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Where Has India's Family Planning Programme Gone?

FIFTY years of Independence and forty-five years of planned interventions for population control—where is India now and where does it want to go? From Family Planning to Family Welfare and now to Reproductive Health. There have been significant transitions over this time, including rapid policy changes during the last decade. On the one hand, these changes have meant the designing of a comprehensive programme in accordance with new, internationally affirmed approaches. On the other hand, frequent policy programme shifts have also led to uncertainty and confusion among programme personnel.

India's Growth Prospects

Statistical estimates and projections are important for planning and formulation of policies. The National Family Health Survey' (1992-93) provided a strong database for population estimates. The survey estimated a total fertility rate (TFR) of 3.4 for India indicating a drop of about two children per woman over the past 20 years. This was still higher than replacement-level fertility that is generally put at 2.1 children and also more than 2.9, the average number of children wanted by ever-married women. However, the significant drop that had been achieved was encouraging. The estimates of fertility provided by the survey had an influence on population policies and programmes for the country.

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¹This nationally representative survey of ever-married women age 13-49 covered 24 States and the National Capital Territory of Delhi. 88,562 household were covered and 89,777 ever-married women (13-49) were interviewed.

V. Jayachandran, T. K. Roy and Arvind Pandey of the International Institute of Population Sciences, in a paper presented to the IUSSP general meeting in Beijing in 1997, reassessed these estimates. Using the data collected in the NFHS, fertility estimates can be derived either from the Household Birth Record or from the Birth History Record. The Household Birth Records include all the births for mothers who were usually resident, even if they were absent at the time of the survey (*de jure* women).

TABLE 1: TOTAL FERTILITY RATES IN INDIA (NFHS)

| | <i>Total fertility rate</i> |
|---|-----------------------------|
| Women in rural areas | 3 . 7 |
| Women in urban' areas | 2 . 7 |
| Women with at least high school education | 2 . 2 |
| Illiterate women | 4 . 0 |

Source: NFHS 1992-93, India Summary Report.

The other source of fertility data was the Birth History Records of individual eligible women interviewed. In this case, birth histories of usually resident women who were absent were not recorded. On the other hand, the birth histories of visitors were recorded (*de facto* women). In the NFHS reports, total fertility rates were based on *de facto* women. This basis was preferred because birth histories were collected directly from the mother and have higher chance of being accurate than Household Birth Records that were collected from responsible family members. It was assumed that the fertility among "usual resident absent" would be compensated for by the fertility of the "visitors present". However, the three authors of the study observed that for all states the fertility for younger women (15-24) was higher among the "usual resident absent" compared to the "visitors present". This may have biased the fertility estimates based on *de facto* women, leading to an overall *under-estimate* of fertility in India.

Revised estimates based on *de jure* women were determined by the authors, employing the P/F ratio method. These estimates were found to be more consistent with levels of the contraceptive prevalence rate and natural fertility.

This immediately raises the question whether the true fertility rate was higher than the NFHS estimates? If yes, then population growth is more acute and a more serious

TABLE 2: ESTIMATES OF TOTAL FERTILITY RATE OF INDIA FROM DIFFERENT SOURCES

| <i>Revised estimates</i> | <i>Original NFHS estimate</i> | <i>Corresponding SRS estimate</i> |
|--------------------------|-------------------------------|-----------------------------------|
| 4.2 | 3.4 | 3.7 |

concern than it is presently viewed. It is somewhat surprising that this study, by three scholars involved in the collection of the NFHS data, has not received greater attention. The outcome of NFHS-II will be awaited with all the more interest to see how accurate the original fertility estimates were.

Recent Strategies of the Government with Respect to Family Welfare

In 1951, India's Family Planning Programme was initiated as a purely demographic programme with the primary aim to stabilise population growth. One of the critical changes since its inception is that the narrow focus of the health worker on family planning has been broadened to incorporate other services including maternal and child health.

The criteria used for setting the direction to the programme and monitoring the performance have also varied considerably over time. Prior to 1963, "population control" was seen as an easily reachable task and there were few pressures for achievement. However, subsequent review showed poor performance and the Planning Commission set specific long-term and short-term objectives. As part of the fourth five-year plan (1969-74) method-specific targets were introduced with the goal of achieving a contraceptive prevalence rate of 60% and a net reproduction rate of one by the end of the plan. The achievement of method-specific time-bound targets was seen as facilitating performance monitoring.

CSSM

The Child Survival and Safe Motherhood programme was implemented in 1992. Besides meeting the health needs of mother and child (care during pregnancy, childbirth and care of newborn, anaemia prophylaxis, oral rehydration therapy, acute respiratory infection), it provided services for birth spacing and limiting.

Pre-ICPD

In the beginning of the 1990s, internal initiatives to review the existing family planning approach created a further momentum for change. The target approach came under scrutiny and its dysfunctional aspects were highlighted. Donor agencies, NGOs, women groups and population experts lobbied with the Government to initiate a change in programme strategies from a method-specific target-driven approach to a broad set of performance goals and measures. Several points of criticism were expressed including:

- The implementation of the programme had always been the responsibility of the state but the targets were set up by the central ministry.

- The target setting process had deteriorated into a numbers game and targets had become more harmful than beneficial for the programme.
- The targets were set without considering local conditions.
- The targets had increased over time to achieve demographic indicators set by the Planning Commission.
- The performance appraisal of District Collectors was measured in terms of achievement of family planning targets. This led to involvement of other departments including the police to achieve targets.
- The expected increase in the contraceptive prevalence rate and the expected fertility decline had not been achieved.
- Demographic targets had the effect of reducing quality of service and negating participatory management.
- The pressure to reach demographic targets led to distortion of performance data.

The Swaminathan Committee formed by the National Development Council prepared a draft population policy that recommended removal of method-specific targets and suggested a radical structural change for programme administration. Though the proposal to remove contraceptive targets was welcomed, the Government was critical of the recommended structural changes. India passed constitutional amendments in 1993 that shifted control of the health and family welfare programme to local governments. However, the central government still continues to control the programme.

International Conference on Population and Development (ICPD)

The need for a change in approach was reaffirmed at the International Conference on Population and Development held in Cairo in 1994. Delegates from 179 States including India took part in negotiations to finalise the Programme of Action in the area of population and development for the next 20 years. The Conference endorsed a new strategy that emphasised linkages between population and development and focused on meeting the needs of individual women and men, rather than on achieving demographic targets. A key feature of this new approach was empowering women and providing them with more choices through improved access to education and health services, skill development and employment and involving them in policy and decision making processes at all levels.

Post ICPD

In 1995, the Government of India, in keeping with its commitment made at Cairo, removed demographic targets on an experimental basis in Tamil Nadu, Kerala and 18 districts in other states. In 1996, the draft policy prepared by the Swaminathan Committee was redrafted to include desired modifications and tabled in parliament. The redrafted

National Population Policy stated that India would remove demographic targets from its family welfare programme.

Implementing the Target Free Approach (TFA)

In 1996, the Government of India, without fully assessing the impact of removing targets in the pilot districts, abruptly abolished all targets in the country. The TFA was conveyed directly to district offices to avoid anticipated resistance from the state directorates. This led to limited sense of ownership by state offices. The monitoring system using demographic targets was no doubt outdated but its abrupt termination in an unplanned manner created a certain amount of chaos and doubt among the staff. The poor planning and implementation of the TFA had a negative influence on the effectiveness of the family welfare programme in many states. There was also a fear of losing sight of demographic objectives. As an expert from one Indian population organisation put it:

"The conventional emphasis on family planning is diluted. The government is throwing out its responsibility of addressing lower population growth because of the focus on reproductive rights. Family planning goals have been set aside. Cairo precipitated the target free approach. This approach is negative for India, the population growth rate is still very high, India is still choking with population pressures."

Many observers felt that it would be a mistake to push demographic objectives to the background. Nonetheless, if reproductive health services could be provided in a comprehensive manner, they would eventually lead to population stabilisation. It should be remembered that family planning is the most important intervention to time and space children and the most important of all the reproductive health interventions. It is also important to note that targets have not disappeared from the system: instead of being determined at the top, they are now supposed to be set by ANMs themselves on the basis of the community needs assessment (CAN) exercise carried out by them themselves. Limited faith in the new system and inadequate understanding of the value and the procedures to implement the TFA at the local level, however, has led to the retention of traditional monitoring using demographic targets in many areas of India.

While there is evidence in some states that the more decentralised community-needs approach is improving the interaction between ANMs and women, there are other areas where targets are still set. By and large, monitoring still remains top-down and community participation still remains rhetoric.

Reproductive and Child Health (RCH)

In 1998, a comprehensive Reproductive and Child Health Programme was operationalised in selected districts of the country. The programme is expected to be implemented in

a phased manner at the national level. The programme combines the Family Welfare programme, the Child Survival and Safe Motherhood programme and new elements, including services to manage reproductive tract infections and sexually transmitted diseases, to increase the safety of abortion services and to give more attention to emergency obstetric care. The project document of the RCH is designed for local-level planning and implementation. It is to be a client-centred, demand-driven, high-quality, integrated-services programme. Evaluation will be linked to increases in utilisation of services and decreases in infant and maternal mortality rates.

What can be seen from the above description is a number of fairly abrupt policy/ programme shifts in the administration of family welfare, even over the relatively short period from 1992 to 1998. The CSSM began in 1992, the TFA appeared in 1996 and the RCH in 1998. It would not be surprising to find a fair amount of confusion among the lower ranks of the family welfare system. An eight-country study by Cleland and others found that lack of policy coherence was among the most important factors leading to slow implementation of family planning programmes and low levels of contraceptive prevalence. This has probably been the case in India, too, in the 1990s.

Has Reproductive Health been Operationalised in the Government Programme?

India has made considerable progress in developing a reproductive health package. However, implementing integrated reproductive health services is a gigantic task. There is a need to improve understanding and to generate support for the new reproductive health approach among the stakeholders, to strengthen human resources, to improve the quality of care and to develop an organisational infrastructure for implementation. The government was unable to meet the needs even of the family welfare programme and now to meet the broader reproductive health provisions is an enormous challenge.

Furthermore, the reproductive health concept is not yet well understood. There is a need for effective advocacy for the new approach, as well as well articulated reproductive health policies and programmes. Demographic targets are still in the mindset of medical functionaries and programme managers. It is inconsistent to change the methods for assessment for the ANM when higher functionaries in the programme are still thinking quantitatively in terms of targets.

Various institutional obstacles also hamper progress towards the reproductive health approach. A lack of continuity within the government, changes in bureaucratic leadership and the lack of political will to work in certain areas affect the programme considerably. There is limited programme experience in integrating family planning to other services like the prevention of RTIs and STDs. The question may be asked—Is the government approaching reproductive health issues simplistically and trying to do things too fast?

There is limited capacity for RTI screening and treatment and no standardisation of drugs. The syndromic approach has not yet been transferred to the grassroots level. Are the

materials in place and available to do the required tests? Until some quick and simple tests become available it may be very difficult to adequately build this element into a primary-health-care programme, considering that many RTIs are asymptomatic. There is undoubtedly an unmet demand but the question is whether there is a capacity to meet the demand.

Sterilisation is often provided in camps that lack equipment for proper infection prevention measures as well as time to counsel clients and no follow up in the case of complications can be provided. Male methods are still neither readily available nor widely promoted.

To sum up, many abrupt policy changes have occurred in the family welfare area over the last few years. A system that had proven largely inadequate—at least in major regions of the country—in providing even a minimum level of services was asked to add several new interventions without adequate preparation. A totally new programming approach was introduced without retraining service providers to counteract an entrenched mindset.

The ICPD+5 and the Hague Forum Report

Five years after Cairo there was a felt need to take stock of ICPD progress and to undertake a global review of the implementation status of the ICPD Programme of Action. The process began in 1998 and will continue through June 1999. National consultations sponsored by UNFPA were organised in partnership with governments and NGOs on the programmatic accomplishments and failings in countries implementing the Programme of Action. These culminated in an International Forum on Population and Development in February 1999, in The Hague, Netherlands, with the participation of around 120 countries and over 1,500 delegates.

At the forum there was a realisation that considerable global progress has been made in the last five years in redesigning policies and programmes. Many initiatives have promoted women's participation at the policy and decision-making level. Positive collaborative efforts to involve civil society have also been initiated.

However, sexual and reproductive needs of over the world's one billion young people have not yet been adequately addressed. There is still limited access to information and thus the inability to make choices. With improved access to safe contraception fertility levels have declined, but over 150 million couples world-wide still have an unmet need for contraception.

There was a realisation that insufficient understanding on how to effectively implement the reproductive health approach among the policy makers and health professionals is still a problem. Decentralised programme implementation has increased the responsibility of programme managers without building the skills and capacity necessary to effectively perform the task.

Overall, however, the Hague Forum documented a widespread willingness to move ahead with the ICPD Programme of Action, as witnessed by the many initiatives to

update policies and begin implementation. The major constraint identified at The Hague was the shortfall in financial resources, especially from donors.

Where will the Donors put their Money?

To implement the reproductive health approach fully, India will have to make a strong financial commitment to increasing programme funding. With structural adjustment measures underway, it seems unlikely that the Government will be able to meet this financial challenge on its own. India's programme allows for limited cost recovery. A large percentage of the population lives below the poverty line, and it is unlikely that the Government or donors will have to continue to play a major role in funding the health and family welfare programme.

In this regard, it is instructive to analyse the priorities of donor countries in terms of assistance to population and reproductive health programmes. The annex table shows an analysis of the statements made at the Hague Forum by several of the most important donor countries. These statements, though of varying degrees of completeness with respect to priorities, provide a recent snapshot of donor thinking vis-a-vis the ICPD.

What should come as a shock for many in India is the right most column, the one indicating family planning as a priority area for funding. Only three out of eleven donors mentioned family planning. HIV/AIDS/STDs, on the other hand, was highlighted by eight donors, sexual health for adolescents by ten donors, and gender equity also by ten donors. Maternal health was on the priority agenda of all donors for which information was available.

To the extent that donors are in the vanguard of global policy thinking on population and reproductive health, this table shows that the world has moved on from concerns about population growth and "population control" to a variety of other concerns related to reproductive health, HIV/AIDS, adolescent reproductive health, sexual health and gender empowerment. The genuine concerns that many policy makers in India still express over the inexorable growth of India's population - how poised to surpass the one billion mark—seemed at the Hague to be oddly out of touch. Although several other countries besides India expressed concerns about population growth in their own countries, the developed countries did not, in general, mirror such concerns. Even the word "population" seemed to be off the radar screen at The Hague.

The Future of Family Planning

Does this mean that anxiety in India over growing population size is now unwarranted? Not necessarily. A more likely explanation is that, in large regions of the world, fertility has fallen to replacement level or at least close to replacement level. Population growth may still be continuing in those areas, but at a constantly decreasing pace which will,

in a decade or two, bring the growth rate close to zero. Thus population growth in many parts of the world is becoming increasingly irrelevant and other issues are coming to the fore.

An allied phenomenon is that in one major region where fertility remains high— sub-Saharan Africa—the spread of HIV/AIDS has quickly overshadowed the issue of rapidly expanding populations. In many African countries, deaths from AIDS have already shaved one percentage point or more off the rate of growth of population. Life expectancy is also plummeting, by as much as 20 years of life in some African countries. Under such circumstances, it is understood that policy concern has shifted, to some degree, from worry about population growth to anxiety about the HIV epidemic.

In a way, India mirrors this global policy scene. Half of India has reached replacement-level fertility, or else is clearly on the road to doing so. The other half of India, however, is still mired in fairly high fertility and the prospects for completing the demographic transition are not necessarily rosy. As detailed above, it is in this half of India where grossly deficient services and entrenched attitudes which perpetuate inequality among the genders are mostly—though not exclusively—found. In the low-fertility half of India, on the other hand, population growth will diminish, year by year, and will soon cease to be a major policy concern.² Over the long term in the high-fertility half of India, on the other hand, population growth will be a major issue for decades to come and we seem to be assured that inconceivable realities—such as an Uttar Pradesh of 250 million people in 20-25 years—will come to pass.

The point is that, within India, the traditional "population control" policy, which is still entrenched within union and state administrations at different levels, even now should be tempered with policies which may be termed "post ICPD". These, as outlined above, include adolescent reproductive health concerns, HIV/AIDS, reproductive tract infections, and safe motherhood. At the same time, the northern states and others where family planning has not become a widespread societal norm should continue to concentrate forces on programmes that will lower fertility. Even from a reproductive health perspective, probably the biggest and most cost-effective gains in women's health and women's empowerment can still be made through family planning. If women in these regions can be given the opportunity to plan their families and achieve their reproductive goals through contraceptive availability and avoidance of unsafe abortion, maternal mortality and morbidity rates will decline considerably. Such women will also have opportunities to make developmental contributions beyond reproduction and to become more empowered.

What is being suggested here is that national policy should accommodate itself better to different situations in different parts of India. The RCH programme is supposed to

²Another question, which should be raised in some other forum, is whether the ultimate population sizes that we can now envisage for states like Tamil Nadu and Andhra Pradesh, for example, will in fact prove to be unsustainable over the long-term from the point of view of natural resources, agricultural capacity and ecological balance.

be client-based and, to the extent that approach actually becomes a reality, the different needs in different regions will, of course, tend to be met. But even at the macro-level, national policy should be bifurcated into one set of policies aimed more at concerns for population growth for some areas, and another set of policies aimed at "post ICPD" concerns for other areas. One size does not fit all. Family planning should not die, but its primacy in the policy pantheon can now legitimately be challenged in some regions of the country.

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Priorities of Donor Countries Emerging from the Hague

| | <i>Maternal Health</i> | <i>Child Health</i> | <i>HIV/AIDS/STDs</i> | <i>Adol./Young Adults</i> | <i>Intl. Migration refugees</i> | <i>Pop. Aging</i> | <i>Gender equity</i> | <i>Access to contraceptives (HIV)</i> | <i>Education</i> | <i>Participation of civil society</i> | <i>Organisation capacity building</i> | <i>Family planning</i> |
|-------------|------------------------|---------------------|----------------------|---------------------------|---------------------------------|-------------------|----------------------|---------------------------------------|------------------|---------------------------------------|---------------------------------------|------------------------|
| U.K. | Yes | | Yes | Yes | | | | Yes | | Yes | | |
| Denmark | Yes | | | Yes | | | Yes | | | Yes | | |
| Netherlands | Yes | Yes | Yes | Yes | Yes | | Yes | | Yes | Yes | | Yes |
| Sweden | Yes | | Yes | Yes | | | Yes | | Yes | Yes | | |
| Finland | Yes | Yes | Yes | Yes | Yes | | Yes | | | | | |
| Norway | Yes | | Yes | Yes | Yes | | Yes | | Yes | Yes | Yes | Yes |
| Australia | Yes | | | | | | Yes | Yes | Yes | Yes | Yes | |
| Japan | Yes | Yes | | Yes | Yes | Yes | Yes | | | Yes | | Yes |
| U.S.A. | Yes | | Yes | Yes | | | Yes | Yes | | Yes | | |
| Switzerland | Yes | | Yes | Yes | Yes | Yes | Yes | | | | Yes | |
| Austria | Yes | Yes | Yes | Yes | | Yes | Yes | Yes | | Yes | | |