

**M. E. Khan\* and John W. Townsend\***

## **Reproductive and Child Health Programme: An Indepth Analysis of Changes in Population Policy and its Impact on the Family Welfare Programme in India**

### **Introduction**

INDIA is on the crossroads of seriously implementing a major paradigm shift in its family welfare programme. This choice represents a shift from the aim of achieving purely demographic goals to the adoption of a comprehensive national development plan which incorporates the goals of the Cairo and Beijing international conferences on population, women and development. The ICPD has helped in accelerating this process. As the first step, the method-specific family planning target approach has been replaced by a reproductive and child health (RCH) programme, which "aims to provide need-based, client-centered, demand-driven, high quality and integrated RCH services" (GOI, 1997).

The RCH programme incorporates the components covered under the child survival and safe-motherhood programme and includes two additional components, one relating to sexually transmitted diseases (STD) and other relating to other reproductive tract infections (RTI). This transition from conventional family planning-maternal and child health care (FP/MCH) to comprehensive reproductive health is complex and challenging for policy makers and all programme managers. The limited experience available suggests that existing programmes, in the short term, face considerable challenges to design, deliver and manage this new package of services. Growing evidence shows that apart from resources and technologies, the programme's ability to upscale RH services depends on how its programmatic and managerial capabilities are strengthened.

This paper is an attempt to review how the Ministry of Health and Family Welfare (MOH&FW) is addressing these challenges. To keep the discussion focused, as a case study, the withdrawal of method-specific targets and its impact has been analyzed as a precursor to the RCH programme. To keep the discussion in perspective, a brief description of the evolution of family planning programme in India has been included.

### **Evolution of Population Policy and Family Welfare Programme**

An historical review of the family planning programme in India clearly indicates that even before the Independence of the country leading intellectuals including educators, political leaders and social workers were fully aware of the linkages between sustainable population growth and development. There was general consensus at the political level that population growth should not be allowed to dilute the benefits of all development efforts. Recognizing this concern, the Government of India in 1952 became the first country in the world to have a government family planning programme.

A review of the plan documents also reveals that in the initial years, family planning was considered more a measure for improving the health of couples than a means for achieving the demographic goals of the country. Over time however, the achievement of demographic goals became the principal and perhaps the only focus of the programme. In 1966-67, method-specific targets were introduced and since then until April 1996 targets were vigorously pursued except for a brief period following the political changes in 1977. In April 1996, the method-specific target approach was replaced by decentralized participatory planning at the Primary Health Care level. The Reproductive and Child Health Programme was launched in September 1997. Table 1 provides a historical perspective of the evolution of the family planning programme in India. For a more detailed discussion on this subject see Visaria and Chari (1998).

### **The Target Approach and its Rationale**

The target approach, which fixed method-specific numerical targets for contraceptive acceptance for each worker, was adopted as a key management tool during the mid-1960s. Annually, the family planning performance of each state, district, primary health centre (PHC) and its targets were set by the central government and passed on to the state government with limited discussion and no participation at the community level. Targets for districts were allocated almost exclusively on the basis of population size, rather than existing contraceptive practice or level of unmet need. In addition, District Magistrates were asked to involve rural development staff, inexperienced in family planning counselling or service provision, in the recruitment of family planning users. Traditionally, half the district target was allocated to non-health staff.

TABLE 1: MILESTONES OF INDIAN FAMILY PROGRAMME

<i>Year</i>	<i>Events /Significance</i>
1949	Establishment of Family Planning Association of India
1952	Family planning programme was officially established as first step towards improvement of health, especially of mothers and children. Demographic objectives of population control were marginal
1956-61	The Second Five Year Plan emphasized need for promoting P.P. for health. Broad programme including IEC, education, marriage counselling and child guidance was underlined
1963	Integration of FP activities with health programme and shift from clinic based approach to extension approach
1965-66	Introduction of incentives to acceptors and motivators of sterilization and IUD
1966-67	Introduction of method-specific target approach. Achievement of demographic goals under strict time schedule became the main focus
1971	Introduction of mass vasectomy camp approach. Stopped in 1973
1972	Medical Termination of Pregnancy Act thereby legally approving abortion
1975-77	Coercion for accepting sterilization under the Emergency rule. It followed major set back to the programme
1983	Introduction of concept of NRR of one as principle guiding targets of FP. Increased emphasis on sterilization targets
1993	Setting up of Dr. M. S. Swaminathan Committee to draft population policy
May 1994	Submission of Swaminathan draft population policy, strongly recommending withdrawal of method-specific targets, need for enhancing access and quality of P.P. and reproductive health services, right of informed choice and a broad-based approach to population and development
1994	India became signatory to ICPD Plan of Action
1995	Withdrawal of P.P. targets from one to two district(s) of each state
April 1996	Withdrawal of target approach from the entire country
Oct 1997	Launching of Reproductive and Child Health Programme
Nov 1999	Submission of National Population Policy to Cabinet, Government of India

The target-based approach was adopted because it was considered an effective tool to intensify the level of effort of the programme, use all available resources to achieve the population goal, assess that the programme was moving in the desired direction, and place pressure on the workers to increase the couple protection rate. For the past 30 years, the achievement of method-specific targets was stressed because it was quantitative, easy to monitor and expected to have a direct link with reductions in fertility. However, over a period it was observed that, though the contraceptive prevalence rate was increasing, the corresponding decline in fertility was lower than expected. This was mainly due to acceptance of family planning by older and higher parity couples; poor promotion of the concept of birth spacing so very few young and lower parity couples adopted contraception; and inflated target achievements reported by the workers. A number of independent studies supported these findings (Jain, 1997; Khan and Cernada, 1996; Srinivasan, 1996, 1995; Visaria and Visaria, 1995).

It was also increasingly acknowledged that in the zeal to achieve targets, inadequate attention was given to the quality of family planning services. Some of the major

limitations of the programme that were repeatedly reported, both in government policy documents and independent studies, include poor counselling, lack of informed choice for clients and poor follow-up services for family planning acceptors. It was also observed that, over time, target achievement had become an end in itself, rather than a means to effectively implement and monitor the programme.

### **Experiences with the Target-free Approach**

Since the early 1980s, several states have emphasised the maternal and child health (MCH) approach, and given lower priority to actually achieving method-specific contraceptive targets. Notable among these localised initiatives is the experience in Tamil Nadu. In 1991-92, the Government of Tamil Nadu withdrew targets for non-health staff in two districts (Periyar and Dindigul). By March 1992, it was clear that Health Department staff actually worked better without competition from the Department of Revenue and Rural Development. Family planning targets were abolished for non-health staff in November 1992.

A review of annual results indicated no decline in the acceptance of sterilisation. However, service statistics fell by 50 per cent for IUDs, pills and condoms. State officials concluded that, when there were targets, service statistics for temporary methods were inflated (Ramasundaram, 1995). In 1993, to avoid criticism of the target-based approach during the preparation for International Conference on Population and Development (ICPD), the Government started using the term "expected levels of achievement" in place of targets, but without any real change in practice (Ramasundaram, 1995). However, there was increasing interest in seeking an alternative to the existing policy and management paradigm.

Tamil Nadu achieved the targets fixed by the Government during 1994-95, and they began to effectively adopt the MCH approach to the family welfare programme. This involved micro-level planning and target-setting for a range of MCH activities, as against the current macro-level target-setting for contraceptive methods. Essentially, under this plan, micro-planning was used to establish local targets for a range of health indicators which were based upon local needs. Targets were set for early registration of every pregnancy, prenatal care, institutional delivery, immunisation of infants and children, and providing information, counselling and services for contraception according to each person's choice. Targets were established based on the population in the female worker's assigned area, the reproductive profile of the population and the available health infrastructure. Tamil Nadu officials concluded that when unhealthy competition from non-health staff was removed and targets de-emphasised, ANMs were able to provide MCH care in their assigned areas much more effectively (Ramasundaram, 1995).

Data from national surveys on family planning and unmet need for contraception reinforced the assumption that there was a significant demand for family planning that

was not being met under the current system (Khan, 1993). According to the National Family Health Survey (IIPS, 1994), while about 36 per cent of married women in India are currently using a modern family planning method, an additional 20 per cent have an unmet need for family planning. The unmet need for spacing births (11 per cent) is slightly greater than the unmet need for limiting births (9 per cent). It is estimated that approximately 30 million women have an unmet need for family planning, and more than one-fourth of them reside in Uttar Pradesh.

While the debate continued at the national level, in June 1994 Tamil Nadu began reorienting the existing target system toward a new (MCH) approach. This involved the abolition of family welfare targets for all non-health department staff and entrusting the entire target to the staff of the Health Department. Individual tubectomy and IUD targets for village health workers were based on the current birth rate of the district, rather than on a uniform norm; and individual vasectomy targets were set for the male health staff (i.e., six men per worker per year) (Poornalingam, 1995).

Concurrently, alternative plans were emerging at the national policy level. In July 1993, the Government of India set up a committee under the Chairmanship of Dr. Swaminathan to review the national family welfare programme and draft a new national population policy. The Swaminathan Committee submitted a draft Population Policy in May 1994, four months before the ICPD in Cairo. The report contained far-reaching recommendations, including withdrawing the target-based approach, empowering women by increasing their opportunities for participation in the paid labour force, shifting the programme emphasis from achieving national demographic targets to helping couples achieve their reproductive goals, and promoting male family planning methods to bring about a more equitable gender balance in the provision of family planning services. Many of the recommendations were consistent with the ICPD Plan of Action.

Soon after ICPD, the Ministry of Health and Family Welfare and World Bank set up a joint working committee to examine proposed modifications in the programme and the strategy of developing a reproductive health package to bring about a paradigm shift (Measham and Heaver, 1996). The working committee examined current strategies and options to shift the focus of the Family Welfare Programme to cover a more comprehensive reproductive and child health approach. There was also a call to remove targets and incentives from the national family welfare programme. Suggestions for alternative approaches to support and monitor the programme were also invited (e.g., Townsend and Khan, 1993).

### New **Initiatives**

#### *Withdrawal of Family Planning Targets from Selected Districts in Each State*

In April 1995, the Ministry of Health and Family Welfare, in an effort to improve the functioning of the family welfare programme and to make it more need-based and

client-oriented, decided to withdraw the method-specific target approach on an experimental basis from one or two districts in each state. The purpose of making selected districts target-free was to get empirical data on how the programme functioned with no targets allocated to functionaries, and to look for alternative approaches to manage the programme without using target achievement as a monitoring tool. The effort was based on the premise that, if managed properly, the public system has the scope to deliver good quality reproductive health and family planning services. It was hypothesised that quality services would eventually lead to greater demographic impacts. Kerala and Tamil Nadu became the first two target-free states, as they were already at or near achieving a replacement level of fertility with crude birth rates (CBR) of 17.9 and 19.0 respectively (SRS, 1997), and had experimented with alternative approaches.

A review of the case studies prepared on the implementation of the target-free approach in seven states and an analysis of the programme performance, as reflected in service statistics, revealed the following<sup>1</sup>:

- In the absence of targets, district authorities and medical officers at PHCs initially found it difficult to plan and monitor services.
- Many strongly believed that family planning targets were essential to get the work done by grassroots workers. However, they now realised the importance of shifting from a purely quantitative target-based approach to a client-centred RCH approach.
- Lack of adequate infrastructure supplies at sub-centres and PHCs continued to be a major bottleneck in improving the quality of services. It was argued that unless these facilities are improved, vacant positions of grassroots workers and supervisors were filled, and logistic support strengthened, the withdrawal of targets alone may not bring about significant change in the access and quality of family welfare service. The need for additional financial support to improve the quality of clinical services was mentioned in various states (*Verma et al.*, 1997; *Mehrotra et al.*, 1997).
- Supportive supervision was identified as a missing element in family planning services at all levels of the public service delivery system (*Verma et al.*, 1997).
- The performance of MCH in general improved in several districts, after the removal of targets. However, the overall reported family planning performance dropped in most districts (*Venkata Ramanna*, 1997; *Salunke and Narvekar*, 1997; *Ghasure et al.*, 1997; *Population Council*, 1998).
- In some states, even after declaring selected districts target-free, there was little change in the way the programme was implemented and district authorities

<sup>1</sup>The states covered include Andhra Pradesh from the South, Gujarat and Maharashtra from the West, Madhya Pradesh from Central India, Rajasthan and Uttar Pradesh from the North and West Bengal from Eastern India.

continued to function as before. For instance, in Sitapur District in Uttar Pradesh during February-March 1996, to improve the drastically reduced family planning performance of the district, the District Magistrate pressurised all workers to achieve at least the 1995-96 level of performance. In Andhra Pradesh, even though on the basis of a needs assessment survey only 35,300 eligible couples were identified as having an interest in sterilisation, the Directorate fixed a target of 45,000 sterilisations for the district (Venkata Ramanna, 1997; Verma *et al.*, 1997; Salunke *et al.*, 1997).

### **Introducing a Target-free Approach at the State Level**

Before the Ministry of Health and Family Welfare decided to withdraw targets in India, the experiences of districts that were made target-free during 1995-96 were reviewed. However, few useful lessons emerged from the review except that in all the states the reported performance of the target-free districts on traditional indicators of contraceptive use had dropped. In the absence of coherent programme experience that was positive, views were divided on making the whole country target-free. Several states suggested the gradual withdrawal of targets over a five-year period (Verma *et al.*, 1997; Ghasure *et al.*, 1997; Salunke *et al.*, 1997). They argued that in absence of proper preparatory work, the withdrawal of targets from the entire state would lead to a decline in performance, without any improvement in the quality of services.

Some were also opposed as they felt that the achievement of targets was the only measure through which the performance of workers could be monitored. They felt that the absence of targets would increase indiscipline among workers (Salunke *et al.*, 1997). The government's decision on February 1, 1996 however, was to remove targets from the entire country, effective from April 1, 1996. The states would now have to develop their own programme goals, guided by needs of the community and individual clients for quality services.

Opinions were mixed regarding the government's declaration on removing targets. For example, an official in West Bengal felt that:

"The policy is a good idea. However, the unexpected announcement came too abruptly with little or no consultation or negotiation with states" (Bondurant, 1997).

Another senior health administrator from Maharashtra said:

"In none of the meetings the experience of Target Free Approach implemented in the selected districts in 1995-96 were analysed, reviewed and taken into consideration before making the entire country target free" (Salunke *et al.*, 1997).

Efforts were made to sensitise state and district health authorities about the principles of a Target-Free Approach, the procedure for assessing individual and

community needs for family welfare services and estimating expected workloads at the sub-centre, PHC and district level. The case studies, however, revealed considerable state-wise variation in the procedures and time frame for sensitising district, PHC and community workers. Thus, while targets were withdrawn from April 1996, training of staff and other preparatory work was completed only in 1997-98. Suggestions for alternative indicators were proposed (Murthy, 1996; Satia and Subramaniam, 1996; and Townsend and Khan, 1996) but a widely accepted standardised set of indicators for monitoring programme performance had been elusive. The states had invested heavily in MIS design over time and were reluctant to risk changes in a volatile political environment.

A review of the implementation process of the target-free approach in different states revealed that while many states totally moved away from the target-based approach, a number of states continued to rely upon it in variant forms. For instance, in Andhra Pradesh not only did method-specific targets continue to operate in 1996-97, the state-level target changed three times during the same year. The sterilisation target was initially fixed at 550,000 but was subsequently increased to 650,000 in October and further raised to 710,000 in December 1996. These revisions were made to meet the objective of the state population policy that replacement fertility must be achieved by 2001. In order to achieve this objective, the state needed to perform 750,000 sterilisations every year for the next four years. The District Magistrate was instructed to ensure the target achievement. In other words, after nearly nine months had passed the workers did not have self-determined levels of achievement for 1997-98 and were working towards a targeted level of achievement developed with the principal consideration of achieving the demographic goals outlined in the state population policy (Venkata Ramana, 1997).

Similarly in Maharashtra, District Magistrates continued to closely monitor the performance of the programme. There is evidence that, based on their interest, the expected level of achievement actually produced a higher level of reported performance in the family welfare programme. In Rajasthan, through a detailed survey of 31,000 villages, couples with an unmet need were identified. Attention was focussed on couples with unmet need and the population living in remote villages to motivate them to accept contraception. The survey also helped to identify other health and MCH needs of the population. The main thrust has been on strict supervision and monitoring of programme, show-cause notices to workers not performing well and an aggressive IEC campaign (Lubhaya, 1997).

Field visits suggest that many states, though officially following the target-free approach, have reimposed contraceptive targets in some districts. For instance, during 1997-98 in Satara district of Maharashtra, the expected level of achievement for sterilisation was first fixed at 18,394 this was subsequently increased to 30,000 by the

Divisional Commissioner. In Gujarat and Uttar Pradesh, under pressure from senior state official, the expected level of achievement worked out by the PHCs and approved by the CMOs has been revised by the state Directorate. A 10 per cent increase over the 1995-96 level of achievement is taken as the minimum acceptable level of performance during the current year.

### **Population Growth and the Target-Free Approach**

The controversial decision to withdraw contraceptive targets continues to generate discussion. Some, particularly advocates of women's health, have applauded the removal of targets. Donors in general have been supportive of target-free initiatives. Others view the debate on targets as a distraction from the more important issues of health financing and broader social development policy (Jain, 1997). Demographers have maintained that dispensing of targets is ineffective.

In a review of policy directions, the Population Foundation of India suggested that the family planning programme needs to evolve further before targets for sterilisation and other methods of contraception are removed. They suggest that every eligible couple and every adolescent boy and girl must be informed of modern methods of contraception and the basics of reproductive health care, particularly in view of the increasing risk of HIV/AIDS (Srinivasan, 1995). While parliamentarians and politicians still like to refer to India's war against the "population explosion", increasingly their public discourse points to the need for greater investment in education and the empowerment of women (Heptulla, 1997).

There has, however been considerable concern about the detrimental effect on population growth under the target-free approach. In three of the least developed states (Bihar, Madhya Pradesh and Uttar Pradesh), "population control" was reported to have suffered a setback as a result of the target-free approach (Rai *et al.*, 1997). In Bihar and Uttar Pradesh, it was suggested that this might have been due to the fact that in these states the administration had been unstable and bureaucrats were constantly being shuffled. Another reason was that the efficiency of health workers and medical officers under the target-free approach was the same as it was before targets were removed.

Many articles have criticised both the state and central governments for their lack of vision and political will to address the larger issues of population growth and social development (Sahay, 1997). Some condemn poor performing states for not effectively using resources from the centre to support the basic minimum needs programme. However, public debate rarely advocates a return to targets. Mostly, there is a call for better implementation of action plans (Regunathan, 1998).

In November 1997, the Population Council in collaboration with the Government of Uttar Pradesh, USAID and the Futures Group International organised a national workshop to review the implementation of the target-free approach in the country. Case

studies on seven states—Andhra Pradesh, Gujarat, Madhya Pradesh, Maharashtra, Rajasthan, Uttar Pradesh and West Bengal—were prepared by the top programme managers in each state. These seven states taken together constitute about 60 per cent of the national population. The meeting was attended by state secretaries of family welfare, senior programme managers, and health scientists from national and international organisations. The presentations highlighted the following points:

- The process of implementing a target-free approach varied considerably across the country. In some states the target-based approach in variant form is still functioning.
- Most of the states would have preferred a gradual withdrawal of family planning targets. It was strongly felt that states should be given more independence in planning and implementing these development programmes.
- The initial 18 months of implementation (April 1996 to October 1997) was a transitional phase, during which the staff was not sure of the content of the target-free approach or how to monitor the programme.
- In most states, District Magistrates no longer monitor the programme. Hence, many health workers have not contributed fully to programme activities. However, in some states, District Magistrates continue to play a key role in monitoring and implementing the programme. The use of non-health staff for recruiting family planning cases, however, has been discontinued.
- Declining service statistics reflect reduced pressure to inflate figures of family planning acceptors, often observed under the target-based approach.
- The sensitisation process of different levels of staff at the district and PHC levels has been completed in all the states. As a result, medical officers and community workers are more conscious of the concept of quality, the importance of informed choice, the need for follow-up of acceptors, and community mobilisation.
- Outreach activities now focus more on younger and lower parity couples, increasing the potential impact on health and demographic factors. Improvements in MCH care, early registration of pregnant women and increase in delivery by trained personnel was reported from many states (e.g., Maharashtra, Gujarat and Uttar Pradesh).
- Senior bureaucrats at the state and national level were concerned about the initial decline in service statistics. Under pressure, some states have reverted to variations on the target-based approach, though officially a target-free policy continues.
- Changing the mind-set of public sector workers including district authorities, medical officers of PHCs and grassroots workers requires time and constant orientation. As grassroots workers and district/PHC doctors have now started

to appreciate the philosophy behind the target-free approach, they are reluctant to see targets reinstated. Any move in this direction will be counter-productive to the new policy and programme initiatives.

The senior bureaucrats representing the seven states recommended that the target-free approach should continue, and problems in implementing the policy should be addressed as a priority.

### **Reproductive and Child Health (RCH) Programme**

The withdrawal of the target approach was the first step and almost an essential requirement for introducing the Reproductive and Child Health (RCH) programme in India. The RCH programme was formally launched by the Ministry of Health and Family Welfare in October 1997. Essential components of the programme strategy included community participation in planning for services, multi-sector approach in implementing and monitoring services, a client-centred, gender-sensitive approach to service provision, upgraded facilities and improved training, emphasis on quality of care, and the absence of contraceptive targets and incentives.

Operationally, the RCH programme is an alternative integrated approach to the vertical programmes aimed at improving the health status of young women and children, which have been operating during the past decade. It incorporates all the components covered under the Child Survival and Safe Motherhood Programme (CSSM) and includes two additional components, one relating to sexually transmitted disease (STD) and another relating to other reproductive tract infection (RTI). Further, it emphasises the provision of services in a manner which is client-centred, demand driven, high quality and based on the needs of the community arrived at through decentralised participatory planning without target (GOI, 1997). Thus the RCH programme seeks to the efficiency of the earlier programmes, bring about a holistic approach to programme implementation and to produce a paradigm shift in implementation based upon clients' needs.

The implementation of the RCH programme has acknowledged the presence of diversity, as the inputs in all districts will not be uniform. Districts with poor infrastructure and capabilities of the health delivery system will get more attention than others. Similarly, more sophisticated facilities are proposed for the relatively advanced districts which have acquired the capability to use them. Accordingly, the districts of India have been grouped into categories A (58), B (184) and C (265), with "A" constituting the advanced districts. The estimated cost of the RCH programme is Rs. 51125.3 million (approximately US\$ 1189 million) during the Ninth Plan period starting 1997-98.

How these new initiatives are making a difference in the performance and quality of family planning and reproductive health services is too early to judge. Baseline data from 250 districts implementing the RCH approach is just becoming available. Hence as a case study, the impact of target-free approach on family planning performance has

been analysed. The target-free approach has already been in operation for more than three years and the available data provides an opportunity to analyse the impact of the recent programmatic changes in India.

### Emerging Evidence on the Effect of a Target-Free Approach 1996-99

Five major sources of data have been used: information on crude birth rates from the Sample Registration System (SRS) maintained by the Office of the Registrar General of India, service Statistics compiled by the Ministry of Health and Family Welfare, two cross-sectional surveys conducted by the Population Council in Uttar Pradesh— in 1995 and 1997 and the results of the National Family Health Surveys (NFHS) conducted in 1993 and 1998, and qualitative research conducted by the Centre for Operations Research and Training (CORT), and the observations of officials in different states.

### Data on the Birth Rate from the Sample Registration System

The Sample Registration System reports that the crude birth rate (CBR) continues to decline at the national level (from 28.3 in 1995 to 27.5 in 1996 and 27.2 in 1997). A review of the decline in the birth rate during the last 10 years shows that the drop in the birth rate during 1996-97 (0.9) was the highest since 1988 (Fig. 1). This decline has persisted during 1997. A continued decline was reported even in areas of chronic high fertility, like Uttar Pradesh, from 34.8 in 1995 to 34.0 in 1996 and 33.5 in 1997 (SRS, 1998). While acknowledging that total fertility is a function of age structure, marital patterns and abortion as well as contraception, the trend is remarkable in its consistent downward direction since 1984.

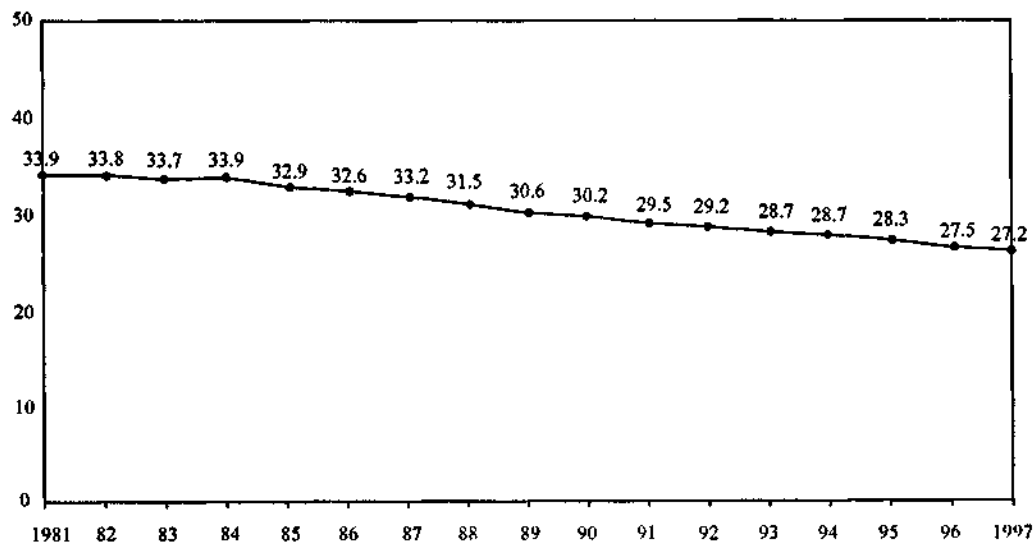


Fig. 1. Estimates of Birth Rates in India—1981-1997  
(Rate per 1000 population per annum)

## Reproductive and Child Health Programme

**Service Statistics from the MOH and FW**

Service Statistics from the Ministry of Health and Family Welfare demonstrate mixed results based on the declining trend in the reported family planning performance since the introduction of target-free approach in 1996-97. While sterilisation and IUD acceptors increased in 1997-98 compared to 1996-97, the number remained marginally lower (4-10 per cent) than 1995-96, the year prior to the withdrawal of the target-based approach (see Table 1). In 1998-99 reported performance of both sterilization and IUD decline again by one per cent. However, given the fact that family planning performance figures under the target-based approach were commonly inflated, the differences are modest.

TABLE 2: ACHIEVEMENTS DURING APRIL-MARCH, 1995-96, 1996-97, 1997-98, 1998-99

Year	Sterilisation		IUD		Oral	Pills	Condom	
	Total in '000'	% variation over 1995-96*	Total in '000'	% variation over 1995- 96*	Total in '000'	% variation over 1995- 96*	Total Nos in '000'	% variation over 1995-96*
1998-99	4182	-5.3	6065	-11.4	6869	+35.0	17308	+0.1
1997-98	4239	-4.1	6173	-9.9	6395	+25.7	16795	-2.8
1996-97	3861	-12.6	5674	-17.1	5178	+1.7	13889	-19.6
1995-96	4420	—	6851	—	5089	—	17282	—

Source: MIES, Ministry of Health and Family Welfare

\* The year after which the target withdrawn

In the case of condom use the trend has been reversed since the major drop (19.6 per cent) in the first year of target-free approach. In 1998-99 it has already achieved the same level of users as before the introduction of target-free approach. It is important to point out that part of the decline in the condom use can be attributed to the Ministry of Health and Family Welfare curtailing support to the free condom distribution programme. Users now have to pay Rs. 1 per piece, reducing both use and inflated reporting.

The increase in reported use of oral pills is noteworthy and persistent. It increased by about 2 per cent in the first year of target-free approach, and since then showed a steep increase—26 per cent in 1997-98 and 35 per cent in 1998-99. It appears that after the withdrawal of targets the initial decline in the use of sterilisation and IUDs could be either due to greater slackness in work and past inflated reporting in performance statistics. However, the more recent minor drop (1 per cent point in 1998-99) in the use of these contraceptive is due to a shift in the pattern of contraceptive use, which might perhaps be due to expanded contraceptive choice, the changing profile of users or less pressure for promoting sterilization or IUDs.

An analysis of reported family planning use from 1992-93 to 1998-99 provides insight into the process of implementing policy change. As Table 3 shows, when the performance of any method is compared with its performance in the previous year, there is a reduction in the pace and direction of change. For instance, during 1993-94, there was almost a 5 per cent increase in sterilisation over the previous year (1992-93). During the next year this increase dropped to only 1.8 per cent. In 1995-96, a year before the country was made target-free, sterilisation registered a decline over the, previous year (1994-95), and further declined by 13 per cent in the first year of the target-free approach. This trend was reversed in the second year of the target-free approach by registering an increase of almost 10 per cent, though it remained about 4 per cent less than in 1995-96. In the third year (1998-99) the performance again dropped by 1 per cent.

TABLE 3: TRENDS IN FAMILY PLANNING PERFORMANCE: 1993-94 TO 1998-99  
(APRIL-MARCH)

Year	Sterilisation		IUD		Pills		Condom	
	% variation over previous year	No. ( '000)	% variation over previous year	No. ( '000)	% variation over previous year	No. ( '000)	% variation over previous year	No. ( '000)
1992-93		4286		4740		3001		15004
1993-94	4.9	4496	26.8	6013	43.2	4299	15.1	17283
1994-95	1.8	4579	11.4	6702	13.3	4873	2.4	17707
1-995-96	-3.4	4420	2.2	6851	4.4	5089	-2.4	17282
1996-97*	-12.6	3861	-17.1	5673	1.7	5177	-19.6	13889
1997-98*	+9.7	4238	+8.8	6173	+23.5	6394	+20.9	16795
1998-99*	-1.3	4182	-1.7	6065	+7.4	6868	+3.1	17308

Source: MIES, Ministry of Health and Family Welfare; \*First, second and third year of target-free approach.

A similar pattern can be seen for IUDs, pills and the condom (Table 3). While pill and condom use has increased since 1997-98, the data suggest that the existing delivery system was not meeting clients' expectations and the impact of programme effort on performance had reached a level of diminishing returns. Alternatively, one could conclude that the service statistics are unreliable source of information, and reflect more internal pressures for results than actual clients' behaviour. However, even with the target-based approach, sustaining further increases in programme performance would have been difficult without a revamping of service delivery strategies, changing its focus to quality of care, and adopting strategies to reach couples with an unmet need, particularly those living in remote rural areas.

### Contribution of Four Large States in National Performance of Family Planning Programme

Four major "Hindi belt" states of India namely Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh, have a significant effect on the social and economic development of the country. These states taken together constitute about 41 per cent of India's population and have generally poor socio-economic and demographic parameters. In view of this, a special analysis was done to assess how, after the withdrawal of family planning targets, these four states have contributed in the national performance of family planning.

Of the four states all, except Rajasthan, showed a much sharper decline in the family planning performance after withdrawal of targets than in the rest of the country. Surprisingly, Rajasthan was the only state in the country where since the withdrawal of targets, no reported reduction in use of *any* method has occurred. This was largely due to the special interest of the state's Family Welfare Secretary, who combined aggressive promotional efforts with close monitoring of individual worker's performance.

In the remaining three states i.e., Bihar, Madhya Pradesh and Uttar Pradesh, the reported performance of all the methods registered much sharper declines than in the rest of the country. In absolute numbers the combined decline in the performance of the three states for each method and the corresponding figures for the country as a whole are given in Table 4.

As the table shows, in the first year (1996-97) these three states taken together contributed 82 per cent of the reductions in sterilisation, 76 per cent in IUD use and 39 per cent in condom use. In the case of pills, while the country registered a net gain of 88,306 equivalent users, the three states together registered a drop of 91,142

TABLE 4: CHANGES IN FAMILY PLANNING PERFORMANCE DURING THE FIRST THREE YEARS OF TARGET-FREE APPROACH WITH RESPECT TO 1995-96: INDIA AND BIHAR. MADHYA PRADESH AND UTTAR PRADESH COMBINED

<i>Method</i>		<i>Change in performance of FP</i>		
		<i>1998-99</i>	<i>1997-98</i>	<i>1996-97</i>
Sterilization	India	(-) 238,075	(-) 181,512	(-) 588,553
	3 states combined	(-)309,197	(-) 343,899	(-) 459,302
IUD	India	(-) 785,189	(-) 677,620	(-) 1,176,987
	3 states combined	(-) 473,323	(-) 462,079	(-) 890,361
Pill	India	(+) 1,179,733	(+) 1,305,862	(+)88,306
	3 states combined	(+) 279,658	(+) 223,737	(-)91,142
Condom	India	(+) 26,059	(-) 486,630	(-) 3,393,080
	3 states combined	(-) 1,134,536	(-) 935,161	(-) 1,329,668

Source: Yearbook 1995-96 and MIES, MOH&FW

equivalent users. In the second (1997-98) and third (1998-99) year of the target-free approach this pattern persisted. For instance, in 1998-99, in absolute numbers the net performance of sterilization in the country was 238,075 less than the performance of 1995-96 (prior to the withdrawal of method-specific targets). While the reports of sterilisation increased in most states, the three states taken together had a corresponding reduction of 309,197 cases of sterilisation—130 percent more than the national figure.

In the case of the IUD the three states contributed 60 percent of the total national decline (Table 3). In 1998-99 while condom use in the country has shown an overall increase with respect to 1995-96, the corresponding figure for the three states taken together still shows a deficit of 1,134,536 equivalent users. The analysis thus shows that while the withdrawal of targets initially had some adverse effect on the family planning performance, slowly it is getting back on track. The overall performance of the country would have been much better but for the continued poor functioning of the programme in Bihar, Uttar Pradesh and Madhya Pradesh. Most noteworthy, however, is the persistent increase in the use of OCP, perhaps indicating an expansion of contraceptive choices for the clients.

The hasty introduction of the target-free approach has contributed to greater declines in reported performance than expected. Further, while service statistics support the fact that the declining trend in performance has been reversed at the national level, they also indicate that some states need special attention to strengthen the reproductive health services. In terms of sterilisation, the states with the greatest decline in performance are Uttar Pradesh, Bihar, Madhya Pradesh and Gujarat. However, it is encouraging to note that the declining trend has apparently been reversed. In the coming years, focusing on client-centred, need-based services with proper attention to quality, supportive supervision and supplies will significantly improve the implementation of the RCH programme.

### **Independent Survey Results**

Two independent, surveys have been used to compare the coverage and potential effects of the family welfare programme before and after the implementation of the Target-Free Approach. It includes two districts survey results in Uttar Pradesh carried out just before the withdrawal of the target approach (1995-96) and then two years after. The second source is comparison of the results of NFHS-1 and NFHS-2 in the states of Bihar, Gujarat, Rajasthan, Uttar Pradesh and West Bengal.

### **Comparison of District Level Survey Results in Uttar Pradesh**

In 1995-96, Agra and Sitapur District in Uttar Pradesh were the first two districts that were made target-free. Prior to this, the State Innovations in Family Planning

Services Agency (SIFPSA), with technical assistance from the Population Council, conducted a detailed community-based survey in which 2,500 eligible couples randomly selected from the entire district were interviewed. Between November 1996 and January 1997 the Population Council supported a repeat survey in these two districts. A comparison of the survey findings shows no evidence of any reduction in contraceptive prevalence under the target-free approach. In fact, results suggest improvements in the quality of services. For example, there was evidence of a modest increase in household visits by grassroots workers, an increase in family planning use among younger couples, and an improvement in prenatal care and the immunisation of children. The total fertility rate in both districts has also declined (see Table 5).

Improvement in the quality of services is evident from the fact that grassroots workers are now giving clients a broader choice of contraceptives. As Table 5 shows compared to 1995, in 1997 a larger proportion of women were given information about various family planning methods including male contraceptives and traditional methods. Similarly, more clients were informed on how the method works and where it can be obtained (83-93 percent in 1997 compared to 22-73 per cent in 1995). While the results from these two districts are well below the desired standard for quality, they do suggest that the changes that have occurred since 1995 are in the right direction.

### **National Family Health Surveys (NFHS)**

The first DHS survey, referred to in India as the National Family Health Survey (NFHS-1), was conducted in 1992-93. It was a massive undertaking 89,777 women from all over the country. The results are available both at the national and individual state levels. The second round of the National Family Health Survey (NFHS-2) was conducted in 1998-99 and the preliminary results have just begun to become available. Table 5 compares the findings of NFHS-1 and NFHS-2 of five major states of India, namely Bihar, Gujarat, Rajasthan, Uttar Pradesh and West Bengal, for which preliminary results are available. The five states taken together contribute about 45 per cent of the country's population.

A comparison of the results clearly indicates an increase in ANC care in all five states, though the size of the increase and overall coverage varies widely between states (see Table 6). Further, the increase in coverage of ANC is largely due to services received at clinics/outside the home as over the period, the provision of ANC services at home has declined. For instance even in generally well performing states like Gujarat, the provision of ANC at home declined from 25 percent to 18 percent. In Uttar Pradesh it dropped from 16 percent to 3 percent. Institutional deliveries, except in Bihar and Uttar Pradesh, have increased significantly elsewhere.

In the case of Child vaccination some improvement could also be seen. While the percentage of children fully protected has not increased, except in West Bengal, the percentage of children who have not received any vaccination has dropped significantly.

TABLE 5: SELECTED INDICATORS IN FAMILY WELFARE ACTIVITIES IN RURAL  
AGRA AND RURAL SITAPUR

<i>Indicator</i>	<i>Agra</i>		<i>Sitapur</i>	
	<i>1995</i>	<i>1997</i>	<i>1994</i>	<i>1997</i>
<b>A. Accessibility and Coverage</b>				
Households visited by health worker in last 3 months	9.6	15.8	1.5	11.8
Pregnant women receiving IFA tablets	230	279	18.3	322
Pregnant women receiving tetanus toxoid injections	342	412	33.3	373
Children aged 12-23 months receiving:				
BCG	41.9	55.8	47.3	52.1
DPT - 3 doses	29.6	32.2	36.3	36.8
Polio - 3 doses	29.0	43.2	36.6	44.3
Percent of currently married women aged 13-49	30.5	33.6	21.0	21.1
Currently using any family method				
13-24	11.0	17.1	11.3	8.4
25-39	37.0	47.9	21.8	28.2
40-49	48.2	48.6	38.1	34.5
Current use by method				
Male sterilisation	0.5	0.4	0.6	0.4
Female sterilisation	14.1	14.4	8.8	9.1
IUD	0.5	0.4	0.5	1.2
Pills	0.9	0.9	1.0	0.6
Condoms	4.3	2.8	2.4	1.9
Other methods	10.2	14.7	7.7	7.9
<b>B. Quality of Care</b>				
Percent of currently married women who had been counselled by a health worker and mentioned a particular method of FP				
Vasectomy	13.2	42.3	22.1	31.9
Tubectomy	70.5	64.7	79.4	69.6
IUD	34.5	36.3	27.4	47.5
Pill	31.7	52.3	27.4	78.1
Condom	37.8	62.9	28.8	63.8
Withdrawal	2.8	8.6	2.7	1.8
Safe period	2.5	15.8	3.3	6.5
<b>C. Demand</b>				
Unmet need for spacing	17.8	15.6	19.7	23.5
Unmet need for limiting	22.3	23.7	23.3	21.3
Total unmet need	40.1	39.3	43.0	44.8
<b>D. Impact</b>				
Total fertility rate per women	5.4	5.1	5.8	5.6

*Source:* Baseline and Endline Surveys in Agra and Sitapur District, Population Council

The knowledge of family planning methods, particularly on non-terminal methods, has increased in all the states. However, the change in contraceptive use presents a

## Reproductive and Child Health Programme

TABLE 6 TFR AND SELECTED REPRODUCTIVE HEALTH INDICATORS  
FROM NFHS-1 (1992-93) AND NFHS-2 (1998-99)

	Bihar		Gujarat		Rajasthan		Uttar Pradesh		West Bengal	
	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2
Accessibility & coverage										
Percent who received										
home visit	NA	2	NA	33	NA	12	NA	3	NA	18
Received 2 or more doses of T T	31	58	63	73	28	52	37	51	70	82
Received IFA Tablets	21	24	69	78	29	39	29	32	56	72
Received ANC through only home visit	10	6	25	18	8	9	16	3	7	3
Received ANC from outside home	26	30	50	69	23	39	31	31	68	87
Institutional delivery	12	15	36	46	12	22	11	16	31	40
Children fully immunized	11	11	50	48	21	16	20	21	34	44
Children received none	54	17	19	7	48	23	43	30	22	14
Total N	3562	2947	1942	1324	2876	3076	8000	4414	2196	1316
Percentage who know										
Pills	57	75	66	60	53	79	65	85	86	92
IUD	44	59	71	66	46	69	56	74	68	73
Condom	55	64	63	54	23	74	67	83	68	79
Percentage										
Currently using										
Any modern method	209	224	454	533	296	381	185	220	377	473
Pills	12	10	11	10	05	15	10	12	38	92
IUD	33	16	06	04	13	12	11	10	13	14
Condom	06	04	33	16	15	31	32	42	19	29
F Sterilization	167	192	366	470	246	308	117	149	267	320
M Sterilization	10	10	24	24	16	15	14	07	39	18
Quality										
Percent of current users who were told about										
Other methods	NA	15	NA	11	NA	16	NA	13	NA	9
Side effect of the method adopted	NA	16	NA	10	NA	13	NA	14	NA	10
Received follow up	64	77	48	71	54	70	54	50	54	31
Impact										
TFR (15-44)	40	35	30	27	36	37	47	40	29	23
Total Sample Size	5949	6661	3832	3845	5211	6573	11438	8918	4238	4116

mixed pattern. In West Bengal, Gujarat and Rajasthan the increase in modern contraceptive use is substantial (8 to 9 percentage points), while in Uttar Pradesh and Bihar in increase is only marginal (3.5 and 1.5 percentage points). In none of the states, except West Bengal, has the use of non-permanent methods shown a significant increase. It suggests that the increase in knowledge gained about non-permanent methods is insufficient to produce changes in use.

NFHS-1 did not have specific questions on the quality of services but NFHS-2 results show that the quality of counselling is still far from satisfactory. The analysis reveals that only 9.15 per cent of the current users were informed about other methods and only 10-16 percent were informed about the side effects of the method they had adopted. In the case of client follow-up, coverage has improved in Bihar (77 per cent), Gujarat (71 per cent) and Rajasthan (70 per cent), but has dropped in Uttar Pradesh (to 50 per cent from 54 per cent) and West Bengal (to 31 per cent from 53 per cent). Despite these problems in service delivery, in terms of demographic change, the Total Fertility Rate has dropped in all the states, somewhat greater in Uttar Pradesh (4.7 to 4.0 in 5 years) and West Bengal (from 2.9 to 2.3) than elsewhere.

The analysis thus complements the earlier observations that the withdrawal of the target approach has not affected fertility and family planning use adversely. The reasons for the observed trends are still hotly debated. The overall quality of service has not improved significantly, counselling continues to be missing and changes in the method mix has just started occurring in a few states. It is, however, encouraging that provision of selected RCH Services (ANC and immunisation) has shown some improvement though ample scope is there for further improvement also.

### **Qualitative Data from Other Sources**

Qualitative studies conducted in Agra district, Uttar Pradesh, and Valsad district, Gujarat (CORT, 1998) showed that in general both the medical officer in-charge of PHCs and grassroots workers are supportive of the Target-Free Approach. According to them, the quality of the family planning programme has improved since targets were abolished, particularly in terms of the coverage and care of pregnant women. Now that grassroots workers are providing MCH services and not merely seeking women for sterilisation, their credibility in the community has improved. The following quotes from focus group discussions among ANMs reflect the general perceptions about the Target-Free Approach and its impact on the family welfare programme.

Previously, duplicate [fake] cases were made, which is not so now. Earlier, operations (sterilizations) were conducted on mothers with 4-5 children for the sake of targets, but today different family planning methods are offered to couples. Now more young couples are being contacted (FGD of ANMs, Agra).

"Earlier (in target approach) to achieve sterilization target we used to recruit several cases from outside the geographical boundary of our work area. Now in target free approach we concentrate in our work area only. Earlier we had to run a lot to chase such cases. We were wasting our time for getting sterilisation at the cost of other services. Target Free Approach has made our work much easier. We can give our time for other services also [referring to MCH]" (FGD of ANMs, Valsad).

"In the target approach, the stress was on sterilisation only, while TFA is concerned with all services. Target approach used to be based on population, while TFA is need-based. Now we conduct survey to know who needs what? (FGD of ANMs, Valsad)."

"Earlier we were called by the villagers as *safedsariwali chudyal* (witch in white sari) and they refused to talk to us. But now our image has slightly improved. Now they themselves ask for family planning methods (FGD of ANMs, Agra)."

The study though did not see any significant improvement in the quality of services provided, the doctors as well as workers were at least more sensitive to the need of improving quality of services. A Dy CMO from Agra district said,

"It (TFA) is a client centred approach. The workers first identify community needs and then plan their work activities. Quality is given more importance than number."

It is interesting to note that, for both medical officers and the grassroots workers, acceptance of contraception, particularly sterilization, by young couples was an important indicator of quality of services.

The CORT qualitative studies in Agra and Valsad Districts indicate that both medical officers as well as grassroots workers perceived the Target-Free Approach as a desirable change in orientation, and strongly believed that it has helped in improving the quality of family planning and coverage of MCH services. However, qualitative interviews with community members suggest that the outreach services of the grassroots workers have not increased significantly, particularly in remote areas. Villages have remained neglected as they were before the TFA.

"She is doing the same as she used to do previously."

"I think there is little change in the sense that she used to be late previously but not now."

"*Ati kya, jab woh hai hi naheen* (How can she come, when there is no ANM), how can we explain changes?"

"I do not see any change. She hardly visits. Yes, now she does not chase people for sterilization."

"She has no medicine to offer. Even if she comes what she will do except offering *goli* (contraceptive pills) or *nirodh* (condom)."

However, community members from sub-centre villages or those villages which are accessible, not only reported somewhat more frequent contact with the ANMs, but also more services, detailed information and no pressure for a particular method such as sterilisation. It is interesting that about 20 percent of the community members (12 out

of 60) contacted and interviewed during the qualitative research were aware that targets had been withdrawn.

Several woman informants, who reported an increase in the frequency of visit of ANMs, said:

"Fo/z *ghar ghar jari hai* (she visits every home), she talks everything about operation, Copper-T, Nirodh. She also gives *lal-goli* (IFA Tablet) to *pel-wall aurat* (pregnant woman). However, *lal-goli* is not available for the past four months."

"I have got Cu T fitted by ANM. First, she told me to use nirodh and if it does not work, then take oral pills. And if you cannot eat OCP, happen to forget, then accept Cu-T. I have taken the decision at my own."

"There is special change, they used to talk about only one thing (probably referring to sterilisation) previously, now they talk about many things. They go from home to home. She is here regularly, tells about operation, and talks about operation camps. Previously someone else was coming, she never mentioned any thing like this. She takes us to the doctor if there is any problem."

Similar observations have been made by a number of officials from Maharashtra and Gujarat also. They felt that the approach has improved coverage of mother and children under the MCH programme. In Maharashtra (Wardha District) not only has ANC improved but also more deliveries were being attended by trained persons. From Rajasthan, Maharashtra and Gujarat, family planning indicators like the follow-up of acceptors, continuation of contraceptive use (not necessarily a single method), acceptor age and parity are given more importance and taken as proxy measures of quality. Community mobilization for the support of the programme has been adopted in Maharashtra and more than 400 district level officers have been trained in effective community partnerships.

### **Discussion and Future Challenges**

Given this management tradition of more than thirty years, and the current state of public sector services, is it possible to have a successful paradigm shift in the form of the RCH programme within a target-free approach in India? Does the absence of method-specific targets ultimately lead to poorer performance? How far will the RCH programme be instrumental in achieving client-centered, need-based quality reproductive health services for all? While there remains much to be done to improve the coverage and quality of family welfare services, it appears as if the programme is moving in the right direction. All these findings come from independent sources, increasing the confidence in the conclusion drawn.

The preliminary findings of NFHS-2 survey available from five large states and district level RCH surveys clearly demonstrate that while coverage of ANC and immunization have improved, the use of family planning has improved only in some states and remains much below expected levels in others. However, it is important to mention that in none of the states, including Bihar, has the contraceptive prevalence rate declined. At the same time, the total fertility rate declined in four of the five states where comparative data are now available. These changes cannot be attributed solely to the official withdrawal of method-specific targets, and much less to the efforts to improve reproductive health through public sector services. During the past five years, obviously a great deal of social change has occurred in India. Nevertheless, it does give some confidence that this controversial policy change, *albeit* implemented imperfectly, did not lead to unwanted population growth. At the same time, the data point to other areas of policy needing immediate attention. Most notably, the quality of services has improved only modestly and new challenges abound as India moves into the 21<sup>st</sup> century. To better guide these efforts, there is also an urgent need of developing, field testing and implementing new performance indicators, which focus on the process and quality of services of the Family Welfare programme, and the coverage of all components of the RCH programme.

In reflecting on the debate and the results presented to date, four elements emerged which merit further discussion. The first is the *background* to this particular issue. Since the first International Conference on Population and Development (ICPD) in Bucharest in 1974, India has been a leader in the world community in recognizing the rights of individuals and couples to freely decide on the number and timing of the births of their children and the means to achieve these reproductive goals. This right was reaffirmed in the 1994 ICPD in Cairo and in other international forums. The Cairo Conference was different from previous meetings of this type in that it represented a paradigm shift, away from the topic of "population control" and toward a more holistic focus on community participation, the need for education, the empowerment of women, and better reproductive health for all. India was a leader in this process, and this perspective is reflected in its policy documents and programme planning at the national and state levels. It should be better reflected in implementation at the client level.

The second issue is *conceptual*. What is the difference between goals and targets? How can a programme function without targets? Goals are expressions of desired achievement, and they are absolutely necessary for individuals as well as for governments. They focus attention on priority issues, assist in mobilizing resources, direct action to priorities and provide a standard against which progress can be measured. National and international goals for stabilizing population growth are legitimate and consistent with other national goals, e.g., of universal access for boys and girls to primary education, reductions in infant and child mortality, access to safe water, adequate housing and security. The goals reflected in the National Population Policy are consistent with the ICPD Plan of Action and are important for giving focus to the paradigm shift.

While population stabilization is an important goal globally, the ultimate goal of all development, including family welfare services, has to be the improvement of the quality of life of present and future generations. The Government of India has clearly defined the path through the demographic transition from high fertility and high mortality to low fertility and low mortality. This path is through economic development and poverty alleviation, improvement of women's status, ensuring of universal access to quality primary education and primary health care, including reproductive health and family welfare services, and educational strategies regarding responsible parenthood. In other words, responding to individuals' and families' needs. The paradigm shift in the family welfare programme reflected in dispensing of the method-specific target approach and launching of the RCH programme are decisions in the right direction. Now the real challenge is proper implementation and management of the programme.

The third comment has to do with *strategy*. India, and indeed the world, is undergoing profound changes in its economic structure and processes. India is moving from a centrally planned economy where expert committees, based upon the best available data, set the agenda for production and consumption, to a more market based economy, where the clients' needs and clients' demand define the nature of goods and services. This secular economic process is accompanied by the move toward greater decentralization of decision-making in government. This move toward decentralization shifts decision making on many issues of national importance from the center to the states and then to the *panchayats* (local governments), and ultimately to the family and individuals. This process of decentralization in planning and implementation is not limited to family welfare sector, but is seen in all elements of the national scene from food products to power. Industries are investing more in market research to understand their clients, and production is based upon today's demand, not simply last year's output.

Within this context of liberalization, government still plays many important roles. Government must define national goals, service strategies, establish standards for quality, and has to be vigilant to ensure that these standards are met by public and private service providers of all types. At the same time, government has to ensure that individuals and communities receive the benefits of development, and that all have access to the basic services they need and to which they have a right. Thus, the strategy the GOI selects for any programme whether it be water and sanitation, primary education or family welfare must be effective and responsive to individuals' needs. In this market driven context, where the client not the service provider defines need, assigning uniform targets to grassroots workers on how many couples in a village should use a condom or accept sterilization services seems somewhat out of date and certainly out of touch.

But quality public services are not produced through wishful thinking or fine public pronouncements. They require *good governance and strong leadership at all levels*. Good governance demands the effective use of resources and vigilance to ensure that

all the elements needed for a quality service are present, when a client seeks a service. Just as a good water system requires more than an abundant source and a thirsty population, so too basic health and family welfare services require more than contraceptive supplies and a population with unmet needs. Good governance ensures that all the intermediate steps required for a quality service are there: accessible and well maintained facilities, competently trained staff, adequate information for clients' to make decisions, counselling on how to best use the methods selected and follow-up. Good governance demands local planning, continuous upgrading of facilities and services, and supervision of implementation. Good governance demands strong leadership at all levels to guarantee that resources provided by the state are directed to those who need and demand care at the village. A renewed focus on the client, on quality and on resolving the systemic issues in implementation are clearly the key management issues for the Indian Family Welfare Programme in the 21st Century.

### **Recommendations**

Specifically, the following recommendations are suggested for policy and programme managers based upon this analysis.

- The TFA and the subsequent launching of the RCH programme are important initiatives to achieve the objectives of paradigm shift in Indian Family Welfare programme. However it is only 28 months since the launch of the RCH programme. To expect any significant impact from the programme is too early. What is important at this juncture is to encourage the states to take innovative approaches and effective management to implement the programme in the same spirit as proposed in the national policy/programme documents and the Cairo Plan of Action. The Central Government also should give more autonomy to the states in planning implementation to better reflect local needs and priorities.
- The focus of the debate in the next few years should be on improving the processes involved in quality of information and care within client-centred, target-free systems. Systemic improvements in quality have been identified for the past ten years as critical for both expanding the acceptability and coverage of care within the family welfare programme. Improving the quality of implementation must be the next step. In order to change the measures of performance, better client-centred indicators are required. The key for the next few years will be to test sets of these indicators in one or more Districts to see how they function as variables, and how they are used by health system managers to improve the package of services.
- Investments must continue to be made in basic infrastructure, supplies and transportation. The trends in service statistics reflect a much broader problem, that is, the under-investment in the public service delivery system by many states. Without ensuring adequate supplies of contraceptives, transportation to facilitate

client-provider contact and supervision, and basic facilities, it is unlikely that the current system will be able to meet the increased number of men and women demanding family planning services in the future. Simultaneously efforts to incorporate the private practitioners and the commercial sector will contribute significantly to the financial sustainability and impact of the programme. Responsibility for the relative success or failure of the RCH should not be laid only at the feet of the ANMs. Senior programme managers and middle level bureaucrats must also be accountable for the implementation of the RCH and family welfare services under the TFA. Supportive supervision is critical for maintaining the focus on quality and good management practice. District Magistrates should continue to ensure that client centred services are available in their Districts.

## References

- Asian Age, 1995, Consumer-oriented policy for better planning, December 22.
- Bondurant, Tony, 1997, The Introduction of Target Free Approach in West Bengal: A Case Study. *Paper presented in the National Workshop on Performance of Family Welfare Programme under Target Free Approach*, organized by Ministry of Health & Family Welfare, Government of Uttar Pradesh in collaboration with the Population Council and Policy Project held at Lucknow, November 24-25.
- Centre for Operations Research and Training (CORT), 1998, *Preliminary report on the implementation of the Target Free Approach in two Districts*, Baroda.
- Expert Group on Population Policy, 1994, Draft National Population Policy. Submitted to MOH&FW, CiOI, New Delhi, May 21, 1994 (unpublished document).
- Ghasura, N. D., Patel, Bella C., Khan, M. E., 1997, Implementing Target Free Approach in Gujarat. *Paper presented in the National Workshop on Performance of Family Welfare Programme under Target Free Approach*, organized by Ministry of Health & Family Welfare, Government of Uttar Pradesh in Collaboration with the Population Council and Policy Project held at Lucknow, November 24-25.
- Heptulla, Najma, 1997, *Role of Empowerment of Women in Population Stabilization*. The Population Foundation of India, New Delhi, November 29.
- International Institute for Population Studies (IIPS), 1994, *National Family Health Survey (MCH and Family Planning), India 1992-93*. Bombay: IIPS.
- Jain, Anurudh, 1997, Consistency between contraceptive use and fertility in India. *Demography India*, 26(1).
- Jain, Devaki, 1997, Population Control: Social Development is the Key. *Times of India*, New Delhi, September 3.
- Khan, M. E. and Cernada, George, 1996, Promoting Spacing: A Step towards Paradigm Shift. In: M.E. Khan and George Cernada (eds.), *Spacing as an Alternative Strategy: India's Family Welfare Programme*. B.R. Publishing Corporation, Delhi.
- Khan, M. E., 1993, *Unmet Need for Family Planning in India—Voices from the Fields of Family Planning Meeting Challenges: Promoting Choices*. The Pathenon Publishing Group, U.K.
- Khan, M. E. and Townsend, John, 1998, Impact of Changes in Populations Policy on the Family Welfare Programme in India. Paper presented in APHA meeting at Washington, November 16-19.
- Kothari, D., Maru, R., Khanna, A., Krishnan.V. K., Paliwal, S. and Abbasi, S., 1997, *Vikalp: Managing the Family Planning in the Post-ICPD Era, an experiment in Rajasthan, India*. Indian Institute of Health Management Research (IIHMR), September.

- Measham, A. and Heaver, M., 1996, *Summary of the Family Welfare Sector Assessment*. The World Bank, New Delhi.
- Mehrotra, P. K., Vemuri, Muralidhar, Khan, M. E., Kole, Subir Kumar, 1997, *Implementing Target Free Approach in Madhya Pradesh*.
- Ministry of Health and Family Welfare (MOH&FW), 1997, *Statement on National Population Policy*. Department of Family Welfare, January.
- Murthy, Nirmala, 1996, Report on a workshop of Health District Implementing Innovations in Reproductive Health. Ahmednagar, Maharashtra, January.
- Parekh, Angana, 1995, One district in major states exempted from FP target. *Indian Express*, New Delhi, April 5.
- Poornalingam, R., 1995, Family Welfare Program—MCH Approach Adoption during 1995-96. GOMs. No. 353, Government of Tamil Nadu, Health and Family Welfare Department, April 30.
- Population Council, 1998, *Updates 1-13*, New Delhi.
- Rai, Usha, 1997, Baby boom may follow target-free approach. *Hindustan Times*, New Delhi, September 23.
- Ram, Lubhaya, 1997, Target Free Approach for family Welfare. A Review of experiences in Rajasthan. *Paper presented in the National Workshop on Performance of Family Welfare Programme under Target Free Approach*, organized by Ministry of Health & Family Welfare, Government of Uttar Pradesh in collaboration with the Population Council and Policy Project held at Lucknow, November 24-25.
- Ramasundaram, S., 1995, End of the Target Era. *Voices*, 111(2), Bangalore, India.
- Regunathan, Sudhamahi, 1998, Doing away with targets. *The Hindustan Times*, New Delhi, March 20, p. 16.
- Sahay, K. B., 1997, Ghost of Malthus: On the continuing boom. *Asian Age*, New Delhi, July 11.
- Salunke, Subhash and Narvekar, Sharad, 1997, Target Free Approach for Family Welfare: A Review of Experiences in Maharashtra. *Paper presented in the National Workshop on Performance of Family Welfare Programme under Target Free Approach*, organized by Ministry of Health & Family Welfare, Government of Uttar Pradesh in Collaboration with Population Council and Policy Project held at Lucknow, November 24-25.
- Satis, J. and Subramaniam, S., 1996, Suggested indicators for the RCH Programme, ICOMP and UNFPA, New Delhi.
- Srinivasan, K., 1995, *Regulating Reproduction in India: Efforts, Results and Recommendations*. Sage India, New Delhi.
- Townsend, J. W. and Khan, M. E., 1993, Target Setting in Family Planning Programme: Problems and Potential Alternatives. *Demography India*, 22(1), 113-125.
- Townsend, J. W. and Khan, M. E., 1996, Indicators and a Management Information and Evaluation System for a Reproductive and Child Health Approach. In: A. Measham and M. Heaver (eds.), *India's Family Welfare Program: Moving to a RCH Approach*. The World Bank, Washington, DC.
- Verma, Lov, Gupta, R. B., Khan, M. E., Townsend, John W., 1997, Implementing Target Free Approach in Uttar Pradesh. *Paper Presented in the National Workshop of Performance of Family Welfare Programme under Target Free Approach*, organized by Ministry of Health & Family Welfare, Government of Uttar Pradesh in Collaboration with the Population Council and Policy Project held at Lucknow, November 24-25.
- Venkata Ramanna, 1997, Target Free Approach for family Welfare: A Review of Experiences in Andhra Pradesh. *Paper Presented in the National Workshop on Performance of Family Welfare Programme under Target Free Approach*, organized by Ministry of Health & Family Welfare, Government of Uttar Pradesh in collaboration with the Population Council and Policy Project held at Lucknow, November 24-25.
- Visaria, Leela, Visaria, Pravin and Jain, Anurudh, 1994, Estimated of contraceptive prevalence based on service statistics and surveys in Gujarat State, India. *Studies in Family Planning*, 25(5): 293-303.

- Visaria, Leela, Visaria, Pravin, 1995, India's Population in Transition. *Population Bulletin*, 50(3), Population Reference Bureau, Washington DC.
- Visaria, Pravin and Charu, Vijayalaxmi, 1998, India's Population Policy and Family Planning Programme: Yesterday, Today and Tomorrow. *In: A. Jain (ed.). Do Population Policies Matters Fertility and Politics in Egypt, India, Kenya and Mexico.* Population Council, New York.