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Learning from Successful Family Welfare Programmes: Selected Observations from NGOs and Organized Sector

ACCORDING to 1981 census, India's population was 685 million. Since then almost 15 million population is being added every year. As a result, the population of the country as on 1st Dec, 1990 is estimated to be 822 million. If population continues to grow at the present rate, India would become the most populous country of the world by the turn of the century.

According to SRS, the natural growth rate of the country for 1989 was 2.03. Due to the young age structure of the population, potential for the continued high population growth in the future years is considerably high, unless special efforts are made to accelerate reduction in fertility.

An examination of the performance of family planning programme shows that even though percentage of couples effectively protected slowly increased from 8.7 per cent during 1967-69 plan period to 43.3 per cent in 1989-90 (March 1990) the impact of the programme on national birth rate is not reflected. As the available statistics shows, despite increase in contraceptive prevalence rate (CPR), the national birth rate has remained stagnant around 32 during the last 8-10 years (GOI, 1990). It is a matter of major concern to all policy makers and programme managers.

The issue of stagnant/slow decline in birth rate is being discussed at various forums. During the last one year both Ministry of Health and Family Welfare (MHFVV) and Planning Commission have organised a number of meetings of experts and programme managers to discuss this issue and measure to be taken to ensure a fast decline in birth rate to,achicve the NRR of 1 within the stipulated time. One aspect which has been repeatedly pointed out is that the programme has failed to attract people's participation in the programme. Similarly, while the Seventh Plan document unambiguously states the need of involving NGOs and mentions that "serious efforts will be made to involve voluntary agencies in various developmental programme" no significant success has been made in this direction. Recent government documents reiterated its faith in NGOs as potential partners for promoting small

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1 However, recent SRS data show some decline and CBR as in 1989 was estimated to he around 30.5.

family norm and complementing government's efforts to achieve national population goals. Accordingly it has been suggested that

> "The programme has to be progressively debureaucratized and non-governmental structures will have to be promoted to provide leadership for the programme. The programme would have to be escalated into a genuine peoples movement."

It further adds:

> "The voluntary organisations will be associated more closely and actively with the program in order to fully exploit their potential innovation, dedication to the cause, proximity and credibility with the people...."

While this is true that participation of NGOs in the programme has still remained limited, recent initiatives of government to involve them in the national programme has started bearing result. Many NGOs, have started taking interest in the family welfare programme and some of them have received grants from the Ministry to undertake the activity. According to an estimate, currently about 300 voluntary organisations are receiving assistance from the government for health and family welfare activities. Majority of them are institution based such as operating hospitals or dispensaries. It is expected that in the coming years involvement of NGOs in the promotion of family welfare programme will be further enhanced. To accelerate this process Government of India has sanctioned a grant to Family Planning Association of India (FPAI) to establish a NGO Consultancy Services Cell. The cell identify, encourage, train and guide NGOs to undertake family planning work. It has been given as mandate to the Steering Committe constituted to draft the 8th Five Year Plan of the Health Sector to outline ways and means to

> "strive to involve NGOs and voluntary agencies for greater community participation to make the family welfare programme in real sense a people's programme."

The document also envisages to give a big thrust in the VIII Five year Plan to "Involve the organised sector and the cooperatives movement in a big way to popularise the concept of two child norm". Considering the expected future involvement of NGOs and organised sector in family welfare programme it will bexif interest to study the experience of some of the NGOs/organised sector which are already actively involved in extending family welfare services. An exercise of this nature, particularly study of some of the successful programmes, may help in identifying the factors which contribute to the success of the programme and are responsible for initiating and sustaining community participation in family welfare. Such understanding would be useful for future planning. The present paper is an attempt in this direction. The paper has been divided into three parts. The first part presents experience of some of the selected NGOs in the area of family welfare programme. The second part reviews the family planning activities in selected organised sector. The third part attempts to integrate the observations made in the paper and discusses its policy relevance.

Experience from NGOs

In India, among the varioius NGOs, Family Planning Association of India (FPAI) is one of the pioneer organisations which has played a crucial role in initiating and promoting planned parenthood in the country. Today perhaps it is the largest voluntary organisation which through its 43 branch offices, spread all over the country, is continuously striving to promote small family size norm in the country. Over the period, FPAI has experimented a number of innovative approaches to evoke community participation in the programme. Community base distribution programme, social marketing, integrated rural family welfare programme are some of the examples of different approaches experimented by the Association in various parts of the country to develop alternative strategies for delivering family planning services at the doorstep of people. According to an estimate, FPAI has recruited 69000 village volunteers in its 21 projects covering 3000 villages and a total population of 2.8 million, for promoting family planning through rural integrated programme. Considering the significance of these projects and the overall contribution made by the Association, in the present review, two of its projects have been analysed and presented here. It includes:

1. Integrated Rural Family Planning Project in Kundam Block, Madhya Pradesh
2. Varanasi Community Based Distribution Project

Apart from these two projects, the following two projects have also been reviewed:

3. Parivar Seva. Sanstha
4. The Vadu Rural Health Project

All the four projects reviewed here represent different approaches and settings. While the first project, ventures to integrate family welfare programme with rural developmental activities, the second tests the concept and usefulness of community based distribution and social marketing approach in a backward rural area. The third demonstrates use of modern business techniques for promoting high quality reproductive health care in crowded urban centres. The fourth project presents an example how a partinersnip between NGO with Government could augement each other efforts to improve delivery of health and family welfare services in rural areas.

Integrated Rural Family Welfare Project, Kundam Block, M. P.

Kundam is the headquarter village of Kuridam Community Development Block. It is one of the thirteen blocks of Jabalpur district in the state of Madhya Pradesh and is located in the south-eastern part of the district. With 192 inhabited and 8 uninhabited villages, the block is spread over 971 square kms of hilly area. The area receives heavy rainfall every year particularly during the months between June and September. A major problem of the block is that it is under forest and except for a few villages on the highway accessibility to the area is difficult. According to 1981 census, the total population of the block was 74,16? persons. Majority (70%) of the population consist of tribals and most belong to the Gono tribe. Generally the tribe has still remained far from modern world and follows traditional life.

The tribal villagers are primitive and generally small and situated in inaccessible remote areas.

In September 1980 the Kundam Rural Family Welfare Project was launched with the following broad objectives:

1. To integrate family planning and maternal and child health care with developmental activities
2. To assist the community in utilising available resources as well as various facilities offered by the government and other agencies.
3. To bring about an improvement in the level of family planning acceptance in the Block through integrated activities leading to community action for acceptance, adoption and promotion of the small family norm.

Selection of Kundam block in consultation with FPAI, Bombay was largely decided by one of the branch offices of FPAI at Jabalpur, which wanted to carry out this study. The head quarter of the Kundam block (the block office) is situated at easily accessible road and could be reached within two hours from Jabalpur by car.

The.total population covered under the project is around 50,000 spread over 63 villages.

A review of the performance of the project, based on the statistics maintained at project office, shows that acceptance of family planning increased from 19.9 per cent in 1980 to 68 in 1985. An independent survey carried out by ORG in 1986 confirmed high (61.3%) prevalence of family planning in the project area. Again according to the statistics maintained by the project office, during the same period BR of the area declined from 36 in 1980 to 25 in 1986. Similarly infant mortality declined from 156 in 1980 to 68 in 1986. However, the two independent surveys carried out by ORG and the other by ICMR did not confirm such drastic decline either in the BR or IMR. According to these studies, in 1986 BR was around 35 and IMR around 110. In other words, while IMR of the area has declined considerably, no appropriate decline in BR has taken place during the same period. The anomali to some extent could be perhaps explained in two ways. First, it is quite possible that the BR at the time of baseline survey was under estimated and it was more than 36. This assumption is supported by the fact that SRS estimate of BR for the state (including urban area) was 39 in 1980-81. The second reason could be that in the initial years, mostly those couples had accepted family planning (mainly sterilisation),who already had a larger family size and hence its impact on BR is not reflected (Khan and Gupta, 1990).

The study clearly demonstrates that the project was successful in promoting family planning and MCH care through community participation in the various developmental activities. From the very beginning the emphasis of the programme was on stimulating collective action among the community members to identify their own needs and then to try to resolve them either by using their own means or availing funds available under various schemes with Block Development Office. Family Planning was taken as one of the various programmes. Initial entry in the community was made through promotion of certain developmental activities many of which have direct bearing on health such as chlorinisation of wells, sanitation. It is important to point out that although the community members basically perceived this project as "Family Planning Project," what makes it different from the government's family planning programme is the beyond family planning approach and this led to higher acceptance of its activities and greater recognition to it by the community

as compared to other similar project. A meticulous planning and care taken at the initial stages of the project paid rich dividends in establishing the project. Formulation of various committees (District level, Block level and Village level) gave legitimacy to the project and its acceptance, at least at local leadership level, was immediate. Involvement of well known social workers in the Liaison Committee and influential block level leaders and officials in the Project Implementation Committee was an important step which ensured support both from local government's developmental agencies as well as informal village leaders and the community at large. Right from the very beginning the project officials had tried to avoid by involving all section of peoples and supporters of political parties, any conflict which could harm the project. Even though all the peoples involved in various committees etc. were not active supporters of the project, their nomination in the committees helped to keep the mitral.

The approach to implement various development activities (including family planning) through local village volunteers by constituting various village level committees (Village Betterment Committee, Youth Club, Mahila Mandal, Village Health Committee, Women Development Committee etc.) was a useful strategy as it helped to broaden the base of the project. Many of these volunteers were subsequently involved as community based depot holders of contraceptives. Formation of these committees also helped in developing leadership quality among young and women and stimulating them to do some thing for their own community which would also boost their own image in the community. Promotion of self image and ambition to gain leadership in the community were some of the most important considerations for the youths for joining various committees.

The project to a great extent was successful in achieving its basic aim of making people self reliant for their own development and creating awareness among them to utilise government resources available under various schemes rather than depending on an outside agency like FPAI. As a result after the first two year, most of the expenditure for carrying out various project activites was either borne by the community or the government while the proportion of contribution of FPAI declined drastically after the second year and subsequently has become negligible. Utilisation of government resources increased to about 75 per cent (Table 1).

TABLE 1 : RELATIVE SHARE OF THE COST TO CARRY OUT VARIOUS ACTIVITIES UNDER PROJECT (PERCENTAGE OF TOTAL COST)

Year	*Sources*		*Total*	
	Government	*FPAI*	*Community*	*(in Rs.)*
1981	—	27.4	72.6	8,925
1982	41.6	38.9	19.5	30,906
1983	53.5	5.6	40.9	1,27,825
1984	74.4	3.0	22.6	2,58,348
1985	78.5	1.2	20.3	13,94,291
1986*	77.1	1.8	21.1	7,63,284

* Expenditure for only 9 months

SOURCE : Khan and Gupta (1990).

Apart from family planning various developmental activities carried out by the project include plantation, sanitation, establishment of adult education centre and balwadis, skill development, training and encouraging women to undertake employment generating activities by providing them soft loan.

Further analysis in terms of the actual amount of money spent reveals a slightly different picture. Even though the percentage share of expenditure borne by FPAI had been reduced from 27.4% in 1981 to only 1.8% in 1986, in monetary terms the contribution from FPAI has increased from Rs. 2,445 in 1981 to Rs. 16,731 in 1985. However, the corresponding increase in expenditure borne by the Government or the community is also much higher. If we compare these figures for 1985, FPAI contributed only Rs. 16,731 for carrying out various developmental and family planning activities as against Rs. 2,83,041 by the community and as high as Rs. 1,094,518 by the Government. These figures indicate that while the project, on the one hand, is successful in motivating the community to pay for its own welfare, on the other it has increased their awareness of various funds available from the Government for community development and subsequently helped them to obtain these funds. The observations also bring out the fact that once the community is convinced that the project or a particular activity is beneficial for the family or the community as a whole, it does not hesitate to contribute towards its implementation, either in cash or in the form of voluntary labour.

The project thus demonstrates that acceptance of family planning could be accelerated at a much higher pace by integrating it with overall community development and encouraging people's participation in the programme. As the project shows in this exercise, role of the implementing agency should be like a catalyst whose prime responsibility is to make people aware of their needs and the resources available under various government schemes which could be tapped to meet these needs. The approach adopted in this project is quite cost effective and apparently replicable but needs to be tested in different settings.

The Varanasi Community Based Distribution Project

The Varanasi Community Based Distribution (CBD) programme was launched by FPAI in collaboration with the Department of Preventive and Social Medicine of Banaras Hindu University in the year 1979. The main concern was to test the efficacy of CBD approach in accelerating the acceptance of family economically backward with high fertility, high infant mortality and very low level of contraception. The project was first initiated in one block but subsequently expanded to eight blocks of Varanasi district. Today it covers 1242 villages with a population of over 1.2 million spread over 1465 square kilometres. The specific objectives of the project include:

- to develop an education and distribution network using trained local volunteers to create the demand for and supply of oral contraceptives and condom
- promote other family planning methods such as IUD and sterilisation
- provide primary health care with special emphasis on services for mothers and children
- support women's programmes and rural development activities in cooperation with government and non-government agencies
- make the programme, as far as possible, financially self supporting, through the use of several marketing techniques.

As in the case of Kundam project, the main strategy of the project is to provide family planning services integrated with primary health care and overall rural development

programme through active participation of people. The volunteer force of 944 Sanyojaks, also referred to as depot holders, is the backbone of the programme. The Sanyojaks are selected for their acknowledged interest in serving the community, their general acceptability and having an assured income from independent sources. They are drawn from a variety of professions such as, registered medical practitioners, farmers, businessmen, shopkeepers, teachers and college students and are respected leaders in their villages. To take advantage of available trained manpower in the study villages, many of the village Health Guides (VHGs) were also included as Sanyojaks. The selected Sanyojaks are first extensively trained and then subsequently given inservice refresher courses to update knowledge, sharpen skills, and share experiences. As mentioned earlier, the health component and women developmental activities such as training for skill development, leading them to income generating activities are integral part of the programme. In all these work, Sanyojaks are the nodal points. The basic health supplies are offered to them at cost-price and they sold it on a marginal profit. Similarly condom, pills etc, are provided to them free of cost but they are allowed to charge a token service charge of one Rupee. The proceeds from marketing of contraceptives are shared equally between the Sanyojaks and the project. In 1987 out of the total Rs. 1.5 million annual budget of the project, about Rs. 71,500 was generated through social marketing approach of primary health care items and conventional contraceptives*. It is expected that soon the project will be able to generate Rs. 100,000 to meet its expenses. Thus the project appears to be more cost effective than many health and family planning schemes.

Apart from generating money through social marketing the project was able to generate certain financial support, either in cash or kind from the community, various governmental departments and other non-governmental agencies. For the year 1987, the contibution of the community was Rs. 1,89,500 (in form of accommodation, Rs. 1,54,000, furniture Rs. 20,500, hospitality Rs. 10,000 and honararium/prize Rs. 5000). Assitance from government departmentcame in the form of drugs (Rs. 15,400), tree saplings (Rs. 55,000), furniture (Rs. 5,050) etc. totalling Rs. 1,53,400. Contribution from government agencis for the year 1987 was Rs. 8,520.*

The women development activities and other rural development work promoted by the workers include skill development leading to their participation in income generating activities (spacing, tailoring, candle, glass beeds, soap, bidi making, etc.), promotion of smokeless chulha, bio-gas, road repair, cleaning of villages etc. Financial resources for these activities are mobilised from various government agencies like Khadi Gramodyog Bhandar. IRDP of Government of India, various nationalised banks which are providing soft loan etc. Community participation is ensured by formation of volunteer committees to organise village groups. The project staff through Sanyojaks have helped in forming 213 Youth Clubs, 53 Mahila Mandals, 315 Village Coimmittees and 11 Farmers Forums. In absence of any independent evaluation of the project, its performance could be judged largely by the statistics maintained at project office. The achievements of the project as presented in its Annual Report is quite impressive and could be seen from Table 2.

* Annual Report: Varanasi Community Based Distribution Project, 1987.

TABLE 2 : PERFORMANCE OF THE VARANASI CBD PROJECT

Programme Indicators	*CBD Area*		*State*
	1979	1984	
Crude birth rate	38 (1980)	34.4	38. 9
Infant mortality rate	145	122	—
% of eligible couples covered	7. 5	33	15. 2
Average number of family planning acceptors motivated by each of the 944 Sanyojaks	—	23	—

SOURCE: Annual Report: Varanasi CBD Project, 1987

The Varanasi CBD project thus demonstrates that CBD approach is a quite feasible and useful concept which could work even in the most backward parts of the country. The project also underlines the usefulness of integrating delivery of family planning services with primary health care and other developmental activities, particularly development of women. It also indicates that people could buy contraceptive and use spacing methods quite effectively if the services are easily and cheaply available. Active participation of people in form of Sanyojaks and their continuity in the project with the very minimal returns available to them, demonstrates mat ordinary community member can be persuaded to respond with commitment to their peers needs and kept involved on a long term basis.

Parivar Seva **Sanstha**

Parivar Seva Sanstha (PSS) which was earlier known as Marie Slopes Society was established by Dr. Sudesh Bahl, an obsetetrician gynaecologist in 1978. Its singular aim is to provide women's reproductive health care. It includes generating awareness regarding contraception through the extensive use of mass media and other channel of communication, helping women to decide about the acceptance of family planning, networking with women's organisation and other welfare agencies for promoting contraception, setting up clinics to provide maternal and child health care including provision of MTP services etc. The unique feature of PSS is that it runs the programme by adopting a managerial style which is typical to that of a well run business enterprise. In a short period of ten years it has emerged as a successful social enterprise using modern management and marketing techniques to achieve social objectives. The activities carried out by PSS include -

— establishing clinics to provide efficient and hygienic medical facilities for high quality curative and preventive services for women
— to provide mobile maternal and child health services
— information, education and communication
— training of doctors to provide safe MTP services
— contraceptive social marketing
— birth and marriage registration
— family life education programme
— industrial workers motivation programme

All through the key concern of PSS is to provide quality reproductive health care at an affordable price. The clinic charges are adjusted according to the paying capacity of the client. Subsidized Treatment Fund is maintained for poor clients in each clinic. While PSS charges fee for providing MTP and other gynaecological services to women, it offers free services for immunisation, sterilisation and other contraceptive services. Its clinics are well maintained and are equipped with modern equipments to conduct MTP in a clean and hygienic environment. The work is done by highly skilled medical personnel. Normally it takes barely 5 minutes to perform an MTP and 10 minutes for sterilisation. Quality of service and safety has been maintained at the highest level and can be judged from the fact that even after performing more than 65,000 MTPs, it has experienced only one case of mortality which is strikingly in contrast to the mortality rate of 1/10,000 as reported in government records. Counselling of client and helping her to take her final decision regarding undergoing MTP or adoption of a particular contraceptive, is given highest importance in PSS clinics. It helps the patient in getting over various hang ups before accepting MTP, sterilisation or choosing a method and counsel her in getting rid of worries which may occur after accepting a method or undergoing MTP. For this purpose, in each clinic a highly trained counsellor has been appointed. Between 1979-88 the number of clinics PSS is running has increased from one to 27 static clinics and two mobile clinics in rural areas. Nine of these clinics are located in U.P., four each in urban and peri-urban areas of Calcutta and Delhi, three each in M. P. and Rajasthan, two in Bihar and one each in Gujarat and Andhra Pradesh.

Majority (65%) of the PSS services are availed by low and lower middle class families with average monthly income of Rs. 1000 or less. Another 17 per cent belong to income groups of Rs. 1000 to 1500 while 18 per cent are from the upper income bracket (Rs. 1500 +).

As mentioned earlier apart from running clinics, PSS is also providing on an experimental basis, mobile maternal and child care services in the selected rural areas of Haryana, (33 villages of Mewat region, Gurgaon district). It is using all channels of communication to educate people about general health, hygiene, nutrition etc. and interpersonal door-to-door communication, to make them aware about the available family planning services and the risk a woman runs by accepting traditional methods of terminating pregnancies. It also tries to inform the general public about existence of safe services for family planning and MTPs. Many of these activities are carried out by involving local women health volunteers.

A similar project has recently been initiated in Rajasthan near Sawan Madhopur to cover villages around Ranthambore National Park.

Realising the fact that India still lacks trained manpower who can perform safe MTP, PSS has also initiated training course of Doctors for conducting MTP. The significance of this exercise could be realised from the fact that out of 4-6 million abortions estimated to be taking place in the country evrey year, hardly about 20 per cent are performed by trained personnel*. From the existing government training facilities in the country, every year only about 1100 Doctors could be trained in MTP services (Ford Foundation, 1987). PSS is trying to augment this capacity and so far has trained 318 Doctors. Instead of expanding the number of training courses and centres, PSS had adopted a pyramid approach whereby it trains one tier of Doctors and enables them to train another tier. So far it has helped in establishing 14

* Parivar Seva Sanstha, Anubhav Series, Ford Foundation, New Delhi.

such training centres in the country. PSS keeps a strict vigilance on the training programme to maintain high medical standard in imparting such training.

Recently PSS has also started social marketing programme which aims at increasing the availability of family planning methods through commercial channel. The products launched by PSS include -

Sawan	—Condom
Bliss	—Delux quality condom
Eoroz	—Oral contraceptive pill

The project is located in Haryana and at present it is on an experimental basis to develop a model so that it could be extended, if found suitable and feasible.

The PSS experiment shows ways how modem business techniques could be efficiently used for a social cause. PSS is also trying to show that even such social services could be run on self financing basis and yet could maintain a high standard in providing quality services. Out of 15 clinics which were established prior to rnid 1987,6 clinics are meeting their recurring expenses including Head Office overheads. While immunisation and family planning services including sterilisation and IUD insertion is done free of charge, abortion, delivery and gynaecological services are charged on graded basis. PSS charges, for example Rs. 100 for carrying out MTP for an eight weeks pregnancy to Rs. 700 for a pregnancy of 20 weeks. Another 6 have been able to cover up to 50 per cent of their costs. How far PSS will succeed in making it an economically viable organisation is to be seen. However, it is a model of action which could be experimented in other settings such as PHCs, in rural areas. It is well known that majority of the PHCs, because of its poor quality of services and lack of proper logistic support, are grossly underutilised. One wonders whether one could draw some lesson from PSS experience as to how to improve the functioning of these PHCs.

Vadu Rural Health Project

Vadu Rural Health Project, initiated by KEM Hospital at Pune in 1977 is yet another good example to demonstrate how an NGO can complement Government's effort to achieve health for all by 2000 AD. KEM Hospital is a trust run teaching institution in Pune which for the past six decades has provided quality medical care to Pune and its surrounding areas. Over the time the authorities of KEM Hospital have realised that big medical institutions in urbai areas and even the PHCs in rural areas cannot be utilised by the rural poor effectively, unless they are made conscious of their health need and availability of various preventive and promotive health services. It was also fully recognised that along with medical interventions a concomitant transformation in the attitudinai and behavioural pattern of the people is also required to ensure good health. It was also felt that there is a gap between the existing health infrastructure and the community and unless a link is established between the two, achievement of various national health goals may remain a far cry. These were some of the considerations which prompted the state government and the KEM hospital authorities to get into a partners hip for managing the health care of Vadu Block consisting of 22 villages and about 30,000 population. According to the understanding Vadu Block was largely put under the administrative control of the KEM.

The project was undertaken with clear objectives to:

1. establish a system of offering a comprehensive health care in the rural areas with full community participation
2. to assess its replicability
3. to integrate primary health care with other socio-economic development programmes and thus using development activities as an entry point for improving the programme acceptability

It was fully appreciated that any alternative model demanding a substantial change in the existing health system may not be acceptable to the government. Thus the project was planned right from the beginning, in such a way that it conforms closely to the government policies and directives so that the lessons learned can be transferred elsewhere. The main strategy of this project is to create a cadre of volunteers from within the community, who could work as community health guides (CHGs) and become a link between the existing health delivery system and the community. In other words, CHGs are expected to act as an interface between regular health infrastructure and the community. They are also expected to function as change agents to bring about overall attitudinal and behavioural change among particularly those relevant for nutrition, health and environmental sanitation. With such expected roles to be played by CHGs altogether 45 persons, 23 males and 22 females were selected for the training of CHGs. The selection criteria for these CHGs were their acceptability in the community and prior record of welfare service and community involvement. The selected CHGs were given 3 weeks intensive training in primary health care. After training they were closely supervised for about 6 months and as some skills were mastered new techniques were introduced to them to strengthen their capability. These CHGs turned out to be the back bone of the Vadu project. The main thrust of the project is maternal and child care. The CHGs as well as other PHC workers have been especially trained to identify high risk children and pregnant women. All identified high risk cases are referred to clinic/Vadu Rural Hospital or if necessary to KEM Hospital where they are given all attention. A separate register of such high risk cases are maintained by the MPWs/CHGs to manage the cases and follow them up. In the Vadu block, the CHGs selected and trained by KEM were accepted as the CHGs which were,,§upposed to be selected and trained by the Government i.e. in the area Government did not directly appoint any CHG.

Maternal and child health care are also provided by the clinic held in the villages. The clinics are conducted by a team consisting of Obstetrician, Gynaecologist, Paediatrician, Nutritionist and a social worker. On an average each village has one such clinic at an interval of about 8 weeks. MPWs/ANMs and CHGs of the area provide the local support to the clinic. In these clinics all the pregnant women and children at high risk are called for examination and subsequent follow up. In these clinics, immunisation, treatment to minor ailment are also offered. Children *who* suffer from severe malnutrition are admitted in the Vadu Rural Hospital along with their mother for treatment. This gives an opportunity to the hospital staff to teach and demonstrate to the mother about methods of feeding children. This helps in avoiding relapse of the disease after the child is disharged from the hospital. As a measure to reduce infant death due to tetanus, apart from immunising mothers against the disease, use of inexpensive, sterilised delivery packs has been promoted.

Though the main thrust of the project is maternal and child care, it also covers other areas such as malnutrition, rehabilitation of handicapped children, control of major communicable diseases and promotion of family planning. Education on public health and hygiene is a vital component of the project and it is imparted through CHGs as well as mer;, bers of the Mahila Mandals. Mothers are taught about environmental sanitation, water born; diseases, cause of diarrohea and its management. Mahila Mandals and Youth Clubs have been organised and are liberally used for imparting health education and information on nutritious diets which could be prepared from locally available cheap ingradients. They are encouraged to plan and implement measures to improve environmental and sanitation conditions of the villages. For educational and demonstration purpose, in the houses of some of the CHGs, latrine has been constructed. However, so far the project has not succeeded in making latrine popular among the villagers.

In an attempt to make health care services as an integrated part of overall development programme and make the people self reliant, recently the project has started, in collaboration with other agencies to bring about general socio- economic developments of the area through community participation. For this purpose the project is utilising resources available with block development officers under various schemes. In this effort, local village bodies, Mahila Mandals and Youth Clubs etc. are expected to participate actively. Available statistics show that overall the project has succeeded in achieving its goals. The impact of the project is evident from the decline in the birth rate of the area. The infant mortality has reduced from 118 in 1978 to 62 in 1986. The use of family planning has increased from 33 per cent to more than 50 per cent in 1986-87. Registration of ante-natal cases has been almost cent per cent. The percentage of women who were fully immunised against tetanus has increased from 45 in 1978 to 66 in 1984. Though most of the deliveries (85%) are still taking place in homes the percentage of usage of sterilised delivery packages has increased from a very low level in 1978 to 80 per cent in 1984. Similarly immunisation of children against various diseases has increased substantially. Thus apparently the Vadu Rural Health Project demonstrates that the approach adopted by the project [appointing link workers (CHGs), using risk approach and encouraging community participation] was quite effective in promoting comprehensive health care and eeuld be taken as a model to be adopted by others. However, how far the model is really replicable is yet to be tested. Interestingly, KEM authorities themselves are trying to test the model in two adjacent blocks viz. Kendur and Nhavra blocks of Pune district. These blocks taken together cover a population of 120,000 spread over 60 villages. As an improvement, the KEM has decided to drop the additional input such as clinic, medical specialist etc., which were provided in the Vadu experiment. Though the experiments are not yet over, KEM is finding it difficult to replicate the Vadu experiment with the same success because, in contrast to Vadu, the administrative control of the PHCs has remained with Zilla Parishad and hence KEM is not getting the same support from the workers as that of Vadu. For them KEM is an external body. Further, the CHGs were already in position when KEM extended the project to these areas and thus could not participate in the selection procedure of CHGs. In spite of these important administrative problems, the project is being implemented and it would be interesting tr 'vatch how far the success of the Vadu is repeated in these blocks.

P.P. in Organised Sector

The importance of organised sector as special segment of population for the promotion of family planning has been well recognised. Its several characteristics such as relatively better socio-economic condition of employees, their concentration in a small working area and availability of health infrastructure which could be readily used for implementing family welfare programme, making them unique and highly conducive for the acceptance of family planning. Further its potential for multiplier effect in urban informal sector and in rural areas from where workers migrate for organised employment but without losing their rural roots also makes it a special group. In terms of number also, it represents a sizeable segment of population. According to the available statistics, the organised sector has a work force of nearly 25 million which represents about 11 per cent of the total labour force of the country. The broad break up of the labour force employed in organised sector is given in Table 3.

TABLE 3 : BREAK-UP OF THE LABOUR FORCE IN ORGANISED SECTOR

Sector	*Employment* (in million)	
Government Sector	11.7	
Central Government		3.3
State Government		6.3
Local bodies		2.1
Public Industrial Sector	5.5	
Central Government		3.3
State Government		2.2
Private Sector	7.3	
Total	24.5	

SOURCE: Ministry of Labour, *Pocket Book of Labour Statistics, 1987.*

Together with family members of workers, the organised sector may also be taken to cover about 11 per cent of the total population of the country. In addition, most of the organised sector workers belong to young age group and almost 80 per cent of them are amongst eligible couples. Realising the potential of this sector, Department of Health and Family Welfare, Government of India is giving special attention to this group and collaborating with other Ministries, international agencies (UNFPA/ILO) and various employers associations to exploit this potential market of family planning acceptors. The employers of both public and private sectors have responded to the need of promoting family planning and small family size norm among its workers. Today in most of the industries, particularly the large one, population education and family planning services are provided as a routine welfare measures of the company. In fact many of major industries had taken this initiative long ago. The earliest initiatives were taken by the TVS-Lucas group of companies in Madras in 1938. The Tata Group of industries also embarked on family planning programme around 1950, other earlier starters were Alembic Chemicals (1956), Godrej & Boyce (1957), India Tea Association (1957 in Assam), Hindustan Spinning and Weaving Mills (1962), Indian Oil Corporation (Gujarat Refinery) 1964.

In 1975, the Employers Federation of India (EFI) conducted a mail questionnaire survey to find out the family planning work being undertaken by its employer constituents. Out of 345 respondents, 278 undertakings (134 Plantations and 146 other industries) had taken action in this field.

In the public sector, the Defence Services set up in 1951, their first family welfare centres in military units supported from unit funds. The Railways, Posts and Telegraphs and several large industrial undertakings followed the suite and have since stepped up their activities.

UNFPA funding to encourage family planning activities including population education in organised sector has also contributed in strengthening the programme and increasing small family size norm among the workers. However, unfortunately, no detailed systematic information is available on the functioning and prevalence of family plannir.? in organised sectors. Some of the statistics from the individual industries/sector which are available, presents quite encouraging picture. For example a survey carried out in 1987 covering 30,165 eligible couples employed in Defence Services reveals that 60-70 per cent of them were practising family planning. Similarly in Coal India Limited (CIL) which has about 661,000 employees on its pay role, 43 per cent of its eligible couples have already sterilised. Yet another substantial proportion of them are using conventional contraceptives. Similar high acceptance of family planning has been reported from Steel Authority of India Limited (SAIL), the second largest employer in the public sector after CIL. In private sectors the leading industries with high prevalence of family planning includes Tata group of industries, Godrej, Larsen & Tubro, Tea Plantation and other large number of industries having 2500 or more employees.

As success of all these industries has not been well documented, in the present review, only two case studies, one from Plantation and the other from Tata Industries have been discussed in detail for drawing certain conclusions. They are -

1. Comprehensive Labour Welfare Scheme of United Planter's Association of South India
2. The TISCO Family Welfare Programme in Jamshedpur

Comprehensive Labour Welfare Scheme of United Planter's Association of South India

Comprehensive Labour Welfare Scheme (CLWS) is an innovative scheme launched by United Planters' Assciation of South India (UPASI). The scheme was initiated in 1971 with financial assistance from United States Agency for International Development (USAID) to promote small family size norm among the workers. In the beginning it covered only 5000 population. Subsequently the project received assistance from Government of India to

* *Family Welfare within andBeyond the Organized Sector—A Comprehensive Plan of Action, IU3* Regional Office Bangkok, 1988, pp. 47-49

** *Ibid.,* pp. 56-58.

continue and expand its activities in 6 planting districts — 2 each from Karnataka, Tamil Nadu and Kerala. Today CLWS is subscribed by 42 per cent of UPASI' s membership, covers more than 2.5 lakhs population (1984) and is fully financed by UPASI and its members subscribing the scheme. As can be judged from the demographic and health indicators the scheme has achieved significant success in achieving its goal.

Indicators	1971	1984
Crude birth rate	40.1	21.8
Crude death rate	9.0	3.5
Infant mortality rate	119.3	48.9
Contraceptive prevalence rate	9.7	48.9
% institutional deliveries	42.0	80.0
% of mothers provided ante-natal care i. e. regular check-up, 3 doses of tetanus oxide and iron folic acid tablets	27	98

To understand what has made the programme so successful, it is necessary to understand the background and the organisational set up in which it functions. As mentioned earlier, the CLWS programme is promoted by UPASI. UPASI is an association of tea plant owners to represent their interest in the organised as well as in the unorganised sector. UPASI actively involves itself in transforming new scientific knowledge and technology to small and marginal growers, irrespective of whether they are member of UPASI or not. The overall objective of UPASI is to improve farm productivity and upgrade the quality of life of both the owners and the workers of the estate, conduct various types of educational and training programmes and set-up demonstration for the growers in new farm technology as well as inter-cropping and crop diversification practices in the area. Recognising the need that to promote a happy family and good standard of living, small family norm and good health of mothers are essential, UPASI planned and launched CLWS with the following objectives:

1. To promote the acceptance of small family as a felt need
2. To improve the quality of life of flie workers by maximising the use of existing facilities provided under the Plantation Labour Act.

UPASI special interest in women was not only because a larger proportion of the workers employed in plantation were women than men but also because UPASI had experimented and found that productivity of a healthy mother in plucking was 50 per cent or more higher than an anaemic woman. Hence investment in the human resource development under CLWS was considered as a means for increasing the productivity than a social service. It was visualised that even though under Plantation Labour Act the workers were provided

adequate health and family welfare facilities*, the facilities were not optimally used. The main reasons were: lack of health education, lack of appreciation by the women about the needs of pre-natal cares and misconception about various family planning methods, particularly sterilisation. Thus right from the beginning, the thrust of the CLWS was on imparting knowledge among the workers about maternal and child care, nutritional support to the children, health education and environmental hygiene. To carry out this work initially a seven person team of medical, paramedical and communication personnel along with audio-visual equipment and a vehicle was used. However, wide spread of the estates over six districts caused serious logistic and operational problems. Hence it was decided that instead of working in all the estate simultaneously and not having any impact, as a strategy perhaps it would be better to concentrate the effort for some time on a relatively smaller area and then shift to the next area. Accordingly, the entire area was divided into various zones and from each zone first an estate was selected for the educational and motivational campaign. Through this approach during 1972-76, the coverage of the population increased from 81,491 to 1,28,164. During the same period it was also observed that in the estate where CLWS team worked in close collaboration with the management, the programme performance was much better than in the estates where CLWS functioned independently and in isolation. Interestingly, these two different models of function emerged simultaneously, depending on the interest of management of the estate in the scheme, rather than in planned way.

After 1976, government funding was withdrawn. UPASI, which during this period was convinced about the usefulness of CLWS, decided to run the programme from its internal resources and subscription fee from its members who wanted CLWS to continue its programme in their estates. Major changes were made in the style of functioning. To reemphasise the need of shifting the thrust of health care services from curative to preventive care, a series of reorientation courses for medical and paramedical staff were organised. Earlier experience had also shown that the extension team of CLWS being a group of outsiders was not easily accepted among the community members and at times was suspected to be the agent of the management. To overcome these problems the concept of link workers was introduced in the scheme in 1977. It demanded selection of a few community workers by the community members themselves, to work on volunatary basis, as link woekrs between health care centre of the estate and the workers at large. The whole idea behind introducing the link workers was the appreciation of the fact that for changing health seeking behaviour of the community from curative to preventive, understanding of social dynamics of the people and their priorities is essential and this could be best done by

* Under the Plantation Labour Act, apart from providing the workers a minimum wage, provident fund, gratuity and matenity benefits each tea estate with 30 or more workers has to maintain and provide a minimum level of health facilities. The level of health facility depends on workers strength as listed below:

1. Estate employing 300 or less workers : First aid post with a compounder or nurse,
2. Estate employing 300-700 workers: A dispensary with either a nurse or compounder with a visiting doctor.
3. 700-1000 workers : A hospital with a resident medical officer, a staff nurse, 2 mid wives, 1 compounder and supporting staff.

The availablity of health and family welfare services in the tea estate is far better than in case of general farmers. Accordingly, a health center is available within 1.5 km radius from any tea estate.

the people from within the community than from outside. Also realising that a worker without doing extra effort cannot keep contact with more than 20 families regularly, it was decided that for each 20 families or about 100 persons, one link worker would be selected. Keeping view on the work requirements (MCH care and promotion of health and hygiene) and promotion of female workers in the estate, it was also decided that the ratio of male and female workers would be 40 : 60. The worker's responsibility, as the name suggests, was establishing a link between health centre and the workers/community at large. On the one hand they were expected to collect information on health and family welfare problems of the community as a whole and those of women and children in particular, and pass it to medical centres for action. On the other hand they were supposed to inform the community about the availability of various health facilities and to educate them about MCH cares and preventive measures including environmental health and sanitation. Establishing chain or link workers was the turning point of CLWS and gave it a new strength and dimension. The insistence of keeping this work only on voluntary basis ensured that only those persons who were really interested in community service came forward to become link workers. This interest in the work and proper guidance from the management/health centre had phenomenal success in improving MCH care and as discussed earlier, today 98 per cent of the pregnant women utilise and consult the clinic for pre-natal cares. Today there are more than 3800 link workers operating the estates covered under CLWS. These workers in their monthly meetings at clinic are regularly oriented about various health problems of the community and their management. All through these orientations, emphasis is given on prevention. An analysis of the factors contributing to the success of CLWS reveals that adequate financial support and availability of a good health infrastructure were two major strengths of UPASI which helped significantly in the success of the scheme. The population of estate was also concentrated in localised area which could be easily observed and monitored. However, perhaps the main cause of the success of the scheme was the conceptual clarity of the organisers about the group dynamics and social behaviour leading them to appreciate that:

(a) social and behaviour interventions for medical purposes are as important as medical interventions themselves and for this, understanding of the social dynamics of the group and their need priorities is essential;
(b) prevention of the disease is easier and less costly than treatment;
(c) bringing about a community awareness about various health probems and their mangement and persuasion for a sustained change in the health seeking behaviour can be best implemented through their own community members than an outsider. This led them to introduce the link workers perhaps the single most important innovation of the entire programme.

The community participation in the programme through their involvement in the selection of link workers also contributed significantly in accepting the concept of self health care by the community. The link workers were thus visualised as their own people who were trying to improve the health situation of their community members and not as'agents of the management. This acceptance of the link workers was immediate and their advices were

valued. The interaction between the link worker and the medical center helped the medical staff to analyse and understand the health problems of people in a better way and plan the interventions if any, accordingly. The interest of the LW workers in the voluntary work was sustained due to the respect and appreciation which they recived both from the management (Health clinics) and the community that gave them confidence and feeling of achievement. It also raised their hope to make them future union leaders.

Earlier experience had shown that chances cf the success of CLWS is much better if the scheme works in close collaboration with the management and hence they made all efforts to ensure their collaboration.

Thus the analysis shows that success of the scheme was because of various factors including adequate funding and better availability of health infrastructure, concentration of population in an organised manner etc. However, perhaps the main factor which made all difference was the understanding of the organisers about the group dynamics and the mechanism through which it works in a community. It is only this understanding which led to the concept of link workers; the most innovative intervention of the scheme leading to success of the programme.

Tata Industries

Tata group of industries are one among the organised sectors who have taken keen interest in the promotion of family planning among its workers and had initiated family welfare programme much earlier than many other large organised sectors. Use of cash incentive for promoting sterilisation was first introduced in Tata Industries as back as 1964. TELCO, one of the Tata's giant industries, located at Jamshedpur, decided to give cash incentive of Rs. 100/- to its workers for adopting sterilisation. Subsequently, in 1967 the incentive money was increased to Rs. 2QO/-. TISCO, the other major industry of Tata, which is also located in Jamshedpur introduced same cash incentive programme for its workers. Today all the Tata Industries are paying cash incentive for family planning and providing various levels of clinical facilities to promote family planning. However, among all, TISCO has taken family planning programme much more seriously and trying to promote it not only among its workers but also extending family planning and MCH facilities to other non-employees living in several *bustees* and peripheral areas in and around Jamshedpur. In the following paragraphs, the TISCO's Family Welfare programme and its success in achieving demographic goals have been briefly reviewed.

The total population covered by the family welfare programme of TISCO is about 600,000 of which about 500,000 live within Jamshedpur Notified Area Committee while the remaining are located in the peripheral area of Jamshedpur. Under family welfare programme both clinical counselling and educational services are provided. The clinical services are offered through nine clinics located in the *bustees* and peripheral areas and two urban family welfare centres. While contraceptive counselling and services for conventional contraceptives and IUD could be obtained from any of the centres, sterilisation (vasectomy) services are offered from the two urban Family Welfare Centres. Laparoscopic tubectomy are conducted in a specially set up operation theatre at one of the family welfare centres.

As TISCO family welfare programme covers couples from diverse socio-economic groups, special care is taken in planning and developing educational and motivational campaigns. These programmes include programme for family life education, programmes for parents of tomorrows, opinion leaders' training of couples of rural area, special oreintation programmes for officers and staff and social workers of various welfare agencies working in Jamshedpur. Trade Union leaders are regularly consulted and their cooperation in the welfare programme has been ensured by constituting Joint Departmental Council (Welfare).

Apart from these, various channels of mass media, folk dance and other innovative approaches are also used to popularise family planning.

As mentioned earlier, TISCO like other Tata Industries has used cash incentive effectively for promoting sterilisation. TISCO from 1967-68 started paying Rs. 200 to its employees. In 1970-71 the incentive scheme was extended to non-employees and Rs 100 was paid to the acceptors of sterilistion. In 1981-82 the incentive for employees and non-employees was doubled to Rs. 400/- and Rs. 200/- respectively. In 1982-83 the amount of incentive paid to employees was raised to Rs. 500/- and for the non-employees it was doubled to Rs. 400/-. Motivators of sterilisation are paid Rs. 20/- irrespective of whether or not they are employees.

A recent evaluation (Bhende, Mukherji and Mitra, 1985) shows that with respect to most of the demographic parameters, the workers of the Tata employees have achieved a level which is below national demographic goals of 2001 AD and is evident from the following figures:

TFR	2.4
CBR	18.6
CDR	7
IMR	39
CPR (modem only)	58.5
CPR (including traditional)	68.2

In absence of any systematic study it is difficult to identify the factors and the total process through which this demographic transformation has been achieved. However, an examination of the performance in sterilisation in various years clearly indicates that incentive has played significant role in attracting a large number of acceptors, particularly from among the poor workers and non-employees of *bastee* and other peripheral areas'. Along with incentive, educational and motivational efforts and its integration with a well managed clinic offering a range of MCH services have also played crucial role in making the programme successful. This is well reflected in the achieved low level of infant mortality and high knowledge about family planning methods. However, it is high time that a detailed

study should be undertaken for understanding and documenting various processes which have led to the programme to a successful level.

Discussions and Conclusions

The present review of few selected successful family welfare programmes of NGOs and organised sectors clearly demonstrates that given the opportunity, NGOs/organised sectors have big potential to complement the efforts of government in achieving national demographic goals. So far because of various administrative and bureaucratic problems, the government's initiation in involving them has not suceeded to the desired level. There is an urgent need to look into the matter and all efforts should be made to establish a *mechanism* to identify and stimulate NGOs/Organised sector to undertake family welfare programme and make them equal partners in this national programme. Many NGOs initially may need consultancy, guidance and training in organising their activities and subsequently monitoring and evaluating their performance. Government should encourage and finance in establishing such consultancy cells in independent research and consultancy organisation. Established NGOs could also be utilised for such purposes. Presently, government is using FPAI for such purposes. However, there is a need for many such cells preferably at regional level.

This review has also shown that many of the alternative model tried! by NGOs in order to improve the delivery of MCH and family welfare services have considerable potential for wider use and should be taken seriously for replicating it in larger areas. In most of the cases the three factors which appears to have significant influence in making the programme successful include (1) an integrated package of MCH and family planning services, (2) use of beyond family planning approach i.e. integration of family welfare programme with general developmental activities particularly those related with women's development and (3) ensuring availability of a contraceptive at their door step through various channels - depot holders, social marketing, community workers etc. The study also shows that family welfare services could be run effectively using business marketing approaches and could be made an economically viable proposition, if the services provided are of high quality and meet the requirements of the people.

The review also shows that community interest and involvement in volunteer activities could be generated and sustained for a long time by giving them due respect and encouraging them to work for their own community. Chances of their continued participation in such volunteer work is higher if they are involved in activities which are needbased. As the needs may be shiting over time, they may find it more interesting and challenging to work on them rather than concentrating on only one activity. The voluntary participation in such social work helps in building their image among the community members and inspire them to become future community/trade union leaders. This is a major incentive for them to work for community upliftment.

The review of the NGO's successful programme also indicates that before initiating the projects, mo'st of them underwent detailed planning processes and had tried to understand the processes of group dynamics and social behaviour in the given social setting. This

understanding was crucial for planning the interventions and approaches to be adopted for ensuring community participation. This indicates that unless our family welfare programme is also modified and made need based, community participation will remain a far cry. Given the inflexible bureaucratic structure which is at present responsible for delivering of the services, there is not much hope to stimulate active community participation. It becomes particularly important then to seek more active collaboration with NGOs in promoting this programme at the grass root levels.

On the other hand, NGOs, thus far, have tended to work in very small pockets of the population and have been relatively isolated from the government; while NGOs cannot be expected to replace the government family welfare programme, they can certainly have an impact at the national level if they are permitted to collaborate actively in the government machinery. An important role which NGOs could effectively play is to test various alternative strategies for delivering health and family welfare services in different settings and provide to the government feasible model to be implemented on a larger scale. While undertaking such exercise, it is crucial that the whole experiment should be closely monitored for its performance, replicability and economic viability. Ideally the government agencies should be aware of, if not involved in these projects, right from the beginning so that upscaling the experiment, if found suitable could be done without much problem. Matlab extension project in Banglesh presents a good model where the partnership between the government agency and NGO for implementing the project on the one hand and rigorous monitoring with continuous data collection on the other were ensured right from the very beginning. Presently in India, unfortunately, except a few cases, most of the NGOs activities are in isolation without proper monitoring and evaluation. Available literature on various success stories in health and family welfare programme hardly provide any detailed information on the cost aspect (directly as well as indirectly) of the project and hence it is difficult to judge the economic viability of the project or compare its performance in comparison with that of the governmental programme. There is a need of undertaking cost benefit analysis of these programmes so that a proper assessment of the projects as compared to existing governmental programme could be made. These are some of the reasons that most of the projects carried out by the NGOs have remained on experimental level or have been implemented in only small pockets with insignificant impact at national level. For upscaling of their experience a joint effort both by the governmental agencies and NGOs, right from the beginning of the project is crucial. An initiation is required from both the sides. The sooner the better for the country.

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