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District Level Approach to Family Welfare Program in India : A Proposal for Effective Action

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Background

The Indian family welfare program is a centrally sponsored scheme, implemented by the State governments within the framework of elaborate guidelines and norms developed by the Central Government. Although each State is encouraged to introduce innovative approaches within these policy parameters, in practice, the family welfare program in the country has been macro in approach, sectoral in coverage, and highly centered. It has, therefore, failed to achieve the desired results. The strategy adopted so far has created a wide gap between the provider and the client, and the lack of involvement of people has led to the failure of the program. Thus, there is a growing concern among policy makers and implementors that the centralized standardized nature of the scheme gives local program managers insufficient flexibility to meet varying local needs.

There is also an increasing awareness that intra-state variations in terms of language, social and religious groupings, distance between settlements, access to services, the health and nutritional status of the local masses and so on are as significant as variations between states, given the continental nature of the country. There is now a growing consensus that the family welfare program should as far as possible be tailored to meet the needs of individual districts, therefore the district should be seen as the basic unit for management of the program.

As a first step in this direction, the Government of India has identified for special attention, 90 districts of the country where the crude birth rate is above 39 births per thousand population on the basis of the 1981 Census. Out of the 90 districts, 83 district are in the four northern Hindi-speaking states of the country which constitute around 40 per cent of the total population of India (Figure 1 is missing).

The Government of India intends to adopt a district-based management system in these districts which will permit local managers to play an important role in order to achieve the set demographic goals at the earliest. The Central Government has, therefore, outlined the processes to be followed so as to achieve the goals; these mainly emphasize "strengthening infrastructure and improving training of staff".

It should however, be noted that merely infrastructural facilities and enhancing training of staff will not allow local managers greater flexibility for designing operational strategies to meet local needs that would help improve the demographic situation unless structural changes are brought about in the program[1]. The main aim of this paper then is to evolve a comprehensive district level approach for the effective implementation of the family welfare program in a decentralized manner. The approach is based mainly on a study conducted in some districts of Rajasthan [2].

Family Welfare Program In India

To control and stabilize the growth of population, the national family planning program was launched in 1952 by the Government of India. Since then, it has gone through several stages of adjustment in terms of strategies and approaches. The program is now being implemented as a family welfare program with mother and child health care as an integral part.

The resources allocated for the program may not be sufficient, but have increased in absolute as well as in real terms over time. A large number of family welfare service centers in the form of Primary Health Centers (PHCs), sub-centers, etc. have been established all over the country. Further, India is fortunate that there is no strong outcry of opposition to the program from any sector of the population. There are organizations to support it but no organized movement against the program. Inspite of this, the program has failed to produce the desired impact on the country's galloping population growth.

It is not that people are averse to the program. Several studies have shown that a majority of couples wish to limit their family size. Various studies support this notion. About five to six million abortions take place in India every year [3], and about 25 per cent of the pregnancies that occur after the third child are reported as unwanted [4]. About 13 million currently married women in the four northern Hindi speaking states of Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan, do not want more children but are not using any form of contraception, and if they did, fertility would drop by around 12 per cents [5].

According to another study [2] conducted in 1989, a sizable number of eligible couples in a demographically backward state like Rajasthan are keen to practice family planning but have not been able to do so because of certain reasons which mainly include poor quality services and inadequate follow-up. A study [6] conducted by the Operations Research Group in 1990 confirmed this and came to the conclusion that around 23 per cent of eligible couples are ready to accept family planning services in Rajasthan but do not do so.

All these findings indicate that people want to limit their family size but the program has not been able to convert both their latent interest and desire into effective demand. This is primarily due to the fact that the program has not been designed on the basis of the socio-cultural ethos and needs of the local people.

Need For Structural Change

There are long-term causes underlying the poor performance of the family welfare program in the country, some of which are structural in nature [7]. The family welfare program is a centralized program with all major decisions percolating downward from the top with little or no participation of the people for whom the program is meant. Therefore, the willingness and commitment of people has not been harnessed. Besides, an area specific approach and marketing strategies have not been adopted, in spite of the fact that in a continental country like ours where wide variations exist in term of population density, degree of development, socio-economic conditions, topography, expectations of the masses, etc. targets are set and guidelines to achieve these are given by the center.

Further, the program has been made the responsibility of the medical department, which is not desirable in the present context, and is quite different from the situation when the program was initiated. Family planning is not so much a clinical or medical problem because a healthy person goes in for firmly planning and a sick person goes to the hospital. Moreover, health is a universal requirement whereas family planning is age specific. With the same people (doctors) being responsible for both medical and family welfare, the former being more urgent in nature gets priority over the latter. Moreover, the role of the medical department in the realm of family welfare is likely to be small in future. This is because the popularity of non-terminal methods is increasing and the role of terminal methods (sterilization) is decreasing. Therefore, the motivator assumes special significance. This also calls for a constant motivational strategy which would need social physicians trained in the art of motivation rather than clinicians to handle the program.

Whenever one talks of population and its control one tends to think of family planning alone. This is because all government efforts or programs of population have been woven around family planning. This is not a correct approach. Although fertility is a complex issue and is influenced by various factors like female literary, female literacy, female status, son preference, age at marriage, level of child mortality, etc., it does not mean that the family welfare program should include under it all these beyond family planning aspects which influence fertility behavior [8]. Therefore, the scope of the program should be defined carefully and it should only be considered as one of the many efforts which help arrest the galloping population growth.

The above discussion suggests that the program should be restructured and revitalized with the district as the nodal point for all activities, and that such restructuring should take a holistic perspective of the situation.

District Level Approach: Scope and Structure

In the proposed approach, as mentioned above, the district would be the nodal point for planning and implementation of all activities pertaining to the family welfare program. The family welfare program restructured on the above basis would be one of the many means of tacking the population problem. The revised program would concentrate on providing basic MCH and family planning services which include ante-natal care and so on. High risk cases requiring clinical attention and persons interested in adopting sterilization would be referred to medical institutions. However, the program would be responsible for ensuring good quality of services and follow-up care. Thus, clinical services would be arranged through a system of operating contracts which the peripheral units could have with the government and private hospitals, PHCs, and so on.

The organizational structure for the proposed approach is diagrammatically presented in Figure 2.

FIGURE 2: Implementation of the family welfare program by an alternative approach: a model (This Figure is Missing)

Line Command Support Structures

The approach envisages a revival of the existing District Family Welfare Bureau (DFWB) and making it responsible for implementing the program.* The DFWB would be an autonomous body with the complete responsibility for managing all the family welfare activities in its district.

The district would further be divided into Tehsil/Taluka Family Welfare Bureaux (TFWB) headed by Family Wwlfare Officers. The TFWBs would be responsible for looking after the needs of the lower level units under their jurisdiction. The Tehsils/Talukas would in turn be divided in to family welfare blocks, headed by a Family Welfare Promoter. Each family welfare block would cater to a population of 30,000. The Family Welfare Promoter would in turn look after six Auxiliary Nurse Midwives (ANMs) each catering to a population of 5000.**

The Bureaux would be in line command and directly responsible for implementing the family welfare program. A District Population Coordination Board would be entrusted with the responsibility of involving various units at the district level and bringing about a consensus on implementing the family welfare program at the district level. Support services in the form of clinical services would be obtained from the family welfare service centers i.e. government and private hospitals and clinics which would constitute the support structures.

Organizational Processes

The new system would be a bottom-up approach and would progress from parts to the whole rather than descend from the top, as is the practice currently. The main features of the new system are described in the paragraphs that follow.

State Family Welfare Bureau

The State Family Welfare Bureau would play a coordinating and supervisory role. It would mainly serve as a liaison agency between the Center and the State and provide guidance for formulating district family welfare plans. It would also evaluate the performance of districts under its jurisdiction and suggest suitable remedial measures, if and when required.

State Population Resource Center

This Center would be an autonomous organization. It would undertake relevant research and consultancy with special relevance to population control and the family welfare program. It would also help the District Family Welfare Bureaux to design district demographic plans and help evaluate the program.

District Population Co-ordination Board

Fertility is a complex issue and is determined by various factors. Hence, various agencies, units and experts would have to be involved even at the district level. The main aim of the District Population Co-ordination Board would be to bring various units like education, agriculture, family welfare, medical and health, social welfare, ICDS program, youth clubs, women's organizations, NGOs, etc. to a common platform to discuss the population problem and bring about a consensus in implementing the family welfare program at the district level. The Board would be headed by the District Collector who would be fully involved in coordinating the activities related to the family welfare program.

District Family Welfare Bureau

The District Family Welfare Bureau (DFWB) would be a nodal agency and would formulate area-specific and need-based plans for the district. A long-term plan could be drawn up for 5-10 years. In addition to this, specific strategies and annual plans could be formulated within the framework of the long-term plan. The plan would show the kind of demographic scenario the distinct would have in the future. The DFWB could get the required help from the State Population Resource Center for designing the demographic plans based on which every District Family Welfare Bureau would be required to set its own annual work targets. Each DFWB would be divided into Tehsil/Taluka Family Welfare Bureaux and these would look after the needs of lower units under their jurisdiction.

Block Family Welfare Bureau and Peripheral Units

The Block Family Welfare Bureau levels would be the actual points at which the family welfare program would come into contact with the public. The needs and of beneficiary clients would be found out and the marketing-mix would be formulated at this point. Any clinical service that is required by the client would be arranged through a system

of operating contracts which the peripheral unit could have with government and private hospitals, clinics, etc. as started earlier. This would stimulate competition among these agencies and, consequently, help to improve the quality of services offered to the beneficiaries. In the proposed approach, incentives in cash and kind would be discontinued and these would be supplemented by good quality services, health insurance and mediclaim facilities for post-operative treatment and so on, if required.

At the peripheral level, the ANM would play an important role both as a motivator and as a provider of basic MCH-Family Planning services like immunization, IUD insertion, etc. The ANM would be required to visit each villages within her jurisdiction twice a month on fixed dates and at a fixed time. This would help the local people to avail of her services with ease, Since it would not be possible for an ANM to cater to all the villages within her jurisdiction (5,000 population) at the same time, it is suggested that the post of a Community Family Welfare Guide (CFWG) be created in every village.

The CFWG could be a person practicing some form of family planning, and would and as a link person between the ANM and the villagers and also help to motivate the villagers to adopt family planning methods. The CFWGs could also act as depot holders for contraceptive like the oral pill and condom for which they would be paid a commission. This would make the CEWG's position viable and strengthen the community based distribution system. The performance of the CFWGs would be evaluated regularly and if found unsatisfactory, another person would be appointed.

A client opting for sterilization would be referred by the CFWG to an ANM, who would, in turn refer the case to a Family Welfare Promoter. The Family Welfare Promoter would be responsible for making the necessary arrangements for the procedure in either a public or a private hospital or clinic, including the existing CHC, PHC, etc. Similarly, in case of the complications, the beneficiary could approach a CFWG who would inform Family Welfare Promoter or ANM and the latter would be responsible for arranging medical help within a stipulated time. This would help create confidence among the people and they would feel assured that they would be taken care of if a complication were to occur. This, in turn, would help increase the acceptance of the family welfare program and hence convert the latent need for family welfare services (which. is quite high) into felt need, thereby increasing the demand for family planning services.

To facilitate the work of the ANM, it is suggested that the current eligible couple approach be replaced by the birth-based approach as this would greatly facilitate the ANMs to locate and approach clients. In the former approach, the ANM would have to

cater to 900 eligible couples (if 18 per cent of the total population is assumed to be eligible) and, in the latter, to only 175 mothers (if the birth rate is assumed to be 35). This would help to reduce the ANMs work-load and improve the quality of services provided. It however, does not mean that other couples would not be able to avail of her services, it simply means that the concentration would be on pregnant women and mothers of one year-old children.

Operational Issues

The suggested model proposes to utilize the existing manpower working in the family welfare program as far as possible. If suitable persons are not available, they would be transferred from other departments on deputation or recruited for the program.

The DFWB would be headed by a Director who would be carefully selected by a selection committee constituted by the State Family Welfare Bureau and given a stable tenure of at least five years. It is, however, not necessary that the Director should be a person with a medical background. An expert in the field of management which would include expertise in marketing, motivation and monitoring could be appointed. The Director would be assisted by three Deputy Directors having expertise in the areas of supply, demand generation and project management including evaluation and monitoring.

The impact of the proposed model would be evaluated on the basis of outcome indicators such as the crude birth rate and not by output indicators like the couple protection rate. For this, a baseline survey would have to be conducted to chalk out a profile of the districts. A demographic profile of likely achievements in terms of the crude birth rate, infant mortality rate, total fertility rate, and maternal mortality rate would also be stated.

The implementation of the program according to the proposed approach would not require additional financial inputs. Hence, the amount for implementing the proposed approach would not exceed the specified budget currently spent for family welfare purposes in a given district. However, in the initial stage, some extra expenditure might have to be incurred.

Expectation from the Government

The successful implementation of the proposed district level model requires some policy decisions on the part of the Government. These include:

1. The District Family Welfare Bureau would be the sole agency to carry out the family welfare program in the district. It would have its own budget.

2. The District Family Welfare Bureau would be declared as an autonomous body (that is, it would be given the freedom to carry out the program based on guidelines set by itself within the format of the new model). The districts would hence be exempted from targets and other requirements imposed from the top. The Bureau would, however, be required to make five yearly demographic plans for the district and their activities would be guided by this plan.

3. The job responsibilities of some workers would have to be redefined, especially those of the paramedical staff who would be working under the DFWB. For example, the responsibilities of the ANM would be confined to basic MCH and family planning services only, as noted above. The budget sanctioned for the family welfare program in a particular district would be given to the respective Bureaux.

4. There are certain clinical units like the Rural Family Welfare Centers, postpartum centers, etc. which are financed by the family planning budget. These would remain with the medical department but would continue to be financed by the existing family welfare budget. However, the job responsibilities of personnel working in these units would be redefined.

Conclusion

The present population scenario in the country is grim. Nevertheless, population control is by no means an impossible task. Many other countries with worse demographic profiles, who started their family planning programs much after India had, have achieved considerable success in controlling their population, through determination, by undertaking imaginative programmers, and by involving the people.

If the threatening growth rate of population is considered a serious problem by the Government of India then it should be tackled in a systematic manner. This calls for

structural changes in the family program so that it can be effectively implemented and easily accepted by the masses. All that is required is a firm and bold decision on the part of the government and a strong political will to implement the proposed model. Perestroika has indeed become a part of our daily life. This word ensures the survival of the fittest and the fittest are those who readily adapt to changing situations. It would be worthwhile to bring about holistic changes in the family welfare based on the guidelines discussed above.

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