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Target Free Approach in Family Planning—A Critique

Introduction

INDIAN Family Planning Programme is the world's largest voluntary programme administered in a democracy. This programme is unique for the gigantic proportion of its mammoth size, set in a vast spectrum of socio-cultural milieu that has transcended a variety of barriers of very complex nature. Perhaps, it must be the third largest operation after decennial censuses and general elections. In the past five decades, this programme has chartered an interesting course with great strides and tribulations. Experimentation has been the cornerstone of Indian family planning programme, be it the conceptual framework, policy enunciation, programme implementation, service provision and validation and evaluation of service statistics. Policy formulation is one' such vital component, which has undergone morphological changes several times and each such change was fraught with consequences of significant importance. Target Free Approach to family planning, introduced in financial year 1996-97, is one such change in the recent times that has generated considerable amount of speculation, which is likely to affect the course of the programme significantly. In this paper, it is endeavoured to take a close look at some aspects of the much maligned targets and the target free approach to family planning.

The objective of this paper is four fold: (a) to review the chronological processes in the target setting in Indian Family Planning Programme, (b) to understand the reasons for the removal of targets, (c) how this target free approach has been implemented in the country, and (d) what are the experiences with the target free approach.

The Prelude to the Target Setting Process in Family Planning

The official Family Planning Programme in India was launched along with the initiation of the planning process during the First Five-Year Plan in 1951. This Programme has continued

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till todate. It gained momentum gradually during the subsequent Five Year Plans with increasing expectations in terms of decline in fertility levels. Consequently, the programme assumed more complex nature with more material and men getting employed in the programme. The first official National Population Policy was formulated in 1976. The name of the programme was changed to family welfare in 1977, by enlarging the scope of the programme from mere family planning to cover maternal and child health also. That was a major deviation, from demographic expectation to a more composite sphere of services. The National Health Policy document of 1983 emphasized the need for small family norm. In 1991, the National Development Council appointed a committee to have a look at the programme. Subsequently, in 1994, an expert group was constituted to draft comprehensive population policy for consideration of the Parliament.

Along with the course of all these developments, however, the programme has undergone several twists and turns since its inception. There has been a gradual but continuous shift in emphasis in the programme with each five year plan. During the initial years efforts were on to promote the demand for family planning services. Primary Health Centres and Family Planning Clinics were set up to deliver the required services. In the initial years of the programme the use of non-sterilization—non-permanent methods, such as, vaginal jelly, foam tablets, diaphragm and condoms were emphasized. Realising the inadequacy of these methods to produce any significant impact on the birth rates, subsequently, sterilization services were introduced as a reliable method than others. But, the emphasis was on male sterilization— vasectomy. 'Cafeteria' approach to family planning was adopted during the Third Five Year Plan with more emphasis on sterilization as a method.

Considering the incongruities involved in the evaluation of the processes and impact of the family planning methods, method specific targets in family planning were introduced during the Fourth Five Year Plan. Then, efforts were on to integrate family planning with maternal and child health services. Advocacy of spacing methods also began during this period. Incentives for adopters of family planning methods and motivators and service providers were introduced during the Fifth Five Year Plan period. During the time of emergency, vasectomy was emphasized.

A working group on population policy was set up by the National Planning Commission to formulate long term goals in family planning in 1979. A long term National goal of Net Reproduction Rate (NRR) of unity or one was set up for the country as a whole by the year 1996 and for all the states by 2001. The NRR of one or unity implied that for a given set of conditions of mortality and fertility, on an average, a woman will be replaced by one daughter. This is how target setting in family planning made its beginning in the country.

Target Setting in Family Planning

The extension approach of the family planning programme followed upto the early part of the Fourth Five Year Plan was found inadequate to meet the demographic outcome as revealed by the 1961 Census. In 1965, the United Nations Advisory Mission to India emphasised a vigorous approach through intensified promotion of sterilizations, IUCD and diversification of the distribution of condoms to achieve a birth rate of 25 per 1000 population by the year

1973 (Raina, 1988). The elusiveness of quantification of the performance under extension approach was one of the reasons that yielded way to targets. Structural changes were affected to the course of family planning programme shifting the focus to "time bound" and "target oriented" approach (Visaria, 1998). Method specific annual targets were set by the central government and these targets were distributed upto the subcentre level functionaries. At that time it was felt that the targets were understood well, have been in use in industry and agriculture for a long time and hence familiar to the administration. Additionally, the ease of quantification of achievements and evaluation of the performance was rightly appreciated and recognised. Allegedly, this was an American management tool brought into the country by a donor agency (Visaria, 1998). Arguably a good tool, which fell prey to the inept handling and administrative indifference. Industrialisation and the subsequent stupendous growth of economic super powers was because of the "targeted" growth of their economies. Targets have been the main stay of planning, production, and quality control in industry and agriculture, even today. What went wrong with targets in Indian family planning programme, has an altogether different perspective which seems to have been misunderstood.

The planners and their advisors who found the method specific targets as a bane *ex-post facto,* had been the proponents of the approach since its inception and did not find fault with it, then. It was they who held key positions in the system, advised the Planning Commission and the Department of Family Planning on matters related to the targets, established data collection methodologies, analyses and projections of programme expectations and performance vis-a-vis decline or otherwise of the birth rates. It did not occur to any one of them, as many of them, rightly, even to this day swear by scientific nature of target setting in the Indian family planning, which is to a greater extent is correct and scientific (Srinivasan *et* o/., 1980;
Kulkami, 1989). It was neither the targets nor the family planning methods that have failed in the Indian family planning programme. It is the unrealistic and over ambitious demographic goals without the proper understanding of the ground realities concerning the programme implementation, inconsistent approach and lack of proper direction and definite political commitment, accountability, late realisation are among some of the reasons which have discredited a proven management tool. Midterm evaluation and suitable corrections have been unknown to the Indian family planning programme.

The establishment of a central statistical unit at the national level as far back as 1955, was an important milestone in the understanding of the targets in family planning. This unit constantly reviewed the procedures and formats used for the collection of data from all over the country and refined them periodically, based on the felt need for a particular quality of data. By the beginning of the proposed Fourth Five Year Plan period, in 1966, though nascent, a reasonably good information system was in place with all the instruments necessary for collecting data on all the aspects of family planning. Both the extent of collection of information, its limitations and internal and external consistency checks concerning the data collection were fully recognised and clearly understood at such early stages itself (Seal, 1977).

With the establishment of statistical division at the central level at the very early stages of the programme and development of necessary data collection instruments was a positive step in the direction of monitoring and evaluation. Many researchers felt confident about the

functioning of the monitoring system. But the later slip up is a matter for research and to rectify the deviations. The search for reasons should start systematically from the subcentre level and lead up to the central statistical division.

How else could we have set the goals for achieving the desired demographic transition in the face of stark realities of illiteracy, poverty, inaccessible healthcare, lack of infrastructure and many more problems? It is an established fact that fertility levels which had slowed down a little while in the 1930s and 1940s (wartime effect?) picked up much greater momentum and the socioeconomic development in the ravaged post-colonial India was out of step with the growth of population, with the exception of a very few pockets. The planning process set into motion at the beginning of the national reconstruction took a serious view of the population being a major impediment in securing benefits of development to all the citizens. Perhaps, the spiraling fertility rates around 1960s due to increased proportion of married females in the population and slow pace of implementation of family planning with extension approach led to the introduction of targets as a reasonably good assessable tool in the implementation of the programme. It was basically meant for prioritisation of task of the field workers. It was measurable directly and summation of such measurements would reflect the outcome of decline or otherwise the fertility levels for a given region. Considerable amount of misconception and misinterpretation has been read into the targets/^/- *se.* Notwithstanding the criticism, it is undeniable that the decline in the fertility rates to the current levels, in a greater measure, is due to target setting.

Target approach in family planning began during Fourth and Fifth Five Year Plan periods. The experience with target setting in terms of crude birth rates to be achieved over five to ten years, as formulated in earlier five year plans, indicates that targets were never achieved and goals have to be revised time and again on the basis of actual performance (Sinivasan, 1997). In terms of specific family planning goals, the following targets were stipulated to be reached by 1990:

(a) An effective couple protection rate of 42 percent.
(b) Crude birth rate of 29.1.
(c) Crude death rate of 10.4.
(d) Infant mortality rate of 90 per 1000 live births.
(e) Universal immunisation of children.
(f) Antenatal care of 75 percent of pregnant women.

Thus, in addition to family planning goals, maternal and child health goals were added. On the other hand. Net Reproduction Rate of one implied that by the turn of the century, India's crude birth rate would be 21, crude death rate of 9, infant mortality rate of 60. life expectancy at birth of 64, and 60 percent of the eligible couples would be protected with contraception.

The Department of Family Welfare and the Planning Commission decided on the objectives for each five year plan period and converted these objectives into method specific targets for each year. Taking into consideration the past performance and the backlog in a plan and realising that the states with poor performance would not be able to contribute to national objectives, higher targets were given to better performing states. The states were divided into

three groups and time period by which replacement levels of fertility should be achieved was determined separately for each group of states. The ministry also introduced an incentive package to encourage better performance, which led to intense competition among states. The first group of states was expected to achieve an NRR of one by 1991-92, the second group of states by 1996-97 and the third group of states by 2001-02 (Table 1).

TABLE 1: FAMILY PLANNING OBJECTIVES SET DURING DIFFERENT TIME PERIODS

Plan Period	*Shot-Term Objective*	*Long-Term Objective*
1962-63		Crude Birth Rate (CBR) of 25 per 1,000 Population (no time period given)
1968	CBR of 32 by 1973-74	CBR of 25 by 1979
1969-74 (Fourth Plan)	CBR of 32 by 1973-74	CBR of 25 by 1981
1974-79 (Fifth Plan)	CBR of 30 by 1978-79	CBR of 25 by 1984
1978	CBR of 30 by 1982-83	
1980-85 (Sixth Plan)	CBR of 30-31 by 1985 Crude Death Rate (CDR) of 9 by 1985 CPR of 36.6 percent by 1985	NRR of l by l996 CPR of 60 percent by 1996
1985-90 (Seventh Plan)	CBR of 29.1 by l989.90 CDR of 10.4byl989.90 CPR of 42% by 1989-90	NRR of I in Group I State by 1991-92, in Group II States by 1996-97; and Group III States by 2001-02
1992-97 (Eighth Plan)	Infant Mortality Rate (IMR) of 90 by 1989-90 CBRof25.7byl996.97 CDRof8.7byl996.97 IMR of 68 by 1996-97	CBR of 21.7 by 2006.07 CDR of 7.4 by 2006-07 IMR of 48 by 2006-07

Source: G. Narayana, *el cil:* "Target Free Approach for Family Planning in India: An Analysis for Policy Formulation". *In Targets for Family Planning in India, An Analysis of Policy Change Consequences and Alternative Choices.* The POLICY Project. The Futures Group International, New Delhi, Oet 5,1998, p. 10.

Targets by and large took into consideration the objectives set for different plan periods. Beginning with Sixth Five Year Plan separate targets for different methods were set. These method specific targets were distributed to the states by the Department of Family Welfare. However, there was no fixed criteria to distribute the targets across the states (Srinivasn *et a!.,* 1980). During the Seventh Five Year Plan period, a participatory system of targets was tried for the first time. The methodology followed for the distribution of targets varied each year. District authorities were involved in the family welfare programme when family planning was considered as a part of Prime Minister's Twenty Point Programme, resulting in the involvement of different departments of the government such as revenue, police and others.

Since its inception in 1951, the Indian family planning programme has laid undue emphasis on sterilization—vasectomy until 1977 and female sterilization thereafter. As of 1995, over 50 percent of eligible couples in the reproductive ages have been protected by a modem method of contraception of which nearly 90 percent are sterilizations particularly female sterilization. There are general complaints with regard to quality of care as follow up services remained inadequate and poor. India has spent nearly Rs. 60 billion for its family planning programme upto 1995. Current expenditure is in the range of Rs. 7.15 billion per year which accounts for

nearly 15 percent of total health budget in the country (Srinivasan, 1995). According to Narayana, target setting process deteriorated into a number's game with no concern for short term and long term objectives of the family planning programme with no changes in the strategies to achieve results (Narayana, 1998).

The entire performance under the regime of targets was not spurious, certainly there were lacunae, which, could have been easily pointed out and eliminated. All that was needed was a will to do so. It was the best available option, after all, in the prevailing scenario through all the eight five year plans, wherein the real development and empowerment of people remained far from expectations.

The problems of implementation of family planning targets at the grass root level and supervision of implementation was a management task requiring knowledge, attitude and behavioural compliance of the task force involved at all levels. Such a management task should have had the backing of a clear vision of a plan and a pragmatic long term policy. At the planning level, the frequent shifts in the desired levels of demographic transition expected over the five year plans; at the executive level, lack of a consistent population policy and adhoc implementation strategies and at the implementation level, overtly fraudulent reporting system of implementation have been in existence for a long period and all concerned at all levels were fully aware of it. Nobody, in their wisdom and for reasons best known to them, questioned this trend and/or suggested remedial measures for correction, all along the entire course of Indian family planning. What was considered as scientific and practical instrument became a problem in itself.

Certainly, there were problems in the implementation of the regime of targets and not in their validity as a tool. Unfortunately, to cloak the disgust and anger at the regime of implementation, it was resorted to find fault with the targets *perse* (Bose, 1996). They have failed to question the role of administrative machinery involved in the implementation of targets which, would have resulted in correcting any aberrations in the implementation of targets noticed at different times in the course of the process. That did not happen. Utmost caution seems to have been exercised while heaping criticism over the targets and sparing the implementation machinery responsible for the implementation, the administration had the control over the resources to which critics would not venture to lose access to. Nor there was any honest and deliberate attempt to seek and redress mistakes in the implementation of targets, if any.

Criticism about Target Setting

In the recent past, the critics of target setting have cited a number of reasons or programme outcomes against the process of target setting. Such criticism was the main plank that was used to demolish target setting regime. Principal among them are:

- Centralized planning with target setting from the top.
- Method specific targets are unrealistic, hence unsuitable.
- About 40 percent of the targets are met in the last quarter of the year.

- Reported performance of some states has not led to corresponding reduction in the birthrate.

  Extent of contraceptive acceptance is less than reported by the states. Achievements were manipulated to boost the performance statistics. Cash incentives have resulted in inflation of performance statistics. Over emphasis on sterilization at the cost of other methods. Monitoring and evaluation is reduced to mere reporting machinery.

A Critique of the Criticism

Eminent researchers, academicians and population experts were involved in the preparation of the plan documents all through the history of developmental planning in India. Inputs for action plans in the plan document were provided by the population experts, who were in the know of the realities in the field situation and accordingly programme directions were initiated. The development planning being a centralised exercise in India, strategies such as target setting in family planning also became a centralised process. The situation could have been remedied automatically, if only the inputs dictated so. At no time the matter was taken seriously and pursued to its logical end. Secondly, the field conditions were not suitable for a perceived change over and even now, are not really ready.

Introduction of cafeteria approach with a basket of methods and emphasis on spacing was at the root of method specific targets. In a country with a large number of illiterate acceptors, with poor access to service provision, inadequate infrastructure and logistics support, it is reasonable to expect collapse of spacing methods. Unrealistic approach, undue pressure brought to bear on the field workers, inadequate supervision, collusion, lack of proper audit are some of the reason that led to the over reporting of coverage of spacing methods. Conversion factors applied at deriving the sterilization equivalents for spacing methods might have prompted inflation of performance statistics in the absence of proper audit. To that extent the method specific targets were unsuitable in Indian context.

In a tradition bound society nestled in agro-economy with varying agro climatic conditions across the country, it is reasonable to expect a slackened performance during festival seasons and agricultural operations. The slackness is reported during the months of September through December and to the extent of 15 percent or less than 5 percent per month. This is made up during the last three months of the financial year, a mere five percent extra per month. This phenomena of completing the backlog of work is not restricted to family planning or health services alone, it has been widely prevalent even in revenue collection and public works. World has not found fault even with ace athletes picking up momentum towards the end of winning sprint!

Lack of strict monitoring has led to the inflation of performance statistics. This was very much obvious from the beginning and there was no need to wait till the National Family Health Survey. 1992-93, to point out the obvious. Sterilization equivalents derived from the spacing methods and performance incentives to the states yielded way for manipulation of the statistics. An efficient monitoring system would have obviated this pernicious practice (Visaria, 1995).

Barring a few instances, cash incentives do not really amount to a large sum of tempting proportion. The amount given to the acceptors as a package for loss of wages and out of pocket expenses and incentive money given to the motivators has been the bone of contention for a long period. In simple terms it is nothing but an equivalent of TA and DA drawn by everybody who works outside of the usual place of work. Since the service delivery points are located far away from the residence of the acceptors and work place of motivators they become eligible for the equivalents ofTA and DA, a fact that can not be denied. The entire expenditure on account of an acceptor getting sterilized is rupees two hundred and ten only (including the cost of drugs, dressings, motivator's and service provider's incentive and a contribution to the miscellaneous fund). In comparison, it is one fifth of the administrative cost of more than one thousand rupees per sterilization equivalent (Srinivasan, 1995). Selectively, there seems to be no controversy about increments given by state and central governments to their employees if they or their spouses undergo sterilization. These increments being perpetual will eventually cost a good deal to me exchequer. Monitoring would effectively eliminate any misuse on account of inflated statistics.

An approach document "Reproductive and Child Health Programme: Schemes for implementation"—released by the MOHFW has many schemes with honoraria for the in-service and casual assistants (MOHFW, 1997). The quantum of such honorarium is several times greater than what was paid as incentive money in family planning programme. There is, every likelihood that, it will be a forerunner of huge number of honoraria in several aspects of healthcare. This must be considered as an outcome of cumulative experience that monetary incentives in several segments of service delivery are necessary for an effective implementation of the programmes. Thus, contrary to the outcry, with the introduction of Reproductive and Child Health schemes there appears to be a resurgence of incentives in many more newer areas of healthcare provision. Some state governments have boldly come out with cash incentive to the service providers and supporting personnel. Unquestionably, it is their considered judgment—a good judgment, which is working well (GOAP, 1998).

In the given background of Indian acceptors, the infrastructure available for the field workers to provide regular supplies of contraceptives and the overriding fertility levels having fulfilled the desired size of the family the programme has to look for sterilization as a preferred method. There is no gainsay about the decline in fertility to the current levels is primarily due to sterilizations. Several studies have pointed out that there is a greater demand for sterilizations followed by other methods (NFHS, 1992-93). Then, the all important question that needs to be answered is that, if the people demand voluntarily terminal contraception as their preferred need should it be denied in preference to the spacing methods? Early marriages and child bearing that is typical of Indian people for whatever reason it is worth, complete their families in a very short span of, say, 4 to 6 years and seek terminal contraception to limit the family size. There had been no concerted efforts to promote spacing methods because of the obvious difficulties in such promotion. Nor the eligible couples are in a position to understand the impact of spacing and adopt such methods, again, for very valid reasons. But for a short duration during the Emergency, acceptance of sterilizations has been more or less voluntary. The socioeconomic development might create demand for spacing methods at a later stage but the fertility levels will be secure with sterilizations, for the time being.

Post ICPD 1994 Scenario in Developing Countries

With the advent of International Conference on Population and Development (ICPD) at Cairo in 1994 and the emergence of Reproductive Health as a panacea for all the ills faced by men and women, especially in the developing world, the decibel level of criticism of targets in Indian family planning reached its crescendo, often bordering outright acrimony (Bose, 1996). All those who criticised targets as 'misguided foreign advice' were quick to embrace the Reproductive Health approach as advocated by the ICPD Cairo, as though it was 'Made in India'.

The much anticipated Reproductive Health approach also seems to have not yielded the desired results, either. Haifa decade after the ICPD Cairo the impact does not seem to be any significant. In an international case study on the implementation of reproductive health policies and related programmes in eight countries in three regions of the world including India, Bangladesh and Nepal, researchers from The POLICY Project of the Futures Group International have gleaned information on the six variables in the process of adoption and implementation of reproductive health programmes as follow up of ICPD 1994. The six variables are: official adoption of the ICPD definition of reproductive health, involvement of stakeholders in reproductive health in policy and planning, receiving support for reproductive health programmes from the stakeholders, establishment of priorities among the elements that make up reproductive health agenda, implementing the national reproductive health programme and resources mobilisation in support of reproductive health programmes (Hardee *etal*., 1999).

The results indicate that the rhetoric has been accepted well in most of the regions. But the priority accorded to resources mobilisation for the purpose and its implementation have been very nominal. This is a clear indication of refusal by the concerned countries to discard the traditional mould vis-a-vis the advocacy of the ICPD 1994. The "paradigm" shift to the reproductive health approach during 1996-97 without sufficient background or preparation, India has tough times ahead with the very poor infrastructure at the primary healthcare level in implementing the reproductive health agenda (Srinivasan, 1999). As a consequence, the family planning programme is set to suffer reverses even in areas with good performance record. This is already evident and has been acknowledged (Srinivasan, 1999).

Reasons for Removal of Targets

Several reasons have been mentioned for the removal of targets in April 1996. To begin with the Department of Family Welfare decided to abolish targets in selected states and selected districts in the remaining states on an experimental basis. The experience of implementing the target free system was never reviewed before a final decision was taken to abolish the targets. An administrative decision was made to abolish targets in the entire country by April 1996.

The contraceptive acceptance was generally lower than that was reported by the respective state governments. Targets were achieved in the last three months of the financial year though the services ought to have been provided evenly throughout the year. Achievement of

contraceptive targets had become an end in itself. The achievement of contraceptive targets and provision of cash incentives have led to the inflation of statistics and neglect of quality of services. Primarily the focus of the programme was on female sterilization as a dominant method promoted. Women in the reproductive ages were targeted groups.

The increase in the contraceptive prevalence rates has no significant impact on the decline in the fertility levels. The programme with emphasis on numerical targets neglected low parity couples and the promotion of spacing methods. Performance data provided by the Department of Family Welfare was incomplete and unreliable. Intense pressure was used to achieve targets which was responsible for distortion of performance statistics at various levels. Target system negated the principle of participatory management with considerable pressure on workers to achieve targets and competition between workers of different departments. Direct and indirect pressure was exerted on workers and acceptors of sterilizations. Given these the system in place was regarded as rotten requiring complete overhaul. On several occasions false promises were made to the acceptors of sterilization methods. Innovative approaches to increase access to and demand for services were never attempted and demographic targets set were never achieved (Narayana, 1998).

There had been a very severe criticism by some social scientists, and researchers in India that the Family Planning Programme in India has only served the demographic goals and not other health needs of the people (Bose, 1996). By definition, the outcome of family planning can only be expected to modulate the demographic needs. No illustrations are available in the literature wherein the family planning programme as a stand-alone could serve the other aspects of health care of people. That was one of the reasons for broad-basing the family planning into family welfare in 1977-78. Beyond the rhetoric, even the current reproductive health approach also has a narrow spectrum of health care activities incorporated in it. Also, it should be realised that it was not impossible to broad base the programme to service the desired ends of health care of people, if only, we had the will with matching resources to undertake such innovations in the public sector in the formative years of the programme or any where in the course of the programme. While pointing out the failure of family planning programme, the failure to provide adequate primary health care in India has not been highlighted at all.

The concept for abolishing the targets had its origin in an altogether different context. Targets allotted to the government employees of other departments in Tamilnadu who were harassing the field workers of the health department were removed to the great relief of the field workers in 1992 (Narayana, 1998).

Target Free Approach to Family Planning in India

Target free approach in Family Welfare Programme was introduced from April 1,1996. The programme was expected to move from a target based approach to client centred activity with emphasis on quality of services. The programme is expected to have community needs assessment approach. It was expected that the Family Welfare Programme will undergo a change from segregated approach to integrated approach. The services to be provided under the new setup included family planning, child survival and safe motherhood, prevention of

reproductive tract infections (RTIs), sexually transmitted diseases (STDs) and AIDS. A PHC level plan will be formulated covering all aspects mentioned above, the materials and supplies required and the operational strategy to achieve the objectives.

The exercise will be carried out by the grass root level workers in consultation with the community to estimate the needs assessment. Grass root level workers like ANM, Multipurpose Health Workers, both Male and Female shall be asked to give an estimate of the Family Welfare activities required in the area. All concerned will be involved in the formulation of the PHC based family welfare/health care plan. Aggregation of all such estimates of grass root level workers of subcentres and at the PHC level will be prepared at the PHC. District Family Welfare plan will be aggregation of all such plans formulated at the PHC level. State level family welfare plan shall be an aggregation of all such district level plans. All state level estimates will be compiled at the state level to workout the requirements of all materials and supplies. Monitoring is expected to be carried out based not only on the performance of achievements but also on indicators and quality of care. The PHC level plan shall be proposed on the basis of the assessment of need of population for family welfare services by ANM and others. The performance of the Medical Officer in charge, PHC, ANM and others will be judged on the basis of achievements in relation to needs assessed.

A memo issued by the Secretary Family Welfare about target free approach was sent to the District Collectors/Magistrates and not to the state level officers. The Ministry asked the districts to conduct re-orientation training and released funds for the purpose directly to the districts without informing the state directly. A new series of formats were devised suggesting a set of indicators and a numerical formula to calculate expected level of performance at the subcentre level. The new system gave a feeling that there is no need to promote family planning as their performance was no longer reviewed or monitored. Narayana has argued that the Department of Family Welfare instead of initiating a decentralised process has replaced one centralised system with another (Narayana, 1998).

Implementation of Target Free Approach

During the financial year 1995-96, Ministry of Health and Family Welfare (MOHFW) selected two districts in every state for experimenting with the implementation of the family planning programme without the rigmarole of targets. The criterion for selection was very simple—the best performing districts, in these states. There were no specific efforts to educate and orient the field staff for the specified task of target free approach in these districts. It is reasonable to expect that in a good performing district there would be an excellent match between the demand, the service provision and acceptor satisfaction. Most of the work in these districts would be demand driven, hence spontaneity in the willingness of the couples to limit their families, leading to better performance. About one quarter to one third of all the districts in every state will fall into this category. This cannot be said about other districts in each state, for various reasons there will be districts with intermediate performance and districts with consistently poor performance, over years. That being the actual state—the ground reality, it was a fallacy to have selected the best performing districts for whatever observation that was proposed, including performance without targets.

Observation of performance under the new target free regime in these districts, during 1995-96, was not completed. As such, there was no evaluation undertaken to analyse the implementation of the new approach, its impact on the programme and the considered views of the persons involved at all the levels of its implementation (Visaria *et al.*, 1999).

Much before the conclusion of the year 1995-96, on the 1st of February 1996, at the meeting of the State Family Welfare Secretaries, the MOHFW announced the introduction of target free approach all over the country. Realisation dawned on the stunned State Family Welfare Secretaries, some of whom expressed serious reservations, but they were witness to *a fiat accompli*., since the decision had already been taken in this regard and they were mere witnesses to the formal announcement and perhaps nothing more, as the arguments advanced by them were not considered at all (Narayana, 1998).

Interestingly, ignoring the State Departments of Health and Family Welfare, Directorates in the states and District Health Officers, the MOHFW chose to write to the District Collectors/ Magistrates to organise the sensitisation workshops at the district level/PHC level, to sensitise atleast 50 percent of the functionaries in March 1996 and the remaining in April 1996. The necessary funds were also released directly to the Collectors (the disproportionate allocation of funds, considerable amount of confusion it created and funds meant for the above workshops eventually reached in August 1996, is altogether a different issue) (Narayana, 1998). The pattern appears to be quite familiar, for reasons not very clear the MOHFW appears to have been under obsessive compulsion to introduce the Target Free Approach all over the country, the MOHFW did not take even the state governments into confidence about such an important decision. There was no debate at any level on a momentous approach which, was to change the course of the programme altogether and could herald problems for the programme and personnel involved. The reasons for the haste were not explained at all. Hitherto unfamiliar route, through the District Collectors, was chartered bypassing the State Health Departments and Directorates to convey the message and initiate the process of implementation of the new approach, was unheard of in the annals of family planning in India (Narayana, 1998).

Target free approach was hailed as a "paradigm shift" in the approach to family planning taking the route of Reproductive Health—the new rhetoric from the ICPD Cairo 1994. At the end of third year there appears to be some paradigm shift—from the performance, from achievement, from reality, from declining fertility rates and from reproductive health too.

Decentralised participatory approach to family planning—the main thrust of the new approach, in which subcentres and PHCs were expected to become the beehives of activity, humming with planning the needs of the communities and execution of such plans and report the same on 14 elaborate formats. Such reports emanating from subcentres upon aggregation at the PHCs will be regarded as PHC plans and performance statistics. Progressively, these aggregations at the district and state levels will constitute plans for the district and states, respectively.

Unfortunately, there are no parallels to this decentralised approach to planning in India or elsewhere, either in health or any other sector, to emulate. The limitations and the intellectual resourcefulness of the work force at the grass root levels were overestimated by the proponents

under several assumptions which were not valid enough to serve the cause. Further, the personnel at the subcentre and PHC levels have no experience of micro-planning given the prevailing socioeconomic and administrative perspective in which they have been working. Nor they have resources or training in this vital aspect. Although they were given training for two days it is highly inadequate for the tasks expected of them. Yet they were expected to articulate a "participatory plan" for their sub-centres in consultation with and by involving more than half a dozen local leaders. These leaders range from gram pradhans, panchayat members, school teachers, practitioners of indigenous system of medicine, traditional birth attendants (TBAs), anganwadi workers to NGO activists and members of village Swasthya Sanghas. These leaders by themselves do not possess sufficient knowledge and resourcefulness to be of any help in a planning process at a micro level. The pilot project initiated by the Population Foundation of India in certain districts of the country to training the gram panchayat members in reproductive health has brought out interesting insights into abilities and knowledge of panchayat members which are not going to be of any help at the moment in the area of micro level health planning (Sekher and Rayappa, 1998).

Initial three to five months of 1996-97—introductory year of target free approach to family planning was almost a lull at all levels in the country which, confirmed the misgivings in the minds of the field workers about idiom "no targets - no work".

Introduction of the target free approach to the family welfare was unique for several reasons. The decision was so spontaneous, as to baffle even the administrators who were holding key positions in all the states. There were no consultations or debates of any kind let alone the debates that measure up to commensurate with the magnitude of the intended changeover or to modulate the time and mode of introducing such an approach. An analysis of the sequence of events in the first half of the financial year 1996-97 would confirm that even the MOHFW was not prepared to brace up with the task from the first day of the financial year. The first ever documentation on the target free approach was issued beginning from the August 1996 (though some of them undated and some dated June 1996). First of the series of four publications was the "Draft Training Module for Training of each level of personnel in the states on Logistics" which, was issued to the participants of the workshop on training of Faculty Officers from State Institutes and State Logistics Officers on the 30th August 1996.

The principal document "Manual on Target Free Approach in Family Welfare Programme" was said have been sent to the District Magistrates for distribution among the Medical Officers of the PHCs, along with two other publications "Manual for Orientation of Auxiliary Nurse Midwife and Supervisors" and "In-service Training under Family Welfare Programme", were issued at the National Workshop on Operationalisation of Target Free Approach to Family Welfare Programme, held at New Delhi, on the 23rd and 24th September 1996. These documents have been prepared between June 1996 and September 1996.

The first ever national level meeting following the introduction of target free approach in the country was held at the Nirman Bhavan, on the 30th and 31st August 1996. It was intended to prepare a training module for training of personnel at all levels in the states on materials management. The outcome of the two-day workshop could be summarised as not very purposeful.

In the letter of 22nd July 1996 to all the Secretaries of the State Health and Family Welfare Departments, the Secretary Family Welfare, MOHFW, explained the need for orienting personnel at all the levels in the country in order to operationalise the target free approach all over the country. It emphasised the need for training the officers and workers in "needs assessment" and development of plans for Family Welfare and Health Care (FWHC). An action plan developed for the purpose was appended, thereon. The letter informed that a national level workshop for training state level officers will be held on the 20th September
1996. State MCH Officers, Principals/Directors of the State Health and Family Welfare Institutes and an officer looking after the Family Welfare Porgramme in the States were required to be nominated for participation. The letter assumed that all over the country state level training to be completed by the October and the Block level training of officers in November 1996. The Field staff (paramedical workers) would be trained in January - February
1997.

This establishes the unmistakable fact that the functionaries involved in Family Welfare Programme all over the country were ignorant of the new approach as late as the end of September 1996 and the field workers would only become knowledgeable about it towards the end of the financial year 1996-97—effectively converting the entire year a virtual "programme holiday" for Family Welfare Programme, all over the country.

The First National Workshop on Target Free Approach was held at the Vigyan Bhavan, New Delhi, on the 23rd September 1996. Several officers from the MOHFW made half-an-hour presentations on topics such as Concept; Making Family Welfare and Health Care Plans; Monitoring, Supervision and Evaluation under TFA; Performance Reporting;

Organisation of State/District/Block level workshops; pulse polio immunisation; Logistics; In-service Training under F.W. Programme and Orientation Training of ANMs. Participants were distributed into four groups for group work, in three sessions, to work out the modalities of training ANMs in the Target Free Approach and the usage of the Manual on Target Free Approach (MOHFW, 1996).

Surprisingly, MOHFW could hardly envisage the magnitude of the training involved in orienting the entire work force, ranging from officers at state, district and block levels all over the country and financial implications of such a massive exercise. The MOHFW had not considered the financial outlay as important in planning for training/orientation of such a proportion.

Contrary to the much exaggerated claims of completing of training programme by September at the nation level, by October at the state level, by November 1996 at the district and block level and through January/February 1997 all the field workers in the country will be trained, formally, it did not take off till the middle of 1997-98 all over the country and got spread over into the earlier half 1998-99, for a modicum of completion of the training/orientation (MOHFW, 1996). Thus, the effective completion of training/orientation which was slated for a mere five months by the MOHFW, could only be achieved in nearly two and a half years.

In the Foreword to the Manual on Community Needs Assessment Approach (CNAA) which replaced the Manual on Target Free Approach, in January 1998, the Secretary Family Welfare, MOHFW. reiterated that "the work and performance target would continue to exist,

but would be a summation of the felt needs of the people". The foreword is an oblique acceptance of the failure of the MOHFW in eliciting the opinion of all the segments of individuals concerned in the implementation before the new approach was introduced in April 1996. There is an assertion that the targets are very much in vogue, but only named differently this time.

In the wake of renaming, three very important dimensions stand out significantly: change in the nomenclature of the programme, realisation of the confusion in the ranks and cumbersome/multiplicity of reporting formats. In scientific parlance, this is similar to midterm evaluation of the programme approach and corrections thereon.

The three vital aspects—a reasonable time frame for training, pre-testing the instruments/ forms used for data collection by ANMs and wider consultations/debates on the issue, were relegated to the background in the introduction of target free approach. It must also be realised that almost three years were needed to complete the training /orientation all over the country—a reasonable period indeed. The universal practice of pre-testing the instruments used in data collection and analyses before they are actually put to use in the field, did not happen in case of fourteen forms required to be filled up by ANMs in the target free approach. Now it appears that the interim period from April 1996 till the first half of 1998-99 served as the period for pre-testing these forms. More than everything, a wider consultation/discussion, even to the limited extent was not allowed in this case. All these vital aspects were ignored in the unseemly haste of introducing the target free approach in April 1996.

Review of Experiences in Selected States

We have some lessons available on the performance of the family welfare programme from selected states in India. A study on the analysis of policy change by the POLICY Project of the Future Group International (TFGI) has provided a detailed account of the policy change on programme performance in three states viz. Andhra Pradesh, Maharashtra and Rajashthan. A few observations based on these experiences are provided below.

In Andhra Pradesh East Godavari was declared as a target free district in 1995-96. The Target Free Approach in East Godavari was interpreted in different ways by different functionaries. This has resulted in low levels of commitment and performance has declined (Venkataramana, 1998). This declining performance in a previously high performing district made it difficult for the state to achieve over all targets. Therefore, the Directorate of Family Welfare in Andhra Pradesh decided to impose targets and monitor the achievement of different health institutions and health functionaries (Narayana, 1998).

Target Free Approach was opposed on the following grounds by the Government of Andhra Pradesh: Lack of discipline among workers would increase and performance would decline without any improvement in the quality of services. The overall performance in Andhra Pradesh was less than the target. Reported performance on oral pills and condoms was more supply driven. Generally better performance was reported when more supplies were available with worst performance in the months with low stock. Most of the health institutions do not have facilities necessary to maintain the minimum required quality of services. Organisational culture generally remained hierarchical and not conducive for converting Government programme into peoples programme.

In Maharashtra, to begin with two districts were selected for experimenting with Target Free Approach viz. Satara and Wardha. In Satara, performance on MCH indicators such as antenatal care, medical attendance at delivery, immunization coverage improved over previous years. However, the number of sterilizations declined by about 6 percent. More or less similar situation prevailed in Wardha district. Many women with lower parity and lower ages came forward to accept contraception. The experience of Target Free Approach as implemented in the selected districts was not reviewed before it was extended to the state level.

Maharashtra changed the name of the Target Free Approach to 'Self Determination of Targets'. For the state as a whole there was a decline in the number of sterilizations (9 percent from 1995-96 to 1996-97), the relative decline was to the tune of 12 percent (Salunke and Narvekar, 1998). For IUD the performance between 1995 and 1997 decreased by 6 percent. In case of oral pills and condoms, the decline was much larger at 22 percent and 37 percent, respectively. It was argued that the oral pill and condoms was supply driven.

Tonk District of Rajasthan (where a scheme Vikalp Yojana was in vogue) was selected for Target Free Approach. In the first year, a significant increase in family planning performance was observed. Similar was the performance with regard to MCH services. Quality of services showed marked improvement in the district. Despite these developments, sterilization performance declined. In comparison to 1994-95, performance dropped by 25 percent in 1995-96. This shortfall was mainly attributed to the non availability of tubal rings and not due to Target Free Approach (Ram Lubhaya, 1998). However, during 1996-97, performance in sterilization improved. In the state as a whole, after the introduction of Target Free Approach in 1996 the sterilization performance in the first three quarters slipped but improved in the last quarter. IUD users between 1995-97 period increased by 24 percent. Significant improvements were observed in the case of oral pills and condoms during 1995-97. Lack of information on continuous users is a major constraint in reaching any conclusions on the actual number of users of oral contraceptives and condoms (Table 2 and Table 3).

Experiences in Karnataka

Mandya district was selected for the initial experimentation with the Target Free Approach during 1995-96. The good perfonnance in Mandya district is recognised as demand driven service provision and has a very steady high performance record over years. The district was directed to perform at the level of previous year's targets. For the first year of universalised Target Free Approach, the district was "given" a target of one birth more than the district average birth rate to compensate for poor performing northern districts in the state. There was no training or orientation during 1995-96 and 1996-97. The district training was initiated during the later half 1997-98 and completed by the end of the year. The district action plans were drawn on the basis of estimated levels of achievements of subcentres and PHCs, even then at the level of one additional birth above the district average. The performance under family welfare programme in the first three years has declined by an average of 20 percent of the pre-target free era (Reddy *et al.*, 1998).

TABLE 2: QUARTERLY STERILIZATION PERFORMANCE OF 1994-95.1995-96 AND 1996-97

Year	*1996-97*	*1995-96*	*1994-95*
Period	*Per cent of Total Performance*	*Percent of Total Performance*	*Per cent of Total Performance*
Andhra Pradesh:			
1 st Quarter	14.3	16.9	17.2
2nd Quarter	20.9	23.8	25.2
3rd Quarter	23.7	23.5	25.9
4th Quarter	41.2	35.7	31.7
Total	100.0	100.0	100.0
Maharashtra:			
1st Quarter	15.7	16.1	15.2
2nd Quarter	20.6	21.4	20.9
3rd Quarter	27.0	28.8	29.3
4th Quarter	36.7	33.7	34.6
Total	100.0	100.0	100.0
Rajasthan:			
1 st Quarter	12.6	22.9	14.9
2nd Quarter	7.1	14.3	12.2
3rd Quarter	16.8	22.6	34.4
4th Quarter	63.5	40.2	38.5
Total	100.0	100.0	100.0

Source: G, Narayana, *el al*. "Target Free Approach for Family Planning in India: An Analysis for Policy Formulation". *In: Targets for Family Planning in India: An Analysis of Policy Change Consequences mid Alternative Choices.* The POLICY Project, The Futures Group International, New Delhi. Oct 5, 1998,p. 10.

Upon review of the performance of Target Free Approach in Hassan district in October 1998—a district adjacent to Mandya, demand driven good-performing-district in the family welfare programme, brought under Target Free Approach in 1996-97, the findings were almost similar to that of Mandya. Hassan district differed with Mandya in respect of district training which extended upto June 1998 and the district "gave" the ELAs on the basis of a survey of births conducted in a few representative subcentres in the district. The decline in the performance of family welfare programme was almost similar to that of Mandya district (Table 4).

Effectively, in Karnataka by the time the PLAs were understood by the field workers it was renamed as ELAs (as happened all over the country). ELAs were "given" at a particular rate for estimation (rather adoption) on which the district action plans were formulated. The decline was perceptible to the extent of 20 percent in the two best performing districts in the first year of Target Free Approach. Ever since, the performance under family welfare programme has either plateaued at the 1995-96 levels or has performed at marginally lower levels, say upto 15 per cent. The plateauing/stagnation of performance is being either ignored as inconsequential or brushed asides as initial 'blues', without a serious thought. Generally,

cumulative performance has been reduced due to loss of expected annual natural increase in performance and due to plateauing at'the 1995-96 level. In other words the achievement has stagnated at 1995-96 level—a no cause for relenting.

TABLE 3: FAMILY PLANNING PERFORMANCE IN THREE STATES

Performance Stale	*Percentage Increase/Decrease between 95 & 96*	*Percentage Increase/Decrease between 95 & 96*	*Percentage Increase/Decrease between 95 & 96*
Andhra Pradesh:			
Sterilization			
Total	-10.6	-2.3	-13.2
IUCD			
Total	-14.5	2.5	-16.6
Oral Pills			
Total	-8.1	-7.5	-16
Condom Users			
Total	-40.8	-77.1	-149.4
Maharashtra:			
Sterilization			
Total	-2.9	-9.1	-12.2
IUCD			
Total	-1.2	-3.8	-5.1
Oral Pills			
Total	13.5	-28.7	-11.4
Condom Users			
Total	-0.4	-69.7	-70.4
Rajasthan:			
Sterilization			
Total	-20.7	16.0	-1.5
IUCD			
Total	7.2	17.7	23.7
Oral Pills			
Total	26.3	74.1	80.9
Condom Users			
Total	8.4	27.9	34.0

Sources:

(a) For Andhra Pradesh. C.B.S. Venkataramana, Target Free Approch for Family Planning: A Review of Experiences in Andhra Pradesh, as cited in Table 1, Table 2, p.39.

(b) For Maharashtra, Subhasli Salunke and Sharad Norvekar, op. *cit*. Table 4, p. 67.

(c) For Rajasthan. Rain Lubhaya, *op. cit*.. p. 94.

Summary and Conclusions

Target setting in India's family planning programme has been a highly controversial topic of early 1990s. Historically, it was introduced as a management tool, a means to assess the performance of the programme and the working of personnel involved. The methodology was sound and scientific with the backing of many a luminary in the field of population, world

over. Country, region and area specific targets, based on set demographic goals, have been worked out on a scientific basis. Monitoring and evaluation mechanisms were set up at all levels to oversee the implementation. Nevertheless, success achieved in reducing the fertility to the current levels is mainly due to the regime of targets.

TABLE 4: ACHIEVEMENT OF VARIOUS CONTRACEPTIVE METHODS IN KARNATAKA AND SELECTED DISTRICTS DURING 1994-1998

Year	*1994-95*	*1995-96*	*/ 996-9 7*	*1997-98*
Hassan:				
Sterilizations	14193	13508	14032	13951
IUCD	10619	11192	11462	11283
Oral Pills	5021	5126	4596	4362
C.C.	16615	12917	12021	9457
Mandya:				
Sterilizations	15448	16385	15085	15685
IUCD	12089	13677	13553	13137
Oral Pills	5016	1962	5111	5064
C.C.	17881	15309	15023	13393
Karniitakn:				
Sterilizations	371535	381571	384056	395624
IUCD	299504	345937	376247	372341
Oral Pills	138232	151145	157545	156494
C.C.	395108	374687	358627	323021
Change From Base Year 1994-95 = 100				
Hassaii:				
Sterilizations		95.2	98.9	98.3
IUCD		105.4	107.9	106.3
Oral Pills		102.1	91.5	86.9
C.C.		77.7	72.4	56.9
Mandya:				
Sterilizations		106.1	97.7	101.5
IUCD		113.1	112.1	108.7
Oral Pills		39.1	101.9	101.0
C.C.		85.6	84.0	74.9
Knrnatiika:				
Sterilizations		102.7	103.4	106.5
IUCD		115.5	125.6	124.3
Oral Pills		109.3	114.0	113.2
C.C.		94.8	90.8	81.8

Source: Computed from data collected from the Directorate of Health and Family Welfare Services, Bangalore.

There were certain problems in the regimen of implementation, as pointed out by several scholars. These problems had their origin in the process of implementation. Important among them being: conversion factors applied for the spacing methods, monetary incentives, involvement of other departmental staff with targets assigned to them, ranking the performance of District Magistrates and undue pressure brought on the field workers. Timely interventions

to correct the problems noticed in the course of implementation were lacking. Core issues like development, universalisation of education, women's empowerment and endurable primary health care services—lack of which were severely affecting family planning acceptance across the country, were not considered. The targets: a performance measurement tool and an instrument useful for monitoring such performance were subjected to unfair criticism and rejected summarily.

In 1996 the family planning targets were abolished all over the country. The Department of Family Welfare removed targets in selected good performing districts in several states during 1995-96, on an experimental basis. But did not wait to analyse the outcome of that experiment. Totally unprepared for the task ahead in any respect, the MOHFW removed the targets all over the country. The programme was renamed in 1997 as Community Needs Assessment Approach. Procedure of needs assessment of the community is a bit cumbersome and staff at the grass root levels who have to do the assessment are inadequately trained.

Four years since the introduction of Target Free Approach, the MOHFW is trying out several permutations and combinations as alternatives. A review of the programme in selected states by The POLICY project of the Futures Group International and our own in Karnataka, confirms the definite pattern of decline/plateauing performance—around 20 per cent per annum—snowballing into a sizeable figure over a four years period.

The family planning programme had registered good deal of success in lowering the fertility levels all over the country in general and certain states in particular. No substitute could be suggested for a strong political commitment and an enduring population policy, which could guide the destiny of the programme in the long run. A definite, pragmatic and achieveable demographic goal projected into a period ofatleast two decades will ensure necessary leverage for manipulation and correction in the midterm. Monitoring and evaluation needs reorientation to the changed approach.

Gross defects in the current infrastructure in the primary health care sector requires urgent rectification to meet the increasing needs of reproductive health approach. Working conditions of the medical and paramedical service providers need to be addressed urgently to boost the morale of the service providers in an environment of increasing expectations and to eliminate frustration. Better financial compensation and reasonably good housing in the remote areas will strengthen work environment. Efficient communication network between the PHCs. first referral units and district health administration is a necessity. Cursory training will neither render the trainee knowledgeable nor the task well accomplished. Task specific durable in-service training and retraining programmes will increase the efficiency of service providers.

Since the components of development are dependent on the political will of the ruling elite, the development process assumes tardy pace in India. But there are examples of fertility transitions preceding development process. The current situation in the country would yield better results even with the proper utilization of resources. The experiences in the selected districts points to the fact that a little more strengthening of primary health care system and support to the service providers would make the miracle to happen and to that extent, there is a need for foresight.

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