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Target Setting in Family Planning Programme: Problems and Potential Alternatives

Background

THE family planning programme in India is now more than four decades old. During this period the programme has expanded enormously both in resource allocation and development of infrastructure. Setting up such a large organizational structure which penetrates deeply in rural areas is itself a commendable achievement. The programme has succeeded in increasing family planning awareness and acceptance in the country.

The allocation of money for the programme increased from just Rs. 6.5 million in the First Five Year Plan in 1952 to Rs. 65,000 million in the Eighth Five Year Plan (1992-97). Over the period, the contraceptive prevalence rate (CPR) has increased from merely 9.4 per centin 1970to44.1 percentin 1991. During the decade 1970-80, the average annual increase in CPR was around 1.3 percentage points. During 1980-90 the acceptability increased at a faster rate, and the average annual increment was about 2.1 percentage points.

However, if the impact of the programme is measured in terms of the decline in birth rate, it is modest and below expectation. Despite an increase in CPR, for the past 7 to 8 years the birth rate of the country remained stable around 35 and only recently some decline has been observed (GOI1992). The impact of the programme is modest largely because:

- some of the impact has been neutralized by the increasing proportion of females of reproductive age in the population which tends to increase the fertility rate;
- the over-emphasis of the programme on achieving the family planning targets, particularly that of sterilization among women at higher levels of parity.

Recently, there has been an increasing criticism of the target approach adopted by the family welfare programme. While the criticisms of the existing system are justified and also appreciated by many programme managers, no viable and appropriate alternative system for programme management has emerged so far. In the present paper a few alternatives, by no means new in the demographic literature, are presented for the consideration and discussion.

The paper has been divided in three sections. In the first section, the rationale for the target setting and its consequences in the Indian context are discussed. In the second section,

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potential alternatives are suggested. And thirdly, the directions for research on testing their efficacy are proposed.

Rationale for Target Setting

The rationale for adopting the target approach in the family welfare programme was spelled out by the Department of Family Planning in its letter (No:5-9/66 P&E, dated 25 May 1966) to all State Government and Union Territories as follows:

> "I am directed to say that as a part of plan to *reorganize* and *intensify* the family planning programme, it has been decided to give it a target orientation and to ensure that every possible effort is made to *achieve the targets.* This would also be helpful in *assessing result* of the programme. Keeping in view *the aimed objective* of reducing the birth rate from 40 to 25 per thousand by 1975, certain broad norms for the use of different methods of birth control have been worked out....." [emphasis is ours].

A careful reading of the above policy statement indicates that the target oriented approach was adopted because it was considered an effective management tool for

- intensifying the level of effort of the programme;
- using all available resources to achieve the targeted population goal;
- assessing that the programme is moving in the desired direction;
- placing pressure on the workers to increase CPR.

Two other assumptions which are not explicitly mentioned in the above letter but have been assumed are:

- the unmet need is high—that is, a large number of people who want to stop child bearing or delay their next pregnancy are not using family planning methods;
- the existing delivery system is not adequate to reach all individuals with unmet nee, unless a special effort is made.

The available literature confirms both of the above assumptions. According to the Third All India Family Planning Survey, conducted at the national level, 24.6 million of the eligible couples (18.3 per cent) were in the 'unmet need' category. The percentage of such couples widely varied from 7.6 per cent in Kerala to 25.9 per cent in Uttar Pradesh (ORG 1990). Similarly, several studies (ICMR, 1988,1989; Narasimhan *et al.* 1992; Satia and Giridhar 1991) show that the existing delivery system is quite inadequate to reach potential users in the remote rural areas. Knowing fully well that the PHC/SC workers cannot achieve the assigned targets, particularly for spacing methods, most state governments are also using other development agencies like Revenue, Rural Development, and others to achieve the state level family planning targets.

Consequences of the Target Approach

The consequences of target approach depend on how the target system is actually implemented. Experiences in India as well as in other countries indicate that when the focus of management is largely on the achievement of method specific targets as a measure of the family planning workers performance, there may be many unwanted consequences. This is particularly true, if disincentives such as withholding payments (e.g. salary, allowances, promotion or show cause letter, others) are linked to the non-achievement of the targets. The Indian experience suggests some of the following consequences.

Targets Produce a Skewed Emphasis on Specific Methods

In the Indian family planning programme, though the workers were given targets for all methods, in reality the main emphasis has always been on the achievement of sterilization targets. As a result, information on and promotion of non-terminal methods remains neglected. According to the 3rd All India Family Planning Survey, sterilization contributed 70 percent of the total family planning acceptors. The proportion of condom, IUD, pill and natural method users was estimated to be around 12,4,3 and 11 percent respectively.

A comparison of the 1980 and 1989 ORG survey results also shows that during 1980-89, while use of sterilization increased by 9 percentage points (from 22.4 in 1980 to 31.3 in 1989), the corresponding increase for the IUD was less than 2 percentage points (0.5 to 1.9), and less than one percentage point for condoms (from 4.4 to 5.3) and oral pills (from 0.8 to 1.4) (Khan and Rajagopal 1993).

Quantity is given Preference over Quality

The Seventh Five Year Plan (1985-90) called for a CPR of 42 per cent To achieve this target, it was estimated that during the period, 31 million sterilizations and 21.25 million IUD insertions had to be performed and during 1990,14.5 million users of condom and oral pills had to be recruited. This was an enormous job and the targets, particularly of sterilization were only achieved by special drives and camps. A large number of studies undertaken during this period, however, also show that the quality of services provided was far from satisfactory. Little attention was paid to counselling, follow-up or providing detailed information on all available contraceptives so that couple could make an informed choice.

Client's Needs are often Neglected

Again, the Indian experience shows that under the pressure of achieving the family planning targets (particularly for sterilization), the client's needs are generally neglected by family planning workers. For example, young couples without children or with only one child are often not approached by the workers to motivate them for delaying their first child or to space subsequent births. Studies on the accuracy of the Eligible Couples Register (ECR) show that the ECR is often not updated, and newly married couples are particularly subject to under-reporting. Similarly, counselling is often neglected or at best poorly provided. The clients are not provided with detailed information about all contraceptives or helped to make

an informed choice. Women's other health needs, particularly ante- and post-natal care are grossing neglected.

Leads to the Inflation of Service Statistics

To demonstrate their performance and avoid the adverse consequences of not achieving assigned targets, often the workers inflate their performance data. Several studies confirmed that the service statistics are considerably inflated. This misreporting is generally more easily done in case of non terminal clinical methods than terminal methods. The Third All India Family Planning Survey as well as concurrent evaluations carried out by several independent agencies reported substantial inflated figures for IUD acceptors and modest under-reporting for condoms, which are also available in the commercial sector (see Table 1).

TABLE 1: COMPARISON OF THE CONTRACEPTIVE PREVALENCE RATE (CPR) AS REPORTED IN ORG SURVEY AND SERVICE STATISTICS

	Sterilization	*IUD*	*Condom*	*Pill*	*Any*
ORG	29.6	1.9	5.2	1.3	38.0
GOI	28.9	5.5	4.2	1.5	40.1

Source: ORG 1990

An Increase in CPR does not Result in a Commensurate Reduction in the Birth Rate

Again, the Indian experience shows that the increase in CPR has not shown a corresponding decline in birth rate. According to a recent study, CBR declines only by 0.18 units for every unit increase in CPR (Rajagopal 1993). According to this study, even if we achieve a CPR of 60, the CBR may remain 27. One of the important reasons for this limited impact of the programme is the over-emphasis on the achievement of sterilization targets. Those who accept sterilization are generally high parity couples with several children (mean of 3.5 children). Sterilization of such couples has a limited demographic impact on the birth rate, and may not be particularly helpful in assisting these couples to achieve their reproductive objectives.

Long Term Demand Generation Activities are Neglected

Under the pressure of achieving family planning targets, particularly for sterilization, motivational and educational activities which are essential for demand generation are neglected or given a very low priority. In the absence of appropriate IE&C activities and proper counseling, misconceptions and myths about various family planning methods, particularly about vasectomy, IUD and pills remain serious hindrances to the acceptance and continuation of these contraceptives. An analysis of the causes of unmet need at the national level shows that they are primarily programme variables rather than social or religious factors (Khan 1992).

Alternatives to the Conventional Target Approach

There are several alternatives to the conventional target approach. Some involve a redefinition of targets. This requires the use of clear language to distinguish old targets, from new goals, expectations for worker activity or guidelines for actions. Examples of this approach in other countries follow.

Versions of Target Systems in Other Countries

There are several types of management systems in other countries which have explicit demographic goals, and which have employed the concept of targets in different ways:

• Mexico has the demographic goal of reducing the rate of population growth to replacement levels by the year 2000. To achieve this, the National Population Council and the Secretary of Health and Family Welfare have set goals for overall contraceptive use at the national and state levels. In 1991, the TFR was estimated at 3.2 and the CPR was 53 percent. There are no method specific targets, no assumptions about the appropriate method mix in a given locality, and no explicit sanctions for lack of achievement Goals are set for states and large political divisions, the equivalent in size and administrative responsibility of districts.

These goals function as a mechanism for ordering the logistics system, which requires at least of a one-year lead time to ensure the availability of methods; they also serve as a way of fostering competition between districts, that is identifying which districts are performing better and, more importantly, understanding why they provide services to a greater proportion of the target population. Successful models of service delivery and effective management strategies are then extended to the states and districts where the degree of achievement of goals has been lower than expected.

• Indonesia has taken recently another approach to targets. In the Five-Year Development Plan, 1989-1994, the immediate goal of the family planning programme was to reduce the total fertility rate from 3.48 children per women 15 to 49 years of age to 2.99 by 1994, and similarly increase contraceptive prevalence from 48 to 53 percent. In order to do this, 21,460,000 couples have to be recruited as family planning users, and encouraged to use more effective and longer-lasting contraceptive devices. At the same time, however, The National Family Planning Coordinating Board (BKKBN) developed a strategy for reducing the public sector's supply of contraceptives from about 80 percent in 1988 to 50 percent in 1994, and to 20 percent in 2000, creating a 'self-reliant' family planning programme.

This strategy for self-reliance, rather than focus on method targets, places emphasis on elements of programme development which improve access to private sector programmmes. Components include: training, supplies and equipment for private practitioners for strengthening their capacity to provide family planning; a 'blue circle' mass media campaign to make people aware that family planning services are now available from private practitioners, on payment of fees, and encourage those who can afford these services to take

advantage of their quality and convenience; support for the commercial marketing of contraceptive methods; and management and technical assistance for improving the capabilities of public and private (NGO) sources of supply.

- Bangladesh has the demographic goal of achieving a net reproduction rate of one by 2010, with a targeted reduction of the birth rate through a series of five-year plans. The short term objective was to attain a contraceptive prevalence of 40 percent which was achieved in 1991. The TFR is now well below 5 compared with a TFR of about seven births per woman in 1975. During this process, Bangladesh experimented off and on with targets with some reluctance. When applied, performance targets were unrealistic, inflexible and dysfunctional. Rewards for achievement were lacking and sanctions for poor performance were rarely imposed (Cleland, *et al.* 1992).

The experience suggests that when targets are used, data quality suffers and programme effectiveness is not particularly enhanced. In contrast, major efforts to increase access to services (e.g. clinical, community outreach, IE&C, commercial sale of contraceptives, improved health services), both through public and private channels, have ensured that every household is exposed to information about family planning (methods for spacing as well as limiting births), and nearly every woman who seeks to regulate her fertility knows how to do so and where modern contraception can be obtained.

Alternatives to Targets in India

What then are potential alternatives to the target system in the Indian context? Rather than simply redefining the nomenclature, these alternatives suggest a change in strategy and rationale for service delivery. The alternatives we would like to explore are three: improving maternal-child health care, responding to the high levels of unmet need for contraception, and effort to enhance the quality of family planning services.

None of these approaches appears at first glance to be a departure from current policy. In theory, maternal-child health care is a central element of most public health and family welfare programmes. In many countries it has been the principal vehicle for the reduction of infant and maternal mortality. Second, responding to unmet need is an assumption of most family planning service delivery programmes, particularly when little investment is made in IE&C or outreach activities.

The major emphasis on contraceptive supply systems, essentially, assumes that there is a significant level of unmet need for contraception, and that major efforts to affect the demand for family planning are unnecessary or at least a lower priority until near universal access to family planning is assured. Thirdly, all family planning programmes have elements of quality; all have at least implicit standards of quality of care, and the components of service delivery vary along a continuum of quality relative to these local standards.

The difference we are highlighting in proposing these alternatives to targets, thus, is not changes in macro level policy, that is, whether these services should be provided, or whether quality is important. Rather the focus is on operational policy, that is, guidelines on how programmes should operate at the sub-centre and village level.

While the theoretical contribution of these alternatives is modest, they do offer management a response to the question posed by state and district level authorities: what can we do to ensure the implementation of the programme if we dispose of targets. This isn't a trivial question, given the relative magnitude of population in need of family planning services in rural areas, the large number of PHCs and sub-centres requiring micro-planning and supervision, and the management responsibilities of district level health personnel.

It is important to note that the ultimate criteria of success of the family welfare programme need not be changed. The criteria of success will continue to be meeting the reproductive objectives of clients as well as overall contraceptive prevalence, and ultimately reductions in the birth rate. The underlying rationale of the programme, however, does change from one focusing almost exclusively on the achievement of demographic targets, to one which increasingly responds to the health needs of clients.

For each of the alternatives highlighted below, the presentation is based on their operation at the sub-center level, which covers a population of about 5000 inhabitants, residing in about 3-7 villages, and where the principal actor is the ANM. Furthermore, in each case the services will rely on a mix of sub-centre based and village outreach activities.

While the home visit has been the programmatic centerpiece of many primary health care schemes, most household surveys suggest that coverage of home visits for family planning services often does not exceed 35 percent in any given year. Concentrating visits, based upon the three alternative strategies, would serve as an organizational tool for programme management and increase the impact of these visits considerably. All alternatives retain the ultimate programme goals of health and family welfare programme, that is improved maternal and child health and lower birth rates for India.

1. *Strengthening Maternal and Child Health*

• *Objective:* Reduce maternal and infant mortality and morbidity, and increase the use of family planning.

• *Priority population:* pregnant women and mothers with children under one year of age. This strategy assumes that the most effective way of increasing contraceptive use is to focus on the health needs of mothers and children, and motivational efforts for family planning during post-partum care.

• *Organization of services:* Assuming 170 eligible women per thousand population in a sub-centre, the total number of eligible women would be around 850. Assuming a birth rate of 35, at any point in time, only about 95 of these would be women in the second and third trimester of pregnancy. Apart from these, there would be another 175 women who have children less than one year of age. Effectively, the priority placed on strengthening maternal and child health would mean that ANMs would have to identify approximately 270 women and 175 children under one year of age in their areas of responsibility, and focus on improving the range of services, including prenatal and postnatal care for women, nutrition, vaccination and primary health services for infants and young children. This mix of services promises to be among the most cost-effective methods in reducing mortality and improving

health status. Safe abortion should be readily available for those women facing an unwanted pregnancy.

For those women who want to delay their next pregnancy, information and spacing methods would be provided to both the women and her spouse about how to achieve the desired birth spacing. For those couples wishing to limit family size, counseling and referral would be provided to the nearest surgical facility. Further emphasis on outreach is required, as currently, only a small proportion of pregnant women in rural areas register for ante-natal care (Misra 1991).

The specific components should be consistent with national Safe Motherhood and Child Survival Strategies, which seek to give maternal care a priority for primary health care services and overall development policy. Some have suggested that this MCH alternative should also serve adolescent girls and boys, offering family life and sex education, to prepare them better for future responsible parenthood and safe motherhood.

• *Monitoring:* Currently an ANM has to maintain about 17 registers for reporting their activity and spend about 25 percent of their time in record keeping. This strategy would reduce the number of forms to a single MCH register similar to that used in the Bangladesh MCH Extension Project, in which all the essential services to the mother and child are included and reported on. Given the high levels of infant and maternal mortality throughout much of India (650 maternal deaths per 100,000 live births, and 84 infant deaths per 1000 live births), particular emphasis must be placed on monitoring the occurrence and causes of infant and maternal death in each locale and using this information to improve the local health services, enhance access to family planning and safe abortion services, and improve the status of women and girls.

• *Expected results:* The focus of services would be the clients and their families, rather than on achieving targets for sterilization. There would be an increasing emphasis on spacing methods, including both modern methods such as the IUD, orals, and condoms, and traditional methods, such as breastfeeding and natural family planning. The option of sterilization, both vasectomy and laparoscopy, would be a necessary service for those couples who have achieved their desired family size through spacing. By improving child survival, the demand for additional children would also be presumably reduced. One potential limitation of this approach continues to be the exclusion of men and boys from IE&C outreach activities and services.

2. *Reduction of Unmet Need for Contraception*

• *Objective:* Meet the unmet needs of men and women for contraceptive information and services.

• *Priority population:* men and women who either want to postpone or delay their next pregnancy, or want to limit their family size, but currently are not using effective family planning methods. The assumption is that approximately 18 percent of couples of

reproduction age (estimates for states may vary from 7 to 25 percent) have unmet need for contraceptive methods for either spacing or limiting the size of their families. This implies that each ANM would have to identify about 180 individuals for priority information and service delivery.

• *Organization of services:* Services would continue to be offered to those men and women coming to service sites. At the same time, a proactive search strategy would be conducted to identify those men and women with unmet need. These groups may include young men and women who are sexually active, but either do not want to become pregnant or want to delay their first pregnancy, women who have temporarily stopped using contraceptives to have a pregnancy and need to resume contraceptive use to space the next pregnancy, and men and women who have achieved their desired family size and may want access to effective long-acting contraceptive services, e.g. IUD or sterilization. The concept has recently been enlarged to include users whose method is unsafe, ineffective, or unsuitable, and among those with unwanted pregnancies who lack access to safe and accessible abortion (Dixon-Mueller and Germain 1992).

• *Monitoring:* Monitoring could be done through a modification in the current eligible couple register. This could be done during April-May of each year when the ANM is expected to update the eligible couple register (ECR). The ECR currently contains most of the demographic information (i.e. age, number of children by sex) and contraceptive status of the couple. It is suggested that a column indicating the women's reproductive intentions (desire for additional children and when) should be added to the register. Along with information on their contraceptive status, this would help to identify the current level of unmet need. Or monitoring could be conducted by quick surveillance techniques, where individuals not currently using contraception would be visited on an annual basis to identify their needs and options for services.

• *Expected results:* Although the unmet need for contraception varies considerably, it is frequently inversely related to the current level of contraceptive prevalence. By focusing on those couples not currently using, but in need of contraception, the program would be assisting couples in achieving reproductive intentions, without necessarily investing in the generation of additional demand. An ancillary benefit of this strategy would be that by segmenting the different types of populations and their specific needs, e.g. young adults, mothers with young children, men, the opportunities for design of innovative services strategies would be enhanced.

One interesting note is that in the short term unmet need may not be significantly reduced through these efforts. One would expect that with an increasing population of reproductive age and an increasing demand for family planning, the absolute number of individuals with unmet need may in fact increase (Westoff, 1978). At the sub-centre level, this would not appear to be a particular problem, but it may affect planning for service delivery at the district or state level.

3. *Improvements in Quality of Family Planning Services*

• *Objective:* Assist current family planning users to meet their reproductive objectives.

• *Priority population:* Current users of family planning services. Assuming contraceptive prevalence of 50 percent, and about a 2 percentage point increase in users each year, the number of individuals to be tracked during their first year of use of any method (including those who switch methods) would be less than 50 for each ANM. The assumption is that it is more important to maintain a successful user, than it is to attract a larger number of users who drop out and view their experience as unsuccessful. Moreover, it assumes that by improving the quality of care, the population's confidence in the services will increase, thereby affecting future demand.

• *Organization of services:* This perspective maintains that the success of a family planning programme should be judged in terms of the quality of service it provides, and the extent to which it is successful in helping individuals active their reproductive objectives (Jain, Bruce and Kumar, 1992). The elements of quality of family planning services from a client's perspective include an expanded range of contraceptive methods to meet the clients needs of contraception over the reproductive life cycle, adequate information to clients so they could make the best choice about the type and timing of contraceptive method, competent providers to ensure the quality of service provided, efforts to follow-up on the client after the choice is made to resolve any problems in use and to facilitate continuation.

As the satisfaction of clients is the critical element, the types of information and services available to clients may differ somewhat between sites. These services should not be confined to family planning, but may include the detection, treatment and prevention of sexually transmitted diseases, or infections of the urinary tract, or services for addressing problems of rape, harassment and domestic violence. While these elements may seem complicated, satisfaction of clients may also depend on more modest elements, such as simply treating people with respect, assuring clients privacy during consultation, allowing women to receive care at the same time as their children, or maintaining clinic hours compatible with the work obligations of women. Care should be taken not to merely focus on quality in the context of clinical services, but rather the analysis should include quality of care at all service delivery points, including community-based distribution efforts and commercial supply networks.

• *Monitoring:* The focus should be on monitoring the critical elements of supply, such as the presence and quality of information, training of providers, reliable supply of a range of contraceptive methods, among others, rather than on simply the number of users achieved through the service. This requires a surveillance system which managers can employ to determine whether the supply system is adequate to attract and maintain users. Periodic follow-up surveys of users, and those who discontinue the use of contraception, would be conducted to understand the use-dynamics, and the contribution of service quality to decisions to use or discontinue contraceptive use.

• *Expected results:* The assumption is that improving the quality of care will improve the continuation of family planning use, and attract new users as the perceived quality of care increases clients' confidence in the delivery system. By focusing on the quality of family planning care, improvements would also be expected in other areas of maternal and child health. It would also provide the basis for planning in-service training, and investment in the strengthening of health services.

Unanswered Questions

There are several important unanswered questions in this paper. Are these alternatives mutually exclusive? It is possible to adopt one or another at the same time, and if so how would they interact? In principle, efforts to improve quality of care of family planning services should not be incompatible with efforts to strengthen maternal and child health. However there is little empirical experience, outside of model projects, to demonstrate that simultaneous changes are easy to implement and manage.

How in fact would these alternatives be implemented in different settings characteristic of the diversity of India, with differences in infrastructure, levels of investment in health, and variance in the apparent demand for family planning. Managers must keep their attention on the supply system, that is those elements of care which improve the population's access to the services they need and ensure that the system under their responsibility offers the quality of care possible within constraints of the existing system. The commitment, leadership and competency of medical officers responsible for PHC and Sub-Centre services are crucial for effective management of these alternatives as they provide many of the inputs needed by ANMs to expand quality (Satia and Giridhar 1991).

Another question relates to the role of local planning in the development and implementation of a population and family welfare policy. How would one or more of these alternative strategies be adopted in a system which currently relies heavily on the directions of the central level of government. It seems that in the review of the proposed new population policy, the sections relating to family welfare, should consider the role of local officials (District and below), women's health advocates and NGOs in defining alternatives to the current *de facto* system of targets. This points to the necessity of establishing a system of district-level planning. How best such planning could be done needs to be conceptualized, planned and field tested.

The third question is whether these alternatives provide opportunities for collaboration with women's health advocates. There is considerable debate about the effect of the current family welfare program on women's health (Pachauri 1993; Shiva 1992). The alternatives to targets proposed should be consistent with the call for improved women's health and status. In India, where critics maintain that the family welfare programme is too focused on statistical objectives and quick solutions, some suggest that a longer-term more moderated approach is needed, centered on a good system of health delivery at the village level, coupled with improvements in literacy, income generation, security and respect for human values (Bose 1989).

While a preliminary analysis suggests that these alternatives should contribute to greater respect for clients, and improved reproductive health, a broader consultation and research

would need to be conducted to determine if the alternatives proposed maintain an unacceptable status quo, or contribute positively to changes in women's' status, the further development of gender sensitive services, and enhance women's decision making about their own sexuality and reproduction.

Directions for Operations Research on these Alternatives

What then are the directions of operations research on these alternatives? There are at least three lines of research that are required to test whether these alternatives to target setting are both effective in meeting the health needs of clients and producing the changes in contraceptive use compatible with reduced birth rates:

I *Test the Feasibility of Field Operations*

The first priority should be to the further development of these alternatives, both from the policy perspective as well as from the manager's operational perspective. Essentially, these tests should respond to some of the unanswered questions cited above, in the context of demonstration projects. These tests should be conducted at the district level, although the focus of many of the services is the village. The district level provides the required administrative structure, budgets and planning function, both to improve the support to village level activities, and to facilitate the replication of successful experiences to other districts.

I *Estimate the Demands on Providers and Programme Managers*

In addition to simple feasibility, the research should explicate the specific demands on both providers and programme managers each alternative poses. These demands may vary by level of contraceptive use, degree of unmet need, and method mix peculiar to each site. And there are larger questions such as how do these alternatives better motivate ANMs to improve the coverage of primary care services at the village level. What are the costs associated with improving the quality of care, and what are the requirements in terms of increased contraceptive availability, training of staff and follow-up of clients? The use of local data for local decision making on the components of care requires a new look at micro-planning processes.

H *Monitor the Acceptability and Effectiveness of Alternatives*

The ultimate test of the success of these alternatives to targets is the response by clients. How is client satisfaction best measured, and how might client response differ among the three alternatives? Does increased attention to individuals with unmet need, indeed, increase contraceptive use? Does the focus on quality of care lead to increased use of services, or greater continuation. Do efforts to reduce maternal mortality and increase child survival lead to increased demand for family planning services.

In conclusion, it is clear to most observers of the Indian programme that the current target system is inadequate both to achieve demographic goals and meet client needs. Tests of alternatives like those presented above provide one avenue to strengthening the quality and impact of the national family welfare programme.

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