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The Target-Free Approach: An Overview

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In 1996 the Government of India initiated the Target-Free Approach (TFA) in family planning as a result of dissatisfaction with over-emphasis on demographic targets, leading to a numbers game, insensitivity to client needs, low demographic impact, violation of reproductive rights, neglect of the quality aspect, and stagnation of the programme. The process and the results of implementation, as documented in various reports, have been analysed to learn lessons from the pilot and the expanded programmes. There were periodical reverses, and the implementation has been uneven. The following factors are critical for the success of the TFA: Commitment of the top bureaucratic leadership; political, administrative and academic support, local adaptation of the approach; effective communication and training; thorough assessment of the clients' needs; effective monitoring and evasion systems; and mobi1isation of community support.

Demographic Status

India has the distinction of being the first country in the developing world to initiate a family planning programme-it later came to be called the Family Welfare Programme (FWP)-with a view to bring down the country's fertility level and contain population growth. Fertility levels have come down throughout the country, albeit at varying paces in different regions. In the country as a whole, the Total Fertility Rate (TFR), or the average number of children born to a woman during her lifetime, declined from about six in the early 1970s to 3.4 in the mid-1990s. Yet, the population has continued to grow at or around 2 per cent per annuin since the 1960s, such that, it has more than doubled from 439 million in 1961 to an estimated 930 million in 1996, and will be well over 1.5 billion before it eventually gets stabilised (Visaria et al. 1999). At this pace, India is likely to become the most populous nation by 2035 (Bose 1996). Apart from the population problem, quality of care and reproductive health are other issues which also pose a challenge to the Indian FWP.

The Family Planning Programme: Chronology of Events

The family planning programme, since its inception in 1951, has undergone many changes to meet the varied challenges faced by it. At different times it has been integrated with different programmes, like the Minimum Needs Programme, Maternal and Child Health (MCH), Child Survival and Safe Motherhood (CSSM) (Visaria et al. 1999); and, now, with Reproductive Health, in order to focus on the entire gamut of services critical for the health of women and children. However, till 1996, the approach of the programme to control the population was target-oriented. The programme has all along been dominated by demographically determined goals of reducing the birch rate and the rate of population growth. In the target approach, on the basis of the demographic goals to be achieved, targets are set in terms of couple protection rate (CPR), which are further broken down to method-specific targets, with special focus on sterilisation. These targets are prescribed by the Central Government for the states, which in turn prescribe them down to the grassroots level. The pursuit of targets has largely obviated both the clients' choice and the provision of a wider range of services.

Attainment of contraceptive targets became the indicator of the success of population control efforts. This, over the years, led to a situation where the achievement of contraceptive targets, especially of sterilisation, became an end in itself. The obsession with targets and emphasis on sterilisation resulted in poor coverage of younger and low parity couples, thereby limiting the demographic impact. The issues of contraceptive choice, clients' needs and quality of care within the family welfare programme were not fully addressed. The centralised planning and target setting from the top hindered innovation and flexibility in programme management. As a result, the overall reproductive health situation in India remained poor and led to stagnation in the programme.

Several researchers, academicians and, especially, non-governmental women s groups in India have expressed ideological objections to the approach of the government-sponsored family planning programme, and they have either distanced themselves from the programme or adopted a reactive mode (Visaria et al. 1999). The Central Government's position that India's birth rate must be brought down by vigorously promoting contraception is viewed by some groups as a violation of human rights. The poor quality of care provided to women by the contraceptive providers has been considered to be indicative of the providers having little regard for regard for women's health.

Why TFA?

In the last 30 years Over-emphasis on demographic targets led to:

- Numbers game.
- Insensitivity to clients' needs
- Low demographic impact
- Violation of reproductive rights
- Neglect of quality of care
- Stagnation of the programme

All these factors resulted in awareness regarding the need to change the approach and address all the reproductive health needs of men and women. This led to a national discussion about the need for a change in policy and implementation strategies. This internal debate was further supported by a change in international thinking on family planning policies, as demonstrated at the International Conference on Population and Development (ICPD) in 1994 and Beijing Women's Conference in 1995.

All these factors brought about a paradigm shift in the government's approach to the population problem. In April 1996, the Government of India abolished method-specific family planning targets throughout the country, and took the policy decision to implement the TFA.

Introduction to the Target-Free Approach

Target-free approach meant that no longer would centrally determined targets-imposed since the mid-1960s-be the driving force behind the programme. Targets were to be replaced by a radically different approach, whose driving force would he the demand, by the community for quality services, thus making it a people's programme. Unlike the earlier centralised target setting, the new approach envisaged decentralised planning at the primary health centre (PHC) level, in consultation with the community at the grassroots level to provide quality services. Targets were now to be set by the grassroots level workers-female auxiliary nurse-midwives (ANMs) and male multi-purpose workers (MPWs)-in response to the community's demands (Visaria et al. 1999). The focus has thus shifted from the providers' needs to the clients' needs.

The major philosophy of TFA is to cater to clients' needs and provide them quality services. The four basic characteristics of TFA are:

1. Providing services according to the clients' needs and moving away from centrally-determined targets.

2. Providing a wider choice by increasing the range of safe methods of contraception and by introducing reproductive health services.

3. Emphasis on quality of services, and decentralised planning and management of the programme at the district level.

4. Building a partnership with the community and making the programme a people's programme.

The Paradigm Shift
Target approach Ù Target-free approach
Driving force Targets Ù Needs of the community
Orientation Provider Ù Client
Concern Target achievement Ù Quality of care
Goal Demographic impact Ù Reproductive health
Approach Top-down Ù Bottom-up

The Central Government decided to experiment with the approach in one or two districts in selected states, and the whole of two of the well performing states (Tamil Nadu and Kerala) during 1995-96 (the pilot phase) before making the entire nation target-free. However, it did not integrate the lessons from the experiences of these districts and states, and went ahead with the decision to make the entire nation target-free. Targets were removed without adequate preparation and without adequate discussion on what would replace the old system. While at the policy level, the shift to the 'target-free' approach was recognised as a necessary step for enhancement of the quality of services at the implementation level (state, district), the only guidance that the programme implementors received was a manual to orient them on decentralised planning at the PHC level (Visaria et al. 1999).

This paper takes stock of the experiences of implementing the target- free approach in various districts and states and to learn from their experiences in order to improve programme management and performance in the changed scenario.

Objectives of the Study

This paper attempts to:

1. Analyse and compare the implementation methodology of the TFA of various districts and states, and their eventual performance; and

2. Identify the factors that led to the success or failure in implementing the TFA, and learn lessons from the experiences.

Methodology

Moving away from targets to the target-free approach is a major organisational change. Implementation of an organisational change of this kind in such a vast bureaucratic system is a daunting task. The process of implementation of change involves three stages, namely, planning, implementation and stabilisation. The main purpose of planning is to evolve a strategy for implementation. It involves identification of critical implementation issues and designing operational strategies to implement the change. The critical implementation issues under the TFA are:

1. Assessment of clients' needs;

2. Estimation of workload;

3. Emphasis on the quality of services (doing the right things in the right way);

4. Management of the programme (logistics, referral, human resource development (HRD), information, education and communication (IEC), monitoring and evaluation);

5. Mechanism for community participation, and

6. Training of all health functionaries on the concept of TFA and its implementation mechanism.

The second stage is implementation, which primarily involves monitoring the change, taking action in relation to the change and making necessary adjustments in the programme which have been accepted for implementation. The end result of the Implementation is institutionalisation and stabilisation of the change.

Each district or state is examined based on the planning and implementation aspects of organisational change in two phases, namely, the pilot phase (1995-96) and the overall implementation phase (1996-97). In order to consolidate the experiences of the TFA, the following states, which have documented their experiences, have been selected:

- Maharashtra
- Rajasthan
- Uttar Pradesh
- Madhya Pradesh
- Gujarat
- Andhra Pradesh

A note of caution: The paper is based on some case studies of the aforementioned states. No primary data has been collected. The case studies have been done and documented primarily by state level administrators, and not by independent researchers. This is the limitation. However, since the objective of the paper is to understand the implementation methodology and gain an insight into how the transition took place from a target approach to a target-free approach, the authors went ahead despite obvious limitations.

Pilot Phase 1995-96

In 1995-96, the Central Government made one or two districts in selected states target-free on a pilot basis. The objective was to learn from their experience and to find out the feasibility of adopting TFA for the country as a whole. The experience with

implementing the TFA and a comparison of selected district against planning and implementation aspects of organisational change are given in Table 1. Most of the discussion that follow are based on case studies of the respective states (Ghasura et al. 1997; Kothari et al. 1997; Lubhaya 1997; Mehrotra et al. 1997; Raman 1997; Salunke and Narvekar 1997; Taludhar et al. 1997; Verma et al. 1997).

Table 1: Comparative Analysis of Implementing TFA in Selected Districts (Pilot Phase: 1995-96)

State	**Maharashtra**	**Rajasthan**	**Maharashtra**	**Uttar Pradesh**	**Madhya Pradesh**	**Gujarat**	**Andhra Pradesh**
District	**Satara**	**Vikalp districts (Tonk & Dausa)**	**Wardha**	**Agra & Sitapur**	**Narsingpur**	**Valsad**	**East Godawari**
Planning							
Clear communication of objective	3	3	6	6	6	6	6
Implementation (Issues concerned)							
Assessment of client's needs	3	3	6	3	3	6	6
Calculation of workload	3	3	6	6	3	6	6
Training	3	3	3	3	3	3	6
Service delivery	6	3	6	3	6	6	6
Monitoring and evaluation	3	3	6	3	6	6	6
Quality	6	3	6	6	6	6	6
Logistics	6	6	6	6	6	6	6
Implementation							
Assessment of client's needs	3	3	6	NA	3	6	6
Calculation of workload	3	3	6	NA	3	6	6
Training	3	3	3	3	3	3	
Service delivery*	6	3	6	NA	6	6	6

Monitoring and evaluation	3	3	6	NA	6	6	6
Performance	↑	↑↑	↑	↓	↓	↓	↓
Perception about TFA	Positive and similar	Positive and similar	Confused and varied	Confused and varied	Confused and varied	Confused and varied	Confused and varied

Note:- : Improvement; -- : Breakthrough achievement; ¯ : Decline.

*innovation programme to increase accessibility & availability of services

NA: The information regarding the implementation of these components is very vague, and hence no categorical statement can be made

Table 1 shows that those districts which had understood the concept of TFA and which could plan or design the implementation had performed well, while the others who could not do so did not. A brief analysis of the selected districts/states follows:

Satara, Maharashtra

Satara district of Maharashtra had clearly defined the objectives that the district had to achieve and communicated them to all levels. Though the district did not plan for each and every implementation issue, it prioritised the most important issues and planned for them. The biggest challenge in the TFA approach involves assessment of clients' needs, monitoring and evaluation of the workers as well as the programme, and improving the quality of services. The first two issues were addressed by the district.

Assessment of Clients' Needs and Monitoring the Programme: The methodology adopted to assess clients' needs and monitor the programme involved the following:

1. An eligible couple (EC) survey was conducted to ascertain the needs of the clients and to provide a basis for calculating the workload.

2. The district officials devised a detailed set of indicators through which the performance of the programme could he monitored and evaluated. The

management information system (MIS) was strengthened to cater to the new set of indicators.

3. A model registration scheme for births and deaths in all villages having PHC headquarters was initiated for evaluating the programme.

4. Workshops were conducted to sensitise and orient the health functionaries about the new approach and the new methodology.

Implementation: The district was able to implement the target-free approach as per plan in the scheduled time period. The perceptions about the TFA at all levels in the district were similar and clear.

Performance: The district showed an improvement in MCH and family planning (FP) services. Antenatal care (ANC) coverage, referral of high risk cases, percentage of institutional deliveries and those attended by trained personnel, immunisation rate and care of the newborn increased. This could be attributed to the fact that with the obsession with targets gone, the workers were in a better position to channelise their energies into MCH activities as desired by the clients. The CPR witnessed an increase from 59.3 per cent in 1994-95 to 60.7 per cent (calculated for sterilisation and IUD) in 1995-96. The percentage of family planning methods used, especially sterilisation, increased at lower ages and parities, though the number of sterilisation acceptors during 1995-96 was less compared to the previous year.

Perceptions: The officials at all levels in the district were supportive of the TFA. All of them had a similar understanding of the approach and the processes of implementation. The officials felt that the approach would enable them to provide quality services to the clients. The monitoring, according to them, had now become more focused and a clear agenda was in place. There was a feeling of ownership of the programme. The health workers felt that the programme had become focused due to parity-wise distribution of potential acceptors. They felt that they had been able to relate themselves with the community through the immunisation programme. They felt that the frequency of contact with the clients had gone up.

Tonk and Dausa (Vikalp Districts), Rajasthan

In Tonk and Dausa districts, there was a breakthrough in achievement. The performance went up significantly, both qualitatively and quantitatively, in just one year. The reason for this was the entire framework to implement the approach having been devised in advance. All the implementation issues and their operationalisation had been worked out. The districts had the support of administrators, politicians and academicians. The model, called *Vikalp*, was conceptualised by IIHMR and implemented by the Government of Rajasthan (GOR).

Vikalp (for details see Kothari et al. 1997) is a population management model, which provides a methodology for managing the FW programme in the broader context of reproductive health. The model is based on four pillars, namely, (a) provision of client-based services, (b) inclusion of non-medical issues, (c) integration of maternal and child health with family planning, and (d) utilisation of a focused approach. Its guiding philosophy is to serve the people who need reproductive health

The methodology adopted by the *Vikalp* districts to implement the change includes:

Assessment of Clients' Needs: A revised version of Eligible Couple Register (ECR) was developed to identify couples who needed services. This was then followed by an EC survey.

Calculation of Workload: Based on the data collected through the ECR, clients who needed various services were divided into the following segments:

1. Couples needing ANC services;

2. Couples needing postnatal care (PNC) services;

3. Couples currently using spacing methods;

4. Couples having unmet need for spacing; and

5. Couples having unmet need for limiting.

The EC survey data is computerised, and the whole process of client segmentation is carried out with the help of a software package. Feedback is given to the workers in the form of a Service Delivery Booklet, which provides detailed name and village-wise information about the clients and their service needs. This booklet serves as a tool for work planning, including decentralised target-setting and performing day-to-day activities.

Service Delivery: A service delivery system, which aims at strengthening the weak areas, namely, accessibility, availability, quality and community involvement, has been developed. The system includes:

1. Instead of providing an entire range of services, it was decided to focus on those that are critical to bringing down the infant mortality rate (IMR), maternal mortality rate (MMR) and crude birth rate (CBR). Having achieved a threshold, it was decided to expand the package of services.

2. Developing and strengthening static centres to be known as Reproductive Health Centres (RHC) in each block of the district. The RHC would serve as a nodal point for service delivery in the block.

3. Conducting *Mahila Swasthya Shivirs* (women's health camps) at each PHC, once in one or two months, for detection and treatment of reproductive tract infections (RTI) and sexually transmitted infections (STI), and for IUD insertion.

4. Using traditional medical practitioners, non-governmental organisations (NGOs), anganwadi workers (AWWs), etc., as depot holders to deliver family welfare services in order to increase contraceptive knowledge and use of spacing methods in the community.

5. Improving facilities at sub-centres, so that it can function as the key element in the community-based service delivery system. To make the job of the ANM, the grassroots level worker, easier and to strengthen her position, the position of a *sahaika* (helper) was created. To bolster the ANM's rapport with the community, it was decided to provide each field worker with a link person at the village level who would inform her on current users of spacing methods, pregnant mothers, new eligible couples, etc.

6. Finally, involving panchayat members, especially the women, to monitor health functionaries at the grassroots level and mobilise community participation in health and population activities.

Monitoring and Evaluation: Monitoring assumes much importance in the target-free approach. *Vikalp* has developed an internal (con- current) monitoring system, which has created a disciplined work environment that attends to the needs and interests of the workers. The internal evaluation on behalf of the district takes place on a monthly basis at the sub-centre level and on a quarterly basis at the block level.

Quality: To ensure quality of services provided, indicators of the process of care were monitored regularly.

Training: Training programmes were conducted to clearly communicate the concept and implementation of TFA according to the *Vikalp* framework.

Implementation: All the components of the plan have been implemented within the scheduled time frame.

Performance: A breakthrough achievement was made in improving the performance of family planning services. There was a significant 150 per cent increase over the previous year in the number of users of family planning services. The CPR in Tonk and Dausa districts shot up from 31 and 35 per cent in 1995 to 47.4 and 48.9 per cent respectively in 1997.

A similar increase was noticed in the use of ANC and immunisation services. The quality of services provided by the programme in terms of client satisfaction, continuation rate of spacing methods, proportion of users reporting problems, level of client-worker inter-action, etc., also improved. Further, with proper planning and training of workers in the areas of motivation and counselling, more than 50 per cent of couples with unmet need accepted modern methods of contraception during 1995-96, and were continuing their rise as on 31 March 1996.

Perceptions: The perceptions about the target-free approach and its implementation according to the *Vikalp* framework were similar and clear at all levels in the district.

Agra and Sitapur, Uttar Pradesh

These districts worked out a plan for assessing client's needs and calculating the workload. However, they could not implement it as planned due to the general lack of readiness of the health facilities in terms of human and material resources critical for effective utilisation and provision of quality services.

Assessment of Clients' Needs and Calculation of Workload: Two approaches, with technical assistance from State Innovations in Family Planning Services Agency (SIFPSA), namely, (a) addressing the clients' needs, and (b) pregnancy-based approach (PBA), were designed to assess clients' needs and work out the workload and implement the approach. The first method involves identifying couples with unmet need and then providing services to them. To facilitate this, the ECR was revised.

In PBA, the ANMs were expected to identify all the pregnant women in their respective areas, and make at least three visits to each of them during the antenatal period and postnatal period. During the visits, the pregnant women are registered, immunised twice with tetanus toxoid, provided with iron/folic acid tablets, given antenatal check-up, and provided information on birth spacing and limiting.

Training: Training was provided to implement the unmet need approach. The ANMs were trained on the improved format, with emphasis on how it is to he used for identifying unmet need and service delivery. Skill development meetings were held to upgrade the skills of the workers in accordance with the requirements of the new approach. The style of the review meeting was changed; it was made a forum for sharing experiences of implementing the new approach.

Service Delivery: Apart from the existing health delivery system, the link person concept was introduced to increase access and improve the quality of family planning and maternal and child health services. The link person is a women volunteer from a community of about 50 house-holds, who facilitates community meetings on a scheduled day, at a fixed time and at a fixed place, once a month.

Monitoring and Evaluation: Monitoring of activities at the sub-centre (SC) and PHC levels was initiated by visiting ANMs at their SCs and villages, and documenting their performance based on service statistics. The council staff, along with the PHC staff, made numerous visits to SCs to monitor the workers' activities. Supportive supervision was introduced to provide continuous supervisory and technical support to ANMs,

changing from the traditional methods of monitoring performance to actually understanding the field problems, and helping the ANMs to solve them.

Implementation: The districts could not achieve much success in implementing the approaches as there was a general lack of readiness of the health facilities in terms of human and material resources critical for their effective utilisation and providing quality services. The interventions, however, led to a gradual change in attitude and improved the readiness of the workers to work.

Performance: Though the performance of family planning services declined during the pilot phase, the districts can he considered successful to the extent that they could, over one year, improve at least the readiness of the facilities. It can he said that the performance improved in terms of inputs provided and the processes, rather than in terms of output.

In the second year of implementation also, there was a decline in FP performance, but it gradually started improving in the third year.

Perceptions: Opinions about the approach were different and the issues of implementation were not very clear, even at the district level. The district authorities, as well as medical officers, initially found it very difficult to understand the concept and implementation of the approach, especially monitoring in the absence of targets. Initially, it was believed that the FP targets were essential to get the work done through grassroots level workers. However, after understanding the approach, they slowly became appreciative of the TFA.

Wardha, Maharashtra

In the absence of guidelines from the Central Government, the district failed to develop its own plan of action to implement the approach. Only sensitisation training was conducted to sensitise the workers about the new approach. Quality of services, client sensitivity, etc., were emphasised but the district officials did not talk about implementation issues in the training programme, i.e., how was all this to be achieved? The training programmes created confusion in the minds of the workers. It was therefore decided to follow the target- oriented approach.

Performance: The performance of the TFA in Wardha cannot be assessed, as the approach was not implemented. But, the fact that targets were no more important led to a certain relaxation in attitude, and energies were channelised into other MCH services.

As a result, performance of MCH indicators improved. The overall performance in family planning improved, though the number of sterilisation acceptors was marginally lower. However, this performance can not be attributed to the TFA, as it was never implemented. In the second year also, the district did not try anything innovative, but went by the instructions received from the state directorate. Overall, performance in FP declined.

Perceptions about the TFA: In the first year of implementation of the TFA, since no guidelines had been received, there was a lot of confusion, and the approach was not implemented.

Narsingpur, Madhya Pradesh

Narsingpur district did work out a methodology to assess clients' needs and calculate the workload. An eligible couple survey was planned and conducted to identify the need of the community. On the basis of this, the total workload could be determined and then shared by the workers. All ANMs, MPWs and AWWs were trained for conducting the survey. Though some special efforts were made to monitor the programme, in the absence of a well-defined monitoring and evaluation system, it was difficult to extract work from the workers and produce results. The opinions and understanding about the approach were also varied. The performance of FP in the district declined. However, in the second year of implementation, the decline was marginal.

Valsad, Gujarat

Valsad district of Gujarat was declared a target-free district, but it was in reality not so, as the performance was monitored on the basis of the targets given during the previous year. However, sensitisation workshops were held to orient the workers on the new approach. There was lack of clarity about the implementation aspects of the approach.

East Godavari, Andhra Pradesh

East Godavari district worked without targets for the first nine months but was totally dependent on the Central Government for providing guidelines to implement the approach. In the absence of guidelines and their own initiative, performance declined considerably. After reviewing the situation, the State Government imposed targets, particularly for sterilisation operations.

Lessons Learnt During the Pilot Phase

Whenever an organisational change is introduced, initial decline in performance is not unexpected. However, three districts proved other- wise-Satara in Maharashtra and the *Vikalp* districts, Tonk and Dausa, in Rajasthan. These districts showed improved performance due to the following reasons:

1. A clear understanding of the concept and programme implementation issues;

2. Clearly defined objectives;

3. Effective and clear communication about the approach, objectives and implementation issues at all levels;

4. Area-specific strategy to implement the approach;

5. Innovation and initiative in programme implementation.

6. Leadership provided by the district managers, and in case of *Vikalp*, the leadership provided by the Commissioner (FW) and Project Co-ordinator.

7. Commitment to excel and to the cause of population control.

8. Problem-solving attitude.

9. Development of well-defined systems such as:

    - Assessment of clients' needs;

    - Management information system (monitoring and evaluation);

    - Service delivery system, etc.

The other districts could not succeed due to lack of many of the above factors. However, though these districts were a bit slow at innovation, they have at least initiated the process of sensitisation. The initial falls in performance and the confusion regarding the concept are understandable. However, this transition period from the target-oriented attitude to the target-free approach needs to be shortened. The positive experiences of the other districts are encouraging, and by sharing these, it would definitely be feasible to shorten the transition period, and achieve success in implementing the approach and producing desired results.

Expansion of the Target-Free Approach in all the Districts of the States in 1996-97

At the end of one year of pilot testing of the approach in one or two districts of each state, the Central Government organised a meeting on 1 February 1996 to announce the target-free approach for the en- tire country. No serious efforts were made during the meeting to analyse the experiences of the districts that had implemented the target-free approach and learn lessons from them. Several state secretaries expressed serious concern about the introduction of TFA without adequate preparation. The two major concerns voiced were: (a) that indiscipline among workers would increase, and (b) performance would decline without any improvement in the quality of services (Raman 1997: 8).

The Central Government was not able to fully integrate the experience of the pilot districts into the national policy, as a systematic review of the pilot experiments was not conducted before the announcement of the policy for nation-wide implementation. Due to apprehensions of state officials about the approach, the Central Government sent communications directly to the district collectors (heads of the district administration) on 4 March 1997 informing them about the government's decision to implement TFA, its objective of improving quality of services and meeting clients' needs. Instructions were also given to conduct sensitisation workshops and to prepare PHC level and district plans by 30 April and 15 May 1997. Apart from communicating 'what' needed to be done, nothing was mentioned about 'how' it was to be done. The only guidelines given for preparing the plans was 'to develop PHC level family welfare and healthcare plan for client satisfaction, and to conduct village-by-village assessment of grassroots workers in consultation with the opinion leaders, primary school teachers, health workers, *gram pradhans* (village chiefs), local council members, non-governmental organisations and other opinion leaders'. There were delays in releasing the budget sanctioned for holding the training workshops. A manual for the target-free approach and a methodology for setting targets in accordance with clients' needs were developed and distributed to the state authorities during May 1996.

Experiences of Implementing TFA

As in the case of districts, the states which had developed detailed strategies and implementation plans were able to do well, while the others are still grappling with implementation problems.

The Comparative Picture

Table 2 reveals that all the states, except Rajasthan and the SIFPSA districts in UP, followed the Central Government guidelines to implement the approach. Though a few of them, like Gujarat and UP translated the TFA manual into the local languages, there were problems at all levels in comprehending the implementation aspects of TFA which led to decline in performance. The training programmes organised by each of the states could not address the implementation issues and their operationalisation, leading to some confusion among the workers. They could not successfully transfer the skills of community need assessment. Monitoring remained target-oriented. In brief, the implementation of the approach was limited to sensitisation of the workers about TFA, conducting surveys and calculating the work-load (in some cases), but the service delivery in the field was not on the basis of clients' needs and the quality of care objective. The mindset was still target-oriented. Monitoring was more on the basis of whether targets, now called Expected Level of Achievement (ELA), had been achieved or not. Emphasis on how they were achieved was missing; which is important in TFA, as providing quality services is its major objective.

Table 2: Comparative Analysis of Implementing TFA in Selected States (1996-97)

Category	Maharashtra	Uttar Pradesh	Madhya Pradesh	Gujarat	Andhra Pradesh	Rajasthan
Planning	Followed Central Government's guidelines	Followed Central Government's guidelines.*	Reviewed experience of implementing TFA in pilot district. Followed Central Government's guidelines.	Followed Central Government's guidelines.	Followed Central Government's guidelines.	Developed a comprehensive strategy to implement the change.
Methodology	Followed TFA Manual with	Followed TFA Manual	Followed TFA Manual.	Followed TFA manual	Followed TFA manual.	Conducted eligible

	slight modifications to meet state requirements. Manual was translated into local language and distributed during Dec. 1996.	and translated it into local language	Conducted target couple survey to assess community need.	and translated it into local language.		couple survey. Microplanning. Service delivery booklets. Initiatedsev eral innovative schemes.
Training	Sensitisation workshop were conducted No consistency among district trainers No guidelines for training. The training did not clearly address the issue of community needs assessment.	Sensitisation workshop were conducted. The workshops stretched over to the next year and were completed by May 1997.	Sensitisation workshops were conducted to convey the concept and methodology for assessing community needs. Training was not well organised and failed to address implementation needs.	Sensitisation workshops were conducted.	Sensitisation workshops were conducted but they failed to transfer skills of community needs assessment to the workers.	Training institute/centres were set up and training policy made. Training was conducted and it was able to transfer skill to a large extent.
Monitoring and evaluation	MIS formats were modified, though they continued to remain numerical. Monitoring remained target-oriented	Uncertainty prevailed on how to monitor the programme, and district officials did not seriously review the programme.	Followed the TFA Manual. No efforts were made to review programme and take corrective action. No feedback was given to workers. Lack of interest in verifying information and monitoring. Was totally numerical. No awareness	There was lack of monitoring at the beginning, but it was strengthened towards the end of the fiscal year 1996-97.	Monitoring was based on targets.	Developed their own monitoring and evaluation system. The salient features of the system are concurrent evaluation and feedback mechanism.

			about indicators of quality services.			
Implementation	In the first year TFA could not be totally implemented In the second year, efforts were made to strengthen TFA, but it took a lot of time to assess community needs and, therefore, the state calculated expected level of achievement and distributed them at all levels. Thus, in the field, the approach was still target-oriented and community needs were not the basis for service delivery.	Preparatory phase continued till June 1997. Service were not provided as per TFA till June 1997.	Target couple survey could not be completed in time. Implementation was from April 1997. Targets of previous financial year were used.	In the field, the approach was not implemented. Survey was conducted, but it was not used for calculating workload. Targets of previous year continued.	The approach remained target-oriented. Targets were distributed, keeping in mind the demographic goal that AP had set for itself.	Implemented as per plan.
Performance during the fiscal year 1996-97, as compared to 1995-96	Performance of all methods declined, except IUD.	Overall performance declined. In SIFSA-supported districts, performance declined, with the exception of the use of oral pills and condoms.	Overall performance declined.	Overall performance declined.	Performance of all methods declined, except IUD.	Overall performance for all methods improved.
Perception of the family	Varied opinions. TFA, though	Confused and varied. District	Uncertainty prevailed about	Varied. State officials did not find	Varied No uniformity in	Uniformity in understandi

welfare service providers about TFA	ideologically good, from implementation standpoint, it was difficult. MOs abided by the approach theoretically, but their mindset was still target-oriented. Workers were appreciative of TFA.	officials used different approaches to calculate workload and assess community needs some didn't know the steps for doing the same. Workers tried to capitalise on the prevailing confusion by shirking work.	implementation issues. TFA was considered good ideologically. The opinions about the eligible couple survey and its reliability were divided. Quality indicators were not clear at all levels, and some considered targets important.	the methodology provided by the Central Government realistic. Some felt that using cafeteria approach for illiterate people was unrealistic and difficult.	understanding the methodology of the bottom-up approach.	ng TFA. Concept of unmet need, which is the basis for providing services, has percolated down to all levels.

Note: In UP, the discussion does not include SIFPSA districts due to lack of adequate information.

*Out of 83 districts 15 are priority districts, wherein six are provided technical assistance by SIFPSA.

The data on performance is available only for family planning services. Moreover, this data too is quantitative in nature. Within the states, there were a few districts/regions that did relatively better. This can be attributed to the varying commitment and initiative of district officials rather than the methodology. Table 3 shows that the performance in the selected states, except Rajasthan, registered a decline during the first year of implementation in all the methods. In Maharashtra, there was improvement in performance of IUD.

Table 3: Performance of Selected States during TFA (1996-97) as Compared to the Previous Year

State	Percentage change in 1996-97 as compared to 1995-96			
	Sterilisation	**IUD**	**Oral pills**	**Condom**
Maharashtra	-8.3	30.9	-13.7	-28.6
UP	-49.6	-27.2	-10.9	30.6
MP	-3.3	-25.1	-3.7	-12.5
Gujarat	-10.0	-9.4	-0.1	-7.3
AP	-2.3	2.6	-6.8	-43.5
Rajasthan	19.0	21.5	286.5	38.8

The comparative profile of UP for 1996-97 and 1997-98 for the months of April to August (see Table 4) shows that there was a general decline in performance of the family welfare programme in the first year of TFA. The decline was particularly more in IUD and condom use. In the second year, though sterilisation declined, it was just marginal. In other methods, there was an increase in performance.

Table 4: Percentage Change in FP Performance of Selected States during 1996-97 and 1997-98 for the Months April to September

State	**Sterilisation**		**IUD**		**Oral pills**		**Condoms**	
	Change in 1996-97 compared to 1995-96	Change in 1997-98 compared to 1996-97	Change in 1996-97 compared to 1995-96	Change in 1997-98 compared to 1996-97	Change in 1996-97 compared to 1995-96	Change in 1997-98 compared to 1996-97	Change in 1996-97 compared to 1995-96	Change in 1997-98 compared to 1996-97
UP	-32.3137	-2.07179	-65.2349	143.1073	-21.4191	62.94811	-50.8294	31.19991
MP	-20.3457	-7.07267	-31.1678	11.65032	-7.34844	8.486785	-12.1493	-6.68653
Gujarat	-17.1083	-2.8301	-18.4018	-5.12004	-13.737	-1.3167	-8.44597	-20.8286

Note: In case of UP, the data is for the months April to August.

When compared to other districts in UP, and in UP as a whole, the decline in performance in the focused districts (districts that were given technical assistance by SIFPSA) was relatively less (see Table 5) (Table 5 is missing) ; in case of pills and condoms, there was no reduction. In the second year, there was improvement in all spacing methods. This was encouraging. It shows that the over-emphasis on sterilisation was wearing off, and the focus was now on younger couples, to enable them to achieve their reproductive goals.

The family planning performance in MP registered a decline in the first year of TFA (see Table 4). In the second year 1997-98 (April-September), the performance of sterilisation declined, but that of spacing methods improved. In Gujarat, the performance continued to decline, though the decline was relatively less when compared to that in the first year of implementation. It can be observed that the performance during the second year of implementation was gradually improving, especially in case of spacing methods.

At the same time, due to decline in performance in the first year, Maharashtra went back to the top-down approach. Though the exercise of assessing community needs and calculating workloads continued the state developed its state plan and communicated district targets, now called Expected Levels of Achievement. The justification was that, till the workers had acquired the skills needed for implementing TFA, work should not suffer in the absence of targets. Andhra Pradesh too continued with its top-down approach. Monitoring in most states continued to be quantitative in nature.

As the TFA gets further institutionalised, the programme managers will face new challenges. First, in places where performance has started improving, especially in spacing methods, the challenge is to sustain the continuity of spacing methods. The data does not shed light on the quality of services, the age and parity of clients, and the continuity of spacing methods. There is a need to develop process indicators to monitor quality of services. Second, whenever there has been an initial decline in performance, there is a need to check the tendency of the states to revert to the earlier top-down methodology.

Lessons Learnt

The expanded Implementation of the TFA in selected states reinforced the lessons learnt during tile pilot implementation. The experience showed that the following factors need to be attended to for successfully implementing this new approach:

- Leadership and commitment of the Commissioner-cum-Secretary;
- academic, administrative and political support;
- local adaptation of the TFA to deal with its implementation aspect;
- effective communication and training;
- well-defined methodology for assessment of clients' needs;
- a well-designed monitoring and evaluation system; and
- strategies to mobilise community support.

Conclusion

Such a massive organisational change as that from a target to a target-free approach in the family planning programme in a bureaucrats set up is by no means an easy task. In the process of organisational change, it is natural to expect some confusion, ambiguity and resultant decline in performance. To minimise this confusion and to effectively implement the change, it is important to develop a systematic strategy to deal with the transition from a target-oriented and top-down to a target- free and bottom-up programme implementation approach.

Cultural change is a long-term process. The decline in performance in the initial stages should not discourage policy makers. A few of the states have shown the tendency of reverting to the top-down approach. There is a need to realise that just as the ends are important, so are the means by which the ends are achieved. The urgency to achieve demo- graphic goals should not adversely affect the reproductive rights of the people. Reverting to targets would harm the programme. Therefore, it becomes extremely important for the policy-makers to keep faith and to go on consistently communicating the importance of this approach along with fine-tuning of the programme.

The preconditions for the success of the approach are the top management's commitment to the approach and its clear communication to all levels, as well as

management capability for planning and implementation. The states, which already had better capability, performed better than the others. The states must adapt the centrally developed programme implementation methodologies by modifying them according to local area-specific requirements.

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