REPRODUCTIVE HEALTH IN POLICY & PRACTICE

INDIA

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PRB


CHINA
PAKISTAN
TIBET
NEPAL
BHUTAN
Rajasthan
BANGLADESH
INDIA
MYANMAR
(BURMA)
Bay
of
Bengal
Arabian
Sea
Tamil
Nadu
SRI
LANKA

Summary

India was the first country in the developing world to initiate a state-sponsored family planning program, more than 45 years ago, to lower the country's population growth rate. From the early 1960s, centrally determined targets for contraceptive acceptance dominated the management of the program. The government's zeal to achieve these targets met with increasing criticism over the years. Just a few years after the 1994 International Conference on Population and Development (ICPD), a major national policy shift occurred: The "Target-Free Approach," announced in 1996, eliminated national targets for contraceptive acceptance. Instead, the new approach called for planning at the community level, where grassroots workers would set targets for themselves after assessing the needs of individual clients.

The study examines issues such as the way in which the workload of the public-sector health workers is determined, whether the program has become more responsive to the needs of clients, and whether the range and quality of services has improved.

Factors that enabled policy change

Several factors contributed to India's "paradigm shift." In the early 1990s, government planners recognized that the family planning program had stagnated. There was a clear inconsistency between the slow decline in the birth rate and the reported rise in the number of family planning acceptors in various states across the country, indicating that over-reporting of acceptors was common. At the same time, the excessive concern with fulfilling numerical targets was accompanied by a lack of concern for quality and an absence of motivation to provide basic health services. Women's groups and other NGOs repeatedly raised concerns about the narrow range of services offered and lack of concern for clients' needs. Some donor agencies shared these concerns and sponsored research and seminars to bring women's health needs to light. The ICPD provided these groups with an opportunity to pursue their agenda with government officials at national seminars. The evidence generated from the process provided the impetus to revamp the program.

Implementation of the new approach in two states

The case study examines the process of implementation of the government's new approach in the state of Rajasthan, in the northern part of the country, and in Tamil Nadu, in the south. Although they have different economic and social characteristics (Tamil Nadu is the more advanced of the two), both governments are committed to implementing the new approach to family planning. The study examines issues such as the way in which the workload of the public-sector health workers is determined, whether the program has become more responsive to the needs of clients, and whether the range and quality of services has improved.

The family planning workload (or targets for contraceptive methods) of the grassroots-level workers in both states is decided on the basis of the number of living children of the couples living in their area of work. The workers have to motivate or encourage the couples to accept the method that is

supposed to be best suited for them. With minor variations, both states follow a "client segmentation" approach to determine their targets. As a general rule, workers encourage couples with two or more children to accept sterilization and those with fewer children to accept temporary (or reversible) contraceptive methods. While the health workers still have to report their performance in quantitative terms to higher authorities, they say that they are not reprimanded for not meeting the targets, as they were in the past. Interviews and focus group discussions indicate that clients in both states perceive that the pressure to accept sterilization has lessened, and that health workers inform and encourage couples to accept reversible family planning methods.

Annual service statistics show that in the year following the introduction of the target-free approach (1996-97), the number of family planning users declined in the country as a whole—possibly because the pressure to distort the statistics had disappeared. However, during 1997-98, use of all methods increased, thereby allaying the fears of many skeptics that contraceptive use would decline in a target-free environment.

Other reproductive health services

In Tamil Nadu, immunization services, prenatal check ups, health-worker visits to villages, and mothers' meetings to discuss wide-ranging issues have all increased significantly in the last seven or eight years, even prior to the ICPD. The workers in Tamil Nadu enjoy a better status as health care providers than they did as family planning providers. In Rajasthan, improvements have also begun, but at a slower pace than in Tamil Nadu.

At the same time, abortion services, which are legal in India, and facilities for the treatment of reproductive tract infections are yet to be initiated in public health facilities in both states, or in the whole country. Safe abortion services are unavailable in public health centers, as they require trained medical doctors who are usually not available in small towns and rural areas. Consequently, most women seeking an abortion go to private practitioners who charge high fees. Similarly, very few public health centers offer screening or treatment for reproductive tract infections (such as sexually transmitted diseases). If a woman complains of possible symptoms, nurses can only advise women to go to a private practitioner.

Program funding and future prospects

With respect to resource flows for the family planning program, the study focused on actual government expenditures during the 1990s. The data show that, after adjusting for population growth and inflation, the program has not mobilized a much larger volume of public resources since the ICPD. However, the recently negotiated assistance from the World Bank for the reproductive health program will provide new funds for improving the range and quality of services throughout the country.

While the role of the central government in development planning is beginning to diminish, the state governments are likely to continue to make strong efforts to strengthen social services. It is likely that health and family welfare will, along with education, receive a high priority in this process. In the years ahead, the health sector is expected to provide a wide range of reproductive health services, taking into account the needs of the community and concerns about quality. However, additional progress will require significant efforts to strengthen infrastructure, retrain the workforce, and muster financial resources.

Introduction

The primary objective of this study is to review whether and how central elements of the 1994 ICPD Programme of Action are being translated into action in India. Such an assessment less than four years after the Cairo conference is in one sense premature, particularly for a federal democratic country with almost one-sixth of the world's population, and where the national family planning program has been operating since 1952. It is not easy to quickly revamp an extensive infrastructure that has been built up to provide maternal care, child health, and family planning services.

There are few things that India has not tried during the past 45 years to alter the childbearing behavior of its people or to raise their standard of living. Yet there is widespread disappointment both within and outside India about its presumed potential and actual efforts regarding population policy and improving the living conditions of its people. On the other hand, many observers have been impressed and have given India high marks for attempting a major shift in the orientation of its family planning program since the Cairo conference. Whether or not the Cairo conference directly influenced the policy shift is open to debate. Nevertheless, it is useful to review the process leading to the policy change.

The study reviews policy developments at the all-India or central government level, where shifts in policy are most clearly articulated. However, policy implementation is difficult to assess in a country with 16 major states with populations of 10 million or more each and another 16 states, or "union territories," with a population ranging between 52,000 and 7 million each. We have, therefore, focused our study on one northern state (Rajasthan) and one southern state (Tamil Nadu). The two states have different demographic characteristics, but they have a combined population of about 114 million.

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The diversity and conditions in the two states are outlined in Appendix 1. In two districts in each of the two states, we interviewed the state-level decision-makers and district-level officers in charge of the family planning program. These discussions were supplemented by visits to two primary health center (PHC) sites in each district. We conducted focus group discussions (FGDs) and in-depth interviews with service delivery personnel and clients or potential users of the services in two subcenter villages within each PHC area. In all, the research team visited four districts and eight PHCs and conducted 22 FGDs and 21 in-depth interviews. Appendix 2 provides detail on the data collection efforts and explains the differences between the FGDs conducted in the two states as well as the criteria adopted for the selection of the two districts in each of the two states. On the whole, this study relied on qualitative data collected in the two selected states, but it is grounded in the authors' broad familiarity with the situation.

Background

India was the first country in the developing world to initiate a state-sponsored family planning program—more than four decades ago in 1952—to lower its birth and population growth rates. During 1956-58, empirical studies and economic arguments highlighted the potential benefits of a reduction in fertility, or average births per woman. Experts agree that lower fertility would contribute to a decline in the number of children needing support, higher savings rates, capital formation, and acceleration in the growth rate of per capita income.[1] During the past 28 years, the birth rate has decreased throughout the country, albeit at varying paces in different regions. In the country as a whole, the birth rate has declined from about 40 per 1,000 population in the 1960s to 28 per 1,000 population in 1995-96. On the other hand, the population has continued to grow at or around 2 percent annually since the 1960s because of the decline in the death rate, and thus the population has more than doubled from 439 million in 1961 to an estimated 930 million in 1996. It could be well over 1.5 billion before it eventually stabilizes sometime between 2056 and 2061.

Since the mid-1960s, the government has made attempts to integrate the Indian family planning program with other programs such as the Minimum Needs Program (MNP), Maternal and Child Health (MCH), and Child Survival and Safe Motherhood (CSSM) programs. The MNP, initiated in the early 1970s, sought to link family welfare and primary health care with efforts to alleviate poverty in the country. The MCH program received a boost after the Parliament adopted the National Health Policy in 1983. As a part of the overall strategy to reduce infant and child mortality, the Universal Immunization Program was launched in 1985-86 to control vaccine-preventable diseases. The CSSM, begun in 1992, aimed to accelerate the decline in infant and child mortality and decrease maternal mortality. Around the same time, the government initiated an effort—through the Social Safety Net program—to pay special attention to 80 districts where the 1981 census data had indicated relatively high levels of fertility. Despite these welcome efforts to integrate family planning with health, as demonstrated by the re-designation of the program as the "family welfare program," the demographically driven goals of reducing the birth rate and the population growth rate continued to dominate the program's monitoring and assessment.

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In fact, the national goal of achieving a birth rate of 25 per 1,000 was translated into targets for the number of users (or acceptors) of different contraceptive methods to be enrolled in different states, districts, and even villages and towns of the country. The central government set the state-level targets, and the states in turn allocated them down to the grassroots functionaries such as female health workers. The pursuit of targets largely overlooked the concern for client choice and the provision of a wide range of services to suit the needs and preferences of the people.

Impetus to Reorient the Family Planning Program

In the late 1970s and early 1980s, there was public backlash against the pressures of the emergency era (1975–77) to promote vasectomies and female sterilizations. At that time, program managers recognized the need to reorient the family planning program in favor of reversible contraceptive methods. Yet despite the substantial increase in the reported number of users of reversible methods in several states of the country, the birth rate did not seem to decline. This led to a rethinking about both the data on the acceptors of different contraceptive methods and gradually on the demographically driven goals themselves. There was a mounting concern about the quality of the services provided, which evolved into a commitment to providing more comprehensive reproductive and child health services. The shift in emphasis was marked by the abolition, in April 1996, of method-specific family planning targets throughout the country.[2]

Several factors, such as a recognition of a slow decline in the birth rate in most of the states in the country, a lack of motivation at all levels in the delivery of family planning services, concerns raised by the women's groups and other nongovernmental organizations (NGOs) about narrow range of services offered, and the climate created by the ICPD, were all to a greater or lesser extent responsible for bringing about the shift in India's approach to family planning programs. In addition, after the 1991 Census results, the Indian government set up two independent commissions to review the population situation and advise on policy changes. The first committee was headed by Mr. Karunakaran, the chief minister of Kerala state. The second was an expert group chaired by Dr. Swaminathan, a former deputy chairman of India's Planning Commission. The Indian government may not have officially acknowledged all of their recommendations, but some found their way into the documents on the reoriented family planning program.

Recognition of stagnation in the program

The government of India realized as early as 1992 that the family planning program had stagnated. In fact, the Eighth Five-Year Plan (1992–97) document prepared in 1992 had candidly listed several aspects of both planning and implementation of the program that contributed to its limited impact on the population growth rate. The family planning program, conceived as an independent program of the Ministry of Health and Family Welfare (MOHFW), suffered because of centralized planning and target setting from the top, which permitted little innovation or flexibility.

Although the ministry emphasized integrating MCH with family planning services, very few maternal health services were actually available to women, apart from providing immunizations to children and pregnant mothers. The monitoring of the program had been reduced to a routine, target-reporting exercise, making it impossible to identify service delivery problems and to take corrective action. The responsibility for achieving the method-specific contraceptive targets set by the central government was passed to successive lower administrative units such as states, districts, PHCs, subcenters, and their functionaries. Failure to achieve the targets led to reprimands from supervisors, threats of withdrawal of annual salary increases, or job transfers to undesirable posts. Consequently, providers often over-reported the use of reversible contraceptives or pressured couples to accept sterilization. In short, the program, as implemented, had become insensitive to the needs of the people and discouraged community involvement.

The Eighth Plan document also admitted that both initial and on-the-job training of the service providers was poor. The information, education,

and communication (IEC) activities portrayed the problem of population growth as a national issue, instead of explaining to individuals how family limitation would improve their own economic and social status. The Plan also suggested that the program had meager resources for new initiatives and for strengthening health care services. This awareness and candid expression of the limitations of the program in 1992 cleared the way for a major shift in the approach of the family planning program.

At the same time, empirical research provided evidence that the statistics collected to measure the performance of the family planning program had produced a distorted picture. Some area-specific studies revealed inconsistencies between observed fertility levels and the contraceptive use rates derived from service statistics as well as discrepancies between survey-based contraceptive prevalence rates and the official couple protection rates.[3] Partly as a result of such distortions and exaggerations in the reported performance, the birth-rate targets remained elusive throughout the 1970s and the 1980s.

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Environment for women's advancement

The ICPD recommendations for women's empowerment in 1994 also coincided with a social and political environment in India that favored an improvement in the status of Indian women. Excess female mortality—an anomalous feature of the Indian demographic scene—has been on the decline, and female life expectancy has begun to exceed that of men, both in rural and urban India. As shown in Appendix 1, the female disadvantage in life expectancy up to the end of the 1970s has reversed, and according to the latest estimates for 1989-93, life expectancy was 59.7 years for women and 59 years for men.[4]

The 1991 Census gave an impression of an increase in the deficit of women in the country, and there is a widespread concern about female feticide as well as outright female infanticide. The former problem led the Indian parliament to enact the Prenatal Diagnostic Technique (Regulation and Prevention of Misuse) Act, 1994, which went into force on January 1, 1996. However, as has been observed in many parts of the world, implementation of such legislation is not an easy task in a country with the rural population widely scattered in nearly 600,000 villages. Even in urban centers, where rural women usually have abortions, it is difficult to ensure the cooperation of doctors, technicians, and the people seeking their services.

At the same time, female literacy rates have risen. According to a national survey of 73,000 households conducted during 1995-96 in urban India, almost 67 percent of the women ages 15 and older were literate; the corresponding rate for rural women was only 32 percent, and the national average was almost 41 percent. These rates were markedly higher than those reported at the time of the 1991 Census (60 percent, 25 percent, and 34 percent, respectively).

In addition, recent decentralization efforts under the 73rd and the 74th Constitution Amendment Acts (passed in 1992) have reserved one-third of all seats for women in district-level governing bodies (*Panchayats*). A similar effort to reserve one-third of seats for women in the national Parliament has not succeeded so far, but it is only a matter of time before the various political parties agree to it. In the short run, these progressive measures may appear more symbolic than real in improving the status of

women. They have the potential to gradually alter community life in dispersed rural settings and in households. The current changes are accompanied by a growing concern about various crimes against women. Quite likely, the crimes have not increased, but the awareness and publicity surrounding them have increased. Several NGOs have become active in recent years in fighting discrimination against women, and the National Commission for Women, set up by the government, supports their efforts.

Concerns voiced by women's groups

Several nongovernmental women's groups in India have objected to the approach of the government-sponsored family planning program, and either distanced themselves from the program or opposed it. Many groups saw the government's approach of vigorously promoting contraception while nearly ignoring quality of care as a violation of human rights or a lack of respect for women.[5] Some groups also protested the clinical trials of hormonal contraceptives, claiming that proper ethical procedures were not adhered to. For the most part, these protests or views received little attention from the official quarters, although they received some publicity in the media.

There was little or no positive dialogue between the government and NGOs in the 1970s and early 1980s. However, during the latter half of the 1980s, the government recognized and publicly acknowledged the constraints in state-administered social sector programs. The MOHFW, for example, saw a role for the voluntary sector in the delivery of family planning services. Many voluntary groups who received government funding and implemented the government program adopted a client-centered approach with a strong concern for quality.

During 1992-94, in a process largely funded by the donor community and in response to an expressed need, several individuals from the women's groups, advocates of primary health care, demographers, and family planning service providers met in state-level meetings in India to discuss the draft Programme of Action of the Cairo conference. Although some used the platform to attack the establishment and to ventilate strong anti-family planning views, the process brought diverse groups together and demonstrated the need to network, dialogue, and iron out internal differences for a common larger goal.

There was a consensus that ethical considerations, proper procedures, and high-quality care cannot be compromised in a zealous pursuit of demographic goals. The process also identified four key concerns: the need for efficient program management, ensuring quality of care, widening the scope to reproductive health, and using the media to disseminate information.[6] National-level meetings on the first three themes were held during 1994, before the Cairo conference, to evolve specific action points. However, the government has yet to fully acknowledge the wider role that voluntary sector can play in monitoring, reviewing, and evaluating social service activities in general and health and family planning services in particular.

Impetus from ICPD and the donor community

For some time before the Cairo conference, the donor community had tried to understand the reproductive health needs of Indian women, to assess the quality of services provided, and to bring about changes in the focus of the family planning program. The ICPD in 1994 and the Women's Conference in 1995 gave them an excellent opportunity to pursue their agenda. The donors, especially the United Nations Population Fund (UNFPA) and the Ford Foundation, supported Indian NGOs' initiatives for dialogue on women's health needs and the elements of women-sensitive population programs. Some of the donor agencies also supported field-based research on women's health and quality of health care. Researchers and donor agencies discussed the findings in workshops and seminars where government officials were also invited to participate. The evidence generated provided the impetus to revamp the program.

Changes Introduced in the Family Welfare Program Since 1995

Target-free approach

Soon after the Cairo conference, at a meeting of state secretaries of Health and Family Welfare in April 1995, the secretary to the Department of Family Welfare proposed that one or two districts from each of the major states could become target-free on an experimental basis. The state secretaries selected the districts to be freed from method-specific targets in consultation with the officials from the center; in most states the better performing districts were selected. The announcement was sudden. However, a year later, in April 1996, the government made an even bolder decision—that the entire nation would become target-free. Again, some felt that this decision was made without adequately discussing the strategies that would replace the old system, and without assessing the experience of the districts that had been made target-free in 1995.

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The target-free approach of 1996 meant that the centrally determined targets, assigned since the mid-1960s, were no longer to "be the driving force behind the program." Instead, community demand for quality services was to be the driving force of the program.[7] The new approach envisaged decentralized planning at the level of PHC, where grassroots workers would set targets for themselves after assessing the needs of the clients.

The ministry gave the program managers a manual to orient them on decentralized planning at the level of the PHCs. During the first year, there was a great deal of skepticism and confusion about the target-free approach. Some skeptics felt that workers would interpret target-free as responsibility-free, allowing them to relax their performance; or that target-free meant they could ignore family planning; or that the new approach would reverse all gains made thus far on the population control (i.e., sterilization) front. Questions remained: If no targets were to be imposed, how would worker performance be evaluated? What would happen if family planning performance declined, as it likely would?

As a result of these concerns, during 1996-97, many states imposed targets, using the previous year's centrally assigned targets as a base. The only change was that the target-setting exercise emanated from the state or the district level rather than the central level. In the next section, beginning on page 12, we will examine in some detail the extent and manner in which the target-free approach is now being implemented in the states of Rajasthan and Tamil Nadu.

Shift to reproductive and child health

The Indian government's bold policy step of removing family planning targets was followed by a widening of the program's scope to include the services of a gynecologist at some of the district or subdistrict hospitals designated as First Referral Units (FRUs). The village-level health workers are expected to direct the patients needing detailed examination and health care to the *taluka*, or district-level hospitals. This objective is challenging because of the scarcity of trained gynecologists willing to work in *taluka* towns and because of the lack of anesthetists and blood transfusion facilities.

Nevertheless, some effort has been made to implement the idea through the externally aided Reproductive and Child Health (RCH) project, which was formally launched during October 1997 and funded by the World Bank. There are also plans to contract with private sector gynecologists who will visit designated PHCs on specified days.

The RCH project envisages changes not only at the policy level but also in the management and implementation of the program. Besides the removal of targets, other policy changes relate to: (a) encouraging the states to remove in phases the incentive payments to both providers and acceptors of certain family planning methods; (b) shifting financial priorities from further build-up of infrastructure to increased sustainability and use of existing facilities; and (c) expanding access by encouraging the use of NGOs and the private sector to fill gaps in public sector services.

Program-level changes include (a) district-level planning and monitoring that is more responsive to local needs; (b) improved quality of care and increased client focus; (c) expanded community involvement and responsibility for the female health workers through the decentralized system of government (*Panchayati Raj*); and (d) the improved referral system for health care seekers. At the service delivery level, the changes include revitalization of the existing network of rural health facilities through better supplies of drugs and equipment, training, and better information and counseling for clients and communities.[8]

Some efforts, such as IEC training and program monitoring, are nationwide, whereas others are introduced only in selected districts. Within the districts, the interventions will be introduced in a phased manner based on the existing institutional capacity and reproductive health needs of the population in the blocks, or subdistrict units. This approach is expected to allow each district to gain experience in a limited number of blocks, track local experience, and identify causes of failure or implementation bottlenecks, prior to expansion on a larger scale. In addition, focused interventions are planned in 24 districts or cities identified as having weak social indicators, in order to increase access to health care for particularly disadvantaged groups such as scheduled castes, tribes, and the urban poor.

> While the details of the Reproductive and Child Health project document can be debated and discussed, it does address several issues that have been neglected in India's family welfare program.

Besides addressing the issues of quality and informed choice, the RCH project provides (a) a vehicle for continued policy dialogue; (b) continuing evaluation and reviews; and (c) significant flexibility for implementing recommendations of the evaluations and reviews through annual and state-specific modifications to implementation plans. While the details of the RCH project document can be debated and discussed, it does address several issues that have been neglected in India's family welfare program.

Since RCH has been launched only very recently, it is too early to assess the impact of any of the activities initiated under the program. However, while examining the implementation of RCH in the states of Rajasthan and Tamil Nadu, we have considered not only the actual changes but also the processes that introduce changes in the program.

Implementation of New Approaches in Rajasthan and Tamil Nadu

In order to assess the impact of the paradigm shift reported above, we have tried to understand the changes that have occurred or been initiated in the states of Rajasthan and Tamil Nadu. We selected Rajasthan for the analysis because it is a large, North Indian state, with a strong tradition of feudal leadership and historically high fertility. Recently, an enlightened state leadership has been trying to initiate legislation to influence the reproductive behavior of the people.

Tamil Nadu, in contrast, has historically been more progressive. The social reform movement in Tamil Nadu has reportedly supported women's advancement and limitation of births, but the effectiveness of these efforts is often doubted. The state government has nevertheless taken the lead in abandoning targets for family planning acceptors, and our study aimed to determine whether government workers had changed their approach since the ICPD. Our focus has been on two major changes—the target-free approach and the introduction of RCH—in the family welfare program since the Cairo conference.

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Implementation of the target-free approach

While the target-free approach has marked a welcome first step in India's shift to a comprehensive reproductive and child health program, changes to date appear unclear. In order to understand how the target-free approach works on the ground, we discussed with various personnel during FGDs and in-depth interviews (a) how the workload of the health workers is decided; (b) how the records are maintained; (c) what activities are emphasized during the review meetings at all levels; (d) the perceptions of the health workers about the shift in focus; and (e) changes that clients have noticed in the quality and range of services offered to them.

We have also examined the information on annual acceptors of various methods of family planning beginning with the years 1991-92, compiled by the MOHFW for all India and by the Directorates of Family Welfare for the states of Rajasthan and Tamil Nadu. The annual statistics are presented in the graphs on p.13 and Appendix 3. After the target-free approach was introduced in the entire country in 1996, the absolute number of acceptors of all family planning methods (except oral pills) in the country as a whole declined during 1996-97. The decline was most evident in the reported number of users of condoms and to a lesser extent in the new acceptors of IUDs, presumably because the pressure to distort the statistics had disappeared. However, during 1997-98, the acceptance of all methods improved, thereby allaying the fears of many skeptics that contraceptive prevalence would decline in the target-free climate.

Interestingly enough, there was no decline in the number of acceptors in Rajasthan, where the removal of targets made little difference in the steady increase in the annual acceptors of all family planning methods. This and other positive observations about the political will and bureaucratic commitment have led some to remark that Rajasthan state will be the first

to break from the group of four large, North Indian states with poor development indicators.

In the state of Tamil Nadu, even though couples are reportedly highly motivated to accept family planning after two or three children, the number of acceptors of all methods of family planning declined between 1995 and 1997. However, it is too early to assess the performance of the program; the evidence presented in Appendix 3 for the period between 1991 and 1998 does not suggest any dramatic decline in performance in the last three years compared to the previous three years. While reported contraceptive use has declined, a similar decline was observed in earlier years as well, and the recent statistics may reflect the fact that exaggerated reporting has diminished or ceased.

Shift in focus of program

The experience of some states and districts suggests that the focus of the family planning program is indeed undergoing change. In Tamil Nadu, program implementers are making efforts to provide more comprehensive health care to couples. This is evident in the fact that during the past seven to eight years, immunization services, prenatal check-ups, health worker visits to villages, and the mothers' meetings have all increased significantly. Mothers' meetings are held to discuss issues ranging from benefits of balanced diet during pregnancy to the advantages and disadvantages of various methods of family planning.

As a respondent noted during an in-depth interview: "There has been a tremendous change. Earlier, people used to be scared of using contraceptives, but now the nurse informs and explains to us in detail about them during the mothers' meetings, so people are no longer scared to use them. Earlier even the government neglected this aspect and did not care about explaining the methods."

On the other hand, indirect evidence about seasonal variations in Rajasthan reveals a lack of any major shift in the approach. Discussions with health workers and other officials in the PHCs suggest that

Figure 1

Contraceptive use in India, 1991-98

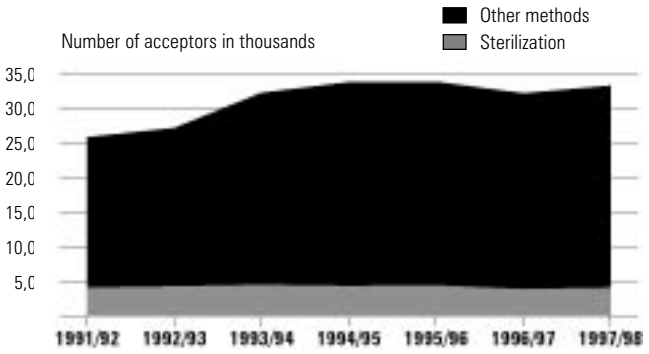


Figure 2

Contraceptive use in Rajasthan, 1991-98

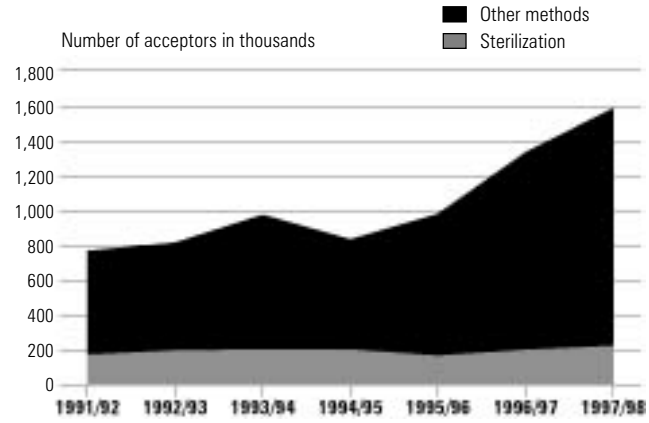
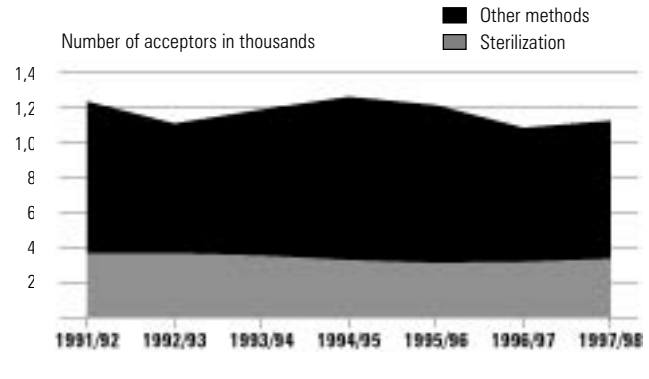


Figure 3

Contraceptive use in Tamil Nadu, 1991-98



the last quarter of 1996-97 (January to March) accounted for a much larger number of sterilization acceptors than other quarters. It is unclear whether this seasonal increase reflects the needs of the workers to fulfill annual targets, or the fact that women are freer from agricultural work at that time or prefer the winter months to get sterilized.

Moreover, the program has yet to address other women's health needs, such as reproductive illness or gynecological problems. Health workers in both Rajasthan and Tamil Nadu reported that some women do seek help or treatment for problems of excessive bleeding during menstruation or white discharge (leucorrhoea), but the health workers send the women to government hospitals. Some auxiliary nurse-midwives (ANM) give iron and folic acid tablets to these women, although these are unlikely to cure infections.

The demand for and use of abortion services seemed high in both states. However, abortion services are available only at district hospitals in Rajasthan. In Tamil Nadu, some of the upgraded PHCs do provide abortion services, but women needing these services continue to depend on the private sector, where the cost tends to be high and dependent on the duration of pregnancy.

Basis for deciding the workload of grassroots health workers

During our discussions, it was evident that in both the states, the family planning targets are not prescribed from the center but are determined at the local level, with the help of an improved version of the former Eligible Couples Register. As an ANM from Rajasthan district said during a FGD, "First we survey the village to prepare the survey register with all the information about the women, their name, age, number of children, etc. We also find out about their unmet need for family planning. If we find that they already have at least one girl and one boy, then we suggest them to accept operation [sterilization]. To those who have only one small child, we suggest copper-T [an intra-uterine device]."

...in both the states, the family planning targets are not prescribed from the center but are determined at the local level, with the help of an improved version of the former Eligible Couples Register...An ANM from the Dausa district in Rajasthan reported that: "The program is not target-free. The targets are still there except that we set the targets ourselves."

The new manual provided to the grassroots workers is called the Community Needs Assessment Manual. It is expected to help identify the unmet need of the population for family planning as well as to segment couples in terms of the number of surviving children. The annual population survey that the ANMs are required to conduct during the months of April to June is perhaps done more systematically than it was earlier. The information on the number of children born to women in the reproductive ages (or eligible couples), their current contraceptive status, and so forth, is used to determine the needs for supplies of different contraceptives and medicines or drugs. It can be used to monitor the health worker's performance.

This approach is different from the earlier approach in the sense that, instead of giving uniform targets to each worker, the targets are determined on the basis of actual population information. An ANM from the Dausa district in Rajasthan reported that: "The program is not target-free. The targets are still there except that we set the targets ourselves. We set them based on the unmet need of our area."

The information sought during the survey varied considerably between Rajasthan and Tamil Nadu. Since 1996 Rajasthan has adopted a survey format designed by the Indian Institute of Health Management Research (IIHMR) in Jaipur. According to this approach, information is collected on unmet need and other characteristics of women. As one ANM of Dausa district articulated: "During the survey we ask an additional question to the woman who reports that she is not using any method of family planning, whether she wants to have a child. If the answer is no, then we advise the woman to accept a family planning method depending upon the number and sex composition of her existing children." However, in the Dausa district, monitored by the IIHMR, the PHCs collected the information somewhat more systematically than in the other selected district, Bharatpur.

In Tamil Nadu, the village workers did not seem to emphasize the survey. Instead, the district-specific estimate of the current birth rate (based on a 1995 survey) is applied to the population assigned to the village health worker to arrive at the number of births likely to take place in her area. This provides a basis for the number of pregnancies that the health worker would have to register in a year.

While providing services to pregnant mothers, the health worker is expected to inquire about the number of children born and surviving to each woman, determine the method suited for her, and encourage her to accept that method. An ANM from Tamil Nadu said during one of our FGDs, "When we enumerate the eligible couples in our population, we ask a question about the number of living children, and on the basis of that, we advise women with one child to use temporary method and those who have more children to undergo sterilization."

Each state determines the family planning workload of the health workers differently, but both do translate the workload into targets and expect health workers to achieve them. The health workers' own involvement in determining the workload is minimal, and the client segmentation is done on the basis of the number of surviving children.

Record keeping

The target-free manual suggests formats for recording the events or services provided, which are expected to simplify the record-keeping work of the health workers. However, in both the states, most of the health workers seemed to be preoccupied with keeping their records up-to-date and brought up the difficulties that they faced in doing so during the discussions. One ANM in Rajasthan complained that, "There is so much of record-keeping work that we do not get any time for our practical (field) work."

In both Rajasthan and Tamil Nadu, the health workers indicated that the number of registers has increased and there was much duplication in recording the same event in several registers or copying the same information from one register to another. They reported spending several hours each day maintaining and updating the registers, a task that involves asking for help from more educated family members or their supervisors.

Further, they are still not able to appreciate the purpose of or need for collecting all the information they are required to, which (in their opinion) does not help them understand the needs of the clients or plan their own work schedule. Most health workers, therefore, feel that record keeping is a waste of their time. An ANM from Rajasthan said, "During training we were taught about malaria and how to give injections. Now we are expected to do statistical work. If we knew beforehand what this job was all about, perhaps we would not have come for it."

In the Dausa district, in Rajasthan, record keeping is computerized, thanks to the intervention of IIHMR, but the health workers there seem confused and find the task too complex to fully comprehend. We were told that some workers have stopped using the computerized records and have gone back to the old manual system.

The health workers in the Salem and North Arcot districts in Tamil Nadu also complained about the increase in the paperwork, yet reported they

could do the work on their own—perhaps due to their higher level of schooling. All the same, health workers in Tamil Nadu found little time for the statistical work during the weekdays and reported having to do it on weekends and holidays.

Monitoring, supervision, and training

The experiences in Tamil Nadu and Rajasthan also varied in the frequency of contact between the health workers and their superiors, the emphasis on various activities, and the basis of their performance evaluation.

In Tamil Nadu, health workers have weekly meetings with the medical officers at the PHCs, where they report not only on their family planning work, but also on all the other activities such as immunization, pregnancies registered, and prenatal care provided to pregnant women. The health workers in Tamil Nadu meet the medical officers on average six times per month, either at the PHCs or when the doctors come to the field. In Tamil Nadu, family planning acceptance is high, but the government is concerned about relatively high infant mortality and is therefore monitoring infant deaths closely. Consequently, the program emphasizes pregnancy care through prenatal visits and immunization.

In Rajasthan, the meetings between health workers and the medical officers are held once a month, as in the past, and besides sterilization performance the ANMs are asked about spacing methods, especially the IUD. The program still emphasizes family planning performance. However, in the Dausa district, evaluation efforts are monitoring the performance of the workers quite regularly.

Overall, targets continue to be assigned, although now they are determined at the district level or at the level of PHC. Clients' needs are rarely considered. Also, the health workers' involvement in determining the targets is minimal. Yet the workers now feel that they are given "correct" or realistic targets. Also, community-level planning is not yet undertaken, and strategies to involve village-level groups, women's groups and Panchayat representatives are yet to be evolved and implemented. However, discussions with government workers at various levels, as well as observations made during the visits to the subcenters and PHCs, do suggest that attempts are being made to redress several limitations of the old approach. The program is trying to provide a broad range of services and each of the services is viewed as important.

…community-level planning is not yet undertaken, and strategies to involve village-level groups, women's groups and Panchayat representatives are yet to be evolved and implemented.

In Tamil Nadu, for example, training in the new approach has begun for the workers of both the PHCs and the subcenters. The training includes such previously neglected topics as quality of care, informed choice, assessment of community needs, and participatory learning and awareness building. Most of the ANMs in both districts of Tamil Nadu had gone through the train-ing and seemed satisfied with the range of issues that were covered in the six-day training course.

Rajasthan seems to be lagging behind in initiating training for the workers and efforts are underway to organize training there. Program managers have identified an agency to coordinate the training activities and are preparing modules in the local language.

Provision of reproductive health services

There are few replicable models for providing comprehensive reproductive health services. Observers have raised doubts, for example, that the implementation of the RCH approach requires skills and training beyond the present capacity; that

the implied requirement of upgrading facilities and services at the peripheral level is unrealistically high under the current conditions in rural India; and once again, that contraceptive needs will be ignored. Further, some estimates made of the likely costs of expanding services suggest that they will be formidable.[9]

Our FGDs with both health workers and clients about reproductive health services centered around four major components of reproductive health: family planning, maternal or prenatal care, abortion services, and treatment for reproductive tract infections. Understandably, the perceptions of the health workers and the clients differed on certain issues.

Family planning services

We tried to ascertain from both health care providers and potential recipients about the choice or the range of contraceptives available now, as opposed to the past, when method-specific targets were laid down for the workers. In both Rajasthan and Tamil Nadu, the workers indicated that they follow the client segmentation approach and motivate or encourage women who have two or more children to accept sterilization. Women in Rajasthan with one surviving child are encouraged to accept IUDs, oral contraceptive pills, or condoms. If women report that they would not like to use IUDs because of unpleasant experiences with the method, they are offered the choice of oral pills and then condoms. But during one of the FGDs with clients in Rajasthan, we heard some conflicting views.

We believe that when the relationship between the villagers and the ANM is not cordial, both sides accuse each other with statements such as: "There are no contraceptives available in the village—not even with the nurse. She does not tell us anything about spacing methods." And, "We have even heard that the nurse sells the condoms and the pills that she gets for free distribution from the government to a shopkeeper."

In Tamil Nadu, the workers reported that over the past four or five years, they did not have to motivate or coax couples or women to accept family planning. The women come on their own to seek postpartum sterilization. During an FGD with clients in Salem in Tamil Nadu, one woman said: "We make a decision (to get sterilized) ourselves. My husband did not want me to get sterilized. I asked the nurse for her views and suggestions. She advised me to go in for sterilization since I did not want to any more children, and I went in for it."

During the weekly mothers' meetings held in the villages, the health workers reportedly spend a few hours discussing and describing the various methods of contraception that are available through the program, their relative advantages, and shortcomings. Women ask questions to learn more about methods such as rhythm, injectables, and traditional methods that they may have heard of from other sources. Many clients in Tamil Nadu were positive about the services provided by the health workers in their area. "The nurses insert loop, give tablets. They advise us to accept family planning method. They also tell us about the advantage and side effects of each method."

Rajasthan and Tamil Nadu have adopted different approaches to incentive payments, or the compensation program. In 1998, the government modified the program of cash compensation for loss of wages to sterilization and IUD acceptors and gave the states flexibility to apportion the amount among various expenditure items. As a result, Rajasthan has completely withdrawn the cash payment and the provision of free transport and other services to family planning acceptors. The money saved is presumably used to pay for the private doctors who perform sterilizations and provide drugs and dressing materials.

The sterilization acceptors complained about not receiving the cash payment as their elders did a few years ago. At the same time, they said clearly that payment or no payment, they would accept sterilization when they were ready for it. In an FGD held in Rajasthan one woman noted that, "Earlier, the women who got operated upon [sterilized] were given some cash, which

helped them during recuperation. But now nothing is given and the poor women can't take care of their post-operative requirements of more nutritious food or medicines."

Tamil Nadu, on the other hand, has decided to continue the payment of cash compensation to the acceptors of sterilization. They do not, however, offer any "additional" compensation. The rationale for offering the cash incentive is that the amount can be used to buy more nutritious food after the surgery. The state government also continues to provide transport services after the operation, and the officials feel that they cannot abruptly withdraw payments that they have given for so many years. As one of the village health nurses put it: "It is good that the incentive payment is continuing. In fact, it should be increased. Rich people do not need and expect cash payment, but poor people expect money."

Maternal care

On paper, maternal care has long been an integral part of India's family welfare program. Yet, apart from some very minimal services, such as the provision of tetanus toxoid injections to women during pregnancy and the distribution of iron and folic acid tablets, hardly any other maternal services have been available. The health workers in Tamil Nadu reported that the monthly family planning targets did not allow them to concentrate on MCH services, because they were always busy talking to the clients and motivating them to accept family planning. As one said: "But now the pressure is off and we are able to inquire about women's health, their children's health. We are also better accepted in the community. People do not identify us only as family planning workers but consult us about ailments of all family members."

In Tamil Nadu, since the health workers follow the pregnancy-based approach, they report that they are now able to register pregnancies quite early. The women say that they report the pregnancy during the third month to the health worker and inquire about tetanus toxoid injections and iron and folic acid tablets. The health worker checks their nails, hands, and eyes to determine whether they have anemia and starts giving the tablets at the fifth month of pregnancy or even earlier. On average, women report that they contact the health workers six to seven times during their pregnancy. Women also report that the health workers give them dietary advice and ask them to eat leafy vegetables and not reduce their intake of food during pregnancy. Only a few health workers have scales that work and can measure weight gain during pregnancy. Other services for checking blood pressure or hemoglobin are not yet available.

During an FGD in Salem, clients reported a significant change in the quality of services. "Earlier the health workers used to advise us not to feed the baby soon after delivery. They also did not allow us to wash the baby soon after birth. They did not weigh the child. But now they ask us to feed the baby immediately after birth, wash it, and the baby is kept beside the mother. It is also weighed. Now the baby care and mother care is much better than before."

The health workers in Tamil Nadu are aware of the drive to lower infant mortality in the state and that they have to attend to pregnant women and provide all immunizations to the infants. A high degree of concern for lowering maternal deaths is also visible at all levels. The health workers encourage every pregnant woman to deliver her infant in an institution rather than at home.

The situation in Rajasthan is somewhat different. There was an overall feeling among both health workers and clients that the coverage of pregnant women with prenatal services has improved, whereas in the past, the percentage of women receiving tetanus toxoid injections was reportedly low. The workers of the Integrated Child Development Services Scheme (ICDS) are called upon to help the health workers identify the pregnant women in the community. The supply of iron and folic acid tablets has improved and the health workers distribute them

to women, although it is unclear how many women actually take the tablets.

Also, the majority of deliveries in Rajasthan take place at home. Health workers distribute safe delivery kits to pregnant women, although the women gave somewhat conflicting reports about their use. According to some women, the *dais* (birth attendants) are expected to bring the kits when they come to deliver the child, yet they rarely do so.

Abortion services

Although abortion is legal in India, safe abortion services are unavailable in public health facilities in either Rajasthan or Tamil Nadu. This is because the provision of abortion services requires a trained medical doctor. An insufficient number of doctors are trained in these procedures, and they are often not available to work in the small public sector hospitals or health centers located in rural areas or small towns. Consequently, most women desiring an abortion continue to go to private practitioners in district towns. This is clear from a statement during an FGD held in Rajasthan. "There is no facility for abortion in our village. If any woman wants to get abortion done, she has to go to the private hospital in Bharatpur, where they charge Rs. 1000 [approximately US$25] for it. This facility is not available even in the block-level hospital."

Women in Tamil Nadu reported that the charges for private abortion services tend to be quite high and are dependent upon the duration of pregnancy. According to some women, the fees are determined at the rate of Rs. 300 [about US$7.50] for every month of pregnancy. (During 1997, the average monthly expenditure per person in rural Rajasthan and Tamil Nadu was Rs. 452 and Rs. 441, respectively.) However, the public transport network is very good throughout the state of Tamil Nadu and women can easily return the same day after undergoing an abortion in a nearby town. Transport in Rajasthan is more difficult, even if women or couples can afford to pay a private practitioner.

However, in Tamil Nadu, where nearly 40 percent of the doctors in the PHCs are women, some of the PHC doctors provide abortion services at a reasonable cost. We could not verify this report, but the doctors in Tamil Nadu are permitted private practice after their official duty hours. Although they cannot set up private nursing homes, some of them may have set up private clinics at home or might be using the PHC facilities, such as labor rooms or operation theaters, to perform abortions.

A client in Vellore district reported that: "Government doctors perform abortions at their private clinics. Once, when I went to government hospital, the doctor asked me to come to her home. She said that she would not perform the abortion in the government hospital. I, therefore, had to go to her house. She charged me Rs. 300. We cannot afford to spend that much."

Also, according to some women, if a pregnant woman told the health workers that she would like to have an abortion, the health worker would offer to take the pregnant woman to a private doctor, provided the woman accepted some method of family planning. Again, it is difficult to verify such statements and whether they reflect the past, the present, or both.

Services for reproductive tract infections

As indicated earlier, very few public sector institutions in India offer services to treat reproductive tract infections. Our discussions with women and health workers indicated that many women do seek help from health workers and report to them some of their obvious problems, such as white discharge and excessive bleeding. Apart from advising the women to go to the private practitioner in the nearby town, the health workers are unable to do much. As one client stated in Tamil Nadu: "The nurse does not help us with such problems and does not have medicines for them. She just gives medicine to the children."

Resource Flows for the Family Welfare Program

An important issue relevant to the implementation of the Cairo Programme of Action is the extent to which governments have committed additional resources for the promotion of reproductive health. Admittedly, the objectives of the RCH program and the goal of improving service quality can be partly achieved through reorientation and retraining of the program personnel or gains in productivity and effectiveness of the staff. However, the scale of reorientation required in response to the Cairo agenda is large enough to require an increase in the resource flows to those seeking to deliver the much broader range of high-quality services.

In evaluating resource data, one must note that resource allocation is a function of the strength of government revenues and its tax-raising capacity at any given point of time. Generally speaking, over the past decade or so, governments worldwide have been retreating from the heyday of planning and the concept of the welfare state, under which the state intervenes in almost any matter in support of social engineering to ensure rapid social and economic development.

In India, as elsewhere, there is now much greater reliance on market forces and strengthening of the private sector to achieve more cost-effective solutions without increasing the size of the government bureaucracy. However, governments do recognize the need for effective interventions to improve social conditions and to restrain the rate of population growth as part of the measures to strengthen the economy. Accordingly, the Indian government is making efforts to mobilize resources from within and outside the country to upgrade the social sector institutions in the public sector as well as the private or NGO sector.

Data from the ministry of health and family welfare

Against this background, it needs to be noted that from its very inception, the Indian family welfare program has been a centrally sponsored program, and the central government is expected to meet the cost of all the (approved) initiatives to achieve its goals. Accordingly, we have focused first on the total expenditure on the family welfare program as reported by the Department of Family Welfare of the MOHFW of the government of India. These data, summarized in Appendix 4, Table 4.1, reportedly include the expenditures by the governments in states and the union territories as well.

The 12 years cover the Seventh Five-Year Plan period of 1985-90, two annual plan years of 1990-92 and the Eighth Five-Year Plan period of 1992-97. Within each plan period, actual budgetary allocations are influenced by the government's need to adjust spending to strengthen the performance of different sectors in light of internal and external developments.

The data indicate that during the Seventh Plan period, the expenditure on Family Welfare was about Rs. 31.21 billion, or 1.4 percent of the total Plan expenditure of the order of Rs. 2,187 billion. The expenditure was less than the initial allocation of Rs. 32.56 billion. During the Eighth Plan period 1992-97, against a Plan allocation of Rs. 65 billion (1.5 percent of the total plan), the actual expenditure (Rs. 82.67 billion) exceeded the allocated amount by 27 percent. About 9 percent of the reported expenditure represented payments to state governments as arrears or late payments of amounts agreed earlier.

Expenditure on family welfare reported by the MOHFW constituted between 0.18 and 0.21 percent of the total gross domestic product of India. The arrears are included in the calculation of these ratios, because they are likely to have related to expenditure within the five-year period.

The central government's budget allocation for the family welfare program for 1998-99 (Rs. 24,894 million) is 36 percent higher than the 1997-98 budget; but the latter was less than the reported expenditure during the previous year 1996-97. Quite likely, the substantial rise in budget allocation for 1998-99 reflects the availability of external assistance for the RCH program.

The annual expenditure on the family welfare program has risen by almost 284 percent over the 12-year period 1985-86 to 1996-97. However, because of population growth of the order of 182 million (24.1 percent), per capita expenditure had risen by only 209 percent. (The allowance for population growth partly adjusts for the cost of services required by every person, although the number of government personnel overseeing a given population is not raised every year or immediately.)

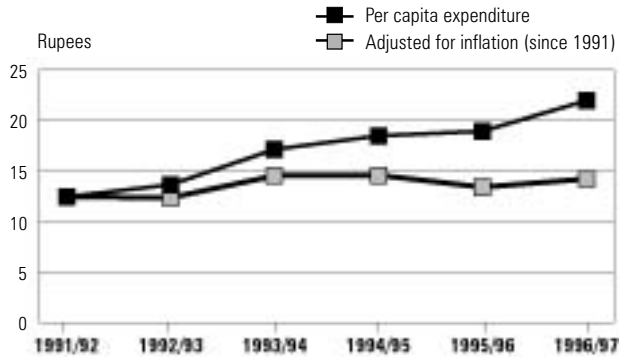
More importantly, when allowance is made for the rise in the cost of living or inflation measured by the consumer price index on the order of 164 percent, the per capita expenditure on family welfare has risen by 27 percent in real terms since 1985, and only 14 percent since 1991 (see Figure 4). The effective rise in expenditure in real terms may be even less, insofar as the expenditure of the Department of Family Welfare partly includes imported commodities, whose cost has risen in the wake of the depreciation of the Indian rupee.

The annual fluctuations in the resources made available for the family planning program are also evident in Table 4.1. Over the 11-year period beginning 1986-87, the increase in per capita expenditure fell short of the rise in the cost of living in four years, and exceeded the latter in seven years. To some extent the revision of the salaries of the public sector employees, with a modest time lag, requires that the inadequate increases in one year are partly or largely corrected in a later year. Also, the state governments are allowed to spend more than the allotted amounts and they get reimbursed in a subsequent year as arrears, when the central ministry gets the requisite allocation.

During 1993-94, the Department of Family Welfare had succeeded in raising the per capita expenditure on its activities by almost 26 percent, but subsequently, the pace of increase could not be maintained. As noted above, during the current year, 1998-99, the budget allocation for family welfare has been raised by over 36 percent; and allowing for the growth of population of the order of 1.9 percent, the increase will approximate a little over one third.

Figure 4

Per capita spending on family welfare, India 1991-97



Note: in 1996/97, US$1 = 35.5 rupees

The increase in the budget allocation for the Department of Family Welfare during 1998-99 has been possible probably because of the successful negotiation of external assistance of the order of US$960 million for the RCH program from the World Bank (approximately $490 million), the European Community ($250 million), UNFPA ($100 million), the United Nations Children's Fund ($121.5 million), and other bilateral donors, including the United States Agency for International Development (USAID). To the best of our knowledge, this external assistance is unlikely to be affected by the sanctions applied by some western countries in the wake of the nuclear tests conducted by India in May 1998.

For the Ninth Plan period, 1997-2002, the Department of Family Welfare has sought from the Planning Commission an allocation of Rs. 167.5

billion from the domestic budgetary support and Rs. 53 billion from external assistance. If this request is accepted, the resources available for family welfare (Rs. 220.5 billion) will exceed the actual expenditure of Rs 76.75 billion during the Eighth Plan period, 1992-97, by 187 percent. Depending on the actual pace of the depreciation of the Indian rupee, the target for externally aided expenditures may well be achieved. It is both essential and quite likely that the domestic budgetary allocation will be raised significantly.

Expenditures on family welfare by program or activity

The preceding discussion has focused on the total expenditures on the family planning program by the central government in India. It is useful to consider how spending on different components of the family welfare program has changed over the last five years, when the emphasis has gradually shifted to the RCH approach.

The relevant data are summarized in Table 4.2 in Appendix 4. The unit of reporting is in tens of millions of rupees, or *crores*. The central government spent a total of nearly 83 billion rupees on the program. About 9 percent of this, or Rs. 7.4 billion, was paid to the states as arrears to honor the central government's commitments during the previous year(s). Ideally, one would like to know the specific program on which the state governments had spent the amount. However, it is not easy to obtain such a detailed breakdown of state-level expenditure data. For the rest of the central expenditures, accounting for 91 percent of reported disbursements, it is possible to identify the activity or the subprogram on which it was spent.

Table 4.2 considers 19 different activities or subprograms, and groups them into three distinct categories according to whether over the five-year period from 1992-93 to 1996-97, the expenditure had (a) increased in real terms (i.e., faster than the rate of inflation, estimated at 40 percent), (b) decreased in real terms but not in nominal terms (i.e., did not keep pace with inflation), and (c) decreased in nominal and real terms. The subprograms are listed according to the percentage increase (or decrease) in expenditure during the last year of the Eighth Plan, relative to that during the first year of the Plan period.

The separation of subprograms or activities is admittedly somewhat approximate and does not always indicate the precise nature of what is done. To illustrate, the area projects, which accounted for about 8.7 percent of the total expenditure (Rs. 7.2 billion), were basically financed by different international agencies and covered different areas in the country. The nature of activities supported by these expenditures on area projects included maternal and child health, which is identified as a separate budget head.

Activities on which spending increased in real terms

According to the data presented in Table 4.2 (B), expenditure on 10 subprograms or activities had increased in real terms. If rural and urban family welfare services are grouped together, expenditure on them formed 37 percent of the total and it had risen by 69 percent over the five-year period. Spending on some other components of the program such as area projects, rural and urban family welfare centers, training and post-partum programs has increased by between 58 percent and 140 percent over the five-year period. Most important of all, the expenditure on MCH, which accounted for one-seventh of the total expenditure on family welfare, shows an increase of 334 percent over the five-year period.

The Family Planning Services Project in Uttar Pradesh, funded by USAID, had barely begun in 1992-93 and its spending during 1996-97 was 29 times that in the earlier year. Spending on involving voluntary organizations in the family planning program had risen by 481 percent, but it remained a very small part of the total expenditure.

Spending on direction and administration and on the free distribution of contraceptives accounted for about 9.5 percent of the total. While the former had increased by 46 percent, spending on the free

distribution of contraceptives had risen by 44 percent, with some interesting differences within the budget-head. The expenditure on IUDs and oral pills had risen by 117 percent and 427 percent, partly because of the import content but also because of the rise in their use. Spending on condoms rose less than the rate of inflation, probably because their production by the Hindustan Latex Ltd., a public sector firm, helped to ensure that their prices remained virtually unchanged. The decline in the popularity of laparoscopies contributed to an absolute decline in the expenditure on laparoscopes by 60 percent.

Activities on which spending declined in real terms

Five subprograms on which expenditure had declined in real terms (adjusted for inflation), though not in nominal terms, were sterilization beds, IEC activities, research and evaluation activities, India's contribution to international organizations, and compensation to acceptors. The last of these budget heads probably reflects the implementation of the policy to de-emphasize the incentives for demographic targets.

The decline in the real expenditure on research and evaluation may partly reflect the use of the externally funded National Family Health Survey to strengthen the population research centers. But quite likely, policymakers have been skeptical about the benefits of much of the research undertaken by the scholarly community and about the gains from IEC expenditures. Those engaged in these activities are caught in a vicious circle: they do not have the needed infrastructure to fulfill high expectations, and as a result, they also get a rough deal from the decisionmakers.

Activities on which spending declined in nominal terms as well

Over the five-year period, the special input for the 90 backward districts declined sharply, presumably because of the doubtful nature of the returns from the investments. The expenditure to involve other departments in family welfare work was also brought down through efforts to persuade those departments to make the necessary additional provisions. The Village Health Guide Scheme, introduced in 1978 after the revocation of the emergency, has gradually lost its purpose and it is being wound down.

The fourth scheme in this category was the commercial distribution of contraceptives, condoms and oral pills. Spending on oral pills had more than doubled, but spending on condoms had dropped considerably, with some sharp annual fluctuations. Overall, however, the new scheme of social marketing of contraceptives is likely to be an improvement over the earlier scheme, and it is likely that the expenditure data on the subject are not comparable over time.

Overall, the expenditure data reveal a marked reallocation of expenditures in favor of spending to strengthen the delivery of family welfare services both in rural and urban areas, along with related MCH activities. Of course, the Department of Family Welfare alone cannot eliminate the constraints of poor infrastructure in the country, particularly those arising from the wide dispersal of the rural population and the unsatisfactory transport and communications. Likewise, the social sector development or the strengthening of the quality of schools and a rise in the levels of school attendance and literacy have been lagging behind in the backward states. The expenditure required to overcome these constraints far exceeds the capacity of the public sector institutions during the 1990s, when the government has been trying to restrict the fiscal deficit and public investment even on infrastructure projects has been lagging behind.

Expenditures on family welfare in Rajasthan and Tamil Nadu

Tables 4.3, 4.4, and 4.5 in Appendix 4 present data on expenditure on family welfare in Rajasthan and Tamil Nadu. Table 4.3 presents the total expenditures on medical education, public health, and family welfare in Rajasthan, with the breakdown between the revenue and capital accounts. It makes the point

that the expenditure on the capital account formed only a small part of the total expenditure on health and family welfare during 1986-87 to 1990-91, but thereafter, its share increased to about 7 percent as funds became available for construction of PHC and subcenter buildings. The capital expenditure tends to fluctuate more than revenue expenditure from year to year. Because the revenue expenditure forms a major or main part of the total expenditure, we focus on it in Tables 4.4 and 4.5.

An interesting feature of these tables is the marked difference between the state government figures on expenditure on family welfare and those provided by the central government. The latter are substantially below the state estimates; their use in any analysis understates the actual expenditure by between 13 percent to 41 percent in Rajasthan (except in 1991-92, when the two sets of number converged closely) and by between 28 to 112 percent for Tamil Nadu. The problem of arrears only partly explains the divergence between the two sets of data. Among other things, the central government has covered the salary cost of ANMs employed by each state since 1970; those employed earlier continue to be paid by the state governments from their own funds. Some other items of expenditure incurred by state governments may not be covered by the central government scheme.

Overall, the annual per capita expenditure on family welfare in the two states was nearly the same, around Rs. 7-8 during 1986-89, but it increased to between Rs. 21-24 during 1994-98 in Rajasthan and to between Rs. 17-21 in Tamil Nadu during the same period. As noted earlier, the fertility decline has been much faster in Tamil Nadu than in Rajasthan, despite the relatively lower level of expenditure. It illustrates the need to examine the other correlates of social and demographic change, including the dispersal of population, the state of infrastructure and the level of development in the areas under study. Such analysis needs to continue.

The fertility decline has been much faster in Tamil Nadu than in Rajasthan, despite the relatively lower level of expenditure.

Private spending on health and family welfare

The preceding discussion has been concerned solely with public sector expenditure on health. In addition, individual households spend on services. According to the National Family Health Survey conducted during 1992-93, public-sector sources supplied services to about 62 percent of urban users of modern contraceptive methods and 87 percent of their rural counterparts. The private medical sector met the needs of about 26 percent of the urban and 10 percent of the rural users of contraceptives. About 11 percent of urban users and 3 percent of rural users reported other sources for the services, such as shops, husbands, and friends.

According to a nationwide survey of consumption expenditures in the country, annual medical expenditure (institutional as well as non-institutional) totaled Rs. 183 billion, approximately twice that incurred by the central and state governments together. For family welfare also, private expenditures are likely to exceed the percentage of users relying on the private medical and other sources. This can be explained by the relatively high prices charged by the private hospitals, clinics, and doctors as well as pharmacies and drug stores for providing sterilizations, IUD insertions or supplies of oral pills. However, it is not possible to quantify these expenditures without detailed research.

Conclusion

As noted above, there are clear signs of a shift in orientation of public sector administrators engaged in the task of promoting family planning and lowering of fertility. Since the Indian family planning program began more than 25 years ago, a high proportion of the male and female health workers are now in their late 40s or early 50s. A shift of gears is not likely to be an easy task for these workers. However, there is reason to believe that senior policymakers recognize the importance of broadening the reach and scope of the services provided under the family planning program. There has been some movement toward modifying the training of the grassroots workers and toward providing them with backup support from well-trained senior health care providers. Given the size and diversity of the country, this is a Herculean task and the resources required for the purpose will be immense.

India appears to have succeeded in securing external assistance on the order of US$1.2 billion for the RCH program. A similar effort is being made to secure World Bank credits or loans to strengthen health services in several states of the country (health reform projects have already been launched in Andhra Pradesh, Karnataka, and West Bengal, and negotiations are in advanced stages for Maharashtra, Orissa, and Madhya Pradesh). Both Rajasthan and Tamil Nadu, which we studied, expect that external assistance will help raise the spending on family welfare significantly. The challenge nevertheless seems to lie in increasing the productivity of the large manpower through more effective training and more responsive administration. This will raise the credibility of the entire program among the people, by trying to reach out to them with a holistic and empathetic approach and concern for their preferences and problems.

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Appendix 1

Selected Demographic Statistics for Rajasthan and Tamil Nadu States

	INDIA	RAJASTHAN	TAMIL NADU
Population			
1981 (million)	683.3	34.2	48.4
1991 (million)	846.3	44.0	55.8
1998 (million, estimated)	975.0	52.7	61.0
Percent increase, 1981-91	23.8	28.4	15.3
Area ('000 kms.)	3,287	342	130
Density (persons per sq. km.)			
1981	208	100	372
1991	257	129	429
Sex ratio (males per 1,000 females)			
1981	1,071	1,088	1,024
1991	1,079	1,095	1,029
Percent of urban population			
1981	23.7	21.0	32.9
1991	26.1	22.8	34.1
Villages			
(a) Number ('000)	587	38	16
(b) Av. population per village	1,061	896	2,325
(c) Households per village	262	192	533
(d) Average household size	5.5	6.0	4.5
(e) Percent of households with a female head (1993-94)	10	7.6	15.5
Percent of households using electricity for lighting, 1993-94			
Rural	37.1	41.0	54.0
Urban	82.8	88.7	81.7
Percent of population covered by television, 1993-94	84.5	61.6	91.3
Daily per capita calorie Intake, 1993-94			
Rural areas	2,153	2,470	1,884
Urban areas	2,071	2,184	1,992
Average *monthly* per capita expenditure in 1997 (current prices)			
Rural areas	395	452	441
Urban areas	645	608	658

	INDIA		RAJASTHAN		TAMIL NADU	
Annual per capita net national/state domestic product at current prices 1994-95	7,196		6,452		9,180	
Total fertility						
1980-82	4.5		5.4		3.4	
1990-92	3.6		4.5		2.2	
1995	3.5		4.4		2.2	
Percent of deliveries taking place in institutions, 1995						
All areas	25.2		7.6		64.2	
Rural	17.4		4.0		51.7	
Urban	59.6		28.6		92.4	
	Males	**Females**	**Males**	**Females**	**Males**	**Females**
Life expectancy at birth						
1970-75	50.5	49.0	49.2	49.2	49.6	49.5
1981-85	55.4	55.7	53.3	53.8	56.5	57.4
1989-93	59.0	59.7	57.4	58.5	61.4	63.4
Mean age at marriage, 1991						
All areas	25.2	19.6	24.5	9.0	27.0	21.3
Rural areas	24.5	18.0	22.0	17.1	27.0	20.8
Urban areas	27.0	21.3	24.0	19.2	28.4	22.1
Literacy among persons ages 7 and over (%)						
1981	56.5	29.8	44.8	14.0	68.0	40.4
1991	64.1	39.1	55.0	20.4	73.7	51.3
Students per 1,000 children ages 10-14,1991						
Rural	66.6	44.6	66.0	20.9	77.4	62.5
Urban	81.1	73.8	81.1	62.5	83.8	79.1
Industrial distribution of workers 1993-94						
Rural areas						
Primary	74.1	86.1	69.6	92.9	63.9	78.5
Secondary	11.2	8.5	18.7	4.9	17.3	13.8
Tertiary	14.7	5.6	11.7	2.3	18.8	7.6
Urban areas						
Primary	9.0	24.7	8.2	16.1	8.3	12.2
Secondary	32.9	29.1	22.5	30.1	37.6	38.4
Tertiary	58.1	46.2	59.3	53.8	54.0	49.4

Appendix 2

Criteria for the Selection of Districts and Focus Groups

During our initial visits to the states of Rajasthan and Tamil Nadu, we discussed with state officials and selected research institute faculty members the criteria to be adopted for the selection of districts within each state. After discussing logistics and other factors, we selected one of the two districts in each state where family planning targets had been removed in 1995, before they were removed from the entire country in 1996. The state directorates had opted for the better performing districts for the removal of targets. The second district selected for our study in both states was a relatively backward district (in terms of relatively low family planning performance) or had a low urban population, or was inhabited by backward communities such as scheduled castes or tribes.

Rajasthan

In Rajasthan, the government removed targets from the Dausa and Tonk districts in 1995. The state government, in collaboration with the Indian Institute of Health Management Research (IIHMR), also selected the Dausa and Tonk districts for an operations research project testing innovative or alternative ways of providing family planning and other health services. We selected Dausa for our study, which is located about 65 kilometers from the state capital of Jaipur. The second district we selected was Bharatpur, located farther from Jaipur, with weaker infrastructure such as a relatively poor road network and relatively poor family planning performance.

Within each district, in consultation with district officials, we selected two primary health centers (PHCs) based on their performance both in family planning and other health services. We selected a good and a poor performing PHC for holding discussions with health care providers. Within each PHC area, covering a population of about 30,000, there are generally six subcenters, each functioning with a female health worker and providing services to a population of 5,000. We selected two subcenter villages for focus group discussions (FGDs) with women or clients. A team of two assistant professors, one moderator, and two team assistants from IIHMR assisted in conducting the FGDs and in-depth interviews in both districts.

The FGDs with the village health workers (known as ANMs) proved difficult in Rajasthan because many ANMs do not live in the subcenter villages, either because there are no subcenter buildings, or even if there are, the ANMs prefer to live in nearby towns. Many ANMs working in Rajasthan have come from Kerala and prefer to live in urban areas, partly because of difficulties in being assimilated in the traditional rural society of Rajasthan. The ANMs from the two PHCs in each district, who could be contacted and brought together at one PHC, participated in the FGD. Thus, instead of two FGDs with the providers in each district, we could conduct only one FGD in Dausa district, with six ANMs, and one FGD in Bharartpur district, with five ANMs.

In the Dausa district, instead of four FGDs with clients—selected from two subcenter villages from each of the two PHCs selected—five FGDs were conducted. One full-scale FGD was conducted in Dausa to familiarize the moderator and two assistants with the issues that were to be covered by the FGD. The information gathered through this training FGD has also been incorporated in the analysis. The number of participants in FGDs in Dausa district ranged between eight and 10.

In Bharatpur district, the team conducted four FGDs with the participants drawn from two sub-center villages in each of the two PHCs. The number of participants in these FGDs ranged between six and 12.

In addition, the team conducted 12 in-depth interviews with women from the subcenter villages of both districts. The women were selected to represent specific services that they had used in the recent past, such as reversible methods of contraception, prenatal care, and abortion services.

Tamil Nadu

In 1995, when other states selected one or two districts to be freed from method-specific targets, all of the districts in Tamil Nadu (and in the neighbouring Kerala state) were made target-free because both states had already attained fertility levels below or near the replacement level. In Tamil Nadu, the government began to experiment with removing method-specific family planning targets in 1992 in the district of North Arcot. We therefore decided to include this district in our study. The second district selected for the study is Salem, where both the birth and death rates have been higher than the state average. The Salem district is also a part of the region where some communities have been reported to be practicing female infanticide.

We applied the same criteria for selecting PHCs and subcenters in Tamil Nadu as we used in Rajasthan. In both districts of Tamil Nadu, we conducted four FGDs of clients and two FGDs of service providers or village health nurses (ANMs are known as VHNs in Tamil Nadu). The number of clients in the FGDs ranged between eight and 12. All six VHNs from one of the PHCs selected in the North Arcot district and five from each of the two PHCs selected in the Salem district participated in the FGDs. The team also conducted a total of 10 in-depth interviews with clients. A team of three Ph.D. candidates, under the supervision of a professor in the Population Studies Department of Bharathiar University in Coimbatore, conducted the FGDs and in-depth interviews.

RAJASTHAN		TAMIL NADU	
Dausa	**Bharatpur**	**North Arcot**	**Salem**
5 FGDs with Clients (43)	4 FGDs with Clients (33)	4 FGDs with Clients (45)	4 FGDs with Clients (38)
1 FGD with ANMs (6)	1 FGD with ANMs (5)	2 FGD with ANMs (12)	2 FGD with ANMs (10)
In-depth interviews (5)	In-depth interviews (7)	In-depth interviews (2)	In-depth interviews (8)

Appendix 3

Family Planning Acceptors in Rajasthan, Tamil Nadu, and All India, 1991–98

YEAR	STERILIZATION		IUD		CC*		ORAL PILLS	
	Number of acceptors (in thousands)	Percent change over previous year	Number of acceptors (in thousands)	Percent change over previous year	Number of acceptors (in thousands)	Percent change over previous year	Number of acceptors (in thousands)	Percent change over previous year
ALL INDIA								
1991–92	4,090		4,386		13,875		3,366	
1992–93	4,286	+ 4.8	4,740	+ 8.1	15,004	+ 8.1	3,001	– 10.8
1993–94	4,496	+ 4.9	6,013	+ 26.9	17,279	+ 15.2	4,299	+ 43.3
1994–95	4,332	– 3.6	6,702	+ 11.5	17,707	+ 2.5	4,873	+ 13.4
1995–96	4,422	+ 2.1	6,858	+ 2.3	17,297	– 2.3	5,091	+ 4.5
1996–97	3,870	– 12.5	5,681	– 17.2	17,214	– 0.5	5,250	+ 3.1
1997–98	4,083	+ 5.5	6,088	+ 7.2	16,708	– 2.9	6,241	+ 18.9
RAJASTHAN								
1991–92	173		159		376		60	
1992–93	198	+ 14.5	179	+ 12.6	391	+ 4.0	47	– 21.7
1993–94	203	+ 2.5	170	– 5.0	512	+ 30.9	90	+ 91.5
1994–95	203	0.0	156	– 8.2	383	– 25.2	92	+ 2.2
1995–96	168	– 17.2	168	+ 7.7	519	+ 35.5	125	+ 35.9
1996–97	201	+ 19.6	205	+ 22.0	723	+ 39.3	204	+ 63.2
1997–98	224	+ 11.4	223	+ 8.8	837	+ 15.8	301	+ 47.5
TAMIL NADU								
1991–92	365		432		271		157	
1992–93	365	0.0	398	– 7.8	240	– 11.4	97	– 38.2
1993–94	352	– 3.6	358	– 10.1	320	+ 33.3	149	+ 53.6
1994–95	326	– 6.8	388	+ 8.4	322	+ 0.6	216	+ 45.0
1995–96	310	– 4.9	402	+ 3.6	276	– 14.3	216	0.0
1996–97	316	+ 1.9	384	– 4.5	208	– 24.6	168	– 22.2
1997–98	333	+ 5.4	406	+ 5.7	186	– 10.6	191	+ 13.7

* CC= Conventional contraceptives, mainly condoms.

Appendix 4

Resource Flows for Family Welfare and Related Programs

Table 4.1

Expenditures on family welfare in India by the governments at the center, states, and union territories, 1985-1997

YEAR	EXPENDITURE (IN MILLIONS RS.)	PERCENT CHANGE	POPULATION (IN MILLIONS)	PCE (RS.)	PERCENT CHANGE	PERCENT RISE CPI*
1985-86	5,365	—	755	7.11	—	+ 6.5*
1986-87	5,702	+ 6.3	771	7.40	+ 4.1	+ 8.7
1987-88	6,421	+ 12.6	788	8.15	+ 10.1	+ 9.6
1988-89	7,129	+ 11.0	805	8.86	+ 8.7	+ 7.9
1989-90	8,197	+ 15.0	822	9.97	+ 12.5	+ 6.6
1990-91	9,329	+ 13.8	839	11.12	+ 11.5	+ 11.0
1991-92	10,656	+ 14.3	856	12.45	+ 12.0	+ 13.7
1992-93	11,904	+ 11.7	872	13.65	+ 9.6	+ 10.4
1993-94	15,226	+ 27.9	888	17.15	+ 25.6	+ 6.9
1994-95	16,718	+ 9.8	904	18.49	+ 7.8	+ 7.4
1995-96	17,434	+ 4.3	920	18.95	+ 2.5	+ 11.6
1996-97	20,593	+ 18.1	937	21.98	+ 16.0	+ 9.3

Notes: PCE=Per Capita Expenditure; CPI=Consumer Price Index.

* Provisional estimates

Notes:

1. Data on expenditure are taken from Government of India, Ministry of Health and Family Welfare, Department of Family Welfare, *Family Welfare Programme in India: Year Book 1993-94* (New Delhi, 1997): 271.

2. Population figures for the mid-point of the financial year (April 1 to March 31) are taken from: Government of India, Department of Statistics, *National Accounts Statistics—1997* (New Delhi, 1997): 265.

3. The consumer price index relates to urban non-manual employees (with 1984-85 as the base). Figures are taken from: Government of India, Ministry of Finance, *Economic Survey—1997-98* (New Delhi, 1998): S-54, S-66.

Table 4.2

Expenditures on family welfare during the eighth plan period, 1992-1997 (in 10 million rupees)

ACTIVITY	1992-93	1993-94	1994-95	1995-96	1996-97	TOTAL OF EIGHTH PLAN
(a) Data from the Ministry of Health and Family Welfare						
1. Total expenditures	1,190	1,522	1,714	1,781	2,059	8,267
(a) Arrears paid to state governments	100	210	150	162	113	736
(b) Total excluding arrears	1,090	1,312	1,565	1,619	1,946	7,531
2. Total expenditures on family welfare (FW) as percent of GDP	0.19	0.21	0.20	0.18	0.18	0.19
(b) Data from the Ministry of Finance						
3. Total expenditures on medical & public health, water supply, & sanitation (MPHWSS)	8,265	9,536	11,091	12,453	15,029*	56,374
4 (a) Expenditures on FW	1,055	1343	1,489	1,827	1,985*	7,699
(b) FW as percent of MPHWSS and FW	11.3	12.3	11.8	12.8	11.7	12.0
5. (a) Expenditures on MPHWSS and FW	9,320	10,879	12,580	14,280	17,014*	64,073
(b) 5(a) as percent of GDP	1.5	1.5	1.4	1.4	1.5	1.5
6. Mid-year population (millions)	872	888	904	920	937	—
7. Per capita expenditures on MPHWSS and FW						
(a) Rupees	107	122	139	155	182	142
(b) Dollars	**3.49**	**3.89**	**4.43**	**4.63**	**5.13**	**4.31**
(c) Exchange rate (Rs. per $1)	30.65	31.37	31.40	33.45	35.50	—

Note: Average exchange rates are taken from: Ministry of Finance, *Economic Survey, 1997-98* (New Delhi, 1997-98): S-78.

* Revised estimates, subject to further revision after audit.

Source: Data from the Ministry of Finance cover both revenue and capital expenditures by the center and the state governments. They are taken from: Economic Division of the Department of Economic Affairs, Ministry of Finance, Government of India, *Indian Public Finance Statistics, 1997* (1997): 1.

Table 4.2 (A)

Programs on which expenditures increased in real terms, i.e., by more than 40 percent (the rate of inflation) between 1992 and 1997 (in 10 million rupees)

NAME OF PROGRAM	1992-93	1993-94	1994-95	1995-96	1996-97	TOTAL OF EIGHTH PLAN	PERCENT INCREASE 1992-97
(a) Family planning services project in Uttar Pradesh	1	5	30	21	29	86	+2,810.0
(b) Involvement of voluntary organizations	1	4	8	9	8	30	+ 480.9
(c) Maternal and child health	100	143	241	281	434	1,199	+ 334.2
(d) Area projects	74	149	148	172	177	721	+ 140.1
(e) Rural FW services	430	503	568	626	726	2,862	+ 69.0
(f) Urban FW services	30	38	44	36	50	198	+ 64.8
(g) Training	27	27	33	37	43	166	+ 61.3
(h) Postpartum program	57	67	75	80	90	369	+ 58.2
(i) Direction and administration	51	58	62	62	75	308	+ 46.1
(j) Free distribution of conventional contraceptives	68	98	129	85	98	478	+ 44.1
Nirodh/condoms	48	59	69	49	60	286	+ 24.8
IUD	10	22	23	17	22	94	+ 117.2
Oral pills	2	13	25	15	13	69	+ 427.2
Laparascopes	7	4	12	4	3	30	– 60.1

Table 4.2 (B)

Programs on which expenditure increased but did not keep pace with inflation

NAME OF PROGRAM	1992-93	1993-94	1994-95	1995-96	1996-97	TOTAL OF EIGHTH PLAN	PERCENT INCREASE 1992-97
(a) Sterilization beds	1	1	2	2	2	8	+ 35.3
(b) Information, education, and communication	19	23	23	29	24	118	+ 28.4
(c) Research and evaluation	13	13	17	15	16	75	+ 21.1
(d) India's contribution to international organizations	1	1	1	1	1	5	+ 8.9
(e) Payment as compensation to acceptors	90	92	96	87	90	456	Negligible

Table 4.2 (C)

Programs on which expenditures declined between 1992 and 1997

NAME OF PROGRAM	1992-93	1993-94	1994-95	1995-96	1996-97	TOTAL OF EIGHTH PLAN	PERCENT INCREASE 1992-97
(a) Special input for 90 backward districts	45	31	19	5	4	105	– 91.2
(b) Involvement of other departments in family welfare	6	5	1	1	1	14	– 89.0
(c) Health guide scheme	21	14	13	16	11	75	– 47.0
(d) Commercial distribution of contraceptives	34	19	26	16	31	127	– 10.6

Table 4.3

Total expenditures on medical, health, and family welfare in Rajasthan, 1990-99 (in million rupees)

YEAR	REVENUE ACCOUNT	CAPITAL ACCOUNT	TOTAL	PERCENT CHANGE IN TOTAL OVER PREVIOUS YEAR
1990-91	2,507 (97)	72 (3)	2,579 (100)	+ 17.4
1991-92	2,795 (93)	208 (7)	3,005 (100)	+ 16.5
1992-93	3,319 (96)	143 (4)	3,462 (100)	+ 15.3
1993-94	3,846 (97)	108 (3)	3,954 (100)	+ 14.2
1994-95	4,609 (96)	176 (4)	4,784 (100)	+ 21.0
1995-96	5,146 (89)	606 (11)	5,752 (100)	+ 20.2
1996-97	5,905 (90)	640 (10)	6,546 (100)	+ 13.8
1997-98 (EST.)	6,397 (87)	956 (13)	7,353 (100)	+ 12.3
1998-99 (EST.)	7,923 (93)	615 (7)	8,538 (100)	+ 16.1

Note: Figures in parentheses show the distribution of total expenditures between revenue and capital accounts.

Table 4.4

Rajasthan: Revenue expenditures on family welfare, 1986-1999, according to state sources and central government reports (in million rupees)

YEAR	STATE SOURCES	CENTRAL GOVERNMENT REPORTS	STATE ESTIMATES AS PERCENT OF CENTRAL	PERCENT INCREASE		PER CAPITA EXPENDITURES[c]	
				STATE REPORTS	CENTRAL REPORTS	(RS.)	PERCENT CHANGE
1986-87	262	214	+122	—	—	7	—
1987-88	303	268	+113	+ 16	+ 25	8	+ 13.6
1988-89	317	256	+124	+ 5	– 5	8	+ 1.3
1989-90	398	322	+124	+ 26	+ 26	9	+ 23.7
1990-91	465	407	+114	+ 17	+ 26	11	+ 13.8
1991-92	539	536	+101	+ 16	+ 32	12	+ 13.1
1992-93	630	500	+126	+ 17	– 7	14	+ 14.9
1993-94	766	544	+141	+ 22	+ 9	16	+ 17.3
1994-95	1,022	—	—	+ 33	—	21	+ 30.7
1995-96	1,068	—	—	+ 5	—	22	+ 1.9
1996-97	1,190	—	—	+ 11	—	24	+ 8.8
1997-98[a]	1,253	—	—	+ 5	—	24	+ 3.0
1998-99[b]	1,072	—	—	– 14	—	20	– 16.5

[a] Revised estimates presented in the budget for 1998-99.

[b] Budget estimates approved by the State Legislature for the year beginning April 1, 1998.

[c] Figures are based on the state budget estimates of expenditures on family welfare.

Table 4.5

Tamil Nadu: Expenditures on family welfare, 1986-1999, according to state sources and central government reports (in million rupees)

YEAR	STATE SOURCES	CENTRAL GOVERNMENT REPORTS	STATE ESTIMATES AS PERCENT OF CENTRAL	PERCENT INCREASE		PER CAPITA EXPENDITURE[c]	
				STATE REPORTS	CENTRAL REPORTS	(RS.)	PERCENT CHANGE
1986-87	335	239	+140	—	—	6	—
1987-88	357	278	+128	+ 6	+ 16	7	+ 5.0
1988-89	436	288	+151	+ 22	+ 3	8	+ 20.3
1989-90	567	61	+157	+ 30	+ 26	10	+ 28.3
1990-91	631	378	+167	+ 11	+ 5	11	+ 9.8
1991-92	768	398	+193	+ 22	+ 5	13	+ 20.2
1992-93	871	493	+177	+ 13	+ 24	15	+ 12.0
1993-94	1,016	479	+212	+ 17	– 3	18	+ 15.3
1994-95	1,160	—	—	+ 9	—	19	+ 7.7
1995-96	1,224	—	—	+ 11	—	21	+ 9.3
1996-97	1,034	—	—	– 16	—	17	– 16.5
1997-98[a]	1,193	—	—	+ 15	—	20	+ 14.1
1998-99[b]	1,409	—	—	+ 18	—	23	+ 16.7

Note: Figures for years up to 1996-97 show reported actual expenditures during the year. Change in per capita expenditures on family welfare over successive years has been calculated with more detailed figures than are presented in this table.

[a] Revised estimates presented in the budget for 1998-99.

[b] Budget estimates approved by the State Legislature for the year beginning April 1, 1998.

[c] Figures are based on the state budget estimates of expenditures on family welfare.

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