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**Target Free Approach for Family Welfare in Gujarat:  
A Review of Policy and Its Implementation**

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## **Abstract**

The introduction of the Target Free Approach (TFA) has been a major policy shift in the health and family welfare programme of India. This study reviewed the process of change in the implementation of new policy and its impact on the quality of health care and reproductive and child health services. In this study both quantitative as well as qualitative data were collected and analysed, which included Focus Group Discussions of users and providers of health and family welfare services. Since policy implementation is difficult to assess for all districts, we selected two districts of the state namely Valsad and Bhavnagar. It was assumed that the policy change would improve programme performance.

The review suggested that in the initial stage, there was some confusion among the middle and lower level programme managers and field workers about the philosophy, content and monitoring procedure of the new approach. This was reflected in a sharp fall in the family planning service statistics in the year following the introduction of the TFA. However, a marginal decline in the second year and a modest recovery since 1998-99 indicated that most of the health workers had been sensitised and oriented to understand the objectives of the new approach. Almost all grassroots level workers welcomed the change in the policy. Now, they feel less pressure of achieving family planning targets and they confirmed that their workload has increased with the introduction of TFA. The health workers and their supervisors jointly set targets, called as workloads at Primary Health Centre level. Health workers for motivating couples for contraceptive use adopt a client segmentation approach based on the number of surviving children. Moreover, in the new approach, priority is given to Reproductive and Child Health activities both in reporting as well as in the programme review.

Several positive changes have occurred in the implementation of the new approach. However, its impact on fertility and mortality is not very substantial. Gujarat state has to go a long way to achieve many of the fertility and family planning programme goals set in Population Policy 2002.

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## **1 Background, Objectives and Research Methodology of the Study**

In India family planning program began in 1952 with an objective to lower the country's population growth. It was renamed as family welfare program (FWP) in seventies. Although the official family planning program has contributed to India's fertility decline still many demographers and family planning experts believe that the method specific target oriented approach has proved to be counterproductive overtime (Couly and Camp, 1992; Satia and Jejeebhoy, 1991; and Visaria and Visaria, 1995). It has largely remained target oriented program with over-riding concern for numbers - as measured by the recruitment of sterilization acceptors at the expense of quality of services and clients' reproductive health needs. Improvement in the health and wellbeing of women and their families was thus, sidelined in the implementation of the program. The program also could not pay much attention on promoting genuine use of reversible methods.

This attracted frequent criticism from various women's groups, and NGOs also. This led the Government of India to initiate a new approach moving away from quantitative targets. The 1994 International Conference on Population and Development (ICPD) held in Cairo also provided strong impetus for a change in policy. The Program of Action (PoA) proposed at Cairo states that "the aim of the family planning program must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so, and to ensure informed choices and make available a full range of safe and effective methods", (UNFPA, 1995). The Ministry of Health and Family Welfare (MOHFW), Government of India, therefore, decided to introduce the Target Free Approach (TFA) for family welfare, in 1995. In the first place one or two districts of major states were selected to implement the new policy on pilot basis. From April 1996, TFA was extended to all districts in all states.

## **1.1 Target Free Approach – A Paradigm Shift**

The TFA envisages replacement of the system of setting contraceptive targets from the top by a system of decentralized participatory planning at the Primary Health Centre (PHC) level. The Target Free Approach was, however, renamed as Community Needs Assessment Approach in 1998. As Mavalankar (1999) has put it in very simple words, "the basic idea behind the target free approach was that the Central Government will not give method specific contraceptive targets any more. The states should develop their own system of performance planning and performance, monitoring based on assessing the community needs. A participatory planning process was to be adopted by the grassroots level workers to arrive at the needs of the community. These needs had to be aggregated at the PHC and then at the district level to form the action plan". Thus, the new approach requires removal of numerical targets and focus more on improving quality of services and clients' needs.

Thus, nearly five years have passed since the abolition of the target system for family planning. A few attempts have been made to assess the impact of the new approach on the program performance (Visaria and Visaria, 1998; Khan and Townsend, 1999; Mavalankar, 1999), though at the infant stage of the introduction of the new policy. Prasad and Mangal (2001) have recently reviewed the implementation of the Community Needs Assessment Approach in Gujarat. Though state and country level experiences are available from these studies but very little is known about how this policy change has happened at the more disaggregated levels of Primary Health Centre (PHC) and Sub-Centre (SC). Understanding field level realities is essential for further action to reorient the program. Viewed against this perspective, the present study attempts to examine the following aspects of the process of change in policy implementation and its impact on the program performance:

### **1.2 Objectives of the Study**

#### **A. Implementation Aspects**

1. To review the process of change in the family welfare policy at the state, district and lower levels;
2. To know how the shift in focus of program from target to no target has been

conceived and understood by the program managers;

3. How the workload of the grassroots level workers is decided in changed policy situation?
4. What are the new procedures adopted for monitoring and supervision of the TFA? How different they are from earlier ones?

**B. Impact Assessment Aspects**

1. Evaluation of family planning performance separately for permanent and reversible methods;
2. Meeting unmet needs for contraception;
3. Health care coverage;
4. Ensuring quality Reproductive and Child Health (RCH) services;
5. Community participation and
6. Bottom up planning

Thus, the effectiveness of the TFA would be evaluated from multiple perspectives - including of all stakeholders such as program managers, field supervisors, outreach health workers, community and potential clients.

**1.3 Research Methodology**

This is a case study of Gujarat state. Since it is difficult to assess policy implementation for all the districts, we selected two districts, namely Valsad and Bhavnagar. Valsad was chosen because it was selected for pilot TFA in 1995-96 and Bhavnagar because it had very poor family planning performance before the introduction of the target free approach. We assumed that implementation of TFA would improve program performance.

In each district two PHCs were selected in consultation with district officials on the basis of the performance of the family welfare program. Thus, one good and one poor performing PHC was selected for detailed inquiry. Further, in each PHC, five sub-centres were visited and health workers were interviewed and their activities were observed by spending at least one day at each sub-centre.

In addition to that we selected two sub-centres in each PHC for Focus Group Discussions (FGDs) of women, who are the clients of the service provider. A total of 111 women from 8 sub-centres participated in small groups of 4 to 9 women at a time. FGDs of one each of Male Health Workers and Female Health Supervisors were also held in Valsad district. Before going to the sub-centres, we held detail discussions with the program managers and administrators in charge of the family welfare program at the state, district and PHC levels.

## **2 Implementation of Target Free Approach in Gujarat**

Gujarat state is located in western part of India. According to the 2001 census, total population of the state was 50.6 million, accounting for 4.9 per cent of India's population. It is one of the most urbanized and industrialized states in India. The state is favourably placed in terms of several health and demographic indicators such as lower density of population, higher levels of literacy and urbanization. The state also had lower fertility and mortality rates compared to the all India averages. The population of the state grew at 21.2 per cent during the decade 1981-91, which was lower than the annual growth rate of 23.9 per cent for the country as a whole. However, the state experienced a population growth of 22.3 per cent during 1991-2001, which was higher than the 21.3 per cent growth for India (Table 1).

### **2.1 Process of Change from Target to No Target**

To begin with, the government of Gujarat decided to implement TFA in Valsad district on an experimental basis in February 1995. The district health officers were informed about the state's decision in March 1995, and as a matter of change in policy no specific targets for family planning were allocated to the district for the year 1995-96.

As a quick follow-up to it, the Additional Director of Family Welfare briefed up the district health officers on the new approach in April 1995. At the same time, they were also told to explain the new approach to the Medical Officers (MOs) of PHCs. The MOs were explained by the district officers that the TFA is a paradigm shift in the policy. In the new approach more emphasis should be placed on improving quality of service and involving community in assessing its needs for family planning and Mother and Child Health (MCH) services. The MOs were, in turn, supposed to pass on this message to the grassroots field workers. But in the absence of clear instructions and proper guidelines, the message was not delivered adequately to the field workers. Hence, the confusion prevailed among the grassroots health functionaries about the TFA. It was reflected in the drastic decline in the performance of family planning program in Valsad district. At the end of the year, the number of sterilization acceptors declined from 16,989 in 1994-95 to 14,590 or by 17.2 per cent in 1995-96. The performance of temporary methods also exhibited a decline in the district. Compared to 1994-95 situation the percentage of acceptors of IUD declined by 21 per cent, Oral Pills by 12 per cent and Condoms by 16.5 per cent. After one year of the TFA implementation on experimental basis, the state and district officers suggested a gradual expansion of the TFA to other districts of the state.

## **2.2 Expansion of the TFA to All Districts**

The Ministry of Health and Family Welfare (MOHFW) decided to expand the TFA to all districts in the country from April 1996. Hence, at the behest of the Centre, the State Government also introduced the TFA in all districts from the year 1996-97. All district health officers were informed about the state's decision in April 1996 and no method specific targets were given for 1996-97. The district collectors were also informed by the Secretary to coordinate the implementation of the TFA. But in the absence of clear guidelines and instructions on the implementation of the TFA nothing much happened in the state till October 1996. Only in November 1996, an orientation workshop was held in the state for the state and district level officers. In this workshop, the TFA manual and the planning and reporting formats were discussed. The participants were also explained about the process of preparing sub-centre, PHC and district plans. At the end, the workshop participants were asked to hold such orientation workshops at district level to train PHCs and block level health, family welfare and Integrated Child Development Scheme (ICDS) functionaries in the new approach. However, district level workshops could be held only in the months of June and July of 1997.



During the above workshop, the district officers were supplied the TFA manual which was in English language. The manual included norms for estimating the expected levels of achievement for family planning and MCH services. Using these norms, the PHC and district officers attempted to estimate the workload for the year 1996-97. However, the workload estimated by them was found to be unrealistically high. As expressed by one of the Deputy Directors, the targets were almost three times higher than that of the 1995-96. Hence, the program managers decided to adopt the targets of the previous year i.e. 1995-96 as a workload for the year 1996-97. As a result, confusion compounded about the validity of the new approach among the field workers as well as the program managers. A review workshop was held at Lucknow in November 1997, about the implementation of the Target Free Approach. In that workshop, Ghasura and others (1997) observed that there was some confusion among the staff in the initial few months, hence, much of the first 18 months (April 1996 to October 1997) of the TFA in the state was devoted to preparatory work only. Prasad and Mangal (2001) also talked about the same in the review of the Community Needs Assessment Approach in Gujarat state. According to them the implementation of the TFA and preparation of sub-centre plans were done amidst a state of confusions due to lack of clear guidelines and proper training of field workers. The situation did not improve much during 1997-98 also.

Meanwhile, the MOHFW also received feedback from several states about the complexity of the TFA manual. The planning and reporting formats were so complicated that it was difficult for even many MOs and PHC level supervisory staff to comprehend. Moreover, the manual and formats were supplied in English language, which was difficult to follow by the field workers. In the initial stage, misnomers also prevailed among the workers about the philosophy of the Target Free Approach. Some of them considered it as 'tension free approach' or 'no work' approach. This confusion led to inaction, which was reflected in the declining program performance in many states including Gujarat (Mavalankar, 1999).

Realizing the limitations of the TFA manual and the negative effect of the term TFA the MOHFW held several consultation meetings and workshops. Based on the recommendations of these workshops, the manual was revised and the planning and reporting formats were reduced from 14 to 9. Formats were also made simple. To clear the confusion, the approach was also renamed as Community Needs Assessment Approach (CNAA), in September 1997.

However, the state government received the CNAA manual in 1998 again in English. The translation of the manual took a lot of time. Hence, only in November 2000, the field level workers of a few districts could receive a copy of the Gujarati version of the CNAA manual. Kumar (2002) in his study on planning and management of health infrastructure and manpower found that several of field workers and supervisors were not supplied the Gujarati version of the CNNA manual till the end of 2001.

Given the policy shift of 'bottom up' approach which lays more emphasis on decentralized planning, more intensive efforts were required to train field workers and enhance management skills of the middle and lower level managers. However, nothing much could happen in this area. Training of workers always remained a major issue. Discussions with the state and district officers indicate that only during the financial year 1996-97, state level orientation workshops were held.

The MOs and field workers were 'however', given some orientation in the TFA in June and July 1997. The state demographer also trained statistical assistants, clerks and other staff at the district level in the TFA, so that they can help in the monitoring of the program. During January to April 1998, a six-day RCH training program was conducted for FHWs/ANMs at the district level in which one of the sessions was devoted to develop sub-centre plans as suggested in the TFA manual. But no training or orientation sessions in the new approach were conducted for the grassroots workers, since the introduction of the CNAA in 1998. Even after five years of completion of the new approach, several of the health workers did not know how to prepare the Sub-Centre Action Plan. The field supervisors were also not trained adequately to guide the grassroots workers. The medical officers and other health workers were informed about the new approach only during their routine monthly meetings. Since April 1998 the SC action plan is prepared at the PHC level with the help of the supervisory staff, and field workers submit monthly progress reports in the CNAA formats. Because of last two years continuous exposure in the new approach, at least the process of sensitizing different levels of health and family welfare staff has been done and health workers, at all levels including PHC and SC have become quality conscious. By now, they have very well learnt that the new approach is community based, client centred and seeks for quality in family planning and MCH services.

During our field visits in December 2000, we were informed by the FHWs that they had received a Gujarati version of the CNAA manual only in November 2000, which they had not gone through. Till December 2000, they were submitting monthly progress reports in formats printed in English. However, they were hopeful to get formats printed in Gujarati by the end of March 2001. The experiences of grassroots level workers on the implementation of the TFA and CNAA is discussed later.

### **2.3 Administrative and Program Level Changes**

Discussions with the state and district level officers indicate that no major change has been done in the existing structure of family welfare program after introduction of TFA. Neither any appreciable effort is done in decentralization of administrative or financial powers. Major policy decisions are taken at the state level, and district is the nodal unit for program management and monitoring. The main program implementing agencies are PHC and SC at the grassroots level. District hospitals, CHCs and First Referral Units (FRUs), are also there at taluka or district places to cater to the secondary and tertiary health services. The only major change has been the launching of RCH Program in 1997. RCH societies have been registered in all districts but yet not started fully functioning. However, with the registration of RCH societies, a separate fund is made available to the society, under which, a Medical Officer of the PHC is authorized to spend annually Rs. 1,000/- to meet small contingencies at the PHC. This has certainly given him some degrees of freedom to work. Earlier he was to depend on district authorities for such needs.

## **3 Assessment of Family Planning Performance**

Compared to 1995-96 and earlier situation, there has been a decline in the performance of all methods of family planning both in absolute number as well as in percentage achievements. The decline in the sterilization cases was much sharp in the year following the introduction of TFA. In the second year, it was only a marginal decline. However, the performance started looking up since 1998-99. The same is true for temporary methods. On the whole, the decline in the performance of sterilization and IUD was of the order of 7 and 8 per cent respectively, while OP showed marginal increase between 1995-96 and 1999-2000. Overall achievement rates for the year 1999-2000 were 82.2 per cent for sterilization and 86.4 per cent for

IUD. It was 83.2 and 86.7 for OP and CC respectively (Table 2). Prior to the introduction of TFA in 1995-96, the achievement rates were more than hundred per cent for all family planning methods.

District level analysis provides a mixed picture. After TFA, Valsad exhibited an improvement in the performance of sterilization and IUD while Bhavnagar showed a marginal improvement in sterilization but decline in the acceptors of other methods (Table 3). However, the decline in the performance of sterilization and IUD has been larger than 10 per cent in several districts. Improvement in the contraceptive use was reported in a few districts only.

With the decline in the total number of family planning acceptors from 4.61 million in the state in 1995-96 to 4.58 million in 1999-2000, couple protection rate also went down from 59.5 per cent to 56.6 per cent respectively. However, the contribution of terminal methods has remained unchanged to about 65 per cent of all acceptors. Among temporary methods, some improvement was reported in the IUD acceptors. Their share in the total couples protected increased from 19.2 per cent to 21.4 per cent between 1995-96 and 1999-2000, and the share of other reversible methods such as OP and CC declined by about three percentage points. Gujarat data also show little relationships between couple protection rate and crude birth rate (Table 4). Neither any definite trend is visible in the infant mortality rate. Moreover, no major change was observed in the distribution pattern of monthly performance of sterilization either for Gujarat state or for Valsad and Bhavnagar districts. About 55-60 per cent of sterilization is still performed in the last four months of the year, i.e. between December and March (Table 5).

The trend, however, shows that still most of the couples are protected by female sterilization, and the share of male sterilization in total is only one per cent. The number of male sterilization conducted in the state declined steadily from 8195 in 1995-96 to 4554, 3118, 2786 in the following years and finally to 2539 in 1999-2000. Although the ICPD proposal puts emphasis on men's shared responsibility and promoting their active involvement in responsible parenthood, sexual and reproductive behaviour including family planning, a steady decline in men's contribution in total sterilization acceptors is a matter of great concern.

Thus, the overall family planning performance trend shows a decline in both the absolute number as well as percentage achievements of acceptors of all FP methods except use of oral pills. However, the analysis of state data of sterilization and I.U.D. acceptors by age of wife and number of children (presented in Tables 6 and 7) reveal a gradual increase in the acceptors of couples with lower parity. Percentage of women aged 30 or more who choose sterilization show a consistent decline. Similar decline is also seen in the percentage sterilization acceptors of three or more children. Such trend is more vividly discernible since 1997-98. The state FP program managers consider it a qualitative change in the program performance.

Another qualitative improvement noted in the FP program was related to the progressive decline in the deaths due to sterilization (Table 8). The number of sterilization deaths per 10,000 population in the state declined from 2.20 in 1976-77 to 0.50 in 1994-95 and further to only 0.20 by 1998-99. Incidentally, not a single case of sterilization death was reported during the last four years in any of the PHC visited by us.

### **3.1 Changes in Fertility and Mortality Rates**

The Sample Registration System (SRS) estimates for Gujarat presented in Table 9 show a decline in Crude Birth Rate (CBR) from 27.9 per thousand population in 1991 to 25.4 in 1999. Similarly, the Crude Death Rate (CDR) also declined from 8.5 to 7.9 during the same period. Despite decline in both CBR and CDR, the population of the state continued to grow because, the decline in CBR has not been as rapid as decline in the CDR. A relatively higher growth of population in the state during last decade is the reflection of such a phenomenon.

Although Gujarat has lower fertility and mortality rates than the all India figures, the decline in the Total Fertility Rate (TFR) and Infant Mortality Rate (IMR) has been quite low in the state. Moreover, there are no changes in the vital indicators such as CBR, CDR, IMR and TFR, particularly since 1996. This is more true for rural areas of the state.

### 3.2 Results of National Family Health Surveys

The National Family Health Surveys (NFHSs) conducted in 1993 and 1998-99 provide state and national level data on fertility, family planning, reproductive and child health and other aspects of family health. Important results on fertility and family planning for both the surveys are presented in Tables 10 and 11.

Table 10 reports that fertility continued to decline both in Gujarat and in India. The total fertility rate declined from 2.99 to 2.72 in the state, between 1993 and 1998-99. The CBR also declined from 27.2 to 24.2 during the same period. However, the decline was much lower in the state compared to what has been experienced at the country level. Age specific fertility rate is another good measure of fertility. The age specific fertility in the state follow the expected pattern with fertility highly concentrated in the 20-29 age groups and a decline thereafter. Similar pattern has been observed for the country as a whole. However, the average fertility rates of the major fertile age groups i.e. 20-34 years are higher in the state compared to the all-India averages. The pattern is similar for both rural and urban areas.

Table 11 shows an increase in contraceptive prevalence by the currently married women in the state. Fifty nine per cent of women age 15-49 are using contraception in 1998-99 is higher by about 20 per cent than 49.3 per cent use at the time of NFHS-1. Although female sterilization continues to dominate contraceptive use, the share of spacing methods has improved, particularly of IUD and condoms. The increase has been significant in the use of traditional methods by currently married women. It increased from 2.4 per cent to 5.6 per cent between two surveys. However, the effectiveness of temporary and traditional methods in controlling birth rates needs more empirical studies.

The NFHS estimates are also available on unwanted fertility rates for Gujarat state. These are 0.66 and 0.64 children in 1993 and 1998-99 respectively. It indicates little change in the unwanted fertility rate between two surveys.

It is evident from Table 12 that despite an increase in contraceptive use, about 9 per cent of women's need for contraception remained unmet, and the unmet need is more for spacing methods. It is quite encouraging to note that meeting of unmet need has increased in the state, over the years.

### **3.3 Performance of Mother and Child Health Program**

A perusal of Table 13 indicates that there has been a considerable improvement in the vaccination coverage of children aged 12-23 months. Coverage of BCG, DPT, Polio and Measles was higher in 1998-99 (NFHS-2 compared to 1993 (NFHS-1) situation. As a result, percentage of children given all required doses of six preventable diseases increased from 50 to 53 per cent. Between 1993 and 1998-99, percentage of children not getting even any immunization declined from 18.9 per cent to 6.6 per cent. The decline was reported to be higher in rural areas.

The NFHS data also show a substantial improvement in the ante-natal care and pregnancy services in Gujarat, in recent years. Pregnant women who received two or more doses of TT and women supplied with Iron and Folic Acid tablets increased between 1993 and 1998-99. Institutional deliveries also show an increase from 35.6 to 46.4 per cent between 1993 and 1998-99. The data also reflect a quality change in delivery services as percentage of deliveries attended by doctor and other health workers reported increase over time.

The analysis of MCH service statistics reported by the Department of Health and Family Welfare (Table 14) also shows progressive improvement in the immunization coverage of children in the state. This is more so since 1997-98. The data show more than fifty per cent immunization coverage of children aged 12-23 months and it is increasing over years. But the effective vaccination coverage of children against the six childhood diseases is still rather low in Gujarat compared to the objective set for 1990 to cover at least 85 per cent of all infants. Moreover, a large gap of about 12 and 15 per cent existing in the first and the third dose of DPT and polio respectively is a matter of concern. It is also clear from Table 14 that drop-out rates for DPT and Polio are higher in rural areas than in urban areas.

### **3.4 PHC and SC Level Situation**

In the health and family welfare sector PHC and SC are the basic facility centres operating in rural areas for providing family planning and basic curative and preventive health services. At the PHC level Medical Officer (MO) is responsible for both health and family planning. He is assisted by two field supervisors (one male and one female), paramedical staff and other support staff.

Each PHC operates as a referral and control unit for six to eight sub-centres. All of the PHCs should have facilities including a four to six-bed in-patient ward, basic laboratory services, and a theater for sterilization operations. However, out of the four PHCs we visited, only one had the above facilities, others were providing only out-patient services. Medical officer was found posted at each PHC, but only three were present at the time of our visit. One proceeded on long leave for which no replacement was done. It was learnt from the district officers that about 30-40 per cent MOs serving in Gujarat PHCs were from outside state (22 out of 38 in Bhavnagar district) and very high turn over was reported of outsiders.

Supervisory staff at PHC level was also found inadequate for reasons such as many posts lying vacant and staff remaining out for training. Positions of male supervisors and Block Extension Educators (BEEs) were reported vacant at many PHCs. Out of the 4 PHCs we visited, only one had BEE and 2 had male supervisors in position. It was also told by the available supervisory staff that they find little time for field visits as they remain busy for most of time in meetings, training and attending other programs of the department. They also devote large part of their time on preparing various progress reports.

Sub-centre (SC) is the basic grassroots level health facility. A SC is meant for 5000 population in normal areas and 3000 population in tribal areas. Each SC is supposed to be staffed by one Female Health Worker (FHW) and one Male Multipurpose Worker (MPW). Although FHW was found posted at each sub-centre, a significant number of male workers' posts was currently vacant as the replacement rate of male workers after retirement was very poor in Gujarat state. For example, only 15 MPWs were in position in 37 SCs of 4 PHCs. The work progress of each SC worker is reviewed at PHC, every month in sector meeting, generally held in the third week of the month.

### **3.5 Access and Availability of SC Health Workers**

We visited 20 SCs in four PHCs. Basic information collected through interviews of the FHWs is presented in Tables 15 and 16. The following are the important observations.



1. Significant variations exist across SCs in terms of number of villages, population and eligible couples to be served. Average population served by several SCs in Valsad district, which is predominantly tribal, is higher than the mandated population figure of 3000 per SC for a tribal area.
2. Each sub-centre has a female health worker but the number of male workers is quite low compared to its mandatory ratio of one in each SC. As a result, male workers in many SCs have to cover larger population and sometimes their work area extends to more than one SC.
3. All FHWs seem to have good work experience. All of them are in service for more than ten years and most of them are posted in the present SCs for more than ten years.
4. Although SC buildings are provided at many places yet more than fifty per cent (11 out of 20) of the FHWs do not stay in the SC villages. They are living in nearby towns and commuting.
5. Considerable differences in the workload as well as achievements across SCs are also seen. The average number of eligible couples reported by the FHWs were found to be much less than what it should have been of about 160 to 170 per 1000 population as per the census norms. The discrepancies indicate towards the fact that EC registers are not updated regularly in many SCs.

### **3.6 Facilities at the Sub-Centre**

The basic requirement for the SC to provide good quality care adequately to the mandated population is the facilities for accommodations and the SC building in which services are provided. During our visits, we were told by the MOs that at many places, the location of the SC was reported to be a major problem. In one of the PHCs we visited in Bhavnagar, 4 out of 6 sub-centre buildings were located at the periphery of the village, and two of them had reported a menace of anti-social elements. Such SCs were neither convenient for the public to get most of the health services, nor were safe for the worker to stay. Moreover, female health workers find it difficult to work in remote areas as they do not feel secure moving alone.

Information was also collected about the technical quality of care provided at the SC level as well as the knowledge, procedures and clinical practices followed by the health worker, while providing family planning and RCH services. As mentioned

earlier, our investigator spent at least one day with FHW at each SC and observed her activity schedule. It was found that almost all FHWs had considerable knowledge about modern contraceptive methods, their side effects and all necessary services required to be delivered to the pregnant and lactating mothers. They also attend deliveries. Most of them also know about the maximum gestation period by the time one can go for safe abortion. However, many of them did not know to measure blood pressure and do blood/urine tests, which they are supposed to do. Most of the FHWs reported that they used gloves while inserting IUDs and conducting deliveries.

Supply of contraceptives and other necessary MCH service materials was not a problem, told by MOs at PHC level. At majority of SCs, we also found sufficient quantities of vitamin A solution, condoms, IUDs and packets of Oral Pills. However, the stock registers were not found updated at many places.

The important problems reported by majority of the FHWs include inadequacy of logistical support for pre-and post sterilization transfer of women as surgical facilities are available at very limited number of PHCs. Moreover, the number of trained Medical Officers, posted at PHCs, for conducting MTP and sterilization operation is also limited. Out of four MOs of selected PHCs only two had training in conducting sterilization and MTPs, and only one PHC, out of four had facilities of operation theatre. During discussions with district level officials, it was learnt that very few MOs were willing to undergo training and take responsibility for conducting sterilization. A doctor is paid Rs. 10 only for each sterilization operation which was fixed in 70s. Moreover, increasing awareness among consumers led to more complaints about failure cases. All these are the constraining factors.

### **3.7 Decentralized Planning**

In the new approach preparation of sub-centre action plan is the first step in the process of decentralized planning. It provides a basis for determining the service requirements of the population of the area. According to the Community Needs Assessment Approach (CNAA) formerly known as target free approach, at each sub-centre level, a female health worker is expected to do the following in chronological order:

1. Conducting a household survey to complete necessary information about all women of age 15-49 with number of children of 0-5 years by sex;
2. Based on this, initiate a consultation process with women for limiting the family and other health care requirements of the community. It would be useful if the health worker (FHW/ANM) develops a list of questions with which she could initiate interaction;
3. Comparison of community needs assessed by her with figures of earlier years and validate with general estimates based on demographic trends such as number of pregnancies, births etc. (GOI, 1998).

The above procedure will help her to identify unmet needs of the community both for family planning and mother and child health care services. We sought opinion of the health workers on following the above procedure. Almost every one said that they conduct a household survey every year in the month of March through house visits and prepare a survey register which contain information on all women about their name, age and number of surviving children by sex. On the basis of this two tables are prepared and submitted to the PHC. One contains information of family planning acceptors and non-acceptors by age of wife and another by number of children. These two tables and the past performance of the worker become the basis for determining the sub-centre level workload, which is decided at the PHC. Thus, although the workload is determined on the basis of information supplied from the sub-centre, practically, no sub-centre action plan is prepared in the CNAA prescribed format (Form No. 1). It was, however, told by the workers that based on the basic household level information, unmet need for family planning is assessed and suitable method is suggested. For example, a couple with two or more children is suggested to accept sterilization while newly married couples and women with one child are advised to use temporary methods.

From our observations and qualitative information gathered from women, it was recognized that women with two or more children and those currently pregnant form likely target for persuasion for accepting female sterilization. It was told by FHWs that pregnancies are now registered early and pregnant women are frequently visited. In this process, all necessary ANC and PNC services are provided to such women and their children. Thus, a partial segmentation approach is adopted in motivating likely acceptors of family planning. However, no one reported that a list of questions was prepared in advance to initiate interaction with the community. Virtually, little attention

is given by the worker to identify felt needs for the spacing methods. Of course, supply of contraceptives is not a problem, and health worker is always ready to cater to the supplies but very little efforts are being done to pursue hard the couples who are eligible for using spacing methods. The IUDs are inserted but their retention rate was reported to be quite low for method specific problems.

Thus, workloads are now determined at the PHC level and given to the sub-centre health workers. Although a segmentation approach is adopted in providing family planning service but still women with two or more children form the major target group for family planning and female sterilization is the main focus of the program. Even male workers are not contributing much in motivating males to accept either terminal or temporary methods to a significant extent.

### **3.8 Record Keeping**

As we said earlier conducting annual survey and updating of eligible couple register is basic for adopting a segmented approach. However, eligible couple registers were found complete or updated only at 6 out of 20 sub-centres. At two sub-centres such registers were not readily traceable; and at few other places the basic information was found recorded on loose sheets. No one knew when it was updated last. Moreover, none of the FHW was in a position to tell us clearly, how much family planning work remained to be done in her area.

Significant variations that exist across sub-centres in terms of number of eligible couples is a pointer to the fact that the information contained in the eligible couple register has not been properly updated. However, wherever couple registers were there, a mark "TL" with red ink was found to be given to those couples who have accepted sterilization, but no proper records were available in the register about the contraceptive use history of users of temporary methods. From the available information it was difficult to know when one started using IUD or other spacing method and when and why one discontinued using. Often it becomes difficult for the worker herself to trace out who are the current regular users of spacing methods. The EC registers are hardly checked by the supervisory staff. The observed contraceptive use pattern was mostly restricted to female sterilization only. This indirectly substantiates the fact that there is an absence of method choice.

### **3.9 Identification of Unmet Needs**

The success of the new approach depends largely on understanding the needs and satisfying the unmet needs of people by providing appropriate and quality services. This is only possible if most of unprotected couples are covered by sustained pre-and post acceptance contact and counseling leading to increase in the contraceptive prevalence rate. With increase in the health worker's visits to the households and households visiting the PHCs, there has been increased awareness among the people about the use of family planning methods. The NFHS surveys of both 1993 as well as 1998-99 reveal that knowledge of terminal methods is nearly universal in Gujarat but of spacing method is less. Percentages of women acceptors of any contraceptive method and women coming for pregnancy termination have increased. A change in the perception of the society about the value of children was also noted during our survey. Even in tribal areas of Valsad, many people told us that they cannot afford more children because cost of bringing up children has increased due to inflation. Improved child survival rate also induce them for change in their attitude and consequent lower fertility. But still large number of couples accepts family planning when the size of the family either becomes complete or unmanageable.

During discussions with the workers as well as with supervisory staff, it was learnt that under the present socio-cultural set up, it is very difficult for the worker to assess the actual needs of the community. According to some program managers, the major problem is that people are not willing to reveal their real needs. Moreover, people's choice for different family planning methods may be influenced by the socio-economic characteristics of the clients. One of the FHWs working in the predominantly tribal area asked us "Sir, do you think that the illiterate tribal (especially women) are in a position to reveal their contraceptive needs? They are poor and live mostly in one room houses with little privacy." She further elaborated that their socio-economic conditions are the major constraining factors for using any spacing method. She believes that for most of the tribal and poor population, female sterilization is the most suitable method. It is a one time adoption, hence, avoids all unnecessary hassles of regular supplies and side effects.

### **3.10 Provision of Mother and Child Health Care**

The field level health workers also reported early registration of pregnancies, now due

to house to house visits and larger immunization coverage of children due to adoption of campaign approach such as Intensive Pulse Polio Program. Before introduction of the CNA, maternal care was largely restricted to provision of tetanus toxoid injections to pregnant women and supply of iron and folic acid tablets. Since implementation of CNA and safe motherhood program, more attention is given on providing the necessary ante-natal, natal and post-natal services. As mentioned earlier, almost all the female health workers reported increase in their workload after introduction of the TFA or CNA. The targets are worked out at the PHC, and sub-centre worker has to report monthly progress of both FP and MCH in the prescribed CNA format (Form No. 6).

Under the CNA Approach, health workers frequently visit pregnant women. Women who visit health centre clinic are benefited with the services like measurement of weight, blood pressure, hemoglobin tests etc. Women are also advised to eat more vegetables and take nutritious diet during pregnancy. Information collected from three PHCs on various MCH services (Table 17) show significant coverage of women and children by the health workers.

### **3.11 Other Reproductive Health Services**

In the RCH program, emphasis is placed on safe abortion and identification of reproductive tract infections and provision of services to treat such infections. However, such services are available only at limited number of PHCs. Number of doctors trained for this is quite insufficient. At sub-centre level facilities for diagnosis and treatment of RTIs and STDs are almost absent, nor the health workers are properly trained to provide these services. Very few workers reported identification of such cases and referred them to PHC or First Referred Unit (FRU).

Initiatives have already been taken by the state government to improve quality and range of RCH services. RCH societies have been registered in both the districts but appointments of specialists who are to be hired on contractual basis are yet to be filled-in. There are also vacancies of staff nurses to be posted at FRUs. Although decentralization of monetary powers under the RCH program has increased the degrees of freedom to work for PHC level doctors, the availability of services of specialists and supportive services is quite inadequate at many places. It was noted that considerable amount of the funds allotted to RCH activities remained unutilized. For example, in Bhavnagar district, yearly grant of Rs. 5,40,000 meant for the year 1999-2000 was found unspent till December 2000.

#### **4 Health Workers' Perceptions about Target Free Approach**

Both the district as well as PHC staff was supportive of the target free approach. According to them the new approach focuses more on improvement of quality of the family welfare program. It was also told by them that grassroots level health workers have welcomed such a change in the policy.

We visited 20 sub-centres and each female health worker was interviewed. Besides, conducting a situation analysis, the following questions were asked to each one of them.

1. What do they understand about Target Free Approach or Community Needs Assessment Approach?
2. Who decides workload and how?
3. Is target pressure still there?
4. How sub-centre action plan is prepared?
5. Has record keeping improved after TFA?
6. Has there been any change in their work style?
7. Has quality of work improved?

It was more like a qualitative interview. The following responses were recorded.

A few of the workers said that there is no difference between the new and the old program. Previously they had targets but now they have workload. However, all of them agreed to the fact that family planning targets are not given from the above but are decided at the PHC level. The number of eligible couples and their children now form the basis for determining sub-centre workload. They also pointed out that the target free approach has made their work much easier. They feel less pressurized now. In the new approach they give more attention to mother and child services. Earlier they were concentrating more on recruiting only sterilization cases, now they have to cover entire population; hence, overall workload has increased. The following

quote reflects some of the perceptions of the workers:

"Target free approach is need based".

"Unlike previously there is no competition from non-health staff. We work independently and with less pressure".

"No difference between new and old. Targets are there in the form of workload. Workload is decided at the PHC".

"In earlier program (with the target approach) we were to concentrate on sterilization cases only. Now we work for entire population. Hence, overall workload has increased".

"In order to achieve sterilization targets, earlier duplicate and outside area cases were included, now, we can concentrate more on sub-centre area. Earlier more time and energy was wasted in chasing the cases, now people on their own come to us."

"New approach is better. We feel less pressurized. In the reporting and in review at sector meeting MCH activities get priority over FP.

Narrating the history of the family planning program one worker said: "Previously there were targets to follow, then came the target free approach and very recently we have been given a copy of CNAA manual. Thus, frequent changes in policy create confusion among workers. However, on the whole, the CNAA approach is better. In this approach, although our workload has increased we find a satisfaction to serve the community."

Thus, three things come out clearly from the above statements: (1) on the whole, the new approach is better than the old one; (2) the worker now feel less pressure of meeting family planning targets; and (3) there is an overall increase in the workload on the workers because they have to provide now more services besides focusing only on sterilization.

It was also reported by health workers that there is no pressure on them of achieving family planning targets (workload). But most of them said that the workload set for temporary methods is not realistic. Although workload of temporary methods is calculated on the basis of the age and parity status of the eligible couples, it is not necessary that it is the reflection of their real needs. Several social and cultural



factors constraint regular use of spacing methods such as condoms, oral pills etc. This was also corroborated by a few MOs at PHCs that the reliability of reported achievement levels of temporary methods was doubtful. We cannot rely on their effectiveness with more confidence as we do for sterilizations and to some extent on IUDs.

#### **4.1 Women's Perspective on Quality of RCH Services**

Women of reproductive age groups were consulted to understand users perspectives and needs. They were consulted in small groups through Focus Group Discussions (FGDs). The discussions were organized within the broad quality of care framework developed by Bruce (1990). The focus was on service coverage, quality of care and client satisfaction. The following insights were obtained.

##### **4.2.1 Service Coverage**

The issue of access to and availability of health facilities has already been discussed earlier. Qualitative interviews of women, however, suggested that outreach services of the grassroots level workers had increased, though the access is limited for remote and dispersed population. Majority of women reported increase in the frequency of visits by the health workers. They said:

"The number of field workers and their frequency of visits have increased during recent past. The campaign approach has enabled the workers to come frequently in the contact of the clients".

Women visiting PHCs and sub-centre clinic admitted that they receive adequate health care at every stage of before, during and after childbirth. The health workers are easily accessible and provide necessary services. Supply of contraceptives and other child health care material is not a problem.

#### 4.2.2 Quality of Care and Client Satisfaction

The quality of care received by women at PHC level was reported to be adequate. Pregnant women informed that they were examined properly, given iron and folic acid tablets and advised to visit again. Most of the women reported that their children received most of the vaccines. They also said that immunization cards have been given to both mothers and children. However, they asked for more medicines to be given by the health workers. Women on their own come forward for MCH services. Some of them said:

"We go to the Nurseben for immunization. The Nurseben also visit us regularly".

Regarding family planning, majority of women expressed their approval and preference for female sterilization. Interestingly, all past acceptors of female sterilization expressed their satisfaction with the method, particularly with the follow-up services. But most of them expressed their desire to go for operation after two children, preferably one son and one daughter. About spacing method they said:

"Spacing methods are not convenient to use. IUD causes bleeding and backache. Oral pills do not suit. Supply of spacing methods is not a problem but sterilization is more convenient and safe. Therefore, we decided to go for sterilization. The health workers visit us regularly, supply vitamin tablets, insert IUD and also advice us to accept family planning methods."

However, their opinion about the knowledge and information on possible side effects of temporary methods was found divided. A few said that the workers tell us about the possible side effects of IUD and Oral Pills, but many made complaints that they knew about the problems of IUD only after they used it. Few women also wanted to know more about traditional methods of family planning.

On an average, women's responses were quite positive. Follow-up services in the case of past acceptors of sterilization were quite satisfactory. Also in majority cases, complaints of temporary methods especially IUD were attended. The health workers talk nicely and are generally socially acceptable. However, one thing clearly comes out of this qualitative enquiry is that access and quality of RCH services is relatively better at PHC and at those sub-centres where the health worker stays in the village.

## **5 Conclusion**

The Target Free Approach (TFA) was introduced in the state on full scale in the year 1996-97. Less than five years have passed since its introduction and it is only two years since the launching of the community Needs Assessment Approach (CNAA, a revised form of TFA). Hence it is relatively short time to study its impact. However, our review suggests that with the initial fall in the service statistics, the program shows a recovery since 1998-99. So far as implementation process is concerned, our field observations validate that most of the important first steps have been taken in making a paradigm shift. For example, the process of sensitizing the grassroots level workers has been completed since the introduction of CNAA and decentralization of planning process is now underway. District officials and health workers of PHC and SC levels have understood the philosophy of the new approach and conceded that the new approach is no more a top down program with target driven approach but responds to people's needs and quality of care. According to them client satisfaction is the main concern of the new approach. But targets are still set at PHC level by health workers and their supervisors, and information supplied by the sub-centre level health workers forms the basis for determining workload.

Although action plan is not prepared at the sub-centre level, the health worker adopts client segmentation approach based on the number of surviving children for motivating the couples for contraceptive use. Now, most of the workers know the importance of quality services including need for follow-up and reaching to lower parity couples. But, still the major emphasis is on female sterilization and use of spacing methods is very limited. The performance of maternal and child health care has also improved considerably after the introduction of the TFA. Almost all grassroots level workers welcomed the change in the policy. Now, they feel less pressure of achieving family planning targets, however, all of them confirmed that their workload has increased after the implementation of the TFA. Earlier they were to chase only target women, now they have to cover sub-centre population with a range of RCH services. A complete change in the reporting and review procedure was also expressed by most of the health workers. In the new monitoring system, priority is given to RCH activities both in reporting as well as in review. In the sector

meetings, review starts with the MCH activities. Family planning program gets back seat. Overall, reporting of both MCH and FP activities have improved. The monthly progress reports are prepared and sent in time.

Although Gujarat has made considerable progress recently in the area of maternal and childcare but no significant improvements have been recorded in the family planning sector. Not even after introduction of the TFA/CNAA. Hence, more intensive efforts are required to achieve the goal set in the Gujarat's Population Policy, 2000 of reducing the total fertility rate from its current level of 3.2 to replacement level of 2.1 by the year 2010.

If the policy change is assessed well beyond targets (i.e. removal of method specific targets alone) and examined in the broader context of reproductive and child health program, several positive changes have occurred in the implementation of the new approach. Overall, the program is moving in the right direction. It is in the second gear now and ready to gradually increase its speed. However, proper orientation and training of health workers has always been a major issue. More efforts are needed to improve motivational and counseling skills of grassroots level health workers. Strengthening health care infrastructure and support systems to improve access to quality services is equally important. Immediate attention is needed to improve the range and quality of RCH services. The objective must be to achieve the demographic goal by increasing access to quality services.

**Table 1: Important Demographic Data of Gujarat and India**

	<b>Gujarat</b>	<b>India</b>
Population, 2001 (in million)	50.6	1027.0
Density of population 1 sq.km.	258	324
Sex ratio total population (females for 1000 males)	921	933
Sex ratio , 0-6 population	878	927
Per cent urban, 1991	34.5	26.1
Per cent Scheduled Castes	7.4	16.7
Per cent Scheduled Tribes	14.9	8.0
Decadal population growth rate (1991-2001)	22.5	31.3
Literacy rate, 2001		
Total	70.0	65.4
Male	80.5	75.9
Female	58.6	54.2
Crude birth rate, 1998 (per 1000 population)	25.3	26.4
Crude death rate, 1998 (per 1000 population)	7.8	9.0
Life expectancy at birth (years) 1996-2001		
Male	61.5	62.4
Female	62.8	63.4
Infant mortality rate, 1998	64	72

Source: Government of Gujarat (2001) Basic Health Statistics, Gujarat 2000-2001.

**Table 2: Gujarat State: Performance of Contraceptive Use**

Year	No.	Percent Change	
		Over previous year	Over 1995-96
<b>Sterilization</b>			
1995-1996	280054 (100.2)	-	-
1996-1997	242949 (83.8)	-13.2	-13.2
1997-1998	242364 (86.1)	-0.2	-13.5
1998-1999	250379 (82.1)	+3.2	-10.6
1999-2000	260273 (82.2)	+3.8	-7.1
<b>Intra-Uterus Device (IUD)</b>			
1995-1996	452077 (98.3)	-	-
1996-1997	409248 (85.3)	-9.5	-9.5
1997-1998	401736 (84.6)	-1.8	-11.1
1998-1999	413198 (87.5)	+2.8	-8.6
1999-2000	414350 (86.4)	+0.3	-8.3
<b>Condom (CC)</b>			
1995-1996	1105274 (NA)	-	-
1996-1997	1016191	-8.1	-8.1
1997-1998	(101.6)	-18.9	-25.5
1998-1999	823923 (92.1)	+8.0	-19.5
1999-2000	889945 (89.0)	-0.7	-20.1
	883242 (86.7)		
<b>Oral Pill (OP)</b>			
1995-1996	172985	-	-
1996-1997	(104.8)	-7.4	-7.4
1997-1998	160116 (97.0)	+1.1	-6.4
1998-1999	161910 (82.2)	+6.8	-0.0
1999-2000	172983 (86.5)	+2.4	+2.4
	177124 (83.2)		

Note: Figures in brackets are per cent achievements of targets  
 NA Targets not given

Source: Government of Gujarat (2000) and (2001), Basic Health Statistics, Gujarat.

**Table 3: Performance Change in Contraceptive Use in 1999-2000 Over 1995-96**

	Per cent Change	Districts
<b>Sterilization</b>		
Increase	< 10%	Surendranagar (3.5), Bhavnagar (0.8), Valsad (6.7)
	10% >	Banaskantha (17.4), Sabarkantha (22.0), Dangs (33.9)
Decrease	< 10%	Jamnagar (8.5), Rajkot (8.7), Amreli (7.8), Kheda (1.4), Vadodara (7.4), Bharuch (3.1)
	10% >	Junagadh (12.3), Kachchh (15.2), Mehsana (10.1), Gandhinagar (18.8), Ahmedabad (32.1), Panchmahals (19.8)
<b>IUD</b>		
Increase	< 10%	Sabarkantha (4.2), Mahesana (6.3), Panchmahals (5.4), Bharuch (2.7), Valsad (7.8)
	10% >	Banaskantha (15.7), Dangs (22.2)
Decrease	< 10%	Rajkot (6.0), Surendranagar (1.4), Amreli (1.3), Gandhinagar (3.0), Kheda (1.6), Surat (8.9)
	10% >	Jamnagar (12.1), Bhavnagar (11.8), Junagadh (23.0), Kachchh (33.2), Ahmedabad (18.4), Vadodara (42.6)
<b>Condom</b>		
Increase	< 10%	Gandhinagar (9.9)
	10% >	Kachchh (20.2)
Decrease	< 10%	Rajkot (5.7), Bharuch (2.3), Dangs (8.2)
	10% >	Jamnagar (34.0), Surendranagar (24.9), Bhavnagar (21.3), Amreli (13.2), Junagadh (26.6), Banaskantha (26.2), Sabarkantha (12.3), Mahesana (18.4), Ahmedabad (10.1), Kheda (28.5), Panchmahals (45.9), Vadodara (34.0), Surat (19.7), Valsad (16.5)
<b>Oral Pills</b>		
Increase	< 10%	Surendranagar (4.8), Banaskantha (1.3), Surat (5.2)
	10% >	Rajkot (19.6), Amreli (17.1), Kachchh (27.6), Sabarkantha (16.9), Mahesana (25.7), Gandhinagar (11.8), Panchmahals (17.5), Bharuch (16.6), Dangs (151.7)
Decrease	< 10%	Bhavnagar (2.5), Vadodara (5.9), Valsad (8.5)
	10% >	Jamnagar (14.1), Junagadh (12.1), Ahmedabad (12.7), Kheda (21.0)

Source: Government of Gujarat, State Bureau of Health Intelligence, Commissionerate of Health, Medical Services and Medical Education, Gandhinagar

**Table 4: Couples Effectively Protected and Crude Birth Rate, Gujarat**

Year	Estimated no. of eligible couples (in `000)	Percent couples effectively protected	Couple Effectively Protected Due to				Crude birth rate	IMR
			Steri- lisation	IUD	CC+ OP	Total		
1991	6929	61.5	68.0	19.2	12.8	100.0	27.5	69
1992	7060	60.6	69.1	19.1	11.9	100.0	28.1	67
1993	7223	56.8	68.5	20.2	11.3	100.0	28.0	58
1994	7470	58.2	66.2	18.0	15.8	100.0	27.1	64
1995	7611	61.0	63.6	19.3	17.1	100.0	26.7	62
1996	7750	59.5	64.9	19.1	16.0	100.0	25.7	62
1997	7801	59.5	64.4	21.2	14.4	100.0	25.6	62
1998	7922	57.2	66.0	21.6	12.4	100.0	25.3	64
1999	7980	57.4	65.1	21.4	13.5	100.0	-	63
2000	8098	56.6	65.2	21.4	13.4	100.0	-	-

Source: Same as in Table 3



**Table 5: Monthly Performance of Sterilization in Gujarat State (in Per Cent)**

<b>Months</b>	<b>1991-92</b>	<b>1992-93</b>	<b>1993-94</b>	<b>1994-95</b>	<b>1995-96</b>	<b>1996-97</b>	<b>1997-98</b>	<b>1998-99</b>	<b>1999-2000</b>
April	3.0	2.4	1.7	2.2	2.2	2.7	2.3	2.2	2.2
May	3.6	3.3	2.8	3.0	3.1	3.6	3.3	2.8	3.3
June	4.0	4.2	3.8	3.5	3.9	4.1	3.8	3.7	4.9
July	5.2	4.8	4.6	3.7	5.3	4.5	4.4	4.9	5.3
August	4.9	4.1	5.1	5.0	4.5	4.7	4.7	5.3	6.0
September	6.7	6.4	8.1	5.8	7.4	5.6	5.9	6.3	6.7
October	5.9	5.0	7.2	5.2	5.4	6.1	5.2	3.9	5.9
November	9.0	9.7	7.0	9.4	10.1	6.5	7.7	9.9	6.5
December	14.3	13.2	17.1	19.3	16.0	15.7	9.8	14.5	17.0
January	15.5	15.5	16.7	14.6	16.1	16.8	20.1	16.9	17.9
February	13.2	12.6	12.3	12.2	12.2	14.4	16.4	16.2	12.9
March	14.7	18.8	13.6	16.1	13.8	15.3	16.4	13.4	11.4
Total	100.0 (252338)	100.0 (257378)	100.0 (287568)	100.0 (300874 )	100.0 (280077)	100.0 (242949)	100.0 242394)	100.0 (250379)	100.0 (260223)

Source: Same as in Table 3

**Table 6: Gujarat State: Family Planning Method Use by Age of Wife**

(Figures in Percent)

Age of wife (Years)	Sterilization					IUD				
	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000
15-19	0.1	0.2	0.1	0.2	0.2	4.0	3.0	2.6	1.7	5.0
20-24	16.3	18.0	21.3	22.6	19.7	39.2	43.6	39.3	36.8	38.7
25-29	41.5	42.7	44.3	41.8	44.2	31.5	34.1	35.7	34.9	34.6
30-34	28.9	26.4	23.6	23.9	25.6	17.0	12.9	16.4	19.1	15.3
35-39	11.4	11.8	10.0	10.7	9.9	6.6	4.8	5.1	6.7	5.9
40-44	1.8	0.9	0.7	0.8	0.4	1.7	1.6	0.9	0.8	0.5
Total	100.0 (280)	100.0 (243)	100.0 (242)	100.0 (250)	100.0 (260)	100.0 (452)	100.0 (409)	100.0 (402)	100.0 (413)	100.0 (414)

Source: Same as in Table 3

**Table 7: Gujarat State: Family Planning Method Use by Number of Children**

(Figures in Percent)

No. of Children	Sterilization					IUD				
	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000
0	-	-	-	-	-	2.8	0.4	1.3	0.2	0.4
1	1.2	0.8	1.4	3.1	1.6	39.7	42.5	40.7	38.7	37.2
2	33.7	32.1	33.5	36.8	37.1	32.3	33.9	34.3	35.4	35.0
3	36.4	38.0	40.1	38.4	36.5	16.3	15.4	16.1	16.6	18.2
4	19.1	20.0	17.1	15.0	17.4	6.3	5.8	5.9	6.6	6.9
5	9.6	9.1	7.9	6.7	7.4	2.6	2.0	1.7	2.5	2.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Same as in Table 3.

**Table 8: Death Rate per 10,000 Sterilization Operations, Gujarat State**

<b>Year</b>	<b>No. of Sterilization Operations</b>	<b>No. of Deaths</b>	<b>Rate per 10,000</b>
1976-77	317123	70	2.20
1980-81	200594	40	1.99
1983-84	235853	36	1.53
1985-86	333423	54	1.62
1988-89	241079	29	1.20
1989-90	237255	17	0.72
1990-91	240520	22	0.91
1991-92	257335	20	0.77
1992-93	257378	17	0.66
1993-94	287568	20	0.69
1994-95	301298	15	0.50
1995-96	280054	10	0.36
1996-97	203512	5	0.24
1997-98	241000	10	0.42
1998-99	250000	4	0.20

Source: Personal Communication with Professor Dileep Mavalankar of IIM, Ahmedabad.

**Table 9: Vital Statistics of Gujarat State and All-India**

Indicators	Gujarat State			All India		
	Rural	Urban	Total	Rural	Urban	Total
<b>Crude Birth Rate</b>						
1981	36.1	29.8	34.5	35.6	37.0	33.9
1991	28.2	25.9	27.9	30.9	24.3	29.5
1996	26.9	23.0	25.7	29.3	21.6	27.5
1997	27.0	22.6	25.6	28.9	21.5	27.2
1998	26.9	21.9	25.3	28.0	21.0	26.4
1999	27.0	22.0	25.4	27.6	20.8	26.1
<b>Crude Death Rate</b>						
1981	12.4	10.7	12.0	13.7	7.8	12.5
1991	8.8	7.9	8.5	10.6	7.1	9.8
1996	8.2	6.2	7.6	9.7	6.5	8.9
1997	8.3	6.2	7.6	9.6	6.5	8.9
1998	8.5	6.3	7.8	9.7	6.6	9.0
1999	8.8	5.9	7.9	9.4	6.3	8.7
<b>Total Fertility Rate</b>						
1981	4.6	3.4	4.5	4.8	3.3	4.5
1991	3.2	2.9	3.1	3.9	2.7	3.6
1996	3.2	2.6	3.0	3.7	2.4	3.4
1998	3.0	2.3	2.7	3.1	2.3	2.8
<b>Infant Mortality Rate</b>						
1981	123	89	116	119	62	110
1991	73	57	69	87	53	80
1996	68	46	62	78	46	72
1997	69	46	62	77	45	71
1998	71	46	64	77	45	72
1999	70	45	63	75	44	70

Source: Same as in Table 2

**Table 10: Age-Specific Fertility Rate**

Age group	Gujarat State			All India		
	NFHS-1	NFHS-2	% decline	NFHS-1	NFHS-2	% decline
15-19	0.086	0.087	+1.2	0.116	0.107	7.7
20-24	0.251	0.230	8.4	0.231	0.210	9.1
25-29	0.157	0.148	5.7	0.170	0.143	15.9
30-34	0.074	0.052	29.7	0.097	0.069	28.9
35-39	0.021	0.018	14.3	0.044	0.028	36.4
40-44	0.005	0.005	-	0.015	0.008	46.7
45-49	0.004	0.003	25.0	0.005	0.003	40.0
TFR	2.99	2.72	9.0	3.39	2.85	15.9
CBR	27.2	24.2	11.0	28.0	24.8	11.4

Note: NFHS-1 = National Family Health Survey, 1993  
 NFHS-2= National Family Health Survey, 1998-99

Source: National Family Health Survey, Reports 1993 and 1998-99 for Gujarat State

**Table 11: Percent of Currently Married and Currently Using Contraceptive Methods, Gujarat State**

	NFHS - 1			NFHS - 2			
	Urban	Rural	Total	Urban	Rural	Total	% increase
Any method	52.7	47.5	49.3	61.8	57.0	59.0	19.7
Any modern method	49.0	45.7	46.9	53.3	53.3	53.3	13.6
Pill	1.7	0.7	1.0	2.2	1.0	1.5	50.0
IUD	5.5	1.7	3.0	5.1	1.6	3.1	3.3
Condom	3.7	0.8	1.8	6.4	1.3	3.5	94.4
Female sterilization	34.8	38.9	37.5	37.6	47.0	43.0	14.7
Male sterilization	3.3	3.7	3.5	2.0	2.4	2.3	-34.3
Any traditional method	2.7	1.7	2.4	8.3	3.6	5.6	133.3
Rhythm/safe period	2.8	1.1	1.7	6.8	3.2	4.8	182.3
Withdrawal	0.9	0.6	0.7	1.4	0.4	0.8	14.3
Other method	-	-	-	0.2	0.0	0.1	-
Not using any method	47.3	52.5	50.7	38.2	43.0	41.0	-19.1

Notes & Source: Same as in Table 10

**Table 12: Gujarat State: Unmet Need for Family Planning**

	NFHS – 1			NFHS-2
	Urban	Rural	Total	Total
<b>Unmet Need for FP</b>				
To space	7.1	8.0	7.6	4.8
To limit	6.0	5.2	5.5	3.7
Total	13.0	13.2	13.1	8.5
<b>Not Need Current Using</b>				
To space	4.0	1.8	2.6	4.9
To limit	48.7	45.7	46.7	54.2
Total	52.7	47.5	49.3	59.0
<b>Total Demand for FP</b>				
To space	11.1	9.8	10.2	9.7
To limit	54.6	50.9	52.2	57.8
Total	65.7	60.6	62.4	67.5
Percent of need satisfied	80.2	78.3	79.0	87.4

Notes & Source: Same as in Table 10

**Table 13: Percentage of Children Aged 12-23 Months who Received Immunization and Mothers Assisted at the time of Delivery in Gujarat State**

MCH Service	NFHS-1 (1993)			NFHS-2 (1998-99)		
	Rural	Urban	Total	Rural	Urban	Total
<b>Immunization</b>						
B.C.G	74.2	82.9	77.1	83.9	86.0	84.7
Polio-1	74.8	83.5	77.8	89.3	90.4	89.7
Polio-2	66.9	79.7	71.2	80.2	85.3	82.0
Polio-3	59.2	70.3	62.9	59.7	68.3	62.7
D.P.T-1	74.8	83.5	77.8	81.9	85.3	83.1
D.P.T-2	67.2	79.7	71.4	72.9	80.1	75.4
D.P.T-3	60.5	70.3	63.8	59.3	72.7	64.1
Measles	53.2	61.4	55.9	61.4	67.5	63.6
All vaccines	46.2	57.0	49.8	44.9	54.3	53.0
No vaccines	21.0	14.6	18.9	6.2	7.4	6.6
<b>ANC and Delivery Service</b>						
Received two or more doses of TT	64.9	81.1	69.9	66.8	83.0	72.7
Received iron & folic acid tablets	65.5	77.8	69.3	75.0	83.2	78.0
Percent institutional deliveries	23.7	62.2	35.6	33.2	69.4	46.4
Deliveries assisted by:						
a. Doctor	19.7	48.4	28.6	26.7	56.2	37.4
b. Other health workers	13.1	17.9	14.5	15.1	18.0	16.1
c. Trained birth attendant	52.7	27.6	44.9	52.9	24.2	42.4
d. Others	14.5	6.1	12.0	5.3	1.6	4.1

Notes & Source: Same as in Table 10.

**Table 14: Progress of Mother and Child Health Services in Gujarat**

(Figure in thousands)

<b>MCH Services</b>	<b>1995-1996</b>	<b>1996-1997</b>	<b>1997-1998</b>	<b>1998-1999</b>	<b>1999-2000</b>	<b>Percent change in 1999-00 over 1995-96</b>
T.T. (Mother)	1247	1228	1248	1251	1309	5.0
D.P.T	1190	1169	1172	1202	1217	2.3
Polio	1217	1176	1179	1218	1223	0.5
B.C.G	1214	1193	1209	1214	1224	0.8
Measels	1100	1113	1108	1115	1180	7.3
I.F.A (Mother)	-	1143	1146	852	1397	22.2
Vitamin A - 1st dose	1052	957	951	877	1033	-1.8
Vitamin A - 2nd dose	823	735	771	736	819	-0.5
D.P.T. Booster	-	830	841	890	918	10.6
Polio Booster	-	907	873	916	923	1.8
Delivery registered	1120	1113	1147	1131	1179	5.3
Institutional deliveries (% to total)	-	411 (36.9)	463 (40.4)	495 (43.8)	550 (46.5)	33.8
Domicile deliveries	-	702	684	636	629	-4.0
Percent domicile deliveries attended by:						
a. Health workers	-	34.4	32.3	33.6	34.2	-
b. Trained dais	-	51.8	52.5	57.2	56.9	-
c. Untrained dais	-	13.8	15.2	9.2	8.9	-

Source: Same as in Table 3



**Table 15: Basic Information about Sub-Centres**

	Valsad District		Bhavnagar District	
	PHC-1	PHC-2	PHC-1	PHC-2
<b>No. of SCs Visited</b>	5	5	5	5
<b>Average no. per SC</b>				
Villages	1.6	1.4	1.6	2.4
Population	3993	3234	4066	4133
No. of eligible couples	416	380	444	479
No. of health workers				
a. Male	0.75	0.25	0.67	0.33
b. Female	1.00	1.00	1.00	1.00
<b>Details of FHWs</b>				
Age	38.8	41.2	38.0	36.0
No. of years in service	16.8	17.4	12.4	11.8
No. of years with posting in same SC	12.4	11.6	7.2	11.4
Sub-centre building available	3	4	4	4
How many stay in the SC village	2	2	2	3

Source: Field Survey

**Table 16: Sub-Centrewise Population, Eligible Couples, and Workload and Achievements for the Year 1999-2000**

	Coverge		Eligible Couples		Workload				Achievements in %			
	Vill- age	Popu- lation	Repo- rted	Expec- ted as per census norm	Steri- liza- tion	IUD	OP	CC	Steri- lization	IUD	OP	CC
<b>Valsad District</b>												
<b>PHC-1</b>												
SC 1	1	3745	344	618	21	19	16	58	90.5	100.0	106.2	100.0
2	1	5250	374	866	25	20	16	75	96.0	35.0	100.0	100.0
3	3	4009	473	661	20	19	14	60	125.0	15.8	107.1	101.7
4	2	2826	262	466	15	8	10	40	120.0	75.0	0.0	162.5
5	1	4137	629	682	21	10	20	65	80.0	60.0	100.0	107.7
<b>PHC-2</b>												
SC 1	2	4277	259	706	17	17	14	56	94.1	100.0	107.1	64.3
2	1	2583	369	426	18	15	12	56	111.1	66.7	100.0	100.0
3	2	2669	266	440	16	16	14	57	187.5	112.5	92.8	78.9
4	1	2710	515	447	18	18	12	60	88.9	116.7	100.0	100.0
5	1	3938	491	650	16	18	14	40	131.2	116.7	85.7	120.0
<b>Bhavnagar District</b>												
<b>PHC-1</b>												
SC 1	2	6185	517	1020	21	42	12	50	119.0	102.4	100.0	100.0
2	1	2307	345	381	22	28	10	45	100.0	146.4	120.0	122.2
3	2	2658	376	422	24	40	12	50	125.0	102.5	100.0	100.0
4	1	6778	447	1118	24	40	12	40	70.8	102.5	100.0	100.0
5	2	2500	537	412	21	42	10	50	152.4	102.4	100.0	100.0
<b>PHC-2</b>												
SC 1	2	3570	610	589	20	38	10	20	110.0	94.2	100.0	100.0
2	2	4782	356	789	15	32	10	20	333.7	68.7	100.0	100.0
3	2	4057	580	669	22	40	10	20	150.0	82.5	100.0	100.0
4	3	3408	506	562	22	16	10	20	159.0	181.2	100.0	100.0
5	3	4846	342	800	22	28	10	20	90.0	107.1	100.0	50.0

Source: Field Survey

**Table 17: Achievements of Different MCH Programmes in Selected PHCs**

(Figures in Per cent)

Program	PHCs		
	Dhamni	Dungri	Bhandaria
ANC	104.7	110.3	104.0
TT Mother	96.7	100.4	104.6
Delivery	96.5	78.2	101.0
PNC	96.5	78.2	101.0
Infant	105.3	109.2	119.2
Pre school	91.7	97.9	102.5
B.C.G.	103.5	111.4	111.4
D.P.T.	99.8	110.8	108.3
Polio	99.8	110.8	108.1
Messels	96.3	115.0	103.4
D.P.T. polio	72.6	-	104.0
D.T	68.3	102.4	92.5
Vit. A	96.3	198.1	105.1
IFA 60 mg. (Mother)	162.7	112.1	123.8
IFA 20 mg.(Child)	-	154.4	107.4
TT 10+	16.2	87.1	100.8
TT 16+	20.2	77.8	100.5

Source: Field Survey

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