The elimination of contraceptive acceptor targets and the evolution of population policy in India

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Abstract. In 1996 the government of India announced a new national population policy that eliminated numerical targets for new contraceptive acceptors. This paper examines the history of target setting in India and factors that led to the elimination of targets. The analysis is based on published and unpublished reports on India’s population policy and the family planning programme and interviews with senior Indian and foreign officials and population specialists. Five factors are identified as playing a role in the evolution from target setting to a target–free policy: (1) the research of India’s academics; (2) the work of women’s health advocates; (3) the support of officials in the state bureaucracy who approved the target–free approach; (4) the influence of the donors to India’s family planning programme, especially the World Bank; and (5) the International Conference on Population and Development.

INTRODUCTION

In 1996 the government of India announced a new national population policy that eliminated numerical targets for new contraceptive acceptors. These targets, which prescribed how many new family planning acceptors were to be recruited by grassroots workers, had been the hallmark of India’s national family planning programme, known euphemistically as the family welfare programme.

This paper examines the factors that led to the elimination of contraceptive acceptor targets in India and discusses the impact of the new policy. The analysis is based on a review of published and unpublished reports on India’s population policy and the family welfare programme, as well as interviews with a small sample of senior Indian and foreign officials and population specialists involved in the policy change.

The evolution of policy on target setting is an illustration of society-wide changes that are taking place throughout India and in many other countries. These changes are leading to more decentralized political and administrative structures, and more client-centred bureaucracies. Understanding the forces that led to changes in India’s family planning target system provides a sense of the complexity of policy changes in the health and population sector and in the larger society as well.

Many people argue that one or two critical factors determine the evolution of national population policies. Sometimes strong national leadership is highlighted as a key factor (Freedman 1987). Others emphasize the importance of research demonstrating the need for a particular policy (Porter 1995). The influence of foreign donors is another popular explanation (Keesbury 2000). In my view, rarely does a single element or critical factor determine public policy. Significant policy change typically results from the interplay of a variety of factors over time.

The change in target-setting policy in India has been described in reports prepared by Indian demographers and by staff from the international donor agencies that support India’s population and health programme (Measham and Heaver 1996a and 1996b; Visaria, Jejeebhoy, and Merrick 1999). But the change is not well known beyond the population and reproductive health specialists interested in India. Even in the specialized publications and reports, the factors that shaped the evolution of population policy in India are not discussed in detail.

Population and family planning policies in India are significant not only because of their impact in India but also because they provide ideas and strategies that are influential elsewhere. Population issues in India are also important because the country’s large size and still relatively high growth rate mean that India contributes significantly to the level and pattern of world population growth. India represents 16 per cent of the world’s population. In 1999, the rate of natural increase was 1.9 per cent, which means that India added approximately 16 million people to its population in that year. According to the United Nations (1998, p. xvi), India would account for 21 per cent of the growth of the world’s population between 1995 and 2000.
Demography in India

India’s population in 2001 has been estimated to be slightly over one billion people. Total fertility is 3.2, a significant decline from a total fertility of nearly 6.0 in the 1960s. Almost half (48 per cent) of married women of reproductive age practise some form of contraception, with about 43 per cent using modern methods (Haub and Cornelius 2001). Abortion is legal in India, although the quality of and access to services vary widely. Some estimates suggest that one million abortions are performed annually.

There is substantial variation in these demographic indicators by state. All-India averages also conceal significant differences by class and gender as well as between rural and urban areas. In 1997, for example, total fertility in the state of Kerala was 1.8, while in Uttar Pradesh it was 4.8 (Registrar General 1999, pp. 117 and 229). Contraceptive prevalence, education of females, and measures of health status show similar variations. The development of state population policies has also varied, with more explicit policies and better quality services available in some states than in others. This paper is concerned with the evolution of population policy at the national level, and so these variations by state and sub-population are not examined. There is little indication that target-setting practices varied significantly by state. Even in the states with low fertility, grassroots workers were expected to recruit new acceptors.

Target Setting

Before the 1950s, Indian experts concluded that rapid population growth was a threat to economic development and to India’s ability to feed its population (Caldwell 1998). (The classic American account of the negative impact of rapid population growth by Ansley Coale and Edgar Hoover was published in 1958 and used India as a case study.) Eager to slow growth, Indian officials tried to reduce the number of births through programmes to promote contraceptive use among married women of reproductive age.

Governments throughout Asia employed a common administrative strategy to implement family planning programmes and to increase the use of contraception. This strategy was to estimate a desirable number of new contraceptive users and to organize their recruitment by allocating ‘targets’ – specified numbers of new acceptors of particular contraceptive methods – to health or family planning workers in given geographic areas. Almost all the new users were women. Evaluators would judge the success of the family planning programmes, and managers would judge the quality of the staff, by the extent to which these targets were achieved.

Target-setting systems were seen as facilitating the management of family planning programmes and were widely used. Targets were useful for estimating supplies and budgets, and for assigning staff. Some analysts note that donors providing development assistance liked targets because family planning programmes could be judged by the extent to which the targets were achieved (Khalil and Myntti 1994, p. 4).

Computer programs were designed that could calculate the number of new contraceptive acceptors needed to reach a specified birth rate (Bongaarts and Stover 1986). Staff in the Population Division of the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) encouraged the use of these software packages.

The rationale for targets in India was spelled out by the Department of Family Welfare in 1966 (quoted in Khan and Townsend 1998, p. 1):

‘... to reorganize and intensify the family planning programme, it has been decided to give it a target orientation and to ensure that every possible effort is made to achieve the targets. ... Keeping in view the aimed objective of reducing the birth rate from 40 to 25 per thousand by 1975, certain broad norms for the use of different methods of birth control have been worked out ...’.

Staff at the Department of Family Welfare (within the Ministry of Health and Family Welfare) and the Planning Commission calculated targets for the number of new contraceptive acceptors by method (sterilization, IUD, condoms) and allocated them by district throughout India. Grassroots workers, many of whom were not formally associated with the family welfare programme, were responsible for achieving these targets. The targets became contraceptive-specific and provider-specific quotas.

Early on, only population size and past performance were taken into account in setting the targets. Later, more elaborate calculations were made which incorporated the percentage of the population living in urban areas, female literacy rates, income levels, and state expenditures on family planning (Narayana 1998, p. 2). (Ross 1975) reviews the approach used to establish targets in India and 12 other countries. Narayana, Kakkar, and Srinivasan (1998) examine changes over time in the distribution of targets to states and districts.)
Targets as quotas

The use of targets at the local level to tell workers how many acceptors to recruit is what has troubled many observers. Khalil and Myntti (1994, p. 5) note that ‘pressures to meet targets were transferred down through the system to the community-based family planning worker, who was then made to show numerical results’. Often these pressures were applied regardless of whether the level of contraceptive prevalence was high or low. Although little research has been published on the links between targets and the quality of contraceptive services, a great deal of anecdotal evidence suggests that the pressure to meet targets often meant that providers paid less attention to users’ perceived needs, offered less choice of methods, and less information about potential side-effects, problems, or other methods.

Many factors in addition to targets influenced the quality of family planning services in India. The family welfare programme suffered the problems of large-scale health programmes in poor countries around the world: logistical difficulties; a poorly functioning personnel system; frequent changes in leadership; difficulties coordinating with external donors; a weak research and evaluation system; confused responsibility for implementation in the field; difficulties achieving a workable partnership between the health and family planning branches of the Ministry; and until recently, a reluctance to accept the organizations of civil society into full partnership or to allow competition between the government and the private sector for the provision of contraceptive services. All these factors worked to lessen the quality of care. Choice of methods and the range of reproductive health services were frequently limited. Not all clients received adequate information. Some providers were not technically competent. Treatment of clients was often shabby and sometimes much worse, and client follow-up was limited. Targets were just one element of this malfunctioning system, albeit for many people a particularly visible and objectionable feature. (See Koenig, Foo, and Joshi (2000) for a review of research on the quality of reproductive health services.)

The target-free approach

In August 1993 the Indian government appointed an expert group headed by M.S. Swaminathan to draft a new national population policy. A report was submitted in May 1994 (Expert Group 1994). The draft report, which suggested abandoning targets and improving the quality of services, was circulated widely among members of parliament. In order to become official policy, it also needed to be formally tabled in parliament and discussed in the National Development Council. This did not happen, in part because of changes in the national government. Nonetheless, without officially adopting a national policy, the Indian government began to reorient the family planning programme.

The Swaminathan report followed an earlier report, known as the Karunakaran Committee report, which had been submitted in November 1992 (Planning Commission 1992). The Committee recommended that district leaders (magistrates and collectors) be given greater responsibility for programme activities and that they adopt more flexible approaches to implementation.

In April 1995, the Secretary of the Department of Family Welfare within the Ministry of Health and Family Welfare ‘… proposed that one or two districts from each of the major states could become target free on an experimental basis. … [A] year later, in April 1996, the government made an even bolder decision – that the entire nation would become target free’ (Visaria and Visaria 1998, p. 10). According to the Visarias (1998, p. 10), some felt that this decision was made suddenly ‘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’. John Ross (1998, p. iii) is more critical, claiming that the target system ‘was abruptly terminated … in a confusing and incomplete manner, leaving all personnel in the dark about what had ended and what was to come’.

The target-free approach, renamed the ‘community needs assessment approach’, has been codified by the Ministry of Health and Family Welfare (Department of Family Welfare 1998, pp. 12–13). Grassroots workers, auxiliary nurse midwives (ANM) ‘… are expected to consult families and local communities in the beginning of every year in order to assess their needs and preferences and then work out for themselves the programme and requirement for the coming year. The requirement for each village needs to be worked out to arrive at the requirements for the ANM; this becomes the targets for ANM for the year. … The mechanism for quantifying work load and the unthinking rigidities associated till now with the targets have undergone change. The arbitrariness of the top down targets is being given up to allow the choices of the citizens to be ascertained and fulfilled’.

Factors influencing Indian population policy

Five factors played a direct role in the transition of India’s population policy from target-oriented to...
target-free. The five factors were: (1) the research of Indian academics; (2) the work of women's health advocates; (3) the support of the officials who approved the target-free approach; (4) the influence of the donors to India's family welfare programme, especially the World Bank; and (5) the United Nations sponsored International Conference on Population and Development.

These five factors interacted with each other and with other societal elements to produce the change in the target-setting policy. Discussing the five factors in turn may make the process of policy change seem more orderly than it was. There was rarely, perhaps never, consensus on key issues. There were arguments among advocates of different points of view within and between groups, including the Ministry of Family Welfare, as different people formed conclusions about the utility of the target system.

**Scientific research**

Research by Indian demographers, economists, and sociologists documented weaknesses in the design and implementation of the contraceptive acceptor targets. Three streams of research were important. First, studies based on India's vital registration system and on reports of contraceptive prevalence provided by the Ministry of Health and Family Welfare and independent research organizations showed that fertility was not declining as much as would be expected given the reported increases in contraceptive use. Anrudh Jain (1989, p. 2729) concluded that '[t]he estimated declines in the state-level birth rates during 1981-87 for most of the states are much less than would be expected on the basis of the reported increases in the state-level contraceptive prevalence during this period'. The Third All India Survey conducted by the Operations Research Group found that IUD insertions may have been over-reported by almost three times (cited in Townsend and Khan 1993, p. 116). In a study in Gujarat, the Visarias and Jain (1994, p. 302) concluded that ‘Overstating the use of reversible methods stems from the current system of method-specific, time bound targets assigned to the field-workers, and the pressure exercised at various administrative levels to achieve them. This practice has resulted in widespread falsification of statistics ...’. These findings are now incorporated into almost all official discussions of the family welfare programme. (See, for example, Department of Family Welfare 1998, p. 11.)

A second stream of research was particularly important in the later stages of the policy dialogue that led to the target-free system. The National Family Health Survey (NFHS) of 89,777 ever-married women (IIPS 1995, p. 33, Table 2.1) was conducted from April 1992 to September 1993, as part of the multi-country Demographic and Health Survey project funded primarily by the US Agency for International Development. The NFHS provided national and state-level data on fertility, family size preferences, demand for contraception, unwanted fertility, and aspects of maternal and child health.

The NFHS showed that there was substantial unmet need for family planning services in India. That is, there was a large group of women who said they wanted no more children or wanted to space their next birth, but who were not practising family planning. According to the report of the NFHS (IIPS 1995, p. 187): ‘... 20 percent of women in India have an unmet need for family planning ... If all of the women who say they want to space or limit their births were to use family planning, the contraceptive prevalence rate would increase ... to 60 percent of married women. ... If the level of unmet need ... is assumed to reflect the needs of all currently married women age 13–49 in India, then about 30 million women in India have an unmet need for family planning’.

Additional analysis of the NFHS data indicated that meeting the unmet need for family planning services, thereby increasing the contraceptive prevalence rate, ‘could lower total fertility in India from 3.4 children per woman, the level indicated by the NFHS for the early 1990s, to 2.3 children per woman. Given current mortality levels in India, a total fertility of 2.3 is only slightly above the population-replacement level’ (Pathak, Feeney, and Luther 1998a, p. 14). A World Bank team reached a similar conclusion, in part because their analysis was also based on NFHS data (Measham and Heaver 1996b, p. 29). Documentation of this high level of unmet need encouraged senior programme managers at the Ministry of Health and Family Welfare to consider seriously suggestions that the family welfare programme be oriented to meet unmet need, rather than continuing to focus on recruiting new sterilization acceptors. Some critics suggest that this change was in part prompted by the view that it would produce the same result with less coercive means.

Because sterilization was the most effective method, it had been judged to have the greatest effect on the birth rate. Targets were specified that gave workers more credit for a sterilization acceptor than for acceptors of other methods. In fact the effects of contraception on the birth rate depend
heavily on the age and parity distributions of women using various methods. Analysis of the NFHS data confirmed the finding that sterilization did not have as significant an impact on the birth rate as expected. According to the NFHS, sterilized women averaged 4.0 children. These women were older and had more children than women who used other contraceptive methods. The NFHS data suggested that it would be necessary for more younger, low parity women to use temporary contraceptive methods if fertility was to be lowered substantially. Increased use of temporary methods was seen as the key to accelerating India’s fertility decline (Pathak, Feeny, and Luther 1998b, pp. 2–4).

A third stream of research, much of it conducted under the auspices of non-governmental organizations, examined the prevalence of reproductive health problems in India. This research documented the reproductive health problems that troubled Indian women and, by implication if not always with compelling data, showed how the focus on contraceptive targets had led the family welfare programme to ignore serious reproductive health problems faced by millions of women (Bang et al. 1989; Bhatia et al. 1997; and Ford Foundation 1997).

The most troubling finding was that maternal mortality continued to be very high in India. The maternal mortality ratio was estimated by the National Family Health Survey (IIPS 1995, p. 226) to be 437 per 100,000 live births, several times higher than the level found in other less developed countries. Other research showed that the prevalence of HIV/AIDS had increased dramatically, its spread speeded in part by the high prevalence of sexually transmitted disease (Low–Beer et al. 1998, pp. 339–344). Researchers carrying out this work formed a lobby that encouraged the government to take their studies into account and to consider changes in policy. Numerous conferences, workshops, and seminars were held to exchange views and disseminate research findings and other data on these issues.

Women's health advocates

Women’s health advocates (not all of whom were women) and women-centred non-governmental organizations (NGOs) played important roles in the evolution of India’s population policy. Saroj Pachauri (1999, p. xiv) concludes that they were in the forefront of advancing this agenda to move away from targets. Women’s groups lobbied both the government and the public to move to a more client-centred family planning policy. Women’s health advocates networked with like-minded women inside and outside India and developed ideas for analysis, advocacy strategies, and programme alternatives. Several were influential outside India and were prominent in international efforts to reshape the international discussion of population issues. (See Sen, Germain, and Chen (1994) for examples of this work.)

Women writers were particularly strong in their description of the problems caused by the target-setting system. In a characteristic example, Batliwala (1993) quoted in Correa 1994 (p. 52) notes that the system led to ‘unimaginable atrocities committed on the poor … backward castes and minorities, to force them to undergo sterilization […] Government employees faced salary cuts; children were barred from school if their parents were not sterilized; irrigation water was withheld from villages that did not fill their sterilization quotas’.

Among the women who played important roles in the transformation of India’s family planning policy were professionals who had been associated with population and family planning issues in India for some time, often for decades. They were well acquainted with population issues in India and elsewhere and occupied important positions in the women’s movement, the population and family planning community, the international demographic and reproductive health communities, and among the donors of development assistance funds. Among the members of this group were Shireen Jejeebhoy, Saroj Pachauri, and Leela Visaria. All were well qualified and respected professionals who were well known in India and overseas because of their research and writing on population and reproductive health in India. Each of them either worked for or served as a consultant for one or more international agencies. Each was also a frequent traveller outside India and therefore well informed about the ways in which family planning, reproductive health, and women’s issues were viewed in other countries. Each was also well connected to women’s groups, both within India and overseas. They served as policy entrepreneurs who, as Sato (1999, p. 30) notes, ‘package[d] their ideas to attract the attention of decisionmakers, build coalitions, and seize political opportunities to accomplish their ends’.

The press was receptive to articles on population issues and ran pieces by critics of the family planning programme expressing their views and outlining alternative reproductive health strategies. (See Narayana, Kakkar, and Srinivasan (1998) for more on the role of the press.) A large number of specialized publications also helped critics,
especially those from the women’s movement, to spread word of their criticisms of the target-setting system (Ramasundaram 1995).

The women’s movement raised connaissance, identified issues, contributed to a sense of solidarity, and helped mobilize resources. But population professionals worked on the target-setting issue independently, drawing on the ideas and some of the people involved in the women’s movement. Contraceptive acceptor targets were not a core issue for India’s women’s movement. Indian feminists were concerned with the economic condition of women, including low earnings and poor working conditions, dowry and dowry-related crimes, rape and violence against women, and women’s health. (See Kumar (1995) for an overview of the women’s movement in India.) Feminists cited target setting as an example of the Ministry of Health and Family Welfare’s – and therefore the male dominated government’s – disregard of individual women’s needs in favour of the implementation of bureaucratic policy. (For a description of other work of these NGOs, see Mavalankar, Bang, and Bang 1998 and Sokhi 1998.)

There was an absence of protest about the target-setting system among poor women, those who were most likely to be harmed by the system. There were several reasons for this. Poor women in India are disenfranchised and without the means or opportunity to protest. Second, many, probably most, poor women had low expectations of the quality of family planning and health services. Third, the decline in fertility suggests that, over time, more and more women wanted to control their fertility and that the targets – especially when not aggressively pursued – may have been less at odds with individual reproductive goals than when they were first introduced or than some opponents of the system thought they were.

Government officials

To be effective, the target-free approach needed the support of officials at the Ministry of Health and Family Welfare. Although sometimes dismissed as hanging on to a discredited policy for too long, senior officials at the Ministry recognized the problems caused by the target-oriented approach to delivering family planning services and played a decisive role in the shift to a target-free policy. Ministry officials participated in committees, including the National Development Council subcommittee, that reviewed the implementation of the family planning programme and drafted a new population policy proposal in May 1994. V.K. Shunglu, J.C. Pant, and Y.N. Chaturvedi, successive Secretaries of Family Welfare, threw their personal energy and reputations into the fray in order to bring about a change in the system. (The Secretary of Family Welfare is one of two top administrative positions at the Ministry of Health and Family Welfare. V.K. Shunglu served as Secretary from April 1994 to May 1995. J.C. Pant served from June 1995 to January 1997, and Y.N. Chaturvedi from January 1997 to July 1999.)

Anthony Measham (1999) who worked closely with Shunglu, describes him as ‘bold, confident and assertive,’ and says ‘He looked into the programs – he was new to it – carefully, and his enthusiasm grew for what we [the World Bank] were doing. Eventually, he remarked that the conclusion of the [Bank’s] report were those of the GOI [Government of India]. ... Partly because of Shunglu’s support, we decided to go for broke and strongly recommend that the targets be dropped’.

John Townsend (1999), who worked for the Population Council in India when Shunglu was Secretary of Family Welfare, confirms this view, noting that ‘Shunglu listened to people. He didn’t know population, but he met with people and listened and would say, “Show me”. He wanted to look at the data. In the case of targets, the data were pretty clear. Targets weren’t useful’. Townsend says that Secretary Shunglu approved experiments that allowed the Population Council and others to collect data on alternative target-free delivery systems. The United Nations Population Fund had obtained permission earlier to conduct such experiments as part of their support for the move to a target–free system but in fact they did not support any research.

Secretary Pant, who took over when Shunglu left the Ministry for another assignment, is also given credit for supporting the target-free policy. His willingness to do so was said to come in part from the fact that he was scheduled to retire after leaving his post as Secretary of Family Welfare. Another factor, according to Townsend, was that Pant ‘wanted to close the loan with the [World] Bank. The government was having major budget problems and there were budget shortfalls’. The flexible funds available to the Ministry and needed for innovative activities were very small.

Secretary Chaturvedi helped carry forward the target-free policy and make it operational. He played a particularly important role in the development of the Reproductive and Child Health Programme, the umbrella programme under which the target-free policy is being implemented.

Earlier Secretaries were aware of the problems with the target orientation, but had worried that, if
they supported the target-free approach and it failed, i.e., if acceptors declined and fertility increased, their futures in the government service would be in jeopardy. Indeed, although it was never implemented, the Ministry had prepared a statement of a target-free policy in 1993, when Usha Vohra was Secretary of Family Welfare.

In India, health and family welfare activities are a combination of central government and state government functions. The central government Secretaries played an important role in the development of the target-free policy. But the bureaucracies involved in policy formulation and implementation are vast and widely dispersed and cannot be controlled by one person sitting in New Delhi. The Secretaries’ support was necessary for the policy change but not sufficient. In the case of the target-free policy in particular, there were conflicts between the union government and the state bureaucracies. Some civil servants were happy to see the targets go because, in some respects, the system coerced them as well as family welfare clients. Moreover, because of its false reports, coercive practices, low quality of care, and unhappy clients, the system was nettlesome to administer.

*The World Bank*

Many Indian population specialists, women’s health advocates, and NGO leaders have strong opinions about the role and impact of foreign experts and international donor agencies. Demographer Ashish Bose (1996, p. 36), for example, blames the onset of what he refers to as ‘targetitis’ on ‘misguided foreign advice’. Other population specialists share Bose’s belief that foreigners played key roles in the development of the target system in India.

Donor influence on national population policies is not unusual. Barrett and Tsui (1999) recently analyzed the US Agency for International Development’s funding of population activities in 114 less developed countries over 20 years and concluded that adopting a population policy increased the likelihood of a country receiving international aid and the amount received. India’s population policy is what Barrett and Tsui describe as a ‘symbolic statement’. The change to a target-free policy was important not only for what it signalled to the international community but also because working on policy reform allowed donors to India’s family welfare programme to send the national government a message about what constituted appropriate population and health policy.

The World Bank played a particularly noteworthy role in the evolution of India’s population policy. The Bank had a long-standing influence on Indian population policy and programmes. The 1958 Coale-Hoover report, which shaped discussions of the relationship between population growth and economic development in India and elsewhere, was funded by the World Bank. Partly because of this report, Bank staff and consultants encouraged Indian officials to try to slow population growth. By the 1960s, according to one account, Bank staff created ‘pressure to accelerate the pace of progress toward reducing the birth rate’ and contributed ‘to the movement to introduce compulsory sterilization in the Indian family planning programme’ (Visaria and Chari 1998, p. 80). Whatever the Bank’s role in the early days of target setting, by the late 1980s the Bank specialists, like many others, had grown disillusioned with the system.

In 1989, World Bank specialist Susan Stout completed a report on the family welfare programme that documented many of the problems that later Bank reports would also highlight. Stout (1989, p. 25) concluded that ‘... the program is being used primarily by those who have already completed their family sizes, and ... has not adjusted the provision of services to meet the needs of younger, lower parity families’. She criticized the emphasis on sterilization, noting that ‘workers perceive that their main job is the provision of sterilization services’ (Stout 1989, p. ix). According to Stout, this preoccupation with permanent methods meant that less attention was paid to spacing methods and to the provision of maternal and child health (MCH) services. Stout (1989, pp. 49–50) noted that the sterilization programme’s impact was less than anticipated or hoped for because of the old age and relatively high parity of acceptors.

Because of objections from Indian officials, Stout’s analysis of the problems with the family welfare programme was never published officially by the Bank. But it was read within the Bank by those concerned about population issues in India, including those who worked on World Bank loans to support India’s family welfare programme. Anthony Measham (1999), who led the Bank’s 1994 sector review, notes ‘Our 1995 report did not say a lot more than Susan [Stout] did but our work had more impact because there was a growing consensus; the work was done more collaboratively; and the Bank pushed harder’.

World Bank acquiescence in the use of acceptor targets continued even after Stout’s report. But Bank staff were steadily growing less willing to
underwrite a family planning programme based on targets. Bank experts were concerned about the effects of targets on the pattern of contraceptive use, especially the dominance of sterilization in the method mix and the apparent slowing in the growth of new contraceptive acceptors. In 1994, the Bank’s Board of Governors approved a ninth population project for India. The project provided funds for state-level family welfare activities but, according to one Bank staff member, the project supported ‘a blatant spoils system’ among local officials. Senior Bank staff made it clear to Indian officials that future loans would require a comprehensive sector review. According to Measham (1999), ‘They were not happy but went along’.

The Ministry of Health and Family Welfare wanted a tenth World Bank project and so was prepared to work with Bank staff and consultants on a sector review. Such a review began in mid-1994, a few months before the International Conference on Population and Development (ICPD) but following the Swaminathan report and well into the pre-conference process that brought together women's health advocates, NGO leaders, and scholars to discuss, and in many cases to lobby for, a new target-free population policy. Senior Bank staff in New Delhi and Washington who were specialists in population policy, family planning, and reproductive health oversaw the Bank’s work and assisted with the policy evaluation and reformulation.

The Programme of Action endorsed by the Indian government and agreed at the ICPD meeting in Cairo enabled the Bank staff to say that, based on changes in the field and the Programme of Action, it was necessary to re-think the implementation of the family welfare programme. Bank personnel encouraged discussions of the target-setting system and its consequences, among other donors, representatives of government, women's groups, and NGOs. In November 1994, one month after the International Conference on Population and Development, a joint Government of India-World Bank mission recommended a new target-free population policy and promised funds to help support it (Pachauri 1999, p. xiv). India accepted the key elements of the proposed policy. Although Bank officials insist there was no quid pro quo regarding the amount or type of assistance, India eventually received US$ 250 million over five years from the World Bank for a tenth population project. Not all donors agreed with the Bank’s reformist agenda. Some senior staff at the US Agency for International Development in New Delhi worried that removing targets would cause serious problems, even though the system had problems of its own.

Observers disagree about the effect of various World Bank reports, missions, and meetings on India’s population policy and family welfare programme. One Indian expert (Khan 1999) argues that the donors’ influence was decisive, but other analysts seem less certain. According to Visaria and Chari, ‘The possibility of external assistance from the World Bank and other donor agencies … might have helped the shift in policy, although by early 1996, the foreign exchange reserves of India were large enough to limit the need to alter specific policies for extraneous reasons’ (1998, p. 104). But a page later, they modify their conclusion: ‘The willingness of the World Bank and other donors to provide substantial sums of money … is also expected to help change policymakers’ approach to population-related issues’.

The Ford Foundation was another influential donor. The foundation and other international donors supported research by Indian academics and advocacy by staff from NGOs showing the problems of India’s family planning programme. International donors also supported a network of women’s NGOs and encouraged the NGO-government dialogue (Keesbury 2000, pp. 12–13). The US Agency for International Development (USAID) paid for the National Family Health Survey, the results of which were crucial in encouraging changes in fertility and health policy. USAID also provided funding for Population Council staff to participate in the population sector review. The United Nations Population Fund (UNFPA) also supported many of these initiatives. So did other donors, including the British, the Dutch, and the Scandinavians.

The influence of the donors – especially the World Bank – was significant but not overwhelming. India’s population policy changed because a variety of factors encouraged the change. The donors were pushing for policy reform along the same lines that many women’s health advocates and demographers had been urging and that senior government bureaucrats had become convinced was appropriate. So the donors’ arguments (and, no doubt, occasional threats) fell on fertile ground. But for them to be effective, senior Indian policymakers and programme managers had to accept and act on the donors’ point of view.

The International Conference on Population and Development

The fifth element that played a role in moving India to a target-free policy was the United Nations
sponsored International Conference on Population and Development (ICPD), which was held in Cairo in October 1994. At the ICPD, representatives of 180 countries agreed that population policies should address social development beyond family planning, especially the advancement of women, and that the family planning services should be provided in the context of comprehensive reproductive health care (Ashford and Makinson 1999, p. 6).

The ICPD was what Jeremy Shiffman (2000, p. 6) calls an ‘attention-generating focusing event’ that influenced the priority that the target issue had on a national policy agenda. According to Shiffman, ‘[t]hese ... large-scale happenings such as crises, conferences, accidents, disasters and discoveries ... attract broad notice from wide audiences. They ... draw attention to issues previously hidden and [raise] them high on the forum of visibility. ... [T]he occurrence of such events leads to heavy media coverage, interest group mobilization, policy community interest, and policy-maker interest, causing shifts in national issues agendas’. Shiffman (2000, p. 7) comments on the global impact of the ICPD, noting that ‘there was a significant and concentrated shift in global attention during and just after the conference ... and that is to be attributed to the power of the ICPD as a focusing event’. The conference documents and presentations crystallized a huge amount of scientific research, policy analysis, and issue advocacy that preceded the meeting. In India, the ICPD provided a rationale and occasions (especially in pre-conference workshops and reports) for critics of the family welfare programme in general, and of the target-setting system in particular, to discuss their opposition and to lobby for a new policy. A second important aspect of the ICPD and another reason for its influence was that participants at the ICPD agreed with the prevailing diagnosis that target systems had serious problems that needed to be remedied. This added the force of international opinion to domestic Indian efforts, to reform the system.

The most comprehensive and even-handed reviews of the ICPD cite the importance of the movement away from targets as a part of the ICPD’s impact (Ashford 1995, p. 7; McIntosh and Finkle 1995, p. 227). Farrell, Agarwal, and Cross (1998, p. 7) conclude that ‘[o]ne of the most significant contributions from Cairo has been the impetus and international support for eliminating method-specific targets, especially for female sterilization procedures’. The ICPD Programme of Action (United Nations 1994, Paragraph 7.12) noted that ‘demographic goals, while legitimately the subject of government development strategies, should not be imposed on family planning providers in the form of targets or quotas for the recruitment of clients’.

ICPD-related meetings were also occasions to test new ideas about how to argue against the target system. The international meetings showed Indian delegates that concern about acceptor targets and about promoting a more comprehensive reproductive health orientation were on the population policy agenda internationally as well as domestically. One observer (Pachauri 1998) notes that, ‘Whoever went to Cairo came home convinced that change was necessary’. The ICPD and the UN sponsored preparatory meetings held in preparation for it (known as ‘prep-coms’) legitimized the concerns about target-setting in India expressed by those who wished to change the family welfare system. The ICPD Programme of Action, agreed by all the national delegates, endorsed the perspective of the World Bank reports on India, and implied that donors were ready to accept and support the policy changes that were underway.

DISCUSSION

The five factors examined above might be called the ‘proximate determinants’ of the abandonment of the target-setting policy. Other factors set the stage for this change. Among the most influential of these background factors was India’s 1976 political crisis when Prime Minister Indira Gandhi declared emergency rule and suspended normal democratic procedures. At the time, her son, Sanjay, was a powerful political figure, deeply committed to slowing population growth. He exhibited ‘a vastly greater emphasis on family planning than ever before demonstrated by a top level political leader’ (Gwatkin 1979, p. 35). According to Conly and Camp (1992, p. 7), '[Sanjay Gandhi] encouraged state governments to mobilize their entire administrative machinery to carry out family planning activities. In the restrictive political climate, overzealous family planning workers, anxious to achieve their targets, resorted to a variety of unethical practices. Aggressive harassment to undergo sterilization became widespread. ... Over 1.7 million sterilizations were performed in the month of September 1977 alone – a number equivalent to the annual average for the previous 10 years. But public anger against the sterilization drive was mounting. Anti-family planning demonstrations and riots flared, especially in conservative Muslim areas. Finally, the Indian public rebelled, rejecting Mrs. Gandhi’s government in the 1977 general election’.
The events of the Emergency had a significant impact on the attitudes of Indian politicians, government bureaucrats, and the public. The aggressive, often coercive, campaigns that took place during the Emergency showed the dangers of target setting and of the dominance of one contraceptive method in the national programme. One well informed observer has noted that during the Emergency, ‘to get numbers, all quality and respect for people was sacrificed’ (Pachauri 1998).

The Emergency weakened political support for family planning and increased the political risks of supporting the government’s growth reduction and family planning policies. Commitment to the target system was never again as high as it had been before the Emergency.

Almost everyone mentions the impact of the Emergency when discussing changes in the policy of target setting. More than 20 years after the Emergency, the first paragraph of the Ministry of Health and Family Welfare’s description of its ‘Reproductive and Child Health Programme’ notes that ‘[d]uring the seventies, the Family Planning Programme was focused mainly on terminal methods and the Programme received a setback due to rigid implementation of a target based approach’ (Department of Family Welfare 1997, p. 1).

Another important background influence was declining fertility in India. Over the past 25 years, there have been significant declines in fertility and infant mortality. At the same time, there have been increases in female literacy and school enrollment. Mass media and new ideas have spread and more effective public health campaigns have been implemented (Visaria and Chari 1998, pp. 75–76).

Thirty years ago, rapid population growth was seen as a paramount issue, and at the time of the Emergency, a decisive factor in India’s welfare. But by the mid-1990s, India’s ability to feed its population and the fact that fertility had declined, substantially so in the southern states, lessened people’s concern with population growth and probably diminished their willingness to accept the contraceptive targets. These attitudes were consonant with a shift in international opinion towards a view that still saw slowing population growth as an important goal, but one that was by no means as important as it had been from 1960 to 1990.

Another feature of the process of policy change was the absence of a large number of outspoken advocates of the target-setting system. Some donors and some senior bureaucrats were unsupportive of the policy change because they worried that removal of the targets would mean less attention to family planning without any increase in the quality of services. But they did not campaign vigorously against the change.

**Impact of the new policy**

The Indian government’s conclusion is that the movement to a target-free system ‘has resulted in a major shift in the programme with a focus on decentralised, need-based, participatory planning and monitoring systems which emphasises the quality of care and delivery of essential health services’ (Chaturvedi 1999, p. 3).

In fact the data and research required to evaluate properly all the effects of the change in India’s target system are not yet available. There is considerable diversity among states in the implementation of the target-free policy, which makes it difficult to judge overall impact. One review of the early stages of the implementation of the target-free approach found that targets remained in some states (Andhra Pradesh, for example) and were re-instated in some districts of other states; Maharashtra, Gujarat, and Uttar Pradesh were cited (Khan and Townsend 1998, pp. 8–9). A report of the Ministry of Health and Family Welfare (1997–98, p. 81) noted that ‘After the withdrawal of targets for individual contraceptives … performance levels … had fallen substantially in 1996–97. Partly it was because the cause for over-reporting … to show the fulfillment of targets was no longer there and partly withdrawal of targets temporarily led to feeling of complacency in some states. The mechanism of determining local needs … and … meeting such needs … has reversed the trend and contraceptive use is on the increase again in 1997–98’.

A more recent report, prepared for a five year review of the International Conference on Population and Development, notes the early impact of the policy change and the variations among states in implementation of the policy (Ministry of Health and Family Welfare 1999, p. 25). Farrell, Agarwal, and Cross (1998, p. 17) conclude that ‘since the 1994 ICPD, India has made progress in moving away from a demographically targeted and single-method family planning programme to an approach focused on clients and their individual choices’. But they note (1998, p. 20) ‘implementation – as often is the case – has suffered from inadequate planning and therefore has lagged’.

While initially acceptance of contraception probably fell somewhat throughout much of India, the available evidence suggests that fertility has continued to decline. Townsend and Khan (1999) report that the fall in contraceptive acceptance did
not lead to a marked reduction in the pace of the fertility decline underway in India. Data from a second round of the National Family Health Survey conducted in 1998–99 confirm that fertility has continued to decline and contraceptive use has continued to increase (IIPS 2000, p. 6; Population Reference Bureau 2000). A new system of local assessments of reproductive health needs and ‘client segmentation’ is being put into practice. Despite the evidence of widespread unmet need, the perception of many family welfare staff (and of many other people) is that men, women, and their families need to be persuaded to accept particular methods. Many family planning workers apparently continue to believe that there is a need to recruit new acceptors (that unmet need is lower than the NFHS data indicate) and that permanent methods should be promoted. Some informants speak of the end of ‘top-down’ and the emergence of ‘bottom-up’ targets. While the choice of methods has increased, to date there is very little evidence about other aspects of the quality of family planning and reproductive health services, such as counselling, follow-up services, or improvements in the way programme personnel deal with clients. These shortcomings are not related to the new policy, but to a low level of training, a lack of resources, low motivation, resistance to change, and a lack of administrative support.

Reducing population growth also remains a concern in some circles in India. The 30-year history of India’s previous population policy means that support for using the family welfare programme to lower fertility as a means of slowing population growth lingers within the bureaucracy and outside. Numerical targets remain in some places, often because senior health workers and programme administrators fear that, without targets, lower level workers ‘would have no motivation ... to get anyone to use contraception’ (Van Hollen 1998, p. 104). One Ministry of Health and Family Welfare report reminds readers that ‘population goals remain the same as before ... targets from above [were] withdrawn ...’ (Department of Family Welfare 1998, p. 12). The vulnerability of the new policy is evident on the walls of the Ministry of Health and Family Welfare headquarters in New Delhi. After the target-free policy was announced, former Minister of Health and Family Welfare, Renuka Chaudhury, had signs installed that said: ‘One is fun. Population control’. The popular media also provide reports of continuing enthusiasm for targets and sterilization among state leaders (Dugger 2001).

Potter’s (1999, p. 730) description of the situation in Mexico and Brazil has parallels in India: ‘These efforts involve large institutions, many thousands of professionals practicing in thousands of localities, and a health bureaucracy that is now largely decentralized to the state level. Change in the nature and quality of the services is likely to be difficult. Some of the more objectionable practices ... have been controlled by way of strongly worded administrative directives, but the way the programs relate to their clients may well prove more resistant to change’. Hull and Iskandar (2000, p. 89) provide an account of the changing target system in Indonesia that also has many parallels to the Indian experience.

India’s latest population policy statement is another, more important, sign of the country’s continuing concern with population growth and the assumption that fertility remains high because many couples, especially among the poor, want large families. The National Population Policy 2000 recently adopted by the Cabinet embodies the enduring focus on population growth (USAID 2000). The policy freezes the number of representatives in the lower house of the Indian parliament at levels that were set in 1971, so as not to reward the faster growing states with a larger number of votes. The policy also included ‘promotional and motivational measures for adoption of the small family norm’ (Department of Family Welfare 2000, p. 11 and p. 13). The measures include incentives for poor women who marry after age 18, health insurance for those sterilized after their second child, and cash incentives for female children (to reduce infanticide). Although the policy endorses the target-free approach, it is possible that enthusiasm for targets could re-emerge, especially for their use in the rapidly growing northern states. Acceptor targets could be used again, perhaps on the ground that they were useful mechanisms to promote more effective implementation of India’s population policy.

That said, the change in target-setting policy is characteristic of other changes in public policy that have taken place in India over the past several years. The new, more open, economic policy is another example. As in the case of the target system, the change in economic policy was an Indian government initiative, but was influenced by data on the probable impact of such a policy shift, by private sector leaders eager to lessen the central government’s role in economic planning and coordination, and by the foreign business community and the international monetary institutions. The fact that changes toward a more decentralized system are underway in other sectors...
of Indian social and economic life reinforces the target-free policy and makes its reversal less likely.

NOTES

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