implementation Level**-

Below, it are the most important field level operational staff who actually implement the Act i.e -the Appropriate Authorities (AA) and Advisory Committees (ACs- to assist AAs). AAs may be one (state AA[27]) or more per state/UT (district AA[28]). When appointed for the whole state/UT, AA means a 3 member body –Joint Director H & FW, a prominent woman from women's organization and a Law officer of State /UT.

• **Main Functions of AA** –

"(a) Grants, Suspends or Cancels registration of PNDT centres
(b) Enforces prescribed standards and code of conduct for such centres
(c) Investigates complaints of breach of provisions of Act / rules
(d) Takes appropriate legal action against use of any sex selection technique by any person at any place suo- moto or when brought to its notice and also initiates independent investigations in such matter
(f) Creates public awareness against practice of sex selection or pre-natal sex determination
(g) Recommends to CSB and SSB any modifications in rules in accordance with changes in technology or social conditions"[29].

• **The Powers of AA-**

"Include summoning any person having any information, document or material object relating to alleged violation of provisions of the Act / rules; can issue search warrant for any place suspected to be indulging in sex determination/selection techniques"[30].

"Can enter, search and examine any record, register, document, book, pamphlet, advertisement or any other material object found therein and seize and seal the same as evidence of commission of an office punishable under Act"[31].

[25] Section 16 of Act
[26] Section 16A of Act
[27] Section 17(1) and 17(3) of Act –State AA are appointed by Centre for each state/UT
[28] Section 17(2) of Act- DAAs appointed by State
[29] Section 17(4) of Act
[30] Section 17(A) of Act
[31] Section 30 of Act

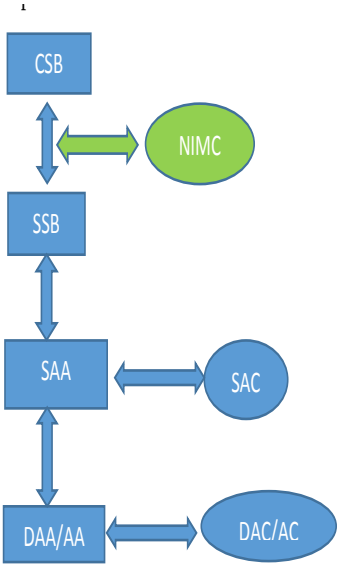
- **Advisory Committee-**

This is to assist AAs and "consist of (a) three medical experts from amongst gynaecologists, obstericians, paediatricians and medical geneticists (b) one legal expert (c) information and publicity officer (d) three eminent social workers"[32].

- **National Inspection and Monitoring Committee (NIMC)**:

Not provided under Act, was first constituted at National level in 2001 (in response to CEHAT PIL of 2000 on lacklustre implementation) and re-constituted in March 2005 with representatives from WCD, National Commission for Women and Indian Council for Medical Research to assess the implementation of Act and ground realities through field visits. The NIMC is the intermediate link between the CSB and SSB and was set up to visit vulnerable states/districts. It also monitors cases filed against defaulters. NIMC initiates investigation on two grounds: (a) when it receives a direct complaint, and (b) as routine inspection, in vulnerable areas with low sex ratios (PHFI 2010: 47-48, **Annexure 4A[33]).** On similar lines, IMCs at State and District level (SIMC/DIMC) were to be constituted.

Implementation structure as per the Act



Implementation can be effective if Structures work in tandem

Main Functions of the various bodies

CSB: "Advise on policy matters, review and oversee implementation, lay down code of conduct"

SSB: "Create awareness about the Act, review AA's activities, monitor implementation, send reports to CSB"

NIMC: "Not provided in the Act, but formed by Government to monitor implementation by all states, conduct sample inspections and investigations"

SAA and DAA: "Implement the Act at the state/District level, register clinics, inspect

- **Offences and Penalties[34]-**

Advertisement in any form on pre natal sex determination of foetus or sex selection at preconception/any stage or non-compliance to Act Provisions attracts default. Defaulters (company, centre owner/in charge, doctor, assistant, even the honorary functionary) can be imprisoned for 3 years with fines up to Rs 10000/= on 1st offence; and up to 5 years and Rs 50000/= on repeat offence. AA will recommend suspending the registration of medical practitioner to the Medical Council if charges are framed by court and for temporary removal of his name from MCI register for 5 years on 1st conviction and permanently on repeat offence. Similarly, the person/relative of pregnant woman who sought aid of

[32] Section 17(5)(6) of Act
[33] RTI reply dated 3 Aug 2015 by MoH & FW on NIMC members and functions
[34] Section 22-26 of Act

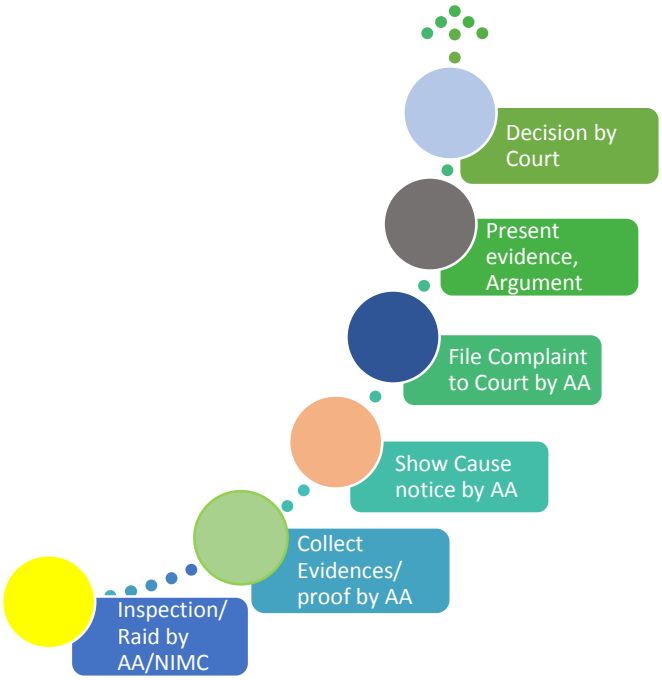
centre/doctor/anyone at centre for sex selection / determination can be jailed for 3 years with fine of Rs 50000/= on 1st offence ;and for 5 years with Rs 100000/= fine on repeat offence. These penalties will not apply to pregnant woman, the court assumes (unless othervise proved) that she was compelled to undergo any test for such defaults by her husband/relative and such persons will face action as above.

• **Cognizable, Non-Bailable and Non-Compoundable** –

"An offence under this law is
1. Cognizable –i.e A police officer may arrest offender without warrant
2. Non-bailable –i.e Getting bail is not right of the accused. Courts have discretion to grant bail
3. Non- compoundable –i.e Parties to the case cannot settle it out of court"[35].

• **Cognizance of Offences-(Who & Where One Can Complain)**

"No court shall take cognizance of an offence under this Act .A complaint can be made by—
(a) AA or any officer authorised by Central or State Government or
(b) Any person (incl. NGO) and even a group of persons can file a complaint to AA and if AA fails to act on complaint within 15 days, complaint can be filed in designated court.
(c) No court other than that of a Metropolitan Magistrate or a Judicial Magistrate of first class shall try any offence punishable under Act"[36] .



• **Maintenance/Inspection of Various types of Records[37]-**

Act also stipulates guidelines for maintaining all records including consent form from pregnant women for 2 years or till any matter is disposed of by court. AAs can always demand inspection of such records.

• **Protection of Action taken in Good Faith-**

"Act provides that No suit, prosecution or other legal proceeding shall lie against the Central / State Government or AA for anything which is in good faith, done or intended to be done in pursuance of provisions of Act"[38].

[35] Section 27 of Act
[36] Section 28 of Act
[37] Section 29 of Act
[38] Section 31 of Act

- **Power to Make Rules/regulations**-

"Central Government has made and may amend /make rules for carrying out provisions of Act with approval of Parliament"[39].

4.3 Act Amendment in 2003[40] and PC & PNDT Rules –

- Writ petition no. 301 of 2000 was filed in Supreme Court in 2000 by CEHAT (an NGO), Mausam -another NGO and Dr Sabu George technical expert in the field, pointing to the poor performance of the Act (already a case of policy failure?). SC order dated 4 May 2001(MoH &FW 2006:122-125) passed detailed direction to Central Government, CSB, State Governments/UTs, AAs which inter-alia directs–

a) To create public awareness and to indicate full details of campaigns undertaken along with results;
b) For regular holding of meetings by CSB, SSB, ACs;
c) CSB to review and monitor the Act;
d) Quarterly returns from all state AAs to CSB on implementation covering inspections, registrations, action taken in violations and advocacy campaigns launched;
e) CSB to examine necessity to amend in view of emerging technologies and issue code of conduct to be followed at centres;
f) States to constitute ACs, publish AAs, ACs list in media, create public awareness & send regular reports to CSB;
g) AAs to take prompt actions in case of violations in case of publishing of advertisement on sex selection/determination and against unregistered centres and to carry necessary inspections of centres & to take criminal action by filing complaint under section 28 of Act. SC on 19 Sep 2001 noticed that AAs merely issue warnings instead (MoH &FW 2006: 126).

- SC in its order dated 11 Dec 2001 also passed directions to manufactures/suppliers to provide list of clients to whom USG machines were sold in last 5 years for AAs to register them after inspections, and not to sell machines to unregistered clinics. SC in its order of 29 Jan.2002 advised that Authorities may seek Help of IMA, IRIA and FOGSI[41] to implement the Act effectively (MoH&FW 2006:132-134).
- Consequent upon SC directions, the principal rules dated 1st January, 1996 were amended first on 14th February, 2003{with the Act also being amended in 2003 as PC & PNDT Act (Prohibition of Sex Selection) 1994} and thereafter[42] to further improve the implementation aspect.

Notable among these being instructions on minimum qualifications and experience of persons eligible to operate at machines (particularly USG machines) providing PNDT facilities ; regularizing the use of mobile/portable USG machines; elaborate defining of responsibilities/powers of AAs; putting a limit to number of clinics in which one radiologist

[39] Section 32-34 of Act
[40] Refer Para 4.0 also.
[41] Indian Medical Association, Indian Radiological and Imaging Association, Federation of Obstetrics and Gynaecologists society of India
[42] vide notification of 31st May, 2011; 7th February, 2012; 4th June, 2012; 9th January, 2014; 31st January, 2014 and 24 Feb 2014 .

can work; ensuring no one having clash of interest is a member of AC, SSB or CSB; instructions on pre-intimation of change in persons working at PNDT center .

- February 2014 amendments in rules[43] lay down that every registered complaint is to be investigated in 24 hours; AAs to carryout regular and periodic inspection of all centers in 90 days cycle; AAs to monitor data on sale/resale of the USG machines from companies and cases to be files against defaulting companies which sell machines to unregistered clinics.

4.4 Fund Availability and Utilisation-

Funds are not a problem. Apart from central allocation, funds generated from registration suffice for implementation of Act (PHFI 2010:78-79).

PIB note (21 Aug 2013) showing funds allocated to the States / UTs for implementation of the Act (including Setting up of PNDT cells to effectively monitor the implementation of the Act) during 2009-12 as under and details (2012-15) received vide RTI reply** {**RTI reply dated 31 Aug 2015 by MoH & FW (Annexure 4B)}** indicate poor utilisation of the budget.

Financial year	Fund Allocation/MoH&FW approved State projection** (In Rs Lacs)	Fund Utilisation/ Expenditure (In Rs Lacs)	Fund Utilisation %
2009-10	1238	730	59 %
2010-11	11417*(2079**)	733	35 %
2011-12	1411	597	42 %
2012-13**	1984(1590**)	1078	68 %
2013-14**	1626	930	57 %
2014-15**	2311	863	37 %

* Allocation includes Public-Private /Non-Governmental Organisation Partnership (i.e towards Grant- in- Aid NGO scheme).

4.5 Stakeholders in the Act/Policy -

From state side- MoH & FW, CSB, NIMC, SSB, SAC, SIMC, AA, DIMC, DAC and NCW/SWC[44] are the stakeholders. From private sector- doctors (and their associations- IMA,IRIA,FOGSI), USG equipment manufacturers/suppliers and from Community side- NGOs, CBOs, Politicians, Religious leaders, celebrities (cine /TV/sports stars, girl achievers) and women themselves are the stakeholders.

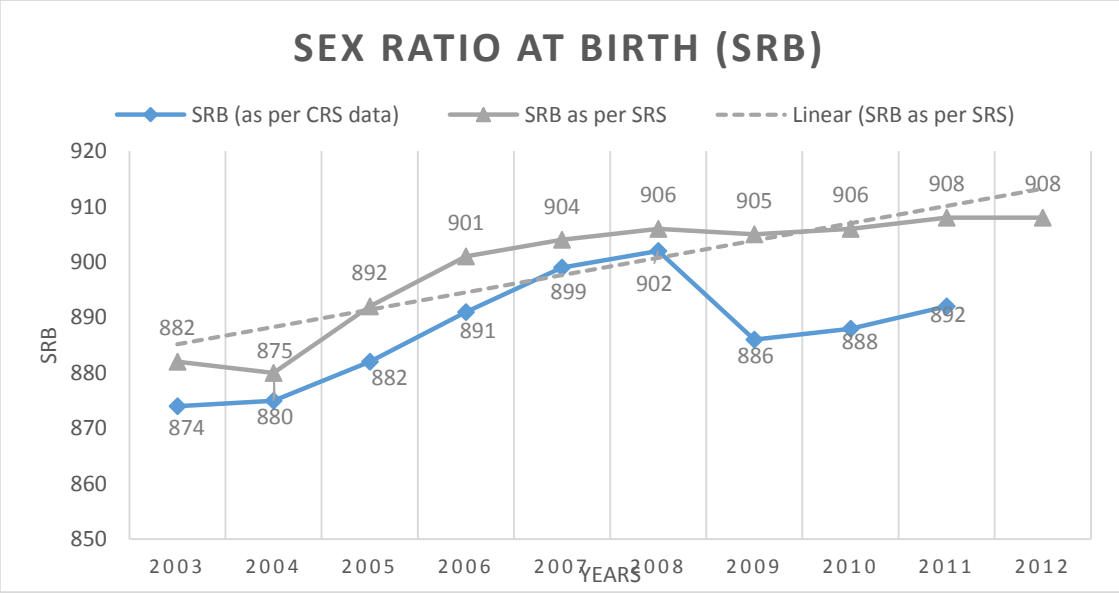
[43] Rule 18 A- of Act-http://www.statehealthsocietybihar.org/administrative/PCPNDT_gazette_LNo-2747.pdf
[44] National / State Women Commissions

4.6 Impact Achieved-

Act has a sharp focussed aim to regulate the use of technology for its legitimate purpose and prohibits and prevents its misuse for any act of sex selection or determination, leading to female foeticide.

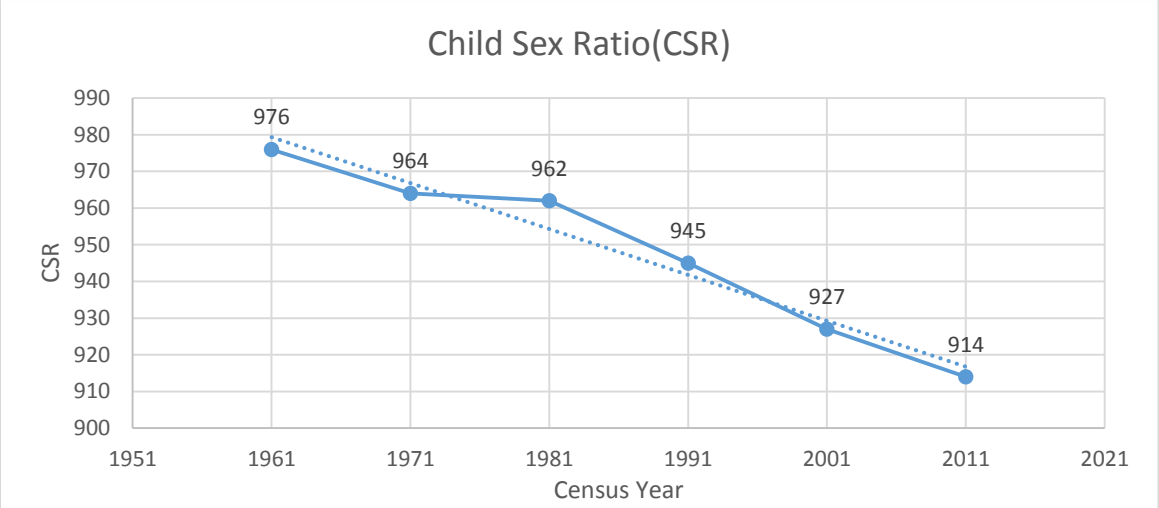
Envisaged Impact	Results
Improved Sex Ratio at Birth	• In last 10 years SRB shows upward trend (chart below). • For last 5 years it has stagnated.
Improved Child Sex Ratio	• The overall CSR in 1991, 2001 and 2011 was 945, 927 and 914 respectively. This shows a continuous decadal decline by 18 and 13 points, respectively. Retardation in decline by 5 points is indicated.
	• Out of total 35 states/UTs, 8 states/UTs show improved CSR in the period 2001-11 (Table at **Chapter 3**). • Comparing 1991 with 2011 census, CSR in only 3 states has improved **(Annexure 4 C)**.

1) **SRB-** Since Act amendment in 2003, the SRB is shown below. Data from two government sources[45] has been taken. "Data on SRB is periodically collected at the national level by Civil Registration System (CRS) and Sample Registration System (SRS) {both published annually by ORGI}. The CRS data is not reliable due to gross under-registration of births in some states. SRS estimates are the most frequently used and quoted source of SRB data. These estimates provide results at state and national level, but not for district level" (UNFPA 2010:1).



2) **CSR**- Following chart shows Child Sex Ratio as per Census of India.

[45] ***Data Source: 1.*** *OFFICE OF THE REGISTRAR GENERAL, INDIA, MINISTRY OF HOME AFFAIRS, VITAL STATISTICS DIVISION (http://crsorgi.gov.in/web/uploads/download/CRS_Report2012.pdf)Page 41*
2. SRS source-http://www.censusindia.gov.in/vital_statistics/SRS_Reports_2013.html
3. http://www.censusindia.gov.in/vital_statistics/SRS_Reports.html(for year 2011)


Child Sex Ratio(CSR)
990
980
970
960
950
940
930
920
910
900
CSR
976
964
962
945
927
914
1951
1961
1971
1981
1991
2001
2011
2021
Census Year

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Chapter V

Analysis of Act Effectiveness

5.0 Background-

Here, I investigate the effectiveness of PC&PNDT Act 1994 by assessing implementation and monitoring mechanisms within Capacity framework by systematically taking all bodies one by one, starting from top-most Central Supervisory Board.

The Investigation is based upon evidences collated from an exhaustive desk study of secondary sources of last 10 year period.

5.1 Analysing the Implementation Mechanism

A safe assumption should be that with Act in its 19th year of operation (Act launched in 1994, comprehensively amended in 2003, followed by many more amendments in Rules) implementation must have taken a reasonably mature, stable and effective shape.

Implementation mechanism was analysed from three perspectives-

(i) Whether mandated structures (official machinery) are in place and functional,
(ii) if these have required awareness level - about Act provisions, their rights/entitlements and responsibility under Act and specially at AA level on legal rigour required to prepare, present the court cases, and also
(iii) type of practices these follow in field viz- a- viz those envisaged.

5.1.1 Structures

Evidences from Desk study of secondary sources for 10 year period are **tabulated below**:

Evidences from Review of Secondary Sources on Implementation Structures

CSB	*Structure of CSB found as provided under the Act*	*(PHFI 2010:55-56),*
SSB	*Gaps found in the SSBs composition - like none or misplaced representation of women representatives of the Legislative Assembly (2008-09 study).* *14 states with the most skewed child sex ratio asked to Constitute SSBs (as mandated)*	*(PHFI 2010:55-56).* *(MoH & FW 2014:29-31).*
AAs	*AAs were appointed at the state and district levels in all of the surveyed 18 states(2008-09)* *State Appropriate Authority (SAAs) generally a multi-member body (not strictly constituted as mandated) and in 7 states, an individual appointed as the SAA(2008-09)* *In study of 10 poor CSR states, barring Maharashtra, SAA either not formed as mandated (Bihar); vacant SAA in Rajasthan and non- functional SAA in UP due to frequent transfer of office holders(2011-13)* *In most of the states, the District Collector/ Magistrate (DC/DM) is functioning as the DAA as per recommendations of Union Government) though the "operational work relating to implementation of the Act is generally delegated to the Chief Medical (& Health) Officer (CMO/ CMHO) and a Senior Medical Officer (SMO) at the sub-district/ block level, where ever sub district AAs are constituted(2008-09)* *Barring Andhra Pradesh, Rajasthan and Maharashtra, Block/Sub-District level AAs did not exist in 15 states (out of total 18 states surveyed) despite Supreme Court directions(2008-09)*	*PHFI (2010)* *(PHFI 2010: 56-57).* *(GirlsCount 2014: 47-54).* *(PHFI 2010:46 ,57-58)* *(PHFI: 2010: 46, 56- 59).*
ACs	*Gaps in the SAC constitution found in Haryana, Gujrat and Maharashtra and SAC not functional in Goa(2008-09)* *DACs were constituted in almost all states, "there were variations in their constitution/membership. In some DACs there was over representation of government committee members, and in others there under- or misrepresentation of certain groups"* *While the Act provides nominating NGO representative in ACs, but SACs and DACs do not appoint them often and as such NGOs are under-utilized* *DACs were not formed in all districts of the state. And in many districts, it was not re-constituted every 3 years as required under the Act and that the SAC although formulated but was non-functional (Government of Bihar and UNFPA 2014:7-9, 41).*	*(PHFI 2010:59)* *(PHFI 2010:62).* *(PHFI 2010:91).* *(Government of Bihar and UNFPA 2014:7-9, 41)*
IMCs	*Central Government in affidavit of 17.11.01 in CEHAT PIL case, informed the Supreme Court (Writ Petition (Civil) No. 349 of 2006 in SC) that government "has decided to take concrete steps for the implementation of the Act and suggested to set up a (NIMC) for the implementation of the Act"}to strengthen the monitoring of the implementation of the Act* *Form monitoring committees at district level to assist AAs in inspections/monitoring.* *During 2008-09, NIMC found non –functional and "out of 18 surveyed states, in 8 states either SIMC or both SIMC and DIMC were not formed till 2009 and in rest of states, the SIMC and /or DIMC were very newly constituted and not fully functional".* *MoH & FW's annual report for 2013-14 mentions that 14 low CSR states directed to constitute SIMCs* *States were directed to form SIMC and DIMC at state and district level for better operationalising/implementing the Act*	*(PHFI 2010:47).* *Regional workshop (MoH&FW:2006)* *(PHFI 2010: 62-63)* *(MoH&FW2014:29-31)* *(Girls count: 2014).*

Above Evidences show:

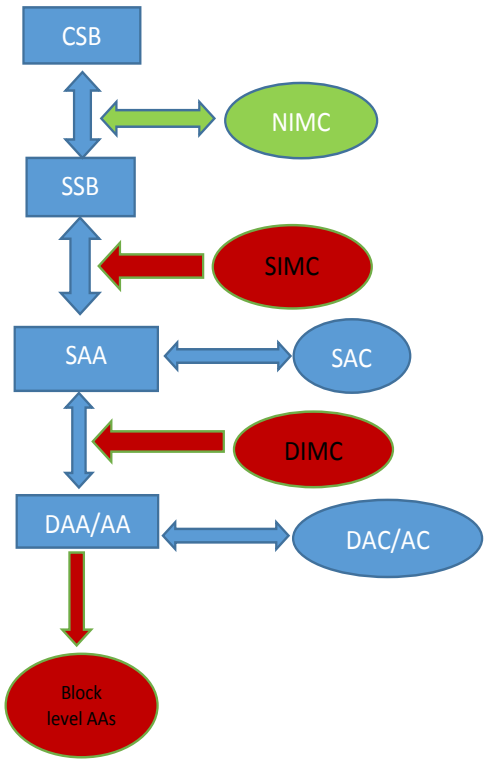
(i) Non-constitution or non-standard SSB/SAC/DAC (NGOs under represented or ignored totally and political bias in appointing non-official members) defeats the very purpose for which representations from various quarters has been mandated in Act. It is a case where important stakeholders are missed in the process which is required for their cooperation, support, accountability and ownership (UNDP-PPPUE: undated, World bank: 1986).

(ii) Even if CSB/SSB are constituted , defunct or non-functionalism (not meeting regularly or meeting for formality sake) shows a missing link in the implementation chain. These are danger signals indicating non-engagement of key stakeholder(Thaker 2009:4) where either they have not appreciated their roles and responsibilities or see no benefit in engagement(Griffiths et al 2008:36-37, World bank:1986).

(iii) One man SAA formulation shows lacunae in implementation & monitoring mechanism. One man can't effectively discharge various jobs –i.e supervising implementation of Act in whole state, monitoring the progress on various parameters, coordinating with centre, launching state wide awareness campaigns etc.

(iv) Non-appointing Block/sub-district level AAs adversely affects implementation and monitoring of Act as district is geographically vast, and gigantic task of routine inspections, registration etc could never be satisfactorily completed by one DAA(RTI replies,**Annex-5A** show poor % of inspections).

Implementation Structure- the Missing links (in red)



(v) DC/DM as DAA means improvement in implementation of Act as he yields all powers at district level (PHFI 2010:59) but CSB representative though largely in sync with arrangement (as it also takes care of the fraternity angle while CMO being the DAA) had a forceful argument that implementation of Act remains low on priority as DC/DM has several other responsibilities. Also, in reality field level jobs are still delegated to CMOs thereby eclipsing very advantage of AA being from outside medical fraternity (PHFI 2010:70-71). NGOs too had shown apprehensions that doctors do not implicate members from their own fraternity (PHFI 2010:83). This conflicting interest is a serious gap in implementations and monitoring at key implementer level (the CMO as AA).

(vi) Non-constitution of or non-functional SIMC/DIMC is serious drawback as it directly affects prime tasks of inspections and monitoring.

(vii) A very limited scope of NIMC (just 24 inspections in a year) & SIMCs sans any statutory powers (have to essentially take AA along with as Act rests all powers to search, seize with AAs) is also a bottleneck in effective implementation.

In sum total, the implementation structures are yet not in place due to some missing links or non-functional links in the chain. Ignoring set procedural rules (on constitution, composition, meetings, inspections etc) by implementers results in inefficient implementation chain (UN FAO: undated).

5.1.2 Awareness (Competency)

Evidences from desk study of secondary sources of 10 year period are shown in **table below.** These show that

(i) Awareness levels specially at main implementing level of AAs is sub- optimal like- AAs lack technical and legal awareness on key jobs of search, seizure, evidence collection, case preparation etc.,

(ii) Prosecutors and Judiciary too lag in awareness and knowledge level;

(iii) ACs and Police not fully conversant with Act provisions and their functions/roles.

(iv) NGOs and even women too are not fully aware of the act, their entitlements/ powers under the act.

As per Thaker (2009:8) untrained, ignorant stakeholders can't make meaningful participation in the process and leads to absence of responsibility accountability at their levels (Hut 2008)

Evidences from Review of Secondary Sources on Awareness (Competency) of Implementation Bodies

AAs	*Particularly weak in the areas of conducting search and seizures, collecting evidence, conducting decoy operations, filing complains, maintaining records, watching sale data of USG machines is noted*	*(All India Conference, MoH&FW :2005), (Regional Level Workshop, MoH&FW :2006), (State Level Workshop, MoH&FW :2009) (PHFI 2010:66) (National Level Workshop, MoH&FW :2012).*
	AAs need to be fully aware of the provisions of Act, their powers & procedures	*All India Conference (MoH&FW: 2005), Regional level workshop (MoH&FW:2006)*
	AAs may engage lawyers to understand the Act & follow up in courts.	*Regional level workshop (MoH&FW:2006)*
	AAs lacked legal expertise.	*(WPC & UNFPA 2009:20).*
ACs	*ACs need to be fully aware of the provisions of Act, their powers & procedures*	*All India Conference (MoH&FW: 2005), Regional level workshop (MoH&FW:2006)*
	Overall awareness of the DAC members is low and were not aware of their functions too	*(Government of Bihar and UNFPA 2014:50)*
Public Prosecutors and Judiciary	*Lack of knowledge among legal fraternity. 39 % of Public Prosecutors (PPs) said it was average and 35 % said it was poor and even one third Judicial Magistrates (JMs) themselves felt that the awareness level on the Act among judiciary is poor*	*(PHFI 2010:67-68).*
	Recommended training judiciary.	*Regional level workshop (2006)*
	National level workshop 2009, records judiciary was not much informed about the Act	*(WPC & UNFPA 2009:21).*
Women	*Don't know the provisions of Act and where & how to complain when coerced into a sex determination*	*PHFI (2010:15)*
NGOs/CSOs	*Around 45 % of NGO & CS Representatives acknowledged low awareness among community*	*(PHFI 2010:68-69).*
Police	*Police not proactive and knows not much on how to assist AAs in search & seizures*	*Regional level Workshop (2006)*

5.1.3 Practices

Evidences from Desk study of secondary sources for 10 year period are **tabulated below**.

For comprehensive assessment, especially at main implementation level i.e AAs, I have investigated three key areas to examine how far or how close are on-field practices (adopted by various levels in the implementation chain) viz-a-viz those on paper–

(i) On inspections,
(ii) On record keeping and
(iii) On handling of court cases**.**

Evidences from Review of Secondary Sources on Practices followed by Implementation Bodies

CSB	*CSB is not holding regular meetings.* *CSB virtually defunct as it had not held even a single meeting in 2008-09*	*All India Conference (MoH&FW:2005)* *(PHFI 2010:70).*
SSB	*"SSB is mandated to meet at least once in four months to review the implementation of the Act in state/s, in half of the 18 surveyed states, required number of meetings were not held due to insufficient quorum. Whatever meetings held were weak in terms of content and thoroughness and less focus on weighty issues like results of monitoring/review of activities of DAAs; in some cases there was no structured agenda ; minutes of the meetings often not kept (like in west Bengal) & some SSB meetings were a mere formality lasting just 10 minutes (like in MP)"* *Lack of regular meetings of the SSBs.* *In 2013-14, 14 states with the most skewed child sex ratio asked to conduct regular meetings of SSB* *In 2013-15, Lack of regular and sufficient meetings of SSBs*	*(PHFI 2010:13,72).* *National level workshop (MoH&FW:2012)* *(MoH & FW 2014:29-31).* *Regional Review Meetings for Central region, North Eastern Region, Western region held in 2013-15, (MOH & FW RTI reply dated 16 Sept 2015)*
AAs	***Inspections:*** *most important area in Act implementation-* *Were infrequent and insufficient.* *In Delhi, pharmacists or the Public Health Nurse assisted AAs in the investigation of complaints".* *At National level workshop in 2009, Director PNDT MoH&FW said violations increasing mainly due to non-registered centres and compounded further by the fact that the implementing cum enforcement authorities were rather slack .*	*(All India Conference, MoH&FW: 2005, Regional level workshop, MoH&FW: 2006, PHFI 2010:76, National level workshop, MoH&FW: 2012,).* *(PHFI 2010:75)* *(WPC & UNFPA 2009:20).*

	Dr. Neelam Singh, member CSB and NIMC said- updated list of operational centres not available with the AAs and large number were with incomplete addresses; even after centres had closed down the registration certificate not surrendered to AAs; NIMC steered surprise inspections faced information leaks; lacklustre follow up by the state on violations reported by NIMC visit; and in number of cases, clinic/centres de-sealed without filing cases in the court despite NIMC inspections had found serious irregularities . Previously, Joint Secretary MoH& FW also made similar observations. (Graphics from www.dailymail.co.uk) **A GRIM SCENARIO** ■ National Inspection and Monitoring Committee formed by the SC in 2003 says PCPNDT Act which banned female foeticide in 1994 is not being strictly implemented ■ Members are facing certain "on the field" difficulties ■ Local authorities in most states are in collusion with errant clinics ■ Clinics closed for violations allowed to function within days without filing cases being filed against them ■ In states like Jharkhand and Haryana, there were instances of the search team being threatened and held hostage ■ States not cooperating for surprise checks as tipped off clinics close before the team arrives *During the Bihar study by UNFPA and Government of Bihar in 2012-13, the survey team found 145 unregistered clinics; 60 % respondents had not informed AA regarding the unusable machines; 80 % clinics did not display registration details , rest 20 % refused to share; 75 % of DAC members were of the view that no legal action was taken against those found violating the law (self-evident from the fact that not even in a single case, any punishment was pronounced by the courts)* *For 2010-14, Orissa claimed 1336 inspections and 39 violations, but unable to provide district vise break up or clinic details to audit team; new registrations and renewals done without AA inspections and bypassing DAC; audit found ineligible persons operating USG machines.* *2008-09 study noted that while the number of PNDT clinics have increased across the country, the inspections have not increased correspondingly.* *Varsha Deshpande, member NIMC and CSB raised similar observations that when thousands of machines are being purchased, the registration figures remain quite low and also that though Maharashtra launched the Act much earlier in 1988, it had registered only 156 cases, out of which only 4 were imprisoned meaning state government has made half-hearted effort and been lenient towards doctors.*	*(21st CSB meeting, MoH&FW:23 Jul 2013)* *(Tehelka: 4 Feb 2012) (National level workshop, MoH&FW : 2012)* *(UNFPA & Government of Bihar 2014:7-9).* *C & AG Odisha Audit report (2014:61-73) and* *C & AG Odisha Audit report (2015:13-15).* *(PHFI 2010:76-77).* *(The DNA India: 28 June 2011)*

	2011-13 study found AAs in Delhi were issuing notices but were not following up and generally lacked cooperation with SIMC or NIMC). It also observed that SAA were not proactive (either in spreading awareness or in case filing) - like Tamilnadu, Chhatisgarh, Delhi, Haryana, Himachal Pradesh.	*(Girlscount 2014: 47-54)*
	"Draft report of the Sectoral Innovation Council[68] concluded that inspecting mechanism at the national and state levels is either ineffective or dysfunctional, there is no regulation on sale and purchase of ultrasound machines and while there are around 40,000 registered diagnostic centres, the number of machines has been estimated to be over 1,50,000."	*(UNFPA 2013b:73)*
	Records Maintenance	
	At National level workshop in 2009, Director PNDT MoH&FW said the violations are increasing for which non-maintenance of records is one chief reason.	*(WPC & UNFPA 2009:20)*
	2008-09 study of 18 states found only 35% AAs maintained list of manufacturers of ultrasound machines, 40% AAs maintained Forms F and minutes of meetings; Very often complete files of court cases were not maintained	*(PHFI 2010:74-75) and (C & AG Odisha Audit report 2014:61-73)*
	National level workshop in 2012 observed non Form F record keeping, nil scrutiny of quarterly sales reports from ultrasound machine manufacturers at AA level.	*(MoH&FW: 2012)*
	2011-13 study found AAs in Bihar were not keeping inspection records.	*Girlscount (2014: 47-54)*
	MoH & FW's 'Annual Report 2013-14' lists same directions to AAs to- ensure analysis and scrutiny of Form -F; Obtain regular information from USG machine suppliers/manufacturers on sales data which is mandatory as per the Act	*(MoH & FW 2014:29-31).*
	During the Bihar study by UNFPA and Government of Bihar in 2012-13, the survey team found Less than 60 % of the respondents maintained Form F (a mandatory requirement of the Act) and a small % said that they were submitting these to AAs; 25 % DAAs mentioned that records of all monitoring visits were not maintained;	*(UNFPA & Government of Bihar 2014:7-9).*
	2010-14 Orissa audit found clinics were not filling Form -F, and were mostly not submitting timely to DAA office	*C & AG Odisha Audit report (2014:61-73)*

[68] Constituted by the Ministry of Women & Child Development vide its Notification No. 6-20/2011-CP, dated 16 February 2012

	2013 Odisha audit shows though District inspection teams were formed, but it did almost nil inspections (0 in 2010-13 in Ganjam district, 1 in Nayagarh, Bhadrak could not produce documentary evidence of any inspections). ***Handling of Court Cases (another key area to nail the defaulting clinics found violating the Act)*** *Practically NIL Conviction rate, emphasised remedial measures.* *PPs felt that "AAs were not aware of the legal requirements of investigation reports while conducting inspections or raids at clinics and often, the reports lacked quality and completeness and hence not admissible as evidence in court". Judicial Magistrates too agreed that the low conviction rate was primarily due to lack of proper documentation, witnesses, and evidences. Other reasons of poor convictions cited by PPs included Out of court settlement and mid-trial Clinics registration.* *2008-09 study found one-third of AAs were not handling a PCPNDT case., Assam and Tamil Nadu AAs had never handled a single case and AAs themselves acknowledged poor awareness on case preparation and filing in court.* *As per Union Health Minister's reply to Parliament in 2015[69], till Dec 2014 ie. in 19 years span, total 206 convictions were secured under the act (of which till 2010, mere 37 were booked) and 23 states/UTs had booked NIL convictions This comes to a just 10 % conviction rate (as 2021 cases were filed in courts). He also informed Parliament (ibid) that total 50743 PNDT centres were registered in the country till Dec 2014, 1716 machines were sealed and licenses of 98 doctors have been cancelled for violations under the Act.*	*(C & AG Odisha Audit Report 2015:13-15)* *All India conference 2005 (PHFI 2010:88,90)* *(PHFI 2010:79-80)* *(MoH&FW:2015).*
ACs	*In 2008-09, SAC and DAC meetings held irregularly; struggled in completing the quorum; No prior circulation of agenda and "that in some districts, no meetings were ever held"* *lack of regular meetings of the ACs*	*PHFI (2010:86)* *National level workshop (MoH&FW:2012)*

[69] Parliament Question replied in Feb 2015

	In 2011-2013 study of 10 poor CSR states, barring Rajasthan and Maharashtra, SAC and DAC meetings in Bihar, Himachal, Punjab, UP, Haryana, Chhattisgarh were irregular and insufficient, non-participation by members (they depute proxies), no follow up on cases, superficial and weak agendas, political bias in nomination of non-official members (all belong to ruling party) and with special instance of UP where SAC was more into finding loopholes in the Act than acting. *C & AG Odisha Audit in the 4 sample districts of state shows that SAC and DACs were ineffective, SAC met only 6 times during 2010-13 against mandated 18 times and DACs met 29 times against mandated 72 times.* *Usefulness of ACs, at all levels, still remain a challenge.* *lack of regular meetings of the ACs*	*(Girlscount 2014:47-54).* *C & AG Odisha Audit (2014:61-73)* *CSB in its 22nd meeting (13 Oct 2014)* *Regional Review Meetings for Central region, North Eastern Region, Western region held in 2013-15, (as per RTI MOH & FW reply dated 16 Sept 2015)*
IMCs	*NIMC was dormant from 2007 - 2010. The Union of India affidavit dated September 2011 stated that in most states SIMCs have been notified, but the minutes 20th meeting of the CSB (16 Jan 2013) read "States including Punjab, Rajasthan, Uttrakhand and Jharkhand have not taken any follow up action on the recommendations of NIMC....SIMCs are not yet functional"* *In the 2011-2013 study of 10 poor CSR states, found that SIMC virtually did not function in Bihar, Maharashtra and was formed only in 2014 in Tamilnadu, not formed in Chhattisgarh or carried very limited inspections mostly in complaint cases or when there was pressure from top (Delhi) and there too full team did not go for inspections (Delhi, Haryana, Rajasthan and UP)* *In 2014-15, just 16 inspection by 140 + member NIMC till Feb 2015*	*(Writ Petition (Civil) No. 349 of 2006).* *(GirlsCount 2014: 47-54).* *(MoH & FW reply to parliament: 2015)*
PPs	***Many*** *of them treat this an additional responsibility. In Orissa, PCPNDT cases could not be filed in court due to the unavailability of PP who was handling other cases.*	*(PHFI 2010:87).*

Above Tabulated Evidences on Practices followed by various levels in Implementation chain show:

I could not think of better example than National Capital of Delhi where both state government and National Governments sit and things are pretty much in media and civil society scan. The state of affairs in Delhi (last three year data is as under) gives a snapshot of what is happening all over the country. Source :(Delhi Govt report: 2013-14):

Year	Inspected clinics/ Total Regd. clinics	% clinics inspected
2011-12	602/1650	35 %
2012-13	754/1550	50 %
2013-14	448/1550	29 %

Tabulated evidences show that practices adopted by every level speak of disinterest and disregard to implementation of Act. Non-functional SSBs/SACs/DACs/SIMCs/DIMCs (e.g no meetings/insufficient and infrequent meetings, non -participation & attendance by proxies, non - structured & weak in content agendas, non-recording of minutes etc) are adversely affecting implementation of Act.

(a) At main implementation level ie at AA level- main tool to enforce regulation on use of USG machines is - inspections. We saw that these are insufficient and infrequent resulting in-

(i) Functioning of unregistered clinics,
(ii) Non-following of code of conduct by centre operators,
(iii) Poor maintenance of records (Form F, G importantly) by centres,
(iv) Non-enforcements of regular submission of sales data by machine suppliers and manufacturers,

(b) In addition, incidences of -

(i) Information leaks regarding raids by NIMC,
(ii) Non-follow-up of SSB, NIMC directions,
(iii) Non- record keeping on inspections at AA level {UNFPA (2013b: 74) says that "Necessary records are not being maintained; even F forms are rarely filled, and those that are, often do not contain correct data[46]."} and
(iv) Very little interactions with IMA, IRIA, FOGSI (key stakeholders) have affected performance of Act in field.

(c) On handling of PCPNDT court cases, data have shown poor conviction rate (**Annex-5D**). Few AAs had never handled any court case under the Act. Evidences also expose the difference between machines sold/in use to those registered, indicating operation of non-registered USG centres across country.

[46] Draft Report of the Sectoral Innovation Council, Constituted by the Ministry of Women & Child Development vide its Notification No. 6-20/2011-CP, dated 16 February 2012, 14

So, we saw that:

(A) Non appointing of block level AAs, manpower crunch with AAs show that inefficiency in implementation is also on account of failure on human resource allocation (Jann & Wegrich 2007:52) . These shortcomings lead to massive time overrun in achieving the objectives of intervention (MoUD 2011:1-4). Lack of ownership, engagement and sustained interest by key implementers in the chain results in failures of the whole implementation chain (WorldBank: 1996). Above details indicate that commitment and seriousness to enforce the Act is apparently low on scale and implementation structures need to be strengthened at all levels and especially at district level (George: undated). Concerns of Stakeholders which can make or break the project (Thaker 2009:1, UNDP 2011,Hut 2008) like AAs in particular are not addressed and the potential blockers (doctors, equipment suppliers) who have vested interests and see no benefit for them in scheme show that engagement is not guaranteed always and lack ownership, commitment (Griffiths et al 2008:21,36-37).

(B) Non planning the creation of infrastructure (implementation structures, processes, training of managers/implementers)in advance and adopting practices that are far from good results in poor efficiency of whole chain (MoUD 2011:3-6). Not taking the concerns of main implementers on-board mean that implementation structures, awareness level and the practices followed cannot mature and stabilise {Darman (1998) in Aggarwal and Somanathan (2005)}.

Details have shown that implementation aspect is still plagued by the very same problems it was experiencing 10 years ago from all three angles- ie. The structures (official machinery right from top to field level), the awareness & knowledge levels (especially at actual implementation level i.e AAs) and the on-ground real practices followed by various levels in the implementation chain. BBC News (23 May 2011) points to failure in implementation of Act. Associated Press of US (10 Sept 2013) brings out that U.S. congressional panel condemned Indian Government failure to enforce law against for systematic "extermination" of female foetuses. Law is acknowledged to be a powerful one, but appears to be sorely lacking in implementation (Joshi: 2014)

Case aligns with views of O'Toole 2000 in Jan & Wegrich (2007:50} that implementation is nothing but gaps between theory and practice (clearly visible here) and apprehensions shown by Hogwood & Gunn (1984) (ibid) that on ground administrative actions are neither perfect nor controllable as is assumed, appear to be true here too.

Findings have also proved the observations by Grindle and Thomas(1989:121-150) right that - (i) assuming that implementation is just no more than a mechanical process is a serious mistake which policy makers do at their own peril (ii) In reality, it is the implementation that decides if the reform exercise /intervention will bear success or not (iii) Divorce between decision making and implementation is one big cause of failed interventions in field as it during this phase that many unforeseen/unanticipated reactions and oppositions come.

I think at such a juncture, the buck stops as to if capacity exists to overcome these obstacles? Policy makers (CSB, MoH& FW) should be conscious that (a) instead of taking the intervention for granted and leaving everything to implementers yields results which are far from those intended (Grindle and Thomas 1989b: 239-241) and (b) instead of handling policy cycle in piece-meal manner, need is to involve right up to the implementation, so that whole chain yields effective and efficient results (Grindle and Thomas 1989:121-150).

5.2 Analysing the Monitoring Mechanism

Whole issue was investigated from secondary data sources and Primary data collected by visiting Central Government and State Government websites and also through RTI replies received from MoH& FW and various state Governments.

Following perspectives were analysed-

- Whether mandated structures (official machinery) and systems/processes are in place and functional,
- Type of practices followed by various levels in the chain.

5.2.1 Evidences from review **of secondary sources** in shown in **table below**.

5.2.2 Thereafter, next two tables show **primary data** collected on following key issues for a thorough analysis of monitoring mechanism.

(a) Health Secretary in his meetings with Principal Health Secretaries of states in 2011 had directed rigorous monitoring of implementation, commissioning online complaint booking web portal and comprehensive website displaying all relevant details by each state (PIB :20 Apr 2011). Press Information Bureau note (7 Aug 2013) mentions Central Government directions that each state will establish PNDT cell for which funds to the tune of Rs 898.19 lakhs and Rs 846.41 lakhs for year 2012-13 and 2013-14 were also earmarked. CSB in its 22nd meeting (13 Oct 2014) had directed that PNDT unit at Ministry be strengthened and for all above actions. MoH & FW's Annual report of 2013-14 (MOH & FW: 2014: 29-31) "states have been asked to take advantage of funding available under NRHM for strengthening infrastructure and augmentation of human resources required for effective implementation of the Act and Rs. 2935.79 lakh and Rs.1731.56 lakh have been allocated under NRHM during 2012-13 and 2013-14 respectively"

To test compliance on these directives, real-time primary data was collected by accessing few of state government (representing all regions of India) websites.

(b) The QPRs[47] of quarter ending 30 June 2015 were requested vide RTI from MoH & FW as well as state Governments to check the compliance on regular /periodic inspections of all PNDT Centres in a cycle of 90 days, Main problems AAs face and performance of SIMCs etc.

[47] MoH& FW reply dated 18 Sept 2015 to RTI Query(**Annex 5A**)

Evidences from Review of Secondary Sources on Monitoring Structures and Practices

CSB	*The top most body CSB is responsible for monitoring the Act at centre level but there is no agenda item on structured monitoring and no format, parameters & benchmarks (barring QPR).* *MoH & FW/CSB's instructions regarding constituting SIMC, DIMC, state PNDT cells, establishing web portal for online complaint booking and a comprehensive website displaying all relevant information regarding the Act, scrutinising/auditing Form F by DAAs have not found compliance in the field.*	*21st,22nd, 24th CSB meetings in 2013-2015, and RTI Reply dated 15 Sept 2015 by MoH & FW* *(22nd CSB meeting of 13 Oct 2014)*
Ministry's PNDT cell	*MoH&FW established PC and PNDT Cell in 2009 to strengthen the implementation and monitoring of the Act but the last published Annual report on PCPNDT is of 2006 and the staff strength is meagre.* *The Ministry's cell could provide QPRs of quarter ending 30 June 2015 (in Sept 2015) for only 4 states against 12 which were demanded. It also replied that it does not have data on how many states are using NGO grant in aid scheme and if any complaints are filed by AAs against USG machine suppliers for non-supply of quarterly sales data and how many complaints are investigated by AAs in 24 hours as per 2014 rules.* *It also replied that it does not have data on which states have commissioned PNDT cells, online complaint booking facility and on line Form F submission* *Ministry cell did not have data if the 2014 instructions on periodic inspections of all USG centres by AAs in every 90 days cycle is complied and if the registered complaints are investigated in 24 hours as per rule 18 A of 2014*[70] *and how many states have formed SIMCs and DIMCs.*	*(RTI reply dated 25 Aug 2015 by MoH&FW*[71]*).* *RTI Reply dated 18 Sept 2015 by MoH & FW* *RTI Reply dated , 3 Aug and 15 Sept 2015 by MoH & FW* *RTI Reply dated 3 Aug 2015 by MoH & FW*
NIMC	*NIMC, though 140+ member body, has limited scope of just 24 inspections a year in critically low CSR areas and is virtually power-less as it depends on AAs to take along for any raid, surprise inspections as the law rests power to search, inspect and seize with AAs only*	*RTI Reply dated 3 Aug 2015 by MoH & FW*
SSB	*Already detailed above that SSBs are not holding regular meetings.*	
State PNDT cells	*Not established in most of states.*	*Primary Data as shown in Table and various RTI replies*

[70] RTI reply dated 3 Aug 2015 by MoH& FW
[71] RTI reply dated 25 Aug 2015 by MoH& FW

SIMCs and DIMCs	*Already seen at Para 5.1.1 in chapter V that SIMCs are either not constituted or remain non-functional and defunct.* *In a meeting with Principal Secretaries (Health) of 18 poor CSR states in Apr 2011, the Union Health Secretary directed that SIMCs should be set up; online filing of complaints by informers, the online form F filing; that State/District/ Sub-District Appropriate Authorities are actively made functional*	*Primary Data as shown in Table* *(MoH &FW:2011).*
Block level DAAs and DIMCs	*Already seen at Para 5.1.1 in chapter V that Block level AAs not formed in 15 of 18 surveyed states. DIMCs are either not constituted or remain non-functional and defunct.* *Gaps & irregularity in submission of Quarterly Progress Reports by States/AAs.* *For 2010-14, Orissa claimed 1336 inspections and 39 violations, but were not able to provide district vise break up or clinic details to audit team* *Regional Review meetings held 2013-15 also show that states were not sending complete, error free and timely Quarterly reports to CSB* ***(Annexure 5B).***	*National level workshop (2012)* *C & AG Odisha Audit report (2014:61-73)*

State	Date of web site visit	PCPNDT cell constituted	Online complaint booking available	Is the website info Updated	CSB, SSB, SAA, DAA, DAC constitution available?	List of clinics available	Qtrly Progress report available ?
National[72]	16 July 2015.	Yes	No, A helpline 1800110500[73] Av. (The 2006 annual report on PCPNDT Act is the latest report found). Interactive India Map available, one can click each state, but does not show updated data. Shows no AA details for Bihar, Chhattisgarh, Nil data for Assam, Arunachal Pradesh etc[74].	No. Still Shows Ex- PM, Ex-President etc. One cannot see most basic information like -Act, Rules, Judgement, NIMC constitution, NGO scheme etc of without password access.	Could not find present CSB composition	No	No
Delhi[75]	16 July 2015	Not clear	No	No. Last updated in March 2014	Yes	Link exists but not opening any details.	Data Up to 2013-14 found, not streamlined.
Haryana[76]	16 July 2015	No	No. In 2013[77] Govt announcement said 102 can be used for complaints and will start online complaint booking. But not done till now.	2013 last updated	Yes	No	No

[72] www.pndt.gov.in

[73] MoH & FW Annual report 2013-14, though says that anonymous complaint can be booked on this number (MOH & FW: 2014: 29-31). My personal call to this number in July 2015 revealed that it Works only in office hours. Not a 24X7 service. It only gives details on Act, awareness and does not take complaint booking

[74] MoH & FW Annual report 2013-14, though says that website (by all states) displays all relevant information(MOH & FW: 2014: 29-31)

[75] http://delhi.gov.in/wps/portal

[76] http://haryanahealth.nic.in/menudesc.aspx?Page=2

[77] Times of India (3 Apr 2013) 'Dial 102 for Pre-Natal Diagnostic Act violations in Haryana'

Punjab[78]	*16 July 2015*	*Could not get any info*	*No*	*No*	*Yes*	*Yes*	*Yes*
Rajasthan[79]	*16 July 2015*	*One of the best site*	*Yes*[80]	*Yes*	*Yes*	*No*	*No*
MP[81]	*16 July 2015*		*Yes*[82]		*Yes*	*No*	*No*
Kerala[83]	*16 July 2015*	*Yes, in 2012*	*No*	*Monthly Health service magazine by state health deptt mentions nothing on PNDT activities*	*No*	*No*	*No*
Odisha[84]	*16 July 2015*	*Yes*	*Yes.* *A helpline no. also exists 1800-345-6746*	*Not*	*SSB of 2011*	*Yes*	*No, requires password to see*
Maharashtra[85]	*16 July 2015*		*Yes. TOLL FREE NUMBER ALSO AVAILABLE-18002334475*		*Yes*	*No*	*No*

[78] http://pbhealth.gov.in/pndt.html
[79] http://www.rajswasthya.nic.in/PCPNDT.htm
[80] http://www.hamaribeti.nic.in/Public/Agency.aspx?Type=0
[81] http://www.health.mp.gov.in/pndt.htm
[82] http://www.hamaribitiya.in/ContactAddressRep1.aspx
[83] http://dhs.kerala.gov.in/index.php/family-welfare
[84] http://www.pndtorissa.gov.in/
[85] http://www.amchimulgi.in/

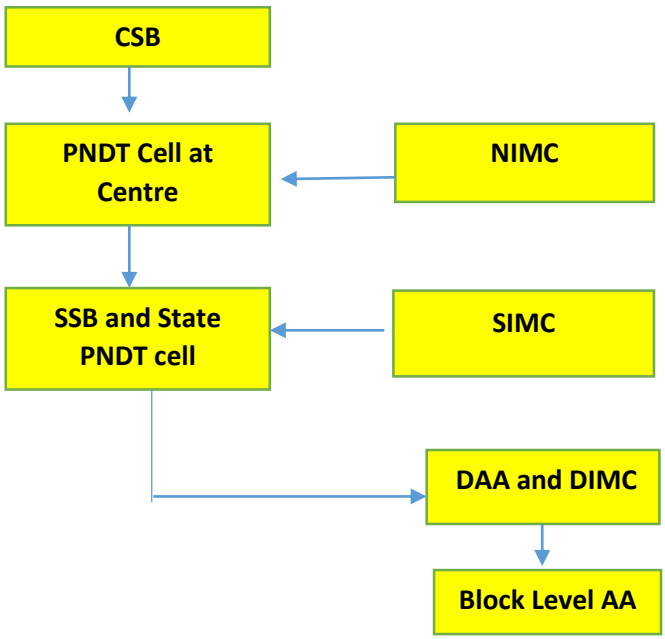
State	Quarter Ending	Total Registered PNDT Centres	Inspections During quarter	% of Centres Inspected	Other key information noted from QPR
Assam*	30 June 2015	782	48	6 %	• SSB, SAA & SAC has met only 3 times , 4 times and 8 times since inception of Act • During the qtr none had a meeting. • Assam has 27 districts, so average centres per district=29 • Of 782 centres, 367 did not submit Form F in the month.
Odisha*	30 June 2015	786	69	9 %	• SSB, SAA & SAC has met only 5 times , 7 times and 11 times since inception of Act • During the qtr SAC had one meeting. • Odisha has 30 districts, so average centres per district=26.
Rajasthan*	30 June 2015	2411	180	7 %	• SSB, SAA & SAC met 1 times , 2 times each during the qtr . • Rajasthan has 36 districts, so average centres per district=67 • Jaipur Urban and Jaipur Rural districts have 512 and 227 centres and inspected only 7 and 8 centres in the qtr respectively
Haryana*	30 June 2015	1675	1170	70 %	• SSB, SAA & SAC has met only 11 times , 111 times and 11 times since inception of Act • During the qtr SAA met 5 times. • Haryana has 21 districts, so average centres per district=80.
Delhi^	30 June 2015	1559	236	15 %	• Delhi has 11 districts, so average centres per district=142 • Only 9 and 20 inspections in 2013-14 and 14-15 by SIMC.
Delhi^	31 Mar 2015	1555	287	18 %	Shortage of manpower indicated as main bottleneck in RTI reply
Kerala^	30 June 2015	-	-	-	• Could not provide QPR of 30 June 2015, even in October 2015. • SIMCs and DIMCs established in May 2015.

					• *Sate Cell doesn't have data on USG machine suppliers sales data* • *As per RTI reply by district Medical officers, Alappuzha and Wayanad Districts inspected 15 % and 17 % of total PNDT centres under them in the 1st quarter of 2015-16*
Punjab^	*30 June 2015*	*1440*	*1027*	*71 %*	• *Only 2 or 3 meetings of SSB held in year.* • *SIMC formed in 2012. DIMCs is not formed.* • *SIMC carried 14 inspection sin 2013-14 and 24 in 2014-15* • *Shortage of manpower indicated as main bottleneck in RTI reply.* • *RTI reply says state has only 48 registered mobile USG machines.*
Odisha#					*RTI reply not received even after 55 days of query*
UP#					*RTI reply not received even after 55 days of query*
Bihar#					*RTI reply not received even after 55 days of query*
MP#					*RTI reply not received even after 55 days of query*

QPR Data collected through RTIs (RTI reply dated 18 Sept 2015 by MoH& FW (Annexure- 5G**), ^ Delhi State reply (7 Oct 2015) Kerala state reply (15 Oct 2015), Punjab State reply (21 Oct 2015)*

 # Reply not received till 2nd Nov 2015(RTI reply to be sent in 30 days period as per RTI 2005 Act)

Monitoring structures mandated under the Act (IMCs are beyond Act, but as per Ministry's Instruction) are shown below:



(a) From study of Act provisions (**chapter IV)**, the evidences collated in respect of implementation mechanism (already discussed) ,evidences tabulated on monitoring issues, and **Annexures 4A, 5A, 5B, 5C** we saw:

(i) Barring QPR, structured set of monitoring indicators/parameters is not spelt out
(ii) Limited scope and no statutory powers vested with NIMC/SIMCs,
(iii) Non-constitution and non-functional SIMCs/DIMCs,
(iv) Insufficient and infrequent inspections and monitoring by AAs,
(v) State PNDT cells are not fully functional in most of states

– All these mean that inspection and monitoring aspect suffers. This goes on to show that monitoring structures (institutional arrangements) are grossly lacking. Gathering and analysing data which could have guided the capacity development needs (World bank: 1996) is not possible here.

(b) We have already noted irregular, incomplete, non-documented (non-substantiating) information given by state units in quarterly reports to centre (tables above). For an efficient monitoring cum evaluation framework, timeliness, completeness and correctness of inputs are pre-requisites to point out shortfalls and investigate need for revised-allocation of resources including the human resources (Gage and Dunn 2009, Frankel and Gage 2007 in UN Women:undated). Evidently, it is impossible herein.

(a) In addition to above shortcomings:
  (i) Most states have not established updated and comprehensive websites on PNDT activities,
  (ii) No data exists in public domain on number and location of registered clinics, quarterly reports on inspections and action taken report etc.

(iii) Online Form-F submission, could have been quite useful in supervision and monitoring, is also not commissioned by majority of states.

(iv) Very basic complaint booking by a citizen is far from convenient; non-commissioning of online complaint booking and tracking facility and the helplines numbers by most states cripples the feedback and monitoring mechanism– and all this despite repeated instructions.

Non-establishing toll free number or help line and the complaint booking,absence of key monitoring tools renders monitoring and evaluation extremely difficult (World Bank: 1986). Non fixation of any time frame to complete these activities and non-supervising regular progress on these aspects, non-penalising the slack state units etc are failures on part of CSB (top most body responsible for monitoring the Act implementation).

Near absent monitoring mechanism makes evaluation automatically unachievable & turns whole policy cycle inefficient thus making it extremely difficult to assess the effectiveness, efficiency, impact and sustainability of Act (International Platform for Sports and Development, World bank 1986, Gage and Dunn 2009 and Frankel and Gage 2007 in UN Women:undated). Constant feedback, produced by a sound monitoring system aims to see what problems the programme is facing and also vital to assess efficiency of whole implementation system (Bamberger in World Bank: 1986) - is clearly missing. The strengths and weakness of the intervention noticed during the implementation are utilised for any design revision for making the programme more efficient (World bank: 1986), is out of question here.

Then Hyderabad Collector (DAA too) had said that it is the ignorance and non- monitoring at state level, which is causing poor performance (Tehelka: 4 Feb 2012).

In sum total, we have seen a near absent Monitoring (and feedback, evaluation) mechanism is hugely contributing to lacklustre performance of Act.

5.3 Analysing the Capacity Aspect

206 convictions and cancellations of license of 98 doctors in 19 years (MoH&FW: 2015 Minister's reply to parliament[48]) of Act being in operation conveys big message.

Elaborate evidences on capacity aspect (in its all five dimensions) from secondary data sources of about 10 years period is **Tabulated below**:

[48] **Annexure-5D**

Findings Based upon Review of Secondary sources on the Capacity Aspect

At Individual Level	CMOs (AAs) say they face difficulties working as AAs not only because they are already overloaded with routine office /administrative duties & have to monitor so many other government health programmes and also because they face shortage of manpower, space & legal assistance. 2008-09 study shows that AAs feel it is full time job and should be handled by dedicated task force and should be allowed to engage private lawyers. AAs don't get support from CM & HO and other wings to hold workshops; many did not have computers and internet & there was no mechanism to check mobile machines Capacity enhancement/training recommended at all levels including prosecutors and judiciary in the implementing chain for building strong cases against offenders.	Regional level workshop (MoH&FW 2006:9) (PHFI 2010:83) State level workshop (MoH&FW: 2009) National level workshop (2012) and (MoH & FW 2014:29-31)
At Organisation level	In 19th year of operation, Ministry told it is developing Standard Operating Procedure (SOP) for uniform & effective implementation of the Act at AAs level. Ministry again tells SOP shall be made and necessary guidelines shall be issued to the AAs.	CSB in its 22nd meeting (13 Oct 2014) 24th CSB meeting (24 June 2015)
At Task Network level (Inter-organisational/ Coordination level issues)	At 2009 National level workshop Director PNDT, MoH & FW said several states did not send the quarterly progress reports regularly or in time and expressed helplessness that no action could be taken against them other than sending reminders Non-compliance to SSB instruction by DAAs. MoH & FW/CSB's repeated instructions regarding constituting SIMC, DIMC, state PNDT cells, establishing web portal for complaint booking and a comprehensive website displaying all relevant information regarding the Act, auditing Form F by DAAs, mapping all USG clinics despite funds allocation have not found compliance in the field. Annual report 2013-14 says 14 states with the most skewed child sex ratio asked to ensure that SSBs send quarterly progress report as mandated under the Act 2008-09 study noted Nil interaction at AA level with important stakeholders like IMA, State Medical Council in Maharashtra, Tamil Nadu, and West Bengal NIMC assisted inspections are neither followed up nor complied with by state units Member CSB commented state bodies are generally in denial mode and lack ownership, and stressed on better coordination between the state and district level officials	(WPC & UNFPA 2009:21) C & AG Odisha Audit report (2014:61-73) 22nd CSB meeting: 13 Oct 2014) (MoH & FW 2014:29-31). (PHFI 2010:79). Seen at Implementation Findings (National level workshop: 2012).

	In a meeting with Principal Secretaries (Health) of 18 poor CSR states in Apr 2011, the Union Health Secretary emphasisied States should involve the district administration for the enforcement of the law Annual Report 2013-14 records Medical Council of India agreed to include a chapter on DCSR (& PNDT Act) in the MBBS curriculum for the sensitizations future doctors (this step happened only after 18 years of Act inception)	(MoH &FW: 2011) (MoH & FW 2014:29-31).
At Institutional and Contextual level -	Strong patriarchal society with 'son preference-daughter aversion' mind-set. Political bias in nominating non-official members in all bodies, Doctors -politicians in client-patrimony relationship, Corruption –where guilty are not brought to book, and equipment sellers and the medical community ignoring their social responsibility just to make fast bucks Weakness in policy making process	Already dealt in great details **at** chapter III.

Analysing the Capacity Aspect

Tabular details above and para 5.1 show:

1 **At Individual level (Human Resource Level)** –

(i) Inadequacy of technical (operational) & legal knowledge at AA level,
(ii) Low general awareness level at PP, Judiciary (corroborated by very low case registrations and conviction rates), ACs, NGOs/CSOs and even at the level of women themselves reveal serious capacity constraints.
(iii) Main implementation level ie AAs feel handicapped being overloaded with routine jobs, lack resources (manpower, space, computers). Most AAs feel handling PNDT Act related job as full time job which, as per them be handled by a task force.

Every Govt. source, though claims to have carried out training efforts (seminars/workshops), there exists a considerable scope to enhance awareness, knowledge and expertise, at individual level, which can go a long way to improve implementation aspect of Act. The content, usefulness and practicality of trainings imparted are also put to probing.

2. **At organisation level,** we have seen poor and inefficient practices are followed at almost all levels

(i) Act is in 19th year of operation, but SOP for AAs is yet not issued (24th CSB meeting);
(ii) No guidelines on monitoring the use of mobile machines and enforcing suppliers of machines to give sales data.
(iii) Then Director, PNDT Division, MoH&FW during National level Workshop in 2009 had informed that online Form F filing trainings would start soon(WPC & UNFPA 2009:21), which is yet to be completed in most states**.**

3. The details shows **weak inter-organisation network**.

There is no paucity of funds from centre, but we saw that centre is not enforcing the implementation. State units are not complying with instructions of central bodies (CSB, NIMC) like on commissioning state PNDT cells, online complaint booking mechanism, online Form F submission and scrutiny of form F, mapping of all machines etc.

(i) State units do not send the key quarterly progress report in time and in correctness to CSB **(Annex-5A).**
(ii) We also saw that there is minimal interaction of AA with IMA or state medical council.
(iii) Member CSB had commented that state bodies are generally in denial mode and also indicated lack of ownership by the state team and stressed on better coordination between the state and district level officials (National level workshop: 2012).
(iv) We noted that the NIMC assisted inspections are neither followed up nor complied with by state units.
(v) Moreover, one essential element of capacity framework i.e the legal and statutory framework is missing in NIMC/SIMCs constitution as these bodies are not vested with any statutory powers to conduct raid, inspections independently and have to depend on AAs to come along as law rests all power to search, seize with AAs only

4 At the overarching **institutional and context level** - weak political system and state capacity, feeble democracy dominated by informal institutions of corruption, client patrimony setup of society and the cultural & gender norms of society (**chapter III**) further affect the implementation adversely . Elite doctors having political links survive action by law (The Pioneer: 5 Apr 2015). UNFPA (2013b:74) says "The strong links between sections of a powerful medical fraternity (that make profits through use of sex-selection technologies) and political and administrative elements have also rendered the law ineffective.[49]"

The weaknesses in policy making process that concerns of key implementers are not discussed prior launch of Act (Agarwal and Somanathan 2005:6, Maheshwari 1987:346-351) is visible here too (AAs, PPs, equipment suppliers, doctors ignored). The key/secondary stakeholders (SSBs, ACs, AAs, PPs) are not owning up and show signs of disengaged participation. The process has not exploited the potential context setters cum secondary stakeholders (high power - less interest groups) like- politicians, celebrities, Religious leaders, NGOs/CBOs). Some important secondary stakeholders (like NIMC, SIMC, DIMC, SSB, and ACs) are not managed (scantly or ineffectively used) as per envisaged roles. The process completely ignores some of the potential stakeholders (like- the research institutes, cine and sports stars, girl achievers). We have seen lack of guided efforts to tackle potential blockers (doctors & various associations, equipment manufacturers/suppliers/importers) who have vested interest and see no tangible benefit for them in the Act .**Thus the view that overall system, environment or context all affect the capacity and its development {UNDP 1998 in in Lustheus et al (1999:3), Fukuda et al (2002) and World bank (2005: 7)}, is true here too.**

At all levels, lack of ability to perform their functions efficiently to solve the problem in a sustainable manner shows capacity constraints (UNDP 1997 in Lustheus et al 1999:3 and same is evident here. We have appreciated that capacity, which is combination of people, institutions and practices to achieve developmental goals (World Bank: 1998), is found lacking in all dimensions.

Thus the view that capacity can make or break any plan/program/intervention and second that, capacity in its all five dimensions is to be assessed, built and developed for success of such an intervention (Grindle and Hildebrand 1995:441,445-447) (UNDP 2009: 5-13, Fukuda et al 2002:9), has been held in the present findings as we saw sub-optimal capacity in each dimension at all levels, almost.

5.3.1 Capacity Augmentation efforts by Government:

a) Central Government acknowledged these capacity gaps and in 2011 issued guidelines[50] **(NGOs Grant in Aid Scheme**, MoHFW 2011:5-6) allowing engaging NGOs (in 18 states and districts with highly skewed sex ratio) to facilitate effective implementation of PC&PNDT Act (at AAs level) aiming enhanced capacity in both service delivery and awareness raising by ways like –

i. Information collection on female infanticide/ feticide cases, catching wrongdoers using decoy customers, making complaints against violators and following it up

[49] Draft Report of the Sectoral Innovation Council, Constituted by the Ministry of Women & Child Development vide its Notification No. 6-20/2011-CP, dated 16 February 2012, 14

[50] NGOs Grant in Aid Scheme launched by MoH&FW in 2011-http://www.pbnrhm.org/docs/file168.pdf

ii. Assist in Medical audit of PNDT records, especially Form-F submitted by clinics and monitoring the renewal status of clinics
iii. Help AAs in building a credible case against violations and also Follow-up ongoing court cases
iv. Breaking the chain of referrals (doctors, field workers, dais, etc) doing sex selective abortions
v. Conducting awareness-cum-training for implementers, medical fraternity, public prosecutors, Judiciary in collaboration with National/State/District Legal Service Authority.

Monitoring again was found lacking when MoH & FW in its RTI reply dated 18 Sept 2015(**Annex-5B)** replied that it does not have details regarding which states are utilising this scheme. Launched in 2011, in my view, impact is not visible looking at stagnated SRB and poor utilisation of funds for past 5 years (**chapter IV**).

b) Further,with **Beti Bachao Beti Padao (BBBP)(Save Girl Child, Educate Girl Child)** scheme[51] launched in 2015, a positive step has been taken to Strengthen District PC & PNDT cells and augment AAs level capacity with specific fund approvals conveyed to 100 critically low CSR districts - by recruitment of at least 05 human resources (Cell administrator, Legal Consultant, Inspector (Retd.) for monitoring, and Data Entry Operators-2) with office equipment and space (MWCD 2014,2015: 8-15). BBBP (this being a recent scheme, results yet to be seen) lays specific directions (ibid) to ensure that:

(a) Statutory Institutional bodies (DAAs and DACs) and DIMC are set up in these districts
(b) To start anonymous online complaint portal
(c) To Map all available ultra-sonography machines in districts and update data after every 03 month
(d) Train DAAs & other functionaries under PC& PNDT Act &
(e) Undertake training of Frontline workers such as AWWs[52]/ ASHAs to enhance their understanding of Act for better awareness among target population.

These steps, are in line with various theories that capacity development is not a one-off action, but a continuous process of **design-application-learn-adjustments** (UNDP 2008:405). These steps, in my opinion are directed at enhancing the capacity of AAs that had been found lacking and adversely affecting smooth implementation of Act. With these in place, hopefully the things should take better shape, so to say, at least in chronic states/districts. However, caution remains that since capacity resides at level of individuals, organisations and institutions (UNDP 2008:5), the envisaged capacity development change process would also be internal to people, organisations & has to be owned by them only, otherwise it never happens. If and how CD happens is dependant mostly on demand side as well as external contextual factors(ADB 2008:6-7) and hence proper plans, strategies have to be in place to extract most benefit of such

[51] Beti Bachao Beti Padao (BBBP) scheme ,with MWCD being nodal Ministry and MoH&FW and MHRD the other 2 participating Ministries launched in 2015-
http://wcd.nic.in/BBBPscheme/launch/workshop/Guidelines_BBBP_23January2015.pdf

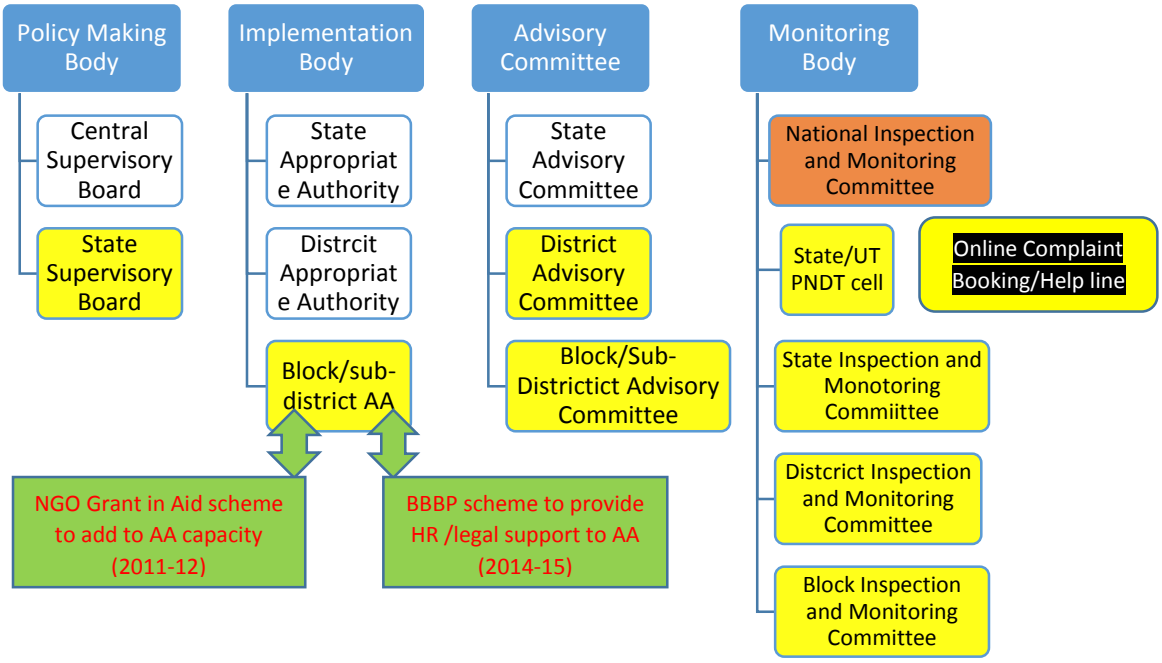
[52] Anganwadi (means courtyard) workers under the ICDS (integrated child development services) is an MWCD initiative since 1975. As on March 2013, there were 1,330,000 Anganwadi centres providing basic health care in villages including immunisation, health check-up, nutrition education and supplementation ,contraceptive counselling and supply , Antenatal care of expectant mothers , Postnatal care of nursing mothers as well as pre-school activities. (https://en.wikipedia.org/wiki/Anganwadi)

capacity enhancement efforts. Fact that capacity development has key ingredient of mind-sets and attitude change (UNDP 2009:5) would mean full engagement of implementers, policy makers, all stakeholders including society.

5.4 Summary Outcome on Implementation, Monitoring and Capacity aspects:

From detailed analysis of three vital aspects i.e the implementation and monitoring mechanism, the capacity aspect, we can now appreciate the following graphic:

Structures in Place (white boxes), Missing or non-functional structures (Yellow boxes), Important structures with limited mandate (Brown box). Some good news on capacity augmentation (Green boxes)



5.5 Results Analysis (Output, Outcome Analysis)

Impact achieved, so far, was discussed **in Chapter IV.**

It is now possible to appreciate the achieved output and outcomes of Act (**see Table below**)

Envisaged Output	Results
Establishing implementation structures in Place, (mobilising resources-human, financial etc)	• Missing links found in implementation structures. • The SSB/ACs/IMCs are not timely constituted or not constituted as mandated. • Even if constituted, detailed findings at **Para 5.1** have shown that they are non-functional/defunct in many states. •
Only Registered Clinics will operate. (No un-registered clinics to operate)	• The secondary data analysis shows a big gap in sold machines and registered machines more so when sales data is not audited by AAs.
Awareness and capacity building at all levels	• The Main implementation level (AAs) suffer mainly from technical and legal aspect of the Act and are handicapped in search, seizure, raid operations, evidence collection, case preparation etc. • The very poor conviction rate speaks it all. 23 states/UTs had booked NIL convictions till 2014 and 13 States had not filed even single case in court • PPs, Judiciary, AC members and even women lack information on their rights/roles and responsibilities under the Act. • AAs and PPs have concerns and think that this full time job be handled by independent cells. They lack HR resources.
Monitoring structures to be established. (Other factors in building a robust monitoring mechanism are in next serials)	• NIMC constituted in 2001. SIMCs and DIMCs were also to be established. NIMC remained dormant till 2010. • Too little mandate of NIMC/SIMCs and without statutory powers is hindering factor. • Non constitution and Non-functional SIMCs/DIMCs adding to inefficiency.
No sale of Ultrasound machines to unregistered clinics. (Companies/suppliers to regularly send sales data to AAs)	• Companies do not send regular sales data to authorities. No mechanism in place to reign in the suppliers/manufacturers. Amended Rule 18-A (2003) not practised. • No mechanism to check sale/operation of mobile ultrasound machines.
Proper Record maintenance by Centres (Most important –Form F) - AAs to audit form Fs regularly	• Gaps found on record maintenance (Form F,G etc by AAs and centres), submission of Form F by centres to AAs. • Form F Audit by AAs also too little.

	• Online Form F submission still not in place in majority of states.
Easy Complaint booking and tracking Process be there. (Helpline and Online web based Complaint booking)	Majority of states have not commissioned online complaint booking.
Establishing State PNDT cells for effective monitoring.	Majority of states have not commissioned PNDT cells.
Comprehensive Information available in Public domain (comprehensive website displaying all information)	Majority of states have not commissioned.
Regular submission of QPRs by states to Centre	• Secondary data analysis shows that many states/UTs are not sending correct reports in time. • Findings have shown that even MoH & FW not enforcing discipline • The reports sent are irregular, not substantiated with details and error prone
Coordinated effort of all agencies	• CSB, SSB and NIMC have found their directions not being implemented in field. • AAs and SSB coordination with Centre still has gaps.
Implementing structures adopt practices as envisaged	Practices adopted are far from those envisaged

Envisaged Outcome	**Results**
Maturation/ stabilisation of the Implementing Structures, processes	• Key Implementing Structures at many levels are non-functional (NIMC, SSBs, SIMCs, ACs, DIMCs etc.). • Poor Fund utilisation (averaged less than 50 % for last 6 years) indicates serious capacity constraints.
Effective Monitoring Mechanism in place.	• The online complaint booking process, comprehensive websites by all states, establishing state PNDT cells, online Form F submission, regular inspections of all centres in 90 days period still not achieved by majority of states. • CSB meetings do not have a structured monitoring mechanism. • The directions issued by CSB, NIMCs are not followed up. • MoH&FW does not watch performance/compliance on issued instructions.
Regular inspection of all USG /PNDT centres every 90 days (Feb 2014 Amendment)	• Too little achievement on this key action. • Barring Haryana, Punjab, for qtr ending 30 June 2015, in most of states mere 10 % of Clinics inspected on average in 90 days cycle

Complaint Investigation in 24 hours (Feb 2014 Amendment)	No data given vide RTI reply
Self- discipline by machine suppliers and Medical Fraternity	• Machine Suppliers still not submit the regular sales data to AAs. There uis no mechanism to rein in defaulting agencies for non-supply of data • Gaps in record keeping at centres, AAs there.
Increased awareness about issue and Act at all levels	The main implementation level (AAs) suffers from adequate technical and legal knowledge specially related to search and seizure, evidence collection, case preparation,
Improved conviction rate in court cases	As per Union Health Minister's reply to Parliament in 2015, till Dec 2014 ie. in 19 years span, total 206 convictions were secured under the act (of which till 2010, mere 37 were booked[53]) and 23 states/UTs had booked NIL convictions[54] (MoH&FW:2015). This comes to a just 10 % conviction rate (as 2021 cases were filed in courts). He also informed Parliament (ibid) that total 50743 PNDT centres were registered in the country till Dec 2014, 1716 machines were sealed and licenses of 98 doctors have been cancelled for violations under the Act.
Improved Sex Ratio at Birth	SRB data shows upward trend line (shown in chart below).
Arresting Decline in Child Sex Ratio	The decline in National CSR from 1991 to 2001 was by 18 points. During 2001-2011, it was by 13 points.
	Out of total 35 states/UTs, in 27 states/UTs CSR has declined in the period 2001-11 but in 10 states/UTs out of these, the decline is retarded. In 8 states, the decline is reversed (**Table at Chapter III**).
	The number of districts in lower CSR category (ie. CSR 800-849 & 850-899) has doubled during 2001-2011.

Going back to **chapter III**, above analysis , in my view coincides with identified weakness in Indian Policy Arena as pointed out by Agarwal and Somanathan (2005:3) that "India has been an under-performer mainly due to adopting wrong public policies and poorly implementing the right public policies", and this case clearly falling in latter category.

5.6 Unbundling the Determinants-An Unholy Nexus of 'Tradition' and 'Technology'?

Details above have shown that it is a case of '*Effective Policy: Ineffective Implementation'* as whole process suffers from poor implementation, near absent monitoring, disengaged participation, further exacerbated by glaring capacity gaps in all dimensions. Analysis would

remain incomplete if role/contribution of very determinants of the problem (DCSR) in whatever results PC & PNDT Act has delivered is not deliberated.

Determinants of child sex ratio (elaborated at **Chapter- III**) and diagram at **Para 3.4** show that technology is just one part of the problem .There are other social/cultural(& gender) norms and contextual factors that shape mind-set of society in patriarchal structure wherein the age old 'son preference –daughter aversion' tradition/culture is deeply rooted. All these factors play their role in dictating CSR. Onset of technology just provided an accurate scientific solution to society in meeting their acute desire of a son through misuse of PNDT (mainly the USG) technology. Enough studies show that bans would not work (even if a sound legal system exists), if they are too idealistic and away from ground reality with population finding ways to disobey it (Sharma et al 2007:856). Bans may lead to problems like sending the practice underground thus making it more difficult to monitor; doctors paying regular bribes to policemen, officials and judiciary{Kishwar (1993:113-115, 1995:3), (OHCHR, UNFPA, UNICEF, UN Women and WHO 2011:6)}.Unless the root cause and not symptoms are attended, laws alone can't do much (Oomman and Ganatra 2002:187) , Arnold et al (2001:783). Moreover, with abortions having being legalised in India under MTP Act 1971 (even covering conditions like failed contraceptive) proving that an abortion was done on sex selection grounds is very difficult (OHCHR, UNFPA, UNICEF, UN Women and WHO 2011:1).

Argument:

With above, it is argued that when technology is not the sole cause of Declining Child Sex Ratio, restricting the use of technology to determine foetus' sex, can only be a short term solution (also due to fast changing technologies) and will not be successful in isolation. Rather, the most effective strategies have to be "multifaceted and take into account the specific drivers and expressions of son preference" (Gilles and Feldman 2012:3). Majority of these drivers being centuries old, deep rooted social and cultural (& gender) norms, this legislation alone does not alter the 'son-preference: daughter aversion' culture and cannot counter all social and economic factors that prize a man and devalue a woman (Kishwar: 1995). The Act does not seem to align or be in concert with dominating (gender) norms/values of Indian society. The PC & PNDT Act's objective to regulate the technology use is only one part of the solution and one could say that PC & PNDT Act alone is not the 'magic-pill' which will curb this evil social practice because society support, committed and unified stakeholders(women too) are must to gain maximum from intervention. Thus, Measures to address all other factors (which devalue/discriminate a woman) are of equal and utmost importance to address the problem of DCSR {(OHCHR, UNFPA, UNICEF, UN Women and WHO 2011-2), (Nandi and Deolalikar 2013:7, 23-24), (George and Dahiya 1998:2191-98), UNFPA (undated)}.

5.7 Concluding Remarks

(i) So, '**Do we require the Act at all**?' While I fully agree that root cause of problem (i.e mind-set) needs to be attacked, I firmly believe that in strong patriarchal Indian society, such value change will take decades. One can't remain a silent spectator to this social crime and it's during this interval that stringently enforced prohibitive laws against misuse of technology need to be supported (Oomman and Ganatra 2002:187). There is no need to trash PNDT law, "the fault lies in non-implementation" (The Hindu, 4 Feb 2012). Going beyond, not only we need to strengthen the current legal regime to prevent misuse of medical technology

(PC&PNDT Act) but also counter emerging new technologies (including pre-conception genetic manipulation) which will render this single legal remedy in the coming decade obsolete and redundant {(Naqvi and Shiva Kumar (2012 :1-6)[53] }.

(ii) I will close by agreeing with Nandi and Deolalikar, who go against general perception that Act has failed completely and show (2013:7,23-24) from their study of more than 500,000 Indian villages and 1500 towns longitudinal (segregated) (unlike most of studies which take highly aggregated state or district level data) data from 1991 and 2001 census show a strikingly different outcome that PNDT Act has made a significantly positive impact of an increase about 14-26 points in the CSR and they go on to show that another 106000 girl children would have been missing if Act was not in place. As per Nandi and Deolalikar (ibid) Act has arrested further worsening of CSR in India.

Falling back on data we saw that in most of states, situation has remained static or become worse in last decade (Census of India 2001, 2011). Out of 35 states/UTs, in 8 CSR has turned positive, but other 27 show a decline. A closer look at these 27 states/UT show that in 10 states, CSR decline has slowed down (**Annex -4C**). Overall too, decadal CSR decline has slowed down from 18 points in 2001 to 13 points in 2011. In states, such as Punjab, Haryana there has been substantial CSR improvement and Maharashtra, Rajasthan have done well in implementing the Act.

(iii) Exhaustive analysis shows that it is a case of 'double whammy' where ineffective implementation, near absent monitoring and visible capacity gaps in all dimensions further exacerbated by overall socio-cultural(&gender) norms have rendered in limited/partial success of the intervention.

To achieve better performance, A Lot Needs to be Done and Done Quickly.

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[53] National Advisory Council's Working Group on Gender and Sex Ratio

Chapter VI

Conclusion

6.0 Finding Answers to Research Sub-Questions:

Trends, determinants and repercussions of declining child sex ratio were discussed at **Chapter-III**. Introduction and fast spread of ultrasound technology since 1980s provided scientific solution to son obsessed Indian society to choose sex of offspring & led to steep fall in CSR. Census (2001, 2011) show that DCSR menace has extended to erstwhile healthy CSR states (Southern and North-Eastern states) though North-Western regions continue to show stronger son-preference. Decline is now more pronounced in rural regions, a trend which was more urban centric initially. Deep rooted, age old 'son preference – daughter aversion' culture in patriarchal set up has been the engine behind persistent decline. Small family trend, rising economic pressure have added to problem and even educated and well-offs are following this evil practice.

Chapter-IV discussed objectives, provisions of PC & PNDT Act 1994 which targets pre-birth scenario (foeticide) to address the problem. Comprehensive amendment of Act in 2003, primarily on account of poor implementation itself acknowledged Policy failure. Fund allocation/utilisation reveals that funding is not an issue and on contrary, funds going lapsed indicate poor capacity of system. Though a gentle upward slope in SRB is noticed (reached 908 in 2012), it is still much lower than global average of 952 and stagnated for past 5-6 years. However, CSR decline still continues.

Analysis of Implementation and Monitoring mechanism, Capacity aspect of Act at **Chapter-V** showed:

1. Act implementation is suffering from all three angles- ie.

    a) At many levels, structures are either missing or non-functional (SSBs, SAA, Advisory committees, IMCs). Few key structures have limited scope and are devoid of statutory powers (NIMC, SIMC, DIMC),
    b) Sub-optimal Awareness & knowledge at most of levels (including AAs, ACs, PPs, Judiciary and even women) and especially the technical and legal knowledge at AA level is lacking ,and
    c) There is big gap between 'on-ground' v/s 'on paper' practices followed by various levels in implementation chain.

2. A near absent monitoring and feedback mechanism -

    a) A structured set of indicators is neither spelt out nor has CSB established any mechanism to oversee vital parameters in a regular and structured manner,
    b) IMCs at National, state and district levels have limited scope and no statutory powers vested with them,
    c) Insufficient and infrequent inspections and monitoring by AAs,

d) Irregular, incomplete, non-documented (non-substantiating) and incorrect information given by state units in quarterly reports to centre,
e) Non- establishing updated and comprehensive web portals,
f) Non- commissioning of online complaint booking –

Paper has shown that monitoring structures and processes (institutional arrangements) are weak thereby making it impossible to gather and analyse data which itself could have guided the capacity development needs, which are definitely there or could have been fed into design review for better and more effective implementation.

3. Capacity gaps are visible in all 5 dimensions

a) At individual level- inadequacy of technical (operational) & legal knowledge at AA level, general awareness level at PP, Judiciary (corroborated by very low case registrations and conviction rates),ACs, NGOs/CSOs and even at level of women themselves reveal serious capacity constraints.
b) Main implementation level ie AAs feel handicapped being overloaded with routine jobs, lack resources (manpower, space and computers). Studies have shown AAs feel handling PNDT Activities as a full time job which, as per them be handled by a task force. RTI replies from states indicate manpower shortage as one of main bottlenecks in smooth implementation.
c) At organisation level, we have seen poor and inefficient practices are followed at almost all levels. No structured monitoring by CSB/SSB, no SOP for AAs, no mechanism for checking mobile/portable machines, no mechanism to rein in defaulting suppliers of USG machines who do not give sales data to AAs etc are other key shortcomings.
d) At inter-organisation (task network) network- State units are not complying with instructions of central bodies (CSB, NIMC). These do not send correct & timely quarterly progress report to CSB. NIMC assisted inspections are neither followed up nor complied with by state units. MCI agreeing to include chapter on Act in MBBS syllabus in 19th year of Act is also an example of poor inter-organisational set-up.
e) At overarching institutional and context level- the weak political system, weak policy making process ,feeble democracy infested with informal institutions of corruption, client-patrimony setup along with strongly embedded patriarchal mind-set and socio-cultural (& gender) norms of society contribute immensely to limited success achieved by Act,

6.1 Finding Answer to Main Research Question

I now take up the **main research Question** i.e To What Extent has Central Government's PC & PNDT Act (1994) been (in)effective in Addressing the Persistent Declining Child Sex - Ratio ?.This part will also address the questions 'Has the Act been effective to arrest DCSR? And 'which issues are solved and what are left unresolved?' For finding answers to these, we need to recall Act's Impact (**Para 4.6)** and Act's outputs and outcomes (**Para 5.5)** viz a viz objectives of Act.

We saw that CSR decline has been persistent (Census of India: 1991, 2001 and 2011). Majority of studies cite that Act has failed to achieve its goal of arresting DCSR{ (Luthra 1994, Jha et al 2006, Hatti and Sekhar 2004, Arnold at al 2002, Visaria 2007 in Nandi and Deolalikar (2013:7)}, (CGHR:2011). Supreme Court too admonished Government on 4 Mar 2013, 22 Sept 2014 on sloppy implementation (The DailyMail UK: 7 Apr 2014, The Lex-Warrier: 22 Sep 2014). Union Minister, WCD, Govt of India and Maharashtra WCD minister say that 20 year old PNDT Act is a failure & not been able to save any more lives. Both further recommend to "make sex determination tests legal to let parents know whether unborn child is a girl or boy, and then lawmakers should start tracking the development of child from thereon" (The Pioneer:5 Apr 2015). The mentioned outputs, outcomes at **chapter V** also lead to straight answer that Act has been a failed attempt to address DCSR.

But, I argue that we need to delve deeper to fetch a correct picture.

(a) First, we recall that CSR is sum total of Sex Ratio at Birth, differential mortality between boys and girls and omissions/misreporting of child age/sex. A clinical look at the objectives of the Act (which are quite focused), shows that it specifically aims to regulate the use of technology and prohibit its misuse for sex determination which leads to female foeticide. 'Sex Ratio at Birth', is a more accurate and refined indicator of extent of prenatal sex selection (UNFPA 2010: 2). As such, Act primarily attacks pre-birth scenario (foeticide) and aims to improve Sex Ratio at Birth, -the main component of Child Sex Ratio. Therefore, we need to be clear that the post birth scenario of CSR (which includes infanticide, higher girls' mortality in 0-6 year age group) and omissions/misreporting of age/sex are not in ambit of Act.

(b) Sex Ratio at Birth during 2003-2013 shows a gentle positive gradient (though stagnated for past 5-6 years and still much less than globally accepted SRB of 952) ,but pace of rise is not attractive.

(c) Analysis at **Chapter V** show that Act performance has been limited/partial in improving the SRB. I think reasons are twofold:

1 This paper has shown that much better results could have been achieved if
- i. Act did not suffer from lacklustre implementation at almost all levels;
- ii. A sound monitoring and feedback system was established;&
- iii. Capacity constraints seen in all five dimensions were properly addressed

On all these aspects a lot, needs to done, and done soon

2 The paper has also shown that it is case of 'unholy nexus of tradition and technology' . Technology is just one part of problem and there are other social/cultural (& gender) norms and contextual factors that shape age old 'son preference –daughter aversion' culture in country. Onset of technology just provided an accurate scientific solution to the society in meeting their acute desire of a son through misuse of PNDT (mainly USG) technology. So, when technology is not the sole cause of Declining Child Sex Ratio, restricting the use of technology to determine foetus' sex, can only be a short term solution (that too when technologies change rapidly) and will not be successful in isolation. Multifaceted strategies targeting specific drivers and expressions of son preference would see better results. Since Mind-set change takes decades it's during this interval that stringently enforced prohibitive

laws against misuse of technology need to be supported and we need to Strengthen the current legal regime to prevent misuse of medical technology.

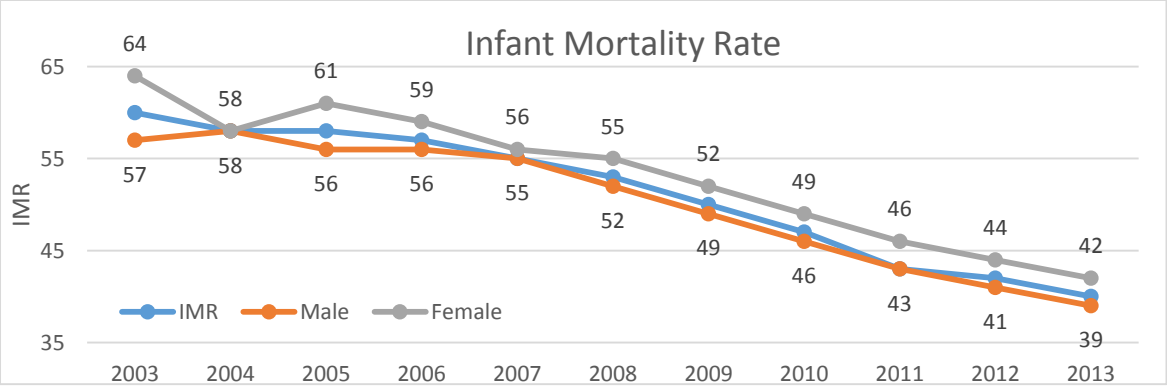
6.2 'An Unexplained Puzzle'- Need to Dis-entangle/De-bundle the Components of DCSR-

By nature (biologically), Girls face disadvantage of numbers at the time of birth but have better survival rate up to age 5 due to lesser vulnerability to perinatal conditions during which male mortality tends to be higher {Waldron 1998 and UN 2011 in Rai et al (2013:3)}. But, India presents a special case which goes against this natural norm as females here are at disadvantage at both counts (Rai et al 2013:3, Joshi: 2014) .This distortion is due to non-biological reasons (sex selection at birth and discrimination/ disadvantage to girls in medical, health facilitates etc) and India is quoted as the worst example of such twin practices (Alkema.et al 2014:521).

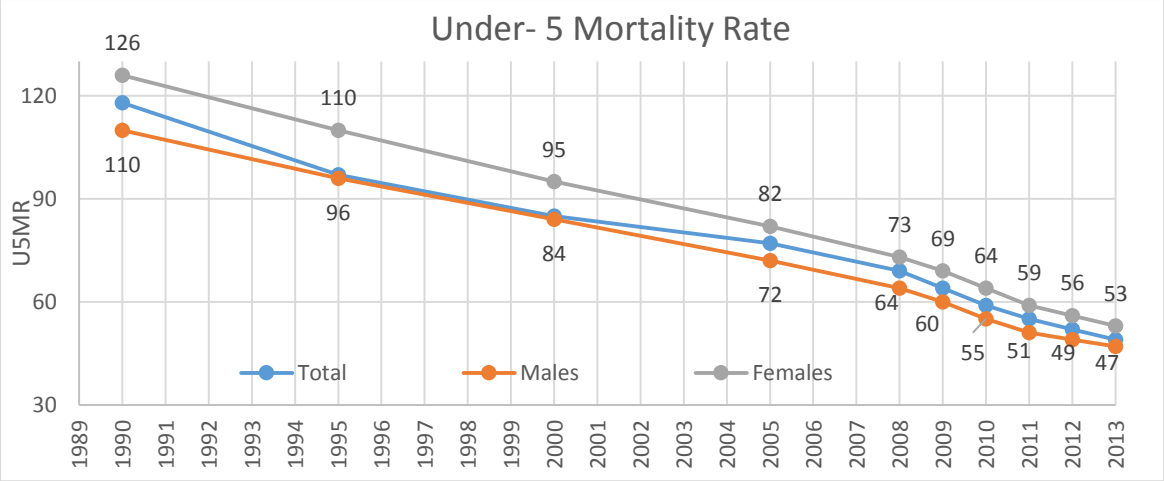
In their study of 195 countries from 1990 till 2012, authors (ibid) found that in India, the rates of female infant mortality (IMR; 0–1 year) {except Neo natal stage up to 1 month when biological factors are more dominant and male mortality is higher (Rai et al 2013:3)}, female child mortality (CMR; 1–4 years), and female under-5 mortality (U5MR) are worst. In India in 2012, in U5 scenario 160000 excess girls died (Alkema et al 2014: 522-528). UNICEF data for 2012, lancet Medical Journal (Krishnan 2013), Joshi (2014) and 3rd National Family Health Survey of 2005-06 (MoH & FW 2009:16) also show higher female child mortality

In skewed Child sex ratio, High female child mortality is accounted for by Rai et al (2013:2,6) & they show that while in 2001 the contribution of Sex Ratio at Birth was 40 % and that of high female child mortality was 60 %, the situation reversed in 2011 when SRB contribution was two-thirds and that of female child mortality of one third.

Continuing from Para 6.1(a) above, When Government data shows constant female-male infant mortality differential {constantly maintaining a difference of 3 points (IMR graph below)} and reducing female- male child mortality gap (U5MR graph below), reasons of declining Child Sex Ratio despite upward slope of SRB need to be further probed. Is it due to girl discriminatory practices (under reporting of female infanticide[54] and U5MR) or non-reporting of female births (omissions) or age/sex misreporting - all these need to be probed further to find answer to the puzzle.



[54] While low SRB proves female foeticide, registered Infanticide cases in 2011, 2012, 2013 were 63, 81 & 82 (for both sex) (NCRB 2014:96)



(Source-http://www.censusindia.gov.in/vital_statistics/SRS_Bulletins/Bulletins.html) and http://www.censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR_release_070711.pdf

6.3 Overall Conclusion

In sum total, paper has shown that:

(a) It is a case of 'double whammy' where ineffective implementation, near absent monitoring and visible capacity gaps in all dimensions further exacerbated by overall socio-cultural (& gender) norms have ensured that PC & PNDT Act 1994 is partially successful in meeting its objective of improving Sex Ratio at Birth. Much better results could be achieved if implementation aspect was strengthened/enforced, a sound monitoring mechanism was put in place and the capacity constraints noticed in all five dimensions were properly addressed.

(b) Imbalance in child sex ratio cannot be entirely attributed to practice of pre-natal sex-selection. Technology being not the sole cause of Declining Child Sex Ratio and use of fast developing technologies can't be restricted, the issue can only be addressed by tackling multi-faceted specific determinants and expressions of 'son preference-daughter aversion culture' in Indian patriarchal set-up. Since centuries old mind-set change means long gestation period, need during this interval is to strictly and effectively enforce the prohibitive PC & PNDT Act 1994.

(c) More research is needed to investigate that despite Sex Ratio at Birth showing a gentle upward slope and with female-male infant and child mortality differential maintained/declined, why Child Sex Ratio is not showing upward trend.

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Annexure 3A

Refers Para 3.2.4

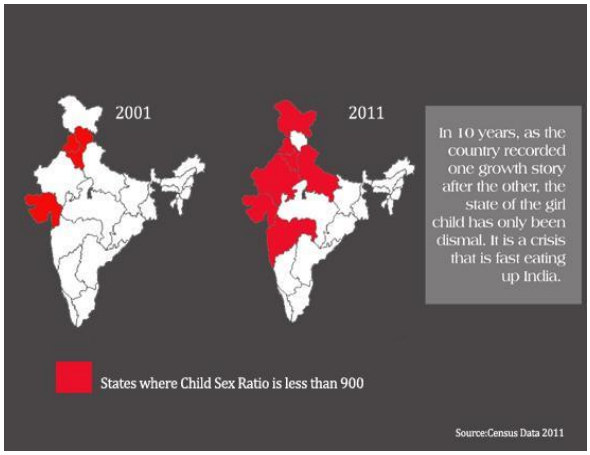
Trends of Declining Child Sex Ratio in India

Below, I discuss the key trends of DCSR in Indian Context.

(a) A PAN-India Syndrome?-

Few observations noticed in Census 2011 are quite frustrating-

(a) Census 2011 data shows that barring Himachal Pradesh, there is no other Northern state where CSR is better than 900
(b) There is clear difference between upper North half and lower south half (better CSR)
(c) North Eastern states boast of highest CSR and
(d) Out of total 35 states/UTs , only 8 states/UTs show improved CSR in the period 2001-11 . Major concern emerging from Census 2011 being that DCSR pattern is now spread to even those states which were known to keep a healthier CSR*(Graphic* source: www.actionaidusa.org).



Ranges of CSR	Census Year	
	2001	2011
Total Districts	640	640
<800	18	6
800-849	36	52
850-899	71	135
900-949	224	266
950-999	279	178
1000+	12	3

The table on right (Census of India: 2001,2011) shows the decadal change in CSR pattern and one can notice that overall situation has worsened as the number of districts in lower CSR category (ie. CSR 800-849 & 850-899) has doubled. Kuzhiparambil and Rajani (2012:265) from their longitudinal analysis of Census 1991, 2001, 2011 data show that bad CSR epicentres are expanding due to the shockwaves emanating from these and affecting neighbouring regions but good CSR epicentres have no such impact and, on the contrary, are shrinking.

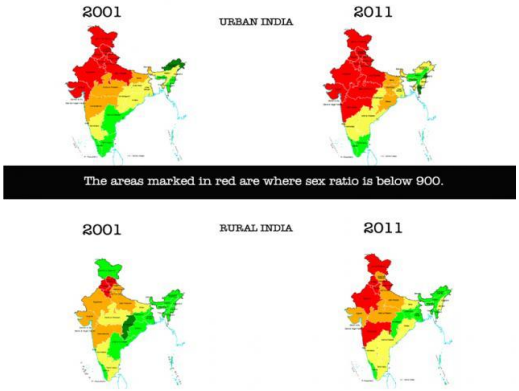
(b) An Urban or a Rural phenomenon or Both (?) -A comparison:

Below, the graphic on right shows that the rural and urban populations, both show DCSR, but the noticeable point (table below) is that the while the decline in cities is somewhat slowed down, the decline in Rural India is steeper (> 3 times that in Urban India) during 2001-2011

The plausible reason being that initially USG technology was costly and city centric, the earlier trends indicated urban population more engaged in Sex determination and SSAs. Lately, not only the technology became affordable at as little as Rs 500 i.e less than USD 10, but with its

penetration to rural belts (where mobile ultrasound machines are commonly is use) the trend of DCSR has infested rural belts too (Census of India: 2011) resulting that the practice of sex determination/selection and SSA has become universal phenomena across whole India

Census	Total	Rural	Urban
1991	945	948	935
2001	927	933	906
2011	914	919	902
change	-13	-14	- 4



(Graphic Source: www.actionaid.org)

(c) Does North- South divide exist? (More appropriately North-West vs Rest of India)-

It has been a matter of debate for long that there is a clear North-south divide in the CSR pattern across India. Nayak (2014:51-52) brings out that the previously held notion that the son preference is higher in North India got even stronger in 2011 census when it is seen that barring Himachal Pradesh, all other states in North have CSR below 900. But the pattern is becoming more visible in other parts of country and is real cause of worry (Rustagi 2006:12-13).

States	Index of Son Preference*	Rank
Andhra Pradesh	13.8	11
Bihar	24.5	4
Gujarat	23	6
Haryana	14.3	10
Karnataka	20	8
Kerala	11.7	12
Madhya Pradesh	27.1	2
Maharashtra	18	9
Orissa	23.4	5
Punjab	20.3	7
Rajasthan	25	3
Tamilnadu	9.2	13
Uttar Pradesh	21.6	1
West Bengal	14.3	10
All India	20	

*Index of Son preference =100 (E/C),

Where, E =the excess number of sons over daughters considered ideal. , C = the ideal family size

Bhattacharya and Saxena's econometric study (2015:13), John (2011:11) show similar findings that South and East India maintained a more balanced sex ratio) as these parts do not follow the son preference that maniacally as in North/West India. Singariya (2012:10) quotes studies by Dyson and Moore (1983), Aggarwal (1986) and Sen (2003) about North-South dichotomy that North and western parts have more rigid seclusion for women, limited economic participation, exorbitant dowry practice whereas South and East India has comparatively liberal and more autonomous setup favouring women, with more active participation in education and economic activities and thus enjoys consistent better sex ratio (though it is also falling). Singarya (2013:120) attributes CSR in north with low level of literacy and high agrarian society; in the south India with higher levels of literacy and better medical facilities.

Nayak (ibid) has brought out an interesting study by presenting index of son preference for major Indian states where one can notice a clear north (J

& K, Punjab, Haryana, Delhi, UP, ,MP, Bihar and including north-western states like Rajasthan and Gujrat)- south divide*(see table).*

While there is some optimism from census data 2011 that most of Northern western states like Gujrat, Haryana, Punjab Chandigarh, Himachal Pradesh have shown no further decline than 2001 (may be due to the fact that states might have reached plateau) but the central and eastern India is now showing a negative trend for which John (2011:11) recommends that a more contextual micro study needs to be done.

(d) Social Groups vise Patterns –

Studies by Bhattacharya and Saxena (2015:10), Varghese et al (2005:15), Malhotra (2006:152) show that minority groups like Muslims are less prone to sex determination and SSAs. State vise Census data (1991, 2001 and 2011) is enough to indicate that Communities of Gujjars, Rajputs, Hindu Punjabis, Sikhs, other Northern and Western belt communities are more involved in these unlawful practices. Malhotra (2006: 152) also shows that Sikhs, Jains have strong male child preference. Nandi and Deolalikar (2013: 22) cite Miller (1981), Agnihotri et all (2002) that SCs, STs unlike Hindu upper castes, do not indulge in rigid dowry norms and other rituals limiting women autonomy. The critical point is that the spread of DCSR even to North-Eastern and southern regions (Census: 2011), though not that skewed and prominent as in North - western belts, indicate that the practice cuts across the caste lines.

(e) SRB affected by birth order & sex of the previous children-

Enough studies, including one by ORGI[55] (1998) show that SSAs become more prominent on 2nd or 3rd birth order in the family with previous child/children being girl/s. The table below, which is based on a Joint study by ORGI and Christian Medical Association of India (Varghese et al 2005:13) of 11268 births from a hospital in Delhi during 2000-2001, is a true reflection of male child obsessed Indian society, which goes on to show that 2nd order SRB is almost in normal range and is also not that bad at 3rd order birth if family had previous male children, but the SRB falls drastically if the family had previously the girl child/children no matter what may be the religious affiliation of the household.

.

Birth Order	Sex of Previous Child	Sex ratio at Birth (girls per 1000 males)
2nd order	1 male child	959
	1 female child	542
3rd order	1 male and 1 female child	558
	2 male children	894
	2 female children	219

Mason and Bennett (1977:285-296) show that the decision to use sex selection technique hinges on the outcome of the earlier birth/s. In a major study of all states of India, Jha et al (2006:211-218) show similar findings that risk of selective abortion was clearly higher to the women already having one or two girls. Mason and Bennett (ibid) show that the technology does not have disturbing effect of on sex ratio where population has unbiased preferences (like

[55] ORGI-Office of Registrar General of India – Census of India

US) but at places with biased sex preference like strong son preference (India), or for daughters (Belgium), it can have larger impact on sex ratio of population.

Perwez et al (2012:75-76) study compares three data sets for 2004-05 period from Maharashtra, Bijnor (UP) and Salem (TN) and look at the problem from a new angle. They say (ibid) that though SRB declines in families already having 1 or 2 girls, but SSA in such families does not contribute much to DCSR reason being that these families already have 1 or 2 daughters. As per them (ibid), it is the 'squeeze on family size' (which they call as 'stopping behaviour' i.e the families adopting smaller family norm stop reproducing, at 1st or 2nd son) that further undermines the preference for girl. George (2006:604) too shares similar message that smaller family is at the cost of girl child.

(f) DCSR v/s Literacy and Economic standard –

Finding correlation of literacy and economic standards with CSR has been a topic of research. Mishra and Dilip from their study of 15 Indian states (2003) show that "There is a step by step increase in number of SSAs by literacy level from 27 per 1000 live births among illiterates to 87 per 1000 live births among higher secondary and above category". In similar findings, Nandi and Deolalikar (2013:22) also find negative link of female literacy with CSR. Chaturvedi (undated)also highlights that economically well off states like Haryana, Punjab, Delhi, etc., have recorded the sharpest decline in CSR than poor states like Orissa, West Bengal ,Sikkim etc..

Similarly, a large number of researchers have shown that sex selective abortion use was more among middle or higher income groups (Retherford and Roy 2003:71-73), (Sharma et al 2007:854). Mishra and Dilip in the study of 15 states (ibid) have shown that "number of SSAs per 1000 live births was 35, 45 and 48 among women with low, medium and high standard of living respectively". Srivastava and Sushma (undated) bring out negative correlation between urban sex ratio and urban literacy rate due to awareness of technology with working women going for smaller families and opting for male child. ORGI (1998) study brings out that the higher infant and child mortality rates among girls in the higher socio-economic groups not only indicate discriminatory treatment towards female child but also the stronger desire for a male child.

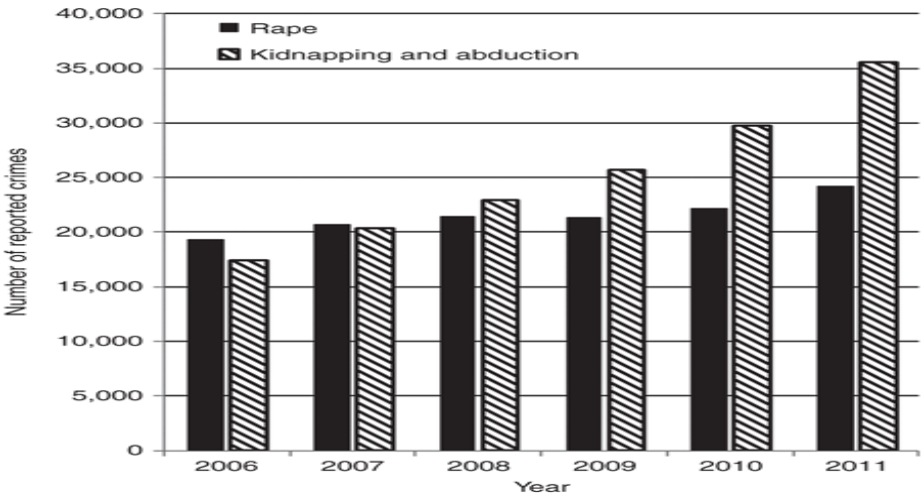
Annexure 3B

Refers Para 3.5

Repercussions of Declining Child Sex Ratio (Result of failure of Act?)

(i) Rising Crimes Against Women-

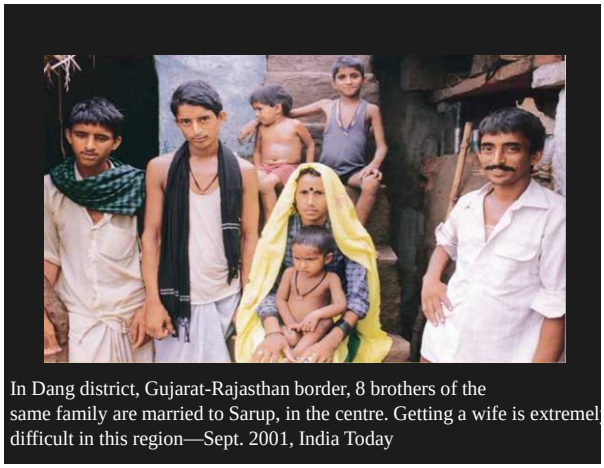
Studies by Hesketh and Xing (2006:13271,73) (2011:1374-77), Madan and Breuning (2014:429) point that scarcity of women and surplus of men is showing its ugly face in shape of rising crimes against women with serious concerns that the situation is only going to be grimmer with social fabric at high risk. The Times of India (21 April 2015) brought out a news captioned "Forced bachelorhood for 4.12 crore men in country as brides go missing" .These men, who have already reached reproductive age are not finding brides to marry and in a society where marriage is a mandatory and virtually universal institution, this is leading towards lowering self-esteem, various psychological problems (like withdrawal, depression) and marginalisation (specially the lower socio-economic class men who are not well educated and/or are poor are regarded as least desirable men) ,enhanced anti-social behaviour, rising sexual offences/rapes against women, acts of kidnapping and trafficking (Madan and Breuning 2014:428). Nayak (2014:51) also lists similar repercussions of DCSR. The NCRB data (**Table below**) also depicts year- on- year upward trend in such crimes. **Appendix -1** shows the data on various types of crime against women during 2009 - 2013 and % change in 2013 over 2012**.**



Hesketh and Xing say (2006:13273) that "Gender is well established individual-level correlate of crime and specially the violent crime" and refer to studies by Messner and Samson (1991), Oldenberg (1992), Ullman and Fidell (1989) showing consistent findings that societies with high number of young, unmarried, low-status males report a larger percentage of violent crime perpetrated by these sexually frustrated, unmarried men. Studies by Dreze and Khera (2000:335-352), Hudson and Boer (2004) too indicate a relationship between sex-ratio and homicide rates across Indian states and do not rule out a scenario (Hudson and Boer: 2002) where they argue that these single young men would congregate and pose a serious threat by involving in organised aggression and may be attracted to military like organisations bringing national and international peace at risk.

(ii) Bride Purchasing, Trafficking and Polyandry cases going up –

Cases of bride purchasing, trafficking and even polyandry are also reported to be reappearing in many parts of India {Madan and Breuning (2014:429), Misra (2011:152), Khichi and Bir (2015:100-101)}, especially in the states which have critically low sex-ratio like Haryana (830/1000), Punjab (846/1000) Rajasthan (883/1000) {Census of India:2011}. There are ample media reports that in these states there are villages which do not have single marriageable girl and brides are being brought from poor regions of distant states like Chhattisgarh, Bihar, West-Bengal, Assam or even Bangladesh and Nepal also (MoH&FW: 2006, The HT 11 Nov 2007)



In Dang district, Gujarat-Rajasthan border, 8 brothers of the same family are married to Sarup, in the centre. Getting a wife is extremely difficult in this region—Sept. 2001, India Today

Photo on right- Devra village of Jaislmer district has the distinction of receiving a baraat (bridegroom's party) after 110 years in 1997, when Jaswant Kanwar got married.(by Anuradha Dutt, The Pioneer, October 28. 2001) <http://docslide.us/documents/tr-sabla.html>(Quoted in MoHFW 2006)

The National(19 June 2009) reported an incidence of acute shortage of women leading two brothers(Sohan Singh and Mohan Singh) sharing one wife(Manu Kanwar) in Bhilwara even when dowry demand was abandoned.

(iii) Mental and Physical Agony to Women-

Resulting from an obsessive wish for son , under the extreme pressure of groom's family and society as whole, women undergo repeated abortions, which cause adverse psychological/ mental agony, emotional trauma and physical/health damage (Madan and Breuning 2014:429), (Sharma et al 2007:858). Many of them face increased morbidity and mortality due to repeated abortions.

(iv) Adverse impact on Economy-

Singariya (2012:9), Chaturvedi (undated) say that poor sex-ratio / gender gaps in workforce participation is likely to have negative consequences on Economy as women workforce is an important contributor to economy IMF (2015:7).

Appendix-1 to Annexure 3 B

Crime head-wise incidents of crime against women during 2009 - 2013 and percentage variation in 2013 over 2012

Sl. No.	Crime head	Year					Percentage variation in 2013 over 2012
		2009	2010	2011	2012	2013	
1.	Rape (Sec. 376 IPC)	21,397	22,172	24,206	24,923	33,707	35.2
2.	Kidnapping & abduction(Sec. 363 to373IPC)	25,741	29,795	35,565	38,262	51,881	35.6
3.	Dowry death (Sec. 302 / 304 IPC)	8,383	8,391	8,618	8,233	8,083	-1.8
4.	Cruelty by husband or his relatives(Sec. 498-A IPC)	89,546	94,041	99,135	1,06,527	1,18,866	11.6
5.	Assault on women with intent to outrage her modesty (Sec. 354 IPC)	38,711	40,613	42,968	45,351	70,739	56.0
6.	Insult to the modesty of women(Sec. 509 IPC)	11,009	9,961	8,570	9,173	12,589	37.2
7.	Importation of girl from foreign country(Sec. 366-B IPC)	48	36	80	59	31	-47.4
A.	Total IPC crime against Women	1,94,832	2,05,009	2,19,142	2,32,528	2,95,896	27.3
8.	Commission of Sati Prevention Act, 1987	0	0	0	0	0	0.0
9.	Immoral Traffic (Prevention) Act, 1956	2,474	2,499	2,435	2,563	2,579	0.6
10.	Indecent Representation of Women (P) Act,1986	845	895	453	141	362	156.7
11.	The Dowry Prohibition Act, 1961	5,650	5,182	6,619	9,038	10,709	17.9
Reference: Crime in India-2013					*Page*		*81*

Annexure 3C
Refers Para 3.6

Reflection on the Arguments Supporting Sex Determination/Selection

The 'population argument' is at the cost of girl child and is not a gender neutral choice? On 'demand -supply argument', Hesketh and Xing (2006:13274) present a counter view that rise in social status of women (if ever it happens) may bring more benefit to others than herself, like to father ,brother ,husband or in-laws as it is them who control her life and hold her value in Indian patriarchal social setup**.** Tandon and Sharma (2006) are also apprehensive on the scenario anticipating upliftment of woman status and quote anthropological evidences showing that the areas which were having heavily skewed sex ratio in favour of men, were infested with the incidences of gang rapes, polyandry, kidnapping and other inhuman practices against women. Advocate and human right activist Mahabal (2011) gives strong answer that a patriarchal set up controls sexuality, fertility, economic participation with scant respect to her bodily integrity and a society where woman is treated just like a sex object, whether they will be treated better when scarce? Oomman and Ganatra (2002:185) also echo same concern.

The 'fatalistic argument' fails, as going by the same all poor should be killed to save them from lifelong poverty. It is just illogical that instead of tackling the root cause poverty, here too we are not ready to address the core issue i.e discrimination**.** Similarly the 'burden argument' falls flat as it is built on the very existence of evil dowry practice which is not created by girls and there is no such institution in western society**.**

Oomman and Ganatra (2002:185) say that many studies how that women themselves endorse sex- selection(i.e **choice argument'**), but the main question remains as to if sex selection really indicates woman's right to free choice and control over her reproduction? Do women have freedom to take decisions themselves? They say (ibid) that woman choice is not free and is made in context of family and community which are bounded by patriarchal structures, and so it is more a response to pressure of society and system that define her choice. Shah and Taneja (1991:28-39) from their study of 300 men and women in North Delhi brings out that more female than males respondents held positive opinions about female foeticide might be due to the "consequences they themselves faced on giving birth to a female child, or may have themselves suffered when they were young and treated as an unwanted child". Kaur (1993:40-43) brings out the ground reality that although women are aware of the health problems resulting from such decisions but favour it for socio-economic pressures which are so acute (including all coercive methods like desertion, divorce, ill-treatment, threat of 2nd marriage etc) that even those who consider abortion to be a sin are prepared to abort a female foetus. She says (ibid) that women whether educated or not, rich or poor, is not conscious of her own identity and are so obsessed a 'two-child family' with one son must.

Reflection - I think one should not be blinded by all these so called pro-SDT/SSA arguments as none of these withstand a simple ,genuine ,humane logic that girl has equal right to be born and brought up in similar environment which is guaranteed to peer male children. Contrary to the opinion echoed by some researchers that there is nothing wrong in foetus sex determination and that it should be left to the couples to plan their families on size and composition dimensions (Hoskins & Homes 1984, Lingam 1998 referred in Rustagi (2006:8), I agree to a reasonable extent with Tandon and Sharma(2006) that advocators of population control (and all others who air various justifications, as detailed in above para, supporting SSA) have placed women in India in the category of 'endangered species'.

Annexure 4A

Refers Para 4.1(NIMC), Para 5.1.1(iv,vi) and Evidences on Monitoring

Online RTI Request Form Details 4.7.2015

RTI Request Details :-

RTI Request Registration number	MOHFW/R/2015/61836
Public Authority	Department of Health & Family Welfare

Personal Details of RTI Applicant:-

Name	SURESH PURI
Gender	Male
Address	272, NUOVO apartments, sector 10 ,Plot 25 , Dwarka , New Delhi
Pincode	110075
Country	India
State	Delhi
Status	Urban
Educational Status	Literate
Phone Number	+91-1125071300
Mobile Number	+91-9868133104
Email-ID	puri_suresh[at]yahoo[dot]com

Request Details :-

Citizenship	Indian
Is the Requester Below Poverty Line ?	No

(Description of Information sought (upto 500 characters)

Description of Information Sought

Please refer to your letter No V.11011/8/2013- (PNDT Section) dated 21 March, 2014 vide which notification dated 26.02.2014 published in the Gazette of India incorporating rule 18A in the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Rules 1996 relating to Code of Conduct to be observed by the Appropriate Authorities under PC & PNDT Act, 1994 was forwarded by you to various Chairperson /State Appropriate Authorities of PC & PNDT Act (All States/UT s).

Sub rule 8(i) under newly inserted Rule 18(A) requires AAs to conduct regular inspection of all the registered facilities once in every ninety days.

1 Please supply state/UT vise data from quarterly information/progress report in respect of all states/UTs from 1st April 2014 onwards clearly indicating total number of registered

facilities installed and inspected every 90 days under their jurisdiction to assess if the instructions to inspect 100 % facilities every 90 days are being compiled by AAs or not.

Sub rule 3(iii) under newly inserted Rule 18(A) requires all AAs to investigate all the complaints within twenty four hours of receipt of the complaint and complete the investigation within forty-eight hours of receipt of such complaint.

2 Please comment if the above instructions are being complied by AAs in the field. Ministry and the Central Supervisory Board or even the NIMC is supposed to watch action/progress on these rules. Up to what extent these instructions are being followed by AAs.

Other queries pertaining to implementation of PC & PNDT Act 1994 are as below:
3 On the lines of NIMC, Is there any proposal to constitute State level and or district level Inspection and monitoring committees. Please indicate clear status on this aspect. If some states have already constituted such bodies, please furnish names of such states/UTs.
4 What is the constitution, functions and powers of the NIMC.
5 How many and which states/UTs have already implemented on-line complaint filing system related to sex selection or sex determination activities(Like the one done by Maharashtra and Rajasthan).
6 How many and which sates/UTs have already implemented real time/online Form F filing (submission) facility.
7 For the last 5 years, what is the annual budget allocated to and utilized by states/UTs for implementation of PC & PNDT Act 1994 provisions to arrest falling child sex ratio.

Concerned CPIO	D.K.Sahu
Supporting document (only pdf upto 1 MB)	Supporting document not provided

No. A. 60014/37/2015 - PNDT
Government of India
Ministry of Health & Family Welfare
(PNDT Section)

.....

Nirman Bhawan, New Delhi.
Dated the 03August, 2015

To,

Sh. Suresh Puri
272, Nuova Apartments,
Sector – 10, Plot No.-25,
Dwarka, New Delhi – 75.

Subject: Information under RTI ACT, 2005 – reg.

Sir,

I am directed to refer to your online RTI Application bearing registration number MOHFW/R/2015/61836 dated 04/07/2015 filed under the RTI Act, 2005 seeking information to this Ministry. With regard to your RTI Application the requisite information is as under:-

Information Sought	Information
Point No. 1 & 2	As per Rule 18A (3) (i) *the Appropriate Authorities including the State, District and Sub-district notified under the Act, inter-alia, shall* conduct regular inspection of all the registered facilities once in every ninety days and shall preserve the inspection report as documentary evidence and a copy of the same be handed over to the owner of facility inspected and obtain acknowledgement in respect of the inspection. As per Rule 18A (3)(iii) *the Appropriate Authorities including the State, District and Sub-district notified under the Act, inter-alia, shall* investigate all the complaints within twenty four hours of receipt of the complaint and complete the investigation within forty-eight hours of receipt of such compliant; The Quarterly Progress Reports (QPRs) from the States/UTs are received in this Section and compiled in this Section. A compiled status of QPR (as on date) is enclosed at Annexure – I. No specific details with regard to aforesaid provisions of the PC & PNDT Rules, 1996 are available with this Section. The information pertaining to State Governments may be obtained from State/UTs Government.
Point No. 3	All the States/UTs have been requested to constitute State Inspection & Monitoring Committee and District Inspection & Monitoring Committee. The details pertaining to State/UT Governments may be obtained from the concerned State/UT Governments.
Point No. 4	The list of NIMC members is at Annexure-II.

Point No. 5	All States/UTs have been requested to develop an online grievance/complaint portal for receiving complaints against the unethical practice of Sex Selection. The details pertaining to State/UT Governments may be obtained from the concerned State/UT Governments.
Point No. 6	No information is available with this Section. The requisite information pertaining to State Governments may be obtained from State/UT Governments.
Point No. 7	The requisite information pertains to NHM (Finance) Division. The RTI application is therefore, transferred under Section 6 (3) of the RTI Act, 2005 to Sh. R. K. Thapar, US & CPIO, NHM (Finance), M/o Health & FW with the request to take further necessary action in the matter under provisions of the RTI Act, 2005.

2. You may appeal to the Appellate Authority within 30 days of receipt of this reply. The Appellate Authority in this matter is Ms. Bindu Sharma, Director (RCH), Room No. 209 D, Ministry of Health & Family Welfare, Nirman Bhawan, New Delhi.

Yours faithfully,

Sahu

(D. K. Sahu)
Under Secretary to the Govt. of India & CPIO
Tel: 23062666.

Copy to –

1. Sh. R. K. Thapar, US & CPIO, NHM (Finance), Ministry of Health & FW along with a copy of RTI application, with the request to provide requisite information to the applicant directly w.r.t. point no. 7.

2. RTI Cell, Ministry of Health & FW, Nirman Bhawan, New Delhi.

Annexure 4B

Refers Para 4.4

By Speed Post

A.12021/1/2015-NHM Finance
Government of India
Ministry of Health & Family Welfare
NHM Finance Division

Room No. 510 'D' Wing,
Nirman Bhawan, New Delhi 110 011
August 31, 2015

To

Shri Suresh Puri,
272, Nuova Apartments,
Sector -10, Plot No. 25,
Dwarka,
New Delhi-1100075

Sub: Providing Information under Right to Information Act, 2005– reg.

Sir,

I am directed to refer to your RTI application (Regn. No. MOHFW/R/2015/61836) dated 04.07.2015 received in this Division on 14.8.2015 on transfer under section 6(3) of RTI Act 2005 on the subject mentioned above.

In this connection it is stated that no details is available on last 5 years annual budget allocated to and utilized by States/UTs for implementation of PC and PNDT Act 1994 provisions to arrest falling child sex ratio, however, statement on SPIP approval and expenditure from 2009-2015 in respect of PNDT Activities is available and enclosed as Annexure I.

2. Appeal relating to this Division can be filed before Ms. Kavita Singh, Director (NRHM Finance), Room No.306-D wing Nirman Bhawan, New Delhi - 110108.

Yours faithfully,

01/09/2015

[R. K. Thapar]
CPIO & UNDER SECRETARY TO GOVERNMENT OF INDIA
Tel. No. 2306 1875

Copy to:

1. CPIO & U.S. (PNDT)- w.r.t letter No. A.60014/37/2015-PNDT dt 3.8.2015.
2. S.O. (RTI Cell) - With reference to online RTI application Regn. No. MOHFW/R/2015/61836dated 4.7.2015.

Annexure I

Statement Showing SPIP and Expenditure under PNDT Activities For F.Ys. 2009 -10 to 2014-15

(Rs in lakhs)

S.No.	States / UTs	2009-10		2010-11		2011-12		2012-13		2013-14		2014-15	
		SPIP	Expenditure	SPIP	Expenditure	SPIP	Expenditure	SPIP	Expenditure	SPIP	Expenditure	SPIP	Expenditure
A. High Focus States													
1	Bihar	150.00	4.73	145.25	6.58	50.00	1.70	46.27	9.74	47.38	9.37	29.19	34.57
2	Chattisgarh	27.40	0.20	5.00	0.10	0.00	0.00	14.50	0.00	36.86	0.98	27.00	1.06
3	Himachal Pradesh	25.00	29.91	52.60	49.24	24.00	15.42	10.00	1.37	10.00	27.49	109.68	44.07
4	J&K	53.55	28.67	25.50	15.76	9.10	7.87	17.70	1.10	21.10	7.55	67.88	34.25
5	Jharkhand	17.00	0.00	18.00	0.00	17.00	16.25	24.92	12.24	24.95	9.81	36.89	6.92
6	Madhya Pradesh	87.00	30.39	128.24	122.82	190.52	78.75	134.00	74.79	108.00	37.67	100.51	36.99
7	Orissa	0.00	0.00	21.00	1.91	13.40	0.51	22.64	10.26	26.15	11.06	93.56	18.86
8	Rajasthan	113.68	113.68	143.26	117.60	185.25	124.30	169.35	123.02	160.04	112.48	146.90	73.36
9	Uttar Pradesh	210.20	141.06	50.53	38.96	47.35	12.92	34.40	14.97	254.12	94.43	92.70	90.66
10	Uttarakhand	16.00	15.83	16.00	11.20	0.00	0.00	61.74	18.91	26.00	26.65	85.80	23.83
	Sub Total	699.83	364.47	605.38	364.17	536.62	257.72	535.52	266.41	714.60	337.49	790.11	364.57
B. NE States													
11	Arunachal Pradesh	14.00	1.54	0.00	1.42	9.00	5.61	13.80	4.37	8.50	2.82	-	1.52
12	Assam	8.22	8.22	0.00	0.00	0.00	0.00	18.27	18.27	22.44	0.35	33.76	2.72
13	Manipur	15.00	7.36	8.79	0.12	13.29	4.45	14.16	0.20	8.46	0.15	65.87	3.94
14	Meghalaya	4.24	0.00	4.70	0.17	0.90	0.00	7.71	0.05	6.70	1.23	1.40	0.51
15	Mizoram	1.00	1.00	1.40	1.40	2.40	2.40	2.00	2.00	9.09	9.09	13.21	5.00
16	Nagaland	0.00	0.00	0.00	0.00	21.64	16.04	16.13	20.77	15.20	4.78	48.60	0.23
17	Sikkim	5.43	3.81	1.85	1.35	2.00	7.99	1.97	1.50	2.94	1.96	3.99	3.47
18	Tripura	7.00	0.99	2.47	2.14	2.64	7.00	2.13	0.35	0.80	0.35	13.71	12.66
	Sub Total	54.89	22.92	19.21	6.60	51.87	43.49	76.17	47.51	74.13	20.73	180.54	30.05
C. Bon-High Focus States													
19	Andhra Pradesh	10.00	8.81	25.00	2.05	0.00	14.09	112.33	48.47	65.75	45.23	152.56	33.82
20	Telagana	0.00										105.08	21.78
21	Goa	25.00	5.22	15.00	6.52	0.00	1.43	1.75	0.14	19.01	15.38	37.12	38.64
22	Gujarat	76.45	51.48	72.70	51.58	66.85	37.08	121.77	97.60	87.50	64.81	183.52	123.61
23	Haryana	30.76	18.97	53.10	21.51	90.16	40.99	92.36	57.83	71.31	57.34	80.22	57.35
24	Karnatka	104.78	32.09	187.50	32.17	31.40	11.69	59.48	12.18	59.48	18.28	55.00	3.84
25	Kerala	0.00	0.00	14.70	8.23	0.00	0.00	-	-	2.50	2.53	8.85	-
26	Maharashtra	59.70	35.50	645.44	98.74	184.40	139.16	469.40	371.19	291.68	195.62	153.96	40.29
27	Punjab	62.80	137.08	95.04	81.53	295.28	2.88	8.22	136.02	142.26	110.22	186.46	85.61
28	Tamilnadu	38.50	0.00	128.52	0.00	0.00	0.00	-	6.55	-	12.71	-	4.12
29	West Bengal	50.00	41.29	182.00	43.30	65.60	22.04	51.49	26.95	24.15	30.51	242.18	27.83
	Sub Total	457.99	330.44	1419.00	345.63	733.69	269.36	916.80	756.92	763.64	552.62	1204.95	436.89
D. Small States/UTs													
30	Andaman & Nicobar	0.00	0.00	0.00	0.00	0.20	0.09	12.16	0.61	1.12	1.30	11.48	1.10
31	Chandigarh	3.74	1.95	3.12	3.03	13.19	12.55	0.24	0.07	10.69	8.15	38.71	12.15
32	Dadar & Nagar	0.40	0.36	0.40	0.40	1.40	1.30	1.40	0.70	4.00	1.94	9.67	3.38
33	Daman	3.00	2.53	3.00	1.93	5.00	2.15	-	-	-	-	4.53	1.76
34	Delhi	15.80	6.26	25.75	8.16	65.23	8.90	45.10	4.70	54.00	6.64	63.20	10.84
35	Lakshadeep	1.00	0.55	2.00	2.16	2.00	0.00	0.50	1.19	2.00	-	2.00	-
36	Puducherry	1.85	0.70	2.00	1.90	2.00	2.02	2.50	0.71	2.50	1.68	6.00	3.04
	Sub Total	25.79	12.35	36.27	17.58	89.02	27.01	61.90	7.99	74.31	19.71	135.59	32.28
	Grand Total	1238.50	730.18	2079.86	733.98	1411.20	597.58	1590.39	1078.84	1626.68	930.54	2311.19	863.79

Note: The above figue are as per FMR as reported by states/Uts. Hence Provisional.

Annexure 4 C

(Refers Para 4.6 & Para 5.7(ii))

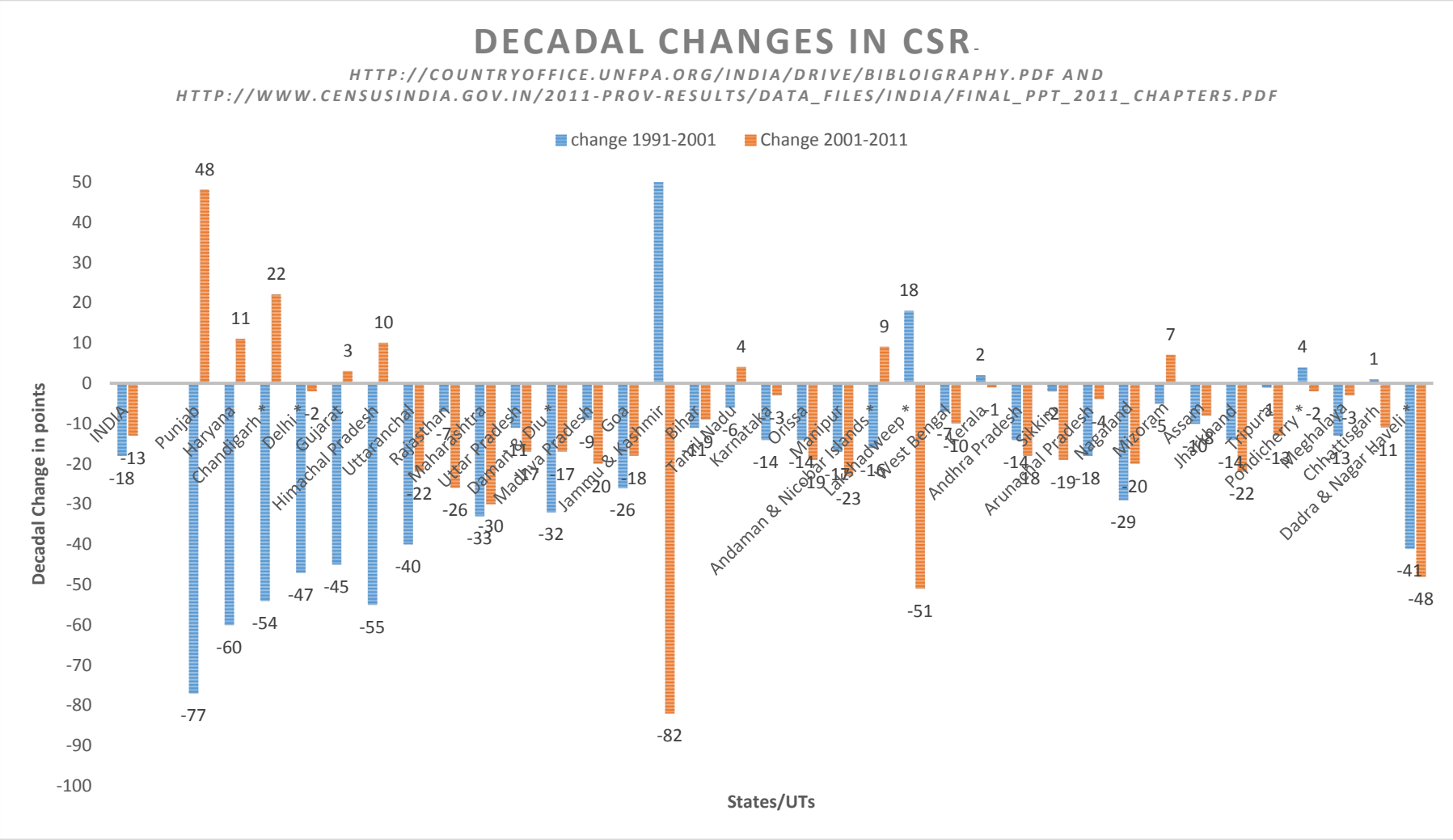
Decadal Change in CSR from 1991-2011

India and State/Union Territory	Child Sex Ratio (0-6 years)					1991 to 2011	
1991 2001 2011 Change	1991	2001	change 2001 v/s 1991	2011	change 2011 v/s 2001	change in decline 2011 v/s 2001	change in decline 2011 v/s 1991
INDIA	945	927	-18	914	-13	5	-31
						0	0
Punjab	875	798	-77	846	48	125	-29
Haryana	879	819	-60	830	11	71	-49
Chandigarh *	899	845	-54	867	22	76	-32
Delhi *	915	868	-47	866	-2	45	-49
Gujarat	928	883	-45	886	3	48	-42
Himachal Pradesh	951	896	-55	906	10	65	-45
Uttaranchal	948	908	-40	886	-22	18	-62
Rajasthan	916	909	-7	883	-26	-19	-33
Maharashtra	946	913	-33	883	-30	3	-63
Uttar Pradesh	927	916	-11	899	-17	-6	-28
Daman & Diu *	958	926	-32	909	-17	15	-49
Madhya Pradesh	941	932	-9	912	-20	-11	-29
Goa	964	938	-26	920	-18	8	-44
Jammu & Kashmir		941	941	859	-82	-1023	859
Bihar	953	942	-11	933	-9	2	-20
Tamil Nadu	948	942	-6	946	4	10	-2
Karnataka	960	946	-14	943	-3	11	-17
Orissa	967	953	-14	934	-19	-5	-33
Manipur	974	957	-17	934	-23	-6	-40
Andaman & Nicobar Islands *	973	957	-16	966	9	25	-7
Lakshadweep *	941	959	18	908	-51	-69	-33
West Bengal	967	960	-7	950	-10	-3	-17
Kerala	958	960	2	959	-1	-3	1
Andhra Pradesh	975	961	-14	943	-18	-4	-32
Sikkim	965	963	-2	944	-19	-17	-21
Arunachal Pradesh	982	964	-18	960	-4	14	-22
Nagaland	993	964	-29	944	-20	9	-49

Mizoram	969	964	-5	971	7	12	2
Assam	975	965	-10	957	-8	2	-18
Jharkhand	979	965	-14	943	-22	-8	-36
Tripura	967	966	-1	953	-13	-12	-14
Pondicherry *	963	967	4	965	-2	-6	2
Meghalaya	986	973	-13	970	-3	10	-16
Chhattisgarh	974	975	1	964	-11	-12	-10
Dadra & Nagar Haveli *	1013	972	-41	924	-48	-7	-89
* indicates union territory							
Source:							
Census of India 1991 & 2001							

Annexure 4C

(Refers Para 4.6 & Para 5.7(ii))



Annexure 5A
Refers Para 5.2.2(b) and Evidences on Monitoring

Online RTI Request Form Details 27.8.2015

RTI Request Details :-

RTI Request Registration number	MOHFW/R/2015/62388
Public Authority	Department of Health & Family Welfare

Personal Details of RTI Applicant:-

Name	SURESH PURI
Gender	Male
Address	272, NUOVO apartments, sector 10 ,Plot 25 , Dwarka , New Delhi
Pincode	110075
Country	India
State	Delhi
Status	Urban
Educational Status	Literate
Phone Number	+91-1125071300
Mobile Number	+91-9868133104
Email-ID	puri_suresh[at]yahoo[dot]com

Request Details :-

Citizenship	Indian
Is the Requester Below Poverty Line ?	No

(Description of Information sought (upto 500 characters)

Description of Information Sought

Under the PC & PNDT Act, please supply copies of Quarterly progress report of Delhi, Punjab, Haryana, Odisha, west Bengal, Tamilnadu, Kerala, Karnataka, Assam, Madhya Pradesh, Bihar and UP for 1st quarter of 2015-16.

In case any additional fee is to be deposited, please raise the demand online so that payment can be made.

Concerned CPIO	D.K.Sahu
Supporting document (only pdf upto 1 MB)	Supporting document not provided

No. A. 60014/37/2015-PNDT
Government of India
Ministry of Health & Family Welfare
(PNDT Section)

.....

Nirman Bhawan, New Delhi.
Dated the 18 September, 2015.

To

Shri Suresh Puri,
272, NUOVO apartments,
Sector-10. Plot – 25,
Dwarka, New Delhi – 110075.

Subject: Information sought under RTI ACT, 2005.

Sir,

Kindly refer to your RTI applications dated 27.08.2015, received through online RTI portal bearing registration no MOHFW/R/2015/62388, under the RTI Act, 2005, seeking information from this Ministry. With regard to your RTI application the requisite information is as under:-

Information Sought	Information
Point No. 1	We have received Quarterly Progress Report (QPR) from 4 States i.e. Assam, Haryana, Odisha & West Bengal out of the States listed by you copies of which are enclosed. The rest States are being reminded to send the QPR.

If you are not satisfied with the above information furnished to you, you may appeal to the Appellate Authority within 30 days of receipt of this reply. The Appellate Authority in this matter is Smt. Bindu Sharma, Director (PNDT), Room No. 209 D, Ministry of Health & Family Welfare, Nirman Bhawan, New Delhi.

Yours faithfully,

Sahu

(D. K. Sahu)
Under Secretary to the Govt. of India & CPIO
Tel: 23062666.
Email: dilip.sahu@gov.in

Copy to: -

1. RTI cell, Ministry of H&FW, Nirman Bhawan, New Delhi.

(A) The report asked was for period ending 30.6.15

(B) States supposed to send by 5th of next month

Annexure 5B

Refers Para 5.3.1(a) and Evidences on Monitoring

Online RTI Request Form Details 27.8.15

RTI Request Details :-

RTI Request Registration number	MOHFW/R/2015/62386
Public Authority	Department of Health & Family Welfare

Personal Details of RTI Applicant:-

Name	SURESH PURI
Gender	Male
Address	272, NUOVO aprtments, sector 10 ,Plot 25 , Dwarka , New Delhi
Pincode	110075
Country	India
State	Delhi
Status	Urban
Educational Status	Literate
Phone Number	Details not provided
Mobile Number	Details not provided
Email-ID	puri_suresh[at]yahoo[dot]com

Request Details :-

Citizenship	Indian
Is the Requester Below Poverty Line ?	No

(Description of Information sought (upto 500 characters)

Description of Information Sought

Under the PC & PNDT Act 1994, As per new Rule 18 A (3)(iii) All the Appropriate Authorities including the State, District and Sub-district notified under the Act, shall investigate all the complaints within twenty four hours of receipt of the complaint and complete the investigation within forty-eight hours of receipt of such compliant .

As per new Rule 18 A (7) All the Appropriate Authorities including the State, District and Sub-district notified under the Act, inter-alia, shall (i) monitor the sales and import of ultrasound machines including portable or buyback, assembled, gift, scrap or demo (ii) ensue regular quarterly reports from ultrasound manufacturers, dealers, wholesalers and retailers and any person dealing with the sales of ultrasound machines at the State level (iii) conduct periodical survey and audit of all the ultrasound machines sold and operating in the State or district to identify the unregistered machines (iv) file complaint against any owner of the unregistered ultrasound machine and against the seller of the unregistered

ultrasound machine.

Please provide following information:
1 How many total complaints were booked in 2014-15 against violations in the Act,in whole country and in state/UT vise manner.
2 How many of these were investigated within 24 hours of complaint booking.Please provide data/numbers in All India and state/UT vise manner
3 In How many of total booked complaints , the investigation was completed within 48 hours of complaint booking.(All India and state/UT vise data (number))
4 In the year 2014-15, how many complaints were filed by AAs against owners of unregistered ultrasound machine cases.
5 In the year 2014-15, how many complaints were filed by AAs against the seller of the unregistered ultrasound machine.
6 Is Ministry developing any Standard operating procedure to ensure quarterly sales data from machine suppliers/manufacturers/retailers/importers. If yes, give relevant details.
7 NGO Grant in Aid scheme has been delegated by Ministry to states. As of today, please indicate names of those states/UTs that have appointed/fixed the NGOs under the scheme.
8 Is there any statutory power vested with AAs to prosecute the suppliers/manufacturers /retailers /importers if they do not provide regular sales data to AAs. Please give details .

Concerned CPIO	D.K.Sahu
Supporting document (only pdf upto 1 MB)	Supporting document not provided

No. A. 60014/37/2015-PNDT
Government of India
Ministry of Health & Family Welfare
(PNDT Section)
.....

Nirman Bhawan, New Delhi.
Dated the 18 September, 2015.

To

Shri Suresh Puri,
272, NUOVO apartments,
Sector-10. Plot – 25,
Dwarka, New Delhi – 110075.

Subject: Information sought under RTI ACT, 2005.

Sir,

Kindly refer to your RTI application dated 27.08.2015, received through online RTI portal bearing registration no MOHFW/R/2015/62386, under the RTI Act, 2005, seeking information from this Ministry. With regard to your RTI application the requisite information is as under:-

Information Sought	Information
Points No. 1, 2, 3, 4, 5 & 7	The information mainly concern State Governments. You may please approach the concerned State Government. The information compiled by this Ministry based on QPR received from States/UTs is enclosed
Point No. 6	A list of recent action taken by the Ministry for effective implementation of the Act is enclosed.
Point No. 8	The information sought by you is mainly in the nature of seeking clarification/answer/interpretation. It is stated in this regard that non existing information is not covered under the definition of 'information' in the RTI Act, 2005. Under the RTI Act, 2005 information available in material form can be provided to the applicant. The Public Information Officer is not required to furnish information which requires drawing of inference and/or making assumption; or to interpret information; or to solve the problems raised by the applicants; or to furnish replies to hypothetical question. However, you may please refer Section 17A of the PC & PNDT Act, 1994 and Rule 3A of the PC & PNDT Rules, 1996. Copy enclosed.

Contd....

2. If you are not satisfied with the above information furnished to you, you may appeal to the Appellate Authority within 30 days of receipt of this reply.The Appellate Authority in this matter is Smt. Bindu Sharma, Director (PNDT), Room No. 209 D, Ministry of Health & Family Welfare, Nirman Bhawan, New Delhi.

Yours faithfully,

Sahu

(D. K. Sahu)
Under Secretary to the Govt. of India & CPIO
Tel: 23062666.
Email: dilip.sahu@gov.in

Copy to: -

1. RTI cell, Ministry of H&FW, Nirman Bhawan, New Delhi.

Annexure 5C

Refers Para 5.1.1(iv)(vi) and Evidences on Monitoring

Online RTI Request Form Details 20.8.2015

RTI Request Details :-

RTI Request Registration number	MOHFW/R/2015/62312
Public Authority	Department of Health & Family Welfare

Personal Details of RTI Applicant:-

Name	SURESH PURI
Gender	Male
Address	272, NUOVO apartments, sector 10 ,Plot 25 , Dwarka , New Delhi
Pincode	110075
Country	India
State	Delhi
Status	Urban
Educational Status	Literate
Phone Number	+91-1125071300
Mobile Number	+91-9868133104
Email-ID	puri_suresh[at]yahoo[dot]com

Request Details :-

Citizenship	Indian
Is the Requester Below Poverty Line ?	No

(Description of Information sought (upto 500 characters)

Description of Information Sought

For the PC & PNDT ACT, please supply following information:
1What are the monitoring bodies at National level to monitor the Act implementation, performance
2What is their mandate/scope
3What are the monitoring benchmarks that are being regularly being monitored at National level and particularly by the CSB At what frequency these are monitored
4Please supply the format in which these parameters are being monitored.
5Does the CSB in its 6 monthly meeting watch the state vise achievement against those parameters
6Please supply the relevant extracts of last 4 CSB meetings minutes concerning this point.
7Is there any online monitoring mechanism Please give details.
8Today, NIMC is how many member body How many inspections it has done in last 3 years How many court cases are filed against NIMC inspections for these 3 years

9Does CSB keep a watch over NIMC inspections and also the SIMC inspections Please give relevant extracts from last 4 CSB minutes.
10What was initial/original deadline for states to establish state PNDT cells
11Has the State PNDT cell been established by all states and UTs Please give month/year of establishment of state PNDT cell for all states/UTs.
12What was initial/original deadline for states to establish online web portal for facilitating online complaint booking against violations in the Act
13Has the online web portal for complaint booking been established by all states and UTs Please give month/year of establishment of state PNDT cell for all states/UTs.
14What is the deadline for establishing online form F filing/submission facility by the states
15How many states have established online form F submission/filing and mention the month and year also
16What is the position on scrutiny/audit of Form F, state vise
17What is the target date for states to complete mapping of all USG centres What are the states supposed to do under it
18What are the monitoring bodies at State level to monitor the Act implementation, performance What is their mandate/scope What monitoring parameters do they watch and at what frequency
19How many inspections were done by SIMCs in various states in last 3 years Please Give state vise data.
20What are the monitoring bodies at district level to monitor the Act implementation, performance What is their mandate/scope
21Is the CSB apprised of the National Level workshop and regional level workshop findings and recommendations Please supply relevant extracts of last 4 CSB meeting minutes on this point.
22What is the status of commissioning the District level Inspection and monitoring teams/committees Please give state vise data.

Concerned CPIO	D.K.Sahu
Supporting document (only pdf upto 1 MB)	Supporting document not provided

No. A. 60014/37/2015-PNDT
Government of India
Ministry of Health & Family Welfare
(PNDT Section)
.....

Nirman Bhawan, New Delhi.
Dated the 15 September, 2015.

To

Shri Suresh Puri,
272, NUOVO apartments,
Sector-10. Plot – 25,
Dwarka, New Delhi – 110075.

Subject: Information sought under RTI ACT, 2005.

Sir,

Kindly refer to your RTI application dated 20.08.2015, received through online RTI portal bearing registration no MOHFW/R/2015/62312, under the RTI Act, 2005, seeking information from this Ministry.

2. The information sought by you is mainly in the nature of seeking clarification/answer/interpretation. It is stated in this regard that non existing information is not covered under the definition of 'information' in the RTI Act, 2005. Under the RTI Act, 2005 information available in material form can be provided to the applicant. The Public Information Officer is not required to furnish information which requires drawing of inference and/or making assumption; or to interpret information; or to solve the problems raised by the applicants; or to furnish replies to hypothetical question. However, with regard to your RTI application the requisite information is as under:-

Information Sought	Information
Point No. 1	The CSB and NIMC monitor the implementation/performance. CSB constituted under Section – 7 of the PC & PNDT Act, 1994 and NIMC has been funtional as per direction of the Supreme Court.
Points No. 2, 3, & 4	You may please refer Section 7 to 16A of the PC & PNDT Act, 1994. Copy enclosed
Point No. 5	You may please refer to the Section – 16 of the PC & PNDT Act, 1994(Copy enclosed) and copies of minutes last 4 CSB meetings also enclosed.
Point No. 6,9 & 21	Copies of minutes of last 4 CSB meeting enclosed.
Point No. 7	The information mainly concern State Governments. You may approach the concerned State Government.
Point No. 8	Lists of NIMC members and inspections are enclosed. So far as court cases against NIMC inspections are concerned, the matter pertains to state Government. You may approach State Government, in this regard.
Point No.10 to 20 & 22	The information mainly concern State Governments. You may please approach the State Government concerned.

Contd...

2. If you are not satisfied with the above information furnished to you, you may appeal to the Appellate Authority within 30 days of receipt of this reply. The Appellate Authority in this matter is Smt. Bindu Sharma, Director (PNDT), Room No. 209 D, Ministry of Health & Family Welfare, Nirman Bhawan, New Delhi.

Yours faithfully,

Sahu

(D. K. Sahu)
Under Secretary to the Govt. of India & CPIO
Tel: 23062666.
Email: dilip.sahu@gov.in

Copy to: -

1. RTI cell, Ministry of H&FW, Nirman Bhawan, New Delhi.

Annexure-5D

Referes Para 5.1.3(c), Para 5.3 & outcome table at Para 5.5

GOVERNMENT OF INDIA

MINISTRY OF HEALTH AND FAMILY WELFARE

LOK SABHA

UNSTARRED QUESTION NO 799

ANSWERED ON 27.02.2015

FEMALE FOETICIDE

799 . SANJAY HARIBHAU JADHAV

Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:-

(a) whether the cases of female and infant foeticide have increased in the country during each of the last three years and the current year;

(b) if so, the details thereof, State/UTwise and the reasons therefor;

(c) whether the Government has sought report/ clarifications from States/UTs in this regard;

(d) if so, the details thereof, State/UTwise along with the status of such report/ clarifications; and

(e) the corrective steps taken/being taken by the Government to prevent female and infant foeticide across the country?

ANSWER

THE MINISTER OF HEALTH AND FAMILY WELFARE (SHRI JAGAT PRAKASH NADDA)

(a) & (b): Yes. A total of 132 cases, 210 cases and 221 cases were reported under foeticide and a total of 63 cases, 81 cases and 82 cases were reported under infanticide during 2011, 2012 and 2013 respectively. State/UT-wise data relating to cases registered under foeticide and infanticide during 2011-2013, as maintained by the National Crime Record Bureau (NCRB) are at Annexure-I & II, respectively. Some of the reasons for neglect of girl child and low child sex ratio are son preference and the belief that it is only the son who can perform the last rites, that lineage and inheritance

runs through the male line, sons will look after parents in old age, men are the bread winners etc. Exorbitant dowry demand is another reason for female foeticide/infanticide. Small family norm coupled with easy availability of sex determination tests may be a catalyst in the declining child sex ratio, further facilitated by easy availability of Pre-conception sex selection facilities.

(c) & (d): As per Quarterly Progress Reports (QPRs) submitted by States/ UTs, 50743 diagnostic facilities including Genetic Counselling Centre, Genetic Laboratory, Genetic Clinic, Ultrasound Clinic and Imaging Centre have been registered under the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994. So far, a total of 1716 machines have been sealed and seized for violations of the PC & PNDT Act. A total of 2021 court cases have been filed by the concerned Appropriate Authorities and 206 convictions have so far been secured under the Act. Following conviction the medical licenses of 98 doctors have been suspended/ cancelled. The State/UT wise details are at Annexure-III.

(e): Government has adopted a multi-pronged strategy entailing schemes and programmes and awareness gene-ration/advocacy measures to build a positive environment for the girl child through gender sensitive policies, provisions and legislation. The measures include the following:-

The Government has intensified effective implementation of the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 and amended various provisions of the Rules.

The Government is rendering financial support to the States and UTs for operationalisation of PNDT Cells, Capacity Building, Orientation & Sensitisation Workshop, Information, Education and Communication campaigns and for strengthening structures for the implementation of the PC & PNDT Act under the National Rural Health Mission (NRHM).

The Minister of Health and Family Welfare has requested all the State Governments to strengthen implementation of the Act and to ensure timely steps to stop illegal sex determination.

Program review at the state level has been intensified. Five regional review workshops for North, West, central, north east and Southern regions were organized at Srinagar, Pune, Hyderabad, Kolkata and Bhopal during 2013-14 to evaluate and review the progress of implementation of PCPNDT Act in the country. During the current financial year 2014-15, four review workshops for North, West, north east and Southern regions were organized.

National campaign “Beti Bachao, Beti Padhao” was launched in 100 gender critical districts in par- tnership with Ministry of Woman and Child Develo- pment and Human Recourse Development.

Directions given vide Order dated 04.03.2013 by the Hon’ble Supreme Court in the matter of WP(C) 349/2006 were communicated to the States/ UTs at the level of Health Minister to Chief Ministers and Chief Secretaries to ensure immediate compliance.

Inspections by the National Inspection and Monitoring Committee (NIMC) have been scaled up. In year 2014-15, 16 inspection visits have been completed in the states including Madhya Pradesh, Uttarakhand, Andhra Pradesh, Himachal Pradesh, Karnataka, Uttar Pradesh, Odisha, West Bengal, Delhi (Twice), Chhattisgarh, Bihar, Manipur, Jharkhand, Tamilnadu and Gujarat.

States have been advised to focus on Districts/ Blocks/Villages with low Child Sex Ratio to ascertain the causes, plan appropriate behaviour change commu- nication campaigns and effectively implement provi- sions of the PC & PNDT Act.

State wise Details on Convictions till Dec 2014

S. No.	States/ UTs	No. of convictions
1	Andhra Pradesh	0
2	Arunachal Pradesh	0
3	Assam	0
4	Bihar	11
5	Chhattisgarh	0
6	Goa	0
7	Gujarat	6
8	Haryana	54
9	Himachal Pradesh	1
10	Jammu & Kashmir	1
11	Jharkhand	0
12	Karnataka	0
13	Kerala	0
14	Madhya Pradesh	2
15	Maharashtra	61
16	Manipur	0
17	Meghalaya	0
18	Mizoram	0
19	Nagaland	0
20	Odisha	3
21	Punjab	28
22	Rajasthan	37
23	Sikkim	0
24	Tamil Nadu	0
25	Tripura	0
26	Uttarakhand	0
27	Uttar Pradesh	1
28	West Bengal	0
29	A & N. Island	0
30	Chandigarh	0
31	D. & N. Haveli	0
32	Daman & Diu	0
33	Delhi	1
34	Lakshadweep	0
35	Puducherry	0
TOTAL		**206**

As per Quarterly Progress Reports (QPRs) submitted by States/ UTs, A total of 295 court cases for non-registration of clinics have been filed by the concerned Appropriate Authorities under the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994.

Reference: Ministry of Health and Family Welfare (2015) 'Effective Implementation of PNDT Act'. Press Information Bureau, Government of India. Accessed 18 Aug 2015<
http://pib.nic.in/newsite/PrintRelease.aspx?relid=116303>and
<http://www.akuva.in/2015/03/health-secretary-holds-review-meeting.html>

Total convictions under PC & PNDT Act (up to December, 2014)

Year-wise convictions under PC & PNDT Act (Since 2009 to December, 2014)							
S. No.	States/ UTs	2009	2010	2011	2012	2013	2014
1	Andhra Pradesh	0	0	0	0	0	0
2	Arunachal Pradesh	0	0	0	0	0	0
3	Assam	0	0	0	0	0	0
4	Bihar	0	0	0	0	11	0
5	Chhattisgarh	0	0	0	0	0	0
6	Goa	0	0	0	0	0	0
7	Gujarat	2	1	0	0	3	0
8	Haryana	0	4	7	0	38	5
9	Himachal Pradesh	0	0	0	0	1	0
10	Jammu & Kashmir	0	0	0	0	1	0
11	Jharkhand	0	0	0	0	0	0
12	Karnataka	0	0	0	0	0	0
13	Kerala	0	0	0	0	0	0
14	Madhya Pradesh	0	0	1	0	1	0
15	Maharashtra	1	2	11	3	44	0
16	Manipur	0	0	0	0	0	0
17	Meghalaya	0	0	0	0	0	0
18	Mizoram	0	0	0	0	0	0
19	Nagaland	0	0	0	0	0	0
20	Odisha	0	0	0	3	0	0
21	Punjab	1	0	0	1	0	0
22	Rajasthan	0	0	0	0	37	0
23	Sikkim	0	0	0	0	0	0
24	Tamil Nadu	0	0	0	0	0	0
25	Tripura	0	0	0	0	0	0
26	Uttarakhand	0	0	0	0	0	0
27	Uttar Pradesh	0	0	0	0	0	1
28	West Bengal	0	0	0	0	0	0
29	A & N. Island	0	0	0	0	0	0
30	Chandigarh	0	0	0	0	0	0
31	D. & N. Haveli	0	0	0	0	0	0
32	Daman & Diu	0	0	0	0	0	0
33	Delhi	0	0	0	0	1	0
34	Lakshadweep	0	0	0	0	0	0
35	Puducherry	0	0	0	0	0	0
TOTAL		4	7	19	7	137	6

Note: Total 180 convictions were secured since 2009 out of total 206; remaining 26 were secured before 2009.

Reference: Ministry of Health and Family Welfare (2015) 'Effective Implementation of PNDT Act'. Press Information Bureau, Government of India. Accessed 18 Aug 2015<
http://pib.nic.in/newsite/PrintRelease.aspx?relid=116303>and
<http://www.akuva.in/2015/03/health-secretary-holds-review-meeting.html>

Annexure 6A

Tables for Different charts in the Paper

Census Year	Sex Ratio	Child Sex Ratio
1961	941	976
1971	930	964
1981	934	962
1991	927	945
2001	933	927
2011	940	914

Year	SRB (as per CRS data)	SRB as per SRS
2003	874	882
2004	875	880
2005	882	892
2006	891	901
2007	899	904
2008	902	906
2009	886	905
2010	888	906
2011	892	908
2012		908

Year	IMR	Male	Female
2003	60	57	64
2004	58	58	58
2005	58	56	61
2006	57	56	59
2007	55	55	56
2008	53	52	55
2009	50	49	52
2010	47	46	49
2011	43	43	46
2012	42	41	44
2013	40	39	42

http://www.censusindia.gov.in/vital_statistics/SRS_Bulletins/Bulletins.html

U5MR				
Year	Total	Males	Females	Female over males
1990	118	110	126	16
1995	97	96	110	14
2000	85	84	95	11
2005	77	72	82	10
2008	69	64	73	9
2009	64	60	69	9
2010	59	55	64	9
2011	55	51	59	8
2012	52	49	56	7
2013	49	47	53	6

http://www.censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR_release_070711.pdf