National Programmes

A Paradigm Shift— A New Approach to the National Family Welfare Programme

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India is the largest democracy in the world and has the second largest population. On 2.4% of the world's land area, it supports 16% of the global population. The population is increasing by about 17 million every year. Recognizing the importance of planning families, India under the Prime Ministership of Jawaharlal Nehru was the world's first country to initiate a comprehensive Family Planning Programme in 1951. It remained low key till the early seventies and the population increased from 361 million in 1951 to 548 million in 1971. Certain harsh strategies were put into action in the early seventies which unfortunately acted as a backlash and the programme went into a decline. To change the perception of people, it was renamed the Family Welfare Programme instead of Family Planning Programme as hitherto. Since then while the programme has made substantial gains (though not enough) the vasectomy component has never picked up.

During the past four decades, India has achieved significant improvement in health indices like infant and early childhood mortality and some improvement in fertility rates. The infant mortality rate has come down from 146 to 74 per thousand live births and the death rate declined from 20.8 to 9.2 during the same period (Sample Registration System 1994). The total fertility rate (TFR) has declined from about 6 to 3.4 and crude birth rate from 41.7 during 1951-61 to 28.6 in 1994. However, this compares unfavorably with China's 22 and Indonesia's 25. Maternal mortality remains at an awesome rate of 437. At the current rate of fertility decline, India will not achieve its goal of replacement level fertility (2.1 births per woman) by the turn of the century. Analysis of the National Family Health Survey (NFHS) data shows that at least 20% of fertility is unwanted and this was due to non-availability of services and contraceptives, distance, lack of requisite information *etc.* and that eliminating unwanted births would take India half way to replacement level fertility. Reduction in unwanted births would also depend on further progress in female education and other human resource indicators, besides providing a client friendly efficient health delivery system.

After almost five decades of its implementation through a strategy concentrating on contraceptive targets, with continuing emphasis on female sterilization and provisions for cash incentives to acceptors and providers, India's Family Planning Programme finally became target-free on April 1,1996.

The 1994 International Conference on Population and Development (ICPD) established growing international consensus on a new approach to policies to achieve population stabilization. It has been widely acknowledged that fertility reduction concerns should be addressed at the level of

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broad social policy including reduction of gender discrimination in education, increasing the age at marriage, access to health care and income generation. Reproductive health programmes should focus on the needs of actual and potential clients, not only for limiting births but for healthy sexuality and child bearing, and with concern for women's health. Such a shift in emphasis is more likely to address the needs of women who are at risk of unwanted births and in so doing assist the country to accelerate fertility decline. Reproductive health interventions would enable clients to make informed choices, to receive counselling and education for responsible and healthy sexual behavior, to access user friendly services for preventing unwanted pregnancies and safe abortion, maternity care and child survival and management of reproductive tract infections (RTI).

For almost three decades, a target oriented strategy was adhered to with a rather single minded objective of reducing fertility as quickly as possible. The health staff were given targets (mainly sterilization) and they spent all their time and effort to achieve these and had no time or concern for anything else. Their work was assessed only on achievement or otherwise of targets and at the monthly meeting that was the only question asked. Non-achievement resulted in an adverse report with its various consequences. ANMs have been known even to cook food for the client following her sterilization! Often they spent more money on the client than they received as an incentive. The target oriented programme destroyed the MCH component of primary health care.

The insensitivity and lack of empathy associated with this target approach had to be seen to be believed. Women were gathered on a particular day for a camp, where sterilizations would be performed. The standard of care, asepsis and necessary surgical requisites were often far from adequate, but what was most pathetic was to see these 'clients' after the operation lying around in the compound and finding their own means of getting home. Ashish Bose, the well known demographer, called it targetitis and not family planning. Because of monetary considerations, some doctors are supposed to have performed several hundred laproscopic sterilizations at one session! The targets were nearly all women, as if men did not contribute to population increase. Besides, the women who ultimately underwent sterilization were usually 4 para plus, and so it did not make much difference to the population growth. The use of other contraceptives was minimal. Under the National 20 Point Programme, many states received awards for family planning but this did not reflect in the population growth pattern in the states.

It had been seen that the large part of the target was being achieved in the last three months of the financial year. In a race for achieving targets, little attention was given to counselling clients and offering them choice of other contraceptives.

Induced abortion was legalized in 1971 with the enactment of the Medical Termination of Pregnancy (MTP). The Ministry of Health and Family Welfare subsequently undertook a systematic effort to train doctors to provide equipment and approve facilities where procedures could be carried out. The number of legal abortions rose rapidly but now the number has leveled off at about 600,00 annually. On the other hand, although data are limited, the incidence of illegal procedures is increasing and the number could be ten times the legal ones. Some recent studies attribute the small number of MTP at Government facil-

ities to the differences in a pproved facilities and registered pra ctitioner s from one part of the countr y to anoth er. For examp le, wh ile in Maharashtra there is one approv ed institution for 8,000 coupl es, in Bihar there is only one for 132,000 couples. Private practitioners, indigenous practitioners, dais, traditional healers and family members continue to perform abortions and the deaths have been estimated to range from 15,000 to 20,000 per year(l,2). The incidence of infections and damage to the genital trac t can be well imagined.

The strategy had changed over the last 2-3 years with the adoption of a cafeteria approach, where the client could make a choice between various contraceptives. IUD was the choice of many women, but due to lack of co unselling many women re - moved it because of bleeding or other perceived symptoms. Due to a lack of aseptic precau tions, infec tion was another problem. By and large fema le sterilization was still pursued more than any other method and targets continued to be used.

However, recognizing the need for a holistic approach in the interest of the community, disaggregate and vertical programmes under Family Welfare were intensively reviewed. The sector review led to the Government's conviction for a change from a provider driven approach to a demand driven approach, instead of targets, as the best opt ion for improved performance. There was also a realization that improving the quality of services and making them user friendly was essential for enhancing the demand from the clients.

The chan ge in approa ch has been promoted in rec ognition of the fact that contra - ceptive targets and cash incentives do not go hand-in-hand with lower ing the birth rate and hence reducing population growth and quality of services and a regard for human dignity.

The decision to make the programme target-free was not taken overnight. As a first step, the Government of India did not fix contrac eptive targets for the states of Kerala and Tamil Nadu durin g 1995-96 while in other states one or two districts were made target free. This approach was welcomed because it was felt that the programme was bound down by numerical statistics.

The initial euphoria on the new family planning approach was becaus e ever yone thought there was no need to work. It was felt that since targets were withdr awn, there were no goals against which perfor - mance coul d be judge d. However , since the numerical targets have been removed, an alternative system of getting estimates of levels of acceptance has to be introduced. This exercise is to be arrived at by the grassroot workers in consultation with the community. This will reflec t the real need of the community which will thereafter be met by the family planning set up with the formulation of an action plan to be worked out at the Primary Health Center (PHC) level. Grass-roots level planning with a bottom-up approach will help to create a sense of participation and belonging among the 70% of the natio n's po pulation living in the rural areas, who have remained at the receiving en d of Government policy so far.

The action plan will take into consider - ation the needs ass essment generat ed by grassroot workers and the commu nity. The survey will involve the local non-government organi zation, primary school teachers, pradhans and panchayat members. The District Family Welfare Plan will be the totality of all plans formula ted at the PHC level. The District Plans will formulate the State Family Welfare Plan.

The various compo nents of the new approach are:

- Target-free programme from April 1,1996.
- Greater emphasis on quality
- Decentralized participatory planning, bottom-up approach, community involvement in planning process
- Integrated Reproductive and Child Health (RCH) package
- State-specific interventions
- Service fee for condoms under free distribution
- Comprehensive integrated training with district as Organizer/Co-ordinator/implementor of all training.
- Increased involvement of NGOs/private practitioners
- Area specific IEC campaigns
- Introduction of systemic technical assessment/audit at PHC/district level.
- Rapid and independent evaluation
- Convergence with other sectors to promote nutrition
- Increased male participation
- Gender sensitivity

Planning which hitherto was done at the top level and percolated down to the grassroots for implementation will begin at the village level with participation of the Panchayat members and Mahila Swasthya Sangh and needs assessment done at the village level and from there to the SC level. This will then be in aggregated at the PHC level and from there to the district level. In what is termed as the bottom up approach, the decentralized planning process will prompt the sub-center and PHC to aggregate the need of villages under its coverage area, to prepare the PHC plan. Client perspective is central to this whole strategy.

There will be a state specific RCH package depending on the level of women and child care existing in the state. Considering that states display a wide variation in health parameters such as infant and maternal mortalities, an area specific RCH approach has been worked out separately for three groups of states plus the special category states. 'A group' states are those where 70-80% of the deliveries take place in institutions. 'B group' states are those where the home and institutional deliveries are equal and category 'C are those where most of the deliveries take place at home. Special category states are those where considerable infrastructure input is flowing from IDA under State Health System projects.

The essential components of Reproductive Health Services have been classified under four broad heads: *(i)* Prevention and management of unwanted pregnancy; *(ii)* Maternal care which includes antenatal, delivery and post-partum services; *(iii)* Child survival services for newborns and infants; and *(iv)* Management of RTI/Sexually Transmitted Diseases (STDs).

The programme is designed with utmost care to improve the equality of services at all levels. The minimum basic programme under these broad heads has been chalked out with responsibilities of services separately and specially at First Referral Unit (FRU) level, PHC, sub-center and the community level. A guideline for preparing the district plan on the basis of assessment of clients needs has also been prepared and sent to the districts.

NGOs will be involved in community involvement, training, IEC, monitoring, *etc*. private rural medical practitioners and practitioners of indigenous system of medicine will also be involved in preparing the Sub-center Action Plan and PHC plan.

Training

It has been decided that all future train-

ing under Family Welfare would cover a comprehensive RCH package. Appropriate managerial and communication skills which earlier got a low priority will be included. An important feature of the training programmes would be the involvement of field functionaries and the Anganwadi workers. Continuing education for upgradation of knowledge and skills at each service delivery point would be institutionalized. Planning and management of training programmes would be the responsibility of the districts. The central and state governments will support the training of trainees, production of training material, operation research and evaluation. NGOs will be involved in all these activities.

The 18 Population Centers will do a rapid annual survey so that the data can be made use of for any corrective action. Eight regional teams constituted by the Government will also be doing cross checking of activities. The entry of independent rapid survey system and evaluation will strengthen the belief that a target-free approach does not mean cessation of all work.

Alternative quality and impact indicators have replaced targets for monitoring the work done. Good quality care, prompt service, increasing accessibility are some of the indicators to check the progress and implementation of the new strategy. The process of planning for their own work will also bring about attitudinal changes in health personnel at every level.

The Government has introduced a scheme on watershed development integrated Family Welfare issues for small farmers with provision for community mobilizaton and participation. Under this scheme, which covers 30,000 villages, Mitra Krishak Mandals in the villages will operate funds even for referrals for high risk pregnancy cases. A community award scheme has also been introduced for the best performing village in the district.

IEC

IEC skills of the health personnel will be put to test when they approach their clients; and the training will be geared towards improving their skills to motivate and persuade people to avail the right kind of services for their health needs.

The road ahead is not easy and some strategies may have to be changed with experience but as long as the objective of achieving a RCH package is clear, the end result should be a positive one. The existing staff can be rechannelized. On an average each district has 16-20 lac population and has 20 CHCs and 80 PHCs. There are seven senior officers between the PHC and the district. Each of these can look after 3-4 CHCs, which should not be difficult. It would be too simplistic to rely on the Pulse Polio approach (which was a great success, no doubt) as the beacon. It is possible to work up people's enthusiasm for two polio vaccine doses. The cause and effect is easy to explain. However, it is well recognized that even in the routine immunization programme, compliance goes on diminishing and the number of children covered with booster doses of DPT and polio vaccine goes on diminishing. According to the National Family Health Survey (1992-93) only 35% children were fully immunized. All the same a target-free approach with people's participation is the right strategy and requires everyone's enthusiastic support and participation. One hopes there will be more male participation and involvement in achieving a small family norm and it will not, in the ultimate analysis, be considered only a woman's responsibility. For achieving optimum results from this new strategy, it is imperative that this should go hand in hand with strategies

regarding basic issues like raising the age at marriage, improving female literacy, removing mortality and nutrition differentials between sexes and raising the status of women. Control over their fertility should be viewed as their basic right and not only a means for reducing population growth.

REFERENCES

1. Illegal Abortion in Rural Areas: A Task Force Study. New Delhi, Indian Council of Medical Research, 1989.
2. Chhabra R, Nuna SC. Abortion in India: An Overview. New Delhi, Ford Foundation, 1994.